**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 on the next page 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.

### Services Original Medicare covers without a deductible or coinsurance

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
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<tbody>
<tr>
<td>Abdominal aortic aneurysm (AAA)</td>
<td>Once in a lifetime <strong>ultrasound screening</strong> if you are at risk for AAA and receive a referral from your provider.</td>
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<tr>
<td>Alcohol misuse screening and counseling</td>
<td>An annual screening, and up to four brief counseling sessions every year if your provider determines that you are misusing alcohol. You do not need to show signs or symptoms of alcohol abuse to qualify for screening.</td>
</tr>
<tr>
<td>Annual Wellness Visit (AWV)</td>
<td>An annual 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. Not a head-to-toe physical. You cannot receive your AWV within the same year as your Welcome to Medicare preventive visit.</td>
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<tr>
<td>Breast cancer screenings</td>
<td>An annual <strong>mammogram screening</strong> for women age 40+ and one baseline mammogram for women age 35-39.</td>
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<td></td>
<td><strong>A breast examination</strong> once every 24 months for all women. You may be eligible for an exam every 12 months if Medicare considers you at risk.</td>
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<tr>
<td>Cervical cancer screenings</td>
<td><strong>A pap smear</strong> and <strong>pelvic examination</strong> once every 24 months for all women. You may be eligible for an exam every 12 months if Medicare considers you at risk.</td>
</tr>
<tr>
<td>Colorectal cancer screenings</td>
<td><strong>Fecal occult blood test:</strong> once every 12 months if you are age 50+ <strong>Colonoscopy:</strong> once every 24 months if Medicare considers you at high risk <strong>Flexible sigmoidoscopy:</strong> once every 48 months if you are age 50+ and Medicare considers you at high risk</td>
</tr>
<tr>
<td>Screening Type</td>
<td>Description</td>
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<tr>
<td>Depression screenings</td>
<td>An annual screening in a primary care setting. You do not need to show signs or symptoms of depression to qualify for screening.</td>
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<tr>
<td>Diabetes screening</td>
<td>An annual screening, including a <strong>fasting blood glucose test</strong> and/or a <strong>post-glucose challenge test</strong>, if Medicare considers you at risk.</td>
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<tr>
<td>HIV screening</td>
<td>An annual screening for anyone age 15-65, or younger than 15 or older than 65, and at an increased risk.</td>
</tr>
<tr>
<td>Heart disease screening</td>
<td><strong>Blood tests</strong> for heart disease once every five years, when ordered by your provider. <strong>An annual cardiovascular disease risk reduction visit</strong> with your PCP.</td>
</tr>
</tbody>
</table>
| Hepatitis C screening                | One screening if your PCP orders the test for you:  
  - Were born between 1945 and 1965  
  - Had a blood transfusion before 1992  
  - Or, are considered high risk due to current or past history using federally prohibited, injectable substances  
If Medicare considers you at high risk, you also qualify for yearly screenings following the initial screening. |
| Lung cancer screening                | An annual screening and **Low-Dose Computed Tomography** (LDCT, also called low-dose CT) chest scan. |
| Medical nutritional therapy (MNT)    | Three hours of therapy for the first year and two hours every subsequent year if you get a referral from your PCP, see a registered dietician or other qualified nutrition specialist, and have one of the following conditions:  
  - Diabetes  
  - Chronic renal disease  
  - Or, have had a kidney transplant in the past three years. |
| Behavioral counseling                | **Body mass index (BMI) screenings** and **behavioral counseling** to help you lose weight if you are obese. You are obese if you have a BMI of 30 or higher. |
| Bone mass measurements               | Measurement once every 24 months if you are at risk for osteoporosis. Medicare will also cover follow-up measurements and/or more frequent screening if your doctor prescribes them. |
| Prostate cancer screenings           | An annual screening for all men age 50+. The screening includes a **digital rectal exam (DRE)** and a **prostate-specific antigen (PSA) test**. |
| Sexually transmitted infection (STI) screenings | Screenings tests for chlamydia, gonorrhea, syphilis, and/or hepatitis B if you are at high or increased risk of contracting an STI or pregnant. Screenings are covered annually if you receive a referral from your PCP or at certain times during pregnancy. |
Smoking cessation counseling | Two **smoking cessation counseling attempts** each year if you use tobacco. Each counseling attempt includes up to four face-to-face sessions with your provider, for a total of up to eight sessions.

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<tr>
<th>Services</th>
<th>Influenza (flu) shots: one flu shot every flu season.</th>
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<tbody>
<tr>
<td>Vaccinations</td>
<td><strong>Pneumococcal (pneumonia) shots:</strong> first shot if you have never received Part B coverage for a pneumonia shot before. A different, second vaccination 12 months after receiving the first shot.</td>
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<tr>
<td>Welcome to Medicare visit</td>
<td><strong>Hepatitis B shots:</strong> Vaccination if you are at medium or high risk.</td>
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Welcome to Medicare visit | 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. Note that you must receive this visit within the first 12 months of your Part B enrollment.

**Services Original Medicare covers with a deductible or coinsurance**

Original Medicare covers the following services at 80% of the Medicare-approved amount. If you receive the service from a participating provider, you pay a 20% coinsurance after you meet your Part B deductible.

Colorectal cancer screenings | **Barium enema:** Once every 24 months if you are age 50+ and Medicare considers you at high risk.

Diabetes self-management training | Up to 10 hours during the first year you receive training. After your first year, Medicare covers up to two hours of additional training annually.

Glaucoma screenings | An annual screening if Medicare considers you at high risk. The screening must be performed or supervised by an eye doctor who is licensed to provide this service in your state.