

Medicare Coverage for Cancer Prevention and Early Detection

Medicare pays for certain preventive health care services and some of the screening tests used to help find cancer. Talk to your health care provider about your cancer risk and what cancer screening tests you might need. (See [The American Cancer Society Guidelines for the Early Detection of Cancer](#)¹ for more information.)

<p>Breast cancer screening (mammogram)</p>	<p>One screening mammogram every 12 months (1 year) is covered for all women with Medicare age 40 and older. You can get one baseline mammogram between ages 35 and 39, too. Medicare also covers newer digital mammograms. You pay nothing for the test if the doctor or other qualified health care provider accepts assignment.</p> <p>Note: Part B also covers diagnostic mammograms more frequently than once a year when medically necessary. You pay 20% of the Medicare-approved amount for diagnostic mammograms and the Part B deductible applies.</p>
<p>Cervical cancer screening</p>	<p>Part B covers one Pap test and pelvic exam every 24 months (2 years). As part of the pelvic exam, Medicare covers a clinical breast exam to check for breast cancer.</p> <p>Medicare covers these screening tests every 12 months (1 year) if you are at high-risk for cervical or vaginal cancer or if you're of childbearing age and had an abnormal Pap test in the past 36 months.</p> <p>Part B also covers human papillomavirus (HPV) tests (as part of a Pap test) once every 5 years if you're age 30 to 65 without any symptoms.</p> <p>You pay nothing for the lab Pap or the lab HPV with Pap test if your doctor or other qualified health care provider accepts assignment. You also pay nothing for the Pap test specimen collection, pelvic exam and breast exam if your doctor or other qualified health care provider accepts assignment.</p>

	<p>care provider accepts assignment.</p>
<p>Colorectal cancer screening</p>	<p>Screening fecal occult blood tests (FOBTs) and fecal immunochemical tests (FITs)</p> <p>Medicare covers screening FOBTs/FITs once every 12 months (1 year) if you're 45 or older.</p> <p>You pay nothing for this test if your doctor or other qualified health care provider accepts assignment.</p> <p>Multi-target stool DNA lab test</p> <p>This is covered once every 3 years if you meet all of these conditions:</p> <ul style="list-style-type: none"> • You're age 45 to 85. • You show no symptoms of colorectal disease including, but not limited to one of these: <ul style="list-style-type: none"> Pain in the lower abdomen Blood in your stool Positive FOBT or FIT <ul style="list-style-type: none"> • You're at average risk for developing colorectal cancer, meaning: <ul style="list-style-type: none"> You have no personal history of adenomatous polyps, colorectal cancer, or inflammatory bowel disease, including Crohn's disease and ulcerative colitis. You have no family history of colorectal cancer or adenomatous polyps, familial adenomatous polyposis (FAP), or hereditary nonpolyposis colorectal cancer (HNPCC, also known as Lynch syndrome). <p>You pay nothing for this test if your doctor or other qualified health care provider accepts assignment.</p> <p>If you have a positive result on a screening FOBT, FIT or stool DNA lab test, Medicare will cover the cost of a follow-on screening colonoscopy. You will not have to pay for this test as long as your doctor or other qualified health care provider accepts assignment. However, if a polyp or other tissue is found and removed during the colonoscopy, you may have to pay 15% of the Medicare approved amount for your doctor's services.</p>

	<p>Screening colonoscopy</p> <p>Medicare covers screening colonoscopy once every 24 months (2 years) if you're at high risk for colorectal cancer. If you aren't at high risk for colorectal cancer, Medicare covers the test once every 120 months (10 years), or once every 48 months (4 years) after a previous flexible sigmoidoscopy. There's no minimum age requirement.</p> <p>You pay nothing for this test if your doctor or other qualified health care provider accepts assignment.</p> <p>However, if a polyp or other tissue is found and removed during the colonoscopy, you may pay 15% of the Medicare approved amount of your doctor's services and a copayment in a hospital setting. The Part B deductible doesn't apply.</p> <p>Screening flexible sigmoidoscopy</p> <p>Medicare covers screening flexible sigmoidoscopy once every 48 months (4 years) for most people 45 or older. If you aren't at high risk, Medicare covers this test 120 months (10 years) after a previous screening colonoscopy.</p> <p>You pay nothing if your doctor or other qualified health care provider accepts assignment.</p> <p>If a screening flexible sigmoidoscopy results in the biopsy or removal of a lesion or growth during the same visit, the procedure is considered diagnostic and you may have to pay coinsurance and/or a copayment, but the Part B deductible doesn't apply.</p>
<p>Lung cancer screening</p>	<p>Part B covers the cost for a lung cancer screening with Low-Dose Computed Tomography (LDCT) once per year if you meet <u>all</u> of these conditions:</p> <ul style="list-style-type: none"> • You're age 50 to 77. • You don't have signs or symptoms of lung cancer (asymptomatic). • You either currently smoke or have quit smoking within the last 15 years. • You have a tobacco smoking history of at least 20 "pack years" (an average of one pack (20 cigarettes) per day for 20 years). • You get a written order from your doctor. <p>You pay nothing for this service if your doctor or health care provider accepts assignment.</p>
<p>Prostate</p>	<p>After discussing the benefits, limitations, and risks of prostate cancer screening with your doctor,</p>

<p>cancer screening</p>	<p>doctor, you may or may not decide to get screened. If you decide to get screened, Part B covers digital rectal exams (DREs) and prostate-specific antigen (PSA) blood tests once every 12 months (1 year) for men over 50 (beginning the day after your 50th birthday).</p> <ul style="list-style-type: none"> • Digital rectal exam: If your doctor performs this test, you pay 20% of the Medicare approved amount for a yearly DRE and for your doctor's services related to the exam. The Part B deductible applies. If the DRE is done in a hospital outpatient setting, there is a copayment. • PSA test: You pay nothing for a yearly PSA blood test. If you get the test from a doctor that doesn't accept assignment, you may have to pay an additional fee for doctor's services, but not for the test itself.
<p>Tobacco use cessation* (quitting tobacco)</p>	<p>Part B covers up to 8 visits of smoking and tobacco-use cessation counseling visits in a 12-month (1 year) period.</p> <p>You pay nothing for the counseling sessions if your doctor or other health care provider accepts assignment.</p> <p>Over-the-counter drug treatments for tobacco cessation such as nicotine patches and gum are not covered by Medicare. Your Part D plan, however, might cover prescription drugs for tobacco cessation.</p> <p>*Find information about how to quit smoking².</p>

To learn more about Medicare coverage, visit www.medicare.gov³.

Hyperlinks

1. www.cancer.org/healthy/find-cancer-early/american-cancer-society-guidelines-for-the-early-detection-of-cancer.html
2. www.cancer.org/healthy/stay-away-from-tobacco/guide-quit-smoking.html
3. www.medicare.gov

References

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