150 State Street, Suite 301 Albany, New York 12207-1698 Telephone (518) 449-2707 Fax (518) 455-8908 Web www.nyahsa.org

MEMORANDUM

TO: RHCF and Community Services Members

FROM: Patrick Cucinelli, Senior Financial Policy Analyst

DATE: January 13, 2009

SUBJECT: **Medicare Physician Fees and Other Part B Changes for 2009**

ROUTE TO: Administrator, CFO, Medical Director, Billing Director, Therapy Director

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ABSTRACT: CMS releases Medicare Part B fee schedule and other Part B changes for 2009.

Introduction

As mandated by the Balanced Budget Act of 1997 (BBA), skilled nursing facilities (SNFs), home health agencies (HHAs), comprehensive outpatient rehabilitation facilities (CORFs), physicians, and other providers became subject to fee screens on January 1, 1999 for all Medicare Part B services, as determined by the *Medicare Physician Fee Schedule* (MPFS).

On November 19, 2008 the Centers for Medicare and Medicaid Services (CMS) published the final MPFS rule for calendar year (CY) 2009 in the *Federal Register* (volume 73, number 224). There are two attachments to this memo. The first is a summary of the MPFS rates for the most frequently used SNF therapy codes (see Table 1.) for each designated region of the state, and the second contains the corresponding SNF physician evaluation and management (E&M) codes (see Table 2.).

MIPPA

The statutory formula which ties the annual adjustment in Medicare Part B rates to CMS' determination of an economic sustainable growth rate (SGR) continues to be problematic.

Beginning with 2002, the current methodology for calculating the MPFS has called for reductions. In most years, Congress has intervened to override any reductions. For the CY 2007 rates for example, we started the year with a 5.0 percent reduction, and then waited until

January for Congress to pass the *Tax Relief and Health Care Act of 2006*, which ultimately froze the CY 2007 rates at the CY 2006 level. This marked the second year in a row of a rate freeze.

For CY 2008, the SGR-based formula mandated a 10.1 percent reduction in rates. Through the *Medicare, Medicaid, and SCHIP Extension Act of 2007*, Congress acted to override the reduction and implemented a 0.5 percent increase for the first six months of the year. Through this same Act, Congress also implemented a six month extension to the therapy caps exception process.

In July of 2008 Congress voted to approve the *Medicare Improvements for Patients and Providers Act of 2008* (MIPPA). This Act extended the therapy caps exception process through December 31, 2009 (see below) and placed an additional 18-month moratorium on any MPFS rate cuts by providing for an extension of the 0.5 percent rate increase for the remainder of 2008 and a 1.1 percent increase for 2009. Without this Congressional override, 2009 rates would have decreased by 15.1 percent.

With MIPPA mandating a 1.1 percent increase, CMS was able to circumvent the SGR in developing its rate calculation for 2009. Providers should keep in mind that the 1.1 percent is used to calculate an overall average increase in rates and other elements in the calculation may cause some variation from this average.

While MIPPA addressed the issue of a rate reduction for 2009, providers should also keep in mind that each year in which Congress overrides the SGR-based calculation the potential for an even larger negative rate adjustment in future is increased. MIPPA does not change the underlying SGR formula or modify payments beyond 2009. The Congressional Budget Office currently estimates that MPFS rates would have to be cut by 21 percent in 2010 unless Congress takes further action or an alternative to the SGR is implemented.

- **Additional Note on Therapy Caps**

As noted above, MIPPA extends the exceptions process to the therapy caps to December 31, 2009. Outpatient therapy service providers, including SNFs, may continue to submit claims with the KX modifier for therapy services that exceed the cap.

For physical therapy and speech language pathology services combined, the limit on incurred expenses is $1,840 for CY 2009. For occupational therapy services, the limit is $1,840. Deductible and coinsurance amounts applied to therapy services count toward the amount accrued before a cap is reached. Services that meet the exceptions criteria and are reported with the KX modifier are covered beyond this limit.

Details on applying the KX modifier and the therapy caps exception process are available in Medlearn Matters article # SE0637. Details on the most recent changes to CMS therapy policies are available in Medlearn Matters article # MM5921.

Additional Resources

AAHSA offers a worksheet that members can use to calculate selected Part B rates available by clicking here or going to the AAHSA Web site at: www.aahsa.org. The AAHSA template works by inserting the values for the geographic practice cost indices (GPCI) for your region and having the template then calculate the rates for the listed HCPCS codes. The GPCI values are included as part of the worksheet.

CMS has an MPFS Web page available at: http://www.cms.hhs.gov/PhysicianFeeSched/. Providers should check this page for any periodic updates to the MPFS. This page also links to the *Physician Center,* which CMS describes as a one-stop resource web page focused on the informational needs and interests of Medicare Fee-for-Service physicians.

Highlights of 2008 Changes

The November 19, 2008 final rule (referenced above) is an extensive document that covers a wide variety of issues besides the MPFS, including, the following:

- ***Independent Diagnostic Testing Facilities*** - The final rule failed to implement a requirement that organizations providing diagnostic testing services (except for mammograms) must enroll with Medicare as independent diagnostic testing facilities (IDTFs). However, CMS is requiring that entities providing mobile diagnostic testing services enroll in Medicare, comply with IDTF performance standards and bill Medicare directly for their services (although CMS is not requiring *mobile* testing entities to bill directly for the services they furnish when such services are furnished "under arrangement" with hospitals). The final rule also cites a mandate under MIPPA requiring accreditation of entities providing specified advanced testing procedures by January 1, 2012.

- ***PQRI Provisions*** - Under the Physician Quality Reporting Incentive (PQRI) CMS selected a final set of 153 quality measures for reporting in 2009, which is an increase of 35 measures from 2008. The new measures proposed in the rule are either endorsed by the National Quality Forum (NQF), adopted by the AQA Alliance (AQA), or measures currently under consideration by the NQF or the AQA. The PQRI incentive for CY 2009 is two percent of the professional's (the PQRI may include physician extenders and therapists) total Medicare allowed charges for the year. There were several other refinements to the reporting process and an additional two percent incentive for the use of electronic prescribing. Details on PQRI reporting for CY 2009 are available on the CMS Web site at: http://www.cms.hhs.gov/PQRI/15_MeasuresCodes.asp.

- ***Practice Expense Methodology Transition*** - The MPFS final rule for CY 2007 introduced the implementation of a change in the practice expense methodology for physician practices and to ensure continued beneficiary access to services. CMS is implementing this change with a four-year transition to the new relative value units (RVUs) established in last year's final rule. During the current transition period the RVUs will be based upon a blend of the current and new methodology, starting with 25 percent new methodology in 2007, 50 percent in 2008, 75 percent in 2009, and 100 percent in 2010 and thereafter. A budget neutrality factor is being applied to ensure that MPFS rates do not vary by more than $20 million from what they would have been if the adjustments were not made.

- ***Part B Drug ASP Methodology*** - CMS is still codifying changes to the Part B drug average sales price payment methodology resulting from the *Medicare, Medicaid, and SCHIP Extension Act of 2007*. CMS had proposed several changes to the competitive acquisition program (CAP), which offers physicians the option to acquire certain injectable and infused Part B drugs from an approved CAP vendor rather than buying and billing the drugs directly. On September 10, 2008, CMS announced it was postponing the

2009 CAP indefinitely. In light of this postponement, CMS is not adopting changes in the CAP at this time, but the agency continues to solicit public feedback on a range of CAP issues.

- ***Physician Enrollment and Reporting*** - The final rule implements a series of enrollment and documentation changes. The rule reduces the retroactive billing period for newly enrolled physicians and physician extenders from 27 months to 30 days. In addition, the rule requires physicians and other practitioners to report to their carrier any changes of ownership, adverse legal actions, or change in practice location within 30 days (instead of the current 90 days) or face revocation of Medicare billing privileges and the recoupment of Medicare payments from the date of the reportable change. CMS provides an enrollment FAQ Web resource at: http://www.cms.hhs.gov/MedicareProviderSupEnroll. CMS also maintains a reporting responsibilities Web page for physicians and physician extenders at: http://www.cms.hhs.gov/MedicareProviderSupEnroll.

- ***Record Retention Requirements*** - The final rule amends record retention requirements for providers and suppliers to maintain ordering and referring documentation (including the referring physician's National Provider Identifier) for 7 years (rather than the proposed 10 years) years from the date of service, and it requires physicians and non-physician practitioners to maintain written ordering and referring documentation for 7 years (rather than 10 years) from the date of service.

- ***In-Home Oxygen*** - The final rule details that as of January 1, 2009 new provisions for the coverage of in-home oxygen and related supplies and service will take effect. For the first 36 months of coverage, the basic provisions remain unchanged. Under a new law, however, the agency providing service as of the 36th month remains responsible for continuing to provide all necessary oxygen, supplies and maintenance for an extended 24-month period. CMS states that payments for the first 36 months incorporate payment to cover the cost of the extended two-year service period, except for the cost of oxygen tank refills. Additional details on the change are available at: http://www.medicare.gov/Publications/pubs/pdf/11405.pdf.

- ***HPSA*** - Under current provisions of the Health Professionals Shortage Area (HPSA), Medicare provides for an additional 10-percent bonus payment for physicians' services furnished in a year to a covered individual in an area that is designated as a geographic HPSA by the Secretary prior to the beginning of such year. The final rule provides additional clarification that physicians who furnish services in areas that are designated as geographic HPSAs as of December 31st of the prior year but not included on the list of zip codes for automated HPSA bonus payments should use the "AQ" modifier to receive the HPSA bonus payment.

- ***Speech-Language Pathology*** - In the rule, CMS implements a provision in the MIPPA legislation that allows speech-language pathologists (SLP) to enroll and begin billing Medicare for outpatient SLP services furnished in private practice, beginning July 1, 2009. The SLP private practice benefit is modeled after the physical therapist private practice benefit under Medicare regulations.

Telehealth Issues

Additions or deletions to the list of Medicare telehealth services are effective on a calendar year basis. Changes to the list of Medicare telehealth services are made using the annual physician fee

schedule proposed rule published in the summer and the final rule published by November 1st each year (see http://www.cms.hhs.gov/Telehealth/01_Overview.asp#TopOfPage).

CMS has added HCPCS codes specific to follow-up inpatient consultation delivered via telehealth and clarified that the criteria for these services will be consistent with Medicare policy for consultation services. For 2009, Medicare contractors will pay for the Medicare telehealth originating site facility fee as described by Healthcare Common Procedure Coding System (HCPCS) code Q3014 at 80 percent of the lesser of the actual charge or $23.72. The beneficiary is responsible for any unmet deductible amount or coinsurance.

Currently, telehealth may substitute for a face-to-face, “hands on” encounter for professional consultations, office visits, office psychiatry services, and a limited number of other PFS services that CMS has determined to be appropriate for telehealth. Medicare will make a fixed payment to the originating site as well as a PFS payment to the physician. The originating site must be located in a non-metropolitan statistical area (non-MSA) county or rural HPSA. To date, originating sites have been limited to: the office of a physician or practitioner; a hospital; a critical access hospital (CAH); a rural health clinic; and a federally qualified health center. The MIPPA recognizes the following additional originating sites, effective for services furnished on or after January 1, 2009: a hospital-based or CAH-based renal dialysis center (including satellites); a SNF; and a community mental health center.

For additional changes please refer to MM 6349 at:
http://www.cms.hhs.gov/mlnmattersarticles/downloads/MM6349.pdf

Comprehensive Outpatient Rehabilitation Facilities

For CORFs, the final rule includes provisions that reference personnel qualifications for physical therapy (PT), occupational therapy (OT), and SLP and clarifies that alternate premises for the provision of PT, OT, and SLP services may be the patient’s home.

The final rule updates the CORF personnel requirements for individuals furnishing respiratory therapy to be consistent with current respiratory therapy professional standards. Specifically, only individuals with the Registered Respiratory Therapist designation can furnish respiratory therapy in a CORF. Individuals with a “certified respiratory therapist” designation do not meet the CORF personnel standards.

In addition, the rule has clarified that CPT Codes 96150 through 96154 and 90801 through 90899 are not appropriate for CORF use. The new G code describes 15 minutes of face-to-face individual time with a social worker or psychologist. This provision follows up on the 2008 final MPFS rule in which CMS clarified that social work or psychological services furnished by CORFs must directly relate to or further the rehabilitation goals established in the therapy plan of care.

CMS has created a new G code for social work and psychological services provided in CORFs. The CORF specific G-code is “G0409 - social work and psychological services.” This code must reflect services directly related to the patient’s rehabilitation goals and is billed in 15 minute intervals for face-to-face, individual encounters.

Rate Calculation

To calculate the payment for every physician service, the components of the fee schedule (physician work, practice expense (PE), and malpractice insurance (MP) RVUs) are adjusted by a geographic practice cost index (GPCI). The GPCIs reflect the relative costs of physician work, PE, and MP in an area compared to the national average costs for each component. Payments are converted to dollar amounts through the application of a Conversion Factor (CF), which is calculated by the Office of the Actuary and is updated annually for inflation. The formula for calculating the Medicare fee schedule amount for a given service and fee schedule area can be expressed as:

*[Work RVU * Budget Neutrality Adjustor (0.8806)) (round product to two decimal places) * Work GPCI + (Transitioned Non-Facility PE RVU * PE GPCI + (MP RVU * MP GPCI] * CF*

Please note that the 1.0 percent floor imposed on the GPCI for 2006 and 2007 expired as of January 1, 2008.

As noted above, the MPFS final rule update for CY 2009 is 1.1 percent (instead of a projected 15.1% cut which would have occurred if Congress had not enacted MIPPA).

- **Note on Conversion Factor**

The CF for 2009 is $36.0666, approximately two dollars less than the 2008 conversion factor of $37.8975. The 2009 CF includes the 5-year review budget neutrality adjustment which had previously been taken out of work RVUs only. By law, if changes to RVUs would result in an increase in total Medicare payments under the fee schedule of more than $20 million, CMS must implement budget neutrality provisions. Previously, CMS had accomplished this through a reduction to work RVUs. However, MIPPA now requires CMS to apply the budget neutrality adjustment to the CF rather than work RVUs. The CY 2009 CF Budget Neutrality Adjustment factor is 0.08 percent. The 5-year Review Budget Neutrality Adjustment is -6.41 percent (0.9359).

As a result, the almost 12 percent reduction in work RVUs that was effective in 2008 is eliminated. Instead, it is replaced by a decrease in the overall CF of about 5 percent. Codes that have higher than average work RVUs will benefit from this change. Work RVUs comprise, on average, 55 percent of total RVUs. Codes for which work RVUs are less than 55 percent of total RVUs will be affected negatively.

- **Additional Factors**

The estimated SGR for CY 2009 is 7.4 percent and the Medicare Economic Index (MEI) is 1.6 percent. The MEI measures the weighted average annual price change for various inputs needed to produce MPFS services.

Coding Resources

Members are reminded that CMS and AMA implement annual updates to both the ICD-9-CM diagnosis codes and HCPCS (Level II) procedure codes on an annual basis. The HCPCS procedure codes are updated effective January 1st of each year. The ICD-9-CM diagnosis codes are updated effective October 1st of each year.

The current diagnosis code updates are posted by CMS at: http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/01_overview.asp#TopOfPage. Details on current changes to transactions and code sets are available at: http://www.cms.hhs.gov/TransactionCodeSetsStands/01_Overview.asp#TopOfPage. Although not currently valid for coding, a revised version of the ICD-10 has just been posted by CMS at: http://www.cms.hhs.gov/ICD10/02_ICD-10-PCS.asp#TopOfPage. The general CMS Web page resource on coding is found at: http://www.cms.hhs.gov/MedHCPCSGenInfo/. Refer to http://www.cms.hhs.gov/HCPCSReleaseCodeSets/ANHCPCS/list.asp#TopOfPage for a complete CMS reference on the 2009 HCPCS. The AMA also maintains the latest information on Common Procedural Terminology (CPT) codes at: http://www.ama-assn.org/ama/pub/category/3113.html.

NYAHSA reminds members that there is no longer a 90-day grace period for either the ICD-9-CM or HCPCS code updates. Providers must begin using the updated codes as of the date they become effective, or risk a claim rejection.

Fee Screen Amounts and Localities

For your convenience, NYAHSA has extracted the updated fee screen amounts for selected therapy **(Table 1: *2009 MPFS Rates*)** and E&M **(Table 2*: 2009 E&M Rates*)** services in New York State by locality and HCPCS code.

This in not meant to be a comprehensive listing of all billable codes and there may be additional codes for which a provider may be reimbursed. These rates may or may not be in effect for all of CY 2008. NYAHSA cautions that there are often some errors in the first run of the fee screen amounts and that CMS will likely publish corrections in its quarterly updates. The attached lists of fee screen amounts are divided into five sections, representing different localities in New York State. The corresponding counties for each payment locality are listed below.

Payment Locality:	**Counties:**
Manhattan	New York
NYC Suburbs/Long Island	Bronx, Brooklyn, Kings, Nassau, Richmond, Rockland, Staten Island, Suffolk, Westchester
Poughkeepsie/NYC Suburbs	Columbia, Delaware, Dutchess, Greene, Orange, Putnam, Sullivan, Ulster
Queens	Queens
Rest of State	All Other Counties

For additional questions, please contact me at pcucinelli@nyahsa.org or 518-449-2707 ext. 145.

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Attachments

ATTACHMENT

Table 1. 2009 MPFS Rates **Page 1 of 3** **NYAHSA 01/09**

CPT/ HCPCS Codes	Description	Manhattan	NYC Suburbs/ Long Island	NYC Suburbs/ Poughkeepsie	Queens	Rest of State
0029T	Magnetic treatment for incontinence (carrier covered/priced)	$0.00	$0.00	$0.00	$0.00	$0.00
29065	Application of long arm cast *	$99.24	$99.63	$86.37	$96.63	$76.53
29075	Application of forearm cast *	$92.33	$92.63	$80.18	$89.79	$70.95
29085	Apply hand/wrist cast *	$97.94	$98.26	$85.30	$95.29	$75.71
29086	Apply finger casr *	$75.03	$74.97	$65.15	$72.63	$57.98
29105	Application of long arm splint *	$90.19	$90.39	$78.88	$87.71	$70.42
29125	Application of forearm splint *	$70.60	$70.58	$61.33	$68.39	$54.57
29126	Application of forearm splint *	$80.32	$80.19	$70.24	$77.77	$63.06
29130	Application of finger splint *	$41.97	$42.08	$37.16	$40.91	$33.57
29131	Application of finger splint *	$52.16	$51.94	$45.86	$50.39	$41.56
29200	Strapping of chest	$55.43	$55.24	$49.04	$53.66	$44.65
29220	Strapping of low back	$57.38	$57.19	$50.62	$55.52	$45.95
29240	Strapping of shoulder	$62.20	$62.13	$54.94	$60.35	$49.78
29260	Strapping of elbow or wrist	$54.29	$54.22	$47.62	$52.61	$42.86
29280	Strapping of hand or finger	$52.50	$52.28	$45.95	$50.69	$41.44
29345	Application of long leg cast *	$141.58	$142.33	$123.96	$138.19	$110.31
29355	Application of long leg cast *	$145.90	$146.75	$128.14	$142.57	$114.31
29365	Application of long leg cast *	$127.47	$128.02	$111.23	$124.22	$98.77
29405	Apply short leg cast *	$93.81	$94.16	$81.83	$91.35	$72.69
29425	Apply short leg cast *	$100.87	$101.22	$88.39	$98.26	$78.92
29445	Apply rigid leg cast *	$153.51	$154.35	$135.64	$150.08	$121.82
29505	Application long leg splint *	$79.95	$79.93	$69.56	$77.46	$61.99
29515	Application lower leg splint *	$74.36	$74.45	$65.10	$72.24	$58.27
29520	Strapping of hip	$52.71	$52.49	$46.27	$50.91	$41.86
29530	Strapping of knee	$55.06	$54.98	$48.35	$53.36	$43.58
29540	Strapping of ankle	$45.16	$45.25	$39.85	$43.97	$35.92
29550	Strapping of toes	$44.10	$44.20	$38.78	$42.92	$34.81
29580	Application of paste boot	$55.96	$56.04	$48.99	$54.39	$43.83
29590	Application of foot splint	$58.66	$58.85	$52.22	$57.27	$47.39
64550	Apply neurostimulator	$17.10	$17.03	$15.04	$16.52	$13.62
90901	Biofeedback, any method	$39.87	$39.68	$35.01	$38.48	$31.70
90911	Biofeedback peri/uro/rectal	$103.28	$102.89	$89.87	$99.67	$80.52
92506	Speech and hearing evaluation	$183.43	$182.24	$156.25	$175.88	$137.44
92507	Speech/hearing therapy	$74.99	$74.53	$64.67	$72.07	$57.59
92508	Speech/hearing therapy	$35.62	$35.41	$30.78	$34.25	$27.47
92526	Oral function therapy	$96.74	$96.12	$82.86	$92.85	$73.29
92601	Cochlear implant f/up exam <7@	$176.95	$175.84	$157.66	$170.91	$145.15
92602	Reprogram cochlear implent <7@	$111.89	$111.44	$98.95	$108.22	$90.15
92603	Cochlear implant f/up exam 7>@	$157.71	$156.75	$141.46	$152.52	$131.05
92604	Reprogram cochlear implent 7>@	$94.52	$94.20	$84.30	$91.61	$77.38
92607	Exam for speech device rx, 1 hr.	$194.70	$193.77	$161.52	$186.31	$137.62
92608	Exam for speech device rx, additional	$37.40	$37.56	$31.00	$36.16	$26.01
92609	Use of speech device service	$103.51	$103.13	$85.87	$99.18	$73.03
92610	Evaluate swallowing function	$100.29	$100.26	$83.17	$96.47	$70.32
92611	Motion fluoroscopy/swallow	$109.18	$109.10	$90.55	$104.96	$76.63
92612	Endoscopy swallow test (fees)	$185.49	$184.28	$159.89	$178.17	$142.42

Table 1. 2009 MPFS Rates **Page 2 of 3** **NYAHSA 01/09**

CPT/ HCPCS Codes	Description	Manhattan	NYC Suburbs/ Long Island	NYC Suburbs/ Poughkeepsie	Queens	Rest of State
92614	Laryngoscopic sense test	$163.95	$162.89	$142.02	$157.62	$127.14
92616	Fees with laryngeal sense test	$224.14	$222.70	$194.83	$215.61	$175.02
95831	Limb muscle testing, manual	$30.30	$30.12	$26.46	$29.18	$23.87
95832	Hand muscle testing, manual	$28.24	$28.16	$24.79	$27.31	$22.39
95833	Body muscle testing, manual	$41.24	$41.02	$36.43	$39.82	$33.20
95834	Body muscle testing, manual	$48.46	$48.25	$43.03	$46.89	$39.37
95851	Range of motion measurements	$19.61	$19.53	$17.02	$18.91	$15.22
95852	Range of motion measurements	$15.35	$15.31	$13.25	$14.81	$11.76
96000	Motion analysis, video/3d	$96.02	$95.91	$88.12	$93.73	$82.88
96001	Motion test w/ft press measure	$113.30	$112.92	$104.12	$110.34	$98.34
96002	Dynamic surface emg	$22.55	$22.48	$20.64	$21.95	$19.41
96003	Dynamic fine wire emg	$19.61	$19.57	$18.01	$19.12	$16.97
96105	Assessment of aphasia	$93.63	$94.49	$77.59	$91.04	$64.54
96110	Developmental test, limited (carrier-priced)	$14.98	$16.39	$12.33	$15.96	$8.74
96111	Developmental test, extended	$145.19	$145.16	$132.66	$141.78	$124.10
96115	Nuerobehavior status exam					
97001	Physical therapy evaluation	$80.17	$79.79	$72.17	$77.70	$66.97
97002	Physical therapy re-evaluation	$43.42	$43.16	$38.85	$41.98	$35.90
97003	Occupational therapy evaluation	$85.69	$85.35	$76.74	$83.05	$70.77
97004	Occupational therapy re-evaluation	$50.44	$50.13	$44.68	$48.68	$40.88
97012	Mechanical traction therapy	$16.51	$16.43	$14.88	$16.00	$13.82
97016	Vasopneumatic device therapy	$18.04	$17.96	$15.81	$17.42	$14.29
97018	Paraffin bath therapy	$9.69	$9.69	$8.32	$9.38	$7.30
97020	Microwave therapy					
97022	Whirlpool therapy	$20.93	$20.84	$18.17	$20.17	$16.25
97024	Diathermy treatment	$6.41	$6.44	$5.60	$6.25	$4.97
97026	Infrared therapy	$5.94	$5.97	$5.21	$5.80	$4.64
97028	Ultraviolet therapy	$7.18	$7.20	$6.33	$6.99	$5.70
97032	Electrical stimulation	$18.85	$18.75	$16.82	$18.24	$15.48
97033	Electrical current therapy	$29.07	$28.90	$25.34	$27.99	$22.82
97034	Contrast bath therapy	$17.32	$17.24	$15.36	$16.75	$14.04
97035	Ultrasound therapy	$13.10	$13.05	$11.86	$12.73	$11.05
97036	Hydrotherapy	$30.30	$30.12	$26.46	$29.18	$23.87
97039	Physical therapy treatment					
97110	Therapeutic exercises	$32.51	$32.36	$29.09	$31.48	$26.83
97112	Neuromuscular re-education	$33.55	$33.31	$29.96	$32.38	$27.68
97113	Aquatic therapy/exercises	$40.66	$40.37	$35.81	$39.16	$32.63
97116	Gait training therapy	$28.35	$28.16	$25.41	$27.39	$23.55
97124	Massage therapy	$25.97	$25.80	$23.20	$25.09	$21.41
97139	Physical medicine procedure					
97140	Manual therapy	$29.97	$29.76	$26.90	$28.96	$24.96
97150	Group therapeutic procedures	$20.56	$20.44	$18.33	$19.87	$16.87
97504	Orthotic training (not with 97116)					
97520	Prosthetic training					
97530	Therapeutic activities	$34.57	$34.33	$30.76	$33.35	$28.31
97532	Cognitive skills development	$27.55	$27.35	$24.93	$26.65	$23.33

Table 1. 2009 MPFS Rates Page 3 of 3 NYAHSA 01/09

CPT/ HCPCS Codes	Description	Manhattan	NYC Suburbs/ Long Island	NYC Suburbs/ Poughkeepsie	Queens	Rest of State
97533	Sensory integration	$29.89	$29.68	$26.88	$28.88	$24.99
97535	Self care management training	$34.49	$34.24	$30.74	$33.28	$28.34
97537	Community/work reintegration	$30.74	$30.52	$27.63	$29.70	$25.68
97542	Wheelchair management training	$31.21	$30.99	$28.02	$30.15	$26.02
97601	Wound(s) care, selective *					
97703	Prosthetic checkout					
97750	Physical performance test	$33.45	$33.29	$29.87	$32.38	$27.50
97799	Physical medicine procedure (carrier priced)					
V5299	Hearing Service					
G0279	Excorp shock treatment, elbow epi (carrier covered/priced)					
G0280	Excorp shock treatment, other than (carrier covered/priced)					
G0281	Electric stimulation for press	$13.36	$13.31	$11.93	$12.95	$10.96
G0283	Electric stimulation other than wound	$13.36	$13.31	$11.93	$12.95	$10.96

* Codes for splints and casts will not apply to therapy cap when billed by physician and non-physician practitioner

@ Codes for audiology procedures will not apply to therapy cap when billed by an audiologist

Table 2. 2009 MPFS E and M Rates NYAHSA 01/09

E and M Codes	Manhattan	NYC Suburbs/ Long Island	NYC Suburbs/ Poughkeepsie	Queens	Rest of State
99304	$89.82	$89.29	$82.11	$87.15	$77.44
99305	$124.99	$124.24	$114.55	$121.31	$108.27
99306	$160.07	$159.10	$146.95	$155.39	$139.14
99307	$44.77	$44.56	$40.73	$43.46	$38.17
99308	$68.44	$68.07	$62.25	$66.39	$58.39
99309	$90.69	$90.25	$82.55	$88.04	$77.42
99310	$133.36	$132.62	$121.72	$129.42	$114.55
99315	$65.32	$65.05	$59.51	$63.47	$55.81
99316	$85.03	$84.64	$77.61	$82.60	$72.96
99318	$93.66	$93.08	$85.77	$90.87	$81.04