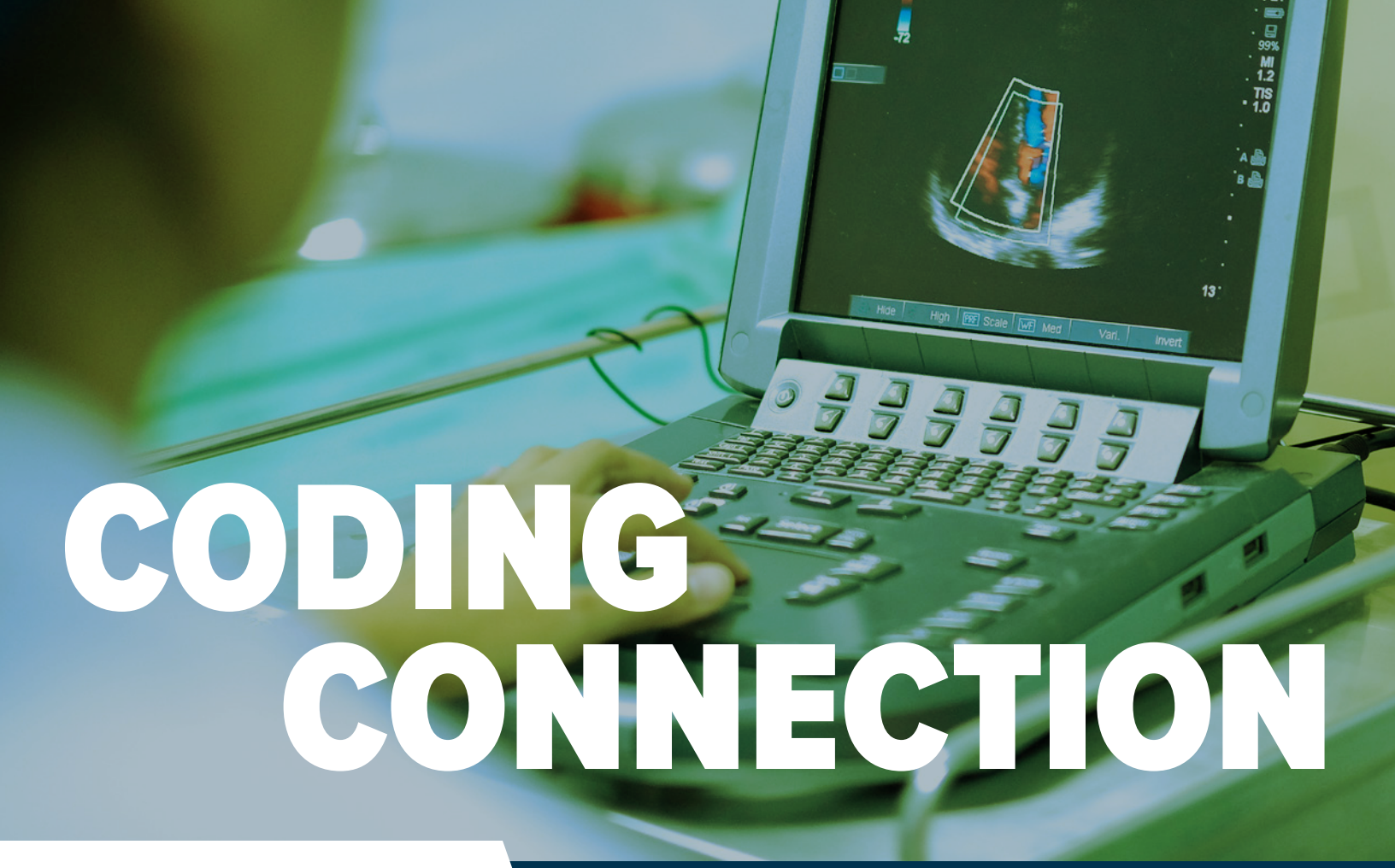


CODING CONNECTION

ASE works closely with other stakeholders to ensure that adequate coding, coverage, and reimbursement processes are in place for echocardiography services. It is important for practices and groups to annually review and potentially update documentation in the office and facility to ensure the CPT® codes are accurate and up to date. Our goal is that this newsletter will assist in that process.

ASE American Society of Echocardiography
Sound Saves Lives

JUNE 2025

UNDERSTANDING BILLING DIFFERENCES

Between 93306 and 93308

When billing for transthoracic echocardiograms (TTEs), it's crucial to distinguish between CPT® codes **93306** and **93308**, as they represent **significantly different service levels and reimbursement rates**.

93306

Describes a **comprehensive** transthoracic echocardiogram with Doppler and color flow imaging. This exam includes:

- 2D imaging,
- M-mode recording (when performed),
- Spectral Doppler (pulsed and/or continuous wave),
- Color flow Doppler.

Because of its breadth and inclusion of Doppler analysis, 93306 commands a higher reimbursement and reflects a more detailed assessment of cardiac structure and hemodynamics.

93308

Describes a **limited** or **follow-up** transthoracic echocardiogram. It includes:

- 2D imaging,
- M-mode recording (when performed)

This code does not include Doppler or color flow imaging. This service is typically used for focused studies, such as reevaluating known pathology or monitoring a specific clinical concern without a full cardiac assessment.

Feature	93306 Comprehensive TTE with Doppler	93308 Limited or Follow-up TTE
2D Imaging	✓	✓
M-Mode (if performed)	✓	✓
Spectral Doppler	✓ (Required)	✗ (Not included)
Color Flow Doppler	✓ (Required)	✗ (Not included)
Scope of Exam	Full cardiac assessment	Focused, problem-specific study
Typical Use Case	Initial evaluation or detailed assessment	Follow-up or limited evaluation
Documentation Requirements	Full imaging + Doppler findings	Limited imaging findings

BILLING IMPLICATIONS

- **93306 should be billed when a full cardiac assessment is performed**, including Doppler evaluation of blood flow, assessment of cardiac structure, valve function, blood flow dynamics, and intracardiac pressure gradients.
- **93308 should be billed when only a partial study is medically necessary** to evaluate specific cardiac concerns or monitor known findings, without the full Doppler and color flow components.
- Supporting documentation must clearly justify the level of service billed. Payers may deny **93306** if the full elements, including Doppler, are not documented.

Correctly differentiating between these codes ensures accurate reimbursement and compliance with payer requirements.

The Critical Role of the RUC Process in Shaping Physician Payment

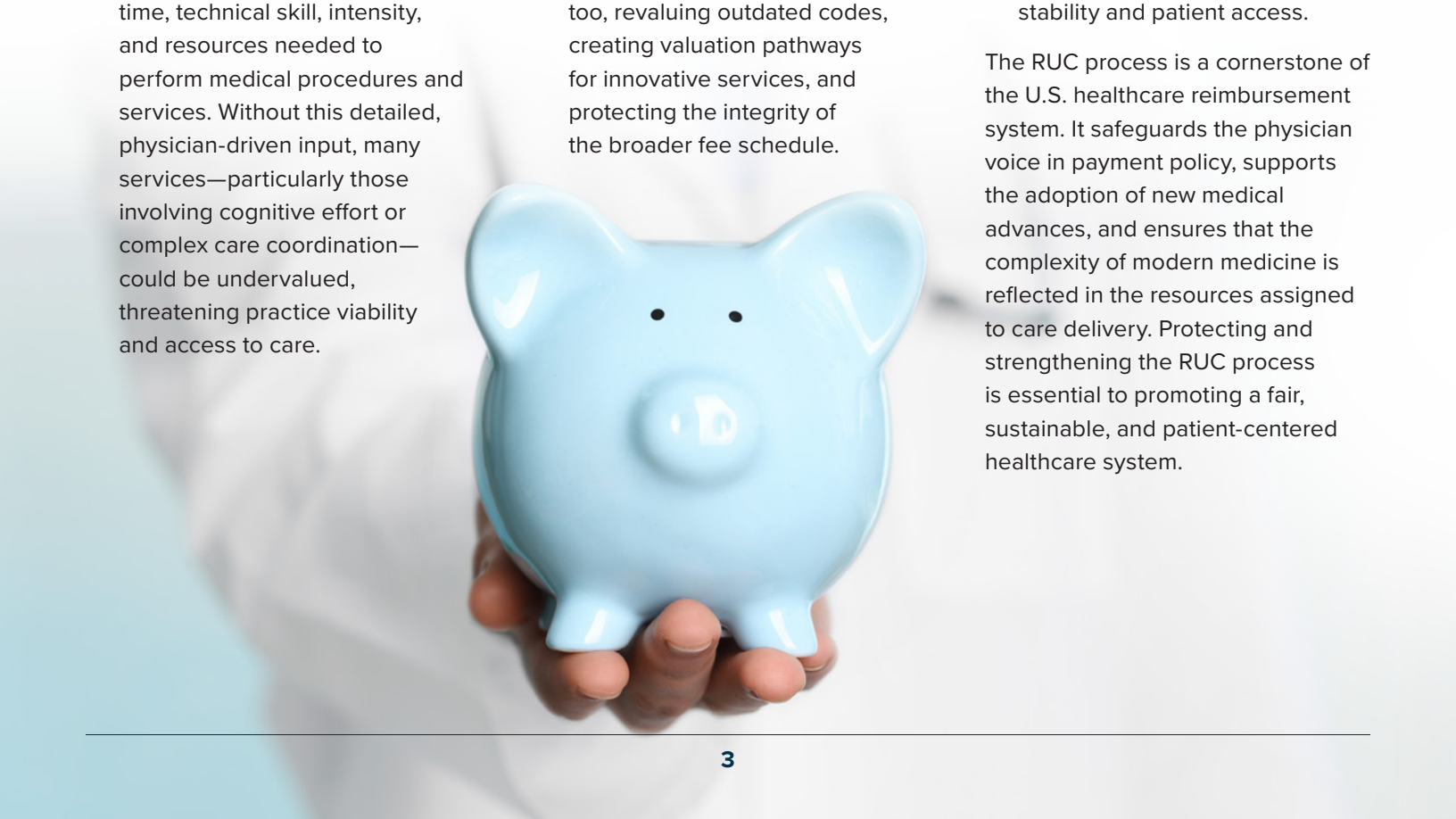
The **Relative Value Scale Update Committee (RUC)** plays a vital role in the U.S. healthcare system by helping to ensure that physician services are appropriately valued under Medicare and often by commercial insurers. Convened by the American Medical Association (AMA), the RUC is a multispecialty panel that reviews, analyzes, and recommends relative value units (RVUs) for new and revised medical services. These RVUs ultimately drive how much physicians are paid for the care they deliver.

WHY THE RUC PROCESS MATTERS:

» **Preserving Fair and Accurate Reimbursement**
The RUC process evaluates the time, technical skill, intensity, and resources needed to perform medical procedures and services. Without this detailed, physician-driven input, many services—particularly those involving cognitive effort or complex care coordination—could be undervalued, threatening practice viability and access to care.

» **Providing Clinical Expertise to Policymakers**
The Centers for Medicare & Medicaid Services (CMS) depends on RUC recommendations when updating the Medicare Physician Fee Schedule. The RUC's expert analyses ensure that reimbursement decisions are informed by frontline physicians relaying clinical realities rather than purely administrative assumptions.

» **Maintaining a Balanced Payment System**
Medicine evolves rapidly. New technologies, procedures, and care models emerge each year. The RUC process ensures that physician payment evolves too, revaluing outdated codes, creating valuation pathways for innovative services, and protecting the integrity of the broader fee schedule.



» **Supporting Specialty Advocacy and Innovation**
The RUC provides a forum where specialties can advocate for fair recognition of their services. It gives medical societies like ASE the opportunity to submit data, highlight practice changes, and promote innovations that enhance patient care.

» **Driving Sustainable Access to Care**
By ensuring that critical services are valued accurately, the RUC supports sustainable practice models—especially in under-resourced fields like primary care, rural medicine, and complex procedural specialties. Fair payment underpins physician workforce stability and patient access.

The RUC process is a cornerstone of the U.S. healthcare reimbursement system. It safeguards the physician voice in payment policy, supports the adoption of new medical advances, and ensures that the complexity of modern medicine is reflected in the resources assigned to care delivery. Protecting and strengthening the RUC process is essential to promoting a fair, sustainable, and patient-centered healthcare system.

WHY YOUR VOICE MATTERS:

How ASE Members Can Engage in the RUC Process

Did you know that ASE members have an opportunity to influence how echocardiography services are valued and reimbursed? Through participation in the AMA's Relative Value Scale Update Committee (RUC) process, your clinical expertise helps ensure valuation reflects the real-world complexity and resource needs of cardiac imaging.

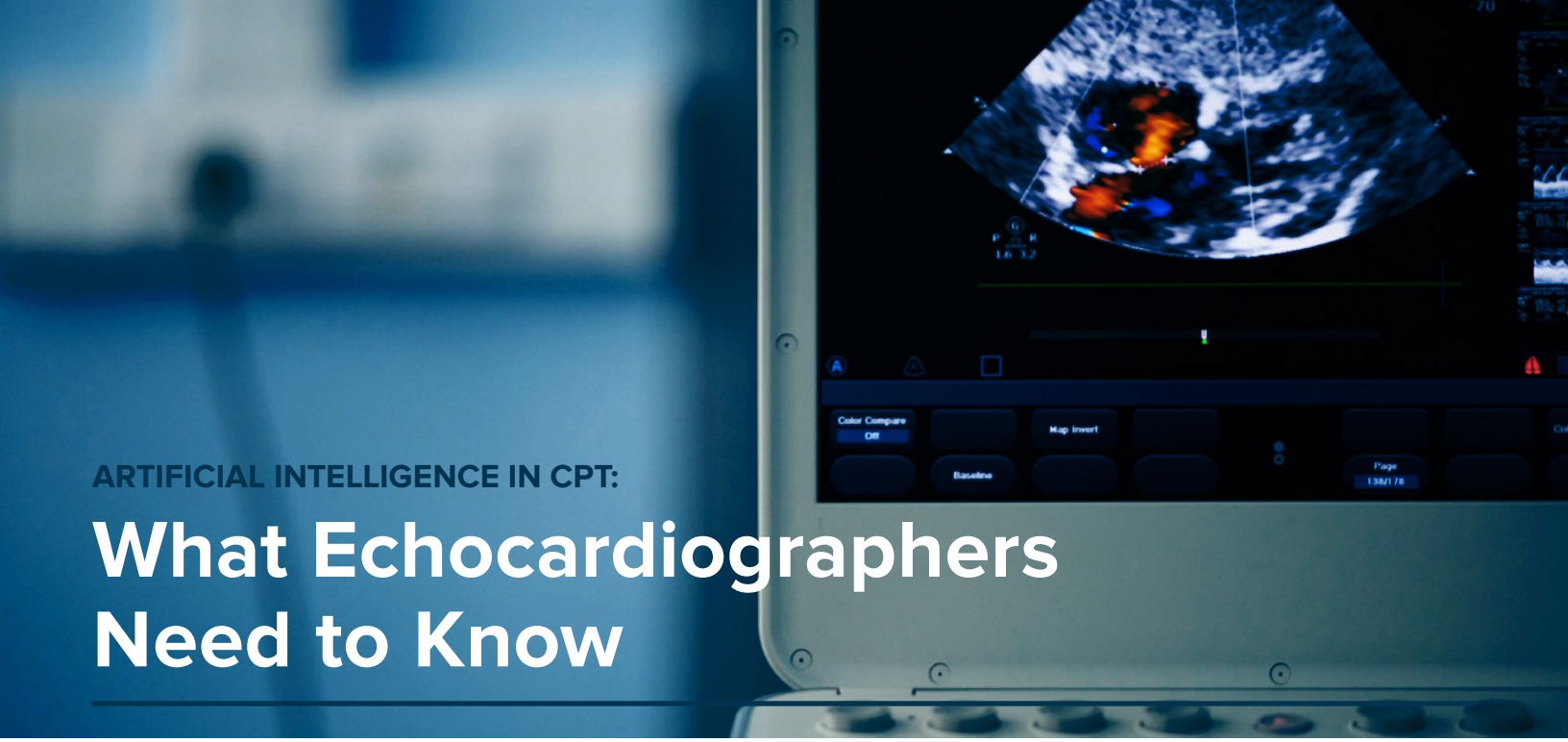
The RUC is responsible for reviewing the time, intensity, and cost associated with medical procedures and making recommendations to the Centers for Medicare & Medicaid Services (CMS). Without strong physician input—especially from ASE members—key echocardiography services risk being undervalued.

HERE'S HOW YOU CAN GET INVOLVED:

- **Complete RUC Surveys Thoughtfully**
  When new or revised CPT codes are under review, ASE distributes specialty-specific surveys. These surveys are critical—they collect data on how long procedures take, how intense they are, and the clinical decision-making involved. Your responses provide the evidence relied upon to assign appropriate value.
- **Support Code Development**
  ASE members can participate in the drafting of new or revised code proposals, clinical vignettes, and service descriptions to guide valuation discussions. Your firsthand experience is invaluable in communicating what it takes to deliver high-quality echocardiographic care.
- **Be an Advocate and Educator**
  Even if you don't join a committee, you can help by encouraging colleagues to participate in surveys and learn about the process. The more our community engages, the stronger ASE's voice becomes.

Bottom line: Participating in the RUC process helps protect fair reimbursement for echocardiography—and ensures our patients continue to receive the high-quality cardiovascular imaging they deserve.

Resources: The RUC Process (video, Completing the RUC Online Survey in Qualtrics (video)



ARTIFICIAL INTELLIGENCE IN CPT:

What Echocardiographers Need to Know

Artificial intelligence (AI) is increasingly being integrated into echocardiography—from automated measurements and image optimization to diagnostic support. As these tools become more common in clinical practice, the CPT code set must adapt to reflect their role in patient care and reimbursement. Importantly, most current tools are augmentative—they support, but do not replace physician interpretation.

CPT'S EVOLVING AI FRAMEWORK

To address emerging technologies, the CPT Editorial Panel has adopted a classification system that distinguishes between:

- **Assistive AI** (e.g., tool helps with image capture)
- **Augmentative AI** (e.g., AI analyzes data but requires physician integration)
- **Autonomous AI** (e.g., AI provides a diagnosis without physician review)

Most AI applications in echocardiography fall into the augmentative category, meaning the physician remains central to interpretation and decision-making.

WHAT ASE IS DOING

ASE is actively engaged in CPT and RUC discussions to ensure AI-assisted echocardiography is appropriately represented. Key issues under review include:

- Whether an AI technologies warrants new CPT code(s)
- Who orders and documents the AI analysis
- How to define the physician's role in reviewing and integrating AI output

ASE is advocating for policies that reflect the clinical value of AI while protecting physician work and fair reimbursement. ASE makes determinations on codes that the Society may support that ensure appropriate reimbursement pathways based on the ASE AI Procedures for CPT Designation.

WHY IT MATTERS

Medicare and commercial payers rely on CPT codes to determine payment. If AI use in echo is not accurately captured, it could lead to confusion, underpayment, or barriers to adoption. ASE's goal is to ensure that any coding changes promote access, innovation, and quality care.

Resources: ASE AI Policy Statement, AMA Appendix S – AI Taxonomy

CY2025 CODING UPDATES:

What You Need to Know

Each year, the release of the new CPT code set brings important changes that impact how physicians report services, document clinical activity, and receive reimbursement. For Calendar Year 2025, updates include new codes that reflect emerging technologies, refinements to remote care services, and ongoing efforts to modernize the CPT code set.

1. NEW CATEGORY III CODE: 0932T FOR AI-ASSISTED ECHO ANALYSIS

Effective January 1, 2025, CPT code 0932T—*Noninvasive detection of heart failure derived from augmentative analysis of an echocardiogram that demonstrated preserved ejection fraction, with interpretation and report by a physician or other qualified health care professional*—has been added to track the use of artificial intelligence (AI)-enabled software that analyzes echocardiographic images. This Category III code describes an adjunctive service in which software applies machine learning algorithms to standard transthoracic echo images for the purpose of assisting with cardiac function evaluation or disease classification.

Key points about 0932T:

- The service requires physician review and interpretation of the AI-generated output; it is not a replacement for the primary interpretation (e.g., 93306).
- As a Category III code, 0932T is not assigned RVUs and coverage is at payer discretion—but it lays the groundwork for potential permanent coding in the future.

2. TELEHEALTH POLICY AND CODE CONTINUATION

Telehealth coverage has been extended, but commercial insurance policies differ on coding and coverage

The Centers for Medicare & Medicaid Services (CMS) has extended telehealth flexibilities for Medicare beneficiaries through **September 30, 2025**, ensuring continued access to virtual care services. Originally introduced during the COVID-19 pandemic, these policies have revolutionized care delivery, especially in rural and underserved areas, by removing barriers to access and expanding provider reach.

Three key updates for physicians:

- **Payment parity remains in place** – Medicare will continue to reimburse telehealth services at the same rate as in-person visits. This applies across a wide range of services, including chronic disease management, preventive care, and specialty consultations.
- **Geographic restrictions have been lifted** – All Medicare beneficiaries, regardless of location, may receive telehealth services from their home. Additionally, audio-only services remain reimbursable under specific conditions, benefiting patients without reliable broadband access.
- **Provider and place of service expansion remains in place** – Physicians, nurse practitioners, psychologists, and therapists can all continue to deliver care via telehealth. Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) also retain their ability to serve as telehealth providers, maintaining access for underserved populations. Furthermore, hospital-based telehealth services are still permitted, allowing hospitals to bill for care delivered remotely by their physicians—even when the patient is at home.

What You Need to Know

New codes for reporting telehealth services

The 2025 CPT update included new codes to describe telehealth services more precisely:

- 98000–98007 for synchronous audio-visual telehealth services
- 98008–98015 for synchronous audio-only telehealth
- 90816 for "virtual check-in"

CMS did not adopt the new CPT telehealth codes (98000–98015) for Medicare billing. Instead, providers must continue to use existing evaluation and management (E/M) codes and other approved telehealth services. When reporting telehealth services, use Place of Service (POS) 10 (for patients at home) or POS 02 (for patients in other locations). Additionally, Modifier 93 must be appended to audio-only services to ensure proper identification and reimbursement.

GUIDANCE FOR BILLING PRIVATE PAYERS

Given the variability and frequent updates to payer guidelines, physician practices are strongly encouraged to verify coverage and reporting requirements for each payer and plan with which they work.

ASE will continue to advocate for permanent telehealth expansion, urging policymakers to ensure that both access and reimbursement remain intact beyond the current expiration. Providers and practices should remain informed and engaged as this evolving care model continues to shape the future of medicine.

LOOKING AHEAD

As innovation in care delivery continues, the CPT code set will evolve to capture new technologies, workflows, and modalities. ASE is actively monitoring these developments and advocating for codes that reflect the complexity, time, and expertise involved in cardiovascular imaging and interpretation—whether performed in person or supported by emerging digital tools.

Resources: CMS list telehealth services, Department of HHS, National Consortium of Telehealth Resource Centers

OVERVIEW:

Physician Practice Information Survey (PPIS) and Its Impact on Physician Payment

The **Physician Practice Information Survey (PPIS)** is a national data collection initiative conducted by the American Medical Association (AMA) to gather comprehensive information on the costs and structure of physician practices across medical specialties. The Centers for Medicare & Medicaid Services (CMS) uses data from the PPIS to calculate the **practice expense (PE)** component of the **Medicare Physician Fee Schedule (MPFS)**—a major determinant of physician reimbursement.

Practice expense comprises a significant portion of the **Relative Value Units (RVUs)** assigned to most services and includes both **direct costs** (e.g., clinical labor, supplies, equipment) and **indirect costs** (e.g., rent, utilities, administrative staff). The PPIS data are used to derive **practice expense per hour (PE/HR)** values for each specialty, which CMS uses to allocate payments across procedures. Because the PE component is **budget-neutral**, changes in one specialty's PE/HR can directly affect payments to others.

The last PPIS was conducted in 2007–2008. As the healthcare landscape has evolved significantly since then, outdated data have contributed to distortions in reimbursement—under- or overvaluing services depending on how accurately historical data reflect current practice operations. The AMA's current PPIS update, currently under review at CMS, will serve as the foundation for revised CMS payment rates beginning in **Calendar Year (CY) 2026**.

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POTENTIAL IMPACTS ON CY 2026 CMS PAYMENTS:

- **Updated Practice Expense Inputs:** The PPIS provides CMS with refreshed data on the real-world costs of operating physician practices. These updated inputs are critical for recalibrating the PE portion of RVUs and ensuring that reimbursement more accurately reflects current resource use.
- **Redistribution of Payments:** As CMS incorporates new PE/HR values from the PPIS, some specialties may see increased reimbursement (if practice costs have grown), while others may face decreases—depending on how their costs have changed relative to others.
- **Adjustments to the Medicare Economic Index (MEI):** PPIS data will also inform updates to the MEI, which measures inflation in physician practice costs. Accurate MEI adjustments are essential to maintain the adequacy of Medicare payment over time.
- **System-Wide Effects:** Because many commercial payers benchmark their rates to Medicare, changes to MPFS payments driven by the PPIS could have broad implications across the entire healthcare system.

CONCLUSION:

The PPIS is a critical mechanism for modernizing Medicare reimbursement. The data could have important implications for echocardiography, a specialty heavily influenced by practice expense inputs due to high equipment, labor, and overhead costs. If accurately captured and implemented, updated PPIS data may lead to improved reimbursement for echo services beginning as early as CY 2026. However, because the Physician Fee Schedule is budget-neutral, there is also a risk of downward adjustments if costs are underrepresented. PPIS implementation will impact how CMS values physician services, promoting a payment system that better reflects today's clinical, operational, and economic realities.

Source: RUC PPI Presentation

Top 10 Coding Questions

Q: What is the guidance for reporting congenital echo codes vs non congenital codes?

A: Per CPT guidance July 2021: If an echocardiography detects any congenital anomalies, use the appropriate echocardiography for congenital cardiac anomalies code(s)

Codes 93303, Transthoracic echocardiography for congenital cardiac anomalies, complete, and; 93304, follow-up or limited study, should not be used when complex congenital heart disease is suspected but not found on echocardiographic evaluation or in the specific diagnoses of congenital anomalies, such as PFO or BAV. In those cases, the noncongenital echocardiography codes (93306-93308) should be used.

Q: What is the coding guidance for CPT Code 0932T for noninvasive detection of heart failure and what is augmentative analysis?

A: Per CPT guidance: *0932T Noninvasive detection of heart failure derived from augmentative analysis of an echocardiogram that demonstrated preserved ejection fraction, with interpretation and report by a physician or other qualified health care professional*

(Use 0932T in conjunction with a concurrent echocardiography [separately reported] or a previously performed transthoracic echocardiography [ie, 93306, 93307, 93308, 93350, 93351])

CPT defines the category of an Augmentative AI application as:
The work performed by the machine for the physician or other QHP is augmentative when the machine analyzes and/or quantifies data to yield clinically meaningful output. Requires physician or other QHP interpretation and report.

Q: Can 93356 be billed for right ventricle / left atrium, or is it just for the left ventricle?

A: There isn't specific code guidance as to what areas of the heart are evaluated.

This is the CPT clinical vignette as an example:

> A 68-year-old female is receiving trastuzumab in treatment of HER2-positive breast cancer. She presents for an echocardiogram to exclude chemotherapy-related cardiotoxicity. A complete echocardiogram is performed with myocardial strain imaging.
>
> The physician reviews request for service to clarify the indications for the procedure and determine the clinical questions that need to be answered by the myocardial strain echo examination. Analyze images of the acquired myocardial strain data (static and real time) on an appropriate software program to determine regional and global longitudinal, radial, and/or circumferential strain and/or strain rates. Compare these data to previous studies, when available. Dictate a report and review the findings in detail with the referring physician.

Top 10 Coding Questions (cont.)

Q: Can 93319 be reported with non-congenital TEE codes?

A: CPT guidance indicates that 93319 may be reported with 93312 or 93314 TEE codes, which do not describe congenital echo.

> *+93319 3D echocardiographic imaging and postprocessing during transesophageal echocardiography, or during transthoracic echocardiography for congenital cardiac anomalies, for the assessment of cardiac structure(s) (eg, cardiac chambers and valves, left atrial appendage, interatrial septum, interventricular septum) and function, when performed (List separately in addition to code for echocardiographic imaging)*
>
> *(Use 93319 in conjunction with 93303, 93304, 93312, 93314, 93315, 93317)*
>
> *(Do not report 93319 in conjunction with 76376, 76377, 93325, 93355)*

Q: Please clarify when to code 3D with CPT 93319, and when to code CPT 76376 or 76377.

A: CPT code +93319 must be utilized with a base echocardiography code:

- Congenital Transthoracic (CPT codes 93303, 93304), or
- Transesophageal Echocardiography (CPT codes 93312, 93314, 93315, 93317).

CPT code +93319 should be appended when 3D imaging is provided during the imaging capture portion of the study.

If 3D rendering with image interpretation and image post-processing is performed post image capture, then utilize CPT codes 76376 and 76377.

Q: What are the criteria for complete or limited echoes?

A: Per the CPT Echocardiography Introduction Section of the CPT code book, here are the definitions of a complete or limited echo that must be met.

- **Complete echo:** 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 may not be required but may also be included.
- **Limited echo:** 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. The purpose of this exam is best described and documented as a focused clinical exam to answer 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.

Top 10 Coding Questions (cont.)

Q: Do payers consider strain medically necessary?

A: Coverage and medical necessity indications for strain vary among payers. Some consider the procedure experimental and some do cover with restrictions.

Here is a sample of how some payers may cover. Check with each payer for their coverage policies. If a payer requires prior authorization for the echo, include the strain code.

Myocardial strain imaging (CPT® 93356, speckle tracking longitudinal strain) is indicated for the initial evaluation of left ventricular hypertrophy, in addition to the primary echocardiogram, when there is documentation of both:

- Unclear etiology
- Concern for infiltrative cardiomyopathy

Myocardial strain imaging (CPT® 93356) in addition to the primary echocardiogram in individuals receiving therapy with cardiotoxic agents for ANY of the following:

- Initial evaluation-prior to treatment with EITHER:
- Medications that could result in cardiotoxicity/heart failure
- Radiation that could result in cardiotoxicity/heart failure
- Re-evaluation of an individual previously or currently undergoing therapy as per echocardiogram parameters
- Re-evaluation of an individual undergoing therapy with worsening symptoms
- Initial post-treatment evaluation 3-12 months after completion of treatment; or
- Periodic surveillance for medium- and high-risk survivors.

Q: Can strain and contrast be reported together?

A: There are no billing edits that restrict reporting strain or contrast when reported together. Note, that strain is assigned as an “add-on” code and must be reported with the base echo, such as TTE. As with all procedures, medical necessity is required to be documented as to why contrast and strain are clinically indicated.

Q: What code is reported for a saline echo study?

A: There is not a specific code for reporting a saline echo. When performing a complete TTE, report CPT code 93306. For a limited echo, report CPT 93308.

Per CMS NCCI billing edits, for procedures requiring intravenous injection of dye or other diagnostic agent, CMS considers the Introduction of a needle (36000) and IV push injection (96374-96376) integral to the procedure and not separately reportable. IV insertion is not separately paid.

Q: Can an echo be repeated outside of the payer frequency rules.

A: Payer policies vary. In general, a repeat echo is indicated (without regard for the number or timing of previous echo studies) if there is a change in clinical status or new signs and symptoms related to heart function. Ensure the record is well documented.

ASE American Society of Echocardiography
Sound Saves Lives

2530 Meridian Parkway, Suite 450
Durham, NC 27713 USA
Phone: 1-919-861-5574 • Fax: 1-919-882-9900

ASEcho.org • ASEcho.org/Advocacy

Facebook.com/ASECHO

Instagram.com/ASE360

@ASE360

Connect.ASEcho.org

YouTube.com/ASE360

American Society of Echocardiography

@ase360.bsky.social