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Optometry Coding & Billing Alert

Don't Let Global Periods Plug Up Your Plug-Insertion Cash Flow

Rely on documentation and modifier -58 for permanent implant payment

When you insert permanent punctal plugs after a patient has tried temporary plugs, your patient can usually count on relief for his dry-eye syndrome - but you can't count on getting paid unless you know the global period and modifier rules.

Example: Your patient complains of dry eyes. You decide to insert temporary collagen implants into the puncta to see if they help the condition. If they do, you intend to insert permanent silicone plugs.

You insert the collagen plugs and bill CPT code 68761 (Closure of the lacrimal punctum; by plug, each) linked to diagnosis ICD-9 code 375.15 (Other disorders of lacrimal gland; tear film insufficiency, unspecified). A week later you see that the patient has much improved, so you insert permanent plugs - billing with the same codes.

There's a good chance this second claim will be denied. Here's how to keep these denials from happening to you.

It's a Small Global, After All

Medicare has set the "global period" for 68761 at 10 days, says **Dina Winstead**, office manager for Gregory Hagedom, OD, in Henderson, Ky. If you bill 68761 again before the 10 days have expired, carriers may scoff at reimbursement for the second procedure. They would consider the second procedure to be included in the global surgical package of the first, and thus not separately reimbursable.

For full reimbursement, you should wait until the global period has ended before inserting the permanent plug, Winstead says - unless, of course, medical necessity requires you to do it earlier. But things get tricky when an optometrist decides not to wait until the global period has expired before inserting the permanent plugs.

Disaster averted: You can append modifier -58 (Staged or related procedure or service by the same physician during the postoperative period) to the second procedure if you have documented in your notes from the previous (temporary) procedure that you "planned" on placing the permanent, silicone plugs, Winstead says.

This shouldn't happen often, says **David Gibson, OD, FAAO,** practicing optometrist in Lubbock, Texas. "I can't think of any reason why permanent plugs might be necessary before the global time expires for the temporary plugs," he says.

Back Off From Modifier -78

What if you don't have this documentation in your notes? Related procedures that do not meet the requirements of -58 and are performed in the postoperative period can be billed with modifier -78 (Return to the operating room for a related procedure during the postoperative procedure), but only under specific circumstances.

Modifier -78 requires an operating room setting. According to the Medicare Carriers Manual, modifier -78 should be used for "treatment for postoperative complications which require a return trip to the operative room."

MCM further specifies that an operating room, for the purpose of modifier -78, is "a place of service specifically equipped and staffed for the sole purpose of performing procedures," including cardiac catheterization suites, laser suites and endoscopy suites.

Patients' rooms, minor-treatment rooms, recovery rooms and intensive care units are not classified as operating rooms.

Because optometrists most commonly place punctual plugs in minor-treatment rooms, the operating room requirement of -78 is not met, so you can't use this modifier to bill repeat plug insertion procedures, Winstead says.

If the placement of the permanent plugs occurs after the 10-day period, you can bill the procedure again. The only modifiers required are the eyelid modifiers, E1-E4.

Treat Removal as Office Visit

There is no appropriate way to charge in the Medicare program for removing plugs, even if you're not the optometrist who put them there in the first place. If there is no specific code in CPT for the removal of a suture or implanted device, Medicare considers the removal to be included in the global package of insertion, even if it's after the 10-day global period, says **Diana Franklin**, insurance clerk at Clovis Vision Associates in Clovis, N.M. If someone other than the implanting doctor removes the plugs, Medicare believes the service should be coded as a low-level office visit.

Swallow Plug Costs for Medicare Carriers

Don't expect payment for punctal plug supplies from Medicare. CMS and some private carriers bundle payment for both the temporary collagen implant (HCPCS code A4262, Temporary, absorbable lacrimal duct implant, each) and the permanent silicone plug (A4263, Permanent, long-term, nondissolvable lacrimal duct implant, each) into the fee for 68761, Franklin says.

When billing a payer other than Medicare, you can attempt to bill the supplies with the HCPCS codes or CPT code 99070 (Supplies and materials [except spectacles], provided by the physician over and above those usually included with the office visit or other services rendered [list drugs, trays, supplies, or materials provided]).

When using code 99070, list the item in the comments area or Box 19 of your claim form and include an invoice listing the cost of the item, Franklin says. But beware: Since Medicare gives 99070 a "B" status code (meaning they will make no separate payment for it), it's "probably not worth it" to report it, Franklin says.

Note: For more information on specific billing scenarios for different carriers, see "Keep Your Plug Coding Options Straight" later in this issue.