

In order to ensure that people who are dually eligible for Medicare and Medi-Cal continue to get needed medications during the transition of drug coverage from Medi-Cal to Medicare, Governor Arnold Schwarzenegger directed the California Department of Health Services (CDHS) to immediately begin temporarily covering the cost of medications for those who are unable to obtain them from Medicare. This program began the evening of January 12, 2006, and will continue on an emergency basis for five days and provide emergency payment for prescription drugs to beneficiaries who are dually eligible for Medi-Cal and Medicare if the pharmacy has tried and been unable to obtain reimbursement from Medicare.

This process is only available in cases where the pharmacy has attempted to obtain Medicare billing information and has attempted to bill Medicare for this drug. To receive reimbursement, a pharmacy must certify that certain conditions have been met.

This program will provide payment for emergency supplies of drugs for these dual eligibles that are unable to obtain their drugs under the Medicare program. This emergency program is available to full-benefit, dual eligible beneficiaries previously covered either by fee-for-service Medi-Cal or by a Medi-Cal managed care plan.

Billing Criteria

These emergency drug benefits are available only when one of the following has occurred:

- The pharmacy has submitted a claim for the provision of drug benefits to the full-benefit dual eligible beneficiary's Medicare Drug Plan and the claim has been denied payment for reasons other than processing errors or omissions made by the pharmacy, lack of medical necessity or health or safety reasons. **Note:** Pharmacy billing of inappropriate quantities (for example, billing greater than a 30-day supply when only a 30-day supply is allowed under the Medicare Drug Plan) is considered a pharmacy processing error.
- The pharmacy is unable to submit a claim solely due to the unavailability of complete or accurate Medicare Drug Plan enrollment information from the full-benefit dual eligible beneficiary's Medicare Drug Plan, the Centers for Medicare and Medicaid Services (CMS) or entities under contract with the CMS to provide enrollment information, including having attempted to obtain eligibility information from the Medicare E1 eligibility system.
- The Medicare Drug Plan provides information that the full-benefit dual eligible beneficiary's deductible or co-payment amount is higher than the \$1 to \$5 co-payment amounts that are established by Medicare for full-benefit dual eligible beneficiaries.

Process

The Department has developed a process that allows pharmacy providers to submit this emergency claim electronically. The pharmacy provider need only indicate that the Code I requirements of the claim have been met. By doing so, the pharmacy provider is certifying that **all** of the following conditions are met:

- (A) One of the three situations noted above has occurred.
- (B) The pharmacist provides or dispenses the drug as a critical service.
- (C) The pharmacist has not previously provided or dispensed, nor has knowledge that another pharmacist has provided or dispensed, a quantity of the same drug that is sufficient to cover the period of time for which the prescription is being dispensed.
- (D) The date of service (date the prescription is dispensed) is from January 12 through 17 inclusive.

For claims where Medicare has set the co-payment amount to be greater than that for dual eligibles (\$1 to \$5), the pharmacy should submit an “other coverage” claim. The amount billed field should contain the pharmacy’s usual and customary charge for the prescription and the other coverage paid field should contain the amount that the Medicare program is reimbursing the pharmacy plus the normal co-payment due for the patient. This is the same method used for all Medi-Cal claims for beneficiaries who have other coverage.

CODE I (RESTRICTIONS):

Code I drugs typically require prior authorization in accordance with Section 51003, unless used under the conditions specified in the Contract Drugs List. In this instance, the Code I is being used outside the Contract Drugs List. The emergency claims discussed in this notice are subject to the prescription documentation requirements in CCR, Title 22, Section 51476(c).

To submit a Code 1:

- **Paper:** Place a “Y” in the “CODE I MET” box on the 30-1 claim form (Indicates the Code I restriction for the drug was met.) The provider should also note in the “Specific Details/Remarks” section of the form that the claim is for “Medicare Part D drugs”.
- **Electronic:** Place a “7=Medically Necessary” in the Submission Clarification Code (42Ø-DK). (Code indicating that the pharmacist is clarifying the submission.)

This use of the Code I indicator shall only be used for Medicare Part D emergency drug benefit claiming. Other emergency claims for Medi-Cal beneficiaries shall continue using the paper claim process.

If the claim meets the three conditions above and is denied by the Medi-Cal claims processing system due to the beneficiary not meeting their monthly share of cost, the pharmacy must submit the claim on paper via a 30-1 claim form as indicated above. The "Remarks" section must be filled in as noted.

Please note that Med-Cal is the payor of last resort available only when information to be paid by Medicare cannot be obtained and this prescription is a one-time emergency supply. It is critical that providers work with beneficiaries, the Medicare drug plan and Medicare to resolve these problems to allow for the proper administration of the Medicare drug program on an ongoing basis. Providers who misuse this program are subject to state audit and recovery.

This program is temporary and will continue until 11:59 p.m. on January 17, 2006. Governor Arnold Schwarzenegger is seeking to obtain emergency legislation to extend this program.