

MEDICARE REIMBURSEMENT FOR PUNCTAL OCCLUSION BY FORM FIT® PLUG

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QUESTION: Does Medicare cover punctal occlusion with the Form Fit® Intracanalicular Plug?

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

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QUESTION: What documentation is required in the medical chart to support 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. At the very least, other therapies would usually include artificial tears, and may include ointments.

3

QUESTION: How should the procedure be documented?

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 which 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.

4

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

ANSWER: The 2009 national Medicare Physician Fee Schedule allowable is \$122.99. This amount is adjusted by local wage indices in each area.

When two 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 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.

5

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 this is the case, 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 disease.

For additional information, request our FAQ on reimbursement rules related to modifier 25.

January 1, 2009

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6 **QUESTION:** Is separate reimbursement made for the plugs themselves?

ANSWER: Medicare has never made separate payment for temporary plugs. Effective January 1, 2002, Medicare no longer pays separately for permanent punctal plugs, although other payers may. Commercial payers may accept CPT code 99070 (*miscellaneous supplies*); include a description of the supply and the number of plugs inserted on the claim form. Some payers accept HCPCS code A4263 (*permanent, long term, non-dissolvable lacrimal duct implant, each*).

8 **QUESTION:** What if we need to explain a Form Fit plug?

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

7 **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
E2	Left lower lid
E3	Right upper lid
E4	Right lower lid

Most private payers (and some Medicare contractors) do not recognize these “E” modifiers, but will accept RT and LT on the claim. Bilateral services may be reported as 68761-50.

9 **QUESTION:** May an ASC receive payment for a facility fee if the procedure is performed there?

ANSWER: Yes. CMS inaugurated a new payment system for ASCs on January 1, 2008, which mirrors the Ambulatory Payment Classification (APC) system utilized in hospital outpatient departments (HOPDs). The system is now in its second year of transition. The 2009 ASC facility payment for 68761 is \$71.05. Prior to 2008, it was ineligible for reimbursement in an ASC.

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