

## 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.

## 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.

## 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.

## Conditions for payment

BCBSM Medicare Advantage private fee-for-service plans use Centers for Medicare & Medicaid Services deemed provider<sup>1</sup> 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 <a href="http://bcbsm.com/ma">bcbsm.com/ma</a>
Payable locations	Consistent with Original Medicare
Frequency/limitations	Once annually
CPT/HCPCS codes	Consistent with Original Medicare
Diagnosis restrictions	
Age restrictions	No restrictions

<sup>1</sup> 2009 Terms and conditions

## 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 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 screening mammography coverage.

Group name and number		
BCBSM/NBU Retirees 80311, 80312	BCBSM/BU Retirees 80306	
City of Detroit Option E 81100, 81101	City of Detroit Option F 54731, 81097	City of Detroit Option G 04436
City of Dearborn 50908	City of Southgate 50737	Ervin Industries 50755
Grosse Pointe Municipalities 51376, 51517, 51518, 51566, 51567	Hope College 51623	
Kadant Johnson 50309	MPSERS 59000	
Michigan State AFL – CIO 50781	Oakwood Healthcare 47064, 47067	
Robert Bosch LLC 51644	State of MI Retirees Troopers 81820	
State of MI Retirees Nontroopers 81821, 81828	UAW Retirees of the Dana Corporation Health & Welfare Trust 51643	

## 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](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](http://www.bcbsm.com/pdf/systems_resources_prof_837_835.pdf)
  - b. Providers outside of Michigan should contact their local BCBS plan.