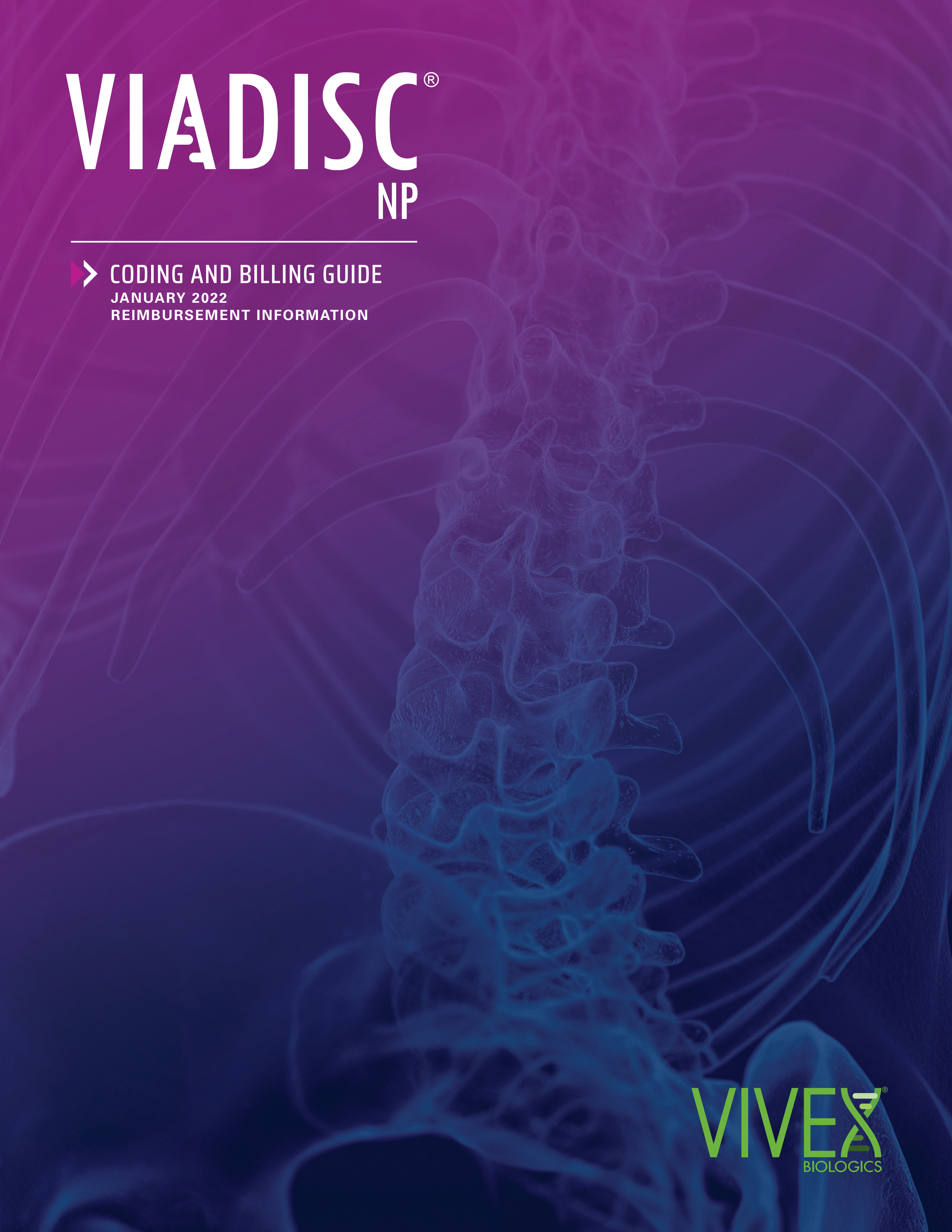

VIADISC® NP

CODING AND BILLING GUIDE

JANUARY 2022
REIMBURSEMENT INFORMATION

VIVEX® BIOLOGICS

VIADISC® NP

VIA Disc® NP is intended to supplement degenerated intervertebral discs. VIA Disc NP is shipped in a single use package containing nucleus pulposus (NP) tissue. VIA Disc NP is mixed with sterile saline prior to use to form a single, injectable allograft.

CODING OPTIONS

This guide provides physician, hospital outpatient and ambulatory surgery center coding with key considerations for addressing the status of the code options provided. 2022 Medicare national average reimbursement rates are included.

COMMON PROCEDURAL TERMINOLOGY (CPT) CODES[1] FOR VIA DISC NP

CODE	LONG DESCRIPTION
0627T	Percutaneous injection of allogeneic cellular and/or tissue-based product, intervertebral disc, unilateral or bilateral injection, with fluoroscopic guidance, lumbar; first level
+0628T	each additional level (List separately in addition to code for primary procedure)
0629T	Percutaneous injection of allogeneic cellular and/or tissue-based product, intervertebral disc, unilateral or bilateral injection, with CT guidance, lumbar; first level
+0630T	each additional level (List separately in addition to code for primary procedure)

2022 REIMBURSEMENT REFERENCE GUIDE

Medicare national unadjusted payment rates.

CPT CODE[1]	LONG DESCRIPTION	OUTPATIENT HOSPITAL[2]	AMBULATORY SURGICAL CENTER[3]
0627T	Percutaneous injection of allogeneic cellular and/or tissue-based product, intervertebral disc, unilateral or bilateral injection, with fluoroscopic guidance, lumbar; first level	APC: 5115 Status Indicator: JI Payment: $12,593.29	Payment Indicator: G2 Payment Weight: 120.59 Payment: $6,019.41
+0628T	each additional level (List separately in addition to code for primary procedure)	APC: NA Status Indicator: N	Payment Indicator: N1
0629T	Percutaneous injection of allogeneic cellular and/or tissue-based product, intervertebral disc, unilateral or bilateral injection, with CT guidance, lumbar; first level	APC: 5115 Status Indicator: JI Payment: $12,593.29	Payment Indicator: G2 Payment Weight: 120.59 Payment: $6,019.41
+0630T	each additional level (List separately in addition to code for primary procedure)	APC: NA Status Indicator: N	Payment Indicator: N1

KEY OPPS/ASC INDICATORS

J1: Hospital Part B Services paid through comprehensive APC
N/N1: Non-covered service
G2: Payment based on OPPS relative payment rates

FREQUENTLY ASKED QUESTIONS

DO CPT CODES 0627T, 0628T, 0629T AND 0630T HAVE A GLOBAL PERIOD?

- 0627T and 0629T have a global period of YYY. These are contractor-priced codes, for which MACs determine the global period.
- 0628T and 0630T – these are add-on codes and are billed with the primary codes. The global period for the primary code applies to the primary codes.

WHAT DIAGNOSIS CODE MAY BE REPORTED WHEN SUBMITTING A CLAIM FOR VIA DISC NP?

The possible codes are:[4]

- M51.36 (Other intervertebral disc degeneration, lumbar region)
- M51.86 (Other intervertebral disc disorders, lumbar region)
- M54.4- (Lumbago with sciatica)*
- M54.5- (Low back pain)*
- M54.9 (Dorsaliga, unspecified)

* These codes require additional details after dash for billing purposes.

IS THE PROCEDURE COVERED BY PAYERS?

The procedure may be covered on a case by case basis based on medical necessity. Please contact your patient's plan for coverage.

DOES THIS PROCEDURE NEED A PRIOR AUTHORIZATION FROM THE PAYER?

A prior authorization may be needed. The prior authorization process does not change when using CPT Category III codes. Prior authorization will require documentation to support the CPT Category III codes being used in order to help the payer understand what is being requested. Please contact your patient's payer for their prior authorization process.

CAN MY PATIENT USE THEIR HEALTH SAVINGS ACCOUNT (HSA) OR FLEXIBLE SPENDING ACCOUNT (FSA) TO PAY FOR THE PROCEDURE?

Yes, your patient can use their HSA or FSA as this procedure falls under the section 213(d) definition of the Internal Revenue Code of medical care.

CUSTOMERS USING VIA DISC NP CAN CONTACT VIVEX REIMBURSEMENT SUPPORT AT 877.475.0888 OR REIMBURSEMENT@VIVEX.COM.

VIVEX has used reasonable efforts to provide accurate information herein, but this information should not be construed as providing clinical advice, dictating reimbursement policy, guaranteeing coverage, or as a substitute for the judgment of a health care provider. It is always the health care provider's responsibility to determine the appropriate codes, charges for services, and use of modifiers for services rendered and to verify coverage with payers, including the applicability of any non-coverage policies that may exist. Reimbursement laws, regulations, and payer policies change frequently without notice, and VIVEX Biologics assumes no responsibility for the timeliness, accuracy, or completeness of the information provided. It is highly recommended that health care providers consult with their payers, coding specialists, and/or legal counsel regarding coverage, coding, and payment issues.

1. *CPT Copyright 2021 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.*
2. *The payment rate for APC 5115 (Level 5 Musculoskeletal Procedures) can be found in Addendum A of the CY 2022 OPPS/ASC final rule.*
3. *The Ambulatory Surgical Center payment can be found in Addendum AA -Final ASC Covered Surgical Procedures for CY 2022*
4. *Centers for Disease Control and Prevention, National Center for Health Statistics. International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM). http://www.cdc.gov/nchs/icd/icd10cm.htm. Updated October 1, 2021*

VIVEX BIOLOGICS
2430 NW 116th Street, Miami, FL 33167
(888) 684-7783 | vivex.com | customercare@vivex.com