The summary of information presented in this brochure is intended for Medicare fee-for-service physicians, providers, suppliers, and other health care professionals who furnish or provide referrals for and/or file claims for the Medicare-covered preventive benefits discussed in this brochure.

Every year the statistics are getting better. Focusing on the early detection and prevention of cancer has worked! The national mortality rates for most types of cancer have decreased tremendously, and certain cancers can be cured, if detected early. Medicare's cancer screening benefits can help detect cancers earlier when outcomes are best.

SCREENING MAMMOGRAPHY

A screening mammography 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 and includes a physician's interpretation of the results.

Medicare provides coverage of an annual screening mammogram (i.e., at least 11 full months have passed following the month in which the last Medicare screening mammography was covered) for all female beneficiaries age 40 or older. Medicare also provides coverage of one baseline mammogram for female beneficiaries between the ages of 35 and 39.

Coverage of a screening mammogram is provided as a Medicare Part B benefit. The coinsurance or copayment applies. There is no Medicare Part B deductible for this benefit.

NOTE: A doctor's prescription or referral is not necessary for a screening mammogram to be covered by Medicare.

Medicare also covers digital technologies for screening mammography services. The coinsurance or copayment applies. There is no Medicare Part B deductible for this benefit. However, in a hospital outpatient setting the coinsurance or copayment applies.

SCREENING PAP TESTS

Medicare provides coverage of a screening Pap test for all female beneficiaries when the test is ordered and collected by a doctor of medicine or osteopathy or other authorized practitioner (i.e., a certified nurse midwife, physician assistant, nurse practitioner, or clinical nurse specialist, who is authorized under State law to perform the examination) under one of the following conditions:

Covered once every 12 months

- There is evidence (on the basis of her medical history or other findings) that the woman is of childbearing age and has had an examination that indicated the presence of cervical or vaginal cancer or other abnormalities during any of the preceding 3 years; and at least 11 months have passed following the month that the last covered Pap test was performed.
- There is evidence that the woman is in one of the high risk categories (see high risk factors) for developing cervical or vaginal cancer and at least 11 months have passed following the month that the last covered screening Pap test was performed.

High risk factors for cervical and vaginal cancer include:

- Early onset of sexual activity (under 16 years of age)
- Multiple sexual partners (five or more in a lifetime)
- History of a sexually transmitted disease [including human papillomavirus (HPV) and/or human immunodeficiency virus (HIV)]
- Fewer than three negative Pap tests within the previous 7 years
- DES (diethylstilbestrol)-exposed daughters of women who took DES during pregnancy

Covered once ever 24 months

Medicare provides coverage of a screening Pap test for all other female beneficiaries (low risk) every 2 years (i.e., at least 23 months have passed following the month in which the last covered screening Pap test was performed).

Coverage for a screening Pap test is provided as a Medicare Part B benefit. The coinsurance or copayment applies for the Pap test collection; however, there is no Medicare Part B deductible for test collection. The beneficiary will pay nothing for the Pap laboratory test (there is no deductible and no coinsurance or copayment for the Pap laboratory test).

SCREENING PELVIC EXAMINATION

Medicare provides coverage of a screening pelvic examination for all female beneficiaries when performed by a doctor of medicine or osteopathy, or by a certified nurse midwife, physician assistant, nurse practitioner, or clinical nurse specialist who is authorized under State law to perform the examination (this examination does not have to be ordered by a physician or other authorized practitioner).

The Medicare-covered screening pelvic examination includes a complete physical examination of a woman's external and internal reproductive organs by a physician or qualified non-physician practitioner. The screening also includes a clinical breast examination.

Covered once every 12 months

Medicare provides coverage of a screening pelvic examination annually (i.e., at least 11 months have passed following the month in which the last Medicare-covered pelvic examination was performed) for beneficiaries who meet one (or both) of the following criteria:

- There is evidence that the woman is in one of the high risk categories (see high risk factors listed above) for developing cervical or vaginal cancer and at least 11 months have passed following the month that the last covered screening pelvic examination was performed.
- A woman of childbearing age had an examination that indicated the presence of cervical or vaginal cancer or other abnormalities during the preceding 3 years.

Covered once every 24 months

Medicare provides coverage of a screening pelvic examination for all asymptomatic female beneficiaries every 2 years (i.e., at least 23 months have passed following the month in which the last Medicare-covered pelvic screening examination was performed).

Coverage for the screening pelvic examination is provided as a Medicare Part B benefit. The coinsurance or copayment applies. There is no Medicare Part B deductible.

COLORECTAL CANCER SCREENING

Medicare provides coverage of colorectal cancer screening tests/procedures for the early detection of colorectal cancer. All Medicare beneficiaries age 50 and older are covered; however, when an individual is at high risk, there is no minimum age required to receive a screening colonoscopy or a barium enema (rendered in place of the screening colonoscopy).

The covered screening tests/ procedures include:

- Screening Fecal Occult Blood Test
- Screening Flexible Sigmoidoscopy
- Screening Colonoscopy
- Screening Barium Enema (as an alternative to a covered screening flexible sigmoidoscopy or screening colonoscopy)

Screening Fecal Occult Blood Test (FOBT)

Medicare provides coverage of an annual screening FOBT (i.e., at least 11 months have passed following the month in which the last Medicare-covered screening FOBT was performed) for beneficiaries age 50 and older. This screening requires a written order from the beneficiary's attending physician. Payment may be made for an immunoassay-based FOBT as an alternative to the guaiac-based fecal occult blood test. However, Medicare will only provide coverage for one FOBT per year, not both.

Screening Flexible Sigmoidoscopy

Medicare provides coverage of a screening flexible sigmoidoscopy for beneficiaries age 50 or older. A screening flexible sigmoidoscopy must be performed by a doctor of medicine or osteopathy, or by a physician assistant, nurse practitioner, or clinical nurse specialist.

Beneficiaries at High Risk for Developing Colorectal Cancer
Medicare provides coverage of a screening flexible sigmoidoscopy once every 4 years (i.e., at least 47 months have passed following the month in which the last covered screening flexible sigmoidoscopy was performed) for beneficiaries at high risk for colorectal cancer.

Beneficiaries Not at High Risk for Developing Colorectal Cancer
Medicare provides coverage of a screening flexible sigmoidoscopy once every 4 years (i.e., at least 47 months have passed following the month in which the last covered screening flexible sigmoidoscopy was performed) for beneficiaries age 50 and older **unless** the beneficiary does not meet the high risk criteria for developing colorectal cancer **and** the beneficiary has had a screening colonoscopy within the preceding 10 years, then the next screening flexible sigmoidoscopy will be covered only after at least 119 months have passed following the month in which the last covered screening colonoscopy was performed.

Screening Colonoscopy

Medicare provides coverage of a screening colonoscopy for all beneficiaries without regard to age. A doctor of medicine or osteopathy must perform this screening.

Beneficiaries at High Risk for Developing Colorectal Cancer
Medicare provides coverage of a screening colonoscopy once every 2 years for beneficiaries at high risk for colorectal cancer.

Beneficiaries Not at High Risk for Developing Colorectal Cancer
Medicare provides coverage of a screening colonoscopy once every 10 years but not within 47 months of a previous screening sigmoidoscopy.

Screening Barium Enema
Medicare provides coverage of a screening barium enema as an alternative to either a screening sigmoidoscopy or a high risk screening colonoscopy.

Beneficiaries at High Risk for Developing Colorectal Cancer
Medicare provides coverage of a screening barium enema, as an alternative to a screening colonoscopy, once every 2 years (i.e., at least 23 months have passed following the month in which the last covered screening barium enema was performed) for beneficiaries at high risk for colorectal cancer, without regard to age.

Beneficiaries Not at High Risk for Developing Colorectal Cancer
Medicare provides coverage of a screening barium enema, as an alternative to a screening flexible sigmoidoscopy, once every 4 years (i.e., at least 47 months have passed following the month in which the last covered screening barium enema was performed) for beneficiaries not at high risk for colorectal cancer, but who are age 50 or older.

Coverage of colorectal cancer screenings is provided as a Medicare Part B benefit. The beneficiary will pay nothing for the FOBT (there is no coinsurance or copayment and no deductible for this benefit). For all other colorectal screening procedures, the coinsurance or copayment applies; however, there is no deductible.

NOTE: The deductible is not waived if the colorectal cancer screening test becomes a diagnostic colorectal test; that is, the service actually results in a biopsy or removal of a lesion or growth.

PROSTATE CANCER SCREENING

Medicare provides coverage of an annual preventive prostate cancer screening prostate specific antigen (PSA) blood test and digital rectal exam (DRE) for the early detection of prostate cancer once every 12 months for all male beneficiaries age 50 and older (coverage begins the day after the beneficiary's 50th birthday), if at least 11 months have passed following the month in which the last Medicare-covered screening service was performed.

Screening Prostate Specific Antigen (PSA) Blood Test
The preventive screening PSA blood test must be ordered by the beneficiary's physician (doctor of medicine or osteopathy) or by the beneficiary's physician assistant, nurse practitioner, clinical nurse specialist, or certified nurse midwife who is fully knowledgeable about the beneficiary's medical condition, and would be responsible for explaining the results of the test to the beneficiary.

Screening Digital Rectal Examination (DRE)
The screening DRE must be performed by a doctor of medicine or osteopathy, physician assistant, nurse practitioner, clinical nurse specialist, or by a certified nurse midwife who is authorized under State law to perform the examination, be fully knowledgeable about the beneficiary's medical condition, and be responsible for explaining the results of the examination to the beneficiary.

Coverage of the screening PSA blood test and the screening DRE are provided as Medicare Part B benefits. The coinsurance or copayment applies for the screening DRE after the yearly Medicare Part B deductible has been met. The screening PSA blood test is a lab test for which neither the deductible nor coinsurance or copayment apply.

IMPORTANT NOTE: When submitting claims for the annual preventive prostate cancer screening PSA test it is important to bill for a screening test, which is covered once every 12 months, and not for a diagnostic test.

FOR MORE INFORMATION

The Centers for Medicare & Medicaid Services (CMS) has developed a variety of educational resources as part of a broad outreach campaign to promote awareness and increase utilization of preventive services covered by Medicare. For more information about coverage, coding, billing, and reimbursement of Medicare-covered preventive services and screenings, visit *http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp#TopOfPage* on the CMS website.

MEDICARE LEARNING NETWORK (MLN)

The Medicare Learning Network (MLN) is the brand name for official CMS educational products and information for Medicare fee-for-service providers. For additional information visit the Medicare Learning Network's web page at *http://www.cms.hhs.gov/MLNGenInfo* on the CMS website.

BENEFICIARY-RELATED INFORMATION

The official U.S. Government website for people with Medicare is located on the web at *http://www.medicare.gov*, or more information can be obtained by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

This brochure was prepared as a service to the public and is not intended to grant rights or impose obligations. This brochure may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

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