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Internal Medicine Coding Alert

This Foolproof Action Plan Secures BP Test Payment

Take these steps to satisfy insurers' 9378493790 requirements

Now you can collect up to $115 for ambulatory blood pressure monitoring (ABPM) with ease--if you meet certain diagnosis and test-related criteria.

Step 1: Bone Up on Medicare's ICD-9 Requirements

When you're submitting an ABPM claim to Medicare, coverage hinges on the internist's testing for white-coat hypertension (WCH). "Medicare is very black and white on its ABPM's diagnosis requirements," says **Maria M. Torres, CPC, CMM,** with Bermudez Medical Consulting in Tampa, Fla. National Medicare policy only accepts a diagnosis of 796.2 (Elevated blood pressure reading without diagnosis of hypertension), according to the CMS Medlearn Matters' article MM2726.

"Often, physicians try to get reimbursed for ABPM that Medicare doesn't feel was medically necessary," Torres says. For instance, a patient may have an abnormal BP reading one day, report that an at-home reading was also abnormal and present to the office for another reading that is normal. These records, however, would fail to meet Medicare's criteria, she says.

Best bet: To qualify for WCH, the physician must document the following:

• in-office BP readings greater than 140/90 mm Hg on at least three separate visits with the nurse or other staff taking two separate measurements at each visit

• at least two documented separate BP measurements less than 140/90 mm Hg, taken by an appropriate non-office source (e.g., a paramedic, a nurse at a health fair, or a validated measurements at a pharmacy)

• no evidence of end-organ damage (for example, kidney or heart problems related to hypertension).

Disaster averted: To keep reimbursement coming when an internist orders ABPM for a Medicare patient who doesn't meet 796.2's criteria, have the patient sign an advance beneficiary notice (ABN). Explain to the patient that because he doesn't meet the diagnosis requirements if he chooses to have the test, he will be responsible for payment, says **Stephanie Watson, CMC, CMOM**, business office manager at Memphis Internal Medicine in Tennessee. If the patient has private insurance, "we would not have the patient sign an ABN, but we would point out that the insurer may not cover the test."

Step 2: Research Payers' Medical-Necessity Rules

Private payers may have less stringent diagnosis coding guidelines. Some third-party insurers also cover ABPM for hypertension and "reimburse anywhere from $90 to $115," Watson says. Medicare pays locally about $67 for the test. (The 2005 National Physician Fee Schedule assigns the complete ABPM code 1.96 relative value units or reimburses the test at $74.28.)

Real-world policy: Blue Cross of California, for example, may cover ABPM for three additional ICD-9 code series:

• 401.0-405.99--Hypertensive disease diagnoses

• 458.0--Orthostatic hypotension

• 780.2--Syncope and collapse.

In these instances, a physician must order ABPM for the evaluation of individuals with one of these conditions, and the patient must meet all criteria:

• **Resistant hypertension:** A secondary form of hypertension, this condition usually develops in hypertension (401.x) patients who are unresponsive to medications. Requirement: Treatment must include three or more medications for resistant hypertension.

• **Hypotensive symptoms and/or syncopal events:** These conditions occur in hypertensive patients and are thought to be related to antihypertensive medications or neurological syndromes, including autonomic dysfunction. The patients may develop low blood pressure or faint.

• **Episodic hypertension:** An internist may suspect a patient has this condition when office BP measurements are normal and associated symptoms (such as excessive sweating, palpitations and/or pallor) suggest episodic hypertension secondary to an existing condition (for example, pheochromocytoma).

Step 3: Assign an Appropriate Component Code

After determining the ICD-9 code you'll use, it's time to choose from CPT's four ABPM 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.

Action: To select the correct ABPM code, ask yourself what role the internist played in the monitoring and its interpretation. Hint: Think of 93786-93790 as the technical and professional components of the base code 93784. "Instead of using modifier 26 (Professional component) and TC (Technical component), CPT assigned a specific ABPM component," Torres says. Here's how the codes break down:

"Use 93784 for everything," Torres says. The machine uses magnetic tape to record the data and provides scanning analysis. The internist interprets the information and issues a separate report.

The next two codes--93786 and 93788--represent two different types of ABPM equipment. Good idea: Watson recommends checking with the equipment's manufacturer for its coding guidelines:

1. If you own a machine that provided recording without scanning analysis, assign 93786 for the hook-up and recording.

2. For machines that include scanning analysis and no recording, report 93788.

Remember: These codes do not include any physician interpretation or report. When the internist owns one of these "partial" devices and issues an interpretation and report (I&R), you should separately code the physician's professional services with 93790.

Example: Torres' internists use a device that provides recording only; they also interpret the data and issue a separate written report. For these technical and professional components, you should assign 93786 (recording only) and 93790 (I&R), she says.

Step 4. Make Sure Test Meets 3 Additional Criteria

Although you've chosen your CPT and ICD-9 codes for ABPM submission, Medicare and some other payers impose additional test-related requirements. Remember to obtain an ABN or payment waiver unless the testing meets these three criteria:

• the test is an outpatient service (Hospital inpatients and residential institution patients do not qualify for coverage.)

• the device monitors the patient's ambient blood pressure for at least 24 hours

• the internist interprets the ABPM results.

Also: Contact your major insurers to make sure they add your internists as ABPM providers, Torres says. "Otherwise, some plans, such as United, Cigna and Humana, restrict 93784-93790 to cardiologists."

Resources: To read the CMS Medlearn Matters' article on ABPM, download the document from www.cms.hhs.gov/medlearn/matters/mmarticles/2004/MM2726.pdf.