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Image Guided Therapy

Structural Heart Disease Imaging

2024 Medicare coding and reimbursement

Medicare National Averages

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ICD-10 coding

ICD-10-CM diagnosis[1]

Due to the varying coding options available, specific ICD-10 diagnosis codes are not listed in this guide. Refer to ICD-10-CM 2024: The Complete Official Codebook for complete coding options.

ICD-10 procedure[2]

Refer to ICD-10-PCS 2024: The Complete Official Codebook for complete coding options and guidelines.

Questions

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Medicare 2024 National Reimbursement Guide

Structural Heart Disease Procedures Billable with ICE

Hospital Inpatient MS-DRGs (Medicare Severity Diagnosis Related Groups)

Medicare reimburses inpatient care under the FY2024 Inpatient Prospective Payment System (IPPS), which utilizes the Medicare Severity Diagnosis Related Groups (MS-DRGs) system. MS-DRG payment is driven by the patient's primary procedure (eg, ablation) and/or diagnosis(es) as documented in the patient's medical record. Use of ICE, TTE and TEE does not affect MS-DRG assignment, as they are not the principal reason for admission. The DRGs listed below are most common for structural heart procedures.

MS-DRG	Descriptor	Medicare 2024 National Average Payment
LAAC / PFO / Intracardiac Ablation		
273	Percutaneous and other intracardiac procedures w/ MCC	$27,285
274	Percutaneous and other intracardiac procedures wo MCC	$22,691
Ventricular septal defect closure		
228	Other cardiothoracic procedures with MCC	$35,279
229	Other cardiothoracic procedures without MCC	$22,262
Mitral valve / Tricuspid valve / TAVR / TEER		
266	Endovascular cardiac valve replacement & supplement procedures with MCC	$43,733
267	Endovascular cardiac valve replacement & supplement procedures without MCC	$34,169

Hospital Outpatient and Physician - Medicare 2024 National Average Payment

		Outpatient Hospital		Physician				
					Facility		Non facility (OBL)	
CPT Code	CPT description	APC/ Status	Payment	Work RVU	Total RVU	Payment	Total RVU	Payment
Intracardiac Echocardiography (ICE)								
+93662	Intracardiac echocardiography during therapeutic/ diagnostic intervention, including imaging supervision and interpretation (List separately in addition to code for primary procedure)	N	Packaged	1.44	2.05	$68	Not payable	
In instances where ICE is performed with a CPT code outside of the primary codes listed in this guide, the unlisted CPT code 93799 should be used.								
93799	Unlisted cardiovascular service or procedure	5721/S	$149	NA	Carrier Determined		Carrier Determined	

Tips for Billing ICE

CPT code +93662 (ICE) is a designated add-on code, which per CPT® definition, may only be reported in conjunction with a primary procedure. This guide lists structural heart procedures considered primary procedure codes for +93662 (ICE). Consult your current CPT guide for all appropriate primary codes reportable with ICE. **In instances where ICE is the only procedure performed or is performed outside of the primary codes listed in this guide, the unlisted code 93799 should be used.**

Report CPT code +93662 once per patient encounter. This includes preliminary evaluation, use during an intervention and follow up studies.

Do not use Coronary IVUS, OCT or Doppler codes to describe ICE procedures. ICE procedures are utilized for evaluation of cardiac chamber, structure and morphology.

Structural Heart - Primary Procedures for ICE

CPT Code	CPT description	Outpatient Hospital		Physician				
					Facility		Non facility (OBL)	
		APC/ Status	Payment	Work RVU	Total RVU	Payment	Total RVU	Payment
Left Atrial Appendage Closure (LAAC)								
33340	Percutaneous transcatheter closure of the left atrial appendage with endocardial implant, including fluoroscopy, transseptal puncture, catheter placement(s), left atrial angiography, left atrial appendage angiography, when performed, and radiological supervision and interpretation	Inpatient only		14.00	22.84	$760	Not payable	
Septal defect / PFO								
93580	Percutaneous transcatheter closure of congenital interatrial communication (ie, Fontan fenestration, atrial septal defect) with implant	5194/J1	$16,707	17.97	28.52	$949	Not payable	
93581	Percutaneous transcatheter closure of a congenital ventricular septal defect with implant	5194/J1	$16,707	24.39	38.70	$1,288	Not payable	
93582	Percutaneous transcatheter closure of patent ductus arteriosus	5194/J1	$16,707	12.31	19.32	$643	Not payable	
93583	Percutaneous transcatheter septal reduction therapy (eg, alcohol septal ablation) including temporary pacemaker insertion when performed	Inpatient only		13.75	21.68	$722	Not payable	
Transcathter atrial septostomy (TAS)								
33741	Transcatheter atrial septostomy (TAS) for congenital cardiac anomalies to create effective atrial flow, including all imaging guidance by the proceduralist, when performed, any method (eg, Rashkind, Sang-Park, balloon, cutting balloon, blade)	Inpatient only		14.00	21.99	$732	Not payable	
Transcathter intracardiac shunt (TIS)								
33745	Transcatheter intracardiac shunt (TIS) creation by stent placement for congenital cardiac anomalies to establish effective intracardiac flow, including all imaging guidance by the proceduralist, when performed, left and right heart diagnostic cardiac catheterization for congenital cardiac anomalies, and target zone angioplasty, when performed (eg, atrial septum, Fontan fenestration, right ventricular outflow tract, Mustard/Senning/Warden baffles); initial intracardiac shunt	Inpatient only		20.00	31.42	$1,046	Not payable	
Aortic valve								
92986	Percutaneous balloon valvuloplasty; aortic valve	5192/J1	$5,446	22.60	38.98	$1,298	Not payable	
93591	Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, aortic valve	5194/J1	$16,707	17.97	25.70	$855	Not payable	
Mitral valve								
33418	Transcatheter mitral valve repair, percutaneous approach, including transseptal puncture when performed; initial prosthesis	Inpatient only		32.25	52.84	$1,759	Not payable	

Structural Heart - Primary Procedures for ICE (continued)

CPT Code	CPT description	Outpatient Hospital		Physician				
				Work RVU	Facility		Non facility (OBL)	
		APC/ Status	Payment		Total RVU	Payment	Total RVU	Payment
Mitral valve (continued)								
92987	Percutaneous balloon valvuloplasty; mitral valve	5193/J1	$10,482	23.38	40.17	$1,337	Not payable	
93590	Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, mitral valve	5194/J1	$16,707	21.70	31.26	$1,041	Not payable	
0345T	Transcatheter mitral valve repair percutaneous approach via the coronary sinus	Inpatient only		NA	Carrier Determined		Carrier Determined	
0483T	Transcatheter mitral valve implantation/replacement (TMVI) with prosthetic valve; percutaneous approach, including transseptal puncture, when performed	Inpatient only		NA	Carrier Determined		Carrier Determined	
0484T	Transcatheter mitral valve implantation/ replacement (TMVI) with prosthetic valve; transthoracic exposure (eg, thoracotomy, transapical)	Inpatient only		NA	Carrier Determined		Carrier Determined	
0543T	Transapical mitral valve repair, including transthoracic echocardiography, when performed, with placement of artificial chordae tendineae	Inpatient only		NA	Carrier Determined		Carrier Determined	
0544T	Transcatheter mitral valve annulus reconstruction, with implantation of adjustable annulus reconstruction device, percutaneous approach including transseptal puncture	Inpatient only		NA	Carrier Determined		Carrier Determined	
Tricuspid valve (The only tricuspid valve procedure considered a primary code with ICE is listed below; the unlisted CPT code 93799 should be used if ICE is used in conjunction with other tricuspid valve procedures.)								
0545T	Transcatheter tricuspid valve annulus reconstruction with implantation of adjustable annulus reconstruction device, percutaneous approach	Inpatient only		NA	Carrier Determined		Carrier Determined	
Pulmonary valve								
33477	Transcatheter pulmonary valve implantation, percutaneous approach, including pre-stenting of the valve delivery site, when performed	Inpatient only		25.00	38.37	$1,277	Not payable	
92990	Percutaneous balloon valvuloplasty; pulmonary valve	5193/J1	$10,482	18.27	32.17	$1,071	Not payable	
Transcatheter aortic valve replacement (TAVR)								
33361	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; perc femoral artery approach	Inpatient only		22.47	35.42	$1,179	Not payable	
33362	; open femoral artery approach	Inpatient only		24.54	38.60	$1,285	Not payable	
33363	; open axillary artery approach	Inpatient only		25.47	40.06	$1,334	Not payable	
33364	; open iliac artery approach	Inpatient only		25.97	39.88	$1,328	Not payable	
33365	; transaortic approach (eg, median sternotomy, mediastinotomy)	Inpatient only		26.59	41.73	$1,389	Not payable	
33366	; transapical exposure (eg, left thoracotomy)	Inpatient only		29.35	45.92	$1,529	Not payable	
Pulmonary artery - angioplasty								
92997	Percutaneous transluminal pulmonary artery balloon angioplasty; single vessel	5193/J1	$10,482	11.98	18.53	$617	Not payable	

Structural Heart - Primary Procedures for ICE (continued)

CPT Code	CPT description	Outpatient Hospital		Physician				
				Work RVU	Facility		Non facility (OBL)	
		APC/ Status	Payment		Total RVU	Payment	Total RVU	Payment
EP Ablation								
93620	Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia; with right atrial pacing and recording, right ventricular pacing and recording, His bundle recording	5212/J1	$7,116	11.32	17.97	$598	Not payable	
93653	Comprehensive EP eval with insertion and repositioning of multiple electrode catheters, induction or attempted induction of an arrhythmia with right atrial pacing and recording and catheter ablation of arrhythmogenic focus, inc intracardiac electrophysiologic 3-dimensional mapping, right ventricular pacing and recording, left atrial pacing and recording from coronary sinus or left atrium, and His bundle recording, when performed; with treatment of supraventricular tachycardia by ablation of fast or slow atrioventricular pathway, accessory atrioventricular connection, cavo-tricuspid isthmus or other single atrial focus or source of atrial re-entry	5213/J1	$22,629	15.00	24.42	$813	Not payable	
93654	Comprehensive EP eval with insertion and repositioning of multiple electrode catheters, induction or attempted induction of an arrhythmia with right atrial pacing and recording and catheter ablation of arrhythmogenic focus, inc intracardiac electrophysiologic 3-dimensional mapping, right ventricular pacing and recording, left atrial pacing and recording from coronary sinus or left atrium, and His bundle recording, when performed; with treatment of ventricular tachycardia or focus of ventricular ectopy including left ventricular pacing and recording, when performed	5213/J1	$22,629	18.10	29.42	$979	Not payable	
93656	Comprehensive EP eval including transseptal catheterizations, insertion and repositioning of multiple electrode catheters with intracardiac catheter ablation of atrial fibrillation by pulmonary vein isolation, inc intracardiac electrophysiologic 3-dimensional mapping, intracardiac echocardiography including imaging supervision and interpretation, induction or attempted induction of an arrhythmia including left or right atrial pacing/recording, right ventricular pacing/recording, and His bundle recording, when performed	5213/J1	$22,629	17.00	27.69	$922	Not payable	

Structural Heart - Primary Procedures for ICE (continued)

CPT Code	CPT description	Outpatient Hospital		Physician				
					Facility		Non facility (OBL)	
		APC/ Status	Payment	Work RVU	Total RVU	Payment	Total RVU	Payment
Cardiac Catheterization								
93451	Right heart catheterization including measurement(s) of oxygen saturation and cardiac output, when performed	5191/J1	$3,105	2.47	3.81	$127	25.50	$849
93452	Left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed	5191/J1	$3,105	4.50	6.89	$229	26.52	$883
93453	Combined right and left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed	5191/J1	$3,105	5.99	9.20	$306	33.84	$1,126
93454	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation;	5191/J1	$3,105	4.54	6.96	$232	26.74	$890
93455	; with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) including intraprocedural injection(s) for bypass graft angiography	5191/J1	$3,105	5.29	8.11	$270	29.79	$992
93456	; with right heart catheterization	5191/J1	$3,105	5.90	9.07	$302	33.27	$1,107
93457	; with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) including intraprocedural injection(s) for bypass graft angiography and right heart catheterization	5191/J1	$3,105	6.64	10.18	$339	36.26	$1,207
93458	; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed	5191/J1	$3,105	5.60	8.59	$286	30.76	$1,024
93459	; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography	5191/J1	$3,105	6.35	9.73	$324	33.09	$1,101
93460	; with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed	5191/J1	$3,105	7.10	10.88	$362	36.71	$1,222
93461	; with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography	5191/J1	$3,105	7.85	12.03	$400	40.50	$1,348

Structural Heart - Primary Procedures for ICE (continued)

CPT Code	CPT description	Outpatient Hospital		Physician				
					Facility		Non facility (OBL)	
		APC/ Status	Payment	Work RVU	Total RVU	Payment	Total RVU	Payment
Cardiac Catheterization (continued)								
93593	Right heart catheterization for congenital heart defect(s) including imaging guidance by the proceduralist to advance the catheter to the target zone; normal native connections	5191/J1	$3,105	3.99	5.51	$183	Not payable	
93594	Right heart catheterization for congenital heart defect(s) including imaging guidance by the proceduralist to advance the catheter to the target zone; abnormal native connections	5191/J1	$3,105	6.10	8.37	$279	Not payable	
93595	Left heart catheterization for congenital heart defect(s) including imaging guidance by the proceduralist to advance the catheter to the target zone, normal or abnormal native connections	5191/J1	$3,105	5.50	7.59	$253	Not payable	
93596	Right and left heart catheterization for congenital heart defect(s) including imaging guidance by the proceduralist to advance the catheter to the target zone(s); normal native connections	5191/J1	$3,105	6.84	9.44	$314	Not payable	
93597	Right and left heart catheterization for congenital heart defect(s) including imaging guidance by the proceduralist to advance the catheter to the target zone(s); abnormal native connections	5191/J1	$3,105	8.88	12.33	$410	Not payable	
Endomyocardial biopsy								
93505	Endomyocardial biopsy	5191/J1	$3,105	4.12	6.63	$221	19.12	$636

HCPCS Codes

In the outpatient setting, when devices are used in combination with device-related procedures, hospitals report C codes. While the supply codes are not paid separately from the procedure, the assignment of charges and reporting these supply codes, identify device-related costs.

HCPCS Code	Descriptor	Device Name	APC/Payment
C1759	Catheter, intracardiac echocardiography	VeriSight Pro (2D/3D)	Packaged

APPENDIX A

Some physicians may choose to use ICE as well as TTE or TEE before, during or after a structural heart procedure. While the imaging codes listed in this Appendix are not considered primary codes for ICE, payers may cover these codes based on medical necessity, documentation and coverage guidelines. Check with your payer for appropriateness of billing both ICE and TTE/TEE during the same procedure.

Moderate sedation codes included in this Appendix may be used for procedures listed in this Guide. Payer documentation requirements and coverage policies should be reviewed prior to billing.

Transthoracic Echocardiogram (TTE)

In some cases, TTE may be performed in conjunction with an ICE-guided LAAO procedure to confirm cardiac function. The following codes are applicable for TTE procedures.

		Outpatient Hospital		Physician				
					Facility		Non facility (OBL)	
CPT Code	CPT description	APC/ Status	Payment	Work RVU	Total RVU	Payment	Total RVU	Payment
TTE with contrast (hospital outpatient only)								
C8923	Transthoracic echocardiography (TTE) with contrast, or without contrast followed by with contrast, real-time with image documentation (2D), includes M-mode recording, when performed, complete, without spectral or color doppler echocardiography	5573/S	$763	NA	Facility only		Facility only	
C8924	Transthoracic echocardiography (TTE) with contrast, or without contrast followed by with contrast, real-time with image documentation (2D), includes M-mode recording when performed, follow-up or limited study	5572/S	$366	NA	Facility only		Facility only	
C8929	Transthoracic echocardiography (TTE) with contrast, or without contrast followed by with contrast, real-time with image documentation (2D), includes M-mode recording, when performed, complete, with spectral doppler echocardiography, and with color flow doppler echocardiography	5573/S	$763	NA	Facility only		Facility only	
TTE without contrast								
93306	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, with spectral Doppler echocardiography, and with color flow Doppler echocardiography	5524/S	$526	1.46	2.02	$67	Not payable	
93307	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, without spectral or color Doppler echocardiography	5523/S	$233	0.92	1.27	$42	Not payable	
93308	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, follow-up or limited study	5523/S	$233	0.53	0.73	$24	Not payable	

Transesophageal Echocardiography (TEE)

CPT Code	CPT description	Outpatient Hospital		Physician				
					Facility		Non facility (OBL)	
		APC/ Status	Payment	Work RVU	Total RVU	Payment	Total RVU	Payment
Intraoperative TEE								
CPT code 93355 bundles Doppler, color flow, 3D reconstruction & all echo imaging related to the evaluation, performance and completion of a percutaneous structural heart intervention. This TEE procedure must be performed by a physician NOT performing the structural heart 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 intra-procedural), real-time image acquisition and documentation, guidance with quantitative measurements, probe manipulation, interpretation, and report, including diagnostic transesophageal echocardiography and, when performed, administration of ultrasound contrast, Doppler, color flow, and 3D	N	Packaged	4.66	6.58	$219	Not payable	
Transesophageal Echocardiography (TEE)								
CPT codes 93312-93318 include conscious sedation and should not be billed separately. CPT codes 76376 and 76377 and 93319 (3D echocardiography) should be billed in conjunction with the base code for the imaging procedure.								
TEE with contrast (hospital outpatient only)								
C8925	Transesophageal echocardiography (TEE) with contrast, or without contrast followed by with contrast, real time with image documentation (2D) (with or without M-mode recording); including probe placement, image acquisition, interp and report	5573/S	$763	NA	Facility only		Facility only	
C8927	Transesophageal echocardiography (TEE) with contrast, or without contrast followed by with contrast, for monitoring purposes, including probe placement, real time (2D) image acquisition and interpretation leading to ongoing (continuous) assessment of (dynamically changing) cardiac pumping function and to therapeutic measures on an immediate time basis	5573/S	$763	NA	Facility only		Facility only	
TEE without contrast								
93312	Echocardiography, transesophageal, real-time with image documentation (2D) (with or without M-mode recording); including probe placement, image acquisition, interpretation and report	5524/S	$526	2.30	3.11	$104	7.06	$235
93313	; placement of transesophageal probe only	5524/S	$526	0.26	0.33	$11	0.33	$11

Transesophageal Echocardiography (TEE) (continued)

CPT Code	CPT description	Outpatient Hospital		Physician				
				Work RVU	Facility		Non facility (OBL)	
		APC/ Status	Payment		Total RVU	Payment	Total RVU	Payment
TEE without contrast (continued)								
93314	Echocardiography, transesophageal, real-time with image documentation (2D) (with or without M-mode recording) ; image acquisition, interpretation and report only	N	Packaged	1.85	2.60	$87	6.77	$225
93318	Echocardiography, transesophageal (TEE) for monitoring purposes, including probe placement, real time 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	5524/S	$526	2.15	2.97	$99	Not payable	
+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 echo imaging)	N	Packaged	0.50	0.69	$23	1.66	$55
+93320	Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echo imaging); complete	N	Packaged	0.38	0.52	$17	1.52	$51
+93321	; follow-up or limited study (List separately in addition to codes for echocardiographic imaging)	N	Packaged	0.15	0.21	$7	0.75	$25
+93325	Doppler echocardiography color flow velocity mapping (List separately in addition to code for echo)	N	Packaged	0.07	0.09	$3	0.70	$23
3D Rendering								
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	N	Packaged	0.20	0.28	$9	0.75	$25
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	N	Packaged	0.79	1.12	$37	2.34	$78

Moderate Sedation

CPT Code	CPT description	Outpatient Hospital		Physician				
					Facility		Non facility (OBL)	
		APC/ Status	Payment	Work RVU	Total RVU	Payment	Total RVU	Payment
Moderate Sedation	Moderate sedation is separately reported with codes 99151-99157. Review documentation requirements prior to billing. CPT codes 93312-93318 include conscious sedation and should not be billed separately.							
99151	Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; initial 15 minutes of intraservice time, patient younger than 5 years of age	N	Packaged	0.50	0.71	$24	1.82	$61
99152	; initial 15 minutes of intraservice time, patient age 5 years or older	N	Packaged	0.25	0.36	$12	1.51	$49
+99153	; each additional 15 minutes intraservice time (List separately in addition to code for primary service)	N	Packaged	0.00	0.35	$12	0.35	$12
99155	Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; initial 15 minutes of intraservice time, patient younger than 5 years of age	N	Packaged	1.90	2.45	$82	2.45	$82
99156	; initial 15 minutes of intraservice time, patient age 5 years or older	N	Packaged	1.65	2.22	$74	2.22	$74
+99157	; each additional 15 minutes intraservice time (List separately in addition to code for primary service)	N	Packaged	1.25	1.76	$59	1.76	$59

Structural Heart Disease Imaging

ICE and TEE Coding Questions & Tips[1,2]

Can ICE and TEE be billed together?

This will depend on the procedure, provider, etc. We recommend consulting CPT guidelines, NCCI edits and payer requirements. In general:

- TEE and ICE are not billable together if TEE is performed to confirm the findings of ICE.
- ICE is an add-on code that may only be performed in conjunction with primary procedures listed in this guide. TEE codes 93312 – 93318 and 93355 are considered primary codes. As long as there are no NCCI edits restricting TEE, and documentation supports the procedure and medical necessity is met, TEE may be billable.

ICE and TEE

- Report CPT code 93355 (intraoperative monitoring) if utilized to measure and guide valvuloplasty or percutaneous valve replacement procedures. CPT code +93662 (ICE) is reported with mitral valvuloplasty (92987), PFO closure (93580) and VSD closure (93581). ICE is not reported with transcatheter valve procedures involving valve placements, replacements, repair or other valvuloplasties.
- ICE is bundled with TMVI (code 0483T); TEE (93355) may be separately reportable if utilized.

ICE (+93662)

- ICE may be billed in addition to PFO or VSD closure if used to guide safe placement of the device and perform bubble studies to evaluate for residual shunting during the procedure.

TEE – Intraoperative Monitoring (CPT 93355)

- Report CPT code 93355 for TEE procedures during percutaneous structural heart interventions. Do not report CPT code 93319 with CPT code 93355 as 3D reconstructions are bundled with 93355.
- CPT code 93355 bundles Doppler, color flow, 3D reconstruction, and all echo imaging related to the evaluation, performance and completion of a percutaneous structural heart intervention.
- **CPT code 93355 must be performed by a physician NOT performing the structural heart intervention.**
- In order to bill CPT code 93355, TEE providers must meet the minimum threshold of BOTH placing the probe AND performing the interpretive study. Any other modalities, such as the use of Doppler or color flow mapping, will be bundled into 93355. **CMS has recently published a decision which allows the billing of 93355 only when it is performed by someone who is not also providing anesthesia on the case**. In other words, an anesthesiologist can bill for 93355 as long as someone else, i.e., his/her partner, was providing the anesthesia.[3]

1. Zhealth Publishing, Cardiothoracic Surgery Coding Reference. 2021 and 2023
2. Zhealth Publishing, Diagnostic & Interventional Cardiovascular Coding Reference. 2021 and 2023.
3. TEE Documentation Requirements for Anesthesia Providers. https://www.anesthesiallc.com/publications/anesthesia-provider-news-ealerts/1389-tee-documentationrequirements-for-anesthesia-providers

TEE

- Coding for TEE is based on the same basic logic as radiology and ultrasound procedures: there is one code for placement of the probe (93313), one code for interpretation of the images (93314), and one for the comprehensive service (93312). There are also codes for enhanced services: Doppler echocardiography pulsed wave and/or continuous wave with spectral display (93320), follow-up Doppler study (93321), color flow velocity mapping (93325), and 3D rendering with interpretation and reporting of CT, MRI, ultrasound or other tomographic modality (76376).
- While TEE is often billed in conjunction with anesthesia and invasive monitoring for cardiovascular cases, it may be performed as a stand-alone diagnostic service. If TEE is being performed by an anesthesiologist or a cardiologist as a separate diagnostic service, it may require a MAC anesthetic, which is also separately billable.
- Codes 93312 and 93315 describe the complete procedure and include placement of the probe with supervision and interpretation of findings of the TEE.
- Codes 93313 and 93316 describe placement of the probe only. These would be used if two physicians were involved, one placing the probe and the other supervising the scanning and performing interpretation of the results.
- Codes 93314 and 93317 describe supervising the scanning and the interpretation only. Placement of the probe is performed by another physician.
- Hospitals should report either the code describing a complete procedure (96312 or 96315) or placement of only the probe (93313 or 93316). Codes 99314 and 93317 are reportable by hospitals but are not paid separately.
- Use CPT code 93318 for continuous TEE monitoring during surgical and other invasive endovascular procedures that requires constant monitoring of cardiovascular function and when used to assist in making therapeutic decisions during these procedures.
- CPT code +93319 was added effective 1/1/22. This add-on code describes the clinical work involved in 3D echocardiographic imaging and post-processing during TEE, or during TEE for congenital cardiac anomalies and includes the assessment of cardiac structures and function. It is important to note that this is not an add-on code for CPT code 93355 since this code already includes 3D imaging for guidance of a structural intervention. CPT codes 76376 and 76377 are not add-on codes and are appropriate for reporting 3D-rendering services provided on a date separate from the base-imaging study.[4]

Ablation - 93656

- Effective 1/1/22, CPT code 93656 includes +93662 - do not bill separately for ICE.

-77 Repeat Procedure by Another Physician[5]

- This modifier defines a repeat procedure by another physician during the same patient encounter. It is approved for physician and hospital use. As an example, when a TEE procedure is repeated by another physician, the second exam would require use of the -77 modifier and assumes that the second physician was aware this was a repeat procedure. For example, if a different physician acquires additional images, interprets, and prepares a report in addition to the preoperative TEE, then 93314 (image acquisition, interpretation/report) or 93317 (congenital image acquisition, interpretation/report) can be reported with modifier -77. This indicates that the additional image acquisition and interpretation was provided by a different physician. The medical record should reflect the medical necessity for repeating these procedures.

4. New Add-on CPT Code and Value for Three-Dimensional Echocardiography. https://www.asecho.org/newadd-on-cpt-code-and-value-for-three-dimensional-echocardiography/
5. American Society of Echocardiography. 2017 Coding and Reimbursement Newsletter. https://pdf4pro.com/amp/view/2017-coding-and-reimbursement-newsletter-1fe319.html

Third-party and References

Third-party sources

- 2016 CPT Changes, An Insider's View
- 2017 CPT Changes, An Insider's View
- CPT Assistant
- 2024 ICD-10-CM and ICD-10-PCS: The Complete Official Codebook
- 2024 CPT-4 Professional Edition
- ZHealth Publishing
- American Society of Echocardiography

References

[1] Medicare Inpatient Prospective Payment System FY2024 Final Rule with Correction Notice. Table 5 CN. Payment rates assume full update amount for hospitals which have submitted quality data and hospitals have a wage index greater than 1.

[2] Medicare Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs. CY2024 Final Rule, OPPS Addendum B, 122123.

– *Status J1: Comprehensive APC – accounts for all costs and component services typically involved in the provision of the complete primary procedure; Status N: No separate APC payment. Packaged into payment for other services; Status Q2: T-Packaged Codes - Packaged APC payment if billed on the same date of service as a HCPCS code assigned status indicator "T" or "J1". In other circumstances, payment is made through a separate APC payment.*

[3] Medicare Physician Fee Schedule. Final Policy, Payment, and Quality Provisions in the Medicare Physician Fee Schedule for Calendar Year 2024, Addendum B using MPFS 2024 conversion factor 33.2875 effective 030924 through 123124.

Questions

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