Prescription Drug Program

MONTANA DPHHS

Healthy People. Healthy Communities.

Department of Public Health & Human Services

July 2016

This publication supersedes all previous pharmacy provider handbooks. Published by the Montana Department of Public Health & Human Services, July 2001.

Updated October 2001, December 2001, May 2002, June 2002, September 2002, January 2003, August 2003, July 2004, November 2004, May 2011, August 2011, October 2011, December 2011, January 2013, March 2013, July 2013, September 2013, March 2015, June 2015, January 2016, and July 2016.

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My NPI/API:

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Key Contacts

See the Contact Us link in the left menu on the Provider Information website for additional contacts and websites.

Drug Prior Authorization

For all questions regarding drug prior authorization:

800-395-7961
406-443-6002 (Helena)
8 a.m. to 5 p.m., Monday–Friday
Mountain Time

Mail or fax backup documentation to:

Mountain-Pacific Quality Health
3404 Cooney Drive
Helena, MT 59602
800-294-1350 Fax
406-513-1928 Fax Helena

Point-of-Sale (POS) Help Desk

For assistance with online POS claims adjudication:

Xerox, Atlanta
Technical POS Help Desk
800-365-4944
6 a.m to midnight, Monday–Saturday;
10 a.m. to 9 p.m., Sunday
Eastern Time

Program Policy

For program policy questions:

406-444-4540 Phone
406-444-1861 Fax

Allied Health Services Bureau
1400 Broadway
P.O. Box 202951
Helena, MT 59620

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Drug Program

Thank you for your willingness to serve members of the Montana Medicaid program and other medical assistance programs administered by the Department of Public Health and Human Services.

Manual Organization

This manual provides information specifically for Prescription Drug Program providers. Other essential information for providers is contained in the separate *General Information for Providers* manual. **Providers are responsible for reviewing both manuals.**

A table of contents and an index allow you to quickly find answers to most questions. The margins contain important notes with extra space for writing notes. There is a list of Key Contacts at the beginning of this manual, and additional contacts are on the Contact Us link in the left menu on the Provider Information website. The inside front cover of this manual has a space for you to record your NPI/API for quick reference when calling Provider Relations.

Manual Maintenance

Manuals must be kept current. Changes to manuals are provided through provider notices and replacement pages. When replacing a page in a paper manual, file the old pages and notices in the back of the manual for use with claims that originated under the old policy.

Rule References

Providers must be familiar with all current rules and regulations governing the Montana Medicaid program. Provider manuals are to assist providers in billing Medicaid; they do not contain all Medicaid rules and regulations. Rule citations in the text are a reference tool; they are not a summary of the entire rule. **In the event that a manual conflicts with a rule, the rule prevails.** Links to rules are available on the Provider Information website. Paper copies of rules are available through the Secretary of State's office. (See the Contact Us link in the left menu on the Provider Information website.) In addition to the general Medicaid rules outlined in the *General Information for Providers* manual, the following rules and regulations are also applicable to the Prescription Drug Program:

- Code of Federal Regulations (CFR)
  - 42 USC 1396r-8, Payment for Covered Outpatient Drugs
- Montana Codes Annotated (MCA)
  - MCA 37-7-101 – MCA 37-7-1408, Pharmacy
- Administrative Rules of Montana (ARM)
  - ARM 37.86.1101 – ARM 37.86.1105, Outpatient Drug Services

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Claims Review (MCA 53-6-111, ARM 37.85.406)

The Department is committed to paying Medicaid providers' claims as quickly as possible. Medicaid claims are electronically processed and usually are not reviewed by medical experts prior to payment to determine if the services provided were appropriately billed. Although the computerized system can detect and deny some erroneous claims, there are many erroneous claims which it cannot detect. For this reason, payment of a claim does not mean that the service was correctly billed or the payment made to the provider was correct. Periodic retrospective reviews are performed which may lead to the discovery of incorrect billing or incorrect payment. If a claim is paid and the Department later discovers that the service was incorrectly billed or paid or the claim was erroneous in some other way, the Department is required by federal regulation to recover any overpayment, regardless of whether the incorrect payment was the result of Department or provider error or other cause.

Getting Questions Answered

The provider manuals are designed to answer most questions; however, questions may arise that require a call to a specific group (such as a program officer, Provider Relations, or a prior authorization unit). The Key Contacts chapter and the Contact Us link on the Provider Information website have important phone numbers and addresses. Medicaid manuals, provider notices, replacement pages, fee schedules, forms, and more are available on the Provider Information website.

Drug Program Goal

The Prescription Drug Program covers pharmaceuticals and pharmacist services to members served by the Department in the Medicaid program and the Mental Health Services Plan (MHSP).

Who May Prescribe, Administer, or Dispense Legend Drugs and Controlled Substances?

Primary authority for the prescribing of legend drugs and controlled substances comes from individual professional practice acts, usually in the section of the act which defines the scope of practice for the profession. The definition of scope of practice is the responsibility of the board that licenses the professional. Only those providers not excluded by federal programs are eligible.

DUR Board

The Drug Use Review (DUR) Board performs drug utilization review and educational interventions. Five pharmacists and four physicians comprise the DUR Board which is coordinated by a full-time registered Montana pharmacist. The DUR Board meets monthly to review utilization and advise the Department.

The DUR Board and The University of Montana Skaggs School of Pharmacy also advise the Department on its outpatient drug formulary. Drugs are evaluated for safety, effectiveness, and clinical outcome. The Department has also contracted with Oregon Health Sciences University and participates in the Drug Effectiveness Review Project to provide the DUR Board with the latest evidence-based systematic reviews of relevant drug classes. Drugs recommended for formulary exclusion have no significant, clinically meaningful therapeutic advantage over drugs recommended for inclusion.

Drug Use Review (DUR) Board meetings are posted on the Provider website.

On the Pharmacy page, click on the Drug Use Review (DUR) Board pane.

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Medicaid Covered Products

What Drugs and Pharmaceutical Supplies Are Covered?

Drug coverage is limited to those products where the pharmaceutical manufacturer has signed a rebate agreement with the federal government. Federal regulations further allow states to impose restrictions on payment of prescription drugs through prior authorization and preferred drug lists (PDL).

The Medicaid Prescription Drug Program covers the following:

1. Legend drugs, subject to the PDL and prior authorization requirements.

2. Medicaid covers the following **prescribed** over-the-counter (OTC) products manufactured by companies who have signed a federal rebate agreement:
   - Antacids*
   - Aspirin**
   - Diphenhydramine
   - Doxylamine
   - Folic Acid
   - H2 antagonist GI products
   - Head lice treatment
   - Insulin
   - Ketotifen ophthalmic solution
   - Laxatives*
   - Levonorgestrel
   - Nonsedating antihistamines
   - OTC nicotine patches with prior authorization
   - Oxybutynin transdermal
   - Proton pump inhibitors
   - Pyridoxine
   - Triamcinolone acetonide nasal spray

   *Nursing facilities are responsible for providing OTC laxatives, antacids, and aspirin to their residents.

3. Compounded prescriptions

4. Contraceptive supplies and devices

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5. Federal law allows states the discretion to cover certain medications listed in 42 USC 1396r-8. Montana Medicaid has opted to cover the following medications for all recipients, including Medicare Part D recipients:
   - Prescription cough and cold medications
   - OTC medications listed above. Medicaid does not cover proton pump inhibitors or non-sedating antihistamines for Part D members when the member's prescription drug plan covers these classes of drugs.
   - Prescription vitamins and minerals will be granted prior authorization when indicated for the treatment of an appropriate diagnosis.

What Drugs and Pharmaceutical Supplies Are Not Covered?

The Medicaid Prescription Drug Program does not reimburse for the following items or services:

1. Drugs supplied by drug manufacturers who have not entered into a federal drug rebate agreement.
2. Drugs supplied by other public agencies such as the United States Veterans Administration, United States Department of Health and Human Services, local health departments, etc.
3. Drugs for Medicare Part D dual eligible patients, except for drugs covered under #5 above.
4. Drugs prescribed:
   - To promote fertility
   - For erectile dysfunction
   - For weight reduction
   - For cosmetic purposes or hair growth
   - For an indication that is not medically accepted as determined by the Department in consultation with federal guidelines, the DUR Board, or the Department medical and pharmacy consultants.
5. Drugs designated as less-than-effective (DESI drugs) or drugs that are identical, similar, or related to such drugs.
6. Drugs that are experimental, investigational, or of unproven efficacy or safety.
7. Free pharmaceutical samples.
8. Obsolete National Drug Code (NDC).
9. Terminated drug products.

10. Any drug, biological product, or insulin provided as part of, or incident to and in the same setting as, any of the following:
    - Inpatient hospital setting
    - Hospice services
    - Outpatient hospital services emergency room visit
    - Other laboratory and x-ray services
    - Renal dialysis
    - Incarceration

11. Any of the following drugs:
    - Outpatient nonprescription drugs (except those OTC products previously listed)
    - Covered outpatient drugs for which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee.

12. Medical supplies (non-drug items) are not covered under the Prescription Drug Program.

    Exception:
    - Contraceptive supplies and devices

The Montana Preferred Drug List

To address the rising costs of prescription drugs, Montana Medicaid implemented a preferred drug list (PDL) in 2005. The Department of Public Health and Human Services uses this program to provide clinically effective and safe drugs to its members at the best available price.

The PDL addresses certain classes of medications and provides a selection of therapeutically effective products for which the Medicaid program will allow payment without restriction in those targeted classes. The Department, through its Formulary Committee, designates this listing of preferred drugs as “preferred” based primarily on clinical efficacy. In the designated classes, drug products that are non-preferred on the PDL will require prior authorization.

The Department updates the PDL annually and periodically as new drugs and information become available.

The current Montana PDL can be found on the Provider Information website. Providers may address questions regarding the PDL and requests for prior authorization to the Drug Prior Authorization Unit. (See the Key Contacts. chapter) **The PDL/Prior Authorization Help Line is for providers only.** Medicaid members with questions can ask their providers or call the Medicaid Help Line, 1-800-362-8312.

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Medicare Part B and Part D Drug Claims

Part D

Medicare added prescription drug coverage for its beneficiaries under the Medicare Modernization Act, 42 USC 1302 Sec. 1395. Members enrolled in Medicare Part A and/or Part B are eligible for Medicare Part D and are required to receive their drug benefits through a Medicare Prescription Drug Plan (PDP). Members enrolled in both Medicaid and Medicare are considered "dual eligible" and are auto-enrolled in a Medicare PDP if they do not choose a plan. Montana Medicaid's reimbursement for outpatient drugs provided to a full-benefit dual eligible member will be limited to the excluded drugs identified in this chapter and the Part B drugs described in the following paragraph.

Part B

Claims cross over automatically if the provider's NPI/API is on file with Medicaid. The taxonomy code for the pharmacy is required on the claim.

To bill paper claims:

- Submit your claims on a CMS-1500 form.
- Attach the Medicare EOMB.
- Use your NPI/API.
- Mail to the Claims Processing Unit, P.O. Box 8000, Helena, MT 59604.
- Providers using paper claims must wait 45 days after Medicare paid date to submit claims.

Part B crossover claims will be reimbursed using the following "lower of" pricing methodology:

- Medicaid allowed minus the Medicare paid; **or**
- Medicare coinsurance plus Medicare deductible.

Medicaid allowed for the pharmacy supplying and dispensing fee is $4.94.

For an updated list of covered Part B drugs, visit the CMS website, www.cms.gov.

MHSP Covered Products

The Mental Health Services Plan (MHSP)

1. The Mental Health Services Plan (MHSP) formulary is limited to specific psychotropic and adjunct legend drugs. The formulary is available on the Pharmacy page of the Provider Information website.

2. The Department has rebate agreements with pharmaceutical manufacturers for many of the drugs on the formulary. Non-preferred products require a higher member cost sharing. Providers are asked to use preferred products to the extent possible. See the Provider Information website.

3. Members are responsible for the following cost sharing or the cost of the medication if lower than the copay:
   - Preferred generic drug$12.00/script
   - Preferred brand drug with generic available$12.00/script
   - Preferred brand drug with no generic available$12.00/script
   - All non-preferred drugs$17.00/script

4. Clozaril, all strengths, is exempt from cost sharing.

5. For members with MHSP coverage, there is a $425 pharmacy cap. The MHSP program pays for the first $425 in prescriptions for the member each month, and the member must pay privately for any amounts over that cap.

6. Drug claims for the MHSP are processed through the same system used for Medicaid claims. To avoid confusion and claim denials, follow the instructions below:
   - **Point-of-Sale:** To submit MHSP claims, use Group Number **0064206420**.
   - **Paper Claims:** Clearly write **MHSP ONLY** on the face of each paper claim.

MHSP Formulary

The MHSP formulary includes the following types of drugs:

- Adrenergic blocking agents
- Antianxiety drugs
- Anticonvulsants for adjunct therapy
- Antidepressants
- Antihyperkinesis/Adrenergic agents

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- Antimania drugs
- Antipsychotics (limited to 15-day initial fill)
- Anti-cholinergics
- MAO inhibitors
- Miscellaneous psychotherapeutic agents
- Nonbarbituate sedatives, hypnotics
- SSRIs

Refer to the MHSP formulary on the Pharmacy page of the Provider Information website.

Dispensing Limitations

Prescription Quantity (ARM 37.86.1102)

1. Drugs are limited to a 34-day supply except for the following specific package sizes:
   - Seasonale® 91-day supply
   - Poly-vi-Flor® (and generics with or without iron) 50- to 100-day supply
   - Depo-Provera® 90-day supply
   - Vitamin B-12 injections 90-day supply
   - Maintenance supplies

   The Medicaid DUR Board has recommended the following drug classes be considered for maintenance supplies. (Examples are in parentheses.)

Drug Classes Considered for Maintenance Supplies

Heart Disease	Diabetes Medications	Blood Pressure	Women's Health	Thyroid
Digitalis glycosides (digoxin, lanoxin)	Insulin release stimulant type (glipizide)	Hypotensive, vasodilators (prasozin)	Folic acid preparations	Thyroid hormones (levothyroxine)
Antiarrythmics (quinidine)	Biguanides (metformin)	Hypotensive, sympatholytic (clonidine)	Prenatal vitamins	
Potassium replacement	Alpha-glucosidase inhibitors (acarbose)	ACE inhibitors (lisinopril)	Oral contraceptives	
Thiazide and related diuretics (HCTZ)	Insulin release stimulant/biguanide combo	ACE inhibitors/ diuretic combos		
Potassium sparing diuretics and combinations (spironolactone)		ACE inhibitor/ Calcium channel blocker combos		
Loop diuretics (furosemide)		Calcium Channel Blockers (diltiazem)		
		Alpha/beta adrenergic blocking agents (carvedilol)		
		Alpha adrenergic blocking agents and thiazide combos		
		Beta-adrenergic blocking agents (propranolol)		

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2. No more than two prescriptions of the same drug may be dispensed in a calendar month except for the following:
   - Antibiotics
   - Schedule II and V drugs
   - Antineoplastic agents
   - Compounded prescriptions
   - Prescriptions for suicidal patients or patients at risk for drug abuse
   - Topical preparations

Other medications may not be dispensed in quantitites greater than a 34-day supply except where manufacturer packing cannot be reduced to a smaller quantity.

The DUR Board has set monthly limits on certain drugs. Use over these amounts requires prior authorization.

Prescription Refills

Prescriptions for non-controlled substances may be refilled after 75% of the estimated therapy days have elapsed. Prescriptions for controlled substances (CII-CV), Ultram (tramadol), Ultracet (tramadol/acetaminophen), carisoprodol, and gabapentin may be refilled after 90% of the estimated therapy days have elapsed. The POS system will deny a claim for “refill to soon” based on prescriptions dispensed on month-to-month usage.

A prescription may be refilled early only if the prescriber changes the dosage, or if the member was admitted to a nursing facility. The pharmacist must document any dosage change. In any circumstance, the provider must contact the Drug Prior Authorization Unit to receive approval. (See Key Contacts.)

Pharmacists who identify members who experience difficulties in managing their drug therapy may consider unit dose prescriptions (see below).

Generic Drugs

The Department has a mandatory generic edit in the claims processing system. The edit is enabled once there are two rebateable AB-rated generic drugs available in the marketplace. Typically, the first generic labeler will have a six-month period of market exclusivity. To maximize value to the State, the Department recommends dispensing the brand name drug over the generic during this period of market exclusivity. When there are “preferred brands” on the Department’s Preferred Drug List (PDL), generic equivalent drugs, during a period of market exclusivity, will require a prior authorization.

For drugs not subject to PDL restrictions and for those drugs listed in the Dispense As Written (DAW) section of the Billing Procedures chapter, if the brand name drug is prescribed instead of a generic equivalent, the prescriber must get prior authorization.

Authorization is based on medical need such as adverse reactions or therapeutic failures (clinically demonstrated, observed and documented) which have occurred when the generic drug has been used.

Unit Dose Prescriptions

Pharmacy-packaged unit dose medications may be used to supply drugs to patients in nursing facilities, group homes, and other institutional settings.

Members who are not in one of the above facilities may also be considered high-risk and eligible for unit dose packaging if they:

- Have one or more of the following representative disease conditions: Alzheimer's disease, blood clotting disorders, cardiac arrhythmia, congestive heart failure, depression, bipolar, cancer, diabetes, epilepsy, HIV/AIDS, hypertension, schizophrenia, or tuberculosis; **and**
- Consume two or more prescribed concurrent chronic medications which are dosed at three or more intervals per day; **or**
- Have demonstrated a pattern of noncompliance that is potentially harmful to their health.

Unit dose prescriptions may not exceed the 34-day supply limit.

Compounding

The Department shall reimburse pharmacies for compounding drugs only if the member's drug therapy needs cannot be met by commercially available dosage strengths and/or forms of the therapy.

Prescription claims for compound drugs shall be billed and reimbursed using the National Drug Code (NDC) number and quantity for each compensable ingredient in the compound. No more than 25 ingredients may be reimbursed in any compound. Reimbursement for each drug component shall be determined in accordance with ARM 37.86.1101. Prior authorization requirements for individual components of a compound must be met for reimbursement purposes. The Department does not consider reconstitution to be compounding.

The Department may reimburse for compounded non-rebateable API bulk powders and excipients on the Department's drug formulary maintained in accordance with ARM 37.86.1102.

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Prior Authorization

Many drug products require prior authorization **before** the pharmacist provides them to the member. Requests are reviewed for medical necessity.

- To request prior authorization, providers must submit the information requested on the Request for Drug Prior Authorization form to the Drug Prior Authorization Unit. See the Forms link in the left menu on the Provider Information website.
- The prescriber (e.g., physician) or pharmacy may submit requests by mail, telephone, or fax to:

  Drug Prior Authorization Unit
  Mountain-Pacific Quality Health
  3404 Cooney Drive
  Helena, MT 59602
  406-443-6002 or 800-395-7961 (Phone)
  406-513-1928 or 800-294-1350 (Fax)

- Requests are reviewed and decisions made immediately in most cases. Decisions on requests with special circumstances that require further peer review are made within 24 hours. Requests received after the Drug Prior Authorization Unit's regular working hours of 8 a.m. to 5 p.m., Monday through Friday, or on weekends or holidays, are considered received at the start of the next working day.
- An emergency 72-hour supply may be dispensed for emergency, after-hours, weekend, and holiday requests. Payment will be authorized by using a "3" in the Days Supply field and a value of "8" in the Prior Authorization Type Code field.

Prior Authorization for Retroactively Eligible Members

All prior authorization requirements must be met for retroactively eligible members.

When a member is determined retroactively eligible for Medicaid, the member should give the provider a Notice of Retroactive Eligibility (160-M).

The provider has 12 months from the date retroactive eligibility was determined to bill for those services.

Retroactive Medicaid eligibility does not allow a provider to bypass prior authorization requirements.

When a member becomes retroactively eligible for Medicaid, the provider may:

- Accept the member as a Medicaid member from the current date.
- Accept the member as a Medicaid member from the date retroactive eligibility was effective.
- Require the member to continue as a private-pay member.

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Providers may choose whether to accept retroactive eligibility. (See the *General Information for Providers* manual, Member Eligibility and Responsibilities chapter.) All prior authorization requirements must be met to receive Medicaid payment.

When submitting claims for retroactively eligible members, attach a copy of the Notice of Retroactive Eligibility (Form 160-M) to the claim if the date of service is more than 12 months earlier than the date the claim is submitted.

MHSP Prior Authorization Criteria

For a list of drugs requiring prior authorization, contact the Drug Prior Authorization Unit. (See Key Contacts.)

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Reimbursement

Reimbursement for Covered Drugs

Reimbursement for covered drugs is the lesser of:

1. The provider's usual and customary charge of the drug to the general public; or
2. The allowed ingredient cost plus a professional dispensing fee. Where allowed ingredient cost is defined as the lower of:
   a. The Average Acquisition Cost (AAC); or
   b. Submitted ingredient cost.
      i. If an AAC rate is not available, drug reimbursement is determined at the lower of:
         1) Wholesale Acquisition Cost;
         2) Affordable Care Act Federal Upper Limit (ACA FUL); or
         3) Submitted ingredient cost.

Average Acquisition Cost

Average acquisition cost (AAC) is the calculated average drug ingredient cost per drug determined by direct pharmacy survey, wholesale survey, and other relevant cost information. The AAC rates are published online under the Pharmacy Provider webpage.

Submitted Ingredient Cost

Submitted Ingredient is a pharmacy's actual ingredient cost. For drugs purchased under the 340B Drug Pricing Program, submitted ingredient cost means the actual 340B purchase price. For drugs purchased under the Federal Supply Schedule (FSS), submitted ingredient cost means the actual FSS purchase price.

Usual and Customary

The usual and customary charge is the price the provider most frequently charges the general public for the same drug. In determining "usual and customary" prices, the Department:

- Does not include prescriptions paid by third party payers, including health insurers, governmental entities, and Montana Medicaid, in the general public.
- Includes discounts advertised or given (including but not limited to cash rebate, monetary price discount, coupon of value) to any segment of the general public.
- Uses the lower of the two pricing policies if a provider uses different pricing for "cash" and "charge" members.
- Will use the median price if during an audit, the most frequent price cannot be determined from pharmacy records.

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Federal Maximum Allowable Cost (MAC)

- The FMAC is based on the Federal Upper Limit pricing set by the U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS). The FMAC limitation shall not apply in a case where a physician certifies in his/her own handwriting the specific brand is medically necessary for a particular member. An example of an acceptable certification is the handwritten notation "Brand Necessary" or "Brand Required." A check off box on a form or rubber stamp is not acceptable.

Dispensing Fee

- The dispensing fee shall range between a minimum of $2.00 and a maximum of $4.94 for brand name and non-preferred brand name and generic drugs, and a minimum of $2.00 and a maximum of $6.78 for preferred brand name drugs and preferred generic drugs, and for generic drugs not identified on the PDL.
- The dispensing fee for each compounded drug shall be $12.50, $17.50, or $22.50 based on the level of effort required by the pharmacist.
- The maximum dispensing fee is $3.50 for out-of-state pharmacies.
- New pharmacy providers are assigned the maximum dispensing fee. Failure to comply with the six-month dispensing fee questionnaire requirement will result in assignment of a dispensing fee of $2.00.
- Pharmacies may receive an additional $0.75 for dispensing pharmacy-packaged unit dose prescriptions.
- Dispensing fee surveys are available from the Department of Public Health and Human Services Prescription Drug Program. (See Key Contacts.)

Vaccine Administration Fee

Pharmacies can receive a vaccine administration fee. This fee is in lieu of the standard dispensing fee. The fee for the first vaccine administered will be $21.32; the fee for each additional vaccine administered will be $12.68.

The Remittance Advice

The remittance advice is the best tool providers have to determine the status of a claim. Remittance advices accompany payment for services rendered. The remittance advice provides details of all transactions that have occurred during the previous remittance advice cycle. Each line of the remittance advice represents all or part of a claim, and explains whether the claim or service has been paid, denied, or suspended (also referred to as pending). If the claim was suspended or denied, the remittance advice also shows the reason. See the *General Information for Providers* manual for more information on the remittance advice.

As of July 2013, all new providers were required to enroll in electronic funds transfer (EFT) and receive electronic remittance advices. Providers who enrolled prior to July 2013 who received paper checks or paper remittance advices were transitioned to the electronic-only system over time.

Credit Balances

Credit balances occur when claim adjustments reduce original payments causing the provider to owe money to the Department. These claims are considered in process and continue to appear on the remittance advice until the credit has been satisfied. Credit balances can be resolved in two ways:

1. By working off the credit balance. Remaining credit balances can be deducted from future claims. These claims will continue to appear on consecutive remittance advices until the credit has been paid.
2. By sending a check payable to DPHHS for the amount owed. This method is required for providers who no longer submit claims to Montana Medicaid. Attach a note stating that the check is to pay off a credit balance and include your provider number. Send the check to Third Party Liability.

Rebilling and Adjustments

Rebillings and adjustments are important steps in correcting any billing problems you may experience. Knowing when to use the rebilling process versus the adjustment process is important. When submitting a reversal (void) use a B2 NCPDP transaction and when submitting a rebilled claim or an adjustment use a B3 NCPDP transaction (void & rebill).

Timeframe for Rebilling or Adjusting a Claim

- Providers may resubmit or adjust any initial claim within the timely filing limits described in the Billing Procedures chapter of this manual. Depending on switch-vendor requirements, some point-of-sale adjustments must be completed within three months. In this case, adjustments may be submitted on paper within the timely filing limits.
- These time periods do not apply to overpayments that the provider must refund to the Department. After the 12-month time period, a provider may not refund overpayments to the Department by completing a claim adjustment. The provider may refund overpayments by issuing a check or asking the Third Party Liability Unit to complete a gross adjustment.

Rebilling Medicaid

Rebilling is when a provider submits a claim or claim line to Medicaid that was previously submitted for payment but was either returned or denied. Pharmacy providers can rebill Medicaid via point-of-sale or on paper. Paper claims are often returned to providers before processing because information such as the NPI or authorized signature/date are missing or unreadable. See the Billing Procedures chapter for tips on preventing returned or denied claims.

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When to Rebill Medicaid

- ***Claim Denied.*** Providers can rebill Medicaid when a claim is denied in full, as long as the claim was denied for reasons that can be corrected. When the entire claim is denied, check the Explanation of Benefits (EOB) code, make the appropriate corrections, and resubmit the claim (not an adjustment).
- ***Line Denied.*** When an individual line is denied on a multiple-line claim, correct any errors and rebill Medicaid. Either submit the denied service on a new MA-5 form, or cross out paid lines and resubmit the form, or submit via point-of-sale. Do not use an adjustment form.
- ***Claim Returned.*** Rebill Medicaid when the claim is returned under separate cover. Occasionally, Medicaid is unable to process the claim and will return it to the provider with a letter stating that additional information is needed to process the claim. Correct the information as directed and resubmit your claim.

How to Rebill

- Check any EOB code listed and make your corrections on a copy of the claim, or produce a new claim with the correct information, or rebill using point-of-sale.
- When making corrections on a copy of the claim, remember to cross out or omit all lines that have already been paid. The claim must be neat and legible for processing.
- Enter any insurance (third party liability) information on the corrected claim, or attach insurance denial information to the corrected claim, and send it to Claims Processing.

Adjustments

If a provider believes that a claim has been paid incorrectly, the provider may call Provider Relations. Once an incorrect payment has been verified, the provider may submit an Individual Adjustment Request form to Provider Relations or submit an adjustment through point-of-sale. If incorrect payment was the result of a Xerox keying error, the provider should contact Provider Relations.

When adjustments are made to previously paid claims, the Department recovers the original payment and issues appropriate repayment. The result of the adjustment appears on the provider's RA as two transactions. The original payment will appear as a credit transaction. The replacement claim reflecting the corrections will be listed as a separate transaction and may or may not appear on the same remittance advice as the credit transaction. The replacement transaction will have nearly the same ICN number as the credit transaction, except the 12th digit will be a 2, indicating an adjustment. Adjustments are processed in the same time frame as claims.

When to Request an Adjustment

- Request an adjustment when a claim was overpaid or underpaid.
- Request an adjustment when a claim was paid but the information on the claim was incorrect (e.g., member ID, NPI, date of service, NDC, prescribing provider, units).

How to Request an Adjustment

To request an adjustment, use the Individual Adjustment Request form. Adjustments may also be made using point-of-sale. The requirements for adjusting a claim are as follows:

- Claims Processing must receive individual claim adjustment requests within 12 months of the date of service. (See Timely Filing Limits in the Billing Procedures chapter.) After this time, gross adjustments are required.
- Use a separate adjustment request form for each TCN.
- If you are correcting more than one error per TN, use only one adjustment request form, and include each error on the form.
- If more than one line of the claim needs adjusting, indicate which lines and items need to be adjusted in the Remarks section of the adjustment form.

Completing an Adjustment Request Form

1. You may download the Individual Adjustment Request form from the Provider Information website. Complete Section A first with provider and member information and the claim's TCN.
2. Complete Section B with information about the claim. Complete only the items that need to be corrected. (See the table on next page.)
    - Enter the date of service or the line number in the Date of Service or Line Number column.
    - Enter the information from the claim that was incorrect in the Information on Statement column.
    - Enter the correct information in the Corrected Information column.
3. Attach copies of the remittance advice and a corrected claim if necessary.
    - If the original claim was billed electronically, a copy of the remittance advice will suffice.
    - If the remittance advice is electronic, attach a screen print of it.
4. Verify the adjustment request has been signed and dated.
5. Send the adjustment request to Claims Processing.
    - If an original payment was an underpayment by Medicaid, the adjustment will result in the provider receiving the additional payment amount allowed.
    - If an original payment was an overpayment by Medicaid, the adjustment will result in recovery of the overpaid amount through a credit balance or a check from the provider. (See Credit Balances earlier in this chapter.)
    - Any questions regarding claims or adjustments must be directed to Provider Relations.

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Completing an Individual Adjustment Request Form	
Field	**Description**
Section A Complete all fields using the remittance advice for information.	
1. Provider name and address	Provider's name and address (and mailing address if different).
2. Member name	The member's name.
3. Internal control number (ICN)	Enter the TCN number. There can be only one TCN per adjustment request form. When adjusting a claim that has been previously adjusted, use the TCN of the most recent claim.
4. NPI/API	The provider's NPI/API.
5. Member Medicaid number	Member's Medicaid ID number.
6. Date of payment	Date claim was paid is found on remittance advice.
7. Amount of payment	The amount of payment from the remittance advice.
Section B Complete only the items that need to be corrected.	
1. Units of service	If a payment error was caused by an incorrect number of units, complete this line.
2. Procedure code/NDC/Revenue code	If the procedure code, NDC, or revenue code is incorrect, complete this line.
3. Dates of service (DOS)	If the date of service is incorrect, complete this line.
4. Billed amount	If the billed amount is incorrect, complete this line.
5. Personal resource (nursing facility)	If the member's personal resource amount is incorrect, complete this line.
6. Insurance credit amount	If the member's insurance credit amount is incorrect, complete this line.
7. Net (Billed Amount - TPL or Medicare paid)	If the payment error was caused by a missing or incorrect insurance credit, complete this line. Net is billed amount minus the amount third party liability or Medicare paid.
8. 8. Other/Remarks	If none of the above items apply, or if you are unsure what caused the payment error, complete this line.

Mass Adjustments

Mass adjustments are done when it is necessary to reprocess multiple claims. They generally occur when:

- Medicaid has a change of policy or fees that is retroactive. In this case federal laws require claims affected by the changes to be mass adjusted.
- A system error that affected claims processing is identified.

Providers are informed of mass adjustments by a provider notice or on the first page of the remittance advice. Mass adjustment claims shown on the RA have an ICN that begins with a 4.

Payment and the Remittance Advice

Providers receive their Medicaid payment and remittance advices weekly. To sign up for EFT (direct deposit) and register for the web portal to view or download remittance advices, providers need to complete the EFT and ERA Authorization Agreement and the EDI Trading Partner Agreement and mail or fax them to Provider Relations. See the Provider Enrollment page for those documents.

A letter from your financial institution verifying legitimacy of the account is also required. The letter must include the name and contact information of the bank representative and be signed by the bank representative. Do not send voided checks or deposit slips.

Once enrolled in EFT and registered for the MATH web portal, providers are able to receive their electronic remittance advices. Due to space limitations, each remittance advice is available on the web portal for 90 days.

For assistance on enrolling in EFT, completing the EDI Trading Partner Agreement, and registering for the MATH web portal, contact Provider Relations.

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Billing Procedures

Provider Number

- The Department uses the pharmacy's NPI as the provider number for billing purposes.
- The Department-assigned provider number is used for payment and reporting purposes.
- Changes in pharmacy ownership or NABP (NCPDP) number must be reported immediately to ensure that payments are received by the billing owner. Contact Provider Relations to report all ownership changes.

Provider Enrollment
P.O. Box 4936
Helena, MT 59604

800-624-3958
406-442-1837

Tamper-Resistant Pads

Written prescriptions must contain all of the following.

- One or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form;
- One of more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber; and
- On or more industry-recognized features designed to prevent the use of counterfeit prescription forms.

Outpatient pharmacy claims for Montana Medicaid and MHSP require the prescription origin code to indicate the source of the prescription. Valid values for prescription origin code are:

- 0 – Not specified
- 1 – Written prescription
- 2 – Telephone
- 3 – Electronic
- 4 – Facsimile

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How Long Do I Have to Bill?

Providers are required to submit a clean claim no later than 365 days from:

- The date of service;
- The date retroactive eligibility is determined;
- The date disability is determined; or
- Within 6 months of the date Medicare pays, whichever is later.

A clean claim is one that can be adjudicated without correction or additional information or documentation from the provider.

Prescription Tracking and Claim Reversals

For purposes of billing for prescribed drugs, the date of service means the date a prescription is filled. If the drug has not been received by the member or the member's representative within 15 days after the prescription is filled, the pharmacy must reverse the claim and refund the payment to the Department.

Tips to Avoid Timely Billing Denials

- Correct and resubmit denied claims promptly. (See the Reimbursement chapter, Remittance Advices and Adjustments section in this manual.)
- If a claim submitted to Medicaid does not appear on the remittance advice within 30 days, contact Provider Relations for claim status.

When to Bill Medicaid Members (ARM 37.85.406)

In most circumstances, providers may not bill Medicaid members for services covered under Medicaid. The main exception is that providers may collect cost sharing from members.

More specifically, providers cannot bill members directly:

- For the difference between charges and the amount Medicaid paid.
- For a covered service provided to a Medicaid-enrolled member who was accepted as a Medicaid member by the provider, even if the claim was denied.

Under certain circumstances, providers may need a signed agreement in order to bill a Medicaid member (see the following table).

When to Bill a Patient (ARM 37.85.406)			
	Patient Is Medicaid-Enrolled and Provider Accepts Patient as a Medicaid Member	**Patient Is Medicaid-Enrolled and Provider Does Not Accept Patient as a Medicaid Member**	**Patient Is Not Medicaid-Enrolled**
Service Is Covered by Medicaid	Provider can bill patient **only** for cost sharing.	Provider can bill Medicaid if the patient has signed a routine agreement.	Provider can bill patient.
Service Is Not Covered by Medicaid	Provider can bill patient only if custom agreement has been made between the patient and provider before providing the service.	Provider can bill Medicaid if the patient has signed a routine agreement.	Provider can bill patient.

Routine Agreement: This may be a routine agreement between the provider and patient which states that the patient is not accepted as a Medicaid member, and that he/she must pay for the services received.

Custom Agreement: This agreement lists the service the patient will receive and states that the service is not covered by Medicaid and that the patient will pay for the services received.

Billing for Retroactively Eligible Members

When the provider accepts the member's retroactive eligibility, the provider has 12-months from the date retroactive eligibility was determined to bill for those services.

When submitting claims for retroactively eligible members in which the date of service is more than 12 months earlier than the date the claim is submitted, attach a copy of the Provider Notice of Eligibility (Form 160-M). The provider must request the form from the member's local Office of Public Assistance.

See http://dphhs.mt.gov/hcsd/OfficeofPublicAssistance. For more information on retroactive eligibility, see the Member Eligibility and Responsibilities chapter in the *General Information for Providers* manual.

Usual and Customary Charge (ARM 37.85.406)

Providers should bill Medicaid their usual and customary charge for each service; that is, the same charge that is made to other payers for that service.

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Member Cost Sharing (ARM 37.85.204 and 37.85.402)

For the Prescription Drug Program, cost sharing is as follows:

- Preferred brands: $4
- Non-preferred brands and brands not on the PDL: $8
- No monthly cap
- Cost share exemption on generics and select therapeutic drug classes

For all members, the following drugs are exempt from cost sharing:

- Clozaril, all strengths
- Family planning prescriptions
- Compounded prescriptions for infusion therapy
- Tobacco cessation products

The following are exempt from cost sharing:

- Members under 21 years of age
- Pregnant women (until end of postpartum, which begins on the last day of pregnancy and ends at the end of the month in which 60 days have passed)
- Nursing facility residents
- Members with third party liability (TPL) when Medicaid is the secondary payer.
- American Indians and Alaska Natives who have ever been treated at an IHS, Tribal, or Urban facility or through referral under contract health services with appropriate documentation.

To exempt cost sharing on POS, enter a “4” in the Prior Authorization Type Code field. On a paper claim, enter a “4” in Drug Name field. See the Point-of-Service and Billing a Paper Claim chapters in this manual.

The provider must always use the complete 11-digit NDC from the dispensing container.

For members with Mental Health Services Plan (MHSP) coverage, there is a $425 pharmacy cap. The MHSP program pays for the first $425 in prescriptions for the member each month, and the member must pay privately for any amounts over that cap.

A provider cannot deny services to a Medicaid member because the member cannot pay cost sharing fees at the time services are rendered. However, the member’s inability to pay cost sharing fees when services are rendered does not lessen the member’s obligation. If a provider has a policy on collecting delinquent payment from non-Medicaid members, that same policy may be used for Medicaid members. A provider may sever the relationship with a member who has unpaid cost sharing obligation, as long as a consistent policy is followed with Medicaid and non-Medicaid members. Once the relationship is severed, with prior notice to the member either verbally or in writing, the provider may refuse to serve the member.

National Drug Codes (NDC)

All outpatient prescription drugs are billed using the drug's NDC, the 11-digit code assigned to all prescription drug products by the labeler or distributor of the product under FDA regulations.

The Department accepts only the 5-4-2 NDC format. All 11 digits, including zeros, must be entered. The three segments of the NDC are:

SAMPLE NDC: 12345-6789-10
12345 = labeler code
6789 = product code
10 = package size

Claims must accurately report the NDC dispensed, the number of units dispensed, days supply, and the date of dispensing. Use of an incorrect NDC or inaccurate reporting of a drug quantity will cause the Department to report false data to drug manufacturers billed for drug rebates.

The Department will recover payments made on erroneous claims discovered during dispute resolution with drug manufacturers. Pharmacies are required to document purchase for quantities of brands of drugs reimbursed by the Department if disputes occur.

Dispense As Written (DAW)

Prescribers and pharmacies must prescribe and dispense the generic form of a drug whenever possible. Except for those drugs listed below, Prior authorization is required when a brand name drug is prescribed instead of a generic equivalent. Please use the following DAW codes for these situations:

- DAW 1 may only be used only if authorized by the Drug Prior Authorization Unit. In addition to prior authorization requirements, brand name drugs with a generic equivalent (except those required by the PDL) may be billed only when the prescriber has handwritten "brand necessary" or "brand required" on the prescription. The pharmacy must retain brand certifications as documentation.
- DAW 5 may be used in instances where the drug dispensed is generic but is listed as a brand (branded generics) and prior authorization is required.
- DAW 7 may be used for seizure medications with an appropriate diagnosis without prior authorization. Based on DUR Board recommendations only anti-epileptic medications being used for a seizure diagnosis, and anti-hemophilic factors will be continue to be considered narrow therapeutic index (NTI) drugs. A DAW 7 override will be allowed on these drugs only. See the 2009 provider notice on the Pharmacy page of the website for additional information.
- DAW 9 is used when a brand name multisource drug is preferred and pharmacy is dispensing the brand name drug, this exempts the pharmacy from using the generic and allows reimbursement at the brand name rate.

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Abuse and Misutilization

The following practices constitute abuse and misutilization:

1. **Excessive Fees:** Commonly known as prescription splitting or incorrect or excessive dispensing fees. Billing inappropriately in order to obtain dispensing fees in excess of those allowed by:
   - Supplying medication in amounts less than necessary to cover the period of the prescription.
   - Supplying multiple medications in strengths or quantities less than those prescribed to gain more than one dispensing fee.
2. **Excessive Filling:** Billing for an amount of a drug or supply greater than the prescribed quantity.
3. **Prescription Shorting:** Billing for drug or supply greater than the quantity actually dispensed.
4. **Substitution to Achieve a Higher Price:** Billing for a higher priced drug than prescribed even though the prescribed lower priced drug **was** available.

Point-of-Sale

What Is the Pharmacy Point-of-Sale (POS)?

The point-of-sale (POS) system finalizes claims at the point of entry as either paid or denied. Pharmacies arrange their own telecommunications switch services to accept Montana Medicaid point of sale and are responsible for any charges imposed by these vendors. Hard copy (paper) billing is still accepted when billed on form MA-5. All claims are processed and edited through the POS system regardless of how the claim was originally submitted.

If the claim continues to deny for eligibility past 3 working days, call Provider Relations at 1-800-624-3958.

Possession of a Montana Access to Health (MATH) Medicaid ID card **is not** proof of eligibility.

Member eligibility may change monthly, so providers should verify eligibility each month. Both the 7-digit member number and the patient's Social Security number are billable numbers. If a claim is rejected online, a provider should verify eligibility by one of the methods (MATH web portal, IVR, FaxBack, calling Provider Relations) described in the *General Information for Providers* manual.

Pro-DUR

The POS system performs all major prospective drug utilization review (Pro-DUR) edits. In some circumstances, the Pro-DUR edits result in denied claims. When a Pro-DUR denied claim needs to be overridden, pharmacy providers may enter one Reason for Service Code (formerly DUR Conflict Code) from each category in the following order, as long as the indicated situations exist and the pharmacy retains documentation in its files:

1. Two-byte alpha Reason for Service Code, *followed by...*

2. Two-byte alphanumeric Professional Service Code, *followed by...*

3. Two-byte alphanumeric Result of Service Code

By placing codes into the claim, the provider is certifying that the indicated DUR code is true and documentation is on file. For questions regarding DUR codes, contact the Drug Prior Authorization Unit.

NCPDP DUR Codes

See the Other Resources section of the Pharmacy page of the Provider Information website. for the NCPDP Payer Sheet and code information.

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Billing a Paper Claim

Completing Pharmacy Claim Form MA-5

Instructions for completing the MA-5 are described on the next page. The form is available on the Forms page of the Provider Information website.

For MHSP claims, clearly write **MHSP ONLY** on the face of each paper claim.

Providers electing to bill the Department on the paper MA-5 form will be required to write the type of prescription media received plainly on the face of the form. Providers not indicating the prescription media type will be assigned a not specified status and will be subject to audit.

Valid values for prescription origin code are:

- 0 – not specified
- 1 – written prescription
- 2 – telephone
- 3 – electronic
- 4 – facsimile

For more information, see the 2008 provider notice on the Pharmacy page of the website. Paper claims must be mailed to the following address:

Claims Processing Unit
P.O. Box 8000
Helena, MT 59604

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MA-5 Instructions

Field	Field Title	Instructions
1	Name – Provider	Enter the pharmacy name.
2	NPI	Enter the pharmacy's 10-digit national provider identifier (NPI).
3	Address – Provider	Enter the pharmacy street address, city, state and ZIP code.
4	MHSP or Medicaid	Select the appropriate option.
5	Cardholder ID Number – Recipient	Enter the cardholder/recipient 9-digit ID.
6	Name – Recipient	Enter the recipient's last name, first name, and middle initial.
7	Date of Birth – Recipient	Enter the recipient's date of birth in mm/dd/yy format.
8	Prescriber Number	Enter the prescribing physician's NPI.
9	Prescription Type	Use drop-down box to make selection: electronic, fax, telephone, written.
10	Date Filled	Enter the date the prescription was filled in mm/dd/yy format.
11	Refill	Enter Y (Yes) or N (No).
12	Compound	Select Yes or No.
13	NDC	Enter the manufacturer's 11-digit NDC number from the dispensing container.
14	Days' Supply	Enter the days supply of the medication dispensed.
15	Quantity	Enter the quantity of the medication dispensed.
16	Charge	Enter the pharmacy's usual and customary charge, including the dispensing fee.
17	Unit Dose	Select Yes or No.
18	Prescription Number	Enter the pharmacy-assigned prescription number.
19	DAW	Dispensed As Written: Indicate DAW 1, 5, or 7 when physician has certified "Brand Required" or "Brand Necessary," or the drug is "Branded Generic," and the following conditions are met: • DAW 1 – Requires prior authorization. • DAW 5 – If the brand is generic but listed as a brand – requires prior authorization. • DAW 7 – For those drugs listed in the Billing Procedures chapter, *Dispense As Written (DAW)*.
20	Drug Description	Enter name of drug dispensed.
21	Level of Effort	Enter level of effort to determine appropriate difficultly of compounding a product.
22	Submission Clar Code	Montana only uses Value 8 – process compound for improved ingredients.
23	Other Coverage Code	0 not specified; 1 no other coverage exists; 2 other coverage exists; payment collected; 3 other coverage exists; this claim not covered; 4 other coverage exists; payment not collected.
24	Total Charges	Enter the total charges for the individual prescription on the line.
25	Other Coverage Amount	Enter amount other carrier paid, if applicable.
26	Patient Paid	Enter amount the patient paid on this prescription.
27	Net Billed	Enter the amount being billed after deducting other insurance paid on this prescription.
28	Total charges	Enter the total charges of all prescriptions on the form and the amounts to be paid by Medicaid and the recipient.
29	Certification, Signature, and Date	Claims must contain the pharmacist or dispensing physician's signature (hand-written, stamped, or computer-generated).

Montana County List

Number	County
01	Beaverhead
02	Big Horn
03	Blaine
04	Broadwater
05	Carbon
06	Carter
07	Cascade
08	Chouteau
09	Custer
10	Daniels
11	Dawson
12	Deer Lodge
13	Fallon
14	Fergus
15	Flathead
16	Gallatin
17	Garfield
18	Glacier
19	Golden Valley
20	Granite
21	Hill
22	Jefferson
23	Judith Basin
24	Lake
25	Lewis & Clark
26	Liberty
27	Lincoln
28	Madison

Number	County
29	McCone
30	Meagher
31	Mineral
32	Missoula
33	Musselshell
34	Park
35	Petroleum
36	Phillips
37	Pondera
38	Powder River
39	Powell
40	Prairie
41	Ravalli
42	Richland
43	Roosevelt
44	Rosebud
45	Sanders
46	Sheridan
47	Silver Bow
48	Stillwater
49	Sweet Grass
50	Teton
51	Toole
52	Treasure
53	Valley
54	Wheatland
55	Wilbaux
56	Yellowstone

Appendix A: Forms

The forms below and others are available on the Forms page of the Provider Information website:

- Drug Prior Authorization Form
- Individual Adjustment Request
- Link Request, Montana Access to Health Web Portal
- Prescription Claim Form MA-5

Definitions and Acronyms

See the Definitions and Acronyms page of the Provider Information website for terminology related to the Prescription Drug Program.

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