

**Centers for Medicare & Medicaid Services (CMS)
National Training Program (NTP)
Instructor Information Sheet**

Module 7—Medicare Preventive Services

Module Description

The lessons in this 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. It can be easily adapted for presentations to groups of beneficiaries.

Time Considerations

The module consists of 48 PowerPoint slides with corresponding speaker's notes, media used, activities, and quiz questions. It can be presented in about 45 minutes. Allow approximately 15 more minutes for discussion, questions, and answers. Additional time may be added for add-on activities.

Course Materials

Most materials are self-contained within the module.

Module 7: Medicare Preventive Services

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2015 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 2015. To check for an updated version, visit [CMS.gov/outreach-and-education/training/cmsnationaltrainingprogram/index.html](https://www.cms.gov/outreach-and-education/training/cmsnationaltrainingprogram/index.html).

The CMS National Training Program provides this as an informational resource for our partners. It’s not a legal document or intended for press purposes. The press can contact the CMS Press Office at press@cms.hhs.gov. 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

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 for preventive services is based on age, gender, and medical history

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Preventive services may find health problems early, when treatment works best. Medicare Part B covers preventive services like screening exams, wellness visits, lab tests, and immunizations to help prevent, find, and manage medical problems.

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 plan. 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 (and sometimes Part D) 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 (PACE).

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

Paying for Preventive Services in 2015

- 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 a copayment
 - If doctor performs other services not part of covered preventive benefits, or
 - For *certain* preventive services

*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.

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Under Original Medicare you’ll 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’ll 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.

Section 4104 of the Affordable Care Act waived deductibles, copayments, or coinsurance effective for date of service or after January 1, 2011, for the following Medicare-covered preventive services:

- The Initial Preventive Physical Examination (IPPE) or (“Welcome to Medicare” preventive visit);
- The Yearly “Wellness” visit; and
- Those preventive services that
 - Are identified with a grade of A or B by the United States Preventive Services Task Force (USPSTF) for any indication or population; and
 - Are appropriate for the beneficiary

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
- Cardiovascular disease screenings
- Cervical and vaginal cancer screening
- Colorectal cancer screenings
 - Screening fecal occult blood test
 - Screening flexible sigmoidoscopy
 - Screening colonoscopy
 - Screening barium enema
 - Multi-target stool DNA test **NEW!**
- Depression screening
- Diabetes screenings
- Diabetes self-management training
- Flu shots (Vaccine)
- Glaucoma tests
- Hepatitis B shots (Vaccine)
- Hepatitis C screening test **NEW!**
- HIV screening
- Lung Cancer Screening **NEW!**
- Medical nutrition therapy services
- Obesity screening and counseling
- Pneumococcal shots **UPDATE**
- Prostate cancer screening
- Sexually-transmitted infections screening and counseling
- Tobacco use cessation counseling

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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 of these services are right for you.

“Welcome to Medicare” Preventive Visit

- Once within first 12 months of getting Part B
- The doctor or health care provider will
 - Review your medical and social history
 - Take your blood pressure, 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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The “Welcome to Medicare” preventive visit is a great way to get up-to-date information on important screenings and vaccines and to review your medical history. It's only offered 1 time within the first 12 months of getting Medicare Part B.

During your preventive visit, your doctor or health care provider will perform the following services:

- Review your medical and social history
- Take your blood pressure, height, weight, and body mass index
- 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'll get advice to help you prevent disease, improve your health, and stay well. You'll also get a brief written plan (like a checklist), letting you know which screenings and other preventive services you need.

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” preventive visit doesn't include any clinical lab tests.

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”
 - It’s not a “routine physical checkup”
- Available once every 12 months
 - After you’ve had Part B for longer than 12 months
 - You’ll pay nothing for this exam if the doctor accepts assignment

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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 1 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 got 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 at no cost to you. You can work with your doctor 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's a preventive wellness visit and is **not** a “routine physical checkup.”

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, weight, and body mass index 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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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 factors) 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'll also receive advice to help you prevent disease, improve your health, and stay well. You'll get a brief written plan, like a checklist, letting you know which screenings and other preventive services you'll 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 updates to your risk factors and conditions
 - Personalized health advice
 - Referrals for health education and preventive counseling to help you stay well
 - Updated health risk assessment

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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 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 your written screening schedule as developed at the first yearly "Wellness" visit providing PPPS
- Updates to 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 65-75 who've smoked more than 100 cigarettes
 - In their lifetime
- No copayment or deductible with Original Medicare
- No longer requires referral from "Welcome to Medicare" preventive visit
 - Can get referral from your doctor, doctor's assistant, nurse practitioner, or clinical nurse specialist at anytime

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The aorta is the largest artery in your body. It carries blood away from your heart. When it reaches your abdomen, it's 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's 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 doctor, doctor's assistant, nurse practitioner, or clinical nurse specialist.

Effective January 1, 2014, you no longer need to get a referral during the "Welcome to Medicare" preventive visit for an Abdominal Aortic Aneurysm Screening. All other eligibility and frequency limitations remain the same.

You are considered at risk if either of the following apply to you:

- You have a family history of abdominal aortic aneurysms
- You are a man 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 4 face-to-face counseling sessions if you
 - Misuse alcohol
 - Aren't alcohol dependent
 - Are competent and alert when counseled
 - Counseling must be furnished
 - By a qualified primary care provider
 - In a primary care setting
- Medicare doesn't identify specific screening tool
- No cost if provider accepts assignment

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Medicare covers an annual alcohol misuse screening. Various screening tools are available for screening for alcohol misuse. Medicare doesn't 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 4 brief (15-minute), face-to-face behavioral counseling interventions per year for Medicare beneficiaries (including pregnant women) who meet the following requirements:

- Misuse alcohol, but whose levels or patterns of alcohol consumption don't meet criteria for alcohol dependence (defined as at least 3 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 doctors or other primary care practitioners in a primary care setting

A primary care setting is defined as one in which there's 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 aren't 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
 - You're being monitored to assess your response to FDA-approved osteoporosis drug therapy
- Every 24 months (more often if medically necessary)
- No copayment or deductible with Original Medicare

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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's 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 1 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
- Individuals being monitored to assess their response to the U.S. 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 35 and 39
 - Once a year starting at 40
- No copayment or deductible with Original Medicare

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

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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 doctor's interpretation of the results.

Medicare provides coverage of an annual screening mammogram for all female beneficiaries 40 and older. Medicare also provides coverage of 1 baseline screening mammogram for female beneficiaries 35 through 39.

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's 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 doctor judges by your history and other significant factors that a mammogram is appropriate. The coinsurance or copayment and the Part B deductible applies for diagnostic mammograms.

Cardiovascular Disease (CVD) Risk Reduction Visit

- One CVD (also referred to as cardiovascular disease) risk reduction visit per year
 - Behavioral therapy
 - 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 covers intensive behavioral therapy for cardiovascular disease (referred to as a CVD risk reduction visit).

Medicare covers 1 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 doctor or other primary care practitioner in a primary care setting.

A primary care setting is defined as one in which there's 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 aren't 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 45-79 and women 55-79
- Screening for high blood pressure in adults 18 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%) of the Medicare population is under 45 (men) or 55 (women), therefore the vast majority of beneficiaries should receive all 3 components. Intensive behavioral counseling to promote a healthy diet is broadly recommended to cover close to 100% of the population due to the prevalence of known risk factors.

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 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 don't pay a copayment or deductible for this screening.

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
 - Helps detect masses, lumps, and breast cancer

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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 doctor'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're either
 - At high risk for cervical or vaginal cancer
 - Of childbearing age and had an 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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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're at high risk for cervical or vaginal cancer (based on your medical history or other findings)
- You're 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)
- Multiple sexual partners (5 or more in a lifetime)
- History of sexually transmitted disease (including human immunodeficiency virus)
- Fewer than 3 negative or no Pap tests within the previous 7 years
- DES (diethylstilbestrol)-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
 - Multi-target stool DNA test (Cologuard™)

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In the United States, colorectal cancer is the fourth most common cancer in men and women. If caught early, it's 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), or a multi-target stool DNA test (Cologuard™).

Medicare defines high risk of developing colorectal cancer as someone who has 1 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; or
- 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% 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
Screening Fecal Occult Blood Test 50 or older	12 months	12 months	No deductible or copayment for this test
Screening Flexible Sigmoidoscopy 50 or older	4 years or 10 years after a previous screening colonoscopy	4 years	No deductible or copayment for this test
Screening Colonoscopy No minimum age	10 years (generally) or 4 years after a previous flexible sigmoidoscopy	24 months (unless a screening flexible sigmoidoscopy is performed, then only every 4 years)	No deductible or copayment for this test
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All Medicare beneficiaries 50 and older who **aren't** at high risk for colorectal cancer are covered for the following screenings:

- Fecal occult blood test every year
- Flexible sigmoidoscopy once every 4 years or 47 months have passed (unless a screening colonoscopy has been performed, and then Medicare may cover a screening sigmoidoscopy after 10 years or 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)

All Medicare beneficiaries 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 (or 47 months have passed)
- 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)

People with Original Medicare don't pay a copayment or deductible for fecal occult blood tests, flexible sigmoidoscopy, and colonoscopy.

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.

Colorectal Cancer Screenings Continued

Screening Test	If Normal Risk Covered Once Every	If High Risk, Covered Once Every	You Pay
Screening Barium Enema 50 or older	4 years when used instead of a sigmoidoscopy or colonoscopy	24 months (as an alternative to a covered screening colonoscopy)	There is no deductible for this test. You pay 20% of the Medicare-approved amount for the doctor's services. In a hospital outpatient setting, you pay a copayment.
Multi-target Stool DNA test (Cologuard™)	3 years	3 years	There is no deductible or copayment for this test.
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All Medicare beneficiaries 50 and older who **aren't** at high risk for colorectal cancer are covered for the following screenings:

- Barium enema every 4 years when used instead of a sigmoidoscopy or colonoscopy
- Multi-target stool DNA test (Cologuard™) every 3 years

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

- Barium enema every 24 months as an alternative to a covered screening colonoscopy
- Multi-target stool DNA test (Cologuard™)

People with Original Medicare don't pay a deductible for a screening barium enema but you pay the Medicare-approved amount for the doctor's services. In a hospital setting, you pay a copayment. There is no deductible or copayment for the multi-target stool DNA test.

Check Your Knowledge—Question 1

Which statement is true about the “Welcome to Medicare” preventive 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.

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Check Your Knowledge—Question 1

Which statement is true about the “Welcome to Medicare” preventive 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.

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 annual “Wellness” visits in later years. There's 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” preventive visit. If your provider feels you need a lab test, you pay separately.

Check Your Knowledge—Question 2

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

a. True

b. False

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Check Your Knowledge—Question 2

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

- a. True
- b. False

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.

Check Your Knowledge—Question 3

You must get a referral during your “Welcome to Medicare” preventive visit to be covered for the Abdominal Aortic Aneurysm Screening benefit.

a. True

b. False

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Check Your Knowledge—Question 3

You must get a referral during your “Welcome to Medicare” preventive visit to be covered for the Abdominal Aortic Aneurysm Screening benefit.

a. True

b. False

ANSWER: b. False.

Effective January 1, 2014, you no longer need to get a referral during the “Welcome to Medicare” preventive visit for an abdominal aortic aneurysm screening. You can get the referral anytime from either a doctor, doctor’s assistant, nurse practitioner, or clinical nurse specialist.

Check Your Knowledge—Question 4

Martha is 57 and has Original Medicare. Her colonoscopy resulted in a biopsy. Which statement is true?

- a. She will pay 20% of the Medicare-approved amount
- b. She isn't covered because she isn't 65 or older
- c. The procedure is considered diagnostic and she'll have to pay coinsurance or a copayment

d. a and c

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Check Your Knowledge—Question 4

Martha is 57 and has Original Medicare. Her colonoscopy resulted in a biopsy. Which statement is true?

- a. She will pay 20% of the Medicare-approved amount
- b. She isn't covered because she isn't 65 or older
- c. The procedure is considered diagnostic and she'll have to pay coinsurance or a copayment
- d. a and c

ANSWER: d. Both a and c are correct.

If a screening colonoscopy results in a 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. Since it's diagnostic, she must pay a 20% coinsurance.

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

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Medicare covers an 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. CMS doesn't 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 doesn't 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, 1 in 6 suffers from depression. Depression in older adults is estimated to occur in 25% 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's estimated that 50-75% of older adults who commit suicide saw their medical doctor during the prior month for general medical care, and 39% 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; tearfulness; feelings of worthlessness; and thoughts of death or suicide.

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% of the Medicare-approved amount for the other service and the Part B deductible may apply.

Diabetes Screening

- For people at risk of
 - 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

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Diabetes is a disease in which your blood glucose, or sugar levels, are 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 doesn't make insulin. With Type 2 diabetes, the more common type of diabetes, your body doesn't 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 a 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 2 diabetes screening tests within a 12-month period (but not less than 6 months apart). For people without diabetes, who've not been diagnosed as pre-diabetic or who've never been tested, Medicare covers 1 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 screenings as a Medicare Part B benefit after a referral from a doctor or qualified non-doctor 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% after Part B deductible if the provider/supplier accepts assignment
- Medicare Coverage of Diabetes Supplies & Services (CMS Product No. 11022)

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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% 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 (DME) and supplies as a Medicare Part B benefit. The Medicare Part B deductible and coinsurance or copayment applies. If the provider or supplier doesn't accept assignment, the amount you pay may be higher. In this case, Medicare will provide you with payment of the Medicare-approved amount.

For more information, please 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 (up to 10 hours per year)
 - Instruction in self-monitoring blood glucose
 - Education about diet and exercise
 - Insulin treatment plan
 - In Original Medicare you pay 20% after the Part B deductible
- Foot Exams and Treatment
 - For diabetes-related nerve damage
 - In Original Medicare you pay 20% after the Part B deductible
 - In a hospital outpatient setting, you also pay the hospital copayment

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Medicare provides coverage of diabetes self-management training for beneficiaries who've 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 a 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's 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 any of the following apply:

- 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% 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

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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 Part B provides coverage of 1 seasonal flu shot per flu season for all beneficiaries. This may mean that a beneficiary may receive more than 1 seasonal flu shot in a 12-month period. Medicare may provide coverage for more than 1 seasonal flu shot per flu season if a doctor determines, and documents in your medical record, that the additional shot is reasonable and medically necessary. For example, if someone gets a flu shot late in the flu season in January 2015, he or she will also be covered if he or she receives a shot in October, November, or December of 2015, because that is the start of a new flu season.

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 50 or older
 - Hispanic and 65 or older
- In Original Medicare you pay
 - 20% of the Medicare-approved amount and the Part B deductible applies for the doctor visit
 - A copayment in a hospital outpatient setting

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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 50 or older
- You are Hispanic and 65 or older

An eye doctor who's legally authorized by the state must perform the test. You pay 20% 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 doesn't provide coverage for routine eye refractions.

Hepatitis B Shots (Vaccine)

- Hepatitis is a serious disease (virus attacks the liver)
 - Can cause lifelong infection resulting in
 - Cirrhosis (scarring) of the liver
 - Liver cancer, liver failure
 - Death
- Covered for people at medium to high risk, including but not limited to
 - 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

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Hepatitis B is a serious disease caused by the Hepatitis B virus (HBV). The virus can affect people of all ages. Hepatitis B 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 Hepatitis B 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 (ESRD)
- Individuals with hemophilia who received Factor VIII or IX
- 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 don't pay a copayment or deductible for this vaccine if their provider accepts assignment.

Hepatitis C Screening Test

NEW!

- Hepatitis C virus (HCV) is a serious disease (virus attacks the liver)
 - Can cause chronic liver disease
 - Cirrhosis (scarring of the liver)
 - Liver cancer, liver failure, and even death
- Covered when ordered by primary care practitioner in a primary care setting
 - Single, once-in-a-lifetime HCV screening test if born from 1945 to 1965
 - Annually, if high-risk person with prior negative HCV screening test
- No copayment or deductible with Original Medicare

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- Hepatitis C virus (HCV) is an infection that attacks the liver and is a major cause of chronic liver disease. Inflammation over long periods of time (usually decades) can cause scarring, called cirrhosis. A cirrhotic liver fails to perform the normal functions of liver, which leads to liver failure. Cirrhotic livers are more prone to become cancerous and liver failure leads to serious complications, even death.

Effective 6/2/2014, this screening is covered when ordered by the primary care practitioner within the context of a primary care setting for beneficiaries who meet either of the following conditions:

- A single once-in-a-lifetime screening test is covered for adults who don't meet the high-risk determination, and were born from 1945 through 1965.
- Repeat screening for high-risk persons is covered annually only for people who've had continued illicit injection drug use since the prior negative screening test.
 - The determination of "high risk for HCV" is identified by the primary care doctor or practitioner who assesses the patient's history, which is part of any complete medical history, typically part of an annual "Wellness" visit, and considered in the development of a comprehensive prevention plan. The medical record should be a reflection of the service provided.

You pay nothing for the screening test if the doctor or other qualified health care provider accepts assignment. Medicare will only cover Hepatitis C screening tests if they're ordered by a primary care doctor or practitioner.

Human Immunodeficiency Virus (HIV) Screening

- Except for individuals who are pregnant, Medicare covers one annual, voluntary HIV screening for its beneficiaries who are
 - Between the ages of 15 and 65 years, without regard to perceived risk
 - Younger than 15 and older than 65 years, who are at increased risk as defined.
- For Medicare beneficiaries who are pregnant, up to 3 voluntary screenings during a pregnancy are covered
- No cost for the test if provider accepts assignment
- Pay 20% of Medicare-approved amount for visit

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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. Once infected, it may take years for recognizable illness to develop. Thus a person may be infected with HIV for years before the condition is suspected.

Except for pregnant women, Medicare covers 1 annual, voluntary HIV screening for beneficiaries between the age of 15 and 65, without regard to perceived risk. Except for pregnant beneficiaries, Medicare will also cover 1 annual, voluntary screening for people who are younger than 15 or older than 65, who are at increased risk for the infection.

Except for pregnant beneficiaries, Medicare covers 1 annual, voluntary HIV screening for people with Medicare between 15 and 65, without regard to perceived risk. Except for pregnant beneficiaries, Medicare will also cover 1 annual, voluntary screening for people who are younger than 15 or older than 65, who are at increased risk for the infection. The following people are considered at increased risk for HIV infection:

- Men who have sex with men
- Men and women having unprotected sex
- 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 who have acquired or request testing for other sexually-transmitted infectious diseases
- Persons with a history of blood transfusion between 1978 and 1985
- Persons who request the HIV test despite reporting no individual risk factors
- Persons with new sexual partners
- Persons whose individualized medical history, as properly assessed and documented by an appropriate health care professional, indicates an increased risk for the disease

For Medicare beneficiaries who are pregnant, up to 3 voluntary screenings during a pregnancy are covered.

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

Lung Cancer Screening

NEW!

- Medicare covers lung cancer screening with Low Dose Computed Tomography once per year for people with Medicare who meet all of these criteria:
 - Are 55-77
 - Are either a current smoker or have quit smoking within the last 15 years
 - Have a tobacco smoking history of at least 30 “pack years”
 - Get a written order from their doctor or qualified non-doctor practitioner

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- Medicare covers lung cancer screening with Low Dose Computed Tomography once per year for people with Medicare who meet all of these criteria:
 - Are 55-77
 - Are either a current smoker or have quit smoking within the last 15 years
 - Have a tobacco smoking history of at least 30 “pack years” (an average of one pack a day for 30 years)
 - Get a written order from their doctor or qualified non-doctor practitioner.
 - Before your first lung cancer screening, you’ll need to schedule an appointment with your doctor to discuss the benefits and risks of lung cancer screening. You and your doctor can decide whether lung cancer screening is right for you.

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

Obesity Screening and Counseling

- Obesity = body mass index (BMI) $\geq 30 \text{ kg/m}^2$
- Intensive behavioral therapy consists of
 - 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

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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 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 doctor or other primary care practitioner in a primary care setting, CMS covers one face-to-face visit every

- Week for the first month
- Other week for months 2-6
- 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 doctor's office records for applicable beneficiaries consistent with usual practice. For beneficiaries who don't 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.

Pneumococcal Shots

UPDATE

- Effective 9/19/2014, Medicare covers
 - An initial pneumococcal vaccine for all Medicare beneficiaries who've never received the vaccine under Medicare Part B, and
 - A different second pneumococcal vaccine 1 year after the first vaccine was administered (11 full months have passed following the month in which the last pneumococcal vaccine was administered)
- All people with Medicare are eligible
- No copayment or deductible for the vaccines with Original Medicare if the provider accepts assignment

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Effective 9/19/2014, Medicare covers the following:

- An initial pneumococcal vaccine for all Medicare beneficiaries who've never received the vaccine under Medicare Part B, and
- A different second pneumococcal vaccine 1 year after the first vaccine was administered (11 full months have passed following the month in which the last pneumococcal vaccine was administered)

Since the updated Advisory Committee on Immunization Practices recommendations are specific to vaccine type and sequence of vaccination, prior pneumococcal vaccination history should be taken into consideration. For example, if a beneficiary who's 65 or older received the 23-valent pneumococcal polysaccharide vaccine (PPSV23) a year or more ago, then the 13-valent pneumococcal conjugate vaccine (PCV13) should be administered next as the second in the series of the 2 recommended pneumococcal vaccinations. Receiving multiple vaccinations of the same vaccine type is not generally recommended. Ideally, providers should readily have access to vaccination history, such as with electronic health records, to ensure reasonable and necessary pneumococcal vaccinations.

Medicare doesn't require that a doctor of medicine or osteopathy order the vaccines; therefore, the beneficiary may receive the vaccine upon request without a doctor's order and without doctor supervision.

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

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

- Family history of prostate cancer
- Men 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 50 and older (coverage begins the day after their 50th birthday). The 2 most common screenings used by doctors 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 2 individual 20-to 30-minute, face-to-face, high-intensity behavioral counseling sessions each year
- No cost if the provider accepts assignment

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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 2 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.

Smoking and Tobacco-use Cessation Counseling

- Medicare covers cessation counseling
 - Two attempts of up to 8 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 these services if the doctor or other health care provider accepts assignment

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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 covers 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 doctor or other Medicare-recognized practitioner

Medicare will cover 2 cessation attempts per year. Each attempt may include up to 4 counseling sessions, with the total annual benefit covering up to 8 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 aren't covered if the primary reason for the hospital stay is tobacco cessation. You must get counseling from a qualified Medicare provider (doctor, doctor's assistant, nurse practitioner, clinical nurse specialist, or clinical psychologist).

Both the copayment and deductible are waived if the counseling sessions are furnished by a doctor or other health care provider who accepts assignment.

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 doctor.

Check Your Knowledge—Question 5

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

- a. He'll pay nothing for the covered test if his doctor accepts assignment
- b. He generally will pay nothing out of pocket
- c. The Part B deductible doesn't apply
- d. Based on the results of his test, he may be eligible for 4 diabetes screenings each year

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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 pay nothing out of pocket.
- c. The Part B deductible doesn't apply.
- d. Based on the results of his test, he may be eligible for 4 diabetes screenings each year.

ANSWER: d. Based on the results of his test, he may be eligible for 4 diabetes screenings each year.

The incorrect answer is d because Medicare covers up to 2 diabetes screenings each year if your doctor determines you're at risk for diabetes.

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

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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

ANSWER: b. False.

Various screening tools are available for screening for depression. CMS doesn't 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.

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 you turn 65

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Check Your Knowledge—Question 7

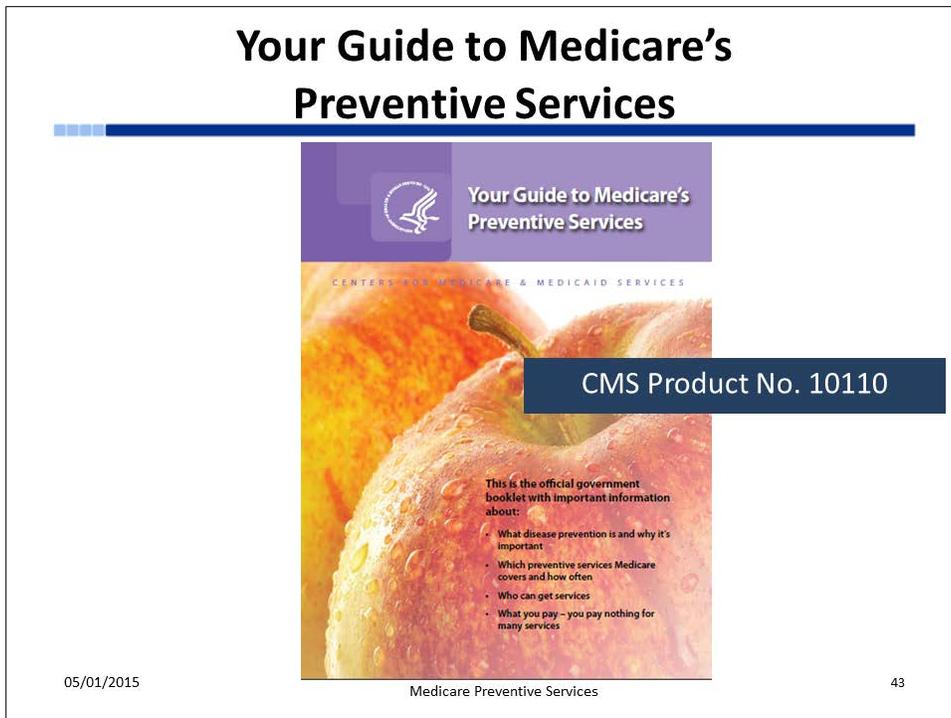
How often does Medicare cover a flu vaccine for all people with Medicare?

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

ANSWER: c. Once every flu season

Medicare provides coverage of one seasonal flu shot per flu season for all beneficiaries. This may mean that a beneficiary may receive more than 1 seasonal flu shot in a 12-month period. Medicare may provide coverage for more than one seasonal flu shot per flu season if a doctor 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 2015 he or she will also be covered if he or she receives a shot in October, November, or December of 2015 because that is the start of a new flu season.

Your Guide to Medicare's Preventive Services



“Your Guide to Medicare’s Preventive Services” is a publication written in plain language so that people with Medicare can better understand the preventive benefits that are covered, the criteria for who is covered, the frequency of coverage, and the costs associated with these services. This publication is available at [Medicare.gov/Pubs/pdf/10110.pdf](https://www.Medicare.gov/Pubs/pdf/10110.pdf).

Preventive Services Checklist

Are You Up-To-Date on Your Preventive Services?

Medicare covers a full range of preventive services to help keep you healthy and help find problems early, when treatment is most effective. Ask your doctor which of these services is right for you.



✓	Preventive service	Date	Notes
	One time "Welcome to Medicare" Preventive Visit—within the first 12 months you have Medicare Part B		
	Yearly "Wellness" Visit—get this visit 12 months after your "Welcome to Medicare" preventive visit or 12 months after your Part B effective date		
	Abdominal Aortic Aneurysm Screening		
	Alcohol Misuse Screening and Counseling		
	Bone Mass Measurement (Bone Density Test)		
	Cardiovascular Disease (Behavioral Therapy)		
	Cardiovascular Screenings (cholesterol, lipids, triglycerides)		
	Colorectal Cancer Screenings		
	Depression Screening		
	Diabetes Screening		

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A helpful checklist is available for people with Medicare. It lists Medicare-covered preventive services and can help them keep track of when they receive those services for which they qualify. This can be found at [Medicare.gov/Pubs/pdf/11420.pdf](https://www.Medicare.gov/Pubs/pdf/11420.pdf).

Medicare Learning Network on CMS.gov

This Preventive Services page provides educational products for health care professionals including coverage, coding, billing, reimbursement, and claim filing information.

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MLN Products

- MLN Catalog
- Web-Based Trainings (WBT)
- Preventive Services
- MLN Provider Compliance
- Ophthalmology Resource Information
- Advanced Practice Registered Nurses, Anesthesiologist Assistants, and Physician Assistants
- Health Care Professional Frequently Used Web Pages
- MLN Opinion Page
- MLN Publications
- MLN Multimedia

Preventive Services

Medicare Learning Network

Official Information Health Care Professionals Can Trust

This Medicare Learning Network® (MLN) Preventive Services page provides educational products for health care professionals. These products contain coverage, coding, billing, reimbursement, and claim filing information.

Medicare covers the following preventive services and screenings, subject to certain eligibility and other limitations:

- Abdominal Aortic Aneurysm Screening;
- Adult Immunizations;
- Annual Wellness Visit, Including Personalized Prevention Plan Services;
- Bone Mass Measurements;
- Cancer Screenings;
- Cardiovascular Screening;
- Diabetes Screening;
- Diabetes Self-Management Training;
- Diabetes Supplies;
- Glaucoma Screening;
- HIV Screening;
- Initial Preventive Physical Exam ("Welcome to Medicare" Physical Exam);
- Intensive Behavioral Therapy for Cardiovascular Disease;
- Intensive Behavioral Therapy for Obesity;
- Medical Nutrition Therapy (for Medicare beneficiaries with diabetes or renal disease);

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This Medicare Learning Network Preventive Services page is located at [CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/PreventiveServices.html](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/PreventiveServices.html). This Preventive Services page provides educational products for health care professionals including coverage, coding, billing, reimbursement, and claim filing information.

Appendix A: Preventive Services Resource Guide

Preventive Services Resource Guide		Medicare Products
Resources		
<p>Medicare.gov Medicare.gov 1-800-MEDICARE (1-800-633-4227) (TTY 1-877-466-2048)</p> <p>Local State Health Insurance Assistance Programs (SHIP) Medicare.gov/contacts</p> <p>Centers for Disease Control and Prevention CDC.gov</p> <p>Flu Information FLU.gov</p> <p>HHS Tobacco Cessation Resources surgeongeneral.gov/initiatives/tobacco/index.html</p> <p>National Cancer Institute cancer.gov 1-800-4-CANCER (TTY-1-800-332-8615)</p> <p>Medline Plus nlm.nih.gov/medlineplus 05/01/2015</p>	<p>American Cancer Society cancer.org 1-800-ACS-2345 (1-800-227-2345)</p> <p>American Diabetes Association diabetes.org/ 1-800-DIABETES (1-800-342-2383)</p> <p>American Lung Association lungusa.org 202-785-3355</p> <p>National Kidney Foundation kidney.org 1-800-622-9010</p> <p>Medicare Preventive Services</p>	<p>“Medicare & You Handbook” CMS (Product No. 10050)</p> <p>“Your Guide to Medicare’s Preventive Services” (CMS Product No. 10110)</p> <p>“Medicare Coverage of Diabetes Supplies & Services” (CMS Product No. 11022)</p> <p>“Welcome to Medicare Q&A – Preventive Services” (CMS Product No. 11532)</p> <p>“Staying Healthy” (CMS Product No. 11100)</p> <p>“6 Things You Should Know” (CMS Product No. 11533)</p> <p>View and order single copies at Medicare.gov.</p> <p>Order multiple copies (partners only) at productordering.cms.hhs.gov/. You must register your organization.</p>

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
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
MA	Medicare Advantage
NTP	National Training Program
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

CMS National Training Program (NTP)

To view all available NTP training materials, or to subscribe to our email list, visit

[CMS.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram/index.html](https://www.cms.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram/index.html)

For questions about training products email

training@cms.hhs.gov

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