CMS Manual System

Pub. 100-04 Medicare Claims Processing

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 109 | **Date: FEBRUARY 27, 2004**

CHANGE REQUEST 2726

I. SUMMARY OF CHANGES: This instruction provides updated policy and claims processing instructions for Ambulatory Blood Pressure Monitoring (ABPM). This instruction:

(1) Adds HCPCS 93788 to the list of codes approved for payment by Medicare;
(2) Specifies by provider type which HCPCS codes can be billed to the FIs; and
(3) Adds ABPM information to the new Internet only manual.

NEW/REVISED MATERIAL - EFFECTIVE DATE: April 1, 2004
***IMPLEMENTATION DATE: April 5, 2004**

Disclaimer for manual changes only: The revision date and transmittal number apply only to the red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will only receive the new/revised information, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
N	32/TOC
N	32/10/ Diagnostic Blood Pressure Monitoring
N	32/10.1/Ambulatory Blood Pressure Monitoring (ABPM) Billing Requirements

***III. FUNDING:**

These instructions shall be implemented within your current operating budget.

IV. ATTACHMENTS:

X	**Business Requirements**
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

***Medicare contractors only**

Attachment - Business Requirements

Pub. 100-04	Transmittal: 109	Date: February 27, 2004	Change Request 2726

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

I. GENERAL INFORMATION

This instruction contains updated policy and claims processing instructions for ABPM. This instruction adds HCPCS 93788 to the list of codes approved for payment by Medicare; specifies by provider type, which codes specifically can be billed to the fiscal intermediary (FI) and adds ABPM billing instructions to the new Internet only manual. The Arkansas Part A Shared System (APASS) is exempt from making the changes described in the requirements below. The FIs using APASS are exempt from these requirements until the completion of their transition to the Fiscal Intermediary Shared System (FISS).

A. Background: ABPM involves the use of a non-invasive device, which is used to measure blood pressure in 24-hour cycles. These 24-hour measurements are stored in the device and are later interpreted by a physician. Effective April 1, 2002, ABPM is covered for those beneficiaries with suspected "white coat hypertension" (WCH). Suspected "WCH" is defined as: (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. ABPM is not covered for any other uses. ABPM must be performed for at least 24 hours to meet coverage criteria. Payment is not allowed for institutionalized beneficiaries, such as those receiving Medicare covered skilled nursing in a facility. In the rare circumstance that ABPM needs to be performed more than once for a beneficiary, the qualifying criteria described above must be met for each subsequent ABPM test.

Effective July 1, 2003, the coverage policy was revised to specify that a physician is required to perform interpretation of the data obtained through ABPM, but there are no requirements regarding the setting in which the interpretation is performed. Refer to Medicare National Coverage Determinations Manual, Chapter 1, Section 20.19, for complete information regarding the policy for ABPM.

Effective dates for applicable Common Procedure Coding System (HCPCS) codes for ABPM for suspected WCH are:

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 such as 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

In addition, the following diagnosis code must be present:

Diagnosis Code	Description
796.2	Elevated blood pressure reading without diagnosis of hypertension.

B. Policy: Refer to the Medicare National Coverage Determinations Manual, Chapter 1, Section 20.19.

C. Provider Education: A provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article or a direct link to this article on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article must be included in your next regularly scheduled bulletin.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement #	Requirements	Responsibility
2726.1	FIs and local carriers shall cover ABPM performed for at least 24 hours for suspected WCH.	FIs and local carriers
2726.2	The FI shall accept ABPM services when billed with diagnosis code 796.2 on the following types of bills: 13x, 14x, 23x, 71x, 73x, 75x and 85x.	FISS
2726.2.1	The FI shall pay for hospital outpatient ABPM services billed on a 13x and 14x type of bill with HCPCS 93786 and/or 93788 as follows: (1) Outpatient Prospective Payment System (OPPS) hospitals pay based on the Ambulatory Payment Classification (APC); (2) non-OPPS hospitals (Indian Health Services Hospitals, Hospitals that provide Part B services only, and hospitals located in American Samoa, Guam, Saipan and the Virgin Islands) pay based on reasonable cost; except for Maryland Hospitals which are paid based on a percentage of cost.	FISS
2726.2.2	The FI shall pay for Comprehensive Outpatient Rehabilitation Facility (CORF) ABPM services billed on a 75x type of bill with HCPCS code 93786 and/or 93788 based on the Medicare Physician Fee Schedule (MPFS) amount for that HCPCS code.	FISS

2726.2.3	The FI shall pay for ABPM services for critical access hospitals (CAHs) billed on a 85x type of bill as follows: (1) for CAHs that elected the Standard Method and billed HCPCS code 93786 and/or 93788, pay based on reasonable cost for that HCPCS code; and (2) for CAHs that elected the optional method and billed any combination of HCPCS codes 93786, 93788 and 93790 pay based on reasonable cost for HCPCS 93786 and 93788 and pay 115% of the MPFS amount for HCPCS 93790.	FISS
2726.2.4.	The FI shall pay for ABPM services for skilled nursing facility (SNF) outpatients billed on a 23x type of bill with HCPCS code 93786 and/or 93788, based on the MPFS.	FISS
2726.2.5	The FI shall accept independent and provider-based rural health clinic (RHC) visits billed under the all-inclusive rate when the RHC bills on a 71x type of bill with rev code 052x for providing the professional component of ABPM services. FIs shall not make a separate payment to a RHC for the professional component of ABPM services in addition to the all-inclusive rate.	FISS
2726.2.6	The FI shall accept free-standing and provider-based federally qualified health center (FQHC) visits billed under the all-inclusive rate when the FQHC bills on a 73x type of bill with rev code 052x for providing the professional component of ABPM services. FIs shall not make a separate payment to a FQHC for the professional component of ABPM services in addition to the all-inclusive rate.	FISS
2726.2.7	The FI shall pay provider-based RHCs/FQHCs for the technical component of ABPM services when billed under the base provider's number using the above requirements for that particular base provider type, i.e., a OPPS hospital-based RHC would be paid for the ABPM technical component services under the OPPS using the APC for code 93786 and/or 93788 when billed on a 13x type of bill. (See III.A. X-Ref Requirement # 2726.2.5-2726.2.6.)	FISS
2726.3	The local carrier shall accept and pay for ABPM services billed with diagnosis code 796.2 and with HCPCS codes 93784 or for any combination of 93786, 93788 and 93790, based on the MPFS for the specific HCPCS code(s) billed.	SSM (local carriers)

2726.4	FIs and local carriers shall apply coinsurance and deductible to payments for ABPM services except for payments by the FI to FQHCs where only co-insurance applies.	SSM (FISS & local carriers)
2726.5	FIs and local carriers need not search their files to adjust ABPM claims paid prior to this instruction. However, contractors should adjust claims brought to their attention by providers if they find errors in previous ABPM instructions prevented providers from receiving payment in a prior period when Medicare covered this procedure for this type of provider.	FIs and local carriers

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions:

X-Ref Requirement #	Instructions
2726.2.5 –2726.2.6	Independent and free-standing RHC/FQHC practitioners are only paid for providing the technical component of ABPM services when billed to the carrier following the instructions for billing the carrier.

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date: April 1, 2004 **Implementation Date:** April 5, 2004 **Pre-Implementation Contact(s):** Gertrude Saunders 410-786-5888 (FI claims processing); Yvette Cousar 410-786-2160 (carrier claims processing); and Pat Brocato-Simons 410-786-0261 (coverage policy only) **Post-Implementation Contact(s):** Appropriate regional office	**These instructions shall be implemented within your current operating budget.**

Medicare Claims Processing Manual

Chapter 32 – Billing Requirements for Special Services

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10.1 - Ambulatory Blood Pressure Monitoring (ABPM) Billing Requirements

10. Diagnostic Blood Pressure Monitoring

(Rev. 109, 02-27-04)

10.1. Ambulatory Blood Pressure Monitoring (ABPM) Billing Requirements

(Rev. 109, 02-27-04)

A. Coding Applicable to Local Carriers & Fiscal Intermediaries (FIs)

*Effective April 1, 2002, a National Coverage Decision was made to allow for Medicare coverage of ABPM for those beneficiaries with suspected "white coat hypertension" (WCH). ABPM involves the use of a non-invasive device, which is used to measure blood pressure in 24-hour cycles. These 24-hour measurements are stored in the device and are later interpreted by a physician. Suspected "WCH" is defined as: (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. ABPM is not covered for any other uses. Coverage policy can be found in Medicare National Coverage Determinations Manual, Chapter 1, Section 20.19. (*www.cms.hhs.gov/masnuals/103 cov determ/ncd103index.asp*)*

The ABPM must be performed for at least 24 hours to meet coverage criteria. Payment is not allowed for institutionalized beneficiaries, such as those receiving Medicare covered skilled nursing in a facility. In the rare circumstance that ABPM needs to be performed more than once for a beneficiary, the qualifying criteria described above must be met for each subsequent ABPM test.

Effective dates for applicable Common Procedure Coding System (HCPCS) codes for ABPM for suspected WCH and their covered effective dates 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 such as magnetic tape and/or computer disk, for 24 hours or longer; scanning analysis with report.*	*01/01/2004*

HCPCS	*Definition*	*Effective Date*
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*

In addition, the following diagnosis code must be present:

Diagnosis Code	*Description*
796.2	*Elevated blood pressure reading without diagnosis of hypertension.*

B. FI Billing Instructions

The applicable types of bills acceptable when billing for ABPM services are 13X, 14X, 23X, 71X, 73X, 75X, and 85X. Chapter 25 of this manual provides general billing instructions that must be followed for bills submitted to FIs. The FIs pay for hospital outpatient ABPM services billed on a 13x and 14x type of bill with HCPCS 93786 and/or 93788 as follows: (1) Outpatient Prospective Payment System (OPPS) hospitals pay based on the Ambulatory Payment Classification (APC); (2) non-OPPS hospitals (Indian Health Services Hospitals, Hospitals that provide Part B services only, and hospitals located in American Samoa, Guam, Saipan and the Virgin Islands) pay based on reasonable cost, except for Maryland Hospitals which are paid based on a percentage of cost.

The FIs pay for comprehensive outpatient rehabilitation facility (CORF) ABPM services billed on a 75x type of bill with HCPCS code 93786 and/or 93788 based on the Medicare Physician Fee Schedule (MPFS) amount for that HCPCS code.

The FIs pay for ABPM services for critical access hospitals (CAHs) billed on a 85x type of bill as follows: (1) for CAHs that elected the Standard Method and billed HCPCS code 93786 and/or 93788, pay based on reasonable cost for that HCPCS code; and (2) for CAHs that elected the Optional Method and billed any combination of HCPCS codes 93786, 93788 and 93790 pay based on reasonable cost for HCPCS 93786 and 93788 and pay 115% of the MPFS amount for HCPCS 93790.

The FIs pay for ABPM services for skilled nursing facility (SNF) outpatients billed on a 23x type of bill with HCPCS code 93786 and/or 93788, based on the MPFS.

The FIs accept independent and provider-based rural health clinic (RHC) bills for visits under the all-inclusive rate when the RHC bills on a 71x type of bill with revenue code 052x for providing the professional component of ABPM services. The FIs should not make a separate payment to a RHC for the professional component of ABPM services in

addition to the all-inclusive rate. RHCs are not required to use ABPM HCPCS codes for professional services covered under the all-inclusive rate.

The FIs accept free-standing and provider-based federally qualified health center (FQHC) bills for visits under the all-inclusive rate when the FQHC bills on a 73x type of bill with revenue code 052x for providing the professional component of ABPM services. The FIs should not make a separate payment to a FQHC for the professional component of ABPM services in addition to the all-inclusive rate. FQHCs are not required to use ABPM HCPCS codes for professional services covered under the all-inclusive rate.

The FIs pay provider-based RHCs/FQHCs for the technical component of ABPM services when billed under the base provider's number using the above requirements for that particular base provider type, i.e., a OPPS hospital based RHC would be paid for the ABPM technical component services under the OPPS using the APC for code 93786 and/or 93788 when billed on a 13x type of bill.

Independent and free-standing RHC/FQHC practitioners are only paid for providing the technical component of ABPM services when billed to the carrier following the carrier instructions.

C. Carrier Claims

Local carriers pay for ABPM services billed with diagnosis code 796.2 and HCPCS codes 93784 or for any combination of 93786, 93788 and 93790, based on the MPFS for the specific HCPCS code billed.

D. Coinsurance and Deductible

The FIs and local carriers shall apply coinsurance and deductible to payments for ABPM services except for services billed to the FI by FQHCs. For FQHCs only co-insurance applies.