Pharmacy Self-Auditing

Control Practices to Improve Medicaid Program Integrity and Quality Patient Care—Booklet 4: Billing Practices

Content Summary

This booklet is the fourth in a four-booklet series that discusses areas of pharmacy practice prone to triggering audits that pharmacy health care professionals should examine. This booklet focuses on billing practices. The other booklets examine provider prescribing practices, controlled substance management, and invoices and claims management. The four booklets may be used together or independently as a self-audit to identify areas of risk as well as opportunity for improvement.

The Affordable Care Act of 2010 expanded Medicaid eligibility in States that have adopted Medicaid expansion. In such States, Americans who earn less than 138 percent of the Federal poverty level, $33,465 for a family of four in 2015, are eligible to enroll in Medicaid.[1] The National Health Expenditure Projections Forecast for 2014–2024 estimates Medicaid spending will grow by 5.9 percent on average annually from 2015 through 2024.[2]

The Medicaid expansion will impact Medicaid prescription drug utilization and expenditures. Private insurers lose about 1 to 1.5 percent of expenditures to fraud, while Medicaid may be closer to 10 to 15 percent.[3] Experts estimate another 20 to 30 percent of Medicaid dollars are lost to abuse or unnecessary services.[4]

According to the Kaiser Family Foundation, the Medicaid program paid 520 million prescription claims and spent $20.6 billion in total utilization expenditures in 2012, after recouping rebates.[5] The sheer volume of claims and expenditures requires Medicaid to protect itself from fraud, waste, and abuse.

Pharmacists' unique role in the health care system often allows for intervention before fraud, waste, or abuse occurs. Due to the high risk for improper payments, the Centers for Medicare & Medicaid Services (CMS) developed this toolkit to educate pharmacy providers on self-audit precautions related to invoice management, controlled substances management, proper billing practices, and proper prescribing practices. In addition, this toolkit addresses potential fraud, waste, and abuse related to pharmacy services and how to report them.

Pharmacy providers can identify areas of practice that require further scrutiny and can use these tools to educate staff about potential fraud, waste, and abuse.

Title 18 of the United States Code defines health care fraud as knowingly and willfully executing, or attempting to execute, a scheme to defraud a health care program or obtain money or property from a health care program under false pretenses.[6] Medicaid fraud artists intentionally submit false claims or misrepresent facts to obtain funds to which they are not entitled.[7]

Federal Medicaid regulations do not define waste. Waste is similar to fraud, but it is not usually associated with criminal actions.[8] Think of waste as overutilization or misuse of services. Abuse may encompass waste and includes any action that may cost the Medicaid system unnecessary dollars. Abuse may include improper payment for services, payment for services that fail to meet professionally recognized standards of care, or payment for services that are medically unnecessary.[9] Abuse includes reimbursement for claims to which the provider is not entitled, but health care professionals guilty of abuse do not intentionally misrepresent facts to obtain payment. Like waste, abuse is not usually associated with criminal actions.

The Federal False Claims Act (FCA) is an important tool for combating fraud. In general, the FCA imposes civil liability on people who knowingly submit a false or fraudulent claim or engage in various types of misconduct involving Federal government money or property. From January 2009 through the end of the 2013 fiscal year, the Justice Department used the FCA to recover more than $12.1 billion in health care fraud.[10]

A 2012 Office of Inspector General (OIG) report identified 2,637 retail pharmacies with questionable billing practices. The investigation found suspect pharmacies billed high dollar amounts per beneficiary, billed a high number of prescriptions per beneficiary, or billed for a high number of prescriptions per physician prescriber.[11] As a result, the OIG recommends CMS strengthen oversight of pharmacies and pharmacy audits.[12] Pharmacists can take the initiative to self-monitor practices within the pharmacy to prevent, identify, and correct potential fraud, waste, or abuse.

The audit process is a means of reviewing pharmacy practices to ensure staff members uphold operational procedures. State and Federal programs, such as Medicaid and Medicare Part D, State licensing boards, the

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United States (U.S.) Drug Enforcement Administration (DEA), the U.S. Internal Revenue Service (IRS), and other third-party payers, conduct pharmacy audits. Through the pharmacy self-audit tool, pharmacy staff members can evaluate daily practices, pinpoint potential audit triggers, and proactively address vulnerabilities. Like any developing habit, a self-audit can become a part of daily, weekly, or monthly tasks.[13] Pharmacy managers can customize the pharmacy self-audit to ensure it addresses all pharmacy-specific compliance and operational procedures. When developing the blueprint for a customized pharmacy self-audit, consider the different forms of prescription drug fraud, waste, or abuse that may occur in the particular pharmacy setting, and focus on these vulnerabilities.

Fraud, waste, or abuse may occur as a result of billing miscalculations—quantity miscalculations or days' supply miscalculations. Fraud, waste, or abuse may also occur in the pharmacy as a result of inappropriate practices, including refill practices, overrides, partial fills, delivery documentation, or package size selection.

Pharmacists can help protect State Medicaid patients from harm and State Medicaid dollars from waste by educating staff members, providing billing job aids, and making sure all pharmacy staff members know what to do in the event a Medicaid billing error is discovered.

Billing Practices Self-Audit

This booklet (Booklet 4—Billing Practices) contains 15 of the 50 steps to conduct a pharmacy self-audit and examines common quantity and days' supply billing errors. In addition, inappropriate refill practices, overrides, partial fill procedures, and package size selection are discussed. A thorough review of these steps as they pertain to pharmacy practice will help pharmacies preserve State Medicaid program integrity and improve the quality of patient care for State Medicaid beneficiaries. Consider each step, answer the questions listed, and examine existing policies and procedures to identify any audit triggers related to billing practices.

The three additional booklets in the "Pharmacy Self-Auditing: Control Practices to Improve Medicaid Program Integrity and Quality" Toolkit (Booklet 1—Prescribing Practices, Booklet 2—Controlled Substances Management, and Booklet 3—Invoice Management) contain the remaining steps, with audit questions and detailed information regarding each step. The steps in the four booklets correspond to the steps in the document titled "Pharmacy Auditing and Dispensing: The Self-Audit Control Practices to Improve Medicaid Program Integrity and Quality Patient Care Checklist."

Pharmacists represent a unique line of defense against fraud, waste, and abuse. Pharmacists may help uncover unnecessary costs to the Medicaid system by taking a close look at billing practices that include billing units, refill practices, overrides, partial fill procedures, package size selection, and proof of delivery documentation. If the following self-audit steps reveal potential overpayments, the self-audit toolkit explains what to do next.

36. Discuss billing procedures with staff to determine whether staff members correctly submit claims for drugs commonly submitted with improper billing units. Provide staff members with job aids associated with common types of quantity and/or days' supply miscalculations. The examples below are not comprehensive but suggest potential targets for job aids.

- Oral products;
  - Anti-migraine agents;
  - Bowel preparations;
  - Multi-drug/multi-month packs; and
  - Osteoporosis agents.

- Other dosage forms;
  - Inhalers;
  - Ophthalmic products;
  - Topical products; and
  - Vaginal products.
- Injections; and
- Kits.

Reimbursements and rebates are two components of Medicaid prescription drug programs. When a pharmacy dispenses a prescription for a Medicaid beneficiary, the State Medicaid agency (SMA) reimburses the pharmacy, and then pharmaceutical manufacturers provide statutorily-defined rebates to the SMA for each unit of drug that was dispensed. SMAs reimburse pharmacies using the National Council for Prescription Drug Program's Billing Unit Standard (BUS), while pharmaceutical manufacturers submit rebates to SMAs using CMS unit of measure standards. Because SMAs must convert BUS units to CMS units, a pharmacy BUS claim submission error may also result in inaccurate pharmaceutical manufacturer rebates to the SMA.[14] If a pharmacy submits a claim for a drug with a National Drug Code (NDC) other than the NDC for the drug the pharmacy actually dispensed, the SMA may receive a rebate to which the State was not entitled or may not receive a rebate to which the State was entitled.

37. Review prescription requirements for non-controlled and controlled substances.[15, 16, 17]
    - ☐ Date of issuance;
    - ☐ Prescriber's signature;
    - ☐ Prescriber's authority to prescribe (For example: mid-level prescribers versus physicians; State regulations versus Federal days' supply regulations; and authorization to prescribe specific controlled drug schedules);
    - ☐ Drug name;
    - ☐ Drug strength;
    - ☐ Drug dosage form;
    - ☐ Quantity of drug prescribed;
    - ☐ Directions for use;
    - ☐ Number of refills authorized by the prescriber (if any);
    - ☐ "Brand name medically necessary" if no generic substitution is allowed;
    - ☐ If handwritten, controlled substance prescriptions must be written in ink or pencil that cannot be erased; and
    - ☐ Prescribers must manually sign controlled substance prescriptions on the date issued.

38. Ensure staff members are able to correctly calculate a day's supply for prescriptions.
    - ☐ Multiply the number of doses per day by the number of days of therapy to determine the correct quantity to dispense; and
    - ☐ Reverse-verify by dividing the quantity dispensed by the number of doses per day to determine the number of days' supply.

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39. Talk to pharmacy staff members about prescriptions written for odd quantities.

☐ Reduce the quantity dispensed to correspond to a number of days equal to or less than the plan-imposed maximum if the days' supply calculated by dividing the quantity dispensed by the number of doses per day exceeds the plan-imposed maximum allowable days' supply.

Upon review of the prescription, pharmacists may see quantities and days' supplies that do not align. Inaccurate claim submission of these types of discrepancies may lead to negative audit findings. For example, if the prescription presented is written for 100 tablets for a 30 days' supply, but the sig code states the drug should be taken three times daily, the pharmacist must either adjust the dispensed quantity to 90 tablets for 30 days or adjust the days' supply to 33.

40. Talk to pharmacy staff members about prescriptions written for doses that exceed Food and Drug Administration (FDA) labeling.

☐ Examine high doses with scrutiny;

☐ Consult the FDA label;

☐ Contact the prescriber to verify the dose if it exceeds FDA recommendations; and

☐ Document all communication on the hard copy.

Pharmacists should consult a drug reference if a prescribed dose appears in excess to determine if the dose prescribed is within FDA-labeled guidelines. The National Library of Medicine provides a free drug reference, DailyMed, accessible at https://dailymed.nlm.nih.gov/dailymed/index.cfm on the National Institutes of Health website. In addition, the FDA maintains a database of approved prescription labeling, Drugs@FDA, accessible at https://www.accessdata.fda.gov/scripts/cder/drugsatfda/ on the FDA website. Simply enter the name of the drug, navigate to the drug in question, and consider the dosage and administration guidelines listed in the product label. If the dose prescribed exceeds FDA-labeled recommendations, contact the prescriber to verify the dose. Document the verification on the hard copy. Include the diagnosis and the reason for override on the hard copy, if available.

41. Talk to pharmacy staff members about prescriptions that include the use-as-directed sig code for dispensed quantities more than one billing unit per month.

☐ Shampoos—Document frequency of use and size of area to be treated;

☐ Creams and ointments—Document frequency of use and size of area to be treated;

☐ Migraine medications—Document number of headaches treated per month;

☐ Insulin—Document exact regular dosage and maximum daily dosage for any sliding scale directions; and

☐ Diabetic syringes, test strips, or lancets—Document maximum use per day.

Prescriptions that require more than one billing unit per month require more concise directions to accurately represent the days' supply. Contact the prescriber to determine the maximum daily dose and gather detailed information for each of these types of medications.

42. Talk to pharmacy staff members about refill practices.

☐ Do not push-bill or auto-refill without patient consent or request or when prohibited by State law;

☐ Do not refill and mail to patients without request or patient consent, and only perform patient outreach to initiate refills in attempts to improve medication adherence and clinical outcomes; and

☐ Do not use financial incentives to influence beneficiary decisions about when or where to fill prescriptions paid by a federally funded program.

Consider the risk for fraud, waste, or abuse if pharmacy staff members use inappropriate refill practices (for example: push-billing and auto-refills, refilling and mailing to patients without request or consent, or financial incentives). Push-billing occurs when pharmacy providers auto-refill prescriptions without beneficiary consent or request. The U.S. Department of Justice's Civil Fraud Division investigated auto-refill practices at a major retail chain and alleged the chain auto-refilled and billed prescriptions without patient consent while pressuring pharmacists to meet 40 percent auto-refill enrollment goals.[18]

A suspect refill tactic targeted at Medicaid beneficiaries includes refilling prescriptions without a patient request and mailing the completed prescriptions to the beneficiary. Pharmacy providers should not auto-refill without a request from the beneficiary. Providers should only contact a beneficiary to solicit requests for medication refills if the pharmacy provider has assessed the beneficiary's prescription history and the patient outreach is an attempt to improve the patient's medication adherence and clinical outcome.[19]

Financial incentives influence a patient's choice of pharmacy services for prescription refills and are prohibited. "Pharmacies are not allowed to improperly influence the decision-making of Medicare and Medicaid patients about where to fill prescriptions," said Special Agent in Charge Glenn R. Ferry for the U.S. Department of Health and Human Services, Office of Inspector General (HHS-OIG). "Pharmacy chains that manipulate patient choices in this way will be held accountable."[20] Financial incentives may include shopper loyalty programs that provide cents off gallons of gas or store credit, gift cards, or merchandise. Pharmacies should not waive copayments (if applicable) as an incentive for the patient to refill unneeded prescriptions. However, most States require a pharmacy to fill and dispense a Medicaid prescription, even if the beneficiary cannot pay the copayment or refuses to pay the copayment.

43. Consider possible patient-driven inappropriate refill practices.

☐ Counsel patients if stockpiling is suspected;

☐ Be aware of red flags that may indicate diversion and require further scrutiny; and

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☐ If diversion is suspected, report concerns to the proper authorities.

Patients may stockpile—accumulate excessive and inappropriate amounts of prescription and over-the-counter drugs—for future use. Patient motives for stockpiling vary from fear of drug shortages or unexpected changes in prescription drug benefits to accumulation of drugs for the purpose of diversion or abuse.[21] Patients who stockpile may seek prescriptions from multiple prescribers, and unnecessarily accumulating drugs contributes to waste and abuse in the health care system.[22]

Drug diversion occurs when patients or other individuals divert drugs from the legal supply chain to an illegal supply chain for unlawful, often recreational, purposes. Drug diversion may occur anywhere along the supply chain: manufacturer, distributor, wholesaler, pharmacy, or end-user. Illicit drug distribution occurs in absence of a legal and medically necessary purpose. Costs of the prescription drug diversion epidemic to State Medicaid programs go far beyond the cost of the drug itself. Diversion results in additional costs to the SMA associated with emergency room visits, physician's visits, and rehabilitation services.[23] Ensure pharmacy staff members are familiar with ways patients commonly divert prescription drugs, including: card sharing, medication sharing, prescription pad theft, forged or altered prescriptions, doctor shopping, and theft.

Red flags that may indicate diversion include:

- The patient requests to pay cash when insurance coverage exists;
- One patient drops off or picks up multiple similar prescriptions for two or more patients;
- Similar or identical prescriptions originate from the same prescriber or practice for inordinately large quantities of medications typically diverted;
- Groups of patients drop off similar or identical prescriptions for commonly diverted medications, often written by a prescriber who practices in another city or county;
- The patient is unable to provide identification when requested;
- The diagnosis given by the patient does not match the diagnosis given by the prescriber;
- The prescriber is unable or unwilling to give a diagnosis or provides the same diagnosis for all patients, such as back pain or degenerative disc disease;
- The prescriber is unavailable to speak directly with the pharmacist, will not return calls, or takes an unusual amount of time to respond to the pharmacist;
- The prescriber has not committed his or her DEA registration number to memory;
- The prescription does not contain all federally-mandated information; or
- The prescription does not comply with tamper-resistance industry standards or appears tampered with.

The DEA will hold accountable prescribers who issue prescriptions outside of legitimate medical use. The DEA also expects a pharmacist to exercise a corresponding responsibility to question prescriptions that do not appear to have been issued for a legitimate medical use.[24] Pharmacists should report their suspicions. Agencies that may be notified include:

- Local law enforcement;
- U.S. DEA;
- State Medicaid Fraud Control Unit; and
- State licensing board if a health care professional is involved.

Or contact:

U.S. Department of Health and Human Services, Office of Inspector General
ATTN: Hotline
P.O. Box 23489
Washington, DC 20026
Phone: 1-800-HHS-TIPS (1-800-447-8477)
TTY: 1-800-377-4950
Fax: 1-800-223-8164
Email: HHSTips@oig.hhs.gov
Website: https://forms.oig.hhs.gov/hotlineoperations/

44. Talk to pharmacy staff members about overrides at the point of sale (POS).

☐ Submit claims with vacation supply override codes only if the patient is on vacation; and

☐ Submit claims with known prior authorization (PA) override codes only if the patient meets the PA criteria.

Consider the risk for fraud, waste, or abuse if pharmacy staff members use override codes to adjudicate claims without appropriate substantiation. Inappropriate overrides for vacation supplies or PA at the POS are another potential source of risk for fraud. Recently, CareMed, a specialty pharmacy in New York, agreed to pay $9.5 million in fees to the Federal government and roughly $450,000 to the State of New York for falsifying PA information to process claims for Medicare and Medicaid beneficiaries. Pharmacy employees, with knowledge of the criteria at various insurance companies, would provide clinical information to the insurance representatives so the patient would "meet" the necessary requirements to have the medication covered.[25] Talk to staff members about when overrides are appropriate.

45. Talk to pharmacy staff members about prescription origin codes.

☐ Do not alter prescription origin codes; and

☐ Verify the prescriber DEA number and office telephone number for all controlled substance prescriptions received by telephone. If the caller or prescriber is unknown, confirm the contact information with a

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secondary source. If the contact information differs, call the prescriber's office at a published telephone number to confirm the prescription.

Prescription Origin Codes[26]

Code	Appropriate Use
1	Written—Prescription is presented to the pharmacy on a paper prescription pad.
2	Telephone—Prescription is conveyed to the pharmacy verbally by telephone call, voicemail, or other electronically recorded verbal message.
3	Electronic—Prescription is transmitted to the pharmacy by the National Council for Prescription Drug Programs' SCRIPT Standard or Health Level 7 (HL7) Standard transactions.
4	Facsimile—Prescription is transmitted to the pharmacy by facsimile machine.
5	Pharmacy—A prescription origin code value of 5 is used when a pharmacy staff member must create a new prescription number from an existing prescription. This may occur due to prescription transfer between pharmacies, prescription transfer between pharmacies in the same parent organization, sale of prescription records from one pharmacy to another, or changes in pharmacy software requirements. A prescription code value of 5 is also appropriate when a pharmacist has prescriptive authority and dispenses a pharmacist-prescribed product, such as emergency contraceptives or Controlled Substances Act Schedule V cough preparations.

Consider the risk for fraud, waste, or abuse if pharmacy staff members adjudicate a claim with an origin code that does not apply. A prescription origin code identifies the method by which a pharmacy receives a prescription. It is important to note any changes made to the original prescription do not change the origin code.[27] Prescriptions received via phone may be particularly vulnerable given the capability to misrepresent a physician's office and provide a callback number that does not belong to the physician.[28] In one case

involving the New York Medicaid program, 69 of 172 prescriptions indicated as phoned-in from an initial sample audit were found to be improper.[29]

46. Talk to pharmacy staff members about product selection (dispense as written—DAW) codes.

☐ Only use the DAW 1 product selection code when the prescriber has indicated product substitution is not allowed on the prescription; and

☐ Only use the DAW 2 product selection code when the patient has requested to receive the brand name drug rather than the generic equivalent.

Prescription Selection Codes[30]

DAW Code	Appropriate Use
0	Appropriate when the prescriber indicates product substitution is allowed or when the prescriber does not include a product selection code on the written prescription. The pharmacy provider may dispense multi-source and single-source generic drugs or single-source brand name drugs using this product selection code.
1	Appropriate only when the prescriber indicates verbally or on the written prescription that substitution is not allowed— "substitution is not allowed," "dispense as written," or "brand name medically necessary." The pharmacy provider may only dispense the brand name version of the drug prescribed using this product selection code.
2	Appropriate only when the patient indicates he or she requests the brand name version of the drug prescribed. The pharmacy provider may dispense only the brand name version of the drug prescribed using this product selection code and may do so even though the prescriber did not indicate substitution is not allowed.
3	Appropriate if a generic drug is available, but the pharmacist opted to dispense the brand name drug even though the generic drug was in stock.
4	Appropriate if a generic drug is available, but the pharmacist opted to dispense the brand name drug because the generic drug was not in stock.
5	Appropriate if a generic drug is available, but the pharmacist opted to dispense the brand name drug and elected to be reimbursed for the generic drug.
6	Appropriate when an override DAW code is required.
7	Appropriate when substitution is not allowed because the brand name drug is required to be dispensed by State law. This may occur if State law requires drug testing of generic drugs that has not yet been completed.
8	Appropriate when the generic drug is not available. This may occur if the generic drug has been approved by the FDA but not yet manufactured and distributed.
9	Appropriate when the prescriber indicates product substitution is allowed, but the beneficiary's prescription drug plan requires the pharmacy to dispense the brand name product.[31] For example, the SMA may require the pharmacy to dispense the brand name product to meet the requirements of a statutorily defined manufacturer rebate agreement.

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Consider the risk for fraud, waste, or abuse if pharmacy staff members adjudicate claims with inaccurate product selection codes. The DAW product selection code designation references the reason a particular brand is dispensed based upon direction from the prescriber.[32] Excessive use of certain DAW codes may raise red flags from an audit perspective, especially the use of DAW 1 on multi-source products. Review acceptable use of DAW 1 and DAW 9 codes with staff and emphasize appropriate documentation procedures. Proper documentation on prescriptions, especially those received via phone, is critical to withstand audit scrutiny and avoid fraudulent accusations of modifying the prescription to increase revenue. The phrases "brand name medically necessary" or "dispense as written" are needed in the cases of DAW 1 prescriptions. In some situations, SMAs may request a brand instead of generic substitution. In these instances with proper documentation, DAW 9 is appropriate.

47. Talk to pharmacy staff members about partial fill procedures.

☐ Adjudicate partial fills appropriately. Do not "owe" patients any drug quantity if the full quantity to be dispensed has already been billed;

☐ Only use the partial fill functionality of the billing system when unable to fill the full quantity to be dispensed;

☐ Do not bill the payer for the full amount of a partial refill; and

☐ Do not bill the payer for a second dispensing fee when completing a partial refill.

Consider the risk for fraud, waste, or abuse if pharmacy staff members bill for the entire prescribed quantity but dispense a partial supply while waiting for additional stock to be delivered. A partial fill occurs when a pharmacy does not dispense the total quantity of the medication indicated on the prescription. Potential fraud exists because the pharmacy may receive reimbursement to which it was not entitled. If the pharmacy bills and receives reimbursement for a complete fill and "owes" the beneficiary the remainder of the fill, the beneficiary may not pick up the owed portion, or the pharmacy may not be able to obtain additional supply of the medication. When the medication is returned to stock, the pharmacy inventory is inaccurate, and Medicaid has overpaid the pharmacy. This topic was the subject of an OIG investigation related to $25 million in overpayments by Medicare Part D for Schedule II prescriptions partial fill completions billed as refills.[33] In addition, pharmacies may create partial fill claims as a means to generate a second dispensing fee. As is

the case with other potential audit red flags, an excess of partial fills has the potential to trigger an audit. Implement a sound partial-fill protocol, including proper documentation, to avoid accusations of partially filling prescriptions in an effort to generate dispensing fee revenue.

48. Talk to pharmacy staff members about how they select package sizes when more than one size is available.

- ☐ Select the smallest commercially available package size to address the prescription requirements;
- ☐ Ensure the NDC dispensed matches the NDC billed, particularly for generic and compounded medications;
- ☐ Adhere to State-specific Medicaid compound prescription billing requirements;
- ☐ Bill accurate quantities of medications used in compounded medications; and
- ☐ Confirm that commercially available equivalents do not exist and that the compounded medications are treating a medically necessary indication.

Consider the risk for fraud, waste, or abuse if pharmacy staff members select a package size larger than is necessary. Areas that are particularly vulnerable to audit findings include topical preparations, reconstituted products, and compounds. Review with staff the importance of selecting the smallest commercially available package size, and in cases where this does not occur, document the reason for the larger package size on the prescription (for example: affected area for topical preparations). Staff must ensure the NDC dispensed matches the NDC billed. For compounded medication in particular, if a staff member bills for the entire contents of a package to create a compound when a smaller volume would have been adequate to create the compound, potential for fraud, waste, or abuse exists. In addition, pharmacy staff members may inappropriately flag non-compound products as compounds to increase revenue. A pharmacy owner in West Virginia recently pleaded guilty to defrauding Medicare and Medicaid for dispensing compounded generic medications and billing for the brand. Medicare and West Virginia Medicaid will recover $1.1 million from a settlement with the pharmacy.[34] Review compound prescription billing procedures with staff to ensure the correct package size and NDC are selected and billed appropriately and to prevent future audit recovery.

49. Talk to pharmacy staff members about how they document beneficiary receipt of prescriptions.

- ☐ Always obtain signatures from patients or their agents at the time of prescription pickup.

Consider the risk for fraud, waste, or abuse if pharmacy staff members do not document proof of delivery. Routine examination of signature logs is worthwhile to prepare for potential audits or to uncover fraud in the form of forged signatures. The potential for fraud exists when no records demonstrate proof of delivery because pharmacy employees may forge a beneficiary's signature for a prescription that never reaches the beneficiary.[35]

50. If a Medicaid overpayment is identified, take one of the following steps:

- ☐ Reverse any claim within the last year;
- ☐ Send a check and an explanation for any older claim; or
- ☐ Self-disclose the overpayments to your SMA or the OIG.

Pharmacies must report the overpayment within 60 days from the date the overpayment is identified.[36] Overpayments usually include the following situations:[37]

- At the time of the service, the individual receiving the service was not eligible for Medicare or Medicaid;
- Medicare or Medicaid mistakenly paid as primary where another third-party payer was properly primary;
- The payment amount was miscalculated and excessive;

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- The service did not fall within one of the statutory benefits or was subject to a statutory exclusion; or
- The service was not medically necessary.

The FCA contains a whistleblower provision allowing an individual, known as a "relator," to file a lawsuit on behalf of the Federal government against a person or business based on evidence of fraud against Federal programs or contracts. The whistleblower is entitled to a portion of any monies recovered.[38] The FCA includes a treble damages provision (a tripling of actual and compensatory damage) for persons who have "actual knowledge, deliberate ignorance of the truth or falsity of the information, or reckless disregard of the truth or falsity of the information."[39] In addition, persons may be found to have violated the FCA in reverse—not by receiving money to which the person is not entitled, but by avoiding payment of monies due the Federal government.[40] In addition, a pharmacy may be terminated as a Medicaid provider for cause because the pharmacy has engaged in fraud for abusing billing privileges (for example: billing for services that were not provided or failing to repay a Medicaid overpayment).[41] Identifying and reporting overpayments in a timely manner will prevent negative consequences and offers the pharmacy the opportunity to provide staff training to prevent future overpayments.

Conclusion

CMS is committed to educating pharmacy providers about potential fraud, waste, and abuse related to pharmacy services. The four Pharmacy Self-Auditing booklets in the "Pharmacy Self-Auditing: Control Practices to Improve Medicaid Program Integrity and Quality" Toolkit provide self-audit steps to identify potential audit triggers in a pharmacy practice. The booklets address areas prone to potential fraud, waste, and abuse related to pharmacy services, and provide instruction on how to report suspected fraud, waste, and abuse. Pharmacy providers can use audit findings to identify areas of practice that require further scrutiny as well as use these tools to educate pharmacy personnel about potential fraud, waste, and abuse.

This booklet discusses how evaluating billing practices can be incorporated into a pharmacy self-audit. The booklet contains 15 of the 50 steps to conduct a pharmacy self-audit and examines common quantity and days' supply billing errors. In addition, inappropriate refill practices, overrides, partial fill procedures, and package size selection are discussed. A thorough review of these steps as they pertain to pharmacy practice will help pharmacies preserve State Medicaid program integrity and improve the quality of patient care for State Medicaid beneficiaries.

To review any of the three additional booklets in the "Pharmacy Self-Auditing: Control Practices to Improve Medicaid Program Integrity and Quality" Toolkit (Booklet 1—Prescribing Practices, Booklet 2—Controlled Substances Management, and Booklet 3—Invoice Management), with audit questions and detailed information regarding each step, visit https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html on the CMS website. The steps in the four booklets correspond to the steps in the document titled "Pharmacy Auditing and Dispensing: The Self-Audit Control Practices to Improve Medicaid Program Integrity and Quality Patient Care Checklist."

To see the electronic version of this booklet and the other products included in the "Pharmacy Self-Auditing: Control Practices to Improve Medicaid Program Integrity and Quality" Toolkit, visit the Medicaid Program Integrity Education page at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html on the CMS website.

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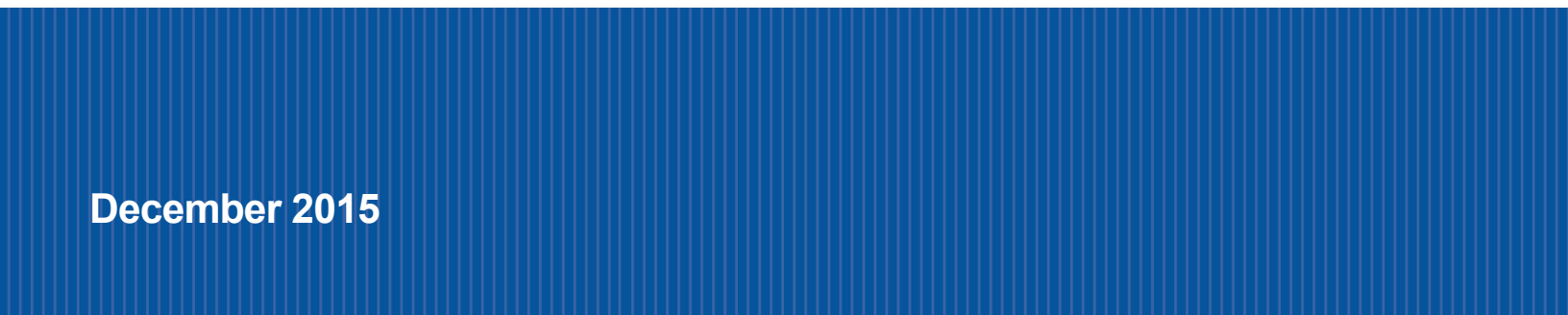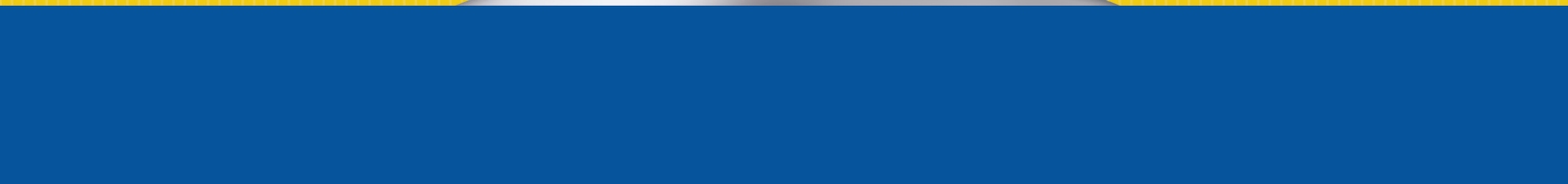
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