VISCO-3™ Coding Reference Guide

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VISCO-3™ Sodium Hyaluronate is a sterile, viscoelastic non-pyrogenic solution of purified, high molecular weight sodium hyaluronate (hyaluronan). One mL of VISCO-3 contains 10 mg of sodium hyaluronate (hyaluronan) dissolved in a physiological saline (1.0% solution), and each injection contains 2.5mL of volume. Each treatment course consists of three injections given in a weekly cadence, with each injection containing 25mg of Sodium Hyaluronate (hyaluronan).

HCPCS (Healthcare Common Procedure Coding System)

Code	Description
J7333	Hyaluronan or derivative, VISCO-3, for intraarticular injection, per dose.

CPT® (Current Procedural Terminology) Codes

Code	Description
20610	Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); without ultrasound guidance
20611	Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); with ultrasound guidance, with permanent recording and reporting

CPT and HCPCS Modifiers

Modifier	Description
EJ	Subsequent claims for a defined course of therapy, e.g., EPO, sodium hyaluronate, infliximab (Report modifier EJ for subsequent injections of the product)
LT	Left side (used to identify procedures performed on the left side of the body)
RT	Right side (used to identify procedures performed on the right side of the body)
50	Bilateral Procedure
59	Distinct Procedural Service (indicates that a procedure or service was distinct or independent from other non-E/M services performed on the same day)

Sample ICD-10-CM Diagnosis Codes

Code	Description
M17.0	Bilateral primary osteoarthritis of knee
M17.10	Unilateral primary osteoarthritis, unspecified knee
M17.11	Unilateral primary osteoarthritis, right knee
M17.12	Unilateral primary osteoarthritis, left knee
M17.2	Bilateral post-traumatic osteoarthritis of knee
M17.30	Unilateral post-traumatic osteoarthritis, unspecified knee
M17.31	Unilateral post-traumatic osteoarthritis, right knee
M17.32	Unilateral post-traumatic osteoarthritis, left knee
M17.4	Other bilateral secondary osteoarthritis of knee
M17.5	Other unilateral secondary osteoarthritis of knee
M17.9	Osteoarthritis of the knee, unspecified

UPC/NDC (Universal Product Code/National Drug Code)

Code	Description
87541-0301-31	VISCO-3 Sodium Hyaluronate

Coding and Billing for VISCO-3

- Prior authorization/pre-determination is suggested prior to administration of VISCO-3 Sodium Hyaluronate. The payer will want to review the product specifically, dosage, route of administration and medical necessity.
- It is recommended providers bill for VISCO-3 Sodium Hyaluronate showing both the J7333 HCPCS code and the NDC as reflected on the sample CMS-1500 claim form below.
- The following qualifiers are to be used when entering supplemental information for the billing of VISCO-3 Sodium Hyaluronate.

  N4 National Drug Codes (NDC)
  ML Milliliter

  To enter supplemental information, begin at 24A on the CMS-1500 claim form by entering the qualifier and then the information. Do not enter a space between the qualifier and the number/code/information. Do not enter hyphens or spaces within the number/code. Add the supplemental information in the following order: qualifier, NDC code, one space, unit/basis of measurement qualifier, quantity. The number of digits for the quantity is limited to eight digits before the decimal and three digits after the decimal. If entering a whole number, do not use a decimal. Do not use commas.

Sample CMS-1500 Claim Form

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. M17XX B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER XXXXXXXXXX

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	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	XX	XX	XX	XX	XX	XX	11		20610	LT	A	XXX	XX	1		NPI XXXXXXXXXX
2	N487541030131 ML2.5															
	XX	XX	XX	XX	XX	XX	11		J7333	LT	A	XXX	XX	1		NPI XXXXXXXXXX
3																NPI

SUPPLIER INFORMATION

Field 21: Enter the ICD-10-CM diagnosis code(s)
Field 23: Enter the payer prior authorization number received during the benefit investigation
Field 24A: Enter the product supplemental information (qualifier, NDC, measurement qualifier, quantity) along with the date of service
Field 24D: Enter the CPT/HCPCS code(s) for the services/products provided and any appropriate modifiers
Field 24E: Enter the diagnosis code reference letter (pointer) from field 21 to relate the date of service and the procedures performed to the primary diagnosis.
Field 24F: Enter the charge amount for each listed service.
Field 24G: Enter the number of days or units.

- The payment allowance limits for drugs and biologicals that are not included in the ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File, other than new drugs that are produced or distributed under a new drug application (or other application) approved by the Food and Drug Administration, are based on the published Wholesale Acquisition Cost (WAC) or invoice pricing, except under OPPS where the payment allowance limit is 95 percent of the published AWP. In determining the payment limit based on WAC, the contractors follow the methodology specified in Publication 100-04, Chapter 17, Drugs and Biologicals, for calculating the AWP, but substitute WAC for AWP. The payment limit is 106 percent of the lesser of the lowest-priced brand or median generic WAC.

  MACs shall develop payment allowance limits for covered drugs when CMS does not supply the payment allowance limit on the ASP drug pricing file. At the contractors' discretion, contractors may contact CMS to obtain payment limits for drugs not included in the quarterly ASP or NOC files or otherwise made available by CMS on the CMS Web site. If the payment limit is available from CMS, contractors will substitute CMS-provided payment limits for pricing based on WAC or invoice pricing. CMS will provide the payment limits either directly to the requesting contractor or via posting an MS Excel file on the CMS Web site.

  Source: Medicare Claims Processing Manual, Chapter 17 – Drugs and Biologicals, 20.1.3 – Exceptions to Average Sales Price (ASP) Payment Methodology

- The Wholesale Acquisition Cost (WAC) of VISCO-3 Sodium Hyaluronate is published and available. Providers should be able to direct Medicare Administrative Contractors (MACs) to the published WAC before having to manually submit invoice documentation.

Hospital Outpatient and Ambulatory Surgical Center (ASC)				
CPT® Code	**Description**	**Ambulatory Payment Classification**	**OPPS Status Indicator**	**ASC Payment Indicator**
20610	Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); without ultrasound guidance	5441	T	P3
20611	Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); with ultrasound guidance, with permanent recording and reporting	5441	T	P3
J7333	Hyaluronan or derivative, VISCO-3, for intraarticular injection, per dose.	TBD	TBD	TBD

OPPS - Medicare's Outpatient Prospective Payment System.
APC: 5441 - Level 1 Nerve Injections
Paid under OPPS; separate APC payment. T – Multiple procedure reduction applies.
Payment Indicators: P3 – Payment based on Medicare's Physician Fee Schedule (MPFS) non-facility Practice Expense (PE) Relative Value Units (RVUs).

Medicare Guidance for Injection Services

Where the sole purpose of an office visit was for the patient to receive an injection, payment may be made only for the injection service (if it is covered). Conversely, injection services included in the Medicare Physician Fee Schedule (MPFS) are not paid for separately if the physician is paid for any other physician fee schedule service furnished at the same time. Payment may be made for those injection services only if no other physician fee schedule service is being paid. All injection claims must include the specific name of the drug and dosage. Identification of the drug enables payment for the services.

Source: Medicare Claims Processing Manual, 20.5.7 – Injection Services

For further assistance with reimbursement questions, contact the Zimmer Biomet Reimbursement Hotline at 866-946-0444 or reimbursement@zimmerbiomet.com, or visit our reimbursement web site at zimmerbiomet.com/reimbursement.

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