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

Page updated: August 2020

This section includes instructions for billing the Hepatitis-B vaccine and submitting claims for *Treatment Authorization Request* (TAR)-approved procedures by Pharmacy providers. This information is designed to supplement the explanations in the *Pharmacy Claim Form (30-1) Completion* and *Compound Drug Pharmacy Claim Form (30-4) Completion* sections of this manual.

Submitting Copies of TARs

Providers must not submit copies of TARs with claims as proof of authorization. Instead, providers should accurately and legibly copy the 10-digit TAR Control Number followed by the Pricing Indicator (PI) from the *Adjudication Response* in the *TAR Control Number* field on the claim form. Omissions, errors or illegibility will cause claim denial.

TAR Corrections for TARs Over One Year Old

Providers may request to have recipient information corrected or modified on a TAR within a year of the TAR's original approval date. The Department of Health Care Services (DHCS) consultant will not change the recipient's Medi-Cal ID number, Social Security Number (SSN), name, date of birth or sex if the TAR is more than one year old.

For corrections, a provider should fill out the Transmittal Form MC 3020 found on the DHCS website and submit it to the TAR Processing Center with the corrections clearly noted.

Mismatched TAR and Claim Data

If a claim is denied because the recipient data on the claim does not match the recipient data on the TAR, providers may request claim reconsideration by attaching a copy of a TAR to a *Claims Inquiry Form* (CIF).

Hepatitis-B Vaccine

Hepatitis-B vaccines provided by pharmacies for administration to Hepatitis-B vaccines provided by pharmacies for administration to Medi-Cal patients by Nursing Facility (NF) Level A or B staff require authorization from a Medi-Cal field office drug unit. The vaccine should be billed as a non-formulary drug on the *Pharmacy Claim Form* (30-1). It should not be billed as a blood derivative.

Compound Pharmacy Billings

The Compound Pharmacy Claim Form (30-4) is used by pharmacies to bill Medi-Cal for compound drug prescriptions. 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.

POS

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, including program requirements. There is currently no batch Computer Media Claims (CMC) submission method for compound pharmacy claims.

Providers can access the POS network using vendor-supplied hardware and software. Compound pharmacy claims submission is not currently allowed on the POS device available through the California MMIS Fiscal Intermediary. For more information, call the Telephone Service Center (TSC) at 1-800-541-5555.

Internet

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. 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 FI at the following address:

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

Non-compound pharmacy claims must not be billed as compounds. 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.

Compounding Fees

The compounding fees established by DHCS are as follows:

- **Capsules, Powders, Tablets, Lozenge**
 - 6-36: \$1.98
 - 37 and over: \$3.98
- **Ointments and Creams**
 - 1 gm to 179 gm: \$1.64
 - 180 gm and over: \$3.29
- **Suppositories**
 - 1-23: \$3.29
 - 24 and over: \$5.76
- **Sterile Eye Preparations**
 - All: \$2.04
- **Nose and Ear Preparations**
 - All: \$0.81
- **Emulsions, Lotions**
 - 1 cc to 239 cc: \$0.81
 - 240 cc and over: \$1.64
- **Liquids other than simple pouring or reconstituting, Solutions, Shampoos, Elixirs, Syrups, Suspensions, Enemas**
 - All: \$0.99

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

Enteral Nutrition Product Non-Benefit Exceptions

Providers can be reimbursed for enteral nutrition products that are otherwise Medi-Cal non-benefits if the recipient is eligible for “aid paid pending” or received a positive fair hearing decision. Providers must:

- Obtain an approved TAR with “aid paid pending” or “per hearing decision” noted in the comments section.
- Submit a paper *Pharmacy Claim Form* (30-1) with the approved TAR attached.

Enteral nutrition products that are Medi-Cal non-benefits are items considered to be regular food or items for which there is no manufacturer contract with DHCS.

For additional information about aid paid pending and fair hearings, providers may refer to the *TAR Deferral/Denial Policy* (*Frank v. Kizer*) provider manual section.

Newborn Infant Using Mother’s ID Number

When submitting a claim for a newborn infant using the mother’s ID number, providers may enter the infant’s name, sex and year of birth in the appropriate spaces. Providers should enter the complete date of birth (MMDDYYYY) and write “Newborn infant using mother’s ID number” in the *Specific Details/Remarks* area of the claim.

Point of Service (POS) Network Users

Claims for newborns using their mother’s ID number must be billed on paper.

If the infant has not yet been named at the time the service is billed, providers should write the mother’s last name and “Baby Boy” or “Baby Girl” in the *Patient Name* field (for example, Jones, Baby Girl). If newborn infants from a multiple birth are being billed, each newborn must also be designated by number or letter (for example, Jones, Baby Girl, Twin A).

Billing Limit

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.

Restricted Eligibility

Claims for recipients with eligibility restrictions (see the *Eligibility: Recipient Identification* section in the Part 1 manual) must include a statement in the *Specific Details/Remarks* area such as, “This service is related to ... [applicable restriction]” POS network users and CMC submitters must bill these claims on paper.

Special Project Enrollees

As a general rule, claims for services rendered to Medi-Cal recipients enrolled in pilot projects or prepaid health plans should not be submitted to the CA-MMIS FI.

Drugs Administered by a Physician or Clinic

Unless otherwise exempt through Assignment of Benefit (AOB) or Short-Doyle exceptions, any drug administered by a physician or clinic must be billed by the physician or clinic, not by the pharmacy providing the drug for such administration.

<<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.