Local Coverage Article: Diagnostic Evaluation and Medical Management of Moderate-Severe Dry Eye Disease (DED) - coding guidelines (A54680)

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Contractor Information

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Article Information

General Information

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A54680

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N/A

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Article Guidance

Article Text:

Coding Guidelines

Medicare does not allow separate payment for the following diagnostic tests: tear break-up time (TBUT), Schirmer test, ocular surface dye staining pattern (Rose Bengal, fluorescein, or lissamine green). These tests are considered part of a general ophthalmological examination or evaluation and management (E&M) service.

CPT Code 68761 is used to represent the "closure of the lacrimal punctum; by plug, each". The word "each" refers to each plug that is placed in a punctum. The punctum is an opening in the vertical lacrimal canaliculi, located on the upper and lower eyelid margin near the nose.

Since there are two puncta in each eye, if plugs are inserted in both puncta of one eye it is appropriate to bill 68761 twice on separate lines with the appropriate modifiers. If both eyes are treated (all four puncta), then 68761 should be billed four times on separate lines with the appropriate modifiers.

The following modifiers should be applied to 68761 as indicated:

E1 – Upper left eyelid
E2 – Lower left eyelid
E3 – Upper right eyelid
E4 – Lower right eyelid

When more than one punctum is involved in the same session, the subsequent procedures are reimbursed at 50% of the allowed amount, consistent with Medicare’s multiple surgery rules.

CPT code 68761 does not differentiate between collagen and silicone plugs. The same code is used for either type. Consequently, there may be both a diagnostic occlusion of the puncta and a therapeutic occlusion done on the same patient in a short time frame. Modifier 76 (repeat procedure by same physician) should NOT be reported in this instance, because the two services, although coded the same, are performed for different purposes and are NOT repeat in nature.

Note: While the choice of initially using collagen (temporary/dissolvable) or silicone (semi-permanent/non-dissolvable) is left to the clinician’s discretion, the semi-permanent plugs afford a more extensive trial of punctal closure, and may better serve to delineate candidates for permanent closure.

CPT code 68761 has a global period of 10 days (minor procedures with preoperative relative values on the day of the procedure and postoperative relative values during a 10-day postoperative period included in the fee schedule amount; evaluation and management (E&M) services on the day of the procedure and during this 10-day postoperative period are generally not payable). After the 10th day following the insertion of lacrimal punctal plugs, visits related to insuring the integrity of the plugs may be billed as an E&M service.

Medicare does not allow separate payment for temporary punctual plugs (A4262-temporary, absorbable lacrimal duct implant, each) or silicone punctual plugs (A4263-permanent, long-term, nondissolvable lacrimal duct implant, each), as these are included in the procedure. However, these HCPCS codes should be reported concurrently to the implant procedure as applicable.

In the event punctual dilation is required to facilitate plug insertion, the National Correct Coding Initiative (NCCI) edits developed by the Centers for Medicare& Medicaid Service (CMS) bundle this procedure (CPT code 68801 – dilation of lacrimal punctum with or without irrigation) with the insertion of punctual plugs. Back to Top
Coding Information

Bill Type Codes:

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the article does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the article should be assumed to apply equally to all claims.

N/A

Revenue Codes:

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory. Unless specified in the article, services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the article should be assumed to apply equally to all Revenue Codes.

N/A

CPT/HCPCS Codes N/A
ICD-10 Codes that are Covered N/A
ICD-10 Codes that are Not Covered N/A

Revision History Information

N/A Back to Top Related Local Coverage Document(s) N/A
Related National Coverage Document(s) N/A
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Rules and Regulations URL(s) N/A
CMS Manual Explanations URL(s) N/A
Other URL(s) N/A

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Keywords

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