Medlearn Matters
Information for Medicare Providers

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Updated Policy and Claims Processing Instructions for Ambulatory Blood Pressure Monitoring (ABPM)

Provider Types Affected

Physicians, Hospitals, Critical Access Hospitals (CAHs), Comprehensive Outpatient Rehabilitation Facilities (CORFs), Skilled Nursing Facilities (SNFs), Federally Qualified Health Centers (FQHCs), and Rural Health Clinics (RHCs).

Provider Action Needed

STOP – Impact to You

Medicare has expanded payment for ABPM to include HCPCS code 93788 in addition to the three HCPCS codes already payable. (HCPCS code 93788 is defined as "ABPM utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; scanning analysis with report.") ABPM is only payable for patients with suspected "white coat hypertension" (WCH). Note: This is designated as an outpatient service; patients admitted to a hospital or residing in institutions (such as SNFs) who receive ABPM are not qualified for coverage. Additionally, if ABPM must be performed more than once for a particular beneficiary, the qualifying criteria (described in the *Background* section) must be met for each subsequent ABPM test.

CAUTION – What You Need to Know

ABPM involves the use of a non-invasive devise to measure blood pressure in 24-hour segments, the results of which are stored in the device and interpreted later by a physician. To be covered, ABPM must be performed for at least a 24-hour time period; the diagnosis code 796.2 (Elevated blood pressure reading without diagnosis of hypertension) must be used; and the results must be interpreted by a physician.

GO – What You Need to Do

Refer to the *Additional Information* section for HCPCS code information by provider type specific to ABPM for suspected WCH FI and for carrier billing instructions, which can be found in the Medicare Claims Processing Manual, Chapter 32, and in CR 2726, at: http://www.cms.hhs.gov/manuals/pm_trans/R109CP.pdf

Background

The qualifying criteria for white coat hypertension include:

1. Clinic/office blood pressure >140/90 mm Hg on at least three separate clinic/office visits with two separate measurements made at each visit;
2. At least two documented separate blood pressure measurements taken outside the clinic/office which are <140/90 mm Hg; and
3. No evidence of end-organ damage.

Additional Information

When a claim for ABPM is made, the diagnosis code 796.2 (Elevated blood pressure reading without diagnosis of hypertension) must be used. Additionally, the effective dates for applicable HCPCS codes for ABPM for suspected WCH are as follows:

HCPCS	Definition	Effective Date
93784	ABPM, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer, including recording, scanning analysis, interpretation and report.	04/01/2002
93786	ABPM, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; recording only.	04/01/2002
93788	ABPM, utilizing a system of magnetic tape and/or computer disk, for 24 hours or longer; scanning analysis with report.	01/01/2004
93790	ABPM, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; physician review with interpretation and report.	04/01/2002

The above HCPCS codes can be billed by the following providers, for outpatients, as specified below:

- Hospitals (except CAHs) bill on a 13x or 14x type of bill with HCPCS 93786 and/or 93788.
- CORFs bill on a 75x type of bill with HCPCS code 93786 and/or 93788.
- CAHs bill on an 85x type of bill as follows: (1) for CAHs that elected the Standard Method, bill HCPCS code 93786 and/or 93788; and (2) for CAHs that elected the Optional Method, bill any combination of HCPCS codes 93786, 93788 and 93790 as appropriate.
- SNFs bill on a 23x type of bill with HCPCS code 93786 and/or 93788.
- RHCs bill for the professional component as a visit under the all-inclusive rate on a 71x type of bill with rev code 052x.
- FQHCs bill for the professional component as a visit under the all-inclusive rate on a 73x type of bill with rev code 052x.

- Provider-based RHCs/FQHCs bill for the technical component under their base provider's number using the above requirements for their particular base provider type.
- Independent and free-standing RHCs/FQHCs practitioners bill for the technical component to the carrier.

The official instruction issued to your carrier regarding this change may be found by going to:

http://www.cms.hhs.gov/manuals/pm_trans/R109CP.pdf

You may also refer to *Medicare National Coverage Determinations Manual, Chapter 1, Section 20.19*, which may be found at:

http://www.cms.hhs.gov/manuals/103_cov_determ/ncd103index.asp