



**Centers for Medicare & Medicaid Services  
National Training Program  
Instructor Information Sheet**

**Module 7 - Medicare Preventive Services**

**Module Description**

The lessons in the Medicare Preventive Services module explain Medicare-covered preventive services.

The materials—up-to-date and ready-to-use—are designed for information givers/trainers who are familiar with the Medicare program, and would like to have prepared information for their presentations.

**Objectives**

- Which preventive services are covered
- Who is eligible to receive them
- How much you pay
- Where to get more information

**Target Audience**

This module is designed for presentation to trainers and other information givers.

**Time Considerations**

The module consists of 49 PowerPoint slides with corresponding speaker's notes and knowledge check activities. It can be presented in 45 minutes. Allow approximately 15 more minutes for discussion, questions, and answers. Additional time may be needed for add-on activities.

**Course Materials**

Most materials are self-contained within the module.

## Module 7: MEDICARE PREVENTIVE SERVICES

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# 2014 National Training Program



## Module 7

## Medicare Preventive Services

Module 7 explains Medicare-covered preventive services.

This training module was developed and approved by the Centers for Medicare & Medicaid Services (CMS), the federal agency that administers Medicare, Medicaid, the Children’s Health Insurance Program (CHIP), and the Federally-facilitated Health Insurance Marketplace. The information in this module was correct as of May 2014.

To check for an updated version of this training module, visit [cms.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram/index.html](http://cms.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram/index.html).

This set of CMS National Training Program materials isn’t a legal document. Official Medicare Program legal guidance is contained in the relevant statutes, regulations, and rulings.

## Session Objectives

This session explains the following:

- Which preventive services are covered
- Who is eligible to receive them
- How much you pay
- Where to get more information

05/01/2014

Medicare Preventive Services

This Medicare Preventive Services session explains the following:

- Which preventive services are covered
- Who is eligible to receive them
- How much you pay
- Where to get more information

## Lesson 1 – Introduction

- Medicare preventive services
  - Find health problems early, when treatment works best
- Covered by Medicare Part B (Medical Insurance)
  - Whether you get your coverage from
    - Original Medicare
    - Medicare Advantage Plan
    - Other Medicare health plans
- Coverage based on age, gender, and medical history

05/01/2014

Medicare Preventive Services

Medicare Part B covers preventive services like screening exams, wellness visits, lab tests, and immunizations to help prevent, find, and manage medical problems.

Preventive services may find health problems early, when treatment works best.

You must have Medicare Part B for Medicare to cover these services.

These services are covered whether you get your coverage from Original Medicare, a Medicare Advantage (MA) Plan, or other Medicare health plans. However, the rules for how much you pay for these services may vary. A Medicare health plan is a plan offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. Medicare health plans include all MA Plans, Medicare Cost Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly.

Talk with your doctor about which preventive services you need, how often you need them to stay healthy, and if you meet the criteria for coverage based on your age, gender, and medical history.

### Need more information?

Your Guide to Medicare's Prevention Services, CMS Product No. 10110, gives an overview of Medicare's covered preventive services:

[medicare.gov/Pubs/pdf/10110.pdf](https://www.medicare.gov/Pubs/pdf/10110.pdf).



## Paying for Preventive Services in 2014

- In Original Medicare you
  - Pay nothing for most preventive services if your provider accepts *assignment*\*
  - May pay more if provider doesn't accept assignment
  - May have copayment
    - If doctor performs other services not part of covered preventive benefits, or
    - For *certain* preventive services, or
    - If you are in a Medicare Advantage or other Medicare health plan

\*Assignment is an agreement by your doctor, provider, or supplier to be paid directly by Medicare, to accept the Medicare-approved amount as full payment for covered services and not to bill you for anymore than the Medicare deductible and coinsurance.

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Medicare Preventive Services

Under Original Medicare you will pay nothing for most preventive services, if you get the services from a doctor or other provider who accepts assignment.

Assignment is an agreement by your doctor, provider, or supplier to be paid directly by Medicare, to accept the Medicare-approved amount as full payment for covered services, and not to bill you for any more than the Medicare deductible and coinsurance.

You will pay nothing for certain preventive services. However, if your doctor or other health care provider performs additional tests or services during the same visit that aren't covered under the preventive benefits, you may have to pay a copayment, and the Part B deductible may apply. Later, we'll discuss which preventive services require a copayment.

If you are in a Medicare Advantage Plan or other Medicare health plan and get Medicare-covered preventive services, you may have to pay copayments.

### Need more information?

The Medicare & You Handbook, CMS Product No. 10050, includes guidelines for who is covered and how often Medicare will pay for these services:

[medicare.gov/Pubs/pdf/10050.pdf](http://medicare.gov/Pubs/pdf/10050.pdf).



## Lesson 2 – What Is Covered?

- Welcome To Medicare Preventive visit
- Yearly “Wellness” visit
- Abdominal aortic aneurysm screening
- Alcohol misuse screening and counseling
- Bone mass measurement
- Breast cancer screening (mammogram)
- Cardiovascular disease (CVD) Risk Reduction Visit
- CVD screenings
- Cervical and vaginal cancer screening
- Colorectal cancer screenings
  - Screening fecal occult blood test
  - Screening flexible sigmoidoscopy
  - Screening colonoscopy
  - Screening barium enema
- Depression screening
- Diabetes screenings
- Flu shots (Vaccine)
- Glaucoma tests
- Hepatitis B shots (Vaccine)
- HIV screening
- Obesity screening and counseling
- Pneumococcal shot (Vaccine)
- Prostate cancer screening
- Sexually transmitted infections screening and counseling
- Tobacco use cessation counseling

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Medicare Preventive Services

Lesson 2 - This lesson will explain which preventive services are covered by Medicare.

Medicare covers many preventive services to help you stay healthy. Talk to your health care provider about which services are right for you.

## “Welcome to Medicare” Preventive Visit

- Once within first 12 months of getting Part B
- The doctor or healthcare provider will
  - Review your medical and social history
  - Take your height, weight, and body mass index
  - Perform a simple vision test
  - Review risk factors for depression
  - Review functional ability and safety
  - Educate and counsel you to help you stay well
  - Refer you for additional screenings if needed
- You pay nothing if doctor accepts assignment
  - Lab tests are not included

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Medicare Preventive Services

The “Welcome to Medicare” preventive visit is a great way to get up-to-date on important screenings and vaccines and to review your medical history. It is only offered one time within the first 12 months of getting Medicare Part B.

Your preventive visit will include the following services:

- Review your medical and social history
- Take your height, weight, body mass index, and blood pressure
- Perform a simple vision test
- Review potential risk factors for depression
- Review functional ability and level of safety, which means an assessment of hearing impairment, ability to successfully perform activities of daily living, fall risk, and home safety

You will get advice to help prevent disease, improve your health, and stay well. You will also get a brief written plan (like a checklist), letting you know which screenings and other preventive services you need.

Your doctor may also refer you for additional Medicare-covered screenings if you receive the referral as a result of your “Welcome to Medicare” preventive visit.

There is no cost if your doctor accepts Medicare assignment.

**IMPORTANT:** This service is a preventive visit and not a routine physical checkup. The Welcome to Medicare visit does not include any clinical lab tests.

### Need more information?

For more information, visit [cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/mm7079.pdf](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/mm7079.pdf).



## Yearly Wellness Visit

- Can't be within 12 months of your Welcome to Medicare Preventive Visit
- Focus is on "wellness"
- Available once every 12 months
  - After you've had Part B for longer than 12 months
- Personalized Prevention Plan Services

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Medicare Preventive Services

After you've had Part B for longer than 12 months, you can get a yearly wellness visit to develop or update a prevention plan just for you. Medicare covers one yearly wellness visit every 12 months.

You don't need to get the "Welcome to Medicare" preventive visit before getting a yearly wellness visit. If you received the "Welcome to Medicare" preventive visit, you'll have to wait 12 months before you can get your first yearly wellness visit.

Medicare will cover a yearly wellness visit providing personalized prevention plan services at no cost to you. You can work with your physician to develop and update your personalized prevention plan. This benefit provides an ongoing focus on prevention that can be adapted as your health needs change over time.

You'll pay nothing for this exam if the doctor accepts assignment.

**IMPORTANT:** The Yearly Wellness Visit is a preventive wellness visit and is not a "routine physical checkup."



### Need more information?

For more information, visit [cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/mm7079.pdf](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/mm7079.pdf).

## Initial Yearly Wellness Visit Providing Personalized Prevention Plan Services

- Includes
  - Health risk assessment
  - Review of functional ability and level of safety
  - Blood pressure, height, and weight measurements
  - Review of potential risk factors for depression
  - Personalized prevention plan
  - Written screening schedule
  - Personalized health advice
  - Referrals for health education and preventive counseling to help you stay well
  - List of medical providers
  - Detection of cognitive impairments

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Medicare Preventive Services

Your health professional will ask you to answer some questions before your visit. This is called a health risk assessment. Your responses to the questions will help you and your health professional get the most from your yearly wellness visit.

During your visit, your health care professional will:

- Record your blood pressure, height, and weight measurements
- Review your potential risk factor for depression
- Review your functional ability, and level of safety, which includes assessing your
  - Hearing
  - Ability to successfully perform activities of daily living (like walking, eating, etc.)
  - Fall risk
  - Home safety

You will also receive advice to help prevent disease, improve your health, and stay well. You will get a brief written plan, like a checklist, letting you know which screenings and other preventive services you need over the next 5 to 10 years.

## Subsequent Yearly Wellness Visits

- Includes
  - Updates to your medical/family history
  - Measurements of weight, blood pressure, and other routine measurements
  - Updates to your list of medical providers
  - Detection of cognitive impairments
  - Updates to your written screening schedule as provided in the initial yearly wellness visit with personalized prevention plan services
  - Personalized health advice
  - Referrals for health education and preventive counseling to help you stay well
  - Updated health risk assessment

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Medicare Preventive Services

Subsequent yearly wellness visits providing personalized prevention plan services (PPPS) include the following:

- Updates to your medical/family history
- Measurements of your weight (or waist circumference), blood pressure, and other routine measurements as deemed appropriate, based on the your medical and family history
- Updates to the list of your current medical providers and suppliers that are regularly involved in your medical care, as was developed at the first Yearly Wellness Visit providing PPPS
- Detection of any cognitive impairment that you may have
- Updates to the your written screening schedule as developed at the first Yearly Wellness Visit providing PPPS
- Updates to the your list of risk factors and conditions for which primary, secondary, or tertiary interventions are recommended or are underway for you, as was developed at your first Yearly Wellness Visit providing PPPS
- Personalized health advice and a referral, as appropriate, to health education or preventive counseling services or programs
- An updated health risk assessment

## Abdominal Aortic Aneurysm Screening

- Abdominal aortic aneurysms (weak area bulges)
- One-time ultrasound screening
- Risk factors
  - Family history of abdominal aortic aneurysms, or
  - Men age 65-75
    - Smoked more than 100 cigarettes
- No copayment or deductible with Original Medicare
- No longer requires referral from Welcome to Medicare preventive visit **NEW!**

05/01/2014

Medicare Preventive Services

The aorta is the largest artery in your body, and it carries blood away from your heart. When it reaches your abdomen, it is called the abdominal aorta.

The abdominal aorta supplies blood to the lower part of the body. When a weak area of the abdominal aorta expands or bulges, it is called an abdominal aortic aneurysm. Aneurysms develop slowly over many years and often have no symptoms. If an aneurysm expands rapidly, tears open (ruptured aneurysm), or blood leaks along the wall of the vessel (aortic dissection), serious symptoms may suddenly develop.

For a one-time screening ultrasound, you must get a referral from your physician, physician's assistant, nurse practitioner, or clinical nurse specialist.

Effective January 1, 2014, you will no longer need to get a referral during the Welcome to Medicare Preventive Visit for an Abdominal Aortic Aneurysm Screening. You will still need to get a referral from either a physician, physician's assistant, nurse practitioner, or clinical nurse specialist, but it won't have to be during your Welcome to Medicare Preventive visit. All other eligibility and frequency limitations remain the same.

You are considered at risk if you:

- Have a family history of abdominal aortic aneurysms
- Are a man age 65 to 75 and have smoked at least 100 cigarettes in your lifetime

If either of these apply to you, Medicare covers ultrasound screening for abdominal aortic aneurysms with no deductible or copayment if the doctor accepts assignment.

## Alcohol Misuse Screening and Counseling

- Annual screening
  - Up to four face-to-face counseling sessions if you
    - Misuse alcohol
    - Are not alcohol dependent
    - Are competent and alert when counseled
  - Counseling must be furnished
    - By a qualified primary care provider
    - In a primary care setting
    - Medicare does not identify specific screening tool
- No cost if provider accepts assignment

05/01/2014

Medicare Preventive Services

Medicare covers an annual alcohol misuse screening. Various screening tools are available for screening for alcohol misuse. Medicare does not identify specific alcohol misuse screening tools. Rather, the decision to use a specific tool is at the discretion of the clinician in the primary care setting.

For those who screen positive, Medicare covers up to four brief (15-minute), face-to-face behavioral counseling interventions per year for Medicare beneficiaries (including pregnant women) who meet the following requirement:

- Misuse alcohol, but whose levels or patterns of alcohol consumption do not meet criteria for alcohol dependence (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, sustains social, occupational, or recreational disability, use continues despite adverse consequences)
- Are competent and alert at the time that counseling is provided
- Counseling is furnished by qualified primary care physicians or other primary care practitioners in a primary care setting

A primary care setting is defined as one in which there is provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. Emergency departments, inpatient hospital settings, ambulatory surgical centers, independent diagnostic testing facilities, skilled nursing facilities, inpatient rehabilitation facilities, and hospices are not considered primary care settings under this definition.

## Bone Mass Measurement

- Measures bone density
  - Osteoporosis can weaken bones (make brittle)
- Covered if you meet specific criteria
  - You're at risk for osteoporosis based on your medical history
  - Your X-rays show possible problems
  - You're taking prednisone or steroid-type drugs
  - You have hyperparathyroidism
- Every 24 months (more often if medically necessary)
- No copayment or deductible with Original Medicare

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Medicare Preventive Services

Medicare covers bone mass measurements to measure bone density. These test results help you and your doctor choose the best way to keep your bones strong.

Osteoporosis is a disease in which your bones become weak and more likely to break. It is a silent disease, meaning that you may not know you have it until you break a bone.

Bone mass measurement is covered once every 24 months, or more often if medically necessary, if you fall into at least one of the following categories:

- A woman who is estrogen-deficient and at risk for osteoporosis, based on her medical history
- Individuals with vertebral abnormalities
- Individuals receiving (or expecting to receive) steroid therapy for more than 3 months
- Individuals with hyperparathyroidism, or
- Individuals being monitored to assess their response to Food and Drug Administration approved osteoporosis drug therapy

In Original Medicare there is no deductible or copayment.

## Breast Cancer Screening (Mammogram)

- Covered for all women with Medicare
  - One baseline mammogram
    - Between ages 35 and 39
  - Once a year starting at age 40
- No copayment or deductible with Original Medicare

Note: Diagnostic mammograms are covered if you have signs/symptoms, or history of breast disease

05/01/2014

Medicare Preventive Services

Breast cancer is the most frequently diagnosed non-skin cancer in women and is second only to lung cancer as the leading cause of cancer-related deaths among women in the United States. Every woman is at risk, and this risk increases with age. Breast cancer also occurs in men.

A screening mammogram is a radiologic procedure, an X-ray of the breast, used for the early detection of breast cancer in women who have no signs or symptoms of the disease and includes a physician's interpretation of the results.

Medicare provides coverage of an annual screening mammogram for all female beneficiaries aged 40 and older. Medicare also provides coverage of one baseline screening mammogram for female beneficiaries 35 through 39 years of age.

You don't need a doctor's referral, but the X-ray supplier will need to send your test results to a doctor.

In Original Medicare, there is no deductible or copayment if the doctor or qualified health care provider accepts assignment.

Diagnostic mammograms are done to check for breast cancer in men and women after a lump or other sign of breast cancer is found, if you have a history of breast cancer, or if your physician judges by your history and other significant factors that a mammogram is appropriate. The coinsurance or copayment and the Part B deductible apply for diagnostic mammograms.

## Cardiovascular Disease Screening

- Blood test for early risk detection
  - Heart disease
  - Stroke
- Medicare covers tests for
  - Total cholesterol
  - High-density lipoproteins
  - Triglycerides
- Covered once every 5 years
- No copayment or deductible with Original Medicare

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Medicare Preventive Services

Medicare covers cardiovascular screening tests that check your cholesterol and other blood fat (lipid) levels. High levels of cholesterol can increase your risk for heart disease and stroke.

Tests for total cholesterol, high-density lipoproteins (HDL) cholesterol, and triglyceride levels are covered once every 5 years for all people with Medicare who have no apparent signs or symptoms of cardiovascular disease.

People with Original Medicare do not pay a copayment or deductible for this screening.

## Cardiovascular Disease (CVD) Risk Reduction Visit

- One CVD risk reduction visit per year
  - Provided by a primary care provider in a primary care setting
- The visit includes the following components
  - Encouraging aspirin use if benefits outweigh risks
  - Screening for high blood pressure
  - Intensive behavioral counseling to promote healthy diet

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Medicare Preventive Services

Medicare covers intensive behavioral therapy for cardiovascular disease (CVD) (referred to as a CVD risk reduction visit).

Medicare covers one face-to-face CVD risk reduction visit per year for Medicare beneficiaries who are competent and alert at the time that counseling is provided, and whose counseling is furnished by a qualified primary care physician or other primary care practitioner in a primary care setting.

A primary care setting is defined as one in which there is a provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. Emergency departments, inpatient hospital settings, ambulatory surgical centers, independent diagnostic testing facilities, skilled nursing facilities, inpatient rehabilitation facilities, and hospices are not considered primary care settings under this definition.

The CVD risk reduction visit consists of the following components:

- Encouraging aspirin use for the primary prevention of CVD when the benefits outweigh the risks for men age 45-79 years and women 55-79 years
- Screening for high blood pressure in adults age 18 years or older
- Intensive behavioral counseling to promote a healthy diet for adults with hyperlipidemia, hypertension, advancing age, and other known risk factors for cardiovascular- and diet-related chronic disease

Only a small portion (about 4 percent) of the Medicare population is under 45 years (men) or 55 years (women), therefore the vast majority of beneficiaries should receive all three components. Intensive behavioral counseling to promote a healthy diet is broadly recommended to cover close to 100 percent of the population due to the prevalence of known risk factors.

## Cervical and Vaginal Cancer Screening

- Pap tests and pelvic exams with clinical breast exam
- Pap tests help find cervical and vaginal cancer
- Screening pelvic exam helps find fibroids and ovarian cancers
- Clinical breast exam

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Medicare Preventive Services

Medicare covers Pap tests, pelvic exams, and clinical breast exams.

- The screening Pap test (Pap smear) covered by Medicare is a laboratory test that consists of a routine exfoliative cytology test (Papanicolaou test) provided for the purpose of early detection of cervical cancer. It includes collection of a sample of cervical cells and a physician's interpretation of the test.
- A screening pelvic examination is performed to help detect pre-cancers, genital cancers, infections, sexually transmitted diseases (STDs), other reproductive system abnormalities, and genital and vaginal problems.
- In addition, a Medicare-covered screening pelvic examination includes a clinical breast examination, which can be used as a tool for detecting, preventing, and treating breast masses, lumps, and breast cancer.

## Cervical and Vaginal Cancer Screening (continued)

- Pap test and pelvic exam with clinical breast exam
- Covered for all women
  - Once every 24 months
  - Once every 12 months, if you are
    - At high risk for cervical or vaginal cancer, or
    - Childbearing age and abnormal Pap test in past 36 months
- You pay nothing for the Pap lab test, Pap test specimen collection, and pelvic and breast exams if the doctor accepts assignment

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Medicare Preventive Services

These tests are covered services for all women with Medicare and will usually be performed during the same office visit. These services are covered once every 24 months for most women. However, they may be covered every 12 months if one of the following applies:

- You are at high-risk for cervical or vaginal cancer (based on your medical history or other findings)
- You are of childbearing age and have had an abnormal Pap test in the past 36 months

High-risk factors for cervical or vaginal cancer include the following:

- Early onset of sexual activity (under 16 years of age)
- Multiple sexual partners (five or more in a lifetime)
- History of sexually transmitted diseases (including human immunodeficiency virus)
- Fewer than three negative or any Pap smears within the previous 7 years
- Diethylstilbestrol (DES)-exposed daughters of women who took DES during pregnancy

You pay nothing for the Pap lab test, Pap test specimen collection, and pelvic and breast exams if the doctor accepts assignment.

## Colorectal Cancer Screening

- Helps prevent or find cancer early
- Helps find pre-cancerous growths
- One or more of the following tests may be covered
  - Screening Fecal Occult Blood Test
  - Screening Flexible Sigmoidoscopy
  - Screening Colonoscopy
  - Screening Barium Enema

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Medicare Preventive Services

In the United States, colorectal cancer is the fourth most common cancer in men and women. If caught early, it is often curable.

To help find pre-cancerous growths and help prevent or find cancer early, when treatment is most effective, your doctor may order one or more of the following tests if you meet certain conditions: screening fecal occult blood test; screening flexible sigmoidoscopy, screening colonoscopy; or screening barium enema (as an alternative to a covered screening flexible sigmoidoscopy or a screening colonoscopy).

Medicare defines high risk of developing colorectal cancer as someone who has one or more of the following risk factors:

- Close relative (sibling, parent, or child) who has had colorectal cancer or polyps
- Family history of familial polyps
- Personal history of colorectal cancer
- Personal history of inflammatory bowel disease, including Crohn's disease and ulcerative colitis

For Medicare beneficiaries at high risk of developing colorectal cancer, the frequency of covered screening tests varies from the frequency of covered screenings for those beneficiaries not considered at high risk.

**NOTE:** If a polyp or other tissue is found and removed during a screening colonoscopy, you may have to pay 20 percent of the Medicare-approved amount for the doctor's services and a copayment in a hospital outpatient setting.

Colorectal Cancer Screenings			
Screening Test	If Normal Risk Covered Once Every	If High Risk, Covered Once Every	You Pay
<b>Screening Fecal Occult Blood Test</b> Age 50 or older	12 months	12 months	No deductible or copayment for this test.
<b>Screening Flexible Sigmoidoscopy</b> Age 50 or older	4 years or 10 years after a previous screening colonoscopy	Every 4 years	No deductible or copayment for this test.
<b>Screening Colonoscopy</b> No minimum age	10 years (generally) or 4 years after a previous flexible sigmoidoscopy	Every 24 months (unless a screening flexible sigmoidoscopy is performed, then only every 4 years)	No deductible or copayment for this test.
<b>Screening Barium Enema</b> Age 50 or older	4 years when used instead of a sigmoidoscopy or colonoscopy	Every 24 months (as an alternative to a covered screening colonoscopy)	There is no deductible for this test. You pay 20 percent of the Medicare-approved amount for the doctor's services. In a hospital outpatient setting, you pay a copayment.

05/01/2014 Medicare Preventive Services

All Medicare beneficiaries age 50 and older who are not at high risk for colorectal cancer are covered for the following screenings:

- Fecal occult blood test every year
- Flexible sigmoidoscopy once every 4 years (unless a screening colonoscopy has been performed, and then Medicare may cover a screening sigmoidoscopy after at least 119 months)
- Colonoscopy every 10 years (unless a screening flexible sigmoidoscopy has been performed and then Medicare may cover a screening colonoscopy after at least 4 years have passed) (no minimum age)
- Barium enema (as an alternative to a covered screening flexible sigmoidoscopy)

All Medicare beneficiaries age 50 and older who are at high risk for colorectal cancer are covered for the following screenings:

- Fecal occult blood test every year
- Flexible sigmoidoscopy once every 4 years
- Colonoscopy once every 2 years (unless a screening flexible sigmoidoscopy has been performed, and then Medicare may cover a screening colonoscopy only after at least 47 months)
- Barium enema (as an alternative to a covered screening colonoscopy)

People with Original Medicare do not pay a copayment or deductible for fecal occult blood tests, flexible sigmoidoscopy, and colonoscopy. Deductible and cost sharing applies for barium enemas.

**NOTE:** If during the course of a screening colonoscopy, a lesion or growth is detected that results in a biopsy or removal of the growth, this becomes a diagnostic procedure (G0105). The procedure may be subject to a copayment.

## Check Your Knowledge—Question 1



Which statement is true about the “Welcome to Medicare” visit?

- a. You need to have this visit to be covered for yearly “Wellness” visits.
- b. You can get this visit only within the first 12 months you have Part B.
- c. You pay nothing for the visit, if the provider accepts assignment but the Part B deductible applies.
- d. All lab tests are included in the visit with no additional cost.



Refer to page 50 to check your answers.

## Check Your Knowledge—Question 2



In Original Medicare you pay nothing for most preventive services if your provider accepts assignment.

- a. True
- b. False



Refer to page 50 to check your answers.

## Check Your Knowledge—Question 3



Only Medicare beneficiaries who receive a referral during their “Welcome to Medicare” preventive visit will be covered for the Abdominal Aortic Aneurysm Screening benefit.

- a. True
- b. False



Refer to page 50 to check your answers.

## Check Your Knowledge—Question 4



Martha has Original Medicare and had a colonoscopy that resulted in a biopsy. Which statement is true?

- a. She will pay 20 percent of the Medicare-approved amount for the colonoscopy.
- b. Only people age 65 or older with Medicare are covered for a colonoscopy.
- c. If a screening colonoscopy results in a biopsy during the same visit, the procedure is considered diagnostic and she may have to pay coinsurance or a copayment.
- d. It will be covered by Part A.



Refer to page 51 to check your answers.

## Depression Screening

- Annual screening must be done in a primary care setting
  - With staff-assisted depression care supports
    - To ensure accurate diagnosis, effective treatment, and follow-up
- Various screening tools are available
  - Choice of tool at discretion of clinician
- No copayment or deductible with Original Medicare

05/01/2014

Medicare Preventive Services

Medicare covers annual screening for depression (up to 15 minutes) for people with Medicare in primary care settings that have staff-assisted depression care supports in place to ensure accurate diagnosis, effective treatment, and follow-up.

Various screening tools are available for screening for depression. The Centers for Medicare & Medicaid Services does not identify specific depression screening tools. Rather, the decision to use a specific tool is at the discretion of the clinician in the primary care setting.

Coverage is limited to screening services and does not include treatment options for depression or any diseases, complications, or chronic conditions resulting from depression, nor does it address therapeutic interventions such as pharmacotherapy (treatment with drugs), combination therapy (counseling and medications), or other interventions for depression.

Among people older than 65 years, one in six suffers from depression. Depression in older adults is estimated to occur in 25 percent of those with other illness including cancer, arthritis, stroke, chronic lung disease, and cardiovascular disease. Other stressful events, such as the loss of friends and loved ones, are also risk factors for depression. Opportunities are missed to improve health outcomes when mental illness is under-recognized and under-treated in primary care settings.

Older adults have the highest risk of suicide of all age groups. It is estimated that 50-75 percent of older adults who commit suicide saw their medical doctor during the prior month for general medical care, and 39 percent were seen during the week prior to their death. Symptoms of major depression that are felt nearly every day include, but are limited to, feeling sad or empty; less interest in daily activities; weight loss or gain when not dieting; less ability to think or concentrate; and tearfulness, feelings of worthlessness, and thoughts of death or suicide.

Medicare covers one depression screening per year. The screening must be done in a primary care setting (like a doctor's office) that can provide follow-up treatment and referrals. You pay nothing for this test if the doctor or other qualified health care provider accepts assignment. If you get the depression screening and another service, you may need to pay 20 percent of the Medicare-approved amount for the other service and the Part B deductible may apply.

## Diabetes Screening

- For people at risk
  - High blood pressure
  - High cholesterol and triglyceride levels
  - Obesity
  - History of high blood sugar
  - Family history of diabetes
- Testing includes fasting blood glucose test
- Talk with your doctor about frequency
  - Up to twice in a 12-month period
    - With certain risk factors or if pre-diabetic
  - If not at risk, covered once in a 12-month period
- No copayment or deductible with Original Medicare

05/01/2014

Medicare Preventive Services

Diabetes is a disease in which your blood glucose (sugar levels) is too high. Glucose comes from the foods you eat. Insulin is a hormone that helps the glucose get into your cells to give them energy.

With Type 1 diabetes, your body does not make insulin. With Type 2 diabetes, the more common type of diabetes, your body does not make or use insulin well. Without enough insulin, the glucose stays in your blood.

Over time, having too much glucose in your blood can cause serious problems. It can damage your eyes, kidneys, and nerves. Diabetes is the leading cause of acquired blindness among adults in the United States. Diabetes can also cause heart disease, stroke and even the need to remove a limb. Pregnant women can also get diabetes, called gestational diabetes.

Other people at risk are those with high blood pressure, high cholesterol and triglyceride levels, obesity, history of high blood sugar, and family history of diabetes.

Medicare covers diabetes screenings for all people with Medicare with certain risk factors for diabetes or diagnosed with pre-diabetes. The diabetes screening test includes a fasting blood glucose test.

Talk with your doctor about how often you should get tested. For people with pre-diabetes, Medicare covers a maximum of two diabetes screening tests within a 12-month period (but not less than 6 months apart). For people without diabetes, who have not been diagnosed as pre-diabetic or who have never been tested, Medicare covers one diabetes screening test within a 12-month period. A normal fasting blood sugar level is 100 mg/dL. Diabetes diagnosis occurs at 126 mg/dL, and a person with blood sugar readings between 101-125 mg/dL is considered pre-diabetic.

Medicare provides coverage for diabetes screening as a Medicare Part B benefit after a referral from a physician or qualified non-physician practitioner for an individual at risk for diabetes. You pay nothing for this screening (there is no coinsurance or copayment and no deductible for this benefit).

## Covered Diabetes Supplies

- Blood sugar testing supplies
- Insulin and related supplies
  - Insulin pumps
  - Therapeutic shoes
- In Original Medicare
  - You pay 20 percent after Part B deductible if the provider/supplier accepts assignment
- Medicare Coverage of Diabetes Supplies & Services (CMS Product No. 11022)



05/01/2014

Medicare Preventive Services

Medicare covers insulin pumps, special foot care, and therapeutic shoes for people with diabetes who need them.

Insulin associated with an insulin pump is covered by Medicare Part B. Injectable insulin not associated with the use of an insulin infusion pump is covered under Medicare prescription drug coverage (Part D).

In Original Medicare, you pay 20 percent of the Medicare-approved amount after the yearly Part B deductible for a glucometer, lancets, and test strips.

Medicare provides coverage for diabetes-related durable medical equipment and supplies as a Medicare Part B benefit. The Medicare Part B deductible and coinsurance or copayment applies. If the provider or supplier does not accept assignment, the amount you pay may be higher. In this case, Medicare will provide you with payment of the Medicare-approved amount.

### Need more information?

Review Medicare Coverage of Diabetes Supplies & Services (CMS Product No. 11022) at [medicare.gov/Pubs/pdf/11022.pdf](https://www.medicare.gov/Pubs/pdf/11022.pdf).



## Covered Diabetes Services

- Diabetes Self-Management Training
  - Instruction in self-monitoring blood glucose
  - Education about diet and exercise
  - Insulin treatment plan
- In Original Medicare you pay 20 percent after Part B deductible
- Foot Exams and Treatment
  - For diabetes-related nerve damage
  - In Original Medicare you pay 20 percent after the Part B deductible
  - In a hospital outpatient setting, you also pay the hospital copayment

05/01/2014

Medicare Preventive Services

Medicare provides coverage of diabetes self-management training for beneficiaries who have recently been diagnosed with diabetes, were determined to be at risk for complications from diabetes, or were previously diagnosed with diabetes before meeting Medicare eligibility requirements and have since become eligible under the Medicare program.

Medicare Part B covers up to 10 hours of diabetes outpatient self-management training during one calendar year. It includes education about how to monitor your blood sugar, diet, exercise, and medication. You must get an order from your doctor or qualified provider who is treating your diabetes.

Each session lasts for at least 30 minutes and is provided in a group of 2 to 20 people.

Exception: You can get individual sessions if no group session is available or if your doctor or qualified provider says you have special needs that would prevent you from participating effectively in group training.

You may also qualify for up to 2 hours of follow-up training each year if one of the following applies:

- Your doctor or a qualified provider ordered it as part of your plan of care
- It takes place in a calendar year after the year you got your initial training

The Medicare Part B deductible and coinsurance or copayment apply. Some providers must accept assignment.

Medicare also covers foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions. You pay 20 percent of the Medicare-approved amount, and the Part B deductible applies. In a hospital outpatient setting, you also pay the hospital a copayment.

## Flu Shot (Influenza) Vaccine

- Influenza, also known as the flu
  - Medicare generally covers the flu shot once every flu season
- All people with Medicare are eligible
- No copayment or deductible for the vaccine with Original Medicare if the provider accepts assignment

05/01/2014

Medicare Preventive Services

Influenza, also known as the flu, is a contagious disease caused by influenza viruses that generally occurs during the winter months. It attacks the respiratory tract in humans (nose, throat, and lungs). Influenza can lead to pneumonia.

Medicare provides coverage of one seasonal flu shot per flu season for all beneficiaries. This may mean that a beneficiary may receive more than one seasonal flu shot in a 12-month period. Medicare may provide coverage for more than one seasonal flu shot per flu season if a physician determines, and documents in your medical record, that the additional shot is reasonable and medically necessary. Medicare Part B (Medical Insurance) covers one flu shot per flu season. For example, if someone gets a flu shot late in the flu season in January 2014, they will also be covered if they receive a shot October, November, or December 2014 because that is the start of a new flu season.

Medicare Part B covers the flu vaccine. You pay no coinsurance and no Part B deductible in Original Medicare for the vaccine if your health care provider accepts assignment.

## Glaucoma Test

- Glaucoma is caused by increased eye pressure
- Exam covered once every 12 months if at high risk
  - Diabetes
  - Family history of glaucoma
  - African American and age 50 or older
  - Hispanic and age 65 or older
- In Original Medicare you pay
  - 20 percent of the Medicare-approved amount and the Part B deductible applies for the doctor's visit
  - A copayment in a hospital outpatient setting

05/01/2014

Medicare Preventive Services

Glaucoma is an eye disease caused by above-normal pressure in the eye. It usually damages the optic nerve and you may gradually lose sight without symptoms. It can result in blindness, especially without treatment. The best way for people at high risk for glaucoma to protect themselves is to have regular eye exams.

You are considered high risk for glaucoma and eligible for Medicare coverage of the glaucoma test if any of the following apply:

- You have diabetes.
- You have a family history of glaucoma.
- You are African American and age 50 or older.
- You are Hispanic and age 65 or older.

An eye doctor who is legally authorized by the state must perform the test. You pay 20 percent of the Medicare-approved amount, and the Part B deductible applies for the doctor's visit. In a hospital outpatient setting, you pay a copayment.

**NOTE:** Medicare does not provide coverage for routine eye refractions.



**Need more information about influenza?**

Visit [cdc.gov](http://cdc.gov) and [flu.gov](http://flu.gov).

## Hepatitis B Shots (Vaccine)

- Hepatitis is a serious disease (virus attacks the liver)
  - Can cause lifelong infection
  - Cirrhosis (scarring) of the liver
  - Liver cancer, liver failure
  - Death
- Covered for people at medium to high risk
  - End-Stage Renal Disease, hemophilia and diabetes mellitus
  - Conditions that lower resistance to infection
  - Certain health care professionals
- No copayment or deductible with Original Medicare

05/01/2014

Medicare Preventive Services

Hepatitis B is a serious disease caused by the Hepatitis B virus (HBV). The virus can affect people of all ages. HBV attacks the liver and can cause chronic (life-long) infection, resulting in cirrhosis (scarring) of the liver, liver cancer, liver failure, and death.

Medicare provides coverage for the HBV vaccine (series of shots) and its administration for beneficiaries at intermediate or high risk of contracting HBV.

High-risk groups currently identified include the following:

- Individuals with End-Stage Renal Disease
- Individuals with hemophilia who received Factor VIII or IX concentrates
- Individuals with diabetes mellitus
- Clients of institutions for the developmentally disabled
- Individuals who live in the same household as an HBV carrier
- Homosexual men
- Illicit injectable drug users

Intermediate risk groups currently identified include the following:

- Staff in institutions for the developmentally disabled
- Workers in health care professions who have frequent contact with blood or blood-derived body fluids during routine work

People with Original Medicare do not pay a copayment or deductible for this vaccine if their provider accepts assignment.

## Human Immunodeficiency Virus (HIV) Screening

- Covered for
  - Pregnant women
    - Covered up to three times during a pregnancy
  - People at increased risk for the infection
  - Anyone who asks for the test
- Covered once every 12 months
- No cost for the test if provider accepts assignment
- Pay percent of Medicare-approved amount for visit

05/01/2014

Medicare Preventive Services

Human immunodeficiency virus (HIV) is the virus that causes AIDS. HIV attacks the immune system by destroying a type of white blood cell that is vital to fighting off infection. The destruction of these cells leaves people infected with HIV vulnerable to infections, diseases, and other complications.

Medicare covers HIV screening for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test.

These people are considered at increased risk for HIV infection:

- Men who have sex with men after 1975
- Men and women having unprotected sex with more than one partner
- Past or present injection drug users
- Men and women who exchange sex for money or drugs, or have sex partners who do
- Individuals whose past or present sex partners were HIV-infected, bisexual, or injection drug users
- Persons being treated for sexually transmitted diseases
- Persons with a history of blood transfusions between 1978 and 1985
- Persons who request the HIV test

Medicare covers this test once every 12 months and up to three times during a pregnancy.

There is no cost for the test, but you generally have to pay 20 percent of the Medicare-approved amount for the doctor's visit.

## Obesity Screening and Counseling

- Obesity = body mass index (BMI)  $\geq 30 \text{ kg/m}^2$
- Intensive behavioral therapy
  - Screening for obesity using BMI measurement
  - Dietary (nutritional) assessment
  - Intensive behavioral counseling and therapy
  - In primary care setting
- Coverage includes
  - One face-to-face visit every week for the first month
  - Then every other week for months 2-6
  - Then every month for months 7-12
    - Must lose 6.6 lbs in first 6 months to continue
- No cost if primary care doctor/practitioner accepts assignment

05/01/2014

Medicare Preventive Services

Clinical evidence indicates that intensive behavioral therapy for obesity, defined as a body mass index (BMI)  $\geq 30 \text{ kg/m}^2$ , is reasonable and necessary for the prevention or early detection of illness or disability and is appropriate for individuals entitled to benefits under Part A or enrolled under Part B. Medicare may cover up to 22 face-to-face intensive counseling sessions over a 12-month period.

Intensive behavioral therapy for obesity consists of the following:

- Screening for obesity in adults using measurement of BMI calculated by dividing weight in kilograms by the square of height in meters (expressed in  $\text{kg/m}^2$ )
- Dietary (nutritional) assessment
- Intensive behavioral counseling and behavioral therapy to promote sustained weight loss through high-intensity interventions of diet and exercise

For Medicare beneficiaries with obesity, who are competent and alert at the time that counseling is provided and whose counseling is furnished by a qualified primary care physician or other primary care practitioner and in a primary care setting, the Centers for Medicare & Medicaid Services covers the following:

- One face-to-face visit every week for the first month
- One face-to-face visit every other week for months 2-6
- One face-to-face visit every month for months 7-12, if the beneficiary meets the 3 kg (6.6 lbs.) weight loss requirement as discussed below

At the 6-month visit, a reassessment of obesity and a determination of the amount of weight loss must be performed. To be eligible for additional face-to-face visits occurring once a month for an additional 6 months, beneficiaries must have achieved a reduction in weight of at least 3 kg (6.6 lbs.) over the course of the first 6 months of intensive therapy. This determination must be documented in the physician office records for applicable beneficiaries consistent with usual practice. For beneficiaries who do not achieve a weight loss of at least 3 kg during the first 6 months of intensive therapy, a reassessment of their readiness to change and BMI is appropriate after an additional 6-month period.

## Pneumonia Shot (Vaccine)

- Pneumococcal disease is an infection that may cause pneumonia, ear infections, and other serious health issues
  - One vaccine could be all you ever need to prevent pneumococcal pneumonia
- All people with Medicare are eligible
- No copayment or deductible for the vaccines with Original Medicare if the provider accepts assignment

05/01/2014

Medicare Preventive Services

Pneumococcal disease is an infection caused by the bacteria *Streptococcus pneumoniae*, also known as pneumococcus. The most common types of infections caused by this bacterium include: middle ear infections, pneumonia, blood stream infections (bacteremia), sinus infections, and meningitis. While influenza viruses generally strike during the winter months, pneumococcal disease occurs year-round.

Most people only need a pneumococcal pneumonia vaccine once in their lifetime. Medicare will cover additional vaccines if your doctor decides it is necessary or if there is uncertainty that a vaccination was ever received.

Medicare Part B covers these vaccines. You pay no coinsurance and no Part B deductible in Original Medicare for the vaccine if your health care provider accepts assignment.

## Prostate Cancer Screening

- All men are at risk for prostate cancer
- Covered for all men with Medicare once every 12 months
  - Beginning the day after 50th birthday
- Tests include
  - Digital rectal exam
  - Prostate-specific antigen (PSA) blood test
- In Original Medicare you pay
  - Nothing for the PSA blood (lab) test
  - 20 percent after Part B deductible for digital rectal exam
  - In hospital outpatient setting, hospital copayment applies

05/01/2014

Medicare Preventive Services

All men are at risk for prostate cancer. However, the causes of prostate cancer are not yet clearly understood. Through research, several factors have been identified that increase your risk, including the following:

- Family history of prostate cancer
- Men aged 50 and older
- Diet of red meat and high-fat dairy
- Smoking

Medicare provides coverage of prostate cancer screening tests/procedures for the early detection of prostate cancer once every 12 months for all men with Medicare aged 50 and older (coverage begins the day after their 50th birthday). The two most common screenings used by physicians to detect prostate cancer are the screening prostate-specific antigen (PSA) blood test and the screening digital rectal examination.

The screening PSA test must be ordered by a doctor. You pay nothing for the screening PSA blood test (there is no coinsurance or copayment and no Medicare Part B deductible for this benefit) although a copayment may apply in a hospital outpatient setting. The Medicare Part B deductible and copayment apply to the digital rectal exam.

## Sexually Transmitted Infections (STI) Screening and Counseling

- Covers STI screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B
- Covered for pregnant women and for certain people who are at risk
- Covered once every 12 months or at certain times during a pregnancy
- Covers up to two individual 20- to 30-minute, face-to-face, high intensity behavioral counseling sessions each year

05/01/2014

Medicare Preventive Services

Medicare covers sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for people with Medicare who are pregnant, and for certain people who are at increased risk for an STI, when the tests are ordered by a primary care doctor or other primary care practitioner. Medicare covers these tests once every 12 months or at certain times during pregnancy.

Medicare covers up to two individual 20- to 30-minute, face-to-face, high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. Medicare will only cover these counseling sessions if they're provided by a primary care doctor or other practitioner and take place in a primary care setting (like a doctor's office). Counseling conducted in an inpatient setting, like a skilled nursing facility, won't be covered as a preventive service.

You pay nothing for these services if the primary care doctor or other qualified primary care practitioner accepts assignment.

## Tobacco-Use Cessation Counseling

- Whether or not diagnosed with a tobacco-related disease, Medicare covers cessation counseling
  - Two attempts of up to eight face-to-face visits in a 12-month period
  - Inpatient or outpatient
  - Intermediate or intensive
- In Original Medicare you pay
  - No copayment or deductible for asymptomatic beneficiaries billed for certain services
  - 20 percent after Part B deductible for other counseling codes billed to Medicare (symptomatic beneficiaries)

05/01/2014

Medicare Preventive Services

Tobacco use continues to be the leading cause of preventable disease and death in the United States. Smoking can contribute to and worsen heart disease, stroke, lung disease, cancer, diabetes, hypertension, osteoporosis, macular degeneration, abdominal aortic aneurysms, and cataracts. Smoking harms nearly every organ of the body and generally diminishes the health of smokers.

Medicare will cover counseling to prevent tobacco use for outpatient and hospitalized beneficiaries:

- Who use tobacco, regardless of whether they have signs or symptoms of tobacco-related disease
- Who are competent and alert at the time that counseling is provided
- Whose counseling is furnished by a qualified physician or other Medicare-recognized practitioner

Medicare will cover two cessation attempts per year. Each attempt may include up to four counseling sessions, with the total annual benefit covering up to eight sessions in a 12-month period.

Tobacco cessation counseling services can be provided in the hospital or on an outpatient basis. However, tobacco cessation counseling services are not covered if the primary reason for the hospital stay is tobacco cessation. You must get counseling from a qualified Medicare provider (physician, physician's assistant, nurse practitioner, clinical nurse specialist, or clinical psychologist).

Both the copayment and deductible are waived for beneficiaries who show no symptoms of tobacco-related disease but have a history of tobacco use and are billed for tobacco cessation counseling for prevention. The waived copayment and deductible does not currently apply to other tobacco-use cessation counseling codes billed to Medicare. The copayment and deductible do apply if the beneficiary has been diagnosed with a tobacco-related disease or an adverse health condition that has been linked to tobacco use, or who is taking a therapeutic agent whose metabolism or dosing is affected by tobacco use.

A copayment may apply in a hospital outpatient setting.

Medicare's Part D prescription drug benefit also covers smoking and tobacco-use cessation agents prescribed by a physician.

## Check Your Knowledge—Question 5



Oliver has Original Medicare and has questions about diabetes screening. Which statement is NOT true?



- a. He will pay nothing for the covered test if his doctor accepts assignment.
- b. He generally will have to pay 20 percent of the Medicare-approved amount for the doctor's visit.
- c. The Part B deductible doesn't apply.
- d. Based on the results of his test, he may be eligible for four diabetes screenings each year.



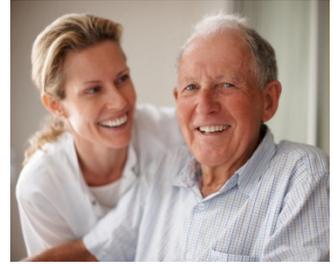
Refer to page 51 to check your answers.

## Check Your Knowledge—Question 6



Medicare has identified specific depression screening tools that a clinician in the primary care setting must use.

- a. True
- b. False



Refer to page 51 to check your answers.

## Check Your Knowledge—Question 7



How often does Medicare cover a flu vaccine for all people with Medicare?

- a. Annually
- b. Every 2 years
- c. Once every flu season
- d. Once, when your turn 65



Refer to page 51 to check your answers.

Reference Chart: Preventive Services

Preventive Service	Who Is Covered	How Often It's Covered	Your Costs
<p><b>Welcome to Medicare Preventive Visit</b></p> <p>This one-time preventive visit includes a review of your medical and social history related to your health. Depending on your general health and medical history, your doctor may refer you for additional tests or services. Your doctor will develop a personalized written plan letting you know which screenings and other preventive services you need.</p>	All people joining the Medicare program.	One time within the first 12 months you have Medicare Part B.	There is no cost if your doctor accepts Medicare assignment.
<p><b>Yearly "Wellness" Visit</b></p> <p>Medicare provides an annual wellness visit that lets you visit your physician to develop or update a personalized prevention plan based on your current health and risk factors.</p>	All people with Medicare.	If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update your personalized prevention plan. This visit is covered once every 12 months. <b>Note:</b> Your first annual wellness visit can't take place within 12 months of your Welcome to Medicare visit.	There is no cost if your doctor accepts Medicare assignment.
<p><b>Abdominal Aortic Aneurysm Screening</b></p> <p>This ultrasound screening test checks the aorta for weak area expansions or bulges, which indicate a life-threatening condition.</p>	Men and women with Medicare who have been identified by their physician as being at risk for having an abdominal aortic aneurysm. Risk factors include: <ul style="list-style-type: none"> <li>▪ A family history of abdominal aortic aneurysm</li> <li>▪ Being a man age 65 to 75 who has smoked at least 100 cigarettes in his lifetime</li> </ul>	This is a one-time screening ultrasound test. In order to have this screening covered by Medicare, patients that have been identified as high-risk must get a referral from their doctor or practitioner.	There is no cost if your doctor accepts Medicare assignment.
<p><b>Alcohol Misuse Screening and Counseling</b></p> <p>Medicare covers annual alcohol screening and up to four brief face-to-face behavioral counseling sessions.</p>	People with Medicare, including pregnant women, who misuse alcohol, but whose levels or patterns of alcohol consumption do not meet criteria for alcohol dependence.	Screening for alcohol misuse is covered once every 12 months. For those that screen positive, up to 4 brief counseling sessions are covered during the 12 months following the date of the screening.	There is no cost if your doctor accepts Medicare assignment.

Preventive Service	Who Is Covered	How Often It's Covered	Your Costs
<p><b>Bone Mass Measurement</b></p> <p>Medicare covers bone mass measurements to determine whether you are at risk for osteoporosis.</p>	<p>People with Medicare who fall into at least one of the following categories:</p> <ul style="list-style-type: none"> <li>▪ A woman who is estrogen deficient and at clinical risk for osteoporosis</li> <li>▪ People with vertebral abnormalities</li> <li>▪ People receiving (or expecting to receive) steroid therapy for more than 3 months.</li> <li>▪ People with hyperparathyroidism</li> <li>▪ People being monitored to assess their response to FDA-approved osteoporosis drug therapy</li> </ul>	<p>This service is usually covered once every 24 months (or more frequently if medically necessary).</p>	<p>There is no cost if your doctor accepts Medicare assignment.</p>
<p><b>Cardiovascular Disease Screening</b></p> <p>These blood tests help detect conditions that may lead to a heart attack or stroke. They test your cholesterol, lipid, and triglyceride levels.</p>	<p>All people with Medicare.</p>	<p>Medicare covers these tests once every five years.</p>	<p>There is no cost if your doctor accepts Medicare assignment.</p>
<p><b>Cardiovascular Disease (CVD) Risk Reduction Visit</b></p> <p>Medicare covers intensive behavioral therapy for cardiovascular disease (also known as a CVD risk reduction visit), which includes:</p> <ul style="list-style-type: none"> <li>▪ Encouraging aspirin use when benefits outweigh risks,</li> <li>▪ Screening for high blood pressure, and</li> <li>▪ Intensive behavioral counseling to promote a healthy diet.</li> </ul>	<p>All people with Medicare.</p>	<p>Medicare covers intensive behavioral therapy for cardiovascular disease (a CVD risk reduction visit) once every 12 months.</p>	<p>There is no cost if your doctor accepts Medicare assignment.</p>

Preventive Service	Who Is Covered	How Often It's Covered	Your Costs
<p><b>Colorectal Cancer Screening</b></p> <p>To help find precancerous growths or find cancer early, when treatment is most effective. Your doctor may order one of the following tests:</p> <ul style="list-style-type: none"> <li>■ Screening Fecal Occult Blood Test</li> <li>■ Screening Flexible Sigmoidoscopy</li> <li>■ Screening Colonoscopy</li> <li>■ Screening Barium Enema</li> </ul>	<p>Men and women with Medicare age 50 and older who are at risk of developing colorectal cancer.</p>	<p><b>Normal risk</b></p> <p><b>Fecal Occult Blood Test</b> Annually</p> <p><b>Flexible Sigmoidoscopy</b> Once every 4 years (unless a screening colonoscopy has been performed and then Medicare may cover a screening sigmoidoscopy after at least 119 months)</p> <p><b>Screening Colonoscopy</b> Every 10 years (unless a screening flexible sigmoidoscopy has been performed and then Medicare may cover a screening colonoscopy only after at least 47 months)</p> <p><b>Barium Enema</b> (As an alternative to a covered screening flexible sigmoidoscopy).</p> <p><b>High risk</b></p> <p><b>Fecal Occult Blood Test</b> Annually</p> <p><b>Flexible Sigmoidoscopy</b> Once every 4 years</p> <p><b>Screening Colonoscopy</b> Every 2 years (unless a screening flexible sigmoidoscopy has been performed and then Medicare may cover a screening colonoscopy only after at least 47 months)</p> <p><b>Barium Enema</b> (As an alternative to a covered screening colonoscopy)</p>	<p><b>Fecal Occult Blood Test</b> There is no cost if your doctor accepts Medicare assignment.</p> <p><b>Flexible Sigmoidoscopy</b> There is no cost if your doctor accepts Medicare assignment.</p> <p><b>Colonoscopy</b> There is no cost if your doctor accepts Medicare assignment.</p> <p><b>Barium Enema</b>—You pay 20% of the Medicare approved amount for the doctor's services. In a hospital outpatient setting, you also pay the hospital a copayment</p>

Preventive Service	Who Is Covered	How Often It's Covered	Your Costs
<p><b>Depression Screening</b> Medicare covers screening for depression, which, is limited to screening services, and does not include treatment options, interventions, or treatment of complications or chronic conditions resulting from depression.</p>	All people with Medicare	This service is covered once every 12 months, if furnished in a primary care setting, such as a doctor's office.	There is no cost if your doctor accepts Medicare assignment.
<p><b>Diabetes Screening</b> Medicare covers a fasting blood glucose test to screen people at risk for diabetes.</p>	<p>Men and women with Medicare with any of the following risk factors:</p> <ul style="list-style-type: none"> <li>▪ High blood pressure (hypertension)</li> <li>▪ History of abnormal cholesterol and triglyceride levels (dyslipidemia)</li> <li>▪ Obesity</li> <li>▪ History of high blood sugar</li> <li>▪ Family history of diabetes</li> </ul>	<p>Up to two screening tests per year if you have pre-diabetes.</p> <p>One screening test per year if you do NOT have pre-diabetes or have never been tested before.</p>	There is no cost if your doctor accepts Medicare assignment
<p><b>Diabetes Self-Management Training (DSMT)</b> Medicare covers DSMT for people with diabetes to help them successfully manage their diabetes and help prevent its complications.</p>	People with Medicare that have diabetes and have a written order from their physician or qualified provider treating their diabetes.	<p>Up to 10 hours of training within a continuous 12-month period.</p> <p>Up to 2 hours of follow-up training each year thereafter if ordered by your physician or qualified provider treating their diabetes.</p>	Medicare beneficiaries pay 20% of the Medicare-approved amount after the yearly Part B deductible.

Preventive Service	Who Is Covered	How Often It's Covered	Your Costs
<p><b>Glaucoma Tests</b></p> <p>A glaucoma screening eye exam is used to detect glaucoma. Glaucoma is caused by abnormally high pressure in the eye which damages the optic nerve and, without treatment, can gradually lead to blindness.</p>	<p>Men and women with Medicare that are considered high risk. You are considered high risk if you have one of the following risk factors:</p> <ul style="list-style-type: none"> <li>■ You have diabetes</li> <li>■ You are African-American and are age 50 or older</li> <li>■ You are Hispanic and are 65 or older</li> <li>■ You have a family history of glaucoma</li> </ul>	<p>Medicare covers glaucoma screenings every 12 months for high risk patients.</p>	<p>Medicare beneficiaries pay 20% of the Medicare-approved amount after the yearly Part B deductible.</p>
<p><b>Hepatitis B Shots (Vaccines)</b></p> <p>A series of three shots are needed for complete protection from this disease which infects the liver.</p>	<p>Men and women with Medicare whose doctor identifies them as medium to high risk for Hepatitis B.</p> <p>Risk factors include:</p> <ul style="list-style-type: none"> <li>■ Hemophilia</li> <li>■ End Stage Renal Disease</li> <li>■ Diabetes mellitus</li> </ul>	<p>One series of Hepatitis B shots provides complete lifetime protection.</p>	<p>There is no cost if your doctor accepts Medicare assignment.</p>
<p><b>HIV Screening</b></p> <p>This is a blood test to screen for Human Immunodeficiency Virus (HIV).</p>	<p>Men and women with Medicare who are at increased risk for infection, as well as anyone that asks to be tested.</p>	<p>Medicare covers HIV screening once every 12 months for people with Medicare who are at increased risk for the infection, as well as for anyone that asks to be tested. Medicare also covers HIV screening for women who are pregnant up to three times during the pregnancy (when you become pregnant, during 3<sup>rd</sup> trimester, and at delivery if ordered by your doctor).</p>	<p>There is no cost for the test, but you generally have to pay 20% of the Medicare-approved amount for the doctor's visit.</p>

Preventive Service	Who Is Covered	How Often It's Covered	Your Costs
<p><b>Influenza “Flu” Shots (Vaccine)</b> The Centers for Disease Control recommends a flu shot as the first and most important step in protecting against flu viruses.</p>	All people with Medicare	Medicare covers an influenza shot once each flu season. It's best to have the immunization in the fall or early winter.	There is no cost if your doctor accepts Medicare assignment.
<p><b>Obesity Screening and Counseling</b> Medicare offers intensive behavioral therapy for beneficiaries with obesity, defined as a body mass index (BMI) <math>\geq 30</math> kg/m<sup>2</sup>.</p>	All people with Medicare may be screened for obesity. Counseling is covered for anyone found to have a BMI $\geq 30$ kg/m <sup>2</sup> .	Beneficiaries with BMIs $\geq 30$ kg/m <sup>2</sup> are eligible for: <ul style="list-style-type: none"> <li>▪ One face-to-face visit each week for the first month;</li> <li>▪ One face-to-face visit every other week for months 2-6;</li> <li>▪ One face-to-face visit every month for months 7-12 if the beneficiary loses 3kg (6.6 pounds) during months 1-6.</li> </ul>	There is no cost if your doctor accepts Medicare assignment.
<p><b>Cervical and Vaginal Cancer Screening</b> These tests and exams check for cervical, vaginal, and breast cancers.</p>	All women with Medicare	Pap tests and pelvic exams are covered by Medicare every 24 months. Note: If you are of childbearing age and have had an abnormal Pap test within the past 36 months, or if your doctor determines you are at high risk for cervical or vaginal cancer, Medicare will cover a Pap test and pelvic exam every 12 months.	There is no cost if your doctor accepts Medicare assignment.
<p><b>Pneumococcal Shot (Vaccine)</b> This immunization protects beneficiaries from pneumococcal pneumonia, an inflammation of the lungs caused by bacterial infection.</p>	All people with Medicare	Most people need just one shot in their lifetime. Medicare will cover additional shots if your doctor decides that they are medically necessary.	There is no cost if your doctor accepts Medicare assignment.

Preventive Service	Who Is Covered	How Often It's Covered	Your Costs
<p><b>Prostate Cancer Screening</b></p> <p>The tests included in this screening are the Prostate Specific Antigen (PSA) blood test and a digital rectal exam.</p>	<p>Men with Medicare age 50 and older. Coverage begins the day after your 50th birthday</p>	<p>Medicare covers PSA screening tests and digital rectal examinations for prostate cancer once every 12 months.</p>	<p>There is no cost for the PSA blood test. Deductibles and copayment cost sharing applies for the digital rectal exam.</p>
<p><b>Breast Cancer Screening (Mammogram)</b></p> <p>A type of X-ray to check for breast cancer.</p>	<p>All women with Medicare</p>	<p>Screening mammograms are covered by Medicare once every 12 months for women age 40 and over. Medicare covers one baseline mammogram for women between ages 35 and 39.</p>	<p>There is no cost if your doctor accepts Medicare assignment.</p>
<p><b>Sexually Transmitted Infections (STIs) and High-Intensity Behavioral Counseling to Prevent STIs (HIBC)</b></p> <p>Medicare covers screening for indicated STIs with the appropriate lab tests when ordered by the primary care physician or practitioner, and performed by an eligible Medicare provider.</p> <p>Medicare also covers up to two individual 20-30 minute face-to-face counseling sessions if referred for this service by a primary care provider and provided by a Medicare eligible primary care provider in a primary care setting.</p>	<p>Chlamydia and gonorrhea screening:</p> <ul style="list-style-type: none"> <li>▪ Pregnant women age 24 or younger</li> <li>▪ Pregnant women at increased risk of STI</li> <li>▪ Women at increased risk for STIs</li> </ul> <p>Syphilis screening:</p> <ul style="list-style-type: none"> <li>▪ Pregnant women</li> <li>▪ Men and women at increased risk for STIs</li> </ul> <p>Hepatitis B screening:</p> <ul style="list-style-type: none"> <li>▪ Pregnant women</li> </ul> <p>High-Intensity behavioral counseling:</p> <ul style="list-style-type: none"> <li>▪ All sexually active adolescents and adults at increased risk of STI</li> </ul>	<p>Chlamydia and gonorrhea screening:</p> <ul style="list-style-type: none"> <li>▪ When pregnancy diagnosis is made, and repeated during the third trimester if high-risk sexual behavior has occurred since the initial screening test.</li> <li>▪ Once every 12 months for women at increased risk.</li> </ul> <p>Syphilis screening:</p> <ul style="list-style-type: none"> <li>▪ When pregnancy diagnosis is made, and repeated during the third trimester and at delivery if high-risk sexual behavior has occurred since the last screening test.</li> <li>▪ Once every 12 months for men and women at increased risk.</li> </ul> <p>Hepatitis B screening:</p> <ul style="list-style-type: none"> <li>▪ At first prenatal visit and at delivery for those with new or continuing risk factors.</li> </ul> <p>High-Intensity behavioral counseling:</p> <ul style="list-style-type: none"> <li>▪ Two 20-30 minute sessions once every 12 months.</li> </ul>	<p>There is no cost if your doctor accepts Medicare assignment.</p>

Preventive Service	Who Is Covered	How Often It's Covered	Your Costs
<p><b>Tobacco Use Cessation Services</b> Tobacco Use cessation services include counseling sessions.</p>	<p>Medicare beneficiaries who use tobacco and have a recognized tobacco related disease, or who have signs or symptoms of tobacco-related disease</p>	<p>Medicare will cover two cessation attempts per year. Each attempt may include up to four counseling sessions, with the total annual benefit covering up to eight sessions in a 12 month period.</p>	<p>Deductibles and copayment cost sharing apply. Many drugs are available to aid tobacco use cessation, including nicotine patches. These drugs may be covered by Medicare Part D plans. Check with your plan for specific details.</p>
<p><b>Counseling to Prevent Tobacco Use</b></p>	<p>Medicare beneficiaries who use tobacco, regardless of whether they have signs or symptoms of tobacco related disease</p>	<p>Medicare will cover two cessation attempts per year. Each attempt may include up to four counseling sessions, with the total annual benefit covering up to 8 sessions in a 12 month period.</p>	<p>There is no cost if your doctor accepts Medicare assignment.</p>

**NOTE:** \*If a medically necessary evaluation and management service is furnished in the same visit as an IPPE or AWW visit, cost sharing requirements will apply to the additional service only."

05/01/2014

Medicare Preventive Services

Preventive Services Resource Guide

Preventive Services Resource Guide		Medicare Products
Resources		
<p><b>Medicare.gov</b> <a href="http://www.medicare.gov">www.medicare.gov</a></p> <p>1-800-MEDICARE (1-800-633-4227) (TTY) 1-877-466-2048)</p> <p><b>Local State Health Insurance Assistance Programs (SHIP)</b> <a href="http://www.medicare.gov/contacts">www.medicare.gov/contacts</a></p> <p><b>Centers for Disease Control</b> <a href="http://www.cdc.gov">www.cdc.gov</a></p> <p><b>Flu Information</b> <a href="http://www.flu.gov">www.flu.gov</a></p> <p><b>HHS Tobacco Cessation Resources</b> <a href="http://www.surgeongeneral.gov/tobacco">www.surgeongeneral.gov/tobacco</a></p> <p><b>National Cancer Institute</b> <a href="http://www.cancer.gov">www.cancer.gov</a> 1-800-4CANCER (TTY) 1-800-332-8615)</p> <p><b>Medline Plus</b> <a href="http://www.nlm.nih.gov/medlineplus">www.nlm.nih.gov/medlineplus</a></p>	<p><b>American Cancer Society</b> <a href="http://www.cancer.org">www.cancer.org</a> 1-800-ACS-2345 (1-800-227-2345)</p> <p><b>American Diabetes Association</b> <a href="http://www.diabetes.org">www.diabetes.org</a> 1-800-DIABETES (1-800-342-2383)</p> <p><b>American Lung Association</b> <a href="http://www.lungusa.org">www.lungusa.org</a> 202-785-3355</p> <p><b>National Kidney Foundation</b> <a href="http://www.kidney.org">www.kidney.org</a> 1-800-622-9010</p>	<p><b>Medicare &amp; You Handbook</b> CMS (Product No. 10050)</p> <p><b>Your Guide to Medicare's Preventive Services</b> (CMS Product No. 10110)</p> <p><b>Medicare Coverage of Diabetes Supplies &amp; Services</b> (CMS Product No. 11022)</p> <p><b>Welcome to Medicare Q&amp;A – Preventive Services</b> (CMS Product No. 11532)</p> <p><b>Staying Healthy</b> (CMS Product No. 11100)</p> <p><b>6 Things You Should Know</b> (CMS Product No. 11533)</p> <p>View and order single copies at <a href="http://www.medicare.gov">Medicare.gov</a></p> <p>Order multiple copies (partners only) at <a href="http://productordering.cms.hhs.gov">http://productordering.cms.hhs.gov</a> You must register your organization.</p>

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# Check Your Knowledge Answer Key



## Question 1 (page 20)

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Which statement is true about the “Welcome to Medicare” visit?

**Answer: b**

You can get this visit only within the first 12 months you have Part B. Remember, you don’t need to have the Welcome to Medicare visit first to qualify for the Yearly Wellness visits in later years. There is no cost as long as your provider accepts assignment, and the Part B deductible doesn’t apply. Lab tests are not included in the Welcome to Medicare visit. If your provider feels you need a lab test, you pay separately.

## Question 2 (page 21)

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In Original Medicare you pay nothing for most preventive services if your provider accepts assignment.

**Answer: a**

True. Remember assignment means that your doctor, provider, or supplier has signed an agreement with Medicare (or is required by law to accept the Medicare-approved amount as full payment for covered services). Most doctors, providers, and suppliers accept assignment, but you should always check to make sure, because some who are enrolled in Medicare don’t accept assignment.

## Question 3 (page 22)

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Only Medicare beneficiaries who receive a referral during their “Welcome to Medicare” preventive visit will be covered for the Abdominal Aortic Aneurysm Screening benefit.

**Answer: b**

False. Effective January 1, 2014, you will no longer need to get a referral during the Welcome to Medicare Preventive Visit for an abdominal aortic aneurysm screening. You will still need to get a referral from either a physician, physician’s assistant, nurse practitioner, or clinical nurse specialist, but it won’t have to be during your Welcome to Medicare Preventive Visit.

## Question 4 (page 23)

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Martha has Original Medicare and had a colonoscopy that resulted in a biopsy. Which statement is true?

**Answer: c**

If a screening test results in the biopsy or removal of a lesion or growth during the same visit, the procedure is considered diagnostic and you may have to pay coinsurance or a copayment, but the Part B deductible doesn't apply.

## Question 5 (page 37)

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Oliver has Original Medicare and has questions about diabetes screening. Which statement is NOT true?

**Answer: d**

The incorrect answer is "d," because Medicare covers up to two diabetes screenings each year if your doctor determines you are at risk for diabetes.

## Question 6 (page 38)

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Medicare has identified specific depression screening tools that a clinician in the primary care setting must use.

**Answer: b**

False. Various screening tools are available for screening for depression. The Centers for Medicare & Medicaid Services does not identify which tool must be used. Rather, the decision to use a specific tool is at the discretion of the clinician in the primary care setting.

## Question 7 (page 39)

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How often does Medicare cover a flu vaccine for all people with Medicare?

**Answer: c**

Medicare provides coverage of one seasonal flu shot per flu season for all beneficiaries. This may mean that a beneficiary may receive more than one seasonal flu shot in a 12-month period. Medicare may provide coverage for more than one seasonal flu shot per flu season if a physician determines, and documents in your medical record, that the additional shot is reasonable and medically necessary. Medicare Part B (Medical Insurance) covers one flu shot per flu season. For example, if someone gets a flu shot late in the flu season in January 2014 they will also be covered if they receive a shot October, November, or December 2014 because that is the start of a new flu season.

## Acronyms

BMI	Body mass index
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
CVD	Cardiovascular disease
ESRD	End-Stage Renal Disease
DES	Diethylstilbestrol
DME	Durable medical equipment
HBV	Hepatitis B virus
HIV	Human Immunodeficiency Virus
PACE	Programs of All-inclusive Care for the Elderly
PPPS	Personalized prevention plan services
PSA	Prostate-specific antigen
STD	Sexually transmitted disease
STI	Sexually transmitted infections

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