Prior Authorization Review Panel
MCO Policy Submission

A separate copy of this form must accompany each policy submitted for review.
Policies submitted without this form will not be considered for review.

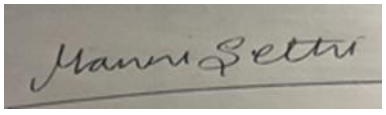
Plan: AmeriHealth Caritas Pennsylvania & Keystone First	Submission Date:5/1/2026
Policy Number: CCP.1108	Effective Date: 10/1/2014 Revision Date: 4/1/2026
Policy Name: Ambulatory blood pressure monitoring	

Type of Submission:

☐ New Policy	☒ Prior Authorization Policy
☒ Revised Policy*	☐ Base Policy
☐ Annual Review- no revisions	☐ Experimental/Investigational Policy
	☐ Statewide PDL
	☐ Other:

*All revisions to the policy must be highlighted using track changes throughout the document.

Please provide any clarifying information for the policy below:

Name of Authorized Individual (Please type or print): Manni Sethi, MD, MBA, CHCQM	Signature of Authorized Individual: 

Ambulatory blood pressure monitoring

Clinical Policy ID: CCP.1108

Recent review date: 4/2026

Next review date: 8/2027

Policy contains: Ambulatory blood pressure monitoring; masked hypertension; white coat hypertension

AmeriHealth Caritas Pennsylvania has developed clinical policies to assist with making coverage determinations. AmeriHealth Caritas Pennsylvania clinical policies are based on guidelines from established industry sources, such as the Centers for Medicare & Medicaid Services (CMS), state regulatory agencies, the American Medical Association (AMA), medical specialty professional societies, and peer-reviewed professional literature. These clinical policies along with other sources, such as plan benefits and state and federal laws and regulatory requirements, including any state- or plan-specific definition of "medically necessary," and the specific facts of the particular situation are considered by AmeriHealth Caritas Pennsylvania on a case by case basis when making coverage determinations. In the event of conflict between this clinical policy and plan benefits and/or state or federal laws and/or regulatory requirements, the plan benefits and/or state and federal laws and/or regulatory requirements shall control. AmeriHealth Caritas Pennsylvania clinical policies are for informational purposes only and not intended as medical advice or to direct treatment. Physicians and other health care providers are solely responsible for the treatment decisions for their patients. AmeriHealth Caritas Pennsylvania clinical policies are reflective of evidence-based medicine at the time of review. As medical science evolves, AmeriHealth Caritas Pennsylvania will update its clinical policies as necessary. AmeriHealth Caritas Pennsylvania clinical policies are not guarantees of payment.

Coverage policy

The use of 24-hour ambulatory blood pressure monitoring is clinically proven and, therefore, may be medically necessary for the diagnosis of hypertension in adult members for any of the following indications (Muntner, 2019; Whelton, 2018):

- Suspected white coat hypertension with a systolic blood pressure > 130 mm Hg but < 160 mm Hg or diastolic blood pressure > 80 mm Hg but < 100 mm Hg after a three-month trial of lifestyle modification.
- Known white coat hypertension with a daytime blood pressure < 130/80 mm Hg on ambulatory or home blood pressure monitoring, when annual monitoring is medically necessary to detect conversion to sustained hypertension.
- Treated hypertension with office readings not at goal and home blood pressure monitoring suggests significant white coat effect.
- Treated hypertension with multiple drug therapies and office blood pressure within 10 mm Hg above goal.
- Suspected masked hypertension with an office blood pressure consistently between 120-129/75-79 mm Hg in untreated members after a three-month trial of lifestyle modification.
- If daytime blood pressure ≥ 130/80 mm Hg on ambulatory or home blood pressure monitoring, annual monitoring is medically necessary to detect conversion to sustained hypertension.
- Suspected masked uncontrolled (treated) hypertension and either elevated home blood pressure readings prior to intensification of antihypertensive drug treatment, or presence of target organ damage or increased overall cardiovascular disease risk and office readings at goal.

The use of 24-hour ambulatory blood pressure monitoring is clinically proven and, therefore, may be medically necessary to assist in the diagnosis of hypertension in pediatric members, using monitors that have been

validated in a pediatric population and apply pediatric normative data, for any of the following clinical indications (Flynn, 2017):

- To confirm hypertension when office blood pressure measurements are at:
    - Elevated blood pressure category for 1 year or more, defined as: in children ages 1 to 13 years, in ≥ 90th percentile to < 95th percentile or 120/80 mm Hg to < 95th percentile (whichever is lower); in children ages 13 years or older, 120/< 80 mm Hg to 129/< 80 mm Hg.
    - Stage 1 hypertension defined as: in children ages 1 to 13 years, ≥ 95th percentile to < 95th percentile + 12 mmHg, or 130/80 mm Hg to 139/89 mm Hg (whichever is lower); in children ages 13 years or older, 130/80 mm Hg to 139/89 mm Hg.
    - Stage 2 hypertension after one week, defined as: in children ages 1 to 13 years, ≥ 95th percentile + 12 mm Hg, or ≥ 140/90 mm Hg (whichever is lower); in children ages 13 years or older, ≥ 140/90 mm Hg.
- To confirm treatment effectiveness.
- To diagnose suspected white coat hypertension.
- To routinely assess hypertension severity and determine the presence of abnormal circadian blood pressure patterns in the presence of high-risk conditions, including, but not limited to:
    - Secondary hypertension.
    - Chronic kidney disease or renal abnormalities.
    - Type 1 and type 2 diabetes mellitus.
    - Solid organ transplantation.
    - Obesity.
    - Known or suspected obstructive sleep apnea syndrome.
    - Repaired aortic coarctation.
    - Genetic syndromes associated with hypertension (e.g., neurofibromatosis, Turner syndrome, Williams syndrome, or aortic coarctation).
    - Prematurity.

Limitations

All other uses of ambulatory blood pressure monitoring are investigational/not clinically proven and, therefore, not medically necessary.

The following quality criteria for ambulatory blood pressure monitoring must be met:

- Monitoring is performed for at least 24 hours.
- Automatic readings are set at ≤ 30-minute intervals.
- Monitoring is performed using a U.S. Food and Drug Administration-approved device that has been validated according to international, standardized protocols prior to use.

Repeat ambulatory blood pressure monitoring may be obtained if the first examination has less than 70% of the expected values due to a high number of artifacts.

Routine repeat ambulatory blood pressure monitoring is investigational/not clinically proven and, therefore, not medically necessary.

In a circumstance when ambulatory blood pressure monitoring needs to be performed more than once on a member, the medical necessity and quality criteria described above must be met for each subsequent test.

Alternative covered services

- Office or clinic blood pressure measurement.
- Home blood pressure measurement.

Background

According to the Centers for Disease Control and Prevention (2023), approximately one of every two adults in the United States has hypertension, and only one of four has their blood pressure under control. Among U.S. children, the prevalence of hypertension is 10.4%, with especially high rates for those with children with coarctation of the aorta, solid-organ or stem-cell transplant, chronic kidney disease, and sickle cell disease (Chung, 2023). Primary (essential) hypertension is now identifiable in children and adolescents and is often associated with a positive family history of hypertension or cardiovascular disease, obesity, and lifestyle factors (Flynn, 2017).

Hypertension is classified as follows (systolic/diastolic blood pressure) (Whelton, 2018):

- Normal: < 120 mm Hg/< 80 mm Hg.
- Elevated hypertension: 120 – 139 mm Hg/< 80 mm Hg.
- Stage 1 hypertension: 130 – 139 mm Hg/80 – 89 mm Hg.
- Stage 2 hypertension: ≥ 140 mm Hg/≥ 90 mm Hg.

Accurate blood pressure measurement is essential to correctly classify individuals, ascertain blood pressure-related risk, and guide management. To date, office blood pressure measurements define the relationship between blood pressure and risk but are subject to fluctuations and phenomena such as white coat hypertension (hypertensive in office, normotensive in ambulatory/home setting) or masked hypertension (normotensive in office, hypertensive in ambulatory/home setting). Evidence suggests an association between white coat or masked hypertension and intermediate harmful health outcomes indicating these conditions may not be benign. A diagnosis of white coat hypertension or masked hypertension requires repeated measurements to minimize misclassification of individuals as hypertensive or normotensive (Muntner, 2019).

Masked hypertension and nocturnal blood pressure fall patterns are associated with significantly higher risk of cardiovascular events (Salles, 2016). Nocturnal hypertension and non-dipping may be early markers of masked hypertension (O'Brien, 2016).

Ambulatory blood pressure monitoring is a noninvasive method of obtaining multiple blood pressure readings at regular intervals over a 24-hour (or sometimes 48-hour) period in the person's own living environment. The rationale for its use within carefully selected populations is to provide more precise and accurate blood pressure data that will lead to improved care management and patient outcomes. The purported clinical advantages are to:

- Detect lower blood pressure (white coat hypertension) or higher blood pressure (masked hypertension) out-of-office compared to in-office measurement.
- Determine the presence or absence of normal nocturnal dipping status (i.e., decreases in an individual's blood pressure during nighttime hours or when sleeping).
- Assess the adequacy of blood pressure control in persons taking complex antihypertensive medication regimens.
- Provide detailed information on blood pressure patterns in persons with episodic hypertension, chronic kidney disease, diabetes, and autonomic dysfunction.
- Identify persons with apparently refractory hypertension but relatively little to no target organ damage.
- Confirm hypertension in patients in whom there is a large discrepancy between clinic and home blood pressure measurements.

In the United States, several ambulatory blood pressure monitors have been cleared for marketing via the 510(k) process (U.S. Food and Drug Administration, 2024). However, monitors that have not undergone validation

testing or U.S. Food and Drug Administration clearance can also be sold in the United States, but few have been formally validated in children (Flynn, 2017).

Findings

The body of evidence on ambulatory blood pressure monitoring continues to grow, with major guidelines now issuing their strongest-level recommendations for out-of-office blood pressure confirmation in the diagnosis of hypertension (Jones, 2025). Recent individual participant data meta-analyses and systematic reviews reinforce the prognostic superiority of 24-hour ambulatory blood pressure monitoring over office measurement for predicting cardiovascular outcomes, including mortality, stroke, and coronary events (Kollias, 2024; Panagiotakos, 2024; Zhang, 2025). Emerging evidence further demonstrates the clinical significance of nocturnal blood pressure patterns captured by ambulatory monitoring, with non-dipping and reverse-dipping profiles associated with elevated risk of cerebral small vessel disease and cardiovascular events (Antza, 2025; Salles, 2016). Network meta-analyses comparing blood pressure measurement methods confirm that discrepancies between office and ambulatory readings are not fixed but widen at higher blood pressure levels, underscoring the importance of ambulatory monitoring for accurate classification across the blood pressure spectrum (Yeh, 2025).

Guideline Recommendations for Ambulatory Blood Pressure Monitoring

Diagnostic Role and Clinical Indications

Major international guidelines consistently recognize ambulatory blood pressure monitoring as a critical diagnostic tool in hypertension management. The European Society of Hypertension recommends ambulatory blood pressure monitoring to confirm the presence or absence of white coat hypertension in patients with grade 1 hypertension, masked hypertension, clinically suspected nocturnal blood pressure phenotypes, and true resistant hypertension. Additional indications include diagnosing hypertension when office measurements show high variability, evaluating 24-hour blood pressure control in high-risk individuals, and assessing symptoms of hypotension (Mancia, 2023).

The 2023 European Society of Hypertension Guidelines emphasize using ambulatory blood pressure monitoring alongside traditional office-based readings to diagnose hypertension. These guidelines place greater importance on ambulatory monitoring to confirm hypertension subtypes compared to their 2018 version. They maintain an office blood pressure threshold of > 140/90 mm Hg for diagnosing hypertension (grade 1), while readings between 130-139/85-89 mm Hg are classified as "normal" or "high-normal," potentially indicating white coat or masked hypertension when compared with out-of-office readings (Vemu, 2024).

The 2024 European Society of Cardiology guidelines provide specific indications for ambulatory blood pressure monitoring in adults, including suspected white-coat hypertension with office systolic blood pressure of 130-160 mm Hg or diastolic of 80-100 mm Hg after lifestyle modifications, treated patients whose blood pressure is not meeting targets or is within 10 mm Hg of the target while on multiple medications, and untreated patients with office blood pressure consistently between 120-129 mm Hg systolic or 75-79 mm Hg diastolic after lifestyle changes (Burlacu, 2025).The 2024 European Society of Cardiology guidelines provide specific indications for ambulatory blood pressure monitoring in adults, including suspected white-coat hypertension with office systolic blood pressure of 130-160 mm Hg or diastolic of 80-100 mm Hg after lifestyle modifications, treated patients whose blood pressure is not meeting targets or is within 10 mm Hg of the target while on multiple medications, and untreated patients with office blood pressure consistently between 120-129 mm Hg systolic or 75-79 mm Hg diastolic after lifestyle changes (Burlacu, 2025). An individual participant data meta-analysis of 14 prospective

cohorts (n = 14,230; 176,021 person-years of follow-up) from the International Database of Ambulatory Blood Pressure in Relation to Cardiovascular Outcomes examined the percentage of time that ambulatory blood pressure remained within the 2024 European Society of Cardiology target range and found that longer time within target was associated with reduced cardiovascular risk, with a hazard ratio of 0.30 (95% confidence interval, 0.23-0.39) for the composite cardiovascular endpoint per 1 standard deviation increase in time within target (Zhang, 2025). The study also demonstrated that office blood pressure frequently misclassified the actual ambulatory blood pressure control status of individuals; even at an office blood pressure of 120/70 millimeters of mercury, the probability of being in the best ambulatory blood pressure control quartile was only 35% to 44% in untreated individuals (Zhang, 2025).

The American College of Cardiology/American Heart Association recommends ambulatory blood pressure monitoring, along with clinic blood pressure monitoring, to detect white coat effect and masked hypertension (Whelton, 2018). Similar recommendations have been issued by the National Institute for Health and Care Excellence (2023).The American College of Cardiology/American Heart Association recommends ambulatory blood pressure monitoring, along with clinic blood pressure monitoring, to detect white coat effect and masked hypertension (Whelton, 2018). The 2025 joint guideline from the American Heart Association, the American College of Cardiology, and 11 additional professional societies gave out-of-office blood pressure measurement a Class 1 recommendation with Level of Evidence A for confirming a hypertension diagnosis using ambulatory blood pressure monitoring or home blood pressure monitoring (Jones, 2025). It gave ambulatory blood pressure monitoring a Class 2a recommendation with Level of Evidence C-LD for excluding white-coat effect in apparent treatment-resistant hypertension (Jones, 2025). The guideline identifies ambulatory blood pressure monitoring as the reference standard for out-of-office measurement and notes that it is preferred over home blood pressure monitoring for excluding white-coat hypertension and masked hypertension among individuals not taking antihypertensive medication, while home blood pressure monitoring is preferred for individuals already on treatment due to the practical difficulty of repeated ambulatory monitoring (Jones, 2025). Similar recommendations have been issued by the National Institute for Health and Care Excellence (2023).

The 2021 US Preventive Services Task Force recommendation statement advises initial screening with office blood pressure measurement, followed by confirmation of elevated readings using ambulatory blood pressure monitoring before starting treatment. This statement positions ambulatory blood pressure monitoring as the gold standard for accurately diagnosing sustained hypertension and minimizing misclassification from white-coat hypertension (US Preventive Services Task Force, 2021). The United States Preventive Services Task Force and the Canadian Hypertension Education Program recommend ambulatory blood pressure monitoring to confirm initially elevated office-based readings to avoid potential over-diagnosis of isolated clinic hypertension and unnecessary treatment (Cloutier, 2015; Siu, 2015).

Current guidelines across organizations acknowledge the diagnostic superiority of 24-hour ambulatory blood pressure monitoring for identifying sustained hypertension by excluding white coat hypertension, detecting masked hypertension, and providing additional prognostic information from nocturnal blood pressure patterns (Flynn, 2017; O'Brien, 2016).

Screening Protocols and Frequency

The US Preventive Services Task Force recommends annual screening with ambulatory blood pressure monitoring for adults aged 40 years or older and those at higher risk, such as Black individuals, those with high-normal blood pressure, or those who are overweight or obese. For lower-risk adults aged 18 to 39 years with prior normal readings, screening every three to five years is suggested (US Preventive Services Task Force, 2021).

Quality Standards for Measurement

The European Society of Cardiology established specific quality standards for ambulatory blood pressure monitoring, requiring that monitoring span a minimum of 24 hours, include automatic readings every 30 minutes or less, and use devices validated according to international standards (Burlacu, 2025). Other guidelines similarly emphasize standardized, accurate measurement techniques (Vemu, 2024; Mancia, 2023).

Special Populations

Pediatric Populations

The American Academy of Pediatrics found ambulatory blood pressure monitoring more accurate than clinic measurement for diagnosing hypertension and more reproducible than either casual or home blood pressure measurements in children. The Academy identified several high-risk conditions for which ambulatory blood pressure monitoring may be useful (Flynn, 2017). The European Society of Cardiology guidelines recommend ambulatory monitoring for confirming hypertension in pediatric patients when office measurements show elevated blood pressure or stage 1 or 2 hypertension, and for evaluating treatment effectiveness (Burlacu, 2025).

Pregnant Women

A systematic review of six studies indicated that among hypertensive pregnant women, outcome risks were similar between self-monitoring and clinic-based monitoring of blood pressure (Yeh, 2022). A systematic review and meta-analysis of 69 studies (n = 9,398) examining 24-hour ambulatory blood pressure monitoring during pregnancy and the postpartum period found that individuals later diagnosed with hypertensive disorders of pregnancy had significantly higher 24-hour systolic blood pressure (Hedges' g = 1.45; 95% confidence interval, 0.59-2.31) and diastolic blood pressure (Hedges' g = 1.57; 95% confidence interval, 0.80-2.34) during pregnancy compared to individuals without these disorders. These differences were statistically significant in the second and third trimesters but not in the first trimester. The authors noted that 45.61% of included studies used ambulatory blood pressure devices not validated for use in pregnant individuals (Sommer, 2025).

Areas of Consensus and Variation

Despite broad agreement on the value of ambulatory blood pressure monitoring, there is a lack of consensus among guidelines regarding the definition of hypertension in adult populations based on ambulatory measurements (Mancia, 2023; National Institute for Health and Care Excellence, 2023). Guidelines typically apply thresholds based on a definition of hypertension (e.g., office blood pressure > 140/90 mm Hg) from clinical trials that examined the benefits of treating hypertension. Less robust data exist to support basing treatment guidelines on ambulatory blood pressure measurement (Mancia, 2023).

There also remains a lack of consensus on the best method for identifying individuals who would most likely benefit from ambulatory blood pressure monitoring screening for conditions other than white coat hypertension. Several indices have been developed to identify candidates for ambulatory blood pressure monitoring who have normal office blood pressure, but they require further validation before routine clinical use (Bromfield, 2016; Schwartz, 2016; Sheppard, 2016).

Systematic Reviews and Meta-Analyses

Cardiovascular Risk Prediction

A systematic review for the United States Preventive Services Task Force summarized evidence on rescreening intervals and diagnostic and predictive accuracy for cardiovascular events of different blood pressure methods (Piper, 2015).

A systematic review and meta-analysis by Panagiotakos examined eight prospective cohort studies with 7535 participants and found that 24-hour ambulatory blood pressure monitoring significantly predicts cardiovascular

disease risk, even after adjusting for office blood pressure measurements and other potential confounding factors. For each standard deviation increase in systolic blood pressure measured by ambulatory monitoring, the risk of cardiovascular disease increased by 32%, while diastolic blood pressure showed a 15% higher risk per standard deviation increment (Panagiotakos, 2024).

A systematic review and meta-analysis by Kollias evaluated six prospective outcome studies with 4830 participants to compare the prognostic value of home blood pressure monitoring and ambulatory blood pressure monitoring. The study found that 24-hour ambulatory blood pressure monitoring is a strong predictor of cardiovascular outcomes, with a pooled hazard ratio of 1.38 per 10 mm Hg increase in systolic blood pressure, indicating a 38% increased risk of cardiovascular events for each 10 mm Hg rise. This predictive ability was comparable to that of home monitoring (hazard ratio of 1.36) and superior to office measurements across studies that included all three methods (Kollias, 2024).A systematic review and meta-analysis by Kollias evaluated six prospective outcome studies with 4830 participants to compare the prognostic value of home blood pressure monitoring and ambulatory blood pressure monitoring. The study found that 24-hour ambulatory blood pressure monitoring is a strong predictor of cardiovascular outcomes, with a pooled hazard ratio of 1.38 per 10 mm Hg increase in systolic blood pressure, indicating a 38% increased risk of cardiovascular events for each 10 mm Hg rise. This predictive ability was comparable to that of home monitoring (hazard ratio of 1.36) and superior to office measurements across studies that included all three methods (Kollias, 2024). In a systematic review and meta-analysis of 24 studies (n = 6,822), Antza and colleagues found that ambulatory blood pressure monitoring identifies elevated blood pressure loads associated with cerebral small vessel disease, with individuals with the condition demonstrating a mean nighttime systolic blood pressure 9.20 millimeters of mercury higher (95% confidence interval, 6.88-11.52) than individuals without the condition. Non-dipping status, detectable only through ambulatory monitoring, was associated with 2.24 times higher odds of cerebral small vessel disease (95% confidence interval, 1.31-3.16), and reverse dipping was associated with 3.02 times higher odds of cerebral microbleeds (95% confidence interval, 1.61-4.42) (Antza, 2025).Diagnostic Accuracy

A series of meta-analyses (52 studies, n = 215534) performed for the US Preventive Services Task Force assessed the benefits and risks of screening adults for hypertension. Sensitivity and specificity were 54% and 90% for initial office-based blood pressure screening; 80% and 55% for office-based confirmation; and 84% and 60% for home-based confirmation. Authors concluded "major accuracy limitations" exist in effective screening (Guirguis-Blake, 2021).

A systematic review of 16 studies (n = 10158) showed high sensitivity and specificity (96.2% and 94.0%) of blood pressure measurements using automated devices detecting atrial fibrillation in office settings, but accuracy of detection using ambulatory measurements is not well studied (Tang, 2022).

A systematic review and meta-analysis of 15 studies (n = 5729) showed a "slight to fair" ability to reproduce masked hypertension using ambulatory or home blood pressure monitoring, with somewhat better results using ambulatory monitoring. Reproduction may be reduced due to inaccurate office-based results (Antza, 2022).A systematic review and meta-analysis of 15 studies (n = 5729) showed a "slight to fair" ability to reproduce masked hypertension using ambulatory or home blood pressure monitoring, with somewhat better results using ambulatory monitoring. Reproduction may be reduced due to inaccurate office-based results (Antza, 2022). A systematic review and network meta-analysis of 65 studies (n = 40,022) found that the differences between blood pressure measurement methods are not constant but depend on the blood pressure level itself; at higher blood pressure levels, the discrepancy between office and ambulatory readings widens progressively (Yeh, 2025). For example, at an office systolic blood pressure of 140 millimeters of mercury, the corresponding 24-hour ambulatory value was 130.71 millimeters of mercury (95% confidence interval, 129.32-132.11), but at 180 millimeters of mercury the corresponding ambulatory value was 148.49 millimeters of mercury (95% confidence interval, 140.60-156.38), a widening gap that suggests current fixed conversion thresholds between methods may be imprecise at the extremes (Yeh, 2025).

A systematic review and meta-analysis of 26 studies determined that 7% of patients were diagnosed with white coat hypertension after automated office blood pressure measurement versus 14% after manual measurement. As 13% of patients had masked hypertension after automated measurement, this technique needs to be further refined (Bo, 2021).

Masked Hypertension

The use of ambulatory blood pressure monitoring for diagnosing masked hypertension warrants further consideration, as a significant portion of untreated and treated persons with non-elevated clinic blood pressure have masked hypertension and abnormal nocturnal blood pressure profiles.

Masked hypertension and masked uncontrolled hypertension are more likely in individuals of African descent, with increased cardiovascular risk and disease states (e.g., diabetes, chronic renal failure, and metabolic syndrome), older persons, males, shortened sleep time, and obstructive sleep apnea (Colantonio, 2017; Franklin, 2017; Thomas, 2017; Wang, 2017). Persons with prehypertension are more likely to have masked hypertension than those with optimal blood pressure and frequently develop target organ damage prior to transitioning to sustained hypertension (Colantonio, 2017; Franklin, 2017).

Longitudinal data from the Jackson Heart Study provides information derived from an African American population, with updated definitions of ambulatory hypertension while pointing out the need for practitioners to interpret these values in the context of their own patient populations (Ravenell, 2017).

It is reasonable to apply ambulatory blood pressure monitoring to individuals with normal or elevated (prehypertensive) casual measurements when there is a clinical suspicion of hypertension (e.g., presence of left ventricular hypertrophy) to minimize misclassification of such individuals as normotensive or with controlled hypertension.

Cost Effectiveness

A cost effectiveness analysis found ambulatory blood pressure measurement was the dominant diagnostic strategy of choice over clinical or home blood pressure measurement in primary care settings for most U.S. adults across all age groups regardless of initial screening results (Beyhaghi, 2019).

In 2026, we updated the coverage criteria to include apparent treatment-resistant hypertension as an indication for ambulatory blood pressure monitoring, consistent with the 2025 American Heart Association/American College of Cardiology joint guideline (Jones, 2025). We added new systematic reviews, meta-analyses, and an individual participant data meta-analysis that further support the prognostic and diagnostic value of ambulatory blood pressure monitoring (Antza, 2025; Sommer, 2025; Yeh, 2025; Zhang, 2025).References

On March 11, 2026, we searched PubMed and the databases of the Cochrane Library, the U.K. National Health Services Centre for Reviews and Dissemination, the Agency for Healthcare Research and Quality, and the Centers for Medicare & Medicaid Services. Search terms were “blood pressure monitoring, ambulatory” (MeSH), “hypertension/diagnosis” (MeSH), and “ambulatory blood pressure monitoring.” We included the best available

evidence according to established evidence hierarchies (typically systematic reviews, meta-analyses, and full economic analyses, where available) and professional guidelines based on such evidence and clinical expertise.

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Policy updates

5/2014: initial review date and clinical policy effective date: 10/2014

4/2015: Policy references updated.

4/2016: Policy references updated.

4/2017: Policy references updated.

4/2018: Policy references updated. Policy indications expanded for ambulatory blood pressure monitoring based on new guidelines.

4/2019: Policy references updated. Policy ID changed.

4/2020: Policy references updated. Policy indications expanded to Medicare members.

4/2021: Policy references updated.

4/2022: Policy references updated.

4/2023: Policy references updated.

4/2024: Policy references updated.

4/2025: Policy references updated.

4/2026: Policy references updated.

Related codes

Below are the most commonly submitted codes for the service(s)/item(s) subject to this policy CCP.1108 This is not an exhaustive list of codes. Providers are expected to consult the appropriate coding manuals and bill accordingly.

Code	Code 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; review with interpretation and report