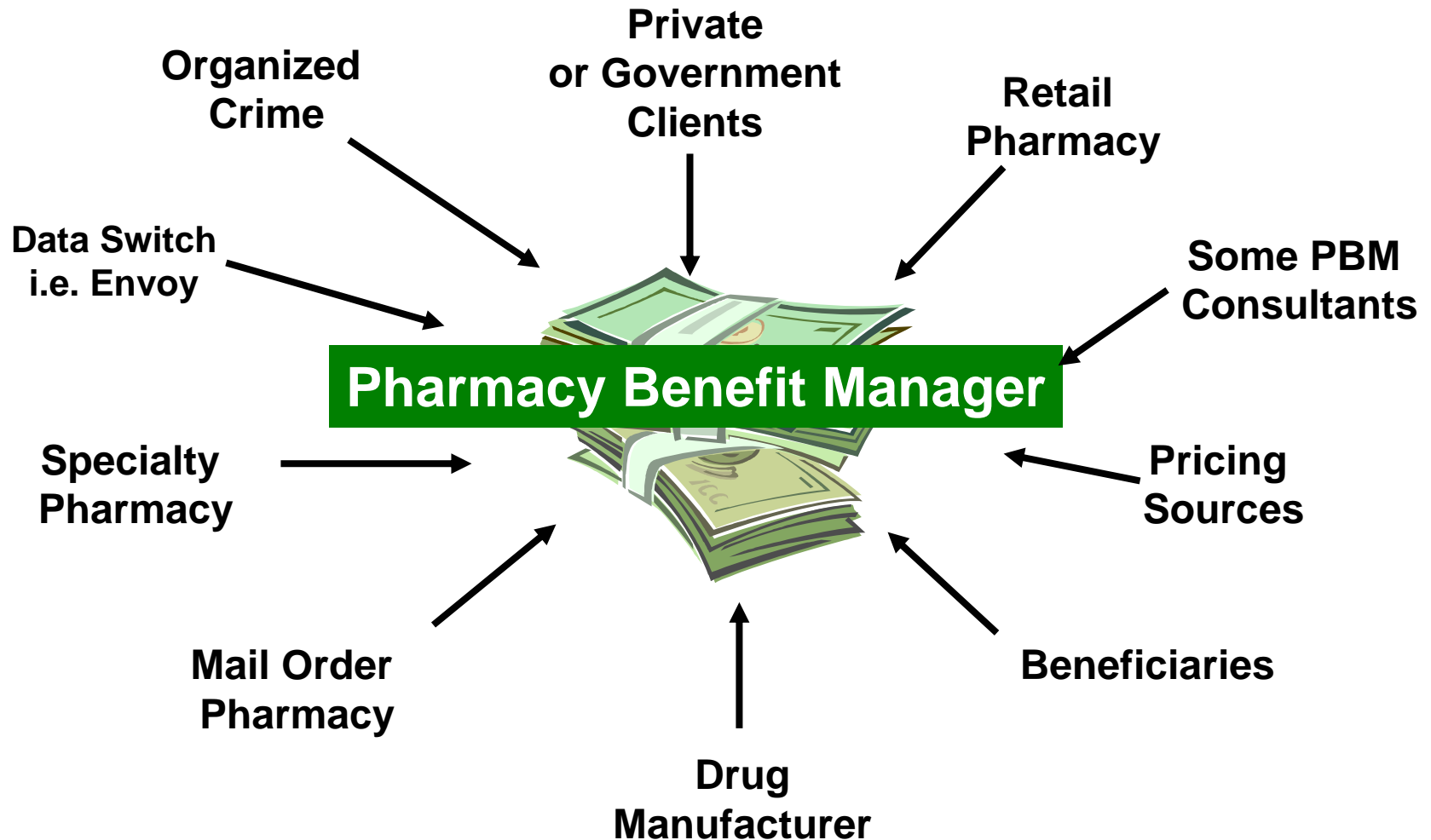




MORGAN
HEALTHCARE AUDITS, LLC

**Pharma Industry Audits
Risk Factors, Schemes and
Audit Solutions**

www.healthcareaudits.com



Contract Audits

Business Practice Audits

- that siphon money from Clients, Beneficiaries and Prescription Programs
- “Computer Forensics”

- ▶ Compliance with pricing terms
- ▶ Package size issues
- ▶ Non-covered drugs
- ▶ Formulary Steering to higher priced drugs
- ▶ Days supply exceeded
- ▶ Proper copays used (Zero Cost Prescriptions)
- ▶ Proper fees applied
- ▶ Proper MAC & Generic Utilization/Pricing
- ▶ And more of the boring stuff

- ▶ Using highest pricing sources
 - ▶ Obtaining multiple Administration Fees
 - ▶ Double Billing
 - ▶ Rebates by any other name is still a rebate*
 - ▶ Limit System Edits allowing claim approval rather than rejection
- 12-14% of processed Paid Claims have invalid/fictitious Physican ID's

* See Next Page

1. Study fees
2. Research study programs
3. Unrestricted educational grants
4. Preceptorship service agreements
5. Data service fees
6. Program set-up fees
7. Enrollment fees
8. Application fees
9. Eligibility fees
10. Denial fees
11. Distribution fees
12. Dispensing fees
13. Alternate funding fees
14. Case management fees
15. Reship fees
16. Ingredient fees
17. Shipping carrier fees
18. Interest charges
19. Call center fees
20. Printed material fees
21. Product acquisition costs
22. Patient registry fees
23. Patient management fees
24. Implementation fees
25. Lunch & Learn funding
26. Performance reimbursements
27. Reimbursements
28. Base rebates
29. Performance rebates
30. Data license fees
31. Data fees
32. Administrative fees
33. Professional service fees
34. Fees
35. Consumer price index fees
36. All other “undefined” Rebate Names

- ▶ Drug diversion schemes using PBM Prescriptions to balance narcotic counts
- ▶ Fraudulent submission of claims for payment (False claims submission)
- ▶ Billing a higher priced generic than what was dispensed
- ▶ Dispensing illegally imported or outdate drugs
- ▶ Not reversing errors or prescriptions returned to stock
- ▶ Collusion with Benes, Physicians, Nurse Practitioners & Criminal Entities
- ▶ Using PBM Scripts to fill up the CMS Part D “Donut Hole” accelerating Bene to catastrophic benefits
- ▶ Split prescription to obtain multiple fees
- ▶ Dispensing unauthorized refills
- ▶ Illegal drug substitution

- ▶ Pricing spreads between Client Billing & Pharmacy payments, increasing PBM profits
- ▶ Zero cost prescriptions *
- ▶ Allowing payment of claims with invalid prescriber ID
- ▶ Pay pharmacy using a lower pricing source vs. the higher prices used to bill Client thereby creating a \$ spread (Kept by the PBM)
- ▶ Pay pharmacies to switch to PBM preferred drug
- ▶ Up to triple payment of admin fee on reversed drugs
- ▶ Payment spread on professional fee
- ▶ Allow inflated pricing from re-packagers

***Explanation on next page**

1. The Patient has a \$20.00 copay
2. The Pharmacy’s prescription Ingredient Cost is \$3.00
3. The Dispensing Fee is \$2.00

The patient/member should only pay **\$5.00** for the prescription yet the PBM allows the Pharmacy to charge and keep the full copay of **\$20.00**. This nets an additional **\$15.00** profit to the pharmacy.

4. The Client only sees that they are billed a “Zero Cost for the Claim”

How does the PBM benefit ?

During the contract negotiations between the PBM and the Pharmacy, the PBM uses this windfall to drive down it’s re-imbusement terms to the pharmacy thereby creating a greater spread between what the Client is billed and what the Pharmacy is paid. The **MEMBER’s** inflated Out of Pocket subsidizes the PBM and Pharmacy Profit Scheme.

- ▶ Review State Pharmacy Law

- ▶ Claims analysis

 - Establish demographic baselines for utilization (high level reporting)

 - Look for pharmacies that fall outside the norms for

 - Narcotic dispensing

 - High cost prescriptions

 - Street abused drugs (Growth Hormones/ Steroids)

 - Identify medical practitioners

 - Too large a geographic footprint

 - Prescribing outside their expertise (Dentist – BC Pills)

 - Excessively high prescription writers

 - Limited Drug Mix

- ▶ Sentinel Effect

▶ **Desk Audits** (Alone or in conjunction with On Site Audit)

- Data analysis to target pharmacies to be audited
- Determine if findings warrant an on site audit
- Letter to beneficiaries
- Letters to physicians
- Obtain & review drug wholesaler reports

▶ **On Site Audits**

- Target pharmacies through claims analysis
- Verify valid licensure
- Verify safety of drugs
- Pull & copy targeted prescriptions
- Obtain signature logs (paper or electronic)
- Does pharmacist know how to reverse a claim?
- Verify shelf stock matches billings to CMS
- Observe & question pharmacist's due diligence

- ▶ Perform Desk Audit to gather additional information
- ▶ Generate executive & detail reports
- ▶ ID criminal verse civil activities
- ▶ Work with appropriate agency for recovery or further investigation
- ▶ Participate in “Meet & Discuss” with pharmacy
- ▶ Provide expert witness testimony

- ▶ Some consulting firms are shells established by PBMs
- ▶ Advice PDPs who unknowingly participate in PBM schemes
- ▶ Experts at steering a PDP to a specific PBM
- ▶ Experts at including abstract terms in contract during negotiations
(Contract will then not hold up in court)

- ▶ PBM pays consultants based on contract size (Number of Lives)
- ▶ Bonuses paid for obtaining approval of Client (PDP) on specific contract clauses (i.e. which drug pricing source to use)

- ▶ These companies need to be identified
- ▶ Participating PDPs need to be made aware of these consultants and firms
- ▶ Any signed contracts or agreements that PBM consultant participated in need to be reviewed
- ▶ Vigilance

- ▶ Many pricing sources are available
- ▶ Each pricing source calculates & reports AWP differently
- ▶ Pricing sources allow drug manufacturers to retroactively change prices (sometimes going back 10 years)
- ▶ Client may not be aware they are using a high pricing source

- ▶ The PBM uses the pricing courses to create a spread between the PBM bills the Client & what they pay the pharmacy (pocketing the difference)
- ▶ Retroactive price changes may show the PBM being in contract compliance now, when on the date of service, they were not

- ▶ Re-adjudicate billing & payments at the lowest pricing source & recover differences
- ▶ Use a pricing file that accurately reflects the pricing on the date of service
- ▶ ID Retroactive price changes & track them in a separate drug pricing file
- ▶ Determine if retroactive price changes give PBM favorable financial advantage

- ▶ Collusion for profit & “Donut Hole” filling
- ▶ Loaning or selling the use of their cards
- ▶ Obtaining drugs for resale
- ▶ Personal abuse of drugs
- ▶ Doctor shopping
- ▶ Medication sharing

- ▶ Zero Cost Prescriptions
 - Beneficiary unknowingly subsidizes the PBM by creating a Pharmacy/Client spread by over paying on drugs less than the copay

- ▶ Nearly all findings are identified using the DUR process
- ▶ Letters to physicians
- ▶ Letters to pharmacies
- ▶ Obtain copies of prescriptions & signature logs from pharmacies
- ▶ Cross reference doctor visits, hospital stays & performed medical procedures against patient medication history
- ▶ Interview beneficiary

- ▶ Rebates (not being passed on to Client/Payer)
 - “Undefined” or “Unnamed” PBM reimbursements
- ▶ Formulary steering
- ▶ Marketing incentives
- ▶ Re-packaging
- ▶ Retro-active re-pricing

- ▶ Disguising Rebates as other types of payments
- ▶ PBM paid to market manufacturer's drugs
- ▶ PBM paid to include manufacturer's drugs in formulary (even if at higher cost to Client)
- ▶ Allowing PBM to re-package & assign a higher Average Wholesale Price "AWP"
- ▶ Retroactive price changes that compensate for PBM pricing indiscretions

- ▶ Obtain rebate agreements with PBM
- ▶ Audit financial records between PBM & manufacturer
- ▶ Obtain all contracts & agreements between PBM & manufacturer
- ▶ Obtain invoices for bulk purchases
- ▶ Verify sales to or from re-packager
- ▶ Verify that all rebates are being passed from PBM to Client
- ▶ Reports produced in executive format
- ▶ Standard report to Client with samples
- ▶ Detail report with all supporting documentation

- ▶ Duplicate billing & dispensing
- ▶ Automatic refills when not needed
- ▶ Exceeding contractual days supply
- ▶ Re-packaging & charging a higher price
- ▶ Unapproved drug switching
- ▶ Dispensing low cost generic & billing a higher cost generic

- ▶ Manipulation of MAC pricing
- ▶ Mail Order claims are adjudicated through a different process than the retail claims which has been found to have fewer edits
- ▶ PBM does not check for inflated re-packaging prices from the Mail Order facility
- ▶ PBM uses Mail Order facility to
 - Market drugs to beneficiaries & physicians
 - Increase profitability with inconsistent manufacturer drug updates (Mail Order has been known to institute price updates 3 to 6 months ahead of official price updates from the drug manufacturers)

- ▶ Auditing contract compliance is basically the same as a retail pharmacy audit

- ▶ The business practice relationship between the mail order pharmacy & the PBM can become quite extensive, requiring:
 - Manufacturer Drug invoices
 - Manufacturer/PBM/mail order pharmacy financial records
 - Review of phone records
 - Review of physician/beneficiary correspondence
 - Review of re-packaging facility & associated practices

- ▶ Package size pricing errors
- ▶ Dispensing of diluted medications
- ▶ Extreme over-pricing of IV's & compounds
- ▶ Not audited by the PBM as a reward for staying in-network
- ▶ Improper storage & shipping of specialty drugs

- ▶ PBM's look the other way on over-pricing to keep pharmacy in-network
- ▶ PBM never audits the Specialty Pharmacy
- ▶ Pricing submitted by Specialty Pharmacy is rarely altered by the PBM
- ▶ It has been reported that the PBM & Specialty Pharmacy share in the over-pricing scheme

- ▶ We highly recommend that IV & compound drugs submitted by Specialty Pharmacies be manually priced
- ▶ IV & compound claims, if paid electronically, should be followed by a copy of the original prescription, listing the NDCs of ALL ingredients
- ▶ Random testing for potency should be instituted
- ▶ Regular on-site visits should be scheduled to verify storage & shipping conditions
- ▶ Beneficiaries should be polled to determine if medication, left by a delivery person, was exposed to extreme heat or cold

- ▶ Administration/switching fees can be passed on to Client disguised as part of other pricing
- ▶ Duplicate billings can occur due to communication interruptions at the switch causing the pharmacy to resubmit
- ▶ Switch programming errors may cause claims to be paid incorrectly
- ▶ Switch gets paid by pharmacies to change NDC to the most expensive AWP on file

- ▶ Pricing discrepancies could feasibly be traced back to an incompatibility issue between the switch and PBM

- ▶ When all entities have been eliminated from being the source of a pricing or data problem, the data switch will be tested to determine if they are the cause
- ▶ Procedures will be established to track a claim from its source, through the data switch, to the PBM & back to the source

- ▶ State Medicaid has been utilized as a source of drugs (Antibiotics) for the Eastern European black market (Russian Mafia), Narcotic Diversion (Chinese Mafia & other organized crime syndicates)
- ▶ Terrorist Sleeper Cells have been profiled to use government resources, including prescription programs, to obtain medication for their own protection from biologicals
- ▶ Control Drug Diversion

- ▶ When regional patterns of diversion are identified, the proper agencies will be notified. We will provide knowledge, analysis & support for those investigations

How PBM Business Practices Have Affected Their Revenue Flow

