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QUESTION: Does Medicare cover punctal occlusion by plug?

ANSWER: Yes, when medically necessary. Use 68761 (*Closure of lacrimal punctum; by plug, each*) to describe the professional service. The CPT code makes no distinction between types or brands of punctal plugs.

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QUESTION: What are the indications for punctal occlusion with plug?

ANSWER: This procedure provides an alternative when drops and ointments have proven unsatisfactory. It is most commonly performed for dry eye syndrome and keratitis sicca, but other conditions support use as well. It may also be helpful treating a symptomatic patient following refractive or other anterior segment surgery.

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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. When the need for a repeat plug occurs, or for plugs designed for more frequent intervals, medical necessity must be present for each insertion.

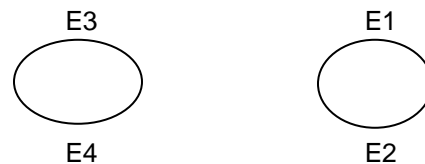
As with any surgical procedure, the patient's informed consent is obtained. An appropriate operative report should be in the medical record; this includes any preparatory drops, which puncta were occluded, and a description of the brand, size and lot number of the plugs. Postoperative instructions should also be noted.

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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. Your ICD-10 diagnosis code(s) will indicate the eye(s) treated.

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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 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, usually a separate disease.

When a 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." This is very different from an exam that determines the need for a major procedure with a 90-day global period.

February 13, 2024

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QUESTION: What is the Medicare reimbursement to the physician for 68761?

ANSWER: In 2024, the national Medicare Physician Fee Schedule allowable for in-office procedures is \$143; it is reduced to \$114 in a facility (e.g., 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: Is there a facility fee if the procedure is performed in an ASC or HOPD?

ANSWER: Yes. Punctal occlusion by plug is assigned to APC code 5501. The 2024 ASC facility allowable for 68761 is \$94; the HOPD rate is \$278. Multiple surgery rules apply so second and subsequent procedures are allowed at a reduced rate. There is no separate payment made for the supply of the plugs.

Even though there is a facility fee, this procedure is rarely performed in that setting. Remember that all procedures performed in an ASC are subject to Medicare’s Conditions for Coverage rules; HOPDs have their own requirements.

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QUESTION: How frequently is this procedure performed?

ANSWER: CMS data for 2021 shows that 68761 was associated with about 2% of all office visits. That is, for every 100 exams for Medicare beneficiaries, Medicare paid for this service twice.

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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: What if we need to explant a punctal plug?

ANSWER: In rare cases, punctal occlusion may contribute to even greater patient discomfort and epiphora than was present prior to the procedure.

Dislodging an intracanalicular plug may be readily accomplished by irrigating the lacrimal system with saline. Use CPT code 68801 (*Dilation of lacrimal punctum, with or without irrigation*) or 68840 (*Probing of lacrimal canaliculi, with or without irrigation*) to report this procedure, depending on the position and manipulation of the irrigating cannula. As with other lacrimal procedures, the multiple surgery rule applies.

Removal of other types of plugs, such as the “cap and anchor” style of silicone plug, is usually readily accomplished with forceps at the slit lamp. There would be no separate charge for this; it would be included with the exam on that date.

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