

Welch Allyn ABPM

2010 REIMBURSEMENT INFORMATION



CPT®* CODING OPTIONS FOR AMBULATORY BLOOD PRESSURE MONITORING AND MEDICARE FEE SCHEDULE

Code	Description	National Average ¹	Alabama	San Francisco
93784	Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report	\$64.59	\$56.48	\$86.73
93786	Recording only	\$29.23	\$24.80	\$41.75
93788	Scanning analysis with report	\$16.24	\$13.72	\$23.03
93790	Physician review with interpretation and report	\$19.12	\$17.95	\$21.95

Fee schedule as of 1/1/2010.

For reference only. Information does not constitute a guarantee of coverage or payment.

¹ National Average Medicare Physician Fee Schedule Amounts: 70 Fed. Reg. 68132-68215 (2005) (to be codified at 42 CFR § 484).

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MEDICARE Medicare has instituted a National Coverage Determination (NCD) outlining coverage guidelines for ambulatory blood pressure monitoring (ABPM) for Medicare beneficiaries.

ABPM is covered only for those patients with suspected white coat hypertension. White coat hypertension is defined as a condition in which the physician suspects the patient has higher blood pressure during a physician office visit than during daily life due to anxiety or other factors the patient experiences in the office.

The clinical criteria for white coat hypertension are defined as:²

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

In addition to the above criteria, ABPM must be performed for a period of at least 24 hours to be eligible for Medicare reimbursement.

PRIVATE PAYERS

ABPM may be covered by private payers for suspected white coat hypertension meeting similar clinical criteria as defined by Medicare. Some private payer plans may also cover ABPM for additional clinical indications, possibly including but not necessarily limited to the following:

- Resistant hypertension (little prior response to hypertension medications)
- Evaluation of hypotensive symptoms as a response to hypertension medications
- Nocturnal angina
- Episodic hypertension
- Evaluation of syncope (in conjunction with a Holter monitor to test for arrhythmia)

Coverage guidelines and payment levels vary by payer and specific plan. Providers should contact each specific plan to determine coverage and payment for ABPM or may call the Customer Care Line for assistance.

OTHER CONSIDERATIONS

- Include documentation in the patient's records to indicate medical necessity for a separate service, including:
 - Reason for patient encounter
 - Patient symptoms
 - Who performs the service
 - Time and effort spent in performing procedure
 - Results of the ABPM services provided
- Confirm that proper ICD-9-CM diagnosis codes are reported to justify medical necessity of ABPM.
- Some payers may have specific requirements for using certain codes, including prior authorization, restricted medical diagnoses, or specialty provider types.

Be sure to confirm the requirements and specific coding, coverage, medical necessity, and reimbursement guidelines of the payer you are billing before submitting claims by reviewing your managed care contracts, consulting the *Physicians' Current Procedural Terminology, Fourth Edition (CPT-4)* or *The Federal Register*, or contacting provider services.