4123-6-21 **Payment for 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.

(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) An allowed condition in the claim must be included as an FDA-approved use of a prescribed medication or be widely accepted as an appropriate use of a prescribed medication in order for the medication to be considered for reimbursement.

(D) Payment for medications to pharmacy providers shall include a product cost component and a dispensing fee component. 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 dispensing fee component will be a flat rate fee. The percentage amount added or subtracted from the average wholesale price and the dispensing fee rate shall be subject to annual review. Payment for extemporaneous or simple compounded medications will be made at the same rate as that of other medications. 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 or its agent. Pharmacy providers are required to submit for billing the national drug code of the stock bottle from which the dispensed medication is obtained.

(E) A maximum allowable cost may be established 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 management and cost containment division's medical policy department and shall be subject to annual review. The bureau may choose to utilize the maximum allowable cost list for a vendor or utilize other available methodologies, such as the health care finance administration's federal upper limit (FUL) list.

(F) 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, if prior authorization for the brand name drug is not obtained by the prescriber.

(G) 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.

(H) Claimant reimbursement 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.

(I) The bureau or its agent 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.

(J) 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.

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

(K) Medications dispensed to a claimant while the claimant is admitted to a hospital during an approved inpatient admission or to a claimant during the course of an outpatient visit in a hospital are excluded from this rule. Charges for this medication should be filed on the standard hospital billing form approved for use by the bureau. Providers who do not qualify as a pharmacy provider but who may administer parenteral medications to injured workers should bill for those administered parenteral medications using the appropriate CPT code on the appropriate billing form.

(L) 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, be responsible for maintaining a drug formulary, and establish and enforce dispensing limitations. The bureau or its agent may utilize other services or established procedures of the vendor which may enable the bureau or its agent to control costs and utilization and detect fraud.

(M) The bureau or its agent will consider reimbursement for compounded parenteral and sterile product prescriptions and parenteral and enteral nutrition products at a rate established by the administrator with the assistance of the bureau's medical management and cost containment division as authorized by section 4121.121 of the Revised Code. The method of reimbursement may include, but is not limited to, use of per diem rates, percent of allowed charge, usual, customary, and reasonable rates, or rates based on ingredient cost of the therapy.

(N) The bureau or its agent may consider reimbursement for pharmacist professional services (also known as cognitive services) on a case-by-case basis in which payment for such services results in a measurable, positive outcome. The bureau or its agent shall be responsible for developing the criteria which will be used to assess the compensability of billed pharmacist professional services. The bureau or its agent 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 management and cost containment division.

Effective:

R.C. 119.032 review dates: 10/15/2002

_____

Certification

_____

Date

Promulgated Under:	119.03
Statutory Authority:	4121.12, 4121.30, 4121.31, 4123.05
Rule Amplifies:	4121.121, 4121.44, 4121.441, 4123.66
Prior Effective Dates:	01/27/97