**Frequently Asked Coding Questions (FAQ)**

1. **Is there a limited TEE code?**

There is no "limited" code for TEE. The TEE codes were not established based on the distinction of complete or limited, and the Introductory CPT language does not specify what is considered a complete or limited for these procedures. There is no CPT guidance as to what anatomy is included in a TEE exam.

1. **Does a bicuspid aortic valve finding on TTE qualify for congenital TTE?**

The CPT manual is not specific, but the August 2013 CPT Assistant does state: congenital heart disease, which includes defects such as atrial and ventricular septal defects, patent ductus arteriosis, Tetralogy of Fallot, transposition of the great arteries, single ventricle, and congenital defects of the cardiac valves.

1. **What modifiers are applicable to echocardiography?**

Modifiers consist of two alphanumeric characters. Because modifiers may affect payment, they must be used correctly or claims may be denied and an audit may be initiated by a payer. Documentation in the medical record or interpretation report must support the use of a modifier. The AMA CPT codebook defines modifier usage. In some cases, CMS and other payers may establish varying guidelines different from the AMA. A complete list of modifiers can be found on the inside cover page of the AMA codebook. Note, there are separate lists for hospital and physician approved modifiers.

**Modifiers to Report Technical and Professional Components:** These modifiers are used with diagnostic testing codes, as they have two components: technical and professional. For payment purposes under the Medicare Part B Physician Fee Schedule (PFS) , two modifiers (TC and 26) are used to describe the circumstances when diagnostic testing services are reported separately by the physician and the outpatient setting that is covered under the Medicare PFS (i.e. imaging center and office). The acquisition of the image is the technical component, and the professional component is the physician interpretation of the exam.

***-TC Technical component*:** The technical component provided in ambulatory settings such as doctors offices and IDTFs is reported by adding modifier TC to the CPT code. The TC modifier is reported by the entity that only provides the technical service. Institutions such as hospitals do not append the TC modifier. The use of this modifier affects payment.

***-26 Professional Component:*** The physician service only is reported separately by adding modifier -26 to the CPT code. The use of this modifier affects payment.

***No modifier:*** When both components are furnished by one provider, Medicare makes a single global payment that is equal to the sum of the payment for the components. No modifier is necessary.  
Note that some codes such as stress test codes (93015-93018) and stress echocardiography contrast administration (93352) are designated as global codes and are never reported with -26 or TC modifiers.

The following codes may be reported with these modifiers: 93312-93314,93315,93317,93318, 93320, 93321, 93325, 93350, 93351

***-22 Increased Procedural Services:***This modifier is used to identify that the work required to provide a service is substantially greater than typically required. Modifier 22 is not a hospital approved modifier. The appropriate use of this modifier is subject to payer discretion and typically will trigger individual claim review. Specifically, CMS restricts the use of modifier -22 to only surgical procedures that have a global period of 0, 10, or 90 days. **For Medicare claims, it would be inappropriate to append modifier -22 to cardiovascular ultrasound procedures.**

The following modifiers may be appropriate for all echocardiography codes, depending upon the circumstances:

***-51 Multiple Procedures:***When multiple procedures, other than E/M services, Physical Medicine and Rehabilitation services or provision of supplies (eg, vaccines), are performed at the same session by the same individual, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s). Note: This modifier should not be appended to designated "add-on" codes.

***-52 Reduced Services***

This modifier is used to describe a service or procedure that is partially reduced or eliminated. It is approved for physician and hospital use. As an example, this modifier can be used to report an arterial extremity study (93922-52) on a patient with an above the knee amputation, since the procedure was not performed in its entirety.

***-59 Distinct Procedural Service:***

This modifier is used to report procedures that are not normally reported together but are appropriate under the circumstances. Modifier59 is used to clearly designate non routine instances when distinct and separate multiple services are provided to a patient on a single date of service. It is approved for physician and hospital use. Modifier -59 should only be used if no other modifier more appropriately describes the relationships of the two or more procedure codes.  
As an example, if a transthoracic echo (93306) is done for a particular indication, and based on the result, a TEE is also performed; the 59 modifier would be appended to the TEE (93312).

***77 Repeat Procedure by Another Physician:***

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, interp/report) or 93317 (congenital image acquisition, interp/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.

**ICD-10 New Code Set Implementation is Delayed**

The Protecting Access to Medicare Act of 2014, which delayed the scheduled 24% cut to Medicare physician reimbursement rates ,also pushed the implementation of the new ICD-10 code set from October 2014 to no sooner than October 2015.

Accordingly, the U.S. Department of Health and Human Services expects to release an interim final rule in the near future that will include a **new compliance date that would require the use of ICD-10 beginning October 1, 2015**. The rule will also require HIPAA covered entities to continue to use ICD-9-CM through September 30, 2015.

The postponement allows for more time to strengthen clinical documentation improvement programs, and training for the eventual transition to ICD-10 codes.