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DENNIS RICHARDSON
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LESLIE CUMMINGS
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ARCHIVES DIVISION
MARY BETH HERKERT
DIRECTOR

800 SUMMER STREET NE
SALEM, OR 97310
503-373-0701

# PERMANENT ADMINISTRATIVE ORDER

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## DMAP 11-2018
CHAPTER 410
OREGON HEALTH AUTHORITY
HEALTH SYSTEMS DIVISION: MEDICAL ASSISTANCE PROGRAMS

FILING CAPTION: Comply with Amended CFRs, Revise Reimbursement Methodology, Clarify Vaccine Reimbursement, and Remove Copays

EFFECTIVE DATE: 03/02/2018

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CONTACT: Sandy Cafourek
503-945-6430
sandy.c.cafourek@dhsoha.state.or.us

500 Summer St. NE
Salem,OR 97301

Filed By:
Sandy Cafourek
Rules Coordinator

RULES:
410-121-0000, 410-121-0150, 410-121-0155, 410-121-0185, 410-121-0200, 410-121-0220

AMEND: 410-121-0000

RULE TITLE: Foreword and Definition of Terms

NOTICE FILED DATE: 05/11/2017

RULE SUMMARY: The Division needs to amend these rules to ensure compliance with recent Covered Outpatient Drug Final Rule (CMS-2345-FC) (81 FR 5170) to better align reimbursement with a cost-based reimbursement methodology required by CMS and to provide direction and clarification to Oregon pharmacies who provide pharmacy services to fee-for-service Oregon Health Plan clients. The Division will better align with a cost-based reimbursement methodology by: (1) Applying the rate set by the National Average Drug Acquisition Cost (NADAC) when there is no Oregon Average Actual Acquisition Cost (AAAC) and (2) Removing consideration of the Federal Upper Limit (FUL). Adding NADAC allows the Division to reduce reliance on the Wholesale Acquisition Cost (WAC). The changes in this filing apply to fee-for-service coverage of pharmacy benefits.

RULE TEXT:
(1) The Health Systems Division (Division) Oregon Administrative Rules (OAR) are designed to assist providers in preparing claims for services provided to the Division's fee-for-service clients. Providers must use Pharmaceutical OARs in conjunction with the General Rules OARs (chapter 410, division 120) for Oregon Medical Assistance Programs.

(2) Pharmaceutical services delivered through a managed care plan or a Coordinated Care Organization (CCO) contracted with the Division under the Oregon Health Plan (OHP) are subject to the policies and procedures established in the OHP administrative rules (chapter 410, division 141) and by the specific managed care plan or CCO.
(3) Definition of Terms:
(a) "Actively Practicing" means the active practice of medicine as described in ORS chapter 689 or the active practice of pharmacy as described in ORS chapter 677.
(b) "Authority" means the Oregon Health Authority. See the Oregon Health Authority definition in General Rules

(chapter 410, division 120);
(c) “Average Manufacturer’s Price (AMP)” means the average price that manufacturers sell medication to wholesalers and retail pharmacies, as further clarified in 42 CFR 447;
(d) “Bulk Dispensing” means multiple doses of medication packaged in one container labeled as required by pertinent federal and state laws and rules;
(e) “Centers for Medicare and Medicaid Services (CMS) Basic Rebate” means the quarterly payment by the manufacturer of a drug pursuant to the manufacturer’s CMS Medicaid Drug Rebate Agreement made in accordance with Section 1927(c) of the Social Security Act (42 U.S.C. 1396r-8(c)). See 410-121-0157;
(f) “CMS Consumer Price Index (CPI) Rebate” means the quarterly payment by the manufacturer pursuant to the manufacturer’s CMS Medicaid Drug Rebate Agreement made in accordance with Section 1927(c)(2) of the Social Security Act (42 U.S.C. 1396r-8(c));
(g) “Compendia” means those resources widely accepted by the medical profession in the efficacious use of drugs, including the following sources:
(A) The American Hospital Formulary Service Drug information;
(B) The United States Pharmacopeia Drug Information (or its successor publications);
(C) The American Medical Association drug evaluations;
(D) Peer-reviewed medical literature;
(E) Drug therapy information provided by manufacturers of drug products consistent with the federal Food and Drug Administration requirements.
(h) “Community Based Care Living Facility” means for the purposes of the Division’s Pharmacy Program, a home, facility, or supervised living environment licensed or certified by the State of Oregon that provides 24-hour care, supervision, and assistance with medication administration. These include but are not limited to:
(A) Supportive living facilities;
(B) Twenty-four hour residential services;
(C) Adult foster care;
(D) Semi-independent living programs;
(E) Assisted living and residential care facilities;
(F) Group homes and other residential services for people with developmental disabilities or needing mental health treatment; and
(G) Inpatient hospice.
(i) “Compounded Prescription” means the following:
(A) A prescription that is prepared at the time of dispensing and involves the weighting of at least one solid ingredient that must be a reimbursable item or a legend drug in a therapeutic amount;
(B) Compounded prescription further defined to include the Oregon Board of Pharmacy definition of compounding (see OAR 855-006-0005).
(j) “Dispensing” means issuance of a prescribed quantity of an individual drug entity by a licensed pharmacist;
(k) “Director” means the director of the Authority;
(L) “Drug Order/Prescription” means the following:
(A) A medical practitioner's written or verbal instructions for a patient's medications; or
(B) A medical practitioner's written order on a medical chart for a client in a nursing facility.
(m) “Durable Medical Equipment and Supplies (DME)” means equipment and supplies as defined in OAR 410-122-0010, Durable Medical Equipment, Prosthetics, Orthotics, and Supplies;
(n) “Intermediate Care Facility” means a facility providing regular health-related care and services to individuals at a level above room and board, but less than hospital or skilled nursing levels as defined in ORS 442.015;
(o) “Legend Drug” means a drug limited by Section 503(b)(1) of the Federal Food, Drug, and Cosmetic Act to being dispensed by or upon a medical practitioner’s prescription because the drug is:
(A) Habit-forming;

(B) Toxic or having potential for harm; or
(C) Limited in its use to being used under a practitioner's supervision by the new drug application for the drug:
(i) The product label of a legend drug is required to contain the statement: "CAUTION: FEDERAL LAW PROHIBITS DISPENSING WITHOUT A PRESCRIPTION;"
(ii) A legend drug includes prescription drugs subject to the requirement of Section 503(b)(1) of the federal Food, Drug, and Cosmetic Act that shall be exempt from Section 502(F)(1) if certain specified conditions are met.
(p) "Long Term Care Facility" means skilled nursing facilities and intermediate care facilities with the exclusions found in ORS 443.400 to 443.455;
(q) "Maintenance Medication" means drugs that have a common indication for treatment of a chronic disease, and the therapeutic duration is expected to exceed one year. This is determined by a First DataBank drug code maintenance indicator of "Y" or "1;"
(r) "Mental Health Drug" means a type of legend drug defined by the Oregon Health Authority (Authority) by rule that includes but is not limited to those drugs classified by First DataBank in the following Standard Therapeutic Classes:
(A) Therapeutic Class 7 ataractics-tranquilizers and Therapeutic Class 11 psychostimulants-antidepressants;
(B) Depakote, Lamictal, and their generic equivalents and other drugs that the Division specifically carved out from capitation from CCOs, Fully Capitated Health Plans (FCHPs) in accordance with OAR 410-141-3070 and 410-141-0070.
(s) "Narrow Therapeutic Index (NTI) Drug" means a drug that has a narrow range in blood concentrations between efficacy and toxicity and requires therapeutic drug concentration or pharmacodynamic monitoring;
(t) "National Average Drug Acquisition Cost (NADAC)" means the rate that is established by CMS or its contractor by rolling surveys of pharmacies nationwide to verify the actual invoice amount paid by the pharmacy or corporate entity to wholesalers, manufacturers, or distribution centers for the product. The NADAC is the average of invoice amounts for individual drug products based on the Generic Sequence Number (GSN);
(u) "Net Price" means the amount a drug costs the Division and is calculated using the following formula: OR-AAAC, minus CMS Basic Rebate, minus CMS CPI Rebate, minus State Supplemental Rebate;
(v) "Nominal Price" means sales at less than 10 percent of the Average Manufacturer's Price (AMP);
(w) "Non-Preferred Products" means any medication in a class that has been evaluated and that is not listed on the Practitioner-Managed Prescription Drug Plan Preferred Drug List in OAR 410-121-0030;
(x) "Nursing Facility" means an establishment that is licensed and certified by the Department's Aging and People with Disabilities Division (APD) as a Nursing Facility;
(y) "Oregon Average Actual Acquisition Cost (OR-AAAC)" means the rate that is established by the Division or its contractor by rolling surveys of enrolled pharmacies to verify the actual invoice amount paid by the pharmacy or corporate entity to wholesalers, manufacturers, or distribution centers for the product. The AAAC is the average of invoice amounts for individual drug products based on the Generic Sequence Number (GSN);
(z) "Pharmacist" means an individual who is licensed as a pharmacist under ORS chapter 689;
(aa) "Physical Health Drug" means all other drugs not included in the definition of a "mental health drug" according to this rule;
(bb) "Point-of-Sale (POS)" means a computerized, claims submission process for retail pharmacies that provides on-line, real-time claims adjudication;
(cc) "Preferred Drug List (PDL)" means the list of prescription drugs in selected classes that the Authority in consultation with the Pharmacy & Therapeutics Committee (P & T) has determined represent the most effective drugs available at the best possible price. (See details for the Division's PMPDP PDL in OAR 410-121-0030.)The following are two types of preferred drug lists:
(A) "Enforceable Physical Health Preferred Drug List" means the list of "preferred" drug products used to treat physical health conditions. The "preferred" drugs may nevertheless require prior authorization (PA) for clinical reasons. Drugs prescribed that do not appear on the PDL (non-preferred products) shall be subject to PA;
(B) "Voluntary Mental Health Preferred Drug List" means the list of "preferred" drug products used to treat mental

health conditions. Any drug prescribed for the treatment of mental health diagnosis shall be exempt from non-clinical PA requirements by the Division.
(dd) “Preferred Products” means products in classes that have been evaluated and placed on the Practitioner Managed Prescription Drug Plan (PMPDP) PDL in OAR 410-121-0030;
(ee) “Prescriber” means any person authorized by law to prescribe drugs;
(ff) “Prescription Splitting” means any one or a combination of the following actions:
(A) Reducing the quantity of a drug prescribed by a licensed practitioner for prescriptions not greater than 34 days, except as needed for Prescription Synchronization (see OAR 410-121-0146);
(B) Billing the agency for more than one dispensing fee when the prescription calls for one dispensing fee for the quantity billed, except as needed for Prescription Synchronization (see OAR 410-121-0146);
(C) Separating the ingredients of a prescribed drug and billing the agency for separate individual ingredients, with the exception of compounded medications (see OAR 410-121-0146); or
(D) Using multiple 30-day cards to dispense a prescription when a lesser number of cards will suffice.
(gg) “Prescription Synchronization” means the process of, at the client’s direction, aligning the refill dates of a client’s prescription drugs so drugs that are refilled at the same frequency may be refilled concurrently;
(hh) “Prior Authorization Program (PA)” means the prior authorization program is a system of determining, through a series of therapeutic and clinical protocols, which drugs require authorizations prior to dispensing:
(A) OAR 410-121-0040 lists the drugs or categories of drugs requiring PA;
(B) The practitioner or practitioner's licensed medical personnel listed in OAR 410-121-0060 may request a PA.
(ii) “State Supplemental Rebates” means the Division and CMS approved discounts paid by manufacturers per unit of drug. These rebates are authorized by the Social Security Act section 42 USC 1396r-8(a)(1) and are in addition to federal rebates mandated by the Omnibus Budget Rehabilitation Act (OBRA 90) and the federal rebate program;
(jj) “Unit Dose” means a sealed, single unit container of medication so designed that the contents are administered to the patient as a single dose, direct from the container, and dispensed following the rules for the unit dose dispensing system established by the Oregon Board of Pharmacy;
(kk) “Urgent Medical Condition” means a medical condition that arises suddenly, is not life-threatening, and requires prompt treatment to avoid the development of more serious medical problems;
(LL) “Usual and Customary Price” means a pharmacy's charge to the general public that reflects all advertised savings, discounts, special promotions, or other programs including membership based discounts initiated to reduce prices for product costs available to the general public, a special population, or an inclusive category of customers;
(mm) “Wholesale Acquisition Cost (WAC)” means the price paid by a wholesaler for drugs purchased from the wholesaler's supplier, typically the manufacturer of the drug. WAC is the price of a covered product by the National Drug Code (NDC) as published by First DataBank, MediSpan, or Red Book;
(nn) “340B Pharmacy” means a federally designated community health center or other federally qualified covered entity that is listed on the Health Resources and Services Administration (HRSA) website.
NOTE: Publications referenced are available from the agency.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.065, 414.325

STATUTES/OTHER IMPLEMENTED: ORS 414.065

AMEND: 410-121-0150

RULE TITLE: Billing Requirements

NOTICE FILED DATE: 05/11/2017

RULE SUMMARY: The Division needs to amend these rules to ensure compliance with recent Covered Outpatient Drug Final Rule (CMS-2345-FC) (81 FR 5170) to better align reimbursement with a cost-based reimbursement methodology required by CMS and to provide direction and clarification to Oregon pharmacies who provide pharmacy services to fee-for-service Oregon Health Plan clients. The Division will better align with a cost-based reimbursement methodology by: (1) Applying the rate set by the National Average Drug Acquisition Cost (NADAC) when there is no Oregon Average Actual Acquisition Cost (AAAC) and (2) Removing consideration of the Federal Upper Limit (FUL). Adding NADAC allows the Division to reduce reliance on the Wholesale Acquisition Cost (WAC). The changes in this filing apply to fee-for-service coverage of pharmacy benefits.

RULE TEXT:

(1) All 340B covered entities that fill Medicaid patient prescriptions with drugs purchased at the prices authorized under Section 340B of the Public Health Service Act shall bill Medicaid at the actual acquisition cost, plus the entity's assigned professional dispensing fee.

(2) Pharmacies that purchase drugs at Nominal Price outside of 340B or the Federal Supply Schedule shall bill their actual acquisition cost.

(3) With the exception of Indian Health Service pharmacies and Tribal 638 pharmacies, pharmacies who purchase drugs through the Federal Supply Schedule must bill their actual acquisition cost. Refer to AI/AN rules OAR chapter 410, division 146 for billing rules for Indian Health Service pharmacies and Tribal 638 pharmacies.

(4) When billing the Health Systems Division (Division) for drug products, the provider:

(a) May not bill in excess of the usual and customary charge to the general public:

(A) The sum of charges for both the product cost and dispensing fee may not exceed a pharmacy's usual and customary charge for the same or similar service;

(B) When billing the Division for a prescription, the pharmacy shall bill the lowest amount accepted from any member of the general public who participates in the pharmacy provider's savings or discount program;

(b) Shall indicate the National Drug Code (NDC) as it appears on the package from which the prescribed medications are dispensed;

(c) Shall bill the actual metric decimal quantity dispensed;

(d) Unless specifically provided by another rule, when clients have other insurances, shall bill the other insurances as primary and the Division as secondary;

(e) When clients have Medicare prescription drug coverage, shall bill Medicare as primary and the Division as secondary.

(5) When submitting a paper claim, the provider shall furnish accurately all information required on the 1.2 Universal Claims Form.

(6) The prescribing provider's National Provider Identifier (NPI) is mandatory on all fee-for-service client drug prescription claims. Claims shall deny for a missing or invalid prescriber NPI. An exception to this includes but is not limited to a prescribing provider who does not have an NPI for billing, but who prescribes fee-for-service prescriptions for clients under Coordinated Care Organizations (CCOs), prepaid health plans (PHPs), long-term care, or other capitated contracts. This provider is to be identified with the:

(a) Non-billing NPI-assigned for prescription writing only;

(b) Clinic or facility NPI until an individual NPI is obtained; or

(c) Supervising physician's NPI when billing for prescriptions written by the physician assistant, physician students, physician interns, or medical professionals who have prescription writing authority.

(7) Billing for Death With Dignity services:

(a) Claims for Death With Dignity services may not be billed through the Point-of-Sale system;

(b) Services shall be billed directly to the Division, even if the client is in a CCO or PHP;
(c) Prescriptions shall be billed on a 1.2 Universal Claims Form paper claim form using an NDC number. Claims shall be submitted to the address indicated in the Division's Supplemental Information for Pharmaceutical Services.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.065

STATUTES/OTHER IMPLEMENTED: ORS 414.065

AMEND: 410-121-0155

RULE TITLE: Reimbursement

NOTICE FILED DATE: 05/11/2017

RULE SUMMARY: The Division needs to amend these rules to ensure compliance with recent Covered Outpatient Drug Final Rule (CMS-2345-FC) (81 FR 5170) to better align reimbursement with a cost-based reimbursement methodology required by CMS and to provide direction and clarification to Oregon pharmacies who provide pharmacy services to fee-for-service Oregon Health Plan clients. The Division will better align with a cost-based reimbursement methodology by: (1) Applying the rate set by the National Average Drug Acquisition Cost (NADAC) when there is no Oregon Average Actual Acquisition Cost (AAAC) and (2) Removing consideration of the Federal Upper Limit (FUL). Adding NADAC allows the Division to reduce reliance on the Wholesale Acquisition Cost (WAC). The changes in this filing apply to fee-for-service coverage of pharmacy benefits.

RULE TEXT:

(1) The Division shall pay the lesser of the provider's billed amount or the ingredient cost plus a professional dispensing fee.

(2) The ingredient cost is established by the Division as follows:

(a) The Oregon Average Actual Acquisition Cost (OR-AAAC) of the drug;

(b) In cases where no OR-AAAC is available, the National Average Drug Acquisition Cost (NADAC);

(c) In cases where no OR-AAAC and no NADAC is available, the Wholesale Acquisition Cost (WAC).

(3) For ingredient cost for trade name forms of multiple source products:

(a) Except as provided in (3)(b) below, the Division shall apply the OR-AAAC or NADAC of the generic form when a trade name form of a multiple source product is dispensed;

(b) The Division shall pay the OR-AAAC or NADAC of the trade name form only when the prescribing practitioner certifies the trade version is required or when the brand drug is listed on the Division’s Preferred Drug List.

(4) The Division shall revise its OR-AAAC weekly. Pharmacies must make available to the Division or its contractor any information necessary to determine the pharmacy’s actual acquisition cost of drug products dispensed to the Division’s clients.

(5) The OR-AAAC shall serve as the basis for reimbursement. Individual pharmacies are required to participate in an OR-AAAC survey conducted by the Division or its contractor not more than one time per every 18 to 24-month period. Pharmacies that do not respond to OR-AAAC survey requests may be subject to disenrollment as providers for the Oregon Health Plan.

(6) If a provider is unable to purchase a particular drug product at the OR-AAAC, the provider shall report this to the Division or its contractor for further review through a dispute resolution process. Providers may submit inquiries via telephone, facsimile, via electronic mail, or the contractor’s secure web site: http://www.mslc.com/Oregon/AAACRateReview.aspx:

(a) The Division or its contractor shall respond to all inquiries or complaints within 24 hours and resolve the issue within five business days;

(b) The pricing dispute resolution process shall include the Division or its contractor verifying the accuracy of pricing to ensure consistency with marketplace pricing and drug availability;

(c) Price adjustments shall be made during the next weekly pricing update.

(7) The Division restricts claims for hemophilia blood factors to a single provider. This restriction does not apply for clients with other insurances or Medicare in addition to OHP. The sole source provider of blood factors is the Hemophilia Center at OHSU. Questions concerning hemophilia case management and blood factors shall be directed to this provider by calling: 877 346-0640.

(8) No professional dispensing fee is allowed for dispensing pill splitters/cutters or diabetic supplies and glucose monitors.

(9) Payment for pill splitters/cutters with a National Drug Code (NDC) number shall be reimbursed at the lesser of the

billed amount or the ingredient cost and:
(a) A practitioner prescription is required; and
(b) The Division shall pay only for one pill splitter/cutter per client in a twelve-month period.
(10) A prescription is required for glucose monitors and related diabetic supplies.
(11) Payment for glucose monitors and related diabetic supplies billed with an NDC shall be reimbursed at a percentage of Medicare's rate for the HCPCS procedure code. The Division's reimbursement rates are listed in the Division's fee schedule located at: http://www.oregon.gov/OHA/healthplan/pages/feeschedule.aspx.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.065

STATUTES/OTHER IMPLEMENTED: ORS 414.065

AMEND: 410-121-0185

RULE TITLE: Pharmacy Based Immunization Delivery

NOTICE FILED DATE: 05/11/2017

RULE SUMMARY: The Division needs to amend these rules to ensure compliance with recent Covered Outpatient Drug Final Rul (CMS-2345-FC) (81 FR 5170) to better align reimbursement with a cost-based reimbursement methodology required by CMS an provide direction and clarification to Oregon pharmacies who provide pharmacy services to fee-for-service Oregon Health Plan clients. The Division will better align with a cost-based reimbursement methodology by: (1) Applying the rate set by the National Average Drug Acquisition Cost (NADAC) when there is no Oregon Average Actual Acquisition Cost (AAAC) and (2) Removing consideration of the Federal Upper Limit (FUL). Adding NADAC allows the Division to reduce reliance on the Wholesale Acquisiti Cost (WAC). The changes in this filing apply to fee-for-service coverage of pharmacy benefits.

RULE TEXT:

(1) Pursuant to ORS 689.645 and the Board of Pharmacy administrative rules 855-019-0270 through 855-019-0290, pharmacist may prescribe and administer vaccines to persons who are at least seven years of age.

(2) To receive reimbursement for vaccine administration and serum for adults (ages 19 and older), the pharmacy may bill either:

(a) Through Point-of-Sale (POS) using the appropriate National Drug Code (NDC) for the serum, and the administration fee shall automatically be applied equivalent to Current Procedural Terminology (CPT) codes 90470-90474 ; or

(b) Bill on a CMS-1500, OHP 505, or Provider Web Portal professional claim using the appropriate immunization CPT code for th serum; or

(c) Bill as a Provider Web Portal pharmacy claim.

(3) If billing as a professional claim, the pharmacy must include:

(a) A primary diagnosis to the highest degree of specificity;

(b) The appropriate CPT code for the serum, code ranges 90476-90749; and

(c) The appropriate CPT code for the administration, code ranges 90470-90474.

(4) Vaccines for Children (VFC) is a federal program that provides vaccine serums at no cost to providers for patients under age 1 All vaccines for this age group and for conditions covered by the VFC program must be obtained through the VFC program. For information about the VFC program or to enroll as a VFC provider, contact the Public Health Immunization Program. The Oregon VFC program website is located at http://public.health.oregon.gov/PreventionWellness/VaccinesImmunization/ImmunizationProviderResources/vfc/Pages/index.a

(5) The Division shall reimburse only for the administration, not the serum, of vaccines available for free through the VFC progra For a list of vaccines provided through the VFC program, see the current Oregon Immunization Program State-Supplied Vaccine Billing Codes table available at http://bit.ly/1c3T6zy.

(6) To receive reimbursement for vaccine administration to a child age 7 through 18, the pharmacy must:

(a) Be enrolled as a pharmacy provider in the VFC program;

(b) Bill on a CMS-1500, OHP 505, or Provider Web Portal professional claim;

(c) Use the appropriate immunization CPT code for the serum; and

(d) Include the appropriate modifier –SL or -26;

(7) For detailed information on billing for the VFC Program, refer to Medical Surgical Services OAR 410-130-0255.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.065

STATUTES/OTHER IMPLEMENTED: ORS 414.065

AMEND: 410-121-0200

RULE TITLE: Billing Forms

NOTICE FILED DATE: 05/11/2017

RULE SUMMARY: The Division needs to amend these rules to ensure compliance with recent Covered Outpatient Drug Final Rule (CMS-2345-FC) (81 FR 5170) to better align reimbursement with a cost-based reimbursement methodology required by CMS and to provide direction and clarification to Oregon pharmacies who provide pharmacy services to fee-for-service Oregon Health Plan clients. The Division will better align with a cost-based reimbursement methodology by: (1) Applying the rate set by the National Average Drug Acquisition Cost (NADAC) when there is no Oregon Average Actual Acquisition Cost (AAAC) and (2) Removing consideration of the Federal Upper Limit (FUL). Adding NADAC allows the Division to reduce reliance on the Wholesale Acquisition Cost (WAC). The changes in this filing apply to fee-for-service coverage of pharmacy benefits.

RULE TEXT:

Guidelines for using the Prescription Drug Invoice 1.2 Universal Claim Form.

(1) When a paper claim form is needed, this form is used to bill for all pharmacy services, home blood glucose monitors, and related diabetic supplies. These services must be billed with a National Drug Code (NDC).

(2) The provider may bill on the form when a valid Medical Care Identification has been presented (Refer to OAR 410-120-1140 Verification of Eligibility).

(3) All completed 1.2 Universal Claim Forms must be mailed to the Health Systems Division (Division).

(4) All other durable medical equipment and certain Enteral/Parenteral Nutrition and IV Services must be billed on the CMS-1500, using the billing instructions found in the Division's Durable Medical Equipment and Medical Supplies administrative rules (division 122) and Supplemental Information, and the Division's Home Enteral/Parenteral Nutrition and IV Services Administrative rules (division 148) and Supplemental Information. These services are billed with HCPCS procedure codes.

NOTE: Publications referenced are available from the agency.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.065

STATUTES/OTHER IMPLEMENTED: ORS 414.065

AMEND: 410-121-0220

RULE TITLE: Instructions for Completion of the Prescription Drug Invoice

NOTICE FILED DATE: 05/11/2017

RULE SUMMARY: The Division needs to amend these rules to ensure compliance with recent Covered Outpatient Drug Final Rule (CMS-2345-FC) (81 FR 5170) to better align reimbursement with a cost-based reimbursement methodology required by CMS and to provide direction and clarification to Oregon pharmacies who provide pharmacy services to fee-for-service Oregon Health Plan clients. The Division will better align with a cost-based reimbursement methodology by: (1) Applying the rate set by the National Average Drug Acquisition Cost (NADAC) when there is no Oregon Average Actual Acquisition Cost (AAAC) and (2) Removing consideration of the Federal Upper Limit (FUL). Adding NADAC allows the Division to reduce reliance on the Wholesale Acquisition Cost (WAC). The changes in this filing apply to fee-for-service coverage of pharmacy benefits.

RULE TEXT:
(1) The 1.2 Universal Claim Form is the required billing form for pharmacies billing on a paper claim. Use the standard instructions for completion of the 1.2 Universal Claim Form.
(2) Enter all applicable information for billing of prescription drug claims for clients on the Oregon Health Plan.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.034, 414.065

STATUTES/OTHER IMPLEMENTED: ORS 414.065