Submitting a Claim – Best Practices

May 19, 2022

In addition to the *Medi-Cal Rx Billing Tips for Claims on or after January 1, 2022*, the following table will help pharmacy providers follow best practices when submitting a claim.

Submissions	
Field Type	**Best Practices**
Bank Identification Number (BIN), Processor Control Numbers (PCN), and Group ID	Bill all pharmacy claims to Medi-Cal Rx with the following BIN, PCN, and Group ID: • BIN: 022659 • PCN: 6334225 • Group ID: MEDICALRX
Benefits Identification Card (BIC) Client Index Number (CIN)	• Make sure BIC and CIN information is entered correctly. – For more information, see the *Requirements for Medi-Cal Rx Claims*. • Look up beneficiary eligibility by logging in to the Medi-Cal Rx Provider Portal.
Newborn Claims	• 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 BIC or CIN. • For additional information, refer to the *Newborns* section in both the *Medi-Cal Rx Provider Manual* and the *Medi-Cal Rx Claim Submission Reminders*.

Submissions	
Field Type	**Best Practices**
Share of Cost (SOC)	• If a beneficiary has not met their spenddown, you will need to clear a beneficiary's SOC. • If you receive an **AA – Patient Spenddown Not Met** Reject Code 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 SOC. See the *Share of Cost Clearance or Reversal* section of the Medi-Cal *AEVS Transactions* document.
Coordination of Benefits (COB)	• Claims should be billed to the beneficiary's primary payer prior to submitting claims to Medi-Cal Rx. • See the *Coordination of Benefits (COB)* section of the *Medi-Cal Rx Provider Manual* for more detailed information.
Medicare Part B COB Claims	• This option is for claims that do not automatically crossover from Medicare. • Providers must identify a Crossover claim on the *Universal Claim Form* (UCF) by notating "Crossover" on the claim form. • Part B COB claims can also be submitted from the Point of Service (POS). • Submit nonautomatic pharmacy crossovers using National Drug Codes (NDCs) on the UCF or the *California Specific Pharmacy Claim Form (30-1)*. • See the *Medicare Part B Crossover Claims* section of the *Medi-Cal Rx Provider Manual*.
Prior Authorization (PA)	• To determine if a PA is required, use the Medi-Cal Rx Drug Lookup Tool or the Medi-Cal Rx Contract Drugs List (CDL).

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Diagnosis	• As a rule, a diagnosis is recommended but not always required. • Diagnosis code qualifier is required if adding a diagnosis code.
Emergency Fills	• Field 418-DI – Level of Service is required. Enter "3" in the field to self-certify that the emergency statement has been met.
Reimbursement for Brand-Name Drugs	• A Dispense as Written 1 (DAW 1) claim will be reimbursed at the brand-name price if the beneficiary claim history includes a paid claim for the same brand-name drug or 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 for approval of the medically necessary brand-name drug and brand-name price. • A PA Type Code (PATC) value equal to 1 is no longer required for a medically necessary brand-name drug PA to pay at the brand-name price.
Compound Claims	• Medi-Cal Rx supports up to 24 compound product IDs and one for the container count (25 product IDs if a container count is included). • Required fields – **Field 436-E1** – Product/Service ID Qualifier – This should be entered as "00" for compound. – **Field 407-D7** – Product/Service ID – Should be entered as "0" for compound claims. – **Field 995-E2** – Route of Administration – Value = SNOMED; required when submitting compound claims.

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	– **Field 996-G1** – Compound Type – Required when needing to clarify the type of compound. – **Field 438-E3** – Incentive Amount Submitted – Required if its value has an effect on the Gross Amount Due (430-DU) calculation. Used to indicate the Compound Sterilization Fee. – **Field 479-H8** – Other Amount Claimed Submitted Qualifier. Enter value 09 = Compound Prep Cost. Required if Other Amount Claimed Submitted (480-H9) is used. Used to indicate Compounding Fee. – **Field 480-H9** – Other Amount Claimed Submitted – Required if its value has an effect on the Gross Amount Due (430-DU) calculation. Used to indicate Compounding Fee. – **Field 488-RE** – Compound Product ID Qualifier – Include value 03, which equals NDC. – **Field 489-TE** – Compound Product ID – When specifying the number of containers as an ingredient, the NDC should be equal to 99999999997. – **Field 448-ED** – Compound Ingredient Quantity – Enter in the number of compound ingredients. – **Field 449-EE** – Compound Ingredient Drug Cost – Enter the ingredient drug cost (must be greater than $0.00).

Additional Information

Refer to the *Claim Submission Reminders* document on additional reminders for pharmacy claim submissions.