Medicare Preventive Care Services
Frequently Asked Questions

1. What are preventive care services?

Preventive care services are health care services intended to promote your health and detect disease early. Preventive care seeks to prevent disease discover conditions early when they are most treatable and curable, and manage disease so that complications can be avoided. It can help you to stay healthy and encourage good health habits, such as exercise, proper nutrition, keeping a healthy weight, and not smoking. Preventive care services can consist of exams, shots, lab tests, and screenings, as well as counseling, health monitoring, and health education to help you understand and promote your health and well being.

2. Does Medicare cover preventive care services?

Yes. Medicare covers many preventive care services in order to promote the health and well being of Medicare beneficiaries. Most of these services have been recommended by the U.S. Preventive Services Task Force have no cost sharing because of the Affordable Care Act.

3. Can I get preventive care services if I have a Medicare Advantage plan?

Yes. Preventive care services are covered under Medicare, regardless of whether you have Original Medicare or a Medicare Advantage plan. As long as you meet basic eligibility standards, you have the right to receive these services.

4. What is the difference between preventive services and diagnostic services?

A service is considered preventive if you have no prior symptoms of the disease. In some cases, Medicare only covers preventive care services if you have certain risk factors. On the other hand, diagnostic services tend to address symptoms or conditions that you already have. The classification of services as preventive versus diagnosis is important because it affects what you owe for them. You typically need to pay a copay, coinsurance, and/or deductible for diagnostic services.

5. Are preventive services free?

Usually if you have Original Medicare, you have no coinsurance or deductible for certain Medicare preventive care services if you see a health care provider who accepts Medicare assignment. Doctors who accept assignment cannot charge you more than the Medicare approved amount for services. If you have a Medicare Advantage plan, your plan cannot 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 typically apply.

6. I received my Medicare Summary Notice and saw charges associated with some preventive care services. Why am I being charged for this preventive service?
Many preventive services are provided alongside care that is diagnostic or alongside other health care services. For example, the Annual Wellness Visit is a preventive screening and no cost sharing applies. However, if your provider investigates or treats a health issue during the Annual Wellness Visit, this additional care is not a part of the Annual Wellness Visit. Charges for additional health services typically apply for services related or unrelated to the preventive care. You also may be charged for a doctor’s visit if you meet with a physician before or after the service. Speak with your provider before receiving a preventive care service to understand the service and potential costs.

7. Does Medicare cover an annual physical as a preventive care service?

No. Rather than covering an annual physical, Medicare covers an initial Welcome to Medicare visit, and subsequent Annual Wellness visits to promote preventive care. These are not head-to-toe physical exams. You can still receive an annual physical from your primary care provider under Medicare, but charges typically apply to this service.

8. What happens during the Welcome to Medicare visit?

The Welcome to Medicare visit is designed to map out your health needs and create a preventive service plan or checklist to keep you healthy. The Welcome to Medicare preventive visit is not a head-to-toe physical, but comprises screenings and conversation with your provider to create your preventive health care plan. Medicare covers this one-time, initial examination within the first 12 months you enroll in Medicare Part B. All people new to Medicare qualify for this visit.

The Welcome to Medicare visit includes:

- Review of your medical and social history
- Review of the potential for depression or other mental health conditions
- Review of your ability to function safely in the home and community
- Check of your height, weight, blood pressure, body mass index, and vision
- Education, counseling and referrals related to risk factors and what the provider found during the visit
- Education, counseling and referrals related to other preventive services covered by Medicare. This includes a written plan created by your provider, creating a 5-10 year preventive care schedule based on your needs. A checklist is an example of a written plan your provider may give you.
- Discussions about health care advance directives
  - Health care advance directives are legal documents that typically allow you to appoint someone to act for you and to identify what medical treatment you want if you can no longer make health care decisions yourself.

An electrocardiogram (EKG) may also be included in a Welcome to Medicare visit. However, Part B deductibles and coinsurances apply.

As a result of the Welcome to Medicare visit, you may receive a referral for an Abdominal Aortic Aneurysm (AAA) screening. If you receive a referral because you are at risk for an AAA, Medicare should cover an AAA ultrasound with no deductible or coinsurance. This is true if you see a health care provider who accepts assignment.

Original Medicare covers the Welcome to Medicare visit with no coinsurance or deductible if you see providers who accept Medicare assignment. If you have a Medicare Advantage plan, your plan
cannot charge you copays or deductibles for the visit, as long as you see an in-network provider. If you see providers that are not in your plan’s network, charges typically apply.

Understand that if you receive any additional services or screenings during the Welcome to Medicare visit, then you will likely have an additional charge for those services. Services not included in the Welcome to Medicare visit are billed separately. You may be charged your usual copay and deductible if the additional service is covered by Medicare.

9. What happens during the Annual Wellness visit?

It depends on your previous visits and your individual plan of preventive care. The Annual Wellness Visit is a yearly appointment to discuss your plan of preventive care in the coming year. The Annual Wellness Visit is similar to the one-time Welcome to Medicare visit but continues to examine your health and update your preventive care plan. Like the Welcome to Medicare visit, the Annual Wellness Visit is not a head-to-toe physical. You cannot receive your Annual Wellness Visit within the first year you are enrolled in Medicare or within the same year you have your Welcome to Medicare exam.

During the first Annual Wellness Visit, you and your health care provider create a prevention plan based on your needs. As part of the visit, your doctor:

- Gives you a health-risk assessment
  - This may include a questionnaire that you complete (with or without the help of your doctor) before or during the visit that looks at your health status, injury risks, risky behaviors and urgent health needs.
- Takes your medical and family history
- Makes a list of your current providers, durable medical equipment (DME) suppliers and medications
  - Medications include prescription medications, as well as vitamins and supplements that you may take.
- Creates a written 5-10 year screening schedule or check-list
  - This checklist depends on your individual health status, screening history and what age appropriate, Medicare covered, preventive services you are eligible for.
- Identifies risk factors and current medical and mental health conditions along with related current or recommended treatments
- Checks your height, weight, blood pressure, and body mass index
- Screens for cognitive impairment
  - Cognitive impairment includes diseases such as Alzheimer’s or other forms of dementia. Medicare does not require that physicians use a test to screen patients. Doctors are asked to rely on their observation of the patient or on reports by the patient and others.
- Reviews risk factors for depression
- Reviews 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 also your level of safety in your home.
- Gives health advice and referrals to health education or preventive counseling services or programs aimed at reducing identified risk factors and promoting wellness
  - These include weight loss, physical activity, smoking cessation, fall prevention, and nutrition.
Annual Wellness Visits after your first visit may be slightly different. As part of subsequent wellness visits, your doctor:

- Updates your health-risk assessment
- Updates your medical and family history
- Checks your weight and blood pressure
- Updates your list of current medical providers and suppliers
- Screens for cognitive issues
- Updates your written screening schedule from previous wellness visits
- Updates your list of risk factors and conditions and the care you are receiving or that is recommended
- Provides health advice and referrals, to health education or preventive counseling services or programs

Original Medicare covers the Annual Wellness Visit with no coinsurance or deductible if you see providers who accept Medicare assignment. If you have a Medicare Advantage plan, your plan cannot charge you copays or deductibles for the visit, as long as you see an in-network provider. If you see providers that are not in your plan’s network, charges typically apply.

Understand that if you receive any additional services or screenings during the Welcome to Medicare preventive visit, then you will likely have an additional charge for those services. Services not included in the Welcome to Medicare visit will be billed separately. You may be charged your usual copay and deductible if the additional service is covered by Medicare. If you receive any additional services not covered under Medicare, such as a routine hearing exam, then you or your supplemental insurance (if you have it) are responsible for 100 percent of its cost.

10. **Do I have to see a specific provider for preventive care services?**

**Yes.** In general, in order for services to be covered by Medicare, you must see a provider that accepts Medicare. If you have Original Medicare, this means that you must see a Medicare-participating provider, which is a provider who accepts Medicare assignment and participates in the Medicare program. If you have a Medicare Advantage plan, this means that you must see a provider that is in your plan’s network, which is a provider who accepts your Medicare Advantage plan as insurance. If you do not see a Medicare-participating provider or an in-network provider, charges typically apply to your preventive care service.

Know that in order for some preventive care services to be covered, Medicare requires that you receive them from a certain kind of provider, such as a primary care provider. The chart in Question 11 describes the preventive care services covered by Medicare, and makes note if Medicare requires that you receive the service from a certain kind of provider.

11. **What preventive care services are covered by Medicare?**

See the chart below for a detailed explanation of all preventive care services covered by Medicare. Note the rules and guidelines for each service, as well as the cost sharing associated with the service.
<table>
<thead>
<tr>
<th>Service</th>
<th>What is covered</th>
<th>Cost</th>
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<tr>
<td><strong>Abdominal Aortic Aneurysm (AAA) Screening</strong></td>
<td>Covers a one-time screening for at risk beneficiaries if beneficiary is referred by physician or other health care provider and was never screened before. You are at risk if you have a family history of AAA; or are a man age 65 through 75 who has smoked 100 or more cigarettes in his lifetime.</td>
<td>Covered at 100 percent by Medicare Part B. Must see Medicare-participating provider, or in-network provider.</td>
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<td><strong>Alcohol Misuse Screening and Counseling</strong></td>
<td>Covers annual screenings to reduce alcohol misuse 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 (an “alcoholic”). Someone is considered to be misusing alcohol if they are: ▪ 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 covers four, brief counseling sessions given by the same primary care provider in a primary care setting.</td>
<td>Covered at 100 percent by Medicare Part B. Must see Medicare-participating provider, or in-network provider.</td>
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<td><strong>Bone Mass Measurement</strong></td>
<td>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 (or is expected to receive) daily steroid treatments for more than three months</td>
<td>Covered at 100 percent by Medicare Part B. Must see Medicare-participating provider, or in-network provider.</td>
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| 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 Covered at 100 percent by Medicare Part B. Must see Medicare-participating provider, or in-network provider. |
| Colorectal Cancer Screening | Covers the following screenings for people age 50 and over:  
- **Barium enema**: once every 48 months if you are age 50 or older, and once every 24 months if you are at high risk and when used instead of a colonoscopy or sigmoidoscopy.  
- **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 if you are 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. **Note**: There is no minimum age requirement for colonoscopies.  
- **DNA Stool Test (such as Cologuard TM)**: Covered once every 3 years for asymptomatic average risk beneficiaries between 50 and 85 years old. Some colorectal cancer screenings have cost sharing; others are covered fully by Medicare.  
For a **barium enema**: Medicare covers 80 percent of the service. The Part B deductible does not apply.  
All other colon cancer screenings--colonoscopies, flexible sigmoidoscopies, fecal occult blood tests and DNA stool tests--are covered at 100 percent by Medicare Part B (as long as they are not diagnostic screenings). |

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

**Note:** A sigmoidoscopy is similar to a colonoscopy. A sigmoidoscopy examines up to the sigmoid (a part of the colon) while a 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.

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<th>Depression Screening</th>
<th>Covered annually for all Medicare beneficiaries. Must be performed in a primary care setting.</th>
<th>Annual depression screening covered at 100 percent by Medicare Part B. Must see Medicare-participating provider, or in-network provider. Note that most mental health services are covered at 80 percent by Medicare after someone has met their Part B deductible.</th>
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<td>Screening typically includes a questionnaire completed by the patient, with the help of your primary care provider in some cases.</td>
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<td>If the screening finds symptoms of depression, your primary care provider provides treatment or refers to specialists (psychologists, psychiatrists, social worker, etc.).</td>
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| Diabetes screening | Covered **once a year** if you:  
- Have hypertension;  
- Have dyslipidemia (any kind of cholesterol problem);  
- Have a prior blood test showing low glucose (sugar) tolerance; **OR**  
- Are obese (body mass index of 30 or more). | Covered at 100 percent by Medicare Part B. Must see Medicare-participating provider, or in-network provider. |
|-------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|
|                   | Covered **once a year** if you meet **at least two** of the following criteria:  
- 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; |                                                                                                 |
| **Diabetes self-management training** | Covered twice a year if you have been diagnosed with pre-diabetes.  
Cover 10 hours of training during your first year, if you are at risk of complications from diabetes or have just been diagnosed with the disease.  
Also covers 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.  
Both insulin and non-insulin diabetics are eligible to have Medicare cover self-management training. | Cost sharing applies; you are responsible for a 20 percent coinsurance of the Medicare-approved amount, after you meet the Part B deductible for the year. |
| **Glaucoma screening** | Covered if you are at risk.  
At risk means that you:  
- Have a family history of glaucoma  
- Have diabetes  
- Are African American and age 50 or older  
- Are Hispanic and age 65 or older | Cost sharing applies; you are responsible for a 20 percent coinsurance of the Medicare-approved amount, after you meet the Part B deductible for the year. |
| **HIV screening** | Covered for all Medicare beneficiaries once every 12 months, or up to three times during a pregnancy. | Covered at 100 percent by Medicare Part B.  
Must see Medicare-participating provider, or in-network provider. |
| **Heart disease screening lab test** | Covers blood tests for all Medicare beneficiaries every five years to test for:  
- Cholesterol,  
- Lipid, lipoprotein and  
- Triglyceride levels | Covered at 100 percent by Medicare Part B.  
Must see Medicare-participating provider, or in-network provider. |
| **Hepatitis C screening** | Covers once per lifetime time blood test to detect hepatitis C for Medicare beneficiaries who:  
- Were born between 1945 and 1965;  
- Had a blood transfusion before 1992;  
OR  
- Are considered high risk due to current or past history of illegal injectable drug use. | Covered at 100 percent by Medicare Part B.  
Must see Medicare-participating provider, or in-network provider. |
Test must be ordered by your primary care provider.

High risk individuals also qualify for yearly screenings following the initial test.

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<th>Lung cancer screening</th>
<th>Covers yearly screenings to detect lung cancer for certain people who:</th>
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<td>• Are age 55 to 77 and currently smoke or have quit smoking in the past 15 years;</td>
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<td>• Have smoked an average of one pack per day for at least 30 years;</td>
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<td>• Have no symptoms or signs of lung cancer; and</td>
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<td>• Receive the chest scan at a qualified radiology facility.</td>
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Includes a yearly Low Dose Computed Tomography chest scan (LDCT or low dose CT). You must have a visit with your provider to discuss the scan benefits and risks. The provider also advises you about the importance of quitting/avoiding smoking and provides information about smoking cessation services when appropriate.

After the first scan, a separate counseling visit is not required for subsequent scans.

Speak to your radiology facility to see if it is qualified to perform this scan.

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<th>Screening mammograms</th>
<th>Medicare covers:</th>
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<td>• One baseline screening for all women 35-39 years of age</td>
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<td>• Annual screening for all women age 40+</td>
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Note that this is a **screening** mammogram. Cost sharing applies to all diagnostic mammograms.

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<th>Screening is covered at 100 percent by Medicare Part B.</th>
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<td>Must see Medicare-participating provider, or in-network provider for screening.</td>
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<td>Cost sharing applies if you are referred for diagnostic mammograms (as the result of abnormal screening mammogram or physical breast exam); a 20 percent coinsurance of the Medicare-approved amount, after you meet the Part B deductible for the year.</td>
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| **Medical nutrition therapy** | Covered with a doctor’s referral, medical nutrition therapy for Medicare beneficiaries if you:  
- Have diabetes  
- Have chronic renal disease  
- Have had a kidney transplant in the past three years  
Covers 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.  
You must get these services from a registered dietitian or other qualified nutrition professional. | Covered at 100 percent by Medicare Part B.  
Must see Medicare-participating provider, or in-network provider. |
| **Obesity screening and counseling** | Covers screening and counseling therapy from a primary care provider in a primary care setting to help beneficiaries who are obese lose weight  
- Obese= have a Body Mass Index (BMI) of 30 or more  
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 you lose 6.6 lbs after first six months | Covered at 100 percent by Medicare Part B.  
Must see Medicare-participating provider, or in-network provider. |
| **Pap smears, pelvic exams and breast exams** | Covered every two years for women with Medicare who are considered low risk for vaginal or cervical cancer Medicare.  
Covered once per year for women with Medicare who are 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.  
You are considered at high risk for cervical or vaginal cancer if:  
- You were active sexually early (under 16 years of age)  
- You have had multiple sexual partners (5 or more)  
- You have had a sexually | Covered at 100 percent by Medicare Part B.  
Must see Medicare-participating provider, or in-network provider. |
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| **Prostate cancer screenings** | **Covers** **Prostate-Specific Antigen (PSA)** blood test for all men with Medicare age 50+ once every 12 months.  
If you need this service more than once a year, the exams are considered diagnostic and cost sharing applies.  
**Covers Digital Rectal Exam** annually for all male beneficiaries age 50+. | **PSA blood test**: Covered at 100 percent by Medicare Part B.  
**Digital Rectal Exam**: Cost sharing applies; you are responsible for a 20 percent coinsurance of the Medicare-approved amount, after you meet the Part B deductible for the year. |
| **Sexually transmitted infection (STI) screening** | **Covered only if you are pregnant and/or considered high risk for an STI.**  
**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.**  
Each specific STI test is covered differently for different people. All tests are performed on pregnant women in certain situations. 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 | **Covered at 100 percent by Medicare Part B.**  
**Must see Medicare-participating provider, or in-network provider.** |
- 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)
- 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

| Smoking cessation | Covers two counseling attempts at quitting smoking per year, whether if you have not been diagnosed with an illness that is caused or complicated by smoking. Each attempt includes four sessions. Medicare covers a total of eight sessions every 12 months. | Covered at 100 percent by Medicare Part B if you have not been diagnosed with an illness that is caused or complicated by smoking and you see a Medicare-participating provider or in-network provider. Cost sharing applies if you have been diagnosed with a disease or condition caused by smoking; you are responsible for a 20 percent coinsurance of the Medicare-approved amount, after you meet the Part B deductible for the year. |

| Vaccines and immunizations | Flu shots: Covered 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:** Covers two separate, different doses of the pneumonia vaccine. Currently, there are two types of pneumonia vaccines available. Medicare Part B covers an initial pneumonia vaccine if you have never received the pneumonia vaccine under Medicare Part B before. Medicare also covers a second, different type of pneumonia vaccine at least one year after the first vaccine was administered. | Flu shot: Covered at 100 percent by Medicare Part B. Must see Medicare-participating provider, or in-network provider.  
Pneumonia shot: Both shots covered at 100 percent by Medicare Part B. Must see Medicare-participating provider, or in-network provider.  
Hepatitis C: Covered at 100 percent by Medicare Part B, if you are at medium to high risk for Hepatitis C. Must see a Medicare-participating provider or in-network provider.  
Note: Covered by Part D if you are at low risk for Hepatitis C. Cost sharing may apply. |
You are not required to provide a vaccination history when receiving the pneumonia vaccine. You can verbally tell the health care professional administering the shot if and when you have received any pneumonia vaccines.

**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

If you are at a low-risk for hepatitis B, the shot is covered under Part D.

**Note: 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.