Clinical Criteria Worksheet:
Viscosupplementation Therapy with Hyaluronan or Derivative

Claim Submission

- Claim processing may be delayed if the information submitted in this worksheet is illegible.
- If the worksheet is left blank or information is missing the claim will be rejected for not enough documentation and reimbursement will be delayed.
- A claim should not be submitted until the product has been administered to the patient.
- The manufacturer invoice showing the acquisition cost of the product administered, including all discounts, rebates, and incentives must be submitted with the claim. The invoice must be dated within 6 months prior to the date of service and/or should include the expiration date of the product, or it will be rejected for not enough documentation.

Enrollee Information

Enrollee Last Name:

Enrollee First Name:

Date of Birth (MM/DD/YYYY): / /

Enrollee Medicaid ID (2 letters, 5 numbers, 1 letter):

Address:

City, Town or Post Office:

State:

ZIP Code:

Prescriber Information

Prescriber Last Name:

Prescriber First Name:

National Provider Identifier (NPI) Number:

Preferred Contact (Telephone Number) – –

Coverage Conditions

- Reimbursement will not be provided for a diagnosis of osteoarthritis of the knee. Please see the article titled "Viscosupplementation of the Knee: Non-coverage Decision" in the March 2014 issue of the *Medicaid Update* for additional information. Coverage will continue to be provided for compendia-supported uses.
- For billing guidance and a list of covered products, providers may refer to the billing guidelines and fee schedules located on the eMedNY Physician Manual web page.

Enrollee Last Name: | | | | | | | | | | | | |

Enrollee First Name: | | | | | | | | | | | | |

Clinical Criteria – Product Information

Product Administration:

Provide the date of product administration (MM/DD/YYYY):

☐☐ / ☐☐ / ☐☐☐☐

Provide the expiration date of the product if the invoice date is greater than 6 months from the date of product administration (MM/DD/YYYY):

☐☐ / ☐☐ / ☐☐☐☐

Product Name and Healthcare Common Procedure Coding System (HCPCS) Code:

☐ EUFLEXXA® – J7323

☐ Gel-One® – J7326

☐ HYALGAN® – J7321

☐ SUPARTZ® – J7321

☐ VISCO-3™ – J7321

☐ Other: ___________________________________

Strength: ___________________________________ **Directions:** ___________________________________

Quantity: ___________________________________

New Treatment: ☐ Yes ☐ No

If **No**, date therapy initiated: ____

Clinical Criteria – Diagnosis

☐ Arthropathy – disorder of shoulder

☐ Subacromial impingement, syndrome of the shoulder

Attestation

I attest that this is medically necessary for this patient and that all of the information on this form is accurate to the best of my knowledge. I attest that documentation of the above diagnosis and medical necessity is available for review if requested by the New York State Medicaid Program.

____ _____________________

Prescriber Signature (Required) **Date (MM/DD/YYYY)**