Corcoran Consulting Group

A Division of Ardare Corporation

Reimbursement Guidelines for Punctal or Intracanalicular Occlusion by Plug

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Reimbursement Guidelines for Punctal or Intracanalicular Occlusion by Plug

by

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Objective: *This report is provided as a general discussion of reimbursement for punctal occlusion by plugs and related issues. Variations in coverage and payment policies among Medicare Administrative Contractors (MACs) may occur which are not described here. Other non-Medicare payers may promulgate policies that differ from those of Medicare and its contractors. The user is strongly encouraged to review official instructions of the Centers for Medicare & Medicaid Services (CMS), the MACs, and other third party payers.*

Notice: *All fee schedule amounts noted in this document are the national Medicare allowed amounts. Actual fee schedule amounts and payments vary by locality.*

Disclaimer: *This document is not an official source nor is it a complete guide on all matters pertaining to coding (CPT, HCPCS, or ICD-10-CM) and reimbursement. Neither OASIS Medical, Inc. nor Corcoran Consulting Group guarantees that the use of this information will result in payment for services. The reader is reminded that this information can and does change over time, and may be incorrect at any time following publication. The continued availability of cited references as hyperlinks, whether embedded or not, cannot be ensured.*

This document does not constitute legal or medical advice. Physicians and other providers should use independent judgment when selecting codes that most appropriately describe the services provided to a patient. Physicians and hospitals are solely responsible for compliance with applicable laws, Medicare regulations, and other payers' requirements and should confirm the applicability of any coding or billing practice with applicable payers prior to submitting claims.

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INTRODUCTION

This monograph addresses reimbursement associated with punctal occlusion utilizing Oasis products including FORM FIT® (intracanalicular) plugs, SOFT PLUG® silicone (punctum) plugs, SOFT PLUG Flow Control (silicone partial-occlusion) plugs, SOFT PLUG Extended Duration (90-day and 180-day temporary) plugs, and SOFT PLUG (collagen temporary) plugs.

Reimbursement by Medicare or other third party payers for this procedure involves a number of issues including coverage guidelines, the locations where services are rendered, and coding. This discussion addresses all of these variables in order to provide the reader with a comprehensive understanding of the topic.

THE DEVICES

There are a number of different Oasis plugs described below.[1]

Oasis FORM FIT intracanalicular plugs [2] come in 2-packs and 10-packs. There is just one size (0.3 mm). The device hydrates over a 10-minute period to create a custom-fit that "*completely fills the vertical canalicular cavity*". There are no special storage considerations and they are biocompatible and easily removed. They come pre-loaded on an inserter. The device is said to be more comfortable because there is no cap or anchor system which might cause a foreign body sensation or awareness.

Oasis SOFT PLUG silicone plugs[3] come on pre-loaded inserters in sterile 2-packs and 6-packs; inserters are available as either Classic or Pen-style. The Soft Plug silicone plugs come in sizes from 0.4mm - 0.8mm. There is also a not-pre-loaded Economy Pack that includes 10 sterile packed trays of 2 plugs each; inserters for the Economy Pack are available separately at no additional charge.

Oasis SOFT PLUG silicone Flow Control plugs [4] come on pre-loaded inserters in 2-packs only in sizes from 0.6mm - 0.8mm. There is a small lumen through the center of the plug allowing for partial occlusion with limited tear drainage.

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1 All product information and images provided by Oasis Medical, Inc.

2 Oasis Medical, Inc. Product information, FORM FIT intracanalicular plugs. Link here. Accessed 05/31/23.

3 Oasis Medical, Inc. Product information, SOFT PLUG silicone plugs. Link here. Accessed 05/31/23.

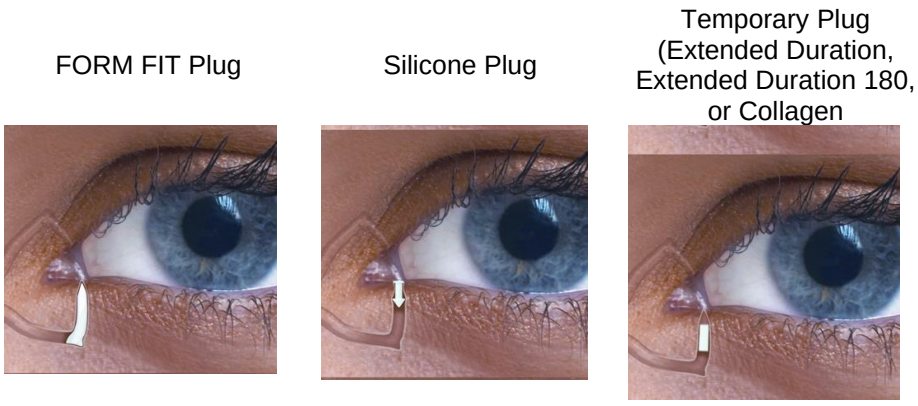
4 Oasis Medical, Inc. Product information, SOFT PLUG silicone Flow Control plugs. Link here. Accessed 05/31/23.

Oasis SOFT PLUG Extended Duration temporary plugs[5] come in a sterile 20-pack and 40-pack in sizes from 0.2mm - 0.5mm for the 90-day duration variety and 0.3 – 0.5 mm size for the 180-day duration plugs. Both types of Extended Duration plugs are also available in sterile Variety Packs that include plugs of different sizes. The Extended Duration absorbable plugs are designed to provide patient comfort up to 3 months and Extended Duration 180 Plugs may provide comfort for up to 6 months. The new Soft Plug Extended duration 180-T Tapered Canalicular Plug is, as the name says, tapered from 0.25 to 0.60 for ease of insertion. These long-lasting plugs are effective and economical for transient dry symptoms after surgery or seasonally. Insertion is accomplished with forceps.

Oasis SOFT PLUG collagen temporary plugs[6] come in a sterile 60-pack in sizes from 0.2mm - 0.4mm. The collagen absorbable plugs are designed to provide a quick 2-5 day diagnostic test to determine the effectiveness of punctal occlusion for the patient prior to more permanent occlusion. The plugs have a smooth proprietary finish that simplifies insertion, which is accomplished with forceps.

Coding, billing, payment rates, and charting are the same for all types of Oasis plugs. When a temporary or extended duration plug is selected, be sure that the medical record for that date of service supports the medical necessity for the modality selected on that day.

Figure 1 **Insertion and Placement of Plugs**



THE PROCEDURE

A drop of anesthesia on the punctum is recommended. The plug is inserted into the punctum (or vertical canal for intracanalicular plugs).

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[5] Oasis Medical, Inc. Product information, SOFT PLUG Extended Duration temporary plugs. Link here. Accessed 05/31/23.

[6] Oasis Medical, Inc. Product information, SOFT PLUG Collagen temporary plugs. Link here. Accessed 05/31/23.

INDICATIONS FOR USE

Punctal occlusion by plug provides a therapeutic alternative when eye drops and ointments have proven unsatisfactory for the treatment of dry eyes. Punctal occlusion has made many patients more comfortable. Table 1 contains a list of common diagnosis codes associated with this procedure.

Table 1 **Common Diagnosis Codes**

ICD-10	Description
H04.12-	Dry Eye Syndrome
H16.22-	Keratoconjunctivitis Sicca
H16.14-	Punctate keratitis
H16.20-	Keratoconjunctivitis, unspecified
M35.0-	K. sicca with Sjögren's Syndrome

NOTE: Listed codes are representative of covered diagnoses but differences in payment policies exist for many payers. This list is neither exhaustive nor universally accepted; see your payer bulletins. The ending dash means a longer code is required for greater specificity.

DRY EYES AND LASIK

During laser-assisted in situ keratomileusis (LASIK) surgery, some corneal nerves are severed. Many doctors believe that most LASIK patients develop dry eye, which sometimes last for months, because they might not blink often enough because they can't "feel" as much discomfort. For severe or intractable cases, punctal occlusion may be advisable. Patients need to be informed prior to surgery about the risk of dry eye and counseled about possible treatment, primarily artificial tears and ointments.

Coverage of this procedure following LASIK depends on several considerations:

- Some third party payers cover punctal occlusion to treat a symptomatic patient with a postoperative complication, even if the LASIK surgery itself is a non-covered service.
- Insertion of punctal plugs prior to LASIK as a prophylactic measure, or immediately following LASIK before a trial of topical medications, would generally be considered prophylactic and, therefore, medically unnecessary and ineligible for reimbursement.

Patients may also benefit from punctal occlusion with plugs following other refractive procedures and other anterior segment procedures.

DOCUMENTATION

Claims for reimbursement of punctal occlusion with plugs for dry eye syndrome must be supported by documentation of medical necessity in the patient's chart. Chart documentation should include:

- a complaint indicative of dry eyes (*e.g.*, itch, burn, watery)
- dysfunction (*e.g.*, blurry vision)
- lifestyle issues (*e.g.*, unable to see clearly to read, can't work out of doors)
- failure of prior treatment (*e.g.*, no relief from artificial tears)
- abnormal findings (*e.g.*, corneal changes, staining, poor tear film)
- results of tests (*e.g.*, Schirmer's, tear break-up time, or tear assay)
- diagnoses (*e.g.*, dry eye syndrome, keratoconjunctivitis sicca, and associated systemic diseases)
- plan (*i.e.*, description of treatment risks and benefits)

Also keep the following points in mind.

Standard of care. Reimbursement is only made for medically necessary procedures. Because several therapeutic options exist for treating dry eyes, and the severity of the disease determines which therapy is appropriate, it is important to establish the gravity of the condition and the effectiveness of earlier treatments. According to American Academy of Ophthalmology (AAO) Preferred Practice Pattern (PPP) guidelines, *"For patients with aqueous tear deficiency, punctal occlusion is considered when the medical means of aqueous enhancement are ineffective or impractical"*.[7] Include all relevant information in the medical record.

History. The history must include current symptoms and any disability, as well as mention of any comorbidities that might be related to the ophthalmic disease.

Exam and Tests. The examination must include, at a minimum, the patient's visual acuity, an external examination and a slit lamp exam. Additional diagnostic tests may include tear break-up time (BUT), Schirmer's tear test, and staining with rose bengal, fluorescein or

[7] American Academy of Ophthalmology. Dry Eye Syndrome PPP - 2018. Published November, 2018. Link here. Accessed 05/31/23.

lissamine green. Some doctors employ a lactoferrin assay to detect protein abnormalities in tears. Any one or more of these tests can be used to help support the diagnosis of dry eye syndrome. Results should be clearly documented in the chart.

Treatment. According to AAO's PPP, *"For patients with aqueous tear deficiency, punctal occlusion is considered when the medical means of aqueous enhancement are ineffective or impractical. Punctal plugs are best used once tear homeostasis is achieved."*[8] Use in mild dry eye or when other means have not been used or are demonstrated as impractical or impossible for an individual patient is likely to be questioned. The PPP also states, "*…The effectiveness in increasing the lower tear meniscus was similar with upper or lower tear duct occlusion."*[9] This paper makes the point that occlusion of either upper- or lower-puncta provides the same clinical effect. Additional treatment of the other puncta may be indicated if, *"A separate procedure for occlusion of upper puncta may be medically necessary for members with insufficient relief from occlusion of lower puncta."*

Interestingly, if a plug should come out after a few years, more than 33% of canaliculi have stenosed (closed),[10] so repeat plug replacement in those cases is not always indicated. In that case, carefully document patency and the continued medical need to support plug replacement.

Novitas Solutions, the MAC for a number of northeastern states, notes the following in its Local Coverage Determination (LCD) L35095.[11]

> *"Lacrimal punctum plugs are indicated in the treatment of chronic dry eye syndrome that has not responded to more conservative treatment of synthetic tears. Symptoms of chronic dry eye syndrome include complaints of foreign body sensation, itching, excessive mucus secretion, dryness, burning, photosensitivity, redness, and pain. The decision to use lacrimal punctum plugs should include at least one the following:*
>
> - *Superficial punctate keratopathy*
> - *Corneal erosions or ulceration*
> - *Filamentary keratitis*

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8 American Academy of Ophthalmology. Dry Eye Syndrome PPP - 2018. Published November 2018. Link here. Accessed 05/31/23.

9 Chen F, Wang J, et al. Upper punctal occlusion versus lower punctal occlusion in dry eye. *Invest Ophthalmol Vis Sci*. 2010 Nov; 51(11):5571-7. Link here. Accessed 05/31/23.

10 Horwath-Winter J, Thaci A, et al. Long-term retention rates and complications of silicone punctal plugs in dry eye. *Am J Ophthalmol.* 2007 Sep;144(3):441-4. Link to PubMed abstract here. Accessed 05/31/23.

11 Novitas Solutions, Inc. LCD L35095 (Retired). Lacrimal Punctum Plugs. Rev. eff. 11/14/19. Link here. Accessed 05/31/23. NOTE: A retired LCD is not inactivated, it is simply not renewed. Information in the LCD is still used by the MAC in determining coverage.

- *Corneal scarring*
- *Conjunctival findings, such as from the keratoconjunctivitis associated with Sjögren's syndrome*
- *Dry eye symptoms (e.g., blurred vision, reflex tearing, mucous precipitation) not adequately relieved by artificial tears"*

In the same LCD, Novitas requires the following chart documentation.

- "*Patient's complaints normally associated with dry eye syndrome;*
- *Documentation of trial period of synthetic tears; and*
- *Decreased tear meniscus, punctate keratopathy, corneal ulcers, or erosions, an early tear break-up time, oily tear film, corneal filaments, corneal scars or nodules or an abnormal Schirmer's test.*"

If you do not follow the treatment guidelines described in the PPP and payer policies, then coverage and reimbursement may be challenged.

Operative Report and Consent

Surgical procedures, major and minor, require an operative report regardless of where they are performed. The operative report should include:

- Preoperative and postoperative diagnoses
- Indications for surgery
- Manner in which surgery performed
- Discharge instructions

The operative report is part of the patient's permanent record and is usually separate from the same-day office note (see Appendix for a sample).

As with all operative procedures, the chart notes should include documentation of the patient's informed consent for the surgery.

Explanting Punctal Plugs

In rare cases, punctal occlusion may contribute to even greater patient discomfort and epiphora than was present prior to the procedure. Removal of most types of punctum plugs, such as the cap and anchor style of silicone plug, is usually readily accomplished with

forceps at the slit lamp. Removal is an incidental part of the office visit; no separate charge applies.

When forceps won't work, dislodging the plug may be accomplished by irrigating the lacrimal system with saline. The American Academy of Ophthalmology has published an article that discusses removal of punctum plugs.[12]

BILLING ISSUES

CPT Codes

CPT code 68761 describes the insertion of punctal plugs (*closure of the lacrimal punctum; by plug, each*). Reimbursement is made per punctum by Medicare.

In the unusual instance when plugs must be removed (explanted), CPT code 68801 (*Dilation of lacrimal punctum, with or without irrigation*) or 68840 (*Probing of lacrimal canaliculi, with or without irrigation*) is used, depending on the position and manipulation of the irrigating cannula.

Modifiers

The following modifiers may be applicable on claims for punctal occlusion.

24	…….	Unrelated evaluation and management service by the same physician during a postop period
25	…….	Significant, separately identifiable evaluation and management service by the same physician on the same day of the minor procedure
50	…….	Bilateral procedure
51	…….	Multiple procedure (not used on claims to Medicare)
58	…….	Staged or related procedure or service by the same physician during the postoperative period
79	…….	Unrelated procedure by the same physician during the postop period
E1	…….	Left upper eyelid
E2	…….	Left lower eyelid

[12] American Academy of Ophthalmology. Punctal Plugs. Link here. Accessed 05/31/23.

E3 ……. Right upper eyelid

E4 ……. Right lower eyelid

GA ……. Waiver of liability statement issued as required by payer policy (signed ABN on file)

GX ……. Notice of liability issued, voluntary under payer policy (signed ABN on file)

GY ……. Item or service statutorily excluded or does not meet the definition of any Medicare benefit or, for non-Medicare insurers, is not a contract benefit

GZ ……. Medicare probably does not cover this service. No ABN on file

RT or LT ... Right or left eye

Staged procedures. When a second surgical procedure is pre-planned and then performed within the global surgery period of the first procedure, modifier 58 is used on the claim for the second procedure. For example, two plugs are inserted in the lower puncta. If the patient does not experience prompt symptomatic improvement, the plan is to occlude the upper puncta, too. One week later, the patient returns complaining of residual symptoms; the upper puncta are occluded. Modifier 58 is used with the second claim to indicate an anticipated related procedure was performed within the postoperative period of the first procedure. Note that other payers may have different coverage and/or payment guidelines.

Exam on the Day of the Procedure

Medicare considers punctal occlusion with plugs to be a *minor* surgery. Minor surgery is defined by Medicare as any surgical procedure with a zero or 10 day postoperative period. CPT 68761 has a 10-day postoperative period. Medicare applies the concept of a *global surgery package* to both major and minor surgeries.[13] The global package for a minor procedure includes the preoperative visit on the day of surgery, postoperative visits related to recovery, and supplies.

An exam on the same day as a minor procedure is sometimes reimbursed in addition to the surgery, but not always. MCPM Chapter 12 §40.2A.4 [14] contains these instructions:

> *"…The '-57' modifier is not used with minor surgeries because the global period for minor surgeries does not include the day prior to the surgery. Moreover, where the decision to perform the minor procedure is typically*

[13] For additional discussion of Medicare rules for surgery, please request our monograph, Medicare Reimbursement for Surgical Procedures.

[14] Centers for Medicare & Medicaid. Medicare Claims Processing Manual, Chapter 12 §40.2A.4. Link here. Accessed 05/31/23.

done immediately before the service, it is considered a routine preoperative service and a visit or consultation is not billed in addition to the procedure."

However, if the exam on the day of the minor procedure is done for a reason other than a routine preoperative service, then modifier 25 is used with the visit code to claim separate reimbursement for the office visit. CPT includes this definition of modifier 25:

> *"The physician may need to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. Note: This modifier is not used to report an E/M service that resulted in a decision to perform surgery. See modifier -57."*

For example, modifier 25 would be appropriate if the patient is being seen in follow-up for an unrelated chronic condition (*e.g.*, glaucoma). It would also apply if the patient is seen in follow-up for a related condition that requires the performance of additional evaluation.

Example

Your patient with systemic lupus erythematosus is being followed for potential toxicity due to Plaquenil therapy. During today's scheduled, comprehensive eye exam, the patient also complains of a strong foreign body sensation in both eyes that has not responded to over-the-counter artificial tears suggested by a pharmacist. Your examination identifies keratoconjunctivitis sicca and associated dry mouth. You diagnose secondary Sjögren's syndrome. Due to the severity of the condition, you recommend continuation of the artificial tears as well as punctal occlusion with plugs in the lower puncta. The plugs are inserted today, and a follow-up visit is scheduled in two weeks. The claim will read as follows.

17 REFERRING/ORDERING PROVIDER	17a.		
	17b.	NPI	
19 ADDITIONAL CLAIM INFORMATION			
21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY ICD Ind. 0			
A. M32.9 B. Z79.899 C. M35.01 D.			

24. A. DATES OF SERVICE From MM DD YY	To MM DD YY	B. POS	C. EMG	D. PROCEDURES, SVCS CPT/HCPCS	MODIFIER	E. DX POINTER	F. $ CHARGES	G. UNITS	H. EPSDT	I. ID QUAL.	J. RENDERING PROVIDER I.D.
mm dd yyyy		11		92014	25	A,B	xxx xx	1		NPI	1234567890
mm dd yyyy		11		68761	50	C	xxx xx	2		NPI	1234567890

Financial Waivers

An Advance Beneficiary Notice of Non- Coverage (ABN, CMS-R-131)[15] is a written notice a health care provider gives to a Medicare beneficiary when the provider believes that Medicare will not pay for items or services. It applies to both assigned and non-assigned claims. By signing an ABN, the Medicare beneficiary acknowledges that he or she has been advised that Medicare will not pay and agrees to be responsible for payment, either personally or through another insurance plan. For an ABN to have any utility, it must be signed before providing the item or service.

The format of an ABN cannot be modified to any significant degree. You must add your name, address and telephone to the header. You may add your logo and other information if you wish. The "Items or Services," "Reason Medicare May Not Pay," and "Estimated Cost" boxes are customizable, so you can add pre-printed lists of common items and services or denial reasons. Anything you add in the boxes must be high contrast ink on a pale background. Blue or black ink on white paper is preferred. You may not make any other alterations to the form. It must be one page, single-sided, although an addendum is allowed.

The patient must *sign* and *date* the form; an unsigned or undated form is not valid. Once the patient has signed the completed form, he or she must receive a legible copy. The same guidelines apply to the copy as to the original: blue or black ink on white paper is preferred; a photocopy is fine. You keep the original in your files.

You must complete your portion of the form before asking the beneficiary to sign. Fill in the beneficiary's name and identification number (but not HIC number) at the top of the form. Complete the "Items or Services" box, describing what you propose to provide. Use simple language the beneficiary can understand. You may add CPT or HCPCS codes, but codes alone are not sufficient without a description. Complete the "Reason Medicare May

[15] Advance Beneficiary Notice of Noncoverage. Link here. Accessed 05/31/23.

Not Pay" box with the reason(s) you expect a denial. The reason(s) must be specific to the particular patient; general statements such as "medically unnecessary" are not acceptable. The "Estimated Cost" field is required.

The beneficiary must *personally* choose from Option 1, 2 or 3.

- ☐ Option 1 I *want the items or services listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but* ***I can appeal to Medicare*** *by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.*
- ☐ Option 2 I *want the items or services listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment, and* ***I cannot appeal if Medicare is not billed.***
- ☐ Option 3 I *don't want the items or services listed above. I understand with this choice I am* ***not*** *responsible for payment, and* ***I cannot appeal to see if Medicare would pay.***

If the beneficiary chooses Option 1, you must file a claim and append an appropriate modifier to the reported item(s) or service(s). Option 2 applies to situations where Medicare is precluded from paying for the item or service and the beneficiary does not dispute the point; you are not required to file a claim. If the beneficiary chooses Option 3, there is no claim to file or charge to make; the service is not provided because the patient declines.

You do not need an ABN for items or services that are statutorily (*i.e.*, by law) non-covered by Medicare. Statutorily non-covered services in an eye care practice include refractions and cosmetic procedures such as refractive surgery. Instructions, published on September 5, 2008,[16] allow the use of an ABN *voluntarily* for items excluded from Medicare coverage. At your discretion, you may choose to notify a beneficiary that these services are never covered using the ABN. Written notification is strongly recommended to avoid confrontations with beneficiaries about payment.

In CMS Transmittal R1921CP,[17] effective April 1, 2010, two modifiers were updated to distinguish between *voluntary* and *required* use of liability notices.

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[16] CMS. *MLN Matters* (MM6136). Revised Form CMS-R-131 Advance Beneficiary Notice of Noncoverage. Link here. Accessed 05/31/23.

[17] CMS. Transmittal R1921CP. Billing for Services Related to Voluntary Uses of Advanced Beneficiary Notices of Noncoverage (ABNs). February 19, 2010. Link here. Accessed 05/31/23.

- Modifier GA is defined as "Waiver of Liability Statement Issued as Required by Payer Policy". It applies when you believe Medicare will consider a service not medically necessary in a particular situation. Ask the patient to sign an ABN and submit your claim with modifier GA, allowing the payer to decide if the service is covered.
- Modifier GX is defined as "Notice of Liability Issued, Voluntary Under Payer Policy". It applies when a service is always noncovered; it addresses the fact that most beneficiaries will elect Option 1 in the hope that Medicare might pay, despite your assurances to the contrary. Therefore, if the patient selects Option 1, append modifiers GX and GY to that claim to obtain a denial.
- Modifier GY is defined as "Item or service statutorily excluded or does not meet the definition of any Medicare benefit".

Note that Medicare Advantage plans (Medicare Part C) are prohibited from using the regular Medicare ABN form but may still require prior financial notice. In many cases, they are required to provide a coverage or non-coverage determination in advance. Check plan websites for appropriate instructions.

For non-Medicare beneficiaries, some of the principles outlined above are just as applicable. While the concept of waiver of liability may not be present, or at least not as vigorously, it is still prudent to ensure that patients appreciate the distinction between covered and non-covered services and accept financial responsibility for the latter.

Prohibited Code Combinations

In 1996, CMS developed the National Correct Coding Initiative (NCCI)[18] to control improper coding leading to inappropriate payments in Part B claims.[19] NCCI consists of a series of edits to analyze codes reported on claims for reimbursement. They ensure the most comprehensive groups of codes are billed rather than the component parts; this is the concept informally known as "bundles". Additionally, the edits check for mutually exclusive code pairs – procedures that are medically incompatible – so just one of the pair may be reimbursed. New edits are published quarterly by the National Technical Information Service (NTIS). Some carriers have also published local policies with additional limitations. Of note, you may not use an ABN to circumvent the NCCI edits.

New edits are published quarterly by the National Technical Information Service (NTIS). Some carriers have also published local policies with additional limitations. Of note, you

[18] Centers for Medicare & Medicaid Services. National Correct Coding Initiative Edits. Link here. Access 05/31/23.

[19] Medicare Claims Processing Manual, Chapter 23, §20.9. Correct Coding Initiative. Link here. Accessed 05/31/23.

may not use an ABN to circumvent the NCCI edits. Table 2 identifies the current NCCI bundles affecting punctal occlusion with plugs.

Table 2 **NCCI Edits**

Primary Code	***Do Not Bill These Codes With Primary Code***
68761	67500 68440 68770 68801 68810 68811 69990[0] 92012 92014 92018 92019 99211 99212 99213 99214 99215 99217 99218 99219 99220 99221 99222 99223 99231 99232 99233 99234 99235 99236 99238 99239 99241 99242 99243 99244 99245 99251 99252 99253 99254 99255 99291 99292 99304 99305 99306 99307 99308 99309 99310 99315 99316 99334 99335 99336 99337 99347 99348 99349 99350 99446[0] 99447[0] 99448[0] 99449[0]

Edits effective April 1, 2023. Note that only common ophthalmic codes are shown. Check the full listing for all possible code combinations. [20]

Codes marked with superscript [0] may not be unbundled for any reason. Other codes may be unbundled in some situations (*e.g.*, other eye).

UTILIZATION RATES

Both ophthalmologists and optometrists perform punctal occlusion with plugs. At present, punctal occlusion with plugs is the most common minor procedure in optometry, and ranks in the top four for ophthalmology. According to the most recent utilization data available for the Medicare program (2018), this procedure is performed by ophthalmologists and optometrists about 2 times per 100 eye exams. Utilization of 68801 and 68840 is miniscule. Commercial utilization rates are not readily available.

If your utilization rate exceeds the expected norms, you will likely garner attention from Medicare and other third party payers. Careful attention to documentation of the procedure and the reasons it was performed are your best defense against reproach in the event of post-payment review.

PAYMENT RATES

National Medicare Physician Fee Schedule payment rates for the codes discussed in this monograph are shown below. Note that payment amounts vary by site of service as well as geographically.

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[20] Centers for Medicare & Medicaid Services. National Correct Coding Initiative Edits. Link here. Accessed 05/31/23.

For all of these codes, the multiple surgery rule applies. Further, when more than one 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 Medicare Claims Processing Manual 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."*[21] The effect of this approach reduces payment for the third and fourth puncta to 37.5% of the allowed amount for each.

Table 3 **2023 Medicare National Physician Payment Rates**

		PAR Allowable[22]	Non-PAR Allowable	Limiting Charge for Non-PAR
68761	Non-facility	$147.41	$140.04	$161.04
	Facility	$117.25	$111.39	$128.10
68801	Non-facility	$96.92	$92.07	$105.88
	Facility	$78.96	$75.01	$86.26
68840	Non-facility	$134.19	$127.48	$146.61
	Facility	$117.25	$111.39	$128.10

REIMBURSEMENT FOR SUPPLIES

Prior to January 1, 2002, Medicare paid separately for the supply of permanent plugs; temporary plugs have always been included in the procedure reimbursement. The HCPCS codes used by Medicare to describe punctum plugs were A4263 (*supply code for silicone plug, each*) and A4262 (*supply code for collagen plug, each*).

Separate payment for the supply is no longer made by Medicare, although a few commercial payers may continue to pay for the plugs. In those cases, use CPT code 99070 (*miscellaneous supply*) to describe the plug(s). The number of plugs inserted is identified

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[21] CMS. Medicare Claims Processing Manual, Chapter 12, §40.6.C16. Claims for Multiple Surgeries. Link here. Accessed 05/31/23.

[22] Participating physicians (PAR) agree to accept Medicare allowed amounts on all covered services as their maximum payment from all sources. This is known as "accepting assignment". Non-participating physicians (Non-PAR) may accept assignment on a case-by-case basis, but are also limited in the amount they may charge the patient if they do not accept assignment. For additional discussion, see information published by CMS for patients here. Link accessed 05/31/23.

in the “units” column (24G) of the claim form. Some payers require a copy of the invoice for description and cost.

CONCLUSION

This discussion is meant to assist the reader to better understand the rules and regulations regarding reimbursement for punctal occlusion with plugs, however the responsibility for appropriate usage, adequate documentation and proper coding are always the physician’s.

Billing Tips

- Bill for punctal occlusion per punctum.
- Use E-modifiers to identify each punctum for most Medicare jurisdictions.

  Some payers do not accept E-modifiers; use RT/LT instead, or bill with modifier 50.
- Multiple surgery reductions apply when more than one punctum is treated.
- When an exam for a separately identifiable reason is performed on the same day, append modifier 25 to the exam.
- Medicare and most other payers bundle the supply of the plugs into the professional fee. If a payer allows separate payment for the supplies, bill with 99070 and the quantity of plugs inserted.
- When other than permanent plugs are placed, be sure to support use with proper documentation of medical necessity as to the reason that option is selected and is most appropriate for the patient on that date.
- When there is concern about coverage eligibility, obtain an appropriate financial waiver or pre-determination prior to the procedure.
- Watch the NCCI edits – do not bill bundled codes.

APPENDIX

Sample Operative Report

Date: _____

Patient's name:_____

Preoperative diagnosis: Dry eye syndrome

Postoperative diagnosis: Dry eye syndrome

Procedure: Punctal Occlusion with Plug **[Indicate location]**

The patient has been previously diagnosed with dry eye syndrome and treated with a number of different artificial tears with little or no improvement. The procedure, alternatives, risks and possible complications have been explained to the patient and the patient has given consent for punctal occlusion with punctal plug. No guarantee or assurance has been given to the patient as to the results that may be obtained.

A drop of anesthesia **[indicate which anesthetic drop]** was placed on the punctum. **[Insert plug type here]** was removed from its package and inserted into the vertical canal of the **[insert which punctum here]**. **[IF NEEDED]** A like procedure was performed in the **[insert location here]**.

The patient tolerated the procedure well and left in good condition. Postoperative instructions were given including the medications as well as a follow-up appointment.

Physician's signature _____

Sample Letter for Pre-Certification

Date

[Insurer Name]
[Attn:_____]
[Street Address]
[City, State, Zip Code]

Re: [Patient Name]
[Patient's Identification Number]

Dear [Insurer]:

This letter is to request pre-certification for punctal occlusion with plugs for the treatment of dry eye syndrome, or keratoconjunctivitis sicca (KCS) **[OR OTHER CONDITION].** This letter provides the clinical rationale for performing the procedure along with a description of the procedure.

Background

An estimated 50 to 60 million Americans suffer from dry eye syndrome. Common treatments include ointments, eye drops, protective glasses and anti-inflammatory therapy. In cases where these treatments are ineffective or contraindicated, surgical intervention may be warranted. Punctal occlusion is a safe and effective treatment for KCS, as well as ocular surface disease, reflex tearing, and other conditions caused by dry eyes.

Punctal occlusion with plugs is used for moderate to severe dry eye sufferers to help retain tear fluid by stemming drainage. It may also enhance the delivery and absorption of topical medications in the eye. This procedure may prevent more serious corneal disease and facilitate a return to contact lenses.

Patient's Diagnosis and Clinical Rationale for Selecting Treatment

The history and clinical course of **[Patient Name]**'s dry eye syndrome is as follows:

> **[Please insert a paragraph discussing your patient's diagnosis and history. Include copies of test results, a complete summary of all previous treatments (including treatment response or failure) and documentation of clinical improvements and failures.]**

A variety of treatments are available to individuals with dry eye syndrome. Selecting the most appropriate treatment depends on a thorough evaluation of all the relevant factors that could cause or contribute to the condition. Because of **[Patient Name]**'s continued battle with dry eye syndrome and despite failed prior treatment with artificial tears, and after

careful examination and review of this patient's condition, I would like to perform punctal occlusion with plugs.

Treatment Description

The physician inserts the plug into the punctum because other treatment methods have been documented to have failed to solve the symptoms.

Request for Coverage Approval

Dry eye syndrome is a serious and often neglected ophthalmic condition. Unfortunately **[Patient Name]** has received every other available therapy without success. In light of the patient's medical history, it is my opinion that this procedure is medically necessary. I request that you consider coverage of this procedure and provide pre-certification. If you have any further questions about this procedure, please contact me at **[Phone]**.

Sincerely,

[Physician Name]

Sample Letter of Appeal

Date

[Insurer Name]
[Attn:_____]
[Street Address]
[City, State, Zip Code]

Re: [Patient Name]
[Patient's Identification Number]

Dear [Insurer]:

This letter is in response to your denial of the enclosed claim for punctal occlusion with plugs for the treatment of dry eye syndrome or keratoconjunctivitis sicca (KCS). I am submitting this claim for reconsideration. This letter provides the clinical rationale for performing the procedure along with a description of the procedure.

Background

An estimated 50 to 60 million Americans suffer from dry eye syndrome. Common treatments include ointments, eye drops, protective glasses and anti-inflammatory therapy. In cases where these treatments are ineffective or contraindicated, surgical intervention may be warranted. Punctal occlusion is a safe and effective treatment for KCS, as well as ocular surface disease, reflex tearing, and other conditions caused by dry eyes.

Punctal occlusion with plugs is used for moderate to severe dry eye sufferers to help retain tear fluid by stemming drainage. It may also enhance the delivery and absorption of topical medications in the eye. This procedure may prevent more serious corneal disease and facilitate a return to contact lenses.

Patient's Diagnosis and Clinical Rationale for Selecting Treatment

The history and clinical course of **[Patient Name]**'s dry eye syndrome is as follows:

> **[Please insert a paragraph discussing your patient's diagnosis and history. Include copies of test results, a complete summary of all previous treatments (including treatment response or failure) and documentation of clinical improvements and failures.]**

A variety of treatments are available to individuals with dry eye syndrome. Selecting the most appropriate treatment depends on a thorough evaluation of all the relevant factors that could cause or contribute to the condition. Because of **[Patient Name]**'s continued battle with dry eye syndrome and despite failed prior treatment with artificial tears, and after

careful examination and review of this patient's condition, I performed punctal occlusion with plugs.

Treatment Description

The plug was inserted into the punctum because other treatment methods have been documented to have failed to solve the symptoms.

Request for Coverage Approval

Dry eye syndrome is a serious and often neglected ophthalmic condition. Unfortunately **[Patient Name]** has received every other available therapy without success. In light of the patient's medical history, it is my opinion that this procedure is medically necessary. I request that you reconsider coverage of this procedure and pay my claim for reimbursement. If you have any further questions about this procedure, please contact me at **[Phone]**.

Sincerely,

[Physician Name]