Pharmacy Audit

Industry Overview

Inaugural Pharmacy Customer Meeting
Fort Worth, TX

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Payment Integrity Services

September 14, 2012
Pharmacy Audit Industry Overview

Agenda

- Healthcare Provider Audits
- Pharmacy Audit Industry Estimates
- Defining Fraud, Waste & Abuse
- Government Audits vs. Commercial Audits
- Provider Audit Landscape
- Pharmacy Industry Regulation
- Retail Pharmacy Audit Programs
- Retail Pharmacy Audit Criteria & Top Findings
- Specialty Pharmacy—Various Care Settings
- DME Audits
- Facility Audits
- CMS RAC Audit Summary
- Re-evaluate Pharmacy Audit Industry Estimates
- Potential Audit Remediation Strategies
### Honesty and Ethical Standards by Field

"Pharmacists are among the most trusted professionals"

#### Nov. 28-Dec. 1, 2011

<table>
<thead>
<tr>
<th>Field</th>
<th>% Very high/High</th>
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<tr>
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<td>Lawyers</td>
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<td>Labor union leaders</td>
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<td>Advertising practitioners</td>
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<td>Lobbyists</td>
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<td>Car salespeople</td>
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GALLUP
Third Party Payer - Provider Audit Focus
By Provider Type & Reimbursement Methodology

Facility
(Inpatient & Outpatient)
- DRG Audit
- Hospital Charge Audit
- Medical Necessity Audit
- Per Diem & Case Rates
- Exclusions
  • Implants
  • High Cost Drugs

Professional & Ancillary
- E/M & Modifier Audits
- Correct Coding Initiatives (CCI)
- Physician Administered Injectables
- Home Infusion
- Renal Dialysis
- Durable Medical Equipment (DME)

Retail & Mail Order Pharmacy
- Retail Pharmacy Audit
- Mail Order Pharmacy Audit
- Audit of PBM’s & SPP’s

Retrospective Reviews:
- Onsite Audits
- Remote/Desk Audits
  - Electronic
  - Telephone
  - Facsimile
“Pharmacy is one of the most Regulated of all Professions”

- Financial Recovery
- Patient Safety
- Quality Assurance
- Fraud, Waste, Abuse
- Federal & State Government
- Internal Controls
- Contract Compliance

Healthcare Provider Audits
Retail Pharmacy & Audit Industry Metrics & Estimates

Retail Pharmacies

- 60,000 Pharmacies
- $277 Billion in Retail Pharmacy Prescription Revenue
- $4.6M in Prescription Revenue/Pharmacy
- 3%-10% Fraud, Waste & Abuse & (Error)
- $8 Billion to $28 Billion in Retail Pharmacy Fraud, Waste & Abuse

Audit Estimates

- $5k to $50k in Audit Recoupment's/Year/Pharmacy
- $300 Million to $3 Billion in Audit Recoupment's/Year
- 3% to 11% of the FWA Estimate is Identified and Recovered via Audits
- $14 to $140 in Audit Errors/Day
- 0.1% to 1.0% of Prescription Revenue
- 1.0% to 10% of Prescription Profits
Defining Fraud, Waste and Abuse

**Fraud:** The intentional deception or misrepresentation that an individual knows to be false or does not believe to be true and makes, knowing that deception could result in some unauthorized benefit.

**Waste:** Acting with gross negligence or reckless disregard for the truth in a manner that results in any unnecessary cost or any unnecessary consumption of a healthcare resource.

**Abuse:** Those incidents that are inconsistent with accepted medical or business practices, improper or excessive.
The False Claims Act now prohibits knowingly:

– Submitting a claim known to be false or fraudulent for payment or reimbursement.
– Making or using a false record or statement material to a false or fraudulent claim or to an obligation to pay money to the government.
– Engaging in a conspiracy to defraud by the improper submission of a false claim.
– Concealing, improperly avoiding or decreasing an ‘obligation’ to pay money to the government.

Penalties

– Civil fines range from $5,000 to $11,000 per claim, plus 3 times the amount of damages

Qui Tam or ‘Whistleblower’ Protection

– In accordance with the False Claims Act, individuals who come forward as ‘whistleblowers’ are afforded certain rights, and may not be retaliated against

• Reward up to 30% of the Recovery
Perceptions Differ From Reality

Special Investigations

Fraud, Waste & Abuse

- SIU Fraud Investigation

Provider Audit

Billing & Payment Error

Clinical Coding Errors

Unit & Calculation Errors

Contract Reimbursement Errors

$ $

Traditional Audit Programs

- DRG Audit
- Hospital Charge Audit
- Medical Necessity Audit
- High Cost Injectables
- Renal Dialysis Audit
- Home Infusion Audit
- DME Audit
- Retail Pharmacy Audit
- Mail Order Pharmacy
- PBM Audit
- Labs
- Radiology
- Ambulance
- Other
Audit Philosophy
Govt. vs. Commercial

**Government - Fraud Approach**

- Strict Regulatory, Compliance & Documentation Requirements
- Fraud, Waste, Abuse Mandates
- Aggressive Audit Methodology
- Recover Payments even on Valid Services Provided if Obviating a Policy
- Limited Appeal Flexibility for Missing Documentation
- Automatic Offset of Future Payments – Aggressive Recovery
- Sanctions, Fines & Penalties

**Commercial - Error Approach**

- Payment Integrity – Identify and Recovery Overpayment
- Financial Recovery of Overpayments Specific to Contract Rates
- Work more closely (than Govt) with Providers to Mutually Reconcile Discrepancies
- Appeal Flexibility for Missing Documentation for Valid Services
- Maintain Provider Relations and Network Integrity
- Request Refund Check 1st or Offset to Recover Overpayments Refunds Due
Multiple Audit Programs
Pharmacies are a growing target for Multiple Audits per Year

Audit Methodologies
- Comprehensive Onsite
- Remote/Desk
- Telephone Audit
- Fax Audit
- Mail Audit
- Electronic Audit

Fraud and Audit Leads can come from:
CMS, state boards of pharmacy, various local, state and federal law enforcement agencies, state Medicaid agencies, the National Health Care Anti-Fraud Association (NHCAA), the National Association of Drug Diversion Investigators (NADDI), the Association of Certified Fraud Examiners (ACFE), American Society of Pharmacy Law (ASPL), national pharmacy organizations, health plans and their members
Third Party Payer Audits
Who’s Auditing Who?

Consultants

Self Insured Employer Groups

Third Party Payer
(Plan Sponsor)

PBM

Prepay Claims Audit

Pharmacy Network Audit

External Vendor

PBM Benefit Audit

Pharmacy Provider Audit

Patient History Audit

PBM
(POS Edits)
Retail Pharmacy Audit Programs

Pre-Payment Audit or Concurrent Review
- Audits performed by some PBM’s
- Look for statistical outliers (utilization & high dollars)
- Mostly key punch errors and approximately 70% are reversed before the plan sponsor pays the claim

Post-Payment Audit – Data Driven Review
- Audits performed by PBM’s, Payer or External Vendor
- Relational Databases analysis
- Multitude of statistical analytics, outlier & error targeting
Pre-Payment Audit – PBM Electronic POS Edits

Real-time data analysis

- PBM real-time edits
  - Programmed system edits to proactively deny claim errors
    - Formularies
    - Exclusion Lists
    - Generic Substitution
    - MAC Pricing
    - Plan Benefit Criteria and Limits
    - Frequency of Billings
    - Drug Interactions
    - Prior Authorizations
    - Financial Controls & Adjustments
    - Other...
Retail & PBM Pharmacy Audit Programs
Current Payer Audit Solutions

**External Audit Vendors - Improved Outlier Analytics**
Retrospective data analysis and overpayment recovery

- Audit PBM’s & Network Pharmacies
  - Validate benefits and edits are managed accurately
    - Powerful analytical systems & sophisticated processes
    - Overpayment recovery from PBM for benefit programming errors, rebate reimbursement, etc.
    - Overpayment recovery from retail pharmacies for documentation & dispensing errors
    - Overpayment recovery from mail order pharmacies
    - Overpayment recovery from Specialty Pharmacy Providers (SPP’s)
    - Crosswalk Pharmacy and Medical data
    - Target for Onsite, Remote, Fax & Telephonic Audits
Retail Pharmacy Audit Programs
Data Analytics & Statistical Analysis

**Post-Payment Audit – Data Driven Review**

- Relational Databases “Post-Pay Analytics”
  - “Targeted” approach
    - Data Mining: data queries, data manipulation & sorting
    - Identify “Outlier” Units, Paid Amounts, Frequency
      - Analysis by Drug
      - Analysis by Provider
      - Analysis by Patient
Overpayment “Root Cause” by Transaction Type

Patient
- Forged Rx
- Altered Qty
- Altered DAW
- Early Refills
- Stock-Piling

Retail Pharmacy (Chain)
- Missing Rx
- DAW Errors
- Qty/Days Supply Errors
- Early Refill Overrides
- RTS - Missing Reversals
- Missing Signature in Log

Retail Pharmacy (Independent)
- Missing Rx
- DAW Errors
- Qty/Days Supply Errors
- Early Refill Errors
- RTS - Missing Reversals
- Missing Signature in Log

Mail Order Pharmacy
- Pt. Forged Rx
- Pt. Altered Quantity
- Pt. DAW Alterations

Diversion, Stock-Piling & Black Market

Errors & Procedural Short-Cuts

Errors, Procedural Short-Cuts & Potential Financial Incentive

Procedural Short-Cuts
# Retail Pharmacy Audit Criteria

<table>
<thead>
<tr>
<th><strong>Documentation Error</strong></th>
<th><strong>Calculation /Billing Error</strong></th>
<th><strong>Benefit Error</strong></th>
<th><strong>Statistical Outlier</strong></th>
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<tbody>
<tr>
<td>• Dispense As Written</td>
<td>• Incorrect Quantities</td>
<td>• Excluded Drugs</td>
<td>• Excessive Refill</td>
</tr>
<tr>
<td>• Missing Rx</td>
<td>• Incorrect Days Supply</td>
<td>• Refills &gt; 1 Year</td>
<td>Pattern</td>
</tr>
<tr>
<td>• Missing Signature Log</td>
<td>• Incorrect Package Size</td>
<td>• Secondary Payer</td>
<td>• Same Day Refill</td>
</tr>
<tr>
<td>• Incorrect Product (NDC)</td>
<td>• Insulin Days Supply</td>
<td>• Exceed Plan Limits</td>
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<tr>
<td>• Obsolete NDC</td>
<td>• Syringes Days Supply</td>
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<td>• Excessive Overrides</td>
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<tr>
<td>• Missing Oral Rx</td>
<td>• Test Strips Days Supply</td>
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<td>• Low Reversal Rate</td>
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<tr>
<td>&quot;As Directed&quot; / U.D.</td>
<td>• Ophthalmics Days Supply</td>
<td></td>
<td>• Low Generic Sub. Rate</td>
</tr>
<tr>
<td>• Invalid DEA#/NPI</td>
<td>• Inhaler Days Supply</td>
<td></td>
<td>• High Avg Cost/Pharmacy</td>
</tr>
<tr>
<td>• Transfer Log</td>
<td></td>
<td></td>
<td>• High Avg # Rx’s/Patient</td>
</tr>
<tr>
<td>• Brand for Generic</td>
<td></td>
<td></td>
<td>• High Compounded Rx’s</td>
</tr>
<tr>
<td>• Returned to Stock</td>
<td></td>
<td></td>
<td>• High DAW 1, 2 Usage</td>
</tr>
<tr>
<td>• Short Counts</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Forged/Altered Rx</td>
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<td></td>
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<tr>
<td>• Exceed Refills on Rx</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>• IOU’s &amp; Short Fills</td>
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<tr>
<td>• Rx Splitting</td>
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</table>
Third Party Payer Audits
Retail Pharmacy Audit

External Audit Vendors

“Never Allow 3rd Party Auditors Access to the Pharmacy Computer System”

• Third-party auditors are generally entitled to review hard-copy prescription records and usually signature logs for services the pharmacy billed to them

• Patients from other plans, prescriptions and coverage's are confidential, and the auditor should be restricted from accessing them. Third Party auditors should Never have access to a pharmacies computer system

• The Health Insurance Portability and Accountability Act (HIPAA) restrictions placed upon personally identifiable health information makes such a practice a federal offense.
Dispense As Written (DAW)
#1 Most Common & Costly Audit Finding

State Law & Pharmacy Contract Supports Recovery for Errors

**Approximately 5% DAW for Brand, costing ~ $8 Billion/Yr**

<table>
<thead>
<tr>
<th>DAW Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>DAW-0</td>
<td>No product selection indicated</td>
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<tr>
<td>DAW-1</td>
<td>Substitution not allowed by prescriber</td>
</tr>
<tr>
<td>DAW-2</td>
<td>Substitution allowed - patient requested product dispensed</td>
</tr>
<tr>
<td>DAW-3</td>
<td>Substitution allowed - pharmacist selected product dispensed</td>
</tr>
<tr>
<td>DAW-4</td>
<td>Substitution allowed - generic not in stock</td>
</tr>
<tr>
<td>DAW-5</td>
<td>Substitution allowed - brand-name drug is dispensed as generic</td>
</tr>
<tr>
<td>DAW-6</td>
<td>Override</td>
</tr>
<tr>
<td>DAW-7</td>
<td>Substitution not allowed - brand-name drug is mandated by law</td>
</tr>
<tr>
<td>DAW-8</td>
<td>Substitution allowed - generic drug not available in marketplace</td>
</tr>
<tr>
<td>DAW-9</td>
<td>Other</td>
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</table>
Missing Signature in Log – Documentation Issue

- New Rx or Refill – Patient does not sign or Pharmacy Loses Signature Log
  - Patient non-compliance
  - Procedural short-cut
  - Poor Documentation Policies & Procedures

Missing Signature in Log – Return To Stock (RTS)

- New Rx or Refill – Patient Never Picks Up Rx
  - 4-14 day policy to Return medication to inventory & Reverse Transaction
    - Extra work to reverse/credit transaction – procedural short-cut
    - Financial incentive to return to inventory without reversal credit

Missing Signature in Log – Fraudulent Billing

- New Rx or Refill – Pharmacy Never Filled
  - Fraudulent billing of new Rx – Never prescribed for valid Patient on file
  - Fraudulent refill of valid Rx - Patient never requested refill
    - Patterns of excessive volume refills on Weekends, Holidays, Nights
    - Pattern of high volume of expensive newer medications
    - Sometimes expensive, multiple drugs with contraindications
Missing Prescription Documentation

Significant Financial Impact, especially government audits

* Scan, Index & Archive all Rx’s into system
Early Refills
Pharmacy Overrides – Statistical Outliers are Targets for Audit

- Vacation Supply
  - Document Correct Override/Reason Code

- Lost or Spilled Medication
  - Document Correct Override/Reason Code

- Dosage or Therapy Change
  - Document Correct Override/Reason Code

- Maximum Daily Dosage Exceeded
  - Document Correct Override/Reason Code
Pharmacies should have clear policies and processes to “Fill & Bill” the prescription exactly as documented AND in accordance with Plan Benefit Guidelines. If the Physician writes for #100 tablets:

**Rx**
- Dosage & Frequency exactly as Documented on Rx
  - 1 tablet twice a day

**Plan Benefit Limits**
- Plan Benefit Allows a maximum 30 Day Supply
  - 2 tablets/day x 30 days = 60 tablets

**Quantity**
- Correct Quantity Billed is #60 Tablets

**Days Supply**
- Correct Days Supply is #30 Days

If a physician authorizes a change in quantity, directions or refills; always document changes on the prescription but it is always safest to obtain a new prescription rather than amending the old order.
Oral/Telephone Rx’s

**Required:**

- Patient's first and last name
- Drug name, strength, dosage unit, and quantity
- Dosing directions (avoid U.D.) and refill authorizations
- Prescriber's name and DEA number (when applicable)
- Prescriber's substitution preference (DAW or BMN mandate), if applicable

• Many pharmacies neglect to check **DAW/BMN** on verbal prescriptions that physicians specify brand product only.

• Many auditors determine these should be billed as generic vs. brand and will not accept “additional verification” to reverse original findings.
"Use As Directed" or UAD

• Ambiguous orders result in significant audit findings and refunds

• Plan benefit maximums in terms of days supply and quantity of medication dispensed cannot be validated when "As directed" prescriptions are filled

• The safest procedure is to contact the prescribing physician for clearer definition. Remember to document this information on the hard-copy prescription

• Never use "as directed" to obviate plan limitations

• Statistical analysis of quantities billed allow auditors to target and find these prescriptions
Billing for Insulin & Syringes

- Consistently Billing for 2 or more vials of insulin per month may be targets for audit. Statistical analysis will identify pharmacies that have a common practice of billing large quantities of insulin per month.

- Most Patients utilize less than 1 vial of insulin per month

- Patients may stockpile insulin & syringes and pharmacies have traditionally allowed for excessive billing of vials per month.

- Situations that do warrant more than 2 vials per month need to be documented on the prescription and additional verification and documentation is needed for “Use As Directed” prescriptions.
Ophthalmic Drops

• Auditors target ophthalmic glaucoma drops for possible days supply conflicts over-dispensing

• According to the American Journal of Ophthalmology, 15 or 20 drops per milliliter is a reference used by Auditors. The package size for a 30-day plan rarely calculates to be more than the smallest package size manufactured

• Larger size bottles or multiple bottles per 30 day supply are prime targets for audit recoupment's
Professional & Ancillary Providers
Specialty Pharmacy Audits
Professional & Ancillary Audits
Medical Benefit Claims (HCFA 1500/CMS 1500)

- E/M & Modifier Audits
- Correct Coding Initiatives (CCI)
- Physician Administered Injectables
- Home Infusion
- Renal Dialysis
- Durable Medical Equipment (DME)
E/M Upcoding Level of Care

• Physician profile reports for those outlier physician providers who have billing trends and patterns above the expected distribution of E/M coding levels specific to their NPI Specialty, (level 4 & 5 billing codes exceed expected billing)

• History-based analysis detects new patient and established patient visits and profiles physicians billing trends to their peers as an educational tool as well as a leading indicator for selecting probe audit samples for comprehensive review by a certified coding professional to validate billings for potential recovery.

• Each patient’s claim history is analyzed against expected levels of billing for office visits to determine potential upcoding trends or anomalies.
Physician E/M Upcoding Professional Visits

**PROVIDER EVALUATION MANAGEMENT**
**CUSTOMIZED TRENDS REPORT**

Provider, Smith, M.D  
Provider Street Address  
Prov City, State, Zip

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<thead>
<tr>
<th>Billing Category</th>
<th>L1 99211</th>
<th>L2 99212</th>
<th>L3 99213</th>
<th>L4 99214</th>
<th>L5 99215</th>
<th>L4 &amp; L5 99214-15</th>
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<tr>
<td>Your Billing Distribution¹</td>
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<td>-</td>
<td>-</td>
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<td>-</td>
<td>110</td>
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<td>Your Billing Distribution %</td>
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<td>0.0%</td>
<td>0.0%</td>
<td>100.0%</td>
<td>0.0%</td>
<td>100.0%</td>
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<tr>
<td>Expected Billing Distribution²</td>
<td>3.2%</td>
<td>5.9%</td>
<td>58.2%</td>
<td>30.0%</td>
<td>2.7%</td>
<td>32.7%</td>
</tr>
<tr>
<td>Your variance to expected:</td>
<td>3.2%</td>
<td>5.9%</td>
<td>58.2%</td>
<td>-70.0%</td>
<td>2.7%</td>
<td>-67.3%</td>
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</table>

![Graph showing billing distribution](image-url)
Physician & Professional Claims
Correct Coding Initiative (CCI) Audits

• Correct Coding Initiative (CCI) editing process analyze claim billing data to ensure accuracy in billing and subsequent reimbursement

• Comprehensive and accurate method to identify physician claim errors based specifically on extensive CCI criteria, policy and issues

• The rules utilized are open-sourced (e.g. CMS, AMA) and the edits and supporting information can be made transparent to providers

• CCI Auditing is performed either Pre-Payment, in the form of system edits or Post-Payment recovery audits
Professional & Ancillary
Specialty Injectable Audits

- Physician Administered Injectables
- Oncologists
- Home Infusion Providers
- Renal Dialysis Providers

**HCPCS Drug Codes (J,Q,C,P)**

- Over 600 HCPCS Drug Codes (J,Q,C,P) representing Injectable Products for Billing

- Over 250 HCPCS Drug Codes identified with history of significant over-billing of units resulting in millions of dollars in overpayments annually

- Most of these HCPCS Drug Codes involve multiple manufacturers (e.g., Doxorubicin = 5)

- Each product may have multiple formulations and package sizes available (e.g., Doxorubicin = 22)
High Cost Specialty Injectable Reimbursement Across Multiple Care Settings

**PROBLEM:**
Billing & Reimbursement for Specialty Pharmaceuticals and all Injectable products are based on a variety of complexities

- Inadequately trained billing and reimbursement personnel
- Inadequate coding system – not representative of normal dosage or package size
- Complex coverage and medical necessity rules – driven by diagnosis
- Individualized dosing specific to patients varying clinical needs or size
- Multiple equivalent products, packages and dosage forms available
- EDI claim submission relies on integrity of codes and units billed
- No reasonable process to manually validate actual treatment plans
Unit Errors – Root Cause Issues
Billing Code vs. Package Size vs. Drug Dosage

**HCPCS Codes** do not represent normal dosing of drugs

J1745 = Remicade = **10mg/unit**

**NDC Codes** do not represent normal dosing of drugs

57894-0030-01 = Remicade = **100mg Vial**

**Treatment Plan** or Order is the only document to validate correct dosing of units

Remicade **500mg dosage Schedule** (0,2,6 & maintenance every 8 weeks)

**High potential for unit errors upon billing by Provider and reimbursement by Payer**
Case Study #1 – Duplicate Billing & Unit Discrepancy

**Remicade (Infliximab) Rheumatoid Arthritis, Crohn’s**

- SPP billed J-Code on behalf of Outpatient Facility - EDI
- Physician billed for administration & the drug using J-Code on HCFA-1500
- Duplicate Billing as 2 systems do not cross-walk each other
- J-Code vs. NDC unit discrepancies also noted

**Hospital Outpatient Facility – Utilizes SPP to provide drug and bill Payer**

- Billed Remicade J-Code (10mg/1 unit) for a 500mg Dose as 50 vials for total billed charge of $34,580 (AWP). Units are correct to J-Code description but not in vials. The cost of vial billed instead of cost of 1 unit per the J-Code description
- Remicade comes in 100mg. Vial = $691.60, should be 5 vials = $3,458, resulting in **$31,122** over-billing at AWP

**Physician also billed for same drug billed by SPP**

- Billed Remicade using J-Code (10mg/1 unit) for 500mg. Dose as 5 vials – correct number of vials and cost per vial billed, but incorrect units per the J-Code description. Payer reimbursed twice for same drug, once at exponential increased cost. Additional savings of **$3,458**

**Total Audit Savings: $ 34,580**
Herceptin (Trastuzumab) Metastatic Breast Cancer

- Usual Dose: 4mg/kg over 90 min. for initial dose then 2mg/kg once per week (cardio toxic drug)
- 150lb. Woman = approx. 68 kg patient
- 272mg first dose and each dose is approx. 136mg per week
- Specialty Rx Vendor is shipping and billing:
  - 440mg multi-dose vial per week (stable for 28 days)
  - Avg. patient could be treated for up to 3 week period or
  - 1 vial treats 3 avg. patients for 1 week
  - 1 vial $2,805.45 AWP
  - Payer could be reimbursing up to $8,416.35 for 3 vials vs. 1 vial or overpaying $5,610.90 per 3 week period
  - Patients can be on regimen for up to 48 weeks

Total Audit Savings: $ 90,672
Specialty Pharmacy Audits
Large Commercial Plan – Actual Overpayments 2.94% of Claims

<table>
<thead>
<tr>
<th>Claims w/Error</th>
<th>Total Billed</th>
<th>Total Paid</th>
<th>Total Overpaid</th>
<th>Avg Overpaid</th>
<th>Overpayment %</th>
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</thead>
<tbody>
<tr>
<td>5,067</td>
<td>$23,093,436</td>
<td>$18,054,267</td>
<td>$8,000,249</td>
<td>$1,579</td>
<td>44%</td>
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Top 20 JCodes with Overpayment Errors

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>HCPCS Description</th>
<th>CLAIMS</th>
<th>BILLED</th>
<th>PAID</th>
<th>SAVINGS</th>
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</thead>
<tbody>
<tr>
<td>J1569</td>
<td>INJ IG GAMMAGARD LIQ IV NONLYOPHILIZED 500 MG</td>
<td>492</td>
<td>$2,900,070.71</td>
<td>$2,809,325.39</td>
<td>$884,243.65</td>
</tr>
<tr>
<td>J9355</td>
<td>INJECTION TRASTUZUMAB 10 MG</td>
<td>177</td>
<td>$2,860,823.43</td>
<td>$1,687,488.73</td>
<td>$835,176.44</td>
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<tr>
<td>J9171</td>
<td>INJECTION DOCETAXEL 1 MG</td>
<td>27</td>
<td>$1,012,476.53</td>
<td>$715,449.05</td>
<td>$644,626.88</td>
</tr>
<tr>
<td>J9999</td>
<td>NOT OTHERWISE CLASSIFIED ANTINEOPLASTIC DRUG</td>
<td>69</td>
<td>$2,129,221.80</td>
<td>$1,468,040.36</td>
<td>$608,951.00</td>
</tr>
<tr>
<td>J1745</td>
<td>INJECTION INFlixIMAB 10 MG</td>
<td>174</td>
<td>$2,019,551.88</td>
<td>$1,200,512.08</td>
<td>$503,089.32</td>
</tr>
<tr>
<td>J1561</td>
<td>INJ IG GAMUNEX IV NONLYOPHILIZED 500 MG</td>
<td>160</td>
<td>$850,602.51</td>
<td>$797,184.56</td>
<td>$147,328.05</td>
</tr>
<tr>
<td>J2505</td>
<td>INJECTION PEGFILGRASTIM 6 MG</td>
<td>95</td>
<td>$945,942.84</td>
<td>$707,899.09</td>
<td>$237,653.86</td>
</tr>
<tr>
<td>J3490</td>
<td>UNCLASSIFIED DRUGS</td>
<td>261</td>
<td>$694,397.08</td>
<td>$1,097,230.99</td>
<td>$315,675.80</td>
</tr>
<tr>
<td>J2323</td>
<td>INJECTION NATALIZUMAB 1 MG</td>
<td>27</td>
<td>$374,763.81</td>
<td>$334,857.37</td>
<td>$282,981.14</td>
</tr>
<tr>
<td>J3590</td>
<td>UNCLASSIFIED BIOLOGICS</td>
<td>75</td>
<td>$376,442.00</td>
<td>$362,696.07</td>
<td>$18,045.93</td>
</tr>
<tr>
<td>J3385</td>
<td>INJECTION VELAGLUCERASE ALFA 100 UNITS</td>
<td>15</td>
<td>$279,359.03</td>
<td>$279,314.03</td>
<td>$255.00</td>
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<tr>
<td>J9310</td>
<td>INJECTION RITUXIMAB 100 MG</td>
<td>58</td>
<td>$969,878.92</td>
<td>$519,170.89</td>
<td>$450,908.03</td>
</tr>
<tr>
<td>J7192</td>
<td>FACTOR VIII PER IU NOT OTHERWISE SPECIFIED</td>
<td>53</td>
<td>$58,525.11</td>
<td>$944,640.02</td>
<td>$131,923.72</td>
</tr>
<tr>
<td>J9041</td>
<td>INJECTION BORTEZOMIB 0.1 MG</td>
<td>14</td>
<td>$259,405.42</td>
<td>$150,191.48</td>
<td>$109,213.94</td>
</tr>
<tr>
<td>J0207</td>
<td>INJECTION AMIFOSTINE 500 MG</td>
<td>2</td>
<td>$192,807.00</td>
<td>$115,684.20</td>
<td>$77,122.80</td>
</tr>
<tr>
<td>J9035</td>
<td>INJECTION BEVACIZUMAB 10 MG</td>
<td>47</td>
<td>$482,991.84</td>
<td>$361,633.53</td>
<td>$121,358.31</td>
</tr>
<tr>
<td>J0129</td>
<td>INJECTION ABATACEPT 10 MG</td>
<td>9</td>
<td>$196,044.00</td>
<td>$113,164.80</td>
<td>$82,879.20</td>
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<tr>
<td>J9390</td>
<td>INJECTION VINORELBINE TARTRATE 10 MG</td>
<td>31</td>
<td>$156,315.92</td>
<td>$94,799.38</td>
<td>$61,516.54</td>
</tr>
<tr>
<td>J1170</td>
<td>INJECTION HYDROMORPHONE UP TO 4 MG</td>
<td>28</td>
<td>$96,741.50</td>
<td>$95,445.80</td>
<td>$1,295.70</td>
</tr>
<tr>
<td>J2912</td>
<td>INJECTION, SODIUM CHLORIDE, 0.9%, PER 2 ML</td>
<td>1,146</td>
<td>$166,598.88</td>
<td>$70,412.07</td>
<td>$96,186.81</td>
</tr>
</tbody>
</table>

**Total Claims with Error:** 5,067
**Total Billed:** $23,093,436
**Total Paid:** $18,054,267
**Total Overpaid:** $8,000,249
**Average Overpaid:** $1,579
**Total Overpayment %:** 44%
DME Audits

• DME Audit is a specialized review of the high volume of low dollar claims for durable medical equipment submitted to payers for reimbursement.

• Often, these claims represent lower cost products and services, not traditionally reviewed by clinical experts, where complex policies and contract terms are difficult to adjudicate. For example, monthly rental charges for DME can often exceed purchase price maximum allowable reimbursement.

• Additionally, these services, generally billed on an ongoing monthly basis are often unbundled from global rates or there can be upcoding of the product to a high level reimbursement, where only validation of actual services provided is necessary to verify accurate payment.
DME Audit Results
Top 4 Audit Errors for Large Commercial Payer

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>HCPCS Description</th>
<th>CLAIMS</th>
<th>BILLED</th>
<th>PAID</th>
<th>REFUND</th>
<th>AVG REFUND/CLAIM</th>
</tr>
</thead>
<tbody>
<tr>
<td>E0601</td>
<td>CONTINUOUS AIRWAY PRESSURE DEVICE</td>
<td>232,262</td>
<td>$78,042,023</td>
<td>$27,375,354</td>
<td>$4,091,551</td>
<td>$17.62</td>
</tr>
<tr>
<td>E0470</td>
<td>RESP ASST DEVC BI-LEVL PRSS CAP. W/O BACKU</td>
<td>27,934</td>
<td>$16,786,634</td>
<td>$6,512,740</td>
<td>$1,219,909</td>
<td>$43.67</td>
</tr>
<tr>
<td>E0471</td>
<td>RESP ASST DEVC BI-LEVL PRSS CAP. W/BACK-UP</td>
<td>5,526</td>
<td>$6,606,999</td>
<td>$2,611,851</td>
<td>$437,697</td>
<td>$79.21</td>
</tr>
<tr>
<td>E0260</td>
<td>HOS BED SEMI-ELEC W/SIDE RAIL W/MAATTRESS</td>
<td>11,023</td>
<td>$2,714,029</td>
<td>$1,112,556</td>
<td>$154,212</td>
<td>$13.99</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>276,745</td>
<td>$104,149,686</td>
<td>$37,612,500</td>
<td>$5,903,369</td>
<td>$21.33</td>
</tr>
</tbody>
</table>

- High Volume of Small Dollar Claims
- Automated Audit Identification
- Rental To Purchase Price Maximums
- Unbundled Services
Facility Bill Audit Services
Medical Necessity Audit (MNA)

• Hospitals often admit patients on an inpatient basis as opposed to providing an alternative and more appropriate level of care in observation or the outpatient department, costing Medicare and commercial payers hundreds of millions of dollars.

• Medical Necessity audits identify specific claims that have a high potential for overpayment based on the level of care, severity of illness and intensity of service provided.

• MNA cases undergo a unique data mining routine that looks for potential inappropriate admissions, as well as potentially non-covered services that may be medically unnecessary.

• RN Auditors must be proficient in the use of either InterQual or Milliman clinical criteria. RN auditors are generally Certified Case Managers and Utilization Review professionals who review medical record documentation on select claims and document unsupported admissions.
DRG Audits

• DRG Audit is a comprehensive review and validation audit, applicable wherever hospital inpatient reimbursement is based on any form of a Diagnosis Related Group (DRG) payment methodology.

• Service ensures that the diagnosis and procedure codes that generate the diagnosis related groups are accurate, valid and sequenced in accordance with AHIMA and national coding standards.

• The audit process utilizes a multi-tiered electronic and manual approach to identifying problematic DRGs, focused on ICD 9 clinical coding errors causing incorrect payments.

• DRG Analyst auditing teams are comprised of AHIMA accredited DRG Analysts with extensive experience in the coding industry.

• DRG reimbursement for commercial Payers often include additional payment in the form of “carve-outs” for high cost drugs.

• **High Cost Drug Carve-outs account for significant high cost drug billing errors.**
Hospital Contract Compliance Audit

• Hospital Contract Compliance Reviews is a focused niche review and analysis of a payer’s unique hospital reimbursement contracts and policies specific to the billing of Per Diem’s, Case Rates, high cost implants, **high cost drugs** and other exclusions to standard contract reimbursement.

• Often, reimbursement is complex and difficult for traditional claims adjudication systems to accurately reimburse under these complex terms and guidelines. Typically, reimbursement made based on invoice or cost plus agreements have a high incidence of overbilling and overpayment.

• Registered nurse auditors and pharmacists with clinical expertise specific to these high cost products and services reconcile and validate reimbursement to these unique and often complex contract terms.
The HCA audit process includes clinical review of the medical record, physician orders, nursing notes and reconciling that to the itemized bill.

Applies to inpatient and outpatient claims reimbursed at a percent of billed charges.

Medical Record reviews are performed onsite at the hospital or remotely.

HCA audit professionals work with the facility to gain mutual agreement on services provided and revised charges are confirmed with a signed agreement.

Hospital claims are screened and claims with a high potential for overpayment are targeted for review. Claims with overpayment are identified on over 80% of the cases selected for comprehensive review.

Hospital Pharmacy billings on Inpatient & Outpatient claims account for the majority of all errors found in the hospital audit process.
CMS RAC Audit Activity – Exponential Growth

$2.1 Billion in Payment Errors

• 36% of audit denials were appealed
• 75% of the appeals were overturned
## Retail Pharmacies

- 60,000 Pharmacies
- $277 Billion in Prescription Revenue
- $4.6M in Prescription Revenue/Pharmacy
- 3%-10% Fraud, Waste & Abuse & (Error)
- $8 Billion to $28 Billion in Retail Pharmacy Fraud, Waste & Abuse

### Audit Estimates

- $5k to $50k in Audit Recoupment's/Year/Pharmacy
- $300 Million to $3 Billion in Audit Recoupment's/Year
- 3% to 11% of the FWA Estimate is Identified and Recovered via Audits
- $14 to $140 in Audit Errors/Day
- 0.1% to 1.0% of Prescription Revenue
- 1.0% to 10% of Prescription Profits
## Audit Error Remediation Plan

<table>
<thead>
<tr>
<th>Description</th>
<th>Low End Estimate</th>
<th>High End Estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audit Refunds Due Back Plan Sponsor</td>
<td>$ 5,000</td>
<td>$ 50,000</td>
</tr>
<tr>
<td>Dispensing Fee</td>
<td>$ 4.00</td>
<td>$ 4.00</td>
</tr>
<tr>
<td>Dispensing Fee's at Stake by # of Rx's</td>
<td>1,250</td>
<td>12,500</td>
</tr>
<tr>
<td>Rx's Per Day</td>
<td>250</td>
<td>250</td>
</tr>
<tr>
<td>Days of Dispensing Fee's to Cover Audit Recoveries</td>
<td>5</td>
<td>50</td>
</tr>
</tbody>
</table>

### Cost of Remediation - Year 1

<table>
<thead>
<tr>
<th>Description</th>
<th>Low End Estimate</th>
<th>High End Estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacist Online Training - focus on audit errors</td>
<td>$ 150</td>
<td>$ 750</td>
</tr>
<tr>
<td>Pharmacy Onsite Internal Audit/Training</td>
<td>$ 1,000</td>
<td>$ 2,000</td>
</tr>
<tr>
<td>Incentive/Reward for Mitigation</td>
<td>$ 500</td>
<td>$ 2,500</td>
</tr>
<tr>
<td><strong>Year 1 Total</strong></td>
<td><strong>$ 1,650</strong></td>
<td><strong>$ 5,250</strong></td>
</tr>
</tbody>
</table>

### Cost of Remediation - Year 2

<table>
<thead>
<tr>
<th>Description</th>
<th>Low End Estimate</th>
<th>High End Estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacist Online Training - focus on audit errors</td>
<td>$ 150</td>
<td>$ 750</td>
</tr>
<tr>
<td>Pharmacy Onsite Internal Audit/Training</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Incentive/Reward for Mitigation</td>
<td>$ 500</td>
<td>$ 2,500</td>
</tr>
<tr>
<td><strong>Year 2 Total</strong></td>
<td><strong>650</strong></td>
<td><strong>3,250</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Description</th>
<th>Low End Estimate</th>
<th>High End Estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 Year Mitigation Plan Cost</td>
<td>$ 2,300</td>
<td>$ 8,500</td>
</tr>
<tr>
<td>2 Year Pre-Mitigation Plan Audit Refund Amount</td>
<td>$ 10,000</td>
<td>$ 100,000</td>
</tr>
<tr>
<td>2 Year Mitigation Plan Savings (80% of Errors)</td>
<td>$ 8,000</td>
<td>$ 80,000</td>
</tr>
<tr>
<td><strong>2 Year Net Value to the Pharmacy</strong></td>
<td><strong>$ 5,700</strong></td>
<td><strong>$ 71,500</strong></td>
</tr>
</tbody>
</table>

| Dispensing Fee's (Rx's) to generate Net Value                               | 1,425            | 17,875            |
| Dispensing Fee's (Rx's/Day) to generate Net Value                          | 4                | 49                |

### Potential ROI

- MITIGATION PLAN: $ 5,700 / $ 71,500
- NET VALUE TO THE PHARMACY: $ 5,700 / $ 71,500

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Potential Technology Solutions

Investment in technology to develop more advanced edits at the time of filling/billing to remediate common “Auditable” errors

Real-time analysis specific to Statistical Outliers on claims based on pharmacy dispensing history – “Audit Warning” to Pharmacist

- DAW Statistical Outlier Usage
- Early Refill Override Code Usage
- Quantity/Days Supply
- DEA#/NPI# usage
- “Use as Directed” Rx’s
- Insulin, Syringes, Test Strips, Ophthalmic, Inhalers
Thank You!