



Corcoran
Consulting
Group

A Division of Ardare Corporation

**Reimbursement Guidelines
for
Punctal Occlusion Using
Form Fit[®] Intracanalicular Plug**

Prepared for

OASIS[®] 

January 2009

Reimbursement Guidelines for Punctal Occlusion Using Form Fit® Intracanalicular Plug

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 Medicare administrative contractors may occur which are not described here. The user is strongly encouraged to review official instructions promulgated by the Centers for Medicare and Medicaid Services (CMS) and its contractors; this document is not an official source nor is it a complete guide on all matters pertaining to reimbursement. In addition, users should check local coverage policies for approved diagnosis codes and usage guidelines for the services discussed.

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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 Form Fit® Intracanalicular Plug from OASIS Medical, Inc. 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

The Form Fit Intracanalicular 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 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

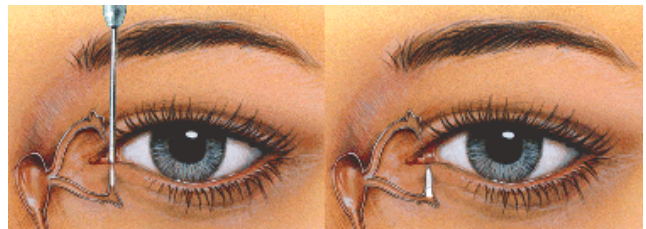
NOTE: Listed codes are representative of covered diagnoses but differences in payment policies exist for many carriers. This list is neither exhaustive nor universally accepted. See your carrier bulletins for specifics. Review the bulletin in the Appendix for further discussion.

THE PROCEDURE

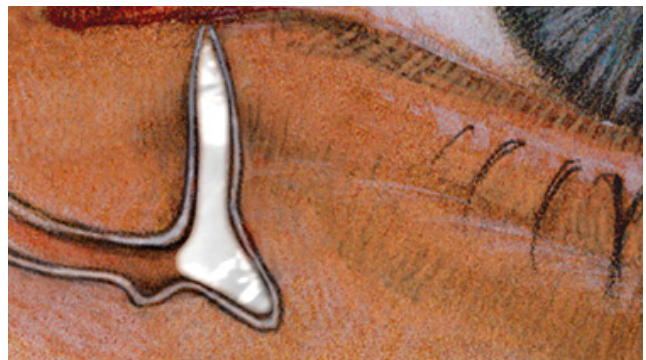
The Form Fit Intracanalicular Plug is one of the newest advances in dry eye treatment. It is offered in one size, as a single solution in punctal occlusion. A drop of anesthesia on the punctum is recommended. The polyimide sheath is then inserted into the vertical canal. The inserter handle is squeezed gently and the hydrogel plug

is expelled into the canal; the sheath is then removed. The hydrogel expands over 20 times its normal size to custom-fit the vertical canaliculus when it comes into contact with the tear film. It takes approximately 10 minutes for the hydrated gel to completely fill the vertical canalicular cavity. The Form Fit is easily removed by irrigating the tear duct with normal saline or balanced salt solution.

Insertion and Placement of the Form Fit Intracanalicular Plug



Expanded View of the Form Fit Intracanalicular Plug in Place



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 responsibility, ask the patient to sign an Advance Beneficiary Notice of Noncoverage (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.

BILLING ISSUES

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 third and fourth puncta to 37.5% of the allowed amount for each.

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 Form Fit 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 for a minor procedure 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 Form Fit.

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 or LT...	Right or 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: “... *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 visit 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.

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 17b 12345678				
19						
21 1. 710.0 2. V58.69		3. 710.2				
24a	24b	24d	24e	24f	24g	
mm/dd/yyyy	11	92014-25	1	xxx.xx	1	
mm/dd/yyyy	11	68761-E2	3	xxx.xx	1	
mm/dd/yyyy	11	68761-51E4	3	xxx.xx	1	

Prohibited Code Combinations

The Centers for Medicare and Medicaid Services (CMS)¹ instructs the Medicare Administrative Contractors (MACs) 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 one another. 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 MACs 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 51701 51702
	51703 62318 62319 64402 64415
	64416 64417 64450 64470 64475
	67500 68440 68770 68801 68810
	68811 69990 ⁰ 96360 96365 96372
	96374 96375 J2001

January 1, 2009 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 payers may continue to pay for the supply. In

¹ Formerly known as the Health Care Financing Administration (HCFA)

those cases, use CPT code 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 payers require a copy of the invoice for description and cost.

The 1999 Medicare Physician Fee Schedule addressed the supply issue². 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. Over the past 5 years, this procedure has steadily grown in popularity. At present, punctal occlusion with plugs is the most common minor procedure in optometry, and ranks in the top three for ophthalmology. According to the most recent utilization data available for the Medicare program (2007), this procedure is performed by ophthalmologists and optometrists 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 for 68761 are shown below. Note

² November 2, 1998 Federal Register, Vol. 63, No. 211, p 58831-2

that payment amounts vary geographically.

Medicare National Payment Rates for 68761

Participating	\$123
Non-participating	\$119
Limiting charge for non-participating physicians	\$137

Explanting Form Fit

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.

Medicare National Payment Rates for 68801 and 68840

	<u>68801</u>	<u>68840</u>
Participating.....	\$102	\$104
Non-Participating.....	\$99	\$100
Limiting Charge for Non-Participating Physicians..	\$114	\$115

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

Form Fit is a unique punctum plug made from hydrogel, which conforms to the size and shape of the vertical canalicular cavity, 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

Sample ABN Form

Print your name, address and telephone number. Logo is optional.

Patient Name: Identification Number:

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

NOTE: If Medicare doesn't pay for items or services below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the items or services below.

Table with 3 columns: Items or Services, Reason Medicare May Not Pay, Estimated Cost.

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
Ask us any questions you may have after you finish reading.
Choose an option below about whether to receive the ... listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

OPTIONS: Check only one box. We cannot choose a box for you.

[] 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.

Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227 / TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

Signature: Date:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Sample Operative Report

Date: _____

Patient's name: _____

Preoperative diagnosis: Dry eye syndrome

Postoperative diagnosis: Dry eye syndrome

Procedure: Punctal occlusion with Form Fit[®] **[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 Form Fit. No guarantee or assurance has been given to the patient as to the results that may be obtained.

A drop of anesthesia **[indicate type of anesthetic]** was placed on the punctum. Form Fit was removed from its package and the polyimide sheath was inserted into the vertical canal. While gently squeezing the inserter handle, the hydrogel plug was expelled. The sheath was removed while the inserter handle was squeezed. Form Fit was allowed to absorb tear film; as it did so, the hydrogel material expanded to fill the vertical canalicular cavity.

The procedure was repeated for the other punctum.

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). 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 gently places Form Fit IntraCanalicular Plug into the punctum. Inside the punctum, the plug expands to fill the vertical canalicular cavity. The innovative design and hydrogel material of Form Fit 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 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 ophthalmologist or optometrist gently places the Form Fit Intracanalicular Plug into the vertical canal. Inside the canal, the Form Fit expands to fill the vertical canalicular cavity. The innovative design and hydrogel material of Form Fit 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)

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, 8th 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
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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				17a.			
				17b. 1234567890			
19.							
21. 375.15							
24.a.	24.b.	24.c.	24.d.		24.e.	24.f.	24.g.
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				17a.			
				17b. 1234567890			
19.							
21. 375.15							
24.a.	24.b.	24.c.	24.d.		24.e.	24.f.	24.g.
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				17a.			
				17b. 1234567890			
19.							
21. 375.15							
24.a.	24.b.	24.c.	24.d.		24.e.	24.f.	24.g.
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"> ➤ Used HCPCS code (A4263) instead of CPT (99070) ➤ Carrier policy may reduce or prohibit reimbursement (check with carrier)
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)