Enhanced wellness visit

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**

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.

Medicare Plus Blue℠ 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 one enhanced wellness visit is provided to members under all individual Medicare Plus Blue PPO plans and select Medicare Plus Blue Group PPO 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 Blue Cross 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

Medicare Plus Blue plans' maximum payment amount to providers 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 Medicare's 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

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