Medi-Cal Rx Billing Tips for Claims on or after January 1, 2022

Version 2.0

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Revision History

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0.1	01/05/2021	Anita Martin/Ashley Sipes	Initial Creation
		Bridgette Devine	Document Review
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		Bridgette Devine	Document Review
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		Rhonda Rollins	Document Review

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1.0 Introduction

On January 1, 2022, the California Department of Health Care Services (DHCS) will transition all Medi-Cal pharmacy services from Managed Care Plan (MCP) to Fee-for-Service (FFS). The following information is to be used by pharmacy providers and prescribers as a "quick reference guide" for changes taking place with this transition. Additional information can be found in the *Medi-Cal Rx Provider Manual* and the *National Council for Prescription Drug Programs* (*NCPDP) Payer Specifications Sheet* on the Medi-Cal Rx Web Portal.

NOTE: This document is not all-inclusive of the changes occurring with the FFS 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 FFS delivery system billable by FFS 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 National Drug Code (NDC).	Provider Manual *(Section 13.0 – Medical Supplies)*

Claim Submission		
Change Taking Place	***Effective* 01/01/2022**	**Corresponding Reference Document**
Code I Restrictions	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 ID: 420-DK) 7 – Medically Necessary.	Provider Manual *(Section 11.1 – Code 1 Restrictions)*
Cost Ceiling	Claims will be subject to a $10,000 cost ceiling (certain drugs are exempt – see *Section 11.8 – Cost Ceiling* in the *Medi-Cal Rx Provider Manual*). **NOTE:** Providers may call the Medi-Cal Rx Customer Service Center (CSC) at 1-800-977-2273 for a real-time override if specific criteria are met. Alternatively, providers can request a Prior Authorization (PA) that, if approved, will eliminate the need to call every time the prescription is filled.	Provider Manual *(Section 15.6 – Cost Ceiling)*
Crossover Claims	Allowed via POS. Please enter '444444' in the Other Payer ID field (NCPDP Field ID: 340-7C) to identify this as a crossover claim.	Provider Manual *(Section 10.1.2 – Medicare Part B Crossover Claims)*

Claim Submission		
Change Taking Place	***Effective* 01/01/2022**	**Corresponding Reference Document**
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)	Provider Manual *(Section 16.0 – Drug Use Review [DUR])*
Emergency Fills/Claims	Emergency claims (72-hour supply) can be submitted via Paper *or* POS. **NOTE:** Prior to 01/01/2022, these claims required paper submission.	Provider Manual *(Section 15.7 – Emergency Fills)*

Claim Submission		
Change Taking Place	***Effective* 01/01/2022**	**Corresponding Reference Document**
Quantity Prescribed/ Incremental Fills	A single prescription for a Drug Enforcement Administration (DEA) Schedule II drug may be filled in multiple increments on separate claims (known as an incremental fill) only if ALL of 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.	Provider Manual *(Section 15.3 – Incremental Fills)*
Morphine Milligram Equivalent (MME)	Claims submitted for Opioid products > 90 MME will reject. Claims submitted for Opioid products >/= 500 MME will deny and a PA will be required. **NOTE:** The limits mentioned above will be applied cumulatively, across all concurrent Opioid prescriptions, allowing refill variance equal to an Early Refill tolerance of 90%. The	Provider Manual *(Section 15.1.3 – Opioid Management)*

Claim Submission		
Change Taking Place	***Effective* 01/01/2022**	**Corresponding Reference Document**
	submission of DUR codes to bypass Early Refill rejection(s) will **not** be allowed for Opioids.	
Newborn Claims	Claims for newborns may be submitted via POS *or* paper. Providers submitting newborn pharmacy claims when using the mother's ID number via POS are required to submit a "3" in the Patient Relationship Code field (NCPDP Field ID: 306-C6) and a Prior Authorization Type Code (PATC) (NCPDP Field ID: 461-EU) of "8" to identify the claim as a newborn claim.	Provider Manual *(Section 8.2.2 – Newborns)*

Claim Submission		
Change Taking Place	***Effective* 01/01/2022**	**Corresponding Reference Document**
Patient Residence	A Patient Residence value **must** be entered to identify a beneficiary as Long-Term Care. 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) will no longer be utilized to identify Long Term Care.	Provider Manual *(Section 8.2.1 – Long-Term Care Claims Processing)*
Prior Authorization(s)	Authorizations will use the term "Prior Authorization" or "PA." **NOTE:** Information regarding PAs, including PA request methods, can be found in the *Medi-Cal Rx Provider Manual* (see next column for specific section reference).	Provider Manual *(Section 14.0 – Prior Authorization Overview, Request Methods, and Adjudication)*

Claim Submission		
Change Taking Place	***Effective* 01/01/2022**	**Corresponding Reference Document**
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 = three (3).	NCPDP Payer Specifications Sheet (*Section 4.0 – NCPDP Payer Specifications Changes*)

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 Claim Form Changes

To obtain forms or information on fax numbers, addresses, or submission methods, please visit the Provider Portal on the Medi-Cal Rx Web Portal and click the **Forms and Information** and **Provider Manual** links.

NOTE: 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 Compound Pharmacy Claim Form(s) (30-4)	When submitting a Paper Compound Claim Form (30-4), pharmacies **must** leave Box 25 (ROA) **BLANK**. The SNO-MED value **must** be entered in Box 48 (Specific Details/Remarks). **NOTE:** SNO-MED values can be found in the *Medi-Cal Rx Provider Manual*.	Provider Manual *(Section 18.2.2.1 – Completion Instructions for California Specific Compound Pharmacy Claim Form [30-4])*
Claims Inquiry Forms (CIFs)	A *new* Claims Inquiry Form will be available and must be completed and sent to the Medi-Cal Rx vendor for a Claim Inquiry (Adjustment, Reconsideration, Tracer).	Provider Manual *(Section 18.4 – Claims Inquiry Form)*

Paper Claim Forms		
Change Taking Place	**Effective 01/01/2022**	**Corresponding Reference Document**
Prior Authorization Form (formerly known as a Treatment Authorization Request [TAR])	A *new* Medi-Cal Rx Prior Authorization Request form will be available and should be completed and sent to the Medi-Cal Rx vendor via fax or mail.	Provider Manual *(Appendix E – Acceptable Medi-Cal Rx PA Request Forms)*
Provider Claim(s) Appeals	A *new* Provider Claim Appeal form will be available and must be completed and sent to the Medi-Cal Rx vendor via fax or mail.	Provider Manual *(Section 18.5 – Provider Claim(s) Appeal Forms)*
Universal Claim Form	Providers will be 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.	Provider Manual *(Section 18.1 – Universal Claim Form)*

4.0 NCPDP Payer Specifications Changes

The Bank Identification Number (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 Mom'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.
Number of Refills Authorized 414-DF Required	0 = No refills authorized 1-99 = Authorized Refill Number	Required to indicate the number of refills authorized.

NCPDP Field Name and Number	NCPDP Field Values Effective 01/01/2022	Comments/Situation
Submission Clarification Code Count 354-NX Required when needed for Code 1 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 1. 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 when needed for Newborn Claims or Pricing PAs.	1 = Prior Authorization (PA) (used for Medi-Cal pricing) 8 = Newborn Claims	Do not submit the PATC "1" unless communicating PA has been approved to override Medi-Cal pricing. Submit "8" for newborn claims.
Prior Authorization Number Submitted 462-EV Required when needed for PA.		Not needed to identify the PA.

NCPDP Field Name and Number	NCPDP Field Values Effective 01/01/2022	Comments/Situation
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.
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 Other Coverage Code (308-C8) = "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.

NCPDP Field Name and Number	NCPDP Field Values Effective 01/01/2022	Comments/Situation
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)	Submit "3" for newborn claims using Mom's Medi-Cal Cardholder ID. Submit "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.

5.0 Acronyms

Term	Definition
BIN	Bank Identification Number
CIFs	Claims Inquiry Forms
CSC	Customer Service Center
DEA	Drug Enforcement Administration
DHCS	Department of Health Care Services
DOS	Date of Service
DUR	Drug Use Review
eTAR	Electronic Treatment Authorization Request
FFS	Fee-for-Service
MCP	Managed Care Plan
MME	Morphine Milligram Equivalent
NCPDP	National Council for Prescription Drug Programs
NDC	National Drug Code
OHC	Other Health Coverage
PA	Prior Authorization
PCN	Processor Control Number – A 10-digit number maintained by MMA that is used for internal record keeping.
POS	Point of Sale
ROA	Route of Administration
SCCs	Submission Clarification Codes
TAR	Treatment Authorization Request