

<b>CMS Manual System</b>	<b>Department of Health &amp; Human Services (DHHS)</b>
<b>Pub 100-06 Medicare Financial Management</b>	<b>Centers for Medicare &amp; Medicaid Services (CMS)</b>
<b>Transmittal 176</b>	<b>Date: November 12, 2010</b>
	<b>Change Request 7223</b>

**SUBJECT: Clarification for Data Entry on Health Professional Shortage Area Reports**

**I. SUMMARY OF CHANGES:** This CR will clarify how contractors are to define "physicians" for data entry on HPSA reports. It also updates references from "carriers" to "carriers/Part B MACs."

**EFFECTIVE DATE: \*December 13, 2010**

**IMPLEMENTATION DATE: December 13, 2010**

*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.

<b>R/N/D</b>	<b>CHAPTER / SECTION / SUBSECTION / TITLE</b>
R	6/ 290/Completing Health Professional Shortage Area (HPSA) Quarterly Reports, Form CMS 1565E - General
R	6/290.1/Heading
R	6/290.2/Checking Reports
R	6/290.3/Current Quarter Payments
R	6/290.4/Current Quarter Reviews
R	6/290.5/Prior Quarter(s) Reviews
R	6/290.6/Error Descriptions

**III. FUNDING:**

**For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:**

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.*



#### IV. SUPPORTING INFORMATION

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

*Use "Should" to denote a recommendation.*

X-Ref Requirement Number	Recommendations or other supporting information:

**Section B: For all other recommendations and supporting information, use this space: N/A**

#### V. CONTACTS

**Pre-Implementation Contact(s):** Leslie Trazzi at [Leslie.Trazzi@cms.hhs.gov](mailto:Leslie.Trazzi@cms.hhs.gov)

**Post-Implementation Contact(s):** Appropriate Regional Office or Project Officer.

#### VI. FUNDING

**Section A: For *Fiscal Intermediaries (FIs)*, *Regional Home Health Intermediaries (RHHIs)*, and/or *Carriers*:**

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.

## **290 - Completing Health Professional Shortage Area (HPSA) Quarterly Report, Form CMS-1565E - General**

*(Rev. 176, Issued: 11-12-10, Effective: 12-13-10, Implementation: 12-13-10)*

The carriers/*Part B MACs* prepare and submit to CMS each quarter a report on information regarding incentive payments made to physicians who render covered Medicare services in HPSAs (see Pub. 100-04, Chapter 12, §§90.4 – 90.4.7) on the results of its review of sample claims for HPSA incentive payments processed during the reporting quarter. It submits this report via the Contractor Reporting of Operational Workload Data (CROWD Form S) system no later than the 75<sup>th</sup> day following the close of the reporting quarter.

### **290.1 - Heading**

*(Rev. 176, Issued: 11-12-10, Effective: 12-13-10, Implementation: 12-13-10)*

This report is referenced as Form S in the CROWD system. The carrier/*Part B MAC* completes the ADD/UPDATE/DELETE DATA criteria screen with the appropriate information to bring the reporting format to its screen.

### **290.2 - Checking Reports**

*(Rev. 176, Issued: 11-12-10, Effective: 12-13-10, Implementation: 12-13-10)*

Before submitting Form S to CMS, the carrier/*Part B MAC* checks for completeness and arithmetical accuracy. It uses the following checklist:

- Line 2 plus line 3 must equal line 1. Effective with the first quarterly report of 2005, that is due no later than 75 days after the close of the first calendar quarter of 2005, this will no longer be applicable.
- Line 5 plus line 6 must equal line 4. Line 2 plus line 3 must equal line 1. Effective with the first quarterly report of 2005, that is due no later than 75 days after the close of the first calendar quarter of 2005, this will no longer be applicable.
- Line 8 must be less than or equal to line 7.
- Line 9 must be greater than or equal to line 7.
- Line 10 must be less than or equal to line 9.
- Line 13 plus line 14 plus line 15 must be less than or equal to line 12.
- Line 16 must be greater than or equal to line 12.
- Line 17 must be less than or equal to line 16.
- Sum of lines 19-30, column 1 must equal line 10.

- Sum of lines 19-30, column 2 must equal line 17.

### **290.3 - Current Quarter Payments**

*(Rev. 176, Issued: 11-12-10, Effective: 12-13-10, Implementation: 12-13-10)*

The carrier/*Part B MAC* reports in lines 1-3 the number of physicians receiving incentive payment checks during the current reporting quarter and in lines 4-6 the respective amounts of payment issued.

*Note: For data reporting purposes for this report, “physicians” will be defined as NPI/PIN combinations as provided to the carriers/Part B MACs by the Shared System.*

#### **Physicians Receiving Checks**

**Line 1. Total Physicians** - total number of physicians receiving incentive payments.

**Line 2. Urban HPSAs** - number of physicians receiving incentive payments classified as providing services in a HPSA urban setting. Effective with the first quarterly report of 2005, that is due no later than 75 days after the close of the first calendar quarter of 2005, this line must no longer be entered.

**Line 3. Rural HPSAs** - number of physicians receiving incentive payments classified as providing services in a HPSA rural setting. Effective with the first quarterly report of 2005, that is due no later than 75 days after the close of the first calendar quarter of 2005, this line must no longer be entered.

#### **Amount Of Incentive Payments**

**Line 4. Total Incentive Payments** - total amount of incentive payments issued to physicians.

**Line 5. Urban HPSAs** - amount of incentive payments issued to physicians for services provided in a HPSA urban setting. Effective with the first quarterly report of 2005, that is due no later than 75 days after the close of the first calendar quarter of 2005, this line must no longer be entered.

**Line 6. Rural HPSAs** - amount of incentive payments issued to physicians for services provided in a HPSA rural setting. Effective with the first quarterly report of 2005, that is due no later than 75 days after the close of the first calendar quarter of 2005, this line must no longer be entered.

## **290.4 - Current Quarter Reviews**

*(Rev. 176, Issued: 11-12-10, Effective: 12-13-10, Implementation: 12-13-10)*

The carrier/*Part B MAC* reports in lines 7-11 information on physicians identified for review based on data for the current reporting quarter **excluding** those physicians reviewed because they were noncompliant in the previous quarter.

*Note: For data reporting purposes for this report, “physicians” will be defined as NPI/PIN combinations as provided to the carriers/Part B MACs by the Shared System.*

**Line 7. Physicians Reviewed** - number of physicians identified for review based on data for the current reporting quarter. The carrier/*Part B MAC* excludes those physicians reviewed because of noncompliance in the previous quarter.

**Line 8. Physicians Paid Incorrectly** - number of physicians reviewed on line 7 that incorrectly received an incentive bonus on at least one claim.

**Line 9. Claims Reviewed** - number of total claims reviewed for physicians reported on line 7.

**Line 10. Claims Paid Incorrectly** - number of claims included on line 9 where the physician incorrectly received incentive payments.

**Line 11. Incentive Amount Paid Incorrectly** - total incentive amount incorrectly paid on claims identified on line 10.

## **290.5 - Prior Quarter(s) Reviews**

*(Rev. 176, Issued: 11-12-10, Effective: 12-13-10, Implementation: 12-13-10)*

The carrier/*Part B MAC* reports in lines 12-18 information on physicians reviewed because they were noncompliant in the previous quarter(s).

*Note: For data reporting purposes for this report, “physicians” will be defined as NPI/PIN combinations as provided to the carriers/Part B MACs by the Shared System.*

**Line 12. Physicians Reviewed** - number of physicians who were identified in lines 8, 13, 14, or 15 on the previous quarter report as noncompliant.

**Line 13. Physicians Noncompliant Two Quarters** - number of physicians identified in line 12 that were noncompliant in the current and previous quarters, but no quarters prior.

**Line 14. Physicians Noncompliant Three Quarters** - number of physicians identified in line 12 that were included in line 13 in the previous quarter's report and still noncompliant in the current quarter.

**Line 15. Physicians Noncompliant Four or More Quarters** - number of physicians identified in line 12 that were included in line 14 in the previous quarter's report and still noncompliant in the current quarter.

**Line 16. Claims Reviewed** - number of claims reviewed for the physicians identified in line 12.

**Line 17. Claims Paid Incorrectly** - number of claims in line 16 that were paid incorrectly.

**Line 18. Incentive Amount Paid Incorrectly** - total incentive amount paid on those claims identified in line 17.

## **290.6 - Error Descriptions**

*(Rev. 176, Issued: 11-12-10, Effective: 12-13-10, Implementation: 12-13-10)*

This report breaks down the number of claims found to be paid incorrectly by selected error categories for "Current Quarter Reviews" and "Prior Quarter(s) Reviews". Claims counts reported in lines 19-30 under the "Number of Claims Current Quarter" column should total to the number reported in line 10. Similarly, claims counts reported in lines 19-30 under the "Number of Claims Prior Quarter(s)" column should total to the number reported in line 17. In a case where the claim could fall into more than one category, the carrier/*Part B MAC* makes a determination as to which category to put the claim in. Each claim incorrectly receiving a HPSA incentive payment should be counted only once under the "Error Descriptions" section.

**Line 19. Office In, Service Outside HPSA** - number of claims where the provider's office is located in a HPSA, but the provider travels to a non-HPSA to provide services.

**Line 20. Office Outside, Service Outside HPSA** - number of claims where neither the provider's office nor the place of service is located in a HPSA.

**Line 21. Multiple Offices, Service Non-HPSA Office** - number of claims when the physicians with multiple offices (some of which may be in a HPSA, and some of which are not) bill for services provided in their non-HPSA office.

**Line 22. Beneficiary in HPSA, Services Outside HPSA** - number of claims where the provider used the beneficiary's address for HPSA incentive eligibility instead of the place of service.

**Line 23. Provider Codes Prior to Effective Date HPSA** - number of claims where the services were provided before the effective date the area was designated as a HPSA. The effective date providers can begin coding claims for HPSA incentive payments is the first day of the second month following the date CMS is notified by PHS. CMS will transmit the effective date to the carrier/*Part B MAC*. Effective January 1, 2005, the effective date of a HPSA designation will be the date of the HPSA designation letter which will be reflected on the HPSA Web site.

**Line 24. Service Area No Longer HPSA** - number of claims requesting HPSA payment after the area is no longer classified as a HPSA. CMS will transmit the termination date to the carrier/*Part B MAC*.

**Line 25. Non-Physician Practitioner** - number of claims coded for HPSA incentives, but the services were provided by someone other than a physician. An example is a claim submitted with the HPSA modifier, and the service was provided by a nurse practitioner.

**Line 26. Non-Physician Service** - number of claims coded for HPSA incentives which were for services other than physician professional services. Examples of services furnished by a physician, but not subject to the HPSA incentive, are technical components of diagnostic tests, drugs, and separately payable supplies.

**Line 27. Carrier/*Part B MAC* Provided Incorrect Information** - number of claims that were incorrectly coded by the provider for HPSA incentives as a result of incorrect information the carrier/*Part B MAC* provided.

**Line 28. Carrier/*Part B MAC* Published Incorrect Notice** - number of claims where the provider code for HPSA incentives was based on a population group (noncovered) HPSA notice the carrier/*Part B MAC* incorrectly published.

**Line 29. Carrier Keying/Processing Error** - number of claims paid for the HPSA incentives inappropriately due to keying or processing errors made by carrier/*Part B MAC* staff.

**Line 30. Other** - number of claims that do not fit into any of the other categories. Although not routinely required, carriers/*Part B MACs* may be asked to expand on the reason for error on these types of claims.