Reimbursement FAQ

- What is CPT Code 83861?
  - 83861, Microfluidic analysis utilizing an integrated collection and analysis device, tear osmolarity.

- What fee schedule is 83861 paid from?
  - 83861 is paid from the Medicare Clinical Laboratory Fee Schedule (CLFS), not the Physician Fee Schedule.

- Where may the Tear Osmolarity Test, 83861 be performed? By whom?
  - 83861 may be performed by a lab certified under the Clinical Laboratory Improvement Act (CLIA), including a lab that has a CLIA Waiver certificate. Note that "CLIA Waiver" is the simplest level of CLIA categorization and does not "waive" the laboratory from the requirement to obtain CLIA Waiver certification. 83861 is a clinical laboratory test and is considered to be a low-complexity test under CLIA. This means that in addition to being performed by a CLIA-Certified laboratory, it also may be performed by a physician office lab that has CLIA Waiver certification. The test may be performed by clinical staff that meet CLIA requirements (e.g., education, training and licensure requirements, as applicable). No personnel requirements exist for CLIA-Waived testing, other than the requirement to follow manufacturer's instructions for performing the test.

- I don't have a CLIA-Certified or a CLIA-Waived lab, may I perform or report this test?
  - No.
- What are the requirements for reporting this test?

  - 83861 can be reported after the test is performed. Depending on payer coding rules, each eye tested should be reported separately with either an "RT" or "LT" modifier, or conversely, if the payer does not recognize the LT or RT modifiers, report 83861 only once, with or without a modifier, but with 2 units of service when testing both eyes.

  - For Medicare Part B patients, the claim must include the "QW" modifier to indicate that the test was performed by a CLIA-Waived laboratory. The QW modifier should be coded first, before the RT or LT modifier, so when testing both eyes, code as follows: "83861 QW RT" and "83861 QW LT."

  - Also, for Medicare Part B claims, the laboratory's CLIA number must be included in Field 23 of the CMS 1500 form. Check the "No" box in Field 20 and include the Referring and rendering Physician individual NPI # in Field 17b and Field J, usually the same as the physician managing the patient.

- Is 83861 covered by payers?
    - Currently CMS has no National Coverage Determinations (NCD) that define diagnosis codes to bill for CPT 83861 tear osmolarity test, so a decision to perform a test based on signs or symptoms of dry eye disease is up to the physician. Commercial payer policies may vary. Therefore, physicians should check with each payer, including Medicare, to determine the payer's coverage policy and other requirements in your area.
    - Medicare does not cover screening tests.
- When should I perform a Tear Osmolarity Test?
    - The decision to perform tear osmolarity is up to the physician. Tear osmolarity should be reported and billed to Medicare or any other payer only when it is performed in compliance with any applicable coverage and reimbursement policies.
    - For example, Medicare has several requirements for covering and reimbursing diagnostic tests such as tear osmolarity. First, the test must be ordered by the physician treating the Medicare beneficiary for the medical problem that was the reason for ordering the test. Second, the physician who orders the test must use the results of the test in the management of the beneficiary's medical problem. Third, the test must be medically reasonable and necessary for the diagnosis of the patient's problem.
- Can I perform Tear Osmolarity Test before I see the patient?
    - Yes. The test may be performed before or after the physician sees the patient.
    - However, the test may be reported and billed only if it meets the applicable payer's coverage and reimbursement requirements.
- Can I bill for tear osmolarity if the test is normal?
    - Yes. However, even though the result of the test is not relevant with respect to coverage and reimbursement, any applicable payer coverage and reimbursement requirements must be met. The ICD-10 diagnosis code should be chosen based on what was known about the patient at the time the test was performed.
    - If the tear osmolarity test result is normal and dry eye is "ruled out", code for the final or confirmed diagnosis, and *"the symptoms that prompted ordering the test may also be reported as additional diagnosis if they are not fully explained or related to the confirmed diagnosis". (*Ref: CMS Program Memorandum AB-01-144, Sept 26, 2001).

- CMS coverage rules for laboratory tests state, *"The testing of a person to rule out or to confirm a suspected diagnosis because the patient has a sign and/or symptom is a diagnostic test, not a screening. In these cases, the sign or symptom should be used to explain the reason for the test".* (Ref: Fed Reg Vol 66, No 226, Nov 23, 2001)

- What if I perform tear osmolarity before I see the patient and it turns out that the test wasn't medically necessary?
    - Physicians need to check with each payer to determine the basis on which a payer will pay for tests. In the case of Medicare, the physician should not bill Medicare for tests that are not medically necessary.

- What documentation do I need to keep in my medical record?

    - Medicare has several requirements for documenting laboratory tests such as tear osmolarity, which must be noted in the patient chart or Electronic Health Record (EHR). Please ensure that every tear osmolarity test performed is documented appropriately as follows:

    - 1. The sign or symptom of disease that prompted the ordering of the test.

    - 2. A notation in the medical record that a "tear osmolarity test was ordered" with "tear osmolarity" specifically identified.

    - 3. The numerical tear osmolarity test results and indication if the results were normal or abnormal.

    - 4. Treatment/Management Plan - the medical action as a result of the tear osmolarity test, and referencing the test results in the plan.

    - 5. Managing clinician's signature at the end of the record indicating that everything in the record that day was reviewed and confirmed as medically necessary.

    - Note that Medicare and most commercial payers do not cover screening tests, thus a sign or symptom of dry eye, or a previously diagnosed but "unstable" dry eye under management, must be properly documented prior to submitting a claim for reimbursement for a tear osmolarity test.

- Does the documentation have to be in my progress note?
    - No. The documentation can appear anywhere in the medical record.

- What is the payment for 83861?

  - For the Medicare Part B program, the national limitation amount (NLA) is $22.48 for 2023 CPT 83861 is paid off the Clinical Laboratory Fee Schedule, not the Physician Fee Schedule, and as such, there is no patient coinsurance, and the Part B deductible is not applied. The laboratory will receive 100% of the National Limit Amount (NLA) from Medicare Part B.

  - Commercial payer payment policies including Medicare Advantage Part C, may vary. Therefore, physicians should contact the payer to determine the payment amount and any applicable policies on deductibles and copayments/coinsurance.