BlueCross BlueShield of New Mexico

Annual Health Assessment

The Blue Cross Medicare Advantage[SM] HMO Annual Health Assessment (AHA) serves as a platform to identify essential clinical and care management needs and meets the requirements of the Medicare initial preventive and annual visits. The components of the AHA include the member's past medical history, social history, family history, physical exam (including BMI), preventive screenings, and chronic disease monitoring. These assessments can occur in the provider's office or member's home to remove barriers to completion. The Annual Health Assessments is a part of the Quality Program.

Initial Health Risk Assessment

CMS requires that a good faith effort is made to conduct an initial health assessment of all new members within 90 days of the effective date of enrollment and follows up on unsuccessful attempts to contact an enrollee.

Process for Submitting AHA – Paper Submission Procedure

1. The IPA provider conducts a face-to-face annual visit with the member and completes the Annual Health Assessment Form according to the instructions provided.

2. The IPA provider completes the encounter claim documenting the appropriate diagnosis codes and submits via normal claims submission to the IPA.
    a. The IPA provider shall document on the encounter claim the appropriate HCPCS codes for well visits for medical billing purposes:
        i. **G0402 – Initial Preventive Physical Examination**
        Code is limited to new beneficiary during the first 12 months of Medicare Enrollment.
        ii. **G0438 – Annual Wellness Visit (AWV), Initial**
        The initial AWV, G0438, is performed on patients that have been enrolled with Medicare for more than one year, including new or established patients.
        iii. **G0439 – Annual Wellness Visit (AWV), Subsequent**
        The subsequent AWV occurs one year after the patient initial visit.

3. The IPA ensures all required fields are completed on the AHA form and shall fax the completed Annual Health Assessment to (312) 233-6002. Please send any questions in reference to this form to: gyneth_c_saquido@bcbsil.com.

Medicare Beneficiaries receiving these services must have their copayment and/or coinsurance waived.

The codes, G0402, G0438, and G0439 are preventative services and members receiving these services do not pay a copayment for their visit. If the provider bills an Evaluation & Management (E & M) code (example: 99245) with the "G" code, your claim processing system must waive the copayment, because the "G" code is considered a preventative service.

Both the E & M code and the "G" code should be submitted to Blue Cross Medicare Advantage as part of the monthly delegated claims encounter submission.