Subject: Hyaluronan Injections in Joints Other Than the Knee

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Current Effective Date: 09/27/2017

Last Review Date: 08/03/2017

Description/Scope

This document addresses the use of hyaluronan injections for the replacement or supplementation of naturally occurring intra-articular lubricants in individuals with musculoskeletal conditions in joints other than the knee, including osteoarthritis and temporomandibular joint disease. This therapy may also be referred to as viscosupplementation.

Note: Please see the following related document for additional information:

- CG-DRUG-29 Hyaluronan Injections in the Knee

Position Statement

Medically Necessary:

A single course of intra-articular injections of hyaluronan is considered medically necessary for the treatment of pain due to reducing and non-reducing disc displacement disease of temporomandibular joint disorders. A single course usually involves weekly injections (7 days apart) for 3 to 5 consecutive weeks.

Investigational and Not Medically Necessary:

Intra-articular injections of hyaluronan for other musculoskeletal conditions of joints other than the knee, including but not limited to osteoarthritis of the ankle, shoulder or hip, are considered investigational and not medically necessary.

Clinically Equivalent Cost Effective Agents

Note: When hyaluronan is determined to be medically necessary based on the clinical criteria above, the benefit plan may have in addition a medically necessary criterion that the treatment be cost effective. When such language exists, the benefit plan may determine which hyaluronan therapy is covered.

A benefit plan may select any one or more of the following as clinically equivalent cost effective hyaluronan agents: Euflexxa® (1% sodium hyaluronate), Gel-One® (sodium hyaluronate), Gelsyn™ (sodium hyaluronate), Gen Vise 850® (sodium hyaluronate), Hylagan® (sodium hyaluronate), Hymovis® (hyaluronic acid), Monovisc® (sodium hyaluronate), Orthovisc® (hyaluronic acid), Supartz FX™ (sodium hyaluronate), Synvisc® (hylan G-F 20), Synvisc-One® (hylan G-F 20). For a listing of cost effective agents, please click here.
In benefit plans where there is a requirement to use a cost effective hyaluronan agent, requests for a hyaluronan agent which is not cost effective may be approved when the individual has had a trial and inadequate response or intolerance to one cost effective agent.

**Rationale**

**Temporomandibular Joint Disorders (TMJ)**

A literature search identified several published randomized controlled clinical trials that consistently reported that compared to placebo or corticosteroid injection, hyaluronan injection provided improved pain relief, improvement in range of motion and jaw function, and decreased rate of recurrence in subjects with TMJ disorders (Alpaslan, 2001; Bertolami, 1993; Bjornland, 2007; Hepguler, 2002).

A recent study by Li and colleagues (2015) reported observations of TMJ condylar changes and function of the joint for individuals with osteoarthritis of the TMJ who received hyaluronic acid injections. A total of 141 individuals were randomized to one of two study groups: the superior or inferior joint space injection group. The participants received hyaluronic acid injections once every 2 weeks for a total of 3 injections. Participants were evaluated at 3 and 9 months post injection with cone-beam computed tomography and clinical exam. TMJ function was assessed by mandibular movement, maximal mouth opening, protrusive and lateral excursion, tenderness of masticatory muscles, tenderness of the TMJ, and TMJ noise. At the 3-month visit, 126 participants were available for follow-up. In the superior group 44 participants and 51 participants in the inferior group showed reparative remodeling. Severe degenerative changes were noted in 13 participants in the superior group and 5 participants in the inferior group. No change was found in 8 participants in the superior group and 4 participants in the inferior group. Most of the participants showed improvement in TMJ function. A total of 74 participants were available at the 9-month follow-up and most of the available participants showed better condylar morphology than at the 3-month visit and most also had improved TMJ function. At the 3-month visit, new bone formation was noted in many of the participants. Some of the participants who were found to have severe degenerative changes at 3 months showed reparative remodeling at 9 months. While this study suggested that the use of hyaluronic acid injections of the joint space in treating TMJ osteoarthritis is effective, there are some limitations to the study including the large number of participants lost to follow-up and no placebo control. While the studies addressing hyaluronan injections as a treatment of TMJ dysfunction are limited in number, viscosupplementation is an accepted in clinical practice as a treatment for TMJ disorders.

**Osteoarthritis of Other Joints**

Hyaluronan injection has also been studied in other joints, including the hip, shoulder, ankle, and thumb.

**Hip**

Qvistgaard and colleagues (2006) reported on the results of a randomized placebo-controlled trial of hyaluronan injections in 101 individuals with osteoarthritis of the hip compared to corticosteroid or saline injection. The researchers reported that over the 3-month evaluation period, the participants who received hyaluronan injections reported only a small reduction in pain with walking compared to those injected with corticosteroid who reported significant pain reductions with walking.

In a systematic review for osteoarthritis of the hip (Fernández López, 2006), two independent reviewers applied a series of inclusion and exclusion criteria to the studies located in the search, and selected only those that included...
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more than 20 participants; had a follow-up period of more than 1 week; and exclusively assessed the efficacy and/or effectiveness of hyaluronan in those with confirmed osteoarthritis of the hip. A total of eight studies consisting of clinical trials and one review, met the inclusion criteria. Only two of the trials were controlled: one compared two hyaluronan products of different molecular weights; and the other compared hyaluronan injections with corticoids and a placebo. Pain relief was estimated to be around 40-50% by most studies, although the duration of this post-treatment effect was not known. The researchers concluded that based on available evidence, hyaluronan injections as a treatment of osteoarthritis of the hip should be used under careful supervision by the clinician and only in those instances where other treatments have failed. The researchers noted that methodological limitations include short follow-up periods, dissimilar ways of measuring outcomes and the absence of a control group in many of the studies.

Another systematic review (van den Bekerom, 2008) sought to identify studies relating to the use of viscosupplementation as a treatment for osteoarthritis of the hip. Sixteen articles addressing the efficacy of viscosupplementation in a total of 509 participants with osteoarthritis of the hip were included. The products evaluated included Hylan G-F 20, Hyalgan, Ostenil, Durolane, Fermatron and Orthovisc. While the researchers concluded that viscosupplementation might have a beneficial effect in relieving pain in individuals suffering with osteoarthritis of the hip, additional comparative studies are needed before it can be recommended as standard therapy in osteoarthritis of the hip.

Richette and colleagues (2009) reported the findings of a multicenter, randomized, parallel-group, placebo-controlled trial which evaluated the efficacy and tolerability of a single intra-articular injection of hyaluronic acid for the treatment of osteoarthritis of the hip. A total of 85 participants were randomized to either the hyaluronic acid group (n=42) or placebo group (n=43). At the end of 3 months no difference in efficacy was noted between the two groups. The findings indicated that a single intra-articular injection of hyaluronic acid was no more effective than placebo in treating the symptoms of osteoarthritis of the hip. However, the value of the study results were limited by the small number of participants included in each study arm and the fact that the hyaluronan injections were administered only once versus the multiple injections typically administered for other indications.

A retrospective review by Migliore and colleagues (2012) reported on 224 participants who received injections of hylan G-F 20 and who were then followed to see if total hip replacement was required. Of the study participants, 56 were classified as being candidates for total hip replacement and 168 participants were classified to not being candidates for a total hip replacement. Following injections, 84 participants later required total hip replacement (32 of these participants came from the non-surgical candidate group). Survival time (in months) was the amount of time between start of treatment with injections and total hip replacement, if performed. Twelve-month survival was achieved by 206 participants, 24-month survival was achieved by 170 participants, and 5-year survival was achieved by 69 participants. This study is limited by its retrospective design and lack of a control group. The authors also note that intra-articular treatment is known to have a placebo effect and additional studies are needed to gain further insight into functional and clinical improvement.

A 2016 study by Rivera reports on 207 participants with osteoarthritis of the hip who received a single intra-articular injection of hyaluronic acid. Participants were assessed prior to the injection, and at 3, 6, and 12 months following the injection. Primary outcome measure was the score on the Modified Brief Pain Inventory with a pain severity score of 0-10. Participants were also evaluated using the Harris Hip Score from 0-100 which addressed pain domain, function domain, range of motion domain, and no deformity domain. Visual analog scale was also used to assess pain scores. A total of 121 participants filled out the questionnaires for Modified Brief Pain
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Inventory and Harris Hip Score at 1 year following the injection while 104 participants completed the questionnaire for visual analog score. The Modified Brief Pain Inventory mean score at the initial assessment was 4.07 and 2.55 between 6-12 months. The mean Harris Hip Scores ranged from 68.35 at initial evaluation to 81.76 between 6-12 months. The visual analog scores were reported as “a statistically highly significant improvement” between initial evaluation and the 3 month follow-up. This study has limitations including a loss of participants from initial evaluation to the 12-month post injection follow-up, and lack of a control group. Randomized trials are needed.

The American College of Rheumatology has no recommendation for the use of intraarticular hyaluronate injections for the management of osteoarthritis of the hip (Hochberg, 2012).

Shoulder
Blaine and colleagues (2008) reported on the results of a multi-institutional randomized study of 660 individuals with shoulder pain related to glenohumeral osteoarthritis, rotator cuff tear or adhesive capsulitis. All participants had failed prior management with physical therapy, at least one corticosteroid injection and the administration of oral pain medications. Baseline pain levels ranged from 40 to 90 mm on a 100 mm visual analog scale. Limitation of active range of motion in at least one of several directions was also required. Participants were randomized to either a course of 3 or 5 injections of hyaluronan or placebo injection. The primary outcome was improvement in shoulder pain at 13 weeks; the secondary outcome was the maintenance of pain relief through the 26-week follow-up. A total of 456 participants completed the 26 weeks of follow-up; 20% had discontinued the study at week 26. Using an intent-to-treat analysis, at week 13 (the primary outcome measure), all three groups showed significant reductions in pain from baseline that were not significantly different from one another. At week 26, the 3-injection hyaluronan group did show a small but statistically significant reduction in pain compared to the placebo group. Specifically, compared to the placebo group, the difference in mean reduction from baseline was 7.2 mm on a 100 mm scale for the 3-injection group. This trial did not meet its primary outcome, and the questionable clinical significance of the modest improvements noted at other time points is another limitation of this study.

Another study reported on 39 individuals with osteoarthritis of the shoulder who received injections of Hylan G-F 20 (Noel, 2010). Baseline visual analog scores ranged from 40/100 to 90/100. Each participant received 1 intra-articular injection of Hylan G-F 20. Participants could be scheduled for a second injection at the 1-month, 2-month, or 3-month visit. Participants were reevaluated at 7 days and 1, 2, 3, and 6 months following the injection. Thirty-three individuals received an initial injection, and 16 individuals required a second injection. Four participants left the study due to unacceptable pain (which left 29 total participants). Visual analog score decreased from 61.2 mm at baseline to 37.1 mm at 3 months following an injection. In this particular study 52% of participants reported good pain relief following 1 injection; however the authors did state that “controlled trials are needed to confirm our results and determine optimal treatment schedule.”

Ankle
A study by DeGroot and colleagues (2012) enrolled 64 participants to randomly receive either a single injection of hyaluronic acid for ankle osteoarthritis or a single injection of normal saline solution. In this randomized, double-blind, placebo-controlled study, a total of 56 participants completed the study (8 participants withdrew from the study). The primary outcome measure was the change from baseline using the American Orthopaedic Foot & Ankle Society (AOFAS) clinical rating score. Participants were rated at baseline, 6 weeks following injection and 12 weeks following injection. Secondary outcome measures were the change from baseline in the Ankle Osteoarthritis Scale (AOS) score and a self-reported visual analog score. Both groups (active treatment and placebo) had improvements in the primary outcome measure at 12 weeks. The mean AOS scores in the active treatment group

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improved from baseline by 5.0 points at 6 weeks and 5.3 points at 12 weeks. The mean AOS scores in the placebo group improved by 8.4 points at 6 weeks and 14.8 points at 12 weeks. Using the visual analog score, the pain scores in the active group improved from baseline by 6.4 points at 6 weeks and 4.1 points at 12 weeks. In the placebo group, the visual analog scores improved by 3.0 points at 6 weeks and 11.1 points at 12 weeks. The authors noted that both the active treatment group and placebo group had improvements in scores at 12 weeks, but the improvements in the groups were not significantly different and a single dose of hyaluronic acid is not superior to a single dose of normal saline for the treatment of ankle osteoarthritis.

A prospective study by Lucas and colleagues (2013) reported on 18 individuals with osteoarthritis of the ankle who received a series of 3 injections of viscosupplementation. The participants were evaluated at 4 and 12 months and then annually using the AOFAS score. The AOFAS scores increased from 61.8 ± 15 before receiving the injections to 74.4 ± 14.5 after 4 months and 73.7 ± 16.6 after 12 months. Literature search identified trials focusing on osteoarthritis of the ankle, but trials remain limited to small group sizes (Cohen, 2008; Karatosun, 2008; Salk, 2006; Witteveen, 2010) and retrospective studies (Han, 2014).

A 2015 Cochrane report by Witteveen and colleagues assessed the benefits and harms of conservative treatment for osteoarthritis of the ankle. The conclusions were that since simple analgesics are recommended for osteoarthritis of the hip and knee it would be reasonable to use these to treat osteoarthritis of the ankle. Based on a low quality of evidence it was unclear if there is a benefit or harm to using hyaluronan as a treatment of osteoarthritis of the ankle compared to placebo at 6 months and results were inconclusive when hyaluronan was compared to other treatments.

**Thumb**

Similarly, randomized controlled trials comparing hyaluronan and corticosteroid injection in individuals with osteoarthritis of the thumb have reported superior results associated with the corticosteroid injection (Fuchs, 2006; Stahl, 2005).

The United States FDA has approved several different intra-articular injections as devices through their pre-market approval (PMA) process.

### Background/Overview

One treatment for TMJ disorders is the injection of substances into the joint, to replace synovial fluid. Hyaluronates are one class of synovial fluid replacements. Although hyaluronates have not been labeled by the FDA for use in the TMJ, the evidence from randomized controlled trials indicates that this treatment has a beneficial effect in individuals with osteoarthritis or disc disorders of the TMJ.

### Description of Disease(s)

Osteoarthritis is a degenerative condition of the joints and is the most common form of arthritis. Osteoarthritis commonly affects the hands and the weight-bearing joints, such as the knees, hips, feet and spine. Osteoarthritis affects an estimated 27 million Americans, mostly at or after 50 years of age, and occurs in women more commonly than men. Afflicted joints experience loss of synovial fluid, a protective substance which aids in absorbing shock and lubrication in the joints. Low synovial fluid levels and other mechanisms cause a progressive breakdown of the cartilage lining the ends of bones that are necessary for proper cushioning and smooth function of joints. Because of
this breakdown of cartilage, bones rub against each other causing pain, loss of movement, and further destruction of the joint. The severity of osteoarthritis can range from very mild to very severe.

According to the National Institute of Dental and Craniofacial Research of the National Institutes of Health, over 10 million people in the United States suffer from TMJ problems at any given time. The TMJ is the joint where the lower jaw connects to the skull. There are two matching joints, one on each side of the skull, located just in front of the ears. Additionally, the term “TMJ” may be used to refer to any disorders or symptoms related to this joint. Such symptoms include popping sounds in the jaw, inability to fully open the mouth, jaw pain or locking, headaches, earaches, toothaches, and various other types of facial pain. Many TMJ-related symptoms are caused by the effects of physical and emotional stress on the structures around the joint. These structures include the muscles of the jaw, face, and neck; the teeth, the cartilage disc in the joint space and nearby ligaments, blood vessels and nerves. In most individuals, pain associated with the TMJ is a result of displacement of the cartilage disc that cushions the joint which causes pressure and stretching of the associated sensory nerves. Popping or clicking occurs when the disc snaps out of and back into place when the jaw moves. The term “reducing disc displacement” is frequently used to describe the condition where the displaced disc returns to its normal position following displacement. Non-reducing disc displacement refers to situations where the disc does not return to its normal position, commonly resulting in a “locked” jaw or limited range of motion.

Hyaluronan injections can vary and an initial course of treatment can range from a single injection to weekly injections (7 days apart) for 2 to 5 consecutive weeks.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Usual Dosing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Euflexxa (sodium hyaluronate)</td>
<td>1 injection (per affected joint)</td>
</tr>
<tr>
<td></td>
<td>weekly for 3 weeks</td>
</tr>
<tr>
<td>Gel-One (Cross-linked sodium hyaluronate)</td>
<td>1 injection (per affected joint)</td>
</tr>
<tr>
<td></td>
<td>one time</td>
</tr>
<tr>
<td>Gelsyn-3 (sodium hyaluronate)</td>
<td>1 injection (per affected joint)</td>
</tr>
<tr>
<td></td>
<td>weekly for 3 weeks</td>
</tr>
<tr>
<td>GenVisc (sodium hyaluronate)</td>
<td>1 injection (per affected joint)</td>
</tr>
<tr>
<td></td>
<td>weekly for 5 weeks</td>
</tr>
<tr>
<td>Hyalgan (sodium hyaluronate), all dose forms</td>
<td>1 injection (per affected joint)</td>
</tr>
<tr>
<td></td>
<td>weekly for 5 weeks</td>
</tr>
<tr>
<td>Hymovis (non-crosslink sodium hyaluronate)</td>
<td>1 injection (per affected joint)</td>
</tr>
<tr>
<td></td>
<td>weekly for 2 weeks</td>
</tr>
<tr>
<td>Monovisc (sodium hyaluronate)</td>
<td>1 injection (per affected joint)</td>
</tr>
<tr>
<td></td>
<td>one time</td>
</tr>
<tr>
<td>Orthovisc (hyaluronic acid)</td>
<td>1 injection (per affected joint)</td>
</tr>
<tr>
<td></td>
<td>weekly for 3 or 4 weeks</td>
</tr>
<tr>
<td>Supartz FX (sodium hyaluronate)</td>
<td>1 injection (per affected joint)</td>
</tr>
<tr>
<td></td>
<td>weekly for 5 weeks</td>
</tr>
<tr>
<td>Synvisc (hylan G-F 20 [polymer of A and B])</td>
<td>1 injection (per affected joint)</td>
</tr>
<tr>
<td></td>
<td>weekly for 3 weeks</td>
</tr>
<tr>
<td>Synvisc-Oné (hylan G-F 20 [polymer of A and B])</td>
<td>1 injection (per affected joint)</td>
</tr>
<tr>
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<td>one time</td>
</tr>
</tbody>
</table>

**Definitions**

Intra-articular injections: A medical procedure using a hypodermic needle to inject a substance, such as a drug, into the space between two bones.

Osteoarthritis: A degenerative condition of the joints that causes destruction of the material in the joints that absorbs shock and allows proper movement.

Reducing and non-reducing disc displacement: In the TMJ there is a disc of cartilage that cushions the area where the skull and lower jaw meet. In some TMJ conditions this disc becomes loose and moves in the joint space,
causing clicking, popping, or locking of the joint. When the disc is reduced it returns to the correct position after
being displaced. In non-reducing disease the disc does not return to its proper position.

Temporomandibular joint (TMJ): The joint where the lower jaw meets the skull.

Viscosupplementation: Intra-articular injections commonly used to treat osteoarthritis; thought to increase joint
lubrication.

### Coding

The following codes for treatments and procedures applicable to this document are included below for informational purposes. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

**When services may be Medically Necessary when criteria are met:**

**HCPCS**

- J7320: Hyaluronan or derivative, GenVisc 850, for intra-articular injection, 1 mg
- J7321: Hyaluronan or derivative, Hyalgan or Supartz, for intra-articular injection, per dose
- J7322: Hyaluronan or derivative, Hymovis, for intra-articular injection, 1 mg
- J7323: Hyaluronan or derivative, Euflexxa, for intra-articular injection, per dose
- J7324: Hyaluronan or derivative, Orthovisc, for intra-articular injection, per dose
- J7325: Hyaluronan or derivative, Synvisc or Synvisc-One, for intra-articular injection, 1 mg
- J7326: Hyaluronan or derivative, Gel-One, for intra-articular injection, per dose
- J7327: Hyaluronan or derivative, Monovisc, for intra-articular injection, per dose
- J7328: Hyaluronan or derivative, Gel-Syn, for intra-articular injection, 0.1 mg

**ICD-10 Diagnosis**


**When services are Investigational and Not Medically Necessary:**

For the procedure codes listed above for all other diagnoses except those listed below related to knee conditions
(which are excluded from this document), or when the code describes a procedure indicated in the Position
Statement section as investigational and not medically necessary.

**ICD-10 Diagnosis**

For *all other diagnoses* except the following knee conditions (which are not addressed):

- M08.861-M08.869: Other juvenile arthritis, knee
- M08.961-M08.969: Juvenile arthritis, unspecified, knee
- M12.561-M12.569: Traumatic arthropathy, knee
- M12.861-M12.869: Other specific arthropathies, not elsewhere classified, knee
- M13.861-M13.869: Other specified arthritis, knee
- M17.0-M17.9: Osteoarthritis of knee
- M21.061-M21.069: Valgus deformity, not elsewhere classified, knee

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- M21.261-M21.269 Flexion deformity, knee
- M22.00-M22.92 Disorder of patella
- M23.000-M23.92 Internal derangement of knee
- M24.361-M24.369 Pathological dislocation of knee, not elsewhere classified
- M24.461-M24.469 Recurrent dislocation, knee
- M24.561-M24.569 Contracture, knee
- M24.661-M24.669 Ankylosis, knee
- M25.361-M25.369 Other instability, knee
- M25.561-M25.569 Pain in knee
- M25.661-M25.669 Stiffness of knee, not elsewhere classified
- M25.761-M25.769 Osteophyte, knee
- M25.861-M25.869 Other specified joint disorders, knee
- M66.0 Rupture of popliteal cyst
- M67.361-M67.369 Transient synovitis, knee
- M67.461-M67.469 Ganglion, knee
- M67.50-M67.52 Plica syndrome
- M67.861-M67.869 Other specified disorders of synovium and tendon, knee
- M70.40-M70.42 Prepatellar bursitis
- M70.50-M70.52 Other bursitis of knee
- M71.20-M71.22 Synovial cyst of popliteal space
- M71.561-M71.569 Other bursitis, not elsewhere classified, knee
- M92.40-M92.42 Juvenile osteochondrosis of patella
- M92.50-M92.52 Juvenile osteochondrosis of tibia and fibula
- M94.261-M94.269 Chondromalacia, knee
- S80.00-SA80.02XS Contusion of knee
- S83.001A-S83.32XS Subluxation and dislocation of knee
- S83.401A-S83.92XS Sprain of knee
- S87.00XA-S87.02SX Crushing injury of knee
- Z96.651-Z96.659 Presence of artificial knee joint

References

Peer Reviewed Publications:

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Government Agency, Medical Society, and Other Authoritative Publications:


Websites for Additional Information

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Gel-One
GelSyn 3
Gen Visc 850
Hyalgan
Hymovis
Monovisc
Orthovisc
Supartz FX
Synvise
Synvisc-One
Viscosupplementation

The use of specific product names is illustrative only. It is not intended to be a recommendation of one product over another, and is not intended to represent a complete listing of all products available.

Document History

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<th>Status</th>
<th>Date</th>
<th>Action</th>
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<tr>
<td>Reviewed</td>
<td>08/03/2017</td>
<td>Medical Policy &amp; Technology Assessment Committee (MPTAC) review. Updated Rationale and References sections.</td>
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<tr>
<td>Revised</td>
<td>02/02/2017</td>
<td>MPTAC review. Added new “Clinically Equivalent Cost Effective Agents” section. Removed Hylan G-F 20 from Position Statement. Updated Description/Scope, Background/Overview, References and Index sections.</td>
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<tr>
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<td>01/01/2017</td>
<td>Updated Coding section to include 01/01/2017 HCPCS changes; removed codes C9471, Q9980 deleted 12/31/2016.</td>
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<td>08/04/2016</td>
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<td>08/06/2015</td>
<td>MPTAC review. Spelled out temporomandibular joint in Position Statement. Updated Rationale, Background/Overview, and Reference sections.</td>
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Reviewed 08/09/2012  MPTAC review. Title changed to “Hyaluronan Injections in Joints Other Than the Knee.” Updated Rationale, References and Web Sites for Additional Information.

01/01/2012 Updated Coding section with 01/01/2012 HCPCS changes.

Reviewed 08/18/2011  MPTAC review. Updated Rationale and References.

Revised 08/19/2010  MPTAC review. Revised document to address musculoskeletal conditions in joints other than the knee. Updated the Description, Rationale, Background/Overview, Coding, References, Index and History sections.

Reviewed 05/13/2010  MPTAC review. Updated review date, Rationale, References and History sections of the document.

01/01/2010 Updated Coding section with 01/01/2010 HCPCS changes; removed HCPCS J7322 deleted 12/31/2009.

Revised 05/21/2009  MPTAC review. Modified position statements to: (1) include new hyaluronan product (Synvisc-One) as medically necessary (2) clarify that hyaluronan injections for other musculoskeletal conditions including but not limited to osteoarthritis of the ankle, shoulder and hip, are considered investigational and not medically necessary. Updated Rationale, Background/Overview, Coding, References, Index and History sections.

Revised 05/15/2008  MPTAC review. Medical necessity criteria revised to include the requirement that there is documentation that the patient has failed to respond adequately to conservative nonpharmacologic therapy (e.g., activity modification, home exercises, protective weight bearing) and to simple analgesics, e.g., acetaminophen. Updated review date, References and History sections.

01/01/2008 Updated Coding section with 01/01/2008 HCPCS changes; removed HCPCS Q4083, Q4084, Q4085, Q4086 deleted 12/31/2007. The phrase “investigational/not medically necessary” was clarified to read “investigational and not medically necessary.” This change was approved at the November 29, 2007 MPTAC meeting.

Reviewed 05/17/2007  MPTAC review. Updated References, review date and History section. Coding section updated; removed HCPCS J7319.

01/01/2007 Updated Coding section with 01/01/2007 CPT/HCPCS changes; removed HCPCS J7317, J7320 deleted 12/31/2006.

Revised 06/08/2006  MPTAC review. Revised language to (1) Remove brand names from Position Statement and the Background/Overview sections of the document. (2) Expanded the Index section to include generic names and Euflexxa™.

Reviewed 03/23/2006  MPTAC review.


Pre-Merger Organizations

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<th>Pre-Merger Organizations</th>
<th>Initial Effective Date</th>
<th>Document Number</th>
<th>Title</th>
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<td>10/27/2004</td>
<td>DRUG.00017</td>
<td>Hyaluronan Injections for Musculoskeletal Conditions</td>
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Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The member’s contract benefits in effect on the date that services are rendered must be used. Medical Policy, which addresses medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

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