LCD Reference Article	Billing and Coding Article

Article - Billing and Coding: Nasal Punctum-Nasolacrimal Duct Dilation and Probing with or without Irrigation (A57284)

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Contractor Information

CONTRACTOR NAME	CONTRACT TYPE	CONTRACT NUMBER	JURISDICTION	STATES
CGS Administrators, LLC	MAC - Part A	15101 - MAC A	J - 15	Kentucky
CGS Administrators, LLC	MAC - Part B	15102 - MAC B	J - 15	Kentucky
CGS Administrators, LLC	MAC - Part A	15201 - MAC A	J - 15	Ohio
CGS Administrators, LLC	MAC - Part B	15202 - MAC B	J - 15	Ohio

Article Information

General Information

Article ID
A57284

Article Title
Billing and Coding: Nasal Punctum-Nasolacrimal Duct Dilation and Probing with or without Irrigation

Article Type
Billing and Coding

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N/A

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N/A

AMA CPT / ADA CDT / AHA NUBC Copyright Statement

CMS National Coverage Policy

Language quoted from Centers for Medicare and Medicaid Services (CMS). National Coverage Determinations (NCDs) and coverage provisions in interpretive manuals is *italicized* throughout the policy. NCDs and coverage provisions in interpretive manuals are not subject to the Local Coverage Determination (LCD) Review Process (42 CFR 405.860[b] and 42 CFR 426 [Subpart D]). In addition, an administrative law judge may not review an NCD. See Section 1869(f)(1)(A)(i) of the Social Security Act.

Unless otherwise specified, *italicized* text represents quotation from one or more of the following CMS sources:

Title XVIII of the Social Security Act (SSA):

Section 1862(a)(1)(A) excludes expenses incurred for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

Section 1833(e) prohibits Medicare payment for any claim which lacks the necessary information to process the claim.

Article Guidance

Article Text

This article gives guidance for billing, coding, and other guidelines in relation to local coverage policy L34171Nasal Punctum-Nasolacrimal Duct Dilation and Probing with or without Irrigation.

Specific coding guidelines:

CPT codes 68801, 68810-68815 and 68840 have a 10-day global period. An evaluation and management (E&M) code is not separately payable on the same day as these procedures unless a separately identifiable service is provided and documented in which case, it would be appropriate to attach modifier –25 to the E&M code.

CPT codes 68801, 68810-68815 and 68840 are unilateral codes and must be submitted with a site modifier (LT, RT, or –50). Only one of these modifiers may be billed on a claim line. Bilateral services must be billed with a –50 modifier, rather than RT and LT modifier.

Dilation of nasolacrimal punctum (CPT code 68801) will be paid only once per eye regardless of the number of times the punctum is dilated.

No separate reimbursement is made for the dilation of nasolacrimal punctum (CPT code 68801) when performed on the same day and same side as the probing procedures (CPT codes 68810-68815 or 68840). If these are billed together for the same side on the same date of service only CPT codes 68810, 68811, 68815 or 68840 will be paid.

CPT 68810, 68811 or 68815 are primarily pediatric procedures, and are only rarely required in adults, whereas CPT

68840 is more commonly performed in the adult population. Providers with unusually frequent billing of 68810 may be subject to review. The submitted CPT code must reflect the true extent of a reasonable and necessary procedure. Thus, if it is only medically necessary to dilate the puncta or probe the canaliculi it would be inappropriate to submit 68810, for example. Claims for 68810 will be downcoded to 68840 or 68801, or denied if the medical record fails to demonstrate medical necessity and adequate documentation according to the requirements of this policy.

General Guidelines for Claims submitted to Part A or Part B MAC:

Procedure codes may be subject to National Correct Coding Initiative (NCCI) edits or OPPS packaging edits. Refer to NCCI and OPPS requirements prior to billing Medicare. For services requiring a referring/ordering physician, the name and NPI of the referring/ordering physician must be reported on the claim. A claim submitted without a valid ICD-10-CM diagnosis code will be returned to the provider as an incomplete claim under Section 1833(e) of the Social Security Act. The diagnosis code(s) must best describe the patient's condition for which the service was performed. For diagnostic tests, report the result of the test if known; otherwise the symptoms prompting the performance of the test should be reported.

Advance Beneficiary Notice of Non-coverage (ABN) Modifier Guidelines

An ABN may be used for services which are likely to be non-covered, whether for medical necessity or for other reasons. Refer to CMS Publication 100-04, Medicare Claims Processing Manual, Chapter 30, for complete instructions.

Effective from April 1, 2010, non-covered services should be billed with modifier –GA, -GX, -GY, or –GZ, as appropriate.

The –GA modifier (“Waiver of Liability Statement Issued as Required by Payer Policy”) should be used when physicians, practitioners, or suppliers want to indicate that they anticipate that Medicare will deny a specific service as not reasonable and necessary and they do have an ABN signed by the beneficiary on file. Modifier GA applies only when services will be denied under reasonable and necessary provisions, sections 1862(a)(1), 1862(a)(9), 1879(e), or 1879(g) of the Social Security Act. Effective April 1, 2010, Part A MAC systems will automatically deny services billed with modifier GA. An ABN, Form CMS-R-131, should be signed by the beneficiary to indicate that he/she accepts responsibility for payment. The -GA modifier may also be used on assigned claims when a patient refuses to sign the ABN and the latter is properly witnessed. For claims submitted to the Part A MAC, occurrence code 32 and the date of the ABN is required.

Modifier GX (“Notice of Liability Issued, Voluntary Under Payer Policy”) should be used when the beneficiary has signed an ABN, and a denial is anticipated based on provisions other than medical necessity, such as statutory exclusions of coverage or technical issues. An ABN is not required for these denials, but if non-covered services are reported with modifier GX, will automatically be denied services.

The –GZ modifier should be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny an item or service as not reasonable and necessary and they have not had an ABN signed by the beneficiary. If the service is statutorily non-covered, or without a benefit category, submit the appropriate CPT/HCPCS code with the -GY modifier. An ABN is not required for these denials, and the limitation of liability does not apply for beneficiaries. Services with modifier GY will automatically deny.

Documentation Requirements

The patient's medical record should include but is not limited to:

- The assessment of the patient by the ordering provider as it relates to the complaint of the patient for that visit,
- Relevant medical history
- Results of pertinent tests/procedures
- Signed and dated office visit record/operative report (Please note that all services ordered or rendered to Medicare beneficiaries must be signed.)

For claims submitted to the Part B MAC:

Claims for Nasal Punctum/Nasolacrimal Duct Dilation and Probing with or without Irrigation services are payable under Medicare Part B in the following places of service:

- CPT codes 68801, 68810 and 68840 are payable in the following places of service: office (11), assisted living facility (13), inpatient hospital (21), outpatient hospital (22), emergency room (23), ambulatory surgical center (24), skilled nursing facility (Part A stay) (31), nursing facility (not in a Part A stay)(32), custodial care facility (33), independent clinic (49).
- CPT codes 68811 and 68815 are payable in the following places of service: office (11), inpatient hospital (21), outpatient hospital (22), emergency room (23), ambulatory surgical center (24), and independent clinic (49).

For claims submitted to the Part A MAC:

<u>Hospital Inpatient Claims:</u>

- The hospital should report the patient's principal diagnosis in Form Locator (FL) 67 of the UB-04. *The principal diagnosis is the condition established after study to be chiefly responsible for this admission.*
- *The hospital enters ICD-10-CM codes for up to eight additional conditions in FLs 67A-67Q if they co-existed at the time of admission or developed subsequently, and which had an effect upon the treatment or the length of stay. It may not duplicate the principal diagnosis listed in FL 67.*
- For inpatient hospital claims, the admitting diagnosis is required and should be recorded in FL 69. (See CMS Publication 100-04, *Medicare Claims Processing Manual*, Chapter 25, Section 75 for additional instructions.)

<u>Hospital Outpatient Claims:</u>

- The hospital should report the full ICD-10-CM code for the diagnosis shown to be chiefly responsible for the outpatient services in FL 67. If no definitive diagnosis is made during the outpatient evaluation, the patient's symptom is reported. If the patient arrives without a referring diagnosis, symptom or complaint, the provider should report an ICD-10-CM code for Persons Without Reported Diagnosis Encountered During Examination and Investigation of Individuals and Populations (Z00.00-Z13.9).
- The hospital enters the full ICD-10-CM codes in FLs 67A-67Q for up to eight other diagnoses that co-existed in addition to the diagnosis reported in FL 67.

Other Comments:

- For claims submitted to the Part A MAC: This coverage determination also applies within states outside the primary
- geographic jurisdiction with facilities that have nominated CGS Administrators, LLC to process their claims.
- Bill type codes only apply to providers who bill these services to the Part A MAC. Bill type codes do not apply to physicians, other professionals and suppliers who bill these services to the carrier or Part B MAC.
- Limitation of liability and refund requirements apply when denials are likely, whether based on medical necessity or other coverage reasons. The provider/supplier must notify the beneficiary in writing, prior to rendering the service, if the provider/supplier is aware that the test, item or procedure may not be covered by Medicare. The limitation of liability and refund requirements do not apply when the test, item or procedure is statutorily excluded, has no Medicare benefit category or is rendered for screening purposes.
- For outpatient settings other than CORFs, references to "physicians" throughout this policy include non-physicians, such as nurse practitioners, clinical nurse specialists and physician assistants. Such non-physician practitioners, with certain exceptions, may certify, order and establish the plan of care for Nasal Punctum-Nasolacrimal Duct Dilation and Probing with or without Irrigation services as authorized by State law. (See Sections 1861[s][2] and 1862[a][14] of Title XVIII of the Social Security Act; 42 CFR, Sections 410.74, 410.75, 410.76 and 419.22; 58 FR 18543, April 7, 2000.)

Coding Information

CPT/HCPCS Codes

Group 1 Paragraph:

N/A

Group 1 Codes: (6 Codes)

CODE	DESCRIPTION
68801	DILATION OF LACRIMAL PUNCTUM, WITH OR WITHOUT IRRIGATION
68810	PROBING OF NASOLACRIMAL DUCT, WITH OR WITHOUT IRRIGATION;
68811	PROBING OF NASOLACRIMAL DUCT, WITH OR WITHOUT IRRIGATION; REQUIRING GENERAL ANESTHESIA
68815	PROBING OF NASOLACRIMAL DUCT, WITH OR WITHOUT IRRIGATION; WITH INSERTION OF TUBE OR STENT
68816	PROBING OF NASOLACRIMAL DUCT, WITH OR WITHOUT IRRIGATION; WITH TRANSLUMINAL BALLOON CATHETER DILATION
68840	PROBING OF LACRIMAL CANALICULI, WITH OR WITHOUT IRRIGATION

CPT/HCPCS Modifiers

N/A

ICD-10-CM Codes that Support Medical Necessity

Group 1 Paragraph:

It is the responsibility of the provider to code to the highest level specified in the ICD-10-CM. The correct use of an ICD-10-CM code listed below does not assure coverage of a service. The service must be reasonable and necessary in the specific case and must meet the criteria specified in this determination.

Group 1 Codes: (30 Codes)

CODE	DESCRIPTION
H04.201 - H04.203	Unspecified epiphora, right side - Unspecified epiphora, bilateral
H04.221 - H04.223	Epiphora due to insufficient drainage, right side - Epiphora due to insufficient drainage, bilateral
H04.411 - H04.413	Chronic dacryocystitis of right lacrimal passage - Chronic dacryocystitis of bilateral lacrimal passages
H04.431 - H04.433	Chronic lacrimal mucocele of right lacrimal passage - Chronic lacrimal mucocele of bilateral lacrimal passages
H04.541 - H04.543	Stenosis of right lacrimal canaliculi - Stenosis of bilateral lacrimal canaliculi
H04.551 - H04.553	Acquired stenosis of right nasolacrimal duct - Acquired stenosis of bilateral nasolacrimal duct
H04.561 - H04.563	Stenosis of right lacrimal punctum - Stenosis of bilateral lacrimal punctum
H10.401 - H10.403	Unspecified chronic conjunctivitis, right eye - Unspecified chronic conjunctivitis, bilateral
H10.421 - H10.423	Simple chronic conjunctivitis, right eye - Simple chronic conjunctivitis, bilateral
H10.431 - H10.433	Chronic follicular conjunctivitis, right eye - Chronic follicular conjunctivitis, bilateral

ICD-10-CM Codes that DO NOT Support Medical Necessity

Group 1 Paragraph:

Use of any ICD-10-CM code not listed in the "ICD-10-CM Codes that Support Medical Necessity" section of this LCD will be denied. In addition, the following ICD-10-CM code is specifically listed as not supporting medical necessity for emphasis, and to avoid any provider errors.

Group 1 Codes: (3 Codes)

CODE	DESCRIPTION
H04.211	Epiphora due to excess lacrimation, right lacrimal gland
H04.212	Epiphora due to excess lacrimation, left lacrimal gland

CODE	DESCRIPTION
H04.213	Epiphora due to excess lacrimation, bilateral lacrimal glands

ICD-10-PCS Codes

N/A

Additional ICD-10 Information

N/A

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.

CODE	DESCRIPTION
011x	Hospital Inpatient (Including Medicare Part A)
013x	Hospital Outpatient
083x	Ambulatory Surgery Center
085x	Critical Access Hospital

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.

Revenue codes only apply to providers who bill these services to the and suppliers who bill these services to the carrier or Part B MAC.

Please note that not all revenue codes apply to every type of bill code. Providers are encouraged to refer to the FISS revenue code file for allowable bill types. Similarly, not all revenue codes apply to each CPT/HCPCS code. Providers are encouraged to refer to the FISS HCPCS file for allowable revenue codes.

All revenue codes billed on the inpatient claim for the dates of service in question may be subject to review.

CODE	DESCRIPTION
0360	Operating Room Services - General Classification

CODE	DESCRIPTION
0361	Operating Room Services - Minor Surgery
0490	Ambulatory Surgical Care - General Classification
0510	Clinic - General Classification
0519	Clinic - Other Clinic
0520	Freestanding Clinic - General Classification
0769	Specialty Services - Other Specialty Services

Other Coding Information

N/A

Revision History Information

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION
11/22/2023	R6	Revision Effective: 11/22/2023 Revision Explanation: Updated LCD Reference Article section.
05/25/2023	R5	R5 Revision Effective: 06/02/2022 Revision Explanation: Annual review, no changes made.
06/02/2022	R4	R4 Revision Effective: 06/02/2022 Revision Explanation: Annual review, no changes made.
05/27/2021	R3	R3 Revision Effective: 05/27/2021 Revision Explanation: Annual review, migrated Other Comments from the LCD into the article text section of the billing and coding article.

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION
01/02/2020	R2	R2 Revision Effective: n/a Revision Explanation: Annual review, no changes made.
01/02/2020	R1	R1 Revision Effective: 01/01/2020 Revision Explanation: Added three new sections to article text specific coding information, claims submission information for Part B and Part A.

Associated Documents

Related Local Coverage Documents

Articles

A52391 - (MCD Archive Site)

LCDs

L34171 - Nasal Punctum-Nasolacrimal Duct Dilation and Probing with or without Irrigation

Related National Coverage Documents

N/A

Statutory Requirements URLs

N/A

Rules and Regulations URLs

N/A

CMS Manual Explanations URLs

N/A

Other URLs

N/A

Public Versions

UPDATED ON	EFFECTIVE DATES	STATUS
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11/15/2023	11/22/2023 - N/A	Currently in Effect (This Version)
05/19/2023	05/25/2023 - 11/21/2023	Superseded

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