Codify
BY AAPC

Internal Medicine Coding Alert

Reader Questions: Unbundling Error Costs Practice $2.50+

Question: On a claim for 94760-91 x 2, the insurer denied the second pulse oximetry as unbundled to the first one (which was paid). What is the difference between 94760 and 94761?

New York Subscriber

Answer: Both codes describe pulse oximetry (Noninvasive ear or pulse oximetry for oxygen saturation ...), but 94760 is for a "single determination," and 94761 describes "multiple determinations." You should assign:

• 94760 if the internist takes a single reading.

• 94761 if he performs two or more readings. For instance, an internist takes a patient's resting pulse oxygen rate, has the patient walk around and then checks the rate again.

Impact: The descriptors for codes 94760-94761 mean the following rules apply:

1. "The appropriate quantity (units) for CPT codes 94760 or 94761 is one on any given date of service," according to Empire Medicare Services coding guidelines.

2. When a physician performs 94760 and 94671 on the same date of service, "reimbursement for procedure code 94760 is included in the payment for procedure code 94761," states the local coverage determination for Empire (Part B carrier for New York, Connecticut, Delaware and Massachusetts).

Bottom line: The insurer in the scenario you describe was correct to deny your claim for two units of 94760. But you should resubmit the claim requesting payment on 94761 (0.13 total nonfacility relative value units or $4.93 using the 2006 National Physician Fee Schedule) instead of on 94760 (0.06 RVUs or $2.27 national unadjusted rate).

You should also not append pulse oximetry codes with modifier 91 (Repeat clinical diagnostic laboratory test). Reserve this modifier for lab tests, of which pulse oximetry is not one.