



## ADMINISTRATIVE POLICY STATEMENT OHIO MEDICAID

<b>Original Issue Date</b>	<b>Next Annual Review</b>	<b>Effective Date</b>
	8/01/2019	08/01/2018
<b>Policy Name</b>		<b>Policy Number</b>
Medical Necessity for DAW		PAD-0005-OH-MCD
<b>Policy Type</b>		
Medical	<b>ADMINISTRATIVE</b>	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 new morbidity, 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.

F.

RELATED POLICIES/RULES.....	4
G. REVIEW/REVISION HISTORY .....	4
H. REFERENCES.....	4



- Formulary Drug List: a list of prescription drugs which includes a group of selected generic and brand-

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

**E. CONDITIONS OF COVERAGE**

As above.

**F. RELATED POLICIES/RULES**

None applicable.

**G. REVIEW/REVISION HISTORY** e f 98 12. 0.48 04f 0.9107(RS(a)1cR.48 ed ( )Tj 0.30/sB8

DATES	ACTION
-------	--------