

Medi-Cal Rx Provider Manual

Version 17.0

April 1, 2024

Revision History

Document Version	Date	Description
<p><i>Updates are visually identified in this manual via symbol and font color: >>updated text. Search for >> to quickly find updated text or select the hyperlinked section number in this Revision History Table to jump to the updated section.</i></p>		
2.0	12/01/2022	<p>Version 2.0 posted with the following updates:</p> <ul style="list-style-type: none"> • Section 15.8: <ul style="list-style-type: none"> – Added verbiage and link regarding Appendix H – List of Physician Administered Drugs (PADs) with Reject Code 816. • Section 17.0: <ul style="list-style-type: none"> – Updated section title. • Sections 17.5 and 17.6: <ul style="list-style-type: none"> – Added verbiage regarding product coverage and reimbursement for COVID-19 oral antiviral, Paxlovid, and COVID-19 monoclonal antibody, Bebtelovimab. • Sections 18.0 and 18.1: <ul style="list-style-type: none"> – Added verbiage regarding product coverage and reimbursement for the mpox vaccine. • Appendix H: <ul style="list-style-type: none"> – Added list of Physician Administered Drugs that will reject with Reject Code 816.
3.0	01/01/2023	<p>Version 3.0 posted with the following updates:</p> <ul style="list-style-type: none"> • Section 4.3: <ul style="list-style-type: none"> – Updated verbiage and section title. • Sections 10.0, 10.1, 10.1.2, 10.1.3, 10.1.4.1, 10.1.5, and 10.1.6: <ul style="list-style-type: none"> – Updated verbiage and section title (10.1.2). • Section 11.2 (New): <ul style="list-style-type: none"> – Added verbiage about certain drugs or classes of drugs that are excluded from coverage. • Sections 17.6 and 17.6.1: <ul style="list-style-type: none"> – Removed all language regarding Bebtelovimab. These sections are no longer present. • Section 20.4:

Document Version	Date	Description
		<ul style="list-style-type: none"> – Updated verbiage.
4.0	02/01/2023	<ul style="list-style-type: none"> • Section 12.5: <ul style="list-style-type: none"> – Updated verbiage. • Section 17.0: <ul style="list-style-type: none"> – Added NDCs. • Appendix D: <ul style="list-style-type: none"> – Updated the appendix. • Appendix G: <ul style="list-style-type: none"> – Updated the appendix. • Appendix H: <ul style="list-style-type: none"> – Updated the appendix.
5.0	03/01/2023	<p>Version 5.0 posted with the following updates:</p> <ul style="list-style-type: none"> • Sections 12.1, 12.2, 12.3, 12.3.2, 12.3.5, 12.4, and 12.5: <ul style="list-style-type: none"> – Updated language. • Section 17.5: <ul style="list-style-type: none"> – Added information about Remdesivir (Veklury). • Section 18.2 (New): <ul style="list-style-type: none"> – Added information about product availability, billing, dosages, and reimbursement for Tecovirimat (TPOXX).
6.0	04/01/2023	<p>Version 6.0 posted with the following updates:</p> <ul style="list-style-type: none"> • Section 4.6.13: <ul style="list-style-type: none"> – Updated language. • Section 16.2: <ul style="list-style-type: none"> – Updated language.
7.0	05/01/2023	<p>Version 7.0 posted with the following updates:</p> <ul style="list-style-type: none"> • Section 12.3.5: <ul style="list-style-type: none"> – Adjusted formatting. • Section 18.0: <ul style="list-style-type: none"> – Updated language. • Appendix G: <ul style="list-style-type: none"> – Updated the appendix. • Appendix H:

Document Version	Date	Description
		<ul style="list-style-type: none"> – Updated the appendix.
8.0	06/01/2023	<p>Version 8.0 posted with the following updates:</p> <ul style="list-style-type: none"> • Section 3.6 and 3.6.1.1: <ul style="list-style-type: none"> – Updated language. • Section 4.6.11 and 4.6.14: <ul style="list-style-type: none"> – Updated language. • Section 12.0: <ul style="list-style-type: none"> – Updated language. • Section 13.1: <ul style="list-style-type: none"> – Updated language.
9.0	07/01/2023	<p>Version 9.0 posted with the following updates:</p> <ul style="list-style-type: none"> • Section 8.2.3: <ul style="list-style-type: none"> – Added language. • Section 13.0: <ul style="list-style-type: none"> – Updated language. • Section 13.1: <ul style="list-style-type: none"> – Updated language. • Section 13.2: <ul style="list-style-type: none"> – Updated language. • Section 13.5 (New): <ul style="list-style-type: none"> – Added information about reimbursement and requirements about blood pressure devices and cuffs. • Section 15.1.2: <ul style="list-style-type: none"> – Updated language in table.
10.0	09/01/2023	<p>Version 10.0 posted with the following updates:</p> <ul style="list-style-type: none"> • Section 3.3.3.1: <ul style="list-style-type: none"> – Updated language and image. • Section 12.0, 12.1, 12.2, 12.3, 12.4, 12.5, 12.6, and 12.7: <ul style="list-style-type: none"> – Updated language. • Section 12.8 (New): <ul style="list-style-type: none"> – Added information regarding enteral nutrition policy.

Document Version	Date	Description
		<ul style="list-style-type: none"> • Section 15.7.1 and 15.7.3: <ul style="list-style-type: none"> – Updated language. • Section 17.0, 17.1, 17.2, 17.3, and 17.4: <ul style="list-style-type: none"> – Updated language regarding specific NDCs and removed language of pediatric coverage and table. • Appendix D: <ul style="list-style-type: none"> – Updated the appendix.
11.0	10/01/2023	<p>Version 11.0 posted with the following updates:</p> <ul style="list-style-type: none"> • Sections 12.4 and 12.5: <ul style="list-style-type: none"> – Updated language. • Section 16.3 (New): <ul style="list-style-type: none"> – Added language regarding automatic refill programs for members.
12.0	11/01/2023	<p>Version 12.0 posted with the following updates:</p> <ul style="list-style-type: none"> • Section 4.4: <ul style="list-style-type: none"> – Updated language. • Section 4.4.1 (New): <ul style="list-style-type: none"> – Added language regarding NDC policy. • Sections 12.0, 12.3, and 12.4: <ul style="list-style-type: none"> – Updated language. • Sections 13.0, 13.1, 13.2, 13.3, and 13.4: <ul style="list-style-type: none"> – Updated language. • Sections 17.3 and 17.3.1: <ul style="list-style-type: none"> – Updated language. • Sections 17.5 and 17.5.1 (New): <ul style="list-style-type: none"> – Added language about policy and reimbursement for commercial COVID-19 vaccines. • Appendix C: <ul style="list-style-type: none"> – Updated the appendix.
13.0	12/01/2023	<p>Version 13.0 posted with the following updates:</p> <ul style="list-style-type: none"> • Sections 2.1.4 and 2.1.4.1:

Document Version	Date	Description
		<ul style="list-style-type: none"> – Added language and updated contact information. • Sections 3.6 and 3.6.1.1: <ul style="list-style-type: none"> – Updated language. • Section 4.2.1: <ul style="list-style-type: none"> – Added language. • Sections 13.2, 13.3, and 13.4: <ul style="list-style-type: none"> – Updated and added new language. • Section 17.5: <ul style="list-style-type: none"> – Added language.
14.0	01/01/2024	<p>Version 14.0 posted with the following updates:</p> <ul style="list-style-type: none"> • Section 12.5.1: <ul style="list-style-type: none"> – Updated table. • Section 12.5.5: <ul style="list-style-type: none"> – Updated and added language. • Sections 12.5.5.1, 12.5.5.2, 12.5.5.3, 12.5.5.4, 12.5.5.5, and 12.5.5.6: <ul style="list-style-type: none"> – Reinstated language. • Section 12.8: <ul style="list-style-type: none"> – Updated and added language. • Sections 12.8.1 and 12.8.2 (New): <ul style="list-style-type: none"> – Added language regarding product interchangeability requirements. – Added language regarding prescription requirements for enteral nutrition product substitutions. • Section 13.0: <ul style="list-style-type: none"> – Updated and added language. • Section 13.6 (New): <ul style="list-style-type: none"> – Added language regarding non-covered medical supplies. • Section 17.4.1: <ul style="list-style-type: none"> – Updated language pertaining to the FDA approval of Paxlovid. • Section 17.4.1.1 (New):

Document Version	Date	Description
		<ul style="list-style-type: none"> – Added language regarding commercial transition of Paxlovid. • Section 17.4.2: <ul style="list-style-type: none"> – Updated language. • Sections 17.4.3 and 17.4.3.1 (New): <ul style="list-style-type: none"> – Added language regarding Lagevrio and commercial Lagevrio. • Section 17.4.4 (New): <ul style="list-style-type: none"> – Added language regarding reimbursement for COVID-19 oral antiviral products. • Section 17.4.4.1 (New): <ul style="list-style-type: none"> – Added language regarding reimbursement for pharmacist services on a medical claim. • Section 17.4.5 (New): <ul style="list-style-type: none"> – Added language about reimbursement for commercial COVID-19 oral antiviral products.
15.0	02/01/2024	<p>Version 15.0 posted with the following updates:</p> <ul style="list-style-type: none"> • Section 3.3.3.1: <ul style="list-style-type: none"> – Updated language. • Section 3.3.3.2 (New): <ul style="list-style-type: none"> – Added language and updated images. • Section 3.3.3.3 (New): <ul style="list-style-type: none"> – Added language. • Section 15.8: <ul style="list-style-type: none"> – Updated language. • Section 15.8.1 (New): <ul style="list-style-type: none"> – Added language. • Section 15.8.2 (New): <ul style="list-style-type: none"> – Added language. • Section 15.8.3 (New): <ul style="list-style-type: none"> – Added language.

Document Version	Date	Description
16.0	03/01/2024	Version 16.0 posted with the following updates: <ul style="list-style-type: none"> • Section 12.5.2: <ul style="list-style-type: none"> – ICD-10 diagnosis code removed. • Section 13.4: <ul style="list-style-type: none"> – Updated language.
17.0	04/01/2024	Version 17.0 posted with the following updates: <ul style="list-style-type: none"> • Section 15.7.1: <ul style="list-style-type: none"> – Updated language. • Section 15.14: <ul style="list-style-type: none"> – Updated language.

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1.0 Introduction

The Medi-Cal program objective is to provide essential medical care and services to preserve health, alleviate sickness, and mitigate disabling conditions for individuals or families on public assistance, or whose income is not enough to meet their individual needs. The covered services are generally recognized as standard medical services required in the treatment or prevention of diseases, disability, infirmity, or impairment. These services are comprehensive and provide care in the major disciplines of health care.

From the inception of the Medi-Cal program in March 1966, the State has contracted with a Fiscal Intermediary (FI) to receive and process Medi-Cal claims. Beginning January 1, 2022, the new California Department of Health Care Services (DHCS) FI for Medi-Cal Rx pharmacy services is Magellan Medicaid Administration, LLC (MMA).

1.1 Medi-Cal Rx Pharmacy

This manual provides claims submission guidelines for Providers for the fee-for-service Medi-Cal Rx pharmacy programs managed by the Medi-Cal Rx vendor for DHCS.

The pharmacy component of the following programs is a part of Medi-Cal Rx:

- Medi-Cal
- California Children's Services (CCS)
- Genetically Handicapped Persons Program (GHPP)
- Family Planning, Access, Care, and Treatment (Family PACT)

Billing guidelines and information regarding pharmacy claims specified throughout this manual pertain to all pharmacy programs, as do any references to Medicaid/DHCS, unless specifically stated otherwise.

Note: Items billed as medical claims, such as Durable Medical Equipment (DME) and certain disposable medical supplies should be submitted to the California Medicaid Management Information Systems (CA-MMIS) FI or the applicable Managed Care Plan (MCP).

1.2 Medi-Cal Rx Vendor

The DHCS contracts with its Medi-Cal Rx vendor to

- Adjudicate claims.
- Distribute payment and Remittance Advices (RAs).
- Review PA requests.
- Perform Prospective Drug Utilization Review (ProDUR) and Retrospective Drug Utilization Review (RetroDUR).
- Conduct post-payment audits.
- Provide clinical support to Pharmacy Providers and Prescribers seeking coverage details and information.
- Process batch files for claim reimbursement.

- Operate a Customer Service Center for Beneficiaries, Pharmacy Providers, Prescribers and Managed Care Liaisons.
- Provide Program Integrity functions, which includes reviewing, validating, and referring to DHCS identified Fraud, Waste and Abuse (FWA).

Note: The above list is *not* all-inclusive.

2.0 Billing Overview and Background

2.1 Enrolling as a Medi-Cal Pharmacy Provider

Providers rendering services to Medi-Cal members must be enrolled as Medi-Cal providers by DHCS. To enroll, see the *Provider Enrollment Contact Information* table in [Section 2.1.2](#) below.

The DHCS Provider Enrollment Division (PED) is responsible for the timely enrollment and re-enrollment of eligible Medi-Cal fee-for-service health care providers. The DHCS PED assists providers as follows:

- Accepts and verifies all applications for enrollment.
- Enrolls each provider using a National Provider Identifier (NPI).
- Maintains a Provider Master File (PMF) of provider names and addresses.
- Updates the enrollment status of providers for Medi-Cal records.

2.1.1 Participation Requirements

Provider requirements for providers approved for participation in the Medi-Cal program include:

Federal Laws and Regulations, Welfare and Institutions Code, and California Code of Regulations

Compliance with the Social Security Act (*United States Code*, Title 42, Chapter 7); the *Code of Federal Regulations*, Title 42; the *California Welfare and Institutions Code* (W&I Code) Chapter 7 (commencing with Section 14000) and, in some cases, Chapter 8; and the regulations contained in the *California Code of Regulations* (CCR), Title 22, Division 3 (commencing with Section 50000), is periodically amended.

Record Keeping

Providers must keep necessary records pursuant to CCR, Title 22, Section 51476.

Nondiscrimination

Providers must not discriminate against any member based on sex, race, color, religion, ancestry, national origin or ethnic group identification, age, physical or mental disability, medical condition, genetic information, marital status, or sexual orientation.

2.1.2 Provider Application and Validation for Enrollment and Provider Enrollment Division Information

The Provider Application and Validation for Enrollment (PAVE) Provider Portal is a secure, web-based Provider Portal that simplifies and accelerates enrollment processes. Providers accessing PAVE can complete and submit new enrollment applications, report changes to existing enrollments, and respond to Provider Enrollment Division (PED) initiated requests for continued enrollment or revalidation. To access PAVE, use the following link:

<https://pave.dhcs.ca.gov/sso/login.do>.

PED is responsible for the enrollment and re-enrollment of Medi-Cal fee-for-service health care service providers. PED is also responsible for developing enrollment policy and updating and maintaining provider information in the PMF database that is used in the claims payment process. To access PED, use the following link:

<https://www.dhcs.ca.gov/provgovpart/Pages/PED.aspx>.

Additional enrollment information can be found at the following link:

<https://mcweb.apps.prd.cammis.medi-cal.ca.gov/references/provider-enrollment>.

In addition to the information above, see *Table 2.1.2-1* for further available resources:

Provider Enrollment Contact Information	
<p>For:</p> <ul style="list-style-type: none"> • Clarification of Enrollment Requirements • Explanation of Application Denial • Medi-Cal Provider Enrollment Process • Revalidation/Re-Enrollment 	<p>PED Message Center</p> <ul style="list-style-type: none"> • Telephone Number: (916) 323-1945 • Online Inquiries: https://www.dhcs.ca.gov/provgovpart/Pages/PED.aspx – select Inquiry Form under “Provider Resources” • Address: Department of Health Care Services Provider Enrollment Division MS 4704 P.O. Box 997412 Sacramento, CA 95899-7412
<p>For:</p> <ul style="list-style-type: none"> • PAVE Technical Issues • PAVE Internet Browser Compatibility • PAVE Log-On • System Navigation/Functionality • Uploading/Accessing Documents 	<p>PAVE Technical Support</p> <ul style="list-style-type: none"> • Website: https://www.dhcs.ca.gov/provgovpart/Pages/PAVE.aspx • Telephone Number: (866) 252-1949 • Hours of Operation: Monday-Friday 8:00 a.m. – 6:00 p.m. PT, excluding holidays

Table 2.1.2-1: Provider Enrollment Contact Information

2.1.3 Provider Guidelines

2.1.3.1 Change of Pay-To and/or Mailing Address

A change of pay-to address, mailing address, telephone number, or status must be submitted using the PAVE Portal (<https://pave.dhcs.ca.gov/sso/login.do>).

Providers who have changed their pay-to address, mailing address, status, or any other related information must notify the DHCS PED.

Pharmacy providers reporting changes should consider whether the change requires the Board of Pharmacy to issue a new Pharmacy Permit. The Board of Pharmacy can be contacted at 1-916-518-3100. If the change requires the Board of Pharmacy to issue a new Pharmacy Permit, the pharmacy provider is required to complete a new application using the PAVE Portal (<https://pave.dhcs.ca.gov/sso/login.do>). If a new Pharmacy Retail Permit is *not* required as a result of the change being reported, the Pharmacy provider is required to submit a supplemental change application (see [Section 2.1.3.2 – Enrollment Information](#)) with the PAVE Portal (<https://pave.dhcs.ca.gov/sso/login.do>).

2.1.3.2 Enrollment Information

In response to fraud and abuse within Medi-Cal, DHCS has adopted regulations governing provider enrollment to ensure program integrity. These regulations require the submission of consistent information that can be used to verify the identity and qualifications of individuals and groups requesting Medi-Cal Rx provider status and establish requirements for the enrollment of most noninstitutional providers who submit fee-for-service claims.

The following types of providers are **not** impacted by these regulations:

- Institutional providers.
- Other Providers licensed or certified by the California Department of Public Health.

Medi-Cal Supplemental Changes

DHCS must have current provider information. It is the responsibility of the provider to report any changes in information to DHCS **within 35 days** of the change. Deactivation of the provider billing number will occur if DHCS is unable to contact a provider at the last known pay-to, business, or mailing address. DHCS has developed the supplemental change application that must be submitted using the PAVE Portal (<https://pave.dhcs.ca.gov/sso/login.do>) to report the following changes, additions, or actions:

- Pay-to address, mailing address, or phone number changes.
- Managing employee.
- Pharmacist-in-charge if the provider is a pharmacy.
- Name under which the provider or provider group is Doing Business As (DBA).
- CLIA number.
- Providers can disenroll through PAVE.
- The days and/or hours of operation of the applicant's or provider's business.

- A change of less than 50 percent in the person(s) with an ownership or control interest, as described in CCR, Title 22, Section 51000.40, of the provider, or provider group that does not result in a new Taxpayer Identification Number (TIN) being issued by the IRS. Any cumulative change of 50 percent or more in the person(s) with an ownership or control interest since the information provided in the last complete application package was approved for enrollment, requires a new application required pursuant to CCR, Title 22, Section 51000.30(b)(6).
- Specialty Code.

2.1.3.3 Enrollment Applications

Change of Ownership or Control Interest of 50 Percent or More

Providers must submit a new enrollment application with PED via the PAVE Portal if the provider undergoes a change of 50 percent or more in ownership or control interest within 35 days of the change of ownership.

Reporting Additional Business Locations

Providers or provider groups that want to submit claims for services rendered at an additional business address are required to submit an enrollment application with PED via the PAVE Portal, as applicable to the provider type. A new application must be submitted via the PAVE Portal for each additional location.

Application Deficiencies

Applicants are allowed 60 days to resubmit their corrected application when DHCS returns it due to deficiencies.

If an applicant fails to resubmit the application to DHCS within 60 days, or fails to remediate the deficiencies identified by DHCS, the application shall be denied. Applicants denied for failure to resubmit in a timely manner or for failure to remediate may re-apply at any time.

Adding Rendering Providers to a Provider Group

Rendering providers are required to submit their applications via PAVE.

For additional information regarding the types of providers considered to be *rendering providers*, including information on licensing and required documents go to the following website:

<https://www.dhcs.ca.gov/provgovpart/Pages/RenderingProviderApplicationInformation.aspx>.

Rendering providers in good standing may join existing provider groups. The group may begin billing for the services delivered by an already enrolled rendering provider by affiliating with the rendering provider via the PAVE Portal. Rendering providers need to apply to Medi-Cal only once but must affiliate with each subsequent group they work for via the PAVE Portal. To initially enroll as a rendering provider, the applicant needs to submit a complete application package to PED via the PAVE Portal on the DHCS website

<https://www.dhcs.ca.gov/provgovpart/Pages/PAVE.aspx>.

How to Apply for Enrollment or Submit Supplemental Changes via the PAVE Portal

To submit enrollment and supplemental applications, providers can access the PAVE Portal on the DHCS website (<https://www.dhcs.ca.gov/provgovpart/Pages/PAVE.aspx>).

How to Obtain Enrollment and Supplemental Changes Forms

Changes previously reported on the *Medi-Cal Supplemental Changes* (DHCS 6209) form must now be reported via the PAVE Portal (<https://pave.dhcs.ca.gov/sso/login.do>), paper forms are no longer accepted.

2.1.3.4 Obligations to Members

Eligibility Verification Obligates Provider to Render Services

When a provider elects to verify a member's Medi-Cal eligibility, the provider has agreed to accept an individual as a Medi-Cal patient once the information obtained verifies that the individual is eligible to receive Medi-Cal benefits. The provider is then bound by the rules and regulations governing Medi-Cal once a Medi-Cal patient has been accepted into the provider's care.

After receiving verification that a member is Medi-Cal Rx eligible, a provider cannot deny services because:

- The member has other health insurance coverage in addition to Medi-Cal. Providers must not bill the member for private insurance cost-sharing amounts such as deductibles, coinsurance, or copayments because such payments are covered by Medi-Cal up to the Medi-Cal maximum allowances. Providers are reminded that Medi-Cal is the payer of last resort. Medicare and Other Health Coverage must be billed prior to submitting claims to Medi-Cal.
- The member has both Medicare and Medi-Cal Rx. Providers must not treat the member as if the member is eligible only for Medicare and then collect Medicare deductibles and coinsurance from the member, according to a 1983 United States District Court decision, *Samuel v. California Department of Health Services*.
- The service requires the provider to obtain authorization.

Circumstances that Exempt Providers from Rendering Services

A provider may decline to treat a member, even after eligibility verification has been requested, under the following circumstances:

- The member has refused to pay or obligate to pay the required Share of Cost (SOC).
- The member has only limited Medi-Cal Rx benefits and the requested services are not covered by Medi-Cal Rx.
- The member is required to receive the requested services from a designated health plan. This includes cases in which the member is enrolled in an MCP or has private insurance through a Health Maintenance Organization (HMO) or exclusive provider network, and the provider is not a member provider of that health plan.
- The provider cannot render the particular service(s) that the member requires.

- The member is not eligible for Medi-Cal Rx for the month in which service is requested.
- The member is unable to present corroborating identification with the BIC to verify that he or she is the individual to whom the BIC was issued.

Payment From Members

When Medi-Cal Rx eligibility has been verified, providers must submit a claim for reimbursement according to the rules and regulations of Medi-Cal Rx. Provider must not attempt to obtain payment from members for the cost of Medi-Cal Rx covered health care services. Payment received by providers from DHCS in accordance with Medi-Cal Rx fee structures constitutes payment in full.

Provider Billing after Member Reimbursement

For information about billing Medi-Cal Rx after reimbursing the member, refer to [Section 19.6 – Member Reimbursement Claims](#).

Non-SOC Payments Must be Refunded

Unless it is used to satisfy an SOC requirement, any payment received from a Medi-Cal Rx member must be refunded upon receipt of a Medi-Cal Rx Remittance Advice (RA) reflecting payment for that service.

2.1.3.5 Electronic Claim Submission

Providers may submit claims to the Medi-Cal Rx vendor via telecommunications and other electronic media in the manner and format approved by California W&I Code, Section 14040. Regulations for participation are located in CCR, Title 22, Section 51502.1.

Participation as a Web Claims submitter/Direct Data Entry submitter is open to most Medi-Cal Rx providers, assuming submitted claims are in an acceptable format.

To obtain approval to submit claims electronically through the Medi-Cal Rx vendor, providers must enroll via UAC (see [Section 3.6.1.2 – Secured Provider Portal](#)).

2.1.3.6 DHCS and Provider Tax Reporting Responsibilities

Introduction

DHCS is required by Federal Regulation, Section 3406 of the *Internal Revenue Service (IRS) Code*, to report the amount of payments made to providers and the provider name/Taxpayer Identification Number (TIN) combination associated with these payments using *Form 1099-MISC*. DHCS will only issue the *Form 1099-MISC* on total amount RA reimbursements greater than or equal to \$600 per NPI.

Form W-9

DHCS sends a letter of notification and a copy of *Form W-9* to providers reported by the IRS as having an invalid name/TIN combination. An invalid name/TIN combination occurs when a provider enrolls in Medi-Cal Rx with a TIN that the IRS shows as belonging to another person;

for example, "Fred Jones," enrolls in Medi-Cal Rx with a TIN that the IRS shows as belonging to "Bob Smith."

If providers do not furnish DHCS with a completed *Form W-9* by the date indicated on the notice, DHCS is required to withhold 31 percent of the provider's payments until a *W-9* is received. These withheld amounts are forwarded to the IRS, and the provider must work with the IRS to receive any refunds through justification requests. To expedite the correction, providers should include a copy of the IRS payment coupon, or other document from the IRS, that displays both the provider's name and TIN.

To prevent any withholding action, providers must return a completed and signed *Form W-9* to the appropriate address on the notice. The notification letter must accompany the *W-9* to ensure credit to the correct provider number. Substitute forms will not be accepted.

Common TIN Errors

The following section outlines some of the most common mistakes that cause invalid TIN information.

Name Changes

Providers change their business name and fail to notify DHCS. Because DHCS is still using the old name, the new name will cause a mismatch with IRS records. Providers must notify DHCS if their business name changes. Because multiple business name changes indicate an ownership change, providers must be prepared to demonstrate that there has been no ownership change. However, if there has been a change, a new provider number will be issued with an application.

Social Security Numbers (SSN)

SSN errors can occur when a provider who is a partnership, corporation, hospital, or clinic is using an individual provider's SSN. In this situation, the Employee Identification Number (EIN) of the partnership, corporation, hospital, or clinic should be used. Providers should only use an SSN with an individual's name. SSN errors can also occur if the provider is an individual provider who should be using his or her own SSN, but instead the provider is using the EIN of the partnership, corporation, hospital, or clinic of which he or she is a member. Providers should always use their SSN in combination with their name.

EIN Mix-Ups

EIN mix-ups occur when the provider is an operating unit of a larger business entity, and the operating unit is using its own name with the larger business entity's EIN. This will cause a mismatch with IRS records. In this case, operating units should apply for their own EIN or use the name of the larger business entity. Mix-ups also occur when the provider is identifying the business with initials instead of his or her complete name, as recorded with the IRS. This will cause a mismatch of the provider's name and EIN with IRS records. Providers should use their complete name as recorded with the IRS.

Doing Business As (DBA)

DBA errors can occur when the provider is a sole owner using his or her DBA name with his or her SSN or EIN of sole ownership. A sole owner must always put his or her name first; the DBA name may be listed second.

Change of Ownership

Change of ownership errors can occur when the provider's business has changed ownership and the provider failed to notify DHCS. Since DHCS is still using the TIN and name of the previous owner, this will cause a mismatch with IRS records. Providers must notify DHCS when their business has changed ownership.

IRS Contacts

The second page of the *Form W-9* gives more specific instructions about the name of the TIN that should be submitted to DHCS in accordance with IRS reporting requirements. For more information about TINs, call the IRS at 1-800-829-1040. If you need more information about how to apply for a TIN, call the IRS at (209) 452-4010, Monday through Friday, 6 a.m. to 6 p.m. For more information about SSNs, contact your nearest Social Security Administration district office.

2.1.3.7 Inactivated Providers

Introduction

DHCS conducts a periodic inactivation of pharmacy providers who no longer bill Medi-Cal Rx. Providers who receive Medi-Cal Rx bulletins with their provider number on the mailing label, but who have discontinued billing Medi-Cal Rx and have not received a payment during the last 12 months, may have their provider number inactivated.

Exceptions

Providers who are located where Medi-Cal Rx is administered by a prepaid health program directed by the county are exempt from periodic inactivation.

Inactivation for Returned Mail

DHCS regularly inactivates providers when their mail (including Medi-Cal Rx checks) is returned by the post office as undeliverable. Therefore, providers who have changed their service and/or pay-to-address, or any other related information, should notify DHCS DATA Unit.

Inactivation Benefits

Periodic inactivation reduces:

- Payment errors such as sending a payment to the wrong provider because the provider number entry is incorrect.
- The cost of handling return mail from providers who are no longer in business at the address indicated on the PMF.

Reactivation Procedures

If a provider number has been inactivated but the provider wants to return to participating in Medi-Cal Rx, information on the PMF must be updated. Providers wishing to reactivate their provider number must complete a provider-specific Medi-Cal Rx enrollment application indicating their provider number and send it to DHCS DATA Unit.

2.1.3.8 Terminating Participation

Voluntary Provider Termination

Providers may terminate their participation with Medi-Cal Rx at any time. Providers who wish to voluntarily terminate their participation are required to request deactivation via the PAVE Portal (<https://pave.dhcs.ca.gov/sso/login.do>).

2.1.4 Provider Guidelines: Billing Compliance

Pursuant to CCR, Title 22, Section 51172, if a prescription has not been received by the member or the member's representative within 15 days of the fill date, the pharmacy must reverse the claim and refund the payment to DHCS.

2.1.4.1 Medi-Cal Provider Fraud, Waste and Abuse

The Program Integrity/Special Investigations Unit (PI/SIU) is responsible for reviewing, validating, and referring suspected FWA to DHCS under the terms of the Medi-Cal Rx Contract. Medi-Cal Rx takes allegations of fraud very seriously and expects providers to adhere to all Medi-Cal policies, including those related to Program Integrity. Providers suspected of abusing Medi-Cal Rx should be reported to Medi-Cal Rx through the following avenues listed in *Table 2.1.4.1-1*:

Avenues for Communicating Compliance Concerns and Suspected FWA		
Department	Methods	Hours
Medi-Cal Rx PI/SIU	Medi-Cal Rx specific FWA hotline (1-800-375-1251, TTY 711)	Staffed live by Medi-Cal Rx vendor SIU Specialists Monday – Friday 6 a.m. PT to 6 p.m. PT. Voice mail available on State holidays, Monday – Friday 6 p.m. PT to 6 a.m. PT, and Friday 6 p.m. PT to Monday 6 a.m. PT.
	Referrals sent to PI/SIU physical address via USPS, FedEx, or other delivery service: Medi-Cal Rx PI/SIU 11000 White Rock Rd Rancho Cordova, CA 95670	

Avenues for Communicating Compliance Concerns and Suspected FWA		
Department	Methods	Hours
Prime Therapeutics SIU	<p>Emails to FraudTipHotline@primetherapeutics.com</p> <p>Forms sent via interoffice mail</p> <p>Facsimiles sent to the SIU (1-877-290-1555)</p> <p>Prime Therapeutics Compliance Hotline (1-800-474-8651)</p> <p>Prime Therapeutics SIU Pharmacy FWA Hotline (1-800-349-2919)</p>	<p>Staffed live Monday – Friday 6 a.m. PT to 6 p.m. PT.</p> <p>Voice mail available on State holidays, Monday – Friday 6 p.m. PT to 6 a.m. PT, and Friday 6 a.m. PT to Monday 6 a.m. PT.</p>
	<p>Referrals sent to SIU physical address via USPS, FedEx, or other delivery service:</p> <p>Prime Therapeutics Attn: Pharmacy Audit & SIU 2900 Ames Crossing Road Eagan, MN 55121</p>	
Compliance	<p>Prime Therapeutics Corporate Compliance Hotline Anonymous: (1-800-474-8651)</p> <p>Prime Therapeutics Questions: (1-612-777-5523)</p> <p>Emails to the Prime Therapeutics Compliance Department (www.lighthouse-services.com/prime)</p> <p>Emails to the Medi-Cal Rx Compliance Department: MediCalRxCompliance@primetherapeutics.com</p>	<p>The Compliance Hotline is available 24 hours a day, 7 days a week. All Medi-Cal Rx calls reported through the Compliance Hotline are investigated by the Medi-Cal Rx Compliance Officer.</p>
Customer Service	<p>Calls to the Medi-Cal Rx Customer Service Center (CSC) (1-800-977-2273)</p>	<p>Customer Service Representatives (CSRs) are provided with training and procedures on identification and reporting of suspected FWA to PI/SIU.</p>

Table 2.1.4.1-1: Avenues to Communicate FWA

2.1.4.2 Suspended and Ineligible List

Suspension by DHCS

DHCS may terminate the participation of a provider through suspension in accordance with the regulations contained in W&I Code Section 14123 and CCR, Title 22, Chapter 3, Article 6, commencing with Section 51452.

Suspended and Ineligible Provider List

On occasion, providers are suspended or determined ineligible to participate in Medi-Cal Rx (see [Section 6.0](#) and [Section 7.0](#) for information on claim denials for Sanctioned Providers). The [Suspended and Ineligible Provider List](#) (S&I List) is available on the Medi-Cal website.

2.2 Important Contact Information

Refer to [Appendix B – Directory](#) at the end of this manual for important phone numbers, mailing address, and websites.

3.0 Service Support

3.1 Customer Service Center (CSC)

The Medi-Cal Rx Customer Service Center (CSC) is available 7 days a week, 24 hours a day, and 365 days per year excluding approved holidays.

Pharmacies, prescribers, members, MCP representatives, and other interested parties can access the CSC via:

- Toll-Free Telephone: 1-800-977-2273

Nationwide Toll-Free Number 1-800-977-2273	Main Menu Options
	For Beneficiaries, press 1
	For Pharmacies, press 2
	For Prescribers, press 3
	For authorized MCP representatives, press 4
	For TTY, press 7
	All other callers, press 8

- Live Chat Channel
 - Chat channel can be accessed through the [Medi-Cal Rx Web Portal](#) (for unsecured chat) or through the [Medi-Cal Rx Provider Portal](#) (for secured chat).
- Email
 - Email channel can be accessed through the [Medi-Cal Rx Provider Portal](#).

Note: The CSC will also be able to assist Portal users with user lock out and/or password reset assistance, provide web support for inquiries regarding Portal navigation, and help with links or questions/concerns with the email/chat channel(s).

Examples of available assistance include, but are not limited to:

- Member inquiries related to:
 - Eligibility
 - **Note:** For members dually enrolled in Medicaid and Medicare and for questions about Medicare-covered benefits, members and Providers will be directed to 1-800-Medicare or to the help desk of the enrolled Medicare Part D prescription drug plan.
 - Benefits/coverage
 - Pharmacy locations
 - Reimbursements (Conlan claims)
 - Share-Of-Cost (SOC) obligations
 - Privacy rights
- Provider, or MCP representative inquiries related to:
 - Member eligibility
 - PA requests
 - Status of previously submitted PA requests
 - Reasoning of PA request decisions
 - Assistance in resolving denied PA requests
 - Pharmacy claims
 - Claim reimbursement/payment status
 - Checkwrite/Financial inquiries (limited to pharmacy claims)
 - **Note:** Finance CSRs will be available Monday-Friday 8 a.m. to 5 p.m. PT. Voicemail will be available for after-hours inquiries and will be returned on the next business day.

Refer to [Appendix B - Directory](#) at the end of this manual for important phone numbers, addresses, and hours of operations for the CSC.

3.2 Software Vendor Certification

The Software Vendor/Certification Number (NCPDP Field# 110 – AK) of the Transaction Header Segment is required for claims submission under the NCPDP Version D.0; providers should submit the value that is assigned to them when being certified. Certifications occur when the industry moves to a new version of the software such as NCPDP V3.2 to NCPDP V5.1 and then NCPDP V5.1 to NCPDP VD.0. When the next named NCPDP version is announced, the Medi-Cal Rx vendor will certify, through testing, the readiness of the pharmacy system.

For assistance with software vendor certification, contact the Medi-Cal Rx vendor's CSC (1-800-977-2273).

3.3 Electronic Funds Transfer (EFT), Checkwrite Schedule, and Remittance Advices (RAs)

Providers enrolled in Medi-Cal Rx will have the ability to access the [Medi-Cal Rx Secured Provider Portal](#) to request payment preferences. Choices include:

- Receiving paper check or Electronic Funds Transfer (EFT).
- Updating banking information including account and routing numbers.
- Receiving paper remittance or electronic HIPAA compliant 835 remittance file.
- Receiving paper or online download of 1099s (the PDF will be available on the Medi-Cal Rx Secured Provider Portal).
- Designating more than one receiver for RAs.

Note: If no designations are selected, payments, RAs and 1099s shall all default to paper and will be mailed.

Note: Choices can be applied or changed at any time by utilizing the [Medi-Cal Rx Provider Portal](#).

3.3.1 Electronic Funds Transfer (EFT)

An EFT payment option is available to all eligible Medi-Cal Rx providers. The EFT allows providers the option of receiving payments via direct deposit, eliminating the need for paper checks.

Note: Providers have the ability to opt out of EFT and return to paper checks at any time. The request will be processed on the next upcoming checkwrite.

To request EFT, a pharmacy must complete the *Electronic Transfer Authorization Form* available on the [Medi-Cal Rx Provider Portal](#) by selecting [Forms & Information](#). The Medi-Cal Rx Provider Portal will allow users to submit EFT applications and view or update existing EFT information.

To request EFT via a paper application, go to the [Medi-Cal Rx Provider Portal](#) and select **Forms & Information**. Completed paper EFT applications should be forwarded to the Medi-Cal Rx vendor (see [Appendix B – Directory](#) for mailing address). Providers with questions regarding EFTs can call the Customer Service Center (CSC) at 1-800-977-2273.

3.3.2 Checkwrite Schedule

The weekly claim adjudication cycle will commence on Thursday at 12:00 a.m. concluding on Wednesday at 11:59 p.m.

Checkwrite processing for the adjudication week shall occur over the next two weeks with payments and remittances released the third Friday. Holiday weeks may delay payment release dates. The annual checkwrite release calendar shall be available on the [Medi-Cal Rx Provider Portal](#) for providers.

To view the annual checkwrite calendar, go to the Medi-Cal Rx Provider Portal and then select **Forms & Information**.

3.3.3 Remittance Advice (RA)

The Medi-Cal Rx vendor provides the HIPAA ANSI X12 835, Version 5010 A1 Electronic Remittance Advice (ERA), delivered electronically or by mail for the paper RA documents. The ERA/RA lists pharmacy provider's claims adjudicated during a given time frame as outlined in *Section 3.3.2 – Checkwrite Schedule*. The ERA/RA delivery coincides with the Medi-Cal Rx Payment Release Date.

The Medi-Cal Rx-provided ERA/RA is used by pharmacy providers to reconcile their records with claims that have been paid, reversed, or denied. The ERA/RA is provided weekly by Medi-Cal Rx checkwrite streams in which claims submitted by the pharmacy provider were adjudicated. The Medi-Cal Rx checkwrite streams are Abortion, Medi-Cal, CCS, GHPP, and State Children's Health Insurance Program (SCHIP). Pharmacy providers receive a separate payment for each Medi-Cal Rx checkwrite stream in which claims were adjudicated and a net payment was determined.

To request ERAs, a pharmacy provider must complete an ERA Authorization Agreement. The agreement may be submitted two ways:

1. The pharmacy provider may log in to the [Medi-Cal Rx Secured Provider Portal](#) and select **Finance Portal** from the left-hand menu to access the ERA information page and the ERA Authorization Agreement.
2. The pharmacy provider may complete and mail the *Medi-Cal Rx Electronic Remittance Advice (ERA) Authorization Agreement Form* (DHCS 6550) by going to the [Medi-Cal Rx Provider Portal Forms & Information](#) page. DHCS 6550 forms are mailed to the Medi-Cal Rx vendor (see [Appendix B – Directory](#) for mailing address)

While completing the ERA Authorization Agreement (by either method), the pharmacy provider may also identify others they want to allow access to their ERAs; these selected others are known as Receivers. The ERA and Receiver information can be updated, by the pharmacy

provider, at any time by either of the methods described. Pharmacy providers with questions regarding ERA Authorization Agreements may call the Customer Service Center (CSC) at 1-800-977-2273.

ERAs are directly delivered through the Medi-Cal Rx Secured Provider Portal. Once logged in to the Medi-Cal Rx Secured Provider Portal, the pharmacy provider and designated Receivers are able to download the HIPAA-compliant 835 file to their preferred application, or they are able to view and print from a CMS-provided Medicare Remit Easy Print (MREP) Software tool.

Note: The MREP tool can be downloaded from the Medi-Cal Rx Provider Portal [Forms & Information](#) page.

ERAs are produced weekly in coordination with the Medi-Cal Rx payment release schedule. They may appear a day or two prior to the payment release date.

If the pharmacy provider has not opted-in for ERAs, a paper RA is mailed to the provider’s Pay To address that is on file with the DHCS PED. To update the Pay To address on file with PED, the pharmacy provider needs to utilize the [PAVE Portal](#) In addition to the mailed paper RA, the pharmacy provider can access a soft-copy PDF document once they are logged in to the [Medi-Cal Rx Provider Portal](#).

See *Section 3.3.3.1 – Paper RA Example* for an explanation of form fields and sample reimbursement data for Medi-Cal Rx claims. The mailed paper RA is a two-sided, 8½ x 11-inch document.

3.3.3.1 Paper RA Example

A paper RA details the pharmacy provider’s adjudicated claim and Accounts Receivable (AR) activity for a given checkwrite stream.

Remittance Fields and Descriptions

See *Table 3.3.3.1-1* below for the paper RA field descriptions.

RA Field	Description
Each NPI/Owner Remittance Shall Contain the Following:	
Payee	Pharmacy Provider’s Legal Name and Pay To address
Payee No.	10-digit NPI plus 2-digit Owner Number
Run Date	Date RA is printed
Page	Page number and total pages (page 1 of...)
Checkwrite Program	Checkwrite Stream: Medi-Cal, SCHIP, Abortion, CCS, GHPP, OPH
Check/EFT Number	Check or EFT Number
Check/EFT Date	Medi-Cal Rx payment release date
Rx Number	The prescription number as assigned by the Pharmacy or the Medi-Cal Rx-assigned AR number for an AR transaction

RA Field	Description		
Each NPI/Owner Remittance Shall Contain the Following:			
Date Filled	Date of service (DOS) for the claim or the AR open date for an AR transaction		
Last Name	Member's last name as submitted on the claim		
First Name	Member's first name as submitted on the claim		
Beneficiary ID Number	Member's Medi-Cal ID number as submitted on the claim		
National Drug Code	The NDC as submitted on the claim; for compound claims, this field will contain the first ingredient submitted on the claim		
Drug Name	Drug name for the NDC on the claim or AR description for an AR transaction		
Refill	The refill number as submitted on the claim		
Qty	The dispensed quantity of the drug as submitted on the claim		
Amount Billed (\$)	The gross amount due (GAD) (NCPDP 430-DU) from the submitted claim (as recommended by NCPDP). See <i>Figures 3.3.3.2-1</i> and <i>3.3.3.2-2</i> for sample RAs. Prior to September 12, 2023: The Usual and Customary Charge (NCPDP 426-DQ) amount from the submitted claim.		
Amount Allowed (\$)	The Medi-Cal Rx-allowed amount for the claim as determined during adjudication per Medi-Cal Rx reimbursement methodology		
Amount Deducted (\$)	The amount deducted for payment reductions as determined during adjudication per Medi-Cal Rx reimbursement methodology		
Amount Paid (\$)	The final claim reimbursement amount or AR payment/recoupment amount		
Claim Type	Claim Type Code or AR transaction type code value assigned to the account activity. The Claim Type Code Description is provided for reference.		
		Claim Type Code	Claim Type Code Description
	1.	MA	Mass Adjustment Claim
	2.	POS	POS Claim (POS = Point-of-Sale)
	3.	01B	Payment Suspension
	4.	02A	Cash Advance
	5.	02M	Audits & Investigations
6.	02N	Negative Balance	

RA Field	Description		
Each NPI/Owner Remittance Shall Contain the Following:			
	7.	02S	HMS* Audit (Recovery)
	8.	02Y	Conlan
	9.	08L	Lien/Levy Withholds
	10.	08T	IRS Withholds
	* Health Management Systems, Inc. (on behalf of DHCS TPLRD)		
PA Flag	"Y" (Yes) or "N" (No) to indicate if a PA was on file and was used to adjudicate the claim		
Error Code	NCPDP-compliant reject (denial) codes		
Totals	Total transaction count		
Subtotal	Total dollars for "Amount Billed," "Amount Allowed," "Amount Deducted," and "Amount Paid" fields		
Legends			
Error Code	NCPDP reject (denial) code value		
Description	NCPDP reject (denial) code description		
Claim Type	Claim Type Code or AR transaction type code value assigned to the account activity. The Claim Type Code Description is provided for reference.		
		Claim Type Code	Claim Type Code Descriptions
	1.	MA	Mass Adjustment Claim
	2.	POS	POS Claim (POS = Point-of-Sale)
	3.	01B	Payment Suspension
	4.	02A	Cash Advance
	5.	02M	Audits & Investigations
	6.	02N	Negative Balance
	7.	02S	HMS Audit (Recovery)
	8.	02Y	Conlan
	9.	08L	Lien/Levy Withholds
	10.	08T	IRS Withholds
Description	Claim Type Code or AR transaction type code description		
Transaction Summary Section			
Total No. of PAID	Lists transaction total and dollars for paid claims		

RA Field	Description
Each NPI/Owner Remittance Shall Contain the Following:	
Total No. of VOIDED	Lists transaction total and dollars for voided (reversed) claims
Total No. of DENIED	Lists transaction total and dollars for denied claims
Total of Withhold	Total recoupment transactions reducing the pharmacy provider's payment
Total of Payout	Total of transactions that increase the payment to the pharmacy provider
Grand Total	Lists transaction total and dollars for all claims – equals the check/EFT payment to the pharmacy provider

Table 3.3.3.1-1: Paper RA Field Descriptions

3.3.3.2 RA Samples


The Payee, Payee Number, Rx Number, Last Name, First Name, and Beneficiary ID Number are not included in the samples due to Protected Health Information (PHI)/Personally Identifiable Information (PII).

- The sample in *Figure 3.3.3.2-1* includes a negative balance recoupment (02N) in the amount of \$579.33, which is greater than the accumulated total of claim dollars to be paid, resulting in a zero-dollar (\$0.00) check amount.
- The sample in *Figure 3.3.3.2-2* includes a negative balance recoupment (02N) in the amount of \$6.96, which is less than the accumulated total of paid claim dollars, resulting in a check amount of \$132.31.
- Both RA examples also display the update made on September 12, 2023, populating the Amount Billed field with the GAD (NCPDP 430-DU) instead of the Usual and Customary (NCPDP 426-DQ) amount.

Payee:		REMITTANCE ADVICE										DHCS		Run Date: 02-Dec-2023	
Payee No:		Medi-Cal RX(FI) Administered By PO Box 610 Rancho Cordova, CA 95741-0610										Checkwrite Program: CAMEDICAL		Page: 1 of 2	
												Check / EFT Number: 7001303009		Check / EFT Date: 15-Dec-2023	
RX Number	Date Filled	Last Name	First Name	Beneficiary ID Number	National Drug Code	Drug Name	Refill	Qty	Amount Billed (\$)	Amount Allowed (\$)	Amount Deducted (\$)	Amount Paid (\$)	Claim Type	PA Flag	Error Code
	28-Nov-23				00169477212	OZEMPIC	00	3	297.97	297.97	0.00	297.97	POS	N	
	28-Nov-23				00002143480	TRULICITY	01	2	272.55	272.55	0.00	272.55	POS	N	
	22-Nov-23				70074067524	PEDIASURE GRDW-GAIN	00	5688	70.39	51.00	0.00	51.00	POS	N	
	27-Nov-23				33342032954	TRIAMCINOLONE ACETONIDE	01	454	5.45	5.45	0.00	5.45	POS	N	
	29-Nov-23				00781729685	ALBUTEROL SULFATE HFA	00	6.7	5.41	5.41	0.00	5.41	POS	N	
	27-Nov-23				69097014260	ALBUTEROL SULFATE HFA	01	6.7	4.59	4.59	0.00	4.59	POS	N	
	29-Nov-23				69097014260	ALBUTEROL SULFATE HFA	00	6.7	4.59	4.59	0.00	4.59	POS	N	
	28-Nov-23				00904722320	ROBAFEN DM	00	480	4.32	4.32	0.00	4.32	POS	N	
	28-Nov-23				00904722359	ROBAFEN DM	00	480	4.32	4.32	0.00	4.32	POS	N	
	29-Nov-23				67877022310	GABAPENTIN	01	120	1.92	1.92	0.00	1.92	POS	N	
	28-Nov-23				65862037501	ESCITALOPRAM OXALATE	00	90	1.80	1.80	0.00	1.80	POS	N	
	27-Nov-23				00555088702	ESTRADIOL	01	30	1.23	1.23	0.00	1.23	POS	N	
	27-Nov-23				16571082230	LORATADINE	00	60	1.20	1.20	0.00	1.20	POS	N	
	27-Nov-23				68180037803	LOSARTAN POTASSIUM	00	90	1.17	1.17	0.00	1.17	POS	N	
	28-Nov-23				64380071307	BENZONATATE	00	42	1.10	1.10	0.00	1.10	POS	N	
	27-Nov-23				68180012202	CEPHALEXIN	00	20	0.90	0.90	0.00	0.90	POS	N	
	27-Nov-23				68180012201	CEPHALEXIN	00	20	0.90	0.90	0.00	0.90	POS	N	
	27-Nov-23				00904679480	ASPIRIN	00	90	0.72	0.72	0.00	0.72	POS	N	
	27-Nov-23				10005070022	VITAMIN B-12	01	30	0.69	0.69	0.00	0.69	POS	N	
	27-Nov-23				65862042001	SULFAMETHOXAZOLE-TRIM ETHOPRIM	00	20	0.56	0.56	0.00	0.56	POS	N	
	27-Nov-23				65862085999	FAMOTIDINE	00	60	0.54	0.54	0.00	0.54	POS	N	
	27-Nov-23				00143122710	DICYCLOMINE HCL	00	60	0.54	0.54	0.00	0.54	POS	N	
	27-Nov-23				00310621030	FARXIGA	01	30	0.27	0.27	0.00	0.27	POS	N	
	27-Nov-23				00536122308	GAS RELIEF	00	60	2.94	0.00	0.00	0.00	POS	N	75
	28-Nov-23				11534015901	PHENTERMINE HCL	00	30	1.20	0.00	0.00	0.00	POS	N	75
	15-Nov-23				69452015120	VITAMIN D2	00	12	-0.24	-0.24	0.00	-0.24	POS	N	
	27-Nov-23				68180012201	CEPHALEXIN	00	20	-0.90	-0.90	0.00	-0.90	POS	N	
	28-Nov-23				00904722359	ROBAFEN DM	00	480	-4.32	-4.32	0.00	-4.32	POS	N	
	29-Nov-23				69097014260	ALBUTEROL SULFATE HFA	00	6.7	-4.59	-4.59	0.00	-4.59	POS	N	
	17-Nov-23				08373982700	OPTICAMBER DIAMOND	00	1	-12.24	-11.01	0.00	-11.01	POS	N	
	22-Nov-23				70074067524	PEDIASURE GRDW-GAIN	00	7110	-70.39	-63.35	0.00	-63.35	POS	N	
	01-Jan-00					331231115M01 - POS - Negative Balance	00		0.00	0.00	0.00	-579.33	02N		
				Totals	32	Transactions			594.59	579.33	0.00	0.00			

Payee:		REMITTANCE ADVICE										DHCS		Run Date: 02-Dec-2023	
Payee No:		Medi-Cal RX(FI) Administered By PO Box 610 Rancho Cordova, CA 95741-0610										Checkwrite Program: CAMEDICAL		Page: 2 of 2	
												Check / EFT Number: 7001303009		Check / EFT Date: 15-Dec-2023	
RX Number	Date Filled	Last Name	First Name	Beneficiary ID Number	National Drug Code	Drug Name	Refill	Qty	Amount Billed (\$)	Amount Allowed (\$)	Amount Deducted (\$)	Amount Paid (\$)	Claim Type	PA Flag	Error Code
				Error Code	Description										
				75	Prior authorization required										
				Claim Type	Description										
				02N	Negative Balance										
				POS	POS Claim										
				Transactions		Amount Paid									
				Total No. of PAID	23	\$663.74									
				Total No. of VOIDED	6	-\$84.41									
				Total No. of DENIED	2	\$0.00									
				Total of Withhold	1	-\$579.33									
				Total of Payout	0	\$0.00									
				Grand Total	32	\$0.00									

Figure 3.3.3.2-1: Sample Paper RA – Recouped with a Zero Dollar Check Amount

REMITTANCE ADVICE																
Payee: [Redacted]		Medi-Cal RX(FI) Administered By PO Box 610 Rancho Cordova, CA 95741-0610								Run Date: 02-Dec-2023 Page: 1 of 2						
Payee No: [Redacted]										Checkwrite Program: CAMEDICAL Check / EFT Number: 7001301141 Check / EFT Date: 15-Dec-2023						
RX Number	Date Filled	Last Name	First Name	Beneficiary ID Number	National Drug Code	Drug Name	Refill	Qty	Amount Billed (\$)	Amount Allowed (\$)	Amount Deducted (\$)	Amount Paid (\$)	Claim Type	PA Flag	Error Code	
[Redacted]	28-Nov-23	[Redacted]	[Redacted]	[Redacted]	42806034401	DEXTRORAMPHETAMINE-AMP HETAMINE	00	90	235.20	44.87	0.00	44.87	POS	N		
[Redacted]	24-Nov-23	[Redacted]	[Redacted]	[Redacted]	27241013909	OSELTAMIVIR PHOSPHATE	00	120	406.65	43.96	0.00	43.96	POS	N		
[Redacted]	24-Nov-23	[Redacted]	[Redacted]	[Redacted]	27241013909	OSELTAMIVIR PHOSPHATE	00	60	209.82	28.58	0.00	28.58	POS	N		
[Redacted]	27-Nov-23	[Redacted]	[Redacted]	[Redacted]	43547043109	FENOFIBRATE	00	90	631.68	21.86	0.00	21.86	POS	N		
[Redacted]	01-Jan-00	[Redacted]	[Redacted]	[Redacted]	3311534908M0	POS - Negative Balance	00		0.00	0.00	0.00	-6.96	02N			
Totals				5	Transactions				1,483.35	139.27	0.00	132.31				


REMITTANCE ADVICE															
Payee: [Redacted]		Medi-Cal RX(FI) Administered By PO Box 610 Rancho Cordova, CA 95741-0610								Run Date: 02-Dec-2023 Page: 2 of 2					
Payee No: [Redacted]										Checkwrite Program: CAMEDICAL Check / EFT Number: 7001301141 Check / EFT Date: 15-Dec-2023					
RX Number	Date Filled	Last Name	First Name	Beneficiary ID Number	National Drug Code	Drug Name	Refill	Qty	Amount Billed (\$)	Amount Allowed (\$)	Amount Deducted (\$)	Amount Paid (\$)	Claim Type	PA Flag	Error Code
		Error Code	Description												
		Claim Type	Description												
		02N	Negative Balance												
		POS	POS Claim												
				Transactions		Amount Paid									
Total No. of PAID				4		\$139.27									
Total No. of VOIDED				0		\$0.00									
Total No. of DENIED				0		\$0.00									
Total of Withhold				1		-\$6.96									
Total of Payout				0		\$0.00									
Grand Total				5		\$132.31									

Figure 3.3.3.2-2: Sample Paper RA – Recoupment with Net Positive Check Amount

The RA is designed for line-by-line reconciliation of transactions. Reconciliation of the RA to pharmacy records will help determine which claims are paid, void/reversed, or denied (refer to the figures above for paper RA samples).

Paid:

Paid claims passed Medi-Cal Rx claim adjudication rules. They may be reimbursed as submitted or at reduced amounts according to Medi-Cal Rx reimbursement methodology.

Void/Reversed:

Void/Reversed claims are no longer eligible for payment. The claims may have been reversed by the pharmacy provider or by the Medi-Cal Rx vendor according to Medi-Cal Rx policy and specifications.

Denied:

Denied claims failed the Medi-Cal Rx claim adjudication rules and are unacceptable for payment due to one of the following common adjudication denial conditions, and a specific denial code is reported to explain the reason for the denial:

- Claim information cannot be validated, or

- The billed service is not a program benefit, or
- The claim failed the edit/audit process.

AR Transactions:

RAs may also reflect AR transactions when necessary either to recover funds from or pay funds to a provider. The Medi-Cal Rx vendor’s AR system is used in financial transactions pertaining to the following:

- Recoupments to offset amounts owed to DHCS by the pharmacy provider,
- Withholds from payments to pharmacy providers according to DHCS-provided instructions, or
- Payments to pharmacy providers according to DHCS-provided instructions.

3.3.3.3 Dollar Sign Notation on RA

Effective December 15, 2023, the Medi-Cal Rx Paper RA and the corresponding PDF have been updated; the dollar sign (\$) symbols have been removed from the detail lines and now appear in the column headers for the following fields: Amount Billed, Amount Allowed, Amount Deducted, and Amount Paid. See *Figure 3.3.3.3-1* and *Figure 3.3.3.3-2*. The RA PDFs available on the Medi-Cal Rx Finance Portal prior to December 15, 2023, remain unchanged.

Amount Billed	Amount Allowed	Amount Deducted	Amount Paid	Claim Type	PA Flag	Error Code
\$216.25	\$14.06	\$0.00	\$14.06	POS	N	
\$366.12	\$13.92	\$0.00	\$13.92	POS	N	
\$366.12	\$13.92	\$0.00	\$13.92	POS	N	
\$116.25	\$13.90	\$0.00	\$13.90	POS	N	

Figure 3.3.3.3-1: RA Before Update – Dollar Sign in Detail Lines

Amount Billed (\$)	Amount Allowed (\$)	Amount Deducted (\$)	Amount Paid (\$)	Claim Type	PA Flag	Error Code
4,293.69	3,792.17	0.00	3,792.17	POS	N	
3,112.99	2,886.35	0.00	2,886.35	POS	N	
1,945.99	1,804.62	0.00	1,804.62	POS	N	
1,945.99	1,804.11	0.00	1,804.11	POS	N	
1,883.69	1,638.88	0.00	1,638.88	POS	N	

Figure 3.3.3.3-2: RA After Update – Dollar Sign in Column Headers

3.4 Solving Technical Problems

In the event of POS system downtime (whether scheduled or unscheduled), providers will receive reject codes and supplemental messaging.

Refer to *Table 3.4-1* below for examples:

Reject Code	Message	Explanation
92	System Unavailable/ Host Unavailable	Processing host did not accept transaction or did not respond within time out period.
99	Host Processing Error	Do not retransmit claims.

Table 3.4-1: Reject Codes/Reject Messages

It is strongly encouraged that a pharmacy’s software has the capability to submit backdated claims. Occasionally, a pharmacy may also receive messages that indicate its own network is having problems communicating with the Medi-Cal Rx vendor.

If this occurs, or if a pharmacy is experiencing technical difficulties connecting with the Medi-Cal Rx vendor’s system, pharmacies should follow the steps outlined below:

1. Check the system status which can be found on the [Medi-Cal Rx Web Portal](#).
2. Check the terminal and communications equipment to ensure that electrical power and telephone services are operational.
3. Call the telephone number that the system is dialing and note the information heard (i.e., fast busy, steady busy, recorded message).
4. Contact the software vendor if unable to access this information in the system.
5. If the pharmacy has an internal technical staff, forward the problem to that department.
6. If unable to resolve the problem after following the steps outlined above, directly contact the Medi-Cal Rx Customer Service Center at 1-800-977-2273.

3.5 Automated Eligibility Verification System (AEVS)

The AEVS is an interactive voice response system that allows users the ability – through a touch-tone telephone – to access and clear Share of Cost (SOC) liability, and/or reserve a Medi-Service (a Medi-Service is **not** relevant to pharmacy providers).

Medi-Cal Rx pharmacy providers may use AEVS to lookup Share of Cost and do Share of Cost spend downs.

Medi-Cal Rx pharmacy providers should use the POS system or the Beneficiary Eligibility Lookup tool accessible via the [Medi-Cal Rx Secured Provider Portal](#) to verify member eligibility.

AEVS Telephone Number: 1-800-456-AEVS (2387)

While no enrollment is necessary to participate and utilize AEVS, Providers must use a valid Provider Identification Number (PIN), which is issued when providers enroll with Medi-Cal. In the instance when a provider does not remember their PIN, the TSC technical help desk agents are authorized to release the existing PIN once caller validation protocols have been completed. Providers may call the TSC at 1-800-541-5555 (**Note:** The TSC is *different* from the Medi-Cal Rx Customer Service Center [CSC]). As PIN release is governed by discrete caller validation protocols, there are circumstances in which the TSC technical help desk agent may only be authorized to re-issue the PIN letter with the existing PIN. If this is authorized, the PIN letter will be sent to the provider’s Pay-To address on file.

For more detailed information related to AEVS refer to the applicable links in the [DHCS Provider Manual \(Part 1 – Medi-Cal Program and Eligibility\)](#).

See *Table 3.5-1* for additional contact information.

For Questions About	Call
Operations of AEVS	Help Desk: 1-800-427-1295
For AEVS, AEVS PIN related inquiries and any non-Medi-Cal Rx related inquiries	Telephone Support Center (TSC): 1-800-541-5555

Table 3.5-1: Additional Number Directory

3.6 Medi-Cal Rx Web Portal

The Medi-Cal Rx Web Portal can be accessed at <https://medi-calrx.dhcs.ca.gov/home/>. This dedicated website offers content available on a public platform that is accessible by all. Additionally, secured portals will be available to members, prescribers, pharmacies, billing agents, and health plan partners to ensure that they can access appropriate tools for services that require access to Protected Health Information (PHI).

The following tools are available to pharmacies, prescribers, and health plan partners:

- [Frequently Asked Questions \(FAQs\)](#) – The FAQ page can be accessed at the top of the Medi-Cal Rx home page. The FAQs provide additional guidance and clarification regarding the transition of Medi-Cal’s pharmacy benefit (Medi-Cal Rx). More specific information can be found by using the list of categories on the left side of the FAQ page.
- [Medi-Cal Rx Subscription Service \(MCRxSS\)](#) – The MCRxSS is a free service that keeps pharmacies and prescribers up to date on the latest Medi-Cal Rx news. Subscribers will receive subject-specific emails for urgent announcements and other updates shortly after the updates are posted to the [Medi-Cal Rx Web Portal](#).
 - To enroll for MCRxSS, click **Subscribe Today** under the Medi-Cal Rx Subscription Service (MCRxSS) in the center of the Medi-Cal Rx home page. A new window will open and require an email address, ZIP code, and subscriber type, and provide options to choose subjects of interest.
 - **Note:** Enrolling in the MCRxSS is optional.
- [Education and Outreach](#) – Education and Outreach information can be accessed via the “Education and Outreach” link at the top of the Medi-Cal Rx home page. Topics on the Education and Outreach page include Medi-Cal Rx Background, Overview, Pharmacy Transition Policy, Communication & Training Schedule, and Training Materials and Resources.
- [Find a Pharmacy](#) – Users can enter their location and see Medi-Cal-enrolled pharmacies in their area. The search results can be easily sorted and filtered to find a pharmacy that specifically fits the user preferences.
- [Drug Lookup](#) – This tool is interactive and offers real-time drug lookup. The Drug Lookup feature can be used by anyone to easily search by drug name or NDC and provides coverage information along with any PA requirements, quantity limitations, and generic/brand indications.
- [Medi-Cal Rx Contract Drugs List \(CDL\)](#) – A document containing the complete CDL, which is categorized by drug class and contains dose and strength information, along with coverage restrictions and is searchable.
 - **Note:** The CDL is accessible on the [Medi-Cal Rx Provider Portal](#) by selecting [Forms & Information](#) and then **Covered Products Lists**.

- [List of Contracted Enteral Nutrition Products](#) – This list provides all Medi-Cal Rx contracted enteral nutrition products (for more information on enteral nutrition, see [Section 12.0 – Enteral Nutrition Products](#)).
 - **Note:** The *List of Contracted Enteral Nutrition Products* can be found on the [Medi-Cal Rx Provider Portal](#) by selecting **Forms & Information** and then **Covered Products Lists**.
- [List of Contracted Diabetic Test Strips and Lancets](#) – This list provides all Medi-Cal Rx contracted diabetic test strips and lancets (for more information on Diabetic Supplies, see [Section 13.0 – Medical Supplies](#) and [Section 13.1 – Diabetic Supplies – Test Strips and Lancets](#)).
 - **Note:** The *List of Contracted Diabetic Test Strips and Lancets* can be found on the [Medi-Cal Rx Provider Portal](#) by selecting **Forms & Information** and then **Covered Products Lists**.
- [List of Contracted Self-Monitoring Blood Glucose Systems \(Glucometers\), Control Solutions, and Lancing Devices](#) – This list provides all Medi-Cal Rx contracted Diabetic Blood Glucose testing monitors (Glucometers), compatible contracted control solutions, and contracted lancing devices. For more information on these products, see [Section 13.0 – Medical Supplies](#) and [Section 13.2 – Diabetic Supplies – Self-Monitoring Blood Glucose Systems \(Glucometers\), Control Solutions, and Lancing Devices](#).
 - **Note:** The *List of Contracted Self-Monitoring Blood Glucose Systems (Glucometers), Control Solutions, and Lancing Devices* can be found on the [Medi-Cal Rx Provider Portal](#) by selecting **Forms & Information** and then **Covered Products Lists**.
- [List of Covered Disposable Insulin Delivery Devices](#) – This list provides all Medi-Cal Rx covered disposable insulin delivery devices (for more information, see [Section 13.0 – Medical Supplies](#) and [Section 13.3 – Diabetic Supplies – Disposable Insulin Delivery Devices](#)).
 - **Note:** The *List of Covered Disposable Insulin Delivery Devices* can be found on the [Medi-Cal Rx Provider Portal](#) by selecting **Forms & Information** and then **Covered Products Lists**.
- [List of Contracted Continuous Glucose Monitoring \(CGM\) Systems](#) – This list provides all Medi-Cal Rx contracted Continuous Glucose Monitoring (CGM) Systems (for more information, see [Section 13.0 – Medical Supplies](#) and [Section 13.4 – Diabetic Supplies – CGM Systems](#)).
 - **Note:** The *List of Contracted Continuous Glucose Monitoring (CGM) Systems* can be found on the [Medi-Cal Rx Provider Portal](#) by selecting **Forms & Information** and then **Covered Products Lists**.
- [List of Contracted Pen Needles](#) – This list provides all Medi-Cal Rx contracted Pen Needles (for more information on Diabetic Supplies, refer to [Section 13.0 – Medical Supplies](#)).
 - **Note:** The *List of Contracted Pen Needles* is accessible on the [Medi-Cal Rx Provider Portal](#) by selecting **Forms & Information** and then **Covered Products Lists**.

- [List of Contracted Personal Blood Pressure Monitoring Devices and Blood Pressure Cuffs](#) – This list provides all Medi-Cal Rx contracted blood pressure monitoring devices and blood pressure cuffs (for more information, see [Section 13.0 – Medical Supplies](#)).
 - **Note:** The *List of Contracted Personal Blood Pressure Monitoring Devices and Blood Pressure Cuffs* is accessible on the [Medi-Cal Rx Provider Portal](#) by selecting [Forms & Information](#) and then **Covered Products Lists**.
- [Drug Utilization Review \(DUR\)](#) – This page contains comprehensive information regarding the DUR program.
- [System Status Information](#) – This page ensures that all system issues are reported in real time for planned and unplanned occurrences.
- [Forms & Information](#) – Users can easily access forms and information related to Medi-Cal Rx (paper claim forms, PA forms, appeal forms, etc.).
- Glossary – Provides easy explanations for many Medi-Cal Rx pharmacy and health-related terms.
- Medi-Cal Rx Complaints and Grievances Process – Provides helpful resources and tools relative to Medi-Cal Rx’s Complaints and Grievances Processes and Protocols, inclusive of background information, definitions, CSC contact information, and applicable forms.
- Mass Adjustments – Provides users with the status of completed Mass Adjustments.
- [Medi-Cal Rx Billing Tips](#) – Provides a high-level overview of billing requirements that have changed with the transition to fee-for-service. The document is available to download and/or print and used as a job aid to pharmacies and prescribers.

3.6.1 Medi-Cal Rx Provider Portal

Pharmacies and prescribers can access the unsecured (no login required) and secured Medi-Cal Rx Provider Portals (registration and login required) from the [Medi-Cal Rx Provider Portal](#).

3.6.1.1 Unsecured Provider Portal

Utilizing the [Medi-Cal Rx Provider Portal](#) gives users access to several features and functions without requiring credentials to log in.

On the left side of the screen, several options are available. See *Figure 3.6.1.1.-1*.

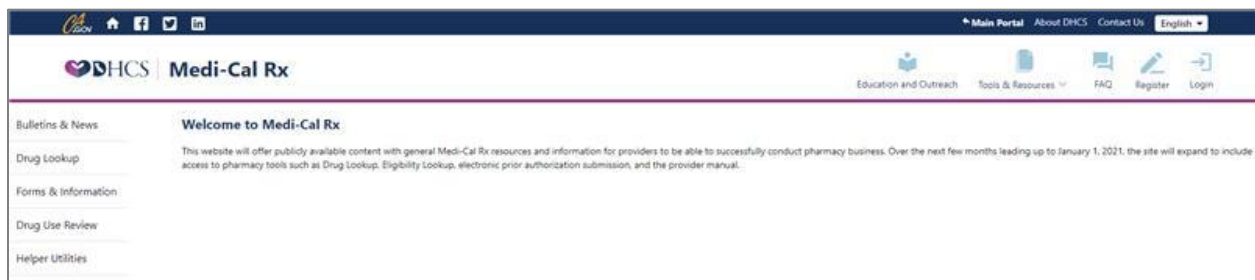


Figure 3.6.1.1-1: Unsecured Provider Portal

Each of the options are links to a separate area of the Medi-Cal Rx Provider Portal.

- [Bulletins and News](#) will take the user to a list of bulletins containing articles and announcements of provider manual updates, general billing and policy changes related to Medi-Cal Rx. This link will also provide news regarding urgent and late breaking information that is updated throughout the month and training schedules with links to registration.
- [Drug Lookup](#) is an interactive tool that allows users real-time drug lookup. The Drug Lookup feature can be used to easily search by drug name or NDC and provides coverage information along with any PA request requirements, quantity limitations, and generic/brand indications.
- [Forms & Information](#) includes, but is not limited to, the following:
 - Reference Materials
 - Billing Tips and Payer Sheets
 - Covered Products Lists
 - Contract Drugs Lists (CDL) – Searchable documents categorized by drug class and contains dose and strength information along with coverage/coverage restrictions.
 - Other Lists of Covered Products
 - Contracted Enteral Nutrition Products
 - Contracted Diabetic Test Strips and Lancets
 - Contracted Self-Monitoring Blood Glucose Systems (Glucometers) Control Solutions, and Lancing Devices
 - Covered Disposable Insulin Delivery Systems
 - Contracted Pen Needles
 - Covered Sterile Syringes with Needles (non-insulin)
 - Family PACT Pharmacy Formulary
 - Pharmacy Reimbursable Physician Administered Drugs (PADs)
 - *Electronic Transfer Authorization Form* (for EFT application/authorization)
 - *Electronic Transfer Authorization Form* (for ERA application/authorization)
 - *Medi-Cal Rx Provider Manual*
 - Downloadable Forms (Paper Claim Forms, PA Request Forms, Provider Claim Appeal(s) Forms, etc.)
 - Provider Welcome Packet
- [Drug Use Review \(DUR\)](#) provides comprehensive information regarding the DUR program.
- [Helper Utilities](#) is an area where the tools needed to support a Medi-Cal Rx Web Portal user can be found. It is important to note that the [Medi-Cal Rx Web Portal](#) will not operate correctly using the Internet Explorer (IE) browser. The Helper Utilities page provides links to alternate browsers that support use of the portal.

3.6.1.2 Secured Provider Portal

Pharmacy providers and prescribers wishing to access the [Medi-Cal Rx Secured Provider Portal](#) can assign a designated staff member to complete registration via the User Administration Console (UAC) application (the UAC is a registration tool that controls and manages the user's access to the secured portal). See *Figure 3.6.1.2-1*. Once this person has successfully registered, he or she can then set-up the remaining staff members and grant them access to the tool.

In order to register via the UAC, providers can click the **Register** link on the [Medi-Cal Rx Provider Portal](#). That link will provide a "UAC Quick Start Guide," which gives step-by-step instructions on how to register for the secured portal and associated applications.

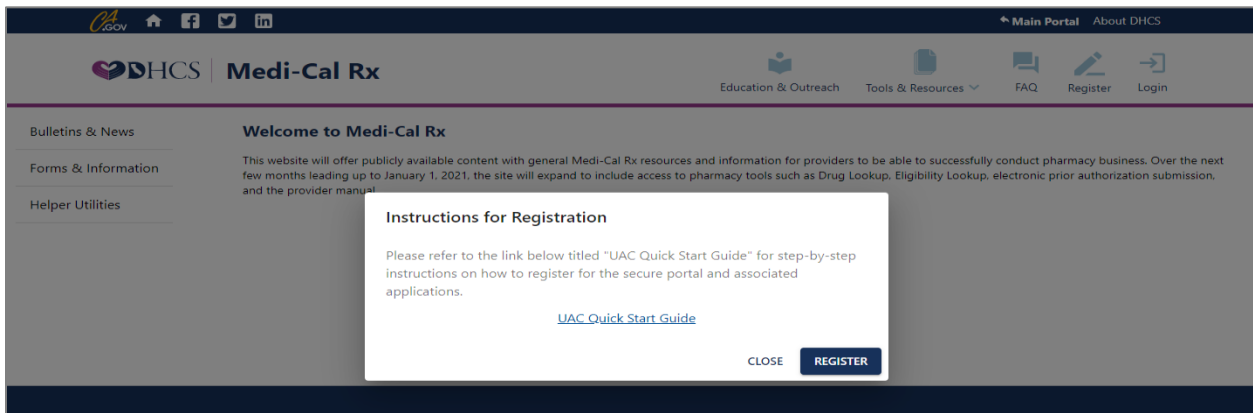


Figure 3.6.1.2-1: Secured Provider Portal

3.6.1.2.1 Web Claim Submission/Direct Data Entry

The Web Claims Submission (WCS)/Direct Data Entry tool allows pharmacy providers to securely (once registered and logged in):

- Submit claims (including reversals and resubmissions).
 - The *NCPDP Payer Specification Sheet* (see [Appendix A – NCPDP Payer Specification Sheet](#)) will provide users with a list of required and situational fields and the valid values for those fields when submitting a claim using WCS.
- Search for claims by cardholder ID and fill date.
 - **Note:** Providers using the WCS tool to search for claims will only be able to search and view claims that were submitted using their NPI.

3.6.1.2.2 Prior Authorization Requests

The PA request tool will allow pharmacies and prescribers to initiate a PA, inquire on a PA status, cancel a PA, add information to an existing PA, and upload attachment to an existing PA. See *Figure 3.6.1.2.2-1*.

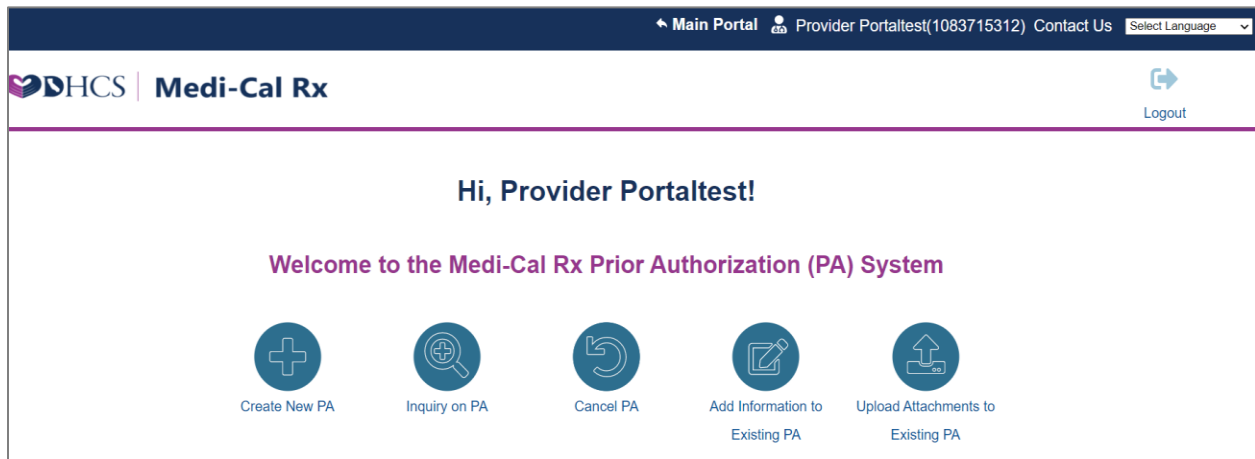


Figure 3.6.1.2.2-1: Prior Authorization Screen

Note: A link to CoverMyMeds® (a tool allowing a true electronic PA [ePA]) can be submitted in real-time by *prescribers*, with most decisions happening in real-time (see [Section 14.4 – CoverMyMeds ePA Submissions](#)). The Medi-Cal Rx vendor’s PA fax form will also be available on the [Medi-Cal Rx Provider Portal](#) by selecting [Forms & Information](#).

3.6.1.2.3 SABA Learning Management System

The **SABA Learning Management System** (LMS) is a training and learning platform that ensures providers have access to appropriate, secure training so that the tools and resources offered can be fully utilized.

The LMS includes:

- Presentations about the Medi-Cal Rx transition and new Medi-Cal Rx resources, including contact information, access points for applications and services, and differences in processes and procedures from a provider perspective.
- Computer-Based Trainings for applications or processes/procedures that providers will use such as Beneficiary Eligibility, Web Claim Submission, and PA requests.
- Application user guides and job aids.
- Informational materials including coverage policy and billing guidance.
- Provider surveys that allow providers access to a survey link they can use to provide feedback on their experience.

3.6.1.2.4 Additional Resources

The [Medi-Cal Rx Secured Provider Portal](#) also provides access to the following:

Tools & Resources

- Beneficiary Eligibility Lookup – Accessible after successful login. This tool allows users to verify the eligibility of a member. See *Figure 3.6.1.2.4-1*.

Figure 3.6.1.2.4-1: Beneficiary Eligibility Lookup Tool

- **Note:** This tool does not show the member’s real-time eligibility information but is current as of the prior day. Providers may view real-time eligibility utilizing the Prior Authorization link from the Tools & Resources drop-down list.
- Password Management – Users will be able to manage passwords from one centralized location.

Contact Us

- Secured Message Center – Accessible after successful login. Pharmacies and prescribers can compose and reply to message.
 - **Note:** Users cannot reply to a message for which a response has not yet been received from a CSR. When a response has been sent to the provider an email notification will be sent to him/her.
- Secured Chat – Accessible after successful login. Provides the ability for users to connect in real-time. See *Figure 3.6.1.2.4-2*.
 - **Note:** A chat window will open, users can start typing questions and a “bot” will answer specific predetermined questions. If further assistance is needed, the user will be connected to a CSR.

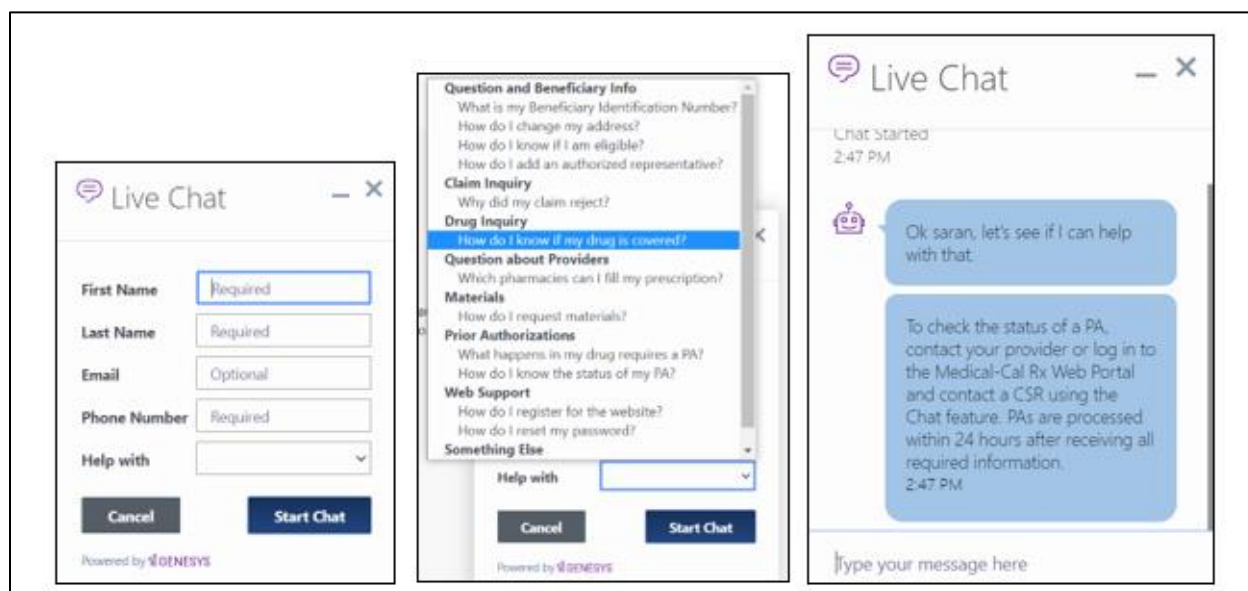


Figure 3.6.1.2.4-2: Secured Chat

4.0 Claims

4.1 Claim Format

While the Medi-Cal Rx vendor strongly recommends claims submission by Point-Of-Sale (POS), for certain billings outside of the norm, batch submission, paper claims, and web claims may be utilized or required. The following HIPAA formats in *Table 4.1-1* are accepted. Each is explained in subsequent sections.

Accepted Claim Formats		
Description	Format	Comments
POS Compound and non-compound pharmacy claims may be submitted through the POS network.	National Council for Prescription Drug Programs (NCPDP) D.0	Online POS submission is preferred.
Provider Compound and non-compound pharmacy claims may be submitted on the Paper Claim forms mentioned in the next column	<i>Universal Claim Form</i> (see Section 19.1 – Universal Claim Form, Version D.0), or <i>California Pharmacy Claim Form (30-1)</i> (for non-compound claims) (see Section 19.2.1 – California Specific Pharmacy Claim Form (30-1)) or <i>California Compound Pharmacy Claim Form (30-4)</i>	<i>Universal Claim Form</i> is used when billing for drugs, covered medical supplies, or compound claims. <i>California Specific Pharmacy Claim Form (30-1)</i> is used when billing for drug-covered medical supply claims and for crossover claims.

Accepted Claim Formats		
Description	Format	Comments
	(for compound) (see Section 19.2.2 – California Specific Compound Pharmacy Claim Form (30-4))	California Specific Compound Pharmacy Claim Form (30-4) is used when billing for Multi-Ingredient compound pharmacy claims, single-ingredient sterile transfer claims, and for crossover claims.
Beneficiary Submitted Paper	<i>Beneficiary Reimbursement Claim Form</i> (see Section 19.6 – Member Reimbursement Claims)	Also referred to as a “Conlan” claim.
Claims Inquiry Form	<i>Claims Inquiry Form</i> (see Section 19.4 – Medi-Cal Rx Provider Claim Inquiry Form (CIF) (DHCS 6570))	<i>Claim Inquiry Forms (CIFs)</i> are used <i>after</i> submitting a claim to request one of the following: <ul style="list-style-type: none"> • An Adjustment • Reconsideration • Tracer
Web Claims Submission (Direct Data Entry)	NCPDP D.0	
Batch File Transfer Protocol (FTP)	NCPDP Batch 1.2	SFTP is the communication method for batch files/media.

Table 4.1-1: Accepted Claim Formats

4.2 NCPDP Version D.0

The Medi-Cal Rx vendor uses a claim(s) processing system that verifies at a minimum the following categories:

- NCPDP claim submission standards
- Member eligibility
- Drug Coverage
- Dispensing limits
- Pricing
- Payment Information
- ProDUR

Note: The Medi-Cal Rx vendor’s claim(s) processing system provides real-time claims messaging and reject codes when a claim is submitted via POS or Web-Claim

Submission/Direct-Data Entry. For example, drug products that have dispensing limits will deny with Reject Code 76 – Plan Limitations Exceeded, if the product was submitted for greater than the allowed limit.

The POS system is used in conjunction with a pharmacy's in-house operating system. While there are a variety of different pharmacy operating systems, the information contained in this manual specifies only the response messages related to the interactions with the Medi-Cal Rx vendor's online system and not the technical operation of a pharmacy's in-house-specific system. Pharmacies should check with their software vendors to ensure their system is able to process the payer specifications listed in [Appendix A – NCPDP Payer Specification Sheet](#) of this manual.

4.2.1 Supported Transaction Types

The Medi-Cal Rx vendor has implemented the following NCPDP Version D.0 transaction types. A pharmacy's ability to use these transaction types will depend on its software. At a *minimum*, pharmacies should have the capability to submit original claims (B1), reversals (B2), re-bills (B3), and eligibility verification transactions (E1). Other transactions supported by Medi-Cal Rx can be found in the [NCPDP Payer Specification Sheet](#).

- Full Claims Adjudication (Code B1) – This transaction captures and processes the claim and returns the dollar amount allowed under the program's reimbursement formula. The B1 transaction will be the prevalent transaction used by pharmacies.
- Claims Reversal (Code B2) – This transaction is used by a pharmacy to cancel a claim that was previously adjudicated. The pharmacy must locate the paid claim which they would like to reverse and then select the reversal option. Pursuant to CCR, Title 22, Section 51172, if a prescription has not been received by the member or the member's representative within 15 days of the fill date, the pharmacy must reverse the claim and refund the payment to DHCS.
 - **Note:** Claims that have not successfully paid (adjudicated) cannot be reversed. Providers may contact the CSC at 1-800-977-2273 if an override is required for a reversal that has not successfully processed.
- Claims Re-Bill (Code B3) – This transaction is used by the pharmacy to adjust and resubmit a claim that has received a PAID status. A "claim re-bill" voids the original claim and resubmits the claim within a single transaction. The B3 claim is identical in format to the B1 claim with the only difference being that the transaction code (Field # 103) is equal to B3.
- Eligibility Inquiry (Code E1) – This transaction is used by the pharmacy to provide the status of a member's Medicare health plan covering the individual, along with details regarding primary and supplemental coverage if applicable.

Note: The following fields must match the original paid claim for a successful transmission of B2 (Reversal) or B3 (Re-Bill):

- Service Provider Identification (ID) – NCPDP Provider Number
- Prescription Number
- Date of Service (Date Filled)

4.2.2 Nonsupported Transaction Types

The Medi-Cal Rx vendor's POS system will **not** accept the following NCPDP Version D.0 transaction types:

- N1 = Information Reporting
- N2 = Information Reporting Reversal
- N3 = Information Re-Bill
- C1 = Controlled Substance Reporting
- C2 = Controlled Substance Reporting Reversal
- C3 = Controlled Substance Reporting Re-Bill

Note: Providers that report 340B claims on N-Type transactions are not and will not be considered compliant with DHCS policy.

4.2.3 Required Data Elements

When a pharmacy is setting-up their POS system to allow access to required fields and to accept adjudication for Medi-Cal Rx claims, the pharmacy's software vendor needs the Medi-Cal Rx vendor's payer specifications (see [Appendix A – NCPDP Payer Specification Sheet](#)).

The Medi-Cal Rx vendor's claims processing system has program specific field requirements (such as, mandatory, required, and required when).

Medi-Cal Rx claims will not be processed without all the required (or mandatory) data elements. Required (or mandatory) fields may or may not be used in the adjudication process. Also, fields not required at this time may be required at a future date.

Payer Specifications and Program Set-up Information

A list of supported transaction types and their field requirements, as well as BIN, PCN, Group#, etc., is available and can be found in [Appendix A – NCPDP Payer Specification Sheet](#).

4.3 NCPDP Batch File Submission

Pharmacy providers who are interested in submitting batch files to Medi-Cal Rx for pharmacy claims, pharmacy PAs, and/or member eligibility verification must ensure the transactions adhere to the NCPDP Versions D.0 and 1.2 Standards. Refer to the [NCPDP Payer Specification Sheet](#) for additional information on the NCPDP transactions and standards.

To initiate the Medi-Cal Rx batch file submission process, send an email request to MediCalSystemsGroup@primetherapeutics.com with the following information:

- As the subject line of the email, include text of "Medi-Cal Rx Batch File Setup Request for [pharmacy name]" to ensure the email is appropriately directed.
- In the body of the email, include:
 - Pharmacy Provider Business Name(s)
 - Pharmacy Provider Service/Business Address(es)
 - Pharmacy NPI(s)

- Contact Name
- Contact Phone Number
- Contact Email Address

Once the request email is received, a Medi-Cal Rx project manager will be in contact to discuss the next steps.

4.4 Paper Claim(s)

All pharmacy and member paper claims must be submitted to the Medi-Cal Rx vendor via one of the following forms:

- Universal Claim Form (UCF)
- California Specific Pharmacy Claim Form (30-1) (for non-compound claims)
- California Specific Compound Pharmacy Claim Form (30-4) (for compound claims)

[Appendix B – Directory](#) at the end of this manual specifies:

- The source for obtaining UCFs, California Pharmacy Claim Form (30-1) and California Compound Pharmacy Claim Form (30-4).
- The mailing address pharmacies must use when sending completed paper claims/billings.

Completion instructions for the UCF, *California Specific Pharmacy Claim Form (30-1)*, and *California Specific Compound Pharmacy Claim Form (30-4)* are listed in the following sections:

- [Section 19.1.1 – Completion Instructions for the Universal Claim Form](#)
- [Section 19.2.1.1 – Completion Instructions for California Specific Pharmacy Claim Form \(30-1\)](#)
- [Section 19.2.2.1 – Completion Instructions for California Specific Compound Pharmacy Claim Form \(30-4\)](#)

Examples of claims for which a UCF, *California Specific Pharmacy Claim Form (30-1)* or *California Specific Compound Claim Form (30-4)* may be submitted include, but are not limited to, the following:

- Prescriptions Exceeding the Timely Filing Limit:
 - Paper claims are allowed when the timely filing limit is exceeded.
 - The pharmacy is responsible for obtaining an authorization override prior to submitting paper claims.
 - Paper claims requiring authorization overrides that are submitted without the pharmacy first obtaining the authorization override will be denied with the applicable reject code and messaging. The denial will be visible via the [Medi-Cal Rx Provider Portal](#), the POS claim system, or on the RA once the paper claim has been processed.
- Non-Compound Claims (UCF or California Specific Pharmacy Claim Form (30-1))
- Multi-Ingredient Compound Claims (UCF or *California Specific Compound Pharmacy Claim Form (30-4)*)

- Claims submitted for drug NDCs in which a price is not available for the “inner” NDC but is available for the “outer” NDC (or vice versa). For additional information, refer to [Section 4.4.1 – Missing Price](#).

Note: Claims made by a member can be submitted using the *Beneficiary Reimbursement Claim Form* (sometimes referred to as a “Conlan Claim Form”). Additional information regarding member claims can be found in [Section 19.6 – Member Reimbursement Claims](#).

4.4.1 Missing Price

Reimbursement for any outpatient drug (including over-the-counter [OTC] drugs, physician administered drugs [PADs], and vaccines) covered under Medi-Cal Rx is based upon various price types that DHCS deems appropriate as identified in [Section 4.6.1 – Legend and Non-Legend Drugs](#). If a drug NDC does not have one of the Medi-Cal Rx recognized price types for reimbursement, claims submitted to Medi-Cal Rx will deny for Reject Code 85 – Claim Not Processed with the following supplemental message, “No price exists for the NDC submitted.”

Note: Medi-Cal Rx utilizes First DataBank (FDB) as its primary source for drug, NDC, and price information. Manufacturers are responsible for providing FDB with all of the information regarding their products.

“Inner” and “Outer” NDCs for Outpatient Drugs

“Inner” and “outer” NDCs for outpatient drugs are a Medi-Cal Rx benefit if the manufacturer reports the price to FDB and the Medi-Cal Rx approved reimbursement methodology can be applied to the claim when processed through the POS claim system. If the manufacturer does not report the NDC price, the claim cannot be processed and the claim will deny with Reject Code 85. This occurs when the “outer” NDC has a price, but the “inner” NDC does not. Pharmacy providers who receive a denied claim for Reject Code 85 when submitting a claim using the “inner” NDC are recommended to resubmit the claim using the “outer” NDC to align with available manufacturer prices. This ensures that the claim can reimburse accurately and in a timely manner.

If the “outer” NDC cannot be used for claim submission, pharmacy providers may submit a paper claim for the drug via the UCF or California Specific Pharmacy Claim Form (30-1). For compound claims, the California Specific Compound Pharmacy Claim Form (30-4) may be used. Pharmacy providers will be required to include the 11-digit “inner” NDC that was used to dispense the prescription along with the “outer” NDC and corresponding claim line number in the remarks area of the claim form. Reimbursement will be calculated using the NDC units of measure (for example, milliliters, grams, etc.) along with the “outer” NDC price. If the paper claim is submitted for the “inner” NDC but does not include the “outer” NDC as a remark on the claim form, the request will be denied.

Although less common, other situations that may occur include the following:

- The “inner” NDC has a price, but the “outer” NDC does not. In these situations, it is recommended to continue processing the claim using the “inner” NDC.

- Both the “outer” and “inner” NDCs do not have a price. In these situations, it is recommended to consider dispensing the drug using an alternate payable NDC from a different manufacturer.

Note:

- Submission of a paper claim in situations of Reject Code 85 does **not** guarantee reimbursement. The claim will continue to be subjected to Medi-Cal Rx policy and claim processing requirements and may deny with reject codes as a result of those requirements.
- The above does not apply to medical supplies. If a claim submitted for a medical supply denies for Reject Code 85, the pharmacy provider should submit the claim to the member’s medical benefit for coverage considerations.

4.5 Web Claims Submission/Direct-Data Entry

The Web Claims Submission (WCS)/Direct Data Entry tool allows pharmacy providers to securely (once registered via UAC and logged in) submit claims and PA requests and also search for claims by Cardholder ID and fill date. For more information on web claims submission/direct-data entry, see [Section 3.6.1.2.1 – Web Claim Submission/Direct Data Entry](#). For information on PA requests and submission methods, see [Section 14.0 – Prior Authorization Request Overview, Request Methods, and Adjudication](#).

4.6 Reimbursement

The following sub-sections contain information regarding how reimbursement is calculated for legend, non-legend drugs, select medical supplies, and enteral nutrition products.

4.6.1 Legend and Non-Legend Drugs

Reimbursement for any outpatient drug (including Over-the-Counter (OTC) drugs, Physician Administered Drugs (PADs), and vaccines) covered under Medi-Cal Rx is the lowest of either of the following:

1. The drug’s ingredient cost, plus a professional dispensing fee.
 - a. Where the drug’s ingredient cost is equal to the lowest of the following:
 - i. National Average Drug Acquisition Cost (NADAC), or when no NADAC is available, the Wholesale Acquisition Cost (WAC).
 - ii. Maximum Allowable Ingredient Cost (MAIC).
 - iii. Federal Upper Limit (FUL).
2. The pharmacy’s usual and customary charge.

Note: Additional product cost due to special packaging will not be reimbursed (for example: unit of use, modified unit dose, or unit dose).

4.6.2 Professional Dispensing Fee

Unless noted otherwise below, DHCS utilizes a two-tiered professional dispensing fee based on a pharmacy's total (both Medicaid and non-Medicaid) annual claim volume as follows:

- Less than 90,000 claims per year = \$13.20
- 90,000 or more claims per year = \$10.05

Note: No fee or markup is calculated when the Total Ingredient/Product Cost is equal to \$0.00. This applies to the two-tier professional fee, sterilization, and compounding fees.

4.6.2.1 Pharmacy Provider Self-Attestation

Pursuant to W&I Code, Section 14105.45, the two-tiered professional dispensing fee is based on a pharmacy provider's total (Medi-Cal Rx and non-Medi-Cal Rx) annual pharmacy claim volume (\$13.20 if fewer than 90,000 claims per year; \$10.05 if 90,000 or more). Reporting the claim volume is a self-attestation process, which must be submitted electronically and must be repeated annually.

Note: DHCS policy is that a claim is equivalent to a dispensed prescription; therefore, the attestation is for the total dispensed prescription volume.

Only Medi-Cal Rx providers dispensing less than 90,000 total prescriptions per calendar year are eligible to receive the higher of the two professional dispensing fees, and they must complete the attestation annually in order to receive it. Medi-Cal Rx providers with more than 90,000 total prescriptions are not required to participate in the annual attestation process. Providers that do *not* submit a timely attestation will be automatically assigned the lower of the two professional dispensing fees.

Self-attestations for each calendar year will begin in March after the close of the calendar year. The attestation period lasts approximately four (4) weeks.

The attestation for each calendar year reporting period will determine the professional dispensing fee component of the pharmacy claim reimbursement for claims with dates of service (DOS) within the state's following fiscal year. As an example, the 2021 calendar year volume attestation will determine the professional dispensing fee for claims within the State's 2022-2023 fiscal year (dates of service *on or after* July 1, 2022, through June 30, 2023).

4.6.2.2 Professional Dispensing Fee Limitations, Frequency of Billing

- Pursuant to CCR, Title 22, Section 51513(b)(3), full payment (drug ingredient cost plus a professional dispensing fee component) to a pharmacy is limited, based on policy for specific products, to a maximum of 3 claims for the same drug and strength dispensed to the same member within any 75-day period. The 4th claim from any provider, and any subsequent claims for the same drug and strength dispensed to the same member within any 75-day period will not be paid a dispensing fee, claims will be paid at the ingredient cost only.

- The exceptions to the frequency of billing rule as mentioned above are:
 - If it is the initial prescription.
 - When authorization is obtained for more frequent billing.
 - When drugs are dispensed in a quantity of 180 or more tablets or capsules.

Examples of Professional Dispensing Fee Control Exceptions:

- Oral Contraceptives require a minimum dispensing quantity of 3 cycles. Liquid Potassium products and Theophylline products require a minimum dispensing quantity of 480cc. If claims for those products are submitted for less than the stated minimum dispensing quantity, as a 30-day supply, the pharmacy will only get a dispensing fee for the first fill. On subsequent fills, only an ingredient cost will be paid and no dispensing fee.
 - The exceptions for the minimum quantity restrictions mentioned above are:
 - If it is the initial prescription.
 - When a PA is obtained for a smaller quantity.

Refer to the CDLs (found on the [Medi-Cal Rx Provider Portal](#) by selecting [Forms & Information](#)) for drugs/products that have a frequency of billing requirement. These products will be marked with a symbol (+).

4.6.3 Drug Price Types

4.6.3.1 National Average Drug Acquisition Cost (NADAC)

When available, the NADAC is used in the formula for determining drug ingredient cost reimbursement for covered outpatient drugs. The NADAC is a national drug-pricing benchmark determined by a federal survey, representing the national average invoice price for drug products based on invoices from wholesalers and manufacturers submitted by retail community pharmacies.

Note: It is the responsibility of providers to monitor the published NADAC pricing on the Centers for Medicare & Medicaid Services (CMS) Pharmacy pricing website. Providers may request a NADAC rate review by completing the *NADAC Request for Medicaid Reimbursement Review* form found at www.medicaid.gov.

4.6.3.2 Maximum Allowable Ingredient Cost (MAIC) Reimbursement Program

The DHCS has contracted with the Medi-Cal Rx vendor, who contracted with Mercer Government Human Services Consulting (Mercer), part of Mercer Health and Benefits LLC, to establish and maintain a Maximum Allowable Ingredient Cost (MAIC) program for generic pharmaceutical drugs.

The objective of the MAIC program is to establish upper limit generic ingredient reimbursement rates that encourage efficient purchasing while being responsive to marketplace drug pricing fluctuations.

The goals and objectives of the DHCS MAIC pharmacy reimbursement program include, but are not limited to the following:

- Ensure MAIC rates are set in accordance with WIC Section 14105.45.
- Evaluate changes in drug product acquisition prices, the availability of generic drug products, brand drug loss of patent protection and update or establish MAIC rates as appropriate.
- Respond to changing circumstances in the drug marketplace that require action to MAIC rates including establishing, reviewing, adjusting, or suspending MAIC rates.
- Evaluate and respond to pharmacy provider MAIC rate inquiries based on current marketplace information, the provider's acquisition cost, and availability of the drug product.

4.6.3.2.1 MAIC Reimbursement Inquiry and Review Process

The intent of the MAIC rate inquiry and review process is to evaluate if the current MAIC rate for a specific product is reflective of current marketplace conditions.

The MAIC rate review will include an evaluation of product availability, drug shortages, changes in published pricing, and therapeutically equivalent generic products. The outcome of the MAIC rate review will be communicated to the provider and adjustments will be made to MAIC rates, as necessary.

Providers with concerns about specific MAIC rates may request a review of an MAIC rate for a specific drug by submitting a request. Required information for the MAIC review includes, but is not limited to the following:

- NDC
- Drug name and strength
- Package size
- Wholesaler
- Lowest attainable package price
- Claim DOS
- Quantity dispensed
- Reimbursement amount
- Current MAIC rate
- Invoice

The MAIC rate inquiry form can be found on the [Medi-Cal Rx Provider Portal](#) by selecting [Forms & Information](#). All required fields on the MAIC rate review form must be completed. Providers will be contacted for supporting documentation or other information, as necessary.

Providers can find MAIC rate lists on the [Mercer Medi-Cal Rx website \(https://ca.mercerrxpassage.us/\)](https://ca.mercerrxpassage.us/). The Mercer Medi-Cal Rx website exclusively supports the Medi-Cal Rx MAIC program.

4.6.3.3 Federal Upper Limit (FUL)

The FUL is an upper-limit of reimbursement for certain multiple-source drugs established independently from the California MAIC program by CMS.

When a drug is listed on both the MAIC and FUL price lists, the maximum cost is the lower of the MAIC or FUL.

FUL drugs and prices are available on the CMS website at www.medicaid.gov.

4.6.4 Situations of Medical Necessity

When medically necessary for a specific member, approval of reimbursement at the NADAC or, if no NADAC, the WAC may be obtained for a product whose price exceeds the MAIC or FUL price limits by requesting a Price Override PA from a Medi-Cal Rx consultant. Reimbursement of the prescription ingredient cost may require the use of a brand of a multiple-source drug and may not exceed the statutory reimbursement limits.

Note: The situations of medical necessity price override does **not** apply to products classified as medical supplies or enteral nutrition products.

4.6.5 340B Pricing Program

Provider's billing drugs purchased pursuant to the 340B program (covered entities and contract pharmacies) are required to bill an amount not to exceed the entity's Actual Acquisition Cost (AAC) plus dispensing fee for the drug. Providers will be reimbursed the lesser of the billed amount (AAC plus Professional Dispensing Fee) or the maximum rate permitted.

4.6.6 Sales Tax

There is not a sales tax on prescriptions.

4.6.7 Compound Prescriptions

The maximum reimbursement for compounded prescriptions is the total of ingredient costs allowed under Medi-Cal Rx reimbursement policy, professional fees, compounding, and sterilization fees.

Compounds may be submitted for all media types (POS, batch, web, or paper).

Note: Medical supplies, diabetic supplies, enteral nutrition products, and blood factors may not be billed on a *California Specific Compound Pharmacy Claim Form (30-4)*. The *California Specific Pharmacy Claim Form (30-1)* or UCF must be completed for non-compounded I.V. solutions. The (30-4) or UCF can be completed for compounded I.V. solutions or sterile transfers.

4.6.7.1 Compound (Injection/Infusion) Pricing

Compound pricing for injections and infusions (Ingredients + Compound Fee + Sterilization Fee + Professional Dispensing Fee) are calculated as follows:

Ingredient Cost = The sum of all the ingredients used in the compound.

- For each ingredient, the system-determined price quantity billed is multiplied by the applicable unit price for the price type in the appropriate algorithm.
- Each ingredient is calculated separately to determine whether the billed amount on the claim (i.e., Gross Amount Due (GAD)) or the system-determined price is the lesser of value; the lesser of value is then used.

Compounding Fee = The Container Count multiplied by a designated compounding fee for the given Route of Administration (ROA) (or Dosage Form, if applicable). The compounding fee must be billed in the "other amount claimed field" on the claim in order to receive reimbursement for a compounding fee. In addition, the Medi-Cal Rx vendor will evaluate the billed compounding fee to the calculated compounding fee and pay the lesser of the two amounts.

- Injection (as defined by ROA Systematized Nomenclature of Medicine (SNOMED) value = 424109004, 385218009 (Injection)) compounding fee is \$0.99 per container, with a maximum of 20 containers.
- Infusion (as defined by ROA SNOMED value = 424494004, C444364, XXX) compounding fee is \$0.99 per container, with a maximum of 20 containers without a PA.

Note: If a claim is submitted with greater than 20 containers on the claim, the claim will deny Reject Code 76 – Plan Limitations Exceeded. A PA can be submitted for an override.

Compounding fees and/or maximum containers may vary for a given timeframe.

Note: An approved PA may override the allowed number of containers used in the calculation.

If the ROA's compounding fee per container is equal to zero, then an alternate method of determining the compounding fee must be based on the Dosage Form.

Refer to [Section 4.6.7.3 – Compounding Fee Breakdown by Dosage Form](#) for additional information on Compounding Fees.

Dosage Form's compounding fees are based on low-end and high-end ranges that vary by dosage form.

Any compound claim billed which contains only the dummy NDC for containers, 99999999997, will be denied with Reject Code 7Z – Compound Requires Two or More Ingredients with supplemental message "*Compounds with container NDC must also include at least one active compounded ingredient.*"

Sterilization Fee = The lowest amount between the billed Incentive Amount or the system-determined Sterilization Fee (using the following formula):

- Injection (as defined by ROA SNOMED value = 424109004, 385218009, XXX, XXX (Injection)) sterilization fee is \$0.32 per container, with a maximum of 20 containers.
- Infusion (as defined by ROA SNOMED value = 424494006, C444364, XXX (Infusion)) sterilization fee is \$0.32 per container, with a maximum of 20 containers.

If a claim is submitted with greater than 20 containers on the claim, the claim will deny Reject Code 76 – Plan Limitations Exceeded.

Sterilization fees and/or maximum containers may vary for a given timeframe.

The sterilization fees must be billed in the “incentive fee field” on the claim in order to receive reimbursement for the sterilization fee. In addition, the Medi-Cal Rx vendor will evaluate the *billed* sterilization fee to the *calculated* sterilization fee and pay the lesser of the two amounts.

Professional Dispensing Fee = Professional Dispensing Fee (defined in [Section 4.6.2 – Professional Dispensing Fee](#)) multiplied by Container Count, with a maximum of 20 containers.

Note: Professional Dispensing Fees and/or maximum containers may vary for a given timeframe.

Note: Prior to April 1, 2017, the professional dispensing fee applied to compounds was a flat rate that varied based on place of services.

4.6.7.2 Compound (Non-Injection/Non-Infusion) Pricing

Non-Injection/Non-Infusion compound pricing (Ingredients + Compounding Fee + Sterilization Fee + Professional Dispensing Fee) are calculated as follows:

Ingredient Cost = The sum of all the Ingredients used in the Compound.

- For each ingredient, the system-determined price quantity billed is multiplied by the applicable unit price for the price type in the appropriate algorithm.
- Each ingredient is calculated separately to determine whether the billed amount on the claim (i.e., GAD) or the system-determined price is the lesser of value: the lesser of value is then used.

Compound Fee = The Container Count of 1 (regardless of what is included on the claim as the container count) multiplied by a designated compounding fee for the given ROA (or Dosage Form, if applicable).

- Nasal (as defined by ROA SNOMED value = 46713006 (Nasal)) compounding fee is \$0.81 per container.
- Ophthalmic (as defined by ROA SNOMED value = 54485002 (Ophthalmic)) compounding fee is \$2.04 per container.
- Otic (as defined as ROA SNOMED value = 1054007 (Otic)) compounding fee is \$0.81 per container.
- Buccal, Dental, Inhalation, Intraperitoneal, Irrigation, Mouth, Throat, Mucous Membrane, Oral, Other Misc., Rectal, Sublingual, Topical, Transdermal, Translingual, Urethral, Vaginal, Enteral (as the ROA) is determined by the Dosage Form.

The compounding fee must be billed in the “other amount claimed field” on the claim in order to receive reimbursement for a compounding fee. In addition, the Medi-Cal Rx vendor will evaluate the *billed* compounding fee to the *calculated* compounding fee and pay lesser of.

Any compound claim billed which contains only the dummy NDC for containers, 99999999997, will be denied with Reject Code 7Z – Compound Requires Two or More Ingredients with supplemental message “*Compounds with container NDC must also include at least one active compounded ingredient.*”

Compounding fees and/or maximum containers may vary for a given timeframe.

Dosage Form’s Compounding Fees are based on low-end and high-end ranges that vary by the dosage form.

Sterilization Fee = Lowest amount between the billed Incentive Amount or the system-determined Sterilization Fee, using the following formula:

System-determined Sterilization Fee = Container Count of 1 (regardless of what is included on claim as the container count) multiplied by a designated sterilization fee for the given ROA.

- Intraperitoneal (as defined by ROA SNOMED value = 38239002 (Intraperitoneal) sterilization fee is \$0.32 per container.
- Irrigation (as defined by ROA SNOMED value = 47056001 (Irrigation) sterilization fee is \$0.32 per container.
- Mucous membrane (as defined by ROA SNOMED value = 419874009 (Mucous membrane)) sterilization fee is \$0.32 per container.
- Ophthalmic (as defined by ROA SNOMED value = 54485002 (Ophthalmic) sterilization fee is \$0.32 per container.
- Urethral (as defined by ROA SNOMED value = 90028008 (Urethral)) sterilization fee is \$0.32 per container.
- Remaining Non-Injection/Infusion Compounds (Buccal, Dental, Inhalation, Mouth throat, Nasal, Oral, Other miscellaneous Otic, Rectal, Sublingual, Topical, Transdermal, Translingual, Vaginal, Enteral) sterilization fee is \$0.00.

Sterilization fees and/or maximum containers may vary for a given timeframe.

The sterilization fees must be billed in the “incentive fee field” on the claim in order to receive reimbursement for the sterilization fee. In addition, the Medi-Cal Rx vendor will evaluate the *billed* sterilization fee to the *calculated* sterilization fee and pay the lesser of the two amounts.

Professional Dispensing Fee = Professional Dispensing Fee (defined in [Section 4.6.2 – Professional Dispensing Fee](#)) multiplied by Container Count of 1 (regardless of what is included on the claim as the container count), with a maximum of 20 containers.

Note: Professional Dispensing Fees and/or maximum containers may vary for a given timeframe.

Note: Prior to April 1, 2017, the professional dispensing fee applied to compounds was a flat rate that varied based upon place of service.

4.6.7.3 Compounding Fee Breakdown by Dosage Form

Note: The values below in *Table 4.6.7.3-1* are subject to change over time.

Compound Dosage Form	Compound Dosage Form Description	Compound Claim Quantity Low Range	Compound Claim Quantity High Range	Compounding Fee
01	CAPSULE	0000000	0000005	00.00
01	CAPSULE	0000006	0000036	01.98
01	CAPSULE	0000037	9999999	03.95
02	OINTMENT	0000000	0000000	00.00
02	OINTMENT	0000001	0000179	01.64
02	OINTMENT	0000180	9999999	03.29
03	CREAM	0000000	0000000	00.00
03	CREAM	0000001	0000179	01.64
03	CREAM	0000180	9999999	03.29
04	SUPPOSITORY	0000000	0000000	00.00
04	SUPPOSITORY	0000001	0000023	03.29
04	SUPPOSITORY	0000024	9999999	05.76
05	POWDER	0000000	0000005	00.00
05	POWDER	0000006	0000036	01.98
05	POWDER	0000037	9999999	03.95
06	EMULSION	0000000	0000000	00.00
06	EMULSION	0000001	0000239	00.81
06	EMULSION	0000240	9999999	01.64
07	LIQUID	0000000	9999999	00.99
10	TABLET	0000000	0000005	00.00
10	TABLET	0000006	0000036	01.98
10	TABLET	0000037	9999999	03.95
11	SOLUTION	0000000	9999999	00.99
12	SUSPENSION	0000000	9999999	00.99
13	LOTION	0000000	0000000	00.00
13	LOTION	0000001	0000239	00.81
13	LOTION	0000240	9999999	01.64

Compound Dosage Form	Compound Dosage Form Description	Compound Claim Quantity Low Range	Compound Claim Quantity High Range	Compounding Fee
14	SHAMPOO	0000000	9999999	00.99
15	ELIXIR	0000000	9999999	00.99
16	SYRUP	0000000	9999999	00.99
17	LOZENGE	0000000	0000005	00.00
17	LOZENGE	0000006	0000036	01.98
17	LOZENGE	0000037	9999999	03.95
18	ENEMA	0000000	9999999	00.99

Table 4.6.7.3-1: Compounding Fee Breakdown by Dosage Form

4.6.8 Drugs Provided to Physicians, Hospitals, Emergency Rooms, Outpatient Clinics, or Nursing Facilities for Dispensing or Administering

Pharmacies are not reimbursed by Medi-Cal Rx for either the cost of ingredients or the professional fee for drugs furnished to other providers to administer or dispense to members. Medi-Cal Rx does not consider this a pharmacy service rendered directly to Medi-Cal Rx members. Pharmacies that furnish drugs to the following providers should bill the provider directly:

- Physicians
- Hospital Emergency Rooms
- Outpatient Clinics
- Nursing Facilities – Pharmacies may bill Medi-Cal Rx for legend drugs and insulin for members in these facilities. All other drugs must be billed to the facility.

4.6.9 Nursing Facility Emergency Drug Supply

Pharmacies that own and maintain a nursing facility emergency drug supply may be reimbursed by Medi-Cal Rx for the ingredient cost and professional fee of a drug administered from the emergency drug supply for a nursing facility member's emergency condition as long as the use of the same drug is not continued after its administration from the emergency drug supply. However, when a drug is administered from the emergency drug supply to a nursing facility member for an emergency condition and the use of the same drug is continued after its administration from the emergency drug supply, the pharmacy may be reimbursed by Medi-Cal Rx for a single prescription only after the total quantity of the prescription has been dispensed to the member.

4.6.10 Pharmacy Discounts

DHCS is aware that certain pharmacies engage in various advertising promotions that essentially result in some form of discount for their customers. Examples include, but are not limited to, the offering of price discounts, cash rebates, and free prescriptions.

Pharmacy providers offering such discounts to the general public must be available with the same terms and conditions to Medi-Cal Rx customers. Failure to do so may result in billing Medi-Cal Rx more than the usual and customary amount charged to the general public for the same service and is prohibited by CCR, Title 22, Sections 51480 and 51513(b)(1)(A), (c) and in accordance with Title 42, *Code of Federal Regulations*, Part 447.331.

4.6.11 Items Not Covered

Pharmacy items excluded from reimbursement under Medi-Cal Rx are:

- Common household items and remedies.
- Non-legend drug preparations:
 - Benzoic and Salicylic Acid Ointment (pre-compounded)
 - Salicylic Acid Cream or Ointment
 - Salicylic Acid Liquid
 - Sodium Chloride Tablets 1 gm
 - Sodium Chloride Tablets 2.5 gm
 - Zinc Oxide Paste
 - Non-legend analgesics except for those listed in the CDL (found on the [Medi-Cal Rx Provider Portal](#) by selecting [Forms & Information](#)).
- Medical food, enteral nutritional supplements, or replacements, except for items included in the *List of Contracted Enteral Nutrition Products* (found on the [Medi-Cal Rx Provider Portal](#) by selecting [Forms & Information](#)) may be covered, subject to authorization.
- Vitamin combinations for people over five years of age (except for prenatal vitamin-mineral combination products for use during pregnancy) included in the CDL.
- Non-legend OTC drugs except insulin are included in the NF-A and NF-B daily rates. Pharmacies will not be reimbursed for OTC drugs, other than insulin, for NF-A or NF-B patients.
- Medical supplies provided to inpatients receiving NF-A or NF-B services are reimbursable only for the medical supplies specified in [Section 8.2.1 - Long Term Care Claims Processing](#).
- Non-legend cough and cold drug products (except for those that meet the requirements found in the CDL).
- Extended-release OTC cough/cold preparations.

4.6.12 Continuing Care

Drugs that have been end-dated or suspended from the CDL (found on the [Medi-Cal Rx Provider Portal](#) by selecting [Forms & Information](#)) will not be reimbursed unless a PA has been obtained for the drug or the member qualifies for continuing care. To be eligible for the PA exemption for continuing care, the following conditions must be met:

- The member must be taking the drug when it is end-dated or suspended from the CDL.
- The Medi-Cal Rx vendor must have received a claim for the drug, in the same dosage form and strength, within 100 days prior to the drug's suspension or deletion. The Medi-Cal Rx Provider Portal will allow a provider to look up a member and view that member's claims (only showing claims for the NPI of the provider who logged in). Any member claims history is only available via the Medi-Cal Rx Provider Portal after a provider has securely logged in.
- To maintain member eligibility under continuing care, a claim must be submitted for the drug in the same dosage, form, and strength within 100 days from the last DOS. The member may switch between brands of the drug in the same dosage form and strength and maintain their continuing care status.

4.6.13 Medical Supply Reimbursement

Medical supply reimbursement guidelines are as follows:

Net Purchase Price

Net purchase price is defined as the actual cost to the provider to purchase the item from the seller, including refunds, rebates, discounts, or any other price-reducing allowances, known by the provider at the time of billing Medi-Cal Rx for the item that reduces the item's invoice amount, pursuant to CCR, Title 22, Section 51008.1(a)(2)(A).

It shall reflect price reductions guaranteed by any contract to be applied to the item(s) billed to Medi-Cal Rx, pursuant to CCR, Title 22, Section 51008.1(a)(2)(B).

It shall not include provider costs associated with late payment penalties, interest, inventory costs, taxes, or labor, pursuant to CCR, Title 22, Section 51008.1(a)(2)(C).

Providers shall not submit bills for items obtained at no cost, pursuant to CCR, Title 22, Section 51008.1(b).

Upper Billing Limit

Claims for medical supplies should not exceed the amount that is the lesser of:

- The usual charges made to the general public.
- The net purchase price of the item (including all discounts and rebates), which shall be documented in the provider's books and records, plus no more than a 100 percent markup. Documentation shall include, but is not limited to including, evidence of purchase such as invoices or receipts.

- The Maximum Allowable Product Cost (MAPC) price on file for the item, plus a 23 percent dealer markup minus a 10 percent payment reduction for the following products:
 - Alcohol Prep Pads, Heparin and Normal Saline Flush solutions, Diaphragms and Cervical Caps, Condoms, Pen Needles, Sterile Syringes with Needles, and Miscellaneous Medical Supplies.
 - Effective July 1, 2022, the MAPC price on file for the item plus the appropriate professional dispense fee for the following products.

Note: A 10 percent payment reduction does NOT apply to these medical supplies:

 - Disposable Insulin Delivery Devices (DIDD), Continuous Glucose Monitoring (CGM) Systems, and Peak Flow Meters and Inhaler Assist Devices.
- The MAPC price on file for the item plus the appropriate professional dispense fee minus a 10 percent payment reduction for the following products:
 - Diabetic Test Strips, Lancets, NDC-Billed Self-Monitoring Blood Glucose Systems, Control Solutions, Lancing Devices, and Insulin Syringes.

Maximum Reimbursement

The maximum amount reimbursed to providers is the lesser of:

- The amount billed.
- The MAPC price on file, plus a 23 percent dealer markup or appropriate professional dispensing fee (if applicable).

4.6.14 Enteral Nutrition Products Reimbursement

The amount reimbursed to providers for enteral nutrition products shall not exceed the published Estimated Acquisition Cost (EAC) plus a 23 percent markup (W&I Code, Section 14105.85) minus a 10 percent reduction (W&I Code, Section 14105.192).

Refer to the *List of Contracted Enteral Nutrition Products* (found on the [Medi-Cal Rx Provider Portal](#) by selecting [Forms & Information](#)) for the published EAC.

4.6.15 Providers Payment Reduction

The reimbursements described in this manual may be subject to reductions or supplements to provider payments required by state law, such as the 10 percent reductions required by Welfare and Institutions Code 14105.192.

Note: Effective July 1, 2022, provider payment reductions will no longer be applied to the following products:

- Continuous Glucose Monitoring (CGM) Systems (see [Section 13.4 – Diabetic Supplies – CGM Systems](#) for information on coverage).
- Inhaled Assisted Devices.
- Peak Flow Meters.
- Disposable Insulin Delivery Devices (DIDD) (see [Section 13.3 – Diabetic Supplies – Disposable Insulin Delivery Devices](#) for information on coverage).

4.6.16 Blood and Blood Derivatives Reimbursement

Blood factor reimbursement is based on the lesser of:

- The manufacturer's reported Average Sales Price (ASP), plus 20 percent OR
- The provider's billed AAC + applicable professional dispensing fee.
 - Claims submitted by federally recognized Hemophilia Treatment Centers (HTC) must use the AAC for the drug as defined in W&I Code section 14105.46, plus a professional dispensing fee of \$0.14 per unit.
 - Claims submitted by all other providers must use the AAC for the drug equal to the invoice price minus any discounts (excluding a prompt pay discount of less than or equal to 2 percent), rebates, or chargebacks, plus a professional dispensing fee of \$0.04 per unit.

Note: It will be up to the submitting pharmacy to submit the billed amount on the claim utilizing their correct AAC and the appropriate professional dispensing fee.

For reference, the ASP is the amount reported to the federal CMS by the manufacturer pursuant to Section 1847A of the federal Social Security Act (42 U.S.C. §1395w-3a).

4.6.17 Prescription and OTC Smoking/Tobacco Cessation Products for Use During Pregnancy

Med-Cal will provide coverage of prescription and OTC smoking/tobacco cessation covered outpatient drugs for pregnant women as recommended in "Treating Tobacco Use and Dependence – 2008 Update: A Clinical Practice Guideline" published by the United States Public Health Service in May 2008 or any subsequent modification of such guideline.

Although the Patient Protection and Affordable Care Act (ACA) Section 4107 authorizes coverage of counseling and pharmacotherapy for tobacco cessation for pregnant women, the United States Preventive Services Task Force concludes that the current evidence is insufficient to assess the balance of benefits and harms of pharmacotherapy interventions for tobacco cessation in pregnant women. Providers should refer to the tobacco cessation guidelines by the American College of Obstetricians and Gynecologists (ACOG) before prescribing tobacco cessation medications during pregnancy.

Prescription and OTC smoking/tobacco cessation products for pregnant women are covered via the CDL (found on the [Medi-Cal Rx Provider Portal](#) by selecting [Forms & Information](#)) or via PA.

4.6.18 Vaccine Administration Fee

For claims submitted with a DOS *on or after* January 1, 2022, Medi-Cal Rx will reimburse a provider for the professional services associated with an immunization when a pharmacy provider submits for reimbursement of a vaccine administration.

To receive the professional services immunization administration fee, the provider must complete the following fields on the claim being submitted to identify that the pharmacy is administering the vaccine:

- Enter a dollar amount of the incentive fee in the Incentive Fee Amount Submitted field (NCPDP Field ID: 438-E3)
- Select the following Reason for Service Code (NCPDP Field ID: 439-E4):
 - PH = Preventive Health Care
- Select the following Professional Service Code (NCPDP Field ID: 440-E5):
 - MA = Medication Administration
- Select the following Result of Service Code (NCPDP Field ID: 441-E6):
 - 3N = Medication Administration
 - DHCS will reimburse the lesser of the billed amount of \$3.79 for the professional services associated with the administration of an adult vaccine.
 - The professional services immunization administration fee is eligible to be reimbursed for all vaccines eligible for pharmacy reimbursement under Medi-Cal Rx when utilized pursuant to the guidelines published by the Centers for Disease Control and Prevention (CDC) for members 19 years of age and older.

4.7 Filing Limitations

4.7.1 Timely Filing Limitations

POS claims are generally submitted at the time of dispensing. However, there may be circumstances that require a claim to be submitted retroactively. Refer to *Table 4.7.1-1* for claim filing limits.

Claims that exceed the maximum filing limit, as indicated below, will deny with Reject Code 81 – Timely Filing Exceeded. Providers may request an override by contacting the CSC at 1-800-977-2273.

Note: These limits will utilize the Adjudication Date and DOS. For information regarding specific fields that must be entered for successful transmission of transactions, refer to [Appendix A – NCPDP Payer Specification Sheet](#).

Type Description/ Transaction Description	Filing Limit	Comments
B1 = original claim	365 days	<p>Claims exceeding the maximum filing limit of 365 days will deny with Reject Code 81 – Timely Filing Exceeded</p> <p>Note: May be subject to Timely Filing Claim Cutback, see Section 4.7.3 – Timely Filing Claim Cutback.</p>

Type Description/ Transaction Description	Filing Limit	Comments
B2 = reversal	Unlimited	No filing limitations for B2 (reversal) transaction.
B3 = re-bill	365 days	Claims exceeding the maximum filing limit of 365 days will deny with Reject Code 81 – Timely Filing Exceeded Note: Claims may be subject to Timely Filing Claim Cutback, see Section 4.7.3 – Timely Filing Claim Cutback .
Requests for timely filing overrides		All requests for Timely Filing Overrides will be reviewed.
Timely Filing Cutback		For full reimbursement, claims must be submitted to Medi-Cal Rx within 6 months (known as the 6-month Billing Limit) following the month of the DOS of the claim. If claims are not received within the 6-month time window, claims reimbursement will be cutback/reduced. For additional information refer to Section 4.7.2 – Six-Month Billing Limit and Section 4.7.3 – Timely Filing Claim Cutback .

Table 4.7.1-1: Claim Filing Limits

4.7.2 Six-Month Billing Limit

For full reimbursement, claims must be submitted to Medi-Cal Rx within 6 months following the month of the DOS of the claim. This requirement is referred to as the six-month billing limit. See *Table 4.7.2-1*.

- For example, if services are provided on April 15, the claim must be received by the Medi-Cal Rx vendor prior to October 31 to avoid payment reduction (see [Section 4.7.3 – Timely Filing Claim Cutback](#)) or denial for late billing.

If the Date of Service is in this month:	Then Claims must be received by the last day of this month:
JANUARY	JULY
FEBRUARY	AUGUST
MARCH	SEPTEMBER
APRIL	OCTOBER
MAY	NOVEMBER
JUNE	DECEMBER
JULY	JANUARY
AUGUST	FEBRUARY
SEPTEMBER	MARCH
OCTOBER	APRIL
NOVEMBER	MAY
DECEMBER	JUNE

Table 4.7.2-1: Six-Month Billing Limit

Exceptions to Six-Month Billing Limit

Exceptions to the six-month billing limit can be made if the reason for the late billing is one of the delay reasons allowed by regulations (see the *Over-One-Year Billing Exceptions* table in [Section 19.3.1 – Submission and Timeliness Instructions](#)). Delay reason codes are used on claims to designate approved reasons for late claim submission. These delay reasons (submission of a *Claims Inquiry Form* [CIF], submission of Appeal) also have time limits as seen in *Figure 4.7.2-1* below. Exceptions with required documentation are required to be submitted via paper (see [Section 19.0 – Claim Forms](#) and applicable subsections).

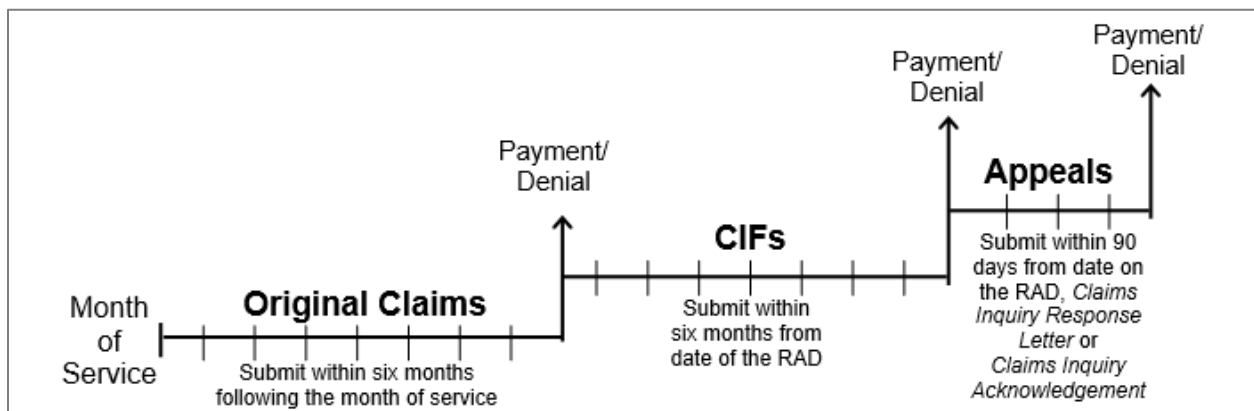


Figure 4.7.2-1: Claim Timeline Chart

4.7.3 Timely Filing Claim Cutback

Claims that are not received by MMA within the six-month billing limit and do not have an approved exception will be reimbursed at a reduced rate or will be denied as follows:

- Claims received during the 7th through the 9th month after the month of service will be reimbursed at 75 percent of the payable amount.
- Claims received during the 10th through 12th month after the month of service will be reimbursed at 50 percent of the payable amount.
- Claims received after the 12th month following the month of service will be denied.

5.0 Medi-Cal Rx Provider Claim Appeal Processes

A claim appeal is the final step in the administrative process. The appeal process offers Medi-Cal Rx providers a method for resolving problems related to their claim disputes. Each claim will be reviewed on its own merit, using applicable history files and documentation that the provider presents with the appeal, which will allow a fair decision to be rendered.

The Medi-Cal Rx Provider Claim Appeal process is only applicable to pharmacy fee-for-service claims processed by Medi-Cal Rx or by CA-MMIS.

5.1 Preparing a Claim Appeal

An appeal must be submitted on a *Medi-Cal Rx Provider Claim Appeal Form* (DHCS 6571) (see [Section 19.5 – Medi-Cal Rx Provider Claim Appeal Form \(DHCS 6571\)](#) for additional information). The form can be found on the [Medi-Cal Rx Provider Portal](#) by selecting [Forms & Information](#). Resubmission, underpayment, and overpayment requests for the same member may be combined on one form. However, each appeal should include only **one member**.

The provider must identify the claim(s) involved and specifically describe the disputed action or inaction regarding each claim.

The *Medi-Cal Rx Provider Claim Appeal Form* (DHCS 6571) can be mailed to the Medi-Cal Rx Claims Department (see [Appendix B – Directory](#) for the mailing address).

Providers may file a second appeal within 90 days from the initial appeal if the following apply:

- The Medi-Cal Rx Claim Appeal Team fails to act.
- The Medi-Cal Rx Appeal Acknowledgement Letter has not been sent from the Medi-Cal Rx Claim Appeal Team within fifteen (15) days of receipt of the appeal.
- The provider is dissatisfied with the action taken by the Medi-Cal Rx Claim Appeal Team regarding that appeal.

The Medi-Cal Rx Claim Appeal Team accepts appeals related to pharmacy claim processing issues only. Appeals for Medi-Cal Rx-related items that do *not* pertain to pharmacy claim processing (such as member eligibility determination and provider enrollment) must be submitted to the appropriate state or county department.

5.2 Claim Appeal Timeliness

5.2.1 90-Day Deadline

Providers must submit an appeal within 90 days of the action/inaction precipitating the complaint. Failure to submit an appeal within this 90-day time period will result in the appeal being denied. See CCR, Title 22, Section 51015.

5.2.2 Over-One-Year Dates of Service

Appeals submitted for claim billing services rendered more than 13 months prior to the appeal date should include one of the following, if available, to show proof of recipient eligibility:

- Copy or screen print of the Medi-Cal Rx Claim Appeal Team's Beneficiary Eligibility Lookup tool (see [Section 8.0 – Member Eligibility](#) for additional information) response.
- RA showing payment for same member for the same month of service billed.
- Copy of the original County Letter of Authorization (LOA) form (MC-180) signed by an official of the county.

5.2.3 Timeliness Verification

The Medi-Cal Rx Claim Appeal Team will **only** accept the following documents to verify the timely submission of a claim:

- A copy of an RA.
- A Medi-Cal Rx Claim Inquiry Response Letter.
- A Medi-Cal Rx Claim Inquiry Acknowledgement Letter.
- Any dated correspondence from the Medi-Cal Rx Claim Appeal Team with a date falling within the six-month billing limit for claim submission.

Note: A copy of the *Medi-Cal Rx Provider Claim Inquiry Form (CIF)* **without** its accompanying *Medi-Cal Rx Claim Inquiry Acknowledgement Letter* does **not** prove timely follow-up and may cause an appeal to be denied.

5.3 Reasons for a Claim Appeal

The following are three common reasons for an appeal:

- Eligibility – There was a Medi-Cal Rx claim denial due to member eligibility.
- Crossover – There was a Medi-Cal Rx crossover claim denial, overpayment, or underpayment.
- Adjustment Request – There was a Medi-Cal Rx claim overpayment or underpayment.

The above options are available in *Part 3 – Appeal Reason* of the *Medi-Cal Rx Provider Claim Appeal Form* (DHCS 6571) (see [Section 19.5 – Medi-Cal Rx Provider Claim Appeal Form \(DHCS 6571\)](#) for additional information on the form). If a provider is submitting a claim appeal for any reason other than the above options, this must be explained in the provided lines of *Part 3 – Appeal Reason* of the *Medi-Cal Rx Provider Claim Appeal Form* (DHCS 6571).

5.4 Supporting Documentation for a Claim Appeal

Necessary documentation, such as those listed below, should be submitted with each appeal to help the Medi-Cal Rx Claim Appeal Team perform a thorough review of the appeal. All supporting documentation must be legible. A copy of any of the following attachments is acceptable:

- Corrected claim (if necessary).
- RAs pertaining to claim history.
- Explanation of Medicare Benefits (EOMB) or Medicare Remittance Notice (MRN).
- Other Health Coverage (OHC) payments or denials.
- All CIFs, Medi-Cal Rx Claim Inquiry Acknowledgement Letters, Medi-Cal Rx Claim Inquiry Response Letters, or other dated correspondence to and from the Medi-Cal Rx Claim Appeal Team documenting timely follow-up.
- PA request(s).
- Copy of POS printout or internet eligibility response attached to the claim.
- If there is no record of an adjudicated claim found for a CIF Tracer, the provider should attach the CIF Tracer, Medi-Cal Rx Tracer No Hit Letter, and any additional supporting documentation.

Each appeal **must** contain proof of timeliness. See [Section 5.2 – Claim Appeal Timeliness](#) and corresponding subsections for acceptable documentation to verify timely submission.

Note: In cases where a CIF has been filed prior to an appeal, the provider has one (1) year from the date of the *Medi-Cal Rx Claim Inquiry Acknowledgement Letter* to file an appeal if no action resulted from the CIF. The *Medi-Cal Rx Claim Inquiry Acknowledgement Letter* **must** be submitted with the appeal; if it is not, the 90-day rule applies. If the 90-day timeline is not met, the appeal is subject to denial.

5.5 Acknowledgement of Appeal

The Medi-Cal Rx Claim Appeal Team will acknowledge each appeal within 15 days of receipt and make a decision within 30 days of receipt. If a decision is not made within 30 days, the appeal is referred to the professional review unit for an additional 30 days.

If the appealed claim is approved for reprocessing, it will appear on a future RA as a claim (the claim will be reprocessed using the same prescription number and member ID from the appeal request). The reprocessed claim will continue to be subjected to Medi-Cal Rx policy and claim processing criteria and could also be denied for a separate reason.

Medi-Cal Rx will send a letter of explanation in response to each appealed claim. Providers who are dissatisfied with the decision may submit subsequent appeals. In these cases, indicate the reason for appealing the decision in the *Part 3 – Appeal Reason* field of the form and attach a copy of the claim and any supporting documentation (including timeliness documentation).

5.6 Judicial Remedy: One-Year Limit

Providers who are not satisfied with Medi-Cal Rx's decision after completing the appeal process may seek relief by judicial remedy **not later than one year** after the appeal decision. Providers who elect to seek judicial relief may file a suit in a local court, naming DHCS as the defendant. (See W&I Code, Section 14104.5.)

6.0 Service Provider (Pharmacy ID) and Prescriber ID

6.1 Service Provider (Pharmacy ID)

Service Providers must submit the National Provider Identifier (NPI) number on all claims. If the service provider qualifier ID is not equal to '01,' the claim will be denied with Reject Code B2 – M/I Service Provider ID with the supplemental message *"NPI must be submitted."*

Sanctioned Service Providers – If a service provider has been sanctioned, claims will reject with Reject Code 559 – ID Submitted is assocd with Sanctioned Pharmacy with the additional message *"Pharmacy is Sanctioned. No claims allowed for Pharmacy."*

6.2 Prescriber ID

Pharmacies must submit the NPI number for the prescriber on all claims. If the prescriber qualifier is not equal to '01 – National Provider Identifier,' the claim will deny with Reject Code 25 – M/I Prescriber ID.

Note: The Prescriber NPI *cannot* equal the Service Provider NPI on claims.

Sanctioned Prescribers – If a prescriber is sanctioned, claims will reject with Reject Code A1 – ID Submitted Associated with a Sanctioned Prescriber with the additional message *"Prescriber is Sanctioned. No claims allowed for Prescriber."*

7.0 Provider Procedure/Drug Code Limitation (P/DCL)

In accordance with SB 857 and W&I Code, Section 14044, a Procedure/ Drug Code Limitation (P/DCL) may be imposed on a provider's use of one or more codes (CPT®, NDC, or HCPCS) for a period of up to 18 months, if one of the following conditions exists:

- DHCS determines, by audit or other investigation, that excessive services, billings, or abuse have occurred by a provider.
- A provider's licensing authority or a court of competent jurisdiction limits a licensee's practice of medicine, where the limitation precludes the licensee from performing services that could otherwise be reimbursed.

A provider placed on P/DCL sanction will not be able to receive reimbursement for those services under restriction. In addition, providers who fill orders for lab tests, drugs, medical supplies, or any other restricted services prescribed or ordered by a provider under restriction will not be reimbursed.

The limitation becomes effective after DHCS gives the provider notice of the proposed limitation and no appeal is submitted within 45 days or following the denial of an appeal.

DHCS reviews provider appeal evidence and issues the appeal decision within 45 days of receipt. If the appeal is not granted, the code-use limitations become effective 15 days after provider notification.

In a situation where the sanction could interfere with the provider's or other prescriber's ability to render health care services to a member, the burden to transfer the member's care to another qualified provider remains the responsibility of the provider.

The P/DCL may be used separately or in tandem with other existing anti-fraud and abuse efforts.

Specific information on procedure/drug code limitations will be added to this manual as it becomes available.

Pharmacy claims that are submitted where the *prescriber* is placed on a P/DCL sanction will deny with Reject Code 71 – Prescriber ID is Not Covered with the additional message "*Prescriber is sanctioned from prescribing certain or all drugs.*"

Pharmacy claims that are submitted where the *pharmacy* is placed on a P/DCL sanction will deny with Reject Code 70 – Product/Service not covered with the additional message "*Pharmacy is sanctioned from dispensing certain or all drugs.*"

8.0 Member Eligibility

Member eligibility can be validated via several methods:

- CSC
 - Nationwide Toll-Free Number: 1-800-977-2273
- [Medi-Cal Rx Secured Provider Portal](#)
 - Once a provider has logged in, the Beneficiary Eligibility Look-Up tool will be available under Tools & Resources (see [Section 3.6.1.2.4 – Additional Resources](#) and [Section 10.1.1.2 – Identifying Member's OHC via Beneficiary Eligibility Lookup Tool](#)).
- Eligibility Verification via NCPDP E1 Transaction

Member Identification: Provider Obligations

When a provider verifies that an individual is eligible to receive Medi-Cal Rx benefits, the provider is accepting the individual as a Medi-Cal Rx member. The provider is then bound by the rules and regulations governing Medi-Cal Rx regarding that member. If the provider is unwilling to accept an individual as a Medi-Cal Rx member, the provider has no authority to access confidential eligibility information.

Note: To receive reimbursement, the member *must* be eligible for Medi-Cal Rx fee-for-service on the DOS. This also applies to Medi-Cal Rx claims for members enrolled in CCS, GHPP, or Family PACT.

8.1 Identification Numbers, Cards, and Claims

8.1.1 Beneficiary ID

See *Table 8.1.1-1* for information regarding the format of both the BIC ID and HAP ID.

Description	Format	For Submission Purposes
BIC ID		Fourteen Characters
HAP ID	Eight numbers then a letter Note: These IDs begin with the number 9 and end with either an 'X' or 'Y'	Nine Characters

Table 8.1.1-1: BIC and HAP ID Information

Each Medi-Cal Rx member will have their own unique ID number.

The BIC ID is on the member's card and is 14 alpha-numeric characters. For claim submission, the pharmacy can submit the first 9 characters of the BIC ID, or the full 14 characters on the claim.

Note: For pharmacies submitting claims for same-day, newly enrolled Medi-Cal members, the full 14-character BIC ID **must be entered** on the claim for services rendered on the enrollment date.

Altered ID Cards

Medi-Cal Rx ID cards must **not** be altered by either the member or provider. If a member presents a card that is photocopied or contains erasures, strikeouts, white-outs, typeover, or any other form of alteration, providers should request that the member obtain an unaltered card and check other identification to ensure the patient is the Medi-Cal Rx member. Do not accept altered Medi-Cal Rx cards as proof of eligibility.

8.1.2 Benefits Identification Card (BIC)

Each member is issued a Benefits Identification Card (BIC), which can be in one of the following formats:

- Plastic Benefits Identification Card
- Paper ID Card
 - In exceptional situations, county welfare departments may issue temporary paper cards to individuals.

8.1.3 Health Access Program (HAP) Card

Providers are furnished with plastic, prenumbered, teal-colored cards to distribute to members at the time of their first service so there is no delay in care. Because a member's HAP identification number is entered at a provider's site in real-time through the POS network, a provider can render services and submit a claim for reimbursement without delay.

An activated plastic HAP card offers access to program-specific medical, laboratory and pharmacy services by referral from the member’s physician.

Note: Members can have both types of identification cards and applicable services associated with each card.

8.2 Special Eligibility/Client Conditions

The following populations in *Table 8.2-1* exist in Medi-Cal Rx:

Description	Identified By	Details
Hospice	Restriction code in Medi-Cal Eligibility Data System (MEDS).	There are no differences to claims processing for Hospice. All rules/edits apply.
Pregnancy/Postpartum	N/A	There are no claims processing differences. All rules/edits apply.
Long Term Care (LTC)	Claim(s) submitted with Patient Residence = 3 – Nursing Facility or 9 – Intermediate Care Facility/Individuals with Intellectual Disabilities	See Section 8.2.1 – Long-Term Care Claims Processing .
Newborn	Claim(s) submitted with Relationship Code = 03 Dependent & PA Type Code = ‘8’	There are no claims processing differences. Newborns are covered under their mother’s Medi-Cal Rx ID for the 1 st month of birth to the end of the following month (up to 60 days). Newborn claims are submitted under the mother’s ID. All drug coverage rules/edits apply. See Section 8.2.2 – Newborns .
Family Planning Services	HAP ID and Aid Code 8H	Family PACT members have different coverage. See Section 8.2.4 – Family Planning, Access, Care, and Treatment (Family PACT) .
Early Periodic Screening, Diagnosis, and Treatment (EPSDT)		Members that are younger than 21 and have Full Scope coverage are EPSDT eligible.

Description	Identified By	Details
CCS		See Section 8.2.5 – California Children’s Services (CCS) Program & Genetically Handicapped Persons Program (GHPP)
GHPP		See Section 8.2.5 – California Children’s Services (CCS) Program & Genetically Handicapped Persons Program (GHPP) .
Programs of All-Inclusive Care for the Elderly (PACE) Managed Care Plan (MCP)		All claims deny for Reject Code AF-Patient Enrolled Under Managed Care with the supplemental message <i>“Please resubmit to PACE XXX Plan.”</i> Note: XXX will have a numeric value corresponding to the plan number.
Cal MediConnect MCP		All claims deny for Reject Code AF-Patient Enrolled Under Managed Care with the supplemental message <i>“Please resubmit to Cal MediConnect XXX Plan.”</i> Note: XXX will have a numeric value corresponding to the plan number.
SCAN (Senior Care Action Network) MCP		All claims deny for Reject Code AF-Patient Enrolled Under Managed Care with the additional message <i>“Please resubmit to SCAN XXX Plan.”</i> Note: XXX will have a numeric value corresponding to plan number.

Table 8.2-1: Special Eligibility/Client Conditions in Medi-Cal Rx

8.2.1 Long Term Care Claims Processing

Long Term Care (LTC) members will be identified via the 'Patient Residence' claim field. A submitted value of '3' – Nursing Facility or '9' – Intermediate Care Facility/Individuals with Intellectual Disabilities will identify the member as LTC.

All PA, CDL, and ProDUR edits will apply.

OTC products, *except for **Insulin***, are excluded from coverage as they should be provided by the facility.

Medical supplies provided to inpatients receiving Nursing Facility Level A (NF-A) Services or Nursing Facility Level B (NF-B) services, whether or not rendered in a hospital setting (CCR, Title 22, Sections 51510 and 51511), are separately reimbursable only for the medical supplies listed below and only when required by a specific patient for that patient's exclusive use.

- Diabetic test strips and lancets, specific to the published List
- Self-monitoring Blood Glucose Systems (Glucometers), Control Solutions, and Lancing Devices specific to published List
- Disposable Insulin Delivery Devices (PA only) specific to published List
- Continuous Glucose Monitoring (CGM) Systems (PA only)
- Condoms
- Diaphragms
- Infusion Supplies – Heparin and Saline Flush

Note: Information regarding *Outpatient Hemodialysis, Nursing Facilities: Supplies Limited Use, Inpatient Hospital Services, or Supplies for Rented DME* can be found in the *Medical Supplies* section of the [DHCS Provider Manual \(Part 2\)](#).

There are no differences in claims processing when the member is in Hospice care *in addition to* LTC.

All services must be rendered in accordance with Medicare requirements.

8.2.2 Newborns

Newborn members will be covered under their mother's Medi-Cal Rx ID for the first month of birth to the end of the following month (up to 60 days). After this time, the infant must have his or her own Medi-Cal ID number.

Newborns will be identified via the Relationship Code and PA Type Code (PATC). A submitted value of '03' – Dependent and a PATC value of '8' will identify the member as a Newborn.

All drug coverage rules and edits found in the CDL (found on the [Medi-Cal Rx Provider Portal](#) by selecting [Forms & Information](#)) will still apply for Newborn members.

8.2.3 Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)

In California, the Child Health and Disability Prevention (CHDP) program administers the screening component of the federally mandated EPSDT benefit for individuals under the age of 21. The standards to meet medical necessity differ between Medi-Cal and EPSDT. The EPSDT standard is as follows:

EPSDT services are medically necessary or a medical necessity if they correct or ameliorate defects and physical and mental illnesses and conditions discovered through screening. This standard is set forth in Title XIX of the Social Security Act, Section 1905(r)(5) and in *Welfare and Institutions Code (W&I Code)*, Section 14059.5(b)(1).

Pharmacy claims submitted to Medi-Cal Rx for certain products not covered by Medi-Cal may be covered under EPSDT with an approved PA for members under the age of 21 and with full scope Medi-Cal.

8.2.4 Family Planning, Access, Care, and Treatment (Family PACT)

The Family PACT services are designed to support contraceptive needs of women and men, as well as assistance with family planning-related services to achieve and maintain optimal reproductive health.

The Family PACT program covers contraceptive drugs, devices, and supplies, and drugs for the treatment of specified sexually transmitted infections (STIs) and urinary tract infections (UTIs).

Quantity and frequency limitations apply as noted in the [Medi-Cal Rx Family Planning, Access, Care, and Treatment Pharmacy Formulary](#) found on the [Medi-Cal Rx Provider Portal](#) by selecting [Forms & Information](#).

All Medi-Cal Rx drug coverage edits apply to the Family PACT program, in addition to program-specific edits with one exception. Compounds are **not** a covered benefit of the Family PACT program. These claims will deny with Reject Code 7Y – Compounds Not Covered with the additional message “*Compounds are not a covered benefit of FPACT.*”

8.2.4.1 Family PACT Pharmacy Billing Overview

Pharmacy Dispensing: Medi-Cal Rx pharmacy providers may bill Family PACT for the U.S. Food and Drug Administration (FDA)-approved drugs and medical supplies that are included in the [Medi-Cal Rx Family Planning, Access, Care, and Treatment Pharmacy Formulary](#) and are prescribed by an enrolled Family PACT provider or associated practitioner, or an enrolled Medi-Cal provider (when the client is referred by an enrolled Family PACT provider). The [Medi-Cal Rx Family Planning, Access, Care, and Treatment Pharmacy Formulary](#) can be found on the [Medi-Cal Rx Provider Portal](#) by selecting [Forms & Information](#).

No Enrollment Necessary for Medi-Cal Pharmacy Providers: Medi-Cal pharmacy providers are not required to enroll in the Family PACT program. In addition, pharmacy providers are not

required to attend a Provider Orientation in order to be reimbursed for services rendered to Family PACT clients.

Web Claims Submission/POS System: It is recommended that pharmacies use the Web Claims Submission method or submit claims via POS for all Family PACT pharmacy billing transactions.

Reimbursement Rate: The reimbursement rates for Family PACT drugs and contraceptive supplies dispensed at pharmacies are the same as those for the Medi-Cal program (see [Section 4.6 – Reimbursement](#) for additional information).

Codes for Contraceptives: Pharmacists must bill the following contraceptive supplies using a National Drug Code (NDC):

- Condoms (internal and male)
- Diaphragms
- Cervical Caps
- Basal thermometers
- Lubricating jelly
- Spermicides and vaginal films

8.2.4.2 Family PACT Prior Authorization(s)

All drugs to manage a preselected complication of a Family PACT benefit require authorization using a PA request (see [Section 14.0 – Prior Authorization Request Overview, Request Methods, and Adjudication](#) for additional information). Drugs needed to treat complications are limited to drugs and supplies identified in the [Medi-Cal Rx Family Planning, Access, Care, and Treatment Pharmacy Formulary](#) (which can be found on the [Medi-Cal Rx Provider Portal](#) by selecting [Forms & Information](#)).

Use of Authorized Labelers: For the list of current authorized labelers, refer to the [Medi-Cal Rx Contract Drugs List – Authorized Drug Manufacturer Labeler Codes](#) on the [Medi-Cal Rx Provider Portal](#) by selecting [Forms & Information](#).

8.2.5 California Children’s Services (CCS) Program and Genetically Handicapped Persons Program (GHPP)

All CCS-only and GHPP-only services require a PA .

The CCS program provides health care services, including diagnostic, treatment, dental, administrative case management, physical therapy, and occupational therapy services, to children from birth up to 21 years of age with CCS-eligible medical conditions.

The GHPP program provides health care services for members aged 21 years and older with specific genetic diseases. However, members younger than 21 years of age with a GHPP eligible medical condition that do not qualify for GHPP may be eligible for the program. For more information, refer to the [GHPP website](#).

As mentioned in [Section 10.0 – Coordination of Benefits \(COB\)](#), Medi-Cal Rx is the always the payer of last resort. Providers are required to bill a CCS or GHPP member’s OHC prior to billing the CCS program or GHPP program.

Pharmacy claims for CCS-only, GHPP only, CCS/Medi-Cal Rx and GHPP/Medi-Cal Rx members may be submitted electronically either using the POS system, or web-claim submission/direct-data entry billing or manually via Pharmacy Claim Form 30-1 or the UCF (see [Section 19.0 – Claim Forms](#) and its subsections for additional information on completion of forms and tips for billing).

For dates of service prior to January 1, 2022

- Claims for members in CCS Whole Child Model (WCM) are completely carved into an MCP and are identified and processed exactly like all other MCP members with the exception of Blood Factors and specified clotting disorder treatments, which are processed as fee-for-service.
- Claims for members not in an MCP are processed as a fee-for-service claim.

For dates of service on or after January 1, 2022

- All CCS-only and GHPP-only services require a PA request.
 - CCS-only will process according to CCS policy.
 - GHPP-only will process according to GHPP policy.
- CCS/Medi-Cal and GHPP/Medi-Cal member claims will process according to Medi-Cal fee-for-service policy. Services not covered by Medi-Cal may be eligible for a PA under the CCS or GHPP program.

8.2.5.1 General CCS Requirements

In order to provide products to a CCS-only member for a CCS condition, or condition secondary to a CCS condition (defined below), a CCS paneled provider must prescribe it.

A list of CCS covered medical conditions can be found on the following website:

<https://www.dhcs.ca.gov/services/ccs/Pages/medicaleligibility.aspx>.

Secondary to CCS Condition

Conditions that are secondary to CCS conditions are interpreted as CCS conditions for the purposes of CCS policy. A PA will be required and will evaluate the secondary conditions for applicability to one or more CCS conditions.

CCS Paneled Providers (Prescribers)

“Paneled Providers” have been determined by the CCS program to meet the advanced educations, training, and/or experience requirements for their provider type in order to render services to a CCS applicant or member. Listings and files for “Paneled Providers” are available at <https://www.dhcs.ca.gov/services/ccs/Pages/CCSProviders.aspx>.

8.2.5.1.1 CCS Prior Authorization Requirements

The following PA requirements apply for CCS-only or CCS/Medi-Cal members:

- **CCS-only Policy:** In order to provide the drugs/supplies that require a PA for CCS, a CCS paneled provider must prescribe it. The prescriber or pharmacy will complete the request for PA.
- **CCS/Medi-Cal Policy:** In order to provide the drugs/supplies that require a PA for CCS, a CCS paneled provider must prescribe it. The prescriber or pharmacy will complete the request for PA.
- **Medi-Cal Policy (including EPSDT):** If PA is required for drugs/supplies, evaluate per medical necessity.

For additional information regarding PA submission methods see [Section 14.0 – Prior Authorization Request Overview, Request Methods, and Adjudication](#).

8.2.5.1.2 Special Care Center Required Prior Authorizations

The following PA requirements apply for CCS members as they pertain to Special Care Centers:

- **CCS-only Policy:** In order to provide the following products to a CCS member, a CCS Special Care Center Provider must complete a PA. If the drug is oral, it is preferred if the pharmacy submits the PA, with the Special Care Center providing justification.
- **CCS/Medi-Cal Policy:** In order to provide the following products to a CCS member, a CCS Special Care Center Provider must complete a PA. If the drug is oral, it is preferred if the pharmacy submits the PA, with the Special Care Center providing justification.

See *Table 8.2.5.1.2-1* for the current list of drugs requiring prescription by a CCS Special Care Center or subspecialist:

Drug	Special Care Center/ Specialist Requirement
Cerliponase Alfa (Brineura)	Special Care Center
Voretigene Neparvovec-rzyl (Luxturna)	CCS-paneled retinal specialist
Palynziq (pegvaliase-pqpz)	Special Care Center (REMS)
Tisagenlecleucel (Kymriah)	Special Care Center (REMS)
Kalydeco, Orkambi, Symdeko, Trikafta	Special Care Center
Gn RH agonist (Lupron, Histrelin acetate, Triptorelin pamoate)	CCS paneled endocrinologist
Epidiolex	CCS paneled neurologist
Nusinersen	Special Care Center
Botulinum toxin	CCS paneled neurologist or physiatrist

Table 8.2.5.1.2-1: Drugs Requiring CCS Special Care Center Prescription

8.2.5.2 General GHPP Requirements

All GHPP-only services require Prior Authorization.

For additional information regarding PA submission methods see [Section 14.0 – Prior Authorization Request Overview, Request Methods, and Adjudication](#).

For GHPP-only members, the prescriber does *not* have to be a CCS paneled provider and does *not* need to treat a CCS condition nor a GHPP condition., as GHPP provides comprehensive coverage (i.e., if an individual is enrolled in GHPP all services for that individual are covered, not just services for the GHPP condition). Eligibility requires only that the member has a diagnosis of a GHPP eligible condition.

A list of GHPP covered medical conditions can be found on the following website:
<https://www.dhcs.ca.gov/services/ghpp/Pages/MedicalEligibility.aspx>.

8.2.5.3 CCS Program County Office Directory

The CCS county office directory (<https://www.dhcs.ca.gov/services/ccs/Pages/CountyOffices.aspx>) identifies the CCS county offices as dependent or independent, and which state offices are responsible for the county providing their administrative oversight.

The following guidelines may be helpful in selecting the correct office:

- For questions about eligibility, contact the CCS independent county office.
- For questions about eligibility (residential eligibility or financial questions) in dependent counties, contact the CCS dependent county office.

8.2.6 Managed Care Plans (MCPs)

As of January 1, 2022, Medi-Cal Rx has taken over the responsibility from Medi-Cal MCPs for administering the following **when billed by a pharmacy on a pharmacy claim:**

- Covered Outpatient Drugs, including PADs
- Certain Medical Supplies
- Enteral Nutrition Products

The transition will not apply to PACE, Cal MediConnect, or SCAN. As of January 1, 2022, any pharmacy claims for members enrolled in the PACE, Cal MediConnect Plans, and SCAN plans billed to the Medi-Cal Rx plan will deny with Reject Code AF – Patient Enrolled Under Managed Care with additional messaging "*Please resubmit to PACE/Cal MediConnect/SCAN XXX Plan.*"

8.2.7 Retroactive Eligibility

Some Medi-Cal Rx members become eligible for Medi-Cal Rx after the month in which services were rendered. When submitting claims for Medi-Cal Rx members who have retroactive eligibility and additional information is required, a paper claim form will be required in the same manner as for other late billings. Refer to [Section 19.3.1 – Submission and Timeliness Instructions](#), and the *Billing Limit Exceptions* table within that section for more information.

The provider has 60 days from the date of receipt of retroactive eligibility information to bill Medi-Cal Rx. Proof of eligibility must be received within one year from the month service was rendered. For information on identifying member eligibility, including retroactive eligibility, see [Section 8.0 – Member Eligibility](#).

8.2.8 Eligibility Service Restrictions

Under federal and state law, Medi-Cal may place a member on restricted eligibility status. Members who meet the criteria may have utilization restrictions. Medi-Cal Rx will return an error message notifying the provider of the restricted services and a PA is required.

Prescription Drugs

DHCS may restrict access to prescription drugs for members and may be subjected to one or more forms of utilization restrictions.

These members receive a regular BIC, but when verifying eligibility, the Medi-Cal eligibility verification system will deny the claim with Reject Code 75 – Prior Authorization Required and return a message stating *“Recipient has restricted services. Prior Authorization required for drugs.”* This restriction requires an approved PA for all nonemergency prescription drugs. California law stipulates that prescriptions and emergency room visits do not apply to a restricted member in any instance where a bona fide emergency exists which requires immediate treatment.

This restriction requires an approved PA for all nonemergency prescription drugs. Retroactive paper ID cards for members with this restriction will have the code “P/A ALL RX.”

Scheduled Drugs

DHCS may also restrict access to certain scheduled drugs. These members receive a regular BIC, but when verifying eligibility, the Medi-Cal Rx eligibility verification system will deny the claim with Reject Code 75 – Prior Authorization Required and return a message stating *“Recipient has restricted services. Prior Authorization required for scheduled drugs.”* This restriction requires an approved PA for all nonemergency prescription drugs. Retroactive paper ID cards for members with this restriction will have the code “P/A SCHRX.”

Note: Authorization is not required for nonscheduled drugs contained in the CDL (found on the [Medi-Cal Rx Provider Portal](#) by selecting [Forms & Information](#)).

9.0 Member Financial Responsibilities

9.1 Copays

Table 9.1-1 below shows the standard copay for members.

Standard Copay	
Generic	\$0.00
Brand	\$0.00

Table 9.1-1: Standard Copays

9.2 Deductibles

Table 9.2-1 below shows the standard deductible for members.

Description	Standard	Comments
Deductible		N/A

Table 9.2-1: Standard Deductible

9.3 Share of Cost (SOC)

Some Medi-Cal members must pay, or agree to pay, a monthly dollar amount toward their medical expenses before they qualify for Medi-Cal Rx benefits. This dollar amount is called Share of Cost (SOC). A Medi-Cal SOC is similar to a private insurance plan's Out-Of-Pocket (OOP) deductible or can sometimes be referred to as a Spend Down.

The SOC can and may change month to month. DHCS will track when SOC has been met. See *Table 9.3-1*.

Until the member has met the SOC, the claim will be denied for unmet share of cost (Reject Code AA – Patient spenddown not met) with supplemental messaging advising of remaining SOC. However, once the member meets the SOC, the claim will then proceed to be processed per Medi-Cal Rx claim edits and audits. Pharmacy providers with questions regarding SOC, can call the Automated Eligibility Verification System (AEVS) at 1-800-456-AEVS (2387) or the Medi-Cal Telephone Service Center (TSC) at 1-800-541-5555.

Note: The TSC is *different* than the Medi-Cal Rx CSC.

For information on SOC and mechanisms on how to report spend-down, see the applicable links on SOC and on the Automated Eligibility Verification System (AEVS) in the [DHCS Provider Manual \(Part 1\)](#).

Note: Beginning January 1, 2022, Box 28 and Box 29 (Patient’s Share) on the *California Specific Pharmacy Claim Form (30-1)* and *California Specific Compound Pharmacy Claim Form (30-4)*, is **not** required and should be LEFT BLANK.

Description	Standard/Frequency	Comments
Share of Cost	Monthly	

Table 9.3-1: Share of Cost Frequency

9.4 Out-of-Pocket Maximum

Table 9.4-1 below shows the standard out-of-pocket maximum for members.

Description	Standard	Comments
Benefit maximum		N/A

Table 9.4-1: Out-of-Pocket Maximum

9.5 Patient Paid Amount

Table 9.5-1 below shows information regarding the Patient Paid Amount field.

Patient Paid Amount		
Patient Paid Amount field	If greater than \$0, reject the claim if provider submitted claim.	Reject Code DX – M/I patient paid amount submitted with the supplemental message “Patient Paid Amount Must = Zero” if provider submitted.

Table 9.5-1: Patient Paid Amount

10.0 Coordination of Benefits (COB)

COB is the mechanism used to designate the order in which multiple carriers are responsible for benefit payments and prevention of duplicate payments.

Other Health Coverage (OHC) refers to:

- An insurance plan or carrier
- A program
- A commercial carrier

The plan or carrier can be:

- An individual
- A group
- Employer-related
- Self-insured
- A self-funded plan

The program can be Medicare, which has liability for all or part of a member's medical or pharmacy coverage.

Not Considered to be OHC

The following is a partial list of insurance that is not considered to be OHC:

- Personal injury and/or medical payment coverage covered under automobile insurance
- Life insurance
- Workers' Compensation
- Homeowners insurance
- Umbrella insurance
- Accident insurance
- Income replacement insurance (for example, AFLAC®)

The term "Other Health Coverage" (OHC) is used to mean any source other than Medicaid that has a financial obligation for health care coverage.

Medi-Cal Rx is always the payer of last resort unless a member also has CA AIDS Drug Assistance Program (ADAP), Indian Health Services, or Veteran's Administration (VA) Services. This also applies to compounds.

Online COB (for example, cost-avoidance) is performed. COB edits will be applied when OHC exists for the member and claim date of service (DOS). If a claim does not contain COB information for a member who has active OHC on file, the claim will deny with Reject Code 41 – Submit Bill to Other Processor or Primary Payer.

10.1 COB General Instructions

Medi-Cal Rx is always the payer of last resort unless a member also has CA ADAP, Indian Health Services, or VA Services.

The recipient is required to utilize their OHC prior to Medi-Cal Rx when the same service is available under the member's private health coverage. If the member chooses to pursue services not covered by Medi-Cal Rx, Medi-Cal Rx will not assume liability for the cost of those services and claims will be denied with Reject Code 41 – Submit bill to other processor or primary payer.

Note: If the Medi-Cal Rx eligibility verification system(s) indicate that a member has OHC, but the member claims there is no OHC, advise the member to contact the county welfare eligibility worker.

Pharmacy: Self-Certification for OHC

Pharmacy providers may complete self-certification for OHC electronically or by using the UCF, *California Specific Pharmacy Claim Form (30-1)*, and *California Specific Compound Pharmacy Claim Form (30-4)*. Pharmacy providers do not need to submit an OHC attachment. However, pharmacy providers must be able to readily retrieve proof of claim submission and payment if collected from other payer(s).

Electronic Self-Certification

Electronic/online COB (for example, cost-avoidance) is performed when submitting claims via POS or Web Claims Submission. COB edits will be applied when OHC exists for the member and claim DOS. If a claim does not contain COB information for a member who has active OHC on file, the claim will deny with Reject Code 41 – Submit Bill to Other Processor or Primary Payer.

Claim Form Self-Certification

OHC will be self-certified for providers submitting paper claims if the *Other Payer Amount Paid #1/#2* field(s) (Field 84/85 (UCF)), *Other Coverage Paid* field (Box 26 (30-1) or Box 27 (30-4)) and the *Other Coverage* (Field 45 (UCF)), or *Other Coverage Code* field (Box 27 (30-1) or Box 28 (30-4)) are completed as instructed in [Section 19.1.1 – Completion Instructions for the Universal Claim Form](#), [Section 19.2.1.1 – Completion Instructions for California Specific Pharmacy Claim Form \(30-1\)](#), or [Section 19.2.2.1 – Completion Instructions for California Specific Compound Pharmacy Claim Form \(30-4\)](#).

10.1.1 Identifying Other Health Coverage

OHC can be identified using the POS system, the [Medi-Cal Rx Secured Provider Portal](#) on the [Medi-Cal Rx Web Portal](#) under the Beneficiary Eligibility Lookup tool, or Medi-Cal's AEVS (see [Section 3.5 – Automated Eligibility Verification System \(AEVS\)](#)).

10.1.1.1 Identifying Member's OHC via POS Claims

If a member has other coverage on a DOS and it is not reported on the pharmacy's claim submission, the Medi-Cal Rx vendor will deny the claim in the POS system (with Reject Code 41 – Submit Bill to Other Processor or Payer) and return the Other Payer details of the active OHC on file in the "COB Response Segment":

- Other Payer Coverage Type
- Other Payer ID Qualifier
- Other Payer ID
- Other Payer Processor Control Number (PCN)
- Other Payer Cardholder ID
- Other Payer Group ID
- Other Payer Person Code
- Other Payer Help Desk Phone Number
- Other Payer Patient Relationship Code
- Other Payer Benefit Effective Date
- Other Payer Benefit Termination Date

Note: Items returned are subject to information received on the member's COB records.

Reimbursement will be calculated to pay the lesser of the Medi-Cal Rx allowed amount less the third-party payment.

10.1.1.2 Identifying Member’s OHC via Beneficiary Eligibility Lookup Tool

The Beneficiary Eligibility Lookup tool is available to registered providers on the [Medi-Cal Rx Provider Portal](#), also see [Section 3.6.1.2 – Secured Provider Portal](#). Once a provider has successfully logged in, the Beneficiary Eligibility Lookup tool can be found under the Tools & Resources link. When the required member information has been entered (last name, BIC, birth date), providers will click **Search**. Upon a successful match being found, the member information along with their eligibility and claims history will be displayed, including OHC (see [Appendix G – OHC Carrier Information](#) for Medi-Cal OHC Carrier information pertaining to drug-related coverage. The table includes information on Other Payer IDs, Other Payer Names, and corresponding phone numbers). See *Figure 10.1.1.2-1*.



Figure 10.1.1.2-1: Beneficiary Eligibility Lookup Tool

10.1.2 Medicare Part B Coordination of Benefits Claims

Some Medi-Cal members are eligible for services under the federal Medicare program. For most services rendered, Medicare requires a deductible and/or coinsurance that, in some instances, is paid for by Medi-Cal.

The Medi-Cal Rx vendor will allow a POS claim (claim must be submitted with an Other Payer ID of "444444" to identify payment was received by Part B), for coinsurance but will also support paper claims to ensure that Medicare is responsible for their portion of claim payment. For Medicare/Medi-Cal Rx crossover claims for Medicare-approved services that are not able to be billed at POS, the following paper claim forms can be utilized (see [Section 19.1 – Universal Claim Form, Version D.0](#), [Section 19.2.1 – California Specific Pharmacy Claim Form \(30-1\)](#), and [Section 19.2.2 – California Specific Compound Paper Claim Form \(30-4\)](#)). Providers must submit crossover claims to the Medi-Cal Rx vendor (see [Appendix B – Directory](#) for mailing address).

Note: Crossover claims do not require a PA . Straight Medi-Cal Rx claims for Medicare denied or noncovered services may require a PA .

If a member has Medicare Part B coverage, and the pharmacy bills for a Medicare Part B covered drug or diabetic supply (including blood test strips, lancet/lancet devices, glucometers, and control solution), claims will deny with Reject Code A6 – Product/Service May Be Covered Under Medicare Part B with the supplemental message “*Bill Medicare.*”

In the event the claim is billed to Medicare Part B and Medicare Part B denies the claim for PA, a PA request must be submitted to Medicare for coverage. If the PA is denied by Medicare, then a PA request may be submitted to Medi-Cal Rx for consideration.

Full charges for a Medicare Part B eligible drug when the Medicare Part B annual deductible has NOT been met:

- If Medicare Part B denied payment on the claim and the charge was applied to member’s Medicare Part B annual deductible, and all required fields have been entered according to the *NCPDP Payer Specification Sheet* (see [Appendix A – NCPDP Payer Specification Sheet](#)) then the claim will pay.
- If the claim is not covered by Medicare Part B, it should be billed to the member’s Medicare Part D. In this scenario, the claim billed to Medicare Part B will deny with Reject Code 13 – M/I Other Coverage Code with the supplemental message “*Bill Beneficiaries Part D Plan for payment.*”

Copay charges for a Medicare Part B eligible drug when the Medicare Part B annual deductible has been met:

- If the claim does not crossover automatically to the MCP or fee-for-service Medi-Cal, the pharmacy must submit the claim for the copay charge for a Medicare Part B eligible drug to Medi-Cal Rx using the specific Medicare Part B Other Payer ID (“444444”), the applicable Other Coverage Code (OCC), and the dollar amount collected.

Note: Medi-Cal Rx payment is based upon the Medi-Cal Rx allowable amount, minus any payment a pharmacy provider has received from Medicare and from private insurance and member SOC. California law limits Medi-Cal Rx’s reimbursement for a crossover claim to an amount that, when combined with the Medicare payment, should not exceed Medi-Cal Rx’s maximum allowed for similar services. (Refer to W&I Code, Section 14109.5.)

10.1.3 Charpentier Claims

A permanent injunction ([Charpentier v. Belshé \[Coye/Kizer\]](#)) filed December 29, 1994, allows providers to rebill Medi-Cal Rx for supplemental payment for Medicare/Medi-Cal Part B services, excluding physician and laboratory services. This supplemental payment applies to Medi-Cal fee-for-service crossover claims when Medi-Cal Rx’s allowed rates or quantity limitations exceed the Medicare allowed amount. This applies only to Part B services billed to Part B carriers. All Charpentier rebills for pharmacy claims **must** be submitted via a paper claim form. The following definitions apply to Charpentier rebills (see [Section 19.3.3 – Tips for Billing Charpentier Claims](#) for how and where to utilize the following indicators):

- Rates (R) – The Medi-Cal Rx allowed amount for the item or service exceeds the Medicare allowed amount.

- Benefit Limitation (L) – The quantity of the item or service is cut back by Medicare due to a benefit limitation.
- Both Rates and Benefit Limitation (T) – Both the Medi-Cal Rx allowed amount for the item or service exceeds the Medicare allowed amount and the quantity of the item or service is cut back by Medicare due to a benefit limitation.

All Charpentier rebilled claims must have been first processed as Medicare/Medi-Cal crossover claims.

Medicare Allowed Amount

If there is no price on file, Medi-Cal Rx adopts the Medicare allowed amount and a cutback is *not* reflected on the RA.

Exceeds Medicare's Allowed Amount

If Medi-Cal Rx's rates and/or limitations are greater than that of Medicare, rebill the claim by following Charpentier billing instructions and attaching appropriate pricing documentation.

Note: Do not use a *Claims Inquiry Form* (CIF) to rebill a Charpentier claim.

Where to Submit Charpentier Rebills

All Charpentier rebills for pharmacy claims **must be submitted via a paper claim form** (refer to [Section 19.0 – Claim Forms](#) and [Section 19.3.3 – Tips for Billing Charpentier Claims](#) for additional information) and mailed to the Medi-Cal Rx vendor (see [Appendix B – Directory](#) for mailing address).

Submission Requirements

Providers must use the following submission requirements to be considered for supplemental payment under the Charpentier injunction:

- Providers must first bill Medicare and any Other Health Coverage (OHC) to which the member is entitled.
- The claim must then be billed as a crossover and approved by Medi-Cal Rx. This can happen one of two ways:
 - The claim may cross over automatically from the Part B carrier (via POS/electronic submission).
 - The crossover claim may be hard copy billed (paper claim) to Medi-Cal by the provider.

Additional Billing Tips for Charpentier Claims

- A Charpentier rebill must not be combined with a crossover claim.
- Use of Charpentier indicators ("R," "L," or "T") on claims that are not Charpentier claims will result in processing delays.
- Failure to place a Charpentier indicator ("R," "L," or "T") on a legitimate Charpentier claim prevents the system from recognizing the claim as a Charpentier rebill which may result in processing delays or denial of the claim.

- Claims with incorrectly marked Medicare Remittance Notices (MRN) will be denied.
- Providers must obtain an approved PA if a PA would be required when billed as a Medi-Cal Rx only claim.

Providers are not required to submit a copy of the Medicare Appeal and Decision form when billing Medi-Cal Rx for the difference between Medicare and Medi-Cal.

10.1.4 Medicare Part D COB

The Medi-Cal Rx vendor will deny COB claims where the pharmacy indicates by submission of OCC codes = 2 (**Other Coverage Exists Payment Collected**) that a payment has been received from Medicare Part D. The Medi-Cal Rx vendor will also deny COB claims where the pharmacy submits an OCC code = 4 (**Other Coverage Exists Payment Not Collected**) to indicate that Medicare Part D did not deny the claim, but there was no payment received from Medicare Part D. Both of these claim scenarios will deny for Reject Code 13 – M/I Other Coverage Code with the supplemental message *“Medicare Part D copays and deductibles are not covered.”*

Medi-Cal Rx will adjudicate claims for products that are not covered by Part D for members that have Medicare Part D. These products may pay if covered under Medi-Cal Rx. These products can be billed directly to Medi-Cal Rx without COB information.

Claims submitted to Medi-Cal Rx for products that are *not* excluded from Medicare Part D for a member with Medicare Part D coverage, will deny with Reject Code 620 – This Prod/Service may be covered under Medicare Part D.

Medi-Cal Rx will not pay the Medicare Part D medication deductibles or copayments.

10.1.4.1 Medicare and OHC

When a member has both Medicare and OHC, the pharmacy provider must bill payers in the following order:

1. OHC carrier
2. Medicare for Medicare-covered services
3. Medi-Cal Rx

10.1.5 Allowed Other Coverage Codes (OCC) for Standard OHC and Medicare Part D

See *Table 10.1.5-1* for the allowed OCC for standard OHC and Medicare Part D.

OCC	Description	Allowed for Standard OHC Processing	Allowed for Processing When Medicare is Involved
0	Not Specified	Yes – If no, OHC on file. If OHC is on file, claims will deny to bill primary payer.	Yes – If no, OHC on file. If OHC is on file, claims will deny to bill primary payer and the product is covered by Medicare. If OHC is on file, and the product is <i>not</i> covered by Medicare, the claim will pay.
1	No Other Coverage Exists	No – Claim will deny if other coverage is on file, otherwise claim will pay.	No – Claim will deny if other coverage is on file, otherwise claim will pay.
2	Other Coverage Exists Payment Collected	Yes – Reduce and pay submitted claim’s Carrier ID does not have to match to the member’s OHC record if payment received.	No – If COB indicates the primary Payer is Part D. Note: If the drug is a Medicare Excluded Drug, then this OCC value will be allowed. Yes – If COB indicates the primary payer is Part B.
3	Other Coverage Exists Claim Not Covered	Yes – Must be one of the reject codes that are in the OCC3 Reject Codes Table in Section 10.1.6 – OCC3 Reject Codes .	Yes – Only when Medicare rejects with Reject Code 65 – Patient is not covered. Or, with Reject Code A5 – Not covered Under Part D Law. Note: If the drug is a Medicare Excluded Drug, then any Other Reject Code is allowed.
4	Other Coverage Exists Payment Not Collected	Yes	No Note: If the drug is a Medicare Excluded Drug, then this OCC value will be allowed.

Table 10.1.5-1: Allowed OCC for Standard OHC and Medicare Part D

Note: Pharmacy claims will pay at \$0.00 and therefore, will not send a negative amount in the **Amount Paid** field if the OHC and copayment are greater than Medi-Cal Rx’s allowable amount.

10.1.6 OCC3 Reject Codes

See *Table 10.1.6-1* for the OCC3 reject codes and descriptions.

Reject Code	Reject Code Description
52	Non-Matched Cardholder ID
63	Institutionalized Patient Product/Service Not Covered
65	Patient is not covered
66	Patient Age Exceeds Maximum Age
67	Filled before coverage effective
68	Filled after coverage expired
69	Filled after coverage terminated
7Y	Compounds Not Covered
9G	Quantity Dispensed Exceeds Maximum Allowed
9Q	Route of Administration Submitted Not Covered
M1	Patient Not Covered in this Aid Category
N1	No Patient Match Found
A5	Not Covered Under Part D Law
MR	Product Not on Formulary
AA	Patient Spenddown Not Met

Table 10.1.6-1: OCC3 Reject Code Descriptions

Note: The Medi-Cal Rx vendor will deny COB claims for Standard OHC and Medicare Part D where the pharmacy submits an OCC code = 3 (Other Coverage Found Claim Not Covered) indicating the Other Payer denied the claim and the Other Payer Reject Code is not found in the above table (*except for* Medicare Part D COB claims where Reject Code 65 – Patient is not covered and Reject Code A5 – Not Covered Under Part D Law are returned [these are the **only** 2 reject codes accepted]). These claims will deny Reject Code 6E – M/I Other Payer Reject Code with the supplemental message “*Other Payer Reject Code not allowed.*”

Note: For pharmacy providers submitting paper claims (UCF, (30-1), or (30-4)), the OCC3 Reject Codes will be visible on the Provider Portal, via the POS system.

11.0 Contract Drugs List (CDL)

Drugs listed on the Contract Drugs List (CDL) generally include products for which there have been ongoing or past supplemental rebate agreements in place.

The following is available on the [Medi-Cal Rx Provider Portal](#) by selecting [Forms & Information](#):

- [Medi-Cal Rx Contract Drugs List](#) (CDL) – A searchable document containing the complete CDL, which is categorized by drug class and contains dose and strength information, along with coverage restrictions.

11.1 Code I Restrictions

Certain medications are restricted to specific members based on criteria such as age, quantity, drug therapy, drug duration, and type of illness. Code I drugs require authorization in accordance with Section 51003 unless used under the conditions specified in the CDL (found on the [Medi-Cal Rx Provider Portal](#) by selecting [Forms & Information](#)) and are subject to the prescription documentation requirements in CCR, Title 22, Section 51476(c). See CCR, Title 22, Section 51313.3(b).

The Code I requirements must be met in order to receive the medication(s) (see the [CDL](#)) or select **medical supplies** (see [Section 13.1 – Diabetic Supplies – Test Strips and Lancets](#) and [Section 13.2 – Diabetic Supplies – Self-Monitoring Blood Glucose Systems \(Glucometers\), Control Solutions, and Lancing Devices](#)) for more information) without a PA. If the claim submitted does not meet the conditions specified in the CDL or in [Section 13.1 – Diabetic Supplies – Test Strips and Lancets](#) or in [Section 13.2 – Diabetic Supplies – Self-Monitoring Blood Glucose Systems \(Glucometers\), Control Solutions, and Lancing Devices](#), providers must submit a PA request to receive reimbursement.

Note: For Code I restrictions, such as age, quantity, duration, or labeler-restricted products, Medi-Cal claim edits will manage compliance. The submitter will receive an appropriate reject code for situations of noncompliance. Alternatively, for Code I restricted products with a diagnosis/type of illness restriction, the submitter may communicate the restriction has been met using a Submission Clarification Code (SCC) value of '7 – Medically Necessary.' For additional information regarding applicable NCPDP fields, see [Appendix A – NCPDP Payer Specification Sheet](#).

See [Section 14.0 – Prior Authorization Request Overview, Request Methods, and Adjudication](#) for information on the methods available to submit/request a PA.

Code I Limitations will be identified in the CDL and marked with an asterisk (*).

11.2 Limitations on Coverage of Certain Drugs or Classes of Drugs

In compliance with state and federal Centers for Medicare & Medicaid Services (CMS) requirements, pharmacy providers and prescribers are reminded certain drugs or classes of drugs, or their medical uses, are excluded from coverage or otherwise restricted under Medi-Cal Rx pharmacy benefits.

11.2.1 List of Drugs Subject to Restriction

FDA-approved drug products are excluded from coverage or otherwise restricted under Medi-Cal Rx Pharmacy Benefit where the United States FDA indication is **solely**:

- For anorexia, weight loss, or weight gain.
- To promote fertility.
- For cosmetic purposes or hair growth.
- For the treatment of sexual or erectile dysfunction.

11.2.2 Exceptions to Drugs Subject to Restriction

A pharmacy provider or prescriber may submit a PA request for an unlabeled use or a medically accepted use of a restricted FDA approved product for a member when medically necessary. Unlabeled use of drugs means the use of an already marketed drug for a clinical indication not listed in the approved labeling of the drug by the United States FDA.

12.0 Enteral Nutrition Products

Enteral nutrition products are eligible for coverage via Medi-Cal Rx if all of the following requirements are met:

- Product is for outpatient use.
- Product requests meet the established requirements.
- Product is a contracted enteral nutrition product.
- Product is prescribed by a physician, nurse practitioner, clinical nurse specialist, or physician assistant.

All enteral nutrition products require a PA and are used as a “therapeutic regimen to prevent serious disability or death in patients with medically diagnosed conditions that preclude the full use of regular food” (W&I Code, Sections 14105.395, 14105.8, and 14132.86). Contracted enteral nutrition products are subject to the [List of Contracted Enteral Nutrition Products](#). To review the *List*, navigate to the [Medi-Cal Rx Web Portal](#) and select **Contract Drugs & Covered Products Lists** from the Tools & Resources drop-down menu. Certain products (specific Medi-Cal 11-digit NDCs) have additional requirements that must be met, which can be found in the product-specific criteria column within the published [List of Contracted Enteral Nutrition Products](#).

Enteral nutrition products are not separately reimbursable to inpatients receiving inpatient hospital services, Nursing Facility Level A or Level B services, inpatients in an Intermediate Care Facility for the Developmentally Disabled (ICF/DD), Intermediate Care Facility for the Developmentally Disabled/Habilitative (ICF/DD-H), or Intermediate Care Facility for the Developmentally Disabled/Nursing (ICF/DD-N). Enteral nutrition products are reimbursed as part of the facility's reimbursement or daily rate (CCR, Title 22, Sections 51510.1, 51510.2, and 51510.3).

DHCS shall recover overpayments for noncovered services, which include 100 percent of the ingredient cost and professional fee pursuant to CCR, Title 22, Section 51488.1(a)(2).

12.1 Noncovered Nutrition Products

The following nutrition products are **not** covered by Medi-Cal Rx:

- Regular food, including solid, semi-solid, and pureed foods.
- Common household items and remedies such as medical foods, enteral nutritional supplements, or replacements except for items included in the [List of Contracted Enteral Nutrition Products](#).
- Regular infant formula as defined in the Federal Food, Drug and Cosmetic Act (FD&C Act).
- Shakes, cereals, thickened products, puddings, bars, gels, and other non-liquid products.
- Thickeners.
- Products for assistance with weight loss.
- Enteral nutrition products used orally as a convenient alternative to preparing and/or consuming regular, solid, or pureed foods.
- Combination vitamin and mineral products for members 22 years of age and older (except for prenatal vitamin-mineral combination products for use during pregnancy). Vitamins or mineral products used for dietary supplementation are not a benefit.

12.2 Covered Products

Enteral nutrition products covered via Medi-Cal Rx can be found in the [List of Contracted Enteral Nutrition Products](#). The products are categorized as follows:

- Standard: Contain intact macronutrients and be nutritionally complete and a sole source of nutrition where no additional elements, vitamins, minerals, nor macronutrients are additionally required.
- Specialized: Disease-specific with intact macronutrients and modulars.
- Elemental and Semi-elemental: Nutritionally complete formula which contain extensively hydrolyzed (peptide) or fully broken-down (amino acid) protein macronutrients.
- Metabolic: Indicated for inborn errors of metabolism diagnoses for infant, pediatric, and adult Medi-Cal members.

- Specialty Infant: Indicated for specific diagnosis or conditions for individuals 1 year of age and younger.

Note: Contracted products may have additional product category and product specific requirements that must be addressed with the PA submission.

12.3 Prescription Requirements

The California State Plan (3.1-A, 7c.3) states that enteral nutrition products are covered only when supplied by a pharmacy provider upon the prescription of a prescriber within the scope of their practice. A written or electronic prescription signed by a physician, nurse practitioner, clinical nurse specialist, or physician assistant is required for authorization of all enteral nutrition products. The prescriber's full name, address, and telephone number must be clearly supplied if not preprinted on the prescription form.

12.4 Documentation Requirements

All of the following clinical and product information, as documented in the member's medical record, must be clearly supplied on the PA request or as an attachment within the PA request. Required information includes the following:

- Medical diagnosis code related to the product requested.
 - ICD-10-CM codes are required for certain product category types and/or diagnoses. Refer to the following sections for each product category for additional information on ICD-10-CM code requirements.
 - **Note:** If the ICD-10-CM code is not listed in the following product-specific sections, but the prescriber has determined the Medi-Cal member meets the product-specific requirements, documentation should be included supporting the request of the non-listed ICD-10.
- Daily caloric requirements of the requested enteral nutrition product.
 - This information (along with other medical measurements and labs) must be dated within 365 days (12 months) of the request, with the exception of specialty infant products, which must be dated within 120 days (4 months) of the request.
- Indication if member is tube fed or orally fed.
- 11-digit product NDC.
- Optional: height (length) and weight.
 - If provided, height (length) and weight may assist with the evaluation of quantities requested that exceed the maximum caloric limit of 2000 kcal/day.

Note: Providers are encouraged to use the [Medi-Cal Rx Enteral Nutrition Prior Authorization Request Form](#) when submitting requests via fax or U.S. Mail.

12.5 Authorization

All enteral nutrition products require a PA and are eligible for coverage consideration if the following requirements are met:

- Product is dispensed for outpatient use by a pharmacy provider.
- Product prescribed is on the established [List of Contracted Enteral Nutrition Products](#).
- PA meets the documentation requirements. See [Section 12.4 – Documentation Requirements](#).
 - Medical information (where required) must be dated within 120 days (4 months) of the request for specialty infant products. For all other categories, the medical information (where required) must be dated within 365 days (12 months) of the request.
- Product meets the product category specific requirements.
- Product meets the product specific requirements.
- Medical necessity is established meeting the daily caloric requirements. Daily caloric requirements will be assessed during the PA review and will be based on member feeding status and age. The daily caloric requirements are as follows:
 - **Tube Fed:** Maximum daily calorie limit of 2,000 kcal/day for each product
 - **Orally Fed and 22 years of age and older:** Maximum daily calorie limit of 1,200 kcal/day for each product
 - **Orally Fed and 21 years of age and younger:** Maximum daily calorie limit of 1,000 kcal/day for each product

A Medi-Cal Rx PA can be approved, with sufficient clinical documentation, for up to 1 year, up to a 31-day supply for each fill, unless noted.

12.5.1 Standard Products

To be considered for authorization of standard products that are on the [List of Contracted Enteral Nutrition Products](#), the member must meet **one** of the diagnoses as listed below:

- Severe swallowing or chewing difficulty due to one of the following:
 - Cancer of the mouth, throat, or esophagus
 - Injury, trauma, surgery, or radiation therapy involving the head or neck
 - Chronic neurological disorders
 - Severe craniofacial anomalies
 - Transitioning from parenteral or enteral tube feeding to an oral diet

- Diagnosis listed in the following *Standard Product Type Diagnosis Table*. See *Table 12.5.1-1*.

Standard Product Type Diagnosis Table	
ICD-10 Code	Diagnosis
E45	Retarded development following protein-calorie malnutrition
M62	Other disorders of muscle
M62.5	Muscle wasting and atrophy, not elsewhere classified
R63.6	Underweight
R13.1	Dysphagia
R13.19	Other dysphagia
R13.0	Aphagia
K22.0	Achalasia of cardia
E46	Unspecified protein-calorie malnutrition
E43	Unspecified severe protein-calorie malnutrition
E64.0	Sequelae of protein-calorie malnutrition
R64	Cachexia
C15.3	Malignant neoplasm of upper third of esophagus
C15.4	Malignant neoplasm of middle third of esophagus
C15.5	Malignant neoplasm of lower third of esophagus
C15.8	Malignant neoplasm of overlapping sites of esophagus
C15.9	Malignant neoplasm of esophagus, unspecified
K91.30	Postprocedural intestinal obstruction, unspecified as to partial versus complete
K91.89	Other postprocedural complications and disorders of digestive system
K31.8	Other specified diseases of stomach and duodenum
K31.84	Gastroparesis
K14.4	Atrophy of tongue papillae

Table 12.5.1-1: Standard Product Type Diagnosis Table

12.5.2 Specialized Products

To be considered for authorization of specialized products that are on the [List of Contracted Enteral Nutrition Products](#), the member must meet one of the diagnoses as listed below. See [Table 12.5.2-1](#).

- For diabetic, hepatic, or renal specialized products, the member must meet one of diagnosis from the Standard Product Type criteria (see [Section 12.5.1 – Standard Products](#)) as well as one diagnosis from the following *Specialized Products Diagnosis Table*:

Specialized Products Diagnosis Table		
Product Type	ICD-10 Code	Diagnosis
Specialized, Diabetic	E11	Type 2 diabetes mellitus
	E10	Type 1 diabetes mellitus
	E13	Other specified diabetes mellitus
	E08	Diabetes mellitus due to underlying condition
	R73.9	Hyperglycemia, unspecified
	E09	Drug or chemical induced DM
	O24	Diabetes mellitus in pregnancy, childbirth, and puerperium
	E89.1	Postprocedural hypoinsulinemia
Specialized, Hepatic	K76	Other diseases of liver
	K71	Toxic liver disease
	E80	Disorders of porphyrin and bilirubin metabolism
	B15	Acute hepatitis A
	K74	Fibrosis and cirrhosis of liver
	B17	Other acute viral hepatitis
	K70	Alcoholic liver disease
	K72	Hepatic failure, not elsewhere classified
	K83	Other diseases of biliary tract
	Q26	Congenital malformations of great veins
	K91	Intraoperative and postprocedural complications and disorders of digestive system, not elsewhere classified
	P78	Other perinatal digestive system disorders
	N18	Chronic kidney Disease

Specialized Products Diagnosis Table		
Product Type	ICD-10 Code	Diagnosis
Specialized, Renal	I12	Hypertensive chronic kidney disease
	I13	Hypertensive heart and chronic kidney disease
	N17	Acute kidney failure
	Z99.2	Dependence on renal dialysis
	N00	Acute nephritic syndrome

Table 12.5.2-1: Specialized Products Diagnosis Table

- For modular products, the member must meet one diagnosis from the Standard Product Type criteria (see [Section 12.5.1 – Standard Products](#)) as well as provide clinical justification for why additional supplementation is required if the member is taking other enteral nutrition supplementation. The member must have a documented medical diagnosis, and must meet one of the following:
 - For modular lipid (fat) products:
 - Clinical documentation that supports a fat malabsorption diagnosis; or
 - Indication for why the member requires a ketogenic diet for the control of a chronic condition, where other enteral nutrition formulas do not meet the member’s needs. Weight management is not an approvable diagnosis.
 - For modular carbohydrate or protein products:
 - A diagnosis and clinical justification that indicates the need for modified macronutrients with additional caloric intake or macronutrient intake.

12.5.3 Elemental and Semi-Elemental Products Criteria

To be considered for authorization of elemental or semi-elemental products that are on the [List of Contracted Enteral Nutrition Products](#), the member must meet the following requirements:

- Have an intestinal malabsorption diagnosis (ICD-10-CM Codes K90.0 – K90.9 and K91.2); lactose intolerance alone is excluded. The diagnosis name and ICD-10-CM code must be clearly supplied on the authorization request.
- Documentation that the standard or specialized enteral nutrition product has been tried and considered but did not provide adequate nutrition, unless such products are medically contraindicated.

12.5.4 Metabolic Products Criteria

To be considered for authorization of metabolic products on the [List of Contracted Enteral Nutrition Products](#), the member must have a diagnosis of inborn errors of metabolism (genetic, metabolic condition). See *Table 12.5.4-1*.

Exception: For metabolic ketogenic formulas, authorization may also be considered when documentation confirms that the member meets one of the following diagnoses:

- Epilepsy and recurrent seizures (ICD-10-CM Code G40)
- Cystic Fibrosis (ICD-10-CM Code E84)

In addition, metabolic ketogenic formulas require documentation that a contracted standard or specialized enteral nutrition product has been tried or considered and contracted alternatives are otherwise considered to be clinically inappropriate/ inadequate to meet the medical needs of the member.

ICD-10-CM CODE	DIAGNOSIS: Inborn Errors of Metabolism (IEM)
E70.0	Classical phenylketonuria
E70.1	Other hyperphenylalaninemias
E70.20 – E70.29	Disorders of tyrosine metabolism
E70.30 – E70.39	Albinism
E70.40 – E70.49	Disorders of histidine metabolism
E70.5	Disorders of tryptophan metabolism
E70.8	Other disorders of aromatic amino-acid metabolism
E70.9	Disorder of aromatic amino-acid metabolism, unspecified
E71.0	Maple-syrup urine disease
E71.1– E71.19	Other disorders of branched-chain amino acid metabolism
E71.2	Disorder of branched-chain amino-acid metabolism, unspecified
E71.30	Disorder of fatty-acid metabolism, unspecified
E71.310 – E71.318	Disorders of fatty-acid oxidation
E71.32	Disorders of ketone metabolism
E71.39	Other disorders of fatty-acid metabolism
E71.40	Disorder of carnitine metabolism, unspecified
E71.42	Carnitine deficiency due to inborn errors of metabolism
E71.50 – E71.548	Peroxisomal disorders
E72.00 – E72.09	Disorders of amino-acid transport
E72.10 – E72.19	Disorders of sulfur-bearing amino-acid metabolism
E72.20 – E72.29	Disorders of urea cycle metabolism
E72.3	Disorders of lysine and hydroxylysine metabolism
E72.4	Disorders of ornithine metabolism
E72.50 – E72.59	Disorders of glycine metabolism

ICD-10-CM CODE	DIAGNOSIS: Inborn Errors of Metabolism (IEM)
E72.8	Other specified disorders of amino-acid metabolism
E72.9	Disorder of amino-acid metabolism, unspecified
E74.00 – E74.9	Other disorders of carbohydrate metabolism
E75.00 – E75.6	Disorders of sphingolipid metabolism and other lipid storage disorders
E76.01 – E76.9	Disorders of glycosaminoglycan metabolism
E77.0 – E77.9	Disorders of glycoprotein metabolism
E84.0 – E84.9	Cystic fibrosis
E88.40 – E88.49	Mitochondrial metabolism disorders

Table 12.5.4-1: ICD-10-CM Code and Diagnosis

12.5.5 Specialty Infant Products Criteria

The specialty infant products are grouped in the following product types:

- Premature and Low Birth Weight Products
- Human Milk Fortifier
- Extensively Hydrolyzed Products (EH)
- Amino Acid-Based Products (100 percent)
- Renal Products (Renal)
- Chylothorax or long-chain 3-hydroxyacyl-CoA dehydrogenase deficiency (LCHAD deficiency) Products

For infant metabolic products, refer to the products listed under the metabolic category.

Refer to the amino acid-based products (100 percent) for products used in fat malabsorption.

Note: For members 21 years of age and younger, contracted Specialty Infant Products will pay under the Medi-Cal Rx Pharmacy Transition Policy.

Note: Regular infant formula products as defined in the FD&C Act are not covered.

Specialty infant products are restricted for use at time of birth through 12 months of age except when one of the following criteria has been met:

- Corrected Age (CA) applies only to infants born prior to 37 weeks gestation. For example, if birth date is 36 weeks gestation (4 weeks early), remove 4 weeks from Actual Age (AA) since birth to get CA. CA is always younger than AA.
- Use beyond age 12 months (including CA when applicable) requires documented medical justification clearly supplied on or with the PA, as documented in the infant's medical record.

Maximum age at time of authorization is 9 months plus 29 days; CA applies, except when noted.

Quantities for specialty infant enteral nutrition products based on sole source nutrition are approved up to 12 months of age except in the case of infants who do not make expected progress in advancement to solid foods, which is usually associated with a need to lessen body weight in kcals/kg, as recognized by American Academy of Pediatrics. Additional medical documentation is required, stated clearly on or with the PA, as documented in the infant's medical record.

- Authorization for specialty infant products can be approved up to 12 months of age or until the member's age of 11 months and 29 days, up to a 31 days' supply for each fill, except where noted.
- PA renewal requests may be submitted up to 100 days prior to their expiration date, where documentation must be dated within 120 days (4 months) at the time of PA request submission, unless noted.
- To be considered for authorization of specialty infant products that are on the [List of Contracted Enteral Nutrition Products](#) and administered orally or through a feeding tube, the member must meet the criteria listed in *Sections 12.5.5.1* through *12.5.5.6* specific to the product and/or product type requested.

12.5.5.1 Premature and Low Birth Weight Products

- Products 20 or 22 kcal/ounce are limited to members born prior to 37 weeks gestation or birth weight less than 3,500 grams.
- Products 24 or 30 kcal/ounce are authorized for one month only per request and limited to current weight (at time of dispensing) less than 3,500 grams.

12.5.5.2 Human Milk Fortifier Products

Authorization is limited to one month only per request for members with current weight less than 3,600 grams and must meet one of the following:

- Receiving only human milk and no other infant nutrition product (formula) used at the same time.
- Human fed or receiving human milk in combination with infant nutrition product (formula) administered only through a feeding tube.
- Human fed or receiving human milk in combination with infant nutrition product (formula) administered orally when one of the following conditions is currently documented and met:
 - Infant is at risk for necrotizing enterocolitis.
 - Mother of infant is establishing milk supply.
 - Human milk intake is increasing.

Note: Calculate 31-days' supply limit based on expected infant weight gain of 33-34 grams/day during an authorization term.

12.5.5.3 EH Specialty Infant Products

The member must meet one of the following criteria and the specialty infant EH formula is not used in the **prevention** of a chronic or acute disease or condition.

Product-specific criteria may also apply.

- Current diagnosis of Cow's Milk Protein Allergy (CMPA); **or**
- Severe food allergy indicating a sensitivity to intact protein.

12.5.5.4 Amino Acid-Based (100 Percent) Products

The specialty infant Amino Acid-based (100 percent) formula is not used in the **prevention** of a chronic or acute disease or condition **and** all of the following:

- Documented intolerance to human milk or other types of infant formula due to one of the following:
 - A clinical diagnosis of severe CMPA, multiple food protein allergies, or eosinophilic Gastrointestinal (GI) disorder.
 - Protein maldigestion or malabsorption diagnosis.
 - A clinical diagnosis of GI disorders such as short bowel syndrome or GI impairment.
 - Documented clinical fat malabsorption or steatorrhea diagnosis not effectively managed by human milk, regular infant formula, partially hydrolyzed formula, and EH infant formula. Authorization may also be considered for fat malabsorption or steatorrhea as a secondary diagnosis associated with cystic fibrosis, short bowel syndrome, or other related clinical conditions.
- Documentation that contracted EH (semi-elemental) specialty infant nutrition products have been tried or considered and contracted alternatives are determined to be clinically inappropriate/inadequate to meet the medical needs of the member or are contraindicated.
- For initial request, documented in hospital use prior to discharge, establishing the need for the product. Must meet one of the other AA required criteria for subsequent request.

12.5.5.5 Renal Specialty Infant Products

The member must meet one of the following:

- Renal function impairment
- Hypercalcemia
 - Hypocalcemia due to hyperphosphatemia

12.5.5.6 Chyllothorax or LCHAD Deficiency Specialty Infant Products

The member must have one of the following documented diagnoses:

- Chyllothorax
- LCHAD deficiency
- Cystic Fibrosis

- Mitochondrial disorder

12.6 Enteral Nutrition Dispensing Quantity Limitations

Enteral nutrition products will be restricted to a maximum quantity based on a maximum daily calorie limit of 2,000 kcal/day for each product. Claims submitted for quantities that exceed the limitation will deny with Reject Code 76 – Plan Limitations Exceeded and a PA will be required. PA reviews requires the establishment of medical necessity by assessing the requested quantity versus the member’s daily caloric need. If medical necessity cannot be established for the quantity requested which exceeds the maximum daily calorie limit of 2,000 kcal/day, Medi-Cal Rx will have the ability to approve the request with modifications that reflects the member’s daily caloric needs and any other pertinent clinical considerations that may apply. See [Section 14.7 – PA Adjudication](#).

Claims submitted for all enteral nutrition products is limited to a maximum day supply of 31 days per claim. The day supply is based on documented caloric and nutrient requirements per day, converted to a 31-day supply. A “31-day supply” is defined as the member’s daily caloric requirement for product (specified by the physician on the prescription), multiplied by 31 days, divided by caloric density of product, and rounded up to the smallest available package size. Rounding up does not include rounding up to six packs or full cases of product.

$$\begin{aligned} & (\text{Member's Daily Caloric Requirement} \times 31) \div \text{Product Caloric Density} \\ & = \text{Total (Rounded Up)} \end{aligned}$$

12.7 Billing Requirements

Enteral nutrition products are only covered via Medi-Cal Rx when dispensed by a Medi-Cal Rx pharmacy provider for a contracted product with an approved PA. Claims must be submitted using the 11-digit product NDC to Medi-Cal Rx via an NCPDP electronic transaction, on the *Universal Claim Form* (see [Section 19.1 – Universal Claim Form, Version D.0](#)), or on the *California Specific Pharmacy Claim Form (30-1)* (see [Section 19.2.1 – California Specific Pharmacy Claim Form \(30-1\)](#)). Enteral nutrition products may **not** be billed on a *California Specific Compound Pharmacy Claim Form (30-4)*.

12.8 Shortages and Product Interchangeability

In 2022, enteral nutrition coverage policy was temporarily updated to allow substitution of contracted enteral nutrition products without the need for a new PA request from the provider. The national formula shortage has not resolved. As a result, this policy will continue and allow for interchangeability among contracted enteral nutrition products within the same product categories/types.

Notes:

- Interchange between different product categories/types that are not therapeutically equivalent products will require submission of a PA request.
- Quantities exceeding the daily caloric limit of 2000 kcal/day will require submission of a PA request (refer to [Section 12.6 – Enteral Nutrition Dispensing Quantity Limitations](#)).

12.8.1 Product Interchangeability Requirements

To qualify for interchangeability, the following requirements apply and must be documented, either physically or electronically, in the member's file:

- The substituted product must be on the [List of Contracted Enteral Nutrition Products](#).
- The substituted product must be within the same product category/type as the original product.
- The substituted product must have the same published product use as the original product (refer to the manufacturer's website for specific details).
- The substituted product must be the same kcal/gram, milliliter, or each as the original product.
- The product substituted must have the same product-specific criteria as the original product found in the [List of Contracted Enteral Nutrition Products](#).

12.8.2 Prescription Requirements

If the prescriber determines that an enteral nutrition product substitution is required and a new prescription is submitted to the pharmacy for dispensing, prescription requirements for enteral nutrition products remain unchanged (refer to [Section 12.3 – Prescription Requirements](#)).

Prescribers and pharmacy providers must meet all prescription requirements.

If the pharmacy provider determines an enteral nutrition product substitution is required and a new prescription is not submitted by the prescriber, the pharmacy provider must document the following:

- The substitution necessity; and
- The date of the substitution; and
- The original prescription number for the original product is now unavailable; and
- The number of refills remaining on the prescription.

Once the prescription is filled with the substituted enteral nutrition product, the pharmacy provider is required to notify the prescriber that a substitution has been made due to

shortages or recalls. This notification will inform the prescriber of the updated product currently being dispensed to the member and allow the prescriber to review, evaluate, and order a change to the enteral nutrition therapy if desired.

13.0 Medical Supplies

Disposable outpatient medical supplies may be a covered benefit of Medi-Cal Rx when provided on a written or electronic prescription, as prescribed by a physician, nurse practitioner, clinical nurse specialist, or a physician assistant within the scope of their practice (California State Plan, 3.1A, 7c.1). Specific medical supplies are restricted to contracted products found on the covered products lists on the Medi-Cal Rx Web Portal. The lists of covered and contracted products can be accessed via the [Medi-Cal Rx Web Portal](#) by selecting **Contract Drugs & Covered Products Lists** from the **Tools & Resources** drop-down menu.

Notes:

- Listing of contracted products does **not** guarantee the product's availability.
- Refer to [Section 13.6 – Non-Covered Medical Supplies](#) for information on non-listed disposable outpatient medical supplies that are not a benefit of Medi-Cal Rx.
- Refer to [Section 15.1.2 – Medical Supplies Dispensing Quantity Limitations](#) for information on quantity, frequency, and days' supply limits for covered outpatient medical supplies.

Covered Disposable Outpatient Medical Supplies:

The following covered medical supplies products are restricted to a covered or contracted *List*.

- Specific Diabetic Supplies:
 - Disposable Insulin Delivery Devices (DIDDs)
 - Self-Monitoring Blood Glucose Systems (Glucometers)
 - Lancing Devices
 - Control Solutions
 - Glucose, Urine, and Ketone Test Strips
 - Lancets
 - Continuous Glucose Monitoring (CGM) Systems
- Personal Home Blood Pressure Monitoring Devices
- Blood Pressure Cuff for Use with Personal Home Blood Pressure Monitoring Devices
- Pen Needles
- Over-The-Counter COVID-19 Antigen Tests (refer to [Section 17.3 – OTC COVID-19 Antigen Test Kits](#))
- Sterile Syringes with Needles (non-insulin) – Effective January 1, 2024, sterile syringes with needles (non-insulin) are no longer restricted to a covered list. Quantity limits and frequency restrictions will apply.

Note: Medicare covers some medical supplies for diabetes. When Medicare covers an item and the beneficiary is eligible for Medicare Part B, providers should bill Medicare before billing Medi-Cal Rx. Refer to [Section 10.0 – Coordination of Benefits \(COB\)](#) for additional information.

The following covered medical supplies products are not restricted to a covered or contracted *List*. Refer to the [List of Covered Medical Supplies Product Descriptions and Billing Information](#) for product-specific information. Quantity and frequency restrictions apply, and products are reimbursed at the published MAPC for the following:

- Peak Flow Meters and Inhaler Assist Devices
- Condoms
- Basal Thermometers – For Contraception Only
- Diaphragms and Cervical Caps
- Heparin and Normal Saline Flush Solutions
- Insulin Syringes
- Alcohol Pads
- Sterile Syringes with Needles (non-insulin) (Effective January 1, 2024)

Prescription Requirements for Medical Supplies:

Either a written or electronic prescription, signed and dated by the member’s physician, nurse practitioner, clinical nurse specialist, or physician assistant within the scope of their practice, is required. Ordering only supplies necessary for the care of the member and as documented in the member’s medical record is also required.

Note: The prescription must be dated within 12 months of the DOS on the claim (refer to [Section 4.7 – Filing Limitations](#) and its subsections).

In addition to the prescriber’s signature and date prescribed, the following specific information must be supplied clearly on the prescription:

- Member’s name
- Full name, address, and telephone number of the prescribing physician, nurse practitioner, clinical nurse specialist, or physician assistant, if not preprinted on the prescription form
- Product name or description of the medical supply item being prescribed
- Frequency of use
- Quantity to be dispensed

Replacement(s) for specific medical supply devices will be considered when medically necessary and/or outside of a manufacturer's warranty, **not** for recent technology upgrades. The replacement of equipment may also be considered when it has been lost or irreparably damaged. A PA request justifying replacement due to loss or irreparable damage is required.

13.1 Diabetic Supplies – Test Strips and Lancets

Contracted diabetic lancets and test strips (glucose and ketones) are found on the [List of Contracted Diabetic Test Strips and Lancets](#) (which can be found on the [Medi-Cal Rx Web Portal](#) by selecting **Contract Drugs & Covered Products Lists** from the **Tools & Resources** drop-down menu), and are restricted to members being treated by a prescriber for a diabetes diagnosis or pregnancy-related diabetes diagnosis, documented in their medical records. For pregnancy-related diabetes diagnoses, the member can continue to receive up to 6 per day of both test strips and lancets during the pregnancy and up to 12 months postpartum.

Documentation of the expected or actual delivery date is required by either the prescriber on the prescription or in the medical record by the provider.

The following must be documented on the prescription, by the prescriber or pharmacy provider, either written or documented electronically:

- A description of the item prescribed; **and**
- The specific frequency of testing (“as needed” or “PRN” are not acceptable); **and**
- The member is an insulin user or a non-insulin user.

Note: Documentation requirements are subject to audit by DHCS.

Claims billed with or without authorization for Medi-Cal reimbursement are restricted to the contracted products on the [List of Contracted Diabetic Test Strips and Lancets](#).

When billing for test strips or lancets, claim quantities must be appropriate for the product quantity/package size (for example, 10, 25, 50, 100, 150, or 200) dispensed and are limited.

Quantity and Frequency Limits for Test Strips and Lancets:

- A maximum of up to 600 (612 if using the Accu-Chek® Fastclix Lancets) of each product in 100 days (up to 6 test strips and up to 6 lancets, per day) for:
 - A member with a diabetes diagnosis and using insulin; **or**
 - A member with a pregnancy-related diabetes diagnosis during the pregnancy and up to 12 months postpartum.
- A maximum of up to 100 of each product in 100 days (1 test strip and 1 lancet per day) for a member with a diabetes diagnosis and not using insulin.
- Blood ketone test strips: no more than 10 strips per claim, with no more than 3 claims in a 90-day period.
- Urine ketone and ketone/glucose test strips: no more than 50 per claim, with no more than 4 claims in a 365-day period.
- For CGM device users, claim quantities are limited to 25 every 100 days for blood glucose test strips and lancets found on the [List of Contracted Diabetic Test Strips and Lancets](#) for members with a CGM claim within 3 months, documentation of ongoing therapeutic CGM use, and a current or new PA request for a therapeutic CGM. This restriction does not apply to non-therapeutic CGM systems.
- A PA request showing medical necessity is required for quantities over the published allowances or non-diabetic diagnoses. Providers must include on the initial PA request:
 - Diagnosis; **and**
 - Date of most recent face-to-face prescriber meeting (within six months); **and**
 - Prescriber documentation of adherence to the high utilization testing regimen; **and**
 - Most recent (within six months) Hemoglobin A1c (HbA1c) percentage and target HbA1c percent; **and**
 - Justification for high utilization of testing.

13.2 Diabetic Supplies – Self-Monitoring Blood Glucose Systems (Glucometers), Control Solutions, and Lancing Devices

Claims are restricted to the contracted products on the [List of Contracted Self-Monitoring Blood Glucose Systems \(Glucometers\), Control Solutions, and Lancing Devices](#) (which can be found on the [Forms & Information](#) page of the [Medi-Cal Rx Provider Portal](#)). These products are Code I items restricted to members being treated by a prescriber for a diabetes diagnosis documented in their medical records. Providers must document on the prescription the manufacturer and brand of diabetic test strips and lancets the member is currently receiving.

Refer to [Section 15.1.2 – Medical Supplies Quantity Dispensing Limitations](#) for quantity information.

Diabetic self-monitoring blood glucose systems, lancing devices, and control solutions that are non-contracted items are not a benefit of Medi-Cal Rx. They may be a benefit when billed on a medical/institutional claim to the member's respective MCP or through the fee-for-service delivery system.

Prescription Requirements:

The following must be documented on the prescription, either written or documented electronically, and verified by the provider:

- The manufacturer of the diabetic test strips and lancets; **and**
- The brand name of diabetic test strips and lancets.

Refer to [Section 15.1.2 – Medical Supplies Quantity Dispensing Limitations](#) for quantity information.

13.3 Diabetic Supplies – Disposable Insulin Delivery Devices

Disposable Insulin Delivery Devices (DIDD) may be covered by Medi-Cal Rx with an approved PA request, meeting the established requirements, and listed on the [List of Covered Disposable Insulin Delivery Devices](#), which can be found on the [Medi-Cal Rx Web Portal](#) by selecting [Contract Drugs & Covered Products Lists](#) from the Tools & Resources drop-down menu.

DIDDs are not interchangeable with insulin pumps and require a new prescription and a Medi-Cal Rx authorized PA request for coverage. Insulin pumps are a DME benefit, not a pharmacy benefit, and should not be billed to Medi-Cal Rx. Providers should bill insulin pumps and non-contracted DIDDs as a medical benefit, where the medical claims should be submitted by the provider to either the fee-for-service fiscal intermediary or an MCP as applicable. Members should contact their individual plans for coverage and billing information.

Prescription Requirements:

Medical supplies prescription requirements apply; refer to [Section 13.0 – Medical Supplies](#) for additional information. In addition, the following information must also be included on the prescription:

- Member's residence status (home, facility, etc.)
- Date of Birth

DIDDs Billing Requirements:

- Only the contracted product numbers (NDCs) listed on the *List* will be reimbursable under Medi-Cal Rx with an approved pharmacy PA request; **and**
- The package (kit or box) must not be broken apart. The entire package (kit or box) should be dispensed, and the quantity billed equals the number of pods in the package; **and**
- Pharmacy providers must not dispense a quantity of supplies exceeding a member's expected utilization with a maximum dispensing limitation up to 30 pods for a 90-day period, specific to the member's insulin requirements, and requested days' supply. Documentation must clearly justify a request of additional insulin use or other medical needs if more frequent change is required.

DIDDs PA Request Requirements:

All DIDDs require a PA request with required documentation to demonstrate that the established PA request requirements and product-specific requirements are met. Both PA request requirements and product-specific requirements must be met for the product to be considered for coverage via Medi-Cal Rx.

Note: For claims billed for products **not** on the [List of Covered Disposable Insulin Delivery Devices](#), a PA request will **not** override and will **not** allow coverage/payment of the product. Non-covered DIDD devices may be a benefit when billed on a medical/institutional claim to the member's respective MCP or through the fee-for-service delivery system. Members should contact their individual plans for coverage and billing information.

To be considered for authorization, the following requirements must be met and included on the PA request. For **initial authorization** under Medi-Cal Rx, a PA request must have sufficient documentation to support that a member has been using the requested product within the past 90 days, **and** is at risk if therapy is changed, **or** meets all of the following requirements:

- Is under the immediate and ongoing care of, and the device is prescribed by, an endocrinologist or a healthcare practitioner with experience in diabetes management; **and**
- Is within the manufacturer recommendations for appropriate age range; **and**
- Has an insulin-dependent diabetes diagnosis and the appropriate ICD-10 code is documented on the prescription, within the member's medical record, and included in the claim submission. Additionally, it should be included on the PA request; **and**

- Is on an insulin treatment plan that requires multiple (three or more) daily insulin injections with frequent self-adjustments of the insulin dose for at least six months for members 21 years of age or older, or three months for members younger than 21 years of age prior to initiation of the device; **and**
- Has documented frequency of glucose self-testing an average of at least four times per day for the past two months; or has been using a CGM system for the past two months; **and**
- For members with no prior history of insulin pump use, documentation must include an HbA1c greater than seven percent **or** the member does not meet the documented individual targeted goal; **and**
- Has experienced one or more of the following while compliant on multiple (three or more) daily injections of insulin:
 - History of recurring hypoglycemia; **or**
 - Wide fluctuations in blood glucose before mealtime; **or**
 - Dawn phenomenon with fasting blood sugars frequently exceeded 200 mg/dL; **or**
 - History of severe glycemc excursions
- The initial PA request period must not exceed six months; **and**
- The device is being used for the administration of U-100 rapid acting insulins; **and**
- For members residing in an LTC facility setting, clinical justification must be included and demonstrate why an insulin pump or traditional daily insulin injections administered by licensed care staff and continuous medical support reimbursed by state or federal resources does not meet the member’s clinical needs.

For **reauthorization** under Medi-Cal Rx, a PA request must **not exceed** 12 months and must include documentation that the member meets all of the following requirements:

- Has been seen and evaluated by an endocrinologist or health care practitioner with experience in diabetes management at least every six months, either in-person or virtually through video or telephone conferencing; **and**
- Has been seen by their provider at least every six months, either in-person or virtually through video or telephone conferencing; **and**
- Has one annual in-person office visit, if possible, or documentation why an in-person visit is not available; **and**
- HbA1c testing is required and documented at least every six months; **and**
- Has documented frequency of glucose self-testing an average of at least four times daily **or** regular use of a CGM system.

13.4 Diabetic Supplies – CGM Systems

CGM systems may be covered by Medi-Cal Rx with an approved PA request, meeting the established requirements, and subject to contracted products on the [List of Contracted Continuous Glucose Monitoring \(CGM\) Systems](#). Non-contracted CGM systems may be a covered medical benefit through Medi-Cal MCPs. Managed care members should contact their individual plan for more information.

The initial authorization and subsequent reauthorizations are for a period of one year, initiating on the date of approval. Each fill can be up to a 90-day supply. On and after December 1, 2023, a PA request can be submitted for any one component of the CGM system, and the approved PA request will apply to all components of the CGM system. As a result, a PA request will not be required for each component of the CGM system.

Prescription Requirements:

Medical supplies prescription requirements apply. Refer to [Section 13.0 – Medical Supplies](#). In addition, the following information must be included on the prescription:

- Member's residence status (home, facility, etc.)
- Date of Birth (DOB)

Billing Requirements:

- Packages/kits **cannot** be broken. The entire package should be dispensed where the quantity billed equals the number of devices in the package. For example, providers who would dispense a box of three sensors or one sensor would bill for quantities of three each or one each, respectively.
- Quantity, frequency, and age restrictions apply. Refer to the [List of Contracted Continuous Glucose Monitoring \(CGM\) Systems](#) for product-specific requirements and restrictions.
- Simultaneous coverage for more than one CGM system is **not** permitted.
- Claim quantities for blood glucose test strips and lancets are limited to 25 strips and lancets, each, every 100 days for contracted products found on the [List of Contracted Diabetic Test Strips and Lancets](#) for members with a recent CGM claim for Dexcom and Abbott systems. These systems replace traditional blood glucose finger-stick testing. This restriction does not apply to Medtronic CGM systems. Urine glucose test strips and keto test strips are not impacted.

PA Request Requirements for CGM:

All approvals (initial and reauthorization) for CGM devices require a PA request with required documentation to demonstrate criteria is met. The initial authorization and subsequent reauthorizations are for one year initiating on the date of approval, unless otherwise noted to accommodate for gestational diabetes diagnoses, then the authorization will be for the length of the pregnancy plus 12 months postpartum. An expected and/or actual delivery date is required documentation and should be included with each PA request. Each fill can be up to a 90-day supply. Members must meet the CGM category PA request requirements and CGM product-specific criteria for the product requested.

Initial Authorization Requirements:

A CGM PA request must meet the following requirements:

- CGM coverage is limited to prescribing by an endocrinologist, a primary care provider (physician), nurse practitioner, clinical nurse specialist, physician assistant, certified nurse midwife, or other licensed healthcare practitioner with experience in diabetes management; **and**

- The member is within the specific device's recommendations for appropriate age range (refer to the [List of Contracted Continuous Glucose Monitoring \(CGM\) Systems](#) for product-specific age restrictions); **and**
- A diabetes diagnosis as outlined below; **and**
 - Type 1 or Type 2 Diabetes **and** one of the following other requirements:
 - Insulin-dependence
 - The member has claims history of regularly administered insulin in the past year; or
 - Documentation of regularly administered insulin use via chart notes, medical records, or additional clinical supportive documentation; or
 - The member is a new start, issued a new prescription, and will be using insulin administered on a continuing and regular basis.
 - History of problematic hypoglycemia with documentation demonstrating recurrent (more than one) level 2 hypoglycemic events (glucose <54mg/dL [3.0mmol/L]) that persist despite attempts to adjust medication(s) and/or modify the diabetes treatment plan within the past year.
 - Pregnancy-Related Diabetes Diagnoses:
 - Restricted to approval for the duration of the pregnancy and 12 months postpartum; **and**
 - Estimated and/or actual date of delivery must be included on the request.
- An HbA1c value measured within eight months of the date of the request is documented on the PA request; and
- **For members residing in a care-facility setting**, additional clinical justification must be included and demonstrate why traditional use of a Self-Monitoring Blood Glucose Test System administered by licensed care staff and continuous medical support reimbursed by state or federal resources does **not** meet the member's clinical needs.
- **Note:** Members using Point-of-Care diabetic supplies would **not** be eligible for approval of therapeutic CGM since it replaces standard home blood glucose monitoring.

Reauthorization Requirements:

The request must include the following:

- Documentation the member continues to meet CGM PA request coverage criteria (see above); **and**
- The member has been seen and evaluated by the prescriber annually, either in-person or virtually through video or telephone conferencing with documentation of:
 - The date of the most recent visit; **and**
 - The member is using the device as prescribed; **and**
 - The member is maintaining clinical HbA1c targets defined by the prescriber.

- For pregnancy-related diabetes diagnoses:
 - The delivery date must be included; **and**
 - Coverage is approved for the duration of the pregnancy and up to 12 months postpartum; **and**
 - After 12 months postpartum, a new PA request with a non-pregnancy diabetes-related diagnosis would be required; **and**
 - Postpartum PA requests are not renewable after the end of the 12-month postpartum period. After 12 months postpartum, a new PA request with a non-pregnancy diabetes related diagnosis would be required.
- For members residing in a care facility setting, additional clinical justification must be included and demonstrate why traditional use of a Self-Monitoring Blood Glucose Test System administered by licensed care staff and continuous medical support reimbursed by state or federal resources does **not** meet the member's clinical needs.
- **Note:** Members using Point-of-Care diabetic supplies would **not** be eligible for approval of therapeutic CGM since it replaces standard home blood glucose monitoring.

Refill Requirements:

All three requirements must be met:

- Pharmacy providers are required to have contact with the member or caregiver prior to dispensing a new supply of items; **and**
- Pharmacy providers must **not** dispense refills without a refill request from a member. Items dispensed without a valid, documented refill request will be denied as not reasonable or necessary; **and**
- Pharmacy providers must **not** dispense a quantity of supplies exceeding a member's expected utilization, and maximum dispensing limitations apply based upon the products dispensed, utilization limitations, and requested days' supply.

13.5 Personal Home Blood Pressure Monitoring Devices and Blood Pressure Cuffs

Personal home blood pressure monitoring devices and blood pressure cuffs can be a pharmacy-billed benefit through Medi-Cal Rx when billed by Medi-Cal Rx eligible pharmacy providers, pursuant to the *List of Contracted Personal Blood Pressure Monitoring Devices and Blood Pressure Cuffs*. Refer to the [List of Contracted Personal Blood Pressure Monitoring Devices and Blood Pressure Cuffs](#) for contracted products and the [List of Covered Medical Supplies Product Descriptions and Billing Information](#) for coverage criteria, quantity limits, and additional billing information. A Code I diagnosis of any ICD-10-CM diagnosis code that justifies medical necessity for cardiovascular monitoring for a chronic condition or on a regular basis is required; documentation in the electronic file or on the prescription is required. Medical Supplies prescription requirements apply.

Some products require a PA demonstrating medical necessity or diagnosis. Medi-Cal Rx allows one blood pressure monitoring kit (monitor plus cuff) every five years and one replacement

cuff every year. A PA demonstrating medical necessity can override these quantity and frequency restrictions. Medi-Cal Rx prescribers or providers should measure the member's upper arm to ensure cuff fit is appropriate. The [List of Contracted Personal Blood Pressure Monitoring Devices and Blood Pressure Cuffs](#) is subject to change with notification in the provider alerts. The Maximum Acquisition Cost (MAC) is the contracted rate the manufacturer has guaranteed the product is available for purchase for dispensing to Medi-Cal Rx members by Medi-Cal Rx providers from *at least one source*. Contact the manufacturer at the toll-free number in the [List](#) for information accessing products at the published Medi-Cal Rx contracted MAC price.

To receive reimbursement, the Medi-Cal Rx 11-digit billing number, or NDC-like number, on each package (box) dispensed must be an exact match to a Medi-Cal Rx billing code in this spreadsheet and the Medi-Cal Rx billing code submitted on the pharmacy claim. Wrist personal blood pressure monitoring devices and cuffs are not a Medi-Cal Rx benefit.

Non-listed personal blood pressure monitors, blood pressure cuffs, and replacement batteries are not a Medi-Cal Rx benefit. These items can be a covered medical benefit, billed on a *CMS-1500* claim form using an HCPCS code through either CA-MMIS for fee-for-service Medi-Cal members or through the individual Medi-Cal MCPs. Medi-Cal MCP members should contact their individual plan for billing instructions for non-Medi-Cal Rx benefits.

13.6 Non-Covered Medical Supplies

Medical supplies are a partial Medi-Cal Rx benefit, and not all medical supplies are Medi-Cal Rx benefits. Disposable outpatient medical supplies not found on the lists located on the [Contract Drugs & Covered Products Lists](#) page are not a benefit of Medi-Cal Rx. However, these non-listed medical supplies may be a benefit when billed on a medical/institutional claim to the member's respective MCP or through the Medi-Cal fee-for-service delivery system. Members should contact their individual plans for coverage and billing information.

Medi-Cal MCPs have an obligation to provide access to non-listed or excluded Medi-Cal Rx medical supplies to their members via a medical claim. MCPs should review medical claims appropriately to determine if the medical supply is a Medi-Cal Rx non-covered or excluded product. Medi-Cal MCPs should not direct providers to bill Medi-Cal Rx for non-listed or excluded Medi-Cal Rx medical supplies.

14.0 Prior Authorization Request Overview, Request Methods, and Adjudication

14.1 PA Request Overview

Certain pharmacy drug and medical supplies dispensed by a pharmacy are subject to authorization by Medi-Cal Rx before reimbursement can be approved. Authorization requests are made with a PA request. Authorization requirements are based on Federal and State Law. For all PA requests, Medi-Cal Rx will ensure that within 24 hours (or the next business day if request is received after-hours), the Medi-Cal provider will receive a confirmation and/or notice of approval, deferral, modification (Change in Therapy), and/or denial, as directed by DHCS.

There are several ways to submit a PA request for review. Medi-Cal Rx will accept PA requests via the following methods:

- NCPDP P4 – Request Only
- Medi-Cal Rx Provider Portal
- CoverMyMeds
- Fax
- United States (US) Mail

Note: Phone PAs are **not** allowed. A member **cannot** initiate a PA.

The Medi-Cal Rx provider community will be able to access the [Medi-Cal Rx Provider Portal](#) and perform the following tasks:

- Retrieve a copy of the designated Medi-Cal Rx PA form.
- Access to a link to submit a PA electronically through the [Medi-Cal Rx Provider Portal](#).
- Access a link to CoverMyMeds for an option to submit an electronic PA (ePA).
- Access the fax number and US mailing address.

14.2 NCPDP Prior Authorization (P-type) Transactions

The following subsections provide a brief overview of the allowable NCPDP Prior Authorization (P-Type) transactions.

For information regarding reject code required fields, refer to [Appendix A – NCPDP Payer Specification Sheet](#).

14.2.1 P2 Transaction – PA Reversal

Pharmacy providers can submit a P2 – PA Reversal to back out a request for authorization. The P2 will *not* reverse any claims submitted against the PA.

Paid billings should be reversed *before* the PA is reversed.

14.2.2 P3 Transaction – PA Inquiry

A pharmacy can submit a P3 – PA Inquiry to receive a status on a *previously submitted* P1 transaction or a P4 (PA Request Only).

14.2.3 P4 Transaction – PA Request Only

P4 transactions are submitted directly from the *pharmacy* using the NCPDP layout and required fields. The pharmacy can request and submit a PA on behalf of the member or provider.

14.3 Medi-Cal Rx Provider Portal for Electronic Prior Authorization (ePA)

The [Medi-Cal Rx Provider Portal](#) will provide the ability for a prescriber’s office or pharmacy to submit an electronic transaction and PA request (previously known as an eTAR). Submission via the Medi-Cal Rx Provider Portal has a predefined intake form and utilizes the same edits that are stipulated around requirements for the above-mentioned P4 NCPDP record.

The portal will display PAs requiring additional information. The submitter will have an option to submit the additional information via fax or via the portal.

Note: A link to CoverMyMeds and to the Medi-Cal Rx vendor’s PA fax form will also be available on the Provider Portal.

14.4 CoverMyMeds ePA Submissions

Medi-Cal Rx’s prescriber community can submit an electronic web PA request utilizing the CoverMyMeds platform. CoverMyMeds can be accessed at www.covermymeds.com.

Note: Only a *prescriber* can submit a completed PA case directly through CoverMyMeds. Some pharmacies can *initiate* a request through CoverMyMeds, which provides the information included in the case initiation to the prescriber.

CoverMyMeds interacts real-time with the Medi-Cal Rx vendor’s POS claims processing system and with the Medi-Cal Rx vendor’s Clinical Decision Module (CDM) to present covered alternatives and to collect required clinical information from the prescriber.

Note: The CDM will produce a series of questions related to the clinical criteria required for determination on a PA request. The CDM incorporates lists of drugs requiring a PA with alternatives that do not require authorization, diagnostic information, age and gender considerations, or quantity limitations. The CDM also enhances the ability to determine whether medical necessity has been met and is built using clinically based guidelines where Medi-Cal Rx policy will take precedence.

Dependent on the answers to the CDM questions with which the Provider responds, the request can be approved in real-time or routed to a Medi-Cal Rx Clinical Pharmacist who is presented with all appropriate information in order to efficiently make a decision or recommendation.

14.5 Fax PA Submissions

The Medi-Cal Rx vendor will accept PA requests that are received by fax. Faxed requests must be submitted on one of the following forms (see [Appendix E – Acceptable Medi-Cal Rx PA Request Forms](#)):

- Medi-Cal Rx PA Request Form (preferred)
- Medi-Cal Form 50-1
- Medi-Cal Form 50-2
- California Form 61-211

The preferred *Medi-Cal Rx PA Request Form* will also be available on the [Medi-Cal Rx Provider Portal](#) under the [Forms & Information](#) link.

Providers may continue to utilize the *Medi-Cal Form 50-1*, *Medi-Cal Form 50-2*, and *California Form 61-211* after implementation of Medi-Cal Rx.

Faxes can include any additional attachments (i.e., patient records or lab work) that the prescriber provides as medical justification for the request (all pages/attachments that a provider sends in a single fax transaction are received together). Once the CSC reviews the document and a decision is made, a faxed response will be sent to the requestor.

PA requests submitted by fax must be complete, legible, and include any relevant medical justification.

If the fax submission is unsuccessful, the provider should double check that the fax number is correct. If after two attempts the fax is unsuccessful, the provider should contact the CSC by telephone (1-800-977-2273) for further directions.

Note: PA requests *cannot* be submitted via phone.

PA Fax Number: 1-800-869-4325

14.6 US Mail

The Medi-Cal Rx vendor will accept PA requests that are received by US Mail. Mailed requests must be submitted on one of the following forms (see [Appendix E – Acceptable Medi-Cal Rx PA Request Forms](#)):

- Medi-Cal Rx PA Request Form (preferred)
- Medi-Cal Form 50-1
- Medi-Cal Form 50-2
- California Form 61-211

The preferred *Medi-Cal Rx PA Request Form* will also be available on the [Medi-Cal Rx Provider Portal](#) under the [Forms & Information](#) link.

PA requests received by mail can include any additional attachments (i.e., patient records or lab work) that the prescriber provides as medical justification for the request.

US Mail requests for PAs received by the Medi-Cal Rx vendor will be scanned by the mail room and placed into the fax queue. This allows mailed requests to be handled in the same manner and process as a faxed request for PAs.

For paper submissions received via mail, the Medi-Cal Rx vendor will obtain the fax number of the requestor to provide the documented outcome. If the requestor does not have a fax number, the CSC will call the requesting provider with the outcome and mail the written confirmation.

Providers opting to mail PA requests can send their paperwork to the Medi-Cal Rx vendor (see [Appendix B – Directory](#) for the mailing address).

14.7 PA Adjudication

The following process describes the steps that are taken to make a determination regarding a PA request:

- The Medi-Cal Rx vendor first determines eligibility and program coverage by editing against member eligibility factors, including:
 - Program eligibility
 - LTC status
 - Existence of authorized prescribers
 - Existence of program coverage restrictions, as well as other elements specified and approved by the DHCS.
- Once the initial PA is received and reviewed, the Medi-Cal Rx vendor will determine if additional information is needed.
 - If yes, the PA will be deferred. The Medi-Cal Rx vendor will request the following information (also see “Deferred” bullet point below):
 - If a fax number is available, the provider will receive a fax requesting the information needed, and the status of the PA will also be available via the Medi-Cal Rx Provider Portal for electronic submissions.
 - If a fax number is not available and the request was submitted electronically, the status of the PA will be available via the Medi-Cal Rx Provider Portal.
 - If a fax number is not available and the request was submitted via US Mail, an outbound call will be placed, and the status of the PA will also be available through the Medi-Cal Rx Provider Portal.
- Approval
 - If the information furnished by the provider satisfies the criteria, an approval is logged, and the PA is sent to the POS system in real-time so that it is available for claim adjudication.
 - The authorization will be approved for an appropriate duration based on medical necessity and DHCS guidelines.

- A fax and/or correspondence via the submission method will be sent to the requesting provider to inform them of the PA approval.
- Modifications
 - If a request is modified from the original request (strength, quantity, dosage form, etc.) by a Medi-Cal Rx vendor's or DHCS pharmacist and then approved as changed, it is considered "modified."
 - **Note:** This is different than a Change in Therapy, which is when a provider elects to prescribe an alternate medication that does not require a PA and essentially withdraws the PA request.
 - A Modification will generate a Notice of Action (NOA) to the requesting provider and member.
- Deferred
 - If additional information is needed, the case will be deferred, and the provider will be given the reason for the deferral. The case will be in a deferred status for up to 30 days.
 - The reason for deferral will be faxed to the requesting provider indicating the case status. If fax is not available, a letter will be mailed.
 - At the end of the 30 days, if no additional information is provided, an NOA will be sent to the requesting provider, authorized representative (if applicable), and member indicating a denial.
- Denial
 - If the clinical information received does not meet medical necessity and a denial is recommended following review by a Medi-Cal Rx pharmacist, a DHCS Pharmacist will review the case and make the final determination regarding whether the PA will be approved or denied.
 - **Note:** If the authorization is denied or modified, the Medi-Cal Rx vendor will notify the provider and mail appropriate notice to the member within 3 business days.
- PA Appeals
 - The Medi-Cal Rx vendor will review claims history and all past clinical information and will also review new data submitted with the appeal.
 - Providers have 180 days to submit an appeal from the date of the initial denial. If the 180th day falls on a Saturday, Sunday, or holiday, the final date to submit the appeal will be the next business day.

- Provider PA appeals will be accepted via the Provider Portal and via paper by Fax or US mail and must be explicitly noted as an appeal by stating the word “Appeal,” or by the provider selecting the appeal option via Provider Portal submission. Refer to [Appendix B – Directory](#) for mailing address and fax numbers to submit a provider PA appeal.
- Provider appeal requests must contain the date or service being appealed, the reason the appeal should be granted, and any additional documentation to support the appeal.
- Unless specifically noted as an appeal per the directions above, a second PA submitted for a previously denied request is treated as a new initial review.

Appeal Acknowledgement correspondence will be sent to the provider via fax or mail (when fax is unavailable) within one (1) calendar day of an appeal request.

The turnaround time is 60 days for a PA appeal.

Note: The Medi-Cal Rx vendor will send NOA letters to the provider, member, and authorized representative (when applicable) within three (3) business days from the date of the action requiring a letter.

While under review, Medi-Cal providers will be able to communicate with the Medi-Cal Rx staff and access the Medi-Cal Rx vendor’s electronic environment via a secure portal to assist with and resolve clinical pharmacy-related issues, including questions/concerns regarding Medi-Cal Rx timelines and decisions related to pending PA requests.

15.0 Program Specifications

15.1 Limitations

15.1.1 Dispensing Quantity Limitations

Refer to the following table for information on DHCS’ days’ supply dispensing policies and refill limitations.

Note: Certain drugs may have exceptions to the days’ supply limits or have specific quantity limits that supersede the rules described in *Table 15.1.1-1* below.

Description	Standard Limitation	Comments
Days' Supply	Prescription quantities must not be greater than a 100-calendar day supply.	<p>Examples of Exceptions:</p> <ul style="list-style-type: none"> • Oral Contraceptives <ul style="list-style-type: none"> – Can be filled for up to 365 days (1-year supply) at a time. • Self-administered hormonal contraceptives • When a greater days' supply is necessary to bypass the 100-calendar day supply limitation for a specific drug. <p>Note: Providers with questions regarding days' supply and days' supply exceptions can call the CSC at 1-800-977-2273 for assistance.</p>

Table 15.1.1-1: Dispensing Quantity Limitation Rules

15.1.2 Medical Supplies Dispensing Quantity Limitations

See *Table 15.1.2-1* below for dispensing limitations regarding medical supplies. Providers should submit a PA for quantities outside of/exceeding the limitations.

Medical Supply	Limitation(s) without PA
Basal Thermometer	1 per 365-day period
Cervical Cap, for contraceptive use, each	2 per 365-day period; 1 per dispensing
Contraceptive supply, condom, internal, each	No more than 12 per claim and no more than 2 claims per 90-day period.
Contraceptive supply, condom, male, each	36 per 30-day period
Diaphragm, contoured for contraceptive use	1 per 365-day period
Diaphragm, wide seal for contraceptive use	1 per 365-day period
Disposable Insulin Delivery Devices	PA only. For Omnipod, no more than 30 pods per 90-day period. For V-Go, no more than 90 pods per 90-day period.
Inhaler, Assist Devices (Spacer, bag, or reservoir, with or without mask, for use with metered dose inhaler)	2 per 365-day period
Peak Flow Meters, Non-Electronic	1 per 365-day period

Medical Supply	Limitation(s) without PA
Alcohol Pads	200 per 30-day period
Blood Pressure Cuffs	Code I restriction, cardiovascular diagnosis. 1 per 365-day period
Personal Home Blood Pressure Monitoring Devices	Code I restriction, cardiovascular diagnosis. 1 every 5 years
Blood glucose test strips	<p>Code I restriction, diagnosis of diabetes and using insulin:</p> <ul style="list-style-type: none"> Limited to up to six (6) per day, with a maximum of up to 600 in 100 days. <p>Code I restriction, diagnosis of diabetes and not using insulin:</p> <ul style="list-style-type: none"> Limited to up to one (1) per day, with a maximum of up to 100 in 100 days.
Blood ketone test strips	10 per claim and no more than three (3) claims in a 90-day period
Urine test strips	50 per claim and no more than four (4) claims in a 365-day period
Lancets	<p>Code I restriction, diagnosis of diabetes and using insulin:</p> <ul style="list-style-type: none"> Limited to up to six (6) per day, with a maximum of up to 600 (612 if using the Accu-Chek Fastclix Lancets) in 100 days. <p>Code I restriction, diagnosis of diabetes and not using insulin:</p> <ul style="list-style-type: none"> Limited to up to one (1) per day, with a maximum of up to 100 in 100 days.
Glucometers	Code I restriction, diabetic diagnosis. 1 every 5 years
Glucose control solution	Code I restriction, diabetic diagnosis. 1 per 365-day period
Lancing devices	Code I restriction, diabetic diagnosis. 1 per 365-day period
Pen needles	200 per 30-day period
Syringes, Insulin U-500	Restricted for use with Insulin, Regular U-500 only, 100 per 30-day period
Syringes, Insulin, any size	200 per 30-day period

Medical Supply	Limitation(s) without PA	
Sterile Syringes with Needles (non-insulin)	200 per 30-day period	
Continuous Glucose Monitoring (CGM) Systems	Receive/Reader	PA only. 1 every 365 days
	Transmitter	PA only. 1 every 90 days
	Sensor	PA only. Up to 3 every 30 days (based upon the specific manufacturer's recommended use)

Table 15.1.2-1: Medical Supplies Dispensing Quantity Limitations

15.1.3 Controlled Substance Policy

Claims for all controlled drug products, including opioids (DEA Schedule II-V) will have a **maximum days' supply** of 35 days. A PA will be required for claims submitted for greater than (>) 35 days.

Note: This limit does **not** apply to new-start opioid prescriptions, new-start benzodiazepine prescriptions, or buprenorphine products.

New-start opioid claims will be restricted to a 7-day supply or a maximum **quantity** of 30 solid dosage units (each) or 240 mL for liquids and new-start benzodiazepine claims will be limited to a 30-day supply. For additional information on what constitutes a *new-start*, see note below in *Table 15.1.3-1*.

Claims submitted for all injectable forms of opioids will require a PA. This does **not** apply to buprenorphine products (indicated for pain or addiction).

Claims submitted for *new-start* and subsequent fill(s) for opioids will be restricted to the following maximum daily quantity limits:

Maximum Quantity Per Day Limit(s) New-Start <i>and</i> Subsequent Fill(s)	
Dosage Form	Allowable Daily Limit
Solid Dosage Forms	8 each
Liquid Dosage Forms	60 mL
Transdermal Dosage Forms	1 each
Note: These limits do not apply to buprenorphine products.	

Table 15.1.3-1: Maximum Quantity Per Day Limit(s) New-Start *and* Subsequent Fill(s)

Claims submitted for *subsequent* fill(s) for opioids will be restricted to the following maximum quantities *per fill* shown in *Table 15.1.3-2*:

Maximum Quantity Per Fill Subsequent Fill(s)	
Dosage Form	Allowable Per Fill Limit
Solid Oral – Immediate Release	120 each
Solid Oral – <i>Extended Release</i>	90 each
Oral Liquids	180 mL
Parenterals	100 mL
Transdermal Dosage Forms	10 each
Note: These limits do not apply to buprenorphine products.	

Table 15.1.3-2: Maximum Quantity Per Fill Subsequent Fill(s)

As of October 1, 2019, DHCS will utilize current CDC guidelines to establish a maximum Morphine Milligram Equivalent (MME) at which the POS system will return a message to the pharmacy provider, notifying the provider of the excessive dose risk. A warning message will be returned to providers when 90 MME threshold has been exceeded. The message will provide a warning of CDC recommendation for maximum MME. When 500 MME has been exceeded, the claim will deny and require a PA.

The established MME thresholds will apply cumulatively, across all concurrent opioid prescriptions, allowing refill variance(s) equal to an Early Refill (ER) tolerance of 90 percent, indicated by a number of days (for example, 90 percent is 3 days early on a 30-day supply).

Note: New-start is defined as the absence of paid claims for opioids in the past 90 days prior to the current claim’s DOS (cough preparations containing opioids are excluded from this look back). Chronic use is defined as the presence of 90 days of any opioid therapy (including long-acting, short-acting, and buprenorphine products) in the past 120-day period.

The submission of DUR codes (see the [Prospective DUR](#) link on the [Drug Use Review](#) page on the [Medi-Cal Rx Provider Portal](#)) will **not** be allowed to override ER reject(s) for opioids.

The above limitations, with the exception of the maximum quantity per day outlined in *Table 15.1.3-1* and the 90 percent refill threshold mentioned above, will not apply to the following members:

- In LTC facilities
- In hospice
- Receiving palliative or end-of-life care
- With a diagnosis of sickle-cell disease
- In treatment for active cancer-related pain

15.1.4 Benzodiazepine Limitations

All **new-start** (the absence of *any* Benzodiazepine therapy in the past 90 days) Benzodiazepine claims will be limited to a maximum of a 30-day supply.

Exemptions:

- Members with documented history or submitted diagnosis of seizure disorders.

15.2 Partial Fills

Medi-Cal Rx will not accept partial fills.

- Claims submitted with the Dispensing Status code of 'P – Partial Fill' will deny for Reject Code RK – Partial Fill Transaction Not Supported.

15.3 Incremental Fills

Required by CA AB1048, a single prescription for a DEA Schedule II drug may be filled in multiple increments on separate claims (known as an incremental fill) only if ALL of the following conditions are met:

- All incremental fills must be processed by the same pharmacy.
- Total quantity dispensed for all incremental fills must not exceed the total quantity prescribed by the prescriber.
- Any quantity remaining on the prescription after 30 days from the date prescribed cannot be filled.

15.4 Claims Processing Edits

Once a claim has been submitted online by a pharmacy, the POS system will return a message to indicate the outcome. If the claim passes all edits, a PAID message will be returned with the allowed reimbursement amount. A claim that fails an edit(s) and is REJECTED or DENIED will return with a reject code and message. Refer to [Appendix D – NCPDP Reject Codes](#) for a list of reject codes.

Note: For paper claims that have been submitted *and* processed, the claim outcome will be visible via the POS system, Provider Portal, or on the RA.

15.5 Dispense as Written (DAW) Codes

The Medi-Cal Rx vendor will accept the Dispense as Written (DAW) codes in *Table 15.5-1* below. DHCS will allow any DAW code to be submitted on the claim, but use of a DAW code will not override any claim edits (such as pricing or PA requirement(s)). For example, a PA may still be required when a brand name drug is prescribed.

DAW Code	DAW Description	Action
DAW 0	No Product Selection Indicated	Allowed
DAW 1	Substitution Not Allowed by Prescriber	Allowed
DAW 2	Substitution Allowed-Patient Requested Product Dispensed	Allowed
DAW 3	Substitution Allowed- Pharmacist Selected Product Dispensed	Allowed
DAW 4	Substitution Allowed- Generic Drug Not in Stock	Allowed
DAW 5	Substitution Allowed-Brand Drug Dispensed as a Generic	Allowed
DAW 6	Override	Allowed
DAW 7	Substitution Not Allowed-Brand Drug Mandated by Law	Allowed
DAW 8	Substitution Allowed-Generic Drug Not Available in Marketplace	Allowed
DAW 9	Substitution Allowed by Prescriber but Plan Requests Brand	Allowed

Table 15.5-1: Allowed DAW Codes

15.6 Cost Ceiling

Medi-Cal Rx will have a cost ceiling for all drugs of \$10,000.00, except for select drugs contained in the following classes (*Table 15.6-1* below).

Exempt from Cost Ceiling	
Description	Comments
Bleeding Disorders Drugs (including antihemorrhagic, and sickle cell disease drugs)	
Immune Globulins	
Antineoplastics (including colony-stimulating factors)	
Anticonvulsants	

Exempt from Cost Ceiling	
Description	Comments
Psycholeptics (including antipsychotics, sedatives/ hypnotics), and Antidepressants	The following drugs will <i>not</i> be included in the cost-ceiling exception and, therefore, the \$10,000.00 limit will apply: <ul style="list-style-type: none"> • Clonidine HCL • Guanfacine HCL • Chlormezanone • Atomoxetine HCL • Armodafinil • Solriamfetol HCL
Immunosuppressive and Immunomodulators (including MS drugs and MG)	
Systemic Antivirals (including HIV and hepatitis drugs)	
Metabolic Disorder Agents	
Cystic Fibrosis Drugs	
Bile Therapies	
Respiratory Drugs	
Systemic Hormonal Agents	
Pulmonary Hypertension Agents	
Ophthalmic Human Growth Factor Agents	
C1 Esterase Inhibitors	
Pyrimethamine	
Transfer Protein Inhibitor Agents	
SBS - GLP-2 Analogs	
Plasma Kallikrein Inhibitors	

Table 15.6-1: Cost-Ceiling Exemptions

Note: Providers have the following two (2) options to override a Cost-Ceiling rejection:

- Providers can call the CSC (1-800-977-2273) for a real-time override (if criteria are met).
- Providers can request a PA, and if criteria have been met, a PA will be approved (this option will eliminate the need for a provider to call into the CSC for every fill for the drug/product within the approved PA time frame).

15.7 Emergency Fills

15.7.1 >>Emergency Dispensing of 14-Day Supply

>>Beginning February 6, 2022, dispensing of a 14-day emergency supply of all products that are Medi-Cal Rx benefits for which delays in access to therapy due to utilization management (UM) claim edits would withhold a medically necessary service is permitted electronically and via paper claim. Pharmacy Emergency Dispensing is exempt from PA request or Code I requirements. The pharmacist shall self-certify the emergency existed in accordance with CCR, Title 22, Section 51056(c). Emergency fills will be subject to audits, and providers are required to retain documentation of the emergency circumstances for audit purposes.

>>Electronically billed emergency claims will be limited to a 14-day supply and a limit of two fills in a 30-day period for the same product and dose. Claims must be submitted at POS using the Level of Service (LOS) value of '3 – Emergency' to indicate it is an emergency claim (refer to [Medi-Cal Rx Billing Tips](#) for additional information). When an emergency claim is submitted for unbreakable packages such as inhalers, vials, oral contraceptives, etc., the claim will deny with this supplemental message, *"Pharmacist certification of emergency service: For Emergency Fill for an unbreakable package covering more than a 14-day supply submit submission clarification code (SCC) = 65."* Emergency claims for unbreakable packages submitted with LOS = 3 and SCC = 65 will continue to be paid for the full package size even when the days' supply exceeds 14 days.

Note:

- >>If the emergency situation requires a dispensed quantity to exceed a 14-day supply for breakable packages, the provider must submit a paper claim for the service.
- >>Any policy reject codes may be overridden for emergency purposes with the exception of any eligibility edits (including those with an SOC) and OHC reject codes.
- >>For DOS prior to February 6, 2022, electronically billed emergency drug dispensing claims were limited to a 3-day supply and a limit of two fills in a 30-day period for the same drug and dose.

15.7.2 Emergency Dispensing for Out-of-State Providers

A PA request is required for **all** out-of-state services, except for emergency services as defined in CCR, Title 22, Section 51056(c).

15.7.3 Protocol for Overriding Utilization Management (UM) During State of Emergency

During a Federal, State, or locally declared state of emergency, DHCS may authorize providers to override specific claims edits. The authorization may apply to specific counties and/or specific populations as directed by DHCS.

DHCS will notify providers when state of emergency overrides are activated via the [Medi-Cal Rx Web Portal](#), including any applicable restrictions.

15.8 Physician Administered Drugs (PADs)

A PAD is an outpatient drug that is typically administered to a member and billed by a health care provider in locations that include, but are not limited to, physician's offices, clinics, and hospitals, and are not self-administered by a member or caregiver. If a drug is administered by a health care provider other than a pharmacy provider in a pharmacy setting, and not self-administered by the member or caregiver even if the drug is FDA-approved for self-administration, that drug would primarily be considered a medical benefit by merit of the administration by a medical provider. Therefore, the same policy pertaining to other non-self-administered drugs (that is, those not FDA-approved for self-administration) would apply. As such, PADs not administered by a pharmacy provider in a pharmacy setting or dispensed for self-administration are considered a medical benefit.

15.8.1 Coverage

PADs eligible for coverage via Medi-Cal Rx are found on the [Medi-Cal Rx Contract Drugs List](#) (CDL) and the [Medi-Cal Rx Pharmacy Reimbursable Physician Administered Drugs](#) list. Refer to the Covered Products Lists tab on the [Forms & Information](#) page of the [Medi-Cal Rx Provider Portal](#).

Claims submitted to Medi-Cal Rx for PADs are subject to PA request requirements. If PA request requirements apply, pharmacies will only be reimbursed by Medi-Cal Rx with an approved PA request and the claim billed pursuant to claim field requirements provided in the Payer Specifications (see [Appendix A – NCPDP Payer Specification Sheet](#)).

15.8.2 Reject Code 816

Drugs found in [Appendix H – List of Physician Administered Drugs \(PADs\) with Reject Code 816](#) will reject with Reject Code 816 – Pharmacy Benefit Exclusion, May Be Covered Under Patient's Medical Benefit with the following supplemental message: *"Pharmacy Drug Benefit Exclusion. Exception for pharmacy benefit approval may be considered via PA request. May be covered as a medical benefit."* Claims denying with Reject Code 816 should be submitted as a medical claim to the member's respective MCP or through the Medi-Cal fee-for-service delivery system as applicable.

PADs with Reject Code 816 PA Request Requirements:

An exception for coverage of PADs with Reject Code 816 via Medi-Cal Rx may be considered upon PA request submission. Certain situations that may warrant an exception, requiring a claim and PA request submission for the PAD to Medi-Cal Rx, may include but are not limited to the following:

- The medical provider is unable to access a specific PAD, and they may obtain it from a local or mail-order pharmacy.
- The PAD will be dispensed by the pharmacy provider and be administered via home infusion.

- The manufacturer has limited the distribution of the PAD to certain specialty pharmacies and/or distributors of specialty drugs.
- The member requires immediate access to the PAD and the administering provider is unable to provide and bill it as a medical claim.

Only after it has met the exception criteria will the PAD PA request be assessed for medical necessity. The following information must be included on the PA request submission:

- If a PA request is submitted for PADs, providers must include rationale for why the PAD must be billed as a pharmacy claim to Medi-Cal Rx and cannot be billed as a medical claim to the medical benefit for coverage; **and**
- Providers must include clinical rationale to determine medical necessity for PAD therapy.

It is important to remember that exceptions will be made on a case-by-case basis via a Medi-Cal Rx approved PA request and only when absolutely necessary. Once a PA request is approved by Medi-Cal Rx, a pharmacy provider may order, fill, and submit a pharmacy claim for the PAD. The PAD may then be sent to an administering provider to administer the drug appropriately.

15.8.3 MCP Obligation

Medi-Cal members should not be directed to obtain PADs from a pharmacy unless the PAD is found on the CDLs or [Medi-Cal Rx Pharmacy Reimbursable Physician Administered Drugs](#) list or there is a warranted exception. PA request approvals of PADs billed by pharmacy providers are not intended to replace PAD coverage as a medical benefit. PADs will always remain a medical benefit even when made available as a pharmacy benefit on a case-by-case basis. If a medical provider bills for a pharmacy drug as part of a medical visit or incidental to a medical visit, it should be treated as a medical claim, even if the drug is typically considered a pharmacy drug. MCPs should not deny such claims on the basis of their classification as a pharmacy claim. It is important to recognize that such claims are, in fact, medical claims and should be treated as such.

15.9 Pharmacy Administered Immunizations/Vaccines

California law authorizes pharmacists to administer immunizations (that are covered under the CDL (which can be found on the [Medi-Cal Rx Provider Portal](#) by selecting [Forms & Information](#)) pursuant to a legal prescription, a protocol with a prescriber (Business and Professions Code [Bus & Prof Code] Section 4052), or pharmacist initiated pursuant to (Bus & Prof Code Section 4052.8 and CCR, Title 16, Section 1746.4).

Pharmacy administered immunizations and vaccines are a Medi-Cal covered pharmacy benefit and a Medi-Cal covered medical benefit.

Pharmacies are reimbursed for vaccines in a similar method as other pharmacy claims (see [Section 4.6.1 – Legend and Non-Legend Drugs](#) for reimbursement information).

A professional dispensing fee is also paid for fee-for-service pharmacy reimbursement (see [Section 4.6.2 – Professional Dispensing Fee](#)).

Administration fees and Evaluation and Management services associated with initiating the prescription (Bus & Prof Code Section 4052.8 and CCR, Title 16, Section 1746.4) must be billed to either the MCP or fee-for-service Medi-Cal whichever is applicable. For fee-for-service Medi-Cal claims, see [Section 15.12 – Pharmacist Services](#) for billing instruction.

Most vaccines are covered without a PA for Medi-Cal members 19 years of age and older. Medi-Cal members aged 18 years and younger are eligible for the Vaccine For Children's (VFC) Program. Pharmacies participating in the VFC program may be reimbursed for the administration only. Additional vaccine restrictions may be applicable and are listed in the CDL. Immunizations/vaccines covered as a Medi-Cal Rx pharmacy benefit are found in the CDL, otherwise they are covered under the member's medical benefit(s).

15.10 Intravenous or Intra-Arterial Solutions

Simple Intravenous (IV) solutions are typically used for hydration therapy. Commercially available (non-compounded) solutions such as Normal Saline, Dextrose (up to 10 percent in Water) and Lactated Ringer's Solution, as well as commercially prepared solutions of potassium chloride in such solutions are included in this definition. Simple IV solutions should be billed using the product's NDC number.

Parenteral Nutrition Solutions (Total Parenteral Nutrition [TPN] or Hyperalimentation):

These solutions are restricted to dispensing within 10 days following inpatient discharge from an acute care hospital when IV therapy with the same product was started before discharge without prior authorization. There is a maximum of 10-day supply per dispensing within this 10-day period.

Parenteral nutrition solutions are intravenously or intra-arterially administered nutritional products that are typically suspensions or solutions of amino acids or protein, dextrose, lipids, electrolytes, vitamin and/or mineral supplements, and trace elements.

Adjuncts to parenteral nutrition are other drugs which are physically mixed into a parenteral nutrition solution at any time prior to administration. Bill for these products as part of the parenteral nutrition billing.

Note: Non-compounded products must be billed using the product's NDC number. Compounded solutions must be billed as a compound claim. For information regarding specific fields that must be entered for successful transmission of transactions, refer to [Appendix A – NCPDP Payer Specification Sheet](#).

Separately Administered IV Lipids:

These solutions are restricted to dispensing within 10 days following inpatient discharge from an acute care hospital when IV therapy with the same product was started before discharge without prior authorization. There is a maximum of 10-day supply per dispensing within this 10-day period.

IV lipid solutions or suspensions that are administered separately from parenteral nutrition solutions (that is, are not physically mixed into the parenteral nutrition solution container) should be billed using the product's NDC number.

IV Solutions of Unlisted Antibiotics:

Restricted to dispensing within 10 days following inpatient discharge from an acute care hospital when IV therapy with the same antibiotic was started before discharge without prior authorization. There is a maximum of 10-day supply per dispensing within the 10-day period.

Note: Non-compounded products must be billed using the product's NDC number. Compounded solutions must be billed as a compound claim. For information regarding specific fields that must be entered for successful transmission of transactions, refer to [Appendix A – NCPDP Payer Specification Sheet](#).

IV Solutions of Other Unlisted Drugs:

Restricted to dispensing within 10 days following inpatient discharge from an acute care hospital when IV therapy with the same drug was started before discharge without prior authorization. There is a maximum of 10-day supply per dispensing within the 10-day period.

Note: Non-compounded products must be billed using the product's NDC number. Compounded solutions must be billed as a compound claim. For information regarding specific fields that must be entered for successful transmission of transactions, refer to [Appendix A – NCPDP Payer Specification Sheet](#).

Sterile Transfers:

Restricted to dispensing within 10 days following inpatient discharge from an acute care hospital when IV therapy with the same drug was started before discharge. There is a maximum of 10-day supply per dispensing within the 10-day period.

The following sterile transfers require prior authorization:

- Creating "unit-dose" injections from multiple dose products, regardless of time of discharge.
- Claims for more than seven containers, regardless of the 10-day post-discharge window or Contract Drugs List status.

Note: Non-compounded products must be billed using the product's NDC number. Compounded solutions must be billed as a compound claim. For information regarding specific fields that must be entered for successful transmission of transactions, refer to [Appendix A – NCPDP Payer Specification Sheet](#).

Note: Additional information on IV Administration Sets for fee-for-service members can be found in the Medical Supply section of the [DHCS Provider Manual \(Part 2\)](#).

15.11 Blood and Blood Derivatives

Blood Factors: Billing for Bleeding and Clotting Disorders:

Pharmacies must bill blood factor products using the NDC via a pharmacy claim form. Attachments are not required. Pharmacies may submit claims for clotting factors via POS or paper claim form.

For reimbursement information related to Blood and Blood Derivatives see [Section 4.6.16 – Blood and Blood Derivatives Reimbursement](#).

Contracted Providers:

To meet the unique specialized care needs of the Medi-Cal Rx population who utilize specialty drugs, only contracted providers are eligible to provide contract blood factors to Medi-Cal, CCS, and GHPP members. A list of the contracted specialty providers who are eligible to provide those blood factors included in the contract blood factor list is available on the DHCS website (<https://www.dhcs.ca.gov/provgovpart/pharmacy/Pages/BloodFactors.aspx>).

Coagulation factors for bleeding disorders, such as hemophilia, represent the first class of specialty drugs to utilize provider contracts. These products are identified in W&I Code 14105.86(a)(2)(A). The DHCS will contract with any specialty pharmacy that will sign a contract to meet a list of performance obligations. These include, but are not limited to, delivery time requirements, providing patient education and submitting quarterly and yearly reports to DHCS.

Providers who wish to enroll as Specialty Contracted Providers for clotting factor(s) must enroll through the PED by submitting enrollment form MC3155 – Medi-Cal Specialty Pharmacy Provider Application. This form can be found in the Forms section of the DHCS website (<https://mcweb.apps.prd.cammiis.medi-cal.ca.gov/references/forms>).

For information on contracted clotting factors see the CDL on the [Medi-Cal Rx Web Portal](#).

Continuing Care:

Medi-Cal Rx will provide reimbursement for blood factors marked “authorization required” only with an approved PA request or the member qualifies for continuing care. To be eligible for continuing care and exemption from the authorization requirement, the following conditions must be met:

- The member must be taking the drug when it is suspended or deleted from the [Medi-Cal Rx Contract Drugs List – Blood Factors](#).
- The Medi-Cal Rx vendor must have received a claim for the drug, in the same dosage form and strength, within 100 days prior to the drug’s end date or suspension. The [Medi-Cal Rx Provider Portal](#) will allow a provider to look up a member and view that member’s claims (only showing claims for the NPI of the provider who logged in). Any member claims history is only available via the Medi-Cal Rx Provider Portal after a provider has securely logged in to the [Medi-Cal Rx Secured Provider Portal](#).

To maintain member eligibility under continuing care, a claim must be submitted for the drug, in the same dosage form and strength, at least every 100 days from the date of service. The member may switch between brands of the drug in the same dosage form and strength and maintain their continuing care status.

15.12 Pharmacist Services

Pursuant to Assembly Bill (AB) 1114, Chapter 602, Statutes of 2016 added W&I Code Section 14132.968, DHCS is required to establish reimbursement and policy for pharmacist services, provided to a Medi-Cal recipient. These services include:

- Furnishing naloxone.
- Furnishing self-administered hormonal contraception.
- Initiating and administering immunizations.
- Furnishing nicotine replacement therapy.
- Furnishing travel medications.

Note: The services mentioned above **are not** a Medi-Cal Rx benefit. These services must be billed using applicable CPT codes on a *CMS-1500* health claim form, **NOT** a pharmacy claim (submitted via POS or paper).

For additional information and billing requirements, refer to the [DHCS Provider Manual \(Part 2\)](#) on the DHCS site.

15.13 Authorized Drug Manufacturer Labeler Codes

Providers will only be reimbursed for drugs made by manufacturers identified in the [Medi-Cal Rx Contract Drugs List – Authorized Drug Manufacturer Labeler Codes](#) (which can be found on the [Medi-Cal Rx Provider Portal](#) by selecting [Forms & Information](#)). If a claim is submitted for a nonauthorized labeler code, providers will not be reimbursed.

15.14 >>Compound Processing

>>Compound claims may be submitted via the POS system, batch file submission, web claim submission, a Universal Claim Form (see [Section 19.1 – Universal Claim Form, Version D.0](#)), or a [California Specific Compound Pharmacy Claim Form \(30-4\)](#) (see [Section 19.2.2 – California Specific Compound Pharmacy Claim Form \(30-4\)](#)).

Any component of a compound requiring a PA will necessitate an approval prior to receiving payment.

Prescribed drugs listed in the CDL (which can be found on the [Medi-Cal Rx Provider Portal](#) by selecting [Forms & Information](#)) and unlisted drugs approved by authorization that require special compounding by the pharmacist are covered by Medi-Cal Rx, provided that the name of the product(s), quantity of the ingredient(s), and valid NDC(s) of each ingredient are listed on the claim.

Note: Select medical supplies, diabetic supplies, enteral nutrition products, and blood factors may not be billed on a *California Specific Compound Pharmacy Claim Form (30-4)*.

The *California Specific Pharmacy Claim Form (30-1)* must be completed for non-compounded Intravenous (IV) solutions.

The *California Specific Compound Pharmacy Claim Form (30-4)* must be completed for compounded IV solutions or sterile transfers.

Note: If providers are submitting a *California Specific Compound Pharmacy Claim Form (30-4)*, Box 48 (Specific Details/Remarks) **must** have the SNOMED value of the claim.

See the important notes for compound claim submission in *Table 15.14-1* below.

#	Description
1	Compounds will be processed using the Multi-Ingredient Compound functionality as provided by NCPDP version D.0.
2	The Claim Segment Product ID (which is the NDC) is defined as a mandatory field and, therefore, must be submitted for all claims, including multi-ingredient compounds.
3	A nonblank space value is expected in the Claim Segment Product ID field for field validation. The pharmacy submits '0' zero in this field for a multi-ingredient compound. For compound segment transactions, the claim is rejected with the appropriate NCPDP response reject code and message if zero is not submitted as the Product ID.
4	<p>A Submission Clarification Code value of "8" only allows a claim to continue processing if at least one ingredient is covered. Nonapproved labeler ingredients will process with the SCC; but only approved labeler ingredients are eligible for reimbursement. NDCs that require authorization will not receive a payment unless a provider resubmits the claim after an approved PA has been granted.</p> <p>Note: For compound claims where an ingredient in the compound also has a Code I restriction, both the SCC = 8 <i>and</i> the SCC = 7 will have to be billed on the same claim. Alternatively, providers have the option to submit the applicable ICD-10 diagnosis code on the incoming claim to satisfy the Code I Restriction (see Section 11.1 – Code I Restrictions). Providers may contact the CSC at 1-800-977-2273 for assistance regarding SCCs.</p>
5	Pharmacies must transmit the same NDC numbers that are being used to dispense the medication.
6	All compounds must contain at least two ingredients. The Medi-Cal Rx vendor will accept up to 25 ingredients. Compound claims with <i>more</i> than 25 ingredients will not be accepted and will deny with Reject Code 9K – Cmpd Ing Component Cnt Exceeds Num Ing Supported.

#	Description
7	Single ingredient compound claims will not be accepted. These claims will deny with Reject Code 7Z – Compound Requires Two or More Ingredients with the supplemental message “ <i>Compounds must contain at least two ingredients. Compounds with container NDC must also include at least one active compounded ingredient.</i> ”
8	Based on the submitted ingredient cost data per ingredient, if the total submitted ingredient cost on the claim is not equal to the sum of the ingredients’ costs, the claim will deny. Example: A compound with two ingredients is submitted for a total claim cost of \$50. Ingredient A has a submitted cost of \$20 and Ingredient B has a submitted claim cost of \$10; the claim will deny because the sum of the submitted claim cost for both ingredients (A & B) totaled \$30, but the total claim cost was indicated to be \$50.
9	Multiple instances of an NDC within a compound will not be allowed. These claims will deny with Reject Code 21 – M/I Product/Service ID with the supplemental message “ <i>Duplicate compound ingredients are not allowed.</i> ”
10	Duplicate Edits are applied to compounds
11	For ProDUR processing, the compounds are matched on the number of ingredients and same ingredients. Excipient drugs are excluded from the comparison logic. Excipient Drugs/Products include: <ul style="list-style-type: none"> • Sodium/Saline Preparations • IV Solutions: Dextrose Water • Water • Irrigants • Flavorings • Cream bases • Ointment bases
12	SNOMED is a required field for compounds – the route of administration is required – NCPDP # ROUTE OF ADMINISTRATION (Field # 995-E2) Note: If providers are submitting a <i>Compound Claim Form (30-4)</i> , Box 48 (<i>Specific Details/Remarks</i>) must have the SNOMED value of the claim. If providers are submitting a <i>Universal Claim Form (UCF)</i> , Field 66 must have the SNOMED value of the claim.
13	There are dispensing fees applicable for compounds. See Section 4.6.7 – Compound Prescriptions for compound claim reimbursement information.

#	Description
14	<p>Coverage for compounds is the same as non-compounds with exceptions. There are specific products that are not allowed in compounds.</p> <p>The products not allowed in compounds are:</p> <ul style="list-style-type: none"> • Blood Factors • Bulk Ingredients • Condoms • Control Solutions • Diabetic Supplies • Diaphragms/Cervical Caps • Enteral Nutrition Products • Glucometers • Heparin Saline Flush • Incontinence Supplies • Inhaler Assist Devices • Lancing Devices • Medical Supplies • Nutritionals • Pen Needles • Peak Flow Meters <p>These products used within a compound will deny with Reject Code 70 – Product/Service Not Covered with the additional message <i>"Ingredient used is not covered within a compound."</i></p>
16	<p>The container NDC 9999999997 is to be submitted on claims unless it is for a non-injectable compound. The maximum allowed containers submitted per claim on an injection/infusion compound is 20, without prior authorization. If a claim is submitted with more than 20 containers and there is not an approved PA, the claim will deny with Reject Code 76 – Plan Limitations Exceeded with the additional message <i>"Compound container limit exceeded. Prior Authorization Required."</i></p> <p>Note: If the container NDC is not submitted on an injectable or infusion compound, adjudications will assume one container.</p>
17	<p>Compounds are not a covered benefit of Family PACT. These claims will deny with Reject Code 7Y – Compounds Not Covered with the supplemental message <i>"Compounds are not a covered benefit of FPACT."</i></p>

Table 15.14-1: Compound Claim Submission Notes

Note: Refer to [Appendix A – NCPDP Payer Specification Sheet](#) for fields required for claim submission using the POS system.

15.15 Mass Claim Adjustment(s)

Automated claim adjustments are an integrated part of the claim process and will allow re-adjudication with new and/or corrected rules or parameter settings applied that will reverse and rebill claims with the corrected values. The mass claim adjustment process includes identifying the impacted claims by applying a predetermined set(s) of parameters, reversing them, and then reprocessing the transaction to correct the issue.

Mass claim adjustment requests are initiated (typically by DHCS) for any one or more of the following reasons:

- Drug Pricing
- Drug Coverage
- Provider Dispensing Fee Rates
- Share of Cost
- Eligibility
- COB

15.16 Electronic Prescribing (ePrescribing)

Electronic Prescribing (ePrescribing) is the use of an automated data entry system to generate a prescription, replacing the use of handwritten prescriptions.

Electronic prescriptions are computer-generated prescriptions created by the prescriber and sent directly to the member's pharmacy of choice. ePrescribing applications that are certified by SureScripts (the industry leader in ePrescribing), allow new prescription orders and refill authorizations from the prescriber to be sent directly to the computers of the selected pharmacies.

15.16.1 ePrescribing Process

Instead of writing the prescription on a piece of paper, the prescriber enters it directly into an automated data entry system to the pharmacy's computer using a private, secure, and closed network. The ePrescribing process eliminated the need for the member to take a hard copy of the prescription to the pharmacy, saving time and facilitating prescription accuracy.

The Medi-Cal Rx vendor has contracted with SureScripts, the industry leading vendor for ePrescribing.

General information on activated pharmacies with ePrescribing capabilities and that utilize SureScripts within California can be found at www.surescripts.com. Physicians interested in automating the prescribing process must utilize an ePrescribing or Electronic Medical Record (EMR) system that has been certified to connect to the Pharmacy Health Information Exchange, operated by SureScripts.

15.17 End of Life Option Act Services

The End of Life Option Act is a California Law that permits terminally ill adult recipients with the capacity to make medical decisions to be prescribed an aid-in-dying medication if certain conditions are met.

The law is outlined in California *Health and Safety Code* (H&S Code), Division 1, Part 1.85, Section 443.

15.17.1 Pharmacy Billing for End of Life Option Act Services

Medi-Cal Rx will not cover end of life services. End of life services claims submitted via the POS system, *Universal Claim Form (UCF)*, *California Specific Pharmacy Claim Form (30-1)*, or *California Specific Compound Pharmacy Claim Form (30-4)* are not permitted and will be denied.

Pharmacies must bill for end of life services on the *CMS-1500* claim form only. Providers can refer to the [DHCS Provider Manual \(Part 2\)](#) for additional information on the End of Life Services Act and billing information.

16.0 Drug Use Review (DUR)

16.1 DUR Program Overview

Federal rules require that each state Medicaid program include a comprehensive Drug Use Review (DUR) program to improve the quality and cost effectiveness of drug use by ensuring that prescriptions are appropriate, medically necessary, and not likely to result in adverse medical results.

California's Medicaid DUR program is focused on outpatient medication therapies with the broad goals of improving patient outcomes, increasing the quality of prescribing practices, reducing healthcare costs, and improving member, prescriber, and pharmacist satisfaction. To work towards these goals, the DUR program implements strategies that identify and reduce adverse events, fraud, misuse, overutilization, underutilization, and inappropriate/ineffective care associated with specific drugs or groups of drugs. Strategies for improving prescribing medications may include education, data reports, audits, alerts, incentives, decision-making tools, and outreach aimed at members, prescribers, and pharmacists.

There are three key functions of the DUR program Prospective DUR:

- Retrospective DUR
- Educational Outreach
- Information on the three functions above can be found on the [Medi-Cal Rx Provider Portal](#) by selecting Tools and Resources, and then selecting [Drug Use Review](#).

Central to the DUR program is the Global Medi-Cal DUR Board, which is an advisory board that includes volunteer pharmacists and physicians with active practices in California. The Board advises and makes recommendations to the State on common drug therapy problems;

develops criteria to evaluate and improve the quality of drug therapy, reviews, evaluations, and utilization reports; and recommends educational interventions, as needed, in order to improve prescribing and dispensing practices.

The DUR program promotes patient safety through state-administered utilization management tools and systems that interface with the claims processing systems. Additional, consistent with 42 CFR §438.3(s)(4) and (5), the Centers for Medicare and Medicaid Services (CMS).

Note: Prospective (concurrent) DUR edits will apply to all real-time claim types (i.e., POS, Web). Edits will not apply to Paper and Batch claims. Also, prior to 4/1/2021, claim adjudication would allow submission of only the major conflict code to satisfy all DUR conflicts on the claim. Effective April 1, 2021, the pharmacy must submit each DUR conflict code on the claim.

Claims that deny for DUR will deny with Reject Code 88 – DUR Reject Error.

16.1.1 Medi-Cal Rx DUR/PPS Codes for Opioid MME Alert

The following 'HC' Reason for Service code in *Table 16.1.1-1* may be submitted for a single MME claim or cumulative MME across multiple claims where the MME is greater than 90 and less than 500.

Reason for Service Code (NCPDP Field ID: 439-E4)

Value	Description	Definition
HC	High Cumulative Dose	Detects high cumulative drug dose(s) for a single MME claim, or across multiple claims that fall above the standard dosing range.

Table 16.1.1-1: Reason for Service Code (NCPDP Field ID: 439-E4)

Professional Service Code (NCPDP Field ID: 440-E5)

In addition to codes accepted for other ProDUR alerts (see the [Prospective DUR](#) link on the [Drug Use Review](#) page on the [Medi-Cal Rx Provider Portal](#)), for Opioid MME alerts, the Medi-Cal Rx vendor will also accept the following codes in *Table 16.1.1-2*:

Value	Description	Definition
CC	Coordination of care	Case management activities of a pharmacist related to the care being delivered by multiple providers.
DE	Dosing evaluation/determination	Cognitive service whereby the pharmacist reviews and evaluates the appropriateness of a prescribed medication's dose, interval, frequency and/or formulation.
DP	Dosage evaluated	Code indicating that dosage has been evaluated with respect to risk for the patient.

Table 16.1.1-2: Professional Service Code (NCPDP Field ID: 440-E5)

Result of Service Code (NCPDP Field ID: 441-E6)

In addition to codes accepted for other ProDUR alerts (see the [Prospective DUR](#) link on the [Drug Use Review](#) page on the [Medi-Cal Rx Provider Portal](#)), for Opioid MME alerts, the Medi-Cal Rx vendor will accept the following codes in *Table 16.1.1-3*:

Value	Description	Definition
4B	Dispensed, Palliative Care	The pharmacist reviews and evaluates a therapeutic issue (alert) and dispenses the prescription, because it is being used for palliative care.
4C	Dispensed, Hospice	The pharmacist reviews and evaluates a therapeutic issue (alert) and dispenses the prescription, because the patient is in hospice.
4D	Dispensed, Cancer Treatment	The pharmacist reviews and evaluates a therapeutic issue (alert) and dispenses the prescription, because the patient has or is being treated for cancer.
4E	Dispensed, Chronic Pain	The pharmacist reviews and evaluates a therapeutic issue (alert) and dispenses the prescription, because the patient is being treated for chronic pain.
4F	Dispensed, Exempt Per Prescriber	The pharmacist reviews and evaluates a therapeutic issue (alert) and dispenses the prescription due to an exemption as written/communicated by the prescriber.
4G	Dispensed, Surgery/Trauma	The pharmacist reviews and evaluates a therapeutic issue (alert) and dispenses the prescription, because the patient is having or has had a major surgery or trauma.
4H	Dispensed, Hospital Admission/Discharge	The pharmacist reviews and evaluates a therapeutic issue (alert) and dispenses the prescription because the patient is being admitted to or is being discharged from a hospital.
4J	Dispensed, Patient is Not Opioid Naïve	Patient medication history demonstrates patient is not opioid naïve based on clinical guidelines, medication prescribed/dispensed without change.

Table 16.1.1-3: Result of Service Code (NCPDP Field ID: 441-E6)

16.2 Patient Counseling Requirements

Pursuant to FEDERAL STATUTORY REQUIREMENT: Section 1927(g)(2)(ii)(I) of the Act, the pharmacist is required to discuss with each Medicaid member or a caregiver, in person whenever practicable, or by toll-free telephone for long distance calls, matters which, in their professional judgment, the pharmacist deems significant. Such counseling is subject to standards for counseling to be established under state law (*State Pharmacy Practice Act*). Such counseling is to be provided unless refused by the Medicaid member or caregiver.

The statute lists the following subjects for inclusion in counseling:

- The name and description of the medication.
- Dosage form, dose, route of administration, and duration of drug therapy.
- Special directions and precautions for preparation, administration, and use by the patient.
- Common severe side or adverse effects or interactions and therapeutic contraindications that may be encountered, including how they may be avoided, and the actions required if they occur.
- Techniques for self-monitoring drug therapy.
- Proper storage.
- Prescription refill information.
- Action to be taken in the event of a missed dose.

Impact on Pharmacies

Pharmacy providers must observe the following guidelines regarding counseling:

- The pharmacist is responsible for personally conducting the counseling in accordance with the requirements of the California State Board of Pharmacy, CCR, Title 16, Section 1707.2.
- Counseling requirements apply to both new and refill prescriptions, except in situations where the patient's agent is not readily available to receive a counseling offer or the counseling itself.
- Documentation in the form of a signature by the patient or patient's agent is required only if counseling is refused and must be retained in the pharmacy for at least one year from the date of making. Pharmacies are exempt from this requirement during the Coronavirus disease 2019 (COVID-19) public health emergency.
- Pharmacies whose primary patient population is accessible through local measures or toll-free exchange are not required to offer toll-free service for long distance calls.

16.2.1 Patient Record Keeping (Medication Records)

Pursuant to FEDERAL STATUTORY REQUIREMENT: Section 1927(g)(2)(A)(ii)(II) of the Act, the pharmacist is required to make a reasonable effort to obtain, record, and maintain for Medicaid members the following information:

- Name, address, phone number, age (or birth date), and gender.
- Individual history where significant, including disease state(s), known allergies, drug reactions, a comprehensive list of medications and relevant devices.

- Pharmacist's comments relevant to the individual's drug therapy.

Impact on Pharmacies

The pharmacist is responsible for collecting, recording, and maintaining the above patient medication record information in accordance with the requirements of the California State Board of Pharmacy, CCR, Title 16, Section 1707.1.

The pharmacist may rely upon ancillary personnel to collect, record, and obtain patient information for their medication record, but the pharmacist must review and interpret that information and clarify confusing or conflicting information.

It is expected that the pharmacist will be guided by professional judgment as to whether and when individual history information should be sought from the patient's physician or other health care providers.

16.3 Automatic Refill Programs for Members

In general, a pharmacy may offer a program to automatically refill prescriptions to members, provided the pharmacy complies with CCR Title 16, Section 1717.5.

Note: CGM systems are excluded from the automatic refill program. See [Section 13.4 – Diabetic Supplies – CGM Systems](#).

1. A pharmacy may offer a program to automatically refill prescriptions provided the pharmacy complies with this section.
 - a. The pharmacy shall have written policies and procedures describing the program, which shall set forth, at a minimum, how the pharmacy will comply with this section.
 - b. Before a member enrolls, the pharmacy shall provide a written or electronic notice summarizing the program to the member or member's agent. Such notice shall include, at a minimum, instructions about how to withdraw a prescription medication from refill through the program or to disenroll entirely from the program. The member or member's agent shall enroll by written, online, or electronic informed consent to participate in the program for each new prescription, or there is a change in the prescription medication, strength, dosage form, or directions for use.
 - c. For each prescription to be refilled through the program, the pharmacy shall obtain annual renewal of each prescription from the member or member's agent no later than 12 months after the prescription was enrolled in the program.
 - d. The pharmacy shall keep a copy of the written or electronic informed consent to enroll on file for one year from date of dispensing.
 - e. The pharmacy shall complete a drug regimen review for each prescription refilled through the program at the time of refill.
 - f. Each time a prescription is refilled through the program, the pharmacy shall provide a written or electronic notification to the member or member's agent confirming that the prescription medication is being refilled through the program.
 - g. The member or member's agent shall at any time be able to withdraw a prescription medication from automatic refill or to disenroll entirely from the program. The

pharmacy shall document and maintain such withdrawal or disenrollment for one year from the date of withdrawal or disenrollment and shall provide confirmation to the member or member's agent.

- h. The pharmacy shall provide a full refund to the member, member's agent, or payer for any prescription medication refilled through the program if the pharmacy was notified that the member did not want the refill, regardless of the reason, or the pharmacy had been notified of withdrawal or disenrollment from the program prior to dispensing the prescription medication.
 - i. A pharmacy shall make available any written or electronic notification required by this section in alternate languages as required by state or federal law.
2. A licensed health facility, as defined in *Health and Safety Code* (H&S Code), Section 1250, that automatically refills prescriptions for its members need not comply with the provisions of H&S Code, Section 445.
 3. Pharmacies automatically refilling prescriptions for inmates of an adult correctional facility or a juvenile detention facility need not comply with the provisions of this section if the facility has written policies and procedures describing how a member may request that a medication be automatically refilled and how a member may refuse the medication.

Note:

- Authority Cited:
 - *Business and Professions Code* (Bus & Prof Code) Section 4052
- Reference:
 - Bus & Prof Code Sections 4001.1, 4005, 4063 and 4076.6
 - H&S Code, Section 1250

17.0 COVID-19 Vaccines, OTC Antigen Test Kits, and Therapeutics: Coverage and Reimbursements

Medi-Cal Rx will pay for the COVID-19 vaccine as a pharmacy benefit under the following guidelines:

For vaccine(s) provided by the federal government, coverage will apply to members under Medi-Cal Rx, Family PACT, CCS, and GHPP. The vaccines are outlined in the [CDLs](#) on the [Medi-Cal Rx Web Portal](#).

- An SCC is required for submission on incoming claims for COVID-19 vaccines in order to document which dose is being administered and what incentive fees to apply (refer to [Section 17.1 – COVID-19 Vaccine Administration Reimbursement](#) for additional information on incentive fees).
 - SCC 2 – Other Override should be used to identify the initial dose of the vaccine.
 - SCC 6 – Starter Dose should be used to identify the second dose of the vaccine.
 - SCC 7 – Medically Necessary should be used to identify the third dose of the vaccine.

- SCC 10 – Meets Plan Limitations should be used to identify the booster dose of the vaccine.
- For paper claims (UCF or 30-1), pharmacy providers are directed to populate the fill number based on the dose:
 - “0” to indicate the first dose of the Primary series is being administered and billed.
 - “1” to indicate the second dose of the Primary series is being administered and billed.
 - “3” to indicate the third dose for immunocompromised is being administered and billed.
 - “4” to indicate that a booster dose is being administered and billed.
- OHC edits will remain applicable to COVID-19 vaccine claims (see [Section 10.0 – Coordination of Benefits \(COB\)](#) and corresponding subsections for additional information).
- COVID-19 vaccine coverage is applicable to members in all outpatient/non-correctional resident locations.
 - **Note:** This is not applicable to the additional in-home incentive fee (see [Section 17.2 – COVID-19 Supplemental Incentive Fee Reimbursement for In-Home Vaccine Administration](#)).
- Any prescriber ID (NPI) may be billed on the claim.
 - **Note:** Claim submitted using a sanctioned or deceased prescriber will continue to reject.
- COVID-19 vaccines will be a carve-out for MCP members for all plans.
- Pharmacy providers should bill the claim with a Basis of Cost Determination (NCPDP field ID: 423-DN) of “15 – Free Product or No Assoc Cost” when the pharmacist self-initiates the COVID-19 vaccine.
 - **Note:** Pharmacy providers are not required to submit a Basis of Cost Determination on COVID-19 vaccine claims.
- Beginning January 1, 2022, pharmacy providers should bill the claim utilizing the following DUR code values (see [Section 16.0 – Drug Use Review \(DUR\)](#) and corresponding subsections for additional information):
 - Reason for Service Code (NCPDP field 439-E4): PH – Preventive Health Care
 - Professional Service Code (NCPDP field 440-E5): MA – Medication Administration
 - Result of Service Code (NCPDP field 441-E6): 3N – Medication Administration
 - **Note:** Pharmacy providers are not required to submit these DUR codes on COVID-19 vaccine claims.
- Additional information regarding fields required for claim submission can be found in [Appendix A – NCPDP Payer Specification Sheet](#).
- For Bivalent mRNA COVID-19 Vaccines – Pfizer BioNTech or Moderna manufacturers
 - CDC recommends that people ages 6 months and older receive at least one bivalent mRNA COVID-19 vaccine.

- For dates of service on or after April 19, 2023, people ages 65 years and older have the option to receive one additional bivalent mRNA vaccine dose at least four months after the first mRNA COVID-19 bivalent dose.
- For dates of service on or after April 19, 2023, people who are moderately or severely immunocompromised who previously received a bivalent mRNA vaccine dose(s) have the option to receive one or more additional bivalent mRNA vaccine doses at least two months following the last recommended bivalent mRNA COVID-19 vaccine dose.
- For Novavax COVID-19 Booster Dose(s):
 - Booster doses are available for dates of service on or after October 19, 2022, for members who meet the following criteria:
 - The use of a single-booster dose of the Novavax COVID-19 Vaccine may be administered at least six months after completion of primary vaccination to individuals 18 years of age and older.
 - FDA has limited the authorized use of the Novavax COVID-19 Vaccine to individuals 18 years of age and older for whom other authorized or approved COVID-19 vaccines are not accessible or clinically appropriate and to individuals 18 years of age and older who elect to receive the Novavax COVID-19 Vaccine because they would otherwise not receive a booster dose of a COVID-19 vaccine.
- Age Limitations for Vaccines:
 - If a claim is submitted for a member younger than the minimum age, the claim will reject with Reject Code 60 – Product/ Service Not Covered for Patient Age with the additional message “*Age requirement not met. Prior Authorization Required.*” The drug name, dosage, and strength/package size are outlined in the CDLs for age limitations.

17.1 COVID-19 Vaccine Administration Reimbursement

Reimbursement for COVID-19 vaccines is outlined below:

- No ingredient cost will be paid at this time.
 - Reimbursement logic will apply \$0.00 ingredient cost.
- No professional dispensing fee will be paid at this time.
 - Reimbursement logic will apply \$0.00 professional dispensing fee.

For Dates of Service *on or after March 15, 2021:*

- An incentive fee of \$40.00 will be paid per dose administration.

17.2 COVID-19 Supplemental Incentive Fee Reimbursement for In-Home Vaccine Administration

Effective for dates of service *on or after* June 8, 2021, Medi-Cal Rx will reimburse providers an additional \$35.00 per dose when administering a COVID-19 vaccine in the home of a Medi-Cal member who is unable to travel to a vaccination site.

Note: The *additional* in-home incentive fee will only be reimbursed if the *sole purpose* of the in-home visit is to administer a COVID-19 vaccine. The *additional* in-home incentive fee will **not** be reimbursed if another service is provided in the same home on the same date; in those instances, providers will only be reimbursed for the standard incentive fee as outlined in the above section.

The reimbursement of the *additional* in-home incentive fee is limited to the following:

- 2 claims in six months for DOS on or after June 8, 2021 to August 11, 2021
- 3 claims in seven months for DOS on or after August 12, 2021 to September 21, 2021
- 4 claims in seven months for DOS on or after September 22, 2021 to January 2, 2022
- 4 claims in six months for DOS on or after January 3, 2022

If providers are administering a COVID-19 vaccine to *more than one (1) member* in a single home on the *same day*, the following incentive fee reimbursement will be applied:

For dates of service on or after August 25, 2021, the additional in-home incentive fee amount of approximately \$35.00 may be billed up to *five (5) times* when *multiple members* are vaccinated in the *same home* on the *same date of service* if administering the vaccine to fewer than 10 members.

- For example: If a provider is administering six (6) vaccines on the same date to six members in the same home, the provider will be reimbursed approximately \$415.00 (5 × \$35.00 for the in-home vaccine incentive fee rate plus 6 × \$40.00 [standard incentive fee as outlined in the above section] for each dose of the COVID-19 vaccine administered).
- Many types of locations can qualify as a member's home for the additional in-home incentive fee amount such as:
 - A private residence
 - Temporary lodging (for example, a hotel or motel, campground, hostel, or homeless shelter)
 - An apartment in an apartment complex
 - A unit in an assisted living facility or group home
 - When the Medicare member's home has been made provider-based to a hospital during the COVID-19 Public Health Emergency (PHE)

The following locations **do not** qualify as a home for the additional in-home incentive fee amount:

- Communal spaces of a multiunit living arrangement

- Hospitals (except when the Medicare member’s home has been made provider-based to a hospital during the COVID-19 PHE)
- Skilled nursing facilities (SNFs), regardless of whether they are the member’s permanent residence or not

Beginning January 1, 2022, providers will be required to input an applicable “Patient Residence” code (NCPDP Field 384-4X) in order to be reimbursed for the additional in-home incentive fee(s). The applicable “Patient Residence” codes are as follows:

- 1 – Home – Provider should use Patient Residence code = 1 for temporary housing
- 4 – Assisted Living
- 5 – Custodial Care
- 6 – Group Home
- 14 – Homeless Shelter

Note: For historical claims submitted to Medi-Cal Rx with DOS *prior* to January 1, 2022, providers must either use an applicable “Place of Service” code (NCPDP Field 307-C7) or “Patient Residence” code (NCPDP Field 384-4X) in order to be reimbursed for the additional in-home incentive fee(s). The applicable “Place of Service” codes are as follows:

- 04 – Homeless Shelter
- 12 – Home
- 13 – Assisted Living Facility
- 14 – Group Home
- 16 – Temporary Lodging
- 33 – Custodial Care Facility

Billing Policy:

Pharmacies must submit a claim using the NDC “99999999995” (COVID-19 in the Home Supplemental Administration Rate) to be reimbursed for the supplemental home administration.

NDC	Label_Name Generic_Name	Maximum Claim Quantity
99999999995	COVID-19 in the Home Supplemental Administration Rate	1

Table 17.2-1: COVID-19 Home Supplemental Administrative Rate and Maximum Claim Quantity

17.3 OTC COVID-19 Antigen Test Kits

The U.S. Department of Health and Human Services (HHS) issued for immediate release the [Fact Sheet: COVID-19 Public Health Emergency Transition Roadmap](#) stating that the federal COVID-19 PHE ended on May 11, 2023. OTC emergency use authorization (EUA) FDA-authorized, self-administered COVID-19 antigen test kits will continue to remain a Medi-Cal Rx covered pharmacy benefit, subject to utilization controls and board of pharmacy prescription billing requirements.

Coverage is restricted to the specific OTC EUA FDA-authorized, self-administered COVID-19 antigen tests listed in the [List of Covered Emergency Use of Authorization \(EUA\) COVID-19 Antigen Tests](#), which can be found on the [Forms & Information](#) page of the [Medi-Cal Rx Provider Portal](#). Prescriptions must be written (or be an electronic equivalent) and signed by a licensed prescriber or a pharmacist and require dispensing from a pharmacy. Packages/kits cannot be broken or sold as individual tests.

The following criteria applies for coverage of these tests as a Medi-Cal Rx pharmacy benefit:

- Restricted to up to 8 tests total (4 kits for 2 tests/kit), currently on the [List of Covered Emergency Use of Authorization \(EUA\) COVID-19 Antigen Tests](#), per 30 days, per member, where only 1 test-per-kit, or 2 tests-per-kit billing codes (11-digit NDC-like number) are reimbursable, and kits cannot be broken and must be dispensed whole; and
- No refills allowed; the member would need to obtain a new prescription for each dispensing; and
- Dispensed from a Medi-Cal Rx pharmacy provider, written (or electronic equivalent) on a prescription signed by a licensed prescriber or a pharmacist; and
- Pharmacy providers are required to have one-on-one documented contact (in-person, telehealth, or phone) with the member or caregiver prior to dispensing COVID-19 OTC EUA tests; and
- The member/caregiver must request the pharmacy provider dispense the COVID-19 OTC EUA tests; autofill is not permitted. Items dispensed without a valid, documented request will be denied as not reasonable or necessary and are subject to post-adjudication audit review by DHCS.

Note: PA requests for quantities outside the allowed amounts will be denied, unless ordered or administered by a provider, following an individualized clinical assessment with appropriate medical necessity demonstrated.

Note: The OTC EUA FDA-authorized, self-administered COVID-19 antigen tests are only approved/permitted for a specific amount of time through the last day of the first calendar quarter that begins one year after the last day of the COVID-19 emergency period. Once that declaration is terminated or revoked, these medical supplies may no longer be a covered benefit. Notification of the benefit change will be provided on the [Bulletin & News](#) page of the [Medi-Cal Rx Web Portal](#).

17.3.1 OTC COVID-19 Antigen Test Kits Reimbursement

Reimbursement of the covered OTC EUA FDA-authorized, self-administered COVID-19 antigen tests is based upon an established individual test MAPC plus a 23 percent markup. Medical supply reimbursement guidelines apply. The adjustment for the 10 percent provider payment reduction per AB 97 (Chapter 3, Statutes of 2011), effective June 1, 2011, does not apply to these claims.

Providers can bill up to 8 tests per dispensing every 30 days, per member, and are required to have one-to-one documented contact with the Medi-Cal member or caregiver who is requesting the test. Providers filling a prescription for a test without a member- or caregiver-initiated request is prohibited (see [Section 17.4 – COVID-19 Oral Antiviral Product Coverage](#) for specific requirements). Coverage is restricted to a covered *List*, and fill frequencies and quantity limitations apply (refer to [Section 17.3 – OTC COVID-19 Antigen Test Kits](#) for those limitations).

Providers shall not submit claims for items obtained at no cost, and Upper Billing Limits apply. Refer to [Section 4.6.13 – Medical Supply Reimbursement](#) for additional information.

Coverage policy for OTC EUA FDA-authorized, self-administered COVID-19 antigen tests through Medi-Cal was effective March 11, 2021, under the American Rescue Plan Act of 2021. Members who purchased OTC EUA FDA-authorized, self-administered COVID-19 antigen tests between March 11, 2021, and January 31, 2022, over the counter and paid for them out-of-pocket may be able to be reimbursed by Medi-Cal. Reimbursement is limited to 8 tests (4 kits for 2 tests/kit) per 30 days per member. Members must be or have been eligible for Medi-Cal on the date of purchase and must include the proof of purchase and a copy of their BIC with the request for reimbursement. For more information on how a member may obtain a refund for out-of-pocket expenses, refer to the [Medi-Cal Out-of-Pocket Expense Reimbursement \(Conlan\)](#) page on the DHCS [website](#).

17.4 COVID-19 Oral Antiviral Product Coverage

17.4.1 Paxlovid

Paxlovid (nirmatrelvir tablets and ritonavir tablets) [was approved by the FDA on May 25, 2023](#), for the treatment of mild-to-moderate COVID-19 in adults with positive results of direct SARS-CoV-2 viral testing, and who are at high risk for progression to severe COVID-19, including hospitalization or death. In addition, the FDA issued an EUA to make Paxlovid available for the treatment of mild-to-moderate COVID-19 in adults and children 12 years of age and older, weighing at least 88 pounds (40 kg), who are at high risk for progression to severe COVID-19, including hospitalization or death. It is given within five days of symptom onset.

The initial supply of oral antivirals has been purchased and provided by the federal government and distributed to pharmacy providers for free. Coverage will apply to members under Medi-Cal Rx, CCS, and GHPP. The drug name, dosage, and strength/package size are outlined in the [CDLs](#) on the [Medi-Cal Rx Web Portal](#).

Paxlovid may be prescribed for a member by a state-licensed pharmacist under the conditions of the EUA and the eligibility standards specified in the FDA's [Fact Sheet for Healthcare Providers](#). Additionally, pharmacists may independently initiate and furnish Paxlovid in accordance with the California Board of Pharmacy's [Order Waiving Restrictions on Pharmacists Independently Initiating and Furnishing Paxlovid to Individual Patients](#).

17.4.1.1 Commercial Paxlovid

On October 13, 2023, Pfizer, the manufacturer of Paxlovid, reached an agreement with the federal government on a timeline to transition Paxlovid from government-managed distribution to traditional commercial distribution. The commercial transition began on November 1, 2023.

Commercial Paxlovid is a Medi-Cal Rx pharmacy benefit for members 12 years of age and older, with positive results of direct SARS-CoV-2 viral testing, and who are at high risk for progression to severe COVID-19, including hospitalization or death.

17.4.2 Remdesivir (Veklury)

DHCS no longer requires a PA request for the reimbursement of Remdesivir (Veklury) as a pharmacy benefit. Veklury is an antiviral drug that has been approved by the FDA for the treatment of adults and pediatric patients (28 days of age and older and weighing at least 3 kg [6 pounds, 9 ounces]) with positive results of SARS-CoV-2 viral testing. Veklury is for people who are hospitalized or not hospitalized with mild to moderate COVID-19 symptoms and are at high risk for progression to severe COVID-19, including hospitalization or death. For non-hospitalized patients, Veklury is restricted to a maximum of three days' supply per dispensing for each diagnosis, and treatment must be initiated as soon as possible after diagnosis of COVID-19, within seven days of symptom onset. Documentation is required justifying medical necessity for a longer treatment duration. The drug name, dosage, and strength/package size are outlined in the [CDLs](#) on the [Medi-Cal Rx Web Portal](#).

OHC edits remain applicable to COVID-19 oral antiviral claims (see [Section 10.0 – Coordination of Benefits \(COB\)](#) and corresponding subsections for additional information).

17.4.3 Lagevrio

Lagevrio (molnupiravir) is for the treatment of mild-to-moderate COVID-19 in adults (18 years of age and older) with positive results of direct SARS-CoV-2 viral testing, and who are at high risk for progression to severe COVID-19, including hospitalization or death, and alternative COVID-19 treatment options approved or authorized by FDA are not accessible or clinically appropriate. It is given within five days of symptom onset. Lagevrio may only be prescribed for an individual member by physicians, advanced practice registered nurses, and physician

assistants with the ability to prescribe the medication under specific circumstances specified in the FDA's [Fact Sheet for Healthcare Providers: Emergency Use Authorization for Lagevrio™ \(molnupiravir\) Capsules](#).

17.4.3.1 Commercial Lagevrio

Effective November 1, 2023, Lagevrio (molnupiravir) commercial products are available for purchase through commercial channels. The commercial product is not supplied free by the federal government.

Commercial Lagevrio is a Medi-Cal Rx pharmacy benefit for members 18 years of age and older, with positive results of direct SARS-CoV-2 viral testing, and who are at high risk for progression to severe COVID-19, including hospitalization or death, in cases where alternative COVID-19 treatment options approved or authorized by the FDA are not accessible or clinically appropriate.

17.4.4 COVID-19 Oral Antiviral Products Reimbursement

Reimbursement for COVID-19 oral antiviral products that are federally supplied is outlined as follows:

- No ingredient cost will be paid at this time.
 - Reimbursement logic will apply \$0.00 ingredient cost.
- A professional dispensing fee will be paid at this time.
 - Reimbursement logic will apply a \$13.20 or \$10.05 professional dispensing fee based upon the pharmacy's total (both Medicaid and non-Medicaid) annual claim volume (see [Section 4.6.2 – Professional Dispensing Fee](#) for additional information).

17.4.4.1 Paxlovid Reimbursement for Pharmacist Services

Medical Claims (for information only): Claims for the consultation and assessment must be billed to DHCS (CA-MMIS) on a medical claim as a Pharmacist Service using CPT codes 99202 (new patient) and 99212 (existing patient) and reimbursed with the current methodology for pharmacist services found in the [DHCS Provider Manual](#).

- Claims billed with CPT codes 99202 and 99212 must be submitted on a CMS-1500 medical claim form.
- Eligible claims must have an ICD-10-CM diagnosis code, U07.1 (COVID-19).
- DHCS is making a temporary allowance to allow billing with these CPT codes effective immediately through the end of the coverage mandated under ARPA which ends on September 30, 2024.

17.4.5 Commercial COVID-19 Oral Antiviral Products Reimbursement

Effective November 1, 2023, reimbursement for the new commercial COVID-19 oral antiviral products is as follows:

- The ingredient cost plus a professional dispensing fee will be paid at this time.
 - Reimbursement logic will apply a \$13.20 or \$10.05 professional dispensing fee based upon the pharmacy's total (both Medicaid and non-Medicaid) annual claim volume (see [Section 4.6.2 – Professional Dispensing Fee](#) for additional information).

17.5 Commercial COVID-19 Vaccines

Effective September 11, 2023, FDA-approved COVID-19 vaccines supplied by the federal government will transition to the commercial market. The vaccines are not supplied for free by the federal government for most members.

Medi-Cal Rx will pay for the updated commercial COVID-19 vaccines targeting the Omicron XBB1.5 variant as a pharmacy benefit for all members 3 years of age and older. For members 6 months up to 3 years of age, coverage of the vaccine will be available only through the VFC program. Claims submitted to Medi-Cal Rx for members younger than 3 years of age will deny with Reject Code 60 – Product/Service Not Covered For Patient Age with the message, *“Product only available through a Vaccines for Children (VFC) provider for children under 3. To locate an eligible provider, see <https://eziz.org/> or call 1-877-243-8832. Age requirement not met. Prior Authorization Required.”*

Uninsured and underinsured adults may obtain free COVID-19 vaccines through [CDC's Bridge Access Program](#). The vaccines can be accessed through local pharmacies and health care providers, including Federally Qualified Health Centers (FQHCs). For additional details, see the guidance from California Department of Public Health (CDPH)'s [California Bridge Access Program](#).

17.5.1 Commercial COVID-19 Vaccines Administration Reimbursement

Reimbursement for the monovalent commercial COVID-19 vaccines is outlined as follows:

- Pharmacy providers will be reimbursed for the ingredient cost and a \$40 incentive fee for the commercial vaccines.
- No professional dispensing fee will be paid at this time.

Note: An SCC is not required for the commercial COVID-19 vaccines.

18.0 Mpox Vaccine Coverage

Effective for claims with dates of service from August 17, 2022 through January 31, 2023 when the federal and California state governments declared the end of the public health emergency (PHE), Medi-Cal Rx will reimburse the administration of the mpox vaccine as a pharmacy benefit when administered in accordance with FDA approval or Emergency Use Authorization (EUA) and recommendations from the CDC.

- For vaccine(s) provided by the federal government, coverage will apply to members under Medi-Cal Rx, Family PACT, CCS, and GHPP. Billable NDCs and maximum quantities are outlined in *Table 18.0-1*.

NDC	Label_Name Generic_Name	Max. Quantity	Max. Claim Quantity
50632000101	JYNNEOS 0.5 ml Vial (Stockpile) Smallpox and Mpox Vaccine	0.5 ml (Subcutaneous), or 0.1 ml (Intradermal)	0.5 ml

Table 18.0-1: Mpox Vaccine Billable NDCs and Maximum Quantity Limitations

Effective for dates of service on or after February 1, 2023, DHCS will no longer reimburse the administration of mpox vaccines based on the enhanced Medicare rate approved by the federal government since the mpox PHE has ended. Effective for dates of services on or after February 1, 2023, DHCS will no longer reimburse the administration of mpox vaccines for the Family PACT Program.

JYNNEOS is approved by the FDA for subcutaneous (SubQ) injection for the prevention of mpox virus infection in individuals 18 years of age and older at high risk for mpox infection. The standard regimen in the context of the current national PHE was authorized for members under the age of 18 under an EUA, and an alternative regimen involving intradermal (ID) injection was also authorized for members at least 18 years and older, with an increase of JYNNEOS doses by up to five-fold.

Due to a limited supply, the California Department of Public Health (CDPH) is currently prioritizing the JYNNEOS vaccine for individuals who are at high risk for mpox infection. For the most recent dose prioritization or availability of additional doses and expansion of vaccination to a larger group, refer to the guidance from CDPH via the Vaccination section of the [Mpox Q&A](#) website.

Additional guidance on mpox can be found on both the [CDPH](#) and [CDC](#) websites.

- JYNNEOS is administered as two doses of vaccine at least 28 days apart.
 - Adults 18 years of age and older
 - Standard Regimen:
 - SubQ: 0.5 ml per dose, given as 2 doses, separated by 28 days
 - Alternative Regimen:

- ID: 0.1 ml per dose, given as 2 doses, separated by 28 days (EUA-authorized)
- Members under 18 years of age
 - Standard Regimen:
 - SubQ: 0.5 ml per dose, given as 2 doses, separated by 28 days
- People of any age with a history of keloid scars
 - Standard Regimen:
 - SubQ: 0.5 ml per dose, given as 2 doses, separated by 28 days
 - **Note:** Based on available data, the second dose may be given from 24 days to up to 35 days after the first dose.
- Interchangeability of Dosing Regimens (CDC 2022)
 - Adults 18 years and older who received one JYNNEOS dose subcutaneously
 - The second dose may be administered intradermally if necessary to complete the series.
 - A person whose 18th birthday occurs between their first and second dose
 - The series may be completed with the alternative regimen.
- An SCC is required for submission on incoming claims for mpox vaccines in order to document which dose is being administered.
 - SCC 2 – Other Override should be used to identify the initial dose of the vaccine.
 - SCC 6 – Starter Dose should be used to identify the second dose of the vaccine.
- For paper claims (UCF or 30-1), pharmacy providers are directed to populate the fill number based on the dose:
 - 0 to indicate the first dose.
 - 1 to indicate the second dose.
- OHC edits will remain applicable to mpox vaccine claims (refer to [Section 10.0 – Coordination of Benefits \(COB\)](#)) and corresponding subsections for additional information).
- A supplemental warning message will be sent notifying providers of early administration of mpox vaccine administration.

18.1 Mpox Vaccine Reimbursement

For dates of service between August 17, 2022 and January 31, 2023, reimbursement for mpox vaccines is outlined below:

- No ingredient cost will be paid at this time.
 - Reimbursement logic will apply \$0.00 ingredient cost.
- No professional dispensing fee will be paid at this time.
 - Reimbursement logic will apply \$0.00 professional dispensing fee.

- DHCS will only reimburse the professional services associated with an immunization when a pharmacy provider submits a claim for reimbursement of the vaccine administration.
- DHCS will reimburse for mpox vaccine administration at the lesser of the billed amount or at the corresponding Medicare rate (\$17.00) for the same or similar service for claims with dates of service from August 17, 2022, to January 31, 2023. To receive the professional services administration fee, the pharmacy provider must identify that the pharmacist is administering the vaccine, and enter the applicable values in the following NCPDP Fields:
 - Enter a dollar amount of the incentive fee in the Incentive Fee Amount Submitted field (NCPDP Field ID: 438-E3)
 - Select the following Reason for Service Code (NCPDP Field ID: 439-E4)
 - PH = Preventive Health Care
 - Select the following Professional Service Code (NCPDP Field ID: 440-E5)
 - MA = Medication Administration
 - Select the following Result of Service Code (NCPDP Field ID: 441-E6)
 - 3N = Medication Administration
 - **Note:** If any or all of the fields above are left incomplete or blank, claims will continue to adjudicate, but pharmacy providers will not be reimbursed for the professional services administration fee.

For dates of service on or after February 1, 2023, reimbursement for the administration of the mpox vaccine is outlined below:

- No ingredient cost will be paid at this time.
 - Reimbursement logic will apply \$0.00 ingredient cost.
- No professional dispensing fee will be paid at this time.
 - Reimbursement logic will apply \$0.00 professional dispensing fee.
- DHCS will only reimburse the professional services associated with an immunization when a pharmacy provider submits a claim for reimbursement of the vaccine administration.
- DHCS will reimburse for mpox vaccine administration at the lesser of the billed amount or \$3.79. To receive the professional services administration fee, the pharmacy provider must identify that the pharmacist is administering the vaccine, and enter the applicable values in the following NCPDP Fields:
 - Enter a dollar amount of the incentive fee in the Incentive Fee Amount Submitted field (NCPDP Field ID: 438-E3)
 - Select the following Reason for Service Code (NCPDP Field ID: 439-E4)
 - PH = Preventive Health Care
 - Select the following Professional Service Code (NCPDP Field ID: 440-E5)
 - MA = Medication Administration

- Select the following Result of Service Code (NCPDP Field ID: 441-E6)
 - 3N = Medication Administration
- **Note:** If any or all of the fields above are left incomplete or blank, claims will continue to adjudicate, but pharmacy providers will not be reimbursed for the professional services administration fee.

18.2 Mpox Treatment Drugs

For dates of service on or after August 17, 2022, DHCS will reimburse the dispensing of mpox treatment drug, Tecovirimat (TPOXX) as a pharmacy benefit when this is in accordance with the provisions of the FDA-regulated Expanded Access Investigational New Drug (EA-IND) protocol and the CDC’s guidance.

TPOXX is an antiviral drug that is FDA-approved for the treatment of smallpox in adults and pediatric patients. Its use for treatment of mpox is permitted by EA-IND protocol through the CDC. A PA is not required and there is no minimum age required for this treatment.

Pharmacy providers may bill for the dispensing of TPOXX NDCs using NCPDP D.0 claims, web, batch, and paper claims according to the table below.

NDC	Label_Name Generic_Name	Claim Quantity	Max. Quantity
50072001030	TPOXX Tecovirimat	20 ml (200 mg/20 mL in SDV)	42 vials
50072020042	TPOXX Tecovirimat	42 capsules (Each bottle contains 42 × 200 mg capsules)	126 capsules

Table 18.2-1: TPOXX Billable NDCs, Billing Quantity, and Maximum Quantity

Product Availability:

- TPOXX is available from the U.S. Strategic National Stockpile (SNS). It can be ordered from CDPH and does not need to go through CDC.
- Clinicians and care facility pharmacists requesting TPOXX should contact their [local health department](#) for current local availability. Pre-positioned supply may be the fastest route to obtain TPOXX.
- The local health department Medical Health Operational Area Coordinator (MHOAC) will submit a resource request to CDPH and medications will be shipped to the healthcare facility.
- CDC can assist in the diagnosis and management of patients with suspected mpox. If treatment drugs are needed, or additional information is required, providers should contact the CDC Emergency Operations Center at 1-770-488-7100, Monday through Friday 8:00 a.m. to 4:30 p.m. ET; at other times call 1-404-639-2888.

18.2.1 Adult Dosages

Mpox (off-label use):

- IV
 - 35 to <120 kg: 200 mg every 12 hours (CDC 2022a)
 - ≥120 kg: 300 mg every 12 hours (CDC 2022a)
- Oral
 - 40 to <120 kg: 600 mg every 12 hours (CDC 2022a)
 - ≥120 kg: 600 mg every 8 hours (CDC 2022a)

Duration of therapy: 14 days; duration may be longer (up to 90 days) or shorter depending on disease progression and clinical condition of the patient (CDC 2022a). Data on duration other than 14 days are limited.

18.2.2 Pediatric Dosages

Mpox (off-label use):

- Oral

Note: The smallest capsule size is 200 mg; doses lower than 200 mg require manipulation of capsule, increasing risk for dose inaccuracy. Use caution; before use, ensure caregivers are able to prepare as directed (CDC 2022a).

- Infants, Children, and Adolescents (CDC 2022a):
 - <6 kg: 50 mg every 12 hours
 - 6 to <13 kg: 100 mg every 12 hours
 - 13 to <25 kg: 200 mg every 12 hours
 - 25 to <40 kg: 400 mg every 12 hours
 - 40 to <120 kg: 600 mg every 12 hours
 - ≥120 kg: 600 mg every 8 hours

- IV

Note: Use IV formulation with caution in patients less than 2 years of age due to limited experience with hydroxypropyl-B-cyclodextrin excipient.

- Infants, Children, and Adolescents (CDC 2022a):
 - <35 kg: 6 mg/kg/dose every 12 hours
 - 35 to <120 kg: 200 mg every 12 hours
 - ≥120 kg: 300 mg every 12 hours

19.0 Claim Forms

When completing and submitting the forms in the following subcategories, use the legibility and completion standards below:

Legibility and Completion Standards

- **Submitting Forms:** Submit the form to the Medi-Cal Rx vendor and retain a copy for your records. Clarity is necessary for proper scanning.
- **Unacceptable Forms:** Carbon copies, photocopies, computer-generated form facsimiles, or forms created on laser printers are not acceptable for the forms mentioned in this section.
- **Pin-Fed Forms:** Remove all perforated sides and separate each individual form. For accurate scanning, leave a ¼-inch border on the left and right side of the form after removing the perforated sides.
- **Do Not Fold or Crease:** To expedite the sorting and preparation of claims for scanning, do not fold or crease forms to fit into small-sized envelopes. Enclose forms in full-sized envelopes.

Typed and Handwritten Forms:

- **Type all information (using capital letters)** on forms whenever possible for clarity and accuracy using 10-point font or larger (not to exceed the size of the field). Do not use script or italic font.
- **Handwritten forms** should be printed neatly and accurately using a ballpoint pen only. Do not use red pencils or red ink ballpoint pens. All requirements pertaining to typed forms, such as entering data within the text space, apply to handwritten forms.
- **Printer Ribbons:** Use black film-type or high-quality ribbons. Ribbons should be changed regularly to ensure that a clear, distinct character is printed. Frequently change the ink cartridges in the printer to avoid light ink. Blurred or light printing may be misread by the scanning equipment. Avoid printing claim forms using a dot matrix printer. Laser printers are strongly recommended.
- **Type in Designated Areas Only:** Type only in areas of the form designated as fields. Be sure the data falls completely within the text space and is properly aligned. Many of the forms have Elite and Pica alignment boxes.
- **Do not type in shaded areas, or areas labeled "FOR F.I. USE ONLY."** These areas are reserved for use by the Medi-Cal Rx vendor only.
- **Alpha or Numeric Characters:** Use only alphabetical letters or numbers in data entry fields. Do not type zeros with a dot in the center. The scanning equipment may misread dotted zeroes.
- **No Highlighting Pens:** Never highlight information. When the form attachments are scanned on arrival by the Medi-Cal Rx vendor, the highlighted area will show up only as a black mark, obscuring the highlighted information.

Provider Signature

Medi-Cal Rx requires providers or their designees to sign and date all claim forms, PA requests, CIFs, or appeals. An original signature is required on all forms. The signature must be written, not printed. Stamps, initials, or facsimiles are not acceptable. When signing, use a ballpoint pen.

Corrections

Do not strike through errors or use correction tape or fluids.

Attachments

Attached documentation for claims, CIFs, or appeals should clearly reference the field name that requires additional documentation. The claim field name on the attachment should be legible, underlined, or circled in black ballpoint pen. Allow adequate line space between each claim field number description.

- Carbon copies of documents are not acceptable. Instead, make a photocopy of the original.

Note: Do not highlight or use tape to fasten attachments to the claim form. Do not use original claims as attachments since they may be interpreted as original claims.

19.1 Universal Claim Form, Version D.0

The *Universal Claim Form* (UCF) is used by providers who wish to submit a paper pharmacy (non-compound or compound) claim. The UCF may be purchased from NCPDP's vendor, Communiform LLC, or ordered by phone, fax, or online. [Appendix B – Directory](#) at the end of this manual provides the source for obtaining UCFs and the Medi-Cal Rx vendor address and fax number that pharmacies should use to mail or fax UCF submissions. See *Figure 19.1-1* for a sample UCF form.

Note: If submitting a *Charpentier* or *Crossover Claim* on a UCF, these **must** be identified by writing **Charpentier** or **Crossover** on the form.


INSURANCE	1-ID: _____ 2-Group ID: _____		3-Last: _____ 4-First: _____		 UNIVERSAL CLAIM FORM (UCF) Version 1.1 – 05/2009 © 2008-2009, 2010. All rights reserved.						
	5-Plan Name: _____		6-BIN Number: _____ 7-Processor Control Number: _____								
PATIENT	8-Last: _____ 9-First: _____ 10-Person Code: _____		FOR OFFICE USE ONLY 14 (Document Control Number)								
	11-D.O.B: _____ mm dd cyy		12-Gender: _____		13-Relationship: _____						
PHARMACY	15-Service Provider ID: _____ 16-Qualifier: _____		SIGNATURE OF PROVIDER (I certify that the statements on the reverse apply to this bill and are made a part thereof.)								
	17-Name: _____ 18-Tel #: _____		23-(Signed) _____ 24-(Date) _____		ATTENTION PROVIDER! PLEASE READ ATTESTATION STATEMENT ON REVERSE SIDE						
19-Address: _____		20-City: _____ 21-State: _____ 22-Zip: _____									
PRESCRIBER	25-ID: _____ 26-Qualifier: _____		28-ID: _____		29-Qualifier: _____						
	27-Last Name: _____										
CLAIM	30-Prescription/Service Ref. #		31-Qual	32-Fill #	33-Date Written mm dd cyy		34-Date Of Service mm dd cyy		35-Submission Clarification	36-Prescription Origin	
	37-Product/Service ID			38-Qual	39-Product Description				40-Quantity Dispensed	41-Days/42-DAW Supply Code	
	43-Prior Auth # Submitted		44-PA Type	45-Other Coverage	46-Delay Reason	47-Level Of Service	48-Place Of Service				
	C I C A	49-Diagnosis Code		50-Qual	D U R	51-Reason/52-Service/53-Result		54-Level of Effort	55-Procedure Modifier		
		56-Other Payer ID		57-Qual		58-Other Payer Date mm dd cyy	59-Other Payer Rejects	C O B 2	60-Other Payer ID	61-Qual	62-Other Payer Date mm dd cyy
COB	64-Dosage Form Description Code		65-Dispensing Unit Form Indicator		66-Route of Administration		67-Ingredient Component Count				
	68-Product Name				69-Product ID		70-Qual	71-Ingredient Qty	72-Ingredient Drug Cost	73-Basis of Cost	
COMPOUND	1										
	2										
	3										
	4										
	5										
	6										
Pricing (Format (1,234.56))											
74-Usual & Customary Charge		75-Basis of Cost Def.	76-Ingredient Cost Submitted		77-Dispensing Fee Submitted	78-Prof Service Fee Submitted		79-Incentive Amount Submitted		80-Other Amount Submitted	81-Sales Tax Submitted
82-Gross Amount Due (Submitted)		83-Patient Paid Amount		84-Other Payer Amount Paid #1		85-Other Payer Amount Paid #2		86-Other Payer Patient Resp. Amount #1		87-Other Payer Patient Resp. Amount #2	88-Net Amount Due
Copyright 2008, 2009, 2010											

Figure 19.1-1: Universal Claim Form (UCF), Version D.0

19.1.1 Completion Instructions for the Universal Claim Form

The following item numbers and descriptions in *Table 19.1.1-1* below correspond to *Figure 19.1-1 Universal Claim Form (UCF), Version D.0* above. **All items must be completed unless otherwise specified in these instructions.**

Item	Description
Insurance	
1	ID. Enter the member ID, HAP ID, or CIN number as it appears on the Identification Card.
2	Group ID. Enter the Group ID (MEDI-CAL RX)
3	Last. Enter the last name as it appears on the Identification Card.
4	First. Enter the first name as it appears on the Identification Card.
5	Plan Name. Enter the Plan Name (MEDI-CAL RX)
6	BIN Number. Enter the BIN Number (022659)
7	Processor Control Number (PCN). Enter the PCN (6334225)
Patient	
8	Last. Enter the last name of the member.
9	First. Enter the first name of the member.
10	Person Code. Not a required field.
11	D.O.B. (Date of Birth). Enter the member's date of birth in MM/DD/YYYY format. Obtain this information from the member's BIC number. Note: This information <i>must</i> be entered for the claim to process successfully.
12	Gender. Use the capital letter "M" for male, "F" for female, or "U" for Unknown.
13	Relationship. If billing for a newborn using the Mother's ID, a Relationship Code = 03 – Dependent must be entered, otherwise LEAVE BLANK.
14	For Office Use Only (Document Control Number). LEAVE BLANK.
Pharmacy	
15	Service Provider ID. Enter the pharmacy NPI number. This information must be entered for the claim to successfully process.
16	Qualifier. Identifies the NCPDP D.0 standard provider ID type. The only ID qualifier allowed is "01" – NPI.
17	Name. Enter the pharmacy name.
18	Tel. #. Enter the pharmacy telephone number (to include the area code)
19	Address. Enter the pharmacy address.

Item	Description
20	City. Enter the city for the pharmacy.
21	State. Enter the state for the for the pharmacy.
22	Zip. Enter the pharmacy's nine-digit ZIP code. Note: The nine-digit ZIP code entered in this field must match the biller's ZIP code on file for claims to be reimbursed correctly.
23	Signature of Provider. The pharmacist must sign in this field.
24	Date. Enter the date the pharmacist signed the form.
Prescriber	
25	ID. Enter the NPI number of the prescriber or, if applicable, the NPI number of the certified nurse-midwife, nurse practitioner, physician's assistant, neuropathic doctor, or pharmacist who functions pursuant to a policy, procedure, or protocol as required by <i>Business and Professions Code</i> statutes. Do not use the Drug Enforcement Administration Narcotic Registry Number. This information must be entered for the claim to process successfully.
26	Qualifier. Identifies the NCPDP D.0 standard provider ID type. The only ID qualifier allowed is "01" – NPI.
27	Last Name. Enter the last name of the Prescriber.
Pharmacist	
28	ID. Not a required field.
29	Qualifier. Not a required field.
Claim	
30	Prescription/Service Ref. #. Enter the prescription number in this space for reference on the Remittance Advice (RA).
31	Qual. Enter '01" for Rx billing.
32	Fill#. Enter a refill number. 00 = Original Dispensing – The first dispensing 01-99 = Refill Number – Number of the replenishment.
33	Date Written. Enter the date the prescription was written.
34	Date of Service. Enter the date that the prescription was filled in 8-digit MM_DD_YYYY (Month, Day, Year) format. (Example: August 6, 2007 = 08_06_2007)
35	Submission Clarification. Enter a submission clarification code if applicable, otherwise leave blank. Note: Up to 3 submission clarification codes are allowed.

Item	Description												
36	<p>Prescription Origin. Enter the method in which the prescription was received. Example: 0 – Not Specified, 1- Written, 2 – Telephone, 3- Electronic, 4 – Fascimile (Fax), 5 - Pharmacy.</p>												
37	<p>Product/Service ID. Enter the 11-digit NDC for the product being submitted.</p> <p style="text-align: center;">Zero Fill NDC Numbers</p> <p>All NDC numbers <i>must</i> be 11 digits long. NDCs printed on packages often have fewer than 11 digits, with hyphens (-) separating the number into 3 segments. For a complete 11-digit number, the first segment <i>must</i> have 5 digits, the second segment 4 digits, and the third segment 2 digits. Add leading 0's wherever they are needed to complete a segment with the correct number of digits.</p> <p>Examples:</p> <table border="1" data-bbox="256 724 1031 919"> <thead> <tr> <th>Package Number</th> <th>Zero Fill</th> <th>11-digit NDC</th> </tr> </thead> <tbody> <tr> <td>1234-1234-12</td> <td>(01234-1234-12)</td> <td>01234123412</td> </tr> <tr> <td>12345-123-12</td> <td>(12345-0123-12)</td> <td>12345012312</td> </tr> <tr> <td>2-22-2</td> <td>(00002-0022-02)</td> <td>00002002202</td> </tr> </tbody> </table> <p style="text-align: center;">Drug Manufacturer and Product Codes</p> <p>If the item being billed is a drug, refer to the CDL (found on the Medi-Cal Rx Provider Portal by selecting Forms & Information) for information on authorized drug manufacturer labeler codes. The products of manufacturers not listed in the CDL are not covered by Medi-Cal without authorization.</p> <p style="text-align: center;">Medical Supplies</p> <p>Medical supplies that may be billed as “pharmacy only” benefits according to NCPDP claim transaction standards include diabetic supplies, peak flow meters, inhalers, contraceptive products, and enteral nutrition formula (see Section 12.0 – Enteral Nutrition Products and Section 13.0 – Medical Supplies for additional information).</p>	Package Number	Zero Fill	11-digit NDC	1234-1234-12	(01234-1234-12)	01234123412	12345-123-12	(12345-0123-12)	12345012312	2-22-2	(00002-0022-02)	00002002202
Package Number	Zero Fill	11-digit NDC											
1234-1234-12	(01234-1234-12)	01234123412											
12345-123-12	(12345-0123-12)	12345012312											
2-22-2	(00002-0022-02)	00002002202											
38	<p>Qual. Enter “03” – NDC.</p>												
39	<p>Product Description. Enter the name of the drug/product being submitted.</p>												
40	<p>Quantity Dispensed. Enter the quantity dispensed.</p>												
41	<p>Days Supply. Enter the estimated number of days that the drug dispensed will last.</p>												
42	<p>DAW Code. If applicable (if not applicable LEAVE BLANK), enter one of the below values. For more information on DAW codes, see Section 15.5 – Dispense As Written (DAW) Codes.</p> <table border="1" data-bbox="256 1768 1474 1927"> <thead> <tr> <th>Code</th> <th>Description</th> </tr> </thead> <tbody> <tr> <td>0</td> <td>No Product Selection Indicated</td> </tr> <tr> <td>1</td> <td>Substitution Not Allowed by Prescriber</td> </tr> </tbody> </table>	Code	Description	0	No Product Selection Indicated	1	Substitution Not Allowed by Prescriber						
Code	Description												
0	No Product Selection Indicated												
1	Substitution Not Allowed by Prescriber												

Item	Description	
	2	Substitution Allowed – Patient Requested Product Dispensed
	3	Substitution Allowed – Pharmacist Selected Product Dispensed
	4	Substitution Allowed – Generic Drug Not In Stock
	5	Substitution Allowed – Brand Drug Dispensed as a Generic
	6	Override
	7	Substitution Not Allowed – Brand Drug Mandated by Law
	8	Substitution Allowed – Generic Drug Not Available in Marketplace
	9	Substitution Allowed by Prescriber but Plan Requests Brand
43	Prior Auth # Submitted. Required if utilizing Field 44 – PA Type (see below), otherwise leave blank.	
44	<p>PA Type. LEAVE BLANK, unless one of the below options is relevant to the claim being submitted.</p> <p>Submit “1” when PA is approved to override Medi-Cal pricing.</p> <p>Submit “8” for newborns using the Mother’s member ID. For additional information on newborn claims see Section 8.2.2 – Newborns.</p>	
45	<p>Other Coverage. A valid other coverage code is required. Enter one of the following values:</p>	
	Code	Description
	0	Not Specified
	1	No Other Coverage Exists
	2	Other Coverage Exists, Payment Collected
	3	Other Coverage Exists, Claim Not Covered
	4	Other Coverage Exists, Payment Not Collected
46	<p>Delay Reason. If there is an exception to the 6-month billing limitation, enter the appropriate reason code number and include the required documentation. For additional information, see Section 19.3.1 – Submission and Timeliness Instructions.</p>	
	Code	Description
	1	(1) Proof of eligibility unknown or unavailable; includes retroactive eligibility or ID cards, if applicable (2) For Share of Cost (SOC) reimbursement processing
	2	(1) Other Health Coverage, including Medicare, Kaiser, CHAMPUS, and other health insurance (2) Charpentier rebill claims

Item	Description	
	3	Authorization delays in PA approval
	4	Delay by DHCS in certifying providers or by Medi-Cal Rx vendor in supplying billing forms
	5	Delay in delivery of custom-made eye, prosthetic, or orthotic appliances
	6	Substantial damage by fire, flood, or disaster to provider records
	7	Theft, sabotage, or other willful acts by an employee Note: Negligence by an employee is <u>not</u> covered by this reason code
	10	(1) Court order, State, or administrative fair hearing decision (2) Delay or error in the certification or determination of Medi-Cal eligibility (3) Update of a PA beyond the 12-month limit (4) Circumstances beyond the provider's control as determined by DHCS
	A	Claim submitted after the 6-month billing limit and received by MMA during the 7 th – 12 th month after the month of service and none of the exceptions above applied
	<i>Field Left Blank</i>	Not Specified *
47	Level of Service. Enter "3" – Emergency when submitting an emergency claim, otherwise LEAVE BLANK.	
48	Place of Service. (Patient Residence) If the member is a Long-Term Care resident, enter the appropriate Patient Residence code in this field from the options below. If the recipient is not residing in any of these facilities, leave this field blank. 3 - Nursing Facility 9 - Intermediate Care	
Clinical		
49	Diagnosis Code. Enter only if diagnosis code is required for claim submission, otherwise LEAVE BLANK.	
50	Qual. Enter "02" – International Classification of Diseases (ICD-10 CM) only if a diagnosis code was entered in Field 49, otherwise LEAVE BLANK.	
DUR		
51	DUR/PPS Codes – Reason. Enter appropriate DUR Reason Code (see Section 16.0 – Drug Use Review (DUR) for applicable values)) when needed to communicate DUR information, otherwise LEAVE BLANK.	

Item	Description	
52	DUR/PPS Codes – Service. Enter appropriate DUR Service Code (see Section 16.0 – Drug Use Review (DUR) for applicable values)) when needed to communicate DUR information, otherwise LEAVE BLANK.	
53	DUR/PPS Codes – Result. Enter appropriate DUR Result of Service Code (see Section 16.0 – Drug Use Review (DUR) for applicable values)) when needed to communicate DUR information, otherwise LEAVE BLANK.	
54	Level of Effort. Enter appropriate DUR Level of Effort (see Section 16.0 – Drug Use Review (DUR) for applicable values)) when needed to communicate DUR information, otherwise LEAVE BLANK. Note: This field is used for compound claims.	
55	Procedure Modifier. Not a required field.	
COB (If member does not have OHC, leave these fields BLANK)		
COB 1		
56	Other Payer ID. Enter the Payer ID of the member’s other health coverage, if applicable. Otherwise, LEAVE BLANK.	
57	Qual. Enter the Other Payer ID Qualifier of the member’s other health coverage, if applicable. Otherwise, LEAVE BLANK.	
	Code	Description
	01	Standard Unique Health Plan Identifier
	02	Health Industry Number (HIN)
	03	Bank Information Number (BIN)
	04	National Association of Insurance Commissioners
	05	Medicare Carrier Number
	09	Coupon
99	Other	
58	Other Payer Date. Enter if identification of the Other Payer Date is necessary for claim adjudication. Otherwise, LEAVE BLANK.	
59	Other Payer Rejects. Enter the NCPDP Reject Code when the other payer has denied the payment for the billing, designated with Other Coverage Code = “3” (Other Coverage Exists – Claim Not Covered).	
COB 2		
60	Other Payer ID. Enter the Payer ID of the member’s other health coverage, if applicable. Otherwise, LEAVE BLANK.	
61	Qual. Enter the Other Payer ID Qualifier of the member’s other health coverage, if applicable. Otherwise, LEAVE BLANK.	

Item	Description	
	Code	Description
	01	Standard Unique Health Plan Identifier
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	05	Medicare Carrier Number
	09	Coupon
	99	Other
62	Other Payer Date. Enter if identification of the Other Payer Date is necessary for claim adjudication. Otherwise, LEAVE BLANK.	
63	Other Payer Rejects. Enter the NCPDP Reject Code when the other payer has denied the payment for the billing, designated with Other Coverage Code = "3" (Other Coverage Exists – Claim Not Covered).	
Compound (If not submitting a compound, leave these fields BLANK)		
64	Dosage Form Description Code. Enter the appropriate code to indicate the dosage form of the finished compound.	
	Code	Description
	01	Capsule
	02	Ointment
	03	Cream
	04	Suppository
	05	Powder
	06	Emulsion
	07	Liquid
	10	Tablet
	11	Solution
	12	Suspension
	13	Lotion
	14	Shampoo
	15	Elixir
	16	Syrup
	17	Lozenge

Item	Description																																			
18	Enema																																			
<p>Note: Compounding fees are paid based upon the dosage form and route of administration information submitted on the pharmacy claim. To ensure proper payment, be certain to enter this information correctly. See Section 4.6.7.3 – Compounding Fee Breakdown by Dosage Form for additional information.</p>																																				
65	<p>Dispensing Unit Form Indicator. Enter the appropriate code to indicate the way that the finished compound is measure.</p>																																			
<table border="1"> <thead> <tr> <th data-bbox="248 522 537 577">Code</th> <th data-bbox="537 522 1474 577">Description</th> </tr> </thead> <tbody> <tr> <td data-bbox="248 577 537 632">1</td> <td data-bbox="537 577 1474 632">Each</td> </tr> <tr> <td data-bbox="248 632 537 686">2</td> <td data-bbox="537 632 1474 686">Grams (GM)</td> </tr> <tr> <td data-bbox="248 686 537 747">3</td> <td data-bbox="537 686 1474 747">Milliliters (ML)</td> </tr> </tbody> </table>			Code	Description	1	Each	2	Grams (GM)	3	Milliliters (ML)																										
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3	Milliliters (ML)																																			
66	<p>Route of Administration. The SNOMED must be entered in this section.</p> <p>Note: Compounding fees are paid based upon the dosage form and route of administration (SNOMED value) information submitted on the pharmacy claim. To ensure proper payment, be certain to enter this information correctly.</p>																																			
<table border="1"> <thead> <tr> <th data-bbox="248 940 561 1037">Route of Administration</th> <th data-bbox="561 940 1474 1037">SNOMED Value</th> </tr> </thead> <tbody> <tr> <td data-bbox="248 1037 561 1092">Buccal</td> <td data-bbox="561 1037 1474 1092">54417007 or 372473007</td> </tr> <tr> <td data-bbox="248 1092 561 1146">Dental</td> <td data-bbox="561 1092 1474 1146">372449004</td> </tr> <tr> <td data-bbox="248 1146 561 1201">Enteral</td> <td data-bbox="561 1146 1474 1201">417985001</td> </tr> <tr> <td data-bbox="248 1201 561 1255">Infusion</td> <td data-bbox="561 1201 1474 1255">424494006, C44364, or 418114005</td> </tr> <tr> <td data-bbox="248 1255 561 1310">Inhalation</td> <td data-bbox="561 1255 1474 1310">112239003</td> </tr> <tr> <td data-bbox="248 1310 561 1365">Injection</td> <td data-bbox="561 1310 1474 1365">424109004, 385218009, 34206005, or 78421000</td> </tr> <tr> <td data-bbox="248 1365 561 1419">Intraperitoneal</td> <td data-bbox="561 1365 1474 1419">38239002</td> </tr> <tr> <td data-bbox="248 1419 561 1474">Intravenous (IV)</td> <td data-bbox="561 1419 1474 1474">4625008</td> </tr> <tr> <td data-bbox="248 1474 561 1528">Irrigatio</td> <td data-bbox="561 1474 1474 1528">47056001</td> </tr> <tr> <td data-bbox="248 1528 561 1583">Mouth/Throat</td> <td data-bbox="561 1528 1474 1583">26643006 or 26643008</td> </tr> <tr> <td data-bbox="248 1583 561 1638">Mucous Membrane</td> <td data-bbox="561 1583 1474 1638">419874009</td> </tr> <tr> <td data-bbox="248 1638 561 1692">Nasal</td> <td data-bbox="561 1638 1474 1692">46713006</td> </tr> <tr> <td data-bbox="248 1692 561 1747">Ophthalmic</td> <td data-bbox="561 1692 1474 1747">54485002</td> </tr> <tr> <td data-bbox="248 1747 561 1801">Oral</td> <td data-bbox="561 1747 1474 1801">26643006 or 26643008</td> </tr> <tr> <td data-bbox="248 1801 561 1856">Otic</td> <td data-bbox="561 1801 1474 1856">10547007</td> </tr> <tr> <td data-bbox="248 1856 561 1942">Rectal</td> <td data-bbox="561 1856 1474 1942">37161004</td> </tr> </tbody> </table>			Route of Administration	SNOMED Value	Buccal	54417007 or 372473007	Dental	372449004	Enteral	417985001	Infusion	424494006, C44364, or 418114005	Inhalation	112239003	Injection	424109004, 385218009, 34206005, or 78421000	Intraperitoneal	38239002	Intravenous (IV)	4625008	Irrigatio	47056001	Mouth/Throat	26643006 or 26643008	Mucous Membrane	419874009	Nasal	46713006	Ophthalmic	54485002	Oral	26643006 or 26643008	Otic	10547007	Rectal	37161004
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Item	Description	
	Vaginal	16857009
	Topical	6064005
	Transdermal	45890007
	Translingual	404815008
	Urethral	90028008
67	Ingredient Component Count. Enter the total compound ingredient components. Note: Medi-Cal supports up to 24 compound product IDs and 1 for the container count (25 Product IDs if a container count is included).	
68	Product Name. Enter the name of the final compounded drug/product.	
69	Product ID. For a compound claim, enter a single zero (0) in the Product ID field and list each ingredient name, NDC, quantity, and cost in the appropriate fields in the "Compound" section of the form.	
70	Qual. Enter "00" – Other.	
71	Ingredient Qty. Enter the total quantity per ingredient in the compound.	
72	Ingredient Drug Cost. Enter the ingredient drug cost per ingredient in the compound.	
73	Basis of Cost. Enter the appropriate code to indicate the method used to calculate the ingredient cost. If claim was for 340B/Disproportionate Share Pricing/Public Health Service, '08' <u>must</u> be used.	
	Code	Description
	01	AWP (Average Wholesale Price)
	02	Local Wholesalers
	03	Direct
	04	EAC (Estimated Acquisition Cost)
	05	Acquisition
	06	MAC (Maximum Allowable Cost)
	07	Usual & Customary (U&C)
	08	340B/Disproportionate Share Pricing/Public Health Service
	<i>Field Left Blank</i>	Not Specified
Pricing (Format (1,234.56))		
74	Usual & Customary Charge. Enter the Usual & Customary charge being submitted for the claim.	

Item	Description																				
75	<p>Basis of Cost Determination. Enter the appropriate code to indicate the method used to calculate the ingredient cost. If claim was for 340B/Disproportionate Share Pricing/Public Health Service, '08' <u>must</u> be used.</p> <table border="1" data-bbox="253 327 1474 892"> <thead> <tr> <th data-bbox="253 327 535 382">Code</th> <th data-bbox="535 327 1474 382">Description</th> </tr> </thead> <tbody> <tr> <td data-bbox="253 382 535 436">01</td> <td data-bbox="535 382 1474 436">AWP (Average Wholesale Price)</td> </tr> <tr> <td data-bbox="253 436 535 491">02</td> <td data-bbox="535 436 1474 491">Local Wholesalers</td> </tr> <tr> <td data-bbox="253 491 535 546">03</td> <td data-bbox="535 491 1474 546">Direct</td> </tr> <tr> <td data-bbox="253 546 535 600">04</td> <td data-bbox="535 546 1474 600">EAC (Estimated Acquisition Cost)</td> </tr> <tr> <td data-bbox="253 600 535 655">05</td> <td data-bbox="535 600 1474 655">Acquisition</td> </tr> <tr> <td data-bbox="253 655 535 709">06</td> <td data-bbox="535 655 1474 709">MAC (Maximum Allowable Cost)</td> </tr> <tr> <td data-bbox="253 709 535 764">07</td> <td data-bbox="535 709 1474 764">Usual & Customary (U&C)</td> </tr> <tr> <td data-bbox="253 764 535 819">08</td> <td data-bbox="535 764 1474 819">340B/Disproportionate Share Pricing/Public Health Service</td> </tr> <tr> <td data-bbox="253 819 535 892"><i>Field Left Blank</i></td> <td data-bbox="535 819 1474 892">Not Specified</td> </tr> </tbody> </table>	Code	Description	01	AWP (Average Wholesale Price)	02	Local Wholesalers	03	Direct	04	EAC (Estimated Acquisition Cost)	05	Acquisition	06	MAC (Maximum Allowable Cost)	07	Usual & Customary (U&C)	08	340B/Disproportionate Share Pricing/Public Health Service	<i>Field Left Blank</i>	Not Specified
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07	Usual & Customary (U&C)																				
08	340B/Disproportionate Share Pricing/Public Health Service																				
<i>Field Left Blank</i>	Not Specified																				
76	Ingredient Cost Submitted. Enter the Ingredient Cost being submitted for the claim.																				
77	Dispensing Fee Submitted. Enter the Dispensing Fee being submitted for the claim. Note: Only required to be entered if its value has an effect on the Gross Amount Due calculation.																				
78	Prof Service Fee Submitted. Required if claim being submitted is a pharmacist-administered drug (PAD), otherwise LEAVE BLANK.																				
79	Incentive Amount Submitted. Enter the Incentive Amount being submitted for the claim. (Used to indicate Compound Sterilization Fee).																				
80	Other Amount Submitted. Used to indicate Compounding Fee. See Section 4.6.7.3 – Compounding Fee Breakdown by Dosage Form for additional information.																				
81	Sales Tax Submitted. LEAVE BLANK.																				
82	Gross Amount Due (Submitted). Enter the Gross Amount Due submitted for the claim.																				
83	Patient Paid Amount. LEAVE BLANK.																				
84	Other Payer Amount Paid #1. Enter the value that the other payer has approved for payment for some/all of the billing.																				
85	Other Payer Amount Paid #2. Enter the value that the other payer has approved for payment for some/all of the billing.																				
86	Other Payer Patient Resp. Amount #1. Enter the amount the member paid as part of the primary insurance claim.																				

Item	Description
87	Other Payer Patient Resp. Amount #2. Enter the amount the member paid as part of the primary insurance claim.
88	Net Amount Due. Enter the Gross Amount Due – Other Payer Patient Resp. Amount #1 (Field 86) and Other Payer Patient Resp. Amount #2 (Field 87).

Table 19.1.1-1: Universal Claim Form (UCF), Version D.0 Completion Instructions

19.2 California Specific Claim Forms (30-1) and (30-4)

19.2.1 California Specific Pharmacy Claim Form (30-1)

The *California Specific Pharmacy Claim Form (30-1)* is used by pharmacies to bill Medi-Cal Rx for paper claim submission(s). The form is available for download or printing on the [Medi-Cal Rx Provider Portal](#) under the [Forms & Information](#) link. [Appendix B – Directory](#) at the end of this manual provides the Medi-Cal Rx vendor address and fax number that pharmacies should use to mail or fax *California Specific Pharmacy Claim Form (30-1)* submissions. See *Figure 19.2-1* for a sample *California Specific Pharmacy Claim Form (30-1)*.

Note: If billing for a Compound, the *Universal Claim Form (UCF)* or the *California Specific Compound Pharmacy Claim Form (30-4)* must be used.

Crossover pharmacy claims that *do not cross over automatically* via NCPDP must be billed on the *Universal Claim Form (UCF)* (see [Section 19.1 – Universal Claim Form, Version D.0](#)) or the *California Specific Pharmacy Claim Form (30-1)*.

DO NOT STAPLE IN BAR AREA

CLAIM CONTROL NUMBER * FOR F.I. USE ONLY
1

Fasten Here
9

PHARMACY CLAIM FORM

Provider Name, Address: 3A

2 ID QUALIFIER 3 PROVIDER ID 3

4 ZIP CODE

Provider Phone Number: 4

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH
CARE SERVICES

ELITE PICA

← TYPEWRITER ALIGNMENT →

ELITE PICA

PATIENT INFORMATION

5 PATIENT NAME (LAST, FIRST, MI) 6 MEDICAL IDENTIFICATION NO 7 SEX 8 DATE OF BIRTH 9 PATIENT LOCATION 10 MEDICARE STATUS

1

11 PRESCRIPTION NO 12 FILL NUMBER 13 DATE OF SERVICE 14 METRIC QUANTITY 15 CODE 1 MET? 16 EMERGENCY FILL? 17 DAYS SUPPLY

18 BASIS OF COST DETERMINATION 19 PROD ID QUAL 20 PRODUCT ID 21 ID QUAL 22 PRESCRIBER ID

23 PRIMARY ICD-CM 24 SECONDARY ICD-CM 25 CHARGE 26 OTHER COVERAGE PAID 27 OTH COV CODE

28 PATIENT'S SHARE 29 TAR CONTROL NO 30 COMP CODE 31 DELETE

2

32 PRESCRIPTION NO 33 FILL NUMBER 34 DATE OF SERVICE 35 METRIC QUANTITY 36 CODE 1 MET? 37 EMERGENCY FILL? 38 DAYS SUPPLY

39 BASIS OF COST DETERMINATION 40 PROD ID QUAL 41 PRODUCT ID 42 ID QUAL 43 PRESCRIBER ID

44 PRIMARY ICD-CM 45 SECONDARY ICD-CM 46 CHARGE 47 OTHER COVERAGE PAID 48 OTH COV CODE

49 PATIENT'S SHARE 50 TAR CONTROL NO 51 COMP CODE 52 DELETE

3

53 PRESCRIPTION NO 54 FILL NUMBER 55 DATE OF SERVICE 56 METRIC QUANTITY 57 CODE 1 MET? 58 EMERGENCY FILL? 59 DAYS SUPPLY

60 BASIS OF COST DETERMINATION 61 PROD ID QUAL 62 PRODUCT ID 63 ID QUAL 64 PRESCRIBER ID

65 PRIMARY ICD-CM 66 SECONDARY ICD-CM 67 CHARGE 68 OTHER COVERAGE PAID 69 OTH COV CODE

70 PATIENT'S SHARE 71 TAR CONTROL NO 72 COMP CODE 73 DELETE

SPECIFIC DETAILS/REMARKS:

82

This is to certify that the information contained above is true, accurate, and complete and that the provider has read, understands, and agrees to be bound by and comply with the statements and conditions contained on the back of this form.

81

X Signature of provider or person authorized by provider to bind provider by above signature to statements and conditions contained on this form

74 MEDICAL RECORD NO 74

75 BILL LIMIT 75

76 ATTACHMENTS 76

77 DATE BILLED 77

78 DISCHARGE DATE 78

79 F.I. USE ONLY 79

80 80

SEE YOUR PROVIDER MANUAL FOR ASSISTANCE REGARDING THE COMPLETION OF THIS FORM. FORWARD TO APPROPRIATE F.I.

30-1 01/18

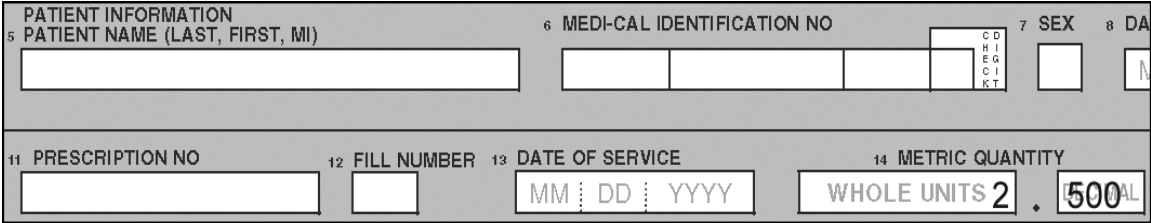
Figure 19.2-1: California Specific Pharmacy Claim Form (30-1)

19.2.1.1 Completion Instructions for California Specific Pharmacy Claim Form (30-1)

The following item numbers and descriptions in *Table 19.2.1.1-1* below correspond to *Figure 19.2-1 California Specific Pharmacy Claim Form (30-1)* above. **All items must be completed unless otherwise specified in these instructions.**

Item	Description
1	Document Control Number. For Medi-Cal Rx vendor use only. <i>Do NOT</i> mark in this area. A unique 14-digit number, assigned by the Claims Team to track each claim, will be entered here when the claim is received by the Medi-Cal Rx vendor.
2	ID Qualifier. Identifies the NCPDP D.0 standard provider ID type. The only ID qualifier allowed is "01" – NPI.
3	Provider ID. Enter your NPI number. Do <i>not</i> submit claims using a Medicare provider number or State license number.
3a	Provider Name, Address, Phone Number. Enter your name, address, and telephone number. Confirm the information entered is correct <i>before</i> submitting claim forms.
4	Zip Code. Enter the pharmacy's nine-digit ZIP code. Note: The nine-digit ZIP code entered in this box must match the biller's ZIP code on file for claims to be reimbursed correctly.
5	Patient Name. Enter the member's last name, first name and middle initial, if known. Avoid nicknames or aliases.
Newborn Infant	
	If submitting a claim for a newborn infant using the mother's ID number, enter the infant's name, sex, and date of birth. If the infant has not yet been named, write the mother's last name followed by "Baby Boy" or "Baby Girl." Infants from a multiple birth must also be designated by number or letter (e.g., "Twin A"). Write "Newborn infant using mother's card, Patient Relationship Code = 3, and PA Type Code = 8" in the Specific Details/Remarks field. Note that services to an infant may be billed with the mother's ID for the month of birth and the following month only , after which the infant must have their own Medi-Cal ID number.
6	Medi-Cal Identification Number. Enter the member ID, HAP ID, or CIN number as it appears on the Identification Card.
7	Sex. Use the capital letter "M" for male, "F" for female or "U" for Unknown. (For newborns, see <i>Item 5 – Newborn Infant</i> .)
8	Date of Birth. Enter the member's date of birth in MM/DD/YYYY format. Obtain this information from the member's BIC number.

Item	Description
	Note: This information <i>must</i> be entered for the claim to process successfully.
9	<p>Patient Location. If the member is a Long-Term Care resident, enter the appropriate Patient Residence code in this field from the options below. If the recipient is not residing in any of these facilities, leave this field blank.</p> <p>3 - Nursing Facility 9 - Intermediate Care</p>
10	<p>Medicare Status. Medicare Status Codes (listed below) are required for Charpentier claims. In all other circumstances, these codes are optional.</p> <p>Note: All codes except for "0" and "8" require documentation.</p> <p>0 – Under 65, does not have Medicare Coverage 1 – Benefits Exhausted 2 – Utilization committee denial or physician noncertification 3 – No prior hospital stays 4 – Facility Denial 5 – Noneligible provider 6 – Noneligible member 7 – Medicare benefits denied or cut short by Medicare intermediary 8 – Noncovered services 9 – PSRO denial L – Medi/Medi Charpentier: Benefit Limitations R – Medi-Medi Charpentier: Rates T – Medi/Medi Charpentier: Both rates and benefit limitations</p> <p>Note: * - Documentation required. Refer to the Section 10.1.3 – Charpentier Claims and Section 19.3.3 – Tips for Billing Charpentier Claims for additional information.</p>
11	<p>Prescription Number. Enter the prescription number in this space for reference on the Remittance Advice (RA) (paper check and voucher).</p>
12	<p>Fill Number. Enter a refill number</p> <p>0 or 00 = Original Dispensing – The first dispensing 1-99 = Refill Number – Number of the replenishment</p>
13	<p>Date of Service. Enter the date that the prescription was filled in 8-digit MMDDYYYY (Month, Day, Year) format (Example: August 6, 2007 = 08062007).</p>

Item	Description
<p>14</p>	<p>Metric Quantity. The quantity dispensed must be submitted in metric decimal form. <u>A decimal is preimprinted on the claim form.</u> Do not include a decimal in either of the boxes of the <i>Metric Quantity</i> field or the claim will be returned.</p> <p>Example: A quantity of 2.5 must be submitted with the number '2' in the "Whole Units" box and the '5' in the "Decimal" box. The "Decimal" field must include trailing zeros, for a total of three (3) characters. Do <i>not</i> include measurement units such as GM, CC, or ML.</p>  <p>The screenshot shows a portion of a claim form. At the top, it says 'PATIENT INFORMATION' and '6 MEDI-CAL IDENTIFICATION NO'. Below that, there are fields for '5 PATIENT NAME (LAST, FIRST, MI)', '7 SEX', and '8 DA'. Further down, there are fields for '11 PRESCRIPTION NO', '12 FILL NUMBER', '13 DATE OF SERVICE' (with sub-fields for MM, DD, and YYYY), and '14 METRIC QUANTITY'. The '14 METRIC QUANTITY' field is split into 'WHOLE UNITS' and 'DECIMAL'. The 'WHOLE UNITS' box contains the number '2' and the 'DECIMAL' box contains '500'.</p> <p>Use Correct Measurement Unit</p> <p>The correct measurement unit is listed beside each item in the CDL (which can be found on the Medi-Cal Rx Provider Portal by selecting Forms & Information). This is the measurement unit to be used for billing. For items requiring a PA, the approved authorization will specify the exact units to be used in the quantity field of the claim form.</p> <p>Package Size Specific Codes</p> <p>Items in the CDL are sometimes package-size specific.</p> <p>In such cases, use the code that corresponds to a trade package made by the manufacturer whose product is dispensed. If the manufacturer does not make a trade package containing the quantity dispensed, use the code that corresponds to the package size that was used in filling the prescription.</p> <p>Example: If 60 grams of an ointment are dispensed out of a 454-gram jar, the code for the 454-gram jar should be used.</p> <p>Prepacks</p> <p>The units (GMs, MLs, or Each) that are to be used when billing the program, are specified in the item's listing. The units specified must be used in all cases. The quantity entered for prepacks should always be in the number of units specified in the CDL.</p>
<p>15</p>	<p>Code I (Restrictions) Met? Enter "Y" if the Code I restriction(s) listed in the CDL (which can be found on the Medi-Cal Rx Provider Portal by selecting Forms & Information) has been met; otherwise enter "N" or leave blank.</p>
<p>16</p>	<p>Emergency Fill? If the drug was dispensed in an emergency, use indicator "Y" for 'yes' or "N" for 'no,' or leave blank.</p>
<p>17</p>	<p>Days Supply. Enter the estimated number of days that the drug dispensed will last.</p>

Item	Description																				
18	Basis of Cost Determination. Enter the appropriate code to indicate the method used to calculate the ingredient cost. If claim was for 340B/Disproportionate Share Pricing/Public Health Service, '08' <u>must</u> be used.																				
	<table border="1"> <thead> <tr> <th data-bbox="264 329 618 380">Code</th> <th data-bbox="618 329 1468 380">Description</th> </tr> </thead> <tbody> <tr> <td data-bbox="264 380 618 436">01</td> <td data-bbox="618 380 1468 436">AWP (Average Wholesale Price)</td> </tr> <tr> <td data-bbox="264 436 618 493">02</td> <td data-bbox="618 436 1468 493">Local Wholesalers</td> </tr> <tr> <td data-bbox="264 493 618 550">03</td> <td data-bbox="618 493 1468 550">Direct</td> </tr> <tr> <td data-bbox="264 550 618 606">04</td> <td data-bbox="618 550 1468 606">EAC (Estimated Acquisition Cost)</td> </tr> <tr> <td data-bbox="264 606 618 663">05</td> <td data-bbox="618 606 1468 663">Acquisition</td> </tr> <tr> <td data-bbox="264 663 618 720">06</td> <td data-bbox="618 663 1468 720">MAC (Maximum Allowable Cost)</td> </tr> <tr> <td data-bbox="264 720 618 777">07</td> <td data-bbox="618 720 1468 777">Usual & Customary (U&C)</td> </tr> <tr> <td data-bbox="264 777 618 833">08</td> <td data-bbox="618 777 1468 833">340B/Disproportionate Share Pricing/Public Health Service</td> </tr> <tr> <td data-bbox="264 833 618 890"><i>Field left blank</i></td> <td data-bbox="618 833 1468 890">Not Specified</td> </tr> </tbody> </table>	Code	Description	01	AWP (Average Wholesale Price)	02	Local Wholesalers	03	Direct	04	EAC (Estimated Acquisition Cost)	05	Acquisition	06	MAC (Maximum Allowable Cost)	07	Usual & Customary (U&C)	08	340B/Disproportionate Share Pricing/Public Health Service	<i>Field left blank</i>	Not Specified
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07	Usual & Customary (U&C)																				
08	340B/Disproportionate Share Pricing/Public Health Service																				
<i>Field left blank</i>	Not Specified																				
19	Product ID Qualifier. This field identifies the type of Product ID submitted. Place a '03' for National Drug Code (NDC).																				
20	<p data-bbox="264 997 1112 1039">Product ID. When billing for drugs, enter the 11-digit NDC.</p> <p data-bbox="264 1050 1468 1102" style="text-align: center;">Zero Fill NDC Numbers</p> <p data-bbox="264 1113 1468 1323">All NDC numbers <i>must</i> be 11 digits long. NDCs printed on packages often have fewer than 11 digits, with hyphens (-) separating the number into 3 segments. For a complete 11-digit number, the first segment <i>must</i> have 5 digits, the second segment 4 digits, and the third segment 2 digits. Add leading 0's wherever they are needed to complete a segment with the correct number of digits.</p> <p data-bbox="264 1375 430 1417">Examples:</p> <table border="1" data-bbox="264 1428 1039 1627"> <thead> <tr> <th data-bbox="264 1428 519 1470"><u>Package Number</u></th> <th data-bbox="519 1428 779 1470"><u>Zero Fill</u></th> <th data-bbox="779 1428 1039 1470"><u>11-digit NDC</u></th> </tr> </thead> <tbody> <tr> <td data-bbox="264 1470 519 1522">1234-1234-12</td> <td data-bbox="519 1470 779 1522">(01234-1234-12)</td> <td data-bbox="779 1470 1039 1522">01234123412</td> </tr> <tr> <td data-bbox="264 1522 519 1575">12345-123-12</td> <td data-bbox="519 1522 779 1575">(12345-0123-12)</td> <td data-bbox="779 1522 1039 1575">12345012312</td> </tr> <tr> <td data-bbox="264 1575 519 1627">2-22-2</td> <td data-bbox="519 1575 779 1627">(00002-0022-02)</td> <td data-bbox="779 1575 1039 1627">00002002202</td> </tr> </tbody> </table> <p data-bbox="264 1638 1468 1690" style="text-align: center;">Drug Manufacturer and Product Codes</p> <p data-bbox="264 1701 1468 1858">If the item being billed is a drug, refer to the CDL (which can be found on the Medi-Cal Rx Provider Portal by selecting Forms & Information) for information on authorized drug manufacturer labeler codes. The products of manufacturers not listed in the CDL are not covered by Medi-Cal without authorization.</p>	<u>Package Number</u>	<u>Zero Fill</u>	<u>11-digit NDC</u>	1234-1234-12	(01234-1234-12)	01234123412	12345-123-12	(12345-0123-12)	12345012312	2-22-2	(00002-0022-02)	00002002202								
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12345-123-12	(12345-0123-12)	12345012312																			
2-22-2	(00002-0022-02)	00002002202																			

Item	Description
	<p style="text-align: center;">Medical Supplies</p> <p>Medical supplies that may be billed as “pharmacy only” benefits according to NCPDP claim transaction standards include diabetic supplies, peak flow meters, inhalers, contraceptive products, and enteral nutrition formula (see Section 12.0 – Enteral Nutrition Products and Section 13.0 – Medical Supplies for additional information).</p>
21	<p>Prescriber ID Qualifier. Identifies the NCPDP D.0 standard provider ID type. The only ID qualifier allowed is “01” – NPI.</p>
22	<p>Prescriber ID. Enter the NPI number of the prescriber or, if applicable, the NPI number of the certified nurse-midwife, nurse practitioner, physician assistant, naturopathic doctor or pharmacist who functions pursuant to a policy, procedure, or protocol as required by <i>Business and Professions Code</i> statutes. Do not use the DEA Narcotic Registry Number. This information must be entered for your claim to successfully process</p>
23	<p>Primary ICD-CM. Optional. If available, enter all letters and/or numbers of the <i>International Classification of Diseases – 10th Revision – Clinical Modification</i> (ICD-10-CM) code for the primary diagnosis, including the fourth through seventh digits, if present. Do not enter the decimal point.</p> <p>Important: For claims with DOS or dates of discharge <i>on or after</i> October 1, 2015, enter the ICD indicator “0” as an additional digit before the ICD-10-CM code. The ICD indicator is required only if a primary diagnosis code is being entered on the claim. Secondary diagnosis codes do not require the indicator. Claims that contain a primary diagnosis code, but no ICD indicator may be denied.</p>
24	<p>Secondary ICD-CM. Optional. The primary diagnosis code should be placed in the first occurrence and the secondary should be placed in the second occurrence.</p>
25	<p>Charge. Enter the dollar and cents amount for this item. <u>Do not</u> enter a decimal point (.) or dollar sign (\$).</p>
26	<p>Other Coverage Paid. Optional item, unless OHC payment was received. Enter the full dollar amount of payment received from OHC carriers. <u>Do not</u> enter a decimal point (.) or dollar sign (\$). Leave blank if not applicable. If the OHC payment received is a negative value, enter zero (0) in this field and enter a “2” in the <i>Other Coverage Code</i> field (Box 27). For NCPDP hardcopy pharmacy crossovers, add the Other Health Coverage Amount(s) and Medicare Paid Amount, enter the combined total.</p>

Item	Description
27	<p>Other Coverage Code. A valid OCC is required. Enter one of the following values:</p> <ul style="list-style-type: none"> 0 – Not Specified 1 – No Other Coverage Exists 2 – Other Coverage Exists, Payment Collected 3 – Other Coverage Exists, Claim not covered 4 – Other Coverage Exists, Payment Not Collected
28	<p>Patient’s Share (of Cost). N/A for Medi-Cal Rx (leave blank). For more information, see Section 9.3 – Share of Cost (SOC).</p>
29	<p>TAR Control Number. N/A LEAVE BLANK (Not used by Medi-Cal Rx vendor)</p>
30	<p>Compound Code. Enter the appropriate code in this box.</p> <ul style="list-style-type: none"> 0 – Not specified 1 – Not a Compound <p>Note: Compound pharmacy claims must be billed on the <i>Universal Claim Form (UCF)</i> or the <i>Compound Pharmacy Claim Form (30-4)</i>, through the POS network, or electronically through the web claims submission on the Medi-Cal Rx Provider Portal.</p>
31	<p>Delete. If an error has been made, enter an “X” in this space to delete the entire line. Enter the correct billing information on another line. When a <i>Delete</i> box is marked “X,” the information on the line will be “ignored” by the system and will not be entered as a claim line.</p>
32-73	<p>Additional Claim Lines. Lines 2 and 3 are used for additional items for the <i>same patient</i> during the <i>same month of service</i>.</p>
74	<p>Medical Record Number. Optional – for provider use only.</p>
75	<p>Billing Limit Exceptions. If there is an exception to the 6-month billing limitation, enter the appropriate reason code number and include the required documentation. (See Section 19.3.1 - Submission and Timeliness Instructions.)</p>
76	<p>Attachments. Enter an “X” if attachments are included with the claim (Example: Catalog pages, invoices, etc.).</p> <p>Leave blank if not applicable.</p> <p>Reminder: If this box is not marked, attachments may not be seen by the claim examiner, which may cause the claim to be denied.</p>
77	<p>Date Billed. Enter the date this statement is being submitted to the Medi-Cal Rx vendor (use MMDDYYYY format).</p>
78	<p>Discharge Date. Leave blank. This will be used for the date the patient was discharged from the hospital.</p>

Item	Description
79-80	Medi-Cal Rx vendor USE ONLY. Leave blank.
81	<p>Signature of Provider and Date. The claim must be signed and dated by the provider or a representative assigned by the provider. Use BLACK ballpoint pen only.</p> <p>Note: An <i>original</i> signature is required on all paper claims. The signature <i>must be written</i>, not printed. Stamps, initials, or facsimiles are not acceptable. The signature does not have to be on file with the Medi-Cal Rx vendor.</p>
82	<p>Specific Details/Remarks. Use this blank space to clarify or detail any line item. <u>Indicate the line item number being referenced.</u> If additional space is needed, insert a capital "X" or "Y" in <i>Box 76 (Attachments)</i> and clip or staple your attachment to the top right-hand corner of the claim.</p> <p>The <i>Specific Details/Remarks</i> area is also used to provide information on Crossovers or Charpentier Rebilling. See Section 19.2.1.2 – (30-1): Tips for Billing for more information.</p>
	<p style="text-align: center;">Emergency Certification Statement</p> <p>Beginning January 1, 2022, emergency claims can be billed via POS, Web-Claim Submission/Direct Data Entry, or paper claim. For emergency claims submitted via paper form(s), they must include an Emergency Certification Statement.</p> <p>The Emergency Certification Statement must be attached to the claim and include:</p> <ul style="list-style-type: none"> • The nature of the emergency, including relevant clinical information about the patient’s condition • Why the emergency services rendered were considered to be immediately necessary • The signature of the physician, podiatrist, dentist, or pharmacist who had direct knowledge of the emergency <p>The statement must be comprehensive enough to support a finding that an emergency existed. A mere statement that an emergency existed is not sufficient. An Emergency Certification Statement may not be used in place of a PA for diabetic test strips and lancets that require authorization when the maximum quantity has been reached.</p>

**Table 19.2.1.1-1: California Specific Pharmacy Claim Form (30-1)
Completion Instructions**

For the *Metric Quantity* field on the (30-1) Form, a decimal point and the trailing zeros *must* be present.

- Example: A quantity of '4' must be submitted as '4.000' (the field must include the trailing zeros). A quantity of '100' should be billed as '100.000.'

For the *Dollar Amount* fields, do not fill in the decimal point. The cents should still be included in the amount.

- Example: \$10.00 should appear as '1000' in the dollar amount field(s).

For the *Other Health Coverage Code* (OTH COV CODE) fields, if the member has other health coverage, enter the appropriate code.

- **Note:** Put '0 – Not Specified or No Other Health Coverage Exists' if the member does not have other health coverage or leave the field blank.

19.2.1.2 (30-1) Tips for Billing

This section contains *Table 19.2.1.2-1*, which details the *California Specific Pharmacy Claim Form (30-1)* fields that must be completed accurately and completely in order to avoid claim denial.

Common Billing Errors		
Field	Description	Error
Upper Left Corner	Provider Name, Address, Phone Number	Not entering the provider phone number on claim form. Billing Tip: Enter provider telephone number with area code. (This is optional, but helpful if there is a need to contact the provider.)
Box 14	Metric Quantity	Quantities must include the decimal point and trailing zeros. <ul style="list-style-type: none"> • Example: The quantity for two 3.5 gm tubes would be 7.000 using metric decimals. An individual tube would be 3.500. Note: Providers must bill the metric decimal quantity to three decimal places. Rounding may cause the claim to pay the incorrect dollar amount and may cause the claim to be denied. <u>Billing Units:</u> <ul style="list-style-type: none"> • Each: Solid oral dosage forms (tablet/capsule), powder filled (dry) vials, packets, patches, etc. • Milliliter (ml): Liquid oral dosage forms, liquid filled vials, ampules, reconstituted oral products, etc. • Grams (gm): Ointments, bulk powders (not IV), etc.

Common Billing Errors		
Field	Description	Error
Box 18	Basis of Cost Determination	<p>Entering "00" – Not Specified when the drug dispensed was not purchased under the 340B Drug Discount Program.</p> <p>Billing Tip: Any provider purchasing drugs through the 340B program <u>must</u> pass the discounted ingredient cost to Medi-Cal. A "08" in this field means the ingredient cost was purchased with a 340B Drug Discount Program contract.</p>
Box 20	Product ID	Do not use hyphens when entering the NDC numbers in this field.
Box 25	Charge	<p>Entering the incorrect billing amount.</p> <p>Billing Tip: Bill full Usual And Customary (U&C) charges, or class of trade price including tax. Do <i>not</i> include the decimal in this box. The amount entered should include cents.</p>
Box 26	Other Coverage Paid	<ul style="list-style-type: none"> • Entering no charges when the Other Coverage Code box contains "2" indicating other coverage payment was collected. • Entering charges in this field when the Other Coverage Code box does <i>not</i> contain "2." <p>Billing Tip: Enter the amount of payment received from Other Health Coverage carriers. Leave blank if not applicable. Do <i>not</i> include the decimal in this box. The amount entered should include cents.</p>
Box 27	Other Coverage Code	<ul style="list-style-type: none"> • Not including a valid code or using a code other than "2" with an amount in the Other Coverage Paid box. • Entering a 'Y,' indicating YES (not an acceptable code) <p>Billing Tip: Valid Codes:</p> <p>0 – Not Specified 1 - No Other Coverage Exists 2 – Other Coverage Exists, Payment Collected 3 – Other Coverage Exists, Claim not covered 4 – Other Coverage Exists, Payment Not Collected</p>

Common Billing Errors		
Field	Description	Error
		Provider must be able to readily retrieve proof of claim submission and payment if collected from the other payer(s). The provider is certifying that the other health insurance was billed.
Box 29	TAR Control Number	N/A. LEAVE BLANK (not used by Medi-Cal Rx vendor)
Box 76	Attachments	Not including attachment with the claim. Billing Tip: Do not mark this box if attachments are <i>not</i> included with the claim.
Common Attachment Reminders	Catalog pages/invoices	Tip: Circle in black the item being billed and indicate claim line number. Quantity per package can be written in (must be able to compute one each price). Retail pricing is never acceptable
Box 81	Signature of Provider and Date	Not including a signature on the claim. Billing Tip: Claim <i>must</i> be signed in BLACK ink. Stamps, initials, or facsimiles are not acceptable.
Box 82	Specific Details/Remarks	Information on claim does not match attachment. Billing Tip: Product numbers, NDC numbers, product information in the <i>Specific Details/Remarks</i> area must match the information supplied on the attachment. Specify the claim line number on the attachment.

Table 19.2.1.2-1: California Specific Pharmacy Claim Form (30-1) Tips for Billing

19.2.2 California Specific Compound Pharmacy Claim Form (30-4)

The *California Specific Compound Pharmacy Claim Form (30-4)* is used by pharmacies to bill Medi-Cal Rx for multi-ingredient compound drug prescriptions and single ingredient sterile transfers. The form is available for download or printing on the [Medi-Cal Rx Provider Portal](#) under the [Forms & Information](#) link. [Appendix B – Directory](#) at the end of this manual provides the Medi-Cal Rx vendor address and fax number that pharmacies should use to mail or fax *California Specific Compound Pharmacy Claim Form (30-4)* submissions. See *Figure 19.2.2-1* for a sample *California Specific Compound Pharmacy Claim Form (30-4)*.

Ingredients that *do not* have an associated NDC will not be accepted. Attachments providing where an NDC can be located (attached catalog page, invoice, or other supporting documentation) will be allowed.

Note: If billing for a non-compound claim, the *Universal Claim Form (UCF)*, or the *California Specific Pharmacy Claim Form (30-1)* must be used.

Crossover compound pharmacy claims that *do not cross over automatically* via NCPDP must be billed on the *California Specific Compound Pharmacy Claim Form (30-4)*. See *Figure 19.2.2-1*. These claims **cannot** be billed via Web Claims Submission/Direct Data Entry or POS Network.

The form is titled "COMPOUND DRUG PHARMACY CLAIM FORM" and is issued by the "STATE OF CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES". It includes a "CLAIM CONTROL NUMBER * FOR F.I. USE ONLY" field (1) and a "Faction Here" label (3). The provider information section (3A) includes fields for "ID QUALIFIER" (2), "PROVIDER ID" (3), and "ZIP CODE" (4). Patient information (5) includes "PATIENT NAME (LAST, FIRST, MI)", "MEDICAL IDENTIFICATION" (6), "SEX" (7), "DATE OF BIRTH" (8), and "DATE OF ISSUE" (9). Prescription details (10) include "PRESCRIPTION NO.", "DATE OF SERVICE" (12), "TOTAL METRIC QUANTITY" (13), "CODE 1 MET" (14), "EMERGENCY FLAG" (15), "DAYS SUPPLY" (16), and "PATIENT LOCATION" (17). Insurance and payment information (18-31) includes "MEDICARE STATUS" (18), "ID QUAL" (19), "PRESCRIBER ID" (20), "PRIMARY ICD-CM" (21), "SECONDARY ICD-CM" (22), "HOSP CODE" (23), "DISP UNIT" (24), "DISP QUANTITY" (25), "TOTAL CHARGE" (26), "OTHER COVERAGE PAID" (27), "OTH CDY CODE" (28), "PATIENT'S SHARE" (29), "INCENTIVE AMOUNT" (30), and "TAR CONTROL NO." (31). A table (32) lists ingredients with columns for "INGREDIENT PRODUCT ID" (33), "WHOLE UNITS" (34), "DECIMAL" (35), "INGREDIENT CHARGE" (35), and "BASE OF COST" (36). Additional fields (37-46) include "MEDICAL RECORD NO." (37), "BILL UMEX" (38), "DATE BILLED" (39), "HOSP DISCHARGE DATE" (40), "INGREDIENT TOTAL CHARGE" (41), "SPECIFIC DETAILS/REMARKS" (48), "PROC FOR APPROVED" (42), "CONTAINER COUNT" (43), "F.I. USE ONLY" (44), and a signature line (45, 46). A certification statement (47) is located at the bottom right. The footer contains the text "SEE YOUR PROVIDER MANUAL FOR ASSISTANCE REGARDING THE COMPLETION OF THIS FORM", "Revision Date: 01/18", and "Form Number: 30-4".

Figure 19.2.2-1: California Specific Compound Pharmacy Claim Form (30-4)

19.2.2.1 Completion Instructions for California Specific Compound Pharmacy Claim Form (30-4)

The following item numbers and descriptions in *Table 19.2.2.1-1* below correspond to the *California Specific Compound Pharmacy Claim Form (30-4)* in *Figure 19.2.2-1* above. **All items must be completed unless otherwise specified in these instructions.**

California Specific Compound Pharmacy Claim Form (30-4)	
Item	Description
1	Document Control Number. For Medi-Cal Rx vendor use only. <i>Do NOT</i> mark in this area. A unique 14-digit number, assigned by the Claims Team to track each claim, will be entered here when the claim is received by the Medi-Cal Rx vendor.
2	ID Qualifier. Identifies the NCPDP D.0 standard provider ID type, the only ID qualifier allows is "01" – NPI.
3	Provider ID. Enter your NPI number. Do <i>not</i> submit claims using a Medicare provider number or State license number.
3a	Provider Name, Address, Phone Number. Enter the provider name, address, and telephone number. Confirm this information is correct <i>before</i> submitting the claim form.
4	Zip Code. Enter the pharmacy's nine-digit ZIP code. Note: The nine-digit ZIP code entered in this box must match the biller's ZIP code on file for claims to be reimbursed correctly.
5	<p>Patient Name. Enter the member's last name, first name and middle initial, if known. Avoid nicknames or aliases</p> <p style="text-align: center;">Newborn Infant</p> <p>When submitting a claim for a newborn infant using the mothers ID number, enter the infant's name, sex, and year of birth in the appropriate spaces. Enter the complete date of birth (MMDDYYYY) and write "Newborn infant using mother's card, Patient Relationship Code = 3, and PA Type Code = 8" in the Specific Details/Remarks field.</p> <p>If the infant has not yet been named, write the mother's last name followed by "Baby Boy" or "Baby Girl" (Example: Jones, Baby Girl). If newborn infants from a multiple birth are being billed in addition to the mother, each newborn must also be designated by number or letter (Example: Jones, Baby Girl, Twin A).</p> <p>Note: Services to an infant may be billed with the mother's ID for the month of birth and the following month only. After this time, the infant must have his or her own Medi-Cal ID number.</p>

California Specific Compound Pharmacy Claim Form (30-4)

Item	Description
6	Medi-Cal Identification Number. Enter the member ID, HAP ID, or CIN number as it appears on the Identification Card.
7	Sex. Use the capital letter "M" for male, "F" for female or "U" for Unknown. (For newborns, see <i>Item 5 – Newborn Infant.</i>)
8	Date of Birth. Enter the member's date of birth in MM/DD/YYYY format. Obtain this information from the member's BIC number. Note: This information <i>must</i> be entered for the claim to process successfully.
10	Prescription Number. Enter the prescription number in this space for reference on the Remittance Advice (RA).
11	Fill Number. Enter a refill number 0 or 00 = Original Dispensing – The first dispensing 1-99 = Refill Number – Number of the replenishment
12	Date of Service. Enter the date that the prescription was filled in 8-digit MMDDYYYY (Month, Day, Year) format (Example: August 6, 2007 = 08062007).
13	Total Metric Quantity. Enter the quantity of the entire amount dispensed and being bill on the claim. Quantities <i>must</i> be in metric decimal format. <u>Do not</u> include a decimal in either of the two fields that make up the metric decimal quantity or the claim <u>will be returned</u> . Do not include measurement descriptors such as "Gm" or "cc." For example: A 2.4 Gm powder will be 2 in the <i>Whole Units</i> box and 4 in the <i>Decimal</i> box and three 2.4cc ampules will be 2.4 x 3 = 7.2 (7 in the <i>Whole Units</i> box and 2 in the <i>Decimal</i> box).
14	Code I (Restrictions) Met? Enter "Y" if the Code I restriction(s) listed in the CDL (which can be found on the Medi-Cal Rx Provider Portal by selecting Forms & Information) has been met; otherwise enter "N" or leave blank.
15	Emergency Fill? If the drug was dispensed in an emergency, use indicator "Y" for 'yes,' "N" for 'no,' or leave blank
16	Days' Supply. Enter the estimated number of days that the drug dispensed will last.
17	Patient Location. If the member is a Long Term Care resident, enter the appropriate Patient Residence code in this field from the options below. If the recipient is not residing in any of these facilities, leave this field blank. 3 – Nursing Facility 9 – Intermediate Care

California Specific Compound Pharmacy Claim Form (30-4)

Item	Description						
18	<p>Medicare Status. Medicare status codes are required for Charpentier claims. In all other circumstances, these codes are optional. The Medicare Status codes are:</p> <p>R – Medi/Medi Charpentier: Rates L – Medi/Medi Charpentier: Benefit Limits T – Medi/Medi Charpentier: Both Rates & Benefit Limitations 0 – Under 65, does not have Medicare coverage</p> <p>If the member is not Medicare eligible leave Item 18 blank.</p>						
19	<p>Prescriber ID Qualifier. Identifies the type of prescriber ID submitted (National Provider Identifier Number (NPI),</p> <p>Note: Medi-Cal Rx currently accepts <i>only</i> a provider’s NPI number. Enter “01” to indicate NPI license number under NCPDP D.0 standards.</p>						
20	<p>Prescriber ID. Enter the NPI, or, if applicable, the NPI number of the certified nurse-midwife, the nurse practitioner, the physicians’ assistant, the naturopathic doctor, or the pharmacist who function pursuant to a policy, procedure or protocol as require by <i>Business and Professions Code</i> statutes. Do <i>not</i> use DEA Narcotic Registry Number. The NPI must be entered for your claim to successfully process.</p>						
21	<p>Primary ICD-CM. Optional. If available, enter all letters and/or numbers of the <i>International Classification of Diseases – 10th Revision – Clinical Modification</i> (ICD-10-CM) code for the primary diagnosis, including the fourth through seventh digits, if present. Do not enter the decimal point.</p> <p>Important: For claims with dates of service or dates of discharge <i>on or after</i> October 1, 2015, enter the ICD indicator “0” as an additional digit before the ICD-10-CM code.</p> <p>The ICD indicator is required only if a primary diagnosis code is being entered on the claim. Secondary diagnosis codes do not require the indicator. Claims that contain a primary diagnosis code, but no ICD indicator may be denied.</p>						
22	<p>Secondary ICD-CM. Optional item. See Item 21 “Primary ICD-CM” for description.</p>						
23	<p>Dosage Form Description Code. Enter the appropriate code to indicate the dosage form of the finished compound.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: center;">Code</th> <th style="text-align: center;">Description</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">01</td> <td>Capsule</td> </tr> <tr> <td style="text-align: center;">02</td> <td>Ointment</td> </tr> </tbody> </table>	Code	Description	01	Capsule	02	Ointment
Code	Description						
01	Capsule						
02	Ointment						

California Specific Compound Pharmacy Claim Form (30-4)

Item	Description									
	03	Cream								
	04	Suppository								
	05	Powder								
	06	Emulsion								
	07	Liquid								
	10	Tablet								
	11	Solution								
	12	Suspension								
	13	Lotion								
	14	Shampoo								
	15	Elixir								
	16	Syrup								
	17	Lozenge								
	18	Enema								
	<p>Note: Compounding fees are paid based upon the dosage form and route of administration information submitted on the pharmacy claim. To ensure proper payment, be certain to enter this information correctly.</p>									
24	<p>Dispensing Unit Form Indicator. Enter the appropriate code to indicate the way that the finished compound is measured.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: center;">Code</th> <th style="text-align: center;">Description</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">1</td> <td>Each</td> </tr> <tr> <td style="text-align: center;">2</td> <td>Grams (GM)</td> </tr> <tr> <td style="text-align: center;">3</td> <td>Milliliters (ML)</td> </tr> </tbody> </table>		Code	Description	1	Each	2	Grams (GM)	3	Milliliters (ML)
Code	Description									
1	Each									
2	Grams (GM)									
3	Milliliters (ML)									
25	<p>Route of Administration. Leave blank. The Systematized Nomenclature of Medicine (SNOMED)/Route of Administration (ROA) code is required and must be entered in <i>Box 48 – Specific Details/Remarks</i>.</p>									
26	<p>Total Charge. Enter the total dollar and cents amount for the claim. This amount should include all compounding, sterility, and professional fees. For intravenous and intraarterial injections only, the fees should be multiplied by the number of containers before adding them to the total charge. <u>Do not</u> enter a decimal point (.) or dollar sign (\$).</p>									

California Specific Compound Pharmacy Claim Form (30-4)

Item	Description										
	Note: Compounding fees are paid based upon the dosage form and route of administration information submitted on the pharmacy claim. To ensure proper payment, be certain to enter this information correctly.										
27	Other Coverage Paid. Optional item, unless OHC payment was received. Enter the full dollar amount of payment received from OHC carriers. <u>Do not</u> enter a decimal point (.) or dollar sign (\$). Leave blank if not applicable. If the OHC payment received is a negative value, enter zero (0) in this field and enter a "2" in the <i>Other Coverage Code</i> field (Box 28). For NCPDP hardcopy pharmacy crossovers, add the Other Health Coverage Amount(s) and Medicare Paid Amount, enter the combined total.										
28	Other Coverage Code. A valid Other Coverage Code is required. Enter one of the following values: 0 – Not Specified 1 - No Other Coverage Exists 2 – Other Coverage Exists, Payment Collected 3 – Other Coverage Exists, Claim Not Covered 4 – Other Coverage Exists, Payment Not Collected										
29	Patient’s Share (of Cost). N/A for Medi-Cal Rx (leave blank). For more information, see Section 9.3 – Share of Cost .										
30	Incentive Amount. Optional item. If sterility testing was performed, enter the full dollar amount of the sterility test charge in this field. <u>Do not</u> enter a decimal point (.) or dollar sign (\$). Leave blank if not applicable. For intravenous and intraarterial injections only, the sterility testing fee should be multiplied by the number of containers.										
31	TAR Control Number. N/A LEAVE BLANK (not used by Medi-Cal Rx vendor)										
32	(Ingredient) Product ID Qualifier. Enter the appropriate code to indicate the type of ingredient that is in Item 33. <table border="1" data-bbox="376 1516 1466 1795"> <thead> <tr> <th align="center">Code</th> <th align="center">Explanation</th> </tr> </thead> <tbody> <tr> <td align="center">01</td> <td>Universal Product Code (UPC)</td> </tr> <tr> <td align="center">03</td> <td>National Drug Code (NDC)</td> </tr> <tr> <td align="center">04</td> <td>Universal Product Number (UPN)</td> </tr> <tr> <td align="center">99</td> <td>Other</td> </tr> </tbody> </table>	Code	Explanation	01	Universal Product Code (UPC)	03	National Drug Code (NDC)	04	Universal Product Number (UPN)	99	Other
Code	Explanation										
01	Universal Product Code (UPC)										
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04	Universal Product Number (UPN)										
99	Other										
33	Ingredient Product ID. Indicates the ingredient used in the compound drug. This must be an NDC number.										

California Specific Compound Pharmacy Claim Form (30-4)

Item	Description																				
34	Ingredient Quantity. Enter the total quantity of the ingredient in all containers. Quantities must be in the metric decimal format. The decimal point must not be included in either of the two fields that make up the metric decimal quantity or the claim will be returned. Do not include measurement descriptors such as "GM," "CC," or "ML."																				
35	Ingredient Charge. Enter the dollar and cents amount for this ingredient for all containers in this field. <u>Do not</u> enter a decimal point (.) or dollar sign (\$).																				
36	<p>(Ingredient) Basis of Cost Determination. Enter the appropriate code to indicate the method used to calculate the ingredient cost. If claim was for 340B/Disproportionate Share Pricing/Public Health Service, '08' <u>must</u> be used.</p> <table border="1"> <thead> <tr> <th align="center">Code</th> <th align="center">Description</th> </tr> </thead> <tbody> <tr> <td align="center">01</td> <td>AWP (Average Wholesale Price)</td> </tr> <tr> <td align="center">02</td> <td>Local Wholesalers</td> </tr> <tr> <td align="center">03</td> <td>Direct</td> </tr> <tr> <td align="center">04</td> <td>EAC (Estimated Acquisition Cost)</td> </tr> <tr> <td align="center">05</td> <td>Acquisition</td> </tr> <tr> <td align="center">06</td> <td>MAC (Maximum Allowable Cost)</td> </tr> <tr> <td align="center">07</td> <td>Usual & Customary (U&C)</td> </tr> <tr> <td align="center">08</td> <td>340B/Disproportionate Share Pricing/Public Health Service</td> </tr> <tr> <td align="center"><i>Field left blank</i></td> <td>Not Specified</td> </tr> </tbody> </table>	Code	Description	01	AWP (Average Wholesale Price)	02	Local Wholesalers	03	Direct	04	EAC (Estimated Acquisition Cost)	05	Acquisition	06	MAC (Maximum Allowable Cost)	07	Usual & Customary (U&C)	08	340B/Disproportionate Share Pricing/Public Health Service	<i>Field left blank</i>	Not Specified
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<i>Field left blank</i>	Not Specified																				
Multiple Ingredient Lines (1-23)	<p>Multiple Ingredient Lines. List all ingredients in the compounded drug. If blank lines are present between ingredients or ingredient lines are crossed out, the claim will be returned. When billing for more than 23 ingredients, enter the following numbers for the 23rd ingredient:</p> <p>Product ID Qualifier = 99 Product ID = 99999999998 Quantity = total quantity of the additional ingredients on the compound drug attachment Charge = total charge for the additional ingredients on the compound drug attachment</p>																				
37	Medical Record Number. Optional item. If a medical record number or account number is assigned to the member field, enter that number to																				

California Specific Compound Pharmacy Claim Form (30-4)

Item	Description																				
	<p>identify the member more easily. A maximum of 10 numbers and/or letters may be used.</p> <p>If unique record-keeping numbers are not assigned to each member, you may enter the member's name.</p>																				
38	<p>Billing Limit Exceptions. If there is an exception to the 6-month billing limitation, enter the appropriate reason code number and include the required documentation.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="background-color: #d9d9d9;">Code</th> <th style="background-color: #d9d9d9;">Description</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">1</td> <td> (1) Proof of eligibility unknown or unavailable; includes retroactive eligibility or ID cards, if applicable (2) For Share of Cost (SOC) reimbursement processing </td> </tr> <tr> <td style="text-align: center;">2</td> <td> (1) Other Health Coverage, including Medicare, Kaiser, CHAMPUS, and other health insurance (2) Charpentier rebill claims </td> </tr> <tr> <td style="text-align: center;">3</td> <td>Authorization delays in PA approval</td> </tr> <tr> <td style="text-align: center;">4</td> <td>Delay by DHCS in certifying providers or by Medi-Cal Rx vendor in supplying billing forms</td> </tr> <tr> <td style="text-align: center;">5</td> <td>Delay in delivery of custom-made eye, prosthetic, or orthotic appliances</td> </tr> <tr> <td style="text-align: center;">6</td> <td>Substantial damage by fire, flood, or disaster to provider records</td> </tr> <tr> <td style="text-align: center;">7</td> <td> Theft, sabotage, or other willful acts by an employee Note: Negligence by an employee is <u>not</u> covered by this reason code </td> </tr> <tr> <td style="text-align: center;">10</td> <td> (1) Court order, State, or administrative fair hearing decision (2) Delay or error in the certification or determination of Medi-Cal eligibility (3) Update of a PA beyond the 12-month limit (4) Circumstances beyond the provider's control as determined by DHCS </td> </tr> <tr> <td style="text-align: center;">A</td> <td>Claim submitted after the 6-month billing limit and received by MMA during the 7th – 12th month after the month of service and none of the exceptions above applied</td> </tr> </tbody> </table>	Code	Description	1	(1) Proof of eligibility unknown or unavailable; includes retroactive eligibility or ID cards, if applicable (2) For Share of Cost (SOC) reimbursement processing	2	(1) Other Health Coverage, including Medicare, Kaiser, CHAMPUS, and other health insurance (2) Charpentier rebill claims	3	Authorization delays in PA approval	4	Delay by DHCS in certifying providers or by Medi-Cal Rx vendor in supplying billing forms	5	Delay in delivery of custom-made eye, prosthetic, or orthotic appliances	6	Substantial damage by fire, flood, or disaster to provider records	7	Theft, sabotage, or other willful acts by an employee Note: Negligence by an employee is <u>not</u> covered by this reason code	10	(1) Court order, State, or administrative fair hearing decision (2) Delay or error in the certification or determination of Medi-Cal eligibility (3) Update of a PA beyond the 12-month limit (4) Circumstances beyond the provider's control as determined by DHCS	A	Claim submitted after the 6-month billing limit and received by MMA during the 7th – 12th month after the month of service and none of the exceptions above applied
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California Specific Compound Pharmacy Claim Form (30-4)

Item	Description
	<i>Field Left Blank</i> Not Specified *
39	Date billed. Enter the date that the prescription will be submitted to the Medi-Cal Rx vendor for processing in 8-digit MMDDYYYY format where "MM" is the 2-digit month, "DD" is the 2-digit day and "YYYY" is the 4-digit year.
40	Hospital Discharge Date. If needed for compliance with program requirements, enter the date the member was discharged from the hospital in 8-digit MMDDYYYY format where "MM" is the 2-digit month, "DD" is the 2-digit day and "YYYY" is the 4-digit year.
41	Ingredient Total Charge. Enter the total charge of all the ingredients. <u>Do not</u> enter fees. <u>Do not</u> enter a decimal point (.) or dollar sign (\$).
42	Process for Approved Ingredients. Optional item. If a "Y" is entered in this field, approved ingredients will be reimbursed, but ingredients not on the Formulary will be paid at \$0. If this field is left blank, any ingredient that requires a PA will cause the claim to deny. If the compound contains inexpensive ingredients that would not be worth getting a prior authorization, then the provider may want to use this field to speed the payment of the claim.
43	Container Count. Enter the member's total number of containers for the compound prescription.
44	Medi-Cal Rx vendor Leave BLANK
45	Medi-Cal Rx vendor Use Only Leave BLANK
46	Medi-Cal Rx vendor Use Only Leave BLANK
47	Signature of Provider and Date. The claim must be signed and dated by the provider or representative assigned by the provider. Use <u>BLACK</u> ballpoint pen only. An <u>original</u> signature is required on all paper claims. The signature must be written, not printed. Stamps, initials, or facsimiles are not acceptable. The signature does not have to be on file with MMA.

California Specific Compound Pharmacy Claim Form (30-4)

Item	Description																																										
48	<p>Specific Details/Remarks Section. The SNOMED/ROA value MUST be included in this section. Note: Compounding fees are paid based upon the dosage form and route of administration (SNOMED value) information submitted on the pharmacy claim. To ensure proper payment, be certain to enter this information correctly. This space can also be used to clarify or detail any line item. <u>Indicate the ingredient line-item number being referenced.</u> The <i>Specific Details/Remarks</i> area is also used to provide information about crossovers.</p> <table border="1" data-bbox="376 709 1474 1934"> <thead> <tr> <th colspan="2" data-bbox="376 709 1474 762">SNOMED CT – NCPDP Field 995-E2</th> </tr> <tr> <th data-bbox="376 762 711 856">Route of Administration</th> <th data-bbox="711 762 1474 856">SNOMED Value</th> </tr> </thead> <tbody> <tr><td data-bbox="376 856 711 909">Buccal</td><td data-bbox="711 856 1474 909">54417007 or 372473007</td></tr> <tr><td data-bbox="376 909 711 961">Dental</td><td data-bbox="711 909 1474 961">372449004</td></tr> <tr><td data-bbox="376 961 711 1014">Enteral</td><td data-bbox="711 961 1474 1014">417985001</td></tr> <tr><td data-bbox="376 1014 711 1066">Infusion</td><td data-bbox="711 1014 1474 1066">424494006, C44364, or 418114005</td></tr> <tr><td data-bbox="376 1066 711 1119">Inhalation</td><td data-bbox="711 1066 1474 1119">112239003</td></tr> <tr><td data-bbox="376 1119 711 1171">Injection</td><td data-bbox="711 1119 1474 1171">424109004, 385218009, 34206005, or 78421000</td></tr> <tr><td data-bbox="376 1171 711 1224">Intraperitoneal</td><td data-bbox="711 1171 1474 1224">38239002</td></tr> <tr><td data-bbox="376 1224 711 1276">Intravenous (IV)</td><td data-bbox="711 1224 1474 1276">4625008</td></tr> <tr><td data-bbox="376 1276 711 1329">Irrigation</td><td data-bbox="711 1276 1474 1329">47050061</td></tr> <tr><td data-bbox="376 1329 711 1381">Mouth/Throat</td><td data-bbox="711 1329 1474 1381">26643006 or 26643008</td></tr> <tr><td data-bbox="376 1381 711 1434">Mucous Membrane</td><td data-bbox="711 1381 1474 1434">419874009</td></tr> <tr><td data-bbox="376 1434 711 1486">Nasal</td><td data-bbox="711 1434 1474 1486">46713006</td></tr> <tr><td data-bbox="376 1486 711 1539">Ophthalmic</td><td data-bbox="711 1486 1474 1539">54485002</td></tr> <tr><td data-bbox="376 1539 711 1591">Oral</td><td data-bbox="711 1539 1474 1591">26643006 or 26643008</td></tr> <tr><td data-bbox="376 1591 711 1644">Otic</td><td data-bbox="711 1591 1474 1644">10547007</td></tr> <tr><td data-bbox="376 1644 711 1696">Rectal</td><td data-bbox="711 1644 1474 1696">37161004</td></tr> <tr><td data-bbox="376 1696 711 1749">Vaginal</td><td data-bbox="711 1696 1474 1749">16857009</td></tr> <tr><td data-bbox="376 1749 711 1801">Topical</td><td data-bbox="711 1749 1474 1801">6064005</td></tr> <tr><td data-bbox="376 1801 711 1854">Transdermal</td><td data-bbox="711 1801 1474 1854">45890007</td></tr> </tbody> </table>	SNOMED CT – NCPDP Field 995-E2		Route of Administration	SNOMED Value	Buccal	54417007 or 372473007	Dental	372449004	Enteral	417985001	Infusion	424494006, C44364, or 418114005	Inhalation	112239003	Injection	424109004, 385218009, 34206005, or 78421000	Intraperitoneal	38239002	Intravenous (IV)	4625008	Irrigation	47050061	Mouth/Throat	26643006 or 26643008	Mucous Membrane	419874009	Nasal	46713006	Ophthalmic	54485002	Oral	26643006 or 26643008	Otic	10547007	Rectal	37161004	Vaginal	16857009	Topical	6064005	Transdermal	45890007
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California Specific Compound Pharmacy Claim Form (30-4)		
Item	Description	
	Translingual	404815008
	Urethral	90028008
	<p style="text-align: center;">Emergency Certification Statement</p> <p>Beginning January 1, 2022, emergency claims can be billed via POS, Web-Claim Submission/Direct Data Entry, or paper claim. For emergency claims submitted via paper form(s), they must include an Emergency Certification Statement.</p> <p>Note: For information regarding what information is required on the Emergency Certification Statement, refer to the end of Section 19.2.1.1 – Completion Instructions for California Specific Pharmacy Claim Form (30-1).</p>	

**Table 19.2.2.1-1: California Specific Compound Pharmacy Claim Form (30-4)
Completion Instructions**

19.2.2.2 (30-4) Tips for Billing

The examples in this section are to assist providers in completing the *California Specific Compound Pharmacy Claim Form (30-4)*. See *Table 19.2.2.2-1* for fields that must be completed accurately and completely in order to avoid claim denial. For information on claim fields not detailed in the following examples, refer to [Section 19.2.2.1 - Completion Instructions for California Specific Compound Pharmacy Claim Form \(30-4\)](#).

Tip: Quantities must be in the metric decimal system. Do not round the quantity. Do not include measurement units (GM, CC, ML). The form has separate fields for the whole number and decimal portions of the quantity fields. Decimal points are not allowed within the fields. The decimal points are preimprinted on the form. All information on an attachment must match the information entered on the claim form.

Compounded Prescription

DO NOT STAPLE IN SAN AREA

CLAIM CONTROL NUMBER * FOR F.I. USE ONLY

3 Fasten Here

Provider Name, Address, Phone
 ABC Home Pharmacy
 123 Main Street
 Sequoia, CA
 (923) 555-1223

COMPOUND DRUG PHARMACY CLAIM FORM

STATE OF CALIFORNIA
 DEPARTMENT OF HEALTH
 CARE SERVICES

ID QUALIFIER: 01 PROVIDER ID: 0123456789
 ZIP CODE: 95823555

ELITE PICA (two sets of boxes)

← TYPEWRITER ALIGNMENT →

PATIENT INFORMATION
 PATIENT NAME (LAST, FIRST, MI): SMITH, JANE
 MEDI-CAL IDENTIFICATION: 90000 000A95001
 SEX: F DATE OF BIRTH: 03/08/1960 DATE OF ISSUE: 02/01/2018

PRESCRIPTION NO: A12345678900 FILL NUMBER: 00 DATE OF SERVICE: 10/01/2016
 TOTAL METRIC QUANTITY: WHOLE UNITS 217 2
 CODE 1 MET: 11 EMERGENCY: YES

PRESCRIBER ID: 9876543210 PRIMARY ICD-CM: DD1D1D1D SECONDARY ICD-CM: 11
 DOBS CODE: 3 DISP UNIT FORM/NO: 3 DISP UNIT LOC: 3

TOTAL CHARGE: 518.56 OTHER COVERAGE PAID: 0 DTH COV CODE: 0 PATIENT'S SHARE: [REDACTED] INCENTIVE AMOUNT: [REDACTED] TAR CONTROL NO: [REDACTED]

PROD ID	INGREDIENT PRODUCT ID	WHOLE UNITS	SCAL	INGREDIENT CHARGE	BASIS OF COST
03	00083380104	4	2	68.54	
03	00009090013	1		23.40	
03	00074488799	60		8.40	
03	00338004916	152		135.40	

MEDICAL RECORD NO: X12345YU BILL LIM EX: [] DATE BILLED: 10/30/2016 HOSP DISCHARGE DATE: [] INGREDIENT TOTAL CHARGE: 235.74

SPECIFIC DETAILS/REMARKS: SNOMED - 4525008

PROC FOR APPROVED INGREDIENTS: [] CONTAINER COUNT: [] F.I. USE ONLY: []

Signature of provider or person authorized by provider to bind provider by above signature to statements and conditions contained on this form

SEE YOUR PROVIDER MANUAL FOR ASSISTANCE REGARDING THE COMPLETION OF THIS FORM. Revision Date: 01/18 Form Number: 30-4

Figure 19.2.2.2-1: Compounded Intravenous Prescription Example

Common Billing Errors		
Field	Description	Error
Box 12	Date of Service	<p>The date of service is entered using the incorrect format.</p> <p>Billing Tip: The date <u>must</u> be entered in an 8-digit MMDDYYYY. For example, August 27, 2007 would be entered 08272007.</p>
Box 21	Primary ICD-CM	<p>The Primary ICD-CM code is entered without the ICD indicator.</p> <p>Billing Tip: The ICD indicator is <i>only required</i> if a <i>primary</i> diagnosis code is being entered on the claim. Secondary diagnosis codes do <i>not</i> require the indicator. Claims that contain a primary diagnosis code, but no ICD indicator may be denied.</p>
Box 25	Route of Administration	<p>A value was entered in this field.</p> <p>Billing Tip: The Route of Administration field should be left blank. If a value is entered in this field, the claim will be returned.</p> <p>Note: Beginning 04/01/2020, the applicable SNOMED value must be entered in the <i>Specific Details/Remarks</i>. In the example above in <i>Figure 19.3.2-1, Box 23 – Dosage Form Description</i> indicates that this is a solution. It is also shown that Box 24 – Dispensing Unit Form Indicator was completed as a “3,” indicating that the Unit of Measure (UOM) of the compound is milliliters (mL). The compound is to be administered intravenously, so SNOMED value 4625008 would be entered in the <i>Specific Details/Remarks</i> field NOT the Route of Administration field.</p>
Box 32	Product ID Qualifiers	<p>Billing Tip: The value entered in this/these field(s) will apply to the associated line. The example above indicates “03” which specifies that NDCs were used.</p>
Box 34	Ingredient Quantity	<p>If a decimal is entered in either of the two fields that make up the metric decimal quantity, the claim will be returned.</p> <p>Billing Tip: Quantities must be entered in the metric decimal format. Do not include measurement descriptors such as “GM,” “CC,” or “ML” in this field.</p>

Common Billing Errors		
Field	Description	Error
		Also note that the pharmacy will enter the sum total of the Ingredient Product ID for the associated line.
Box 35	Ingredient Charge	Billing Tip: The pharmacy will enter the sum total charge for the corresponding line of the compound ingredient.
Box 41	Ingredient Total Charge	The sum of all ingredient charges <i>and</i> fees is entered in this field. Billing Tip: <u>Do not include fees</u> in this field, only include the sum of all ingredient charges.
Box 42	Process for Approved Ingredients	Billing Tip: If a "Y" was entered in this field, it would mean that if any ingredients having NDCs are <i>not</i> found in the Formulary, or if any ingredients require a PA and no PA is present, those ingredients will be priced at zero (0) and the remainder of the ingredients will be paid. This means that when a "Y" is entered in Box 42, a portion of the ingredients may not be paid and the provider accepts payment for the remainder, rather than having the entire claim denied. Note: Box 42 – <i>Process for Approved Ingredients</i> in the example provided in <i>Figure 19.3.2-1</i> has been left blank.
Box 47	Signature of Provider and Date	Not including a signature on the claim Billing Tip: Claim <i>must</i> be signed in BLACK ink. Stamps, initials, or facsimiles are not acceptable.
	Specific Details/Remarks	Billing Tip: As noted above, the applicable SNOMED value must be entered in this field. If a SNOMED value is not entered for the compound claim, the claim will be returned.

Table 19.2.2.2-1: California Specific Compound Pharmacy Claim Form (30-4)
Tips for Billing

19.3 Paper Claim Forms (UCF, (30-1) and (30-4)) Additional Tips

19.3.1 Submission and Timeliness Instructions

This section provides procedures and guidelines for claim submission and timelines. For specific claim completion instructions, refer to [Section 19.1.1 – Completion Instructions for the Universal Claim Form](#), [Section 19.2.1.1 – Completion Instructions for California Specific Pharmacy Claim Form \(30-1\)](#) for non-compound claims, or [Section 19.2.2.1 – Completion Instructions for California Specific Compound Pharmacy Claim Form \(30-4\)](#) for compound claims. Providers mailing paper claim forms can view the mailing address in [Appendix B – Directory](#).

Six-Month Billing Limit

- Original (or initial) Medi-Cal Rx claims must be received by the Medi-Cal Rx vendor within six months following the month in which services were rendered. This requirement is referred to as the six-month billing limit.
 - Example: If services are provided on April 15, 2021, the claim must be received by the Medi-Cal Rx vendor prior to October 31, 2021 to avoid payment reduction or denial for late billing.

Billing Limit Exceptions

- Exceptions to the six-month billing limit can be made if the reason for the late billing is one of the billing limit exceptions allowed by regulations. Billing limit exceptions also have time limits. See *Table 19.3.1-1* and *Table 19.3.1-2* below for a list of billing limit exception codes and required documentation.

Late Billing Instructions

Follow the steps below to bill a late claim that meets one of the approved exception reasons:

- Enter the appropriate billing limit exception reason code (1 through 8 or “A”) in the Delay Reason field (Field 46 (UCF)) or the Billing Limit Exception field (Box 75 (30-1), or Box 38 (30-4)) of the claim.
- Complete the Specific Details/Remarks (on the (30-1) or (30-4) form(s)) area with the information required for reason codes 1 (descriptions 1 and 2) and 3-5.
 - Providers submitting a UCF form should enter the information required for reason code 1 (descriptions 1 and 2) and 3-5 in any available space on the form.
- Attach substantiating documentation to justify late submittal of the claim for reason codes 1 (description 2), 2, and 6-8. The Billing Limit Exceptions charts on the following pages describe the documentation required for each billing exception.
- Providers who do not meet any billing limit exception reasons when submitting claims during the seventh month (July) through the twelfth month (December) after the month of service should enter an “A” in the Delay Reason field (Field 46 (UCF), or Billing Limit Exception field (Box 75 (30-1) or Box 38 (30-4)) of the claim.

Claims Over One Year Old

- The Medi-Cal Rx vendor will review all original claims delayed over one year from the month of service due to court decisions, fair hearing decisions, county administrative errors in determining member eligibility, reversal of decisions on appealed PA requests, Medicare/Other Health Coverage delays, or other circumstances beyond the provider's control. Claims submitted more than 12 months from the month of service must always use delay reason code "10" and must be billed hard copy with the appropriate attachments as listed in the table below.
 - Note:** Providers will receive a RA message indicating the status of their claim.
- Claims submitted to the Over-One-Year Claims Unit must include a copy of the member's proof of eligibility and one of the following documents with the late claim.

See *Table 19.3.1-1* below for billing limit exceptions.

Billing Limit Exceptions		
Reason Code	Description	Documentation Needed
1	(1)° Proof of eligibility unknown or unavailable; includes retroactive eligibility, or ID cards, if applicable.	In the <i>Specific Details/Remarks</i> area, enter month, day, and year when proof of eligibility was received. Example: Proof of eligibility received on March 15, 2006.
	(2) For Share of Cost (SOC) reimbursement processing.	Attach an SOC Medi-Cal Provider Letter (MC 1054) for SOC reimbursement processing.
2 *+	(1) Other Health Coverage, including Medicare, Kaiser, CHAMPUS, and other health insurance.	With the Medi-Cal claim, submit a copy of the Other Health Coverage Explanation of Benefits or Remittance Advice (RA) showing payment of denial.
	(2) Charpentier rebill claims. *	Submit a copy of the RA for the original crossover claim.
3 *	Authorization delays in PA approval.	In the <i>Specific Details/Remarks</i> area, enter only the approval date of the PA or CCS authorization
4 *	Delay by DHCS in certifying providers or by the Medi-Cal Rx vendor in supplying billing forms	In the <i>Specific Details/Remarks</i> area, enter a statement indicating the date of certification and/or the date billing forms were requested, and date received.

Billing Limit Exceptions

Reason Code	Description	Documentation Needed
5 *	Delay in delivery of custom-made eye, prosthetic, or orthotic appliances.	In the <i>Specific Details/Remarks</i> area, enter a statement explaining why the appliance was not previously delivered to the member.
<p><u>Deadlines for Claim Receipt:</u></p> <p>† Claims related to these circumstances will be reimbursed at a reduced rate according to the date the claim was received by the Medi-Cal Rx vendor. Refer to Section 4.7.3 – Timely Filing Claim Cutback for information on reimbursement rate reduction.</p> <p>° Claims related to this circumstance must be received by the Medi-Cal Rx vendor no later than 60 days after the date indicated on the claim that proof of eligibility is received by the provider. Proof of eligibility must be obtained no later than one year after the month in which service was rendered.</p> <p>+ Claims related to these circumstances, together with the Medicare or Other Health Coverage Explanation of Benefits/Remittance Advice or denial letter, must be received by the Other Health Coverage carrier no later than 12 months after the month of service and by the Medi-Cal Rx vendor within 60 days of the other health carrier’s resolution (payment/denial).</p> <p>* Charpentier rebill claims must be received within 6 months of Medi-Cal Rx RA date for the original crossover claim.</p> <p>* Claims related to these circumstances must be <u>received</u> by the Medi-Cal Rx vendor no later than one year from the <u>month</u> of service.</p>		
6 *	Substantial damage by fire, flood, or disaster to provider records.	Attach a letter on provider letterhead describing the circumstances and date of occurrence. The letter must be signed by the provider or provider’s designee.
7 **	Theft, sabotage, or other willful acts by an employee. Note: Negligence by an employee is <u>not</u> covered by this reason code.	Attach a letter on provider letterhead documenting the incident and the date the incident was reported to a law enforcement agency. The letter must be signed by the provider or provider’s designee.

Billing Limit Exceptions		
Reason Code	Description	Documentation Needed
10 **	(1) Court order or State or administrative fair hearing decision.	Submit member proof of eligibility and the court order or fair hearing decision.
	(2) Delay or error in the certification or determination of Medi-Cal Rx eligibility.	Submit a copy of the original LOA form (MC-180) signed by an official of the county. In the <i>Specific Details/Remarks</i> area, indicate date received from the member.
	(3) Update of a PA beyond the 12-month limit.	Submit member proof of eligibility and copy of the updated PA
	(4) Circumstances beyond the provider's control as determined by DHCS.	Submit member proof of eligibility with either a copy of DHCS approval or a copy of the OHC (including Medicare) proof of payment or denial. Note: Claims submitted under this condition must have been billed to the OHC carrier within 12 months from the month of service
A +	Claims submitted after the 6-month billing limit and received by the MMA during the 7th through 12th month after the month of service and none of the exceptions above apply.	None.
<p>Deadlines for Claim Receipt:</p> <p>* Claims related to these circumstances must be <u>received</u> by the Medi-Cal Rx vendor no later than 1 year from the month of service.</p> <p>** Claims related to these circumstances must be <u>received</u> by the Medi-Cal Rx vendor, no later than <u>one year</u> from the date of service.</p> <p>++ Claims related to these circumstances must be <u>received</u> by the Medi-Cal Rx vendor, no later than <u>60 days</u> after the date of resolution of the circumstance which caused the billing delay.</p>		

Table 19.3.1-1: Billing Limit Exceptions

Note: Providers must bill Medicare or the Other Health Coverage within one year of the month of service to meet Medi-Cal timeliness requirements.

The following guidelines in *Table 19.3.1-2* apply to over-one-year-old and original claims.

Over-One-Year Billing Exceptions		
Cause of Delay	Billing Limit Exception Code	Documentation Needed
Retroactive SSI/SSP	10	<ul style="list-style-type: none"> Copy of the original County Letter Authorization (LOA) form (MC-180) signed by an official of the county
Court Order	10	
State or Administrative Hearing	10	
County Error	10	
DHCS Approval	10	
Reversal of Decision on Appealed PA	10	<ul style="list-style-type: none"> Copy of the PA Copy of DHCS letter or court order reversing the PA denial Explanation of the circumstances in the <i>Specific Details/Remarks</i> area
Medicare/OHC	10	<ul style="list-style-type: none"> Copy of the OHC Explanation of Benefits Explanation of the circumstances in <i>Specific Details/Remarks</i> area

Table 19.3.1-2: Over-One-Year Billing Exceptions

19.3.2 Tips for Billing Crossover Claims

19.3.2.1 Billing Tips: Part B Services Billed to Part B Medicare Administrative Carriers

The following billing tips will help prevent rejections, delays, mispayments, and or denials of crossover claims for Part B services billed to Part B Medicare Administrative Carriers (MACs):

- Submit non-automatic pharmacy crossovers using NDCs on the UCF (providers must identify a Crossover claim on the UCF by notating CROSSOVER on the claim form) or the *California Specific Pharmacy Claim Form* (30-1).
- Submit non-automatic pharmacy compound crossovers using NDCs on the UCF (providers must identify a Crossover claim on the UCF by notating CROSSOVER on the claim form) or the *California Specific Compound Pharmacy Claim Form* (30-4).
- If submitting a UCF, *California Specific Pharmacy Claim Form* (30-1), or *California Specific Compound Pharmacy Claim Form* (30-4), the background must be visible.

- A separate copy of the Medicare Remittance Notice (MRN) must be submitted with each claim form.
- MRNs must be complete, legible, and unaltered. For example, make sure the date in the upper right-hand corner is legible.
- Crossover claims must not be combined. For example:
 - Multiple members on one UCF, *California Specific Pharmacy Claim Form (30-1)*, or *California Specific Compound Pharmacy Claim Form (30-4)*.
 - One MRN for multiple UCFs, *California Specific Pharmacy Claim Forms (30-1)*, or *California Specific Compound Pharmacy Claim Forms (30-4)*.
 - Multiple claims (on one or more MRNs) for the same member on one UCF, *California Specific Pharmacy Claim Form (30-1)*, or *California Specific Compound Pharmacy Claim Form (30-4)*.
 - Multiple claim lines from more than one MRN for the same member on one *California Specific Pharmacy Claim Form (30-1)* or *California Specific Compound Pharmacy Claim Form (30-4)*.
- Only use NDC codes for specified Medicare-covered drugs.
- Use NDC codes when billing pharmacy crossovers on claim forms.
- All Medicare-allowed claim lines must be included on the crossover claim and must match each corresponding MRN provided by Medicare.
- Medicare-denied claim lines that appear on the same crossover claim MRN with Medicare-allowed claim lines cannot be paid with the crossover claim.
- If the member has OHC, submit a copy of the MRN or denial letter from the insurance carrier. Part B pharmacy crossovers billed using a UCF, *California Specific Pharmacy Claim Form (30-1)*, and *California Specific Compound Pharmacy Claim Form (30-4)* do not require a copy of the MRN or denial letter from the other insurance carrier.

Submit Medicare adjustment crossovers on a *Claims Inquiry Form (CIF)*.

19.3.2.2 Billing Tips: Part B Services Billed to Part A Medicare Administrative Carriers

The following billing tips will help prevent rejections, delays, mispayments, and or denials of crossover claims for Part B services billed to Part A Medicare Administrative Carriers (MACs):

- Submit non-automatic pharmacy crossovers using NDCs on the UCF (providers must identify a Crossover claim on the UCF by notating CROSSOVER on the top of the claim form) or the *California Specific Pharmacy Claim Form (30-1)*.
- Submit non-automatic pharmacy compound crossovers using NDCs on the UCF (providers must identify a Crossover claim on the UCF by notating CROSSOVER on the top of the claim form) or the *Compound Pharmacy Claim Form (30-4)*.
- If submitting a UCF, *California Specific Pharmacy Claim Form (30-1)*, or *California Specific Compound Pharmacy Claim Form (30-4)*, the background must be visible.
- A separate copy of the Medicare Remittance Notice (MRN) must be submitted with each claim form.

- MRNs must be complete, legible, and unaltered. For example, make sure the date in the upper right-hand corner is legible.
- Crossover claims must not be combined. For example:
 - Multiple members on one UCF, *California Specific Pharmacy Claim Form (30-1)*, or *California Specific Compound Pharmacy Claim Form (30-4)*.
 - One MRN for multiple UCFs, *California Specific Pharmacy Claim Forms (30-1)*, or *California Specific Compound Pharmacy Claim Forms (30-4)*.
 - Multiple claims (on one or more MRNs) for the same member on one UCF, *California Specific Pharmacy Claim Form (30-1)*, or *California Specific Compound Pharmacy Claim Form (30-4)*.
 - Multiple claim lines from more than one MRN for the same member on one *California Specific Pharmacy Claim Form (30-1)* or *California Specific Compound Pharmacy Claim Form (30-4)*.
- Only use NDC codes for specified Medicare-covered drugs.
- Use NDC codes when billing pharmacy crossovers on claim forms.
- All Medicare-allowed claim lines must be included on the crossover claim and must match each corresponding MRN provided by Medicare.
- Medicare-denied claim lines that appear on the same crossover claim MRN with Medicare-allowed claim lines cannot be paid with the crossover claim.
- If the member has OHC, submit a copy of the MRN or denial letter from the insurance carrier. Part B pharmacy crossovers billed using a UCF, *California Specific Pharmacy Claim Form (30-1)*, and *California Specific Compound Pharmacy Claim Form (30-4)* do not require a copy of the MRN or denial letter from the other insurance carrier.

Submit Medicare adjustment crossovers on a *Claims Inquiry Form (CIF)*.

19.3.3 Tips for Billing Charpentier Claims

19.3.3.1 Identifying a Charpentier Claim

After Medi-Cal Rx processes the crossover claim for Medicare-Covered drugs, and the above steps ([Section 19.2.1.1 - Completion Instructions for California Specific Pharmacy Claim Form \(30-1\)](#)) have been executed, complete the UCF, (30-1), and (30-4) fields in [Table 19.3.3.1-1](#) below for Charpentier rebills only:

Paper Claim Form Fields for Charpentier Rebills		
Field UCF (30-1) (30-4)	Description	Steps
Field 84/85 Box 26 Box 27	Other Payer Amount Paid #1/#2 Other Coverage Paid	Enter the sum of previous payments from Medicare, Medi-Cal Rx (crossover claim payment) and any OHC.
	<i>Specific Details/Remarks</i> area	<p>Select one (1) of the following phrases, as previously defined in Section 10.1.3 – Charpentier Claims:</p> <ul style="list-style-type: none"> For <u>Rates</u>, enter the words “Medi/Medi Charpentier: Rates” For <u>Benefit Limitations</u>, enter the words “Medi/Medi Charpentier: Benefit Limitation” For <u>Both Rates and Benefit Limitations</u>, enter the words “Medi/Medi Charpentier: Both Rates and Benefit Limitation” Note: Providers submitting a UCF form should enter the information required for reason Code 1 (descriptions 1 and 2) and 3-5 in any available space on the form.
Box 10 Box 18	Medicare Status	<p>Select one of the following letters that corresponds to the phrase entered in <i>Specific Details/Remarks</i> area:</p> <ul style="list-style-type: none"> For <u>Rates</u>, enter the letter “R” For <u>Benefit Limitation</u>, enter the letter “L” For Both Rates and Benefit Limitations, enter the letter “T” Note: Providers submitting a UCF form should enter the information that corresponds to the information entered regarding the information in the above box in any available space on the form.

Paper Claim Form Fields for Charpentier Rebills		
Field UCF (30-1) (30-4)	Description	Steps
Fields 37, 69 Boxes 21, 41, 62 Box 33	Product ID	<p>If multiple claim lines were originally processed by Medicare and fewer claim lines are now being rebilled to Medi-Cal Rx, indicate with an asterisk (*) on the Medicare EOMB/MRN the items that are being rebilled to Medi-Cal for Charpentier processing. Also indicate the claim line number that corresponds to the asterisk(s).</p> <ul style="list-style-type: none"> When using an NDC, <u>indicate on the Medicare EOMB/MRN</u> (beside the line being rebilled) the Medi-Cal 30-1 claim line number that corresponds to the Medicare Product ID/item <p>Note: Complete the claim using the NDC that most closely reflects the items/services provided and that most closely equates to the Medicare code originally billed to Medicare and to the code shown on the EOMB/MRN. The provider is certifying that the NDC on the claim best reflects the item or service <u>rendered</u> to the member.</p>

Table 19.3.3.1-1: Paper Claim Form Fields for Charpentier Rebills

Additional billing tips for Charpentier claims to help in the prevention of rejections, delays, incorrect payments, and/or denials when rebilling Charpentier claims:

- A Charpentier rebill must not be combined with a crossover claim.
- Use of Charpentier indicators ("R," "L," or "T") on claims that are not Charpentier claims will result in processing delays.
- Failure to place a Charpentier indicator ("R," "L," or "T") on a legitimate Charpentier claim prevents the system from recognizing the claim as a Charpentier rebill which may result in processing delays or denial of the claim.
- Claims with incorrectly marked MRNs will be denied.
- Providers must obtain an approved PA if a PA would be required when billed as a Medi-Cal Rx only claim.
- Providers are not required to submit a copy of the Medicare Appeal and Decision form when billing Medi-Cal Rx for the difference between Medicare and Medi-Cal Rx's allowed amount.

Note: If required information is missing either from the claim form or the attachments provided, the Medi-Cal Rx vendor will attempt to contact the provider to obtain and document the missing information. If the Medi-Cal Rx vendor is unable to reach the provider, the claim will be returned to with a letter requesting the missing information.

19.3.3.2 Charpentier Submission Requirements

All Charpentier rebilled claims **MUST** be processed first as a Part B Crossover Claim (see [Section 10.1.2 – Medicare Part B Coordination of Benefits Claims](#)) and will ONLY be accepted via paper.

Note: A Claim Inquiry Form (CIF) should **NOT** be used to rebill a Charpentier claim.

Providers must use the following submission requirements to be considered for supplemental payment under the Charpentier injunction (see [Section 10.1.3 – Charpentier Claims](#)):

- Providers must first bill Medicare and OHC to which the member is entitled.
- The claim must then be billed as a crossover and approved by Medi-Cal Rx.
 - The claim may crossover automatically from the Part B carrier via electronic/POS submission OR the crossover claim may be billed via paper claim to the Medi-Cal Rx vendor by the provider.

Provider must obtain an approved PA if a PA would be required when billed as a Medi-Cal Rx claim only.

- Providers are NOT required to submit a copy of the Medicare Appeal and Decision form when billing Medi-Cal Rx for the difference between Medicare and Medi-Cal Rx.

All Charpentier claim rebills for pharmacy claims must be submitted via paper claim form and mailed to the Medi-Cal Rx vendor (see [Appendix B – Directory](#) for mailing address).

19.4 Medi-Cal Rx Provider Claim Inquiry Form (CIF) (DHCS 6570)

Providers should submit a CIF *after* submitting a claim to resolve claim payments or denials as identified on the RA. There are seven main reasons to submit a CIF:


- Reconsideration – A claim has been denied and a provider has information that would correct the reason for denial.
- Void – A request to repay monies on a previously paid claim.
- Share of Cost (SOC) – A claim has been paid at a different amount and a provider requests a reimbursement for SOC.
- Tracer – No record of payment or denial of a previously submitted claim exists on the RA and the provider wants to trace the status of a claim.
- Crossover – A request for reconsideration of a denied Crossover claim or an underpaid or overpaid Crossover claim.
- Underpayment – Adjustment for an underpaid claim.
- Overpayment – Adjustment for an overpaid claim.

Providers can access the CIF via the [Medi-Cal Rx Provider Portal](#) by selecting the [Forms & Information](#) link. The CIF also contains additional instructions on how to complete the required form fields. See *Figure 19.4-1*.

Note: The Medi-Cal Rx Provider Claim Inquiry process is applicable to pharmacy fee-for-service claims processed by Medi-Cal Rx or CA-MMIS.

CIFs can be mailed to the Medi-Cal Rx Claims Department (see [Appendix B – Directory](#) for the mailing address).

See *Figure 19.4-1* for a sample of a completed CIF.

State of California Health and Human Services Agency	Department of Health Care Services
Provider Claim Inquiry Form (CIF)	
	
<p>Instructions: The Provider Claim Inquiry Form (CIF) is used to resolve claim payments or denials as identified on the Remittance Advice (RA). Please carefully read the enclosed instructions prior to completing and signing the CIF. All required fields must be completed to process the Provider Claim Inquiry.</p> <p>Providers must print, sign, date, and mail the form as per the instructions in the <i>Form Submission</i> section. Explanations regarding form fields are located below the form in the <i>Explanation of Provider Claim Inquiry Form</i> section. Incomplete forms will not be processed and will be returned to the provider.</p> <p>* Indicates Required Field</p>	
PART 1 – Provider Information	
*Provider Name: ABC Provider	
*Service Address: 123 Any Street	
*City: Anytown	
*State: CA	*ZIP Code: 99999-5555
*National Provider Identifier (NPI) Number: 123456789	
PART 2 – Claim Information	
*Claim Type: <input checked="" type="checkbox"/> 01 – Pharmacy	
*Beneficiary Name: Jane Smith	
*Beneficiary Medi-Cal ID Number: 98745632A	
*For each claim line (up to five claims per form) complete all applicable fields.	
01	Prescription Number: <u>5648210</u> Date of Service: <u>12/21/2021</u> NDC or Medical Supply Billing Code: <u>09874563210</u> Amount Billed: \$ <u>250.00</u> <input checked="" type="checkbox"/> Reconsideration <input type="checkbox"/> Void <input type="checkbox"/> Share of Cost (SOC) <input type="checkbox"/> Tracer <input type="checkbox"/> Crossover <input type="checkbox"/> Underpayment <input type="checkbox"/> Overpayment <input checked="" type="checkbox"/> Attachments (Number of Attachments: <u>3</u>)
DHCS 6570 (12/2021) Page 1 of 5	

02	Prescription Number: _____ Date of Service: _____ NDC or Medical Supply Billing Code: _____ Amount Billed: \$ _____ <input type="checkbox"/> Reconsideration <input type="checkbox"/> Void <input type="checkbox"/> Share of Cost (SOC) <input type="checkbox"/> Tracer <input type="checkbox"/> Crossover <input type="checkbox"/> Underpayment <input type="checkbox"/> Overpayment <input type="checkbox"/> Attachments (Number of Attachments: _____)
03	Prescription Number: _____ Date of Service: _____ NDC or Medical Supply Billing Code: _____ Amount Billed: \$ _____ <input type="checkbox"/> Reconsideration <input type="checkbox"/> Void <input type="checkbox"/> Share of Cost (SOC) <input type="checkbox"/> Tracer <input type="checkbox"/> Crossover <input type="checkbox"/> Underpayment <input type="checkbox"/> Overpayment <input type="checkbox"/> Attachments (Number of Attachments: _____)
04	Prescription Number: _____ Date of Service: _____ NDC or Medical Supply Billing Code: _____ Amount Billed: \$ _____ <input type="checkbox"/> Reconsideration <input type="checkbox"/> Void <input type="checkbox"/> Share of Cost (SOC) <input type="checkbox"/> Tracer <input type="checkbox"/> Crossover <input type="checkbox"/> Underpayment <input type="checkbox"/> Overpayment <input type="checkbox"/> Attachments (Number of Attachments: _____)
05	Prescription Number: _____ Date of Service: _____ NDC or Medical Supply Billing Code: _____ Amount Billed: \$ _____ <input type="checkbox"/> Reconsideration <input type="checkbox"/> Void <input type="checkbox"/> Share of Cost (SOC) <input type="checkbox"/> Tracer <input type="checkbox"/> Crossover <input type="checkbox"/> Underpayment <input type="checkbox"/> Overpayment <input type="checkbox"/> Attachments (Number of Attachments: _____)
*Total Attachments (Required when attachments are included): 3	
*Remarks: (Such as: Corrections or additional information necessary to resubmit a denied claim or request an adjustment for an underpayment or overpayment. What went wrong with the claim? What has the biller/provider done to correct the claim? What do you want Medi-Cal Rx to do with the claim? If listing multiple claims on the CIF, specify to which claim each remark applies.) Please reconsider processing the above claim. It was denied for eligibility when patient was eligible at time of service (please see attached eligibility verification).	

PART 3 – Provider Certification

Privacy Statement (Civil Code Section 1798 et seq.): The information requested on this form is required by the Department of Health Care Services for purposes of identification and document processing. Furnishing the information requested on this form is mandatory. Failure to provide the mandatory information may result in your request being delayed or not processed.

This is to certify that the information contained above is true, accurate, and complete and that the provider has read, understands, and agrees to be bound by and comply with the statements and conditions contained on this form. The signature of the provider or the Authorized Representative binds the provider to statements and conditions contained in this form.

***Signature of Provider or Authorized Representative (Original Signature Required; Use Blue Ink):**

John Doe

***Print Name:**

John Doe

***Date:**

12/31/2021

Form Submission

Print, sign, date, and mail this completed form to the address below. If you have questions about completing this form, please call the Medi-Cal Rx Customer Service Center at 1-800-977-2273.

Medi-Cal Rx Customer Service Center
ATTN: Provider Claim Inquiries
P.O. Box 610
Rancho Cordova, CA 95741-0610

▲ Explanation of Provider Claim Inquiry Form

The CIF is used to resolve claim payments or denials as identified on the Remittance Advice (RA). There are seven main reasons to submit a CIF:

- **Reconsideration** – A claim has been denied and a provider has information that would correct the reason for denial.
- **Void** – Reverse payment on a claim.
- **Share of Cost (SOC)** – A claim has been paid at a different amount and a provider requests a reimbursement for Share of Cost (SOC).
- **Tracer** – No record of payment or denial of a previously submitted claim exists on the RA and a provider wants to trace the status of a claim.
- **Crossover** – Refer to the *Medicare Part B Crossover Claims* section of the *Medi-Cal Rx Provider Manual* for more information.
- **Underpayment** – A claim has been underpaid and a provider requests an adjustment.
- **Overpayment** – A claim has been overpaid and a provider requests an adjustment.

Refer to the *Claim Inquiry Form* section of the *Medi-Cal Rx Provider Manual* at <https://medi-calrx.dhcs.ca.gov/provider/forms> for additional information regarding types of inquiries, timeliness of submission, special billing instructions, exceptions to using a CIF, acceptable attachments, completion reminders, response to CIF and completion tips.

Explanation of Form Fields

Provider Information

Provider Name: Enter the provider name.

Service Address, City, State, ZIP Code: Enter the service address for the provider.

National Provider Identifier (NPI) Number: Enter the provider's NPI number.

Claim Information

Claim Type: Defaulted to Pharmacy. For claim inquiry information for other claim types (e.g., Long Term Care, Inpatient, Outpatient, Medical), visit <https://www.medi-cal.ca.gov/>.

Beneficiary Name: Enter the beneficiary's first and last name.

Beneficiary Medi-Cal ID Number: Enter the beneficiary ID number that appears on the RA showing adjudication of that claim.

Prescription Number: Enter the prescription number.

Date of Service: Enter dates in a MM/DD/YYYY format.

NDC or Medical Supply Billing Code: Enter the National Drug Code (NDC) or 11-digit NDC-like medical supply billing code. When submitting an inquiry for a compound drug claim, enter zero ("0") in place of listing the NDCs, and include each ingredient NDC with the attachment(s).

Amount Billed: Enter the dollar amount originally billed.

Reconsideration: Select this box for a denied claim reconsideration request.

Void: Select this box for a void request.

Share of Cost (SOC) Reimbursement: Select this box for a Share of Cost Reimbursement request.

Tracer: Select this box for a tracer request.

Crossover: Select this box for a Medicare Part B Crossover adjustment request.

Underpayment: Select this box for an underpayment adjustment request.

Overpayment: Select this box for an overpayment adjustment request.

Attachments: Select this box if including attachments related to the request. Note that all claim inquiries should have attachments except when requesting a tracer.

Number of Attachments: Enter the number of attachments submitted for each request.

Total Attachments: Enter the total number of attachments for all requests included on the form.

Remarks: Enter comments specific to each claim on the CIF. If listing multiple claims on the CIF, please specify to which claim each remark applies using the line numbers from the previous section.

Provider Certification

Signature of Provider or Authorized Representative: The signature of the provider or the provider's authorized representative. An original signature is required; use blue ink.

Print Name: Print the name of the person signing the form.

Date: The date on which the form is signed.

Figure 19.4-1: Medi-Cal Rx Provider Claim Inquiry Form (DHCS 6570)

19.4.1 Types of CIF Inquiries and Timelines

See *Table 19.4.1-1* below for descriptions and timelines of various inquiry types.

Type	Description	Timelines and Additional Notes
Reconsideration	This inquiry type is for a claim that has been denied, and a provider has information that would correct the reason for denial.	<p>Within Six-Month Billing Limit: If a claim is denied and the Date of Service (DOS) is within the six-month billing limit or the billing limit exceptions time frame, a corrected claim may be submitted (via POS, Web Claim Submission, or paper claim) instead of completing a CIF.</p> <ul style="list-style-type: none"> • Note: Submitting a new claim within the original six-month billing limit may be a faster process. <p>Beyond Six-Month Billing Limit: To request a reconsideration of a denied claim after the six-month billing limit, providers must complete all applicable and required fields of the CIF and attach a legible copy of the corrected original claim form, a copy of the RA dated within six months of the denial date, and all other pertinent information. (See Section 4.7.2 – Six-Month Billing Limit and Section 19.3.1 – Submission and Timeliness Instructions for additional information regarding timeliness and timeliness exceptions.)</p> <ul style="list-style-type: none"> • Note: CIFs received after six months are subject to automatic denial.

Type	Description	Timelines and Additional Notes
Void (Reversals)	This inquiry type is used to request a void. A void can be requested to fully repay monies previously paid by Medi-Cal Rx.	<p>Void Requests may be submitted <i>any time</i>.</p> <ul style="list-style-type: none"> Note: Voids can be done via the Medi-Cal Rx POS or Web Claims Submission if the claim has a DOS on/after 10/01/2019. <p>See Section 19.4.2.3 – Voids and Resubmissions for additional information regarding CIF Voids.</p>
SOC	This inquiry type is used to request SOC reimbursement. An SOC reimbursement can be requested to fully recover or recoup monies paid toward a member’s SOC.	<p>SOC adjustments must be made within six months following the date of payment on an RA.</p> <p>See Section 19.4.2.2 – CIFs for SOC Reimbursement Claims for additional information regarding SOC Reimbursement.</p>
Tracer	<p>CIF Tracers are submitted by providers who have no record of a payment or denial of a previously submitted claim on an RA, and the provider wants to trace the status of a claim.</p> <p>When a CIF is designated as a <i>tracer</i>, the Medi-Cal Rx Claims Department will search the payment records and will send a letter to the listed provider advising whether a record exists for the claim specified.</p> <p>If a record is found, the letter will specify the action taken on the claim (date of payment, date of denial).</p>	<p>Tracers may be submitted at any time.</p> <p>However, if a tracer is being used to prove timely submission of a claim, the CIF must be received within the same six-month billing limit for claims. If there is no record of receipt of the claim, a Provider Claim Appeal with copies of supporting documentation may be submitted (refer to Section 5.0 – Medi-Cal Rx Provider Claim Appeal Processes and corresponding subsections for additional information).</p> <p>Providers should not send any additional documents with a tracer.</p>

Type	Description	Timelines and Additional Notes
Crossover	This inquiry type is used to request reconsideration of a denied Medicare Crossover claim, an adjustment of an underpaid or overpaid Medicare Crossover claim, or an adjustment related to a Medicare adjustment.	<p>Crossover Underpayment Requests must be made within six months following the date of payment on an RA. CIFs received after six months from the date of the RA on which the underpayment was indicated are subject to automatic denial.</p> <ul style="list-style-type: none"> • Note: Charpentier claims must not be submitted on a CIF. Refer to Section 10.1.3 – Charpentier Claims for additional information. <p>See Section 19.4.2.5 – Medicare/ Medi-Cal Rx Crossover Claims for additional instructions on how to complete a CIF for Medicare/ Medi-Cal Rx Crossover claims.</p>
Underpayment	This inquiry type is used when a claim has been paid at a different amount from the expected maximum allowable and a provider requests an adjustment for underpayment.	<p>Underpayment Requests must be made within six months following the date of payment on an RA. CIFs received after six months from the date of the RA on which the underpayment was indicated are subject to automatic denial.</p> <ul style="list-style-type: none"> • Note: Claims submitted after the six-month billing limit and received without a delay reason will be reimbursed at a reduced rate according to the date which the claim was received. <p>See Section 4.7.2 – Six-Month Billing Limit and Section 19.3.1 – Submission and Timeliness Instructions for additional information regarding timeliness and timeliness exceptions.</p>
Overpayment	This inquiry type is used when a claim has been paid at a different amount from the expected maximum allowable and a provider requests an adjustment for overpayment.	<p>Overpayment Requests may be submitted at any time.</p>

Type	Description	Timelines and Additional Notes
Additional/ Subsequent Inquiries	If further action is desired after a claim inquiry appears on the RA as paid or denied, providers may submit another CIF or a Provider Claim Appeal.	All subsequent CIFs must be submitted within six months from the date of the RA. A Provider Claim Appeal (see Section 5.0 – Medi-Cal Rx Provider Claim Appeal Processes and Section 19.5 – Medi-Cal Rx Provider Claim Appeal Form (DHCS 6571) for additional information) must be submitted within 90 days. Include copies of all previous and pertinent documentation with any CIFs or appeals submitted to substantiate timely follow-up (such as <i>Medi-Cal Rx Claim Inquiry Acknowledgement Letter, RA, or Medi-Cal Rx Claim Inquiry Response Letter</i>).

Table 19.4.1-1: CIF Inquiry Types and Timelines

19.4.2 CIF Completion Instructions

Providers should utilize the CIF and the following subsections for details and information on how to complete the CIF.

19.4.2.1 Tips for CIF Completion

The following information can be used for completing a CIF.

- Providers must fill out each applicable line completely.
- Do not use ditto marks (“”) nor draw an arrow to indicate repetitive information on the CIF.
- Do not use staples on your paper claims. Staples may delay processing time. Providers may use paper clips.
- All information must be exactly the same as that on the RA (including the Beneficiary Medi-Cal ID Number, Prescription/Rx number, DOS, etc.).
 - For example, an incorrect ID number on the RA should be copied exactly the same on the CIF.
- CIFs may contain up to five claim lines per form, but all lines must be for the same member.
- CIFs must contain the applicable DOS of the claim(s) in the completed claim lines.
- All supporting documentation must be clear, concise, and complete.
- Failure to check the Attachment box may cause the claim to be denied (see [Section 19.4.4 – CIF Attachments](#) for additional information).

- Providers submitting a CIF for Underpayment or Overpayment must check the appropriate box on the applicable claim line. Failure to check the Underpayment or Overpayment box, when applicable, may cause a delay in claim processing.
- Providers submitting a CIF for Reconsideration of a denied claim must check the appropriate box on the applicable claim line. Do not check the Underpayment or Overpayment box if submitting a CIF for Reconsideration of a denial. Failure to check the Reconsideration box, when applicable, may cause a delay in claim processing.
- Providers submitting a CIF for Crossover must check the Crossover box and check the appropriate boxes for action to be taken (i.e., Reconsideration, Void, Underpayment, or Overpayment) on the applicable claim line.
- Failure to complete the Remarks section of the CIF may cause claim denial or delayed processing.
- Do not use the Remarks section for additional inquiries.
- State clearly and precisely what is being requested in the Remarks section.
- For Underpayment or Reconsideration CIFs, always indicate the denial reason code from the RA in the Remarks section.
- An RA is not required for SOC or Tracer CIFs.
- Do not attach any documentation for Tracer CIFs.
- Only original CIFs are accepted. Photocopied CIFs will be returned.
- Validate that timeliness requirements are met; refer to [Section 19.4.1 – Types of CIF Inquiries and Timelines](#) for additional information.
 - **Note:** Providers submitting improperly completed CIFs will receive a Medi-Cal Rx Claim Inquiry Acknowledgement Letter. The Acknowledgement will advise the provider that the CIF is rejected, what information is missing, and to resubmit a corrected CIF. Providers should include the Medi-Cal Rx Claim Inquiry Acknowledgement Letter and all other pertinent documentation with the resubmitted CIF. Refer to [Section 19.4.5.1 – Acknowledgement and CIF Processing](#) for additional information on Medi-Cal Rx Claim Inquiry Acknowledgments.

19.4.2.2 CIFs for SOC Reimbursement Claims

In addition to the submission requirements outlined on the CIF and in [Section 19.4 – Medi-Cal Rx Provider Claim Inquiry Form \(CIF\) \(DHCS 6570\)](#) and the associated subsections, use the following instructions to request SOC reimbursement for previously paid claims:

- For SOC CIFs, enter the member’s original ID (the number issued prior to being enrolled in a no-SOC program).
- In the Remarks section of the CIF, state “SOC reimbursement; MC 1054 attached.”
- An RA is not required for SOC CIFs.
- Attach a Share-of-Cost Medi-Cal Provider Letter (MC 1054).
 - **Note:** If requesting SOC reimbursement for denied claims or claims not previously submitted, submit the MC 1054 with the new claim attached to the CIF.

- If SOC is reduced to an amount other than zero (0), wait a minimum of 30 days before submitting a CIF.

19.4.2.3 Voids and Resubmissions

A CIF Void can be requested to fully repay monies paid by Medi-Cal Rx. In many instances, the provider's goal is to return funds. Void requests may be submitted at any time. Voids can be done via the Medi-Cal Rx POS or Web Claims Submission if the claim has a date of service *on or after* 10/01/2019.

Providers requiring a void and subsequent resubmission of a corrected claim must use a two-step process. The CIF void must first be submitted to recoup the full payment. Once the void appears on a future RA, the provider completes the second step by submitting a corrected claim for processing.

Note: If a provider submits a corrected claim before the void has been processed, the claim may deny as a duplicate since the original claim has not yet completed the void process.

19.4.2.4 CIFs for Compound Claims

A pharmacy compound claim with numerous ingredients is processed as one (1) line. An inquiry may not be made for individual ingredients on a compound claim. Therefore, only one (1) claim line should be completed per compound claim on a CIF.

When submitting a CIF for a compound drug claim, enter '0' in the NDC field of the applicable claim line, in place of listing each NDC. Include each ingredient NDC with the supporting attachments (see [Section 19.4.4 – CIF Attachments](#) for information on acceptable documentation).

19.4.2.5 Medicare/Medi-Cal Rx Crossover Claims

19.4.2.5.1 Submitting Crossover CIFs

In addition to the submission requirements outlined in [Section 19.4 – Medi-Cal Rx Provider Claim Inquiry Form \(CIF\) \(DHCS 6570\)](#) and the associated subsections, use the following instructions to complete a CIF for Medicare/Medi-Cal Rx Crossover claims. A CIF may be used to request reconsideration of a denied Crossover claim, an adjustment of an underpaid or overpaid Medicare Crossover claim, or an adjustment related to a Medicare adjustment.

Note: Charpentier claims must **not** be submitted on a CIF. Refer to [Section 10.1.3 – Charpentier Claims](#) for additional information.

Always include supporting documentation with a Crossover CIF, or the claim will be denied.

19.4.2.5.2 Reconsideration of Denied Crossover Claims

Follow the instructions below to complete a CIF for reconsideration of a denied Crossover claim:

- Check the Attachment box in the corresponding claim line on the CIF.

- Attach the following documentation:
 - If Part B services are billed to a Part A intermediary, submit a clear copy of the original Crossover claim form billed to Medi-Cal Rx.
 - If Part B services are billed to a Part B carrier, submit a clear copy of one of the following:
 - Original Crossover claim form billed to Medi-Cal Rx
 - Claim form billed to Medicare
 - Copy of the claim form submitted to Medicare
 - **Note:** All claims for Part B services must include a clear copy of both of the following:
 - Medicare Remittance Notice (MRN)/Medicare National Standard Intermediary Remittance Advice
 - Medi-Cal Rx RA showing the Medi-Cal Rx Crossover denial
- In the Remarks section, indicate the denial code and include any additional information needed to correct the claim.

Note: It is acceptable to make corrections on the claim copy being submitted with the CIF if the **Remarks** section is completed and specifically identifies what corrections are being made.

19.4.2.5.3 Adjustments to Medi-Cal Rx Crossover Payments

Follow the instructions below to complete a CIF for an adjustment to a Medi-Cal Rx Crossover payment:

- Check the Attachment box in the corresponding claim line on the CIF.
 - **Note:** All claims for Part B services must include a clear copy of both of the following:
 - MRN/Medicare National Standard Intermediary Remittance Advice
 - Medi-Cal Rx RA showing the Medi-Cal Rx Crossover denial
- In the Remarks section, indicate the specific reason for the adjustment and the type of action desired.

Note: It is acceptable to make corrections on the claim copy being submitted with the CIF if the **Remarks** section is complete and specifically identifies what corrections are being made.

19.4.2.5.4 Adjustments Related to Medicare Adjustments

When Medicare automatically crosses over a Medicare adjustment, it is not processed by Medi-Cal Rx because Medi-Cal Rx does **not** process Medicare adjustments. As a result, the Medicare adjustment claim **must** be submitted in hard-copy form.

Providers need to properly adjust the original claim submitted to Medicare and resubmit the adjusted claim to Medi-Cal Rx. Providers must also *void* (reverse) the original Medicare payment, or the adjusted claim will be denied due to a duplicate of a previously paid claim.

To receive the correct reimbursement from Medi-Cal Rx for a previously reimbursed Medicare Crossover claim, providers may either submit a CIF or file a Provider Claim Appeal (see

[Section 5.0 – Medi-Cal Rx Provider Claim Appeal Processes](#) and corresponding subsections and [Section 19.5 – Medi-Cal Rx Provider Claim Appeal Form \(DHCS 6571\)](#) for additional information).

When completing a CIF due to a Medicare adjustment, follow these additional instructions:

- Check the Attachment box in the corresponding claim line on the CIF.
- Attach the following documentation for an adjustment related to a Medicare adjustment:
 - If Part B services are billed to a Part B carrier, submit a clear copy of the adjusted Medicare claim form and one of the following:
 - Original Crossover claim form billed to Medi-Cal Rx
 - Original claim form billed to Medicare
 - Copy of the original claim form submitted to Medicare
 - **Note:** All claims for Part B services must include a clear copy of both of the following:
 - Original and adjusted MRN/Medicare National Standard Intermediary Remittance Advice
 - Medi-Cal Rx RA showing the Medi-Cal Rx Crossover payment or denial
- In the Remarks section, indicate the specific reason for the adjustment and the type of action desired.

Note: It is acceptable to make corrections on the claim copy being submitted with the CIF if the **Remarks** section is complete and specifically identifies what corrections are being made.

19.4.2.5.5 Tracing Crossover Claims

A CIF must be submitted to trace a Crossover claim. Providers submitting a CIF to trace a Crossover claim must check the **Tracer and Crossover** boxes on the applicable claim line.

Note: Do **not** submit a Crossover claim to trace a Crossover claim.

19.4.3 Exceptions to Using CIFs

See *Table 19.4.3-1* below for information regarding when CIFs **may** not be used.

Type	Description
Pharmacy Claims: POS Network	Do not submit a hard-copy CIF to void (reverse) a pharmacy claim originally submitted over the POS network <i>unless</i> an overpayment is being returned. Instead, reverse the claim over the POS network and then resubmit a corrected claim if necessary. For assistance in reversing a claim via the POS network, contact the CSC at 1-800-977-2273. Note: A reversal via POS Network can be done for fee-for-service claims with a date of service on/after 10/01/2019.
Pharmacy Claims: Web	Pharmacy providers should not submit a hard-copy CIF to void (reverse) a claim originally submitted via Web Claims Submission <i>unless</i> an overpayment is being returned. Instead, reverse the claim through the

Type	Description	
Claims Submission	<p>Web Claims Submission system and then resubmit a corrected claim if necessary. For assistance in reversing a claim via Web Claims Submission, contact CSC at 1-800-977-2273.</p> <p>Note: A reversal via POS Network can be done for fee-for-service claims with a date of service on/after 10/01/2019.</p>	
Compound Claims	<p>Do not submit a CIF to request reconsideration of a denied <i>pharmacy compound</i> claim if ingredients must be added or deleted. Instead, submit a new original claim within the six-month billing limit or billing limit exceptions time frame. If this period has expired, submit a Provider Claim Appeal (see Section 5.0 – Medi-Cal Rx Provider Claim Appeal Processes and Section 19.5 – Medi-Cal Rx Provider Claim Appeal Form (DHCS 6571) for additional information).</p> <p>A pharmacy compound claim with numerous ingredients is processed as one (1) line. A CIF may not be made for individual ingredients on a compound claim. Therefore, only one (1) claim line should be completed per compound claim on a CIF.</p>	
Certain RA Codes	<p>Do not submit a CIF for the following RA codes. Providers should submit a <i>Provider Claim Appeal Form</i> instead. If the claim has a unique circumstance requiring human intervention, a review by a person in the appeals unit is commonly used to resolve the specific denials listed below. Additional information is available in Section 5.0 – Medi-Cal Rx Provider Claim Appeal Processes and Section 19.5 – Medi-Cal Rx Provider Claim Appeal Form (DHCS 6571) and corresponding subsections.</p>	
	RA/NCPDP Code	Code Description
	65	Patient is not covered
	83	Duplicate Paid/Captured Claim
	67	Filled Before Coverage Effective
	68	Filled After Coverage Expired
	69	Filled After Coverage Terminated
	77	Discontinued Product/Service ID Number

Table 19.4.3-1: Exceptions to Using CIFs

19.4.4 CIF Attachments

All claim inquiries should have attachments *except* when submitting a tracer. Acceptable CIF attachments are as follows:

- Original Claim
- Prior Authorization Request (PA)
- Explanation of Medicare Benefits (EOMB/Medicare Remittance Notice (MRN/Medicare Remittance Advice (RA)
- Explanation of Benefits (EOB) from Other Health Coverage (OHC)
- List of compound drug ingredients
- Copy of POS printout or internet eligibility response attached to the claim
- MC 1054 (SOC reimbursement) form
- Corrected claim noting remarks area, stating the reason and the amount of overpayment return

Note: All supporting documentation must be legible.

19.4.5 Acknowledgement, Response, Review, and Status of a Claim Inquiry

19.4.5.1 Acknowledgement and CIF Processing

Within **7 days** of receipt, the Medi-Cal Rx Claims Department will acknowledge all requests with a *Medi-Cal Rx Claim Inquiry Acknowledgement Letter*. If Medi-Cal Rx makes any adjustment to the claim, it will appear on a future RA. The RA will reflect a negative and positive payment. The Medi-Cal Rx Claims Department will send a *Medi-Cal Rx Claim Inquiry Response Letter* 30 days after the *Medi-Cal Rx Claim Inquiry Acknowledgement Letter*.

- If a Medi-Cal Rx Claim Inquiry Acknowledgement Letter is not received or the claim submitted does not appear on an RA, a Provider Claim Appeal (see [Section 5.0 – Medi-Cal Rx Provider Claim Appeal Processes](#) and [Section 19.5 – Medi-Cal Rx Provider Claim Appeal Form \(DHCS 6571\)](#) for additional information) may be filed.

Status Numbers and Messages

Only **one** *Medi-Cal Rx Claim Inquiry Acknowledgement Letter* is sent to providers for each CIF submitted. *Table 19.4.5.1-1* lists the status numbers and messages used in the *Medi-Cal Rx Claim Inquiry Acknowledgement Letter*.

Status Numbers and Messages	
Status	Message
00	Rejected. Freeform message displays detailed description of rejection.
01	Complete for resubmission of denied claim or underpayment/overpayment.
02	Complete. <i>Medi-Cal Rx Tracer Status Letter</i> will be generated.
03	Rejected. The Beneficiary Medi-Cal ID Number field is blank on form.
04	Complete for submission of void.

Status Numbers and Messages	
Status	Message
05	Rejected. The date of service is blank on form.
06	Rejected. The Rx number is blank on form.
07	Rejected. No MC 1054 form submitted with form.
08	Rejected. No EOMB, RA, or claim submitted with form.
09	Rejected. Original signature is not present on form.

Table 19.4.5.1-1: Status Numbers and Messages

19.4.5.2 Review of CIF

19.4.5.2.1 Underpayment/Overpayment/Reconsideration/Crossover CIF Review Process

For underpayment, overpayment, and reconsideration, the Medi-Cal Rx Claims Department takes the information found in the inquiry and reviews all information presented, both in the computer inquiry and in the attachments submitted with the CIF, and then processes the new claim according to Medi-Cal Rx policy.

- It is important that the information entered on the CIF exactly matches what is displayed on the RA, even if the information is wrong. This assists in finding the claim in history files if available.
- **Note:** If any information is missing or incomplete, the Medi-Cal Rx Claims Department will return the inquiry to the provider along with a Medi-Cal Rx Claim Inquiry Acknowledgement Letter identifying what information is missing and will also request CIF resubmission once corrected.

19.4.5.2.2 Tracer CIF Review Process

A tracer request is submitted when no record of payment or denial of a previously submitted claim exists on the RA. The Medi-Cal Rx Claims Department searches claim payment history based on the information submitted by the provider.

If the claim is not found, the *Medi-Cal Rx Tracer No Hit Letter* is mailed to the provider. When a claim is not found in history, providers should compare the data shown on the claim to the Tracer submitted. If the information differs, submit a corrected Tracer. If the claim you are tracing is still within the six-month billing limitation, you may resubmit an original claim. If the information is correct and more than sixty (60) days have elapsed since the submission of the original claim, file an appeal.

If the claim is found, the *Medi-Cal Rx Tracer Hit Letter* is created and mailed to the provider detailing the findings of the inquiry.

Note: It is important that the information entered on the CIF exactly matches what was submitted on the claim, even if the information is wrong.

19.4.5.2.3 Void CIF Review Process

A CIF Void can be requested to fully repay monies paid by Medi-Cal Rx. In many instances, the provider's goal is to return funds. The Medi-Cal Rx Claims Department searches claim payment history based on the information submitted by the provider CIF. A "void" adjustment appears on the RA as a single line with a negative (-) amount.

Providers requiring a void and subsequent resubmission of a corrected claim must use a two-step process. The CIF void must first be submitted to recoup the full payment. Once the void appears on a future RA, the provider completes the second step by submitting a corrected claim for processing. If a provider submits a corrected claim before the void has been processed, the claim may deny as a duplicate since the original claim has not yet completed the void process.

19.4.5.3 Claim Inquiry Response Letter

- A Medi-Cal Rx Claim Inquiry Response Letter indicating the status of the claim is sent to providers when the CIF is completed. The Medi-Cal Rx Claim Inquiry Response Letter includes the date that the CIF was received and is used to verify that the CIF was submitted within the six-month billing limit.
- If the Medi-Cal Rx Claim Inquiry Response Letter states that the claim cannot be located, resubmit the claim as a Provider Claim Appeal (see [Section 5.0 – Medi-Cal Rx Provider Claim Appeal Process](#) and [Section 19.5 – Medi-Cal Rx Provider Claim Appeal Form \(DHCS 6571\)](#) for additional information). Enclose any necessary attachments, including a copy of the Medi-Cal Rx Claim Inquiry Response Letter.
- Providers may receive a Medi-Cal Rx Claim Inquiry Response Letter requesting additional information. To submit a new CIF, follow the instructions in the Medi-Cal Rx Claim Inquiry Response Letter.

19.4.5.4 Status Inquiries

Providers may inquire about the status of a CIF by calling the CSC at 1-800-977-2273 and referencing the claim prescription number and the Beneficiary Medi-Cal ID Number. If a status request is submitted and received by mail, any written correspondence regarding claim lines referenced on a CIF acknowledgement should include copies of the *Medi-Cal Rx Claim Inquiry Acknowledgement Letter*, CIF, and all other pertinent documents.

19.4.5.5 Filing a Provider Claim Appeal

Providers who want to pursue further action may file a Provider Claim Appeal (see [Section 5.0 – Medi-Cal Rx Provider Claim Appeal Process](#) and [Section 19.5 – Medi-Cal Rx Provider Claim Appeal Form \(DHCS 6571\)](#) for additional information).

19.5 Medi-Cal Rx Provider Claim Appeal Form (DHCS 6571)

19.5.1 Completion Instructions for Medi-Cal Rx Provider Claim Appeal Form (DHCS 6571)

See *Figure 19.5.1-1* for an example of a blank *Medi-Cal Rx Provider Claim Appeal Form* (DHCS 6571).

Information regarding provider claim appeal processes can be found in [Section 5.0 – Medi-Cal Rx Provider Claim Appeal Processes](#).

The *Medi-Cal Rx Provider Claim Appeal Form* (DHCS 6571) can be found on the [Medi-Cal Rx Provider Portal](#) by selecting [Forms & Information](#).

The Medi-Cal Rx Claim Appeal Team reviews each claim individually using the *Medi-Cal Rx Provider Claim Appeal Form* (DHCS 6571) and any acceptable attachments provided to render a fair decision.

Complete the fields on the *Medi-Cal Rx Provider Claim Appeal Form* (DHCS 6571) according to the type of appeal as described in the following paragraphs. Resubmission, underpayment, and overpayment requests for the same member may be combined on one *Medi-Cal Rx Provider Claim Appeal Form* (DHCS 6571). However, each appeal should include only one member.

Required Fields

Complete any fields that are required (required fields are identified by a red asterisk [*] on the form). If any required fields are left blank, providers may receive an appeal rejection letter requesting resubmission of a corrected *Medi-Cal Rx Provider Claim Appeal Form* (DHCS 6571) and all supporting documentation and proof of timely follow-up and submission.

Note: The **correct** Beneficiary Medi-Cal ID number must be entered in *Part 2 – Claim Information* of the form, even if the RA reflects an incorrect Beneficiary Medi-Cal ID number.

Note: If a provider is submitting a claim appeal for any reason other than those listed as checkboxes in *Part 3 – Appeal Reason* of the *Medi-Cal Rx Provider Claim Appeal Form* (DHCS 6571), the reason must be explained in the provided lines of this part of the form.

Appeal a Claim Denial

If appealing a claim denial, enter the denial code from the RA in the applicable claim line under **EOB/RA Code** in *Part 2 – Claim Information* of the *Medi-Cal Rx Provider Claim Appeal Form* (DHCS 6571).

Underpayment and Overpayment Adjustments

If requesting reconsideration of an underpayment or overpayment, enter the payment code from the RA in the applicable claim line under **EOB/RA Code** in *Part 2 – Claim Information* and check the appropriate box in *Part 3 – Appeal Reason* of the *Medi-Cal Rx Provider Claim Appeal Form* (DHCS 6571).

Note: The above also applies to crossover claim adjustment appeals.

If requesting an underpayment or overpayment *adjustment*, attach a legible copy of the original claim form, corrected if necessary, and a copy of the corresponding paid RA.

If requesting an *overpayment* adjustment because the member named is not a provider's patient, attach only a copy of the paid RA.

Correcting National Drug Codes (NDCs)/Medical Supply Billing Codes

To correct the NDC and/or 11-digit NDC-like medical supply billing code information previously submitted on a claim form, complete the required fields identified above. Enter the **correct** NDC/11-digit NDC-like medical supply billing information (Product ID Qualifier, Product ID, Unit of Measure Qualifier, or NDC/11-digit NDC-like medical supply billing code) in *Part 3 – Appeal Reason* of the form.

Compound Claim Appeals

When submitting an appeal for a compound drug claim, enter zero ("0") in place of listing the NDCs and include each ingredient NDC with the attachment(s).

Tracer CIF Appeals

If a provider submits a *Tracer* CIF and the result is that there has been no record of receipt of the claim, a claim appeal may be submitted. Providers **must** include the details of the reason in *Part 3 – Appeal Reason* of the *Medi-Cal Rx Provider Claim Appeal Form* (DHCS 6571) along with copies of any supporting documentation. See [Section 19.4 – Medi-Cal Rx Provider Claim Inquiry Form \(CIF\) \(DHCS 6570\)](#) and corresponding subsections for additional information on CIFs.

Note: If a provider files a claim appeal following the submission, acknowledgement, and response of a CIF, the appeal **must** be submitted within 90 days from the date of the *Medi-Cal Rx Claim Inquiry Response Letter* and must include any previous and pertinent documentation (such as *Medi-Cal Rx Claim Inquiry Acknowledgement Letter* or *Medi-Cal Rx Claim Inquiry Response Letter*, RA, etc.).

Provider Claim Appeal Form



Instructions: The Provider Claim Appeal Form may be submitted for unsatisfactory responses to the processing, payment, and resubmission of a claim or a claim inquiry. Medi-Cal Rx Claim Appeal Team reviews each claim individually using the documents presented by the provider to render a fair decision. Please carefully read the enclosed instructions prior to completing and signing the Provider Claim Appeal Form. All required fields must be completed to process the Provider Claim Appeal.

Providers must print, sign, date, and mail the form as per the instructions in the *Form Submission* section. Explanations regarding form fields are located below the form in the *Explanation of Provider Claim Appeal Form* section. Incomplete forms will not be processed and will be returned to the provider.

* Indicates Required Field

PART 1 – Provider Information	
*Provider Name:	ABC Provider
*Service Address:	123 Any Street
*City:	Anytown
*State:	CA
*ZIP Code:	99999-5555
*National Provider Identifier (NPI) Number:	123456789
PART 2 – Claim Information	
*Claim Type:	<input checked="" type="checkbox"/> Pharmacy
As provided by the <i>California Administrative Code, Title 22, Section 51015 (b-d)</i> , I am submitting an appeal of my claim as defined below. Enclosed are all pertinent documents corresponding to the appeal, including copies of the claim, Explanation of Benefits (EOB), Remittance Advice (RA), Claim Inquiry Form (CIF), Medicare Explanation of Medicare Benefits (EOMB)/Medicare Remittance Notice (MRN), and previous correspondence with Medi-Cal Rx.	
*Beneficiary Name:	Jane Smith
*Beneficiary Medi-Cal ID Number:	98745632A

*For each claim (up to eight claims per form) fill in all claim line information in the associated row below.

	Rx Number	Date of Service (MM/DD/YYYY)	NDC or Medical Supply Billing Code	EOB/RA Code	Number of Attachments
1	8512346	12/21/2021	09876543210	001	3
2					
3					
4					
5					
6					
7					
8					
Total Attachments:					3

PART 3 – Appeal Reason

*Describe the **Appeal Reason** below and enclose all supporting documents, including a copy of the claim. Check all that apply. Refer to the *Claim Appeal Processes* section of the *Medi-Cal Rx Provider Manual* for additional information and guidelines regarding the appropriate items to be submitted with an appeal. If listing multiple claims on the Provider Claim Appeal Form, specify to which claim each reason applies.

- Eligibility (Proof of Eligibility attached)
- Crossover (EOMB attached)
- Adjustment Request (Refer to the *Supporting Documentation for Appeals* section of the *Medi-Cal Rx Provider Manual* for required supporting documentation)
- Other Reason (please describe below):

Please reconsider processing the above claim. It was denied for eligibility when patient was eligible at time of service. See attached Eligibility Verification, RAD, and the original claim.

PART 4 – Provider Certification

Privacy Statement (Civil Code Section 1798 et seq.): The information requested on this form is required by the Department of Health Care Services for purposes of identification and document processing. Furnishing the information requested on this form is mandatory. Failure to provide the mandatory information may result in your request being delayed or not processed.

This is to certify that the information contained above is true, accurate, and complete and that the provider has read, understands, and agrees to be bound by and comply with the statements and conditions contained on this form. The signature of the provider or the authorized representative binds the provider to statements and conditions contained in this form.

***Signature of Provider or Authorized Representative (Original Signature Required; Use Blue Ink):**

John Doe

***Print Name:**

John Doe

***Date:**

12/31/2021

Form Submission

Print, sign, date, and mail this completed form to the address below. For assistance in completing this form, please call the Medi-Cal Rx Customer Service Center at 1-800-977-2273.

Medi-Cal Rx Customer Service Center
ATTN: Provider Claim Appeals
P.O. Box 610
Rancho Cordova, CA 95741-0610

Explanation of Provider Claim Appeal Form

A claim appeal is the final step in the administrative process and a method for Medi-Cal Rx providers with a dispute to resolve problems related to their claims. Resubmission, underpayment, and overpayment requests for the same beneficiary may be combined on one form. However, each claim appeal should include only one beneficiary.

Refer to the *Claim Appeal Processes* and *Provider Claim Appeal Form* sections in the *Medi-Cal Rx Provider Manual* at <https://medi-calrx.dhcs.ca.gov/provider/forms> for claim appeal submission requirements.

Explanation of Form Fields

All required form fields *must* be completed to process the claim appeal. If fields are left blank, providers may receive an appeal rejection letter requesting resubmission of a corrected Provider Claim Appeal Form and all supporting documentation.

Provider Information

Provider Name: Enter the provider name.

Service Address, City, State, ZIP Code: Enter the service address for the provider.

National Provider Identifier (NPI) Number: Enter the provider's 10-digit NPI number.

Claim Information

Claim Type: Defaulted to Pharmacy. For claim appeal information for other claim types (e.g., Long Term Care, Inpatient, Outpatient, Medical), visit <https://www.medi-cal.ca.gov/>.

Beneficiary Name: Enter the beneficiary's first and last name.

Beneficiary Medi-Cal ID Number: Enter the beneficiary ID number that appears on the Remittance Advice (RA) showing adjudication of that claim.

Rx Number: Enter the Rx number.

Date of Service: Enter the date of service of the claim in MM/DD/YYYY format.

NDC or Medical Supply Billing Code: Enter the National Drug Code (NDC) or 11-digit NDC-like medical supply billing code. When submitting an appeal for a compound drug claim, enter zero ("0") in place of listing the NDCs, and include each ingredient NDC with the attachment(s).

EOB/RA Code: Enter the Explanation of Benefits (EOB)/Remittance Advice (RA) Code, if applicable.

Number of Attachments: Enter the number of attachments associated with this request.

Total Attachments: Enter the total number of attachments for all requests included on the form.

Appeal Reason

Appeal Reason: Choose the appropriate Appeal Reason and ensure any required supporting documentation is included with your request.

Provider Certification

Signature of Provider or Authorized Representative: The signature of the provider or the provider's authorized representative. An original signature is required; use blue ink.

Print Name: Print the name of the person signing the form.

Date: The date on which the form is signed.

Figure 19.5.1-1: Medi-Cal Rx Provider Claim Appeal Form (DHCS 6571)

19.5.2 Tips for Appeal Completion

The following information can be used for completing an appeal.

- Providers must fill out each applicable line completely.
- Do not use ditto marks (""") nor draw an arrow to indicate repetitive information on the form.
- Do not use staples on your paper claims, as staples may delay processing time. Providers may use paper clips.
- All information must be exactly the same as that on the RA (including the Beneficiary Medi-Cal ID Number, Prescription/Rx number, Date of Service, etc.).
- The appeal may contain up to eight claim lines per form, but all lines must be for the same member.
- All supporting documentation must be clear, concise, and complete.
- Failure to complete the Remarks section of the appeal may cause delayed processing.
- Do not use the Remarks section for additional inquiries.
- State clearly and precisely what is being requested in the Remarks section.
- Only original appeals are accepted. Photocopied CIFs will be returned.
- Validate that timeliness requirements are met; refer to [Section 5.2 – Claim Appeal Timeliness](#) for additional information.

Note: Providers submitting improperly completed appeals will receive a *Medi-Cal Rx Appeal Acknowledgement Letter*. The Acknowledgement **will inform** the provider that the appeal is rejected, **identify** what information is missing, and **advise providers** to resubmit a corrected appeal. Providers should include the *Medi-Cal Rx Appeal Acknowledgement Letter* and all other pertinent documentation with the resubmitted appeal. Refer to [Section 5.5 – Acknowledgement of Appeal](#) for additional information on the *Medi-Cal Rx Appeal Acknowledgment Letter*.

19.5.3 Medi-Cal Rx Provider Claim Appeal Packet Checklist

Before mailing an appeal to Medi-Cal Rx, review this checklist to ensure that all pertinent information has been documented and all relevant documentation is attached. All supporting documentation must be legible. Each appeal must contain proof of timeliness.

Note: The checklist is not to be included with the appeal sent to Medi-Cal Rx and should only be used to ensure that all pertinent information is provided.

Mark an next to all that apply.

- I have reviewed the *Medi-Cal Rx Provider Claim Appeal Form* (DHCS 6571) and [Section 19.5.1 – Completion Instructions for Medi-Cal Rx Provider Claim Appeal Form \(DHCS 6571\)](#) for completion instructions.
- The *Medi-Cal Rx Provider Claim Appeal Form* (DHCS 6571) has been completed in its entirety (be sure to double-check that **all** required fields (identified by a red asterisk [*] have been completed).

- If the appeal is for a claim that may be an underpayment or overpayment, the "Adjustment Request" box has been checked on the form in *Part 3 – Appeal Reason*.
- If the appeal is for a claim denial, the reject code from the RA has been entered in the "EOB/RA Code" field on the applicable claim line on the form in *Part 2 – Claim Information*.
- For an overpayment adjustment because the provider received payment for the claim and the member on the claim is not the provider's patient, complete all applicable required fields and attach only a copy of the paid RA to the *Medi-Cal Rx Provider Claim Appeal Form (DHCS 6571)*.
- Copy of the original claim included or copy of *Medi-Cal Rx Tracer No Hit Letter* included.
- Corrected claim included (if necessary).
- If the appeal is for a compound drug claim, include each ingredient NDC with the attachment(s).
- RAs pertaining to claim history (include only pertinent RA pages).
- Explanation of Medicare Benefits (EOMB)/Medicare Remittance Notice (MRN) included.
- Prior Authorization request included.
- OHC payments or denials included.
- Copy of Point-of-Sale printout or internet eligibility response attached to the claim included.
- Copy of previously submitted *Medi-Cal Rx Provider Claim Inquiry Form* included.
- Medi-Cal Rx Claim Inquiry Acknowledgement Letter* included.
- Medi-Cal Rx Claim Inquiry Response Letter* included.
- All dated correspondence sent to Medi-Cal Rx included.
- All dated correspondence received from Medi-Cal Rx documenting timely follow-up included.
- Proof of member eligibility if Date of Service (DOS) is over 15 months or last denial was for eligibility included.
- The *Medi-Cal Rx Provider Claim Appeal Form (DHCS 6571)* has been signed and dated – (All appeals must be signed by the provider or authorized representative for the provider. Appeals submitted without a printed name and signature will be returned to the provider).

19.6 Member Reimbursement Claims

Pursuant to two court decisions, *Conlan v. Bonta* and *Conlan v. Shewry*, DHCS implemented a process which enables Medi-Cal members to obtain reimbursement of paid out-of-pocket expenses for Medi-Cal covered services received during specific periods of a member's Medi-Cal eligibility. These periods include the following:

- Retroactive eligibility period ("Retro"): Up to three (3) months prior to the month the member applies for Medi-Cal Rx benefits (i.e., if a member applies on April 1, they are retroactive beginning the previous January 1).
- Evaluation Period ("Eval"): From the date of the member's application until they are issued their BIC (i.e., if a member completes their application on April 1, and is issued their BIC on May 15, they are in the evaluation period between April 1 and May 15).
- Post-Approval Period ("Post"): Any date after the member was issued their BIC (i.e., if a member is issued their BIC on April 1, they are in the post-eligibility period going forward).

In general, members are notified by letter that they may qualify for reimbursement under the terms of the court order.

Members requesting reimbursement for expenses paid out-of-pocket have one (1) year from the date of service to file a reimbursement claim.

19.6.1 CA-MMIS/Gainwell Member Claim Intake Process

To streamline the claim intake process for member reimbursement claim requests, more commonly referred to as "Conlan Claims," CA-MMIS and Gainwell Technologies will provide **all** claim intake services for member reimbursement requests. This includes all member-submitted reimbursement requests for medical, dental, vision and pharmacy. Claims will be handled by CA-MMIS/Gainwell until all required information is submitted and the claim is considered "complete." Once a claim has been deemed as "complete," it will be sent to the Medi-Cal Rx vendor for processing.

19.6.2 Customer Service Center Responsibilities

The CSC is equipped to work with both providers and members to support CA-MMIS/Gainwell with Beneficiary Reimbursement claims (see [Section 19.6.1 – CA-MMIS/Gainwell Member Claim Intake Process](#)). Members may contact the CSC (1-800-977-2273) to obtain information and forms for requesting reimbursement.

19.6.3 Provider Notification(s) and Responsibilities

Provider Notification of Member Request for Reimbursement: If a member's request for reimbursement is validated by the CSC, a letter of request for member reimbursement is sent to the provider. The letter must be submitted with the provider's claim for reimbursement.

Provider Responsibilities: Providers, upon receipt of the member reimbursement letter, are expected to reimburse members for expenses the member paid to the provider for a Medi-Cal covered service, then bill Medi-Cal for the same service. Claims will be denied if the member

has not been reimbursed. In accordance with the court order to obtain prompt reimbursement to the member, providers that do not comply with the request for member reimbursement are subject, when appropriate, to recoupment action by DHCS of all monies paid to the provider by the member for Medi-Cal covered services.

19.6.4 Claim Submission

Providers must, within sixty days of the date on the member reimbursement letter, submit claims to Medi-Cal as follows:

- Submit an original hard copy claim solely for the services mentioned in the member reimbursement letter.
- Enter delay reason code '10' in the appropriate claim field (refer to [Section 19.3.1 – Submission and Timeliness Instructions](#) for additional information).
- Attach the member reimbursement letter.
- Attach any additional required Medi-Cal documentation.

The original claim, member reimbursement letter, and supporting documentation must be submitted to the Medi-Cal Rx vendor (see [Appendix B – Directory](#) for mailing address).

No electronic claim submission is allowed. Because the CSC determines medical necessity, no PA request is required. The six-month billing limit will be modified for these claims.

19.6.5 Reimbursement

The reimbursement rate is the rate on file for the date of service.

Enrollment Requirement

To be reimbursed, the provider must have been enrolled as a Medi-Cal provider on the date of service. Per the instructions on the member reimbursement letter, providers should contact the Medi-Cal Provider Enrollment Division (see [Section 2.1 – Enrolling as a Medi-Cal Pharmacy Provider](#)) if any of the following conditions apply:

- The provider was not a Medi-Cal provider on the DOS but wants to enroll now.
- The provider is a Medi-Cal provider now but was not on the DOS and needs retroactive eligibility.
- The provider was not a Medi-Cal provider on the date of service but wants to temporarily enroll retroactively in Medi-Cal in order to bill for the Beneficiary Reimbursement Process claims.

20.0 Medi-Cal Rx Program Integrity

20.1 Program Integrity Plan (PIP) Introduction

The Medi-Cal Rx vendor is committed to its role in preventing and detecting health care Fraud, Waste, and Abuse (FWA). The *Medi-Cal Rx Program Integrity Plan* (PIP) supports the Medi-Cal Rx vendor's commitment to enforce the highest standard of ethics, professional standards, and compliance. The PIP and its standards apply to all employees and members of the Board of Directors, as well as contractors and subcontractors who must abide by and uphold internal policies, state and federal regulations, Medi-Cal Rx Contract requirements, and external laws that govern Medi-Cal Rx business activities.

The PIP outlines the Medi-Cal Rx vendor's FWA program and mechanism to conduct the following:

- Monitor
- Measure
- Review, validate, refer, and report FWA to DHCS.

The Medi-Cal Rx vendor integrates the PIP into all Operational processes to ensure consistent application of FWA controls and reporting. The Medi-Cal Rx vendor also has responsibility in engaging the Problem Correction Process (PCP), Change Management, and other external processes. All employees are required to complete training regarding the PIP and attest that the PIP has been read and understood within the first 30 days of hire and annually thereafter.

20.2 What are FWA and Overpayment?

In order to detect FWA, you need to familiarize yourselves with what each of these terms mean and understand how potential concerns can be identified through your day-to-day activities.

Fraud – An intentional deception or misrepresentation made by a person with the knowledge that the deception results in unauthorized benefit to herself or himself or another person. The term includes any act that constitutes fraud under applicable federal or state law.

Waste – Mismanagement of resources, including incurring unnecessary costs because of inefficient or ineffective practices or systems.

Abuse – Provider and pharmacy practices that are inconsistent with generally accepted business or medical practices that result in an unnecessary cost to the Medi-Cal Rx program or in reimbursement for medications that are not medically necessary or that fail to meet professionally recognized standards for health care, or member practices that result in unnecessary cost to the Medi-Cal Rx program.

Overpayment – Includes any amount not authorized to be paid by the Medi-Cal Rx program whether paid as a result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse, or mistake.

20.3 Difference Between and Indicators of Potential FWA

There are differences between fraud, waste, and abuse. One of the primary differences is **intent** and knowledge. **Fraud** requires the person to have the intention to obtain payment and the knowledge that their actions are wrong. **Waste** and **Abuse** may involve obtaining an improper payment but do not require the same intent and knowledge.

Now that you know what FWA are, you need to be able to recognize the signs of someone committing FWA. Here are some examples of what to look for:

Potential Member Issues

- Does the prescription look altered or possibly forged?
- Does the member have multiple prescriptions for the same medication?
- Is the prescription appropriate based on the member's other prescriptions?
- Does the member's medical history support the services being requested?
- Is the member traveling a long distance to get their prescription?
- Does the individual providing the clinical information for the PA request appear to have a clinical background?

Potential Provider Issues

- Does the provider write for diverse drugs or primarily only for controlled substances?
- Are the provider's prescriptions appropriate for the member's health condition (medically necessary)?
- Is the provider writing for a higher quantity than medically necessary for the condition?
- Are multiple members of the same family getting the same prescription from the same doctor?

Potential Pharmacy Issues

- Do you see prescriptions being altered (changing quantities or Dispense as Written)?
- Are generics provided when the prescription requires that brand be dispensed?
- Are all members receiving the same or similar combinations of drugs?
- Is the pharmacy consistently billing for higher than the recommended dosage?
- Are all of the pharmacy's prescriptions written by one or a few prescribers?
- Is the pharmacy located far away from the patient or prescriber?
- Is the pharmacy using or abusing indicator codes (for example, pregnancy indicator for a male member, emergency indicator codes, etc.)?
- Do all members have the same diagnosis code when a diagnosis code is required?

The sample scenarios provided above may result in member calls, which might include questions, such as the following:

Q: Why did I receive a Notice of Action (NOA) letter for a denied prescription for a medication that I am not taking?

Q: Why was my prescription denied for early refill when I have not refilled it?

You may also receive calls from individuals who wish to remain anonymous and/or individuals who are only calling to report suspected FWA. These callers should be provided the phone number for the Prime Therapeutics Compliance Hotline (1-800-474-8651), and you should ask if you can transfer the caller to that number. If they refuse to be transferred, request their contact information; if they refuse to provide it, take down as much information as possible, including any names, dates, locations, or other details of the alleged activity.

20.4 How to Report FWA

Everyone is required to report suspected instances of FWA. Suspected instances must be reported within **one (1)** calendar day. FWA related to Medi-Cal Rx should be reported **immediately** via the Medi-Cal Rx specific FWA hotline number or via the email addresses listed below:

- Call the toll-free Medi-Cal Rx-specific FWA hotline (1-800-375-1251, TTY 711)
- Email Prime Therapeutics SIU (FraudTipHotline@primetherapeutics.com)

For non-Medi-Cal Rx-specific FWA or alternative methods of reporting, see below:

- Prime Therapeutics SIU Pharmacy FWA hotline (1-800-349-2919)
- Prime Therapeutics Compliance Hotline (1-800-474-8651)
- Facsimiles sent to Prime Therapeutics (1-877-290-1555)
- Email Prime Therapeutics Compliance Department (Reports@lighthouse-services.com)
- Report suspected instances to Medi-Cal Rx's physical address via USPS, FedEx, or other delivery service:
 - Medi-Cal Rx SIU
11000 White Rock Road
Rancho Cordova, CA 95670
- Report suspected instances to central SIU's physical address via USPS, FedEx, or other delivery service:
 - Prime Therapeutics
Attn: Pharmacy Audit & SIU
2900 Ames Crossing Road
Eagen, MN 55121

21.0 Drug and Product Shortages

The following processes should be used when a provider has determined that a medically necessary drug, medical supply, or enteral nutrition product cannot be acquired from any source in a timely manner.

What Providers Need to Know About Medical Supplies and Enteral Nutrition Products:

- Specific covered products are billed and provided through Medi-Cal Rx as pharmacy-billed benefits.
- Specific products are restricted to the [Covered Products Lists](#).
- For products on the Covered Products Lists and restricted to specific NDC/billing codes, a PA request will not override a contracted NDC/billing code and will not allow a noncontracted product to be substituted.
- For enteral nutrition products through July 1, 2022, substitution has temporarily been allowed without the need for a new prescription from the prescriber. This policy will remain in place until the national supply of infant formulary stabilizes. Prior to the Department removing this substitution without a PA policy in the future, a 90-day notice will be published, allowing substantial notification to providers and stakeholders. Product coverage is restricted to the Covered Products Lists. For more detailed information, refer to the following:
 - Covered Products Lists tab on the [Forms & Information](#) page
 - [Enteral Nutrition Update: Temporary Interchange of Equivalent Contracted Enteral Nutrition Products Due to Recent Formula Recall](#)
 - [Enteral Nutrition Updates: Interchange of Equivalent Contracted Enteral Nutrition Product and Specialty Infant Authorization Term Limit](#)

What Providers Need to Do to Request Alternative Medical Supplies and Enteral Nutrition Products:

- Providers who encounter out-of-stock products for covered benefits and specific to a Covered Products Lists or medical supplies category should immediately contact the CSC at 1-800-977-2273. The CSC is available 24 hours a day, 7 days a week, 365 days per year.
- Providers should have the following information ready:
 - Product NDC/billing code
 - Product name
 - Product category (diabetic test strips, condoms, aerochambers, etc.)
 - Documentation, such as manufacturer documentation or a wholesaler/distributor invoice, demonstrating the product is unavailable from any other source and they have attempted to locate the product
 - Documentation of the alternative product the provider would like to use
 - Provider contact information, Rx number, National Provider Identifier number, and member information

MMA and DHCS will review the request and respond as soon as administratively possible.

Drug Products

Prior to requesting an alternative, providers must:

1. Confirm that other pharmacies (or locations of a chain pharmacy) in the nearby region are also out of stock and unable to order the requested item.
2. Rule-out use of a suitable alternative that is on the [CDL](#) and available without a PA. This should be done *before* requesting approval of a non-CDL alternative.

Once both conditions above have been met, providers should:

- Submit a "Product Unavailable" PA requesting an alternative that is from a Centers for Medicare and Medicaid Services (CMS)-approved manufacturer. Approved products can be located on the [Medi-Cal Rx Approved NDC List](#).
- Include with the PA verification that the CDL alternative is unavailable in the marketplace in the local region where the member resides.
- Provide supporting documentation (wholesaler notification, FDA notification, association bulletin, etc. confirming shortages) with the PA demonstrating that the original product is unavailable and noting the expected duration of the shortage (if known).
- Request products from a non-CMS-approved manufacturer as a last resort when no other options are available.

PA approval may be granted when suitable CDL options are ruled out.

An emergency supply of the alternative medication may be dispensed immediately to the member for up to a 14-day supply. Such a dispensing does not require a PA. If the shortage is expected to be long term, or there is risk of initially providing the emergency product and subsequently switching to a CDL alternative after the emergency supply runs out (e.g., destabilization of the condition), then a PA for extended use of the alternative product should be submitted in a timely manner so it can be adjudicated prior to the emergency supply running out.

22.0 Acronyms

Acronym/Term	Definition
AA	Actual Age
AAC	Actual Acquisition Cost
AB	Assembly Bill
ADAP	AIDS Drug Assistance Program
AEVS	Automated Eligibility Verification System
ASP	Average Sales Price
AWP	Average Wholesale Price
BIC	Benefits Identification Card
CA	Corrected Age
CCR	California Code of Regulations
CCS	California Children's Services
CDL	Contract Drugs List
CDM	Clinical Decision Module
CGM	Continuous Glucose Monitoring
CHDP	Child Health and Disability Prevention
CIF	Claims Inquiry Form
CMPA	Cow's Milk Protein Allergy
CMS	Centers for Medicare & Medicaid Services
COB	Coordination of Benefits
COV	Scope of Coverage
CPT	Current Procedural Terminology
CSC	Customer Service Center
CSR	Customer Service Representative
DAW	Dispense as Written
DBA	Doing Business As
DCN	Document Control Number
DEA	Drug Enforcement Administration
DHCS	Department of Health Care Services
DIDD	Disposable Insulin Delivery Device(s)

Acronym/Term	Definition
DME	Durable Medical Equipment
DOS	Date of Service
DUR	Drug Utilization Review
EAC	Estimated Acquisition Cost
EFT	Electronic Funds Transfer
EH	Extensively Hydrolyzed
EIN	Employee Identification Number
EMR	Electronic Medical Record
EOB	Explanation of Benefits
EOMB	Explanation of Medicare Benefits
ePA	Electronic Prior Authorization
EPSDT	Early Periodic Screening, Diagnosis, and Treatment
ERA	Electronic Remittance Advices
FAQ	Frequently Asked Questions
FD&C Act	Federal Food, Drug and Cosmetic Act
FI	Fiscal Intermediary
FPACT	Family Planning, Access, Care, and Treatment
FTP	File Transfer Protocol
FUL	Federal Upper Limit
FWA	Fraud, Waste, and Abuse
GAD	Gross Amount Due
GHPP	Genetically Handicapped Persons Program
HAP	Health Access Programs
HbA1c	Hemoglobin A1c
HCPCS	Healthcare Common Procedure Coding System
HIPAA	Health Insurance Portability and Accountability Act
HMO	Health Maintenance Organization
HTC	Hemophilia Treatment Center
ICD-10	International Classification of Disease – 10th Revision
ICF/DD	Intermediate Care Facility for the Developmentally Disabled

Acronym/Term	Definition
ICF/DD-H	Intermediate Care Facility for the Developmentally Disabled/Habilitative
ICF/DD-N	Intermediate Care Facility for the Developmentally Disabled/Nursing
ID	Identification
IEM	Inborn Errors of Metabolism
IRS	Internal Revenue Service
IV	Intravenous
LCHAD	Long-chain-3-hydroxyacyl-CoA-dehydrogenase
LOA	Letter of Authorization
LTC	Long Term Care
MAC	Maximum Allowable Cost
MAIC	Maximum Allowable Ingredient Cost
MCP	Managed Care Plan
MEDS	Medi-Cal Eligibility Data System
MMA	Magellan Medicaid Administration, LLC
MRN	Medicare Remittance Notice
NADAC	National Average Drug Acquisition Cost
NCPDP	National Council for Prescription Drug Programs
NDC	National Drug Codes
NOA	Notice of Action
NPI	National Provider Identifier
OCC	Other Coverage Code
OHC	Other Health Coverage
OOP	Out of Pocket
OTC	Over the Counter
P/DCL	Procedure/Drug Code Limitation
PA	Prior Authorization
PACE	Programs of All-Inclusive Care for the Elderly
PAD	Physician Administered Drug
PATC	Prior Authorization Type Code

Acronym/Term	Definition
PAVE	Provider Application and Validation for Enrollment
PCN	Processor Control Number
PCP	Problem Correction Process
PED	Provider Enrollment Division
PI/SIU	Program Integrity/Special Investigations Unit
PIN	Provider Identification Number
PIP	Program Integrity Plan
PMF	Provider Master File
POS	Point of Sale
ProDUR	Prospective Drug Utilization Review
RA	Remittance Advice
RetroDUR	Retrospective Drug Utilization Review
ROA	Route of Administration
S&I	Suspended and Ineligible Provider List
SCAN	Senior Care Action Network
SCC	Submission Clarification Code
SNOMED	Systematized Nomenclature of Medicine
SOC	Share of Cost
SSN	Social Security Number
STI	Sexually Transmitted Infection
TCN	TAR Control Number
TIN	Taxpayer Identification Number
TPN	Total Parenteral Nutrition
U&C	Usual and Customary
UAC	User Administration Console
UCF	Universal Claim Form
UOM	Unit of Measure
UPC	Universal Product Code
UPN	Universal Product Number
US	United States
VFC	Vaccines For Children

Acronym/Term	Definition
W&I Code	Welfare and Institutions Code
WAC	Wholesale Acquisition Cost
WCS	Web Claims Submission

23.0 Appendices

Appendix A – NCPDP Payer Specification Sheet

To access the *NCPDP Payer Specification Sheet* for Medi-Cal Rx, click [here](#).

Appendix B – Directory

To access the Medi-Cal Rx Directory, click [here](#).

Appendix C – Aid Codes

To access the Aid Codes list, click [here](#).

Appendix D – NCPDP Reject Codes

To access the NCPDP Reject Codes list, click [here](#).

Appendix E – Acceptable Medi-Cal Rx PA Request Forms

Medi-Cal Rx PA Request Form (preferred)

The [Medi-Cal Rx Prior Authorization Request Form \(DHCS 6560\)](#) can be found on the [Medi-Cal Rx Provider Portal](#) by selecting [Forms & Information](#).

Alternate PA request forms that may be accepted by Medi-Cal Rx are forms 50-1, 50-2, and 61-211, as shown below:

Medi-Cal Form 50-1

STATE USE ONLY

5

SERVICE CATEGORY

TYPEWRITER ALIGNMENT

CONFIDENTIAL PATIENT INFORMATION

FOR F.I. USE ONLY

1A

CCN

TREATMENT AUTHORIZATION REQUEST

STATE OF CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

F.I. USE ONLY

40

41

42

43

TYPEWRITER ALIGNMENT

43

FOR PROVIDER USE

VERBAL CONTROL NO. (1B)

TYPE OF SERVICE REQUESTED (2)

REQUEST IS RETROACTIVE? (YES/NO)

PATIENT MED-CAL ELIGIBLE? (YES/NO)

PROVIDER PHONE NO. (2A)

PROVIDER NAME AND ADDRESS (2B)

3. PROVIDER NUMBER (3)

NAME AND ADDRESS OF PATIENT (4)

PATIENT NAME (LAST, FIRST, MI.) (4)

MEDI-CAL IDENTIFICATION NO. (5)

SEX (7)

AGE (7)

DATE OF BIRTH (8)

PATIENT STATUS: HOME (8A), BOARD & CARE (8A), SNF / ICF (8B), ACUTE HOSPITAL (8B)

DIAGNOSIS DESCRIPTION (8B)

MEDICAL JUSTIFICATION (8C)

PATIENT'S AUTHORIZED REPRESENTATIVE (IF ANY)

ENTER NAME AND ADDRESS:

32A

33

FOR STATE USE

31 PROVIDER, YOUR REQUEST IS:

1. APPROVED AS REQUESTED (DONES/DEFERRED)

2. APPROVED AS MODIFIED (STEPS MARKED BELOW AS AUTHORIZED MAY BE CLAIMED) (JACKSON VS RANK PARAGRAPH CODE)

BY: MEDICAL CONSULTANT (ID #, DATE, REVIEW/CLAIMING INDICATOR)

COMMENTS/EXPLANATION

RETROACTIVE AUTHORIZATION GRANTED IN ACCORDANCE WITH SECTION 5190 (b)

36

LINE NO.	APPROVED Y/N	APPROVED UNITS	SPECIFIC SERVICES REQUESTED	UNITS OF SERVICE	NDC/UPN OR PROCEDURE CODE	QUANTITY	CHARGES
1			10 10A	10B	11	12	12A
2							
3							
4							
5							
6							

TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS TRUE, ACCURATE AND COMPLETE AND THE REQUESTED SERVICES ARE MEDICALLY INDICATED AND NECESSARY TO THE HEALTH OF THE PATIENT.

39A

SIGNATURE OF PHYSICIAN OR PROVIDER _____ TITLE _____ DATE _____

37 THORIZATION IS VALID FOR SERVICES PROVIDED FROM DATE _____ TO DATE _____

38

TAR CONTROL NUMBER

39 OFFICE SEQUENCE NUMBER PI

NOTE: AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT IS SUBJECT TO PATIENT'S ELIGIBILITY. BE SURE THE PATIENT'S ELIGIBILITY IS CURRENT BEFORE RENDERING SERVICE.

PROVIDER COPY

50-1 03/97

Medi-Cal Form 50-2

STATE
USE
ONLY

4

CONFIDENTIAL PATIENT INFORMATION
FOR F.I. USE ONLY

CCN

F.I. USE ONLY

40 41
42 43

TREATMENT AUTHORIZATION REQUEST
STATE OF CALIFORNIA DEPARTMENT OF HEALTH SERVICES

FOR PROVIDER USE

VERBAL CONTROL NO.

TYPE OF SERVICE REQUESTED: DRUG OTHER

REQUEST IS RETROACTIVE? YES NO

IS PATIENT MEDICARE ELIGIBLE? YES NO

PROVIDER PHONE NO. ()

PROVIDER NAME AND ADDRESS

3. PROVIDER NUMBER

NAME AND ADDRESS OF PATIENT

PATIENT NAME (LAST, FIRST, M.I.)

MEDI-CAL IDENTIFICATION NO.

SEX AGE DATE OF BIRTH

PATIENT STATUS: HOME BOARD & CARE SNF / ICF ACUTE HOSPITAL

DIAGNOSIS DESCRIPTION:

MEDICAL JUSTIFICATION:

PATIENT'S AUTHORIZED REPRESENTATIVE (IF ANY)
ENTER NAME AND ADDRESS:

FOR STATE USE

33 PROVIDER: YOUR REQUEST IS:

APPROVED AS REQUESTED DENIED DEFERRED

APPROVED AS MODIFIED (ITEMS MARKED BELOW AS AUTHORIZED MAY BE CLAIMED) JACKSON VS RANK PARAGRAPH CODE

BY: MEDI-CAL CONSULTANT REVIEW COUNCIL'S INDICATOR

I.D. # DATE

34 35 36 37 38 39 40

COMMENTS/EXPLANATION:

RETROACTIVE AUTHORIZATION GRANTED IN ACCORDANCE WITH SECTION 61003 (b)

41 42 43 44 45 46

LINE NO.	AUTHORIZED		APPROVED UNITS	SPECIFIC SERVICES REQUESTED	UNITS OF SERVICE	HDC/UGC OR PROCEDURE CODE	QUANTITY	CHARGES
	YES	NO						
1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>
2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>
3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>
4	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>
5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>
6	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>

TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS TRUE, ACCURATE AND COMPLETE AND THE REQUESTED SERVICES ARE MEDICALLY INDICATED AND NECESSARY TO THE HEALTH OF THE PATIENT.

SIGNATURE OF PHYSICIAN OR PROVIDER _____ TITLE _____ DATE _____

AUTHORIZATION IS VALID FOR SERVICES PROVIDED

37 FROM DATE 38 TO DATE

TAR CONTROL NUMBER

39 OFFICE SEQUENCE NUMBER **40699748** PI

NOTE: AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT IS SUBJECT TO PATIENT'S ELIGIBILITY. BE SURE THE PATIENT'S ELIGIBILITY IS CURRENT BEFORE RENDERING SERVICE. SEND TO FIELD SERVICES (F.I. COPY) 50-2 06/93 SEE YOUR PROVIDER MANUAL FOR ASSISTANCE REGARDING THE COMPLETION OF THIS FORM.

PRESCRIPTION DRUG PRIOR AUTHORIZATION OR STEP THERAPY EXCEPTION REQUEST FORM

Plan/Medical Group Name: _____ Plan/Medical Group Phone#: (_____) _____
 Plan/Medical Group Fax#: (_____) _____ Non-Urgent Exigent Circumstances

Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization or step-therapy exception request. Information contained in this form is Protected Health Information under HIPAA.

Patient Information				
First Name:	Last Name:	MI:	Phone Number:	
Address:		City:		State: Zip Code:
Date of Birth:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Circle unit of measure Height (in/cm): _____	Allergies:	
Patient's Authorized Representative (if applicable):			Authorized Representative Phone Number:	
Insurance Information				
Primary Insurance Name:			Patient ID Number:	
Secondary Insurance Name:			Patient ID Number:	
Prescriber Information				
First Name:	Last Name:		Specialty:	
Address:		City:		State: Zip Code:
Requestor (if different than prescriber):			Office Contact Person:	
NPI Number (individual):			Phone Number:	
DEA Number (if required):			Fax Number (in HIPAA compliant area):	
Email Address:				
Medication / Medical and Dispensing Information				
Medication Name:				
<input type="checkbox"/> New Therapy <input type="checkbox"/> Renewal <input type="checkbox"/> Step Therapy Exception Request				
If Renewal: Date Therapy Initiated:			Duration of Therapy (specific dates):	
How did the patient receive the medication?				
<input type="checkbox"/> Paid under Insurance Name: _____ Prior Auth Number (if known): _____				
<input type="checkbox"/> Other (explain): _____				
Dose/Strength:	Frequency:	Length of Therapy/#Refills:	Quantity:	
Administration:				
<input type="checkbox"/> Oral/SL <input type="checkbox"/> Topical <input type="checkbox"/> Injection <input type="checkbox"/> IV <input type="checkbox"/> Other:				
Administration Location:				
<input type="checkbox"/> Patient's Home		<input type="checkbox"/> Long Term Care		
<input type="checkbox"/> Physician's Office		<input type="checkbox"/> Home Care Agency		
<input type="checkbox"/> Ambulatory Infusion Center		<input type="checkbox"/> Outpatient Hospital Care		
<input type="checkbox"/> Other (explain): _____				

Revised 12/2016

Form 61-211

Appendix F – P/DCL Provider Limitation List

To access the P/DCL Provider Limitation List, click [here](#).

Appendix G – OHC Carrier Information

To access contact and payer information on Other Health Coverage (OHC) carriers pertaining to drug-related coverage, click [here](#).

Appendix H – List of Physician Administered Drugs (PADs) with Reject Code 816

Claims that reject with Reject Code 816 will return the following supplemental message:
"Pharmacy Drug Benefit Exclusion. Exception for pharmacy benefit approval may be considered via PA request. May be covered as a medical benefit."

Claims should be submitted via the member's medical insurance, but may, under some circumstances, be submitted to Medi-Cal Rx for a PA review and determination.

This list is current at the time of publishing and includes examples of PADs excluded from the Medi-Cal Rx pharmacy benefits. Also, this list is subject to change.

Examples of PADs
Prostin VR® (Alprostadil) Injection
Fentanyl 50 Mcg/ML Carpuject
Neoprofen Injection Indomethacin Injection
Zynrelef™ (Bupivacaine and Meloxicam) ER Topical Solution
Testopel® (Testosterone)
Vasostriect® (Vasopressin)
Virazole® (Ribavirin)
Versed® (Midazolam)
Brevibloc (Esmolol) Injection Labetalol Solution for Injection
Cardene (Nicardipine) IV Cleviprex (Clevidipine) Vial Nicardipine Vial/Ampule Nimodipine Injection Diltiazem Vial Verapamil Syringe

Examples of PADs

<p>Corlopan® (Fenoldopam) Nipride RTU® (Sodium Nitroprusside) Papaverine</p>
<p>Sotradecol® (Sodium Tetradecyl Sulfate) 3% Sotradecol® (Sodium Tetradecyl Sulfate) 1%</p>
<p>Zilretta® (Triamcinolone Acetonide ER)</p>
<p>Entereg® (Alvimopan)</p>
<p>Ammonul Vial</p>
<p>Cafcit® (Caffeine Citrate Injection) Theophylline/Dextrose Injection</p>
<p>Atracurium Bridion (Sugammadex) Nimbex (Cisatracurium) Pancuronium Rocuronium Anectine, Quelicin (Succinylcholine) Vecuronium</p>
<p>Tridil® (Nitroglycerin) Injection Nitroglycerin with Dextrose Injection</p>
<p>Ozurdex® (Dexamethasone) Implant</p>
<p>Beovu® (Brolucizumab) Eylea® (Aflibercept) Lucentis® (Ranibizumab)</p>
<p>Prialt® (Ziconotide)</p>
<p>Quadramet® (Samarium)</p>
<p>Curosurf® (Poractant Alfa) Survanta® (Beractant)</p>
<p>Sinuva® (Beractant)</p>
<p>Vaprisol® (Conivaptan) w/ Dextrose</p>
<p>Sodium Thiosulfate injection indicated for acute cyanide poisoning</p>
<p>Zolgensma (Onasemnogene Abeparvovec-Xioi) Skysona (Elivaldogene Autotemcel)</p>

Examples of PADs

Zynteglo (Betibeglogene Autotemcel)
Radioactive therapeutic agents
Supprelin LA or Vantas (Histrelin) Injection
Tzielid (Teplizumab Injection)
Vabysmo® (Faricmab-Svoa)
Xipere® (Triamcinolone Acetonide)
Iluvien® (Fluocinolone Acetonide) Implant
Healon® (Hyaluronate Sodium) Injection
Omidria® (Phenylephrine/Ketorolac)
Lidocaine 1%/Phenylephrine 1.5% in BSS, Ophthalmic Injection, PF,SF
Byooviz™ (Ranibizumab-nuna)
Dextenza® (Dexamethasone)
Dexycu® (Dexamethasone)
Durysta® (Bimatoprost) Implant
Luxturna® (Voretigene Neparvovec-rzyl) Vial
Miostat® (Carbachol) Vial
Retisert® (Fluocinolone Acetonide) Implant
Yutiq® (Fluocinolone Acetonide) Implant
Susvimo™ (Ranibizumab)
Xiaflex® (Collagenase Clostridium Histolyticum) Vial
Fentanyl (Fentanyl Citrate) Syringe
Spinraza® (Nusinersen Sodium) Vial
Euflexxa/Orthovisc (Hyaluronate Sodium)
Synvisc (Hylan G-F 20) Syringe
Hymovis (Hyaluronate, Modified, Non-Crosslink) Syringe
Monovisc (Hyaluronate Sodium, Stabilized) Syringe
Lamzedo (Velmanase Alfa-Tycv) Vial
Syfovre (Pegcetacoplan/Pf) Vial