Screening

Medicare does not cover routine exams and screening tests performed in the **absence of signs, symptoms, complaints**, or personal history of disease or injury (with a few exceptions).

Non-Covered Screening

Medicare classifies screening tests as secondary prevention and therefore as non-covered. Screening tests are performed on **asymptomatic individuals** in order to identify conditions that have not yet produced clinically evident sequelae (i.e, signs, symptoms, or functional limitations). The guiding principle in determining whether an item or service fits the definition of a screening test is the **intent** of the test. The intent of a screening test is to identify a condition before it manifests clinically, thus allowing for early prevention. [1]

The clinician and beneficiary should discuss the rationale and potential risks and benefits of the testing and inform the patient that they will be billed for the testing if Medicare does not cover it. In the event the beneficiary would like the screening test be performed, the clinician should inform them that the test is not currently covered under the Medicare benefit unless designated screening test below. The ABN-L form provided by Palmetto Health Can be used and you would check "not a Medicare benefit".
Exams required by insurance companies, business establishments, government agencies, or other third parties are considered non-covered screening services.

Guidance to Physicians:

Please clearly identify any routine screening tests on the order/lab requisition.

Please **inform your patient** when you order "screening" tests and remind them that Medicare may not pay for these tests. The laboratory can directly bill the patient.

Covered Screening

Certain screening tests are explicitly authorized by statute as exceptions to the rule and are reimbursable by Medicare. These tests, however, have a **frequency limitation**. For the laboratory, these tests currently are **Pap Smears, PSA, Diabetes, Cardiovascular, HIV Screen and Fecal Occult Blood screening**. Please refer to the specific test for more information and the frequency limitation for each test. An **ABN should be given** to the beneficiary when Medicare denial of payment for exceeding the frequency limit is possible.

[1]. Excerpt from: Palmetto GBA Advisory, Nov 1998, "Clinical Preventive Services and Medicare: Would You Know a Screening Service if Your Ordered it?", Harry Feliciano, MD.