Medi-Cal Rx Monthly Bulletin

February 1, 2022

The monthly bulletin consists of alerts and notices posted to the Bulletins & News page on the Medi-Cal Rx Web Portal. Sign up for the Medi-Cal Rx Subscription Service so you will be notified when new information is posted.

1. Changes to the Contract Drugs List (CDL)

The below changes have been made to the *Contract Drugs List*, effective February 1, 2022.

For more information, see the Contract Drugs List on the Medi-Cal Rx Web Portal.

Drug Name	Description	Effective Date
Bisacodyl EC	Added to CDL.	February 1, 2022
Butenafine HCl	Labeler code restriction (00378) removed.	February 1, 2022
Cinacalcet HCl	**Effective March 1, 2022:** Labeler code restriction (55513) removed.	February 1, 2022
Clindamycin/Benzoyl Peroxide	Added to CDL.	February 1, 2022
Clotrimazole/ Betamethasone Dipropionate	Added to CDL.	February 1, 2022
Colesevelam HCl	**Effective March 1, 2022:** Labeler code restriction (65597) removed from tablets. Labeler code restriction (65597) added to suspension.	February 1, 2022
Dasiglucagon HCl	Added to CDL with restrictions. (Policy effective January 1, 2022.)	February 1, 2022
Diazepam	Solution added to CDL with restrictions.	February 1, 2022
Doxycycline Monohydrate	Capsules & tablets added to CDL.	February 1, 2022
Epinephrine	Labeler code (49502) restriction removed.	February 1, 2022
Erythromycin/Benzoyl Peroxide	Added to CDL.	February 1, 2022

Drug Name	Description	Effective Date
Estrogens, conjugated and Medroxyprogesterone Acetate	Minimum dispensing restriction removed.	February 1, 2022
Ethinyl Estradiol/ Drospirenone	Added to CDL with restrictions.	February 1, 2022
Heparin	Additional formulation (vials) added to CDL.	February 1, 2022
Ketorolac Tromethamine	Labeler code exclusion (00023) removed from 0.4 % solution.	February 1, 2022
Levonorgestrel and Ethinyl Estradiol	Additional strength (0.1 – 0.02 – 0.01 mg) added to CDL with restrictions.	February 1, 2022
Levonorgestrel and Ethinyl Estradiol/Ethinyl Estradiol	Added to CDL with restrictions.	February 1, 2022
Lidocaine/Prilocaine	Added to CDL.	February 1, 2022
Lorazepam	Oral concentration added to CDL with restrictions.	February 1, 2022
Mesalamine	Added to CDL with restrictions.	February 1, 2022
Molnupiravir	**Effective 12/23/2021:** Added to CDL with quantity limit restriction.	February 1, 2022
Nirmatrelvir/Ritonavir	**Effective 12/22/2021:** Added to CDL with quantity limit restriction.	February 1, 2022
Norethindrone/Ethinyl Estradiol/Iron	Added to CDL with restrictions.	February 1, 2022
Oxcarbazepine	Suspension added to CDL.	February 1, 2022

2. Changes to the Contract Drugs List (CDL) – Over-the-Counter Drugs

The below changes have been made to the *Contract Drugs List – Over-the-Counter Drugs*, effective February 1, 2022.

For more information, see the Contract Drugs List – Over-the-Counter Drugs on the Medi-Cal Rx Web Portal.

Drug Name	Description	Effective Date
Butenafine HCl	Added to CDL.	February 1, 2022
Loperamide	Added to CDL.	February 1, 2022
Nicotine Polacrilex	Quantity limit restriction updated.	February 1, 2022

3. Changes to the Family PACT Pharmacy Formulary

The below changes have been made to the *Family PACT Pharmacy Formulary*.

For more information, see the Family PACT Pharmacy Formulary on the Medi-Cal Rx Web Portal.

Drug Name	Description	Effective Date
Segesterone Acetate and Ethinyl Estradiol	Added with quantity limit restrictions.	November 1, 2020
Medroxyprogesterone Acetate	Additional formulation (prefilled syringe, SQ) added.	June 16, 2021
Acyclovir	Capsules (200 mg) removed, and restrictions updated for tablets.	February 1, 2022
Azithromycin	Restrictions updated.	February 1, 2022
Cefixime	Quantity limit restrictions updated.	February 1, 2022
Doxycycline Hyclate & Doxycycline Monohydrate	Restrictions updated.	February 1, 2022
Levofloxacin	Added with restrictions.	February 1, 2022
Metronidazole	Restrictions updated.	February 1, 2022

Drug Name	Description	Effective Date
Moxifloxacin	Restrictions updated.	February 1, 2022
Ofloxacin	Removed FPACT benefit.	February 1, 2022
Probenecid	Restrictions updated.	February 1, 2022
Secnidazole	Added with restrictions.	February 1, 2022
Tinidazole	Additional restrictions added.	February 1, 2022

4. Updates to the Medi-Cal Rx Provider Manual

The updates/additions below have been made to the *Medi-Cal Rx Provider Manual*.

For more information, see the *Medi-Cal Rx Provider Manual* Version 1.10 on the Medi-Cal Rx Web Portal.

Section	Update Description	Effective Date
Section 3.3.3 – Remittance Advice (RA)	• Added language for timing of electronic ERA release schedule. • Updated upper right corner of paper remittance images to include (Checkwrite Program, Check/EFT Number, and Check/EFT Date). • Updated field descriptions for newer remittance version (Checkwrite Program, Check/EFT Number, and Check/EFT Date).	February 1, 2022
Section 5.0 – Medi-Cal Rx Provider Claim Appeal Processes	• Updated provider guidelines for appeal submission.	February 1, 2022
Section 15.1.5 – Muscle Relaxant Limitations	• Section removed	February 1, 2022
Section 15.6 – Cost Ceiling	• Updated and made additions to the descriptions of medications exempt from the $10,000.00 Cost Ceiling.	February 1, 2022

Section	Update Description	Effective Date
Section 17.0 – COVID-19 Vaccine Coverage, Reimbursement, and OTC Antigen Test Kits	• Added the following under **For Pfizer-BioNTech COVID-19 or Pfizer <u>Booster</u> Dose(s):** "Effective for dates of service on or after January 3, 2022, the U.S. FDA amended the EUA for the Pfizer-BioNTech COVID-19 vaccine(s), authorizing the use of a single booster dose administration to include individuals 12 years of age and older who received their second dose of a primary vaccination series at least 5 months ago." • Added the following under **For Moderna COVID-19 <u>Booster</u> Dose(s):** "Effective for dates of service on or after January 7, 2022, the U.S. FDA amended the EUA for the Moderna COVID-19 vaccine to allow for administration of a booster dose to individuals 18 years of age and older who received their second dose of a primary vaccination series at least five months ago." • Added the following verbiage: "**Note:** As of October 26, 2021, moderately and severely immunocompromised people aged 18 years or older… (5 months beginning January 3, 2022, for Pfizer-BioNTech vaccines, and 5 months beginning January 7, 2022 for Moderna vaccines)…"	Varies (see **Update Description** to the left: "Effective for dates of service...")
Section 17.1 – Pediatric COVID-19 Vaccine Coverage	• Added the following verbiage: "Effective for dates of service *on or after* January 3, 2022, the FDA amended the EUA for	January 3, 2022

Section	Update Description	Effective Date
	the use of the Pfizer-BioNTech COVID-19 vaccine for the prevention of COVID-19 to include a third primary series dose for children aged 5 through 11 years. Like the adult dose, children will need a third dose of the Pfizer-BioNTech COVID-19 vaccine 28 days following the second dose."	
Section 17.3 – COVID-19 Supplemental Incentive Fee Reimbursement for In-Home Vaccine Administration	• Added the following verbiage: "The reimbursement of the *additional* in-home incentive is limited to the following: – 4 claims in 6 months for DOS *on or after* January 3, 2022."	January 3, 2022
Section 17.4 – Over-the-Counter (OTC) COVID-19 Antigen Test Kits **(NEW!)**	• Added section to provide coverage policy regarding OTC COVID-19 Antigen Test Kits. • Coverage is limited to the specific test kit(s) listed in the *List of Covered Emergency Use Authorization (EUA) COVID-19 Antigen Tests* (this list is available on the Medi-Cal Rx Web Portal under "Forms & Information"). • Beneficiaries must be eligible on the DOS in order to receive a test or test kit • Coverage is restricted to EUA for the diagnostic condition of suspected COVID-19. • Coverage is restricted to up to 8 tests (4 kits for 2 tests/kit) per 30 days per beneficiary.	February 1, 2022

Section	Update Description	Effective Date
	• No refills are allowed; a new prescription is required for each dispensing. • Prior authorization (PA) requests for quantities outside the allowed amounts will be denied, unless ordered or administered by a provider, following an individualized clinical assessment and with appropriate clinical justification provided.	
Section 17.4.1 – OTC COVID-19 Antigen Test Kits Reimbursement **(NEW!)**	• Added section regarding reimbursement information for OTC COVID-19 Antigen Test Kits. • Reimbursement of the covered OTC EUA U.S. FDA-authorized, self-administered COVID-19 antigen tests is based upon an established individual test Maximum Allowable Product Cost (MAPC) +23% markup. Medical supply reimbursement guidelines apply. The adjustment for the 10% provider payment reduction per Assembly Bill 97 (Chapter 3, Statutes of 2011), effective 06/01/2011, does *not* apply to these claims.	February 1, 2022
Section 18.4 – Medi-Cal Rx Provider Claim Inquiry Form (CIF) (DHCS 6570)	• Updated provider guidelines for CIF submission and added a sample *Medi-Cal Rx Claim Inquiry Form (CIF)*.	February 1, 2022
Section 18.5 – Medi-Cal Rx Provider Claim Appeal Form (DHCS 6571)	• Updated provider guidelines for appeal submission and added a sample *Medi-Cal Rx Provider Claim Appeal Form.*	February 1, 2022

5. Prior Authorization Required: Reject Code 75

Medi-Cal Rx has identified a large volume of pharmacy claim denials that were expected to be adjudicated under the Medi-Cal Rx 180-day transition policy. These claims were adjudicated as "new start" and denied with **Reject Code 75** (Prior Authorization [PA] Required). A temporary override code has been established for documented cases of ongoing therapy, to which providers can attest at the Point of Service (POS) and resubmit the claim.

If you are a pharmacy provider whose claim was denied with this reject code and you have a historical claim on file, please review the following guidance.

Reject Code 75 (PA Required)

If you receive Reject Code 75 from Medi-Cal Rx for a claim and **you have evidence** the beneficiary has a valid approved PA and/or a prior paid claim in your system, please resubmit the claim to Medi-Cal Rx with a value of **55555** in the **Prior Authorization Number Submitted** field (462-EV). The basis for the attestation should be documented and may be subject to audit. (Use of a fill number is acceptable documentation.)

A large volume of claims **with grandfathered/historical PAs** as well as claims with no PA requirement are continuing to reject with Code 75 because the claims are submitted with the PA type code (PATC) field (461EU) marked with the number "1." Submission of this code is **ONLY** required when a Price PA has been requested and approved. For all other scenarios where a PA has been approved or is grandfathered without a price override, the PATC should be left blank on the claim.

Contact Information

Medi-Cal Rx Customer Service Center toll-free number: 1-800-977-2273, available 24 hours a day, 7 days a week, 365 days per year.

6. Medi-Cal Rx Coverage of Over-the-Counter COVID-19 Antigen Test Kits

Effective February 1, 2022, Over-the-Counter (OTC) Emergency Use Authorization (EUA) U.S. Federal Drug Administration (FDA)-authorized, self-administered COVID-19 antigen test kits can be billed and reimbursed as a pharmacy-billed medical supply benefit through Medi-Cal

Rx in accordance with current Centers for Disease Control and Prevention (CDC) recommendations.

Coverage is restricted to specific 1-test-per-kit or 2-tests-per-kit OTC EUA COVID-19 FDA-authorized, self-administered COVID-19 antigen tests listed in the *List of Covered Emergency Use Authorization (EUA) COVID-19 Antigen Tests*, which can be found on the Medi-Cal Rx Web Portal under "Forms and Information," and require dispensing from a pharmacy, written (or electronic equivalent) on a prescription pad signed by a licensed prescriber or a pharmacist. Packages/kits cannot be broken or sold as individual tests.

The following coverage criteria applies:

- Restricted to EUA for the diagnostic condition of suspected COVID-19 (Code I Restriction).
- Restricted to up to 8 tests (4 kits for 2 tests/kit) per 30 days per beneficiary.
- No refills allowed; the beneficiary would need to obtain a new prescription for each dispensing.

NOTE: Prior authorization (PA) requests for quantities outside the allowed amounts will be denied unless ordered or administered by a provider following an individualized clinical assessment and with appropriate clinical justification provided.

In order to receive a test or test kit, the beneficiary must be eligible for Medi-Cal on the date of service. Please refer to the *Medi-Cal Rx Provider Manual* on the Medi-Cal Rx Web Portal for additional coverage and reimbursement information.

Coverage policy for OTC EUA COVID-19 FDA-authorized, self-administered COVID-19 antigen tests through Medi-Cal was effective March 11, 2021, under the American Rescue Plan Act of 2021. Beneficiaries who purchased OTC EUA COVID-19 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 up to 8 tests (4 kits for 2 tests/kit) per 30 days per beneficiary and is restricted to specific 1-test-per-kit or 2-tests-per-kit OTC EUA COVID-19 FDA-authorized, self-administered COVID-19 antigen tests. Beneficiaries must be eligible for Medi-Cal on the date of purchase and must include proof of purchase and a copy of their beneficiary Benefits Identification Card (BIC) with the request for reimbursement. For more information on how to obtain a refund, please visit the Medi-Cal Out-of-Pocket Expense Reimbursement (Conlan) web page on the

California Department of Health Care Services (DHCS) website at https://www.dhcs.ca.gov/services/medi-cal/Pages/Medi-Cal_Conlan.aspx.

Additionally, beginning Wednesday, January 19, 2022, anyone with a U.S. residential address can request four (4) at-home COVID-19 tests to be delivered directly to their home through a new federal government website: www.covidtests.gov. DHCS encourages all Californians to take advantage of this opportunity.

To place an order, all you need is your name and residential address; no identification, credit card, or health insurance information is required. These tests will be delivered in the mail through the U.S. Postal Service. There is an option to provide an email address to receive email notifications with shipping updates. According to the federal government, tests will typically ship within 7-12 days of ordering.

7. Medi-Cal Rx Interim Prior Authorization Approval Edit

Medi-Cal Rx has recently implemented policy changes that affect prior authorization (PA) processes and encompass modifications of claim edits that may result in a paid claim.

Here's how to determine if a PA submitted has been approved under these efforts:

- **Prescribers:**
  - The status will not show in the Medi-Cal Rx Web Portal if a PA is not required under this interim policy.
- **Pharmacies:**
  - PA numbers are not required in order to submit a claim. Once the PA has been approved, pharmacies can reprocess the claim.

Note: Providers who have established fax numbers with Medi-Cal Rx (meaning have received more than three [3] successful faxes with Medi-Cal Rx) will receive a fax that indicates "Per a recent policy edit, we received your PA request, and a clinical PA is not required at this time. Pricing PAs will be processed."

Need Assistance?

You can access the Education and Outreach home page to find additional information.

Medi-Cal Rx Provider Registration

If you need assistance with registering for the secured Medi-Cal Rx Web Portal, check out the UAC Quick Start Guide.

Medi-Cal Rx Subscription Service

To stay up to date on the latest Medi-Cal Rx news, please sign up for the Medi-Cal Rx Subscription Service (MCRxSS).

Medi-Cal Rx Provider Readiness Survey

How do you currently conduct business for Medi-Cal pharmacy services? We'd love to hear from you! Participate in the Medi-Cal Rx Readiness Survey. The results of this survey will be used to prepare future training and materials.

Note: Internet Explorer is no longer a supported web browser. Please utilize Chrome, Microsoft Edge, or another supported web browser when clicking links for the Medi-Cal Rx Web Portal.

8. Reject Code Suspension Notice

Medi-Cal Rx has identified a large volume of pharmacy claim denials. As a result, Medi-Cal Rx has implemented temporary edit suspensions—effective immediately. The edit suspensions listed below will last 90 days, with an end date of April 30, 2022. Please note that these temporary edits are not a guarantee of payment and should still adhere to the billing hints listed below.

On May 1, 2022, these edits will be reinstated. Pharmacy claims will be required to be billed according to the Medi-Cal Rx policies outlined in the Medi-Cal Rx Provider Manual and the Medi-Cal Rx Contract Drugs List (CDL).

Suspended Reject Codes		
Reject Code	**Temporary Edit**	**Billing Tips**
88: DUR Reject Error	Early refill rejection edits have been turned off with the exception of opioids and *benzodiazepines*.	• Thresholds for opioids will remain at 90% and *benzodiazepines* at 75%. • Starting May 1, 2022, you will need to refer to the *Opioid Management* section of the Medi-Cal Rx Provider Manual for billing guidance.
60: Product/ Service Not Covered For Patient Age	Edit suspended if there are historically paid claims on file or claim has been paid using the Reject 75 override instructions.	• For continuation of therapy, please resubmit the claim with a value of 55555 in the Prior Authorization Number Submitted field (462-EV). • Starting May 1, 2022, you will need to refer to the Medi-Cal Rx Contract Drugs List (CDL) for any age limitations.
76: Plan Limitations Exceeded	Edit suspended if there are historically paid claims on file or claim has paid using the Reject 75 override instructions.	• For continuation of therapy, please resubmit the claim with a value of 55555 in the Prior Authorization Number Submitted field (462-EV). • Starting May 1, 2022, check days' supply and metric decimal quantity.
80: Dx Code Submitted Does Not Meet Drug Cov Criteria	Edit suspended; diagnosis is not required for the temporally stated period.	**Starting May 1, 2022:** • Bill with a diagnosis code. • Continue to submit the Submission Clarification Code (SCC) 7.

The following reject codes are not suspended. Please refer to the guidance provided to help resolve your claim.

Additional Reject Codes	
Reject Code	**Billing Tips**
52: Nonmatched Cardholder ID	• Bill with the beneficiary's Benefits Identification Card (BIC), Client Index Number (CIN), or Health Access Program (HAP) number. • The beneficiary's name on the claim needs to be identical to the beneficiary's name as it appears on the BIC or HAP card. • Do not bill with the Managed Care Plan (MCP) ID card. • If billing a newborn claim, refer to the Claims Submission Reminders bulletin. • Refer to Reject Code 52: Nonmatched Cardholder ID for more information.
70: Product/ Service Not Covered	• Do not bill store brand Over-the-Counter (OTC) products as they are not covered. • Drug must have a National Drug Code (NDC).

9. Claim Submission Reminders

Medi-Cal Rx is live! All administrative services related to Medi-Cal pharmacy benefits that are billed on pharmacy claims have transitioned to Medi-Cal Rx. Here are some reminders for pharmacy claim submissions. The Medi-Cal Rx Provider Manual houses valuable resources and information to properly submit claims. Adherence to the following reminders will ensure effective submission of claims and timely payment.

Reject Codes

See the National Council for Prescription Drug Programs (NCPDP) Reject Codes 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, please reference the Medi-Cal Rx Provider Manual.

Reject Codes & Resolutions	
Reject Code	**Resolution**
52: Nonmatched Cardholder ID with message of "Please submit the	• Pharmacies must have the beneficiary's Benefits Identification Card (BIC), Client Index Number

Reject Codes & Resolutions	
Reject Code	**Resolution**
members BIC/CIN/HAP ID which should contain a minimum of 9 characters"	(CIN), or Health Access Program (HAP) number to successfully bill for the medication. • Beneficiaries will **NOT** be able to utilize the Managed Care Plan (MCP) ID card. Please **DO NOT** submit claims with the MCP ID. • If billing a newborn claim, please refer to the *Newborn Claims* section of this document. • Pharmacies may use the Beneficiary Eligibility Lookup Tool by logging in to the Medi-Cal Rx Secured Provider Portal to verify and obtain a beneficiary ID number.
52: Nonmatched Cardholder ID with message of "Submitted First/Last name or DOB does not match to the submitted Member ID"	• Beneficiary name on the claim needs to be identical as it appears on the BIC or HAP. The beneficiary's full last name needs to be entered. See the two examples below: – Full name on BIC/HAP Card: Fred Q Smith-Flintstone • Last name should be billed as: Smith-Flintstone – Full name on BIC/HAP Card: Fred Q Flintstone De Rubble • Last name should be billed as: Flintstone De Rubble • If billing a newborn claim, please refer to the *Newborn Claims* section of this document.
70: Product/Service Not Covered	• Enter the National Drug Code (NDC) listed on the package for the brand. • Verify that the NDC number is entered correctly. • Make sure the billed drug is a covered benefit on the Medi-Cal Rx Contract Drugs List (CDL) or in the Drug Lookup Tool.

Reject Codes & Resolutions	
Reject Code	**Resolution**
	• Review drug limitations and/or restrictions as listed in the Medi-Cal Rx Contract Drugs List by generic drug name and the Drug Lookup Tool searchable using brand name or generic drug name.
PZ: Nonmatched Unit Of Measure To Product/Service ID	Enter the correct unit of measure matching the corresponding drug dosage.
41: Submit Bill To Other Processor Or Primary Payer	The recipient has health coverage other than Medi-Cal (third-party or Medicare). Submit an eligibility verification transaction to determine other health coverage (OHC) and bill other carrier before billing Medi-Cal Rx. If the beneficiary indicates that they do not have OHC, the pharmacy directs them to resources below so it can be corrected. **OHC Online Form:** Other Coverage (ca.gov) (click the **OHC Removal(s) Form**). The URL is https://www.dhcs.ca.gov/services/Pages/TPLRD_OCU_cont.aspx **OHC Online Form Step-by-Step:** *Other Health Coverage Reference Guide* (ca.gov). The URL is https://www.dhcs.ca.gov/services/Documents/OHCReferenceGuide_0619.pdf
80: Drug-Diagnosis Mismatch	Verify Code 1 limitations on the CDL, and if patient meets criteria, resubmit the claim with Submission Clarification Code (*SCC*) code: 7.
10: Missing or Invalid Patient Gender Code	Verify the beneficiary's gender. If the gender on file is incorrect, the member must contact their local county social services office to update the record on file.

Reject Codes & Resolutions	
Reject Code	**Resolution**
61: Product/Service Not Covered For Patient Gender	Verify the beneficiary's gender. If the gender on file is incorrect, the member must contact their local county social services office to update the record on file.
16: M/I Prescription/Service Reference Number	Medi-Cal Rx is temporarily suspending Reject Code 16 M/I Prescription/Service Reference Number. Please resubmit your claims if you have received this rejection.
35: Missing or Invalid Primary Care Provider ID	Verify the primary care provider ID is populated.
40: Pharmacy Not Contracted With Plan On Date Of Service	Confirm you are a Medi-Cal Fee-for-Service (FFS) provider using the California Health and Human Services Open Data Portal and resubmit your claim.
60: Product/Service Not Covered for Patient Age	Refer to the Medi-Cal Rx Contract Drugs List for age limitations and specifications. If you are submitting for the flu vaccine and getting Reject Code 60, vaccines (other than Covid) are covered only for beneficiaries aged *19 and older*.
65: Beneficiary Eligibility	Medi-Cal Rx identified pharmacy claim denials related to beneficiary eligibility and has fixed the issue. If you are a pharmacy provider that received Reject Code 65, please resubmit your claims. We apologize for the inconvenience this may have caused.
75: Prior Authorization Required	If you receive Reject Code 75 from Medi-Cal Rx for a claim and you have evidence the beneficiary has a valid approved PA and/or a prior paid claim in your system, please resubmit the claim to Medi-Cal Rx with a value of **55555** in the **Prior Authorization**

Reject Codes & Resolutions	
Reject Code	**Resolution**
	Number Submitted field (462-EV). Your attestation is subject to audit.
76: Plan Limitations Exceeded for opioid claims	While there are many situations in which Reject Code 76 is returned, specifically for opioid claims it can be returned when the **cumulative** Morphine Milligram Equivalents (MME) calculated across all active claims exceeds 90 mg. This alert can be overridden by a pharmacist. Please submit appropriate Drug Utilization Review (DUR) codes if the dose is deemed medically necessary.

Prior Authorization

- Do not bill with a MCP PA or a Medi-Cal FFS Treatment Authorization Request (TAR) or Service Authorization Request (SAR).
- You may check if a drug is a Medi-Cal Rx benefit by using either the Drug Lookup Tool or the Medi-Cal Rx Contract Drugs List.
- Review the Medi-Cal Rx Pharmacy Transition Policy and Five Ways to Submit a Prior Authorization (PA) Flyer.
- The Prior Authorization (PA) Case Review Process Flyer illustrates the case review process for claims that do not meet Auto-PA rules.
- If you have evidence the beneficiary has a valid approved PA and/or a prior paid claim in your system, please resubmit the claim to Medi-Cal Rx with a value of **55555** in the **Prior Authorization Number Submitted** field (462-EV). Your attestation is subject to audit.

Claims Cutoff

Claims submitted for pharmacy services previously submitted to MCPs are processed by Medi-Cal Rx for dates of service beginning January 1, 2022. Claims with a date of service prior to January 1, 2022, should continue to be sent to the appropriate MCP. Please see the tables below regarding all pharmacy claim transactions including appeals, reversals, inquiries, and prior authorization transactions.

FFS Medi-Cal (i.e., CA-MMIS)

DATE OF SERVICE	SEND TRANSACTION TO:
Prior to 1/1/2022	Medi-Cal Rx
1/1/2022 and after	Medi-Cal Rx

MCP

DATE OF SERVICE	SEND TRANSACTION TO:
Prior to 1/1/2022	Managed Care Plan
1/1/2022 and after	Medi-Cal Rx

Coordination of Benefits

Because Medi-Cal Rx is always the payer of last resort, claims should be billed to the beneficiary's primary payer prior to submitting the claims to Medi-Cal Rx. Coordination of Benefits (COB) claims will be processed accordingly. See the *Coordination of Benefits (COB)* section of the Medi-Cal Rx Provider Manual for more detailed information.

Crossover Claims

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

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

See the *Medicare Part B Crossover Claims* section of the Medi-Cal Rx Provider Manual. Please note that crossover claims do not require a PA request. Straight Medi-Cal Rx claims for Medicare denied or noncovered services may require a PA request. Review the Medi-Cal Rx Contract Drugs List for a comprehensive list of covered services.

Share of Cost (SOC)

- To clear a beneficiary's SOC, providers will need to access the Automated Eligibility Verification System (AEVS) or Transaction Services on the Medi-Cal website and enter a

provider number, Provider Identification Number (PIN), beneficiary's BIC number, BIC issue date, billing code, and service charge. The SOC information is **updated**, and a response is displayed on the screen or relayed over the telephone. For more information on SOC clearance, please consult the *Share of Cost (SOC)* section of the Medi-Cal Rx Provider Manual.

- 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**.
- If you receive a denial for SOC on your Medi-Cal Rx claim, you will need to clear the remaining balance and resubmit your claim. This will require you to follow the existing process to clear the SOC. Please refer to the AEVS: Transactions section of the *Medi-Cal Provider Manual*.
- You can also view the Medi-Cal Rx Share of Cost alert for more detailed information.

BIC/CIN

- Claims must be billed with the beneficiary's Benefits Identification Card (BIC), Client Index Number (CIN), or Health Access Program (HAP) card number to successfully bill for the medication.
- Claims billed with the MCP plan ID number will be denied.
- Providers can look up beneficiary eligibility by logging in to the Medi-Cal Rx Secured Provider Portal.
- You can also review the Requirements for Medi-Cal Rx Claims alert for more detailed information.

Newborn Claims

Services to an infant may be billed with the mother's ID for the month of birth and the following month only, </= 60 days. After this time, infants must have their own Medi-Cal ID number.

Claims for newborn beneficiaries 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 Rx ID number.

Follow the below instructions to submit claims for newborn beneficiaries </= 60 days.

- Insured's ID Number:
  - Enter the mother's BIC ID.
- Insured/Patient Name (First and Last):
  - Enter the mother's first and last name.
- Relationship Code (NCPDP Field ID 306-C6):
  - 03 – Dependent
- Prior Authorization Type Code (NCPDP Field ID 461-EU):
  - 8 – Payer Defined Exemption
- In the **Specific Details/Remarks Field** enter "Newborn using mother's ID" with 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." Newborns from a multiple birth must also be designated by number or letter (e.g., "Twin A" and "Twin B").

- **Newborn claims submitted after the above-mentioned time frame will deny with NCPDP EC 600 – Coverage Outside of Submitted Date of Service.**

Refer to the *Newborns* section of the Medi-Cal Rx Provider Manual for additional information.

Cost Ceiling

Medi-Cal Rx will have a cost ceiling of $10,000.00 for all drugs except for the classes noted in the *Cost Ceiling* section of the Medi-Cal Rx Provider Manual.

Banking Identification Number (BIN), Processor Control Number (PCN), and Group Number

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

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

Contact Information

Medi-Cal Rx provides a wide range of contacts and resources for your convenience.

Department	Contact Information
Customer Service Center (CSC)	Toll-free number: 1-800-977-2273, available 24 hours a day, 7 days a week, 365 days per year.
Pharmacy Service Representatives (PSRs)	Email Education and Outreach requests to: MediCalRxEducationOutreach@magellanhealth.com
Live Chat & Messaging	For assistance, visit the Medi-Cal Rx Provider Portal's Contact Us page.
PSR-Hosted Office Hour	Please join our Medi-Cal Rx Office Hour, each business day from 12 p.m. – 1 p.m. Pacific, for registration and troubleshooting assistance. **Zoom Meeting Link:** https://magellanhealth.zoom.us/j/94964434351?pwd=c1I4cC9oTUNod2tkYm5RRmJmeklUQT09&from=addon Meeting ID: 949 6443 4351 Password: 655990 Dial In: 1-888-788-0099 (US Toll Free)

10. Reject Code 52: Nonmatched Cardholder ID

Medi-Cal Rx has identified a large volume of pharmacy claims denials related to nonmatched Cardholder ID. These claims are being denied with **Reject Code 52: Nonmatched Cardholder ID**.

Please review the following guidance to avoid this rejection.

How to Avoid this Rejection?

Pharmacies must have the beneficiary's Benefits Identification Card (BIC), Client Index Number (CIN), or Health Access Program (HAP) number to successfully bill for the medication. Refer to the following examples:

- The beneficiary's name on the claim needs to be identical to the beneficiary's name as it appears on the BIC or HAP. Additionally, the beneficiary's full last name needs to be entered. See the two examples below:
  - Example 1:
    - Full name on BIC/HAP Card: Fred Q Smith-Flintstone
    - Last name should be billed as: Smith-Flintstone
  - Example 2:
    - Full name on BIC/HAP Card: Fred Q Flintstone De Rubble
    - Last name should be billed as: Flintstone De Rubble
- Beneficiaries will **NOT** be able to utilize the Managed Care Plan (MCP) Plan ID card. Please **DO NOT** submit claims with the MCP ID.
- If billing a newborn claim, refer to the Claims Submission Reminders Alert posted on Medi-Cal Rx Bulletins & News regarding newborn claims.
- Pharmacies can use the Beneficiary Eligibility Lookup Tool by logging in to the Medi-Cal Rx Secured Provider Portal to verify and obtain a beneficiary ID number.
- Pharmacies can also contact the **Customer Service Center (CSC)** at 1-800-977-2273.

  The CSC is available 24 hours a day, seven days a week, 365 days a year. Pharmacies can select option 2 from the CSC main menu prompt. If a BIC is not available, the beneficiary's Social Security number can be used to obtain a beneficiary ID number.
- Another option to obtain the beneficiary ID number is the **Automated Eligibility Verification System (AEVS)** at 1-800-456-2387. AEVS is available from 2 a.m. to 12 a.m. PT, seven days a week. Once in AEVS, select from the following options as described in the AEVS Main Menu Prompt Options. If a BIC is not available, the beneficiary's Social Security number can be used to obtain a beneficiary ID number.
- **Note:** A HAP beneficiary ID number is not available via the CSC or AEVS.

11. Adding or Removing Other Health Coverage for Medi-Cal Beneficiaries

All providers, including pharmacies, can use the DHCS OHC Removal or Addition Form to assist Medi-Cal beneficiaries who need to update or remove their Other Health Coverage (OHC) from the State's system. The OHC Reference Guide provides step-by-step instructions for how to fill out these forms. Requests submitted via these forms are processed by DHCS within 36-72 hours. Providers should fill out and submit the applicable form with the beneficiary's consent (in-person or telephonic acceptable).

Alternatively, providers, including pharmacies, can direct beneficiaries fill out the DHCS OHC Removal or Addition Form on their own, if desired.

Beneficiaries and/or providers may also call the Fee-for-Service Medi-Cal Telephone Service Center, 8 a.m. to 5 p.m., Monday through Friday, except holidays, at the toll-free number 1-800-541-5555, to remove the OHC.

12. Medi-Cal Rx Finance Portal Job Aid Now Available

The Medi-Cal Rx Finance Portal is where pharmacy providers, including chain pharmacies, can sign up and manage Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) authorizations as well as view PDFs of Remittance Advices (RAs) once posted.

The Medi-Cal Rx Finance Portal Job Aid details how to perform the following functions in the Medi-Cal Rx Finance Portal:

- Set up, access, and manage payment options via EFT.
- Set up, access, view, and manage ERA.
- Search documents.
- Download and view 835 RA transactions.
- View and download files and documents associated with individual National Provider Identifiers (NPIs) that are a part of the Chain ID, which the user is authorized to view via the User Administration Console (UAC).

13. Reject Code 73: Max Refill

Medi-Cal Rx has identified a large volume of pharmacy claim denials with **Reject Code 73: Max Refill**. As a result, Medi-Cal Rx suspended the "maximum of 12 refills per Rx" edit, which caused denials for claims billed without a new prescription number for drugs exceeding 12 refills.

A new prescription number for more than 12 refills is not required at this time. If you have received this denial, please resubmit your claims.

Additional Billing Tips

- Make sure the billed drug is a covered benefit on the Medi-Cal Rx Contract Drugs List (CDL) or in the Drug Lookup Tool.
- Review the drug limitations and/or restrictions as listed in the CDL and the Drug Lookup Tool by searching for the appropriate drug's brand name or generic drug name. If the claim submitted does not meet the conditions specified in the CDL, providers must submit a prior authorization (PA) request.
- Review the *Dispensing Quantity Limitations* section in the *Medi-Cal Rx Provider Manual* for further information.

Contact Information

- Pharmacies can also contact the Medi-Cal Rx Customer Service Center at 1-800-977-2273. Agents are available to provide support 24 hours a day, 7 days a week, 365 days per year.

14. Reminder: Pharmacy Claims Submitted to Medi-Cal Rx

With the implementation of Medi-Cal Rx on January 1, 2022, Medi-Cal pharmacy providers and billers must submit their pharmacy claims, which would have been previously submitted to Fee-for-Service (FFS) Medi-Cal (electronic and hard copy) to Medi-Cal Rx, regardless of dates of service on the claim. Claims submitted for services rendered as FFS Medi-Cal are processed by Medi-Cal Rx, regardless of date of service.

Claims submitted for pharmacy services previously submitted to Managed Care Plans (MCPs) are processed by Medi-Cal Rx for dates of service beginning January 1, 2022. Claims with a date of service prior to January 1, 2022, should continue to be sent to the appropriate MCP.

Please see the table below regarding all pharmacy claim transactions including appeals, reversals, inquiries, and prior authorization transactions.

FFS Medi-Cal (i.e., CA-MMIS)

DATE OF SERVICE	SEND TRANSACTION TO:
Prior to 1/1/2022	Medi-Cal Rx
1/1/2022 and after	Medi-Cal Rx

MCP

DATE OF SERVICE	SEND TRANSACTION TO:
Prior to 1/1/2022	Managed Care Plan
1/1/2022 and after	Medi-Cal Rx

Pharmacy claims submitted to FFS Medi-Cal CALPOS or Batch CMC claims are being rejected. Pharmacy claims submitted on paper are forwarded to Medi-Cal Rx until January 31, 2022. On February 1, 2022, pharmacy paper claims submitted to FFS Medi-Cal will be rejected and returned to providers.

Medi-Cal Rx is now the prime claims-processing system for all pharmacy claims. For claim submission instructions and billing guidelines, providers and billers should refer to the Medi-Cal Rx Web Portal.

15. Prior Authorization (PA) Submission Reminders

Medi-Cal Rx is live! All administrative services related to Medi-Cal pharmacy benefits that are billed on pharmacy claims have transitioned to Medi-Cal Rx. The *Medi-Cal Rx Provider Manual* houses valuable resources and information to properly submit claims. Adherence to the following reminders regarding pharmacy claim submissions will ensure effective PA submissions.

Prior Authorization – Submission Methods

As shown in the table below, there are five (5) approved methods for submitting a PA to Medi-Cal Rx. Using a different method will result in a denial.

- **PAs cannot be submitted by phone.**
- **A beneficiary cannot initiate a PA.**
- **Submit a PA only once, using one of the five approved methods.**

Approved PA Submission Methods	
PA Submission Method	**How to Submit**
CoverMyMeds® (CMM)	**PA submission through CMM is the efficient and preferred method to submit a PA to Medi-Cal Rx.** CMM interacts in real time with the Medi-Cal Rx Point-of-Sale (POS) claims processing system and with the Medi-Cal Rx Clinical Decision Module (CDM) to often present real-time determinations and covered alternatives. Only a prescriber can submit a completed PA directly through CMM. Some pharmacies can initiate a request through CMM, which provides the information included in the case initiation to the prescriber. PAs submitted through the Medi-Cal Rx Secured Provider Portal will not be displayed in CMM. More information on using CMM can be found in the Medi-Cal Rx: CoverMyMeds How-To Guide or on the CMM website: https://www.covermymeds.com/.
Medi-Cal Rx Secured Provider Portal for Electronic Prior Authorization (ePA)	Registration is required to submit an ePA via the Medi-Cal Rx Secured Provider Portal. Refer to the User Administration Console (UAC) Quick Start Guide for more information on how to register for UAC. Both pharmacies and prescribers can submit an ePA via the Medi-Cal Rx Secured Provider Portal.

Approved PA Submission Methods	
PA Submission Method	**How to Submit**
National Council for Prescription Drug Programs (NCPDP) transaction using the pharmacy POS system	P4 transactions are submitted directly from the pharmacy using the NCPDP layout. The pharmacy can request and submit a PA on behalf of the beneficiary or provider. If submitting a PA request via a pharmacy POS, pharmacies must go to the Medi-Cal Rx Secured Provider Portal to upload attachments or fax additional information to the Medi-Cal Rx Customer Service Center (CSC) when needed. Reference the Medi-Cal Rx Options for Submission Guide for detailed information.
Fax	Providers can submit a PA request via fax to 1-800-869-4325. When submitting a PA via fax, utilize the preferred Medi-Cal Rx PA Request Form. **Other accepted PA forms include**: • Medi-Cal Form 50-1 • Medi-Cal Form 50-2 • California Form 61-211
Mail	Providers can submit PA requests via mail to: Medi-Cal Rx Customer Service Center P.O. Box 730 Rancho Cordova, CA 95741-0730 When submitting a PA via mail, utilize the preferred Medi-Cal Rx PA Request Form. **Other accepted PA forms include:** • Medi-Cal Form 50-1 • Medi-Cal Form 50-2 • California Form 61-211

Prior Authorization – Completion Reminders

Below are some helpful reminders when completing PA requests:

- For paper PAs, only submit one of the following PA forms:
  - Medi-Cal Rx Prior Authorization Request Form
  - Medi-Cal Form 50-1
  - Medi-Cal Form 50-2
  - California Form 61-211
- Provide a complete signature and date on the paper PA form. Stamps and initials are not a valid form of signature.
- Be sure to complete all required fields in the form such as provider phone number, fax number, National Provider Identifier (NPI), address, etc.
- Provide all necessary information for a decision (i.e., if stating covered alternatives are not acceptable, provide context or other pertinent information such as lab results with dates).
- Provide all beneficiary diagnoses and the corresponding *International Classification of Diseases*, 10th revision (ICD-10).
- Provide tried/failed medications, if applicable.
- Quantity and days of supply must be included.
- Do not use "unknown location" for the beneficiary.
- Do not use the Managed Care Plan (MCP) ID. Only use the following:
  - Benefits Identification Card (BIC) number
  - Client Index Number (CIN)
  - Health Access Program (HAP) number

See the *Prior Authorization Overview, Request Methods, and Adjudication* section of the *Medi-Cal Rx Provider Manual* for more detailed information.

- **When submitting a PA via mail or fax, the PA form will need to be printed and completed, and then either mailed or faxed.**

Prior Authorization – Case Decision

A PA submitted to Medi-Cal Rx will be either **approved**, **deferred**, or **recommended for denial**.

- If the PA is approved, an approval correspondence will be sent to the requesting provider.
- If the PA is deferred, it was determined that additional information is needed and the reason why the PA was placed in a deferred status for up to 30 days will be provided to the submitter. If the submitter does not send a response within 30 days, the PA will be administratively denied.
- The PA is recommended for denial if the submitted information does not meet medical necessity. The PA will be moved to the California Department of Health Care Services (DHCS) for second-level review.

Prior Authorization – Claim Denials

Reject Code 75 (PA Required): If you have evidence the beneficiary has a valid (approved) PA and/or a prior paid claim in your system, please resubmit the claim to Medi-Cal Rx with a value of **55555** in the Prior Authorization Number Submitted field (**462-EV**). Your attestation is subject to audit.

Prior Authorization – Resources

The following resources are readily available on the Medi-Cal Rx website to assist with submitting a PA:

- Covered Drugs List (CDL)
- Medi-Cal Rx Drug Lookup Tool
- PA Job Aid – Resource for submitting an ePA via the Medi-Cal Rx Secured Provider Portal
- Prior Authorization (PA) Case Review Process Flyer – Flyer illustrating the case review process for claims that do not meet auto-PA rules
- Medi-Cal Rx Pharmacy Transition Policy
- Five Ways to Submit a Prior Authorization (PA) flyer
- *Medi-Cal Rx Provider Manual*

Contact Information

Medi-Cal Rx provides a wide range of contacts and resources for your convenience.

Department	Contact Information
Customer Service Center (CSC)	Toll-free number: 1-800-977-2273, available 24 hours a day, 7 days a week, 365 days per year.
Pharmacy Service Representatives (PSRs)	Email Education & Outreach requests to: MediCalRxEducationOutreach@magellanhealth.com
Live Chat & Messaging	For assistance, visit the Medi-Cal Rx Provider Portal's Contact Us page.
PSR-Hosted Office Hours	Please join our Medi-Cal Rx Office Hours held on weekdays (excluding holidays) from 12:00 p.m. – 1:00 p.m. PST for registration and troubleshooting assistance. **Zoom Meeting Link:** https://magellanhealth.zoom.us/j/94964434351?pwd=c1I4cC9oTUNod2tkYm5RRmJmeklUQT09&from=addon • Meeting ID: 949 6443 4351 • Password: 655990 • Dial In: 1-888-788-0099 (US Toll Free)

16. Enteral Nutrition: Extension of Specialty Infant Prior Authorization Term Limitation

The Department of Health Care Services (DHCS) is extending the prior authorization (PA) term duration for authorization of specialty infant products from a maximum two-month term to up to a maximum four-month term. This interim-term duration extension applies to enteral nutrition specialty infant PAs with a date of service on or after January 12, 2022 – July 1, 2022. All other coverage criteria to specialty infant enteral products will remain unchanged.

The *Medi-Cal Rx Provider Manual* will be updated at a later date to reflect this interim policy.

17. COVID-19 Vaccine Updates for Third Dose (Booster Dose) and Shortening of its Time Requirements

Effective for dates of service on or after January 3, 2022, the U.S. Food and Drug Administration (FDA) amended the Emergency Use Authorization (EUA) for the Pfizer-BioNTech COVID-19 vaccine to allow the following:

- Expansion of the use of a single booster dose to include individuals 12 – 15 years of age.
- Shortening the time between the completion of the primary vaccination with the Pfizer-BioNTech COVID-19 vaccine and the administration of the booster dose with an FDA-approved or -authorized mRNA COVID-19 vaccine to at least 5 months for eligible individuals.
- The administration of a third primary-series dose for certain immunocompromised children 5 – 11 years of age.

Additionally, effective for dates of service on or after January 7, 2022, the FDA amended the EUA for the Moderna COVID-19 vaccine to shorten the time between the completion of a primary series of the vaccine and a booster dose to at least five months for individuals 18 years of age and older.

Medi-Cal Rx will expeditiously make the necessary system and operational changes required to enable successful claims adjudication for administration of the third primary-series dose of the Pfizer-BioNTech COVID-19 vaccine to immunocompromised children 5 – 11 years of age, administration of a Pfizer-BioNTech COVID-19 booster dose in individuals 12 – 15 years of age, and reduction of the time between the primary series with Pfizer-BioNTech or Moderna COVID-19 vaccines and a booster dose to at least 5 months for eligible individuals.

Medi-Cal Rx will notify providers when the claims adjudication system is prepared to appropriately adjudicate submitted claims as well as any additional instruction providers should utilize when billing. Until then, providers are advised to administer the primary vaccination series, and the booster dose to eligible children, based on recommendations from the FDA and Centers for Disease Control and Prevention (CDC), and hold the claim submission until further notice.

Current COVID-19 Vaccine Coverage and guidelines are available in the Medi-Cal Rx Provider Manual.

For the most current information regarding Medi-Cal's COVID-19 response, see the COVID-19 Medi-Cal Response page on the Medi-Cal Provider website.

18. Pharmacy Claims Reject Code 65 – Resolved

Medi-Cal Rx identified a pharmacy claims denial related to beneficiary eligibility and has fixed the issue.

If you are a pharmacy provider that received Reject Code 65, please resubmit your claims. We apologize for the inconvenience this may have caused.

19. Drug Utilization Review (DUR) Reject Codes 88 & 76

Medi-Cal Rx has identified a large volume of pharmacy claims denials related to Drug Utilization Review (DUR). If you are a pharmacy provider whose claim was denied with a **Reject Code 88** (DUR Reject Error) or, specifically for opioid claims, a **Reject Code 76** (Plan Limitations Exceeded), please review the following guidance.

Reject Code 88 (DUR Reject Error)

Pharmacy providers will need to review and resolve each identified DUR conflict and if a pharmacist in their professional judgment determines that dispensing the prescription is medically necessary or that benefits of the treatment outweigh the risks, the claim denial can be overridden at Point of Service (POS) in real time.

Pharmacy providers will then resubmit the claim with an appropriate DUR response, which is composed of three components:

1. **Reason for Service Codes** reflect the type of potential therapeutic problem identified by the Medi-Cal Rx claims adjudication system and returned on a claims response.
    - DA: Drug-Allergy Conflict
    - AT: Additive Toxicity
    - PG: Drug-Pregnancy Conflict
    - ID: Ingredient Duplication
    - MC: Drug-Disease Conflict
    - PA: Drug-Age Alert
    - HD: High Dose
    - TD: Therapeutic Duplication
    - LD: Low Dose
    - ER: Overutilization (Early Refill)
    - MX: Incorrect Duration of Therapy
    - LR: Underutilization (Late Refill)

- DD: Drug-Drug Interaction
- SX: Drug-Gender Conflict Professional

2. **Professional Service Codes** consist of alphanumeric characters that identify the action the pharmacist took to resolve the DUR conflict.
   - M0 (M zero): Prescriber consulted
   - P0 (P zero): Patient consulted
   - R0 (R zero): Pharmacist consulted other source
3. **Result of Service Codes** tell the Medi-Cal eligibility verification system if the prescription was dispensed and determine the payment status of the claim.
   - 1A: Filled as is, false positive
   - 1B: Filled prescription as is
   - 1C: Filled with different dose
   - 1D: Filled with different directions
   - 1E: Filled with different drug
   - 1F: Filled with different quantity
   - 1G: Filled with prescriber approval
   - 2A: Prescription not filled
   - 2B: Prescription not filled; direction clarified

Each alert needs to be responded to in order to receive a paid claim. The claim will then be adjudicated accordingly. If the claim is accepted and processed, the pharmacy provider will receive a **paid** response.

Note: *Overutilization Alert (ER) is used when an early refill is medically necessary, but it will not be able to override early refills of opioids.*

Reject Code 76 (Plan Limitations Exceeded) for Opioid Prescriptions

A claim for opioid drug may be denied with Reject Code 76. With *Supplemental Message:* The Centers for Disease Control and Prevention (CDC) recommend that clinicians assess benefits and risks when increasing Opioid Morphine Milligram Equivalent (MME) dosage to >/=90 MME/day. Consider co-prescribing naloxone when a patient is considered to be at risk of an overdose. Please submit appropriate DUR codes if dosage is deemed medically necessary.

The MME alert will trigger in instances where the MME of a single claim or the cumulative MME across multiple claims is >90 and <500. When triggered, claims will deny with **Reject Code 76** (Plan Limitations Exceeded). To override MME alert, providers should submit Reason for Service Code "HC" *only* and populate other fields with appropriate codes.

Note: Claims with an MME ≥500 will deny with Reject Code 75 and require a prior authorization (PA).

For opioid claims with MME >90 and <500, the following DUR codes will be accepted *in addition to the general codes listed earlier in this document.*

Reason for Service Code:

- HC: High Cumulative Dose

Professional Service Codes:

- CC: Coordination of care
- DE: Dosing evaluation/determination
- DP: Dosage evaluated

Result of Service Codes:

- 4B: Dispensed, Palliative Care
- 4C: Dispensed, Hospice
- 4D: Dispensed, Cancer Treatment
- 4E: Dispensed, Chronic Pain
- 4F: Dispensed, Surgery/Trauma
- 4G: Dispensed, Surgery/Trauma
- 4H: Dispensed, Hospital Admission/Discharge
- 4J: Dispensed, Patient is Not Opioid Naïve

More information for this alert can be found in the *Medi-Cal Rx DUR/PPS Codes for Opioid MME Alert* section of the *Medi-Cal Rx Provider Manual*.

Contact Information

Medi-Cal Rx Customer Service Center toll-free number: 1-800-977-2273, available 24 hours a day, 7 days a week, 365 days per year.

20. Billing Guidance for Pharmacy Providers on COVID-19 Oral Antivirals

The Department of Health Care Services (DHCS) is providing the following guidance for pharmacy providers regarding the billing of self-administered free COVID-19 oral antiviral drugs, Paxlovid and Molnupiravir.

On December 22, 2021, the U.S. Food and Drug Administration (FDA) issued an emergency use authorization (EUA) for the unapproved drug Paxlovid (nirmatrelvir tablets and ritonavir tablets, co-packaged for oral use). Paxlovid is a SARS-CoV-2 protease inhibitor antiviral authorized for the treatment of mild-to-moderate COVID-19 in adults and pediatric patients (12 years of age and older weighing at least 40 kg) 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. It is given within 5 days of symptom onset. The dosage for Paxlovid is 300 mg nirmatrelvir (two 150 mg tablets) with 100 mg ritonavir (one 100 mg tablet) with all three tablets taken together orally twice daily for 5 days.

On December 23, 2021, the FDA issued a EUA for the unapproved drug Molnupiravir.

Molnupiravir is a nucleoside analogue that inhibits SARS-CoV-2 replication by viral mutagenesis. It is authorized for the treatment of mild-to-moderate coronavirus disease 2019 (COVID-19) in adults with positive results of direct SARS-CoV-2 viral testing who are at high risk for progressing to severe COVID-19, including hospitalization or death, and for whom alternative COVID-19 treatment options authorized by the FDA are not accessible or clinically appropriate. It is given as soon as possible after a diagnosis of COVID-19 has been made and within 5 days of symptom onset. The dosage in adult patients is 800 mg (four 200 mg capsules) taken orally every 12 hours for 5 days.

Providers to note that for Federally Qualified Health Centers (FQHCs) that carve pharmacy into their Prospective Payment System (PPS), the claims would not be separately reimbursed. For FQHCs that carve out pharmacy benefit, claims would be billed under their pharmacy reimbursement.

Important Billing Instructions

- DHCS will follow Center for Medicare & Medicaid Services guidelines for the reimbursement of COVID-19 oral antivirals when administered in accordance with FDA EUA.
- Since the initial supply of the oral antivirals are purchased by the federal government and distributed free to providers, the providers will not be reimbursed the ingredient cost.
- DHCS is currently reimbursing for only the professional dispensing fee. This will be based on a pharmacy's total (Medicaid and non-Medicaid) annual prescription volume from the previous year as follows:

  - Less than 90,000 claims equal $13.20
  - 90,000 or more claims equal $10.05
- All claims should be submitted to Medi-Cal Rx for processing.
- No prior authorization would be required. The Code 1 restrictions are as follows:
  - Nirmatrelvir/Ritonavir: "Restricted to 30 tablets per dispensing"
  - Molnupiravir: "Restricted to 40 capsules per dispensing"
- DHCS will provide future guidance for the billing and reimbursement of provider-purchased COVID-19 oral antivirals at the appropriate time.
- It is important to provide medication recipients with the EUA fact sheet for patients, parents, and caregivers in accordance with the EUA requirements.

The guidance contained in this directive is only effective for Paxlovid and Molnupiravir purchased by the federal government. DHCS will provide future guidance on the end date of this policy for the reimbursement of provider-purchased medications.

Pharmacy providers may bill for the dispensing of Paxlovid and Molnupiravir National Drug Codes (NDCs) using National Council for Prescription Drug Programs (NCPDP) D.0 claims, web, batch, and paper claims according to the table below.

NDC	Label_Name	Generic_Name	Description	Max Quantity
00069108530	PAXLOVID CO-PACK (EUA)	Nirmatrelvir; Ritonavir	1 box of 30 (outer NDC)	30 tablets
00069108506	PAXLOVID CO-PACK (EUA)	Nirmatrelvir; Ritonavir	1 blister pack of 6 (Inner NDC)	30 tablets
00006505506	MOLNUPIRAVIR 200 MG CAP (EUA)	Molnupiravir	1 bottle of 40	40 capsules
00006505507	N/A	Molnupiravir	1 bottle of 40	40 capsules

Billing Guidance for Electronic Billing Formats

To be reimbursed for the professional dispensing fee on the electronic claim formats (NCPDP D.0, web, or batch), pharmacy providers must submit the claim with the appropriate NDC and the billing quantity as shown above.

Pharmacy providers must bill the claim using a transaction Code (103-A3) of "B1" (Claim Billing) with the Basis of Cost Determination value "15" (free product or no associated cost), with an associated Ingredient Cost Submitted (409-D9) value of $0.00, when the pharmacist dispenses the COVID-19 antivirals.

Billing Guidance for Paper Claim Submission

To be reimbursed for the administration fee when billing on a paper claim (Pharmacy Claim Form [30-1] or Universal Claim Form), pharmacy providers must submit the claim with the NDC and the billing quantity as identified in the table above.

For population of claim form fields other than those identified in this guidance, please review the *Medi-Cal Rx Provider Manual*.

Any concerns regarding delay in reimbursement should not cause providers to decline dispensing Paxlovid or Molnupiravir to patients.

Providers with questions should contact the Medi-Cal Rx Customer Service Center at 1-800-977-2273. Representatives are available 24 hours a day, 7 days a week, 365 days per year.

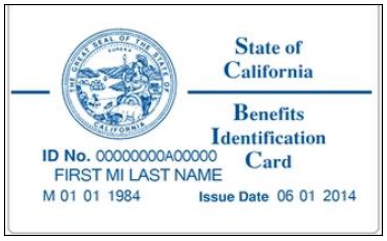
For more information on services covered by Medi-Cal Rx, providers should refer to the Medi-Cal Rx Web Portal.

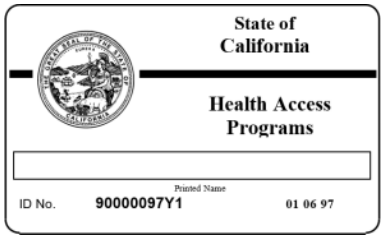
21. Requirements for Medi-Cal Rx Claims

What do Pharmacies Need to Fill Prescriptions?

Important changes for dispensing prescriptions to Medi-Cal Rx beneficiaries include the following:

- Pharmacies must have the beneficiary's Benefits Identification Card (BIC), Client Index Number (CIN), or Health Access Program (HAP) card number to successfully bill for the medication. See the following examples:





- **Beneficiaries will NOT be able to utilize their Managed Care Plan (MCP) ID card.**
- If beneficiaries do not currently have a BIC or CIN, they can obtain a new card by contacting their local county office.
- Providers can look up beneficiary eligibility by logging in to the secured Medi-Cal Rx Provider Portal.
- Effective January 1, 2022, new BIN, PCN, and Group:
  - BIN: 022659
  - PCN: 6334225
  - Group: MEDICALRX

22. Reject Code Suspension

Medi-Cal Rx is temporarily suspending Reject Code 16 M/I Prescription/Service Reference Number. Please resubmit your claims if you have received this rejection.

23. Pharmacy Claims Denial Issue

Medi-Cal Rx has identified a Pharmacy claims denial related to beneficiary eligibility and is working to resolve the problem.

If you are a *pharmacy provider and received Reject Code 65*, please see below for next steps:

1. Verify beneficiary eligibility through the following:
   a. Log in to Transaction Services via the Medi-Cal Web Portal at https://www.medi-cal.ca.gov/mcwebpub/login.aspx?ReturnUrl=%2fCommon%2fMenu.aspx. Refer to the following for available services: https://files.medi-cal.ca.gov/pubsdoco/Services.aspx.

b. A valid Provider Identification Number (PIN) is needed for access. The PIN is issued when providers enroll in Medi-Cal. In the instance when a provider does not remember their PIN, the Medi-Cal Telephone Service Center (TSC) technical help desk agents are authorized to release the existing PIN once caller validation protocols have been completed. The Medi-Cal TSC phone number is 1-800-541-5555; follow the prompts for the **Technical Help Desk**.

c. Look up the beneficiary and review the response.

2. If the beneficiary is eligible, retain a screenshot of the eligibility verification results as documentation for later use.
3. If the beneficiary is eligible and the drug is a covered Medi-Cal Rx benefit, please dispense medication and hold the claim for later submission once this issue has been resolved. You may check if a drug is a Medi-Cal Rx benefit by either of the following:
   a. Drug Lookup Tool at https://medi-calrx.dhcs.ca.gov/provider/drug-lookup/.
   b. Covered Products Lists at https://medi-calrx.dhcs.ca.gov/provider/forms.
4. Updates will be provided as more information becomes available. For the most current information and updates, visit https://medi-calrx.dhcs.ca.gov.