

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

Total Body Skin Examination

January 1, 2008
Updated October 1, 2008

TOTAL BODY SKIN EXAMINATION

A total body skin examination is performed by a trained health care professional, usually a dermatologist, to search for any unusual or suspicious lesions or conditions on the skin's surface. When examining people at risk for skin cancer, providers look for atypical or abnormal looking moles that could be melanoma or other less deadly forms of skin cancer.

During the procedure, the provider will examine the entire skin surface including the hands and arm, legs and feet, torso, scalp, inside of the mouth and the external genital area. Melanoma can arise on any part of the skin, even in places that have never been exposed to the sun.

ORIGINAL MEDICARE

Original Medicare pays for services that are considered medically reasonable and necessary to the overall diagnosis and treatment of the patient's condition. Examinations performed without relationship to treatment or diagnosis for a specific illness, symptom, complaint, or injury are considered routine physical examinations and are not covered under Original Medicare¹. Screening procedures which are performed for asymptomatic conditions are also not covered; therefore Original Medicare does not cover total body skin examination.

Skin examination provided as a follow-up to a previous biopsy of an area or diagnosis of a suspicious lesion is not considered routine, and therefore is covered under Original Medicare.

MEDICARE ADVANTAGE

Coverage for one total body skin examination is provided to members under select Medicare Advantage private fee-for-service plans. The member cost-sharing and other coverage conditions are determined by the group.

Conditions for Payment

BCBSM Medicare Advantage private fee-for-service plans use the Centers for Medicare & Medicaid Services deemed provider² concept for the group specific benefits. The table below specifies payment conditions for total body skin examinations:

¹ Social Security Act, Title XVIII, §1862(a)(7)

² 2008 Terms and conditions

Conditions For Payment	
Eligible providers	Consistent with Original Medicare
Deemed provider	See terms and conditions on bcbsm.com/ma
Payable locations	Office and outpatient hospital
Frequency	Once in a lifetime
CPT codes	<ul style="list-style-type: none"> E&M codes - 99201-99205, 99211-99215 (self-referred patient) Consultation codes - 99241-99245 (referred from another physician) Documentation must be available upon request to support level of E&M service billed.
Diagnosis restrictions	Must be billed with V76.43 (special screening for malignant neoplasms, skin).
Age restrictions	Consistent with Original Medicare

Reimbursement

The maximum payment amount for the total body skin examination 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 total body skin examination coverage:

Member Cost-Sharing Responsibilities				
Individual Group Name and Number	Annual Deductible	Copayment/Coinsurance		Out-of-Pocket Maximum
		Professional Claim	Institutional Claim	
	2008	2008	2008	2008
Medicare Plus Blue - Option A ³ 53910	\$0	\$25 copay applies for location 11 ⁴	Does not apply	\$4000

³ Medicare Plus Blue - Option A Benefit grid

⁴ Office - 11

Member Cost-Sharing Responsibilities				
Individual Group Name and Number	Annual Deductible	Copayment/Coinsurance		Out-of-Pocket Maximum
		Professional Claim	Institutional Claim	
	2008	2008	2008	2008
Medicare Plus Blue - Option B ⁵ 53921	\$0	\$15 copay applies for location 11	Does not apply	Does not apply
Medicare Plus Blue - Option C ⁶ 53901				
Medicare Plus Blue - Option D ⁷ 53903		Does not apply		

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 the 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

⁵ Medicare Plus Blue - Option B Benefit grid

⁶ Medicare Plus Blue - Option C Benefit grid

⁷ Medicare Plus Blue - Option D Benefit grid

- 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.