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

Acronyms

A list of current acronyms is located in the Appendix section of the complete workbook.
Program Coverage

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

The Medi-Cal program covers legend drugs listed on the CDL of the Pharmacy Part 2 provider manual. Legend drugs not listed may be payable subject to authorization from a Medi-Cal field office consultant.

Non-legend drugs or over-the-counter (OTC) products also 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. Please review the Reimbursement (reimbursement) and Pharmacy Claim Form (30-1): Special Billing Instructions (pcf30-1 spec) sections of the Part 2 provider manual for more information. Pharmacy providers offering discounts to the general public must be available on the same terms and conditions to Medi-Cal customers. Failure to do so may result in billing the Medi-Cal program more than the usual and customary amount charged to the general public for the same service and is prohibited by California Code of Regulations (CCR), Title 22, Sections 51480 and 51513 (b)(1)(A), (c) and in accordance with Title 42, Code of Federal Regulations, Part 447.331.
Claims Billing Methods

Electronic Claims

- Online 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)
- Requires Internet access
- Requires provider to be authorized to submit online claims
  - Contact 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), 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
  - Mailing cost
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 on the claim form:
  - If attachments are required, ensure that staples go in the appropriate “Fasten Here” area of the claim form
    - 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 23 ingredients (due to the newly-updated 30-4 form), 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), click the “Transactions” tab to access the login screen for RTIP:

2. On the “Claims” tab, select “RTIP”:
3. Select “Pharmacy Claim”:

![Image of a screen showing the Pharmacy Claim section of a website]

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

![Image of the General Tab section of a claim form]

- Provider ID Qualifier
- * Service Provider ID
- * Place of Service
- * Cardholder ID
- Issue Date
- * Gender
- * Birth Date
- Prescriber ID Qualifier
- * Prescriber ID
- * Proscription Number
- * Fill Number
- * Quantity Dispensed
- * Days Supply
- * Charge
- Patient Paid Amount
- * Other Coverage Code
- Other Coverage Paid
- * ICD-CM Type
- Primary ICD-CM
- Secondary ICD-CM

The image also shows a button labeled “Recall Data From Last Claim.”
a. Any fields designated by "**" require information for the claim submission. You must enter the requested information in the field for your claim to process successfully.

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 and Service Provider ID: The "Provider ID Qualifier" is pre-populated with "01" to identify the NPI number to follow in the "Service Provider ID" field. Only a 10-digit NPI will be accepted. Do not submit claims using a Medicare provider number or state license number.

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.

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.

- Examples of codes:
  01 = Pharmacy
  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.
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. **Gender and Birth Date**: Patient’s gender of female or male. Patient’s Birth Date in MMDDCCYY format, where MM is the two-digit month, DD is the two-digit day, CC is the two-digit century and YY is the two-digit year. An example of a birth date would be 03081945.

k. **Prescriber ID Qualifier** and **Prescriber ID**: The “Prescriber ID Qualifier” is pre-populated with “01” to identify the NPI number to follow in the “Prescriber ID” field. Enter the prescriber’s 10-digit NPI. Do not use the DEA registration number.

l. **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.

m. **Fill Number**: A refill number (0 or 00 for original dispensing, 1 or 01 for the first refill to 99 for the 99th refill) is required in this field.

n. **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.

o. **Days Supply**: Enter the estimated number of days supply for the drug dispensed.

p. **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. Providers are also reminded that the charge is for the total amount dispensed. For example, if the quantity dispensed is seven bags containing 110mL per bag, the quantity dispensed should be 770mL, and the charge should be for 770mL.

q. **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 (share ph) of the Part 2 provider manual.
r. **Other Coverage Code**: Select the appropriate code from the drop-down menu to indicate whether the patient has other insurance coverage, and if so, the extent and status of the coverage for the claim being submitted.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>No other coverage identified</td>
</tr>
<tr>
<td>2</td>
<td>Other coverage exists—payment collected</td>
</tr>
<tr>
<td>3</td>
<td>Other coverage exists—this claim not covered</td>
</tr>
<tr>
<td>4</td>
<td>Other coverage exists—payment not collected</td>
</tr>
</tbody>
</table>

s. **Other Coverage Paid**: Enter the full dollar amount of payment received from other coverage carriers. Use the decimal point (.). Leave blank if not applicable.

t. **ICD-CM Type, Primary ICD-CM and Secondary ICD-CM**: 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.
5. Select the “Compound Pharmacy Claim” tab and continue to fill in the required fields and any additional/optional claim information:

![Compound Pharmacy Claim Form]

- **Product ID Qual**: 99=Other, 0=Compound
- **Product ID**: 0=Not Specified
- **Incentive Amount**: 0.00
- **Prior Auth Type Code**:
- **TCN/Discharge Date**: 04/01/19
- **Route of Administration**:
- **Dosage Form Des Code**:
- **Disp Unit Form Ind**: 0

### Compound Ingredients

<table>
<thead>
<tr>
<th>Ingredient</th>
<th>Product ID (NDC)</th>
<th>Quantity</th>
<th>Cost</th>
<th>Basis of Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

[Recall Data From Last Claim]
a. **Submission Clarification:** Select the appropriate options from the drop-down menu.

```
0=Not Specified
7=Med. Nec. (Code 1 met)
8=Process Compound for Approved Ingredients
99=Other (Code 1 met and Process for Approved Ingredients)
```

Select “7” (Medically Necessary) if the drug(s) is/are subject to Code 1 restrictions and these restrictions have been met per the CDL requirement(s).

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 covered per the CDL will be paid accordingly, while ingredients not covered will not be paid.

Select 99 (Other) if Code 1 is met AND you would like the submission to be processed for approved ingredients only.

Select 0 (Not Specified) if the other three options are not applicable.

b. **Incentive Amount:** Enter the sterility test fee, if sterility testing was performed. Include the decimal point (.) when indicating cents.

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.

```
1=Prior Authorization(TAR)
8=Payer Defined Exemption(Discharge Date)
```

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
02: Dental
03: Inhalation
04: Injection
05: Intraperitoneal
06: Irrigation
07: Mouth/Throat
08: Mucous Membrane
09: Nasal
10: Ophthalmic
11: Oral
12: Other/Miscellaneous
13: Otic
14: Perfusion
15: Rectal
16: Sublingual
17: Topical
18: Transdermal
19: Translingual
20: Urethral
21: Vaginal
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
02: Ointment
03: Cream
04: Suppository
05: Powder
06: Emulsion
07: Liquid
10: Tablet
11: Solution
12: Suspension
13: Lotion
14: Shampoo
15: Elixir
16: Syrup
17: Lozenge
18: Enema
19: Translingual
20: Urethral
21: Vaginal
22: Enteral

10: Tablet
11: Solution
12: Suspension
13: Lotion
14: Shampoo
15: Elixir
16: Syrup
17: Lozenge
18: Enema
19: Translingual
20: Urethral
21: Vaginal
22: Enteral

**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 99999999997.

i. **Ingredient Quantity:** Enter the amount of the product included in the compound mixture, expressed in metric decimal units. Enter the quantity in 9999999.999 format. When indicating the number of containers (with product ID 99999999997), 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.”

**NOTES**
6. Hit the “Submit” button when all fields for the claim have been filled out.

7. Examples of a Compounded Intravenous Prescription:

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.”
9. Pharmacy Claim Reversal

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

![Pharmacy Claim Reversal Option]

b. Select “Recall Data from last Transaction”, if the prescription to reverse is the last one that was billed.

![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. This is to reverse any billed claim.

![Compound Claim Reverse]
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:

**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 14: Indicate “Y” (yes) if the Code 1 restriction for the compound drug has been met. If one or more of the ingredients have a code 1 restriction, all code 1 restrictions must be met to indicate “Y”. If none of the ingredients have a code 1 restriction, the field can be left blank.

**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, use box 17 to indicate patient location.
- 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 21: 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.

![Image of ICD-CM boxes]
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 22: 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.
- 30-4 paper claims do not require decimals to differentiate between dollars and cents.

There is a separation pre-printed on the form to distinguish the difference. Do not enter a dollar ($) sign on a paper claim.
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.

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 32:

- 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 40: This is the field to enter the hospital discharge date, if applicable:
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 42: 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.

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 "99999999997" and the number of containers in the Ingredient Quantity field. The ingredient cost should be zero when indicating the number of containers.

- 30-4 paper claim, box 43: Enter the number of container counts.
Signature of Provider and Date

- RTIP: No signature or date is required
- 30-4 paper claim, box 47: 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 “999999999” for the container count. If the compound contains more than 25 product codes, then a 30-4 paper claim must be submitted.
- 30-4 paper claim: Claim form has only 23 lines, therefore, any additional ingredients will be required to be billed on an attachment.
  - The 23rd 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:

![Image of a claim form with specific details and remarks section]
The Compounded Drug Attachment should contain the pharmacy name, provider ID, prescription number and date of service:

Compounded Drug Attachment

<table>
<thead>
<tr>
<th>Pharmacy Name:</th>
<th>ABC Home Pharmacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Number:</td>
<td>0123456789</td>
</tr>
<tr>
<td>Prescription Number:</td>
<td>1234567</td>
</tr>
<tr>
<td>Date of Service:</td>
<td>03/02/2007</td>
</tr>
</tbody>
</table>

Additional Compound Ingredients:

<table>
<thead>
<tr>
<th>NDC/UPC/HRI #</th>
<th>Quantity</th>
<th>Charge</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>61703022521</td>
<td>360.00</td>
<td>3388.70</td>
<td></td>
</tr>
<tr>
<td>00517240025</td>
<td>300.00</td>
<td>18.41</td>
<td></td>
</tr>
</tbody>
</table>

Totals: 660.000 3405.11

It must also contain the additional compound ingredients (NDCs) and total quantity and charge.
# 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:

<table>
<thead>
<tr>
<th>Item Being Billed</th>
<th>Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost of ingredients</td>
<td>Paid at Actual Acquisition Cost (AAC)</td>
</tr>
<tr>
<td>Cost of supplies consumed in compounding I.V. solution</td>
<td>Paid at Maximum Allowable Product Cost (MAPC*), by report or price on file, up to $5.56 per container</td>
</tr>
<tr>
<td>Cost of empty containers</td>
<td>Paid at Maximum Allowable Product Cost (MAPC*), by report.</td>
</tr>
<tr>
<td><strong>NOTE</strong></td>
<td>Empty containers must be billed separately from the compound claim.</td>
</tr>
<tr>
<td>Cost of sterility testing (only when performed)</td>
<td>Up to $0.32 per container</td>
</tr>
<tr>
<td>Professional Dispensing fee</td>
<td>Less than 90,000 claims per year equals $13.20 (requires annual provider self-attestation)</td>
</tr>
<tr>
<td><strong>NOTE</strong></td>
<td>90,000 or more claims per year equals $10.05.</td>
</tr>
<tr>
<td>Compounding fee</td>
<td>$0.99 per container (in addition to professional fee, for compounded solutions only)</td>
</tr>
<tr>
<td><strong>NOTE</strong></td>
<td>Capsules, powders, tablets, lozenges:</td>
</tr>
<tr>
<td></td>
<td>6-36 ...........................................$1.98</td>
</tr>
<tr>
<td></td>
<td>37 and over .................................$3.95</td>
</tr>
<tr>
<td>Ointments and creams</td>
<td>1 gm to 179 gm .............................$1.64</td>
</tr>
<tr>
<td></td>
<td>180 gm and over ...........................$3.29</td>
</tr>
<tr>
<td>Suppositories:</td>
<td>1 to 23 ..............................$3.29</td>
</tr>
<tr>
<td></td>
<td>24 and over ..............................$5.76</td>
</tr>
<tr>
<td>Sterile eye preparations:</td>
<td>All ..........................................$2.04</td>
</tr>
<tr>
<td>Nose and ear preparations:</td>
<td>All ..........................................$0.81</td>
</tr>
<tr>
<td>Emulsions, lotions:</td>
<td>All ..........................................$0.81</td>
</tr>
<tr>
<td>Liquids other than simple pouring or reconstituting solutions, shampoos, elixirs, syrups, suspensions, enemas:</td>
<td>All ..........................................$0.99</td>
</tr>
</tbody>
</table>

*Maximum Allowable Product Cost as defined by Welfare & Institutions Code 14105.47.*
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 TSC agent cannot sufficiently assist you, please notify the TSC agent that you are requesting to be contacted by your Provider Field Representative for assistance and/or request an onsite visit.

<table>
<thead>
<tr>
<th>TSC Main Menu Prompt Options</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Telephone Service Center (TSC): 1-800-541-5555</strong></td>
</tr>
<tr>
<td>Please select from the following menu:</td>
</tr>
<tr>
<td>Press or say 1</td>
</tr>
<tr>
<td>Press or say 2</td>
</tr>
<tr>
<td>Press or say 3</td>
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<tr>
<td>Press or say 4</td>
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<tr>
<td>Press or say 5</td>
</tr>
<tr>
<td>Press or say 6</td>
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<tr>
<td>Press or say 7</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Secondary Menu Prompt Options</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Option 4</strong></td>
</tr>
<tr>
<td>Press or say 1</td>
</tr>
<tr>
<td>Press or say 2</td>
</tr>
<tr>
<td>Press or say 3</td>
</tr>
</tbody>
</table>

| **Option 5** |
| Press or say 1   | For HAP or Family PACT |
| Press or say 2   | For CHDP |
| Press or say 3   | For CCS or GHP |
| 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 |

| **Option 6** |
| Press or say 1   | For Provider Enrollment |
| Press or say 2   | For TAR |
| Press or say 3   | For Every Woman Counts billing inquiries, EWC |
Resource Information

References

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)

*Share of Cost (SOC): 30-1 for Pharmacy* (share ph)

Medi-Cal Website
From the Medi-Cal home page (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