An Overview of Medicare Preventive Services for Physicians, Providers, Suppliers & Other Health Care Professionals

Forward- Mark McClellan
Prior to the Medicare Prescription Drug Improvement and Modernization Act (the MMA of 2003), the Medicare program provided coverage for many preventive services.

This included annual mammography screening, increased access to PAP tests and pelvic exams, colorectal and prostrate cancer screening, glaucoma screening, diabetes supplies, diabetes self-management training, medical nutrition therapy and bone mass measurement.

The MMA further expanded preventive services for Medicare beneficiaries to include an initial preventive physical examination or Welcome to Medicare Physical Exam, free coverage for cardiovascular screening blood tests and free coverage for diabetes screening tests.

The inclusion of these new benefits continues the Center for Medicare and Medicaid Services' efforts to move Medicare towards a prevention-oriented program. With these new preventive benefits, the preventive coverage in Medicare matches up better than ever with the recommendations of expert groups like the U.S. Preventive Services Taskforce.

This national focus on prevention and early detection has resulted in a higher level of consumer interest in preventive medicine and a greater need for information on Medicare coverage of these preventive services. CMS is taking significant steps to reach out and educate both the provider community and beneficiaries about the array of preventive services and screenings that Medicare covers for eligible beneficiaries.

CMS recognizes the crucial role that healthcare providers play in promoting, providing and educating Medicare patients about these beneficial preventive services and screenings. We need your help to convey the message that prevention, early detection, disease management and life style changes can help improve the quality of life for Medicare beneficiaries.

With your help we will be able to deliver the best possible care to Medicare beneficiaries and continue our initiative towards a prevention-oriented program. Twenty-first century medicine is increasingly about detecting health problems early, preventing their complications before they occur.

And Medicare wants to be a better partner than ever in that effort. We hope you'll work with us to help us move Medicare into a prevention-oriented, 21st Century healthcare program.

2:38 Introduction
VALERIE: Heart disease…cancer…stroke and diabetes are the leading causes of death for Medicare beneficiaries, but all of these can be treated more effectively when detected earlier. The Centers for Medicare & Medicaid Services has the responsibility for informing health care providers and people with Medicare about the new Medicare covered preventive services and screenings. We have joined forces with the American Cancer Society, the American Diabetes Association, and the American Heart Association to help us get the word out that the utilization of the new preventive services along with the other array of Medicare preventive services and screenings will help people with Medicare live longer healthier lives. Hello, I'm Valerie Hart,

Director of the Division of Provider Information Planning & Development at the Centers for Medicare & Medicaid Services, or CMS.

DAVID: And I'm David Nolley, of the CMS Office of External Affairs.

VALERIE: Welcome to this presentation on Medicare Preventive Services brought to you by CMS and the Medicare Learning Network. Before we get into our program, a little background information may be helpful. At its inception in 1965, Medicare only covered services for the diagnosis and treatment of illness or injury. Preventive services were not part of these initial covered services. As the value of prevention became clear, Congress, over the years, began passing a number of bills expanding the preventive benefits covered by Medicare. Both the Balanced Budget Act of 1997 or BBA and the Benefits Improvement and Protection Act of 2000 or BIPA significantly added to or expanded Medicare's preventive benefits.

DAVID: Now, as a result of the expanded coverage of preventive benefits under the *Medicare Prescription Drug, Improvement, and Modernization Act of 2003*, or MMA, Medicare now covers many of the screenings recommended by the US Preventive Services Task Force.

VALERIE: CMS recognizes the extremely important role that providers play in delivering quality health care to Medicare beneficiaries. We are continually striving to deliver the best information that we can to the provider community and we do that through a number of information delivery systems.

Together we help health care professionals navigate the complexities of the Medicare program. The success of getting information out to the Medicare provider community comes from provider education and outreach that occurs at three different levels as, a coordinated effort between CMS Central Office and 10 Regional Offices and Medicare Fee-for-Service Contractors.

The **first tier** is the CMS Central Office. This is a national focus approach utilizing partnerships with National Associations, listserv notifications, provider partner directory email notifications, open door forums, exhibit programs and national conferences to notify the provider community about new information to the Medicare program. Central Office develops a variety of national education products to keep providers educated and informed about the Medicare program; products such as publications, web-based training courses, MLN Matters articles, provider audience web pages, and the Medicare Learning Network's website.

The **second tier** is comprised of CMS' 10 regional offices. The Regional Offices disseminate information to State and Local Medical Societies & Associations for use in their education and outreach activities and use national education products in their provider education and outreach activities.

The **third tier**, of provider communication is via the Medicare Fee-for-Service Contractors, the Fiscal Intermediaries and Carriers. Using their websites, bulletins/newsletters, and local provider education and outreach activities; Carriers distribute information to individual physicians and limited license practitioners and Fiscal Intermediaries distribute information to hospitals and other institutional providers

Using this three tiered approach CMS is able to get information out to the provider community through a variety of communication networks.

DAVID: The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals, or, "The Guide" as we will refer to it in this program, contains some of the information being presented in this video as well as coding, billing, and payment information to help you file claims effectively. We will refer to "The Guide" through out this presentation.

VALERIE: As I mentioned earlier, we are here today to give you an overview of Medicare's array of Preventive Services and screenings including the newest services that became effective January 1, 2005 as a result of MMA.

DAVID: These services and screenings are designed to assist in the early detection of diseases, and to identify those Medicare beneficiaries who are at risk for disease.

VALERIE: The preventive services we will be discussing are covered no matter what kind of Medicare health plan the beneficiary has. Today's program, however, will focus on the Medicare fee-for-service program.

VALERIE: At the conclusion of this program, you should be able to identify the Medicare coverage guidelines for the preventive services covered by Medicare.

DAVID: Before we begin, please take a moment to review your participant materials.

VALERIE: You should have a

- Pre-test
- Post-test
- Program Evaluation Form, and the
- Continuing Education Credit Participant Request Form

VALERIE: The pre-test is made up of 10 questions to be answered prior to the program, and there are 10 post-test questions to be answered at the end of the program. In a few moments, we'll ask you to ***PAUSE*** this program and take the pre test.

DAVID: When today's program ends you will need to take the post-test, complete the evaluation form and the Continuing Education Credit Participant request form, and then mail the pre-test, post-test, course evaluation and the Continuing Education Credit Participant Request Form back to CMS per your packet instructions. We want you to get the credit you deserve for participating, so please follow the instructions carefully.

VALERIE: Your feedback is very important to us so please take the time to complete the program evaluation form. This evaluation will help shape future programs. Please include both potential improvements as well as features that you found especially helpful.

DAVID: Once we receive your packet, and you have successfully met all of the course requirements:

- Completion of the pre-test
- 70% or higher on the post-test
- Completion of the Continuing Education Credit Participant Request Form and
- Completion of the course evaluation

We will send you your Continuing Education Certificate

VALERIE: OK, now that we've laid the groundwork for the program, let's measure where you are right now…**please pause the program** and take the pre test. When you are done, simply continue to play the program. Thank you!

DAVID: Welcome back to the program. Every year hundreds of thousands of Americans die prematurely from diseases that are preventable through immunization or amendable through early detection, treatment, and lifestyle changes.

VALERIE: The good news is that every year the statistics improve. Some of this improvement can be attributed to an increased national focus on early detection and promotion of preventive and screening services.

DAVID: Prior to the MMA, the Medicare program provided coverage for many preventive services, including: annual mammography screening, Pap tests and pelvic exams, colorectal and prostate cancer screening, diabetes self-management training, medical nutritional therapy, bone mass measurements, and glaucoma screening.

VALERIE: Continuing CMS' effort to move Medicare toward a prevention-oriented program, as of January 1, 2005, the MMA further expands preventive services for Medicare beneficiaries to include the Initial Preventive Physical Examination (IPPE), also known as the "Welcome to Medicare" physical exam, coverage for cardiovascular screening blood tests, and coverage for diabetes screening tests.

CMS recognizes the crucial role that health care providers play in promoting, providing, and educating Medicare patients about these and other beneficial preventive services and screenings. We need your help to convey the message that utilization of preventive services, early detection, disease management, and lifestyle changes can help Medicare beneficiaries live longer, healthier lives. The IPPE presents a new opportunity for you to share with your Medicare patients information about prevention and screening services for which they may be eligible and encourage utilization of these benefits as appropriate.

12:29 Initial Preventive Physical Examination (IPPE) the *"Welcome to Medicare" Physical Exam*

DAVID: So let's begin by learning more about the new expanded benefits. We'll start with the IPPE, also known as the "Welcome to Medicare" Physical Exam. After this program you will know a lot about the IPPE:

- What are its components?
- What are the Medicare coverage guidelines? And
- What are the documentation requirements you need to know about?

VALERIE: Here to discuss this new benefit is Dr. Tiffany Sanders, from CMS' Office of Clinical Standards and Quality. Tiffany, thanks for being here. So what do providers need to know about the IPPE?

DR. TIFFANY SANDERS: I'm happy to be here

VALERIE: Can you tell the providers what they need to know about the IPPE?

DR. TIFFANY SANDERS: The IPPE, is one of the most important services that anyone new to Medicare can get. To be eligible for the IPPE, a beneficiary must have been enrolled in Medicare for six months or less. All beneficiaries enrolled in Medicare Part B with effective dates beginning on or after January 1st of 2005, are eligible for this one-time benefit.

The goal of the IPPE, which includes an EKG, is health promotion and disease prevention. It includes patient education, counseling, and referral to screening and preventive services also covered under Medicare Part B. The IPPE consists of **seven elements** that enable the heath care provider to identify risk factors that may be associated with various diseases and to detect diseases early when outcomes are best. The health care provider is then able to educate and counsel the beneficiary about the identified risk factors and possible lifestyle changes that could have a positive impact on the beneficiary's health.

As I mentioned, the IPPE consists of *seven components.* **The *first* component is a review of the beneficiary's medical and social history** with attention to modifiable risk factors. A medical history is taken which should include, at a minimum, past medical and surgical history, including experiences with illnesses, hospital stays, operations, allergies, injuries, and treatments; current medications and supplements, and family history, including a review of medical events in the beneficiary's family, including diseases

Providers can help beneficiaries get ready for the IPPE by suggesting they come prepared with information such as: medical records (including immunization records), family health history in as much detail as possible, and a full list of medications and dietary supplements they are taking
In addition to the beneficiary's medical history, the social history is also taken and should include, at a minimum, history of alcohol, tobacco, and illicit drug use, diet, nutritional status and physical activities.

For **the *second* component, a review is conducted of an individual's potential risk factors for depression**. This includes current or past experiences with depression or other mood disorders, based on the use of appropriate screening instrument for persons without a current diagnosis of

depression. The physician or other qualified non-physician practitioner may select from various available standardized screening tests that are designed for this purpose and recognized by national professional medical organizations.

VALERIE: So we've taken the medical and social histories and conducted a review of potential risk for depression. Let's talk about the ***third*** **component, a review of the individual's functional ability and level of safety**.

DR. TIFFANY SANDERS: There are various available screening questions and standardized questionnaires designed for the purpose of conducting this review. These questions and questionnaires are recognized by national professional medical organizations. The review of the individual's functional ability and level of safety must include, at a minimum, the following areas: review of hearing impairment, activities of daily living, falls risk, and home safety.

The ***fourth*** **component** of the IPPE is an **examination that is conducted to include an individual's height, weight, blood pressure measurement, and visual acuity screen.** The 4th component can also include other elements or factors as deemed appropriate by the physician or non-physician practitioner, based on the findings of the beneficiary's medical and social history and current clinical standards.

The statute required that the IPPE always include a screening EKG. The ***fifth*** **component of the IPPE includes the performance and interpretation of an EKG.** If the primary physician or qualified non-physician practitioner does not perform the EKG during the IPPE visit, the beneficiary should be referred to another physician or entity to perform and/or interpret the EKG. Results of the screening EKG must be documented in the beneficiary's medical record to include performance and interpretation**.** Both the IPPE and the EKG must be performed and interpreted before either is billed.

Education, counseling and referral is the *sixth* component of the IPPE. The beneficiary is offered education, counseling, and referral, as deemed appropriate by the physician or qualified non-physician practitioner, based on the results of the review and evaluation services found in the previous five components I just described. Some examples could include: counseling on diet if the beneficiary is overweight, referral to a cardiologist for an abnormal EKG, or even education on prevention.

The *seventh* component of the IPPE is education, counseling, and referral for other preventive services already covered under Medicare Part B. This would include a brief written plan that is given to the beneficiary, such as a checklist, for obtaining the appropriate screening and/or other Medicare Part B preventive services. This element of the IPPE offers the physician or non-physician practitioner a unique opportunity to discuss other preventive services and screenings with the beneficiary that they may be eligible to receive. It also allows the physician and his front office staff a chance to note any potential screenings that the beneficiary might need in the near future. Because many diseases can be prevented if detected in the early stages, practitioners can lay out a plan for a beneficiary to take advantage of.

DAVID: What is a good way for the physician or non-physician practitioner to document this information?

DR. TIFFANY SANDERS: A good way to do this would be a checklist. The U. S. Preventive Services Task Force and other organizations such as the American Academy of Family Physicians have developed checklists to document this type of information.

VALERIE: So this component allows for the referral as appropriate for other Medicare Part B covered preventive services and screenings such as adult immunizations, cancer screenings, diabetes services, bone mass measurements, and other covered Medicare preventive services.

DAVID: Tiffany, the IPPE does not include any clinical laboratory tests, is that correct?

DR. TIFFANY SANDERS: That's right, David. But the physician, qualified non-physician practitioner, or hospital may also provide and bill separately for the screening and other preventive services that are currently covered and paid for by Medicare Part B.

VALERIE: Let's talk a bit more about Medicare's coverage of the IPPE. What do providers need to know about the coverage of this one-time benefit?

DR. TIFFANY SANDERS: Coverage of the IPPE visit is provided as a Medicare Part B benefit. The coinsurance or copayment applies after the yearly Medicare deductible has been met.

VALERIE: Are there any special documentation requirements for the IPPE?

DR. TIFFANY SANDERS: Yes, Valerie. The physician or qualified non-physician practitioner must document that all seven of the required components of the IPPE were provided or provided and referred. All referrals and a written plan, or checklist, must be included in this documentation.

VALERIE: How can the physician or non-physician practitioner deal with separate issues that might come up during the IPPE visit? For example, what if a patient complained of something like a rash that would require the physician to treat it?

DR. TIFFANY SANDERS: If a separately, identifiable, medically necessary Evaluation and Management, or E/M service is also performed at the time a patient receives the IPPE, the physician and/or qualified non-physician practitioner must also document this in the medical record.

VALERIE: Thanks, Tiffany, for taking the time to talk with us about this important new preventive benefit, the IPPE.

DR. TIFFANY SANDERS: My pleasure Valerie and you're welcome.

review
INITIAL PREVENTIVE PHYSICAL EXAMINATION (IPPE)
Also known as the "Welcome to Medicare" Physical Exam
coverage

All Medicare beneficiaries whose first Part B coverage began on or after January 1, 2005

frequency

Once in a lifetime benefit furnished no later than 6 months after the effective date the first Medicare Part B coverage begins.

test

Always includes a screening EKG

21:49 CARDIOVASCULAR SCREENING BLOOD TESTS

VALERIE: Another new benefit provided by the MMA is the Cardiovascular Screening Blood Test. After watching this segment you should be able to identify the coverage guidelines related to cardiovascular screening blood tests. We recently had an opportunity to talk to Cass Wheeler, CEO of the American Heart Association.

CASS WHEELER: The healthcare provider plays a critical role in whether this is successful or not. They have got to take the time to sit down, visit with their patients about the risk factors to test for things like total cholesterol, high HDLs, triglycerides detect chronic disease before they occur to minimize the risk that they'll develop these diseases in the first place. We want to spread the word about making healthy lifestyle changes. And we're doing that as a partnership between the American Heart Association, the American Cancer Society and the American Diabetes Association to spread that word that people need to eat a healthy diet, they need to maintain a healthy weight, they need to have some sort of physical activity program, they need to avoid tobacco and smoking of any form and they need to consult with their healthcare provider about the lifestyle that they need to maintain to live a healthier, longer life.

DAVID: The MMA of 2003 established Medicare coverage of cardiovascular screening blood tests for the early detection of cardiovascular disease or abnormalities associated with an elevated risk. These tests will determine a beneficiary's cholesterol and other lipid levels such as triglycerides. CMS recommends that all eligible beneficiaries take advantage of this benefit, which can determine whether beneficiaries are at high risk for cardiovascular disease.

VALERIE: Obviously, then, the importance of early recognition and management of cardiovascular disease risk factors cannot be overstated. Let's take a look at the Medicare covered tests in the cardiovascular screening benefit.

DAVID: The cardiovascular screening blood tests covered by Medicare are:

- Total Cholesterol Test
- Cholesterol Test for High-Density Lipoproteins
- Triglycerides Test

VALERIE: David, do any of these tests require fasting?

DAVID: Yes, Valerie, they do. Beneficiaries must fast for 12 hours prior to testing.

VALERIE: This new Medicare coverage of cardiovascular screening blood tests presents a new

opportunity for health care professionals to help Medicare beneficiaries learn if they have an increased risk for developing heart disease and how they can control their cholesterol levels through diet, exercise or, if necessary, with medication.

DAVID: Medicare provides coverage of cardiovascular screening blood tests for all asymptomatic beneficiaries every five years.

VALERIE: And coinsurances or deductibles **do not** apply for this benefit, right David?

DAVID: That's right Valerie, coverage of cardiovascular screening blood tests is provided as a Medicare Part B benefit. The beneficiary will pay nothing; there is no coinsurance and no deductible for this benefit. Cardiovascular screening is provided free of charge to the beneficiary.

VALERIE: David, tell us what documentation is required by Medicare.

DAVID: The documentation must show that the screening tests were ordered by a physician or a qualified non-physician practitioner treating an asymptomatic beneficiary for the purpose of early detection of cardiovascular disease.

As mentioned earlier, the beneficiary must have had the tests performed after a twelve hour fast, and this should be documented. Finally, the appropriate supporting procedure and diagnosis codes should be documented. We hope that providers will take the time to talk with beneficiaries and encourage them to take advantage of these new benefits in order to identify and prevent risk factors for one of America's leading causes of death, cardiovascular disease.

review
CARDIOVASCULAR SCREENING BLOOD TESTS

coverage
All asymptomatic Medicare beneficiaries *Effective for services performed on or after January 1, 2005*

frequency
Every 5 years

tests
Total Cholesterol Test
Cholesterol Test for High-Density Lipoproteins
Triglycerides Test

26:30 DIABETES SCREENING TESTS

VALERIE: We now turn our attention to the third and last of the new MMA preventive benefits, the diabetes screening tests for those considered at risk for the disease. Prior to 2003 Medicare provided some diabetes benefits, but the MMA expanded coverage in order to promote early detection of this sixth leading cause of death in the United States

VALERIE: At the conclusion of this segment you should be able to identify the newly covered diabetes screening tests. Let's join Lynn Nicholas, CEO of the American Diabetes Association.

LYN NICHOLAS: the mission of the ADA is to prevent and cure diabetes and improve the lives of all people affected with diabetes. So within that, obviously, we care for the 18 million people who have the disease but we're also very worried about the 41 million who have pre-diabetes and are subject to having diabetes within their lifetime, actually within about 10 years without a lifestyle change. So we deal with research, we deal with information, prevention, all things to all people with diabetes.

And so people who have pre-diabetes generally are overweight. They're generally not in good shape. They don't exercise well. And without a lifestyle change, without getting that blood sugar down, they will statistically go on to develop diabetes within about 10 years. And so it's something that everyone should be concerned with. You know, of note also, some of our minorities, African Americans and Latino and Hispanic populations, they're even more at risk for diabetes, one and a half times more at risk than Caucasian populations. And so it's something we worry about a great deal.

VALERIE: To help us understand these benefits, we have asked Betty Shaw of the CMS, Office of Clinical Standards and Quality to join us to discuss Medicare's new diabetes screening tests

BETTY SHAW: As you know, the MMA expanded diabetic services covered by Medicare to include diabetes screening for beneficiaries at risk for the disease as well as those diagnosed with pre-diabetes. This new benefit will help improve the quality of life for Medicare beneficiaries by detecting risk factors which could lead to more severe conditions that can occur without proper treatment from undiagnosed or untreated diabetes. To be eligible for the diabetes screening tests, beneficiaries must have any of the following risk factors: Hypertension; Dyslipidemia; Obesity; or previous identification of an elevated impaired fasting glucose or glucose tolerance.

Or, beneficiaries are eligible if they have a risk factor consisting of at least two of the following characteristics: They are overweight, with a body mass index greater than 25kg/m2 but less than 30kg/m2, they have a family history of diabetes, they are age 65 or older, or there is a history of gestational diabetes mellitus, or delivery of a baby weighing greater than 9 pounds.

VALERIE: We've defined Diabetes, and the eligibility requirements for the benefits. Now let's talk about the new coverage itself…the Diabetes Screening Tests and what is covered.

BETTY SHAW: Effective with services provided on or after January 1, 2005, Medicare provides coverage of diabetes screening tests for individuals in the risk groups we discussed or those diagnosed with pre-diabetes.

VALERIE: Betty**,** What diabetes screening blood tests are covered by Medicare?

BETTY SHAW:

- A fasting blood glucose test AND

- Post-glucose challenge tests; not limited to an oral glucose tolerance test with a glucose challenge of 75 grams of glucose for non-pregnant adults or a 2 hour post-glucose challenge test alone.

VALERIE: So, effective with services performed on or after January 1, 2005, Medicare provides coverage for diabetes screening tests. How often can beneficiaries receive these screenings?

BETTY SHAW: For beneficiaries diagnosed with pre-diabetes, Medicare provides coverage for a maximum of two diabetes screening tests within a 12-month period. For those who have not been diagnosed with diabetes or pre-diabetes, Medicare provides coverage for one diabetes screening test within a 12-month period. Coverage for diabetes screening is provided as a Medicare Part B benefit. The Medicare Part B deductible and coinsurance or co-payments do not apply. The beneficiary pays nothing for this screening.

VALERIE: Thanks for your help in explaining the new diabetes screening benefit, Betty. We really appreciate it.

BETTY: Thank you Valerie for having me.

VALERIE: In addition to the new screening tests, Medicare continues to provide coverage for Diabetic Testing Supplies, Diabetes Self-Management Training, and Medical Nutrition Therapy. For more specifics on the coverage limitations of these services and supplies, please consult your Guide.

review
DIABETES SCREENING TESTS

coverage
Medicare beneficiaries with certain risk factors for diabetes or diagnosed with pre-diabetes.
Effective for services performed on or after January 1, 2005
Beneficiaries previously diagnosed with diabetes are not eligible

frequency
2 tests per year if diagnosed with pre-diabetes
1 test per year if previously tested but not diagnosed with pre-diabetes, or if never tested

tests
Fasting Blood Glucose Test
Post-Glucose Challenge Test

VALERIE: Next, We'd like to turn our attention to cancer screenings. In this segment we will discuss Medicare's coverage of cancer screening tests. Medicare covers screening tests for breast, cervical, vaginal, colorectal, and prostate cancers.

DAVID: We recently had a chance to speak with Dr. Len Lichtenfeld, the Deputy Chief Medical Officer of the American Cancer Society about his views on preventive cancer screenings and the

early detection of disease. Here is what he had to say.

DR. LEN LICHTENFELD: The benefit of focusing on prevention is to avoid disease or avoid the complications of disease. Imagine if we could prevent that disease in the first place, imagine what we could do to improve the quality of life of so many people in this country if we just paid attention to what we already know. We could literally save thousands of lives every year, today, if we put into practice what we already know about preventing disease.

We may find people with cancer early and when we find cancer early, we know we can cure 90 percent of the patients. So imagine that if everyone was working together just like CMS and the American Cancer Society working together with that as a goal, imagine the impact we could have.

What we know from our research is that the single most important part of a patient getting a preventive service is their doctor or their health care professional making the recommendation to the patient. If the doctor doesn't say it, if the nurse practitioner, the physician assistant doesn't say it, it doesn't happen. We need to create a culture of prevention. We as doctors have to start believing that prevention works. So when Medicare starts to say, we think prevention is important, others listen.

VALERIE: Very valuable information for Medicare providers. Now, we'd like to discuss Medicare's coverage of these screening tests. Let's start with breast cancer and the Medicare covered mammogram.

34:34 SCREENING MAMMOGRAPHY

DAVID: At the end of this segment you should be able to identify Medicare's coverage guidelines for a screening and diagnostic mammogram.

VALERIE: Doris Lindenmuth, Nursing Coordinator for the Women's Center at St. Agnes Hospital in Baltimore, Maryland recently shared her knowledge on the benefits of the appropriate screening for breast cancer, so let's listen.

DORIS LINDENMUTH: The most important thing in regard to prevention of breast cancer is early detection. It is very important for women to have as early detection as possible of any problems going on with their breast. We can diagnose and treat breast cancer at its earliest stages. And when we do find breast cancer at its earliest stages, it's more than 95% curable, so early detection is critical for patients.

I'd like to talk a little bit about the two types of mammograms that we do. There is a screening mammogram and a diagnostic mammogram. A screening mammogram is a routine annual mammogram that women over the age of 40 will get on a yearly basis. That's a person—a woman who has had no history of breast cancer.

They have no current signs, symptoms or problems related to their breasts and they have not had any atypia or abnormal cells that have shown up in the past on breast biopsy. That's a screening

mammogram. They do two views of each breast. That's done on a yearly basis and results are sent to your doctor—your family doctor and to yourself.

Those should be scheduled about a week or so after your menstrual period. That's the best time to have those mammograms. Now that's a little different than a diagnostic mammogram. A diagnostic mammogram is where we are actually looking and searching for a potential problem.

That might be a patient who was sent in by their doctor because they felt a lump in their breast. The doctor did an examination in the office and he felt a lump or a mass or a thickening in the breast. He might have noticed a nipple discharge that the patient had not noticed before. And I do wanna make a point that all centers who do mammography evaluation must be FDA approved and certified. That is a requirement to do mammography screening.

A diagnostic mammogram does require in most cases some type of follow up because to have been eligible or to have needed a diagnostic mammogram, you are coming in to any center with a potential problem. This could be something as simple as the patient felt a little thickening or a little change in her breast that wasn't there before or her doctor noticed something that wasn't there before. We now know from our years and years of experience in cancer management and treatment that early detection is critical not only in treatment and management but we know that the earlier we find a cancer of any sort, the better and more successful chance we have of treating that cancer and the better the person's long-term prognosis will be

It is very common for people to come in for a blood pressure problem or a belly ache or that type of thing and no one's noticed that the person has not had a mammogram in five years and she's 60 years old. It's really—it's incumbent upon us as healthcare professionals to look at the whole patient in regard to their general health. It really has to be the health practitioner bringing it to the attention of the patient. Once you get that far, patients are much more apt to be able to be compliant with that cause they're thinking, "Okay, if my doctor thinks I need to have this done, it's important for me to have it done". Where, conversely the patient thinks, "If the doctor hasn't mentioned this, I guess I don't need to worry about it". And that's really not the case. So it's really important for us as healthcare practitioners to see that we look at the whole patient, not just the problem that brought them into the office that day.

DAVID: Doris has given us a lot of information. Let's continue with this topic as it relates specifically to Medicare beneficiaries.

VALERIE: There is a screening mammogram and a diagnostic mammogram. And, Medicare Part B provides coverage of a breast cancer screening mammogram annually for all **female** beneficiaries age 40 or over. David, what about the diagnostic mammogram, when is that covered?

DAVID: Well, diagnostic mammograhys are Medicare covered tests under the following conditions:

- A woman has distinct signs and symptoms for which a mammogram is indicated.
- A woman has a history of breast cancer. Or

- A woman is asymptomatic, but based on her history and other factors the physician considers significant, the physician's judgment is that the mammogram is appropriate.

VALERIE: Providers need to make sure that beneficiaries understand that a diagnostic mammogram does require a prescription or referral by a physician or non-physician practitioner in order for it to be covered by Medicare.

review
SCREENING MAMMOGRAPHY

coverage/frequency
Annually for all female Medicare beneficiaries age 40 or older
One baseline for female Medicare beneficiaries ages 35 – 39

tests
Screening Mammogram
Diagnostic Mammogram

39:58 SCREENING PAP TESTS

VALERIE: Now let's move on to Screening Pap tests. Our goal in this section is to give you a good sense of Medicare coverage guidelines and risk factors. Dr. Bill Rogers of CMS' Physicians Regulatory Issues Team or PRIT is joining us to tell us why screening pap tests are so important.

BILL ROGERS: Thanks, Valerie. Most cervical cancers can be caught early with regular screening. However, the early stages of cervical cancer have no detectable symptoms, which is why a Pap smear that checks for changes in the cells of the cervix can help find cancer at an early stage. Cervical cancer mortality increases with age. Women 65 and older account for nearly 25% of all cervical cancer cases and 41% of cervical cancer deaths in the U.S. The good news is that both incidence and mortality rates of cervical cancer are decreasing over time.

VALERIE: And this trend is largely attributed to cervical screening with the Pap test, is that right?

BILL ROGERS: If diagnosed and treated early, any abnormal cell changes that may occur over time can be reduced or prevented.

VALERIE: Besides age, what are some other risk factors for cervical and vaginal cancer?

BILL ROGERS : The high risk factors for cervical and vaginal cancers are:

- Early onset of sexual activity
- Multiple sexual partners
- History of a sexually transmitted disease
- Fewer than three negative Pap tests within the previous seven years
- DES (diethylstilbestrol)-exposed daughters of women who took DES during pregnancy

VALERIE: Thank you Bill. Now in terms of coverage, Medicare provides two levels of coverage for screening Pap tests. Beneficiaries are covered once every 12 months if:

- 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.
- There is evidence that the woman is in one of the previously identified high risk categories for developing cervical cancer.

BILL ROGERS: And Medicare provides coverage of a screening Pap test for all other female beneficiaries once every two years.

review
SCREENING PAP TESTS

coverage
All female Medicare beneficiaries

frequency
Annually if high risk, or childbearing age with abnormal Pap test within past 3 years
Every 24 months for all other women

test
Pap Test

42:27 PELVIC SCREENING EXAMINATION

VALERIE: OK, let's move to Pelvic Screening. As with the other screening tests, our desire here is to help you to be able to identify the Medicare coverage guidelines and the high risk factors associated with vaginal cancer. Pelvic Screening examinations are an important part of Medicare's overall preventive health care strategy. Bill, can you tell us a little about the importance of this screening test?

BILL ROGERS: A pelvic examination is performed to help detect pre-cancers, genital cancers, infections, Sexually Transmitted Diseases (STDs), other reproductive abnormalities and genital and vaginal problems. The pelvic exam is also used to help find fibroid or ovarian cancers. Additionally, pelvic examination can be used to as a prevention tool for detecting, preventing, and treating bladder cancer, the tenth most frequently diagnosed cancer in women. Finally, a pelvic examination includes a clinical breast exam, which aids in detecting breast cancer or other abnormalities.

VALERIE: As you mentioned earlier, the high risk factors for vaginal cancer are the same as those for cervical cancer. Bill, Medicare requires providers to include certain elements in their pelvic examination. Can you tell our audience what those elements are?

BILL ROGERS: Certainly, A pelvic screening examination should include at least seven of the following elements:

- Inspection and palpation of breasts for masses, lumps, tenderness, symmetry, or nipple discharge, and
- Digital rectal examination including for sphincter tone, presence of hemorrhoids, and rectal masses.
- Pelvic examination
    - External genitalia
    - Urethral meatus
    - Urethra
    - Bladder
    - Vagina
    - Cervix
    - Uterus
    - Adnexa/parametria and
    - Anus and perineum

VALERIE: The coverage guidelines for pelvic screenings are similar to those of Pap screening tests. Can you review Medicare's coverage of the pelvic screening for us please?

BILL ROGERS: Medicare provides coverage of a pelvic screening examination annually for beneficiaries that are considered high risk and once every 2 years for all other asymptomatic female beneficiaries.

VALERIE: Thank you for your input, Bill. We appreciate your time.

BILL ROGERS: It's been my pleasure Valerie.

review
SCREENING PELVIC EXAMINATION

coverage
All female Medicare beneficiaries

frequency
Annually if high risk, or childbearing age with abnormal Pap test within past 3 years
Every 24 months for all other women

45:15 COLORECTAL CANCER SCREENING

VALERIE: And now we'll turn our attention to colorectal cancer. Our objective in this section is for you to be able to identify the Medicare- covered colorectal cancer screening tests and the coverage guidelines.

DAVID: Colorectal cancer is the third leading cause of cancer deaths in the United States and the risk increases with age. An estimated 57,000 Americans died of colorectal cancer in 2003. Patients with colorectal cancer rarely exhibit any symptoms, and the cancer can spread unnoticed and

untreated until it becomes fatal. Like many other cancers, the good news is that colorectal cancer can be prevented if diagnosed and treated early.

VALERIE: Colorectal screening is performed to diagnose or determine a patient's risk for developing colon cancer. These screening tests help to find pre-cancerous polyps, or growths in the colon, so they can be removed before they develop into cancer.

DAVID: Colorectal screening can consist of several different procedures. The colorectal screening tests covered by Medicare are:

- Fecal Occult Blood Test (Stool Test)
- Flexible Sigmoidoscopy
- Colonoscopy, and
- Barium Enema

VALERIE: Now let's talk about each of these tests. The Fecal Occult Blood Test checks for hidden blood in the stool. The flexible sigmoidoscopy, which is sometimes used in combination with the fecal occult blood test, is used to detect polyps or precancerous growths in the rectum and lower third of the colon.

DAVID: A colonoscopy is a procedure similar to a flexible sigmoidoscopy except a longer, thin, flexible lighted tube is used to check for polyps or precancerous growths in the rectum. Finally, the barium enema is a procedure in which the beneficiary is given an enema with barium. X-Rays are taken of the colon and they allow the physician to see an outline of the patient's colon to check for polyps or other abnormalities.

VALERIE: The risk factors for colorectal cancer can include any of the following:

- A close relative (sibling, parent, or child) who has had colorectal cancer or an adenomatous polyp.
- A family history of familial adenomatous polyposis
- A family history of nonpolyposis colorectal cancer.
- A personal history of adenomatous polyps.
- A personal history of colorectal cancer, or
- A personal history of inflammatory bowel disease, including Crohn's disease and ulcerative colitis.

DAVID: Colorectal screenings are covered for all Medicare beneficiaries aged 50 or older. Again, for additional preventive services information please consult *The Guide*.

VALERIE: Dr. Hudes, of the St. Agnes Cancer Center spoke with us recently about colorectal cancer and prostate cancer. Let's listen closely as he shares his knowledge on the nature and early detection of these common cancers.

DR. RICHARD HUDES: I think a major benefit of screening for colorectal cancer is—and specifically with colonoscopy or sigmoidoscopy, you have a very unique advantage that you can actually prevent cancer. By that I mean for the patients in who you detect a polyp and then remove

the polyp, particularly adenomatous polyp, you may have prevented the actual transformation of that polyp into a cancer.

Another distinct advantage of a screening colonoscopy is that you can detect the cancers early. It's very interesting that still with the ability to have these procedures performed, that less than 40% of colon cancers are detected in the early stage before it has spread. Since colorectal screening is clearly demonstrated to both prevent and better treat colon and rectal cancers and prevent that patient from potentially having a catastrophic outcome, it certainly behooves us as healthcare professionals to take the time and ensure at the time of every visit with patients that they are, indeed, up to date on their screenings, including colorectal screening.

review
COLORECTAL CANCER SCREENING

coverage
Medicare beneficiaries age 50 and older
For screening colonoscopy; age 50 or older, and others at risk, without regard to age
No minimum age for having a barium enema as an alternative to a high risk screening colonoscopy if the beneficiary is at high risk

frequency/tests
Fecal Occult Blood Test
Annually
Flexible Sigmoidoscopy
Every 4 years or once every 10 years after having a screening colonoscopy
Screening Colonoscopy
Every 2 years at high risk
Every 10 years not at high risk
Barium Enema
Every 2 years at high risk
Every 4 years not at high risk

50:30 PROSTATE CANCER SCREENING

DR. RICHARD HUDES: In considering screening patients for prostrate cancer there's the two methods that are widely accepted, including a digital rectal examination which is very useful to make sure that a patient does not have either enlargement of the prostate or nodules that are palpable. Secondly, the PSA test or prostrate specific antigen which evaluates the presence of a protein from the prostrate which circulates in either a bound or free form through the blood.

In considering the management of cancer in general, the issue of prevention and early detection has definitely had a ground swell of momentum currently not just because we think that it makes sense or it's a good idea, but because there is mounting evidence that proves that we can have an impact on preventing or better managing cancer when it's detected early.

VALERIE: We have heard what Dr. Hudes had to say about colorectal and prostate cancer and the benefits of early detection, now let's learn about coverage for this benefit. After watching this segment you should be able to identify the Medicare covered prostate cancer screening services and the frequency parameters of prostate cancer screening services.

DAVID: Valerie, prostate cancer *is* quite common. It is the second leading cause of cancer-related deaths in men and about 70% of all diagnosed prostate cancers are found in men age 65 or older. Medicare provides coverage of the two most common tests used by physicians to test for prostate cancer; the Prostate Specific Antigen (PSA) Blood Test and the Digital Rectal Exam. Prostate specific antigen is a protein produced by the cells of the prostate gland. The FDA approved the use of the PSA test along with the DRE in men age 50 and older to help detect prostate cancer.

VALERIE: The PSA helps differentiate benign from malignant disease in men with lower urinary tract symptoms. The PSA is also important for men with palpably abnormal prostate glands found during a physical exam and for men with other imaging studies showing the possibility of a malignant prostate.

DAVID: The DRE is a clinical examination of an individual's prostate gland for abnormalities such as swelling and/or nodules. All men are at risk for prostate cancer. A beneficiary is at high risk if his father, brother, or son has a history of prostate cancer. Early detection of prostate cancer can help many beneficiaries to live longer, healthier lives.

VALERIE: Medicare covers prostate cancer screening tests once every 12 months for beneficiaries age 50 and older. Please consult your Guide for complete coverage information.

review
PROSTATE CANCER SCREENING

coverage
DRE All male Medicare beneficiaries 50 or older
PSA All male Medicare beneficiaries 50 or older

frequency
DRE Annually
PSA Annually

test/procedure
Digital Rectal Exam (DRE)
Prostate Specific Antigen Test (PSA)

53:55 ADULT IMMUNIZATION

VALERIE: That ends our segment on cancer screenings. We will now begin our segment on Medicare's coverage of adult immunizations, including Influenza, Pneumococcal, and Hepatitis B

vaccinations. Our objectives are for you to be able to identify the adult immunizations covered by Medicare, who is covered, and at what frequency. Captain Ray Strikas, from the Centers for Disease Control and Prevention (CDC) spoke with us from the HHS studio in Washington D.C and gave us an overview of Medicare covered immunizations.

CAPT. RAY STRIKAS, MD: There are two important vaccines diseases that all Medicare beneficiaries and their providers need to understand are important for prevention. These are influenza and the Pneumococcal (ph.) disease. Influenza causes an average of 36,000 deaths and over 200,000 hospitalizations every year in the United States, on average.

The Pneumococcal disease causes over 30,000 serious cases and 5,000 deaths. The majority of these events are in people 65 years of age and older. We've got safe and effective vaccines that can prevent these illnesses, and Medicare pays for those vaccines so that there's no reason for a Medicare patient not to receive them.

Hepatitis B is an infection that's passed on by contact with infected blood or bodily fluid, much is the way that the AIDS infection is. So the people who are at risk are people who have a regular sexual contact with multiple partners, people who use illicit drugs and inject them and also people who have to have regular injections of materials. And in this case we're talking about patients on renal dialysis, kidney dialysis, who have to have injections. And despite the fact one takes every precaution possible, the risk is still there, albeit it is very low. And, therefore, all people who receive end stage kidney dialysis should receive a Hepatitis B vaccine as, of course, should all the staff taking care of them.

There are a number of strategies providers can use to increase the use of these vaccines in their practice settings. They can set up standing orders so that nurses or other practitioners licensed to give vaccines in their state can do so without a direct physician order in their practice and the physician doesn't have to see the patient. They can also set up reminder systems so that when the provider, the nurse or the doctor sees the patient, there's a flag or a mark to say this patient's eligible for vaccination or other preventive services and should receive that service at that visit or be counseled to come back and receive it at another time.

Well, what the provider can do for patients in particular is to provide educational materials in their office setting, be it print materials or video tapes. Probably just as important, if not more so, is to figure out a way to send reminders to patients that it is time in the fall, for example, for your influenza vaccination and you should come to our office and this is when you can do so.

People seem to pay more attention to the recommendation of someone they know who's in a position of authority over their life, their health status (in this case the doctor or the nurse, the healthcare provider) to give them information they need for their health. Perhaps one of the more important things providers need to understand is the power they have to convert or to educate their patient about something the patient previously didn't want to do. In this case we're talking about vaccination.

And we found through surveys that the number one reason patients don't receive influenza and the Pneumococcal vaccine is they weren't aware of it and their provider didn't recommend the vaccine

and educate them about the importance of this for them in their particular situation because they're an older person and/or because they have some chronic medical conditions.

And the power of that persuasion is something not to be underestimated. It is something providers should take advantage of and try to spend an extra minute or two to say, "Well, gee, did you receive this vaccine? If not, why not? Well, you need to understand, you know, it's safe". "It's effective. It's paid for by Medicare. You're not gonna pay out of pocket." This is something that I encourage practitioners to do and I expect they do it all the time with other issues usually treatment-based, cause providers taking care of patients—adult patients are more used to seeing them in a treatment scenario though preventive health is a big part of what they do.

VALERIE: At least 45,000 Americans die each year from influenza and pneumonia, the sixth leading cause of death in the United States. Ninety percent of these deaths are among people 65 years of age or over. The hepatitis B virus causes significant morbidity and mortality worldwide. According to the Centers for Disease Control and Prevention (CDC), an estimated 1.25 million Americans are chronically infected with HBV.

DAVID: In the United States, chronic hepatitis B virus infection is responsible for about 5,000 annual deaths from cirrhosis of the liver and liver cancer. The Medicare Program provides coverage for the influenza, pneumococcal polysaccharide, and hepatitis b vaccinations and their administration.

VALERIE: Let's look at a good example of how a provider can remind beneficiaries to get their flu shots.

DAVE: How to set up a FLU shot clinic?

- **February**
  - Send letters to retirement communities, churches, municipal buildings and other locations throughout the community offering to set up a flu shot clinic at their site.
- **April**
  - Order vaccine
- **Summer**
  - Decide how many nurses and clerks will need to be hired on a temporary basis to administer the shots and submit the claims
- **September**
  - Begin advertising the flu shot clinics dates, times and locations
- **October & November**
  - Conduct clinics

VALERIE: There are lots of ways to remind beneficiaries to get the appropriate immunization at the right time. We hope this information may help you to implement a reminder system in your office. We'd like to thank Captain Strikas of CDC for the immunization information he shared with us in this segment.

review

ADULT IMMUNIZATION

Influenza (FLU)
coverage
All Medicare beneficiaries
frequency
Once per flu season *More frequently if medically necessary*

Pneumococcal (PPV)
coverage
Generally, all Medicare beneficiaries
frequency
Once in a lifetime *Additional vaccinations based on risk*

Hepatitis B (HBV)
coverage
Medicare beneficiaries at medium to high risk
frequency
Scheduled dosages required

1:00:30 BONE MASS MEASUREMENTS

DAVID: Welcome back. Next we want to discuss bone mass measurements and identify the Medicare coverage guidelines.

VALERIE: Osteoporosis or "porous bone" is a disease of the skeletal system characterized by low bone mass and a deterioration of bone tissue. Loss of bone mass can make you susceptible to painful, sometimes disabling fractures, usually in the wrist, hip, and spine. An estimated 10 million Americans have osteoporosis and over 34 million have low bone mass, putting them at risk for osteoporosis.
There are over 1.5 million osteoporosis-related fractures annually. The good news is osteoporosis can be prevented and with early treatment fractures can be reduced or prevented.

DAVID: Bone mass measurements or bone density studies assess bone mass or density associated with osteoporosis and other bone abnormalities. Bone density is usually studied by using photodensitometry, single or dual photon absorptiometry, or bone biopsy. Bone density is usually measured at the wrist, spine, hip, or heel. Medicare provides coverage for three types of densitometers: A stationary device that is permanently located in an office, a mobile device that is transported by vehicle from site to site and, a portable device that can be picked up and moved from one site to another.

VALERIE: Let's look at a clip from Dr. Ethel Siris of the Columbia Presbyterian Hospital and hear her take on bone mass measurements screenings.

DR. ETHEL SIRIS: I think that it's really important for primary care physicians today to think about osteoporosis and osteoporadic risk factors in their post-menopausal patients, particularly in

women over the age of 65 because age does increase risk. I think it's valuable at every office visit to briefly consider risk factors. Certainly an initial assessment of risk factors is appropriate with a judgment about doing the bone density. And then at subsequent visits, just as you wouldn't dream of not doing a mammogram as appropriate, just as you wouldn't dream of not taking a blood pressure or doing a pap smear in women today, my hope would be that a quick risk factor check, which could be accomplished as part of a little questionnaire – the woman could just check a few things in a box as she's sitting in the waiting room, and then reviewing that appropriate referral for bone density and a consideration of reviewing that from time to time with office visits. I think it's very important in trying to identify those women at high risk, because those are the women where you want to act. A woman who's had a fracture as an adult is an especially high risk patient. If you have a woman who's had a Colles' fracture or a spine fracture or a rib fracture or any fracture, that's the woman you particularly want to focus on, because she's at the highest risk of another one. So you should be thinking in terms of those patients.

I think in closing, I just want to remind my colleagues that osteoporosis is a very common disease. One in two women, after menopause, will suffer an osteoporadic fracture in her remaining lifetime. Hip fractures are associated with a 20% excess mortality in the year after fracture. 50% of women who break their hips never go back to the normal lifestyle they had pre-fracture, and about 25% wind up in nursing homes permanently. A lot of these fractures occur in women in their 70's and 80's, but the process that starts the bone loss is initiated after menopause. So when the post-menopausal woman, whether she's 50 or 55 or if you haven't thought about it until she's 65, then you really need to think about it. You've got to evaluate risk factors, you've got to consider the possibility of doing bone density testing, and if the woman is at risk, you really need to intervene.

We've got to break this cycle of having elderly women losing their independence, losing their ability to function, to be the women they want to be as they grow old. Women lead a third of their lives after menopause and you can do so much in terms of prevention and treatment to keep those years' good years, free from the devastation of serious fractures such as spine or hip fractures.

VALERIE: While anyone can develop osteoporosis, some factors that put individuals at increased risk are:

- Age 50 or older
- Female gender
- Family history of broken bones
- Personal history of broken bones
- Caucasian or Asian ethnicity
- Small-bone structure
- Low body weight (less than 127 pounds)
- Frequent smoking or drinking, or
- Low-calcium diet

DAVID: Medicare covers bone mass measurements once every 2 years when performed on a qualified beneficiary at clinical risk for osteoporosis. For more information on bone mass measurement screening tests and complete coverage guidelines, please consult *The Guide*.

review
BONE MASS MEASUREMENTS

coverage
Qualified Medicare beneficiaries at clinical risk for developing Osteoporosis

frequency
Every 24 months *More frequently if medically necessary*

test
Bone mass measurement or bone density study

1:06:12 GLAUCOMA SCREENING

VALERIE: And now we'd like to present our final topic of discussion, glaucoma screening. At the conclusion of this segment, you should be able to identify: the type of screening covered by Medicare, who is covered, and frequency for glaucoma screening.

DAVID: We recently had an opportunity to visit the Glaucoma area at the Wilmer Eye institute at the Johns Hopkins Hospital. While there we sat down to speak with Dr. Harry Quigley. Please join us in listening to what he has to say about Glaucoma.

DR. HARRY QUIGLEY: There are actually two major forms of glaucoma. Glaucoma's an eye disease that affects older persons predominantly. Though it occurs occasionally in 30 year old people, the incidence and prevalence of the disease go up fairly steeply with age. They're disorders of the eye specifically affecting the optic nerve in the back of the eye so that someone loses vision slowly and without any symptoms whatever in most cases.

The vision that's lost cannot be recovered, but treatment of the disease can prevent the vision loss from happening. Glaucoma's the second leading cause of blindness in the world, the largest preventable cause of blindness in African Americans and Hispanic Americans.

The benefit of preventive screening for a disease that has no symptoms is the patients don't know they have glaucoma. In the United States more than 50% of those who have glaucoma have no idea they have the disease and by the time they personally recognize it, they're often blind in one eye and seriously affected in the other eye.

So for a disorder that has no symptoms preventively identifying the person with the disease ahead of time is really of paramount importance so that we can offer therapy that blocks their vision loss. Screening, as offered by Medicare, is an initial step in the diagnosis of glaucoma.

The risk factors for glaucoma would point a provider to knowing who would best benefit from getting the screening benefit and, in fact, the screening benefit is designed so that you have to have certain risk factors in order to qualify. But for most Medicare patients, and especially those who are Hispanic or African American, the rate of glaucoma is substantially higher.

The older you are, the more likely you are to have glaucoma. We've already talked about family history. That those who have a family member affected are more than 10 times likely to have glaucoma. Those who are extremely nearsighted as well are also much more commonly found to have glaucoma of the open angled glaucoma type.

Once someone loses vision they've lost it permanently. So the beauty of doing preventive care for this disorder of glaucoma is that we have an effective method of treatment, we have screening techniques that are effective enough (especially combined with additional diagnostic testing) that we can identify glaucoma with a very high sensitivity and in that way prevent people from becoming a blind person who otherwise should have continued seeing throughout the rest of their life.

DAVID: The glaucoma screening covered by Medicare consists of a dilated eye examination with an intraocular pressure (IOP) measurement, a direct ophthalmoscopy examination, or a slit-lamp biomicroscopic examination. It is important that Medicare provides coverage for high risk groups**:**

- African-Americans,
- individuals with diabetes, and
- individuals with a family history of glaucoma.

According to the National Eye Institute, African-Americans between the ages of 45 and 64 are 15 times more likely to go blind from glaucoma than Caucasians from the same age group.

VALERIE: Likewise, adults with diabetes are nearly twice as likely to develop glaucoma as other adults, and the longer a person has had diabetes, the more likely he or she is to develop glaucoma.

review
GLAUCOMA SCREENING

coverage
Medicare beneficiaries in one of the high risk groups (diabetes mellitus, family history of glaucoma or African-Americans age 50 & over & Hispanic-Americans age 65 & over

frequency
Annually for beneficiaries in one of the high risk groups

tests
A dilated eye exam with intraocular pressure measurement
A direct ophthalmoscopy exam or slit-lamp biomicroscopic exam

DAVID: Resources and other preventive services information can be found in *The Guide*. This concludes our segment on the glaucoma screening benefit. This also concludes our detailed discussions on Medicare's Preventive Services. At this time we would like to share with you information about a new benefit added to the Medicare Program in March, 2005.

VALERIE: On March 22, 2005 CMS began covering smoking and tobacco use cessation counseling for certain Medicare beneficiaries to help them quit the habit. This new Medicare covered service builds on a series of the Department of Health and Human Services' (HHS) initiatives designed to help Americans quit smoking.

DAVID: And finally beginning January 1, 2006, Medicare will offer coverage for prescription drugs through Medicare prescription drug plans. These plans will help Medicare beneficiaries save money on their prescription drug costs.

VALERIE: Well, that brings us to the end of our discussion of Medicare's preventive services and screenings. We've covered a lot of information and hope you have found it useful. We'd like to ask that you take a few moments to complete the posttest that was mailed to you in the packet of information that came with this video.

DAVID: To successfully complete this course you need to complete the pretest, score 70% or higher on the posttest, complete the evaluation and Continuing Education forms and return all of the above to us per your packet instructions. So pause the tape now, and take the post-test. When you are finished, press play again, and we will have some closing comments.

VALERIE: Welcome back. Thanks for taking the time to fill out not only the posttest, but also the course evaluation. We hope that we have given you the tools to become a lifelong Medicare learner. ***The Guide*** is your best resource, for Medicare Preventive Services!

DAVID: Because of America's aging population, the number of Medicare beneficiaries will nearly double in the next 30 years. Chances are, you will be treating more Medicare beneficiaries than ever, so the more you know now, the better off you will be in the future.

VALERIE: For many years CMS has provided comprehensive provider training and educational programs. This video program is just one example of that. We encourage you to continue to educate yourself about Medicare through the Medicare Learning Network and all the resources we provide.

With your help we will be able to deliver the best possible health care to Medicare beneficiaries and continue our initiative toward a prevention-oriented program.

DAVID: Until next time we wish you all the success and satisfaction that comes from patient care.

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