DEPARTMENT OF HEALTH & HUMAN SERVICES

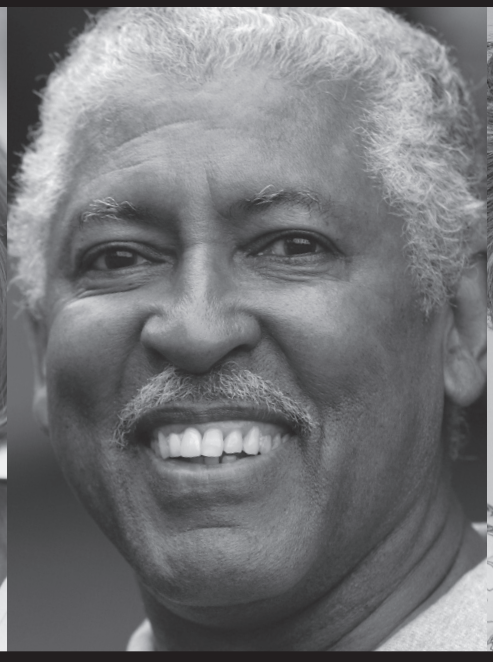
National Medicare

TRAINING PROGRAM

CENTERS FOR MEDICARE & MEDICAID SERVICES

# Medicare Preventive Services Module 7

**...helping people with Medicare make informed health care decisions**



**2011 Workbook**

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# Centers for Medicare & Medicaid Services
# National Train-the-Trainer Workshops
# Instructor Information Sheet
# Module 7
# *Medicare Preventive Services*

**Module Description**

Medicare pays for many preventive services to help people with Medicare live longer and healthier lives. Module 7 - *Medicare Preventive Services* - describes the services covered by Medicare, including screening exams, wellness visits, lab tests, and immunizations to help prevent, find, and manage medical problems.

The materials—up-to-date and ready-to-use—are designed for information givers/trainers that are familiar with the Medicare program, and would like to have prepared information for their presentations. Where applicable, updates from recent legislation are included. The New in 2011 icon is used to highlight changes based on the Affordable Care Act.


The following sections are included in this module:

| | | |
|---|---|---|
| Slides | 1-4 | Medicare Preventive Services Overview |
| Slides | 5-34 | Covered Services |
| Slides | 35- 40 | Preventive Services Chart |
| Slides | 41-42 | More Information and Resources |

**Objectives**

- Understand Medicare preventive services
- Describe who is eligible for preventive services
- Explain how much you pay for preventive services
- Learn where to get more information

**Target Audience**

This module is designed for presentation to trainers and other information givers. It is suitable for presentation to groups of beneficiaries.

**Learning Activities**

This module contains three interactive learning questions that give participants the opportunity to apply the module concepts in a real-world setting.

**Time Considerations**

The module consists of 42 PowerPoint slides with corresponding speaker's notes. It can be presented in 1 hour. Allow approximately 30 more minutes for discussion, questions and answers, and the learning activities.

**References**

To learn more about Medicare Preventive Services, read ***Medicare & You Handbook*** *CMS (Product No. 10050,* ***Your Guide to Medicare's Preventive Services*** *(CMS Product No. 10110) and* ***Staying Healthy*** *(CMS Product No. 11100)*

To learn more about Medicare Preventive Services please visit www.medicare.gov.

To learn more about Diabetes please visit www.diabetes.org.

To learn more about Cancer please visit *www.cancer.gov or call 1-800-4CANCER (TTY users call 1-800-332-8615).*

To learn more about HHS tobacco cessation resources please visit www.surgeongeneral.gov/tobacco.

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# Medicare Preventive Services
# Module 7

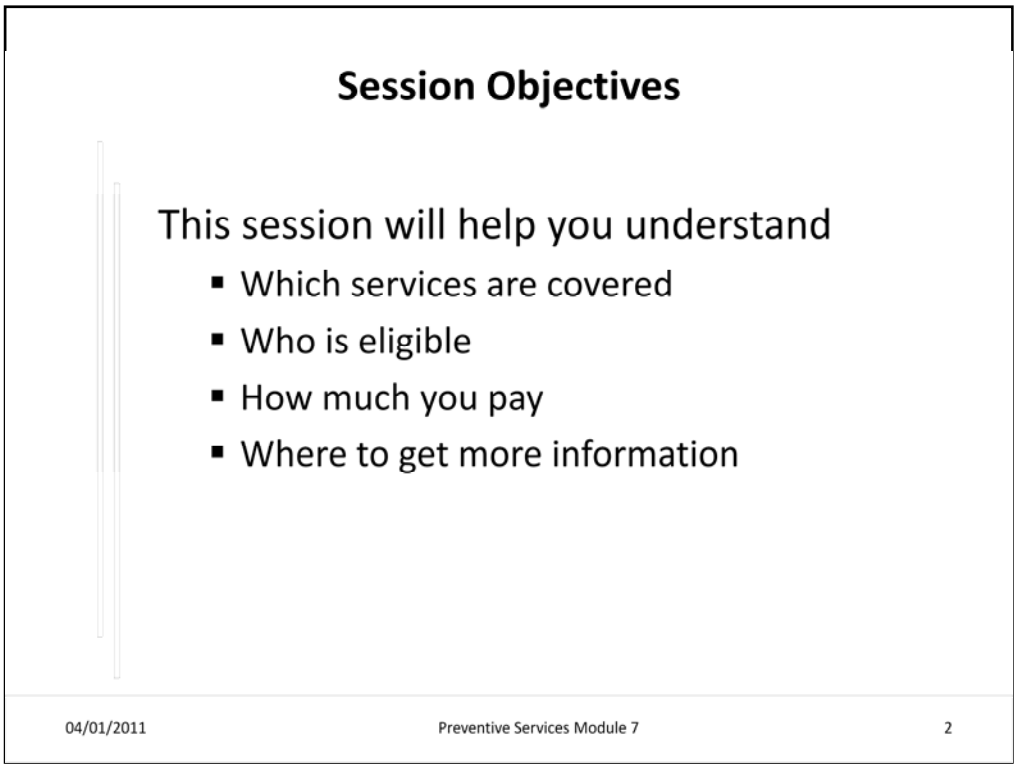
Module 7 explains Medicare Preventive Services.

This training module was developed and approved by the Centers for Medicare & Medicaid Services (CMS), the Federal agency that administers Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). The information in this module was correct as of April 2011.

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

To check for an updated version of this training module, visit www.cms.gov/NationalMedicareTrainingProgram/TI/list.asp on the web.

This set of National Medicare Training Program materials is not a legal document. The official Medicare program provisions are contained in the relevant laws, regulations, and rulings.




- Medicare Preventive Services explains the following:
  - Which services are covered
  - Who is eligible to receive them
  - How much you pay
  - Where to get more information

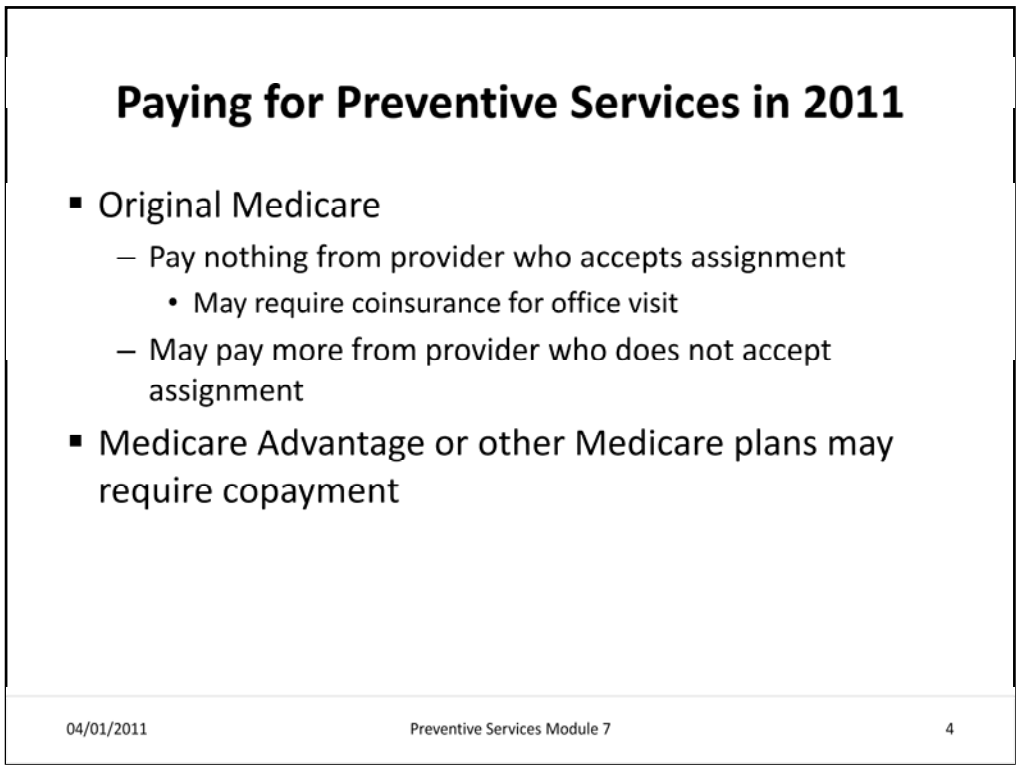
## Medicare Preventive Services

- Covered by Medicare Part B
- Covered by Original Medicare, MA and other plans
- Find problems early, when treatment works best
- Coverage based on
  - Age
  - Gender
  - Medical history



- 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 what kind of Medicare health plan you have. 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.

The Medicare & You Handbook, Product Number 10050, includes guidelines for who is covered and how often Medicare will pay for these services.

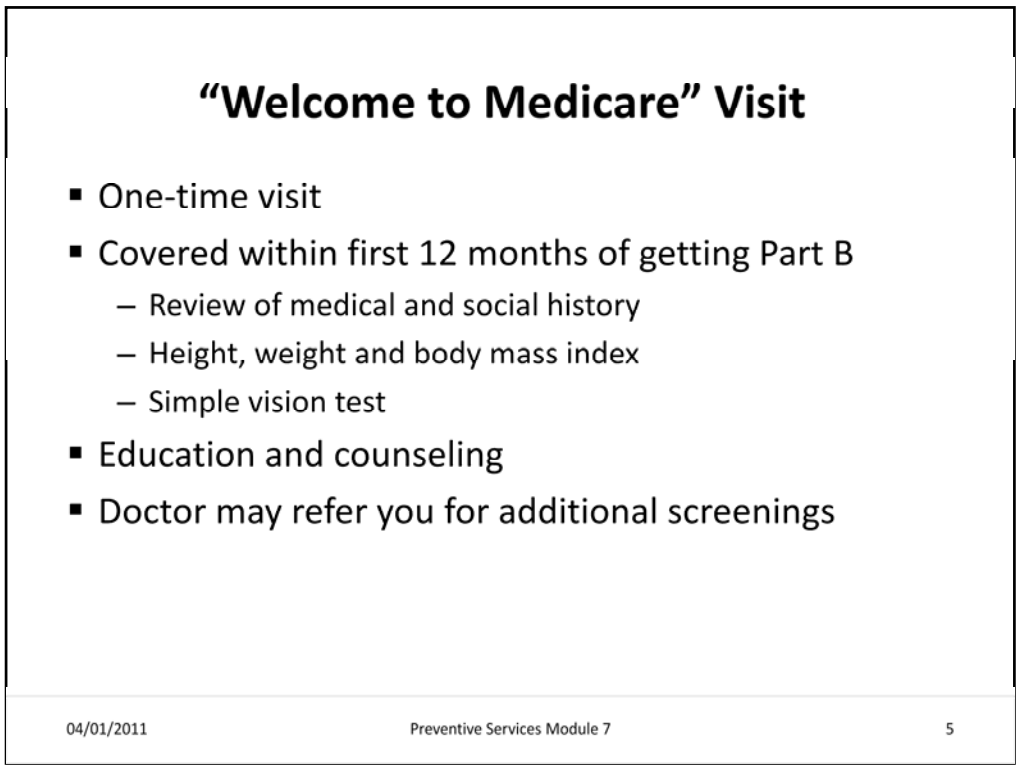



2011 Preventive Services costs under Original Medicare.

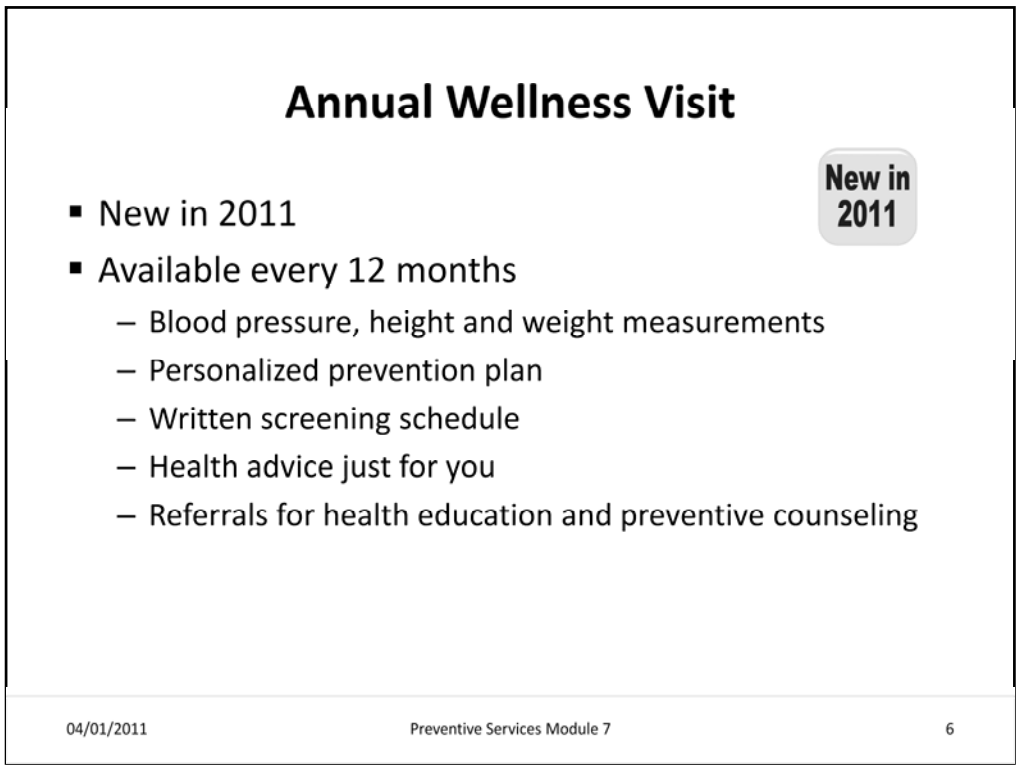
- Under Original Medicare you will pay nothing for most preventive services if you get the services from a doctor or other provider who accepts assignment.
- For some preventives services, you will pay nothing for the service, but you may have to pay coinsurance for the office visit when you get these services. If you are in a Medicare Advantage Plan or other Medicare plan and get Medicare-covered preventive services, you may have to pay copayments.

**Medicare Dictionary:**

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.




- The "Welcome to Medicare" visit is a great way to get up-to-date on important screenings and shots and to review your medical history.
- The "Welcome to Medicare" visit is only offered within the first 12 months of getting Medicare Part B.
- During the exam, your doctor will review the following.
  - Your medical and social history
  - Height, weight, body mass index, blood pressure, and give you a simple vision test
  - Potential (risk factors) for depression
  - Review of 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 initial "Welcome to Medicare" visit.
- There is no cost if your doctor accepts Medicare assignment.

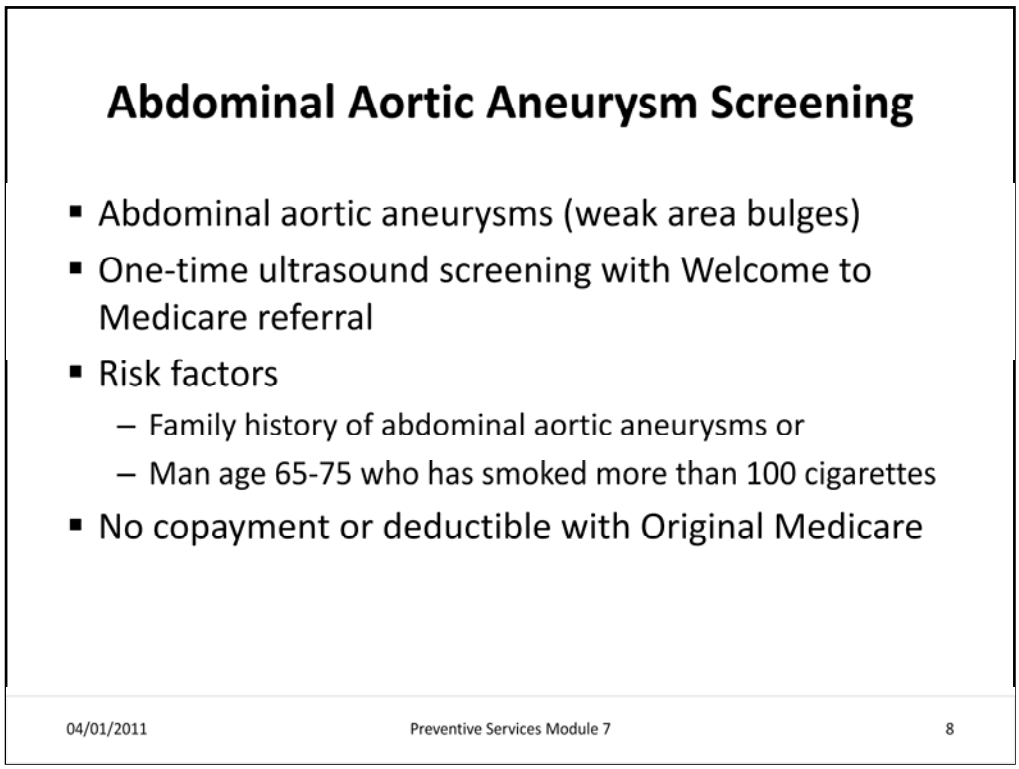



- Starting in 2011, Medicare covers an annual wellness visit.
- After you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a prevention plan just for you. Medicare covers one annual wellness visit every 12 months.
- During the visit, your doctor will:
  - Record your blood pressure, height, and weight measurements
  - Review your potential (risk factors) for depression
  - Review your functional ability, and level of safety, which 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.
- You don't need to get the "Welcome to Medicare Visit" before getting an annual wellness visit.
- If you choose to get the "Welcome to Medicare Visit," you'll have to wait 12 months before you can get your first annual wellness visit.
- You'll pay nothing for this exam if the doctor accepts assignment.

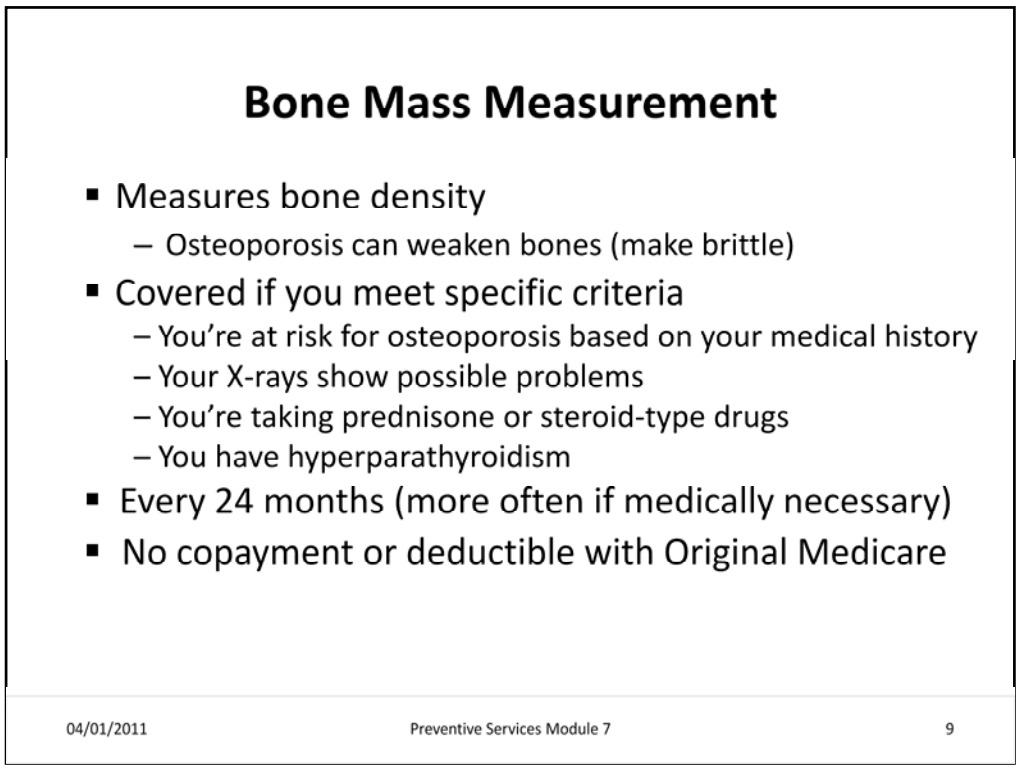
# Exercise

A. Medicare covers just one wellness visit every twelve months.

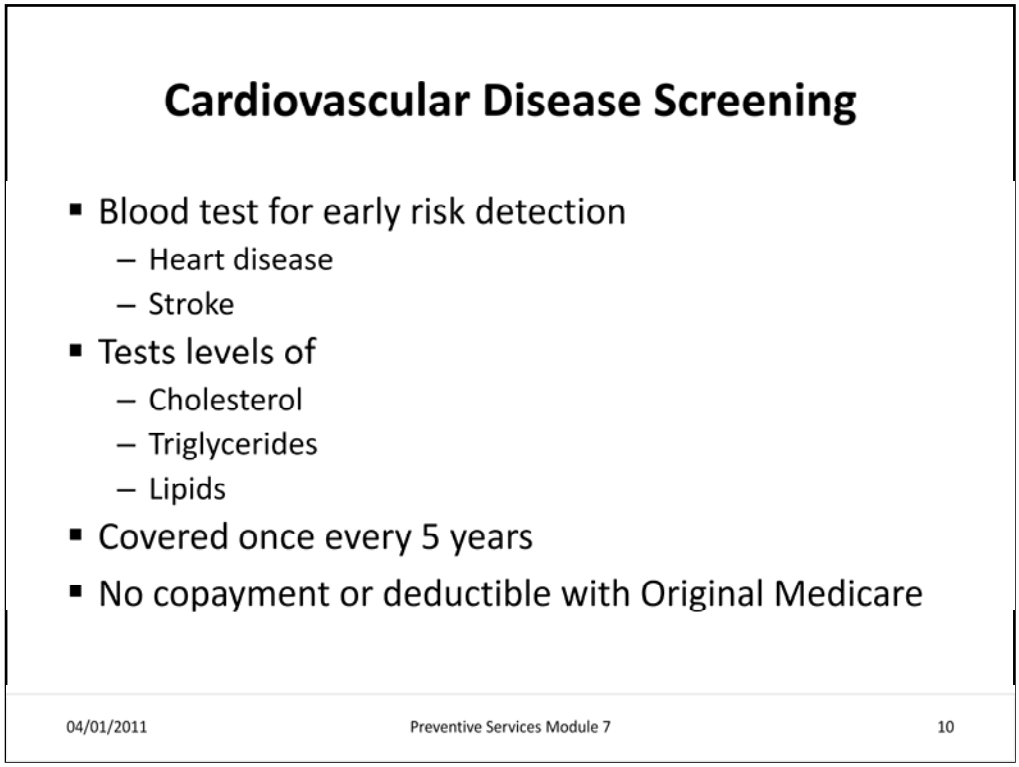
1. True
2. False



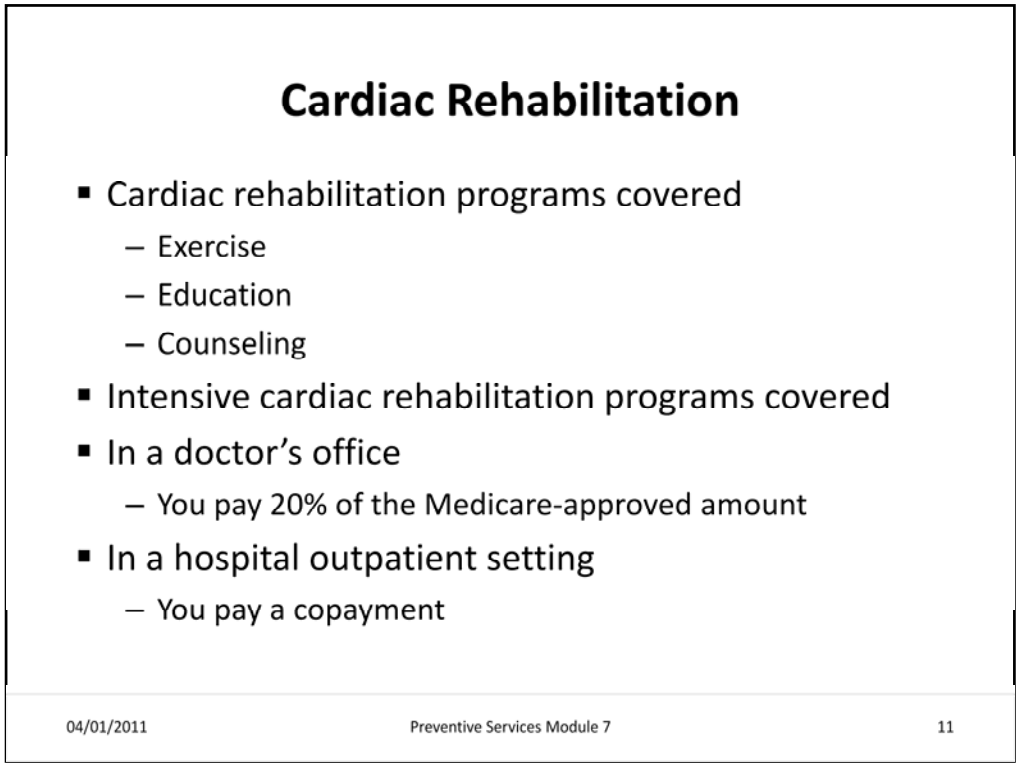

- The aorta is the largest artery in your body, and it carries blood away from your heart. When it reaches your abdomen, it is called the abdominal aorta.
- The abdominal aorta supplies blood to the lower part of the body. When a weak area of the abdominal aorta expands or bulges, it is called an abdominal 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.
- You must get a referral for a one-time screening ultrasound at your "Welcome to Medicare" visit.
- You are considered at risk if you:
  - have a family history of abdominal aortic aneurysms, or
  - are a man age 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.



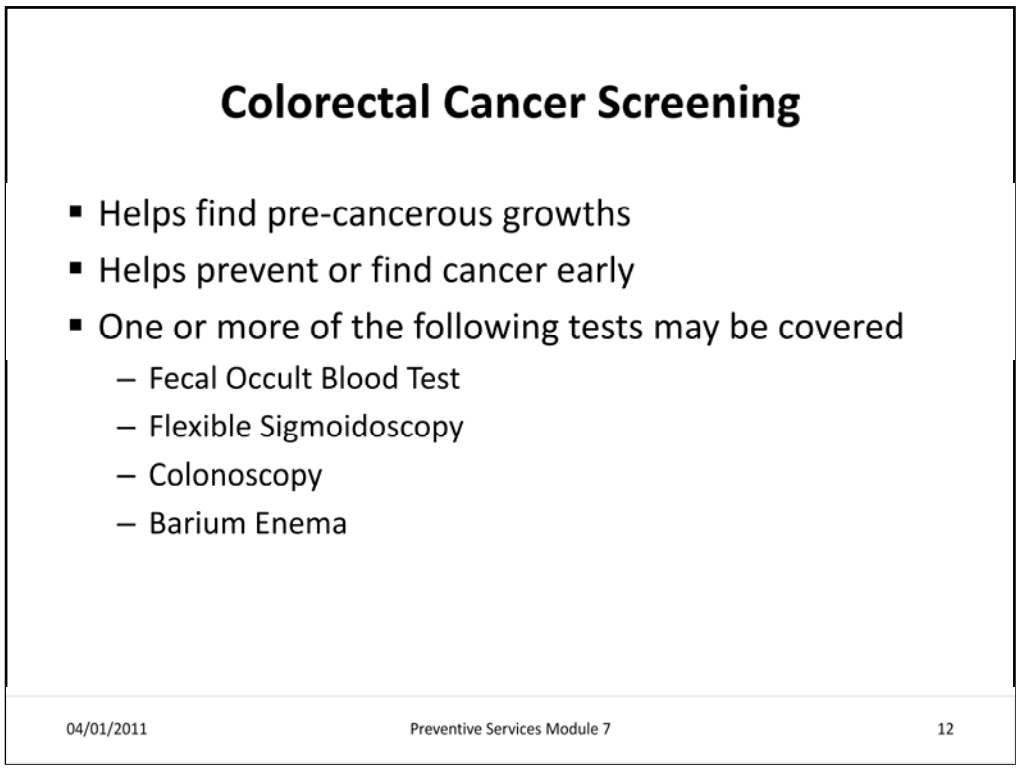

- Medicare covers bone mass measurements to measure bone density. These test results help you and your doctor choose the best way to keep your bones strong.
- Osteoporosis is a disease in which your bones become weak and more likely to break. It is a silent disease, meaning that you may not know you 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:
  - Women determined by their physician or qualified non-physician practitioner to be estrogen deficient and at clinical risk for osteoporosis.
  - Individuals with vertebral abnormalities.
  - Individuals receiving (or expecting to receive) steroid therapy for more than three months.
  - Individuals with hyperparathyroidism.
  - Individuals being monitored to assess their response to FDA-approved osteoporosis drug therapy.
- In Original Medicare there is no deductible or copayment.




- Heart disease is the number one cause of death, and a major cause of disability, in the U.S.
- 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.
- You can help reduce your risk of heart disease by taking steps to control factors that put you at greater risk:
  - Control your blood pressure
  - Lower your cholesterol
  - Don't smoke
  - Get enough exercise
- 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 cholesterol, lipid, 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 cardiac rehabilitation for patients with certain conditions. It is a comprehensive program that includes:
  - Exercise
  - Education
  - Counseling
- Medicare also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.
- You pay 20% of the Medicare-approved amount if you get the services in a doctor's office.
- In a hospital outpatient setting, you pay a copayment.




- In the United States, colorectal cancer is the fourth most common cancer in men and women. 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:
  - Fecal Occult Blood Test
  - Flexible Sigmoidoscopy
  - Colonoscopy
  - Barium Enema
- Medicare defines high risk of developing colorectal cancer as someone who has one or more of the following risk factors:
  - Close relative (sibling, parent, or child) who has had colorectal cancer or polyps.
  - family history of familial polyps.
  - Personal history of colorectal cancer
  - Personal history of inflammatory bowel disease, including Crohn's disease and ulcerative colitis.

**NOTE:** 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.

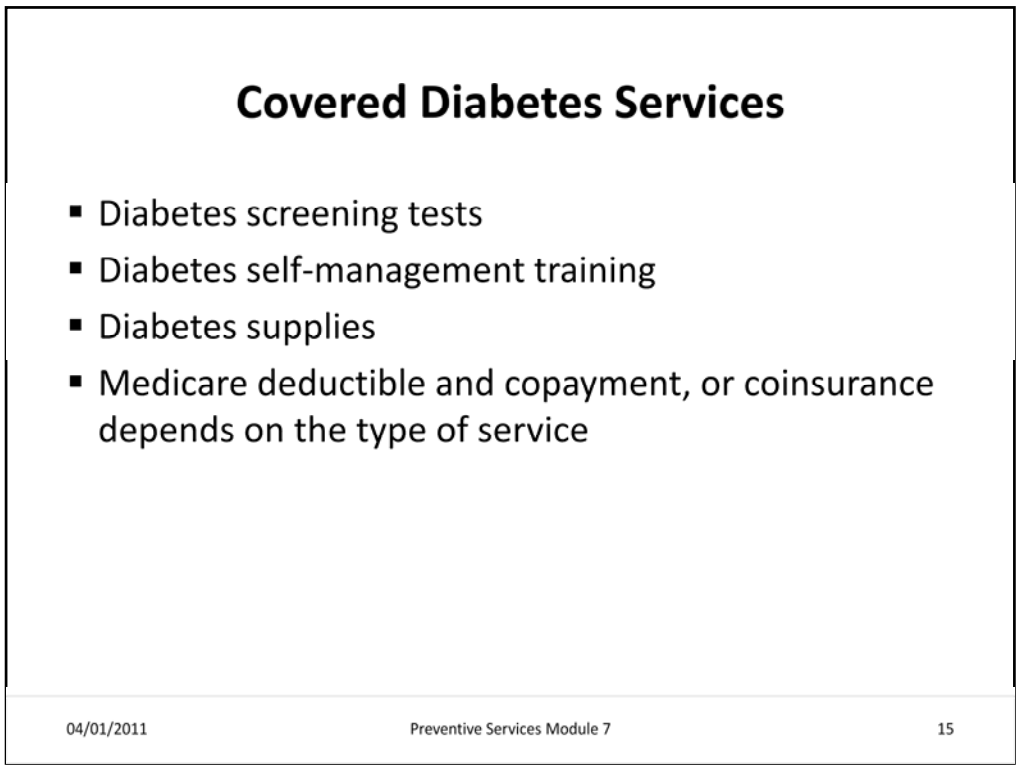
| Colorectal Cancer Screenings | | | |
|---|---|---|---|
| **Test and Requirements** | **If Normal Risk Covered Once Every** | **If High Risk, Covered Once Every** | **You Pay** |
| **Fecal Occult Blood Test**<br><br>Age 50 or older | 12 months | 12 months | No deductible or copayment for this test. |
| **Flexible Sigmoidoscopy**<br><br>Age 50 or older | 48 months or 120 months after a previous screening colonoscopy for those not at high risk | Every 4 years | No deductible or copayment for this test. |
| **Colonoscopy**<br><br>No minimum age | 120 months (generally) (high risk every 24 months) or 48 months 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. |
| **Barium Enema**<br><br>Age 50 or older | 48 months (high risk every 24 months) 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. |
| 04/01/2011 | Preventive Services Module 7 | | 13 |

- All Medicare beneficiaries age 50 and older who are **not** at high risk for colorectal cancer are covered for the following:
  - Fecal Occult Blood Test every year.
  - Flexible Sigmoidoscopy once very 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).
  - 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:
  - Fecal Occult Blood Test every year,
  - 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
  - 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 copayment cost sharing applies for barium enemas.

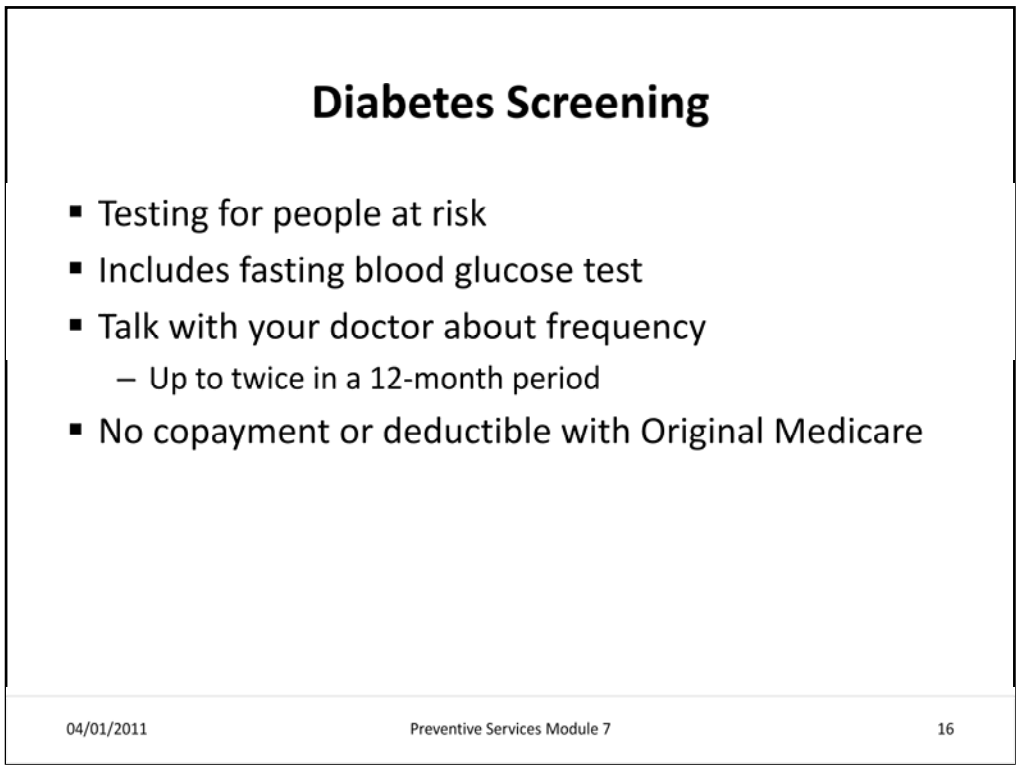
## Exercise

Medicare covers bone mass measurements to measure bone density for all people with Medicare.

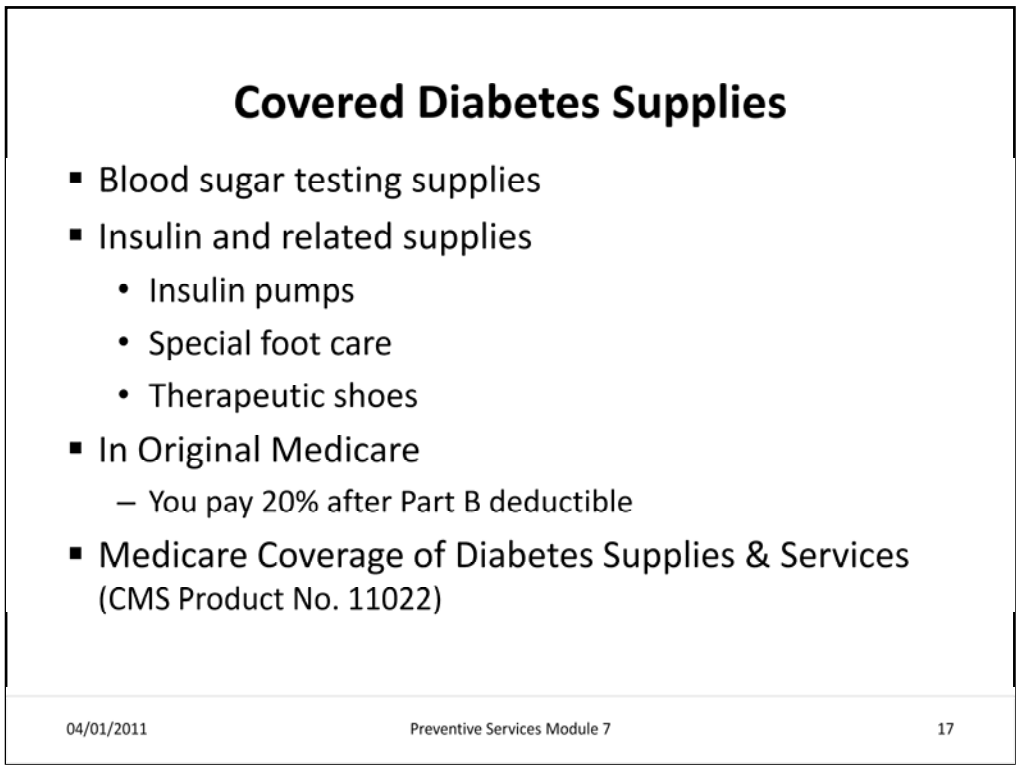
1. True
2. False




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

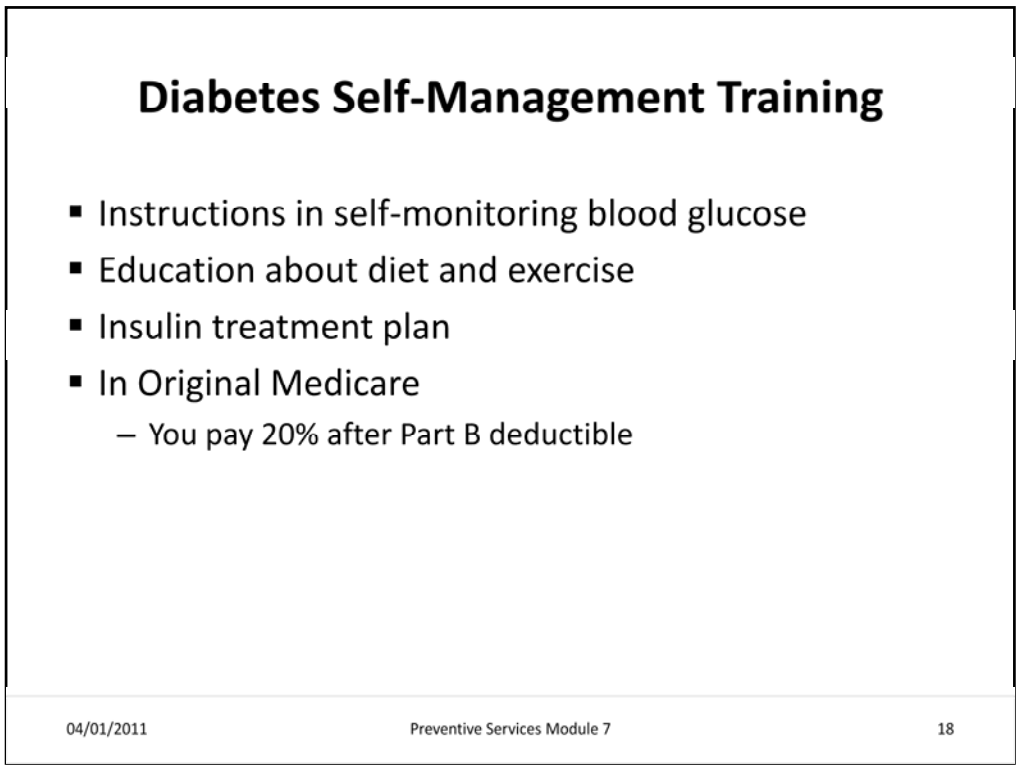



- Diabetes is a disease in which your blood glucose, or sugar levels, are too high. Glucose comes from the foods you eat. Insulin is a hormone that helps the glucose get into your cells to give them energy.
- With Type 1 diabetes, your body does not make insulin. With Type 2 diabetes, the more common 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 US. 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.
- 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).

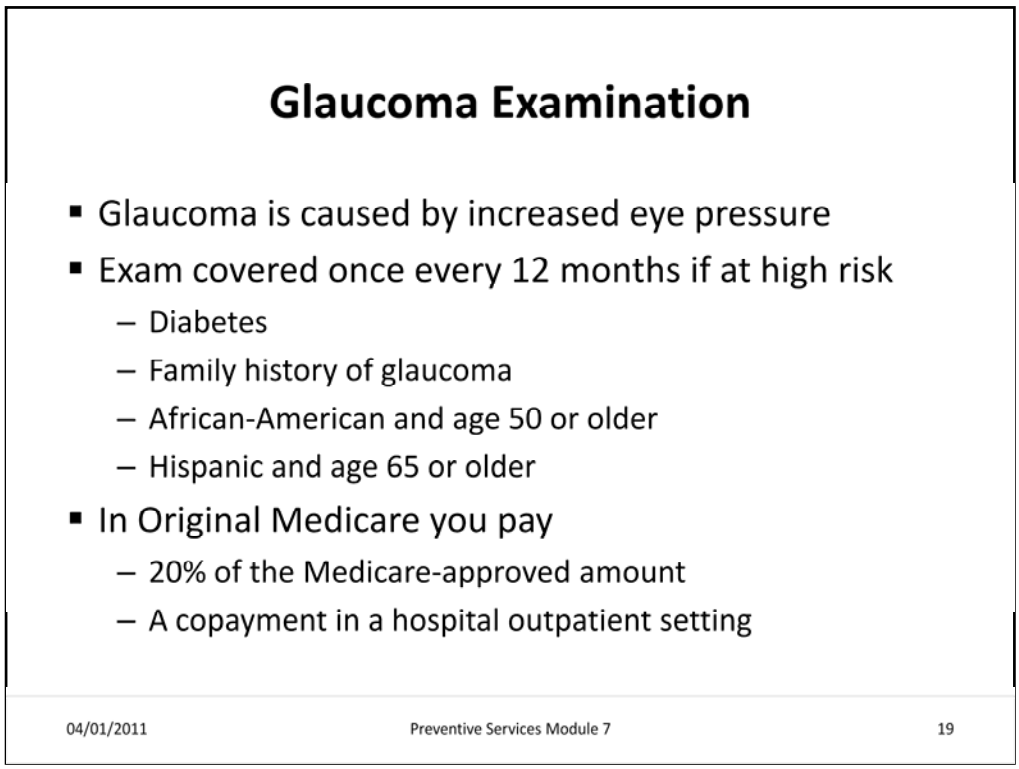



- Medicare covers insulin pumps, special foot care, and therapeutic shoes for people with diabetes who need them.
- Insulin associated with an insulin pump is covered by Medicare part B. Injectable insulin not associated with the use of an insulin infusion pump is covered under Medicare drug plans.
- 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.

For more information, please 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 diabetes.
- 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.
  - 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.

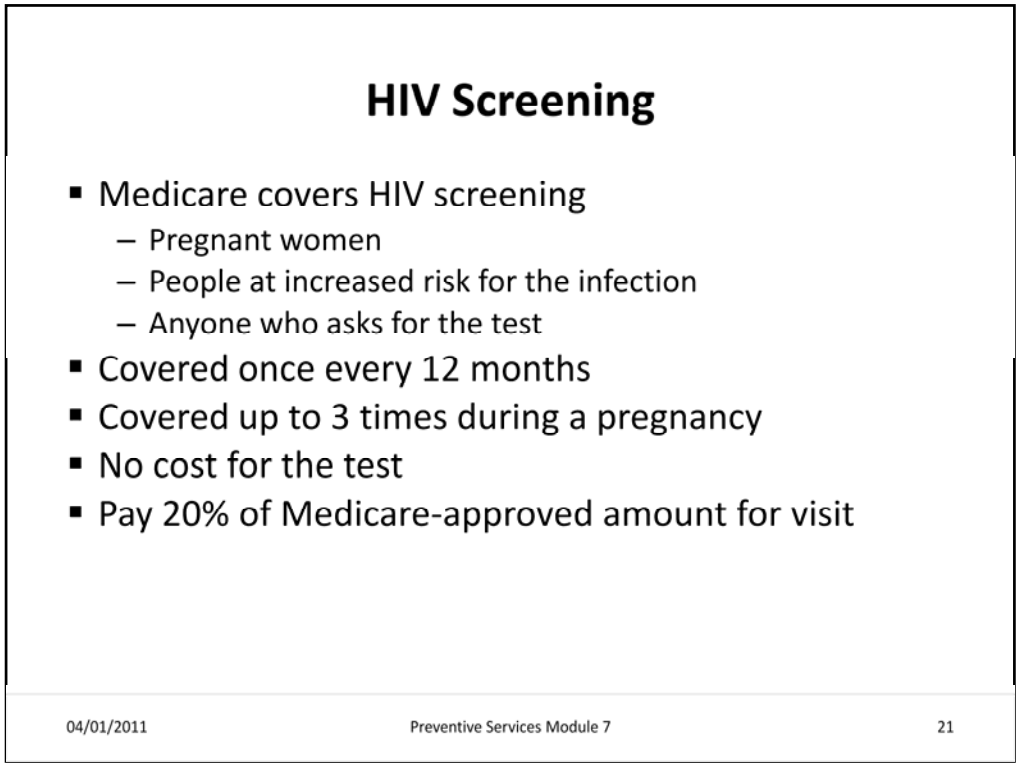



- Glaucoma is an eye disease caused by above-normal pressure in the eye. It usually damages the optic nerve and you may gradually lose sight without symptoms. It can result in blindness, especially without treatment. The best way for people at high risk for glaucoma to protect themselves is to have regular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

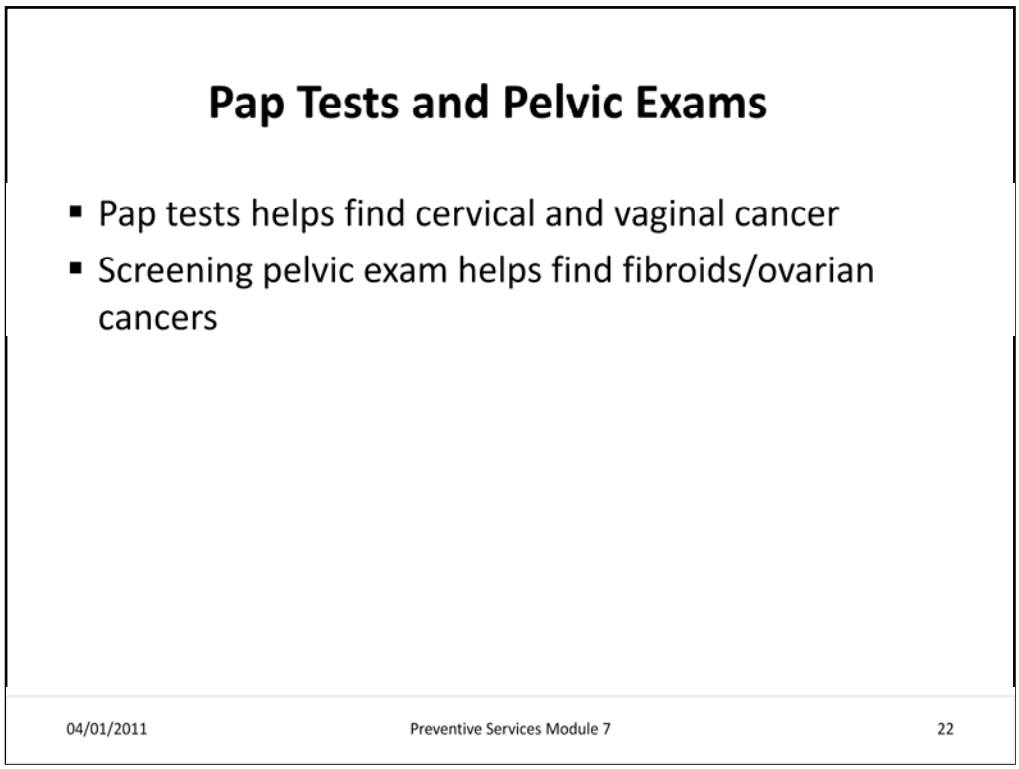
## Exercise

_____ is the leading cause of acquired blindness among adults.

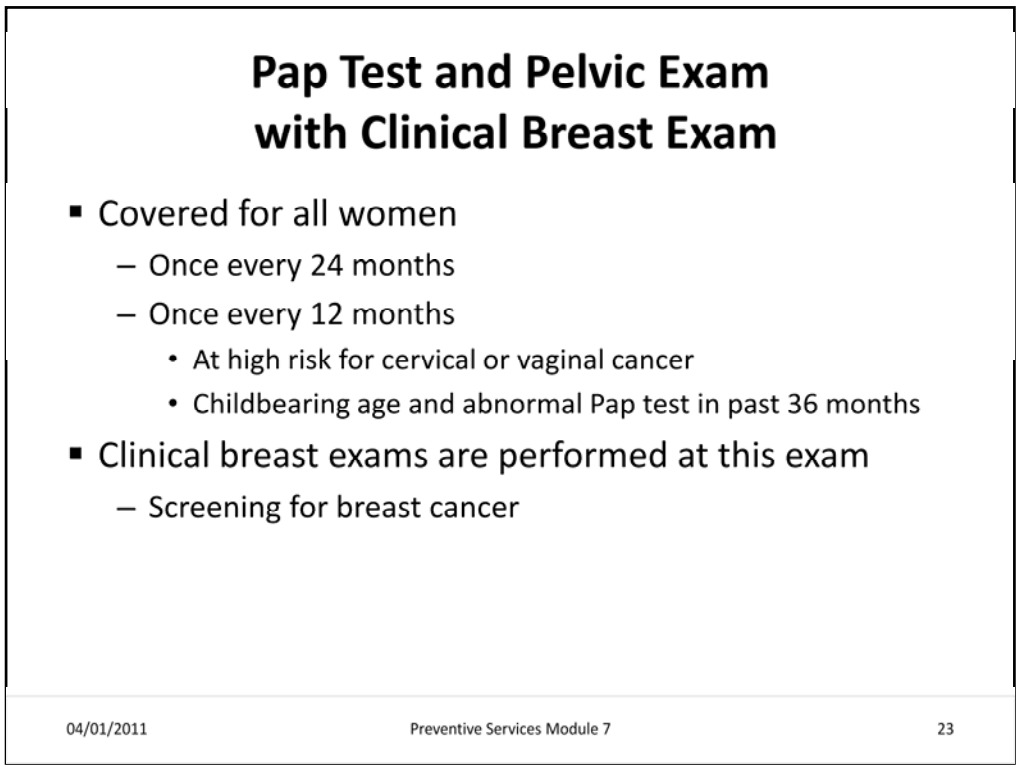
1. Glaucoma
2. Diabetes
3. Cardiovascular disease
4. Elevated cholesterol levels




- 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.
  - 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.

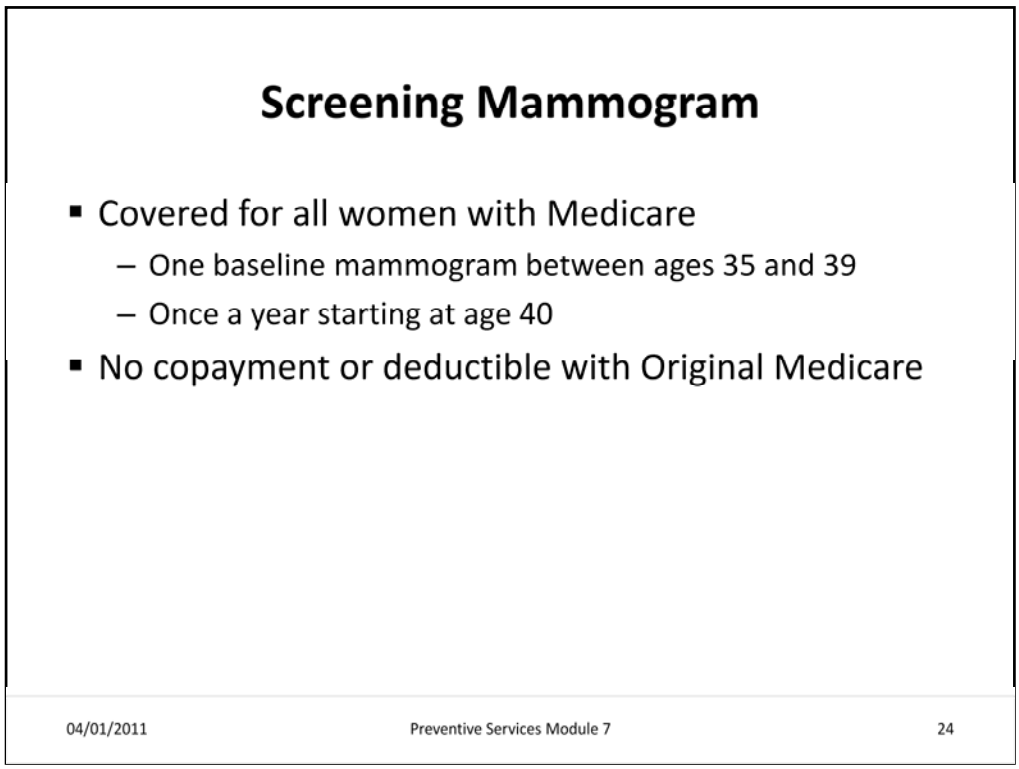



- Medicare covers Pap tests, pelvic exams, and clinical breast exams.
- Pap tests help find cervical and vaginal cancer, screening pelvic exams help find fibroids/ovarian cancers.

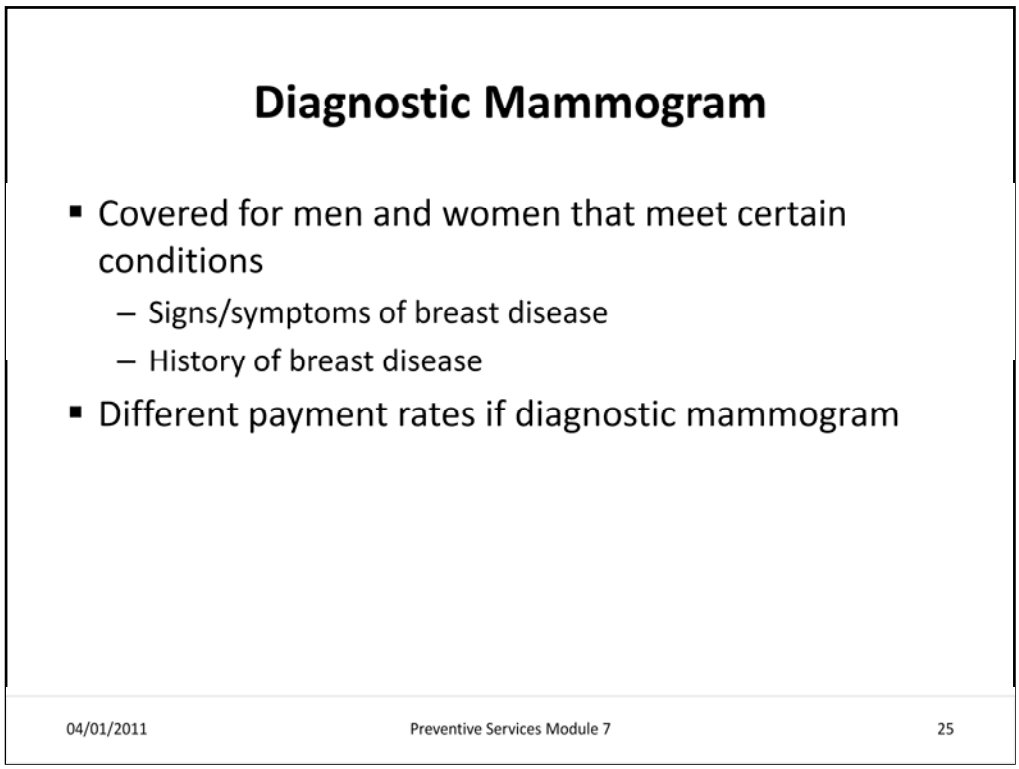



- These tests are covered services for all women with Medicare. These services are covered once every 24 months for most women. However, they may be covered every 12 months if:
  - You are at high risk for cervical or vaginal cancer (based on your medical history or other findings)
  - You are of childbearing 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,
  - DES (diethylstibestrol)-exposed daughters of women who took DES during pregnancy
- Clinical breast exams are another way to look for breast cancer.

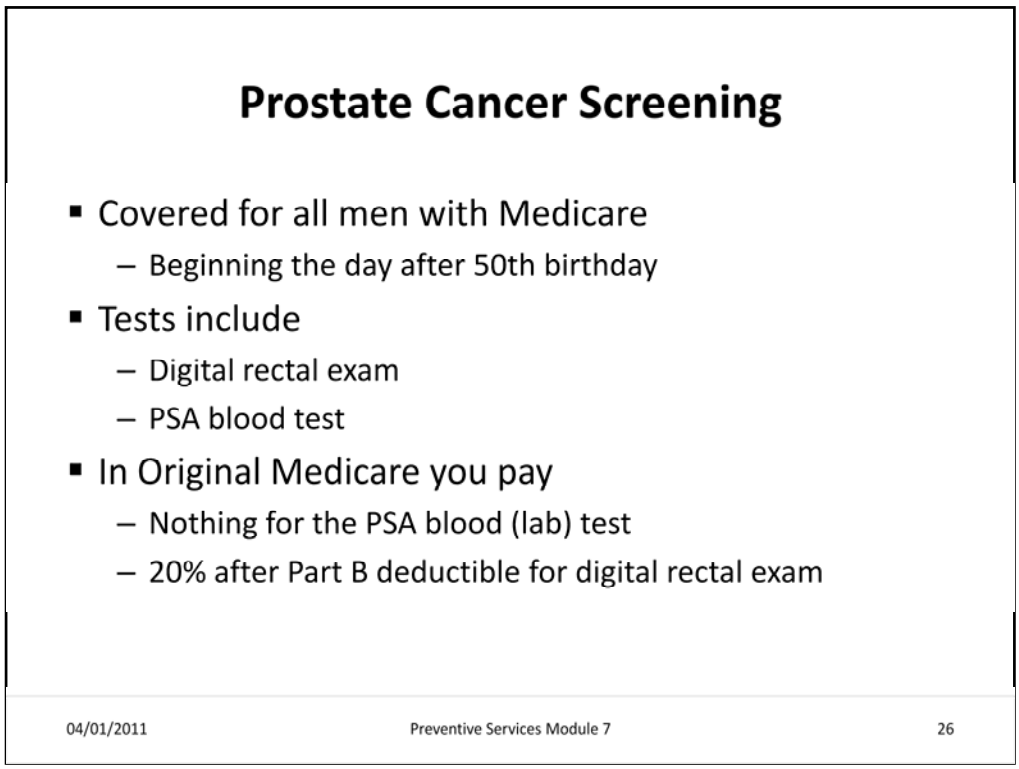
Additional information available on www.medicare.gov.



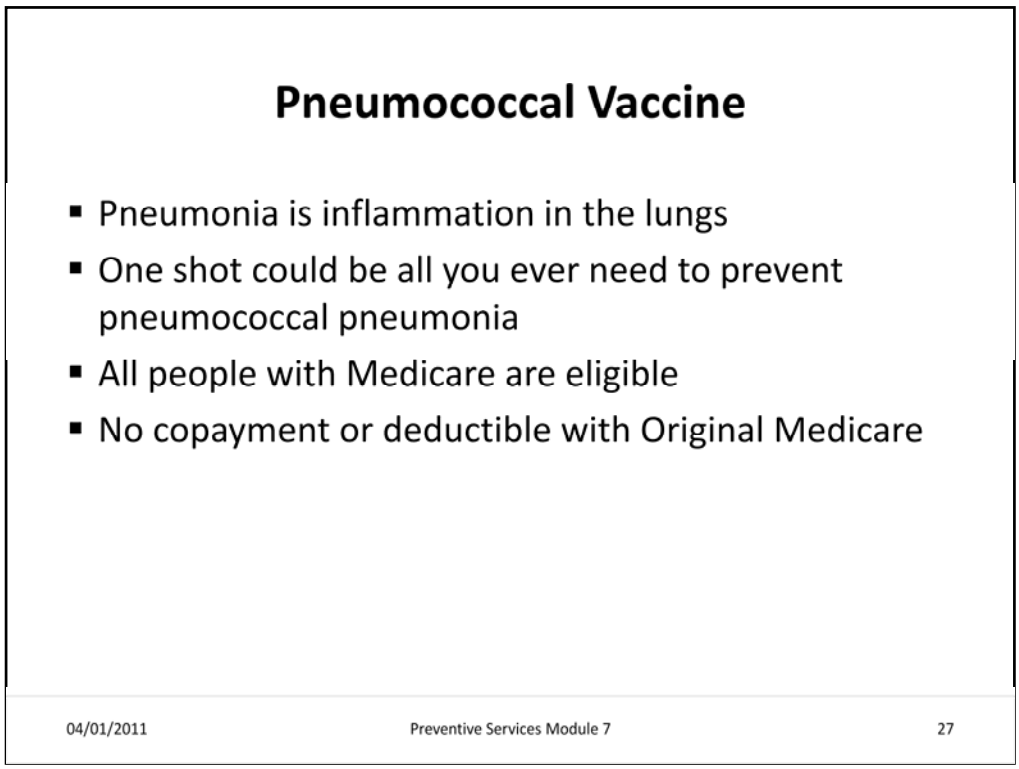

- A screening mammogram is a mammogram of a woman with no signs or symptoms of breast disease. Finding small breast cancers early by a screening mammogram greatly improves a woman's chance for successful treatment.
- This service is covered for all women with Medicare. Medicare covers:
  - One screening mammogram from age 35 to 39. This can be used as a baseline to compare with later mammograms, and
  - One screening mammogram every year starting at age 40.
- 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.



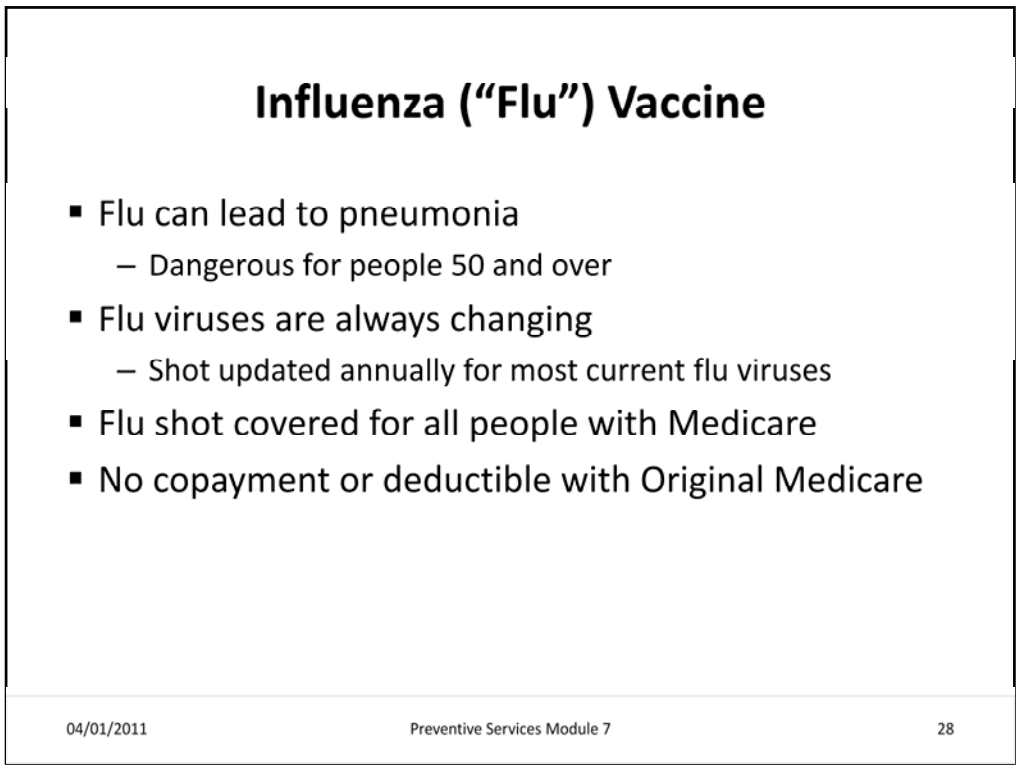

- Medicare covers diagnostic mammograms. A diagnostic mammogram is covered by Medicare for both men and women whose doctor says that they have:
  - Signs or symptoms of breast disease.
  - Personal history of breast cancer.
  - Personal history of biopsy-proven benign breast disease.
- Diagnostic mammograms must be ordered by a doctor.
- Diagnostic mammograms may include additional views of the breast. Medicare pays differently for diagnostic mammograms. Medicare also pays for other diagnostic tests that may be needed, such as ultrasound screening.




- Medicare covers screenings for prostate cancer every 12 months for men age 50 and older.
- Coverage begins the day after your 50th birthday. The tests in this screening include the Prostate Specific Antigen (PSA) blood test and a digital rectal examination.
- You pay 20% of the Medicare-approved amount for the digital rectal examination after the yearly Part B deductible in Original Medicare.
- There is no cost for the PSA blood (lab) test.
- Deductible and copayment cost sharing applies for the digital rectal exam. A copayment may apply in a hospital outpatient setting.




- Medicare covers a pneumococcal vaccination to protect you from this type of pneumonia.
- Pneumonia is an inflammation in the lungs caused by infection with bacteria called streptococcus pneumonia. It can infect the upper respiratory tract and can spread to the blood, lungs, middle ear, or nervous system.
- Most people only need a pneumococcal pneumonia shot once in their lifetime. Medicare will cover additional shots if your doctor decides it is necessary.
- All people with Medicare are eligible for this benefit.
- You pay no coinsurance and no Part B deductible in Original Medicare if your health care provider accepts assignment.




- Influenza, also known as the flu, is a contagious viral disease that attacks the nose, throat, and lungs. In the US 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 US occur in people aged 65 and older.
- You should get a flu shot every year because flu viruses change. The shot is updated annually for the most current flu viruses.
- All people with Medicare are eligible for this benefit.
- People should get a flu shot once each flu season, in the fall or winter.
- The best time to get a flu shot is in October or November. Flu activity in the United States generally peaks between late December and early March. You can still benefit from getting a flu shot after November, even if the flu is present in your community. The shot is available any time during the flu season. Once you get a flu shot, your body makes protective antibodies in about 2 weeks.
- In Original Medicare you generally pay nothing for a flu shot, as long as the doctor or nurse accepts Medicare assignment.
- If you are enrolled in a Medicare Advantage Plan, you generally must see your primary care doctor to get your flu shot, and there may be a copayment for the office visit.

To learn more about influenza www.cdc.gov and www.flu.gov.

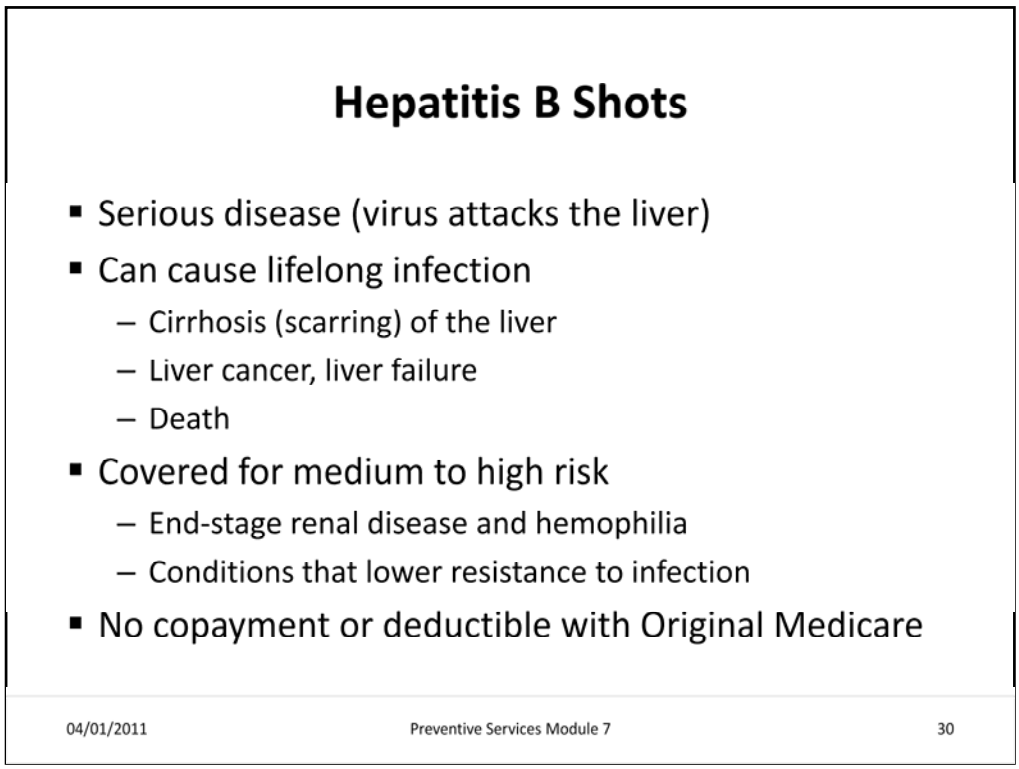
## Shingles Vaccine

- 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.
- Shingles vaccine is covered by Medicare Part D



- At this point, people often ask about the vaccine for shingles.
- 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.
- The shingles vaccine is covered by Medicare Part D Prescription Drug Plans. Medicare Part B does not cover the shingles vaccine.

Questions about reimbursement from Medicare Part D plans should be directed to 1-800-MEDICARE.

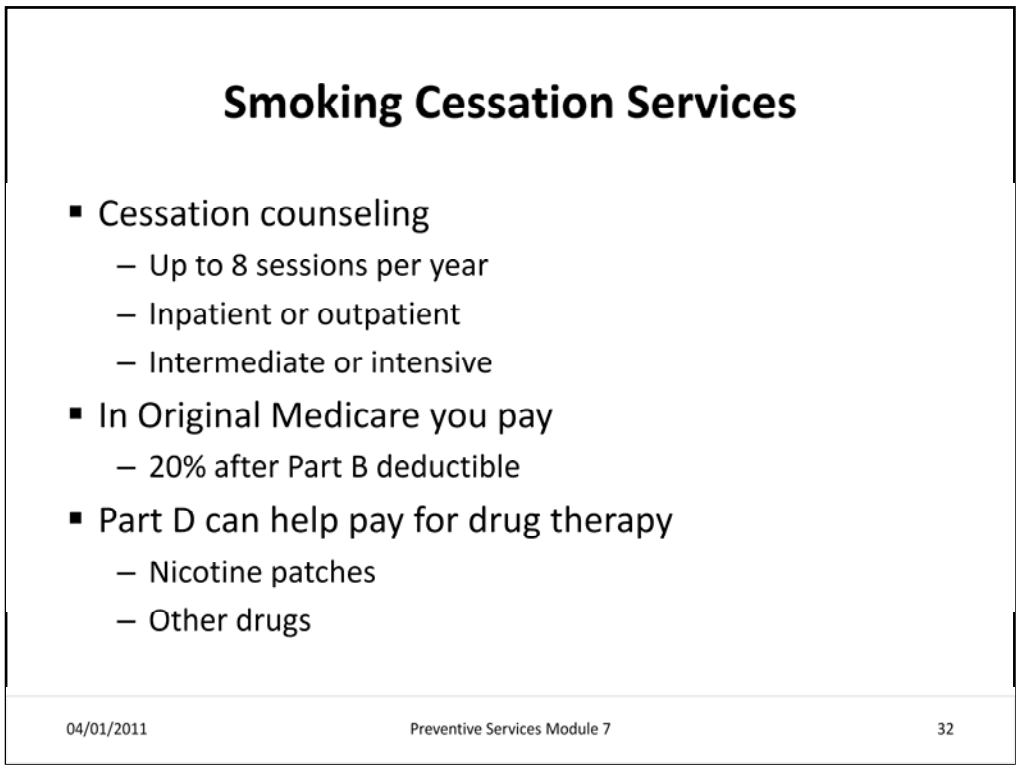



- Hepatitis B is a serious disease caused by a virus that inflames the liver. The virus, which is called hepatitis B virus (HBV), can cause lifelong infection, cirrhosis (scarring) of the liver, liver cancer, liver failure, and death.
- Hepatitis B shots are covered if you are at medium or high risk. Three shots are needed for complete protection. High-risk individuals include those with End-Stage Renal Disease and hemophilia. (End-Stage Renal Disease is permanent kidney failure that is treated with regular dialysis or a kidney transplant. Hemophilia is a bleeding disorder.)
- People with Original Medicare do not pay a copayment or deductible for this screening.

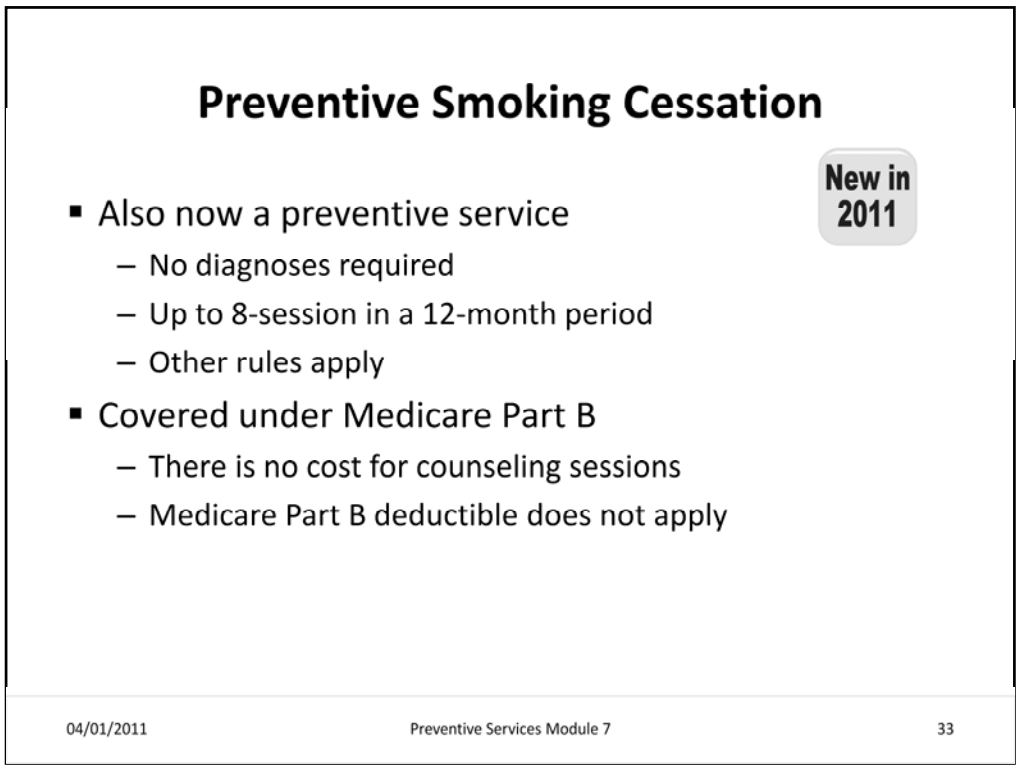
# Exercise

You should get a pneumococcal pneumonia shot every year to guard against pneumonia.

1. True
2. False

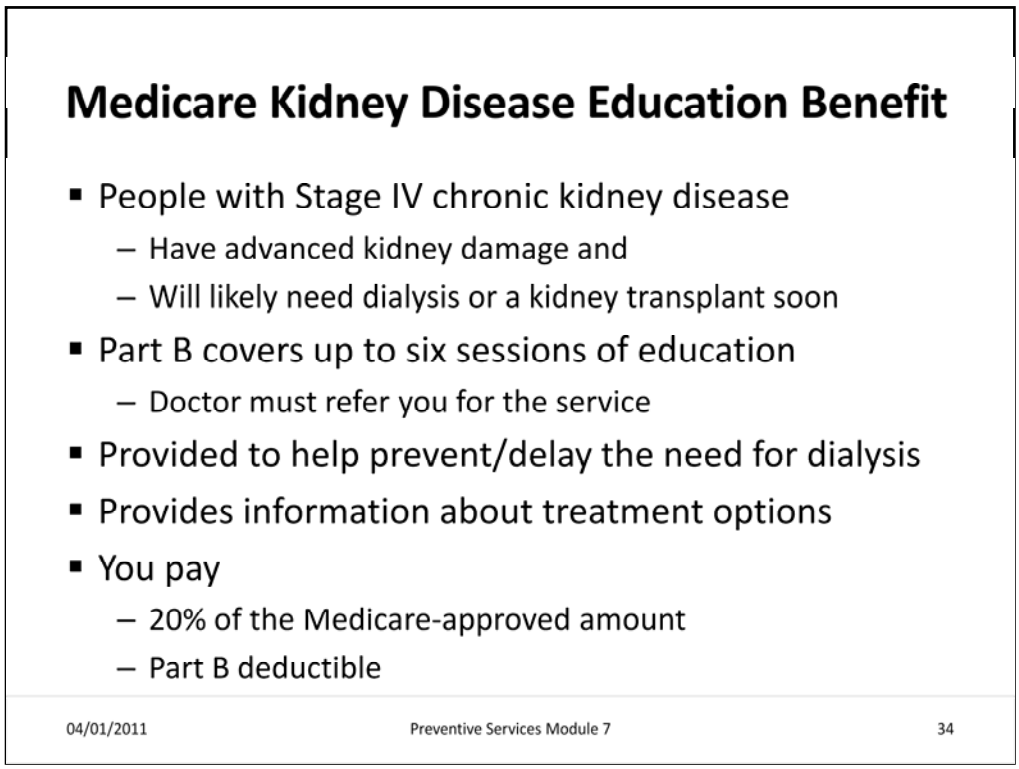



- Medicare Part B covers cessation counseling for individuals who use tobacco and have been diagnosed with a recognized tobacco-related disease or who exhibit symptoms consistent with tobacco-related disease.
- Medicare will cover two cessation attempts per year. Each attempt may include up to four counseling sessions, with the total annual benefit covering up to eight sessions in a 12-month period.
- Services can be provided in the hospital or on an outpatient basis. (However, the benefit does not cover hospitalization if tobacco cessation is the primary reason for the hospital stay.)
- You must get counseling from a qualified Medicare provider (physician, physician assistant, nurse practitioner, clinical nurse specialist, or clinical psychologist).
- Medicare pays 80% of the cost for these services. Deductible and copayment cost sharing applies for the this service. A copayment may apply in a hospital outpatient setting.
- 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.




- As of August 25, 2010, Medicare covers tobacco cessation counseling to prevent tobacco use for outpatient and hospitalized Medicare 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.
  - Services can be provided in the hospital or on an outpatient basis.

**NOTE**: Medicare does not cover tobacco cessation services if tobacco cessation is the primary reason for the patient's hospital stay.




- 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.
- 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.
- 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.

| Preventive Service | Who Is Covered | How Often It's Covered | Your Costs |
|---|---|---|---|
| **Welcome to Medicare Visit**<br><br>This is a one-time visit that includes a medical and social history review of your health. Depending on your general health and medical history, your doctor may refer you for additional tests. Your doctor will develop a personalized written plan letting you know which screenings and other preventive services you should get. | Men and women 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**<br><br>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. | Men and women 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**<br><br>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:<br><br>• a family history of abdominal aortic aneurysm<br>• 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 fully paid by Medicare, patients that have been identified as high-risk must get a referral for this procedure at their Welcome to Medicare visit. | 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**<br><br>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:<br><br>• A woman whose physician says she is estrogen deficient and at clinical risk for osteoporosis.<br>• People with vertebral abnormalities.<br>• People receiving (or expecting to receive) steroid therapy for more than three months.<br>• People with hyperparathyroidism.<br>• 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 Screening**<br><br>These blood tests help detect conditions that may lead to a heart attack or stroke. They test your cholesterol, lipid, and triglyceride levels. | Men and women with Medicare. | Medicare covers these tests once every five years. | There is no cost if your doctor accepts Medicare assignment. |
| **Colorectal Cancer Screening**<br><br>To help find precancerous growths or find cancer early, when treatment is most effective. Your doctor may order one of the following tests: | Men and women with Medicare age 50 and older who are:<br>• At normal risk of developing colorectal cancer; or<br>• At high risk of developing colorectal cancer. | **Normal risk**<br>**Fecal Occult Blood Test**<br>Annually<br><br>**Flexible Sigmoidoscopy**<br>Once every 4 years (unless a screening colonoscopy has been | **Fecal Occult Blood Test**<br>There is no cost if your doctor accepts Medicare assignment.<br><br>**Flexible Sigmoidoscopy**<br>There is no cost if your doctor accepts Medicare assignment. |

| Preventive Service | Who Is Covered | How Often It's Covered | Your Costs |
|---|---|---|---|
| • Fecal Occult Blood Test<br>• Flexible Sigmoidoscopy<br>• Colonoscopy<br>• Barium Enema | | performed and then Medicare may cover a screening sigmoidoscopy after at least 119 months) ,<br><br>**Screening Colonoscopy**<br>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)<br><br>**Barium Enema**<br>(As an alternative to a covered screening flexible sigmoidoscopy).<br><br>**<u>High risk</u>**<br>**Fecal Occult Blood Test**<br>Annually<br><br>**Flexible Sigmoidoscopy**<br>Once every 4 years,<br>Screening Colonoscopy every 2 years (unless a screening flexible sigmoidoscopy has performed and then Medicare may cover a screening colonoscopy only after at least 47 months)<br><br>**Barium Enema**<br>(As an alternative to a covered screening colonoscopy). | **Colonoscopy**<br>There is no cost if your doctor accepts Medicare assignment.<br><br>**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 |
|---|---|---|---|
| **Diabetes Screening**<br><br>Medicare covers a fasting blood glucose test to screen people at risk for diabetes. | Men and women with Medicare that have any of the following risk factors:<br><br>• High blood pressure (hypertension)<br>• History of abnormal cholesterol and triglyceride levels (dyslipidemia)<br>• Obesity<br>• History of high blood sugar<br>• Family history of diabetes | Up to two tests per year if you have pre-diabetes.<br><br>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**<br><br>Medicare covers certain services for people with diabetes to help them successfully manage the disease and help prevent it's complications. | People with Medicare that have diabetes and have a written order from their physician treating their diabetes. | Up to 10 hours of training during the first year.<br><br>Two hours of follow-up training each year thereafter if ordered by your physician. | Medicare beneficiaries pay 20% of the Medicare-approved amount after the yearly Part B deductible. |
| **Pap Tests and Pelvic Exams (including a clinical breast exam)**<br><br>These tests check for cervical, vaginal, and breast cancers. | All women with Medicare | Pap 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. |
| **Screening Mammogram**<br><br>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 |
|---|---|---|---|
| **Prostate Cancer Screening**<br><br>The tests included in this screening are the Prostate Specific Antigen (PSA) blood test and a digital rectal examination. | 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. |
| **Glaucoma Testing**<br><br>A glaucoma screening eye exam is used to detect glaucoma, which 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:<br>• You have diabetes<br>• You are African-American and are age 50 or older<br>• You are Hispanic and are 65 or older<br>• You have a family history of glaucoma | Medicare covers glaucoma screenings every 12 months for high risk patients. | Deductibles and copayment cost sharing apply. |
| **HIV Screening**<br><br>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 labor 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) Shot**<br><br>All people, especially those 65 and older, should get an annual flu shot. | Men and women 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. |

| Preventive Service | Who Is Covered | How Often It's Covered | Your Costs |
|---|---|---|---|
| **Hepatitis B Shots**<br><br>A series of three shots are needed for complete protection | Men and women with Medicare whose doctor identifies them as medium to high risk for Hepatitis B. Risk factors include:<br>• Hemophilia<br>• ESRD | A one-time series of three shots are need for complete lifetime protection. | There is no cost if your doctor accepts Medicare assignment. |
| **Pneumococcal Shot**<br><br>This immunization protects beneficiaries from pneumococcal pneumonia, an inflammation of the lungs caused by bacterial infection. | Men and women 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. |
| **Tobacco Use Cessation Services**<br><br>Tobacco Use cessation services include counseling sessions. | Men and women with Medicare. | 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.<br><br>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. |

# Preventive Services Resource Guide

## Resources

**Medicare.gov**
www.medicare.gov

1-800-MEDICARE
(1-800-633-4227)
(TTY 1-877-466-2048)

**Local State Health Insurance Programs**
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 Products

***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)

***Your Medicare Benefits***
(CMS Product No. 10116)

***Staying Healthy***
(CMS Product No. 11100)

***A Healthier US Starts Here***
(CMS Product No. 11308)

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.

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**NOTES:**


**E-mail: NMTP@cms.hhs.gov**
**Website: cms.gov/NationalMedicareTrainingProgram**

**Centers for Medicare & Medicaid Services**
**7500 Security Boulevard, Baltimore, MD 21244**