

<b>CMS Manual System</b>	<b>Department of Health &amp; Human Services (DHHS)</b>
<b>Pub 100-04 Medicare Claims Processing</b>	<b>Centers for Medicare &amp; Medicaid Services (CMS)</b>
<b>Transmittal 10073</b>	<b>Date: May 1, 2020</b>
	<b>Change Request 11650</b>

**SUBJECT: National Coverage Determination (NCD) 20.19 Ambulatory Blood Pressure Monitoring (ABPM)**

**I. SUMMARY OF CHANGES:** The purpose of this change request is to inform contractors that for dates of service on and after July 2, 2019, CMS will cover Ambulatory Blood Pressure Monitoring for the diagnosis of hypertension in Medicare beneficiaries under updated criteria.

**EFFECTIVE DATE: July 2, 2019**

*\*Unless otherwise specified, the effective date is the date of service.*

**IMPLEMENTATION DATE: June 16, 2020 - MAC local edits; October 5, 2020 - CWF, MCS, FISS edits**

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

**II. CHANGES IN MANUAL INSTRUCTIONS:** (N/A if manual is not updated)

R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

<b>R/N/D</b>	<b>CHAPTER / SECTION / SUBSECTION / TITLE</b>
R	32/10.1/10.1 - Ambulatory Blood Pressure Monitoring (ABPM) Billing Requirements

**III. FUNDING:**

**For Medicare Administrative Contractors (MACs):**

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

**IV. ATTACHMENTS:**

**Business Requirements  
Manual Instruction**

# Attachment - Business Requirements

Pub. 100-04	Transmittal: 10073	Date: May 1, 2020	Change Request: 11650
-------------	--------------------	-------------------	-----------------------

**SUBJECT: National Coverage Determination (NCD) 20.19 Ambulatory Blood Pressure Monitoring (ABPM)**

**EFFECTIVE DATE: July 2, 2019**

*\*Unless otherwise specified, the effective date is the date of service.*

**IMPLEMENTATION DATE: June 16, 2020 - MAC local edits; October 5, 2020 - CWF, MCS, FISS edits**

## I. GENERAL INFORMATION

**A. Background:** Ambulatory Blood Pressure Monitoring (ABPM) is a diagnostic test that allows for the identification of various types of High Blood Pressure (BP). ABPM devices are small portable machines that are connected to a BP cuff worn by patients that record Blood Pressure (BP) at regular periods over 24 to 48 hours while the patient goes about their normal activities, including sleep. The recording is interpreted by a physician or non-physician practitioner, and appropriate action is taken based on the findings. Diagnosis and treatment of high BP is important for the management of various conditions including cardiovascular disease and kidney disease.

Section 20.19 of the Medicare National Coverage Determinations (NCD) Manual establishes conditions of coverage for ABPM. The Centers for Medicare & Medicaid Services (CMS) has covered ABPM since 2001 only for those patients with documented suspected white coat hypertension (WCH). On January 16, 2003, a technical correction for this NCD was issued to clarify that a physician is required to perform the interpretation of the data obtained through ABPM, but there are no requirements regarding the setting in which the interpretation is performed.

NOTE: Please refer to the previous Change Requests (CRs) 2726 and 9751 for additional information.

**B. Policy:** For dates of service on and after July 2, 2019, CMS will cover ABPM for the diagnosis of hypertension in Medicare beneficiaries under the following circumstances:

1. For beneficiaries with suspected WCH, which is defined as average office systolic BP greater than 130 mm Hg but less than 160 mm Hg or diastolic BP greater than 80 mm Hg but less than 100 mm Hg on two separate clinic/office visits with at least two separate measurements made at each visit and with at least two BP measurements taken outside the office which are less than 130/80 mm Hg.
2. For beneficiaries with suspected masked hypertension, which is defined as average office BP between 120 mm Hg and 129 mm Hg for systolic BP or between 75 mm Hg and 79 mm Hg for diastolic BP on two separate clinic/office visits with at least two separate measurements made at each visit and with at least two BP measurements taken outside the office which are greater than or equal to 130/80 mm Hg.

ABPM devices must be:

- capable of producing standardized plots of BP measurements for 24 hours with daytime and night-time windows and normal BP bands demarcated;
- provided to patients with oral and written instructions, and a test run in the physician's office must be performed; and,
- interpreted by the treating physician or treating non-physician practitioner.

Coverage of other indications for ABPM is at the discretion of the Medicare Administrative Contractors.

**NOTE: Effective July 2, 2019, for eligible patients, ABPM is covered once per year.**

## II. BUSINESS REQUIREMENTS TABLE

*"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.*

Number	Requirement	Responsibility									Other
		A/B MAC			D M E M A C	Shared- System Maintainers					
		A	B	H H H		F I S S	M C S	V M S	C W F		
11650 - 04.1	Effective for claims with dates of service on and after July 2, 2019, contractors shall pay ABPM claims containing Healthcare Common Procedure Coding System (HCPCS) codes 93784, along with the International Classification of Diseases Tenth Edition (ICD-10) dx R03.0 elevated blood pressure reading without the diagnosis of hypertension, when billed in accordance with the coverage criteria outlined in Pub 100-03, chapter 1, section 20.19 of the NCD Manual and the claims processing requirements at Pub. 100-04, chapter 32, section 10, Medicare Claims Processing Manual.	X	X			X					
11650 - 04.2	For ABPM claims with dates of service on and after October 5, 2020, the Common Working File (CWF) shall not allow payment for a subsequent ABPM claim, HCPCS 93784, if a previous ABPM, HCPCS 93784, is paid within the past year (12 months).  CWF shall count 11 full months starting with the month a beneficiary's last ABPM (93784) is paid. EX: If a date of service is February 15, 2020, the next eligible date would be February 1, 2021.  NOTE: The existing screen SCRNs Aux File in HMIR will be updated to post the previous ABPM HCPCS 93784.									X	
11650 - 04.3	When denying claims for subsequent ABPM HCPCS 93784, along with ICD-10 dx R03.0 because a previous 93784, along with ICD-10 dx R03.0 is paid within the past year (12 months), contractors shall use the following messages:  Claim Adjustment Reason Code (CARC) 119: "Benefit maximum for this time period or occurrence has been reached."	X	X			X					

Number	Requirement	Responsibility									
		A/B MAC		H H H	D M E M A C	Shared- System Maintainers				Other	
		A	B			F I S S	M C S	V M S	C W F		
	<p>Remittance Advice Remark Code (RARC) N130: “Consult plan benefit documents/ guidelines for information about restrictions for this service.”</p> <p>Medicare Summary Notice (MSN) 20.5: “These services cannot be paid because your benefits are exhausted at this time.”</p> <p>Spanish Version: “Estos servicios no pueden ser pagados porque sus beneficios se han agotado.”</p> <p>Contractors shall use Group Code PR assigning financial liability to the beneficiary, if a claim is received with a signed Advance Beneficiary Notice (ABN) on file.</p> <p>Contractors shall use Group Code CO assigning financial liability to the provider, if a claim is received with no signed ABN on file.</p>										
11650 - 04.4	<p>For ABPM HCPCS 93784 claims CWF shall apply appropriate updates to the Next Eligibility Dates file for dates of service on or after July 2, 2019.</p> <p><b>NOTE:</b> Appropriate updates include modifications to the HIMR (PRVN), Provider Inquiry, HUQA, and Extract Records on the Next Generation Desktop (NGD) and the Medicare Beneficiary Database (MBD).</p>					X	X		X	MBD, NGD	
11650 - 04.5	<p>For ABPM claims with dates of service on and after October 5, 2020, the Multi-Carrier System Desktop Tool shall display the ABPM visits in a format equivalent to the CWF HIMR screen.</p>						X				
11650 - 04.6	<p>Contractors shall not search and adjust ABPM claims, HCPCS 93784, along with ICD-10 R03.0, paid for more than once within a 12-month period processed prior to the full implementation of this CR of October 5, 2020. However, contractors should adjust claims brought to their attention.</p>	X	X								
11650 - 04.7	<p>Contractors shall end-date ABPM editing for procedure codes 93786, 93788, and 93790 effective for claims with dates of service on and after July 2, 2019.</p>	X	X			X	X				

### III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			D M E D I	C E D I
		A	B	H H H		
11650 - 04.8	MLN Article: CMS will make available an MLN Matters provider education article that will be marketed through the MLN Connects weekly newsletter shortly after the CR is released. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1, instructions for distributing MLN Connects information to providers, posting the article or a direct link to the article on your website, and including the article or a direct link to the article in your bulletin or newsletter. You may supplement MLN Matters articles with localized information benefiting your provider community in billing and administering the Medicare program correctly. Subscribe to the “MLN Matters” listserv to get article release notifications, or review them in the MLN Connects weekly newsletter.	X	X			

### IV. SUPPORTING INFORMATION

**Section A: Recommendations and supporting information associated with listed requirements: N/A**

*"Should" denotes a recommendation.*

X-Ref Requirement Number	Recommendations or other supporting information:

**Section B: All other recommendations and supporting information: N/A**

### V. CONTACTS

**Pre-Implementation Contact(s):** David Dolan, 410-786-3365 or David.Dolan@cms.hhs.gov (Coverage and Analysis), Wanda Belle, 410-786-7491 or Wanda.Belle@cms.hhs.gov (Coverage and Analysis), Patricia Brocato-Simons, 410-786-0261 or Patricia.BrocatoSimons@cms.hhs.gov (Coverage and Analysis), William Ruiz, 410-786-9283 or William.Ruiz@cms.hhs.gov (Institutional Claims), Thomas Dorsey, 410-786-7434 or Thomas.Dorsey@cms.hhs.gov (Professional Claims)

**Post-Implementation Contact(s):** Contact your Contracting Officer's Representative (COR).

### VI. FUNDING

**Section A: For Medicare Administrative Contractors (MACs):**

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question

and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

**ATTACHMENTS: 0**

## 10.1 - Ambulatory Blood Pressure Monitoring (ABPM) Billing Requirements

*(Rev. 10073, Issued: 05-01-2020, Effective: 07-02-2019, Implementation: 06-16, 2020, 10-05-2020)*

### A. Coding Applicable to A/B MACs (A and B)

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, Part 1, §20.19.

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 <i>Discontinued 7/2/2019</i>
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 <i>Discontinued 7/2/2019</i>
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 <i>Discontinued 7/2/2019</i>

In addition, the following diagnosis code must be present:

	Diagnosis Code	Description
If ICD-10-CM is applicable	R03.0	Elevated blood pressure reading without diagnosis of hypertension

## **B. Revised Coverage Criteria**

*Effective for dates of service on and after July 2, 2019, Medicare covers ABPM for the diagnosis of hypertension in Medicare beneficiaries under the following circumstances:*

- 1. For beneficiaries with suspected white coat hypertension, which is defined as average office blood pressure of systolic blood pressure greater than 130 mm Hg but less than 160 mm Hg, or diastolic blood pressure greater than 80 mm Hg but less than 100 mm Hg on two separate clinic/office visits with at least two separate measurements made at each visit, and with at least two blood pressure measurements taken outside the office which are less than 130/80 mm Hg.*
- 2. For beneficiaries with suspected masked hypertension, which is defined as average office blood pressure between 120 mm Hg and 129 mm Hg for systolic blood pressure, or between 75 mm Hg and 79 mm Hg for diastolic blood pressure on two separate clinic/office visits with at least two separate measurements made at each visit, and with at least two blood pressure measurements taken outside the office which are greater than or equal to 130/80 mm Hg.*

*ABPM devices must be:*

- capable of producing standardized plots of blood pressure measurements for 24 hours with daytime and night-time windows and normal blood pressure bands demarcated;*
- provided to patients with oral and written instructions, and a test run in the physician's office must be performed; and,*
- interpreted by the treating physician or treating non-physician practitioner.*

*Effective July 2, 2019, for eligible patients, ABPM is covered once per year.*

*Coverage of other indications for ABPM are at the discretion of the Medicare Administrative Contractors.*

## **C. A/B MAC (A) Billing Instructions**

The applicable types of bills acceptable when billing for ABPM services are 13X, 23X, 71X, 77X, 75X, and 85X. Chapter 25 of this manual provides general billing instructions that must be followed for bills submitted to A/B MACs (A). The A/B MACs (A) pay for hospital outpatient ABPM services billed on a 13X type of bill with HCPCS 93786 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. Effective 4/1/06, type of bill 14X is for non-patient laboratory specimens and is no longer applicable for ABPM.

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

The A/B MACs (A) 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 pay based on reasonable cost for that HCPCS code; and (2) for CAHs that elected the Optional Method and billed HCPCS code 93786, pay based on reasonable cost for HCPCS 93786.

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

The A/B MACs (A) 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 A/B MACs (A) 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 A/B MACs (A) 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 77x type of bill with revenue code 052x for providing the professional component of ABPM services.

The A/B MACs (A) 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 A/B MACs (A) 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 OPFS hospital based RHC would be paid for the ABPM technical component services under the OPFS using the APC for code 93786 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 A/B MAC (B) following the MAC's instructions.

#### **D. A/B MAC (B) Claims**

A/B MACs (B) pay for ABPM services billed with ICD-9-CM diagnosis code 796.2 (if ICD-9 is applicable) or, if ICD-10 is applicable, ICD-10-CM diagnosis code R03.0 and HCPCS codes 93784 based on the MPFS for the specific HCPCS code billed.

#### **E. Coinsurance and Deductible**

The A/B MACs (A and B) shall apply coinsurance and deductible to payments for ABPM services except for services billed to the A/B MAC (A) by FQHCs. For FQHCs only co-insurance applies.

#### **F. CWF Editing**

*For ABPM claims with dates of service on and after October 5, 2020, CWF shall not allow payment for a subsequent ABPM claim, HCPCS 93784, if a previous ABPM, HCPCS 93784 is paid in history within the past 12 months.*

*CWF shall count 11 full months starting with the month a beneficiary's last ABPM (93784) is paid in the history file.*

#### **G. Medicare Summary Notices (MSNs), Remittance Advice Remark Codes (RARC), Claim Adjustment Reason Codes (CARCs) and Group Codes**

*When denying claims for subsequent ABPM HCPCS 93784, along with ICD-10 dx R03.0, because a previous 93784, along with ICD-1- dx R03.0, is paid in history within the past 12 months, contractors shall use the following messages:*

*CARC 119: "Benefit maximum for this time period or occurrence has been reached."*

*RARC N130: "Consult plan benefit documents/ guidelines for information about restrictions for this service."*

*MSN 20.5: "These services cannot be paid because your benefits are exhausted at this time."*