

# SOFT PLUG® PUNCTAL OCCLUSION BILLING INFORMATION

**ICD-9 DIAGNOSIS CODES:** Tear Film Insufficiency (375.15)  
Keratoconjunctivitis Sicca (370.33)  
Redness or Discharge (379.93)

**CPT CODE:** 68761 – Punctal Closure with Collagen or Silicone Implant

**SUPPLY CODE:** N/A – Medicare (Payment is included in the professional fee)  
99070 – Commercial/Private

Medicare considers the office visit, dilation of the punctum and the supply of **BOTH** silicone and collagen plugs as inherent to the procedure and **NOT** billable separately. The allowable will vary by carrier and practitioner, and payment will be based on 80% of the allowed amount. Medicare will allow 100% of the first surgical procedure and 50% of the additional procedures (2<sup>nd</sup>, 3<sup>rd</sup>, and 4<sup>th</sup> occlusion).

**MODIFIERS:** E1 – Upper Lid, Left  
E2 – Lower Lid, Left  
E3 – Upper Lid, Right  
E4 – Lower Lid, Right  
25 – Significant, Separately Identifiable Service by the Same Doctor  
on the Same Day of the Procedure  
51 – Additional Procedure  
58 – Staged or Related Procedure, or Service, by the Same Doctor during  
the Post-Op Period  
79 – Unrelated Surgery During Post-Op Period  
99 – Multiple Modifiers

A charge for an office examination on the same day as a plug procedure is allowed **IF** the examination is *separate and completely unrelated* to the Dry Eye Syndrome or is for a new patient. This documented examination should be billed with the **"25"** code modifier.

**POST-OP PERIOD:** Ten (10) Days

## **RECOMMENDED DOCUMENTATION AND/OR TEST TO VERIFY DRY EYE SYNDROME AND JUSTIFY PROCEDURE:**

Medical necessity for punctal occlusion must document evidence of patient complaint(s) that support the presence of dry eye. This includes:

1. Patient complaints which evidence the presence of Dry Eye Syndrome
2. Use of artificial tear supplements for a period of time with continued dry eye symptoms

Recommended documentation and/or tests to verify Dry Eye Syndrome include:

1. Zone Quick® Phenol Red Thread Test
2. Schirmer Tear Test (Cannot Bill Separately – Will Be Bundled with Exam)
3. Fluorescein/Rose Bengal Staining
4. Superficial Punctate Keratitis
5. Tear Break-Up Time

When billing an exam the same day as the procedure, consider the following:

1. An exam should not be billed if the only symptom treated and documented is dry eye.
2. An exam addressing more than a dry eye can be billed for a significant, separate, identifiable diagnosis when used with the "25" modifier. This modifier should be used with the exam code, not the procedure code. *See additional notes on the use of the "25" modifier.*
3. Exams performed to "rule out" an ocular pathology are usually considered "screening exams" and are not covered by Medicare. An exception is made if the patient actually presents with multiple complaints. If the patient has only the complaint of dry eyes, a complete exam is not warranted. *REMEMBER: There should be documentation of evidence of symptoms and use of artificial tear supplements for a period of time.*
4. Medicare manuals clearly indicate that they pay for the reason the patient is in your office and not for what you might find. In order to bill Medicare for any exam or procedure you must document a complaint or symptom from the patient as the reason for exam.
5. Some insurance carriers (other than Medicare) may have a list of their own plug supply codes. If no list is available use "99070" (Miscellaneous Surgical Supply), and enter a description on the comment line. We recommend a short description of dry eyes and the procedure of inserting punctal plugs. Include a comment regarding the cost of the plugs, or a copy of the invoice, to validate the charge being made for the plugs.
6. The "51" additional procedure modifier is used when the same doctor does multiple procedures on a patient on the same day or at the same session. Report the primary procedure as listed and add "-51" to the additional procedure or service.

#### **COMMON MEDICARE ERRORS:**

1. Billing the procedure without the punctum location modifier. (E1, E2, E3, E4)
2. Modifier "25" is on the incorrect line. Remember, the "25" modifier should be used with the exam code and not the procedure code.
3. Billing an unjustified procedure. Reimbursement is based on the reason the patient is in your office (especially with Medicare). In the course of Medicare audits, one of the most common problem areas identified is finding the exam billed based on a diagnosis not compliant to the reason the patient presented for the exam.

There is a global period of ten (10) days for punctal occlusion. Inserting silicone (non-dissolvable) plugs, in the *same puncta*, less than ten (10) days after the collagen (temporary) plug procedure took place is considered a staged procedure. Use modifier "58".

#### **THE "25" MODIFIER:**

Reference from American Academy of Ophthalmology 1996 Coding Seminar: The "25" modifier is explained as a significant, separately identifiable evaluation and management service by the same doctor on the same day of a procedure.

- Use for visit/consultation done on same day as minor procedures (applies to eye codes also)
- Minor procedure equals one with 0–10 days of follow-up
- Attach to visit/consultation code
- Diagnosis code for exam should be different than that for the procedure
- Examples may include: Cataract or Glaucoma

*DISCLAIMER: This information is intended to be accurate, but no assurance or warranty is given. You may wish to refer to your Medicare Part B newsletters and/or contact commercial carriers for specific billing instructions.*