Blood Pressure Monitoring and Devices

CSHCN Services Program Provider Manual

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TEXAS
Health and Human
Services

BLOOD PRESSURE MONITORING AND DEVICES

Table of Contents

11.1 Enrollment 3
11.2 Benefits, Limitations, and Authorization Requirements 3
11.2.1 Blood Pressure Devices 3
11.2.1.1 Self-Measured Blood Pressure Monitoring and Ambulatory Blood Pressure Monitoring 3
11.2.1.2 *Manual and Automated Blood Pressure Devices 4
11.2.1.3 Hospital-Grade Blood Pressure Devices 5
11.2.1.4 Blood Pressure Device Components Repair or Replacement 6
11.2.2 Authorization Requirements 6
11.2.2.1 Ambulatory Blood Pressure Monitoring 6
11.2.2.2 Manual and Automated Blood Pressure Devices 6
11.2.2.3 Hospital-Grade Blood Pressure Devices 7
11.2.2.3.1 Rental 7
11.2.2.3.2 Purchase 8
11.2.2.4 Blood Pressure Device Components Repair or Replacement 8
11.3 Documentation of Receipt 8
11.4 Claims Information 8
11.5 Reimbursement 9
11.6 TMHP-CSHCN Services Program Contact Center 9

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11.1 Enrollment

To enroll in the CSHCN Services Program, durable medical equipment (DME) providers must be actively enrolled in Texas Medicaid, have a valid CSHCN Services Program Provider Agreement, have completed the CSHCN Services Program enrollment process, and comply with all applicable state laws and requirements. Out of state DME (noncustom DME) providers must meet all these conditions, and be located in the United States, within 50 miles of the Texas state border, and approved by the Department of State Health Services (DSHS).

Important: *CSHCN Services Program providers are responsible for knowing, understanding, and complying with the laws, administrative rules, and policies of the CSHCN Services Program and Texas Medicaid.*

By enrolling in the CSHCN Services Program, providers are charged not only with knowledge of the adopted CSHCN Services Program agency rules published in Title 26 Texas Administrative Code (TAC), but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371.

CSHCN Services Program providers also are required to comply with all applicable laws, administrative rules, and policies that apply to their professions or to their facilities. Specifically, it is a violation of program rules when a provider fails to provide health-care services or items to recipients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 TAC §371.1659 for Medicaid providers, which also applies to CSHCN Services Program providers as set forth in 26 TAC §351.6(b)(1). Accordingly, CSHCN Services Program providers can be subject to sanctions for failure to deliver, at all times, health-care items and services to recipients in full accordance with all applicable licensure and certification requirements. These include, without limitation, requirements related to documentation and record maintenance, such that a CSHCN Services Program provider can be subject to sanctions for failure to create and maintain all records required by his or her profession, as well as those required by the CSHCN Services Program and Texas Medicaid.

Refer to: Section 2.1, "Provider Enrollment" in Chapter 2, "Provider Enrollment and Responsibilities" for more detailed information about CSHCN Services Program provider enrollment procedures.

Section 3.1.4, "Services Provided Outside of Texas" in Chapter 3, "Client Benefits and Eligibility" for more detailed information.

11.2 Benefits, Limitations, and Authorization Requirements

11.2.1 Blood Pressure Devices

Blood pressure monitoring by either Self-Measured blood pressure monitoring (SMBPM) or Ambulatory blood pressure monitoring (ABPM) is a benefit of CSHCN Services Program when used as a diagnostic tool to assist a physician in diagnosing hypertension in individuals whose blood pressure is either elevated, or inconclusive when evaluated in the office alone.

Blood pressure devices and components are benefits of the CSHCN Services Program only in the home setting for self-monitoring when the equipment is prescribed by a physician.

Providers must maintain documentation, including the diagnosis, that supports medical necessity of the requested equipment in the client's medical record and is subject to retrospective review.

11.2.1.1 Self-Measured Blood Pressure Monitoring and Ambulatory Blood Pressure Monitoring

SMBPM and ABPM are indicated for the evaluation of one of the following conditions:

- White coat hypertension that is defined as:

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- A clinic or office blood pressure greater than 140/90mm HG on at least three separate clinic or office visits with two separate measurements at each visit.
- At least two documented separate blood pressure measurements taken outside the clinic or office, which are less than 140/90mm Hg.
- No evidence of end-organ damage

- Resistant hypertension
- Hypotensive symptoms as a response to hypertension medications
- Nocturnal angina
- Episodic hypertension
- Syncope

SMBPM and ABPM are indicated for initial diagnosis of hypertension and should not be used for maintenance monitoring. SMBPM may also be indicated for re-evaluation of clients previously diagnosed with hypertension.

11.2.1.2 * Manual and Automated Blood Pressure Devices

Manual blood pressure devices (procedure code A4660) require manual cuff inflation with real-time visualization of the results displayed on the manometer. Automated blood pressure devices (procedure code A4670) inflate the cuff manually or automatically and display the blood pressure results on a small screen.

The purchase of manual or automated blood pressure devices may be considered when submitted with one of the following diagnosis codes:

[Revised] Diagnosis Codes							
I10	I110	I119	I120	I129	I130	I1310	I1311
I132	I150	I151	I152	I158	I159	I160	I161
I169	I1A0	I219	I21A1	I21A9	I21B	I2541	I2582
I2585	I2601	I2602	I2603	I2604	I2609	I2690	I2692
I2693	I2694	I2695	I2696	I2699	I270	I271	I2720
I2721	I2722	I2723	I2724	I2729	I2781	I2782	I2783
I27840	I27841	I27848	I27849	I2789	I279	I340	I341
I342	I3481	I3489	I349	I350	I351	I352	I358
I359	I360	I361	I362	I368	I369	I370	I371
I372	I378	I379	I38	I39	I421	I422	I423
I424	I425	I4281	I4289	I440	I441	I442	I4430
I4439	I444	I445	I4460	I4469	I447	I450	I4510
I4519	I452	I454	I455	I456	I4589	I459	I4710
I4711	I4719	I4720	I4722	I4729	I479	I480	14811
14819	14820	14821	I483	I484	I4891	I4892	I495
I501	I5020	I5021	I5022	I5023	I5030	I5031	I5032
I5033	I5040	I5041	I5042	I5043	I50810	I50811	I50812
I50813	I50814	I5082	I5083	I5084	I5089	I509	I5A
I950	I951	I952	I953	I9581	I9589	I959	N000
N001	N002	N003	N004	N005	N006	N007	N008

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[Revised] Diagnosis Codes							
N009	N00A	N00B1	N00B2	N010	N011	N012	N013
N014	N015	N016	N017	N018	N019	N01A	N02A
N02B1	N02B2	N02B3	N02B4	N02B5	N02B6	N02B9	N030
N031	N032	N033	N034	N035	N036	N037	N038
N039	N03A	N040	N041	N0420	N0421	N0422	N0429
N043	N044	N045	N046	N047	N048	N049	N04A
N04B1	N04B2	N050	N051	N052	N053	N054	N055
N056	N057	N058	N059	N05A	N08	N170	N171
N172	N178	N179	N181	N182	N1830	N1831	N1832
N184	N185	N186	N189	N19	N250	N251	N2589
N259	N269	N270	N271	Q208	Q2110	Q2111	Q2112
Q2113	Q2114	Q2115	Q2116	Q2119	Q2120	Q2121	Q2122
Q2123	R001	T800XXA	T81718A	T8172XA			

Manual and automated blood pressure devices that have been purchased are anticipated to last a minimum of 1 year and may be considered for replacement when 1 year has passed or when the equipment is not functional and not repairable.

11.2.1.3 Hospital-Grade Blood Pressure Devices

The rental or purchase of a hospital-grade blood pressure device (procedure code A9279 with modifier U1) may be considered when documentation from the physician supports medical necessity and explains why the client could not use a standard automatic blood pressure device.

A hospital-grade blood pressure device, as defined by the CSHCN Services Program, includes memory for continuous recording, has an alarm system to notify the caregiver of abnormal readings, and is capable of frequent or continuous automatic blood pressure and heart rate monitoring with correction of motion artifact.

The following indications are recognized by the CSHCN Services Program for hospital-grade blood pressure devices:

- Hypotension
- Essential hypertension
- Hypertensive heart disease
- Hypertensive renal disease
- Myocardial infarction
- Pulmonary embolism
- Acute pulmonary heart disease
- Chronic pulmonary heart disease
- Valve disorders
- Cardiomyopathy
- Conduction disorders
- Cardiac dysrhythmias
- Heart failure

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- Acute kidney failure
- Chronic kidney disease
- Hydronephrosis
- Vesicoureteral reflux with neuropathy
- Bulbus cordis anomalies and anomalies of cardiac septal closure
- Embolism
- Stenosis of either coronary artery stent or peripheral vascular stent

Hospital-grade blood pressure devices that have been purchased are anticipated to last a minimum of 3 years and may be considered for replacement when 3 years have passed or when the equipment is not functional and not repairable.

For clients who are birth through 11 months of age, the rental or purchase of a hospital-grade blood pressure device is a benefit when documentation supports medical necessity and includes an explanation of why the client cannot use a standard automated blood pressure device.

For clients who are 12 months of age or older, the rental or purchase of a hospital-grade blood pressure device is a benefit on a case-by-case basis. Supporting documentation of medical necessity must be provided.

11.2.1.4 Blood Pressure Device Components Repair or Replacement

Replacement of blood pressure cuffs (procedure code A4663) or replacement of other components (procedure code A9900) may be considered when submitted with documentation of medical necessity explaining why a blood pressure cuff or other component(s) needs to be replaced.

Repair of equipment (procedure code A9900) will be considered after the factory warranty has expired.

11.2.2 Authorization Requirements

Providers must submit the CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment (DME) for services that require prior authorization.

To facilitate determination of medical necessity and avoid unnecessary denials, the physician must provide correct and complete information, including documentation of medical necessity for the equipment or supplies requested. The physician must maintain documentation of medical necessity in the client's medical record. The requesting provider may be asked for additional information to clarify or complete a request for a hospital-grade blood pressure monitor.

11.2.2.1 Ambulatory Blood Pressure Monitoring

SMBPM and ABPM do not require authorization or prior authorization.

Providers must document that the SMBPM orABPM was performed for at least 24 hours.

11.2.2.2 Manual and Automated Blood Pressure Devices

Prior authorization is not required for manual (procedure code A4660) and automated (procedure code A4670) blood pressure devices if the client's diagnosis is listed in Section 11.2.1.2 *, "Manual and Automated Blood Pressure Devices" in this chapter. Providers must maintain documentation to support medical necessity in the medical record.

Prior authorization is required for all other diagnoses and requires medical review of written documentation of the medical need for a manual and automatic blood pressure device. Documentation should include the diagnosis and the rationale for monitoring blood pressure in the home.

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11.2.2.3 Hospital-Grade Blood Pressure Devices

Prior authorization is required for the rental or purchase of the hospital-grade blood pressure device. Documentation must support medical necessity for the hospital-grade blood pressure device, support the client's need for self-monitoring, and explain why the client could not use an automated blood pressure device. The documentation must include:

- All pertinent diagnoses.
- Initial evaluation.
- Symptoms.
- Duration of symptoms.
- Any recent hospitalizations (within the past 12 months).
- Comorbid conditions.
- How frequent or continuous BP monitoring will affect treatment.
- All pertinent laboratory and radiology results.
- Client's weight.
- A family or caregiver(s) who has an understanding of cause and effect , awareness of the client's condition, and who has agreed to accept the responsibility to be trained to use the hospital-grade monitor.

11.2.2.3.1 Rental

Prior authorization may be granted for a 6-month rental. The request must be submitted with documentation of medical necessity as outlined above that supports the client's need for self-monitoring and addressing why an automated blood pressure device will not meet the client's needs. The rental of the device may be reimbursed once every calendar month for a maximum of 6 months.

Recertification for one additional 6-month period may be considered when the physician provides current documentation that supports the ongoing medical necessity of self-monitoring and that confirms the client or family is compliant with its use.

Rental of equipment includes all necessary supplies, adjustments, repairs, and replacement parts.

ABPM is limited to two services per lifetime, any provider.

ABPM over two services may be considered when documentation of medical necessity is submitted with the claim.

Only one method of blood pressure monitoring (SMBPM or ABPM) may be reimbursed within a rolling 12-month period. SMBPM submitted within the same rolling 12-month period as AMPM will be denied.

Procedure code 99473 is limited to one service per year, any provider. Procedure code 99473 may be considered for reimbursement more than once per year when the following documentation of medical necessity is submitted with the claim:

- Documentation of erroneous blood pressure readings – excessively high or low blood pressure, blood pressure readings excessively inconsistent with those measured professionally
- Documentation of erroneous blood pressure logs – day of the week, time of day, setting or location, or timing of medication administration inconsistent with prior professional instruction
- Documentation of poor health literacy, developmental, or intellectual challenges that may require repeated client education
- Client purchase or receipt of new blood pressure device

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Procedure code 99474 is limited to four services per year, any provider, and may be reimbursed only if a claim for procedure code 99473 has been submitted within 12 rolling months.

11.2.2.3.2 Purchase

Purchase of a hospital-grade blood pressure device will not be considered for prior authorization until the client has completed a 6-month trial period.

Purchase of a hospital-grade blood pressure device may be prior authorized when all of the following criteria are met:

- The client is 12 months of age or older.
- Documentation of medical necessity supports the client's need for ongoing self-monitoring and addresses why an automated blood pressure device will not meet the client's needs.

All rental costs of the hospital-grade blood pressure device apply toward the purchase price.

11.2.2.4 Blood Pressure Device Components Repair or Replacement

Replacement of blood pressure cuffs or replacement of other components may be considered for purchase with prior authorization when submitted with documentation of medical necessity explaining why the blood pressure cuff or other component(s) need to be replaced.

Repair of equipment will be considered for prior authorization after the factory warranty has expired.

Refer to: Chapter 4, "Prior Authorizations and Authorizations" for more information about authorizations and prior authorizations.

Chapter 17, "Durable Medical Equipment (DME)" for more information about DME service.

Providers must use the following procedure codes for ABPM:

Procedure Codes			
93784	93786	93788	93790

Providers must use the following procedure codes for SMPM:

Procedure Codes	
99473	99474

11.3 Documentation of Receipt

When the equipment is delivered, providers must complete the CSHCN Services Program Documentation of Receipt form. The date of delivery on the form is the date of service that should appear on the claim. The provider must request a signature at the time of delivery from the client or client's representative. The provider should retain this form and not submit it with the claim.

Providers must maintain a copy of this form in their files for the life of the piece of equipment or until the equipment is authorized for replacement.

The documentation of receipt form is available in both English and Spanish.

11.4 Claims Information

Modifier RR must be used for DME rental equipment, and modifier NU must be used for the purchase of new DME equipment. Home health DME providers must use the DM3 benefit code when submitting claims and authorization.

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DME services must be submitted to TMHP in an approved electronic format or on the CMS-1500 paper claim form. Providers may purchase CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a CMS-1500 paper claim form, all required information must be included on the claim, as information is not keyed from attachments. Superbills or itemized statements are not accepted as claim supplements.

The Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes included in policy are subject to National Correct Coding Initiative (NCCI) relationships. Exceptions to NCCI code relationships that may be noted in CSHCN Services Program medical policy are no longer valid. Providers should refer to the Centers for Medicare & Medicaid Services (CMS) NCCI web page for correct coding guidelines and specific applicable code combinations. In instances when CSHCN Services Program medical policy quantity limitations are more restrictive than NCCI Medically Unlikely Edits (MUE) guidance, medical policy prevails.

Refer to: Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement" for general information about claims filing.

Section 5.7.2.4, "CMS-1500 Paper Claim Form Instructions" in Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement" for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

Chapter 41, "TMHP Electronic Data Interchange (EDI)" for information on electronic claims submissions.

11.5 Reimbursement

DME may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid. Items or services that do not have a maximum fee determined by the Health and Human Services Commission (HHSC) are manually priced. If an item is manually priced, the manufacturer's suggested retail price (MSRP) must be submitted for consideration of rental or purchase with the appropriate procedure codes. Manually priced items are considered for reimbursement at the MSRP minus a discount as determined by HHSC.

For fee information, providers can refer to the Online Fee Lookup (OFL) on the TMHP website at www.tmhp.com.

Important: *The provider must agree to accept the CSHCN Services Programs reimbursement as payment in full.*

The CSHCN Services Program implemented rate reductions for certain services. The OFL includes a column titled "Adjusted Fee" to display the individual fees with all percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/resources/rate-and-code-updates/rate-changes.

Note: *Certain rate reductions including, but not limited to, reductions by place of service, client type program, or provider specialty may not be reflected in the Adjusted Fee column.*

11.6 TMHP-CSHCN Services Program Contact Center

The TMHP-CSHCN Services Program Contact Center at 1-800-568-2413 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time, and is the main point of contact for the CSHCN Services Program provider community.

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