Workbook

2013 National Training Program

Module: 7

Medicare Preventive Services

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Inside front cover

Module 7: Preventive Services

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This module can be presented in 1 hour. Allow approximately 30 more minutes for discussion, questions and answers, and the learning activities.

Module 7 explains Medicare-covered preventive services.

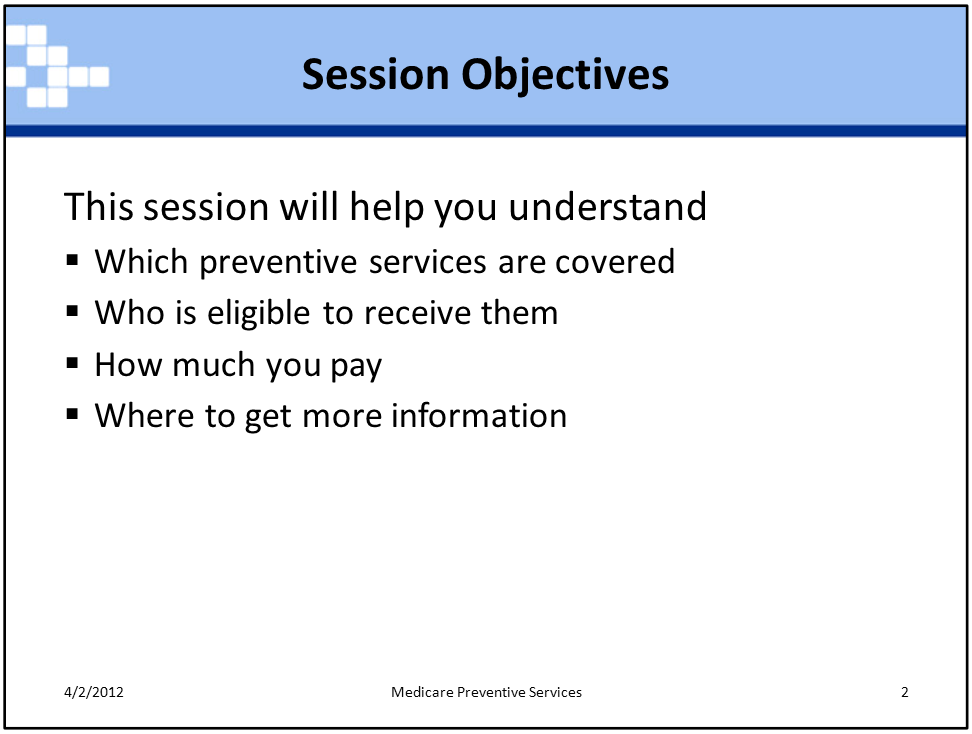
This training module was developed and approved by the Centers for Medicare & Medicaid Services (CMS), the Federal agency that administers Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the Health Insurance Marketplace. The information in this module was correct as of May 2013.

To check for updates on the new health care legislation, visit www.healthcare.gov

To view the Affordable Care Act, visit www.healthcare.gov/law/full/index.html

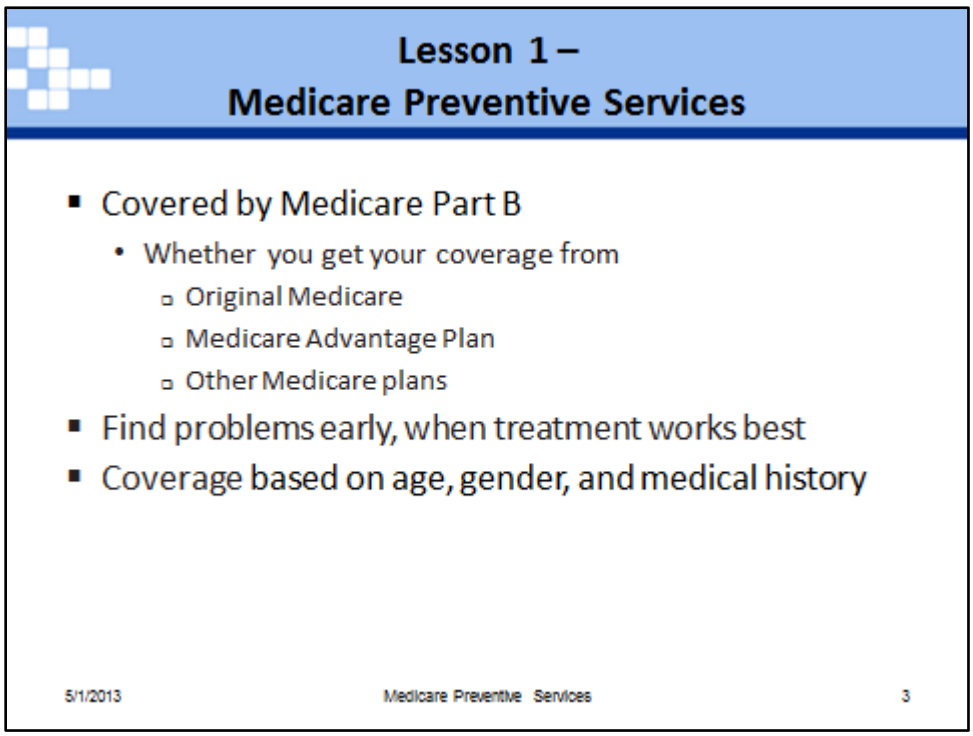
To check for an updated version of this training module, visit http://cms.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram/index.html

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.



Medicare Preventive Services explains the following:

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



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.

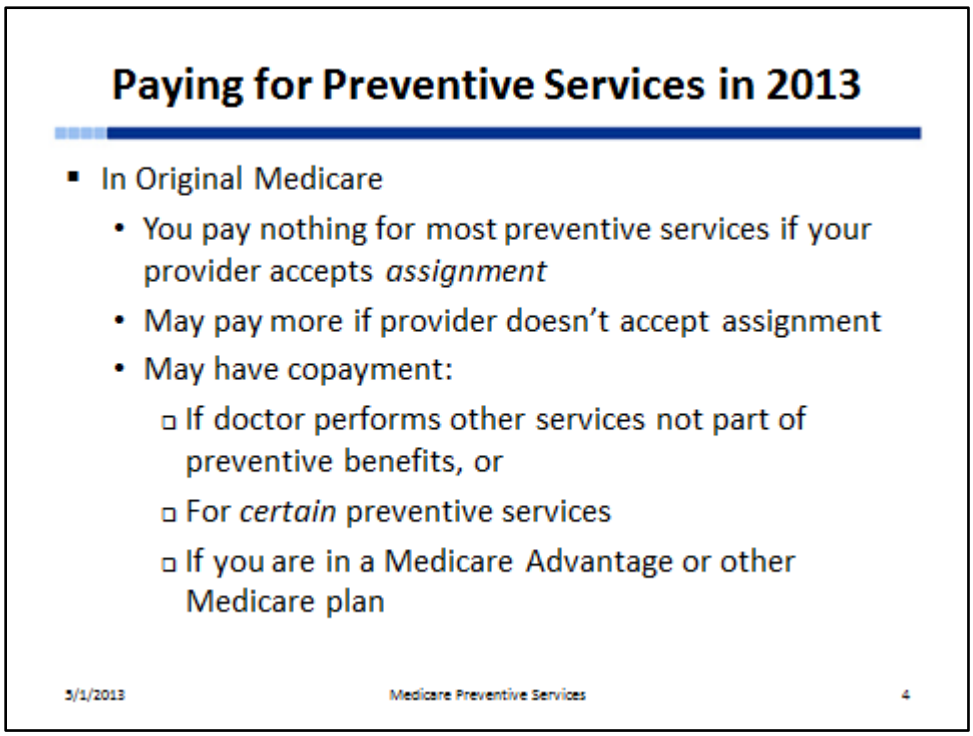
You must have Medicare Part B for Medicare to cover these services.

These services are covered no matter whether you get your coverage from original Medicare, a Medicare Advantage Plan, or other Medicare plans. However, the rules for how much you pay for these services may vary.

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?

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



The preventive services costs under Original Medicare in 2013 include the following:

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.

For some preventives services, you will pay nothing for the service. 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, this module will discuss preventive services that require a copayment.

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

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.

During the visit, your doctor will do the following:

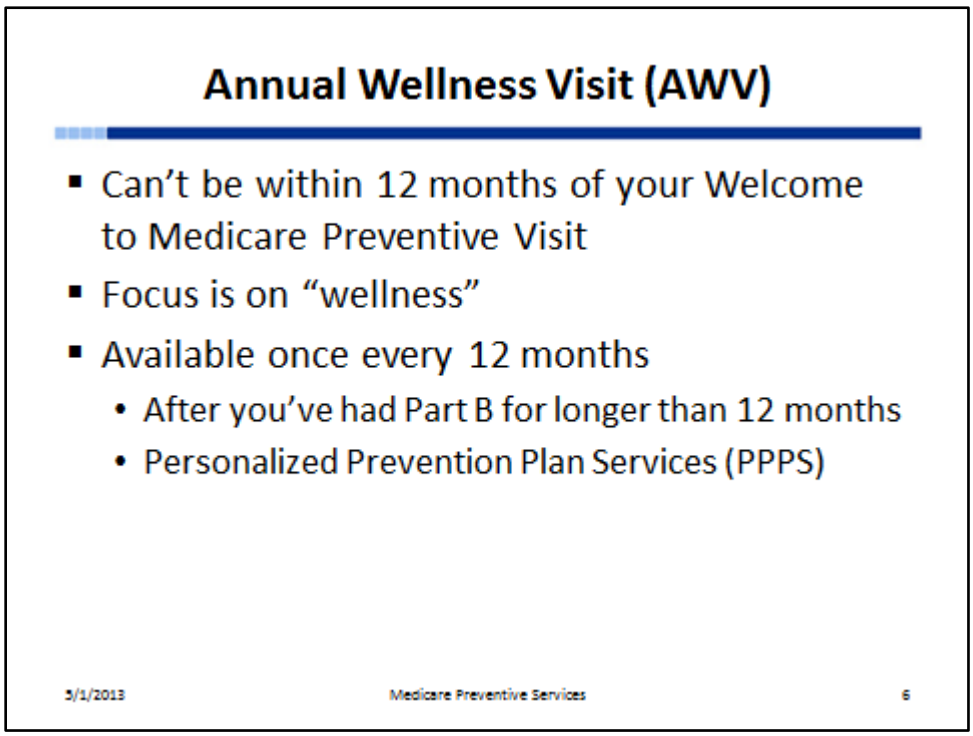
- Review your medical and social history;
- Take your height, weight, body mass index, and blood pressure;
- Perform a simple vision test;
- Review potential (risk factors) for depression; and
- Review functional ability and level of safety, which means an assessment of hearing impairment, ability to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

You will get advice to help you 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 exam is a preventive visit and **not** a "routine physical checkup." The Welcome to Medicare visit does not include any clinical lab tests.



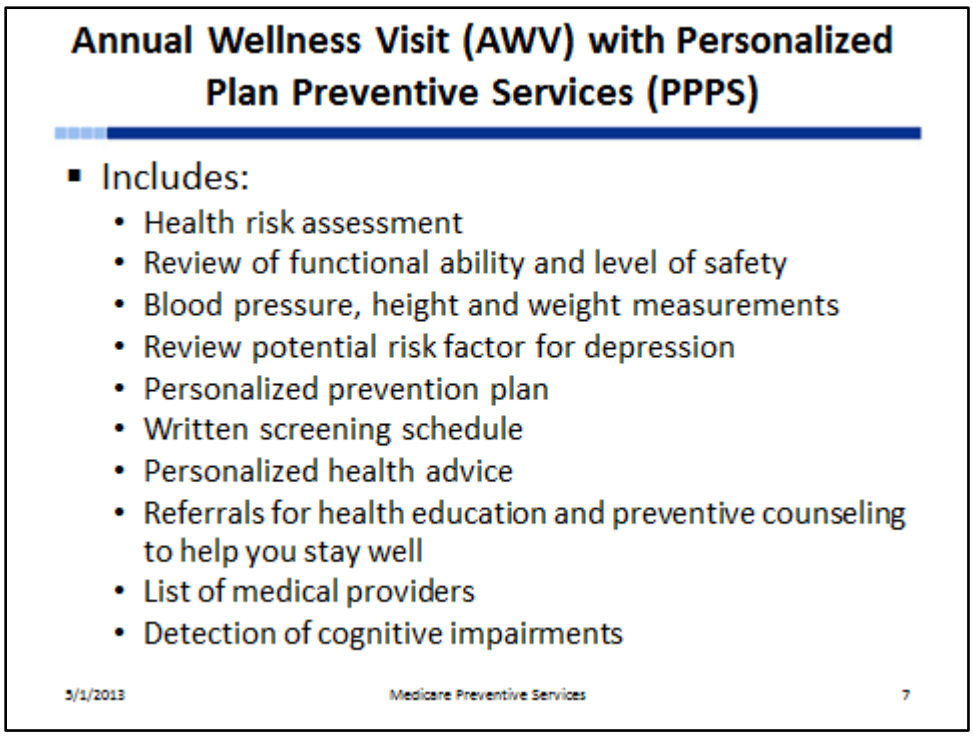
After you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a prevention plan just for you. Medicare covers one annual wellness visit every 12 months.

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

Medicare will cover an Annual Wellness Visit (AWV) including Personalized Prevention Plan Services (PPPS) at no cost to you, so you can work with your physician to develop and update a personalized prevention plan. This new benefit will provide 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 AWV is a preventive wellness visit and is **not** a "routine physical checkup."

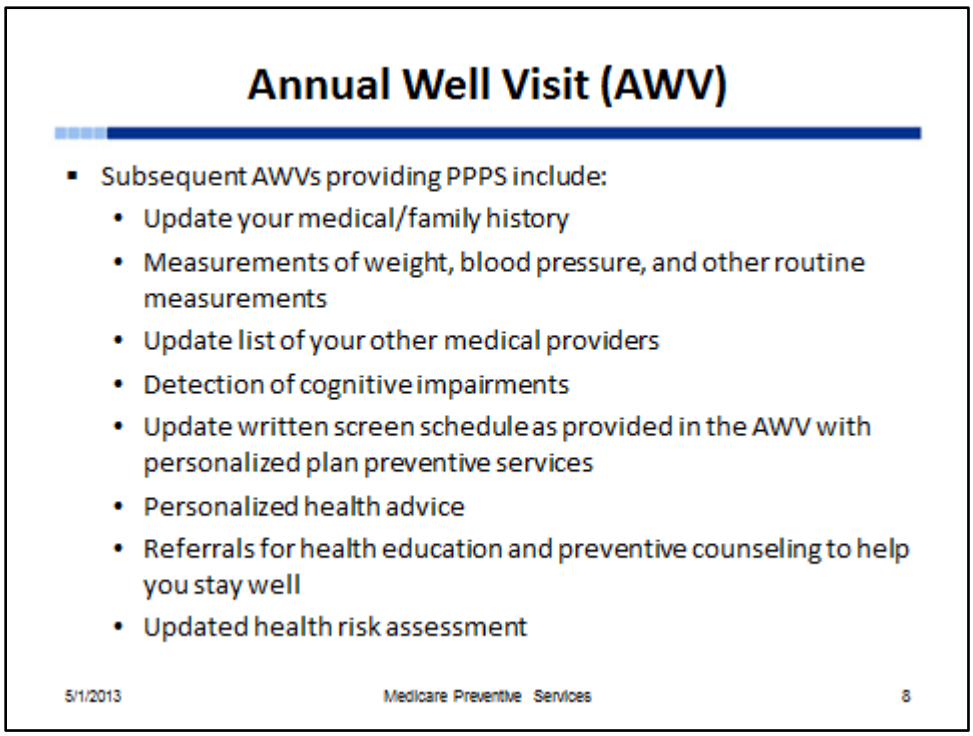


The health professional will ask you to answer some questions before your visit, which is called a health risk assessment. Your responses to the questions will help you and your health professional get the most from your annual wellness visit.

During the visit, your doctor will do the following:

- Record your blood pressure, height, and weight measurements;
- Review your potential (risk factors) for depression; and
- Review your functional ability, and level of safety, which means an assessment of the following:
  - Hearing impairment
  - Ability to successfully perform activities of daily living
  - Fall risk, and
  - Home safety

Give you advice to help you 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.



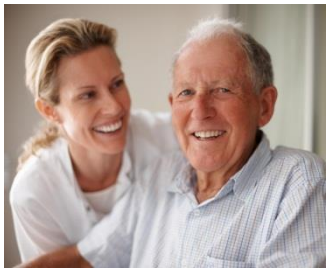
Subsequent annual wellness visits providing personalized plan preventive services (PPPS) include:

- Update to the 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;
- Update to the list of your current medical providers and suppliers that are regularly involved in your medical care, as was developed at the first AWV providing PPPS;
- Detection of any cognitive impairment that you may have;
- Update to the your written screening schedule as developed at the first AWV providing PPPS;
- Update to the your list of risk factors and conditions for which primary, secondary, or tertiary interventions are recommended or are underway for the beneficiary, as was developed at the first AWV providing PPPS;
- Furnish appropriate personalized health advice and a referral, as appropriate, to health education or preventive counseling services or programs; and an
- Updated health risk assessment.

Check Your Knowledge
Lesson 1 – Medicare Preventive Services

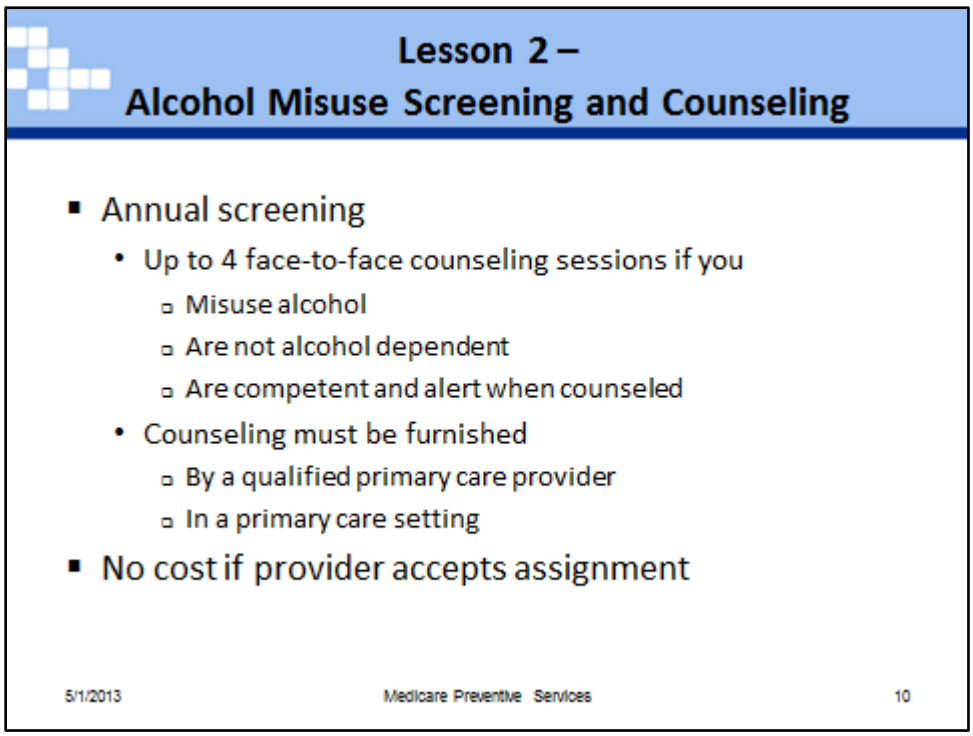
Answer the following questions:

1. Mae has original Medicare and Medicare Part B. Joe has a Medicare Advantage Plan. Who has coverage for preventive services? Why or why not?



2. When can you get your "Welcome to Medicare" visit and your "Annual Wellness" visit?

Refer to page 50 to check your answers.

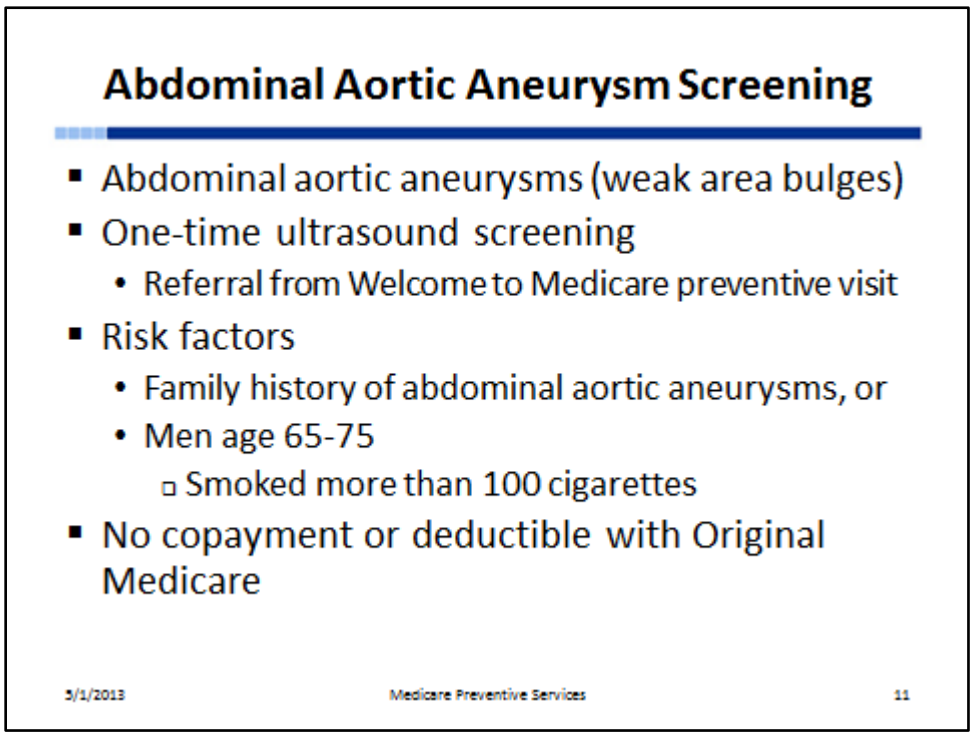


Medicare covers annual alcohol screening. CMS does not identify specific alcohol misuse screening tools. Rather, the decision to use a specific tool is at the discretion of the clinician in the primary care setting. Various screening tools are available for screening for alcohol misuse.

For those that screen positive, Medicare covers up to four brief (15 minutes), face-to-face, behavioral counseling interventions per year for Medicare beneficiaries, including pregnant women:

- who 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);
- who are competent and alert at the time that counseling is provided; and,
- whose counseling is furnished by qualified primary care physicians or other primary care practitioners in a primary care setting.

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.



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.

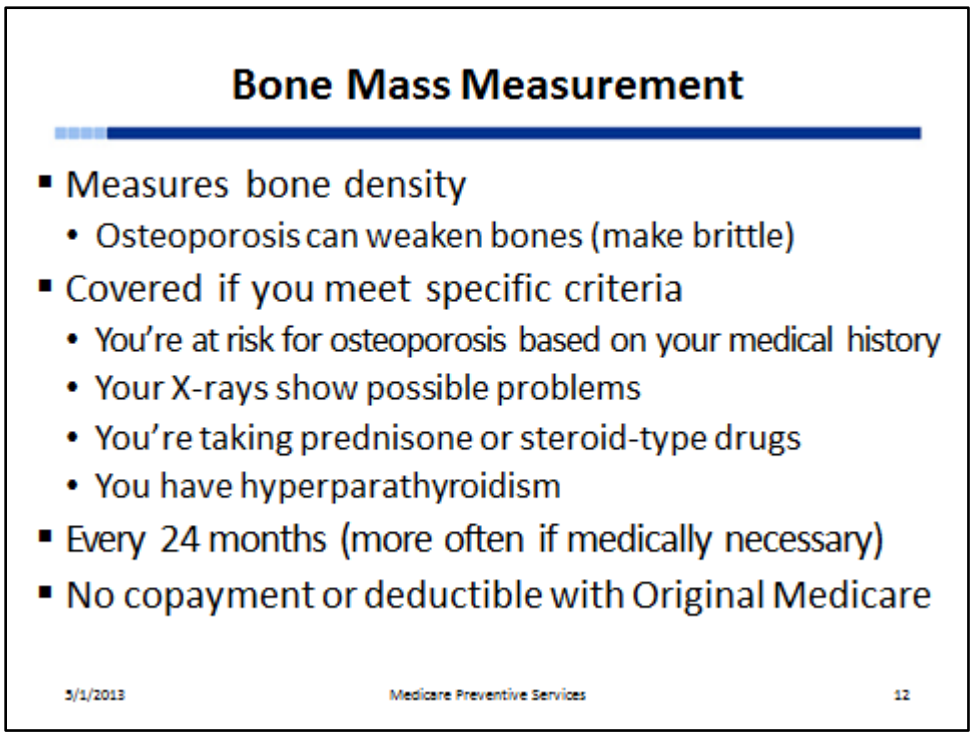
The abdominal aorta supplies blood to the lower part of the body. When a weak area of the abdominal aorta expands or bulges, it is called an abdominal aortic aneurysm. Aneurysms develop slowly over many years and often have no symptoms. If an aneurysm expands rapidly, tears open (ruptured aneurysm),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

For a one-time screening ultrasound, you must get a referral at your "Welcome to Medicare" preventive visit.

You are considered at risk if you

- Have a family history of abdominal aortic aneurysms; or
- Is a man aged 65 to 75 and have smoked at least 100 cigarettes in your lifetime.

Medicare covers ultrasound screening for abdominal aortic aneurysms with no deductible or copayment.



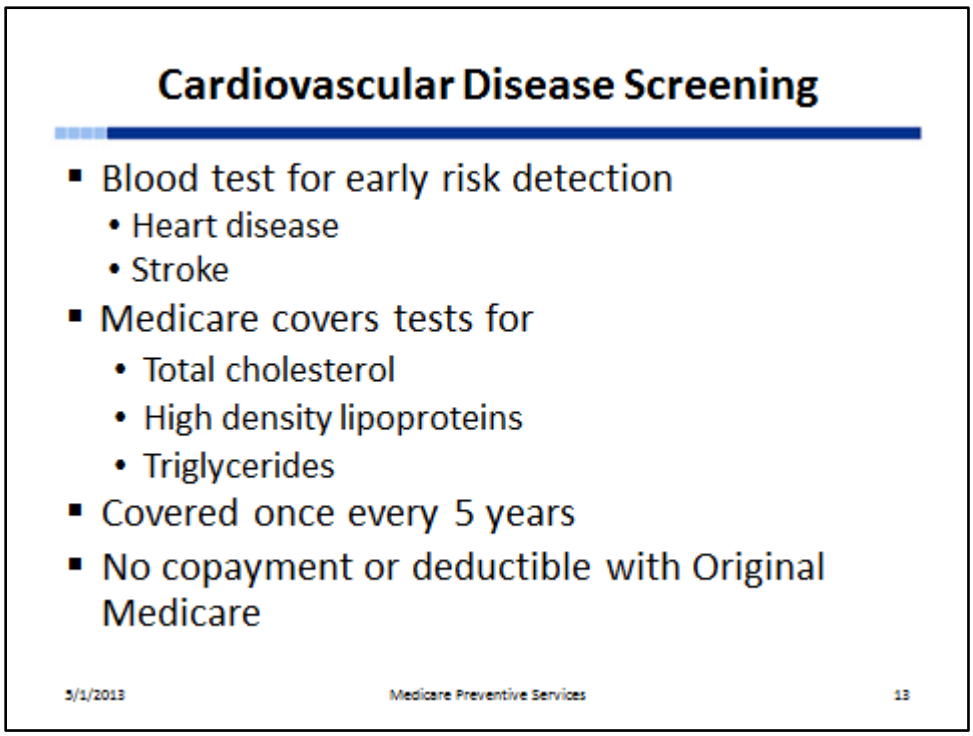
Medicare covers bone mass measurements to measure bone density. These test results help you and your doctor choose the best way to keep your bones strong.

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 three months;
- Individuals with hyperparathyroidism; or
- Individuals being monitored to assess their response to FDA-approved osteoporosis drug therapy.

In Original Medicare there is no deductible or copayment.

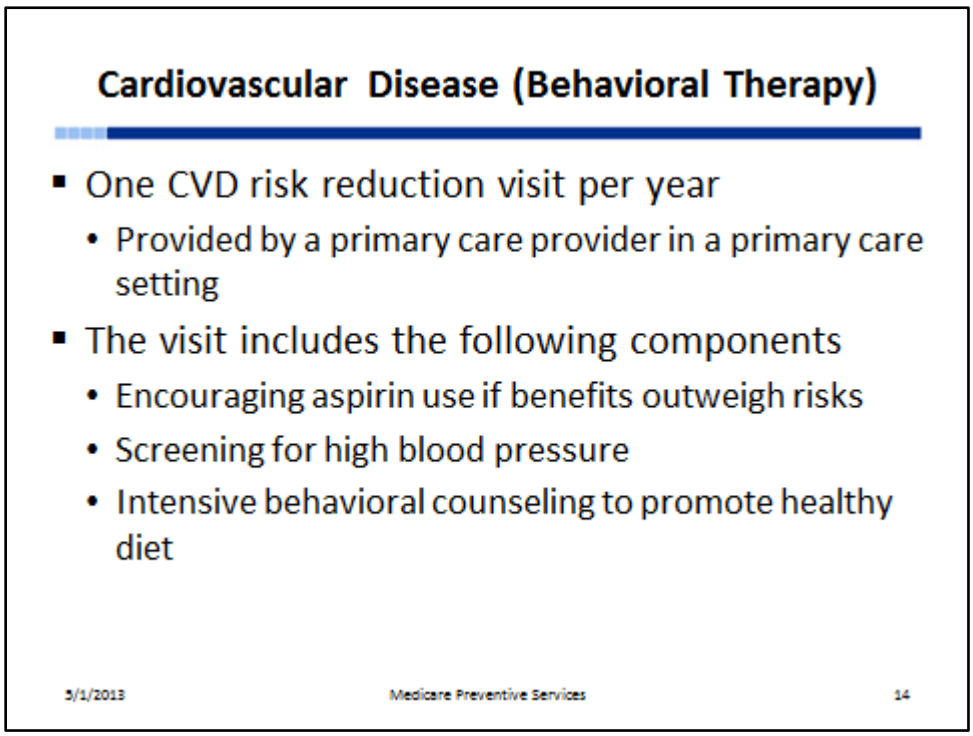


Every year, thousands of Americans die of heart disease and stroke. Millions more currently live with one or more types of cardiovascular disease including: coronary heart disease, stroke, high blood pressure, congestive heart failure, congenital cardiovascular defects, and hardening of the arteries. Heart disease and stroke are also among the leading causes for disability for both men and women in the United States.

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, 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.

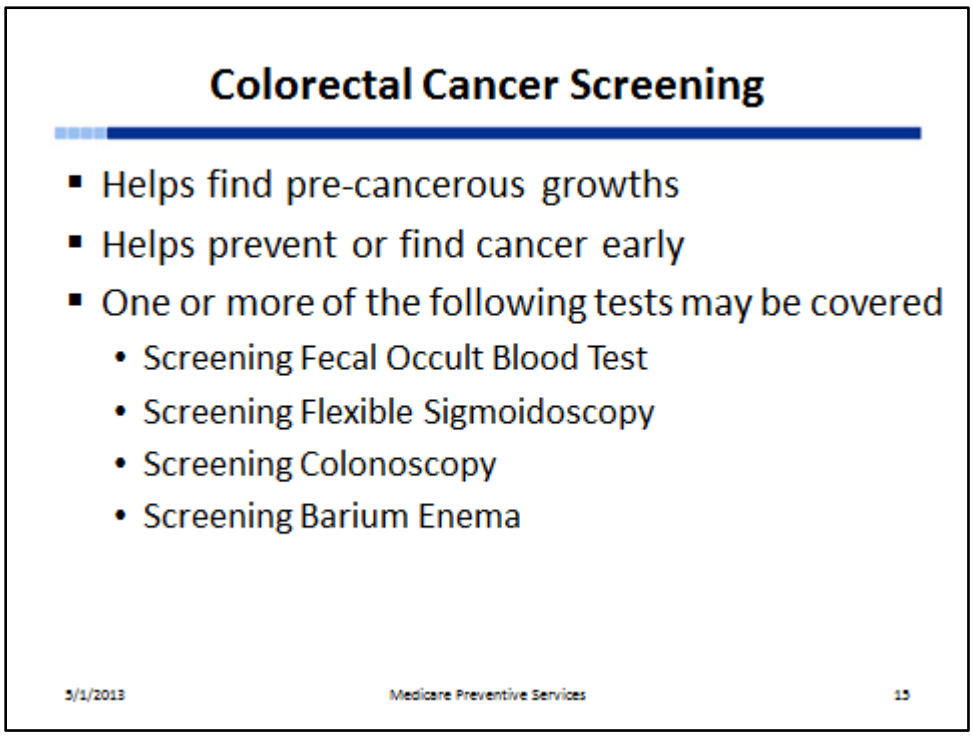
People with Original Medicare do not pay a copayment or deductible for this screening.



Medicare covers intensive behavioral therapy for cardiovascular disease (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 three components:
    1. 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.
    2. Screening for high blood pressure in adults age 18 years or older.
    3. 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 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% of the population due to the prevalence of known risk factors.



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

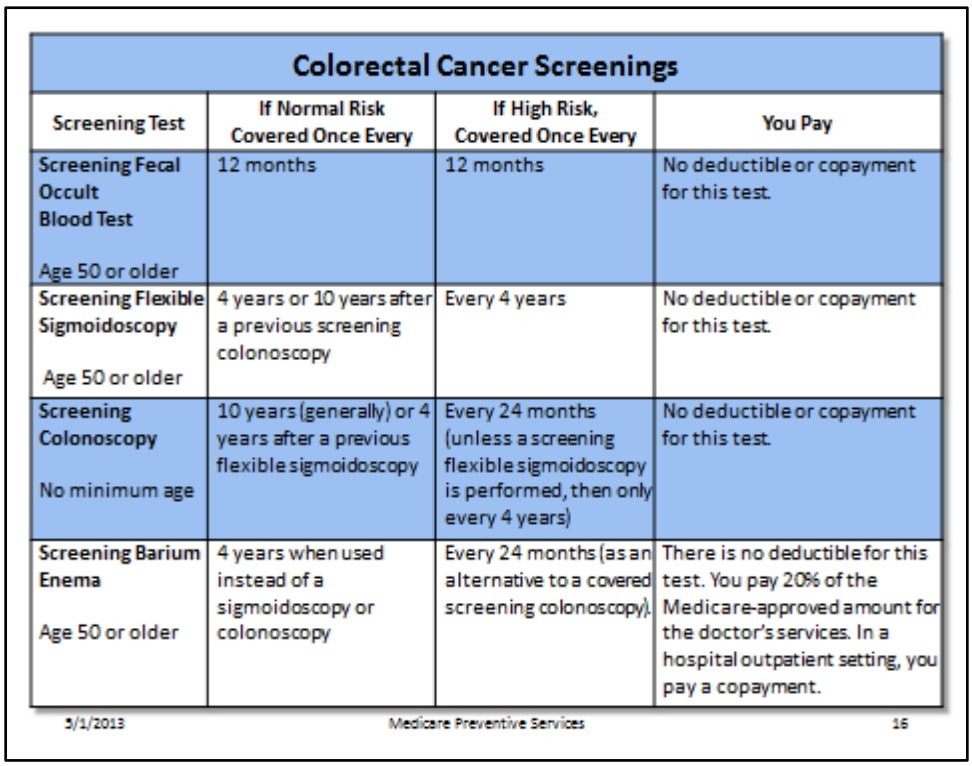
To help find pre-cancerous growths and help prevent or find cancer early, when treatment is most effective, your doctor may order one or more of the following tests if you meet certain conditions: Screening Fecal Occult Blood Test, Screening Flexible Sigmoidoscopy, Screening Colonoscopy; or Screening 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; 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 the 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 Age 50 or older	12 months	12 months	No deductible or copayment for this test.
Screening Flexible Sigmoidoscopy Age 50 or older	4 years or 10 years after a previous screening colonoscopy	Every 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	Every 24 months (unless a screening flexible sigmoidoscopy is performed, then only every 4 years)	No deductible or copayment for this test.
Screening Barium Enema 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% of the Medicare-approved amount for the doctor's services. In a hospital outpatient setting, you pay a copayment.

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

- Screening Fecal Occult Blood Test every year;
- Screening 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);
- Screening 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);
- Screening 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:

- Screening Fecal Occult Blood Test every year;
- Screening Flexible Sigmoidoscopy once every 4 years;
- Screening 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), and
- Screening 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 the Screening Colonoscopy, a lesion or growth is detected which results in a biopsy or removal of the growth, this becomes a diagnostic procedure (G0105). The procedure maybe subject to a copayment.

Check Your Knowledge
Lesson 2 – Preventive Services A-C

Answer the following questions:

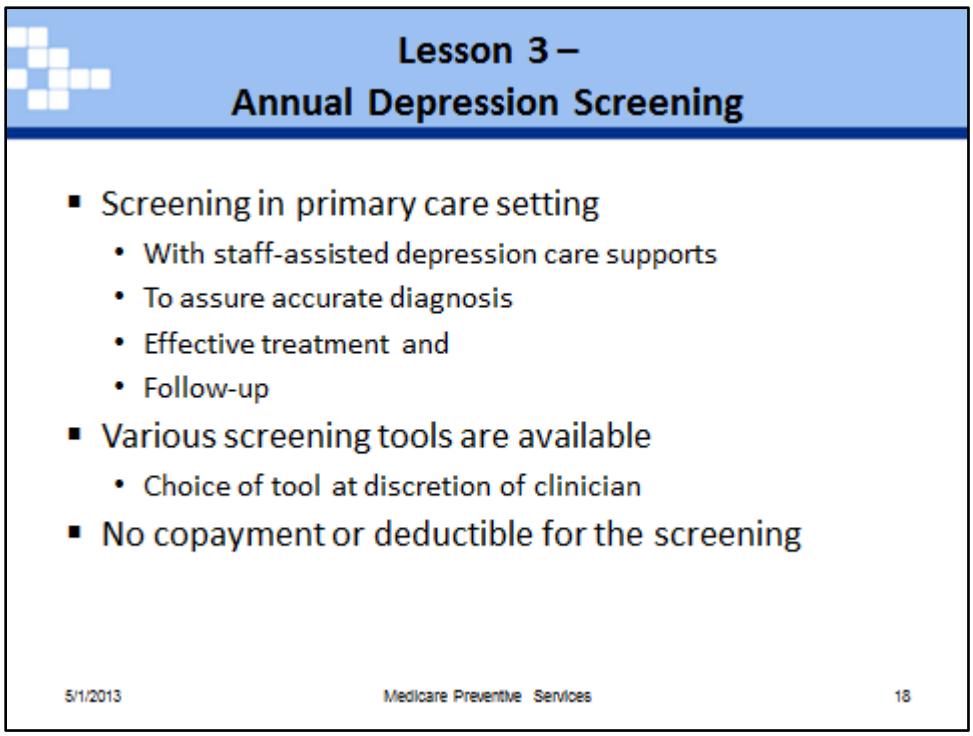
1. How often is an alcohol misuse screening covered?

    a. As needed
    b. Every 6 months
    c. Every 12 months
    d. Every 24 months

2. Anya's doctor tells her that she is at risk for osteoporosis and needs a bone mass measurement. What kind of information does this test provide her doctor?

3. What colorectal cancer screenings are covered by Medicare?

Refer to page 51 to check your answers.



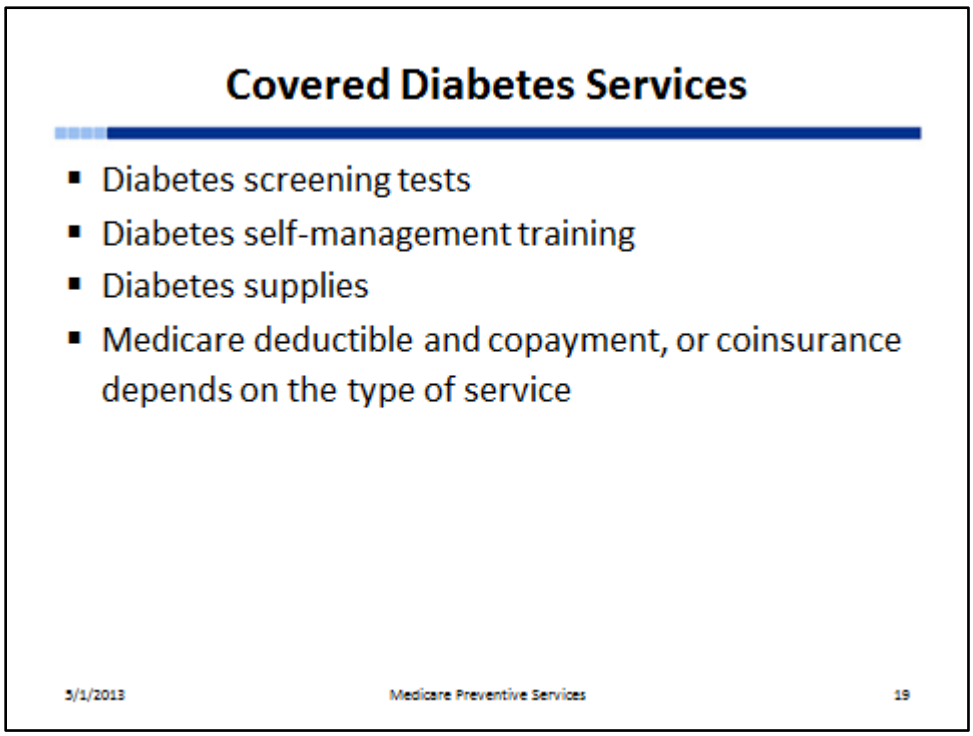
Medicare covers annual screening for depression (up to 15 minutes) for people with Medicare in primary care settings that have staff-assisted depression care supports in place to assure accurate diagnosis, effective treatment, and follow-up.

Various screening tools are available for screening for depression. CMS 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, 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% 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% 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.



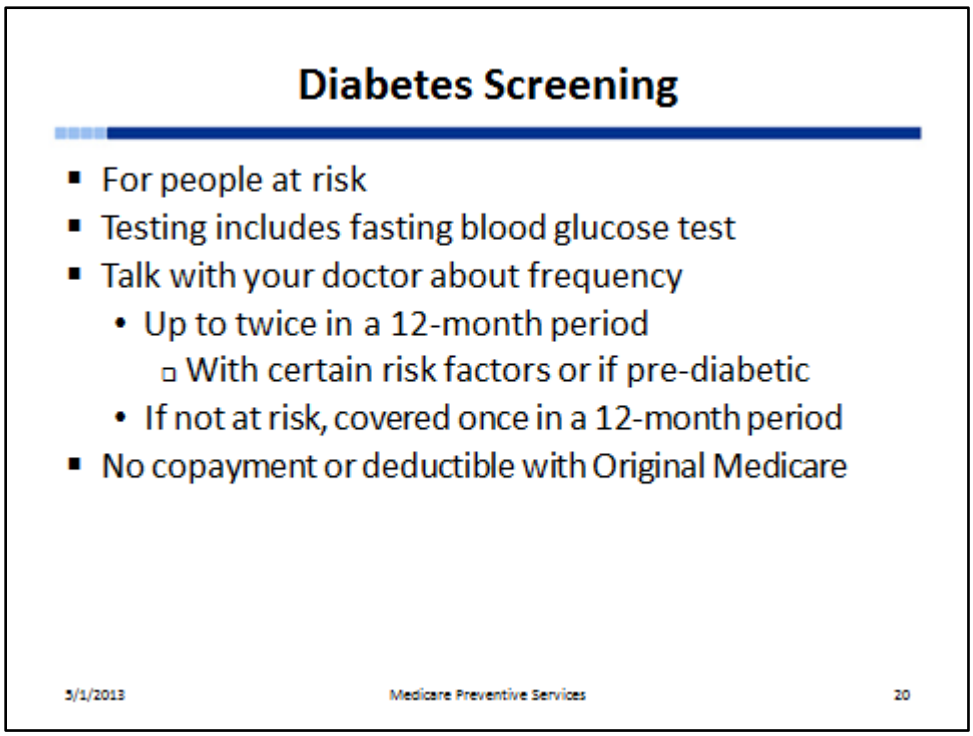
Diabetes is the leading cause of acquired blindness among adults, and the leading cause of End-Stage Renal Disease.

Early detection and treatment of diabetes with diet, physical activity, and medication can prevent or delay many of the complications associated with diabetes.

Medicare covers certain services and supplies for people with diabetes to manage the disease and help prevent its complications. In most cases, your doctor must write an order or referral for you to get these services. These services include:

- Diabetes screening tests;
- Diabetes self-management training; and
- Diabetes supplies.

Copayment and deductible amounts depend on the type of Medicare program you have selected, and the type of service provided.



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.

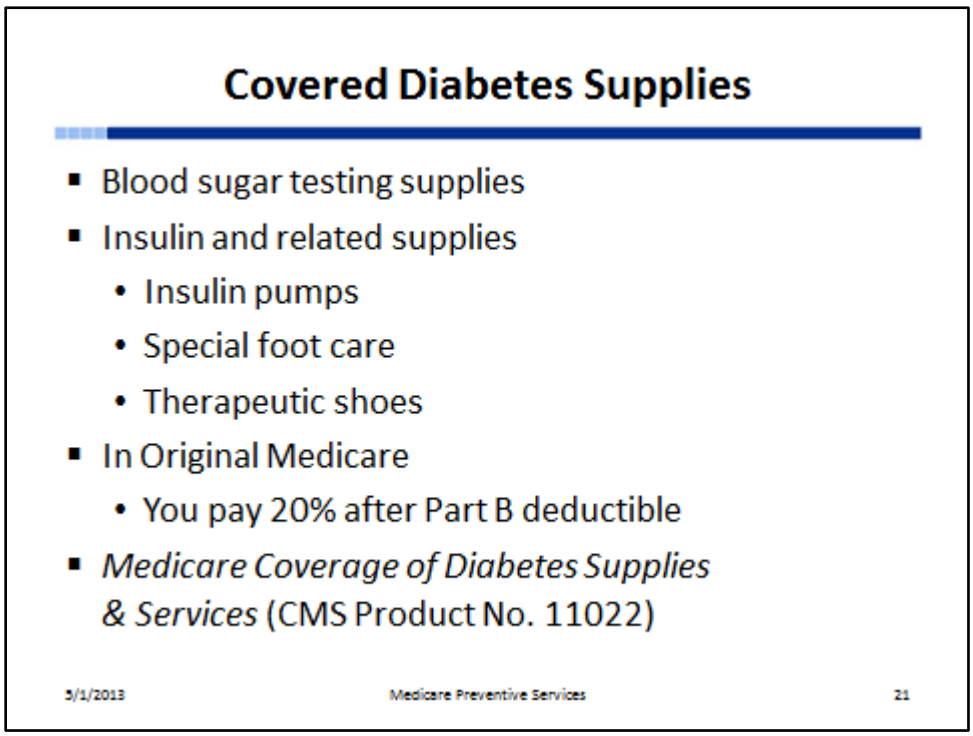
With Type 1 diabetes, your body does not make insulin. With Type 2 diabetes, the more common type of diabetes, your body does not make or use insulin well. Without enough insulin, the glucose stays in your blood.

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 U.S. Diabetes can also cause heart disease, stroke and even the need to remove a limb. Pregnant women can also get diabetes, called gestational 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-diabetics 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).



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

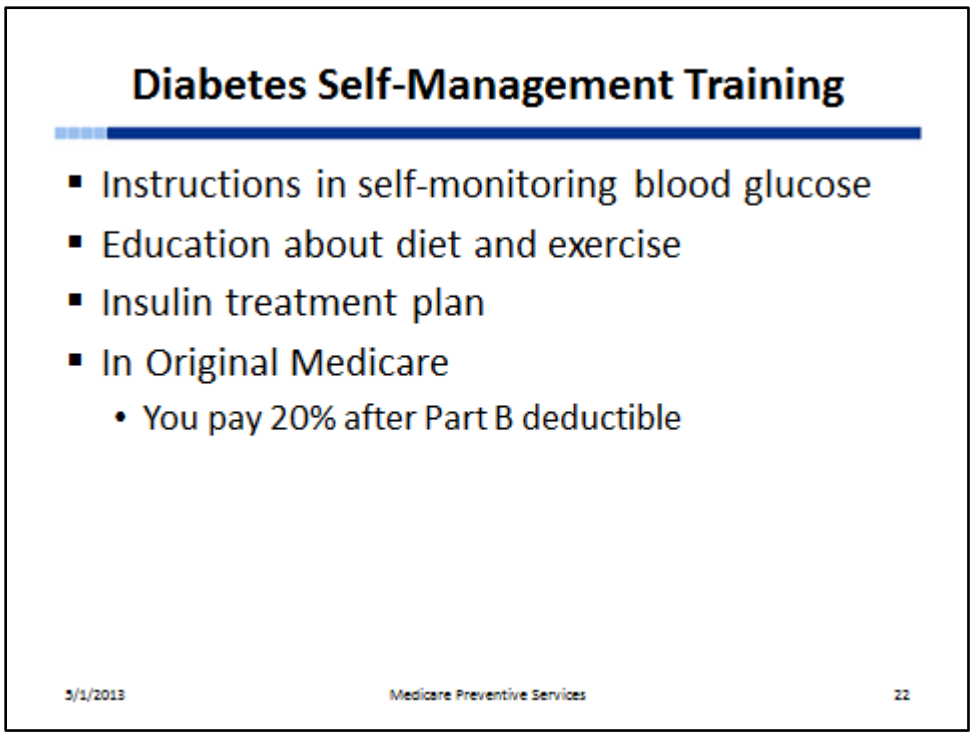
Insulin associated with an insulin pump is covered by Medicare Part B. Injectable insulin not associated with the use of an insulin infusion pump is covered under Medicare drug plans.

In Original Medicare, you pay 20% of the Medicare-approved amount after the annual Part B deductible for diabetes training, a glucometer, lancets, and test strips, as well as medical nutrition therapy.

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 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 www.medicare.gov.



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.

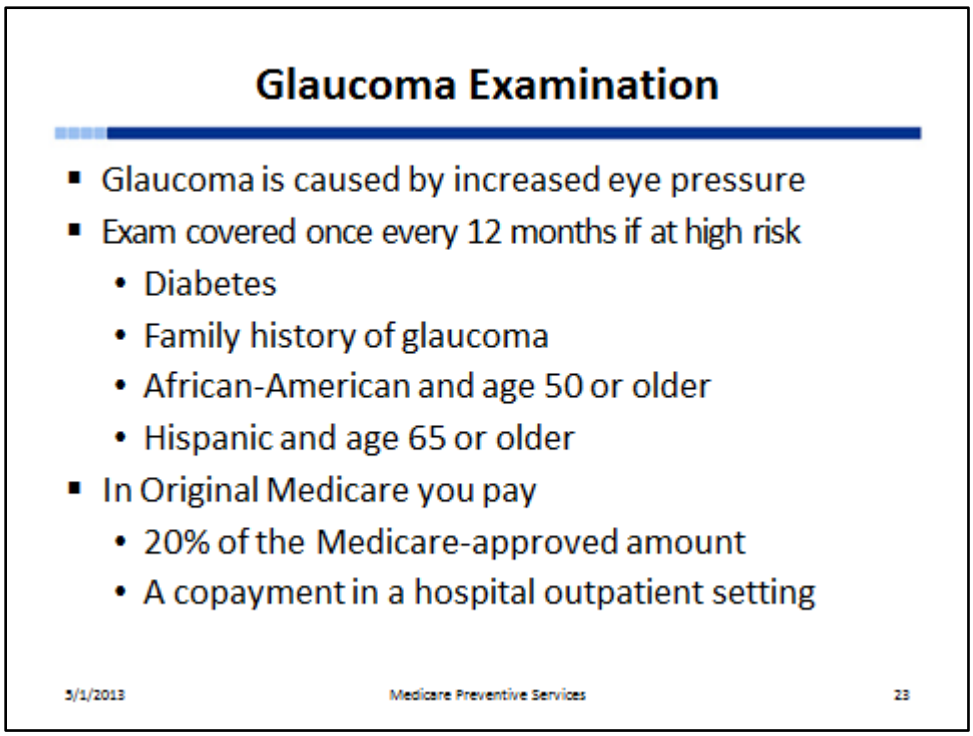
Each session lasts for at least 30 minutes and is provided in a group of 2 to 20 people.

- 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:

- Your doctor or a qualified provider ordered it as part of your plan of care; or
- 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.



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 examination if you:

- Have diabetes;
- Have a family history of glaucoma;
- Are African-American and age 50 or older; or
- Or are Hispanic and age 65 or older.

An eye doctor who is legally authorized by the state must perform the tests. 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. Deductible and copayment cost sharing applies for this service.

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

Check Your Knowledge
Lesson 3 – Preventive Services D-G

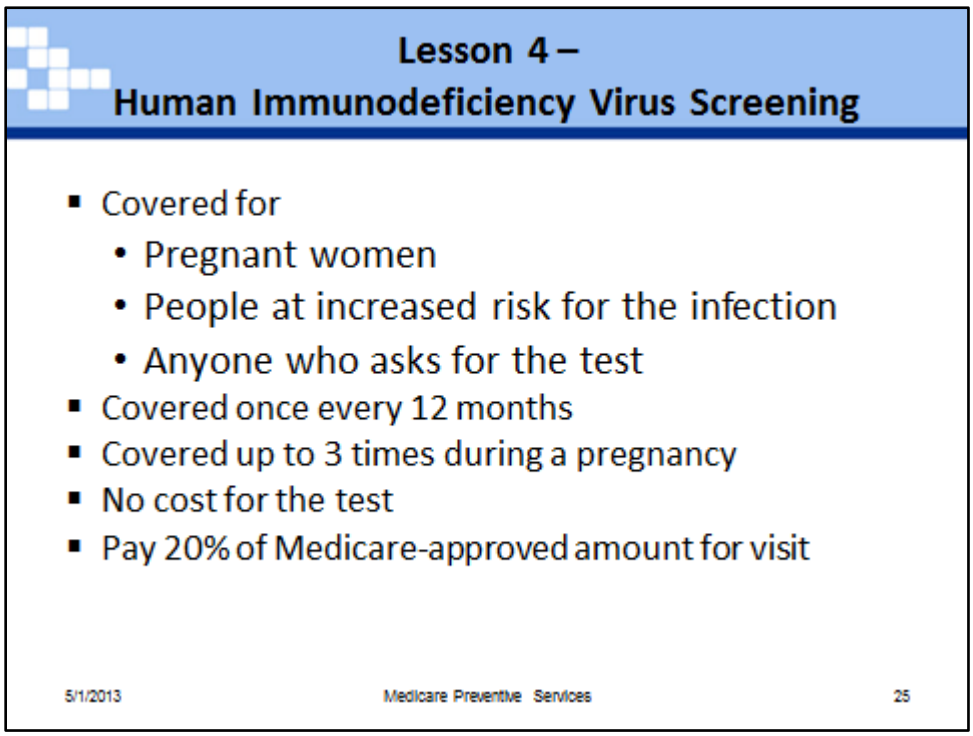
Answer the following questions:

1. Where can you receive a depression screening?

2. If Laurence has diabetes, his doctor may recommend an annual glaucoma examination. People with diabetes are at high risk for glaucoma, a disease caused by above-normal pressure on the eye. Who else is considered at risk for glaucoma? (Select all that apply)?

   a. Women who are aged 50 and older
   b. People who are Hispanic and aged 65 and older
   c. People with a family history of glaucoma
   d. Men who are aged 60 and older
   e. People who are African American and aged 50 or older

Refer to page 52 to check your answers.



HIV, or human immunodeficiency virus, 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.

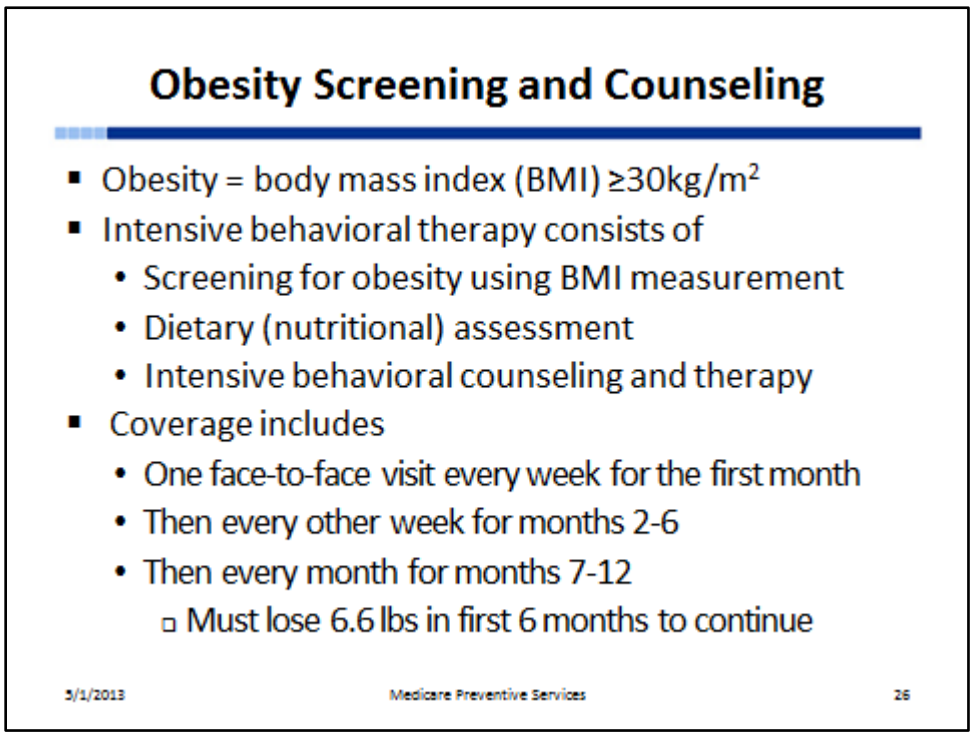
Medicare covers HIV screening for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test.

People considered at increased risk for HIV infection are:

- 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 transfusion between 1978 and 1985; and
- Persons who request the HIV test.

Medicare covers this test once every 12 months and up to 3 times during a pregnancy.

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



Clinical evidence indicates that intensive behavioral therapy for obesity, defined as a body mass index (BMI) ≥ 30 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.

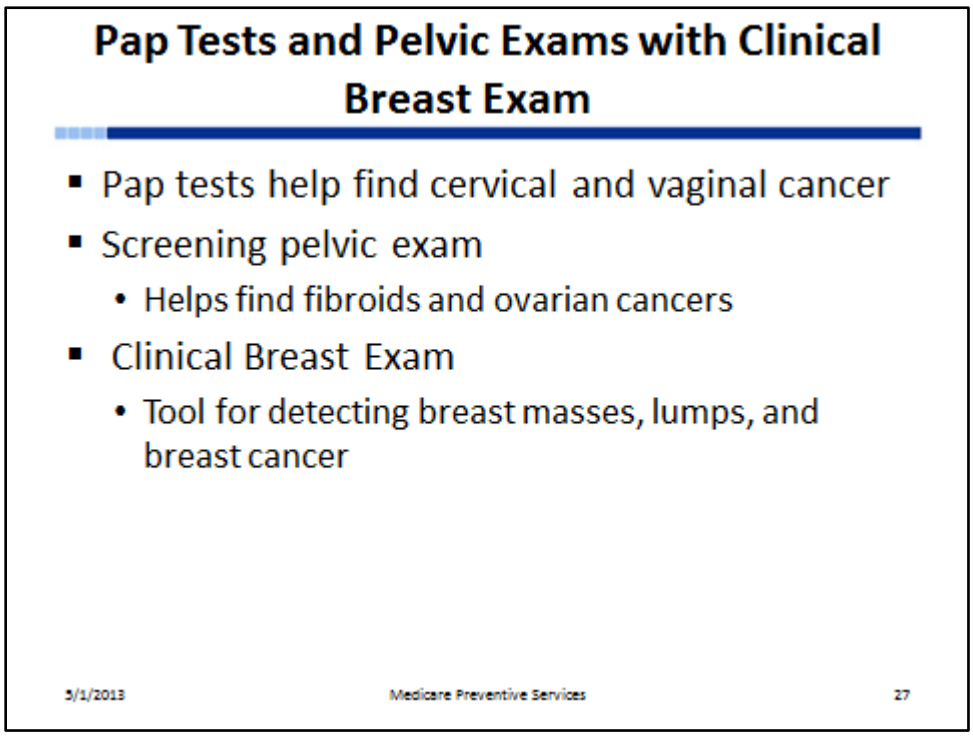
Intensive behavioral therapy for obesity consists of the following:

- 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; and
- Intensive behavioral counseling and behavioral therapy to promote sustained weight loss through high intensity interventions on 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, CMS covers

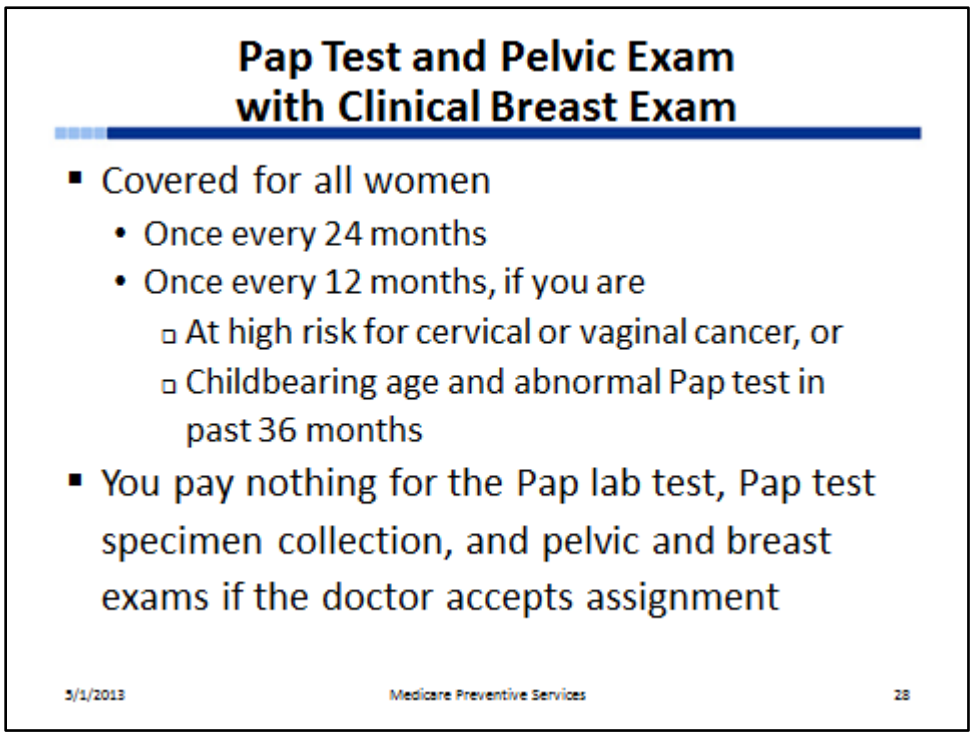
- One face-to-face visit every week for the first month;
- One face-to-face visit every other week for months 2-6;
- One face-to-face visit every month for months 7-12, if the beneficiary meets the 3kg (6.6 lbs.) weight loss requirement as discussed below.

At the six 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 six months, beneficiaries must have achieved a reduction in weight of at least 3kg (6.6 lbs.) over the course of the first six 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 3kg during the first six months of intensive therapy, a reassessment of their readiness to change and BMI is appropriate after an additional six month period.



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.



These tests are covered services for all women with Medicare. These services are covered once every 24 months for most women. However, they may be covered every 12 months if

- You are at high risk for cervical or vaginal cancer (based on your medical history or other findings); or
- 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 are

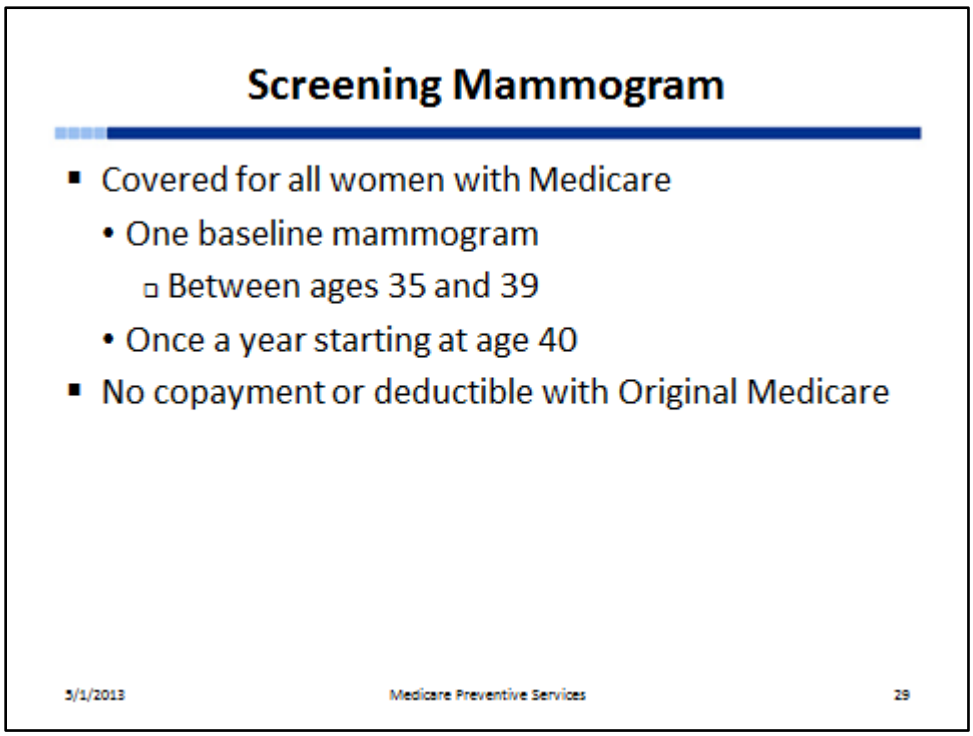
- Early onset of sexual activity (under 16 years of age);
- Multiple sexual partners (five or more in a lifetime);
- History of sexually transmitted disease (including HIV);
- Fewer than three negative or any pap smears within the previous 7 years; and/or
- DES (diethylstilbestrol)-exposed daughters 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.

Clinical breast exams are another way to look for breast cancer.

Need more information?

Visit www.medicare.gov.



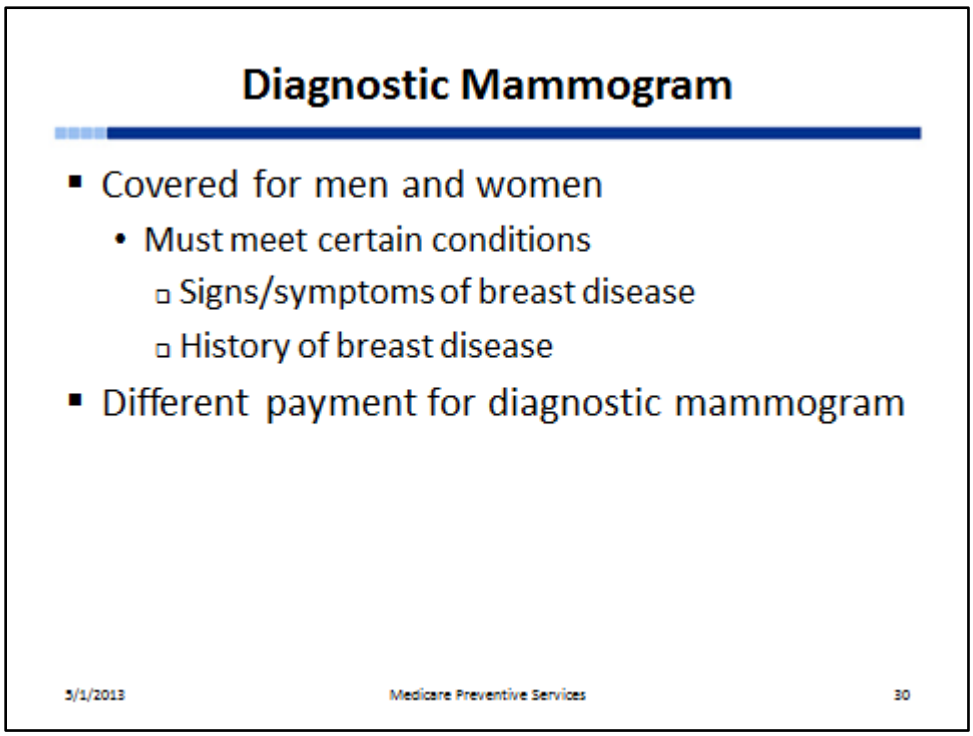
Breast cancer is the most frequently diagnosed non-skin cancer in women and is second only to lung cancer as the leading cause of cancer-related deaths among women in the United States. Every woman is at risk, and this risk increases with age. Breast cancer also occurs in men.

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.

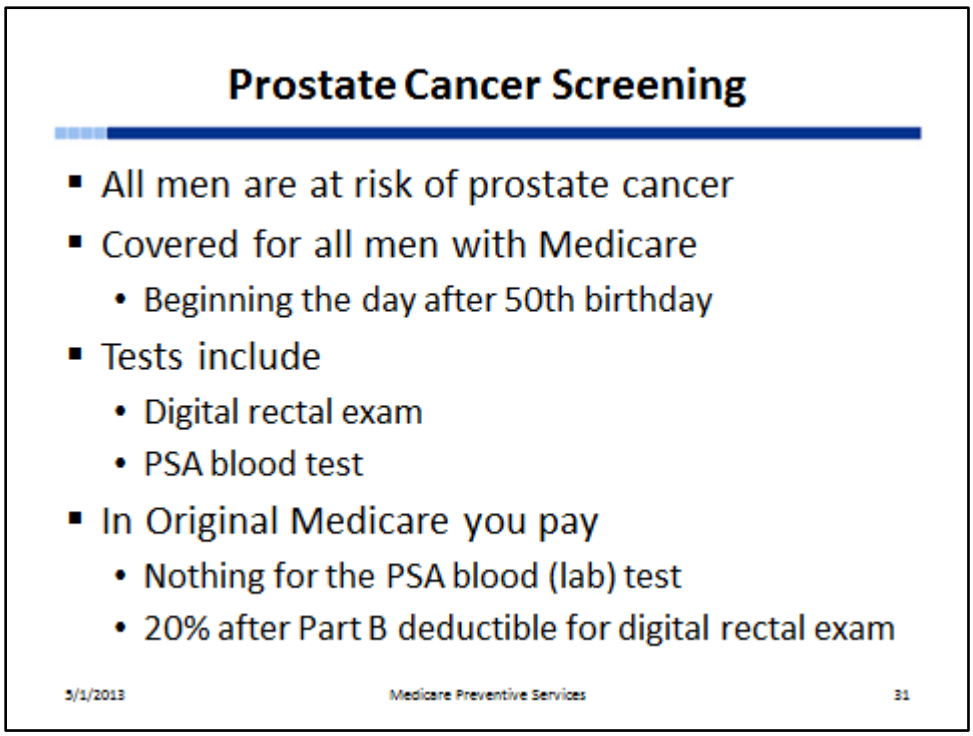


A diagnostic mammogram is an X-ray of the breast to check for breast cancer after a lump or other sign or symptom of breast cancer has been found.

A diagnostic mammogram is a diagnostic test covered by Medicare under the following conditions:

- An individual has distinct signs and symptoms for which a mammogram is indicated;
- An individual has a history of breast cancer; or
- An individual is asymptomatic, but based on the individual's history and other factors the physician considers significant, the physician's judgment is that a mammogram is appropriate.

Diagnostic mammograms must be ordered by a doctor and may include additional views of the breast. Medicare pays differently for diagnostic mammograms. The coinsurance or copayment and Medicare Part B deductible apply for diagnostic mammograms. Medicare also pays for other diagnostic tests that may be needed, such as ultrasound screening.



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, and
- 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 (DRE).

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 DRE.

Check Your Knowledge
Lesson 4 – Preventive Services H-P

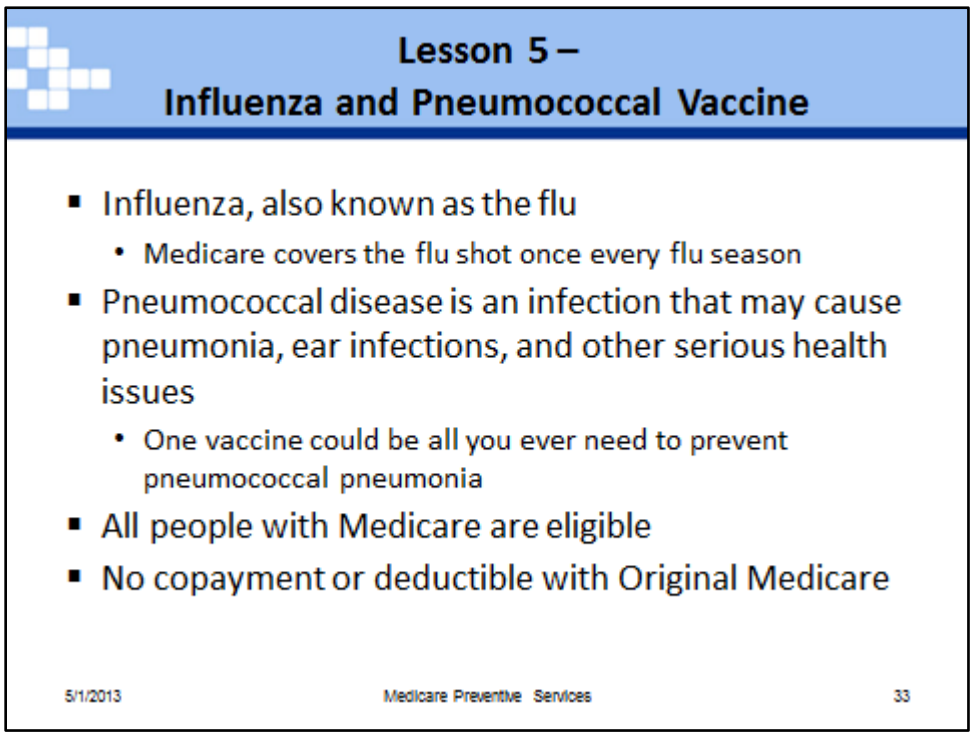
Answer the following questions:

1. Luisa asks her doctor for an HIV screening test. How often is this screening covered by Medicare? (Select all that apply.)

    a. Every 24 months
    b. Every 12 months
    c. Up to 3 times during pregnancy
    d. As many times as a patient requests it

2. Is obesity counseling covered regardless of weight loss over time?

Refer to page 53 to check your answers.



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.

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.

Medicare provides coverage of one seasonal influenza virus vaccine per influenza season for all beneficiaries.

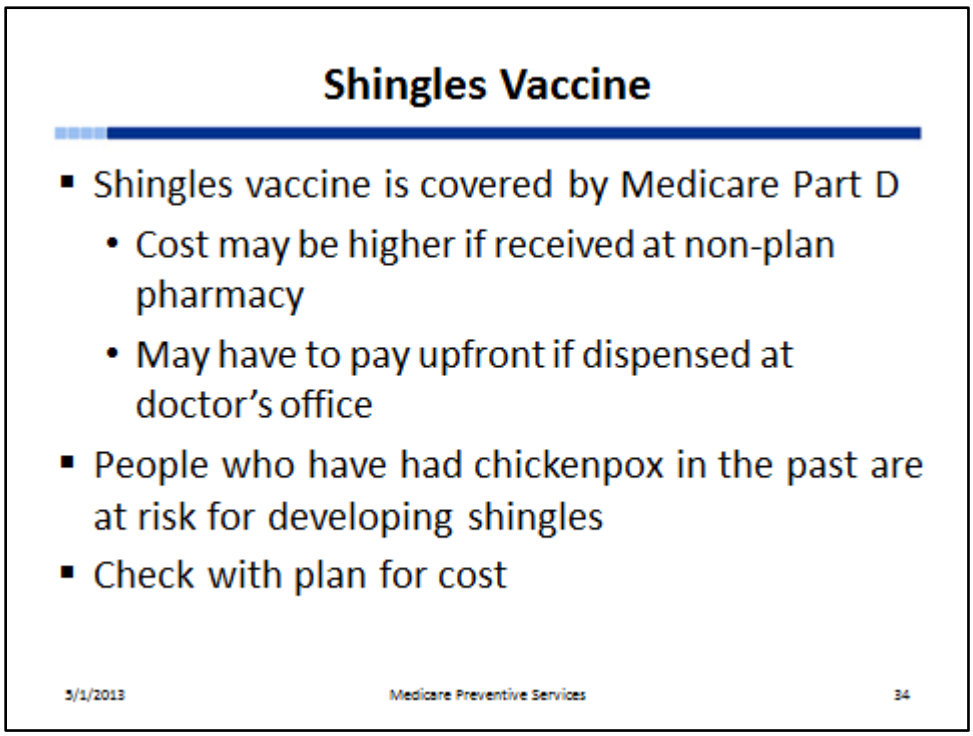
Most people only need a pneumococcal pneumonia vaccine once in their lifetime. Medicare will cover additional vaccines if your doctor decides it is necessary or if there is uncertainty that a vaccination was ever received.

Medicare Part B covers these vaccines.

You pay no coinsurance and no Part B deductible in Original Medicare if your health care provider accepts assignment.

Need more information about influenza?

Visit www.cdc.gov and www.flu.gov.



The shingles vaccine is covered by Medicare Part D Prescription Drug Plans. Medicare Part B does not cover the shingles vaccine.

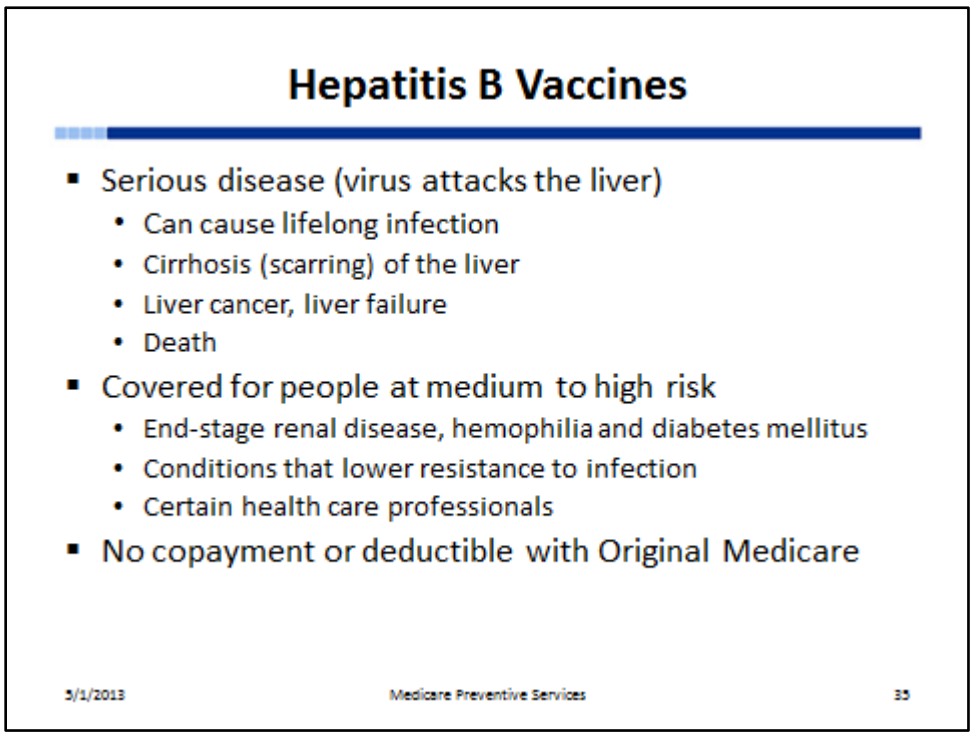
The virus that is responsible for causing chickenpox also causes shingles.

People who have had chickenpox in the past are at risk for developing shingles because the virus remains inactive in certain nerve cells of the body and can become active later in life.

Questions about reimbursement from Medicare Part D plans should be directed to 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Have questions about reimbursement from Medicare Part D plans?

Call 1-800-MEDICARE.



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 and its administration for beneficiaries at intermediate or high risk of contracting HBV.

High-risk groups currently identified include:

- Individuals with End-Stage Renal Disease (ESRD),
- 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, and
- Illicit injectable drug users.

Intermediate risk groups currently identified include:

- Staff in institutions for the developmentally disabled, and
- 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 screening.

Check Your Knowledge
Lesson 5 – Preventive Services Vaccines

Answer the following questions:

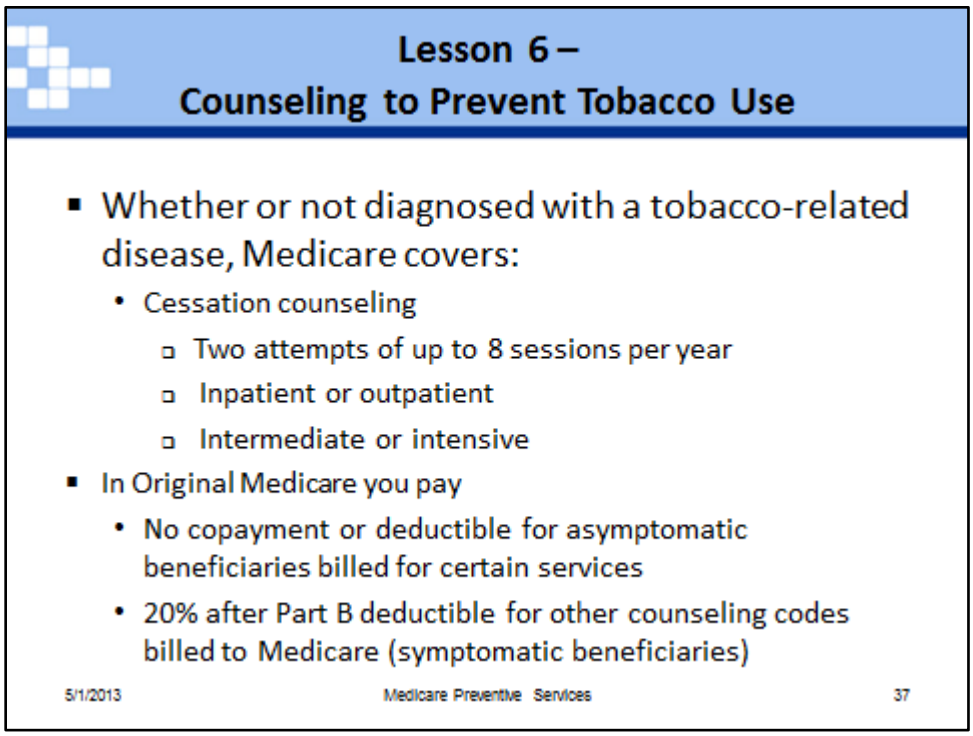
1. Which of the following vaccines is NOT covered by Medicare Part B?

   a. Pneumococcal vaccine
   b. Influenza ("flu") vaccine
   c. Shingles vaccine
   d. Hepatitis B vaccine

2. Which of the following vaccines is covered annually?

   a. Pneumococcal vaccine
   b. Influenza ("flu") vaccine
   c. Shingles vaccine
   d. Hepatitis B vaccine

Refer to page 54 to check your answers.



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; and
- Whose counseling is furnished by a qualified physician or other Medicare-recognized practitioner.

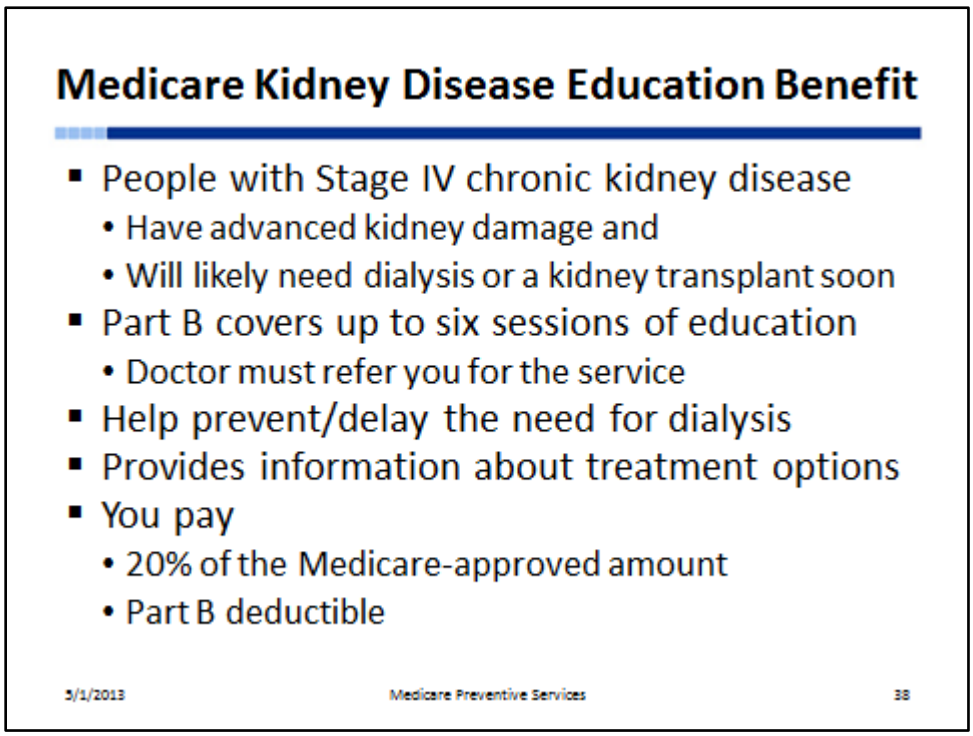
Medicare will cover two cessation attempts per year. Each attempt may include up to four counseling sessions, with the total annual benefit covering up to eight sessions in a 12-month period.

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 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 will not cover tobacco cessation services if tobacco cessation is the primary reason for the patient's hospital stay.

Many drugs are available to help you quit smoking, like nicotine patches, and these drugs may be covered by your Medicare Part D Prescription Drug Plan.



The Medicare Kidney Disease Education Benefit for people with stage IV chronic kidney disease is not considered a preventive service; however, we want to be sure you are aware of this important benefit.

Medicare Part B covers up to six sessions of kidney disease education services if you have stage IV chronic kidney disease and your doctor refers you for the service.

The goal of this service is to provide comprehensive information about

- Managing your condition to help delay the need for renal replacement therapy (such as dialysis or a kidney transplant);
- Helping prevent complications related to your kidney disease; and
- All treatment options so you can make an informed decision about your health care related to kidney disease.

You pay 20% of the Medicare-approved amount, and the Part B deductible applies.

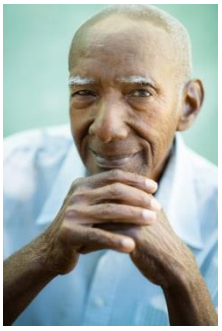
Check Your Knowledge
Lesson 6 – Preventive Services Smoking Cessation

Answer the following questions:

1. How many smoking cessation counseling sessions will Medicare cover per 12-month period?

    a. One cessation attempt with up to 8 counseling sessions (8 total)
    b. Two cessation attempts with up to 4 counseling sessions each (8 total)
    c. Two cessation attempts with up to 8 counseling sessions each (16 total)
    d. Three cessation attempts with up to 4 counseling sessions each (12 total)

2. Jorge has stage IV chronic kidney disease and would like to take advantage of Medicare's kidney disease education benefit. He knows that Part B covers up to six education sessions, but he wants to know how much he will pay for this service. What portion of the fee is he responsible for?



Refer to page 55 to check your answers.

This training module is provided by the National Medicare Training Program. For questions about training products, e-mail training@cms.hhs.gov. To view all available CMS National Training Proguram materials or to subscribe to our email list, visit www.cms.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram.

Preventive Services Checklist

Medicare-Covered Preventive Service	I Need (Yes/No)	Date Last Received	Next Date Medicare Covers This Service
"Welcome to Medicare" Preventive Visit (one-time)			
Yearly "Wellness" Visit			
Abdominal Aortic Aneurysm Screening			
Alcohol Misuse Screening and Counseling			
Bone Mass Measurement			
Breast Cancer Screening (Mammogram)			
Cardiovascular Screenings			
Cervical and Vaginal Cancer Screening			
Colorectal Cancer Screening			
Fecal Occult Blood Test			
Counseling to Prevent Tobacco Use			
Flexible Sigmoidoscopy			
Colonoscopy			
Barium Enema			
Diabetes Screenings			
Diabetes Self-Management Training			
Depression Screening			
Flu Vaccine			
Glaucoma Tests			
Hepatitis B Vaccine			
HIV Screening			
Kidney Disease Education			
Medical Nutrition Therapy Services			
Obesity Screening and Counseling			
Pneumococcal Vaccine			
Prostate Cancer Screenings			
Shingles Vaccine			

Preventive Service	Who Is Covered	How Often It's Covered	Your Costs
Welcome to Medicare Preventive Visit 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.	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.*
Annual Wellness Visit 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.	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. **Note**: 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.*
Abdominal Aortic Aneurysm Screening This ultrasound screening test checks the aorta for weak area expansions or bulges, which indicate a life-threatening condition.	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: • A family history of abdominal aortic aneurysm • Being a man age 65 to 75 who has smoked at least 100 cigarettes in his lifetime	This is a one-time screening ultrasound test. In order to have this screening covered by Medicare, patients that have been identified as at risk must get a referral for this service at their Welcome to Medicare Preventive visit.	There is no cost if your doctor accepts Medicare assignment.
Alcohol Misuse Screening and Counseling Medicare covers annual alcohol screening and up to four brief face-to-face behavioral counseling sessions.	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
Bone Mass Measurement Medicare covers bone mass measurements to determine whether you are at risk for osteoporosis.	People with Medicare who fall into at least one of the following categories: • A woman who is estrogen deficient and at clinical risk for osteoporosis • People with vertebral abnormalities • People receiving (or expecting to receive) steroid therapy for more than 3 months. • People with hyperparathyroidism • People being monitored to assess their response to FDA-approved osteoporosis drug therapy	This service is usually covered once every 24 months (or more frequently if medically necessary).	There is no cost if your doctor accepts Medicare assignment.
Cardiovascular Disease Screening These blood tests help detect conditions that may lead to a heart attack or stroke. They test your cholesterol, lipid, and triglyceride levels.	All people with Medicare	Medicare covers these tests once every five years.	There is no cost if your doctor accepts Medicare assignment.
Behavioral Therapy for Cardiovascular Disease Medicare covers intensive behavioral therapy for cardiovascular disease (also known as a CVD risk reduction visit), which includes: • Encouraging aspirin use when benefits outweigh risks, • Screening for high blood pressure, and • Intensive behavioral counseling to promote a healthy diet.	All people with Medicare.	Medicare covers one CVD risk reduction visit each year.	There is no cost if your doctor accepts Medicare assignment.

Preventive Service	Who Is Covered	How Often It's Covered	Your Costs
Colorectal Cancer Screening To help find precancerous growths or find cancer early, when treatment is most effective. Your doctor may order one of the following tests: • Screening Fecal Occult Blood Test • Screening Flexible Sigmoidoscopy • Screening Colonoscopy • Screening Barium Enema	Men and women with Medicare age 50 and older who are at risk of developing colorectal cancer.	**Normal risk** **Screening Fecal Occult Blood Test** Annually **Screening 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), **Screening Colonoscopy** 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) **Screening Barium Enema** (As an alternative to a covered screening flexible sigmoidoscopy). **High risk** **Screening Fecal Occult Blood Test** Annually **Screening Flexible Sigmoidoscopy** Once every 4 years **Screening Colonoscopy** 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) **Screening Barium Enema** (As an alternative to a covered screening colonoscopy)	**Fecal Occult Blood Test** There is no cost if your doctor accepts Medicare assignment. **Flexible Sigmoidoscopy** There is no cost if your doctor accepts Medicare assignment. **Colonoscopy** There is no cost if your doctor accepts Medicare assignment. **Barium Enema**—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

Preventive Service	Who Is Covered	How Often It's Covered	Your Costs
Depression Screening Medicare covers preventive screening for depression. Preventive coverage is limited to screening services, and does not include treatment options for depression or any diseases, complications, or chronic conditions resulting from depression, or address interventions for depression.	All people with Medicare	This service is usually 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.
Diabetes Screening Medicare covers a fasting blood glucose test to screen people at risk for diabetes.	Men and women with Medicare with any of the following risk factors: • High blood pressure (hypertension) • History of abnormal cholesterol and triglyceride levels (dyslipidemia) • Obesity • History of high blood sugar • Family history of diabetes	Up to two screening tests per year if you have pre-diabetes. One screening test per year if you do NOT have pre-diabetes or have never been tested before.	There is no cost if your doctor accepts Medicare assignment
Diabetes Self-Management Training Medicare covers DSMT for people with diabetes to help them successfully manage their diabetes and help prevent its complications.	People with Medicare that have diabetes and have a written order from their physician or qualified provider treating their diabetes.	Up to 10 hours of training within a continuous 12-month period. Up to 2 hours of follow-up training each year thereafter if ordered by your physician or qualified provider treating their diabetes.	Medicare beneficiaries pay 20% of the Medicare-approved amount after the yearly Part B deductible.
Glaucoma Screening 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.	Men and women with Medicare that are considered high risk. You are considered high risk if you have one of the following risk factors: • You have diabetes • You are African-American and are age 50 or older • You are Hispanic and are 65 or older • You have a family history of glaucoma	Medicare covers glaucoma screenings every 12 months for high risk patients.	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
Hepatitis B Vaccines A series of three shots are needed for complete protection from this disease which infects the liver.	Men and women with Medicare whose doctor identifies them as medium to high risk for Hepatitis B. Risk factors include: • Hemophilia • End Stage Renal Disease • Diabetes mellitus	One series of Hepatitis B shots provides complete lifetime protection.	There is no cost if your doctor accepts Medicare assignment.
HIV Screening This is a blood test to screen for Human Immunodeficiency Virus (HIV).	Men and women with Medicare who are at increased risk for infection, as well as anyone that asks to be tested.	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 3rd trimester, and at delivery if ordered by your doctor).	There is no cost for the test, but you generally have to pay 20% of the Medicare-approved amount for the doctor's visit.
Influenza (Flu) Vaccine The Centers for Disease Control recommends a flu shot as the first and most important step in protecting against flu viruses.	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.
Obesity Screening and Counseling Medicare offers intensive behavioral therapy for beneficiaries with obesity, defined as a body mass index (BMI) ≥ 30 kb/m^2.	All people with Medicare may be screened for obesity. Counseling is covered for anyone found to have a BMI ≥ 30 kg/m^2.	Beneficiaries with BMIs ≥ 30 kg/m^2 are eligible for: • One face-to-face visit each 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 loses 3kg (6.6 pounds) during months 1-6.	There is no cost if your doctor accepts Medicare assignment.

Preventive Service	Who Is Covered	How Often It's Covered	Your Costs
Pap Tests and Pelvic Exams with a Clinical Breast Exam These tests and exams check for cervical, vaginal, and breast cancers.	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.
Pneumococcal Vaccine This immunization protects beneficiaries from pneumococcal pneumonia, an inflammation of the lungs caused by bacterial infection.	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.
Prostate Cancer Screening The tests included in this screening are the Prostate Specific Antigen (PSA) blood test and a digital rectal exam.	Men with Medicare age 50 and older. Coverage begins the day after your 50th birthday	Medicare covers PSA screening tests and digital rectal examinations for prostate cancer once every 12 months.	There is no cost for the PSA blood test. Deductibles and copayment cost sharing applies for the digital rectal exam.
Screening Mammogram A type of X-ray to check for breast cancer	All women with Medicare	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.	There is no cost if your doctor accepts Medicare assignment.

Preventive Service	Who Is Covered	How Often It's Covered	Your Costs
Sexually Transmitted Infections (STIs) and High-Intensity Behavioral Counseling to Prevent STIs (HIBC) 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. 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.	Chlamydia and gonorrhea screening: • Pregnant women age 24 or younger • Pregnant women at increased risk of STI • Women at increased risk for STIs Syphilis screening: • Pregnant women • Men and women at increased risk for STIs Hepatitis B screening: • Pregnant women High-Intensity behavioral counseling: • All sexually active adolescents and adults at increased risk of STI	Chlamydia and gonorrhea screening: • When pregnancy diagnosis is made, and repeated during the third trimester if high-risk sexual behavior has occurred since the initial screening test. • Annually for women at increased risk. Syphilis screening: • 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. • Annually for men and women at increased risk. Hepatitis B screening: • At first prenatal visit and at delivery for those with new or continuing risk factors. High-Intensity behavioral counseling: • Two 20-30 minute sessions annually	There is no cost if your doctor accepts Medicare assignment.
Tobacco Use Cessation Services Tobacco Use cessation services include counseling sessions.	Medicare beneficiaries who use tobacco and have a recognized tobacco related disease, or who have signs or symptoms of tobacco-related disease	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.	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.
Counseling to Prevent Tobacco Use	Medicare beneficiaries who use tobacco, regardless of whether they have signs or symptoms of tobacco related disease	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.	There is no cost if your doctor accepts Medicare assignment.

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

Preventive Services Resource Guide

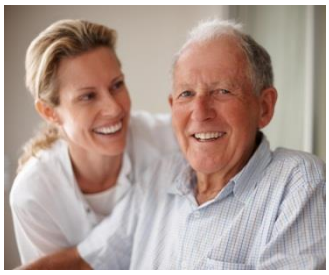
Resources		Medicare Products
Medicare.gov www.medicare.gov 1-800-MEDICARE (1-800-633-4227) (TTY 1-877-466-2048) **Local State Health Insurance Assistance Programs (SHIP)** www.medicare.gov/contacts **Centers for Disease Control** www.cdc.gov **Flu Information** www.flu.gov **HHS Tobacco Cessation Resources**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

Answer Key

Check Your Knowledge
Lesson 1 – Medicare Preventive Services
(from p. 9)

Answer the following questions:

1. Mae has original Medicare and Medicare Part B. Joe has a Medicare Advantage Plan and is not enrolled in Medicare Part B. Who has coverage for preventive services? Why or why not?



   ANSWER: Mae. Preventive services are covered under Medicare Part B. Individuals covered under any Medicare plan who are also enrolled in Medicare Part B have access to preventive services. (p. 3)

2. What is the difference between a "Welcome to Medicare" visit and an "Annual Wellness" visit?

   ANSWER: A "Welcome to Medicare" visit is an initial visit and occurs once within 12 months of getting Part B. The "Annual Wellness" visits are available once every 12 months after your "Welcome to Medicare" visit. (p. 5, 6)

Check Your Knowledge
Lesson 2 – Preventive Services A-C
(from p. 17)

Answer the following questions:

1. How often is an alcohol misuse screening covered?

    a. As needed
    b. Every 6 months
    c. Every 12 months
    d. Every 24 months

    ANSWER: c. Alcohol misuse screenings are covered annually. (p. 10)

2. Anya's doctor tells her that she is at risk for osteoporosis and needs a bone mass measurement. What kind of information does this test provide her doctor?

    ANSWER: A bone mass measurement measures bone density. These test results help you and your doctor choose the best way to keep your bones strong. (p. 12)

3. A colorectal cancer screening helps prevent or find cancer early. What are doctors looking for during this screening?

    ANSWER: Colorectal cancer screening help find precancerous growths. (p. 15)

Check Your Knowledge
Lesson 3 – Preventive Services D-G
(from p. 24)

Answer the following questions:

1. Where would you receive a depression screening?

   ANSWER: Depression screenings are administered in a primary care setting. (p. 18)

2. If Laurence has diabetes, his doctor may recommend an annual glaucoma examination. People with diabetes are at high risk for glaucoma, a disease caused by above-normal pressure on the eye. Who else is considered at high risk for glaucoma? (Select all that apply.)

   a. Women who are aged 50 and older
   b. People who are Hispanic and aged 65 and older
   c. People with a family history of glaucoma
   d. Men who are aged 60 and older
   e. People who are African Americans and aged 50 or older

   ANSWER: b, c, and e. People with diabetes, people with a family history of glaucoma, African Americans who are 50 and older, and Hispanics who are 65 and older are considered at high risk for glaucoma. (p. 23)

Check Your Knowledge
Lesson 4 – Preventive Services H-P
(from p. 32)

Answer the following questions:

1. Luisa asks her doctor for an HIV screening test. How often is this screening covered by Medicare? (Select all that apply.)

    a. Every 24 months
    b. Every 12 months
    c. Up to 3 times during pregnancy
    d. As many times as a patient requests it

    ANSWER: b and c. 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. Medicare covers this test once every 12 months and up to 3 times during pregnancy. (p. 25)

2. Is obesity counseling covered regardless of weight loss over time?

    ANSWER: No. 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 6.6 lbs. over the course of the first 6 months of intensive therapy. (p. 26)

Answer Key (continued)

Check Your Knowledge
Lesson 5 – Preventive Services Vaccines
(from p. 36)

Answer the following questions:

1. Which of the following vaccines is NOT covered by Medicare Part B?

    a. Pneumococcal vaccine
    b. Influenza ("flu") vaccine
    c. Shingles vaccine
    d. Hepatitis B vaccine

ANSWER: c. The shingles vaccine is covered by Medicare Part D Prescription Drug Plans. Medicare Part B does not cover the shingles vaccine. (p. 33-35)

2. Which of the following vaccines is covered annually?

    a. Pneumococcal vaccine
    b. Influenza ("flu") vaccine
    c. Shingles vaccine
    d. Hepatitis B vaccine

ANSWER: b. You should get a flu vaccine every year because flu viruses change. The vaccine is updated annually for the most current flu viruses. (p. 33)

Check Your Knowledge
Lesson 6 – Preventive Services Smoking Cessation
(from p. 39)

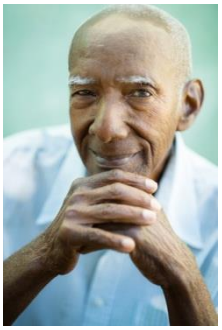
Answer the following questions:

1. How many smoking cessation counseling sessions will Medicare cover per 12-month period?

    a. One cessation attempt with up to 8 counseling sessions (8 total)
    b. Two cessation attempts with up to 4 counseling sessions each (8 total)
    c. Two cessation attempts with up to 8 counseling sessions each (16 total)
    d. Three cessation attempts with up to 4 counseling sessions each (12 total)

    ANSWER: b. Medicare will cover two 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. (p. 37)

2. Jorge has stage IV chronic kidney disease and would like to take advantage of Medicare's kidney disease education benefit. He knows that Part B covers up to six education sessions, but he wants to know how much he will pay for this service. What portion of the fee is he responsible for?

    ANSWER: Jorge is responsible for 20% of the Medicare approved amount, and the Part B deductible applies. (p. 38)

Glossary

The following terms are used throughout this presentation.

Alcohol dependence is defined as at least three of the following: tolerance, withdrawal symptoms, impaired control, preoccupation with acquisition and/or use, persistent desire or unsuccessful efforts to quit, sustains social, occupational, or recreational disability, use continues despite adverse consequences.

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 develop suddenly.

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.

Coinsurance is an amount you may be required to pay as your share of the cost for services after you pay any deductibles. Coinsurance is usually a percentage (for example 20%).

Copayment is an amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or a prescription. A copayment is usually a set amount rather than a percentage. For example, you might pay $10 or $20 for a doctor's visit or prescription.

Depression Among people older than 65 years, one in six suffers from depression. Depression in older adults is estimated to occur in 25% of those with another 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. These patients are important in the primary care setting because 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.

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 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, which is called gestational diabetes.

End-Stage Renal Disease is permanent kidney failure that is treated with regular dialysis or a kidney transplant.

Hemophilia is a bleeding disorder.

Hepatitis B is a serious disease caused by a virus that inflames the liver. The virus, which is called hepatitis B virus (HBV), can cause lifelong infection, cirrhosis (scarring) of the liver, liver cancer, liver failure, and death.

Influenza, also known as the **flu,** is a contagious viral disease that attacks the nose, throat, and lungs. In the United States, between 5% and 20% of the population gets the flu each year. It is estimated that 90% of seasonal flu-related deaths and more than 50% of seasonal flu related hospitalizations in the United States occur in people aged 65 and older.

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.

Heart Disease. There are many different forms of heart disease. The most common cause of heart disease is narrowing or blockage of the coronary arteries, the blood vessels that supply blood to the heart itself, called coronary artery disease. This happens slowly over time and is the major reason people have heart attacks.

HIV, or **human immunodeficiency virus**, 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.

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.

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.

A person with **stage IV chronic kidney disease** has advanced kidney damage and will likely need renal replacement therapy, such as dialysis or a kidney transplant, in the near future.

Acronyms

BMI	Body Mass Index
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
CVD	Cardiovascular Disease
DES	Diethylstilbestrol
DME	Durable Medical Equipment
HIV	Human Immunodeficiency Virus
PSA	Prostate-Specific Antigen

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Website: cms.gov/www.cms.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram

E-mail training@cms.hhs.gov

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