

Preventing Chronic Conditions: Accessing Medicare's Preventive Benefits

The frequency of chronic diseases in the U.S. is on the rise and will continue to increase in coming years as our population ages. The majority—85 percent—of adults 65 and older has one or more chronic condition, and four out of every five health care dollars are spent caring for people with chronic conditions.¹

Given these trends, there more emphasis than ever before on *preventing chronic diseases*. In recent years, the Medicare program has taken significant steps to increase the number of preventive services offered to Medicare beneficiaries to focus on preventing beneficiaries from developing chronic conditions, including diabetes, heart disease, and eye disease. At the very least, these preventive benefits can help diagnose these conditions early to improve the quality of care and life.

The following guide outlines each of Medicare's Preventive benefits, including the cost:

1. **Medicare's Preventive Benefits**
 - ["Welcome to Medicare" Physical](#)
 - [Abdominal Aortic Aneurysm](#)
 - [Vaccinations](#)
 - [Hepatitis B](#)
 - [Pneumococcal](#)
 - [Flu](#)
2. **Screenings**
 - [Diabetes Screening](#)
 - [Glaucoma Screening](#)
 - [Cardiovascular Screening](#)
 - [Osteoporosis Screening](#)
3. **Cancer Screenings**
 - [Mammogram \(Breast Screening\)](#)
 - [Cervical and Vaginal Cancer Screening](#)
 - [Prostate Cancer Screening](#)
 - [Colorectal Cancer Screening](#)

¹ Anderson, Gerard, Jane Horvath. [The Growing Burden of Chronic Disease in America](#). Public Health Reports. May-June 2004.

4. Medical Therapies

- [Smoking Cessation Therapy](#)
 - [Medical Nutrition Therapy](#)
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1. Medicare's Preventive Benefits²

"Welcome to Medicare" Physical

The "Welcome to Medicare" physical is a one time preventive physical exam that is available to beneficiaries within the first 6 months of getting Part B coverage. Effective January 1, 2009, MIPPA extends this timeframe so beneficiaries will actually have up to 12 months to use this service. This exam is a key service that Medicare offers because it provides beneficiaries the opportunity to start preventing chronic diseases immediately upon entering the Medicare system. Beneficiaries should bring medical records and immunization records (if he/she is using a new physician), knowledge of his/her family health background, and current prescriptions.

Beneficiaries should expect the following procedures to occur during the physical:

- A review of his/her medical history
- A blood pressure reading
- height and weight measurements
- Education/counseling on preventive services needed
- Shots (such as the vaccinations provided under the preventive benefits)
- Checklist of other services needed (including a list of other preventive services the beneficiary should utilize).
- BMI assessment
- End-of-life planning

Additional services may include an electrocardiogram (EKG), which measures heart function, and a vision test.

Cost: As of January 1, 2009, the annual Part B deductible will not apply to this service but beneficiaries in Original Medicare are responsible for paying 20 percent of Medicare approved amount after paying the annual Part B deductible. (Often paying for the physical will cover the Part B deductible for that year.)

² Unless otherwise noted, source information for this section - [Preventive Services: A Healthier US Starts Here](#). U.S. Department of Health & Human Services. [Accessed: 5/20/08]

Abdominal Aortic Aneurysm

If the doctor determines that a beneficiary is at risk for an Abdominal Aortic Aneurysm during his/her "Welcome" physical, Medicare will cover a one time screening ultrasound with a physician referral. The physical and the referral must occur during the beneficiary's first six months of Part B coverage, but the actual ultrasound can occur outside the six month window.

Abdominal Aortic Aneurysm (AAA) is a vascular disease that can be fatal. Risk factors include:

- A family history of abdominal aortic aneurysm, and
- Being a male age 65-75 with a history of at least 100 lifetime cigarettes.

A beneficiary can also qualify for this service if he/she has never had an AAA ultrasound covered by Medicare.

Cost: For the AAA screening ultrasound, the beneficiary pays 20 percent of the Medicare-approved amount with no Part B deductible.

Vaccinations

Vaccinations are the most straightforward form of prevention—receiving a vaccine greatly reduces or prevents a person from contracting a disease. Beneficiaries with chronic conditions like cancer and diabetes are more susceptible to the conditions against which vaccines protect, so they are an important part of preventing beneficiaries from contracting multiple chronic conditions.

Medicare covers three vaccines:

- **Flu:** The flu is a highly contagious respiratory infection that causes fatigue, aches, chills, fever, and other cold-like symptoms for a longer period of time and more intensely than the common cold (often for several days to a week). The flu tends to affect older people more intensely and it is strongly suggested that all people over age 65 get a flu shot every year. This vaccination needs to be renewed yearly because the flu is caused by a virus, and the most common strains change yearly and thus so does the content of the vaccine.

Cost: Medicare covers this shot annually in the fall or winter at no cost for all people with Medicare.

- **Pneumococcal:** This vaccine is intended to prevent the development of pneumococcal pneumonia, an infection in the lungs caused by bacteria called *Streptococcus pneumoniae*. This disease can also lead to the development of meningitis, an inflammation of the spinal cord.³ Medicare beneficiaries age 65 and older are among the groups at higher risk for this infection. People with conditions like HIV, sickle cell disease, cancer, diabetes, and chronic lung, heart, kidney or liver disease are more susceptible.

This shot can be received on the same day as the flu shot. Unlike the flu shot, it can be received at any time of the year and is a one time vaccine for most people. If the beneficiary does not have a spleen, is in chronic renal failure, has HIV, cancer, or other conditions that compromise the immune system, he/she should inquire if a second pneumococcal shot will be necessary.

Cost: For those with Medicare Part B, the shot is free when ordered by a doctor.

- **Hepatitis B:** Hepatitis B is a serious and chronic disease caused by a virus that attacks 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.⁴

The Hepatitis B vaccine is a series of three shots. All three are needed to ensure complete protection. Medicare covers the shots for those beneficiaries who have medium or high risk for the vaccine (check with a doctor). Examples of people at medium to high risk are those with hemophilia, end-stage renal disease, or a condition that compromises the immune system (such as cancer or HIV).

Cost: The shots cost 20 percent of the Medicare approved amount after the beneficiary has met the annual Part B deductible.

2. Screenings

Diabetes Screening

Diabetes is a disease that causes the body not to produce enough insulin or reduces the body's response to insulin. As a result, a diabetic's blood sugar is too high because insulin is needed for the body to process sugar properly. High blood sugar can cause MANY complications including:

³ [Pneumococcal Pneumonia](#). MedicineNet.com. [Accessed: 5/21/08]

⁴ [Viral Hepatitis B Fact Sheet](#). National Center for HIV/AIDS, STD and TB Prevention. [Accessed: 5/21/08]

- Eye complications
- Heart disease and stroke
- Kidney disease
- Diabetic neuropathy and nerve damage.

It is these complications and others that make diabetes so interconnected with other chronic conditions. Thus, many of the Medicare preventive benefits can help to identify early warning signs of diabetes and hopefully allow the beneficiary to make lifestyle changes that will prevent him/her from developing the condition.

For people at risk for diabetes, Medicare covers a screening blood sugar test to check for diabetes. Depending on a person's risk factors, this screening may be covered by Medicare up to two times per year. Some examples of diabetes risk factors are:

- High blood pressure
- Abnormal cholesterol/triglycerides
- Obesity
- History of high blood sugar

Other factors may qualify one for a screening; make sure to ask a doctor.

Cost: There is no cost for a beneficiary in Original Medicare.

Diabetes Glucose monitors, test strips, and lancets and Diabetes Self-Management Training are available to those beneficiaries diagnosed with diabetes.

- The monitors, test strips, and lancets are for diabetics to monitor their blood sugar levels.
- The Self Management must be requested by a physician and is to train diabetics on the potential complications of this disease.

Glaucoma Screening

Glaucoma is an eye disease caused by high pressure in the eye. It can cause gradual loss of vision without warning and often without symptoms. The best way for people at high risk for glaucoma to protect themselves is to have regular eye exams.

Medicare covers glaucoma screenings for beneficiaries considered to be at high risk once per year. Factors that indicate high risk include having diabetes or a family history of glaucoma. African-Americans aged 50 and older are also at higher risk.

Cost: Twenty (20) percent of Medicare approved amount after the beneficiary has met the annual Part B deductible.

Cardiovascular Screening

Cardiovascular (heart) disease is the most common cause of death among Americans.⁵ The phrase “heart disease” is an umbrella term that is used to talk about a number of conditions having to do with the heart including heart failure, hypertension (high blood pressure), and heart attack.

Medicare covers cardiovascular screenings once every five years to check the beneficiary's cholesterol and other blood fat (lipid) levels. High levels of cholesterol can increase the risk of heart disease and stroke. These screening tests will let the beneficiary know if s/he has high cholesterol.

This preventive benefit may allow the beneficiary to make lifestyle changes (like change in diet and exercise routine) in order to lower cholesterol and prevent the development of heart disease.

The indicators covered in this screening are ones that may signify vulnerability to diabetes as well—make sure to ask a doctor about both when receiving this test.

Cost: There are no costs for beneficiaries in Original Medicare.

Osteoporosis Screening

Osteoporosis is a disease in which bones become fragile and more likely to break. If not prevented or if left untreated, osteoporosis can progress painlessly until a bone breaks. These broken bones occur typically in the hip, spine, and wrist.⁶

In general, the lower an individual's bone density, the higher his/her risk is for a fracture. Bone mass measurement test results will help determine the best way for a beneficiary to keep his/her bones strong.

Medicare covers a bone mass measurement test once every 24 months (more often if medically necessary) for all people with Medicare who are at risk for osteoporosis.

Risk factors for osteoporosis include:

⁵ [Heart Disease Still Number One Killer; 2006 Statistics Update Reports](#). American Heart Association. [Accessed: 5/21/08].

⁶ <http://www.nof.org/osteoporosis/index.htm>

- Being age 50 or older
- Being a woman
- Having a family history of broken bones
- Having a personal history of broken bones
- Being White or Asian
- Being small-boned
- Having low body weight (less than about 127 pounds)
- Smoking and/or drinking a lot
- Having a low-calcium diet

Cost: Twenty (20) percent of the Medicare-approved amount after the beneficiary has met the annual Part B deductible.

3. Cancer Screenings

Mammogram (Breast Screening)

Breast cancer forms in tissues of the breast, usually the ducts (tubes that carry milk to the nipple) and lobules (glands that make milk).⁷ Breast cancer is the most common non-skin cancer in women and the second leading cause of cancer death in women in the United States. Risk for breast cancer increases with age. Breast cancer can usually be successfully treated when found early.

Risk factors for breast cancer include:

- Had breast cancer in the past
- Have a family history of breast cancer
- Had your first baby after age 30
- Have never had a baby
- Used hormone replacement therapy (HRT) for a long period of time after menopause
- Have two or more alcoholic drinks every day
- Are overweight or obese
- Do not exercise
- Are of Jewish Eastern European descent (Ashkenazi Jew)

⁷<http://www.cancer.gov/cancertopics/types/breast>

Mammograms are covered once every 12 months for all female Medicare beneficiaries age 40 and older. One baseline mammogram is covered for beneficiaries age 35-39.

Cost: Twenty percent of Medicare approved amount after the beneficiary has met the annual Part B deductible.

Cervical and Vaginal Cancer Screening

Cervical cancer forms in tissues of the cervix (the organ connecting the uterus and vagina). It is usually a slow-growing cancer that may not have symptoms.⁸ Vaginal cancer forms in the tissues of the vagina (birth canal). The vagina leads from the cervix (the opening of the uterus) to the outside of the body.⁹

Medicare covers a pap test and a pelvic exam to check for cervical and vaginal cancers. The covered pelvic examine includes a manual breast exam to check for signs of breast cancer.

A pap test and pelvic exam are covered by Medicare once every 24 months EXCEPT if the beneficiary is of childbearing age AND has had an abnormal Pap test within the past 36 months. If the beneficiary is at high risk for cervical or vaginal cancer, Medicare will cover a Pap test and pelvic exam every 12 months.

Risk Factors for cervical cancer include:

- An abnormal Pap test
- A past cancer diagnosis
- Infection with the Human Papilloma Virus (HPV)
- Sex before age 16
- Many sexual partners
- A mother who took DES (Diethylstilbestrol), a hormonal drug, when she was pregnant
- A diet that is low in fruits and vegetables
- Being overweight or obese
- Many full term pregnancies

Cost: There is no cost for the Pap lab test. For Pap test collection and pelvic and breast exams, the beneficiary is responsible for 20 percent of the Medicare-approved amount with no Part B deductible.

⁸<http://www.cancer.gov/cancertopics/types/cervical>

⁹<http://www.cancer.gov/cancertopics/types/vaginal>

Prostate Cancer Screening

Prostate cancer forms in the tissues of the prostate (a gland in the male reproductive system found below the bladder and in front of the rectum). Prostate cancer usually occurs in older men.¹⁰

Prostate cancer can often be found early by testing the amount of Prostate Specific Antigen (PSA) in the blood. This test is called a Prostate Specific Antigen (PSA) test. Another way prostate cancer is found early is through a digital rectal exam.

Both of these methods of detection are covered by Medicare once every 12 months for all male Medicare beneficiaries age 50 and older.

Risk factors for prostate cancer include:

- Having male relatives (i.e. father, brother, or son who has had prostate cancer, especially if he was young when he got the disease);
- Being African-American (prostate cancer is more common in this group for unknown reasons); and
- Getting older (about two out of every three prostate cancers are found in men over the age of 65).

Cost: 20 percent of the Medicare-approved amount for the digital rectal exam after the beneficiary meets the annual Part B deductible. There is no coinsurance and no Part B deductible for the PSA Test.

Colorectal Cancer Screening

Colon cancer forms in the tissues of the colon (the longest part of the large intestine). Rectal cancer forms in the tissues of the rectum (the last several inches of the large intestine before the anus).¹¹

Colorectal cancer is usually found in people age 50 or older, and the risk of getting it increases with age. Medicare covers colorectal screening tests to help find pre-cancerous polyps (growths in the colon) so they can be removed *before* they turn into cancer. Additionally, treatment works best when colorectal cancer is found early.

There are four types of screenings that can be done to detect colon cancer:

- Fecal Occult Blood Test – Covered once every 12 months

¹⁰<http://www.cancer.gov/cancertopics/types/prostate>

¹¹<http://www.cancer.gov/cancertopics/types/colon-and-rectal>

- Flexible Sigmoidoscopy – Covered once every 48 months
- Screening Colonoscopy – Covered once every 24 months (for high risk patients); covered once every 10 years, but not within 48 months of a screening sigmoidoscopy (if not a high risk patient)
- Barium Enema - A doctor can decide to use this test instead of a flexible sigmoidoscopy or colonoscopy. This test is covered every 24 months if the patient is at high risk for colorectal cancer and every 48 months if the patient is not high risk.

Risk Factors for Colon Cancer include:

- Previous colorectal cancer before, even if it has been completely removed
- A close relative, such as a sister or brother, parent, or child, who has/had colorectal polyps or colorectal cancer
- A history of polyps
- A history of inflammatory bowel disease (Ulcerative colitis or Crohn's disease)
- A diet high in fat, especially fat from animal sources
- No exercise
- Being overweight or obese
- Smoking; and
- Having two or more alcoholic drinks every day.

Cost: There is no cost for the fecal occult blood test. For all other screening tests, the coinsurance or co-payment applies, but the Medicare Part B deductible is waived. However, if a screening test results in a biopsy or removal of a lesion or growth, the procedure is considered diagnostic and the deductible is applied. If the flexible sigmoidoscopy or colonoscopy is done in a hospital outpatient department or ambulatory surgical center, it costs 25 percent of the Medicare-approved amount.

4. Medical Therapies

Medical Nutrition Therapy

This benefit is covered for beneficiaries with diabetes or renal disease. It must be provided by a dietician or Medicare approved nutrition professional. The therapy includes:

- Nutritional assessment
- Disease management
- Three hours of one-on-one counseling during the first year

- Two hours a year in each following year

If the condition, treatment, or diagnosis for a patient changes, a physician may be able to get Medicare to cover more hours of therapy. A doctor must prescribe these services and renew referral annually.

Cost: 20% of the Medicare approved amount once the beneficiary has met the annual Part B deductible.

Smoking Cessation Therapy

Who is Eligible?

- People with Medicare who are diagnosed with a smoking-related disease, including heart disease, stroke, certain cancers, lung disease, weak bones, blood clots, and cataracts can get coverage for smoking and tobacco use cessation counseling.
- People with Medicare who take any of the many medications whose effectiveness is complicated by tobacco use including—insulin and some medicines for high blood pressure, blood clots, and depression are also eligible for the counseling.

Smoking cessation is a preventive benefit aimed at making sure prevention is possible for chronic conditions that are more damaging for smokers.

- Medicare will cover up to eight face-to-face visits during a 12-month period.
- These visits must be ordered by a doctor and provided by a qualified doctor or other Medicare-recognized practitioner.

Cost: Twenty (20 percent of Medicare approved amount after the beneficiary has met the annual Part B deductible.