CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 833	**Date: January 7, 2011**
	Change Request 7300

Transmittal 833, dated January 7, 2011 rescinds and replaces Transmittal 828 dated December 29, 2010, to correct the Implementation Date on the Transmittal Sheet to agree with that shown on the One-Time Notification Attachment. All other material remains the same.

SUBJECT: Emergency Update to the CY 2011 Medicare Physician Fee Schedule (MPFS) Database

I. SUMMARY OF CHANGES: Payment files were issued to contractors based on the CY 2011 Medicare Physician Fee Schedule (MPFS) Final Rule. This change request (CR) amends those payment files.
This CR also reinstates three Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) HCPCS L-codes, as described within.

EFFECTIVE DATE: **January 1, 2011**

IMPLEMENTATION DATE: **No later than January 14, 2011 for contractors, January 3, 2011 for CWF**

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/A	

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:

One-Time Notification

**Unless otherwise specified, the effective date is the date of service.*

Attachment – One-Time Notification

Pub. 100-20	Transmittal: 833	Date: January 7, 2011	Change Request: 7300

Transmittal 833, dated January 7, 2011 rescinds and replaces Transmittal 828 dated December 29, 2010, to correct the Implementation Date on the Transmittal Sheet to agree with that shown on the One-Time Notification Attachment. All other material remains the same.

SUBJECT: Emergency Update to the CY 2011 Medicare Physician Fee Schedule (MPFS) Database

Effective Date: **January 1, 2011**

Implementation Date: **No later than January 14, 2011 for contractors**
January 3, 2011 for CWF

I. GENERAL INFORMATION

A. Background: Payment files were issued to contractors based upon the CY 2011 Medicare Physician Fee Schedule (MPFS) Final Rule, issued on November 2, 2010, and published in the *Federal Register* on November 29, 2010. This change request amends those payment files to include MPFS policy and payment indicator revisions described in the CY 2011 MPFS Final Rule Correction Notice, as well as relevant statutory changes applicable January 1, 2011. Therefore, new MPFS payment files have been created and are available.

This Change Request (CR) also reinstates three Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) HCPCS L-codes, as described below.

B. Policy:

Medicare Physician Fee Schedule Revisions and Updates

Some physician work, practice expense (PE) and malpractice (MP) Relative Value Units (RVUs) published in the CY 2011 MPFS Final Rule have been revised to align their values with the CY 2011 MPFS Final Rule policies. These changes are discussed in the CY 2011 MPFS Final Rule Correction Notice and revised RVU values will be found in Addendum B and Addendum C of the CY 2011 MPFS Final Rule Correction Notice. In addition to RVU revisions, changes have been made to some HCPCS code payment indicators in order to reflect the appropriate payment policy. Procedure status indicator changes will also be reflected in Addendum B and Addendum C of the CY 2011 MPFS Final Rule Correction Notice. Other payment indicator changes will be included, along with the RVU and procedure status indicator changes, in the CY 2011 MPFS Final Rule Correction Notice public use data files which will be located at: http://www.cms.gov/PhysicianFeeSched/PFSRVF/list.asp#TopOfPage. Changes to the physician work RVUs and payment indicators can be found in the attachment to this CR.

Due to these revisions, the conversion factor (CF) associated with the CY 2011 MPFS Final Rule has been revised. This CF will be published in the CY 2011 MPFS Final Rule Correction Notice.

Legislative changes subsequent to issuance of the CY 2011 MPFS Final Rule have led to the further revision of the values published in the CY 2011 MPFS Final Rule Correction Notice, including a change to the conversion factor. As such, the MPFS database (MPFSDB) has been revised to include MPFS policy and payment indicator revisions described above, as well as relevant statutory changes applicable January 1, 2011. A new MPFSDB reflecting payment policy as of January 1, 2011, has been created and made available. The CY 2011 MPFS payment file names are as follows:

MU00.@BF12390.MPFS.CY11.RV1.C00000.V1231
MU00.@BF12390.MPFS.CY11.PURDIAG.V1231
MU00.@BF12390.MPFS.CY11.ANES.V1223
MU00.@BF12390.MPFS.CY11.RV1.ABSTR.V1231.FI
MU00.@BF12390.MPFS.CY11.RV1.ALL.V1231.RHHI
MU00.@BF12390.MPFS.CY11.RV1.MAMMO.V1231.FI
MU00.@BF12390.MPFS.CY11.RV1.PAYIND.V1231
MU00.@BF12390.MPFS.CY11.RV1.SNF.V1231.FI
MU00.@BF12390.MPFS.CY11.RV1.SUPL.V1231.FI

A summary of the recent statutory provisions included in the revised MPFS payment files is provided below.

Physician Payment and Therapy Relief Act of 2010

On November 30, 2010, President Obama signed into law the Physician Payment and Therapy Relief Act of 2010. As a result of the Physician Payment and Therapy Relief Act of 2010 a new reduced therapy fee schedule amount (20 percent reduction on the PE component of payment) will be added to the MPFS payment file. Per this Act, CMS will apply the CY 2011 MPFS Final Rule policy of a 25 percent multiple procedure payment reduction (MPPR) on the PE component of payment for therapy services furnished in the hospital outpatient department and other facility settings that are paid under section 1834(k) of the Social Security Act, and a 20 percent therapy MPPR will apply to therapy services furnished in clinicians' offices and other settings that are paid under section 1848 of the Act. This change is detailed in recently released CR 7050, Transmittal 800. This Act also made the therapy MPPR not budget neutral under the PFS and, therefore, the redistribution to the PE RVUs for other services that would otherwise have occurred will not take place. The revised RVUs, in accordance with this new statutory requirement, are included in the revised CY 2011 MPFS payment files.

Medicare and Medicaid Extenders Act of 2011

On December 15, 2010, President Obama signed into law the Medicare and Medicaid Extenders Act of 2010 (MMEA). This new legislation contains a number of Medicare provisions which change or extend current Medicare fee-for-service program policies. A summary of MPFS-related provisions follows.

Physician Payment Update

Section 101 of the MMEA averts the negative update that would otherwise have taken effect on January 1, 2011, in accordance with the CY 2011 MPFS Final Rule. The MMEA provides for a zero percent update to the physician fee schedule for claims with dates of service January 1, 2011, through December 31, 2011. While the physician fee schedule update will be zero percent, other changes to the RVUs (e.g., misvalued code initiative and rescaling of the RVUs to match the revised Medicare Economic Index weights) are budget neutral. To make those changes budget neutral, CMS must make an adjustment to the conversion factor so the conversion factor will not be unchanged in CY 2011 from CY 2010. The revised conversion factor to be used for physician payment as of January 1, 2011 is $33.9764. The calculation of the CY 2011 conversion factor is illustrated in the following table.

December 2010 Conversion Factor		**$36.8729**
MMEA "Zero Percent Update"	**0.0 percent (1.000)**	
CY 2011 RVU Budget Neutrality Adjustment	**0.4 percent (1.0043)**	
CY 2011 Rescaling to Match MEI Weights Budget Neutrality Adjustment	**-8.3 percent (0.9175)**	
CY 2011 Conversion Factor		**$33.9764**

The revised CY 2011 MPFS payment files will reflect this conversion factor.

Extension of Medicare Physician Work Geographic Adjustment Floor
Current law requires the payment rates under the MPFS to be adjusted geographically for three factors to reflect differences in the cost of provider resources needed to furnish MPFS services: physician work, practice expense, and malpractice expense. Section 3102 of the Affordable Care Act extended the 1.0 floor on the physician work geographic practice cost index (GPCI) for services furnished though December 31, 2010. Section 103 of the MMEA extends the existing 1.0 floor on the physician work GPCI for services furnished through December 31, 2011. This change will be included in the revised CY 2011 MPFS payment files. Updated CY 2011 GPCIs can also be found in the attachment to this CR.

Extension of MPFS Mental Health Add-On
Section 138 of the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 increased the Medicare payment amount for specific "Psychiatry" services by 5 percent, effective for dates of service July 1, 2008 through December 31, 2009. Section 3107 of the Affordable Care Act extended this provision retroactive to January 1, 2010, through December 31, 2010. Section 107 of the MMEA extends the five percent increase in payments for these mental health services, through December 31, 2011. This five percent increase will be reflected in the revised CY 2011 MPFS payment files. A list of Psychiatry CPT codes that represent the specified services subject to this payment policy can also be found in the attachment to this CR.

Extension of Exceptions Process for Medicare Therapy Caps
Under the Temporary Extension Act of 2010, the outpatient therapy caps exception process expired for therapy services on April 1, 2010. Section 3103 of the Affordable Care Act continued the exceptions process through December 31, 2010. Section 104 of the MMEA extends the exceptions process for outpatient therapy caps through December 31, 2011. Outpatient therapy service providers may continue to submit claims with the KX modifier, when an exception is appropriate, for services furnished on or after January 1, 2011, through December 31, 2011.

The therapy caps are determined on a calendar year basis, so all patients begin a new cap year on January 1, 2011. For physical therapy and speech language pathology services combined, the limit on incurred expenses is $1,870. For occupational therapy services, the limit is $1,870. Deductible and coinsurance amounts applied to therapy services count toward the amount accrued before a cap is reached.

Extension of Moratorium That Allowed Independent Laboratories to Bill for the Technical Component (TC) of Physician Pathology Services Furnished to Hospital Patients
Under previous law, a statutory moratorium allowed independent laboratories to bill a carrier or a Medicare Administrative Contractor (MAC) for the technical component (TC) of physician pathology services furnished to hospital patients. This moratorium expired on December 31, 2009. Section 3104 of the Affordable Care Act extended the payment to independent laboratories for the technical component of certain physician pathology services furnished to hospital patients retroactive to January

1, 2010, through December 31, 2010. The MMEA restores the moratorium through CY 2011. Therefore, independent laboratories may continue to submit claims to Medicare for the TC of physician pathology services furnished to patients of a hospital, regardless of the beneficiary's hospitalization status (inpatient or outpatient) on the date that the service was performed. This policy is effective for claims with dates of service on or after January 1, 2011 through December 31, 2011.

Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Updates

The following HCPCS codes will not be discontinued as of December 31, 2010:

L3660 SHOULDER ORTHOSIS, FIGURE OF EIGHT DESIGN ABDUCTION RESTRAINER, CANVAS AND WEBBING, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT
SD: Abduct restrainer canvas&web

L3670 SHOULDER ORTHOSIS, ACROMIO/CLAVICULAR (CANVAS AND WEBBING TYPE), PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT
SD: Acromio/clavicular canvas&we

L3675 SHOULDER ORTHOSIS, VEST TYPE ABDUCTION RESTRAINER, CANVAS WEBBING TYPE OR EQUAL, PREFABRICATED INCLUDES FITTING AND ADJUSTMENT
SD: Canvas vest SO

These three "L" codes will continue to stay active codes for January 1, 2011. Instruction for billing and payment will remain the same for these three "L" codes. Contractors shall make payment for codes L3660, L3670, and L3675 with dates of service on or after January 1, 2011, using the following 2011 DMEPOS fee schedule amounts:

	JURIS	CATG	L3660	L3670	L3675
AL	D	PO	$85.06	$118.57	$145.25
AR	D	PO	$85.06	$97.17	$145.24
AZ	D	PO	$100.69	$124.79	$141.00
CA	D	PO	$100.69	$124.79	$141.00
CO	D	PO	$111.02	$93.60	$146.04
CT	D	PO	$113.42	$93.60	$141.00
DC	D	PO	$85.06	$112.42	$141.00
DE	D	PO	$85.06	$112.42	$141.00
FL	D	PO	$85.06	$118.57	$145.25
GA	D	PO	$85.06	$118.57	$145.25
IA	D	PO	$106.53	$124.79	$143.74
ID	D	PO	$85.06	$97.28	$141.00
IL	D	PO	$85.06	$93.60	$144.48
IN	D	PO	$85.06	$93.60	$144.48
KS	D	PO	$106.53	$124.79	$143.74
KY	D	PO	$85.06	$118.57	$145.25
LA	D	PO	$85.06	$97.17	$145.24
MA	D	PO	$113.42	$93.60	$141.00
MD	D	PO	$85.06	$112.42	$141.00
ME	D	PO	$113.42	$93.60	$141.00
MI	D	PO	$85.06	$93.60	$144.48
MN	D	PO	$85.06	$93.60	$144.48
MO	D	PO	$106.53	$124.79	$143.74
MS	D	PO	$85.06	$118.57	$145.25
MT	D	PO	$111.02	$93.60	$146.04
NC	D	PO	$85.06	$118.57	$145.25

ND	D	PO	$111.02	$93.60	$146.04
NE	D	PO	$106.53	$124.79	$143.74
NH	D	PO	$113.42	$93.60	$141.00
NJ	D	PO	$87.06	$110.96	$141.00
NM	D	PO	$85.06	$97.17	$145.24
NV	D	PO	$100.69	$124.79	$141.00
NY	D	PO	$87.06	$110.96	$141.00
OH	D	PO	$85.06	$93.60	$144.48
OK	D	PO	$85.06	$97.17	$145.24
OR	D	PO	$85.06	$97.28	$141.00
PA	D	PO	$85.06	$112.42	$141.00
RI	D	PO	$113.42	$93.60	$141.00
SC	D	PO	$85.06	$118.57	$145.25
SD	D	PO	$111.02	$93.60	$146.04
TN	D	PO	$85.06	$118.57	$145.25
TX	D	PO	$85.06	$97.17	$145.24
UT	D	PO	$111.02	$93.60	$146.04
VA	D	PO	$85.06	$112.42	$141.00
VT	D	PO	$113.42	$93.60	$141.00
WA	D	PO	$85.06	$97.28	$141.00
WI	D	PO	$85.06	$93.60	$144.48
WV	D	PO	$85.06	$112.42	$141.00
WY	D	PO	$111.02	$93.60	$146.04
AK	D	PO	$100.22	$148.35	$141.00
HI	D	PO	$107.12	$158.62	$141.00
PR	D	PO	$82.83	$105.08	$169.21
VI	D	PO	$87.06	$110.96	$169.21

In accordance with the statutory section 1834(a)(14) of the Act, the above fee schedule amounts were updated for CY 2011 by applying the CY 2011 -0.1 percent update factor to the CY 2010 fee schedule amounts. The CY 2011 payment amounts for codes L3660, L3670, and L3675 will be posted as a public use file on the following CMS Web site: http://www.cms.gov/DMEPOSFeeSched/LSDMEPOSFEE/list.asp

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	
7300.1	Contractors shall retrieve the revised payment files, as identified above, from the CMS Mainframe Telecommunications System. Notification will be sent when files are available for retrieval.	X		X	X	X					

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	
7300.2	Contractors shall begin to pay claims using these new files no later than the implementation date of this CR: January 14, 2011.	X		X	X	X					
7300.3	Contractors shall disclose the new MPFS fees on their Web sites as soon as possible, but no later than the implementation date of this CR: January 14, 2011. In addition, contractors shall notify providers via their Web site that the new fees are effective January 1, 2011.	X		X	X	X					
7300.4	Notification of successful receipt shall be sent via email to price_file_receipt@cms.hhs.gov stating the name of the file received and the entity for which it was received (e.g., Medicare contractor name and number).	X		X	X	X					
7300.5	Contractors shall use the 2011 allowed payment amounts listed in the policy section of this change request to pay claims for codes L3660, L3670 and L3675 with dates of service on or after January 1, 2011.	X	X	X		X					
7300.6	Contractors shall remove the termination date of December 31, 2010, for the following HCPCS codes L3660, L3670 and L3675 from their CY 2011 online procedure code files.	X	X	X	X	X				X	

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	
7300.7	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	x	x	x	x						

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	
	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.										

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:

X-Ref Requirement Number	Recommendations or other supporting information:
	N/A

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Sara Vitolo, sara.vitolo@cms.hhs.gov

Post-Implementation Contact(s): Appropriate Regional Office

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.

ATTACHMENT: Emergency Update to the CY 2011 Medicare Physician Fee Schedule Database (MPFSDB)

Effective Date: January 1, 2011
Implementation Date: No later than January 14, 2011 for contractors
January 3, 2011 for CWF

Physician Work RVU and HCPCS/CPT Code Payment Indicator Changes Included in the Emergency Update to the CY 2011 MPFSDB

CPT/HCPCS	Short Descriptor	Action
27685	Revision of lower leg tendon	Bilateral Surgery Indicator: 1
27686	Revise lower leg tendons	Bilateral Surgery Indicator: 1
52332	Cytoscopy and treatment	Work RVU: 2.60
64483	Inj foramen epidural l/s	Work RVU: 1.75
74176	Ct abd & pelvis w/o contrast	Assistant at Surgery Indicator: 9
74176 TC	Ct abd & pelvis w/o contrast	Assistant at Surgery Indicator: 9
74176 26	Ct abd & pelvis w/o contrast	Assistant at Surgery Indicator: 9
77427	Radiation tx management x5	Work RVU: 3.37
74177	Ct abdomen&pelvis w/contrast	Assistant at Surgery Indicator: 9
74177 TC	Ct abdomen&pelvis w/contrast	Assistant at Surgery Indicator: 9
74177 26	Ct abdomen&pelvis w/contrast	Assistant at Surgery Indicator: 9
74178	Ct abd&pelv 1+ section/regns	Assistant at Surgery Indicator: 9
74178 TC	Ct abd&pelv 1+ section/regns	Assistant at Surgery Indicator: 9
74178 26	Ct abd&pelv 1+ section/regns	Assistant at Surgery Indicator: 9
77080	Dxa bone density axial	Work RVU: 0.23
77080 TC	Dxa bone density axial	Work RVU: 0.00
77080 26	Dxa bone density axial	Work RVU: 0.23
77082	Dxa bone density vert fx	Work RVU: 0.13
77082 TC	Dxa bone density vert fx	Work RVU: 0.00
77082 26	Dxa bone density vert fx	Work RVU: 0.13
G0422	Intens cardiac rehab w/exerc	Work RVU: 1.06
G0423	Intens cardiac rehab no exer	Work RVU: 1.06
80100	Drug screen qualitate/multi	Procedure Status Indicator: I
93462	L hrt cath trnsptl puncture	Multiple Surgery Procedure Indicator: 0
93463	Drug admin & hemodynmic meas	Multiple Surgery Procedure Indicator: 0
93464	Exercise w/hemodynamic meas	Multiple Surgery Procedure Indicator: 0
93740	Temperature gradient studies	PC/TC Indicator: 9
93770	Measure venous pressure	PC/TC Indicator: 9
Q2036	Flulaval vacc, 3 yrs & >, im	Procedure Status Indicator: X
Q2037	Fluvirin vacc, 3 yrs & >, im	Procedure Status Indicator: X
Q2038	Fluzone vacc, 3 yrs & >, im	Procedure Status Indicator: X

Medicare and Medicaid Extenders Act of 2011 (MMEA), Extension of Medicare Physician Work Geographic Adjustment Floor

Updated CY 2011 MPFS Geographic Practice Cost Index

Contractor	Locality	Locality name	2011 Work GPCI[1]	2011 PE GPCI [2]	2011 MP GPCI
10102	0	Alabama	1.000	0.928	0.484
831	1	Alaska**	1.500	1.092	0.648
3102	0	Arizona	1.000	0.983	0.913
520	13	Arkansas	1.000	0.923	0.444
1192	26	Anaheim/Santa Ana, CA	1.039	1.271	0.742
1192	18	Los Angeles, CA	1.039	1.220	0.722
1102	3	Marin/Napa/Solano, CA	1.042	1.272	0.443
1102	7	Oakland/Berkeley, CA	1.055	1.286	0.469
1102	5	San Francisco, CA	1.065	1.422	0.464
1102	6	San Mateo, CA	1.072	1.418	0.454
1102	9	Santa Clara, CA	1.080	1.310	0.445
1192	17	Ventura, CA	1.030	1.251	0.684
1102	99	Rest of California*	1.016	1.078	0.546
1192	99	Rest of California*	1.016	1.078	0.546
4102	1	Colorado	1.000	0.997	0.754
13102	0	Connecticut	1.031	1.168	1.102
12202	1	DC + MD/VA Suburbs	1.048	1.218	1.081
12102	1	Delaware	1.012	1.041	0.678
9102	3	Fort Lauderdale, FL	1.000	1.041	2.112
9102	4	Miami, FL	1.000	1.072	2.984
9102	99	Rest of Florida	1.000	0.976	1.635
10202	1	Atlanta, GA	1.006	1.006	0.890
10202	99	Rest of Georgia	1.000	0.943	0.876
1202	1	Hawaii/Guam	1.000	1.198	0.685
5130	0	Idaho	1.000	0.943	0.572
952	16	Chicago, IL	1.028	1.062	2.005
952	12	East St. Louis, IL	1.000	0.962	1.851
952	15	Suburban Chicago, IL	1.021	1.056	1.665
952	99	Rest of Illinois	1.000	0.941	1.274
630	0	Indiana	1.000	0.957	0.603
5102	0	Iowa	1.000	0.934	0.443

5202	0	Kansas	1.000	0.939	0.746
660	0	Kentucky	1.000	0.932	0.701
528	1	New Orleans, LA	1.000	1.018	0.933
528	99	Rest of Louisiana	1.000	0.936	0.816
14102	3	Southern Maine	1.000	1.029	0.584
14102	99	Rest of Maine	1.000	0.947	0.584
12302	1	Baltimore/Surr. Cntys, MD	1.019	1.084	1.147
12302	99	Rest of Maryland	1.002	1.013	0.930
14202	1	Metropolitan Boston	1.021	1.238	0.776
14202	99	Rest of Massachusetts	1.010	1.100	0.776
953	1	Detroit, MI	1.029	1.026	1.855
953	99	Rest of Michigan	1.000	0.960	1.075
954	0	Minnesota	1.000	0.994	0.262
512	0	Mississippi	1.000	0.929	0.782
5302	2	Metropolitan Kansas City, MO	1.000	0.973	1.204
5302	1	Metropolitan St Louis, MO	1.000	0.968	1.064
5302	99	Rest of Missouri	1.000	0.913	1.004
3202	1	Montana ***	1.000	1.000	0.887
5402	0	Nebraska	1.000	0.943	0.280
1302	0	Nevada ***	1.000	1.042	1.149
14302	40	New Hampshire	1.000	1.046	0.658
12402	1	Northern NJ	1.051	1.206	1.077
12402	99	Rest of New Jersey	1.031	1.125	1.077
4202	5	New Mexico	1.000	0.947	1.054
13202	1	Manhattan, NY	1.063	1.263	1.137
13202	2	NYC Suburbs/Long I., NY	1.050	1.278	1.335
13202	3	Poughkpsie/N NYC Suburbs, NY	1.013	1.074	0.945
13292	4	Queens, NY	1.047	1.233	1.351
13282	99	Rest of New York	1.000	0.964	0.492
5535	0	North Carolina	1.000	0.960	0.664
3302	1	North Dakota ***	1.000	1.000	0.453
883	0	Ohio	1.000	0.961	1.230
4302	0	Oklahoma	1.000	0.927	0.671
835	1	Portland, OR	1.003	1.016	0.542
835	99	Rest of Oregon	1.000	0.968	0.542
12502	1	Metropolitan Philadelphia, PA	1.015	1.084	1.619
12502	99	Rest of Pennsylvania	1.000	0.958	1.101
9202	20	Puerto Rico	1.000	0.845	0.249

14402	1	Rhode Island	1.015	1.071	1.089
880	1	South Carolina	1.000	0.952	0.482
3402	2	South Dakota***	1.000	1.000	0.424
10302	35	Tennessee	1.000	0.945	0.566
4402	31	Austin, TX	1.000	0.995	0.859
4402	20	Beaumont, TX	1.000	0.937	1.131
4402	9	Brazoria, TX	1.014	0.967	1.070
4402	11	Dallas, TX	1.009	1.001	0.969
4402	28	Fort Worth, TX	1.000	0.982	0.966
4402	15	Galveston, TX	1.000	0.985	1.100
4402	18	Houston, TX	1.012	0.992	1.131
4402	99	Rest of Texas	1.000	0.943	0.936
3502	9	Utah	1.000	0.953	1.059
14502	50	Vermont	1.000	1.002	0.523
904	0	Virginia	1.000	0.978	0.692
9202	50	Virgin Islands	1.000	0.994	1.007
836	2	Seattle (King Cnty), WA	1.020	1.098	0.785
836	99	Rest of Washington	1.000	0.991	0.770
884	16	West Virginia	1.000	0.912	1.279
951	0	Wisconsin	1.000	0.966	0.476
3602	21	Wyoming ***	1.000	1.000	1.052

[1] 2011 work GPCI reflects an extension of the 1.0 floor required by Section 103 of the MMEA.

[2] 2011 PE GPCI reflects a limited recognition of cost differences for the rent and employee compensation components
and application of the hold harmless provision as required
by ACA.

* Indicates multiple contractors.

** Work GPCI reflects a 1.5 floor in Alaska established by the MIPPA.

*** 2011 and 2012 PE GPCIs reflect a 1.0 floor for frontier states as required by the ACA.

Medicare and Medicaid Extenders Act of 2011 (MMEA), Extension of Physician Fee Schedule Mental Health Add-On

Psychiatry HCPCT/CPT Codes that Represent the MMEA Specified Services

Office or Other Outpatient Facility	
Insight Oriented, Behavior Modifying and/or Supportive Psychotherapy	
90804	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient
90805	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient; with medical evaluation and management services
90806	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient
90807	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient; with medical evaluation and management services
90808	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient
90809	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient; with medical evaluation and management services
Interactive Psychotherapy	
90810	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient
90811	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient; with medical evaluation and management services
90812	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient
90813	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient; with medical evaluation and management services
90814	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient

90815	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient; with medical evaluation and management services
Inpatient Hospital, Partial Hospital or Residential Care Facility	
Insight Oriented, Behavior Modifying and/or Supportive Psychotherapy	
90816	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient
90817	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient; with medical evaluation and management services
90818	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient
90819	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient; with medical evaluation and management services
90821	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to-face with the patient
90822	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to-face with the patient; with medical evaluation and management services
Interactive Psychotherapy	
90823	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient
90824	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient; with medical evaluation and management services
90826	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient
90827	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient; with medical evaluation and management services

90828	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to-face with the patient
90829	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to-face with the patient; with medical evaluation and management services