Billing Guidelines For Punctal Occlusion

Introduction

Beaver-Visitec International (BVI) has developed this guide to provide you with the basic information for obtaining reimbursement for punctal occlusion. We recommend that you review the official instructions from the Centers for Medicare and Medicaid Services (CMS) and local Medicare carriers and to be familiar with the rules and definitions published in Current Procedural Terminology (CPT®). We also suggest that you check with local insurance carriers for approved diagnosis codes and any payer-specific usage guidelines for these services.

Op-Notes

To assist you with filing, Beaver-Visitec provides Op-Notes (peel-and-stick documentation labels) with each punctal occluder. It is important that you use these labels in the patient's chart. These labels specify plug type, size and lot number, along with other required information for traceability.

Op-Notes for various Parasol® products may differ slightly from the example shown here.

Documentation Should Include

- Patient's complaints normally associated with dry eye syndrome (e.g., dryness, redness, burning, reflex tearing, itching, foreign body sensation, grittiness, stinging, soreness, photophobia and pain).
- Physical examination results, including external examination and slit-lamp biomicroscopy exam.
- Results from one or more of the following diagnostic tests: tear break-up time test (TBUT); Schirmer test; ocular surface dye staining pattern (rose bengal, fluorescein, or lissamine green).
- Evidence of a trial period of artificial tears that proved unsuccessful in relieving the patient's symptoms, preceding the decision to place the lacrimal punctal plugs.
- Operative report to include the type of plug used and which puncta were involved.
- Documentation on follow-up visits after placement of the collagen or silicone plugs that indicate the status of the patient's symptoms.
- Discuss and document any risks and benefits of punctal occlusion as well as alternative therapeutic options.

Frequently Asked Questions

Q: Does Medicare cover punctal occlusion?

Yes. Use 68761 (closure of lacrimal punctum; by plug, each to describe the professional service. The same code applies whether permanent or temporary plugs are inserted. Medicare reimbursement for the procedure includes payment for the plugs.

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

In 2018, the national Medicare Physician Fee Schedule allowed amount for 68761 (temporary or permanent plug) for participating physicians is $152.28. This amount is adjusted by local indices in each area. When more than one punctum is occluded at the same time, multiple surgery rules apply. The first procedure is allowed at 100% and each additional procedure is allowed at 50%.

Q: What documentation is required by Medicare?

Medicare and most other payers expect that a minor surgical procedure, such as 68761, will not be performed as an initial treatment for dry eyes. In general, when medical therapy is not effective or contraindicated, punctal occlusion may be accomplished by inserting lacrimal punctal plugs into the punctal orifice to decrease tear clearance and increase retention of the tear film by blocking the outflow of tears to the nasolacrimal system. The chart should include documentation on all other unsuccessful therapies. Your chart documentation should clearly state that you reviewed the risks and benefits of this procedure with the patient, along with non-surgical alternatives. The chart should confirm that you have obtained the patient's consent for the procedure.

Q: Can I bill an office visit on the same day as the insertion of the plugs?

CPT code 68761 is considered to be minor surgery by the CPT and follows all rules surrounding minor surgical procedures.

In accordance with minor surgical rules, an office visit (either 920XX or 992XX) is generally not billable as a separate service when performed on the same date of service as CPT code 68761, as reimbursement for the 68761 code itself already includes compensation for the office visit related to the decision to perform minor surgery. This rule is consistent amongst all medical carriers.

Use of modifier 25 (*Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service*) should be very rare when used in conjunction with occlusion of the punctum(a).

Q: How do I submit a claim?

For detailed diagnosis and procedure codes, along with a sample reimbursement claim, see the reverse side of this guide.

Common Diagnosis Codes

Diagnosis Description	ICD-10
Dry Eye Syndrome	H04.121, H04.122, H04.123, H04.129
Unspecified Superficial Keratitis	H16.101, H16.102, H16.103
Conjunctival xerosis, unspecified	H11.141 - H11.149
Keratoconjunctivitis Sicca, Not Specified As Sjogrens	H16.221, H16.222, H16.223, H16.229
Redness or Discharge	H57.8
Sicca Syndrome Associated with Sjögren's disease	M35.00, M35.01, M35.09

Modifiers Commonly Used With Punctal Occlusion

Modifier 50 Bilateral Procedure	Unless otherwise identified in the listings, bilateral procedures that are performed at the same operative session, should be identified by adding modifier 50 to the appropriate five digit code.			
Modifier 51 Multiple Procedures	When multiple procedures, other than E/M services, Physical Medicine and Rehabilitation services or provision of supplies (e.g., vaccines), are performed at the same session by the same provider, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s).			
Punctum-Specific	E1 Upper lid, left	E2 Lower lid, left	E3 Upper lid, right	E4 Lower lid, right

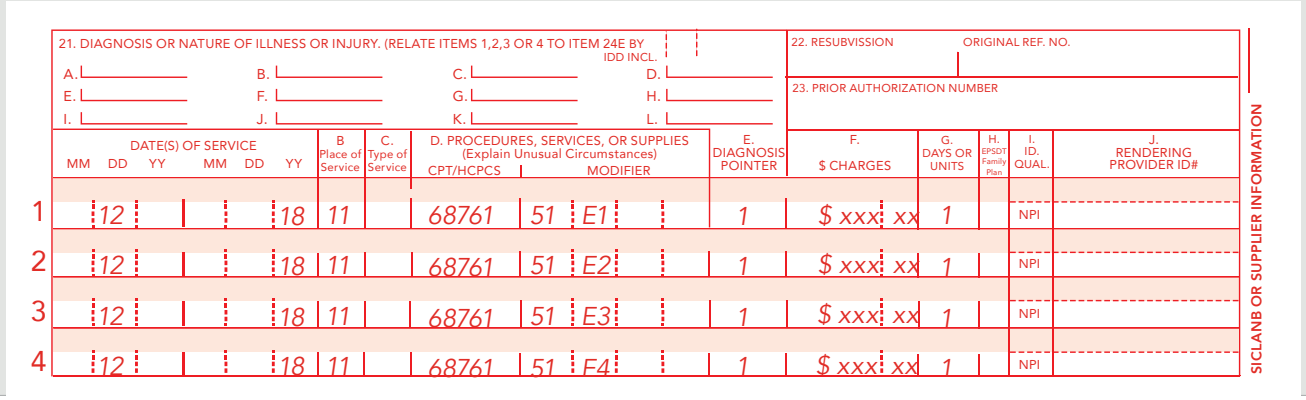
Note: Most private payers and some Medicare contractors do not recognize these modifiers, but will accept RT (right eye) and LT (left eye) on the claim. Bilateral services may be reported as 68761-50, multiplying your price by total number of occlusions performed, and leaving your number of units as 1. Your ICD-10 diagnosis code will also indicate which eye was treated.

Coding Guidelines for Multiple Same Day Occlusions

Two punctal plugs (SAME EYE)	Bill 68761-E? as one line item	Bill 68761-51-E? as second line item
Three punctal plugs	Bill 68761-E?-E? as one line item (2 units)	Bill 68761-51-E? as second line item (1 unit)
Four punctal plugs	Bill 68761-50 as one line item	Bill 68761-50-51 as second line item

Sample Medicare & Private Insurance Reimbursement Claim Form

Collagen/Extend® and silicone plug insertion claims are now submitted the same for both Medicare and most private insurance. Some private insurance companies may accept a supply code (A4262, temporary, absorbable lacrimal duct implant, each or A4263, Permanent, long term, non-dissolvable lacrimal duct implant, each). *Allow a 10-day post-op period before inserting permanent plugs.*



21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY IDD INCL.)
A. B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBVISSION ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	DATE(S) OF SERVICE MM DD YY	MM DD YY	B Place of Service	C. Type of Service	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER		E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID#
1	12	18	11		68761	51	E1	1	$ xxx xx	1		NPI	
2	12	18	11		68761	51	E2	1	$ xxx xx	1		NPI	
3	12	18	11		68761	51	E3	1	$ xxx xx	1		NPI	
4	12	18	11		68761	51	E4	1	$ xxx xx	1		NPI	

SIGNATURE OF PHYSICIAN OR SUPPLIER INFORMATION

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