Making Sense of Medicare’s Preventive Service Benefits || CMA

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With the Balanced Budget Act of 1997 (BBA1997), Congress began an expansion of preventive benefits and services available through Medicare.[1] The Medicare Modernization Act of 2003 (MMA) added additional preventive services.[2] The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) made refinements to Medicare's preventive services.[3] Finally, the Patient Protection and Affordable Care Act of 2010 (ACA) further expanded Medicare-covered preventive services and removed the co-pay for most of them.[4] Understanding the criteria for accessing preventive benefits is tricky, particularly as there are often frequency limitations, condition constraints, and age and gender restrictions.

The Centers for Medicare & Medicaid Services (CMS) website has a list of Questions & Answers commonly associated with understanding Medicare’s preventive services.[5] In addition, CMS has a useful chart, part of its MedLearn Series, which provides an overview of preventive services, relevant billing codes, categories of beneficiaries covered, frequency of coverage, and any beneficiary cost-sharing.[6]

Below we highlight key preventive services associated with the congressional acts noted above:

Preventive Services and the Balanced Budget Act of 1997

- **Annual Mammogram** for women age 40[7] and over (deductible does not apply).[8]
- **Annual Pap Smears and Pelvic Exams** for beneficiaries considered at high risk or following an abnormal Pap smear; for women not in these groups, coverage is for Pap smears and pelvic exams once every two years[9] (deductible does not apply).[10]
- **Prostate Cancer Screening** annually for men over age 50.[11]
- **Colorectal Cancer Screening** tests for beneficiaries age 50 and older. There is no minimum age for having a screening colonoscopy. Fecal occult blood tests are covered annually; flexible sigmoidoscopy is generally covered every 48 months (or every 120 months when used instead of a colonoscopy for those not at high risk); screening colonoscopy is covered every 120 months or every 24 months for those at high risk; and barium enemas are covered every 48 months (or every 24 months for those at high risk) when used instead of sigmoidoscopy or colonoscopy. The Part B related deductible for colorectal screenings was eliminated by the Deficit Reduction Act of 2005 (DRA), effective January 1, 2007.[12]
• Outpatient Diabetes Self-Management Training Services, Blood Testing Strips, and Monitors.[13]

• Medical Nutrition Therapy Services for beneficiaries who have diabetes or renal disease who have not received diabetes outpatient self-management training services within a time period determined by the Secretary, are not receiving maintenance dialysis for which Medicare payment is being made, and who meet such other criteria determined by the Secretary.

• Bone Mass Measurements once every two years for qualified high-risk individuals.[14]

• Glaucoma Screening for individuals determined to be at high risk for glaucoma, individuals with a family history of glaucoma, and individuals with diabetes.[15]

• Tele-Health Services when a beneficiary resides in a rural county designated as a health professional shortage area and where other criteria are met.[16]

• Services not otherwise described that identify medical conditions or risk factors as the Secretary determines.[17]

MIPPA Modifications (2008)

• Preventive Physical Exams. When initially enacted, the law stated that this exam was for an initial physical exam performed no later than six months after the individual's initial date of coverage under Part B.[18] MIPPA, however, changed the time period for this exam to 12 months after the initial date of coverage under Part B, effective January 1, 2009.[19] The term "initial preventive physical examination" means physicians' services consisting of a physical examination (including measurement of height, weight, and blood pressure, and an electrocardiograph) with the goal of health promotion and disease detection and includes education, counseling, and referral with respect to screening and other preventive services described in MIPPA Section 611(b)(2) but does not include clinical laboratory tests.[20]

• Cardiovascular Screening Tests. This is a blood test for the early detection of cardiovascular disease. The tests can only be performed once every two years. The provision was effective on January 1, 2005.[21]

• Diabetes Laboratory Diagnostic Tests. The tests include fasting plasma glucose tests as well as other tests and modifications. Coverage of the tests applies to individuals at risk of diabetes or who have any combination of the following: hypertension; dyslipidemia; obesity (body mass index greater than or equal to 30kg/m2); previous identification of an elevated impaired glucose tolerance; a risk factor consisting of at least two of the following characteristics: overweigh (body mass index greater than 25, but less than 30 kg/m2); a family history of diabetes; a history of gestational diabetes mellitus or delivery of a baby weighing greater than 9 pounds; or being 65 years of age or older.[22]

• Abdominal Aortic Aneurysm Screening. In addition, note that the DRA adds coverage
Abdominal Aortic Aneurysm Screening. In addition, note that the DRA adds coverage for this screening test as part of the "Welcome to Medicare" physical exam for certain Medicare beneficiaries as of January 1, 2007, and eliminates the Medicare Part B Premium for this screening test.[23]

- Screening for Depression in Adults. Coverage is available in primary care settings[24] that have staff-assisted depression care supports in place to assure accurate diagnosis, effective treatment, and follow-up.[25]

- Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse. CMS will cover up to four brief, face-to-face, behavioral counseling interventions per year for Medicare beneficiaries, including pregnant women. Covered are those beneficiaries who misuse alcohol, but whose levels or patterns of alcohol consumption do not meet criteria for alcohol dependence;[26] who are competent and alert at the time that counseling is provided; and whose counseling is furnished by qualified primary care physicians or other primary care practitioners in a primary care setting.[27]

Preventive Services and the Affordable Care Act

- Annual Wellness Visit. Effective January 1, 2011, Medicare beneficiaries are entitled to an annual Wellness Visit which includes the development of a personalized prevention plan,[28] based on an individualized health risk assessment prior to, or as part of, the visit with a health care professional (physician, health educator, registered dietician, or nutrition professional or a team of professionals).[29] The Wellness Visit is not an annual physical, but should include the following:
  - The assessment should establish or update medical and family history; list current providers and suppliers that are regularly involved in providing medical care to the individual (including a list of prescribed medications); record height, weight, body mass index (or waist circumference, if appropriate), blood pressure, and other routine measurements; and indicate any cognitive impairment.[30]
  - Establish a screening schedule for the next five to ten years, as appropriate, based on recommendations of the United States Preventive Services Task Force and the Advisory Committee on Immunization Practices, and the individual's health status, screening history, and age-appropriate preventive services.[31]

- One Time Only "Welcome to Medicare" Physical Exam. A "Welcome to Medicare" check-up or "initial physical examination" is available to beneficiaries once, within 12 months of their becoming covered under Medicare Part B.[32]
  - The exam consists of a physical examination, including measurement of height, weight, and blood pressure, and an electrocardiograph, with the goal of health promotion and disease detection.[33]
  - The exam also includes education, counseling, and referral with respect to screening
and other preventive services, although it does not include clinical laboratory tests.[34]  
- Each beneficiary is entitled to only one "Welcome to Medicare" check-up. Annual exams are not covered.[35]

**ACA eliminated cost-sharing** (including no deductibles and/or copayments) for most of the preventive services covered under Medicare, effective January 1, 2011:[36]

- Mammograms every 12 months for eligible beneficiaries age 40 and older;
- Colorectal cancer screening, including flexible sigmoidoscopy or colonoscopy;
- Cervical cancer screening, including a Pap smear test and pelvic exam;
- Cholesterol and other cardiovascular screenings;
- Diabetes screening;
- Medical nutrition therapy to help people manage diabetes or kidney disease;
- Prostate cancer screening (for most codes);
- Annual flu shot, pneumonia vaccine, and the hepatitis B vaccine;
- Bone mass measurement;
- Abdominal aortic aneurysm screening to check for a bulging blood vessel;
- HIV screening for people who are at increased risk or who ask for the test;
- Smoking cessation counseling.

**Wellness Visit/Personal Prevention Plan.**[37]

**Note:** CMS indicates that the following Medicare-covered preventive services will continue to be subject to cost-sharing:

- Digital rectal examination furnished as a prostate cancer screening service;
- Glaucoma screening;
- Diabetes self-management training services;
- Barium enema furnished as a colorectal cancer screening.[38]

**Preventive Services in Medicare Advantage Plans**

With the exception of hospice care, **Medicare Advantage plans are required to provide all items and services that are covered under Medicare Part A and Part B.**[39] Thus, Medicare Advantage plans are required to offer the new Annual Wellness Visit to their enrollees. Medicare Advantage plans are allowed to impose different cost-sharing than Part A and Part B, as long as the cost-sharing is actuarially equivalent to cost-sharing under traditional Medicare.[40]

While many Medicare Advantage plans have traditionally eliminated cost-sharing for preventive benefits under their authority to offer an actuarially equivalent benefit package, some have not.
CMS has issued regulations that prohibit plans from charging deductibles, copayments, or coinsurance for in-network Medicare-covered preventive services, as specified by CMS on an annual basis, effective January 2012.[41]

Conclusion

Medicare's expanding array of preventive services appropriately emphasizes prevention and wellness. However, as the rules have been added to an existing program over time, the institution of new services has a "patch-work" feel. In addition, as medical practice criteria shift and best practice paradigms are established, frequency limitations often change. It is thus important to review both coverage and frequency of use criteria regularly. To do so, check the CMS Q&As on preventive services, and the list of preventive services for which cost-sharing has been eliminated.

[1] See Balanced Budget Act of 1997 (BBA 1997), Public Law 105-33 (August 17, 1997), §§4101(a)–(b), 4103(a), 4104(a), 4105(a), 4106(a), and 4107 of BIPA, amending §§1834, 1861 of the Social Security Act.


[3] See Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), Public Law 110–275 (July 15, 2008), Pt. I (Prevention, Mental health, and Marketing), §101 (improvements to coverage of preventive services); the Secretary has authority to add preventive services that he or she determines are reasonable and necessary for the prevention or early detection of an illness or a disability, where such preventive services are recommended with a grade of A or B by the U.S. Preventive Services Task Force, and appropriate for individuals entitled to benefits under Part A or enrolled under Part B. In the case of additional preventive services, the Medicare agency will pay 80 percent of the lesser of the actual charge for the service or the amount determined under a fee schedule established by the Secretary.


[5] https://questions.cms.gov/faq.php?id=5005&rtopic=1991. It appears that CMS continues to add to the list and has not removed earlier Q&A responses even as it has refined and modified its thinking. In the main, the items at the top of the list appear to be the most current.


[8] 42 U.S.C. §§1395l(b) and 1395m(c)(2)(A). See also the discussion below with respect to the ACA having eliminated cost-sharing for a host of preventive services, effective January 1, 2011.

In May 2009, Medicare decided that it would not cover virtual colonoscopies. This ruling is likely to change over time as the technology becomes more accepted.

High-risk persons include an estrogen-deficient woman at clinical risk for osteoporosis; an individual with vertebral abnormalities; an individual receiving long-term glucocorticoid steroid therapy; an individual with primary hyperparathyroidism; or an individual being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.

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Alcohol dependence is defined as at least three of the following: tolerance; withdrawal symptoms; impaired control; preoccupation with acquisition and/or use; persistent desire or unsuccessful efforts to quit; sustained social, occupational, or recreational disability; use continues despite adverse consequences.
[29] 42 U.S.C. §1395x(hhh)
[31] ACA §4103(a)(2)(E)
[33] See 42 U.S.C. 1395§x(W), (ww).
[34] See 42 U.S.C. §1395x(ww).
[36] Since there is no cost sharing for these services, providers are not required to issue beneficiaries with an Advance Beneficiary Notice (ABN). If however, the frequency of the services covered by Medicare is surpassed and the patient still wants to continue treatment, the provider must issue an ABN before providing the additional services in order to transfer liability to the beneficiary for the services received. See "CMS Clarifies When the Advance Beneficiary Notice of Non-Coverage (ABN) Must be Issued," Transmittal No.R2480CP, effective September 4, 2012, Advance Beneficiary Notice (ABN), Form CMS-R-131, http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2480CP.pdf; see also the Center's Weekly Alert on Transmittal No. R2480CP at http://www.medicareadvocacy.org/2012/08/16/cms-clarifies-when-the-advance-beneficiary-notice-of-non-coverage-abn-must-be-issued/.
Counter=3830&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=1%2C+2%2C+3%2C+4%2C+5&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date.
[38] See 75 Fed. Reg. 73,169 et seq. (Nov. 29, 2010), amending 42 C.F.R. §§410.152 and 410.160. Table 65 includes a chart of the complete list of codes for preventive services that indicates whether the services are subject to cost-sharing starting in 2011