

Reimbursement

Reimbursement for Covered Drugs

Reimbursement for covered drugs is the lesser of:

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

Average Acquisition Cost

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

Submitted Ingredient Cost

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

Usual and Customary

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

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

Federal Maximum Allowable Cost (MAC)

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

Dispensing Fee

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

Vaccine Administration Fee

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

The Remittance Advice

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

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

Credit Balances

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

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

Rebilling and Adjustments

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

Timeframe for Rebilling or Adjusting a Claim

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

Rebilling Medicaid

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

When to Rebill Medicaid

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

How to Rebill

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

Adjustments

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

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

When to Request an Adjustment

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

How to Request an Adjustment

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

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

Completing an Adjustment Request Form

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

Completing an Individual Adjustment Request Form

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

Mass Adjustments

Mass adjustments are done when it is necessary to reprocess multiple claims.

They generally occur when:

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

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

Payment and the Remittance Advice

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

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

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

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

