Annual Physical Exam Policy

Annual Physical Examinations Applies to:

Blue Medicare Advantage (PPO)
Blue Medicare Advantage Comprehensive (PPO)

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 status.

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

Blue Cross and Blue Shield of Kansas Medicare Advantage (PPO) Benefit

Blue Cross and Blue of Kansas BCBSKS Medicare Advantage (PPO) 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 healthcare plan. This flexibility allows BCBSKS 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 BCBSKS Medicare Advantage (PPO) plans. 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 BCBSKS.

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. 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 for members.

Conditions for Payment

The table below specifies payment conditions for routine physical examinations.

Conditions for Payment	
Eligible provider	MD, DO, Practitioners
Payable location	Home, Office, Outpatient Hospital
Frequency	Once annually
CPT/HCPCS codes	G0402, G0438, G0439
Diagnosis restrictions	Restrictions apply
Age restrictions	No restrictions

Reimbursement

Allowance for the annual physical exam codes and lab panel is based on the BCBKS Competitive Allowance Program pricing. 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

BCBSKS Medicare Advantage (PPO) 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 BCBSKS Medicare Advantage (PPO) 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 member eligibility, benefits and cost share, log on to Availity. From the BCBSKS payer space in the resource tab, select the Blue Medicare Advantage Link.

Billing Instructions for Providers

- Bill services on the CMS 1500 (02/12) claim form.
- Report CPT/HCPCS codes and diagnosis codes to the highest level of specificity.
- Report your National Provider Identifier number on all claims.
- Use electronic billing.
- Submit claims to your local BCBS plan.

Revision History

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