CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 13700	**Date: March 27, 2026**
	Change Request 14424

SUBJECT: Update to the Internet Only Manual (IOM) Publication (Pub.) 100-04, Chapter 32, Section 10.1 Incorporating Manual Updates from Change Request (CR) 11650 - National Coverage Determination (NCD) 20.19 Ambulatory Blood Pressure Monitoring (ABPM) and CR 12376 – Revisions to Chapters 13, 18 and 32 To Update Coding

I. SUMMARY OF CHANGES: The purpose of this CR is to update the manual instructions in IOM 100-04, Chapter 32, Section 10.1 to align with CR 11650 - National Coverage Determination (NCD) 20.19 Ambulatory Blood Pressure Monitoring (ABPM) and CR 12376 – Revisions to Chapters 13,18 and 32 To Update Coding.

EFFECTIVE DATE: April 27, 2026
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 27, 2026

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/revised 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.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	32/10/10.1/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: 13700	Date: March 27, 2026	Change Request: 14424

SUBJECT: Update to the Internet Only Manual (IOM) Publication (Pub.) 100-04, Chapter 32, Section 10.1 Incorporating Manual Updates from Change Request (CR) 11650 - National Coverage Determination (NCD) 20.19 Ambulatory Blood Pressure Monitoring (ABPM) and CR 12376 – Revisions to Chapters 13, 18 and 32 To Update Coding

EFFECTIVE DATE: April 27, 2026
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 27, 2026

I. SUMMARY OF CHANGES: The purpose of this CR is to update the manual instructions in IOM 100-04, Chapter 32, Section 10.1 to align with CR 11650 - National Coverage Determination (NCD) 20.19 Ambulatory Blood Pressure Monitoring (ABPM) and CR 12376 – Revisions to Chapters 13,18 and 32 To Update Coding.

II. GENERAL INFORMATION

A. Background: The purpose of this CR is to update IOM 100-04, Chapter 32, Section 10.1 to ensure alignment with CR 11650 (National Coverage Determination (NCD) 20.19, Ambulatory Blood Pressure Monitoring (ABPM)) and CR 12376 (Revisions to Chapters 13, 18, and 32 to Update Coding) are included in the manual.

It was determined that certain information was missing from the manual, and the content has been consolidated from the following CRs:

- CR 11650 – National Coverage Determination (NCD) 20.19, Ambulatory Blood Pressure Monitoring (ABPM)
- CR 12376 – Revisions to Chapters 13, 18, and 32 to Update Coding

B. Policy: N/A

III. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
14424.1	Contractors shall be aware of the manual updates in IOM Pub. 100-04, chapter 32, section 10.1 titled: Ambulatory Blood Pressure Monitoring (ABPM) Billing Requirements.	X	X							

IV. PROVIDER EDUCATION

Medicare Learning Network® (MLN): CMS will develop and release national provider education content and market it through the MLN Connects® newsletter shortly after we issue the CR. MACs shall link to relevant information on your website and follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 for distributing the newsletter to providers. When you follow this manual section, you don't need to separately track and report MLN content releases. You may supplement with your local educational content after we release the newsletter.

Impacted Contractors: A/B MAC Part B, A/B MAC Part A

V. 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

VI. CONTACTS

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

VII. 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.13700; Issued:03-27-2026; Effective:04-27-2026; Implementation:04-27-2026)

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 use. Coverage policy can be found in Medicare National Coverage Determinations Manual, Chapter 1, Part 1, §20.19. (http://www.cms.hhs.gov/manuals/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 *Discontinued 7/2/2019*
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 *Discontinued 7/2/2019*

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 *Discontinued 7/2/2019*

In addition, one of the following diagnosis codes must be present:

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

is applicable		

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 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. 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 and/or 93788 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 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 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 and/or 93788, 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 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 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-10-CM diagnosis code R03.0 (if ICD-10 is applicable) and HCPCS codes 93784 or for any combination of 93786, 93788 and 93790, 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 (RARCs), 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."

Spanish Version: "Estos servicios no pueden ser pagados porque sus beneficios se han agotado."

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.

Contractors shall use Group Code CO assigning financial liability to the provider, if a claim is received with no signed ABN on file.