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 March 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
Acetaminophen	Additional formulation (500mg/15ml liquid) added.	March 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
Cefixime	Dispensing restriction updated.	March 1, 2022
Cephalexin	Dispensing restriction updated.	March 1, 2022
Ciprofloxacin HCL	Dispensing restriction updated.	March 1, 2022
Clindamycin Hydrochloride	Dispensing restriction updated.	March 1, 2022
Sulfamethoxazole and Trimethoprim	Dispensing restriction updated.	March 1, 2022
Nitrofurantoin	Dispensing restriction updated.	March 1, 2022
Nonoxynol	Verbiage updated from "inserts" to "film."	March 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 1.11 on the Medi-Cal Rx Web Portal.

Section	Update Description	Effective Date
Section 4.6.2.1 – Pharmacy Provider Self-Attestation	• Updated Pharmacy Provider Self-Attestation dates for 2022.	March 1, 2022
Section 12.0 – Enteral Nutrition Products	• Added the following verbiage: – "A prior authorization (PA) for these products is always required." – "Certain products (specific Medi-Cal 11-digit billing numbers [NDCs]) have additional criteria that must be met, which can be found in the product-specific criteria column within the published *List of Covered Enteral Nutrition Products*."	Prior to January 1, 2022
Section 12.3 – Criteria/Authorization	• Added the following verbiage: – "Enteral nutrition PA renewal requests will be considered for renewal up to 30 days in advance."	Prior to January 1, 2022
Section 12.3.5 – Specialty Infant Products Criteria	• Added the following verbiage: – "During the 180-day transition, from January 1, 2022 through June 30, 2022, authorization limitation is expanded to a maximum 4-month term. After July 1, 2022, the limitation will revert back to a maximum 2-month term, except when noted."	Prior to January 1, 2022

5. Reminder: Prior Authorization Policy for Reject Code 75

Medi-Cal Rx has implemented a revised prior authorization (PA) policy retroactive to January 1, 2022. **If you have not done so, pharmacies should resubmit claims that were previously denied with Reject Code 75.**

Medi-Cal Rx is temporarily adjusting some PA requirements, as noted below, to optimize access to patient care and therapies during this period of transition.

Please continue to follow the Point-of-Sale (POS) messages. Pharmacies should not prospectively submit PAs **at this time** if the claim is paying.

Reject Code 75 Edit

Effective immediately, the PA requirement will temporarily be removed for some drugs, except for the following:

1. Psychostimulants – Antidepressants
2. Opioid Analgesics
3. Ataractics – Tranquillizers (including antipsychotics and benzodiazepines)
4. Certain excluded products for children under the age of 21

PAs may still be required for other reject codes such as quantity limits and **Reject Code 76**. The existing Price Override Policy remains in place.

Note: The Contract Drugs List (CDL), Drug Lookup Tool (DLT), and ePrescribing file may not reflect this temporary change.

6. DAW 1 Coding and Reimbursement Rates

During the 180-Day Transition Period

Effective January 1, 2022, a claim identified with a Dispense as Written 1 (DAW1) will be reimbursed at the brand-name price if the beneficiary claim history includes either of the following:

- A paid claim for the same brand-name drug.
- An active prior authorization (PA) for the same brand-name drug.

If there is no beneficiary claim or PA history for the medically necessary brand-name drug, the pharmacy or prescriber may submit a clinical PA justifying the medical need for the brand-name product—as opposed to a less costly generic alternative—for approval of the medically necessary brand-name drug. If the clinical PA is approved, the claim will pay at the brand-name price for the duration of the PA effective date.

Post-Transition Period

Effective July 1, 2022, for a medically necessary brand-name drug to be reimbursed at the brand-name price or continue to be reimbursed at the brand-name price, a prescriber or pharmacy will need to submit a clinical PA for the medically necessary brand-name drug. If the PA is approved, the claim will be reimbursed based on the brand-name price for the duration of the PA effective date.

7. Medi-Cal Rx Policy Updates

Medi-Cal Rx has implemented the following permanent policy updates—effective immediately and retroactively to January 1, 2022.

Incremental Fills

Incremental fills for DEA Schedule II products for Long Term Care (LTC) will now be accepted for up to 60 days from the date the prescription was written. Please resubmit any pharmacy claims that have been denied with **Reject Code 981 – Fill Date for Remaining Incr Fill Exceeds Time Frame** to Medi-Cal Rx.

Noncontrolled Muscle Relaxants

Quantity and supply limitations have been removed for noncontrolled muscle relaxants. Please resubmit any pharmacy claims to Medi-Cal Rx that have been denied with **Reject Code 76 – Plan Limitations Exceeded**.

COVID-19 Vaccine

Medi-Cal Rx has implemented the policy to allow 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.

Newborn Claims Age Limit

Medi-Cal Rx continues to evaluate and implement changes to age-restricted products for newborns. Please resubmit any pharmacy claims to Medi-Cal Rx that have been denied with **Reject Code 60 – Product/Service Not Covered for Patient Age**. Further updates and guidance will be coming soon.

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.

8. Reject Code 606 – Temporary Suspension

Medi-Cal Rx has implemented a revised policy effective immediately and retrospective to January 1, 2022, to temporarily suspend **Reject Code 606 – Brand Drug/Specific Labeler Code Required**, which has caused denials for claims billed outside of the labeler restrictions indicated on the Medi-Cal Rx Contract Drugs List (CDL).

If you have received this denial, please resubmit your pharmacy claims to Medi-Cal Rx.

Note: The CDL, Drug Lookup Tool (DLT), and ePrescribing file may not reflect this temporary change.

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.

9. Medi-Cal Rx Provider Payments

Please refer to the Medi-Cal Rx Checkwrite Schedule for the Medi-Cal Rx Payment Release Dates.

- Pharmacies electing to receive payment via Electronic Funds Transfer (EFT) should see payments posted to the designated bank account between the Payment Release Date and up to 2 additional business days. Payment by EFT should not take more than 2 business days.
- Pharmacies electing to receive a paper check via USPS should receive checks within 7 business days.

On the Payment Release Date, the Remittance Advice (RA), either the Electronic Data Interchange (EDI) 835 file or a .PDF of the paper document mailed via USPS, is available for viewing and downloading from the Medi-Cal Rx Provider Finance Portal.

Pharmacies can update their future RA delivery method via the Medi-Cal Rx Finance Portal; this update does not affect the format of the RAs already provided. The updated RA format chosen may take up to 30 calendar days to take effect.

Refer to the Medi-Cal Rx Provider Finance Portal Job Aid for details on 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).

If payments are not received per the outlined time frame, call the Medi-Cal Rx Customer Service Center at 1-800-977-2273, select Option 2 for Pharmacy, enter your NPI, and then select Option 2 for Checkwrite.

10. Updates to the List of Covered Diabetic Test Strips and Lancets

Effective February 15, 2022, **FORA V30/G30/Premium V10 Blood Glucose Test Strips, Box of 50**, will be added to the List of Covered Diabetic Test Strips and Lancets, which can be found on the Medi-Cal Rx Web Portal. In addition, the product description for "FORA Premium V10 Blood Glucose Test Strips, Box of 50" has also been updated to "FORA Premium V10/**V30** Blood Glucose Test Strips, Box of 50" as requested by the manufacturer.

Product Type	Product Description	Billing Code (11-digit NDC like number)	Manufacturer	MAC/MAPC per strip/lancet	Effective Date
Blood Glucose Test Strips	FORA Premium V10/V30 Blood Glucose Test Strips, Box of 50	16042001059	ForaCare, Inc. 888-307-8188	0.2100	January 1, 2022
Blood Glucose Test Strips	FORA V30/G30/ Premium V10 Blood Glucose Test Strips, Box of 50	16042001040	ForaCare, Inc. 888-307-8188	0.2100	February 15, 2022

11. Pharmacy Professional Dispensing Fee Provider Self-Attestation

Pharmacy Provider Self-Attestation Process begins March 1, 2022 – Register for the February 24, 2022 Webinar

Mercer Government Human Services Consulting (Mercer), on behalf of Magellan Medicaid Administration, Inc. (MMA) and the Department of Health Care Services (DHCS), is administering this year's pharmacy provider self-attestation process. Pursuant to *California Welfare and Institutions Code, Section 14105.45*, the professional dispensing fee is based on a pharmacy's total (Medicaid and non-Medicaid) annual prescription volume from the previous year, as follows:

- Less than 90,000 claims equals $13.20
- 90,000 or more claims equals $10.05

DHCS' policy is that a claim is equivalent to a dispensed prescription.

If your 2021 calendar year claim volume was more than 90,000 claims, you do not need to do anything to receive the $10.05 professional dispensing fee. However, if your 2021 calendar year claim volume was less than 90,000 claims, you will need to complete the Medi-Cal Rx Pharmacy Provider Self-Attestation Form during the attestation period that runs from March 1, 2022 through March 31, 2022. **Failure to attest during that period will result in**

the $10.05 dispensing fee reimbursement for your pharmacy for the 2022/2023 State Fiscal Year. There are no exceptions.

Mercer will host a webinar on February 24, 2022 to walk through the self-attestation process and answer any questions you may have. Register for the webinar via the Medi-Cal Rx Self-Attestation Webinar Registration Zoom link.

When completing the attestation, providers may choose between using the online submission tool or submitting a Microsoft® Excel-formatted template via email. The Excel template will allow a corporate office to submit the attestation for multiple stores under common ownership in one self-attestation survey file.

DHCS and Mercer will be providing an overview of the new attestation process and timelines to providers at the February 24, 2022 webinar.

The web address for the attestation portal is https://mercer.qualtrics.com/jfe/form/SV_3gjeVVVgxII5eZM. Please note that this website will not be live until 12:00 a.m. PST on March 1, 2022.

You will receive additional instructions through mail, email, and/or fax prior to the March 1, 2022 start date. If you have not received any notifications by March 1, 2022, please call the attestation survey helpline at 1-844-294-9982 or send an email to CODSurvey@mercer.com.

Thank you in advance for your participation in the upcoming attestation.

12. Revised Prior Authorization Policy for Prescribers

Medi-Cal Rx has implemented a revised prior authorization (PA) policy effective immediately and retrospective to January 1, 2022.

Medi-Cal Rx is temporarily adjusting some PA requirements, as noted below, to optimize access to patient care and therapies during this period of transition.

CoverMyMeds® (CMM) is the preferred platform to submit PAs for Medi-Cal Rx. CMM interacts in real time, utilizing a clinical decision module that allows for real-time approvals. CMM allows prescribers to submit, add information to, or inquire about a PA. Prescribers should utilize CMM to determine if a PA is needed during this temporary phase.

Reject Code 75 Edit

Effective immediately, the PA requirement will temporarily be removed for some drugs, except for the following:

1. Psychostimulants – Antidepressants
2. Opioid Analgesics
3. Ataractics – Tranquillizers (including antipsychotics and benzodiazepines)
4. Certain excluded products for children under the age of 21

PAs may still be required for other reject codes such as quantity limits and **Reject Code 76**. The existing Price Override Policy remains in place.

Note: The Contract Drugs List (CDL), Drug Lookup Tool (DLT), and ePrescribing file may not reflect this temporary change.

13. Revised Prior Authorization Policy for Pharmacy Providers

Medi-Cal Rx has implemented a revised prior authorization (PA) policy effective immediately and retrospective to January 1, 2022. **Pharmacies should resubmit claims that were previously denied with Reject Code 75.**

Medi-Cal Rx is temporarily adjusting some PA requirements, as noted below, to optimize access to patient care and therapies during this period of transition.

Please follow the Point-of-Sale (POS) messages. Pharmacies should not prospectively submit PAs **at this time** if the claim is paying.

Reject Code 75 Edit

Effective immediately, the PA requirement will temporarily be removed for some drugs, except for the following:

1. Psychostimulants – Antidepressants
2. Opioid Analgesics
3. Ataractics – Tranquillizers (including antipsychotics and benzodiazepines)

4. Certain excluded products for children under the age of 21

PAs may still be required for other reject codes such as quantity limits and **Reject Code 76**. The existing Price Override Policy remains in place.

Note: The Contract Drugs List (CDL), Drug Lookup Tool (DLT), and ePrescribing file may not reflect this temporary change.

14. Revised Emergency Fill Quantity and Frequency Policy

Medi-Cal Rx has implemented a *Revised Emergency Fill Quantity Limit and Frequency Policy* effective immediately.

Fill Quantity Limit and Frequency

Effective immediately, electronically billed emergency drug dispensing claims will be limited to up to fourteen (14) days supply and a limit of two (2) fills in a 30-day period for the same drug and dose.

Note: Unbreakable packages such as inhalers, vials, oral contraceptives, etc. will continue to be paid for the full package size even when the days supply exceeds 14 days.

15. Drug Price Override Billing and PA Instructions

To ensure a review for a Drug Price Override/Reimbursement Below Cost, the criteria in this alert must be met. Medi-Cal Rx reimbursement for any outpatient drug covered under Medi-Cal Rx is always the lowest rate of either of the following:

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

- **Additional product cost due to special packaging is NOT reimbursed—for example, unit of use, modified unit dose, or unit dose.**
- **Price override applies to drugs only.**
- **Medical supplies and enteral nutrition shall not have price overrides applied.**

Criteria for Review

In certain instances, Medi-Cal Rx will review and may approve reimbursement below cost requests. This can only be considered if and when an approved PA for a drug price override is on file at the time the claim is processed.

Pharmacies may submit PA requests for a Drug Price Override/Reimbursement Below Cost via the Medi-Cal Rx Secured Provider Portal, NCPDP P4 transaction, fax, or mail.

- **The PA request must clearly state the request is for a "*Drug Price Override/Reimbursement Below Cost*."**
- **An invoice with acquisition costs is required.**

Once an approval is obtained, the claim needs to be submitted with the PA Type Code (PATC) field (461EU) marked with the number "1." For the claim to pay at the higher reimbursement rate, the pharmacy or billing provider must submit a PATC of "1" AND have an approved Drug Price Override PA on file.

If the drug does not have an approved Drug Price Override PA and the intention is **not** to request a Drug Price Override/Reimbursement Below Cost, using PATC-1 at Point of Service (POS) will cause the claim to deny with a reject code of "75 – Prior Authorization Required" and a transaction message of "PATC=1 on claim indicates Price Override is requested." This rejection should be an indication for the pharmacy to submit a PA request for a Drug Price Override/Reimbursement Below Cost if they so choose.

- **PATC-1 is only used for a price override. 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.**

If a claim has been received prior to PA approval for a drug price override, the pharmacy must reverse the original claim and reprocess it to get the higher reimbursement rate.

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.

16. Medi-Cal Rx Pharmacy Claim Processing for Other Health Care Benefits Coordination

A beneficiary eligible for Medi-Cal Rx may also have Other Health Coverage (OHC) prescription drug/medical supply coverage. The Department of Health Care Services (DHCS) is responsible for ascertaining liable third parties, or OHC, and ensuring the other payer is billed before Medi-Cal Rx. In accordance with State and Federal guidelines: California Welfare and Institutions Code sections 10020 and 14124.90, and Social Security Act section 1902 (a)(25)(A), OHC must be billed prior to billing Medi-Cal Rx.

A beneficiary is required to utilize their OHC prescription drug/medical supply coverage prior to their Medi-Cal Rx benefits when the same service/benefit is available under the beneficiary's private health coverage. Providers are not allowed to refuse Medi-Cal Rx services based upon potential third-party liability. If the beneficiary elects to seek services not covered by Medi-Cal Rx, Medi-Cal Rx is not liable for the cost of those services. To establish Medi-Cal Rx's liability for a covered Medi-Cal Rx service, the provider must obtain an acceptable denial notification (i.e., letter, claim denial information, remittance advice entry, etc.) from the OHC entity. If the OHC pays less than the standard Medi-Cal Rx reimbursement rate, the remaining cost may be billed to Medi-Cal Rx. If the third party denies the claim, the provider may bill Medi-Cal Rx again, including the denial information from the OHC payer.

For pharmacy providers using the Medi-Cal Rx Beneficiary Eligibility Lookup tool, the Demographics & Eligibility Details section in the "Other Health Coverage" field will display the Other Payer Name when the beneficiary's OHC on file with DHCS includes prescription drug/medical supply coverage. Refer to the *Medi-Cal Rx Provider Manual*, *Appendix G – OHC Carrier Information* for OHC contact information by searching for the Other Payer Name. Once the other insurer has been billed and they have either partially paid or denied the claim, a

pharmacy claim can then be submitted to Medi-Cal Rx containing the OHC details and other payer's response. Then the Medi-Cal Rx pharmacy claim will be processed accordingly.

- **In the Medi-Cal Rx Beneficiary Eligibility Lookup tool results, if the beneficiary's OHC coverage on file with DHCS is *other* than prescription/medical supply coverage, the "Other Health Coverage" field will be blank.**

For pharmacy providers submitting Medi-Cal Rx pharmacy claims, if the beneficiary has OHC prescription drug/medical supply coverage on file with DHCS and the other insurer has *not* been billed, the Medi-Cal Rx pharmacy claim will be denied with a message of "Submit bill to other processor or primary payer" (Reject Code 41) along with the Other Payer ID. Refer to the *Medi-Cal Rx Provider Manual*, *Appendix G – OHC Carrier Information* for OHC contact information by searching for the OHC Other Payer ID. Once the other insurer has been billed and they have either partially paid or denied the claim, a subsequent pharmacy claim can then be submitted to Medi-Cal Rx containing the OHC details and other payer's response; the Medi-Cal Rx pharmacy claim will be processed accordingly.

- **Medi-Cal Rx pharmacy claims processing only considers a beneficiary's OHC prescription drug/medical supply coverage that is on file with DHCS. If the beneficiary's OHC coverage is *other* than prescription drug/medical supply coverage, the pharmacy claim will *not* be denied with Reject Code 41.**

For pharmacy providers accessing the Transaction Services or Automated Eligibility Verification System (AEVS) related to share of cost lookups and/or spenddown activities, a beneficiary's OHC coverage (prescription drug/medical supply and other) is provided in the eligibility response message. Prescription drug/medical supply coverage (in the "COV" portion of the message) is indicated with a "P" – Prescription Drugs/Medical Supplies or "R" – Medicare Part D. For additional information on the carrier and other scope of coverage code values, refer to the *Other Health Coverage Guidelines for Billing* and *Other Health Coverage Provider Manual*.

For additional Medi-Cal Rx information, refer to the *Coordination of Benefits (COB)* section of the *Medi-Cal Rx Provider Manual* or the "Coordination of Benefits" references in the *Medi-Cal Rx Payer Sheet*.

If the beneficiary indicates that they do not have prescription drug/medical supply OHC, the pharmacy provider can direct the beneficiary to the resources below so it can be corrected.

- **OHC Online Form:** Other Coverage (ca.gov) (click the **OHC Removal(s) Form** button). The URL for sharing with the beneficiary: 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 for sharing with the beneficiary: https://www.dhcs.ca.gov/services/Documents/OHCReferenceGuide_0619.pdf

17. New Medications for Automatic Prior Authorization (Auto-PA)

From 1/1/22 through 4/30/22, although Prior Authorization (PA) continues to be required for Synagis®, a physical PA does not need to be submitted. Claims for Synagis will be automatically adjudicated at the Point of Sale (POS). Claims for Synagis must continue to meet current DHCS criteria for provision of the drug. Providers who submitted PAs previously do not need to take further action.

From 1/1/22 through 5/31/22, although PA continues to be required for Makena®, a physical PA does not need to be submitted. Claims for Makena will be automatically adjudicated at the POS. Claims for Makena must continue to meet current DHCS criteria for provision of the drug. Providers who submitted PAs previously do not need to take further action.

18. Enteral Nutrition Updates

The Department of Health Care Services (DHCS) has reviewed the published Enteral Nutrition policy and noticed there is no written guidance specific to the 180-day transition policy for these products. Please use this alert as written policy and guidance for the 180-day transition and enteral nutrition products.

Pursuant to the 180-day transition policy, enteral nutrition products with either a previously paid claim or prior authorization (PA) found in the beneficiary's historical record on file with Magellan Medicaid Administration, Inc. (MMA) will continue to process until July 1, 2022, without need for a new PA. For new-start PA requests for enteral nutrition products submitted on or after January 1, 2022, coverage is restricted to products on the List of Covered Enteral Nutrition Products, and products requested for noncovered products will be denied. For claims previously paid as a medical benefit billed on a Center for Medicare & Medicaid Services (CMS) 1500 form when submitting enteral nutrition claims through Medi-Cal Rx, providers should include the active PA previously submitted with the medical benefit claim, document the most recently paid medical claim, and justify the need to continue therapy to ensure that coverage requirements are met. Plans could continue to reimburse enteral nutrition products through their medical benefit if they chose.

A new Medi-Cal Rx PA will be required on or before July 1, 2022, to allow continuation of the enteral nutrition therapy beyond the 180-day transition period. Only products on the List of Covered Enteral Nutrition Products will be reimbursable. To successfully bill an enteral nutrition product through Medi-Cal Rx on or after July 1, 2022, an approved Medi-Cal Rx PA must be on file, and only products on the List of Covered Enteral Nutrition Products will be reimbursable at that time.

Providers can submit enteral nutrition PA requests using the Medi-Cal Rx Prior Authorization Request Form (DHCS 6560) or 50-1, 50-2, or 61-211 forms; all forms are accepted. When submitting a PA through the Medi-Cal Rx Secured Provider Portal, providers are advised to list the specific NDC-like billing code in the "additional information" section. When submitting the enteral nutrition PA through fax, please include the specific NDC-like billing code on the faxed form submission. For more information, see Five Ways to Submit a Prior Authorization (PA).

Effective today, PA review and approval for renewal requests of enteral nutrition products will be considered up to 30 days in advance, based on the date of PA approval, in order to avoid disruption in service and care to beneficiaries.

For these specific PA requests where the approved start date differs from the requested start date, and the date of service is January 1, 2022 – January 28, 2022, providers can submit retroactive PA requests to correct this misalignment.