Coding for HYMOVIS® (high molecular weight viscoelastic hyaluronan) and Associated Services

Coding for HYMOVIS

Most payers recognize Healthcare Common Procedure Coding System (HCPCS) Level II national codes to identify and report products (drugs and medical devices), supplies, and services not included in the Current Procedural Terminology (CPT) code.

For HYMOVIS, payers accept the following HCPCS code:

HCPCS Code	Description	Billing Units	Site of Service	Claim Form (Location)	Payer Type
J7322	Hyaluronan or derivative, HYMOVIS, for intra-articular injection, 1 mg	**24** (1 mg = 1 billing unit. Each syringe = 24 billing units)	Physician office	CMS-1500 (Box 24D)	All
			Hospital outpatient	CMS-1450 (Field 44	
			Ambulatory surgical center	CMS-1450 (Field 44)	

HYMOVIS is supplied in a 5 mL single-use syringe containing 3 mL of HYMOVIS.

- Each mL has 8 mg of hyaluronan
- 3 mL has 24 mg of hyaluronan
- HYMOVIS ***administration does not*** vary by patient – Uniform administration for all patients

Medicare reimburses HYMOVIS at WAC+6%.
Source: Medicare Claims Processing Manual Chapter 17 (Rev. 3932, 12-08-17) Transmittal 20.1.3
https://www.cms.gov/Regulations-and Guidance/Guidance/Manuals/Downloads/clm104c17.pdf
Contact private payers or consult contracts for their reimbursement amounts.

National Health-Related Items Code

For devices such as HYMOVIS, the manufacturer adopts a unique, 3-segment number, known as the National Health Related Items Code (NHRIC), changing to catalog number. Proper billing, especially to Medicare, Medicaid, or via electronic data interchange, requires the NHRIC be submitted in the 11-digit numeric 5-4-2 format (eg, 89122-0496-63). Do not use hyphens when entering the actual data on your claim. For example:

HYMOVIS 11-Digit Example	Reporting on CMS Claim Forms
89122-0496-63	89122049663

Coding for Administration Services

CPT codes are used to identify professional services (eg, administration procedure) provided in the physician office.

CPT 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

Modifier	Modifier Description
RT	Right side (used to identify procedures performed on the right side of the body)
LT	Left side (used to identify procedures performed on the left side of the body)
50	Bilateral procedure
EJ	Indicates subsequent injections of a series. Do not use for first injection of each series.

ICD-10-CM Diagnosis Codes

International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) diagnosis codes are used to report diseases and conditions. ICD-10-CM diagnosis codes identify why a patient needs treatment by documenting the medical necessity for prescribing HYMOVIS®. Coding to the highest level of specificity may expedite the claims adjudication process. The following ICD-10-CM diagnosis codes may be appropriate to describe patients with OA of the knee.

ICD-10-CM	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 knee, unspecified

Coding for HYMOVIS may vary by payer type and plan type (ie, Medicare, private payer, Medicaid). Upon request, the *HYMOVIS Support Hotline* will conduct benefit verifications that provide coverage and coding information that is specific to your patient's health insurance coverage. The Hotline program is available Monday through Friday from 9:00 am to 8:00 pm ET at 1-866-HYMOVIS (1-866-496-6847).

Medicare National Average Reimbursement

Rate Information*

Site of Servicee	CPT Code	Website for Look-up
Physician Office	20610	https://www.cms.gov/Medicare/Medicare-Free-for-Service-Payment/PFSlookup/index.html
	20611	
Hospital Outpatient	20610	https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html
	20611	
Ambulatory Surgical Center	20610	https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html
	20611	

*Reimbursement rates for CPT codes vary by geography; consult the CMS website for regional rates applicable to the practice or contact the local Medicare Administrative Contractor for regional rates.

The information provided in this handout was obtained from many sources and is subject to change without notice as a result of changes in reimbursement laws, regulations, rules, and policies. All content on this handout is informational only, general in nature, and does not cover all situations or all payers' rules and policies. This content is not intended to instruct medical providers on how to use or bill for healthcare procedures, including new technologies outside of Medicare national guidelines. A determination of medical necessity is a prerequisite that we assume will have been made prior to assigning codes or requesting payments. Medical providers should consult with appropriate payers, including Medicare fiscal intermediaries and carriers, for specific information on proper coding, billing, and payment levels for healthcare procedures.

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