Kentucky Medicaid Fee-For-Service (FFS) Pharmacy Benefit Manager (PBM) Pharmacy Provider Point-of-Sale (POS) Billing Manual

01/01/2024

Revision History

Document Version	Date	Name	Comments
1.0	9/14/2023	KY FFS PBM Provider Billing Manual	Document Creation

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Glossary / Definitions

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340B - A government program that requires drug manufacturers to sell outpatient drugs to eligible health care organizations at significantly reduced prices.

A

ABD - See “Aged, Blind & Disabled”

Access - The ability to get needed medical care and services.

Accreditation - An evaluative process in which a healthcare organization undergoes an examination of its policies, procedures and performance by an external organization ("accrediting body") to ensure that it is meeting predetermined criteria.

Accumulator - An amount that represents a beneficiary’s current Deductible, Out-of-Pocket payment, or Benefit Maximum status.

Acute - Requiring short-term treatment.

Adherence - The decision to continue use of drugs that have been prescribed by a health professional to treat an individual’s health conditions.

Adjudication - The process of determining if a claim should be paid, the amount to reimburse the provider, and how much the patient cost share should be after comparing the claim to the benefits

Adverse Benefit Determination - When a claim or request for prior authorization is denied for a covered benefit because the required conditions for approval have not been met.

Adverse Drug Reaction - An unintended and often dangerous response to a drug; an adverse drug reaction should be immediately reported to a health professional.

Aged, Blind & Disabled (ABD) - A Medicaid program that provides health care for beneficiaries who are either age 65 or older, legally blind, or that meet the Supplemental Security Income (SSI) criteria for disability; SSI is administered by the Social Security Administration.

Allergy Treatment - Medical treatment by or under the direction of a physician for allergies, which may include testing, evaluation, injections, or administration of serum.

Analgesic - A drug used to relieve pain.

Anti-infective - A drug used to treat or prevent an infection.

Antineoplastic - A drug used to treat cancer.

Appeal - A request to overturn an Adverse Benefit Determination or Benefit Denial made by a plan sponsor or Pharmacy Benefit Manager (PBM).

Attention Deficit Hyperactivity Disorder (ADHD) - A condition affecting some children and adults that is demonstrated as inattention, excessive activity, and impulsivity.

Authorization - The approval by the health plan for care and/or claim payment.

B

Behavioral Health - Treatment of mental health and/or substance abuse disorders.

Beneficiary - A person who is eligible for and enrolled in a state Medicaid program. Also referred to as member, recipient, or enrollee.

Benefit Limit - A predetermined amount of pharmacy benefit expenses that your plan sponsor will cover before you must pay for your medications at 100%. In most cases, the plan sponsor paid amount is tracked and, once your benefit limit is met, you are responsible for a 100% copayment amount.

Benefit Period - The period of time for which we pay Benefits for Covered Services rendered while the Health Benefit Plan was in effect.

Benefits - The health care items or services covered under a health insurance plan.

Biologic Drug - A drug that is derived from a living organism; biologics are often highly advanced, specialized drugs that are appropriate only in rare cases.

Brand Name Drug - A drug approved by the Federal Drug Administration (FDA) that is manufactured and distributed by or with the approval of the drug company that received the patent approval.

C

Cardholder - The individual that qualifies for coverage under a health plan; in some cases, coverage may extend to dependents of the cardholder that would not qualify themselves.

Cardholder Identifier (ID) - A unique number that is assigned to a cardholder and is used to identify eligibility under a health plan; cardholder ID is required to be submitted on claims and encounters for covered health items and services.

Cardiovascular Drug - A drug that is used to treat conditions of the cardiovascular system, which can include high blood pressure, coronary artery disease, and heart failure.

Care Plan - Identifies the medications and other treatments a health professional prescribes or recommends for treating an individual’s health conditions.

Case Management - A program that helps a patient identify and receive the most appropriate and cost-effective care; often includes ongoing monitoring and assistance.

Centers for Medicare and Medicaid Services (CMS) - The federal agency that runs the Medicare program. In addition, CMS works with the States to run the Medicaid program. CMS works to make sure that the beneficiaries in these programs are able to get high quality health care.

Central Nervous System (CNS) Drug - A drug that is used to treat conditions affecting the brain or spinal cord; CNS drugs can be used to treat depression, anxiety, movement disorders, strokes, seizures, and many other conditions.

Chemotherapy Drug - A drug that is used to treat cancer; chemotherapy typically targets specific types of cancer cells to either kill them or to stop them from reproducing.

Chronic - Requiring long-term treatment.

Claim - A request for payment for a health item or service that was provided; a claim could be submitted by a provider or a beneficiary.

Coinsurance - A fixed amount or percentage that must be paid by a beneficiary for each covered health item or service. See “Copayment”

Complaint - See “Grievance”

Compliance - Taking a drug as it is prescribed or following a health professional’s instructions.

Contraceptive - A drug or device, often requiring a prescription, which is used to prevent pregnancy.

Contraindication - Any condition that would be a reason not to receive a drug or treatment due to a potential health risk. For example, pregnancy may be a contraindication for some medications due to potential harm to the fetus.

Controlled Substance - A drug that the U.S. Food and Drug Administration (FDA) has determined to be habit-forming or addictive, and that is subject to limits in prescribing or use, including complete prohibition in some cases.

Coordination of Benefits (COB) - A program that determines which plan or insurance policy will pay first if two health plans or insurance policies cover the same benefits. Medicaid typically pays last. If one of the plans is a Medicare or Medicaid health plan, Federal law may decide who pays first.

Copayment - A dollar amount paid by a Medicaid beneficiary at the time of receiving a covered service from a participating provider. Copayments may not apply to all beneficiaries or services.

Cost Sharing - Amounts that might be paid by a Medicaid beneficiary at the time of receiving a covered service; cost sharing includes copayments, deductibles, and amounts that exceed maximum benefits.

Covered Benefit - A health service or item that is included in your health plan, and that is paid for either partially or fully.

Covered Outpatient Drug - A drug that is covered by Medicaid outside of a hospital stay; covered outpatient drugs may be subject to utilization management guidelines.

Customer Service Representative (CSR) - An individual that works for a PBM or health plan, and that is available by phone to answer your questions during standard business hours.

D

Deductible - A predetermined amount that some plans require a Medicaid beneficiary to pay before the plan begins covering the beneficiary’s costs.

Denial - When a claim or encounter is not approved for payment by a health plan or PBM; denials often occur when the item or service is not covered under the benefit.

Dependent - A person who is covered by a health plan under another person’s eligibility; dependents are often children, spouses, or domestic partners of the cardholder.

Dermatological Drug - A drug used to treat conditions of the skin.

Diagnosis - The name for the health problem that you have.

Diagnosis Code - A code used by health professionals to describe your health problem.

Diagnostic - A treatment or procedure administered by a health professional to identify a health condition.

Dialysis - A treatment that cleans your blood when your kidneys don't work. It gets rid of harmful wastes and extra salt and fluids that build up in your body. It also helps control blood pressure and helps your body keep the right amount of fluids.

Direct Member Reimbursement (DMR) - Direct member reimbursement is a paper claim submitted directly by a member. This method of reimbursement is used when a member has to pay full price for a drug or does not have their drug identification card with them at the pharmacy store.

Disability - Any condition of the body or mind that makes it more difficult for the person with the condition to do certain activities and interact with the world around them.

Disclosure - When information about you is shared by your health plan, caregivers or others with or without your permission.

Disenroll - Ending your health care coverage with a health plan.

Drug Interaction - An unintended reaction between a drug and another substance in an individual's body, often another drug, that affects how the drug works; drug interactions can make a drug less effective, more effective, or cause other unrelated effects.

Drug Utilization/Use Review (DUR) - Processes that PBMs, plans, and state Medicaid programs use to review prescriptions you are using at the same time to make sure prescriptions are safe and medically necessary.

Dual Eligible - Persons who are entitled to Medicare (Part A and/or Part B) and who are also eligible for Medicaid.

Durable Medical Equipment (DME) - Medical equipment that is ordered by a doctor for use in the home.

E

Eligible - Meets the requirements of the health plan for benefit coverage.

Encounter - Individual service provided by a health care provider, billed to a PBM or Payer.

End Stage Renal Disease (ESRD) - Permanent kidney failure requiring dialysis or a kidney transplant.

Enroll/Enrollment - The process by which a Medicaid eligible person becomes a member of a managed care plan.

Enrollee - A person who is eligible for and enrolled in a state Medicaid program. Also referred to as member, recipient, or beneficiary.

Evidence - Facts that something is true or not true. Doctors may provide evidence that you require a specific drug.

Excluded - Not covered by your Medicaid health plan.

Exclusion - An Item or service that Medicaid does not cover

Experimental Drug - A drug that does not have enough clinical evidence to prove that it is safe or effective in treating the condition it is intended to treat.

Explanation of Benefits (EOB) - A form or letter that is sent to a pharmacy or a beneficiary to describe the payment for prescriptions or services you received.

F

Fee-For-Service - A traditional way to pay for medical services where doctors and hospitals are paid for each service they provide.

Food and Drug Administration (FDA) -Agency, that was created to protect American consumers by enforcing the Federal Food, Drug, and Cosmetic Act and public health laws regulating food, drugs, medical devices, biologics, cosmetics, and other products.

Formulary - A list of certain drugs that are approved for use and coverage by a health plan.

Formulary Exclusion - A drug that is not covered by a health plan.

Fraud - Intentional deception or mistruth (a lie) used to obtain some unauthorized benefit.

G

Gastrointestinal Drug - A drug used to treat conditions of the stomach or intestines.

Generic Drug - A prescription drug that has the same active-ingredient formula as a brand name drug. Generic drugs usually cost less than brand name drugs and are rated by the Food and Drug Administration (FDA) to be as safe and effective as brand name drugs

Generic Substitution - When a generic drug is dispensed instead of the brand name drug equivalent. This can only occur when it is allowed both by law and by the prescriber of the medication.

Grievance - A complaint about the way your health plan is giving care. For example, you may file a grievance if you have a problem calling the plan or if you are unhappy with the way a staff person at the plan has behaved toward you. A grievance is not the way to deal with a complaint about a treatment decision or a service that is not covered (see Appeal).

Guidelines -A set of rules that are developed and used to help make decisions about appropriate health care for very specific situations. For example, clinical guidelines may be applied to determine if a specific drug is appropriate for your use.

H

Health Care Provider - A person who is trained and licensed to give health care. Also, a place that is licensed to give health care. Doctors, nurses, hospitals, and pharmacies are examples of health care providers.

Health Insurance Claims Number (HICN) - The number assigned by the Social Security Administration to an individual identifying him/her as a Medicare beneficiary. This number is shown on the beneficiary's insurance card and is used in processing Medicare claims for that beneficiary.

Health Insurance Portability and Accountability Act (HIPAA) - A law passed in 1996 that is also sometimes called the "Kassebaum-Kennedy" law. This law guarantees patients new rights and protections against the misuse or disclosure of their health records, along with several other protections that promote ongoing health coverage.

Health Plan - An entity that assumes the risk of paying for medical treatments, i.e., uninsured patient, self-insured employer, payer, or (Health Maintenance Organization (HMO).

Hearing - A procedure that gives a dissatisfied claimant an opportunity to present reasons for the dissatisfaction and to receive a new determination based on the record developed at the hearing.

Home Infusion - See “Infusion.” Provided in the home rather than a hospital or outpatient facility.

I

ICD-10 - International Classification of Diseases Revision 10; See “Diagnosis Code”

Identification (I.D.) Card - Printed card or form issued to a beneficiary, containing the Cardholder ID and instructions for providers to submit claims or request authorizations; health providers typically require a beneficiary to present their I.D. card before providing covered services.

Immunization - See “Vaccine”

Immunosuppressive Drug - A prescription drug used to slow down or stop the immune system.

Infertility Drug - A drug that is used to promote pregnancy in patients that have difficulty conceiving or carrying a pregnancy to full term.

Infusion - Fluids or medications that are given into a vein for treatment; infusion drugs typically require slow administration over a period of time and are administered by or under the supervision of health professionals.

Infusion Pump - Pumps for giving fluid or medication into your vein at a specific rate or over a set amount of time.

Injectable Drug - A drug that is administered by needle into a vein, muscle, or other bodily tissue, including under the skin.

L

Legend Drug - A drug that cannot be legally obtained without a written prescription; see “Prescription Drug”

Lifetime Maximum - A limit that the health plan applies for the total dollar benefit that can will be paid for an individual by the plan; in pharmacy, lifetime maximums can apply to all drugs or specific categories of drugs

M

Mail Order Pharmacy - A pharmacy that is not open to the walk-in general public but instead ships or mails drugs to patients; mail order pharmacies typically dispense maintenance drugs in larger quantities at lower costs to beneficiaries and health plans.

Maintenance Drug - A drug that is typically used to treat a chronic condition, and that is usually used regularly for a lengthy period of time; maintenance drugs can sometimes be dispensed in greater quantities than medications used to treat acute conditions.

Managed Care - Health coverage administered by an insurance company on a pre-paid basis.

Managed Care Organization - An insurance company that provides health services on a pre-paid basis through a network of providers.

Maximum Allowable Cost (MAC) - The limit the State/Commonwealth applies to payments made to pharmacies for drugs; usually applies to a list of generic drugs.

Maximum Benefit - A limit that the payer applies to the amount that will be paid for a service or services for a period of time or for the life of a beneficiary.

Maximum Out-of-Pocket - The maximum amount a beneficiary would spend for pharmacy and medical expenses a specified period of time.

Medicaid - A joint federal and state program that helps with medical costs for some people with low incomes and limited resources.

Medicaid Managed Care Organization (MCO) - A Medicaid MCO is contracted with a State/Commonwealth to provide comprehensive services to Medicaid beneficiaries, but not commercial or Medicare enrollees.

Medicare - The federal health insurance program for: people 65 years of age or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure with dialysis or a transplant, sometimes called ESRD).

Medication - A drug used to treat or prevent a health condition.

Member - A person who is eligible for and enrolled in a state Medicaid program. Also referred to as beneficiary, recipient, or enrollee.

Multi-Source Brand - A brand-named drug that is distributed by more than one manufacturer.

N

National Drug Code (NDC) - A medical code set maintained by the Food and Drug Administration that contains codes for drugs that are FDA-approved.

Nebulizer - Equipment to give medicine in a mist form to your lungs.

Network - A group of doctors, hospitals, pharmacies, and other health care experts hired by a health plan to take care of its members.

Non-Formulary - Drugs not on a plan-approved list.

Non-Preferred Drug - A drug that that has been identified by the Commonwealth as non-preferred because it not as clinically effective or cost effective as some alternatives; non-preferred drugs often require prior authorization before a plan will cover them.

O

Out-of-Network - Services provided to beneficiaries by providers that have no contractual or other relationship with a health plan.

Out-of-Pocket - Health care costs that you must pay on your own because they are not covered by Medicaid or other insurance.

Outpatient - A service you get that is not related to an overnight stay at a hospital outpatient department or community mental health center.

Over-the-Counter Drug (OTC) - Does not require a doctor's written prescription. Some OTCs may be covered under your benefit; refer to your benefit plan.

P

Patient - The person who receives health services from a provider.

Payer - In health care, an entity that assumes responsibility for paying for medical treatments. This can be patient or a health plan.

Payment - When a provider is reimbursed for a health service.

Pharmacy - A store or clinic where medications are sold.

Pharmacy Benefit Manager (PBM) - An organization that is responsible for managing pharmacy services and benefits for a payer.

Physician - A medical doctor; licensed by a State to provide medical services.

Plan - See "Health Plan."

Plan Limit - A maximum that a payer applies to a single service that is provided; a maximum day supply of a drug is a common plan limit.

Plan Maximum - See "Maximum."

Plan Sponsor - An organization that sponsors and funds a health plan; a State or Commonwealth is a Medicaid plan sponsor.

Preferred Drug - A drug that has been identified by the Commonwealth as preferred because it is both clinically and cost effective; preferred drugs are the most cost-effective drugs for the beneficiary and health plan.

Preferred Drug List (PDL) - A list of drugs that are preferred by the Commonwealth.

Prescriber - A health professional that is legally permitted to and that does write prescriptions for prescription drugs.

Prescription Drug - A type of drug that cannot be sold or dispensed without the written prescription of a doctor or other permitted health professional.

Preventive Drug - A drug that is used to avoid a health condition; preventive drugs are usually prescribed for individuals at risk for the condition.

Prior Authorization - A process to approve items or service before a plan will pay a provider; medications may require prior authorization when they are not on a Plan formulary.

Protected Health Information (PHI) - Information about your health conditions and treatments, or that can be used to identify you or your health information, and that is protected from disclosure by HIPAA or other regulations.

Provider - A doctor, hospital, health care professional, or health care facility.

Q

Qualified Medicare Beneficiary (QMB) - This is a Medicaid program for beneficiaries who need help in paying for Medicare services.

Quantity Limit - A maximum days of supply or quantity that is permitted under a health plan's pharmacy benefit; quantity limits may vary based on drug.

R

Recipient - A person who is eligible for and enrolled in a state Medicaid program. Also referred to as member, beneficiary, or enrollee.

Reconsideration – A process for providers to seek additional review for a previously denied PA case.

Refill - When a pharmacy dispenses a drug that an individual is already taking, usually for a prescription that has been written for an extended period of time.

Refill-Too-Soon - A denial of a pharmacy claim because a refill is being requested before enough of the previous fill has been used; refill-too-soon denials help to ensure that a drug is not being overused.

Reject - A claim or encounter that did not meet a PBM's information requirements or exceeded plan limits; rejected claims need to be corrected and resubmitted.

Retail Pharmacy - A pharmacy that is open to dispense prescription drugs to the walk-in general public.

Rx - See "Prescription"

S

Secondary Payer - An insurance policy, plan, or program that pays second on a claim for medical care. This could be Medicare, Medicaid, or other insurance depending on the situation.

Side Effect - A problem caused by treatment. For example, medicine you take for high blood pressure may make you feel sleepy. Most treatments have side effects.

Single-Source Brand - A brand name drug with a single source of manufacturing.

Specialty Drug - A type of drug that requires special care, administration, handling, education, or monitoring and that may only be available from a specialty pharmacy.

Specialty Pharmacy - A pharmacy that can provide the additional services required to obtain and dispense specialty drugs; some specialty pharmacies may focus on a specific health condition or type of drug.

State Fair Hearing – A process where members and/or providers can request to resolve a previously denied PA and/or appeal case.

Step Therapy - A type of utilization management process that requires the use of one or more preferred drugs before a non-preferred drug will be approved for payment.es.

T

TANF - See “Temporary Assistance for Needy Families”

Temporary Assistance for Needy Families (TANF) - An assistance program for low-income families with children; TANF recipients are often eligible for Medicaid.

Therapeutic Class - A way to categorize drugs based on the health conditions they are used to treat.

Therapeutic Interchange - When a drug that has been prescribed is substituted with another drug that will have the same effect; a therapeutic interchange is often made to save a health plan or a beneficiary money.

Third Party Liability - Other sources of payment for services covered under Medicaid; these sources usually apply before Medicaid will make a payment.

Transplant Drug - A medication used to reduce the risk of rejection of a new organ after transplant.

Treatment - Something done to help with a health problem. For example, medicine and surgery are treatments.

U

Utilization - When a member uses items or services that are covered by and paid for by the health plan.

Utilization Management - A process to evaluate guidelines to determine if a prescription drug is safe and appropriate and should be covered; quantity limits, prior authorizations and step therapy are types of utilization management.

V

Vaccine - A substance that is usually injected and that provides a patient with immunity against one or more specific diseases.

1.0 Introduction

In April 2023, the Commonwealth of Kentucky Department for Medicaid Services (DMS) awarded the Kentucky Fee-For-Service (FFS) Pharmacy Benefit Manager (PBM) contract to MedImpact to administer pharmacy benefits and services to Kentucky Medicaid members enrolled in the FFS program. DMS provides all oversight and monitoring of the PBM activities and operations.

The pharmacy benefits and services administered by MedImpact are identified collectively as "FFS PBM services," and include, claims processing and administering payments to Kentucky Medicaid pharmacy providers; managing and administering the Kentucky Medicaid single Preferred Drug List (PDL) and benefit design; adjudicating prior authorization (PA) requests using DMS-approved criteria; managing and administering drug rebate programs; managing and administering Kentucky Maximum Allowable Cost (MAC) program; adjudicating reconsiderations and appeals; conducting Retrospective Drug Utilization Review (RetroDUR) activities; providing Kentucky Medicaid pharmacy provider service; pharmacy network auditing; and reporting to DMS.

The MCO PBM program contract remains unchanged and will continue to be served by MedImpact. The award of the FFS PBM contract is independent from the MCO PBM contract.

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 approved by DMS.

Beginning January 1st, 2024, MedImpact is the contracted pharmacy claims processor for the Kentucky FFS Medicaid Program. MedImpact uses a computerized point-of-sale (POS) claims processing application, utilizing the National Council for Prescription Drug Programs (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, Center for Medicare & Medicaid Services (CMS) - approved Kentucky DMS pricing and payment information, and 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 (DOS) on or after January 1st, 2024.

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 FFS 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 Kentucky FFS Medicaid.

In the event pharmacy providers require assistance with processing a pharmacy benefit claim for a Kentucky Medicaid member actively enrolled in the FFS Program, they may contact the MedImpact Pharmacy/Provider Helpdesk, which is available 24 hours per day, seven days per week, at: 1-877-403-6034.

1.1 Important Contact Information

Contact	Phone Number/URL	Availability
MedImpact Pharmacy Provider Web Portal	http://pharmacy.medimpact.com	24 hours a day, 7 days a week
DMS pharmacy website	https://www.chfs.ky.gov/agencies/dms/dpo/ppb/Pages/default.aspx	24 hours a day, 7 days a week
Member Services (CHFS)	800-635-2570	8AM to 5PM Eastern Monday to Friday
Clinical Support Center (prior authorizations)	PHONE: 877-403-6034	8AM to 7PM Eastern, 7 days a week
	FAX: 858-357-2612	24 hours a day, 7 days a week
Pharmacy/Provider Help Desk	PHONE: 877-403-6034	24 hours a day, 7 days a week
MAC Pricing	MAC List: Available on MedImpact Provider Portal under “Documents” page https://kyportal.medimpact.com/provider-documents/provider-documents	24 hours a day, 7 days a week
	To appeal MAC pricing: FAX: 888-656-1951 E-mail: StateMACProgram@medimpact.com	
Voice Response Eligibility Verification Member Eligibility	800-807-1301	24 hours a day, 7 days a week
Provider Management/Enrollment	PHONE: 877-838-5085 FAX: 502-226-1898	8AM to 4:30PM Eastern, Monday to Friday
MedImpact KY FFS PBM Account Team	KYMFFS@MedImpact.com	8AM to 5PM Eastern, Monday to Friday other times: on-call

1.2 Addresses

Address	Format
Provider Paper Claims Billing Address: **Mail:** ATTN: CLAIMS DEPT MedImpact Healthcare Systems, Inc. PO Box 509098 San Diego, CA 92150-9098 **Email:** claims@medimpact.com **Fax:** 858-549-1569	UCF version D.Ø

Providers may purchase NCPDP Universal Claim Forms (UCF) from CommuniForm. Information is available at https://ncpdp.org/Universal-Claim-Forms.aspx.

1.2.1 Websites

- DMS: https://www.chfs.ky.gov/agencies/dms/dpo/ppb/Pages/default.aspx
- MedImpact Provider Portal: http://pharmacy.medimpact.com
- MedImpact KY FFS & MCO website: http://kyportal.medimpact.com

2.0 Claim Processing Configuration

ANSI BIN #	026309
Processor Control #	KYPROD1
Group #	KYF01
Cardholder ID #	Kentucky Medicaid Assigned Identification Number (10-byte value found on member ID card, e.g., 0123456789)
Provider ID #	National Provider Identifier (NPI) only
Prescriber ID #	NPI only
Product Code	NDC 11 only

2.1 Claim Format

- POS claims must be submitted in the NCPDP version D.Ø format (HIPAA defined October 2014 Data Dictionary)
- Paper claims must be submitted using the NCPDP UCF form.

2.2 Media Options

- POS claim billing or reversal
- Paper claim billing for providers only(member claim submission is not permitted)
- Batch claim billing and reversal (to submit batch transaction [NCPDP Batch 1.2])– testing with MedImpact is required. Please contact KYMFFS@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.

Reversals must be submitted with the same Rx number as was submitted on the original paid claim.

- Reversals of Coordination of Benefit (COB) claims should be performed in the correct "back out order", meaning LAST claim billed must be reversed first until getting to the primary claim or a claim to be re-submitted.
- If a claim has been billed as Primary, Secondary, or Tertiary and the pharmacy wishes to reprocess the secondary claim, the tertiary claim must be reversed first, then the secondary reversal. At this point the pharmacy may reprocess the secondary claim as required (the tertiary claim as well).
- The reversal of a COB claim must contain the COB segment with Other Payer Coverage Type so in the case where MedImpact is the payer of more than one claim for the Pharmacy, Rx, Date of Service and Fill Number, the claim for reversal can be correctly identified.

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 FFS PBM program.

3.0 Benefits and Limitations

3.1 Dispensing Rules & Edits

3.1.1 Current Drug Lists

Below are various lists of drugs & coverage limits approved for dispensing to Kentucky Medicaid members. The lists are located at the following URL: https://kyportal.medimpact.com/provider-documents/drug-information

- Diabetic Supplies Preferred Drug List
- Kentucky Medicaid Pharmacy Injectable Drug List
- Maximum Quantity Limits
- FFS Over-the-Counter (OTC) Drug List
- Preferred Drug List (PDL)
- Prior Authorization Criteria

3.1.2 Days Supply

- Maximum day supply for non-maintenance drugs: Thirty-two (32) days
- Maximum day supply for maintenance drugs: Ninety-two (92) days supply. Maintenance drugs of specific route of administration (such as oral), the limits are one-hundred (100) units or ninety-two (92) days supply, whichever is greater.

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 Maximum Quantity Limit list in Section 3.1.1.
- Quantity limits may be per day, per fill, or cumulative over a designated timeframe. Quantity Limits may apply for a defined period of time (e.g., 1 month, 1 year, lifetime) or may be subject to “rolling limitation” where each claim is evaluated to ensure that, during the defined window of evaluation, total units/product dispensed do(es) 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 Partial Fills

NCPDP guidance and standards must be followed, and compliant transactions submitted for the partial dispensing and the completion dispensing. This includes proper claim identification using NCPDP field 343-HD and dependent required fields to complete the required NCPDP fields:

- Dispensing Status (343-HD) The code in this field indicates that the quantity dispensed is an initial partial fill (P) or the completion of a partial fill (C) and is used only in situations where inventory shortages do not allow the full quantity to be dispensed.
- Associated Prescription/Service Date (457-EP) Date of the initial transaction in a partial fill. Used when submitting the “completion” transaction.
- Associated Prescription/Service Reference Number (456-EN) The Prescription or Service Reference Number of the initial transaction in a partial fill. Used when submitting the “completion” transaction.
- Quantity Intended to be Dispensed (344-HF) The metric decimal quantity that would have been dispensed if adequate inventory were available. This field is used only in association with a “P” or “C” in the Dispensing Status field. Note: If populating this field, an assumption is made that the “Days Supply Intended to be Dispensed” is also sent.
- Days Supply Intended to be Dispensed (345-HG) Days supply for the metric decimal quantity that would have been dispensed on original dispensing if adequate inventory were available. This field is used only in association with a “P” or “C” in the Dispensing Status field.
- For long-term care members, multiple partial fills for schedule II controlled substances are allowed.

Dispense fee is paid in full on the initial “partial” fill dispensing and will not be paid on the “completion” fill. If member does not receive balance of fill, prescription should be voided and billed as a standard (not-partial fill) prescription.

LTC pharmacies can submit multiple partial “P” fills for Schedule 2 drugs. Partial fills do not receive a dispense fee, the fee is paid when the remaining whole claim is processed.

3.1.6 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.

3.1.7 Member Gender

Designated drugs may be subject to gender edits as identified by fdb® clinical content or DMS-approved edit.

3.1.8 Plan Maximum Dollar Limit

Claims for non-compound 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/Provider Help Desk 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 Medicaid Allowed Amount does not exceed the value established in this DMS specific price limit edit, the claim will pay without a dollar limit override/prior authorization required. Questions regarding reimbursement limits on claims and specific products may be directed to the MedImpact Pharmacy/Provider Help Desk.

Claims for compound medications with a Medicaid Allowed Amount greater than $100.00 will deny as exceeding the plan maximum per claim dollar limit threshold established by DMS. A smaller quantity may be dispensed, or the provider can request a prior authorization.

Covered OTC products with a Medicaid Allowed Amount greater than $100.00 will deny as exceeding the plan maximum per claim dollar limit threshold established by DMS. A smaller quantity may be dispensed, or the provider can contact the Pharmacy/Provider Help Desk for assistance.

3.1.9 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, the 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.

3.1.10 Medication Replacement

In situations where members need their medications replaced due to loss, theft, or destruction, pharmacy providers may contact the MedImpact Pharmacy/Provider Help Desk for assistance. Documentation may be required for approval of replacement dispensing(s) based on frequency of requests.

3.2 Mandatory Generic Requirements

- Providers should dispense generic drugs whenever appropriate.
- For certain drugs, DMS may prefer the brand product over the generic to be dispensed.
- Multi-source brand drugs that are non-preferred or non-PDL will require prior authorization.
- Brand Medically Necessary criteria generally requires trial and failure with two manufacturers (if available) of covered corresponding generics. Prescribers may request prior authorization for override consideration with chart documentation of prior treatment with generic product(s) or relevant clinical justification. Documents may be found at: https://kyportal.medimpact.com/provider-documents/drug-information

3.3 Proprietary MAC Program

The MAC Program is a service developed and maintained by MedImpact for use by Kentucky DMS. Its purpose is to encourage providers to use less expensive, therapeutically equivalent drugs. MedImpact's Kentucky MAC team regularly reviews the current drug price sources. Generally, a drug may be considered for MAC pricing if there are two or more manufacturers, and it is listed as multi-source. However, MAC reimbursement may also be applied to single-source drugs or drug classifications. 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 MedImpact'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 format can be found on MedImpact's Kentucky Portal. The information 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 there is any MAC pricing that does not meet a pharmacy provider's needs, then this provider will be responsible for completing and submitting the MAC Appeal Request via email or fax. The form can be found on the KY portal at https://kyportal.medimpact.com/provider-documents/provider-documents. Once the MAC Appeal Request is received, MedImpact (MI) is responsible for reviewing the submitted information, performing an investigation, and determining if the current KY MAC pricing is valid or requires an adjustment. If the appeal is approved, then the MAC rate is adjusted. The provider will receive a notice of the outcome of the MAC appeal. 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 Wholesale Acquisition Cost (WAC), Federal Upper Limit (FUL), or National Average Drug Acquisition Cost (NADAC), then NO price adjustment can be granted, as these reimbursement types are regulated by the manufacturer, federal government, or its vendor. 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 by the provider 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 6.0 – Provider Reimbursement.

3.4 Drug Coverage

3.4.1 Included Products

- The Cabinet for Health and Family Services (CHFS), Department for Medicaid Services, has the responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed, or opportunity presented by federal law for the provision of medical assistance to Kentucky's indigent citizenry. KRS 205.560 provides that the scope of medical care for which Medicaid shall pay is determined by administrative regulations promulgated by CHFS. This administrative regulation establishes the provisions for coverage of outpatient drugs through the Medicaid outpatient pharmacy program for FFS recipients and MCO enrollees.

Section 1: A covered drug shall be:

- Medically Necessary;
- Approved by the FDA;

- Prescribed for an indication that has been approved by the FDA or for which there is documentation in official compendia or peer-reviewed medical literature supporting its medical use;
- A rebateable drug; and
- A covered outpatient drug

Section 2: Diabetic supplies. Unless Medicare is the primary payer, the department shall cover the diabetic supplies listed in this section via the department's pharmacy program and not via the department's durable medical equipment program established in 907 KAR 1:479.

- A syringe with needle (sterile, 1cc or less);
- Urine test or reagent strips or tablets;
- Blood ketone test or reagent strips;
- Blood glucose test or reagent strips;
- Calibrating solutions;
- Lancet device;
- Lancets; or
- Home blood glucose monitor.

3.4.2 Excluded Products

The following products shall be excluded from coverage and shall not be reimbursed:

- Cough and cold products, except as specified in the Covered OTC List or designated by DMS
- Diagnostics
- Dietary supplements and vitamins, except prenatal vitamins, fluoride preparations, or designated by DMS
- Digital therapeutics
- Drugs designated by DMS as covered under the Kentucky Medicaid Medical Benefit such as infused drugs and other non-self-administered products
- Drugs used for fertility diagnoses
- Drugs used for obesity diagnoses
- Drugs used for sexual dysfunction diagnoses
- Durable Medical Equipment
- Immunizations, except COVID vaccines
- Less-than-effective Drug Efficacy Study Implementation (LTE DESI) drugs or those identical, related, or similar drugs to the LTE DESI drug for all indications or withdrawn from the market (LTE DESI/IRS code 5 or 6)
- Medical supplies, except covered diabetic supplies or products specified in the Covered OTC List
- OTC products, except insulins and products specified in the Covered OTC List
- Ostomy supplies
- Products from manufacturers who do not participate in the rebate program except as required by federal law for Medication Assisted Treatment (MAT)

3.5 Member Payment Information

3.5.1 Co-payment

The Kentucky Medicaid program co-payment structure is as follows:

- There is no member co-payment (brand or generic) for any pharmacy benefit service.

3.6 Prior Authorization

3.6.1 Clinical Prior Authorization

- Prior authorization requests can be sent to MedImpact via electronic submission, fax, or phone. Generally, prior authorization requests must be initiated by the prescriber or the prescriber's agent.
- Review of prior authorization requests are handled by MedImpact's Clinical Support Center. During regular business hours, the Clinical Support Center will apply DMS approved criteria for approval/change/denial. After hours, the emergency protocol listed below will be in effect.

3.6.2 Emergency Protocols

- 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 are permitted only if submitted outside of normal prescriber/physician business hours.
    - OTCs may not be overridden through this process
    - Controlled substances 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 Pharmacy/Provider Help desk for a claim review and override if authorized

3.7 Coordination of Benefits (COB)

- Coordination of benefits for pharmacy claims ensures compliance with CMS regulations. Under federal rules, Medicaid must be the payer of last resort.
- MedImpact will check at point of sale to prevent DMS from paying a claim until the pharmacy attempts to obtain payment from the member's primary insurance.
- Providers must submit any other coverage results for the member even in the event that member other coverage is not known to MedImpact or DMS

3.7.1 Medicare Part-D

- Drugs eligible for coverage under Medicare Part D will not be covered by Kentucky Medicaid. These claims will deny with NCPDP Error Code "41" indicating the claim must be billed to the appropriate Medicare Part D program.
- Kentucky Medicaid members, eligible for Medicare Part-D, may receive only select Medicare Part D excluded drugs which are covered under the DMS Kentucky FFS program and covered OTC products.

3.7.2 NCPDP Other Coverage Codes (OCC) – NCPDP field 308-C8

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 member 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.

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

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

- Other coverage code "03" – Other coverage exists – claim not covered" (NCPDP field 308-C8) will not require either other payer TPL amount or patient responsibility amount submitted to be greater than zero ($0.00). Use of this code may require submission of the other payer reject code detail in NCPDP fields 471-5E and 472-6E (repeating field).

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.

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

3.7.3 Other Payer Reject Code Allowed Values

(NCPDP Field # 472-6E)

- "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
- "7Y" – Compounds Not Covered
- "A5" – Not covered Under Part D Law
- "MR" – Product Not on Formulary

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 LTC C-II Dispensing Fee

Schedule II (C-II) prescriptions for LTC members are eligible for up to four (4) dispensing fee per drug per pharmacy per 26 days. For detailed dispensing fee and reimbursement algorithm, refer to Section 6.1.

3.8.2 LTC Unit Dose Repackaging Fee

Pharmacies repackaging and dispensing non-unit dose solid dosage form products for LTC members are eligible for a unit dose repackaging fee. An additional fee of $0.02 per unit is allowed up to a maximum of $25.00 per claim. Manufacturer product which is pre-packaged as unit dose is not eligible for this fee. The provider must submit the total unit dose fee expected in the INCENTIVE AMOUNT SUBMITTED field (NCPDP Field # 438-E3) along with PROFESSIONAL SERVICE CODE (NCPDP Field # 440-E5) of TC - PAYER/PROCESSOR CONSULTED and Submission Clarification Code (NCPDP Field # 420-DK) of 10.

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. Compound claims with a Medicaid Allowed Amount greater than $100.00 will deny as exceeding the plan maximum per claim dollar limit threshold established by DMS. A smaller quantity may be dispensed, or the provider can request a prior authorization

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 Diabetic Supplies

Diabetic supplies are covered as part of the KY Medicaid pharmacy benefit. Preferred Diabetic Supply products are included products on the state single PDL and may be found in the Kentucky Medicaid Diabetic Supplies Preferred Product List on the MedImpact Kentucky Portal (https://kyportal.medimpact.com/medicaid-provider-portal/medicaid-provider-portal-home).

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

- Blood glucose test or reagent strips;
- Blood ketone test or reagent strips;
- Calibrating solutions;
- Home blood glucose monitor (Limit of one (1) monitor per year per member);
- Lancets;
- Lancet device;
- Syringes with needles (sterile, 1cc or less);
- Urine test or reagent strips or tablets.

3.11 Hospice

Members in hospice care may have limited pharmacy coverage. Claims for members identified in hospice may reject with a point-of-sale message “Bill through Hospice Services”.

3.12 Incarcerated

Members who are incarcerated are not eligible for pharmacy coverage. Claims for members identified as incarcerated will reject with a point-of-sale message “Drug coverage is suspended due to incarceration”

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 medication’s dosage and directions while reviewing patient information for possible drug interactions or duplicate therapy.

As part of the MedImpact online claims adjudication process, ProDUR 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. Edits may be set at the following levels:

Edit level	Impact	Override
Hard Reject	Denies claim	Prior Authorization
Soft Reject	Denies claim	DUR/PPS Codes or Prior Authorization
Informational Alert	Does not stop claim; pharmacy alert only	N/A

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 (NCPDP Field 439-E4)

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
  - fdb® Drug-Drug Interaction
  - Opioid-Sublocade Concurrent Use
- ID = Ingredient Duplication
  - fdb® Ingredient Duplication

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 (NCPDP Field 440-E5)

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:

- 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 (NCPDP Field 441-E6)

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
- 1G = Filled with prescriber approval

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

4.2.4 DUR Claim Rejects Requiring Prior Authorization

- Claims for members receiving the following alerts will require prior authorization:
  - Age of member is below the limit
  - Calculated dose is greater than 200% of compendia high dose limit
  - Concurrent use of opioid and benzodiazepine
  - Concurrent use of opioid and buprenorphine
  - Duplicative long-acting opioid therapies
  - Exceeding the acetaminophen cumulative dose limit
  - Exceeding the opioid cumulative dose limit
- Prescribers 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.

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 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 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	

Reject Code	Explanation	Field Number Possibly In Error	Possible Solutions
("M/I" Means Missing/Invalid)			
13	M/I Other Coverage Code	3Ø8	*See Section 3.7 – 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.

Reject Code	Explanation	Field Number Possibly In Error	Possible Solutions
("M/I" Means Missing/Invalid)			
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	

Reject Code	Explanation	Field Number Possibly In Error	Possible Solutions
("M/I" Means Missing/Invalid)			
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	

Reject Code	Explanation	Field Number Possibly In Error	Possible Solutions
("M/I" Means Missing/Invalid)			
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	
Reject Code	**Explanation**	**Field Number Possibly In Error**	**Possible Solutions**
(“M/I” Means Missing/Invalid)			
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	

Reject Code	Explanation	Field Number Possibly In Error	Possible Solutions
("M/I" Means Missing/Invalid)			
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®.

Reject Code	Explanation	Field Number Possibly In Error	Possible Solutions
("M/I" Means Missing/Invalid)			
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/Provider Help Desk 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 dates 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		May include Drug-to-Drug, Therapeutic Duplication, Early Refill and other patient safety interventions
89	Rejected Claim Fees Paid		

Reject Code	Explanation	Field Number Possibly In Error	Possible Solutions
(“M/I” Means Missing/Invalid)			
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		

Reject Code	Explanation	Field Number Possibly In Error	Possible Solutions
("M/I" Means Missing/Invalid)			
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	

Reject Code	Explanation	Field Number Possibly In Error	Possible Solutions
("M/I" Means Missing/Invalid)			
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	

Reject Code	Explanation	Field Number Possibly In Error	Possible Solutions
("M/I" Means Missing/Invalid)			
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	

Reject Code	Explanation	Field Number Possibly In Error	Possible Solutions
("M/I" Means Missing/Invalid)			
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	

Reject Code	Explanation	Field Number Possibly In Error	Possible Solutions
("M/I" Means Missing/Invalid)			
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	

Reject Code	Explanation	Field Number Possibly In Error	Possible Solutions
("M/I" Means Missing/Invalid)			
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		

Reject Code	Explanation	Field Number Possibly In Error	Possible Solutions
("M/I" Means Missing/Invalid)			
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	

Reject Code	Explanation	Field Number Possibly In Error	Possible Solutions
("M/I" Means Missing/Invalid)			
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	

Reject Code	Explanation	Field Number Possibly In Error	Possible Solutions
(“M/I” Means Missing/Invalid)			
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		

Reject Code	Explanation	Field Number Possibly In Error	Possible Solutions
(“M/I” Means Missing/Invalid)			
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		

Reject Code	Explanation	Field Number Possibly In Error	Possible Solutions
("M/I" Means Missing/Invalid)			
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	

Reject Code	Explanation	Field Number Possibly In Error	Possible Solutions
("M/I" Means Missing/Invalid)			
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, submitting providers may receive a message that indicates the provider's contracted prescription switch (e.g., Change Healthcare, RelayHealth, QS1, etc.…) is having technical problems communicating with MedImpact. Typical messages received in your switch's response may include:
Host disconnected before session completed.
Processing host did not accept transaction or did not respond within timeout period.

To receive support from your contracted prescription switch regarding their issue we have included their Customer Support Contact Information.
Customer Support Numbers:
Change Healthcare – 866-371-9066
RelayHealth – 800-388-2316
QS1: – 800-845-7558

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
- Average Sale Price (ASP)+6% + dispense fee (for select hemophilia products); OR
- Usual & Customary (U & C);

A professional dispensing fee of $10.64 is paid once per member, per drug, per provider, every 23 days for any qualifying dispensed prescription (except for MAT drugs, see Section 6.2).

The final reimbursement determination pricing information is returned in the claim response Basis of Reimbursement Determination (NCPDP field# 522-FM). The value and the corresponding reference price source are shown below:

- 4 – Usual & Customary Paid as Submitted
- 6 – MAC
- 10 – ASP
- 13 – WAC
- 20 – NADAC
- 24 – FUL

6.2 Medication-Assisted Treatment (MAT) Drugs Dispensing Fee & Professional Service Fees

Pursuant to State of Emergency administrative regulation 907 KAR 23:02E, the Commonwealth of Kentucky Department for Medicaid Services effectuated reimbursement of up to one (1) dispensing fee every seven (7) days for qualifying MAT drugs used in the treatment of a substance use disorder for Kentucky Medicaid members.

Qualifying MAT drugs include transmucosal Buprenorphine-Mono-Products, Buprenorphine-Combined-with-Naloxone Products, or weekly/monthly subcutaneous Buprenorphine prefilled syringe. This was practically implemented as one (1) dispensing fee and up to three additional (3) professional service fees per rolling 28-day period as described below.

- Pharmacy provider will receive one dispensing fee of $10.64 every rolling 28 days per member per qualifying MAT drug.
- To receive the additional professional service fees for qualifying MAT drugs, the

pharmacy provider must submit the required codes in the designated NCPDP fields (refer to table below).
    - By submitting the required codes, the pharmacy provider attests that patient counseling and/or education has been provided or offered to the Medicaid member per the “applicable standard of care” and documented in the patient prescription record.
    - The pharmacy provider must query KASPER prior to each dispensation of a qualifying MAT drug (as defined below).
    - Records documenting the patient counseling, education, or offer to counsel and the review of KASPER are subject to audits.
- Each claim will only be paid with either a dispensing fee or a professional service fee. In the case where a dispensing fee is paid, the professional service fee will not be paid.
- Current dispensing fee limits will continue to apply to non-MAT drugs, injectable buprenorphine (except weekly/monthly subcutaneous Buprenorphine prefilled syringe), and XR-naltrexone.

Dispensing Fee

- **Applicable Drugs:** Qualifying MAT drugs
- **Fee Amount:** Up to $10.64 per claim
- **Limitation:** One (1) dispensing fee every rolling 28 days per member per drug

Professional Service Fee

- **Applicable Drugs:** Qualifying MAT drugs
- **Fee Amount:** Up to $10.64 per claim
- **Limitation:** One (1) professional service fee every rolling 7 days per member per drug
- **Required claim submission fields and values:**

NCPDP Field#	NCPDP Field Name	Required Submitted Value
420-DK	Submission Clarification Code	10 – The pharmacy certifies that the transaction is in compliance with the program's policies and rules that are specific to the particular product being billed.
438-E3	Incentive Amount Submitted	Up to $10.64
440-E5	Professional Service Code (PSC)	PE – Patient education/instruction

6.3 Vaccine Administration Fees

Kentucky FFS Medicaid covers COVID vaccines under pharmacy benefit. Pharmacies will receive $40 professional service fee for COVID vaccines. All other vaccines are not covered under pharmacy benefit for Kentucky FFS Medicaid members.

NCPDP Field#	NCPDP Field Name	Required Submitted Value
438-E3	Incentive Amount Submitted	Up to $40
440-E5	Professional Service Code (PSC)	MA – Medication Administration

Appendix A – Universal Prior Authorization Form

The most recent version of Kentucky Medicaid Universal Prior Authorization Form can be accessed at https://kyportal.medimpact.com/provider-forms/provider-forms.

Appendix B – Payer Specifications

Please review the Kentucky Medicaid 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.

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

The most recent version of Kentucky FFS Medicaid OTC Drug List can be accessed at https://kyportal.medimpact.com/provider-documents/drug-information