Corcoran Consulting Group

A Division of Ardare Corporation

MEDICARE REIMBURSEMENT FOR PUNCTAL OCCLUSION WITH PLUG

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QUESTION: Does Medicare cover punctal occlusion with plug?

ANSWER: Yes, when medically necessary. Use 68761 (*Closure of lacrimal punctum; by plug, each*) to describe the professional service. FCI Ophthal-mics provides a variety of punctum plugs.

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

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. This 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 for in-office procedures is available on our website.

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: 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 the visit is billable, 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 problem. For additional information, request our FAQ or distance learning module on modifier 25.

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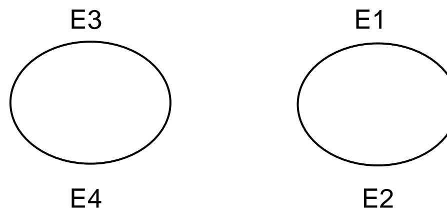
QUESTION: How do we indicate on the claim form which puncta were treated?

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

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



Most private payers and some Medicare contractors do not recognize these 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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The reader is strongly encouraged to review federal and state laws, regulations, code sets (including ICD-9 and ICD-10), and official instructions promulgated by Medicare and other payers. This document is *not an official source* nor is it a complete guide on reimbursement. The reader is reminded that this information, including references and hyperlinks, changes over time, and may be incorrect at any time following publication.

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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. 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: How frequently is this procedure performed?

ANSWER: CMS utilization data for claims paid in 2012 show that 68761 was performed in a bit more than 1% of all office visits. That is, for every 100 exams performed on Medicare beneficiaries, Medicare paid for this service one time.

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QUESTION: What is the Medicare reimbursement to the physician for punctal occlusion with plug?

ANSWER: In 2014, the national Medicare Physician Fee Schedule allowable for in-office procedures is $152.96; it is reduced to $125.02 in an ASC or HOPD. These amounts are adjusted by local wage indices. There is no separate payment made for the supply of the plugs.

When two puncta are occluded at the same session, multiple surgery rules apply. The first procedure is allowed at 100% and the second 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 an ASC receive payment of a facility fee if the procedure is performed there?

ANSWER: Yes. Under current policy, payment for ASCs mirrors the Ambulatory Payment Classification (APC) system utilized by HOPDs. The 2014 ASC facility payment for 68761 is $69.43. There is no separate payment made for the supply of the plugs.

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. For a detailed discussion of ASC reimbursement, please request our monograph, Medicare Reimbursement for the ASC.

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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 this is warranted. Particular care should be taken to document the medical necessity for inserting temporary plugs followed by permanent plugs.

Punctal occlusion with plugs has 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 postoperative period, no modifier is needed. Reimbursement is the same either way.

For a comprehensive discussion of this topic, please request Corcoran's monograph, Reimbursement Guidelines for Punctal Occlusion by Plug.

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