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 found at: <u>https://www.health.ny.gov/health_care/medicaid/program/update/2014/2014-03.htm#vis</u>. 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 found at: <u>https://www.emedny.org/</u> <u>ProviderManuals/Physician/index.aspx</u>.

Enrollee Last Name:	Enrollee First Name:
Clinical Criteria – Product Information	
Product Administration:	
Provide the date of product administration (MM/DD	//////
	, , , , , , , , , , , , , , , , , , , ,
	ice 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:	\mathbf{G}
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.