Medicare Minute Teaching Materials – March 2016
Medicare's Preventive and Screening Services

1) Are preventive services free?
Medicare covers many preventive care services in order to promote your health and wellbeing. If you have Original Medicare, you will pay no coinsurance or deductible for certain 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. When Medicare pays 100 percent of the approved amount as it does with most preventive care, you receive the services free of charge. 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. Speak to your provider about your eligibility for each service, and about scheduling times for services you are eligible for. For more information on Medicare's preventive care services, contact your State Health Insurance Assistance Program (SHIP). Information about how to contact your SHIP is on the last page of these teaching materials. You can also call 1-800-MEDICARE (1-800-633-4227), TTY users should call 1-877-486-2048. You can also visit https://www.medicare.gov/coverage/preventive-and-screening-services.html to find out if Medicare covers your test, service, or item.

2) What is the difference between preventive services and diagnostic services?
Many preventive services are provided alongside care that is diagnostic or alongside other health care 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.
For example, Medicare covers a one-time Hepatitis C screening test if you meet at least one of the following conditions:

- You have a current or past history of illicit injection drug use.
- You have had a blood transfusion before 1992.
- You were born between 1945 and 1965.

In contrast, diagnostic services tend to address symptoms or conditions that you already have. The classification of services as preventive versus diagnostic is important because it affects your out-of-pocket costs. You typically need to pay a copay, coinsurance, and/or deductible for diagnostic services. For example, the Annual Wellness Visit is a Medicare-covered preventive screening, 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 will apply.

3) 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. 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. Understand that if you receive any additional services or screenings that are not on Medicare's list of covered preventive care, you will likely have an additional charge for those services.

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The Welcome to Medicare visit includes:

- Review of your medical and social history.
- Review of the potential for depression and 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 your risk factors.
- Education, counseling, and referrals related to other preventive services covered by Medicare. This can include a schedule or checklist based on your health needs.
- Discussions about health care advance directives.
    - Health care advance directives are legal documents that allow you to appoint someone to act for you in case you are unable to make your own health care decisions, and that identify what medical treatment you want in these situations.

Note: Clinical laboratory tests are not included in the Welcome to Medicare Visit. If your provider needs to evaluate and treat a medical problem during this visit, he or she would need to charge for this separately, and the cost of the tests would be applied to your deductible or copay.

4) What happens during the Annual Wellness Visit?

The Annual Wellness Visit is a Medicare-covered yearly appointment for those enrolled in Part B during which you discuss your plan of preventive care for the coming year with your health care provider. 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.

As part of the Annual Wellness Visit, your provider may:

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

Note: Preventive services include exams, shots, lab tests, and screenings. They also include programs for health monitoring, and counseling and education to help you take care of your own health. However, if you receive additional diagnostic services or screenings during the Annual Wellness Visit, you will likely have an additional charge for those services.

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5) What rules must I follow for Part B-covered vaccines that are considered preventive services (flu, pneumonia, and hepatitis B vaccines)?
Preventive vaccines (flu, pneumonia, and hepatitis B vaccines) are typically covered by Medicare at little or no cost to you. There are specific rules you must follow in order for Medicare to cover your vaccine as a preventive service:

- Flu shot – Part B will cover a flu shot once every flu season. This is true for Original Medicare and for Medicare Advantage Plans. The flu season usually runs from November through April, which spans the fall of each year through the winter of the following year. For example, the 2015/2016 flu season starts in fall 2015 and goes through winter 2016. Therefore, Medicare may cover a flu shot twice in one calendar year. For example, if you received a shot in January 2015 for the 2014/2015 flu season, Medicare would cover another shot in November 2015 for the 2015/2016 flu season. Currently, the seasonal flu shot typically includes both a seasonal flu shot and an H1N1 (swine flu) vaccination.

- Pneumonia shot – Medicare will cover 100 percent of the cost of two separate doses of the pneumonia vaccine with no Part B deductible whether you have Original Medicare or a Medicare Advantage Plan. Medicare Advantage Plans cannot require that you get a referral for the vaccine, but can require that you use in-network providers to administer it. If you have Original Medicare, you will have no copay or deductible if you see providers who take assignment. Currently, there are two types of pneumonia vaccines available. Medicare Part B will cover an initial pneumonia vaccine if you have never before received the pneumonia vaccine under Medicare Part B. Medicare will also cover a second type of pneumonia vaccine at least one year after the first vaccine is administered. Speak with your doctor to learn more about the types of pneumonia vaccines and to discuss receiving them.

- Hepatitis B shot – If your doctor considers you to be at low risk for hepatitis B, the shot will be covered under Medicare Part D. Part B will cover your hepatitis B shot if your doctor finds that you are at medium to high risk for hepatitis B and orders the vaccine. This is true for both Original Medicare and Medicare Advantage Plans. Your risk for Hepatitis B increases if you have hemophilia, End-Stage Renal Disease (ESRD), diabetes, or certain conditions that lower your resistance to infection. Other factors may also increase your risk for Hepatitis B. The Centers for Disease Control and Prevention (CDC) outline other factors at http://www.cdc.gov/vaccines/vpd-vac/hepb/in-short-adult.htm#who. If you are unsure about your risk level, check with your doctor.

6) 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 Senior Medicare Patrol (SMP) for assistance. Information about how to contact your SMP is on the last page of these teaching materials. You can also contact 1-800-MEDICARE (1-800-633-4227) for help. TTY users should call 1-877-486-2048.

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Although preventive services may be covered by Medicare, 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 and costs will apply. Also, if during your Annual Wellness Visit, your doctor needs to investigate or to treat a new or existing problem, costs may apply.

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.

Note: If your health care provider bills Medicare for services you never received, you may be a victim of Medicare billing fraud. You play a vital role in protecting the integrity of Medicare and can help detect fraud by carefully reviewing your summary of claims from Medicare or your Medicare Advantage Plan. If you have Original Medicare, your claims are summarized on your Medicare Summary Notices (MSNs). If you have a Medicare Advantage Plan, your claims are summarized on your Explanations of Benefits (EOBs). You can also sign up to review your claims online at www.mymedicare.gov. 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 X service?") before reporting activity as suspicious.

SHIP Case Study

Scott, who is 66 years old and receives his health coverage through Original Medicare**,** had his Welcome to Medicare preventive visit last year when he first enrolled in Medicare Part B. Now he is interested in receiving his Annual Wellness Visit but is not sure when he will be allowed to receive it, what is included, or how much it will cost. Scott heard from a friend that this visit was considered to be a preventive benefit and would be paid for in full by Medicare, but he would like to be sure that he won't have to pay anything out of his own pocket.

What should Scott do?

- Scott should contact his SHIP to speak with a counselor who can explain the Annual Wellness Visit in more detail.
    - If he doesn't know how to find his SHIP, he can go to www.shiptacenter.org or call 877-839-2675 for assistance.
- The SHIP counselor should explain that the Annual Wellness Visit is covered after Scott has had Part B for longer than 12 months, and at least one year has passed since Scott's Welcome to Medicare visit. The counselor should also note the difference between preventive and diagnostic care and the kinds of preparation Scott should do before his Annual Wellness Visit.

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SMP Case Study
Krystal is 67 years old and enrolled in Original Medicare. This month, she received a bill from her new primary care provider for her Annual Wellness Visit. Krystal 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 Krystal contacted Medicare, she learned that her visit had been denied because her former primary care provider had already billed Medicare for it. Krystal has not visited her former primary care physician at all this year, and worries that she may be the victim of fraudulent billing.

What should Krystal do?

- Krystal should contact her former primary care provider to see if their office made a billing mistake.
- If Krystal still suspects that her previous doctor's office may have billed Medicare fraudulently, she should contact the Senior Medicare Patrol.
    - The SMP representative will counsel her about billing fraud and the SMP program's ability to refer her case to the proper authorities.
    - For help finding her SMP, Krystal can call 1-877-808-2468 or visit www.smpresource.org.
- Medicare will determine if fraud has occurred based on the information Krystal provides.

Local SHIP Contact Information	Local SMP Contact Information
SHIP toll-free: **SHIP email:** **SHIP website:** **To find a SHIP in another state:** Call 877-839-2675 or visit www.shiptacenter.org.	**SMP toll-free:** **SMP email:** **SMP website:** **To find an SMP in another state:** Call 877-808-2468 or visit www.smpresource.org.

The production of this document was supported by Grant Numbers 90ST1001 and 90NP0003 from the Administration for Community Living (ACL). Its contents are solely the responsibility of the SHIP National Technical Assistance Center and Senior Medicare Patrol National Resource Center and do not necessarily represent the official views of ACL.

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