



ASE - Frequently Asked Questions – Echocardiography Coding

May 2019

1. We have a MitraClip program. What echocardiography code is reported when the TEE is performed by the echocardiographer during the procedure?

Code 93355 is reported for TEE real-time guidance during the intervention:

93355: Echocardiography, transesophageal (TEE) for guidance of a transcatheter intracardiac or great vessel(s) structural intervention(s) (eg, TAVR, transcatheter pulmonary valve replacement, mitral valve repair, paravalvular regurgitation repair, left atrial appendage occlusion/closure, ventricular septal defect closure) (peri- and intraprocedural), real-time image acquisition and documentation, guidance with quantitative measurements, probe manipulation, interpretation, and reporting, including diagnostic transesophageal echocardiography and, when performed, administration of ultrasound contrast, Doppler, color flow, and 3D.

Doppler, color flow, 3D, and contrast administration are included in this code so separate codes for those services are not reported in addition to 93355.

Documentation in the report should include the description/findings of images, measurements, and interpretation.

CPT guidance:

- Code 93355 is used to report TEE services during transcatheter intracardiac therapies. It is reported once per intervention only by an individual who is not performing the interventional procedure
- Includes:
 - work of passing the endoscopic ultrasound transducer through the mouth into the esophagus, when performed by the individual performing the TEE
 - diagnostic TEE and
 - ongoing manipulation of the transducer to guide sizing and/or placement of implants, determination of adequacy of the intervention, and assessment for potential complications.
- Real-time image acquisition, measurements, and interpretation of image(s), documentation of completion of the intervention, and final written report are necessary

2. How do we distinguish if a TTE exam is complete or limited?

Guidance found in the Echocardiography Introduction Section of the CPT book provides definitions of a complete or limited echo. Thorough documentation of findings and clinical indications will support code selection.

- Complete echo (93306): A complete echocardiogram is one that includes multiple 2D views of all chambers, valves, pericardium, and portions of the aorta, with appropriate measurements. **The inability to visualize or measure the clinically relevant anatomy requires documentation of the attempt.** Additional anatomy and M mode tracings are not required but may also be included.
- Limited echo (93308): A limited examination is usually a follow-up or focused study that does not evaluate all the structures required for a comprehensive or complete echocardiographic exam. As a focused clinical exam, it answers a specific clinical question.
- Documentation: All reports should include an interpretation of the images with quantitative measurements, and clinically relevant and abnormal findings. When images are attempted but not adequately identified, it should be noted in the report. Recorded studies must be available for subsequent review.
- Note: CPT does not specifically describe Doppler or color Doppler requirements.

2. How do I bill 3D for TEE?

To report 3D, code the TEE code with one of the 3D codes below:

- 76376 3d rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; not requiring image postprocessing on an independent workstation
- 76377 3d rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; requiring image postprocessing on an independent workstation

Ensure medical record/report documentation supports the medical necessity for 3D. This should also be reflected in the ICD-10 codes that are reported. Payers/Medicare may or may not reimburse for 3D depending upon their individual policies.

Sample language in some Medicare coverage policies for medical necessity:

- The pre-operative planning of valve repair for multiple etiologies of mitral regurgitation;
- In the assessment of mitral stenosis and in the accurate calculation of mitral valve area;
- Pre-operative planning for diagnosis and treatment of atrial septal defects; and
- Pres-operative and intraoperative planning for interventional cardiac procedures (e.g., transcatheter placement of occluders for atrial septal defects or patent foramen ovals, or paravalvular dehiscence or leaks;
- Intraoperative mapping for atrial ablation procedure.

3. How frequently can a TTE be billed?

The rules of frequency per indication/diagnosis vary by payers (including Medicare). In general, repeat echocardiography studies should be guided by the clinical status of the patient, which may be outlined in coverage policies. Typically, allowed repeat studies are for those that monitor changes in cardiac structure or function when the clinical status of the patient changes, or when disease progression is

otherwise suspected.

4. How is strain imaging reported?

CPT code 0399T is reported for myocardial strain imaging.

- 0399T Myocardial strain imaging (quantitative assessment of myocardial mechanics using image-based analysis of local myocardial dynamics)

The instructions are as follows: (Use 0399T in conjunction with 93303, 93304, 93306, 93307, 93308, 93312, 93314, 93315, 93317, 93350, 93351, or 93355. Report 0399T once per session)

Separate reimbursement of Category III codes is at the discretion of payers. No national relative value units (RVUs) or national payment is assigned.

See the ASE clinical summary to support a request for payment from payers.

asecho.org/wordpress/wp-content/uploads/2016/01/MLM-Revised-Strain-Code-1-6-16.docx

- The following diagnosis codes may be reported for monitoring cardiac toxicity. Note, these codes do not guarantee coverage or payment.

Z08: Encounter for follow-up examination after completed treatment for malignant neoplasm

Z01.818: Encounter for other preprocedural examination

Z51.11: Encounter for antineoplastic chemotherapy

- Code the diagnosis(es) for the initial pre-chemotherapy echo according to the patient's condition (i.e. cancer diagnosis and other clinical conditions). Ensure there is clear documentation in the medical record supporting the necessity of the echocardiogram. If the echocardiogram occurs at the same visit that chemotherapy is initiated, report ICD-10: Z51.11: Encounter for antineoplastic chemotherapy

5. Can I code a congenital echo if congenital heart disease is suspected but not found?

Per CPT Frequently Asked Questions (May 2015, Volume 25, Issue 5, pages 10-11), congenital echo codes should not be used when complex congenital heart disease is suspected but not found on echocardiographic evaluation or for "simple" congenita anomalies such as patent foramen ovale (PFO) or bicuspid aortic valve. In these cases, the non-congenital echocardiography codes (93306-93308) should be used.

Note: When a congenital procedure code is used, it should be "linked" to a congenital ICD-10-CM diagnosis code to ensure appropriate claim processing.

6. If I have specific questions about coding, who do I contact?

The American Society of Echocardiography is proud to continue improving your access to information regarding Cardiovascular Ultrasound Coding and Reimbursement. Use this link to submit coding questions. <https://www.asecho.org/ask-a-coding-expert/>

This reference is for information purposes only. No guarantee of payment is stated or implied. It is the responsibility of the health care provider to properly code and to seek reimbursement for rendered medically appropriate and necessary services

CPT Copyright 2017 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association. Applicable FARS/DFARS Restrictions Apply to Government Use. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.