Medi-Cal Rx Phased Reinstatement – Frequently Asked Questions (FAQs)

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DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

Table of Contents

Back to Top

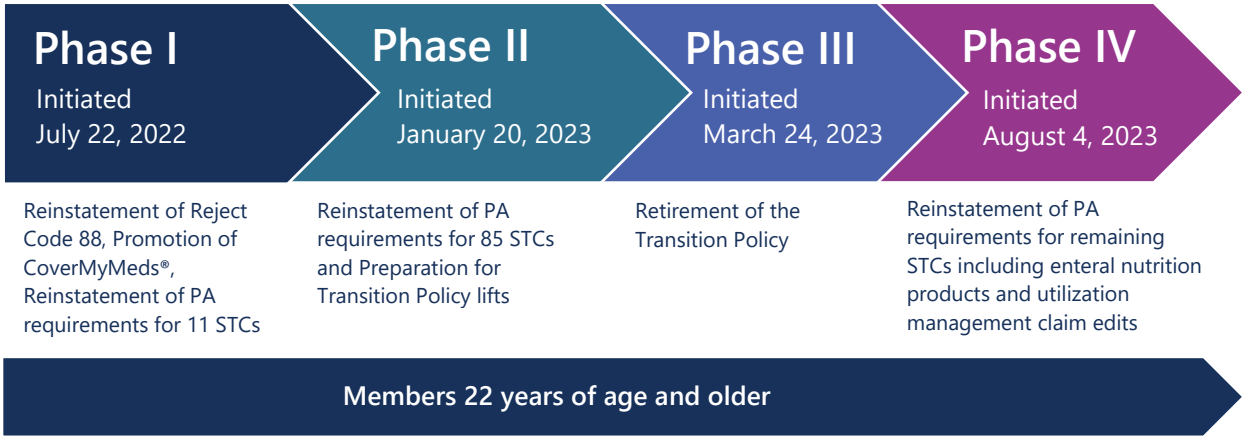
Introduction

On June 1, 2022, the California Department of Health Care Services (DHCS), in collaboration with Magellan Medicaid Administration, LLC (MMA), released the Medi-Cal Rx Reinstatement Plan. DHCS set forth a phased approach to restore select claim edits and prior authorization (PA) request requirements by therapeutic drug class, while phasing out the Transition Policy. To facilitate incremental implementation, the Medi-Cal Rx Reinstatement Plan design employs a series of "waves" and "lifts" or sequenced events within each phase to introduce change.

The following Frequently Asked Questions (FAQs) document provides guidance and clarification regarding Medi-Cal Rx Phased Reinstatement.

Navigation

- Select a phase in the graphic below to jump to FAQs associated with that phase or use the Table of Contents to jump to specific phases, waves, or topics.
- Simultaneously press the **Ctrl** key + **F** key to prompt the search box and type the keyword or phrase to search for that content within this document.
- This document is equipped with a Glossary to provide more detail about complex topics referenced in the questions and answers. Select blue hyperlinked text to quickly jump to the Glossary for expanded details on that topic.



Back to Top

General Reinstatement FAQs

1. **Where can I locate information about Medi-Cal Rx Reinstatement?**

   For information about Medi-Cal Rx Reinstatement, visit the Medi-Cal Rx Education & Outreach page on the Medi-Cal Rx Web Portal and select **Medi-Cal Rx Reinstatement**. Links to specific resources can be located in the *Reinstatement Resources* section in this FAQ.

2. **How are standard therapeutic classes (STCs) selected for phases and waves?**

   Selection of STCs has been based on aggregate analyses with the aim that prior authorization (PA) request volume and adjudication turnaround time (TAT) are both manageable and sustainable over time.

3. **When was Reject Code 80 – Diagnosis Code Submitted Does Not Meet Drug Coverage Criteria implemented?**

   Medi-Cal Rx implemented Reject Code 80 on April 30, 2024.

4. **When will members 21 years of age and younger be impacted by Medi-Cal Rx Reinstatement?**

   Members 21 years of age and younger (including members enrolled in the Genetically Handicapped Persons Program [GHPP], California Children's Services [CCS], and/or Medi-Cal fee-for-service), are excluded from Medi-Cal Rx Reinstatement during Phases I, II, III, and IV, with the exception of the Reinstatement of **Reject Code 76 – Plan Limitations Exceeded** for new start claims.

5. **When will members receiving enteral nutrition products be impacted by Medi-Cal Rx Reinstatement?**

   Enteral nutrition products for members 22 years of age and older were excluded from Medi-Cal Rx Reinstatement during Phases I, II, and III. Phase IV includes reinstatement of prior authorization (PA) request requirements for members 22 years of age and older. Refer to the *90-Day Countdown: Reinstatement of Prior Authorization Requirements for Enteral Nutrition Products for Members 22 Years of Age and Older* alert for additional details.

   Note: Reinstatement of PA request requirements for enteral nutrition products for members 21 years of age and younger will not occur prior to 2024.

6. **Will Medi-Cal Rx Reinstatement impact the processing time for prior authorization (PA) requests?**

   For all PA requests, Medi-Cal Rx will ensure that within 24 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 the Department of Health Care Services (DHCS).

Back to Top

7. **Will the 14-day emergency override still be applicable during Medi-Cal Rx Reinstatement?**

   Yes. Products will continue to be available for emergency dispensing provided they are benefits of Medi-Cal Rx. Refer to the *Emergency Fills* section of the *Medi-Cal Rx Provider Manual* for more information.

Phase I FAQs

General Phase I

8. **What occurred during Phase I?**

   Claim edits for **Reject Code 88 – DUR Reject Error** were reintroduced during Phase I, Wave 1 (P1/W1). Promotion of CoverMyMeds® as the preferred submission method channel for prior authorization (PA) requests occurred during Phase I, Wave 2 (P1/W2). PA request requirements for 11 standard therapeutic classes (STCs) were reinstated for new start prescriptions for members 22 years of age and older during Phase I, Wave 3 (P1/W3).

9. **When did Phase I occur?**

   Phase I started on July 22, 2022, with the last wave implemented on September 16, 2022. This phase included three sequential waves during that time period.

Phase I, Wave 1 (P1/W1)

10. **What is a Prospective Drug Use Review (ProDUR)?**

    A ProDUR is a set of clinical, safety, and/or utilization criteria using First DataBank (FDB) (drug information vendor) modules and Department of Health Care Services (DHCS) policies to ensure safe and effective drug use.

11. **Can Reject Code 88 – DUR Reject Error be overridden by the pharmacist at Point of Sale (POS)?**

    A pharmacist can override Reject Code 88 at POS. If a claim is rejected with Reject Code 88 only, the pharmacist should evaluate the conflict and determine whether the prescription should be filled and then resubmit the claim using appropriate drug use review (DUR) service codes.
    Service codes include:
    - Reason for Service Code
    - Professional Service Code
    - Result of Service Code

    If the claim rejects for multiple Reason for Service Codes, each service code must be addressed independently. If a claim does not meet one or more DUR alerts, the system will either reject the claim or send a message to the provider informing them of the specific conflict(s). If a paid claim is sent with a DUR message for specific conflicts, a pharmacist should evaluate the conflict and determine whether the prescription should be dispensed. For questions or concerns about adjudicating claims for Reject Code 88, contact the

Back to Top

Medi-Cal Rx Customer Service Center (CSC). A prior authorization (PA) request should not be submitted for Reject Code 88.

12. Will Reject Code 88 – DUR Reject Error return a Next Fill Date in the Additional Message Qualified field?

Yes. For overutilization (early refill), the previous date of fill is returned in NCPDP Field ID: 530-FU (Previous Date of Fill), and the next date of fill will be returned in NCPDP Field ID: 544-FY (DUR Free Text Message). For the previous date of fill, the pharmacy name and phone number also will be returned in NCPDP Field ID: 526-FQ (Additional Message Information) Additional Message Qualified field. The additional message returned will state, "Last filled on YYYYMMDD at Pharmacy Name (555) 555-5555."

Phase I, Wave 2 (P1/W2)

13. What is CoverMyMeds®?

CoverMyMeds is the preferred platform for electronic prior authorization (PA) request submission to Medi-Cal Rx.

14. What are the benefits to using CoverMyMeds®?

The benefits to using CoverMyMeds include:

- Requests interact in real time, lowering administrative burden.
- The system gathers the specific clinical information required by asking the questions and minimizing the need for additional outreach.
- Covered alternatives are often presented in real time to assist prescribers.
- Clinical information submitted may allow for real-time prior authorization (PA) request approvals.
- PA requests for controlled substances scheduled II, III, IV, and V may be submitted through CoverMyMeds utilizing a digital signature. The PA request does not require a "wet"/physical signature.
- If a PA request is not required for the member and drug, messaging will be returned in real time to inform the submitter.
- For PA requests submitted via CoverMyMeds, the status of the PA request is available via CoverMyMeds and the Medi-Cal Rx Provider Portal.

Phase I, Wave 3 (P1/W3)

15. When did the reinstatement of prior authorization (PA) request requirements go into effect for the first wave of 11 standard therapeutic classes (STCs)?

Phase I, Wave 3 (P1/W3) went into effect on September 16, 2022. Refer to the *Now Active – Reinstatement of Limited Prior Authorization Requirements for 11 Drug Classes* alert for more information.

Back to Top

16. Which 11 standard therapeutic classes (STCs) were identified for Phase I, Wave 3 (P1/W3)?

Prior authorization (PA) request requirements for the following 11 STCs were reinstated during P1/W3:

Phase I, Wave 3 (P1/W3) Drug Classes *		
Anticoagulants and antiplatelets (STC 77)	Cardiovascular agents (including antiarrhythmics and inotropes) (STC 76, 74)	Hypoglycemics and glucagon (STC 58)
Antihypertensives (STC 71)	Coronary vasodilators (nitrates and pulmonary arterial hypertension agents) (STC 72)	Niacin, Vitamin B, and Vitamin C products (STC 81)
Antilipemic agents (including statins and omega-3 fatty acids) (STC 65, 66)	Diuretics (STC 79, 53)	

* STC refers to the Standard Therapeutic Classification number.

Phase II FAQs

General Phase II

17. Did the prior authorization (PA) request requirements for the standard therapeutic classes (STCs) identified in Phase II apply to members on an existing therapy?

No. Reinstatement of PA request requirements for STCs identified for Phase II only applied to new start prescriptions for members 22 years of age and older.

Phase II, Wave 1 (P2/W1)

18. When did the reinstatement of prior authorization (PA) requests for the Phase II, Wave 1 (P2/W1) 39 standard therapeutic classes (STCs) go into effect?

P2/W1 went into effect on January 20, 2023.

Back to Top

19. Which 39 standard therapeutic classes (STCs) were identified for Phase II, Wave 1 (P2/W1)?

Prior authorization (PA) request requirements for the following 39 STCs were reinstated during P2/W1 as listed in the *30-Day Countdown – Reinstatement of Prior Authorization Requirements for 39 Drug Classes* alert:

Phase II, Wave 1 (P2/W1) Drug Classes *		
All Other Dermatologicals (STC 95)	Corticotropins (STC 50)	Other Antibiotics (STC 27)
Anabolics (STC 59)	Emollients Protectives (STC 93)	Other Hormones (STC 64)
Androgens (STC 60)	Erythromycins (STC 25)	Penicillins (STC 22)
Anesthetic Local, Topical (STC 45)	Estrogens (STC 61)	Progesterone (STC 62)
Antiarthritics (STC 42)	Fat Soluble Vitamins (STC 80)	Streptomycins (STC 23)
Antifungals (STC 94)	Folic Acid Preparations (STC 83)	Sulfonamides (STC 24)
Antimalarials (STC 32)	General Antibacterials and Antiseptics (STC 38)	Systemic Contraceptives (STC 63)
Antiparasitics (STC 31)	Glucocorticoids (STC 51)	TB Preparations (STC 34)
Anti-Parkinson's (STC 09)	Iodine Therapy (STC 57)	Tetracyclines (STC 21)
Anti-Ulcer Preps/ Gastrointestinal Preps (STC 01)	Multivitamins (STC 82)	Thyroid Preps (STC 55)
Antivirals (STC 33)	Muscle Relaxants (STC 08)	Topical Nasal and Otic Preparations (STC 19)
Biologicals (STC 90)	Non-Opioid Analgesics (STC 41)	Urinary Antibacterials (STC 28)
Cephalosporins (STC 26)	Ophthalmic Preparations (STC 20)	Vitamin K (STC 85)

* STC refers to the Standard Therapeutic Classification number.

Back to Top

Phase II, Wave 2 (P2/W2)

20. What occurred during Phase II, Wave 2 (P2/W2)?

During P2/W2, 46 standard therapeutic classes (STCs) were reinstated for new start prescriptions for members 22 years of age and older.

21. When did the reinstatement of prior authorization (PA) requests for Phase II, Wave 2 (P2/W2) 46 standard therapeutic classes (STCs) including medical supplies go into effect?

P2/W2 went into effect on February 24, 2023.

22. Which standard therapeutic classes (STCs) were identified for Phase II, Wave 2 (P2/W2)?

Prior authorization (PA) request requirements for the following 46 STCs, including medical supplies, were reinstated during P2/W2:

Phase II, Wave 2 (P2/W2) Drug Classes		
Adrenergics (STC 18)	B Complex with Vitamin C (STC 84)	Laxatives (STC 06)
All Other Antiobesity Preps (STC 13)	Bile Therapy (STC 05)	Mineralocorticoids (STC 52)
Allergens (STC 89)	Bronchodilators (STC 15)	Oxytocics (STC 97)
Amphetamine Preparations (STC 12)	Chloramphenicol (STC 29)	Parasympathetic Agents (STC 98)
Anesthetics Gen Inhalant (STC 43)	CNS Stimulants (STC 10)	Psychostimulants-Antidepressant (STC 11)
Anesthetics Gen Inject (STC 44)	Coal Tar (STC 92)	Rauwolfias (STC 70)
Anticonvulsants (STC 48)	Cold and Cough Preparations (STC 17)	Sedative Barbiturate (STC 46)
Antidiarrheals (STC 03)	Contraceptives, Non-Systemic (STC 36)	Sedative Non-Barbiturate (STC 47)
Antidotes (STC 54)	Cough Preparations/ Expectorants (STC 16)	Trimethoprim (STC 35)
Antihistamines (STC 14)	Diagnostics (STC 39)	Vaginal Cleansers (STC 37)
Antinauseants (STC 49)	Digestants (STC 67)	Vasodilators Peripheral (STC 73)

Back to Top

Phase II, Wave 2 (P2/W2) Drug Classes		
Antineoplastics (STC 30)	Emetics (STC 02)	Xanthine Derivatives (STC 75)
Antipruritics (STC 91)	Enzymes (STC 69)	Medical Supplies *
Antispasmodic and Anticholinergic Agents (STC 04)	Hematinics and Blood Cell Stimulators (STC 88)	Miscellaneous ** (STC 99)
Antithyroid Preps (STC 56)	Hemorrhoidal Preparations (STC 96)	
Ataractics-Tranquilizers (STC 07)	Hemostatics (STC 78)	

* **Note:** Diabetic supplies, including testing supplies and insulin syringes, are included with Medical Supplies. Diabetic supplies also include Continuous Glucose Monitoring (CGM) Systems and Disposable Insulin Delivery Devices (DIDDs), both of which require an approved Medi-Cal Rx PA request for a paid claim. For more information regarding Medi-Cal Rx coverage of Medical Supplies, refer to the *Medical Supplies* section in the *Medi-Cal Rx Provider Manual* and the Contract Drugs & Covered Products Lists page on the Medi-Cal Rx Web Portal.

** All other drugs not otherwise listed except for enteral nutrition products.

Preparing for Phase III: Retirement of the Transition Policy FAQs

General Phase III Preparation

23. What is Phase III: Retirement of the Transition Policy?

As announced on December 20, 2022, in the alert titled *90-Day Countdown – Phase III: Retirement of the Transition Policy for Beneficiaries 22 Years of Age and Older*, Medi-Cal Rx began phasing out the Transition Policy in a series of lifts beginning March 24, 2023.

24. What can pharmacy providers and prescribers do to prepare for Phase III: Retirement of the Transition Policy?

On January 12, 2023, Medi-Cal Rx published the *How to Prepare for Retirement of the Transition Policy* alert. Pharmacy providers and prescribers should consider transitioning members 22 years of age and older to covered alternatives that may not require a prior authorization (PA) request. If a covered alternative is not appropriate, providers may submit a PA request to Medi-Cal Rx as of February 24, 2023.

Back to Top

25. Where can pharmacy providers and prescribers locate a list of covered alternative therapies that may not require a prior authorization (PA) request?

Pharmacy providers and prescribers can review the *Medi-Cal Rx Approved NDC List* and the lists located on the Contract Drugs & Covered Products Lists page of the Medi-Cal Rx Web Portal. Prescribers can also refer to ePrescribing applications.

26. What message do pharmacies receive when a claim is paying under the Transition Policy?

If a claim pays with the following supplemental message, this claim is eligible for prior authorization (PA) request submission as of February 24, 2023: "*The Medi-Cal Rx transition policy will be retired in a series of transition lifts, starting on 3/24/2023. A Prior Authorization may be required for this benefit/drug. Consider submitting a PA request today. For more information, please visit the Medi-Cal Rx website.*" These drugs/products are eligible for PA request submission, in advance of Phase III: Retirement of the Transition Policy for members 22 years of age and older.

27. Were there any exclusions to prior authorization (PA) request submissions that started February 24, 2023?

Yes. Submission of PA requests for members 21 years of age and younger or enteral nutrition products for members of any age were not accepted during Phase III of Reinstatement. These claims continued to be covered under the Transition Policy beyond Phase III. Additional guidance for enteral nutrition PAs was provided during Phase IV of reinstatement.

Phase III FAQs

General Phase III

28. If a prior authorization (PA) request was submitted in anticipation of Phase III: Retirement of the Transition Policy, and it was approved prior to its respective lift date, is any further action needed during the respective lift that impacts that drug/product?

No. If the PA request is approved, it mitigates the need to submit a PA request when the lift becomes effective and avoids a lapse in care.

29. When submitting prior authorization (PA) requests, how will continuation of care be determined?

All PA requests, including those under consideration for continuation of care, will be reviewed for medical necessity. Pharmacy providers and prescribers should complete all required fields and provide relevant clinical information on PA requests to establish medical necessity. For additional information, refer to the alert titled *Reminder: Establishing Medical Necessity*. Pharmacy providers and prescribers may also refer to the *Medi-Cal Rx Provider Manual* for more information.

Back to Top

30. How is Medi-Cal Rx addressing the impact of prior authorization (PA) request requirements for maintenance medications during Phase III?

To reduce administrative burden while ensuring continued medication safety for members, the Department of Health Care Services (DHCS) has enabled extended duration/multi-year PA requests for up to five years for certain maintenance medications used for chronic conditions. Qualified prescriptions have been automatically extended. Currently, this only applies to members 22 years of age and older. For more information, refer to the alert titled *Extended Duration Prior Authorizations for Maintenance Medications*.

31. What drug classes are included in extended duration prior authorization (PA) requests for maintenance medications?

Extended duration PA requests for maintenance medications are currently in effect and include, but are not limited to, the following drug classes:

Maintenance Drug Classes		
Anti-depressants	Anti-convulsants	Anti-hypertensives
Anti-lipemic agents	Anti-Parkinson's agents	Anti-psychotic agents
Antiviral agents	Asthma inhalers	Cardiovascular agents
Coronary vasodilators	Diabetes medications	Diuretics
Glaucoma agents	Hormone agents	Multiple Sclerosis agents
Oncology agents	Rheumatoid Arthritis agents	

32. What is the length of authorization for a drug that has been identified as eligible for extended duration prior authorization (PA) request?

The current policy regarding the length of authorization for extended duration PA requests is "up to 5 years." For additional questions regarding the extended duration PA request policy, email the Department of Health Care Services (DHCS) at RxCarveOut@dhcs.ca.gov.

33. How are the lengths of authorization for extended duration determined?

The authorization lengths are determined on a case-by-case basis for medical necessity. For additional questions regarding the extended duration prior authorization (PA) request policy, email the Department of Health Care Services (DHCS) at RxCarveOut@dhcs.ca.gov.

34. Where can I find a list of applicable maintenance medication NDCs for extended duration prior authorization (PA) requests?

Medications eligible for the extended duration PA requests are identified on the *Medi-Cal Rx Approved NDC List*.

Back to Top

Phase III, Lift 1 (P3/L1)

35. What standard therapeutic classes (STCs) and Hierarchical Ingredient Code 3 (HIC3s) items were impacted during Phase III, Lift 1 (P3/L1)?

The following STCs * and HIC3s ** were impacted during P3/L1:

Phase III, Lift 1 (P3/L1) Drug Classes		
Diuretics (STC 79, 53)	Anti-Lipemic Agents (STC 65, 66)	Hypoglycemics (STC 58)
Antihypertensives (STC 71)	Coronary Vasodilators (STC 72)	Cardiovascular Agents (STC 76, 74)
Anticoagulants and Antiplatelets (STC 77)	Niacin, Vitamin B and Vitamin C (STC 81)	Opioids (STC 40)
		Benzodiazepines (HIC3: H20, H21, H22, H4A, H8G, H8K)

* STC refers to the Standard Therapeutic Classification number. HIC3 refers to the Specific Therapeutic Classification per First DataBank (FDB).

** Listed HIC3s fall within STCs 07, 47, and 48; other drugs within these STCs were not impacted by this transition lift. Refer to the *Medi-Cal Rx Approved NDC List* for additional details.

Refer to the *30-Day Countdown – Phase III, Lift I: Retirement of the Transition Policy for Beneficiaries 22 Years of Age and Older* alert for more information.

Phase III, Lift 2 (P3/L2)

36. What standard therapeutic classes (STCs) were impacted during Phase III, Lift 2 (P3/L2)?

The following 17 STCs were impacted during P3/L2:

Phase III, Lift 2 (P3/L2) Drug Classes *			
Contraceptives and Hormones (STC 59 – 64)	Ophthalmic, Nasal, and Otic Preparations (STC 19, 20)	Thyroid Agents (STC 55, 57)	Topical Anesthetic Agents (STC 45)
Dermatologic Agents (STC 93, 95)	Biologic Agents (STC 90)	Glucocorticoids and Corticotropins (STC 50, 51)	Anti-Parkinson's (STC 9)

* STC refers to the Standard Therapeutic Classification number.

37. When did Phase III, Lift 2 (P3/L2) occur?

P3/L2 occurred on April 21, 2023.

Back to Top

Phase III, Lift 3 (P3/L3)

38. What standard therapeutic classes (STCs) were impacted during Phase III, Lift 3 (P3/L3)?

The following 22 STCs were impacted during P3/L3:

Phase III, Lift 3 (P3/L3) Drug Classes *		
Anti-Ulcer Preps/ Gastrointestinal Preps (STC 01)	Other Antibiotics (STC 27)	Antiarthritics (STC 42)
Muscle Relaxants (STC 08)	Urinary Antibacterials (STC 28)	Fat Soluble Vitamins (STC 80)
Tetracyclines (STC 21)	Antiparasitics (STC 31)	Multivitamins (STC 82)
Penicillins (STC 22)	Antimalarials (STC 32)	Folic Acid Preparations (STC 83)
Streptomycins (STC 23)	Antivirals (STC 33)	Vitamin K (STC 85)
Sulfonamides (STC 24)	TB Preparations (STC 34)	Antifungals (STC 94)
Erythromycins (STC 25)	General Antibacterials and Antiseptics (STC 38)	
Cephalosporins (STC 26)	Non-Opioid Analgesics (STC 41)	

* STC refers to the Standard Therapeutic Classification number.

39. When did Phase III, Lift 3 (P3/L3) occur?

P3/L3 occurred on May 19, 2023.

Back to Top

Phase III, Lift 4 (P3/L4)

40. What standard therapeutic classes (STCs) were impacted during Phase III, Lift 4 (P3/L4)?

The following 46 STCs were impacted during P3/L4:

Phase III, Lift 4 (P3/L4) Drug Classes *		
Medical Supplies (STC 00)	Chloramphenicol (STC 29)	Enzymes (STC 69)
Emetics (STC 02)	Antineoplastics (STC 30)	Rauwolfias (STC 70)
Antidiarrheals (STC 03)	Trimethoprim (STC 35)	Vasodilators Peripheral (STC 73)
Antispasmodic and Anticholinergic Agents (STC 04)	Contraceptives, Non-Systemic (STC 36)	Xanthine Derivatives (STC 75)
Bile Therapy (STC 05)	Vaginal Cleansers (STC 37)	Hemostatics (STC 78)
Laxatives (STC 06)	Diagnostics (STC 39)	B-Complex with Vitamin C (STC 84)
Ataractics-Tranquilizers (STC 07) (remaining HIC3s)	Anesthetics Gen Inhalant (STC 43)	Hematinics and Blood Cell Stimulators (STC 88)
CNS Stimulants (STC 10)	Anesthetics Gen Inject (STC 44) (remaining HIC3s)	Allergens (STC 89)
Psychostimulants-Antidepressants (STC 11)	Sedative Barbiturate (STC 46)	Antipruritics (STC 91)
Amphetamine Preparations (STC 12)	Sedative Non-Barbiturate (STC 47) (remaining HIC3s)	Coal Tar (STC 92)
All Other Antiobesity Preps (STC 13)	Anticonvulsants (STC 48) (remaining HIC3s)	Hemorrhoidal Preparations (STC 96)
Antihistamines (STC 14)	Antinauseants (STC 49)	Oxytocics (STC 97)
Bronchial Dilators (STC 15)	Mineralocorticoids (STC 52)	Parasympathetic Agents (STC 98)

Back to Top

Phase III, Lift 4 (P3/L4) Drug Classes *		
Cough Preparations/ Expectorants (STC 16)	Antidotes (STC 54)	Miscellaneous (STC 99)
Cold and Cough Preparations (STC 17)	Antithyroid Preps (STC 56)	
Adrenergics (STC 18)	Digestants (STC 67)	

* STC refers to the Standard Therapeutic Classification number. Hierarchical Ingredient Code 3 (HIC3) refers to the Specific Therapeutic Classification per First DataBank (FDB).

41. When did Phase III, Lift 4 (P3/L4) occur?

P3/L4 occurred on June 23, 2023.

Phase IV FAQs

General Phase IV

42. What is Phase IV?

Phase IV completed reinstatement for the adult population, ages 22 and older, with a series of lifts beginning August 4, 2023. As part of this phase, utilization management (UM) claims edits were reinstated, as were prior authorization (PA) request requirements for enteral nutrition products. Members ages 21 and younger were not impacted by Phase IV changes.

Phase IV, Lift 1 (P4/L1)

43. What is Phase IV, Lift 1 (P4/L1)?

P4/L1 is the first in a series of lifts impacting utilization management (UM) claim edits for pharmacy benefits for members 22 years of age and older. This lift began on August 4, 2023.

P4/L1 reinstated the following claim edits (with corresponding reject codes) on August 4, 2023:

- **Reject Code 60 – Product/Service Not Covered for Patient Age**
- **Reject Code 61 – Product/Service Not Covered for Patient Gender**
- **Reject Code 606 – Brand Drug/Specific Labeler Code Required**

Back to Top

44. What can pharmacy providers and prescribers do to prepare for Phase IV, Lift 1 (P4/L1)?

Pharmacy providers and prescribers are encouraged to share this information with vendors, business partners, and staff who need to know about the upcoming change. Pharmacy providers and prescribers should review the following resources:

- *30-Day Countdown: Phase IV, Lift 1: Reinstatement of Claim Edits for Age, Gender, and Labeler Code Restrictions for Beneficiaries 22 Years of Age and Older*
- *Medi-Cal Rx Billing Tips*
- *Appendix D* in the *Medi-Cal Rx Provider Manual*
- *NCPDP Payer Specification Sheet*
- *Prior Authorization Submission Reminders*

Also, continue to review the Medi-Cal Rx Web Portal for additional information.

45. When a claim is submitted for a member that does not meet the Code I Age Limit or the U.S. Food and Drug Administration (FDA)-approved age ranges, what reject code will be sent to Point of Sale (POS)?

The pharmacy claim will deny for **Reject Code 60 – Product/Service Not Covered for Patient Age** with the following supplemental message: *"Age requirement not met. Prior Authorization Required."*

Note: Age restrictions are based on Code I restrictions listed in the *Medi-Cal Rx Contract Drugs List* (CDL) or the FDA-approved age ranges provided in package inserts.

46. What steps do I take to resolve Reject Code 60 – Product/Service Not Covered for Patient Age?

If you submit a pharmacy claim and receive a rejection with Reject Code 60, complete the following steps:

1. If clinically appropriate, providers should consider prescribing alternative therapies that may not require a prior authorization (PA) request.
2. If a change in therapy is not appropriate, providers may submit a PA request via one of the five Medi-Cal Rx PA request submission methods.

Refer to the *Prior Authorization Submission Reminders* alert for more information on PA request submission.

Back to Top

47. When a claim is submitted for a Family Planning, Access, Care, and Treatment (Family PACT) member that does not meet the gender requirement, what reject code will be sent to Point of Sale (POS)?

The pharmacy claim will deny for **Reject Code 61 – Not Covered for Patient Gender** with the following supplemental message: "*Gender requirement not met. Prior Authorization Required.*"

Note: Pharmacy claims submitted for Medi-Cal, California Children's Services (CCS), and Genetically Handicapped Persons Program (GHPP) members will not be impacted by Reject Code 61. The Department of Health Care Services (DHCS) removed current gender utilization management (UM) requirements for all Medi-Cal Rx claims except for Family PACT.

48. What steps do I take to resolve Reject Code 61 – Product/Service Not Covered for Patient Gender?

If you submit a pharmacy claim for a Family Planning, Access, Care, and Treatment (Family PACT) member and receive a rejection with Reject Code 61, complete the following steps:

1. If clinically appropriate, providers should consider prescribing alternative therapies that may not require a prior authorization (PA) request.
2. If a change in therapy is not appropriate, providers may submit a PA request via one of the five Medi-Cal Rx PA request submission methods.

Refer to the *Prior Authorization Submission Reminders* alert for more information on PA request submission.

49. When a claim is submitted for a member that does not meet the Code I Labeler Restriction, what reject code will be sent to Point of Sale (POS)?

The pharmacy claim will deny for **Reject Code 606 – Brand Drug/Specific Labeler Code Required** with the following supplemental message: "*Code 1 Labeler Restriction not met.*"

Note: Labeler Code requirements will be reinstated on brand, multisource drugs where the brand name is less costly than the therapeutically equivalent (AB-rated) generic alternatives. The Department of Health Care Services (DHCS) will continue to evaluate the cost of these brand, multisource drugs and their generic equivalents on a quarterly basis. As generic equivalents become the least costly alternative, labeler code utilization management (UM) requirements will be modified.

Back to Top

50. What steps do I take to resolve Reject Code 606 – Brand Drug/Specific Labeler Code Required?

If you submit a pharmacy claim and receive a rejection with Reject Code 606, complete the following steps:

1. If clinically appropriate, the pharmacy provider should resubmit the claim using the authorized labeler code, found in the Code I column of the *Medi-Cal Rx Contract Drugs List* (CDL).
2. If dispensing of the authorized labeler code is not clinically appropriate, providers may submit a prior authorization (PA) request via one of the five Medi-Cal Rx PA request submission methods.

Refer to the *Prior Authorization Submission Reminders* alert for more information on PA request submission.

Phase IV, Lift 2 (P4/L2)

51. What was reinstated during Phase IV, Lift 2 (P4/L2)?

P4/L2:

- Reinstated utilization management (UM) claim edits for **Reject Code 78 – Cost Exceeds Maximum**.
- Reinstated prior authorization (PA) request requirements for new start therapies for standard therapeutic classes (STCs) 68, 86, and 87, including enteral nutrition products.
- Enabled PA request submissions in advance of the retirement of the Transition Policy for renewing/refilling prescriptions for products in STCs 68, 86, and 87, which include enteral nutrition products.

Refer to the *Reinstatement of Prior Authorization (PA) Request Requirements for Enteral Nutrition Products for Beneficiaries 22 Years of Age and Older* section for more information on enteral nutrition products.

Back to Top

52. What are the Cost Ceiling Limits?

The following Cost Ceiling Limits affect the specified categories of drugs:

Cost Ceiling Limits	
Drug/Product	**Cost Ceiling**
Over-the-counter (OTC)	$50/claim
Generic	$1,000/claim
Single and Multi-Source Brand	$4,000/claim
High-Cost Generics and Brands *	$14,000/claim
Claims over the Cost Ceiling Maximum for each category will trigger Reject Code 78 and will require a prior authorization (PA) request.	

* Drugs/products in this category include generic and brand drugs not in the *Generic* or *Single and Multi-Source Brand* categories, where the claim threshold amount is equal to or greater than $14,000.

53. How can I resolve Reject Code 78 – Cost Exceeds Maximum?

If a claim exceeds the cost ceiling as specified in the table in **question #52**, the claim will deny with Reject Code 78 with the following supplemental message: *"[$XX.00] Maximum Cost Exceeded. For override, call CSC (1-800-977-2273) or submit a Prior Authorization."*

Reject Code 78 requires approval of an override with clinician review to receive a paid claim. Providers should perform the following steps:

1. Check for quantity submission errors and ensure the quantity submitted represents correct billing units.
2. Consider prescribing a less costly therapy, if clinically appropriate.
3. If a change in therapy is not appropriate, submit a prior authorization (PA) request via one of the approved Medi-Cal Rx PA request submission methods.

Refer to the *Prior Authorization Submission Reminders* alert and the *Medi-Cal Rx Provider Manual* for more information on submitting a PA request.

Back to Top

Phase IV, Lift 3 (P4/L3)

54. What was reinstated during Phase IV, Lift 3 (P4/L3)?

P4/L3 reinstated claim edits for **Reject Code 76 – Plan Limitations Exceeded**. This claim edit was already in place for new start claims for all ages but was also applied to refill claims for members 22 years of age and older beginning October 13, 2023. Claims that reject with Reject Code 76 can reject for any of the following reasons:

- Minimum Billed Quantity
- Maximum Billed Quantity
- Days' Supply Limit Exceeded
- Quantity Limit Exceeded
- Maximum Quantity Per Day Limit Exceeded
- Number of Fills Per Specific Time Limit Exceeded

55. How can providers prepare for reinstatement of Reject Code 76 – Plan Limitations Exceeded?

Many of these quantity limitations are outlined in the lists located on the Contract Drugs & Covered Products Lists page on the Medi-Cal Rx Web Portal. However, claims will also be subject to quantity limitations based on U.S. Food and Drug Administration (FDA)-approved or medically accepted maximum daily doses and length of therapy of a particular dose to ensure safe and effective medication use.

Quantity limits may be administered as a quantity over time or a maximum daily dose. Quantity over time is based on dosing guidelines over a rolling time period. Maximum daily dose (maximum quantity per day) is based on maximum number of units of the drug allowed per day. Refer to the specific manufacturer's prescribing information for additional details.

56. How can providers resolve Reject Code 76 – Plan Limitations Exceeded?

To resolve Reject Code 76, pharmacy providers and prescribers should:

1. Consult the following resources:
   a. Contract Drugs & Covered Products Lists page on the Medi-Cal Rx Web Portal
   b. Specific manufacturer's prescribing information
   c. U.S. Food and Drug Administration (FDA)-approved dosing
2. If resubmission of the claim to meet quantity limitations is not appropriate, a prior authorization (PA) request is required for coverage consideration. Point-of-sale (POS) overrides are not available.
3. When applicable, submit a PA request via one of the five approved Medi-Cal Rx PA request submission methods.

Note: If a claim rejects due to quantity limitations exceeding a 100-day supply for drugs/products, a PA request is not reviewable for coverage consideration as it must not exceed this limitation of up to and including a 100-day supply (except FDA-approved self-administered hormonal contraceptives **including transdermal patches and vaginal rings in addition to oral dosage forms**, and sodium fluoride products/drops/solutions).

Back to Top

Phase IV, Lift 4 (P4/L4)

57. What was implemented during Phase IV, Lift 4 (P4/L4)?

On November 10, 2023, P4/L4 was implemented for members 22 years of age and older. P4/L4 implemented:

- Prior authorization (PA) request requirements for standard therapeutic classes (STCs) 68, 86, and 87, which include enteral nutrition products.
- Brand Medically Necessary (BMN) Prior Authorization (PA) request requirements for all claims.

On April 30, 2024, Medi-Cal Rx implemented claim utilization management (UM) edits for **Reject Code 80 – Diagnosis Code Submitted Does Not Meet Drug Coverage Criteria** for members 22 years of age and older.

58. Which standard therapeutic classes (STCs) had prior authorization (PA) request requirements reinstated during Phase IV, Lift 4 (P4/L4)?

PA request requirements have been reinstated for all therapies for members 22 years of age and older in the following drug classes:

Phase IV, Lift 4 (P4/L4) Drug Classes *		
Protein Lysates (STC 68)	Infant Formulas (STC 86)	Electrolytes and Miscellaneous Nutrients (STC 87)

* STC refers to the Standard Therapeutic Classification number.

Note: Enteral nutrition products are included within STCs 68, 86, and 87.

59. What should pharmacy providers and prescribers do to ensure continuous care for members during reinstatement of prior authorization (PA) request requirements for standard therapeutic classes (STCs) 68, 86, and 87?

If a member is 22 years of age and older and currently receiving a drug/product in STCs 68, 86, or 87, pharmacy providers and prescribers should:

- Consider alternate therapies that may not require a PA request, if clinically appropriate. Review the Contract Drugs & Covered Products Lists page on the Medi-Cal Rx Web Portal.
- If a change in therapy is not appropriate, submit a PA request in advance of the retirement of the Transition Policy via one of the approved Medi-Cal Rx PA request submission methods. Refer to the *Prior Authorization Submission Reminders* alert and the *Medi-Cal Rx Provider Manual* for more information on submitting a PA request.

Back to Top

60. What claims are affected by the reinstatement of Brand Medically Necessary (BMN) prior authorization (PA) request requirements for a dispense as written (DAW) code of DAW 1?

BMN PA request requirements have been reinstated for claims for members 22 years of age and older.

Claims submitted with DAW 1 for a brand, multisource product, when the product is not subject to a labeler restriction for the brand drug, will deny for BMN PA request requirements.

Note: Claims submitted for brand, multisource drugs that do not have a Maximum Allowable Ingredient Cost (MAIC) or Federal Upper Limit (FUL) price type will not deny for BMN PA request requirements.

61. What should pharmacy providers and prescribers do to avoid a claim being denied for Brand Medically Necessary (BMN) prior authorization (PA) request requirements?

If a member is 22 years of age and older and a dispense as written (DAW) code of DAW 1 must be submitted on a claim where the product is not labeler restricted and is a brand, multisource product, pharmacy providers and prescribers should:

- Refer to the Contract Drugs & Covered Products List page on the Medi-Cal Rx Web Portal for labeler code information.
- Submit a BMN PA request via one of the approved Medi-Cal Rx PA request submission methods.
- Refer to the *Prior Authorization Submission Reminders* alert and the *Medi-Cal Rx Provider Manual* for more information on submitting a PA request.

Reinstatement of Prior Authorization (PA) Request Requirements for Enteral Nutrition Products for Members 22 Years of Age and Older

General Preparation for Reinstatement of Prior Authorization (PA) Request Requirements for Enteral Nutrition Products

62. What is Reinstatement of Prior Authorization (PA) Request Requirements for Enteral Nutrition Products?

As announced on June 23, 2023, in the alert titled *90-Day Countdown: Reinstatement of Prior Authorization Requirements for Enteral Nutrition Products for Members 22 Years of Age and Older*, Medi-Cal Rx reinstated PA request requirements for new start enteral nutrition products for members 22 years of age and older on September 22, 2023.

Back to Top

63. When can pharmacy providers submit prior authorization (PA) requests in anticipation of Reinstatement of PA requirements for Enteral Nutrition Products?

As of September 22, 2023, PA requests may be submitted in advance of the retirement of the Transition Policy, for enteral nutrition products, for members 22 years of age and older.

Implementation of Reject Code 80

64. When did the implementation of Reject Code 80 – Diagnosis Code Submitted Does Not Meet Drug Coverage Criteria take effect?

As announced in the March 29, 2024, alert, *30-Day Countdown: Implementation of Reject Code 80*, Medi-Cal Rx implemented claim utilization management (UM) edits for Code I Diagnosis restriction (Reject Code 80) on April 30, 2024. This edit applies to claims for members 22 years of age and older for a limited number of medications.

65. What medications are impacted by the implementation of Reject Code 80 – Diagnosis Code Submitted Does Not Meet Drug Coverage Criteria?

Pharmacy providers and prescribers can identify which medications are impacted by the Code I diagnosis restriction by reviewing the *Medi-Cal Rx Diagnosis Crosswalk* or the Medi-Cal Rx Contract Drugs Lists (CDLs). The *Medi-Cal Rx Diagnosis Crosswalk* provides a list of medications requiring Code I diagnosis, along with the diagnosis codes that will be accepted on the submitted claim.

The *Medi-Cal Rx Diagnosis Crosswalk* and the CDLs are available on the Contract Drugs & Covered Products Lists page of the Medi-Cal Rx Web Portal.

66. How does Medi-Cal Rx reduce claims impacted by implementation of Reject Code 80 – Diagnosis Code Submitted Does Not Meet Drug Coverage Criteria?

To support pharmacy providers and prescribers with drugs impacted by the Code I diagnosis requirement, Medi-Cal Rx utilizes diagnosis code(s) found in the member's Medi-Cal medical record to address this requirement, when available.

67. How can prescribers address the Reject Code 80 – Diagnosis Code Submitted Does Not Meet Drug Coverage Criteria diagnosis requirement?

Prescribers have the following options to demonstrate that the diagnosis requirement is met:

- Provide a diagnosis or International Classification of Disease – 10th Revision (ICD-10) code(s) with the prescription.
- Provide a diagnosis or ICD-10 code(s) communicated verbally to the pharmacy provider.
- Submit a prior authorization (PA) request via an approved Medi-Cal Rx submission method establishing the Code I diagnosis restriction is met or establishing medical necessity for an alternate diagnosis.

Back to Top

68. **How can pharmacy providers address the Reject Code 80 – Diagnosis Code Submitted Does Not Meet Drug Coverage Criteria diagnosis requirement?**

    Pharmacy providers have the following options to demonstrate that the diagnosis requirement is met:

    - Attest the diagnosis restriction is met via one of the following options:
        - International Classification of Disease – 10th Revision (ICD-10) Attestation
            - Enter the appropriate ICD-10 code related to the diagnosis.
        - Submission Clarification Code (SCC) 7 Attestation
            - The submitter may communicate that the restriction has been met using SCC 7.
    - Submit a prior authorization (PA) request via an approved Medi-Cal Rx submission method establishing the Code I diagnosis restriction is met or establishing medical necessity for an alternate diagnosis.

    For further information, refer to the *30-Day Countdown: Implementation of Reject Code 80* and *How to Address Reject Code 80 – Diagnosis Code Submitted Does Not Meet Drug Coverage Criteria* alerts.

69. **What will happen if a claim is submitted by a pharmacy provider for an impacted medication without an accepted International Classification of Disease – 10th Revision (ICD-10) code, attestation the diagnosis is met with use of submission clarification code (SCC) 7, or approved prior authorization (PA) request?**

    Claims submitted without an ICD-10 code or with an ICD-10 code that is not accepted (as identified on the *Medi-Cal Rx Diagnosis Crosswalk*), SCC 7 attestation, or approved PA request will reject with **Reject Code 80 – Diagnosis Code Submitted Does Not Meet Drug Coverage Criteria**.

70. **Will the implementation of Reject Code 80 – Diagnosis Code Submitted Does Not Meet Drug Coverage Criteria impact members 21 years of age and younger?**

    No, members 21 years of age and younger are not impacted at this time.

Reinstatement Resources

- In addition to the resources linked within this FAQ, Medi-Cal Rx offers a **Medi-Cal Rx Reinstatement** web page, which is available by selecting **Medi-Cal Rx Education & Outreach** from the Medi-Cal Rx Web Portal, and then selecting **Medi-Cal Rx Reinstatement**.
- The Medi-Cal Rx team also hosts a weekly Reinstatement Webinar. The Medi-Cal Rx Reinstatement Webinar recording is available on YouTube.

Back to Top

- Pharmacy providers and prescribers can stay up to date with all that is happening at Medi-Cal Rx by signing up for the Medi-Cal Rx Subscription Service to receive notification of future alerts.
- You can also call the Medi-Cal Rx Customer Service Center (CSC) at 1-800-977-2273, which is available 24 hours a day, 7 days a week, 365 days per year.
- Pharmacy providers and prescribers can also seek assistance via the Medi-Cal Rx Education & Outreach team by emailing MediCalRxEducationOutreach@primetherapeutics.com.

Back to Top

Glossary

Term	Definition
Approved NDC List	The *Medi-Cal Rx Approved NDC List* is a spreadsheet that contains NDCs eligible for coverage and reimbursement under Medi-Cal Rx. This list is updated monthly and includes drugs listed on the *Medi-Cal Rx Contract Drugs List* (CDL), as well as drugs not listed on the CDL requiring a prior authorization (PA) request. Code I restrictions for drugs listed on the CDL are not included on the NDC List, but can be found on the CDL.
CCS	The California Children's Services (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.
CDL	The *Medi-Cal Rx Contract Drugs List* (CDL) is a list of drugs that have been reviewed and are generally available without a prior authorization (PA) request. The CDL is searchable by generic names only, and some drugs on the CDL may have utilization controls referred to as a Code I. Any labeler restriction (LR) for a drug will be notated with a five-digit LR number.
GHPP	The Genetically Handicapped Persons Program (GHPP) is a health care program for adults with specific genetic diseases. GHPP helps members with their health care costs.
HIC3	Hierarchical Ingredient Code 3 (HIC3) refers to the Specific Therapeutic Classification per First DataBank (FDB).
Medi-Cal Rx Reinstatement	On June 1, 2022, the California Department of Health Care Services (DHCS), in collaboration with Magellan Medicaid Administration, LLC (MMA), released the Medi-Cal Rx Reinstatement Plan (the Plan) for a phased approach to restore select claim edits and prior authorization (PA) requests by therapeutic drug class, while phasing out the Transition Policy. The Plan reflects a methodical, data-driven, and iterative approach to support rapid cycle improvements by incorporating feedback from stakeholders and lessons learned from each phase to facilitate alignment with the objective to reduce disruption as well as ensure timely delivery of the pharmacy benefit. Reinstatement will be gradual with intense focus on stakeholder preparedness and performance monitoring. This will be refined as necessary over time based on data analytics, operational experience, and stakeholder feedback.

Back to Top

Term	Definition
	To facilitate incremental implementation, the Plan design employs a series of "waves" or sequenced events within each phase to introduce change. This allows DHCS to evaluate for change impact, identify opportunities for process improvement, and assess readiness for the next set of changes.
New Start	A "new start" is defined as a new therapy or medication not previously prescribed to the member during the 15-month lookback period.
Reject Code 80	**Reject Code 80 – Diagnosis Code Submitted Does Not Meet Drug Coverage Criteria** alerts pharmacists when a diagnosis code submitted does not meet drug coverage criteria. Refer to the following resource for additional information: • *NCPDP Reject Code 80 and Diagnosis Documentation of Code 1 Restriction: Status Update*
Reject Code 88	**Reject Code 88 – DUR Reject Error** alerts pharmacists when optimal therapy is not reflected in the member's claim history. This alert may present itself in the form of a rejection or an informational message. Refer to the following resources for additional information: • *NCPDP Reject Code 88 DUR Reference Guide* • *Appendix A: Reject Code 88 DUR: Service Codes Scenarios*
STC	Medi-Cal Rx has established a set of standard therapeutic classes (STCs) that are used to guide the selection and coverage of medications within the program. Therapeutic classes are typically defined by a combination of factors, such as the medication's mechanism of action, its intended use, and its chemical structure. These therapeutic classes are used to help ensure that appropriate medications are prescribed for the medical condition being treated, and to promote the use of clinically effective and cost-effective medications. The use of STCs also allows for consistent coverage decisions and helps to ensure that members receive appropriate care. Medi-Cal Rx covers medications within each STC that are clinically appropriate and cost-effective, based on recommendations from clinical guidelines, expert opinion, and other sources of evidence.

Back to Top

Term	Definition
Transition Policy	The Medi-Cal Rx Pharmacy Transition Policy ensures smooth and effective transition for members to Medi-Cal Rx with existing prescriptions. The Transition Policy is a process that ensures Medi-Cal members with existing prescriptions, with or without approved prior authorization (PA) requests, will have continued coverage for covered Medi-Cal pharmacy benefits through historical claims data and "lookback" system logic. This policy includes a 180-day period where the Department of Health Care Services (DHCS) will not require PA requests for existing prescriptions without previously approved PA requests from their applicable Medi-Cal managed care plans (MCPs) (or for prescriptions that have a previously approved PA request that expires prior to the end of the transition period), for drugs not on the *Medi-Cal Rx Contract Drug List* (CDL), or that otherwise have PA request requirements under Medi-Cal Rx. This policy does not apply to new prescriptions or drugs that do not have PA request requirements under Medi-Cal Rx. Visit the Medi-Cal Rx Education & Outreach page and select **Medi-Cal Rx Pharmacy Transition Policy** from the menu to view the Medi-Cal Rx Pharmacy Transition Policy.

Back to Top