A. SUBJECT

Hyaluronic Acid Derivative Injection
- Euflexxa
- Gel-One
- Hyalgan
- Supartz
- Orthovisc
- Synvisc
- Synvisc-One
- Monovisc
- GenVisc 850
- Gel-Syn

B. BACKGROUND

The CareSource Medication Policies are therapy class policies that are used as a guide when determining health care coverage for our members with benefit plans covering prescription drugs. Medication Policies are written on selected prescription drugs requiring prior authorization or Step-Therapy. The Medication Policy is used as a tool to be interpreted in conjunction with the member’s specific benefit plan.

The intent of the Hyaluronic Acid Derivative Injection program is to encourage appropriate selection of therapy for patients according to product labeling and/or clinical guidelines and/or clinical studies, and also to encourage use of preferred agents.

C. DEFINITIONS

N/A
D. POLICY

I. CareSource will approve the use of hyaluronic acid derivatives, and consider their use as medically necessary when the following criteria have been met for:

A. Osteoarthritis of the knee

Hyaluronic acid derivatives are indicated for the treatment of pain in osteoarthritis (OA) of the knee in patients who have failed to respond adequately to conservative non-pharmacologic therapy and simple analgesics (e.g., acetaminophen)

1. Prior Authorization Criteria:
   1.1 Intra-articular injection of hyaluronic acid may be indicated when ALL of the following are present:
   a. Age 50 years or older
   b. Diagnosis of Osteoarthritis confirmed by radiological evidence
   c. Failure to respond (adequate improvement in pain/function) to or inability to tolerate non-operative treatments, including ALL of the following:
      (1) Intra-articular corticosteroid injections
      (2) Lifestyle modifications
      (3) Weight loss for BMI ≥25
      (4) Trial of at least 3 simple analgesic therapy (acetaminophen, NSAIDs, salicylates oral or topical)
      (5) Sufficient trial (e.g. 2 to 3 months) of non-pharmacologic therapies (bracing/orthotics, physical therapy/exercise, weight loss)
   d. Knee osteoarthritis, with pain affecting daily activity and quality of life
   e. No infection of skin disease at injection site
   f. Prescribed by of an Orthopedic Surgeons, Interventional Pain Physicians, Rheumatologists, Physiatrists (PM&R) and all Sports Medicine subspecialties.

   1.2 Non-preferred products may be approved if ALL above criteria are met AND clinical reason is supplied as to why preferred product(s) (formulary) cannot be used

   1.3 One (1) additional course of treatment may be approved if ALL of the following are met:
   a. Documented significant pain relief was achieved with the initial/prior course of treatment
   b. Initial/prior course of treatment has been completed for 6 months or longer
   c. Patient meets all the criteria for the initial approval

Note: Documented diagnosis must be confirmed by contemporaneous portions of the individual's medical record which will confirm the presence of disease and will need to be supplied with prior authorization request. These medical records may include, but not limited to test reports, chart notes from provider's office or hospital admission notes.

Ultrasound guidance for viscosupplement injections is considered experimental and investigational because it has not been established that this approach will improve health outcomes.

All other uses of hyaluronic acid derivative are considered experimental/investigational and may be covered under CareSource's Medical Necessity: Off-Label policy.
Refer to the product package insert for dosing, administration and safety guidelines.

CONDITIIONS OF COVERAGE

HCPCS
- J7321 Hyalgan / Supartz
- J7323 Euflexxa
- J7324 Orthovisc
- J7325 Synvisc / Synvisc-One
- J7326 Gel-One
- J7327 Monovisc
- J7328 Gel-Syn
- J3590 GenVisc 850

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

PLACE OF SERVICE
Office, Outpatient
**Preferred place of service is in the provider’s office.

Note: CareSource supports administering injectable medications in various settings, as long as those services are furnished in the most appropriate and cost effective setting that are supportive of the patient’s medical condition and unique needs and condition. The decision on the most appropriate setting for administration is based on the member’s current medical condition and any required monitoring or additional services that may coincide with the delivery of the specific medication.

AUTHORIZATION PERIOD
Approved initial authorizations are valid for 6 months. ALL authorizations are subject to continued eligibility.

E. REVIEW/REVISION HISTORY
Date Issued: 06/15/2011
Date Reviewed: 06/15/2011, 01/15/2013, 02/14/2014, 02/14/2015
Date Revised: 05/15/2013
- 02/14/2015 – added: all to non-operative failed treatments, Gel-One & J-code & preferred products
- 02/14/2016 – add sub-specialty; sports med group, age change and 1 additional retreatment

F. REFERENCES


The Medical Policy Statement detailed above has received due consideration as defined in the Medical Policy Statement Policy and is approved.

Independent medical review – 5/2011