



News Flash – The Centers for Medicare & Medicaid Services (CMS) has completed the bid evaluation process and announced the single payment amounts for the Round 1 Rebid of the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program. Competitive bidding will determine where Medicare beneficiaries residing in Competitive Bidding Areas must obtain many DMEPOS items as of January 1, 2011. For additional information about the Medicare DMEPOS Competitive Bidding Program, visit <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSCompetitiveBid/index.html> on the CMS website.

MLN Matters® Number: MM7060 **Revised**

Related Change Request (CR) #: 7060

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Implementation Date: January 3, 2011

Incentive Payment Program for Primary Care Services, Section 5501(a) of The Affordable Care Act

Note: This article was updated on August 8, 2012, to reflect current Web addresses. Previously, it was revised on December 6, 2011, to add a reference to MLN Matters® article MM7561 (<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7561.pdf>), which announces that effective April 1, 2012, the Special Remittance Advice for quarterly HPSA, PCIP, and HSIP is being revised to include a summary page of each type of incentive amount paid to the provider by NPI. All other information remains the same.

Provider Types Affected

Physicians and non-physician practitioners submitting claims to Medicare carriers and Part A/B Medicare Administrative Contractors (A/B MAC) for primary care services provided to Medicare beneficiaries are affected.

What You Need to Know

This article, based on Change Request (CR) 7060, explains that Section 5501(a) of The Affordable Care Act provides for an incentive payment for primary care

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services furnished on or after January 1, 2011, and before January 1, 2016, by a primary care practitioner. The incentive payment will be paid on a monthly or quarterly basis in an amount equal to 10 percent of the payment amount for such services under Part B. See the Background and Additional Information Section of this article for further details regarding these changes.

Background

Section 5501(a) of The Affordable Care Act revises section 1833 of The Social Security Act by adding new paragraph (x), "Incentive Payments for Primary Care Services." Section 1833(x) of the Social Security 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 will be paid on a monthly or quarterly basis an amount equal to 10 percent of the payment amount for such services under Part B.

Specifically, the incentive payments will be made on a quarterly basis and will equal 10 percent of the amount paid for primary care services under the Medicare Physician Fee Schedule for those services furnished during the bonus payment year. (For bonus payments to Critical Access Hospitals paid under the optional method, see Chapter 4, Section 250.12 of the "Medicare Claims Processing Manual" at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c04.pdf> on the Centers for Medicare & Medicaid Services (CMS) website.)

NOTE: The new Health Professional Shortage Area (HPSA) Surgical Incentive Payment Program (HSIP) and the new PCIP will be implemented in conjunction with one another for CY 2011. A separate article will be available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7063.pdf> upon release of CR 7063 CR for HSIP. The former "special HPSA remittance" will now be known as the "special incentive remittance". This change is necessary as the PCIP is open to all eligible primary care providers, regardless of the geographic location in which the primary care services are being furnished.

Primary Care Practitioner Defined

Section 5501(a)(2)(A) of The Affordable Care Act defines a primary care practitioner as:

- A physician who has a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine; or

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- 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 Physician Fee Schedule (PFS) for the practitioner in a prior period as determined appropriate by the Secretary of Health and Human Services.

Primary Care Services Defined

Section 5501(a)(2)(B) of The Affordable Care Act defines primary care services as those services identified by the following Current Procedure Terminology (CPT) codes as of January 1, 2009 (and as subsequently modified by the Secretary of Health and Human Services, as applicable):

- 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 (e.g., boarding home), or custodial care E/M services; and domiciliary, rest home (e.g., 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 following table. 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 Codes	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

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CPT Codes	Description
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
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

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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 non-physician 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 for such practitioner during the time period that has been specified by the Secretary.

CMS will provide Medicare contractors with a list of the National Provider Identifiers (NPIs) of the primary care practitioners eligible to receive the incentive payments.

Eligible practitioners would be identified on a claim based on the NPI of the rendering practitioner. If the claim is submitted by a practitioner or group practice, the rendering practitioner's NPI must be included on the line-item for the primary care service (identified in the above table) in order for a determination to be made regarding whether or not the service is eligible for payment under the PCIP. In order to be eligible for the PCIP, Physician Assistants, Clinical Nurse Specialists, and Nurse Practitioners must be billing for their services under their own NPI and not furnishing services incident to physicians' services. Regardless of the specialty area in which they may be practicing, these specific non-physician practitioners are eligible for the PCIP based on their profession and historical percentage of allowed charges as primary care services that equals or exceeds the 60 percent threshold.

Beginning in CY 2011, primary care practitioners will be identified based on their primary specialty of enrollment in Medicare and percentage of allowed charges for primary care services that equals or exceeds the 60 percent threshold from Medicare claims data 2 years prior to the bonus payment year. A provision to accommodate newly enrolled Medicare providers will be released in 2011.

Coordination with Other Payments

Section 5501(a)(3) of The Affordable Care Act provides 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. Therefore, an eligible primary care physician 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.

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Additional Information

If you have questions about this article, please contact your Medicare carrier and/or MAC at their toll-free number which may be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website. The official instruction, CR 7060, issued to your Medicare carrier and/or MAC regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2161CP.pdf> on the CMS website.

You should also review MLN Matters® article MM7115 at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7115.pdf> for additional information relative to this program.

A review of MLN Matters® article MM7267 (<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7267.pdf>) is also helpful because it explains that the PCIP is being amended to include the participation of newly enrolled primary care physicians and NPPs who do not have a prior two year claims history with which to determine eligibility. Review of MLN Matters® article SE1109 (<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1109.pdf>) will give further information about Medicare's Primary Care Incentive Program.

News Flash - Each Office Visit is an Opportunity. Medicare patients give many reasons for not getting their annual flu vaccination, but the fact is that there are 36,000 flu-related deaths in the United States each year, on average. More than 90% of these deaths occur in people 65 years of age and older. Please talk with your Medicare patients about the importance of getting their annual flu vaccination. This Medicare-covered preventive service will protect them for the entire flu season. And remember, vaccination is important for health care workers too, who may spread the flu to high risk patients. **Don't forget to immunize yourself and your staff. Protect your patients. Protect your family. Protect yourself. Get Your Flu Vaccine - Not the Flu.** Remember – Influenza vaccine plus its administration are covered Part B benefits. Note that influenza vaccine is NOT a Part D covered drug. For information about Medicare's coverage of the influenza vaccine and its administration, as well as related educational resources for health care professionals and their staff, please visit http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Flu_Products.pdf and <http://www.cms.gov/Medicare/Prevention/Immunizations/index.html> on the CMS website.

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