

# Home Infusion and Compound Drugs

## Introduction

### Purpose

The purpose of this module is to provide an overview of billing procedures for paper and electronic claim submissions for home infusion and compound drug claims.

### Module Objectives

- Provide information resources
- Understand billing requirements for electronic and paper compound drug claim submissions
- Prevent common denials
- Discuss changes in Medi-Cal

### Resource Information

#### **Medi-Cal Subscription Service (MCSS)**

MCSS is a free subscription service that enables providers and others interested in Medi-Cal to receive subject-specific links to Medi-Cal news, *Medi-Cal Update* bulletins, urgent announcements and/or System Status Alerts via email. For more information and subscription instructions, visit the MCSS Subscriber Form at ([www.medi-cal.ca.gov/mcss](http://www.medi-cal.ca.gov/mcss)).

#### **Provider Manual References**

##### Part 2

*Compound Drug Pharmacy Claim Form (30-4) Completion* (compound comp)

- Provides detailed instruction on how to submit the paper claim

*Compound Pharmacy Claim Form (30-4) Examples* (compound ex)

- Provides samples of paper claim submissions, including:
  - Compounded intravenous prescription
  - Compounded drug with more than 25 ingredients

*Pharmacy Claim Form (30-1): Special Billing Instructions* (pcf30-1 spec)

*Drugs: Contract Drugs List Introduction* (drugs cdl intr)

- Provides the Medi-Cal formulary

*Reimbursement* (reimbursement)

### **Medi-Cal Website**

From the Medi-Cal home page ([www.medi-cal.ca.gov](http://www.medi-cal.ca.gov)), click on the “Publications” tab:

- Select “Provider Manuals” and scroll down to “Pharmacy” to access the pharmacy provider manuals, or
- Select “Provider Bulletins” and scroll down to “Pharmacy (PH)” to access updated announcements on billing instructions and drug coverages

## **Program Coverage**

Prescribed drugs listed on the Contract Drugs List, as well as unlisted drugs approved by authorization that require special compounding by the pharmacist, are covered by the Medi-Cal program, provided that the name, quantity and principal labeler of each ingredient are listed on the claim.

Legend drugs that are listed on the Contract Drugs List of the Part 2 provider manual are covered by the Medi-Cal program. Legend drugs not listed may be covered subject to authorization from a Medi-Cal field office consultant.

Non-legend, over-the-counter (OTC) drugs that are listed in the Contract Drugs List are covered by the Medi-Cal program. OTC drugs not listed, and not otherwise excluded, may be covered subject to authorization from a Medi-Cal field office consultant.

The maximum reimbursement for compounded prescriptions is the total of ingredient costs, professional fees and the compounding fees (reimbursement is reduced by an amount as described under “Pharmaceutical Services” in this section). See the *Pharmacy Claim Form (30-1): Special Billing Instructions* (pcf30-1 spec) section in the Part 2 provider manual for more information. The amount charged is not to exceed the charge to the general public for such prescriptions.

# Claims Billing Methods

## Electronic Claims

- On-Line Point of Service (POS)
- Real-Time Internet Pharmacy (RTIP)
- Advantages
  - National (NCPDP D.0) standards for claim submissions
  - Real-time, online
  - Accurate
  - Easy to process
  - Instant eligibility
  - Fast: immediate claim adjudication
  - If incorrect, claim can be resubmitted
  - No mailing cost
- Disadvantages
  - Can only bill for 25 ingredients (including the container counts)
  - May have to modify your prescription processing system
    - System vendor can find the standard rules for billing (Payer Sheet) at: ([http://files.medi-cal.ca.gov/pubsdoco/Publications/masters-other/5010/20889\\_1\\_payer\\_sheet.pdf](http://files.medi-cal.ca.gov/pubsdoco/Publications/masters-other/5010/20889_1_payer_sheet.pdf))
  - Requires Internet access
  - Requires provider to be authorized to submit online claims
    - Call the Telephone Service Center (TSC) at 1-800-541-5555 for information on how to set up a *Medi-Cal Point of Service (POS) Network/Internet Agreement*
    - URL: ([www.medi-cal.ca.gov/signup.asp](http://www.medi-cal.ca.gov/signup.asp)), under “Pharmacy (RTIP)”

## Paper (Hard Copy) Claims

- Use the Pharmacy 30-4 form for compound drug billing
  - Do not use the 30-1 form, which is for single ingredient billing
- To order forms, call the Telephone Service Center (TSC): 1-800-541-5555
- Advantages of using paper claims:
  - Attachments can be submitted
  - Ability to bill more than 25 ingredients
- Disadvantages:
  - Longer processing time
  - Possibility for errors to occur during the scanning process
  - Mailing cost

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### General rules to prevent incorrect processing or return of claims:

- Fill out the information within the allotted space for each field
- No decimal points
- No dollar (\$) signs
- Use 10-point font or larger
- Keep the printer ink/ribbon full to ensure proper and readable printed information on the claim form
- Typewriter font: Elite or Pica
  - Avoid handwriting if at all possible due to potential for errors
- Computer-generated forms: Any fonts and/or font size that would allow all the information to fit into the allotted space of the fields.
- Do not interfere with the barcode area (outlined in red below) on the claim form:

DO NOT STAPLE IN BAR AREA

CLAIM CONTROL NUMBER \* FOR F.I. USE ONLY

Fasten Here

1

2

3

4

3A

Provider Name, Address, Phone

COMPOUND DRUG PHARMACY CLAIM FORM

STATE OF CALIFORNIA  
DEPARTMENT OF HEALTH  
CARE SERVICES

ELITE PICA

ELITE PICA

TYPEWRITER ALIGNMENT

- If attachments are required, ensure that staples go in the appropriate “Fasten Here” area of the claim form (circled in red above)
  - Do not skip lines
  - Do not leave blank lines or “0” quantities
  - Do not use Wite-Out or other correction fluids/materials

### Attachments

- When compounds contain more than 25 ingredients, please list the remainder of the ingredients on a separate sheet to attach to the claim form.
- Do NOT attach the following:
  - TAR approvals or request forms
  - Catalog pages for items with NDC numbers
  - Prescription copies, order sheets, etc.

# RTIP (Online Claim Submission)

The following provides step-by-step instructions for submitting a compound claim through Real-Time Internet Pharmacy (RTIP).

1. On the home page of the Medi-Cal website ([www.medi-cal.ca.gov](http://www.medi-cal.ca.gov)), click the “Transactions” tab to access the login screen for RTIP:

CA .GOV Department of Health Care Services Medi-Cal

Home Transactions Publications Education Programs References Contact Medi-Cal

System Services Available Enrollment Requirements

Home

**Login to Medi-Cal**

40 days 10 hours 31 minutes 25 seconds

until the HIPAA 4010 and NCPDP 5.1/1.1 formats will no longer be accepted. For information about the new HIPAA formats, see the HIPAA: 5010/NCPDP D.0 & 1.2 page.

Please enter your User ID and Password. Click Submit when done.  
Visit [Transaction Enrollment Requirements for Medi-Cal](#).

Please enter your User ID:

Please enter your Password:

Submit Clear

**TRANSACTIONS**

- User ID & Password Help
- Services Available

2. On the “Claims” tab, select “RTIP”:

CA .GOV Department of Health Care Services Medi-Cal

Home Transactions Publications Education Programs References Contact Medi-Cal

System Services Available Enrollment Requirements

Home

**Claims**

→ Internet Professional Claim Submission (IPCS)

→ **Real Time Internet Pharmacy Claims (RTIP)**

→ Batch Claim Status

**TRANSACTIONS**

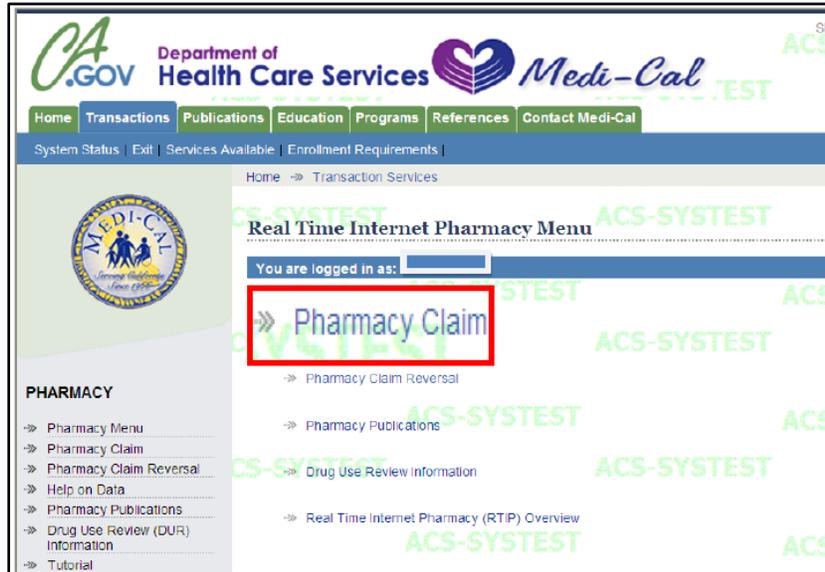
- CMC
- Data Uploads
- Letters
- Subscriber Status
- Batch Internet Eligibility
- Submissions
- Error Reports
- CRUI Issue Inquiry
- Inquiry on CMC
- NCPDP Response Files

→ **Claims**

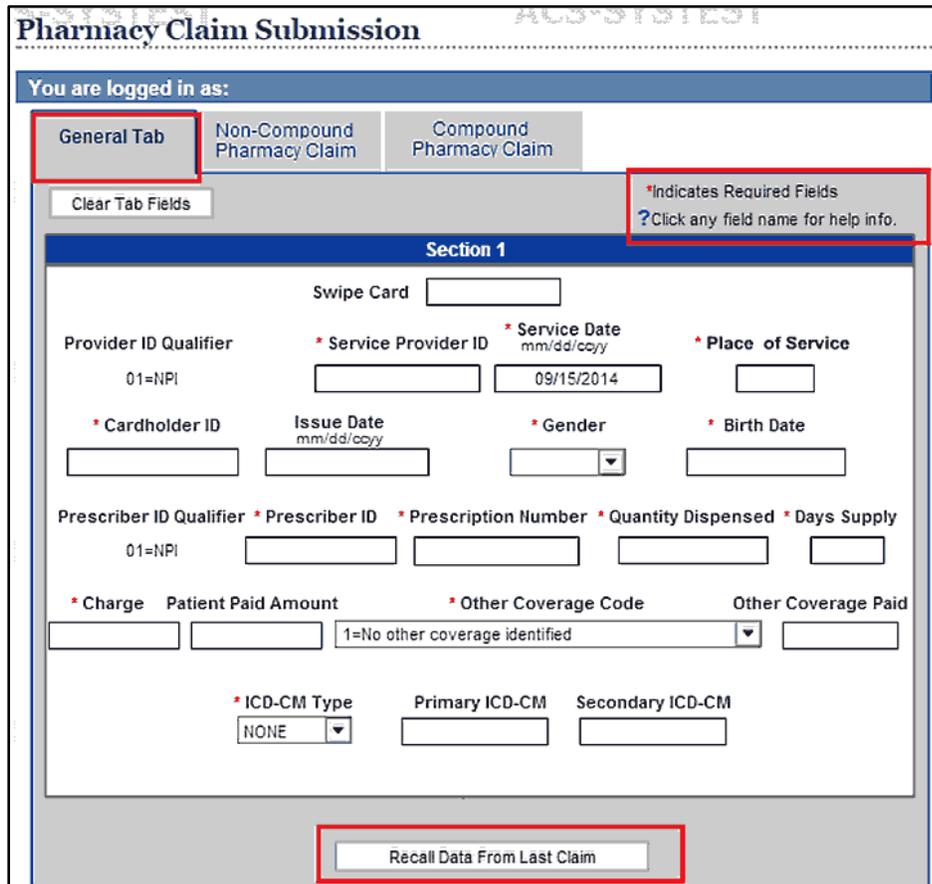
- IPCS
- **RTIP**

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3. Select "Pharmacy Claim":



4. Start with the "General Tab" to fill in all the required information and any optional data for the claim submission:



- a. Any fields designated by “\*” require information for the claim submission.
- b. On any field, help information is available by placing the mouse over the field title and left-clicking. A small help screen will appear with a definition of the field data.
- c. The “Recall Data From Last Claim” button is helpful if you are submitting multiple claims for a single patient. The system re-populates pertinent/required information, eliminating the need to re-type data in each field.
- d. The “Clear Tab Fields” button clears all form fields in one step.
- e. **Provider ID Qualifier:** Only a 10-digit NPI will be accepted. Do not submit claims using a Medicare provider number or state license number. You must enter this information for your claim to process successfully.
- f. **Service Date:** Enter the date the prescription was filled in eight-digit MMDDYYYY (Month, Day, Year) format (for example, January 6, 2015 = 01062015). Do not bill Medi-Cal until the patient or a representative of the patient has received the prescription. You must enter this information for your claim to process successfully.
- g. **Place of Service:** Enter a valid two-digit code that represents Place of Service location. Refer to the Department of Health Care Services (DHCS) California Medicaid Management Information System (CA-MMIS) *NCPDP Standard Payer Sheet*, field number 307-C7 for a list of valid Place of Service codes. You must enter this information for your claim to process successfully.
  - Examples of codes:
    - 12 = Home
    - 13 = Assisted Living Facility
    - 14 = Group Home
    - 20 = Urgent Care Facility
    - 21 = Inpatient Hospital
    - 22 = Outpatient Hospital
    - 23 = Emergency Room
    - 24 = Ambulatory Surgical Center
    - 31 = Skilled Nursing Facility
    - 32 = Nursing Facility
    - 33 = Custodial Care Facility
    - 34 = Hospice
    - 54 = Intermediate Care
- h. **Cardholder ID:** Enter the 9, 10 or 14-character recipient ID number as it appears on the Benefits Identification Card (BIC). You must enter this information for your claim to process successfully. A Social Security Number (SSN) is not allowed for billing.

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- i. **Issue Date:** Enter the Issue date on the Benefits Identification Card (BIC) in MMDDYYYY (Month, Day, Year) format. This information is required if an ID other than the 14-character BIC ID is entered in the Cardholder ID field.
- j. **Prescription Number:** Enter your prescription number in this space for reference on the *Remittance Advice Details* (check warrant and voucher). A maximum of 12 digits may be used. You must enter this information for your claim to process successfully.
- k. **Quantity Dispensed:** Enter the total quantity dispensed. Do not include measurement units such as Gm, CC or ML. Enter the quantity in 9999999.999 format. You must enter this information for your claim to process successfully. Providers are reminded that the quantity should represent the metric measurement of the actual compounded product dispensed. If the dispensed amount is liquid, then the value should represent the amount in milliliters (mL). If the product dispensed is a cream or ointment, the value should represent the amount in grams (G). If the product dispensed is a capsule or tablet or suppository, the value should represent each unit (E). Providers are also reminded that the quantity dispensed represents the total amount dispensed. For example, if the quantity dispensed is seven bags containing 110mL per bag, the quantity dispensed should be 770mL.
- l. **ICD-CM Type:** Enter the ICD code type. The following values are available in this field:
  - NONE
  - ICD-9
  - ICD-10

Users should choose "NONE" only if the claim does not require an ICD code in the *Primary Diagnosis Code* field. The value "NONE" is the default value.

Users choosing "ICD-10" are required to enter an ICD-10 code in the *Primary Diagnosis Code* field. The *Secondary Diagnosis Code* field is optional, but any secondary code entered must be an ICD-10 code.

- m. **Charge:** Enter the dollar and cents amount for this item, including the decimal point (.) to show cents, but not including a dollar (\$) sign. If the item is taxable, include the applicable state and county sales tax. Compounding, professional and sterility testing fees should be included in this total. You must enter this information for your claim to process successfully.
- n. **Patient Paid Amount:** Enter the full dollar amount of the patient's Share of Cost (SOC) for the procedure, service or supply. Include the decimal point (.) when indicating cents. Do not include a dollar (\$) sign. Leave blank if not applicable. For more information, see the *Share of Cost (SOC): 30-1 for Pharmacy* section of the Part 2 provider manual.
- o. **Other Coverage Code:** Select the appropriate code that indicates whether the patient has other insurance coverage, and if so, the extent and status of the coverage for the claim being submitted.
- p. **Other Coverage Paid:** Enter the full dollar amount of payment received from other coverage carriers. Use the decimal point (.). Leave blank if not applicable.
5. Select the "Compound Pharmacy Claim" tab and continue to fill in the required fields and any additional/optional claim information:

The screenshot displays the 'Compound Pharmacy Claim' tab. At the top, there are three tabs: 'General Tab', 'Non-Compound Pharmacy Claim', and 'Compound Pharmacy Claim' (which is selected and highlighted with a red box). Below the tabs, there are buttons for 'Clear Tab Fields' and 'Submit', along with a legend: '\*Indicates Required Fields' and '?Click any field name for help info.'.

The main form area contains the following fields:

- Product ID Qual:** 99=Other
- Product ID:** 0=Compound
- \* Submission Clarification:** 0=Not Specified (dropdown)
- Incentive Amount:** 0.00
- Prior Auth Type Code:** (dropdown)
- TCN/Discharge Date:** mm/dd/yyyy
- \* Route of Administration:** (dropdown)
- \* Dosage Form Desc Code:** (dropdown)
- \* Disp Unit Form Ind:** (dropdown)

Below these fields is a section titled 'Compound Ingredients' with a table for listing ingredients. The table has the following columns: Ingredient, Product ID (NDC), Quantity, Cost, and Basis of Cost. The 'Basis of Cost' dropdown is currently set to 'Not Specified'. Below the table are buttons for 'Remove', 'Add', 'Edit', and 'Save'.

At the bottom of the form is a button labeled 'Recall Data From Last Claim'.

- a. **Submission Clarification:** Select 7 (Medically Necessary) if the drug is subject to Code 1 restrictions and these restrictions have been met. Select 8 (Process for Approved Ingredients) if you would like the claim to be processed even if all of the ingredients are not covered by Medi-Cal. Ingredients that are not covered will be paid zero. Select 99 (Other) if Code 1 is met AND you would like the submission to be processed for approved ingredients only. Select 00 (Not Specified) if not applicable. You must enter this information for your claim to process successfully.
- b. **Incentive Amount:** Enter the sterility test fee, if sterility testing was performed. Include the decimal point (.) when indicating cents. This field is not required.
- c. **Prior Auth Type Code:** Select the appropriate code that indicates whether authorization or a payer-defined exemption (discharge date) is required. This field must be selected if a TAR control number or a discharge date is included on the claim.
- d. **TCN/Discharge Date:** If, in the "Prior Authorization Type Code" selection box, 1=Prior Authorization (TAR) is selected, then the TAR control number is required. Enter the 11-digit TAR control number from the approved TAR. Recipient, quantity, drug, compound ingredients and date of service on the claim must agree with the information on the TAR. If, in the "Prior Authorization Type Code" box, 8=Payer Defined Exemption (Discharge Date) is selected, then enter the discharge date in MMDDYYYY format. If the date of service is 10 days or less from the discharge date, then certain I.V. products that require a TAR will be payable without a TAR.
- e. **Route of Administration:** Select the appropriate code that describes the way the complete compound mixture will be administered. You must enter this information for your claim to process successfully. Codes include:

01: Buccal	12: Other/Miscellaneous
02: Dental	13: Otic
03: Inhalation	14: Perfusion
04: Injection	15: Rectal
05: Intraperitoneal	16: Sublingual
06: Irrigation	17: Topical
07: Mouth/Throat	18: Transdermal
08: Mucous Membrane	19: Translingual
09: Nasal	20: Urethral
10: Ophthalmic	21: Vaginal
11: Oral	22: Enteral

- f. **Dosage Form Desc Code:** Select the appropriate code that describes the dosage form for the complete compound mixture. You must enter this information for your claim to process successfully.

01: Capsule	11: Solution
02: Ointment	12: Suspension
03: Cream	13: Lotion
04: Suppository	14: Shampoo
05: Powder	15: Elixir
06: Emulsion	16: Syrup
07: Liquid	17: Lozenge
10: Tablet	18: Enema

- g. **Disp Unit Form Ind:** Select the appropriate NCPDP standard unit of measure for the final compound mixture.
- Manufactured capsules, tablets, powder vials are measured as **each (E)**.
  - Ointments, creams and dry products, such as powders, are measured in **grams (G)**.
  - Liquids, including injections, are measured in **milliliters (M)**.
- h. **Product ID (NDC):** Enter the National Drug Code (NDC). All NDC numbers must be 11 digits long. NDCs printed on packages often have fewer than 11 digits, with hyphens (-) separating the number into three segments. For a complete 11-digit number, the first segment must have five digits, the second segment four digits and the third segment two digits. Add leading zeroes wherever they are needed to complete a segment with the correct number of digits. To bill for containers, use product ID 9999999997.
- i. **Ingredient Quantity:** Enter the amount of the product included in the compound mixture, expressed in metric decimal units. Enter the quantity in 999999.999 format. When indicating the number of containers (with product ID 9999999997), enter a whole number less than 1000.
- j. **Ingredient Cost:** Enter the ingredient cost for the metric decimal quantity of the product included in the compound mixture indicated in "Compound Ingredient Quantity."
- k. **Basis of Cost:** This field indicates the method by which the ingredient cost was calculated. Select "08=Disproportionate Share/Public Health Service" if the cost basis is Disproportionate Share/Public Health Service; otherwise, select the default value of "00=Not Specified." You must enter this information for your claim to process successfully.

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6. Hit "Submit" when all fields for the claim have been filled out.
7. Examples of a Compounded Intravenous Prescription:

General Tab | Non-Compound Pharmacy Claim | **Compound Pharmacy Claim**

Clear Tab Fields | \*Indicates Required Fields | Submit

?Click any field name for help info.

**Product ID Qual** 99=Other | **Product ID** 0=Compound | **\* Submission Clarification** 7=Med. Nec. (Code 1 met)

**Incentive Amount** 0.00 | **Prior Auth Type Code** 8=Payer Defined Exemption(Discharge D) | **TCN/Discharge Date** mm/dd/ccyy 11/20/2012

**\* Route of Administration** Injection = 424109004 | **\* Dosage Form Desc Code** 07=Liquid | **\* Disp Unit Form Ind** 3=Milliliters

**Compound Ingredients**

* Product ID (NDC)	* Ingredient Quantity	* Ingredient Cost	* Basis Of Cost
			Not Specified

Remove Add Edit Save

Ingredient	Product ID (NDC)	Quantity	Cost	Basis of Cost
1	00338055318	1400.000	203.00	Not Specified
2	60505068704	14.000	300.57	Not Specified
3	99999999999	14.000	0.00	Not Specified

8. After selecting "Submit": Review the message for successful claim adjudication by reviewing the amount paid on the Host Response screen. If the claim payment is unacceptable due to a possible error, the claim can be edited for re-submission by selecting "Edit Claim." If the claim payment is as expected, move on by selecting "Enter New Claim."

**Host Response**

Submitter:

Service Provider ID:  
 Pharmacy transaction status: Accepted-To see if your claim processed successfully, see claim status below.  
 Claim Date of Service: 11/21/2012  
 Provider Mail Message: The System will be unavailable at 23:59.  
 Claim Status: Claim Payable  
 Prescription Number: 012345678910  
 Amount Paid: \$434.14  
 Message:

Edit Claim | Enter New Claim | Print Claim

9. Pharmacy Claim Reversal

- a. Select the “Pharmacy Claim Reversal” option (below the “Pharmacy Claim” option):



- b. Select “Recall Data from last Transaction”:



- c. For reversing a compound claim in RTIP, use “0” for the Product ID. This is the NCPDP product ID value to indicate a compound drug.

# Paper Claim (Pharmacy 30-4 Claim Submission)

For most fields on the paper claim, the required data is the same as for RTIP billing. There are only a few differences to note:

## Prescription Number

- RTIP: Prescription number is 12 bytes/digits
- 30-4 paper claim form, box 10: Prescription number is 7 bytes/digits

## Code 1 Restriction

- RTIP: Option 07 (Medically Necessary) under Submission Clarification is used to indicate the Code 1 restriction has been met. Please refer to the Submission Clarification entry discussed earlier in the billing section.
- 30-4 paper claim form, box 13: Indicate “Y” (yes) if the Code 1 restriction for the drug has been met.

## Patient Location

- RTIP: This field is required. Information must be entered in order for the claim to be processed successfully.
- 30-4 paper claim form, box 15: This is an optional field. If the field is blank, the system calculates the professional fee at \$7.25. If the patient resides in a Nursing Facility as described below, and this is indicated on the claim, the professional fee will be \$8.00.
- If the patient resides in a Nursing Facility, select one of the following codes:
  - C = Nursing Facility (NF) Level A
  - 4 = Nursing Facility (NF) Level B
  - F = Nursing Facility (NF) Level B (Adult Subacute)
  - F = Subacute Care Facility
  - G = Intermediate Care Facility – Developmentally Disabled (NF-A/DD)
  - H = Intermediate Care Facility – Developmentally Disabled, Habilitative (NF-A/DD-H)
  - I = Intermediate Care Facility – Developmentally Disabled, Nursing (NF-A/DD-N)
  - M = Nursing Facility Level B (Pediatric Subacute)

## Primary ICD-CM

- RTIP: The information for this field is dependent on the option chosen for the *ICD-CM Type* field. Review the “RTIP (Online Claim Submission)” section above regarding ICD type and Primary ICD codes.
- 30-4 paper claim form, box 19: This field is optional. Unlike RTIP, there is no separate field for ICD-CM type indication. Providers must input an ICD indicator (“0”) as the first digit in the field with no spaces or dashes separating it from the diagnosis code. Enter ICD indicator “0” followed by an ICD-10 code.

6 MEDICAL IDENTIFICATION				C D H I G C I K T
12 TOTAL METRIC QUANTITY		13 CODE 1 MET?		
WHOLE UNITS		DECIMAL		Y
19 PRIMARY ICD-CM		20 SECONDARY ICD-CM		
0D1D1D1D				

**Secondary ICD-CM**

- RTIP: The information for this field is dependent on the option chosen for the *ICD-CM Type* field. Review the RTIP section regarding ICD type and Secondary ICD codes.
- 30-4 paper claim form, box 20: This field is optional, no ICD indicator is required in the *ICD-CM* field. If ICD indicator “0” is in the *Primary ICD-CM* field, then an ICD-10 code must be utilized for this field.

**Total Charge, Ingredient Charge, Incentive Amount, and Patient Paid Amount**

- RTIP requires a decimal (.) between dollars and cents; i.e., \$324.19. If there is no decimal, then the system adds “.00”; i.e., \$32419.00. Do not enter a dollar (\$) sign on RTIP or on a paper claim.
- 30-4 paper claims do not require decimals to differentiate between dollars and cents. There is a field separation pre-printed on the form to distinguish the difference:

5 PATIENT NAME (LAST, FIRST, MI) SMITH, JANE		6 MEDICAL IDENTIFICATION 90000000A95001		7 SEX F	8 DATE OF BIRTH 03 08 1945	9 DATE OF ISSUE 02 01 2003
10 PRESCRIPTION NO. 1234567	11 DATE OF SERVICE 03 02 2007	12 TOTAL METRIC QUANTITY WHOLE 22000 . DECIMAL	13 CODE 1 MET? Y	14 DAYS SUPPLY 10	15 PATIENT LOCATION DISP UNIT FORM NO 3	16 MEDICARE STATUS ROUTE OF ADMN 04
17 ID QUAL 08	18 PRESCRIBER ID 9876543210	19 PRIMARY ICD-CM	20 SECONDARY ICD-CM	21 DRUG FORM DESC CODE 11	22 INCENTIVE AMOUNT 3 20	23 TAR CONTROL NO 12345678901
24 TOTAL CHARGE 636444	25 OTHER COVERAGE PAID	26 OTH COV CODE 0	27 PATIENT'S SHARE	28 INGREDIENT CHARGE 1719 30 25 00 34 60	29 BASIS OF COST	
30 PROD ID QUAL	31 INGREDIENT PRODUCT ID	32 INGREDIENT QUANTITY		33 INGREDIENT CHARGE		
1 03	00074721703	WHOLE 11000 . DECIMAL	1719 30			
2 03	00517505001	WHOLE UNIT 100 . DECIMAL	25 00			
3 03	00186423962	WHOLE UNITS 2 . 500	34 60			

### Quantity Dispensed and Ingredient Quantity fields

- RTIP requires quantity in 9999999.999 format, including the decimal point.
- 30-4 paper claims do not require a decimal to differentiate between a whole number and tenths or hundredths. The fields already have a decimal pre-printed on the form:

10 PRESCRIPTION NO 1234567	11 DATE OF SERVICE 03 02 2007	12 TOTAL METRIC QUANTITY WHOLE 22000 . DECIMAL	13 CODE 1 MET? Y	14 DAYS SUPPLY 10	15 FAULTS/ LOCATION	16 REFILL STATUS
17 ID QUAL 08	18 PRESCRIBER ID 9876543210	19 PRIMARY ICD-CM	20 SECONDARY ICD-CM	21 DOSG FORM DESC CODE 11	22 DSP UNIT FORM IND 3	23 ROUTE OF ADMIN 04
24 TOTAL CHARGE 636444	25 OTHER COVERAGE PAID	26 OTH COV CODE 0	27 PATIENT'S SHARE	28 INCENTIVE AMOUNT 3 20	29 TAR CONTROL NO 12345678901	
30 PROD ID QUAL 1 03	31 INGREDIENT PRODUCT ID 00074721703	32 INGREDIENT QUANTITY WHOLE 11000 . DECIMAL		33 INGREDIENT CHARGE 1719 30	34 BASIS OF COST	
2 03	00517505001	WHOLE UNITS 100 . DECIMAL		25 00		
3 03	00186423962	WHOLE UNITS 2 . DECIMAL		500		
4 03	00074120001	WHOLE UNITS 10 . DECIMAL		135 00		
5 03	00469031163	WHOLE UNITS 46 . DECIMAL		2 80		

### Ingredient Product ID Qualifier

- RTIP does not require a value
- 30-4 paper claims require a code to indicate type of ingredient to be entered in field 31:

30 PROD ID QUAL	31 INGREDIENT PRODUCT ID	32 INGREDIENT QUANTITY	33 INGREDIENT CHARGE	34 BASIS OF COST
1 03	00074721703	WHOLE 11000 . DECIMAL	1719 30	
2 03	00517505001	WHOLE UNITS 100 . DECIMAL	25 00	
3 03	00186423962	WHOLE UNITS 2 . DECIMAL	500	
4 03	00074120001	WHOLE UNITS 10 . DECIMAL	135 00	
5 03	00469031163	WHOLE UNITS 46 . DECIMAL	2 80	

- Example of values:

Code	Explanation
1	Universal Product Code (UPC)
3	National Drug Code (NDC)
4	Universal Product Number (UPN)
99	Other

### Hospital Discharge Date

- RTIP: Please refer to the TCN/Discharge date field entry as discussed earlier in the billing section.
- 30-4 paper claim, box 38: This is the field to enter the hospital discharge date, if applicable:

35 MEDICAL RECORD NO X12345YU34	36 BILL LIM EX	37 DATE BILLED 9 24 2007	38 HOSP DISCHARGE DATE MM DD YYYY	39 INGREDIENT TOTAL CHARGE 6310 84
SPECIFIC DETAILS/REMARKS:			40 PROC FOR APPROVED INGREDIENTS	41 CONTAINER COUNT 10

## Processed for Approved Ingredient

- RTIP: Please refer to the "Submission Clarification" field entry as discussed earlier in the billing section.
- 30-4 paper claim, box 40: Enter "Y" to process for approved ingredients only. If a "Y" is entered in this field, approved ingredients will be reimbursed, but ingredients not on the list of contract drugs will be paid at \$0. If this field is left blank, any ingredient that requires authorization will cause the claim to be denied. If the compound contains inexpensive ingredients that would not be worth getting authorization for, the provider may want to use this field to expedite payment of the claim.

35 MEDICAL RECORD NO X12345YU34	36 BILL LIM EX 	37 DATE BILLED 9 24 2007	38 HOSP DISCHARGE DATE MM DD YYYY	39 INGREDIENT TOTAL CHARGE 6310.84
SPECIFIC DETAILS/REMARKS:			40 PROC FOR APPROVED INGREDIENTS <input type="checkbox"/>	41 CONTAINER COUNT 10

## Container Count

A *Treatment Authorization Request* (TAR) is required when more than 20 containers are billed for I.V. claims.

- RTIP: For intravenous (I.V.) compound claims, indicate the number of containers by entering a product ID of "9999999997" and the number of containers in the ingredient quantity field. The ingredient cost should be zero when indicating the number of containers.

Compound Ingredients			
* Product ID (NDC)	* Ingredient Quantity	* Ingredient Cost	* Basis Of Cost
9999999997	14.000	0.00	Not Specified
Remove	Add	Edit	Save

- 30-4 paper claim, box 41: Enter the number of container counts.

35 MEDICAL RECORD NO X12345YU34	36 BILL LIM EX 	37 DATE BILLED 9 24 2007	38 HOSP DISCHARGE DATE MM DD YYYY	39 INGREDIENT TOTAL CHARGE 6310.84
SPECIFIC DETAILS/REMARKS:			40 PROC FOR APPROVED INGREDIENTS <input type="checkbox"/>	41 CONTAINER COUNT 10

## Signature of Provider and Date

- RTIP: No signature or date is required
- 30-4 paper claim, box 45: An original signature is required on all paper claims. The claim must be signed and dated by the provider or a representative assigned by the provider. Use black ballpoint pen only. The signature must be written, not printed. Stamps, initials or facsimiles are not acceptable. The signature does not have to be on file with the Fiscal Intermediary (FI). A missing signature will result in the claim being returned.

### Specific Details/Remarks

- RTIP: There is no section for details or remarks.
- 30-4 paper claim: Use this blank space to clarify or detail any line item. Indicate the ingredient line item number being referenced. The *Specific Details/Remarks* area is also used to provide information about crossovers. See the *Medicare/Medi-Cal Crossover Claims: Pharmacy Services* (medi cr ph) section of the Part 2 Pharmacy manual for more information.

### More than 25 Ingredients

- RTIP: There is a limit of 25 product codes; i.e., 25 ingredients or 24 ingredients plus a product ID of "9999999997" for the container count.
- 30-4 paper claim: There are 25 lines for ingredients. If the compound contains more than 25 ingredients, then any additional ingredients will be required to be billed on an attachment.
  - The 25th billing line would require a product ID qualifier of 99 and a product ID of 9999999998. The ingredient quantity and ingredient charges would be the sum of all the remaining ingredients' quantities and charges:

22	03	00074711807	4000	19.20
23	03	00402008530	WHOLE UNITS: 10	2.60
24	03	00074045804	5	12.00
25	99	99999999998	WHOLE UNI: 660	3405.11

35 MEDICAL RECORD NO: X12345YU34  
 36 BILL LIM EX:   
 37 DATE BILLED: 9 24 2007  
 38 HOSP DISCHARGE DATE: MM DD YYYY  
 39 INGREDIENT TOTAL CHARGE: 6310.84

SPECIFIC DETAILS/REMARKS:

40 PROC FOR APPROVED INGREDIENTS:   
 41 CONTAINER COUNT: 10  
 42 F.I. USE ONLY:

- The Compounded Drug Attachment should contain the pharmacy name, provider ID, prescription number and date of service:

### Compounded Drug Attachment

Pharmacy Name:	ABC Home Pharmacy
Provider Number:	0123456789
Prescription Number:	1234567
Date of Service:	03/02/2007

**Additional Compound Ingredients:**

NDC/UPC/HRI #	Quantity	Charge	Description
61703022521	360.00	3386.70	
00517240025	300.00	18.41	
<hr/>			
<b>Totals</b>	660.000	3405.11	

2 – Compounded Drug Attachment Completion PRO Pubs

# Summary and Additional Billing Info

The **ingredient quantity** field is the sum of the amount of that ingredient that is in all containers of the compound. It is not the per-container amount. The **ingredient charge** should reflect the total charge for the ingredient in all containers of the compound. It is not the per-container amount.

## Home Infusion/Compounding Drug Products Reimbursement Chart:

Item Being Billed	Reimbursement
Cost of ingredients	Paid at Estimated Acquisition Cost (EAC)
Cost of supplies consumed in compounding I.V. solution	EAC up to \$5.56 per container
Cost of empty containers <b>Note</b> Empty containers must be billed separately from the compound claim.	Paid at EAC
Cost of sterility testing (only when performed)	Up to \$0.32 per container
Professional fee	\$7.25 per container if compounded, or \$7.25 per prescription, if not compounded
Compounding fee	<p>\$0.99 per container (in addition to professional fee, for compounded solutions only)</p> <p>Capsules, powders, tablets, lozenges:</p> <p>6-36.....\$1.98</p> <p>37 and over.....\$3.95</p> <p>Ointments and creams:</p> <p>1 gm to 179 gm.....\$1.64</p> <p>180 gm and over.....\$3.29</p> <p>Suppositories:</p> <p>1 to 23 .....\$3.29</p> <p>24 and over.....\$5.76</p> <p>Sterile eye preparations:</p> <p>All .....\$2.04</p> <p>Nose and ear preparations:</p> <p>All .....\$0.81</p> <p>Emulsions, lotions:</p> <p>1 cc to 239 cc.....\$0.81</p> <p>240 cc and over.....\$1.64</p> <p>Liquids other than simple pouring or reconstituting solutions, shampoos, elixirs, syrups, suspensions, enemas:</p> <p>All .....\$0.99</p>

## 20 Home Infusion and Compound Drugs

Maximum reimbursement for compounded prescriptions may include any or all of the following:

- Total of ingredient costs
- Professional fees
- Compounding fees

Compounding fees are paid based on the dosage form and route of administration submitted on the compound pharmacy claim. To ensure correct payment, be certain to enter the information correctly.

If the preparation is not for home infusion therapy (capsules, ointments, emulsions, etc.), only one container will be allowed and the cost of supplies, empty containers and sterility testing will not be allowed.

Add-Vantage vial or threaded port vials are not considered to be compounded products.

- Add-Vantage vial or threaded port vials must be billed as non-compound.
- If a TAR is required, then the provider must apply for the TAR as a single drug claim billing.
- If an antibiotic is a continuation drug from the hospital and requires a TAR, this cannot be overridden by the discharge date.
  - Provider must get a TAR with justification of continuation of therapy from hospital discharge.

The rule that states providers must bill within 10 days following the patient's discharge from an acute care hospital applies only when billing for compound drugs.

AIDS or cancer drugs (excluded from the six prescriptions/month limit, per the Contract Drugs List) included as part of the compound drug will also be excluded from the six prescriptions/month limit.

Medical supplies cannot be billed on the 30-4 form. They must be billed using the hard-copy *CMS-1500* claim form or via electronic format.

Effective September 22, 2014, the Department of Health Care Services (DHCS) discontinued accepting Point of Service (POS) device transactions for pharmacy claims.

# Questions and Phone Tree Options

For questions, call the Telephone Service Center (TSC) at 1-800-541-5555 for a TSC agent to assist you with your billing claims needs. If the agent cannot assist you sufficiently, please contact the Provider Regional Representative assigned to your region.

## TSC Main Menu Prompt Options

Telephone Service Center (TSC): 1-800-541-5555

Please select from the following menu:

- Press or say 1 For the Automated Eligibility Verification System
- Press or say 2 For Provider Telecommunications Network
- Press or say 3 For checkwrite
- Press or say 4 For Cancer Detection Programs or the Technical Help Desk, including eTAR
- Press or say 5 For HAP, Family PACT, CHDP, CCS, GHPP, Crossover, LTC and other general billing inquiries
- Press or say 6 For Provider Enrollment, TAR or Every Woman Counts
- Press or say 7 If you are assisting a hearing impaired caller

## Secondary Menu Prompt Options

### Option 4

- Press or say 1 For Cancer Detection Programs
- Press or say 2 For CMC, POS/Internet, eTAR, LSRS, Pharmacy/CALPOS, POS Device, CHDP Gateway, HIPAA or Hospital Presumptive Eligibility
- Press or say 3 For dates and locations of Medi-Cal provider training seminars

### Option 5

- Press or say 1 For HAP or Family PACT
- Press or say 2 For CHDP
- Press or say 3 For CCS or GHPP
- Press or say 4 For Crossover
- Press or say 5 For LTC
- Press or say 6 For general billing
- Press or say 7 For DRG billing

### Option 6

- Press or say 1 For Provider Enrollment
- Press or say 2 For TAR
- Press or say 3 For Every Woman Counts