2009 Final Medicare Physician Fee Schedule (CMS-1403-FC) Rule Summary

The 2009 Final Medicare Physician Fee Schedule will be published in the Federal Register on November 19, 2008. A display copy of this final rule with a comment period can be found in its entirety on the Centers for Medicare and Medicaid (CMS) website at the following hyperlink: http://www.cms.hhs.gov/physicianfeesched/downloads/CMS-1403-FC.pdf?agree=yes&next=Accept Comments will be accepted until December 29, 2008. Unless otherwise indicated, the provisions of this final rule with comment period are effective January 1, 2009.

On July 15, 2008, after the release of the 2009 proposed Medicare fee schedule, Congress enacted the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). Many of the provisions in MIPPA addressed similar issues that were raised in the proposed rule. The 2009 final rule is a combination of finalized proposals from the proposed rule, requests for further comments on proposals from the proposed rule, and discussion of implementation of provisions from MIPPA.

The following are provisions of the final rule of interest to neurologists:

- 2009 Payment Update for Physician Services – 1.1% Update Announced
- Telehealth Services
- Multiple Procedure Payment Reduction for Diagnostic Imaging
- Reduction in Technical Component Payment for Imaging Services
- Portable X-Ray Issues
- Part B Drug Payment – Competitive Acquisition Program (CAP)
- Clinical Lab Fee Schedule Update
- Expansion of Independent Diagnostic Testing Facility (IDTF) Quality Standards to Physicians and NPPs Providing Diagnostic Services
- Physician Self-Referral and Anti-Markup Issues
- Exception for Incentive Payment and Shared Savings Programs
- Quality Initiatives (PQRI, E-Prescribing, Physician Resource Use Feedback Program)
- Other Miscellaneous Provisions

2009 Payment Update for Physician Services – 1.1% Update Announced

CMS implemented a 1.1% positive adjustment for physician services for 2009. A scheduled 15.1% cut was averted through a provision in MIPPA. Despite this positive adjustment, due to technical changes in the calculation of the physician payment rates the conversion factor (CF) will decrease in 2009.

2009 Conversion Factor: The 2009 CF will decrease from $38.0870 (2008) to $36.0666 (2009). This decrease is a result of another provision in MIPPA that requires CMS to change the way it calculates budget neutrality. CMS is required to apply a budget neutrality adjustment because changes caused by the Third Five Year Review of Work RVUs (implemented in 2007 and 2008) and changes in work RVUs in the 2009 MPFS exceeded $20 million. When the $20 million threshold is exceeded, CMS is required by law to offset these costs through a budget neutrality adjustment. While in the previous two years this adjustment had been applied to reductions in

work RVUs, MIPPA requires CMS to apply the adjustment to the conversion factor (CF). This technical change resulted in an approximate 6% reduction in the conversion factor.

Impact of New Budget Neutrality Adjustment Methodology: The application of budget neutrality on the CF being implemented in 2009 will have a greater impact on procedures with high PE values because the previous methodology only reduced work RVUs, this new methodology which adjusts the CF reduces all components of physician payment (work, practice expense (PE), and malpractice RVUs). In other words, procedures done in the office with high cost supplies, and/or expensive equipment will face greater reductions under the 2009 method of budget neutrality (CF adjusted) versus the method implemented in previous years (work RVUs adjusted).

Year 3 of 4 Year Transition to New PE Methodology: The final factor impacting physician payment in 2009 are changes to PE RVUs. PE RVUs represent the resources used in furnishing supplies, office rent/lease, equipment and personnel wages (excluding malpractice expense) when providing physician services. In CY 2007 CMS implemented a new methodology for calculating PE RVUs. CMS is implementing this new methodology over a four year period. CY 2009 will be the third year of this transition. The new methodology will be fully implemented by 2010. Practice expense for any new codes created during this period will be based on the new methodology. The impact of this transition to a new PE methodology varies by individual code.

CMS also finalized minor PE changes to a number of individual codes and continued its discussion on reconfiguring payment localities. Payment localities are used to estimate differences in local costs. The Agency is not making any changes to payment localities at this time.

Impact on Specialties:
Table 48 from the final rule shows the impact of the work RVU changes, practice expense changes and MIPPA changes by specialty. Based on this analysis, Neurology is estimated to experience an impact of 1% from all of these changes in the 2009 final rule. An excerpt from the table is below and the full table is attached.

Table 48: Combined CY 2009 Total Allowed Charge Impact for Work RVU Changes, Practice Expense Changes, and MIPPA Changes

Specialty	Allowed Charges	Work and PE Changes*	MIPPA 133(b)**	MIPPA 131 Update	Total
Total	$81,669	0%	0%	1%	1%
Neurology	$1,489	0%	0%	1%	1%

* PE changes are CY 2009 changes 3rd year transitional changes. Prior to the application of the OPPS imaging caps under DRA 5102.
* MIPPA 133(b) requires CMS to apply budget neutrality adjustment to CF.
* MIPPA 131 provides for a 1.1% update for CY 2009.

Table 49 shows the 2009 Medicare payment rates for high volume selected procedures. An excerpt of the chart highlighting several evaluation and management procedures follows.

Table 49: Impact of Final Rule with Comment Period and Estimated Physician Update on 20009 Payment for Selected Procedures

CPT	Descriptor	Facility (Hospital			Non-Facility (Office)		
		2008	2009	% Change	2008	2009	% Change
99213	Office/outpatient visit, est	$41.90	$44.72	7%	$59.80	$61.31	3%
99214	Office/outpatient visit, est	$65.61	$69.25	6%	$89.89	$92.33	3%
99243	Office consultation	$92.93	$97.38	5%	$122.26	$124.79	2%
99244	Office consultation	$145.49	$154.00	6%	$179.01	$184.30	3%
99253	Initial inpatient consult	$108.55	$144.69	6%	N/A	N/A	N/A
99254	Initial inpatient consult	$156.54	$165.55	6%	N/A	N/A	N/A

Telehealth Services

Medicare policy allows for coverage and payment for Medicare telehealth includes consultation, office visits, individual psychotherapy, and pharmacologic management any additional services specified by the Secretary delivered via a telecommunications system. CMS maintains a list of eligible services. For 2009 CMS proposed creating a new series of HCPCS codes for follow-up inpatient telehealth consultations. Follow-up inpatient telehealth consultations are consultative visits furnished via telehealth to complete an initial consultation or subsequent consultative visits requested by the attending physician.

In this final rule, CMS finalized this proposal to add follow-up inpatient telehealth consultation, as represented by HCPCS codes G0406 through G0408, to the list of Medicare telehealth services.

- G0406, Follow-up inpatient telehealth consultation, limited, typically 15 minutes communicating with the patient via telehealth
- G0407, Follow-up inpatient telehealth consultation, intermediate, typically 25 minutes communicating with the patient via telehealth
- G0408, Follow-up inpatient telehealth consultation complex, typically 33 minutes or more communicating with the patient via telehealth

Changes to Multiple Procedure Payment Reduction for Diagnostic Imaging

Effective January 1, 2006 CMS implemented a multiple procedure payment reduction (MPR) on certain diagnostic imaging procedures. When two or more procedures within one of 11 imaging code families are furnished on the same patient in a single session, the TC of the highest priced procedure is paid at 100 percent and the TC of the subsequent procedure is paid at 75 percent (a 25 percent reduction). The reduction does not apply to the PC.

For CY 2009 CMS will make several changes to the MPR list: ten new procedures have been added and one code will be removed from the list since it was deleted for 2009.

CPT	Descriptor	Action
70336	Magnetic image, jaw joint	Added
70554	Fmri brain by tech	Added
75557	Cardiac mri for morph	Added
75559	Cardiac mri w/stress img	Added
75561	Cardiac mri for morph w/dye	Added
75563	Card mri w/stress img & dye	Added
76776	US exam k transpl w/doppler	Added
76778	US exam K transpl w/ or w/out Doppler	Deleted
76870	Us exam, scrotum	Added
77058	Mri, one breast	Added
77059	Mri, both breasts	Added

Reduction in Technical Component Payment for Imaging Services

Section 5102 of DRA cap requires CMS to cap the technical component of the MPFS payment amount for certain imaging services by the hospital outpatient prospective payment system (HOPPS) amount for imaging services furnished on or after January 1, 2007. For the 2009 the list of codes subject to HOPPS cap has been revised to reflect new and deleted CPT codes for 2009. Codes 78890 (Nuclear medicine data proc) and 78891 (Nuclear med data proc) have been deleted. Code 93306 (Tte w/doppler, complete) has been added to the list.

Portable X-Ray Issues

The current requirements in regulations for the qualifications for technical personnel for portable x-ray services require a training of 24 months. A number of changes in the training and accreditation organizations and the curriculum have occurred since these regulations were established. CMS believes the current regulations are outdated and do not reflect current standards. CMS has finalized proposal to revise references to accrediting organizations to reflect the current entities involved and delete the requirement for formal training of not less than 24 months.

Part B Drug Payment – Competitive Acquisition Program

The Competitive Acquisition Program (CAP) is an alternative to the ASP method of obtaining certain Part B drugs administered in physicians' offices. Physicians who choose to participate in the CAP obtain approximately 190 drugs on the CAP drug list from an approved CAP vendor that was selected through a competitive bidding process and approved by CMS. A physician bills Medicare for administering a CAP drug. An approved CAP vendor bills Medicare for the CAP drug and collects applicable cost-sharing amounts from a beneficiary.

In the 2009 proposed MPFS several refinements to the CAP program were proposed. However since the publication of the proposed rule CMS has announced the postponement of the 2009 CAP program due to contractual issues with CAP bidders. Currently the Agency is soliciting public feedback on the CAP from participating physicians, potential vendors, and other interested parties.

Clinical Lab Fee Schedule Update

The freeze on the annual update to the lab fee schedule expires on January 1, 2009. For the period beginning January 1, 2009 the update will be 5.0 %. MIPPA reduces this increase by 0.5 percent for each of the years 2009 through 2013. For CY 2009 payment will be updated by 4.5 percent.

Expansion of Independent Diagnostic Testing Facility (IDTF) Quality Standards to Physicians and NPPs Providing Diagnostic Services

In the proposed rule CMS solicited comments on a proposal to require that physicians and NPPs who furnish diagnostic testing services, except mammography services, meet most of the quality and performance standards required for Independent Diagnostic Testing Facilities (IDTF).

For 2009, CMS is not adopting its proposal to require physicians and NPPs to meet certain quality and performance standards when providing diagnostic testing services, except mammography services, within their medical practice setting. CMS has stated that they have deferred finalizing this proposal based on Section 135 of MIPPA which requires advanced diagnostic imaging service suppliers to be accredited by an accreditation organization by January 1, 2012. By deferring this decision, CMS maintains the option of finalizing this proposal in the future rulemaking efforts if it deems necessary.

CMS is also finalizing several billing requirement proposals related for mobile entities providing diagnostic services:

- Entities furnishing diagnostic services must enroll in Medicare program as an IDTF regardless of where the services are furnished
- Mobile diagnostic services bill for the services they furnish unless it is part of a hospital service

CMS is also finalizing several proposals related to enrollment and billing privileges of IDTFs in the Medicare program whose billing privileges have been revoked.

Anti-Markup Issues

The 2009 MPFS finalized new policies on the application of the anti-markup provisions as they relate to technical and professional components of diagnostic services, other than clinical laboratory services, provided by both for-profit and not-for-profit organizations. These policies will become effective on January 1, 2009.

<u>What is the Anti-Markup Provision?</u> - Anti-markups become an issue when the individual performing the services is different than the individual billing Medicare for the service.
If the anti-markup provision applies the billing physician must charge CMS the lower of: 1) the performing supplier's net charge to the billing physician; 2) the billing physician's actual charge or 3) the fee schedule charge for the test if the performing supplier billed Medicare directly.

<u>Scenarios in Which the Anti-Markup Provision Does NOT Apply to the TC and/or PC</u>
At least one of the two scenarios must be met in order for the anti-markup to not apply.

- The performing physician performs substantially all of their professional services for the billing physician. In this rule CMS has defined substantially all as at least 75% of his or her professional services. This rule will disallow many part-time arrangements.
- The performing physician provides the service in the office where the billing physician conducts substantially the full range of patient care services that he or she generally furnishes.

Potential Challenges of the Anti-Markup Provisions for Physician Organizations

The "substantially all scenario" rule potentially can be more challenging for smaller practices that may not have enough volume to utilize 75 percent of a provider's time. This rule would probably be less difficult for larger practices with higher volume.

Meeting the "same building" requirement will be difficult for group practices who do not have sufficient volume to meet the "substantially all scenario."

Exception for Incentive Payment and Shared Savings Programs

The Medicare program and other private industry stakeholders are increasingly exploring various types of gainsharing, pay for performance and other similar programs. There is concern that existing exceptions to the physician self-referral statute may not be sufficiently flexible enough to encourage such programs. To address this potential challenge, in the 2009 proposed rule CMS proposed a targeted exception to the physician self-referral statute.

CMS proposed a new, targeted exception to the physician self-referral statute for various types of gainsharing, pay-for-performance, value-based purchasing, and similar styled programs that use economic incentives to foster high quality, cost-effective care. These types of programs seek to align physician economic incentives with those of hospitals by offering physicians a share of the hospitals' variable cost savings attributable to the physicians' efforts in controlling the costs of providing patient care.

This exception would permit incentive payments between physicians and entities furnishing designated health services (DHS), provided that certain conditions are satisfied. The purpose of this proposal was not to create any new programs but to propose an exception that would allow payment to a physician under such a program. CMS believes that such an exception would remove barriers to participation in existing programs.

In this final 2009 CMS is not finalizing any proposals and is reopening the public comment period, seeking additional information. The Agency felt they received insufficient information and there was not consensus among commenters regarding possible modifications to the proposal. Commenters are requested to respond with greater specificity and provide practical examples when possible.

Quality Initiatives (PQRI, E-Prescribing, Physician Resource Use Feedback Program)

Physician Quality Reporting Initiative (PQRI)

The Physician Quality Reporting Initiative (PQRI) was authorized by the Medicare, Medicaid, and SCHIP Extension Act (MMSEA) of 2007. In 2007 and 2008 participating professionals

were eligible for a bonus of 1.5 percent of the estimated total allowed charges for all covered professional services furnished during the reporting period.

2009 PQRI Program Description - The final 2009 rule addresses several elements of the PQRI program.

- *Bonus payment* – MIPPA made PQRI a permanent program and established a 2 percent bonus for the 2009 program
- *Measures* – CMS approved measures for the 2009 program. These include measures from the 2008 PQRI program, additional National Quality Forum (NQF) endorsed measures, additional AQA-adopted measures and additional measures that had not received AQA adoption or NQF endorsement at the time the proposed rule was published but their inclusion was dependent on it.
- *Paired measures* – The 2009 PQRI will include 4 measure sets that will be considered paired measures. Closely related individual measures that are recommended but not required to be submitted together. These paired measures do not constitute a measure group but may be subject to the measure validation strategy posted on the PQRI section of the CMS website.
- *E-prescribing* – E-prescribing has been removed from the PQRI program and will be handled separately.
- *Specifications* - Detailed specifications providing guidance on the reporting of measures for the 2009 PQRI program will be posted on the CMS website no later than December 31.
- *Audiologists* – Audiologists are now eligible to participate in PQRI.

Participation Options - For the 2009 PQRI program providers can submit measures either individually or in measure groups. Measure groups are established by CMS. The 2009 program does not have any neurology-related measure groups. Additionally measures can be reported either through claims or patient registries. While in most cases the reporting period is from January 1 to December 31, 2009, there are opportunities for a shorter alternative reporting period (July 1-December 31, 2009) when reporting measure groups in certain circumstances.

2009 Neurology-Related Measures- The 2009 PQRI program will include the same neurology-related measures used in the 2008 PQRI program:

- Stroke and Stroke Rehabilitation: Carotid Imaging Reports
- Stroke and Stroke Rehabilitation: Deep Vein Thrombosis Prophylaxis (DVT) for Ischemic Stroke or Intracranial Hemorrhage
- Stroke and Stroke Rehabilitation: Discharged on Antiplatelet Therapy
- Stroke and Stroke Rehabilitation: Anticoagulant Therapy Prescribed for Atrial Fibrillation at Discharge
- Stroke and Stroke Rehabilitation: Tissue Plasminogen Activator (t-PA) Considered
- Stroke and Stroke Rehabilitation: Screening for Dysphagia
- Stroke and Stroke Rehabilitation: Consideration of Rehabilitation Services

Electronic Health Record (EHR) based submission for Reporting Individual Measures - In the 2009 proposed rule CMS proposed to begin EHR data submission for PQRI 2009. CMS will not finalize this proposal for 2009 and instead will complete the 2008 testing and continue additional

testing in 2009. In addition, upon completion of satisfactory testing, CMS will qualify EHR vendors and their specific products. By December 31, 2008 CMS will post on the PQRI section of the website a list of requirements that EHR vendors must be able to meet in order to self-nominate their product. To participate in the 2009 testing process, vendors must self nominate by Feb 13, 2009.

Public Reporting of PQRI Data - It was indicated in the proposed rule that the data on PQRI quality measures that are submitted at the individual level could be the basis for public reporting of quality measurement performance results at individual or group level in the future. The Agency's broader goal is to make quality of care data publicly available. In this final rule CMS is soliciting comments on the appropriate use of PQRI data.

Physician and Other Health Care Professional Compare Website – MIPPA requires the Secretary to post on the CMS website, in an easily understandable format, a list of names of eligible professionals (or group practices) who satisfactorily submitted data on quality measures for the PQRI and the names of the eligible professional (or group practices) who are successful electronic subscribers. This cannot be applied retrospectively. CMS plans to launch a Physician and Other Health Care Professional Compare website that will enhance the information found on the current Physician and Other Health Care Professional Directory. The Agency's intent is to identify the eligible professionals who satisfactorily submit data on quality measures for the 2009 PQRI program on the CMS website in 2010. CMS will only post successful participants who receive a bonus payment.

<u>E-Prescribing</u>

MIPPA has authorized a new incentive program for eligible professionals who are successful electronic prescribers. In order to be eligible to participate in the E-prescribing program the electronic quality measure must apply to at least 10 percent of the professional's total Part B allowed charges. E-prescribers must report one of three G-codes described below at least 50% of the time to be considered successful and receive a bonus:

- All prescriptions related to the visit were electronically prescribed
- No prescriptions were generated during the visit
- Some or all prescriptions written or phoned in due to patient request, state or federal law, the pharmacy's system being unable to receive data electronically or because the prescription was for a narcotic or controlled substance

The program uses a mix of carrots and sticks to encourage participation. Successful participants will be eligible for the following bonus payments: 2% in 2009; 2% in 2010; 1% in 2011; 1% in 2012; and, 0.5% in 2013. Eligible participants who are not successful or do not participate will face the following reductions to their Medicare payments: – 1% in 2012; – 1.5% in 2013; and -2.0% in 2014 and each subsequent year. CMS will report publicly the names of eligible professionals who are successful electronic prescribers.

<u>Physician Resource Use Feedback Program</u>

MIPPA requires the Secretary to establish a Physician Feedback Program using Medicare claims data and other data to provide confidential feedback reports to physicians that measure the resources involved in furnishing care to Medicare beneficiaries. CMS is currently implementing Phase I of the program, reviewing claims data from 2004-2007 in two cities to develop feedback

reports. Resource use will be measured on the episode basis and per capita basis. The Agency is soliciting comments on this program to begin finalizing the program for the future.

Other Miscellaneous Provisions

High Cost Supplies

In the proposed rule CMS identified the top 65 high cost supply items over $150 and requested specialty societies to submit documentation on specific pricing information. There was one neurology-related supply on the list: electrode, grid (SD058). CMS was not satisfied with the data received and will continue working with physician groups and other parties to collect additional data.

Potentially Misvalued Services

The proposed rule discussed several methods of identifying potentially misvalued services. CMS stated in the final rule that it will continue to work with the American Medical Association (AMA) and may propose additional changes in future rulemaking.

Services Often Billed Together and Expansion of the Multiple Procedure Reduction (MPPR)

CMS has a long-standing policy of reducing payment for multiple surgical procedures performed on the same patient, by the same physician, on the same day. In recent years this policy has been extended to diagnostic and diagnostic imaging procedures. Concern has been raised that there may be inequities between specialties in the current coding and payment system regarding the extent to which there are opportunities for additional coding and payment for services performed on the same day.

In the proposed rule CMS proposed to perform a data analysis of non-surgical CPT codes that are often billed together to explore this issue further. In the final rule CMS said they will continue to work with the AMA, the Medicare Advisory Payment Commission (MedPAC) and medical specialty societies to determine whether there are additional services that should be either bundled or subjected to a MPPR.

Provider Enrollment and Billing Rules

CMS finalized a number of proposals related to provider enrollment and billing rules including: establishing an effective billing date for physicians and non-physician practitioners, submitting claims after a final adverse action or CMS revocation, revised reporting responsibilities related to change of ownership, final adverse action, or change of location for physicians and non-physician practitioners, and beneficiary signatures for non-emergency ambulance services.

The rule also includes a number of other provisions including: expansion of the Initial Preventive Physical Examination (IPPE) benefit, authority to the Secretary to cover additional preventive services, and an extension of the 1.00 floor on the geographic adjustment to the physician work component of the fee schedule.

TABLE 48: Combined CY 2009 Total Allowed Charge Impact for Work RVU Changes, Practice Expense Changes, and MIPPA Changes

	Specialty	Allowed Charges (mil)	Work and PE RVU Changes*	MIPPA 133(b)**	MIPPA 131 Update	Total***
1	TOTAL	$ 81,669	0%	0%	1%	1%
2	ALLERGY/IMMUNOLOGY	$ 184	1%	-3%	1%	-1%
3	ANESTHESIOLOGY	$ 1,966	-1%	3%	1%	3%
4	CARDIAC SURGERY	$ 400	0%	1%	1%	2%
5	CARDIOLOGY	$ 7,775	-2%	-1%	1%	-2%
6	COLON AND RECTAL SURGERY	$ 136	0%	1%	1%	2%
7	CRITICAL CARE	$ 224	0%	2%	1%	3%
8	DERMATOLOGY	$ 2,557	2%	-2%	1%	1%
9	EMERGENCY MEDICINE	$ 2,451	0%	3%	1%	4%
10	ENDOCRINOLOGY	$ 385	0%	0%	1%	2%
11	FAMILY PRACTICE	$ 5,354	0%	0%	1%	2%
12	GASTROENTEROLOGY	$ 1,883	2%	1%	1%	3%
13	GENERAL PRACTICE	$ 842	0%	0%	1%	2%
14	GENERAL SURGERY	$ 2,408	1%	1%	1%	3%
15	GERIATRICS	$ 175	0%	2%	1%	3%
16	HAND SURGERY	$ 88	-1%	-1%	1%	-1%
17	HEMATOLOGY/ONCOLOGY	$ 2,019	-1%	-2%	1%	-1%
18	INFECTIOUS DISEASE	$ 561	1%	2%	1%	4%
19	INTERNAL MEDICINE	$ 10,662	0%	1%	1%	2%
20	INTERVENTIONAL RADIOLOGY	$ 228	-1%	0%	1%	0%
21	NEPHROLOGY	$ 1,840	-1%	1%	1%	2%
22	NEUROLOGY	$ 1,489	0%	0%	1%	1%
23	NEUROSURGERY	$ 620	-1%	0%	1%	0%
24	NUCLEAR MEDICINE	$ 79	-1%	-2%	1%	-1%
25	OBSTETRICS/GYNECOLOGY	$ 654	0%	0%	1%	0%

	Specialty	Allowed Charges (mil)	Work and PE RVU Changes*	MIPPA 133(b)**	MIPPA 131 Update	Total***
26	OPHTHALMOLOGY	$ 5,026	0%	0%	1%	0%
27	ORTHOPEDIC SURGERY	$ 3,454	0%	0%	1%	0%
28	OTOLARNGOLOGY	$ 984	-1%	-1%	1%	-1%
29	PATHOLOGY	$ 1,007	0%	0%	1%	1%
30	PEDIATRICS	$ 72	1%	0%	1%	2%
31	PHYSICAL MEDICINE	$ 850	0%	1%	1%	1%
32	PLASTIC SURGERY	$ 288	0%	0%	1%	1%
33	PSYCHIATRY	$ 1,169	1%	2%	1%	4%
34	PULMONARY DISEASE	$ 1,828	1%	1%	1%	3%
35	RADIATION ONCOLOGY	$ 1,854	-1%	-3%	1%	-3%
36	RADIOLOGY	$ 5,554	0%	-1%	1%	0%
37	RHEUMATOLOGY	$ 521	0%	-1%	1%	-1%
38	THORACIC SURGERY	$ 431	0%	1%	1%	2%
39	UROLOGY	$ 2,146	0%	-1%	1%	0%
40	VASCULAR SURGERY	$ 685	0%	-1%	1%	1%
41	AUDIOLOGIST	$ 33	-9%	-2%	1%	-10%
42	CHIROPRACTOR	$ 768	-1%	2%	1%	2%
43	CLINICAL PSYCHOLOGIST	$ 571	-2%	3%	1%	2%
44	CLINICAL SOCIAL WORKER	$ 378	-1%	3%	1%	3%
45	NURSE ANESTHETIST	$ 846	0%	4%	1%	5%
46	NURSE PRACTITIONER	$ 963	1%	1%	1%	3%
47	OPTOMETRY	$ 867	0%	-1%	1%	0%
48	ORAL/MAXILLOFACIAL SURGERY	$ 38	1%	-1%	1%	1%
49	PHYSICAL/OCCUPATIONAL THERAPY	$ 1,772	2%	0%	1%	3%
50	PHYSICIAN ASSISTANT	$ 711	0%	1%	1%	2%
51	PODIATRY	$ 1,727	1%	-1%	1%	1%
52	DIAGNOSTIC TESTING FACILITY	$ 1,186	-2%	-5%	1%	-6%
53	INDEPENDENT LABORATORY	$ 878	5%	-4%	1%	2%
54	PORTABLE X-RAY SUPPLIER	$ 87	2%	-4%	1%	-2%

* PE changes are CY 2009 third year transition changes. For fully implemented CY 2010 PE changes, see Table 1.

** Prior to the application of the OPPS imaging caps under DRA 5102

***Components may not sum to total due to rounding