

Routine 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 PPOSM Medicare Plus Blue Group PPOSM Both

Routine physical examinations

Routine 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 physical examinations covered by Original Medicare – one when the beneficiary is new to Medicare and one annual visit thereafter.

- Initial preventive physical examination (also known as the “Welcome to Medicare” physical exam) is provided when certain criteria have been met. This is a one-time review of the beneficiary health, education and counseling about preventive services, and referrals for other care if needed; and must occur no later than 12 months after the effective date of the beneficiary's first Part B coverage period.
- The Annual Wellness Visit is covered if the beneficiary has had Part B for longer than 12 months and hasn't received a Welcome to Medicare visit or AWV within the past 12 months. The AWV is to develop or update a personalized prevention plan based on the beneficiary's current health and risk factors

Preventive visits or routine physical examinations aren't covered under Original Medicare.

Medicare Plus Blue

Medicare Plus Blue plans provide at least the same level of benefit coverage as Original Medicare (Part A and Part B) and provide enhanced benefits beyond the scope of Original Medicare within a single health care plan. This flexibility allows BCBSM to offer enriched plans by using Original Medicare as the base program and adding desired benefit options.

Coverage for routine physical examinations 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 routine physical examinations, the scope of the benefit, reimbursement methodology, maximum payment amounts and member cost-sharing are determined by the member's group.

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

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Reimbursement

Medicare Plus Blue plans' maximum payment amount for routine physical examinations are available in a separate document, *BCBSM Medicare Advantage – Additional Benefits Fee Schedule*. 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 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. You 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 the noncovered service.

For detailed information about a Medicare Plus Blue Group PPO member's benefits and cost-share, providers may verify member benefits via web-DENIS or call CAREN at 1-866-309-1719.

Billing instructions for members

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