Part B Covered Services

**Abdominal Aortic Aneurysm Screening** — Medicare covers a one-time abdominal aortic aneurysm ultra-sound screening for people at risk. They must get a referral for it as part of their one-time “Welcome to Medicare” preventive visit. They pay nothing for the screening if the doctor or other qualified health care provider accepts assignment.

**Alcohol Misuse Counseling** — Medicare covers one alcohol misuse screening per year for adults with Medicare (including pregnant women) who use alcohol but don’t meet the medical criteria for alcohol dependency.

**Ambulance Service** — Medicare covers ground ambulance transportation when a beneficiary needs to be transported to a hospital, critical access hospital or skilled nursing facility for medically necessary services, and transportation in any other vehicle could endanger their health. Medicare will only cover ambulance services to the nearest appropriate medical facility that’s able to give they the care they need. The beneficiary pays 20% of the Medicare-approved amount and the Part B deductible applies.

**Ambulatory Surgical Centers** — Medicare covers the facility fees for approved surgical procedures in an ambulatory surgical center (facility where surgical procedures are performed), and the beneficiary is expected to be released within 24 hours. Except for certain preventive services (for which they pay nothing), the beneficiary pays 20% of the Medicare-approved amount to both the ambulatory surgical center and the doctor who treats them, and the Part B deductible applies.

**Blood** — If the provider gets blood from a blood bank at no charge, the beneficiary won’t have to pay for it or replace it. However, they’ll pay a co-payment for the blood processing and handling services for every unit of blood they get, and the Part B deductible applies. If the provider has to buy blood for them, they must either pay the provider costs for the first three units of blood they get in a calendar year or have the blood donated by someone.

**Bone Density Test** — This test helps to see if an individual is at risk for broken bones. It’s covered once every 24 months (more often if medically necessary) for people who have certain medical conditions or meet certain criteria. The beneficiary pays nothing for this test if the doctor or other qualified health care provider accepts assignment.

**Mammograms** — Medicare covers screening mammograms to check for breast cancer once every 12 months for all women with Medicare 40 and older. Medicare covers one baseline mammogram for women between ages 35 and 39. The beneficiary pays nothing for the test if the doctor or other qualified health care provider accepts assignment.

**Cardiac Rehab** — Medicare covers comprehensive programs that include exercise, education, and counseling, for beneficiaries who meet certain conditions. Medicare also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than regular cardiac rehabilitation programs. The beneficiary pays 20% of the Medicare-approved amount if they get the services in a doctor’s office. In a hospital outpatient setting, they also pay the hospital a co-payment. The Part B deductible applies.

**Cardiovascular Disease** — Medicare will cover one visit per year with a primary care doctor to help lower the risk of cardiovascular disease.

**Cardiovascular Screenings** — These screenings include blood tests, that help detect conditions, which may lead to a heart attack or stroke. Medicare covers these screening tests every five years to test cholesterol, lipid, lipoprotein and triglyceride levels. The beneficiary pays nothing for the tests, but they generally have to pay 20% of the Medicare-approved amount for the doctor’s visit.

**Cervical and Vaginal Cancer Screening** — Medicare covers Pap tests and pelvic exams to check for cervical and vaginal cancers. As part of the exam, Medicare also covers clinical breast exam to check for breast cancer. Medicare covers these screening tests once every 24 months.

**Chemotherapy** — Medicare covers chemotherapy in a doctor’s office, freestanding clinic, or hospital outpatient setting, for people with cancer. For chemotherapy given in a doctor’s office or freestanding clinic, the beneficiary pays 20% of the Medicare-approved amount.

**Chiropractic Services** — Medicare covers these services to help correct a subluxation (when one or more of the bones of the spine move out of position) using manipulation of the spine. The beneficiary pays 20% of the Medicare-approved amount, and the Part B deductible applies.

**Clinical Research Studies** — Clinical research studies test how well different types of medical care work, and if they’re safe. Medicare covers some costs, like office visits and the tests, in qualifying clinical research studies. The beneficiary may pay 20% of the Medicare-approved amount and the Part B deductible may apply.

**Colorectal Cancer Screenings** — Medicare covers these screenings to help find precancerous growths or find cancer early, when treatment is most effective.

**Fecal Occult Blood Test** — This test is covered once every 12 months, if the beneficiary is 50 or older. The beneficiary pays nothing for the test if the doctor, or other qualified health care provider accepts assignment.

**Flexible Sigmoidoscopy** — This test is generally covered once every 48 months, if the beneficiary is 50 or older, or every 120 months after a previous screening colonoscopy for those not at high risk. The beneficiary pays nothing for the test if the doctor or other qualified health care provider accepts assignment.

**Colonoscopy** — This test is generally covered once every 120 months (high risk every 24 months) or 48 months after a previous flexible sigmoidoscopy. There is no minimum age. The beneficiary pays nothing for the test if the doctor, or other qualified health care provider accepts assignment. If a polyp or other tissue is found and removed during the colonoscopy, they may have to pay 20% of the Medicare-approved amount for the doctor’s services and co-payments in a hospital outpatient setting.

**Barium Enema** — This test is generally covered once every 48 months if the beneficiary is 50 or older, (if high risk, once every 24 months) when used instead of a sigmoidoscopy or colonoscopy. The beneficiary pays 20% of the Medicare-approved amount for the doctor services. In a hospital outpatient setting beneficiary also pays the hospital co-payment.

**Defibrillator** — Medicare covers these devices for some people diagnosed with heart failure.

If the surgery takes place in an outpatient setting, the beneficiary pays 20% of the Medicare-approved amount for the doctor’s services.

**Depression Screening** — Medicare covers one depression screening per year. The screening must be done in a primary care setting (like a doctor’s office) that can provide follow-up treatment and referrals.

The beneficiary pays nothing for this test if the doctor or health care provider accepts assignment, but they generally have to pay 20% of the Medicare approved amount for the doctor’s visit.

**Diabetes Screening** — Medicare covers these screenings if their doctor determines a beneficiary is at risk for diabetes. They may be eligible for up to two diabetes screenings each year. They pay nothing for the test if their doctor or other qualified health care provider accepts assignment.

**Diabetes Self-Management Training** — Medicare covers a program to help people cope with and manage diabetes. The beneficiary must have diabetes and a written order from their doctor or other health care provider. The beneficiary pays 20% of the Medicare-approved amount, and the Part B deductible applies.

**Diabetes Supplies** — Medicare covers blood sugar testing monitors, blood sugar test strips, lancet devices and lancets, blood sugar control solutions and therapeutic shoes (in some cases). Medicare only covers insulin if used with an external insulin pump. The beneficiary pays 20% of the Medicare-approved amount, and the Part B deductible applies.

**Doctor and Other Health Screenings** — Medicare covers medically necessary doctor services (including outpatient, and some doctor services, which the beneficiary gets when they’re in a hospital inpatient) and covered preventive services. Medicare also covers services provided by other health care providers, like physician assistants, nurse practitioners, social workers, physical therapists, and psychologists. Except for certain preventive services (for which they may pay nothing), the beneficiary pays 20% of the Medicare-approved amount, and the Part B deductible applies.

**Durable Medical Equipment** — Medicare covers items like oxygen equipment/supplies, wheelchairs, walkers, and hospital beds ordered by a doctor or other health care provider enrolled in Medicare for use in the home. Some items must be rented. The beneficiary pays 20% of the Medicare-approved amount, and the Part B deductible applies. In order for Medicare to pay, beneficiaries must get their covered equipment/supplies, and replacement/repair services, from a Medicare-approved supplier. In some areas of the country, they must use specific suppliers called “contract suppliers” or Medicare won’t pay for the item, and they likely will pay full price.

**EKG** — Medicare covers a one-time screening EKG, if referred by a doctor or other health care provider, as part of the beneficiary’s one-time “Welcome to Medicare” preventive visit. The beneficiary pays 20% of the Medicare-approved amount. An EKG is also covered as a diagnostic test. If the beneficiary has the test at a hospital or a hospital-owned clinic, they also pay the hospital co-payment.

**Emergency Department Services** — These services are covered when someone has an injury, a sudden illness, or an illness that quickly gets much worse. The beneficiary pays a specified co-payment for the hospital emergency department visit, and they pay 20% of the Medicare-approved amount for the doctor’s, or other health care provider’s services. The Part B deductible applies.

**Eyeglasses** — Medicare covers one pair of eyeglasses with standard frames (or one set of contact lenses) after cataract surgery that implants an intraocular lens. The beneficiary pays 20% of the Medicare-approved amount, and the Part B deductible applies.

**Federally Qualified Health Centers** — Medicare covers many outpatient primary care, and preventive services, that beneficiaries get through certain community-based organizations. Generally, the beneficiary pays 20% of the charges. They pay nothing for most preventive services.

**Flu Shots** — Medicare generally covers flu shots once per flu season in the fall or winter. The beneficiary pays nothing for getting the flu shot if the doctor or other qualified health care provider accepts assignment for giving the flu shot.

**Foot Exams and Treatment** — Medicare covers foot exams and treatment, if the beneficiary has diabetes-related nerve damage and/or meets certain conditions. The beneficiary pays 20% of the Medicare-approved amount, and the Part B deductible applies. In a hospital outpatient setting, they also pay the hospital co-payment.

**Glaucoma Tests** — These tests are covered every 12 months for people at high risk for the eye disease glaucoma. They’re at high risk if they have diabetes, a family history of glaucoma, are African American and 50 or older or are Hispanic and 65 or older. An eye doctor, who is legally allowed by the state, must do the tests. The beneficiary pays 20% of the Medicare-approved amount, and the Part B deductible applies for the doctor’s visit. In a hospital outpatient setting, they also pay the hospital a co-payment.

**Hepatitis B Shots** — Medicare covers these shots for people at high, or medium risk for Hepatitis B. The beneficiary pays nothing for the shot if the doctor, or other qualified health care provider accepts assignment.

**Home Health Services** — Medicare covers medically necessary part-time, or intermittent skilled nursing care, and/or physical therapy, speech-language pathology services, and/or services for people with a continuing need for occupational therapy. A doctor enrolled in Medicare, or certain health care providers who work with the doctor, must see the beneficiary face-to-face before the doctor can certify that they need home health services. That doctor must order their care, and a Medicare-certified home health agency must provide it.

**Kidney Dialysis** — Generally, Medicare covers dialysis treatment three times a week, if the beneficiary has ESRD. This includes dialysis drugs, laboratory tests, home dialysis training and related equipment and supplies. The dialysis facility is responsible for coordinating their dialysis services (at home or in a facility). The beneficiary pays 20% of the Medicare-approved amount, and the Part B deductible applies.

**Kidney Disease Education** — Medicare covers up to six sessions of kidney disease education services, if the beneficiary has Stage IV kidney disease, and their doctor, or health care provider refers them for the service. They pay 20% of the Medicare-approved amount, and the Part B deductible applies.

**Laboratory Services** — Medicare covers laboratory services including certain blood tests, urinalysis, and some screening tests. The beneficiary pays nothing for these services, if the doctor or other health care provider accepts assignment.

**Nutrition Therapy** — Medicare may cover medical nutrition therapy, and certain related services. In order to qualify, the beneficiary must have diabetes or kidney disease, or they have had a kidney transplant in the last 36 months. In addition, their doctor, or other health care provider must refer them for the service. They pay nothing for these services if the doctor, or other qualified health care provider accepts assignment.

**Outpatient Mental Health** — Medicare covers mental health care services to help with conditions like depression or anxiety. Coverage includes services generally provided in an outpatient setting (like a doctor’s, or other health care provider’s office, or hospital outpatient department), including visits with a psychiatrist or other doctor, clinical psychologist, nurse practitioner, physician assistant, clinical nurse specialist or clinical social worker. Also covered, certain treatment for substance abuse, and lab tests. Certain limits and conditions apply. For visits to a doctor or other health care provider to diagnose their condition, the beneficiary pays 20% of the Medicare-approved amount. Generally for outpatient treatment of their condition (like counseling or psychotherapy), the beneficiary pays 35% of the Medicare-approved amount. This co-insurance amount decreased to 20% in 2014. The Part B deductible applies for both visits to diagnose or treat their condition.

**Obesity Screening and Counseling** — If they have a body mass index (BMI) of 30 or more, Medicare covers intensive counseling, to help the beneficiary lose weight.

**Occupational Therapy** — Medicare covers evaluation and treatment to help the beneficiary perform activities of daily living (like dressing or bathing) after an illness or accident when their doctor, or other health care provider certifies that they need it. They pay 20% of the Medicare-approved amount, and the Part B deductible applies.

**Outpatient Hospital Services** — Medicare covers many diagnostic and treatment services in participating hospital outpatient departments. Generally, the beneficiary pays 20% of the Medicare-approved amount for the doctor’s or other health care provider’s services. In addition to the amount they pay the doctor, they’ll usually pay the hospital a co-payment for each service they get in a hospital outpatient setting, except for certain preventive service for which there is no co-payment. The Part B deductible applies, except for certain preventive services.

**Physical Therapy** — Medicare covers evaluation and treatment for injuries and diseases that change the beneficiary’s ability to function when their doctor or other health care provider certifies their need for it. They pay 20% of the Medicare-approved amount, and the Part B deductible applies.

**Pneumococcal Shot** — Medicare covers pneumococcal shots to help prevent pneumococcal infections (like certain types of pneumonia). The beneficiary pays nothing if the doctor or other qualified health care provider accepts assignment for giving the shot.

**Prescription Drugs** — Medicare covers a limited number of drugs, such as injections in a doctor’s office, certain oral cancer drugs, drugs used with some types of durable medical equipment (like a nebulizer or external infusion pump), In addition, under very limited circumstances, coverage is provided for certain drugs, in a hospital outpatient setting. The beneficiary pays 20% of the Medicare-approved amount for these covered drugs and the Part B deductible applies. Other than the examples above, they pay 100% for most prescription drugs, unless they have Part D or other drug coverage.

**Prostate Cancer Screening** — Medicare covers a Prostate Specific Antigen (PSA) test and a digital rectal exam once every 12 months for men over 50 (beginning the day after their 50th birthday). The beneficiary pays nothing for the PSA test if the doctor, or other health care provider accepts assignment. They pay 20% of the Medicare-approved amount, and the Part B deductible applies for the digital rectal exam.

**Prosthetic/Orthotic Items** — Medicare covers arm, leg, back and neck braces. Also, artificial eyes, artificial limbs (and their replacement parts) are covered. In addition, Medicare provides coverage for some types of breast prostheses (after mastectomy), and prosthetic devices needed to replace an internal body part or function (including ostomy supplies, and parenteral and enteral nutrition therapy) when ordered by a doctor or other health care provider enrolled in Medicare. The beneficiary pays 20% of the Medicare-approved amount, and the Part B deductible applies.**27**

**Pulmonary Rehabilitation** — Medicare covers a comprehensive pulmonary rehabilitation program if the beneficiary has moderate to very severe chronic obstructive pulmonary disease (COPD), and has a referral from the doctor treating this chronic respiratory disease. The beneficiary pays 20% of the Medicare-approved amount if they get the service in a doctor’s office. They also pay the hospital a co-payment per session if they get the service in a hospital outpatient setting. The Part B deductible applies.

**Rural Health Clinic Services** — Medicare covers many outpatient primary care and preventive services in rural health clinics. Generally, the beneficiary pays 20% of the charges, and the Part B deductible applies. However, they pay nothing for most preventive services.

**Second Surgical Opinions** — Medicare covers second surgical opinions, in some cases, for non-emergency surgery. In some cases, Medicare covers third surgical opinions.

The beneficiary pays 20% of the Medicare-approved amount, and the Part B deductible applies.

**STI Screening and Counseling** — Medicare covers sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis and/or Hepatitis B. These screenings are covered for people with Medicare who are pregnant and/or for certain people who are at increased risk for an STI. These tests must be ordered by a primary care doctor, or other primary care practitioner. Medicare covers these tests once every 12 months, or at certain times during pregnancy. The beneficiary pays nothing for these services if the primary care doctor, or other qualified primary care practitioner accepts assignment.

**Speech and Language Therapy** — If a doctor, or other health care provider certifies that it is needed, then Medicare will provide coverage for evaluation and treatment given to regain, and strengthen speech/language skills. This includes cognitive and swallowing skills. The beneficiary pays 20% of the Medicare-approved amount, and the Part B deductible applies.

**Surgical Dressing Services** — Medicare covers services related to treatment of a surgical or surgically treated wound. The beneficiary pays 20% of the Medicare-approved amount for the doctor’s or other health care provider’s services. They pay a fixed co-payment for these services when they get them in a hospital outpatient setting. They pay nothing for the supplies. The Part B deductible applies.

**TeleHealth** — Medicare covers limited medical or other health services, like office visits and consultations, which are provided via interactive two-way telecommunications system. This must be done by an eligible provider who isn’t at their location. For most of these services, the beneficiary pays 20% of the Medicare-approved amount, and the Part B deductible applies.

**Tests Other Than Labs** — Medicare covers X-rays, MRIs, CT scans, EKGs and some other diagnostic tests. The beneficiary pays 20% of the Medicare-approved amount, and the Part B deductible applies. If they get the test at a hospital as an outpatient, they will also be required to pay the hospital a co-payment, which may be more than 20% of the Medicare-approved amount (co-payment will never more than the Part A hospital stay deductible). See Laboratory Services previously discussed for the tests covered under Part B.

**Tobacco Cessation** — If the beneficiary uses tobacco, and they’re diagnosed with an illness caused, and/or complicated by tobacco use, or they take a medicine that is affected by tobacco, Medicare covers up to eight face-to-face visits in a 12-month period. The beneficiary pays 20% of the Medicare-approved amount, and the Part B deductible applies. In a hospital outpatient setting, they also

pay the hospital a co-payment. If they haven’t been diagnosed with an illness caused or complicated by tobacco use, Medicare coverage of tobacco-use-cessation counseling is considered a covered preventive service. The beneficiary pays nothing for the counseling sessions if the doctor or other qualified health care provider accepts assignment.

**Transplants and Immunosuppressive Drugs** — Medicare covers doctor services for heart, lung, kidney, pancreas, intestine, and liver transplants. In order to qualify, certain conditions must be met, and be provided in a Medicare-certified facility. Medicare covers bone marrow and corneal transplants under certain conditions. Medicare covers immunosuppressive drugs, if the transplant was eligible for Medicare payment, or an employer or union group health plan was required to pay before Medicare paid for the transplant. The beneficiary must have Part A at the time of the transplant, and they must have Part B at the time they get immunosuppressive drugs. The beneficiary pays 20% of the Medicare-approved amount, and the Part B deductible applies. They pay nothing for these services if the doctor or health care provider accepts assignment.

**Travel Outside the U.S.** — Medicare generally does not cover health care while the beneficiary is traveling outside the U.S. (U.S. includes the 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa). There are some exceptions. For example, Medicare may cover medically necessary ambulance transportation to a foreign hospital, only with admission for medically necessary covered inpatient hospital services. The beneficiary pays 20% of the Medicare-approved amount, and the Part B deductible applies.

**Urgent Care** — Medicare covers urgently needed care to treat a sudden illness or injury that isn’t a medical emergency. The beneficiary pays 20% of the Medicare-approved amount for the doctor’s or other health care provider’s services and the Part B deductible applies. In a hospital outpatient setting, they also pay the hospital a co-payment. “Welcome to Medicare” Preventive Visit — During the first 12 months that the beneficiary has Part B, they can get a “Welcome to Medicare” preventive visit. They pay nothing for the “Welcome to Medicare” visit if the doctor, or other qualified health care provider accepts assignment. If their doctor, or other health care provider performs additional tests or services during the same visit that aren’t covered under these preventive benefits, they may have to pay co-insurance, and the Part B deductible may apply.