Preventive Health Services and Procedures

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Instructions for Use

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Coverage Guidelines

Preventive health services and procedures are covered when Medicare coverage criteria are met.

Preventive Services and Screenings Covered by Medicare: As a result of the Affordable Care Act, Medicare now covers many of these services without cost to patients, including the Annual Wellness Visit that was created under the Affordable Care Act. These services are still subject to screening criteria and frequency limits. For further information, refer to the Medicare Preventive Services-MLN Educational Tool at https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html. (Accessed April 13, 2020)

Copayment/Coinsurance:

- Effective for dates of service (DOS) on or after January 1, 2011, Medicare provides 100 percent payment (in other words, waives any deductible, coinsurance or copayment) for many Medicare-covered preventive services. In some cases, the copayment, coinsurance and deductibles have not changed and will be the same for DOS prior to January 1, 2011 as they are for dates of service on or after January 1, 2011. For specific changes to deductibles, copayments, or coinsurances for Medicare covered preventive services, refer to the MLN Matters #SE1129 – Reminder-Beneficiary Cost-Sharing for Medicare-Covered Preventive Services Under the Affordable Care Act. (Accessed April 13, 2020)
- For member-specific copayment/coinsurance information for the following preventive services, refer to the member's EOC/SB or contact the Customer Service Department.

Medicare Covered Preventive Services and Screening

Abdominal Aortic Aneurysm Screening

Ultrasound screening for abdominal aortic aneurysm means (1) a procedure using sound waves (or such other procedures using alternative technologies, of commensurate accuracy and cost, as specified by the Secretary of Health and Human Services, through the national coverage determination process) provided for the early detection of abdominal aortic aneurysms; and (2) includes a physician's interpretation of the results of the procedure.

One-time ultrasound screening for abdominal aortic aneurysm (AAA) is covered for members who meet the following criteria:

- Receives a referral for such an ultrasound screening as a result of an Initial Preventive Physical Examination (IPPE);
- Receives such ultrasound screening from a provider or supplier who is authorized to provide covered diagnostic services;
- Has not been previously furnished such an ultrasound screening under Medicare program; and
- Is included in at least one of the following risk categories:
  - Has a family history of abdominal aortic aneurysm; or
  - Male age 65-75 who has smoked at least 100 cigarettes in his lifetime
  - Member who manifests other risk factors in a category recommended for screening by USPSTF regarding AAA as specified by Secretary of HHS through national coverage determination process.

Refer to the MLN Matters # MM5235 – Implementation of a One-Time Only Ultrasound Screening for Abdominal Aortic Aneurysms (AAA), Resulting from a Referral from an Initial Preventive Physical Examination. Also refer to the Medicare Claims Processing Manual, Chapter 18, §110 – Ultrasound Screening for Abdominal Aortic Aneurysm (AAA). (Accessed April 13, 2020)

Alcohol Screening and Behavioral Counseling Intervention in Primary Care to Reduce Alcohol Misuse

Annual alcohol screening and behavioral counseling intervention in primary care to reduce alcohol misuse is covered when Medicare criteria are met.

Refer to the NCD for Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse (210.8) for coverage guideline. (Accessed April 13, 2020)

Annual Wellness Visit (including Personalized Prevention Plan Services)

Annual Wellness Visit (AWV) is covered when the following requirements are met:

- It is performed by a health professional; and,
- It is furnished to an eligible member who is no longer within 12 months after the effective date of his/her first Medicare Part B coverage period, and he/she has not received either an IPPE or an AWV providing PPPS within the past 12 months.

Notes:

- For UnitedHealthcare Medicare Advantage plans, one (1) annual wellness visit (AWV) is allowed per calendar year (visits do not need to be 12 months apart)
- Annual wellness visit (AWV) will include the establishment of, or update to, the individual's medical/family history, measurement of his/her height, weight, body-mass index (BMI) or waist circumference, and blood pressure (BP), with the goal of health promotion and disease detection and encouraging patients to obtain the screening and preventive services that may already be covered and paid for under Medicare Part B.
- Health professional includes:
  - A physician who is a doctor of medicine or osteopathy (as defined in section 1861(r)(1) of the Social Security Act (the Act); or,
  - A physician assistant, nurse practitioner, or clinical nurse specialist (as defined in section 1861(aa)(5) of the Act); or,
  - A medical professional (including a health educator, registered dietitian, or nutrition professional or other licensed practitioner) or a team of such medical professionals, working under the direct supervision (as defined in CFR 410.32(b)(3)(ii)) of a physician as defined in this section.

Refer to the Medicare Benefit Policy Manual, Chapter 15, §280.5 – Annual Wellness Visit (AWV) Including Personalized Prevention Plan Services (PPPS). (Accessed April 13, 2020)

Bone Mass Measurement

Bone mass measurement is covered when criteria are met; refer to the Coverage Summary for Bone Density Studies/Bone Mass Measurements.

Cancer Screenings

Breast Cancer (Mammogram/Mammography)

Screening Mammogram (Members Without Signs or Symptoms, History Of or Known Breast Disease)

- One baseline mammogram between age 35 through 39
- Screening mammogram every 12 months (including physician interpretation) for all women age 40 or older

Notes:

- A diagnostic mammography is a radiologic procedure furnished to a man or woman with signs and symptoms of breast disease, or a personal history of breast cancer, or a personal history of biopsy-proven benign breast disease, and includes a physician's interpretation of the results of the procedure. For diagnostic mammography guideline, refer to the Coverage Summary for Radiologic Diagnostic Procedures.
- A screening mammography is a radiologic procedure furnished to a woman without signs or symptoms of breast disease, for the purpose of early detection of breast cancer, and includes a physician's interpretation of the results of the procedure. A screening mammography has limitations as it must be, at a minimum a two-view exposure (cranio-caudal and a medial lateral oblique view) of each breast. Unlike diagnostic mammography, there's no need to have signs, symptoms, or history of breast disease for the exam to be covered.
- Digital Breast Tomosynthesis:
  - Effective January 1, 2015, HCPCS code 77063 [Screening digital breast tomosynthesis, bilateral (list separately in addition to code for primary procedure)], must be billed in conjunction with the screening mammography.
  - Effective January 1, 2015, member coinsurance and deductible does not apply to claim lines with 77063 [Screening digital breast tomosynthesis, bilateral (List separately in addition to code for primary procedure)].
  - Payment for 77063 is made only when billed with an ICD-9 code of V76.11 or V76.12 (and when ICD-10 is effective with ICD-10 code Z12.31).

Refer to the:

- NCD for Mammograms (220.4)
- Medicare Benefit Policy Manual, Chapter 15, §280.3 – Screening Mammography
- MLN Matters # MM8874 – Preventive and Screening Services – Update – Intensive Behavioral Therapy for Obesity, Screening Digital Tomosynthesis Mammography, and Anesthesia Associated with Screening Colonoscopy.

(Accessed April 13, 2020)

Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. These LCDs/LCAs are available at https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx?from2=search.asp&.

Cervical and Vaginal Cancer

Screening Pap Smears and Pelvic Examination (including clinical breast examination) are covered when Medicare criteria are met. For Medicare coverage guideline, refer to the NCD for Screening Pap Smears and Pelvic Examination for Early Detection of Cervical or Vaginal Cancer (210.2). Also refer to the Medicare Benefit Policy Manual, Chapter 15, §280.4 – Screening Pap Smears. (Accessed April 13, 2020)

Screening for Cervical Cancer with Human Papilloma Virus (HPV) Testing is covered when Medicare criteria are met. Refer to the NCD for Screening Cervical Cancer with Human Papillomavirus (210.2.1) for coverage guideline. (Accessed April 13, 2020)

Colorectal Cancer

Fecal Occult Blood Test, Flexible Sigmoidoscopy, Colonoscopy and Barium Enema

Colorectal screening tests/procedures for the early detection of colorectal cancer are covered when Medicare criteria are met:

- For people 50 and older:
  - Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months
  - Fecal occult blood test, every 12 months
- For people at high risk of colorectal cancer: Screening colonoscopy (or screening barium enema as an alternative) every 24 months
- For people not at high risk of colorectal cancer: Screening colonoscopy every 10 years, but not within 48 months of a screening sigmoidoscopy

Notes:

- Colorectal cancer high risk individual: Defined as someone who has one or more of the following:
  - A close relative (sibling, parent, or child) who has had colorectal cancer or an adenomatous polyp
  - A family history of familial adenomatous polyposis
  - A family history of hereditary nonpolyposis colorectal cancer
  - A personal history of colorectal cancer
  - A personal history of adenomatous polyps
  - Inflammatory bowel disease, including Crohn's Disease, and ulcerative colitis
- Colonoscopy or Sigmoidoscopy Turned Diagnostic: UnitedHealthcare Medicare Advantage plan members undergoing a screening a colonoscopy or sigmoidoscopy will have a $0 cost share regardless of whether a polyp is found and/or removed during the procedure.

Refer to the NCD for Colorectal Cancer Screening Tests (210.3) and NCD for Fecal Occult Blood Test (FOBT) (190.34). Also refer to the Medicare Benefit Policy Manual, Chapter 15, §280.2 – Colorectal Cancer Screening.
(Accessed April 13, 2020)

Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) for colorectal cancer screening exist and compliance with these policies is required where applicable. These LCDs/LCAs are available at http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx.

Cologuard™ Test

Cologuard™ test is covered when Medicare criteria are met. Refer to the NCD for Colorectal Cancer Screening Tests (210.3) for coverage guideline. (Accessed April 13, 2020)

Blood-Based Biomarker Tests

CMS has determined that the evidence is sufficient to cover a blood-based biomarker test as an appropriate colorectal cancer screening test once every 3 years for when performed in a Clinical Laboratory Improvement Act (CLIA)-certified laboratory, when ordered by a treating physician and when all of the following requirements are met:

- The patient is:

- Age 50-85 years, and,
- Asymptomatic (no signs or symptoms of colorectal disease including but not limited to lower gastrointestinal pain, blood in stool, positive guaiac fecal occult blood test or fecal immunochemical test), and,
- At average risk of developing colorectal cancer (no personal history of adenomatous polyps, colorectal cancer, or inflammatory bowel disease, including Crohn's Disease and ulcerative colitis; no family history of colorectal cancers or adenomatous polyps, familial adenomatous polyposis, or hereditary nonpolyposis colorectal cancer).

- The blood-based biomarker screening test must have all of the following:
  - FDA market authorization with an indication for colorectal cancer screening; and
  - Proven test performance characteristics for a blood-based screening test with both sensitivity greater than or equal to 74% and specificity greater than or equal to 90% in the detection of colorectal cancer compared to the recognized standard (accepted as colonoscopy at this time), based on the pivotal studies included in the FDA labeling.

Note: The currently available Epi proColon® test does not meet the criteria for an appropriate blood-based biomarker CRC screening test. Based on the evidence at this time, we will non-cover the Epi proColon® test.

For the detailed coverage language, refer to the proposed final NCD for Colorectal Cancer Screening Tests (210.3) and decision memo at https://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=299&type=Open&bc=AAgAAAAACAAA&.
(Accessed February 2, 2021)

Prostate Cancer Screening (PSA Blood Test and Digital Rectal Exam)

Prostate Cancer Screening (PSA blood test and digital rectal exam) is covered when Medicare criteria are met.

Refer to the NCD for Prostate Cancer Screening Tests (210.1) for coverage guideline. (Accessed April 13, 2020)

Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) for prostate specific antigen (PSA) exist and compliance with these policies is required where applicable. These LCDs/LCAs are available at http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx.

Lung Cancer [Low Dose Computed Tomography (LDCT)]

Effective February 5, 2015, Medicare has determined that the evidence is sufficient to add a lung cancer screening counseling and shared decision making visit, and for appropriate beneficiaries, annual screening for lung cancer with low dose computed tomography (LDCT), as an additional preventive service benefit when Medicare criteria are met.

Refer to the NCD for Lung Cancer Screening with Low Dose Computed Tomography (LDCT) (210.14) for coverage guideline. (Accessed April 13, 2020)

A list of Medicare approved registries for screening for lung cancer with low dose computed tomography (LDCT) is available at http://www.cms.hhs.gov/MedicareApprovedFacilitie/VAD/list.asp. (Accessed April 13, 2020)

Cardiovascular Disease Screening

Cardiovascular screening blood tests are covered for all asymptomatic members for early detection of cardiovascular disease or abnormalities associated with an elevated risk of cardiovascular disease. This screening includes total cholesterol test, cholesterol test for high density lipoproteins and triglycerides test. Frequency is every five years (i.e., 59 months after the last covered screening tests).

Refer to the MLN Matters #3411 – MMA-Cardiovascular Screening Blood Tests. (Accessed April 13, 2020)
Also refer to the Medicare Claims Processing Manual, Chapter 18, §100 – Cardiovascular Screening. (Accessed April 13, 2020)

Depression Screening in Adults

Depression screening for adults is covered when Medicare criteria are met. Refer to the NCD for Screening for Depression in Adults (210.9) for coverage guideline. (Accessed April 13, 2020)

Diabetes Screening

Diabetes screening tests (fasting plasma glucose test and post-glucose challenge test) are covered when the following criteria are met:

- Member has one of the following risk factors for diabetes:
  - Hypertension
  - Dyslipidemia
  - Obesity (with body mass index greater than or equal to 30 kg/m2)
  - Previous identification of elevated impaired fasting glucose or glucose intolerance

  or,
- Member has two of the following risk factors for diabetes
  - Overweight (a body mass index >25, but <30 kg/m2)
  - Family history of diabetes
  - Age 65 years or older
  - History of gestational diabetes mellitus or giving birth to a baby weighing >9 lbs

Notes:

- Members already diagnosed with diabetes do not qualify for this screening.
- Frequency:
  - Two screening tests per calendar year for members diagnosed with pre-diabetes (limited to one screening tests every 6 months)
  - One screening test per calendar year for individuals previously tested who were not diagnosed with pre-diabetes, or who have never been tested

Refer to the Medicare Claims Processing Manual, Chapter 18 – Preventive and Screening Services, §90 Diabetes Screening. (Accessed April 13, 2020)
Also refer to the MLN Matters #3637 – Diabetes Screening. (Accessed April 13, 2020)

Diabetes Self-Management Training

Diabetes outpatient self-management training services are covered when criteria are met. Refer to Coverage Summary for Diabetes Management, Equipment and Supplies.

Glaucoma Screening

Screening for glaucoma is defined to include (1) a dilated eye examination with an intraocular pressure measurement; and (2) a direct ophthalmoscopy examination, or a slit lamp biomicroscopic examination.

Annual (once every 12 months) glaucoma screening is covered for members with diabetes mellitus or a family history of glaucoma, or African Americans age 50 and over, or Hispanic-Americans age 65 and older.

Note: Optometrist may perform a Medicare covered glaucoma screening, if the service is within the scope of practice permitted by state licensure.
Refer to the Medicare Benefit Policy Manual, Chapter 15, §280.1 – Glaucoma Screening. (Accessed April 13, 2020)

Human Immunodeficiency Virus (HIV) Screening

HIV screening is covered when Medicare criteria are met. Refer to the NCD for Screening for the Human Immunodeficiency Virus (HIV) Infection (210.7) for coverage guideline. (Accessed April 13, 2020)

Immunizations (Seasonal Influenza, Pneumococcal and Hepatitis B)

Vaccinations or inoculations are excluded as immunizations unless they are directly related to the treatment of an injury or direct exposure to a disease or condition, such as anti-rabies treatment, tetanus antitoxin or booster vaccine, botulin antitoxin, antivenin sera, or immune globulin. In the absence of injury or direct exposure, preventive immunization (vaccination or inoculation) against such diseases as smallpox, polio, diphtheria, etc., is not covered. However, pneumococcal, hepatitis B, and influenza virus vaccines are exceptions to this rule. In cases where a vaccination or inoculation is excluded from coverage, related charges are also not covered.

For additional information, refer to the Medicare Benefit Policy Manual, Chapter 15, §50.4.4.2 – Immunizations. (Accessed April 13, 2020)

Influenza (flu) Vaccine

- Covered once a flu season [Note: Generally, one (1) influenza virus vaccination per influenza season is covered, however, more than one influenza virus vaccination per influenza season may be covered if a physician determines and documents that the vaccination is reasonable and medically necessary. The administering provider should maintain documentation.]
- Usually given to any Medicare eligible member
- Physician order is not required to receive a flu vaccine
- Member may self-refer
- No deductible or co-insurance liability
- A flu vaccine is covered regardless of the location in which it is administered.

H1N1 Vaccine: In addition to the seasonal flu vaccine covered once a flu season, the administration of the H1N1 influenza vaccine, also called the "swine flu", will be covered. The vaccine is currently under production and will be available in the Fall of 2009. The federal government will provide the H1N1 vaccine at no cost to the health care providers, therefore, only the administration of the vaccine is payable. There will be no coinsurance or copayment, or deductible applied to this benefit.

Refer to the Medicare Benefit Policy Manual, Chapter 15, §50.4.4.2.C – Influenza Virus Vaccine; available. (Accessed April 13, 2020)

Also refer to the following:

- 2012- 2013 Immunizers' Question and Answer Guide to Medicare Part B, Medicaid and CHIP Coverage of Seasonal Influenza and Pneumococcal Vaccinations at https://www.cms.gov/medicare/prevention/immunizations/downloads/2012-2013_flu_guide.pdf. (Accessed April 13, 2020)
- Medicare Preventive Services-MLN Educational Tool at https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html. (Accessed April 13, 2020)

Pneumococcal Polysaccharide Vaccine (PPV)

For Dates of Service On or After May 1, 1981 through September 18, 2014

- An initial vaccine may be administered only to persons at high risk (refer to below) of pneumococcal disease
  Note: Persons at high risk for whom an initial vaccine may be administered include all people age 65 and older; immunocompetent adults who are at increased risk of pneumococcal disease or its complications because of chronic illness (e.g., cardiovascular disease, pulmonary disease, diabetes mellitus, alcoholism, cirrhosis, or cerebrospinal fluid leaks); and individuals with compromised immune systems (e.g., splenic dysfunction or anatomic asplenia, Hodgkin's disease, lymphoma, multiple myeloma, chronic renal failure, HIV infection, nephrotic syndrome, sickle cell disease, or organ transplantation)
- Re-vaccination may be given only to those members at the highest risk of serious infection and those likely to have had a drop in antibody levels, provided that at least 5 years had passed since receiving the previous vaccination.
  Note: Persons at highest risk and those most likely to have rapid declines in antibody levels are those for whom revaccination may be appropriate. This group includes persons with functional or anatomic asplenia (e.g., sickle cell disease, splenectomy), HIV infection, leukemia, lymphoma, Hodgkin's disease, multiple myeloma, generalized malignancy, chronic renal failure, nephrotic syndrome, or other conditions associated with immunosuppression such as organ or bone marrow transplantation, and those receiving immunosuppressive chemotherapy. It is not appropriate for routine revaccination of people age 65 or older that are not at highest risk.

For Dates of Service On and After September 19, 2014

Effective for dates of service on and after September 19, 2014, an initial pneumococcal vaccine may be administered to all Medicare beneficiaries who have never received a pneumococcal vaccination under Medicare Part B. A different, second pneumococcal vaccine may be administered 1 year after the first vaccine was administered (i.e., 11 full months have passed following the month in which the last pneumococcal vaccine was administered).

Those administering the vaccine should not require the patient to present an immunization record prior to administering the pneumococcal vaccine, nor should they feel compelled to review the patient's complete medical record if it is not available. Instead, provided that the patient is competent, it is acceptable to rely on the patient's verbal history to determine prior vaccination status.

Refer to the Medicare Benefit Policy Manual, Chapter 15, §50.4.4.2.A – Pneumococcal Pneumonia Vaccinations. (Accessed April 13, 2020)

Also refer to the following:

- 2012- 2013 Immunizers' Question and Answer Guide to Medicare Part B, Medicaid and CHIP Coverage of Seasonal Influenza and Pneumococcal Vaccinations at https://www.cms.gov/medicare/prevention/immunizations/downloads/2012-2013_flu_guide.pdf. (Accessed April 13, 2020)
- Medicare Preventive Services-MLN Educational Tool at https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html. (Accessed April 13, 2020)

Hepatitis B Vaccine for Members Who are at High or Intermediate Risk of Contracting Hepatitis B

High-risk groups currently identified include:

- Members with end stage renal disease (ESRD)
- Hemophiliacs who are receiving Factor VIII or IX concentrates
- Members who are residents of institutions for the mentally challenged
- Members who live in the same household as a member infected with Hepatitis B
- Homosexual men
- Illicit injectable drug abusers; and
- Persons diagnosed with diabetes mellitus

Intermediate risk groups currently identified include:

- Staff in institutions for the mentally challenged; and
- Workers in health care professions who have frequent contact with blood or blood-derived body fluids during routine work

Exception: Persons in the above-listed groups would not be considered at high or intermediate risk of contracting hepatitis B, however, if there is laboratory evidence positive for antibodies to hepatitis B. (ESRD patients are routinely tested for hepatitis B antibodies as part of their continuing monitoring and therapy.)

Refer to the Medicare Benefit Policy Manual, Chapter 15, §50.4.4.2. B – Hepatitis B Vaccine. (Accessed April 13, 2020)

Also refer to the following:

- 2012-2013 Immunizers' Question and Answer Guide to Medicare Part B, Medicaid and CHIP Coverage of Seasonal Influenza and Pneumococcal Vaccinations at https://www.cms.gov/medicare/prevention/immunizations/downloads/2012-2013_flu_guide.pdf. (Accessed April 13, 2020)
- Medicare Preventive Services-MLN Educational Tool at https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html. (Accessed May April 13, 2020)

Note: Other than the immunizations covered under Part B outlined above, all other Medicare-covered vaccines, e.g., Varicella vaccine for chickenpox, Zostavax for shingles, meningococcal vaccine, are covered under Part D. Refer to the Member's Pharmacy Program booklet or contact the Prescription Solutions customer service department to determine coverage eligibility for Part D prescription drug benefit.

Refer to the:

- Medicare Benefit Policy Manual, Chapter 15, §50.4.4.2 – Immunizations.
- Medicare Claims Processing Manual, Chapter 18, §10 – Pneumococcal Pneumonia, Influenza Virus, and Hepatitis B Vaccines.

(Accessed April 13, 2020)

Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. Refer to the LCDs/LCAs for Immunizations athttp://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx.

Initial Preventive Physical Examination (IPPE) (also commonly referred to as the "Welcome to Medicare" Preventive Visit)

Sections 1861(s)(2)(w) and 1861(ww) of the Social Security Act (and implementing regulations at 42 CFR 410.16, 411.15(a)(1), and 411.15(k)(11) authorize coverage under Part B for a one-time initial preventive physical examination (IPPE) for new Medicare beneficiaries that meet certain eligibility requirements.

One-time initial preventive physical examination (IPPE) includes:

- Review of a member medical and social history
- Review of a member's potential (risk factors) for depression, including current or past experience with depression or other mood disorder
- Review of the member's functional ability and level of safety, including a minimum review of hearing impairment, activities of daily living, fall risk and home safety
- An examination to include measurement of the member's height, weight, blood pressure, a visual acuity screening
- End-of-life planning as mandatory services (upon an individual's consent) (Effective January 1, 2009)
- Education, counseling, and referral services based on the findings
- Education, counseling, and referral for obtaining the appropriate screening and other preventive services. Screening is for those members without specific signs or symptoms or a diagnosis of the disease being screened.
- Performance and interpretation of an EKG
  Note: Effective for dates of service on or after January 1, 2009, the screening EKG is no longer a required part of the IPPE. It is optional and may be performed as a result of a referral from an IPPE (as part of the educational, counseling, and referral service the member is entitled to during the member's IPPE visit). The screening EKG will be allowed only once in a member's lifetime.
  Refer to the MLN Matters # MM6223 – Update to the Initial Preventive Physical Examination (IPPE) Benefit.
  (Accessed April 13, 2020)
- Measurement of an individual's body mass index (Effective January 1, 2009)

Notes:

- IPPE is a once-a-lifetime benefit and must be performed within six months after the effective date of the member's first Part B coverage, but only if such Part B coverage begins on or after January 1, 2005.
  Effective for IPPEs performed on or after January 1, 2009, a member is eligible for the extended IPPE benefits of MIPPA when he/she first enrolls in Medicare Part B and receives the IPPE benefit within the first 12 months of the effective date of the initial Part B coverage period.
  Refer to MLN Matters # MM6223 – Update to the Initial Preventive Physical Examination (IPPE) Benefit.
  (Accessed April 13, 2020)
- The IPPE does not include other preventive services that are currently separately covered and paid under section 1861 of the Act under Medicare Part B screening benefits. (That is, pneumococcal, influenza and hepatitis B vaccines and their administration, screening mammography, screening pap smear and screening pelvic examinations, prostate cancer screening tests, colorectal cancer screening tests, diabetes outpatient self-management training services, bone mass measurements, glaucoma screening, medical nutrition therapy for individuals with diabetes or renal disease, cardiovascular screening blood tests, and diabetes screening tests.)

Refer to the Medicare Claims Processing Manual, Chapter 18, §80 – Initial Preventive Physical Examination (IPPE).
(Accessed April 13, 2020)

Also refer to the following:

- MLN Matters # MM6223 – Update to the Initial Preventive Physical Examination (IPPE) Benefit.
- MLN Matters # MM3771 – Clarification for Outpatient Prospective Payment System (OPPS) Hospitals Billing the Initial Preventive Physical Exam (IPPE).
- Medicare's Quick Reference for Initial Physical Examination is available at http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QRI_IPPE001a.pdf.

- Medicare Claims Processing Manual, Chapter 12, §30.6.1.1 – Initial Preventive Physical Examination (IPPE) and Annual Wellness Visit (AWN).

(Accessed April 13, 2020)

Intensive Behavioral Therapy for Cardiovascular Disease

Intensive behavioral therapy for cardiovascular disease is covered when Medicare criteria are met. Refer to the NCD for Intensive Behavioral Therapy for Cardiovascular Disease (210.11) for coverage guideline. (Accessed April 13, 2020)

Intensive Behavioral Therapy for Obesity

Intensive behavioral therapy for obesity is covered when Medicare criteria are met. Refer to the NCD for Intensive Behavioral Therapy for Obesity (210.12) for coverage guideline. (Accessed April 13, 2020)

Medical Nutrition Therapy (for Members with Diabetes or Renal Disease)

Medical nutrition therapy for members with diabetes or renal disease is covered when criteria are met; refer to the Coverage Summary for Diabetes Management, Equipment and Supplies.

Sexually Transmitted Infections (STIs) Screening and High-Intensity Behavioral Counseling (HIBC) to Prevent STIs

Sexually transmitted infections (STIs) screening and high-intensity behavioral counseling (HIBC) to prevent STIs are covered when Medicare criteria are met. Refer to the NCD for Screening for Sexually Transmitted Infections (STIs) and High-Intensity Behavioral Counseling (HIBC) to Prevent STIs (210.10). (Accessed April 13, 2020)

Tobacco-Use Cessation Counseling

Tobacco-use cessation counseling is covered when Medicare criteria are met. Refer to the NCD for Counseling to Prevent Tobacco Use (210.4.1) for coverage guideline. (Accessed April 13, 2020)

Screening for Hepatitis C Virus (HCV)

Screening for HCV is covered when Medicare criteria are met. Refer to the NCD for Screening for Hepatitis C Virus (HCV) in Adults (210.13) for coverage guideline. (Accessed April 13, 2020)

Screening for Hepatitis B Virus (HBV) Infection

Screening for HBV infection is covered when Medicare criteria are met. Refer to the NCD for Screening for Hepatitis B Virus (HBV) Infection (210.6) or coverage guideline. (Accessed April 13, 2020)

Kidney Disease Education (KDE)

Face to face kidney disease education (KDE)

Face to face kidney disease education (KDE) services are covered for the following:

- Patient diagnosed with Stage IV CKD, using the Modification of Diet in Renal Disease (MDRD) Study formula (severe decrease in GFR, GFR value of 15-29 mL/min/1.73 m2), and
- Patient with a referral from the physician managing the patient's kidney condition. The referral should be documented in the patient's medical records

Qualified Persons

Medicare Part B covers KDE services provided by a 'qualified person,' meaning a:

- Physician (as defined in Section 30 of the Medicare Benefit Policy Manual, Chapter 15
- Physician assistant, nurse practitioner, or clinical nurse specialist as defined in Sections 190, 200, and 210 of the Medicare Benefit Policy Manual, Chapter 15
- Hospital, critical access hospital (CAH), skilled nursing facility (SNF), comprehensive outpatient rehabilitation facility (CORF), home health agency (HHA), or hospice, if the KDE services are provided in a rural area (using the actual geographic location core based statistical area (CBSA) to identify facilities located in rural areas), or hospital or CAH that is treated as being rural (was reclassified from urban to rural status per 42 CFR 412.103). (Accessed April 13, 2020)

The "incident to" requirements at section 1861(s)(2)(A) of the Social Security Act (the Act) do not apply to KDE services. The following providers are not 'qualified persons' and are excluded from furnishing KDE services:

- A hospital, CAH, SNF, CORF, HHA, or hospice located outside of a rural area (using the actual geographic location CBSA to identify facilities located outside of a rural area), unless the services are furnished by a hospital or CAH that is treated as being in a rural area; and
- Renal dialysis facilities

Limitations for Coverage

- Up to six (6) sessions as a patient lifetime maximum. A session is 1 hour. In order to bill for a session, a session must be at least 31 minutes in duration. A session that lasts at least 31 minutes, but less than 1 hour still constitutes 1 session.
- On an individual basis or in group settings; if the services are provided in a group setting, a group consists of 2 to 20 individuals who need not all be UnitedHealthcare Medicare members.

Refer to the Medicare Benefit Policy Manual, Chapter 15, §310 – Kidney Disease Patient Education Services. (Accessed April 13, 2020)

Routine Physical Examination

Routine physical checkup is not covered under Medicare. Refer to the Medicare Benefit Policy Manual, Chapter 16, §90 – Routine Services and Appliances. (Accessed April 13, 2020)

Note: Depending on the member's plan, some members have coverage for annual routine physical examination. To determinate coverage, refer to the member's EOC/SOB for the member's specific benefit for annual routine physical examination.

Vaccines and Immunizations for International Travel

Vaccines and immunizations for the purpose of international travel are not covered.

In the absence of injury or direct exposure, preventive immunization (vaccination or inoculation) against such diseases as smallpox, polio, diphtheria, etc., is not covered. Refer to the Medicare Benefit Policy Manual, Chapter 15, §50.4.4.2 – Immunizations. (Accessed April 13, 2020)

Imaging for Screening Asymptomatic Persons

Imaging for screening asymptomatic persons are not covered. Examples include but are not limited to:

- Whole-body/skull base to mid-thigh computed tomography (CT) for disease screening in asymptomatic individuals
- Whole-body/skull base to mid-thigh positron emission tomography (PET) or combined positron emission tomography-computed tomography (PET-CT) for disease screening in asymptomatic individuals
- CT scan of the chest as a screening test for lung cancer in smokers or former smokers

Note: Medicare excludes expenses incurred for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

Refer to Title XVIII of the Social Security Act (SSA) Section 1862 (a)(1)(A) at http://www.ssa.gov/OP_Home/ssact/title18/1862.htm. Also refer to the Medicare Benefit Policy Manual, Chapter 16, §20 – Services Not Reasonable and Necessary. (Accessed April 13, 2020)

Counseling for Vitamin D Supplementation

Counseling for vitamin D supplementation to prevent falls is covered; vitamin D supplement is not covered. Charges for medications, e.g., vitamins, given simply for the general good and welfare of the patient and not as accepted therapies for an illness are excluded from coverage.

Refer to the Medicare Benefit Policy Manual, Chapter 15, §50.4.3 – Examples of Not Reasonable and Necessary. (Accessed April 13, 2020)

Cytological Examination of Breast Fluids

Cytological Examination of Breast Fluids for Cancer Screening (Breast Ductal Lavage, Breast Ductal Fluid Aspiration and Cytology and Fiberoptic Ductoscopy, with or without Ductal Lavage)

Medicare does not have a National Coverage Determination (NCD) for cytological examination of breast fluids for cancer screening. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist at this time.

For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy for Cytological Examination of Breast Fluids for Cancer Screening.
Note: After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the policy referenced above for coverage guidelines.

Definitions

Immunization: The process by which a person or animal becomes protected against a disease. This term is often used interchangeably with vaccination or inoculation. Center for Disease Control and Prevention: Vaccines and Immunization; available at http://www.cdc.gov/vaccines/vac-gen/imz-basics.htm. (Accessed April 13, 2020)

Vaccination: Injection of a killed or weakened infectious organism in order to prevent the disease. Center for Disease Control and Prevention: Vaccines and Immunization; available at http://www.cdc.gov/vaccines/vac-gen/imz-basics.htm. (Accessed April 13, 2020)

Vaccine: A product that produces immunity therefore protecting the body from the disease. Vaccines are administered through needle injections, by mouth and by aerosol. Center for Disease Control and Prevention: Vaccines and Immunization; available at http://www.cdc.gov/vaccines/vac-gen/imz-basics.htm. (Accessed April 13, 2020)

Policy History/Revision Information

Date	Summary of Changes
05/01/2021	**Template Update** • Reformatted policy; transferred content to new template

02/16/2021	**Blood-Based Biomarker Tests (new to policy)**
	• Added coverage guidelines to indicate:
	  ○ CMS has determined that the evidence is sufficient to cover a blood-based biomarker test as an appropriate colorectal cancer screening test once every 3 years when performed in a Clinical Laboratory Improvement Act (CLIA)-certified laboratory, when ordered by a treating physician and when all of the following requirements are met:
	  ▪ The patient is:
	  – Age 50-85 years; and
	  – Asymptomatic (no signs or symptoms of colorectal disease including but not limited to lower gastrointestinal pain, blood in stool, positive guaiac fecal occult blood test or fecal immunochemical test); and
	  – At average risk of developing colorectal cancer (no personal history of adenomatous polyps, colorectal cancer, or inflammatory bowel disease, including Crohn's Disease and ulcerative colitis; no family history of colorectal cancers or adenomatous polyps, familial adenomatous polyposis, or hereditary nonpolyposis colorectal cancer)
	  ▪ The blood-based biomarker screening test must have all of the following:
	  – FDA market authorization with an indication for colorectal cancer screening; and
	  – Proven test performance characteristics for a blood-based screening test with both sensitivity greater than or equal to 74% and specificity greater than or equal to 90% in the detection of colorectal cancer compared to the recognized standard (accepted as colonoscopy at this time), based on the pivotal studies included in the FDA labeling

Date	Summary of Changes
	○ The currently available Epi proColon® test does not meet the criteria for an appropriate blood-based biomarker CRC screening test; based on the evidence at this time, we will non-cover the Epi proColon® test ○ For the detailed coverage language, see the proposed final NCD for Colorectal Cancer Screening Tests (210.3) and decision memo at https://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=299&type=Open&bc=AAgAAAAACAAA&

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The benefit information in this Coverage Summary is based on existing national coverage policy; however, Local Coverage Determinations (LCDs) may exist and compliance with these policies are required where applicable.

There are instances where this document may direct readers to a UnitedHealthcare Commercial Medical Policy, Medical Benefit Drug Policy, and/or Coverage Determination Guideline (CDG). In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence (Medicare IOM Pub. No. 100-16, Ch. 4, §90.5).