Guidance for Point-of-Sale Rejections

This is NOT an all-inclusive list of point-of-sale rejections. Notably, the following are not included, so please see the following links on www.hidesigns.com/ndmedicaid for more information:

- Preferred Drug List (PDL) (prior authorization criteria, therapeutic duplication, electronic step, concurrent medications, first fill, and underutilization requirements), which includes the Preferred Diabetic Supply List (PDSL) and Medical Billing Drug Clinical Criteria
- NDC Drug Lookup (search for quantity, age, and prior authorization requirements by NDC or drug name)

For questions on specific pharmacy claims, contact provider relations at 701-328-4086 or 1-800-755-2604 or email medicaidpharmacy@nd.gov. Please include:

- **Member ID:** 000# or ND#, we cannot use Blue Cross Blue Shield (BCBS) numbers which start with YME#
- **Member name and date of birth:** Please spell member's name, particularly last name
- **Caller name and phone number:** For callback
- **Reason for override request**: Include clinical rationale pertinent to the request (prescriber may need to be contacted prior to request). Especially for therapeutic duplication requests, why has one med changed to another? What was the side effect? Was there not enough response?

Table of Contents

AE – QMB Bill Medicare

Reject Message:

"Member eligible for Medicare so Medicaid will not pay for this drug – If member doesn't have a Part D plan, try Humana Linet. Questions call 1-800-783-1307."

Explanation:

ND Medicaid does not cover prescription drugs if the member is eligible for Medicare. ND Medicaid does not pay if Medicare Part D does not cover prescription medication. ND Medicaid does not pay secondary to Medicare Part D.

A select number of OTC medications are covered. An override is not necessary to bill these OTC medications to ND Medicaid as the primary payer.

Action:

If a member has not enrolled with a Part D plan, pharmacies may be able to bill the Humana Limited Income NET (LINET) Program: Phone: 800-783-1307; Fax: 877-210-5592; www.humana.com/LINET

- **This program is not administered by ND Medicaid.**
- This program provides immediate and retroactive drug coverage for individuals who qualify for both Medicare and Medicaid but do not yet have prescription drug coverage through Part D. Many helpful links are found on Medicare's Limited Income NET Program webpage:
    - How to Document for billing information and verifying recipient's eligibility for the program. Please contact the member's human service zone for obtaining ND Medicaid eligibility information.
    - Humana Pharmacy Solutions Pharmacy Manual
        - Navigate to Medicare's Limited Income NET Program (LINET)
    - Tip Sheet

NP – Inv Payer-Pat Resp Amt Qual

Reject Message:

"Other Payer Patient Responsibility Amount Qualifier field 351-NP must be 06."

Explanation:

This rejection will post on Coordination of Benefit (COB) claims if:

- One payer prior to Medicaid: there is no Other Payer Patient Responsibility Amount Qualifier (351-NP) value equal to 06.
- Multiple payers prior to Medicaid: there is no Other Payer Patient Responsibility Amount Qualifier (351-NP) value equal to 06 for the payer with the highest Other Payer Coverage Type (338-5C) value.

Payment will only be considered for Other Payer Patient Responsibility Amount (352-NQ) with a corresponding 351-NP that is equal to 06.

- If multiple 351-NP values equal to 06 with a single payer, the lowest amount will be considered for payment.
- If multiple payers with 351-NP value equal to 06, the corresponding 352-NQ value from the payer with the highest 338-5C value will be considered for payment.

Action:

Review the rejected, in-process claim and verify the Other Payer Patient Responsibility Amount Qualifier (351-NP) value is “06” for payment. Other 351-NP values can be submitted in an additional line for informational purposes.

5C – Inv Other Payer Cov Type

Reject Message:

“Field 338-5C Other Payer Coverage Type must be populated on COB claims.”

“For members with multiple other insurances and Medicaid is tertiary, field 338-5C must be submitted accurately (e.g., value of 01 for primary, value of 02 for secondary).”

“The member copay after the 2nd insurance is showing as higher than member copay after primary insurance – please ensure field 338-5C is accurate for both insurances.”

Explanation:

This rejection will post when the 338-5C field is blank or invalid; or if multiple payers have the same 338-5C value on Coordination of Benefit (COB) claims.

Action:

Review the rejected, in-process claim and verify the submitted Other Payer Coverage Type (338-5C) corresponds to “01” for primary payer, “02” for secondary payer, etc. Two payers cannot have the same 338-5C value. Contact provider relations at 1-800-755-2604 or 701-328-4086 with questions.

19 – Inv Days Supply

Reject Message:

“Please bill daily dose correctly according to prescription. 34 days supply covered for most meds. 90 days for some maintenance. Call 701-328-4086 with questions.”

Explanation:

The quantity of medication dispensed shall not exceed a 34-days supply as outlined in the Provider Manual for Pharmacies, unless:

- If there is a primary payer, other than Medicaid, that pays a portion of the claim, then the primary payer rules apply
- Drug is packaged as a standard or its duration is a standard beyond 34 days
- Drug is a low-cost maintenance medication and is set up to allow 90 days

Action:

Review the rejected, in-process claim and adjust the submitted quantity and days supply accordingly. Please do not bill an incorrect days supply to get the claim to pay without contacting provider relations at 1-800-755-2604 or 701-328-4086.

To request an override due to primary payer requirements, drug packaging, or standard duration, contact provider relations at 1-800-755-2604 or 701-328-4086.

39 – Inv Diagnosis Code – Diagnosis Format Invalid

Example Reject Message:

“First diagnosis code is invalid – we accept valid ICD-10 diagnosis codes.”

Explanation:
Verify an ICD-10 diagnosis code exists and is properly formatted on any claim where a diagnosis code is submitted, whether submission is required or not. Proper format is alpha character followed by two numeric characters. If there are more alpha or numeric characters, they are preceded by a decimal (e.g. F90.0).

Action:
Verify and correct format of submitted ICD-10 code as necessary. Alpha, Numeral, Numeral, Decimal, etc. (e.g. F90.1) Contact provider relations at 1-800-755-2604 or 701-328-4086 with questions.

39 – Inv Diagnosis Code – Diagnosis Not Covered

Reject Message:
"Please submit ICD-10 diagnosis with claim or submitted value is invalid. Plan covers FDA approved diagnoses. Please verify diagnosis with prescriber."

Explanation:
ICD-10 codes are required for certain drugs to ensure appropriate use. In compliance with the Social Security Act 1927, accepted diagnoses must be FDA and compendia supported. ICD-10 code submission at claim adjudication eliminates the need to require prior authorization for diagnosis verification.

If a non-covered ICD-10 code, an invalid ICD-10 code, or no ICD-10 code is submitted, the claim will reject.

Action:
How to submit a diagnosis code:
Work with the pharmacy's software vendor if clarification needed regarding NCPDP fields required for diagnosis submission:

111-AM	Segment Identification	Use "13" since it is in the clinical segment
491-VE	Diagnosis Code Count	Use the number of diagnosis codes being submitted Example: if submitting one diagnosis code, use "1" in this field
492-WE	Diagnosis Code Qualifier	Use "02" since ND Medicaid accepts ICD-10 codes
424-DO	Diagnosis Code	Use the ICD-10 code(s) provided by the prescriber in this field

Reference ND Medicaid Payer Sheet:
https://www.nd.gov/dhs/services/medicalserv/medicaid/docs/b1-b2-b3-payer-sheet.pdf

If the diagnosis is not included on the prescription:
Contact the prescriber to obtain all applicable ICD-10 codes for use of the drug and document that information on the prescription. Resubmit the claim with diagnosis information.

- Diagnosis codes must be obtained from the prescriber
- ND Medicaid cannot provide diagnosis codes

If the diagnosis code is submitted and claim rejects:
Please review the submitted diagnosis codes for accuracy and clarify as needed with prescriber. Federal law requires Medicaid to pay for medications based on FDA approval and compendia-supported drug information. A diagnosis must be supported in the compendia by a strength of recommendation of at least IIb

(Recommended, In Some Cases) and an efficacy of IIa (Evidence Favors Efficacy). ND Medicaid uses DrugDex® produced by Thompson Micromedex as its compendium.

- Diagnosis codes must be obtained from the prescriber. ND Medicaid cannot provide diagnosis codes.
- If diagnosis code provided is FDA or compendia recommended and claim is still rejecting, please contact provider relations at 1-800-755-2604 so to review the diagnosis for possible addition to the coverage list as appropriate.

41 – Submit Bill to Other Processor

Reject Message:

"Member has other insurance – Questions call 701-328-2347."

Explanation:

Medicaid is the payer of last resort. If there is another payer responsible for the claim, they should be billed first. Many insurance companies have PBMs (prescription benefit managers) that administer the prescription benefits (e.g. Prime Therapeutics, Optum Rx, etc.). The phone number for the PBMs may be found on the member's insurance card or by contacting the insurance company.

Action:

Member has other insurance, but other insurance does not cover prescribed medication:

Birth Control: Please provide diagnosis code

- If using for a medical reason – the prescribing physician will need to submit medical notes to the primary payer showing medical need
- If using for contraception – please call 701-328-2347 for an override

Other medication coverage:

- Medicaid cannot pay without primary insurance coverage. Primary insurance policies should be followed, for example:
  - Call primary insurance to find out why medication is not covered
  - Work with primary insurance to find a covered medication
  - Submit a prior authorization/clinical notes to primary insurance

70 – Product/Service Not Covered – Medical Billing Only

Reject Message:

"Drug not covered on pharmacy benefit. Please bill on medical benefit using 837P transactions."

Explanation:

Drugs indicated for inpatient use only or requiring clinic administration should not be billed through the pharmacy point of sale (POS) system. Vaccines and medication therapy management (MTM) are common services pharmacies perform that are billed through medical billing.

Action:

Please bill drugs dispensed for administration in the clinic on the medical benefit through clinic buy and bill rather than pharmacy POS even if the claim does not reject when submitted through pharmacy POS.

Please contact the medical claim call center at 701-328-7098 or 877-328-7098 or by email the mmisinfo@nd.gov

- The pharmacy provider relations team does not support these types of claims

70 – Product/Service Not Covered – Age Not Covered

Reject Message (underlined information is customized to the rejected claim):

"Plan will pay for ages 18 and over"
"Product not covered due to age"

Explanation:

Due to federal law, patient's age must be within FDA approved or compendia approved recommendations to be covered.

Action:

If drug is not FDA-approved nor compendia-supported for patient's age, contact prescriber for alternative drug therapy.

75 – Prior Authorization Required – Prior Authorized

Reject Message:

"Please visit www.hidesigns.com/ndmedicaid. Navigate to Preferred Drug List and PA Forms links. Only forms from this website can be accepted."

Explanation:

Prior authorization is the process to verify that use of a particular drug meets medically necessary criteria for coverage as set by the Drug Use Review board. Prior authorization criteria are designed to promote safety, efficacy, and cost-effectiveness of drug utilization.

Action:

Reference the current PDL (www.hidesigns.com/assets/files/ndmedicaid/NDPDL.pdf) for preferred drugs and criteria for coverage. Contact prescriber to switch to preferred drug or initiate prior authorization. Please use PA Form supplied by the website. Forms that are submitted by using quick buttons in pharmacy software can result in delays and unnecessary back and forth communication if not all information requested on state form is supplied.

75 – Prior Authorization Required – Age Requires Prior Authorization

Reject Message (underlined information is customized to the rejected claim):

"Plan will pay for ages 9 and under"

Explanation:

Some ages require prior authorization to verify additional information, such as indication or inability to swallow.

Example: Verification of indication for sildenafil used for pulmonary hypertension. Any use under the age of 12 is assumed to be for pulmonary hypertension with submitted diagnosis, while use above this age requires additional verification of diagnosis as it is also commonly used for other non-covered indications.

Action:

Inability to swallow

Rationale of inability to swallow a solid dosage form must be provided after age 9 for all non-solid oral dosage forms. Reference the current PDL (www.hidesigns.com/assets/files/ndmedicaid/NDPDL.pdf) for non-solid

dosage preparations criteria. To dispense a non-solid dosage form in patients 9 years of age and older, please submit the General Prior Authorization Form.

Indication verification
Please submit documentation to support FDA approved or compendia supported indication by submitting General Prior Authorization Form.

75 – Prior Authorization Required – Concurrent Therapy/Step Care

Reject Message (entire message is customized to the rejected claim):
"Metformin must be used with DPP4 Inhibitors per ADA guidelines"

Explanation:
Electronic lookback through claim history identifies total days of drug therapy within a specified time span, and the in-process claim will reject if the required days of drug therapy are not met. This lookback can be set to occur prior to the first instance or prior to each instance of dispensing.

- Prior to the first instance of dispensing:
  - Step care requirements look for previous claim in history prior to the first instance of dispensing of a requested drug. Step care may be implemented to ensure appropriate dose titration, minimize PA requirements, etc.
- Prior to each instance of dispensing:
  - Concurrent therapy requires previous claim in history to be used on an ongoing basis and verifies the claim history prior to each refill of a requested drug. Concurrent therapy may be implemented when concomitant drug use is recommended by guidelines, drug manufacturer, etc.

Action:
Review rejection message and reference the current PDL (www.hidesigns.com/assets/files/ndmedicaid/NDPDL.pdf) for additional rationale. Contact prescriber to address concurrent therapy/step care requirements and adjust prescription if needed.

Please have information documenting concurrent therapy/step care requirements (e.g. drug profile, medical history, etc.) have been met or are contraindicated when contacting provider relations at 1-800-755-2604 if requesting an override.

Patient is stable on medication from another plan or from the hospital
Please contact provider relations at 1-800-755-2604 to request an override for step care. Concurrent therapies will likely still be required.

Patient can't tolerate required lookback med
Please submit documentation that the lowest dose has been trialed and still is not tolerated by using the General Prior Authorization Form.

75 – Prior Authorization Required – Brand Preferred

Reject Message:
"Please visit www.hidesigns.com/ndmedicaid. Navigate to Preferred Drug List and PA Forms links. Only forms from this website can be accepted."

"Please use brand name."

Explanation:
Brand name drugs are preferred when there is a significant cost savings to ND Medicaid or if the requirement increases access to products. If the generic product is billed when ND Medicaid prefers brand name, the claim will reject.

Action:
When a brand name product is preferred by ND Medicaid, use **DAW 9** to be reimbursed at the brand rate.

- Please review claims for proper reimbursement
    - **Brand drugs will reimburse at generic rate if not submitted with DAW 9.**
    - Brand drugs not (or no longer) preferred will reject if DAW 9 is used. Generic drug is preferred.
- To use DAW 1 to be reimbursed at a brand rate for prescriber-requested brand preference, please submit the General Prior Authorization Form.

First fill
Overrides can be requested to use generic to fulfill first fill requirements to avoid breaking bottles by contacting provider relations at 1-800-755-2604 to request an override.

Primary Insurance
If primary insurance is involved with payment of the claim, please submit the generic product as well as “06” in the Other Payer-Patient Responsibility Amount Qualifier (351-NP) field. This may result in a paid claim from a system generated override. If the copay required by primary insurance is significant, the claim will reject for a review. Please contact provider relations at 1-800-755-2604 to request a review for an override for brand preference.

Wholesaler does not have in stock
Wholesalers often will not stock brand until there are requests or demand for the product. Please contact provider relations at 1-800-755-2604 to request an override and then request your wholesaler to stock the brand name to be ordered for the next fill.

75 – Prior Authorization Required – Out of State

Reject Message:
“If a drug can be dispensed by a ND pharmacy, it must be dispensed by a ND pharmacy. If not, contact provider relations at 1-800-755-2604.”

Explanation:
ND Medicaid requires medications to be dispensed by an enrolled, in-state pharmacy if possible. In-state is defined as pharmacies located within North Dakota or within a border state (Minnesota, South Dakota, or Montana). Claims for medications identified by ND Medicaid as available only out-of-state will not post this rejection when billed by an enrolled, out-of-state pharmacy. ND Medicaid does not have a preferred out-of-state specialty pharmacy.

Action:
If a retail pharmacy is unable to fill a prescription due to a limited distribution program, verify if another in-state pharmacy has access to the medication. The drug manufacturer and/or in-state specialty pharmacies are good resources to consult.

If a prescription cannot be filled at an in-state pharmacy, the out-of-state pharmacy must be enrolled with ND Medicaid and contact provider relations at 1-800-755-2604 for an override.

76 – Plan Limitations Exceeded – Cumulative Duration or Quantity

Reject Message (entire message is customized to the rejected claim):

"The member has been dispensed XXX days supply in the last YYY days, with this claim the member is ZZZ days supply over the limit."

"The member has been dispensed XXX units in the last YYY days, with this claim the member is ZZZ units over the limit."

Explanation:

Claim history lookback identifies cumulative days (or quantity) of drug therapy within a specified time span, and the in-process claim will reject if the allowed days or quantity of drug therapy are exceeded with that claim. Use of a drug beyond the FDA-approved or compendia-recommended duration of therapy is not covered.

Action:

Review the refill history, verify prescription directions, and reference the current PDL (www.hidesigns.com/assets/files/ndmedicaid/NDPDL.pdf) for coverage information and rationale. Specific information to obtain overrides is also provided in the PDL.

To request an override if extension of therapy duration is appropriate and PA is not required, contact provider relations at 1-800-755-2604.

Duration Example: The recommended duration for Orilissa is for 2 years. Patient has completed 730 days of treatment. In process claim is rejected as it would exceed this duration. No more Orilissa will be covered for this patient.

76 – Plan Limitations Exceeded – First Fill Limitation

Reject Message:

"First Fill Limit. Max 7 days for narcotics. Max 10 days for antipsychotics/ADHD/gabapentin. Next fill, only use a 30-day supply if stable."

Explanation:

First fill limits the day supply that can be used for the first fill of medications that have associated issues with using longer day supplies for the initial fill such as frequent dose finding strength changes, tolerability, or safety. This is used to prevent an accumulation of unused supply at home.

First Fill Categories
All clonidine ER products
All guanfacine ER products
All long-acting stimulant ADHD
All brand name antidepressants and vilazodone
All brand name antipsychotics
All immediate release opioids products
All gabapentin products

Action:

Immediate Release (IR) Opioid Analgesics

If the last dispensed quantity of an IR opioid analgesic lasts longer than 34 days, first fill will post a denial for the next fill. The quantity dispensed for the next fill will need to be modified to not exceed the average daily dose for a duration less than 34 days and an override can be requested by contacting provider relations at 1-800-755-2604. A 34-day supply is the maximum allowed day supply for IR opioid analgesics.

All other categories

The first fill will require less than a 10-day supply to confirm a patient is stable on the dose prior to filling a 30-day supply. Once a 30-day supply is filled, the patient is assumed to be stable and requests for overrides for dose changes on the first 30-day supply will not be approved. If a patient is not yet stable, please continue to fill a 10-day supply or less until a stable dose is achieved.

Brand Required Medications

Overrides can be requested to use generic to fulfill first fill requirements to avoid breaking bottles by contacting provider relations at 1-800-755-2604 to request an override.

76 – Plan Limitations Exceeded - Morphine Milligram Equivalents (MME)

Reject Message:

"Plan will not pay for total morphine milligram equivalents greater than 90 MME/day any given day without prior authorization."

Explanation:

A cumulative maximum of 90 MME/day is allowed without prior authorization. CDC guidelines recommend avoiding opioid doses that exceed 90 MME/day without careful justification. Cancer pain, palliative care pain, sickle cell pain, and post hospitalization dose tapering are considerations for exceptions.

Action:

Patient has request regimen that exceeds 90 MME/day

Please submit the Opioid Analgesic PA Form with clinical documentation specifying met clinical criteria or contraindication to clinical criteria. Please reference the required clinical criteria on the current PDL (www.hidesigns.com/assets/files/ndmedicaid/NDPDL.pdf)

Patient has an early refill on a regimen exceeding 45 MME/day

This rejection will also post if claims are filled too early. Please submit claim when more of the original script is used up.

76 – Plan Limitations Exceeded - Quantity Per Day

Reject Message (entire message is customized to the rejected claim):

"Plan will pay for 2 per day"

Explanation:

Quantity per day coverage rules are placed on medications following FDA and compendia recommended doses and intervals, thereby reducing regimen complexity as much as possible.

Action:

Review the directions on the prescription and the recommended doses and intervals in the package insert or compendia. Interval on prescription should match recommendations.

- If the directions (dose and interval) do not match recommendations, call prescriber to clarify directions and align with recommended dose/interval.
    - ND Medicaid will not override doses/intervals based on prescriber preference that do not align with pharmacokinetics and recommended dosing for the drug.

Quantity Per Day Example: Patient A is getting an atorvastatin prescription for 10mg twice daily. Pharmacy reviews recommendations for daily dosing of atorvastatin. Pharmacy calls prescriber to change directions to 20mg once daily.

In-between doses

Generally, ND Medicaid will cover commercially available strengths. For doses in between the available strengths, the recommended dose increase should be trialed first. If the recommended lower strength is not enough, and the next highest recommended strength is too much, the in-between dose may be considered. In this case, please contact provider relations at 1-800-755-2604.

- Some medications are flat priced (e.g. $10/tablet for 5 mg, 10 mg, and 20 mg), so using more than 1 tablet per day against recommendations drastically increases the cost of the medication.

Loading doses

Please contact provider relations at 1-800-755-2604 to obtain a quantity override for loading doses. Please have indication available when requesting override. This override request may be necessary even if a prior authorization for the drug has already been approved.

- Starter packs usually have built-in quantities that align with titration or loading schedule and do not require overrides. Please use these whenever possible.

Topicals

Quantity for topicals can be evaluated using fingertip units. A fingertip unit is the amount of cream, ointment, etc. that is expressed from a 5 mm diameter nozzle applied from the tip of the index finger of an adult to the distal-skin crease.

- One fingertip unit is enough to cover an area of skin twice the size of an adult's hand with the fingertips together. Two fingertip units are equal to 1 gram on an adult male.
    - An entire adult body is 40 units (20 grams).

Fingertip Unit Calculation: An adult male needs to have a cream applied twice daily over half of his body. Prescription is written for 500 grams for a 10 days supply. 20 grams x ½ the body x 2 times per day x 10 days = 200 grams.

- 500 grams is too large of quantity for this prescription.

79 – Refill Too Soon

Reject Message (entire message is customized to the rejected claim):

"Next Fill: 2020-09-26. Last Fill: 2020-09-02 at <pharmacy name>/"same pharmacy"/"name unavailable"/"pharm name missing". Rx <Rx number>, Ph <Phone Number>."

"If dose has changed and 61% or more has been used (i.e. 19 days of 30 days supply fill) on a non-controlled substance, try conflict codes ER, M0, 1B."

Explanation:

Identifies when the last dispensed supply for this same medication/form/strength has not been used 80% (for non-controlled) or 87% (for controlled) prior to refilling.

Action:

Please have dosing change information (e.g. date of change, current directions, etc.) available when contacting provider relations at 1-800-755-2604 if requesting an override. Follow applicable instruction below.

Dose change

Applicable only to increases in frequency of administration of the same strength of medication (BID to TID). Dosage increases typically are obtained by increasing the strength which would cause a therapeutic duplication rejection.

- If dose has been at least 61% utilized and is not a controlled substance, try DUR conflict codes ER, m0, 1b.
- If dose is less than 61% utilized or a controlled substance, please verify date of direction change, that the patient is out of medication and should be out of medication based on direction change. Please call 1-800-755-2604 to obtain an override.

Dose Change Example: Oxycodone 10mg 3x/day #60 was prescribed on day 1. On day 5, the dose was increased to 5x/day. On day 14, patient requests new fill of oxycodone 10mg. Fill date is appropriate based on direction change date. Pharmacy calls for override.

Vacations

- If dose has been at least 61% utilized and is not a controlled substance, try DUR conflict codes ER, m0, 1b.
- If dose is less 10 days early or a controlled substance, please call 1-800-755-2604 to request an override.
    - If a vacation override is authorized, the days supply overlap will apply to accumulated days supply. Previous supply and authorized early supply must BOTH be utilized before refilling again.

Lost or Stolen

- Generally, ND Medicaid does not cover lost or stolen medications. Some life preserving exceptions may be made. Please try DUR conflict codes ER/m0/1b, contact the drug manufacturer, or search the Drug Repository Program.

79 – Refill Too Soon - Accumulation Refill Too Soon

Reject Message:

"With this claim, member has accumulated a 10 (controlled) or 15 (non-controlled) day supply over the last 6 months. Member must use accumulated supply prior to refill."

Explanation:

Identifies when patient's may have accumulated unused medication at home through continuously filling early as allowed within the refill too soon parameters. Claims will reject for accumulation refill to soon if accumulated supply from early fills exceeds 10 days for controlled substances and 15 days for non-controlled substances.

Action:

Review the refill history, verify prescription directions, and follow applicable instructions below.

Directions have changed

Please recalculate how many days prescription should last based on direction change, document on previous prescription, and adjust day previous days supply based on dose change information. This may require a quantity override (request by calling 1-800-755-2604).

- Alternatively call for an override. Please have dosing change information (e.g. date of change, current directions, etc.) available when contacting provider relations at 1-800-755-2604.

Direction Change Example: Patient A has an insulin dose of 20 units per day for 50 days (1000 units/10 mL dispensed). On day 35 patient asks for new fill with new directions, claim is rejected due to being 15 days early. The change is to 40 units per day and occurred on day 20. Pharmacy notes new directions and date of dose change on previous Rx and rebills previous prescription as 35 days supply. New claim for 40 unit/day goes through.

Compound isn't lasting calculated day supply

Review prescription refill history and calculate how long prescription is lasting patient on average. Reverse and rebill previous (up to 6 months) compounds for duration it is lasting.

Compound Example: Patient B must have his medications compounded. The calculated day supply for the ingredients is 30 days. The pharmacy has counseled parents on how to maximize dose withdrawal from the bottle and verified the dose being given. No matter how they try, parents are running out early every month. Pharmacy calculates compound is lasting average of 26 days and rebills last 6 months of claims in order as 26 days supplies.

Mail outs

Note which day prescription is needed, count back required number of days to mail early. Mail on same date every time (or early for weekends/holidays). A refill override may be requested for the "first" refill to get into the regular filling cycle by calling 1-800-755-2604.

Mail Out Example: Patient C needs prescription on the second and fourth Tuesday of each month and 4 days is needed for mail time, bill on the first and third Friday of each month. Each time, the prescription will be mailed out 4 days early and not cause an accumulation rejection. Refills following the first refill should continue on a 14-day cycle. Filling every 11 days would cause an accumulation rejection.

Patient filling a few days early every month

If prescription information is accurate, the accumulated drug supply must be used before refill.

Early Refills Example: Patient A fills lisinopril 3 days early every month to make sure she has it in time. Month 5 has a holiday weekend, so she fills 5 days early to make sure she has enough medication to get through the holiday. Now patient has 3 extra days accumulated for 4 months + 5 days from holiday month fill, so she has 17 extra days on hand. The accumulated supply should be used before refilling again.

88 – DUR Reject Error – Drug – Disease Interaction

Reject Message (entire message is customized to the rejected claim):

Severity Level 1 (Reported or Inferred):

Contraindication: Drug - Reported Disease (UPPER GI BLEED) - DUR/PPS Reason for Service Code DC- please re-submit with appropriate DUR/PPS codes

Severity Level 2 or 3 (Reported or Inferred):

Interaction: Drug - Inferred Disease (KIDNEY DISEASE WITH REDUCTION IN GFR). Counsel patient or contact prescriber as necessary.

Explanation:

Prospective drug use review (ProDUR) edits will screen for drug-disease interactions with diagnoses inferred from member's pharmacy claim history or diagnoses reported from pharmacy and medical claims history. These DUR messages are intended to assist in pharmacy couseling.

Action:

There are 3 severity levels reported each for reported disease and inferred disease interactions. The highest degree interaction severity level 1 for reported disease will result in a rejected. The prescription may require adjustment. Contact prescriber if needed. DUR conflict codes are provided to override the rejection if the prescription is deemed appropriate to dispense after appropriate clinical evaluation of the interaction.

Reason for Service Code (439-E4)	MC	Drug-Disease (Reported) precaution
Professional Service Code (440-E5) *any of the following as appropriate*	M0 P0 R0	Prescriber consulted Patient consulted Pharmacist consulted
Result of Service Code (441-E6)	Any valid value	

88 – DUR Reject Error - Therapeutic Duplication

Reject Message (entire message is customized to the rejected claim):

"This claim has denied due to concurrent therapy lorazepam 0.5 mg tablet, filled on 2021-08-16. Next fill assuming the concurrent claim ends: 2021-09-11"

If changing med, finish day supply if possible. If concurrent therapy, see therapeutic duplication under applicable section in the PDL at www.hidesigns.com/ndmedicaid "

Explanation:

Concurrent drug use may be non-covered for various reasons, such as duplicative or opposing mechanisms of action, drug-drug interactions, etc. Also, federal law requires Medicaid to pay for medications based on FDA approval and compendia-supported drug information. Practices, such as using multiple medications within the same class or multiple strengths for an "in-between" dose, often lie outside of compendia recommendations and are not covered.

Action:

Reference the current current PDL (www.hidesigns.com/assets/files/ndmedicaid/NDPDL.pdf) for coverage information and rationale. Specific information to obtain overrides is also provided in the PDL.

The prescription may require adjustment for ND Medicaid to cover. Contact prescriber if needed.

To request an override due to primary insurance requirements, contact provider relations at 1-800-755-2604.

88 – DUR Reject Error - Underutilization

Reject Message (entire message is customized to the rejected claim):

"Since 2020-09-23 the patient has missed 020 days of therapy for this drug. Member has taken the drug only 33.33% of the time, and this drug requires 82.00% utilization compliance."

Explanation:

Due to safety concerns of non-adherence or wasted cost of a regimen that is not effective because it is not being taken, coverage may not be continued after action items are completed (adherence counseling is given, barriers are addressed, etc.).

Underutilization is calculated for claims within the past 180 days. When maintenance medications are underutilized, the rejection code will post with the customized sample message. Most of these messages are informative and will pay. However, some medications that have increased risk for safety or efficacy concerns if

not used consistently are set up to reject if utilization percentage over the past 180 days is below threshold and the in-process claim is again a late fill.

Action:

Review the refill history and verify prescription directions.

- If prescription information is accurate, evaluate adherence and identify adherence barriers with patient, notify prescriber of non-adherence, and discuss adherence plan if medication is to be continued/resumed.
- If prescription directions have changed, contact prescriber for an updated prescription.

Please have adherence information (e.g. rationale for missed doses, plan to address identified adherence barriers, etc.) available when contacting provider relations at 1-800-755-2604 if requesting an override.

Pharmacists: Consider enrolling as a provider for the MTM program and submitting a MTM prior authorization form for the adherence service category. Please see the Pharmacy Medical Billing Manual for more information.

Transportation concerns

North Dakota Medicaid provides transportation to and from medical services, including pharmacy and medical offices. The human service zone worker should be contacted to arrange this for a patient if transportation is identified as a barrier to adherence.

Summary of Coverage Rules:

If you feel your patient needs to have a medication that is rejecting, please call and leave as much detail as possible for Medicaid to make a determination / exception.

Albuterol (based on GINA and EPR-3 guidelines on rescue albuterol use and controller maintenance therapy):

- ProAir HFA: Quantity limit 1 inhaler per 90 days or 2 inhalers per 180 days
- Ventolin HFA / ProAir Respiclick: Quantity limit 1 inhaler per 60 days or 2 inhalers per 180 days – requires concurrent inhaled steroid for controller medication
- Nebs and inhalers are not payable together – Inhalers and nebs have equal efficacy and can lead to unnoticed rescue medication overutilization without notification to clinical care team
    - **Exceptions considered:** optimally treated patients with severe COPD or acute infections where coordination of an inhaler is not possible.

One strength of one medication from each class:

- Please make the following updates for these common dosages:
    - Duloxetine 90 mg/day = use 3 x 30 mg capsules instead of 60 mg + 30 mg
    - Escitalopram 30 mg/day = 20 mg x 1 ½ tablets instead of 10 mg + 20 mg
    - Fluoxetine 60 mg/day: use 3 x 20 mg capsules instead of 40 mg + 20 mg
    - Lisinopril 40 mg/day: use 1 x 40 mg tablet instead of 2 x 20 mg tablets
    - Meloxicam 15 mg/day: use 1 x 15 mg tablet instead of 2 x 7.5 mg tablets
    - Metformin 2000 mg/day: use 2 x 1000 mg tablets instead of 4 x 500 mg tablets
    - Sertraline 150 mg/day: use 1 ½ x 100 mg tablet instead of 100 mg + 50 mg
    - Venlafaxine ER 225 mg/day: use 3 x 75mg ER capsules instead of 75mg ER + 150mg ER

Diabetes (based on ADA guidelines):

- Testing supplies:
    - Covered for patients at risk for hypoglycemia
        - Sulfonylurea or insulin treatment
        - Gestational diabetes (with concurrent prenatal vitamin)
        - An approval for 6 months will also be considered for educational purposes for patients with a new diagnosis of diabetes, co-morbid acute/chronic illness affecting blood sugars, or increased activity (e.g., starting team sport)

    - Quantity limit: 200 test strips per 30 days
- Therapeutic Duplication:
    - Insulin and sulfonylureas are not payable together due to risk of hypoglycemia
    - DPP4- inhibitors (e.g. Januvia) require concurrent metformin and are not payable with insulin or GLP-1 agonists
        - GLP-1 agonists and DPP4-inhibitors both work to increase activity at the GLP-1 receptor
        - GLP-1 agonists are more potent

Gabapentin (based on lack of benefit above 1800 mg/day as noted in compendia):

- Max dose allowed is 1800 mg/day. **Exceptions considered:** adjuvant treatment for seizure disorder.
- Quantity limit for 300 mg is 4 per day. Above this limit, a higher strength must be used.
    - **Tapering schedules** to decrease to 1800 mg with a target date will be considered

Proton Pump Inhibitors (based on compendia / FDA-approved dosing):

- Quantity limit is 1 per day. **Exceptions considered:** Omeprazole – Refractory GERD; All other agents - Zollinger-Ellison's Syndrome or Pathological Hypersecretion
- Therapeutic Duplication: PPIs and H2Blockers – Override of addition of H2Blocker to PPI is allowed for 2 months for the indication of nocturnal hypersecretion (due to tachyphylaxis of the H2 blocker)
    - **Tapering schedules** (with or without combination H2blocker) to decrease to 1 per day with a target date will be considered

Stimulants (based on compendia and package insert):

- Vyvanse, Adderall XR, and Mydayis are not payable with an immediate release stimulant (some long-acting and short-acting methylphenidates are payable together – reference PDL)
- Max dose allowed of Adderall IR is 40 mg (20 mg x 2 or 30 mg x 1)
- Adderall XR with PPI: Adderall XR is not payable with a PPI due to increased rate and peak of Adderall XR. **Alternatives:** Adderall IR or methylphenidate ER can be used with a PPI

Long-acting benzos and Sleeping medications (based on DUR Board recommendation and FDA indications):

- Long-acting benzodiazepines and sleeping medications are not payable together due to risk of CNS depression
- Benzodiazepines indicated only for sleep (e.g., temazepam) will only be covered with a tapering plan with a target date of discontinuation to be considered for payment

Muscle Relaxants and Opioids

- Carisoprodol, Methadone: Alternative products must be used
- One muscle relaxant is allowed at a time.
    - **Exception considered:** diagnosis of cerebral palsy
- One short-acting and one long-acting opioid are allowed at a time (i.e., immediate release tramadol, oxycodone, hydrocodone are not payable in combination).