

Community Pharmacist Examples of PBM's Abusive Auditing Practices



The following stories demonstrate just a small sample of the struggle community pharmacy face against the abusive auditing practices of the PBM industry. We encourage you to contact your local community pharmacists and ask how they are impacted by such practices. Pharmacy, pharmacist, insurer and PBM names have been removed to protect those involved.

Example 1

“Two recent audits that stick out in my mind as being outrageous are: We used a patient’s middle name in processing our Rx. Like me, this patient went by his middle name. The PBM had him in their system using his first *and middle name*. We were told that all of this money must be reclaimed by the PBM. The reason that this story sticks out is because this particular patient was one of my pharmacy manager’s husbands. We were obviously not attempting to be fraudulent in our actions. Fighting this claim was very time consuming and in the long run it would have cost as much to fight it through administrative costs as it did to just pay the fine. *There was no monetary error made and the correct medication was dispensed to the correct individual and the proper carrier was charged the correct amount.*

Another ridiculous story is that an auditor was looking at an Rx stating the particular number was a 6 and not a 4. We were told that we were repeatedly dispensing the incorrect amount of medication to this patient. Honestly, I forget exactly what the numbers were for. They were claiming we processed the wrong amount of medication for a particular Rx. We have been working with this Doctor for years and told the auditor “No that is how he writes his 4’s, we know him well”. They would not believe us and attempted to recoup the money for the Rx and all refills. In the long run we were correct and the auditor was wrong. Again, a long process that could have been totally avoided.”

Example 2

“Nursing homes represent half if not more of our business. In most cases Doctors orders are 3+ pages long in this environment, ultimately signed on the last page. Recently we were audited and fined because each page of each order was not signed by the physician. *This is outrageous as the form is identified to be signed on the last page.* This has nothing to do with pharmacists or my pharmacy. Even the physician stated they only sign the last page. *Each page that was not signed was indicated to be in violation.*

Additionally, I was audited some time ago for **\$14,000** for not using a physician’s number. The catch was that it was a CRNP that wrote the order *so there was no physician’s number. They were not a physician! I called the insurance company who told me that this was no problem and I should just use the CRNP License number. Which I did.* In addition to that I also went ahead and attached a copy of the CRNP license just so it was clear what I was doing. Even so, when I was audited they wanted **\$14,000** which was ultimately settled for **\$12,000**. *I was simply doing exactly what I was told to do and even more so to make sure everything was properly documented.*

Another issue we regularly need to work out is the dates of our submissions/Rx do not match the date the physician signed the order. Well, in the nursing home setting the physician may only be in once every 30-60 days to review the orders. *It is impossible for every date to match up exactly and also have us process all of these orders on that day.* Both we and the physician are swamped on those days. I would say this is regularly targeted because they know it’s going to occur each time.

All of the above stories were at least **\$7,500** audits each time they occur. *They occur constantly! Anything you can do would be appreciated.*”

Example 3

“Regarding an audit recently from [REDACTED] on behalf of [REDACTED] the final report showed that there were a dozen or so missing hard copies from the files. If the hard copies cannot be found, then the entire amount of the pay, including all refills, is deducted from pharmacy payments. I personally handled the audit a few months earlier, *and I did not recall any missing hard copies. I went back to the files, and I found all of them, exactly where they should have been. All the rx's even had checks and notations marks that the auditor made.* I challenged this, of course, and went through the process of copying the record and submitting them, again. *I essentially had to do double work because the auditor 'lost' his copies.* Many pharmacies do not go thru the final audit results and challenge findings, because the process is so time consuming. How much money does this represent, nationally, that auditors steal from pharmacies? Other examples of clerical errors that result in chargebacks on entire amount, plus all refills that I have been involved with in the past: If the Dr. signature is not legible, and we pick a different doctor listed on the Rx (a partner or associate). We submit the Dr. ID from the partner, instead of the Dr. that signed, even though the practice is correct.

Once this happened - The patient's name was Joe Matt Smith. He went by Matt, and that is what was on the Rx. The name Joe was not on the Rx, and the insurance records were under Joe Smith. The insurance company said upon audit that the Rx was filled under the wrong name. We had to provide a copy of the driver's license. Problem is, he was a mentally disabled adult and had none. We had to get the elderly parents to dig up his birth certificate and submit that. *The only reason this was successful is that as a community pharmacist I had a face-to-face relationship with this patient and his family. It took a great amount of time but we were able to track down an ID.*

We must submit accurate Dr ID numbers. Some insurance companies require a DEA number, but DEA numbers are not required on non-controlled rx's. If we fill an rx at night or on weekend, and DEA is not on Rx, we must submit a 'dummy' DEA to get claim thru. Upon audit, insurance company will take back money because a bad DEA was submitted. *Even though we complied with all pharmacy law, an insurance company reg can trump pharmacy law and we lose the money. This seems outrageous to me! Do we break a law to save money or do we be complaint with law and pay thousands of dollars back?* We must now submit an 'origin code'. That means, how did we receive the rx (original, phone-in, fax, or e-script). *There is no pharmacy law or reg state or federal where this is required. However, insurance companies require this extra step.* If we submit the wrong code, they will consider this an error, and take back all money paid to pharmacy for rx. *This would be a clerical error that did not influence what med the patient got, and what dollar amount was submitted to insurance company.* This last example highlights what needs to be done with pharmacy audits. If a clerical error occurs that does not influence what was dispensed to the patient and what was billed to the insurance company, then no chargeback should occur.”

Example 4

“Recently we were audited by [REDACTED] the preliminary report said that 1 claim **\$60,000** –was not compliant as they could not make out patient signature.

We then forwarded the requested information, which was accepted and the audit file was closed. About 1 week later we received a call from the insurance company to resubmit the questioned claim above for payment- we resubmitted and were paid. *Basically the insurance company took back the money for the claim before the audit process was completed.* If we did not receive the call to resend the claim we would have never known.

The worst story I have I cannot give too many details on under the settlement agreement with Insurer. It occurred in 2006. I told the story to Governor [REDACTED] and [REDACTED] could not believe it.

The reality is we service Hemophiliac patients where medications run from \$20,000 to \$60,000 per MONTH. Insurers can audit for several claims and if they identify a clerical error of any kind can recoup a large amount. This particular case was attempting to get over \$250,000 from me.

Department sanctions per [REDACTED] – failure to report accurate prescriber license number on a [REDACTED] claim- Out of State Doctors should use format [REDACTED]999999X

I used actual [REDACTED] [State] license number instead of this [REDACTED]999999X. So I used a legally correct number, that identified the correct physician, but since it was for [REDACTED] and was being processed in [REDACTED] I was to use the [REDACTED]999999X number. Does not seem like fraud, waste or abuse to me. Because of using the *legally correct number with everything being dispensed correctly, billed correctly, etc.* I was still hit for over **\$250,000**.

A quarter of a million dollars when no ill intent was intended and no error was even made, harm done to any customer, or money lost by any party involved.”

Example 5

[REDACTED] discovered that a compliance review had been conducted on our 4 independent pharmacies and that [REDACTED] intended to recoup over **\$500,000.00** from our company for 2500 claims they said were paid in error.

The claims in question were submitted electronically. [REDACTED] authorized more than **\$500,000.00** worth of prescriptions from 10-03-03 to 9-20-06 to be dispensed. We requested authorization to dispense these medications before any prescriptions were filled. *We received authorization to dispense and received authorization numbers* from [REDACTED] for every one of the 2500 claims in question. *The claims went through with no rejections, we received payment from [REDACTED] and the customer received their prescriptions correctly. Four years later [REDACTED] wanted their money back. They stated that these 2500 claims could have been billed to [REDACTED] but based on our research, less than 20% of these claims had been billed incorrectly.*

Of the less than 20% that should have been billed to [REDACTED], we were able to recover approximately **\$36,000.00**, as [REDACTED] will only allow a pharmacy to back bill for claims that are less than 18 months old. The other 80% of the **\$500,000.00** consists of claims that were billed correctly to [REDACTED].

If we had received a denial of payment when we submitted these claims, we would not have dispensed the medications under [REDACTED]. We would have immediately billed [REDACTED] first. Their billing system failed to alert for dual eligibility and failed to reject the payment of these claims online. [REDACTED] knew these people were eligible but failed to tell us. We are being penalized because [REDACTED]'s billing system was not up to industry standards. If we had been notified of these billing errors in a timely fashion, we could have corrected them and rebilled these claims to the responsible parties. *We were never given that opportunity.* We were notified much too late to rebill the majority of these claims. Had we been notified within even one year of this problem – we could have corrected it on those claims that needed correction. In other words, [REDACTED] was forced to spend almost **\$100,000.00** to prove that we owed [REDACTED] less than **\$100,000.00 - not \$500,000.00.”**