

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
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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).

When to Bill a Patient (ARM 37.85.406)			
	Patient Is Medicaid-Enrolled and Provider Accepts Patient as a Medicaid Member	Patient Is Medicaid-Enrolled and Provider Does Not Accept Patient as a Medicaid Member	Patient Is Not Medicaid-Enrolled
Service Is Covered by Medicaid	Provider can bill patient only for cost sharing.	Provider can bill Medicaid if the patient has signed a routine agreement.	Provider can bill patient.
Service Is Not Covered by Medicaid	Provider can bill patient only if custom agreement has been made between the patient and provider before providing the service.	Provider can bill Medicaid if the patient has signed a routine agreement.	Provider can bill patient.

Routine Agreement: This may be a routine agreement between the provider and patient which states that the patient is not accepted as a Medicaid member, and that he/she must pay for the services received.

Custom Agreement: This agreement lists the service the patient will receive and states that the service is not covered by Medicaid and that the patient will pay for the services received.

Billing for Retroactively Eligible Members

When the provider accepts the member’s retroactive eligibility, the provider has 12-months from the date retroactive eligibility was determined to bill for those services.

When submitting claims for retroactively eligible members in which the date of service is more than 12 months earlier than the date the claim is submitted, attach a copy of the Provider Notice of Eligibility (Form 160-M). The provider must request the form from the member’s local Office of Public Assistance.

See <http://dphhs.mt.gov/hcsd/OfficeofPublicAssistance>. For more information on retroactive eligibility, see the Member Eligibility and Responsibilities chapter in the *General Information for Providers* manual.

Usual and Customary Charge (ARM 37.85.406)

Providers should bill Medicaid their usual and customary charge for each service; that is, the same charge that is made to other payers for that service.

Member Cost Sharing (ARM 37.85.204 and 37.85.402)

For the Prescription Drug Program, cost sharing is as follows:

- Preferred brands: \$4
- Non-preferred brands and brands not on the PDL: \$8
- No monthly cap
- Cost share exemption on generics and select therapeutic drug classes

For all members, the following drugs are exempt from cost sharing:

- Clozaril, all strengths
- Family planning prescriptions
- Compounded prescriptions for infusion therapy
- Tobacco cessation products

The following are exempt from cost sharing:

- Members under 21 years of age
- Pregnant women (until end of postpartum, which begins on the last day of pregnancy and ends at the end of the month in which 60 days have passed)
- Nursing facility residents
- Members with third party liability (TPL) when Medicaid is the secondary payer.
- American Indians and Alaska Natives who have ever been treated at an IHS, Tribal, or Urban facility or through referral under contract health services with appropriate documentation.

To exempt cost sharing on POS, enter a “4” in the Prior Authorization Type Code field. On a paper claim, enter a “4” in Drug Name field. See the Point-of-Service and Billing a Paper Claim chapters in this manual.

For members with Mental Health Services Plan (MHSP) coverage, there is a \$425 pharmacy cap. The MHSP program pays for the first \$425 in prescriptions for the member each month, and the member must pay privately for any amounts over that cap.

A provider cannot deny services to a Medicaid member because the member cannot pay cost sharing fees at the time services are rendered. However, the member's inability to pay cost sharing fees when services are rendered does not lessen the member's obligation. If a provider has a policy on collecting delinquent payment from non-Medicaid members, that same policy may be used for Medicaid members. A provider may sever the relationship with a member who has unpaid cost sharing obligation, as long as a consistent policy is followed with Medicaid and non-Medicaid members. Once the relationship is severed, with prior notice to the member either verbally or in writing, the provider may refuse to serve the member.



The provider must always use the complete 11-digit NDC from the dispensing container.

National Drug Codes (NDC)

All outpatient prescription drugs are billed using the drug's NDC, the 11-digit code assigned to all prescription drug products by the labeler or distributor of the product under FDA regulations.

The Department accepts only the 5-4-2 NDC format. All 11 digits, including zeros, must be entered. The three segments of the NDC are:

SAMPLE NDC: 12345-6789-10

12345 = labeler code

6789 = product code

10 = package size

Claims must accurately report the NDC dispensed, the number of units dispensed, days supply, and the date of dispensing. Use of an incorrect NDC or inaccurate reporting of a drug quantity will cause the Department to report false data to drug manufacturers billed for drug rebates.

The Department will recover payments made on erroneous claims discovered during dispute resolution with drug manufacturers. Pharmacies are required to document purchase for quantities of brands of drugs reimbursed by the Department if disputes occur.

Dispense As Written (DAW)

Prescribers and pharmacies must prescribe and dispense the generic form of a drug whenever possible. Except for those drugs listed below, Prior authorization is required when a brand name drug is prescribed instead of a generic equivalent. Please use the following DAW codes for these situations:

- DAW 1 may only be used only if authorized by the Drug Prior Authorization Unit. In addition to prior authorization requirements, brand name drugs with a generic equivalent (except those required by the PDL) may be billed only when the prescriber has handwritten "brand necessary" or "brand required" on the prescription. The pharmacy must retain brand certifications as documentation.
- DAW 5 may be used in instances where the drug dispensed is generic but is listed as a brand (branded generics) and prior authorization is required.
- DAW 7 may be used for seizure medications with an appropriate diagnosis without prior authorization. Based on DUR Board recommendations only anti-epileptic medications being used for a seizure diagnosis, and anti-hemophilic factors will be continue to be considered narrow therapeutic index (NTI) drugs. A DAW 7 override will be allowed on these drugs only. See the 2009 provider notice on the Pharmacy page of the [website](#) for additional information.
- DAW 9 is used when a brand name multisource drug is preferred and pharmacy is dispensing the brand name drug, this exempts the pharmacy from using the generic and allows reimbursement at the brand name rate.

Abuse and Misutilization

The following practices constitute abuse and misutilization:

1. **Excessive Fees:** Commonly known as prescription splitting or incorrect or excessive dispensing fees. Billing inappropriately in order to obtain dispensing fees in excess of those allowed by:
 - Supplying medication in amounts less than necessary to cover the period of the prescription.
 - Supplying multiple medications in strengths or quantities less than those prescribed to gain more than one dispensing fee.
2. **Excessive Filling:** Billing for an amount of a drug or supply greater than the prescribed quantity.
3. **Prescription Shorting:** Billing for drug or supply greater than the quantity actually dispensed.
4. **Substitution to Achieve a Higher Price:** Billing for a higher priced drug than prescribed even though the prescribed lower priced drug **was** available.