

Total body skin examination

Applies to:



**Blue Cross
Blue Shield**
of Michigan

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

Medicare Plus BlueSM PPO Medicare Plus BlueSM Group PPO Both

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, arms, legs, 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 Medicare. 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 Plus Blue PPO Enhanced Benefit

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

Coverage for one total body skin examination is provided to members under Medicare Plus Blue plans. This enhanced benefit paper applies to all individual and group plans. The scope of the benefit, reimbursement methodology, maximum allowed payment amounts, member cost-sharing and other coverage conditions are determined by Blue Cross for individual coverage and by the group for those with group based coverage.

Conditions for payment

The table below specifies payment conditions for total body skin examinations. Note: Use ICD-9 diagnosis codes for DOS through September 30, 2015. For DOS beginning with October 1, 2015 and later ICD-10 codes must be used.

Conditions for payment	
Eligible provider	Consistent with Original Medicare
Payable location	Office and outpatient hospital
Frequency	Once in a lifetime

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bcbsm.com/provider/ma

Conditions for payment	
CPT codes	<ul style="list-style-type: none"> Evaluation and Management codes — 99201–99205, 99211–99215 (self-referred patient and referral from another physician) Documentation must be available upon request to support level of E&M service billed.
Diagnosis restrictions	Must be billed with ICD–9: V76.43 ICD–10: Z12.83 (special screening for malignant neoplasms, skin).
Age restrictions	Consistent with Original Medicare

Reimbursement

Medicare Plus Blue plan's 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 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

- Medicare Plus Blue 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. Providers can only collect the appropriate Medicare Plus Blue 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 non-covered service.

To verify benefits and cost-share, providers may utilize web-DENIS or call 1–866–309–1719.

Billing instructions for members

- Bill services on the CMS 1500 (02/12) claim form, UB-04 or the 837 equivalent claim.
- Use the Medicare Advantage PPO unique billing requirements.
- Report CPT/HCPCS codes and diagnosis codes to the highest level of specificity.
- Report your National Provider Identifier number on all claims.
- Submit claims to your local BCBS plan.
- Use electronic billing:

- Michigan providers

Copies of the ANSI ASC X12N 837 and 835 Institutional Health Care Claim and Health Care Claim Payment/Advice (Blue Cross Electronic Data Interchange (EDI) Institutional 837/835 Companion Documents) are available on the BCBSM website under the reference library section at: <http://www.bcbsm.com/providers/help/faqs/electronic-connectivity-edi.html>.

- Providers outside of Michigan should contact their local BCBS plan.

Revision History

Policy Number: MAPPO 1023

Revised: 08/14/2015, 2014

08/14/2015: Updated formatting and billing instructions, added revision history section, removed reference to CAREN, updated web links, added ICD–10 codes.