Screening mammography
Benefit retired as of Dec. 31, 2012
Applies to:

☐ Medicare Plus Blue℠ PPO ☒ Medicare Plus Blue℠ Group PPO ☐ Both

Blue Cross Blue Shield of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

Screening mammography

A 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 can't be felt. Mammograms can also find tiny deposits of calcium in the breast called "microcalcifications" that sometimes indicate the presence of breast cancer.

Original Medicare

Original Medicare provides coverage for a breast cancer screening mammogram annually for all female beneficiaries age 40 or older and 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 2012, begin counting the next month (February 2012) until 11 months have elapsed. Payment can be made for another screening mammography in January 2013.

Medicare Plus Blue Group PPO

Medicare Plus Blue Group PPO plans provide at least the same level of benefit coverage as Original Medicare (Part A and Part B) and provide enhanced benefits beyond the scope of Original Medicare within a single health care plan. This flexibility allows BCBSM to offer enriched plans by using Original Medicare as the base program and adding desired benefit options.

Coverage for screening mammography is provided to members under select Medicare Plus Blue Group PPO plans on an annual basis and the age restriction is waived. The member's cost–sharing is determined by the group.

To determine the member's eligibility, count the months between mammography examinations beginning with the month after the date of the examination. For example, if Mrs. Smith received a screening mammography examination in January 2012, begin counting the next month (February 2012) until 11 months have elapsed. Payment can be made for another screening mammography in January 2013.

Conditions for payment

The table below specifies payment conditions for screening mammography:

Conditions for payment	
Eligible provider	Consistent with Original Medicare
Payable location	Consistent with Original Medicare
Frequency/limitations	Once annually
CPT/HCPCS codes	Consistent with Original Medicare
Diagnosis restrictions	

Conditions for payment	
Age restrictions	Age restriction waived for select Medicare Plus Blue Group PPO plans

Reimbursement

Medicare Plus Blue Group PPO plan's maximum payment amount for the screening mammography 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 aren't allowed to balance bill the member for the difference between the allowed amount and the charge.

Member cost–sharing

- Medicare Plus Blue Group PPO providers should collect the applicable cost–sharing from the member at the time of the service when possible. Cost–sharing refers to a flat–dollar copayment, a percentage coinsurance or a deductible. You can only collect the appropriate Medicare Plus Blue Group PPO cost–sharing amounts from 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 a Medicare Plus Blue Group PPO member's benefits and cost–share, providers may verify member benefits via web–DENIS or call CAREN at 1–866–309–1719.

Billing instructions for members

A member must request payment for private duty nursing services. This information is required:

1. Bill services on the CMS 1500 (8/05) claim form, UB–04 or the 837 equivalent claim.
2. Use the Medicare Advantage PPO 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:
   - 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: ***bcbsm.com/pdf/837_835_institutional_companion.pdf***
     - — A copy of the BCBSM EDI Professional 837/835 Companion Document is available at: ***bcbsm.com/pdf/systems_resources_prof_837_835.pdf***
   - Providers outside of Michigan should contact their local BCBS plan.