



Corcoran  
Consulting  
Group

A Division of Ardare Corporation

**Reimbursement Guidelines**  
**for**  
**Punctal Occlusion by SmartPlug<sup>®</sup>**

*Prepared for*  
**Medennium, Inc.**

**January 2007**



# Reimbursement Guidelines for Punctal Occlusion by SmartPlug<sup>®</sup>

By

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***Objective:*** *This report is provided as a general discussion of Medicare reimbursement for punctal occlusion by plugs and related issues. Local variations between carriers may occur which are not described here. Users are strongly encouraged to review official instructions promulgated by the Centers for Medicare and Medicaid (formerly the Health Care Financing Administration) and their Medicare carriers; this document is not an official source nor is it a complete guide on all matters pertaining to reimbursement. In addition, users should check with their local insurance carriers for approved diagnosis codes and usage guidelines for the services discussed.*

***Acknowledgement:*** *This paper was underwritten by a grant from Medennium, Inc. as an aid to customers and other interested parties.*

*SmartPlug<sup>®</sup> is a registered trademark of Medennium, Inc.*

***Disclaimer:*** *The reader is reminded that this information can and does change over time, and may be incorrect at any time following publication.*



## INTRODUCTION

This document is intended to address the reimbursement issues associated with punctal occlusion utilizing the Medennium SmartPlug®. Medicare reimbursement for this procedure involves a number of issues. These include: Medicare coverage guidelines, the locations where services are rendered, and coding systems that apply to claims submission. This discussion addresses all of these variables in order to provide the reader with a comprehensive understanding of the topic.

## INDICATIONS FOR USE

SmartPlug provides a therapeutic alternative when eye drops and ointments have proven unsatisfactory for the treatment of dry eyes. Punctal occlusion has made many patients much more comfortable. Table 1 contains a list of common ICD-9 codes associated with this procedure.

Table 1 **Common ICD-9 Diagnosis Codes**

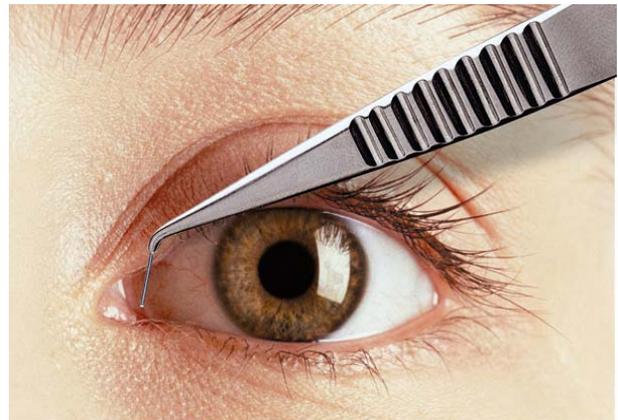
375.15	Dry Eye Syndrome
370.33	Keratoconjunctivitis Sicca
370.21	Punctate keratitis
370.40	Keratoconjunctivitis, unspecified
710.20	K. sicca with Sjögrens Syndrome

NOTE: Listed codes are representative of covered diagnoses but differences in payment policies exist for many carriers. This list is neither exhaustive nor universally acceptable. See your carrier bulletins. Review the bulletin in the Appendix for further discussion.

## THE PROCEDURE

The ophthalmologist or optometrist gently places SmartPlug into the punctum. Anesthetic eye drops may be used. Inside the punctum, the plug shrinks in length and expands in width, adjusting itself to fit the punctum. Once in place, SmartPlug becomes a soft gel. The innovative design of SmartPlug and the thermosensitive acrylic

material minimizes irritation to sensitive tissues. The eye care professional may remove it by irrigating the tear duct with a saline solution.



## 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, BUT, or tear assay)
- diagnoses (*e.g.*, dry eye syndrome, keratoconjunctivitis sicca, and associated systemic diseases)
- plan (*i.e.*, description of treatment risks and benefits)

The doctor must also keep the following points

in mind as he or she takes the history, conducts the examination and makes chart notations.

*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's important to establish the gravity of the condition and the effectiveness of earlier treatments and 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.* 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 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 American Academy of Ophthalmology treatment guidelines, the vast majority of patients with moderate dry eyes only require occlusion of the lower puncta. Occlusion of the upper puncta is only required when severe disease is present, or for those patients who don't obtain symptomatic relief following the occlusion of the lower puncta. If the upper puncta are occluded, chart notations should indicate severe disease or no relief following treatment of the lower puncta.

If you do not follow the treatment guidelines described above, or perform punctal occlusion before documented failure of other medical therapy, then reimbursement might not be forthcoming. To protect the practice and inform the beneficiary of potential financial responsi-

bility, ask the patient to sign an Advance Beneficiary Notice (ABN) and file the claim with modifier GA. If the claim is denied, the ABN gives you the ability to bill the patient for the procedure. Without a signed ABN you cannot bill the beneficiary (see Appendix).

### Operative Report and Consent

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

- Preop and postop 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 sample).

As with all operative procedures, the chart notes should include documentation of the patient's informed consent for the surgery. Informed consent that identifies the risks and benefits of the procedure may be oral but written is stronger.

### **FILING A CLAIM**

CPT code 68761 describes the insertion of punctal plugs (*closure of the lacrimal punctum; by plug, each*). Reimbursement is made per punctum. 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 3<sup>rd</sup> and 4<sup>th</sup> puncta to 37.5% for each puncta. The

code is repeated on the claim form according to how many puncta were occluded (see sample claim forms in the Appendix).

### Other Procedure(s)

When a second surgical procedure is performed within the postoperative period of the first procedure, other modifiers are used on the claim for the second procedure. For example, two SmartPlug are inserted in the lower puncta, and then a week later, two more plugs in the upper puncta are inserted. Modifier 79 is used with the second claim to indicate that the second procedure was performed in a different (and unrelated) location from the first 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 post-operative period. 68761 has a 10-day postoperative period.

Medicare applies the concept of a *global surgery package* to both major and minor surgeries. The global package includes:

- Preoperative visit on the day of surgery
- Postoperative visits related to recovery
- Supplies

### Modifiers

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

- 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
- 79 ..... Unrelated procedure by the same physician during the postop period
- E1 ..... Left upper eyelid
- E2 ..... Left lower eyelid
- E3 ..... Right upper eyelid
- E4 ..... Right lower eyelid
- RT ..... Right eye
- LT ..... Left eye

### Exam on the Day of the Procedure

An exam on the same day as a minor procedure is sometimes reimbursed in addition to the surgery, but not always. Medicare Claims Processing Manual (MCPM), Chapter 12, §40.2A.4 contains these instructions:

*“If evaluation and management services occur on the day of surgery, the physician bills using modifier “-57”, not “-25.” 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 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 E/M service (or eye code) to claim separate reimbursement for the office visit or consultation. 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 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 Sjogren'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 another follow-up visit is scheduled in two weeks. The claim will read as follows:

17 J. Jones, MD	17a A12345				
19					
21 1. 710.0 2. V58.69	3. 710.2				
24a mm/dd/yyyy	24b 11	24d 92014-25	24e 1,2,3	24f xxx.xx	24g 1
mm/dd/yyyy	11	68761-E2	3	xxx.xx	1
mm/dd/yyyy	11	68761-51E4	3	xxx.xx	1

**Other Modifiers**

Modifiers that describe the location of the insertion (which punctum) should be appended to CPT code 68761 for Medicare claims. 'E' modifiers are HCPCS modifiers developed by

Medicare. A few commercial carriers recognize E modifiers, but most still utilize RT (right) or LT (left), or are satisfied with the 51 modifier.

**Bundles**

The Centers for Medicare and Medicaid Services (CMS), the agency formerly known as the Health Care Financing Administration (HCFA), instructs the Medicare carriers to treat some concurrent procedures as a "bundle" for payment purposes. This means that no separate payment is made for another surgery outside of the bundled procedure. In addition, some surgical procedures are considered "mutually exclusive" with each other. This means that, when two procedures are performed on the same day on the same patient, only one of the procedures will be paid; generally the one of lesser value.

The National Correct Coding Initiative (NCCI) is the regulation that updates these payment rules, usually on a quarterly basis. Some carriers have also published local policies with additional limitations. Table 2 identifies the current NCCI bundles affecting punctal occlusion with plugs.

**Table 2 Current Bundles**

Primary Code	Bundled Codes			
68761	36000	36410	37202	62318
	62319	64402	64415	64416
	64417	64450	64470	64475
	67500	68440	68770	68801
	69990 <sup>0</sup>	G0345	G0347	G0351
	G0353	G0354	J2001	

October 1, 2006 NCCI edits

**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 some commercial carriers may continue to pay for the supply. In those cases, use 99070 (*miscellaneous supply*) to describe the plug(s). The number of plugs inserted is identified in the “units” column of the claim form (see sample claim forms in the Appendix). Some carriers require a copy of the invoice for description and cost.

The 1999 Medicare Physician Fee Schedule addressed the supply issue (November 2, 1998 Federal Register, Vol. 63, No. 211, p 58831-2). The Balanced Budget Act provided for a 4-year transition period to implement a new resource-based system for calculating Medicare reimbursement of physician services. As part of this transition, HCFA decided that supply costs for punctal occlusion were already included in the new, higher procedure reimbursement, so separate payment for supplies would be gradually phased out.

## UTILIZATION RATES

Both ophthalmologists and optometrists perform punctal occlusion with plugs in almost every state. Over the past 5 years, this procedure has steadily grown in popularity. At present, punctal occlusion with plugs is the most popular minor procedure in optometry and in the top three for ophthalmology. According to the most recent BESS utilization data available for the Medicare program (2005), this procedure is performed by ophthalmologists about 203,000 times per year or about 1 time per 100 eye exams. Optometrists performed the procedure about 98,000 times per year, also about 1 time per 100 eye exams. 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 postpayment review.

## PAYMENT RATES

Payment rates in 2007 for 68761 are shown below. Note that payment amounts vary geographically.

### Medicare National Payment Rates for 68761

Participating .....	\$132
Non-participating .....	\$125
Limiting charge for non-participating physicians .....	\$144

## EXPLANTING SMARTPLUG

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

## DRY EYES AND LASIK

During laser-assisted in situ keratomileusis (LASIK) surgery, some corneal nerves are severed. Many doctors now believe that this is the reason most LASIK patients develop symptoms of dry eye, which sometimes last for months. 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 that there are methods to deal with it, primarily artificial tears and ointments.

Coverage of this procedure following LASIK depends on several considerations.

- Some third party payers will reimburse for

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 be considered medically unnecessary and ineligible for reimbursement. Obtain a signed ABN from the patient.

## **CONCLUSION**

SmartPlug is a unique punctum plug made from thermosensitive acrylic, which helps it conform to the size and shape of the punctum, unlike collagen or silicone plugs. 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.

## **APPENDIX**



Patient's Name:

Medicare # (HICN):

# ADVANCE BENEFICIARY NOTICE (ABN)

NOTE: You need to make a choice about receiving these health care items or services.

We expect that Medicare will not pay for the item(s) or service(s) that are described below. Medicare does not pay for all of your health care costs. Medicare only pays for covered items and services when Medicare rules are met. The fact that Medicare may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Right now, in your case **Medicare probably will not pay for -**

Items or Services:

Because:

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should **read this entire notice carefully.**

- Ask us to explain, if you don't understand why Medicare probably won't pay.
- Ask us how much these items or services will cost you (**Estimated Cost: \$**\_\_\_\_\_), in case you have to pay for them yourself or through other insurance.

PLEASE CHOOSE ONE OPTION. CHECK ONE BOX. SIGN & DATE YOUR CHOICE.

**Option 1. YES. I want to receive these items or services.**

I understand that Medicare will not decide whether to pay unless I receive these items or services. Please submit my claim to Medicare. I understand that you may bill me for items or services and that I may have to pay the bill while Medicare is making its decision. If Medicare does pay, you will refund to me any payments I made to you that are due to me. If Medicare denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand I can appeal Medicare's decision.

**Option 2. NO. I have decided not to receive these items or services.**

I will not receive these items or services. I understand that you will not be able to submit a claim to Medicare and that I will not be able to appeal your opinion that Medicare won't pay.

Date

Signature of patient or person acting on patient's behalf

NOTE: Your health information will be kept confidential. Any information that we collect about you on this Form will be kept confidential in our offices. If a claim is submitted to Medicare, your health information on this form May be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.

OMB Approval No. 0938-0566 Form No. CMS-R-131-G (June 2002)

## Sample Operative Report

Date: \_\_\_\_\_

Patient's name: \_\_\_\_\_

Preoperative diagnosis: Dry eye syndrome

Postoperative diagnosis: Dry eye syndrome

Procedure: Punctal occlusion with SmartPlug<sup>®</sup>      **[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 SmartPlug. No guarantee or assurance has been given to the patient as to the results that may be obtained.

SmartPlug was removed from its package with forceps and the distal end was gently placed into the punctum. SmartPlug was allowed to come to body temperature; as it did so, the thermosensitive acrylic material shrank in length and expanded in width, adjusting itself to fit the punctum.

The procedure was repeated for the other punctum.

The patient tolerated the procedure well and left in good condition. The 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). 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 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 gently places SmartPlug<sup>®</sup> into the punctum. Inside the punctum, the plug shrinks in length and expands in width, adjusting itself to fit the punctum. Once in place, SmartPlug becomes a soft gel. The innovative design and thermosensitive acrylic material of SmartPlug minimize irritation to sensitive tissues.

## **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 for Claims Denied Coverage

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 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 ophthalmologist or optometrist gently places SmartPlug<sup>®</sup> into the punctum. Inside the punctum, the plug shrinks in length and expands in width, adjusting itself to fit the punctum. Once in place, SmartPlug becomes a soft gel. The innovative design and thermosensitive acrylic material of SmartPlug minimize irritation to sensitive tissues.

## **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**]

## **Representative Local Medical Review Policy (LMRP)**

### **Lacrimal Punctum Closure, Maryland**

#### **LCD Title**

Lacrimal Punctum Closure - O-51B-R1

#### **Contractor's Determination Number**

O-51 (L18457 DC, L18453 DE, L18451 MD, L18345 TX, L18459 VA)

#### **Contractor Name**

TrailBlazer Health Enterprises, LLC

#### **Contractor Number**

- DC Metropolitan Carrier - 00903
- Delaware Carrier - 00902
- Maryland Carrier - 00901
- Texas Carrier - 00900
- Virginia Carrier - 00904

#### **Contractor Type**

- DC Metropolitan Carrier - 00903
- Delaware Carrier - 00902
- Maryland Carrier - 00901
- Texas Carrier - 00900
- Virginia Carrier - 00904

#### **AMA CPT/ADA CDT Copyright Statement**

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#### **CMS National Coverage Policy**

- *Medicare Benefit Policy Manual* - Pub. 100-2.
- *Medicare National Coverage Determinations Manual* - Pub. 100-3.
- *Correct Coding Initiative - Medicare Contractor Beneficiary and Provider Communications Manual* - Pub. 100-9, Chapter 5.
- Social Security Act (Title XVIII) Standard References:

- Section 1862 (a)(1)(A) Medically Reasonable & Necessary.
- Section 1862 (a)(1)(D) Investigational or Experimental.

### **Primary Geographic Jurisdiction**

- DC Metropolitan Carrier - 00903
- Delaware Carrier - 00902
- Maryland Carrier - 00901
- Texas Carrier - 00900
  - Indian Health Service
- Virginia Carrier - 00904

### **Secondary Geographic Jurisdiction**

N/A

### **Oversight Region**

- DC Metropolitan Carrier - III
- Delaware Carrier - III
- Maryland Carrier - III
- Texas Carrier - VI
- Virginia Carrier - III

### **Original Determination Effective Date**

04/21/2005

### **Original Determination Ending Date**

N/A

### **Revision Effective Date**

04/21/2005

### **Revision Ending Date**

N/A

### **Indications and Limitations of Coverage and/or Medical Necessity**

In most cases of dry eye syndrome requiring punctum plugs or punctum closure, placement of one plug in (or closure of) each lower punctum will suffice to alleviate the problem, Medicare will reimburse for two plugs per beneficiary or two permanent closures per beneficiary on any given day. Up to two additional plugs or two additional closures may be performed for a total of four, but documentation must

clearly show that the two additional plugs or closures were medically necessary as additional treatment to alleviate the condition. While the clinician's right to choose between temporary and semi-permanent plugs is respected, the semi-permanent plugs afford a more extensive trial of punctum closure, and may better serve to delineate candidates for permanent closure. Medicare recognizes that a semi-permanent plug may become dislodged before an adequate three-month trial of this therapy is completed. Additional punctum plugs may be provided for within this time period with the submission of documentation. Medicare expects these plugs to be a transitional therapy, as definitive closure and alternative topical pharmacologic therapy is available. Patients who, for defined medical reasons cannot tolerate permanent closure or pharmacologic therapy will be considered for semi-permanent plugs after a three month period, only with the submission of medical documentation.

## Coverage Topics

Category Undefined

## Type of Bill Codes

N/A

## Revenue Codes

N/A

## CPT/HCPCS Codes

**Note:** Providers are reminded to refer to the long descriptors of the CPT codes in their CPT book. The American Medical Association (AMA) and the Centers for Medicare & Medicaid Services (CMS) require the use of short CPT descriptors in policies published on the Web.

68760© Close tear duct opening

68761© Close tear duct opening

68801© Dilate tear duct opening

## ICD-9-CM Codes that Support Medical Necessity

The CPT/HCPCS codes included in this policy will be subjected to "procedure to diagnosis" editing. The following lists include only those diagnoses for which the identified CPT/HCPCS procedures are covered. If a covered diagnosis is not on the claim, the edit will automatically deny the service as "not medically necessary."

Medicare is establishing the following limited coverage for **CPT/HCPCS codes 68760 and 68761:**

### Covered for:

375.15 Dry-eye syndrome

Medicare is establishing the following limited coverage for **CPT/HCPCS code 68801:**

### Covered for:

375.20 -375.22 Epiphora

375.30 - 375.33 Acute and unspecified inflammation of lacrimal passages

375.41 -375.43 Chronic inflammation of lacrimal passages

375.51 - 375.57	Stenosis and insufficiency of lacrimal passages
375.61	Lacrimal fistula
375.69	Other lacrimal fistula
375.81	Granuloma of lacrimal passages
375.89	Other granuloma of lacrimal passages
743.65	Congenital anomalies of lacrimal passages

**Note:** Providers should continue to submit ICD-9-CM diagnosis codes without decimals on their claim forms and electronic claims.

### **Diagnoses that Support Medical Necessity**

N/A

### **ICD-9-CM Codes that DO NOT Support Medical Necessity**

N/A

### **Diagnoses that DO NOT Support Medical Necessity**

All diagnoses not listed in the "ICD-9-CM Codes That Support Medical Necessity" section of this policy.

### **Documentation Requirements**

Documentation supporting the medical necessity should be legible, maintained in the patient's medical record, and must be made available to Medicare upon request.

### **Appendices**

N/A

### **Utilization Guidelines**

N/A

### **Sources of Information and Basis for Decision**

**Hurwitz JJ:** *The lacrimal system*, Philadelphia, 1995, Lippincott-Raven

**Lemp MA:** "Recent Developments in Dry Eye Management," *Ophthalmology* 1987; 94: 1299

**Newell FW:** *Ophthalmology, Principles and Concepts, 8<sup>th</sup> Ed. Chapter 13*, St. Louis, 1996, Mosby-Year books

### **Advisory Committee Meeting Notes**

This policy does not reflect the sole opinion of the contractor or contractor medical director. Although the final decision rests with the contractor, this policy was developed in cooperation with advisory groups, which include representatives from ophthalmology.

### **Advisory Committee meeting dates:**

10/20/2004 MD

10/26/2004 DCMA  
10/27/2004 DE  
10/20/2004 TX  
10/18/2004 VA

**Start Date of Comment Period**

10/27/2004

**Ending Date of Comment Period**

12/13/2004

**Start Date of Notice Period**

03/07/2005

**Revision History**

Number	Date	Explanation
R1	07/25/2005	LCD amended to remove 68801 from limited coverage of that for dilation of the lacrimal punctum, 68801 may be a diagnostic procedure itself independent of performance with punctum closure. Additional ICD-9 codes (375.20-375.22, 375.30-375.33, 375.41-375.43, 375.51-375.57, 375.61, 375.69, 375.81, and 743.65) were added as a separate limited coverage section to reflect the clinical situations where this service may be of value. Change effective: Original effective date of policy.

For documentation previously included in an LMRP (e.g., Coding Guidelines), see related Article: [Article O-51B-R1 Lacrimal Punctum Closure1.htm](#)

**Sample Claim Forms for Punctal Occlusion with Plugs *Two Inferior Puncta***

**PLUG INSERTION FOR MEDICARE**

17. Dr. John Doe				17.a. A00000				
19.								
21. 375.15								
24.a.	24.b.	24.c.	24.d.		24.e.	24.f.	24.g.	24.k.
mm/dd/yyyy	11	2	68761	E2	1	\$XXX	1	
mm/dd/yyyy	11	2	68761	51 E4	1	\$XXX	1	

**PLUG INSERTION FOR NON-MEDICARE**

17. Dr. John Doe				17.a. A00000				
19.								
21. 375.15								
24.a.	24.b.	24.c.	24.d.		24.e.	24.f.	24.g.	24.k.
mm/dd/yyyy	11	2	68761	LT	1	\$XXX	1	
mm/dd/yyyy	11	2	68761	51 RT	1	\$XXX	1	
mm/dd/yyyy	11	9	99070		1	\$XXX	2	

**PLUG INSERTION FOR NON-MEDICARE (ALTERNATE)**

17. Dr. John Doe				17.a. A00000				
19.								
21. 375.15								
24.a.	24.b.	24.c.	24.d.		24.e.	24.f.	24.g.	24.k.
mm/dd/yyyy	11	2	68761	50	1	\$XXX	1	
mm/dd/yyyy	11	9	99070		1	\$XXX	2	

## Common Billing Problems

Common Billing Problems	Source of Problems
Denials on office visit ( <i>when appropriate</i> )	➤ Lack of necessary modifier (-25)
Plugs denied by non-Medicare carriers	<ul style="list-style-type: none"> <li>➤ Used HCPCS code (A4263) instead of CPT (99070)</li> <li>➤ Carrier policy may reduce or prohibit reimbursement (check with carrier)</li> </ul>
Claims denied by Medicaid	➤ Local policy may reduce or prohibit reimbursement (check with carrier)
Insufficient reimbursement for procedure	➤ Incorrect site of service on claim form; when performed in the office, location should be 11 (office) or SOS reduction applies
Denials for repeat procedures within postop period	➤ Lack of necessary modifier (-79)





