

MEDICARE REIMBURSEMENT FOR PUNCTAL OCCLUSION WITH PLUG

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QUESTION: Does Medicare cover punctal occlusion with plug?

ANSWER: Yes, for medically necessary procedures. Use 68761 (*Closure of lacrimal punctum; by plug, each*) to describe the professional service.

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QUESTION: What documentation is required in the chart to support medical necessity for this service?

ANSWER: Medicare expects that a surgical procedure will not be performed as an initial treatment for dry eyes. The chart should include documentation that other less invasive therapies were unsuccessful or contraindicated. At the very least, other therapies would usually include artificial tears, and may include ointments.

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QUESTION: How should the procedure be documented?

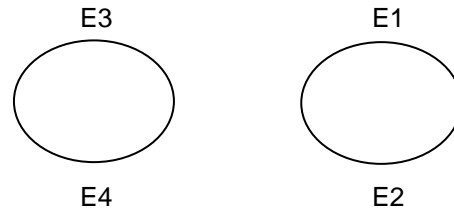
ANSWER: Punctal occlusion with plugs is a surgical procedure. Therefore, the risks, benefits and alternatives need to be reviewed with the patient prior to the procedure, and the patient's informed consent obtained. An appropriate operative report should be placed in the medical record; it includes: any preparatory drops, which puncta were occluded, and a description of the brand, size and lot number of the plugs. Any postoperative instructions should also be noted. A template form for in-office procedures is available on Corcoran's website.

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QUESTION: How do we indicate on the claim which puncta were treated?

ANSWER: Medicare has assigned "E" modifiers to indicate which eyelid was treated.

E1	Left upper lid
E2	Left lower lid
E3	Right upper lid
E4	Right lower lid



Most private payers (and some Medicare contractors) do not recognize these "E" modifiers, but will accept RT (right eye) and LT (left eye) on the claim. Bilateral services may be reported as 68761-50.

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QUESTION: What is the Medicare reimbursement for punctal occlusion with plugs?

ANSWER: In 2011, the Medicare Physician Fee Schedule allowable for in-office procedures is \$141.68; it is reduced to \$115.18 in an ASC or HOPD. These amounts are adjusted by local wage indices.

When two puncta are occluded at the same session, multiple surgery rules apply. The first procedure is allowed at 100% and the second is allowed at 50%. If a third and fourth puncta are also occluded at the same session, the MCPM Chapter 12 §40.6.C16 states, "If any of the multiple surgeries are bilateral surgeries, consider the bilateral procedure at 150 percent as one payment amount, rank this with the remaining procedures, and apply the appropriate multiple surgery reductions." The effect of this approach reduces payment for the third and fourth puncta to 37.5% of the allowed amount for each procedure.

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QUESTION: May we charge for an exam on the same day as the procedure?

ANSWER: Sometimes. Punctal occlusion by plug is considered a minor surgical procedure, with a 10-day global period. Minor surgical procedures include the visit on the day of surgery in the global surgery package unless there is a separate and identifiable reason for the visit.

When there is a separate and identifiable reason for the visit, modifier 25 is appended to the visit code. Modifier 25 indicates that the patient's condition required an additional E/M service beyond the usual preoperative care provided for the procedure or service. CPT adds that *"This [25] modifier is not used to report an E/M service that resulted in a decision to perform surgery."* When the need for punctal occlusion has been previously determined, the exam is included with the procedure unless there is a separate disease. For additional information, request our FAQ on reimbursement rules related to modifier 25.

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QUESTION: Will Medicare cover insertion of collagen plugs as a diagnostic test prior to silicone plugs, and how long must I wait?

ANSWER: Yes; Medicare will cover punctal occlusion with both collagen and silicone, provided that both procedures are medically necessary. However, opinions differ regarding the merits of a trial using collagen punctal plugs, and the physician must decide in each case whether using collagen plugs is warranted. Particular care should be taken to document the medical necessity for inserting collagen plugs followed by silicone plugs.

Punctal occlusion with plugs is a minor procedure with a 10-day global period. When the physician decides to proceed with insertion of silicone plugs within the global period, this is considered a *staged* procedure. Modifier -58 is used on the claim for insertion of silicone plugs to indicate that this is not a duplicate billing. Outside of the 10-day post-operative period, no modifier is needed. Reimbursement is the same either way.

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QUESTION: Is separate reimbursement made for the plugs themselves?

ANSWER: Medicare has never made separate payment for temporary plugs. Since 2002, Medicare no longer pays separately for permanent punctal plugs, although other payers may. For commercial payers, use CPT code 99070, *miscellaneous supplies*; include a description of the supply and the number of plugs inserted on the claim form.

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QUESTION: If a plug "falls out", may the replacement procedure also be billed?

ANSWER: Maybe. The physician may or may not charge based on the reason the plug was lost. A charge is likely if the patient didn't follow post-operative instructions or the plug was in place for a long time. In contrast, a charge is not justified if the wrong size plug was used. Finally, if there are anatomical reasons the plugs do not stay in place, you are likely to use another method of punctal occlusion.

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QUESTION: May an ASC receive payment for a facility fee if the procedure is performed there?

ANSWER: Yes. CMS inaugurated a new payment system for ASCs on January 1, 2008, which mirrors the Ambulatory Payment Classification (APC) system utilized in hospital outpatient departments (HOPDs). The system is in its final year of transition. The 2011 ASC facility allowable for 68761 is \$86.30. Remember that all procedures performed in an ASC are subject to Medicare's Conditions for Coverage rules, which include a comprehensive H&P and various consents prior to surgery.

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