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TITLE 405 OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES

LSA Document #02-1(E)

DIGEST

Temporary amends 405 IAC 5-3-10 and 405 IAC 5-3-13 to revise prior authorization requirements for drugs covered by the Medicaid program. Temporarily adds provisions to set forth procedures and limits for imposing prior authorization for drugs covered by the Medicaid program; to set forth limitations that may be placed on drugs, and; to set forth risk-based managed care exception. Authority: IC 4-22-2-37.1; IC 12-8-1-12. Effective January 7, 2002.

SECTION 1. **Prior authorization requests may be submitted by any of the following:**
(1) Doctor of medicine.
(2) Doctor of osteopathy.
(3) Dentist.
(4) Optometrist.
(5) Podiatrist.
(6) Chiropractor.
(7) Psychologist endorsed as a health service provider in psychology (HSPP).
(8) Home health agency.
(9) Hospitals.
(10) For drugs subject to prior authorization, any provider with prescriptive authority under Indiana law.
Requests from other provider types will not be accepted except for transportation services.

SECTION 2. **(a) Medicaid reimbursement is available for the following services with prior authorization:**
(1) Reduction mammoplasties.
(2) Rhinoplasty or bridge repair of the nose when related to a significant obstructive breathing problem.
(3) Intersex surgery.
(4) Blepharoplasties for a significant obstructive vision problem.
(5) Sliding mandibular osteotomies for prognathism or micrognathism.
(6) Reconstructive or plastic surgery.
(7) Bone marrow or stem cell transplants.
(8) All organ transplants covered by the Medicaid program.
(9) Plasmapheresis.
(10) Strabismus surgery for patients over ten (10) years of age.
(11) Home health services.
(12) Maxillofacial surgeries related to diseases and conditions of the jaws and contiguous structures.
(13) Temporomandibular joint surgery.
(14) Submucous resection of nasal septum and septoplasty when associated with significant obstruction.
(15) Hysterectomy.
(16) Tonsillectomy.
(17) Tonsillectomy and adenoidectomy.
(18) Cataract extraction.
(19) Surgical procedures involving the foot.
(20) Weight reduction surgery, including gastroplasty and related gastrointestinal surgery.
(21) Any procedure ordinarily rendered on an outpatient basis, when rendered on an inpatient basis.
(22) All dental admissions.
(23) Stress electrocardiograms except for medical conditions.

(24) Brand medically necessary drugs.
(25) Other drugs as specified in accordance with 405 IAC 5-24-8.5.
(26) Psychiatric inpatient admissions, including admissions for substance abuse.
(27) Rehabilitation inpatient admissions.
(28) As otherwise specified in this article.
If any of the surgeries listed in this section are performed during a hospital stay for another condition, prior authorization is required for the surgical procedure.

(b) Requests for prior authorization for the surgical procedures in this section will be reviewed for medical necessity on a case-by-case basis in accordance with this rule.

SECTION 3. **(a) Except as provided in SECTION 4 of this document, the office may, in compliance with all state and federal laws that may govern Medicaid prior authorization programs, establish prior authorization requirements for other drugs covered under Medicaid. Before any single source drug is placed on prior authorization in the fee for service program, the office will seek the advice of the drug utilization review board established under IC 12-15-35 at a public meeting held by the board. The single source drugs subsequently identified as subject to prior authorization under this section shall be published in a provider bulletin. Any provider bulletin described in this section shall be made effective no earlier than permitted under IC 12-15-13-6(a).**

(b) The prior authorization number assigned to the approved request must be included on the prescription or drug order issued by the prescriber or relayed to the dispensing pharmacist by the prescriber if the prescription is orally transmitted. Prior authorization will be determined in accordance with the provisions of 405 IAC 5-3 and 42 U.S.C. 1396r-8(d)(5).

SECTION 4. **(a) Central nervous system drugs classified by Drug Facts and Comparisons (published by Facts and Comparisons Division of J.B. Lippincott Company) as antianxiety, antidepressant, or antipsychotic agents, or any drugs cross-indicated (according to The American Psychiatric Press Textbook of Psychopharmacology, The Current Clinical Strategies for Psychiatry, Drug Facts and Comparison, or other publications of similar content and focus) to these classifications will not be placed on prior authorization in the fee for service Medicaid program. Drugs classified in any new category or classification of central nervous system agents (according to Drug Facts and Comparisons) created after the effective date of this rule, when prescribed for the treatment of mental illness (as defined in the latest edition of the Diganostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association), will not be placed on prior authorization in the fee for service Medicaid program. As used in this subsection, "cross-indicated" means a drug that is being used for a purpose generally held to be reasonable, appropriate, and within community standards of practice, even though the use is not included in the FDA-approved labeled indications for the drug.**

(b) Brand name multisource drugs described in subsection (a) shall not be subject to prior authorization under 405 IAC 5-24-8.

(c) A recipient enrolled in the fee for service Medicaid program shall have unrestricted access to the drugs described in this section, except as provided in SECTION 5 of this document.

SECTION 5. **Nothing in this document or 405 IAC 5-24 prohibits the office from placing limits on quantities dispensed or frequency of refills for any drug for purposes of preventing fraud, abuse, waste, overutilization, inappropriate utilization, or implementing disease management. In formulating any such limitations, the office will take into account quality of care and the best interests of Medicaid recipients. Before imposing any limits on quantities dispensed or frequency of refills for any drug, the office will seek the advice of the drug utilization review board established under IC 12-15-35 at a public meeting held by the board. Any limitations imposed shall be published in a provider bulletin. Any provider bulletin described in this subsection shall be made effective no earlier than permitted under IC 12-15-13-6(a).**

SECTION 6. **The use of prior authorization programs or formularies in risk-based managed care shall be subject to IC 12-15-35-46 and IC 12-15-35-47 and are not governed by this document.**

SECTION 7. **This document expires April 7, 2002.**

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