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Optometry Coding & Billing Alert

Understand Eyelid Modifiers and Avoid Coding Confusion

Do you need E1-E4 for punctal plugs and epilation?

Thanks to the abundance of bilateral coding rules, remembering whether you should append the eyelid modifiers for epilation and punctal plug insertions is no easy task -- unless you know these tricks.

CPT provides one modifier for each eyelid: E1 for upper left, E2 for lower left, E3 for upper right, and E4 for lower right. The general rule is to use the E modifiers when a procedure can be performed on any one of the four eyelids -- but real-world coding and billing don't always allow you to.

E1-E4 are informational modifiers, explains **Raequell Duran, CPC**, president of Practice Solutions in California, who led the "2008 Modifier Essentials" seminar at The Coding Institute's Optometry Coding and Reimbursement Conference. Informational modifiers do not affect payment, but they do give the payer more clinical information.

Of all the eyelid procedures in CPT (67700-67999), optometrists commonly perform two procedures that involve specific eyelids: epilation (67820-67835) and punctal plug procedures (68761).

Understand Carrier Rules for Multiple Lashes

Although there may be some instances in which you append E1-E4 to 67820 (Correction of trichiasis; epilation, by forceps only), in most cases you won-t, experts say. Whether you should append eyelid modifiers to 67820 depends mostly on how the carrier pays for the procedure -- by eye, by eyelid, or by patient.

For the epilation codes, CPT 2008 references AMA's July 1998 CPT Assistant, which says that the intent of code 67820 is to report the service per procedure, not per eyelash or per eyelid. Many Medicare Part B carriers have used that reference to amend or clarify their rules for 67820, so that you can no longer report 67820 once for each eyelid you treat.

Caveat: Not all Part B carriers agree beyond that. Some carriers want you to report only one unit of 67820 per date of service, no matter how many eyelashes you removed from one or both eyes. "The intent of this code is to report the service per procedure, not per eyelash or per lid," states Part B carrier Noridian's eyelash epilation policy. "Noridian will allow only one service of CPT 67820 for any given date of service, regardless of the number of lashes or lids treated that day." Other carriers may want you to report 67820 once per eye.

Note: The bilateral status of 67820 is "1", which means that a 150 percent payment adjustment will apply to the procedure if you report it bilaterally, either on two lines with the LT (Left side) and RT (Right side) modifiers appended, or on one line with modifier 50 (Bilateral procedure) appended. When billing Medicare, report one line, Duran recommends.

The eyelid modifiers can still come in handy even if your carrier doesn't pay by the lid. If the optometrist performs epilation on one lid in each eye -- one lash from the lower left and one from the lower right, for example -- he could code on two lines with 67820-E2 and 67820-E4. But for a patient with lashes removed from the upper left and lower left lids, he should only append modifier LT, because you can only bill once per eye.

Report Plugs Once Per Lid

Most Medicare carriers want you to report code 68761 (Closure of the lacrimal punctum; by plug, each) once per eyelid, using E1-E4. But if you insert more than two plugs, be prepared to justify the medical necessity.

Medicare feels that "[i]n most cases of dry-eye syndrome requiring punctum plugs or punctum closure, placement of one

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plug in (or closure of) each lower punctum will suffice to alleviate the problem," states TrailBlazer's local coverage determination for 68761. "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."

Example: A Medicare patient presents with severe dry-eye syndrome. The optometrist places silicone plugs in each eyelid and has documentation showing that all four plugs were medically necessary. Report the service as follows:

Line 1: 68761-E1 (1 unit)

Line 2: 68761-E2 (1 unit)

Line 3: 68761-E3 (1 unit)

Line 4: 68761-E4 (1 unit).

You should use 68761 for punctal plug insertion, regardless of the type of plug you used, says **Dolores Berkery,** practice manager of Gold Ophthalmologic Associates PC in Great Barrington, Mass.

Medicare reimbursement for 68761 includes payment for the plugs themselves. Do not code separately for the supplies with HCPCS codes A4262 (Temporary, absorbable lacrimal duct implant, each) or A4263 (Permanent, long-term, nondissolvable lacrimal duct implant, each). Carriers other than Medicare, however, may let you bill for the supplies with the HCPCS codes or with 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]).

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