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

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Related Change Request (CR) Number: 11650
Effective Date: July 2, 2019
Implementation Date: June 16, 2020 – local MAC edits; October 5, 2020 – Medicare systems

PROVIDER TYPES AFFECTED

This MLN Matters Article is for physicians, hospitals, and other providers billing Medicare Administrative Contractors (MACs) for Ambulatory Blood Pressure Monitoring (ABPM) services provided to Medicare beneficiaries.

WHAT YOU NEED TO KNOW

This article informs you that, for dates of service on and after July 2, 2019, the Centers for Medicare & Medicaid Services (CMS) will cover ABPM for the diagnosis of hypertension in Medicare beneficiaries under updated criteria.

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 White Coat Hypertension (WCH), which is defined as average office systolic Blood Pressure (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

• Interpreted by the treating physician or treating non-physician practitioner

Coverage of other indications for ABPM is at the discretion of the MACs.

**NOTE:** Effective for dates of service on or after July 2, 2019, for eligible patients, ABPM is covered once per year.

When denying claims for subsequent ABPM on or after October 5, 2020, (HCPCS 93784) because a previous claim with HCPCS 93784 is paid in claims history within the past 12 months, MACs will use the following messages:

- Claim Adjustment Reason Code (CARC) 119: Benefit maximum for this time period or occurrence has been reached.
- Remittance Advice Remarks Code (RARC) N130: Consult plan benefit documents/guidelines for information about restrictions for this service.

**NOTE:** Previous ABPM procedure codes 93786, 93788, and 93790 will be end-dated for claims with dates of service on and after July 2, 2019.

**BACKGROUND**

ABPM is a diagnostic test that allows for the identification of various types of high BP. The Medicare National Coverage Determinations (NCD) Manual, Section 20.19, establishes conditions of coverage for ABPM. CMS has covered ABPM since 2001 only for those patients with documented suspected 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:** The ABPM claims processing instructions provided in previous CRs 2726 and 9751 should be consulted for additional information.

**ADDITIONAL INFORMATION**


If you have questions, your MACs may have more information. Find their website at [http://go.cms.gov/MAC-website-list](http://go.cms.gov/MAC-website-list).
DOCUMENT HISTORY

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
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<tbody>
<tr>
<td>April 12, 2021</td>
<td>We replaced article links with links to related CRs.</td>
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<tr>
<td>May 12, 2020</td>
<td>Initial article released.</td>
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