



Prescription Drug Program

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My NPI/API:

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

Claims

Send paper claims to:

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

Direct Deposit Arrangements

Providers who would like to receive their remittance advices electronically and electronic funds transfer fax their request to.

(406) 442-4402

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

Point-of-Sale (POS) Help Desk

For assistance with online POS claims adjudication:

Xerox, 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/Out of state
(406) 442-1837 Helena
8:00 a.m. to 5:00 p.m., Monday–Friday
(Mountain Time)

Send written inquiries to:

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

Send e-mail inquiries to:

MTPRHelpdesk@xerox.com

Provider Enrollment

For enrollment changes or questions:

(800) 624-3958 In/Out of state
(406) 442-1837 Helena
8:00 a.m. to 5:00 p.m., Monday–Friday
(Mountain Time)

Send written inquiries to:

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/Out of state
(406) 442-1837 Helena
8:00 a.m. to 5:00 p.m., Monday–Friday
(Mountain Time)

Send written inquiries to:

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
<p>Healthy Montana Kids (HMK) http://hmk.mt.gov/</p>	<p>Information on Healthy Montana Kids (HMK).</p>
<p>Provider Information http://medicaidprovider.hhs.mt.gov/</p> <p>Montana Access to Health (MATH) Web Portal https://mtaccesstohealth.acs-shc.com</p>	<ul style="list-style-type: none"> • Montana Medicaid Provider Information: Provider manuals, fee schedules, provider notices, replacement pages, forms, FAQs, newsletters, and key contacts. • Pharmacy Page: 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, and 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

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 brand name drugs and 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. 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.

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.

The RA is divided into the following sections:

Sections of the 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 "Adjustments" 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 "The Most Common Billing Errors and How to Avoid Them" section in the "Billing Procedures" 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 <i>suspended</i> and <i>pending</i> 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. 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 ADVISE #123456
 4 EPT/CHK # 7654321
 5 DATE:02/15/2003
 PAGE 2 6
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.

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. EFT/Check #	The EFT transaction number or check number.
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)	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: <u>0 00111 00 123 000123</u> A B C D E A = Claim medium 0 = Paper claim 4 = Electronic claim 6 = Pharmacy B = Julian date (e.g. April 20, 2000, was the 111th day of 2000) C = Microfilm number 00 = Electronic claim 11 = Paper claim D = Batch number E = Claim number
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”). 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., 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. 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. You may download the *Individual Adjustment Request* form from the Provider Information [website](#). Complete Section A first with provider and client information and the claim’s TCN (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.

MONTANA DPHHS
Healthy People. Healthy Communities.
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 Advice and Adjustments chapter in your program manual or the General Information for Providers manual, or call Provider Relations at 1.800.624.3958 (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 and Address: Local Pharmacy
 2. Internal Control Number (ICN): 00204011250000600
 Name: _____
 123 Medical Drive
 Street or P.O. Box: _____
 Anytown, MT 59999
 City State ZIP: _____
 3. NPI/API: 1234567890
 4. Client ID Number: 123456789
 2. Client Name: Jane Doe
 5. Date of Payment: 02/15/03
 6. Amount of Payment: \$ 11.49

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

Item	Date of Service or Line Number	Information on Statement	Corrected Information
1. Units of Service	Line 2	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 D. Smith Date: 04/15/03
 When the form is complete, attach a copy of the RA and a copy of the corrected claim, and mail to:
 Claims
 P.O. Box 8000
 Helena, MT 59604

Sample Adjustment Request Updated 03/2013

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. Ssee the sample RA earlier in this chapter.
7. Amount of payment	The amount of payment from the remittance advice Field 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 "Claims" in the "Key Contacts" chapter.
 - 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 the “Key Fields on the Remittance Advice” table 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 “Key Websites”) Provider Relations (see “Key Contacts”) 	Provider Relations (see “Key Contacts”)
<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"> Provider Information website (see “Key Websites”) Provider’s bank 	Provider Relations (see “Key Contacts”)
<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 “Key Contacts”) MATH web portal (see “Key Websites”) 	Fax to (406) 442-4402.