Codify
BY AAPC

Optometry Coding & Billing Alert

READER QUESTION: Pursue Punctum Plug Answers

Question: There is a big discrepancy in how to post punctal plugs properly, how to bill for replacement plugs in the post-op time frame, and if there is any way to be reimbursed for the plug itself. Would you shed some light on this matter?

Florida Subscriber

Answer: Payers'reimbursement policies for an optometrist's insertion of permanent and temporary punctum plugs are constantly changing, leaving coders perpetually uncertain of who is going to pay for what when it comes to billing punctal plug procedures and supplies.

Now, both permanent and temporary plugs are not separately billable to Medicare when billed with the plug closure procedure 68761 (Closure of the lacrimal punctum; by plug, each). Medicare recently bundled the payment for A4263 (Permanent, long-term, nondis-solvable lacrimal duct implant, each) in the 2002 fee schedule. A4262 (Temporary, absorbable lacrimal duct implant, each) had been bundled and was not separately billable with procedure code 68761 for many years. The deletion of plug reimbursement for the permanent plug was issued as part of the "Emergency Changes to the 2002 Medicare Physician Fee Schedule Database."

You can still bill private payers for punctal plugs and all additional supplies used during the procedure. Use the HCPCS plug codes or procedure 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]) with a detailed invoice for the supplies.

As for replacing plugs in the postoperative period, which is 10 days, you can code for the supply only, with either A4262 or A4263. The procedure can't be billed again during the postoperative period because plug insertion procedures are not performed in a covered setting. The repeat procedure, 68761, would not be considered related.

Related procedures that do not meet the requirements of -58 (Staged or related procedure or service by the same physician during the postoperative period) 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 requires 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 the placement of punctal plugs is most commonly performed in minor treatment rooms, the operating-room requirement of -78 is not met, so this modifier can't be used to bill repeat plug insertion procedures. If the placement of the permanent plugs occurs after the 10-day period, the procedure can be billed again, and a modifier, other than the informational modifiers (E1-E4), is not required.

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