

Module 7 – Medicare Preventive Services

Section Objectives

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

Lesson 1: Introduction

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

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

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

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

Paying for Preventive Services in 2017

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

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

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

Lesson 2: What Is Covered?

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| ▪ "Welcome to Medicare" preventive visit | ▪ Depression screening |
| ▪ Yearly "Wellness" visit | ▪ Diabetes screenings |
| ▪ Abdominal aortic aneurysm screening | ▪ Diabetes self-management training |
| ▪ Alcohol misuse screening and counseling | ▪ Flu shots (Vaccine) |
| ▪ Bone mass measurement | ▪ Glaucoma tests |
| ▪ Breast cancer screening (mammogram) | ▪ Hepatitis B shots (Vaccine) |
| ▪ Cardiovascular disease (CVD) Risk Reduction Visit | ▪ Hepatitis C screening test |
| ▪ Cardiovascular disease screenings | ▪ HIV screening |
| ▪ Cervical and vaginal cancer screening | ▪ Lung Cancer Screening |
| • Human Papillomavirus (HPV) Testing | ▪ Medical nutrition therapy services |
| ▪ Colorectal cancer screenings | ▪ Obesity screening and counseling |
| • Screening fecal occult blood test | ▪ Pneumococcal shots |
| • Screening flexible sigmoidoscopy | ▪ Prostate cancer screening |
| • Screening colonoscopy | ▪ Sexually-transmitted infection screening and counseling |
| • Screening barium enema | ▪ Smoking and tobacco-use cessation counseling |
| • Multi-target stool DNA test | |

"Welcome to Medicare" Preventive Visit

The "Welcome to Medicare" preventive visit, also called the "Initial Preventive Physical Examination (IPPE)", is a great way to get up-to-date information on important screenings and vaccines and to review your medical history. It's only offered one time within the first 12 months of getting Medicare Part B.

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

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

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

There is no cost if your doctor accepts Medicare assignment.

IMPORTANT: This service is a preventive visit and not a routine physical checkup. The “Welcome to Medicare” preventive visit doesn’t include any clinical lab tests.

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

Yearly “Wellness” Visit

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

You don’t need to get the “Welcome to Medicare” preventive visit before getting a yearly “Wellness” visit. If you got the “Welcome to Medicare” preventive visit, you’ll have to wait 12 months before you can get your first yearly “Wellness” visit.

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

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

IMPORTANT: The yearly “Wellness” visit’s a preventive wellness visit and **isn’t** a routine physical checkup.

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

Initial Yearly Wellness Visit Providing Personalized Prevention Plan Services

If you’ve had Part B for longer than 12 months, you can get a yearly “Wellness” visit to develop a personalized plan to help prevent disease or disability based on your current health and risk factors. This visit is covered once every 12 months.

Your health professional will ask you to answer some questions before your visit. This is called a health risk assessment. Your responses to the questions will help you and your health professional get the most from your initial “Wellness” visit and all subsequent yearly “Wellness” visits.

During the initial visit, your health care professional will

- Record your blood pressure, height, and weight measurements
- Review your potential risk factors for depression
- Review your functional ability and level of safety, which includes assessing your

- Hearing
- Ability to successfully perform activities of daily living (like walking, eating, etc.)
- Fall risk
- Home safety
- You'll also receive advice to help you prevent disease, improve your health, and stay well. You'll get a brief written plan, like a checklist, letting you know which screenings and other preventive services you'll need over the next 5 to 10 years.

Subsequent Yearly Wellness Visits

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

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

Abdominal Aortic Aneurysm Screening

Medicare Part B covers a one-time abdominal aortic aneurysm ultrasound. You must get a referral for it from your doctor.

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

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

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

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

- A family history of AAA
- You're a man 65 to 75 and have smoked at least 100 cigarettes in your lifetime
- You're a person with Medicare who has other risk factors in a category recommended for screening by the United States Preventive Services Task Force regarding AAA, as specified by the Secretary of Health and Human Services, through the national coverage determinations process.

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

For more information on risk factors, visit

[Healthfinder.gov/HealthTopics/Category/doctorvisits/screening-tests/talk-to-your-doctor-about-abdominal-aortic-aneurysm](https://www.healthfinder.gov/HealthTopics/Category/doctorvisits/screening-tests/talk-to-your-doctor-about-abdominal-aortic-aneurysm).

Alcohol Misuse Screening and Counseling

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

For those who screen positive, Medicare covers up to 4 brief (15-minute), face-to-face behavioral counseling interventions per year for people with Medicare (including pregnant women) who meet the following requirements:

- Misuse alcohol, but whose levels or patterns of alcohol consumption don't meet criteria for alcohol dependence (defined as at least 3 of the following: tolerance; withdrawal symptoms; impaired control; preoccupation with acquisition and/or use; persistent desire or unsuccessful efforts to quit; sustains social, occupational, or recreational disability; use continues despite adverse consequences)
- Are competent and alert at the time that counseling is provided
- Counseling is furnished by qualified primary care doctors or other primary care practitioners in a primary care setting

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

Bone Mass Measurement

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 are more likely to break. It's a silent disease, meaning that you may not know you have it until you break a bone.

Bone mass measurement is covered once every 24 months, or more often if medically necessary, you are at risk for osteoporosis or meet one or more of these conditions:

- Woman whose doctor or qualified health care provider determines she's estrogen-deficient and at risk for osteoporosis based on her medical history and other findings
- Individuals receiving (or expecting to receive) steroid therapy for more than 3 months
- Individuals with X-rays show possible osteoporosis, osteopenia, or vertebral abnormalities
- Individuals with primary hyperparathyroidism
- Individuals being monitored to assess their response to U.S. Food and Drug Administration–approved osteoporosis drug therapy

In Original Medicare, there's no deductible or copayment.

Resource: MedlinePlus www.medlineplus.gov/osteoporosis.html.

Breast Cancer Screening (Mammogram)

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

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

Medicare provides coverage of an annual screening mammogram for women with Medicare who are 40 and older. Medicare also provides coverage of one baseline screening mammogram for women ages 35 through 39. You don't need a doctor's referral, but the X-ray supplier will need to send your test results to a doctor.

In Original Medicare, there's no deductible or copayment if the doctor or qualified health care provider accepts assignment. Diagnostic mammograms are done to check for breast cancer in men and women after a lump or other sign of breast cancer is found, if you have a history of breast cancer, or if your doctor judges by your history and other significant factors that a mammogram is appropriate. The coinsurance or copayment and the Part B deductible applies for diagnostic mammograms.

Cardiovascular Disease (CVD) Risk Reduction Visit

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

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

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

The CVD risk reduction visit consists of these components:

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

Cardiovascular Disease Screening

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.

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

In Original Medicare, there's no cost if the provider accepts assignment.

Cervical and Vaginal Cancer Screening

Medicare covers Pap tests (Papanicolaou test), pelvic exams, and clinical breast exams.

- The screening Pap test covered by Medicare is a laboratory test that consists of a routine exfoliative cytology test provided for the purpose of early detection of cervical cancer. It includes collection of a sample of cervical cells and a physician's interpretation of the test.

- A screening pelvic examination is performed to help detect fibroids (benign tumors in women of childbearing age), pre-cancers, genital cancers, infections, sexually transmitted infections (STIs), other reproductive system abnormalities, and genital problems.
- In addition, a Medicare-covered screening pelvic examination includes a clinical breast examination, which can be used as a tool for detecting, preventing, and treating breast masses, lumps, and breast cancer.

Resource: vsearch.nlm.nih.gov/vivisimo/cgi-bin/querymeta?v%3Aproject=medlineplus&v%3Asources=medlineplusbundle&query=fibroids&_ga=1.225792538.1476407824.1481571855

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

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

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

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

Part B also covers human papillomavirus (HPV) tests (as part of Pap tests) once every 5 years if you're age 30–65 without HPV symptoms.

In Original Medicare, there's no cost if provider accepts assignment.

Colorectal Cancer Screening

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

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

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

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

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

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

Screening Test	If Normal Risk Covered Once Every	If High Risk, Covered Once Every	You Pay
Screening Fecal Occult Blood Test 50 or older	12 months	12 months	No deductible or copayment for this test
Screening Flexible Sigmoidoscopy 50 or older	4 years, or 10 years after a previous screening colonoscopy	4 years	No deductible or copayment for this test
Screening Colonoscopy No minimum age	10 years (generally) or 4 years after a previous flexible sigmoidoscopy	24 months (unless a screening flexible sigmoidoscopy is performed, then only every 4 years)	No deductible or copayment for this test

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Screening Barium Enema 50 or older	4 years when used instead of a sigmoidoscopy or colonoscopy	24 months (as an alternative to a covered screening colonoscopy)	There is no deductible for this test. You pay 20% of the Medicare-approved amount for the doctor's services. In a hospital outpatient setting, you pay a copayment.
Multi-target Stool DNA test (Cologuard™)	3 years	3 years	There is no deductible or copayment for this test.

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Depression Screening

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

Various screening tools are available for screening for depression. CMS doesn't identify specific depression screening tools. Rather, the decision to use a specific tool is at the discretion of the clinician in the primary care setting.

Coverage is limited to screening services and doesn't include treatment options for depression or any diseases, complications, or chronic conditions resulting from depression. Furthermore, the depression screening doesn't address therapeutic interventions such as pharmacotherapy (treatment with drugs), combination therapy (counseling and medications), or other interventions for depression.

Among people older than 65, one in 6 suffers from depression. Depression in older adults is estimated to occur in 25% of those with other illness including cancer, arthritis, stroke, chronic lung disease, and cardiovascular disease. Other stressful events, such as the loss of friends and loved ones, are also risk factors for depression. Opportunities are missed to improve health outcomes when mental illness is under-recognized and under-treated in primary care settings.

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

You pay nothing for this test if the doctor or other qualified health care provider accepts assignment. If you get the depression screening and another service, you may need to pay 20% of the Medicare-approved amount for the other service and the Part B deductible may apply.

Diabetes Screening

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

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

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

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

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

Talk with your doctor about how often you should get tested. For people with pre-diabetes, Medicare covers a maximum of 2 diabetes screening tests within a 12-month period (but not less than 6 months apart). For people without diabetes, who've not been diagnosed as pre-diabetic or who've never been tested, Medicare covers one diabetes screening test within a 12-month period. A normal fasting blood sugar level is 100 mg/dL. Diabetes diagnosis occurs at 126 mg/dL, and a person with blood sugar readings between 101-125 mg/dL is considered pre-diabetic.

Medicare provides coverage for diabetes screenings as a Medicare Part B benefit after a referral from a doctor or qualified non-doctor practitioner for an individual at risk for diabetes. You pay nothing for this screening if the provider accepts assignment.

Covered Diabetes Supplies

Medicare Part B covers some diabetes supplies, including 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 pump is covered under Medicare prescription drug coverage (Part D).

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

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

Continuous glucose monitors (CGMs) monitor a patient's glucose level on a continuous basis (for example, every 5 minutes). Some therapeutic CGMs approved by the FDA are considered DME if used to replace a blood glucose monitor for use in making diabetes treatment decisions. For more information see CMS Ruling-1682-R dated January 12, 2017, at [CMS.gov/Regulations-and-Guidance/Guidance/Rulings/Downloads/CMS1682R.pdf](https://www.cms.gov/Regulations-and-Guidance/Guidance/Rulings/Downloads/CMS1682R.pdf).

For more information, please review Medicare Coverage of Diabetes Supplies & Services (CMS Product No. 11022) at [Medicare.gov/Pubs/pdf/11022.pdf](https://www.Medicare.gov/Pubs/pdf/11022.pdf).

Covered Diabetes Services

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

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

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

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

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

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

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

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

Flu Shot (Influenza) Vaccine

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

Medicare Part B provides coverage of one seasonal flu shot per flu season for all people with Medicare. This may mean that people with Medicare may receive more than one seasonal flu shot in a 12-month period. Medicare may provide coverage for more than one seasonal flu shot per flu season if a doctor determines, and documents in your medical record, that the additional shot is reasonable and medically necessary. For example, if someone gets a flu shot late in the flu season in January 2017, he or she will also be covered if he or she receives a shot in October, November, or December of 2017, because that is the start of a new flu season.

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

Glaucoma Test

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

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

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

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

NOTE: Medicare doesn't provide coverage for routine eye refractions.

Hepatitis B Shots (Vaccine)

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

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

High-risk groups currently identified include the following:

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

Intermediate risk groups currently identified include the following:

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

People with Original Medicare don't pay a copayment or deductible for this vaccine if their providers accept assignment.

Hepatitis C Screening Test

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

This screening is covered when ordered by the primary care practitioner within the context of a primary care setting for people with Medicare who meet either of the following conditions:

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

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

Human Immunodeficiency Virus (HIV) Screening

Human immunodeficiency virus (HIV) is the virus that causes AIDS. HIV attacks the immune system by destroying a type of white blood cell that is vital to fighting off infection. Once infected, it may take years for recognizable illness to develop. Thus a person may be infected with HIV for years before the condition is suspected.

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

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

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

For people with Medicare who are pregnant, up to 3 voluntary screenings during a pregnancy are covered. There's no cost for the test, but you generally have to pay 20% of the Medicare-approved amount for the doctor's visit.

Lung Cancer Screening

Medicare covers lung cancer screening with low dose computed tomography (x-ray machine scans the body and uses low doses of radiation to make detailed pictures of the lungs) once per year for people with Medicare who meet all of these criteria:

- Are 55-77,
- Are either a current smoker or have quit smoking within the last 15 years,

- Have a tobacco smoking history of at least 30 “pack years” (an average of one pack a day for 30 years), and
- Get a written order from their doctor or qualified non-doctor practitioner
 - Before your first lung cancer screening, you’ll need to schedule an appointment with your doctor to discuss the benefits and risks of lung cancer screening. You and your doctor can decide whether lung cancer screening is right for you.

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

Resource: [cdc.gov/cancer/lung/basic_info/screening.htm](https://www.cdc.gov/cancer/lung/basic_info/screening.htm)

Medical Nutrition Therapy Services

Medicare Part B covers medical nutrition therapy (MNT) services and certain related services. A registered dietician or nutrition professional who meets certain requirements can provide these services, which may include an initial nutrition and lifestyle assessment, one-on-one nutritional counseling, and follow-up visits to check on your progress in managing your diet.

If you’re in a rural area, a registered dietician or other nutritional professional in a different location may be able to provide MNT to you through telehealth. If you get dialysis in a dialysis facility, Medicare covers MNT as part of your overall dialysis care.

People with Part B who meet at least one of these conditions are eligible:

- Have diabetes
- Have kidney disease
- Have had a kidney transplant in the last 36 months

People with Part B must get a referral from their doctor or qualified non-doctor practitioner for the service. You pay nothing for these services if the doctor or other health care professional accepts assignment.

Obesity Screening and Counseling

Clinical evidence indicates that intensive behavioral therapy for obesity, defined as a body mass index (BMI) ≥ 30 kg/m², is reasonable and necessary for the prevention or early detection of illness or disability. It’s appropriate for individuals entitled to benefits under Part A or enrolled under Part B. Medicare may cover up to 22 face-to-face intensive counseling sessions over a 12-month period.

Intensive behavioral therapy for obesity consists of the following:

- Screening for obesity in adults using measurement of BMI calculated by dividing weight in kilograms by the square of height in meters (expressed in kg/m²)
- Dietary (nutritional) assessment

- Intensive behavioral counseling and behavioral therapy to promote sustained weight loss through high-intensity interventions of diet and exercise

For people with Medicare with obesity, who are competent and alert at the time that counseling is provided, and whose counseling is furnished by a qualified primary care doctor or other primary care practitioner in a primary care setting, Medicare covers one face-to-face visit every

- Week for the first month
- Other week for months 2-6
- Month for months 7-12, if the beneficiary meets the 3 kg (6.6 lbs.) weight loss requirement as discussed below

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

Pneumococcal Shots

Medicare covers the following:

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

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

Medicare doesn't require that a doctor of medicine or osteopathy order the vaccines; therefore, people with Medicare may receive the vaccine upon request without a doctor's order and without doctor supervision. Medicare Part B covers these vaccines. You pay no coinsurance and no Part B deductible in Original Medicare for the vaccine if your health care provider accepts assignment.

Prostate Cancer Screening

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

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

Medicare provides coverage of prostate cancer screening tests/procedures for the early detection of prostate cancer once every 12 months for all men with Medicare 50 and older (coverage begins the day after their 50th birthday). The 2 most common screenings used by doctors to detect prostate cancer are the screening prostate-specific antigen (PSA) blood test and the screening digital rectal examination.

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

Sexually Transmitted Infections (STI) Screening and Counseling

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

Medicare covers up to 2 individual 20- to 30-minute, face-to-face, high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. Medicare will only cover these counseling sessions if they're provided by a primary care doctor or other practitioner, and take place in a primary care setting (like a doctor's office). Counseling conducted in an inpatient setting, like a skilled nursing facility, won't be covered as a preventive service. You pay nothing for these services if the primary care doctor or other qualified primary care practitioner accepts assignment.

Smoking and Tobacco-Use Cessation Counseling

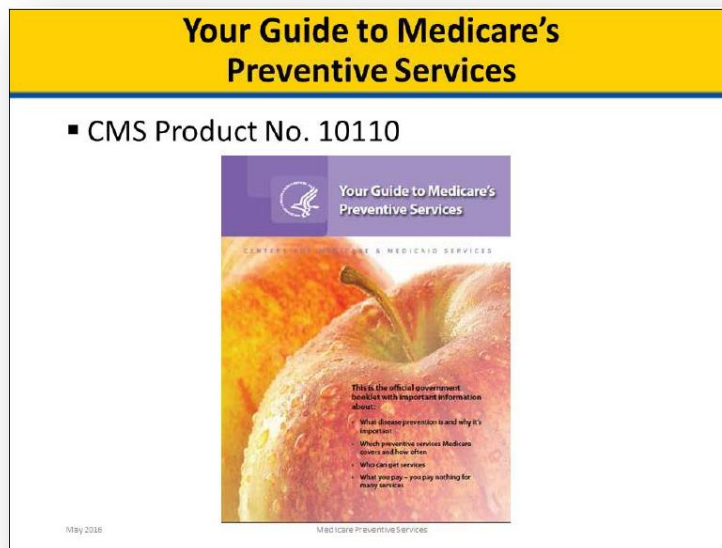
Tobacco use continues to be the leading cause of preventable disease and death in the United States. Smoking can contribute to and worsen heart disease, stroke, lung disease, cancer, diabetes, hypertension, osteoporosis, macular degeneration, abdominal aortic aneurysms, and cataracts. Smoking harms nearly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

Medicare covers counseling to prevent tobacco use for outpatient and hospitalized people with Medicare

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

Medicare will cover 2 cessation attempts per year. Each attempt may include up to 4 counseling sessions, with the total annual benefit covering up to 8 sessions in a 12-month period. Tobacco cessation counseling services can be provided in the hospital, or on an outpatient basis. However, tobacco cessation counseling services aren't covered if the primary reason for the hospital stay is tobacco cessation. You must get counseling from a qualified Medicare provider (doctor, doctor's assistant, nurse practitioner, clinical nurse specialist, or clinical psychologist).

Both the copayment and deductible are waived if the counseling sessions are furnished by a doctor or other health care provider who accepts assignment. A copayment may apply in a hospital outpatient setting. Medicare's Part D prescription drug benefit also covers smoking and tobacco-use cessation agents prescribed by a doctor.



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

Preventive Services Checklist

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

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

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

CMS Product No. 11420

May 2016 Medicare Preventive Services

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

Medicare Learning Network on CMS.gov

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Preventive services topics and educational products for health care professionals including coverage, coding, billing, reimbursement, and claim filing information is located in the Medicare Learning Network.

August 2017 Preventive Services

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

2017 Module 7: Medicare Preventive Services

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Preventive Services Resource Guide

Resources	Medicare Products
<p>Centers for Medicare & Medicaid Services (CMS)</p> <ul style="list-style-type: none"> • Call 1-800-MEDICARE (1-800-633-4227). TTY: 1-877-486-2048. • Medicare.gov • CMS.gov <p>State Health Insurance Assistance Programs and State Insurance Departments</p>  <ul style="list-style-type: none"> • shiptacenter.org/ <p>Centers for Disease Control and Prevention</p> <ul style="list-style-type: none"> • CDC.gov <p>Flu Information</p> <ul style="list-style-type: none"> • FLU.gov <p>Medline Plus</p> <ul style="list-style-type: none"> • nlm.nih.gov/medlineplus 	<ol style="list-style-type: none"> 1. "Medicare & You Handbook" (CMS Product No. 10050) 2. "Your Guide to Medicare's Preventive Services" (CMS Product No. 10110) 3. "Medicare Coverage of Diabetes Supplies & Services" (CMS Product No. 11022) 4. "Welcome to Medicare Q&A – Preventive Services" (CMS Product No. 11532) 5. "Staying Healthy" (CMS Product No. 11100) 6. "6 Things You Should Know" (CMS Product No. 11533) <p>To access these products:</p> <ul style="list-style-type: none"> • View and order single copies at Medicare.gov/publications. • Order multiple copies (partners only) at Productordering.cms.hhs.gov. You must register your organization.
<p>National Cancer Institute</p> <ul style="list-style-type: none"> • Call 1-800-4-CANCER. TTY: 1-800-332-8615 • cancer.gov <p>American Cancer Society</p> <ul style="list-style-type: none"> • Call 1-800-ACS-2345 (1-800-227-2345). • cancer.org <p>American Diabetes Association</p> <ul style="list-style-type: none"> • Call 1-800-DIABETES (1-800-342-2383). • diabetes.org/ <p>American Lung Association</p> <ul style="list-style-type: none"> • Call 202-785-3355. • lungusa.org <p>National Kidney Foundation</p> <ul style="list-style-type: none"> • Call 1-800-622-9010. • kidney.org 	

Acronyms

- **AAA** Abdominal Aortic Aneurysm
- **BMI** Body mass index
- **CHIP** Children's Health Insurance Program
- **CMS** Centers for Medicare & Medicaid Services
- **CVD** Cardiovascular disease
- **DES** Diethylstilbestrol
- **HBV** Hepatitis B Virus
- **HCV** Hepatitis C Virus
- **HIV** Human Immunodeficiency Virus
- **HPV** Human Papillomavirus
- **MA** Medicare Advantage
- **MNT** Medical Nutrition Therapy
- **NTP** National Training Program
- **PSA** Prostate-specific antigen
- **STI** Sexually transmitted infections

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