Medi-Cal Rx

Claim Submission Reminders

January 21, 2022; Updated February 27, 2025

Refer to the following important guidelines for submitting pharmacy claims. The *Medi-Cal Rx Provider Manual* contains useful resources and information that will assist in accurately submitting claims. By following these guidelines, pharmacy providers can ensure that claims are submitted correctly so that payments can be processed without undue delay.

Reject Codes

Refer to *Appendix D – NCPDP Reject Codes* in the *Medi-Cal Rx Provider Manual* for a full list of reject codes. The following reject code and resolution table is not inclusive of all scenarios. For scenarios not applicable to the following resolutions, refer to the *Medi-Cal Rx Provider Manual*.

Reject Codes & Resolutions	
Reject Code	**Resolution**
10: Missing/Invalid (M/I) Patient Gender Code	• Verify the member's gender. • If the gender on file does not match Medi-Cal Rx's records, the member must contact their local county office to update the record on file.
16: M/I Prescription/Service Reference Number	• Verify prescription information for the following: – Member information – Rx number – Fill number • If the claim is for a refill (same member, same prescription number, and same drug/product), resubmit the claim with a new fill number. • If the claim is for either a different member or a different product, resubmit the claim with a new prescription number.
40: Pharmacy Not Contracted With Plan On Date Of Service	• Confirm the pharmacy is a registered Medi-Cal provider. • To enroll as a Medi-Cal provider, visit the Provider Enrollment Division (PED) page on the Department of Health Care Services (DHCS) website.

Reject Codes & Resolutions	
Reject Code	**Resolution**
41: Submit Bill To Other Processor Or Primary Payer	• Verify the member has Other Health Coverage (OHC). If so, ensure the claim is submitted as a coordination of benefits (COB) claim with the appropriate other coverage code (OCC). • Members are required to utilize their OHC prior to Medi-Cal Rx when the same service is available under the member's OHC. If the member chooses to pursue services not covered by the OHC, Medi-Cal Rx will not assume liability for the cost of those services and claims will be denied. • Refer to the *Coordination of Benefits (COB)* section in the *Medi-Cal Rx Provider Manual* and the *Medi-Cal Rx Billing Tips* for information about billing OHC for Medi-Cal Rx. • Refer to the alert titled *Adding or Removing Other Health Coverage for Medi-Cal Members* for information about adding and removing OHC for a member. • **Note:** A prior authorization (PA) request submission may be required for coverage consideration with COB claims.
52: Nonmatched Cardholder ID	Received as a result of one or more of the following not matching: • Client Index Number (CIN), Health Access Program (HAP) ID, or Benefits Identification Card (BIC) ID • Member First/Last Name • Member date of birth (DOB) Received with one of these supplemental messages: • "*Submitted First/Last name or DOB does not match to submitted Member ID. Please validate name or DOB information and resubmit.*" • *"Please submit the members BIC/CIN/HAP ID which should contain a minimum of 9 characters. If ID is correct, Please have member contact their county social services office."*

Reject Codes & Resolutions	
Reject Code	**Resolution**
	Pharmacies must correct the first/last name and/or DOB to match the submitted member ID. If the First/Last name and DOB are correct, verify the member ID is accurate. This information must be accurate to successfully bill the claim. • Pharmacies may use the Member Eligibility Lookup Tool by logging in to the Medi-Cal Rx Secured Provider Portal to verify and obtain a member's ID number. • Members will **not** be able to utilize the Managed Care Plan (MCP) ID card. **Do not** submit claims with the MCP ID. • Verify that the member's name on the claim exactly matches the name on the BIC or HAP. The member's full last name needs to be entered. Refer to the two following examples: – Full name on BIC/HAP Card: John A Smith-Thompson • Last name should be billed as: Smith-Thompson – Full name on BIC/HAP Card: John A Smith Van Thompson • Last name should be billed as: Smith Van Thompson If billing a newborn claim, refer to the *Newborn Claims* section in this document.
60: Product/Service Not Covered for Patient Age	• Refer to the Contract Drugs & Covered Products Lists page for age restrictions.
61: Product/Service Not Covered For Patient Gender *	• Verify the member's gender. • Submit a PA request. * DHCS removed current gender utilization management (UM) requirements for all Medi-Cal Rx claims except for Family Planning, Access, Care, and Treatment (Family PACT).

Reject Codes & Resolutions	
Reject Code	**Resolution**
6Z: Provider Not Elig to Perform Serv/Dispense Product	• Only contracted providers are eligible to dispense contracted blood factors to Medi-Cal, California Children's Services (CCS), and Genetically Handicapped Persons Program (GHPP) members. Contracted specialty providers are identified in the Contracted Specialty Provider List. • Providers who wish to enroll as Specialty Contracted Providers for clotting factor(s) must enroll through the PED by submitting the *Medi-Cal Specialty Pharmacy Provider Application* (MC 3155) enrollment form, which is available in the Provider Enrollment section on the Forms page on the Medi-Cal Providers website.
70: Product/Service Not Covered	• Confirm the drug or product is a covered benefit by reviewing the *Medi-Cal Rx Contract Drugs List* (CDL) or the Drug Lookup Tool. • If appropriate, review the *Medi-Cal Rx Approved NDC List* to identify an alternate NDC of the drug that is eligible for coverage. • If an alternate NDC cannot be dispensed, submit a PA request for coverage considerations.
75: Prior Authorization Required	• Refer to the CDL for covered alternatives. If a covered alternative cannot be dispensed, submit a PA request. – **Note:** Claims for enteral nutrition products require PA request submission for coverage considerations. • Refer to the *Five Ways to Submit a Prior Authorization Request* flyer and the *Prior Authorization Request Overview, Request Methods, and Adjudication* section in the *Medi-Cal Rx Provider Manual* for assistance submitting a PA request. • Refer to the alert titled *Reminder: Establishing Medical Necessity* for details on how to include relevant clinical information on a PA request.

Reject Codes & Resolutions	
Reject Code	**Resolution**
76: Plan Limitations Exceeded	• Claims that deny with Reject Code 76 can deny for one 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 Period Exceeded • 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. • Refer to the alert titled *Diabetic Test Strips and Lancets: Updates to the Code I Diagnosis and Quantity Limit Restrictions* for diabetic test strips and lancet quantity limitations. • Refer to the alert titled *How to Resolve Reject Code 76 – Plan Limitations Exceeded* for general resolution information.
80: Diagnosis (Dx) Code Submitted Does Not Meet Drug Coverage Criteria	Refer to the alert titled *How to Address Reject Code 80 – Diagnosis Code Submitted Does Not Meet Drug Coverage Criteria* for instructions regarding Reject Code 80. • **Note:** As of January 31, 2025, Reject Code 80 applies to all members.
81: Timely Filing Exceeded	• Claims exceeding the maximum filing limit of 365 days will deny with Reject Code 81. • Ensure claims are submitted to Medi-Cal Rx within 365 days. • For additional information, refer to the *Six-Month Billing Limit* and *Timely Filing Claim Cutback* sections in the *Medi-Cal Rx Provider Manual*.
85: Claim Not Processed	• If an NDC does not have a Medi-Cal Rx recognized price type for reimbursement, claims will deny with Reject Code 85 with the supplemental message *"No price exists for the NDC submitted."* • Identify an alternate NDC of the product and resubmit the claim.

Reject Codes & Resolutions	
Reject Code	**Resolution**
	• Refer to the alert titled *Policy Update: Use of "Inner" and "Outer" NDCs for Claim Submission* for information about claims submitted for inner pack NDCs denying with Reject Code 85. • For medical supplies denying with Reject Code 85, confirm the medical supply is a covered benefit by referring to the Contract Drugs & Covered Products Lists page on the Medi-Cal Rx Web Portal. If covered, identify an alternate product NDC for dispensing, and resubmit the claim. If not, submit to the member's medical benefit (for example, Medi-Cal fee-for-service or MCP).
559: Pharmacy is Sanctioned. No Claims Allowed for Pharmacy	• If a service provider has been sanctioned, claims will deny with Reject Code 559 with the supplemental message *"Pharmacy is Sanctioned. No claims allowed for Pharmacy."* • The *Medi-Cal Suspended and Ineligible Provider List* (S&I List) identifies providers who are suspended or determined ineligible to participate in Medi-Cal Rx. • 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.
606: Brand/Drug Specific Labeler Code Required	• Refer to the Contract Drugs & Covered Products Lists page for labeler restrictions.
620: This Prod/Service May Be Covered Under Medicare Part D	• Verify the member has Medicare Part D coverage. • Medi-Cal Rx will adjudicate claims for products excluded from Medicare Part D coverage by law for members that have Medicare Part D. • Medi-Cal Rx is not considered a payer for products eligible for coverage under Medicare Part D. • Medi-Cal Rx will not reimburse Medicare Part D deductibles or copayments. • Refer to the alert titled *Adding or Removing Other Health Coverage for Medi-Cal Members*. • For additional information about claim submission for members with Medicare Part D coverage, refer to the *Medicare Part D COB* section in the *Medi-Cal Rx Provider Manual* and the *Medi-Cal Rx Billing Tips*.

Reject Codes & Resolutions	
Reject Code	**Resolution**
816: Pharmacy Drug Benefit Exclusion	• Claims denying with Reject Code 816 are considered a medical benefit and should be billed as a medical claim to the member's medical benefit (for example, Medi-Cal fee-for-service or MCP). • An exception for pharmacy benefit approval may be considered via a PA request. – PA requests must include rationale for why the physician administered drug (PAD) must be billed as a pharmacy claim to Medi-Cal Rx and cannot be billed as a medical claim for coverage. • Refer to the alert titled *Reminder: Medi-Cal Rx Billing Policy for Physician Administered Drugs* for additional details.
A1: Prescriber is Sanctioned. No Claims Allowed for Prescriber	• If a prescriber is sanctioned, claims will deny with Reject Code A1 with the supplemental message *"Prescriber is Sanctioned. No claims allowed for Prescriber."* • The S&I List identifies providers who are suspended or determined ineligible to participate in Medi-Cal Rx. • 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.
A6: Product/Service May Be Covered Under Medicare Part B	• Verify the member has Medicare Part B coverage. If so, ensure the claim is submitted as a COB claim with the appropriate OCC. • Members are required to utilize their OHC prior to Medi-Cal Rx when the same service is available under the member's OHC. If the member chooses to pursue services not covered by the OHC, Medi-Cal Rx will not assume liability for the cost of those services and claims will be denied. • Refer to the alert titled *How to Resolve Reject Code A6 for Orally Administered Enteral Nutrition Claims* for questions regarding claim submission for orally administered enteral nutrition claims. • Refer to the alert titled *Adding or Removing Other Health Coverage for Medi-Cal Members*.

Reject Codes & Resolutions	
Reject Code	**Resolution**
	• For additional information about claim submission for members with Medicare Part B coverage, refer to the *Medicare Part B COB Claims* section in the *Medi-Cal Rx Provider Manual* and the *Medi-Cal Rx Billing Tips*.
AF: Patient Enrolled Under Managed Care	• All pharmacy claims for members enrolled in the Programs of All-Inclusive Care for the Elderly (PACE), Cal MediConnect Plans, and Senior Care Action Network (SCAN) plans billed to the Medi-Cal Rx plan will deny with Reject Code AF with the supplemental message *"Please resubmit to PACE/Cal MediConnect/SCAN XXX Plan."* • Verify OHC for member. • If no other coverage exists, the member must contact their local county social services office.
PZ: Nonmatched Unit Of Measure To Product/Service ID	• Confirm package size when dispensing a non-breakable package. If dispensing multiple packages, ensure quantity is a correct multiple of one package. – **Example:** For a package size of 3, quantity must be a multiple of 3 (3, 6, 9, etc.). • Enter the correct unit of measure matching the corresponding drug dosage.

Prior Authorization

- Verify if the drug or product is a Medi-Cal Rx covered benefit by using the Drug Lookup Tool or reviewing the Contract Drugs & Covered Products Lists page on the Medi-Cal Rx Web Portal.
- Refer to the *Five Ways to Submit a Prior Authorization Request* flyer, the *Prior Authorization Request Overview, Request Methods, and Adjudication* section in the *Medi-Cal Rx Provider Manual*, and the alert titled *Reminder: Establishing Medical Necessity*.
- Refer to the *Prior Authorization Case Review Process* flyer, which illustrates the case review process for claims that do not meet automated prior authorization (AutoPA) rules.

Claims Cutoff

Claims submitted for pharmacy services previously submitted to MCPs are processed by Medi-Cal Rx for DOS beginning January 1, 2022. Claims with a DOS prior to January 1, 2022, should continue to be sent to the appropriate MCP. Refer to the following tables regarding all pharmacy claim transactions including appeals, reversals, inquiries, and PA request transactions.

Fee-for-Service Medi-Cal (CA-MMIS)	
Date of Service	**Send Transaction to:**
Prior to 01/01/2022	Medi-Cal Rx
01/01/2022 and after	Medi-Cal Rx

MCP	
Date of Service	**Send Transaction to:**
Prior to 01/01/2022	MCP
01/01/2022 and after	Medi-Cal Rx

Coordination of Benefits

COB is the mechanism used to designate the order in which multiple plans or carriers are responsible for benefit payments and prevention of duplicate payments. Members are required to utilize their OHC prior to Medi-Cal Rx when the same service is available under the member's OHC. If the member chooses to pursue services not covered by their OHC, Medi-Cal Rx will not assume liability for the cost of those services and claims will be denied.

Claims should be billed to the member's primary payer prior to submitting the claims to Medi-Cal Rx. COB claims will be processed accordingly. Refer to the *Coordination of Benefits (COB)* section in the *Medi-Cal Rx Provider Manual* and the *Medi-Cal Rx Billing Tips* for more detailed information.

Coordination of Benefits Claims

Submit non-automatic pharmacy crossover claims using NDCs on the *Universal Claim Form* (UCF) or the *California Specific Pharmacy Claim Form* (30-1).

Part B and Medi-Cal Rx claims that do not automatically crossover can be submitted with Other Payer ID (NCPDP Field ID: 340-7C) of "444444," Other Payer ID Qualifier (NCPDP Field ID: 339-6C) of "99-Other," the dollar amount collected, and the applicable OCC. Refer to the *Medi-Cal Rx Billing Tips* for more detailed information.

Providers must identify a Crossover claim on the UCF by notating "Crossover" on the claim form.

Refer to the *Medicare Part B COB Claims* section in the *Medi-Cal Rx Provider Manual*.

Share of Cost

- Claims will deny with Reject Code AA – Patient spenddown not met, with supplemental messaging advising of remaining Share of Cost (SOC) for members with an unmet SOC.
- The SOC will need to be cleared prior to resubmitting the claim.
- Follow the existing process with Medi-Cal to clear the SOC. For questions regarding SOC, providers can call Automated Eligibility Verification System (AEVS) at 1-800-456-AEVS (2387) or the Medi-Cal Telephone Service Center (TSC) at 1-800-541-5555.
- Beginning January 1, 2022, Field 28 (Patient's Share) on the *California Specific Pharmacy Claim Form* (30-1), Field 29 (Patient's Share) on the *California Specific Compound Pharmacy Claim Form* (30-4), Field 81 (Patient Paid Amount) on the *Universal Claim Form* (UCF), Version D.0, or Field 433-DX (Patient Paid Amount Submitted) on the NCPDP Version D.0 B1 transaction are not required and should be left blank.
- You can also refer to the *Share of Cost (SOC)* section in the *Medi-Cal Rx Provider Manual* for more detailed information.

BIC/CIN

- Claims must be billed with the member's CIN, HAP, or BIC ID.
- Pharmacy providers should verify that the member's name and ID number on the claim exactly match the name on the BIC or HAP card. The member's full name needs to be used. Refer to the alert titled *Reminder: Verification of Member Name on Medi-Cal Rx Claims* for more information.
- Claims billed with the MCP ID number will be denied.
- Providers can look up member eligibility by logging in to the Medi-Cal Rx Secured Provider Portal.
- Refer to the alert titled *Requirements for Medi-Cal Rx Claims* for more detailed information.

Newborn Claims

Services to a newborn may be billed with the mother's ID number for the month of birth and the following month only, 60 days of age or younger. After this time, infants must have their own Medi-Cal ID number.

Claims for newborn members who are up to 60 days old (the first month of birth to the end of the following month) are covered under their mother's Medi-Cal ID number.

Refer to the alert titled *Medi-Cal Rx Newborn Claims* for more detailed information about how to submit newborn claims.

Cost Ceiling

Claims submitted to Medi-Cal Rx are subject to the cost ceiling claim edit Reject Code 78 – Cost Exceeds Maximum. To improve pharmacy claim submission and processing quality and to mitigate potential fraud, waste, and abuse (FWA) in Medi-Cal Rx, the previous $10,000 cost ceiling policy has been revised to the following cost ceiling categories as outlined in the following table:

Cost Ceiling Limits		
Drug/Product	**Identifier**	**Value Per Claim**
Over-the-Counter (OTC)	OTC	$50
Generic	Generic	$1,000
Single and Multisource Brand	Brand	$4,000
High-Cost Drug (HCD) – Generic and Brand	HCD	$14,000

Note: Cost ceiling limits impacting drugs for the NDCs provided on the *Medi-Cal Rx Approved NDC List* are categorized by the following Cost Ceiling Limit Identifiers:

- **OTC:** Over-the-counter products where the claim threshold amount is equal to or greater than $50.
- **Generic:** Generic drugs where the claim threshold amount is equal to or greater than $1,000.
- **Brand:** Brand, multisource drugs where the claim threshold amount is equal to or greater than $4,000 when the claim is submitted with a dispense as written (DAW) code of DAW 1. These claims will be subject to Brand Medically Necessary (BMN) PA requirements.
  - **Note:** Claims without a DAW 1 will be evaluated based on the Generic cost ceiling limit.
- **HCD:** High-cost generic and brand drugs, not in the Generic or Single and Multisource Brand categories, where the claim threshold amount is equal to or greater than $14,000.
- **Excluded:** Drugs excluded from the cost ceiling limits.
  - **Note:** Other products excluded from cost ceiling limits include specific disposable medical supplies, diabetic testing supplies, COVID-19 antigen tests, enteral nutrition products, OTC insulin, and drugs submitted as a compound claim.

Refer to the *Cost Ceiling* section in the *Medi-Cal Rx Provider Manual* and the alert titled *How to Resolve Claim Reject Code 78: Cost Exceeds Maximum*.

BIN, PCN, and Group Number

Effective January 1, 2022, bill all pharmacy claims to Medi-Cal Rx with the **new** BIN, Processor Control Number (PCN), and group number.

- BIN: 022659
- PCN: 6334225
- Group: MEDICALRX

Contact Information

You can 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.

For other questions, email Medi-Cal Rx Education & Outreach at MediCalRxEducationOutreach@primetherapeutics.com.