I. POLICY/Criteria

A. HOME BLOOD PRESSURE MONITORS

1. FOR COMMERCIAL MEMBERS:

Home Blood Pressure Monitors (HBPM) are a covered benefit for commercial members (fully funded and self-funded) when all of the following are met:

a. HBPM prescribed by physician.

b. HBPM provided by participating DME vendor or pharmacy with applicable benefit applied.

c. Devices must meet the following:

   i. Arm devices only
   
   ii. Correct cuff size must be assessed and provided by vendor
   
   iii. One device covered per 5 years
   
   iv. Only devices approved by Priority Health will be covered

2. FOR MEDICAID/HEALTHY MICHIGAN PLAN MEMBERS:

   A. Blood pressure monitoring equipment, either manual or automatic, may be covered when specific criteria are met.

   B. A manual blood pressure unit may be covered for a member under the age of 21 when:

      1. Daily titration of medications is required for renal disease.
      
      2. A cardiovascular condition is present that affects blood pressure (e.g. congenital heart disease).
      
      3. A brain lesion or cancer tumor is present that affects the blood pressure.
      
      4. A medication regimen is present that affects blood pressure.

   C. A manual blood pressure unit may be covered for a member over age 21 with uncontrolled blood pressures when one of the following is present:

      1. Fluctuation in blood pressure as a result of renal disease.
2. Medications are titrated based on blood pressure readings.

D. **Automatic** blood pressure monitor is covered when:
   1. Criteria for a manual unit are met.
   2. Member is age 11 or over.

E. Economic alternatives such as a manual blood pressure unit has been either tried or ruled out prior to requesting an automatic blood pressure monitor.

**B. AMBULATORY BLOOD PRESSURE MONITORING – 24 HOUR**

Ambulatory Blood Pressure Monitoring (ABPM) is only covered for those patients with suspected white coat hypertension. Suspected white coat hypertension is defined as:

1. 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 blood pressure measurements taken outside the office which are <140/90 mm Hg; and
3. No evidence of end-organ damage.

ABPM is not a covered benefit for any other diagnoses.

*Note: ABPM is not covered for Priority Health Medicaid or Healthy Michigan Plan members.*

**II. MEDICAL NECESSITY REVIEW**

☐ Required  ☒ Not Required  ☐ Not Applicable

**III. APPLICATION TO PRODUCTS**

Coverage is subject to member’s specific benefits. Group specific policy will supersede this policy when applicable.

- **HMO/EPO:** This policy applies to insured HMO/EPO plans.
- **POS:** This policy applies to insured POS plans.
- **PPO:** This policy applies to insured PPO plans. Consult individual plan documents as state mandated benefits may apply. If there is a conflict between this policy and a plan document, the provisions of the plan document will govern.
- **ASO:** For self-funded plans, consult individual plan documents. If there is a conflict between this policy and a self-funded plan document, the provisions of the plan document will govern.
INDIVIDUAL: For individual policies, consult the individual insurance policy. If there is a conflict between this medical policy and the individual insurance policy document, the provisions of the individual insurance policy will govern.

MEDICARE: Coverage is determined by the Centers for Medicare and Medicaid Services (CMS); if a coverage determination has not been adopted by CMS, this policy applies.

MEDICAID/HEALTHY MICHIGAN PLAN: For Medicaid/Healthy Michigan Plan members, this policy will apply. Coverage is based on medical necessity criteria being met and the appropriate code(s) from the coding section of this policy being included on the Michigan Medicaid Fee Schedule located at: [http://www.michigan.gov/mdch/0,1607,7-132-2945_42542_42543_42546_42551-159815--,00.html](http://www.michigan.gov/mdch/0,1607,7-132-2945_42542_42543_42546_42551-159815--,00.html). If there is a discrepancy between this policy and the Michigan Medicaid Provider Manual located at: [http://www.michigan.gov/mdch/0,1607,7-132-2945_5100-87572--,00.html](http://www.michigan.gov/mdch/0,1607,7-132-2945_5100-87572--,00.html), the Michigan Medicaid Provider Manual will govern.

For Medical Supplies/DME/Prosthetics and Orthotics, please refer to the Michigan Medicaid Fee Schedule to verify coverage.

IV. DESCRIPTION

BLOOD PRESSURE MONITORS

Priority Health will cover home blood pressure monitors for Commercial members if specific criteria are met.

Priority Health may cover blood pressure monitors for Medicaid members if medical necessity is established and no other means of monitoring the member’s blood pressure is available.

AMBULATORY BLOOD PRESSURE MONITORING

Ambulatory blood pressure monitoring (ABPM) involves the use of a non-invasive fully automated device as an outpatient test to measure blood pressure in 24-hour cycles at frequent intervals during the day and night in an effort to determine the variability of a patient's BP. These 24-hour measurements are stored in the device and are later interpreted by the physician.

V. CODING INFORMATION

ICD-10 Codes that may support medical necessity:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>I10</td>
<td>Essential (primary) hypertension</td>
</tr>
<tr>
<td>I11.0 – I11.9</td>
<td>Hypertensive heart disease</td>
</tr>
<tr>
<td>I12.0 – I12.9</td>
<td>Hypertensive chronic kidney disease</td>
</tr>
<tr>
<td>I13.0 – I13.2</td>
<td>Hypertensive heart and chronic kidney disease</td>
</tr>
<tr>
<td>I15.0 – I15.9</td>
<td>Secondary hypertension</td>
</tr>
<tr>
<td>I67.4</td>
<td>Hypertensive encephalopathy</td>
</tr>
<tr>
<td>I95.0 – I95.9</td>
<td>Hypotension</td>
</tr>
<tr>
<td>I97.3</td>
<td>Postprocedural hypertension</td>
</tr>
</tbody>
</table>
O10.011 - O10.93 Pre-existing essential hypertension complicating pregnancy
O11.1 – O11.9 Pre-existing hypertension with pre-eclampsia
O13.1 – O13.9 Gestational [pregnancy-induced] hypertension without significant proteinuria
O14.00 - O14.03 Mild to moderate pre-eclampsia
O15.00 – O15.9 Eclampsia
O16.1 – O16.9 Unspecified maternal hypertension
O90.89 Other complications of the puerperium, not elsewhere classified

R03.0 Elevated blood-pressure reading, without diagnosis of hypertension
R55 Syncope and collapse

CPT/HCPCS Codes
A4660 Sphygmomanometer/blood pressure apparatus with cuff and stethoscope (covered for Medicaid only)
A4663 Blood pressure cuff only (covered for Medicaid only)
A4670 Automatic blood pressure monitor

AMBULATORY BLOOD PRESSURE MONITORING
Not covered for any dx for Medicaid.

ICD-10 Codes): The following procedures are covered for commercial and Medicare plans for these diagnoses only:
I10 Essential (primary) hypertension (dx not covered for Medicare)
R03.0 Elevated blood-pressure reading, without diagnosis of hypertension

CPT/HCPCS Codes:
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
93786 Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; recording only
93788 Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; scanning analysis with report
93790 Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; physician review with interpretation and report

VI. REFERENCES


AMA CPT Copyright Statement:
All Current Procedure Terminology (CPT) codes, descriptions, and other data are copyrighted by the American Medical Association.

This document is for informational purposes only. It is not an authorization, certification, explanation of benefits, or contract. Receipt of benefits is subject to satisfaction of all terms and conditions of coverage. Eligibility and benefit coverage are determined in accordance with the terms of the member’s plan in effect as of the date services are rendered. Priority Health’s medical policies are developed with the assistance of medical professionals and are based upon a review of published and unpublished information including, but not limited to, current medical literature, guidelines published by public health and health research agencies, and community medical practices in the treatment and diagnosis of disease. Because medical practice, information, and technology are constantly changing, Priority Health reserves the right to review and update its medical policies at its discretion.

Priority Health’s medical policies are intended to serve as a resource to the plan. They are not intended to limit the plan’s ability to interpret plan language as deemed appropriate. Physicians and other providers are solely responsible for all aspects of medical care and treatment, including the type, quality, and levels of care and treatment they choose to provide.

The name “Priority Health” and the term “plan” mean Priority Health, Priority Health Managed Benefits, Inc., Priority Health Insurance Company and Priority Health Government Programs, Inc.