



Prescription Drug Program

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.

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Key Contacts

ACS EDI Gateway

For questions regarding your electronic remittance advice:

(800) 987-6719 Phone

(850) 385-1705 Fax

ACS EDI Gateway Services
2324 Killearn Center Boulevard
Tallahassee, FL 32309

Direct Deposit Arrangements

Providers who would like to receive their remittance advices electronically and electronic funds transfer should call the number below and ask for the Medicaid Direct Deposit Manager.

(406) 444-5283

Drug Prior Authorization

For all questions regarding drug prior authorization:

(800) 395-7961

(406) 443-6002 (Helena)

8:00 a.m. to 5:00 p.m., Monday–Friday
(Mountain Time)

Mail backup documentation to:
Mountain-Pacific Quality Health
3404 Cooney Drive
Helena, MT 59602

Fax backup documentation to:

(800) 294-1350

(406) 513-1928 (Helena)

Fraud and Abuse

If you suspect fraud or abuse by an enrolled Medicaid client or provider, you may call one of the Program Compliance Bureau's fraud hotlines:

Client Eligibility Fraud

(800) 201-6308

Medicaid Client Help Line

(800) 362-8312

(to report suspected Medicaid abuse by client)

Provider Fraud

(800) 376-1115

Medicaid Client Help Line

Clients who have Medicaid or Passport questions may call the Montana Medicaid Client Help Line:

(800) 362-8312

Passport to Health

P.O. Box 254

Helena, MT 59624-0254

Paper Claims

Send paper claims to:

ACS Claims Processing Unit

P.O. Box 8000

Helena, MT 59604

Point-of-Sale (POS) Help Desk

For assistance with online POS claims adjudication:

ACS, Atlanta

Technical POS Help Desk

(800) 365-4944

6:00 a.m. to midnight, Monday–Saturday

10:00 a.m. to 9:00 p.m., Sunday

(Eastern Time)

Program Policy

For program policy questions:

(406) 444-4540 Phone

(406) 444-1861 Fax

8:00 a.m. to 5:00 p.m., Monday–Friday

(Mountain Time)

Send written inquiries to:

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

Provider Relations

For questions about eligibility, payments, denials, general claims questions, or to request billing instructions:

(800) 624-3958 In- and out-of-state
(406) 442-1837 Helena

8:00 a.m. to 5:00 p.m., Monday–Friday
(Mountain Time)

Send written inquiries to:

ACS Provider Relations Unit
P.O. Box 4936
Helena, MT 59604

Send e-mail inquiries to:

MTPRHelpdesk@ACS-inc.com

Provider Enrollment

For enrollment changes or questions:

(800) 624-3958 In- and out-of-state
(406) 442-1837 Helena

8:00 a.m. to 5:00 p.m., Monday–Friday
(Mountain Time)

Send written inquiries to:

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

Secretary of State

The Secretary of State's office publishes the most current version of the Administrative Rules of Montana (ARM):

(406) 444-2055 Phone

Secretary of State
P.O. Box 202801
Helena, MT 59620-2801

Third Party Liability

For questions about private insurance, Medicare or other third-party liability:

(800) 624-3958 In- and out-of-state
(406) 442-1837 Helena

8:00 a.m. to 5:00 p.m., Monday–Friday
(Mountain Time)

Send written inquiries to:

ACS Third Party Liability Unit
P.O. Box 5838
Helena, MT 59604

Key Websites	
Web Address	Information Available
<p>ACS EDI Gateway http://www.acs-gcro.com/</p>	<p>ACS EDI Gateway is Montana’s HIPAA clearinghouse. Visit this website for more information on:</p> <ul style="list-style-type: none"> • Provider Services • EDI Support • Enrollment • Manuals • Software • Companion Guides
<p>Provider Information http://medicaidprovider.hhs.mt.gov/</p> <p>Montana Access to Health (MATH) Web Portal https://mtaccessstohealth.acs-shc.com/mt/general/home.do</p>	<ul style="list-style-type: none"> • Medicaid: Medicaid provider information including provider manuals, fee schedules, notices, replacement pages, forms, frequently asked questions, newsletters, and key contacts. • HMK: Information on the Healthy Montana Kids (HMK) Plan • Public Health: Disease prevention (immunizations), health and safety, health planning, and laboratory services • Administration: HPSD budgets, staff and program names and phone numbers, program statistics, and systems information. • News: Recent developments • Preferred Drug List (PDL) • Montana Access to Health (MATH): Eligibility, provider summary information, claim status, payment amounts, X12 transactions, remittance notices, medical claims history, prior authorization, hospitals, physicians, mid-levels, enrollment
<p>Secretary of State www.sos.mt.gov</p> <p>Administrative Rules of Montana www.mtrules.org</p>	<p>Administrative Rules of Montana</p>
<p>State of Montana DPHHS http://www.dphhs.mt.gov</p>	<ul style="list-style-type: none"> • General information about DPHHS: Advisory councils, director’s office, divisions and websites, goals and objectives, organizational charts, phone numbers, and policies and procedures • Legal Information: ADA commendation notice, ARM, Emergency notices, MAR, Other State and Federal legal resources, proposed manual changes, requests for bids or proposals, requests for information • News: Bulletins, events calendar consumer product safety commission, meeting minutes, Montana Medicaid DUR board, press releases • Services: Applications and forms, guidelines, office locations, plans, programs available, publications, related website, reports, statistical information, virtual pavilion
<p>Washington Publishing Company www.wpc-edi.com</p>	<ul style="list-style-type: none"> • EDI implementation guides • HIPAA implementation guides and other tools • EDI education

Drug Program

Thank you for your willingness to serve clients 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. Each provider is asked to review both the general manual and the specific manual for his or her provider type.

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 each manual. We have also included a space on the back side of the front cover to record your Medicaid Provider ID number for quick reference when calling Provider Relations.

Manual Maintenance

Manuals must be kept current. Changes to manuals are provided through notices and replacement pages. When replacing a page in a 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 (see *Key Websites*). Paper copies of rules are available through the Secretary of State's office (see *Key Websites*). 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 37-7-101–37-7-1408, Pharmacy
- Administrative Rules of Montana (ARM)
 - ARM 37.86.1101–37.86.1105, Outpatient Drug Services

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 list of *Key Contacts* at the front of this manual has important phone numbers and addresses pertaining to this manual. The *Introduction* chapter in the *General Information for Providers* manual also has a list of contacts for specific program policy information. Medicaid manuals, notices, replacement pages, fee schedules, forms, and much more are available on the Provider Information website (see *Key Websites*).

Drug Program Goal

The Prescription Drug program covers pharmaceuticals and pharmacist services to clients 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.

DUR Board

The Drug Use Review (DUR) Board program 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 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 Preferred Drug Information link, then scroll to the [DUR Board Meeting Minutes](#) link.

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 (PA) and preferred drug lists (PDL).

The Medicaid prescription drug program covers:

1. Legend drugs, subject to the PDL and PA requirements.
2. Medicaid covers the following **prescribed** over-the-counter (OTC) products manufactured by companies who have signed a Federal rebate agreement:
 - Aspirin*
 - Insulin
 - Laxatives*
 - Antacids*
 - Head lice treatment
 - H2 antagonist GI products
 - Nonsedating antihistamines
 - Diphenhydramine
 - Proton pump inhibitors
 - OTC nicotine patches with prior authorization
 - Vaccines administered to adults in an outpatient pharmacy setting

*Nursing facilities are responsible for providing OTC laxatives, antacids and aspirin to their residents.
3. Compounded prescriptions
4. Contraceptive supplies and devices
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:
 - Benzodiazepines
 - Barbiturates
 - Prescription cough and cold medications

- OTC medications listed above. Medicaid does not cover proton pump inhibitors or nonsedating antihistamines for Part D recipients when the client'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, DUR Board, or the Department medical and pharmacy consultants.
5. Drugs designated as "less-than-effective" (DESI drugs), or which 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) March 7, 2005. The Department of Public Health and Human Services utilizes this program to provide clinically effective and safe drugs to its clients 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 PA.

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

The current Montana PDL can be found on the Department [website](#) (see *Key Websites*).

Providers may address questions regarding the PDL and requests for PA to the Drug Prior Authorization Unit (see *Key Contacts*). **The PDL/PA Help Line is for providers only.** Medicaid clients with questions can ask their providers or call the Medicaid Client Help Line (see *Key Contacts*).

Medicare Part B and Part D Drug Claims

Part D

Beginning January 1, 2006, Medicare added prescription drug coverage for its beneficiaries under the Medicare Modernization Act, 42 USC 1302 Sec. 1395. Clients 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). Clients 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 recipient will be limited to the excluded drugs identified in this chapter and the Part B drugs described in the following paragraph.

Part B

Crossover claims from Medicare Part B drugs with dates of service on or after January 1, 2006, are processed electronically or by paper claim using a CMS-1500 and the appropriate Healthcare Common Procedure Coding System (HCPCS) code. Claims after June 1, 2006, cross over automatically if the provider’s NPI/API is on file with Medicaid.

To bill paper claims:

- Submit your claims on a CMS-1500 form.
- Attach the Medicare EOMB.
- Use your NPI/API.
- Mail to the *Paper Claims* address shown in *Key Contacts*.
- 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 by calling Provider Relations.
2. The Department has rebate agreements with pharmaceutical manufacturers for many of the drugs on the formulary. Nonpreferred products require a higher client cost sharing. Providers are asked to use preferred products to the extent possible. See the Provider Information [website](#).
3. Clients 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 clients with MHSP coverage, there is a \$425 pharmacy cap. The MHSP program pays for the first \$425 in prescriptions for the client each month, and the client 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
- Antimania drugs

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

For an up-to-date list of drugs, refer to the [MHSP Formulary](#) on 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 Drug Utilization Review Board has recommended the following drug classes be considered for maintenance supplies (examples 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 (prazosin)	Folic acid preparations	Thyroid hormones (levothyroxine)
Antiarrhythmics (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)			

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 quantities 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. Refer to the *Prior Authorization* chapter for limits.

Prescription Refills

Prescriptions for noncontrolled 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 client 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 clients 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 PA. 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.

Clients 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.

Prior Authorization

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

- To request PA, providers must submit the information requested on the *Request for Drug Prior Authorization* form to the Drug Prior Authorization Unit. This form is at the end of this chapter.
- 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 PA 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/holiday requests. Payment will be authorized by using a "3" in the Days Supply field and a Medical Certification code of "8" in the PA/MC Code field.

Prior Authorization for Retroactively Eligible Clients

When a client becomes retroactively eligible for Medicaid, he or she should present the provider with an FA-455 (eligibility determination letter). Providers may choose whether to accept retroactive eligibility (see the *General Information for Providers* manual, *Client Eligibility* chapter). All PA requirements must be met to receive Medicaid payment. When requesting PA, attach a copy of the FA-455 to the PA request. It is the client's responsibility to ensure his or her caseworker prepares an FA-455 for each provider who participates in the client's health care during this retroactive period. See the *Billing Procedures* chapter in the manual for retroactive eligibility billing requirements.



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

The drug categories listed below currently require PA. For reference, see the Pharmacy page of the Provider Information [website](#) and the *Drugs Requiring Prior Authorization* table on the following pages. If you have any questions, contact the Drug Prior Authorization Unit (see *Key Contacts*).

Drug Categories

- Antidepressants
- Antiemetics
- Antihistamines
- Atypical Antipsychotics
- Dermatology
- DMARD/TIMS
- Diabetes
- GI
- Growth Hormone
- Migraine
- Pain
- Sleep/Narcolepsy
- Smoking Cessation
- Suboxone
- Vitamins
- XR Meds
- Miscellaneous

MHSP Prior Authorization Criteria

For a list of drugs requiring prior authorization, see the pages that follow. If you have any questions, contact the Drug Prior Authorization Unit (see *Key Contacts*).

DRUGS REQUIRING PRIOR AUTHORIZATION

Antidepressants	Antiemetics	Atypical Antipsychotics	Dermatology	DMARDs/TTMIs	Diabetes	G	Growth Hormone	Migraine	Pain/Inflammation	Sleep/Arcelepsy	Smoking Cessation	Suboxone	Vitamins	XR Meds	MISC.	MISC.2
Cymbalta	Anzemet	Abilify (all forms)	Atralin	Actemra	Actos	Aciphex	Gentropin	Amerge	Abstral	Ambien CR	Chantix	Suboxone	Calomist	Amrix	Acetazol	Relistor
Effexor XR	Emend	Clozani	Clindareach	Arava	Actosplus Met	Dexilant	Humatrope	Axert	Actiq	Dalmane	Nicotine Patches	Suboxone Film	Cyanocobal mine	Intuniv	Ampyra	Requip XR
Lexapro	Kytril	Fanapt	Differin	Cimzia	Byetta	Nexium	Norditropin	Cambria	Avinza	Doral	Zyban	Subutex	CF Vitamins	Kapvay	Auralgan	Revatio
	Marinol	Geodon	Elidel	Enbrel	Cycloset	Prevacid	Nutropin	Frova	Butrans	Eduar			Mephyton	Nexiclon XR	Cialis/ Adcirca	Solodyn
	Metozolv ODT	Invenga (all)	Epiduo	Humira	Duetact	Prilosec	Omnitrope	Imitrex	Celebrex	Lunesta			Nascobal	Requip XR	Combivent	Soma
	Sancuso	Latuada		Kineret	Glucagon EK	Protonix	Saizen	Maxalt	Cymbalta	Nuvigil			Prenatals	Ultram ER/ Ryzolt/ Conzip ER	Daliresp	Spiriva
	Zofran	Risperdal (all forms)	Protopic	Orencia	Victoza		Serostim	Migranol	Duragesic	ProSom			Renal Caps	Xanax SR	Desoxyn	Synagis
		Saphris	Retin A	Remicade			Trev-tropin	Relpax	Embeda	Provigil			Vitamin D	Zanaflex Cap	Difidid	Thalomid
		Seroquel & XR	Veltin	Simponi			Zorbtive	Stadol	Exalgo	Restoril					Duoneb	Tirosint
		Symbyax	Ziana	Stelara				Sumavel	Fentora	Rozerem					Effient	Tracleer
		Zyprexa (all forms)						Treximet	Flector/ Pennsaid	Silenor					Fexamid	Tyvaso
								Zomig	Kadian	Somnote					Gilenya	Uloric
								Lazanda	Sonata						Gralise	

DRUGS REQUIRING PRIOR AUTHORIZATION

Antidepressants	Antiemetics	Atypical Antipsychotics	Dermatology	DMARDs/DTMs	Diabetes	IG	Growth Hormone	Migraine	Pain/Inflammation	Sleep/Narcolepsy	Smoking Cessation	Suboxone	Vitamins	XR Meds	MISC.	MISC.2
								Lidoderm	Xyrem						Horizant	Ventavis
								Methadone	Zolpimist						Incivek	Victrelis
								MS Contin								Vimpat
								Naprelan								Xalatan
								Nucynta/ Nucynta ER							Lamictal ODT/Lamic tel.V.P.	Xolair
								Onsolis							Letairis	Zostavax
								Opiana/ Opiana ER							Latisse	Zyvox
								Oramorph SR							Lorzone	
								Oxycontin							Lumigan	
								Savella							Pradaxa	
								Sprinx							Oracea	
								Toradol							Quaaluin	
								Voltaren Gel								
								Zipsoor								

MHSP Prior Authorization Criteria

Updated 06/28/2011

MHSP FORMULARY

Prescription Drug Program

FORMULARY DRUG	PA Required
HYPOTENSIVES, SYMPATHOLYTIC	
CLONIDINE HCL	Yes
GUANFACINE	Yes
ANTI-ALCOHOLIC PREPARATIONS	
ACAMPROSATE CALCIUM	No
DISULFIRAM	No

SEDATIVE-HYPNOTICS, NON-BARBITURATE	
* = Those limited to initial fill of 15-day supply	
ESZOPICLONE	Yes*
FLURAZEPAM HCL	No
RAMELTEON	Yes*
TEMAZEPAM	No
TRIAZOLAM	No
ZALEPLON	Yes*
ZOLPIDEM TARTRATE	No
ZOLIDEM TARTRATE extended-release	Yes*
ANTI-ANXIETY DRUGS	
ALPRAZOLAM	No
BUSPIRONE HCL	No
CHLORDIAZEPOXIDE HCL	No
CLORAZEPATE DIPOTASSIUM	No
DIAZEPAM	No
LORAZEPAM	No
OXAZEPAM	No
ANTI-PSYCHOTICS, PHENOTHIAZINES	
CHLORPROMAZINE HCL	No
FLUPHENAZINE DECANOATE	No
FLUPHENAZINE HCL	No
PERPHENAZINE	No
THIORIDAZINE HCL	No
TRIFLUOPERAZINE HCL	No
MONOAMINE OXIDASE(MAO) INHIBITORS	
SELEGILINE	No

ANTI-MANIA DRUGS	
LITHIUM CARBONATE	No
LITHIUM CITRATE	No

ANTI-CHOLINERGIC	
BENZTROPINE MESYLATE	No
TRIHEXYPHENIDYL HCL	No
ALPHA-2 RECEPTOR ANTAGONIST ANTIDEPRESSANTS	
MIRTAZAPINE	No

FORMULARY DRUG	PA Required
SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)	
CITALOPRAM HYDROBROMIDE	No
ESCITALOPRAM OXALATE	Yes
FLUOXETINE HCL	No
FLUVOXAMINE MALEATE	No
PAROXETINE HCL	No
SERTRALINE HCL	No
TRICYCLIC ANTIDEPRESSANTS & REL. NON-SEL. RU-INHIB	
AMITRIPTYLINE HCL	No
CLOMIPRAMINE HCL	No
DESIPRAMINE HCL	No
DOXEPIN HCL	No
IMIPRAMINE HCL	No
IMIPRAMINE PAMOATE	No
MAPROTILINE HCL	No
NORTRIPTYLINE HCL	No
PROTRIPTYLINE HCL	No

ANTI-HYPERKINESIS/ADRENERGIC AGENTS	
DEXMETHYLPHENIDATE HCL	No
METHYLPHENIDATE	No
METHYLPHENIDATE HCL	No
METHYLPHENIDATE EXTENDED RELEASE	No
METHYLPHENIDATE TRANSDERMAL	No
AMPHET ASP/AMPHET/D-AMPHET	No
DEXTROAMPHETAMINE SULFATE	No
LISDEXAMFETAMINE DIMESYLATE	No

NARCOTIC ANTAGONISTS	
NALTREXONE HCL	No

ANTICONVULSANTS	
CARBAMAZEPINE	No
CLONAZEPAM	No
DIVALPROEX SODIUM	No
GABAPENTIN	Yes
LAMOTRIGINE	Yes
OXCARBAZEPINE	No
TOPIRAMATE	Yes
VALPROATE SODIUM	No
VALPROIC ACID	No

ANTI-EPS DRUGS, OTHER	
AMANTADINE HCL	No

FORMULARY DRUG	PA Required
SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIS)	
DESVENLAFAXINE SUCCINATE	No
DULOXETINE HCL	No
VENLAFAXINE HCL	No

NOREPINEPHRINE AND DOPAMINE REUPTAKE INHIB (NDRIS)	
BUPROPION HCL	No

SEROTONIN-2 ANTAGONIST/REUPTAKE INHIBITORS (SARIS)	
TRAZODONE HCL	No
MAOIS – NON-SELECTIVE & IRREVERSIBLE	
PHENELZINE SULFATE	No
TRANLYCYPROMINE SULFATE	No
ISOCARBOXAZID (MARPLAN)	No

ANTIPSYCHOTICS, DOPAMINE ANTAGONISTS, BUTYROPHENONES	
HALOPERIDOL	No
HALOPERIDOL DECANOATE	No

THYROID HORMONES	
LIOTHYRONINE SODIUM	Yes
LEVOTHYROXINE	Yes

ANTIHISTAMINES – 1ST GENERATION	
CYPROHEPTADINE HCL	No
DIPHENHYDRAMINE HCL	No
HYDROXYZINE HCL	No
HYDROXYZINE PAMOATE	No

FORMULARY DRUG	PA Required
ANTIPSYCHOTICS, ATYPICAL, DOPAMINE & SEROTONIN ANTAG **Limited to initial fill of 15-day supply**	
ASENAPINE MALEATE	No
CLOZAPINE	No
OLANZAPINE	No
PALIPERIDONE	No
QUETIAPINE FUMARATE	No
RISPERIDONE	No
RISPERIDONE MICROSPHERES	No
ZIPRASIDONE HCL	No
LURASIDONE	No
ILOPERIDONE	No
ANTIPSYCHOTICS, ATYP, D2 PARTIAL AGONIST/5HT MIXED **Limited to initial fill of 15-day supply**	
ARIPIPRAZOLE	No
TX FOR ATTENTION DEFICIT-HYPERACT (ADHD), NRI-TYPE	
ATOMOXETINE HCL	No

SSRI & ANTIPSYCH, ATYP, DOPAMINE & SEROTONIN ANTAG COMB **Limited to initial fill of 15-day supply**	
OLANZAPINE/FLUOXETINE HCL	No
BETA-ADRENERGIC BLOCKING AGENTS	
PINDOLOL	Yes
PROPRANOLOL HCL	Yes

ALPHA-ADRENERGIC BLOCKING AGENTS	
PAZOSIN HCL	Yes

ANTIPSYCHOTICS, DOPAMINE ANTAGONISTS,	
THIOTHIXENE	No



MOUNTAIN-PACIFIC QUALITY HEALTH Request for Drug Prior Authorization

Submitter: Physician Pharmacy

Please Type or Print

Patient Name (Last) (First) (Middle Initial)			Patient Medicaid ID Number			Date of Birth			
						Month	Day	Year	
Physician NPI		Physician Phone		Dates Covered by this Request					
				From			To		
Physician Name				Month	Day	Year	Month	Day	Year
Physician Street Address				Mail, fax or phone completed form to: Drug Prior Authorization Unit Mountain-Pacific Quality Health 3404 Cooney Drive Helena, MT 59602 (406) 443-6002 or 1-800-395-7961 (Phone) (406) 513-1928 or 1-800-294-1350 (Fax)					
Physician City		State	ZIP						
Pharmacy NPI		Pharmacy Phone No.							
Pharmacy Name									
Pharmacy Street Address									
Pharmacy City		State	ZIP						
Drug to be Authorized									
Drug Name				Strength			Directions		
Diagnosis or Condition Treated by this Drug									

LEAVE BLANK – PA UNIT USE ONLY					
Reason for Denial of Drug Prior Authorization					
<p>IMPORTANT NOTE: In evaluating requests for prior authorization, the consultant will consider the drug from the standpoint of published criteria only. If the approval of the request is granted, this does not indicate that the recipient continues to be eligible for Medicaid. It is the responsibility of the provider of service to establish by inspection of the recipient’s Medicaid eligibility card and if necessary, by contact with ACS to determine if the recipient continues to be eligible for Medicaid.</p> <p>Current recipient eligibility may be verified by calling ACS at (800) 624-3958 or (406) 442-1837.</p>					
Approval or Denial Status	Denial Code	Therapeutic Class	Auth ID	Date of Request	Prior Authorization Number

Reimbursement

Reimbursement for Covered Drugs

Reimbursement for covered drugs is the lesser of:

- The state estimated acquisition cost (EAC)
- The Federal maximum allowable cost (FMAC) plus a dispensing fee established by the Department
- The state maximum allowable cost (SMAC) plus a dispensing fee established by the Department
- The provider's usual and customary charge

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" clients.
- Will use the median price if during an audit, the most frequent price cannot be determined from pharmacy records.

Estimated acquisition cost (EAC)

- The EAC is the Department's best estimate of providers' cost for a drug in the package size most frequently purchased.
- The Department uses the average wholesale price (AWP) less 15% as their EAC; **or**
- The Wholesale Acquisition Cost (WAC) plus 2%; **or**
- The Department may set an allowable acquisition cost when the Department determines that acquisition cost is lower than AWP less 15%.

Maximum allowable cost (MAC)

- The MAC reimbursement applies to a listing of specific, therapeutically-equivalent multiple-source drugs with ample availability.

- The MAC 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) or the state maximum allowable cost as determined by the Department.
- Brand name and generic drugs with a MAC established price are reimbursed at the MAC price unless the physician or other licensed practitioner certifies in their own handwriting that in their medical judgement a specific brand name drug is medically necessary for a particular patient.
- Prior authorization for a brand name drug when a generic drug is available must be obtained from the Drug Prior Authorization Unit except for the drugs listed in the *Dispense As Written (DAW)* section of the *Billing Procedures* chapter.

Dispensing Fee

- The dispensing fee shall range between a minimum of \$2.00 and a maximum of \$4.94 for brand name drugs, and a minimum of \$2.00 and a maximum of \$6.40 for preferred and non-preferred generic drugs, and for generic drugs not identified on the PDL.
- The maximum dispensing fee is \$4.94 for in-state pharmacies and \$3.50 for out-of-state pharmacies.
- New pharmacy providers are assigned the maximum dispensing fee. Failure to comply with 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*).

The Remittance Advice

The remittance advice (RA) is the best tool providers have to determine the status of a claim. RAs accompany payment for services rendered. The RA provides details of all transactions that have occurred during the previous RA cycle. Providers may select a one or two week payment cycle (see *Payment and the RA* in this chapter). Each line of the RA 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 RA also shows the reason.

Electronic RA

To receive an electronic RA, the provider must complete the *Electronic Remittance Advice and Payment Cycle Enrollment Form* (see the table later in this chapter), have Internet access, and be registered for the Montana Access to Health (MATH) web portal. You can access your electronic RA through the

web portal on the Internet by going to the MATH web portal (see *Key Websites*) and selecting *Log in to Montana Access to Health*. To access the MATH web portal, you must first complete an *EDI Provider Enrollment Form* and an *EDI Trading Partner Agreement* (see the table later in this chapter).

After these forms have been processed, you will receive a user ID and password that you can use to log on to the MATH web portal. The verification process also requires a provider ID, a submitter ID, and a tax ID number. Each provider must complete an *EDI Trading Partner Agreement*, but if there are several providers in one location who are under one tax ID number, they can use one submitter number. These providers should enter the submitter ID in both the provider number and submitter ID fields. Otherwise, enter the provider number in the provider number field.

RAs are available in PDF format. You can read, print, or download PDF files using Adobe Acrobat Reader, which is available on the MATH web portal. Due to space limitations, each RA is only available for 90 days.

Paper RA

The paper RA is divided into the following sections: RA Notice, Paid Claims, Denied Claims, Pending Claims, Credit Balance Claims, Gross Adjustments, and Reason and Remark Codes and Descriptions. See the following sample paper RA and the *Keys to the Paper RA* table.

Sections of the Paper RA	
Section	Description
RA Notice	The RA Notice is on the first page of the remittance advice. This section contains important messages about rate changes, revised billing procedures, and many other items that may affect providers and claims.
Paid Claims	This section shows claims paid during the previous cycle. It is the provider's responsibility to verify that claims were paid correctly. If Medicaid overpays a claim and the problem is not corrected, it may result in an audit requiring the provider to return the overpayment plus interest. If a claim was paid at the wrong amount or with incorrect information, the claim must be adjusted (see <i>Adjustments</i> later in this chapter).
Denied Claims	This section shows claims denied during the previous cycle. If a claim has been denied, refer to the Reason/Remark column (Field 16). The Reason and Remark Code Description explains why the claim was denied and is located at the end of the RA. See <i>The Most Common Billing Errors and How to Avoid Them</i> in the <i>Billing Procedures</i> chapter.
Pending Claims	<p>All claims that have not reached final disposition will appear in this area of the paper RA (pending claims are not available on X12N 835 transactions). The RA uses "suspended" and "pending" interchangeably. They both mean that the claim has not reached final disposition. If a claim is pending, refer to the Reason and Remark Code column (Field 16). The Reason and Remark Code Description located at the end of the RA explains why the claim is suspended. This section is informational only. Please do not take any action on claims displayed here. Processing will continue until each claim is paid or denied.</p> <p>Claims shown as pending with Reason Code 133 require additional review before a decision to pay or deny is made. If a claim is being held while waiting for client eligibility information, it may be suspended for a maximum of 30 days. If Medicaid receives eligibility information within the 30-day period, the claim will continue processing. If no eligibility information is received within 30 days, the claim will be denied. When a claim is denied for lack of eligibility, the provider should verify that the correct Medicaid ID number was billed. If the ID number was incorrect, resubmit the claim with the correct ID number.</p>
Credit Balance Claims	Credit balance claims are shown here until the credit has been satisfied.
Gross Adjustments	Any gross adjustments performed during the previous cycle are shown here.
Reason and Remark Code Description	This section lists the reason and remark codes that appear throughout the RA with a brief description of each.

Sample Remittance Advice

DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES
HELENA, MT 59604

REMITTANCE ADVICE FOR MEDICAID/CHIP/MHSP

LOCAL PHARMACY
2100 NORTH MAIN STREET
WESTERN CITY MT 59988

(2) VENDOR # 0123456789 (3) REMIT ADVICE #123456 (4) EPT/CHK # 7654321 (5) DATE:02/15/2003 (6) PAGE 2
 (7) NPI # 0123456789 (8) TAXONOMY # 0123456789

RECIP ID	NAME	SERVICE DATES FROM TO	UNIT OF SVC	PROCEDURE REVENUE NDC	TOTAL CHARGES	ALLOWED	CO-PAY	REASON AND REMARK CODES
(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)	(17)

PAID CLAIMS - MISCELLANEOUS CLAIMS

123456789	DOE, JOHN EDWARD	01312010 01312010	28	63653117101	106.53	90.02	Y	
(18) ICN	40204011250000700	PRESCRIPTION # 0012345				2.00	(19)	
		LESS COPAY DEDUCTION						
		CLAIM TOTAL **			106.53	88.02		

DENIED CLAIMS - MISCELLANEOUS CLAIMS

123456789	DOE, JOHN EDWARD	02032010 02032010	56	00597005801	110.74	0.00	N	31MA61
ICN	40204011250000800	PRESCRIPTION # 0012345					(19)	
		CLAIM TOTAL **			110.74			

*****THE FOLLOWING IS A DESCRIPTION OF THE REASON/REMARK CODES THAT APPEAR ABOVE*****

- 31 CLAIM DENIED AS PATIENT CANNOT BE IDENTIFIED AS OUR INSURED.
- MA61 DID NOT COMPLETE OR ENTER CORRECTLY THE PATIENT'S SOCIAL SECURITY NUMBER OR HEALTH INSURANCE CLAIM NUMBER.

Montana Department of Public Health and Human Services

Key Fields on the Remittance Advice	
Field	Description
1. Provider name and address	Provider's business name and address as recorded with the Department.
2. Vendor #	For Montana Medicaid internal use and the billing number for atypical providers.
3. Remittance advice number	The remittance advice (RA) number.
4. Warrant number	Not used.
5. Date	The date the RA was issued.
6. Page number	The page number of the RA.
7. NPI #	A unique HIPAA-mandated 10-digit identification number assigned to health care providers by the National Plan and Provider Enumeration System (NPPES) through the Centers for Medicare and Medicaid Services (CMS).
8. Taxonomy #	Alphanumeric code that indicates the provider's specialty
9. Recipient ID	The client's Medicaid ID number.
10. Name	The client's name.
11. Internal control number (ICN)	<p>Each claim is assigned a unique 17-digit number (ICN). The MMIS converts the 14-digit TCN to an ICN. Use this number when you have any questions concerning your claim. The claim number represents the following information:</p> <p><u>0</u> <u>00111</u> <u>00</u> <u>123</u> <u>000123</u> A B C D E</p> <p>A = Claim medium 0 = Paper claim 4 = Electronic claim 6 = Pharmacy</p> <p>B = Julian date (e.g. April 20, 2000, was the 111th day of 2000) C = Microfilm number 00 = Electronic claim 11 = Paper claim</p> <p>D = Batch number E = Claim number</p>
12. Service dates	Dates services were provided. If services were performed in a single day, the same date will appear in both columns.
13. Unit of service	The units of service rendered under this procedure or NDC code.
14. Procedure/revenue/NDC	The procedure code (CPT, HCPCS, or local), National Drug Code (NDC), or revenue code will appear in this column. If a modifier was used, it will also appear in this column.
15. Total charges	The amount a provider billed for this service.
16. Allowed	The Medicaid allowed amount.
17. Copay	A "Y" indicates cost sharing was deducted from the allowed amount; an "N" indicates cost sharing was not deducted.
18. Reason/Remark Codes	A code which explains why the specific service was denied or pended. Descriptions of these codes are listed at the end of the RA.
19. Deductions, billed amount, and paid amount	Any deductions, such as cost sharing or third party liability are listed first. The amount the provider billed is next, followed by the amount of Medicaid reimbursement.

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 RA 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 RAs 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 (see *Key Contacts*).

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.

How long do I have to rebill or adjust 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 Third Party Liability 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 the provider before processing because key information such as the NPI or authorized signature and date are missing or unreadable. For tips on preventing returned or denied claims, see the *Billing Procedures* and *Submitting a Claim* chapters.

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 (see *Key Contacts*).

Adjustments

If a provider believes that a claim has been paid incorrectly, the provider may call Provider Relations (see *Key Contacts*) or submit a claim inquiry for review (see *Billing Procedures, Claim Inquiry*). Once an incorrect payment has been verified, the provider may submit an *Individual Adjustment Request* form (in *Appendix A*) to Provider Relations or submit an adjustment through point-of-sale. If incorrect payment was the result of an ACS keying error, 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 RA 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. See *Key Fields on the Remittance Advice* earlier in this chapter. 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., client ID, NPI, date of service, NDC, prescribing provider, units).

How to request an adjustment

To request an adjustment, use the *Individual Adjustment Request* form in Appendix A. 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 (see *Definitions*).
- Use a separate adjustment request form for each TCN.
- If you are correcting more than one error per TCN, use only one adjustment request form, and include each error on the form.
- If more than one line of the claim needs to be adjusted, indicate which lines and items need to be adjusted in the *Remarks* section of the adjustment form.

Completing an Adjustment Request Form

1. See the *Individual Adjustment Request* form in Appendix A. You may download the form from the Provider Information [website](#). Complete Section A first with provider and client information and the claim’s TCN number (see following table and sample RA).
2. Complete Section B with information about the claim. Remember to fill in only the items that need to be corrected (see following table):
 - 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 column labeled Corrected Information

Updated 04/2011

Montana Health Care Programs
Medicaid • Mental Health Services Plan • Healthy Montana Kids
Individual Adjustment Request

Instructions:
 This form is for providers to correct a claim which has been paid at an incorrect amount or was paid with incorrect information. Complete all the fields in Section A with information about the paid claim from your statement. Complete only the items in Section B which represent the incorrect information that needs changing. For help with this form, refer to the *Remittance Advices and Adjustments* chapter in your program manual or the *General Information for Providers* manual, or call (800) 624-3958 (Montana and out-of-state providers) or (406) 442-1837 (Helena).

A. Complete all fields using the remittance advice (RA) for information.

1. Provider Name & Address Local Pharmacy	3. Internal Control Number (ICN) 00204011250000600
Name 123 Medical Drive	4. NPI/APL 1234567890
Street or P.O. Box Anytown, MT 59999	5. Client ID Number 123456789
City State ZIP	6. Date of Payment 02/15/03
2. Client Name Jane Doe	7. Amount of Payment \$ 11.49

B. Complete only the items which need to be corrected.

Date of Service or Line Number	Information on Statement	Corrected Information
1. Units of Service	Line 2	28
2. Procedure Code/NDC/Revenue Code		
3. Dates of Service (DOS)	Line 3 02/01/03	01/23/03
4. Billed Amount		
5. Personal Resource (Nursing Facility)		
6. Insurance Credit Amount		
7. Net (Billed – TPL or Medicare Paid)		
8. Other/Remarks (Be specific.)		

Signature: *John R. Smith* Date: 04/15/03

When the form is complete, attach a copy of the RA and a copy of the corrected claim.



Department of Public Health & Human Services

Mail to: ACS
P.O. Box 8000
Helena, MT 59604



A XEROX Company

Sample Adjustment Request

Completing an Individual Adjustment Request Form

Field	Description
Section A	
1. Provider name and address	Provider's name and address (and mailing address if different).
2. Client name	The client'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.*Client Medicaid number	Client's Medicaid ID number.
6. Date of payment	Date claim was paid is found on remittance advice Field 5 (see the sample RA earlier in this chapter).
7. Amount of payment	The amount of payment from the remittance advice Fed 17 (see the sample RA earlier in this chapter.).
Section B	
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 client's personal resource amount is incorrect, complete this line.
6. Insurance credit amount	If the client'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. Other/Remarks	If none of the above items apply, or if you are unsure what caused the payment error, complete this line.

* Indicates a required field

3. Attach copies of the RA and a corrected claim if necessary.
 - If the original claim was billed electronically, a copy of the RA will suffice.
 - If the RA is electronic, attach a screen print of the RA.
4. Verify the adjustment request has been signed and dated.
5. Send the adjustment request to Claims Processing (see *Key Contacts, Paper Claims*).
 - 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 (see *Key Contacts*).

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 (RA Notice section). Mass adjustment claims shown on the RA have an ICN that begins with a “4” (see *Key Fields on the Remittance Advice* earlier in this chapter).

Payment and the RA

Providers may receive their Medicaid payment and RA either weekly or biweekly. Payment can be via check or electronic funds transfer (EFT). Direct deposit is another name for EFT. Providers who wish to receive weekly payment must request both EFT and electronic RAs and specifically request weekly payment. For biweekly payment, providers can choose any combination of paper/electronic payment method and RA.

Electronic Funds Transfer

With EFT, the Department deposits the funds directly in the provider’s bank account. If the scheduled deposit day is a holiday, funds will be available on the next business day. This process does not affect the delivery of the remittance advice that providers currently receive with payments. RAs will continue to be mailed to providers unless they specifically request an electronic RA.

To participate in EFT, providers must complete a *Direct Deposit Sign-Up Form* (Standard Form 1199A) (see the following table). One form must be completed for each provider number.

Once electronic transfer testing shows payment to the provider’s account, all Medicaid payments will be made through EFT. For questions or changes regarding EFT, contact the Technical Services Center and ask for the Medicaid Direct Deposit Manager (see *Key Contacts, Direct Deposit Arrangements*).

Electronic Remittance Advice

The MATH web portal provides the tools and resources to help health care providers conduct business electronically. To receive an electronic RA, a provider must be enrolled in electronic funds transfer and have Internet access. You can access your electronic RA through the MATH web portal on the Internet (see *Key Websites*).

Due to space limitations, each RA is only available for 90 days. For instructions on enrolling, registering, and using the MATH web portal, contact Provider Relations (see *Key Contacts*) or view the web portal tutorial on the MATH web portal (see *Key Websites*).

Required Forms for EFT and/or Electronic RA

All four forms are required for a provider to receive weekly payment

Form	Purpose	Where to Get	Where to Send
<ul style="list-style-type: none"> • Electronic Remittance Advice (RA) • Payment Cycle Enrollment Form 	Allows providers to receive electronic RAs on the MATH web portal. Must also include Montana Enrollment form and MATH forms below.	<ul style="list-style-type: none"> • MATH web portal (see <i>Key Websites</i>) • Provider Relations (see <i>Key Contacts</i>) 	Provider Relations (see <i>Key Contacts</i>)
<ul style="list-style-type: none"> • Direct Deposit Sign-Up Form Standard Form 1199A 	Allows the Department to automatically deposit Medicaid payment into provider's bank account	<ul style="list-style-type: none"> • MATH web portal (see <i>Key Websites</i>) • Provider's bank 	Provider Relations (see <i>Key Contacts</i>)
<p>MATH Forms</p> <ul style="list-style-type: none"> • Trading Partner Agreement • Electronic Billing Agreement • EDI Enrollment Form 	Allow provider to receive a password to access their RA on MATH.	<ul style="list-style-type: none"> • Provider Relations (see <i>Key Contacts</i>) • MATH Web Portal (see <i>Key Websites</i>) • Direct Deposit Arrangements (see <i>Key Contacts</i>) 	Fax to (406) 442-4402.

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 number must be reported immediately to ensure that payments are received by the billing owner. Contact ACS Provider Relations to report all ownership changes:

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

(800) 624-3958
(406) 442-1837

Tamper-Resistant Pads

Written prescriptions filled on or after April 1, 2008, must contain at least one of the tamper-resistant criteria listed below.

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

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 client or the client’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 filing 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 (see *Key Contacts*).

When to Bill Medicaid Clients (ARM 37.85.406)

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

More specifically, providers cannot bill clients directly:

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

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

When to Bill a Medicaid Client (ARM 37.85.406)			
	<ul style="list-style-type: none"> • Client Is Medicaid-Enrolled • Provider Accepts Client as a Medicaid Client 	<ul style="list-style-type: none"> • Client Is Medicaid-Enrolled • Provider Does Not Accept Client as a Medicaid Client 	<ul style="list-style-type: none"> • Client Is Not Medicaid-Enrolled
Service is covered by Medicaid	Provider can bill client only for cost sharing.	Provider can bill Medicaid client if the client has signed a routine agreement.	Provider can bill client.
Service is not covered by Medicaid	Provider can bill client only if custom agreement has been made between client and provider before providing the service.	Provider can bill Medicaid client if the client has signed a routine agreement.	Provider can bill client.

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

Custom Agreement: This agreement lists the service the client is receiving and states that the service is not covered by Medicaid and that the client will pay for it.

Billing for Retroactively Eligible Clients

When a client becomes retroactively eligible for Medicaid, the provider has 12 months from the date retroactive eligibility was determined to bill for those services. When submitting claims for retroactively eligible clients, attach a copy of the FA-455 (eligibility determination letter) to the claim if the date of service is more than 12 months earlier than the date the claim is submitted.

When a provider chooses to accept the client from the date retroactive eligibility was effective, and the client has made a full or partial payment for services, the provider must refund the client’s payment for the services and bill Medicaid for the services. For more information on retroactive eligibility, see the *Client 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.

Client Cost Sharing (ARM 37.85.204 and 37.85.402)

Clients are responsible for cost sharing for Medicaid-covered prescriptions to a maximum of \$25 per month.

For the prescription drug program, cost sharing is as follows:

- 5% of the Medicaid allowed amount with a minimum of \$1.00 and a maximum of \$5.00 per prescription.

The following drugs are exempt from cost sharing:

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

The following are exempt from cost sharing:

- Clients 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
- Clients with third party liability (TPL) when Medicaid is the secondary payer.

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.

For clients 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 client each month, and the client must pay privately for any amounts over that cap.

Providers may choose to collect client cost sharing at the time of service or bill the client later. According to Federal regulation, a provider cannot deny services to a Medicaid client due to the client’s inability to pay cost sharing at the time services are rendered. However, the client’s inability to pay cost sharing at the time services are rendered does not lessen the client’s obligation to pay cost sharing.

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



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

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, PA 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 PA 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 PA is required.
- DAW 6 may only be used when dispensing a brand name medication (with generics available) to comply with the PDL.
- DAW 7 may be used for seizure medications with an appropriate diagnosis without PA. 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](#) for additional information.
- DAW 8 may only be used when the generic drug is not available in the marketplace and the request has been authorized by the Drug Prior Authorization Unit.

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.

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

Client 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 described in the *General Information for Providers* manual (MATH web portal, AVRS, FaxBack, calling Provider Relations).

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 DUR Conflict Code (see following table) 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 DUR Conflict Code, *followed by ...*
2. Two-byte alphanumeric DUR Intervention Code, *followed by ...*
3. Two-byte alphanumeric DUR Outcome 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.



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

NCPDP DUR Codes

DUR Conflict Code	Description
AT	Additive Toxicity
CH	Call POS Help Desk
DA	Drug Allergy Alert
DC	Inferred Drug Disease Precaution
DD	Drug-Drug Interaction
DI	Drug Incompatibility
DL	Drug Lab Conflict
DP	Drug Food Conflict
DS	Tobacco Use Precaution
ER	Overuse Precaution
HD	High Dose Alert
IC	Iatrogenic Condition Alert
ID	Ingredient Duplication
LD	Low Dose Alert
LR	Under Use Alert
MC	Drug Disease Precaution
MN	Insufficient Duration Alert
MX	Excessive Duration Alert
OH	Alcohol Precaution
PA	Drug Age Precaution
PG	Drug Pregnancy Precaution
PR	Prior Adverse Reaction
SE	Side Effect Alert
SX	Drug Gender Alert
TD	Therapeutic Duplication
M0 (M Zero)	MD Interface
P0 (P Zero)	Patient Interaction
R0 (R Zero)	Pharmacist Reviewed

DUR Intervention Code	Description
M0 (M Zero)	MD Interface
P0 (P Zero)	Patient Interaction
R0 (R Zero)	Pharmacist Reviewed
DUR Outcome Code	Description
1A	Filled, False Positive
1B	Filled as is
1C	Filled with Different Dose
1D	Filled with Different Directions
1E	Filled with Different Drug
1F	Filled with Different Quantity
1G	Filled after Prescriber Approval Obtained
2A	Not Filled
2B	Not Filled, Directions Clarified

Billing a Paper Claim

Completing Pharmacy Claim Form MA-5

- The information needed to complete the Pharmacy Claim Form MA-5 is described on the following page. Required fields are indicated by *.
- 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](#).

- Paper claims must be mailed to the following address:

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

MA-5 Instructions

Field	Field Title	Instructions
1*	Name of provider of services	Enter the pharmacy name.
2*	NPI	Enter the pharmacy's 10-digit national provider identifier (NPI).
3*	Provider address	Enter the pharmacy address.
4*	MHSP or Medicaid	Mark the appropriate box.
5*	Cardholder/Recipient ID	Enter the cardholder/recipient 9-digit ID.
6*	Recipient name	Enter the client's last name, first name, middle initial.
7*	Date of birth – Recipient	Enter the client'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.
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 number	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 (Qty.)	Enter the quantity of the medication dispensed.
16*	Amount charged	Enter the pharmacy's usual and customary charge, including the dispensing fee.
17*	Unit dose	Check Yes or No.
18*	Prescription number	Enter the pharmacy-assigned prescription number.
19*	DAW	<p>Dispensed As Written: Check Y and 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:</p> <ul style="list-style-type: none"> • 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 <i>Billing Procedures</i> chapter, <i>Dispense As Written (DAW)</i>.
20*	Drug description	Enter name of drug dispensed.
21*	Level of effort	Enter level of effort to determine appropriate difficulty of compounding a product.
22*	Submission clarification 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.
29*	Certification	Claims must contain the provider's or authorized agent's signature, a facsimile of stamped signature, or a computer-generated name.

* Required field.

Sample Paper Claim (MA-5)

STATE OF MONTANA - DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

FOR USE BY PHARMACIES

PLEASE TYPE OR PRINT

FORM NO. MA-5

Return form to:

CLAIMS PROCESSING UNIT, Dept. MA-5, P.O. Box 8000, Helena, MT 59604
Telephone Number 1-800-624-3958, (406) 442-1837

SECTION I - PROVIDER INFORMATION

1. Name - Provider Getur Drug Store	2. NPI 1234567890
3. Address - Provider (Street, City, State, Zip Code) 100 Main Street Anytown MT 59999	4. <input type="radio"/> MHSP <input checked="" type="radio"/> Medicaid

SECTION II - RECIPIENT INFORMATION

5. Cardholder Identification Number - Recipient 555-55-5555	6. Name - Recipient (Last, First, Middle Initial) Smith, John R.	7. Date of Birth - Recipient 11/02/85
---	--	---

SECTION III - CLAIM INFORMATION

8. Prescriber Number 1234567890	9. Prescription Type Written <input type="button" value="v"/>	10. Date Filled 07/16/01	11. Refill Y	12. Compound <input checked="" type="radio"/> Yes <input type="radio"/> No
13. NDC 	14. Days Supply 30	15. Qty 	16. Charge \$ 70.00	17. Unit Dose <input type="radio"/> Yes <input type="radio"/> No
18. Prescription Number 9876543210	19. DAW 	20. Drug Description 	21. Level of Effort 	22. Sub Clar Code
23. Other Coverage Code 	24. Total Charges \$	25. Other Coverage Amount \$	26. Patient Paid \$	27. Net Billed \$

8. Prescriber Number 	9. Prescription Type Written <input type="button" value="v"/>	10. Date Filled 	11. Refill 	12. Compound <input type="radio"/> Yes <input type="radio"/> No
13. NDC 	14. Days Supply 	15. Qty 	16. Charge \$	17. Unit Dose <input type="radio"/> Yes <input type="radio"/> No
18. Prescription Number 	19. DAW 	20. Drug Description 	21. Level of Effort 	22. Sub Clar Code
23. Other Coverage Code 	24. Total Charges \$	25. Other Coverage Amount \$	26. Patient Paid \$	27. Net Billed \$

8. Prescriber Number 	9. Prescription Type Written <input type="button" value="v"/>	10. Date Filled 	11. Refill 	12. Compound <input type="radio"/> Yes <input type="radio"/> No
13. NDC 	14. Days Supply 	15. Qty 	16. Charge \$	17. Unit Dose <input type="radio"/> Yes <input type="radio"/> No
18. Prescription Number 	19. DAW 	20. Drug Description 	21. Level of Effort 	22. Sub Clar Code
23. Other Coverage Code 	24. Total Charges \$	25. Other Coverage Amount \$	26. Patient Paid \$	27. Net Billed \$

8. Prescriber Number 	9. Prescription Type Written <input type="button" value="v"/>	10. Date Filled 	11. Refill 	12. Compound <input type="radio"/> Yes <input type="radio"/> No
13. NDC 	14. Days Supply 	15. Qty 	16. Charge \$	17. Unit Dose <input type="radio"/> Yes <input type="radio"/> No
18. Prescription Number 	19. DAW 	20. Drug Description 	21. Level of Effort 	22. Sub Clar Code
23. Other Coverage Code 	24. Total Charges \$	25. Other Coverage Amount \$	26. Patient Paid \$	27. Net Billed \$

<p>29. Certification - I certify that the care, services and supplies itemized have been furnished, the amounts listed are due and, except as noted, no part thereof has been paid; payment of fees made in accordance with established schedules is accepted as payment in full. I further certify that the services(s) indicated above has/have been provided without regard to race, color, national origin, creed, sex, religion, political ideas, marital status, age or handicap. I here by agree to maintain and furnish on request to the Department, the Montana Medicaid Fraud Control Bureau, the U.S. DHHS, the Comptroller General of the U.S., or any of their duly authorized agents or representatives such records as necessary to disclose fully the extent of care, services, and supplies provided to individuals under the Montana Medical Assistance Program. I UNDERSTAND THAT PAYMENT OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSIFICATION, OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER FEDERAL AND STATE LAWS. I hereby agree to comply with all rules and requirements pertaining to the Montana Medicaid Program, including but not limited to Title XIX of the Social Security Act, Montana Statutes and the Administrative Rules of Montana.</p>	TOTAL CHARGES 	
Signature - Pharmacist or Dispensing Physician <i>Phannie S. Pharmacist</i>	AMOUNT TO BE PAID BY MEDICAID 	
Date Signed 07/22/01	AMOUNT TO BE PAID BY RECIPIENT 	

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	Wilboux
56	Yellowstone

Appendix A: Forms

Montana Health Care Programs Claim Inquiry Form

Montana Health Care Programs Individual Adjustment Request

Montana Health Care Programs Claim Inquiry Form

Provider Name _____
 Contact Person _____
 Address _____
 Date _____
 Phone Number _____
 Fax Number _____



For status on a claim, please complete the information on this form and mail to the address below or fax to the number shown. You may attach a copy of the claim, but it is not required.

NPI/API _____ Client Number _____ Date of Service _____ Total Billed Amount _____ Date Submitted for Processing _____	ACS Response _____ _____ _____ _____ _____ _____
NPI/API _____ Client Number _____ Date of Service _____ Total Billed Amount _____ Date Submitted for Processing _____	ACS Response _____ _____ _____ _____ _____ _____
NPI/API _____ Client Number _____ Date of Service _____ Total Billed Amount _____ Date Submitted for Processing _____	ACS Response _____ _____ _____ _____ _____ _____

Mail to: Provider Relations
 P.O. Box 8000
 Helena, MT 59604

Fax to: (406) 442-4402

Montana Health Care Programs

Medicaid • Mental Health Services Plan • Healthy Montana Kids

Individual Adjustment Request Montana Health Care Programs

Instructions:

This form is for providers to correct a claim which has been **paid** at an incorrect amount or was **paid** with incorrect information. Complete all the fields in Section A with information about the paid claim from your statement. Complete **only** the items in Section B which represent the incorrect information that needs changing. For help with this form, refer to the *Remittance Advices and Adjustments* chapter in your program manual or the *General Information for Providers* manual, or call (800) 624-3958 (Montana and out-of-state providers) or (406) 442-1837 (Helena).

A. Complete all fields using the remittance advice (RA) for information.

1. Provider Name & Address _____ Name _____ Street or P.O. Box _____ City State ZIP	3. Internal Control Number (ICN) _____ 4. NPI/API _____ 5. Client ID Number _____ 6. Date of Payment _____ 7. Amount of Payment \$ _____
2. Client Name _____	

B. Complete only the items which need to be corrected.

	Date of Service or Line Number	Information on Statement	Corrected Information
1. Units of Service			
2. Procedure Code/NDC/Revenue Code			
3. Dates of Service (DOS)			
4. Billed Amount			
5. Personal Resource (Nursing Facility)			
6. Insurance Credit Amount			
7. Net (Billed – TPL or Medicare Paid)			
8. Other/Remarks (Be specific.)			

Signature: _____ Date: _____

When the form is complete, attach a copy of the RA and a copy of the corrected claim. **Individual**



Mail to: ACS
 P.O. Box 8000
 Helena, MT 59604



Definitions

This section contains definitions, abbreviations, and acronyms used in these billing instructions which relate to the Medicaid Prescription Drug Program.

Administrative Rules of Montana (ARM)

The rules published by the executive departments and agencies of the state government.

Authorization

An official approval for action taken for, or on behalf of, an eligible Medicaid client. This approval is only valid if the client is eligible on the date of service.

Authorized Prescriber

A physician, osteopath, dentist, nurse, physician assistant, optometrist, naturopath, or other person duly authorized by law or rule in the State of Montana to prescribe drugs.

Average Wholesale Price (AWP)

The average wholesale price of a drug product from wholesalers nationwide at a point in time. The Department uses the AWP as reported by First Data Bank.

Brand Name

The proprietary or trade name selected by the manufacturer and placed upon a drug, its container, label, or wrapping at the time of packaging.

Code of Federal Regulations (CFR)

The general and permanent rules published in the Federal Register by the executive departments and agencies of the Federal government.

Client

An applicant for, or recipient of, DPHHS medical care programs.

Coinsurance

The client's financial responsibility for a medical bill as assigned by Medicaid/Medicare (usually a percentage). Medicaid coinsurance is usually 5% of the Medicaid allowed amount, and Medicare coinsurance is usually 20% of the Medicare allowed amount.

Compounding

The act of combining two or more active ingredients or adjusting therapeutic strengths in the preparation of a prescription.

Cost sharing

The client's financial responsibility for a medical bill, usually in the form of a copayment (flat fee) or coinsurance (percentage of charges).

Covered Outpatient Drug

A drug approved for safety and effectiveness as a prescription drug under the federal Food, Drug, and Cosmetic Act, and manufactured or distributed by manufacturers/labelers who have signed a drug rebate agreement with the federal Department of Health and Human Services (DHHS).

Department

The state Department of Public Health and Human Services (DPHHS).

DESI Drug.

Drug Efficacy Study Index (DESI). Also referred to as "less-than-effective" drugs.

Dispense

The interpretation of a prescription or order for a legend drug and, pursuant to that prescription or order, the proper selection, measuring, compounding, labeling, or packaging necessary to prepare that prescription or order for delivery.

Dispensing Fee

A fee set by the Department to reimburse pharmacies for their administrative costs incurred in filling prescriptions for clients.

Drug Efficacy Study Index (DESI) or “Less-Than-Effective Drugs”

An index that measures one drug against a clinical response criteria. If the index is low, the drug is classified as less-than-effective.

Drug Formulary

A list developed by the DUR Board of outpatient drugs covered by the Prescription Drug program including products with limited coverage and requiring prior authorization.

Drug Utilization Review (DUR) Program

A quality assurance program for covered outpatient drugs which assures that prescriptions are appropriate, medically necessary, and not likely to result in adverse medical outcomes.

Estimated Acquisition Cost (EAC)

The Department’s best estimate of the price providers generally and currently pay for a drug marketed or sold by a particular manufacturer or labeler in the package size most frequently purchased by providers.

Explanation of Medicare Benefits (EOMB)

A Federal report generated by Medicare for its providers that displays transaction information regarding Medicare claims processing and payments.

Generic Equivalents

Drug products are considered pharmaceutical equivalents if they contain the same active ingredients, are of the same dosage form, route of administration, and are identical in strength or concentration. Pharmaceutically equivalent drug products are formulated to contain the same amount of active ingredient in the same dosage form and to meet the same or compendial or other applicable standards, but they may differ in characteristics such as shape, scoring configuration, release mechanisms, packaging, excipients (including colors, flavors, preservatives), expiration time, and, within certain limits, labeling (FDA *Approved Drug Products with Therapeutic Equivalence Evaluations*, 23rd Edition, March 2003).

Generic Name

The official title of a drug or drug ingredients published in the latest edition of a nationally-recognized pharmacopoeia or formulary.

Health Improvement Program

An enhanced primary care case management program that is part of Passport to Health. Services for high risk and/or high cost Medicaid and HMK *Plus* Passport patients provided by nurses and health coaches to prevent or slow the progression of disease, disability and other health conditions, prolong life, and promote physical and mental health. Services are provided through community and tribal health centers on a regional basis and include: health assessment, care planning, hospital discharge planning, help with social services and education, and support for clients in self-management of health conditions. Predictive modeling software and provider referral are used to identify patients with the most need.

Legend or Prescription Drugs

Any drugs required by any applicable Federal or state law or regulation to be dispensed by prescription only or which are restricted to use by practitioners only.

Less-Than-Effective Drugs

See DESI.

Maximum Allowable

The maximum dollar amount a provider may be reimbursed for specific services, supplies, or equipment.

Maximum Allowable Cost (MAC) Program

The maximum amount paid for a specified dosage form and strength of a multiple source drug product.

Medicaid

The federal aid Title XIX program under which medical care is provided to:

- Categorically needy as defined in ARM
- Medically needy as defined in ARM

Medical Assistance

The federal aid Title XIX program under which medical care is provided to the categorically needy.

Medically-Accepted Indication

Any use for a covered outpatient drug which is approved under the Federal Food, Drug, and Cosmetic Act, which appears in peer-reviewed medical literature or which is accepted by one or more of the following compendia:

- The American Hospital Formulary Service Drug Information;
- The American Medical Association Drug Evaluations;
- The United States Pharmacopoeia Drug Information; or
- DRUGDEX

Medically Necessary

A term describing a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate, or prevent worsening of conditions in the client. These conditions must be classified as one of the following: endanger life, cause suffering or pain, result in an illness or infirmity, threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There must be no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, when appropriate, no treatment at all.

Medicare

The federal government health insurance program for certain-aged or disabled clients under Titles II and XVIII of the Social Security Act. Medicare has two parts:

- Part A covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.
- Part B is the supplementary medical insurance benefit covering the Medicare doctor's services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care and other health services and supplies not covered under Part A of Medicare.
- Part D allows for prescription drug coverage for Medicare beneficiaries through Medicare Prescription Drug Plans.

Mental Health Services Plan (MHSP)

This plan is for individuals who have a severe disabling mental illness (SDMI), are ineligible for Medicaid, and have a family income that does not exceed an amount established by the Department.

Multiple Source Drug

A drug marketed or sold by two or more manufacturers or labelers or a drug marketed or sold by the same manufacturer or labeler under two or more different proprietary names or both under a proprietary name.

NABP

National Association of Boards of Pharmacies

National Drug Code (NDC)

An 11-digit number the manufacturer assigns to a pharmaceutical product and attaches to the product container at the time of packaging that identifies the product's manufacturer, dose form and strength, and package size.

Nonrebate Drugs

Drugs manufactured or distributed by manufacturers/labelers who have not signed a drug rebate agreement with the Federal Department of Health and Human Services (DHHS) or the state Department of Public Health and Human Services (DPHHS).

Nurse First Advice Line

A 24-hour, 7-day-a-week nurse triage line. Clients can call in with general health questions, medication questions, or questions about illness or injury. If the caller or person they are calling about is symptomatic, a registered nurse follows clinically-based algorithms to an "end point" care recommendation. The care recommendation explains what level of health care is needed, including self-care. If self-care is recommended, clients are given detailed self-care instructions.

Obsolete Drug

A drug that has been identified as obsolete by the manufacturer and is no longer available.

Obsolete NDC

A national drug code replaced or discontinued by the manufacturer or labeler.

Over-the-Counter (OTC) Drug

Drugs (non-legend) that do not require a prescription before they can be dispensed.

Passport Referral Number

A 7-digit number assigned to Passport providers. When a Passport provider refers a client to another provider for services, this number is given to the other provider and is required when processing the claim.

Passport to Health

The Medicaid primary care case management (PCCM) managed care program where the client selects a primary care provider who manages the client's health care needs.

Pharmacist

A person duly licensed by the Montana State Board of Pharmacy to engage in the practice of pharmacy.

Pharmacy

Every site properly licensed by the Board of Pharmacy in which practice of pharmacy is conducted.

Point-of-Sale (POS)

A pharmacy claims processing system capable of adjudicating claims online.

Preferred Drug List

A list of clinically effective medications from selected classes for which the Medicaid program will allow payment without restriction.

Prescription

An order for drugs or devices issued by a practitioner duly authorized by law or rule in the State of Montana to prescribe drugs or devices in the course of his or her professional practice for a legitimate medical purpose.

Prospective Drug Use Review (Pro-DUR)

A process in which a request for a drug product for a particular patient is screened for potential drug therapy problems before the drug is dispensed.

Provider or Provider of Service

An institution, agency, or person:

- Having a signed agreement with the department to furnish medical care and goods and/or services to clients; and
- Eligible to receive payment from the department.

Provider Number

Number issued by the Department for reimbursement.

Remittance and Status Report (RA)

A report produced by the claims processing system that provides detailed information concerning submitted claims and other financial transactions.

Retrospective Drug Use Review (Retro-DUR)

The process in which drug utilization by patients is reviewed on a periodic basis to identify patterns of fraud, abuse, gross over-use, or inappropriate or unnecessary care.

Single Source Drug

A drug produced or distributed under an original new drug application approved by the FDA, including a drug product marketed by any cross-licensed producers or distributors operating under the new drug application.

Team Care

A restricted services program that is part of Passport to Health. Restricted services programs are designed to assist clients in making better health care decisions so that they can avoid over-utilizing health services. Team Care clients are joined by a team assembled to assist them in accessing health care. The team consists of the client, the Passport primary care provider, a pharmacy, the Department, the Department's quality improvement organization, and the Nurse First advice line. The team may also include a community-based care manager from the Department's Health Improvement Program.

Terminated Drug Product

A product whose shelf life expiration date has been met, per manufacturer notification.

Therapeutic Equivalent

Drug products are considered to be therapeutic equivalents only if they are pharmaceutical equivalents and if they can be expected to have the same clinical effect and safety profile when administered to patients under the conditions specified in the labeling. (*FDA Approved Drug Products with Therapeutic Equivalence Evaluations*, 23rd Edition, March 2003)

Third Party

Any entity that is or may be liable to pay all or part of the medical cost of care of a federal Medicaid or state medical care client.

Unit Dose Delivery

A drug delivery system in which each patient's medication is delivered in quantities sufficient only for the day's required dosage.

Usual and Customary

The fee that the provider most frequently charges the general public for a service or item.

Acronyms

This section contains a list of commonly used acronyms. Please refer to *Definitions* or specific chapters for more information.

ARM

Administrative Rules of Montana

AMP

Average manufacturer price

AWP

Average wholesale price

CFR

Code of Federal Regulations

DAW

Dispense as written

DESI

Drug efficacy study index. Also referred to as “less-than-effective drugs.”

DHHS

Federal Department of Health and Human Services

DPHHS

The state Department of Public Health and Human Services. Also referred to as “the Department.”

Due Care

Drug use education and concurrent and retrospective evaluation

DUR

Drug utilization review

EAC

Estimated acquisition cost

EOMB

Explanation of Medicare benefits

FDA

Food and Drug Administration

FUL

Federal upper limit

HCPCS

Healthcare Common Procedure Coding System

MAC

Maximum allowable cost

MHSP

Mental Health Services Plan

NABP

National Association of Boards of Pharmacies

NCPDP

National Council for Prescription Drug Programs

NDC

National drug code

NPI

National provider identifier

OTC

Over-the-counter

PA

Prior authorization

PDL

Preferred drug list

POS

Point of sale

Pro-DUR

Prospective drug utilization review

RA

Remittance advice

Retro-DUR

Retrospective drug utilization review

SMAC

State maximum allowable cost

TPL

Third party liability

VFC

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