Program Memorandum Intermediaries/Carriers

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

Transmittal AB-01-188 **Date: DECEMBER 18, 2001**

CHANGE REQUEST 1985

SUBJECT: Coverage and Billing of Ambulatory Blood Pressure Monitoring (ABPM)

This Program Memorandum (PM) ,summarizes the revision to §50-42 of the Coverage Issues Manual CIM) regarding ambulatory blood pressure monitoring. Please refer to this section of the CIM for complete information regarding the policy.

Coverage

Ambulatory blood pressure monitoring (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 at the physician's office. ABPM must be performed for at least 24 hours to meet coverage criteria. Payment is not allowed for institutionalized beneficiaries.

Effective April 1, 2002, ABPM is covered for those beneficiaries with suspected "white coat hypertension". Suspected "white coat hypertension" is defined as:

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

ABPM is not covered for any other uses. In the rare circumstance that ABPM needs to be performed more than once in a beneficiary, the qualifying criteria described above must be met for each subsequent ABPM test.

Intermediary Billing Instructions

Applicable HCPCS Codes

- 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
- 93786 - ABPM, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; recording only
- 93790 - ABPM, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; physician review with interpretation and report.

HCPCS code 93788 (ABPM, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; scanning analysis with report) is not approved for Medicare payment.

Payment Requirements

Intermediary payment is allowed for non-institutionalized beneficiaries in the following provider settings. Payment is as follows:

- Hospital outpatient department - OPPS, based on the APC

- Comprehensive outpatient rehabilitation facility - Medicare Physician Fee Schedule (MPFS)

- Critical access hospital - Reasonable cost or for those who have selected combined billing (Option Method II) they will receive 115% of MPFS.

- Rural health clinics/federally qualified health centers (RHCs/FQHCs) - All inclusive rate, professional component only, based on the visit furnished to the RHC/FQHC beneficiary. The technical component is outside the scope of the RHC/FQHC benefit. Therefore the provider of the technical service bills their carrier on Form CMS-1500 and payment is made under MPFS. For provider based RHCs/FQHCs payment for the technical component is made as indicated above based on the type of provider the RHC/FQHC is based with. For SNF based RHCs/FQHCs payment for the technical component is made based on the MPFS.

Deductible and coinsurance apply.

Applicable Bill Types

The applicable bill types are 13X, 14X, 23X, 71X, 73X, 75X and 85X.

<u>Special Billing Instructions for RHCs, and FQHCs</u>

Independent RHCs and free-standing FQHCs bill under bill type 71X and 73X for the professional component. The technical component is outside the scope of the RHC/FQHC benefit. The provider of the technical service bills their carrier on Form CMS-1500 or electronic equivalent.

The technical component for a provider based RHC/FQHC is typically furnished by the provider. The provider of that service bills under bill type, 13X, 14X, 23X or 85X as appropriate using their outpatient provider number (not the RHC/FQHC provider number since these services are not covered as RHC/FQHC services.)

Applicable Revenue Codes

The applicable revenue code for the test procedure is 920 except for CAHs, independent RHCs and free-standing FQHCs. CAHs report these procedures under revenue codes 96X, 97X or 98X. Independent RHCs and free-standing FQHCs report these procedures under revenue codes 521 and 520 respectively.

<u>Carrier Billing Instructions</u>

Applicable HCPCS Codes

- 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

- 93786 - ABPM, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; recording only

- 93790 - ABPM, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; physician review with interpretation and report

HCPCS code 93788 (ABPM, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; scanning analysis with report) is not approved for Medicare payment.

Claims Requirements

Follow the general instruction for preparing claims in §2010, Purpose of Health Insurance Claim Form HCFA-1500, Medicare Carriers Manual (MCM) Part 4, Chapter 2. Claims for ABPM are to

be submitted on health insurance claim Form CMS-1500 or electronic equivalent. Claims should be processed in accordance with §4020, Review of Health Insurance Claim Form HCFA-1500, of Part 3, Chapter IV of the Medicare Carriers Manual.

Payment Requirements

Payment and pricing information will be on the April update of the Medicare Physician Fee Schedule Database (MPFSDB). Pay for ABPM on the basis of the MPFS. Deductible and coinsurance apply. Claims from physicians or other practitioners where assignment was not taken are subject to the Medicare limiting charge (refer to MCM Part 3, chapter VII, §7555 for more information).

General Claims Processing Instructions

Claims Editing

Nationwide claims processing edits for pre and post payment review of claim(s) for ABPM are not being required at this time.

Remittance Advice Notice

Use appropriate existing remittance advice reason and remark codes at the line level to express the specific reason if you deny payment for ABPM. If denying services as furnished before April 1, 2002, use existing ANSI X 12-835 claim adjustment reason code 26 "Expenses incurred prior to coverage" at the line level.

Medicare Summary Notice (MSN) Messages

Use the following MSN messages where appropriate:

If a claim for ABPM is being denied because the service was performed prior to April 1, 2002, use the MSN message:

"This service was not covered by Medicare at the time you received it." (MSN Message 21.11)

The Spanish version of the MSN message should read:

"Este servicio no estaba cubierto por Medicare cuando usted lo recibio`." (MSN Message 21.11)

Provider Notification

Contractors should notify providers of this new national coverage in their next regularly scheduled bulletin, on their website, and in routinely scheduled training sessions.

The *effective date* for this PM is April 1, 2002.

The *implementation date* for this PM is April 1, 2002.

These instructions should be implemented within your current operating budget.

This PM may be discarded after April 1, 2003.

If you have any questions, contact the appropriate regional office. Providers and other interested parties should contact the appropriate carrier or intermediary.