METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Payment for physicians' services (includes medical and remedial care and services)

Payment for physician’s services, radiology services and services rendered by other practitioners under the scope of their practice under State law, are covered under the Agency fee schedule. The payment amount for each service paid for under the fee schedule is the product of a uniform relative value unit (RVU) for each service and the Medicare conversion factor (CF). The Medicare CF converts the relative values into payment amounts. The general formula for calculating the fee schedule can be expressed as:

RVU x CF = Rate

EPSDT screenings and eye exams by optometrists have been incorporated into the fee schedule.

Effective February 1, 2010, payment will not be made to physicians or other practitioners for three national coverage determinations which relate to serious, preventable errors in medical care. These errors include surgery performed on wrong body part, surgery performed on wrong patient, and wrong surgery performed on patient.

Vaccines are paid the equivalent to the Medicare Part B allowed charge~~, ASP + 6%~~. When the Medicare Part B allowed charge ~~ASP~~ is not available, an equivalent price is calculated using Wholesale Acquisition Cost (WAC). If no Medicare~~, ASP,~~ or WAC pricing is available, then the price will be calculated based on invoice cost. No payment will be made to physicians or other practitioners for vaccines that were received through the Vaccine for Children’s program.

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Payment for Durable Medical Equipment, Supplies, and Appliances (continued):

For durable medical equipment, supplies, and appliances purchased at the pharmacy point of sale, providers will be reimbursed the equivalent of the Medicare Part B allowed charge~~, ASP + 6%~~. When the Medicare Part B allowed charge ~~ASP~~ is not available, an equivalent price is calculated using Wholesale Acquisition Cost (WAC). If no Medicare~~, ASP,~~ or WAC pricing is available, then the price will be calculated based on invoice cost.

Payment is not made for durable medical equipment, supplies, and appliances that are not deemed as medically necessary or considered over-the-counter.

The Agency does not pay durable medical equipment providers separately for services that are included as part of the payment for another treatment program. For example, all items required at a hospital, nursing facility, or intermediate care facility for individuals with intellectual disabilities are paid through those corresponding institutional rate methodologies.

For any item subject to the DME FFP demonstration, these items will be priced at or under 100% of Medicare rural/non-rural pricing.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Payment for Prescribed Drugs *(continued)*

(b) Ingredient Cost Methodology *(continued)*:

(7) Indian Health Service/Tribal/Urban Indian Clinic Facilities are reimbursed at the OMB encounter rate. This is limited to one pharmacy encounter fee per member per facility per day.

(8) Specialty drugs are reimbursed at the lower of NADAC, WAC, or Specialty Pharmaceutical Allowable Cost (SPAC). The factors included in the SPAC calculation are Medicare Part B pricing, ~~(Average Sales Price plus 6%),~~ WAC, and NADAC plus professional dispensing fee of $11.41.

(9) Prescriptions for members residing in long-term care facilities are reimbursed as the lower of NADAC, WAC, SPAC, or SMAC plus the Professional Dispensing Fee of $11.41.

(10) Clotting factor from specialty pharmacies, Hemophilia Treatment Centers (HTCs), and Centers of Excellence – Is reimbursed at the SPAC rate plus the professional dispensing fee of $11.41 for hemophilia clotting factors.

When a Hemophilia Treatment Center which is a 340B covered entity provides clotting factor to Medicaid members whether the pharmacy is owned by the covered entity or has a contract pharmacy arrangement, the procedure for 340B pharmacies listed on Attachment 4.19-B, page 7, section (b)(4) will apply.

(11) Investigational drugs are not covered; including FDA approved drugs being used in post-marketing studies.

(12) The Professional Dispensing Fee is $11.41 per prescription.

(c) Physician Administered Drugs – are reimbursed at a price equivalent to the Medicare Part B allowed charge~~, ASP + 6%~~. When the Medicare Part B allowed charge ~~ASP~~ is not available, an equivalent price is calculated using WAC.

340B covered entities are allowed to submit their usual and customary cost and are paid at the regular Medicaid allowable rate. At the end of the quarter, the URA is recouped from the covered entity to keep the state whole based on net cost after rebate.

(d) Meeting the Federal Upper Limits (FUL) in the aggregate – By using the lower of NADAC, WAC or SMAC, the FUL will always be met since NADAC is the floor for the FUL.

(e) High-investment drugs – Payment to hospitals for high-investment drugs used to treat members during an inpatient admission or outpatient hospital visit will be the lower of: (1) the Hospital's Actual Acquisition Cost; (2) the WAC; (3) if available, the ~~ASP + 6%~~ Medicare Part B allowed charge; or, (4) billed charges. A list of high-investment drugs is found on www.okhca.org.

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