Module 7:
Medicare Preventive Services

National Medicare
TRAINING PROGRAM
...helping people with Medicare make informed health care decisions

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

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 following sections are included in this module:

Slides	1-4	Medicare Preventive Services Overview
Slides	5-39	Covered Services
Slides	40- 47	Preventive Services Chart
Slides	48-49	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 five interactive learning questions that give participants the opportunity to apply the module concepts in a real-world setting.

Time Considerations
The module consists of 49 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.

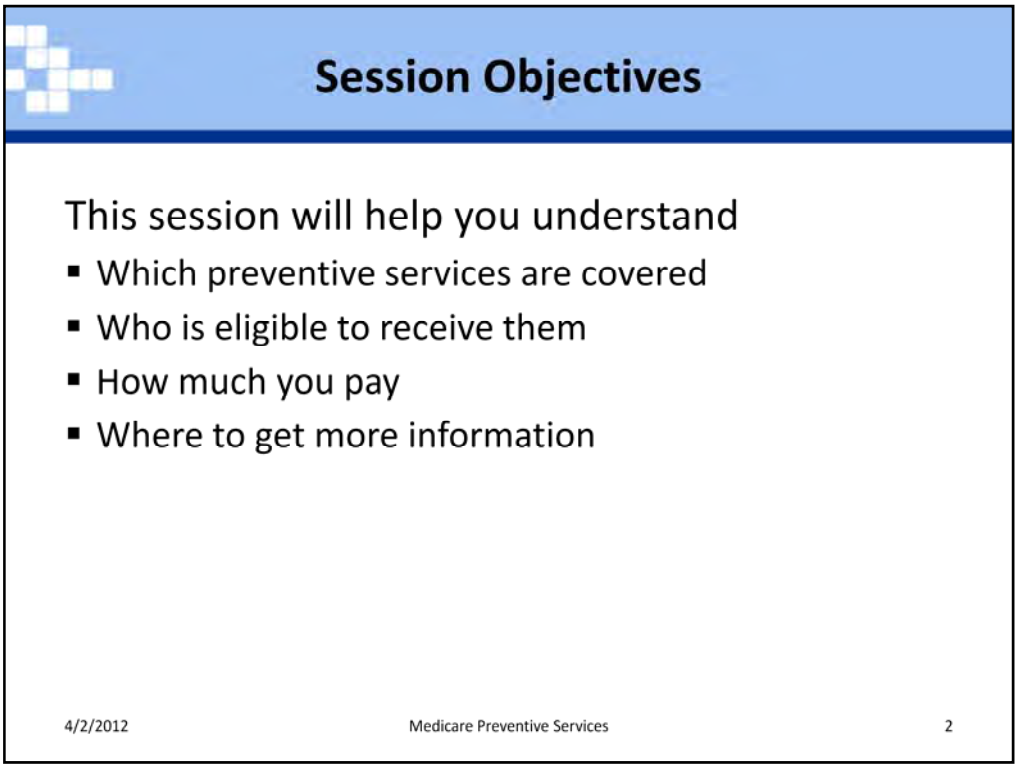
Module 7 explains Medicare-covered Preventive Services.

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 Preexisting Condition Insurance Plans (PCIP). The information in this module was correct as of April 2012.

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

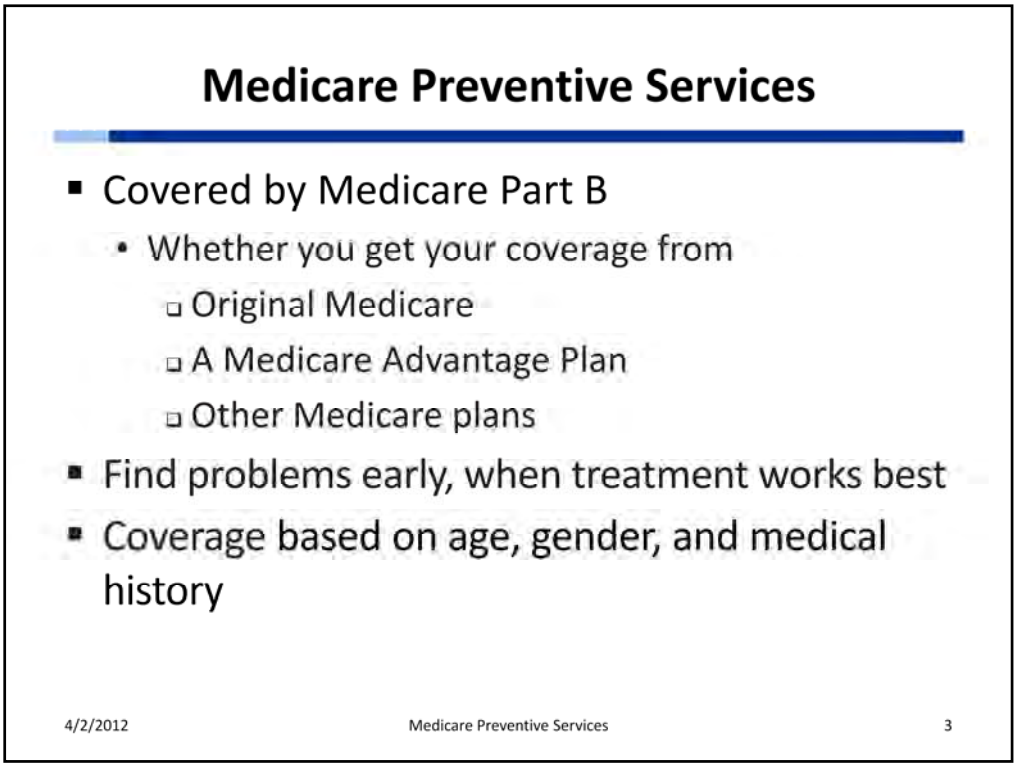
To check for an updated version of this training module, visit www.cms.gov/NationalMedicareTrainingProgram/TI/list.asp on the web.

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 preventive services are covered
- Who is eligible to receive them
- How much you pay
- 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.

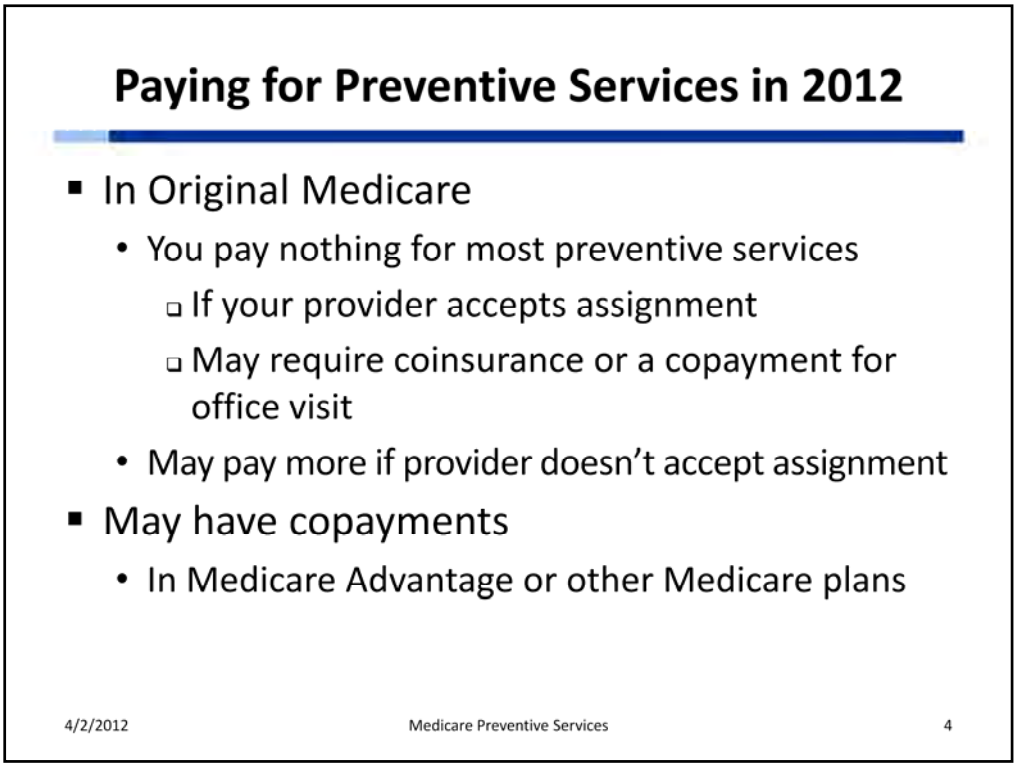
Preventive services may find health problems early, when treatment works best.

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

These services are covered no matter 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*, CMS Product No. 10050, includes guidelines for who is covered and how often Medicare will pay for these services.



2012 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 a copayment 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.

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.

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.

The "Welcome to Medicare" preventive visit is only offered one time within the first 12 months of getting Medicare Part B.

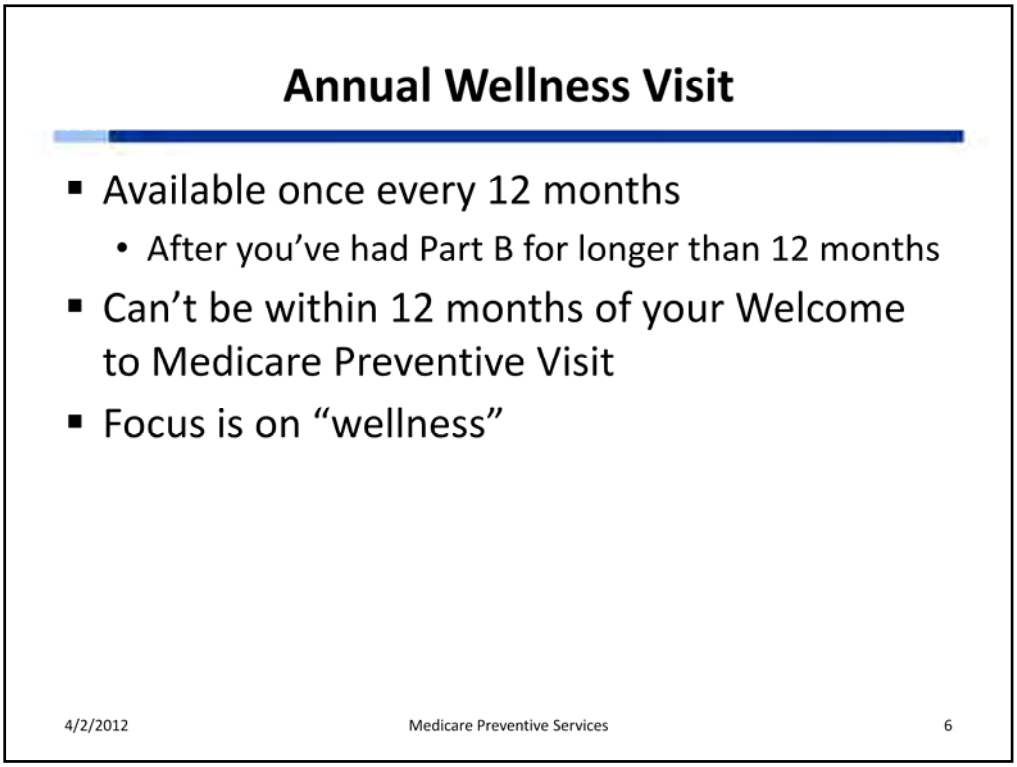
During the visit, your doctor will do the following

- Review your medical and social history
- Take your height, weight, body mass index, blood pressure
- Give you a simple vision test
- Review potential (risk factors) for depression
- Review functional ability and level of safety, which means an assessment of
  - Hearing impairment
  - Ability to successfully perform activities of daily living
  - Fall risk, and
  - Home safety

You will get advice to help 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.

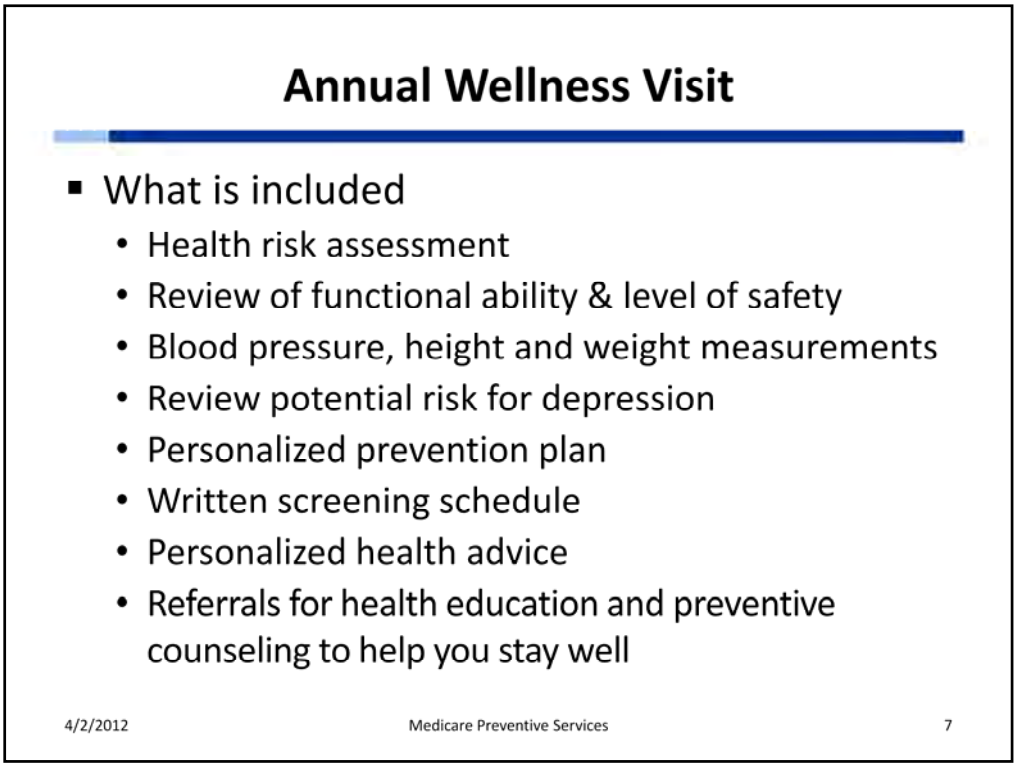


After you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a prevention plan just for you. Medicare covers one annual wellness visit every 12 months.

You don't need to get the "Welcome to Medicare" Preventive Visit before getting an annual wellness visit.

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.

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

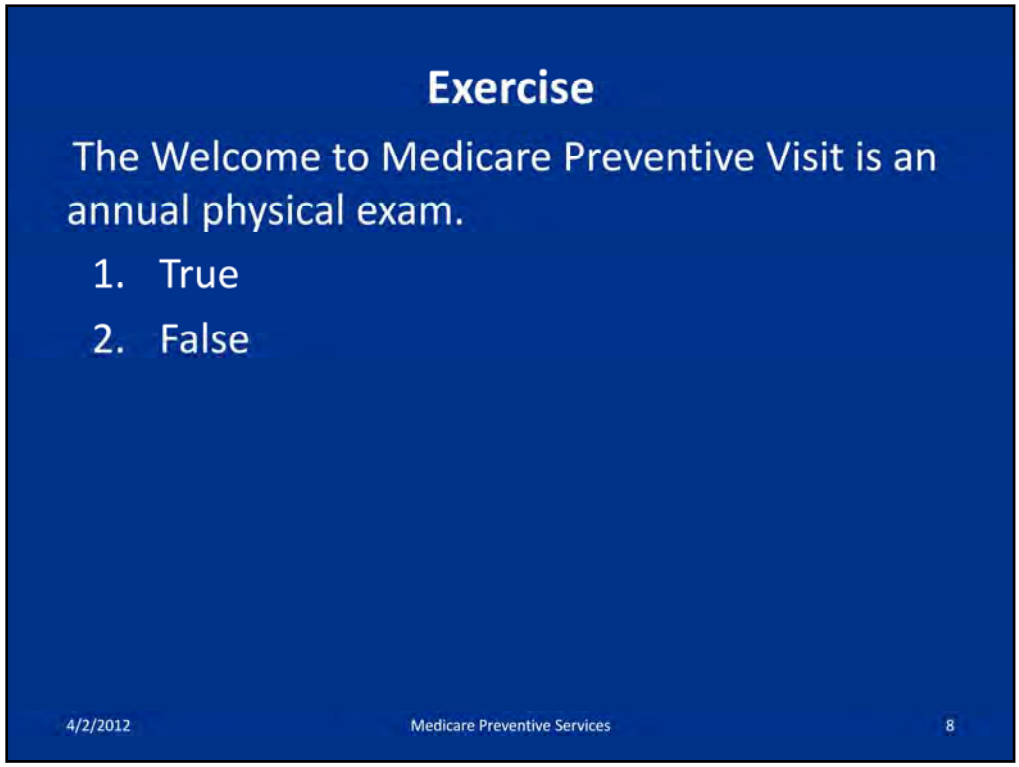


The health professional will ask you to answer some questions before your visit, which is called a health risk assessment. Your responses to the questions will help you and your health professional get the most from your annual wellness visit.

During the visit, your doctor will

- 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.



The Welcome to Medicare Preventive Visit is an annual physical exam.

1. True
2. False

Answer: False

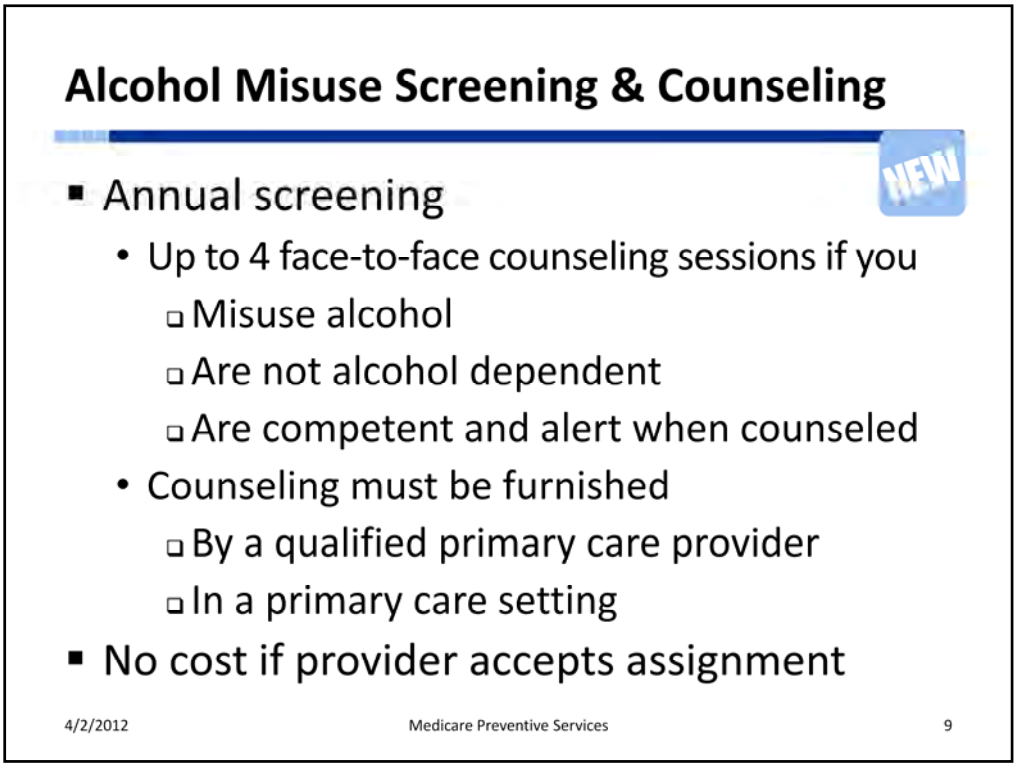
The “Welcome to Medicare” preventive visit provides the opportunity for your doctor to evaluate your general health and medical history and make referrals for additional preventive services as needed.

The "Welcome to Medicare" preventive visit helps you and your doctor develop a personalized plan to prevent disease, improve your health, and help you stay well.

During the visit, your doctor will

- Record and evaluate your medical and social history, current health conditions, and prescriptions.
- Check your blood pressure, vision, weight, and height to get a baseline for your care.
- Review potential risk for depression
- Make sure you're up-to-date with preventive screenings and services, such as cancer screenings and vaccines.
- Make referrals for additional preventive services, depending on your general health and medical history.

Your doctor will give you a plan, such as a checklist, with screenings and preventive services that you need.



CMS will cover annual alcohol screening and, for those tat screen positive, up to four, brief face-to-face behavioral counseling in primary care settings to reduce alcohol misuse.

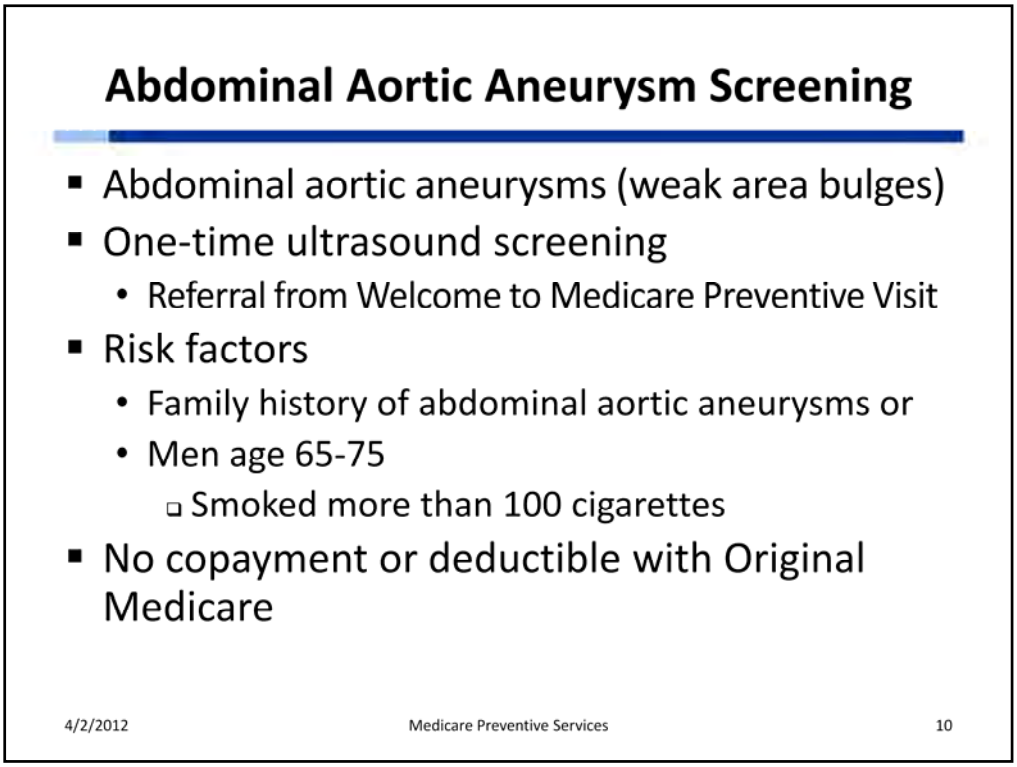
CMS does not identify specific alcohol misuse screening tools. Rather, the decision to use a specific tool is at the discretion of the clinician in the primary care setting. Various screening tools are available for screening for alcohol misuse.

CMS will cover annual alcohol screening, and for those that screen positive, up to four brief, 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); and

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.

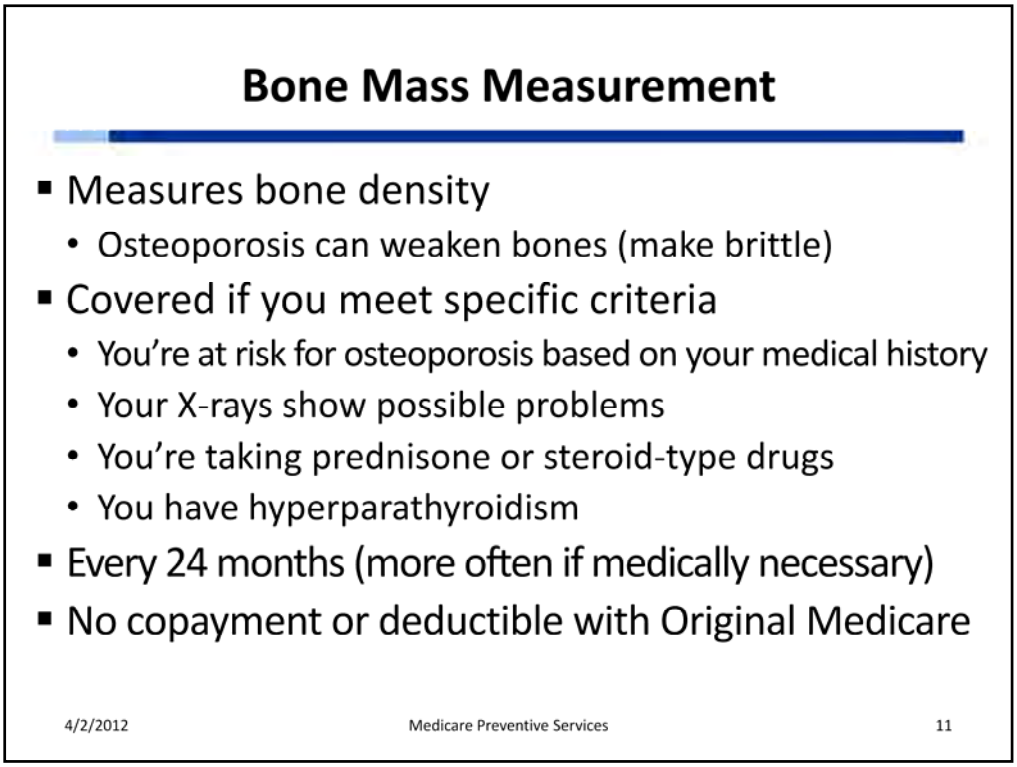
For a one-time screening ultrasound, you must get a referral at your "Welcome to Medicare" Preventive Visit.

You are considered at risk if you

Have a family history of abdominal aortic aneurysms, or

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.



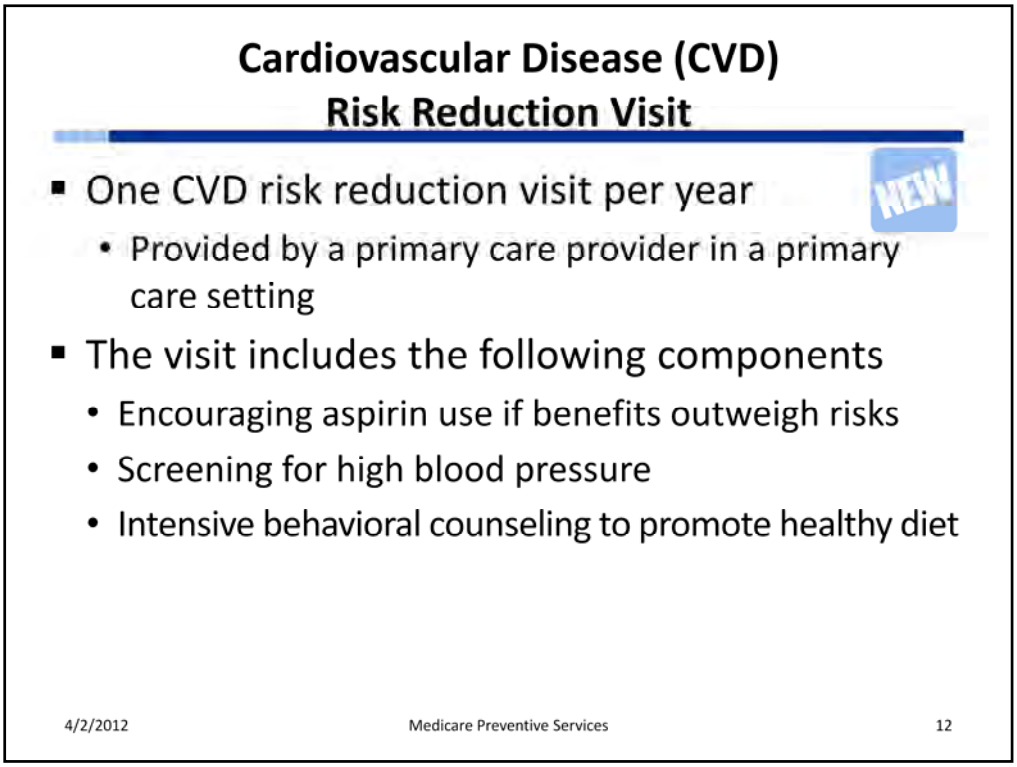
Medicare covers bone mass measurements to measure bone density. These test results help you and your doctor choose the best way to keep your bones strong.

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.



Effective November 8, 2011, CMS covers intensive behavioral therapy for cardiovascular disease (referred to as a CVD risk reduction visit).

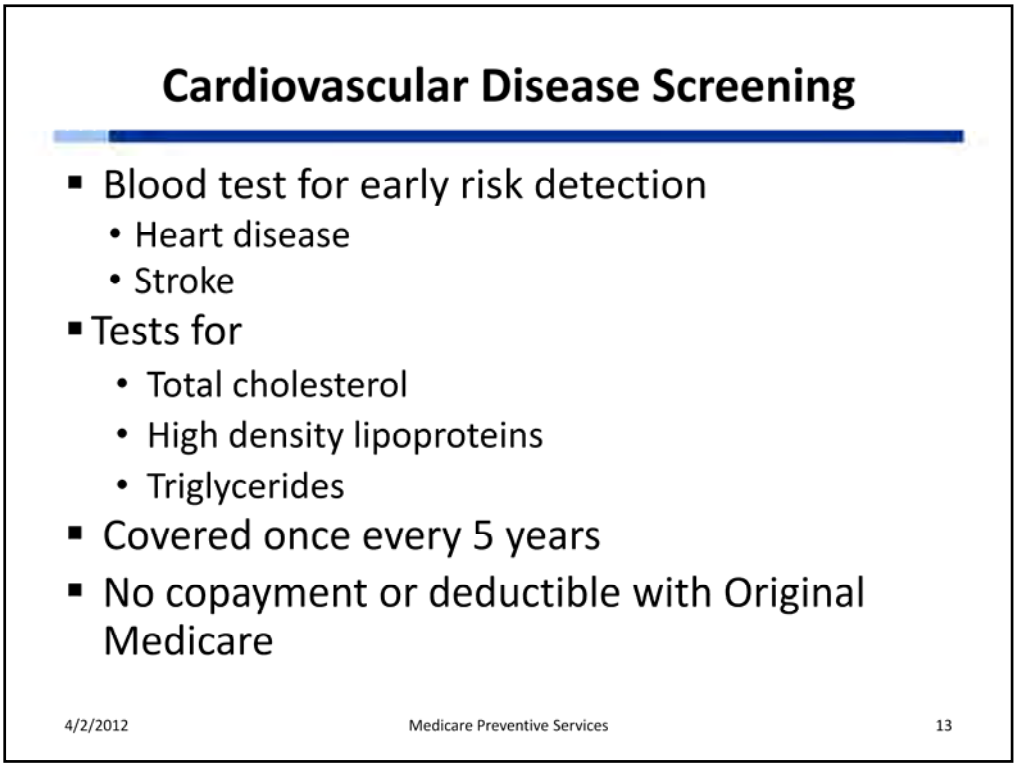
CMS covers one face-to-face CVD risk reduction visit per year for Medicare beneficiaries who are competent and alert at the time that counseling is provided; and whose counseling is furnished by a qualified primary care physician or other primary care practitioner in a primary care setting.

- A primary care setting is defined as the 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

- Encouraging aspirin use for the primary prevention of CVD when the benefits outweigh the risks for men age 45-79 ears and women 55-79 years;
- Screening for high blood pressure in adults age 18 years or older; and
- 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.

We note that 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.

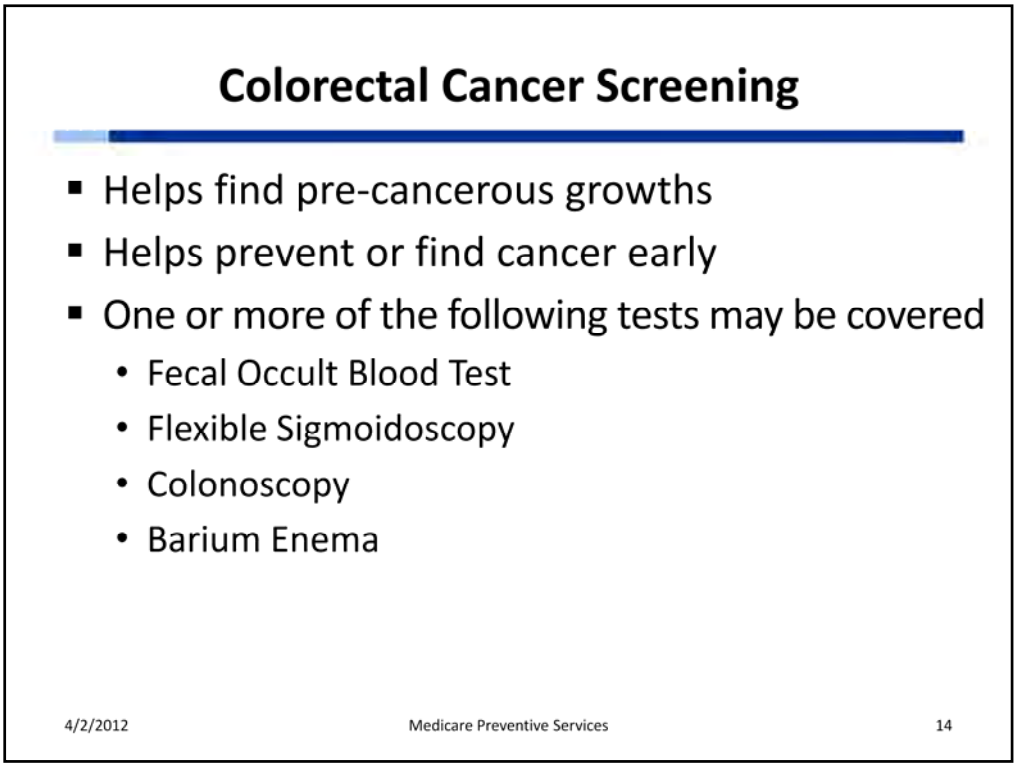


There are many different forms of heart disease. The most common cause of heart disease is narrowing or blockage of the coronary arteries, the blood vessels that supply blood to the heart itself, called coronary artery disease. This happens slowly over time and is the major reason people have heart attacks.

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.



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

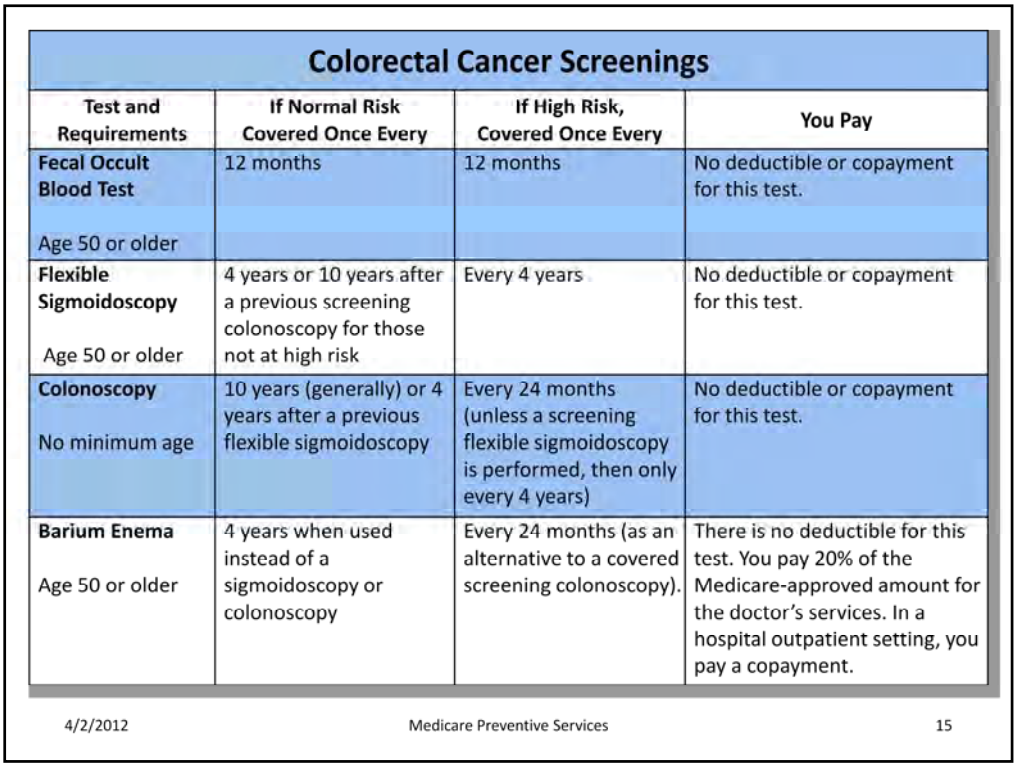
- Fecal Occult Blood Test
- Flexible Sigmoidoscopy
- Colonoscopy
- Barium Enema

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: If a polyp or other tissue is found and removed during the colonoscopy, you may have to pay 2-% of the Medicare-approved amount for the doctor's services and a copayment in a hospital outpatient setting.

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 Age 50 or older	12 months	12 months	No deductible or copayment for this test.
Flexible Sigmoidoscopy Age 50 or older	4 years or 10 years after a previous screening colonoscopy for those not at high risk	Every 4 years	No deductible or copayment for this test.
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.
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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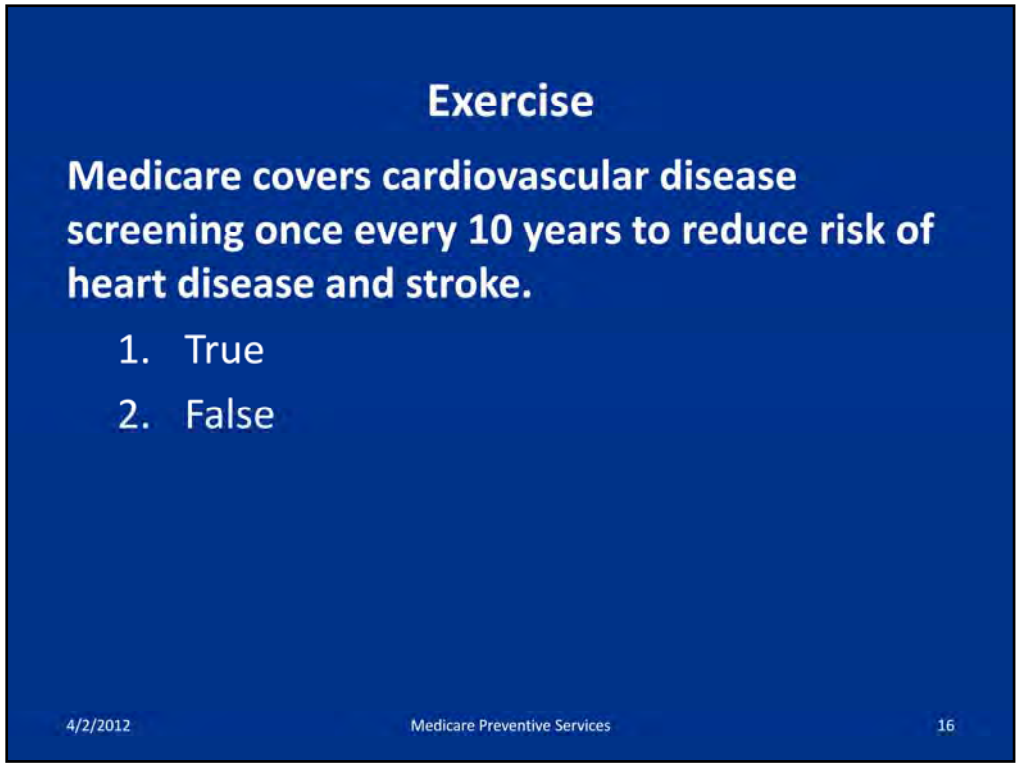
All Medicare beneficiaries age 50 and older who are **not** at high risk for colorectal cancer are covered for the following

- Fecal Occult Blood Test every year.
- Flexible Sigmoidoscopy once every 4 years (unless a screening colonoscopy has been performed and then Medicare may cover a screening sigmoidoscopy after at least 119 months).
- 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).
- 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.

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, the appropriate diagnostic procedure classified as a colonoscopy with biopsy or removal should be billed and paid rather than code G0105.

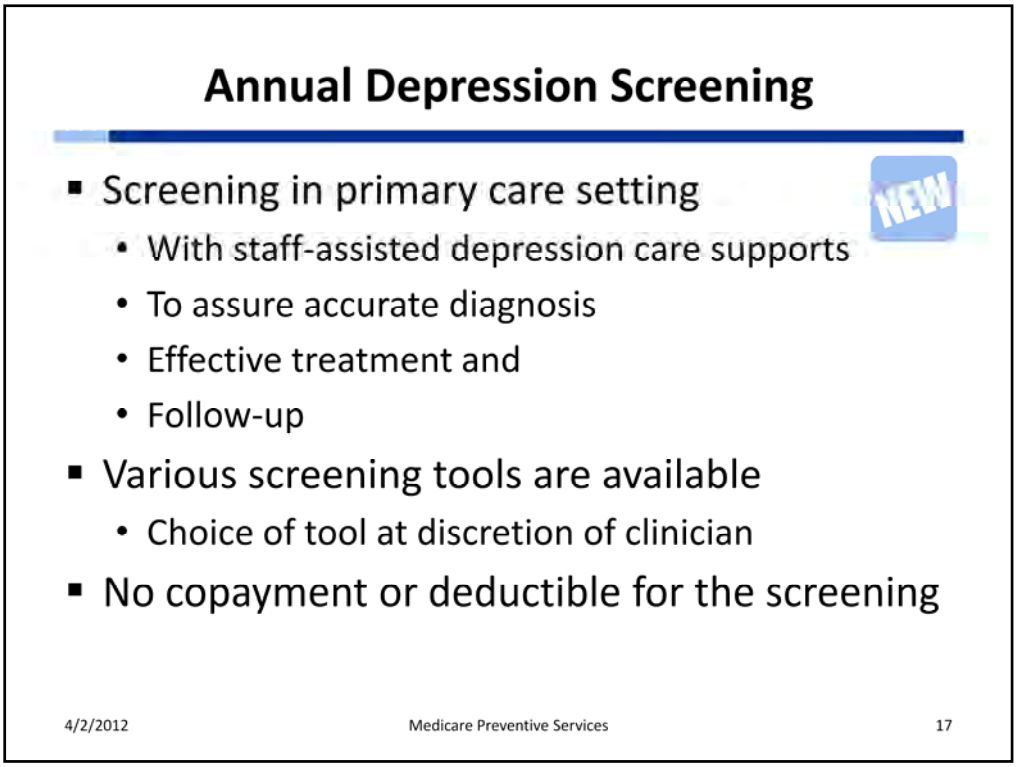


Exercise

Medicare covers cardiovascular disease screening once every ten years to reduce the risk of heart disease and stroke.

1. True
2. False

Answer: False. Medicare covers cardiovascular disease screening once every 5 years.



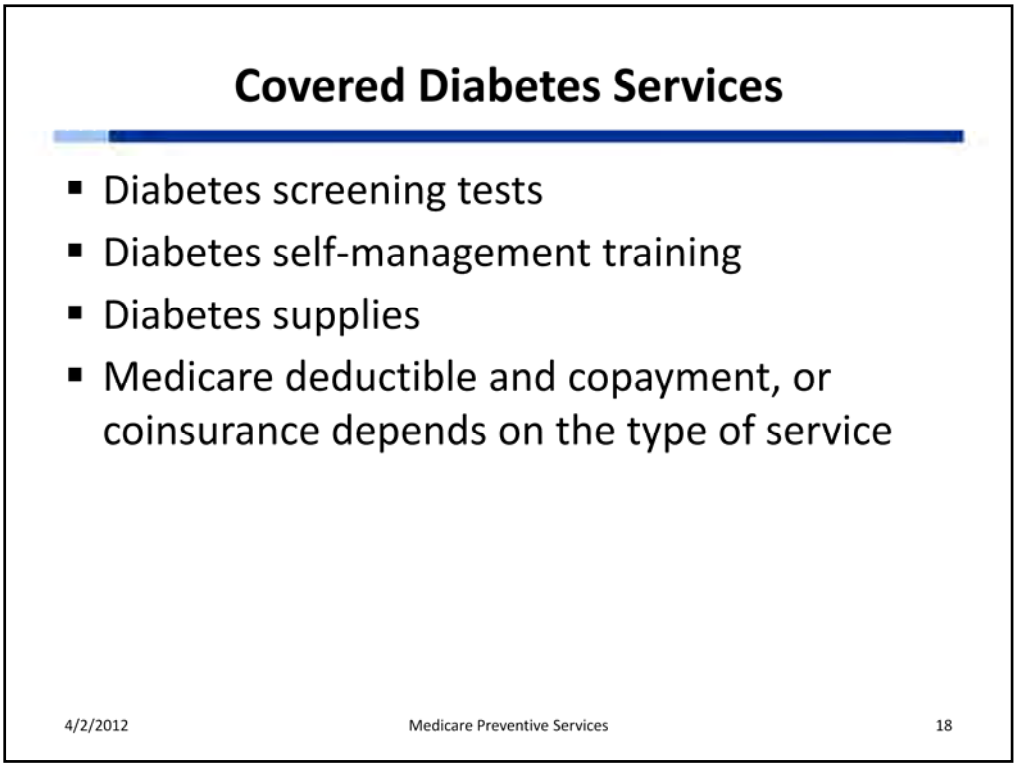
Effective October 14, 2011, CMS covers annual screening for depression for Medicare beneficiaries in primary care settings that have staff-assisted depression care supports in place to assure accurate diagnosis, effective treatment, and follow-up. Various screening tools are available for screening for 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. 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.



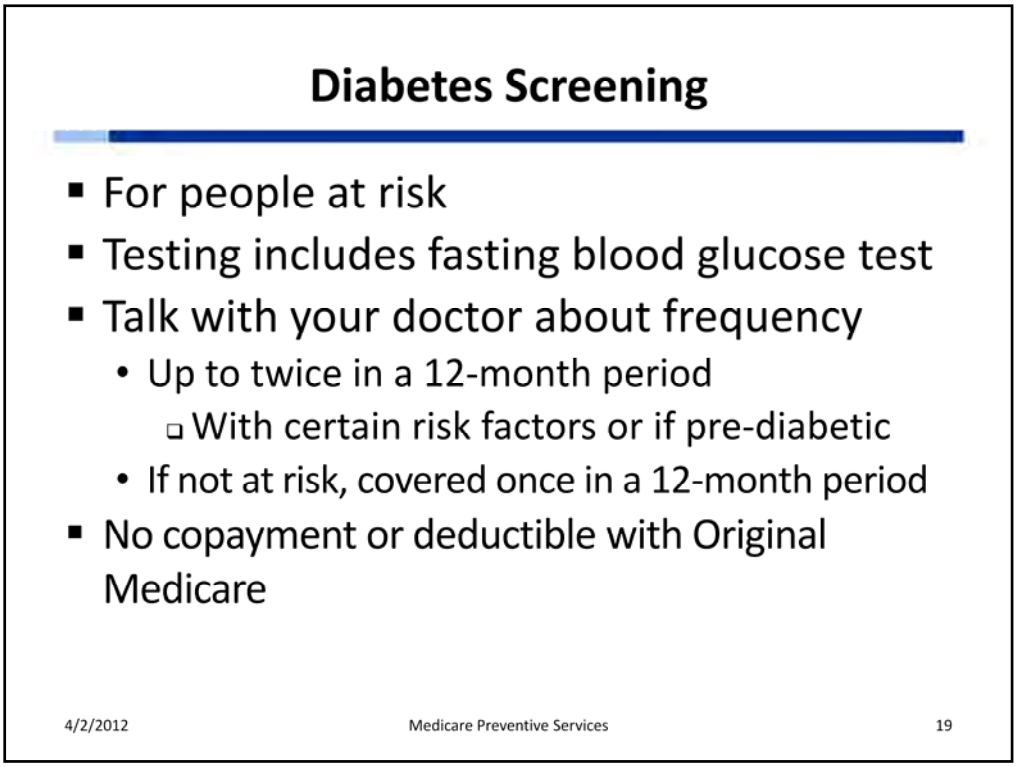
Diabetes is the leading cause of acquired blindness among adults, and the leading cause of end-stage renal disease.

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.

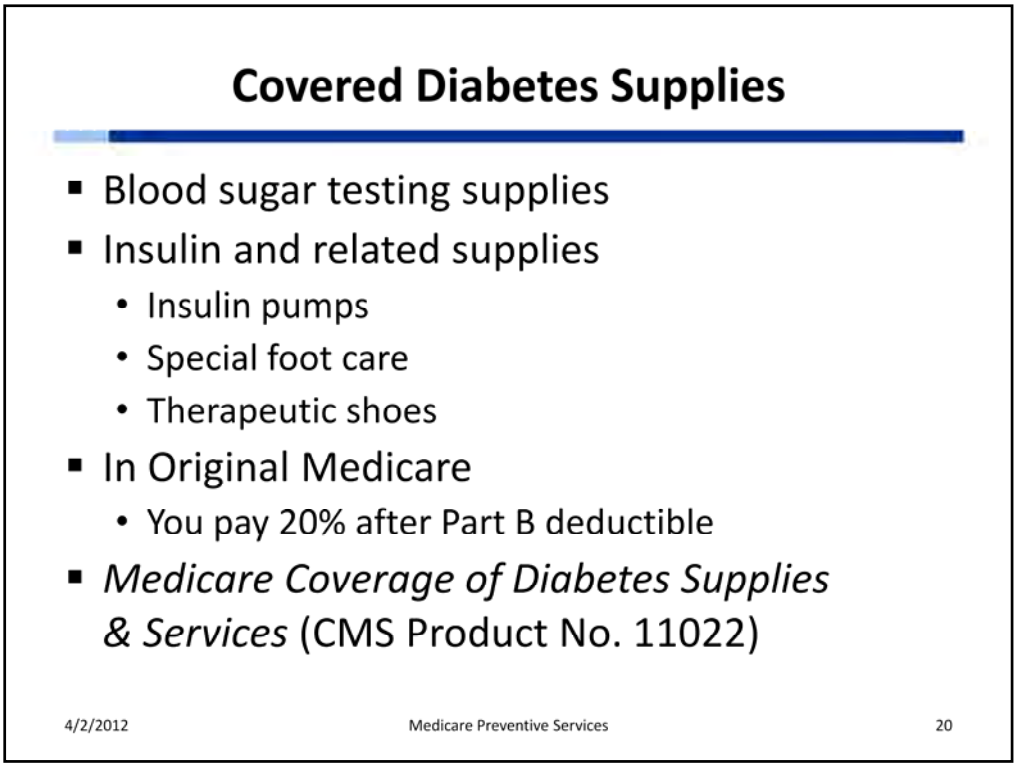
With Type 1 diabetes, your body does not make insulin. With Type 2 diabetes, the more common type of diabetes, your body does not make or use insulin well. Without enough insulin, the glucose stays in your blood.

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 de uctible for this benefit).



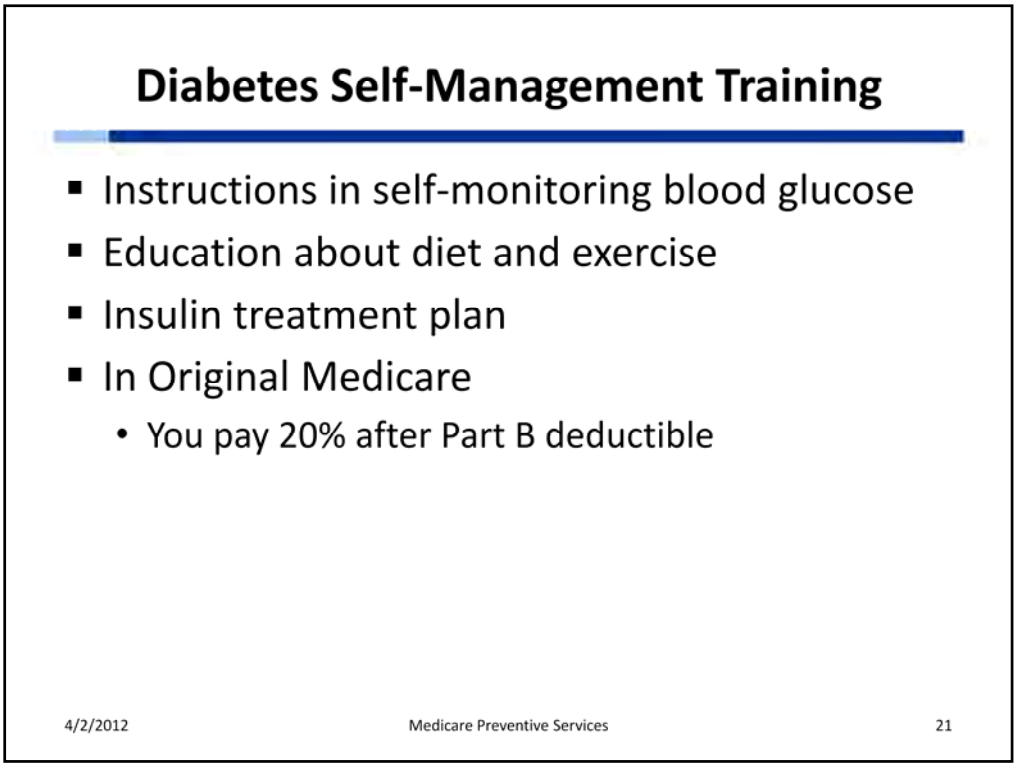
Medicare covers insulin pumps, special foot care, and therapeutic shoes for people with diabetes who need them.

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.

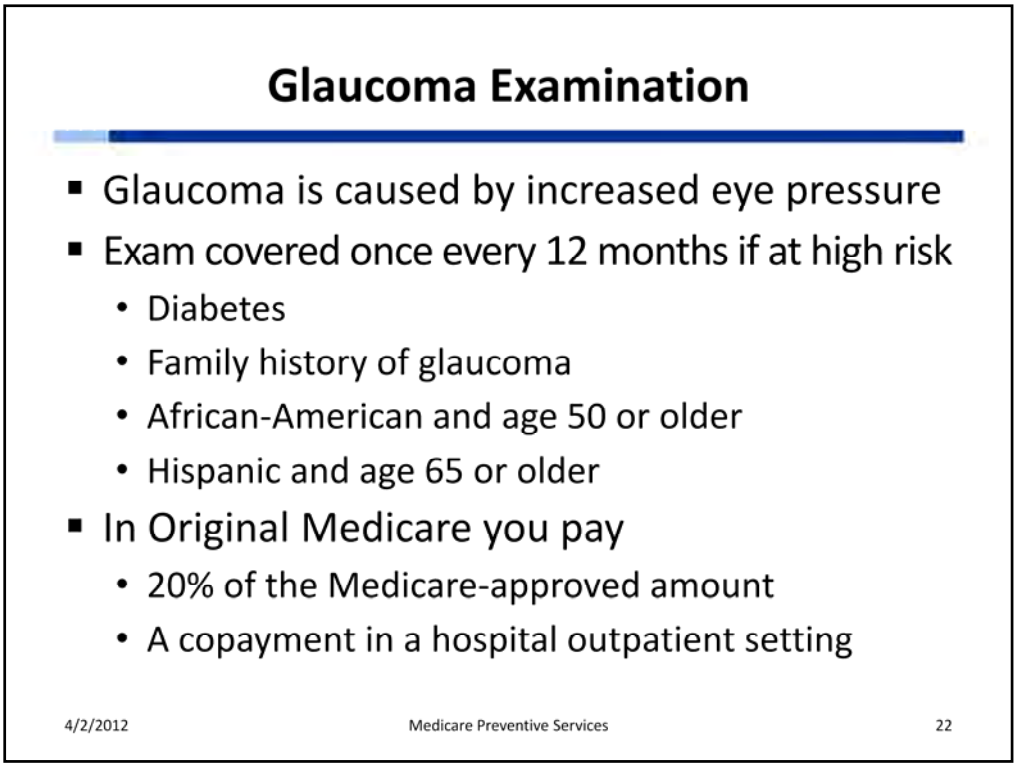
Each session lasts for at least 30 minutes and is provided in a group of 2 to 20 people.

- 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.

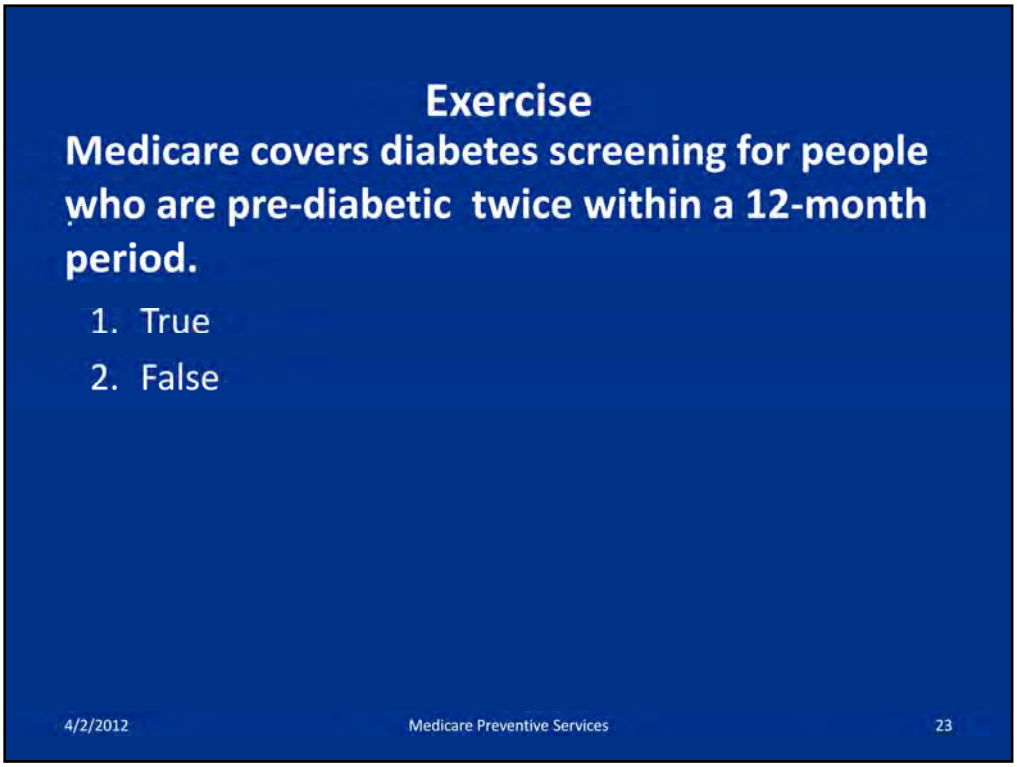
A glaucoma screening is an eye exam used to detect glaucoma.

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

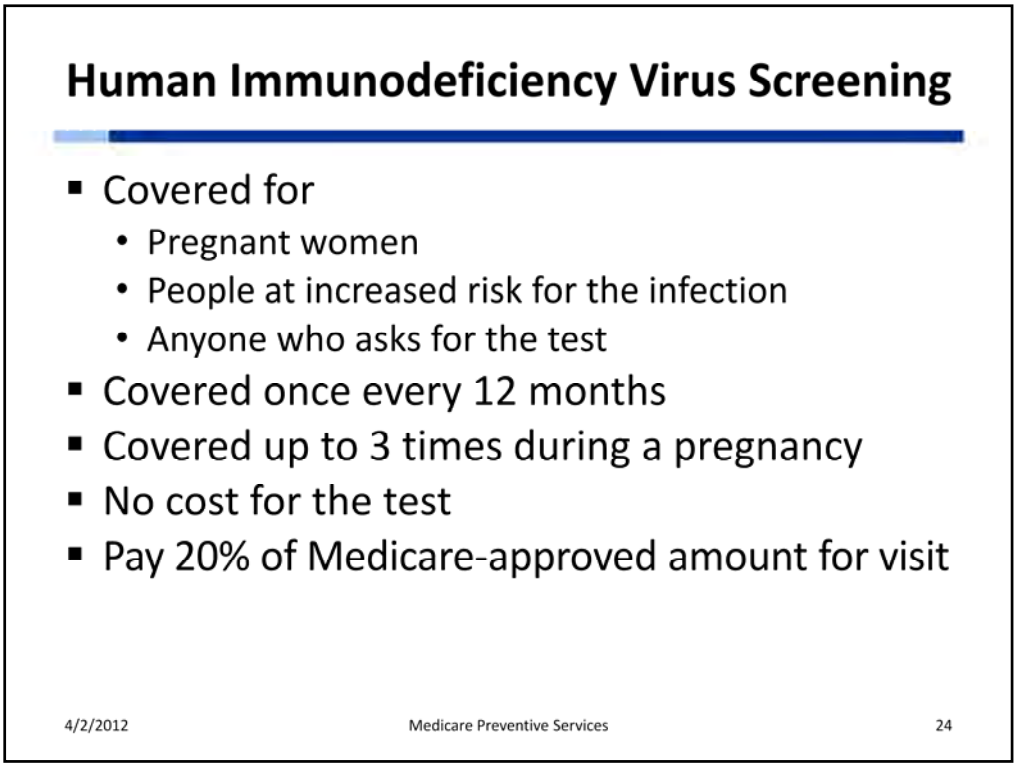
Medicare covers diabetes screening for people who are pre-diabetic twice within a 12-month period.

1. True

2. False

Answer: 1. True.

Medicare covers a diabetes screening for people with certain risk factors for diabetes or diagnosed with pre-diabetes twice within a 12-month period, but not less than 6 months apart. People without diabetes, who have not been diagnosed as pre-diabetic or who have never been tested, Medicare covers one diabetes screening test within a 12-month period.



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.

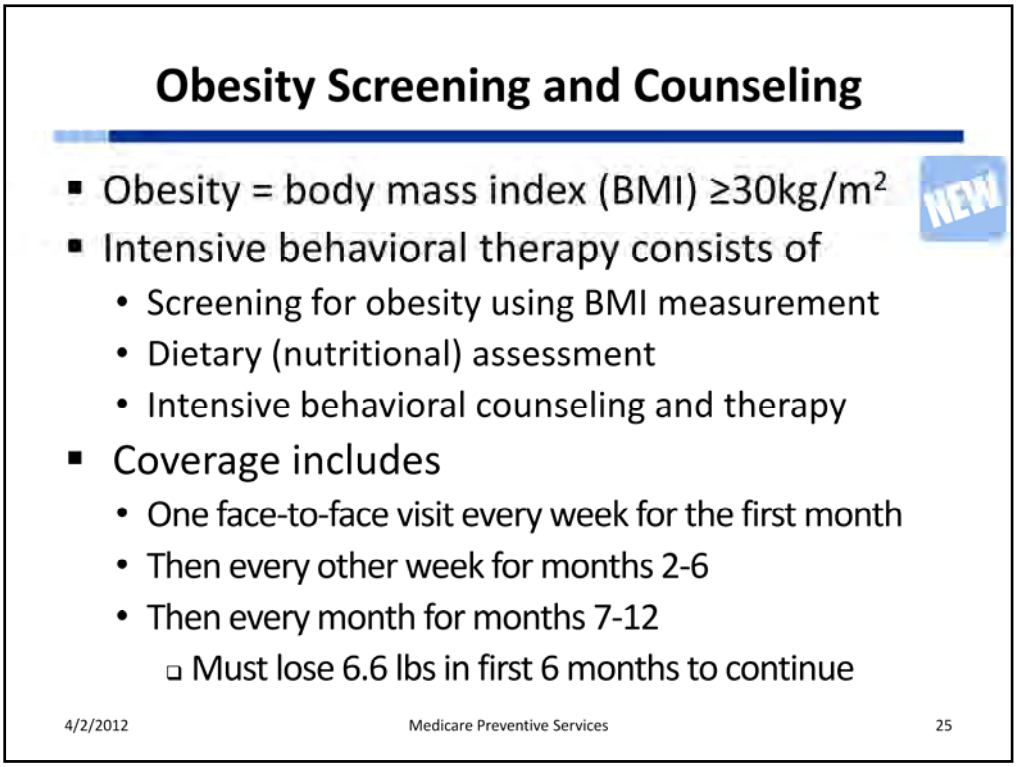
Medicare covers HIV screening for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test.

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.



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.

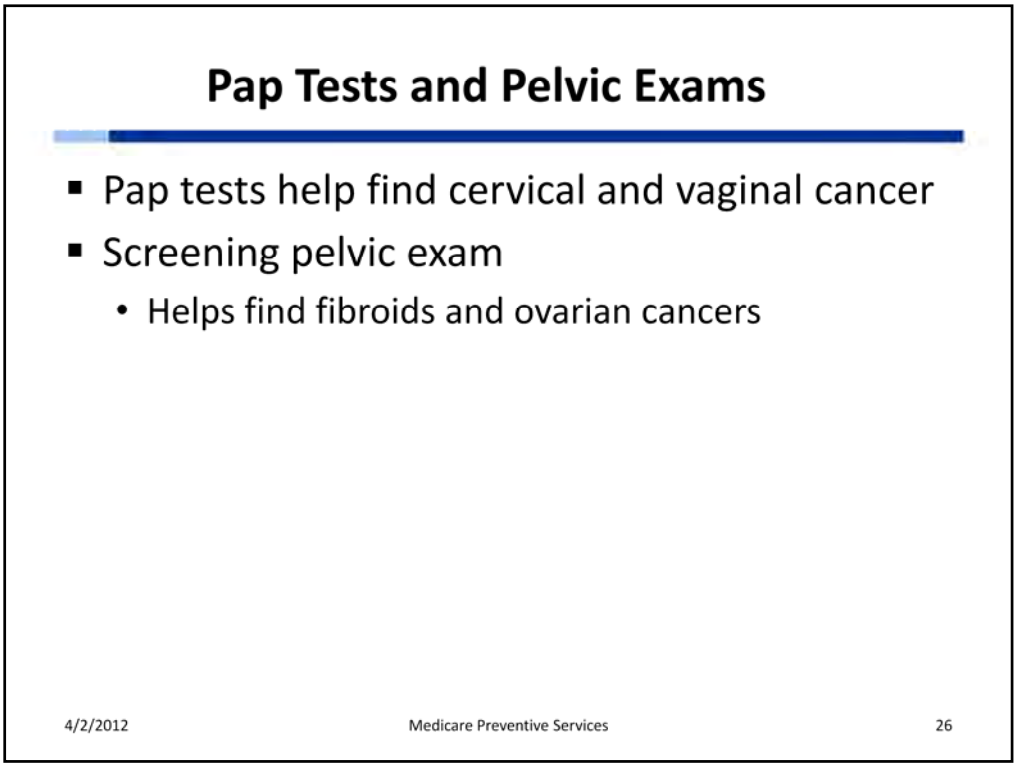
Intensive behavioral therapy for obesity consists of the following

- 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

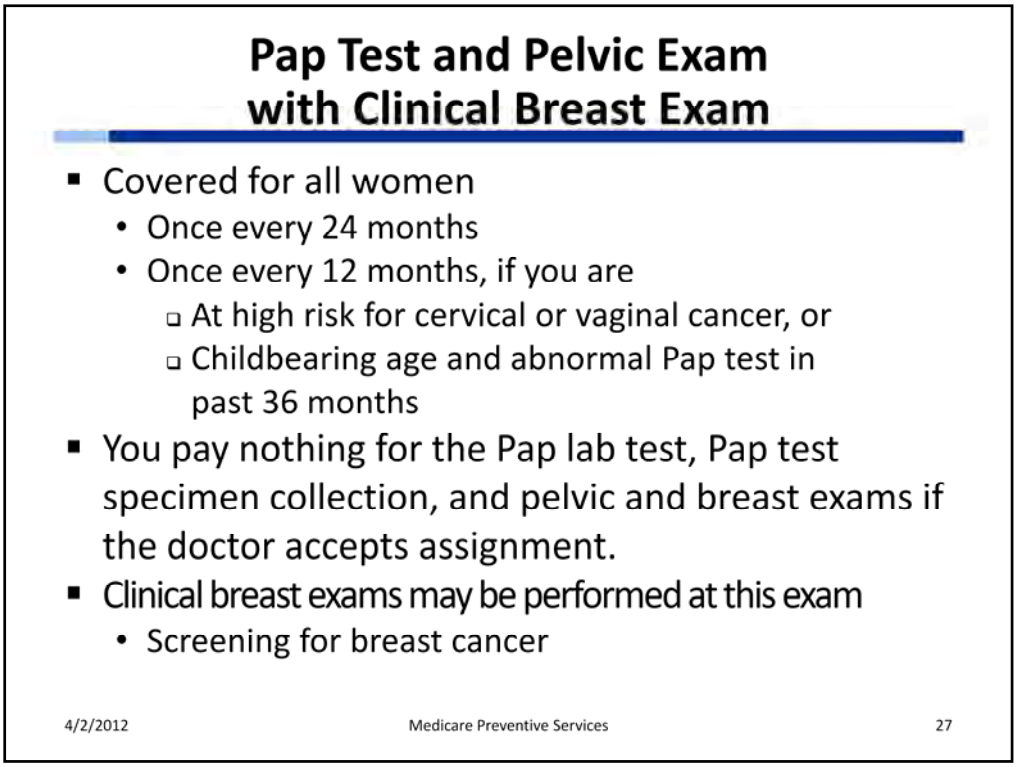
- requirement as discussed below. One face-to-face visit every week for the first month;
- One face-to-face visit every other week for months 2-6;
- One face-to-face visit every month for months 7-12, if the beneficiary meets the 3kg (6.6 lbs) weight loss

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.

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.

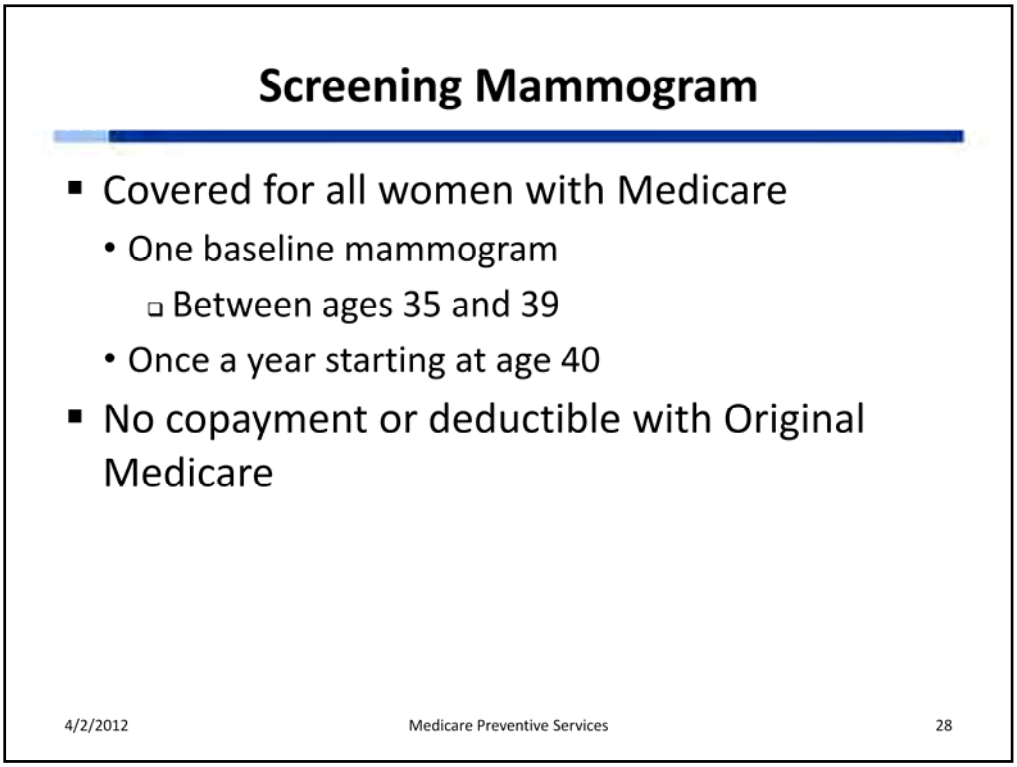
High risk factors for cervical or vaginal cancer are

- 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

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.

Additional information available on www.medicare.gov.



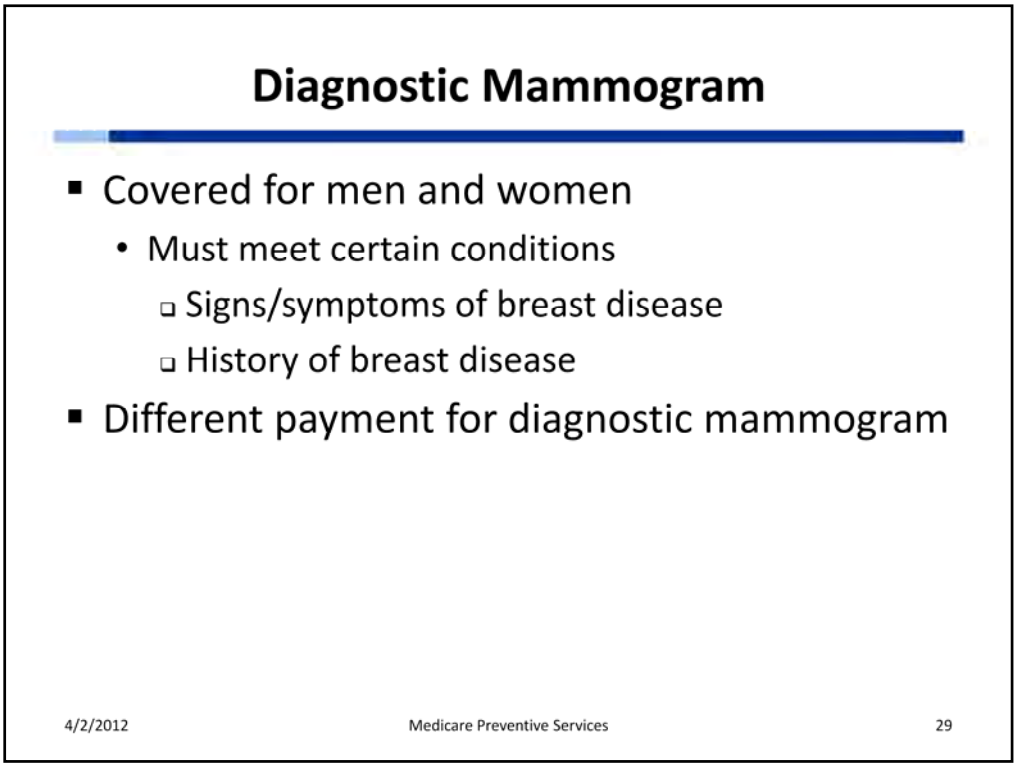
A screening mammogram is a mammogram of a woman with no signs or symptoms of breast disease. Finding small breast cancers early by a screening mammogram greatly improves a woman's chance for successful treatment.

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.

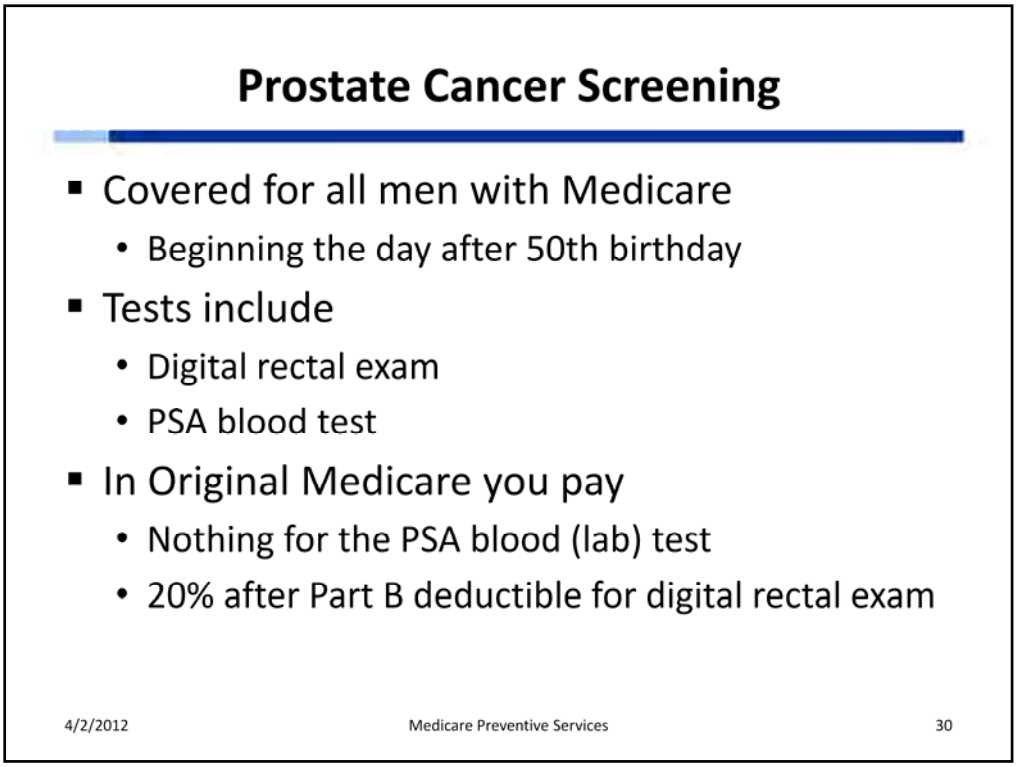


Medicare covers diagnostic mammograms. A diagnostic mammogram is covered by Medicare for both men and women whose doctor says that they have

- 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.



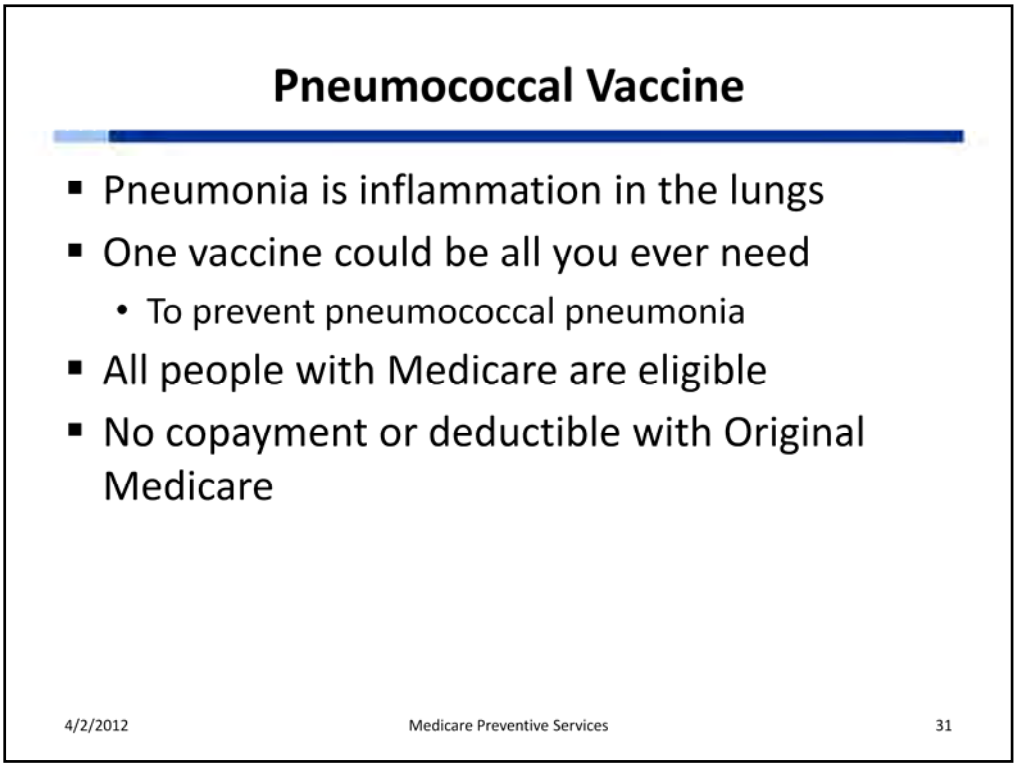
Medicare covers screenings for prostate cancer every 12 months for men age 50 and older.

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.



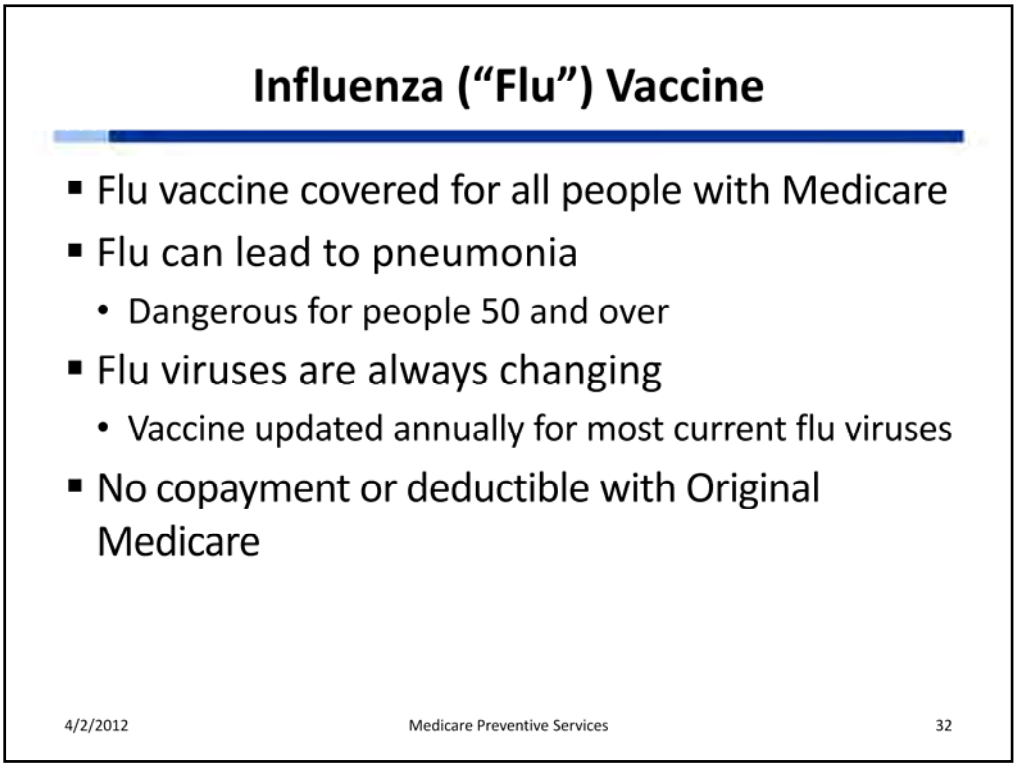
Medicare covers a pneumococcal vaccination to protect you from this type of pneumonia.

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 vaccine once in their lifetime. Medicare will cover additional vaccines 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 vaccine every year because flu viruses change. The vaccine is updated annually for the most current flu viruses.

All people with Medicare are eligible for this benefit.

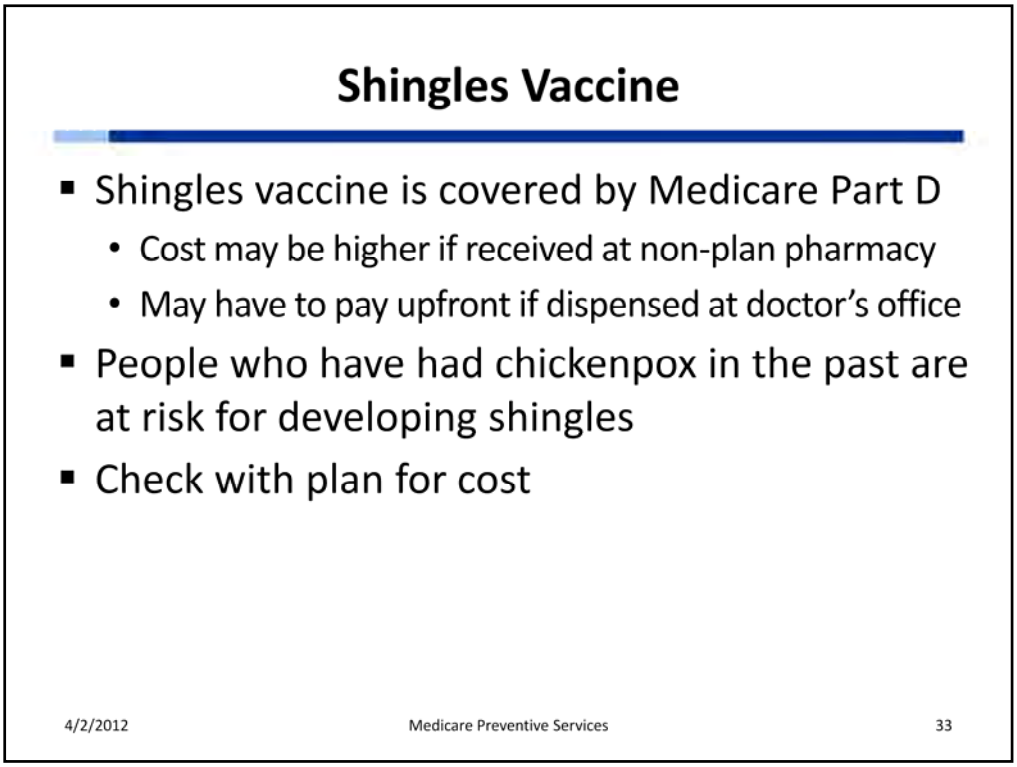
People should get a flu vaccine once each flu season, in the fall or winter.

The best time to get a flu vaccine 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 vaccine after November, even if the flu is present in your community. The vaccine is available any time during the flu season. Once you get a flu vaccine, your body makes protective antibodies in about 2 weeks.

In Original Medicare you generally pay nothing for a flu vaccine, 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 vaccine, and there may be a copayment for the office visit.

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



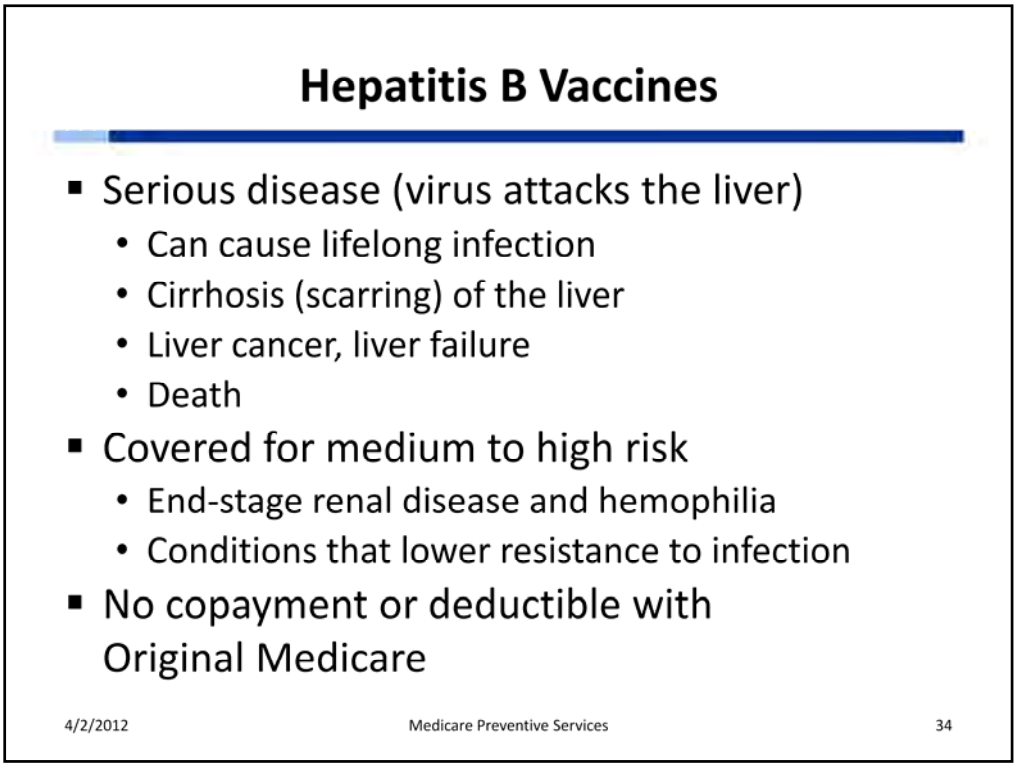
At this point, people often ask about the vaccine for shingles. The shingles vaccine is not covered as a preventive service.

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.

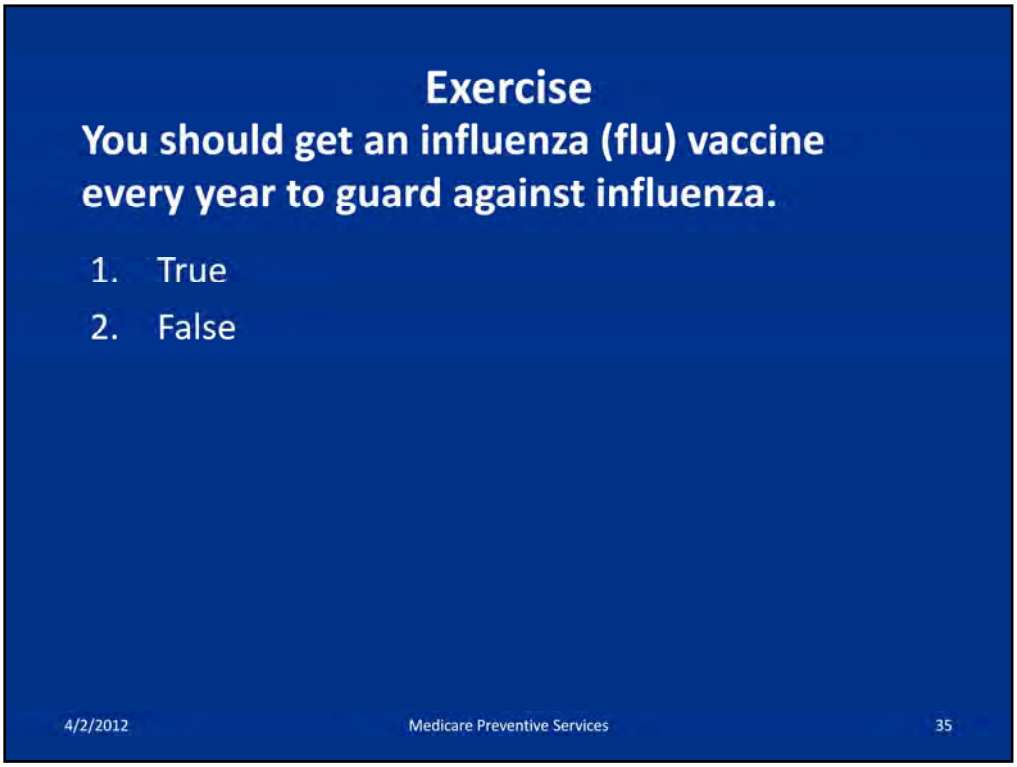
Questions about reimbursement from Medicare Part D plans should be directed to 1-800-MEDICARE.



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 vaccines are covered if you are at medium or high risk. Three vaccines 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.



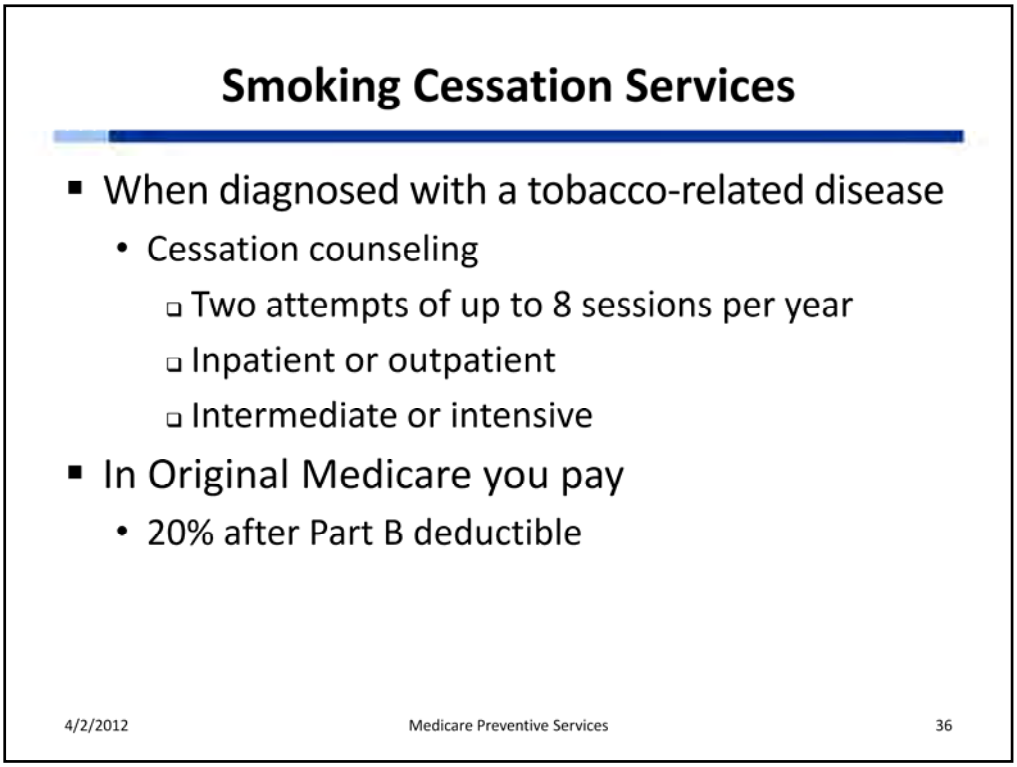
Exercise

You should get an influenza vaccine every year to guard against influenza.

1. True
2. False

Answer: 1. True.

You should get a flu vaccine every year to protect you from the flu virus, which changes from year to year. According to the Centers for Disease Control, it's 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.



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.

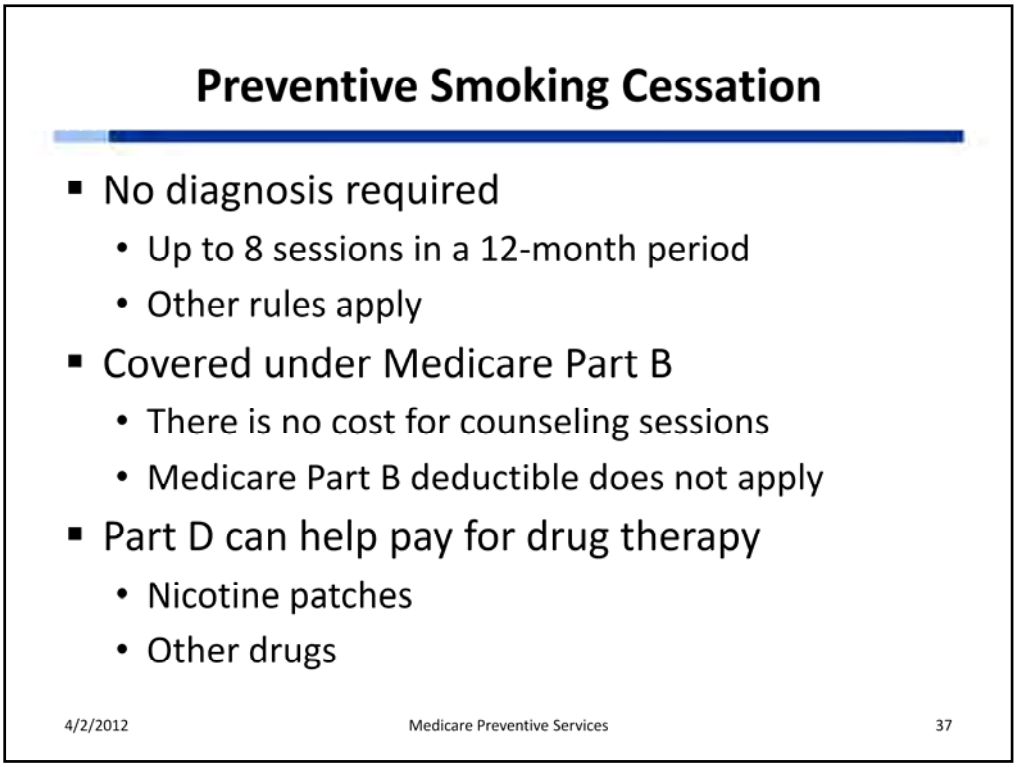
Medicare will cover two cessation attempts per year. Each attempt may include up to four counseling sessions, with the total annual benefit covering up to eight sessions in a 12-month period.

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 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.



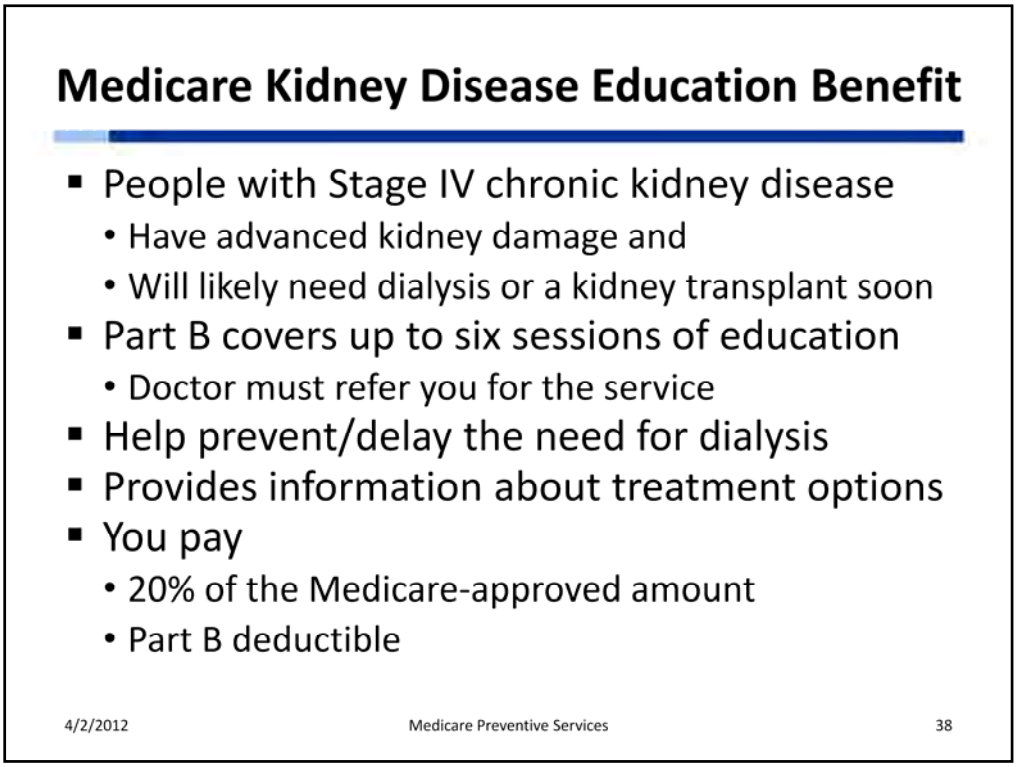
As of August 25, 2010, Medicare covers tobacco cessation counseling to prevent tobacco use for outpatient and hospitalized Medicare beneficiaries

- 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.

Part D can help pay for drug therapy

- Nicotine patches
- Other drugs

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.

Exercise

Which of the following Medicare Preventive Services are new?

1. Alcohol misuse screening, depression screening, diabetes screening
2. Alcohol misuse screening, depression screening, glaucoma examination
3. Alcohol misuse screening, depression screening, pneumococcal vaccine
4. Alcohol misuse screening, depression screening, obesity counseling

Answer 4

Alcohol misuse screening, depression screening and intensive obesity counseling are all new Medicare Preventive Services

Preventive Service	Who Is Covered	How Often It's Covered	Your Costs
Welcome to Medicare Preventive Visit This one-time visit 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 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 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.
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. If the screening is 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 (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 session of intensive behavioral therapy for cardiovascular disease 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: • Fecal Occult Blood Test • Flexible Sigmoidoscopy • Colonoscopy • Barium Enema	Men and women with Medicare age 50 and older who are at risk of developing colorectal cancer.	**Normal risk** **Fecal Occult Blood Test** Annually **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) **Barium Enema** (As an alternative to a covered screening flexible sigmoidoscopy). **High risk** **Fecal Occult Blood Test** Annually **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) **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, interventions, or complications or chronic conditions resulting from depression.	All people with Medicare	This service is usually covered once every 12 months.	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 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 certain services for people with diabetes to help them successfully manage the disease and help prevent its 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. 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.

Preventive Service	Who Is Covered	How Often It's Covered	Your Costs
Glaucoma Examination 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.
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	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.

Preventive Service	Who Is Covered	How Often It's Covered	Your Costs
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) $\geq$ 30 kb/m^2.	All people with Medicare may be screened for obesity. Counseling is covered for anyone found to have a BMI $\geq$ 30 kg/m^2.	Beneficiaries with BMIs $\geq$ 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 during months 1-6.	There is no cost if your doctor accepts Medicare assignment.
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.

Preventive Service	Who Is Covered	How Often It's Covered	Your Costs
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.
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.

Preventive Service	Who Is Covered	How Often It's Covered	Your Costs
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.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)

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)

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Order multiple copies (partners only) at http://productordering.cms.hhs.gov
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