

# HYALGAN® REIMBURSEMENT IN THE PHYSICIAN OFFICE SETTING

## CODING

The codes relevant to HYALGAN® and its administration in the physician office setting are described in the following section. For more information on reporting various codes in the physician office site of care, please refer to the sample CMS-1500 claim form for HYALGAN® therapy on page 11.

Note: While the general codes relevant to HYALGAN® therapy in the physician office setting are noted in this section, other codes beyond those listed here may also be considered appropriate. As coverage for codes may vary by payer, please call *the HYALGAN® Support Hotline* at **1.866.7.HYALGAN (1.866.749.2542)**, Monday to Friday, from 9:00 AM to 8:00 PM EST for assistance to verify specific or unique payer coding requirements.

On a CMS-1500 claim form, applicable ICD-10-CM diagnosis codes must be reported in Box 21.

ICD-10	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

## HCPCS

To report HYALGAN® administration in the physician office, use of the HYALGAN® permanent HCPCS code is appropriate, as noted below:

HCPCS Code	Description
J7321	Hyaluronan or derivative, HYALGAN®, for intra-articular injection, per dose NHRIC (Catalog) 89122-0724-20

On a CMS-1500 claim form, Box 24D should be used for reporting the HYALGAN® permanent HCPCS code.

Medicaid and some payers require an NHRIC code on the CMS-1500 claim form, in the shaded area 24A. Some payers require the NHRIC code to be preceded by “N4” to indicate and NHRIC code is following.

## CPT

To report the physician administration of HYALGAN®, the following CPT code may be appropriate when HYALGAN® is administered in the physician office setting:

CPT	Description
20610	Arthrocentesis, aspiration and/or injection; major joint or bursa (eg, shoulder, hip, knee joint, 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 codes should be reported in Box 24D of the CMS-1500 claim form as well. In certain instances, payers may require modifier “-RT” (right side) or “-LT” (left side) to be documented after CPT code 20610, to specify the knee in which HYALGAN® was administered. For bilateral administration of HYALGAN®, some payers may require modifier “-50” (bilateral procedure) to be documented after CPT code 20610. In addition payers may require EJ modifier, **usually following the first injection**, to indicate subsequent injections in a series of injections. A series of injections for each joint and each treatment, left knee is a separate series from the right knee.

# HYALGAN® CMS-1500 SAMPLE CLAIM FORM

HEALTH INSURANCE CLAIM FORM											
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12											
PICA <input type="checkbox"/>										PICA <input type="checkbox"/>	
1. MEDICARE <input type="checkbox"/> <small>(Medicare#)</small>	MEDICAID <input type="checkbox"/> <small>(Medicaid#)</small>	TRICARE <input type="checkbox"/> <small>(ID#/DoD#)</small>	CHAMPVA <input type="checkbox"/> <small>(Member ID#)</small>	GROUP HEALTH PLAN <input type="checkbox"/> <small>(ID#)</small>	FECA BENEFIT <input type="checkbox"/> <small>(ID#)</small>	OTHER <input type="checkbox"/> <small>(ID#)</small>	1a. INSURED'S I.D. NUMBER <small>(For Program in Item 1)</small>				
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)				3. PATIENT'S BIRTH DATE MM DD YY		SEX M <input type="checkbox"/> F <input type="checkbox"/>	4. INSURED'S NAME (Last Name, First Name, Middle Initial)				
5. PATIENT'S ADDRESS (No., Street)  CITY STATE ZIP CODE TELEPHONE (Include Area Code)				6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		8. RESERVED FOR NUCC USE	7. INSURED'S ADDRESS (No., Street)  CITY STATE ZIP CODE TELEPHONE (Include Area Code)				
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY GROUP OR FECA NUMBER					
a. OTHER INSURED'S POLICY OR GROUP NUMBER				a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO		a. INSURED'S DATE OF BIRTH MM DD YY	SEX M <input type="checkbox"/> F <input type="checkbox"/>				
b. RESERVED FOR NUCC USE				b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		b. OTHER CLAIM ID (Designated by NUCC)					
c. RESERVED FOR NUCC USE				c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		c. INSURANCE PLAN NAME OR PROGRAM NAME					
d. INSURANCE PLAN NAME OR PROGRAM NAME				10d. CLAIM CODES (Designated by NUCC)		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, complete items 9, 9a, and 9d.				
<p><b>READ BACK OF FORM BEFORE COMPLETING &amp; SIGNING THIS FORM.</b></p> <p>12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.</p> <p>13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.</p>											
<p>14. DATE</p> <p>15. OTHER DATE</p> <p>16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION</p> <p>17. OTHER SOURCE</p> <p>17a. QUAL.</p> <p>17b. NPI</p> <p>18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES</p> <p>19. OUTSIDE LAB? \$ CHARGES</p> <p>20. YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)</p> <p>A. <b>M17.0</b></p> <p>B. L</p> <p>C. L</p> <p>D. L</p> <p>E. L</p> <p>F. L</p> <p>22. RESUBMISSION CODE ORIGINAL REF. NO.</p> <p>23. PRIOR AUTHORIZATION NUMBER</p> <p>24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. HCPCS E. MODIFIER F. POINTER G. DAYS OF UNFS H. EPSONI Family Plan I. ID, QUAL. J. RENDERING PROVIDER ID, #</p> <p>1 <b>J7321</b> <b>X</b> <b>NPI</b></p> <p>2 <b>20610</b> <b>50</b> <b>NPI</b></p> <p>3 <b>Box 24G: Days or Units</b> Enter number of HYALGAN® units administered Example: 1 service unit for each dose</p> <p>4 <b>Box 24D: CPT Code</b> Enter appropriate CPT code and modifier Example: 20610—Arthrocentesis, aspiration, and/or injection; major joint or bursa [eg, shoulder, hip, knee joint, subacromial bursa]</p> <p>5 <b>NPI</b></p> <p>6 <b>NPI</b></p> <p>25. FEDERAL TAX I.D. NUMBER SSN EIN</p> <p>26. PATIENT'S ACCOUNT NO.</p> <p>27. ACCEPT ASSIGNMENT? (For prior claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>28. TOTAL CHARGE \$</p> <p>29. AMOUNT PAID \$</p> <p>30. Rsvd for NUCC Use</p> <p>31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)</p> <p>32. SERVICE FACILITY LOCATION INFORMATION</p> <p>33. BILLING PROVIDER INFO &amp; PH # ( )</p> <p>SIGNED DATE a. NPI b. NPI</p>											

**Box 21: Diagnosis Code**  
Enter appropriate ICD-10-CM diagnosis

Example:  
M17.0—Bilateral primary osteoarthritis of knee

**Box 24D: HCPCS Code**  
Enter HCPCS code for HYALGAN J7321—Hyaluronan or derivative, HYALGAN®, for intra-articular injection, per dose

**Box 24D: CPT Code**  
Enter appropriate CPT code and modifier

Example:  
20610—Arthrocentesis, aspiration, and/or injection; major joint or bursa [eg, shoulder, hip, knee joint, subacromial bursa]

**Box 24G: Days or Units**  
Enter number of HYALGAN® units administered

Example:  
1 service unit for each dose

DISCLAIMER: HYALGAN® Sample Claim Form CMS-1500 is intended solely for use as a resource tool to assist physician office and hospital outpatient billing staff regarding reimbursement issues. Any determination about if and how to seek reimbursement should be made only by the appropriate members of the physician office or hospital outpatient staff in consultation with the physician and in consideration of the procedure performed or therapy provided to a specific patient. FIDIA FARMACEUTICI S.P.A/FIDIA PHARMA USA INC. do not recommend or endorse the use of any particular diagnosis or procedure code(s) and makes no determination if or how reimbursement may be available. Of important note, reimbursement codes and payment, as well as health policy/legislation are subject to continual change; information contained in this version of the HYALGAN® Reimbursement Guide is current as of January 2020.

# REIMBURSEMENT

The following section describes public (Medicare/Medicaid) and private payer reimbursement information relevant to HYALGAN® and its administration in the physician office setting.

Note: Because of variability in coverage and reimbursement across Medicaid and private payer plans, it is particularly important to conduct patient-specific insurance verifications for HYALGAN® therapy for patients with these types of healthcare insurance. To contact a reimbursement specialist for conducting patient-specific coverage and reimbursement, please call the *HYALGAN® Support Hotline* at **1.866.7.HYALGAN (1.866.749.2542)**, Monday to Friday, from 9:00 AM to 8:00 PM EST.

## Medicare

When HYALGAN® is provided in the physician office setting, both the product and the services associated with its administration may be reimbursed by Medicare. The payment methodology for HYALGAN® is expected to be based on its Average Sales Price (ASP) plus 6%\*. Please note that Medicare's drug and product payment rates change on a quarterly basis. In addition, services that are associated with HYALGAN® administration would be reimbursed based on the Medicare Physician Fee Schedule (MPFS).

HCPCS Code	Description
J7321	Hyaluronan or derivative, HYALGAN®, for intra-articular injection, per dose

CPT	Description
20610	Arthrocentesis, aspiration and/or injection; major joint or bursa (eg, shoulder, hip, knee joint, 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

In general, Medicare pays 80% of the allowed amount of the drug/product and service. Medicare beneficiaries are responsible for 20% of the allowed amount of the drug/product and service once a deductible has been met. If a Medicare beneficiary has a source of secondary coverage, that insurance may be used toward this cost-sharing requirement.

\*This allowed payment is subject to change.

## Private Payers

Private payers typically negotiate payment rates for HYALGAN<sup>®</sup>, when administered in the physician office setting, that may be based on a fee schedule, a percentage of billed or allowable charges, or a percentage of Wholesale Acquisition Cost (WAC) or ASP. For each patient, cost-sharing requirements, such as coinsurance and annual deductible amounts, will vary by individual insurance plan.

## Medicaid

State Medicaid programs have different payment rates for HYALGAN<sup>®</sup> when administered in the physician office setting. Medicaid payment for HYALGAN<sup>®</sup> and its associated administration services may be based on state-specific or MCO fee schedules. In the physician office setting, HYALGAN<sup>®</sup> may be reimbursed based on methodologies such as a percentage of WAC or invoice price. Certain state Medicaid programs may require nominal cost-sharing by Medicaid beneficiaries for drugs/products and services.