Compound Drug Pharmacy Claim Form (30-4) Completion

Page updated: November 2021

The *Compound Drug Pharmacy Claim Form* (30-4) is used by pharmacies to bill Medi-Cal for multiple ingredient compound drug prescriptions and single ingredient sterile transfers. Ingredients that do not have an associated National Drug Code (NDC) must be billed using the 30-4 claim form and include an attached catalog page, invoice or other supporting documentation reflecting pricing information for the ingredients.

Providers may submit compound drug claims online through the Point of Service (POS) network using the National Council for Prescription Drug Programs (NCPDP), Version D.0 standard and the pharmacy's software. Claims submitted online will be immediately adjudicated, giving the provider immediate feedback that the claim has paid, and the amount paid; or, if the claim is denied, what problems must be corrected to allow payment. There is currently no batch Computer Media Claims (CMC) submission method for compound pharmacy claims.

Providers can access the POS network using the internet. For more information, call the Telephone Service Center (TSC) at 1-800-541-5555.

Pharmacy providers with Internet access also may submit compound pharmacy claims using the Real-Time Internet Pharmacy (RTIP) claim submission system on the Medi-Cal website *(www.medi-cal.ca.gov).* RTIP claim transactions require a completed *Medi-Cal Point of Service (POS) Network/Internet Agreement*. Providers can access the automated POS/Internet agreement form on the Medi-Cal Provider website at *www.medi-cal.ca.gov* on the Transactions page (Providers > Transactions > Enrollment Requirements) ‹‹and the Forms page (Resources > References > Forms).››

RTIP submitters for compound pharmacy claims also must complete the *Medi-Cal Telecommunications Provider and Biller Application/Agreement* and send to the following address:

Attn: CMC Unit
California MMIS Fiscal Intermediary
P.O. Box 15508
Sacramento, CA 95852-1508

Crossover compound pharmacy claims that do not cross over automatically via NCPDP must be billed on the *Compound Drug Pharmacy Claim Form* (30-4). These claims cannot be billed via CMC, POS network or RTIP. For more information and billing examples, refer to the *Medicare/Medi-Cal Crossover Claims: Pharmacy Services Billing Examples* section of this manual.

Non-compound pharmacy claims must be billed using the *Pharmacy Claim Form* (30-1). For more information, refer to the *Pharmacy Claim Form* (30-1) Completion section of this manual. Durable Medical Equipment (DME) and blood products must be billed using the *CMS-1500* claim form. For more information, refer to the *CMS-1500 Completion* section of this manual.

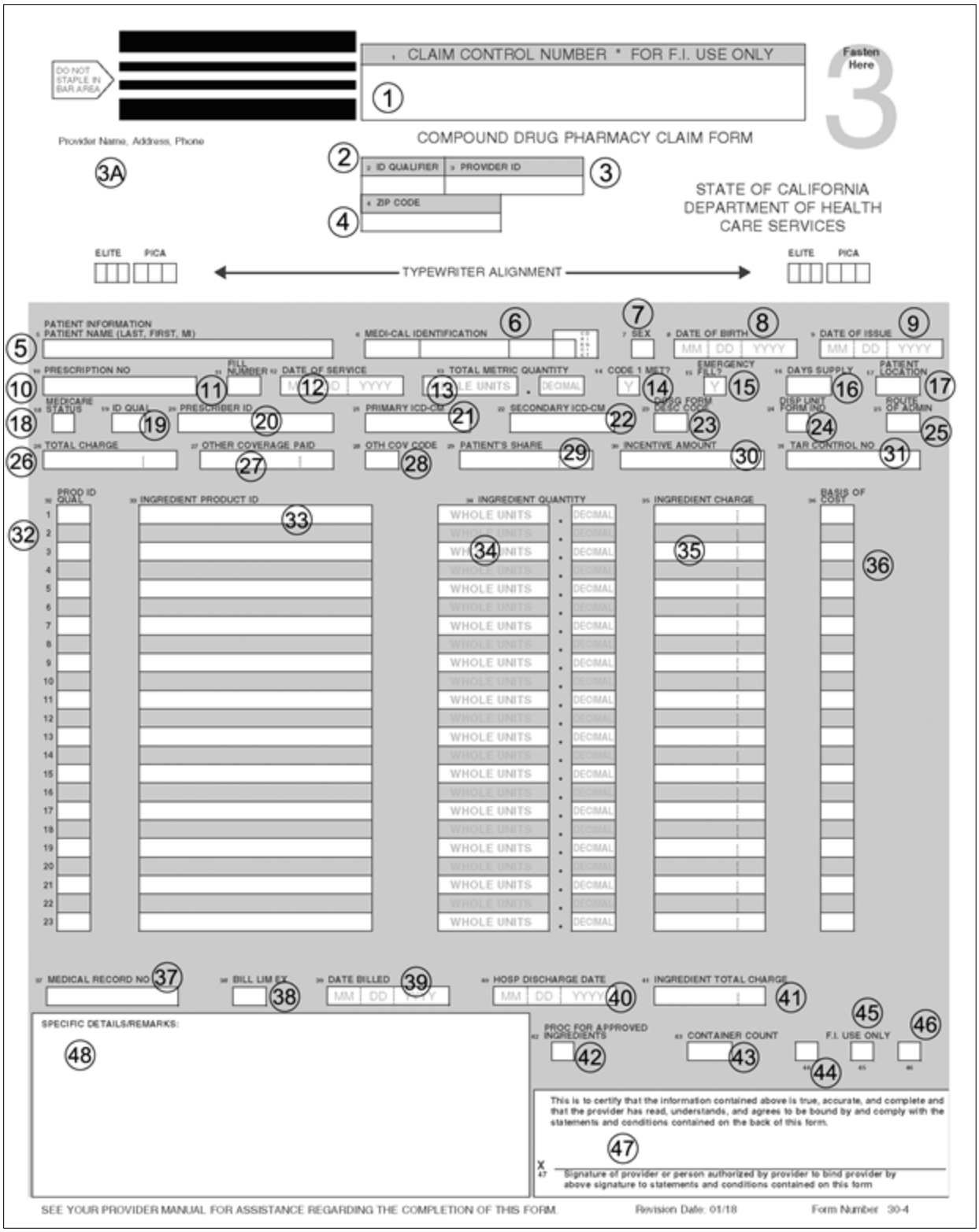

Figure 1: Medi-Cal Required Fields
(Sample *Compound Drug Pharmacy Claim Form* [30-4])

Part 2 – Compound Drug Pharmacy Claim Form (30-4) Completion

Explanation of Form Items

The following item numbers and descriptions correspond to the sample *Compound Drug Pharmacy Claim Form* (30-4) on the previous page. All items must be completed unless otherwise noted in these instructions.

For general paper claim billing instructions, refer to the *Forms: Legibility and Completion Standards* section of this manual.

‹‹Explanation of Form Items››

Item	Description
1.	**Claim Control Number**. For the California MMIS Fiscal Intermediary use only. Do not mark in this area. A unique 13-digit number, assigned by the FI to track each claim, will be entered here when the claim is received by the FI.
2.	**ID Qualifier**. Identifies the NCPDP D.0 standard provider ID type. Enter 05 to indicate a Medi-Cal Pharmacy Provider ID.
3.	**Provider ID**. Enter the National Provider identifier (NPI). Do not submit claims using a Medicare provider number, State license number or NCPDP number.
3a.	**Provider Name, Address, Phone Number**. Enter the provider name, address and telephone number if this information is not pre-imprinted on the claim form. Confirm this information is correct before submitting the claim form.
4.	**ZIP Code**. Enter the provider's nine-digit ZIP code if this information is not already pre-imprinted on the claim form. **Note**: The nine-digit ZIP code entered in this box must match the billing provider's nine-digit ZIP code on file for claims to be reimbursed correctly.
5.	**Patient Name**. Enter the patient's last name, first name and middle initial, if known. Avoid nicknames or aliases.

Newborn Infant

When submitting a claim for a newborn infant using the mother's ID number, enter the infant's name, sex and year of birth in the appropriate spaces. Enter the complete date of birth in (MMDDYYYY) format where "MM" is the two-digit month, "DD" is the two-digit day, and "YYYY" is the four-digit year and write "Newborn infant using mother's card" in the *Specific Details/Remarks* area of the claim.

If the infant has not yet been named, write the mother's last name followed by "Baby Boy" or "Baby Girl" (example: Jones, Baby Girl). If newborn infants from a multiple birth are being billed in addition to the mother, each newborn must also be designated by number or letter (example: Jones, Baby Girl, Twin A).

Services to an infant may be billed with the mother's ID for the month of birth and the following month only. After this time, the infant must have his or her own Medi-Cal ID number.

Explanation of Form Items (continued)

Item	Description
6.	**Medi-Cal Identification Number**. Enter the 14-character recipient ID number as it appears on the Benefits Identification Card (BIC).
7.	**Sex**. ‹‹Use the capital letter "M" for male or "F" for female. (For newborns, see Item 5.)››
8.	**Date of Birth**. Obtain this number from the recipient's BIC. Enter the date in MMDDYYYY format, where "MM" is the two-digit month, "DD" is the two-digit day and "YYYY" is the four-digit year. For example, a birth date of March 8, 2005 should be entered as "03082005." Birth dates may not be in the future. This information must be entered to successfully process the claim.
9.	**Date of Issue**. Obtain this number from the recipient's BIC. Enter the date in MMDDYYYY format, where "MM" is the two-digit month, "DD" is the two-digit day and "YYYY" is the four-digit year. For example, an issue date of March 8, 2005, should be entered as "03082005."
10.	**Prescription Number**. Enter the prescription number in this space for reference on the *Remittance Advice Details* (RAD). A maximum of 12 digits may be used.

‹‹Explanation of Form Items (continued)››

Item	Description
11.	**Fill Number**. A refill number (0 or 00 for original dispensing; 1 or 01 to 99 for refill) must be entered in this field.
12.	**Date of Service**. Enter the date that the prescription was filled in eight-digit MMDDYYYY format where “MM” is the two-digit month, “DD” is the two-digit day and “YYYY” is the four-digit year (for example, March 8, 2005 should be entered as 03082005). Compound pharmacy claims are only accepted on the 30-4 form for dates of service on or after September 22, 2003.
13.	**Total Metric Quantity**. Enter the quantity of the entire amount dispensed and being billed on this claim. Quantities must be in metric decimal format. Do not include a decimal in either of the two fields that make up the metric decimal quantity or the claim will be returned. Do not include measurement descriptors such as “Gm” or “cc”. For example: A 2.5 Gm powder will be 2 in the *Whole Units* box and 5 in the Decimal box and three 2.5 cc ampules will be 2.5 x 3 = 7.5 (7 in the *Whole Units* box and 5 in the *Decimal* box).
14.	**Code I (Restrictions) Met?** Optional item. A “Y” indicates the Code I restriction for the drug was met. Refer to the Contract Drugs List sections in this manual for more information.
15.	**Emergency Fill?** Optional item. If the drug was dispensed in an emergency, use indicator “Y” for “yes” or “N” for “no.”
16.	**Days Supply**. Enter the estimated number of days that the drug dispensed will last.

‹‹Explanation of Form Items (continued)››

Item	Description
17.	**Patient Location**. Optional item. If the recipient is residing in a Nursing Facility (NF) Level A or B or Nursing Facility (NF) Level B (Adult Subacute), enter the appropriate code.

‹‹Table of Facility Codes and Descriptions››

Code	Description
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)
Field left blank	Not Specified*

‹‹Explanation of Form Items (continued)››

Item	Description
18.	**Medicare Status**. Medicare status codes are required for Charpentier claims. In all other circumstances, these codes are optional. The Medicare status codes are:

‹‹Table of Medicare Status Codes››

Code	Explanation
R	Medi/Medi Charpentier: Rates
L	Medi/Medi Charpentier: Benefit Limits
T	Medi/Medi Charpentier: Both Rates and Benefit Limitations
0	Under 65, does not have Medicare coverage
Field left blank	Not Specified *

‹‹Explanation of Form Items (continued)››

Item	Description
19.	I**D Qualifier**. Identifies the type of prescriber ID submitted (National Provider Identifier Number (NPI), State license number, Drug Enforcement Administration [DEA] number, etc). Medi-Cal currently accepts only a provider's NPI number. Enter 01 to indicate a NPI license number under NCPDP D.0 standards.
20.	**Prescriber ID**. Enter the National Provider Identifier Number (NPI) or, if applicable, the NPI number of the certified nurse-midwife, the nurse practitioner, the physician assistant, the naturopathic doctor, or the pharmacist who function pursuant to a policy, procedure, or protocol as required by Business and Professions Code statutes. Do not use the Drug Enforcement Administration Narcotic Registry Number. This information must be entered for your claim to successfully process.
21.	**Primary ICD-CM**. Optional. If available, enter all letters and/or numbers of the *International Classification of Diseases 10th Revision, Clinical Modification* (ICD-10-CM) code for the primary diagnosis, including the fourth through seventh digits, if present. Do not enter the decimal point. **Important**: For claims with dates of service or dates of discharge on or after October 1, 2015, enter the ICD indicator "0" as an additional digit before the ICD-10-CM code. The ICD indicator is required only if a primary diagnosis code is being entered on the claim. Secondary diagnosis codes do not require the indicator. Claims that contain a primary diagnosis code but no ICD indicator may be denied.
22.	**Secondary ICD-CM**. Optional item. See "Primary ICD-CM" for description.

‹‹Explanation of Form Items (continued)››

Item	Description
23.	**Dosage Form Description Code**. Enter the appropriate code to indicate the dosage form of the finished compound.

‹‹Table of Dosage Form Description Codes››

Code	Description
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

Note: Compounding fees are paid based upon the dosage form and route of administration information submitted on the pharmacy claim. To ensure proper payment, be certain to enter this information correctly.

‹‹Explanation of Form Items (continued)››

Item	Description
24.	**Dispensing Unit Form Indicator**. Enter the appropriate code to indicate the way that the finished compound is measured.

‹‹Table of Dispensing Unit Form Indicators››

Code	Description
1	Each
2	Grams
3	Milliliters

‹‹Explanation of Form Items (continued)››

Item	Description
25.	**Route of Administration**. Enter the appropriate code to indicate the route by which the finished compound is administered to the recipient.

‹‹Table of Route of Administration Codes››

Code	Description
1	Buccal
2	Dental
3	Inhalation
4	Injection
5	Intraperitoneal
6	Irrigation
7	Mouth/Throat
8	Mucous Membrane
9	Nasal
10	Ophthalmic
11	Oral
12	Other/Miscellaneous
13	Otic

‹‹Table of Route of Administration Codes (continued)››

Code	Description
14	Perfusion
15	Rectal
16	Sublingual
17	Topical
18	Transdermal
19	Translingual
20	Urethral
21	Vaginal
22	Enteral

Note: Compounding fees are paid based upon the dosage form and route of administration information submitted on the pharmacy claim. To ensure proper payment, be certain to enter this information correctly.

‹‹Explanation of Form Items (continued)››

Item	Description
26.	**Total Charge**. Enter the total dollar and cents amount for this claim. This amount should include all compounding, sterility and professional fees. For intravenous and interarterial injections only, the fees should be multiplied by the number of containers before adding them to the total charge. Do not enter a decimal point (.) or dollar sign ($). For DMERC NCPDP hardcopy pharmacy crossovers, enter the Medicare Allowed Amount. **Note**: Compounding fees are paid based upon the dosage form and route of administration information submitted on the pharmacy claim. To ensure proper payment, be certain to enter this information correctly.
27.	**Other Coverage Paid**. Optional item, unless Other Health Coverage (OHC) payment was received. Enter the full dollar amount of payment received from OHC carriers. Do not enter a decimal point (.) or dollar sign ($). Leave blank if not applicable. For DMERC NCPDP hardcopy pharmacy crossovers, add the Other Health Coverage Amount(s) and Medicare Paid Amount, enter the combined total.

‹‹Explanation of Form Items (continued)››

Item	Description
28.	**Other Coverage Code**. Optional item, unless recipient has OHC. A valid Other Coverage code is required. Enter one of the following values:

‹‹Table of Other Coverage Codes››

Code	Explanation
0	Not Specified or No Other Coverage Exists
2	Other Coverage Exists, Payment Not Collected
7	Other Coverage Exists, Claim was not covered or other coverage was not in effect at time of service
9	Other Coverage Exists, Payment Collected

‹‹Explanation of Form Items (continued)››

Item	Description
29.	**Patient's Share (of Cost).** Optional item, unless recipient paid Share of Cost (SOC) for claim. Enter the full dollar amount of patient's SOC paid by the patient on this claim. Do not enter a decimal point (.) or dollar sign ($). Leave blank if not applicable. For more information, see the *Share of Cost (SOC): 30-1 for Pharmacy* section in this manual.
30.	**Incentive Amount**. Optional item. If sterility testing was performed, enter the full dollar amount of the sterility test charge in this field. Do not enter a decimal point (.) or dollar sign ($). Leave blank if not applicable. For intravenous and interarterial injections only, the sterility testing fee should be multiplied by the number of containers.
31.	**TAR Control Number**. If prior authorization is required, enter the 11-digit TAR Control Number (TCN) from the approved TAR. It is not necessary to attach a copy of the TAR to the claim. Recipient, quantity, drug and date of service on the claim must agree with the information on the TAR. All ingredients listed on the compound claim must be listed on the TAR. When the paper TAR form is used, "99999999996" must be in the TAR service field.

‹‹Explanation of Form Items (continued)››

Item	Description
32.	**(Ingredient) Product ID Qualifier.** Enter the appropriate code to indicate the type of ingredient that is in Item 31.

‹‹Table of Ingredient Product ID Qualifier Codes››

Code	Explanation
01	Universal Product Code (UPC)
03	National Drug Code (NDC)
04	Universal Product Number (UPN)
99	Other

‹‹Explanation of Form Items (continued)››

Item	Description
33.	**Ingredient Product ID**. Indicates the ingredient used in the compound drug. If the ingredient product ID qualifier (Item 30) is “03”, this must be an NDC number. If no NDC number exists for the ingredient, enter the UPC or UPN code, if available, with the product ID qualifier for the code used. If no code exists to describe the ingredient, enter a brief description of the ingredient instead (up to 19 characters). When billing for non-NDC ingredient product ID numbers, a catalog page, invoice or other supporting documentation must be attached showing the price of the ingredient and the quantity of the ingredient at that price.
34.	**Ingredient Quantity**. Enter the total quantity of the ingredient in all containers. Quantities must be in the metric decimal format. The decimal point must not be included in either of the two fields that make up the metric decimal quantity or the claim will be returned. Do not include measurement descriptors such as “Gm,” “cc” or “ml.”
35.	**Ingredient Charge**. Enter the dollar and cents amount for this ingredient for all containers in this field. Do not enter a decimal point (.) or dollar sign ($).

‹‹Explanation of Form Items (continued)››

Item	Description
36.	**Ingredient Basis of Cost Determination**. Enter the appropriate code to indicate the method used to calculate the ingredient cost. If claim was for disproportionate share/Public Health Service, 08 must be used.

‹‹Table of Ingredient Basis of Cost Determination Codes››

Code	Description
01	AWP (Average Wholesale Price)
02	Local Wholesalers
03	Direct
04	EAC (Estimated Acquisition Cost)
05	Acquisition
06	MAC (Maximum Allowable Cost)
07	Usual & Customary
08	Other (Indicates Disproportionate Share/Public Health Service)
Field Left Blank	Not Specified

Multiple Ingredient Lines (1 thru 23)

Multiple Ingredient Lines. List all ingredients in the compounded drug. If blank lines are present between ingredients or ingredient lines are crossed out, the claim will be returned. When billing for more than 23 ingredients, enter the following numbers for the 23rd ingredient:

1. Product ID Qualifier = 99
2. Product ID = 99999999998
3. Quantity = total quantity of the additional ingredients on the compound drug attachment
4. Charge = total charge for the additional ingredients on the compound drug attachment

‹‹Explanation of Form Items (continued)››

Item	Description
37.	**Medical Record Number**. Optional item. If a medical record number or account number is assigned to the beneficiary field, enter that number to more easily identify the beneficiary. A maximum of 10 numbers and/or letters may be used. If unique record-keeping numbers are not assigned to each beneficiary, you may enter the beneficiary's name.
38.	**Billing Limit Exceptions**. If there is an exception to the six-month billing limitation, enter the appropriate reason code number and include the required documentation.

‹‹Table of Billing Limit Exception Reason Codes››

Code	Description
1	(1) Proof of eligibility unknown or unavailable; includes retroactive eligibility or ID cards, if applicable (2) For Share of Cost (SOC) reimbursement processing
2	(1) Other Health Coverage, including Medicare, Kaiser, CHAMPUS and other health insurance (2) Charpentier rebill claims
3	Authorization delays in TAR approval
4	Delay by DHCS in certifying providers or by the CA-MMIS FI in supplying billing forms
5	Delay in delivery of custom-made eye, prosthetic or orthotic appliances
6	Substantial damage by fire, flood or disaster to provider records
7	Theft, sabotage or other willful acts by an employee **Note**: Negligence by an employee is <u>not</u> covered by this reason code
10	(1) Court order or State or administrative fair hearing decision (2) Delay or error in the certification or determination of Medi-Cal eligibility (3) Update of a TAR beyond the 12-month limit (4) Circumstances beyond the provider's control as determined by DHCS

‹‹Table of Billing Limit Exception Reason Codes (continued)››

Code	Description
A	Claims submitted after the six-month billing limit and received by the CA-MMIS FI during the 7th thru 12th month after the month of service and none of the exceptions above apply
Field left blank	Not Specified *

‹‹Explanation of Form Items (continued)››

Item	Description
39.	**Date Billed**. Enter the date that the prescription will be submitted to the FI for processing in eight-digit MMDDYYYY format where “MM” is the two-digit month, “DD” is the two-digit day and “YYYY” is the four-digit year.
40.	**Hospital Discharge Date**. If needed for compliance with program requirements, enter the date the recipient was discharged from the hospital in eight-digit MMDDYYYY format where “MM” is the two-digit month, “DD” is the two-digit day and “YYYY” is the four-digit year (for example, March 8, 2003 should be entered as 03082003).
41.	**Ingredient Total Charge**. Enter the total charge of all the ingredients. Do not enter fees. Do not enter a decimal point (.) or dollar sign ($).
42.	**Process for Approved Ingredients**. Optional item. 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 prior authorization will cause the claim to deny. If the compound contains inexpensive ingredients that would not be worth getting prior authorization, then the provider may want to use this field to speed payment of the claim.
43.	**Container Count**. Enter the recipient’s total number of containers for the compound prescription.
44.	**F.I. Use Only**. Leave blank.
45.	**F.I. Use Only**. Leave blank.
46.	**F.I. Use Only**. Leave blank.

‹‹Explanation of Form Items (continued)››

Item	Description
47.	**Signature of Provider and Date**. The claim must be signed and dated by the provider or a representative assigned by the provider. Use black ballpoint pen only. An original signature is required on all paper claims. 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 FI.
48.	**Specific Details/Remarks Section**. 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* section of this manual for more information.

Emergency Certification Statement

Claims that require documentation, such as an Emergency Certification Statement, cannot be billed through the POS network or CMC format. The Emergency Certification Statement must be attached to the claim and include:

- The nature of the emergency, including relevant clinical information about the patient's condition
- Why the emergency services rendered were considered to be immediately necessary
- The signature of the physician, podiatrist, dentist or pharmacist who had direct knowledge of the emergency

The statement must be comprehensive enough to support a finding that an emergency existed. A mere statement that an emergency existed is not sufficient.

An Emergency Certification Statement may not be used in place of a *Treatment Authorization Request* (TAR) for diabetic supplies that require authorization when the maximum quantity has been reached. For further information, see the *List of Contracted Diabetic Test Strips and Lancets* spreadsheet.

Note: Emergency claims cannot be billed using the CMC format or through the POS network.

‹‹Legend››

‹‹Symbols used in the document above are explained in the following table.››

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.
*	If the recipient is not residing in any of these facilities, leave Item 17 blank.