4123-6-21 **Payment for outpatient medication.**

(A) Medication must be for the treatment of an occupational injury or disease in a claim either allowed by an order of the bureau or the industrial commission, or recognized by a self-insuring employer. The bureau may deny a therapeutic class of drugs as not being reasonably related to or medically necessary for treatment of the allowed conditions in a claim.

(B) Medication must be prescribed by the physician of record in the industrial claim or by the treating physician, or by such other treating provider as may be authorized by law to prescribe such medication.

(C) Drugs covered are limited to those that are approved for use in the United States by the Food and Drug Administration and that are dispensed by a registered pharmacist from an enrolled pharmacy provider.

(D) The bureau may require prior authorization of certain drugs or therapeutic classes of drugs, and shall publish a list of all such drugs or therapeutic classes of drugs for which prior authorization is required.

(E) Drugs which fall into one of the following categories may be approved and reimbursed by an MCO as part of a comprehensive treatment plan submitted by the physician of record or treating physician:

(1) Drugs for the treatment of obesity;

(2) Drugs for the treatment of infertility;

(3) Drug Efficacy Study Implementation (DESI) drugs or drugs that may have been determined to be identical, similar, or related;

(4) Extemporaneous or simple compounded prescriptions;

(5) Injectable drugs not intended for self-administration;

(6) Drugs used to aid in smoking cessation;

(7) Drugs dispensed to a claimant while the claimant is admitted to a hospital during an approved inpatient admission or during the course of an outpatient visit in a hospital.

Drugs approved by the MCO under this rule shall not be reimbursed through the bureau's pharmacy benefits management vendor.

(F) Payment for medications to pharmacy providers shall include a product cost component and a dispensing fee component.

(1) The product cost component shall be the lesser of the following: maximum

allowable cost, if applicable, or the average wholesale price of the commonly stocked package size plus or minus a percentage. The percentage amount added or subtracted from the average wholesale price shall be determined by the bureau, and shall be subject to annual review.

(2) The dispensing fee component shall be a flat rate fee, which shall be subject to annual review.

(a) Only pharmacy providers are eligible to receive a dispensing fee.

(b) The dispensing fee may include an additional incentive component for pharmacy providers that accept assignment.

(c) Except as provided below, dispensing fees shall be limited to one dispensing fee per patient per generic code number (GCN) per rolling twenty-five days. Exceptions to the single dispensing fee are:

(i) Cases where the physician has prescribed a second round of medication within the twenty-five day period;

(ii) Cases where the physician has changed the dosage;

(iii) Cases where the medication did not last for the intended days supply;

(iv) Cases where the medication has been lost, stolen or destroyed;

(v) Controlled substances (which are limited to two dispensing fees per twenty-five days).

(G) The pharmacy provider is required to bill medication at their usual and customary charge. The amount paid to the provider will be the lesser of the provider's usual and customary charge or the reimbursement allowed as determined by the bureau. Pharmacy providers are required to submit for billing the national drug code of the stock bottle from which the dispensed medication is obtained. Drugs may be dispensed in unit dose packaging, but the NDC number of the closest comparable bulk package listed in the bureau or vendor payment system must be used for billing purposes.

(H) The bureau may establish a maximum allowable cost for medications which are pharmaceutically and therapeutically equivalent, that is, contain identical doses of the active ingredient and have the same biological effects as determined by the food and drug administration (FDA) and designated by an "A" code value in the FDA publication, "Approved Drug Products With Therapeutic Equivalence Evaluations." The methodology used to determine a maximum allowable cost for a qualified drug product shall be determined by the medical policy department and shall be subject to annual review. The bureau may choose to utilize the maximum allowable cost

list of a vendor or develop its own maximum allowable cost list.

(I) Claimants who request a brand name drug or whose physician specifies a brand name drug designated by "dispense as written" on the prescription for a medication which has an applicable maximum allowable cost price shall be liable for the product cost difference between the established maximum allowable cost price of the drug product and the average wholesale price plus or minus the bureau established percentage of the dispensed brand name drug.

(J) The following dispensing limitations may be adopted by the bureau:

(1) The bureau may publish a list of drugs identifying those drugs that are considered "chronic" medications. Drugs not identified as "chronic" medications shall be considered "acute" medications.

(2) The bureau may publish supply limitations for acute and chronic drugs which represent the maximum number of days supply that may be dispensed at any one time for a single prescription.

(3) The bureau may publish maximum prescription quantities which represent the largest number of units per drug that may be dispensed at any one time for a single prescription

(4) Requests submitted that exceed any published days supply limit or maximum quantity limit shall be denied. Denials may be overridden by the bureau in cases where medical necessity and appropriateness have been determined.

(5) Refills requested before seventy-five per cent of any published days supply limit has been utilized will be denied, except in cases where the dosage of a noncontrolled drug has been increased and has a new prescription number. Denials may be overridden by the bureau for the following documented reasons:

(a) Previous supply was lost, stolen or destroyed;

(b) Pharmacist entered previous wrong day supply;

(c) Out of country vacation or travel;

(d) Hospital or police kept the medication.

(K) Through internal development or through vendor contracts, an on-line point-of-service adjudication system may be implemented. Upon implementation, pharmacy providers may be required to submit bills for medication by an on-line point-of-service authorization terminal or a host-to-host link with the established bill processing system as a condition of provider enrollment or reimbursement. Submission by paper or by tape-to-tape may be refused upon implementation of an

on-line point-of-service system.

(L) Claimant reimbursement for medications shall not exceed the bureau's established rate for the medication regardless of the price paid by the claimant. Upon implementation of a point-of-service system, claimant reimbursement may be limited to the following situations:

(1) Claimants whose claims are not allowed on the date of service;

(2) Emergency situations where an enrolled pharmacy provider with point-of-service capabilities is not available;

(3) Claimants who reside out of the country.

(M) The bureau may formulate medication utilization protocols for select conditions or diseases consistent with one or more of the following

(1) Compendia consistent of the following:

(a) "United States Pharmacopoeia - Drug Information";

(b) "American Medical Association Drug Evaluations";

(c) "Drug Facts and Comparisons"; or,

(2) Peer reviewed medical literature.

Compliance with the established protocols shall be monitored through the on-line, point-of-service adjudication system. Refusal to comply with the established protocols shall result in refusal of reimbursement for the medications which are not within the established protocols. This rule does not require the discontinuation of treatment with medications that are not within the established protocols, but simply states the bureau's refusal to reimburse for such medications.

(N) A "pharmacy provider" designation and provider number can be obtained by a provider who meets all the following criteria:

(1) Has a valid "terminal distributor of dangerous drugs" as defined in section 4729.02 of the Revised Code if located within Ohio; or an equivalent state license if located outside of Ohio; and,

(2) Has a valid drug enforcement agency (DEA) number; and,

(3) Has a licensed registered pharmacist in full and actual charge of a pharmacy. ; and,

(4) Has the ability and agrees to submit bills at the point of service.

All state and federal laws relating to the practice of pharmacy and the dispensing of medication by a duly licensed pharmacist must be observed.

(O) The bureau may contract with a vendor to perform drug utilization review and on-line bill processing, maintain a pharmacy provider network and prior authorization program for medications, and provide management reports. The bureau or its vendor may also contract rebate agreements with drug manufacturers, and be responsible for maintaining a drug formulary. The bureau may utilize other services or established procedures of the vendor which may enable the bureau to control costs and utilization and detect fraud.

(P) The bureau may identify circumstances under which it may consider reimbursement for pharmacist professional services (also known as cognitive services) when payment for such services results in a measurable, positive outcome. The bureau shall be responsible for developing the criteria which will be used to assess the compensability of billed pharmacist professional services. The bureau shall be responsible for developing the structure of the reporting of the measurable outcomes used to justify the payment of pharmacist professional services. The amount that could be reimbursed for pharmacist professional services shall be determined by the bureau's medical policy department.

(Q) The bureau shall secure the services of a pharmacist to assist the bureau in the review of drug bills. The bureau may employ a staff pharmacist on a full or part-time basis or may contract for such services. The pharmacist may assist the bureau in determining the appropriateness, eligibility, and reasonableness of compensation payments for drug services. The bureau may consult with a pharmacy and therapeutics committee, which shall be a subcommittee of the stakeholders' health care quality assurance advisory committee established by rule 4123-6-22 of the Administrative Code, on the development and ongoing annual review of a drug formulary and other issues regarding medications.

(R) The bureau will publish line by line billing instructions in a health care provider billing and reimbursement manual. At least thirty days written notice will be given prior to required changes in billing procedures.

Replaces:	4123-6-21
Effective:	10/01/2005
R.C. 119.032 review dates:	03/01/2009

CERTIFIED ELECTRONICALLY

Certification

05/19/2005

Date

Promulgated Under:	119.03
Statutory Authority:	4121.12, 4121.121, 4121.30, 4121.31, 4121.44, 4121.441, 4123.05, 4123.66
Rule Amplifies:	4121.121, 4121.44, 4121.441, 4123.66
Prior Effective Dates:	1/27/97, 1/1/03