

Blue Cross Blue Shield of Michigan
Medicare Advantage Private Fee-for-Service

Routine Physical Examinations

January 1, 2008
Updated October 1, 2008

ROUTINE PHYSICAL EXAMINATIONS

Routine physical examinations are performed without relationship to treatment or diagnosis for a specific illness, symptom, complaint, or injury and are not considered medically necessary to treat an illness or injury.

ORIGINAL MEDICARE

Original Medicare covers a broad range of preventive services. Coverage for an initial preventive physical examination (also known as the “Welcome to Medicare” Physical Exam) is provided when certain criteria have been met. Preventive visits or routine physical examinations are not covered under Original Medicare¹.

MEDICARE ADVANTAGE

Coverage for routine physical examinations is provided to members under select Medicare Advantage private fee-for-service plans. Since Original Medicare does not cover routine physical examinations, the scope of the benefit, reimbursement methodology, maximum payment amounts and member cost-sharing are determined by the group.

Conditions for Payment

BCBSM Medicare Advantage private fee-for-service plans use the Centers for Medicare and Medicaid Services deemed provider² concept for group specific benefits. The table below specifies payment conditions for routine physical examinations:

Conditions For Payment	
Eligible providers	M.D., D.O., Practitioners
Deemed provider	See terms and conditions on bcbsm.com/ma
Payable locations	Home, office, outpatient hospital
Frequency	Once annually
CPT/HCPCS codes	<u>MPB Individual plans:</u> 99381-99387, 99391-99397 <u>Group plans:</u> 99381-99387, 99391-99397, 80050

¹ Social Security Act, Title XVIII, §1862(a)(7)

² 2008 Terms and conditions

Conditions For Payment	
Diagnosis restrictions	V03.0-V03.6, V03.8-V04.8, V03.81-V03.82, V03.89, V04.81, V04.89, V05.0-V05.4, V05.8-V06.6, V07.31, V15.82, V16.0-V16.9, V16.40-V16.43, V16.49, V16.51, V16.52, V16.59, V20.0, V20.1-V20.2, V21.0-V21.2, V21.8-V21.9, V25.0-V25.1, V25.01-V25.02, V25.09, V25.3-V25.4, V25.40-V25.42, V25.49, V45.5, V45.51-V45.52, V45.59, V69.0-V69.2, V69.4, V69.9-V70.0, V70.3, V70.5, V70.9, V72.12, V72.19, V72.31, V72.5-V72.9, V73.0-V73.6, V73.8-V74.6, V73.88-V73.89, V73.98-V73.99, V74.8-V76.1, V76.9, V76.10-V76.12, V76.19, V76.2, V76.11-V76.44, V76.47, V76.49-V76.52, V76.8, V76.9, V76.81, V76.89, V77.0-V77.4, V77.8-V77.9, V77.91, V77.99, V79.0-V79.3, V79.8-V79.9, V80.1, V80.3, V82.0, V82.3, V82.39, V82.79, V82.8-V82.9, V82.81, V82.89
Age restrictions	No restrictions

Reimbursement

The maximum payment amount for the routine physical examinations benefit is available in a separate document, [BCBSM Medicare Advantage - Additional Benefits Fee Schedule](#).

The provider will be paid the lesser of the allowable 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 described in the table below. 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.

The cost-sharing chart below identifies members with routine physical examinations coverage.

Member Cost-Sharing Responsibilities						
Group Name and Number	Annual Deductible		Copayment Only		Out-of-Pocket Maximum	
			Professional Claim			
	2007	2008	2007	2008	2007	2008
Medicare Plus Blue Option A ³ 53910	\$0		\$20	\$25 except locations ⁴ 21, 22, 23, 24	\$4000	
Medicare Plus Blue Option B ⁵ 53921			\$10	\$15	\$0	Does not apply
Medicare Plus Blue Option C ⁶ 53901			\$10	\$15	\$0	
Medicare Plus Blue Option D ⁷ 53903			\$0	Does not apply	\$0	
BCBSM Retirees ⁸ 80311, 80312			No MA PFFS plan	\$0	No MA PFFS plan	
City of Detroit ⁹ Option F 54731, 81097	\$0	\$0	Does not apply			

³ Medicare Plus Blue-Option A Benefit grid

⁴ Locations: Inpatient hospital - 21, Outpatient hospital - 22, Emergency room - 23, Ambulatory surgical center - 24

⁵ Medicare Plus Blue - Option B Benefit grid

⁶ Medicare Plus Blue - Option C Benefit grid

⁷ Medicare Plus Blue - Option D Benefit grid

⁸ BCBSM Retirees Benefit grid

⁹ City of Detroit - Option F Benefit grid

Member Cost-Sharing Responsibilities						
Group Name and Number	Annual Deductible		Copayment Only		Out-of-Pocket Maximum	
			Professional Claim			
	2007	2008	2007	2008	2007	2008
City of Detroit- Option G ¹⁰ 04436	\$0	\$0	Does not apply			
State of MI Retirees ¹¹ 81820, 81821, 81828	No MA PFFS plan	\$0	No MA PFFS plan	Does not apply	No MA PFFS plan	Does not apply

Billing Instructions

1. Bill services on the CMS 1500 (8/05) claim form, or 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 BCBSM EDI Professional 837/835 Companion Document is available at:
http://www.bcbsm.com/pdf/systems_resources_prof_837_835.pdf
 - b. Providers outside of Michigan should contact their local BCBS plan.

¹⁰ City of Detroit - Option G Benefit grid

¹¹ State of Michigan Retirees Benefit grid