LACRIVERA®

Billing Guide for Punctal Occlusion

General Information

- **All punctal occlusion is billed the same**, regardless if permanent silicone plugs or temporary synthetic/collagen inserts are used.
- **Allow at least 10 days (post-op period)** following the insertion of collagen plugs before inserting permanent plugs.
- **When occluding more than one punctum at the same time**, the first procedure is allowed at 100% and each additional procedure is allowed at 50%.

Documentation

In addition to proper coding, be sure the procedure is properly and sufficiently documented.

- **Document the patient's dry eye complaint.** Be sure to note the patient's pertinent history, symptoms and affect on daily activities.
- **Document unsuccessful alternative treatments.** This should include the use of artificial tear supplements with continued dry eye symptoms.
- **Document examination and evaluation of tear production to confirm Dry Eye Syndrome.** This may include ZoneQuick, Schirmer, Rose Bengal Staining, and/or Tear Break-Up Time tests. Some tests may not be separately billable.
- **Document that you have clearly explained to the patient the potential risks and benefits of punctal occlusion.**

THE CODES TO KNOW

Primary Diagnosis Codes

H04.121 Dry Eye Syndrome of Right Lacrimal Gland
H04.122 Dry Eye Syndrome of Left Lacrimal Gland
H04.123 Dry Eye Syndrome of Bilateral Lacrimal Glands

Secondary Diagnosis Codes

H16.109 Unspecified superficial keratitis
H16.229 Keratoconjunctivitis sicca
H57.8 Redness or discharge
M35.01 Keratoconjunctivitis sicca associated with Sjögren's disease

CPT Procedure Code

68761 Closure of the lacrimal punctum by plug, each

Supply Code

A4263 (HCPCS) or **99070**

Medicare combines the office visit, procedure and supply of collagen/silicone plugs, thus they are not billed separately. Some private insurance may accept a separate supply code.

Punctum Identification

E1 Upper lid, left
E2 Lower lid, left
E3 Upper lid, right
E4 Lower lid, right

Modifiers

25 Separately identifiable service by the same doctor on the same day
50 Bilateral procedure
51 Multiple procedures

Sample Medicare & Private Insurance Claim Form

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY IDD INCL.)
A. B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBVISSION CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

	DATE(S) OF SERVICE MM DD YY	MM DD YY	B Place of Service	C. Type of Service	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID#
1	10 1 17	10 1 17			68761	51 E1	1	$xxx.xx	1		NPI	
2	10 1 17	10 1 17			68761	51 E2	1	$xxx.xx	1		NPI	
3	10 1 17	10 1 17			68761	51 E3	1	$xxx.xx	1		NPI	
4	10 1 17	10 1 17			68761	51 E4	1	$xxx.xx	1		NPI	

The information in this guide is believed to be accurate but is not intended to serve as an authority or to comprehensively address proper billing procedures. Always refer to official documentation provided by Medicare and/or private insurance carriers.

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