This document is only effective for claims with a date of service prior to Jan.1, 2015.

Routine hepatitis C screening

Applies to:

Blue Cross Blue Shield of Michigan

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

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

Hepatitis C screening

Hepatitis C is a disease of the liver caused by the hepatitis C virus. There are approximately 170 million people worldwide with chronic hepatitis C. An estimated 3.9 million Americans have been infected with HCV, including 2.7 million who have developed chronic hepatitis. Nationally, this makes HCV the most common chronic blood–borne infection.

It's been estimated that from 3 to 20 percent of chronically infected patients will develop cirrhosis within two decades of the onset of HCV infection and will then be at risk of developing hepatocellular carcinoma. Chronic HCV infection is the leading indication for liver transplantation in the United States.

Up to 80 percent of patients infected with hepatitis C may be asymptomatic. Patients may be at risk for hepatitis C if they have.

- Received blood from a donor who later tested positive for hepatitis C
- Injected illegal drugs, even if it was many years ago
- Received a blood transfusion or solid organ transplant before July 1992 (before testing for hepatitis was routinely done)
- Received a clotting factor made before 1987
- Been on long–term kidney dialysis
- Evidence of liver disease (e.g., persistently abnormal ALT levels).

Original Medicare

Original Medicare doesn't cover routine examinations or services performed for a purpose other than treatment or diagnosis of a specific illness, symptoms, complaint or injury except when specifically allowed by law (e.g., prostate cancer screening or colorectal cancer screening). Therefore, routine hepatitis C screening tests aren't covered under Original Medicare because screening tests aren't diagnostic in nature. However, a hepatitis C screening test is covered under Original Medicare when signs or symptoms of the disease may be present and the test is medically necessary for diagnostic purposes.

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.

Enhanced coverage for routine hepatitis C screening is provided to members under select Medicare Plus Blue Group PPO plans. The member's cost-sharing and other coverage conditions are determined by the group.

Hepatitis C test is a covered service when performed as a preventative screening test and, unlike Original Medicare, signs or symptoms of a disease need not be present for the test to be payable.

Conditions for payment

This table specifies payment conditions for routine hepatitis C screening:

Conditions for payment	
Eligible provider	Consistent with Original Medicare
Payable location	Consistent with Original Medicare
Frequency	
CPT codes	
Age restrictions	
Diagnosis restrictions	Restrictions apply

Reimbursement

Medicare Plus Blue Group PPO plan's maximum payment amount for routine hepatitis C screening 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

- When possible, Medicare Plus Blue PPO providers should collect the applicable cost–sharing from the member at the time of the service. 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.