

**CAUTION: Read the [ICD-9 Policy Holding Library](#) page about policy in this document.**

drug  
1

## Drugs: Onsite Dispensing Billing Instructions

This section includes Family PACT (Planning, Access, Care and Treatment) Program billing instructions for drugs (both injectable and non-injectable) and contraceptive supplies dispensed onsite, also known as physician-administered drugs. For a complete list of reimbursable drugs and contraceptive supplies, refer to the *Pharmacy and Clinic Formulary* section and the “Treatment and Dispensing Guidelines for Clinicians” in the *Benefit Grid* section in this manual.

### Reimbursement Rates for Onsite Dispensing

The maximum reimbursement rates for many of the items dispensed onsite are set by the Medi-Cal program and are contained in the Medi-Cal rate table, which may be accessed from the Medi-Cal website ([www.medi-cal.ca.gov](http://www.medi-cal.ca.gov)) by clicking the “Medi-Cal Rates” link.

For injections, the price listed on the “Medi-Cal Rates” includes the one-time administration fee of \$4.46 for the first billed unit. Since the administration fee is paid only once for each drug administered, subsequent units claimed must have the administration fee subtracted from the published rate.

When a Medi-Cal maximum reimbursement rate is not specified, Family PACT sets the reimbursement rates for the drugs and contraceptive supplies in the *Drugs: Onsite Dispensing Price Guide* section in this manual.

Providers participating as eligible entities, and purchasing drugs through the Public Health Service (PHS) 340B program, must not bill more than the actual acquisition cost of the drug, as charged by the manufacturer at a price consistent with the PHS program for covered outpatient drugs. Eligible entities, pursuant to Section 14132.01 of California *Welfare and Institutions Code*, may also bill a clinic dispensing fee and an administration fee, if applicable, as defined below.

Drugs subject to the PHS program must be billed with modifier UD in accordance with Medi-Cal policy.

drug  
2

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**HCPCS Codes for  
Drugs and Supplies  
Dispensed Onsite**

The HCPCS codes for drugs and supplies dispensed in clinics are as follows.

Family PACT rates apply to the following HCPCS codes.

<u>HCPCS Code</u>	<u>Description</u>
<b><u>S5000</u></b>	<b><u>Prescription, generic</u></b>
<b><u>S5001</u></b>	<b><u>Prescription, brand name</u></b>
<b><u>S5199</u></b>	<b><u>Lubricant</u></b>
<b><u>A4267</u></b>	<b><u>Condom, male</u></b>
<b><u>A4268</u></b>	<b><u>Condom, female</u></b>
<b><u>A4269</u></b>	<b><u>Contraceptive supply, spermicide:</u></b>

**Note:** A4269 is billed with modifiers U1, U2, U3 or U4 to indicate the type of contraceptive spermicide.

<b><u>A4269U1</u></b>	<b><u>Gel/jelly/foam/cream</u></b>
<b><u>A4269U2</u></b>	<b><u>Spermicidal suppositories</u></b>
<b><u>A4269U3</u></b>	<b><u>Spermicidal vaginal film</u></b>
<b><u>A4269U4</u></b>	<b><u>Contraceptive sponge</u></b>

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Other HCPCS Codes	<p>Claims submitted with other HCPCS codes for formulary drugs are reimbursed at the lesser of the acquisition cost of the drug plus the dispensing fee and administration fee, if applicable, up to the Medi-Cal maximum rate on file.</p>	
<p><b>National Drug Codes (NDC) Requirement</b></p>	<p>The Federal Deficit Reduction Act of 2005 (DRA) requires all state Medicaid agencies to collect rebates from drug manufacturers for physician-administered drugs. Only those products manufactured by companies participating in the federal Medicaid rebate program are reimbursable by Medi-Cal. A current list of manufacturers participating in the rebate program is available in the <i>Drugs: Contract Drugs List Part 5 – Authorized Manufacturer Labeler Codes</i> section in the Part 2 Medi-Cal Pharmacy manual. Drugs are priced based on the HCPCS code. The NDC and corresponding unit of measure are used for drug rebate processing only.</p>	
<p><b>Physician-Administered Drug Definition</b></p>	<p>A physician-administered drug is any covered outpatient drug provided or administered to a recipient, and billed by a provider other than a pharmacy. Such providers include, but are not limited to, physician offices, clinics and hospitals. A covered outpatient drug is broadly defined as a drug that may be dispensed only upon prescription, and is approved for safety and effectiveness as a prescription drug under the Federal Food, Drug and Cosmetic Act.</p>	

## drug 4

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The following items identify whether or not a product is a drug:

- NDC: The vial or box that held the drug has a NDC printed on it.
- Lot and Expiration Date: All drugs have both a lot number and an expiration date on the vial or box.
- Legend: This refers to statements such as, “Caution: Federal law prohibits dispensing without prescription,” “Rx only” or similar wording. All prescription drugs have these types of statements.

For information on the billing policy and claim completion instructions, refer to the following Part 2 Medi-Cal manual sections:

- *Physician-Administered Drugs – NDC*
- *Physician-Administered Drugs – NDC: CMS-1500 Billing Instructions*
- *Physician-Administered Drugs – NDC: UB-04 Billing Instructions*
- *CMS-1500 Claim Completion*
- *UB-04 Claim Completion*

<u>Onsite Dispensed Drugs Billed with NDC</u>	<u>HCPCS Code</u>	<u>Medication</u>	<u>Dosage Size</u>
	J0561	Penicillin G benzathine	100,000 units
	J0694	Cefoxitin	1 gm injection
	J0696	Ceftriaxone	250 mg injection
	<b><u>Q0144</u></b>	<b><u>Azithromycin dihydrate</u></b>	<b><u>1 gm oral</u></b>
	S5000	Miscellaneous drugs, prescription, generic	
	S5001	Miscellaneous drugs, prescription, brand name	

<u>Onsite Dispensed Contraceptives Billed with NDC</u>	<u>HCPCS Code</u>	<u>Contraceptives</u>	<u>Dosage Size</u>
	J3490U5	Emergency contraception: Ulipristal acetate 30 mg	1 pack
	J3490U6	Emergency contraception: Levonorgestrel 0.75 mg (2 tablet pack) and 1.5 mg (1 tablet pack)	1 pack
	J3490U8	Medroxyprogesterone acetate	150 mg
	J7300	ParaGard intrauterine contraceptive	1 IUC
	J7301	Skyla intrauterine contraceptive	1 IUC
	J7302	Mirena intrauterine contraceptive	1 IUC
	J7303	Contraceptive vaginal ring	1 ring
	J7304	Contraceptive patch	1 patch
	J7307	Etonogestrel contraceptive implant (Implanon)	1 implant
	S4993	Oral contraceptives	1 cycle

## drug 6

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### Onsite Dispensing Price Guide

The *Drugs: Onsite Dispensing Price Guide* section contains the following information for calculating the reimbursement rates for drugs (S5000 and S5001) and contraceptive supplies (A4267, A4268, A4269U1, A4269U2, A4269U3, A4269U4 and S5199) dispensed onsite.

- Billing unit definitions
- Family PACT rate per unit
- Maximum units per claim
- Clinic dispensing fees
- Upper payment limit (drug cost + clinic dispensing fee)
- Fill frequency limit (minimum interval between refills)

### Clinic Dispensing Fee

Community clinics, free clinics, Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) pursuant to the *Welfare and Institutions Code* (W&I Code), Section 14132.01, may also bill for a dispensing fee of \$12 per unit.

The unit is a calendar month, with a maximum allowable of 36 units per device (J7300 – J7302 and J7307) and three (3) units per injection (J3490U8). Eligible entities will be reimbursed the lesser of the acquisition cost of the drug plus the maximum dispensing fee or the Medi-Cal maximum rate on file.

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For drugs and contraceptive supplies billed with HCPCS codes (S5000, S5001, A4267, A4268, A4269U1, A4269U2, A4269U3, A4269U4 and S5199), the Family PACT Program designates clinic dispensing fees by three levels:

- Level A: Pharmacist pre-packaged containers of tablets or capsules (flat rate = \$ 3.00)
- Level B: Manufacturer pre-packaged tubes or other containers (flat rate = \$ 2.00)
- Level C: Contraceptive supplies (10% of subtotal)

Clinic dispensing fees for oral contraceptives, patch, vaginal ring, and emergency contraceptives are included in the basic rate listed in the Medi-Cal rate table.

**Note:** A clinic dispensing fee is not reimbursable for antibiotic injections.

### **Contraceptive Supplies**

Contraceptive supplies may be billed by all Family PACT providers. Covered supplies include FDA-approved male condoms (A4267), female condoms (A4268), spermicides (A4269U1, A4269U2, A4269U3 or A4269U4) and lubricants (S5199).

**drug**  
**8**

Calculating Total Charges

The Family PACT rate per unit is listed in the *Drugs: Onsite Dispensing Price Guide* section in this manual. The following information must be entered in the *Reserved for Local Use* field (Box 19) of the *CMS-1500*, the *Remarks* field (Box 80) of the *UB-04*, or on a claim attachment. Enter the name of the supply (from the *Drugs: Onsite Dispensing Price Guide*) and the size and/or strength, if applicable (for example, 0.75% vaginal gel). Multiply the number of units dispensed by the Family PACT rate per unit to obtain the supply cost. Then add the clinic dispensing fee, if applicable, and enter the total for the claim line.

HCPCS codes A4267, A4268, A4269U1, A4269U2, A4269U3, A4269U4 and S5199 must be listed on separate claim lines.

If any of the four codes (A4267, A4268, A4269, S5199) or any combination of the codes is present on a claim, the total maximum allowable amount for any or all is \$14.99. When billing for contraceptive supplies dispensed for the same patient by the same provider, the minimum interval between dispensing events is 15 days.

The following table contains examples of onsite contraceptive supply claim calculations that are entered in the *Remarks/Reserved for Local Use* field of the claim or on an attachment. For claim form examples, refer to the *Claim Completion: CMS-1500* and *Claim Completion: UB-04* sections in this manual.

Name	Size and/or Strength	Billing Units Multiplied by Family PACT Rate Per Unit = Subtotal	Add Clinic Dispensing Fee *	Total	Units
Male condoms	1 condom	<u>20</u> condoms x \$ 0.28/condom = \$ <u>5.60</u>	\$ <u>0.56</u> **	\$ <u>6.16</u>	<u>20</u>
Spermicidal foam	<u>1</u> can	1 can ( <u>30</u> grams) x \$ 0.21/gm = \$ 6.30	\$ <u>0.63</u> **	\$ <u>6.93</u>	<u>30</u>

\* Refer to the *Drugs: Onsite Dispensing Price Guide* section for current clinic dispensing fees.

\*\* The clinic dispensing fee for contraceptive supplies is the subtotal multiplied by 10 percent.

**Miscellaneous Drugs for  
Non-Surgical Procedures**

Miscellaneous drugs for non-surgical procedures are billed with HCPCS code S5000 or S5001. These codes may be used only by hospital outpatient departments, emergency rooms, surgical clinics and community clinics, in accordance with Medi-Cal guidelines.

Calculating Total Charges

For drugs billed with code S5000 or S5001, the Family PACT rate per unit of medication is listed in the *Drugs: Onsite Dispensing Price Guide* section in this manual. The following information must be entered in the *Remarks* field (Box 80) of the *UB-04* or an attachment. Enter the name of the drug or supply (from the *Drugs: Onsite Dispensing Price Guide*) and the size and/or strength, if applicable (for example, 300 mg tablets). Multiply the number of units dispensed by the Family PACT rate per unit to obtain the drug cost, add the clinic dispensing fee (if applicable), then enter the total for the claim line. Each listed regimen is considered to be one (service) unit, regardless of the number of tablets contained in the regimen.

If multiple drugs are billed using code S5000 or S5001, the billing code can be repeated on additional claim lines with the appropriate National Drug Code (NDC).

**drug**  
**10**

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ICD-9-CM Code

Claims billed with HCPCS code S5000 or S5001 must include two ICD-9-CM codes: the covered family planning-related ICD-9-CM code along with the family planning diagnosis for which the client is being seen. Only one family planning-related ICD-9-CM code must be entered per claim.

If a combination of drug regimens is billed with a single family planning-related ICD-9-CM code, the drug regimens should be entered on separate claim lines.

If two or more drugs are dispensed with different family planning-related ICD-9-CM codes, then a separate claim must be submitted for each ICD-9-CM code and corresponding drug(s).

The family planning-related ICD-9-CM codes and corresponding drugs that are reimbursable by the Family PACT Program are listed in the *Benefits Grid* and *Benefits: Family Planning-Related* sections in this manual.

The following table contains examples of onsite drug claim calculations that are entered in the *Remarks* field (Box 80) of the claim. For claim form examples, refer to the *Claim Completion: UB-04* section in this manual.

Name	Size and/or Strength	Max. Billing Units Multiplied by Family PACT Rate Per Unit = Subtotal	Add Clinic Dispensing Fee *	Total	Units
Acyclovir	200 mg tablets	50 tablets x \$ 0.14/ tablet = \$ 7.00	\$ 3.00	\$ 10.00	1
Clotrimazole	2% cream/ tube	1 tube x \$ 7.16/ tube = \$ 7.16	\$ 2.00	\$ 9.16	1

\* Refer to the *Drugs: Onsite Dispensing Price Guide* section for current clinic dispensing fees.

**Drug and Supplies List Restrictions**

Refer to the *Pharmacy and Clinic Formulary* section in this manual for clinical restrictions for the use of certain drugs and supplies.

The dosage regimens included as Family PACT benefits are based on the current Centers for Disease Control and Prevention (CDC) *Sexually Transmitted Diseases Treatment Guidelines* or the treatment recommendations of the California Department of Public Health (CDPH) Sexually Transmitted Disease Control (STDC) Branch. Covered regimens are listed in the “Treatment and Dispensing Guidelines for Clinicians” in the *Benefits Grid* section of this manual.

**Treatment Authorization Request**

Drugs needed to treat complications are limited to drugs and supplies identified in the Family PACT *Pharmacy and Clinic Formulary* section, and require authorization using a *Treatment Authorization Request (TAR)*.

For more TAR information, refer to the *Treatment Authorization Request (TAR)* section in this manual.