Screening papanicolaou tests/pelvic and clinical breast examinations

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

Screening papanicolaou tests/pelvic and clinical breast examinations

Screening papanicolaou smears are laboratory tests consisting of a routine exfoliative cytology test (papanicolaou test) provided for the purpose of early detection of cervical cancer. It includes a collection of the sample of cells and a physician's interpretation of the test.

A cervical screening detects significant abnormal cell changes that may arise before cancer develops. Therefore, if it's diagnosed and treated early, any abnormal cell changes that may occur over time can be reduced or prevented. The cervical screening benefit can aid in reducing illness and death associated with abnormal cell changes that may lead to cervical cancer.

A screening pelvic examination is an important component of preventive health care for all adult women. A pelvic examination is performed to help detect pre–cancers, genital cancers, infections, sexually transmitted diseases, other reproductive system abnormalities and genital and vaginal problems. STDs in women may be associated with cervical cancer. In particular, the human papillomavirus causes genital warts and cervical and other genital cancers. The pelvic examination is also used to help find fibroids or ovarian cancers and evaluate the size and position of a woman's pelvic organs. In addition, a screening pelvic examination includes a breast examination that can detect and prevent breast masses, lumps and breast cancer. The screening pelvic examination benefit can help beneficiaries maintain their general overall health of the lower genitourinary tract.

Original Medicare

Original Medicare provides coverage for screening Pap tests, pelvic and clinical breast examinations for all female beneficiaries. These screening tests can only be performed on an annual basis if the beneficiary is considered high risk or is of childbearing age with an abnormal Pap test within the previous three years. Otherwise, these screening tests are covered every 24 months.

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 Pap tests, pelvic and clinical breast examinations are provided to members on an annual basis under select Medicare Plus Blue Group PPO plans. The member's cost–sharing is determined by the group.

Note: Effective Jan. 1, 2014, coverage for Pap tests, pelvic and clinical breast examination is the same as Original Medicare. BCBSM will no longer offer enhanced benefits for these services.

Conditions for payment

The table below specifies payment conditions for screening PAP tests, pelvic examination and clinical breast examination.

Conditions for payment	
Eligible provider	Consistent with Original Medicare
Payable location	Consistent with Original Medicare
Frequency/limitations	Once annually
CPT/HCPCS codes	Age restriction waived for select Medicare Plus Blue Group PPO plans
Diagnosis restrictions	
Age restrictions	

Reimbursement

Medicare Plus Blue Group PPO plan's maximum payment amounts for screening Pap tests, pelvic and clinical breast examinations are consistent with Original Medicare. The provider will be paid the lesser of the 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 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

1. Bill services on the CMS 1500 (8/05) claim form, or 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 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.