



Prescription Drug Program

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My NPI/API:

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

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 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.
- The maximum dispensing fee is \$4.94 for in-state pharmacies and \$3.50 for out-of-state pharmacies.
- New pharmacy providers are assigned an interim dispensing fee of \$4.94 until a dispensing fee questionnaire can be completed for a six-month period of operation.
- Pharmacies that fail to respond to a mandatory dispensing fee questionnaire will have their dispensing fee set to \$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 Web-*

- 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.