



# CIGNA MEDICAL COVERAGE POLICY

The following Coverage Policy applies to all plans administered by CIGNA Companies including plans administered by Great-West Healthcare, which is now a part of CIGNA.

**Subject** Ambulatory Blood Pressure  
Monitoring with Automatic  
Portable Monitors

**Effective Date** ..... 6/15/2009  
**Next Review Date** ..... 6/15/2010  
**Coverage Policy Number** ..... 0078

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## Hyperlink to Related Coverage Policies

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### INSTRUCTIONS FOR USE

Coverage Policies are intended to provide guidance in interpreting certain **standard** CIGNA HealthCare benefit plans as well as benefit plans formerly administered by Great-West Healthcare. Please note, the terms of a participant's particular benefit plan document [Group Service Agreement (GSA), Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a participant's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a participant's benefit plan document **always supercedes** the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable group benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. Proprietary information of CIGNA. Copyright ©2009 CIGNA

## Coverage Policy

**CIGNA covers ambulatory blood pressure monitoring (ABPM) over a 24-hour period as medically necessary when ANY of the following criteria are met:**

- suspected white coat hypertension (WCH) (three in-office blood pressure [BP] readings of > 140/90 mm Hg and two out-of-office BP readings of < 140/90) with no evidence of end organ damage
- resistant hypertension in individuals who are being treated with three or more medications
- episodic hypertension suspected when office BP measurements are normal and symptoms (excessive sweating, palpitations, apprehension) suggest episodic hypertension secondary to an existing condition
- hypertensive individuals with hypotensive symptoms thought to be related to antihypertensive medications or neurological syndromes
- suspected masked hypertension
- suspected nocturnal hypertension (i.e., nondippers)
- when there is a large discrepancy between clinic and home BP measurements
- management of isolated systolic hypertension in individuals age 60 or older

## General Background

Elevated blood pressure (BP), also termed hypertension, is a risk factor for cardiovascular diseases and kidney disease. The National Heart, Lung, and Blood Institute's (NHLBI) Joint National Committee (JNC) on

Prevention, Detection, Evaluation, and Treatment of High Blood Pressure defines hypertension as: stage one, systolic pressure of 140–159 mm Hg or diastolic pressure of 90–99 mm Hg; or stage two, systolic pressure greater than or equal to 160 mm Hg, or diastolic pressure greater than or equal to 100 mg Hg (NHLBI, 2004).

Blood pressures are characterized by a clear circadian pattern with values tending to peak during the daytime hours and then fall after midnight. In the early morning hours, BP sharply increases, with daytime levels being reached within a relatively short period. Activity of subjects at the time of BP recording is an important determinant of the level of BP and may affect hypertensive disease (Chobanian, et al., 2003).

BP as recorded in the office setting is the standard technique recommended for the measurement of BP in routine medical care. Clinic BP measurements have limitations even when measured by established guidelines. One limitation is that BP measured in the clinic may not be the same as BP outside the clinic setting. When BP rises in the clinic setting in response to the observer and/or other aspects of the medical environment, it is known as “white coat” hypertension (WCH). The difference between measurements obtained in- and outside the clinic setting can lead to confusion about the diagnosis of hypertension and the need to start or modify therapy. Ambulatory blood pressure monitoring (ABPM) allows for the identification of those patients whose nocturnal BP does not fall, so called “nondippers.” It is reported that these patients have a higher risk of developing complications from their hypertension. More recently, another type of hypertension has been recognized on ambulatory monitoring, so-called “masked hypertension” where values are consistently higher at home than in the physician’s office (Treadway, 2008; Ohkubo, et al., 2005).

### **Ambulatory Blood Pressure Monitoring (ABPM)**

ABPM differs from self-BP monitoring. Self-BP monitoring is performed by a patient using standard BP monitoring equipment (may be manual or digital) and is performed at determined times. ABPM is a noninvasive technique by which multiple indirect BP readings can be obtained automatically over a 24-hour period. Usually, the heart rate and BP will be measured at 15- to 30-minute periods during the day and every 30 minutes to one hour at night. The total number of readings varies between 50 and 100. ABPM devices consist of an inflatable cuff with pressure regulators and valves to measure BP, a cuff microphone or sound transducer and microprocessor to detect and interpret BP sounds, mechanisms for programming and recording BP readings, and an inflation bulb for semiautomatic devices. There are several types of devices including: fully automated, which inflate at pre-programmed intervals; semi-automated, which are patient-activated; and trans-telephonic, which allow the use of telephones to transmit measured automatic digital readings to a computer-assisted receiver. The devices are lightweight and quiet and use auscultatory or oscillometric methods, or both. The monitors can be attached by a trained technician. A series of calibration readings are taken with a mercury sphygmomanometer to ensure the device is giving accurate readings (Pickering, et al., 2005; Hayes, 2004; Ernst, et al., 2002).

### **U.S. Food and Drug Administration (FDA)**

Both semiautomated and fully-automated ABPM monitors are categorized as Class II devices. The FDA has published guidelines regarding the 510(k) approval of noninvasive BP monitors. The guidelines apply to monitors covered by the American National Standards Institute (ANSI) and the Association for the Advancement of Medical Instrumentation (AAMI) for electronic or automated sphygmomanometers (SP10 standard). Included in the SP10 standard are automated noninvasive BP monitors that measure pressure at the arm, finger, or wrist using a standard oscillometric measurement method (FDA, 2006).

### **Literature Review**

Evidence in the published, peer-reviewed scientific literature indicates that automated ABPM is a safe and reliable technique for determining average blood pressure values in a 24-hour period and identifying blood pressure variability throughout an observation period. Evidence in the peer-reviewed medical literature suggests that ABPM is indicated for the management of a selected subset of patients. ABPM is indicated for the evaluation of WCH in the absence of target-organ injury. ABPM is used to assess patients with hypotensive symptoms with antihypertensive medications, resistant hypertension, episodic hypertension and autonomic dysfunction, suspected masked hypertension, suspected nocturnal hypertension, when there is a large discrepancy between clinic and home BP measurements, and for the management of isolated systolic hypertension in patients age 60 or older (Dawes, et al., 2006; Ingelsson, et al, 2006; Paoletti, et al., 2006; Agarwal, et al., 2006; Ohkubo, et al., 2005; Bobrie, et al, 2004; Staessen, et al., 2004; Clement, et al., 2003; Staessen, et al., 1999).

## **Systematic Reviews and Guidelines**

The Institute for Clinical Systems Improvement (ICSI) guideline on hypertension diagnosis and treatment states, “standardized BP measurement techniques, including out of office or home BP measurements, should be employed when confirming an initially elevated BP and for all subsequent measures during follow-up and treatment for hypertension” (ICSI, 2008).

The National Institute for Excellence (NICE) clinical guideline on management of hypertension in adults in primary care advises to identify hypertension (persistent raised BP above 140/90 mmHg), the patient must return for at least two subsequent clinic visits where their BP is assessed from two readings using the best conditions available. The routine use of automated ABPM or home monitoring devices in primary care is not currently recommended because their value has not been adequately established; appropriate use in primary care remains an issue for further research (NICE, 2006).

Goyal et al. (2005) conducted a systematic review of the literature to evaluate the role of ABPM in heart failure. The authors report ABPM has established its use in the definition of WCH and monitoring of essential hypertension; however, more prospective controlled studies in patients with congestive heart failure need to be conducted to define the impact of treatments on circadian BP profile.

Bergel et al. (2002) reported in a Cochrane review of ambulatory versus conventional method for monitoring BP during pregnancy. No randomized controlled trials provided evidence to support the use of ABPM during pregnancy.

## **Professional Societies/Organizations**

In 2008, the American Heart Association (AHA) Professional Education Committee of the Council for High Blood Pressure Research published a Scientific Statement on resistant hypertension evaluation, diagnosis and treatment. The committee recommends that 24-hour ABPM be utilized when clinic BP measurements are consistently higher than out-of-office measurements; in patients who repetitively show signs of overtreatment, particularly orthostatic symptoms; and in patients with chronically high office BP values but an absence of target organ damage (left ventricular hypertrophy, retinopathy, chronic kidney disease). A mean ambulatory daytime BP of > 135/85 mm Hg is considered elevated. If a significant white-coat effect is confirmed, out-of-office measurements should be relied on to adjust treatment (Calhoun, et al., 2008).

The AHA Scientific Statement recommendations for BP measurement states 24-hour ambulatory monitoring gives a better prediction of risk than office measurements and is useful for diagnosing WCH. Other potential applications of ABPM include the identification of individuals with a nondipping BP pattern (e.g., in diabetes), refractory hypertension with little target organ damage, suspected autonomic neuropathy, and patients in whom there is a large discrepancy between clinic and home measurements (Pickering, et al., 2005). This statement has not been updated since 2005.

Practice guidelines of the European Society of Hypertension for clinic, ambulatory and self-BP measurement accepted clinical indications for ABPM include: suspected WCH, nocturnal hypertension and masked hypertension; to establish dipper status, resistant hypertension, and hypertension of pregnancy. Potential indications for ABPM include: elderly patient; as a guide to antihypertensive drug treatment; type I diabetes; evaluation of symptoms suggesting orthostatic hypotension; autonomic failure (O’Brien, et al., 2005).

The National Heart, Lung, and Blood Institute’s (NHLBI) Joint National Committee (JNC) on Detection, Evaluation, and Treatment of High Blood Pressure states in its seventh report that APBM is warranted for the evaluation of WCH in the absence of target organ injury. ABPM is also helpful to assess patients with apparent drug resistance hypertension (i.e., failure to achieve goal BP in patients who are adhering to full doses of an appropriate three-drug regimen that includes a diuretic), hypotensive symptoms with antihypertensive medications, episodic hypertension, and autonomic dysfunction. ABPM also provides a measure of the percentage of BP readings that are elevated, overall BP load, and the extent of BP reduction during sleep. BP in most individuals decreases by 10%–20% during the night. There is an increased risk for cardiovascular events for those individuals who do not have a decrease in BP at night (NHLBI, 2004). This report has not been updated since 2004.

In a statement by the U.S. Preventive Services Task Force (USPSTF) summarizing recommendations on screening for high BP, ABPM was found to be a better predictor of clinical cardiovascular outcome than clinic-

based approaches. The USPSTF states, “due to the limitations in the reliability of BP measurements, experts commonly recommend that clinicians diagnose hypertension only after obtaining two or more elevated readings at two or more office visits at intervals of one to several weeks” (USPSTF, 2003). This statement has not been updated since 2003.

### Summary

Ambulatory blood pressure monitoring (ABPM) provides information about blood pressure (BP) during daily activities and sleep. ABPM can have predictive value for cardiovascular events and adds to the predictive value of office BP measurements. Professional organizations and evidence in the peer-reviewed medical literature suggests that ABPM is indicated for the management of a selected subset of patients. ABPM is indicated for the evaluation of white-coat hypertension (WCH) in the absence of target-organ injury. ABPM is used to assess patients with hypotensive symptoms with antihypertensive medications, resistant hypertension, episodic hypertension and autonomic dysfunction, suspected masked hypertension, suspected nocturnal hypertension, when there is a large discrepancy between clinic and home BP measurements, and for the management of isolated systolic hypertension in patients age 60 or older.

### Coding/Billing Information

**Note:** This list of codes may not be all-inclusive.

**Covered when medically necessary:**

CPT®* Codes	Description
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

ICD-9-CM Diagnosis Codes	Description
401.0-405.99	Hypertensive disease
458.0	Orthostatic hypotension
780.2	Syncope and collapse
796.2	Elevated blood pressure reading without diagnosis of hypertension

\*Current Procedural Terminology (CPT®) © 2008 American Medical Association: Chicago, IL.

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## Policy History

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<u>Pre-Merger Organizations</u>	<u>Last Review Date</u>	<u>Policy Number</u>	<u>Title</u>
CIGNA HealthCare	6/15/2007	0078	Ambulatory Blood Pressure Monitoring with Automatic Portable Monitors

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Connecticut General Life Insurance Company has acquired the business of Great-West Healthcare from Great-West Life & Annuity Insurance Company (GWLA). Certain products continue to be provided by GWLA (Life, Accident and Disability, and Excess Loss). GWLA is not licensed to do business in New York. In New York, these products are sold by GWLA's subsidiary, First Great-West Life & Annuity Insurance Company, White Plains, N.Y.