

Payment Policy: Pulse Oximetry with Evaluation & Management Services

Reference Number: CC.PP.025

Product Types: ALL

Effective Date: 01/01/2014

Last Review Date: 10/13/2025

[Coding Implications](#)
[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Policy Overview

The purpose of this policy is to define payment criteria for pulse oximetry testing when billed separately from an office visit.

Pulse oximetry testing involves application of an electronic oximetry device, typically attached to the finger or ear. The device monitors the amount of oxygen bound to hemoglobin in the bloodstream. The results are provided as a percentage of the maximum binding capacity of oxygen to hemoglobin. A normal oxygen saturation level is between 95-100 percent. The electronic oximetry device may also provide a readout of a patient's pulse rate.

Application

This policy applies to Professional Claims.

Policy Description

Reimbursement

The health plan will deny pulse oximetry when billed with an evaluation and management (E/M) service when billed on the same date by the same provider.

When pulse oximetry is billed with an E/M visit, pulse oximetry will be denied and bundled into the E/M service. Pulse oximetry represents a fundamental component of the assessment services provided to a patient during a procedure and therefore is not separately reimbursable.

Rationale for Edit

Per the Centers for Medicare and Medicaid Services (CMS) NCCI Policy Manual (2025),

Many procedures require cardiopulmonary monitoring either by the physician performing the procedure or an anesthesia practitioner. Since these services are integral to the procedure, they are not separately reportable (p. I-10).

CMS assigns CPT codes 94760 and 94761 (noninvasive ear or pulse oximetry) to a status indicator of "T" in the National Physician Fee Schedule Relative Value File (RVU). Status T procedures are only paid if there are no other services paid under the physician's fee schedule billed on the same date by the same provider. Per chapter 23 of the Medicare Claims Processing Manual: 30.2.2 - MPFSDB Status Indicators

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If any other services payable under the physician fee schedule are billed on the same date, by the same provider, these services are bundled into the physician services for which payment is made.

Coding and Modifier Information

This payment policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT® codes and descriptions are copyrighted 2026, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this payment policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

References

1. Current Procedural Terminology (CPT®), 2026
2. Centers for Medicare and Medicaid Services, Physician Fee Schedule, Relative Value File 2025 <https://www.cms.gov/medicare/payment/fee-schedules/physician/pfs-relative-value-files>
3. Centers for Medicare and Medicaid Services, National Correct Coding Initiative Policy Manual, Chapter I, General Correct Coding Policies, 2025 <https://www.cms.gov/files/document/2025nccimedicarepolicymanualcompletepdf.pdf>
4. Medicare Claims Processing Manual, Chapter 23, Fee Schedule Administration and Coding Requirements, 2025 <https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c23.pdf>

Revision History	
02/13/2018	Converted to new template and confirmed codes
03/04/2019	Conducted review, verified codes, and updated policy
11/01/2019	Annual Review completed
11/01/2020	Annual Review completed
11/30/2021	Annual review completed; no major updates required
12/01/2022	Annual review completed; code table removed to eliminate redundancy
12/15/2023	Annual review completed; dates updated, and references reviewed
02/22/2024	Annual review completed; dates updated, references reviewed, and I added the links for the references.
11/14/2024	Annual Review completed
10/13/2025	Annual review completed; validated policy content, references and links, added revision date

Important Reminder

For the purposes of this payment policy, “Health Plan” means a health plan that has adopted this payment policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any other of such health plan’s affiliates, as applicable.

The purpose of this payment policy is to provide a guide to payment, which is a component of the guidelines used to assist in making coverage and payment determinations and administering

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benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage and payment determinations and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable plan-level administrative policies and procedures.

This payment policy is effective as of the date determined by Health Plan. The date of posting may not be the effective date of this payment policy. This payment policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this payment policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. Health Plan retains the right to change, amend or withdraw this payment policy, and additional payment policies may be developed and adopted as needed, at any time.

This payment policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care and are solely responsible for the medical advice and treatment of members. This payment policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this policy are independent contractors who exercise independent judgment and over whom Health Plan has no control or right of control. Providers are not agents or employees of Health Plan.

This payment policy is the property of Centene Corporation. Unauthorized copying, use, and distribution of this payment policy or any information contained herein are strictly prohibited. Providers, members, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this payment policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this payment policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and LCDs should be reviewed prior to applying the criteria set forth in this payment policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

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