Enhanced wellness visit

Applies to:

☐ BCN Advantage Individual ☐ BCN Advantage Group ☒ Both

BCN Advantage HMO℠
BCN Advantage HMO-POS℠

Blue Care Network of Michigan

Medicare and more

Enhanced wellness visit

The enhanced wellness visit is an annual visit, in addition to the Medicare-covered annual wellness visit, that can occur anytime throughout the calendar year, regardless of the date of the previous annual wellness visit. The visit is intended to help members maintain good health by catching signs of disease early and taking a preventive approach to health care.

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) 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.

BCN Advantage enhanced benefit

BCN Advantage 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 BCN to offer enriched plans by using Original Medicare as the base program and adding desired benefit options.

Coverage for one enhanced wellness visit is provided to members under all individual BCN Advantage plans and select BCN Advantage group plans. Since Original Medicare doesn’t cover annual physical examinations, other than the IPPE, and limits the frequency of the AWV, the scope of the benefit, reimbursement methodology, maximum allowed payment amounts and member cost sharing are determined by BCN for individual coverage and by the group for those with group-based coverage.

Conditions for payment

The table below specifies payment conditions for an enhanced wellness visit.

Conditions for payment	
Eligible provider	M.D., D.O., practitioner, physician assistant, clinical nurse specialist
Payable location	Home, office, outpatient hospital Rural Health Center (RHC), Federally Qualified Health Center (FQHC)
Frequency	One visit per calendar year
CPT/HCPCS codes	G0439, FQHC: G0468
Diagnosis restrictions	No restrictions
Age restrictions	No restrictions

Reimbursement

The BCN Advantage maximum payment amount for an enhanced wellness visit is consistent with Original Medicare's payment for an annual wellness visit. The provider will be paid the lesser of this 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 share

- BCN Advantage providers should collect the applicable cost share from the member at the time of the service, when possible. Cost share refers to a flat dollar copayment, a percentage coinsurance or a deductible. Providers can only collect the appropriate BCN Advantage cost share 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 of Noncoverage to accept financial responsibility for noncovered items. If there is any question about whether an item is covered, seek a coverage determination from Blue Care Network before providing the item to the member. If a provider issues a noncovered item 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 use our provider portal or call 1-800-344-8525.

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 BCN Advantage 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. Use electronic billing:
   a. **Michigan Providers:** Copies of the ANSI ASC X 12N 837 and 835 Institutional Health Care Claim and Health Care Claim Payment/Advice (Blue Cross Electronic Data Interchange (EDI) Institutional 837/835Companion Documents) are available on the Blue Cross website under the reference library section at **bcbsm.com/providers/help/edi/**.
   b. **Providers outside Michigan:** Members of BCN Advantage HMO-POS plans have a point-of-service benefit offered through the nationwide network of Blue Plan Providers via the Blue Cross and Blue Shield Association. Providers outside Michigan who participate with Blue plans can provide preauthorized routine and follow-up care as necessary. Contact your local Blue plan for billing instructions.
   Coverage outside Michigan for members of BCN Advantage HMO plans is limited to medical emergencies, urgently needed services and renal dialysis unless BCN Advantage has approved the out-of-network services, which members must request in advance.

6. Send paper claims to:

BCN Advantage Claims
Blue Care Network
P.O. Box 68753
Grand Rapids, MI 49516-8753

Revision history

Policy number: BCNA

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11/08/2024: Added facility billing instructions.