Claim Submission Reminders

January 11, 2022

Medi-Cal Rx is live! All administrative services related to Medi-Cal pharmacy benefits that are billed on pharmacy claims have transitioned to Medi-Cal Rx. Here are some reminders for pharmacy claim submissions. The Medi-Cal Rx Provider Manual houses valuable resources and information to properly submit claims. Adherence to the following reminders will ensure effective submission of claims and timely payment.

Reject Codes

See the National Council for Prescription Drug Programs (NCPDP) Reject Codes for a full list.

Reject Codes & Resolutions	
Reject Code	**Resolution**
16: M/I Prescription/Service Reference Number	Medi-Cal Rx is temporarily suspending reject code 16 M/I Prescription/Service Reference Number. Please resubmit your claims if you have received this rejection.
35: Missing or Invalid Primary Care Provider ID	Double-check Provider ID on the claim.
40: Pharmacy Not Contracted With Plan On Date Of Service	Confirm you are a Medi-Cal Fee-for-Service (FFS) provider using the California Health and Human Services Open Data Portal and resubmit your claim.
60: Product/Service Not Covered for Patient Age	Refer to the Medi-Cal Rx Contract Drugs List (CDL) for age limitations and specifications. If you are submitting for the flu vaccine and getting Reject Code 60, vaccines (other than Covid) are covered only for beneficiaries aged *19 and older*.

Reject Codes & Resolutions	
Reject Code	**Resolution**
65: Beneficiary Eligibility	Medi-Cal Rx identified a pharmacy claims denial related to beneficiary eligibility and has fixed the issue. If you are a pharmacy provider that received Reject Code 65, please resubmit your claims. We apologize for the inconvenience this may have caused.
75: Prior Authorization Required	If you receive Reject Code 75 from Medi-Cal Rx for a claim and you have evidence the beneficiary has a valid approved PA and/or a prior paid claim in your system, please resubmit the claim to Medi-Cal Rx with a value of **55555** in the **Prior Authorization Number Submitted** field (462-EV). Your attestation is subject to audit.
76: Plan Limitations Exceeded for opioid claims	While there are many situations in which Reject Code 76 is returned, specifically for opioid claims it can be returned when the **cumulative** Morphine Milligram Equivalents (MME) calculated across all active claims exceeds 90 mg. This alert can be overridden by a pharmacist. Please submit appropriate Drug Utilization Review (DUR) codes if the dose is deemed medically necessary.
88: DUR Reject Error	Pharmacy providers will need to review and resolve each identified DUR conflict and if a pharmacist in their professional judgment determines that dispensing the prescription is medically necessary or that benefits of the treatment outweigh the risks, the claim denial can be overridden at Point of Service (POS) in real time. Pharmacy providers will then resubmit the claim with an appropriate DUR response.

Prior Authorization

- Do not bill with a Managed Care Plan (MCP) PA or a Medi-Cal FFS Treatment Authorization Request (TAR) or Service Authorization Request (SAR).
- You may check if a drug is a Medi-Cal Rx benefit by using either the Drug Lookup Tool or the Medi-Cal Rx CDL.
- Review the Medi-Cal Rx Pharmacy Transition Policy and Five Ways to Submit a Prior Authorization (PA) Flyer.
- The Prior Authorization (PA) Case Review Process Flyer illustrates the case review process for claims that do not meet Auto-PA rules.
- If you have evidence the beneficiary has a valid approved PA and/or a prior paid claim in your system, please resubmit the claim to Medi-Cal Rx with a value of **55555** in the **Prior Authorization Number Submitted** field (462-EV). Your attestation is subject to audit.

Claims Cutoff

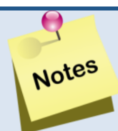
Pharmacy claims with Dates of Service (DOS) **prior to 01/01/2022** will need to be sent to the beneficiary's designated Managed Care Plan (MCP). FFS claims, regardless of DOS, received **on/after 01/01/2022** will be sent to Medi-Cal Rx. Refer to the Countdown to Go-Live – Are You Aware of the Cutoff Dates? alert.

Coordination of Benefits

Because Medi-Cal Rx is always the payer of last resort, claims should be billed to the beneficiary's primary payer prior to submitting the claims to Medi-Cal Rx. Coordination of Benefits (COB) claims will be processed accordingly. See the *Coordination of Benefits (COB)* section of the Medi-Cal Rx Provider Manual for more detailed information.

Crossover Claims

Submit non-automatic pharmacy crossovers using National Drug Codes (NDCs) on the Universal Claim Form (UCF) or the California Specific Pharmacy Claim Form (**30-1**).



- **Providers must identify a Crossover claim on the UCF by notating "Crossover" on the claim form.**

See the *Medicare Part B Crossover Claims* section of the Medi-Cal Rx Provider Manual. Please note that crossover claims do not require a PA request. Straight Medi-Cal Rx claims for Medicare denied or noncovered services may require a PA request. Review the Medi-Cal Rx CDL for a comprehensive list of covered services.

Share of Cost (SOC)

- To clear a beneficiary's SOC, providers will need to access the Automated Eligibility Verification System (AEVS) or Transaction Services on the Medi-Cal website and enter a provider number, Provider Identification Number (PIN), beneficiary identification number, Benefits Identification Card (BIC) issue date, billing code, and service charge. The SOC information is **updated**, and a response is displayed on the screen or relayed over the telephone. For more information on SOC clearance, please consult the *Share of Cost (SOC)* section of the Medi-Cal Rx Provider Manual.
- Beginning January 1, 2022, field 28 (**Patient's Share**) on the California Specific Pharmacy Claim Form (30-1), field 29 (**Patient's Share**) on the California Specific Compound Pharmacy Claim Form (30-4), field 81 (**Patient Paid Amount**) on the Universal Claim Form (UCF), Version D.0, or field 433-DX (**Patient Paid Amount Submitted**) on the NCPDP Version D.0 B1 transaction are not required and should be **left blank**.
- If you receive a denial for SOC 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. Please refer to the AEVS: Transactions section of the *Medi-Cal Provider Manual*.
- You can also view the Medi-Cal Rx Share of Cost alert for more detailed information.

BIC/CIN

- Claims must be billed with the beneficiary's Benefits Identification Card (BIC), Client Index Number (CIN), or Health Access Program (HAP) card number to successfully bill for the medication.
- Claims billed with the Managed Care Plan (MCP) plan ID number will be denied.
- Providers can look up beneficiary eligibility by logging in to the secured Medi-Cal Rx Provider Portal.
- You can also review the Requirements for Medi-Cal Rx Claims alert for more detailed information.

Newborn Claims

Services to an infant may be billed with the mother's ID for the month of birth and the following month only, </= 60 days. After this time, infants must have their own Medi-Cal ID number.

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 Medi-Cal Rx ID number.

Follow the below instructions to submit claims for newborn beneficiaries </= 60 days.

- Insured's ID Number:
  - Enter the mother's BIC ID.
- Insured/Patient Name (First and Last):
  - Enter the mother's first and last name.
- Relationship Code (NCPDP Field ID 306-C6):
  - 03 – Dependent
- Prior Authorization Type Code (NCPDP Field ID 461-EU):
  - 8 – Payer Defined Exemption
- In the **Specific Details/Remarks Field** enter "Newborn using mother's ID" with the infant's name, sex, and date of birth. If the infant has not yet been named, write the mother's last name followed by "Baby Boy" or "Baby Girl." Newborns from a multiple birth must also be designated by number or letter (e.g., "Twin A" and "Twin B").

- **Newborn claims submitted after the above-mentioned time frame will deny with NCPDP EC 600 – Coverage Outside of Submitted Date of Service.**

Refer to the *Newborns* section of the Medi-Cal Rx Provider Manual for additional information.

Cost Ceiling

Medi-Cal Rx will have a cost ceiling of $10,000.00 for all drugs except for the classes noted in the *Cost Ceiling* section of the Medi-Cal Rx Provider Manual.

Banking Identification Number (BIN), Processor Control Number (PCN), and Group Number

Effective January 1, 2022, bill all pharmacy claims to Medi-Cal Rx with the **new** BIN, PCN, and group number.

- BIN: 022659
- PCN: 6334225
- Group: MEDICALRX

Contact Information

Medi-Cal Rx provides a wide range of contacts and resources for your convenience.

Department	Contact Information
Customer Service Center (CSC)	Toll-free number: 1-800-977-2273, available 24 hours a day, 7 days a week, 365 days per year.
Pharmacy Service Representatives (PSRs)	Email Education and Outreach requests to: MediCalRxEducationOutreach@magellanhealth.com
Live Chat & Messaging	For assistance, visit the Medi-Cal Rx Provider Portal's Contact Us page.
PSR-Hosted Office Hour Luncheon	Please join our Medi-Cal Rx Office Hour Luncheon, each business day from 12 p.m. – 1 p.m. Pacific, for registration and troubleshooting assistance. **Zoom Meeting Link:** https://magellanhealth.zoom.us/j/94964434351?pwd=c1l4cC9oTUNod2tkYm5RRmJmeklUQT09&from=addon Meeting ID: 949 6443 4351 Password: 655990 Dial In: 1-888-788-0099 (US Toll Free)