CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2161	**Date: February 25, 2011**
	Change Request 7060

NOTE: Transmittal 2039, dated August 27, 2010 is being rescinded and replaced by Transmittal 2161, dated February 25, 2011. Change Request (CR) 7060 is being reissued to amend data file names and to cross reference additional provider education included in CR 7115 (Primary Care Incentive Payment Program (PCIP), Section 5501(a) of the Affordable Care Act (ACA), Payments made to Critical Access Hospitals).

SUBJECT: Incentive Payment Program for Primary Care Services, Section 5501(a) of the ACA

I. SUMMARY OF CHANGES: Section 5501(a) of the Patient Protection and Affordable Care Act 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 quarterly basis an amount equal to 10 percent of the payment amount for such services under Part B. This CR will be implemented over two releases January and April 2011.

EFFECTIVE DATE: January 1, 2011 - Analysis and April 4, 2011 - Design
IMPLEMENTATION DATE: This CR will be implemented over two releases – the January 3, 2011 release will implement the claim identification of the incentive and the April 4, 2011 release is for full implementation of the instructions.

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
R	12 / Table of Contents
N	12 / 230 / Primary Care Bonus Incentive Payment Program (PCIP)
N	12 / 230.1 / Definition of Primary Care Practitioners and Primary Care Services
N	12 / 230.2 / Coordination with Other Payments
N	12 / 230.3 / Claims Processing and Payment

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.*

Attachment - Business Requirements

Pub. 100-04	Transmittal: 2161	Date: February 25, 2011	Change Request: 7060

NOTE: Transmittal 2039, dated August 27, 2010 is being rescinded and replaced by Transmittal 2161, dated: February 25, 2011. Change Request (CR) 7060 is being reissued to amend data file names and to cross reference additional provider education included in CR 7115 (Primary Care Incentive Payment Program (PCIP), Section 5501(a) of the Affordable Care Act (ACA), Payments made to Critical Access Hospitals).

SUBJECT: Primary Care Incentive Payment Program (PCIP), Section 5501(a) of the Affordable Care Act (ACA)

Effective Date: **January 1, 2011 - Analysis and April 4, 2011 - Design**

Implementation Date: This CR will be implemented over two releases – the January 3, 2011 release will implement the claim identification of the incentive and the April 4, 2011 release is for full implementation of the instructions.

I. GENERAL INFORMATION

A. Background: Section 5501(a) of the ACA revises Section 1833 of the Social Security Act (the Act) by adding 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: Change Request 7063, the new HPSA Surgical Incentive Payment Program (HSIP) and the new Primary Care Incentive Payment Program (PCIP) will be implemented in conjunction with one another for CY 2011. The actions and costs associated with expanding and revising the indicators and the 'special incentive remittance' shall be attributed to Change Request 7063.

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.

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 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 (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 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 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
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

CPT Codes	Description
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 Part B for such practitioners 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 year. If a claim for a primary care service is submitted by a physician or group practice, the primary care professional service must be reported under a practitioner with a qualifying NPI in order for the service to qualify for the incentive payment.

The PCIP payments will be calculated by the Medicare contractors and made quarterly on behalf of the eligible primary care practitioner for the primary care services furnished by the practitioner in that quarter. The primary care practitioners' professional services are paid under the PFS based on a claim for professional services.

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 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.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement

Number	Requirement	Responsibility is indicated by an "X" in each applicable column)						
		A/B	DME	FI	CAR	RHH	Shared-System Maintainers	Other

		M A C	M A C		R I E R	I	F I S S	M C S	V M S	C W F	
7060.1	CMS shall annually provide contractors with two files. First, a Primary Care Incentive Payment Program Eligibility File will list all qualifying NPIs. Second, a Physician/Practitioner Specialty File will list physician and nonphysician practitioner information by NPI.	X			X			X			CMS
7060.1.1	Contractors shall have access to the Physician/Practitioner Specialty File information through the Multi-carrier System Desktop Tool (MCSDT), and this same information shall be available through MCS for those contractors that do not use the MCSDT.	X			X			X			CMS
7060.1.2	Contractors shall post the information in the Primary Care Incentive Payment Eligibility File to their web site by January 31 of the applicable PCIP payment calendar year. Note: Contractors shall not post the Physician/Practitioner Specialty File to their website. This file is to answer practitioner inquiries only.	X			X						
7060.1.3	Contractors shall download from the CMS mainframe the **TEST** files MU00.@BFN2699.PCIP.PAYMENT.CY2011.NPI60.V2 and MU00.@BFN2699.PCIP.PAYMENT.CY2011.INQUIRY.V2. **NOTE:** The Primary Care Incentive Payment Program Eligibility File (MU00.@BFN2699.PCIP.PAYMENT.CY2011.NPI60.V2) is to be used for incentive payment purposes and the Physician/Practitioner Specialty File (MU00.@BFN2699.PCIP.PAYMENT.CY2011.INQUIRY.V2) is to be used for responding to provider inquiries. **Date of retrieval will be on or around October 4, 2010**	X			X			X			All EDCs (CDS, HP)
7060.1. 4	Contractors/data centers shall retrieve the **FINAL** files MU00.@BFN2699.PCIP.PAYMENT.CY2011.NPI60.V2 and MU00.@BFN2699.PCIP.PAYMENT.CY2011.INQUIRY.V2. from the CMS mainframe telecommunication system. **Date of retrieval will be on or around October 25, 2010**	X			X			X			All EDCs (CDS, HP)

Number	Requirement	Responsibility is indicated by an "X" in each applicable column)									
		A / B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
7060.2	Contractors shall make quarterly primary care incentive payments to qualifying practitioners listed on the Primary Care Incentive Payment Program Eligibility File, as updated each year, for claims with dates of service on or after January 1, 2011 through December 31, 2015.	X			X			X			
7060.2.1	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			X			X			
7060.2.2	Payment of the incentive shall be made to the individual or group following normal claims payment protocol.	X			X			X			
7060.3	For each qualifying NPI on the Primary Care Incentive Payment Program Eligibility File, contractors shall accumulate the total paid amount (or review paid claims history) on a quarterly basis for codes 99201 through 99215, and 99304 though 99350.	X			X			X			
7060.4	Contractors shall calculate a payment equal to 10 percent of the <u>amount paid</u> each calendar quarter (4 payments annually) for CPT codes 99201 through 99215, and 99304 though 99350, billed by the PTANs associated with each qualifying NPI listed on the Primary Care Incentive Payment Program Eligibility File. **NOTE**: The incentive payment is based on the amount paid, and not the Medicare approved amount.	X			X			X			
7060.5	Contractors shall revise the special incentive remittance that is currently used for the HPSA physician bonus payment program to include other incentive payments so that physicians can identify which type of incentive payment (HPSA physician, HSIP, or PCIP) was paid for each incentive program.	X			X			X			
7060.6	Contractors shall pay the primary care incentive payment at the same time and on the same check as the HPSA physician bonus.	X			X						All EDCs (CDS, HP), HIGLASS

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	
7060.7	When this instruction is no longer sensitive/controversial, 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						

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
7063.3 – 7063.4	See CR 7063 for requirement and changes to incentive payment indicators and HIGLAS.
7060.7	See CR 7115 for requirements implementing additional PCIP educational materials

Section B: For all other recommendations and supporting information: See the attached Primary Care Incentive Payment Program Eligibility File Layout.

V. CONTACTS

Pre-Implementation Contact(s):

For payment policy questions please call Stephanie Frilling at (410) 786-4507 (or e-mail her at Stephanie.frilling@cms.hhs.gov) and Gaysha Brooks at (410) 786-9649 (or e-mail her at Gaysha.brooks@cms.hhs.gov).

For claims processing questions please call Kathleen Kersell (410) 786-2033 (or e-mail her at Kathleen.Kersell@cms.hhs.gov).

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),* 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.

ATTACHMENTS:

Attachment A – Primary Care Incentive Payment Eligibility File Record Layout

Attachment B – Primary Care Incentive Physician/Practitioner Specialty File Record Layout

Attachment A: CR 7060

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 carrier/MAC number).
NPI	7-16	X(10)	Left justified. NPI of the provider who will be paid the primary care incentive.
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: CR 7060

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 carrier/MAC number).
NPI	7-16	X(10)	NPI of the provider who will be paid the primary care incentive.
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

Medicare Claims Processing Manual
Chapter 12 - Physicians/Nonphysician Practitioners

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230 - Primary Care Incentive Payment Program (PCIP)

(Rev. 2161, Issued: 02-25-11, Effective: 01-01-11- Analysis/04-04-11-Design, Implementation: 01-03-11-Claim Identification/04-04-11-Full Implementation)

Section 5501(a) of the Affordable Care Act 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, there shall be a 10 percent incentive payment for such services under Part B when furnished by a primary care practitioner.

Information regarding Primary Care Incentive Payment Program (PCIP) payments made to critical access hospitals (CAHs) paid under the optional method can be found in Pub. 100-04, Chapter 4, §250.12 of this manual.

230.1 - Definition of Primary Care Practitioners and Primary Care Services

(Rev. 2161, Issued: 02-25-11, Effective: 01-01-11- Analysis/04-04-11-Design, Implementation: 01-03-11-Claim Identification/04-04-11-Full Implementation)

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 Part B 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 Part B for the practitioner in a prior period as determined appropriate by the Secretary.*

Primary care services are defined as HCPCS 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.*

Practitioner Identification

Eligible practitioners will be identified on claims by the National Provider Identifier (NPI) number of the rendering practitioner. If the claim is submitted by a practitioner's group practice, the rendering practitioner's NPI must be included on the line-item for the primary care service and reflect an eligible HCPCS as identified. 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, the specific nonphysician 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 calendar year (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.

Eligible practitioners for PCIP payments in a given calendar year (CY) will be listed by eligible NPI in the Primary Care Incentive Payment Program Eligibility File, available after January 31, of the payment year on their Medicare contractor's website. Practitioners should contact their contractor with any questions regarding their eligibility for the PCIP.

230.2 - Coordination with Other Payments

(Rev. 2161, Issued: 02-25-11, Effective: 01-01-11- Analysis/04-04-11-Design, Implementation: 01-03-11-Claim Identification/04-04-11-Full Implementation)

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 Act. Therefore, an eligible primary care physician 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 12, §90.4) under the HPSA physician bonus program and a PCIP incentive payment under the new program beginning in CY 2011.

230.3 - Claims Processing and Payment

(Rev. 2161, Issued: 02-25-11, Effective: 01-01-11- Analysis/04-04-11-Design, Implementation: 01-03-11-Claim Identification/04-04-11-Full Implementation)

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) for those services furnished during the bonus payment year. For information on PCIP payments to CAHs paid under the optional method, see the Medicare Claims Processing Manual, Pub. 100-04, Chapter 4, §250.12.

On an annual basis Medicare contractors shall receive a Primary Care Incentive Payment Program Eligibility File that they shall post to their website. The file will list the NPIs of all practitioners who are eligible to receive PCIP payments for the upcoming CY.

B. Method of Payment

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

C. Changes for Contractor Systems

The Medicare Carrier System, (MCS), Common Working File (CWF) and the 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; and
Space = Not Applicable.

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