

FAQ

Coverage and Reimbursement Information for CPT Code 83861 - Tear Osmolarity

What is CPT Code 83861?

83861, Microfluidic analysis utilizing an integrated collection and analysis device, tear osmolarity.

What fee schedule is 83861 paid from?

83861 is paid from the Medicare Clinical Laboratory Fee Schedule (CLFS), not the Physician Fee Schedule.

Is TearLab's Tear Osmolarity Test described by 83861?

Yes.

Where may The TearLab Tear Osmolarity Test, 83861 be performed? By whom?

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

If I don't have a CLIA-Certified or a CLIA-Waived lab, may I perform or report this test?

No.

What are the requirements for reporting this test?

83861 can be reported after the test is performed. Depending on payer coding rules, each eye tested should be reported separately with either an "RT" or "LT" modifier, or conversely, if the payer does not recognize the LT or RT modifiers, report 83861 only once, with no modifier, but with 2 units of service when testing both eyes.

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

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

Is 83861 covered by payers?

We are not aware of any published local or national Medicare coverage policies (NCD or LCD) for 83861. Commercial payer policies may vary. Therefore, physicians should check with each payer, including Medicare, to determine the payer's coverage policy and other requirements in your area.

Medicare does not cover screening tests.

When should I perform a Tear Osmolarity Test?

The decision to perform tear osmolarity is up to the physician. Tear osmolarity should be reported and billed to Medicare or any other payer only when it is performed in compliance with any applicable coverage and reimbursement policies.

For example, Medicare has several requirements for covering and reimbursing diagnostic tests such as tear osmolarity. First, the test must be ordered by the physician treating the Medicare beneficiary for the medical problem that was the reason for ordering the test. Second, the physician who orders the test must use the results of the test in the management of the beneficiary's medical problem. Third, the test must be medically reasonable and necessary for the diagnosis of the patient's problem.

Can I perform a Tear Osmolarity Test before I see the patient?

Yes. Physicians may perform tests before or after the physician sees the patient.

However, the test may be reported and billed only if it meets the applicable payer's coverage and reimbursement requirements.

Can I bill for Tear Osmolarity if the test is normal?

Yes. However, even though the result of the test is not relevant with respect to coverage and reimbursement, any applicable payer coverage and reimbursement requirements must be met. The ICD-9 diagnosis code should be chosen based on what was known about the patient at the time the test was performed.

What if I perform Tear Osmolarity before I see the patient and it turns out that the test wasn't medically necessary?

Physicians need to check with each payer to determine the basis on which a payer will pay for tests. In the case of Medicare, the physician should not bill Medicare for tests that are not medically necessary.

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

The medical record should contain an order for the test by the treating physician, the reason for ordering the test (e.g., medical indication), the results of the test and how the test was used in managing the patient.

Does the documentation have to be in my progress note?

No. The documentation can appear anywhere in the medical record.

What is the payment for 83861?

For the Medicare Part B program, the national limitation amount (NLA) is \$22.54 for 2014. CPT 83861 is paid off the Clinical Laboratory Fee Schedule, not the Physician Fee Schedule, and as such, there is no patient coinsurance and the Part B deductible is not applied. The laboratory will receive 100% of the National Limit Amount (NLA) from Medicare.

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

DISCLAIMER *The information in this document is provided by TearLab for general informational purposes only. It is not intended to be legal advice, coding advice, or a promise or guarantee of coverage or payment. Physicians are responsible for the submission of claims, including the accuracy of the information on each claim. Physicians are responsible for knowing applicable payer coverage, coding, and reimbursement requirements and policies. Physicians should contact payers before submitting claims for 83861 to determine those requirements before submitting claims.*