

<b>Division of Medicaid State of Mississippi Provider Policy Manual</b>	<b>New:</b> <b>Revised: X</b> <b>Current:</b>	<b>Effective Date: 12/01/10</b>
<b>Section: General Medical Policy</b>	<b>Section: 53.26</b> <b>Pages: 2</b>	
<b>Subject: Hyaluronate Joint Injection</b>	<b>Cross Reference: Maintenance of Records 7.03</b>	

Hyaluronate is a synthetic synovial fluid approved by the FDA as a medical device and not as a drug. It is approved for the treatment of pain in osteoarthritis of the knee joint only, in those patients who have not responded adequately to conservative therapy (ex: physical therapy, weight loss, simple analgesics, such as acetaminophen, etc.). This device is not indicated for use in end-stage degenerative joint disease.

The literature suggests that maximum benefits may not be obtained for several weeks after injection, and that after a course of treatment, the relief may last for 6 to 8 months in those patients who respond to the treatment.

**Criteria for Coverage**

The following criteria for coverage apply to Hyaluronate:

1. The patient is being treated for pain which is caused by osteoarthritis of the knee joint.
2. The patient does not have end-stage degenerative joint disease.
3. The patient does not respond adequately to conservative therapy (ex: physical therapy, weight loss, and/or simple analgesics, etc).
4. The treatment is performed in accordance with acceptable standards of practice.
5. The medical necessity is documented on the claim by reporting ICD-9 Diagnosis Code 715.16, 715.26, 715.36, and 715.96.
6. Modifier -50, when applicable, is used with the appropriate CPT code which identifies a bilateral arthrocentesis of a major joint (injection into joint).
7. If the first series of injections failed to prove beneficial, repeat injections are considered not medically necessary.
8. The medical device/solution must be FDA approved.

For Mississippi Medicaid, the provider **must** bill separately for each date of service rather than combining and billing after the completion of the full series of injections.

**Documentation Requirements**

The physician performing the procedure must maintain, at a minimum, the following documentation relating to the medical necessity for the procedure.

- Patient History
- Physical Examinations
- Diagnosis(es)
- Examination notes documenting the evaluation and management of the condition/diagnosis(es)
- Relevant clinical signs and symptoms

- Abnormal laboratory, x-ray, and/or other diagnostic test results
- Documentation supporting failure of conservative treatment (Ex: physical therapy, weight loss, simple analgesics, etc.)
- Documentation must indicate the route of administration, the clinical information supporting the indication for use, and the frequency of its use

Documentation must be legible and medical records must be available to the Division of Medicaid, the fiscal agent, and/or Utilization Management/Quality Improvement Organization (UMQIO) upon request.

Refer to Provider Policy Manual section 7.03 for additional documentation requirements and Maintenance of Records policy.

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Refer to Section 7.0, General Policy in this manual for additional documentation information. Refer to Provider Policy Manual section 7.03 for additional documentation requirements and Maintenance of Records policy.