



Prescription Drug Program

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My NPI/API:

Rebilling and Adjustments

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

Timeframe for Rebilling or Adjusting a Claim

- Providers may resubmit or adjust any initial claim within the timely filing limits described in the Billing Procedures chapter of this manual. Depending on switch-vendor requirements, some point-of-sale adjustments must be completed within three months. In this case, adjustments may be submitted on paper within the timely filing limits.
- These time periods do not apply to overpayments that the provider must refund to the Department. After the 12-month time period, a provider may not refund overpayments to the Department by completing a claim adjustment. The provider may refund overpayments by issuing a check or asking 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.) Once an incorrect payment has been verified, the provider may submit an Individual Adjustment Request form to Provider Relations or submit an adjustment through point-of-sale. If incorrect payment was the result of a Xerox keying error, the provider should contact Provider Relations.

When adjustments are made to previously-paid claims, the Department recovers the original payment and issues appropriate repayment. The result of the adjustment appears on the provider's RA as two transactions. The original payment will appear as a credit transaction. The replacement claim reflecting the corrections will be listed as a separate transaction and may or may not appear on the same 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 the Key Fields on the Remittance Advice table 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., member ID, NPI, date of service, NDC, prescribing provider, units).

How to Request an Adjustment

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

- Claims Processing must receive individual claim adjustment requests within 12 months of the date of service. (See Timely Filing Limits in the Billing Procedures chapter.) After this time, gross adjustments are required. (See Definitions.)
- Use a separate adjustment request form for each TCN.