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

[X] **Blue Cross® Medicare Private Fee for Service (PFFS)**

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 existing personalized prevention plan based on the beneficiary's current health and risk factors.

Original Medicare does not cover annual physical examinations or preventive visits (other than those described above).

Blue Cross Medicare PFFS Enhanced Benefit

Blue Cross Medicare PFFS 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 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 the PFFS plan. 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.

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 detailed 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 preventive visit itself. 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.

Conditions for payment

The table below specifies payment conditions for routine physical examinations.

Conditions for payment	
Eligible provider	MD, DO, Nurse Practitioner, Physician Assistant
Payable location	Home, office, outpatient, hospital
Frequency	Once annually
CPT codes	99381 – 99387, 99391 – 99397, 80050
Diagnosis restrictions	Restrictions apply
Age restrictions	No restrictions

Reimbursement

The Blue Cross Medicare PFFS plan's 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

- Blue Cross Medicare PFFS 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 PFFS 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 Blue Cross Medicare PFFS 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. Send your claims to your local BCBS plan.
6. 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 (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

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