Why You Can’t Get An Annual Medicare Physical

In 2011, the Centers for Medicare and Medicaid (CMS) unveiled a new benefit to address the need for annual care for seniors. It was widely hailed as a wonderful thing for Medicare patients who previously had no preventive care unless they paid out-of-pocket for a “complete physical.” What some people overlook is that the new Medicare benefit includes no actual physical examination of any kind.

The “physical” terminology is what trips most people up. The American Medical Association (AMA) owns Current Procedural Terminology (CPT) which is part of the Medicare’s Healthcare Common Procedure Coding System (HCPCS). Neither CPT nor HCPCS lists an “annual physical” or a “complete physical,” with the exception of the preventive visit codes which include an “age-appropriate examination.” The traditional expectation for an annual physical is complete review of all physical systems with reporting of any issues, a complete head to toe physical examination, and any needed tests to confirm/promote wellness or to ascertain illness.

According to CPT/HCPCS, confirming/promoting wellness and ascertaining illness are not both parts of one code, but are addressed in two different types of codes – the well visit codes and the sick visit codes. The question on everyone’s mind is “What if you ascertain and address illness (a new problem) during a well visit?”

I don’t think there is a good answer to this question. There’s the right answer for billing, according to Medicare and there’s the right answer in the minds of most physicians I know, but there is not a single answer that works for billing and what patients want.

Because of this confusion, there is great frustration on the part of physicians and patients. If the office doesn't understand what the patient wants, or the patient doesn't understand their Medicare benefits, there is either a surprise in the exam room, or a surprise at the check-out desk, and no one enjoys that kind of surprise.

The only answer is to help patients understand what Medicare will and will not pay for and to try to match their benefits, their needs and what they are willing to pay for.

Here are the service choices defined by CMS/Medicare:

NAME: Welcome to Medicare Visit

WHEN: Available to all Medicare patients during the first 12 months of Medicare Part B eligibility

WHAT HAPPENS: Review of patient's medical history, risk factors, functional abilities and referrals for education or counseling. Could include an EKG or referral for an EKG. Could include screening for an
abdominal aortic aneurysm (AAA). **Does not include a physical exam.**

WHO PAYS: This visit has no deductible and no co-insurance, unless the patient has a screening EKG. The EKG does have the deductible and co-insurance applied.

NAME: Annual Wellness Visit

WHEN: Available 12 months after the Welcome to Medicare Visit and every 12 months thereafter
Does not include a physical exam.

WHAT HAPPENS: Review of your medical history, risk factors, functional abilities, a depression screening and a written screening schedule.

WHO PAYS WHAT: This visit has no deductible and no co-insurance.

NAME: Sick Visit (standard office visit)

WHEN: No restrictions on how often as long as there is a documented need for the visit.

WHAT HAPPENS: This is a regular office visit for an illness, injury or new problem or for monitoring of an existing problem. The three parts of a standard office visit are the HISTORY, the PHYSICAL EXAM, and the ASSESSMENT/PLAN.

WHO PAYS WHAT: This visit will apply to the deductible ($147 for 2013) if the patient's deductible has not been met, and co-insurance will apply.

SPECIAL NOTE: Patients can have a wellness visit and a sick visit at the same appointment and will not owe anything for the wellness visit but will owe the deductible/co-insurance for the sick visit.

NAME: Preventive Visit (most like the old "annual physical")

WHEN: Annually.

WHAT HAPPENS: This is a visit where the physician will review your medical history and perform an exam, order routine lab

tests and talk to you about risk factor reduction.

WHO PAYS: Medicare does not pay for this service at all and the patient is responsible for 100% of the cost of the visit.