Administrative Policy Statement
INDIANA MEDICAID

Policy Name		Policy Number	Date Effective
Medical Necessity for DAW		PAD-0007-IN-MCD	03/15/2023
Policy Type			
Medical	ADMINISTRATIVE	Pharmacy	Reimbursement

Administrative Policy Statements prepared by CSMG Co. and its affiliates (including CareSource) are derived from literature based on and supported by clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new7 (ndar)0t guiand itnes, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

Administrative Policy Statements prepared by CSMG Co. and its affiliates (including CareSource) do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced in the Administrative Policy Statement. If there is a conflict between the Administrative Policy Statement and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.

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Periodic Screening, Diagnosis, and Treatment (ESPDT) on a case-by-case basis in addition to the criteria above.

Refer to the product package insert for dosing, administration and safety guidelines.

E. Conditions of Coverage

As above.

F. Related Policies/Rules

Medical Necessity – Off Label

G. Review/Revision History

DATES		ACTION
Date Issued	08/01/2018	
Date Revised	08/01/2020	Reviewed content, transferred to new template, added note about non-coverage of off-label/non-supported use.
	10/28/2022	Section D, part I: Changed bullet A to address inefficacy rather than adverse events, since adverse events are addressed in part II. Created criteria to specify durations of approval and requirements for re-authorization. Made grammatical/wording changes for readability.
	3/1/2023	Added note on EPSDT.
Date Effective	3/15/2023	