Ohio Administrative Code

Rule 4123-6-21 Payment for outpatient medication.

Effective: February 16, 2026

(A) Except as otherwise provided in rule 4123-6-21.6 of the Administrative Code, medication must be for the treatment of a work related injury or occupational disease in a claim either allowed by an order of the bureau or the industrial commission. The bureau may deny a drug or therapeutic class of drugs as not being reasonably related to or medically necessary for treatment of the allowed conditions in a claim.

(B) Medication may be prescribed by any treating provider authorized by law to prescribe such medication; however, reimbursement for medication shall be denied under the following circumstances:

(1) Reimbursement for prescriptions written by providers who are not enrolled with the bureau and who refuse to become enrolled shall be denied.

(2) Reimbursement for prescriptions written by providers who are enrolled but non-certified shall be denied, except in the following situations:

(a) The prescription is written by a non-bureau certified provider during initial or emergency treatment of the injured worker if the injured worker's claim and treated conditions are subsequently allowed or payment is permitted under rule 4123-6-21.6 of the Administrative Code.

(b) The prescription is written by a non-bureau certified provider who is outside the state or within the state where no or an inadequate number of bureau certified providers exist and the managed care organization (MCO) has determined that the treatment to be provided by the non-bureau certified provider is not reasonably available through a like bureau certified provider and has authorized the non-bureau certified provider to continue to provide the treatment.

(c) The prescription is written by a non-bureau certified provider for an injured worker with a date of injury prior to October 20, 1993, the provider was the injured worker's physician of record prior to

October 20, 1993, and the injured worker has continued treatment with that non-bureau-certified provider.

(C) Drugs covered 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 an enrolled pharmacy provider.

(D) The bureau may require prior authorization of certain drugs or therapeutic classes of drugs, drugs above a certain cost threshold, drugs submitted outside a certain time frame from the date of injury or the last prescription submitted, or drugs being prescribed for a condition or in a manner not approved by the FDA. The bureau will publish a list of all such drugs or therapeutic classes of drugs, cost thresholds, or time frames for which prior authorization is required.

(E) The bureau may reimburse opioid prescriptions used to treat a work related injury or occupational disease only if the prescriber follows current best medical practices, as outlined in rules 4731-11-13 and 4731-11-14 of the Administrative Code and this rule.

A prescriber's failure to comply with these rules may be subject to peer review by the bureau of workers' compensation pharmacy and therapeutics (P&T) committee pursuant to rule 4123-6-21.2 of the Administrative Code, the bureau of workers' compensation stakeholders' health care quality assurance advisory committee (HCQAAC) pursuant to rule 4123-6-22 of the Administrative Code, or other peer review committee established by the bureau, and subject to decertification pursuant to rule 4123-6-02.7 of the Administrative Code.

(F) Prescriptions for compounded drug products:

(1) Prior authorization may be required for reimbursement of compounded sterile drug products.

(2) Reimbursement for non-sterile compounded prescriptions will be denied, except when a commercially available formulary product becomes unavailable (listed on the "Food & Drug Administration Drug Shortages List," or "American Society of Health-System Pharmacists Drug Shortages List"). In such cases:

(a) A prior authorization request for reimbursement for non-sterile compounded prescriptions must be submitted, and

(b) Approval for reimbursement of non-sterile compounded prescriptions will be for an initial period of thirty days with subsequent approvals contingent upon commercial product availability. Not more than one prescription for a non-sterile compounded prescription will be approved for reimbursement in any thirty day period.

(G) Drugs which fall into one of the following categories may be approved by an MCO as part of a comprehensive treatment plan submitted by the physician of record or treating physician and reimbursed by the MCO or by the bureau's pharmacy benefit manager (PBM):

(1) Drugs for the treatment of obesity;

(2) Drugs for the treatment of infertility;

(3) Non-compounded parenteral drugs not intended for self-administration;

(4) Drugs used to aid in smoking cessation;

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

(6) Home infusion services.

(H) 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: the provider's billed charge, the maximum allowable cost, 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 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 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.

(I) The pharmacy provider is required to bill medication at their usual and customary charge. Pharmacy providers are required to submit for billing the 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 the bureau's PBM's

payment system must be used for billing purposes. The pharmacy provider shall:

(1) Include prescriber information within bills submitted electronically to the bureau or the bureau's pharmacy benefits manager 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, or 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 bureau, the bureau's PBM, or an MCO 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.

(J) The bureau may establish a maximum allowable cost (MAC) for single source medications and multi-source medications which are pharmaceutically and therapeutically equivalent. Pharmaceutically and therapeutically equivalent means the medications contain identical doses of the active ingredient and have the same biological effects as determined by the FDA publication "Approved Drug Products With Therapeutic Equivalence Evaluations" in effect on the billed date(s) of service. The methodology used to determine the MAC shall be determined by the bureau. The bureau may utilize the MAC list of a vendor or develop its own MAC list.

(K) 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 medication exist, as defined in paragraph (J) of this rule, 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 bureau may approve reimbursement of the dispensed brand name drug in accordance with paragraph (H) 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.

(L) The bureau may adopt the following dispensing limitations:

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

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

(5) The bureau may override dispensing limitations 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 bureau through the prior

authorization process.

(M) Except as otherwise provided in paragraph (G) of this rule, outpatient medications shall be billed to and reimbursed through the bureau's pharmacy benefits manager. Pharmacy providers must submit bills for medication by an on-line point-of-service authorization terminal or a host-to-host link with the bureau's PBM'S established bill processing system as a condition of provider enrollment or reimbursement. Submission by paper will not be accepted by the bureau or the bureau's PBM. The bureau shall not 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 bureau for payment.

(N) A claimant may request outpatient medication reimbursement in accordance with rule 4123-6-26 of the Administrative Code using form C-17, "Request for Injured Worker Outpatient Medication Reimbursement," or equivalent. Claimant reimbursement may be limited to the following situations:

(1) Claimants whose medication is not payable under division (I) of section 4123.511 of the Revised Code on the date of service, but later becomes payable;

(2) Emergency situations where an enrolled pharmacy provider is not available;

(3) Claimants who reside out of the country.

(O) 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 4729.01 of the Revised Code if located within Ohio; or an equivalent state license if located outside of Ohio;

(2) Has a valid DEA number if applicable; and,

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

All state and federal laws and regulations relating to the practice of pharmacy and the dispensing of

medication by a duly licensed pharmacist must be observed.

(P) The bureau may contract with a PBM 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. The bureau may utilize other services or established procedures of the PBM which may enable the bureau to control costs and utilization and detect fraud.

(Q) 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, which may include reimbursement for the dispensing fee component. The amount that could be reimbursed for pharmacist professional services shall be determined by the bureau.

(R) The bureau shall retain a registered pharmacist licensed in the state of Ohio to act as the full-time pharmacy program director to assist the bureau in the review of drug bills. The pharmacy program director may assist the bureau in determining the appropriateness, eligibility, and reasonableness of compensation payments for drug services.