PHARMACY AUDIT BOOT CAMP
“AUDIT PROOFING YOUR PHARMACY”

June 1, 2012
9:40AM - 11:10AM
Mark Jacobs RPh

Learning Objectives for Pharmacists
1. Identify practices in your pharmacy that are most likely to trigger an audit.
2. Describe proactive measures pharmacies can take to lessen the likelihood of pharmacy audits.
3. Discuss how pharmacy employees can incorporate audit prevention strategies efficiently into pharmacy workflow.

Learning Objectives for Pharmacy Technicians
1. Identify practices in your pharmacy that are most likely to trigger an audit.
2. Describe proactive measures pharmacies can take to lessen the likelihood of pharmacy audits.
3. Discuss how pharmacy employees can incorporate audit prevention strategies efficiently into pharmacy workflow.
So why all the audits?

• Increased scrutiny of all health care claims
• Physician providers: Medical records did not support the level of service billed
• Pharmacy is no exception
• Obama Legislation – PPACA March 2010

Other reasons for audits

• Improper Payments
• Detection of Fraud
• Money

Improper Payments

• (A) means any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements; and

• (B) includes any payment to an ineligible recipient, any payment for an ineligible good or service, any duplicate payment, any payment for a good or service not received (except for such payments where authorized by law), and any payment that does not account for credit for applicable discounts

Source: Improper Payments and Information Act 2002 and Improper Payments Elimination and Recovery Act of 2009
Detection of Fraud

According to Transactional Records Access Clearinghouse (TRAC)

• Health care fraud prosecutions on pace to rise 85% over last year
• 903 prosecutions so far this year
• 24% increase over all of 2010

Money

Enforcement yields huge returns

• Government $4.50 for every dollar spent
• Private Insurers $7.60 for every dollar spent

— National Healthcare Anti-Fraud Association

More Money

Enforcement yields huge returns

• FY 2010 $16.70 to $1.00 expected ROI
• $3.8 Billion expected through court order or civil settlements
• $1.1 Billion agreed to be pursued as a result of OIG disallowance recommendations

— Office of Inspector General
1.1.2: ROI resulting from OIG involvement in health care fraud and abuse oversight activities

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Conviction of Fraud

A couple of big busts this year:

- February 2011 case that brought in 111 people
- Doctors, nurses and executives were accused of falsely billing Medicare more than $225 million.
- In 2010, the government recovered a record $4 billion from health fraud cases.
September 7, 2011 – 91 Charged

- $295 Million in false billing
- Highest amount of false billings in Medicare history
- Doctor’s, Nurses and other health professionals
- False or fraudulent claims

Fraud Programs

HIPAA 1996 established the Health Care Fraud and Abuse Control Program (HCFAC)
- Program has grown to new heights

HEAT - Health Care Fraud Prevention and Enforcement Action Team
- A joint initiative between DOJ & HHS
- Medicare Fraud Strike Force Teams

HEAT - Health Care Fraud Prevention and Enforcement Action Team

Focus on seven hottest areas:
- Detroit
- Brooklyn, NY
- South Florida (Miami)
- Baton Rouge, LA
- Tampa, FL
- Los Angeles
- Houston
Criminal Health Care Fraud Prosecutions

Number Year-to-date 903
Percent Change from previous year 85.4
Percent Change from 5 years ago 157
Percent Change from 10 years ago 115
Percent Change from 20 years ago 822

Source: Transactional Records Access Clearinghouse (TRAC)
Report date: August 17, 2011

Criminal Health Care Fraud Prosecutions over the last 20 years

Top Charges Filed

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Source: Transactional Records Access Clearinghouse (TRAC)
Report date: August 17, 2011
Top 10 Districts (per one million people)
Source: Transactional Records Access Clearinghouse - Report Date: August 17, 2011

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Patient Protection Affordable Care Act (PPACA)
- New Tools to Fight Fraud, Strengthen Medicare and Protect Taxpayer Dollars
- Tough New Rules and Sentences for Criminals
- Enhanced Screening and Other Enrollment Requirements
- Projected to save $2.1 Billion over 5 years by helping states identify and recover improper Medicaid payments

PPACA - New tools to fight Medicare Fraud
- Transition from pay and chase to fraud prevention

In January 2011, HHS announced new rules that will create:
- A rigorous screening process
- Mandatory licensure checks
Affordable Care Act
- Possible Finger printing
- Criminal background checks
- The law also allows the Secretary to withhold payment to any Medicare or Medicaid providers if a credible allegation of fraud has been made and an investigation is pending.

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Enhanced Penalties to Deter Fraud and Abuse
New penalties:
- For Individuals who order or prescribe an item or service while being excluded from a Federal health care program
- Make false statements on applications or contracts to participate in a Federal health care program
- Providers who identify a Medicare overpayment and do not return it
- States may terminate a provider under Medicaid if a provider is terminated under Medicare or another State Medicaid program
**Exclusions Program - Mandatory**

Mandatory exclusions:

1. Medicare or Medicaid fraud
2. Patient abuse or neglect
3. Felony convictions for other health care-related fraud, theft, or other financial misconduct
4. Felony convictions relating to unlawful manufacture, distribution, prescription, or dispensing of controlled substances

**Exclusions Program - Permissive**

Permissive exclusions:

1. Misdemeanor convictions related to health care fraud other than Medicare or a State health program
2. Misdemeanor convictions relating to the unlawful manufacture, distribution, prescription, or dispensing of controlled substances
3. Suspension, revocation, or surrender of a license to provide health care for reasons bearing on professional competence, professional performance

4. Financial integrity – Provision of unnecessary or substandard services
5. Engaging in unlawful kickback arrangements
6. Defaulting on health education loan or scholarship obligations
Exclusions Program – Primary Effect

- No payment will be provided for any items or services furnished, ordered or prescribed
- Both excluded individual or entity.

One Example: Take your pick...
1. $4 million or
2. 3 years Pharmacist Salary X 40% X 2
3. Litigate and risk $10,000 CMP penalty

How much does it really cost?

I HAD NO IDEA!

08-19-2011 After it self-disclosed conduct to the OIG, Hospice of the Finger Lakes (HFL), New York, agreed to pay $35,831.70 for allegedly violating the Civil Monetary Penalties Law. The OIG alleged that HFL employed an individual that it knew or should have known was excluded from participation in Federal health care programs.

09-06-2011 After it self-disclosed conduct to the OIG, Kmart Corporation (Kmart), Indiana, agreed to pay $945,021.19 for allegedly violating the Civil Monetary Penalties Law. The OIG alleged that Kmart employed four individuals that it knew or should have known were excluded from participation in Federal health care programs.
I HAD NO IDEA!

06-22-2011 After it self-disclosed conduct to the OIG, University of Nevada School of Medicine (UNSOM), Nevada, agreed to pay $138,321.70 for allegedly violating the Civil Monetary Penalties Law. The OIG alleged that UNSOM submitted or caused to be submitted claims for physicians’ services provided by two physicians to beneficiaries of Federal health care programs using the provider identification numbers of two physicians who did not furnish the services.

06-21-2011 Daniel Herrington, the owner of One Source Medical Services a durable medical equipment (DME) company, Florida, agreed to pay $124,141.50 for allegedly violating the Civil Monetary Penalties Law. The OIG alleged that Herrington, through the DME company, billed Medicare for custom molded diabetic shoe inserts when in fact only prefabricated inserts were provided to beneficiaries.

I HAD NO IDEA!

11-24-2010 After it self-disclosed conduct to the OIG, Miami County Medical Center (MCMC), Kansas, agreed to pay $403,935.30 for allegedly violating the Civil Monetary Penalties Law. The OIG alleged that MCMC billed Medicare for physical therapy services that lacked sufficient documentation.

8-19-2010 Hackley Professional Pharmacy, Inc. (Hackley), Michigan, agreed to pay $150,565.97 for allegedly violating the Civil Monetary Penalties Law. The OIG alleged that Hackley employed an individual that it knew or should have known was excluded from participation in Federal health care programs.

04-14-2010 After it self-disclosed conduct to the OIG, A Drug Store in New York, agreed to pay $8,002.95 for allegedly violating the Civil Monetary Penalties Law. The OIG alleged that the pharmacist filled unauthorized telephone prescriptions and submitted claims for those prescriptions to Medicare.

I HAD NO IDEA!

03-11-2009 After it self-disclosed conduct to the OIG, Walgreen Louisiana Co. (Walgreen), Louisiana, agreed to pay $1,053,774.82 for allegedly violating the Civil Monetary Penalties Law. The OIG alleged that Walgreen employed an individual that Walgreen knew or should have known was excluded from participation in Federal health care programs.

Tip: Be safe – Check Exclusion Lists Frequently!
Avoiding Civil Monetary Penalties

To avoid CMP liability, health care entities:

- Need to routinely (at least annually) check the LEIE to ensure that new hires & current employees are not on the excluded list.
- No program payment will be made for anything that an excluded person furnishes, orders, or prescribes.

Avoiding Civil Monetary Penalties

From the Medco 2011 Provider Manual:

Section 1.5 Credentialing Requirements

- Require and verify that Provider and all personnel employed by or contracted with Provider have not been excluded or debarred by any federal or state program.

Every three months, Provider will check the applicable state and federal exclusion lists to verify that no employees or contractors are on the list. Provider must inform Medco of the fact that any entity or individual is listed on the exclusion list within 10 days. No compensation will be provided for claims for which work has been done by an excluded person or entity.

MEDCO CREDENTIALING REQUIREMENTS

Require and verify that any individual for whom there has been a restriction, suspension, revocation, any other disciplinary action taken, or who is on a state or federal exclusion list, does not provide any service for Medco members and inform Medco of any restrictions, suspensions, revocations or other disciplinary action taken against the Provider.
Fraud Waste and Abuse Compliance

How does this apply to pharmacies?

- Pharmacies and pharmacists are included in the definitions of “providers” and “downstream entities.”
- Therefore, several provisions of the guidance either require or recommend that plan sponsors place compliance burdens on pharmacies.

Fraud Waste and Abuse Compliance

Plan Sponsor
(Health Plan)

First Tier Entity
(PBM)

Downstream Entity
(Pharmacy)

Fraud Waste and Abuse Compliance


All Sponsors are required to have a comprehensive plan to detect, correct and prevent fraud, waste and abuse.

1. Written Policies and Procedures and Standards of Conduct
2. Compliance Officer and Compliance Committee
3. Training and Education
4. Effective Lines of Communication
5. Enforcement of Standards through well publicized disciplinary guidelines
6. Monitoring and Auditing
7. Corrective Action Procedures
8. Comprehensive Fraud and Abuse Plans – Procedures to voluntarily self-report potential fraud or misconduct
Overview of Compliance Pharmacies may be asked to provide:

- Exclusion List Monitoring
- Written Policies and Procedures
- Code of Conduct or Conflict of Interest
- Training and Education
- Enforcement of Standards: Communication (Employee Handbook)
- Monitoring and Auditing
- Corrective Action Procedures
- Proof of Compliance

Overview of Requirements

40.1 – Delegating Compliance Functions to First Tier Entities, Downstream Entities, and Related Entities

CMS realizes each Sponsor has a unique business model and structure and some Sponsors will subcontract certain functions that other Sponsors may choose to perform themselves.

Sponsors will rely on the expertise and operations that first tier entities, downstream entities, and related entities offer.

Sponsors have the flexibility to determine how and to what extent they will delegate their program to control fraud, waste and abuse to these entities, just as Sponsors have the flexibility to determine how and to what extent they will delegate other aspects of their contractual requirements.

Overview of Requirements

40.2 – Contracts Executed Between Sponsors and First Tier Entities, Downstream Entities, and Related Entities

Data Submission by First Tier Entities, Downstream Entities, and Related Entities

Sponsors are responsible for all data submitted to CMS, including data generated and/or submitted by related entities, first tier entities, and downstream entities.

CMS requires that any related entity, contractor, or subcontractor that generates claims data on behalf of a Sponsor certify to CMS the accuracy, completeness, and truthfulness of that data.

Sponsors are responsible for exercising oversight of Part D data generated or submitted by first tier entities, downstream entities.
What to Remember – Make sure you have a Fraud, Waste and Abuse Compliance Program!

- The Affordable Care Act has key initiatives to:
  - Reduce Improper Payments: any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements
  - Fight Fraud and curbing Waste
  - Ensure Medicare and Medicaid Compliance

Have a FWA Compliance Program!
Check Exclusion Lists – A Lot!

What are plans monitoring and auditing?

- Brand vs. Generic Drugs
- Early Refills (e.g. Overrides, Excessive Use)
- Plan Limitation Guidelines and Compliance (e.g. Day Supply, Refill limitations)
- Sig Logs
- Changes to a prescription order

Monitoring and Auditing for Pharmacy

- Regulatory Requirements & FWA Compliance
- Date Written
- Billing for non-existent prescriptions
- Prescribing Patterns by Physician
- And more!
Top Audit Issues Reported

- Prescriber ID's
- Early Refills
- Undocumented actions
- Unauthorized refills
- Day Supply
- Name of the person calling in the Rx (ESI)

Tip: Be safe – Always obtain a new Rx for additional refills

PREPARING FOR AN AUDIT

When is the best time to prepare for an audit?

Who should be involved?

Actively engaged or passive?

Who best to answer auditor questions?

Provider must dispense Covered Services to Eligible Persons in a practice setting approved by Medco. Shipping Covered Services to Eligible Persons by mail or other common carrier as a routine business practice is unapproved without the express written permission of Medco.

Payments for claims involving unauthorized mail or other remote delivery carrier are subject to full recovery.
PPACA - Implementation Progress to Date to help Fight Fraud

• Requires inclusion of the National Provider Identifier NPI# on all applications and claims

• Requires physicians and eligible professionals who order or refer supplies, items, or services to be Medicare enrolled

• Requires physicians and suppliers to provide documentation of written orders for DME, home health or other items and services

NPI# Compliance Requirement Dates

• Compliance date for all covered entities was May 23, 2007

• Compliance for small health plans was May 23, 2008

• The only HIPAA Compliant Prescriber Identification Enumerator

NPI# Requirements by Plan

❖ Medco 2011 Manual
  • A valid NPI#, DEA# or State License #
  • Should be the prescribing provider’s individual NPI# 
  • May not submit pharmacy NPI# or DEA# 
  • NPI# is preferred and sometime required

❖ Express Scripts 2011 Manual
  • Network Provider must submit Part D and Medicaid claims using ONLY the Prescriber NPI beginning January 1, 2011
  • May submit other claims with NPI or DEA until further notice – NPI preferred
NPI# Requirements by Plan

- **Prime Therapeutics (Sept 1, 2011 Manual)**
  - Prime prefers NPI
  - Some plans require NPI
  - Dummy number is prohibited
  - No post audit documentation

- **Caremark (2009)**
  - NPI for all claims including controlled substances
  - Provider may use an alternative number if NPI# not available

DEA# Submission Requirements

- Always submit a valid DEA# for controlled substances
- Plans may not reject an “Incorrect” DEA#
- “Invalid” numbers = Dummy Numbers
- Examples of Invalid DEA Numbers:
  - **DO NOT USE**
  - AA5555555
  - AB1111119
  - BB0000000
  - AB1234563

DEA Prescription Requirements

- **21 CFR - Section 1306.05 Manner of issuance of prescriptions**. (Code of Federal Regulations)
  - All prescriptions for controlled substances shall be dated as of, and signed on, the day when issued and shall bear the full name and address of the patient, the drug name, strength, dosage form, quantity prescribed, directions for use, and the name, address and registration number of the practitioner.

- Can a pharmacist make changes or add information to a C-II Rx?
Changes or additions to a C-II Rx


In the preamble to that Rule, DEA stated that “the essential elements of the [schedule II] prescription written by the practitioner (such as the name of the controlled substance, strength, dosage form, and quantity prescribed) …may not be modified orally.”

(Previous DEA Web site advice) The pharmacist may add or change the patient’s address upon verification. The pharmacist may add or change the:
- dosage form, drug strength, drug quantity, directions for use, or issue date

• Pharmacists are instructed to adhere to state regulations or policy regarding those changes that a pharmacist may make to a schedule II prescription

• Only after consultation with and agreement of the prescribing practitioner.

• Such consultations and corresponding changes should be noted by the pharmacist on the prescription.

DEA Letter to NABP (August 24, 2011)

• DEA expects pharmacists (to) use their professional judgment and knowledge of state and federal laws and policies to decide whether it is appropriate to make changes to that prescription

• “Adding the practitioner’s DEA number to the prescription or correcting the patient’s name or address, varies case-by-case based upon the facts present.” — Joseph Rannazzisi, Deputy Assistant Administrator/Deputy Chief of Operations – Office of Diversion Control
Controlled Substances from LTC/ NH Facilities

- Authorized agents of the prescriber may now phone in and fax Schedule III, IV and V prescriptions.
- Remember… Faxed orders must be “practitioner signed”.
- Schedule II Rxs may not be called in by an agent of the prescriber.

\[\text{TIP} \quad \text{Review all written and faxed orders for a prescriber signature}\]

Controlled Substances from LTC/ NH Facilities

- The DEA believes it is in everyone’s best interest that such authorization be reduced to writing.
- DEA recommends that a signed “Agency Agreement” between the agent and the prescriber exist. \textit{Fed Reg. Vol. 75 No 193}

\[\text{TIP: The DEA provides a Sample Written Authorization of an Agency Agreement}\]

DEA AGENCY AGREEMENT

A signed copy should also be provided to:
1. The practitioner’s designated agent
2. The agent’s employer (if other than the practitioner) and
3. Any pharmacies that regularly receive communications from the agent pursuant to the agreement.
True or False: Agents of the prescriber at a LTC Facility may now sign and fax orders for Schedule III, IV and V substances.

Answer:
1) True
2) False (Orders must be practitioner signed)

Nurse Practitioner and PA Prescriptions

- NPs and PA-C’s should have their own unique NPI number

- Avoid confusing Rx’s that contain both the mid-level practitioner’s and a collaborating physician’s signature

Tip: Know and follow your state law for PA-C and NP Prescribing
Controlled Substances by Nurse Practitioners and PA-Cs

- PA-C’s and NP’s must have their own DEA number to prescribe controlled drugs
- Using the supervising physician’s DEA number spells audit trouble
- PA-C’s and NP’s cannot sign a physician’s name for them
  
  Use the DEA # of the actual prescriber

STATE LAWS

- Be sure you know and follow your state laws for prescription
- Hard copy requirements vary by state
- Third-party insurance companies will hold you accountable to the stricter of their own requirements or state and federal law.

Rx Blank Requirements – Audit Issues

Prescription Forms with quantity check boxes:
- 1–24
- 25–49
- 50–74
- 75–100
- 101–150
- 151 and over.
Rx Blanks with Rules – Audit Issues

- Not Valid for Controlled Substances
- No more than one prescription per Rx Blank
- DAW Implications: For example a specific line required for the prescriber’s signature
- (State Regulations)

Authorized Changes to a Rx Order

- Document all authorized changes to a prescription

Prime Therapeutics
- “Verbal changes and clarifications to the prescribing provider’s prescription order must be documented on the hard copy or electronically noted”***

*** Be cautious; Must contain a system assigned user, date and time stamp!

Prescription Changed or Altered?

RXC – Prescription changed or altered
- “Rx Clarifications” can use a clinical note or clinical message
- “Authorized Changes” are best treated as a new prescription order

Tip: Don’t forget prescriber changes to a prescription
Framework for a Clinical Note

1. What’s wrong?
2. Who did you contact?
3. What did they say?
4. Date, (Time), RPh Initials

Tip: If it wasn’t documented...

Framework for a Clinical Note

1. Subjective: CC, HPI – What’s wrong?
2. Objective – Who did you contact?
3. Assessment – What did they say?
4. Plan – What will you do?
5. Date, (Time), RPh Initials

Tip: Make a S.O.A.P. Note

Clinical Messages

Medco
- Drug Utilization Review (“DUR”) Messaging
- Clinical Management Programs
- Drug-to-Drug Interaction
- DUR Conflict, Intervention, and Outcome Codes and Descriptions

Tip: If Pharmacists hope to get paid for professional services – they need to get good at Documenting
Clinical Messages

Medco

• Maximum Daily Dosage (“MDD”)

• Refill-Too-Soon Edits

Maximum Daily Dosage

Medco - 02

1. Verify that the Day Supply and Quantity Dispensed are correct.
2. Contact the Prescriber to confirm the dosage, as needed. Document the conversation on the original prescription.
3. Document on the original prescription:
   - the reason for the override
   - the authorization code, if applicable
   - the name of the Medco representative, if applicable.

Early Refills

• What is an early refill and what can we do about it?
• Was the quantity and DS entered correctly?
• Did the dosage change?

Industry standard is to allow refills after 75% of the current supply is used up.
Example: 30 tablets X 0.75 = 22.5 (23) Days
Early Refills

• If the pt lost or spilled their Rx, do they have a provision for replacement?

• What about vacation supplies?

  **Avoid these mistakes:**
  • The biggest mistake on early refills is not documenting why on the HC.
  • Second biggest mistake is not having a valid reason.

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Medco Early Refill Edits

• 03 – Vacation Supply
• 04 – Lost or spilled medicine
• 05 – Therapy change

**Key Concerns:**
• Not all plans have provisions for overrides
• Be careful that the code is not set to “default”.
• For natural disaster – contact the help desk

**Caution:** Make sure your software doesn’t retain these codes!

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Drug-to-Drug Interactions

Medco
1. Contact the Prescriber to discuss the potential “Drug-to-Drug” interaction.
2. If the Prescriber approves the prescription to be dispensed with no change after the alert,

  **Resubmit the claim using all three of the following codes:**
  • DUR Reason for Service Code = DD (Drug-to-Drug Interaction)
  • DUR Professional Service Code = MD (Prescriber Consulted)
  • DUR Result of Service Code = 1G (Filled, with Prescriber’s Approval)
Refill-Too-Soon Edits

Medco

5.6.4 Submission Clarification Codes

- If Provider receives a "refill-too-soon" rejection message, the following responses are appropriate:
  - 03 – Vacation supply refill
  - 04 – Lost or spilled prescription
  - 05 – Change to daily dosage, therapy changed by Prescriber

- If the Eligible Person requests an "early refill" for no apparent reason, inform the Eligible Person of the plan limitations and let that Eligible Person know when the prescription can be refilled without a rejection.

Record Retention

Medco 7.1 REQUIRED RECORDS

- You must retain all records in accordance with industry standards and applicable laws, rules, and regulations (or for 6 years, whichever is greater). Records for Medicare Part D Covered Services must be maintained for 11 years (the current contract year plus 10 years).
  - HIPAA = 6 years
  - Part B = 7 years
  - State Law

Record Retention – Scanned Records

Medco 7.2 Scanned Prescriptions (Abbreviated)

- For Covered Services that are controlled substances (Schedules II, III, IV, and V) and for Covered Services dispensed to Medicare Part D eligibles, you must also retain the hard-copy paper prescriptions.
- Must scan and retain both sides of the hard-copy prescription, and include any notes or override info.
- The scanned image should be retained as a full-color document for a minimum of three (3) years after the date of service.
Fax and E-Prescriptions – Audit requirements

Medco

7.3 FAXSIMILE OR ELECTRONICALLY TRANSMITTED PRESCRIPTIONS

• You may accept prescriptions that have been faxed or electronically transmitted if they meet all applicable laws, rules, and regulations.

• At the time of dispensing, you must print the facsimile or electronic record and subsequently file it with other hard-copy or scanned prescriptions.

E-Prescription Audit Guidelines

Audited Items include:

• Date and Time Stamp
• SPI# (Doc ID)
• Unique Message ID# (e-Rx Trace, SSI#)
• Electronic Signature

TIP: Print and File E-Rxs with Original Hard Copy Rxs

Brand Vs Generic Requirements

4.4 BRAND AND GENERIC DRUG STANDARDS

4.4.1 Promote the Formulary – Medco (Abbreviated)

• For most plans, use of generics is encouraged.

• In some instances, a Plan may have a preferred brand product rather than a generic.

• If a brand drug is appropriate - Preferred co-branded drug products for non-preferred co-branded drug products
DAW Requirements - Common codes

- **DAW - 0** Generic or Single Source Brand (Most Common)

- **DAW - 1** Physician DAW

- **DAW - 2** Patient DAW (Document Pt requests brand on HC)

Common Issues with Common codes

**DAW - 0** Generic or Single Source Brand (Most Common)
1. Set as default
2. Wrong DAW transmitted

**DAW - 1** Physician DAW
1. Not documented – Computer data entry is not documentation
2. Prescriber didn’t authorize – different handwriting
3. Rx re-ordered – But No DAW indicated

**DAW - 2** Patient DAW
1. Not documented
2. Rx not "Written for Brand Name"

DAW Codes - Not typically accepted

- **DAW - 3** Pharmacist Selected Brand
- **DAW - 4** Generic not in stock in pharmacy
- **DAW - 6** (Currently not in use)
- **DAW - 9** Other, No meaningful application. Generic pricing may be applied – You may be subject to recovery by some TP’s!

New

DAW Requirements – Accepted sometimes

DAW – 5 Brand dispensed, Priced as Generic

DAW – 7 Brand mandated by Law

DAW – 8 Generic not available in Marketplace

Be Careful!

TIP: Copy and attach recent invoices to hard copy

POP-QUIZ

True or False: If a patient requests brand name,

Document DAW-2 on the hard copy and transmit DAW “2”

Answers:
1) True
2) False

Pt can’t select brand on Generic written Rx
Rx Origin Codes

New Version D.0 Effective January 1, 2012
Ø = Not Known
1 = Written
2 = Telephone
3 = Electronic
4 = Facsimile
5 = Transfer

Rx Origin Codes in Detail

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ø</td>
<td>Not Known</td>
</tr>
<tr>
<td>1</td>
<td>Written</td>
</tr>
<tr>
<td>2</td>
<td>Telephone</td>
</tr>
<tr>
<td>3</td>
<td>Electronic</td>
</tr>
<tr>
<td>4</td>
<td>Facsimile</td>
</tr>
<tr>
<td>5</td>
<td>Pharmacy</td>
</tr>
</tbody>
</table>

- Telephone Transfer
  - Prescription obtained via oral instructions or interactive voice response using a phone.
- Electronic
  - Prescription obtained via SCRIPT or HL7 Standard transactions.
- Facsimile
  - Prescription obtained via transmission using a fax machine.
- Pharmacy
  - This value is used to cover any situation where a new Rx number needs to be created from an existing valid prescription such as traditional transfers, intrachain transfers, file buys, software upgrades/migrations, and any reason necessary to "give it a new number." This value is also the appropriate value for "Pharmacy dispensing" when applicable such as BTC (behind the counter), Plan B, etc.

Source: NCPDP External Code List

Rx Origin Codes – NCPDP Guidelines

- Question: What Prescription Origin Code is used in a transfer from one pharmacy to another?

Graceland Pharmacy
Traditional Transfer
New York Pharmacy

- If clarification is required, then it is what it took to dispense the med.
  (If have to do something else to complete the script to be able to dispense, you use the last method.)
“As Directed”, “UD” or “PRN” Directions

- Specific Directions
- Directions may be obtained by direct communication with the patient or prescriber (Caremark)
- Insulin “UD” or “Sliding Scale” – Obtain dosage range

“As Directed” Exceptions by ESI – 2011 Provider Manual

- Smallest pkg size is dispensed
- Test Strips and Lancets – one box of 100 for 30 days
- Insulin Vials – up to 2 vials for a 30-day supply
- Insulin Syringes – 1 box of 100 for a 30-day supply (or 9 packages of 10)
- Insulin Cartridges/Pens - 1 box for 30 days
- Pen Needles – 1 box for 30 days

“As Directed” Exceptions by ESI – 2011 Provider Manual

- Warfarin products: If dispensed as a 1 for 1 ratio, dispense with “as directed” (e.g. 30 for 30 days, 90 for 90 days)
- Steroids: When directions are “as directed per tapering dose,”
- All oral solids dispensed in manufacturer’s original packaging must have directions for use except: Drugs on current Quality Level Limits (QLL) list (e.g. Viagra, Imitrex). If QLL is exceeded, must have directions for use.
- Manufacturers’ packaging has pre-printed patient instructions (e.g. Fosamax).
Day Supply Considerations

**Migraine Medications**
- Require mathematically useful directions to calculate day supply
- Quantities > #6 or #9 also require clarification of maximum # of tablets/30 days

Day Supply (DS) Considerations

**Inhaled Medications**
- Always calculate a correct DS
- Qty # 2 Inhalers – Directions have to justify
- Contact Help Desk for Unique situations

**Budesonide – 0.25mg, 0.50mg, 1mg**
- 62 units Max on Medicare Part B
  Warning: Do not bill ml’s to Medicare Bill “Units of Service”
  Double Warning: 1mg counts as 2 units/vial = Max 31

Day Supply (DS) Considerations

**Insulin**
- Always calculate a correct DS
- Qty # 2 Vials – Directions have to justify
- UUD not acceptable
- Obtain range or “up-to” directions
- Do not exceed plan limits (Exceptions: ESI)

**Insulin Pens**
- 5 pens/ box X 300 units = 1500 units
- Calculate a correct DS

Tip: Don’t forget Product Expiration Date Criteria
Eye Drop Considerations – Day Supply

Glaucoma Drops
- Always calculate a correct DS
- Contact Prescriber for patients with manual dexterity problems
- Stock primarily 2.5ml bottles

Antibiotic Drops
- Dispense smallest bottle
- Stock primarily 3ml bottles

Loading Dose – Quantity and Day Supply
- How many to dispense – first fill
- Second fill?
- Two prescriptions or one?

Ramp-up Dose – Quantity and Day Supply
- How many to dispense – first fill
- Second fill?
- Two prescriptions or one?
Unauthorized Refill

ESI Definition:
- Prescription was submitted for refills in excess of the number indicated on the original prescription.
- Increase in refills must be documented either on the hard copy prescription or electronically (where permitted by state law) with the date and name of the authorizing party.
- This documentation must be viewable at the time of audit.

Tip: Be safe – Always obtain a new Rx for additional refills

Issues with Date Written

- Always enter the correct date written
- Was the Rx prescribed before it was filled? UAR, FBW
- Will the Rx be filled after it expires?

Tip: Make the date written field a “forced entry”.

What is included on a “Complete” Hard Copy Rx?

- Pt F/L Name
- Date written
- Complete Drug Name & Strength/Dosage Form
- Quantity to dispense
What is included on a “Complete” Hard Copy Rx?

- Mathematically useful directions
- Refill information
- Prescriber Signature
- NPI and DEA (for CS Rxs) Number

Avoiding audit chargebacks

- Print and read Provider Manuals
- Have a valid Rx and make sure the Rx is complete - Everyone QA Rx records
- Calculate correct day supply
- Transmit correct NPI#
- Enter correct date and refills
- Keep meticulous records

Audit Prevention Strategies - Pharmacy Technician Roles

Pharmacy technicians can play an important role in audit prevention:

Daily QA Prescriptions prior to filing
  - Check Date written vs. Date entered
  - Check Patient Name and DOB
  - Verify Quantity and Day Supply
  - Verify Directions match hard copy
  - Check number of Refills authorized vs. entered
  - Verify Prescriber NPI# and DEA# if controlled
  - Are all changes or modifications documented?
What can be used as LTC Orders?

- Hard Copy Prescription
- Rx Drug Order and/or Chart Order
- Discharge orders including refill information, a clear start and stop date, or for cycle fills a “continue until told to discontinue date”
- Progress notes (must contain all req’d Rx elements)
- Fax or Phone orders

Inadequate LTC Orders

- MAR’s
- Labels lacking all required Rx info
- Progress notes lacking all requires Rx info
- Screen prints (unless E-prescription)
- Refill sticker alone

What is required for Signature Logs?

- Date of pick-up or delivery
- Rx number
- Signature of member or representative
What is required for LTC Signature Logs?

- Delivery manifest (with all req’d elements)
- MAR showing administration, name and signature of person administering, date and time
- Dated and signed statement from nurse or staff members on every page with all required information

Missing Signature Logs

No Signature Log – A patient signed affidavit is no longer accepted!

Now...
Only a notarized letter signed by the patient will be accepted for this discrepancy type. (Express Scripts)

Must include:
- Date of the prescription
- Drug name and
- A note that he or she picked up the prescription.

LTC On-Site Pharmacy Audits

- Because not all LTC Rx records are traditional 4”X6” Paper – request full Rx numbers upon notification of an audit
- Ask if MARs or delivery manifests are acceptable as signature logs
- Prepare to show any “Fill Protocols” that pharmacy has in place with the LTC Facility
- Make sure all orders are “prescriber signed”
COMPOUND RXS ON D.0

- Add each ingredient
- Set compound flag
- Enter Level of Effort for Compound if Insurance Plan accepts
- Follow Plan Policy Manual Requirements

CIGNA REQUIREMENTS JANUARY 2012

**Multi-Ingredient Compound Prescription Dispense Fee:** Unless explicitly agreed upon by both parties, effective 01/01/2012, Cigna Healthcare will reimburse Pharmacy a ten dollar ($10.00) compound dispense fee for the total amount of the compound (not per individual NDC).

CAREMARK

- Caremark provides level of effort December 30, 2011 D.0 Update

**Disclaimer – Chart is abbreviated. Refer to Caremark Provider Compliance Update December 30, 2011 or most current information from Provider Manual or Help Desk.**

<table>
<thead>
<tr>
<th>LOE</th>
<th>DUR Code</th>
<th>Professional Allowance</th>
<th>Compound Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>11</td>
<td>$15.00</td>
<td>Single Ing. Cap</td>
</tr>
<tr>
<td>2</td>
<td>12</td>
<td>$20.00</td>
<td>2-3 Ing. Cap or Transdermal Gel</td>
</tr>
<tr>
<td>3</td>
<td>13</td>
<td>$30.00</td>
<td>4+ Ing. Cap/4&lt; cream or supp/&lt;3 Suspension</td>
</tr>
<tr>
<td>4</td>
<td>14</td>
<td>$45.00</td>
<td>4+ Cap/cream/ Complex Suspensions/HRT</td>
</tr>
<tr>
<td>5</td>
<td>15</td>
<td>$60.00</td>
<td>Sterile Products</td>
</tr>
</tbody>
</table>
The details provided below should assist in clarifying compound claim submission, adjudication, and reimbursement using the new NCPDP Telecommunication Standard, version D.0. This new standard was adopted and must be implemented by the industry on or before April 1, 2012.

There also are several claim elements that are NEW and required for Multi-Ingredient Compound (MIC) logic. These include: NDC for each ingredient (Product ID), quantity for each ingredient, ingredient cost for each ingredient, final route of administration (SNOMED), final product dosage form, and Level of Effort. A list of applicable fields is provided.

Coverage Determination per Ingredient: Response messaging is sent on non-Medicare Part D business on specific ingredient(s) not covered. The pharmacy may choose to accept the claim for payment, excluding reimbursement associated with the non-covered items, by submission of a Submission Clarification Code (SCC) of 08 [NCPDP Field 420-DK].

With the exception of claims associated with government plans (the pharmacy may balance bill the Eligible Person for the cost associated with the non-covered item(s), not to exceed the submitted ingredient cost for the individual item(s)). [Note: Non-covered ingredients in a Medicare Part D compound (when combined with a covered ingredient) will not cause a claim rejection or require SCC08 submission.]

Total Allowable Ingredient Cost: Total Allowable Ingredient Cost will be determined by the following methodology:

1. Determination of the Allowable Cost of Each Ingredient, for Covered Items (coverage determination is at an ingredient level), based on the NDC and quantity of the individual ingredients submitted; this is defined as lesser of the following three values:
   a. MAC (maximum allowable cost)
   b. Network Rate (brand/generic discount rate)
   c. Ingredient Cost submitted [NCPDP Field 449-EE]

   [Note: compound powders are typically not applicable to MAC and considered single-source/brand products]
CAREMARK UPDATE - DECEMBER 30, 2011

2. The Total Allowable Ingredient Cost is then defined as the sum of the following values:
   a. Allowable Ingredient Cost (of each ingredient)
   b. Level of Effort (LOE) value based on submitted or applicable LOE Value (NCPDP Field 474-8E) and fee schedule provided; definitions of appropriate LOE designations are provided in Caremark Provider Manual

COMPOUND RXS ON D.0

• Express Scripts Effective January 1, 2012
• Must return compound network supplement to Express Scripts

**Disclaimer – Chart is abbreviated. Refer to ESI Professional Service Fee Table or most current information from Provider Manual or Help Desk.

<table>
<thead>
<tr>
<th>LOE</th>
<th>DUR Code</th>
<th>Professional Allowance</th>
<th>Compound Type</th>
<th>Time Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>11</td>
<td>$15.00</td>
<td>Non-Sterile BASIC</td>
<td>≤15 minutes</td>
</tr>
<tr>
<td>2</td>
<td>12</td>
<td>$30.00</td>
<td>Non-Sterile MEDIUM</td>
<td>&gt;15&lt;30 minutes</td>
</tr>
<tr>
<td>3</td>
<td>13</td>
<td>$60.00</td>
<td>Non-Sterile HIGH</td>
<td>&gt;30 minutes</td>
</tr>
<tr>
<td>4</td>
<td>14</td>
<td>$100.00</td>
<td>STERILE</td>
<td>No time requirements</td>
</tr>
</tbody>
</table>

EXPRESS SCRIPTS PROVIDER MAN. 1/11

• Each compound prescription must contain at least one Legend Drug ingredient covered under Member’s Prescription Drug Program.
• Compounded prescriptions using a Legend Drug when there is no approved FDA treatment are not covered by any Prescription Drug Program and may result in full recoupment of the paid amount, if any.
• In order to be reimbursed for a compounded prescription, all compound medication ingredients must be approved by the FDA for human use.
EXPRESS SCRIPTS PROVIDER MAN. 1/11

- Payment for compound claims will be based upon the Usual and Customary Retail Price submitted, or the submitted ingredient cost plus the preferred brand dispensing fee, whichever is less. Network Provider shall not be reimbursed for non-FDA approved ingredients, including bulk chemicals, used in compounding.

- Network Provider shall not be reimbursed for non-FDA approved ingredients, including bulk chemicals, used in compounding. In the event Network Provider uses only bulk chemicals in the compounding of a prescription drug, then Network Provider shall receive no reimbursement for such prescription drug. Notwithstanding the foregoing, in the event ESI determines, in its sole discretion, that reimbursement for bulk chemicals is appropriate in a situation, then Network Provider shall receive the lesser of: AWP of the FDA-approved readily available product or AWP of the compound or bulk chemical(s).

EXPRESS SCRIPTS PROVIDER MAN. 1/11

- Compound claims are highly susceptible to audit each time the claim is submitted for payment. During the audit process, ESI’s AWP will be utilized to determine the appropriate payment due.

- Claims found to be in excess of the allowable amount will be reduced accordingly by ESI and offset in the Network Provider’s next regularly scheduled remittance. Additionally and for clarification only, in the event ESI determines upon audit or otherwise that a compound is submitted in violation of any of the foregoing requirements, such claim(s) shall be subject to recoupment and offset.

2011 MEDCO PHARMACY MANUAL

Section 2.17 Compounds

A Compounded Prescription is one that meets the following criteria:

- The compound consists of two or more solid, semisolid, or liquid ingredients, one of which is a Federal Legend Drug that is weighed, measured, prepared, or mixed according to the prescription order.

2.17.5 Excluded From Reimbursement Under Version D.0

- Charges for ancillary supplies, flavoring, equipment, equipment depreciation, and/or labor are not eligible for reimbursement. In addition, ingredients without NDC numbers and obsolete drugs are not eligible for reimbursement. Investigational drugs are allowed only when covered by the Plan Sponsor.
For Plan Sponsors covering compound claims, if one ingredient submitted on a multi-ingredient compound claim is covered under the member’s plan benefit design, then all the ingredients will be paid at the contracted rate. Certain exceptions may apply according to the member’s plan benefit design.

Medco will not reject individual ingredients in a compound unless the NDC submission represents an experimental drug, a recall drug, or it contains an invalid NDC. The NCPDP Submission Clarification Code of “8” to override the rejection of an individual ingredient will not be used.

New Rejection codes associated with vD.Ø multi-ingredient compound processing:
1. Compounds Not Covered = Reject “7Y”
2. Duplicate Product ID (a duplicate product submitted) = Reject “9Z”
3. Compound Requires at Least One Covered Ingredient (not all ingredients are covered) = Reject “8A”

The following types of compound drugs are generally not covered by health plans and should not be submitted to Prime:

- Modified-release compounds.
- Any compound that contains active ingredients not approved by the FDA.
- A compound for which the stability is unknown at the time of dispensing or cannot be determined by reference of an USP-approved reference material.
- For Medicare business, compound components, methods of administration, or other criteria that do not satisfy the definition of a Medicare drug.
- Experimental/investigational items, products or services.
Prime does not consider the following a compound drug and these must not be submitted to Prime as a compound drug: (Not a complete list)

- Reconstituted non sterile products, in which only water, alcohol or sodium chloride solution are added to the active ingredient (for example, children’s antibiotic suspensions).
- Any finished product that does not include a Federal Legend Drug as an ingredient.

Actual Pharmacy Questions

1) If a doctor writes for a quantity of 30 with 5 refills and the patient can get 90 at a time. When we call the doctor to confirm that it is ok, should we generate a new RX for 90 with 1 refill OR can we just write on the RX what the doctor says?

I have always assumed for the above examples after confirmation with the prescriber, that I should generate a new prescription instead of just writing on the original RX that has been written in error. Am I correct?

Actual Pharmacy Questions

2) now with origin codes being “so important” ..... if we discuss a change such as in the examples listed above... should we now consider them a “phoned in” RX and hence put them in as an origin code “2” or would they remain an origin code “1” because they were written RX’s to begin with?

To be on the safe side I have been listing them as “2” and having my computer generate a phoned in RX card for my files.
Actual Pharmacy Questions

3) If the doctor writes an rx for say Cleocin 600mg #30 take 1 capsule qid. Cleocin only comes as 300mg caps.
   • We need to call the doctor to confirm that 300mg #60 take 2 capsules qid is ok.
   • Are we allowed to just write on the RX that we checked it with the MD or should we generate a new RX?

Rx Origin Code

Actual Pharmacy Questions

4) If the doctor writes for a size of cream or ointment that does not exist (ex. Lotrisone 60 grams) Should we just scribble out the quantity and put 45 grams after it is ok’d by the doctor or should we generate a new RX to cover ourselves.

New Rx?
Rx Origin Code?

Actual Pharmacy Questions

5) If a doctor writes for Cymbalta 50mg #30 take one capsule qd. The product comes in 20mg, 30mg and 60mg capsules forms.

After we confirm it with the doctor should we make 2 separate rx’s for the 20mg and the 30mg strengths .each one for #30 and take one capsule qd?

New Rx?
Rx Origin Code?
Audit Preparation Strategies - Pharmacy Technician Roles

Pharmacy technicians can play an important role in audit preparation as well:

**Before an Audit Notice**
1. Make sure all prescriptions are filed chronologically
2. Document all records filed and reviewed – date and initial
3. Keep sig logs complete, organized and filed in a readily retrievable manner (paper records)

**After an Audit Notice**
1. Locate records prior to an on-site audit
2. Copy and organize records for a desk audit
3. Monitor and direct auditor activity
4. Help Protect HIPAA Privacy

**On-Site Audits**
- Schedule extra help
- Print claims history
- Locate all hard copies
- Include all notes on your hard copy
- Work directly with the auditor

**Desk Audits**
- Gather all documents
- Include all notes on your hard copy
- Remember to include Rx front, back, fill sticker, and sig log
- National Audit requests 100 Prescriptions, Sig Logs, and Computerized Dispensing Records including refills
- Organize and peer review documents before sending
Educational Objectives
1. Identify four practices in your pharmacy that are most likely to trigger an audit.

• Incorrect Prescriber ID
• Day Supply vs. Quantity Dispensed
• Early Refills
• High Cost
• Compounds
• DAW

Educational Objectives
2. Describe three proactive measures pharmacies can take to lessen the likelihood of pharmacy audits.
Educational Objectives

2. Describe three proactive measures pharmacies can take to lessen the likelihood of pharmacy audits.
   - Use correct Prescriber ID's
   - Fill and bill within plan guidelines
   - Avoid early refill overrides unless warranted
   - Don’t make changes on a prescription

Educational Objectives

3. List two ways pharmacy employees can incorporate audit prevention strategies efficiently into pharmacy workflow.
   - Involve everyone in the audit prevention process
   - Tell them what to look for
   - Tell them what auditors are looking for
   - Print and read current Provider Manuals
   - Follow up on all hard copy deficiencies
Educational Objectives

4. What Act is partially responsible for the increased emphasis on controlling health care costs?

- The Patient Protection and Affordable Care Act

5. List three reasons why Exclusion List monitoring for all employees is so important and how frequently it should be performed.
Educational Objectives

5. List three reasons why Exclusion List monitoring for all employees is so important and how frequently it should be performed.

- Payment is recaptured on every Rx paid for with federal dollars
- Permissive Exclusions may result in one of your employees unsuspectingly being on a list.
- Fines often exceed $100,000!
- Civil monetary penalties may be just the start of your troubles
- Medco requires screening at least every three months

PHARMACY AUDIT BOOT CAMP

Thank you for attending!

Mark Jacobs RPh
608-873-1342