Medi-Cal Rx

Pediatric Integration: Most Common Claim Reject Codes

April 4, 2025

Reject Code 75 – Prior Authorization Required

Why Am I Getting Reject Code 75?

If Reject Code 75 is received, the submitted drug/product requires a prior authorization (PA) for coverage consideration. Medi-Cal Rx requires submission of a PA request to establish medical necessity for some drugs/products.

Are California Children's Services (CCS) Paneled Providers Subject to Reject Code 75?

CCS Paneled Providers are exempt from receiving Reject Code 75 when the claim is submitted for an **included** product for a member who is 20 years of age or younger.

If Reject Code 75 is received, the claim is for an **excluded** drug/product. Review the *Medi-Cal Rx Approved NDC List* to verify inclusion/exclusion status.

How Do I Resolve Reject Code 75?

- Review the *Medi-Cal Rx Approved NDC List* and the lists on the Contract Drugs & Covered Products Lists page for an alternative therapy, if appropriate.
- Submit a PA request via one of the approved Medi-Cal Rx PA submission methods and include applicable documentation. Review the *Prior Authorization Submission Reminders* for more details regarding the PA submission methods.

How Do I Avoid Reject Code 75?

- Proactively review the *Medi-Cal Rx Approved NDC List* and the lists on the Contract Drugs & Covered Products Lists page to determine if an alternative therapy is appropriate.
- Submit a PA request if an alternative therapy is not appropriate.
- Refer to the Becoming a California Children's Services Provider page and determine if being a CCS Paneled Provider is right for you.

Reject Code 76 – Plan Limitations Exceeded: Quantity Limits

Why Am I Getting Reject Code 76?

Reject Code 76 occurs when the pharmacy claim has been denied due to the prescribed quantity exceeding the maximum dose or the total quantity allowed over a specific time frame or per dispensing.

Are CCS Paneled Providers Subject to Reject Code 76?

Yes.

How Do I Resolve Reject Code 76?

- Review the lists on the Contract Drugs & Covered Products Lists page on the Medi-Cal Rx Web Portal to identify established QLs for the drug/product being submitted.
  - **Note:** Refer to the *Medical Supplies Dispensing Quantity Limitations* section in the *Medi-Cal Rx Provider Manual* for more information regarding QLs for continuous glucose monitoring (CGM) systems, disposable insulin delivery devices (DIDDs), and other medical supplies.
- Submit a PA request via one of the approved Medi-Cal Rx PA submission methods if it is not appropriate to resubmit the claim to meet the established QLs. Refer to the *Prior Authorization Submission Reminders*.

How Do I Avoid Reject Code 76?

- Review the *Medi-Cal Rx Contract Drugs List* (CDL) for QL restrictions and consider a change in therapy if medically appropriate. If submitting a PA request for an enteral nutrition product, refer to the following QLs:
  - **Tube Fed:** Up to 2,000 calories/day for all products except infant products
  - **Orally Fed and 22 years of age and older:** Up to 1,200 calories/day
  - **Orally Fed and 21 years of age and younger:** Up to 1,000 calories/day
  - **Infant Products and younger than 1 year of age:** Up to 800 calories/day regardless of feeding status
- Proactively submit a PA request to Medi-Cal Rx with the prescription to avoid any delays in care.
- Review the alert titled *How to Resolve Reject Code 76 – Plan Limitations Exceeded* for additional information.

Reject Code 78 – Cost Exceeds Maximum

Why Am I Getting Reject Code 78?

If Reject Code 78 is received, the total dollar amount for the claim exceeds the cost ceiling threshold for that drug/product type category and you may need to submit a PA request. Cost ceilings are in place to improve pharmacy claim submission, processing quality, and to mitigate Fraud, Waste, and Abuse (FWA) on high-cost drugs and products.

Are CCS Paneled Providers Subject to Reject Code 78?

Yes.

How Do I Resolve Reject Code 78?

- Confirm the claim is submitted accurately and validate the prescription's quantity and days' supply amount is correct.
- Consider prescribing a less costly therapy, if clinically appropriate.
- Submit a PA request via one of the approved Medi-Cal Rx submission methods if a change in therapy is not appropriate.

How Do I Avoid Reject Code 78?

- Confirm accuracy when submitting claims to ensure quantity and days' supply amounts are correct.
- Identify the cost ceiling drug/product type category for a drug/product by utilizing the *Medi-Cal Rx Approved NDC List*.
- Review the cost ceiling limits to understand when a reject may occur. Cost ceilings per claim are as follows per drug/product type:
  - Over-the-Counter (OTC) = $50
  - Generic = $1,000
  - Single and Multisource Brand = $4,000
  - High-Cost Drug (HCD) – Generic and Brand = $14,000
- Proactively submit a PA request to Medi-Cal Rx with the claim to avoid any delays in care.
- Refer to the alert titled *How to Resolve Claim Reject Code 78: Cost Exceeds Maximum* for additional information.

Reject Code 80 – Diagnosis Code Submitted Does Not Meet Drug Coverage Criteria

Why Am I Getting Reject Code 80?

If Reject Code 80 is received, the diagnosis requirement for the drug/product submitted with the claim was not met. Medi-Cal Rx has diagnosis requirements for certain drugs/products and if the claim is not submitted with the applicable diagnosis, or the applicable diagnosis cannot be found in the member's Medi-Cal medical record, the claim will reject with Reject Code 80.

Are CCS Paneled Providers Subject to Reject Code 80?

Yes.

How Do I Resolve Reject Code 80?

- Verify the Code I diagnosis restriction is met by reviewing the *Medi-Cal Rx Diagnosis Crosswalk* and identifying applicable diagnoses for drugs/products.
- If the diagnosis is provided and meets the requirement, and accepted *International Classification of Diseases – 10th Revision – Clinical Modification* (ICD-10-CM) code(s) cannot be identified, the dispensing pharmacy provider may attest the Code I diagnosis restriction is met and resubmit the claim using a submission clarification code (SCC) value of 7 – Medically Necessary.
  - **Note:** SCC 7 should only be used to communicate the restriction has been met.
- If the claim is submitted without a diagnosis or ICD-10-CM code(s) and the diagnosis cannot be verified, submit a PA request to Medi-Cal Rx.

How Do I Avoid Reject Code 80?

- Review the *Medi-Cal Rx Diagnosis Crosswalk* to identify accepted diagnoses or ICD-10-CM code(s) to meet the Code I diagnosis restriction.
- For additional information, refer to the alert titled *How to Address Reject Code 80 – Diagnosis Code Submitted Does Not Meet Drug Coverage Criteria*.

Prescribers:

- Provide the applicable diagnosis or ICD-10-CM code with prescription.
- Proactively submit a PA request to Medi-Cal Rx with the prescription to avoid any delays in care.

Pharmacy Providers:

- Review ICD-10-CM Code I restrictions prior to submission of the claim and if applicable, attest the Code I diagnosis is met using SCC 7.
- Proactively submit a PA request to Medi-Cal Rx with the claim to avoid any delays in care.

Reject Code 83 – Duplicate Paid/Captured Claim

Why Am I Getting Reject Code 83?

If Reject Code 83 is received, a duplicate claim has been submitted to Medi-Cal Rx for the same drug/product with the same date of service (DOS) as another claim for the same member. Medi-Cal Rx uses Reject Code 83 to ensure that accidental duplicate claims are not paid, resulting in errors in pharmacy billing.

Are CCS Paneled Providers Subject to Reject Code 83?

CCS Paneled Providers who are physicians or certified nurse practitioners are exempt from receiving Reject Code 83 when the claim is submitted for a contracted enteral nutrition product for a member who is 20 years of age or younger. Refer to the *List of Contracted Enteral Nutrition Products* for more information.

Claims submitted by CCS Paneled Providers are subject to Reject Code 83 when the claim is not for a contracted enteral nutrition product.

How Do I Resolve Reject Code 83?

- Review the member's dispensing history to determine if the claim is a true duplicate request. Refer to the alert titled *NCPDP Reject Code 83 – Duplicate Paid/Captured Claim* for more information regarding true duplicates.
- Contact the Medi-Cal Rx Customer Service Center (CSC) for assistance if the claim is denying with only Reject Code 83 and:
  - It cannot be determined if the claim is a true duplicate, and the pharmacy provider needs to know at which pharmacy the last claim was billed and resulted in a paid claim; **OR**
  - It can be determined that the claim is not a true duplicate, is medically necessary, and is to be filled for the same DOS as the previous paid claim; **OR**
  - It can be determined that the claim is a duplicate, is medically necessary, and must be filled for the same DOS.
    - Providers may also submit a PA request to Medi-Cal Rx in this situation.

How Do I Avoid Reject Code 83?

- Review the member's dispensing history to determine if the claim is a duplicate request.
- Contact the Medi-Cal Rx CSC for assistance with submitting a claim.
- Proactively submit a PA request to Medi-Cal Rx with the prescription to avoid any delays in care.
- Refer to the Becoming a California Children's Services Provider page and determine if being a CCS Paneled Provider is right for you.
- Refer to the alert titled *NCPDP Reject Code 83 – Duplicate Paid/Captured Claim* for additional information.

Reject Code 606 – Brand Drug/Specific Labeler Code Required

Why Am I Getting Reject Code 606?

If Reject Code 606 is received, the requirement for a specific drug or labeler code was not met. Medi-Cal Rx has requirements for certain brands or labelers to be used for certain drugs or products; if that requirement is not met, the claim will deny with Reject Code 606 and a PA may be required.

Are CCS Paneled Providers Subject to Reject Code 606?

Yes.

How Do I Resolve Reject Code 606?

- Consider alternate therapies or NDCs that may not require a PA, if clinically appropriate. Review the lists on the Contract Drugs & Covered Products Lists page and the *Medi-Cal Rx Approved NDC List*.
  - Prescribers: Refer to your ePrescribing application.
- Submit a PA request via one of the approved Medi-Cal Rx PA submission methods if a change in therapy is not appropriate.

How Do I Avoid Reject Code 606?

- Review the lists on the Contract Drugs & Covered Products Lists page prior to claim submission to identify any Code I labeler restrictions and consider a change in therapy, if appropriate.
- Proactively submit a PA request to Medi-Cal Rx with the claim to avoid any delays in care.

Contact Information

You can call the Medi-Cal Rx 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@primetherapeutics.com.