

Medicare covers many preventive care services without charge. Most of these services have been recommended by the U.S. Preventive Services Task Force. However, which beneficiaries qualify to receive these services and when can be confusing. A synthesized overview of each preventive service is outlined below. Preventive services are covered under Medicare Part B.

Things to Remember

Is the service Preventive or Diagnostic?

Screenings to detect disease are typically considered preventive if the patient has no prior symptoms of the disease. Medicare covers most preventive care free of charge. In some cases, Medicare will only cover these tests if you have certain risk factors. Diagnostic services tend to be those to address symptoms or conditions you already have. You typically need to pay a deductible, copays or coinsurances for diagnostic services.

Medicare Advantage plans cannot charge for preventive care services that are free for people with Original Medicare as long as beneficiaries see in-network providers. If people see providers outside of their plan network, charges will typically apply.

Who Gets What?

Medicare Covered Preventive Services Explained

The Welcome to Medicare Visit versus the Initial Annual Wellness Visit versus the Subsequent Annual Wellness Visits (Distinguishing between Medicare preventive visits)

The Welcome to Medicare Visit is a one-time visit with a physician or other health care provider that must occur within the first 12 months of someone's enrollment into Medicare. This visit is designed to map out your health needs and to help create a preventive service plan or checklist to keep you healthy .

The Annual Wellness Visits (first and subsequent) are similar to but not the same as the Welcome to Medicare visit. The annual wellness visit is a yearly visit with your primary care doctor to create or update a 5-10 year preventive schedule based on your needs.

None of these annual preventive visits is considered a traditional annual head-to-toe physical.

The Welcome to Medicare and the all Annual Wellness Visits should include:

- Medical and family history
- Weight and blood pressure
- Written screening plan or schedule of preventive care
- Health advice and referrals

Outline of the additional services you should expect at each visit:

| Welcome to Medicare (IPPE) | First Annual Wellness Visit | Subsequent Annual Wellness Visits |
|--|--|---|
| | Complete a Health Risk Assessment questionnaire that collects information about your physical and mental health, your personal behavior, and your functional level of safety | Update Health Risk Assessment |
| Referral for Abdominal Aortic Aneurysm (AAA) screening ultrasound | | |
| Medical and family history | Medical and family history | Medical and family history |
| | Create a list of current risk factors and/or conditions and associated current or recommended treatment options) Create list of current providers and suppliers | Update list of current risk factors and/or conditions and associated current or recommended treatment options Update list of current providers and suppliers |
| Creation of a written preventive service checklist based on your needs | Creation of a written 5-10 year preventive screening schedule based on your risk factors and health | Annual updates to your 5 to 10 year preventive care schedule |
| Health advice and referrals to outside services (i.e. weight loss, nutrition and smoking cessation counseling) | Health advice and referrals to outside services (i.e. weight loss, nutrition and smoking cessation counseling) | Health advice and referrals to outside services (i.e. weight loss, nutrition and smoking cessation counseling) |
| | Detect cognitive problems by checking for symptoms of Alzheimer's or dementia | Detect cognitive problems by checking for symptoms of Alzheimer's or dementia |
| Review risk factors for depression and other mental health issues | Review risk factors for depression and other mental health issues | |
| Height, weight, blood pressure, body mass index & vision screening | Height, weight, blood pressure & body mass index screening (no vision specially required) | Weight & blood pressure screening (no height or vision specifically required) |
| Review your functional ability and level of safety | Review your functional ability and level of safety | |
| End of life planning and advance directive discussion | This includes screening for hearing impairments and your risk of falling | |
| Electrocardiogram (EKG) may be included (cost sharing applies) | | |

Note: The initial Annual Wellness Visit cannot happen in the same twelve months as the Welcome to Medicare Visit. Similarly, no Annual Wellness Visit can occur in the same 12 month period as the previous Annual Wellness Visit. You do not have to have had a Welcome to Medicare Visit to be eligible for Annual Wellness Visits.

Services covered at 100 percent by Medicare Part B

Abdominal Aortic Aneurysm (AAA) Screening

Medicare covers this one time screening only for at risk beneficiaries. Beneficiaries are at risk if:
They have a family history of AAA, or,

Are a man age 65 through 75 who has smoked 100 or more cigarettes in his lifetime. AAA screening only covered as referral from Welcome to Medicare Visit and if you were never screened for AAA before.

Alcohol Misuse Screening and Counseling

Medicare covers annual screenings to reduce alcohol misuse at 100 percent for all beneficiaries. A beneficiary is misusing alcohol if they have drinking habits that go beyond recommended levels but they are not yet considered alcohol dependent (and “alcoholic”)

Someone is considered to be misusing alcohol if they are a:

- Woman under the age of 65 who has more than three drinks at a time or seven drinks per week
- Man under the age of 65 who has more than four drinks at a time or 14 drinks per week
- Anyone over the age of 65 who has more than three drinks at a time or seven drinks per week

If someone with Medicare is thought to be misusing alcohol by their primary care physician, Medicare will pay in full for four, brief counseling sessions given by the same primary care provider in a primary care setting

Bone Mass Measurements

Medicare covers a bone density measurement test every two years for those at risk for osteoporosis if they:

- Are an estrogen-deficient woman
- Have vertebral abnormalities that were shown on an x-ray
- Have received daily steroid treatments for more than three months
- Have hyperparathyroidism
- Take an osteoporosis drug

Cardiovascular Risk Reduction Visit

All Medicare beneficiaries are eligible for this annual screening

During this visit, doctors should:

- Encourage aspirin use for all men ages 45-79 and for all women ages 55-79 if the health benefits outweigh the risks
- Screen for high blood pressure for all adults age 18 years and older
- Provide behavioral counseling and tips to encourage a healthy diet for people with Medicare

Colorectal Cancer Screenings

Medicare covers the following screenings for people 50 and over

Note: There is no minimum age requirement for colonoscopies

Fecal occult blood test: once a year

Flexible sigmoidoscopy: once every four years (48 months) but not within 120 months (10 years) of a screening colonoscopy for people not at high risk for colon cancer

Colonoscopy: Medicare covers colonoscopies once every 10 years but not within 48 months of a screening flexible sigmoidoscopy

Colonoscopies are covered once every two years (24 months) if you are at high risk* for colorectal cancer

Services covered at 100 percent by Medicare Part B —cont.

If a colon cancer screening becomes diagnostic, costs will apply. For example, if a doctor finds and removes a polyp during the procedure.

*High risk means a patient has a family history of the disease, have had colorectal polyps, colorectal cancer, or have had inflammatory bowel disease

Note: A sigmoidoscopy is similar to a colonoscopy. A sigmoidoscopy examines up to the sigmoid (a part of the colon) while colonoscopy examines the whole large bowel. There are two different kinds of sigmoidoscopies, a flexible and a rigid, depending on the type of camera used. Only flexible sigmoidoscopies are covered at 100 percent by Medicare.

Depression Screenings

Covered annually for all Medicare beneficiaries

Must be performed in a primary care setting

The annual depression screening will typically include a questionnaire completed by patient and or with the help of your primary care provider

If the screening finds symptoms of depression, the primary care provider will provide treatment or refer the beneficiaries to specialists (psychologists, psychiatrists, social worker, etc.)

Most mental health services are covered at 60 percent by Medicare after someone has met their Part B deductible

Diabetes screening

Medicare covers the full cost of diabetes screenings either once or twice a year

Once a year for people who:

Have hypertension;

Have dyslipidemia (any kind of cholesterol problem);

Have a prior blood test showing low glucose (sugar) tolerance;

Are obese (body mass index of 30 or more);

OR for people who meet at least two of the following:

are overweight (body mass index between 25 and 30);

have a family history of diabetes;

have a history of diabetes during pregnancy (gestational diabetes);

have had a baby over nine pounds;

are 65 years of age or older.

Twice a year for people who have been diagnosed with pre-diabetes

Services covered at 100 percent by Medicare Part B —cont.

HIV Screening

Medicare covers the full cost of yearly HIV lab test screenings for everyone with Medicare once every 12 months or up to three times during a pregnancy

Heart Disease Screening Lab Tests

For all beneficiaries Medicare covers blood tests **every five years** to test for:

Cholesterol,
Lipid, lipoprotein **and**
Triglyceride levels

Screening Mammograms

Medicare covers one baseline screening for all women 35-39 years of age

All women with Medicare are eligible for an annual screening at no cost after they turn 40

Cost sharing applies to all diagnostic mammograms

Both men and women with Medicare who are referred for diagnostic mammograms (as the result of an abnormal screening mammogram or physical breast exam) are subject to a 20 percent Medicare coinsurance or copayment after the Part B deductible

Medical Nutrition Therapy

Medicare covers medical nutrition therapy, which may include dietary counseling for people with diabetes and other chronic diseases so they may better manage their illnesses

With a doctor's referral, medical nutrition therapy is covered by Medicare for people:

With diabetes
With chronic renal disease
Who have had a kidney transplant in the past three years

Three hours of medical nutritional therapy for the first year and **two hours** every year thereafter.

More hours are covered if your doctor says you need them

In order to have Medicare cover them, you must get these services from a registered dietitian or other qualified nutrition professional

Obesity Screening and Counseling

Medicare covers screening and counseling from a primary care provider in a primary care setting to help beneficiaries who are obese lose weight

Someone is obese if they have a Body Mass Index (BMI) of 30 or more

If a beneficiary is obese, they qualify for counseling therapy

Counseling therapy consists of

One face-to-face visit every week for the first month;
One face-to-face visit every other week during months 2-6;
One face-to-face visit every month during months 7-12, if the beneficiary loses 6.6 lbs after the first six months

Services covered at 100 percent by Medicare Part B —cont.

Pap Smears, Pelvic Exams and Breast Exams

For women with Medicare who are considered **low risk** for vaginal or cervical cancer Medicare covers 100 percent of a Pap smear, Pelvic exam and breast exam every **two years**

Medicare will cover **one** Pap smear, Pelvic exam and breast exam **per year** if someone is at high risk for cervical or vaginal cancer and for women who are of childbearing age and have had an abnormal Pap smear in the past 36 months

Women who are considered at **high risk** for cervical or vaginal cancer:

- They were active sexually early (under 16 years of age)
- They have had multiple sexual partners (5 or more)
- They have had a sexually transmitted disease
- Their mother was given the drug diethylstilbestrol (DES) during pregnancy
- They smoke
- They have received fewer than three negative pap tests or no pap test during the past 7 years
- They have used birth control pills for an extended period of time (5 years or more)

Prostate Cancer Screenings

Medicare covers 100 percent of the cost of an annual **Prostate-Specific Antigen (PSA)** blood test for all male beneficiaries who are 50 years old and over once every 12 months

If someone needs these services more than once a year, the exams are considered diagnostic and cost sharing applies

Sexually Transmitted Infection (STI) Screening

Medicare will only pay for STI testing and counseling if the beneficiary is pregnant and/or considered high risk for an STI

Medicare covers up to two individual 20 to 30 minute, face-to-face counseling sessions annually for sexually active teenagers and adults at increased risk for STIs provided by a primary care provider in a primary care setting

Beneficiaries are considered at increased risk if they:

- Have had multiple sex partners
- Use condoms inconsistently
- Have sex under the influence of alcohol or drugs
- Have sex in exchange for money or drugs
- Are a woman who is 24 years old or younger and sexually active (chlamydia & gonorrhea only)
- Have had an STI within the past year
- Have engaged in IV drug use (for hepatitis B only)
- Are a man who has sex with men and engages in high risk sexual behavior, regardless of your age

Each specific STI test is covered differently for different people & has complicated rules

All tests will be performed on pregnant women in certain situations (MedicareInteractive.org for details)

All tests except Hepatitis B are also covered for people at increased risk

- Chlamydia & gonorrhea: Annually if you are a woman at increased risk
- Syphilis: Annually if you are a man or woman at increased risk
- Hepatitis B: first prenatal visit of all pregnant beneficiaries only

Services covered at 100 percent by Medicare Part B —cont.

Smoking Cessation

Medicare covers two counseling attempts at quitting smoking per year at 100 percent

Each attempt includes four sessions

Medicare will cover a total of eight sessions every 12 months

No cost sharing for smoking cessation counseling if you have not been diagnosed with an illness that is caused or complicated by smoking and you see a Medicare-recognized doctor or other health care provider

Medicare also covers smoking cessation counseling for those people with Medicare who have been diagnosed with a disease or condition caused by smoking

In this case, Medicare will pay 80 percent of the approved amount for smoking cessation counseling after the deductible is met

Vaccines and Immunizations

Flu shots

Medicare covers the full cost of a flu shot **once every flu season** for everyone with Medicare

The flu season usually runs from November through April. Therefore, Medicare may cover a flu shot twice in one calendar year.

Pneumonia shots

Medicare will cover the full cost of a pneumonia shot **once in a lifetime** for everyone with Medicare

If someone is at high risk Medicare will cover more frequent vaccinations

You are at high risk if you have:

No spleen or a spleen that does not function properly (e.g., from sickle cell disease)

Human Immunodeficiency Virus (HIV)

Leukemia

Lymphoma

Hodgkin's disease

Multiple myeloma

Generalized malignancy

Chronic renal failure

Nephrotic syndrome

Other conditions associated with immunosuppression

Hepatitis B

Covered at 100 percent for people at medium to high risk for hepatitis B:

Those with End-Stage Renal Disease (ESRD) also known as kidney failure

Hemophiliacs

Clients and staff at institutions for the developmentally disabled

Those who live in the same household as an hepatitis B carrier

Homosexual men

Illicit drug users

Health care professionals who have frequent contact with blood or other body fluids during routine work

Note: If a beneficiary is at a low-risk for hepatitis B, the shot will be covered under Part D

Shingles (*not preventive*)

The shingles vaccine **is not a preventive service**; all Medicare Part D plans must have the shingles vaccine on their formularies but it does not have to be covered at 100 percent

Services Original Medicare Covers with 20 percent cost sharing

Colorectal Cancer Screening

Medicare will cover 80 percent of the service. The Part B deductible does not apply.

Barium enema: once every 48

once every 24 months for persons at high risk and when used instead of a colonoscopy or sigmoidoscopy

All other colon cancer screenings: colonoscopies, flexible sigmoidoscopies, and fecal occult blood tests are covered at 100 percent by Medicare depending on patient risk and frequency of the test

Glaucoma screening

For those who are at risk, Medicare will cover 80 percent of the service after you meet your Part B deductible for the year

Considered at risk if:

- Have a family history of glaucoma
- Have diabetes
- Are African American and age 50 or older
- Are Hispanic and age 65 or older

Prostate Cancer Screening

Medicare will cover 80 percent of the service after you meet your Part B deductible for the year

Digital Rectal Exam: once a year for all male beneficiaries over 50 years old

Diabetes self-management training

Medicare will cover 10 hours of training during your first year if a person are at risk of complications from diabetes or has just been diagnosed with the disease.

Medicare will also cover two hours of training every year afterward as long as the trainings are conducted in groups of 2-20 people and the sessions last at least thirty minutes. Medicare beneficiaries with diabetes will pay 20 percent coinsurance for training sessions after they meet the Part B deductible. Both insulin and non-insulin diabetics are eligible to have Medicare cover self-management training.

The preventive services that are covered with coinsurances in Original Medicare. If you're in a Medicare Advantage plan, check with your plan to find out how much you'll pay for these services.

Note: Diabetes testing supplies like test strips, glucose monitors and lancets are covered by Medicare Part B with a 20 percent coinsurance. If you have your diabetes supplies sent to you in the mail, Medicare's National Mail-Order Program for diabetic testing supplies requires you to order from a national mail-order contract supplier, no matter where you live. If you pick up diabetic supplies from a local store or pharmacy, you can continue to do so, but make sure it accepts assignment. Remember, syringes and insulin are covered by Medicare Part D.