

# TruKera™ MEDICAL

## Billing Guides



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# ALABAMA BILLING GUIDE



If any denial is received for CPT 83861 contact the Trukera Medical Reimbursement Support Center promptly at [rsc@trukera.com](mailto:rsc@trukera.com) for assistance.

## Reimbursement Support Specialist

Amanda Rotteck

Fax: (858) 225-8749

Cell: (704) 928-9009

Email: [arotteck@trukera.com](mailto:arotteck@trukera.com)

### This guide addresses billing recommendation for:

- **CPT Code 83861** is specific for “Microfluidic analysis utilizing an integrated collection and analysis device, tear osmolality”.
- A covered service by CMS Medicare under the Clinical Laboratory Fee Schedule.
- CLIA Certificate of Waiver is required to perform and bill this laboratory tests.
- Providers are encouraged to review payor-provider contracts for rate and claim submission requirements.
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- Frequency of testing is based on Medical Necessity as determined by the clinician.
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Payor Name	Lines	Modifier(s)	Units per Line
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BCBS AL	2	RT/LT	1
BCBS Federal Employee Plan	2	RT/LT	1
Cigna	2	RT/LT	1
Humana Medicare	2	QW/RT/LT/59	1
Medicaid AL	2	QW/RT/LT	1
Medicare	2	QW/RT/LT	1
United Healthcare	1	QW	2
Viva Healthcare	2	RT/LT	1

## Billing Format Examples

**Medicare:** Note the CLIA # in box 23 and the QW/RT, QW/LT in box 24D are required for processing. **The QW modifier should be placed first.** Claims lacking these elements will be rejected.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.		17b. NPI 1234567890		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY					
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB?		\$ CHARGES							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. ICD-10 Code(s) B. C. D. E. F. G. H. I. J. K. L.										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.							
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #										CPT/HCPCS		MODIFIER		23. PRIOR AUTHORIZATION NUMBER 10D2345678					
11	01	23	11	01	23	11		83861	QW	RT			A	50	00	1		NPI	1234567890
11	01	23	11	01	23	11		83861	QW	LT			A	50	00	1		NPI	1234567890

**Most Commercial Plans:** Note that the QW and CLIA # are not required.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.		17b. NPI 1234567890		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY					
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11	01	23	11	01	23	11		83861	RT				A	50	00	1		NPI	1234567890
11	01	23	11	01	23	11		83861	LT				A	50	00	1		NPI	1234567890

**United Health Care Commercial Plans:** UHC does not recognize the RT/LT modifiers. The CLIA number is required in box 23 with the **QW Modifier only** with 2 units of service. Double the billed charge.

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11	01	23	11	01	23	11		83861	QW				A	100	00	2		NPI	1234567890
																		NPI	

**Humana Medicare Advantage Plans:** Humana requires additional modifiers. The CLIA number is required in box 23 with the QW/RT/LT/59 with 2 lines of service, 1 unit per line.

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11 01 23 11 01 23			11		83861 QW RT 59					A	50 00		1		NPI	1234567890					
11 01 23 11 01 23			11		83861 QW LT 59					A	50 00		1		NPI	1234567890					

### Reimbursement for Medicare Part B (fee-for-service)

**2021-2024 Clinical Laboratory Fee Schedule (CLFS) Rate:** \$22.48 per test (\$44.96 per patient)

#### Sequestration Withhold

- Medicare intermediaries are required to withhold two percent of the allowable.

#### Medicare CMS Part B

- CMS Medicare pays at 100% of CLFS throughout the United States.
- No deductible or patient co-payment applies.
- Free standing, global lab code.
- CLIA Certification required.

#### Billing Software Requirements

- **ANSI 5010 E-claim Crosswalk**

In loop 2300, Segment REFO2, enter the CLIA Certification number – 10 digits - (Do not enter “CLIA” with the certificate number as this will cause claims to deny as an invalid identification number).

Field #	Claim Description	Segment	Electronic Description
23.	Prior Authorization number	REF01	Reference identification qualifier =X4
		REF02	CLIA Certification number

## Common Notification Reasons for Medicare Denials

If there is no CLIA number on the claim, Medicare sends RA messages MA 120 and MA 130, which state:

- MA 120 - Did not complete or enter accurately the CLIA number.
- MA 130 - Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is un-processable. Please submit the correct information to the appropriate FI or carrier.
- B7 - "This provider was not certified/eligible to be paid for this procedure/service on this date of service."
- The laboratory is not approved for this type of test.

# ALASKA BILLING GUIDE



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## Reimbursement Support Specialist

Bridget Bolles

Cell: (317) 797-7151

Fax: (858) 225-8749

Email: [bbolles@trukera.com](mailto:bbolles@trukera.com)

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HealthNet	2	QW/RT/LT	1
Medicaid AK	2	QW/RT/LT	1
Medicare	2	QW/RT/LT	1
Premera	1	None	2
United Healthcare	1	QW	2

## Billing Format Examples

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												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
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A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER									
B. _____												10D2345678									
C. _____																					
D. _____																					
E. _____																					
F. _____																					
G. _____																					
H. _____																					
I. _____																					
J. _____																					
K. _____																					
L. _____																					
24. A. DATE(S) OF SERVICE			B. PLACE OF SERVICE			C.	D. PROCEDURES, SERVICES, OR SUPPLIES				E.	F.		G.	H.	I.	J.				
From To			SERVICE			EMG	(Explain Unusual Circumstances)				DIAGNOSIS	\$ CHARGES		DAYS OR UNITS	EPSDT Family Plan	ID. QUAL.	RENDERING PROVIDER ID. #				
MM DD YY MM DD YY							CPT/HCPCS MODIFIER				POINTER										
11 01 23 11 01 23			11				83861 QW RT				A	50 00		1		NPI	1234567890				
11 01 23 11 01 23			11				83861 QW LT				A	50 00		1		NPI	1234567890				

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MM DD YY MM DD YY							CPT/HCPCS MODIFIER				POINTER										
11 01 23 11 01 23			11				83861 RT				A	50 00		1		NPI	1234567890				
11 01 23 11 01 23			11				83861 LT				A	50 00		1		NPI	1234567890				

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MM DD YY MM DD YY							CPT/HCPCS MODIFIER				POINTER										
11 01 23 11 01 23			11				83861 QW				A	100 00		2		NPI	1234567890				
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# ARIZONA BILLING GUIDE



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## Reimbursement Support Specialist

Amanda Rotteck  
Cell: (704) 928-9009

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Humana Medicare	2	QW/RT/LT/59	1
Medicaid AZ	2	QW/RT/LT	1
Medicare	2	QW/RT/LT	1
Mercy Care Plan	1	QW	2
UHC Community Plan	1	QW	2
United Healthcare	1	QW	2

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										<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO											
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11 01 23 11 01 23 11										83861		QW RT A 50 00 1 NPI 1234567890									
11 01 23 11 01 23 11										83861		QW LT A 50 00 1 NPI 1234567890									

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11 01 23 11 01 23 11										83861		RT A 50 00 1 NPI 1234567890									
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11 01 23 11 01 23 11										83861		QW A 100 00 2 NPI 1234567890									
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K.																									
L.																									
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11	01	23	11	01	23	11				83861	QW	RT	59	A	50	00	1			NPI	1234567890				
11	01	23	11	01	23	11				83861	QW	LT	59	A	50	00	1			NPI	1234567890				

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**2021-2024 Clinical Laboratory Fee Schedule (CLFS) Rate:** \$22.48 per test (\$44.96 per patient)

### Sequestration Withhold

- Medicare intermediaries are required to withhold two percent of the allowable.

### Medicare CMS Part B

- CMS Medicare pays at 100% of CLFS throughout the United States.
- No deductible or patient co-payment applies.
- Free standing, global lab code.
- CLIA Certification required.

### Billing Software Requirements

- **ANSI 5010 E-claim Crosswalk**

In loop 2300, Segment REFO2, enter the CLIA Certification number – 10 digits - (Do not enter “CLIA” with the certificate number as this will cause claims to deny as an invalid identification number).

Field #	Claim Description	Loop	Segment	Electronic Description
23.	Prior Authorization number	2300	REF01	Reference identification qualifier =X4
			REF02	CLIA Certification number

### Common Notification Reasons for Medicare Denials

If there is no CLIA number on the claim, Medicare sends RA messages MA 120 and MA 130, which state:

- MA 120 - Did not complete or enter accurately the CLIA number.
- MA 130 - Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is un-processable. Please submit the correct information to the appropriate FI or carrier.
- B7 - "This provider was not certified/eligible to be paid for this procedure/service on this date of service."
- The laboratory is not approved for this type of test.

# ARKANSAS BILLING GUIDE



If any denial is received for CPT 83861 contact the Trukera Medical Reimbursement Support Center promptly at [rsc@trukera.com](mailto:rsc@trukera.com) for assistance.

## Reimbursement Support Specialist

Amanda Rotteck  
Cell: (704) 928-9009

Fax: (858) 225-8749  
Email: [arotteck@trukera.com](mailto:arotteck@trukera.com)

### This guide addresses billing recommendation for:

- **CPT Code 83861** is specific for “Microfluidic analysis utilizing an integrated collection and analysis device, tear osmolality”.
- A covered service by CMS Medicare under the Clinical Laboratory Fee Schedule.
- CLIA Certificate of Waiver is required to perform and bill this laboratory tests.
- Providers are encouraged to review payor-provider contracts for rate and claim submission requirements.
- Medical Necessity requires current signs or symptoms of disease at time of test.
- Frequency of testing is based on Medical Necessity as determined by the clinician.
- Laboratory Test - multiple procedure discounts do not apply.

Payor Name	Lines	Modifier(s)	Units per Line
Aetna	2	RT/LT	1
BCBS AR	2	RT/LT	1
Cigna	2	RT/LT	1
Humana Medicare	2	QW/RT/LT/59	1
Medicaid AR	2	QW/RT/LT	1
Medicare	2	QW/RT/LT	1
United Healthcare	1	QW	2

## Billing Format Examples

**Medicare:** Note the CLIA # in box 23 and the QW/RT, QW/LT in box 24D are required for processing. **The QW modifier should be placed first.** Claims lacking these elements will be rejected.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																							
										17b. NPI		1234567890																							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES																							
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.												22. RESUBMISSION CODE ORIGINAL REF. NO.																							
A. ICD-10 Code(s)																																			
B. _____																																			
C. _____																																			
D. _____																																			
E. _____																																			
F. _____																																			
G. _____																																			
H. _____																																			
I. _____																																			
J. _____																																			
23. PRIOR AUTHORIZATION NUMBER												10D2345678																							
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER										E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From To										EMG																									
MM DD YY MM DD YY																																			
11 01 23 11 01 23														83861 QW RT										A		50 00		1				NPI		1234567890	
11 01 23 11 01 23														83861 QW LT										A		50 00		1				NPI		1234567890	

**Most Commercial Plans:** Note that the QW and CLIA # are not required.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																							
										17b. NPI		1234567890																							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES																							
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.												22. RESUBMISSION CODE ORIGINAL REF. NO.																							
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C. _____																																			
D. _____																																			
E. _____																																			
F. _____																																			
G. _____																																			
H. _____																																			
I. _____																																			
J. _____																																			
23. PRIOR AUTHORIZATION NUMBER																																			
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER										E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From To										EMG																									
MM DD YY MM DD YY																																			
11 01 23 11 01 23														83861 RT										A		50 00		1				NPI		1234567890	
11 01 23 11 01 23														83861 LT										A		50 00		1				NPI		1234567890	

**United Health Care Commercial Plans:** UHC does not recognize the RT/LT modifiers. The CLIA number is required in box 23 with the **QW Modifier only** with 2 units of service. Double the billed charge.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																							
										17b. NPI		1234567890																							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES																							
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.												22. RESUBMISSION CODE ORIGINAL REF. NO.																							
A. ICD-10 Code(s)																																			
B. _____																																			
C. _____																																			
D. _____																																			
E. _____																																			
F. _____																																			
G. _____																																			
H. _____																																			
I. _____																																			
J. _____																																			
23. PRIOR AUTHORIZATION NUMBER												10D2345678																							
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER										E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From To										EMG																									
MM DD YY MM DD YY																																			
11 01 23 11 01 23														83861 QW										A		100 00		2				NPI		1234567890	



**Humana Medicare Advantage Plans:** Humana requires additional modifiers. The CLIA number is required in box 23 with the **QW/RT/LT/59** with 2 lines of service, 1 unit per line.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical		17a.	17b. NPI 1234567890		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY													
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)					20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO													
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. ICD-10 Code(s) B. C. D. E. F. G. H. I. J. K. L.					22. RESUBMISSION CODE ORIGINAL REF. NO.													
23. PRIOR AUTHORIZATION NUMBER 10D2345678																		
24. A. DATE(S) OF SERVICE From To MM DD YY MM DD YY		B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EFSDT (Family Plan)	I. ID. QUAL.	J. RENDERING PROVIDER ID. #							
11	01	23	11	01	23	11		83861	QW	RT	59	A	50	00	1		NPI	1234567890
11	01	23	11	01	23	11		83861	QW	LT	59	A	50	00	1		NPI	1234567890

### Reimbursement for Medicare Part B (fee-for-service)

**2021-2024 Clinical Laboratory Fee Schedule (CLFS) Rate:** \$22.48 per test (\$44.96 per patient)

### Sequestration Withhold

- Medicare intermediaries are required to withhold two percent of the allowable.

### Medicare CMS Part B

- CMS Medicare pays at 100% of CLFS throughout the United States.
- No deductible or patient co-payment applies.
- Free standing, global lab code.
- CLIA Certification required.

### Billing Software Requirements

#### ANSI 5010 E-claim Crosswalk

In loop 2300, Segment REFO2, enter the CLIA Certification number – 10 digits - (Do not enter “CLIA” with the certificate number as this will cause claims to deny as an invalid identification number).

Field #	Claim Description	Loop	Segment	Electronic Description
23.	Prior Authorization number	2300	REF01	Reference identification qualifier =X4
			REF02	CLIA Certification number

### Common Notification Reasons for Medicare Denials

If there is no CLIA number on the claim, Medicare sends RA messages MA 120 and MA 130, which state:

- MA 120 - Did not complete or enter accurately the CLIA number.
- MA 130 - Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is un-processable. Please submit the correct information to the appropriate FI or carrier.
- B7 - "This provider was not certified/eligible to be paid for this procedure/service on this date of service."
- The laboratory is not approved for this type of test.

# CALIFORNIA BILLING GUIDE



If any denial is received for CPT 83861 contact the Trukera Medical Reimbursement Support Center promptly at [rsc@trukera.com](mailto:rsc@trukera.com) for assistance.

## Reimbursement Support Specialist

Amanda Rotteck  
Cell: (704) 928-9009

Fax: (858) 225-8749  
Email: [arotteck@trukera.com](mailto:arotteck@trukera.com)

### This guide addresses billing recommendation for:

- **CPT Code 83861** is specific for “Microfluidic analysis utilizing an integrated collection and analysis device, tear osmolality”.
- A covered service by CMS Medicare under the Clinical Laboratory Fee Schedule.
- CLIA Certificate of Waiver is required to perform and bill this laboratory tests.
- Providers are encouraged to review payor-provider contracts for rate and claim submission requirements.
- Medical Necessity requires current signs or symptoms of disease at time of test.
- Frequency of testing is based on Medical Necessity as determined by the clinician.
- Laboratory Test - multiple procedure discounts do not apply.

Payor Name	Lines	Modifier(s)	Units per Line
Aetna	2	RT/LT	1
Anthem - Wellpoint	1	None	2
BS CA	1	None	2
CalOptima	1	QW	2
Cigna	1	QW	2
HealthNet	2	RT/LT	1
Inland Empire Health Plan (IEHP)	2	RT/LT	1
L.A. Care - Medi-Cal	1	None	2
Medicaid CA	2	QW/RT/LT	1
Medicare	2	QW/RT/LT	1
UHC	1	QW	2

## Billing Format Examples

**Medicare:** Note the CLIA # in box 23 and the QW/RT, QW/LT in box 24D are required for processing. **The QW modifier should be placed first.** Claims lacking these elements will be rejected.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical			17a.			17b. NPI 1234567890			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY						
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)									20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. ICD-10 Code(s) B. C. D. E. F. G. H. I. J. K. L.									22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER 10D2345678						
24. A. DATE(S) OF SERVICE From To MM DD YY MM DD YY			B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER				E. DIAGNOSIS POINTER	F. \$ CHARGES		G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
11 01 23 11 01 23			11		83861 QW RT				A	50 00		1		NPI	1234567890
11 01 23 11 01 23			11		83861 QW LT				A	50 00		1		NPI	1234567890

**Most Commercial Plans:** Note that the QW and CLIA # are not required.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical			17a.			17b. NPI 1234567890			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY						
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)									20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. ICD-10 Code(s) B. C. D. E. F. G. H. I. J. K. L.									22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER						
24. A. DATE(S) OF SERVICE From To MM DD YY MM DD YY			B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER				E. DIAGNOSIS POINTER	F. \$ CHARGES		G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
11 01 23 11 01 23			11		83861 RT				A	50 00		1		NPI	1234567890
11 01 23 11 01 23			11		83861 LT				A	50 00		1		NPI	1234567890

**United Health Care Commercial Plans:** UHC does not recognize the RT/LT modifiers. The CLIA number is required in box 23 with the **QW Modifier only** with 2 units of service. Double the billed charge.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical			17a.			17b. NPI 1234567890			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY						
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)									20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. ICD-10 Code(s) B. C. D. E. F. G. H. I. J. K. L.									22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER 10D2345678						
24. A. DATE(S) OF SERVICE From To MM DD YY MM DD YY			B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER				E. DIAGNOSIS POINTER	F. \$ CHARGES		G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
11 01 23 11 01 23			11		83861 QW				A	100 00		2		NPI	1234567890
														NPI	

### Reimbursement for Medicare Part B (fee-for-service)

**2021-2024 Clinical Laboratory Fee Schedule (CLFS) Rate:** \$22.48 per test (\$44.96 per patient)

### Sequestration Withhold

- Medicare intermediaries are required to withhold two percent of the allowable.

### Medicare CMS Part B

- CMS Medicare pays at 100% of CLFS throughout the United States.
- No deductible or patient co-payment applies.
- Free standing, global lab code.
- CLIA Certification required.

### Billing Software Requirements

#### - ANSI 5010 E-claim Crosswalk

In loop 2300, Segment REFO2, enter the CLIA Certification number – 10 digits - (Do not enter “CLIA” with the certificate number as this will cause claims to deny as an invalid identification number).

Field #	Claim Description	Loop	Segment	Electronic Description
23.	Prior Authorization number	2300	REF01	Reference identification qualifier =X4
			REF02	CLIA Certification number

### Common Notification Reasons for Medicare Denials

If there is no CLIA number on the claim, Medicare sends RA messages MA 120 and MA 130, which state:

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- The laboratory is not approved for this type of test.

# COLORADO BILLING GUIDE



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## Reimbursement Support Specialist

Amanda Rotteck  
Cell: (704) 928-9009

Fax: (858) 225-8749  
Email: [arotteck@trukera.com](mailto:arotteck@trukera.com)

### This guide addresses billing recommendation for:

- **CPT Code 83861** is specific for “Microfluidic analysis utilizing an integrated collection and analysis device, tear osmolality”.
- A covered service by CMS Medicare under the Clinical Laboratory Fee Schedule.
- CLIA Certificate of Waiver is required to perform and bill this laboratory tests.
- Providers are encouraged to review payor-provider contracts for rate and claim submission requirements.
- Medical Necessity requires current signs or symptoms of disease at time of test.
- Frequency of testing is based on Medical Necessity as determined by the clinician.
- Laboratory Test - multiple procedure discounts do not apply.

Payor Name	Lines	Modifier(s)	Units per Line
Aetna	2	RT/LT	1
Anthem	2	RT/LT	1
BCBS Federal Employee Plan	2	RT/LT	1
Cigna	2	RT/LT	1
Colorado Access	2	RT/LT	1
Colorado Community Health Alliance (CCHA)	2	RT/LT	1
Health Colorado	2	RT/LT	1
HealthNet	2	QW/RT/LT	1
Medicare	2	QW/RT/LT	1
Rocky Mountain Health Plans	1	None	2
United Healthcare	1	QW	2

## Billing Format Examples

**Medicare:** Note the CLIA # in box 23 and the QW/RT, QW/LT in box 24D are required for processing. **The QW modifier should be placed first.** Claims lacking these elements will be rejected.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
										17b. NPI		1234567890									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)															20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.															22. RESUBMISSION CODE ORIGINAL REF. NO.						
A. ICD-10 Code(s) B. C. D. E. F. G. H. I. J. K. L.															23. PRIOR AUTHORIZATION NUMBER 10D2345678						
24. A. DATE(S) OF SERVICE From To MM DD YY MM DD YY			B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER				E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #			
11 01 23 11 01 23			11				83861 QW RT				A		50.00		1		NPI	1234567890			
11 01 23 11 01 23			11				83861 QW LT				A		50.00		1		NPI	1234567890			

**Most Commercial Plans:** Note that the QW and CLIA # are not required.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
										17b. NPI		1234567890									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)															20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.															22. RESUBMISSION CODE ORIGINAL REF. NO.						
A. ICD-10 Code(s) B. C. D. E. F. G. H. I. J. K. L.															23. PRIOR AUTHORIZATION NUMBER						
24. A. DATE(S) OF SERVICE From To MM DD YY MM DD YY			B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER				E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #			
11 01 23 11 01 23			11				83861 RT				A		50.00		1		NPI	1234567890			
11 01 23 11 01 23			11				83861 LT				A		50.00		1		NPI	1234567890			

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										17b. NPI		1234567890									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)															20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.															22. RESUBMISSION CODE ORIGINAL REF. NO.						
A. ICD-10 Code(s) B. C. D. E. F. G. H. I. J. K. L.															23. PRIOR AUTHORIZATION NUMBER 10D2345678						
24. A. DATE(S) OF SERVICE From To MM DD YY MM DD YY			B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER				E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #			
11 01 23 11 01 23			11				83861 QW				A		100.00		2		NPI	1234567890			
																NPI					

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- The laboratory is not approved for this type of test.



# CONNECTICUT BILLING GUIDE



If any denial is received for CPT 83861 contact the Trukera Reimbursement Support Center promptly at [rsc@trukera.com](mailto:rsc@trukera.com) for assistance

## Reimbursement Support Specialist

Bridget Bolles

Cell: (317) 797-7151

Fax: (858) 225-8749

Email: [bbolles@trukera.com](mailto:bbolles@trukera.com)

### This guide addresses billing recommendation for:

- **CPT Code 83861** is specific for “Microfluidic analysis utilizing an integrated collection and analysis device, tear osmolality”.
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Connecticut Medicaid	2	RT/LT	1
United HC	1	QW	2
Aetna	2	RT/LT	1
Cigna	2	RT/LT	1
Emblem HIP/GHI/Commercial	2	RT/LT	1
Humana Medicare	2	QW/RT/LT 59	1
UHC	1	QW	2

### Connecticut Providers:

**Humana Commercial:** Will deny claim (Diagnostic testing for dry eye syndrome is not separately reimbursable).

## Billing Format Examples

**Medicare:** Note the CLIA # in box 23 and the QW/RT, QW/LT in box 24D are required for processing. **The QW modifier should be placed first.** Claims lacking these elements will reject.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
										17b.		NPI 1234567890									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. ICD-10 Code(s) B. C. D. E. F. G. H. I. J. K. L.										22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER 10D2345678											
24. A. DATE(S) OF SERVICE From To MM DD YY MM DD YY			B. PLACE OF SERVICE		C.	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER				E. DIAGNOSIS POINTER	F. \$ CHARGES		G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #					
11 01 23 11 01 23			11			83861 QW RT				A	50 00		1		NPI	1234567890					
11 01 23 11 01 23			11			83861 QW LT				A	50 00		1		NPI	1234567890					

**Most Commercial Plans:** Note that the QW and CLIA # are not required.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
										17b.		NPI 1234567890									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. ICD-10 Code(s) B. C. D. E. F. G. H. I. J. K. L.										22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER											
24. A. DATE(S) OF SERVICE From To MM DD YY MM DD YY			B. PLACE OF SERVICE		C.	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER				E. DIAGNOSIS POINTER	F. \$ CHARGES		G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #					
11 01 23 11 01 23			11			83861 RT				A	50 00		1		NPI	1234567890					
11 01 23 11 01 23			11			83861 LT				A	50 00		1		NPI	1234567890					

**United Health Care Commercial Plans:** UHC does not recognize the RT/LT modifiers. The CLIA number is required in box 23 with the **QW Modifier only** with 2 units of service. Double the billed charge.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
										17b.		NPI 1234567890									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. ICD-10 Code(s) B. C. D. E. F. G. H. I. J. K. L.										22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER 10D2345678											
24. A. DATE(S) OF SERVICE From To MM DD YY MM DD YY			B. PLACE OF SERVICE		C.	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER				E. DIAGNOSIS POINTER	F. \$ CHARGES		G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #					
11 01 23 11 01 23			11			83861 QW				A	100 00		2		NPI	1234567890					
															NPI						

**Humana Medicare Advantage Plans:** Humana requires additional modifiers. The CLIA number is required in box 23 with the **QW/RT/LT/59** with 2 lines of service, 1 unit per line

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																	
Dr. Trukera Medical										17b. NPI		1234567890																	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES																	
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.																	
A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER																	
E.												10D2345678																	
I.																													
J.																													
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From To										SERVICE				CPT/HCPCS MODIFIER															
MM DD YY MM DD YY																													
11 01 23 11 01 23										11				83861 QW RT 59				A		50 00		1				NPI 1234567890			
11 01 23 11 01 23										11				83861 QW LT 59				A		50 00		1				NPI 1234567890			

### Reimbursement for Medicare Part B (fee-for-service)

**2023-2024 Clinical Laboratory Fee Schedule (CLFS) Rate:** \$22.48 per test (\$44.96 per patient)

#### Sequestration Withhold

- Medicare intermediaries are required to withhold two-percent of the allowable.

#### Medicare CMS Part B

- CMS Medicare pays at 100% of CLFS throughout the United States.
- No deductible or patient co-payment applies.
- Free standing, global lab code.
- CLIA Certification required.

#### Billing Software Requirements

- **ANSI 5010 E-claim Crosswalk**

In loop 2300, Segment REFO2, enter the CLIA Certification number – 10 digits - (Do not enter “CLIA” with the certificate number as this will cause claims to deny as an invalid identification number).

Field #	Claim Description	Loop	Segment	Electronic Description
<b>23.</b>	<b>Prior Authorization number</b>	<b>2300</b>	<b>REF01</b>	Reference identification qualifier = <b>X4</b>
			<b>REF02</b>	CLIA Certification number

## Common Notification Reasons for Medicare Denials

If there is no CLIA number on the claim, Medicare sends RA messages MA 120 and MA 130, which state:

- MA 120 - Did not complete or enter accurately the CLIA number.
- MA 130 - Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is un-processable. Please submit the correct information to the appropriate FI or carrier.
- B7 - "This provider was not certified/eligible to be paid for this procedure/service on this date of service."
- The laboratory is not approved for this type of test

# DELAWARE BILLING GUIDE



If any denial is received for CPT 83861 contact the Trukera Reimbursement Support Center promptly at [rsc@trukera.com](mailto:rsc@trukera.com) for assistance

## Reimbursement Support Specialist

Bridget Bolles

Cell: (317) 797-7151

Fax: (858) 225-8749

Email: [bbolles@trukera.com](mailto:bbolles@trukera.com)

### This guide addresses billing recommendation for:

- **CPT Code 83861** is specific for “Microfluidic analysis utilizing an integrated collection and analysis device, tear osmolality”.
- A covered service by CMS Medicare under the Clinical Laboratory Fee Schedule.
- CLIA Certificate of Waiver is required to perform and bill this laboratory tests.
- Providers are encouraged to review payor-provider contracts for rate and claim submission requirements.
- Medical Necessity requires current signs or symptoms of disease at time of test.
- Frequency of testing is based on Medical Necessity as determined by the clinician.
- Laboratory Test - multiple procedure discounts do not apply.

Payor Name	Lines	Modifier(s)	Units per Line
Medicare	2	QW/RT/LT	1
Highmark	2	RT/LT	1
Cigna	2	RT/LT	1
Aetna	2	RT/LT	1
Independence BC	2	RT/LT	1
DE Medicaid	2	QW/RT/LT	1
Humana Medicare	2	QW/RT/LT 59	1
Geisinger	2	QW/RT/LT	1
Medicare	2	QW/RT/LT	1

### Delaware Providers:

**Humana Commercial:** Will deny claim (Diagnostic testing for dry eye syndrome is not separately reimbursable).

## Billing Format Examples

**Medicare:** Note the CLIA # in box 23 and the QW/RT, QW/LT in box 24D are required for processing. **The QW modifier should be placed first.** Claims lacking these elements will reject.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																							
Dr. Trukera Medical										17b.		NPI 1234567890																							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES																							
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.																							
A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER																							
B. _____												10D2345678																							
C. _____																																			
D. _____																																			
E. _____																																			
F. _____																																			
G. _____																																			
H. _____																																			
I. _____																																			
J. _____																																			
K. _____																																			
L. _____																																			
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)										E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From To														CPT/HCPCS MODIFIER																					
MM DD YY MM DD YY																																			
11 01 23 11 01 23										11				83861 QW RT										A		50 00		1				NPI		1234567890	
11 01 23 11 01 23										11				83861 QW LT										A		50 00		1				NPI		1234567890	

**Most Commercial Plans:** Note that the QW and CLIA # are not required.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																							
Dr. Trukera Medical										17b.		NPI 1234567890																							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES																							
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.																							
A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER																							
B. _____																																			
C. _____																																			
D. _____																																			
E. _____																																			
F. _____																																			
G. _____																																			
H. _____																																			
I. _____																																			
J. _____																																			
K. _____																																			
L. _____																																			
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)										E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From To														CPT/HCPCS MODIFIER																					
MM DD YY MM DD YY																																			
11 01 23 11 01 23										11				83861 RT										A		50 00		1				NPI		1234567890	
11 01 23 11 01 23										11				83861 LT										A		50 00		1				NPI		1234567890	

**United Health Care Commercial Plans:** UHC does not recognize the RT/LT modifiers. The CLIA number is required in box 23 with the **QW Modifier only** with 2 units of service. Double the billed charge.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																							
Dr. Trukera Medical										17b.		NPI 1234567890																							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES																							
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.																							
A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER																							
B. _____												10D2345678																							
C. _____																																			
D. _____																																			
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I. _____																																			
J. _____																																			
K. _____																																			
L. _____																																			
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)										E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From To														CPT/HCPCS MODIFIER																					
MM DD YY MM DD YY																																			
11 01 23 11 01 23										11				83861 QW										A		100 00		2				NPI		1234567890	

**Humana Medicare Advantage Plans:** Humana requires additional modifiers. The CLIA number is required in box 23 with the **QW/RT/LT/59** with 2 lines of service, 1 unit per line

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Dr. Trukera Medical										17b. NPI		1234567890																							
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												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.																							
A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER																							
B. [ ]												10D2345678																							
C. [ ]																																			
D. [ ]																																			
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J. [ ]																																			
K. [ ]																																			
L. [ ]																																			
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)										E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From To										SERVICE				CPT/HCPCS MODIFIER																					
MM DD YY MM DD YY																																			
11 01 23 11 01 23										11				83861 QW RT 59										A		50 00		1				NPI		1234567890	
11 01 23 11 01 23										11				83861 QW LT 59										A		50 00		1				NPI		1234567890	

### Reimbursement for Medicare Part B (fee-for-service)

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#### Sequestration Withhold

- Medicare intermediaries are required to withhold two-percent of the allowable.

#### Medicare CMS Part B

- CMS Medicare pays at 100% of CLFS throughout the United States.
- No deductible or patient co-payment applies.
- Free standing, global lab code.
- CLIA Certification required.

#### Billing Software Requirements

- **ANSI 5010 E-claim Crosswalk**

In loop 2300, Segment REFO2, enter the CLIA Certification number – 10 digits - (Do not enter “CLIA” with the certificate number as this will cause claims to deny as an invalid identification number).

Field #	Claim Description	Loop	Segment	Electronic Description
23.	Prior Authorization number	2300	REF01	Reference identification qualifier =X4
			REF02	CLIA Certification number

## Common Notification Reasons for Medicare Denials

If there is no CLIA number on the claim, Medicare sends RA messages MA 120 and MA 130, which state:

- MA 120 - Did not complete or enter accurately the CLIA number.
- MA 130 - Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is un-processable. Please submit the correct information to the appropriate FI or carrier.
- B7 - "This provider was not certified/eligible to be paid for this procedure/service on this date of service."
- The laboratory is not approved for this type of test



# DISTRICT OF COLUMBIA BILLING GUIDE



If any denial is received for CPT 83861 contact the Trukera Reimbursement Support Center promptly at [rsc@trukera.com](mailto:rsc@trukera.com) for assistance

## Reimbursement Support Specialist

Bridget Bolles

Cell: (317) 797-7151

Fax: (858) 225-8749

Email: [bbolles@trukera.com](mailto:bbolles@trukera.com)

### This guide addresses billing recommendation for:

- **CPT Code 83861** is specific for “Microfluidic analysis utilizing an integrated collection and analysis device, tear osmolality”.
- A covered service by CMS Medicare under the Clinical Laboratory Fee Schedule.
- CLIA Certificate of Waiver is required to perform and bill this laboratory tests.
- Providers are encouraged to review payor-provider contracts for rate and claim submission requirements.
- Medical Necessity requires current signs or symptoms of disease at time of test.
- Frequency of testing is based on Medical Necessity as determined by the clinician.
- Laboratory Test - multiple procedure discounts do not apply.

Payor Name	Lines	Modifier(s)	Units per Line
Medicare	2	QW/RT/LT	1
CareFirst BCBS	2	RT/LT	1
United HC	1	QW	2
BCBS Fed	2	RT/LT	1
Aetna	2	RT/LT	1
Cigna	2	RT/LT	1
Amerihealth Caritas	2	RT/LT	1
Medstar Health	2	RT/LT	1
DC Medicaid	2	QW/RT/LT	1

### District of Columbia Providers:

**Humana Commercial:** Will deny claim (Diagnostic testing for dry eye syndrome is not separately reimbursable).

## Billing Format Examples

**Medicare:** Note the CLIA # in box 23 and the QW/RT, QW/LT in box 24D are required for processing. **The QW modifier should be placed first.** Claims lacking these elements will reject.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES									
Dr. Trukera Medical										17b.		NPI 1234567890									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES									
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.									
A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER									
B. _____												10D2345678									
C. _____																					
D. _____																					
E. _____																					
F. _____																					
G. _____																					
H. _____																					
I. _____																					
J. _____																					
K. _____																					
L. _____																					
24. A. DATE(S) OF SERVICE			B. PLACE OF SERVICE			C.	D. PROCEDURES, SERVICES, OR SUPPLIES				E.	F.		G.	H.	I.	J.				
From To			SERVICE			EMG	(Explain Unusual Circumstances)				DIAGNOSIS	\$ CHARGES		DAYS OR UNITS	EPSDT Family Plan	ID. QUAL.	RENDERING PROVIDER ID. #				
MM DD YY MM DD YY							CPT/HCPCS MODIFIER				POINTER										
11 01 23 11 01 23			11				83861 QW RT				A	50 00		1		NPI	1234567890				
11 01 23 11 01 23			11				83861 QW LT				A	50 00		1		NPI	1234567890				

**Most Commercial Plans:** Note that the QW and CLIA # are not required.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES									
Dr. Trukera Medical										17b.		NPI 1234567890									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES									
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.									
A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER									
B. _____																					
C. _____																					
D. _____																					
E. _____																					
F. _____																					
G. _____																					
H. _____																					
I. _____																					
J. _____																					
K. _____																					
L. _____																					
24. A. DATE(S) OF SERVICE			B. PLACE OF SERVICE			C.	D. PROCEDURES, SERVICES, OR SUPPLIES				E.	F.		G.	H.	I.	J.				
From To			SERVICE			EMG	(Explain Unusual Circumstances)				DIAGNOSIS	\$ CHARGES		DAYS OR UNITS	EPSDT Family Plan	ID. QUAL.	RENDERING PROVIDER ID. #				
MM DD YY MM DD YY							CPT/HCPCS MODIFIER				POINTER										
11 01 23 11 01 23			11				83861 RT				A	50 00		1		NPI	1234567890				
11 01 23 11 01 23			11				83861 LT				A	50 00		1		NPI	1234567890				

**United Health Care Commercial Plans:** UHC does not recognize the RT/LT modifiers. The CLIA number is required in box 23 with the **QW Modifier only** with 2 units of service. Double the billed charge.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES									
Dr. Trukera Medical										17b.		NPI 1234567890									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES									
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.									
A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER									
B. _____												10D2345678									
C. _____																					
D. _____																					
E. _____																					
F. _____																					
G. _____																					
H. _____																					
I. _____																					
J. _____																					
K. _____																					
L. _____																					
24. A. DATE(S) OF SERVICE			B. PLACE OF SERVICE			C.	D. PROCEDURES, SERVICES, OR SUPPLIES				E.	F.		G.	H.	I.	J.				
From To			SERVICE			EMG	(Explain Unusual Circumstances)				DIAGNOSIS	\$ CHARGES		DAYS OR UNITS	EPSDT Family Plan	ID. QUAL.	RENDERING PROVIDER ID. #				
MM DD YY MM DD YY							CPT/HCPCS MODIFIER				POINTER										
11 01 23 11 01 23			11				83861 QW				A	100 00		2		NPI	1234567890				
																NPI					

**Humana Medicare Advantage Plans:** Humana requires additional modifiers. The CLIA number is required in box 23 with the **QW/RT/LT/59** with 2 lines of service, 1 unit per line

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																							
Dr. Trukera Medical										17b. NPI		1234567890																							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES																							
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.																							
A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER																							
B. [ ]												10D2345678																							
C. [ ]																																			
D. [ ]																																			
E. [ ]																																			
F. [ ]																																			
G. [ ]																																			
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K. [ ]																																			
L. [ ]																																			
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)										E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From To										SERVICE				CPT/HCPCS MODIFIER																					
MM DD YY MM DD YY																																			
11 01 23 11 01 23										11				83861 QW RT 59										A		50 00		1				NPI		1234567890	
11 01 23 11 01 23										11				83861 QW LT 59										A		50 00		1				NPI		1234567890	

### Reimbursement for Medicare Part B (fee-for-service)

**2023-2024 Clinical Laboratory Fee Schedule (CLFS) Rate:** \$22.48 per test (\$44.96 per patient)

#### Sequestration Withhold

- Medicare intermediaries are required to withhold two-percent of the allowable.

#### Medicare CMS Part B

- CMS Medicare pays at 100% of CLFS throughout the United States.
- No deductible or patient co-payment applies.
- Free standing, global lab code.
- CLIA Certification required.

#### Billing Software Requirements

- **ANSI 5010 E-claim Crosswalk**

In loop 2300, Segment REFO2, enter the CLIA Certification number – 10 digits - (Do not enter “CLIA” with the certificate number as this will cause claims to deny as an invalid identification number).

Field #	Claim Description	Loop	Segment	Electronic Description
23.	Prior Authorization number	2300	REF01	Reference identification qualifier =X4
			REF02	CLIA Certification number

## Common Notification Reasons for Medicare Denials

If there is no CLIA number on the claim, Medicare sends RA messages MA 120 and MA 130, which state:

- MA 120 - Did not complete or enter accurately the CLIA number.
- MA 130 - Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is un-processable. Please submit the correct information to the appropriate FI or carrier.
- B7 - "This provider was not certified/eligible to be paid for this procedure/service on this date of service."
- The laboratory is not approved for this type of test

# FLORIDA BILLING GUIDE



If any denial is received for CPT 83861 contact the Trukera Medical Reimbursement Support Center promptly at [rsc@trukera.com](mailto:rsc@trukera.com) for assistance.

## Senior Reimbursement Support Specialist

Amanda Rotteck  
Cell: (704) 928-9009

Fax: (858) 225-8749  
Email: [arotteck@trukera.com](mailto:arotteck@trukera.com)

### This guide addresses billing recommendation for:

- **CPT Code 83861** is specific for “Microfluidic analysis utilizing an integrated collection and analysis device, tear osmolality”.
- A covered service by CMS Medicare under the Clinical Laboratory Fee Schedule.
- CLIA Certificate of Waiver is required to perform and bill this laboratory tests.
- Providers are encouraged to review payor-provider contracts for rate and claim submission requirements.
- Medical Necessity requires current signs or symptoms of disease at time of test.
- Frequency of testing is based on Medical Necessity as determined by the clinician.
- Laboratory Test - multiple procedure discounts do not apply.

Payor Name	Lines	Modifier(s)	Units per Line
Medicare	2	QW/RT/LT	1
BCBS Florida	2	RT/LT	1
United HC	1	QW	2
Humana Medicare	2	QW/RT/LT/59	1
Aetna	2	RT/LT	1
Cigna	2	RT/LT	1
FL Medicaid	2	QW/RT/LT	1
Anthem	2	RT/LT	1
BCBSFED	2	RT/LT	1
UHC Community	1	QW	2

### Florida Providers:

**Humana Commercial:** Will deny claim (**Diagnostic testing for dry eye syndrome is not separately reimbursable**).

## Billing Format Examples

**Medicare:** Note the CLIA # in box 23 and the QW/RT, QW/LT in box 24D are required for processing. **The QW modifier should be placed first.** Claims lacking these elements will be rejected.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																				
										17b. NPI		1234567890																				
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? \$ CHARGES																						
										<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																						
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										22. RESUBMISSION CODE ORIGINAL REF. NO.																						
A. ICD-10 Code(s)										23. PRIOR AUTHORIZATION NUMBER																						
E. _____										10D2345678																						
I. _____																																
24. A. DATE(S) OF SERVICE			B. PLACE OF SERVICE			C. EMG			D. PROCEDURES, SERVICES, OR SUPPLIES			E. DIAGNOSIS POINTER			F. \$ CHARGES			G. DAYS OR UNITS			H. EPSDT Family Plan			I. ID. QUAL.			J. RENDERING PROVIDER ID. #					
From To									(Explain Unusual Circumstances)																							
MM	DD	YY	MM	DD	YY				CPT/HCPCS		MODIFIER																					
11	01	23	11	01	23	11			83861		QW RT			A			50 00	1						NPI			1234567890					
11	01	23	11	01	23	11			83861		QW LT			A			50 00	1						NPI			1234567890					

**Most Commercial Plans:** Note that the QW and CLIA # are not required.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																				
										17b. NPI		1234567890																				
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? \$ CHARGES																						
										<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																						
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										22. RESUBMISSION CODE ORIGINAL REF. NO.																						
A. ICD-10 Code(s)										23. PRIOR AUTHORIZATION NUMBER																						
E. _____																																
I. _____																																
24. A. DATE(S) OF SERVICE			B. PLACE OF SERVICE			C. EMG			D. PROCEDURES, SERVICES, OR SUPPLIES			E. DIAGNOSIS POINTER			F. \$ CHARGES			G. DAYS OR UNITS			H. EPSDT Family Plan			I. ID. QUAL.			J. RENDERING PROVIDER ID. #					
From To									(Explain Unusual Circumstances)																							
MM	DD	YY	MM	DD	YY				CPT/HCPCS		MODIFIER																					
11	01	23	11	01	23	11			83861		RT			A			50 00	1						NPI			1234567890					
11	01	23	11	01	23	11			83861		LT			A			50 00	1						NPI			1234567890					

**United Health Care Commercial Plans:** UHC does not recognize the RT/LT modifiers. The CLIA number is required in box 23 with the **QW Modifier only** with 2 units of service. Double the billed charge.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																				
										17b. NPI		1234567890																				
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? \$ CHARGES																						
										<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																						
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										22. RESUBMISSION CODE ORIGINAL REF. NO.																						
A. ICD-10 Code(s)										23. PRIOR AUTHORIZATION NUMBER																						
E. _____										10D2345678																						
I. _____																																
24. A. DATE(S) OF SERVICE			B. PLACE OF SERVICE			C. EMG			D. PROCEDURES, SERVICES, OR SUPPLIES			E. DIAGNOSIS POINTER			F. \$ CHARGES			G. DAYS OR UNITS			H. EPSDT Family Plan			I. ID. QUAL.			J. RENDERING PROVIDER ID. #					
From To									(Explain Unusual Circumstances)																							
MM	DD	YY	MM	DD	YY				CPT/HCPCS		MODIFIER																					
11	01	23	11	01	23	11			83861		QW			A			100 00	2						NPI			1234567890					
																								NPI								

**Humana Medicare Advantage Plans:** Humana requires additional modifiers. The CLIA number is required in box 23 with the QW/RT/LT/59 with 2 lines of service, 1 unit per line.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																							
										17b. NPI		1234567890																							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB?		\$ CHARGES																							
										<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.																							
A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER																							
E.												10D2345678																							
I.																																			
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)										E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From To										SERVICE				CPT/HCPCS MODIFIER																					
MM DD YY MM DD YY										11 01 23 11 01 23		11		83861 QW RT 59										A		50 00		1				NPI		1234567890	
11 01 23 11 01 23 11												83861 QW LT 59										A		50 00		1				NPI		1234567890			

**Reimbursement for Medicare Part B (fee-for-service)**

**2021-2024 Clinical Laboratory Fee Schedule (CLFS) Rate:** \$22.48 per test (\$44.96 per patient)

**Sequestration Withhold**

- Medicare intermediaries are required to withhold two percent of the allowable.

**Medicare CMS Part B**

- CMS Medicare pays at 100% of CLFS throughout the United States.
- No deductible or patient co-payment applies.
- Free standing, global lab code.
- CLIA Certification required.

**Billing Software Requirements**

- **ANSI 5010 E-claim Crosswalk**

In loop 2300, Segment REFO2, enter the CLIA Certification number – 10 digits - (Do not enter “CLIA” with the certificate number as this will cause claims to deny as an invalid identification number).

Field #	Claim Description	Loop	Segment	Electronic Description
23.	Prior Authorization number	2300	REF01	Reference identification qualifier =X4
			REF02	CLIA Certification number

### Common Notification Reasons for Medicare Denials

If there is no CLIA number on the claim, Medicare sends RA messages MA 120 and MA 130, which state:

- MA 120 - Did not complete or enter accurately the CLIA number.
- MA 130 - Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is un-processable. Please submit the correct information to the appropriate FI or carrier.
- B7 - "This provider was not certified/eligible to be paid for this procedure/service on this date of service."
- The laboratory is not approved for this type of test.



# GEORGIA BILLING GUIDE



If any denial is received for CPT 83861 contact the Trukera Medical Reimbursement Support Center promptly at [rsc@trukera.com](mailto:rsc@trukera.com) for assistance.

## Reimbursement Support Specialist

Amanda Rotteck  
Cell: (704) 928-9009

Fax: (858) 225-8749  
Email: [arotteck@trukera.com](mailto:arotteck@trukera.com)

### This guide addresses billing recommendation for:

- **CPT Code 83861** is specific for “Microfluidic analysis utilizing an integrated collection and analysis device, tear osmolality.”
- A covered service by CMS Medicare under the Clinical Laboratory Fee Schedule.
- CLIA Certificate of Waiver is required to perform and bill this laboratory tests.
- Providers are encouraged to review payor-provider contracts for rate and claim submission requirements.
- Medical Necessity requires current signs or symptoms of disease at time of test.
- Frequency of testing is based on Medical Necessity as determined by the clinician.
- Laboratory Test - multiple procedure discounts do not apply.

Payor Name	Lines	Modifier(s)	Units per Line
Aetna	2	RT/LT	1
Anthem/BCBS	2	RT/LT	1
Caresource	2	RT/LT	1
Cigna	2	RT/LT	1
Humana Medicare	2	QW/RT/LT/59	1
Medicaid GA	2	QW/RT/LT	1
Medicare	2	QW/RT/LT	1
Peach St Medicaid	2	QW/RT/LT	1
United Healthcare	1	QW	2

## Billing Format Examples

**Medicare:** Note the CLIA # in box 23 and the QW/RT, QW/LT in box 24D are required for processing. **The QW modifier should be placed first.** Claims lacking these elements will be rejected.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																							
										17b. NPI		1234567890																							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB?		\$ CHARGES																							
										<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.																							
A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER																							
E.												10D2345678																							
I.																																			
J.																																			
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)										E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From To										SERVICE				CPT/HCPCS MODIFIER																					
11 01 23 11 01 23										11				83861 QW RT										A		50 00		1				NPI		1234567890	
11 01 23 11 01 23										11				83861 QW LT										A		50 00		1				NPI		1234567890	

**Most Commercial Plans:** Note that the QW and CLIA # are not required.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																							
										17b. NPI		1234567890																							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB?		\$ CHARGES																							
										<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.																							
A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER																							
E.																																			
I.																																			
J.																																			
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)										E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From To										SERVICE				CPT/HCPCS MODIFIER																					
11 01 23 11 01 23										11				83861 RT										A		50 00		1				NPI		1234567890	
11 01 23 11 01 23										11				83861 LT										A		50 00		1				NPI		1234567890	

**United Health Care Commercial Plans:** UHC does not recognize the RT/LT modifiers. The CLIA number is required in box 23 with the **QW Modifier only** with 2 units of service. Double the billed charge.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																							
										17b. NPI		1234567890																							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB?		\$ CHARGES																							
										<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.																							
A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER																							
E.												10D2345678																							
I.																																			
J.																																			
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)										E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From To										SERVICE				CPT/HCPCS MODIFIER																					
11 01 23 11 01 23										11				83861 QW										A		100 00		2				NPI		1234567890	

**Humana Medicare Advantage Plans:** Humana requires additional modifiers. The CLIA number is required in box 23 with the **QW/RT/LT/59** with 2 lines of service, 1 unit per line.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																	
										17b. NPI		1234567890																	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB?		\$ CHARGES																	
										<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.																	
A. ICD-10 Code(s)																													
B.																													
C.																													
D.																													
E.																													
F.																													
G.																													
H.																													
I.																													
J.																													
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From To														CPT/HCPCS MODIFIER															
MM DD YY MM DD YY																													
11 01 23 11 01 23										11				83861 QW RT 59				A		50 00		1				NPI 1234567890			
11 01 23 11 01 23										11				83861 QW LT 59				A		50 00		1				NPI 1234567890			

**Reimbursement for Medicare Part B (fee-for-service)**

**2021-2024 Clinical Laboratory Fee Schedule (CLFS) Rate:** \$22.48 per test (\$44.96 per patient)

**Sequestration Withhold**

- Medicare intermediaries are required to withhold two percent of the allowable.

**Medicare CMS Part B**

- CMS Medicare pays at 100% of CLFS throughout the United States.
- No deductible or patient co-payment applies.
- Free standing, global lab code.
- CLIA Certification required.

**Billing Software Requirements**

**ANSI 5010 E-claim Crosswalk**

In loop 2300, Segment REFO2, enter the CLIA Certification number – 10 digits - (Do not enter “CLIA” with the certificate number as this will cause claims to deny as an invalid identification number).

Field #	Claim Description	Loop	Segment	Electronic Description
23.	Prior Authorization number	2300	REF01	Reference identification qualifier =X4
			REF02	CLIA Certification number

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- MA 130 - Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is un-processable. Please submit the correct information to the appropriate FI or carrier.
- B7 - "This provider was not certified/eligible to be paid for this procedure/service on this date of service."
- The laboratory is not approved for this type of test.

# HAWAII BILLING GUIDE



If any denial is received for CPT 83861 contact the Trukera Medical Reimbursement Support Center promptly at [rsc@trukera.com](mailto:rsc@trukera.com) for assistance.

## Reimbursement Support Specialist

Amanda Rotteck  
Cell: (704) 928-9009

Fax: (858) 225-8749  
Email: [arotteck@trukera.com](mailto:arotteck@trukera.com)

### This guide addresses billing recommendation for:

- **CPT Code 83861** is specific for “Microfluidic analysis utilizing an integrated collection and analysis device, tear osmolality.”
- A covered service by CMS Medicare under the Clinical Laboratory Fee Schedule.
- CLIA Certificate of Waiver is required to perform and bill this laboratory tests.
- Providers are encouraged to review payor-provider contracts for rate and claim submission requirements.
- Medical Necessity requires current signs or symptoms of disease at time of test.
- Frequency of testing is based on Medical Necessity as determined by the clinician.
- Laboratory Test - multiple procedure discounts do not apply.

Payor Name	Lines	Modifier(s)	Units per Line
BCBS Federal Employee Plan	2	RT/LT	1
Cigna	2	RT/LT	1
Hawaii Medical Services Association (HMSA)	1	None	2
HealthNet	2	QW/RT/LT	1
Medicaid HI	2	QW/RT/LT	1
Medicare	2	QW/RT/LT	1
United Healthcare	1	QW	2

## Billing Format Examples

**Medicare:** Note the CLIA # in box 23 and the QW/RT, QW/LT in box 24D are required for processing. **The QW modifier should be placed first.** Claims lacking these elements will be rejected.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
										17b. NPI		1234567890									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB?		\$ CHARGES									
										<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.									
A. ICD-10 Code(s)																					
E. _____												23. PRIOR AUTHORIZATION NUMBER									
I. _____												10D2345678									
24. A. DATE(S) OF SERVICE			B. PLACE OF SERVICE			C.	D. PROCEDURES, SERVICES, OR SUPPLIES				E.	F.		G.	H.	I.	J.				
From To			SERVICE			EMG	(Explain Unusual Circumstances)				DIAGNOSIS	\$ CHARGES		DAYS OR UNITS	EPSDT Family Plan	ID. QUAL.	RENDERING PROVIDER ID. #				
MM DD YY MM DD YY							CPT/HCPCS MODIFIER				POINTER										
11 01 23 11 01 23			11				83861 QW RT				A	50 00		1			NPI 1234567890				
11 01 23 11 01 23			11				83861 QW LT				A	50 00		1			NPI 1234567890				

**Most Commercial Plans:** Note that the QW and CLIA # are not required.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
										17b. NPI		1234567890									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB?		\$ CHARGES									
										<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.									
A. ICD-10 Code(s)																					
E. _____												23. PRIOR AUTHORIZATION NUMBER									
I. _____																					
24. A. DATE(S) OF SERVICE			B. PLACE OF SERVICE			C.	D. PROCEDURES, SERVICES, OR SUPPLIES				E.	F.		G.	H.	I.	J.				
From To			SERVICE			EMG	(Explain Unusual Circumstances)				DIAGNOSIS	\$ CHARGES		DAYS OR UNITS	EPSDT Family Plan	ID. QUAL.	RENDERING PROVIDER ID. #				
MM DD YY MM DD YY							CPT/HCPCS MODIFIER				POINTER										
11 01 23 11 01 23			11				83861 RT				A	50 00		1			NPI 1234567890				
11 01 23 11 01 23			11				83861 LT				A	50 00		1			NPI 1234567890				

**United Health Care Commercial Plans:** UHC does not recognize the RT/LT modifiers. The CLIA number is required in box 23 with the **QW Modifier only** with 2 units of service. Double the billed charge.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
										17b. NPI		1234567890									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB?		\$ CHARGES									
										<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.									
A. ICD-10 Code(s)																					
E. _____												23. PRIOR AUTHORIZATION NUMBER									
I. _____												10D2345678									
24. A. DATE(S) OF SERVICE			B. PLACE OF SERVICE			C.	D. PROCEDURES, SERVICES, OR SUPPLIES				E.	F.		G.	H.	I.	J.				
From To			SERVICE			EMG	(Explain Unusual Circumstances)				DIAGNOSIS	\$ CHARGES		DAYS OR UNITS	EPSDT Family Plan	ID. QUAL.	RENDERING PROVIDER ID. #				
MM DD YY MM DD YY							CPT/HCPCS MODIFIER				POINTER										
11 01 23 11 01 23			11				83861 QW				A	100 00		2			NPI 1234567890				
																	NPI				

### Reimbursement for Medicare Part B (fee-for-service)

**2021-2024 Clinical Laboratory Fee Schedule (CLFS) Rate:** \$22.48 per test (\$44.96 per patient)

### Sequestration Withhold

- Medicare intermediaries are required to withhold two percent of the allowable.

### Medicare CMS Part B

- CMS Medicare pays at 100% of CLFS throughout the United States.
- No deductible or patient co-payment applies.
- Free standing, global lab code.
- CLIA Certification required.

### Billing Software Requirements

- **ANSI 5010 E-claim Crosswalk**

In loop 2300, Segment REFO2, enter the CLIA Certification number – 10 digits - (Do not enter “CLIA” with the certificate number as this will cause claims to deny as an invalid identification number).

Field #	Claim Description	Loop	Segment	Electronic Description
<b>23.</b>	<b>Prior Authorization number</b>	<b>2300</b>	<b>REF01</b>	Reference identification qualifier = <b>X4</b>
			<b>REF02</b>	CLIA Certification number

### Common Notification Reasons for Medicare Denials

If there is no CLIA number on the claim, Medicare sends RA messages MA 120 and MA 130, which state:

- MA 120 - Did not complete or enter accurately the CLIA number.
- MA 130 - Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is un-processable. Please submit the correct information to the appropriate FI or carrier.
- B7 - "This provider was not certified/eligible to be paid for this procedure/service on this date of service."
- The laboratory is not approved for this type of test.



# IDAHO BILLING GUIDE



If any denial is received for CPT 83861 contact the Trukera Reimbursement Support Center promptly at [rsc@trukera.com](mailto:rsc@trukera.com) for assistance

## Reimbursement Support Specialist

Bridget Bolles

Cell: (317) 797-7151

Fax: (858) 225-8749

Email: [bbolles@trukera.com](mailto:bbolles@trukera.com)

### This guide addresses billing recommendation for:

- **CPT Code 83861** is specific for “Microfluidic analysis utilizing an integrated collection and analysis device, tear osmolality”.
- A covered service by CMS Medicare under the Clinical Laboratory Fee Schedule.
- CLIA Certificate of Waiver is required to perform and bill this laboratory tests.
- Providers are encouraged to review payor-provider contracts for rate and claim submission requirements.
- Medical Necessity requires current signs or symptoms of disease at time of test.
- Frequency of testing is based on Medical Necessity as determined by the clinician.
- Laboratory Test - multiple procedure discounts do not apply.

Payor Name	Lines	Modifier(s)	Units per Line
Aetna	2	RT/LT	1
BCBS Federal Employee Plan	2	RT/LT	1
BCBS ID	1	None	2
Cigna	2	RT/LT	1
HealthNet	2	QW/RT/LT	1
Medicaid ID	2	QW/RT/LT	1
Medicare	2	QW/RT/LT	1
Pacificsource	2	RT/LT	1
Regence	1	None	2
SelectHealth	1	None	2
United Healthcare	1	QW	2

## Billing Format Examples

**Medicare:** Note the CLIA # in box 23 and the QW/RT, QW/LT in box 24D are required for processing. **The QW modifier should be placed first.** Claims lacking these elements will reject.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
										17b. NPI		1234567890									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.												22. RESUBMISSION CODE ORIGINAL REF. NO.									
A. ICD-10 Code(s) B. C. D.												23. PRIOR AUTHORIZATION NUMBER 10D2345678									
E. F. G. H.																					
I. J. K. L.																					
24. A. DATE(S) OF SERVICE			B. PLACE OF SERVICE			C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER				E. DIAGNOSIS POINTER	F. \$ CHARGES		G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #				
From MM DD YY To MM DD YY			SERVICE																		
11 01 23 11 01 23			11				83861 QW RT				A	50 00		1		NPI	1234567890				
11 01 23 11 01 23			11				83861 QW LT				A	50 00		1		NPI	1234567890				

**Most Commercial Plans:** Note that the QW and CLIA # are not required.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
										17b. NPI		1234567890									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.												22. RESUBMISSION CODE ORIGINAL REF. NO.									
A. ICD-10 Code(s) B. C. D.												23. PRIOR AUTHORIZATION NUMBER									
E. F. G. H.																					
I. J. K. L.																					
24. A. DATE(S) OF SERVICE			B. PLACE OF SERVICE			C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER				E. DIAGNOSIS POINTER	F. \$ CHARGES		G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #				
From MM DD YY To MM DD YY			SERVICE																		
11 01 23 11 01 23			11				83861 RT				A	50 00		1		NPI	1234567890				
11 01 23 11 01 23			11				83861 LT				A	50 00		1		NPI	1234567890				

**United Health Care Commercial Plans:** UHC does not recognize the RT/LT modifiers. The CLIA number is required in box 23 with the QW Modifier only with 2 units of service. Double the billed charge.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
										17b. NPI		1234567890									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.												22. RESUBMISSION CODE ORIGINAL REF. NO.									
A. ICD-10 Code(s) B. C. D.												23. PRIOR AUTHORIZATION NUMBER 10D2345678									
E. F. G. H.																					
I. J. K. L.																					
24. A. DATE(S) OF SERVICE			B. PLACE OF SERVICE			C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER				E. DIAGNOSIS POINTER	F. \$ CHARGES		G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #				
From MM DD YY To MM DD YY			SERVICE																		
11 01 23 11 01 23			11				83861 QW				A	100 00		2		NPI	1234567890				

**Humana Medicare Advantage Plans:** Humana requires additional modifiers. The CLIA number is required in box 23 with the **QW/RT/LT/59** with 2 lines of service, 1 unit per line

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																							
Dr. Trukera Medical										17b. NPI		1234567890																							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES																							
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.																							
A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER																							
B. [ ]												10D2345678																							
C. [ ]																																			
D. [ ]																																			
E. [ ]																																			
F. [ ]																																			
G. [ ]																																			
H. [ ]																																			
I. [ ]																																			
J. [ ]																																			
K. [ ]																																			
L. [ ]																																			
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)										E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From To										SERVICE				CPT/HCPCS MODIFIER																					
MM DD YY MM DD YY																																			
11 01 23 11 01 23										11				83861 QW RT 59										A		50 00		1				NPI		1234567890	
11 01 23 11 01 23										11				83861 QW LT 59										A		50 00		1				NPI		1234567890	

### Reimbursement for Medicare Part B (fee-for-service)

**2023-2024 Clinical Laboratory Fee Schedule (CLFS) Rate:** \$22.48 per test (\$44.96 per patient)

#### Sequestration Withhold

- Medicare intermediaries are required to withhold two-percent of the allowable.

#### Medicare CMS Part B

- CMS Medicare pays at 100% of CLFS throughout the United States.
- No deductible or patient co-payment applies.
- Free standing, global lab code.
- CLIA Certification required.

#### Billing Software Requirements

- **ANSI 5010 E-claim Crosswalk**

In loop 2300, Segment REFO2, enter the CLIA Certification number – 10 digits - (Do not enter “CLIA” with the certificate number as this will cause claims to deny as an invalid identification number).

Field #	Claim Description	Loop	Segment	Electronic Description
23.	Prior Authorization number	2300	REF01	Reference identification qualifier =X4
			REF02	CLIA Certification number

### Common Notification Reasons for Medicare Denials

If there is no CLIA number on the claim, Medicare sends RA messages MA 120 and MA 130, which state:

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- MA 130 - Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is un-processable. Please submit the correct information to the appropriate FI or carrier.
- B7 - "This provider was not certified/eligible to be paid for this procedure/service on this date of service."
- The laboratory is not approved for this type of test

# ILLINOIS BILLING GUIDE



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## Reimbursement Support Specialist

Bridget Bolles

Cell: (317) 797-7151

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### This guide addresses billing recommendation for:

- **CPT Code 83861** is specific for “Microfluidic analysis utilizing an integrated collection and analysis device, tear osmolality”.
- A covered service by CMS Medicare under the Clinical Laboratory Fee Schedule.
- CLIA Certificate of Waiver is required to perform and bill this laboratory tests.
- Providers are encouraged to review payor-provider contracts for rate and claim submission requirements.
- Medical Necessity requires current signs or symptoms of disease at time of test.
- Frequency of testing is based on Medical Necessity as determined by the clinician.
- Laboratory Test - multiple procedure discounts do not apply.

Payor Name	Lines	Modifier(s)	Units per Line
Aetna	1	None	2
BCBS Federal Employee Plan	2	RT/LT	1
BCBS IL	2	RT/LT	1
CountyCare	2	RT/LT	1
Health Alliance Plan (HAP)	2	RT/LT	1
Humana Medicare	2	QW/RT/LT/59	1
IlliniCare	2	RT/LT	1
Medicaid IL	2	RT/LT	1
Medicare	2	QW/RT/LT	1
Meridian Health Plan	2	RT/LT	1
Aetna Better Health	1	None	2

### Illinois Providers:

**HealthCare and Family Services:** (HFS - IL Medicaid) To establish payment, it requires that the practice fax a copy of the CLIA certificate along with provider NPI numbers to DHFS Provider Enrollment

- This does not apply to **Illini Care or Aetna Better Health**.

## Billing Format Examples

**Medicare:** Note the CLIA # in box 23 and the QW/RT, QW/LT in box 24D are required for processing. **The QW modifier should be placed first.** Claims lacking these elements will reject.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.		17b. NPI 1234567890		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)														20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. ICD-10 Code(s) B. C. D. E. F. G. H. I. J. K. L.														22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER 10D2345678									
24. A. DATE(S) OF SERVICE From To MM DD YY MM DD YY			B. PLACE OF SERVICE		C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER				E. DIAGNOSIS POINTER	F. \$ CHARGES		G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #							
11 01 23 11 01 23			11			83861 QW RT				A	50 00		1		NPI	1234567890							
11 01 23 11 01 23			11			83861 QW LT				A	50 00		1		NPI	1234567890							

**Most Commercial Plans:** Note that the QW and CLIA # are not required.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.		17b. NPI 1234567890		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)														20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
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11 01 23 11 01 23			11			83861 RT				A	50 00		1		NPI	1234567890							
11 01 23 11 01 23			11			83861 LT				A	50 00		1		NPI	1234567890							

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19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)														20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
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24. A. DATE(S) OF SERVICE From To MM DD YY MM DD YY			B. PLACE OF SERVICE		C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER				E. DIAGNOSIS POINTER	F. \$ CHARGES		G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #							
11 01 23 11 01 23			11			83861 QW				A	100 00		2		NPI	1234567890							
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Dr. Trukera Medical										17b. NPI		1234567890																							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES																							
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																							
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A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER																							
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C. [ ]																																			
D. [ ]																																			
E. [ ]																																			
F. [ ]																																			
G. [ ]																																			
H. [ ]																																			
I. [ ]																																			
J. [ ]																																			
K. [ ]																																			
L. [ ]																																			
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)										E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From To										SERVICE				CPT/HCPCS MODIFIER																					
MM DD YY MM DD YY																																			
11 01 23 11 01 23										11				83861 QW RT 59										A		50 00		1				NPI		1234567890	
11 01 23 11 01 23										11				83861 QW LT 59										A		50 00		1				NPI		1234567890	

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			REF02	CLIA Certification number

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# INDIANA BILLING GUIDE



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## Reimbursement Support Specialist

Bridget Bolles

Cell: (317) 797-7151

Fax: (858) 225-8749

Email: [bbolles@trukera.com](mailto:bbolles@trukera.com)

### This guide addresses billing recommendation for:

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- Providers are encouraged to review payor-provider contracts for rate and claim submission requirements.
- Medical Necessity requires current signs or symptoms of disease at time of test.
- Frequency of testing is based on Medical Necessity as determined by the clinician.
- Laboratory Test - multiple procedure discounts do not apply.

Payor Name	Lines	Modifier(s)	Units per Line
Aetna	2	RT/LT	1
Anthem	2	RT/LT	1
BCBS Federal Employee Plan	2	RT/LT	1
Caresource	2	RT/LT	1
Humana Medicare	2	QW/RT/LT /59	1
MDWISE	2	RT/LT	1
Medicaid IN	2	QW/RT/LT	1
Medicare	2	QW/RT/LT	1
SIHO	2	RT/LT	1

### Indiana Providers:

**Humana Commercial:** Will deny claim (Diagnostic testing for dry eye syndrome is not separately reimbursable).

## Billing Format Examples

**Medicare:** Note the CLIA # in box 23 and the QW/RT, QW/LT in box 24D are required for processing. **The QW modifier should be placed first.** Claims lacking these elements will reject.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																							
Dr. Trukera Medical										17b.		NPI 1234567890																							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES																							
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.																							
A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER																							
B. _____												10D2345678																							
C. _____																																			
D. _____																																			
E. _____																																			
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G. _____																																			
H. _____																																			
I. _____																																			
J. _____																																			
K. _____																																			
L. _____																																			
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)										E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From To														CPT/HCPCS MODIFIER																					
MM DD YY MM DD YY																																			
11 01 23 11 01 23										11				83861 QW RT										A		50 00		1				NPI		1234567890	
11 01 23 11 01 23										11				83861 QW LT										A		50 00		1				NPI		1234567890	

**Most Commercial Plans:** Note that the QW and CLIA # are not required.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																							
Dr. Trukera Medical										17b.		NPI 1234567890																							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES																							
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.																							
A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER																							
B. _____																																			
C. _____																																			
D. _____																																			
E. _____																																			
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K. _____																																			
L. _____																																			
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)										E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From To														CPT/HCPCS MODIFIER																					
MM DD YY MM DD YY																																			
11 01 23 11 01 23										11				83861 RT										A		50 00		1				NPI		1234567890	
11 01 23 11 01 23										11				83861 LT										A		50 00		1				NPI		1234567890	

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17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																							
Dr. Trukera Medical										17b.		NPI 1234567890																							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES																							
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.																							
A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER																							
B. _____												10D2345678																							
C. _____																																			
D. _____																																			
E. _____																																			
F. _____																																			
G. _____																																			
H. _____																																			
I. _____																																			
J. _____																																			
K. _____																																			
L. _____																																			
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)										E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From To														CPT/HCPCS MODIFIER																					
MM DD YY MM DD YY																																			
11 01 23 11 01 23										11				83861 QW										A		100 00		2				NPI		1234567890	

**Humana Medicare Advantage Plans:** Humana requires additional modifiers. The CLIA number is required in box 23 with the **QW/RT/LT/59** with 2 lines of service, 1 unit per line

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																							
Dr. Trukera Medical										17b. NPI		1234567890																							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES																							
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.																							
A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER																							
B. [ ]												10D2345678																							
C. [ ]																																			
D. [ ]																																			
E. [ ]																																			
F. [ ]																																			
G. [ ]																																			
H. [ ]																																			
I. [ ]																																			
J. [ ]																																			
K. [ ]																																			
L. [ ]																																			
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)										E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From To										SERVICE				CPT/HCPCS MODIFIER																					
MM DD YY MM DD YY																																			
11 01 23 11 01 23										11				83861 QW RT 59										A		50 00		1				NPI		1234567890	
11 01 23 11 01 23										11				83861 QW LT 59										A		50 00		1				NPI		1234567890	

### Reimbursement for Medicare Part B (fee-for-service)

**2023-2024 Clinical Laboratory Fee Schedule (CLFS) Rate:** \$22.48 per test (\$44.96 per patient)

#### Sequestration Withhold

- Medicare intermediaries are required to withhold two-percent of the allowable.

#### Medicare CMS Part B

- CMS Medicare pays at 100% of CLFS throughout the United States.
- No deductible or patient co-payment applies.
- Free standing, global lab code.
- CLIA Certification required.

#### Billing Software Requirements

- **ANSI 5010 E-claim Crosswalk**

In loop 2300, Segment REFO2, enter the CLIA Certification number – 10 digits - (Do not enter “CLIA” with the certificate number as this will cause claims to deny as an invalid identification number).

Field #	Claim Description	Loop	Segment	Electronic Description
23.	Prior Authorization number	2300	REF01	Reference identification qualifier =X4
			REF02	CLIA Certification number

## Common Notification Reasons for Medicare Denials

If there is no CLIA number on the claim, Medicare sends RA messages MA 120 and MA 130, which state:

- MA 120 - Did not complete or enter accurately the CLIA number.
- MA 130 - Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is un-processable. Please submit the correct information to the appropriate FI or carrier.
- B7 - "This provider was not certified/eligible to be paid for this procedure/service on this date of service."
- The laboratory is not approved for this type of test

# IOWA BILLING GUIDE



If any denial is received for CPT 83861 contact the Trukera Reimbursement Support Center promptly at [rsc@trukera.com](mailto:rsc@trukera.com) for assistance

## Reimbursement Support Specialist

Bridget Bolles

Cell: (317) 797-7151

Fax: (858) 225-8749

Email: [bbolles@trukera.com](mailto:bbolles@trukera.com)

### This guide addresses billing recommendation for:

- **CPT Code 83861** is specific for “Microfluidic analysis utilizing an integrated collection and analysis device, tear osmolality”.
- A covered service by CMS Medicare under the Clinical Laboratory Fee Schedule.
- CLIA Certificate of Waiver is required to perform and bill this laboratory tests.
- Providers are encouraged to review payor-provider contracts for rate and claim submission requirements.
- Medical Necessity requires current signs or symptoms of disease at time of test.
- Frequency of testing is based on Medical Necessity as determined by the clinician.
- Laboratory Test - multiple procedure discounts do not apply.

Payor Name	Lines	Modifier(s)	Units per Line
Aetna	2	RT/LT	1
Amerigroup	2	59 on 2 <sup>nd</sup> line	1
Anthem	2	RT/LT	1
BCBS Federal Employee Plan	2	RT/LT	1
Cigna	2	RT/LT	1
HealthNet	2	QW/RT/LT	1
Medica	2	RT/LT	1
Medicaid IA	2	QW/RT/LT	1
Medicare	2	QW/RT/LT	1
United Healthcare	1	QW	2
Wellmark	1	QW	2

## Billing Format Examples

**Medicare:** Note the CLIA # in box 23 and the QW/RT, QW/LT in box 24D are required for processing. **The QW modifier should be placed first.** Claims lacking these elements will reject.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
										17b. NPI		1234567890									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. ICD-10 Code(s) B. C. D. E. F. G. H. I. J. K. L.										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.									
												23. PRIOR AUTHORIZATION NUMBER 10D2345678									
24. A. DATE(S) OF SERVICE From To MM DD YY MM DD YY			B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER				E. DIAGNOSIS POINTER	F. \$ CHARGES		G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #						
11 01 23 11 01 23			11		83861 QW RT				A	50 00		1		NPI	1234567890						
11 01 23 11 01 23			11		83861 QW LT				A	50 00		1		NPI	1234567890						

**Most Commercial Plans:** Note that the QW and CLIA # are not required.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
										17b. NPI		1234567890									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. ICD-10 Code(s) B. C. D. E. F. G. H. I. J. K. L.										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.									
												23. PRIOR AUTHORIZATION NUMBER									
24. A. DATE(S) OF SERVICE From To MM DD YY MM DD YY			B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER				E. DIAGNOSIS POINTER	F. \$ CHARGES		G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #						
11 01 23 11 01 23			11		83861 RT				A	50 00		1		NPI	1234567890						
11 01 23 11 01 23			11		83861 LT				A	50 00		1		NPI	1234567890						

**United Health Care Commercial Plans:** UHC does not recognize the RT/LT modifiers. The CLIA number is required in box 23 with the QW Modifier only with 2 units of service. Double the billed charge.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
										17b. NPI		1234567890									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. ICD-10 Code(s) B. C. D. E. F. G. H. I. J. K. L.										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.									
												23. PRIOR AUTHORIZATION NUMBER 10D2345678									
24. A. DATE(S) OF SERVICE From To MM DD YY MM DD YY			B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER				E. DIAGNOSIS POINTER	F. \$ CHARGES		G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #						
11 01 23 11 01 23			11		83861 QW				A	100 00		2		NPI	1234567890						
														NPI							

**Humana Medicare Advantage Plans:** Humana requires additional modifiers. The CLIA number is required in box 23 with the **QW/RT/LT/59** with 2 lines of service, 1 unit per line

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																							
Dr. Trukera Medical										17b. NPI		1234567890																							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES																							
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.																							
A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER																							
B. [ ]												10D2345678																							
C. [ ]																																			
D. [ ]																																			
E. [ ]																																			
F. [ ]																																			
G. [ ]																																			
H. [ ]																																			
I. [ ]																																			
J. [ ]																																			
K. [ ]																																			
L. [ ]																																			
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)										E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From To										SERVICE				CPT/HCPCS MODIFIER																					
MM DD YY MM DD YY																																			
11 01 23 11 01 23										11				83861 QW RT 59										A		50 00		1				NPI		1234567890	
11 01 23 11 01 23										11				83861 QW LT 59										A		50 00		1				NPI		1234567890	

### Reimbursement for Medicare Part B (fee-for-service)

**2023-2024 Clinical Laboratory Fee Schedule (CLFS) Rate:** \$22.48 per test (\$44.96 per patient)

#### Sequestration Withhold

- Medicare intermediaries are required to withhold two-percent of the allowable.

#### Medicare CMS Part B

- CMS Medicare pays at 100% of CLFS throughout the United States.
- No deductible or patient co-payment applies.
- Free standing, global lab code.
- CLIA Certification required.

#### Billing Software Requirements

- **ANSI 5010 E-claim Crosswalk**

In loop 2300, Segment REFO2, enter the CLIA Certification number – 10 digits - (Do not enter “CLIA” with the certificate number as this will cause claims to deny as an invalid identification number).

Field #	Claim Description	Loop	Segment	Electronic Description
23.	Prior Authorization number	2300	REF01	Reference identification qualifier =X4
			REF02	CLIA Certification number

## Common Notification Reasons for Medicare Denials

If there is no CLIA number on the claim, Medicare sends RA messages MA 120 and MA 130, which state:

- MA 120 - Did not complete or enter accurately the CLIA number.
- MA 130 - Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is un-processable. Please submit the correct information to the appropriate FI or carrier.
- B7 - "This provider was not certified/eligible to be paid for this procedure/service on this date of service."
- The laboratory is not approved for this type of test



# KANSAS BILLING GUIDE



If any denial is received for CPT 83861 contact the Trukera Medical Reimbursement Support Center promptly at [rsc@trukera.com](mailto:rsc@trukera.com) for assistance.

## Reimbursement Support Specialist

Amanda Rotteck

Fax: (858) 225-8749

Cell: (704) 928-9009

Email: [arotteck@trukera.com](mailto:arotteck@trukera.com)

### This guide addresses billing recommendation for:

- **CPT Code 83861** is specific for “Microfluidic analysis utilizing an integrated collection and analysis device, tear osmolality.”
- A covered service by CMS Medicare under the Clinical Laboratory Fee Schedule.
- CLIA Certificate of Waiver is required to perform and bill this laboratory tests.
- Providers are encouraged to review payor-provider contracts for rate and claim submission requirements.
- Medical Necessity requires current signs or symptoms of disease at time of test.
- Frequency of testing is based on Medical Necessity as determined by the clinician.
- Laboratory Test - multiple procedure discounts do not apply.

Payor Name	Lines	Modifier(s)	Units per Line
Aetna	2	RT/LT	1
BCBS Kansas	2	RT/LT	1
BCBS Kansas City Missouri	2	RT/LT	1
Cigna	2	RT/LT	1
HealthNet	2	QW/RT/LT	1
Humana Medicare	1	QW/RT/LT/59	2
Medicare	1	QW/RT/LT	2
UHC Community Plan	1	QW	2
United Healthcare	1	QW	2

**Humana Commercial Plans:** Humana considers all diagnostic testing for dry eye, integral to the office visit, and payment for diagnostic testing is therefore considered by Humana as part of the office visit fee. Unfortunately, the Humana policy for commercial, non-Medicare claims, considers tear osmolality, a laboratory test, in the same category as slit lamp procedures such as ocular surface staining and tear break up time.

**BCBS KS:** The plan considers this test experimental and a non-covered service.

## Billing Format Examples

**Medicare:** Note the CLIA # in box 23 and the QW/RT, QW/LT in box 24D are required for processing. **The QW modifier should be placed first.** Claims lacking these elements will be rejected.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																							
Dr. Trukera Medical										17b. NPI		1234567890																							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES																							
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.																							
A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER																							
B. _____												10D2345678																							
C. _____																																			
D. _____																																			
E. _____																																			
F. _____																																			
G. _____																																			
H. _____																																			
I. _____																																			
J. _____																																			
K. _____																																			
L. _____																																			
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)										E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From To														CPT/HCPCS MODIFIER																					
MM DD YY MM DD YY																																			
11 01 23 11 01 23										11				83861 QW RT										A		50 00		1				NPI		1234567890	
11 01 23 11 01 23										11				83861 QW LT										A		50 00		1				NPI		1234567890	

**Most Commercial Plans:** Note that the QW and CLIA # are not required.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																							
Dr. Trukera Medical										17b. NPI		1234567890																							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES																							
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.																							
A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER																							
B. _____																																			
C. _____																																			
D. _____																																			
E. _____																																			
F. _____																																			
G. _____																																			
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K. _____																																			
L. _____																																			
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)										E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From To														CPT/HCPCS MODIFIER																					
MM DD YY MM DD YY																																			
11 01 23 11 01 23										11				83861 RT										A		50 00		1				NPI		1234567890	
11 01 23 11 01 23										11				83861 LT										A		50 00		1				NPI		1234567890	

**United Health Care Commercial Plans:** UHC does not recognize the RT/LT modifiers. The CLIA number is required in box 23 with the **QW Modifier only** with 2 units of service. Double the billed charge.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																							
Dr. Trukera Medical										17b. NPI		1234567890																							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES																							
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.																							
A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER																							
B. _____												10D2345678																							
C. _____																																			
D. _____																																			
E. _____																																			
F. _____																																			
G. _____																																			
H. _____																																			
I. _____																																			
J. _____																																			
K. _____																																			
L. _____																																			
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)										E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From To														CPT/HCPCS MODIFIER																					
MM DD YY MM DD YY																																			
11 01 23 11 01 23										11				83861 QW										A		100 00		2				NPI		1234567890	

**Humana Medicare Advantage Plans:** Humana requires additional modifiers. The CLIA number is required in box 23 with the **QW/RT/LT/59** with 2 lines of service, 1 unit per line.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical			17a.			17b. NPI 1234567890			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY													
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.												22. RESUBMISSION CODE ORIGINAL REF. NO.										
A. ICD-10 Code(s) B. C. D. E. F. G. H. I. J. K. L.												23. PRIOR AUTHORIZATION NUMBER 10D2345678										
24. A. DATE(S) OF SERVICE From To MM DD YY MM DD YY			B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER				E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
11	01	23	11	01	23	11		83861	QW	RT	59		A	50	00	1			NPI	1234567890		
11	01	23	11	01	23	11		83861	QW	LT	59		A	50	00	1			NPI	1234567890		

### Reimbursement for Medicare Part B (fee-for-service)

**2021-2024 Clinical Laboratory Fee Schedule (CLFS) Rate:** \$22.48 per test (\$44.96 per patient)

### Sequestration Withhold

- Medicare intermediaries are required to withhold two percent of the allowable.

### Medicare CMS Part B

- CMS Medicare pays at 100% of CLFS throughout the United States.
- No deductible or patient co-payment applies.
- Free standing, global lab code.
- CLIA Certification required.

### Billing Software Requirements

- **ANSI 5010 E-claim Crosswalk**

In loop 2300, Segment REFO2, enter the CLIA Certification number – 10 digits - (Do not enter “CLIA” with the certificate number as this will cause claims to deny as an invalid identification number).

Field #	Claim Description	Loop	Segment	Electronic Description
23.	Prior Authorization number	2300	REF01	Reference identification qualifier =X4
			REF02	CLIA Certification number

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If there is no CLIA number on the claim, Medicare sends RA messages MA 120 and MA 130, which state:

- MA 120 - Did not complete or enter accurately the CLIA number.
- MA 130 - Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is un-processable. Please submit the correct information to the appropriate FI or carrier.
- B7 - "This provider was not certified/eligible to be paid for this procedure/service on this date of service."
- The laboratory is not approved for this type of test.

# KENTUCKY BILLING GUIDE



If any denial is received for CPT 83861 contact the Trukera Reimbursement Support Center promptly at [rsc@trukera.com](mailto:rsc@trukera.com) for assistance

## Reimbursement Support Specialist

Bridget Bolles

Cell: (317) 797-7151

Fax: (858) 225-8749

Email: [bbolles@trukera.com](mailto:bbolles@trukera.com)

### This guide addresses billing recommendation for:

- **CPT Code 83861** is specific for “Microfluidic analysis utilizing an integrated collection and analysis device, tear osmolality”.
- A covered service by CMS Medicare under the Clinical Laboratory Fee Schedule.
- CLIA Certificate of Waiver is required to perform and bill this laboratory tests.
- Providers are encouraged to review payor-provider contracts for rate and claim submission requirements.
- Medical Necessity requires current signs or symptoms of disease at time of test.
- Frequency of testing is based on Medical Necessity as determined by the clinician.
- Laboratory Test - multiple procedure discounts do not apply.

Payor Name	Lines	Modifier(s)	Units per Line
Aetna	2	RT/LT	1
Anthem	2	RT/LT	1
BCBS Federal Employee Plan	2	RT/LT	1
Caresource	2	RT/LT	1
Cigna	2	RT/LT	1
Humana Medicare	2	QW/RT/LT 59	1
Medicaid KY	2	QW/RT/LT	1
Medicare	2	QW/RT/LT	1
Passport Health Plan - Medicaid	2	QW/RT/LT	1
Sierra Life	2	RT/LT	1
United Healthcare	1	QW	2

### Kentucky Providers:

**Humana Commercial:** Will deny claim (**Diagnostic testing for dry eye syndrome is not separately reimbursable**).

## Billing Format Examples

**Medicare:** Note the CLIA # in box 23 and the QW/RT, QW/LT in box 24D are required for processing. **The QW modifier should be placed first.** Claims lacking these elements will reject.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
										17b. NPI		1234567890									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. ICD-10 Code(s) B. C. D. E. F. G. H. I. J. K. L.										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.									
												23. PRIOR AUTHORIZATION NUMBER 10D2345678									
24. A. DATE(S) OF SERVICE From To MM DD YY MM DD YY			B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER				E. DIAGNOSIS POINTER	F. \$ CHARGES		G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #						
11 01 23 11 01 23			11		83861 QW RT				A	50 00		1		NPI	1234567890						
11 01 23 11 01 23			11		83861 QW LT				A	50 00		1		NPI	1234567890						

**Most Commercial Plans:** Note that the QW and CLIA # are not required.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
										17b. NPI		1234567890									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. ICD-10 Code(s) B. C. D. E. F. G. H. I. J. K. L.										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.									
												23. PRIOR AUTHORIZATION NUMBER									
24. A. DATE(S) OF SERVICE From To MM DD YY MM DD YY			B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER				E. DIAGNOSIS POINTER	F. \$ CHARGES		G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #						
11 01 23 11 01 23			11		83861 RT				A	50 00		1		NPI	1234567890						
11 01 23 11 01 23			11		83861 LT				A	50 00		1		NPI	1234567890						

**United Health Care Commercial Plans:** UHC does not recognize the RT/LT modifiers. The CLIA number is required in box 23 with the QW Modifier only with 2 units of service. Double the billed charge.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
										17b. NPI		1234567890									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. ICD-10 Code(s) B. C. D. E. F. G. H. I. J. K. L.										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.									
												23. PRIOR AUTHORIZATION NUMBER 10D2345678									
24. A. DATE(S) OF SERVICE From To MM DD YY MM DD YY			B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER				E. DIAGNOSIS POINTER	F. \$ CHARGES		G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #						
11 01 23 11 01 23			11		83861 QW				A	100 00		2		NPI	1234567890						
														NPI							

**Humana Medicare Advantage Plans:** Humana requires additional modifiers. The CLIA number is required in box 23 with the **QW/RT/LT/59** with 2 lines of service, 1 unit per line

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																							
Dr. Trukera Medical										17b. NPI		1234567890																							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES																							
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.																							
A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER																							
B. [ ]												10D2345678																							
C. [ ]																																			
D. [ ]																																			
E. [ ]																																			
F. [ ]																																			
G. [ ]																																			
H. [ ]																																			
I. [ ]																																			
J. [ ]																																			
K. [ ]																																			
L. [ ]																																			
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)										E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From To										SERVICE				CPT/HCPCS MODIFIER																					
MM DD YY MM DD YY																																			
11 01 23 11 01 23										11				83861 QW RT 59										A		50 00		1				NPI		1234567890	
11 01 23 11 01 23										11				83861 QW LT 59										A		50 00		1				NPI		1234567890	

### Reimbursement for Medicare Part B (fee-for-service)

**2023-2024 Clinical Laboratory Fee Schedule (CLFS) Rate:** \$22.48 per test (\$44.96 per patient)

#### Sequestration Withhold

- Medicare intermediaries are required to withhold two-percent of the allowable.

#### Medicare CMS Part B

- CMS Medicare pays at 100% of CLFS throughout the United States.
- No deductible or patient co-payment applies.
- Free standing, global lab code.
- CLIA Certification required.

#### Billing Software Requirements

- **ANSI 5010 E-claim Crosswalk**

In loop 2300, Segment REFO2, enter the CLIA Certification number – 10 digits - (Do not enter “CLIA” with the certificate number as this will cause claims to deny as an invalid identification number).

Field #	Claim Description	Loop	Segment	Electronic Description
23.	Prior Authorization number	2300	REF01	Reference identification qualifier =X4
			REF02	CLIA Certification number

## Common Notification Reasons for Medicare Denials

If there is no CLIA number on the claim, Medicare sends RA messages MA 120 and MA 130, which state:

- MA 120 - Did not complete or enter accurately the CLIA number.
- MA 130 - Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is un-processable. Please submit the correct information to the appropriate FI or carrier.
- B7 - "This provider was not certified/eligible to be paid for this procedure/service on this date of service."
- The laboratory is not approved for this type of test



# LOUISIANA BILLING GUIDE



If any denial is received for CPT 83861 contact the Trukera Medical Reimbursement Support Center promptly at [rsc@trukera.com](mailto:rsc@trukera.com) for assistance.

## Reimbursement Support Specialist

Amanda Rotteck  
Cell: (704) 928-9009

Fax: (858) 225-8749  
Email: [arotteck@trukera.com](mailto:arotteck@trukera.com)

### This guide addresses billing recommendation for:

- **CPT Code 83861** is specific for “Microfluidic analysis utilizing an integrated collection and analysis device, tear osmolality.”
- A covered service by CMS Medicare under the Clinical Laboratory Fee Schedule.
- CLIA Certificate of Waiver is required to perform and bill this laboratory tests.
- Providers are encouraged to review payor-provider contracts for rate and claim submission requirements.
- Medical Necessity requires current signs or symptoms of disease at time of test.
- Frequency of testing is based on Medical Necessity as determined by the clinician.
- Laboratory Test - multiple procedure discounts do not apply.

Payor Name	Lines	Modifier(s)	Units per Line
Aetna	2	RT/LT	1
Amerigroup	2	59 on second line of service	1
AmeriHealth Caritas LA	2	RT/LT	1
Anthem	2	RT/LT	1
BCBS LA	2	RT/LT	1
Cigna	2	RT/LT	1
Humana Medicare	2	QW/RT/LT/59	1
Medicare	2	QW/RT/LT	1
Peoples Health	2	RT/LT	1
UHC Community Plan	1	QW	2
United Healthcare	1	QW	2

## Billing Format Examples

**Medicare:** Note the CLIA # in box 23 and the QW/RT, QW/LT in box 24D are required for processing. **The QW modifier should be placed first.** Claims lacking these elements will be rejected.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.											18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY										
										17b.	NPI	1234567890																			
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)																				20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. ICD-10 Code(s) B. C. ICD Ind. D. E. F. G. H. I. J. K. L.										22. RESUBMISSION CODE ORIGINAL REF. NO.										23. PRIOR AUTHORIZATION NUMBER 10D2345678											
24. A. DATE(S) OF SERVICE From To MM DD YY MM DD YY						B. PLACE OF SERVICE EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER						E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #							
11 01 23 11 01 23						11		83861 QW RT						A		50 00		1		NPI		1234567890									
11 01 23 11 01 23						11		83861 QW LT						A		50 00		1		NPI		1234567890									

**Most Commercial Plans:** Note that the QW and CLIA # are not required.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.											18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY										
										17b.	NPI	1234567890																			
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)																				20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. ICD-10 Code(s) B. C. ICD Ind. D. E. F. G. H. I. J. K. L.										22. RESUBMISSION CODE ORIGINAL REF. NO.										23. PRIOR AUTHORIZATION NUMBER											
24. A. DATE(S) OF SERVICE From To MM DD YY MM DD YY						B. PLACE OF SERVICE EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER						E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #							
11 01 23 11 01 23						11		83861 RT						A		50 00		1		NPI		1234567890									
11 01 23 11 01 23						11		83861 LT						A		50 00		1		NPI		1234567890									

**United Health Care Commercial Plans:** UHC does not recognize the RT/LT modifiers. The CLIA number is required in box 23 with the **QW Modifier only** with 2 units of service. Double the billed charge.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.											18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY										
										17b.	NPI	1234567890																			
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)																				20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. ICD-10 Code(s) B. C. ICD Ind. D. E. F. G. H. I. J. K. L.										22. RESUBMISSION CODE ORIGINAL REF. NO.										23. PRIOR AUTHORIZATION NUMBER 10D2345678											
24. A. DATE(S) OF SERVICE From To MM DD YY MM DD YY						B. PLACE OF SERVICE EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER						E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #							
11 01 23 11 01 23						11		83861 QW						A		100 00		2		NPI		1234567890									
																				NPI											

**Humana Medicare Advantage Plans:** Humana requires additional modifiers. The CLIA number is required in box 23 with the **QW/RT/LT/59** with 2 lines of service, 1 unit per line.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical		17a.			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES												
		17b. NPI	1234567890		FROM	TO											
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)				20. OUTSIDE LAB? \$ CHARGES													
				<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO													
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)				22. RESUBMISSION CODE		ORIGINAL REF. NO.											
A. ICD-10 Code(s)				23. PRIOR AUTHORIZATION NUMBER													
B. ICD-10 Code(s)				10D2345678													
C. ICD-10 Code(s)																	
D. ICD-10 Code(s)																	
E. ICD-10 Code(s)																	
F. ICD-10 Code(s)																	
G. ICD-10 Code(s)																	
H. ICD-10 Code(s)																	
I. ICD-10 Code(s)																	
J. ICD-10 Code(s)																	
K. ICD-10 Code(s)																	
L. ICD-10 Code(s)																	
24. A. DATE(S) OF SERVICE		B. PLACE OF SERVICE	C. D. PROCEDURES, SERVICES, OR SUPPLIES		E. DIAGNOSIS POINTER	F. \$ CHARGES											
From To		EMG	(Explain Unusual Circumstances)			G. DAYS OR UNITS											
MM DD YY	MM DD YY		CPT/HCPCS	MODIFIER		H. EPSDT Family Plan											
11 01 23	11 01 23	11	83861	QW RT 59	A	I. ID. QUAL.											
						J. RENDERING PROVIDER ID. #											
11	01	23	11	01	23	11	83861	QW	RT	59	A	50	00	1		NPI	1234567890
11	01	23	11	01	23	11	83861	QW	LT	59	A	50	00	1		NPI	1234567890

### Reimbursement for Medicare Part B (fee-for-service)

**2021-2024 Clinical Laboratory Fee Schedule (CLFS) Rate:** \$22.48 per test (\$44.96 per patient)

### Sequestration Withhold

- Medicare intermediaries are required to withhold two percent of the allowable.

### Medicare CMS Part B

- CMS Medicare pays at 100% of CLFS throughout the United States.
- No deductible or patient co-payment applies.
- Free standing, global lab code.
- CLIA Certification required.

### Billing Software Requirements

- **ANSI 5010 E-claim Crosswalk**

In loop 2300, Segment REFO2, enter the CLIA Certification number – 10 digits - (Do not enter “CLIA” with the certificate number as this will cause claims to deny as an invalid identification number).

Field #	Claim Description	Loop	Segment	Electronic Description
23.	Prior Authorization number	2300	REF01	Reference identification qualifier =X4
			REF02	CLIA Certification number

### Common Notification Reasons for Medicare Denials

If there is no CLIA number on the claim, Medicare sends RA messages MA 120 and MA 130, which state:

- MA 120 - Did not complete or enter accurately the CLIA number.
- MA 130 - Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is un-processable. Please submit the correct information to the appropriate FI or carrier.
- B7 - "This provider was not certified/eligible to be paid for this procedure/service on this date of service."
- The laboratory is not approved for this type of test.

# MAINE BILLING GUIDE



If any denial is received for CPT 83861 contact the Trukera Reimbursement Support Center promptly at [rsc@trukera.com](mailto:rsc@trukera.com) for assistance

### Reimbursement Support Specialist

Bridget Bolles

Cell: (317) 797-7151

Fax: (858) 225-8749

Email: [bbolles@trukera.com](mailto:bbolles@trukera.com)

### This guide addresses billing recommendation for:

- **CPT Code 83861** is specific for “Microfluidic analysis utilizing an integrated collection and analysis device, tear osmolality”.
- A covered service by CMS Medicare under the Clinical Laboratory Fee Schedule.
- CLIA Certificate of Waiver is required to perform and bill this laboratory tests.
- Providers are encouraged to review payor-provider contracts for rate and claim submission requirements.
- Medical Necessity requires current signs or symptoms of disease at time of test.
- Frequency of testing is based on Medical Necessity as determined by the clinician.
- Laboratory Test - multiple procedure discounts do not apply.

Payor Name	Lines	Modifier(s)	Units per Line
Medicare	2	RQW/RT/LT	1
Anthem	2	RT/LT	1
Harvard Pilgrim	1	none	2
Maine Medicaid	2	QW/RT/LT	1
Aetna	2	RT/LT	1
Cigna	2	RT/LT	1
Martin's Point ADV/GENERATION	1	QW	2
Martin's Point Commercial	1	none	2
Humana Medicare	2	QW/RT/LT 59	1

### Maine Providers:

**Medicaid:** Provider may need to update contract for reimbursement. Place of Service 81.

**Humana Commercial:** Will deny claim (**Diagnostic testing for dry eye syndrome is not separately reimbursable**).

## Billing Format Examples

**Medicare:** Note the CLIA # in box 23 and the QW/RT, QW/LT in box 24D are required for processing. **The QW modifier should be placed first.** Claims lacking these elements will reject.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES									
										17b. NPI		1234567890									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES									
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.									
A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER									
B. _____												10D2345678									
C. _____																					
D. _____																					
E. _____																					
F. _____																					
G. _____																					
H. _____																					
I. _____																					
J. _____																					
K. _____																					
L. _____																					
24. A. DATE(S) OF SERVICE			B. PLACE OF SERVICE			C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER	F. \$ CHARGES		G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #				
From To							CPT/HCPCS MODIFIER														
MM	DD	YY	MM	DD	YY																
11	01	23	11	01	23	11	83861	QW	RT	A	50	00	1			NPI	1234567890				
11	01	23	11	01	23	11	83861	QW	LT	A	50	00	1			NPI	1234567890				

**Most Commercial Plans:** Note that the QW and CLIA # are not required.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES									
										17b. NPI		1234567890									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES									
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.									
A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER									
B. _____																					
C. _____																					
D. _____																					
E. _____																					
F. _____																					
G. _____																					
H. _____																					
I. _____																					
J. _____																					
K. _____																					
L. _____																					
24. A. DATE(S) OF SERVICE			B. PLACE OF SERVICE			C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER	F. \$ CHARGES		G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #				
From To							CPT/HCPCS MODIFIER														
MM	DD	YY	MM	DD	YY																
11	01	23	11	01	23	11	83861	RT		A	50	00	1			NPI	1234567890				
11	01	23	11	01	23	11	83861	LT		A	50	00	1			NPI	1234567890				

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17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES									
										17b. NPI		1234567890									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES									
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.									
A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER									
B. _____												10D2345678									
C. _____																					
D. _____																					
E. _____																					
F. _____																					
G. _____																					
H. _____																					
I. _____																					
J. _____																					
K. _____																					
L. _____																					
24. A. DATE(S) OF SERVICE			B. PLACE OF SERVICE			C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER	F. \$ CHARGES		G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #				
From To							CPT/HCPCS MODIFIER														
MM	DD	YY	MM	DD	YY																
11	01	23	11	01	23	11	83861	QW		A	100	00	2			NPI	1234567890				
																NPI					

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Dr. Trukera Medical										17b. NPI		1234567890																	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES																	
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.																	
A. ICD-10 Code(s)										B.		C.																	
E.										F.		G.																	
I.										J.		K.																	
23. PRIOR AUTHORIZATION NUMBER												10D2345678																	
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From To										SERVICE				CPT/HCPCS MODIFIER															
11 01 23 11 01 23										11				83861 QW RT 59				A		50 00		1				NPI 1234567890			
11 01 23 11 01 23										11				83861 QW LT 59				A		50 00		1				NPI 1234567890			

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In loop 2300, Segment REFO2, enter the CLIA Certification number – 10 digits - (Do not enter “CLIA” with the certificate number as this will cause claims to deny as an invalid identification number).

Field #	Claim Description	Loop	Segment	Electronic Description
23.	Prior Authorization number	2300	REF01	Reference identification qualifier =X4
			REF02	CLIA Certification number

## Common Notification Reasons for Medicare Denials

If there is no CLIA number on the claim, Medicare sends RA messages MA 120 and MA 130, which state:

- MA 120 - Did not complete or enter accurately the CLIA number.
- MA 130 - Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is un-processable. Please submit the correct information to the appropriate FI or carrier.
- B7 - "This provider was not certified/eligible to be paid for this procedure/service on this date of service."
- The laboratory is not approved for this type of test



# MARYLAND BILLING GUIDE



If any denial is received for CPT 83861 contact the Trukera Reimbursement Support Center promptly at [rsc@trukera.com](mailto:rsc@trukera.com) for assistance

## Reimbursement Support Specialist

Bridget Bolles

Cell: (317) 797-7151

Fax: (858) 225-8749

Email: [bbolles@trukera.com](mailto:bbolles@trukera.com)

### This guide addresses billing recommendation for:

- **CPT Code 83861** is specific for “Microfluidic analysis utilizing an integrated collection and analysis device, tear osmolality”.
- A covered service by CMS Medicare under the Clinical Laboratory Fee Schedule.
- CLIA Certificate of Waiver is required to perform and bill this laboratory tests.
- Providers are encouraged to review payor-provider contracts for rate and claim submission requirements.
- Medical Necessity requires current signs or symptoms of disease at time of test.
- Frequency of testing is based on Medical Necessity as determined by the clinician.
- Laboratory Test - multiple procedure discounts do not apply.

Payor Name	Lines	Modifier(s)	Units per Line
Medicare	2	QW/RT/LT	1
Carefirst	2	RT/LT	1
Aetna	2	RT/LT	1
Cigna	2	RT/LT	1
United HC	1	QW	2
Priority	1	none	2
Anthem	2	RT/LT	1
Humana Medicare	2	QW/RT/LT 59	1
BCBS FED	2	RT/LT	1
UHC Community	1	QW	2
Medicaid	2	QW/RT/LT	1

### Maryland Providers:

Humana Commercial: Will deny claim (**Diagnostic testing for dry eye syndrome is not separately reimbursable**).

## Billing Format Examples

**Medicare:** Note the CLIA # in box 23 and the QW/RT, QW/LT in box 24D are required for processing. **The QW modifier should be placed first.** Claims lacking these elements will reject.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES												
Dr. Trukera Medical										17b. NPI		1234567890												
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES												
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO												
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.												
A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER												
E. _____												10D2345678												
I. _____																								
J. _____																								
24. A. DATE(S) OF SERVICE			B. PLACE OF SERVICE			C. EMG			D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
MM	DD	YY	MM	DD	YY				CPT/HCPCS	MODIFIER														
11	01	23	11	01	23	11			83861	QW	RT			A		50	00	1				NPI	1234567890	
11	01	23	11	01	23	11			83861	QW	LT			A		50	00	1				NPI	1234567890	

**Most Commercial Plans:** Note that the QW and CLIA # are not required.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES												
Dr. Trukera Medical										17b. NPI		1234567890												
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES												
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO												
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.												
A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER												
E. _____																								
I. _____																								
J. _____																								
24. A. DATE(S) OF SERVICE			B. PLACE OF SERVICE			C. EMG			D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
MM	DD	YY	MM	DD	YY				CPT/HCPCS	MODIFIER														
11	01	23	11	01	23	11			83861		RT			A		50	00	1				NPI	1234567890	
11	01	23	11	01	23	11			83861		LT			A		50	00	1				NPI	1234567890	

**United Health Care Commercial Plans:** UHC does not recognize the RT/LT modifiers. The CLIA number is required in box 23 with the **QW Modifier only** with 2 units of service. Double the billed charge.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES												
Dr. Trukera Medical										17b. NPI		1234567890												
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES												
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO												
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.												
A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER												
E. _____												10D2345678												
I. _____																								
J. _____																								
24. A. DATE(S) OF SERVICE			B. PLACE OF SERVICE			C. EMG			D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
MM	DD	YY	MM	DD	YY				CPT/HCPCS	MODIFIER														
11	01	23	11	01	23	11			83861	QW				A		100	00	2				NPI	1234567890	
																						NPI		

**Humana Medicare Advantage Plans:** Humana requires additional modifiers. The CLIA number is required in box 23 with the **QW/RT/LT/59** with 2 lines of service, 1 unit per line

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																							
Dr. Trukera Medical										17b. NPI		1234567890																							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES																							
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.																							
A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER																							
B. [ ]												10D2345678																							
C. [ ]																																			
D. [ ]																																			
E. [ ]																																			
F. [ ]																																			
G. [ ]																																			
H. [ ]																																			
I. [ ]																																			
J. [ ]																																			
K. [ ]																																			
L. [ ]																																			
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)										E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From To										SERVICE				CPT/HCPCS MODIFIER																					
MM DD YY MM DD YY																																			
11 01 23 11 01 23										11				83861 QW RT 59										A		50 00		1				NPI		1234567890	
11 01 23 11 01 23										11				83861 QW LT 59										A		50 00		1				NPI		1234567890	

### Reimbursement for Medicare Part B (fee-for-service)

**2023-2024 Clinical Laboratory Fee Schedule (CLFS) Rate:** \$22.48 per test (\$44.96 per patient)

#### Sequestration Withhold

- Medicare intermediaries are required to withhold two-percent of the allowable.

#### Medicare CMS Part B

- CMS Medicare pays at 100% of CLFS throughout the United States.
- No deductible or patient co-payment applies.
- Free standing, global lab code.
- CLIA Certification required.

#### Billing Software Requirements

- **ANSI 5010 E-claim Crosswalk**

In loop 2300, Segment REFO2, enter the CLIA Certification number – 10 digits - (Do not enter “CLIA” with the certificate number as this will cause claims to deny as an invalid identification number).

Field #	Claim Description	Loop	Segment	Electronic Description
23.	Prior Authorization number	2300	REF01	Reference identification qualifier =X4
			REF02	CLIA Certification number

## Common Notification Reasons for Medicare Denials

If there is no CLIA number on the claim, Medicare sends RA messages MA 120 and MA 130, which state:

- MA 120 - Did not complete or enter accurately the CLIA number.
- MA 130 - Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is un-processable. Please submit the correct information to the appropriate FI or carrier.
- B7 - "This provider was not certified/eligible to be paid for this procedure/service on this date of service."
- The laboratory is not approved for this type of test

# MASSACHUSETTS BILLING GUIDE



If any denial is received for CPT 83861 contact the Trukera Reimbursement Support Center promptly at [rsc@trukera.com](mailto:rsc@trukera.com) for assistance

## Reimbursement Support Specialist

Bridget Bolles

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Email: [bbolles@trukera.com](mailto:bbolles@trukera.com)

### This guide addresses billing recommendation for:

- **CPT Code 83861** is specific for “Microfluidic analysis utilizing an integrated collection and analysis device, tear osmolality”.
- A covered service by CMS Medicare under the Clinical Laboratory Fee Schedule.
- CLIA Certificate of Waiver is required to perform and bill this laboratory tests.
- Providers are encouraged to review payor-provider contracts for rate and claim submission requirements.
- Medical Necessity requires current signs or symptoms of disease at time of test.
- Frequency of testing is based on Medical Necessity as determined by the clinician.
- Laboratory Test - multiple procedure discounts do not apply.

Payor Name	Lines	Modifier(s)	Units per Line
Medicare	2	QW/RT/LT	1
BCBS MA	2	RT/LT	1
Tufts	1	none	2
MA Medicaid	1	none	2
Harvard Pilgrim	1	none	2
United HC	1	QW	2
BMC Healthnet	2	RT/LT	1
Fallon HP	2	RT/LT	1
Allways HP	2	QW/RT/LT	1
Cigna	2	RT/LT	1
Health New England MC	2	RT/LT	1

### Massachusetts Providers:

**Mass Health:** Provider profile should be updated by faxing CLIA cert to enrollment/credentialing dept. at fax# (617) 988 8974. When entering claims, make sure box 17 is rendering provider, rather than referring.

**Humana Commercial:** Will deny claim (**Diagnostic testing for dry eye syndrome is not separately reimbursable**).

## Billing Format Examples

**Medicare:** Note the CLIA # in box 23 and the QW/RT, QW/LT in box 24D are required for processing. **The QW modifier should be placed first.** Claims lacking these elements will reject.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES									
										17b. NPI		1234567890									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? \$ CHARGES											
										<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.										22. RESUBMISSION CODE ORIGINAL REF. NO.											
A. ICD-10 Code(s)																					
E. _____										23. PRIOR AUTHORIZATION NUMBER											
I. _____										10D2345678											
24. A. DATE(S) OF SERVICE			B. PLACE OF SERVICE		C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER	F. \$ CHARGES		G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #					
From To			Service			CPT/HCPCS MODIFIER															
MM DD YY			MM DD YY																		
11 01 23			11 01 23		11	83861 QW RT				A	50 00		1		NPI 1234567890						
11 01 23			11 01 23		11	83861 QW LT				A	50 00		1		NPI 1234567890						

**Most Commercial Plans:** Note that the QW and CLIA # are not required.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES									
										17b. NPI		1234567890									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? \$ CHARGES											
										<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.										22. RESUBMISSION CODE ORIGINAL REF. NO.											
A. ICD-10 Code(s)																					
E. _____										23. PRIOR AUTHORIZATION NUMBER											
I. _____																					
24. A. DATE(S) OF SERVICE			B. PLACE OF SERVICE		C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER	F. \$ CHARGES		G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #					
From To			Service			CPT/HCPCS MODIFIER															
MM DD YY			MM DD YY																		
11 01 23			11 01 23		11	83861 RT				A	50 00		1		NPI 1234567890						
11 01 23			11 01 23		11	83861 LT				A	50 00		1		NPI 1234567890						

**United Health Care Commercial Plans:** UHC does not recognize the RT/LT modifiers. The CLIA number is required in box 23 with the **QW Modifier only** with 2 units of service. Double the billed charge.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES									
										17b. NPI		1234567890									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? \$ CHARGES											
										<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.										22. RESUBMISSION CODE ORIGINAL REF. NO.											
A. ICD-10 Code(s)																					
E. _____										23. PRIOR AUTHORIZATION NUMBER											
I. _____										10D2345678											
24. A. DATE(S) OF SERVICE			B. PLACE OF SERVICE		C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER	F. \$ CHARGES		G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #					
From To			Service			CPT/HCPCS MODIFIER															
MM DD YY			MM DD YY																		
11 01 23			11 01 23		11	83861 QW				A	100 00		2		NPI 1234567890						
															NPI						

**Humana Medicare Advantage Plans:** Humana requires additional modifiers. The CLIA number is required in box 23 with the **QW/RT/LT/59** with 2 lines of service, 1 unit per line

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																							
										17b. NPI		1234567890																							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES																							
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)												22. RESUBMISSION CODE ORIGINAL REF. NO.																							
A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER																							
B.												10D2345678																							
C.																																			
D.																																			
E.																																			
F.																																			
G.																																			
H.																																			
I.																																			
J.																																			
K.																																			
L.																																			
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)										E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From To										SERVICE				CPT/HCPCS MODIFIER																					
MM	DD	YY	MM	DD	YY																														
11	01	23	11	01	23	11				83861	QW	RT	59			A		50	00	1				NPI		1234567890									
11	01	23	11	01	23	11				83861	QW	LT	59			A		50	00	1				NPI		1234567890									

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- Medicare intermediaries are required to withhold two-percent of the allowable.

#### Medicare CMS Part B

- CMS Medicare pays at 100% of CLFS throughout the United States.
- No deductible or patient co-payment applies.
- Free standing, global lab code.
- CLIA Certification required.

#### Billing Software Requirements

- **ANSI 5010 E-claim Crosswalk**

In loop 2300, Segment REFO2, enter the CLIA Certification number – 10 digits - (Do not enter “CLIA” with the certificate number as this will cause claims to deny as an invalid identification number).

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			REF02	CLIA Certification number

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- MA 130 - Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is un-processable. Please submit the correct information to the appropriate FI or carrier.
- B7 - "This provider was not certified/eligible to be paid for this procedure/service on this date of service."
- The laboratory is not approved for this type of test



# Michigan BILLING GUIDE



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## Reimbursement Support Specialist

Bridget Bolles

Cell: (317) 797-7151

Fax: (858) 225-8749

Email: [bbolles@trukera.com](mailto:bbolles@trukera.com)

### This guide addresses billing recommendation for:

- **CPT Code 83861** is specific for “Microfluidic analysis utilizing an integrated collection and analysis device, tear osmolality”.
- A covered service by CMS Medicare under the Clinical Laboratory Fee Schedule.
- CLIA Certificate of Waiver is required to perform and bill this laboratory tests.
- Providers are encouraged to review payor-provider contracts for rate and claim submission requirements.
- Medical Necessity requires current signs or symptoms of disease at time of test.
- Frequency of testing is based on Medical Necessity as determined by the clinician.
- Laboratory Test - multiple procedure discounts do not apply.

Payor Name	Lines	Modifier(s)	Units per Line
BCBS Federal	1	No Mod	2
BCBS MI	1	No Mod	2
BCN Advantage	2	QW/RT/LT	1
Cigna	2	RT/LT	1
Golden Rule	1	QW	2
Health Alliance Plan (HAP)	2	RT/LT	1
McLaren Health	2	RT/LT	1
Medicaid MI	1	QW	2
Humana Medicare	2	QW/RT/LT/59	1
Medicare	2	QW/RT/LT	1
Medicare Plus Blue	2	RT/LT	1
Meridian Health Plan	1	QW	2
Molina	1	QW	2
Priority Health	2	QW/RT/LT/59	1
PHP	2	QW/RT/LT	1
Total Health Plan	1	QW	2
UHC Community Plan	1	QW	2
United Healthcare	1	QW	2

**Michigan Providers:**

**Humana Commercial:** Will deny claim (Diagnostic testing for dry eye syndrome is not separately reimbursable).

**BLUE Cross and Blue Shield Mi:**

The following BCBS MI benefit plans do not cover CPT 83861:

- AUTO GROUPS,
- URMBT (UAW Retiree Medical Benefits Trust),
- MPSERS, Messa, and SOM.

**BLUE Cross and Blue Shield Mi Contact Numbers:**

**BCBSM, BCN, BCNA, :**

• Provider Automated Response System (PARS) 1-800-344-8525

**BCBSM-Blue Cross Blue Shield of Michigan:**

• Provider Inquiry 1-800-245-9092

**BCBSM-Medicare Advantage:**

• Provider Inquiry 1-866-309-1719

**BCC-Blue Cross Complete (AmeriHealth):**

• Provider Inquiry, Eligibility or Claim Status Inquiry 1-888-312-5713

**BCN-Blue Care Network and BCNA-Blue Care Network Advantage:**

• Provider Inquiry 1-800-255-1690

**Billing Format Examples**

**Medicare:** Note the CLIA # in box 23 and the QW/RT, QW/LT in box24D are required for processing. **The QW modifier should be placed first.** Claims lacking these elements will reject.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																	
										17b. NPI		1234567890		FROM		MM		DD		YY		TO		MM		DD		YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)															20. OUTSIDE LAB? \$ CHARGES														
															<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO														
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.															22. RESUBMISSION CODE ORIGINAL REF. NO.														
A. ICD-10 Code(s)																													
B. _____																													
C. _____																													
D. _____																													
E. _____																													
F. _____																													
G. _____																													
H. _____																													
I. _____																													
J. _____																													
K. _____																													
L. _____															23. PRIOR AUTHORIZATION NUMBER														
															10D2345678														
24. A. DATE(S) OF SERVICE			B. PLACE OF SERVICE			C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)					E. DIAGNOSIS POINTER	F. \$ CHARGES		G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #											
MM	DD	YY	MM	DD	YY		CPT/HCPCS	MODIFIER																					
11	01	23	11	01	23	11	83861	QW RT				A	50 00	1			NPI	1234567890											
11	01	23	11	01	23	11	83861	QW LT				A	50 00	1			NPI	1234567890											

**Most Commercial Plans:** Note that the QW and CLIA # are not required.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																	
										17b. NPI		1234567890																	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? \$ CHARGES																			
										<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION ORIGINAL REF. NO.																	
A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER																	
E.																													
I.																													
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From			To																										
MM	DD	YY	MM	DD	YY	SERVICE	EMG	CPT/HCPCS	MODIFIER							\$													
11	01	23	11	01	23	11		83861	RT					A		50	00	1				NPI	1234567890						
11	01	23	11	01	23	11		83861	LT					A		50	00	1				NPI	1234567890						

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17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																	
										17b. NPI		1234567890																	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? \$ CHARGES																			
										<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION ORIGINAL REF. NO.																	
A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER																	
E.												10D2345678																	
I.																													
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From			To																										
MM	DD	YY	MM	DD	YY	SERVICE	EMG	CPT/HCPCS	MODIFIER							\$													
11	01	23	11	01	23	11		83861	QW					A		100	00	2				NPI	1234567890						
																						NPI							

**Humana Medicare Advantage Plans:** Humana requires additional modifiers. The CLIA number is required in box 23 with the **QW/RT/LT/59** with 2 lines of service, 1 unit per line

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																							
Dr. Trukera Medical										17b. NPI		1234567890																							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES																							
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.																							
A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER																							
B. [ ]												10D2345678																							
C. [ ]																																			
D. [ ]																																			
E. [ ]																																			
F. [ ]																																			
G. [ ]																																			
H. [ ]																																			
I. [ ]																																			
J. [ ]																																			
K. [ ]																																			
L. [ ]																																			
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)										E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From To										SERVICE				CPT/HCPCS MODIFIER																					
MM DD YY MM DD YY																																			
11 01 23 11 01 23										11				83861 QW RT 59										A		50 00		1				NPI		1234567890	
11 01 23 11 01 23										11				83861 QW LT 59										A		50 00		1				NPI		1234567890	

### Reimbursement for Medicare Part B (fee-for-service)

**2023-2024 Clinical Laboratory Fee Schedule (CLFS) Rate:** \$22.48 per test (\$44.96 per patient)

#### Sequestration Withhold

- Medicare intermediaries are required to withhold two-percent of the allowable.

#### Medicare CMS Part B

- CMS Medicare pays at 100% of CLFS throughout the United States.
- No deductible or patient co-payment applies.
- Free standing, global lab code.
- CLIA Certification required.

#### Billing Software Requirements

- **ANSI 5010 E-claim Crosswalk**

In loop 2300, Segment REFO2, enter the CLIA Certification number – 10 digits - (Do not enter “CLIA” with the certificate number as this will cause claims to deny as an invalid identification number).

Field #	Claim Description	Loop	Segment	Electronic Description
23.	Prior Authorization number	2300	REF01	Reference identification qualifier =X4
			REF02	CLIA Certification number

## Common Notification Reasons for Medicare Denials

If there is no CLIA number on the claim, Medicare sends RA messages MA 120 and MA 130, which state:

- MA 120 - Did not complete or enter accurately the CLIA number.
- MA 130 - Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is un-processable. Please submit the correct information to the appropriate FI or carrier.
- B7 - "This provider was not certified/eligible to be paid for this procedure/service on this date of service."
- The laboratory is not approved for this type of test

# Minnesota BILLING GUIDE



If any denial is received for CPT 83861 contact the Trukera Reimbursement Support Center promptly at [rsc@trukera.com](mailto:rsc@trukera.com) for assistance

## Reimbursement Support Specialist

Bridget Bolles

Cell: (317) 797-7151

Fax: (858) 225-8749

Email: [bbolles@trukera.com](mailto:bbolles@trukera.com)

### This guide addresses billing recommendation for:

- **CPT Code 83861** is specific for “Microfluidic analysis utilizing an integrated collection and analysis device, tear osmolality”.
- A covered service by CMS Medicare under the Clinical Laboratory Fee Schedule.
- CLIA Certificate of Waiver is required to perform and bill this laboratory tests.
- Providers are encouraged to review payor-provider contracts for rate and claim submission requirements.
- Medical Necessity requires current signs or symptoms of disease at time of test.
- Frequency of testing is based on Medical Necessity as determined by the clinician.
- Laboratory Test - multiple procedure discounts do not apply.

Payor Name	Lines	Modifier(s)	Units per Line
Aetna	2	RT/LT	1
BCBS MN	2	RT/LT	1
Cigna	2	RT/LT	1
Health Alliance	2	RT/LT	1
Health Partners	2	RT/LT	1
Humana Medicare	2	QW/RT/LT/ 59	1
McLaren Health	2	RT/LT	1
Medica	1	None	2
Medicaid MN	2	QW/RT/LT	1
Medicare	2	QW/RT/LT	1
Meridian Health Plan	2	RT/LT	1
Molina	1	QW	2
Preferred One	1	RT/LT	1
Priority Health	2	QW/RT/LT 59	1
UCare	2	QW/ 91(2 <sup>nd</sup> line)	1
UHC Community Plan	1	QW	2
United Healthcare	1	QW	2

**Minnesota Providers:**

**Humana Commercial:** Will deny claim (Diagnostic testing for dry eye syndrome is not separately reimbursable).

**Minnesota Health Care Programs (MHCP):** Provider need to fax CLIA Certification and Provider NPI MHCP Provider Enrollment. ( 1-651-431-7462)

**Billing Format Examples**

**Medicare:** Note the CLIA # in box 23 and the QW/RT, QW/LT in box24D are required for processing. **The QW modifier should be placed first.** Claims lacking these elements will reject.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																							
Dr. Trukera Medical										17b. NPI		1234567890																							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES																							
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.																							
A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER																							
B.												10D2345678																							
C.																																			
D.																																			
E.																																			
F.																																			
G.																																			
H.																																			
I.																																			
J.																																			
K.																																			
L.																																			
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)										E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From To														CPT/HCPCS MODIFIER																					
MM DD YY MM DD YY																																			
11 01 23 11 01 23										11				83861 QW RT										A		50 00		1				NPI		1234567890	
11 01 23 11 01 23										11				83861 QW LT										A		50 00		1				NPI		1234567890	

**Most Commercial Plans:** Note that the QW and CLIA # are not required.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																							
Dr. Trukera Medical										17b. NPI		1234567890																							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES																							
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.																							
A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER																							
B.																																			
C.																																			
D.																																			
E.																																			
F.																																			
G.																																			
H.																																			
I.																																			
J.																																			
K.																																			
L.																																			
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)										E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From To														CPT/HCPCS MODIFIER																					
MM DD YY MM DD YY																																			
11 01 23 11 01 23										11				83861 RT										A		50 00		1				NPI		1234567890	
11 01 23 11 01 23										11				83861 LT										A		50 00		1				NPI		1234567890	





**Humana Medicare Advantage Plans:** Humana requires additional modifiers. The CLIA number is required in box 23 with the **QW/RT/LT/59** with 2 lines of service, 1 unit per line

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																							
Dr. Trukera Medical										17b. NPI		1234567890																							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES																							
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.																							
A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER																							
B. [ ]												10D2345678																							
C. [ ]																																			
D. [ ]																																			
E. [ ]																																			
F. [ ]																																			
G. [ ]																																			
H. [ ]																																			
I. [ ]																																			
J. [ ]																																			
K. [ ]																																			
L. [ ]																																			
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)										E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From To										SERVICE				CPT/HCPCS MODIFIER																					
MM DD YY MM DD YY																																			
11 01 23 11 01 23										11				83861 QW RT 59										A		50 00		1				NPI		1234567890	
11 01 23 11 01 23										11				83861 QW LT 59										A		50 00		1				NPI		1234567890	

### Reimbursement for Medicare Part B (fee-for-service)

**2023-2024 Clinical Laboratory Fee Schedule (CLFS) Rate:** \$22.48 per test (\$44.96 per patient)

#### Sequestration Withhold

- Medicare intermediaries are required to withhold two-percent of the allowable.

#### Medicare CMS Part B

- CMS Medicare pays at 100% of CLFS throughout the United States.
- No deductible or patient co-payment applies.
- Free standing, global lab code.
- CLIA Certification required.

#### Billing Software Requirements

- **ANSI 5010 E-claim Crosswalk**

In loop 2300, Segment REFO2, enter the CLIA Certification number – 10 digits - (Do not enter “CLIA” with the certificate number as this will cause claims to deny as an invalid identification number).

Field #	Claim Description	Loop	Segment	Electronic Description
23.	Prior Authorization number	2300	REF01	Reference identification qualifier =X4
			REF02	CLIA Certification number

## Common Notification Reasons for Medicare Denials

If there is no CLIA number on the claim, Medicare sends RA messages MA 120 and MA 130, which state:

- MA 120 - Did not complete or enter accurately the CLIA number.
- MA 130 - Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is un-processable. Please submit the correct information to the appropriate FI or carrier.
- B7 - "This provider was not certified/eligible to be paid for this procedure/service on this date of service."
- The laboratory is not approved for this type of test

# MISSISSIPPI BILLING GUIDE



If any denial is received for CPT 83861 contact the Trukera Medical Reimbursement Support Center promptly at [rsc@trukera.com](mailto:rsc@trukera.com) for assistance.

## Reimbursement Support Specialist

Amanda Rotteck  
Cell: (704) 928-9009

Fax: (858) 225-8749  
Email: [arotteck@trukera.com](mailto:arotteck@trukera.com)

### This guide addresses billing recommendation for:

- **CPT Code 83861** is specific for “Microfluidic analysis utilizing an integrated collection and analysis device, tear osmolality”.
- A covered service by CMS Medicare under the Clinical Laboratory Fee Schedule.
- CLIA Certificate of Waiver is required to perform and bill this laboratory tests.
- Providers are encouraged to review payor-provider contracts for rate and claim submission requirements.
- Medical Necessity requires current signs or symptoms of disease at time of test.
- Frequency of testing is based on Medical Necessity as determined by the clinician.
- Laboratory Test - multiple procedure discounts do not apply.

Payor Name	Lines	Modifier(s)	Units per Line
Aetna	2	RT/LT	1
BCBS MS	2	RT/LT	1
Cigna	2	RT/LT	1
Humana Medicare	2	QW/RT/LT/59	1
Medicaid MS	2	QW/RT/LT	1
Medicare	2	QW/RT/LT	1
Molina	1	QW	2
United Healthcare	1	QW	2
UHC Community Plan	1	QW	2

## Billing Format Examples

**Medicare:** Note the CLIA # in box 23 and the QW/RT, QW/LT in box 24D are required for processing. **The QW modifier should be placed first.** Claims lacking these elements will be rejected.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																							
Dr. Trukera Medical										17b. NPI		1234567890																							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES																							
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.																							
A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER																							
B. _____												10D2345678																							
C. _____																																			
D. _____																																			
E. _____																																			
F. _____																																			
G. _____																																			
H. _____																																			
I. _____																																			
J. _____																																			
K. _____																																			
L. _____																																			
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)										E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From To														CPT/HCPCS MODIFIER																					
MM DD YY MM DD YY																																			
11 01 23 11 01 23										11				83861 QW RT										A		50 00		1				NPI		1234567890	
11 01 23 11 01 23										11				83861 QW LT										A		50 00		1				NPI		1234567890	

**Most Commercial Plans:** Note that the QW and CLIA # are not required.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																							
Dr. Trukera Medical										17b. NPI		1234567890																							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES																							
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.																							
A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER																							
B. _____																																			
C. _____																																			
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G. _____																																			
H. _____																																			
I. _____																																			
J. _____																																			
K. _____																																			
L. _____																																			
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)										E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From To														CPT/HCPCS MODIFIER																					
MM DD YY MM DD YY																																			
11 01 23 11 01 23										11				83861 RT										A		50 00		1				NPI		1234567890	
11 01 23 11 01 23										11				83861 LT										A		50 00		1				NPI		1234567890	

**United Health Care Commercial Plans:** UHC does not recognize the RT/LT modifiers. The CLIA number is required in box 23 with the **QW Modifier only** with 2 units of service. Double the billed charge.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																							
Dr. Trukera Medical										17b. NPI		1234567890																							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES																							
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.																							
A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER																							
B. _____												10D2345678																							
C. _____																																			
D. _____																																			
E. _____																																			
F. _____																																			
G. _____																																			
H. _____																																			
I. _____																																			
J. _____																																			
K. _____																																			
L. _____																																			
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)										E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From To														CPT/HCPCS MODIFIER																					
MM DD YY MM DD YY																																			
11 01 23 11 01 23										11				83861 QW										A		100 00		2				NPI		1234567890	

**Humana Medicare Advantage Plans:** Humana requires additional modifiers. The CLIA number is required in box 23 with the QW/RT/LT/59 with 2 lines of service, 1 unit per line.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical		17a.	17b. NPI 1234567890		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY													
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)					20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO													
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. ICD-10 Code(s) B. C. D. E. F. G. H. I. J. K. L.					22. RESUBMISSION CODE ORIGINAL REF. NO.													
23. PRIOR AUTHORIZATION NUMBER 10D2345678					24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #													
11	01	23	11	01	23	11		83861	QW	RT	59	A	50	00	1		NPI	1234567890
11	01	23	11	01	23	11		83861	QW	LT	59	A	50	00	1		NPI	1234567890

### Reimbursement for Medicare Part B (fee-for-service)

**2021-2024 Clinical Laboratory Fee Schedule (CLFS) Rate:** \$22.48 per test (\$44.96 per patient)

### Sequestration Withhold

- Medicare intermediaries are required to withhold two percent of the allowable.

### Medicare CMS Part B

- CMS Medicare pays at 100% of CLFS throughout the United States.
- No deductible or patient co-payment applies.
- Free standing, global lab code.
- CLIA Certification required.

### Billing Software Requirements

#### - ANSI 5010 E-claim Crosswalk

In loop 2300, Segment REFO2, enter the CLIA Certification number – 10 digits - (Do not enter “CLIA” with the certificate number as this will cause claims to deny as an invalid identification number).

Field #	Claim Description	Loop	Segment	Electronic Description
23.	Prior Authorization number	2300	REF01	Reference identification qualifier =X4
			REF02	CLIA Certification number

### Common Notification Reasons for Medicare Denials

If there is no CLIA number on the claim, Medicare sends RA messages MA 120 and MA 130, which state:

- MA 120 - Did not complete or enter accurately the CLIA number.
- MA 130 - Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is un-processable. Please submit the correct information to the appropriate FI or carrier.
- B7 - "This provider was not certified/eligible to be paid for this procedure/service on this date of service."
- The laboratory is not approved for this type of test.

# MISSOURI BILLING GUIDE



If any denial is received for CPT 83861 contact the Trukera Medical Reimbursement Support Center promptly at [rsc@trukera.com](mailto:rsc@trukera.com) for assistance.

## Reimbursement Support Specialist

Amanda Rotteck  
Cell: (704) 928-9009

Fax: (858) 225-8749  
Email: [arotteck@trukera.com](mailto:arotteck@trukera.com)

### This guide addresses billing recommendation for:

- **CPT Code 83861** is specific for “Microfluidic analysis utilizing an integrated collection and analysis device, tear osmolality.”
- A covered service by CMS Medicare under the Clinical Laboratory Fee Schedule.
- CLIA Certificate of Waiver is required to perform and bill this laboratory tests.
- Providers are encouraged to review payor-provider contracts for rate and claim submission requirements.
- Medical Necessity requires current signs or symptoms of disease at time of test.
- Frequency of testing is based on Medical Necessity as determined by the clinician.
- Laboratory Test - multiple procedure discounts do not apply.

Payor Name	Lines	Modifier(s)	Units per Line
Aetna	2	RT/LT	1
Anthem	2	RT/LT	1
BCBS KC	2	RT/LT	1
CIGNA	2	RT/LT	1
HealthNet	2	QW/RT/LT	1
Home - Medicaid	2	QW/RT/LT	1
Medicaid	2	QW/RT/LT	1
Medicare	2	QW/RT/LT	1
United Healthcare	1	QW	2
UHC Community	1	QW	2
Wellcare	2	RT/LT	1

### Missouri Providers:

**MO Medicaid:** To establish payment, it requires that the practice fax a copy of the CLIA certificate along with provider NPI numbers to Provider Enrollment, Fax# 1-573-751-5065

## Billing Format Examples

**Medicare:** Note the CLIA # in box 23 and the QW/RT, QW/LT in box 24D are required for processing. **The QW modifier should be placed first.** Claims lacking these elements will be rejected.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																	
										17b. NPI		1234567890																	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? \$ CHARGES																			
										<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										22. RESUBMISSION CODE ORIGINAL REF. NO.																			
A. ICD-10 Code(s)										23. PRIOR AUTHORIZATION NUMBER																			
B. _____										10D2345678																			
C. _____																													
D. _____																													
E. _____																													
F. _____																													
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H. _____																													
I. _____																													
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K. _____																													
L. _____																													
24. A. DATE(S) OF SERVICE From To										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
MM DD YY MM DD YY														CPT/HCPCS MODIFIER															
11 01 23 11 01 23										11				83861 QW RT				A		50 00		1				NPI 1234567890			
11 01 23 11 01 23										11				83861 QW LT				A		50 00		1				NPI 1234567890			

**Most Commercial Plans:** Note that the QW and CLIA # are not required.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																	
										17b. NPI		1234567890																	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? \$ CHARGES																			
										<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										22. RESUBMISSION CODE ORIGINAL REF. NO.																			
A. ICD-10 Code(s)										23. PRIOR AUTHORIZATION NUMBER																			
B. _____																													
C. _____																													
D. _____																													
E. _____																													
F. _____																													
G. _____																													
H. _____																													
I. _____																													
J. _____																													
K. _____																													
L. _____																													
24. A. DATE(S) OF SERVICE From To										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
MM DD YY MM DD YY														CPT/HCPCS MODIFIER															
11 01 23 11 01 23										11				83861 RT				A		50 00		1				NPI 1234567890			
11 01 23 11 01 23										11				83861 LT				A		50 00		1				NPI 1234567890			

**United Health Care Commercial Plans:** UHC does not recognize the RT/LT modifiers. The CLIA number is required in box 23 with the **QW Modifier only** with 2 units of service. Double the billed charge.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																	
										17b. NPI		1234567890																	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? \$ CHARGES																			
										<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										22. RESUBMISSION CODE ORIGINAL REF. NO.																			
A. ICD-10 Code(s)										23. PRIOR AUTHORIZATION NUMBER																			
B. _____										10D2345678																			
C. _____																													
D. _____																													
E. _____																													
F. _____																													
G. _____																													
H. _____																													
I. _____																													
J. _____																													
K. _____																													
L. _____																													
24. A. DATE(S) OF SERVICE From To										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
MM DD YY MM DD YY														CPT/HCPCS MODIFIER															
11 01 23 11 01 23										11				83861 QW				A		100 00		2				NPI 1234567890			



## Reimbursement for Medicare Part B (fee-for-service)

**2021-2024 Clinical Laboratory Fee Schedule (CLFS) Rate:** \$22.48 per test (\$44.96 per patient)

## Sequestration Withhold

- Medicare intermediaries are required to withhold two percent of the allowable.

## Medicare CMS Part B

- CMS Medicare pays at 100% of CLFS throughout the United States.
- No deductible or patient co-payment applies.
- Free standing, global lab code.
- CLIA Certification required.

## Billing Software Requirements

### - ANSI 5010 E-claim Crosswalk

In loop 2300, Segment REFO2, enter the CLIA Certification number – 10 digits - (Do not enter “CLIA” with the certificate number as this will cause claims to deny as an invalid identification number).

Field #	Claim Description	Loop	Segment	Electronic Description
23.	Prior Authorization number	2300	REF01	Reference identification qualifier =X4
			REF02	CLIA Certification number

## Common Notification Reasons for Medicare Denials

If there is no CLIA number on the claim, Medicare sends RA messages MA 120 and MA 130, which state:

- MA 120 - Did not complete or enter accurately the CLIA number.
- MA 130 - Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is un-processable. Please submit the correct information to the appropriate FI or carrier.
- B7 - “This provider was not certified/eligible to be paid for this procedure/service on this date of service.”
- The laboratory is not approved for this type of test.

# MONTANA BILLING GUIDE



If any denial is received for CPT 83861 contact the Trukera Reimbursement Support Center promptly at [rsc@trukera.com](mailto:rsc@trukera.com) for assistance

## Reimbursement Support Specialist

Bridget Bolles

Cell: (317) 797-7151

Fax: (858) 225-8749

Email: [bbolles@trukera.com](mailto:bbolles@trukera.com)

### This guide addresses billing recommendation for:

- **CPT Code 83861** is specific for “Microfluidic analysis utilizing an integrated collection and analysis device, tear osmolality”.
- A covered service by CMS Medicare under the Clinical Laboratory Fee Schedule.
- CLIA Certificate of Waiver is required to perform and bill this laboratory tests.
- Providers are encouraged to review payor-provider contracts for rate and claim submission requirements.
- Medical Necessity requires current signs or symptoms of disease at time of test.
- Frequency of testing is based on Medical Necessity as determined by the clinician.
- Laboratory Test - multiple procedure discounts do not apply.

Payor Name	Lines	Modifier(s)	Units per Line
Aetna	2	RT/LT	1
BCBS Federal Employee Plan	2	RT/LT	1
BCBS Montana	2	RT/LT	1
Cigna	2	RT/LT	1
HealthNet	2	QW/RT/LT	1
Humana Medicare	2	QW/RT/LT 59	1
Medicaid MT	2	QW/RT/LT	1
Medicare	2	QW/RT/LT	1
Pacificsource	2	RT/LT	1

**Montana Medicaid:** Send a copy of your CLIA certificate waiver to: is [mtprhelpdesk@conduent.com](mailto:mtprhelpdesk@conduent.com)

## Billing Format Examples

**Medicare:** Note the CLIA # in box 23 and the QW/RT, QW/LT in box 24D are required for processing. **The QW modifier should be placed first.** Claims lacking these elements will reject.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.											18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
										17b.	NPI 1234567890										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)																				22. RESUBMISSION CODE ORIGINAL REF. NO.										
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.																				23. PRIOR AUTHORIZATION NUMBER 10D2345678										
24. A. DATE(S) OF SERVICE		B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #										
MM	DD	YY	MM	DD	YY		CPT/HCPCS	MODIFIER																						
11	01	23	11	01	23	11	83861	QW	RT		A	50	00	1				NPI	1234567890											
11	01	23	11	01	23	11	83861	QW	LT		A	50	00	1				NPI	1234567890											

**Most Commercial Plans:** Note that the QW and CLIA # are not required.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.											18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
										17b.	NPI 1234567890										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)																				22. RESUBMISSION CODE ORIGINAL REF. NO.										
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.																				23. PRIOR AUTHORIZATION NUMBER										
24. A. DATE(S) OF SERVICE		B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #										
MM	DD	YY	MM	DD	YY		CPT/HCPCS	MODIFIER																						
11	01	23	11	01	23	11	83861		RT		A	50	00	1				NPI	1234567890											
11	01	23	11	01	23	11	83861		LT		A	50	00	1				NPI	1234567890											

**United Health Care Commercial Plans:** UHC does not recognize the RT/LT modifiers. The CLIA number is required in box 23 with the QW Modifier only with 2 units of service. Double the billed charge.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.											18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
										17b.	NPI 1234567890										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)																				22. RESUBMISSION CODE ORIGINAL REF. NO.										
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.																				23. PRIOR AUTHORIZATION NUMBER 10D2345678										
24. A. DATE(S) OF SERVICE		B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #										
MM	DD	YY	MM	DD	YY		CPT/HCPCS	MODIFIER																						
11	01	23	11	01	23	11	83861	QW			A	100	00	2				NPI	1234567890											

**Humana Medicare Advantage Plans:** Humana requires additional modifiers. The CLIA number is required in box 23 with the **QW/RT/LT/59** with 2 lines of service, 1 unit per line

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																							
Dr. Trukera Medical										17b. NPI		1234567890																							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES																							
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.																							
A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER																							
B. [ ]												10D2345678																							
C. [ ]																																			
D. [ ]																																			
E. [ ]																																			
F. [ ]																																			
G. [ ]																																			
H. [ ]																																			
I. [ ]																																			
J. [ ]																																			
K. [ ]																																			
L. [ ]																																			
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)										E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From To										SERVICE				CPT/HCPCS MODIFIER																					
MM DD YY MM DD YY																																			
11 01 23 11 01 23										11				83861 QW RT 59										A		50 00		1				NPI		1234567890	
11 01 23 11 01 23										11				83861 QW LT 59										A		50 00		1				NPI		1234567890	

### Reimbursement for Medicare Part B (fee-for-service)

**2023-2024 Clinical Laboratory Fee Schedule (CLFS) Rate:** \$22.48 per test (\$44.96 per patient)

#### Sequestration Withhold

- Medicare intermediaries are required to withhold two-percent of the allowable.

#### Medicare CMS Part B

- CMS Medicare pays at 100% of CLFS throughout the United States.
- No deductible or patient co-payment applies.
- Free standing, global lab code.
- CLIA Certification required.

#### Billing Software Requirements

- **ANSI 5010 E-claim Crosswalk**

In loop 2300, Segment REFO2, enter the CLIA Certification number – 10 digits - (Do not enter “CLIA” with the certificate number as this will cause claims to deny as an invalid identification number).

Field #	Claim Description	Loop	Segment	Electronic Description
23.	Prior Authorization number	2300	REF01	Reference identification qualifier =X4
			REF02	CLIA Certification number

## Common Notification Reasons for Medicare Denials

If there is no CLIA number on the claim, Medicare sends RA messages MA 120 and MA 130, which state:

- MA 120 - Did not complete or enter accurately the CLIA number.
- MA 130 - Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is un-processable. Please submit the correct information to the appropriate FI or carrier.
- B7 - "This provider was not certified/eligible to be paid for this procedure/service on this date of service."
- The laboratory is not approved for this type of test

# NEBRASKA BILLING GUIDE



If any denial is received for CPT 83861 contact the Trukera Reimbursement Support Center promptly at [rsc@trukera.com](mailto:rsc@trukera.com) for assistance

**Reimbursement Support Specialist**

Bridget Bolles

Cell: (317) 797-7151

Fax: (858) 225-8749

Email: [bbolles@trukera.com](mailto:bbolles@trukera.com)

**This guide addresses billing recommendation for:**

- **CPT Code 83861** is specific for “Microfluidic analysis utilizing an integrated collection and analysis device, tear osmolality”.
- A covered service by CMS Medicare under the Clinical Laboratory Fee Schedule.
- CLIA Certificate of Waiver is required to perform and bill this laboratory tests.
- Providers are encouraged to review payor-provider contracts for rate and claim submission requirements.
- Medical Necessity requires current signs or symptoms of disease at time of test.
- Frequency of testing is based on Medical Necessity as determined by the clinician.
- Laboratory Test - multiple procedure discounts do not apply.

Payor Name	Lines	Modifier(s)	Units per Line
Aetna	2	RT/LT	1
BCBS Federal Employee Plan	2	RT/LT	1
BCBS NE	1	None	2
Cigna	2	RT/LT	1
HealthNet	2	QW/RT/LT	1
Medica Health Plans	2	RT/LT	1
Medicaid NE	2	QW/RT/LT	1
Medicare	2	QW/RT/LT	1
UHC Community Plan	1	QW	2
United Healthcare	1	QW	2
Wellcare	2	RT/LT	1



**Humana Medicare Advantage Plans:** Humana requires additional modifiers. The CLIA number is required in box 23 with the **QW/RT/LT/59** with 2 lines of service, 1 unit per line

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																							
Dr. Trukera Medical										17b. NPI		1234567890																							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES																							
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.																							
A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER																							
B. [ ]												10D2345678																							
C. [ ]																																			
D. [ ]																																			
E. [ ]																																			
F. [ ]																																			
G. [ ]																																			
H. [ ]																																			
I. [ ]																																			
J. [ ]																																			
K. [ ]																																			
L. [ ]																																			
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)										E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From To										SERVICE				CPT/HCPCS MODIFIER																					
MM DD YY MM DD YY																																			
11 01 23 11 01 23										11				83861 QW RT 59										A		50 00		1				NPI		1234567890	
11 01 23 11 01 23										11				83861 QW LT 59										A		50 00		1				NPI		1234567890	

### Reimbursement for Medicare Part B (fee-for-service)

**2023-2024 Clinical Laboratory Fee Schedule (CLFS) Rate:** \$22.48 per test (\$44.96 per patient)

#### Sequestration Withhold

- Medicare intermediaries are required to withhold two-percent of the allowable.

#### Medicare CMS Part B

- CMS Medicare pays at 100% of CLFS throughout the United States.
- No deductible or patient co-payment applies.
- Free standing, global lab code.
- CLIA Certification required.

#### Billing Software Requirements

- **ANSI 5010 E-claim Crosswalk**

In loop 2300, Segment REFO2, enter the CLIA Certification number – 10 digits - (Do not enter “CLIA” with the certificate number as this will cause claims to deny as an invalid identification number).

Field #	Claim Description	Loop	Segment	Electronic Description
23.	Prior Authorization number	2300	REF01	Reference identification qualifier =X4
			REF02	CLIA Certification number



## Common Notification Reasons for Medicare Denials

If there is no CLIA number on the claim, Medicare sends RA messages MA 120 and MA 130, which state:

- MA 120 - Did not complete or enter accurately the CLIA number.
- MA 130 - Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is un-processable. Please submit the correct information to the appropriate FI or carrier.
- B7 - "This provider was not certified/eligible to be paid for this procedure/service on this date of service."
- The laboratory is not approved for this type of test

# NEVADA BILLING GUIDE



If any denial is received for CPT 83861 contact the Trukera Medical Reimbursement Support Center promptly at [rsc@trukera.com](mailto:rsc@trukera.com) for assistance.

## Reimbursement Support Specialist

Amanda Rotteck  
Cell: (704) 928-9009

Fax: (858) 225-8749  
Email: [arotteck@trukera.com](mailto:arotteck@trukera.com)

### This guide addresses billing recommendation for:

- **CPT Code 83861** is specific for “Microfluidic analysis utilizing an integrated collection and analysis device, tear osmolality.”
- A covered service by CMS Medicare under the Clinical Laboratory Fee Schedule.
- CLIA Certificate of Waiver is required to perform and bill this laboratory tests.
- Providers are encouraged to review payor-provider contracts for rate and claim submission requirements.
- Medical Necessity requires current signs or symptoms of disease at time of test.
- Frequency of testing is based on Medical Necessity as determined by the clinician.
- Laboratory Test - multiple procedure discounts do not apply.

Payor Name	Lines	Modifier(s)	Units per Line
Aetna	2	RT/LT	1
Anthem	2	RT/LT	1
Cigna	2	RT/LT	1
HealthNet	2	QW/RT/LT	1
Humana Medicare	2	QW/RT/LT/59	1
Medicaid NV	2	QW/RT/LT	1
Medicare	2	QW/RT/LT	1
Sierra Life	2	RT/LT	1
United Healthcare	1	QW	2

## Billing Format Examples

**Medicare:** Note the CLIA # in box 23 and the QW/RT, QW/LT in box 24D are required for processing. **The QW modifier should be placed first.** Claims lacking these elements will be rejected.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE				17a.		17b. NPI		1234567890				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES												
Dr. Trukera Medical												FROM MM DD YY TO MM DD YY												
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES												
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO												
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)												22. RESUBMISSION CODE ORIGINAL REF. NO.												
A. ICD-10 Code(s) B. C. D. E. F. G. H. I. J. K. L.												23. PRIOR AUTHORIZATION NUMBER												
												10D2345678												
24. A. DATE(S) OF SERVICE			B. PLACE OF SERVICE			C. EMG			D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)			E. DIAGNOSIS POINTER			F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From To									CPT/HCPCS MODIFIER			A			50 00		1		NPI		1234567890			
11 01 23 11 01 23			11			83861			QW RT			A			50 00		1		NPI		1234567890			
11 01 23 11 01 23			11			83861			QW LT			A			50 00		1		NPI		1234567890			

**Most Commercial Plans:** Note that the QW and CLIA # are not required.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE				17a.		17b. NPI		1234567890				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES												
Dr. Trukera Medical												FROM MM DD YY TO MM DD YY												
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES												
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO												
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)												22. RESUBMISSION CODE ORIGINAL REF. NO.												
A. ICD-10 Code(s) B. C. D. E. F. G. H. I. J. K. L.												23. PRIOR AUTHORIZATION NUMBER												
24. A. DATE(S) OF SERVICE			B. PLACE OF SERVICE			C. EMG			D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)			E. DIAGNOSIS POINTER			F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From To									CPT/HCPCS MODIFIER			A			50 00		1		NPI		1234567890			
11 01 23 11 01 23			11			83861			RT			A			50 00		1		NPI		1234567890			
11 01 23 11 01 23			11			83861			LT			A			50 00		1		NPI		1234567890			

**United Health Care Commercial Plans:** UHC does not recognize the RT/LT modifiers. The CLIA number is required in box 23 with the **QW Modifier only** with 2 units of service. Double the billed charge.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE				17a.		17b. NPI		1234567890				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES												
Dr. Trukera Medical												FROM MM DD YY TO MM DD YY												
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES												
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO												
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)												22. RESUBMISSION CODE ORIGINAL REF. NO.												
A. ICD-10 Code(s) B. C. D. E. F. G. H. I. J. K. L.												23. PRIOR AUTHORIZATION NUMBER												
												10D2345678												
24. A. DATE(S) OF SERVICE			B. PLACE OF SERVICE			C. EMG			D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)			E. DIAGNOSIS POINTER			F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From To									CPT/HCPCS MODIFIER			A			100 00		2		NPI		1234567890			
11 01 23 11 01 23			11			83861			QW			A			100 00		2		NPI		1234567890			
																			NPI					

**Humana Medicare Advantage Plans:** Humana requires additional modifiers. The CLIA number is required in box 23 with the **QW/RT/LT/59** with 2 lines of service, 1 unit per line.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																	
										17b. NPI		1234567890		FROM		MM		DD		YY		TO		MM		DD		YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)															20. OUTSIDE LAB? \$ CHARGES														
															<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO														
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.															22. RESUBMISSION CODE ORIGINAL REF. NO.														
A. ICD-10 Code(s) B. C. D. E. F. G. H. I. J. K. L.															23. PRIOR AUTHORIZATION NUMBER														
															10D2345678														
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER										F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #											
MM DD YY MM DD YY										EMG		CPT/HCPCS		MODIFIER															
11 01 23 11 01 23 11										83861		QW RT 59		A		50 00		1		NPI		1234567890							
11 01 23 11 01 23 11										83861		QW LT 59		A		50 00		1		NPI		1234567890							

### Reimbursement for Medicare Part B (fee-for-service)

**2021-2024 Clinical Laboratory Fee Schedule (CLFS) Rate:** \$22.48 per test (\$44.96 per patient)

### Sequestration Withhold

- Medicare intermediaries are required to withhold two percent of the allowable.

### Medicare CMS Part B

- CMS Medicare pays at 100% of CLFS throughout the United States.
- No deductible or patient co-payment applies.
- Free standing, global lab code.
- CLIA Certification required.

### Billing Software Requirements

- **ANSI 5010 E-claim Crosswalk**

In loop 2300, Segment REFO2, enter the CLIA Certification number – 10 digits - (Do not enter “CLIA” with the certificate number as this will cause claims to deny as an invalid identification number).

Field #	Claim Description	Loop	Segment	Electronic Description
23.	Prior Authorization number	2300	REF01	Reference identification qualifier =X4
			REF02	CLIA Certification number

### Common Notification Reasons for Medicare Denials

If there is no CLIA number on the claim, Medicare sends RA messages MA 120 and MA 130, which state:

- MA 120 - Did not complete or enter accurately the CLIA number.
- MA 130 - Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is un-processable. Please submit the correct information to the appropriate FI or carrier.
- B7 - "This provider was not certified/eligible to be paid for this procedure/service on this date of service."
- The laboratory is not approved for this type of test.

# NEW HAMPSHIRE BILLING GUIDE



If any denial is received for CPT 83861 contact the Trukera Reimbursement Support Center promptly at [rsc@trukera.com](mailto:rsc@trukera.com) for assistance

## Reimbursement Support Specialist

Bridget Bolles

Cell: (317) 797-7151

Fax: (858) 225-8749

Email: [bbolles@trukera.com](mailto:bbolles@trukera.com)

### This guide addresses billing recommendation for:

- **CPT Code 83861** is specific for “Microfluidic analysis utilizing an integrated collection and analysis device, tear osmolality”.
- A covered service by CMS Medicare under the Clinical Laboratory Fee Schedule.
- CLIA Certificate of Waiver is required to perform and bill this laboratory tests.
- Providers are encouraged to review payor-provider contracts for rate and claim submission requirements.
- Medical Necessity requires current signs or symptoms of disease at time of test.
- Frequency of testing is based on Medical Necessity as determined by the clinician.
- Laboratory Test - multiple procedure discounts do not apply.

Payor Name	Lines	Modifier(s)	Units per Line
Medicare	2	QW/RT/LT	1
Anthem BCBS	2	RT/LT	1
Cigna	2	RT/LT	1
Harvard Pilgrim	1	none	2
NH Medicaid	2	QW/RT/LT	1
BMC Healthnet	2	RT/LT	1
Humana Medicare	2	QW/RT/LT 59	1
Tufts	1	none	2
UHC	1	QW	2
Medicare	2	QW/RT/LT	1
Anthem BCBS	2	RT/LT	1

### New Hampshire Providers:

Humana Commercial: Will deny claim (**Diagnostic testing for dry eye syndrome is not separately reimbursable**).

## Billing Format Examples

**Medicare:** Note the CLIA # in box 23 and the QW/RT, QW/LT in box 24D are required for processing. **The QW modifier should be placed first.** Claims lacking these elements will reject.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES												
										17b. NPI		1234567890												
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO												
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.												
A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER 10D2345678												
E. _____																								
I. _____																								
J. _____																								
24. A. DATE(S) OF SERVICE			B. PLACE OF SERVICE			C. EMG			D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
MM	DD	YY	MM	DD	YY				CPT/HCPCS	MODIFIER														
11	01	23	11	01	23	11			83861	QW	RT			A		50	00	1				NPI	1234567890	
11	01	23	11	01	23	11			83861	QW	LT			A		50	00	1				NPI	1234567890	

**Most Commercial Plans:** Note that the QW and CLIA # are not required.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES												
										17b. NPI		1234567890												
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO												
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.												
A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER												
E. _____																								
I. _____																								
J. _____																								
24. A. DATE(S) OF SERVICE			B. PLACE OF SERVICE			C. EMG			D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
MM	DD	YY	MM	DD	YY				CPT/HCPCS	MODIFIER														
11	01	23	11	01	23	11			83861		RT			A		50	00	1				NPI	1234567890	
11	01	23	11	01	23	11			83861		LT			A		50	00	1				NPI	1234567890	

**United Health Care Commercial Plans:** UHC does not recognize the RT/LT modifiers. The CLIA number is required in box 23 with the **QW Modifier only** with 2 units of service. Double the billed charge.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES												
										17b. NPI		1234567890												
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO												
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.												
A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER 10D2345678												
E. _____																								
I. _____																								
J. _____																								
24. A. DATE(S) OF SERVICE			B. PLACE OF SERVICE			C. EMG			D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
MM	DD	YY	MM	DD	YY				CPT/HCPCS	MODIFIER														
11	01	23	11	01	23	11			83861	QW				A		100	00	2				NPI	1234567890	
																						NPI		

**Humana Medicare Advantage Plans:** Humana requires additional modifiers. The CLIA number is required in box 23 with the **QW/RT/LT/59** with 2 lines of service, 1 unit per line

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																							
Dr. Trukera Medical										17b. NPI		1234567890																							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES																							
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.																							
A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER																							
B. [ ]												10D2345678																							
C. [ ]																																			
D. [ ]																																			
E. [ ]																																			
F. [ ]																																			
G. [ ]																																			
H. [ ]																																			
I. [ ]																																			
J. [ ]																																			
K. [ ]																																			
L. [ ]																																			
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)										E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From To										SERVICE				CPT/HCPCS MODIFIER																					
MM DD YY MM DD YY																																			
11 01 23 11 01 23										11				83861 QW RT 59										A		50 00		1				NPI		1234567890	
11 01 23 11 01 23										11				83861 QW LT 59										A		50 00		1				NPI		1234567890	

### Reimbursement for Medicare Part B (fee-for-service)

**2023-2024 Clinical Laboratory Fee Schedule (CLFS) Rate:** \$22.48 per test (\$44.96 per patient)

#### Sequestration Withhold

- Medicare intermediaries are required to withhold two-percent of the allowable.

#### Medicare CMS Part B

- CMS Medicare pays at 100% of CLFS throughout the United States.
- No deductible or patient co-payment applies.
- Free standing, global lab code.
- CLIA Certification required.

#### Billing Software Requirements

- **ANSI 5010 E-claim Crosswalk**

In loop 2300, Segment REFO2, enter the CLIA Certification number – 10 digits - (Do not enter “CLIA” with the certificate number as this will cause claims to deny as an invalid identification number).

Field #	Claim Description	Loop	Segment	Electronic Description
23.	Prior Authorization number	2300	REF01	Reference identification qualifier =X4
			REF02	CLIA Certification number



## Common Notification Reasons for Medicare Denials

If there is no CLIA number on the claim, Medicare sends RA messages MA 120 and MA 130, which state:

- MA 120 - Did not complete or enter accurately the CLIA number.
- MA 130 - Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is un-processable. Please submit the correct information to the appropriate FI or carrier.
- B7 - "This provider was not certified/eligible to be paid for this procedure/service on this date of service."
- The laboratory is not approved for this type of test

# New Jersey BILLING GUIDE



If any denial is received for CPT 83861 contact the Trukera Reimbursement Support Center promptly at [rsc@trukera.com](mailto:rsc@trukera.com) for assistance

## Reimbursement Support Specialist

Bridget Bolles

Cell: (317) 797-7151

Fax: (858) 225-8749

Email: [bbolles@trukera.com](mailto:bbolles@trukera.com)

### This guide addresses billing recommendation for:

- **CPT Code 83861** is specific for “Microfluidic analysis utilizing an integrated collection and analysis device, tear osmolality”.
- A covered service by CMS Medicare under the Clinical Laboratory Fee Schedule.
- CLIA Certificate of Waiver is required to perform and bill this laboratory tests.
- Providers are encouraged to review payor-provider contracts for rate and claim submission requirements.
- Medical Necessity requires current signs or symptoms of disease at time of test.
- Frequency of testing is based on Medical Necessity as determined by the clinician.
- Laboratory Test - multiple procedure discounts do not apply.

Payor Name	Lines	Modifier(s)	Units per Line
Medicare	2	QW/RT/LT	1
Horizon BCBS NJ	2	RT/LT	1
United HC	1	QW	2
Aetna	2	RT/LT	1
Cigna	2	RT/LT	1
QualCare	2	RT/LT	1
UHC Community	1	QW	2
Anthem	2	RT/LT	1
NJ Medicaid	2	QW/RT/LT	1

### New Jersey Providers:

Humana Commercial: Will deny claim (**Diagnostic testing for dry eye syndrome is not separately reimbursable**).

## Billing Format Examples

**Medicare:** Note the CLIA # in box 23 and the QW/RT, QW/LT in box 24D are required for processing. **The QW modifier should be placed first.** Claims lacking these elements will reject.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																							
Dr. Trukera Medical										17b.		NPI 1234567890																							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES																							
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.																							
A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER																							
B. _____												10D2345678																							
C. _____																																			
D. _____																																			
E. _____																																			
F. _____																																			
G. _____																																			
H. _____																																			
I. _____																																			
J. _____																																			
K. _____																																			
L. _____																																			
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)										E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From To														CPT/HCPCS MODIFIER																					
MM DD YY MM DD YY																																			
11 01 23 11 01 23										11				83861 QW RT										A		50 00		1				NPI		1234567890	
11 01 23 11 01 23										11				83861 QW LT										A		50 00		1				NPI		1234567890	

**Most Commercial Plans:** Note that the QW and CLIA # are not required.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																							
Dr. Trukera Medical										17b.		NPI 1234567890																							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES																							
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.																							
A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER																							
B. _____																																			
C. _____																																			
D. _____																																			
E. _____																																			
F. _____																																			
G. _____																																			
H. _____																																			
I. _____																																			
J. _____																																			
K. _____																																			
L. _____																																			
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)										E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From To														CPT/HCPCS MODIFIER																					
MM DD YY MM DD YY																																			
11 01 23 11 01 23										11				83861 RT										A		50 00		1				NPI		1234567890	
11 01 23 11 01 23										11				83861 LT										A		50 00		1				NPI		1234567890	

**United Health Care Commercial Plans:** UHC does not recognize the RT/LT modifiers. The CLIA number is required in box 23 with the **QW Modifier only** with 2 units of service. Double the billed charge.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																							
Dr. Trukera Medical										17b.		NPI 1234567890																							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES																							
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.																							
A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER																							
B. _____												10D2345678																							
C. _____																																			
D. _____																																			
E. _____																																			
F. _____																																			
G. _____																																			
H. _____																																			
I. _____																																			
J. _____																																			
K. _____																																			
L. _____																																			
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)										E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From To														CPT/HCPCS MODIFIER																					
MM DD YY MM DD YY																																			
11 01 23 11 01 23										11				83861 QW										A		100 00		2				NPI		1234567890	

**Humana Medicare Advantage Plans:** Humana requires additional modifiers. The CLIA number is required in box 23 with the **QW/RT/LT/59** with 2 lines of service, 1 unit per line

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																	
Dr. Trukera Medical										17b. NPI		1234567890																	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES																	
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION ORIGINAL REF. NO.																	
A. ICD-10 Code(s)										B.		C.																	
E.										F.		G.																	
I.										J.		K.																	
23. PRIOR AUTHORIZATION NUMBER												10D2345678																	
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From To										SERVICE				CPT/HCPCS MODIFIER															
11 01 23 11 01 23										11				83861 QW RT 59				A		50 00		1				NPI 1234567890			
11 01 23 11 01 23										11				83861 QW LT 59				A		50 00		1				NPI 1234567890			

### Reimbursement for Medicare Part B (fee-for-service)

**2023-2024 Clinical Laboratory Fee Schedule (CLFS) Rate:** \$22.48 per test (\$44.96 per patient)

#### Sequestration Withhold

- Medicare intermediaries are required to withhold two-percent of the allowable.

#### Medicare CMS Part B

- CMS Medicare pays at 100% of CLFS throughout the United States.
- No deductible or patient co-payment applies.
- Free standing, global lab code.
- CLIA Certification required.

#### Billing Software Requirements

- **ANSI 5010 E-claim Crosswalk**

In loop 2300, Segment REFO2, enter the CLIA Certification number – 10 digits - (Do not enter “CLIA” with the certificate number as this will cause claims to deny as an invalid identification number).

Field #	Claim Description	Loop	Segment	Electronic Description
23.	Prior Authorization number	2300	REF01	Reference identification qualifier =X4
			REF02	CLIA Certification number

## Common Notification Reasons for Medicare Denials

If there is no CLIA number on the claim, Medicare sends RA messages MA 120 and MA 130, which state:

- MA 120 - Did not complete or enter accurately the CLIA number.
- MA 130 - Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is un-processable. Please submit the correct information to the appropriate FI or carrier.
- B7 - "This provider was not certified/eligible to be paid for this procedure/service on this date of service."
- The laboratory is not approved for this type of test

# NEW MEXICO BILLING GUIDE



If any denial is received for CPT 83861 contact the Trukera Medical Reimbursement Support Center promptly at [rsc@trukera.com](mailto:rsc@trukera.com) for assistance.

## Reimbursement Support Specialist

Amanda Rotteck  
Cell: (704) 928-9009

Fax: (858) 225-8749  
Email: [arotteck@trukera.com](mailto:arotteck@trukera.com)

### This guide addresses billing recommendation for:

- **CPT Code 83861** is specific for “Microfluidic analysis utilizing an integrated collection and analysis device, tear osmolality.”
- A covered service by CMS Medicare under the Clinical Laboratory Fee Schedule.
- CLIA Certificate of Waiver is required to perform and bill this laboratory tests.
- Providers are encouraged to review payor-provider contracts for rate and claim submission requirements.
- Medical Necessity requires current signs or symptoms of disease at time of test.
- Frequency of testing is based on Medical Necessity as determined by the clinician.
- Laboratory Test - multiple procedure discounts do not apply.

Payor Name	Lines	Modifier(s)	Units per Line
Aetna	2	RT/LT	1
BCBS Federal Employee Plan	2	RT/LT	1
BCBS NM	2	RT/LT	1
Cigna	2	RT/LT	1
HealthNet	2	QW/RT/LT	1
Humana Medicare	2	QW/RT/LT/59	1
Medicaid NM	2	QW/RT/LT	1
Medicare	2	QW/RT/LT	1
Molina Healthcare	1	QW	2
Presbyterian Healthcare Services	2	RT/LT	1
United Healthcare	1	QW	2

## Billing Format Examples

**Medicare:** Note the CLIA # in box 23 and the QW/RT, QW/LT in box 24D are required for processing. **The QW modifier should be placed first.** Claims lacking these elements will be rejected.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY										
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										17b. NPI		1234567890										
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. ICD-10 Code(s) B. C. D. E. F. G. H. I. J. K. L.										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.										
23. PRIOR AUTHORIZATION NUMBER 10D2345678										F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #				
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY			B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER				E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
11 01 23 11 01 23			11				83861 QW RT				A		50 00		1				NPI		1234567890	
11 01 23 11 01 23			11				83861 QW LT				A		50 00		1				NPI		1234567890	

**Most Commercial Plans:** Note that the QW and CLIA # are not required.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY										
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										17b. NPI		1234567890										
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. ICD-10 Code(s) B. C. D. E. F. G. H. I. J. K. L.										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.										
23. PRIOR AUTHORIZATION NUMBER										F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #				
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY			B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER				E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
11 01 23 11 01 23			11				83861 RT				A		50 00		1				NPI		1234567890	
11 01 23 11 01 23			11				83861 LT				A		50 00		1				NPI		1234567890	

**United Health Care Commercial Plans:** UHC does not recognize the RT/LT modifiers. The CLIA number is required in box 23 with the **QW Modifier only** with 2 units of service. Double the billed charge.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY										
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										17b. NPI		1234567890										
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. ICD-10 Code(s) B. C. D. E. F. G. H. I. J. K. L.										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.										
23. PRIOR AUTHORIZATION NUMBER 10D2345678										F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #				
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY			B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER				E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
11 01 23 11 01 23			11				83861 QW				A		100 00		2				NPI		1234567890	
																			NPI			

**Humana Medicare Advantage Plans:** Humana requires additional modifiers. The CLIA number is required in box 23 with the **QW/RT/LT/59** with 2 lines of service, 1 unit per line.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																							
										17b. NPI		1234567890		FROM		MM		DD		YY		TO		MM		DD		YY							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? \$ CHARGES																									
										<input type="checkbox"/> YES		<input checked="" type="checkbox"/> NO																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION ORIGINAL REF. NO.																							
A. ICD-10 Code(s)										B.		C.		D.		E.		23. PRIOR AUTHORIZATION NUMBER		10D2345678															
E.										F.		G.		H.																					
I.										J.		K.		L.																					
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)										E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From			To																																
MM	DD	YY	MM	DD	YY			CPT/HCPCS	MODIFIER																										
11	01	23	11	01	23	11		83861	QW	RT	59																								
11	01	23	11	01	23	11		83861	QW	LT	59																								

**Reimbursement for Medicare Part B (fee-for-service)**

**2021-2024 Clinical Laboratory Fee Schedule (CLFS) Rate:** \$22.48 per test (\$44.96 per patient)

**Sequestration Withhold**

- Medicare intermediaries are required to withhold two percent of the allowable.

**Medicare CMS Part B**

- CMS Medicare pays at 100% of CLFS throughout the United States.
- No deductible or patient co-payment applies.
- Free standing, global lab code.
- CLIA Certification required.

**Billing Software Requirements**

- **ANSI 5010 E-claim Crosswalk**

In loop 2300, Segment REFO2, enter the CLIA Certification number – 10 digits - (Do not enter “CLIA” with the certificate number as this will cause claims to deny as an invalid identification number).

Field #	Claim Description	Loop	Segment	Electronic Description
23.	Prior Authorization number	2300	REF01	Reference identification qualifier =X4
			REF02	CLIA Certification number



### Common Notification Reasons for Medicare Denials

If there is no CLIA number on the claim, Medicare sends RA messages MA 120 and MA 130, which state:

- MA 120 - Did not complete or enter accurately the CLIA number.
- MA 130 - Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is un-processable. Please submit the correct information to the appropriate FI or carrier.
- B7 - "This provider was not certified/eligible to be paid for this procedure/service on this date of service."
- The laboratory is not approved for this type of test.

# NEW YORK BROOKLYN QUEENS BILLING GUIDE



If any denial is received for CPT 83861 contact the Trukera Reimbursement Support Center promptly at [rsc@trukera.com](mailto:rsc@trukera.com) for assistance

## Reimbursement Support Specialist

Bridget Bolles

Cell: (317) 797-7151

Fax: (858) 225-8749

Email: [bbolles@trukera.com](mailto:bbolles@trukera.com)

### This guide addresses billing recommendation for:

- **CPT Code 83861** is specific for “Microfluidic analysis utilizing an integrated collection and analysis device, tear osmolality”.
- A covered service by CMS Medicare under the Clinical Laboratory Fee Schedule.
- CLIA Certificate of Waiver is required to perform and bill this laboratory tests.
- Providers are encouraged to review payor-provider contracts for rate and claim submission requirements.
- Medical Necessity requires current signs or symptoms of disease at time of test.
- Frequency of testing is based on Medical Necessity as determined by the clinician.
- Laboratory Test - multiple procedure discounts do not apply.

Payor Name	Lines	Modifier(s)	Units per Line
Medicare	2	QW/RT/LT	1
UHC	1	QW	2
BCBS Empire	2	RT/LT	1
Aetna	2	RT/LT	1
Health First	2	RT/LT	1
Oxford	2	RT/LT	1
Cigna	2	RT/LT	1
Medicaid of NY	0	0	0

### New York Providers:

**Humana Commercial:** Will deny claim (**Diagnostic testing for dry eye syndrome is not separately reimbursable**).

**Oxford:** Optometry providers may not be covered in states outside Connecticut

**New York Medicaid:** Does not cover Tear Osmolarity

## Billing Format Examples

**Medicare:** Note the CLIA # in box 23 and the QW/RT, QW/LT in box 24D are required for processing. **The QW modifier should be placed first.** Claims lacking these elements will reject.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
										17b.		NPI 1234567890									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. ICD-10 Code(s) B. C. D. E. F. G. H. I. J. K. L.										22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER 10D2345678											
24. A. DATE(S) OF SERVICE From To MM DD YY MM DD YY			B. PLACE OF SERVICE		C.	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER				E. DIAGNOSIS POINTER	F. \$ CHARGES		G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #					
11 01 23 11 01 23			11			83861 QW RT				A	50 00		1		NPI	1234567890					
11 01 23 11 01 23			11			83861 QW LT				A	50 00		1		NPI	1234567890					

**Most Commercial Plans:** Note that the QW and CLIA # are not required.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
										17b.		NPI 1234567890									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. ICD-10 Code(s) B. C. D. E. F. G. H. I. J. K. L.										22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER											
24. A. DATE(S) OF SERVICE From To MM DD YY MM DD YY			B. PLACE OF SERVICE		C.	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER				E. DIAGNOSIS POINTER	F. \$ CHARGES		G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #					
11 01 23 11 01 23			11			83861 RT				A	50 00		1		NPI	1234567890					
11 01 23 11 01 23			11			83861 LT				A	50 00		1		NPI	1234567890					

**United Health Care Commercial Plans:** UHC does not recognize the RT/LT modifiers. The CLIA number is required in box 23 with the **QW Modifier only** with 2 units of service. Double the billed charge.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
										17b.		NPI 1234567890									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. ICD-10 Code(s) B. C. D. E. F. G. H. I. J. K. L.										22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER 10D2345678											
24. A. DATE(S) OF SERVICE From To MM DD YY MM DD YY			B. PLACE OF SERVICE		C.	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER				E. DIAGNOSIS POINTER	F. \$ CHARGES		G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #					
11 01 23 11 01 23			11			83861 QW				A	100 00		2		NPI	1234567890					
															NPI						

**Humana Medicare Advantage Plans:** Humana requires additional modifiers. The CLIA number is required in box 23 with the **QW/RT/LT/59** with 2 lines of service, 1 unit per line

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																							
Dr. Trukera Medical										17b. NPI		1234567890																							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES																							
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.																							
A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER																							
B. [ ]												10D2345678																							
C. [ ]																																			
D. [ ]																																			
E. [ ]																																			
F. [ ]																																			
G. [ ]																																			
H. [ ]																																			
I. [ ]																																			
J. [ ]																																			
K. [ ]																																			
L. [ ]																																			
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)										E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From To										SERVICE				CPT/HCPCS MODIFIER																					
MM DD YY MM DD YY																																			
11 01 23 11 01 23										11				83861 QW RT 59										A		50 00		1				NPI		1234567890	
11 01 23 11 01 23										11				83861 QW LT 59										A		50 00		1				NPI		1234567890	

**Reimbursement for Medicare Part B (fee-for-service)**

**2023-2024 Clinical Laboratory Fee Schedule (CLFS) Rate:** \$22.48 per test (\$44.96 per patient)

**Sequestration Withhold**

- Medicare intermediaries are required to withhold two-percent of the allowable.

**Medicare CMS Part B**

- CMS Medicare pays at 100% of CLFS throughout the United States.
- No deductible or patient co-payment applies.
- Free standing, global lab code.
- CLIA Certification required.

**Billing Software Requirements**

- **ANSI 5010 E-claim Crosswalk**

In loop 2300, Segment REFO2, enter the CLIA Certification number – 10 digits - (Do not enter “CLIA” with the certificate number as this will cause claims to deny as an invalid identification number).

Field #	Claim Description	Loop	Segment	Electronic Description
23.	Prior Authorization number	2300	REF01	Reference identification qualifier =X4
			REF02	CLIA Certification number

## Common Notification Reasons for Medicare Denials

If there is no CLIA number on the claim, Medicare sends RA messages MA 120 and MA 130, which state:

- MA 120 - Did not complete or enter accurately the CLIA number.
- MA 130 - Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is un-processable. Please submit the correct information to the appropriate FI or carrier.
- B7 - "This provider was not certified/eligible to be paid for this procedure/service on this date of service."
- The laboratory is not approved for this type of test

# NEW YORK LONG ISLAND BILLING GUIDE



If any denial is received for CPT 83861 contact the Trukera Reimbursement Support Center promptly at [rsc@trukera.com](mailto:rsc@trukera.com) for assistance

## Reimbursement Support Specialist

Bridget Bolles

Cell: (317) 797-7151

Fax: (858) 225-8749

Email: [bbolles@trukera.com](mailto:bbolles@trukera.com)

### This guide addresses billing recommendation for:

- **CPT Code 83861** is specific for “Microfluidic analysis utilizing an integrated collection and analysis device, tear osmolality”.
- A covered service by CMS Medicare under the Clinical Laboratory Fee Schedule.
- CLIA Certificate of Waiver is required to perform and bill this laboratory tests.
- Providers are encouraged to review payor-provider contracts for rate and claim submission requirements.
- Medical Necessity requires current signs or symptoms of disease at time of test.
- Frequency of testing is based on Medical Necessity as determined by the clinician.
- Laboratory Test - multiple procedure discounts do not apply.

Payor Name	Lines	Modifier(s)	Units per Line
Medicare	2	QW/RT/LT	1
UHC	1	QW	2
BCBS Empire	2	RT/LT	1
Aetna	2	RT/LT	1
Health First	2	RT/LT	1
Oxford	2	RT/LT	1
Cigna	2	RT/LT	1
Medicaid of NY	0	0	0

### New York Providers:

**Humana Commercial:** Will deny claim (**Diagnostic testing for dry eye syndrome is not separately reimbursable**).

**Oxford:** Optometry providers may not be covered in states outside Connecticut

**New York Medicaid:** Does not cover Tear Osmolarity

## Billing Format Examples

**Medicare:** Note the CLIA # in box 23 and the QW/RT, QW/LT in box 24D are required for processing. **The QW modifier should be placed first.** Claims lacking these elements will reject.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES									
Dr. Trukera Medical										17b.		NPI 1234567890									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES									
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.									
A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER									
B. _____												10D2345678									
C. _____																					
D. _____																					
E. _____																					
F. _____																					
G. _____																					
H. _____																					
I. _____																					
J. _____																					
K. _____																					
L. _____																					
24. A. DATE(S) OF SERVICE			B. PLACE OF SERVICE			C.	D. PROCEDURES, SERVICES, OR SUPPLIES				E.	F.		G.	H.	I.	J.				
From To			SERVICE			EMG	(Explain Unusual Circumstances)				DIAGNOSIS	\$ CHARGES		DAYS OR UNITS	EPSDT Family Plan	ID. QUAL.	RENDERING PROVIDER ID. #				
MM DD YY MM DD YY							CPT/HCPCS MODIFIER				POINTER										
11 01 23 11 01 23			11				83861 QW RT				A	50 00		1		NPI	1234567890				
11 01 23 11 01 23			11				83861 QW LT				A	50 00		1		NPI	1234567890				

**Most Commercial Plans:** Note that the QW and CLIA # are not required.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES									
Dr. Trukera Medical										17b.		NPI 1234567890									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES									
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.									
A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER									
B. _____																					
C. _____																					
D. _____																					
E. _____																					
F. _____																					
G. _____																					
H. _____																					
I. _____																					
J. _____																					
K. _____																					
L. _____																					
24. A. DATE(S) OF SERVICE			B. PLACE OF SERVICE			C.	D. PROCEDURES, SERVICES, OR SUPPLIES				E.	F.		G.	H.	I.	J.				
From To			SERVICE			EMG	(Explain Unusual Circumstances)				DIAGNOSIS	\$ CHARGES		DAYS OR UNITS	EPSDT Family Plan	ID. QUAL.	RENDERING PROVIDER ID. #				
MM DD YY MM DD YY							CPT/HCPCS MODIFIER				POINTER										
11 01 23 11 01 23			11				83861 RT				A	50 00		1		NPI	1234567890				
11 01 23 11 01 23			11				83861 LT				A	50 00		1		NPI	1234567890				

**United Health Care Commercial Plans:** UHC does not recognize the RT/LT modifiers. The CLIA number is required in box 23 with the **QW Modifier only** with 2 units of service. Double the billed charge.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES									
Dr. Trukera Medical										17b.		NPI 1234567890									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES									
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.									
A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER									
B. _____												10D2345678									
C. _____																					
D. _____																					
E. _____																					
F. _____																					
G. _____																					
H. _____																					
I. _____																					
J. _____																					
K. _____																					
L. _____																					
24. A. DATE(S) OF SERVICE			B. PLACE OF SERVICE			C.	D. PROCEDURES, SERVICES, OR SUPPLIES				E.	F.		G.	H.	I.	J.				
From To			SERVICE			EMG	(Explain Unusual Circumstances)				DIAGNOSIS	\$ CHARGES		DAYS OR UNITS	EPSDT Family Plan	ID. QUAL.	RENDERING PROVIDER ID. #				
MM DD YY MM DD YY							CPT/HCPCS MODIFIER				POINTER										
11 01 23 11 01 23			11				83861 QW				A	100 00		2		NPI	1234567890				
																NPI					

**Humana Medicare Advantage Plans:** Humana requires additional modifiers. The CLIA number is required in box 23 with the **QW/RT/LT/59** with 2 lines of service, 1 unit per line

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																							
Dr. Trukera Medical										17b. NPI		1234567890																							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES																							
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.																							
A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER																							
B. [ ]												10D2345678																							
C. [ ]																																			
D. [ ]																																			
E. [ ]																																			
F. [ ]																																			
G. [ ]																																			
H. [ ]																																			
I. [ ]																																			
J. [ ]																																			
K. [ ]																																			
L. [ ]																																			
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)										E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From To										SERVICE				CPT/HCPCS MODIFIER																					
MM DD YY MM DD YY																																			
11 01 23 11 01 23										11				83861 QW RT 59										A		50 00		1				NPI		1234567890	
11 01 23 11 01 23										11				83861 QW LT 59										A		50 00		1				NPI		1234567890	

### Reimbursement for Medicare Part B (fee-for-service)

**2023-2024 Clinical Laboratory Fee Schedule (CLFS) Rate:** \$22.48 per test (\$44.96 per patient)

#### Sequestration Withhold

- Medicare intermediaries are required to withhold two-percent of the allowable.

#### Medicare CMS Part B

- CMS Medicare pays at 100% of CLFS throughout the United States.
- No deductible or patient co-payment applies.
- Free standing, global lab code.
- CLIA Certification required.

#### Billing Software Requirements

- **ANSI 5010 E-claim Crosswalk**

In loop 2300, Segment REFO2, enter the CLIA Certification number – 10 digits - (Do not enter “CLIA” with the certificate number as this will cause claims to deny as an invalid identification number).

Field #	Claim Description	Loop	Segment	Electronic Description
23.	Prior Authorization number	2300	REF01	Reference identification qualifier =X4
			REF02	CLIA Certification number



## Common Notification Reasons for Medicare Denials

If there is no CLIA number on the claim, Medicare sends RA messages MA 120 and MA 130, which state:

- MA 120 - Did not complete or enter accurately the CLIA number.
- MA 130 - Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is un-processable. Please submit the correct information to the appropriate FI or carrier.
- B7 - "This provider was not certified/eligible to be paid for this procedure/service on this date of service."
- The laboratory is not approved for this type of test

# NEW YORK UPSTATE BILLING GUIDE



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## Reimbursement Support Specialist

Bridget Bolles

Cell: (317) 797-7151

Fax: (858) 225-8749

Email: [bbolles@trukera.com](mailto:bbolles@trukera.com)

### This guide addresses billing recommendation for:

- **CPT Code 83861** is specific for “Microfluidic analysis utilizing an integrated collection and analysis device, tear osmolality”.
- A covered service by CMS Medicare under the Clinical Laboratory Fee Schedule.
- CLIA Certificate of Waiver is required to perform and bill this laboratory tests.
- Providers are encouraged to review payor-provider contracts for rate and claim submission requirements.
- Medical Necessity requires current signs or symptoms of disease at time of test.
- Frequency of testing is based on Medical Necessity as determined by the clinician.
- Laboratory Test - multiple procedure discounts do not apply.

Payor Name	Lines	Modifier(s)	Units per Line
Medicare	2	QW/RT/LT	1
UHC	1	QW	2
Fidelis	2	RT/LT	1
Excellus	2	RT/LT	1
NY Medicaid	0	0	0
BS NENY	2	RT/LT	1
MVP	2	RT/LT	1
CDPHP	2	RT/LT	1

### New York Upstate Providers:

**Humana Commercial:** Will deny claim (**Diagnostic testing for dry eye syndrome is not separately reimbursable**).

**Oxford:** Optometry providers may not be covered in states outside Connecticut

**New York Medicaid:** Does not cover Tear Osmolarity

**Fidelis Care:** May require Modifier 59 or XS on the second line if RT/LT is not accepted.

## Billing Format Examples

**Medicare:** Note the CLIA # in box 23 and the QW/RT, QW/LT in box 24D are required for processing. **The QW modifier should be placed first.** Claims lacking these elements will reject.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																							
Dr. Trukera Medical										17b.		NPI 1234567890																							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES																							
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.																							
A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER																							
B. _____												10D2345678																							
C. _____																																			
D. _____																																			
E. _____																																			
F. _____																																			
G. _____																																			
H. _____																																			
I. _____																																			
J. _____																																			
K. _____																																			
L. _____																																			
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)										E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From To														CPT/HCPCS MODIFIER																					
MM DD YY MM DD YY																																			
11 01 23 11 01 23										11				83861 QW RT										A		50 00		1				NPI		1234567890	
11 01 23 11 01 23										11				83861 QW LT										A		50 00		1				NPI		1234567890	

**Most Commercial Plans:** Note that the QW and CLIA # are not required.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																							
Dr. Trukera Medical										17b.		NPI 1234567890																							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES																							
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.																							
A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER																							
B. _____																																			
C. _____																																			
D. _____																																			
E. _____																																			
F. _____																																			
G. _____																																			
H. _____																																			
I. _____																																			
J. _____																																			
K. _____																																			
L. _____																																			
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)										E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From To														CPT/HCPCS MODIFIER																					
MM DD YY MM DD YY																																			
11 01 23 11 01 23										11				83861 RT										A		50 00		1				NPI		1234567890	
11 01 23 11 01 23										11				83861 LT										A		50 00		1				NPI		1234567890	

**United Health Care Commercial Plans:** UHC does not recognize the RT/LT modifiers. The CLIA number is required in box 23 with the **QW Modifier only** with 2 units of service. Double the billed charge.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																							
Dr. Trukera Medical										17b.		NPI 1234567890																							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES																							
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.																							
A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER																							
B. _____												10D2345678																							
C. _____																																			
D. _____																																			
E. _____																																			
F. _____																																			
G. _____																																			
H. _____																																			
I. _____																																			
J. _____																																			
K. _____																																			
L. _____																																			
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)										E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From To														CPT/HCPCS MODIFIER																					
MM DD YY MM DD YY																																			
11 01 23 11 01 23										11				83861 QW										A		100 00		2				NPI		1234567890	

**Humana Medicare Advantage Plans:** Humana requires additional modifiers. The CLIA number is required in box 23 with the **QW/RT/LT/59** with 2 lines of service, 1 unit per line

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																							
Dr. Trukera Medical										17b. NPI		1234567890																							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES																							
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.																							
A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER																							
B. [ ]												10D2345678																							
C. [ ]																																			
D. [ ]																																			
E. [ ]																																			
F. [ ]																																			
G. [ ]																																			
H. [ ]																																			
I. [ ]																																			
J. [ ]																																			
K. [ ]																																			
L. [ ]																																			
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)										E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From To										SERVICE				CPT/HCPCS MODIFIER																					
MM DD YY MM DD YY																																			
11 01 23 11 01 23										11				83861 QW RT 59										A		50 00		1				NPI		1234567890	
11 01 23 11 01 23										11				83861 QW LT 59										A		50 00		1				NPI		1234567890	

### Reimbursement for Medicare Part B (fee-for-service)

**2023-2024 Clinical Laboratory Fee Schedule (CLFS) Rate:** \$22.48 per test (\$44.96 per patient)

#### Sequestration Withhold

- Medicare intermediaries are required to withhold two-percent of the allowable.

#### Medicare CMS Part B

- CMS Medicare pays at 100% of CLFS throughout the United States.
- No deductible or patient co-payment applies.
- Free standing, global lab code.
- CLIA Certification required.

#### Billing Software Requirements

- **ANSI 5010 E-claim Crosswalk**

In loop 2300, Segment REFO2, enter the CLIA Certification number – 10 digits - (Do not enter “CLIA” with the certificate number as this will cause claims to deny as an invalid identification number).

Field #	Claim Description	Loop	Segment	Electronic Description
23.	Prior Authorization number	2300	REF01	Reference identification qualifier =X4
			REF02	CLIA Certification number

## Common Notification Reasons for Medicare Denials

If there is no CLIA number on the claim, Medicare sends RA messages MA 120 and MA 130, which state:

- MA 120 - Did not complete or enter accurately the CLIA number.
- MA 130 - Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is un-processable. Please submit the correct information to the appropriate FI or carrier.
- B7 - "This provider was not certified/eligible to be paid for this procedure/service on this date of service."
- The laboratory is not approved for this type of test

# NORTH CAROLINA BILLING GUIDE



If any denial is received for CPT 83861 contact the Trukera Medical Reimbursement Support Center promptly at [rsc@trukera.com](mailto:rsc@trukera.com) for assistance.

## Reimbursement Support Specialist

Amanda Rotteck

Fax: (858) 225-8749

Cell: (704) 928-9009

Email: [arotteck@trukera.com](mailto:arotteck@trukera.com)

### This guide addresses billing recommendation for:

- **CPT Code 83861** is specific for “Microfluidic analysis utilizing an integrated collection and analysis device, tear osmolality”.
- A covered service by CMS Medicare under the Clinical Laboratory Fee Schedule.
- CLIA Certificate of Waiver is required to perform and bill this laboratory tests.
- Providers are encouraged to review payor-provider contracts for rate and claim submission requirements.
- Medical Necessity requires current signs or symptoms of disease at time of test.
- Frequency of testing is based on Medical Necessity as determined by the clinician.
- Laboratory Test - multiple procedure discounts do not apply.

Payor Name	Lines	Modifier(s)	Units per Line
Medicare	2	QW/RT/LT	1
BCBSNC	2	RT/LT	1
NC Medicaid	1	none	2
UHC	1	QW	2
Humana Medicare	2	QW/RT/LT/59	1
CIGNA	2	RT/LT	1
Aetna	2	RT/LT	1
BCBS FED	2	RT/LT	1

### North Carolina Providers:

**Humana Commercial:** Will deny claim (**Diagnostic testing for dry eye syndrome is not separately reimbursable**).

**North Carolina Medicaid:** CLIA # / NPI & Optometry Taxonomy need to be loaded through Provider Enrollment before processing claims.

## Billing Format Examples

**Medicare:** Note the CLIA # in box 23 and the QW/RT, QW/LT in box 24D are required for processing. **The QW modifier should be placed first.** Claims lacking these elements will be rejected.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a.											18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES														
Dr. Trukera Medical										17b.	NPI	1234567890										FROM	MM	DD	YY	TO	MM	DD	YY						
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)																				20. OUTSIDE LAB? \$ CHARGES															
																				<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO															
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)															ICD Ind.					22. RESUBMISSION CODE ORIGINAL REF. NO.															
A. ICD-10 Code(s)					B.					C.					D.																				
E.					F.					G.					H.					23. PRIOR AUTHORIZATION NUMBER															
I.					J.					K.					L.					10D2345678															
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)										E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
MM	DD	YY	MM	DD	YY					CPT/HCPCS	MODIFIER							\$																	
11	01	23	11	01	23	11				83861	QW	RT					50	00	1				NPI	1234567890											
11	01	23	11	01	23	11				83861	QW	LT					50	00	1				NPI	1234567890											

**Most Commercial Plans:** Note that the QW and CLIA # are not required.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a.											18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES														
Dr. Trukera Medical										17b.	NPI	1234567890										FROM	MM	DD	YY	TO	MM	DD	YY						
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)																				20. OUTSIDE LAB? \$ CHARGES															
																				<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO															
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)															ICD Ind.					22. RESUBMISSION CODE ORIGINAL REF. NO.															
A. ICD-10 Code(s)					B.					C.					D.																				
E.					F.					G.					H.					23. PRIOR AUTHORIZATION NUMBER															
I.					J.					K.					L.																				
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)										E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
MM	DD	YY	MM	DD	YY					CPT/HCPCS	MODIFIER							\$																	
11	01	23	11	01	23	11				83861		RT					50	00	1				NPI	1234567890											
11	01	23	11	01	23	11				83861		LT					50	00	1				NPI	1234567890											

**United Health Care Commercial Plans:** UHC does not recognize the RT/LT modifiers. The CLIA number is required in box 23 with the **QW Modifier only** with 2 units of service. Double the billed charge.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a.											18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES														
Dr. Trukera Medical										17b.	NPI	1234567890										FROM	MM	DD	YY	TO	MM	DD	YY						
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)																				20. OUTSIDE LAB? \$ CHARGES															
																				<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO															
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)															ICD Ind.					22. RESUBMISSION CODE ORIGINAL REF. NO.															
A. ICD-10 Code(s)					B.					C.					D.																				
E.					F.					G.					H.					23. PRIOR AUTHORIZATION NUMBER															
I.					J.					K.					L.					10D2345678															
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)										E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
MM	DD	YY	MM	DD	YY					CPT/HCPCS	MODIFIER							\$																	
11	01	23	11	01	23	11				83861	QW						100	00	2				NPI	1234567890											
																							NPI												

**Humana Medicare Advantage Plans:** Humana requires additional modifiers. The CLIA number is required in box 23 with the **QW/RT/LT/59** with 2 lines of service, 1 unit per line.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical		17a.	17b. NPI 1234567890		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY						
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)					20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. ICD-10 Code(s) B. C. D. E. F. G. H. I. J. K. L.					22. RESUBMISSION CODE ORIGINAL REF. NO.						
					23. PRIOR AUTHORIZATION NUMBER 10D2345678						
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
11 01 23 11 01 23		11		83861 QW RT 59		A	50.00	1		NPI	1234567890
11 01 23 11 01 23		11		83861 QW LT 59		A	50.00	1		NPI	1234567890

### Reimbursement for Medicare Part B (fee-for-service)

**2021-2024 Clinical Laboratory Fee Schedule (CLFS) Rate:** \$22.48 per test (\$44.96 per patient)

### Sequestration Withhold

- Medicare intermediaries are required to withhold two percent of the allowable.

### Medicare CMS Part B

- CMS Medicare pays at 100% of CLFS throughout the United States.
- No deductible or patient co-payment applies.
- Free standing, global lab code.
- CLIA Certification required.

### Billing Software Requirements

- **ANSI 5010 E-claim Crosswalk**

In loop 2300, Segment REFO2, enter the CLIA Certification number – 10 digits - (Do not enter “CLIA” with the certificate number as this will cause claims to deny as an invalid identification number).

Field #	Claim Description	Loop	Segment	Electronic Description
23.	Prior Authorization number	2300	REF01	Reference identification qualifier =X4
			REF02	CLIA Certification number



### Common Notification Reasons for Medicare Denials

If there is no CLIA number on the claim, Medicare sends RA messages MA 120 and MA 130, which state:

- MA 120 - Did not complete or enter accurately the CLIA number.
- MA 130 - Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is un-processable. Please submit the correct information to the appropriate FI or carrier.
- B7 - "This provider was not certified/eligible to be paid for this procedure/service on this date of service."
- The laboratory is not approved for this type of test.

# NORTH DAKOTA BILLING GUIDE



If any denial is received for CPT 83861 contact the Trukera Reimbursement Support Center promptly at [rsc@trukera.com](mailto:rsc@trukera.com) for assistance

## Reimbursement Support Specialist

Bridget Bolles

Cell: (317) 797-7151

Fax: (858) 225-8749

Email: [bbolles@trukera.com](mailto:bbolles@trukera.com)

### This guide addresses billing recommendation for:

- **CPT Code 83861** is specific for “Microfluidic analysis utilizing an integrated collection and analysis device, tear osmolality”.
- A covered service by CMS Medicare under the Clinical Laboratory Fee Schedule.
- CLIA Certificate of Waiver is required to perform and bill this laboratory tests.
- Providers are encouraged to review payor-provider contracts for rate and claim submission requirements.
- Medical Necessity requires current signs or symptoms of disease at time of test.
- Frequency of testing is based on Medical Necessity as determined by the clinician.
- Laboratory Test - multiple procedure discounts do not apply.

Payor Name	Lines	Modifier(s)	Units per Line
Aetna	2	RT/LT	1
BCBS Federal Employee Program	2	RT/LT	1
BCBS ND	2	RT/LT	1
Cigna	2	RT/LT	1
HealthNet	2	QW/RT/LT	1
Medica Health Plans	2	RT/LT	1
Medicaid ND	2	QW/RT/LT	1
Medicare	2	QW/RT/LT	1
Sanford Health	2	RT/LT	1

## Billing Format Examples

**Medicare:** Note the CLIA # in box 23 and the QW/RT, QW/LT in box 24D are required for processing. **The QW modifier should be placed first.** Claims lacking these elements will reject.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
										17b.		NPI 1234567890									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.										22. RESUBMISSION CODE ORIGINAL REF. NO.											
A. ICD-10 Code(s) B. C. D. E. F. G. H. I. J. K. L.										23. PRIOR AUTHORIZATION NUMBER 10D2345678											
24. A. DATE(S) OF SERVICE From To			B. PLACE OF SERVICE		C.	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER				E. DIAGNOSIS POINTER	F. \$ CHARGES		G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #					
11 01 23 11 01 23			11			83861 QW RT				A	50 00		1		NPI	1234567890					
11 01 23 11 01 23			11			83861 QW LT				A	50 00		1		NPI	1234567890					

**Most Commercial Plans:** Note that the QW and CLIA # are not required.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
										17b.		NPI 1234567890									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.										22. RESUBMISSION CODE ORIGINAL REF. NO.											
A. ICD-10 Code(s) B. C. D. E. F. G. H. I. J. K. L.										23. PRIOR AUTHORIZATION NUMBER											
24. A. DATE(S) OF SERVICE From To			B. PLACE OF SERVICE		C.	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER				E. DIAGNOSIS POINTER	F. \$ CHARGES		G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #					
11 01 23 11 01 23			11			83861 RT				A	50 00		1		NPI	1234567890					
11 01 23 11 01 23			11			83861 LT				A	50 00		1		NPI	1234567890					

**United Health Care Commercial Plans:** UHC does not recognize the RT/LT modifiers. The CLIA number is required in box 23 with the **QW Modifier only** with 2 units of service. Double the billed charge.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
										17b.		NPI 1234567890									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.										22. RESUBMISSION CODE ORIGINAL REF. NO.											
A. ICD-10 Code(s) B. C. D. E. F. G. H. I. J. K. L.										23. PRIOR AUTHORIZATION NUMBER 10D2345678											
24. A. DATE(S) OF SERVICE From To			B. PLACE OF SERVICE		C.	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER				E. DIAGNOSIS POINTER	F. \$ CHARGES		G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #					
11 01 23 11 01 23			11			83861 QW				A	100 00		2		NPI	1234567890					
															NPI						

**Humana Medicare Advantage Plans:** Humana requires additional modifiers. The CLIA number is required in box 23 with the **QW/RT/LT/59** with 2 lines of service, 1 unit per line

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																							
Dr. Trukera Medical										17b. NPI		1234567890																							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES																							
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.																							
A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER																							
B. [ ]												10D2345678																							
C. [ ]																																			
D. [ ]																																			
E. [ ]																																			
F. [ ]																																			
G. [ ]																																			
H. [ ]																																			
I. [ ]																																			
J. [ ]																																			
K. [ ]																																			
L. [ ]																																			
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)										E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From To										SERVICE				CPT/HCPCS MODIFIER																					
MM DD YY MM DD YY																																			
11 01 23 11 01 23										11				83861 QW RT 59										A		50 00		1				NPI		1234567890	
11 01 23 11 01 23										11				83861 QW LT 59										A		50 00		1				NPI		1234567890	

### Reimbursement for Medicare Part B (fee-for-service)

**2023-2024 Clinical Laboratory Fee Schedule (CLFS) Rate:** \$22.48 per test (\$44.96 per patient)

#### Sequestration Withhold

- Medicare intermediaries are required to withhold two-percent of the allowable.

#### Medicare CMS Part B

- CMS Medicare pays at 100% of CLFS throughout the United States.
- No deductible or patient co-payment applies.
- Free standing, global lab code.
- CLIA Certification required.

#### Billing Software Requirements

- **ANSI 5010 E-claim Crosswalk**

In loop 2300, Segment REFO2, enter the CLIA Certification number – 10 digits - (Do not enter “CLIA” with the certificate number as this will cause claims to deny as an invalid identification number).

Field #	Claim Description	Loop	Segment	Electronic Description
23.	Prior Authorization number	2300	REF01	Reference identification qualifier =X4
			REF02	CLIA Certification number

## Common Notification Reasons for Medicare Denials

If there is no CLIA number on the claim, Medicare sends RA messages MA 120 and MA 130, which state:

- MA 120 - Did not complete or enter accurately the CLIA number.
- MA 130 - Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is un-processable. Please submit the correct information to the appropriate FI or carrier.
- B7 - "This provider was not certified/eligible to be paid for this procedure/service on this date of service."
- The laboratory is not approved for this type of test

# OHIO BILLING GUIDE



If any denial is received for CPT 83861 contact the Trukera Reimbursement Support Center promptly at [rsc@trukera.com](mailto:rsc@trukera.com) for assistance

### Reimbursement Support Specialist

Bridget Bolles

Cell: (317) 797-7151

Fax: (858) 225-8749

Email: [bbolles@trukera.com](mailto:bbolles@trukera.com)

### This guide addresses billing recommendation for:

- **CPT Code 83861** is specific for “Microfluidic analysis utilizing an integrated collection and analysis device, tear osmolality”.
- A covered service by CMS Medicare under the Clinical Laboratory Fee Schedule.
- CLIA Certificate of Waiver is required to perform and bill this laboratory tests.
- Providers are encouraged to review payor-provider contracts for rate and claim submission requirements.
- Medical Necessity requires current signs or symptoms of disease at time of test.
- Frequency of testing is based on Medical Necessity as determined by the clinician.
- Laboratory Test - multiple procedure discounts do not apply.

Payor Name	Lines	Modifier(s)	Units per Line
Aetna	1	QW	2
BCBS OH	2	RT/LT	1
Buckeye Health - Medicaid	1	QW	2
Caresource	2	RT/LT	1
Cigna	2	RT/LT	1
Humana Medicare	2	QW/RT/LT 59	1
Medicaid OH	1	QW	2
Medical Mutual	1	none	2
Medicare	2	QW/RT/LT	1
Molina	1	QW	2
UHC Community Plan /UHC	1	QW	2

### Ohio Providers:

**Humana Commercial:** Will deny claim (**Diagnostic testing for dry eye syndrome is not separately reimbursable**).

## Billing Format Examples

**Medicare:** Note the CLIA # in box 23 and the QW/RT, QW/LT in box 24D are required for processing. **The QW modifier should be placed first.** Claims lacking these elements will reject.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
										17b. NPI		1234567890									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. ICD-10 Code(s) B. C. D. E. F. G. H. I. J. K. L.										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.									
												23. PRIOR AUTHORIZATION NUMBER 10D2345678									
24. A. DATE(S) OF SERVICE From To MM DD YY MM DD YY			B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER				E. DIAGNOSIS POINTER	F. \$ CHARGES		G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #						
11 01 23 11 01 23			11		83861 QW RT				A	50 00		1		NPI	1234567890						
11 01 23 11 01 23			11		83861 QW LT				A	50 00		1		NPI	1234567890						

**Most Commercial Plans:** Note that the QW and CLIA # are not required.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
										17b. NPI		1234567890									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. ICD-10 Code(s) B. C. D. E. F. G. H. I. J. K. L.										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.									
												23. PRIOR AUTHORIZATION NUMBER									
24. A. DATE(S) OF SERVICE From To MM DD YY MM DD YY			B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER				E. DIAGNOSIS POINTER	F. \$ CHARGES		G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #						
11 01 23 11 01 23			11		83861 RT				A	50 00		1		NPI	1234567890						
11 01 23 11 01 23			11		83861 LT				A	50 00		1		NPI	1234567890						

**United Health Care Commercial Plans:** UHC does not recognize the RT/LT modifiers. The CLIA number is required in box 23 with the QW Modifier only with 2 units of service. Double the billed charge.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
										17b. NPI		1234567890									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. ICD-10 Code(s) B. C. D. E. F. G. H. I. J. K. L.										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.									
												23. PRIOR AUTHORIZATION NUMBER 10D2345678									
24. A. DATE(S) OF SERVICE From To MM DD YY MM DD YY			B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER				E. DIAGNOSIS POINTER	F. \$ CHARGES		G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #						
11 01 23 11 01 23			11		83861 QW				A	100 00		2		NPI	1234567890						
														NPI							

**Humana Medicare Advantage Plans:** Humana requires additional modifiers. The CLIA number is required in box 23 with the **QW/RT/LT/59** with 2 lines of service, 1 unit per line

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																							
Dr. Trukera Medical										17b. NPI		1234567890																							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES																							
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.																							
A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER																							
B. [ ]												10D2345678																							
C. [ ]																																			
D. [ ]																																			
E. [ ]																																			
F. [ ]																																			
G. [ ]																																			
H. [ ]																																			
I. [ ]																																			
J. [ ]																																			
K. [ ]																																			
L. [ ]																																			
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)										E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From To										SERVICE				CPT/HCPCS MODIFIER																					
MM DD YY MM DD YY																																			
11 01 23 11 01 23										11				83861 QW RT 59										A		50 00		1				NPI		1234567890	
11 01 23 11 01 23										11				83861 QW LT 59										A		50 00		1				NPI		1234567890	

**Reimbursement for Medicare Part B (fee-for-service)**

**2023-2024 Clinical Laboratory Fee Schedule (CLFS) Rate:** \$22.48 per test (\$44.96 per patient)

**Sequestration Withhold**

- Medicare intermediaries are required to withhold two-percent of the allowable.

**Medicare CMS Part B**

- CMS Medicare pays at 100% of CLFS throughout the United States.
- No deductible or patient co-payment applies.
- Free standing, global lab code.
- CLIA Certification required.

**Billing Software Requirements**

- **ANSI 5010 E-claim Crosswalk**

In loop 2300, Segment REFO2, enter the CLIA Certification number – 10 digits - (Do not enter “CLIA” with the certificate number as this will cause claims to deny as an invalid identification number).

Field #	Claim Description	Loop	Segment	Electronic Description
23.	Prior Authorization number	2300	REF01	Reference identification qualifier =X4
			REF02	CLIA Certification number



## Common Notification Reasons for Medicare Denials

If there is no CLIA number on the claim, Medicare sends RA messages MA 120 and MA 130, which state:

- MA 120 - Did not complete or enter accurately the CLIA number.
- MA 130 - Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is un-processable. Please submit the correct information to the appropriate FI or carrier.
- B7 - "This provider was not certified/eligible to be paid for this procedure/service on this date of service."
- The laboratory is not approved for this type of test

# OKLAHOMA BILLING GUIDE



If any denial is received for CPT 83861 contact the Trukera Medical Reimbursement Support Center promptly at [rsc@trukera.com](mailto:rsc@trukera.com) for assistance.

## Reimbursement Support Specialist

Amanda Rotteck  
Cell: (704) 928-9009

Fax: (858) 225-8749  
Email: [arotteck@trukera.com](mailto:arotteck@trukera.com)

### This guide addresses billing recommendation for:

- **CPT Code 83861** is specific for “Microfluidic analysis utilizing an integrated collection and analysis device, tear osmolality.”
- A covered service by CMS Medicare under the Clinical Laboratory Fee Schedule.
- CLIA Certificate of Waiver is required to perform and bill this laboratory tests.
- Providers are encouraged to review payor-provider contracts for rate and claim submission requirements.
- Medical Necessity requires current signs or symptoms of disease at time of test.
- Frequency of testing is based on Medical Necessity as determined by the clinician.
- Laboratory Test - multiple procedure discounts do not apply.

Payor Name	Lines	Modifier(s)	Units per Line
Aetna	2	RT/LT	1
BCBS Federal Employee Plan	2	RT/LT	1
BCBS OK	2	RT/LT	1
Cigna	2	RT/LT	1
HealthChoice	2	RT/LT	1
Humana Medicare	2	QW/RT/LT/59	1
Medicaid OK	2	QW/RT/LT	1
Medicare	2	QW/RT/LT	1
United Healthcare	1	QW	2

## Billing Format Examples

**Medicare:** Note the CLIA # in box 23 and the QW/RT, QW/LT in box 24D are required for processing. **The QW modifier should be placed first.** Claims lacking these elements will be rejected.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																	
										17b. NPI		1234567890																	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? \$ CHARGES																			
										<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										22. RESUBMISSION CODE ORIGINAL REF. NO.																			
A. ICD-10 Code(s)										23. PRIOR AUTHORIZATION NUMBER																			
E. _____										10D2345678																			
I. _____																													
24. A. DATE(S) OF SERVICE			B. PLACE OF SERVICE			C. EMG			D. PROCEDURES, SERVICES, OR SUPPLIES			E. DIAGNOSIS POINTER			F. \$ CHARGES			G. DAYS OR UNITS			H. EPSDT Family Plan			I. ID. QUAL.			J. RENDERING PROVIDER ID. #		
From To									(Explain Unusual Circumstances)																				
MM	DD	YY	MM	DD	YY				CPT/HCPCS		MODIFIER																		
11	01	23	11	01	23	11			83861		QW RT			A			50 00	1						NPI			1234567890		
11	01	23	11	01	23	11			83861		QW LT			A			50 00	1						NPI			1234567890		

**Most Commercial Plans:** Note that the QW and CLIA # are not required.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																	
										17b. NPI		1234567890																	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? \$ CHARGES																			
										<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										22. RESUBMISSION CODE ORIGINAL REF. NO.																			
A. ICD-10 Code(s)										23. PRIOR AUTHORIZATION NUMBER																			
E. _____																													
I. _____																													
24. A. DATE(S) OF SERVICE			B. PLACE OF SERVICE			C. EMG			D. PROCEDURES, SERVICES, OR SUPPLIES			E. DIAGNOSIS POINTER			F. \$ CHARGES			G. DAYS OR UNITS			H. EPSDT Family Plan			I. ID. QUAL.			J. RENDERING PROVIDER ID. #		
From To									(Explain Unusual Circumstances)																				
MM	DD	YY	MM	DD	YY				CPT/HCPCS		MODIFIER																		
11	01	23	11	01	23	11			83861		RT			A			50 00	1						NPI			1234567890		
11	01	23	11	01	23	11			83861		LT			A			50 00	1						NPI			1234567890		

**United Health Care Commercial Plans:** UHC does not recognize the RT/LT modifiers. The CLIA number is required in box 23 with the **QW Modifier only** with 2 units of service. Double the billed charge.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																	
										17b. NPI		1234567890																	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? \$ CHARGES																			
										<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										22. RESUBMISSION CODE ORIGINAL REF. NO.																			
A. ICD-10 Code(s)										23. PRIOR AUTHORIZATION NUMBER																			
E. _____										10D2345678																			
I. _____																													
24. A. DATE(S) OF SERVICE			B. PLACE OF SERVICE			C. EMG			D. PROCEDURES, SERVICES, OR SUPPLIES			E. DIAGNOSIS POINTER			F. \$ CHARGES			G. DAYS OR UNITS			H. EPSDT Family Plan			I. ID. QUAL.			J. RENDERING PROVIDER ID. #		
From To									(Explain Unusual Circumstances)																				
MM	DD	YY	MM	DD	YY				CPT/HCPCS		MODIFIER																		
11	01	23	11	01	23	11			83861		QW			A			100 00	2						NPI			1234567890		
																								NPI					

**Humana Medicare Advantage Plans:** Humana requires additional modifiers. The CLIA number is required in box 23 with the **QW/RT/LT/59** with 2 lines of service, 1 unit per line.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical			17a.	17b. NPI 1234567890			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)							20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.							22. RESUBMISSION ORIGINAL REF. NO.									
A. ICD-10 Code(s) B. C. D. E. F. G. H. I. J. K. L.							23. PRIOR AUTHORIZATION NUMBER 10D2345678									
24. A. DATE(S) OF SERVICE		B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER			E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS	H. EFSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
MM	DD	YY	MM	DD	YY											
11	01	23	11	01	23	11		83861	QW RT 59	A	50	00	1		NPI	1234567890
11	01	23	11	01	23	11		83861	QW LT 59	A	50	00	1		NPI	1234567890

### Reimbursement for Medicare Part B (fee-for-service)

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### Billing Software Requirements

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In loop 2300, Segment REFO2, enter the CLIA Certification number – 10 digits - (Do not enter “CLIA” with the certificate number as this will cause claims to deny as an invalid identification number).

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			REF02	CLIA Certification number

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- MA 120 - Did not complete or enter accurately the CLIA number.
- MA 130 - Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is un-processable. Please submit the correct information to the appropriate FI or carrier.
- B7 - "This provider was not certified/eligible to be paid for this procedure/service on this date of service."
- The laboratory is not approved for this type of test.

# OREGON BILLING GUIDE



If any denial is received for CPT 83861 contact the Trukera Reimbursement Support Center promptly at [rsc@trukera.com](mailto:rsc@trukera.com) for assistance

## Reimbursement Support Specialist

Bridget Bolles

Cell: (317) 797-7151

Fax: (858) 225-8749

Email: [bbolles@trukera.com](mailto:bbolles@trukera.com)

### This guide addresses billing recommendation for:

- **CPT Code 83861** is specific for “Microfluidic analysis utilizing an integrated collection and analysis device, tear osmolality”.
- A covered service by CMS Medicare under the Clinical Laboratory Fee Schedule.
- CLIA Certificate of Waiver is required to perform and bill this laboratory tests.
- Providers are encouraged to review payor-provider contracts for rate and claim submission requirements.
- Medical Necessity requires current signs or symptoms of disease at time of test.
- Frequency of testing is based on Medical Necessity as determined by the clinician.
- Laboratory Test - multiple procedure discounts do not apply.

Payor Name	Lines	Modifier(s)	Units per Line
Aetna	2	RT/LT	1
BCBS Federal Employee Plan	2	RT/LT	1
Cigna	2	RT/LT	1
HealthNet	2	QW/RT/LT	1
Medicaid OR	2	QW/RT/LT	1
Medicare	2	QW/RT/LT	1
Pacificsource	2	RT/LT:59 2nd	1
Providence Health Plan	2	RT/LT	1
Regence Blue	1	None	2
United Healthcare	1	QW	2
Aetna	2	RT/LT	1

## Billing Format Examples

**Medicare:** Note the CLIA # in box 23 and the QW/RT, QW/LT in box 24D are required for processing. **The QW modifier should be placed first.** Claims lacking these elements will reject.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.											18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
										17b.	NPI 1234567890										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)																				22. RESUBMISSION CODE ORIGINAL REF. NO.										
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.																				23. PRIOR AUTHORIZATION NUMBER 10D2345678										
24. A. DATE(S) OF SERVICE		From		To		B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER	F. \$ CHARGES		G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #												
MM	DD	YY	MM	DD	YY			CPT/HCPCS	MODIFIER																					
11	01	23	11	01	23	11		83861	QW	RT		A	50	00	1			NPI	1234567890											
11	01	23	11	01	23	11		83861	QW	LT		A	50	00	1			NPI	1234567890											

**Most Commercial Plans:** Note that the QW and CLIA # are not required.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.											18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
										17b.	NPI 1234567890										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)																				22. RESUBMISSION CODE ORIGINAL REF. NO.										
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.																				23. PRIOR AUTHORIZATION NUMBER										
24. A. DATE(S) OF SERVICE		From		To		B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER	F. \$ CHARGES		G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #												
MM	DD	YY	MM	DD	YY			CPT/HCPCS	MODIFIER																					
11	01	23	11	01	23	11		83861		RT		A	50	00	1			NPI	1234567890											
11	01	23	11	01	23	11		83861		LT		A	50	00	1			NPI	1234567890											

**United Health Care Commercial Plans:** UHC does not recognize the RT/LT modifiers. The CLIA number is required in box 23 with the QW Modifier only with 2 units of service. Double the billed charge.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.											18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
										17b.	NPI 1234567890										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
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21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.																				23. PRIOR AUTHORIZATION NUMBER 10D2345678										
24. A. DATE(S) OF SERVICE		From		To		B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER	F. \$ CHARGES		G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #												
MM	DD	YY	MM	DD	YY			CPT/HCPCS	MODIFIER																					
11	01	23	11	01	23	11		83861	QW			A	100	00	2			NPI	1234567890											
																		NPI												

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17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																							
Dr. Trukera Medical										17b. NPI		1234567890																							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES																							
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.																							
A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER																							
B. [ ]												10D2345678																							
C. [ ]																																			
D. [ ]																																			
E. [ ]																																			
F. [ ]																																			
G. [ ]																																			
H. [ ]																																			
I. [ ]																																			
J. [ ]																																			
K. [ ]																																			
L. [ ]																																			
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)										E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From To										SERVICE				CPT/HCPCS MODIFIER																					
MM DD YY MM DD YY																																			
11 01 23 11 01 23										11				83861 QW RT 59										A		50 00		1				NPI		1234567890	
11 01 23 11 01 23										11				83861 QW LT 59										A		50 00		1				NPI		1234567890	

### Reimbursement for Medicare Part B (fee-for-service)

**2023-2024 Clinical Laboratory Fee Schedule (CLFS) Rate:** \$22.48 per test (\$44.96 per patient)

#### Sequestration Withhold

- Medicare intermediaries are required to withhold two-percent of the allowable.

#### Medicare CMS Part B

- CMS Medicare pays at 100% of CLFS throughout the United States.
- No deductible or patient co-payment applies.
- Free standing, global lab code.
- CLIA Certification required.

#### Billing Software Requirements

- **ANSI 5010 E-claim Crosswalk**

In loop 2300, Segment REFO2, enter the CLIA Certification number – 10 digits - (Do not enter “CLIA” with the certificate number as this will cause claims to deny as an invalid identification number).

Field #	Claim Description	Loop	Segment	Electronic Description
23.	Prior Authorization number	2300	REF01	Reference identification qualifier =X4
			REF02	CLIA Certification number



## Common Notification Reasons for Medicare Denials

If there is no CLIA number on the claim, Medicare sends RA messages MA 120 and MA 130, which state:

- MA 120 - Did not complete or enter accurately the CLIA number.
- MA 130 - Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is un-processable. Please submit the correct information to the appropriate FI or carrier.
- B7 - "This provider was not certified/eligible to be paid for this procedure/service on this date of service."
- The laboratory is not approved for this type of test

# PENNSYLVANIA BILLING GUIDE



If any denial is received for CPT 83861 contact the Trukera Reimbursement Support Center promptly at [rsc@trukera.com](mailto:rsc@trukera.com) for assistance

## Reimbursement Support Specialist

Bridget Bolles

Cell: (317) 797-7151

Fax: (858) 225-8749

Email: [bbolles@trukera.com](mailto:bbolles@trukera.com)

### This guide addresses billing recommendation for:

- **CPT Code 83861** is specific for “Microfluidic analysis utilizing an integrated collection and analysis device, tear osmolality”.
- A covered service by CMS Medicare under the Clinical Laboratory Fee Schedule.
- CLIA Certificate of Waiver is required to perform and bill this laboratory tests.
- Providers are encouraged to review payor-provider contracts for rate and claim submission requirements.
- Medical Necessity requires current signs or symptoms of disease at time of test.
- Frequency of testing is based on Medical Necessity as determined by the clinician.
- Laboratory Test - multiple procedure discounts do not apply.

Payor Name	Lines	Modifier(s)	Units per Line
Medicare	2	QW/RT/LT	1
HighMark	2	RT/LT	1
Independence BC	2	none	2
Aetna	2	RT/LT	1
UPMC	2	RT/LT	1
United HC	1	QW	2
Geisinger	2	QW/RT/LT	1
PA Medicaid	0	none	0
Cigna	2	RT/LT	1
BCBS FED	2	RT/LT	1
Gateway	2	QW/RT/LT	1
Capital Blue	2	none	1

### Pennsylvania Providers:

Humana Commercial: Will deny claim (**Diagnostic testing for dry eye syndrome is not separately reimbursable**).

Pennsylvania Medicaid: TearLab is a non-covered service

## Billing Format Examples

**Medicare:** Note the CLIA # in box 23 and the QW/RT, QW/LT in box 24D are required for processing. **The QW modifier should be placed first.** Claims lacking these elements will reject.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES													
Dr. Trukera Medical										17b.		NPI		1234567890											
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)														20. OUTSIDE LAB? \$ CHARGES											
														<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.				22. RESUBMISSION CODE ORIGINAL REF. NO.											
A. ICD-10 Code(s)										B.		C.		D.		23. PRIOR AUTHORIZATION NUMBER									
E.										F.		G.		H.		10D2345678									
I.										J.		K.		L.											
24. A. DATE(S) OF SERVICE			B. PLACE OF SERVICE			C.	D. PROCEDURES, SERVICES, OR SUPPLIES				E.	F.		G.	H.	I.	J.								
From To			SERVICE			EMG	(Explain Unusual Circumstances)				DIAGNOSIS	\$ CHARGES		DAYS OR UNITS	EPSDT Family Plan	ID. QUAL.	RENDERING PROVIDER ID. #								
MM DD YY MM DD YY							CPT/HCPCS MODIFIER				POINTER														
11 01 23 11 01 23			11				83861 QW RT				A	50 00		1		NPI	1234567890								
11 01 23 11 01 23			11				83861 QW LT				A	50 00		1		NPI	1234567890								

**Most Commercial Plans:** Note that the QW and CLIA # are not required.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES													
Dr. Trukera Medical										17b.		NPI		1234567890											
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)														20. OUTSIDE LAB? \$ CHARGES											
														<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.				22. RESUBMISSION CODE ORIGINAL REF. NO.											
A. ICD-10 Code(s)										B.		C.		D.		23. PRIOR AUTHORIZATION NUMBER									
E.										F.		G.		H.											
I.										J.		K.		L.											
24. A. DATE(S) OF SERVICE			B. PLACE OF SERVICE			C.	D. PROCEDURES, SERVICES, OR SUPPLIES				E.	F.		G.	H.	I.	J.								
From To			SERVICE			EMG	(Explain Unusual Circumstances)				DIAGNOSIS	\$ CHARGES		DAYS OR UNITS	EPSDT Family Plan	ID. QUAL.	RENDERING PROVIDER ID. #								
MM DD YY MM DD YY							CPT/HCPCS MODIFIER				POINTER														
11 01 23 11 01 23			11				83861 RT				A	50 00		1		NPI	1234567890								
11 01 23 11 01 23			11				83861 LT				A	50 00		1		NPI	1234567890								

**United Health Care Commercial Plans:** UHC does not recognize the RT/LT modifiers. The CLIA number is required in box 23 with the **QW Modifier only** with 2 units of service. Double the billed charge.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES													
Dr. Trukera Medical										17b.		NPI		1234567890											
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)														20. OUTSIDE LAB? \$ CHARGES											
														<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.				22. RESUBMISSION CODE ORIGINAL REF. NO.											
A. ICD-10 Code(s)										B.		C.		D.		23. PRIOR AUTHORIZATION NUMBER									
E.										F.		G.		H.		10D2345678									
I.										J.		K.		L.											
24. A. DATE(S) OF SERVICE			B. PLACE OF SERVICE			C.	D. PROCEDURES, SERVICES, OR SUPPLIES				E.	F.		G.	H.	I.	J.								
From To			SERVICE			EMG	(Explain Unusual Circumstances)				DIAGNOSIS	\$ CHARGES		DAYS OR UNITS	EPSDT Family Plan	ID. QUAL.	RENDERING PROVIDER ID. #								
MM DD YY MM DD YY							CPT/HCPCS MODIFIER				POINTER														
11 01 23 11 01 23			11				83861 QW				A	100 00		2		NPI	1234567890								
																NPI									

**Humana Medicare Advantage Plans:** Humana requires additional modifiers. The CLIA number is required in box 23 with the **QW/RT/LT/59** with 2 lines of service, 1 unit per line

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																							
Dr. Trukera Medical										17b. NPI		1234567890																							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES																							
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.																							
A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER																							
B. [ ]												10D2345678																							
C. [ ]																																			
D. [ ]																																			
E. [ ]																																			
F. [ ]																																			
G. [ ]																																			
H. [ ]																																			
I. [ ]																																			
J. [ ]																																			
K. [ ]																																			
L. [ ]																																			
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)										E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From To										SERVICE				CPT/HCPCS MODIFIER																					
MM DD YY MM DD YY																																			
11 01 23 11 01 23										11				83861 QW RT 59										A		50 00		1				NPI		1234567890	
11 01 23 11 01 23										11				83861 QW LT 59										A		50 00		1				NPI		1234567890	

### Reimbursement for Medicare Part B (fee-for-service)

**2023-2024 Clinical Laboratory Fee Schedule (CLFS) Rate:** \$22.48 per test (\$44.96 per patient)

#### Sequestration Withhold

- Medicare intermediaries are required to withhold two-percent of the allowable.

#### Medicare CMS Part B

- CMS Medicare pays at 100% of CLFS throughout the United States.
- No deductible or patient co-payment applies.
- Free standing, global lab code.
- CLIA Certification required.

#### Billing Software Requirements

- **ANSI 5010 E-claim Crosswalk**

In loop 2300, Segment REFO2, enter the CLIA Certification number – 10 digits - (Do not enter “CLIA” with the certificate number as this will cause claims to deny as an invalid identification number).

Field #	Claim Description	Loop	Segment	Electronic Description
23.	Prior Authorization number	2300	REF01	Reference identification qualifier =X4
			REF02	CLIA Certification number

## Common Notification Reasons for Medicare Denials

If there is no CLIA number on the claim, Medicare sends RA messages MA 120 and MA 130, which state:

- MA 120 - Did not complete or enter accurately the CLIA number.
- MA 130 - Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is un-processable. Please submit the correct information to the appropriate FI or carrier.
- B7 - "This provider was not certified/eligible to be paid for this procedure/service on this date of service."
- The laboratory is not approved for this type of test

# RHODE ISLAND BILLING GUIDE



If any denial is received for CPT 83861 contact the Trukera Reimbursement Support Center promptly at [rsc@trukera.com](mailto:rsc@trukera.com) for assistance

**Reimbursement Support Specialist**

Bridget Bolles

Cell: (317) 797-7151

Fax: (858) 225-8749

Email: [bbolles@trukera.com](mailto:bbolles@trukera.com)

**This guide addresses billing recommendation for:**

- **CPT Code 83861** is specific for “Microfluidic analysis utilizing an integrated collection and analysis device, tear osmolality”.
- A covered service by CMS Medicare under the Clinical Laboratory Fee Schedule.
- CLIA Certificate of Waiver is required to perform and bill this laboratory tests.
- Providers are encouraged to review payor-provider contracts for rate and claim submission requirements.
- Medical Necessity requires current signs or symptoms of disease at time of test.
- Frequency of testing is based on Medical Necessity as determined by the clinician.
- Laboratory Test - multiple procedure discounts do not apply.

**Rhode Island Providers:**

**Humana Commercial:** Will deny claim (Diagnostic testing for dry eye syndrome is not separately reimbursable).

**Billing Format Examples**

**Medicare:** Note the CLIA # in box 23 and the QW/RT, QW/LT in box24D are required for processing. **The QW modifier should be placed first.** Claims lacking these elements will reject.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																	
										17b. NPI		1234567890		FROM		MM		DD		YY		TO		MM		DD		YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)															20. OUTSIDE LAB? \$ CHARGES														
															<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO														
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)															22. RESUBMISSION CODE ORIGINAL REF. NO.														
A. ICD-10 Code(s)															23. PRIOR AUTHORIZATION NUMBER														
B. PLACE OF SERVICE															10D2345678														
C. EMG																													
D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)																													
E. DIAGNOSIS POINTER																													
F. \$ CHARGES																													
G. DAYS OR UNITS																													
H. EPSDT Family Plan																													
I. ID. QUAL.																													
J. RENDERING PROVIDER ID. #																													
11	01	23	11	01	23	11		83861	QW	RT		A		50,00	1			NPI	1234567890										
11	01	23	11	01	23	11		83861	QW	LT		A		50,00	1			NPI	1234567890										

**Most Commercial Plans:** Note that the QW and CLIA # are not required.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.											18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
										17b.	NPI 1234567890										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)																				22. RESUBMISSION CODE ORIGINAL REF. NO.										
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.																				23. PRIOR AUTHORIZATION NUMBER										
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) EPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #																														
11	01	23	11	01	23	11		83861	RT			A	50	00	1			NPI	1234567890											
11	01	23	11	01	23	11		83861	LT			A	50	00	1			NPI	1234567890											

**United Health Care Commercial Plans:** UHC does not recognize the RT/LT modifiers. The CLIA number is required in box 23 with the **QW Modifier only** with 2 units of service. Double the billed charge.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.											18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
										17b.	NPI 1234567890										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)																				22. RESUBMISSION CODE ORIGINAL REF. NO.										
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.																				23. PRIOR AUTHORIZATION NUMBER										
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) EPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #																														
11	01	23	11	01	23	11		83861	QW			A	100	00	2			NPI	1234567890											
																		NPI												

**Humana Medicare Advantage Plans:** Humana requires additional modifiers. The CLIA number is required in box 23 with the **QW/RT/LT/59** with 2 lines of service, 1 unit per line

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																	
Dr. Trukera Medical										17b. NPI		1234567890																	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES																	
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.																	
A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER																	
E.												10D2345678																	
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From		To		From		To		CPT/HCPCS		MODIFIER		POINTER																	
MM	DD	YY	MM	DD	YY	MM	DD	YY																					
11	01	23	11	01	23	11			83861	QW	RT	59		A		50	00	1			NPI	1234567890							
11	01	23	11	01	23	11			83861	QW	LT	59		A		50	00	1			NPI	1234567890							

### Reimbursement for Medicare Part B (fee-for-service)

**2023-2024 Clinical Laboratory Fee Schedule (CLFS) Rate:** \$22.48 per test (\$44.96 per patient)

#### Sequestration Withhold

- Medicare intermediaries are required to withhold two-percent of the allowable.

#### Medicare CMS Part B

- CMS Medicare pays at 100% of CLFS throughout the United States.
- No deductible or patient co-payment applies.
- Free standing, global lab code.
- CLIA Certification required.

#### Billing Software Requirements

- **ANSI 5010 E-claim Crosswalk**

In loop 2300, Segment REFO2, enter the CLIA Certification number – 10 digits - (Do not enter “CLIA” with the certificate number as this will cause claims to deny as an invalid identification number).

Field #	Claim Description	Loop	Segment	Electronic Description
23.	Prior Authorization number	2300	REF01	Reference identification qualifier =X4
			REF02	CLIA Certification number



## Common Notification Reasons for Medicare Denials

If there is no CLIA number on the claim, Medicare sends RA messages MA 120 and MA 130, which state:

- MA 120 - Did not complete or enter accurately the CLIA number.
- MA 130 - Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is un-processable. Please submit the correct information to the appropriate FI or carrier.
- B7 - "This provider was not certified/eligible to be paid for this procedure/service on this date of service."
- The laboratory is not approved for this type of test

# SOUTH CAROLINA BILLING GUIDE



If any denial is received for CPT 83861 contact the Trukera Medical Reimbursement Support Center promptly at [rsc@trukera.com](mailto:rsc@trukera.com) for assistance.

## Reimbursement Support Specialist

Amanda Rotteck

Fax: (858) 225-8749

Cell: (704) 928-9009

Email: [arotteck@trukera.com](mailto:arotteck@trukera.com)

### This guide addresses billing recommendation for:

- **CPT Code 83861** is specific for “Microfluidic analysis utilizing an integrated collection and analysis device, tear osmolality”.
- A covered service by CMS Medicare under the Clinical Laboratory Fee Schedule.
- CLIA Certificate of Waiver is required to perform and bill this laboratory tests.
- Providers are encouraged to review payor-provider contracts for rate and claim submission requirements.
- Medical Necessity requires current signs or symptoms of disease at time of test.
- Frequency of testing is based on Medical Necessity as determined by the clinician.
- Laboratory Test - multiple procedure discounts do not apply.

Payor Name	Lines	Modifier(s)	Units per Line
Medicare	2	QW/RT/LT	1
BCBS SC	1	QW	2
SC Medicaid	2	QW/RT/LT	1
Humana Medicare	2	QW/RT/LT/59	1
Select Health of SC	1	none	2
United HC	1	QW	2
Cigna	2	RT/LT	1
Molina	2	RT/LT	1
Absolute Total Care	2	QW/RT/LT	1
Aetna	2	RT/LT	1
Wellcare	2	RT/LT	1

### South Carolina Providers:

**Humana Commercial:** Will deny claim (**Diagnostic testing for dry eye syndrome is not separately reimbursable**).

**South Carolina Medicaid:** CLIA # / NPI need to be loaded through Provider Enrollment before processing claims.

## Billing Format Examples

**Medicare:** Note the CLIA # in box 23 and the QW/RT, QW/LT in box 24D are required for processing. **The QW modifier should be placed first.** Claims lacking these elements will be rejected.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																							
Dr. Trukera Medical										17b. NPI		1234567890																							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES																							
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.																							
A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER																							
B. _____												10D2345678																							
C. _____																																			
D. _____																																			
E. _____																																			
F. _____																																			
G. _____																																			
H. _____																																			
I. _____																																			
J. _____																																			
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)										E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From To										SERVICE				CPT/HCPCS MODIFIER																					
MM DD YY MM DD YY																																			
11 01 23 11 01 23										11				83861 QW RT										A		50 00		1				NPI		1234567890	
11 01 23 11 01 23										11				83861 QW LT										A		50 00		1				NPI		1234567890	

**Most Commercial Plans:** Note that the QW and CLIA # are not required.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																							
Dr. Trukera Medical										17b. NPI		1234567890																							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES																							
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.																							
A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER																							
B. _____																																			
C. _____																																			
D. _____																																			
E. _____																																			
F. _____																																			
G. _____																																			
H. _____																																			
I. _____																																			
J. _____																																			
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)										E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From To										SERVICE				CPT/HCPCS MODIFIER																					
MM DD YY MM DD YY																																			
11 01 23 11 01 23										11				83861 RT										A		50 00		1				NPI		1234567890	
11 01 23 11 01 23										11				83861 LT										A		50 00		1				NPI		1234567890	

**United Health Care Commercial Plans:** UHC does not recognize the RT/LT modifiers. The CLIA number is required in box 23 with the **QW Modifier only** with 2 units of service. Double the billed charge.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																							
Dr. Trukera Medical										17b. NPI		1234567890																							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES																							
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.																							
A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER																							
B. _____												10D2345678																							
C. _____																																			
D. _____																																			
E. _____																																			
F. _____																																			
G. _____																																			
H. _____																																			
I. _____																																			
J. _____																																			
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)										E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From To										SERVICE				CPT/HCPCS MODIFIER																					
MM DD YY MM DD YY																																			
11 01 23 11 01 23										11				83861 QW										A		100 00		2				NPI		1234567890	

**Humana Medicare Advantage Plans:** Humana requires additional modifiers. The CLIA number is required in box 23 with the **QW/RT/LT/59** with 2 lines of service, 1 unit per line.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES												
										17b. NPI		1234567890		FROM MM DD YY				TO MM DD YY						
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? \$ CHARGES														
										<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO														
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.												
A. ICD-10 Code(s)																								
E.										F.		23. PRIOR AUTHORIZATION NUMBER												
I.										J.		10D2345678												
24. A. DATE(S) OF SERVICE			B. PLACE OF SERVICE			C. EMG			D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From MM DD YY			To MM DD YY						CPT/HCPCS MODIFIER															
11 01 23			11 01 23			11			83861 QW RT 59				A		50 00		1				NPI 1234567890			
11 01 23			11 01 23			11			83861 QW LT 59				A		50 00		1				NPI 1234567890			

### Reimbursement for Medicare Part B (fee-for-service)

**2021-2024 Clinical Laboratory Fee Schedule (CLFS) Rate:** \$22.48 per test (\$44.96 per patient)

### Sequestration Withhold

- Medicare intermediaries are required to withhold two percent of the allowable.

### Medicare CMS Part B

- CMS Medicare pays at 100% of CLFS throughout the United States.
- No deductible or patient co-payment applies.
- Free standing, global lab code.
- CLIA Certification required.

### Billing Software Requirements

- **ANSI 5010 E-claim Crosswalk**

In loop 2300, Segment REFO2, enter the CLIA Certification number – 10 digits - (Do not enter “CLIA” with the certificate number as this will cause claims to deny as an invalid identification number).

Field #	Claim Description	Loop	Segment	Electronic Description
23.	Prior Authorization number	2300	REF01	Reference identification qualifier =X4
			REF02	CLIA Certification number

### Common Notification Reasons for Medicare Denials

If there is no CLIA number on the claim, Medicare sends RA messages MA 120 and MA 130, which state:

- MA 120 - Did not complete or enter accurately the CLIA number.
- MA 130 - Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is un-processable. Please submit the correct information to the appropriate FI or carrier.
- B7 - "This provider was not certified/eligible to be paid for this procedure/service on this date of service."
- The laboratory is not approved for this type of test.

# SOUTH DAKOTA BILLING GUIDE



If any denial is received for CPT 83861 contact the Trukera Reimbursement Support Center promptly at [rsc@trukera.com](mailto:rsc@trukera.com) for assistance

## Reimbursement Support Specialist

Bridget Bolles

Cell: (317) 797-7151

Fax: (858) 225-8749

Email: [bbolles@trukera.com](mailto:bbolles@trukera.com)

### This guide addresses billing recommendation for:

- **CPT Code 83861** is specific for “Microfluidic analysis utilizing an integrated collection and analysis device, tear osmolality”.
- A covered service by CMS Medicare under the Clinical Laboratory Fee Schedule.
- CLIA Certificate of Waiver is required to perform and bill this laboratory tests.
- Providers are encouraged to review payor-provider contracts for rate and claim submission requirements.
- Medical Necessity requires current signs or symptoms of disease at time of test.
- Frequency of testing is based on Medical Necessity as determined by the clinician.
- Laboratory Test - multiple procedure discounts do not apply.

Payor Name	Lines	Modifier(s)	Units per Line
Aetna	2	RT/LT	1
BCBS Federal Employee Plan	2	RT/LT	1
BCBS SD - Wellmark	2	RT/LT	1
Cigna	2	RT/LT	1
DakotaCare	2	QW/RT/LT	1
HealthNet	2	QW/RT/LT	1
Humana Medicare	2	QW/RT/L/59	1
Medica Health Plans	2	QW/RT/LT	1
Medicaid SD	2	QW/RT/LT	1
Medicare	2	QW/RT/LT	1
Sanford Health	2	RT/LT	1

## Billing Format Examples

**Medicare:** Note the CLIA # in box 23 and the QW/RT, QW/LT in box 24D are required for processing. **The QW modifier should be placed first.** Claims lacking these elements will reject.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.											18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
										17b.	NPI 1234567890										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)																				22. RESUBMISSION CODE ORIGINAL REF. NO.										
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.																				23. PRIOR AUTHORIZATION NUMBER 10D2345678										
24. A. DATE(S) OF SERVICE		From		To		B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER	F. \$ CHARGES		G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #												
MM	DD	YY	MM	DD	YY			CPT/HCPCS	MODIFIER																					
11	01	23	11	01	23	11		83861	QW	RT		A	50	00	1		NPI	1234567890												
11	01	23	11	01	23	11		83861	QW	LT		A	50	00	1		NPI	1234567890												

**Most Commercial Plans:** Note that the QW and CLIA # are not required.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.											18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
										17b.	NPI 1234567890										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)																				22. RESUBMISSION CODE ORIGINAL REF. NO.										
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.																				23. PRIOR AUTHORIZATION NUMBER										
24. A. DATE(S) OF SERVICE		From		To		B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER	F. \$ CHARGES		G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #												
MM	DD	YY	MM	DD	YY			CPT/HCPCS	MODIFIER																					
11	01	23	11	01	23	11		83861		RT		A	50	00	1		NPI	1234567890												
11	01	23	11	01	23	11		83861		LT		A	50	00	1		NPI	1234567890												

**United Health Care Commercial Plans:** UHC does not recognize the RT/LT modifiers. The CLIA number is required in box 23 with the QW Modifier only with 2 units of service. Double the billed charge.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.											18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
										17b.	NPI 1234567890										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)																				22. RESUBMISSION CODE ORIGINAL REF. NO.										
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.																				23. PRIOR AUTHORIZATION NUMBER 10D2345678										
24. A. DATE(S) OF SERVICE		From		To		B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER	F. \$ CHARGES		G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #												
MM	DD	YY	MM	DD	YY			CPT/HCPCS	MODIFIER																					
11	01	23	11	01	23	11		83861	QW			A	100	00	2		NPI	1234567890												

**Humana Medicare Advantage Plans:** Humana requires additional modifiers. The CLIA number is required in box 23 with the **QW/RT/LT/59** with 2 lines of service, 1 unit per line

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																							
Dr. Trukera Medical										17b. NPI		1234567890																							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES																							
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.																							
A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER																							
B. [ ]												10D2345678																							
C. [ ]																																			
D. [ ]																																			
E. [ ]																																			
F. [ ]																																			
G. [ ]																																			
H. [ ]																																			
I. [ ]																																			
J. [ ]																																			
K. [ ]																																			
L. [ ]																																			
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)										E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From To										SERVICE				CPT/HCPCS MODIFIER																					
MM DD YY MM DD YY																																			
11 01 23 11 01 23										11				83861 QW RT 59										A		50 00		1				NPI		1234567890	
11 01 23 11 01 23										11				83861 QW LT 59										A		50 00		1				NPI		1234567890	

### Reimbursement for Medicare Part B (fee-for-service)

**2023-2024 Clinical Laboratory Fee Schedule (CLFS) Rate:** \$22.48 per test (\$44.96 per patient)

#### Sequestration Withhold

- Medicare intermediaries are required to withhold two-percent of the allowable.

#### Medicare CMS Part B

- CMS Medicare pays at 100% of CLFS throughout the United States.
- No deductible or patient co-payment applies.
- Free standing, global lab code.
- CLIA Certification required.

#### Billing Software Requirements

- **ANSI 5010 E-claim Crosswalk**

In loop 2300, Segment REFO2, enter the CLIA Certification number – 10 digits - (Do not enter “CLIA” with the certificate number as this will cause claims to deny as an invalid identification number).

Field #	Claim Description	Loop	Segment	Electronic Description
23.	Prior Authorization number	2300	REF01	Reference identification qualifier =X4
			REF02	CLIA Certification number



## Common Notification Reasons for Medicare Denials

If there is no CLIA number on the claim, Medicare sends RA messages MA 120 and MA 130, which state:

- MA 120 - Did not complete or enter accurately the CLIA number.
- MA 130 - Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is un-processable. Please submit the correct information to the appropriate FI or carrier.
- B7 - "This provider was not certified/eligible to be paid for this procedure/service on this date of service."
- The laboratory is not approved for this type of test

# TENNESSEE BILLING GUIDE



If any denial is received for CPT 83861 contact the Trukera Medical Reimbursement Support Center promptly at [rsc@trukera.com](mailto:rsc@trukera.com) for assistance.

## Reimbursement Support Specialist

Amanda Rotteck  
Cell: (704) 928-9009

Fax: (858) 225-8749  
Email: [arotteck@trukera.com](mailto:arotteck@trukera.com)

### This guide addresses billing recommendation for:

- **CPT Code 83861** is specific for “Microfluidic analysis utilizing an integrated collection and analysis device, tear osmolality”.
- A covered service by CMS Medicare under the Clinical Laboratory Fee Schedule.
- CLIA Certificate of Waiver is required to perform and bill this laboratory tests.
- Providers are encouraged to review payor-provider contracts for rate and claim submission requirements.
- Medical Necessity requires current signs or symptoms of disease at time of test.
- Frequency of testing is based on Medical Necessity as determined by the clinician.
- Laboratory Test - multiple procedure discounts do not apply.

Payor Name	Lines	Modifier(s)	Units per Line
Aetna	2	RT/LT	1
Amerigroup	2	59 on second line of service	1
Anthem	2	RT/LT	1
BCBS TN	2	RT/LT	1
Cigna	2	RT/LT	1
Humana Medicare	2	QW/RT/LT/59	1
Medicare	2	QW/RT/LT	1
UHC Community Plan	1	QW	2
United Healthcare	1	QW	2
Aetna	2	RT/LT	1

## Billing Format Examples

**Medicare:** Note the CLIA # in box 23 and the QW/RT, QW/LT in box 24D are required for processing. **The QW modifier should be placed first.** Claims lacking these elements will be rejected.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																	
										17b. NPI		1234567890																	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES																	
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.																	
A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER																	
E.												10D2345678																	
I.																													
J.																													
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From To														CPT/HCPCS MODIFIER															
11 01 23 11 01 23										11				83861 QW RT				A		50 00		1				NPI 1234567890			
11 01 23 11 01 23										11				83861 QW LT				A		50 00		1				NPI 1234567890			

**Most Commercial Plans:** Note that the QW and CLIA # are not required.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																	
										17b. NPI		1234567890																	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES																	
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.																	
A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER																	
E.																													
I.																													
J.																													
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From To														CPT/HCPCS MODIFIER															
11 01 23 11 01 23										11				83861 RT				A		50 00		1				NPI 1234567890			
11 01 23 11 01 23										11				83861 LT				A		50 00		1				NPI 1234567890			

**United Health Care Commercial Plans:** UHC does not recognize the RT/LT modifiers. The CLIA number is required in box 23 with the **QW Modifier only** with 2 units of service. Double the billed charge.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																	
										17b. NPI		1234567890																	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES																	
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.																	
A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER																	
E.												10D2345678																	
I.																													
J.																													
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From To														CPT/HCPCS MODIFIER															
11 01 23 11 01 23										11				83861 QW				A		100 00		2				NPI 1234567890			

**Humana Medicare Advantage Plans:** Humana requires additional modifiers. The CLIA number is required in box 23 with the **QW/RT/LT/59** with 2 lines of service, 1 unit per line.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical		17a.	17b. NPI 1234567890		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY													
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)					20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO													
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. ICD-10 Code(s) B. C. D. E. F. G. H. I. J. K. L.					22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER 10D2345678													
24. A. DATE(S) OF SERVICE From To MM DD YY MM DD YY		B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER			E. DIAGNOSIS POINTER	F. \$ CHARGES		G. DAYS OR UNITS	H. EFSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #					
11	01	23	11	01	23	11		83861	QW	RT	59	A	50	00	1		NPI	1234567890
11	01	23	11	01	23	11		83861	QW	LT	59	A	50	00	1		NPI	1234567890

### Reimbursement for Medicare Part B (fee-for-service)

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### Billing Software Requirements

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- MA 130 - Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is un-processable. Please submit the correct information to the appropriate FI or carrier.
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- The laboratory is not approved for this type of test.

# TEXAS BILLING GUIDE



If any denial is received for CPT 83861 contact the Trukera Medical Reimbursement Support Center promptly at [rsc@trukera.com](mailto:rsc@trukera.com) for assistance.

## Reimbursement Support Specialist

Amanda Rotteck  
Cell: (704) 928-9009

Fax: (858) 225-8749  
Email: [arotteck@trukera.com](mailto:arotteck@trukera.com)

### This guide addresses billing recommendation for:

- **CPT Code 83861** is specific for “Microfluidic analysis utilizing an integrated collection and analysis device, tear osmolality.”
- A covered service by CMS Medicare under the Clinical Laboratory Fee Schedule.
- CLIA Certificate of Waiver is required to perform and bill this laboratory tests.
- Providers are encouraged to review payor-provider contracts for rate and claim submission requirements.
- Medical Necessity requires current signs or symptoms of disease at time of test.
- Frequency of testing is based on Medical Necessity as determined by the clinician.
- Laboratory Test - multiple procedure discounts do not apply.

Payor Name	Lines	Modifier(s)	Units per Line
Aetna	2	RT/LT	1
Amerigroup	2	59 on second line of service	1
Anthem Blue Cross	1	None	2
BCBS of TX	2	RT/LT	1
Cigna	2	RT/LT	1
Community Health Choice	2	RT/LT	1
Humana Medicare	2	QW/RT/LT/59	1
Medicare	2	QW/RT/LT	1
Scott & White	2	RT/LT	1
United Healthcare	1	QW	2
UHC Community Plan	1	QW	2

## Billing Format Examples

**Medicare:** Note the CLIA # in box 23 and the QW/RT, QW/LT in box 24D are required for processing. **The QW modifier should be placed first.** Claims lacking these elements will be rejected.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																							
Dr. Trukera Medical										17b. NPI		1234567890																							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES																							
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.																							
A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER																							
B. _____												10D2345678																							
C. _____																																			
D. _____																																			
E. _____																																			
F. _____																																			
G. _____																																			
H. _____																																			
I. _____																																			
J. _____																																			
K. _____																																			
L. _____																																			
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)										E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From To														CPT/HCPCS MODIFIER																					
MM DD YY MM DD YY																																			
11 01 23 11 01 23										11				83861 QW RT										A		50 00		1				NPI		1234567890	
11 01 23 11 01 23										11				83861 QW LT										A		50 00		1				NPI		1234567890	

**Most Commercial Plans:** Note that the QW and CLIA # are not required.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																							
Dr. Trukera Medical										17b. NPI		1234567890																							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES																							
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.																							
A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER																							
B. _____																																			
C. _____																																			
D. _____																																			
E. _____																																			
F. _____																																			
G. _____																																			
H. _____																																			
I. _____																																			
J. _____																																			
K. _____																																			
L. _____																																			
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)										E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From To														CPT/HCPCS MODIFIER																					
MM DD YY MM DD YY																																			
11 01 23 11 01 23										11				83861 RT										A		50 00		1				NPI		1234567890	
11 01 23 11 01 23										11				83861 LT										A		50 00		1				NPI		1234567890	

**United Health Care Commercial Plans:** UHC does not recognize the RT/LT modifiers. The CLIA number is required in box 23 with the **QW Modifier only** with 2 units of service. Double the billed charge.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																							
Dr. Trukera Medical										17b. NPI		1234567890																							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES																							
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.																							
A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER																							
B. _____												10D2345678																							
C. _____																																			
D. _____																																			
E. _____																																			
F. _____																																			
G. _____																																			
H. _____																																			
I. _____																																			
J. _____																																			
K. _____																																			
L. _____																																			
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)										E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From To														CPT/HCPCS MODIFIER																					
MM DD YY MM DD YY																																			
11 01 23 11 01 23										11				83861 QW										A		100 00		2				NPI		1234567890	

**Humana Medicare Advantage Plans:** Humana requires additional modifiers. The CLIA number is required in box 23 with the **QW/RT/LT/59** with 2 lines of service, 1 unit per line.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																	
										17b. NPI		1234567890		FROM		MM		DD		YY		TO		MM		DD		YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? \$ CHARGES																			
										<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION ORIGINAL REF. NO.																	
A. ICD-10 Code(s)												CODE																	
E.												23. PRIOR AUTHORIZATION NUMBER																	
I.												10D2345678																	
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER				E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OF UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From			To																										
MM	DD	YY	MM	DD	YY																								
11	01	23	11	01	23	11		83861	QW	RT	59		A	50	00	1				NPI	1234567890								
11	01	23	11	01	23	11		83861	QW	LT	59		A	50	00	1				NPI	1234567890								

### Reimbursement for Medicare Part B (fee-for-service)

**2021-2024 Clinical Laboratory Fee Schedule (CLFS) Rate:** \$22.48 per test (\$44.96 per patient)

### Sequestration Withhold

- Medicare intermediaries are required to withhold two percent of the allowable.

### Medicare CMS Part B

- CMS Medicare pays at 100% of CLFS throughout the United States.
- No deductible or patient co-payment applies.
- Free standing, global lab code.
- CLIA Certification required.

### Billing Software Requirements

#### - ANSI 5010 E-claim Crosswalk

In loop 2300, Segment REFO2, enter the CLIA Certification number – 10 digits - (Do not enter “CLIA” with the certificate number as this will cause claims to deny as an invalid identification number).

Field #	Claim Description	Loop	Segment	Electronic Description
23.	Prior Authorization number	2300	REF01	Reference identification qualifier =X4
			REF02	CLIA Certification number



### Common Notification Reasons for Medicare Denials

If there is no CLIA number on the claim, Medicare sends RA messages MA 120 and MA 130, which state:

- MA 120 - Did not complete or enter accurately the CLIA number.
- MA 130 - Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is un-processable. Please submit the correct information to the appropriate FI or carrier.
- B7 - "This provider was not certified/eligible to be paid for this procedure/service on this date of service."
- The laboratory is not approved for this type of test.

# UTAH BILLING GUIDE



If any denial is received for CPT 83861 contact the Trukera Medical Reimbursement Support Center promptly at [rsc@trukera.com](mailto:rsc@trukera.com) for assistance.

## Reimbursement Support Specialist

Amanda Rotteck  
Cell: (704) 928-9009

Fax: (858) 225-8749  
Email: [arotteck@trukera.com](mailto:arotteck@trukera.com)

### This guide addresses billing recommendation for:

- **CPT Code 83861** is specific for “Microfluidic analysis utilizing an integrated collection and analysis device, tear osmolality.”
- A covered service by CMS Medicare under the Clinical Laboratory Fee Schedule.
- CLIA Certificate of Waiver is required to perform and bill this laboratory tests.
- Providers are encouraged to review payor-provider contracts for rate and claim submission requirements.
- Medical Necessity requires current signs or symptoms of disease at time of test.
- Frequency of testing is based on Medical Necessity as determined by the clinician.
- Laboratory Test - multiple procedure discounts do not apply.

Payor Name	Lines	Modifier(s)	Units per Line
Aetna	2	RT/LT	1
Cigna	2	RT/LT	1
EMI Health	2	RT/LT	1
HealthNet	2	QW/RT/LT	1
Medicaid UT	2	QW/RT/LT	1
Medicare	2	QW/RT/LT	1
Molina	1	QW	2
Public Employees Health Plan (PEHP)	2	RT/LT	1
Regence Blue	2	RT/LT	1
SelectHealth	2	RT/LT	1
United Healthcare	1	QW	2
University of Utah Health Plans	2	RT/LT	2

## Billing Format Examples

**Medicare:** Note the CLIA # in box 23 and the QW/RT, QW/LT in box 24D are required for processing. **The QW modifier should be placed first.** Claims lacking these elements will be rejected.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
										17b. NPI		1234567890									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)															20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.															22. RESUBMISSION CODE ORIGINAL REF. NO.						
A. ICD-10 Code(s) B. C. D.															23. PRIOR AUTHORIZATION NUMBER						
E. F. G. H.															10D2345678						
I. J. K. L.																					
24. A. DATE(S) OF SERVICE			B. PLACE OF SERVICE			C.	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER	F. \$ CHARGES		G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #				
From To			SERVICE			EMG	CPT/HCPCS MODIFIER														
11 01 23 11 01 23			11				83861 QW RT				A	50 00		1		NPI 1234567890					
11 01 23 11 01 23			11				83861 QW LT				A	50 00		1		NPI 1234567890					

**Most Commercial Plans:** Note that the QW and CLIA # are not required.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
										17b. NPI		1234567890									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)															20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.															22. RESUBMISSION CODE ORIGINAL REF. NO.						
A. ICD-10 Code(s) B. C. D.															23. PRIOR AUTHORIZATION NUMBER						
E. F. G. H.																					
I. J. K. L.																					
24. A. DATE(S) OF SERVICE			B. PLACE OF SERVICE			C.	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER	F. \$ CHARGES		G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #				
From To			SERVICE			EMG	CPT/HCPCS MODIFIER														
11 01 23 11 01 23			11				83861 RT				A	50 00		1		NPI 1234567890					
11 01 23 11 01 23			11				83861 LT				A	50 00		1		NPI 1234567890					

**United Health Care Commercial Plans:** UHC does not recognize the RT/LT modifiers. The CLIA number is required in box 23 with the **QW Modifier only** with 2 units of service. Double the billed charge.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
										17b. NPI		1234567890									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)															20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.															22. RESUBMISSION CODE ORIGINAL REF. NO.						
A. ICD-10 Code(s) B. C. D.															23. PRIOR AUTHORIZATION NUMBER						
E. F. G. H.															10D2345678						
I. J. K. L.																					
24. A. DATE(S) OF SERVICE			B. PLACE OF SERVICE			C.	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER	F. \$ CHARGES		G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #				
From To			SERVICE			EMG	CPT/HCPCS MODIFIER														
11 01 23 11 01 23			11				83861 QW				A	100 00		2		NPI 1234567890					
																NPI					

## Reimbursement for Medicare Part B (fee-for-service)

**2021-2024 Clinical Laboratory Fee Schedule (CLFS) Rate:** \$22.48 per test (\$44.96 per patient)

## Sequestration Withhold

- Medicare intermediaries are required to withhold two percent of the allowable.

## Medicare CMS Part B

- CMS Medicare pays at 100% of CLFS throughout the United States.
- No deductible or patient co-payment applies.
- Free standing, global lab code.
- CLIA Certification required.

## Billing Software Requirements

### - ANSI 5010 E-claim Crosswalk

In loop 2300, Segment REFO2, enter the CLIA Certification number – 10 digits - (Do not enter “CLIA” with the certificate number as this will cause claims to deny as an invalid identification number).

Field #	Claim Description	Loop	Segment	Electronic Description
23.	Prior Authorization number	2300	REF01	Reference identification qualifier =X4
			REF02	CLIA Certification number

## Common Notification Reasons for Medicare Denials

If there is no CLIA number on the claim, Medicare sends RA messages MA 120 and MA 130, which state:

- MA 120 - Did not complete or enter accurately the CLIA number.
- MA 130 - Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is un-processable. Please submit the correct information to the appropriate FI or carrier.
- B7 - “This provider was not certified/eligible to be paid for this procedure/service on this date of service.”
- The laboratory is not approved for this type of test.

# VERMONT BILLING GUIDE



If any denial is received for CPT 83861 contact the Trukera Reimbursement Support Center promptly at [rsc@trukera.com](mailto:rsc@trukera.com) for assistance

## Reimbursement Support Specialist

Bridget Bolles

Cell: (317) 797-7151

Fax: (858) 225-8749

Email: [bbolles@trukera.com](mailto:bbolles@trukera.com)

### This guide addresses billing recommendation for:

- **CPT Code 83861** is specific for “Microfluidic analysis utilizing an integrated collection and analysis device, tear osmolality”.
- A covered service by CMS Medicare under the Clinical Laboratory Fee Schedule.
- CLIA Certificate of Waiver is required to perform and bill this laboratory tests.
- Providers are encouraged to review payor-provider contracts for rate and claim submission requirements.
- Medical Necessity requires current signs or symptoms of disease at time of test.
- Frequency of testing is based on Medical Necessity as determined by the clinician.
- Laboratory Test - multiple procedure discounts do not apply.

Payor Name	Lines	Modifier(s)	Units per Line
Medicare	2	QW/RT/LT	1
Anthem	2	RT/LT	1
Humana Medicare	2	QW/RT/LT/59	1
Aetna	2	RT/LT	1
United HC	1	QW	2
Cigna	2	RT/LT	1
Optima	2	RT/LT	1
BCBS FED	2	RT/LT	1
Premier HP	2	RT/LT	1
UHC Community	1	QW	2

### Vermont Providers:

Vermont Medicaid: Provider fax CLIA to 802.878.3440 Att: Enrollment

Premier: If billing bilateral modifier 50 is need.

Humana Commercial: Will deny claim (**Diagnostic testing for dry eye syndrome is not separately reimbursable**).

## Billing Format Examples

**Medicare:** Note the CLIA # in box 23 and the QW/RT, QW/LT in box 24D are required for processing. **The QW modifier should be placed first.** Claims lacking these elements will reject.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																							
Dr. Trukera Medical										17b.		NPI 1234567890																							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES																							
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.																							
A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER																							
B. _____												10D2345678																							
C. _____																																			
D. _____																																			
E. _____																																			
F. _____																																			
G. _____																																			
H. _____																																			
I. _____																																			
J. _____																																			
K. _____																																			
L. _____																																			
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)										E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From To														CPT/HCPCS MODIFIER																					
MM DD YY MM DD YY																																			
11 01 23 11 01 23										11				83861 QW RT										A		50 00		1				NPI		1234567890	
11 01 23 11 01 23										11				83861 QW LT										A		50 00		1				NPI		1234567890	

**Most Commercial Plans:** Note that the QW and CLIA # are not required.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																							
Dr. Trukera Medical										17b.		NPI 1234567890																							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES																							
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.																							
A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER																							
B. _____																																			
C. _____																																			
D. _____																																			
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J. _____																																			
K. _____																																			
L. _____																																			
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)										E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From To														CPT/HCPCS MODIFIER																					
MM DD YY MM DD YY																																			
11 01 23 11 01 23										11				83861 RT										A		50 00		1				NPI		1234567890	
11 01 23 11 01 23										11				83861 LT										A		50 00		1				NPI		1234567890	

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17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																							
Dr. Trukera Medical										17b.		NPI 1234567890																							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES																							
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.																							
A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER																							
B. _____												10D2345678																							
C. _____																																			
D. _____																																			
E. _____																																			
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H. _____																																			
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J. _____																																			
K. _____																																			
L. _____																																			
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)										E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From To														CPT/HCPCS MODIFIER																					
MM DD YY MM DD YY																																			
11 01 23 11 01 23										11				83861 QW										A		100 00		2				NPI		1234567890	

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17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																							
Dr. Trukera Medical										17b. NPI		1234567890																							
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21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.																							
A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER																							
B. [ ]												10D2345678																							
C. [ ]																																			
D. [ ]																																			
E. [ ]																																			
F. [ ]																																			
G. [ ]																																			
H. [ ]																																			
I. [ ]																																			
J. [ ]																																			
K. [ ]																																			
L. [ ]																																			
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)										E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From To										SERVICE				CPT/HCPCS MODIFIER																					
MM DD YY MM DD YY																																			
11 01 23 11 01 23										11				83861 QW RT 59										A		50 00		1				NPI		1234567890	
11 01 23 11 01 23										11				83861 QW LT 59										A		50 00		1				NPI		1234567890	

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- MA 130 - Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is un-processable. Please submit the correct information to the appropriate FI or carrier.
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- The laboratory is not approved for this type of test



# VIRGINIA BILLING GUIDE



If any denial is received for CPT 83861 contact the Trukera Reimbursement Support Center promptly at [rsc@trukera.com](mailto:rsc@trukera.com) for assistance

## Reimbursement Support Specialist

Bridget Bolles

Cell: (317) 797-7151

Fax: (858) 225-8749

Email: [bbolles@trukera.com](mailto:bbolles@trukera.com)

### This guide addresses billing recommendation for:

- **CPT Code 83861** is specific for “Microfluidic analysis utilizing an integrated collection and analysis device, tear osmolality”.
- A covered service by CMS Medicare under the Clinical Laboratory Fee Schedule.
- CLIA Certificate of Waiver is required to perform and bill this laboratory tests.
- Providers are encouraged to review payor-provider contracts for rate and claim submission requirements.
- Medical Necessity requires current signs or symptoms of disease at time of test.
- Frequency of testing is based on Medical Necessity as determined by the clinician.
- Laboratory Test - multiple procedure discounts do not apply.

Payor Name	Lines	Modifier(s)	Units per Line
Medicare	2	QW/RT/LT	1
Anthem	2	RT/LT	1
Humana Medicare	2	QW/RT/LT/59	1
Aetna	2	RT/LT	1
United HC/ UHC Community	1	QW	2
Cigna	2	RT/LT	1
Optima	2	RT/LT	1
BCBS FED	2	RT/LT	1
Premier HP	2	RT/LT	1
Virginia Medicaid	1	QW	2

### Virginia Providers:

**Humana Commercial:** Will deny claim (**Diagnostic testing for dry eye syndrome is not separately reimbursable**).

**Premier:** If billed as bilateral use a modifier 50

## Billing Format Examples

**Medicare:** Note the CLIA # in box 23 and the QW/RT, QW/LT in box 24D are required for processing. **The QW modifier should be placed first.** Claims lacking these elements will reject.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																							
Dr. Trukera Medical										17b. NPI		1234567890																							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES																							
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.																							
A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER																							
B. _____												10D2345678																							
C. _____																																			
D. _____																																			
E. _____																																			
F. _____																																			
G. _____																																			
H. _____																																			
I. _____																																			
J. _____																																			
K. _____																																			
L. _____																																			
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)										E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From To														CPT/HCPCS MODIFIER																					
MM DD YY MM DD YY																																			
11 01 23 11 01 23										11				83861 QW RT										A		50 00		1				NPI		1234567890	
11 01 23 11 01 23										11				83861 QW LT										A		50 00		1				NPI		1234567890	

**Most Commercial Plans:** Note that the QW and CLIA # are not required.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																							
Dr. Trukera Medical										17b. NPI		1234567890																							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES																							
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.																							
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B. _____																																			
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E. _____																																			
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L. _____																																			
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)										E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From To														CPT/HCPCS MODIFIER																					
MM DD YY MM DD YY																																			
11 01 23 11 01 23										11				83861 RT										A		50 00		1				NPI		1234567890	
11 01 23 11 01 23										11				83861 LT										A		50 00		1				NPI		1234567890	

**United Health Care Commercial Plans:** UHC does not recognize the RT/LT modifiers. The CLIA number is required in box 23 with the **QW Modifier only** with 2 units of service. Double the billed charge.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																							
Dr. Trukera Medical										17b. NPI		1234567890																							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES																							
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.																							
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B. _____												10D2345678																							
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24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)										E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From To														CPT/HCPCS MODIFIER																					
MM DD YY MM DD YY																																			
11 01 23 11 01 23										11				83861 QW										A		100 00		2				NPI		1234567890	

**Humana Medicare Advantage Plans:** Humana requires additional modifiers. The CLIA number is required in box 23 with the **QW/RT/LT/59** with 2 lines of service, 1 unit per line

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																	
Dr. Trukera Medical										17b. NPI		1234567890																	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES																	
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.																	
A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER																	
E.												10D2345678																	
I.																													
J.																													
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From To										SERVICE				CPT/HCPCS MODIFIER															
MM DD YY MM DD YY																													
11 01 23 11 01 23										11				83861 QW RT 59				A		50 00		1				NPI 1234567890			
11 01 23 11 01 23										11				83861 QW LT 59				A		50 00		1				NPI 1234567890			

### Reimbursement for Medicare Part B (fee-for-service)

**2023-2024 Clinical Laboratory Fee Schedule (CLFS) Rate:** \$22.48 per test (\$44.96 per patient)

#### Sequestration Withhold

- Medicare intermediaries are required to withhold two-percent of the allowable.

#### Medicare CMS Part B

- CMS Medicare pays at 100% of CLFS throughout the United States.
- No deductible or patient co-payment applies.
- Free standing, global lab code.
- CLIA Certification required.

#### Billing Software Requirements

- **ANSI 5010 E-claim Crosswalk**

In loop 2300, Segment REFO2, enter the CLIA Certification number – 10 digits - (Do not enter “CLIA” with the certificate number as this will cause claims to deny as an invalid identification number).

Field #	Claim Description	Loop	Segment	Electronic Description
23.	Prior Authorization number	2300	REF01	Reference identification qualifier =X4
			REF02	CLIA Certification number

## Common Notification Reasons for Medicare Denials

If there is no CLIA number on the claim, Medicare sends RA messages MA 120 and MA 130, which state:

- MA 120 - Did not complete or enter accurately the CLIA number.
- MA 130 - Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is un-processable. Please submit the correct information to the appropriate FI or carrier.
- B7 - "This provider was not certified/eligible to be paid for this procedure/service on this date of service."
- The laboratory is not approved for this type of test

# WASHINGTON BILLING GUIDE



If any denial is received for CPT 83861 contact the Trukera Reimbursement Support Center promptly at [rsc@trukera.com](mailto:rsc@trukera.com) for assistance

## Reimbursement Support Specialist

Bridget Bolles

Cell: (317) 797-7151

Fax: (858) 225-8749

Email: [bbolles@trukera.com](mailto:bbolles@trukera.com)

### This guide addresses billing recommendation for:

- **CPT Code 83861** is specific for “Microfluidic analysis utilizing an integrated collection and analysis device, tear osmolality”.
- A covered service by CMS Medicare under the Clinical Laboratory Fee Schedule.
- CLIA Certificate of Waiver is required to perform and bill this laboratory tests.
- Providers are encouraged to review payor-provider contracts for rate and claim submission requirements.
- Medical Necessity requires current signs or symptoms of disease at time of test.
- Frequency of testing is based on Medical Necessity as determined by the clinician.
- Laboratory Test - multiple procedure discounts do not apply.

Payor Name	Lines	Modifier(s)	Units per Line
Aetna	2	RT/LT	1
BCBS Federal Employee Plan	2	RT/LT	1
Cigna	2	RT/LT	1
Coordinated Care Health Plan	2	RT/LT	1
HealthNet	2	QW/RT/LT	1
Medicare	2	QW/RT/LT	1
Molina	1	QW	2
Premera Blue Cross	1	None	2
Regence Blue Cross	1	None	2
UHC Community Plan/UHC	1	QW	2
Humana Medicare Advantage	2	QW/RT/LT/59	1

## Billing Format Examples

**Medicare:** Note the CLIA # in box 23 and the QW/RT, QW/LT in box 24D are required for processing. **The QW modifier should be placed first.** Claims lacking these elements will reject.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.											18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
										17b.	NPI 1234567890										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)																				22. RESUBMISSION CODE ORIGINAL REF. NO.										
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. ICD-10 Code(s) B. C. D. E. F. G. H. I. J. K. L.																				23. PRIOR AUTHORIZATION NUMBER 10D2345678										
24. A. DATE(S) OF SERVICE From To MM DD YY MM DD YY			B. PLACE OF SERVICE		C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER				E. DIAGNOSIS POINTER	F. \$ CHARGES		G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #														
11 01 23 11 01 23			11			83861 QW RT				A	50 00		1		NPI	1234567890														
11 01 23 11 01 23			11			83861 QW LT				A	50 00		1		NPI	1234567890														

**Most Commercial Plans:** Note that the QW and CLIA # are not required.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.											18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
										17b.	NPI 1234567890										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
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24. A. DATE(S) OF SERVICE From To MM DD YY MM DD YY			B. PLACE OF SERVICE		C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER				E. DIAGNOSIS POINTER	F. \$ CHARGES		G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #														
11 01 23 11 01 23			11			83861 RT				A	50 00		1		NPI	1234567890														
11 01 23 11 01 23			11			83861 LT				A	50 00		1		NPI	1234567890														

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										17b.	NPI 1234567890										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)																				22. RESUBMISSION CODE ORIGINAL REF. NO.										
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24. A. DATE(S) OF SERVICE From To MM DD YY MM DD YY			B. PLACE OF SERVICE		C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER				E. DIAGNOSIS POINTER	F. \$ CHARGES		G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #														
11 01 23 11 01 23			11			83861 QW				A	100 00		2		NPI	1234567890														
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												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																							
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B. [ ]												10D2345678																							
C. [ ]																																			
D. [ ]																																			
E. [ ]																																			
F. [ ]																																			
G. [ ]																																			
H. [ ]																																			
I. [ ]																																			
J. [ ]																																			
K. [ ]																																			
L. [ ]																																			
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)										E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From To										SERVICE				CPT/HCPCS MODIFIER																					
MM DD YY MM DD YY																																			
11 01 23 11 01 23										11				83861 QW RT 59										A		50 00		1				NPI		1234567890	
11 01 23 11 01 23										11				83861 QW LT 59										A		50 00		1				NPI		1234567890	

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#### Medicare CMS Part B

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- No deductible or patient co-payment applies.
- Free standing, global lab code.
- CLIA Certification required.

#### Billing Software Requirements

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- MA 130 - Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is un-processable. Please submit the correct information to the appropriate FI or carrier.
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- The laboratory is not approved for this type of test



# WEST VIRGINIA BILLING GUIDE



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## Reimbursement Support Specialist

Bridget Bolles

Cell: (317) 797-7151

Fax: (858) 225-8749

Email: [bbolles@trukera.com](mailto:bbolles@trukera.com)

### This guide addresses billing recommendation for:

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- Providers are encouraged to review payor-provider contracts for rate and claim submission requirements.
- Medical Necessity requires current signs or symptoms of disease at time of test.
- Frequency of testing is based on Medical Necessity as determined by the clinician.
- Laboratory Test - multiple procedure discounts do not apply.

Payor Name	Lines	Modifier(s)	Units per Line
Medicare	2	QW/RT/LT	1
Aetna	2	RT/LT	1
HighMark	2	RT/LT	1
The Health Plan-PEIA	2	QW/RT/LT	1
Unicare	2	RT/LT	2
WV Medicaid	2	QW/RT/LT	1
Humana Medicare	2	QW/RT/LT/59	1
BCBS FED	2	RT/LT	1
Cigna	2	RT/LT	2
United HC	1	QW	2

### West Virginia Providers:

Humana Commercial: Will deny claim (**Diagnostic testing for dry eye syndrome is not separately reimbursable**).

West Virginia Medicaid: CLIA # and NPI need to be loaded through Provider Enrollment before processing claims

## Billing Format Examples

**Medicare:** Note the CLIA # in box 23 and the QW/RT, QW/LT in box 24D are required for processing. **The QW modifier should be placed first.** Claims lacking these elements will reject.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES									
Dr. Trukera Medical										17b. NPI		1234567890									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES									
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.									
A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER									
B. _____												10D2345678									
C. _____																					
D. _____																					
E. _____																					
F. _____																					
G. _____																					
H. _____																					
I. _____																					
J. _____																					
K. _____																					
L. _____																					
24. A. DATE(S) OF SERVICE			B. PLACE OF SERVICE			C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER	F. \$ CHARGES		G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #				
From MM DD YY To MM DD YY			SERVICE				CPT/HCPCS MODIFIER														
11 01 23 11 01 23			11				83861 QW RT				A	50 00		1		NPI 1234567890					
11 01 23 11 01 23			11				83861 QW LT				A	50 00		1		NPI 1234567890					

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17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES									
Dr. Trukera Medical										17b. NPI		1234567890									
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												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.									
A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER									
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24. A. DATE(S) OF SERVICE			B. PLACE OF SERVICE			C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER	F. \$ CHARGES		G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #				
From MM DD YY To MM DD YY			SERVICE				CPT/HCPCS MODIFIER														
11 01 23 11 01 23			11				83861 RT				A	50 00		1		NPI 1234567890					
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24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)										E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From To										SERVICE				CPT/HCPCS MODIFIER																					
MM DD YY MM DD YY																																			
11 01 23 11 01 23										11				83861 QW RT 59										A		50 00		1				NPI		1234567890	
11 01 23 11 01 23										11				83861 QW LT 59										A		50 00		1				NPI		1234567890	

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- MA 130 - Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is un-processable. Please submit the correct information to the appropriate FI or carrier.
- B7 - "This provider was not certified/eligible to be paid for this procedure/service on this date of service."
- The laboratory is not approved for this type of test

# WISCONSIN BILLING GUIDE



If any denial is received for CPT 83861 contact the Trukera Reimbursement Support Center promptly at [rsc@trukera.com](mailto:rsc@trukera.com) for assistance

## Reimbursement Support Specialist

Bridget Bolles

Cell: (317) 797-7151

Fax: (858) 225-8749

Email: [bbolles@trukera.com](mailto:bbolles@trukera.com)

### This guide addresses billing recommendation for:

- **CPT Code 83861** is specific for “Microfluidic analysis utilizing an integrated collection and analysis device, tear osmolality”.
- A covered service by CMS Medicare under the Clinical Laboratory Fee Schedule.
- CLIA Certificate of Waiver is required to perform and bill this laboratory tests.
- Providers are encouraged to review payor-provider contracts for rate and claim submission requirements.
- Medical Necessity requires current signs or symptoms of disease at time of test.
- Frequency of testing is based on Medical Necessity as determined by the clinician.
- Laboratory Test - multiple procedure discounts do not apply.

Payor Name	Lines	Modifier(s)	Units per Line
Aetna	2	RT/LT	1
Anthem	2	RT/LT	1
BadgerCare Plus	2	QW/RT/LT	1
Children's Community Health Plan	2	RT/LT	1
Cigna	2	RT/LT	1
Dean Health Plan	2	RT/LT	1
Humana Medicare	2	QW/RT/LT/59	1
Medicaid WI	2	QW/RT/LT	1
Medicare	2	QW/RT/LT	1
Molina	1	QW	2
UHC Community Plan/UHC	1	QW	2
WEA Trust	2	RT/LT	1

### Wisconsin Providers:

Medicaid Does not cover OD's

Humana Commercial: Will deny claim (**Diagnostic testing for dry eye syndrome is not separately reimbursable**).

## Billing Format Examples

**Medicare:** Note the CLIA # in box 23 and the QW/RT, QW/LT in box24D are required for processing. **The QW modifier should be placed first.** Claims lacking these elements will reject.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																	
										17b. NPI		1234567890																	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB?		\$ CHARGES																	
										<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.																	
A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER																	
E. _____												10D2345678																	
I. _____																													
J. _____																													
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From To										SERVICE				CPT/HCPCS MODIFIER															
MM DD YY MM DD YY																													
11 01 23 11 01 23										11				83861 QW RT				A		50 00		1				NPI 1234567890			
11 01 23 11 01 23										11				83861 QW LT				A		50 00		1				NPI 1234567890			

**Most Commercial Plans:** Note that the QW and CLIA # are not required.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Trukera Medical										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																	
										17b. NPI		1234567890																	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB?		\$ CHARGES																	
										<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.																	
A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER																	
E. _____																													
I. _____																													
J. _____																													
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From To										SERVICE				CPT/HCPCS MODIFIER															
MM DD YY MM DD YY																													
11 01 23 11 01 23										11				83861 RT				A		50 00		1				NPI 1234567890			
11 01 23 11 01 23										11				83861 LT				A		50 00		1				NPI 1234567890			





**Humana Medicare Advantage Plans:** Humana requires additional modifiers. The CLIA number is required in box 23 with the **QW/RT/LT/59** with 2 lines of service, 1 unit per line

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																							
Dr. Trukera Medical										17b. NPI		1234567890																							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES																							
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.																							
A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER																							
B. [ ]												10D2345678																							
C. [ ]																																			
D. [ ]																																			
E. [ ]																																			
F. [ ]																																			
G. [ ]																																			
H. [ ]																																			
I. [ ]																																			
J. [ ]																																			
K. [ ]																																			
L. [ ]																																			
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)										E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From To										SERVICE				CPT/HCPCS MODIFIER																					
MM DD YY MM DD YY																																			
11 01 23 11 01 23										11				83861 QW RT 59										A		50 00		1				NPI		1234567890	
11 01 23 11 01 23										11				83861 QW LT 59										A		50 00		1				NPI		1234567890	

### Reimbursement for Medicare Part B (fee-for-service)

**2023-2024 Clinical Laboratory Fee Schedule (CLFS) Rate:** \$22.48 per test (\$44.96 per patient)

#### Sequestration Withhold

- Medicare intermediaries are required to withhold two-percent of the allowable.

#### Medicare CMS Part B

- CMS Medicare pays at 100% of CLFS throughout the United States.
- No deductible or patient co-payment applies.
- Free standing, global lab code.
- CLIA Certification required.

#### Billing Software Requirements

- **ANSI 5010 E-claim Crosswalk**

In loop 2300, Segment REFO2, enter the CLIA Certification number – 10 digits - (Do not enter “CLIA” with the certificate number as this will cause claims to deny as an invalid identification number).

Field #	Claim Description	Loop	Segment	Electronic Description
23.	Prior Authorization number	2300	REF01	Reference identification qualifier =X4
			REF02	CLIA Certification number

## Common Notification Reasons for Medicare Denials

If there is no CLIA number on the claim, Medicare sends RA messages MA 120 and MA 130, which state:

- MA 120 - Did not complete or enter accurately the CLIA number.
- MA 130 - Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is un-processable. Please submit the correct information to the appropriate FI or carrier.
- B7 - "This provider was not certified/eligible to be paid for this procedure/service on this date of service."
- The laboratory is not approved for this type of test

# WYOMING BILLING GUIDE



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## Reimbursement Support Specialist

Bridget Bolles

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### This guide addresses billing recommendation for:

- **CPT Code 83861** is specific for “Microfluidic analysis utilizing an integrated collection and analysis device, tear osmolality”.
- A covered service by CMS Medicare under the Clinical Laboratory Fee Schedule.
- CLIA Certificate of Waiver is required to perform and bill this laboratory tests.
- Providers are encouraged to review payor-provider contracts for rate and claim submission requirements.
- Medical Necessity requires current signs or symptoms of disease at time of test.
- Frequency of testing is based on Medical Necessity as determined by the clinician.
- Laboratory Test - multiple procedure discounts do not apply.

Payor Name	Lines	Modifier(s)	Units per Line
Aetna	2	RT/LT	1
BCBS Federal Employee Plan	2	RT/LT	1
BCBS WY	2	RT/LT	1
Cigna	2	RT/LT	1
HealthNet	2	QW/RT/LT	1
Medicaid WY	2	QW/RT/LT	1
Medicare	2	QW/RT/LT	1
United Healthcare	1	QW	2

## Billing Format Examples

**Medicare:** Note the CLIA # in box 23 and the QW/RT, QW/LT in box 24D are required for processing. **The QW modifier should be placed first.** Claims lacking these elements will reject.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																							
Dr. Trukera Medical										17b.		NPI 1234567890																							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES																							
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.																							
A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER																							
B. _____												10D2345678																							
C. _____																																			
D. _____																																			
E. _____																																			
F. _____																																			
G. _____																																			
H. _____																																			
I. _____																																			
J. _____																																			
K. _____																																			
L. _____																																			
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)										E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From To														CPT/HCPCS MODIFIER																					
MM DD YY MM DD YY																																			
11 01 23 11 01 23										11				83861 QW RT										A		50 00		1				NPI		1234567890	
11 01 23 11 01 23										11				83861 QW LT										A		50 00		1				NPI		1234567890	

**Most Commercial Plans:** Note that the QW and CLIA # are not required.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																							
Dr. Trukera Medical										17b.		NPI 1234567890																							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES																							
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.																							
A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER																							
B. _____																																			
C. _____																																			
D. _____																																			
E. _____																																			
F. _____																																			
G. _____																																			
H. _____																																			
I. _____																																			
J. _____																																			
K. _____																																			
L. _____																																			
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)										E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From To														CPT/HCPCS MODIFIER																					
MM DD YY MM DD YY																																			
11 01 23 11 01 23										11				83861 RT										A		50 00		1				NPI		1234567890	
11 01 23 11 01 23										11				83861 LT										A		50 00		1				NPI		1234567890	

**United Health Care Commercial Plans:** UHC does not recognize the RT/LT modifiers. The CLIA number is required in box 23 with the **QW Modifier only** with 2 units of service. Double the billed charge.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																							
Dr. Trukera Medical										17b.		NPI 1234567890																							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES																							
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.																							
A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER																							
B. _____												10D2345678																							
C. _____																																			
D. _____																																			
E. _____																																			
F. _____																																			
G. _____																																			
H. _____																																			
I. _____																																			
J. _____																																			
K. _____																																			
L. _____																																			
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)										E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From To														CPT/HCPCS MODIFIER																					
MM DD YY MM DD YY																																			
11 01 23 11 01 23										11				83861 QW										A		100 00		2				NPI		1234567890	

**Humana Medicare Advantage Plans:** Humana requires additional modifiers. The CLIA number is required in box 23 with the **QW/RT/LT/59** with 2 lines of service, 1 unit per line

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																	
Dr. Trukera Medical										17b. NPI		1234567890																	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES																	
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.																	
A. ICD-10 Code(s)												23. PRIOR AUTHORIZATION NUMBER																	
E.												10D2345678																	
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From		To		From		To		CPT/HCPCS		MODIFIER		POINTER																	
MM	DD	YY	MM	DD	YY	MM	DD	YY																					
11	01	23	11	01	23	11			83861	QW	RT	59		A		50	00	1			NPI	1234567890							
11	01	23	11	01	23	11			83861	QW	LT	59		A		50	00	1			NPI	1234567890							

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- CLIA Certification required.

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In loop 2300, Segment REFO2, enter the CLIA Certification number – 10 digits - (Do not enter “CLIA” with the certificate number as this will cause claims to deny as an invalid identification number).

Field #	Claim Description	Loop	Segment	Electronic Description
<b>23.</b>	<b>Prior Authorization number</b>	<b>2300</b>	<b>REF01</b>	Reference identification qualifier = <b>X4</b>
			<b>REF02</b>	CLIA Certification number

## Common Notification Reasons for Medicare Denials

If there is no CLIA number on the claim, Medicare sends RA messages MA 120 and MA 130, which state:

- MA 120 - Did not complete or enter accurately the CLIA number.
- MA 130 - Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is un-processable. Please submit the correct information to the appropriate FI or carrier.
- B7 - "This provider was not certified/eligible to be paid for this procedure/service on this date of service."
- The laboratory is not approved for this type of test