

Blue Cross Blue Shield of Michigan
Medicare Advantage Private Fee-for-Service

Colorectal Cancer Screening

January 1, 2008
Updated October 1, 2008

COLORECTAL CANCER SCREENING

Colorectal cancer is a term used to refer to cancer that develops in the colon or the rectum.

One of the most powerful weapons in preventing colorectal cancer is regular colorectal cancer screening or testing. Regular colorectal cancer screening can, in many cases, prevent colorectal cancer altogether because some polyps, or growths, can be detected and removed before they have the chance to turn into cancer. Screening can also result in finding colorectal cancer early, when it is highly curable.

Screening for colorectal cancer is recommended for all adults ages 50 and older, although screening may start at younger ages for individuals who are at high risk for colon cancer. The frequency of screening is based on an individual's risk for colorectal cancer and the type of screening test that is used.

ORIGINAL MEDICARE

Original Medicare provides coverage for a fecal occult blood test, a flexible sigmoidoscopy, a screening colonoscopy and a barium enema with varying frequency limitations as indicated below:

- Fecal occult blood test – once annually
- Flexible sigmoidoscopy – every 4 years or once every 10 years after having a screening colonoscopy
- Screening colonoscopy – every 24 months if high risk, otherwise, every 10 years
- Barium enema – every 24 months if high risk, otherwise, every 4 years

MEDICARE ADVANTAGE

Coverage for colorectal cancer screening on an annual basis is provided to members under select Medicare Advantage private fee-for-service plans. The member's cost-sharing and other coverage conditions, such as frequency, are determined by the group.

Conditions for Payment

BCBSM Medicare Advantage private fee-for-service plans use the Centers for Medicare & Medicaid Services deemed provider¹ concept for group specific benefits. The table below specifies payment conditions for colorectal cancer 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	Once annually
CPT/HCPCS codes	Consistent with Original Medicare
Diagnosis restrictions	
Age restrictions	

Reimbursement

The maximum payment amount for the colorectal cancer screening benefit is consistent with Original Medicare. The provider will be paid the lesser of Medicare's allowable 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 described in the table below. 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.

The cost-sharing chart below identifies the members with colorectal cancer screening coverage:

Member Cost-Sharing Responsibilities								
Group Name and Number	Annual Deductible		Coinsurance				Out-of-Pocket Maximum	
			Professional Claim		Institutional Claim			
	2007	2008	2007	2008	2007	2008	2007	2008
BCBSM Retirees ² 80311, 80312	No MA PFFS plan	\$0	No MA PFFS plan	5% all codes except 82270	No MA PFFS plan	SOB ³	No MA PFFS plan	\$1000 all codes except 82270

¹ 2008 Terms and conditions

² BCBSM Retirees Benefit grid

Member Cost-Sharing Responsibilities								
Group Name and Number	Annual Deductible		Coinsurance				Out-of-Pocket Maximum	
			Professional Claim		Institutional Claim			
	2007	2008	2007	2008	2007	2008	2007	2008
City of Detroit Option E ⁴ 81100, 81101	\$175 Waived	\$0	20% all locations except 21 and code 82270	None	SOB ⁵	SOB ⁶	\$825 all codes except 82270	Does not apply
City of Detroit Option F ⁷ 54731, 81097			None				Does not apply	
City of Detroit Option G ⁸ 04436			Does not apply					
State of MI Retirees ⁹ 81820, 81821, 81828	No MA PFFS plan	\$0	No MA PFFS plan		No MA PFFS plan		No MA PFFS plan	Does not apply

³ 2008 Summary of benefits

⁴ City of Detroit - Option E Benefit grid

⁵ 2007 Summary of benefits

⁶ 2008 Summary of benefits

⁷ City of Detroit - Option F Benefit grid

⁸ City of Detroit - Option G Benefit grid

⁹ State of Michigan Retirees Benefit grid

Member Cost-Sharing Responsibilities										
Group Name and Number	Annual Deductible			Coinsurance				Out-of-Pocket Maximum		
				Professional Claim		Institutional Claim				
	2007	2008		2007	2008		2007	2008	2007	2008
MPSERS ¹⁰ 59000	\$250 all codes except 82270	1/1 to <u>3/31</u> \$250 all codes except 82270	4/1 to <u>12/31</u> \$0	10% all locations except location 21 and code 82270	1/1 to <u>3/31</u> 10% all locations except 21 and code 82270	4/1 to <u>12/31</u> 10% all codes G0328 and 82270	SOB ¹¹	SOB ¹²	\$500 all codes except 82270	

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.

¹⁰ MPSERS Benefit grid

¹¹ 2007 Summary of benefits

¹² 2008 Summary of benefits