

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

Screening Mammography

January 1, 2008

Updated October 1, 2008

SCREENING MAMMOGRAPHY

Screening mammogram is a radiologic procedure (an x-ray of the breast) used for the early detection of breast cancer in women who have no signs or symptoms of the disease and include a physician's interpretation of the results. It usually involves two x-rays of each breast. Mammograms make it possible to detect tumors that cannot be felt. Mammograms can also find microcalcifications (tiny deposits of calcium in the breast) that sometimes indicate the presence of breast cancer.¹

ORIGINAL MEDICARE

Original Medicare provides coverage of a breast cancer screening mammogram annually for all female beneficiaries age 40 or older. Medicare also provides coverage of one baseline mammogram for female beneficiaries between the ages of 35 and 39.

To start counting the months between mammographies, begin with the month after the date of the examination. For example, if Mrs. Smith received a screening mammography examination in January 2008, begin counting the next month (February 2008) until 11 months have elapsed. Payment can be made for another screening mammography in January 2009.²

MEDICARE ADVANTAGE

Coverage for screening mammography is provided to group members on an annual basis. The age restriction is waived under select Medicare Advantage private fee-for-service plans. The member's cost-sharing is determined by the group.

To determine the member's eligibility, count the months between mammographies beginning the month after the date of the examination. For example, if Mrs. Smith received a screening mammography examination in January 2008, begin counting the next month (February 2008) until 11 months have elapsed. Payment can be made for another screening mammography in January 2009.³

¹ CMS "The guide to Medicare preventative services for physicians, suppliers, and other health care professionals"

http://www.cms.hhs.gov/MLNProducts/downloads/mps_guide_web-061305.pdf

² WPS Medicare National Coverage Provision RAD-016
http://wpsmedicare.com/part_b/policy/rad016.pdf

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Conditions for Payment

BCBSM Medicare Advantage private fee-for-service plans use the Centers for Medicare & Medicaid Services deemed provider⁴ concept for group specific benefits. The table below specifies payment conditions for screening mammography:

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 / Limitations	Once annually
CPT/HCPCS codes	Consistent with Original Medicare
Diagnosis restrictions	
Age restrictions	No restrictions

Reimbursement

The maximum payment amount for the screening mammography 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 members with coverage for screening mammography:

⁴ 2008 Terms and conditions

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 ⁵ 80311, 80312	No MA PFFS plan	\$0	No MA PFFS plan	\$0	No MA PFFS plan	SOB ⁶	No MA PFFS plan	Does not apply
City of Detroit Option E ⁷ 81100, 81101	\$175 Waived	\$0	\$0	\$0	SOB ⁸		Does not apply	
City of Detroit Option F ⁹ 54731, 81097							Does not apply	
City of Detroit Option G ¹⁰ 04436	\$175 Waived	\$0	\$0	\$0	SOB	SOB	Does not apply	
MPSERS ¹¹ 59000	\$250	<u>1/1-3/31</u> \$250 <u>4/1-12/31</u> \$0	10% for all locations except 21 ¹²	<u>1/1-3/31</u> 10% for all locations except 21 <u>4/1-12-31</u> 10%			\$500	<u>1/1-3/31</u> \$500 <u>4/1-12/31</u> \$500
State of MI Retirees ¹³ 81820, 81821, 81828	No MA PFFS plan	\$0	No MA PFFS plan	\$0	No MA PFFS plan		No MA PFFS plan	Does not apply

⁵ BCBSM Retirees Benefit grid

⁶ 2008 Summary of benefits

⁷ City of Detroit - Option E Benefit grid

⁸ 2007 Summary of benefits

⁹ City of Detroit Option - F Benefit grid

¹⁰ City of Detroit Option - G Benefit grid

¹¹ MPSERS Benefit grid

¹² Inpatient hospital - 21

¹³ State of Michigan Retirees Benefit grid

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.