

HEPATITIS C SCREENING

Hepatitis C is a disease of the liver caused by the hepatitis C virus. There are approximately 170 million people with chronic hepatitis C worldwide. An estimated 3.9 million Americans have been infected with HCV, including 2.7 million who have developed chronic hepatitis. Nationally, this makes HCV the most common chronic blood-borne infection. It has been estimated that from three to twenty percent of chronically infected patients will develop cirrhosis within two decades of the onset of HCV infection and will then be at risk of developing hepatocellular carcinoma. Chronic HCV infection is the leading indication for liver transplantation in the United States.

Up to 80% of patients infected with hepatitis C may be asymptomatic. Patients may be at risk for hepatitis C if they have:

- Received blood from a donor who later tested positive for hepatitis C
- Injected illegal drugs, even if it was many years ago
- Received a blood transfusion or solid organ transplant before July 1992 (before testing for hepatitis was routinely done)
- Received clotting factor(s) made before 1987
- Been on long-term kidney dialysis
- Evidence of liver disease (e.g., persistently abnormal ALT levels)

ORIGINAL MEDICARE

Medicare does not cover routine examinations or services performed for a purpose other than treatment or diagnosis of a specific illness, symptoms, complaint or injury except when specifically allowed by law (e.g., prostate cancer screening or colorectal cancer screening).¹ Therefore, routine hepatitis C screening tests are not covered under Original Medicare because screening tests are not diagnostic in nature. However, a hepatitis C screening test is covered under Original Medicare when signs or symptoms of the disease may be present and the test is medically necessary for diagnostic purposes.

MEDICARE ADVANTAGE

Coverage for routine hepatitis C screening is provided to members under select Medicare Advantage private fee-for-service plans. The member's cost-sharing and other coverage conditions are determined by the group.

Hepatitis C test is a covered service when performed as a preventative screening test and, unlike Original Medicare, signs or symptoms of a disease do not need to be present in order for the test to be payable.

¹ http://www.ssa.gov/OP_Home/ssact/title18/1862.htm

Conditions for payment

BCBSM Medicare Advantage private fee-for-service plans use Centers for Medicare & Medicaid Services deemed provider² concept for group specific benefits. The table below specifies payment conditions for routine hepatitis C screening:

Conditions for payment	
Eligible providers	Consistent with Original Medicare
Deemed provider	See terms and conditions on bcbsm.com/ma
Payable locations	Consistent with Original Medicare
Frequency	
CPT codes	
Age restrictions	
Diagnosis codes restrictions for BCBSM and SOM Retirees	

Reimbursement

The maximum payment amount for routine hepatitis C screening benefit is consistent with Original Medicare. The provider will be paid the lesser of Medicare's allowed amount or the provider's charge, minus the member's cost-share. This represents payment in full and providers are not allowed to balance bill the member for the difference between the allowed amount and the charge.

Member cost-sharing

- Deemed providers must agree to collect from the member only the cost-sharing amounts. They may not otherwise charge or bill the member.
- If the member elects to receive a noncovered service, he or she is responsible for the entire charge associated with the noncovered service.

For detailed information about BCBSM Medicare Advantage member's benefits and cost-share, review the group plan's [Summary of Benefits](#). The chart below identifies members with routine hepatitis C screening coverage.

Group name and number	
BCBSM/NBU Retirees 80311, 80312	
State of MI Retirees Troopers 81820	State of MI Retirees Nontroopers 81821, 81828

² 2009 Terms and conditions

Billing instructions

1. Bill services on the CMS 1500 (8/05) claim form, UB-04 or the 837 equivalent claim.
2. Use the Medicare Advantage private fee-for-service unique billing requirements.
3. Report CPT/HCPCS codes and diagnosis codes to the highest level of specificity.
4. Report your National Provider Identifier number on all claims.
5. Submit claims to your local BCBS plan.
6. Use electronic billing:
 - a. Michigan providers:
 - A copy of the ANSI ASC X12N 837 and 835 Institutional Health Care Claim and Health Care Claim Payment/Advice (BCBSM Electronic Data Interchange (EDI) Institutional 837/835 Companion Document) is available at: http://www.bcbsm.com/pdf/837_835_institutional_companion.pdf
 - A copy of the BCBSM EDI Professional 837/835 Companion Document is available at: http://www.bcbsm.com/pdf/systems_resources_prof_837_835.pdf
 - b. Providers outside of Michigan should contact their local BCBS plan.