CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2169	**Date: March 3, 2011**
	Change Request 7115

Transmittal 2081, dated December 3, 2010, is being rescinded and replaced by Transmittal 2169 dated March 3, 2011, to amend data file names and to include an additional contractor education requirement. All other information remains the same.

SUBJECT: Incentive Payment Program for Primary Care Services, Section 5501(a) of the Patient Protection and Afforable Care Act (the ACA), Payment to a CAH Paid Under the Optional Method

I. SUMMARY OF CHANGES: Primary Care Incentive Payment Program (PCIP), Section 5501(a) of the Patient Protection and Affordable Care Act (the ACA), Payment to a CAH Paid under the Optional Method.

EFFECTIVE DATE: April 1, 2011
IMPLEMENTATION DATE: April 4, 2011

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N	4/Table of Contents
R	4/250/2.2/Zip Code Files
N	4/250/12/Primary Care Incentive Payment Program (PCIP) Payments to Critical Access Hospitals (CAHs) Paid Under the Optional Method
N	4/250/12.1/Definition of Primary Care Practitioners and Primary Care Services
N	4/250/12.2/Identifying Primary Care Services Eligible for the PCIP
N	4/250/12.3/ Coordination with Other Payments
N	4/250/12.4/Claims Processing and Payment for Critical Access Hospitals Paid Under the Optional Method

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs):
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.
For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:
Business Requirements
Manual Instruction
**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-04	Transmittal: 2169	Date: March 3, 2011	Change Request: 7115

Transmittal 2081, dated December 3, 2010, is being rescinded and replaced by Transmittal 2169 , dated March 3, 2011, to amend data file names and to include an additional contractor education requirement. All other information remains the same.

SUBJECT: Primary Care Incentive Payment Program (PCIP), Section 5501(a) of the Patient Protection and Affordable Care Act (the ACA), Payment to a CAH Paid Under the Optional Method

Effective Date: **April 1, 2011**

Implementation Date: April 4, 2011

I. GENERAL INFORMATION

A. Background: Section 5501(a) of the ACA revises section 1833 of the Social Security Act (the Act) by adding a new paragraph (x), "Incentive Payments for Primary Care Services." Section 1833(x) of the Act states that in the case of primary care services furnished on or after January 1, 2011 and before January 1, 2016 by a primary care practitioner, there also shall be paid on a monthly or quarterly basis an amount equal to 10 percent of the payment amount for such services under Part B.

NOTE: The former "Quarterly HPSA and Scarcity Report for CAHs" is now known as the "Special Incentive Remittance for CAHs." This change is necessary as PCIP payments are made for all primary care services furnished by eligible primary care practitioners, regardless of the geographic location where the primary care services are furnished.

B. Policy: The ACA defines a primary care practitioner as: (1) a physician who has a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine; or (2) a nurse practitioner, clinical nurse specialist, or physician assistant, and in all cases, for whom primary care services accounted for at least 60 percent of the allowed charges under Part B for the practitioner in a prior period as determined appropriate by the Secretary.

The ACA defines primary care services as those services identified by the following CPT codes:

● 99201 through 99215 for new and established patient office or other outpatient evaluation and management (E/M) visits;

● 99304 through 99340 for initial, subsequent, discharge, and other nursing facility E/M services; new and established patient domiciliary, rest home (eg, boarding home), or custodial care E/M services; and domiciliary, rest home (eg, assisted living facility), or home care plan oversight services; and

● 99341 through 99350 for new and established patient home E/M visits.

These codes are displayed in the table below. All of these codes remain active in calendar year (CY) 2011 and there are no other codes used to describe these services.

Primary Care Services Eligible for Primary Care Incentive Payments in CY 2011

CPT Code	Description
99201	Level 1 new patient office or other outpatient visit
99202	Level 2 new patient office or other outpatient visit
99203	Level 3 new patient office or other outpatient visit
99204	Level 4 new patient office or other outpatient visit
99205	Level 5 new patient office or other outpatient visit
99211	Level 1 established patient office or other outpatient visit
99212	Level 2 established patient office or other outpatient visit
99213	Level 3 established patient office or other outpatient visit
99214	Level 4 established patient office or other outpatient visit
99215	Level 5 established patient office or other outpatient visit
99304	Level 1 initial nursing facility care
99305	Level 2 initial nursing facility care
99306	Level 3 initial nursing facility care
99307	Level 1 subsequent nursing facility care
99308	Level 2 subsequent nursing facility care
99309	Level 3 subsequent nursing facility care
99310	Level 4 subsequent nursing facility care
99315	Nursing facility discharge day management; 30 minutes
99316	Nursing facility discharge day management; more than 30 minutes
99318	Other nursing facility services; evaluation and management of a patient involving an annual nursing facility assessment.
99324	Level 1 new patient domiciliary, rest home, or custodial care visit
99325	Level 2 new patient domiciliary, rest home, or custodial care visit
99326	Level 3 new patient domiciliary, rest home, or custodial care visit ~~f~~
99327	Level 4 new patient domiciliary, rest home, or custodial care visit
99328	Level 5 new patient domiciliary, rest home, or custodial care visit
99334	Level 1 established patient domiciliary, rest home, or custodial care visit
99335	Level 2 established patient domiciliary, rest home, or custodial care visit
99336	Level 3 established patient domiciliary, rest home, or custodial care visit
99337	Level 4 established patient domiciliary, rest home, or custodial care visit
99339	Individual physician supervision of a patient in home, domiciliary or rest home recurring complex and multidisciplinary care modalities; 30 minutes
99340	Individual physician supervision of a patient in home, domiciliary or rest home recurring complex and multidisciplinary care modalities; 30 minutes or more
99341	Level 1 new patient home visit
99342	Level 2 new patient home visit
99343	Level 3 new patient home visit
99344	Level 4 new patient home visit
99345	Level 5 new patient home visit
99347	Level 1 established patient home visit
99348	Level 2 established patient home visit
99349	Level 3 established patient home visit
99350	Level 4 established patient home visit

Eligibility for Payment under the Primary Care Incentive Payment Program (PCIP)

For primary care services furnished on or after January 1, 2011 and before January 1, 2016, a 10 percent incentive payment will be provided to primary care practitioners, identified as: (1) in the case of physicians, enrolled in Medicare with a primary specialty designation of 08-family practice, 11-internal medicine, 37-pediatrics, or 38-geriatrics; or (2) in the case of nonphysician practitioners, enrolled in Medicare with a primary care specialty designation of 50-nurse practitioner, 89-certified clinical nurse specialist, or 97-physician assistant; and (3) for whom the primary care services displayed in the above table accounted for at least 60 percent of the allowed charges under the PFS (excluding hospital inpatient care and emergency department visits) for such practitioner during the time period that has been specified by the Secretary.

CMS provides contractors with a list of the national provider identifiers (NPIs) of the eligible primary care practitioners around the beginning of the incentive payment year. If a claim for a primary care service is submitted by a CAH paid under the optional method for an eligible primary care physician's or nonphysician practitioner's professional services, the "other provider" field on the claim must be populated by the eligible primary care practitioner's NPI in order for the primary care service to qualify for the incentive payment. Primary care services potentially eligible for the incentive payment and furnished on different days must be submitted on separate CAH claims so a determination about the eligibility of the service based on the rendering practitioner can be made. If the CAH claim for a single date of service includes more than one primary care professional service, the incentive payment for all primary care services for that date, shall be made to the CAH on behalf of the eligible primary care practitioner based on the NPI in the "other provider" field. In addition to the CAH NPI, the "other provider" NPI shall be shown on the Special Incentive Remittance for CAHs.

PCIP Payments to Critical Access Hospitals

Physicians and nonphysician practitioners billing on type of bill (TOB) 85X for professional services rendered in a CAH paid under the optional method have the option of reassigning their billing rights to the CAH. When the billing rights are reassigned to the CAH, payment is made to the CAH for professional services (revenue codes (RC) 96X, 97X or 98X).

Two files are developed by CMS for the use of contractors in implementing payment under the PCIP. The first file is the 'Primary Care Incentive Payment Program Eligibility File.' This file specifies the NPIs of eligible primary care physicians and nonphysician practitioners and shall be posted to contractors' websites by January 31 of the incentive payment year. The second file, the 'Physician/Practitioner Specialty File,' is provided by CMS and used by contractors to answer practitioner eligibility questions. Both the Primary Care Incentive Payment Program Eligibility File and the Physician/Practitioner Specialty File are revised annually based on updated claims data regarding primary specialty designation and primary care services' allowed charges percentage.

The 10 percent PCIP payment is payable to a CAH billing under the optional method for the primary care professional services of eligible primary care physicians and nonphysician practitioners who have reassigned their billing rights to CAH. The incentive payment is paid based on 10 percent of the 115 percent of the Medicare Physician Fee Schedule (PFS) amount paid to the CAH for those professional services. PCIP payments are calculated by Medicare contractors and made quarterly on behalf of the eligible primary care physician or nonphysician practitioner to the CAH for the primary care services furnished by the practitioner in that quarter.

The ACA authorizes payment under the PCIP beginning in CY 2011 as an additional payment amount for specified primary care services without regard to any additional payment for the service under the existing health professional shortage area (HPSA) physician bonus payment program. Therefore, eligible primary care physicians and nonphysician practitioners furnishing a primary care service in a HPSA may receive both a

HPSA physician bonus payment under the established program and a PCIP payment under the new program beginning in CY 2011.

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7115.1	CMS shall provide contractors with a Primary Care Incentive Payment Program Eligibility File on an annual basis. This file will list all the NPIs that are entitled to a primary care incentive payment throughout the calendar year.	X		X			X				CMS
7115.1.1	CMS shall provide Contractors with a Physician/Practitioner Specialty File, on an annual basis, to respond to practitioner eligibility questions or concerns.	X		X			X				CMS
7115.1.2	Contractors shall access the Primary Care Incentive Payment Program Eligibility File and the Physician/Practitioner Specialty File information through the fiscal intermediary standard system (FISS).	X		X			X				
7115.1.3	Contractors shall post the information in the Primary Care Incentive Payment Eligibility File to their website by January 31 of the applicable PCIP payment calendar year. NOTE: Contractors will not post the Physician/Practitioner Specialty File to their website. This file is to answer practitioner inquiries only.	X		X							
7115.1.4	Contractors shall download from the CMS mainframe the initial files MU00.@BFN2699.PCIP.PAYMENT.CY2011.NPI60.V2 and MU00.@BFN2699.PCIP.PAYMENT.CY2011.INQUIRY.V2 **NOTE:** These initial files are the Primary Care Incentive Payment Program Eligibility File (MU00.@BFN2699.PCIP.PAYMENT.CY2011.NPI60.V2) to be used for incentive payment purposes and the **Physician/Practitioner Specialty File (**MU00.@BFN2699.PCIP.PAYMENT.CY2011.INQUIRY.V2**) to be used for provider inquiries.** **Date of retrieval will be January 3, 2011.**	X		X			X				EDC
7115.1.5	Contractors/data centers shall retrieve the **FINAL** files from the CMS mainframe telecommunication systems on or	X		X			X				EDC

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	around January 24, 2011.										
7115.2	Contractors shall make quarterly primary care incentive payments to CAHs paid under the optional method on TOB 85X with RC 96X, 97X or 98X for all qualifying primary care services furnished by a physician or nonphysician practitioner with an NPI (as specified on the "other provider" field on the claim) that is listed on the Primary Care Incentive Payment Program Eligibility File for claims with dates of service on or after January 1, 2011 through December 31, 2015.	X		X			X				
7115.2.1	Contractors shall educate providers, in the case of multiple primary care services furnished by different practitioners on the same date of service, that only one "other provider" can be submitted on a claim and that payment will be made to the CAH on behalf of the eligible primary care practitioner based on the NPI in the "other provider" field for all primary care services for that date. NOTE: If the primary care services were furnished on different days and the primary care services are potentially eligible for the PCIP payment, then the CAH should submit a separate claim for each date of service, with the NPI of the practitioner who furnished the primary care service listed in the "other provider" field on the claim.	X		X							
7115.2.2	Contractors shall code their systems to be able to extend the end date of the program, if required, in a manner requiring the least amount of effort as possible.						X				
7115.2.3	Once the type of incentives have been identified by the shared systems, the shared system shall transmit the HPSA/PSA/HSIP/PCIP indicator to CWF and modify their systems to set the indicator on the claim line as follows: 1 = HPSA 2 = PSA 3 = HPSA and PSA 4 = HSIP 5 = HPSA and HSIP 6 = PCIP 7 = HPSA and PCIP Space = Not Applicable						X			X	
7115.2.4	Contractors shall modify their systems to set the HPSA/PSA/HSIP/PCIP indicator on the claim line to '6' for the PCIP payment.	X		X			X				
7115.2.5	Contractors shall modify their systems to accept a value of									X	NCH

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	'6' in the HPSA/PSA/HSIP/PCIP indicator.										
7115.2.6	Contractors shall modify their systems to set the HPSA/PSA/HSIP/PCIP indicator on the claim line to '7' when both a HPSA and PCIP payment is made.	X		X			X				
7115.2.7	Contractors shall modify their systems to accept a value of '7' in the HPSA/PSA/HSIP/PCIP indicator.									X	NCH
7115.2.8	FISS shall make the incentive payment to CAHs paid under the optional method for each primary care professional service on a claim with an eligible primary care practitioner NPI in the "other provider" field.						X				
7115.3	For each NPI on the Primary Care Incentive Payment Program Eligibility File, FISS shall accumulate the total paid amount for each CAH (or review paid claims history) on a quarterly basis for codes 99201 through 99215, and 99304 through 99350.						X				
7115.4	FISS shall calculate a PCIP payment equal to 10 percent of the amount paid each calendar quarter (4 payments annually) for CPT codes 99201 through 99215, and 99304 though 99350, billed by a CAH paid under the optional method on TOB 85X with RC 96X, 97X or 98X for each qualifying NPI (in the "other provider" field) listed on the Primary Care Incentive Payment Program Eligibility File. **NOTE:** The incentive payment is paid based on the amount paid, not the Medicare approved amount.						X				
7115.5	FISS shall rename the "Quarterly HPSA and Scarcity Report for CAHs" as the "Special Incentive Remittance for CAHs."						X				
7115.6	FISS shall revise the special incentive remittance that is forwarded with the special incentive remittance for payment so that CAHs paid under the optional method may identify which type of incentive payment (original HPSA, PSA (if it should become available again at a later date), HPSA Surgical Incentive Payment Program (HSIP), or PCIP) was paid.						X				
7115.6.1	FISS shall revise the special incentive remittance so that CAHs paid under the optional method may identify the NPI in the "other provider" field.						X				
7115.7	FISS shall send contractors the HIGLAS 810 invoice for incentive payments including the new PCIP payment.						X				HIGLAS
7115.8	FISS shall combine the CAH's HPSA, PSA (if it should become available again at a later date), HSIP, and PCIP payment into one incentive invoice per CAH.						X				HIGLAS
7115.9	FISS shall receive the HIGLAS 835 payment file from						X				HIGL

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	HIGLAS showing a single incentive payment per CAH.										AS

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7115.10	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X		X							
7115.11	CMS will provide contractors with education in the proper use of the Physician/Practitioner Specialty File in responding to Medicare Practitioner Eligibility Questions. CMS will prepare a "Tips Sheet" and a presentation via a PCUG call.	X		X							CMS

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:

.

X-Ref Requirement Number	Recommendations or other supporting information:
7146	HSIP payment to a CAH Paid under the Optional Method

Section B: For all other recommendations and supporting information:

V. CONTACTS

Pre-Implementation Contact(s): Stephanie Frilling at Stephanie.Frilling@cms.hhs.gov or 410-786-4507

For claims processing questions, please contact Sue Guerin at Susan.Guerin@cms.hhs.gov or 410-786-6138 or Yvonne Young at Yvonne.Young@cms.hhs.gov or (410) 786-61886

Post-Implementation Contact(s): Contact your Contracting Officer's Technical Representative (COTR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs)*:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *For Medicare Administrative Contractors (MACs)*:

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Medicare Claims Processing Manual
Chapter 4 - Part B Hospital
(Including Inpatient Hospital Part B and OPPS)

Table of Contents
(Rev.2169, Issued: 03-03-11, Effective: 04-01-11, Implementation: 04-04-11)

250.2.2 - Zip Code Files
(Rev. 2169, Issued: 03-03-11, Effective: 04-01-11, Implementation: 04-04-11)

The CMS provided a file of ZIP Codes for the primary care and specialist care Physician Scarcity Area (PSA) bonus payment. The file is effective for claims with dates of service January 1, 2005 through June 30, 2008. Prior to January 1, 2005, CMS posted on its Web site ZIP Codes that are eligible for the bonus payment. Through regularly scheduled bulletins and list serves, intermediaries must notify the CAH to verify their ZIP Code eligibility via the CMS Web site.

ZIP Code files for the automated payment of the Health Professional Shortage Area (HPSA) bonus payment will be developed and updated annually. Effective for claims with dates of service on or after January 1, 2009, only services provided in areas that are designated as of December 31 of the prior year are eligible for the HPSA bonus payment. Physicians providing services in areas that were designated as of December 31 of the prior year but not on the automated file may use the AQ modifier. Only services provided in areas that were designated as of December 31 of the prior year but not on the automated file may use the modifier. Services provided in areas that are designated throughout the year will not be eligible for the HPSA bonus payment until the following year, provided they are still designated on December 31. Services provided in areas that are de-designated throughout the year will continue to be eligible for the HPSA bonus through the end of the calendar year.

The contractors and standard systems will be provided with a file at the appropriate time prior to the beginning of the calendar year for which it is effective. This file will contain ZIP Codes that fully and partially fall within a HPSA bonus area for both mental health and primary care services. A recurring update notification will be issued for each annual update. Contractors will be informed of the availability of the file and the file name via an email notice.

Contractors will automatically pay bonuses for services rendered in ZIP Code areas that: 1) fully fall within a designated primary care or mental health full county HPSA; 2) are considered to fully fall in the county based on a determination of dominance made by the United States Postal Service (USPS); or 3) are fully within a non-full county HPSA area. Should a ZIP Code fall within both a primary care and mental health HPSA, only one bonus will be paid on the service. Bonuses for mental health HPSAs will only be paid when performed by psychiatrists.

For services rendered in ZIP Code areas: 1) that do not fall within a designated full county HPSA; 2) are not considered to fall within the county based on a determination of dominance made by the USPS; or 3) are partially within a non-full county HPSA, the CAH must still submit a AQ modifier to receive payment for claims. To determine whether a modifier is needed, the CAH must review the information provided on the CMS Web site for HPSA designations to determine if their location is, indeed, within a HPSA bonus area.

For service rendered in ZIP Code areas that cannot automatically receive the bonus, it will be necessary to know the census tract of the area to determine if a bonus should be paid and a modifier submitted. Census tract data can be retrieved by visiting the U.S. Census Bureau Web site at www.Census.gov.

Special Incentive Remittance for CAHS

A Special Incentive Remittance for CAHs is generated on a quarterly basis that identifies beneficiary and claims information for which a HPSA, PSA, Primary Care Incentive Payment Program (PCIP) or HPSA Surgical Incentive Payment Program (HSIP) payment is being made. Since there is a possibility that more than one type of incentive payment may be paid for a single service, each type of incentive payment being made is identified on the remittance as follows:

1 = HPSA

2 = PSA

3 = HPSA and PSA

4 = HSIP

5 = HPSA and HSIP

6 = PCIP

7 = HPSA and PCIP

Space = Not Applicable

See sections 250.12 through 250.12.4 for more information on PCIP payments to CAHs paid under the optional method.

Use the information in the Professional Component/Technical Component (PC/TC) indicator field of the CORF extract of the Medicare Physician Fee Schedule Supplementary File to identify professional services eligible for HPSA and physician scarcity bonus payments. The

following are the rules to apply in determining whether to pay the bonus on services furnished within a geographic HPSA billed with a QB or QU modifier for dates of service prior to January 01, 2006 or the AQ modifier for services on or after January 01, 2006, and/or whether to pay the bonus on services furnished within a Physician Scarcity Area with the AR modifier effective for dates of service January 01, 2005, through June 30, 2008.

(Field 20 on the full MPFS file layout)

PC/TC Indicator	Bonus Payment Policy
0	Physician services. The concept of PC/TC does not apply since physician services cannot be split into professional and technical components. ACTION: Pay the bonus
1	Globally billed. Only the professional component of this service qualifies for the bonus payment. The bonus cannot be paid on the technical component of globally billed services. ACTION: Return the service as unprocessable and notify the CAH that the professional component must be re-billed if it is performed within a qualifying bonus area. If the technical component is the only component of the service that was performed in the bonus area, there wouldn't be a qualifying service.
1	Professional Component (modifier 26). ACTION: Pay the bonus.
1	Technical Component (modifier TC). ACTION: Do not pay the bonus.
2	Professional Component only. ACTION: Pay the bonus.
3	Technical Component only. ACTION: Do not pay the bonus.
4	Global test only. Only the professional component of this service qualifies for the bonus payment. ACTION: Return the service as unprocessable. Instruct the provider to re-bill the service as separate professional and technical component procedure codes.
5	Incident to codes. ACTION: Do not pay the bonus.

6	Laboratory physician interpretation codes. ACTION: Pay the bonus
7	Physical therapy service. ACTION: Do not pay the bonus.
8	Physician interpretation codes. ACTION: Pay the bonus.
9	Concept of PC/TC does not apply. ACTION: Do not pay the bonus.

NOTE: Codes that have a status of "X" on the CORF extract Medicare Physician Fee Schedule Database (MFSDB) have been assigned PC/TC indicator 9 and are not considered physician services for MFSDB payment purposes. Therefore, neither the HPSA bonus nor the physician bonus payment (5 percent) will be paid for these codes.

250.12 - Primary Care Incentive Payment Program (PCIP) Payments to Critical Access Hospitals (CAHs) Paid Under the Optional Method

*(Rev. **2169, Issued: 03-03-11, Effective: 04-01-11, Implementation: 04-04-11**)*

Section 5501(a) of the Affordable Care Act revises section 1833 of the Social Security Act by adding a new paragraph, (x), "Incentive Payments for Primary Care Services." Section 1833(x) of the Act states that in the case of primary care services furnished on or after January 1, 2011, and before January 1, 2016, there shall be a 10 percent incentive payment for such services under Part B when furnished by a primary care practitioner.

250.12.1 - Definition of Primary Care Practitioners and Primary Care Services

*(Rev. **2169, Issued: 03-03-11, Effective: 04-01-11, Implementation: 04-04-11**)*

Primary care practitioners are defined as:

(1) A physician who has a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine for whom primary care services accounted for at least 60 percent of the allowed charges under the PFS (excluding hospital inpatient care and emergency department visits) for the practitioner in a prior period as determined appropriate by the Secretary; or

(2) A nurse practitioner, clinical nurse specialist, or physician assistant for whom primary care services accounted for at least 60 percent of the allowed charges under the PFS (excluding hospital inpatient care and emergency department visits) for the practitioner in a prior period as determined appropriate by the Secretary.

Primary care services are defined as CPT Codes:

(1) 99201 through 99215 for new and established patient office or outpatient evaluation and management (E/M) visits;

(2) 99304 through 99340 for initial, subsequent, discharge, and other nursing facility E/M services; new and established patient domiciliary, rest home or custodial care E/M services; and domiciliary, rest home or home care plan oversight services; and

(3) 99341 through 99350 for new and established patient home E/M visits.

250.12.2 - Identifying Primary Care Services Eligible for the PCIP

CAHs paid under the optional method billing on TOB 85X for professional primary care services (revenue code 96X, 97X or 98X) furnished by primary care physicians and nonphysician practitioners who have reassigned their billing rights to the CAH are eligible for PCIP payments.

The National Provider Identifier (NPIs) of primary care practitioners eligible for PCIP payment in a given calendar year (CY) are posted on Medicare contractor web sites in the Primary Care Incentive Payment Program Eligibility File by January 31 of the applicable incentive payment CY. Eligible practitioners for PCIP payment in a given calendar year who were newly enrolled in Medicare in the year immediately preceding the PCIP payment year will be identified later in the payment year and posted on their Medicare contractor's website at that point in time. CAHs paid under the optional method should contact their contractor with any questions regarding the eligibility of physician and nonphysician practitioners for PCIP payments.

Primary care practitioners furnishing primary care services will be identified on CAH claims by the NPI of the rendering practitioner as specified in the "other provider" field on the claim for the primary care service. If the claim for a primary care service is submitted by a CAH paid under the optional method, the rendering physician's NPI must be included in the "other provider" field on the claim for the primary care service specified by an eligible CPT code. In order for a primary care service to be eligible for PCIP payment, the CAH paid under the optional method must be billing for the professional services of physicians under their NPIs or of physician assistants, clinical nurse specialists, or nurse practitioners under their own NPIs because they are not furnishing services incident to physicians' services.

If the CAH claim for a single date of service includes more than one primary care professional service, the incentive payment for all primary care services for that date, shall be made to the CAH on behalf of the eligible primary care physician or nonphysician practitioner based on the NPI in the "other provider" field.

If primary care services are furnished on different dates of service to the same patient, the CAH should ensure that the primary care professional service furnished each day is on a separate CAH claim so the NPI in the "other provider" field reflects the NPI of the physician or non physician practitioner who rendered that primary care service. This permits correct attribution of the primary care service to an NPI, so contractors can then determine if that NPI is eligible for PICP payment and, if so, then the contractor would include the PCIP payment for that service in the quarterly incentive payment to the CAH.

See section 230.1 for more information on primary care practitioner identification.

250.12.3 - Coordination with Other Payments

(Rev. 2169, Issued: 03-03-11, Effective: 04-01-11, Implementation: 04-04-11)

Section 5501(a)(3) of the ACA authorizes payment under the PCIP as an additional payment amount for specified primary care services without regard to any additional payment for the service under Section 1833(m) of the Social Security Act, the established Health Professional Shortage Area (HPSA) Medicare physician bonus program. Therefore, a CAH paid under the optional method and billing for the professional services of an eligible primary care physician or nonphysician practitioner furnishing a primary care service in a health professional shortage area (HPSA) may receive both a HPSA physician bonus payment (as described in the Medicare Claims Processing Manual, Pub. 100-04, Chapter 4, Section 250.2) under the HPSA physician bonus program and a PCIP incentive payment under the new program beginning in CY 2011.

250.12.4 - Claims Processing and Payment for Critical Access Hospitals Paid Under the Optional Method

(Rev. 2169, Issued: 03-03-11, Effective: 04-01-11, Implementation: 04-04-11)

A. General Overview

Incentive payments will be made on a quarterly basis and shall be equal to 10 percent of the amount paid for such services under the Medicare Physician Fee Schedule (PFS) times 1.15 percent for those services furnished during the incentive payment year. PCIP payments for newly enrolled practitioners may be delayed due to the lag in claims data processing. PCIP payments for services by a newly enrolled primary care practitioner will be paid in the quarter following eligibility determination, and then quarterly for all subsequent incentive payments. Retroactive payments will be provided from the beginning of the PCIP year once these primary care practitioners are deemed eligible.

On an annual basis Medicare contractors shall receive a Primary Care Incentive Payment Program Eligibility File that they shall post to their websites. The file will list the NPIs of all physicians and nonphysician practitioners who are eligible to receive PCIP payments for the upcoming CY. The NPIs of eligible newly enrolled primary care practitioners will be posted to the contractors' websites later in the payment year.

On an annual basis Medicare contractors shall receive a Physician/Practitioner Specialty File. This file it to be used by contractors to answer provider inquiries regarding eligibility for the PCIP.

The PCIP payments will be calculated by Medicare contractors and made quarterly to CAHs paid under the optional method on behalf of the eligible primary care physician or nonphysician practitioner for the primary care services furnished by the practitioner in that quarter. The PCIP payments will be based on 10 percent of 115 percent of the PFS amount that the CAH was paid for the professional service.

B. Method of Payment

- *Calculate and pay a CAH paid under the optional method based on primary care services furnished by qualifying primary care physicians and nonphysician practitioners an additional 10 percent incentive payment;*
- *Calculate the payment based on 115 percent of the PFS amounts that were paid to the CAH for the services; not the Medicare approved amounts;*
- *Combine the PCIP incentive payments, when appropriate, with other incentive payments, including the physician HPSA bonus payment and the HPSA Surgical Incentive Payment Program (HSIP) payment;*
- *Provide a special remittance for CAHs form that is forwarded with the incentive payment so that CAHs paid under the optional method can identify which type of incentive payment was paid for which services.*
- *CAHs paid under the optional method should contact their contractor with any questions regarding PCIP payments.*

C. Changes for Contractor Systems

The Fiscal Intermediary Standard System (FISS), Common Working File (CWF) and National Claims History (NCH) shall be modified to accept a new PCIP indicator on the claim line. Once the type of incentive payment has been identified by the shared systems, the shared system shall modify their systems to set the indicator on the claim line as follows:

1 = HPSA

2 = PSA

3 = HPSA and PSA

4 = HSIP

5 = HPSA and HSIP

6 = PCIP

7 = HPSA and PCIP

Space = Not Applicable

The FISS shall send the HIGLAS 810 invoice for incentive payment invoices, including the new PCIP payment. The contractor shall also combine the CAH's HPSA bonus, physician scarcity (PSA) bonus (if it should become available at a later date), HSIP payment and/or PCIP payment invoice per CAH. The contractor shall receive the HIGLAS 835 payment file from HIGLAS showing a single incentive payment per CAH.

Attachment A:

Primary Care Incentive Payment Eligibility File
Record Layout

FIELD NAME	START/END POSITION	PIC	COMMENT
Filler	1-6	X(6)	Value spaces (in the future, this field may contain the fiscal intermediary/MAC number).
NPI	7-16	X(10)	Left justified. NPI of the physician or nonphysician practitioner on whose behalf the primary care incentive payment will be made to the CAH.
Filler	17-17	X(1)	Value spaces
Incentive Payment Year	18-21	X(4)	CCYY (quarterly Primary Care Incentive payments are made using claims data from this year).
Filler	22-22	X(1)	Value spaces
Qualifying Year	23-26	X(4)	CCYY (claims history data from this year was used to determine if the NPI qualified for the Primary Care Incentive).
Filler	27-46	X(20)	Value spaces

(7/16/2010)

Attachment B:

Primary Care Incentive
Physician /Practitioner Specialty File
Record Layout

FIELD NAME	START/END POSITION	PIC	COMMENT
HEADER RECORD			
Header Indicator	1-4	X(4)	Value "HEAD"
Filler	5-6	X(2)	Value spaces
Incentive Payment Year	7-10	X(4)	CCYY (value denotes the four character payment year for the incentive).
Filler	11-155	X(145)	Value spaces
DATA RECORD			
Filler	1-6	X(6)	Value spaces (in the future, this field may contain the fiscal intermediary/MAC number).
NPI	7-16	X(10)	NPI of the physician or nonphysician practitioner on whose behalf the primary care incentive payment will be made to the CAH.
Filler	17-17	X(1)	Value spaces
Incentive Payment Year	18-21	X(4)	CCYY (quarterly Primary Care Incentive payments are made using claims data from this year).
Filler	22-22	X(1)	Value spaces
Qualifying Year	23-26	X(4)	CCYY (claims history data from this year was used to determine if the NPI qualified for the Primary Care Incentive).
Filler	27-30	X(4)	Value spaces
Provider Specialty Code	31-32	X(2)	Self Selected Designation
Filler	33-36	X(4)	Value Spaces
Percentage of Primary Care Services	37-39	9(3)	Right justified. Must be 60% for qualification (whole number range from 000% to 100%).
Filler	40-43	X(4)	Value Spaces
Total Primary Care Allowed Charges	44-53	9(8)v99	Right justified.
Filler	54-61	X(8)	Value Spaces
Total of All Allowed Charges	62-71	9(8)v99	Right justified.
Filler	72-155	X(84)	Value Spaces