

COMMONWEALTH OF THE NORTHERN MARIANA ISLANDS  
SAIPAN, MARIANA ISLANDS

VOLUME 14 NO.1



JANUARY 15, 1992

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***COMMONWEALTH***  
***REGISTER***

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# COMMONWEALTH HEALTH CENTER

OFFICE OF THE DIRECTOR

GOVERNMENT OF THE NORTHERN MARIANA ISLANDS  
DEPARTMENT OF PUBLIC HEALTH-ENVIRONMENTAL SERVICES

## CERTIFICATION OF RULES REGARDING INCREASE HOSPITAL MEDICAL SERVICE FEES

I, Dr. Jose L. Chong, the Director of the Department of Public Health and Environmental Services, which is promulgating the Rules regarding Hospital Medical Service Fees published in the Commonwealth Register on January 15, 1992 at pages 8666 to 8737, by signature below hereby certify that such Rules are a true, complete, and correct copy of the Rules regarding Increased Hospital Medical Service Fees formally adopted by the Department of Public Health and Environmental Services. I further request and direct that this Certification be published in the Commonwealth Register and then be attached by both the Office of the Registrar of the Corporations and Office of the Governor to the Rules Regarding Increased Hospital Medical Service Fees referenced above.

I declare under penalty of perjury that the foregoing is true and correct and that this declaration was executed on the 17th day of February, 1992 at Saipan, Commonwealth of the Northern Mariana Islands.

Signature: \_\_\_\_\_

*J. Chong*  
Dr. Jose L. Chong, Director  
Department of Public Health and  
Environmental Services

Date: \_\_\_\_\_

*2/17/92*

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OFFICE of the ATTORNEY GENERAL	
DATE:	<i>2/17/92</i>
TIME:	<i>1:45</i> AM/PM
BY:	<i>[Signature]</i>
REGISTRAR OF CORPORATIONS Commonwealth of the Northern Mariana Islands	

DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENTAL SERVICES  
PUBLIC NOTICE

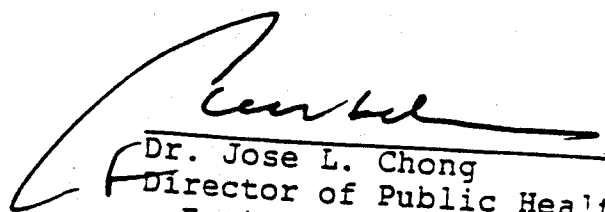
ADOPTION OF THE AMENDMENT ON HOSPITAL MEDICAL SERVICE FEES  
DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENTAL SERVICES

In accordance with Public Law 1-8, Chapter 12, Section 4, the Department of Public Health and Environmental Services (DPH&ES) has the authority to adopt rules and regulations it may deem necessary in all matters over which it has jurisdiction. The Director of the Department has the responsibility to promulgate and implement these rules and regulations.

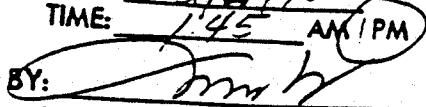
In accordance with this authority, the Director adopted the amended Hospital Fee Schedule for the provision of medical services. It is the intent of the Department to establish and amend fees with full public knowledge and consideration. The Department has adopted and established the following service fees:

- A. Medical Services
  - a. Professional Services
  - b. Respiratory Therapy
  - c. Physical Therapy
- B. Surgical and Anesthesia Services
- C. Maternity Care and Delivery Services
- D. Laboratory and Pathology Services
- E. Radiology Services
- F. Room and Board and Other Fees
- G. Dental Services

Copies of the adopted Fee Schedule may be obtained from the Director's Office at the Commonwealth Health Center.

  
Dr. Jose L. Chong  
Director of Public Health and  
Environmental Services

Date: 2/18/92

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MA ADAPTA NA AMENDASION POT I APAS I ~~SETBISION~~  
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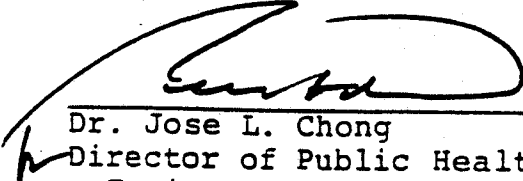
DEPATTAMENTON I HINEMLO YAN I SETBISION ENVIRONMENTAL

Sigun gi Lai Publiku 1-8, Kapitulu 2, Seksiona 4, i Depattamenton i Public Health yan i Environmental Services (DPH&ES), guaha atoridad-na na para ufama' tinas areklamento siha ni man nisisario gi para i mina'lek i Depattamento. I Direktod, guaha fuetsa-na na para hu cho'gue este siha na areklamento.

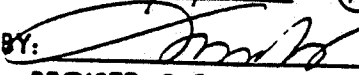
Sigun gi sinangan yan i atoridad, I Direktod ha adapta na para humaenda probinsion i apas i setbision mediku. I Depattamento ha adapta para hu tulaika osino ha establesi i apas para i sigiente siha na setbisio:

- A. Setbision Mediku Siha
  - a. Professinat Na Setbisio
  - b. Respiratory Therapy
  - c. Physical Therapy
- B. Setbision Operation siha
- C. Ma Atienden i man managu yan man mapotge' siha
- D. Setbision Labatorio
- E. Setbision Radiology siha
- F. Kuatto, nengkano yan otro siha na apas
- G. Dental Services

I kopian este na amendasion, sina ma'chu'le ginen i ufusinan i Direktod gi Commonwealth Health Center.

  
Dr. Jose L. Chong  
Director of Public Health and  
Environmental Services

2/19/92  
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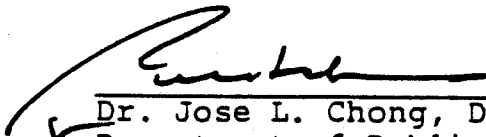
Adaptaal Lliiwelil Alleghul Espitood Reel Abwossul Medical Service Bwulasiyool Public Health Me Environmental Services.

Reel aileewal alleghul towlap ye (Public Law 1-8, Chapter 12, Section 4, nge Dipatamentool Public Health Fengal me Environmental Services (DPHS&ES), eyoor bwangil bwe ebwe ifeer me bweibwogh allegh reel milikka ebwe fil ngali mwoghutughutul me lemelemil bwulasiyo yeel reel meta kka ebwe emmwelil tepengiir aramas reel. Samwoolul Bwulasiyo yeel, nge emmwel ngali me eyoor bwangil bwe ebwe feeru me alegheleghulo allegh kkaal.

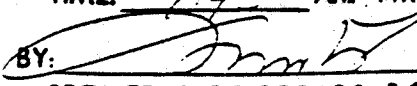
Reel aileewal me bwangil, nge Direktood aa adaptaalil lliiwelil abwossul espitood me sedbisyool. Bwulasiyo yeel aa adapta me feerii abwossul tappal kka faal:

- A. Medico me akkaaw alillis
  - a. Professional me akkaaw alillis
  - b. Respiratory Therapy
  - c. Physical Therapy
- B. Alillisil tittil me anesthesia
- C. Ammweler mal bwoobwo me mal lailai
- D. Alillisil Laboratorio me Pathology
- E. Alillisil Radiology
- F. Kuation, mungo me akkaaw alillis
- G. Dental Serives

KKoopiyal adaptal abwos kkaal nge emmwel aramas ebwello bweibwogh mellol Bwulasiyool Direktoodul Commonwealth Health Center.

  
Dr. Jose L. Chong, Director  
Department of Public Health  
& Environmental Services

  
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REGISTRAR OF CORPORATIONS Commonwealth of the Northern Mariana Islands

COMMONWEALTH HEALTH CENTER  
HOSPITAL DIVISION  
PROPOSED FEE  
FISCAL YEAR 1992

DEFINITIONS AND ITEMS OF COMMONALITY

The descriptive terms and numerical identifying codes for medical services and procedures used in the Proposed Fee Schedule are based on Current Procedural Terminology, Fourth Edition (CPT-4).

Terms and phrases common to the practice of medicine that are used in Proposed Fee are defined as follows:

**Current Procedural Terminology (CPT):** Is a listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians. The purpose of the terminology is to provide a uniform language that will accurately describe medical, surgical, and diagnostic services, and will thereby provide an effective means for reliable nationwide communication among physicians, patients, and third parties. CPT 1990 is the most recent revision of the book.

**New Patient:** A patient who is new to the physicians and whose medical and administrative records need to be established.

**Established Patient:** A patient whose medical and administrative records are available to the physician. The designation of new or established patient does not preclude the use of specific level of service.

**Levels of Service:** Examinations, evaluations, treatment, conferences with or concerning patients, preventive pediatric and adult health supervision, and similar medical services necessitate the wide variations in skill, effort, time, responsibility and medical knowledge required for prevention or diagnostic and treatment of illness and the promotion of optimal health. Each level of service may be used by all physicians. Six levels are recognized:

**Minimal Level of Service:** A level of service supervised by a physician but not necessarily requiring his presence. For example, injections, minimal dressings, removal of sutures, etc.

**Brief Level of Service:** A level of service pertaining to the evaluation and treatment of a condition requiring only an abbreviated history and examination. For example, acute tonsillitis, minor trauma, review of recent X-ray report, etc.

Limited Level of Service: A level of service pertaining to the evaluation of a circumscribed acute illness or to the periodic reevaluation of a problem including an interval history and examination, the review of effectiveness of past medical management, the ordering and evaluation of appropriate diagnostic tests, the adjustment of therapeutic management as indicated, and the discussion of findings and/or medical management.

For example: treatment of acute respiratory infection; review of interval history; physical status and control of diabetic patient; review of recent history, determination of blood pressure; etc.

Intermediate Level of Service: (A complete history and physical examination of one or more organ systems, but not requiring a comprehensive evaluation of the patient as a whole.)

A level of service pertaining to the evaluation of a new or existing condition complicated with a new diagnostic or management problem not necessarily relating to the primary diagnostic that necessitates the obtaining and evaluation of pertinent history and physical or mental status findings, diagnostic tests and procedures, and the ordering of appropriate therapeutic management; or a formal patient, family, or hospital staff conference regarding patient medical management and progress.

For example: evaluation of a patient with arteriosclerotic heart disease; review of interval history, reexamination of musculoskeletal systems; conference with patient and/or family to review studies, hospital course, and findings; etc.

Extended Level of Service: A level of service requiring an unusual amount of effort or judgement including a detailed history, review of medical records, examination, and a formal conference with the patient, family or staff; or a comparable medical diagnostic and/or therapeutic service; but necessitating a complete examination or reexamination of the patient as a whole.

For example: Reexamination of neurological findings; review of results of diagnostic evaluation; reevaluation of a psychotic delusional patient; etc.

Comprehensive Level of Service: (A complete evaluation of the patient.)

A level of service providing an in-depth evaluation of a

patient with a new or existing problem requiring the development or complete reevaluation of medical data. This procedure includes the recording of a chief complaint(s), and present illness, family history, past medical history, personal history, system review, a complete physical examination, and the ordering of appropriate diagnostic tests and procedures.

**Inpatient Hospital Care:**

Initial Hospital Inpatient Care(90200): Signifies a level of service for a condition involving variables for which neither comprehensive or intermediate initial hospital care services are appropriate. This procedure includes documentations of the indication for inpatient medical care, abbreviated history, pertinent examination and a plan of investigation and/or medical management.

Intermediate Initial Hospital Care(90215): A service involving the evaluation or re-evaluation of a patient with an acute or active problem(s) that require hospitalization. This procedure includes the recording of the chief complaint, present illness or current medical history, and an appropriate physical examination related to the acute or active problem in a patient who has had a previously documented evaluation that is current and available to the physician, and the ordering of appropriate medical diagnostic tests and procedures.

Comprehensive Initial Hospital Inpatient Care(90220): see Comprehensive Level of Service Definition.

Hospital Discharge Day Management: Preparation of patient for discharge and preparation of discharge records.

Referral: A referral is the transfer of the total or specific care of a patient from one physician to another and does not constitute a consultation. Initial evaluation and subsequent services are designated as listed in Levels of Service.

Consultation: Includes services rendered by a physician whose opinion or advice is requested by a physician or other appropriate source for the further evaluation and/or management of the patient. A consultant initiates diagnostic or therapeutic services at the request of the attending physicians. The consultant must document that he has recommended a course of action to the attending physician and is initiating treatment at his request. When the consulting physician assumes responsibility for the continuing care of the patient, any subsequent services rendered by him will cease to be



consultation. The five levels of consultation are as follows:

Limited: The physician confines his service to the examination or evaluation of a single organ system. This procedure includes documentation of the complaint(s), present illness, pertinent examination, review of medical data and establishment of a plan of management relating to the specific problem. An example might be a dermatological opinion about an uncomplicated skin lesion.

Intermediate: Involves examination or evaluation of an organ system, a partial review of the general history, recommendations and preparation of a report. An example would be the evaluation of the abdomen for possible surgery that does not proceed to surgery.

Extended: Involves the evaluation of problems that do not require a comprehensive evaluation of the patient as a whole. This procedure includes the documentation of a history of the chief complaint(s), past medical history and pertinent physical examination, review and evaluation of the past medical data, establishment of a plan of investigative and/or therapeutic management, and the preparation of an appropriate report.

Comprehensive: Involves an in-depth evaluation of a patient with a problem requiring the development and documentation of medical data (the chief complaints, present illness, family history, past medical history, personal history, system review and physical examination, review of all diagnostic tests and procedures that have previously been done), the establishment or verification of a plan for further investigative and/or therapeutic management and the preparation of a report.

Complex: Is an uncommonly performed service that involves an in-depth evaluation of a critical problem that requires unusual knowledge, skill and judgment on the part of the consulting physician, and the preparation of an appropriate report.

Unlisted Procedures or Services: This is for services or procedures performed by physicians that are not found in CPT. A number of specific code numbers have been designated for reporting unlisted procedures. When an unlisted procedure number is used, the service or procedure should be described.

**MEDICINE SERVICES:** (Definition or Identification of other items unique to Medicine Services.)

Modifiers: Listed services and procedures may be modified under certain circumstances. The modifying circumstances will be identified by the addition of the appropriate modifier code. The modifier will be reported by two digit number placed after the usual procedure number from which it is separated by a hyphen. The most commonly used are as follows:

-22 Unusual Services: When the service(s) provided is greater than that usually required for the listed procedure.

-52 Reduced Services: Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's election. Under these circumstances the service provided is identified by its usual procedure number and the addition of the modifier -52, signifying the service is reduced. This provides means of reporting reduced services without disturbing the identification of the basic service.

-90 Reference (Outside) Laboratory: When Laboratory procedures are performed by a party other than the Hospital Laboratory Facility.

Materials Supplied By Physician: Supplies and materials provided to patients (eg, sterile trays/drugs), over and above those usually included with the office visit or other services rendered.

Critical Care: Includes the care of critically ill patients in a variety of medical emergencies that requires the constant attention of the physician (eg, cardiac arrest, shock, bleeding, respiratory failure, etc.) Critical Care is usually, but not always, given in a critical care area, such as ICU or the emergency care facility.

**ANESTHESIA SERVICES:** (Definitions and Identifications of other items unique to Anesthesia Services.)

Anesthesia services may include but are not limited to general, regional, supplementation of local anesthesia, or other supportive services in order to afford the patient the anesthetic care deemed optimal by the anesthesiologist during any procedure.

**COMPUTATION OF ANESTHESIA SERVICE FEE:**

Charges for anesthesia service are calculated by multiplying total anesthesia value by the proposed relative value fee of \$25.00.

or

TOTAL ANESTHESIA FEE = (BASIC VALUE {as listed or modified}  
+ TIME UNITS) x PROPOSED FEE OF \$25

Anesthesia Value is determined by adding a Basic Value, which is related to the complexity of the service, plus Modifying Units (if any), plus Time Units.

Basic Value: CHC is using the basic value listed in the Relative Value Guide published by the American Society of Anesthesiologists. The latest revision is the Relative Value Guide for 1990.

The Basic Value for anesthesia when multiple surgical procedures are performed during a single anesthetic administration is the Basic Value for the procedure with the highest unit value.

Time Units are computed by allowing one unit for each fifteen (15) minutes of anesthesia time.

Time Reporting: Time reported for anesthesia procedures. Anesthesia time begins when the anesthesiologist begins to prepare the patient for the induction of anesthesia in the operating room or in an equivalent area and ends when the anesthesiologist is no longer in personal attendance, that is, when the patient is safely placed under postoperative supervision.

Modifying Units: See definition of Modifiers previous page.

**SURGERY SERVICES:** (Definitions and Identifications of other items unique to Surgery Services.)

Surgical procedures include the surgery, local infiltration, metacarpal/digital block or topical anesthesia when used, and the normal, uncomplicated follow-up care.

Unlisted Surgery Procedure: A surgery procedure not listed in CPT. Such procedures are reported using appropriate unlisted surgery procedure code and a special report.

## SURGICAL PROCEDURE MODIFIERS

Unusual Surgical Services (Code -22)

Reduced Surgical Services (Code -52)

Surgical Assistants (Code -80) Add modifier -80 to the listed surgery procedure to identify charges for Surgical Assistants.

By Report (BR): BR in the value column indicates that the value of the surgery procedure is to be determined "by report," because the service is too unusual or variable to be assigned a value.

Service "Sv" Items: "Sv" in the value columns indicates that the value is to be calculated as the sum of various services rendered at the Hospital.

Asterisk (\*) Items: Where an asterisk (\*) precedes a procedure number the following rules apply:

- a) The listed value is for Surgical Procedure Only.
- b) When a starred (\*) procedure requires hospitalization, an appropriate hospital visit is listed in addition to the starred (\*) procedure and its follow-up care.
- c) All Post-Operative Care is to be added on a fee-for-service basis (eg, office or hospital visit, cast change).

**MATERNITY CARE AND DELIVERY SERVICES:** (Definitions and Identifications of other items unique to Maternity Care and Delivery Services.)

All Inclusive, "Global" Obstetric Care: This is for uncomplicated maternity cases (which is either vaginal or cesarean section delivery). "Global obstetric care includes antepartum care, delivery, and postpartum care.

Antepartum Care: Initial and subsequent history, physical examination, recording of weight, blood pressure, fetal heart tones, routine chemical urinalysis, and monthly visits up to 28 weeks gestation, bi-weekly visits to 36 weeks gestation, and weekly visits until delivery. Any other visits or services within this period are an additional charge and should use a separate procedure code.

Postpartum Care: Hospital and Office visits following vaginal or cesarean section delivery.

Incomplete Global Obstetric Care: Charge antepartum or postpartum care if delivery is not performed by CHC physician due to termination of pregnancy by abortion or referral to another physician for delivery.

LABORATORY SERVICES: (Definitions and Identifications of other items unique to Laboratory Services.)

Panel (Profile) Tests: Certain multiple tests performed on a single specimen of blood or urine. They are distinguished from the single or multiple test(s) performed on an "individual," "immediate," or "stat" reporting basis.

PHARMACEUTICAL AND MEDICAL SUPPLIES:

Retail price for pharmaceutical and medical supplies is computed based on actual landed costs plus administrative overhead. The average cost method is used in computing the inventory costs. Minimum Fee for both pharmaceutical and medical supplies is \$3.00.

The proposed fees once adopted will supercede all previously established Hospital fees.

COMMONWEALTH HEALTH CENTER  
HOSPITAL DIVISION  
PROPOSED MEDICAL SERVICES FEES  
- PROFESSIONAL SERVICES  
FISCAL YEAR 1992

CPT DESCRIPTION	CPT CODE	PROPOSED FEE
Office and other outpatient medical services.		
New Patient: Brief Service		
-Limited Service	90000	\$28
-Intermediate Service	90010	\$36
-Extended Service	90015	\$48
-Comprehensive	90017	\$60
-Minimal Service	90020	\$80
	90030	\$10
Office and other outpatient medical services.		
Established Patients: Brief Visit		
-Limited Services	90040	\$18
-Intermediate Service	90050	\$26
-Extended Service	90060	\$38
-Comprehensive Service	90070	\$50
	90080	\$70
Initial Hospital Care: Brief History and Examination, initiation of diagnostic and treatment programs, and preparation of Hospital Records		
-Intermediate History	90200	\$50
-Comprehensive History	90215	\$100
-Newborn Care	90220	\$150
	90225	\$75
Subsequent Hospital Care, Each Day: Limited Service		
-Intermediate Service	90240	\$30
-Extended Service	90260	\$40
-Comprehensive Service	90270	\$55
-Normal Newborn Service	90280	\$85
Hospital discharge day management	90282	\$50
Emergency Department Service:	90292	\$25
-Brief Service		
-Limited Service	90505	\$35
-Intermediate Service	90510	\$45
-Extended Service	90515	\$70
-Comprehensive Service	90517	\$110
	90520	\$130
Initial and Follow-up Consultation: Pediatric Only:		
-Limited		
-Brief	90600	\$20
-Intermediate	90640	\$30
-Extensive	90605	\$40
-Comprehensive	90610	\$50
-Complex	90620	\$60
	90630	\$85
Initial Consultation (Other Specialty Fields):		

COMMONWEALTH HEALTH CENTER  
HOSPITAL DIVISION  
PROPOSED MEDICAL SERVICES FEES  
- PROFESSIONAL SERVICES  
FISCAL YEAR 1992

CPT DESCRIPTION	CPT CODE	PROPOSED FEE
-Limited	90600	\$30
-Intermediate	90605	\$55
-Extensive	90610	\$75
-Comprehensive	90620	\$100
-Complex	90630	\$120
Follow-up Consultation (Other Specialty Fields):		
-Brief	90640	\$40
-Limited	90641	\$55
-Intermediate	60942	\$75
-Complex	90643	\$100
Confirmatory and Additional Opinion Consultation: Limited	90650	\$35
Intermediate	90651	\$45
Extended	90652	\$60
Comprehensive	90653	\$85
Complex	90654	\$110
Unlisted Medical Services. General (specify procedure)	90699	BF
Hemodialysis procedures/treatment	90937	\$400
Hemodialysis service charge for visiting Patient	90999	\$30
Hemodialysis Treatment Kit	99070	Actual Cost plus Admin. Overhead
ECG (EKG). Routine. with interpretation and report	93000	\$40
ECG (EKG). Routine. tracing only (w/out interpretation and report)	93005	\$30
ECG (EKG). Routine. interpretation and report only	93010	\$20
<b>SPECIAL SERVICES AND REPORTS:</b>		
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Materials supplied by physicians (including anesthesia supplies)	99070	Actual Cost plus Admin. Overhead
Medical Testimony - per hour	99075	\$50
Special Reports (insurance form. review of medical records): per 30 minutes	99080	\$10
Patient Escort	99082	Actual Cost
Critical Care. Initial. Including the Diagnostic and Therapeutic services and direction of care of the critically ill or multiple injured or comatose patient requiring		

COMMONWEALTH HEALTH CENTER  
HOSPITAL DIVISION  
PROPOSED MEDICAL SERVICES FEES  
- PROFESSIONAL SERVICES  
FISCAL YEAR 1992

CPT DESCRIPTION	CPT CODE	PROPOSED FEE
the prolonged presence of the physician: each hour	99160	\$100
Critical Care. Initial. Including Diagnostic: each additional 30 minutes	99162	\$30



COMMONWEALTH HEALTH CENTER  
HOSPITAL DIVISION  
PROPOSED MEDICAL SERVICES FEES  
- RESPIRATORY THERAPY  
FISCAL YEAR 1992

CPT DESCRIPTION	CPT CODE	PROPOSED FEE
Cardiovascular Stress Test using maximal or submaximal treadmill or bicycle exercise: continuous electrocardiographic monitoring, with interpretation and report	93015	\$160
Electrocardiographic Monitoring for 24 hours by continuous original ECG waveform recording and storage without superimposition scanning utilizing a device capable of producing a full miniaturized printout: includes recording, microprocessor-based analysis with report, physicians review and interpretation(HM)	93230	\$150
Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), and/or maximal voluntary ventilation (PFT)	94010	\$40
Bronchospasm evaluation: spirometry as in 94010, before and after bronchodilator (aerosol or parenteral) or exercise (PFT)	94060	\$80
Ventilator assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; first day	94656	\$350
Ventilator assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; subsequent days (prorated by actual hours used)	94657	\$300
Aerosol or vapor inhalations for sputum mobilization, bronchodilation, or sputum induction for diagnostic purposes: initial demonstration and/or evaluation (H/H Nebulizer Tx. or Sputum Induction)	94664	\$30
Aerosol or vapor inhalations for sputum mobilization, bronchodilation, or sputum induction for diagnostic purposes: subsequent (H/H Nebulizer Tx. or Sputum Induction)	94665	\$30
Manipulation chest wall, such as cupping, percussing, and vibration to facilitate lung function (Chest Physiotherapy)	94667	\$40
Analysis of Arterial Blood Gas (oxygen saturation, pO2, pCO2, CO2, pH)	94700	\$60

COMMONWEALTH HEALTH CENTER  
HOSPITAL DIVISION  
PROPOSED MEDICAL SERVICES FEES  
- RESPIRATORY THERAPY  
FISCAL YEAR 1992

CPT DESCRIPTION	CPT CODE	PROPOSED FEE
Noninvasive ear or pulse oximetry for oxygen saturation: single determination	94760	\$20
Carbon dioxide, expired gas determination by infrared analyzer (END Tidal CO2 Monitor)	94770	\$30
Oxygen	94799	\$1 per hr
Respiratory Therapy: Patient Instruction	94799	\$10
Oxyhood	94799	\$20
Oxygen Tent	94799	\$20
Respiratory Therapy Code Blue Assistance; per hour	94799	\$30
STAT Fee	94799	\$10
Unlisted Pulmonary Services Procedures (specify procedure)	94799	BR
Electroencephalogram	95821	\$120
Respiratory Therapy Disposable Equipment	99070	Actual Cost plus Admin. Cost

COMMONWEALTH HEALTH CENTER  
HOSPITAL DIVISION  
PROPOSED MEDICAL SERVICES FEES  
- PHYSICAL THERAPY  
FISCAL YEAR 1992

CPT DESCRIPTION	CPT CODE	PROPOSED FEE
Muscle testing: extremity(excluding hand) or trunk, with report	95831	\$25
Muscle testing: hand (with or without Comparison with normal side)	95832	\$35
Muscle testing: total evaluation of body excluding hands	95833	\$100
Muscle testing: total evaluation of body, including hands	95834	\$130
Range of motion measurement & report: each extremity, excluding hand	95851	\$35
Range of motion measurement & report: hand, with or w/out comparison with normal side	95852	\$40
Assessment of higher cerebral function with medical interpretation; developmental testing	95881	\$20
Assessment of higher cerebral function with medical interpretation; cognitive testing and others	95882	\$20
Physical Medicine Treatment to one area: Hot/Cold Packs	97010	\$20
Physical Medicine Treatment to one area: Mechanical traction	97012	\$25
Physical Medicine Treatment to one area: Electrical Stimulation (unattended)	97014	\$20
Physical Medicine Treatment to one area: Paraffin Bath	97018	\$25
Physical Medicine Treatment to one area: Whirlpool	97022	\$25
Physical Medicine Treatment to one area: Diathermy	97024	\$20
Physical Medicine Treatment to one area: Ultraviolet	97028	\$20
Physical Medicine Treatment to one area: Unlisted Modality	97039	\$20
Physical Medicine to one area, initial 30 minutes, each visit: Therapeutic exercis	97110	\$30
Physical Medicine to one area, initial 30 minutes, each visit: Neuromuscular reeducation	97112	\$45
Physical Medicine to one are, initial 30 minutes, each visit: Functional activities	97114	\$45
Physical Medicine to one area, initial 30		

COMMONWEALTH HEALTH CENTER  
HOSPITAL DIVISION  
PROPOSED MEDICAL SERVICES FEES  
- PHYSICAL THERAPY  
FISCAL YEAR 1992

CPT DESCRIPTION	CPT CODE	PROPOSED FEE
minutes, each visit: Gait training Physical Medicine to one area, initial 30	97116	\$22
minutes, each visit: Electrical Stimulation (manual)	97118	\$30
Physical Medicine to one area, initial 30 minutes, each visit: Massage	97124	\$30
Physical Medicine to one area, initial 30 minutes, each visit: Ultrasound	97128	\$15
Physical Medicine to one area, initial 30 minutes, each visit: Cardiac Rehab.	97139	\$15
Physical Medicine to one area, initial 30 minutes, each visit, Splinting	97139	\$30
Physical Medicine to one area, initial 30 minutes: debridement	97139	\$30
Physical Medicine to one area, initial 30 minutes, each visit: Unlisted Procedure (specify procedure)	97139	BR
Physical Medicine treatment to one area, each additional 15 minutes	97145	\$20
Orthotics training, upper extremities; initial 30 minutes, each visit	97500	\$25
Orthotics training, upper extremities; each additional 15 minutes	97501	\$10
Prosthetic training: initial 30 minutes, each visit	97520	\$25
Prosthetic training: initial 30 minutes, each additional 15 minutes	97521	\$10
Kinetic activities, coordination, initial 30 minutes, each visit	97530	\$20
Kinetic activities, coordination, each additional 15 minutes	97531	\$10
Training Activities of Daily Living: initial 30 minutes, each visit	97540	\$25
Training Activities of Daily Living: each additional 15 minutes	97541	\$8
Office visit, with report: activities of daily living check-out: initial 30 minutes each visit	97700	\$45
Office visit, with report: activities of daily living check-out: each additional 15 minutes	97701	\$15
Sensory Mapping	97799	\$19