Corcoran Consulting Group
a subsidiary of MEDICAL CONSULTING GROUP

MEDICARE REIMBURSEMENT FOR PUNCTAL OCCLUSION BY PLUG

CORCORAN & CORCORAN

1

QUESTION: Does Medicare cover punctal occlusion by plug?

ANSWER: Yes, when medically necessary. This procedure provides an alternative when eye drops and ointments have proved unsatisfactory. It is most commonly performed for dry eye disease (DED). It may help treat dry eye following corneal refractive surgery or other anterior segment surgery.

2

QUESTION: What chart documentation is required to support medical necessity for this procedure?

ANSWER: Documentation of medically necessary punctal occlusion entails adherence to the TFOS Dry Eye Workshop II guidelines and the AAO's Preferred Practice Pattern (PPP) for treating DED. The PPP says, "*For patients with aqueous tear deficiency, punctal occlusion is considered when the medical means of aqueous enhancement are ineffective or impractical.*"

Medicare expects that punctal occlusion, a surgical procedure, will not be performed as an initial treatment for DED. The chart should include documentation that other, less invasive, therapies were unsuccessful or contraindicated. When the need for a repeat procedure occurs, medical necessity must be documented each time.

As with any surgical procedure, the patient's informed consent is required. Use an appropriate operative report in the medical record. Identify which puncta were occluded and describe the brand, size, and lot number of the plugs.

3

QUESTION: What CPT code is used on a claim form to report punctal occlusion by plug?

ANSWER: Use 68761 (*Closure of lacrimal punctum; by plug, each*) to report the professional service. The CPT code makes no distinction between types or brands of plugs. Medicare has assigned "E" modifiers to indicate which eyelid was treated. E1 for left upper lid, E2 for left lower lid, E3 for right upper lid, and E4 for right lower lid.

Other third-party payors might not recognize these modifiers but will accept RT (right eye) and LT (left eye) on a claim. Bilateral services are reported as 68761-50. Your ICD-10 diagnosis codes will indicate the eyes treated.

4

QUESTION: May we charge for an exam on the same day as the procedure?

ANSWER: Sometimes. Punctal occlusion by plug is a minor surgical procedure for Medicare, with a 10-day global period. Minor surgical procedures include the visit on the day of surgery in the global surgery package unless there is a significant, separate identifiable reason for the visit beyond the minor procedure.

When a visit qualifies, modifier -25 is appended to the visit code. Modifier -25 indicates that the patient's condition required an additional E/M service beyond the usual preoperative care provided for the procedure or service. CPT adds that *"This [25] modifier is not used to report an E/M service that resulted in a decision to perform surgery."* This is different from modifier -57 that identifies an exam that determines the need for a major procedure with a 90-day global period.

April 1, 2025

The reimbursement information is provided by Corcoran & Corcoran based on publicly available information from CMS, the AMA, and other sources. The reader is strongly encouraged to review federal and state laws, regulations, code sets, and official instructions promulgated by Medicare and other payors. This document is *not an official source* nor is it a complete guide on reimbursement. Although we believe this information is accurate at the time of publication, the reader is reminded that this information, including references and hyperlinks, changes over time, and may be incorrect at any time following publication.

© 2025 Corcoran & Corcoran. All rights reserved. No part of this publication may be reproduced or distributed in any form or by any means, or stored in a retrieval system, without the written permission of the publisher. CPT is a registered trademark of the American Medical Association.

Corcoran Consulting Group
a subsidiary of MEDICAL CONSULTING GROUP

MEDICARE REIMBURSEMENT FOR PUNCTAL OCCLUSION BY PLUG

CORCORAN & CORCORAN

5

QUESTION: What is the Medicare physician reimbursement for 68761?

ANSWER: In 2025, the national Medicare Physician Fee Schedule allowable for 68761 in office is $139; it is reduced to $113 in a facility (*i.e.,* ASC or HOPD). These amounts are adjusted by local wage indices. There is no separate payment made for the supply of the plugs.

When two puncta are occluded at the same session, multiple surgery rules apply. The first procedure is allowed at 100% and the second at 50%. If a third and fourth puncta are also occluded at the same session, the MCPM Chapter 12 §40.6.C16 states, *"If any of the multiple surgeries are bilateral surgeries, consider the bilateral procedure at 150 percent as one payment amount, rank this with the remaining procedures, and apply the appropriate multiple surgery reductions."* This means the third and fourth puncta are reimbursed at 37.5% of the allowed amount for each procedure.

6

QUESTION: Does punctal occlusion for DED impact reimbursement for cataract surgery?

ANSWER: The condition of the cornea and tear film affect the outcome of cataract surgery, so some surgeons treat DED just before surgery. In 2025, the MIPS cataract surgery cost measure counts punctal occlusion as resource use when it occurs within the 151-day time period (60 days prior and 90 days following). This only affects Part B Medicare patients. Greater resource use than peers lowers a physician's MIPS score and potentially reduces Medicare reimbursement two years later in 2027. For additional information, please refer to our comprehensive monograph *Reimbursement Guidelines for Punctal or Intracanalicular Occlusion by Plug*.

7

QUESTION: How frequently is this procedure performed?

ANSWER: The most recent CMS data, from 2022, shows that 68761 was associated with about 1% of office visits by ophthalmologists and optometrists. That is for every 100 exams on Medicare beneficiaries, Medicare paid for this service once.

8

QUESTION: If a plug falls out prematurely, may a replacement procedure be billed?

ANSWER: Maybe; it depends on the reason. A charge is warranted if the patient didn't follow post-operative instructions. A charge is not justified if the wrong size plug was used. Finally, if there are anatomical reasons a plug does not stay in place, you probably will use another method of punctal occlusion or a different treatment.

9

QUESTION: What if we need to explant a punctal plug?

ANSWER: In rare cases, punctal occlusion may contribute to greater patient discomfort and epiphora than was present prior to the procedure. Dislodging an intracanalicular plug may be accomplished by forcefully irrigating the lacrimal system with saline. Use CPT code 68801 (*Dilation of lacrimal punctum, with or without irrigation*) or 68840 (*Probing of lacrimal canaliculi, with or without irrigation*) to report this procedure depending on the position and manipulation of the irrigating cannula.

Removal of other types of plugs, such as the "cap and anchor" style of silicone plug, is usually accomplished with forceps at the slit lamp. Then, only an eye exam is billed.

April 1, 2025

The reimbursement information is provided by Corcoran & Corcoran based on publicly available information from CMS, the AMA, and other sources. The reader is strongly encouraged to review federal and state laws, regulations, code sets, and official instructions promulgated by Medicare and other payors. This document is *not an official source* nor is it a complete guide on reimbursement. Although we believe this information is accurate at the time of publication, the reader is reminded that this information, including references and hyperlinks, changes over time, and may be incorrect at any time following publication.

© 2025 Corcoran & Corcoran. All rights reserved. No part of this publication may be reproduced or distributed in any form or by any means, or stored in a retrieval system, without the written permission of the publisher. CPT is a registered trademark of the American Medical Association.