Why You Can’t Get An Annual Medicare Physical

In 2011, the Centers for Medicare and Medicaid (CMS) unveiled a new benefit to address the need for annual care for seniors. It was widely hailed as a wonderful thing for Medicare patients who previously had no preventive care unless they paid out-of-pocket for a “complete physical.” What some people overlook is that the new Medicare benefit includes no actual physical examination of any kind.

The “physical” terminology is what trips most people up. The American Medical Association (AMA) owns Current Procedural Terminology (CPT) which is part of the Medicare’s Healthcare Common Procedure Coding System (HCPCS). Neither CPT nor HCPCS lists an “annual physical” or a “complete physical,” with the exception of the preventive visit codes which include an “age-appropriate examination.” The traditional expectation for an annual physical is complete review of all physical systems with reporting of any issues, a complete head to toe physical examination, and any needed tests to confirm/promote wellness or to ascertain illness.

According to CPT/HCPCS, confirming/promoting wellness and ascertaining illness are not both parts of one code, but are addressed in two different types of codes – the well visit codes and the sick visit codes. The question on everyone’s mind is “What if you ascertain and address illness (a new problem) during a well visit?”

I don’t think there is a good answer to this question. There’s the right answer for billing, according to Medicare and there’s the right answer in the minds of most physicians I know, but there is not a single answer that works for billing and what patients want.

Because of this confusion, there is great frustration on the part of physicians and patients. If the office doesn't understand what the patient wants, or the patient doesn't understand their Medicare benefits, there is either a surprise in the exam room, or a surprise at the check-out desk, and no one enjoys that kind of surprise.

The only answer is to help patients understand what Medicare will and will not pay for and to try to match their benefits, their needs and what they are willing to pay for.

Here are the service choices defined by CMS/Medicare:

NAME: Welcome to Medicare Visit

WHEN: Available to all Medicare patients during the first 12 months of Medicare Part B eligibility

WHAT HAPPENS: Review of patient's medical history, risk factors, functional abilities and referrals for education or counseling. Could include an EKG or referral for an EKG. Could include screening for an
abdominal aortic aneurysm (AAA). **Does not include a physical exam.**

WHO PAYS: This visit has no deductible and no co-insurance, unless the patient has a screening EKG. The EKG does have the deductible and co-insurance applied.

NAME: Annual Wellness Visit

WHEN: Available 12 months after the Welcome to Medicare Visit and every 12 months thereafter
Does not include a physical exam.

WHAT HAPPENS: Review of your medical history, risk factors, functional abilities, a depression screening and a written screening schedule.

WHO PAYS WHAT: This visit has no deductible and no co-insurance.

NAME: Sick Visit (standard office visit)

WHEN: No restrictions on how often as long as there is a documented need for the visit.

WHAT HAPPENS: This is a regular office visit for an illness, injury or new problem or for monitoring of an existing problem. The three parts of a standard office visit are the HISTORY, the PHYSICAL EXAM, and the ASSESSMENT/PLAN.

WHO PAYS WHAT: This visit will apply to the deductible ($147 for 2013) if the patient's deductible has not been met, and co-insurance will apply.

SPECIAL NOTE: Patients can have a wellness visit and a sick visit at the same appointment and will not owe anything for the wellness visit but will owe the deductible/co-insurance for the sick visit.

NAME: Preventive Visit (most like the old "annual physical")

WHEN: Annually.

WHAT HAPPENS: This is a visit where the physician will review your medical history and perform an exam, order routine lab

tests and talk to you about risk factor reduction.

WHO PAYS: Medicare does not pay for this service at all and the patient is responsible for 100% of the cost of the visit.

CMS Presents Two Calls and a Webinar: EHR Incentives, IPPE & Annual Wellness Visit

1. **Thursday, March 22 – Webinar: Introduction and Overview of the EHR Incentive Programs**

2. **Wednesday, March 28 – Provider Call on Medicare Initial Preventive Physical Exam and Annual Wellness Visit**

3. **Thursday, March 29 – National Provider Call: Medicare & Medicaid EHR Incentive Program Basics for Eligible Professionals**

(Image credit: Getty Images via @daylife)

Webinar: Introduction and Overview of the EHR Incentive Programs

Thu Mar 22, 3-4pm ET

CMS and the Professional Association of Health Care Office Management (PAHCOM) are holding a free webinar on the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs. The webinar will provide an overview of how the Medicare and Medicaid EHR Incentive Programs are structured and administered, and will provide key insights for providers regarding their participation and navigation of the programs.

Registration Information: Registration Closed

National Provider Call: Medicare Preventive Services: Initial Preventive Physical Exam and Annual Wellness Visit

Wed Mar 28; 2:30-4pm ET

Don’t miss this opportunity to get the information you need about the Initial Preventive Physical Exam (IPPE – also known as the “Welcome to Medicare” Preventive Visit) and the Annual Wellness Visit (AWV). This year, the CY2012 Medicare Physician Fee Schedule Final Rule added a Health Risk Assessment to the AWV. CMS experts will be on hand to discuss both the IPPE and AWV, when to perform them, who can perform each service, who is eligible, and how to code and bill for each service, followed by a question and answer session.

Target Audience: Physicians, physician assistants, nurse practitioners, clinical nurse specialists, health educators, registered dietitians, nutrition professionals, medical

billers and coders, and other interested healthcare professionals

Registration Information: In order to receive call-in information, you must register for the call at http://www.eventsvc.com/blhtechnologies. Registration will close at 12pm on the day of the call or when available space has been filled; no exceptions will be made, so please register early.

Presentation: The presentation for this call will be posted at least one day beforehand at http://www.CMS.gov/NPC/Calls/-itemdetail.asp?itemID=CMS1256439. In addition, the presentation will be emailed to all registrants on the day of the call.

National Provider Call: Medicare & Medicaid EHR Incentive Program Basics for Eligible Professionals

Thu Mar 29; 3-4:30pm ET

As of Tue Jan 31, more than $3.2 billion in Medicare and Medicaid electronic health record (EHR) incentive payments have been made; more than 191,000 eligible professionals, eligible hospitals, and critical access hospitals are actively registered. Learn if you are eligible and, if so, what you need to do to earn an incentive. This session will inform individual practitioners about the basics of the Medicare & Medicaid EHR Incentive Programs.

Registration Information: In order to receive call-in information, you must register for the call at http://www.eventsvc.com/blhtechnologies. Registration will close at 12pm on the day of the call or when available space has been filled; no exceptions will be made, so please register early.

Presentation: The presentation for this call will be posted at least one day beforehand at http://www.CMS.gov/NPC/Calls. In addition, the presentation will be emailed to all registrants on the day of the call.

Updated 2011 CMS Policies: Incentive Payments, GPCI Revisions, Multiple Procedure Payment Reductions for Therapy, and Modification of Multiple Procedure Payment Policy for Advanced Imaging Services

Elimination of Deductible and Coinsurance for Most Preventive Services

Effective January 1, 2011, the Affordable Care Act waives the Part B deductible and the 20 percent coinsurance that would otherwise apply to most preventive services.

Note: I covered this in my post here and it's pretty straightforward.

Coverage of Annual Wellness Visit (AWV) Providing a Personalized Prevention Plan

The Affordable Care Act extends the preventive focus of Medicare coverage, which currently pays for a one-time initial preventive physical examination (IPPE or the "Welcome to Medicare Visit"), to provide coverage for annual wellness visits in which beneficiaries will receive personalized prevention plan services (PPPS). The law states that the AWV will include at least the following six elements, as determined by the Secretary of Health and Human Services:

- Establish or update the individual's medical and family history;
- List the individual's current medical providers and suppliers and all prescribed medications;
- Record measurements of height, weight, body mass index, blood pressure and other routine measurements;
- Detect any cognitive impairment
- Establish or update a screening schedule for the next 5 to 10 years including screenings appropriate for the general population, and any additional screenings that may be appropriate because of the individual patient's risk factors; and
- Furnish personalized health advice and appropriate referrals to health education or education or preventive services.

CMS has developed two separate Level II HCPCS codes for the first annual wellness visit (G0438 – Annual wellness visit, including personalized prevention plan services, first visit), to be paid at the rate of a level 4 office visit for a new patient (similar to the IPPE), and for subsequent annual wellness visits (G0439 – Annual wellness visit, including personalized prevention plan services, subsequent visit), to be paid at the rate of a level 4 office visit for an established patient.

Note: Payment for annual wellness visits (AWV) is now covered by Medicare and the payment will be equivalent to a established level 4 visit. I've received a lot of questions about who can perform the PPPS and CMS says "A medical professional (including a health educator, registered dietitian, or nutrition professional or other licensed practitioner) or a team of such medical professionals, working under the direct supervision of a physician."

An evaluation and management code (EM) may be billed with the annual wellness visit if the EM service is medically necessary. If so, a modifier 25 must be appended to the EM service and the documentation for the EM service must have no components of the annual wellness visit used in determining the level of service for the EM visit. A separate note containing the history, exam and medical decision making, relative to the presenting problem, must be separately documented.

Incentive Payments to Primary Care Practitioners for Primary Care Services

The Affordable Care Act provides for incentive payments equal to 10 percent of a primary care practitioner's allowed charges for primary care services under Part B, furnished on or after January 1, 2011, and before January 1, 2016. Under the final policy, primary care practitioners are: (1) physicians who have a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine; as well as nurse practitioners, clinical nurse specialists, and physician assistants; and (2) for whom primary care services accounted for at least 60 percent of the practitioner's Medicare Physician Fee Schedule (MPFS) allowed charges for a prior period as determined by the Secretary of Health and Human Services.

The law also defines primary care services as limited to new and established patient office or other outpatient visits (CPT codes 99201 through 99215); nursing facility care visits, and domiciliary, rest home, or home care plan oversight services (CPT codes 99304 through 99340); and patient home visits (CPT codes 99341 through 99350).

In the final rule with comment period, CMS excluded consideration of allowed charges for hospital inpatient care and emergency department visits in determining whether the 60 percent primary care threshold is met. These exclusions will make it easier for practitioners of eligible specialties to become eligible for the payment incentive program. The incentive payments will be made quarterly based on the primary care services furnished in CY 2011 by the primary care practitioner, in addition to any physician bonus payments for services furnished in Health Professional Shortage Areas (HPSAs). CMS will determine a practitioner's eligibility for incentive payments in CY 2011 using claims data and the provider's specialty designation from CY 2009 for practitioners enrolled in CY 2009. For newly enrolled practitioners, CMS will use claims data from CY 2010 to make an eligibility determination regarding CY 2011 incentive payments. For subsequent years, CMS will revise the list of primary care practitioners on a yearly basis, based on updated data regarding an individual's specialty designation and percentage of allowed charges for primary care services.

Note: There is nothing to count or report: the bonuses arrive quarterly. Providers in HPSAs will receive two bonuses. Want to know if you're in a HPSA? Click here.

Incentive Payments for Major Surgical

Procedures in Health Professional Shortage Areas

The Affordable Care Act also calls for a payment incentive program to improve access to major surgical procedures ”“ defined as those with a 10-day or 90-day global period under the MPFS ”“ that are furnished by physicians in HPSAs on or after January 1, 2011, and before January 1, 2016. To be eligible for the incentive payment, the physician must be enrolled in Medicare as a general surgeon. The amount of the incentive payment is equal to 10 percent of the MPFS payment for the surgical services furnished by the general surgeon. The incentive payments will be made quarterly to the general surgeon when the major surgical procedure is furnished in a zip code that is located in a HPSA. CMS will use the same list of HPSAs that it has used under the existing HPSA bonus program.

Note: 10% bonus for general surgeons in HPSAs. Want to know if you’re in a HPSA? Click here.

Revisions to the Practice Expense Geographic Adjustment

As required by the Medicare law, CMS adjusts payments under the MPFS to reflect local differences in practice costs. CMS assigns separate geographic practice cost indices (GPCIs) to the work, practice expenses (PE), and malpractice insurance cost components of each of more than 7,000 types of physicians’ services. The final rule with comment period discusses CMS’ analysis of PE GPCI data and methods, and incorporates new data as part of the sixth GPCI update, while maintaining the current GPCI cost share weights pending the results of further CMS and Institute of Medicine studies.

The Affordable Care Act establishes a permanent 1.0 floor for the PE GPCI for frontier states (currently, Montana, Wyoming, Nevada, North Dakota, and South Dakota). The Affordable Care Act limits recognition of local differences in employee wages and office rents in the PE GPCIs for CYs 2011 and 2012 as compared to the national average. Localities are held harmless for any decrease in CYs 2011 and 2012 in their PE GPCIs that would result from the limited recognition of cost differences. CMS will continue to review the GPCIs in CY 2011, in accordance with the Affordable Care Act provision that requires the Secretary of Health and Human Services to analyze current methods of establishing PE GPCIs in order to make adjustments that fairly and reliably distinguish the costs of operating a medical practice in the different fee schedule areas.

Note: Check your GPCI (pronounced "gypsy") for changes this year and every year. The GPCI changes the RVU values so they are specific to your location.

Where do I find my GPCI? Click here, click on Physician Fee Schedule Search at the top, click to accept the AMA terms, click on Geographic Practice Cost Index, enter your locality and click submit.

Improved Access to Certified Nurse-Midwife Services

The Affordable Care Act increases the Medicare payment for certified nurse-midwife services from 65 percent of the PFS amount for the same service furnished by a physician to 100 percent of the PFS amount for the same service furnished by a physician (or 80 percent of the actual charge if that is less). The increased payment amount is effective for services furnished on or after Jan. 1, 2011.

Misvalued Codes under the Physician Fee Schedule

The Affordable Care Act requires CMS to periodically review and identify potentially misvalued codes and make appropriate adjustments to the relative values of the services that may be misvalued. CMS has been engaged in a vigorous effort over the past several years to identify and revise potentially misvalued codes. The final rule with comment period identifies additional categories of services that may be misvalued, including codes with low work RVUs commonly billed in multiple units per single encounter and codes with high volume and low work RVUs. The final rule also includes CMS' response to recommendations from the American Medical Association (AMA) Relative Value Update Committee (RUC) for CY 2011 regarding the work or direct practice expense inputs for 325 CPT codes.

Note: People and organizations are always lobbying to change the work or practice expense component of RVUs and some portion of the codes change every year. Make sure your computer is updated with the correct RVU components and total so your productivity reports are spot on.

Multiple Procedure Payment Reduction Policy for Therapy Services

The Affordable Care Act requires CMS to identify and make adjustments to the relative values for multiple services that are frequently billed together when a comprehensive service is furnished. CMS is adopting a multiple procedure payment reduction (MPPR) policy for therapy services in order to more appropriately recognize the efficiencies when combinations of therapy services are furnished together. The policy, as described in the CY 2011 MPFS final rule with comment period, states that the MPPR for "always" therapy services will

reduce by 25 percent the payment for the practice expense component of the second and subsequent therapy services furnished by a single provider to a beneficiary on a single date of service. This policy will apply to all outpatient therapy services paid under Part B, including those furnished in office and facility settings.

Since publication of the CY 2011 MPFS final rule with comment period, this policy has been modified by the Physician Payment and Therapy Relief Act of 2010. Per this Act, CMS will apply the CY 2011 MPFS final rule policy of a 25 percent MPPR to therapy services furnished in the hospital outpatient department and other facility settings that are paid under section 1834(k) of the Social Security Act (referring to durable medical equipment), and a 20 percent therapy MPPR will apply to therapy services furnished in clinicians' offices and other settings that are paid under section 1848 (payments to physicians) of the Act.

Note: The reduction applies solely to the practice expense (PE) portion of the fee schedule payment for "Always Therapy Services" when more than one service is provided the same patient on the same day. "Always therapy" services are always considered to be therapy regardless who provides the service (qualified therapist, physician, non-physician practitioner (NPP)). This is the list of services being referred to:

- 92506""Speech /hearing evaluation
- 92507""Speech/hearing therapy
- 92508""Speech/hearing therapy
- 92526""Oral function therapy
- 92597""Oral speech device evaluation
- 92604""Exam for speech device
- 92609""Use of speech device service
- 96125""Standardized cognitive performance test
- 97001""PT evaluation
- 97002""PT re-evaluation
- 97003""OT evaluation

- 97001””OT re-evaluation
- 97012””Mechanical traction
- 97016””Vasopneumatic device
- 97018””Paraffin bath
- 97022””Whirlpool
- 97024””Diathermy (microwave)
- 97026””Infrared
- 97028””Ultraviolet
- 97032””Electrical stimulation
- 97033””Electric current
- 97034””Contrast bath
- 97035””Ultrasound
- 97036””Hydrotherapy
- 97110””Therapeutic exercise
- 97112””Neuromuscular reeducation
- 97113””Aquatic therapy
- 97116””Gait training
- 97124””Massage
- 97140””Manual therapy
- 97150””Group therapeutic
- 97530””Therapeutic activities
- 97533””Sensory integration
- 97535””Self-care management
- 97537””Community work reintegration
- 97542””Wheelchair management
- 97750””Physical performance test
- 97755””Assistive technology assessment
- 97760””Orthotic management & training
- 97761””Prosthetic training
- 97762””Checkout for orthotic or prosthetic use
- G0281””Electrical stimulation for ulcers (unattended)
- G0283””Electrical stimulation other than wound (unattended)
- G0329””Electromagnetic therapy for ulcers

Modification of Equipment Utilization Factor and Modification of Multiple Procedure Payment Policy for Advanced Imaging Services

The Affordable Care Act adjusts the equipment utilization rate assumption for expensive diagnostic imaging equipment. Effective January 1, 2011, CMS will assign a 75 percent equipment utilization rate assumption to expensive diagnostic imaging equipment used in diagnostic computed tomography (CT) and magnetic resonance imaging (MRI) services. In addition, beginning on July 1, 2010, the Affordable Care Act increased the established MPFS multiple procedure payment reduction for the technical component of certain single-session imaging services to consecutive body areas from 25 to 50 percent for the second and subsequent imaging procedures performed in the same session.

Note: These are the services that were added by this policy:

- 70496-CT angiography, head
- 70498-CT angiography, neck
- 70544-MR angiography head w/o dye
- 70545-MR angiography head w/dye
- 70546-MR angiography head w/o & w/dye
- 70547-MR angiography neck w/o dye
- 70548-MR angiography neck w/dye
- 70549-MR angiography neck w/o & w/dye
- 71275-CT angiography, chest
- 71555- MRI angiography chest w/ or w/o dye
- 72159-MRI angiography spine w/o & w/dye
- 72191-CT angiography, pelvis w/o & w/ dye
- 72198-MRI angiography pelvis w/ or w/o dye
- 73206-CT angio upper extremity w/o & w/dye
- 73225-MR angio upper extremity w/o & w/dye
- 73706-CT angiography lower ext w/o & w/dye

- 73725-MR angio lower extremity w or w/o dye
- 74175-CT angiography, abdomen w/o & w/ dye
- 74185-MRI angiography, abdomen w/ or w/o dye
- 75565-Cardiology MRI velocity flow map add-on
- 75574-CT angiography heart w/3d image
- 75635-CT angiography abdominal arteries
- 76380-CAT scan follow-up study
- 77079-CT bone density, peripheral

Image via Wikipedia

Medicare 2011: What's Covered and How Physician Practices Can Deal With the Changes

More information on Medicare wellness visits in 2011 can be found here.

Information on the 2011 Medicare Part A and Part B deductibles and premiums can be found here.

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The extensive changes coming for Medicare Part B coverage in 2011 should have primary care practices and some specialty practices thinking about their current processes. If you meet with your team now to educate them about the Medicare changes and explore process tweaking, you'll be ready when January 1 rolls around.

Image via Wikipedia

Here are a few areas to think about:

1. Advance Beneficiary Notices (ABNs) – Many practices struggle with the who and when of ABNs and the new coverage might not make it easier. There are lots of services now covered with **new frequency limitations**, so practices must be on their toes to recognize when a service is covered and when it isn't. Sure, you can ignore ABNs and wait for Medicare to tell you a service is not covered, but then it's too late to collect from the patient – not only too late, but also illegal to collect.
2. The annual wellness visit is going to be a special challenge because the timing is precise. Medicare patients will hear "annual visit", but won't realize it will not be paid for if performed within 12 months of a previous wellness visit (Welcome to Medicare exam or annual visit). I've not seen any practice management software that handles this really well, but maybe it's out there. I'd love to see Medicare patients scheduling their **annual visits during their birthday month** so staff would have a fighting chance of identifying the last annual visit and getting the date right. Of course, using your electronic recall will work too if you **schedule the next year's visit when the patient is checking out.** (Do you proactively contact your Medicare patients to invite them to come in for their Welcome to Medicare exam?) Also encourage patients to keep up with the preventive services they are eligible to receive by **registering with the My Medicare website** (https://mymedicare.gov/). This is their personal Medicare website for tracking their Medicare services. It will send them e-mail reminders when they are

eligible for Medicare coverage of preventive services. Great idea!

3. **Who will be doing the counseling** about the "preventive services covered by Medicare" during the annual exam? Let's hope Medicare puts out a really great handout!
4. Most EMRs will let you load requirements for services based on diagnosis – for example, diabetes. Make sure you are taking advantage of the EMR's ability to **set up protocols for age, diagnosis and risk factors**. If you are not on EMR yet, use your **appointment schedule or recall system to set reminder appointments** to contact patients for their services.
5. **Don't forget your patients on Medicare who are not yet age 65.** Run a report to find these patients and flag them to acknowledge that their Medicare services are at different times.
6. **Collections at time of service will change** too, of course, as most services listed below will not be applied to the deductible. Exceptions are glaucoma screening, diabetes monitoring and education, medical nutritional, and smoking cessation. Patients understandably will be confused, so make sure your check-out staff are crystal clear.

Medicare Benefits Beginning January 1, 2011

- **Medicare covers a one-time preventive physical exam within the first twelve months of having Part B**. The exam will include a thorough review of health, education and counseling about the preventive services covered by Medicare and referrals for other care if needed. No Part B deductible and effective January 1, 2011 you pay nothing if the doctor accepts assignment.
- **Abdominal Aortic Aneurysm Screening** – People at risk for abdominal aortic aneurysms may get a referral for a one-

time screening ultrasound at their “Welcome to Medicare” physical exam. Effective January 1, 2011 no deductible and no copayment.

- **New Annual Wellness Visit** – Effective January 1, 2011 Medicare will cover an Annual Wellness Visit that includes a thorough review of health, education and counseling about the preventive services covered by Medicare and referrals for other care if you need it. It is available every 12 months (after first 12 months of Part B coverage) but not within 12 months of receiving either a “Welcome to Medicare” physical exam or another Annual Wellness Visit. No Part B deductible ”“ Medicare pays 100% of the approved amount.
- **Cardiovascular Screening Blood Tests** – Medicare covers cardiovascular screening tests that check cholesterol and other blood fat (lipid) levels every 5 years. Includes:
    - Total Cholesterol Test
    - Cholesterol Test for High Density Lipoproteins; and
    - Triglycerides Test
    - No Part B deductible ”“ Medicare pays 100% of approved amount.
- **Diabetes Screening Tests** – Anyone enrolled in Medicare identified as “high risk” for diabetes will be able to receive screening tests to detect diabetes early. Covers up to two screenings each year. Includes:
    - Fasting plasma glucose test
    - Post-glucose challenge test
    - No Part B deductible ”“ Medicare pays 100% of approved amount
- **Glaucoma Screening** – Must be done or supervised by an eye doctor (optometrist or ophthalmologist). Covered annually for:
    - Those with diabetes

    - Those with a family history of glaucoma
    - African-Americans age 50 and older
    - Hispanic-Americans age 65 and older
    - Other high risk individuals
    - Medicare pays 80% of the approved amount after you meet the yearly Part B deductible.
- **Bone Mass Measurement –** For those enrolled in Medicare at high risk for losing bone mass. Effective January 1, 2011 no Part B deductible "" Medicare pays 100% of approved amount.
- **Screening Mammography** (including new digital technologies) – For women age 40 and older enrolled in Medicare:
    - Covered annually
    - No Part B deductible "" Medicare pays 100% of approved amount beginning January 1, 2011.
- **Screening Pap Test & Pelvic Examination** (Includes clinical breast examination) – For all women enrolled in Medicare:
    - Covered once every two years for most
    - Covered annually for women at high risk
    - No Part B deductible "" Medicare pays 100% of approved amount for Pap test and effective January 1, 2011 pays 100% of approved amount for pelvic and breast exam.
- **Colorectal Cancer Screening** – For all those enrolled in Medicare age 50 and older:
    - Fecal-Occult blood test covered annually "" No Part B deductible & Medicare pays 100% of approved amount.
    - Flexible sigmoidoscopy once every four years or 10 years after a previous screening colonoscopy"" No Part B deductible or copayment starting January 1, 2011.
    - Barium enema can be substituted for sigmoidoscopy or colonoscopy "" No Part B deductible – Medicare

pays 80% of the approved amount. You will pay a higher coinsurance if the test is done in a hospital outpatient department.
    - Colonoscopy for any age enrolled in Medicare
    - Average risk – Once every ten years, but not within four years after a screening flexible sigmoidoscopy
    - High-risk – Once every two years
    - No Part B deductible and effective January 1, 2011 Medicare pays 100%.
- **Prostate Cancer Screening Tests** -For all men enrolled in Medicare age 50 and older:
    - Covered annually
    - Digital rectal exam ”“ Medicare pays 80% of the approved amount after the deductible
    - Prostate Specific Antigen (PSA) test
    - No Part B deductible – Medicare pays 100% of approved amount.
- **Diabetes Monitoring and Education** – Covers Type I and Type II diabetics enrolled in Medicare who must monitor blood sugar (Not paid for those in a nursing home) Covered services:
    - Glucose-monitoring devices, lancets & strips
    - Education & training to help control diabetes
    - Foot care once every 6 months for those with peripheral neuropathy
    - Medicare pays 80% of the approved amount after you meet the yearly Part B deductible.
- **Medical Nutritional Therapy** – Covered for those with diabetes or kidney disease. Includes diagnosis of special nutrition needs, therapy and counseling services to help you manage your disease. Medicare pays 80% of the approved amount after you meet the yearly Part B deductible.

- **Smoking Cessation Services** – Medicare will cover up to 8 counseling sessions per year for individuals who have an illness caused or complicated by tobacco use or you take medication affected by tobacco use. Medicare pays 80% of the approved amount after you meet the yearly Part B deductible.
- **Flu Vaccination Annually** (Medicare pays once per season. You do not have to wait 365 days since your last one.) No Part B deductible ”“ you pay nothing if your doctor accepts assignment. My post on billing for the flu shot is **here.**
- **H1N1 Flu Vaccine** Medicare covers the administration of the H1N1 flu shot. You cannot be charged for the vaccine. No Part B deductible or co-insurance.
- **Pneumococcal Pneumonia Vaccination**– Once per lifetime for all enrolled in Medicare. (A doctor may order additional ones for those with certain health problems.) No Part B deductible ”“ Medicare pays 100% of approved amount.
- **Hepatitis B Shots** – Covered for those who are at medium or high risk. Effective January 1, 2011, there will be no Part B deductible and Medicare pays 100%.