Reimbursement

Page updated: November 2023

This section contains information about reimbursement for legend and non-legend drugs, select medical supplies and sales tax.

Reimbursement Guidelines

Legend and Non-Legend Drugs

Effective for dates of service on or after April 1, 2017, reimbursement for any outpatient drug covered under the Medi-Cal program is the lowest of either of the following:

Actual acquisition cost (AAC) plus a professional dispensing fee. The AAC is equal to the lowest of the following:

a) National Average Drug Acquisition Cost (NADAC), or when no NADAC is available, the wholesale acquisition cost (WAC)

b) Maximum allowable ingredient cost (MAIC)

c) Federal upper limit (FUL)

The pharmacy's usual and customary charge.

Note: Additional product cost due to special packaging is not reimbursed (for example, unit of use, modified unit dose or unit dose).

Professional Dispensing Fee

Effective for dates of service on or after April 1, 2017, the Department of Health Care Services (DHCS) utilizes a two-tiered professional dispensing fee based upon a pharmacy's total (both Medicaid and non-Medicaid) annual claim volume as follows:

- Less than 90,000 claims per year equals $13.20 (requires annual provider self-attestation)
- 90,000 or more claims per year equals $10.05

Self-attestations for each calendar year will begin in mid-January after the close of the calendar year. The attestation period lasts approximately six weeks.

Note: DHCS policy is that a claim is equivalent to a dispensed prescription; therefore, the attestation is for the total dispensed prescription volume.

National Average Drug Acquisition Cost (NADAC)

Effective for dates of service on or after April 1, 2017, the NADAC is used as the basis for the actual acquisition cost-based ingredient cost reimbursement for covered outpatient drugs. The NADAC is a national drug-pricing benchmark determined by a federal survey, representing the national average invoice price for drug products based on invoices from wholesalers and manufacturers submitted by retail community pharmacies.

Providers are reminded that it is their responsibility to monitor the published NADAC pricing on the Centers for Medicare & Medicaid Services (CMS) Pharmacy Pricing website. Providers may request a NADAC rate review by completing the NADAC *Request for Medicaid Reimbursement Review* form found at the following link and submitting it along with the necessary supporting documentation to the NADAC Help Desk: *www.medicaid.gov/medicaid/prescription-drugs/downloads/retail-price-survey/hdform.pdf.*

Maximum Allowable Ingredient Cost (MAIC)

The maximum allowable ingredient cost (MAIC) program, authorized by *Welfare and Institutions Code* (W&I Code), Section 14105.45(b)(4), allows DHCS to establish a list of MAICs for generically equivalent drugs. Each MAIC may be established only when three or more generically equivalent drugs are available for purchase and dispensing by retail pharmacies within California.

Generically equivalent drugs are defined as drug products with the same active chemical ingredients of the same strength and dosage form, and of the same generic drug name as determined by the United States Adopted Names (USAN) Council and accepted by the federal Food and Drug Administration (FDA), as those drug products having the same chemical ingredients.

Pharmacies will receive notification of a MAIC implementation or change at least 30 days prior to the effective date. If, pursuant to a request from providers, DHCS determines that a change in a MAIC is warranted to reflect current available market prices, a specific MAIC may be updated prior to notifying providers.

Federal Upper Limit (FUL)

The federal upper limit (FUL) is an upper-limit of reimbursement for certain multiple-source drugs established independently from the California MAIC program by the Centers for Medicare & Medicaid Services (CMS).

When a drug is listed on both the MAIC and FUL price lists, the maximum cost is the lower of the MAIC or FUL.

National Drug Codes (NDCs) from specific manufacturers as notated with a labeler code restriction in the Contract Drugs List are exempt from FUL and MAIC implementation.

FUL drugs and prices are available on the CMS website at *www.medicaid.gov/medicaid/prescription-drugs/pharmacy-pricing/index.html.*

Situations of Medical Necessity

When medically necessary for a specific recipient, approval of reimbursement at the NADAC or, if no NADAC, the WAC may be obtained for a product whose price exceeds the MAIC or FUL price limits by requesting authorization from a Medi-Cal consultant. Reimbursement of the prescription ingredient cost may require the use of a brand of a multiple-source drug and may not exceed the statutory reimbursement limits.

Drugs Purchased Under the 340B Pricing Program

Providers billing drugs purchased pursuant to the 340B program (covered entities and contract pharmacies) are required to bill an amount not to exceed the entity's actual acquisition cost for the drug, as charged by the manufacturer at a price consistent with United States Code, Section 256b, Title 42, plus the professional dispensing fee pursuant to W&I Code, Section 14105.45. Providers will be reimbursed the lesser of the billed amount (actual acquisition cost plus professional dispensing fee) or the maximum rate permitted under W&I Code, Section 14105.45.

Prescription and Over-the-Counter (OTC) Smoking/Tobacco Cessation Products For Use During Pregnancy

Medi-Cal will provide coverage of prescription and over-the counter (OTC) smoking/tobacco cessation covered outpatient drugs for pregnant women as recommended in "Treating Tobacco Use and Dependence -2008 Update: A Clinical Practice Guideline" published by the U.S. Public Health Service in May 2008 or any subsequent modification of such guideline.

Although the Patient Protection and Affordable Care Act (ACA) Section 4107 authorizes coverage of counseling and pharmacotherapy for tobacco cessation for pregnant women, the U.S. Preventive Services Task Force concludes that the current evidence is insufficient to assess the balance of benefits and harms of pharmacotherapy interventions for tobacco cessation in pregnant women. Providers should refer to the tobacco cessation guidelines by the American College of Obstetricians and Gynecologists (ACOG) before prescribing tobacco cessation medications during pregnancy.

‹‹Prescription and OTC smoking/tobacco cessation for pregnant women are covered via the Contract Drugs List.››

Sales Tax

Sales tax on taxable items is included in the Medi-Cal reimbursement. After the Medi-Cal allowable amount is computed, sales tax, at rates appropriate to the county, is added to the reimbursement. The determination of which items are taxable is made in accordance with Board of Equalization rules.

‹‹Providers should include sales tax on Medi-Cal claims for taxable supplies and equipment. Providers must report sales tax, including the amount received from Medi-Cal, to the Board of Equalization.››

Compounded Prescriptions

‹‹The maximum reimbursement for compounded prescriptions is the total of ingredient costs, professional fees and the compounding fees. The amount charged is not to exceed the charge to the general public for such prescriptions.››

Drugs Provided to Physicians, Hospital Emergency Rooms, Outpatient Clinics, or Nursing Facilities for Dispensing or Administering

Pharmacies are not reimbursed by Medi-Cal for either the cost of ingredients or the professional fee for drugs furnished to other providers to administer or dispense to recipients. Medi-Cal does not consider that this is a pharmacy service rendered directly to Medi-Cal recipients. Pharmacies that furnish drugs to the following providers should bill the provider directly:

- Physicians
- Hospital emergency rooms
- Outpatient clinics
- Nursing facilities. Pharmacies may bill Medi-Cal for legend drugs and insulin for recipients in these facilities. All other drugs must be billed to the facility.

Nursing Facility Emergency Drug Supply

Pharmacies that own and maintain a nursing facility emergency drug supply may be reimbursed by Medi-Cal for the ingredient cost and professional fee of a drug administered from the emergency drug supply for a nursing facility patient emergency condition if the use of the same drug is not continued after its administration from the emergency drug supply. However, when a drug is administered from the emergency drug supply to a nursing facility patient for an emergency condition and the use of the same drug is continued after its administration from the emergency drug supply, the pharmacy may be reimbursed by Medi-Cal for a single prescription only after the total quantity of the prescription has been dispensed to the patient.

Disposable Intravenous Pumps

Disposable intravenous pumps, such as the Intermate and the Home Pump, are medical supplies that are potentially reimbursable by Medi-Cal subject to authorization. Disposable pumps may be approved when medically necessary and represent the least costly method that will fulfill the needed purpose.

Providers should submit *Treatment Authorization Requests* (TARs) for disposable pumps to the TAR Processing Center. When asking for authorization for a disposable pump, please address the following questions on the TAR:

1. Is a pump medically necessary? Is this a drug that could be administered without a pump?
2. Assuming a pump is medically necessary, why is a disposable pump needed? Could a less-expensive pump be used to administer the drug? (Examples of alternative pumps might include gravity controllers, pole-type pumps or syringe pumps.) If not, why not?

Disposable intravenous pumps must be billed using medical supply HCPCS codes A4305 or A4306 (disposable drug delivery system). Refer to the *Medical Supplies Billing Codes, Units and Quantity Limits* spreadsheet.

Note: Providers should not bill disposable pumps as "containers," intravenous administration sets or hypodermoclysis sets. Examiners are instructed to deny payment for disposable pumps billed as containers or administration sets.

Non-disposable intravenous pumps require authorization from a local Medi-Cal field office and must be billed as Durable Medical Equipment (DME).

Home Infusion Preparation

The program allows reimbursement for home infusion preparations, on a per container basis, at the following rates:

Cost	Paid
Cost of ingredients	Paid at AAC
Cost of supplies consumed in compounding I.V. solution	Paid at maximum allowable product cost (MAPC*) by report or price on file up to $5.56 per container
Cost of empty containers	Paid at MAPC* by report
Cost of sterility testing (only when performed)	Up to $0.32 per container
Professional fee	Refer to "Professional Dispensing Fee" on a previous page.
Compounding fee	0.99 per container (in addition to professional fee, for compounded solutions only)

Note: Empty containers must be billed separately from the compound claim.

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.

‹‹Medical supplies, diabetic testing supplies (home blood-glucose monitoring), enteral nutrition products, incontinence products and blood factors (see the *Blood and Blood Derivatives* section of the provider manual) may only be billed on a CMS-1500, UB-04, or equivalent electronic transaction.››

After Hours and Delivery Services

Under no circumstances may a Medi-Cal recipient be billed or charged directly for after hours or delivery services.

If a pharmacy routinely charges all customers a fee for these services, the charge may be included in the usual and customary amount billed to Medi-Cal. However, payment is limited to the usual maximum reimbursement (that is, the appropriate professional fee, plus the allowable ingredient cost, or the amount billed, whichever is less).

If a pharmacy does not routinely charge all customers a fee for these services, a charge may not be included in the usual and customary amount billed to Medi-Cal.

Medi-Cal does not pay for these services as separate additional fees. The cost of these components is considered part of the professional fee.

Signature Requirement for Medication Delivery

In accordance with *Welfare and Institutions Code* (W&I Code), Section 14043.341, providers must obtain either a handwritten or electronic signature for prescription medications sent to a beneficiary. Providers may obtain the signature of a beneficiary or the recipient either before the medication is sent, or upon receipt when delivered to the beneficiary.

Signature Prior to Delivery

Providers have two options to obtain a beneficiary's signature when the beneficiary is not in person, such as during a telehealth visit.

- Recorded oral signature: Providers must ensure that they are able to collect an audio or video recording that can be stored in the provider's case record and retrieved upon request. Providers may use either of the following two options for audio or video-recorded signatures.
  - Recording only the signature portion of the telehealth visit. When recording only the signature portion of the visit, providers must record the portion of the visit where the beneficiary acknowledges and confirms the medications they will be receiving and provides their understanding that the oral signature holds the same weight as a written signature; or
  - Recording the entire visit with the oral signature included

- Electronic signature: Providers may obtain an electronic signature. Consistent with the Uniform Electronic Transactions Act, California Civil Code Section 1633.2, an "electronic signature" is an electronic sound, symbol, or process attached to or logically associated with an electronic record and executed or adopted by a person with the intent to sign the electronic record. An electronic signature includes a "digital signature" defined in subdivision (d) of Section 16.5 of the Government Code to mean an electronic identifier, created by a computer, intended by the party using it to have the same force and effect as a manual signature. Regardless of the type of electronic signature collected, providers must ensure that they are able to store and/or easily access documentation of the electronic signature in the beneficiary's medical record.

Signature upon Receipt of Delivery

Providers may obtain a beneficiary's handwritten or electric signature upon receipt of delivery if the delivery service offers physical or electronic return receipts, such as those offered through the United States Postal Service. Providers must retain documentation of the signature in the beneficiary's medical record.

‹‹Pharmacy Medication Therapy Management

Medication therapy management (MTM) reimbursement for Medi-Cal providers who participate in the delivery of pharmacist services authorized pursuant to W&I Code, Section 14132.968 and Section 14132.969. Additional billing limitations can be found in the Medication Therapy Management section of this manual.

Pharmacy MTM Maximum Reimbursement Rates

CPT Code	Code Description	Maximum Reimbursement Rate (in dollars)
99605	Medication therapy management service(s) provided by a pharmacist, individual, face-to-face with patient, with assessment and intervention if provided; initial 15 minutes, new patient	43
99606	Medication therapy management service(s) provided by a pharmacist, individual, face-to-face with patient, with assessment and intervention if provided; initial 15 minutes, established patient	43
99607	Medication therapy management service(s) provided by a pharmacist, individual, face-to-face with patient, with assessment and intervention if provided; each additional 15 minutes.	32››

Pharmacy Discounts

DHCS is aware that certain pharmacies engage in various advertising promotions that essentially result in some form of discount for their customers. Examples include, but are not limited to, the offering of price discounts, cash rebates and free prescriptions.

Pharmacy providers offering such 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.

Dispensing Quantity Limitations

100 Calendar Day Supply

Prescription quantities must not be greater than a 100 calendar day supply.

Exceptions:

a. Sodium Fluoride prescriptions
b. When a greater quantity is necessary to comply with the following minimum quantity restrictions:

Quantity Restrictions

1. Oral contraceptives: Oral contraceptives must be dispensed in a minimum quantity of three cycles.

Exceptions:

a. The initial prescription
b. When authorization is obtained for a smaller quantity

2. Minimum 480cc dispensing quantities

Prescriptions for liquid potassium supplements and for theophylline liquid must be dispensed in a minimum quantity of 480cc. They are:

- Potassium Chloride
- Potassium Triplex
- Theophylline

Exceptions:

a. The initial prescription
b. When authorization is obtained for a smaller quantity

Reimbursement Limitations

Skin Cream or Feces and Urine Washes (Cleaners)

Providers are reminded that “Skin Cream” or “Feces and Urine Washes,” specifically promoted for ostomate or incontinence usage, may only be provided for ostomates or for incontinent patients with chronic pathologic conditions causally related to the patient’s incontinence.

Three in 75-Day Billing Limitation

Reimbursement for tablets or capsules listed in the Contract Drugs List on the Medi-Cal Rx website preceded by “+” is limited to full payment for a maximum of three claims for the same drug and strength dispensed to the same recipient within any 75-day period. As used here, “full payment” means the drug ingredient cost plus a professional fee component. The fourth claim from any provider, and any subsequent claim, for the same drug and strength dispensed to the same recipient within any 75-day period will be paid at the drug ingredient cost only.

Exceptions:

a. The initial prescription
b. When authorization is obtained for smaller quantities resulting in more frequent billing
c. Drugs dispensed in a quantity of 180 or more tablets or capsules

Items Not Covered

Pharmacy items excluded from reimbursement under the Medi-Cal program are:

1. Non-legend drug preparations:
   a. Benzoic and Salicylic Acid Ointment (pre-compounded)
   b. Salicylic Acid Cream or Ointment
   c. Salicylic Acid Liquid
   d. Sodium Chloride Tablets 1 Gm
   e. Sodium Chloride Tablets 2.5 Gm
   f. Zinc Oxide Paste
   g. ‹‹Non-legend Analgesics››
2. Medical foods, enteral nutritional supplements or replacements, except for items included in the *List of Enteral Nutrition Products* may be covered, subject to authorization.
3. ‹‹Vitamin combinations for people over 5 years of age››
4. Non-legend (OTC) drugs except insulin are included in the NF-A and NF-B daily rates. Pharmacies will not be paid for OTC drugs, other than insulin, for NF-A or NF-B patients. Medical supplies for NF-A or NF-B patients are reimbursable only as specified in Medical Supplies List sections of this manual and CCR, Title 22, Section 51510.

Note: Incontinence pads are included in the facility's per diem rates.

Continuing Care

‹‹Drugs lined out and marked with a “§” symbol have been suspended from the Contract Drugs List. Medi-Cal will not provide reimbursement for drugs annotated with the “§” symbol unless you obtain a *Treatment Authorization Request* (TAR) for the drug, or the recipient qualifies for continuing care. To be eligible for the TAR exemption for continuing care, the following conditions must be met:››

- The recipient must be taking the drug when it is suspended or deleted from the Contract Drugs List.
- A claim for the drug, in the same dosage form and strength, within 100 days prior to the drug’s suspension or deletion.
- To maintain recipient eligibility under continuing care, a claim must be submitted for the drug, in the same dosage form and strength, at least every 100 days from the date of service. The recipient may switch between brands of the drug in the same dosage form and strength and maintain their continuing care status.

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.
*	MAPC as defined by W&I Code, Section 14105.47