



Transesophageal Echocardiography (TEE)

This guide provides coverage and payment information for transesophageal echocardiography. SonoSite provides this information as a courtesy to assist providers in determining appropriate codes and other information for reimbursement purposes. It is the provider's responsibility to determine and submit appropriate codes, modifiers, and claims for services rendered. SonoSite makes no guarantees concerning reimbursement or coverage. Please feel free to contact the SonoSite reimbursement staff if you have any questions at 1-888-482-9449.

Documentation Requirements

A final written interpretation of all diagnostic echocardiography studies, including TEE, must be produced and maintained in the patient's record. The rationale for performing the study must be clearly documented in the medical record.

Echocardiography codes require the production and retention of image documentation. Permanent images, either electronic or hardcopy must be retained in the patient's record or some other archive in order to meet the requirements of billing these CPT¹ codes.

Allowable Frequency of Studies and Indications for Use

Many Medicare Contractors have published coverage policies for echocardiography services, including both transthoracic and transesophageal echocardiograms. These policies vary as to which indications justify the use of echocardiography services. Check with your local carrier for clinical indications and allowable frequencies of use.

Diagnostic TEE (CPT codes 93312-93314) that is not performed during a surgical procedure is covered for a variety of cardiac conditions, although the details vary and providers are advised to check with their third party payers to obtain their specific coverage policies. However, because of the invasiveness of the procedure and the associated risks, TEE is not considered medically necessary if adequate information to guide the patient's management is available using transthoracic echocardiography (TTE). The patient's medical record should document the necessity for TEE, and TEE should only be performed if it is expected to alter the care of the patient.

Intraoperative TEE for monitoring purposes (CPT code 93318) is a noncovered service by the majority of Medicare Contractors. A few carriers provide coverage of this service for a small group of high-risk patients. Providers are advised to check their individual carrier's website. Medical necessity should be documented in the patient's record.

Diagnostic intraoperative TEE is covered under certain circumstances. Most Medicare Contractors consider diagnostic intraoperative TEE to be medically necessary if it is required for the optimal performance of a cardiac surgical procedure such as proper valve placement, placement of a septation device, or evaluation of mitral balloon valvuloplasty. Routine use of intraoperative TEE, even in patients undergoing bypass or valvular procedures, is not covered by most carriers. Specific carrier policies vary and providers should contact their carriers to learn the applicable details.

Diagnostic intraoperative TEE must be documented in the patient's record with videotape or another recording technique and the physician must provide a written interpretation.

Coding Information

Echocardiography services performed with hand-carried ultrasound systems are reported using the same codes that are submitted for studies performed with cart-based ultrasound systems so long as the usual requirements are met. All echocardiography examinations, regardless of the type of ultrasound equipment that is used, must meet the requirements of medical necessity as set forth by the payer, must meet the requirements of completeness for the code that is chosen and must be documented in the patient's record.

It is the physician's responsibility to select the codes that accurately describe the service performed and the corresponding reason for the study. Under the Medicare program, the physician should select the diagnosis or ICD-10 based upon the test results, with two exceptions. If the test does not yield a diagnosis or was normal, the physician should use the pre-service signs, symptoms and conditions that prompted the study. If the test is a screening examination ordered in the absence of any signs or symptoms of illness or injury, the physician should select "screening" as the primary reason for the service and record the test results, if any, as additional diagnoses.

Transesophageal Echocardiography (TEE)

The following specific coding advice is suggested by SonoSite's reimbursement staff. (Complete descriptors for codes referenced in the following paragraphs are listed in the attached chart.

- CPT code 93312 - Echocardiography, transesophageal, real time with image documentation (2D) (with or without M-mode recording); including probe placement, image acquisition, interpretation and report describes the entire TEE service when it is performed by a single physician with or without the assistance of a sonographer for image acquisition.
- If the site of service is the hospital (inpatient, outpatient or ED), a Skilled Nursing Facility (SNF), or an Inpatient Rehabilitation Facility (IRF), the -26 modifier, indicating that only the professional service was provided, must be added by the physician to the CPT code for the ultrasound service. Payers will not reimburse physicians for the technical component in these settings.
- In instances in which the TEE service is provided by two physicians, CPT code 93313 is reported by the physician who places the TEE probe only. The other physician codes 93314 to report the remaining elements of the service.
- No modifiers are used with CPT code 93313 for probe placement as this code does not have separate professional and technical components. In the hospital setting, the physician performing all elements of the service except probe placement reports CPT code 93314 with the -26 modifier attached.
- CPT codes 93312 and 93314 require image documentation and a written interpretation to satisfy the requirements of billing the service. These codes can be used to describe intraoperative and non-intraoperative TEE procedures.
- CPT code 93318 - Echocardiography, transesophageal (TEE) for monitoring purposes is used to describe intraoperative TEE that is performed to monitor the patient's cardiovascular function during surgery or another intervention.
- To report a color Doppler examination of the flow of blood through the heart's chambers and valves, report CPT code +93325 in addition to the codes for 2D transesophageal echocardiography. Note that code +93325 is an "add-on" code and cannot be reported separately. It can be used in conjunction with 93312 and 93314, but cannot be reported with codes 93313 or 93318.
- To report a quantitative evaluation of flow, CPT codes +93320 and +93321- pulsed and/or continuous wave Doppler - can be reported for complete studies and limited studies respectively. CPT codes +93320 and +93321 are "add-on codes" and cannot be reported separately. They may be reported in conjunction with 93312 and 93314, but cannot be reported with codes 93313 or 93318.
- Under the Medicare Outpatient Prospective Payment System (OPPS) the technical component of "add-on" codes +93320, +93321 and +93325 are listed as packaged services. When these services are provided in the outpatient department the payment for the "add-on" services is included in the reimbursement for the 2D echocardiography service.

Transesophageal Echocardiography (TEE)

Payment Information

The following chart provides payment information that is based on the national unadjusted Medicare physician fee schedule for the ultrasound services discussed in this guide. Payment will vary by geographic region. Use the column entitled "Global Payment" to estimate reimbursement for services in the physician office setting. Use the "Professional Payment" column to estimate reimbursement to the physician for services provided in facility settings.

Ambulatory Payment Classification (APC) codes and payments are used by Medicare to reimburse facilities for the technical component under the Hospital Outpatient Prospective Payment System (OPPS). Payment rates are also based on the national unadjusted Hospital OPPS amounts. The actual payment will vary by location.

		Medicare Physician Fee Schedule - National Average*		Hospital Outpatient Prospective Payment System (OPPS)†		
CPT Code	CPT Code Descriptor	Global Payment	Professional Payment	Technical Payment	APC Code	APC Payment
93312	Echocardiography, transesophageal, real time with image documentation (2D) (with or without M-mode recording); including probe placement, image acquisition, interpretation and report.	\$310.63	\$123.61	\$187.02	5534	\$698.65
93313	Echocardiography, transesophageal, real time with image documentation (2D) (with or without M-mode recording); placement of transesophageal probe only	No In-Office Payment	Payable in Facility Only \$23.29	No Payment	5534	\$698.65
93314	Echocardiography, transesophageal, real time with image documentation (2D) (with or without M-mode recording); image acquisition, interpretation and report only	\$303.46	\$105.69	\$197.77	Packaged Service	No Payment
93318	Echocardiography, transesophageal (TEE) for monitoring purposes, including probe placement, realtime 2-dimensional image acquisition and interpretation leading to ongoing (continuous) assessment of (dynamically changing) cardiac pumping function and to therapeutic measures on an immediate time basis.	No In-Office Payment	Very Limited Coverage \$118.95	No Payment	5534	\$698.65
+93320	Doppler Echocardiography, pulsed wave and/or continuous wave with spectral display. (List separately in addition to codes for 2D echocardiographic imaging); complete	\$54.82	\$18.63	\$36.90	Packaged Service	No Payment
+93321	follow up or limited study	\$27.59	\$7.52	\$20.06	Packaged Service	No Payment
+93325	Doppler echocardiography color flow velocity mapping (List separately in addition to codes for echocardiography)	\$25.80	\$3.22	\$22.57	Packaged Service	No Payment

CPT® five digit codes, nomenclature and other data are Copyright 2015 American Medical Association. All rights reserved. No fee schedule, basic units, relative values or related listings are included in CPT. The AMA assumes no liability for the data contained herein. Applicable FARS/DFARS restrictions apply to government use.

*Federal Register November, 2015 †Federal Register November, 2015.

Reimbursement rates shown for payment of services under the Physicians Fee Schedule reflect a conversion factor of \$35.8279.

The information in this handout is intended to assist providers in determining appropriate codes and the other information for reimbursement purposes. It represents the information available to SonoSite as of the date listed above. Subsequent guidance might alter the information provided. SonoSite disclaims any responsibility to update the information provided. The only persons authorized by SonoSite to supply information regarding any reimbursement matter not reflected in a circular such as this are members of SonoSite's reimbursement staff.

It is the provider's responsibility to determine and submit appropriate codes, modifiers, and claims for the services rendered. Before filing any claims, providers should verify current requirements and policies with the applicable payer. SonoSite makes no guarantees concerning reimbursement or coverage. A provider should not rely on any information provided by SonoSite in submitting any claim for payment, without confirming that information with an authoritative source.

¹Current Procedural Terminology (CPT®) Copyright 2015 American Medical Association.