Ambulatory Blood Pressure Monitoring

I. Description

Ambulatory blood pressure monitoring (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 the physician.

II. Criteria/Guidelines

A. ABPM is covered (subject to Administrative Guidelines) for those patients with suspected "white coat" hypertension, defined as:
   1. Office blood pressure is greater than 140/90 mm Hg on at least three separate office/clinic visits with two separate measurements made at each visit.
   2. Two or more documented blood pressure measurements taken outside the office/clinic are less than 140/90 mm Hg.
   3. No evidence of end-organ damage.

B. ABPM must be performed for at least 24 hours and the information obtained must be necessary to determine the appropriate management of the patient.

III. Administrative Guidelines

A. Precertification is not required. HMSA reserves the right to perform retrospective reviews using the above criteria to validate if services rendered were medically necessary.

B. Applicable Codes

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>93784</td>
<td>ABPM, utilizing a system such as magnetic tape and/or computer disk, for 24</td>
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<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>93786</td>
<td>recording only</td>
</tr>
<tr>
<td>93788</td>
<td>scanning analysis with report</td>
</tr>
<tr>
<td>93790</td>
<td>physician review with interpretation and report</td>
</tr>
</tbody>
</table>

### IV. Important Reminder

The purpose of this Medical Policy is to provide a guide to coverage. This Medical Policy is not intended to dictate to providers how to practice medicine. Nothing in this Medical Policy is intended to discourage or prohibit providing other medical advice or treatment deemed appropriate by the treating physician.

Benefit determinations are subject to applicable member contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control.

This Medical Policy has been developed through consideration of the medical necessity criteria under Hawaii’s Patients’ Bill of Rights and Responsibilities Act (Hawaii Revised Statutes §432E-1.4), generally accepted standards of medical practice and review of medical literature and government approval status. HMSA has determined that services not covered under this Medical Policy will not be medically necessary under Hawaii law in most cases. If a treating physician disagrees with HMSA’s determination as to medical necessity in a given case, the physician may request that HMSA reconsider the application of the medical necessity criteria to the case at issue in light of any supporting documentation.

### V. References