Kentucky Medicaid MCO PBM Pharmacy Provider Point-of-Sale (POS) Billing Manual

6/19/2021

Revision History

Document Version	Date	Name	Comments
DRAFT 1.0	6/19/2021	KY MCO PBM Provider Billing Manual	DRAFT Document Creation

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1.0 Introduction

In 2020 the Kentucky General Assembly passed S.B. 50, which Governor Andy Beshear subsequently signed into law.1 This statute mandates that CHFS identify and contract with a single pharmacy benefit manager (PBM) to administer all pharmacy benefits for Beneficiaries in the Medicaid Managed Care Program. Specifically, each contract entered into or renewed for the delivery of Medicaid services by a Managed Care Organization (MCO), after CHFS has selected and contracted with the state MCO PBM, shall require the MCO to contract with and utilize the CHFS-identified PBM. In addition, the Department of Medicaid Services (DMS) was also required to establish a single preferred drug list (PDL) for the Medicaid Managed Care Program and to promulgate administrative regulations establishing pharmacy reimbursement minimum fee schedules and professional dispensing fees to be used by the MCO PBM for each Kentucky contracted Medicaid MCO.

In response to S.B. 50, 2020 Leg. Reg. Sess. (Ky. 2020) DMS awarded the MCO PBM contract to MedImpact to administer pharmacy benefits and services to Kentucky Medicaid members enrolled in the managed care delivery system. DMS provides all oversight and monitoring of the MCO PBM activities and operations and facilitates and ensures collaboration between the MCO PBM, MedImpact, and contracted MCOs.

The pharmacy benefits and services administered by MedImpact will be identified collectively as "MCO PBM services." MCO PBM services provided include, claims processing and administering payments to Kentucky Medicaid pharmacy Providers; applying the Kentucky Medicaid preferred drug list (PDL) and benefit design; adjudicating prior authorization (PA) requests using DMS-established criteria; adjudicating first level PA appeals; conducting Retrospective Drug Utilization Review (RetroDUR) activities; providing Kentucky Medicaid pharmacy Provider and Beneficiary customer service; pharmacy network auditing; reporting to DMS and contracted MCOs.

The fee-for-service (FFS) PBM serving the Commonwealth's Medicaid FFS program will retain responsibility for processing FFS pharmacy claims, supporting the development of the Kentucky Medicaid PDL, and processing federal and state supplemental drug rebates. The FFS PBM will provide the MCO PBM with a weekly file at the National Drug Code (NDC) level reflecting the Kentucky Medicaid PDL and any restrictions, as well as any utilization management (UM) updates to drugs subject to the Kentucky Medicaid PDL.

MedImpact is required to implement the Kentucky Medicaid pharmacy benefit as directed by DMS without exception. MedImpact may not implement claims processing restrictions such as PA, quantity and/or duration limits, age/gender restrictions, Prospective Drug Utilization Review (ProDUR) edits, or other restrictions more stringent than those specified by DMS.

Beginning July 1st, 2021 MedImpact is the contracted pharmacy claims processor for the Kentucky Medicaid contracted MCOs. MedImpact uses a computerized point-of-sale (POS) claims processing application, utilizing NCPDP D.0 compliant telecommunications standards for

claim transactions. The system allows participating pharmacies real-time access and claim processing including member eligibility evaluation, drug coverage determination, CMS-approved Kentucky DMS pricing and payment information, and prospective drug utilization review (ProDUR) across all Kentucky Medicaid enrolled pharmacies. Pharmacy providers must be enrolled with Kentucky Medicaid and have an active status for any submitted claim with a date of service on or after July 1, 2021.

Any claim processing application enhancements required of the provider's practice management solution must be handled directly with their contracted switch vendor. Provider claim submission certification is not a requirement of this KY MCO PBM program.

This manual is intended to provide pharmacy claims submission guidelines to providers enrolled with Kentucky Medicaid when processing claims for members enrolled with any of the contracted Kentucky Medicaid contracted MCOs. In the event pharmacy providers require assistance with processing a pharmacy benefit claim for a Kentucky Medicaid member actively enrolled in an MCO, they may contact the MedImpact Provider and Member Call Center, which is available 24 hours per day, seven days per week, at: 1-800-210-7628.

1.1 Important Telephone Numbers

Contact	Phone Number/URL	Availability
MedImpact Pharmacy Web Portal	http://pharmacy.medimpact.com	24 hours a day, 7 days a week
DMS pharmacy website	http://chfs.ky.gov/dms/Pharmacy.htm	24 hours a day, 7 days a week
Member Services (CHFS)	800-635-2570	8:00 a.m.–5:00 p.m., Eastern Monday–Friday
Clinical Support Center (prior authorizations)	PHONE: 844-336-2676	8:00 a.m. – 7:00 p.m., Eastern 7 days a week
	FAX: 858-357-2612	24 hours a day, 7 days a week
Pharmacy/Provider & Member Help Desk	PHONE: 800-210-7628	24 hours a day, 7 days a week
MAC Pricing (Administered by DMS' contracted FFS Pharmacy PBM)	MAC price look-up: https://kyportal.magellanmedicaid.com/provider/public/documents.xhtml under the "Drug Info" tab	24 hours a day, 7 days a week
	To appeal MAC pricing: Fax: 888-656-1951 or email: StateMacProgram@magellanhealth.com	
Voice Response Eligibility Verification (VRSV) – Member Eligibility	800-807-1301	24 hours a day, 7 days a week
Provider Management/Enrollment	PHONE: 877-838-5085 FAX: 502-226-1898	10:00 a.m.–4:30 p.m., ET, Monday–Friday
KY MCO PBM Account Director	Daniel Yeager 858-790-6683	8AM-5PM (Mon-Fri) Eastern other times: on-call
KY MCO PBM Clinical Program Managers	Robyn Seely 619-509-1073 Kevin Chang 619-820-8322	8AM-5PM (Mon-Fri) Eastern other times: on-call

1.2 Addresses

Address	Format
Provider Paper Claims Billing Address: MedImpact ATTN: CLAIMS DEPT 10181 Scripps Gateway Court San Diego, CA 92131	UCF version D.Ø

1.2.1 Websites

- DMS: http://chfs.ky.gov/dms/Pharmacy.htm
- MedImpact Provider Portal: http://pharmacy.medimpact.com
- MedImpact KY MCO PBM website: http://kyportal.medimpact.com

2.0 Claim Processing Configuration

ANSI BIN #	023880
Processor Control #	KYPROD1
Group #	KYM01
Cardholder ID #	Kentucky Medicaid Assigned Identification Number
Provider ID #	National Provider Identifier (NPI) only
Prescriber ID #	NPI only
Product Code	NDC only

2.1 Claim Format

- POS claims must be submitted in the NCPDP version D.Ø format (HIPAA defined October 2014 Data Dictionary)
- The Universal Claim Form (UCF) must be submitted for provider paper claim submissions.

2.2 Media Options

- POS Claim billing or reversal
- Provider Submitted Paper (member claims are not permitted)
- Batch (to submit batch transaction (NCPDP Batch 1.2)– testing with MedImpact is required please contact KYMCOPBM@medimpact.com for assistance).

2.3 Transaction Types

The following transaction types are defined in NCPDP standards:

2.3.1 Billing Claim Adjudication (Transaction type B1)

This transaction captures and processes the claim and returns the dollar amount allowed under the Kentucky DMS' reimbursement formula to the pharmacy.

2.3.2 Reversal Claim Processing (Transaction type B2)

This transaction is used by the pharmacy to cancel a claim that was previously processed. To submit a reversal, the provider must void a claim that has received a "Paid" status. To reverse a claim, the provider selects the reversal (void) option in the pharmacy's computer system.

2.4 Required Data Elements

NCPDP descriptions for each field status code data element:

Code	Description
M	Designated as MANDATORY in accordance with the NCPDP Telecommunication Implementation Guide Version D.Ø. These fields must be sent if the segment is required for the transaction.
S	Designated as SITUATIONAL in accordance with the NCPDP Telecommunication Implementation Guide Version D.Ø. It is necessary to send these fields in noted situations.
	Some fields designated as situational by NCPDP may be required for all Kentucky Medicaid transactions.
R***	The "R***" indicates that the field is REPEATING. One of the other designators "M" or "S" will precede it.

MedImpact will not process submitted claims without all mandatory or required data elements submitted in the transaction. A complete Kentucky Medicaid payer specifications sheet, including NCPDP field numbers, is located in Appendix B of this manual.

2.5 Timely Filing Limits

- For all original claims, reversals, and adjustments, the timely filing limit from the DOS is three hundred and sixty-six (366) days.
- Claims submitted as a result of retro-eligibility determination remain subject to program timely filing limit edits and will only be approved for up to three hundred sixty-five (365) days from the date the retro-eligibility was put on file by Kentucky Medicaid.
- Members are not permitted to submit claims for direct member reimbursement (DMR) in the KY MCO PBM program.

3.0 Benefits and Limitations

3.1 Dispensing Rules & Edits

Note: As detailed in the introduction, the KY MCO PBM benefit was designed by DMS to replicate, as closely as possible, the state FFS benefit. This includes, but is not limited to, state single PDL, product coverage, restrictions, utilization management and patient safety edits, and prescription pricing/provider reimbursement. To ensure standardized program documentation, this billing manual may reference content posted on the MedImpact website and/or the contracted Kentucky FFS Vendor website.

3.1.1 Current Drug Lists

Below are various lists of drugs approved for dispensing to Kentucky Medicaid recipients:

- Covered Prescription Cold, Cough, and Vitamin Product
- Maximum Quantity Limits
- Preferred Drug List (PDL)
- Prior Authorization Criteria

The above lists are located under the "Resources/Drug Info/General Drug Info" tab at the following URL: https://kyportal.magellanmedicaid.com/provider/public/documents.xhtml

3.1.2 Days Supply

- Maximum Day Supply (non-maintenance drugs) = thirty-two (32) days.
- Maintenance Drugs (as defined by First Databank (fdb®): ninety-two (92) days or 100 units. For those drugs, providers should dispense up to a ninety-two (92) day supply or one hundred (100) units as per the prescriber's directions.

3.1.3 Maximum Quantity Limit (QL) and Maximum Duration (MD)

- Certain DMS designated drugs are limited to specific quantities on either a per dispensing or accumulated total dose basis. These drugs are identified on the Kentucky DMS Maximum Quantity Limit list posted online on the FFS and MCO PBM websites.
- Quantity limits may be per fill or cumulative over a designated timeframe. Qualtity Limits may apply for a defined period of time (e.g. 1 month, 1 year, lifetime) or may subject to "rolling limitation" where each claim is evaluated to ensure that, during the defined window of evaluation, total units/product dispensed does not exceed DMS promulgated quantity limits.
- Providers may request a prior authorization review and decision if seeking an override that would allow the member to exceed the defined quantity limit or duration of therapy. When requesting this type of override please be sure to include the justification and any supporting documentation from research or primary medical literature.

3.1.4 Refills

- Non-controlled drugs: Limited to an original fill, plus up to eleven (11) refills within three hundred and sixty-six (365) days from original date written.
- Schedule II: No refills allowed. Each fill requires a new prescription.
- Schedule III, IV, and V: Limited to an original fill, plus five (5) refills within one hundred and eighty (180) days from original date the prescription was written.

3.1.5 Member Age

In addition to fdb® established patent MinAge and MaxAge edits, certain designated drugs are subject to DMS defined age edits (AE). These products may be subject to an established member minimum age or member maximum age.

All prescriber requested variance to these established patient safety edits must provide case specific documentation and any primary literature research or published article(s) regarding the age exception requested.

3.1.6 Member Gender

Designated drugs are subject to gender edits as identified by fdb® clinical content.

3.1.7 Plan Maximum Dollar Limit

Claims for medications with a Medicaid Allowed Amount greater than $5,000.00 will deny as exceeding the plan maximum per claim dollar limit threshold established by DMS.

- Providers should validate that the appropriate quantity was entered.
- Providers may contact the Pharmacy Support Center at 1-800-210-7628 for override consideration. Calls not immediately eligible for override may be referred to the clinical call center for review and action.

In addition to the $5,000.00 global maximum per claim dollar limit, DMS has established higher per claim limits, at the drug, strength, and dosage form level, for certain high-cost products based upon established product dosage, unit cost, and survey of historical high-cost individual claims. In the event a high-cost drug product prescription final price does not exceed the value established in this DMS specific price limit edit, the claim will pay without dollar limit override/prior authorization required.

3.1.8 Diagnosis Codes

MedImpact provides automated clinical criteria evaluation for program clinical edits. Many drugs or drug category criteria requirements include the evaluation of member diagnosis for PA approval. Providers should enter appropriate ICD-10 code(s) on submitted claims to indicate the

member diagnosis when clinical criteria requires a diagnosis to refine or trigger clinical criteria approval to dispense. To ensure accuracy and claim documentation, before a member's diagnosis code is submitted on a claim transaction, that diagnosis code must be written on the face of the original prescription or verified with the prescriber.

In the event automated criteria evaluation is not successful and a manual prior authorization is required capture and documentation of member diagnoses relevant to the product dispensed is still required to make the determination to approve. Please ensure you capture the diagnosis or contact the prescriber to submit the prior authorization request for review by the MedImpact clinical team.

3.1.9 Medication Replacement

Members needing their medications replaced due to loss, theft, or destruction should contact Member Services at 1-800-210-7628. Frequency limitations and required documentation may be required for approval of replacement dispensing(s).

3.2 Mandatory Generic Requirements

- Providers should prescribe and dispense generic drugs whenever appropriate
- Multi-source brand drugs that do not have a Maximum Allowable Cost (MAC) associated with them will require prior authorization
- Providers may request prior authorization for override consideration with chart documentation of prior treatment with generic product(s) or relevant clinical justification
- Brand or multi-source PDL drugs may have additional criteria requirements related to trial of generic agents before non-preferred Brand/multi-source products could be approved – please refer to Kentucky Single PDL documentation for additional information

3.3 Proprietary MAC Program

(content shared from DMS' contracted MAC vendor billing manual)

The MAC Program is a service developed and maintained by Magellan Rx Management for use by Kentucky DMS. Its purpose is to encourage a provider to use a less expensive, therapeutically equivalent drug. Magellan Rx Management's Clinical Management Consultants regularly review the current drug price sources. A drug may be considered for MAC pricing if there are two or more manufacturers and it is listed as multi-source. Other factors considered are therapeutic equivalency ratings and availability in the marketplace. The MAC pricing is updated weekly. The specific drug pricing resources, algorithm, and MAC prices are proprietary and confidential. Distribution and access to this information is therefore limited to prevent Magellan Rx Management's competitors from obtaining free access to the information, which would result in not having to incur the costs associated with developing, maintaining, or licensing their own MAC service.

The full MAC List in a PDF can be found at https://kyportal.magellanmedicaid.com/provider/public/documents.xhtml under the "Resources/Drug Info/MAC" tab. To access the list, the provider must click on the "OK" button to agree with the Confidentiality Terms and Conditions of Use Statement, validating that the information received is for use in billing by Kentucky Medicaid providers only and that any unauthorized reproduction, distribution, or other use of the MAC List is strictly prohibited.

If a provider does not think a MAC price is valid, he/ she may appeal the price by e-mailing or faxing a completed MAC Price Research Request Form (located at https://kyportal.magellanmedicaid.com/provider/public/documents.xhtml under the "Resources/Drug Info/MAC" tab) to the Magellan Rx Management MAC Department. If a provider does not have Internet access, he/ she can call the Magellan Rx Management Pharmacy Support Center at 1-800-432-7005 to request that the form be faxed. If available, the provider will be supplied with one or more manufacturers that have a price comparable to the MAC price. If it is determined that there are no longer any manufacturers in that price range or if the provider can document that they do not have access to the supplied manufacturers, the MAC price and effective date will be adjusted accordingly, retroactive to the date of service for the MAC price prescription in question or other relevant date. Once the change is in effect, the provider will be informed and he/ she can re-bill the claim for the price adjustment.

Pharmacy providers should note that reimbursement paid according to the MAC price type, is the only reimbursement type that can be appealed to Kentucky Medicaid. Upon adjudication, if the final price type is WAC, FUL, or NADAC then NO price adjustment can be granted, as these reimbursement types are regulated by the federal government. If the reimbursement is calculated at Usual and Customary (U&C), the provider will need to reverse and rebill accordingly as this price is submitted on the incoming claim.

The different price types are identified on the return claim response in NCPDP field #522FM. For additional information regarding Kentucky Medicaid's drug pricing and reimbursement, please see Section 6 –Provider Reimbursement.

3.4 Drug Coverage

3.4.1 Included Items

Federal legend drugs where the product manufacturer participates in the OBRA90 Medicaid Drug Rebate Program (MDRP) and OTC products defined by DMS (with or without federal rebate eligible status).

- A prescription is required for covered OTC products
- The KY MCO PBM program has a unique and expanded Covered OTC Drug List. This list can be found as an attachment in Appendix C at the end of this document.

3.4.2 Excluded Products

(CMS Medicaid Exclusions & DMS Pharmacy Benefit Exclustions)

- Anorexia medications
- Biologicals (except Antisera)
- Blood/Blood Plasma products
- Bulk chemicals and excipients
- Cosmetic use
- Cough and Cold Products identified by the FDA (unless covered on OTC list)
- DESI/IRS/LTE
- Diagnostics
- Fertility medications
- Herbal Drugs
- Impotency medications
- Injectable contraceptives, contraceptive patches, contraceptive vaginal ring
- Lice Bedding Spray
- Mifeprex (mifepristone)
- Mineral products (except and fluoride preps if < 16 years old).
- Non-rebateable products except for covered vitamins, diabetic supplies.
- Nutritional/Dietary Supplements
- Other supplies (DME, ostomy)
- Palladone (Hydromorphone)
- Topical Contraceptives (such as condoms, diaphragms, cervical caps, and intravaginal contraceptives), unless covered on OTC list
- Weight loss and gain medications

3.5 Member Payment Information

3.5.1 Co-payment

The Kentucky Medicaid co-pay structure is as follows:

- No Member Copay (Brand or Generic) for any pharmacy benefit drug products.

3.6 Emergency Procedures

- All providers should follow normal PA procedures, except in emergency conditions.
- Emergency override execution is intended for unique circumstances where general prior authorization procedures cannot be followed or the prescriber cannot be reached/cannot respond and the situation is considered life threatening for the member.
- Providers may override PA requirements by entering LEVEL OF SERVICE (NCPDP Field # 418-DI) – "Ø3" (emergency) under the following guidelines:
    - Provider overrides must be submitted outside of normal business hours.
    - OTCs may not be overridden through this process

- Drugs normally not covered under the benefit cannot be overridden (e.g. exclusions)
- Provider overrides must be for a three (3)-day supply except where the package must be dispensed intact. In the event a claim will not process due to an unbreakable package size that exceeds a 3 day supply (high-dose alert or other limitation triggered) provider must contact the member and provider helpdesk at 800-210-7628 for a claim review and override if authorized.

3.7 Coordination of Benefits

- Online COB (cost avoidance) is required.
- Kentucky Medicaid is always the payer of last resort. Providers must bill all other payers first and then bill the Kentucky Medicaid.
- All member other insurance coverage must be exhausted before submission to the Kentucky MCO PBM program. Providers must submit any other coverage results for the member even in the event that member other coverage if not known to MedImpact, the member's MCO plan, or DMS.

3.7.1 Medicare Part-D

- Medicare Part B and Part D drugs will not be covered by the Kentucky Department for Medicaid Services. These claims will deny with NCPDP Error Code "41" indicating the claim must be billed to the appropriate Medicare Drug Coverage program.
- Kentucky Medicaid members, eligible for Medicare Part-D, may receive only selected Medicare Part D excluded drugs under the DMS Kentucky MCO PBM program.

3.7.2 NCPDP Other Coverage Codes (OCC)

NCPDP defined OCC codes are available to document other insurance. If the member record contains other health insurance information, one of the following codes must be used to identify the action/response of the previous payer:

1 - *No Other Coverage Identified*: Use this code when the recipient does not have current coverage by any other insurance plans but their member record indicates other health insurance information.

2 - *Other Coverage Exists* - Payment Collected: Use this code when the third party pays all or part of the claim.

3 - *Other Coverage Exists* - This Claim Not Covered: Use this code when the third party denies payment.

4 - *Other Coverage Exists - Payment Not Collected*: Use this code when a third party pays nothing on the claim, but applies the charges to a deductible or other patient liability amount.

- Other coverage code "02" (NCPDP field 308-C8) will require provider submit a TPL amount (431-DV) greater than zero ($0.00) reflecting the payment from the other health insurance plan.

- Other coverage code "03" – Other coverage exists – claim not covered" (NC)DP field 308-C8) will not require either other payer TPL amount or patient responsibility amount submitted to be greater than zero ($0.00).

Providers having difficulty submitting claims to more than one payer should contact their software vendor for assistance.

3.7.3 Other Payer Reject Code
(NCPDP Field # 472-6E)

- "04" – Pharmacy not contracted with plan on date of service
- "65" – Patient is not covered
- "67" – Filled before coverage effective
- "68" – Filled after coverage expired
- "69" – Filled after coverage terminated
- "70" – Product/Service not covered
- "73" – Refills are not covered
- "76" – Plan limitations exceeded

3.8 Long-Term Care (LTC)

- In order to identify that the patient is in a Long-Term Care (LTC) facility, providers should enter Patient Residence (NCPDP Field # 384-4X) =
  - "2" (Skilled Nursing Facility);
  - "3" (Nursing Home);
  - "4" (Assisted Living Facility);
  - "5" (Custodial Care Facility);
  - "6" (Group Home); or
  - "9" (Intermediate Care Facility).

3.8.1 OTC Products and LTC Per Diem products:

- Smoking Deterrents, Insulins, the products listed below, generic, and single-source brand (SSB) products that are NOT listed on the Per Diem list, NOT DESI, and ARE rebateable will be covered.
  - Abreva
  - Alaway OTC/Zaditor OTC
  - Plan B
  - Diabetic Supplies
  - Lancets
  - Dispense Syringes W/WO Needles (Insulin)
  - Needles/Disposable Insulin
  - Blood Sugar Diagnostics
  - Urine Acetone Test Aids

- Urine Glucose Test, Strip
- Urine Gluc-Acet Combination Test, Strip

- OTCs that are MSB (with the exception of Smoking Deterrents, Insulins, or the products listed below), DESI, on the Per Diem list (also listed below) and NOT rebateable will continue to deny for 70-NDC not covered.
- The Kentucky DMS has identified drugs that are not covered for LTC members for reimbursement through the pharmacy benefit. The drugs listed below are covered through LTC "per diem" reimbursement. Products include:
  - Acetaminophen 160 mg/5 ml Elixir
  - Acetaminophen 325 mg Tablet
  - Acetaminophen 650 mg Suppositories or Aspirin 650 mg Suppositories
  - Aluminum/Magnesium Hydroxide + Simethicone Suspension
  - Aluminum/Magnesium Hydroxide Suspension
  - Aspirin 650 mg Compressed Tablet
  - Bisacodyl 5mg Tablet
  - Bismuth Subsalicylate Suspension
  - Concentrated Aluminum/Magnesium Hydroxide + Simethicone Suspension
  - Concentrated Aluminum/Magnesium Hydroxide Suspension
  - Docusate Sodium 100mg Capsule
  - Guaifenesin Syrup
  - Hydrogen Peroxide 10%
  - Isopropyl Alcohol 70%
  - Kaolin/Pectin Suspension
  - Kaolin/Pectin w/Belladonna Alkaloids Suspension
  - Milk of Magnesia
  - Milk of Magnesia w/Cascara Sagrada
  - Mineral Oil
  - MiraLAX
  - Mouthwash
  - Neomycin/Polymyxin/Bacitracin Topical Ointment
  - Povidone Iodine Solution
  - Topical Skin Moisturizing Lotion

3.9 Compounds

Compound claims must be submitted in accordance with NCPDP guidance, field requirements and provider submission of the Multi-Ingredient Compound Segment is required to properly evaluate the claim for safety, program compliance and ensures accurate claim pricing.

Fields Required when submitting Multi-Ingredient Compounds (MIC):

In CLAIM segment

- Enter COMPOUND CODE (NCPDP Field #4Ø6-D6) value of "2"

- Enter PRODUCT CODE/NDC (NCPDP Field # 4Ø7-D7) as "Ø" on the claim segment to identify the claim as a multi-ingredient compound.
- Enter QUANTITY DISPENSED (NCPDP Field # 442-E7) of entire product.
- SUBMISSION CLARIFICATION CODE (NCPDP Field # 42Ø-DK) = Value "8" will only be permitted for POS and should be used only for compounds with at least one rebateable ingredient along with non-rebateable ingredients. Submitting value SCC=8 allows the provider to be reimbursed only for rebateable ingredient(s).

In Pricing segment

- Enter GROSS AMOUNT DUE (NCPDP Field # 43Ø-DU) for entire product.

In Compound segment:

- COMPOUND DOSAGE FORM DESCRIPTION CODE (NCPDP Field # 45Ø-EF)
- COMPOUND DISPENSING UNIT FORM INDICATOR (NCPCP Field # 451-EG)
- ROUTE OF ADMINISTRATION (NCPCP Field # 995-E2)
- COMPOUND INGREDIENT COMPONENT COUNT (NCPCP Field #447-EC) (Maximum of 25)

For Each Item in the compound claim:

- COMPOUND PRODUCT ID QUALIFIER (NCPCP Field # 488-RE) of "3"
- COMPOUND PRODUCT ID (NCPDP Field # 489-TE)
- COMPOUND INGREDIENT QUANTITY (NCPDP Field # 448-ED)
- COMPOUND INGREDIENT COST (NCPDP Field # 449-EE)

3.10 Lock-In

- Member Lock-In identification, management, and updates remain the responsibility of the member's MCO plan. MCO's provide member lock-in files to MedImpact on a "prn" schedule, sending updated member restriction records when changes are necessary.
- Lock-in override requests are also managed by the member's enrolled MCO and their care management teams have permission to update a member lock-in record, if necessary, to ensure member access to medication therapy.
- A member may be locked into a prescriber, pharmacy provider, or both.

3.11 Diabetic Supplies

As part of the KY MCO PBM benefit, many diabetic supplies are covered as part of the pharmacy benefit. Diabetic Supply products are included products on the state single PDL and may be found in the posted DMS Single PDL document at the following URL: https://kyportal.magellanmedicaid.com/public/client/static/kentucky/documents/PreferredDrugGuide_full.pdf

Covered supply product categories include, but are not limited to:

- Syringes with needles (sterile, 1cc or less)
- Urine test or reagent strips or tablets
- Blood ketone test or reagent strip
- Blood glucose test or reagent strips for home blood glucose monitor
- Normal, low, or high calibrator solution, chips
- Spring-powered device for lancet
- Lancets
- Home blood glucose monitor (Limit of 1 monitor per year per member)

Diabetic Supply Information: For the most current list of PDL product status and information relating to covered diabetic supplies, please visit the MedImpact Provider Portal or the Kentucky Fee-for-Service program website listed above for updated product coverage documentation as part of the Kentucky Medicaid Single Preferred Drug List (PDL).

4.0 Prospective Drug Utilization Review (ProDUR)

Prospective drug utilization review involves evaluating a patient's planned drug therapy before a medication is dispensed. This process allows the pharmacist to identify and resolve problems before the patient has received the medication. Pharmacists routinely perform prospective reviews in their daily practice by assessing a prescription medications dosage and directions while reviewing patient information for possible drug interactions or duplicate therapy.

As part of the MedImpact online claims adjudication process, prospective DUR employs computerized algorithms using compendia supplied clinical intervention rules, to perform drug therapy checks including drug interactions, duplications or contraindications with the patient's disease state or health condition. Programmatic ProDUR conflict evaluation and claim response detail supplements the pharmacist's review and may further identify situations in which potential drug problems may exist. When performed as part of the claim submission and processing steps in pharmacy practice systematic ProDUR evaluations and alerts help pharmacists ensure that patients receive safe and appropriate medication therapy.

4.1 Therapeutic Interventions

ProDUR (concurrent) edit review is performed for all claims unless MedImpact is otherwise directed by DMS.

4.2 DUR Claim Response Fields

For any DUR response/intervention where provider-level overrides have been authorized by DMS, providers should use the codes explained below if permitted and clinically appropriate.

4.2.1 DUR Reason for Service Code

The DUR Reason for Service Code provides detail regarding the type of conflict detected.

Valid DUR Reason for Service Codes and response scenarios deployed for the Kentucky Medicaid Program are as follows:

- DD = Drug to Drug Interaction
  - Non-LTC member – deny for Severity level 1,
  - LTC member - message/report Severity level 1
- TD = Therapeutic Duplication
  - Deny with permitted provider level override allowed (PPS code submission)
  - Clinical PA required for TD where member is receiving >2 Long or >2 Short acting stimulant products
- ID = Ingredient Duplication
  - Deny with permitted provider level override allowed (PPS code submission)
- PG = Drug to Pregnancy Precaution

- Deny Severity Level 1 with permitted provider level override allowed (PPS code submission)
-

Invalid values sent during claim submission will return NCPDP claim reject code/message below:

NCPDP Reject Code E4 -M/I DUR Conflict/Reason for Service Code.

4.2.2 DUR Professional Service Code

The DUR Professional Service Code captures reported information regarding actions and resolution detail for the identified intervention performed by the submitting pharmacist.

Valid DUR Professional Service Codes for the Kentucky Medicaid Program are:

- GP = Generic product selection
- MØ = Prescriber consulted
- MR = Medication review
- PH = Patient medication history
- PØ = Patient consulted
- RØ = RPh consulted other source

Invalid values sent during claim submission will return NCPDP claim reject code/message below:

NCPDP Reject Code E5 - M/I DUR Intervention/Professional Service Code.

4.2.3 DUR Result of Service

The DUR Result of Service Code is used to report the action taken by the pharmacist to address or resolve the DUR intervention reported in the original claim response.

Valid DUR Result of Services Codes for the Kentucky Medicaid Program include the following:

- 1A = Filled as is, false positive
- 1B = Filled prescription as is
- 1C = Filled with different dose
- 1D = Filled with different directions
- 1E = Filled with different drug
- 1F = Filled with different quantity
- 1G = Filled with prescriber approval
- 2A = Prescription not filled
- 2B = Not filled, directions clarified
- 3C = Discontinued
- 3D = Regimen changed
- 3E = Therapy changed

Invalid values sent during claim submission will return NCPDP claim reject code/message below:

- NCPDP Reject Code E6 -M/I DUR Result of Service Code

5.0 Program Edit Responses
(NCPDP 511-FB reject codes)

5.1 Point-of-Sale Claim Processing Status & Messages

Following online claim submission by a pharmacy, MedImpact's POS system will return a message to indicate claim status. If the submitted claim transaction passes all edits, a "Paid" claim status is returned along with the Kentucky DMS Medicaid Allowed Amount detailing provider payment information for that claim.

If a claim does not pass all program edits the transaction and claims are rejected (or denied) and the POS claim processing engine will return a message to the submitter indicating the reason for the rejected/denied response. The following table contains a list of NCPDP rejection codes (NCPDP Field 511-FB) and the NCPDP defined error description.

As shown below, all NCPDP reject codes are returned with an NCPDP message. Where applicable, the NCPDP field possibly in error related to that transaction response may be considered an initial source of additional information regarding the claim rejection/denial.

5.1.1 NCPDP defined point-of-sale Reject Codes and Descriptions:

Note: All reject codes in the table that follows may not apply to this program at this time but are included for future reference should program rules or benefit design change to include additional edits and resulting reject codes.

Reject Code	Explanation	Field Number Possibly In Error	Possible Solutions
("M/I" Means Missing/Invalid)			
Ø1	M/I Bin	1Ø1	Enter 023880
Ø2	M/I Version Number	1Ø2	NCPDP version D. Ø is required.
Ø3	M/I Transaction Code	1Ø3	Transactions allowed = B1, B2
Ø4	M/I Processor Control Number	1Ø4	Enter KYPROD1
Ø5	M/I Pharmacy Number	2Ø1	Enter Pharmacy NPI.
Ø6	M/I Group Number	3Ø1	Enter KYM01
Ø7	M/I Cardholder ID Number	3Ø2	Enter the Kentucky Medicaid Member ID number only. Do not enter any other patient ID. Do not enter any dashes. Providers should always examine a member's ID card before services are rendered.
Ø8	M/I Person Code	3Ø3	
Ø9	M/I Birth Date	3Ø4	Format = YYYYMMDD (no dashes). • YYYY = Year • MM = Month • DD = Day
1Ø	M/I Patient Gender Code	3Ø5	Values: • Ø = not specified • 1 = male • 2 = female
11	M/I Patient Relationship Code	3Ø6	1 (cardholder).
12	M/I PLACE OF SERVICE	3Ø7	
13	M/I Other Coverage Code	3Ø8	*See Section 3.8 – Coordination of Benefits.*
14	M/I Eligibility Clarification Code	3Ø9	

15	M/I Date of Service	4Ø1	Format = YYYYMMDD (no dashes). A future date is not allowed in this field. • YYYY = Year • MM = Month • DD = Day
16	M/I Prescription/Service Reference Number	4Ø2	Format = NNNNNNN. ▪ N = number
17	M/I Fill Number	4Ø3	Enter "Ø" for a new prescription. Acceptable values for a refill prescription range from 1 to 99.
19	M/I Days Supply	4Ø5	Format = NNN. Enter the days supply
2C	M/I Pregnancy Indicator	335	Enter "2" to indicate the patient is pregnant.
2E	M/I Primary Care Provider ID Qualifier	468	
2Ø	M/I Compound Code	4Ø6	
21	M/I Product/Service ID	4Ø7	Enter eleven (11) digit NDC only. Do not enter dashes.
22	M/I Dispense As Written (DAW)/Product Selection Code	4Ø8	
23	M/I Ingredient Cost Submitted	4Ø9	
25	M/I Prescriber ID	411	Enter the NPI.
26	M/I Unit of Measure	6ØØ	Enter the appropriate Unit of Measure (UM) for the product dispensed. Values: • EA = each • GM = grams • ML = milliliters
28	M/I Date Prescription Written	414	Format = YYYYMMDD (no dashes). A future date is not allowed. • YYYY = Year • MM = Month • DD = Day

29	M/I Number Refills Authorized	415	Enter the number of refills as authorized by the prescriber.
3A	M/I Request Type	498-PA	
3B	M/I Request Period Date-Begin	498-PB	
3C	M/I Request Period Date-End	498-PC	
3D	M/I Basis of Request	498-PD	
3E	M/I Authorized Representative First Name	498-PE	
3F	M/I Authorized Representative Last Name	498-PF	
3G	M/I Authorized Representative Street Address	498-PG	
3H	M/I Authorized Representative City Address	498-PH	
3J	M/I Authorized Representative State/Province Address	498-PJ	
3K	M/I Authorized Representative Zip/Postal Zone	498-PK	
3M	M/I Prescriber Phone Number	498-PM	
3N	M/I Prior Authorized Number Assigned	498-PY	
3P	M/I Authorization Number	5Ø3	
3R	Prior Authorization Not Required	4Ø7	
3S	M/I Prior Authorization Supporting Documentation	498-PP	
3T	Active Prior Authorization Exists Resubmit at Expiration of Prior Authorization		
3W	Prior Authorization In Process		

3X	Authorization Number Not Found	5Ø3	
3Y	Prior Authorization Denied		
32	M/I Level of Service	418	
33	M/I Prescription Origin Code	419	
34	M/I Submission Clarification Code	42Ø	
35	M/I Primary Care Provider ID	421	
38	M/I Basis of Cost	423	
39	M/I Diagnosis Code	424	Enter an appropriate verified ICD-10 Code.
4C	M/I Coordination of Benefits/Other Payments Count	337	
4E	M/I Primary Care Provider Last Name	57Ø	
4X	M/I Patient Residence Code	384	
4Ø	Pharmacy Not Contracted with Plan on Date of Service	None	Call the Provider Management/Enrollment Department if necessary (see Section 1.1 – Important Contact Information).
41	Submit Bill to Other Processor or Primary Payer	None	
5C	M/I Other Payer Coverage Type	338	
5E	M/I Other Payer Reject Count	471	
5Ø	Non-Matched Pharmacy Number	2Ø1	
51	Non-Matched Group ID	3Ø1	Enter KYM01 as group.
52	Non-Matched Cardholder ID	3Ø2	Enter member's Kentucky Medicaid ID number only. Do not enter any other patient ID.
53	Non-Matched Person Code	3Ø3	

54	Non-Matched Product/Service ID Number	4Ø7	Enter eleven (11) digit NDC.
55	Non-Matched Product Package Size	4Ø7	
56	Non-Matched Prescriber ID	411	Enter the NPI.
58	Non-Matched Primary Prescriber	421	
6C	M/I Other Payer ID Qualifier	422	
6E	M/I Other Payer Reject Code	472	
6Ø	Product/Service Not Covered for Patient Age	3Ø2, 3Ø4, 4Ø1, 4Ø7	
61	Product/Service Not Covered for Patient Gender	3Ø2, 3Ø5, 4Ø7	
62	Patient/Card Holder ID Name Mismatch	31Ø, 311, 312, 313, 32Ø	
63	Institutionalized Patient Product/Service ID Not Covered		Check drug coverage exclusions for member in an LTC facility.
64	Claim Submitted Does Not Match Prior Authorization	2Ø1, 4Ø1, 4Ø4, 4Ø7, 416	
65	Patient Is Not Covered	3Ø3, 3Ø6	
66	Patient Age Exceeds Maximum Age	3Ø3, 3Ø4, 3Ø6	
67	Filled Before Coverage Effective	4Ø1	Enter member's Kentucky Medicaid ID number only. Do not enter any other patient ID. Check claim DOS.
68	Filled After Coverage Expired	4Ø1	Enter member's Kentucky Medicaid ID number only. Do not enter any other patient ID. Check claim DOS.
69	Filled After Coverage Terminated	4Ø1	

7C	M/I Other Payer ID	34Ø	
7E	M/I DUR/PPS Code Counter	473	
7Ø	Product/Service Not Covered	4Ø7	Enter eleven (11) digit NDC. Drug not covered (may be CMS exclusion, rebate status, etc…)
71	Prescriber is Not Covered	411	
72	Primary Prescriber is Not Covered	421	
73	Refills are Not Covered	4Ø2, 4Ø3	
74	Other Carrier Payment Meets or Exceeds Payable	4Ø9, 41Ø, 442	
75	Prior Authorization Required	462	
76	Plan Limitations Exceeded	4Ø5, 442	Validate submitted claim days supply and quantity dispensed. Follow PA procedures if appropriate.
77	Discontinued Product/Service ID Number	4Ø7	Validate eleven (11) digit NDC. NDC is obsolete per fdb®.
78	Cost Exceeds Maximum	4Ø7, 4Ø9, 41Ø, 442	Claims will deny if greater than $5,000.00 or DMS defined drug specific maximum allowed cost. Provider must contact the Pharmacy Call Center for claim review and override request.
79	Refill Too Soon	4Ø1, 4Ø3, 4Ø5	
8C	M/I Facility ID	336	
8E	M/I DUR/PPS Level of Effort	474	
8Ø	Drug-Diagnosis Mismatch	4Ø7, 424	
81	Claim Too Old	4Ø1	Check submitted claim DOS
82	Claim is Post-Dated	4Ø1	Future fill dated are not allowed

83	Duplicate Paid/Captured Claim	2Ø1, 4Ø1, 4Ø2, 4Ø3, 4Ø7	
84	Claim Has Not Been Paid/Captured	2Ø1, 4Ø1, 4Ø2	
85	Claim Not Processed	None	
86	Submit Manual Reversal	None	
87	Reversal Not Processed	None	
88	DUR Reject Error		
89	Rejected Claim Fees Paid		
9Ø	Host Hung Up		
91	Host Response Error		
92	System Unavailable/Host Unavailable		
95	Time Out		
96	Scheduled Downtime		
97	Payer Unavailable		
98	Connection to Payer is Down		
99	Host Processing Error		Do not retransmit claim(s) immediately. Resubmit after a pause.
AA	Patient Spend down Not Met		
AB	Date Written is After Date Filled		
AC	Product Not Covered Non-Participating Manufacturer		
AD	Billing Provider Not Eligible to Bill this Claim Type		
AE	QMB (Qualified Medicare Beneficiary) Bill Medicare		

AF	Patient Enrolled Under Managed Care		
AG	Days Supply Limitation for Product/Service		
AH	Unit Dose Packaging Only Payable for Nursing Home Members		
AJ	Generic Drug Required		
AK	M/I Software Vendor/Certification ID	11Ø	
AM	M/I Segment Identification	111	
A9	M/I Transaction Count	1Ø9	
BE	M/I Professional Service Fee Submitted	477	
B2	M/I Service Provider ID Qualifier	2Ø2	Enter "Ø1" for NPI.
CA	M/I Patient First Name	31Ø	
CB	M/I Patient Last Name	311	
CC	M/I Cardholder First Name	312	
CD	M/I Cardholder Last Name	313	
CE	M/I Home Plan	314	
CF	M/I Employer Name	315	
CG	M/I Employer Street Address	316	
CH	M/I Employer City Address	317	
CI	M/I Employer State/Province Address	318	
CJ	M/I Employer Zip Postal Zone	319	
CK	M/I Employer Phone Number	32Ø	
CL	M/I Employer Contact Name	321	

CM	M/I Patient Street Address	322	
CN	M/I Patient City Address	323	
CO	M/I Patient State/Province Address	324	
CP	M/I Patient Zip/Postal Zone	325	
CQ	M/I Patient Phone Number	326	
CR	M/I Carrier ID	327	
CW	M/I Alternate ID	33Ø	
CX	M/I Patient ID Qualifier	331	
CY	M/I Patient ID	332	
CZ	M/I Employer ID	333	
DC	M/I Dispensing Fee Submitted	412	
DN	M/I Basis of Cost Determination	423	
DQ	M/I Usual & Customary Charge	426	
DR	M/I Prescriber Last Name	427	
DT	M/I Special Packaging Indicator	429	
DU	M/I Gross Amount Due	43Ø	
DV	M/I Other Payer Amount Paid	431	
DX	M/I Patient Paid Amount Submitted	433	
DY	M/I Date of Injury	434	
DZ	M/I Claim/Reference ID	435	
EA	M/I Originally Prescribed Product/Service Code	445	
EB	M/I Originally Prescribed Quantity	446	

EC	M/I Compound Ingredient Component Count	447	
ED	M/I Compound Ingredient Quantity	448	
EE	M/I Compound Ingredient Drug Cost	449	
EF	M/I Compound Dosage Form Description Code	45Ø	
EG	M/I Compound Dispensing Unit Form Indicator	451	
EH	M/I Compound Route of Administration	452	
EJ	M/I Originally Prescribed Product/Service ID Qualifier	453	
EK	M/I Scheduled Prescription ID Number	454	
EM	M/I Prescription/Service Reference Number Qualifier	445	
EN	M/I Associated Prescription/Service Reference Number	456	
EP	M/I Associated Prescription/Service Date	457	
ER	M/I Procedure Modifier Code	459	
ET	M/I Quantity Prescribed	46Ø	
EU	M/I Prior Authorization Type Code	461	
EV	M/I Prior Authorization Number Submitted	462	
EW	M/I Intermediary Authorization Type ID	463	

EX	M/I Intermediary Authorization ID	464	
EY	M/I Provider ID Qualifier	465	
EZ	M/I Prescriber ID Qualifier	466	Enter "Ø1" for NPI.
E1	M/I Product/Service ID Qualifier	436	
E2	M/I Route of Administration	995	
E3	M/I Incentive Amount Submitted	438	
E4	M/I Reason for Service Code	439	
E5	M/I Professional Service Code	44Ø	
E6	M/I Result of Service Code	441	
E7	M/I Quantity Dispensed	442	
E8	M/I Other Payer Date	443	
E9	M/I Provider ID	444	
FO	M/I Plan ID	524	
GE	M/I Percentage Sales Tax Amount Submitted	482	
HA	M/I Flat Sales Tax Amount Submitted	481	
HB	M/I Other Payer Amount Paid Count	341	
HC	M/I Other Payer Amount Paid Qualifier	342	
HD	M/I Dispensing Status	343	
HE	M/I Percentage Sales Tax Rate Submitted	483	
HF	M/I Quantity Intended to be Dispensed	344	
HG	M/I Days Supply Intended to be Dispensed	345	

H1	M/I Measurement Time	495	
H2	M/I Measurement Dimension	496	
H3	M/I Measurement Unit	497	
H4	M/I Measurement Value	499	
H5	M/I Primary Care Provider Location Code	469	
H6	M/I DUR Co-Agent ID	476	
H7	M/I Other Amount Claimed Submitted Count	478	
H8	M/I Other Amount Claimed Submitted Qualifier	479	
H9	M/I Other Amount Claimed Submitted	48Ø	
JE	M/I Percentage Sales Tax Basis Submitted	484	
J9	M/I DUR Co-Agent ID Qualifier	475	
KE	M/I Coupon Type	485	
M1	Patient Not Covered in this Aid Category		
M2	Member Locked In		
M3	Host PA/MC Error		
M4	Prescription/Service Reference Number/Time Limit Exceeded		
M5	Requires Manual Claim		
M6	Host Eligibility Error		
M7	Host Drug File Error		
M8	Host Provider File Error		

ME	M/I Coupon Number	486	
MZ	Error Overflow		
NE	M/I Coupon Value Amount	487	
NN	Transaction Rejected At Switch or Intermediary		
PA	PA Exhausted/Not Renewable		
PB	Invalid Transaction Count for This Transaction Code	1Ø3, 1Ø9	
PC	M/I Claim Segment	111	
PD	M/I Clinical Segment	111	
PE	M/I COB/Other Payments Segment	111	
PF	M/I Compound Segment	111	
PG	M/I Coupon Segment	111	
PH	M/I DUR/PPS Segment	111	
PJ	M/I Insurance Segment	111	
PK	M/I Patient Segment	111	
PM	M/I Pharmacy Provider Segment	111	
PN	M/I Prescriber Segment	111	
PP	M/I Pricing Segment	111	
PR	M/I Prior Authorization Segment	111	
PS	M/I Transaction Header Segment	111	
PT	M/I Workers' Compensation Segment	111	

PV	Non-Matched Associated Prescription/Service Date	457	
PW	Non-Matched Employer ID	333	
PX	Non-Matched Other Payer ID	34Ø	
PY	Non-Matched Unit Form/Route of Administration	451, 452, 6ØØ	
PZ	Non-Matched Unit Of Measure to Product/Service ID	4Ø7, 6ØØ	
P1	Associated Prescription/Service Reference Number Not Found	456	
P2	Clinical Information Counter Out of Sequence	493	
P3	Compound Ingredient Component Count Does Not Match Number of Repetitions	447	
P4	Coordination of Benefits/Other Payments Count Does Not Match Number of Repetitions	337	
P5	Coupon Expired	486	
P6	Date of Service Prior to Date of Birth	3Ø4, 4Ø1	
P7	Diagnosis Code Count Does Not Match Number of Repetitions	491	
P8	DUR/PPS Code Counter Out of Sequence	473	
P9	Field is Non-Repeatable		
RA	PA Reversal Out of Order		
RB	Multiple Partials Not Allowed		
RC	Different Drug Entity Between Partial and Completion		

RD	Mismatched Cardholder/Group ID-Partial to Completion	3Ø1, 3Ø2	
RE	M/I Compound Product ID Qualifier	488	
RF	Improper Order of "Dispensing Status" Code on Partial Fill Transaction		
RG	M/I Associated Prescription/Service Reference Number on Completion Transaction	456	
RH	M/I Associated Prescription/Service Date on Completion Transaction	457	
RJ	Associated Partial Fill Transaction Not on File		
RK	Partial Fill Transaction Not Supported		
RM	Completion Transaction Not Permitted With Same "Date of Service" as Partial Transaction	4Ø1	
RN	Plan Limits Exceeded on Intended Partial Fill Values	344, 345	
RP	Out Of Sequence "P" Reversal on Partial Fill Transaction		
RS	M/I Associated Prescription/Service Date on Partial Transaction	457	
RT	M/I Associated Prescription/Service Reference Number on Partial Transaction	456	
RU	Mandatory Data Elements Must Occur Before Optional Data Elements in a Segment		

R1	Other Amount Claimed Submitted Count Does Not Match Number of Repetitions	478, 48Ø	
R2	Other Payer Reject Count Does Not Match Number of Repetitions	471, 472	
R3	Procedure Modifier Code Count Does Not Match Number of Repetitions	458, 459	
R4	Procedure Modifier Code Invalid for Product/Service ID	4Ø7, 436, 459	
R5	Product/Service ID Must be Zero When Product/Service ID Qualifier Equals Ø6	4Ø7, 436	
R6	Product/Service Not Appropriate for this Location	3Ø7, 4Ø7, 436	
R7	Repeating Segment Not Allowed in Same Transaction		
R8	Syntax Error		
R9	Value in Gross Amount Due Does Not Follow Pricing Formula	43Ø	
SE	M/I Procedure Modifier Code Count	458	
TE	M/I Compound Product ID	489	
UE	M/I Compound Ingredient Basis of Cost Determination	49Ø	
VE	M/I Diagnosis Code Count	491	
WE	M/I Diagnosis Code Qualifier	492	
XE	M/I Clinical Information Counter	493	
ZE	M/I Measurement Date	494	

5.2 Host System or Processing Issues

Occasionally, providers may receive a message that indicates their prescription switch is having technical problems communicating with MedImpact
Host disconnected before session completed.
Processing host did not accept transaction or did not respond within timeout period.

5.2.1 System Hours of Availability

Twenty-four (24) hour availability. In the event scheduled down-time or planned outage is required during the contract term the following NCPDP reject code will be returned in the transaction response and claim will not adjudicate. Please do not resubmit the claim immediately; visit the MedImpact Kentucky Provider Portal at: http://kyportal.medimpact.com for additional information related to the scheduled down-time.

NCPDP Reject Code	Message
99	Host Processing Error

6.0 Provider Reimbursement

6.1 Provider Payment Algorithms

The provider is paid at the lesser of:

- Wholesale Acquisition Cost (WAC) + dispense fee; OR
- Federal Upper Limit (FUL) + dispense fee; OR
- State Maximum Allowable Cost (MAC) + dispense fee; OR
- National Average Drug Acquisition Cost (NADAC) + dispense fee; OR
- Usual & Customary (U & C);

A professional dispensing fee of $10.64 per recipient, per drug, per provider, per month (currently set at 23 days) shall be reimbursed for any qualifying dispensed Rx as noted above.

If a non-preferred product is submitted and the claim pays at MAC or FUL, providers can submit a DAW Code of "1" to override MAC and/or FUL once a PA request is submitted and approved.

Appendix A – Universal Prior Authorization Form

Kentucky Medicaid
Pharmacy Prior Auth

Sample (page 1 only):

Rev. 7.1.2021

Kentucky Medicaid Pharmacy Prior Authorization Form

- For Drug Requests (unless noted below) — Complete ONLY page 1 of this form.
- For ALL Opioid Requests — Complete page 1 AND page 2 of this form.
- For Hepatitis C Direct Acting Antiviral (DAA) Therapy or Synagis® Requests — Complete page 1 AND page 3 of this form.
- For Buprenorphine Products: For Pain Management Diagnosis — Complete page 1 AND page 2 of this form.

Complete each section legibly and completely. Include any supporting documents as needed (lab results, chart notes, etc.).

Please fax completed form to the corresponding fax number of the health plan partner your patient is currently enrolled. Additional prior authorization forms can be found by clicking on hyperlinks provided to the right.	Plan:	Phone number:	Fax number:
	☐ Fee-For-Service (Magellan)	1 (800) 477-3071	1 (800) 365-8835
	☐ All Kentucky MCO Plans (MedImpact)	1 (800) 210-7628	1 (858) 357-2612

Patient Information:

Member Name:	Date of Birth:
Address: City, State, Zip:	
Sex: ☐ Male ☐ Female	Height: / Weight:
Member ID:	Medication Allergies:

Prescriber Information:

Prescriber Name:	NPI:
Prescriber Address: City, State, Zip:	
Prescriber Specialty:	DEA:
Phone:	Fax:

Diagnosis and Medical Information for Requested Medication: ☐ INITIAL REQUEST ☐ REAUTHORIZATION (REFILL) Request with current plan

Diagnosis:	ICD-10 Code:	Date of Diagnosis:

Medication Requested (name, strength and dosage form):
If request is for an opioid, please continue to page 2.

Quantity:	Days' Supply:	Expected Duration of Therapy:

Directions for Use:

Rationale for Prior Authorization:

Brand Medically Necessary? ☐ Yes ☐ No *If yes, please provide medical justification why the patient cannot be appropriately treated with the generic form of the drug.*

Please indicate previous treatment outcomes below:

Previous Medication	Strength	Quantity	Directions (Sig)	Dates (from and to)	Reason for Discontinuation

☐ Patient recently hospitalized— *If requesting ATYPICAL ANTIPSYCHOTICS, please provide hospitalization dates and discharge dosage of atypical antipsychotic medications in table above.*

Additional Clinical Information or Medical Rationale for Request:

Requesting Provider: ☐ Prescriber ☐ Pharmacy	Date of Request:
*Requestor Name (print):	*Requestor Signature:

**On behalf of the Prescriber or Pharmacy Provider, I certify that the information stated above is true, made to allow Kentucky Medicaid to offer prescription coverage to this member for the medication requested above. I understand the designated health plan will retain this document and any attached materials for the purposes of possible future audit(s).*

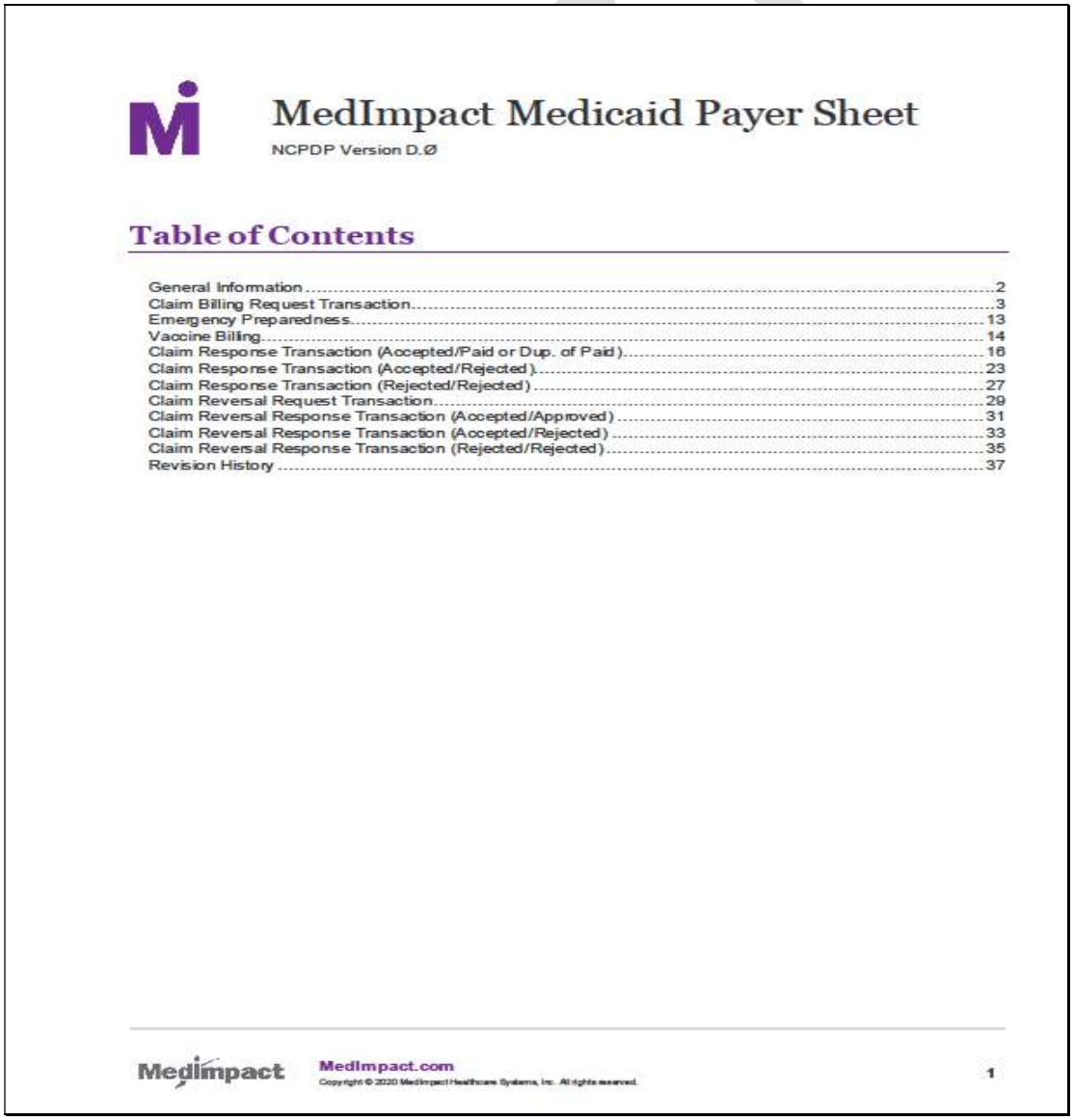
CONTINUE TO PAGE 2 ONLY IF REQUESTING ANY OPIOID
CONTINUE TO PAGE 3 ONLY IF REQUESTING HEPATITIS C DAA THERAPY OR SYNAGIS®

Appendix B – Payer Specifications

Please review the Kentucky MCO PBM NCPDP D.0 Billing Manual at https://pharmacy.medimpact.com for the current program D.0 Payer Specification document. NCPDP Provider registration credentials may be used to access the MedImpact pharmacy provider portal address above and embedded below for convenience.

MedImpact KY MCO PBM Medicaid Payer

Sample (Table of Contents):



MedImpact Medicaid Payer Sheet

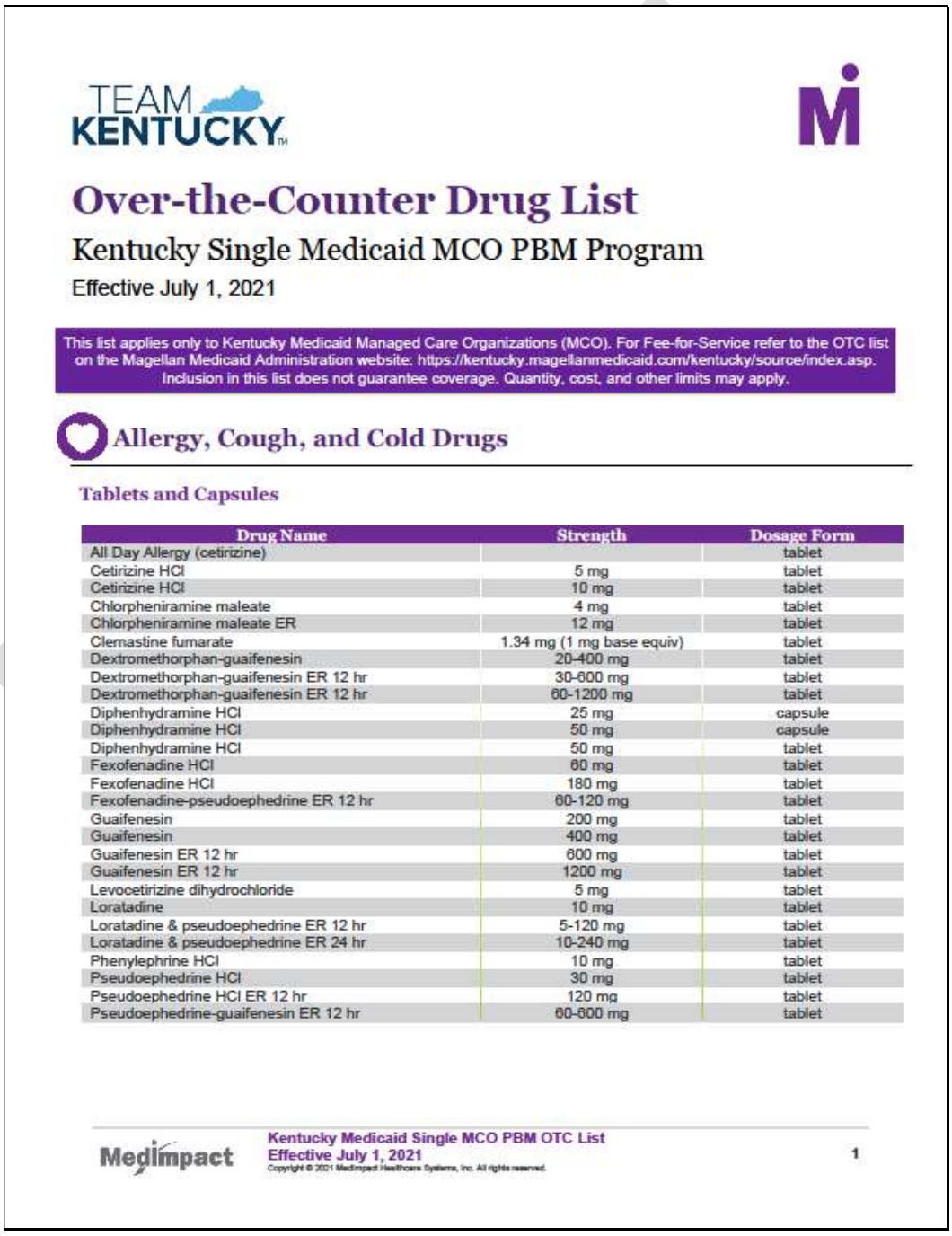
NCPDP Version D.Ø

Table of Contents

Appendix C – Kentucky MCO PBM Over-the-Counter Drug List

KY Medicaid OTC List 07012021.pdf

Sample:



TEAM KENTUCKY

Over-the-Counter Drug List

Kentucky Single Medicaid MCO PBM Program

Effective July 1, 2021

This list applies only to Kentucky Medicaid Managed Care Organizations (MCO). For Fee-for-Service refer to the OTC list on the Magellan Medicaid Administration website: https://kentucky.magellanmedicaid.com/kentucky/source/index.asp. Inclusion in this list does not guarantee coverage. Quantity, cost, and other limits may apply.

Allergy, Cough, and Cold Drugs

Tablets and Capsules

Drug Name	Strength	Dosage Form
All Day Allergy (cetirizine)		tablet
Cetirizine HCl	5 mg	tablet
Cetirizine HCl	10 mg	tablet
Chlorpheniramine maleate	4 mg	tablet
Chlorpheniramine maleate ER	12 mg	tablet
Clemastine fumarate	1.34 mg (1 mg base equiv)	tablet
Dextromethorphan-guaifenesin	20-400 mg	tablet
Dextromethorphan-guaifenesin ER 12 hr	30-600 mg	tablet
Dextromethorphan-guaifenesin ER 12 hr	60-1200 mg	tablet
Diphenhydramine HCl	25 mg	capsule
Diphenhydramine HCl	50 mg	capsule
Diphenhydramine HCl	50 mg	tablet
Fexofenadine HCl	60 mg	tablet
Fexofenadine HCl	180 mg	tablet
Fexofenadine-pseudoephedrine ER 12 hr	60-120 mg	tablet
Guaifenesin	200 mg	tablet
Guaifenesin	400 mg	tablet
Guaifenesin ER 12 hr	600 mg	tablet
Guaifenesin ER 12 hr	1200 mg	tablet
Levocetirizine dihydrochloride	5 mg	tablet
Loratadine	10 mg	tablet
Loratadine & pseudoephedrine ER 12 hr	5-120 mg	tablet
Loratadine & pseudoephedrine ER 24 hr	10-240 mg	tablet
Phenylephrine HCl	10 mg	tablet
Pseudoephedrine HCl	30 mg	tablet
Pseudoephedrine HCl ER 12 hr	120 mg	tablet
Pseudoephedrine-guaifenesin ER 12 hr	60-600 mg	tablet