37.20 PROVIDER AUDITS

Overview

Introduction

Federal and State laws and regulations require the State Medicaid Agency to ensure the integrity of the program through various monitoring, review and audit mechanisms. The Louisiana Pharmacy Benefits Management Program Section is responsible for auditing Medicaid pharmacy providers. T his section explains the audit program and provider responsibilities relative to audits.

In This Section

This Section contains:

37.20.1 AUDIT PURPOSE

The purpose of the pharmacy review/audit function is to assure that Medicaid pharmacy providers are billing and being reimbursed in compliance with federal and state laws and regulations and Louisiana Medicaid Pharmacy Program policy.

37.20.2 AUDIT AUTHORITY

State Medicaid programs are required to conduct reviews and audits of claims in order to comply with federal regulations **42 CFR 447.202**.

The Louisiana Department of Health and Hospitals (DHH) is a covered entity under HIPAA. Therefore, DHH is exempt from the HIPAA privacy regulations regarding records for any claims which Medicaid reimbursement is sought. This exemption extends to DHH contractors when acting on behalf of DHH. The federal HIPAA privacy regulations, 45 CFR 164.506 (a), provide that covered entities are permitted to use or disclose Protected Health Information (PHI) for treatment, payment, or health care operations. In addition, a "HIPAA Authorization" or "Opportunity to Agree or Object" by the individual is not required for uses and disclosures required by law.

37.20.3 AUDIT OVERVIEW AND PROCESS

Since the inception of Medicaid, the Louisiana Medicaid Pharmacy Program has complied with the federal audit mandate. This was done primarily by conducting annual field audits of providers and auditing each pharmacy for multiple types of discrepancies.

Louisiana has revised and enhanced its pharmacy compliance review/audit process through new technology to make audits more efficient and cost effective.

The LMPBM Section uses a technology based risk assessment methodology to identify paid pharmacy claims that may be out of compliance with Medicaid rules and policies. This review ensures the review of paid claims on a timely basis, resulting in quicker corrective action by the provider.

Medicaid monitors the use of overrides for bypassing denial edits. Improper use of overrides and codes associated with these overrides by pharmacy providers may result in the disallowance of these overrides and administrative sanctions by Medicaid and the Board of Pharmacy.

Program reviews are also conducted of billings to assure required documentation is noted on hardcopy prescriptions for all pharmacy claims when an override indicator was used.

Therefore, pharmacists may receive written or telephonic requests from the auditors requesting additional information or copies of the hardcopy prescriptions or invoices in an effort to complete audit functions. When applicable, they may only ask for affirmation of correct billing.

37.20.4 PROVIDER RESPONSIBILITIES

Each provider upon enrolling in the Title XIX Medicaid Program agrees to dispense prescriptions and operate within the Program's laws and regulations as set forth in the Louisiana Medicaid Program Provider Manual and other directives.

In an effort to facilitate the pharmacy audit process, information must be available upon request. This information is necessary in order to comply with the requirements for a pharmacy services provider enrolled in Louisiana's Medicaid Program as stated in the PE-50 (Provider Enrollment Form) and to meet the requirements of the Louisiana State Board of Pharmacy.

At the time of audit, all Medicaid pharmacy providers must be able to produce a daily log, or prescription register. This daily log whether routinely produced in hard copy or producible in hard copy at the time of audit, must contain at a minimum, for audit purposes, the following prescription data:

- Prescription number;
- Indicator as to new or refill prescription (0-5);
- Date of dispensing;
- Patient's name;
- Prescriber's name;
- Drug name;
- NDC number;
- Quantity dispensed;
- Plan identifier indicating case or plan making payment; and
- Amount paid (including both copayment and plan payment, which may or may not be separated, i.e., *AMOUNT PAID = AMOUNT PLAN PAID + AMOUNT PATIENT PAID)*.

Providers are required to refund overpayments identified by the audits and take appropriate corrective action.