

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 BlueSM PPO Medicare Plus BlueSM 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 aren't 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.

- The initial preventive physical examination (also known as the "Welcome to Medicare" physical exam) 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 is covered for a beneficiary who has had Part B coverage for longer than 12 months and who hasn't received either a Welcome to Medicare or AWV within the past 12 months. The purpose of the AWV is to develop or update an existing personalized prevention plan based on the beneficiary's current health status.

Original Medicare doesn't cover annual physical examinations or preventive visits (other than those described above).

Medicare Plus BlueSM PPO enhanced benefit

Medicare Plus Blue is a Medicare Advantage plan that 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 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 doesn't cover annual physical examinations, other than the IPPE and AWV, 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, auscultation 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 doesn't fall within the scope of a preventive screening or covered immunization as defined under Original Medicare for both individual and group members.

Blue Cross Blue Shield of Michigan

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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 Rural Health Center (RHC), Federally Qualified Health Center (FQHC)
Frequency	Once annually
CPT/HCPCS codes	99381-99387, 99391-99397, 80050
Diagnosis restrictions	No restrictions
Age restrictions	No restrictions

Reimbursement

Medicare Plus Blue plans' maximum payment amount to providers for annual physical examinations is available on our provider website on the Medicare Plus Blue 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 aren't allowed to 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 that service.
- Providers may not have members sign an Advance Beneficiary Notice to accept financial responsibility for noncovered items or services. If there is any question about whether an item or service is covered, seek a coverage determination from Blue Cross before providing the item or service to the member. If a provider provides a noncovered item or service to a member without first obtaining a coverage determination, the member must be held harmless for all charges except for any applicable cost share.

To verify benefits and cost share, providers may utilize our provider portal or call 1-866-309-1719.

Billing instructions for providers

1. Bill services on the CMS 1500 (02/12) claim form for all payable locations, except for Federally Qualified Health Center (FQHC) providers; which should be billed on the CMS UB-04 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 Blue Cross plan.
6. Use electronic billing:
 - a. Michigan providers
Copies of the ANSI ASCX 12N 837 and 835 Institutional Health Care Claim Payment/Advice (Blue Cross Electronic Data Interchange (EDI) Institutional 837/835 Companion Documents) are available on the Blue Cross website under the reference library section at bcbsm.com/providers/help/edi.
 - b. Providers outside of Michigan should contact their local Blue Cross plan.

Revision history

Policy number: MAPPO 1017

Reviewed: 11/21/2022, 08/31/2022, 08/25/2021, 01/04/2021, 09/08/2020, 07/17/2018

Revised: 11/21/2022, 01/04/2021, 09/08/2020, 8/7/2015, 2012

11/21/2022: Removed diagnosis restrictions.

01/04/2021: Removed "State Health Plan MA only" from the payable location.

09/08/2020: Added Payable location for State Health Plan MA only: Rural Health Center (RHC), Federally Qualified Health Center (FQHC).

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.