



BILLING GUIDELINES FOR PUNCTAL OCCLUSION

INTRODUCTION

Odyssey Medical has developed this guide to provide you with basic information for obtaining reimbursement for punctal occlusion. The reader is strongly encouraged to review official instructions from the Centers for Medicare and Medicaid Services (CMS) and local Medicare carriers and to be familiar with the rules and definitions published in Current Procedural Terminology (CPT® the American Medical Association). In addition, check with local insurance carriers for approved diagnosis codes and any payer-specific usage guidelines for these services.

OP-NOTES™

To assist you with filing, Odyssey provides Op-Notes™ peel-and-stick documentation labels with each punctal occluder (see example below). It is important that you use these labels in your chart, as they contain the plug type, size and lot number, along with other required information for traceability.



Op-Notes™ for various Odyssey products may differ slightly from example shown here.

DOCUMENTATION TIPS

HISTORY Note the patient's symptoms (i.e., itching, burning, redness, tearing) as well as related illnesses such as Sjögrens disease or rheumatoid arthritis. Identify any inhibitions to regular activities of daily living that result from the patient's condition. Describe the patient's prior experience with artificial tears or other therapies for dry eyes. List current medications, particularly any with ocular side effects.

EXAMINATION Document evaluation of tear production (using TBUT, Lissamine Green, Zone Quick, Schirmer Test or observation of tear meniscus, etc.) and patient's corneal condition.

TREATMENT Discuss and document risks and benefits of punctal occlusion as well as alternative therapeutic options.

POST-OPERATIVE PERIOD

Many third-party payers consider occlusion of punctum by plug, 68761, to have a ten day post-op global period following the insertion of temporary or permanent plugs. As a result of these restrictions and of common clinical protocol, providers usually wait ten days after the insertion of temporary plugs, before assessing the benefit of the plugs and then inserting permanent plugs.

FREQUENTLY ASKED QUESTIONS

Does Medicare cover punctal occlusion?

Yes. Use 68761 (Closure of lacrimal punctum; by plug, each) to describe the professional service. The same code applies whether permanent or temporary plugs are inserted. Medicare reimbursement for the procedure includes payment for the plugs.

What is the Medicare reimbursement for punctal occlusion with plugs?

The 2008 Medicare relative value for 68761 (for temporary or permanent plug) is 3.70, which results in a 2008 national average Medicare allowed amount of \$128.00 per punctum. This amount is adjusted by local indices in each area. When more than one punctum is occluded at the same time, multiple surgery rules apply. The first procedure is allowed at 100% and each additional procedure is allowed at 50%.

What documentation is required by Medicare?

Medicare and most other payers expect that a minor surgical procedure, such as 68761, will not be performed as an initial treatment for dry eyes. The chart should include documentation that other therapies were unsuccessful. Your chart documentation should clearly state that you reviewed the risks and benefits of this procedure with the patient, along with non-surgical alternatives. The chart should also confirm that you have obtained the patient's consent for the procedure.

When can I bill an office visit on the same day as the insertion of the plugs?

As is true for all minor surgical procedures (debridement, insertion of plug, removal of foreign body, etc.), no office visit is billed on the same day unless there are unusual circumstances. In most cases, the 68761 will be reported without an office visit. In some cases an office visit is reported; e.g. if the need for surgery is determined during a visit for a condition that is completely unrelated to the dry eye condition, such as a periodic evaluation for open angle glaucoma. The office visit would then be chosen based on the content of the medical record and would be reported with the 25 modifier attached. Also, it is important to report the office visit with the diagnosis code appropriate to the other diagnosis, in this example open angle glaucoma, and the 68761 in combination with the diagnosis for the dry eye condition.

How do I submit a claim?

For detailed diagnosis and procedure codes, along with a sample reimbursement claim form, see the reverse side of this guide.



DIAGNOSIS AND PROCEDURE CODES

DIAGNOSIS CODES (ICD-9)

375.15 Tear film insufficiency

NOTE: Supplemental diagnoses may apply, such as:

365.11 Primary open angle glaucoma

370.20 Superficial keratitis

370.33 Keratoconjunctivitis sicca

710.2 K. sicca associated with Sjögren's disease

714.0 Rheumatoid arthritis

CPT PROCEDURE CODES

68761 Closure of the lacrimal punctum; by plug, each

MODIFIERS

25 Separately identifiable E/M service on the day of a procedure

51 Multiple procedures

PUNCTUM-SPECIFIC CODES

E1 Left upper lid

E2 Left lower lid

E3 Right upper lid

E4 Right lower lid

SAMPLE MEDICARE & PRIVATE INSURANCE REIMBURSEMENT CLAIM FORM

Collagen/EXTEND™ and silicone plug insertion claims are now submitted the same for both Medicare and most private insurance. Some private insurance companies may accept a supply code (A4263 or 99070).

COLLAGEN / EXTEND INSERTION — ALL FOUR LIDS —	21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)													
	1. <u>365.11</u>					3. _____								
	2. <u>375.15</u>					4. _____								
	24. A DATE(S) OF SERVICE						B	C	D			E	F	G
	From To						Place	Type	PROCEDURES, SERVICES, OR SUPPLIES			DIAGNOSIS	\$ CHARGES	DAYS
	MM	DD	YY	MM	DD	YY	of	of	(Explain Unusual Circumstances)			CODE		OR
							Service	Service	CPT/HCPCS	MODIFIER				UNITS
09	10	06	09	10	06	11		992xx	25		1	\$ xxx.xx	1	
09	10	06	09	10	06	11		68761	E1		2	\$ xxx.xx	1	
09	10	06	09	10	06	11		68761	E2	51	2	\$ xxx.xx	1	
09	10	06	09	10	06	11		68761	E3	51	2	\$ xxx.xx	1	
09	10	06	09	10	06	11		68761	E4	51	2	\$ xxx.xx	1	

Allow a 10-day post-op period before inserting permanent plugs.

SILICONE PLUG INSERTION — LOWER RIGHT/LEFT LIDS —	21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)													
	1. <u>375.15</u>					3. _____								
	2. _____					4. _____								
	24. A DATE(S) OF SERVICE						B	C	D			E	F	G
	From To						Place	Type	PROCEDURES, SERVICES, OR SUPPLIES			DIAGNOSIS	\$ CHARGES	DAYS
	MM	DD	YY	MM	DD	YY	of	of	(Explain Unusual Circumstances)			CODE		OR
							Service	Service	CPT/HCPCS	MODIFIER				UNITS
09	27	06	09	27	06	11		68761	E2		1	\$ xxx.xx	1	
09	27	06	09	27	06	11		68761	E4	51	1	\$ xxx.xx	1	

