Medi-Cal Rx Billing Tips

Version 3.0
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DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

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1.0 Introduction

On January 1, 2022, the Department of Health Care Services (DHCS) transitioned Medi-Cal pharmacy services from Managed Care Plan (MCP) to fee-for-service. The following information is to be used by pharmacy providers and prescribers as a "quick reference guide" to provide billing tips for pharmacy claim submission to Medi-Cal Rx.

For beneficiaries with Medicare Medi-Cal Plans (MMPs or Medi-Medi Plans), coverage will continue to be processed through coordination of benefits (COB) with Medicare Part B and Part D prior to coverage through Medi-Cal. Pharmacy benefits for Medi-Cal will be processed through Medi-Cal Rx as the payer of last resort for products that are **specifically** excluded from Medicare Part D.

Additional billing and claim processing information, specifically COB and other health coverage (OHC), can be found in the *Medi-Cal Rx Provider Manual* and the *NCPDP Payer Specifications Sheet* on the Medi-Cal Rx Web Portal.

For information about Medi-Cal Rx covered products, refer to the Covered Products Lists on the Forms & Information page on the .

Note: This document is not all-inclusive of the changes occurring with the fee-for-service transition.

2.0 Claim Submission Changes

Claim Submission		
Change Taking Place	**Effective 01/01/2022**	**Corresponding Reference Document**
Pen Needles	• Pen needles, when used in conjunction with injection pens to deliver injectable medications, will be administered through the Medi-Cal Rx fee-for-service delivery system. This is billable by fee-for-service pharmacy providers via Point of Sale (POS) or on a pharmacy claim form (Universal Claim Form [UCF], California Specific Pharmacy Claim Form [30-1]) using the contracted product's 11-digit NDC.	*Medi-Cal Rx Provider Manual* (*Section 13.0 – Medical Supplies*)
Code I Restrictions for Diagnosis	• The applicable diagnosis code (NCPDP Field ID: 424-DO) may be entered on the claim to satisfy the requirement **or** Submission Clarification Code (SCC) (NCPDP Field 420-DK) 7 – Medically Necessary.	*Medi-Cal Rx Provider Manual* (*Section 11.1 – Code 1 Restrictions*)
Cost Ceiling	• Claims are subject to a $10,000cost ceiling (certain products are exempt – see *Section 15.6 – Cost Ceiling* in the *Medi-Cal Rx Provider Manual*). **Note:** Pharmacy providers may call the Medi-Cal Rx Customer Service Center (CSC) at 1-800-977-2273 for a real-time override if applicable or submit a prior authorization (PA).	*Medi-Cal Rx Provider Manual* (*Section 15.6 – Cost Ceiling*)

Claim Submission		
Change Taking Place	**Effective 01/01/2022**	**Corresponding Reference Document**
Dual Eligible Part B COB	• For pharmacy claims that do not automatically cross over, COB claim submission is allowed via POS. Enter "444444" in the Other Payer ID field (NCPDP Field ID: 340-7C) to identify this as a Part B COB claim. • If the Medicare Part B payer accepts the claim but the amount equals $0.00, the provider should submit OCC equals 4. • If the Medicare Part B payer amount is greater than $0.00, the provider should submit Other Coverage Code (OCC) equals 2. **Note:** • Part B COB is not to be used when the claim is paid under Medicare Part D benefit. • COB claims may be subject to Medi-Cal Rx utilization management (UM) requirements. Examples include: – Diabetic testing supplies not listed on the Covered Products Lists. – Physician Administered Drugs (PADs) denying for **NCPDP Reject Code 816**.	*Medi-Cal Rx Provider Manual* (*Section 10.1.2 – Medicare Part B Coordination of Benefits Claims*) *Medi-Cal Rx Provider Manual* (*Section 10.1.5 – Allowed Other Coverage Codes (OCC) for Standard OHC and Medicare Part D*)

Claim Submission		
Change Taking Place	**Effective 01/01/2022**	**Corresponding Reference Document**
Dual Eligible Part D COB	• Medicare Part D deductibles or copayments are not covered by Medi-Cal Rx. • For Medicare Part D excluded products, pharmacies can submit the claim directly to Medi-Cal Rx without Medicare COB information. • For claims that receive either an **NCPDP Reject Code 65 (Patient is Not Covered)** or **A5 (Not Covered Under Part D Law)** from Medicare, pharmacies can submit a claim to Medi-Cal Rx with OCC equals 3 (Other Coverage Exists Claim Not Covered). • If the claim is for a Medicare Part D excluded product, then OCC equals 4 will be allowed, but a COB claim is not required. • For other Part D COB scenarios, refer to the *Medi-Cal Rx Provider Manual*.	*Medi-Cal Rx Provider Manual* *(Section 10.1.4 – Medicare Part D COB)*
DUR Conflict Codes	• Claims submitted **must** include **each** Drug Use Review (DUR) conflict code on the claim. • Reason for Service Code (NCPDP Field ID: 439-E4) • Professional Service Code (NCPDP Field ID: 440-E5) • Result of Service Code (NCPDP Field ID: 441-E6)	*Medi-Cal Rx Provider Manual* *(Section 16.0 – Drug Use Review (DUR))*

Claim Submission		
Change Taking Place	**Effective 01/01/2022**	**Corresponding Reference Document**
Emergency Fills (up to 14-day supply)	• Claims for emergency fills (up to a 14-day supply) can be submitted via paper or POS. • 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. • Must submit Level of Service (NCPDP Field ID: 418-DI) – "3."	*Medi-Cal Rx Provider Manual* (*Section 15.7 –Emergency Fills*)
Declared State of Emergency Fills	Use SCC (NCPDP Field ID: 420-DK) – "13."	*Medi-Cal Rx Provider Manual* (*Section 15.7.3 – Protocol for Overriding UM During State of Emergency*)
Quantity Prescribed/ Incremental Fills	• A single prescription for a Drug Enforcement Administration (DEA) Schedule II product may be filled in multiple increments on separate claims (known as an incremental fill) only if **ALL** the following conditions are met: – All incremental fills **must** be processed by the **same** pharmacy. – Total quantity dispensed for all incremental fills must not exceed the total quantity prescribed by the prescriber. • Any quantity remaining on the prescription after 30 days from the date prescribed **cannot** be filled.	*Medi-Cal Rx Provider Manual* (*Section 15.3 – Incremental Fills*

Claim Submission		
Change Taking Place	**Effective 01/01/2022**	**Corresponding Reference Document**
Morphine Milligram Equivalent (MME)	• Claims submitted for opioid products greater than 90 MME, either on a single claim or cumulative with concurrent opioid claims in history, will be denied with **NCPDP Reject Code 76**, but can be overridden using appropriate DUR codes. • Claims submitted for opioid products greater than or equal to 500 MME, either on a single claim or cumulative with concurrent opioid claims in history, will deny and a PA will be required.	*Medi-Cal Rx Provider Manual* (*Section 15.1.3 – Controlled Substance Policy*)
Newborn Claims	• Claims for newborns may be submitted via POS **or** paper. • Pharmacy providers submitting newborn pharmacy claims when using the mother's ID number via POS are required to input a "3" in the Patient Relationship Code field (NCPDP Field ID: 306-C6) and a PA Type Code (Prior Authorization Type Code [PATC]) (NCPDP Field ID: 461-EU) of "8" to identify the claim as a newborn claim.	*Medi-Cal Rx Provider Manual* (*Section 8.2.2 – Newborns*)
Opioid Management	• Claims submitted for controlled products, including opioids (DEA Schedule II – V) will have a maximum days' supply of 35 days. • Claims submitted for greater than 35 days will require a PA. (This does **not** apply to new start opioid prescriptions, new start benzodiazepine prescriptions, or buprenorphine products.) • Claims submitted for all injectable forms of opioids will require a PA.	*Medi-Cal Rx Provider Manual* (*Section 15.1.3 – Controlled Substance Policy*)

Claim Submission		
Change Taking Place	**Effective 01/01/2022**	**Corresponding Reference Document**
	• **New start** quantity per day limits and quantity per fill limits apply. **Note:** Refer to the *Medi-Cal Rx Provider Manual* for exceptions.	
Patient Residence	• A Patient Residence value must be entered to identify a beneficiary as Long Term Care. • Pharmacy providers must use one of the following Patient Residence values (NCPDP Field ID: 384-4X): – 3 – Nursing Facility – 9 – Intermediate Care Facility/Individuals with Intellectual Disabilities. **Note:** Patient Location (NCPDP Field ID: 307-C7) is no longer utilized to identify Long Term Care.	*Medi-Cal Rx Provider Manual* (*Section 8.2.1 – Long Term Care Claims Processing*)
Prior Authorization(s)	• Authorizations use the term "Prior Authorization" or "PA."	*Medi-Cal Rx Provider Manual* (*Section 14.0 – Prior Authorization Overview, Request Methods, and Adjudication*)
Submission Clarification Codes (SCCs)	• Multiple SCCs (NCPDP Field ID: 420-DK) may be entered on a single claim (if necessary). **Note:** Maximum SCCs allowed on a single claim is three.	*Medi-Cal Rx NCPDP Payer Specification Sheet* (*Section 1.1 – B1/B3 – Claim Billing/Claim Re-Bill Request*)

Additional information can be found in the *Medi-Cal Rx Provider Manual*, *NCPDP Payer Specifications Sheet*, etc. on the Medi-Cal Rx Web Portal.

3.0 Other Coverage Codes (OCCs)

Other Coverage Codes (OCCs) are used to communicate claim information to the next downstream payer. For example, if you submit a claim to a primary payer and then submit a claim to the secondary payer (next downstream payer), the OCC communicates how the previous payer responded to the claim. The OCC field (NCPDP Field ID: 308-C8) is used when billing a COB claim and is used to identify what portion of the claim is a downstream payer's responsibility.

When submitting claims with OCCs, the process can vary after Medi-Cal Rx receives the claim. You will either receive a paid claim or NCPDP reject code. If Medi-Cal Rx denies the claim with an NCPDP reject code, the provider should determine next steps to address the reject code, which may include submission of a Medi-Cal Rx PA. PA submissions should be handled according to Medi-Cal Rx processes and procedures outlined in the *Medi-Cal Rx Provider Manual*.

3.1 COB with OCC Equals 2 or OCC Equals 4

Scenarios		
Scenario When COB with Medi-Cal Rx	**Details**	**Actions**
Medicare Part B coverage – deductible met	Medicare Part B covered the claim, and the Medicare Part B payer amount is greater than $0.00.	When the Medicare Part B payer paid amount greater than $0.00, the provider should submit a Medi-Cal Rx claim with OCC equals 2. If the claim does not cross over automatically to the MCP or Medi-Cal fee-for-service, pharmacy providers must submit the Medi-Cal Rx claim for the copay charge for a Medicare Part B eligible product to Medi-Cal Rx using: • The specific Medicare Part B Other Payer ID (NCPDP Field ID: 340-7C) of "444444." • Other Payer ID Qualifier (NCPDP Field ID: 339-6C) with "99-Other." • OCC (NCPDP Field ID: 308-C8) equals "2." • Other Payer Amount Paid (NCPDP Field: 431-DV) to include the dollar amount paid by the primary coverage.

Scenarios		
Scenario When COB with Medi-Cal Rx	**Details**	**Actions**
		• Refer to the *Medi-Cal Rx NCPDP Payer Specification Sheet* for additional required fields for Medi-Cal Rx COB claims. • Benefit Stage-related information (Benefit Stage Count [NCPDP Field ID: 392-MU], Benefit Stage Qualifier [NCPDP Field ID: 393-MV], Benefit Stage Amount [NCPDP Field ID: 394-MW]) is useful information to include on the claim, however it does not alleviate the need to send the other requested COB information on the Medi-Cal Rx claim. **Note:** Medi-Cal Rx UM requirements will apply.
Medicare Part B coverage – deductible not met	The Medi-Cal Rx claim will pay **if** Medicare Part B accepted the claim but the charge was applied to beneficiary's Medicare Part B deductible and all required fields have been entered according to the *Medi-Cal Rx NCPDP Payer Specification Sheet*.	If Medicare Part B accepted the claim and payer returned a paid amount equals $0.00; provider should submit Medi-Cal Rx claim with OCC equals 4. If the claim does not cross over automatically to the MCP or Medi-Cal fee-for-service, pharmacy providers must submit the Medi-Cal Rx claim for the copay charge for a Medicare Part B eligible product to Medi-Cal Rx using: • The specific Medicare Part B Other Payer ID (NCPDP Field ID: 340-7C) of "444444." • Other Payer ID Qualifier (NCPDP Field ID: 339-6C) with "99-Other." • OCC (NCPDP Field ID: 308-C8) equals "4." • Other Payer Amount Paid (NCPDP Field: 431-DV) to include the dollar amount paid by the primary coverage (in this instance $0.00).

Scenarios		
Scenario When COB with Medi-Cal Rx	**Details**	**Actions**
		• Refer to the *Medi-Cal Rx NCPDP Payer Specification Sheet* for additional required fields for Medi-Cal Rx COB claims. • Benefit Stage-related information (Benefit Stage Count [NCPDP Field ID: 392-MU], Benefit Stage Qualifier [NCPDP Field ID: 393-MV], Benefit Stage Amount [NCPDP Field ID: 394-MW]) is useful information to include on the claim. However, it does not alleviate the need to send the other requested COB information on the Medi-Cal Rx claim. **Note:** Medi-Cal Rx UM requirements will apply.
Medicare Part D coverage – Part D excluded products	Medicare Part D does not cover the claim as the product is excluded.	OCC equals 4 can be submitted on a Medi-Cal Rx claim for products excluded from coverage by Medicare Part D. This will allow the claim to be billed to Medi-Cal Rx as the payer. It is not required to submit OCC equals 4 in this situation. **Note:** Medi-Cal Rx UM requirements will apply. If the product is Medicare Part D excluded, then OCC equals 4 will be allowed, but a COB claim is not required.

Scenarios		
Scenario When COB with Medi-Cal Rx	**Details**	**Actions**
Medicare Part D coverage – Part D covered products	Medicare Part D does cover the claim as the product is not excluded from Part D and the Medi-Cal Rx claim was submitted with OCC equals 2 or OCC equals 4. Medi-Cal Rx will deny secondary claim with **NCPDP Reject Code 13 M/I Other Coverage Code**. Claims submitted directly to Medi-Cal Rx for products that are **not excluded** from Medicare Part D will deny with **NCPDP Reject Code 620 – This Prod/Service may be covered under Medicare Part D**. Claims submitted for COB claim will deny for Reject Code 13 with the following supplemental message: "*Medicare Part D copays and deductibles are not covered.*"	OCC and COB information should be removed, and the claim should be submitted to Medicare Part D as the payer.
OHC (non-Medicare) – beneficiary paying less than 100 percent of the claim amount	OHC covered product and the OHC payer paid amount greater than $0.00.	When the OHC payer paid amount is greater than $0.00, the pharmacy provider should submit a Medi-Cal Rx claim with OCC equals 2.
OHC (non-Medicare) – beneficiary paying 100 percent of the claim amount	OHC covered product, OHC accepted the claim, and the OHC payer paid amount equals $0.00.	If the OHC payer accepted the claim and returned a paid amount equaling $0.00; the pharmacy provider should submit a Medi-Cal Rx claim with OCC equals 4.

4.0 Claim Form Changes

To obtain forms or information on fax numbers, addresses, or submission methods, visit the Medi-Cal Rx Web Portal Medi-Cal Rx Provider Portal and from the **Forms & Information** page, select the **Provider Manual** tab.

Note: Pharmacy providers submitting a Charpentier claim **must** write/enter CHARPENTIER on the form.

Paper Claim Forms		
Change Taking Place	**Effective 01/01/2022**	**Corresponding Reference Document**
California Specific Compound Pharmacy Claim Form (30-4)	When submitting a *California Specific Compound Pharmacy Claim Form (30-4)* pharmacies **must** leave Box 25 (Route of Administration [ROA]) **BLANK**. The Systematized Nomenclature of Medicine (SNOMED) value **must** be entered in Box 48 (Specific Details/Remarks). **Note:** SNOMED values can be found in the *Medi-Cal Rx Provider Manual*.	*Medi-Cal Rx Provider Manual* (*Section 19.2.2.1 – Completion Instructions for California Specific Compound Pharmacy Claim Form (30-4)*)
Claim Inquiry Form (CIF)	Claim Inquiry Forms are used after submitting a claim to request one of the following: • Adjustment • Reconsideration • Tracer Pharmacy providers can access the CIF via the Medi-Cal Rx Web Portal on the Forms & Information page.	*Medi-Cal Rx Provider Manual* (*Section 19.4 – Medi-Cal Rx Provider Claim Inquiry Form (CIF) (DHCS 6570)*)

Paper Claim Forms		
Change Taking Place	**Effective 01/01/2022**	**Corresponding Reference Document**
Prior Authorization Form (formerly known as a Treatment Authorization Request [TAR])	The *Medi-Cal Rx Prior Authorization Request Form* should be completed and sent to the Medi-Cal Rx vendor via fax or mail. Pharmacy providers can access the *Medi-Cal Rx Prior Authorization Request Form* on the Forms & Information page. **Note:** Other acceptable PA request forms: • Medi-Cal Form 50-1 • Medi-Cal Form 50-2 • California Form 61-211	*Medi-Cal Rx Provider Manual* (*Appendix E – Acceptable Medi-Cal Rx PA Request Forms*)
Provider Claim(s) Appeals	The *Provider Claim Appeal Form* must be completed and sent to the Medi-Cal Rx vendor via fax or mail. Pharmacy providers can access the *Provider Claim Appeal Form* on the Forms & Information page.	*Medi-Cal Rx Provider Manual* (*Section 19.5 – Medi-Cal Rx Provider Claim Appeal Form (DHCS 6571)*)
Universal Claim Form	Pharmacy providers are able to submit an NCPDP Universal Claim Form for pharmacy claims (including compound pharmacy claims). Universal Claim Forms can be ordered from the NCPDP website.	*Medi-Cal Rx Provider Manual* (*Section 19.1 – Universal Claim Form, Version D.0*)

5.0 NCPDP Payer Specification Changes

The BIN and Processor Control Number (PCN) have changed.

Transaction Header Segment			
Transaction Type	Transaction Code 1Ø3-A3	BIN 1Ø1-A1	PCN 1Ø4-A4
Claim Billing Request	B1	022659	6334225
Claim Billing Reversal Request	B2		
Claim Rebill	B3		
Eligibility Verification Request	E1		
Prior Authorization Reversal	P2		
Prior Authorization Inquiry	P3		
Prior Authorization Request Only	P4		
Drug Pricing Inquiry	B1	022667	393

Additional information can be found in the *Medi-Cal Rx Provider Manual*, *NCPDP Payer Specifications Sheet*, etc. on the Medi-Cal Rx Web Portal.

NCPDP Field Name and Number	NCPDP Field Values Effective 01/01/2022	Comments/Situation
1.1 B1/B3 – Claim Billing/Claim Rebill Request		
Group ID 301-C1 Required.	MediCalRx	
Patient Relationship Code 306-C6 Required.	1 – Cardholder 3 – Child 4 – Other (use for Transplant Donor)	Submit "3" for newborn claims using mother's Medi-Cal Cardholder ID. Submit "4" for claims for a transplant donor, when using transplant recipient's Medi-Cal Cardholder ID.
Pregnancy Indicator 335-2C Required when patient is pregnant.	Blank – Not Specified 1 – Not Pregnant 2 – Pregnant	Required if the patient is known to be pregnant.
Patient Residence 384-4X Required when needed to identify Long Term Care.	3 – Nursing Facility 9 – Intermediate Care Facility/Individuals with Intellectual Disabilities	Required for Long Term Care.

NCPDP Field Name and Number	NCPDP Field Values Effective 01/01/2022	Comments/Situation
Number of Refills Authorized 414-DF Required.	0 – No Refills Authorized 1-99 – Authorized Refill Number	Required to indicate the number of refills authorized.
Submission Clarification Code Count 354-NX Required when needed for Code I or Compounds.	Maximum Count of 3	• SCC 2 is used for initial dose of COVID-19 vaccine. • SCC 6 is used for final dose of COVID-19 vaccine. • SCC 7 is used for Code I. • SCC 8 is used for Compounds. • SSC 20 is used to identify a 340B drug.
Unit of Measure 600-28 Required.	EA – Each GM – Grams ML – Milliliters	
Level of Service 418-DI Required for emergency claims.	3 – Emergency	Required when self-certifying the Emergency Statement is met for a 72-hour emergency supply on POS claims.
Prior Authorization Type Code 461-EU Required for Newborn Claims.	8 – Newborn Claims	Submit "8" for newborn claims. **Note:** PATC "1" is no longer used for Pricing PAs for claims with date of service (DOS) on or after March 4, 2022.
Prior Authorization Number Submitted 462-EV Required when needed for PA.		Not needed to identify the PA.
Compound Type 996-G1 Required when the claim is a compound.		Required when needed to clarify the type of compound.
Patient Paid Amount Submitted 433-DX Not required – do not send.		Not required. Do not send.

NCPDP Field Name and Number	NCPDP Field Values Effective 01/01/2022	Comments/Situation
Other Payer Reject Count 471-5E Required when OCC is "3."	Maximum count of 5	Required if Other Payer Reject Code (472-6E) is used.
Other Payer Reject Code 472-6E Required when OCC is "3."		Required when the other payer has denied the payment for the billing, designated with OCC (308-C8) equals "3" (Other Coverage Billed – claim not covered).
2.1 B2 – Claim Reversal Request		
Other Coverage Code 308-C8 Required when OCC was submitted on the original claim that is being reversed.		Required when OCC was submitted on the original claim that is being reversed.
Coordination of Benefits/Other Payments Count 337-4C Required when OCC was submitted on the original claim that is being reversed.	Maximum count of 9	Required when OCC was submitted on the original claim that is being reversed.
Other Payer Coverage Type 338-5C Required when OCC was submitted on the original claim that is being reversed.		Required when OCC was submitted on the original claim that is being reversed.
5.1 P4 – Prior Authorization Request Only Request		
Patient Relationship Code 306-C6 Required.	1 – Cardholder 3 – Child 4 – Other (use for Transplant Donor)	Input "3" for newborn claims using mother's Medi-Cal Cardholder ID. Input "4" when submitting claims for a transplant donor, when using transplant recipient's Medi-Cal Cardholder ID.
Patient Residence 384-4X Required when needed to identify Long Term Care.	3 – Nursing Facility 9 – Intermediate Care Facility/Individuals with Intellectual Disabilities.	Required if this field could result in different coverage, pricing, or patient financial responsibility. Required for Long Term Care.

6.0 Acronyms

Term	Definition
BIN	Bank Identification Number
CIF	Claims Inquiry Form
COB	Coordination of Benefits
CSC	Customer Service Center
DEA	Drug Enforcement Administration
DHCS	Department of Health Care Services
DUR	Drug Use Review
MCP	Managed Care Plan
MME	Morphine Milligram Equivalent
MMP/Medi-Medi-Plans	Medicare Medi-Cal Plans
NCPDP	National Council for Prescription Drug Programs
NDC	National Drug Code
OCC	Other Coverage Code
OHC	Other Health Coverage
PA	Prior Authorization
PATC	Prior Authorization Type Code
PCN	Processor Control Number – A 10-digit number maintained by Magellan Medicaid Administration, LLC (MMA) that is used for internal record keeping.
POS	Point of Sale
ROA	Rout of Administration
SCC	Submission Clarification Code
SNOMED	Systemized Nomenclature of Medicine
TAR	Treatment Authorization Request
UCF	Universal Claim Form
UM	Utilization Management