InflammaDry®

Coding Guidelines

Dry Eye

Reimbursement code

The assigned CPT® (Current Procedural Terminology)[1] code for the InflammaDry test is 83516, "immunoassay for analyte other than infectious agent antibody or infectious agent antigen; qualitative or semi-quantitative, multiple step method." The 2017 CMS national limit for this code is $15.82; state limits may vary. Offices submitting reimbursement for claims are required to have a Clinical Laboratory Improvement Amendments (CLIA) Certificate of Waiver.[2]

Modifiers

Medicare and Medicaid claims

For Medicare, the modifier "QW" is added to the CPT code to report the use of a CLIA-waived test. This also applies to most Medicaid claims. CPT code 83516QW is paid from the Clinical Laboratory Fee Schedule (not the Physician Fee Schedule).

Bilateral testing

Ocular surface inflammation often presents asymmetrically, and therefore testing both eyes with the InflammaDry test is recommended. The InflammaDry test is a single use item, so bilateral testing requires two separate InflammaDry tests.

When billing for bilateral testing, it is necessary to use a modifier. To date, the majority of payers prefer the use of the "59" modifier for the second eye. Alternatively, some payers may prefer that the modifiers " LT " and "RT" be added to the CPT codes. Given the many and varied payers and policies, it is possible that certain payers may have different coding requirements; Quidel offers reimbursement support to assist you with questions about InflammaDry coding and reimbursement.

	Medicare/Medicaid	Commercial Payers	2017 National Limit
1st Eye	83516QW	83516	$15.82
2nd Eye	83516QW + Modifier	83516 + Modifier	$15.82

Reimbursement support

Quidel has a Reimbursement Support Team available to assist you with questions about InflammaDry coding and reimbursement. For reimbursement support, please contact technicalsupport@quidel.com or call 800.874.1517.

Related diagnostic codes

The following ICD-10-CM diagnostic codes describe conditions that may apply to a dry eye diagnosis and/or dry eye symptoms. Approximate conversions between ICD-9-CM codes and ICD-10-CM codes may require clinical interpretation in order to determine the code(s) for your specific coding situation. Other codes may apply.

ICD Codes Associated with Dry Eye

Diagnosis	Unspecified	Unspecified	Right Eye	Left Eye	Bilateral
Keratoconjunctivitis sicca, non-Sjögren's	370.33	H16.229	H16.221	H16.222	H16.223
Exposure keratoconjunctivitis	370.34	H16.219	H16-211	H16.212	H16.213
Conjunctival xerosis, unspecified	372.53	H11.149	H11.141	H11.142	H11.143
Dry eye syndrome of unspecified lacrimal gland	375.15	H04.129	H04.121	H04.122	H04.123
Sicca symdrome (Sjögren) with keratoconjunctivitis	710.20	M35.01	–	–	–
Sicca symdrome (Sjögren), unspecified	710.20	M35.00	–	–	–
Superficial keratitis, unspecified	370.20	H16.109	H16.101	H16.102	H16.103
Filamentary keratitis	370.23	H16.129	H16.121	H16.122	H16.123
Punctate keratitis	370.21	H16.429	H16.141	H16.142	H16.143
Neurotrophic keratoconjunctivitis	370.35	H16.239	H16.231	H16.232	H16.233

Electronic medical record (EMR) system setup

Setting up EMR systems vary by product/provider. In general, we recommend coding the descriptor as, "immunoassay for analyte other than infectious agent antibody or infectious agent antigen; qualitative or semi-quantitative, multiple step method." We recommend this descriptor not be changed. There should be a free text note field that can accommodate added description. We recommend entering "InflammaDry" in such a note field.

[1]CPT is a copyright and registered trademark of the American Medical Association (AMA). Please consult the current CPT Manual for full descriptors and instructions regarding the use of CPT codes.

[2]CLIA stands for Clinical Laboratory Improvement Amendments and is a registration with the U.S. Department of Health and Human Services that allows physicians or medical office personnel to collect a sample and perform a laboratory test within their office.

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