



**BlueCross BlueShield
of Alabama**

Name of Policy:

Automated Ambulatory Blood Pressure

Policy #: 128
Category: Medicine

Latest Review Date: July 2018
Policy Grade: B

Background/Definitions:

As a general rule, benefits are payable under Blue Cross and Blue Shield of Alabama health plans only in cases of medical necessity and only if services or supplies are not investigational, provided the customer group contracts have such coverage.

The following Association Technology Evaluation Criteria must be met for a service/supply to be considered for coverage:

- 1. The technology must have final approval from the appropriate government regulatory bodies;*
- 2. The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes;*
- 3. The technology must improve the net health outcome;*
- 4. The technology must be as beneficial as any established alternatives;*
- 5. The improvement must be attainable outside the investigational setting.*

Medical Necessity means that health care services (e.g., procedures, treatments, supplies, devices, equipment, facilities or drugs) that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury or disease or its symptoms, and that are:

- 1. In accordance with generally accepted standards of medical practice; and*
- 2. Clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease; and*
- 3. Not primarily for the convenience of the patient, physician or other health care provider; and*
- 4. Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.*

Description of Procedure or Service:

Ambulatory blood pressure (BP) monitors (24-hour sphygmomanometers) are portable devices that continually record BP while the patient is involved in daily activities. There are various types of ambulatory monitors; this evidence review addresses fully automated monitors, which inflate and record BP at preprogrammed intervals. Ambulatory blood pressure monitoring (ABPM) has the potential to improve the accuracy of diagnosing hypertension and thus improve the appropriateness of medication treatment.

Typically done over a 24 hour period with a fully automated device, ABPM provides more detailed BP information than readings typically obtained during office visits. The greater number of readings with ABPM ameliorates the variability of single BP measurements and is more representative of the circadian rhythm of BP.

There are a number of potential applications of ABPM. One of the most common is evaluating suspected “white-coat hypertension” (WCH), which is defined as an elevated office blood pressure with normal blood pressure readings outside the physician’s office. The etiology of WCH is poorly understood but may be related to an “alerting” or anxiety reaction associated with visiting the physician's office.

In assessing patients with elevated office blood pressure, ABPM is often intended to identify patients with normal ambulatory readings who do not have sustained hypertension. Because this group of patients would otherwise be treated based on office blood pressure readings alone, ABPM could improve outcomes by allowing these patients to avoid unnecessary treatment. However, this assumes patients with WCH are not at increased risk for cardiovascular events and would not benefit from antihypertensive treatment.

Other uses of ABPM include monitoring patients with established hypertension under treatment; evaluating refractory or resistant blood pressure; evaluating whether symptoms such as lightheadedness correspond with blood pressure changes; evaluating nighttime blood pressure; examining diurnal patterns of blood pressure; and/or other potential uses.

This evidence review does not directly address other uses of ABPM, including the use of ABPM for the evaluation of ‘masked’ hypertension. Masked hypertension refers to normal blood pressure (BP) readings in the office and elevated BP readings outside of the office. This phenomenon has recently received greater attention, with estimates that up to 10-20% of individuals may exhibit this pattern.

Policy:

Effective for dates of service on or after February 1, 2015:

Automated Ambulatory Blood Pressure Monitoring meets Blue Cross and Blue Shield of Alabama’s medical criteria for coverage for a **onetime** 24-hour period for patients with elevated office blood pressure (BP), when performed to differentiate between “white coat” hypertension and true hypertension when **all** of the following conditions are met:

- Office blood pressure elevation is in the mild to moderate range (<180/110), not requiring immediate treatment with medication; **AND**
- There is no hypertensive end-organ damage on physical exam and laboratory testing.

For pediatric patients, Automated Ambulatory Blood Pressure Monitoring meets Blue Cross and Blue Shield of Alabama’s medical criteria for coverage for a **onetime** 24-hour period for patients with elevated office blood pressure (BP), when performed to differentiate between “white coat” hypertension and true hypertension when **all** of the following conditions are met:

- Office blood pressure elevation beyond the pediatric normative threshold levels, not requiring immediate treatment with medication, **AND**
- There is no hypertensive end-organ damage on physical exam and laboratory testing,

AND with the following special considerations:

- A device should be selected that is appropriate for use in pediatric patients, including use of a cuff size appropriate to the child’s size, **AND**
- Threshold levels for the diagnosis of hypertension should be based on pediatric normative data, which use gender and height specific values derived from large pediatric populations, **AND**
- Must meet recommendations from AHA guidelines concerning classification of hypertension in pediatric patients using clinic and ambulatory BP are given in the following table:

Classification	Clinic Blood Pressure	Mean Ambulatory SBP	SBP Load, % ^a
Normal blood pressure	<95th percentile	<95th percentile	<25
White coat HTN	>95th percentile	<95th percentile	<25
Masked HTN	<95th percentile	>95th percentile	>25
Pre-HTN	>95th percentile	<95th percentile	25-50
Ambulatory HTN	>95th percentile	>95th percentile	25-50
Severe Ambulatory HTN	>95th percentile	>95th percentile	>50

All other uses of Automated Ambulatory Blood Pressure Monitoring for patients with elevated office BP, including but not limited to, repeated testing in patients with elevated office BP, and monitoring of treatment effectiveness, **does not meet** Blue Cross and Blue Shield of Alabama’s medical criteria for coverage and is considered **investigational**.

Blue Cross and Blue Shield of Alabama does not approve or deny procedures, services, testing, or equipment for our members. Our decisions concern coverage only. The decision of whether or not to have a certain test, treatment or procedure is one made between the physician and his/her patient. Blue Cross and Blue Shield of Alabama administer benefits based on the member’s contract and corporate medical policies. Physicians should always exercise their best medical

judgment in providing the care they feel is most appropriate for their patients. Needed care should not be delayed or refused because of a coverage determination.

Key Points:

The most recent literature review was updated through April 9, 2018.

This review was informed by a TEC Assessment (1999)² and a subsequent 2001 reanalysis of this report conducted by the Centers for Medicare & Medicaid Services.

Evidence reviews assess whether a medical test is clinically useful. A useful test provides information to make a clinical management decision that improves the net health outcome. That is, the balance of benefits and harms is better when the test is used to manage the condition than when another test or no test is used to manage the condition.

The first step in assessing a medical test is to formulate the clinical context and purpose of the test. The test must be technically reliable, clinically valid, and clinically useful for that purpose. Evidence reviews assess the evidence on whether a test is clinically valid and clinically useful. Technical reliability is outside the scope of these reviews, and credible information on technical reliability is available from other sources.

24-Hour Automated Ambulatory Blood Pressure Monitoring

The focus of the current review is on the use of ambulatory blood pressure monitoring (ABPM) in previously untreated patients with elevated office blood pressure (BP). In this situation, ABPM is primarily intended to evaluate white coat hypertension (WCH), or “isolated clinic hypertension.” This entity is defined as an elevated office BP with normal BP readings outside the physician’s office. It is diagnosed by obtaining multiple out-of-office BP measurements and comparing them with office readings.

Clinical Context and Test Purpose

The purpose of 24-hour automated ABPM in patients who have elevated office BP is to confirm a diagnosis of hypertension and to initiate an appropriate treatment regimen.

The question addressed in this evidence review is: Does use of 24-hour automated ABPM in patients with elevated office BP confirm a diagnosis of hypertension so that appropriate treatment can be initiated or rule out hypertension so inappropriate treatment is not initiated?

The following PICOTS were used to select literature to inform this review.

Patients

The relevant population of interest is individuals with elevated office BP.

Interventions

The test being considered is 24-hour automated ABPM.

Comparators

The following tests are currently being used: office BP measurement and home BP measurement.

Outcomes

The general outcomes of interest are accurate blood pressure readings so to confirm a diagnosis of hypertension and to initiate appropriate treatment for those with elevated BP readings and to rule out hypertension to avoid inappropriate treatment and adverse events of therapy.

Timing

24-hour automated ABPM may be used when there is persistent unexplained variability in serial elevated BP measurements over a 1-3 month period.

Setting

The appropriate setting, after initial setup, is the home or workplace.

Technically Reliable

Assessment of technical reliability focuses on specific tests and operators and requires review of unpublished and often proprietary information. Review of specific tests, operators, and unpublished data are outside the scope of this evidence review and alternative sources exist. This evidence review focuses on the clinical validity and clinical utility.

Reference Values for ABPM Monitoring

Establishing reference values for ABPM is integral to providing guidelines for “normal” and “abnormal” ABPM readings. Studies that have compared ABPM measurements with office measurements have consistently reveal lower values for ABPM. Therefore, it is not possible to use reference values for office BP to evaluate the results of ABPM.

Reference values for ABPM have been derived by several methods: (1) estimates of population-based ABPM results to define the range and distribution of ABPM values; (2) direct comparisons of the average values for ABPM and office BP to determine the level of ABPM, which corresponds to an office BP of 140/90; and (3) correlations of ABPM results with cardiovascular outcomes to determine the ABPM levels at which the risk for cardiovascular events increases, or is similar to the risk for an office BP of 140/90.

Although the specific recommendations vary slightly, current thresholds for defining a normal ABPM are 24-hour average BP of 130/80 and daytime average BP of 135/85. A 1999 ABPM consensus conference task force considered data on the statistical distribution of ABPM, the correlation with office BP, and the correlation with cardiovascular outcomes in deriving recommendations for reference values for ABPM. Their recommendations are summarized in Table 1. Subsequent studies have identified racial and ethnic variation in ABPM results, but impacts of these differences on clinical management may be minimal.

Table 1. ABPM Consensus Conference Task Force IV: Adult ABPM Thresholds

ABPM* Measure	95th Percentile	Normotension	Hypertension
24-hour average	132/82	≤130/80	>135/85
Daytime average	138/87	≤135/85	>140/90
Nighttime average	123/74	≤120/70	>125/75

*ABPM: ambulatory blood pressure monitoring.

Clinically Valid

A test must detect the presence or absence of a condition, the risk of developing a condition in the future, or treatment response (beneficial or adverse).

Adults

Many prospective cohort studies have compared ABPM with office BP in predicting cardiovascular events. Although results of these studies are not entirely consistent, most have reported that ABPM has greater predictive ability for cardiovascular events than office BP measurement. A summary of relevant systematic reviews and meta-analyses of these studies follows.

Hansen et al (2007) conducted a patient-level meta-analysis using data from 4 populations in Belgium, Denmark, Japan, and Sweden (total N=7030 patients). The predictive values of ABPM and in-clinic BP for fatal and nonfatal cardiovascular events were reported. Both ABPM and office BP were predictors of outcomes in univariate and partially adjusted multivariate models. In the fully adjusted model, ABPM remained a significant predictor of outcomes while office BP did not.

Conen and Bamberg (2008) conducted a meta-analysis of 20 cohort studies that evaluated the correlation between ABPM and outcomes, controlling for office BP in the analysis. Reviewers reported that ABPM was a strong predictor of cardiovascular outcomes and that controlling for office BP had little effect on risk estimates. These results support the hypothesis that risk information obtained from ABPM is independent of that obtained from office BP.

A systematic review by Piper (2015), conducted for the U.S. Preventive Services Task Force (USPSTF), identified 7 studies of diagnostic accuracy were identified. Four were rated high quality and 3 moderate quality. Four studies directly compared ABPM with automated office BP readings. Using ABPM as the reference standard, the sensitivity of office BP measurement for the diagnosis of hypertension ranged from 51% to 91%, specificity ranged from 97% to 98%, and the positive predictive value ranged from 76% to 84%.

Numerous other studies have directly compared ABPM with office BP and/or home self-measured BP. Hodgkinson et al (2011) performed a systematic review of studies that compared ABPM with home or office BP and used defined thresholds to determine the accuracy of diagnosis of hypertension. Of 10 studies identified, 7 compared ABPM with office BP measurements and 3 compared ABPM with home self-measurement. Using a 24-hour ABPM threshold of 135/85 mm Hg, clinic BP measurements had a sensitivity of 75% (95% confidence interval [CI], 61% to 85%) and a specificity of 75% (95% CI, 48% to 90%). Home BP self-

measurement had a sensitivity of 86% (95% CI, 78% to 91%) and a specificity of 62% (95% CI, 48% to 75%). The accuracy of office and home BP was considered inadequate for use as a single diagnostic test for hypertension, and it was hypothesized that the use of office and/or home measurements might lead to substantial overdiagnosis and overtreatment.

In a similar systematic review, Stergiou and Bliziotis (2011) compared the accuracy of ABPM with home BP measurement for the diagnosis of hypertension. Sixteen studies were selected for analysis. The sensitivity of home BP measurement, compared with ABPM, ranged from 36% to 100% (median, 74%). The specificity ranged from 44% to 96% (median, 84%). Reviewers also reported the diagnostic agreement between the 2 methods of BP measurement, as measured using the κ statistic. Kappa could be calculated in 11 studies; the range of scores was 0.37 to 0.73 (median, 0.46). This κ level indicates moderate agreement between ABPM and home monitoring in the diagnosis of hypertension.

ABPM in Children and Adolescents

ABPM has been used in children and adolescents for similar purposes as in adults, including use in children and adolescents with elevated office BP to distinguish true hypertension (HTN) from WCH. The evidence on use in children and adolescents is smaller but generally consistent with evidence in adults. A representative sample of studies identified is described below.

Normative values for pediatric patients have been established by large population-based studies of children and adolescents. Elevated readings are defined as values greater than the 95th percentile for sex, age, and height. These studies also have established that patterns of ambulatory BP in children differ from those in adults. In children, ambulatory BP is generally higher than the corresponding office BP, in contrast to adult ambulatory BP readings that are on average lower than office BP. This pattern is more pronounced in younger children, and the difference progressively declines with age. Guidelines for classification of hypertension in children and adolescents were published by the American Heart Association in 2008.

In a European study reported by Valent-Moric et al (2012), 139 children and adolescents between the ages of 4 and 19 years with elevated office BP were evaluated by ABPM monitoring. Thirty-two (23.0%) of 139 participants had WCH, as evidenced by a normal 24-hour ABPM result. Of patients with true hypertension, 21 (19.6%) of 107 had evidence of target organ damage, compared with none of the patients with WCH. In a similar study from the United States, Sorof and Portman (2000) reported on 67 otherwise healthy children underwent ABPM, 51 of whom had an elevated office BP. Using 3 definitions of WCH of varying BP cutoffs, WCH was identified in 22% to 53% of children with elevated office BP. In a 2002 study from Japan, Matsuoka et al (2002) assessed 206 children and adolescents between the ages of 6 and 25 years underwent ABPM, 70 of whom had elevated office BP. Among the 70 patients with elevated office BP, 33 (47%) had WCH, as defined by a normal ABPM result. A “white coat” effect of 10 mm Hg or more was reported in 50% of patients with office hypertension and 25% of patients with normal office BP.

Section Summary: Clinically Valid

For adults, studies comparing home BP monitoring to office monitoring with ABPM as the criterion standard have reported that the sensitivity and specificity of alternative methods of

diagnosing hypertension are suboptimal. For children and adolescents, reference values for normal and abnormal ABPM results, derived from epidemiologic research, have been used to differentiate WCH from true hypertension in pediatric patients.

Clinically Useful

A test is clinically useful if the use of the results informs management decisions that improve the net health outcome of care. The net health outcome can be improved if patients receive correct therapy, or more effective therapy, or avoid unnecessary therapy, or avoid unnecessary testing.

Direct Evidence

Direct evidence of clinical utility is provided by studies that have compared health outcomes for patients managed with and without the test. Because these are intervention studies, the preferred evidence would be from randomized controlled trials.

Direct evidence of the efficacy of ABPM improving outcomes in this setting would be obtained from randomized controlled trials (RCTs) comparing outcomes of: (1) patients diagnosed and treated based on conventional BP measurements alone with (2) patients additionally undergoing ABPM used to guide therapy (e.g., withholding or randomizing treatment among those with WCH). This notion parallels the statement from the National High Blood Pressure Education Program Working Group on Ambulatory Blood Pressure Monitoring in 1992, “Ideally, de novo longitudinal studies should be undertaken to determine which ambulatory profiles are associated with increased cardiovascular risk and what transformations of ambulatory profiles induced by antihypertensive therapy are associated with reductions in risk.” RCTs using ABPM for monitoring treatment response but not to diagnose hypertension have been conducted. However, a substudy of the Systolic Hypertension in Europe (Syst-Eur) trial did address this question indirectly.

The Syst-Eur trial, a large, multicenter RCT (2000), enrolled patients 60 years of age or older with isolated systolic hypertension and randomized them to antihypertensive treatment or placebo. A subgroup analysis evaluated 695 patients (from the total Syst-Eur sample of 4695 patients) who underwent 24-hour ABPM in addition to the usual study protocol. Conventional BP was defined from the mean of six baseline clinic BPs: two readings obtained with the patient seated at three baseline visits equal to or more than one month apart. Participants were classified into three groups based on ABPM readings: nonsustained hypertension (i.e., WCH), mild-sustained hypertension, and moderate-sustained hypertension. The reduction in cardiovascular events was compared between active and placebo groups among patients in each category. For patients with nonsustained hypertension, there was a numerically lower rate of adverse outcomes in the treated group for stroke (0 vs 2, $p=0.16$) and cardiovascular events (2 vs 6, $p=0.17$), i.e., differences were not statistically significant. There was a significant reduction in events with treatment only among patients with moderate-sustained hypertension.

Staessen et al (1999) analyzed follow up data (median follow-up 4.4 years) from an apparently overlapping subset of 808 older individuals from the Syst-Eur trial who had isolated systolic hypertension measured conventionally (systolic BP, 160-219 mm Hg; diastolic BP, <95 mm Hg) and BPs by ABPM. Average systolic and diastolic BPs were higher with conventional

measurements (by 21.9 and 1.9 mm Hg, respectively). ABPM was significantly associated with cardiovascular end points, even when conventional BP was taken into account.

Chain of Evidence

Indirect evidence on clinical utility rests on clinical validity. If the evidence is insufficient to demonstrate test performance, no inferences can be made about clinical utility.

Well-designed, prospective cohort studies could provide indirect evidence on the potential benefit of treatment for patients with WCH. Ideally, prospective studies would compare outcomes of untreated patients with WCH with normotensive and sustained hypertensive patients (the latter being treated). Studies should control for important potential confounders such as adequacy of BP control, age, sex, smoking status, lipid levels, and diabetes. Well-designed and conducted prospective cohort studies finding that untreated WCH patients have a cardiovascular event risk similar to that of normotensive patients would imply these patients accrue little treatment benefit. In contrast, if the cardiovascular risk for patients with WCH is increased, then there is a potential benefit to treatment.

A systematic review by Piper et al (2015) was performed for the U.S. Preventive Services Task Force (USPSTF) and identified 11 cohort studies that compared ABPM with alternate measurement methods for predicting cardiovascular events. Six studies were rated good quality and 5 were rated fair quality. There was a significant correlation between ABPM measures and outcomes in most studies. For each 10-mm increase in the average 24-hour systolic BP, the hazard ratio (HR) for fatal and nonfatal cardiovascular events ranged from 1.11 to 1.42, and the hazard ratio for stroke ranged from 1.28 to 1.40.

Section Summary: Clinically Useful

Data from large prospective cohort studies have established that ABPM correlates more strongly with cardiovascular outcomes than other methods of BP measurement and that WCH, as defined by ABPM, is associated with an intermediate risk of cardiovascular outcomes compared with normotensive and hypertensive patients.

Summary of Evidence

For individuals with elevated office BP who receive 24-hour automated ABPM, the evidence includes randomized controlled trials, cohort studies, and studies of diagnostic accuracy. Relevant outcomes are test accuracy, other test performance measures, morbid events, and medication use. Data from large prospective cohort studies have established that ABPM correlates more strongly with cardiovascular outcomes than with other methods of BP measurement. When compared directly with other methods, ABPM performed over a 24-hour period has higher sensitivity, specificity, and predictive value for the diagnosis of hypertension than office or home BP measurements. Substantial percentages of patients with elevated office BP have normal BP on ABPM (WCH). Prospective cohort studies have reported that patients with WCH have an intermediate risk of cardiovascular outcomes compared with normotensive and hypertensive patients. The benefit of medication treatment in these patients is uncertain, and they are at risk for overdiagnosis and overtreatment based on office BP measurements alone. Use of ABPM in these patients will improve outcomes by eliminating unnecessary pharmacologic treatment and avoiding adverse events in patients not expected to benefit. The

evidence is sufficient to determine qualitatively that the technology results in a meaningful improvement in the net health outcome.

Practice Guidelines and Position Statements

American Academy of Pediatrics

The American Academy of Pediatrics published clinical guidelines for the screening and management of high blood pressure (BP) in children and adolescents in 2017. Table 2 lists recommendations made.

Table 2. Guidelines on Screening and Management of High BP in Children and Adolescents

Recommendation	LOE	SOR
“ABPM should be performed for confirmation of HTN in children and adolescents with office BP measurements in the elevated BP category for 1 year or more or with stage 1 HTN over 3 clinic visits.”	C	Moderate
“Routine performance of ABPM should be strongly considered in children and adolescents with high-risk conditions to assess HTN severity and determine if abnormal circadian BP patterns are present, which may indicate increased risk for target organ damage.”	B	Moderate
“ABPM should be performed by using a standardized approach with monitors that have been validated in a pediatric population, and studies should be interpreted by using pediatric normative data.”	C	Moderate
“Children and adolescents with suspected WCH should undergo ABPM.”	B	Strong

ABPM: ambulatory blood pressure monitoring; BP: blood pressure; DBP: diastolic blood pressure; HTN: hypertension; LOE: level of evidence; SBP: systolic blood pressure; SOR: strength of recommendation; WCH: white coat hypertension

American College of Cardiology et al

The American College of Cardiology, with 10 other medical specialty societies, published guidelines on the prevention, detection, evaluation, and management of high BP in adults in 2017. Table 3 lists recommendations made.

Table 3. Guidelines on Prevention, Detection, Evaluation, and Management of High BP in Adults

Recommendations	COR	LOE
“In adults with an untreated SBP greater than 130 mm Hg but less than 160 mm Hg or DBP greater than 80 mm Hg but less than 100 mm Hg, it is reasonable to screen for the presence of white coat hypertension by using either daytime ABPM or HBPM before diagnosis of hypertension”	IIa	B-NR
“In adults with white coat hypertension, periodic monitoring with either ABPM or HBPM is reasonable to detect transition to sustained hypertension”	IIa	C-LD
“In adults being treated for hypertension with office BP readings not at goal and HBPM readings suggestive of a significant white coat effect, confirmation by ABPM can be useful”	IIa	C-LD
“In adults with untreated office BPs that are consistently between 120 mm Hg and 129 mm Hg for SBP or between 75 mm Hg and 79 mm Hg for DBP, screening for masked hypertension with HBPM (or ABPM) is reasonable”	IIa	B-NR
“In adults on multiple-drug therapies for hypertension and office BPs within 10 mm Hg above goal, it may be reasonable to screen for white coat effect with HBPM (or ABPM)”	IIb	C-LD

ABPM: ambulatory blood pressure monitoring; COR: class of recommendation; DBP: diastolic blood pressure; HBPM: home blood pressure monitoring; LOE: level of evidence; SBP: systolic blood pressure.

American Heart Association

The American Heart Association published consensus recommendations in 2008.

These recommendations were updated in 2014. Consensus recommendations for routine ABPM included the following:

- “To confirm the diagnosis of hypertension in a patient with hypertension according to casual BP measurements
 - Determine whether sustained hypertension or white coat hypertension exists.
- To evaluate for the presence of masked hypertension when there is a clinical suspicion of hypertension but normal or prehypertensive casual measurements
- To assess BP patterns in high-risk patients
 - Assess for abnormal circadian variation in BP, such as blunted dipping or isolated sleep hypertension in patients with diabetes mellitus, chronic kidney disease, solid organ transplants, and severe obesity with or without sleep-disordered breathing.
 - Assess the severity and persistence of BP elevation in patients at high risk for hypertensive target-organ damage.
- To evaluate effectiveness of drug therapy for hypertension
 - Confirm BP control in treated patients, especially those with secondary forms of hypertension.
 - Evaluate for apparent drug-resistant hypertension.
 - Determine whether symptoms can be attributed to drug-related hypotension.”

National Institute for Health and Clinical Excellence

The U.K.’s National Institute for Health and Care Excellence issued updated hypertension guidelines in 2011 (updated in 2016). For diagnosing hypertension, National Institute for Health and Care Excellence makes the following recommendations concerning ambulatory blood pressure monitoring ABPM:

- "If the clinic blood pressure is 140/90 mm Hg or higher, offer ambulatory blood pressure monitoring (ABPM) to confirm the diagnosis of hypertension.
- When using ABPM to confirm a diagnosis of hypertension, ensure that at least two measurements per hour are taken during the person’s usual waking hours.

Use the average of at least 14 measurements taken during usual waking hours to confirm a diagnosis of hypertension.”

U.S. Preventive Services Task Force

The U.S. Preventive Services Task Force (USPSTF) published a recommendation in 2015 for hypertension. The following recommendation was given a grade A rating:

“The USPSTF recommends screening for high blood pressure in adults aged 18 years or older. The USPSTF recommends obtaining measurements outside of the clinical setting for diagnostic confirmation before starting treatment.”

The document further elaborated on the choice of office measurements, with the following statement about ABPM:

“The USPSTF found convincing evidence that ABPM is the best method for diagnosing hypertension. Although the criteria for establishing hypertension varied across studies, there was significant discordance between the office diagnosis of hypertension and 12- and 24-hour average blood pressures using ABPM, with significantly fewer patients requiring treatment based on ABPM. Elevated ambulatory systolic blood pressure was consistently and significantly associated with increased risk for fatal and nonfatal stroke and cardiovascular events, independent of office blood pressure. For these reasons, the USPSTF recommends ABPM as the reference standard for confirming the diagnosis of hypertension.”

Key Words:

Automated ambulatory blood pressure monitoring, ABPM, 24-hour sphygmomanometers

Approved by Governing Bodies:

Many ABPMs have received clearance to market through the FDA 510(k) marketing clearance process. As an example of an FDA indication for use, the Welch Allyn ABPM 6100 is indicated “as an aid or adjunct to diagnosis and treatment when it is necessary to measure adult or pediatric patients’ systolic and diastolic blood pressures over an extended period of time.

Benefit Application:

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

ITS: Home Policy provisions apply

FEP contracts: Special benefit consideration may apply. Refer to member’s benefit plan. FEP does not consider investigational if FDA approved and will be reviewed for medical necessity.

Current Coding:

CPT 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** ; Recording only
- 93788** ; Scanning analysis with report
- 93790** ; Physician review with interpretation and report

These separate CPT codes may be used if different individuals perform the individual tasks. However, if one physician performs all of the above services, CPT code 93784 may be used. Code 93784 is a comprehensive code describing recording, scanning analysis, and interpretation and report.

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Policy History:

Medical Policy Group, September 2003

Medical Policy Administration Committee, September 2003

Available for comment September 8-October 22, 2003

Medical Policy Group, July 2005 (1)

Medical Policy Group, July 2007 (1)

Medical Policy Group, August 2008 (3)

Medical Policy Group, August 2010 **(1)**: No new info to change coverage statement
Medical Policy Group, March 2012 **(3)**: 2012 Updates: Policy, Key Points, Key Words, References
Medical Policy Administration Committee, March 2012
Available for comment March 28 through May 14, 2012
Medical Policy Panel, December 2012.
Medical Policy Group, December 2012 **(3)**: 2012 Updates: Key Points, Summary, References. Policy statement remains unchanged
Medical Policy Group, December 2012 **(3)**: 2013 Coding Update – Code 93790-removed “physician”.
Medical Policy Panel, December 2013
Medical Policy Panel, January 2014
Medical Policy Panel, January 2015
Medical Policy Group, January 2015 **(4)**: 2013, 2014 and 2015 updates to Description, Key Points and References. Updated Policy section with ABPM for pediatrics
Medical Policy Administration Committee, February 2015
Available for comment January 30 through March 15, 2015
Medical Policy Panel, July 2016
Medical Policy Group, October 2016 **(4)**: Updates to Key Points and References; removed policy statements that were effective prior to 3/2012. No change to policy statement.
Medical Policy Panel, June 2017
Medical Policy Group, June 2017 **(4)** Updates to Description, Key Points, and References. No change to policy statement.
Medical Policy Panel, June 2018
Medical Policy Group, July 2018 **(4)**: Updates to Description, Key Points, and References. No change to policy statement. Removed policy statements for effective dates of service March 28, 2012 through January 31, 2015:

This medical policy is not an authorization, certification, explanation of benefits, or a contract. Eligibility and benefits are determined on a case-by-case basis according to the terms of the member’s plan in effect as of the date services are rendered. All medical policies are based on (i) research of current medical literature and (ii) review of common medical practices in the treatment and diagnosis of disease as of the date hereof. 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.

This policy is intended to be used for adjudication of claims (including pre-admission certification, pre-determinations, and pre-procedure review) in Blue Cross and Blue Shield’s administration of plan contracts.