Ohio Administrative Code

Rule 4123-6-21.1 Payment for outpatient medication by self-insuring employer.

Effective: February 16, 2026

(A) Medication must be for treatment of a work related injury or occupational disease in a claim either allowed by an order of the bureau or the industrial commission, or recognized by a self-insuring employer.

(B) Any treating provider authorized by law to prescribe medication may prescribe such medication.

(C) Drugs covered in self-insuring employer claims are limited to those that are approved for human use in the United States by the food and drug administration (FDA) and that are dispensed by a registered pharmacist from a pharmacy provider.

(D) A self-insuring employer may approve and reimburse for various drugs as a part of a comprehensive treatment plan submitted by the physician of record or a treating physician when reasonably related to and medically necessary for treatment of the allowed conditions in the claim, provided that such approval and reimbursement shall not constitute the recognition of any additional conditions in the claim even if such drugs are used to treat conditions that have not been allowed in the claim.

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

(1) Except as provided in this paragraph, the product cost component shall be the lesser of the following, unless the self-insuring employer has negotiated a payment rate with the pharmacy provider pursuant to rule 4123-6-46 of the Administrative Code: the provider's billed charge, the maximum allowable cost established under paragraph (N) of this rule, if applicable, or the average wholesale price (AWP) of the commonly stocked package size minus fifteen per cent.

(a) For repackaged brand name medications, the product cost component shall be calculated using the AWP of the original labeler.

(b) For compounded prescriptions, the product cost component shall be limited to the lesser of the maximum allowable cost, if applicable, for each ingredient or the AWP of the commonly stocked package size minus fifteen per cent for each ingredient.

(c) The maximum product cost component reimbursement for any one non-sterile compounded prescription will be one hundred dollars.

(2) Only pharmacy providers are eligible to receive a dispensing fee component. Unless the self-insuring employer has negotiated a payment rate with the pharmacy provider pursuant to rule 4123-6-46 of the Administrative Code or a different dispensing fee is required by law for the state in which the pharmacy is located for prescriptions filled outside of Ohio, the dispensing fee component will be paid as follows:

(a) For non-compounded prescriptions, the dispensing fee component shall be three dollars and fifty cents.

(b) For sterile and non-sterile compounded prescriptions, the dispensing fee component shall be based on the time necessary to compound, as follows:

(i) One to four minutes: fifteen dollars;

(ii) Five to fourteen minutes: twenty-five dollars;

(iii) Fifteen to twenty-nine minutes: thirty-five dollars;

(iv) Thirty to fifty-nine minutes: fifty dollars;

(v) Sixty or more minutes: seventy-five dollars.

(F) The pharmacy provider is required to bill medication at their usual and customary charge. Pharmacy providers are required to submit for billing the national drug code (NDC) number 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.

(G) The pharmacy provider shall:

(1) Include prescriber information within bills submitted electronically to the self-insuring employer or its vendor for payment. The prescriber information must include the national provider identifier (NPI);

(2) Not pay, allow, or give, or offer to pay, allow, or give, any consideration, money, or other thing of value to an injured worker, of to any other person, firm, or corporation (including but not limited to free or discounted medications or other goods or services) as an inducement to or in return for the injured worker ordering or receiving from the provider any medications or other goods or services for which payment may be made by the self-insuring employer or its vendor or QHP under Chapter 4121., 4123., 4127., or 4131. of the Revised Code;

(3) Comply with all applicable billing instructions contained in the bureau's provider billing and reimbursement manual in effect on the billed date(s) of service.

(H) Claimant reimbursement for medications shall be in accordance with rule 4123-6-26 of the Administrative Code and shall at least be equal to the bureau's established rate for the medication, unless the self-insuring employer has negotiated a payment rate with the pharmacy provider utilized by the claimant pursuant to rule 4123-6-46 of the Administrative Code, in which case the claimant reimbursement shall be at least the rate negotiated with the provider. Requests for reimbursement must be paid within thirty days of receipt of the request.

(I) Self-insuring employers must obtain a drug utilization review from a physician before terminating payment for current medications, as follows:

(1) Except as otherwise provided in paragraph (I)(7) of this rule, before terminating payment for current medications, the self-insuring employer shall notify all parties to the claim (including authorized representatives) and the prescribing physician, in writing, that a physician drug review is being performed, or has been performed, regarding the necessity and appropriateness of the

continued use of current medications (by therapeutic drug class).

(2) The written notice shall inform all parties to the claim (including authorized representatives) and the prescribing physician that they have twenty-one days from receipt of the notice to provide additional information and/or medical documentation to justify the need for continued use of the medications (by therapeutic drug class).

(3) The self-insuring employer shall provide all medically related information regarding the medications to an independent physician reviewer for review and opinion as to the necessity or appropriateness of the medications. If the self-insuring employer has obtained an independent physician reviewer's report prior to sending the notice required by paragraph (I)(1) of this rule and subsequently receives additional information and/or medical documentation pursuant to paragraph (I)(2) of this rule, the self-insuring employer shall provide the additional information and/or medical documentation to the independent physician reviewer and obtain an addendum. The independent physician reviewer's report (and addendum, if applicable) shall address the medical rationale, necessity and appropriateness of the drug treatment in the control of symptoms associated with the allowed conditions in the claim.

(4) When the independent physician reviewer's report (and addendum, if applicable) indicates the drug treatment is not medically necessary or appropriate for treatment or in the control of symptoms associated with the allowed conditions in the claim, the self-insuring employer may terminate reimbursement for the medications (by therapeutic drug class) effective as of the date of receipt of the independent physician reviewer's report, or addendum if one is obtained, or in the case that a drug is in a therapeutic class that requires a "weaning-off" period, in accordance with the tapering schedules set forth in the appendix to rule 4123-6-21.5 of the Administrative Code or such other date as agreed to by the prescribing physician and self-insuring employer.

(5) In the event the self-insuring employer terminates reimbursement for the medications as set forth in paragraph (I)(4) of this rule, the self-insuring employer or its authorized representative shall provide all parties to the claim (including authorized representatives) and the prescribing physician with a copy of the independent physician reviewer's report (and addendum, if applicable) and the self-insuring employer shall notify the injured worker and the injured worker's representative in writing of its decision to terminate. The employer's notification to the injured worker and injured

worker's representative shall indicate that the injured worker has the right to request a hearing before the industrial commission.

(6) In the event there is a dispute as to whether the drug treatment is medically necessary or appropriate for treatment of the symptoms associated with the allowed conditions in the claim, the disputed matter shall be adjudicated in accordance with paragraph (L)(5) of rule 4123-19-03 of the Administrative Code.

(7) The self-insuring employer may terminate current medications that have been removed from the bureau's outpatient medication formulary set forth in the appendix to rule 4123-6-21.3 of the Administrative Code without obtaining a physician drug review. However, the tapering schedules set forth in rule 4123-6-21.5 of the Administrative Code would apply.

(J) Self-insuring employers may deny initial requests for a drug or therapeutic class of drugs as not being reasonably related to or medically necessary for the treatment of the allowed conditions in a claim.

(K) Self-insuring employers may contract with a pharmacy benefits manager PBM. A self-insuring employer utilizing a PBM may require pharmacy providers to submit bills for medication by an on-line point-of-service authorization terminal or a host-to-host link with the pharmacy benefits manager's established bill processing system as a condition of reimbursement, and may refuse submission by paper. Self-insuring employers utilizing a PBM may refuse to reimburse any third-party pharmacy biller that submits pharmacy bills on behalf of a pharmacy provider or that has purchased pharmacy bills from a pharmacy provider for subsequent submission to the self-insuring employer for payment.

(L) Self-insuring employers utilizing a PBM may require prior authorization of drugs or therapeutic classes of drugs which appear on the bureau's published list of drugs or therapeutic classes of drugs for which prior authorization is required. Notwithstanding rule 4123-19-03 of the Administrative Code, the self-insuring employer shall approve or deny a prior authorization request within three business days of the request.

(M) Self-insuring employers utilizing a PBM may apply the following dispensing limitations,

adopted by the bureau, to medications approved and reimbursed by the self-insuring employer:

(1) Supply limitations for drugs which represent the maximum number of days supply that may be dispensed at any one time for a single prescription.

(2) Quantity limitations which represent the largest number of units per drug that may be dispensed at any one time for a single prescription.

(3) Requests submitted that exceed either the days supply limit or maximum quantity limit shall be denied; provided, however, that the pharmacy provider may still fill the prescription up to the days supply limit or maximum quantity limit, as applicable.

(4) Refills of drugs not scheduled by the DEA requested before eighty per cent of the days' supply has been utilized will be denied.

(5) Refills of drugs scheduled by the DEA requested before ninety per cent of the days' supply has been utilized will be denied.

(6) The self-insured employer may override denials for the following reasons with supporting documentation:

(a) The pharmacy is submitting an early refill for a shortened days supply to support medication synchronization;

(b) The injured worker is traveling and will be unable to refill medications during that time;

(c) The injured worker's pharmacy will be closed for more than two days.

(d) An emergency or disaster is declared by the president of the United States or the governor of the state in which the injured worker is located .

(e) Medical necessity and appropriateness have been determined by the self-insuring employer.

(N) Self-insuring employers utilizing a PBM may apply the maximum allowable cost list of the pharmacy benefits manager.

(O) Injured workers 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 for which pharmaceutically and therapeutically equivalent medications exist, as defined in paragraph (J) of rule 4123-6-21 of the Administrative Code, shall be liable for the product cost difference between the AWP of the dispensed brand name drug minus fifteen per cent and the established maximum allowable cost price of the drug product. However, the self-insuring employer or its vendor may approve reimbursement of the dispensed brand name drug in accordance with paragraph (E) of this rule if the following circumstances are met:

(1) The injured worker has a documented, systemic allergic reaction as a result of taking the generic equivalent; or

(2) The injured worker has not achieved the intended therapeutic benefit after a reasonable trial or an unacceptable adverse event has occurred as a result of taking the generic equivalent.

(P) A self-insuring employer has sufficient grounds to refuse to pay for the dispensing of drugs and other medications when a pharmacy provider fails to observe any state or federal law relating to his or her professional licensure or to the dispensing of drugs and other medication.