

**April 1, 2026**

**PROVIDER ALERT: Preferred Viscosupplementation Products for  
Knee Osteoarthritis**

**EFFECTIVE DATE: Dates of Service on or after May 1, 2026**

This notice is to inform you of an upcoming update to coverage criteria for **viscosupplementation injections used in the treatment of knee osteoarthritis.**

This change will take effect **30 days from the date of this notice.**

Viscosupplementation injections are considered medically necessary for the treatment of knee osteoarthritis when clinical criteria are met.

Coverage will be **limited to the following preferred products:**

- Durolane (J7318)
- Gel-One (J7326)
- Euflexxa (J7323)

All other viscosupplementation products will be considered **non-preferred** and **not covered** unless **medical necessity is demonstrated and prior authorization is approved.**

Providers prescribing viscosupplementation therapies should review current treatment plans and ensure the use of preferred products whenever clinically appropriate. Requests for non-preferred products must include supporting documentation demonstrating medical necessity.

**Prior authorization is required for the above preferred products.**

For questions concerning this Provider Alert, please contact the MedStar Family Choice District of Columbia Provider Customer Service Department, Monday through Friday, 8 a.m. to 5:30 p.m. at **800-261-3371** or by email: [mfcfdc-providerrelations@medstar.net](mailto:mfcfdc-providerrelations@medstar.net)

<b>MEDSTAR FAMILY CHOICE - DC QUICK AUTHORIZATION GUIDE</b>  <i>Effective 05/01/2026</i>	<b>MEDSTAR FAMILY CHOICE DC Healthy Families</b>
<b>ALL OUT-OF-NETWORK/ NON-PAR SERVICE</b>	<b>Prior Authorization Required</b>
Emergency Medical Conditions (ED)	No Prior Authorization Required
INPATIENT Elective Procedures (in network or out of network)	Prior Authorization Required
INPATIENT & OUTPATIENT Admission for a Psychiatric diagnosis when the Bed Type is for Psychiatric Services (in network or out of network)	Prior Authorization Required
<b>OUTPATIENT In-Network (Practitioner AND Facility)</b>  Facility based procedures (includes outpatient Chemotherapy and Radiation Therapy)	No Prior Authorization Required, <u>unless included below</u> under the 'Exceptions Requiring Prior Authorization' section  (See <b>EXCEPTIONS</b> below)
<b>EXCEPTIONS REQUIRING PRIOR AUTHORIZATION</b>	
ABA Services	Prior Authorization Required
<b>Abortions</b>  	Elective Therapeutic Abortions are <b>NOT A COVERED BENEFIT</b> by MFC-DC.  <b>Prior Authorization Required</b> for Medical Abortions ONLY if the Federal Criteria are met
Acupuncture for Children < 21 years old	Prior Authorization Required for >10 visits <i>per calendar year</i>
Acupuncture for Enrollees ≥21 years old	<b>NOT A COVERED BENEFIT</b>
<b>Audiology Services Cochlear Implants</b>	<b>Prior Authorization Required</b> for: - Cochlear implant (BAHA) devices. - Replacement components (except microphone,
Bariatric Surgery Program - Including OP Surgeries	Prior Authorization Required
Cardiac Rehabilitation	Prior Authorization Required
Chiropractic Services for Enrollees <21 years old	Prior Authorization Required for >10 visits <i>per calendar year</i>
Chiropractic Services for Enrollees ≥21 years old	<b>NOT A COVERED BENEFIT</b>
Clinical Trials	Prior Authorization Required

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<p>Cosmetic procedures</p>	<p><b>NOT A COVERED BENEFIT</b> Examples of cosmetic procedures include (but not limited to): -Breast reduction (male or female) -Blepharoplasty -Brow ptosis -Rhinoplasty -Sclerotherapy -Septoplasty -Skin tag removal -Panniculectomy</p>
<p>Coumadin Clinics</p>	<p><b>Prior Authorization Required</b></p>
<p>Diabetes and Nutritional Counseling</p>	<p><b>Prior Authorization Required</b> after &gt; THREE (3) visits <i>per Calendar Year</i> (Office, Homecare or Hospital Based services)</p>
<p>Early Intervention Services</p>	<p><b>Prior Authorization Required</b></p>
<p>Epidural injections (cervical and lumbar) Facet blocks Rhizotomies SI Joint</p>	<p><b>No</b> Prior Authorization Required</p>
<p>Erectile Dysfunction Procedures</p>	<p><b>Prior Authorization Required</b></p>
<p>Eye procedures and surgeries</p>	<p><b>Prior Authorization Required</b> for: -Blepharoplasty; -Capsulotomy; -Corneal relaxing incision for correction of surgically induced astigmatism; -Corneal wedge resection for correction of surgically induced astigmatism; -Destruction of lesion of lid margin; -Ectropion repair; -Entropion repair; -Eyelid lesion excision or reconstruction; -Implantation of Intraocular devices; -Insertion of intraocular lens prosthesis (secondary implant) not associated with concurrent cataract removal; -Keratoplasty, -Orbital Prosthesis; -Ptosis repair; -Radial keratotomy; -Strabismus repair; <i>* Some eye procedure may be found under the Cosmetic Procedures *</i></p>
<p>Genetic Counseling</p>	<p><b>Prior Authorization Required</b></p>
<p>Genetic Testing</p>	<p><b>Prior Authorization Required</b></p>
<p>Gender Reassignment Surgery/Transgender Surgery</p>	<p><b>Prior Authorization Required</b></p>

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Heart Failure Clinics	Prior Authorization Required
Medications - High Cost Med List	<p><b>Prior Authorization Required</b> whether being administered inpatient or outpatient for the following medications:</p> <p>Abecma, Actimmune, <b>Adcetris</b>, Amondys 45,  <b>Blincyto</b>, Breyanzi,  Cablivi, Carvykti, <b>Cerezyme</b>, Cinryze, <b>Crysvita</b>,  Danyelza,  Elaprase, Empaveli, Evkeeza,  Gattex,  Haegarda, Hemlibra,  Kimmtrak, Korlym, <b>Krystexxa</b>,  Myalept,  <b>Nexvazyme</b>, Novoseven, Nulibry,  Onpattro, Orfadin, Orladeyo, Oxlumo,  Poteligeo, <b>Procysbi</b>, Pyrukynd,  Ravicti, Revcovi,  Scemblix, Soliris, Spinraza,  Takhzyro, <b>Tepezza</b>, <b>Tivdak</b>,  Ultomiris, <b>Uplizna</b>, Viltepsa, Vimizim, <b>Vyondys 53</b>, Vyvgart,  Yervoy,  Zolgensma, <b>Zynlonta</b></p> <p><b>Post-administration retrospective requests for authorization will not be accepted for review.</b></p>
Home Health Care	Prior Authorization Required for all visits
Hospice Care (IP and OP) Skilled Nursing Facility Acute Rehab Facility	Prior Authorization Required <b>Custodial Care (long-term care) not covered by the MCO</b>
Hyperbaric Oxygen	Prior Authorization Required
Infertility Services	NOT A COVERED BENEFIT
Infusion Services (in the Home and Free-Standing Facility)	No Prior Authorization Required for the Home Infusion Therapy or Medications from in-network provider

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<b>Investigational Surgery Emerging Technology, Services, Procedures (Also See Clinical Trials)</b>	<b>Prior Authorization Required</b>			
<b>Laboratory Services (includes Genetic Testing)</b>	<b>No Prior Authorization Required</b> if done at an in-network freestanding lab facility.			
<b>Biosimilar Medical Drug Formulary</b>	The following drugs require prior authorization.			
	<b>Chemical Name (Drug Class)</b>	<b>HCPDS</b>	<b>Preferred Products</b>	<b>Non-Preferred Products</b>
	Aflibercept (VEGF Inhibitor)	Q5147	Pavblu	Eylea J0178
	Bevacizumab (VEGF inhibitor)	Q5118	Zirabev	Avastin J9035 Mvasi Q5107 Vegzelma Q5129
	Infliximab (TNF inhibitor)	Q5121	Avsola	Remicade J1745 Renflexis Q5104 Inflectra Q5103
	Pegfilgrastim (Hematopoietic agent)	Q5108	Fulphila	NeulastaJ2506 Fylnetra Q5130 Nyvepria Q5122 Stimufend Q5127
	Ranibizumab (VEGF Inhibitor)	Q5128	Cimerli	Lucentis J2778 Byooviz Q5124
	Rituximab (Anti-CD20 monoclonal antibody)	Fara	Riabni Ruxience	Rituxan J9312 Truxima Q5115
	Tocilizumab (IL-6 antagonist)	Q5135	Tyenne	Actemra J3262 Tofidence Q5133
	Trastuzumab (HER2 receptor antagonist)	Q5114 Q5113	Ogivri Herzuma	Herceptin J9355 Kanjinti Q5117 Ontruzant Q5112 Trazimera Q5116
	Denosumab (RANKL inhibitor)	Q5136 Q5157	Jubbonti/Wyost Stoboclo/Osenvelt	Prolia/Xgeva J0897
	Ustekinumab (IL-23 inhibitor)	Q5100 Q5099	Yesintek Steqeyma	Stelara J3357, AJ3358 Otulfi Q9999 Selarsdi Q9998 Wezlana Q5137
<b>Medical Drug Buy and Bill</b>	Prior Authorization Required for all J and Q codes listed on the DC Fee Schedule that have a PA (prior auth) associated with them. Please check the DC Fee Schedule for those drugs.			

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<p>Mount Washington Pediatric Hospital Services (Weight Smart Program/Outpatient Feeding Program and Sleep Studies)</p>	<p>Prior Authorization Required</p>
<p>Neuropsychological Testing</p>	<p>Prior Authorization Required</p>
<p>Outpatient Rehabilitation Services Physical Therapy (PT) Occupational Therapy (OT) Speech Language Pathology (SLP)</p>	<p>Prior Authorization Required <u>after &gt;30 visits per calendar year</u></p>
<p>Personal Care Aide (PCA)</p>	<p>Prior Authorization Required</p> <p>For Assessments (Initial/ Recertification/condition change): Submit <b>ePOF</b> (Electronic Prescription Order Form), along with any clinical information from the PCP/ treating physician via <a href="#">DHCF portal</a></p>
<p>PET Scans</p>	<p>No Prior Authorization Required if performed at participating free-standing facilities or at contracted hospital</p>
<p>Private Duty Nursing</p>	<p>Prior Authorization Required</p>
<p>Pulmonary Rehabilitation</p>	<p>Prior Authorization Required</p>
<p>Radiology: CT Scans, MRI's, X-RAYS, Nuclear Medicine, Sonograms, Digital Mammography</p>	<p>No Prior Authorization Required if performed at a participating free-standing facilities or at a contracted hospital.</p>
<p>Site of Service Prior Authorization Requirements</p>	<p>The following codes No Prior auth required if performed in an in network Ambulatory Surgery Center POS 24. Prior auth required in Off Campus Outpatient Hospitals POS 19, On Campus Outpatient Hospital POS 22 and Out of network. CPT Codes: 29888, 42820, 43239, 45378, 45379, 45380, 45381, 45382, 45384, 45385, 45386, 45388, 45389, 45390, 45391, 45392, 45393, 45398, G0105 and G0121</p>
<p>Sleep Studies and Polysomnograms</p>	<p>No Prior Authorization Required if performed at a participating free-standing facilities or at a contracted hospital.</p>
<p>Spinal Cord Stimulators, Vagus Nerve Stimulators and Sacral Nerve and Peripheral Nerve Stimulators trial and implantation</p>	<p>Prior Authorization Required</p>
<p>Sterilization Reversals</p>	<p>NOT A COVERED BENEFIT</p>
<p>Transplant Services: Pre-Transplant and Post- Transplant services</p>	<p>Prior Authorization Required</p> <p>HLA Testing for BMT requires prior authorization.</p>
<p>Transplant Surgery</p>	<p>Prior Authorization Required <b>BY DHCF</b> for the Transplant surgery. MFC-DC only covers pre and post transplant services.</p>
<p>Viscosupplementation for Knee Osteoarthritis</p>	<p>The following drugs require prior authorization. Durolane J7318 Gel-One J7326 Euflexa J7323</p>
<p>Transportation: - Ambulance - Van Transport - Wheelchair</p>	<p>No Prior Authorization Required for: - PAR Vendors - DC Fire and Emergency Medical Services (DC FEMS); and - Urgent hospital to hospital transfers</p> <p>Prior Authorization Required for: Non PAR vendors</p>

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<b>DME:</b> <b>PAR providers - Prior authorization required for items billed &gt; \$1000 or rental equipment over 90 days.</b> <b>Non PAR providers - Prior authorization required regardless of cost.</b>	*Visit website or contact Enrollee Services (1-888-404-3549) for in-network providers.
<b>Custom shoes</b> <b>Diabetic Shoes</b> <b>Orthotics (Braces, Splints)</b> <b>Prosthetics</b>	Prior Authorization Required per item billed over \$500 or exceeds Max Units for PAR provider.  No Prior Authorization Required for CAM Walking Boots. The specific codes are: <b>L4360, L4361, L4386, L4387</b>
<b>Hearing Aids</b> <b>Cochlear Implants</b> <b>Auditory Osseointegrated Devices</b>	Prior Authorization Required for: - All Hearing Aids - All auditory osseointegrated devices (BAHA) - Cochlear implant devices and replacement components (except microphone, transmitting cables and transmitting coils) - Repair and replacement of any hearing devices
<b>Insulin Pumps</b> <b>Continuous Glucose Monitors</b>	Prior Authorization Required No Prior Authorization Required only for FREESTYLE LIBRE
<b>Soft supplies and disposable items:</b> <b>Includes enteral/parenteral supplies, batteries, ear molds, components for hearing aids, cochlear implant or auditory osseointegrated devices</b>	Prior Authorization Required per item billed over \$750, per Enrollee/per provider/per month for PAR providers.  *Visit our website or contact Enrollee Services (1-888-404-3549) for In-Network providers.

\*Please visit our website at [MedStarFamilyChoiceDC.com](http://MedStarFamilyChoiceDC.com) for assistance with finding in network vendors, physicians or facilities.

\*\*\* This is a Quick Authorization Guide.

It is not meant to be all inclusive.

For questions, please contact MFC-DC at: 1-(855)-798-

4244; Local: (202)-363-4348

The codes and guidance in this document is subject to Enrollee eligibility and the existence of coverage per the DC Medicaid Fee Schedule on the date of service.