CLINICAL CRITERIA POLICY

CLINICAL CRITERIA POLICY TO ESTABLISH MEDICAL NECESSITY					
BENEFIT	**EYE CARE**	**POLICY SECTION**	**300 DIAGNOSTIC TESTING**	**POLICY NO**	**300.05**
POLICY TITLE	**Tear Osmolarity Testing**				
POLICY DATE	**01/01/2020**	**REVISION DATE**	**08/08/2022**	**APPROVAL DATE**	**08/10/2022**
DISCLAIMER LANGUAGE	- **Policy content and application may have state specific variance and considerations** - **Health Plan specific 'Indications and Limitations of Coverage' may apply as specified** - **Line of Business considerations (i.e., Medicaid, Medicare, Commercial) may apply as specified**				
EXCLUSIONS	- **Appropriate diagnosis must be utilized, even when/if the test does not require a prior authorization.**				

I. POLICY STATEMENT

Coverage for Tear Osmolarity Testing will be provided when medically indicated and in accordance with applicable state requirements and, as specific to Medicare, national and local coverage determinations. To establish medical necessity for this service, Avēsis aligns its criteria with the evidence and consensus based clinical practice guidelines set forth by the American Academy of Ophthalmology (AAO). The AAO incorporates evidence based best practice and FDA approval and/or recommendations[1]. Avēsis Medical Directors and clinical staff are licensed medical professionals and review criteria and documentation submitted by requesting providers using sound medical judgment.

II. INDICATIONS AND LIMITATION OF COVERAGE and/or MEDICAL NECESSITY

1.0 Tear Osmolarity Testing is "microfluidinic analysis utilizing an integrated collection and analysis device" which is used to manage ocular surface disease associated with dry eyes. Avēsis considers Tear Osmolarity Testing medically necessary when patient presents with signs or symptoms of dry eye as determined by the physician/clinician.

1.1 The code is unilateral and should be billed with a modifier:

1.1.1 Right eye – RT

1.1.2 Left eye – LT

III. MEDICAL NECESSITY REQUIREMENTS for APPLICABLE CPT/HCPCS CODE 83861

1.0 All coverage criteria must be clearly & legibly documented in the patient's medical record and made available to Avēsis upon request.

2.0 Documentation must support the medical necessity of this service as outlined in the Indications and Limitations of Coverage and/or Medical Necessity section of this policy.

3.0 Physician signature on chart note, procedure note, orders, and testing interpretation.

4.0 Medical necessity supported by clinic/progress notes and clinical findings.

5.0 The sign or symptom of disease that prompted the ordering of the test must be documented.

6.0 "Tear osmolarity" must be specifically identified in the medical record and the numerical result of testing and indication of normal or abnormal.

7.0 Medical action taken as a result of the test with reference of test results in the treatment plan.

8.0 The ordering physician must also be the managing physician of patient's medical.

9.0 Test interpretation note must include:

9.1 Date of test

9.2 Findings

9.3 Progression/Stable notation (unless baseline)

9.4 Diagnosis

9.5 Physician signature

10.0 In order to determine medical necessity, Avēsis may request a copy of the clinical records, which must justify the diagnosis listed on the claim and the reason(s) procedure(s) were necessary for planning therapy and monitoring the progress of the disease diagnosed. When the documentation guidelines do not meet the criteria for the service rendered, or the documentation does not establish the medical necessity for the services, such services will be denied as not reasonable and necessary.

IV. UTILIZATION GUIDELINES

1.0 Physicians are responsible for knowing applicable payer coverage, coding, and reimbursement requirements and policies.

2.0 Generally, Tear Osmolarity Testing is expected to be performed no more than bi-annually, however will be reimbursed if medically necessary.

3.0 CLIA Waiver Certificate must be up-to-date and on file with Avēsis, and available upon request.

V. ICD-10 CODES SUPPORTING MEDICAL NECESSITY

1.0 For any code not listed below, please supply proper documentation with your prior authorization request, and Avēsis will consider and make a determination based on medical necessity.

ICD-10 Code	Description
H04.121 – H04.129	Dry eye syndrome of lacrimal gland
H11.141 – H11.149	Conjunctival xerosis, unspecified
H16.101 – H16.109	Unspecified superficial keratitis
H16.121 – H16.129	Filamentary keratitis
H16.141 – H16.149	Punctate keratitis
H16.211 – H16.219	Exposure keratoconjunctivitis
H16.221 – H16.229	Keratoconjunctivitis sicca, not specified as Sjögren's
H16.231 – H16.239	Neurotrophic keratoconjunctivitis
H18.831 – H18.839	Recurrent erosion of cornea
M35.00	Sicca syndrome, unspecified
M35.01	Sicca syndrome with keratoconjunctivitis