PROVIDER REQUIREMENTS AND PARTICIPATION GUIDELINES

This section describes pharmacy provider qualifications, enrollment and provider records, how the provider can make changes to the provider record, Internal Revenue Services (IRS) reporting, provider rights and responsibilities, record keeping requirements, billing agents, and point of sale (POS) enrollment.

Providers should refer to Chapter 1 – General Information and Administration of the *Medicaid Services Manual* for additional information on provider enrollment and requirements, including general standards for participation. (See Section 37.5.4 for information on accessing Chapter 1).

Provider Qualifications

The Medicaid Program reimburses pharmacies, not individual pharmacists, for the provision of prescribed drugs.

A pharmacy is a facility licensed in accordance with R.S. 37:1164 (36): "Pharmacy means any place located within this state where drugs are dispensed and pharmacy primary care is provided, and any place outside of this state where drugs are dispensed and pharmacy primary care is provided to residents of this state."

To enroll in the Medicaid Program, the pharmacy must have a community pharmacy or institutional pharmacy permit issued by the Louisiana Board of Pharmacy as defined by the Board's regulations at LAC 46:LIII.1301 and §1701.

Administering Pharmacists

Pharmacists who have the "Authority to Administer" authorized by the Louisiana Board of Pharmacy may administer the influenza vaccines. For COVID-19 vaccines only, the administration of the vaccine may be given by a pharmacist, and/or a qualified pharmacy technician, and/or a state-authorized pharmacy intern acting under the supervision of a qualified pharmacist during a Public Health Emergency (PHE). Pharmacists who have this authority are required to obtain a Medicaid provider number in order for the enrolled pharmacies to be reimbursed for the administration of this vaccine. (Refer to Section 37.5.11 Medication Administration of this manual chapter for detailed information on medication administration, including vaccinations).

Dispensing Physicians

Payment will be made for medications dispensed by a physician on a continuous basis only if the physician meets all of the following conditions:

1. Is permitted as a dispensing physician with the Louisiana Board of Medical Examiners;

2. When their main office is more than five miles from a facility which dispenses drugs; and

3. Enrolls in the Medicaid Program as a pharmacy provider and complies with all other requirements of the prescribed drug services program.

Under the above circumstances, vendor payment (when the treating physician dispenses their own medications and bills under their own name or the name of their own clinic or hospital) will be made on the same basis as to pharmacy providers. (Refer to Section 37.3 Reimbursement for Services of this manual chapter for detailed information on reimbursement).

Provider Rights and Responsibilities

Right to Refuse Services

A provider is not required to provide services to every beneficiary who requests services. A provider can limit the number of Medicaid beneficiaries that the provider serves, and accept or reject beneficiaries according to the pharmacy's policies, except for the reasons described below:

1. A provider cannot deny services to a beneficiary solely due to race, creed, color, national origin, disabling condition, or disability in accordance with the federal anti-discrimination laws; and

2. A provider cannot deny services to a beneficiary solely due to the presence of third party insurance coverage or the beneficiary's inability to pay a Medicaid co-payment.

Medical Assistance Program Integrity

The Louisiana Medical Assistance Program Integrity Law (MAPIL), R.S. 46:437.1-46 and 440.3, imposes terms and conditions on Medicaid providers. See Chapter 1 of the *Medicaid Services Manual*, Section 1 for information concerning the terms and conditions.

Prescription Provider Fee

A prescription provider fee shall be paid by each pharmacy and dispensing physician for each outpatient prescription (Medicaid and non-Medicaid) dispensed. The fee shall be $.10 per prescription dispensed by a pharmacist or dispensing physician. When a prescription is filled outside of Louisiana, but not shipped or delivered in any form or manner to a patient in the state, no provider fee shall be imposed. However, out-of-state pharmacies or dispensing physicians dispensing prescriptions which are shipped, mailed or delivered in any manner inside the state of Louisiana, shall be subject to the $0.10 fee per prescription. Medicaid enrolled pharmacy providers must comply with this requirement as a condition of participation in the Medicaid Program.

Activity reports, either manually or electronically produced, must be available upon request and on-site at the pharmacy. These reports must detail the number of prescriptions dispensed and which provider fees were paid by month for any given month. Providers are assessed on a quarterly basis by the Louisiana Department of Health (LDH). This information must be readily available during an audit when requested by a representative of the Medicaid Program.

Cost of Professional Dispensing Fee Survey

All pharmacy providers must complete the cost of professional dispensing fee surveys. These surveys are conducted periodically to determine the accuracy of the maximum allowable overhead cost (professional dispensing fee).

Federal Anti-Discrimination Laws

Providers must adhere to the following federal laws in order to maintain eligibility:

1. Civil Rights Act of 1964, which prohibits discrimination on the basis of race, creed, color or national origin;

2. Section 504 of the Rehabilitation Act of 1975, which prohibits discrimination on the basis of a disabling condition; and

3. Americans with Disabilities Act of 1990, which assures equal access to services for persons with disabilities.

Solicitation

In accordance with R.S. 46:438.2, 46:438.4 and 42 U.S.C.1320a-7b, it is unlawful to knowingly solicit, offer, pay or receive any remuneration (including any kickback, bribe or rebate) directly or indirectly, overtly or covertly, in cash or in kind, in return for referring an individual to a person for the furnishing, or arranging for the furnishing, of any item or service for which payment may be made, in whole or in part, under the Medicaid Program, or in return for obtaining, purchasing, leasing, ordering, or arranging for or recommending, obtaining, purchasing, leasing, or ordering any goods, facility, item or service for which payment may be made, in whole or in part, under the Medicaid Program.

Confidentiality

All information about Medicaid beneficiaries is confidential under federal law. Information cannot be released without the patient's written consent unless the provider is billing a third party or releasing the information to a billing agent. Billing agents must adhere to all federal and state confidentiality requirements.

All medical and billing records must be made available to official representatives of the Medicaid Program upon request. The representative making the request must possess proper identification.

Health Insurance Portability and Accountability Act

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

LDH is a covered entity under the Health Insurance Portability and Accountability Act (HIPAA) and is exempt from the HIPAA privacy regulations regarding records for any claims for which Medicaid reimbursement is sought. This exemption extends to LDH contractors when acting on behalf of LDH. The 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.

Record Keeping Requirements

The provider must retain all medical, fiscal, professional, and business records on all services provided to all Medicaid beneficiaries for a period of six (6) years from the date of service. The records must be accessible, legible and comprehensible. If the provider is being audited, records must be retained until the audit is complete, even if six (6) years is exceeded.

These records may be paper, film, or electronic, except as otherwise required by law or Medicaid policy.

Types of Records That Must Be Retained

The following types of records, as appropriate for the type of service provided, must be retained (the list is not all inclusive):

1. Medicaid claim forms and any documents that are attached;
2. Professional records, such as patient treatment plans and patient records;
3. Prior authorization and service authorization information;
4. Prescription records for Medicaid and other third party payors (including Medicare, private pay and cash);
5. Business records, such as accounting ledgers, financial statements, purchase/acquisition records, invoices, inventory records, check registers, canceled checks, sales records, etc.;
6. Tax records, including purchase documentation; and
7. Provider enrollment documentation.

Requirements for Prescription Record

A patient record must be maintained for each beneficiary for whom new or refill prescriptions are dispensed. The record may be electronic or hard copy. The pharmacy's patient record system must provide for the immediate retrieval of the information necessary for the pharmacist to identify previously dispensed drugs when dispensing a new or refill prescription.

All records must be maintained in accordance with the Louisiana Board of Pharmacy regulations.

Right to Review Records

Authorized state and federal agencies and their authorized representatives may audit or examine a provider's or facility's records without prior notice. This includes, but is not limited to, the following governmental authorities: LDH, the State Attorney General's Medicaid Fraud Control Unit and the Department of Health and Human Services (DHHS). Providers must allow access to all Medicaid beneficiary records and other information that cannot be separated from the records.

If requested, providers must furnish, at the provider's expense, legible copies of all Medicaid related information to LDH, federal agencies or their representatives.

Incomplete Records

Providers who are not in compliance with the Medicaid documentation and record retention policies described in this section may be subject to administrative sanctions and recoupment of Medicaid payments. Medicaid payments for services lacking required documentation or appropriate signatures will be recouped.

Prohibition of Reassignment of Provider Claims

Medicaid payments cannot be reassigned to a factor. A factor is defined as an individual or organization, such as a collection agency or service bureau, that advances money to a provider for accounts receivable that the provider has assigned, sold or transferred to the individual organization for an added fee or a deduction of a portion of the accounts receivable. A factor does not include a billing agent.

Out-Of-State Providers

Enrollment Criteria

In accordance with LAC 50:I.701 (B), out-of-state pharmacies may enroll as providers in the Louisiana Medicaid Program to secure reimbursement for a specific claim or claims **only** under the following circumstances:

1. When an emergency arises from an accident or illness;

2. When the health of the individual would be endangered if they undertook travel or if care and services are postponed until their return to Louisiana;

3. When it is general practice for residents of a particular locality to use medical resources in the medical trade areas outside of the state; or

4. When the medical care and services, or needed supplementary resources, are not available within the state. Prior approval for these services is required.

If services are provided to a Medicaid beneficiary in accordance with the criteria detailed above, enrollment will be allowed to obtain a Medicaid provider number to secure payment of the claim. However, this Medicaid provider number will only be active to finalize the claim at issue, not to allow the out-of-state pharmacy to maintain continuous and active enrolled provider status.
In no event can an out-of-state Medicaid provider number be active for 12 months from the date of service to secure payment of a single claim.

Medicare Crossover Claims

Out-of-state pharmacy providers will be allowed continuous Medicaid enrollment for crossover claims only. The out-of-state pharmacy must be enrolled in Medicare prior to enrolling in Louisiana's Medicaid Program. When enrolling in the Medicaid Program, the out-of-state pharmacy must indicate that crossover billing is requested and submit a copy of their Medicare certification letter.

Enrollment Forms

Enrollment for the payment of a claim or claims meeting the above-referenced criteria, or for the payment of Medicare crossover claims, providers need to complete the "Basic Provider Enrollment Packet for Entities/Businesses" and the provider type-specific packet "26 Pharmacy". (See Section 37.5.4 for information regarding provider enrollment).

Beneficiaries Out of the Country

Medicaid does not reimburse for services provided to beneficiaries when they are out of the United States.

Provider Enrollment

Every pharmacy must submit a provider enrollment application and sign an agreement in order to provide Medicaid services.

Medicaid Durable Medical Equipment/Supplies

A pharmacy provider is enrolled to bill for pharmacy services and durable medical equipment/supplies with one provider number.

NOTE: Refer to the *Medicaid Services Manual*, Chapter 18 Durable Medical Equipment for detailed information.

Medicare Enrollment

Pharmacies must contact the Medicare regional carrier to enroll as a Medicare provider. (See Section 37.5.4 for contact information).

Refer to Section 37.5.7 Medicare Prescription Drug Coverage of this manual chapter for detailed information on Medicare prescription drug coverage.

Enrollment Process

The provider must submit a completed Medicaid enrollment package to the Medicaid fiscal intermediary (FI). The provider will be notified in writing by the FI when enrollment is complete. Refer to Section 37.5.4 for information on how to obtain provider enrollment forms.

The enrollment packet must include the following documents:

1. Completed Form PE-50;

2. Copy of pre-printed IRS document showing employer identification number (EIN) – CPO-545 or pre-printed payment coupon is acceptable – (W-9 forms are not acceptable);

3. Completed Disclosure of Ownership and Control Interest Statement (CMS-1513) Form;

4. Completed Dispensing Cost Survey forms;

5. Completed POS forms (located in provider type-specific packet 26-Pharmacy);

6. Copy of a voided check from the account where funds are to be electronically deposited (deposit slips are not accepted); and

7. Copy of pharmacy license from the Louisiana Board of Pharmacy.

NOTE: If the request is for retroactive coverage, the license must be submitted that covers the retroactive period of coverage.

Out-of-State Pharmacy

When a pharmacy is located out-of-state and mails or delivers drugs to the state of Louisiana, the Louisiana Board of Pharmacy permit must be submitted along with the provider's Board of Pharmacy permit from their home state.

Accuracy of Information

All statements or documents submitted by the provider must be true and accurate. Filing of false information is sufficient cause for termination from participation or denial of an application for enrollment.

Effective Date of Enrollment

Providers can request the desired date their new Medicaid provider number will become effective. The effective date entered will be considered in the enrollment process. All eligibility requirements must be met on the date requested for the date to be considered.

Reimbursement due shall not precede the Louisiana Board of Pharmacy permit due.

Providers shall not bill Medicaid prior to receipt of confirmation that they are successfully enrolled. Reimbursement will not be provided prior to the provider's effective date of enrollment.

Licensure and Permits

Prescribed drug services providers must submit complete and legible copies of the required licenses and permits with the enrollment applications.

National Provider Identifier

As a provision of the Health Insurance Portability and Accountability Act (HIPAA), providers must obtain and use their national provider identifier (NPI) number on all claims submissions. Providers who do not provide medical services are exempt from this requirement (i.e., non-emergency transportation, case management, and some home and community-based waiver services). Although HIPAA regulations address only electronic transactions, the Medicaid Program requires both the NPI number and the legacy seven-digit Medicaid provider number on hard copy claims.

Termination

A provider agreement can be terminated for any reason, at any time, by the provider or the state with 30-day written notice. All the conditions of the agreement remain in effect during the 30-day notice period and until termination is completed.

Exceptions to the 30-day notice, including but not limited to, are:

1. If the provider is required to be licensed or certified, the effective date of termination will be the date that the license or certification became invalid;

2. If the provider is suspended, excluded or terminated from Medicare or any state's Medicaid program; or

3. If the provider's business is closed, abandoned, or non-operational, the effective date of termination will be the date that the business was closed, abandoned, or became non-operational.

Reinstatement

A provider must submit a new application, provider agreement, and other required forms to the fiscal agent to request reinstatement after a termination or suspension period. If the provider is

enrolling under a different name or different tax ID number, the provider must furnish the prior name and tax ID number with the application.

POS Enrollment

POS claims processing provides on-line adjudication of Medicaid claims. With POS, a claim is electronically processed through the claims processing cycle in real-time with a response to the pharmacy within seconds of submission that indicates the beneficiary's eligibility, and whether the claim is payable or rejected.

Application Forms

Providers must obtain authorization to submit claims via POS by completing the required forms included in the provider enrollment packet:

1. Medicaid Pharmacy POS Provider Certification;
2. Medicaid POS Agreement; and
3. Pharmacy Provider Enrollment Amendment POS Enrollment.

Annual Re-certification

POS Certifications must be renewed annually. All applicable sections of this form must be completed in order for the recertification to be accepted by LDH. Recertification forms are mailed in October by LDH and are effective the following January.

Provider Record

A provider record is created by the Medicaid FI for each provider based on the information from the initial enrollment application.

Provider Identification Number

A seven-digit provider identification (ID) number is assigned by the FI when the provider has been approved for enrollment in the Medicaid Program. The provider ID number is used to identify the

provider for billing and correspondence purposes. The provider ID number must be included on all correspondence to the FI or the Medicaid office.

Reporting Changes

All changes must be reported promptly to the FI. Information in a provider's record can only be changed by submitting a written, signed and dated request on the provider's letterhead stationery to the FI. (See Section 37.5.4 for contact information for Provider Enrollment).

NOTE: All correspondence must include the Medicaid provider number.

Change of Address

The provider must notify the FI of any change of address. The notification must include:

1. The new business and mailing address(es);
2. The physical location, if different;
3. The provider's previous address(es); and
4. The effective date of the change.

Medicaid correspondence is sent to the billing address listed on the provider record.

Change in Telephone Number

The provider must notify the FI of any changes in telephone numbers. Notice of a change in telephone number(s) must include:

1. The new telephone number(s);
2. The provider's previous telephone number(s); and
3. The effective date of the change.

Change in Electronic Funds Transfer

The provider must notify the FI in writing **at least 60 days in advance of any change in financial institutions or accounts**. Failure to do so may result in lack of payment.

Change in Federal Tax ID/ Social Security Number

A new provider enrollment application must be completed if a provider's federal tax identification/social security number changes.

Provider No Longer Accepts Medicaid

The provider must notify the FI should the pharmacy no longer accept Medicaid for any reason, including closing the business.

Change of Ownership

The provider must notify the FI immediately of a change in ownership. Failure to do so may result in departmental review. (See the *Medicaid Services Manual*, Chapter 1, Section 1.1, for a full description of Change in Ownership).

The Pharmacy Program defines change of ownership based on the Louisiana Board of Pharmacy's definition. Therefore, if a new Board of Pharmacy permit is issued due to a 50 percent or more shift in ownership, the provider is required to obtain a new Medicaid provider number.

Reporting to the IRS

Federal law requires Medicaid to report to IRS all payments made during the calendar year to any provider under a tax ID number.

Louisiana Medicaid Website

The "Pharmacy and Prescribing Providers" link on the Louisiana Medicaid website contains information to assist pharmacy providers in obtaining the following commonly requested information (See Section 37.5.4 for web address):

1. **Single Preferred List** - The Single Preferred Drug List is a reference for the most current listing of preferred drugs as well as those drugs requiring prior authorization. This list is updated every 6 months. For additional information, refer to the Prior Authorization and Single Preferred Drug List in Section 37.1 Covered Services, Limitations, and Exclusions of this manual chapter;

2. **Clinical Drug Inquiries -** The Clinical Drug Inquiry is a component of the Clinical Data Inquiry (e-CDI) that is available to pharmacists. It promotes the deliberate evaluation by providers to help prevent duplicate or inappropriate drug therapy. The e-CDI is available 24 hours a day and is updated on a daily basis. Encounters from MCO pharmacy claims have a lag time before available on e-CDI. The e-CDI will provide clinical historical data on each Medicaid beneficiary for the current month, prior month, or prior 12 months. A copy of the displayed information can be printed in a print friendly version for the beneficiary's clinical chart;

3. **Prescriber Numbers -** A list of prescribing practitioner numbers and National Provider Identifier (NPI) numbers are available on the website. This listing is updated on a daily basis. Encounters from MCO pharmacy claims have a lag time before available. For additional information refer to the "Accessing Prescriber Numbers" in Section 37.5.6 Prescribers of this manual chapter for more detailed information;

4. **Prior Approval Program -** Details about the Prior Approval (PA) Program and process are available on the website along with contact numbers;

5. **Beneficiary Eligibility:**

    a. **Medicaid Eligibility Verification System (MEVS) -** MEVS is an electronic system used to verify Medicaid beneficiary eligibility and third party liability information. This electronic verification process expedites reimbursement, reduces claim denials, and helps to eliminate fraud. Eligibility information for a beneficiary, including third party liability, health plan linkages, service limits and any restrictions, including Lock-In, may be obtained by accessing information through MEVS. Only one eligibility inquiry at a time may be made when using the web application. This system is available seven days a week, 24 hours per day except for occasional short maintenance periods. For additional information, refer to

"Medicaid Verification" in Chapter 1 of the *Medicaid Services Manual*, Section 1.2 Beneficiary Eligibility; and

b. **Recipient Eligibility Verification System (REVS) -** A telephonic system is also available to providers to verify eligibility information. REVS may be accessed through touch-tone telephone equipment using the fiscal intermediary's toll-free telephone number. (See Section 37.5.4 for contact information). For additional information, refer to "Medicaid Verification" in Chapter 1 of the *Medicaid Services Manual*, Section 1.2 Beneficiary Eligibility.

6. **POS User Guide -** The POS User Guide details the required information for claim submittal. This helpful manual lists National Council for Prescription Drug Program (NCPDP) fields and instructions for proper usage;

7. **Vendor Specifications Document for the POS System -** Pharmacy providers using the Medicaid POS system are required to transmit their POS claims through an authorized telecommunications switch vendor. This document outlines the requirements necessary for switch vendors to transmit pharmacy claims; and

8. **Third Party Liability Carrier Code List -** Private insurance companies are assigned a unique Louisiana carrier code. Pharmacy providers are asked to submit the third party liability (TPL) carrier code when coordinating claims for payment with a primary payor. For additional information, refer to "Third Party Liability" in Chapter 1 of the *Medicaid Services Manual*, and Section 37.3 of this manual chapter.

Medicaid Fraud and Abuse

To maintain the programmatic and fiscal integrity of the Medicaid Program, the federal and state governments have enacted laws, promulgated regulations and policies concerning fraud and abuse. It is the responsibility of the provider to become familiar with these laws and regulations.

In order for the LDH to receive federal funding for Medicaid services, federal regulations mandate that LDH perform certain program integrity functions. The primary functions of the Program Integrity Section are:

1. Provider Enrollment;

2. Fraud and Abuse Detection;

3. Investigations;

4. Enforcement;

5. Administrative Sanctions; and

6. Payment Error Rate Measurement (PERM).

Refer to Chapter 1 of the *Medicaid Services Manual*, Section 1.3 Program Integrity, to become familiar with the laws and regulations concerning fraud, abuse and other incorrect practices. This section is not all-inclusive nor does it constitute legal authority.

To report Medicaid fraud and/or abuse, contact Program Integrity. (Refer to the Section 37.5.4 for contact information).

Beneficiary Prescription Verification Letters

Prescription verification letters are sent to beneficiaries in an effort to ensure that pharmacy services billed to Medicaid were received by the correct beneficiary and correctly billed. Each dispense date includes a picture of the actual drug(s) billed to Medicaid on the patient's behalf. The beneficiary is asked to verify:

1. They received a drug on that date of service;

2. That the drug they received looks like the drug in the picture; and

3. Confirm the amount of co-payment that they were asked to pay, if any.

All exceptions are investigated.

Surveillance Utilization Review Subsystem

The fiscal intermediary, through its Surveillance Utilization Review Subsystem (SURS), can identify potential fraud and abuse situations by means of profile (SURS) reports. For detailed

information concerning SURs and SURs profile reports, refer to Title 50, Part I, Subpart 5, Chapter 41 – the Surveillance Utilization Review System (SURs) Rule.

Appeals

LDH provides a hearing to any provider who feels that he has been unfairly sanctioned. Specifically, the Division of Administrative Law (DAL), Health and Hospitals Section is responsible for conducting hearings for providers who have complaints. Requests for hearings should explain the reason for the request and should be made in writing. The request should be sent directly to the DAL.

Detailed information regarding the appeals procedure may be obtained from the DAL. (See Section 37.5.4 for contact information).

Provider Audits

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 Pharmacy Program is responsible for auditing Medicaid pharmacy providers. This section explains the audit program and provider responsibilities relative to audits.

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 Pharmacy Program policy.

Audit Authority

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

LDH is a covered entity under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Therefore, LDH is exempt from the HIPAA privacy regulations regarding records for any claims which Medicaid reimbursement is sought. This exemption extends to LDH contractors when acting on behalf of LDH. 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.

Audit Overview and Process

Since the inception of Medicaid, the Pharmacy Program has complied with the federal audit mandate.

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 or electronic records for pharmacy claims when an override indicator was used.

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

Provider Responsibilities

Each provider upon enrolling in the Medicaid Program agrees to dispense prescriptions and operate within the Program's laws and regulations as set forth in the approved Medicaid State Plans, administrative rules, *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 the Medicaid Program as stated in the provider enrollment form (PE 50) 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:

1. Prescription number;

2. Indicator as to new or refill prescription (0-11);

3. Date of dispensing;

4. Beneficiary's name;

5. Prescriber's name;

6. Drug name;

7. NDC number;

8. Quantity dispensed;

9. Plan identifier indicating case or plan making payment; and

10. 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.