Medi-Cal Rx Monthly Bulletin

December 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 to be notified when new information is posted.

1. Changes to the Contract Drugs List

The following changes have been made to the Contract Drugs List (CDL), effective December 1, 2022. For more information, see the Contract Drugs List on the Medi-Cal Rx Web Portal.

Drug Name	Description	Effective Date
Aztreonam Lysine	Added to CDL with restriction.	December 1, 2022
Brompheniramine Maleate with Pseudoephedrine HCL and Dextromethorphan	Added to CDL.	December 1, 2022
Cefaclor	Removed Code I restriction.	December 1, 2022
Clindamycin Phosphate	Additional formulation (lotion) added.	December 1, 2022
Dornase Alfa	Added to CDL with restriction.	December 1, 2022
Estradiol Transdermal System Once-Weekly Patch	Additional strengths (0.0375 mg/24 hr, 0.6 mg/24 hr) added.	December 1, 2022
Estradiol Transdermal System Twice-Weekly Patch	Additional strengths (0.025 mg/24 hr, 0.0375 mg/24 hr, 0.05 mg/24 hr, 0.075 mg/24 hr) added.	December 1, 2022
Fluticasone Propionate	Additional formulation (cream) added.	December 1 2022
Glycopyrrolate	Additional formulation (solution) added.	December 1, 2022
Hydrocortisone Sodium Succinate (PF)	Added to CDL.	December 1, 2022
Ibrutinib	Additional formulation (suspension) added with restrictions.	December 1, 2022
Lacosamide	Added to CDL.	December 1, 2022
Nivolumab	Additional formulation (vial) added with restrictions.	December 1, 2022
Tobramycin	Additional formulation (ampule) added with restriction.	December 1, 2022

2. 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 2.0 on the Medi-Cal Rx Web Portal.

Updates

Section	Update Description	Effective Date
Section 15.8 – Physician Administered Drugs	• Added verbiage and link regarding *Appendix H – List of List of Physician Administered Drugs (PADs) with Reject Code 816.*	December 1, 2022
Section 17.0 – COVID-19 Vaccine Coverage, Reimbursement, OTC Antigen Test Kits, Oral Antiviral Product Coverage, and Monoclonal Antibody Product Coverage	• Updated section title.	December 1, 2022
Section 17.5 – COVID-19 Oral Antiviral Product Coverage (**NEW!**)	• Added verbiage regarding product coverage and reimbursement for COVID-19 oral antiviral, Paxlovid.	December 1, 2022
Section 17.6 – COVID-19 Monoclonal Antibody Product Coverage (**NEW!**)	• Added verbiage regarding product coverage and reimbursement for COVID-19 monoclonal antibody, Bebtelovimab.	December 1, 2022
Section 18.0 – Monkeypox Vaccine Coverage (**NEW!**)	• Added verbiage regarding product coverage for the Monkeypox vaccine.	December 1, 2022
Section 18.1 – Monkeypox Vaccine Reimbursement (**NEW!**)	• Added verbiage regarding reimbursement for the Monkeypox vaccine.	December 1, 2022

Section	Update Description	Effective Date
Appendix H – List of Physician Administered Drugs with Reject Code 816 (**NEW!**)	• Added list of Physician Administered Drugs that will reject with *NCPDP EC 816 – Pharmacy Benefit Exclusion, May Be Covered Under Patient's Medical Benefit.*	December 1, 2022

3. Changes to the Family PACT Pharmacy Formulary

The below changes have been made to the Family Planning, Access, Care and Treatment (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
Contraceptive Coverage Clarification	Verbiage added to clarify that Family PACT defers to the Medi-Cal Rx Contract Drugs List for coverage and restrictions.	November 1, 2022

4. NCPDP Reject Code 80 and Diagnosis Documentation of Code 1 Restriction

What Pharmacy Providers Need to Know

Code 1 drugs require authorization in accordance with *California Code of Regulations (CCR)* Title 22, Section 51003, unless used under the conditions specified in the *Contract Drugs List (CDL)*, and are subject to the prescription documentation requirements in CCR, Title 22, Section 51476(c). If the prescribed drug is subject to Code 1 restriction(s), pharmacy providers are to document the meeting of Code 1 restrictions and to keep that information readily available. Medi-Cal Rx would like to remind pharmacy providers about processes related specifically to Code 1 documentation associated with **NCPDP Reject Code 80 – Diagnosis Code Submitted Does Not Meet Drug Coverage Criteria**.

What Pharmacy Providers Need to Do

- **Prescribers:** A general diagnosis or *International Statistical Classification of Disease – 10th Revisio*n (ICD-10) code(s) communicated by the prescriber is acceptable to identify if the Code 1 restriction(s) for diagnosis are met. Medi-Cal Rx does not require diagnosis or ICD-10 code(s) be written on the prescription.
- **Pharmacy Providers:** ICD-10 Code(s) or Submission Clarification Code (SCC) value of "7 – Medically Necessary" can be used to manage claims submitted for Code 1 restricted products with a diagnosis/type of illness restriction. Claims submitted with SCC value of "7" indicate that the Code 1 restriction has been met. Medi-Cal Rx is aware that various ICD-10 Codes reflect a single diagnosis and as a result does not require a specific ICD-10 code to be entered at the time of claim submission. Pharmacy providers may attest the Code 1 restriction is met by using ICD-10 Codes or the SCC value of "7". If the pharmacy software requires resolution with an ICD-10 code, then the pharmacy provider should enter the appropriate ICD-10 code related to the diagnosis (diagnosis confirmed with patient, pharmacy prescriber, or other source of knowledge with the diagnosis). Medi-Cal Rx does not require a specific ICD-10 code to be entered at time of claim submission.

  Note: NCPDP Reject Code 80 has not been reinstated at this time as mentioned in the August 2022 alert, *Code 1 Documentation and Postponement of Implementation of NCPDP Reject Code 80*.

5. Prior Authorization Required: Reject Code 75 Reminder

What Providers Need to Know

The purpose of this notice is to remind providers of the policy originally published on January 26, 2022, concerning **Reject Code 75** and use of the "**55555**" override code to indicate evidence of a prior valid prior authorization (PA) or paid claim for new claim submission.

Per the January 26 alert, Medi-Cal Rx had 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 ("55555") was established for documented cases of ongoing therapy, to which providers could attest at the Point of Service (POS) and resubmit the claim.

Per policy, pharmacy providers can use the override code when:

- There is documentation of an approved PA or paid claim, provided under either managed care or fee-for-service Medi-Cal, within the past 15 months; and
- The claim is for a covered service.

  Note: The "55555" override code will not work for a non-covered service.

Providers should be aware that the Department of Health Care Services (DHCS) Audit & Investigations Division monitors for program integrity and may review claims data for potential issues. Any claims identified as misusing the "55555" override may be subject to corrective action including, but not limited to, recoupment.

What Providers Need to Do

For claims denied with Reject Code 75, for which the pharmacy provider has evidence that the beneficiary, while covered by Medi-Cal, has a valid approved PA and/or a prior paid claim in their system, the claim can be resubmitted with a 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 is subject to audit.

6. Prior Authorization Appeals and Claim Appeals: A Reminder for Providers

The purpose of this alert is to remind pharmacy providers and prescribers about the processes for submitting prior authorizations (PAs) and claim appeals. A Medi-Cal pharmacy provider or prescriber may submit PA appeals following a PA denial determination by the Department of Health Care Services (DHCS). Similarly, claim appeals offer Medi-Cal pharmacy providers a method for resolving problems related to claim disputes for Fee-for-Service claims processed by either -Medi-Cal Rx or the California Medicaid Management Information System (CA-MMIS).

Pharmacy Provider and Prescriber PA Appeals

- Provider PA appeals are accepted via the Medi-Cal Rx Provider Portal, fax, or U.S. Mail.
- Providers have 180 days to submit a PA appeal from the date of the initial denial.

- PA appeal requests must explicitly indicate "appeal."
  - **Medi-Cal Rx Provider Portal Submission:** Select the appeal option.
  - **Fax/U.S. Mail Submission:** State the word "appeal" on the *Medi-Cal Rx Prior Authorization Request Form*.

  Note: Unless the PA appeal request is specifically noted as an appeal, a second PA submitted for a previously denied request is treated as a new initial review.
- Medi-Cal Rx issues PA Appeal Acknowledgement correspondences to the provider via fax or U.S. Mail (when fax is unavailable) within one (1) calendar day of an appeal request.

For more information, refer to the *PA Adjudication* section of the *Medi-Cal Rx Provider Manual*.

Pharmacy Provider Claim Appeals

- Claim appeals are accepted via U.S. Mail to the Medi-Cal Rx Claims Department.

  Medi-Cal Rx Customer Service Center
  ATTN: Provider Claim Appeals
  P.O. Box 610
  Rancho Cordova, CA 95741-0610
- Claim appeals must be submitted on a Medi-Cal Rx Provider Claim Appeal Form.
- Each claim appeal should include only one beneficiary.
- Providers must submit an appeal within 90 days of the action/inaction precipitating the complaint.
- Claim appeals should include the following legible supporting documentation as available/applicable:
  - Corrected claim (if necessary)
  - Remittance advice pertaining to claim history
  - Explanation of Medicare Benefits or Medicare Remittance Notice
  - Other Health Coverage payments or denials
  - All Provider Claim Inquiry Forms, Medi-Cal Rx Claim Inquiry Acknowledgement Letters, Medi-Cal Rx Claim Inquiry Response Letters, or other dated correspondence to and from the Medi-Cal Rx Claim Appeal Team documenting timely follow-up. Providers must identify the claim(s) involved and specifically describe the disputed action or inaction regarding each claim.

- Medi-Cal Rx Claim Appeal Team will acknowledge each claim appeal within 15 calendar days of receipt.

Refer to the *Medi-Cal Rx Provider Claim Appeal Processes* section of the *Medi-Cal Rx Provider Manual* prior to submitting the claim appeal for submission requirements and information concerning timeliness.

7. Recommencement of Pharmacy Retroactive Claim Adjustments in November 2022

Pursuant to the February 2016 Centers for Medicare & Medicaid Services (CMS) rule on covered outpatient drugs, the Department of Health Care Services (DHCS) is required to use a pricing methodology based on actual acquisition cost (AAC). Adoption of this policy necessitated retroactive adjustments for impacted claims with dates of service April 1, 2017, through February 23, 2019.

While DHCS had initiated adjustments in May 2019, this effort was paused. The purpose of this alert is to notify pharmacies of the planned resumption of retroactive adjustments in November 2022, with recoupments set to begin in January 2023.

As some changes have occurred since the first iteration of adjustments were processed in May 2019, an overview of the process is provided below. Updated Medi-Cal Rx Frequently Asked Questions (FAQs) will be released in the next few weeks.

Background

In February 2016, CMS published its final rule on covered outpatient drugs (CODs) requiring State Medicaid agencies to adopt a methodology based on AAC for CODs. California's State Plan Amendment 17-002 was approved by CMS and became effective April 1, 2017. The associated system changes went into effect on February 23, 2019.

CMS required retroactive adjustments for impacted claims with dates of service from the policy effective date of April 1, 2017, through the implementation date of February 23, 2019. DHCS processed the first iteration of these adjustments (claims with dates of service in the month of April 2017) in May 2019 and paused further adjustments. Claims with dates of service from April 2017 through February 2019 will be reprocessed with this recommencement.

Resumption of Claim Adjustment Phase

Retroactive claim adjustments are scheduled to begin in November 2022. These adjustments appear on the Medi-Cal Remittance Advice Details (RAD) forms available through the Medi-Cal Provider Portal.

Note: This is not the Medi-Cal Rx Provider Portal.

The RAD will display the detail of the claims adjusted and the total adjustment. No recoupments will occur during the claim adjustment phase. All adjustments will appear on RAD forms with **Code 0812: Covered Outpatient Drug Retroactive Payment Adjustment**. Web links will be provided in the updated FAQs.

Resumption of Recoupments Phase

The retroactive claim adjustments will be transitioned to Medi-Cal Rx and Account Receivables (AR) will be created. The first recoupment is planned for January 2023. A recoupment schedule and additional information will be available in the updated FAQs.

Pharmacies meeting the requirements of AB 179, Statutes of 2022, which allowed DHCS to forego the recoupment of overpayments from independent pharmacies, will be notified of their AR cancellations in early 2023.

Contact Information

Contact Information will be provided in the updated FAQs.

8. Bivalent COVID-19 Vaccines Administration Now a Benefit

Effective for dates of service on or after August 31, 2022 for adults and October 12, 2022 for the pediatric populations, the United States Food and Drug Administration (FDA) authorized the use of the Moderna and Pfizer-BioNTech bivalent COVID-19 Vaccines as a booster dose.

Medi-Cal Rx will now pay for the COVID-19 bivalent vaccines as a pharmacy benefit under the following guidelines:

- **Moderna COVID-19 Vaccine:** The FDA amended the Emergency Use Authorization (EUA) for the Moderna COVID-19 Vaccine to be administered at least two months after primary vaccination or booster dose with any authorized/approved monovalent COVID19 vaccine in individuals 6 years of age or older as a single booster dose.
- **Pfizer-BioNTech COVID-19 Vaccine:** The FDA amended the EUA for the Pfizer-BioNTech COVID-19 Vaccine to be administered at least two months after primary vaccination or booster dose with any authorized/approved monovalent COVID-19 vaccine in individuals 5 years of age or older as a single booster dose.

9. Update to Policy and Billing Guidance for Pharmacy Providers on COVID-19 Oral Antiviral, Paxlovid

The Department of Health Care Services (DHCS) is providing the following guidance for pharmacy providers regarding the billing of self-administered COVID-19 oral antiviral drug, Paxlovid, authorized for the treatment of mild-to-moderate COVID-19 when independently initiated and furnished by a pharmacist.

On July 6, 2022, the U.S. Food and Drug Administration (FDA) updated the Emergency Use Authorization (EUA) for Paxlovid to allow pharmacists to prescribe the medication under specific circumstances. With this update, Paxlovid may be prescribed for an individual patient by a state-licensed pharmacist under the conditions of the EUA and the eligibility standards specified in the FDA's Fact Sheet for Healthcare Providers. Additionally, pharmacists must independently initiate and furnish Paxlovid in accordance with the California Board of Pharmacy Waiver; refer to the Department of Consumer Affairs (DCA) Order Waiving Restrictions on Pharmacists Independently Initiating and Furnishing Paxlovid to Individual Patients.

DHCS will reimburse pharmacists for the prescribing and/or dispensing of Paxlovid when this is in accordance with a California Board of Pharmacy Waiver and the FDA's EUA.

Important Billing Instructions

- DHCS will reimburse pharmacists for the prescribing (consultation and assessment of need for treatment) and/or the dispensing of Paxlovid.

- Since the initial supply of Paxlovid is purchased by the federal government and distributed free to pharmacy providers, pharmacy providers will not be reimbursed the ingredient cost but will be reimbursed the professional dispensing fee.
  - Claims for reimbursement of the dispensing fee must be submitted to **Medi-Cal Rx** for processing.
- Claims for the consultation and assessment must be billed to **DHCS** on a medical claim as a Pharmacist Service using Common Procedural Terminology (CPT) codes 99202 (new patient) and 99212 (existing patient) and reimbursed with the current methodology for pharmacist services found in the *Medi-Cal Provider Manual*.
  - Claims for reimbursement of the consultation and assessment (billed with CPT codes 99202 and 99212) must be submitted on a *CMS-1500* health insurance claim form.
  - Eligible claims must have an ICD-10-CM diagnosis code, **U07.1 (COVID-19)**.
  - DHCS is making a temporary allowance to allow billing with these CPT codes, effective immediately, through the end of the declared public health emergency.

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

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

10. Policy and Payment Allowance Update for Provider-Purchased Bebtelovimab for Treatment of COVID-19

Effective for dates of service (DOS) on or after August 15, 2022, the Department of Health Care Services (DHCS) will reimburse pharmacy providers for provider-purchased Bebtelovimab, a monoclonal antibody for the treatment of COVID-19, when dispensed and/or administered in accordance with the Emergency Use Authorization (EUA) requirements and California State Board of Pharmacy (BOP) statutes.

On February 11, 2022, the Food and Drug Administration (FDA) authorized the emergency use of Bebtelovimab 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) . Since its approval, Bebtelovimab

has been supplied free to providers by the federal government, and there has been no reimbursement of the free product.

On August 15, 2022, drug manufacturer Eli Lilly started the commercial distribution of Bebtelovimab. DHCS will reimburse for provider-purchased products at the pharmacy rate currently defined as the lower of one of the following:

- National Average Drug Acquisition Cost (NADAC) or, when the NADAC is not available, the Wholesaler Acquisition Cost (WAC) plus 0 percent
- Federal Upper Limit (FUL)
- Maximum Allowable Ingredient Cost (MAIC), plus a pharmacy dispensing fee

Providers may have both federally purchased and commercial products in their inventory initially. For DOS on or after August 15, 2022, providers are to only bill DHCS for product reimbursement if a commercially purchased product is used. Providers must not bill for federally purchased free products. Administering providers may bill for administering either type of product as instructed below.

Providers are instructed to check the batch number on the vial. If the batch number is D534422, the product was commercially purchased. Eli Lilly will release more information about future batch numbers.

Important Billing Instructions

- Dispensing or administering is restricted to the requirements of the EUA and BOP statutes.
- DHCS will not reimburse the drug ingredient cost for products that are federally purchased and supplied free to providers.
- DHCS will reimburse the drug ingredient cost for provider-purchased products at the pharmacy rate currently defined as the lower of one of the following:
  - NADAC or, when the NADAC is not available, the WAC plus 0 percent
  - FUL
  - MAIC
- DHCS will reimburse the professional dispensing fee for either product.

- DHCS will not make separate payment for the preparation of monoclonal antibodies for use by another provider or supplier to specialty pharmacies that prepare the product prior to infusion by another provider.
- DHCS will reimburse the administration/infusion of Bebtelovimab by a qualified provider when billed to DHCS as a medical claim as instructed below.

Reimbursement of Administration/Infusion Fee

- DHCS will reimburse the administration/infusion of Bebtelovimab by a provider who is enrolled as a COVID-19 immunizer working within their scope of practice when administered consistently with the EUA and BOP statutes.
- Provider must administer monoclonal antibodies in appropriate settings.
- Administering provider must bill separately for reimbursement of the administration fees by submitting the following administration codes to DHCS as a medical claim on a *CMS-1500* form:
  - M0222: Intravenous injection, includes injection and post administration monitoring.
  - M0223: Intravenous injection, includes injection and post administration monitoring in the home or residence; this includes a beneficiary's home that has been made provider based to the hospital during the COVID-19 public health emergency.
- Reimbursement would be at the current Medicare rate, which is published in the Medi-Cal Rates page in the *Medi-Cal Provider Manual*.

Product Distribution Information

- Bebtelovimab has become available for purchase from the distributor AmerisourceBergen (ABC) beginning the week of August 15, 2022. Distribution of Bebtelovimab that was purchased by the federal government and distributed to providers through state allocation has ended.
- For details regarding the transition to commercial supply and the timeline for the transition, providers are to refer to HHS Update: Bebtelovimab Commercial Transition.

11. Historical Pricing and Reimbursement Corrections for Ixinity, Alprolix, Eloctate, and NovoSeven 4Q 2021 through 3Q 2022

Retroactive for dates of services between October 1, 2021 and September 30, 2022, the hemophilia products Ixinity®, Alprolix®, Eloctate®, and NovoSeven® had pricing adjustments that require payment corrections for the National Drug Codes (NDCs) listed below.

Medi-Cal Rx will perform an Erroneous Payment Correction (EPC) on pharmacy claims during these periods for the affected NDCs. Providers may also elect to use this updated billing policy to correct and resubmit previous claims as described in *Section 18.4 – Medi-Cal Rx Provider Claim Inquiry Form (CIF)* (DHCS 6570) of the *Medi-Cal Rx Provider Manual*. If applicable, claims should be resubmitted with Delay Reason Code "10" and documented in the Remarks area.

The NDCs and their affected quarter are as follows:

4th Quarter 2021 (10/01/2021 – 12/31/2021)	
NDC	**Product Name**
70504028205	IXINITY UNIT CARTON 1000 IU
70504028305	IXINITY UNIT CARTON 1000 IU
70504028405	IXINITY UNIT CARTON 1500 IU
70504028905	IXINITY UNIT CARTON 3000 IU
71104080101	ELOCTATE 250 IU
71104080201	ELOCTATE 500 IU
71104080301	ELOCTATE 750 IU
71104080401	ELOCTATE 1000 IU
71104080501	ELOCTATE 1500 IU
71104080601	ELOCTATE 2000 IU
71104080701	ELOCTATE 3000 IU
71104080801	ELOCTATE 4000 IU
71104080901	ELOCTATE 5000 IU

1st Quarter 2022 & 2nd Quarter 2022 (01/01/2022 – 06/30/2022)	
NDC	Product Name
71104096601	ALPROLIX 250 IU
71104091101	ALPROLIX 500 IU
71104092201	ALPROLIX 1000 IU
71104093301	ALPROLIX 2000 IU
71104094401	ALPROLIX 3000 IU
71104097701	ALPROLIX 4000 IU
71104080101	ELOCTATE 250 IU
71104080201	ELOCTATE 500 IU
71104080301	ELOCTATE 750 IU
71104080401	ELOCTATE 1000 IU
71104080501	ELOCTATE 1500 IU
71104080601	ELOCTATE 2000 IU
71104080701	ELOCTATE 3000 IU
71104080801	ELOCTATE 4000 IU
71104080901	ELOCTATE 5000 IU
71104081001	ELOCTATE 6000 IU

3rd Quarter 2022 (07/01/2022 – 09/30/2022)	
NDC	Product Name
00169720801	NOVOSEVEN RT 8 mg VIAL

12. Coverage of Sterile Syringes with Needles (Non-Insulin)

Summary

Medi-Cal Rx would like to remind pharmacy providers that coverage of sterile syringes with needles (non-insulin) continues to be restricted to products on the *List of Covered Sterile Syringes with Needles (Non-Insulin)* for Medi-Cal beneficiaries as a Medi-Cal Rx **pharmacy**

benefit. For additional coverage information, reimbursement, and billing requirements, refer to the *Medi-Cal Rx Provider Manual* on the Medi-Cal Rx Web Portal.

Which Syringes are Considered a Pharmacy Benefit?

Claims for syringes found on the *List of Covered Sterile Syringes with Needles (Non-Insulin)* can be submitted to Medi-Cal Rx using standard pharmacy claim processing information.

Which Syringes are Considered a Medical Benefit?

- Sterile needles, syringes without needles, and non-insulin syringes with needles excluded from the *List of Covered Sterile Syringes with Needles (Non-Insulin)* are considered a medical benefit.
- Non-listed non-insulin sterile syringes with needles should be billed on a medical claim through the California Medicaid Management Information Systems fiscal intermediary via a Healthcare Common Procedure Coding System (HCPCS) code on a *CMS-1500* claim form for Fee-for-Service Medi-Cal beneficiaries. Medi-Cal Managed Care Plan members should contact their individual plan for coverage policy for non-covered Medi-Cal Rx benefits.
- Insulin syringes are a covered Medi-Cal Rx pharmacy benefit and not subject to a contracted List. Providers can bill for insulin syringes if the billing code/National Drug Code is active in the system. Please refer to the *Covered Medical Supplies Product Descriptions and Billing Information* Excel spreadsheet for pricing and restrictions.

Further Questions Regarding Syringes?

For questions or concerns regarding Medi-Cal policy specific to syringes with needles (non-insulin), email RXCarveOut@dhcs.ca.gov.

13. Medical Supplies: Correction to Limitations for Contraceptive Supply

What Providers Need to Know

The contraceptive supply for female/internal condoms is subject to quantity limitations of 2 claims per 90 days with a minimum quantity of 3 and a maximum quantity of 12. However,

from January 1, 2022 to August 11, 2022, claims were rejecting for female/internal condoms regardless of quantity submitted due to a systems billing issue. Medi-Cal Rx resolved this discrepancy on August 12, 2022, and has taken measures to reimburse these claims appropriately based on current policy restrictions.

What Providers Need to Do

Providers who were unsuccessful in processing claims for female/internal condoms with a date of service from January 1, 2022 to August 11, 2022, due to National Council for Prescription Drug Programs (NCPDP) 76 (quantity) rejection should resubmit their claims at this time. Providers are encouraged to call the Medi-Cal Rx Customer Service Center (CSC) if they encounter any issues when resubmitting such claims.

14. Reminder for Providers Regarding Patient Privacy

Under California law, (Cal. Family Code § 6925, 6926), minors aged 12 and over may access services without parental consent for medical care related to the prevention or treatment of pregnancy and the prevention or treatment of sexually transmitted diseases.

This alert is a reminder for providers and prescribers, including pharmacists, to maintain strict patient privacy. Personal health information should never be provided to anyone who is not the patient, even if it is the patient's legal guardian or representative without the minor's (age 12 and above) written consent. This patient privacy requirement applies to all providers associated with Medi-Cal, including doctors, nurses, clinicians, and pharmacists.

For additional information about minor consent and confidentiality laws, refer to the California Minor Consent and Confidentiality Laws. For any questions, review the Medi-Cal Provider Manual section relevant to your programs as well as the Medi-Cal Health Insurance Portability and Accountability Act (HIPAA) web page for HIPAA requirements and additional information.

15. Updates to the List of Covered Enteral Nutrition Products

The Medi-Cal Rx *List of Covered Enteral Nutrition Products* has been updated to correct several Compleat® Standard products which were placed in the incorrect product category.

Contact Information

You can call the Medi-Cal Rx Customer Service Center (CSC) at 1-800-977-2273, which is available 24 hours a day, 7 days a week, 365 days per year.

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