



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, January 2013, March 2013, July 2013, September 2013, March 2015, and June 2015.

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My NPI/API:

Prior Authorization

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

- To request prior authorization, providers must submit the information requested on the Request for Drug Prior Authorization form to the Drug Prior Authorization Unit. See the [Forms page](#) of the Provider Information website.
- 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 Drug Prior Authorization 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, and holiday requests. Payment will be authorized by using a "3" in the Days Supply field and a value of "8" in the Prior Authorization Type Code field.

Prior Authorization for Retroactively Eligible Members

When a member is determined retroactively eligible for Medicaid, the member should give the provider a Notice of Retroactive Eligibility (160-M).

The provider has 12 months from the date retroactive eligibility was determined to bill for those services.

Retroactive Medicaid eligibility does not allow a provider to bypass prior authorization requirements.

When a member becomes retroactively eligible for Medicaid, the provider may:

- Accept the member as a Medicaid member from the current date.
- Accept the member as a Medicaid member from the date retroactive eligibility was effective.
- Require the member to continue as a private-pay member.



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

Providers may choose whether to accept retroactive eligibility. (See the *General Information for Providers* manual, Member Eligibility and Responsibilities chapter.) All prior authorization requirements must be met to receive Medicaid payment.

When submitting claims for retroactively eligible members, attach a copy of the Notice of Retroactive Eligibility (Form 160-M) to the claim if the date of service is more than 12 months earlier than the date the claim is submitted.

MHSP Prior Authorization Criteria

For a list of drugs requiring prior authorization, contact the Drug Prior Authorization Unit. (See Key Contacts.)

Reimbursement

Reimbursement for Covered Drugs

Reimbursement for covered drugs is the lesser of:

- The state estimated acquisition cost (EAC); or
- The federal maximum allowable cost (FMAC) plus a dispensing fee established by the Department; or
- The state maximum allowable cost (SMAC) plus a dispensing fee established by the Department; or
- 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" members.
- 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 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.

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

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

800-624-3958
406-442-1837

Tamper-Resistant Pads

Written prescriptions must contain all of the following.

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

When to Bill Medicaid Members (ARM 37.85.406)

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

More specifically, providers cannot bill members directly:

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

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

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