CPT Editorial Panel – Initial Notes

Echo IQ Ltd

Echo IQ had their category III CPT code application heard at the CPT Panel Meeting in Chicago this morning, 19 September 2025. At CPT meetings, two assigned Panel discussants open each item and can explicitly recommend the application "with support," "without support," or "for discussion." The two panel discussants – Dr Timothy Swan and Dr Richard Frank – both explicitly opened "without support". This indicates that they're formally advising the Panel to vote *against* the request as submitted – a strong negative signal. The aggregate tone of the panellists can fairly be characterised as 'not persuaded' that the code, as written and evidenced, meet's the CPT's general/Cat II criteria. Dr Steven Hao, a cardiologist on the CPT panel, was not present for the hearing.

The application is for "Noninvasive evaluation of aortic valvular stenosis derived from augmentative analysis of the aortic valve and cardiac phenotype, including interpretation and report; related to concurrently performed transthoracic echocardiogram." Echo IQ submitted an alternative code descriptor proposal package (Option B) after a facilitation meeting with the three Panel Reviewers (Swans, Frank, Hao), intended to repair the original two Cat III codes that had each drawn non-support.

Are the other panel members likely to vote with Dr Swan and Dr Frank? Lead discussants have outsized influence; their read of coding fit, distinctness, and evidentiary sufficiency tends to shape the room unless other panellists (or advisors in the record) make a compelling counter-case. A dual "without support" recommendation therefore materially lowers the odds of a "yes" vote on the current wording.

Is it likely that X533T gets approved (as submitted) in this session? Unlikely. The Panel has four basic actions: approve/add, refer to workgroup, postpone, or reject. After both discussants recommend "without support," the most common outcomes are postpone (to revise and resubmit) or reject; outright approval is possible but rare without a clear countervailing case on the record. That said, Category III codes do have a lower evidentiary bar than Category I. A Cat III application can succeed if the service is currently/recently performed in humans and at least one of these is true: (a) at least one CPT/HCPAC Advisor supports it, (b) there's supportive peer-reviewed literature, or (c) there's an IRB-approved protocol/US trial or other evidence of evolving use. If X533T lacked visible advisor support and the discussants weren't persuaded by the literature/trial story, that would explain the "without support" stance.

Bottom line: strong signal that the panel will vote to postpone or reject the application.

At 12:26pm today, the Company has provided an update to the market stating that they are aware of current speculation from media outlets and market participants but wishes to advise it has not received an indication of panel votes at this time. These results will be announced by the American Medical Association (AMA) in the next two to four weeks. Following this, the Company will provide a broader update.

Recommendation	**UR**
Share Price	**$0.22**
Fair Valuation	**UR**
TSR	**-**

Company Profile	
Market Cap	$142.5m
Enterprise Value	$129.2m
SOI (undiluted)	647.8m
Free Float	80%
ADV (3-month)	$497k
52-Week Range	$0.185 - $0.37

Price Performance

Company Overview

Echo IQ Limited (ASX: EIQ) is an Australian medical technology company specialising in AI-driven solutions to improve clinical decision making in cardiology. The company's flagship product, EchoSolv, leverages advanced AI and proprietary algorithms to enhance the diagnosis and assessment of severe structural heart diseases, particularly Aortic Stenosis (AS) and Heart Failure (HF). Validated through rigorous clinical studies, EchoSolv-AS received FDA 510(k) clearance in October 2024 and is now in commercialisation through integration partnerships with leading imaging software providers and large hospital networks across the US.

Analyst

Jacob Hoenig jh@eveq.com
Healthcare Analyst 02 8379 2960

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Dr Frank, of the CPT Editorial Panel:
"There are a number of issues remaining with this application with option B, that which I put on the floor without support…The two proposed category three codes each presented sufficient issues that after iterative Q&A by email, panel reviewers issued a letter of non-support. Following a facilitation meeting including all three panel reviewers, applicants submitted option B, which we find does not resolve the issues for a service which may contribute to physician confidence and is not shown to actually improve physician performance. These issues include…from the stand point of workflow, it is not clear how the output from the algorithm is reported and to whom, and whether and how it contributes to the interpretation of the echocardiogram either by the specialist, for example in their final echocardiogram report, or by the ordering physician as a data element for ENM.

"From the standpoint of clinical utility, it is unclear what the output from the algorithm contributes to patient care, not only for a physicians concurrent read of the echocardiogram, but most particularly, for use with prior acquisitions. Applicants referred to quote "phenotypic data not currently utilised by physicians" but did not show how the transparency and explicability would allow for physician judgement in their interpretation of the output for patient care. The use of services such as this on previously acquired echocardiograms raises the issue of population health applications, which is a matter for coverage decisions, but should be anticipated in framing codes such as this for example by judicious wording of the typical patient and the description of procedure, or guardrails on the reporting of such a code. By way of example, the authors of the publication provided concluded that this device has the capacity to be uniformly applied in an automated alert system in routine clinical practice. Although the FDA authorised indication for use (IFU) mentions the application of recognised aortic stenosis clinical practice guidelines, the benefit of the output is characterised as quote "provides information to facilitate rendering an accurate diagnosis of aortic stenosis", which in the report, is manifest as quote "suggestive of high probability of severe aortic stenosis." Were this to be the basis for the choice of a term from Appendix S, it would be 'assistive' rather than 'augmentative' because it is not actually reporting a quantitative or categorical output, but only a suggestion of such.

"And finally, applicant option B arrived too late for the resolution of any of the above issues, which would be necessary before we begin to contemplate whether some approach like an add-on code would be appropriate. So, in summary, I place applicant option B on the floor without support.

Context: The Necessity of a Category III CPT Code
Echo IQ's US revenue model is explicitly tethered to reimbursement: its "utilisation-indexed SaaS" charges each hospital roughly (annual echo volume × CPT reimbursement rate × expected approval rate), which under today's catch-all 93799 code translates to only intermittent payment (≈20–40% claim success at ~US$100–150) and therefore cautious adoption by value-analysis committees. A dedicated Category III CPT code is the catalyst that standardises billing, lifts expected claim success (modelled ~40–60%) and baseline rate (modelled ~US$150) and critically reduces procurement friction so sites can scale EchoSolv use.

Beyond near-term monetisation, Cat III is the evidence-collection bridge that enables broader payer acceptance and, ultimately, a path to Cat I, mirroring adoption curves seen after code assignment in analogous cardiology/AI tools – making it the linchpin for predictable, contractable ARR and portfolio-level value creation. Recent panel feedback underscores that without a fit-for-purpose Cat III descriptor, reimbursement remains sporadic and the pace of hospital onboarding – and thus the investment case – will lag its potential.

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Evolution Capital Pty Ltd
Level 8, 143 Macquarie Street Sydney, NSW 2000
Tel: +61 (2) 8379 2960
www.eveq.com