KENT J. MOORE

WHAT'S NEW IN MEDICARE PREVENTIVE BENEFITS

The list of covered services has grown significantly in the last 10 years and includes some additions for 2007.

In case you missed the news, 2007 brought some new preventive benefits and changes to existing preventive benefits under Medicare. Knowing what Medicare will pay for, how often, and whether coinsurance and deductibles apply should facilitate your billing of these services. The table on page 26 summarizes what's covered.

A new benefit and some changes

In general, the Medicare statute provides coverage only for diagnosis and treatment of an illness, injury or impairment of a body part. However, through a series of legislative changes over the years, the Medicare program now covers a broad range of preventive and screening services for Part B beneficiaries.

The most recent addition to the list of covered benefits took effect Jan. 1, 2007, when Medicare began paying for preventive ultrasound screening for abdominal aortic aneurysms for at-risk beneficiaries as part of the Welcome to Medicare physical. The screening will be available to men age 65 to 75 who have smoked at least 100 cigarettes in their lifetimes, individuals with a family history of abdominal aortic aneurysm and any other individuals recommended for screening by the United States Preventive Services Task Force guidelines. The *FPM* encounter form for Welcome to Medicare physicals has been updated accordingly; it is available online in the *FPM* Toolbox at http://www.aafp.org/fpm/20060900/medicarepreventiveexam.pdf.

Two other changes to Medicare's preventive services coverage are important to note:

- Medicare expanded the bone mass measurement benefit by increasing the number of patients who qualify due to long-term steroid therapy. For these beneficiaries, Medicare reduced the dosage equivalent required for eligibility by one-third, from an average of 7.5 milligrams per day of prednisone for at least three months to 5 milligrams.
- Medicare exempted colorectal cancer screening from the Part B deductible, eliminating a potential financial barrier to using this benefit.

For more information about Medicare preventive benefits, you can access the prevention page on the Centers for Medicare & Medicaid Services' Web site at http://www.cms.hhs.gov/prevntiongeninfo/01_overview.asp. You and your Medicare patients can also download a copy of the *Guide to Medicare's Preventive Services* at http://www.medicare.gov/publications/pubs/pdf/10110.pdf. ➤

About the Author

Kent Moore is the AAFP's manager for health care financing and delivery systems and is a contributing editor to *FPM*.
Author disclosure: nothing to disclose.

Send comments to **fpmedit@aafp.org.**

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A SUMMARY OF MEDICARE PREVENTIVE SERVICES

The table below lists all of the Part B covered preventive services for 2007.

Service	Who and what is eligible?	How often can a Medicare beneficiary get this service?	Is it subject to coinsurance or deductible?
Flu shot	All people with Medicare.	Once a flu season, or more frequently if medically necessary.	No coinsurance or deductible.
Pneumococcal shot	All people with Medicare.	Once in a lifetime.	No coinsurance or deductible.
Hepatitis B shot	People with Medicare who are at medium to high risk.	One series if ordered by a doctor.	Coinsurance and deductible apply.
Initial preventive physical examination (also known as the "Welcome to Medicare" physical exam)	All new enrollees in Medicare. NEW: Beginning in 2007, people with Medicare who are at risk for abdominal aortic aneurysm may get a referral for a one-time screening ultrasound at their Welcome to Medicare physical.	One time only, within the first 6 months the patient has Medicare Part B.	Coinsurance and deductible apply. The patient pays 20 percent of the Medicare-approved amount with no Part B deductible for the abdominal aortic ultrasound screening.
Bone mass measurement	People with Medicare who are at risk for osteoporosis.	Every 24 months (more often if medically necessary).	Coinsurance and deductible apply.
Cardiovascular disease screening (lipid assessment)	All people with Medicare Part B.	Every 60 months.	No coinsurance or deductible.
Colorectal cancer screening	People with Medicare who are age 50 or older, with two exceptions: 1) there is no minimum age for screening colonoscopy, and 2) those with a high risk of developing colorectal cancer are eligible for barium enema screening, regardless of age.	• Fecal occult blood test – every 12 months. • Flexible sigmoidoscopy – every 48 months (or 10 years following a screening colonoscopy). • Screening colonoscopy – every 24 months if the patient is at high risk; every 10 years if the patient is not at high risk and it has been at least 48 months since a flexible sigmoidoscopy was performed. • Barium enema (as an alternative to flexible sigmoidoscopy or colonoscopy) – every 24 months if the patient is at high risk; every 48 months if the patient is not at high risk.	No coinsurance or deductible for fecal occult blood tests. NEW: Beginning in 2007, Medicare will waive the Part B deductible for flexible sigmoidoscopy, colonoscopy and barium enema screening. Coinsurance still applies.
Diabetes screening	People with Medicare who have high blood pressure, dyslipidemia, obesity, history of high blood sugar or two of the following characteristics: age 65 or older, overweight, family history of diabetes, or a history of gestational diabetes or delivery of a baby weighing more than 9 pounds. A fasting blood glucose test and a glucose challenge test or a two-hour glucose challenge test alone may be given.	• One screening per year if the patient has never been tested or if the patient was previously tested but not diagnosed with pre-diabetes. • Two screenings per year, at least six months apart, if the patient is diagnosed with pre-diabetes.	No coinsurance or deductible.

Service	Who and what is eligible?	How often can a Medicare beneficiary get this service?	Is it subject to coinsurance or deductible?
Glaucoma test	People with Medicare who have diabetes, a family history of glaucoma, are African-American age 50 or older, or are Hispanic-American age 65 or over.	Every 12 months.	Coinsurance and deductible apply.
Mammogram	Women with Medicare who are age 40 or older.	Every 12 months.	Coinsurance applies; no deductible.
	Women with Medicare who are age 35 to 39.	One baseline mammogram.	
Pap test and pelvic screening exam	All women with Medicare.	• Every 24 months. • Every 12 months if the patient is high-risk or if she is of childbear-ing age and has had an abnormal Pap test in the past 36 months.	Coinsurance applies, but there is no deductible for the pelvic exam. Beneficiary pays nothing for the lab analysis.
Prostate cancer screening	All men with Medicare who are over age 50.	Every 12 months for digital rectal exam (DRE) and prostate-specific antigen (PSA) test.	Coinsurance and deductible apply for DRE. The DRE is reimbursable when provided with a noncovered service, such as an annual physical. No coinsurance or deductible for PSA test.

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