



2010 Medicare Fee Schedule for Speech-Language Pathologists

This ASHA document provides an overview of the *2010 Medicare Physician Fee Schedule*, comments on relevant revisions, and a list of all procedures used by speech-language pathologists with their national average payment amounts. This document also describes three methods for accessing the exact payment figure based on your geographic location and includes a convenient link to ASHA's table of Medicare SLP coding rules.

Please check the ASHA Billing and Reimbursement Web site at <http://www.asha.org/practice/reimbursement/medicare> for the most up-to-date information. The rates published here, pursuant to legislation enacted in late December, are in effect only for January-February 2010. For additional information, please contact the Health Care Economics and Advocacy Team by e-mail at reimbursement@asha.org.

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Overview

The Centers for Medicare and Medicaid Services (CMS) issued the 2010 Outpatient Medicare Physician Fee Schedule (MPFS) for Part B services on October 30, 2009 with a 21.2% reduction in the conversion factor that affects all services paid under the physician fee schedule. This reduction was overridden on a temporary basis by a section of the Department of Defense Appropriations Act of 2010, signed into law December 23, 2009. The legislation, maintaining the 2009 conversion factor (\$36.0666), is a temporary fix because it is in effect only for services rendered January-February 2010. Please continue to check for updates to this document at <http://www.asha.org/practice/reimbursement/medicare/feeschedule.htm>.

In 2009, the American Medical Association (AMA) Specialty Society Relative Value Scale Update Committee (RUC) reviewed data presented by ASHA for four speech-language pathology procedures because the profession's services are now reflected in the professional expense—rather than the practice expense—component following the change in direct billing status for speech-language pathologists (SLPs) that went into effect on July 1, 2009. CMS accepted the RUC's recommendations for all but one procedure—92597, voice prosthetic device evaluation. CMS maintains that a surgical CPT procedure contains some of the professional work that the RUC included in the value for 92597.

New Developments

Current Procedural Terminology (CPT) Codes

There are no new or revised CPT codes related to speech-language pathology services. However, remember that as of 2009, the introduction to the Special Otorhinolaryngologic Services section of the CPT codebook no longer includes the following paragraph:

"All services include medical diagnostic evaluation. Technical procedures (which may or may not be performed by the physician personally) are often part of the service, but should not be mistaken to constitute the service itself."

The deletion of this paragraph reflects recognition of the professional work of speech-language pathologists and audiologists.

Therapy Cap

The Medicare combined speech-language pathology and physical therapy cap will be \$1,860 for 2010. The current exceptions process for the cap will expire at the end of 2009 unless Congress acts to extend it (as has been annually for many years). A two-year extension to the exceptions process has been included in both the Senate and House health care reform bills under consideration.

As always, the cap does not apply to services provided in hospitals. For information on the exceptions process, go to the ASHA Web site at <http://www.asha.org/practice/reimbursement/ExceptionProcess.htm>.

Physician Quality Reporting Initiative (PQRI)

A PQRI bonus of 2% is available to private practice speech-language pathologists submitting quality indicator information. SLPs will be able to report outcomes for stroke patients in eight functional domains from ASHA's National Outcomes Measurement System (NOMS): spoken language comprehension, reading, spoken language expression, writing, motor speech, swallowing, attention, and memory.

Telehealth Services

There are no new developments regarding telehealth services. Fees for such services performed by SLPs cannot be considered until the Medicare law is amended to permit payment for speech-language pathology services at a distant site.

Summary of Tables

Table 1 illustrates the impact on payment for speech-language pathology services when not accepting Medicare assignment.

Table 2 is a topical list of procedure codes used by or of interest to speech-language pathologists. The codes are grouped to differentiate the categories according to major speech-language pathology practices.

Table 3 lists the procedures in numerical order with the RVUs and national fee data.

Table 4 lists the geographic adjustment indices for the fee schedule.

Payment Rules of the Medicare Physician Fee Schedule

The Medicare Physician Fee Schedule (MPFS), also referred to as the Physician Fee Schedule or Medicare Fee Schedule, is based on the Current Procedural Terminology (CPT) codes in the Healthcare Common Procedural Coding System (HCPCS).¹ The MPFS has set Medicare Part B² prospective payment rates since 1992 for speech-language pathologists, physicians, other private practitioners, and medical clinics. Reimbursement for outpatient rehabilitation services in such facilities as hospitals, skilled nursing facilities, and rehabilitation agencies was included in the MPFS in 1999. The MPFS includes both facility and non-facility rates. CMS determined that the higher non-facility rates apply to speech-language pathology and audiology services (as well as to physical therapy and occupational therapy) even when rendered in a facility.³

Private Practice Status for Speech-Language Pathologists

As of July 1, 2009, SLPs may enroll as a private practitioner under Medicare Part B. The reader is referred to ASHA's Billing & Reimbursement Web site, <http://www.asha.org/practice/medicare/slpprivatepractice>, for more information.

Standard 20% Copayment

All Part B services require the patient to pay a 20% copayment. The fee schedule does not deduct the copayment amount. Therefore, the actual payment by Medicare is 20% less than shown in this fee schedule.

¹ HCPCS Level I: CPT Codes
 HCPCS Level II: Alphanumeric codes developed by CMS for equipment, supplies, and procedures not described in CPT Codes.

² Medicare Part B covers outpatient services and inpatient physician visits. Inpatient rehabilitation and diagnostic services are covered by Part B after depletion of the Part A 100-day skilled nursing facility stay or 90-day hospital stay or disqualification of skilled nursing status.

³ *Federal Register*, July 22, 1999 (p. 39623)

Geographic Adjustment of the Fee Schedule

You may apply the calculation example at the beginning of **Table 4** or you may request a fee schedule adjusted for your geographic area from Medicare Administrative Contractor (MAC) that processes your claims. You can also select geographic areas by going to the CMS Web site at http://www.cms.hhs.gov/pfslookup/02_PFSsearch.asp. Select HCPCS (CPT) codes and your locality for a list of exact payment rates. In general, urban states and areas have payment rates that are 5% to 10% above the national average. Likewise, rural states are lower than the national average. (See **Table 4**).

CPT Modifiers

Untimed CPT codes represent "typical" visit lengths or times to conduct a typical test unless the time is specified in the CPT descriptor. For significantly atypical procedures, a **"-22" modifier** can be used to indicate much longer than normal procedures and a **"-52" modifier** for an abbreviated procedure. Modifier **"-22"** should not be used frequently because the Medicare contractor could make the determination that the procedure reflects typical service delivery. For claims with the -22 modifier a description of the need for extended services should accompany the claim. **Modifier "-59"** is used to establish one procedure as distinct from another procedure billed on the same day.

Medicare Rehabilitation CPT Code Modifiers

Part B services provided under plans of care for speech-language pathology or dysphagia services *require* a **GN** modifier as a suffix to the CPT code. The requirement applies to physician offices as well as facilities and private practices. Occupational therapy and physical therapy modifiers are GO and GP, respectively.

Medicare CPT Coding Rules

Medicare and the AMA have established rules for using specific CPT codes. The Medicare rule always supersedes the AMA rule when billing Medicare. ASHA's Web site includes the full CPT descriptors and rules for their appropriate usage at http://www.asha.org/practice/reimbursement/medicare/SLP_coding_rules.htm. Note that many third party payers selectively adopt Medicare coding rules.

Use of Physical Medicine Codes (97000 series)

CMS staff have concluded that speech-language pathologists should not report physical medicine codes 97110 (Therapeutic exercises, each 15 minutes) and 97112 (Neuromuscular reeducation, each 15 minutes). Although CMS has not issued a formal policy statement regarding this issue, agency officials have stated their position, based on the official descriptors and vignettes for the codes. Please note that cognitive therapy (97532) and sensory integration (97533) by speech-language pathologists is covered in all Medicare Local Coverage Determinations (LCDs). Highmark Medicare Services does include 97110, 97530, and 97535 in its SLP LCD. Palmetto GBA includes 97535 in its SLP LCD.

- Assessment of aphasia (96105, per hour)
- Standardized cognitive performance testing (96125, per hour)

“Limiting Charge”

Independent speech-language pathologists paid by Medicare as private practitioners under the fee schedule may elect to be “nonparticipating” even while enrolled as a Medicare supplier. This status allows payment at a higher rate than specified in the fee schedule if the SLP does *not* accept assignment. Medicare payment is made directly to the supplier, instead of the patient, when accepting assignment (except the 20% co-payment, for which all Part B patients are responsible).

Designation of Time

Most CPT/HCPCS codes billed by speech-language pathologists are “untimed” (i.e., they do not include time designations). They represent a typical visit length and are billed as one unit. Exceptions are:

- Evaluation for speech-generating device (92607, first hour; 92608, each additional 30 minutes)
- evaluation of auditory rehabilitation status (92626, first hour; 92627, each additional 30 minutes).

Nonparticipating SLPs who do not accept assignment may add a *limiting charge* of up to 15% to the total fee schedule amount, as long as the 115% result does not surpass the SLP’s customary fee for that particular CPT code. The net gain for the SLP is 9.25% (not 15%) because nonparticipating practitioners are reimbursed at 95% of the fee schedule amount.

The following calculations in **Table 1** illustrate fees without and with the limiting charge add-on.

Table 1: Impact of Assignment on Medicare Payments

	Scenario 1: <i>Participating Provider Accepts Assignment (not entitled to limiting charge add-on)</i>	Scenario 2: <i>Nonparticipating Provider Accepts Assignment (not entitled to limiting charge add-on)</i>	Scenario 3: <i>Nonparticipating Provider Does <u>Not</u> Accept Assignment (thus, entitled to limiting charge add-on)</i>
Fee Schedule Amount	\$100	\$100	\$100
Total Allowed Payment	\$100	\$100 x 95% = \$95	\$100 x 95% x 115% = \$109.25 total allowed payment
Medicare Pays	80% x \$100 = \$80	80% x \$95 = \$76	Not applicable
Patient Pays	20% x \$100 = \$20	20% x \$95 = \$19	\$76 + \$19 (20% co-pay x \$95) + \$14.25 limiting charge add-on = \$109.25

*All CPT codes and descriptors are copyright 2009 American Medical Association

National Correct Coding Initiative (NCCI) Edits

The Centers for Medicare and Medicaid Services (CMS) use an automated edit system to control specific code pairs that can be reported on the same day. The National Correct Coding Initiative (NCCI or, more commonly, CCI) has been in place since January 1, 1996, and is updated quarterly. The goal of the National Correct Coding Initiative is to prevent payment of “mutually exclusive” code pairings or otherwise inappropriate pairs to be delivered to the same patient on the same day. The edits apply to all Part B settings.

Prior to 2006, CCI edits were limited to services reimbursed by carriers (e.g., physician offices and private practice physical and occupational therapists). Now, all provider settings are affected. Go to the ASHA Web site for tables listing current and historic CCI edits for speech-language pathology and swallowing at:

http://www.asha.org/practice/reimbursement/coding/CCI_edits_SLP.htm

A complete list of code edits for Part B services other than those billed by hospitals is found at <http://www.cms.hhs.gov/NationalCorrectCodInitEd/NCCIEd/list.asp>. The Outpatient Code Editor (OCE) applies only to hospital outpatient services. Typically, the OCE edits for speech-language pathology and audiology are similar to those in the CCI system. The OCE revisions also occur quarterly but one quarter after the revised CCI edits are implemented. See <http://www.cms.hhs.gov/NationalCorrectCodInitEd/NCCIEHOPPS/list.asp> for the full OCE edits.

Relationship to Non-Medicare Payers

Many state Medicaid programs and private health plans, including HMOs and PPOs, have adopted the MPFS while designating their own conversion factor. Speech-language pathologists may request that payers negotiate their rates using such resources as the ASHA publication, *Negotiating Health Care Contracts and Calculating Fees: A Guide for Speech-Language Pathologists and Audiologists*, rather than adopt the MPFS rankings. This publication (Item #0112450) can be ordered online at <http://www.asha.org/shop>.

ASHA Participation in American Medical Association Relative Value Committees

ASHA represents the speech-language pathology profession in both the American Medical Association

(AMA) Relative Value Update Committee (RUC) and the AMA CPT Editorial Panel. The ASHA Health Care Economics Committee (HCEC) coordinates recommendations from ASHA members and related organizations in developing new procedures or revising current ones for adoption by the CPT Editorial Panel. The committee also conducts surveys and holds consensus panel meetings to develop data that are presented to the AMA and CMS to develop relative values for new and revised CPT codes.

Speech-language pathology members of the HCEC in 2010 are Gretchen Bebb, Becky Cornett, Bernard Henri, R. Wayne Holland (ASHA AMA CPT Editorial Panel Advisor), and Vice Chair, Dee Adams Nikjeh (ASHA AMA RUC Alternate Advisor). For further information, contact Steven White, ex-officio of the HCEC and Director, Health Care Economics & Advocacy Team, at swhite@asha.org.

2010 Medicare Relative Units & Fee Calculations

The MPFS uses a resource-based relative value system (RBRVS) that assigns a relative value to each current procedural terminology (CPT) procedure. The relative weighting factor (relative value unit or RVU) is derived from a resource-based relative value scale (**see Table 3**). The components of the RBRVS for each procedure are the (a) professional component (i.e., work as expressed in the amount of time, technical skill, physical effort, stress, and judgment for the procedure) required of physicians and certain other practitioners; (b) technical component (i.e., the practice expense expressed in overhead costs such as assistant’s time, equipment, supplies); and (c) professional liability component.

**Jan.–Feb. 2010 Temporary Conversion Factor:
\$36.0666**

Each relative value unit (RVU) is multiplied by a **2010 Conversion Factor** of **\$28.4061** to yield the fee.

Payers other than Medicare that adopt these relative values may apply a higher or lower conversion factor. Rates are adjusted according to the geographic indices given in **Table 4**. Past and present payment rates already calculated for each locality are available at: http://www.cms.hhs.gov/pfslookup/02_PFSsearch.asp. Click “accept” at bottom of the page. Then select CPT codes and locality for a list of exact payment rates.

Table 2: Topical List of Codes*

Speech-Language Pathology		Physical Medicine and Rehabilitation ⁴	Dysphagia	Instrumental Assessment ⁵
92506	92626	97532	92526	31575
92507	92627	97533	92610	31579
92508	92630	97535	92611	70371
92597	92633		92612	74230
92605	96105		92613	76536
92606	96110		92614	92511
92607	96111		92615	92520
92608	96125		92616	
92609			92617	

⁴ Except for CPT 97532 (cognitive skills development), speech-language pathologists' appropriate use of physical medicine and rehabilitation codes should be discussed with the Medicare contractor or verified in the Local Coverage Determination.

⁵ Endoscopy and radiology services may require physician supervision based on State practice acts and Medicare local coverage determinations.

Table 3: 2010 Medicare Physician Fee Schedule*
**Jan.-Feb. 2010 Temporary Conversion Factor:
\$28.4061**
Modifiers:

26 = "Professional component," the portion of diagnostic test that involves a physician's work and allocation of the practice expense.

TC = "Technical component," for diagnostic tests, the portion of a procedure that does not include a physician's participation. The TC value is the difference between the global values and the professional component (26).

No Modifier = "Global value," includes both professional and technical components.

CPT/HCPCS	Mod	Description	Physician Work RVUs	Non-Facility Practice Expense RVUs	Malpractice RVUs	Non-Facility Total RVUs	Fee (see geographic adjustors in Table 4)
31575⁶		Diagnostic laryngoscopy	1.10	1.80	0.10	3.00	\$108.20
31579⁷		Diagnostic laryngoscopy with stroboscopy	2.26	3.18	0.21	5.65	\$203.78
70371⁸		Pharyn. & speech eval., cine/video	0.84	1.67	0.02	2.53	\$91.25
70371⁸	26	Pharyn. & speech eval., cine/video	0.84	0.28	0.01	1.13	\$40.76
70371⁸	TC	Pharyn. & speech eval., cine/video	0.00	1.39	0.01	1.40	\$50.49
74230⁸		Modified barium swallow	0.53	1.83	0.03	2.39	\$86.20
74230⁸	26	Modified barium swallow	0.53	0.19	0.02	0.74	\$26.69
74230⁸	TC	Modified barium swallow	0.00	1.64	0.01	1.65	\$59.51
76536⁸		Ultrasound exam of head and neck	0.56	2.43	0.03	3.02	\$108.92
76536⁸	26	Ultrasound exam of head and neck	0.56	0.19	0.02	0.77	\$27.77
76536⁸	TC	Ultrasound exam of head and neck	0.00	2.24	0.01	2.25	\$81.15
92506		Speech, lang., aud. process evaluation	0.86	3.37	0.05	4.28	\$154.37

⁶ This procedure is for medical diagnosis by a physician

⁷ This procedure is not defined as a therapy procedure by CMS and must be performed in a physician office, hospital, physician-directed clinic, or other setting supervised by a physician. 'Physician' includes nurse practitioners and physician assistants.

⁸ The 70000 series are radiology codes. The physician component includes an interpretation by radiologists. The practice expense component is for the radiologic technician and overhead. These codes are included here for information purposes and not for billing by speech-language pathologists.

CPT/HCPCS	Mod	Description	Physician Work RVUs	Non-Facility Practice Expense RVUs	Malpractice RVUs	Non-Facility Total RVUs	Fee (see geographic adjustors in Table 4)
92507		Speech, lang., aud. process treatment	0.52	1.23	0.02	1.77	\$63.84
92508		Speech/hearing treatment, group	0.26	0.60	0.01	0.87	\$31.38
92511		Nasopharyngoscopy	0.84	3.22	0.03	4.09	\$147.51
92512		Nasal function studies	0.55	1.04	0.02	1.61	\$58.07
92520 ⁹		Laryngeal function studies	0.75	0.92	0.03	1.70	\$61.31
92526		Swallowing treatment	1.34	1.39	0.02	2.75	\$99.18
92597		Voice prosthetic evaluation	1.26	1.61	0.03	2.90	\$104.59
92605		Evaluation for non-speech generating device	0.00	0.00	0.00	0.00	\$0.00
92606		Non-speech generating device services	0.00	0.00	0.00	0.00	\$0.00
92607		Evaluation for speech-generating device; first hour. (If less than 1 hr, use -52 modifier.)	0.00	4.33	0.06	4.39	\$158.33
92608		Evaluation for speech-generating device; additional 30 minutes	0.00	0.88	0.01	0.89	\$32.10
92609		Speech-generating device services	0.00	2.35	0.03	2.38	\$85.84
92610		Evaluate swallowing function	1.30	1.79	0.01	3.10	\$111.81
92611		Motion fluoroscopy/swallow	1.34	1.98	0.01	3.33	\$120.10
92612 ⁹		Endoscopy swallow test (FEES)	1.27	3.00	0.05	4.32	\$155.81
92613		Physician interpretation (FEES)	0.71	0.31	0.03	1.05	\$37.87
92614 ⁹		Laryngoscopic sensory test	1.27	2.53	0.05	3.85	\$138.86
92615		Physician interpretation, laryngoscopic sensory test	0.63	0.28	0.02	0.93	\$33.54

⁹ This procedure is not defined as a therapy procedure by CMS and must be performed in a physician office, hospital, physician-directed clinic, or other setting supervised by a physician. 'Physician' includes nurse practitioners and physician assistants.

CPT/HCPCS	Mod	Description	Physician Work RVUs	Non-Facility Practice Expense RVUs	Malpractice RVUs	Non-Facility Total RVUs	Fee (see geographic adjustors in Table 4)
92616 ¹⁰		FEES with laryngeal sense test (FEESST)	1.88	3.29	0.08	5.25	\$189.35
92617		Physician interpretation (FEESST)	0.79	0.33	0.03	1.15	\$41.48
92626 ¹¹		Evaluation of auditory rehab status; first hour	1.40	0.79	0.05	2.24	\$80.79
92627 ¹¹		Evaluation of auditory rehab status add-on (each 15 min.)	0.33	0.20	0.01	0.54	\$19.48
92630 ¹²		Auditory rehab, pre-lingual hearing loss	0.00	0.00	0.00	0.00	\$0.00
92633 ¹²		Auditory rehab, post-lingual hearing loss	0.00	0.00	0.00	0.00	\$0.00
96105		Assessment of aphasia, per hour	0.00	2.04	0.03	2.07	\$74.66
96110		Developmental testing, limited	0.00	0.19	0.01	0.20	\$7.21
96111		Developmental test, extended	2.60	0.89	0.12	3.61	\$130.20
96125		Standardized cognitive performance testing, per hour	1.70	0.85	0.05	2.60	\$93.77
97532		Cognitive skills development, each 15 min.	0.44	0.23	0.01	0.68	\$24.53
97533 ¹³		Sensory integration, each 15 min.	0.44	0.29	0.01	0.74	\$26.69
97535 ¹³		Self-care/home management training, each 15 min.	0.45	0.39	0.01	0.85	\$30.66

¹⁰ This procedure is not defined as a therapy procedure by CMS and must be performed in a physician office, hospital, physician-directed clinic, or other setting supervised by a physician. 'Physician' includes nurse practitioners and physician assistants.

¹¹ Speech-language pathologists may report these evaluation codes.

¹² Medicare will not reimburse for auditory rehabilitation codes. CMS guidance instructs speech-language pathologists to use 92507 (see *Federal Register*, November 21, 2005, p. 70281).

¹³ Medicare contractors may require physical medicine procedures performed by speech-language pathologists to be coded as speech-language pathology treatment (92507) or dysphagia treatment (92526).

Geographic Adjustment Calculations

The method for calculating geographic adjustments is illustrated below. You may also request a fee schedule from your carrier or intermediary. Precise payment rates by locality are available at: http://www.cms.hhs.gov/apps/ama/license.asp?file=/pfslookup/02_PFSsearch.asp.

- ✓ Click “Accept” at bottom of page.
- ✓ Choose your “HCPC (CPT code) criteria” and select “Pricing Information”
- ✓ Select “Specific Locality”
- ✓ Enter the code or codes you are looking for, choose “All modifiers”, and select locality

The first column of results, “Non-facility price”, applies to *all* SLP services, whether in a facility or not.

Example: Calculating geographic adjustments

CPT Description and Geographic Index	Work RVUs	Practice RVUs	Malpractice RVUs	Total RVUs	2010 Conversion Factor	Adjusted Fee
CPT 92610						
Evaluate swallowing →	1.30	1.79	0.01			
Alabama index →	<u>x0.982</u>	<u>x0.853</u>	<u>x0.496</u>			
Alabama RVUs →	1.2766	+ 1.52687	+ 0.00496	= 2.80843	x 36.0666	= \$101.29

Table 4: 2009 Geographic Practice Cost Indices (GPCIs)

Carrier No.	Locality No.	Locality Name	Work ^{**}	Practice Expense	Malpractice
10102	00	Alabama	0.982	0.853	0.496
00831	01	Alaska	1.500	1.090	0.646
03102	00	Arizona	0.988	0.957	0.822
00520	13	Arkansas	0.961	0.846	0.446
01192	26	Anaheim/Santa Ana, CA	1.034	1.269	0.811
01192	18	Los Angeles, CA	1.041	1.225	0.804
01102	03	Marin/Napa/Solano, CA	1.034	1.265	0.432
01102	07	Oakland/Berkley, CA	1.053	1.286	0.425
01102	05	San Francisco, CA	1.059	1.441	0.414
01102	06	San Mateo, CA	1.072	1.433	0.394
01102	09	Santa Clara, CA	1.083	1.294	0.377
01192	17	Ventura, CA	1.027	1.265	0.766
01102	99	Rest of California [*]	1.007	1.058	0.549

** CY 2010 work GPCI does not reflect the 1.000 floor established by the MIPPA which expires 01/01/10 and reflects 1.500 floor in Alaska established by the MIPPA.

* Indicates multiple contractors.

Carrier No.	Locality No.	Locality Name	Work**	Practice Expense	Malpractice
01192	99	Rest of California*	1.007	1.058	0.549
04102	01	Colorado	0.986	0.992	0.641
13102	00	Connecticut	1.038	1.185	0.980
12202	01	DC + MD/VA Suburbs	1.047	1.218	1.032
12102	01	Delaware	1.011	1.046	0.678
09102	03	Fort Lauderdale, FL	0.989	1.018	2.250
09102	04	Miami, FL	1.000	1.069	3.167
09102	99	Rest of Florida	0.973	0.939	1.724
10202	01	Atlanta, GA	1.009	1.014	0.836
10202	99	Rest of Georgia	0.979	0.883	0.829
01202	01	Hawaii/Guam	0.998	1.161	0.665
05130	00	Idaho	0.967	0.883	0.546
00952	16	Chicago, IL	1.025	1.080	1.940
00952	12	East St. Louis, IL	0.989	0.919	1.793
00952	15	Suburban Chicago, IL	1.017	1.068	1.629
00952	99	Rest of Illinois	0.975	0.880	1.219
00630	00	Indiana	0.986	0.918	0.599
05102	00	Iowa	0.965	0.870	0.434
05202	00	Kansas	0.969	0.882	0.557
00660	00	Kentucky	0.969	0.860	0.652
00528	01	New Orleans, LA	0.986	1.044	0.956
00528	99	Rest of Louisiana	0.970	0.878	0.892
14102	03	Southern Maine	0.980	1.025	0.492
14102	99	Rest of Maine	0.962	0.893	0.492
12302	01	Baltimore/Surr. Cntys, MD	1.012	1.057	1.086
12302	99	Rest of Maryland	0.994	0.982	0.874
14202	01	Metropolitan Boston	1.029	1.291	0.764
14202	99	Rest of Massachusetts	1.007	1.106	0.764
00953	01	Detroit, MI	1.036	1.040	1.906
00953	99	Rest of Michigan	0.998	0.923	1.083
00954	00	Minnesota	0.992	0.983	0.245
00512	00	Mississippi	0.959	0.854	0.808
05302	02	Metropolitan Kansas City, MO	0.990	0.945	1.188
05302	01	Metropolitan St Louis, MO	0.993	0.931	1.075
05302	99	Rest of Missouri*	0.949	0.821	0.997
03202	01	Montana	0.950	0.847	0.673
05402	00	Nebraska	0.959	0.890	0.245
01302	00	Nevada	1.002	1.026	1.083
14302	40	New Hampshire	0.982	1.039	0.462
12402	01	Northern NJ	1.057	1.228	1.116

*
Indicates multiple contractors.

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Carrier No.	Locality No.	Locality Name	Work**	Practice Expense	Malpractice
12402	99	Rest of New Jersey	1.042	1.126	1.116
04202	05	New Mexico	0.973	0.890	1.096
13202	01	Manhattan, NY	1.064	1.298	1.010
13202	02	NYC Suburbs/Long I., NY	1.051	1.289	1.235
13202	03	Poughkpsie/N NYC Suburbs, NY	1.014	1.077	0.822
13292	04	Queens, NY	1.032	1.239	1.220
13282	99	Rest of New York	0.997	0.921	0.425
05535	00	North Carolina	0.972	0.925	0.634
03302	01	North Dakota	0.947	0.844	0.387
00883	00	Ohio	0.993	0.927	1.232
04302	00	Oklahoma	0.964	0.850	0.627
00835	01	Portland, OR	1.002	1.015	0.472
00835	99	Rest of Oregon	0.968	0.927	0.472
12502	01	Metropolitan Philadelphia, PA	1.016	1.097	1.617
12502	99	Rest of Pennsylvania	0.993	0.925	1.081
09202	20	Puerto Rico	0.904	0.694	0.250
14402	01	Rhode Island	1.013	1.088	0.996
00880	01	South Carolina	0.975	0.906	0.446
03402	02	South Dakota	0.942	0.864	0.420
10302	35	Tennessee	0.978	0.889	0.608
04402	31	Austin, TX	0.992	0.984	0.969
04402	20	Beaumont, TX	0.984	0.875	1.346
04402	09	Brazoria, TX	1.019	0.922	1.223
04402	11	Dallas, TX	1.009	1.001	1.110
04402	28	Fort Worth, TX	0.998	0.953	1.110
04402	15	Galveston, TX	0.991	0.959	1.223
04402	18	Houston, TX	1.016	0.986	1.345
04402	99	Rest of Texas	0.968	0.879	1.065
03502	09	Utah	0.977	0.907	1.026
14502	50	Vermont	0.968	0.983	0.489
00904	00	Virginia	0.982	0.942	0.657
09202	50	Virgin Islands	0.997	0.978	1.009
00836	02	Seattle (King Cnty), WA	1.014	1.085	0.706
00836	99	Rest of Washington	0.987	0.974	0.693
00884	16	West Virginia	0.973	0.827	1.353
00951	00	Wisconsin	0.988	0.921	0.409
03602	21	Wyoming	0.956	0.842	0.889
04402	28	Fort Worth, TX	0.998	0.953	1.110