MEDICARE RIGHTS CENTER Getting Medicare right | SHIP State Health Insurance Assistance Program Navigating Medicare | SMP Senior Medicare Patrol

Medicare Minute Teaching Materials — March 2022
Medicare Coverage of Preventive Services

1. What are the costs associated with preventive care?

Preventive care is the care you receive to prevent illness, detect medical conditions, and keep you healthy. If you meet the eligibility requirements and guidelines for a preventive service, Part B of Original Medicare or your Medicare Advantage Plan must cover that service. Under Original Medicare, you owe nothing (no deductible or coinsurance) for preventive services recommended by the U.S. Preventive Services Task Force if you see a health care provider who takes assignment. If you have a Medicare Advantage Plan you owe nothing for those services, as long as you see an in-network provider.

In some cases, you may be charged for services you receive related to your preventive service, even if the preventive service itself is covered at 100% of the Medicare-approved amount. During the course of your preventive visit, your provider may discover and need to investigate or treat a new or existing problem. This additional care may be diagnostic, meaning your provider is treating you because of certain symptoms or risk factors. You may be responsible for cost sharing related to any diagnostic care you receive, even during a preventive visit. You also may be responsible for paying a facility fee, depending on where you receive the service.

2. How is preventive care different from diagnostic care?

A service is considered preventive if you have no prior symptoms of the disease. For example, a colonoscopy would be considered preventive care for an individual who has no prior signs of colon cancer or suspected polyps. In some cases, Medicare only covers preventive care services if you have certain risk factors. In contrast, diagnostic services address symptoms or conditions that you already have. Many preventive services are provided alongside care that is diagnostic or alongside other health care services. The classification of services as preventive versus diagnostic is important because it affects your out-of-pocket costs. You typically owe a copay, coinsurance, and/or deductible for diagnostic services. For example, the Annual Wellness Visit is a Medicare-covered preventive service, and no cost-sharing applies. However, if your provider investigates or treats a symptom you are experiencing during your Annual Wellness Visit, this additional care is not part of the Annual Wellness Visit and cost-sharing—like a coinsurance or copay—will apply.

3. How do I know which preventive services Medicare covers?

To find out if Medicare covers your test, service, or item you can visit Medicare.gov's page on Preventive & Screening Services, call 1-800-MEDICARE (1-800-633-4227), or read your 2022 *Medicare & You* handbook. You can also contact your State Health Insurance Assistance Program (SHIP) to learn more about preventive services. Contact information for your local SHIP is on the last page of this document.

Some examples of Medicare-covered preventive services include:

- Pap smears, pelvic exams, and breast exams
- Colorectal cancer screenings (such as colonoscopies)
- Mammogram screenings
- Prostate cancer screenings

- Bone mass measurements
- Medical nutrition therapy
- HIV screenings
- Depression screenings
- Diabetes screenings

4. What is the Welcome to Medicare preventive visit?
The Welcome to Medicare preventive visit is a one-time appointment you can choose to receive when you are new to Medicare. The aim of the visit is to promote general health and help prevent diseases. Medicare Part B covers your one-time Welcome to Medicare preventive visit, and you must receive this visit within the first 12 months of your Part B enrollment. The Welcome to Medicare preventive visit is not a head-to-toe physical.

During the course of your Welcome to Medicare preventive visit, your provider should:
- Check your height, weight, blood pressure, body mass index (BMI), and vision
- Review your medical and social history
- Review your potential for depression and other mental health conditions
- Review your ability to function safely in the home and community
- Provide you with education, counseling, and referrals related to your risk factors and other health needs
- Give you a checklist and/or written plan with information about other preventive services you may need

5. What is the Annual Wellness Visit?
The Annual Wellness Visit (AWV) is a yearly appointment with your primary care provider (PCP) to create or update a personalized prevention plan. This plan may help prevent illness based on your current health and risk factors. Keep in mind that the AWV is not a head-to-toe physical. Also, this service is similar to but separate from the one-time Welcome to Medicare preventive visit (see question 4). Medicare Part B covers the Annual Wellness Visit if you have had Part B for over 12 months and you have not received an AWV in the past 12 months. Additionally, you cannot receive your AWV within the same year as your Welcome to Medicare preventive visit.

During your first Annual Wellness Visit, your PCP will develop your personalized prevention plan. Your PCP may also:
- Check your height, weight, blood pressure, and other routine measurements.
- Give you a health risk assessment.
    - This may include a questionnaire that you complete before or during the visit. The questionnaire asks about your health status, injury risks, behavioral risks, and urgent health needs.
- Review your functional ability and level of safety.
    - This includes screening for hearing impairments and your risk of falling.
    - Your doctor must also assess your ability to perform activities of daily living (such as bathing and dressing), and your level of safety at home.
- Learn about your medical and family history.
- Make a list of your current providers, durable medical equipment (DME) suppliers, and medications

- Medications include prescription medications, as well as vitamins and supplements you may take.
- Create or update a written 5-10 year screening schedule or check-list.
  - Your PCP should keep in mind your health status, screening history, and eligibility for age-appropriate, Medicare-covered preventive services.
- Screen for cognitive impairment, including diseases such as Alzheimer's and other forms of dementia.
  - Medicare does not require that doctors use a test to screen you. Instead, doctors are asked to rely on their observations and/or on reports by you and others.
- Screen for depression.
- Provide health advice and referrals to health education and/or preventive counseling services aimed at reducing identified risk factors and promoting wellness.
  - Health education and preventive counseling may relate to weight loss, physical activity, smoking cessation, fall prevention, nutrition, and more.

AWVs after your first visit may be different. At subsequent AWVs, your doctor should:

- Check your weight and blood pressure
- Update the health risk assessment you completed
- Update your medical and family history
- Update your list of current medical providers and suppliers
- Update your written screening schedule
- Screen for cognitive issues
- Provide health advice and referrals to health education and/or preventive counseling services

6. What kinds of cancer screenings are covered by Medicare with no cost-sharing?
Medicare covers preventive screenings for several kinds of cancer at 100% of the Medicare-approved amount, meaning that if you meet the eligibility requirements, you will not have to pay anything (no deductible nor coinsurance). If you receive diagnostic screenings, or if, during the course of a screening, your provider discovers and needs to treat a new or existing problem, charges will most likely apply to your visit. The following screenings are covered with no cost-sharing except where otherwise indicated:

- **Colorectal cancer screenings**: Medicare Part B covers different colorectal cancer screenings, each with separate eligibility requirements. Note that you may be at high risk for colorectal cancer if you have a family history of the disease, have had colorectal cancer or colorectal polyps, or if you have had an inflammatory bowel disease.
  - Fecal occult blood test: Once a year (every 12 months) if you are age 50+
  - Flexible sigmoidoscopy: Once every four years (48 months) if you are age 50+ and at high risk, or once every 10 years after a colonoscopy if you are age 50+ and not at high risk
  - Colonoscopy: Once every two years (24 months) if you are at high risk for colorectal cancer, or once every 10 years if you are not at high risk (but not within 48 months of a screening flexible sigmoidoscopy)
  - Barium enema: Once every two years if you are age 50+ and at high risk, or once every four years if you are age 50+ and not at high risk (but not within 48 months of a screening flexible sigmoidoscopy). Barium enemas are covered at 80% of the Medicare-approved amount

- Multi-target stool DNA tests: Once every three years if you are age 50-85, show no symptoms of colorectal disease, and are not at high risk for developing colorectal cancer
- Blood-based biomarker tests: Once every three years if you are age 50-85, show no symptoms of colorectal disease, and are not at high risk for developing colorectal cancer

- **Lung cancer screenings**: Medicare Part B covers a yearly lung cancer screening and a yearly Low Dose Computed Tomography (LDCT, also called low-dose CT) chest scan for people with certain risk factors. Before your first LDCT scan, you must have a visit with your primary care provider (PCP) to discuss the benefits and risks of the scan. Your PCP will also provide counseling on the importance of quitting or avoiding smoking and information about smoking cessation services when appropriate. After your first scan, a separate counseling visit is not required before you receive your annual LDCT. Medicare Part B will only cover these services if you:
  - Are 55-77 years old
  - Currently smoke or have quit smoking in the past 15 years
  - Have smoked an average of one pack per day for at least 30 years
  - Have no symptoms of lung cancer
  - And, receive the screening and LDCT at a Medicare-approved radiology facility

- **Mammograms**: If you do not have symptoms or a prior history of breast cancer, Medicare Part B covers preventive mammograms—one baseline mammogram for women 35-39 years old, and one screening mammogram every 12 months for women over 40 years old. Medicare does not cover preventive mammograms for men. Medicare does cover diagnostic mammograms for everyone. Your doctor might recommend a diagnostic mammogram if your screening shows an abnormality or if a physical exam reveals a lump. Medicare covers as many diagnostic mammograms as necessary, but they are covered at 80% of the Medicare-approved amount, while preventive mammograms are covered at 100% of the Medicare-approved amount.

- **Pap smears, pelvic exams, and physical breast exams**: Pap smears can detect cervical or vaginal cancer in its early stages. They can also screen for sexually transmitted diseases, fibroids, and various types of genital and vaginal problems including cancer. The pelvic exam includes a breast/chest examination, which can help detect signs of breast/chest cancer. Medicare covers these services every 24 months. You may be eligible for these screenings every 12 months if you are at a high risk for cervical or vaginal cancer or if you are of childbearing age and have had an abnormal Pap smear in the last 36 months. Medicare may consider you at a high risk for cervical or vaginal cancer if:
  - You were sexually active before age 16
  - You have had five or more sexual partners
  - You have had a sexually transmitted infection (STI)
  - Your parent/mother was given the drug diethylstilbestrol (DES) during pregnancy
  - You have received fewer than three negative Pap tests or no Pap smear within the past seven years.

- **Prostate cancer screenings**: Medicare Part B covers one annual prostate cancer screening for individuals age 50+. The prostate screening includes a digital rectal exam (DRE) and a prostate-specific antigen (PSA) test.

Note: Some cancer screenings and other services are associated with specific genders in Medicare materials and rules but are covered regardless of the gender marker in your Social Security record, as long as the screening is clinically appropriate for you. Medicare has specific billing modifiers that your provider should use when submitting claims for services when the gender marker on your Social Security record could cause an incorrect coverage denial.

7. What are depression screenings?

Depression is a mental health condition that affects mood. Depression screenings should be conducted by your primary care provider (PCP) or another trusted health professional to ensure that you are correctly diagnosed and treated. Medicare Part B covers an annual depression screening. You do not need to show signs or symptoms of depression to qualify for screening. However, the screening must take place in a primary care setting, like a doctor's office. This means Medicare will not cover your screening if it takes place in an emergency room, skilled nursing facility (SNF), or hospital.

The annual depression screening includes a questionnaire that you complete yourself or with the help of your doctor. This questionnaire is designed to indicate if you are at risk or have symptoms of depression. If your results show that you may be at risk of depression, your provider will perform a thorough assessment and will refer you for follow-up mental health care if appropriate. In most cases, you should receive your depression screening when you have a scheduled doctor's office visit. However, your provider can choose to screen you during a separate visit.

Note: Your provider is required to review your potential for depression and other mental health conditions during your Welcome to Medicare Visit (see question 4) and your first Annual Wellness Visit (see question 5). However, your provider is not required to formally screen you for depression during either visit. During a review, your provider should discuss your risk factors for depression, such as a family history, but you will not receive a screening questionnaire.

8. What rules must I follow for Part B-covered vaccines that are considered preventive services?

Part D covers many vaccines and immunizations. However, there are certain vaccinations that are covered by Part B:

- **Flu shot:** Medicare Part B covers one flu shot every flu season. The flu season usually runs from November through April. Depending on when you choose to get your flu shot, Medicare may cover a flu shot twice in one calendar year. For example, if you got a shot in January 2022 for the 2021/2022 flu season, you could get another shot in November 2022 for the 2022/2023 flu season.

- **Pneumonia shot**: Medicare Part B covers two separate pneumonia shots. Currently there are two separate pneumonia vaccines available. Part B covers the first shot if you have never received Part B coverage for a pneumonia shot before. You are covered for a different, second vaccination one year after receiving the first shot. You are not required to provide a vaccination history when receiving the pneumonia vaccine. You can tell the health care professional administering the shot if/when you have received past shots.

- **Hepatitis B shot**: Medicare Part B covers hepatitis B vaccination if you are at medium or high risk for hepatitis B. If you are at a low risk for hepatitis B, the shot will be covered under Part D, the Medicare prescription drug benefit. Medicare considers you at medium or high risk if you:
    - Have End-Stage Renal Disease (ESRD)
    - Have hemophilia
    - Are a client of or staff member at an institution that serves people with developmental disabilities
    - Live in the same household as a hepatitis B carrier
    - Have unprotected sex with multiple sex partners or with someone who has hepatitis B
    - Use certain federally prohibited drugs/substances
    - Are a health care professional and you are in frequent contact with blood or other bodily fluids during routine work

- **COVID-19 vaccination:** Original Medicare Part B covers COVID-19 vaccines, regardless of whether you have Original Medicare or a Medicare Advantage Plan. The Food and Drug Administration (FDA) has approved an additional dose of the COVID-19 vaccine or booster for people age 12 or older. The additional dose or booster is covered by Medicare with zero-cost sharing. Speak with your doctor to learn more about getting a third dose or booster.

9. Does Medicare cover COVID-19 tests?
Medicare Part B covers one coronavirus test without an order from a doctor or other qualified health care provider. For other tests, Medicare requires you to get an order from your provider. Original Medicare covers coronavirus testing and associated provider visits at 100% of the Medicare-approved amount when you receive the service from a participating provider. This means you owe nothing (no deductible or coinsurance). Medicare Advantage Plans are required to cover coronavirus testing without applying deductibles, copayments, or coinsurance when you see an in-network provider.

As of January 15, 2022, many people with an individual or group private health plan can go online, or to a pharmacy or store to obtain an at-home over-the-counter COVID-19 diagnostic test authorized by the U.S. Food and Drug Administration (FDA) at no cost through their insurance. Medicare Advantage Plans may, but are not required, to participate. At this time, Original Medicare beneficiaries do not have access to insurance covered home testing, but the Centers for Medicare and Medicaid Services (CMS) announced plans to make over-the-counter COVID-19 tests available to people with Medicare at no cost by early spring. According to the agency, "[u]nder the new initiative, Medicare beneficiaries will be able to access up to eight over-the-counter COVID-19 tests per month for free. Tests will be available through eligible pharmacies and other participating entities." Until the program is in effect, people with Medicare can obtain free tests through the federal website (www.covidtests.gov), community health centers, and Medicare-certified health clinics. For more information and future updates, visit the CMS at-home COVID tests and Medicare FAQ page.

10. What do I do if I think I was inappropriately charged for a service?
If you think you were charged for a preventive service and should not have been, contact your health care provider first. Some providers are not familiar with the full list of Medicare-covered preventive services, and

they may have made a simple mistake due to their lack of knowledge about the benefits. If you are unable to resolve the problem by contacting your health care provider, contact your local SHIP, and a SHIP counselor will help you. (Contact information for your SHIP is on the last page of this document.) You can also contact 1-800-MEDICARE for help.

You may be charged additional fees for certain services related to preventive care. For example:

- You may have costs for part of a preventive care visit if your doctor makes a diagnosis during the visit or conducts additional tests or procedures. Doctors do diagnostic tests and procedures when patients have distinct symptoms of a condition or a history of that condition. For example, if your doctor finds and removes a polyp during a colonoscopy, the colonoscopy is diagnostic care and costs will apply.
- You may owe a facility fee depending on where you receive your preventive care service. For example, certain hospitals will often charge separate facilities fees when you are receiving a preventive service.

If you are in a Medicare Advantage Plan, your plan will not be able to charge you for preventive care services that are free for people with Original Medicare, as long as you see in-network providers. If you see providers that are not in your plan's network, charges will typically apply.

If your health care provider bills Medicare for services you never received, you may be a victim of Medicare fraud or abuse. You can help detect fraud by carefully reviewing your health care statements from Medicare or your Medicare Advantage Plan. Claims summaries and medical bills can be confusing, so it is usually a good idea to ask your provider questions (for example, "Why was I billed for this service?") before reporting activity as fraudulent. If you believe that you have been a victim of fraud or abuse, or if you have additional questions about this, you can contact your local Senior Medicare Patrol (SMP). Contact information for your SMP is on the last page of this document.

11. Who should I contact about Medicare-covered preventive services?

Your doctor or other health care provider: If you would like to schedule an Annual Wellness Visit (AWV), Welcome to Medicare screening, or another kind of preventive service, contact your doctor or health care provider. Additionally, reach out to your doctor or health care provider first if you believe you were inappropriately charged for a preventive service.

State Health Insurance Assistance Program (SHIP): Contact your SHIP if you would like to learn more about how Medicare covers preventive services or if you are confused about why a provider is charging you for preventive care. SHIP counselors are certified and trained to provide individualized, unbiased Medicare information. Contact information for your SHIP is on the last page of this document.

Senior Medicare Patrol (SMP): Contact your SMP if you believe a provider is fraudulently billing you for preventive services. SMPs empower and assist Medicare beneficiaries, their families, and caregivers to prevent, detect, and report health care fraud, errors, and abuse.

1-800-MEDICARE: Medicare answers questions about which preventive services Medicare covers, what eligibility criteria must be met for certain services, and how to find a Medicare-participating provider. You can

call Medicare at 1-800-MEDICARE (800-633-4227) or visit medicare.gov. (If you have a Medicare Advantage Plan, contact your plan to learn about their in-network providers.)

SHIP case Study

Jane has Original Medicare. She goes to get a Pap smear, pelvic exam, and physical breast exam every two years, though she has no symptoms of breast, cervical, or vaginal cancer. During the physical breast exam this year, her doctor noticed something abnormal and told her that she should get a diagnostic mammogram. Jane wants to know what her costs will be for these services.

What should Jane do?

- Jane should contact her SHIP to speak with a counselor who can explain the costs of preventive services more thoroughly.
    - If she doesn't know how to find her SHIP, she can go to www.shiphelp.org or call 877-839-2675 and say "Medicare" when prompted for assistance.
- The SHIP counselor should explain the difference between preventive and diagnostic services. The counselor can tell Jane that her first screening was preventive, meaning that she had no prior symptoms of the disease for which she was being screened. As long as Jane went to a participating provider, she should not owe any cost-sharing for the screening.
- The SHIP counselor can tell Jane that the mammogram is diagnostic, meaning it addresses symptoms or conditions that she already has. Since preventive and diagnostic services are covered differently by Medicare Part B, Jane will likely have to pay nothing for the first screening but will owe normal Medicare cost-sharing for the diagnostic mammogram. Since Jane has Original Medicare, she should expect to have a 20% coinsurance for the diagnostic mammogram.

SMP case study

Esther is 68 years old and enrolled in a Medicare Advantage Plan. This month, she received a bill from her new primary care provider for her Annual Wellness Visit. Esther was confused because she knew that Medicare should cover the full cost of this annual visit, so long as she didn't receive diagnostic care or non-preventive services during it. When Esther contacted her plan, she learned that her visit had been denied because her former primary care provider had already billed Medicare for it. Esther has not visited her former primary care physician at all this year and worries she may be the victim of fraud.

What should Esther do?

- Esther should contact her former primary care provider to see if the office made a billing error.
- If Esther still suspects that her previous doctor's office may have billed Medicare fraudulently, she should contact her SMP for help.
    - If Esther does not know her local SMP's contact information, she can call 877-808-2468 or visit www.smpresource.org.
    - The SMP representative will assist Esther to report her case to the proper authorities and ensure CMS has corrected the error if applicable.

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Local SHIP Contact Information	Local SMP Contact Information
Mesa County RSVP **970-243-9839, ext. 1** **www.mesacountyrsvp.org**	
To find a SHIP in another state: Call 877-839-2675 or visit www.shiphelp.org.	**To find an SMP in another state:** Call 877-808-2468 or visit www.smpresource.org.

SHIP National Technical Assistance Center: 877-839-2675 | www.shiphelp.org | info@shiphelp.org
SMP National Resource Center: 877-808-2468 | www.smpresource.org | info@smpresource.org

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