

## UTMB COMPLIANCE STANDARD

UTMB OFFICE OF INSTITUTIONAL COMPLIANCE	mm/dd/yy	-Effective
Documentation, Billing, and Coding Policy	mm/dd/yy	-Revised

### Billing for Pulse Oximetry

<b>Purpose</b>	To define the requirements for billing pulse oximetry at UTMB
<b>Audience</b>	Physicians, Non-Physician Providers, Department Administrators, Billing Managers, Billing and Coding Staff
<b>Policy</b>	Billing for pulse oximetry requires that the appropriate code is selected, that there is a specific physician order, and that medical necessity is supported in the medical record. UTMB will follow the procedure described below to ensure accurate billing for pulse oximetry.
<b>Procedure CPT</b>	<p>There are currently three levels of pulse oximetry listed in Current Procedural Terminology (CPT) 2006.</p> <ul style="list-style-type: none"><li>• 94760 (Non-invasive ear or pulse oximetry for oxygen saturation; single determination) should be used when the physician orders a single one-time reading of the oxygen saturation (O<sub>2</sub>sat) level. This code should not be billed when pulse oximetry is used routinely as a vital sign or when it is performed by a nurse as part of a routine assessment without a physician order and/or specific medical necessity.</li><li>• 94761 (Non-invasive ear or pulse oximetry for oxygen saturation; multiple determinations, e.g. during exercise) should be used to code oximetry when the physician orders more than one measurement (but not continuous monitoring). The measurement device can stay in place but several separate measurements (i.e., during a stress test, during oxygen treatment) should be documented.</li><li>• 94762 (Non-invasive ear or pulse oximetry for oxygen saturation; by continuous overnight monitoring, separate procedure) should be billed when continuous measurement is ordered and documented.</li></ul>
<b>Medicare</b>	If pulse oximetry is used during spirometry, vital capacity, or other pulmonary testing, it should be coded and billed. However, for Medicare the reimbursement will be packaged into the primary procedure. Medicare considers pulse oximetry to be a technical only

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<b>Medicaid</b>	<p>charge. In a provider based setting it is billed with the CDM code only (the four digit code). The physician billing is accounted for by including the interpretation as part of the E/M. In a office based setting, the place of service determines the reimbursement. Pulse oximetry interpretation is considered bundled for physician billing for critical care services.</p> <p>Please note that Medicare has a National Coverage Decision regarding diagnoses covered by Medicare for pulse oximetry.</p> <p>Medicaid does not cover standard pulse oximetry (94760) when billed on the same day by the same provider as an outpatient office visit (99201-99205 or 99211-99215) or an outpatient consultation (99241-99245). Medicaid also considers 94760 or 94761 performed with surgical or anesthesia services to be incidental to the surgery or anesthesia.</p> <p>Noninvasive oximetry may not be billed separately when used for monitoring a patient on conscious/moderate sedation. It is bundled in the description for conscious/moderate sedation.</p> <p>Separate billing for pulse oximetry services is no longer required by CMS for billing observation services for covered diagnoses; however, any pulse oximetry ordered and performed should be documented and may be separately billable.</p>
<b>References</b>	<p>Current Procedural Terminology (CPT) 2006, American Medical Association</p> <p>CPT Assistant, February 1997 page 10, July 1998 page 2, June 1999 page 10</p> <p>Trailblazer Health Enterprises, online FAQs</p> <p>Trailblazer Health Enterprises online Physician Fee Schedule</p> <p>Texas Medicaid Provider Manual 2005, 34-9, 34-17, and 34-28</p>