

01-93875-16

Original Effective Date: 01/01/89

Reviewed: 12/07/23

Revised: 12/15/23

Subject: Ambulatory Blood Pressure Monitoring (ABPM) for Diagnosis of Hypertension in Members With Elevated Office Blood Pressure

THIS MEDICAL COVERAGE GUIDELINE IS NOT AN AUTHORIZATION, CERTIFICATION, EXPLANATION OF BENEFITS, OR A GUARANTEE OF PAYMENT, NOR DOES IT SUBSTITUTE FOR OR CONSTITUTE MEDICAL ADVICE. ALL MEDICAL DECISIONS ARE SOLELY THE RESPONSIBILITY OF THE PATIENT AND PHYSICIAN. BENEFITS ARE DETERMINED BY THE GROUP CONTRACT, MEMBER BENEFIT BOOKLET, AND/OR INDIVIDUAL SUBSCRIBER CERTIFICATE IN EFFECT AT THE TIME SERVICES WERE RENDERED. THIS MEDICAL COVERAGE GUIDELINE APPLIES TO ALL LINES OF BUSINESS UNLESS OTHERWISE NOTED IN THE PROGRAM EXCEPTIONS SECTION.

Position Statement	Billing/Coding	Reimbursement	Program Exceptions	Definitions	Related Guidelines
Other	References	Updates			

DESCRIPTION:

Ambulatory blood pressure (BP) monitors are portable devices that continually record BP while the patient is involved in daily activities. There are various types of ambulatory monitors; such as fully automated monitors, which inflate and record BP at preprogrammed intervals. Ambulatory blood pressure monitoring (ABPM) has the potential to improve the accuracy of diagnosing hypertension and thus improve the appropriateness of medication treatment.

ABPM is typically done over a 24-hour period with a fully automated device and provides more detailed BP information than readings typically obtained during office visits. The greater number of readings with ABPM improves the variability of single BP measurements and is more representative of the circadian rhythm of BP compared with the limited number obtained during office measurement.

There are a number of potential applications of ABPM. One of the most common is evaluating suspected white coat hypertension (WCH), which is defined as an elevated office BP with normal BP readings outside the physician's office. The etiology of WCH is poorly understood but may be related to an "alerting" or anxiety reaction associated with visiting the physician's office.

In assessing patients with elevated office BP, ABPM is often intended to identify those with normal ambulatory readings who do not have sustained hypertension. Because this group of patients would otherwise be treated based on office BP readings alone, ABPM could improve outcomes by allowing these patients to avoid unnecessary treatment. However, this assumes patients with WCH are not at increased risk for cardiovascular events and would not benefit from antihypertensive treatment.

POSITION STATEMENT:

Automated ambulatory blood pressure monitoring over a 24-hour period with an FDA approved device **meets the definition of medical necessity** for members with elevated office blood pressure (BP), when performed 1 time to differentiate between “white coat hypertension” and true hypertension, when **ALL** of the following conditions are met:

- Office BP elevation is in the mild-to-moderate range (<180/110 mm Hg), not requiring immediate treatment with medications; and
- There is an absence of hypertensive end-organ damage on physical examination and laboratory testing **OR**
- The member is post kidney or heart transplant.

All other uses of ambulatory blood pressure monitoring for members with elevated office BP, including but not limited to repeated testing in members with persistently elevated office BP, and monitoring of treatment effectiveness, is considered **experimental or investigational**. The evidence is insufficient to determine the effects of the technology on health outcomes.

Note: Per USPSTF Screening for High Blood Pressure in Adults (Grade A recommendation): Ambulatory blood pressure monitoring may be used to confirm a diagnosis of hypertension after initial screening.

BILLING/CODING INFORMATION:

CPT Coding:

93784	Ambulatory blood pressure monitoring, utilizing report-generating software, automated, worn continuously for 24 hours or longer; including recording, scanning analysis, interpretation and report
93786	Ambulatory blood pressure monitoring, utilizing report-generating software, automated, worn continuously for 24 hours or longer; recording only
93788	Ambulatory blood pressure monitoring, utilizing report-generating software, automated, worn continuously for 24 hours or longer; scanning analysis with report
93790	Ambulatory blood pressure monitoring, utilizing report-generating software, automated, worn continuously for 24 hours or longer; review with interpretation and report

HCPCS Coding:

A4670	Automatic blood pressure monitor
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REIMBURSEMENT INFORMATION:

Ambulatory blood pressure monitoring is limited to one (1) in twelve (12) months. In the rare circumstances that ABPM needs to be performed more than once in a member, the qualifying criteria must be met for each subsequent ABPM test.

NOTE: Services in excess of the limitations shown above (e.g. repeat study for follow-up) are subject to medical review of documentation for determination of medical necessity. The following information

may be required documentation to support medical necessity: physician history and physical, conservative treatment plan, physician progress notes, and all laboratory studies.

LOINC Codes:

DOCUMENTATION TABLE	LOINC CODES	LOINC TIME FRAME MODIFIER CODE	LOINC TIME FRAME MODIFIER CODES NARRATIVE
Attending physician progress note	18741-9	18805-2	Include all data of the selected type that represents observations made six months or fewer before starting date of service for the claim.
Chemistry Studies (i.e., fasting blood glucose, serum BUN, creatinine, sodium, potassium, calcium, blood hematocrit, lipid profile, albumin/creatinine ratio)	19011-6	18805-2	Include all data of the selected type that represents observations made six months or fewer before starting date of service for the claim.
Current, Discharge, or administered medications	34483-8	18805-2	Include all data of the selected type that represents observations made six months or fewer before starting date of service for the claim.
Medication Current	19009-0	18805-2	Include all data of the selected type that represents observations made six months or fewer before starting date of service for the claim.
Physician history and physical	28626-0	18805-2	Include all data of the selected type that represents observations made six months or fewer before starting date of service for the claim.
Urinalysis Studies	18729-4	18805-2	Include all data of the selected type that represents observations made six months or fewer before starting date of service for the claim.

PROGRAM EXCEPTIONS:

Federal Employee Program (FEP): Follow FEP guidelines.

State Account Organization (SAO): Follow SAO guidelines.

Medicare Advantage products: The following National Coverage Determination (NCD) was reviewed on the last guideline reviewed date: Ambulatory Blood Pressure Monitoring (20.19) located at [cms.gov](https://www.cms.gov).

If this Medical Coverage Guideline contains a step therapy requirement, in compliance with Florida law 627.42393, members or providers may request a step therapy protocol exemption to this requirement if

based on medical necessity. The process for requesting a protocol exemption can be found at [Coverage Protocol Exemption Request](#)

DEFINITIONS:

No guideline specific definitions apply.

RELATED GUIDELINES:

[Preventive Services, 01-99385-03](#)

OTHER:

None applicable.

REFERENCES:

1. Blue Cross Blue Shield Association Evidence Positioning System®; 1.01.02, Automated Ambulatory Blood Pressure Monitoring for Diagnosis of Hypertension in Patients With Elevated Office Blood Pressure, 08/23.
2. Blue Cross Blue Shield Association Technology Evaluation Center, “Ambulatory Blood Pressure Monitoring for Diagnosis of Hypertension in Adults,” (06/99; updated 2001).
3. Centers for Medicare & Medicaid Services (CMS), National Coverage Determination (NCD) for Ambulatory Blood Pressure Monitoring (20.19), accessed at cms.gov.
4. Chobanian A, Bakris G et al. The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure. The JNC 7 Report. JAMA. 2003; 289:2560-2572.
5. Gartlehner G, Vander Schaaf EB, et al. Screening for Hypertension in Children and Adolescents: Updated Evidence Report and Systematic Review for the US Preventive Services Task Force. JAMA. 2020 Nov 10;324(18):1884-1895.
6. Krist AH, Davidson KW, et al. Screening for Hypertension in Adults: US Preventive Services Task Force Reaffirmation Recommendation Statement. JAMA. 2021 Apr 27;325(16):1650-1656.
7. Muntner P, Shimbo D, et al. Measurement of Blood Pressure in Humans: A Scientific Statement From the American Heart Association. Hypertension. May 2019; 73(5): e35-e66.
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9. Palmas W, Pickering TG, Teresi J, Schwartz JE, Moran A, Weinstock RS, Shea S. Ambulatory blood pressure monitoring and all-cause mortality in elderly people with diabetes mellitus. Hypertension. 2009 Feb;53 (2):120-7. Epub 2009 Jan 5.
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11. Prado JC, Lopez A, et al, Immediate post renal transplant period and hypertension: concordance between clinic and ambulatory blood pressure; JASH April 2016, Volume 10 , Issue 4 , e34.
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14. Townsend RR, Cohen J. Out-of-office blood pressure measurement: Ambulatory and self-measured blood pressure monitoring. In: UpToDate, Bakris GL, Gersh BJ, Forman JP, Kunins L (Eds); UpToDate, Waltham, MA; accessed at uptodate.com.
15. U.S. Preventive Services Task Force (USPSTF). Hypertension in Adults: Screening, Release Date: April 2021; accessed at uspreventiveservicestaskforce.org.
16. U.S. Preventive Services Task Force (USPSTF). High Blood Pressure in Children and Adolescents: Screening, Date: November 2020; accessed at uspreventiveservicestaskforce.org.
17. U.S. Preventive Services Task Force; Krist AH, Davidson KW, et al. Screening for Hypertension in Adults: US Preventive Services Task Force Reaffirmation Recommendation Statement. JAMA. 2021 Apr 27;325(16):1650-1656.
18. Whelton PK, Carey RM, et al. 2017 ACC/AHA/AAPA/ABC/ACPM/AGS/APhA/ASH/ASPC/NMA/PCNA Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults: Executive Summary: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines. J Am Coll Cardiol. May 15 2018;71(19):2199-2269.

COMMITTEE APPROVAL:

This Medical Coverage Guideline (MCG) was approved by the Florida Blue Medical Policy and Coverage Committee on 12/07/23.

GUIDELINE UPDATE INFORMATION:

01/01/89	Medical Coverage Guideline secondary to BCA TEC in 1988 – investigational.
06/15/02	Reformatted & revised – investigational – Medicare coverage added.
05/15/03	Reviewed; no change (investigational).
07/15/04	Scheduled review and revision; consisting of updated references and added coverage statement with set criteria.
08/15/05	Scheduled review and revision; consisting of updated references.
09/15/07	Review; coverage statement maintained, guideline reformatted, and updated references.
07/15/11	Revision; formatting changes.
03/15/12	Review; Position Statement and Reimbursement section revised, references updated; formatting changes.
01/01/13	Annual HCPCS coding update; revised descriptor for 93790
05/11/14	Revision: Program Exceptions section updated.
08/15/16	Revision; note added to position statement section and references updated.
10/15/16	Revision; title, description, position statements, coding, and references updated.
12/15/17	Review; position statement and references updated.
08/15/19	Review; position statements maintained and references updated.
01/01/20	Annual CPT/HCPCS coding update. Revised codes 93784-93790.
09/15/21	Review; position statements maintained; references updated.
05/22/23	Update to Program Exceptions section.

12/15/23

Review: Position statements maintained; description and references updated.