Annual physical 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

Annual physical examinations

Annual 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. There are two types of annual preventive office visits that are covered by Original Medicare.

- Initial preventive physical examination (also known as the "Welcome to Medicare" physical exam); this visit must occur no later than 12 months after the effective date of the beneficiary's first Part B coverage period. This visit consists of a one–time review of the beneficiary's health status and risk factors, and provides education and counseling about preventive services and the development of a personalized prevention plan for the beneficiary.
- The Annual Wellness Visit (AWV) is covered for a beneficiary who has had Part B coverage for longer than 12 months and who has not received either a Welcome to Medicare or AWV within the past 12 months. The purpose of the AWV is to develop and/or update an exisiting personalized prevention plan based on the beneficiary's current health status.

Original Medicare does not cover Annual Physical Examinations or Preventive Visits (other than those described above).

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 healthcare 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 an Annual Physical Examination is provided to members under all individual Medicare Plus Blue PPO plans and Medicare Plus Blue Group PPO plans. Since Original Medicare does not cover Annual Physical Examinations, the scope of the benefit, reimbursement methodology, maximum allowed payment amounts and member cost–sharing are determined by Blue Cross for individual coverage and by the group for those with group–based coverage.

The annual physical exam includes a detailed history and physical that focuses on the member's medical history, family history, and the performance of a head to toe assessment with a hands on examination of all body systems. For example, the practitioner must use visual inspection, palpitation, ausculation and manual examination of the enrollee to assess overall general health and detect abnormalities or signs that could indicate a disease process that should be addressed. There is no member cost–share for the visit itself for members with individual coverage. For members with group coverage, refer to the group EOC to determine if any member cost share applies to the visit. However, additional cost–share may apply for any service that does not fall within the scope of a preventive screening or covered immunization as defined under Original Medicare for both individual and group members.

Conditions for payment

The table below specifies payment conditions for routine physical examinations.

Conditions for payment	
Eligible provider	M.D., D.O., Practitioners
Payable location	Home, office, outpatient hospital
Frequency	Once annually
CPT/HCPCS codes	99381–99387, 99391–99397, 80050
Diagnosis restrictions	Restrictions apply
Age restrictions	No restrictions

Reimbursement

Medicare Plus Blue plans' maximum payment amount to providers for annual physical examinations is available on our provider website, **bcbsm.com/providers/help/faqs/medicare-advantage/provider-toolkit/enhanced-benefits.html** in the MA enhanced benefits fee schedule. 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 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 non–covered 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 providers

1. Bill services on the CMS 1500 (02/12) claim form.
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:
   a. Michigan providers

      Copies of the ANSI ASCX 12N 837 and 835 Institutional Health Care Claim Payment/Advice (BCBSM 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***

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

Revision History

Policy Number: MAPPO 1017

Revised: 8/7/2015, 2012

8/7/2015: Updated formatting, renamed benefit from 'Routine Physical Examinations' to 'Annual Physical Examinations' per the 2016 Bid Announcement, expanded the description and content of the enhanced benefit, added revision history section and policy number, removed reference to CAREN, updated provider billing instructions and web links for fee schedule and reference documents.