TEXAS HEALTH AND HUMAN SERVICES COMMISSION

OFFICE OF INSPECTOR GENERAL

AUDIT OF BEST MED, INC.

A Texas Vendor Drug Program Provider

July 3, 2019

HHSC OIG
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WHY OIG CONDUCTED THIS AUDIT

The audit objectives were to determine whether Best Med, Inc. (Best Med) (a) properly billed the Texas Vendor Drug Program (VDP) for Medicaid claims submitted and (b) complied with contractual and Texas Administrative Code (TAC) requirements.

Best Med processed 18,113 Texas Medicaid claims for prescriptions through VDP during the audit period of September 1, 2013, through August 31, 2016. These claims resulted in the pharmacy receiving reimbursements of $1.1 million from Texas Medicaid.

WHAT OIG RECOMMENDS

Best Med should ensure (a) it retains and provides documentation as required, (b) all claims contain the correct prescriber identification number, (c) all claims contain the correct prescription issuance date, (d) maintain all records, including medication invoices, and (e) any changes in medication quantity dispensed are properly authorized by the prescriber and documented prior to dispensing.

Best Med should return $96,892.92 to the State of Texas.

For more information, contact:
OIG.AuditDivision@hhsc.state.tx.us

WHAT OIG FOUND

Best Med complied with TAC and contract provisions related to refills, controlled substances, warehouse billing, and acquisition cost. Information technology general controls were adequate, and the data used to form audit conclusions was reliable.

There were exceptions related to claims validity, NDC usage, and quantity. Best Med did not bill VDP properly, or comply with other contractual or TAC requirements, for 18 of the 120 claims tested. The 18 claims resulted in $15,674.94 subject to extrapolation and recoupment. The total amount due to the State of Texas is $96,892.92.

Best Med did not retain invoice documentation for 119 of the 120 claims in the sample. Best Med's not maintaining invoices did not invalidate the authorization for dispensed medications. Of the 119 claims, 91 may be subject to the assessment of penalties.

The OIG Audit Division presented the audit results, issues, and recommendations to Best Med in a draft report on May 28, 2019, and requested that it provide management responses to the recommendations no later than June 18, 2019. As of the date of this report, Best Med had not provided those responses.

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INTRODUCTION

The Texas Health and Human Services Commission (HHSC) Office of Inspector General (OIG) Audit Division has completed an audit of Best Med, Inc. (Best Med), a Texas Vendor Drug Program (VDP) provider.

NPI Number: 1740283811

License Number: 16860

Address: 116 S. Park Drive
Brownwood, Texas 76801

Best Med processed 18,113 Medicaid claims for dispensed prescriptions through VDP during the audit period, for which it received reimbursements of $1.1 million.

Objectives and Scope

The audit objectives were to determine whether Best Med (a) properly billed VDP for Medicaid claims submitted and (b) complied with contractual and Texas Administrative Code (TAC) requirements.

The audit scope included both initial fill claims and refill claims for the period from September 1, 2013, through August 31, 2016, as well as a review of relevant activities, internal controls, and information technology (IT) general controls through the end of fieldwork in January 2019.

Methodology

The OIG Audit Division collected information for this audit through discussions, interviews, and electronic communications with Best Med management and staff and by reviewing:

- Supporting documentation for a sample of all claims billed to VDP during the audit scope
- Best Med's policies and procedures
- IT general controls involving the QS1 system

The OIG Audit Division used the population of paid claims with service dates ranging from September 1, 2013, through August 31, 2016, for this audit. The population contained both initial fill claims and refill claims for the audit period and a sample of 120 claims was selected.

For the claims contained in the sample, the OIG Audit Division tested Best Med's compliance in six areas: (a) claims validity, represented by claims documentation maintained by the provider, (b) National Drug Code (NDC) usage, (c) quantity, (d) refills, (e) controlled substances, and (f) acquisition cost. This report details results, issues, and recommendations in those areas, when applicable, and the results of limited testing of IT general controls, performed to determine whether data used to form audit conclusions was reliable.

The OIG Audit Division presented the audit results, issues, and recommendations to Best Med in a draft report on May 28, 2019, and requested that it provide management responses to the recommendations no later than June 18, 2019. As of the date of this report, Best Med had not provided responses.

Criteria

- Tex. Hum. Res. Code § 32.039 (2011 and 2015)
- 1 Tex. Admin. Code § 354.1835 (2002 and 2016)
- 1 Tex. Admin. Code § 354.1863(b) (2008 and 2016)
- 22 Tex. Admin. Code §§ 291.34(b)(5)(A) (2012) and 291.34(b)(6)(A) (2013 through 2016)
- 22 Tex. Admin. Code §§ 291.34(b)(7)(A) (2012) and 291.34(b)(8)(A)(i) (2013 through 2016)
- Vendor Drug Program Pharmacy Provider Contract #350069 (2005) and #351037 (2016)

Auditing Standards

Generally Accepted Government Accounting Standards

The OIG Audit Division conducted this audit in accordance with generally accepted government auditing standards issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for the issues and conclusions based on our audit objectives. The OIG Audit Division believes the evidence obtained provides a reasonable basis for our issues and conclusions based on our audit objectives.

ISACA

The OIG Audit Division performs work in accordance with the IT Standards, Guidelines, and Tools and Techniques for Audit and Assurance and Control Professionals published by ISACA.

AUDIT RESULTS

Best Med complied with TAC and contract provisions related to refills, controlled substances, and acquisition cost. IT general controls were adequate, and the data used to form audit conclusions was reliable.

There were exceptions related to claims validity, NDC usage, and quantity. Details of these exceptions are included in the sections that follow. One claim may have more than one exception and be included in more than one finding in this report. When calculating the error rate and the extrapolation value, each claim is only counted as an error once.

Of the 120 claims tested, there were 18 unsupported claims. Of the 18 unsupported claims, one claim had two errors, resulting in a total of 19 errors. The unsupported claims represent overpayments to Best Med. Results indicated an extrapolated overpayment amount of $96,892.92 for 18 unsupported claims. See Appendix B for details about these claims.

Best Med did not retain invoice documentation for 119 of the 120 claims in the sample. Best Med's not maintaining invoices did not invalidate the authorization for dispensed medications. Of the 119 claims, 91claims may be subject to the assessment of penalties. See Appendix C for details about these claims.

CLAIMS VALIDITY

VDP participating pharmacies are contractually required to maintain documents to support Medicaid claims. Claims validity is demonstrated by documentation maintained by the pharmacy. In consideration for payment under the VDP contract, participating pharmacies must comply with all applicable laws, rules, and regulations, including Pharmacy Board rules and regulations in effect at the time the prescription is serviced.[1] According to Pharmacy Board rules, a prescription or a physician order must contain several elements in order to be valid, including (a) name of the patient, (b) address of the patient, (c) name, address, and telephone number of the practitioner at the practitioner's usual place of business, (d) name and strength of the drug prescribed, (e) quantity prescribed, (f) intended use for the drug unless the practitioner determines the furnishing of this information is not in the best interest of the patient, and (g) date of issuance.[2]

If the pharmacy (a) does not maintain or cannot produce documents to support the dispensing of the medication or (b) if any of the required elements are not

[1] Texas State Board of Pharmacy rules are published in 22 Tex. Admin. Code, Part 15.

[2] 22 Tex. Admin. Code § 291.34(b)(6)(A) (June 7, 2012) and 22 Tex. Admin. Code § 291.34(b)(7)(A) (Sept. 8, 2013, through June 12, 2016).

documented on the face of the prescription or physician order, then the related claim is invalid and not eligible for reimbursement by VDP. Relevant criteria follow.

1 Tex. Admin. Code §354.1835 (May 24, 2002, and May 15, 2016) provides, "Vendors must enter the identification number of the prescriber, as listed with the appropriate medical specialty board, on each claim."

1 Tex. Admin. Code § 354.1863(b) (Sept. 23, 2008, and May 15, 2016) provides, "A signed prescription must be maintained in the dispenser's file and available for audit at any reasonable time. … The name of the prescriber and the signature of the dispensing pharmacist must be documented."

Vendor Drug Program Pharmacy Provider Contract #350069, Part 2(G) (Apr. 1, 2005) and *Vendor Drug Program Pharmacy Provider Contract #351037, Part 3(F) (June 25, 2016)* provide, "The Provider agrees that information contained in all claims data submitted by or on behalf of the Provider: (1.) Is true, complete and accurate."

Vendor Drug Program Pharmacy Provider Contract #350069, Part 2, (H) (Apr. 1, 2005) states, "The Provider will comply with all Texas and federal laws that regulate fraud, abuse, and waste in health care and the Medicaid and Vendor Drug Programs. This includes, without limitation, the following obligations:
1. To keep and maintain all the records necessary for the purchasing and dispensing of Recipient prescriptions, and furnish all reports in such form and scope as HHSC may require. This includes without limitation: (a) All prescription documents, medication invoices, and medication acquisition documents; (b) Any other records pertinent to the services for which a claim was submitted, or the claims presented for payment for such services; and (c) All other records required to be maintained by HHSC's standards of participation in the Vendor Drug Program."

Vendor Drug Program Pharmacy Provider Contract #351037, Part 3(G) (June 25, 2016) states, "The Provider will comply with all Texas and federal laws that regulate fraud, abuse, and waste in health care and the Vendor Drug Program. This includes, without limitation, the following obligations:
1. To keep and maintain all the records necessary for the purchasing and dispensing of Recipient prescriptions, and furnish all reports in such form and scope as HHSC may require. This includes without limitation: (a) All prescription documents, medication invoices, and medication acquisition documents; (b) All records pertinent to the services for which a claim was submitted, or the claims presented for payment for such services; and (c) All other records required to be maintained by HHSC's standards of participation in the Vendor Drug Program."

Vendor Drug Program Pharmacy Provider Contract #350069, Part 2, (I) (Apr. 1, 2005) and *Vendor Drug Program Pharmacy Provider Contract #351037, Part 3(H)*

(June 25, 2016) provide, "The records and documents referenced in [the preceding subpart] of this Contract must be retained for a minimum of five years from the Date of Service."

Vendor Drug Program Pharmacy Provider Contract #350069, Part 2, (L)(9)(i) (Apr. 1, 2005) and *Vendor Drug Program Pharmacy Provider Contract #351037, Part 3(M)(11) (June 25, 2016)* provide that the provider will comply with all laws, rules, regulations applicable to the contract, as amended or modified, including without limitation, "Texas State Board of Pharmacy rules and regulations in effect at the time the prescription is serviced."

Issue 1: Missing Supporting Documentation

Best Med did not provide supporting documentation for six claims it dispensed and billed to VDP.

Best Med did not follow TAC and contract guidelines, which require pharmacies to maintain prescriptions as supporting documentation for VDP claims. Since Best Med was unable to produce prescriptions for these claims, VDP reimbursed Best Med $6,534.80 for 6 unsupported claims. See Appendix B for details about these claims. The $6,534.80 for 6 unsupported claims is subject to extrapolation and recoupment.

Recommendation 1

Best Med should ensure all claim records are (a) maintained for at least five years and (b) supplied within a reasonable amount of time after requested.

Management Response

The OIG Audit Division presented the audit results, issues, and recommendations to Best Med in a draft report on May 28, 2019, and requested that it provide management responses to the recommendations no later than June 18, 2019. As of the date of this report, Best Med had not provided those responses.

Issue 2: Incorrect Prescriber Identification Numbers

Best Med dispensed and billed VDP for five prescriptions with a prescriber identification number that was not associated with the physician who signed the prescription.

Best Med did not follow TAC and contract guidelines, which require VDP claims to be paid only when the prescriber number is associated with the physician who signs a prescription. As a result, VDP reimbursed Best Med $8,332.99 for

5 unsupported claims. See Appendix B for details about these claims. The $8,332.99 for 5 unsupported claims is subject to extrapolation and recoupment.

Recommendation 2

Best Med should ensure that all claims it submits to VDP for reimbursement contain a prescriber identification number associated with the physician who signed the prescription.

Management Response

The OIG Audit Division presented the audit results, issues, and recommendations to Best Med in a draft report on May 28, 2019, and requested that it provide management responses to the recommendations no later than June 18, 2019. As of the date of this report, Best Med had not provided those responses.

Issue 3: Incorrect Prescription Issuance Date

Best Med dispensed and billed VDP for four prescriptions with the incorrect prescription issuance date.

Best Med did not follow TAC and contract guidelines, which require VDP claims to be paid only when the date of issuance on the claim and the prescription label match the prescription date. As a result, VDP reimbursed Best Med $777.08 for 4 unsupported claims. See Appendix B for details about these claims. The $777.08 for 4 unsupported claims is subject to extrapolation and recoupment.

Recommendation 3

Best Med should ensure that all claims it submits to VDP for reimbursement contain the correct prescription issuance date as written on the prescription by the prescribing physician.

Management Response

The OIG Audit Division presented the audit results, issues, and recommendations to Best Med in a draft report on May 28, 2019, and requested that it provide management responses to the recommendations no later than June 18, 2019. As of the date of this report, Best Med had not provided those responses.

NATIONAL DRUG CODE

The NDC for the medication dispensed by a pharmacy must match the NDC for the medication billed to VDP. Only medications listed on the VDP formulary are eligible for reimbursement. Relevant criteria follow.

Tex. Hum. Res. Code § 32.039 (b) (Sept. 1, 2011, and Apr. 2, 2015) provides, "A person commits a violation if the person: … (3) fails to maintain documentation to support a claim for payment in accordance with the requirements specified by commission rule or medical assistance program policy or engages in any other conduct that a commission rule has defined as a violation of the medical assistance program."

Tex. Hum. Res. Code § 32.039 (b-1) (Sept. 1, 2011, and Apr. 2, 2015) provides, "A person who commits a violation … is liable to the commission for either the amount paid in response to the claim for payment or the payment of an administrative penalty in an amount not to exceed $500 for each violation, as determined by the commission."

Vendor Drug Program Pharmacy Provider Contract #350069, Part 2 (H)(1) (Apr. 1, 2005) and *Vendor Drug Program Pharmacy Provider Contract #351037, Part 3(G)(1) (June 25, 2016)* provide that the provider is obligated "To keep and maintain all the records necessary for the purchasing and dispensing of Recipient prescriptions, and furnish all reports in such form and scope as HHSC may require. This includes without limitation: (a) All prescription documents, medication invoices and medication acquisition documents."

Vendor Drug Program Pharmacy Provider Contract #350069, Part 2, (I) (Apr. 1, 2005) and *Vendor Drug Program Pharmacy Provider Contract #351037, Part 3(H) (June 25, 2016)* provide, "The records and documents referenced in [the preceding subpart] of this Contract must be retained for a minimum of five years from the Date of Service."

Issue 4: Missing Medication Invoice

Best Med did not maintain invoices to support 119 out of the 120 sampled claims. The OIG Audit Division, however, obtained invoices from the manufacturers for 118 claims to verify the NDC of medication dispensed. Best Med dispensed and billed VDP for one claim for which an invoice was not provided and the auditors could not verify the NDC of the medication dispensed. VDP reimbursed Best Med $26.54 for this claim. See Appendix B for details about this claim. The payment associated with this claim was identified as an overpayment in Issue 2.

Best Med did not follow contract requirements, which require pharmacies to maintain all records related to prescription services, including medication invoices. VDP reimbursed Best Med $140,141.22 for 119 claims for medication dispensed, but Best Med did not maintain invoices to verify medications were purchased by the pharmacy. The absence of invoices does not affect the authorization of the prescription, so failing to maintain invoices is a record keeping error.

Of the 119 claims with record keeping errors, VDP reimbursed for 15 claims totaling $15,644.87 identified as overpayments in Issue 1through Issue 3, VDP reimbursed for 3 claims including dispensing fees totaling $30.07 which were identified as overpayments in Issue 5, and 10 claims were removed as exceptions since the dates of service on the claims were outside of the required 5 year record retention period. The remaining 91 claims, totaling $115,236.30, may be subject to the assessment of penalties. See Appendix C for details about these claims.

Recommendation 4

Best Med should maintain all records related to prescription services, including medication invoices.

Management Response

The OIG Audit Division presented the audit results, issues, and recommendations to Best Med in a draft report on May 28, 2019, and requested that it provide management responses to the recommendations no later than June 18, 2019. As of the date of this report, Best Med had not provided those responses.

QUANTITY

Pharmacists may dispense a different quantity of medication than ordered by the prescribing physician as long as the prescribing physician is contacted and authorizes the change, which must be documented by the pharmacy. Quantity changes made to comply with Medicaid limitations for reimbursement purposes do not override the pharmacist's obligation to obtain the prescriber's authorization for quantity changes. Relevant criteria follow.

22 Tex. Admin. Code § 291.34(b)(5)(A) (June 7, 2012) and *22 Tex. Admin. Code § 291.34(b)(6)(A) (Sept. 8, 2013, through June 12, 2016)* provide, "Original prescriptions may be dispensed only in accordance with the prescriber's authorization as indicated on the original prescription drug order including clarifications to the order given to the pharmacist by the practitioner or the practitioner's agent and recorded on the prescription."

Issue 5: Incorrect Medication Quantities

Best Med dispensed and billed VDP for a different quantity of medication than was ordered, without documented authorization from the prescribing physician, for three claims.

Best Med did not follow TAC guidelines, which require VDP claims to be paid only when changes in quantity are properly authorized by the prescribing physician and documented prior to dispensing. As a result, VDP reimbursed Best Med $540.19 for 3 unsupported claims. See Appendix B for details about these claims. The dispensing fee amount of $30.07 for the 3 unsupported claims is subject to extrapolation and recoupment.

TAC states "original prescriptions may be dispensed only in accordance with the prescriber's authorization as indicated on the original prescription drug order including clarifications to the order given to the pharmacist by the practitioner or the practitioner's agent and recorded on the prescription."[3]

However, in general practice and with approval of the Pharmacy Board, pharmacists only need to obtain the prescriber's authorization when dispensing a quantity greater than the quantity indicated on the face of the prescription, not when dispensing less. According to a letter received from the executive director of the Pharmacy Board dated February 20, 2018, "the Board will be considering amending its rules to clarify that a pharmacist may dispense less than prescribed at the request of the patient or the patient's agent at a future Board meeting."

Pharmacies are paid a professional dispensing fee as compensation for the administrative effort required to fill a Medicaid prescription. The basis of this finding is that Best Med did not follow TAC or VDP rules when processing claims identified. The Pharmacy Board's acceptance of the general practice by pharmacies to contact the prescriber only when dispensing over the prescribed amount is not acceptable to VDP. In recognition of this, the OIG determined the professional dispensing fees are recoupable.

Recommendation 5

Best Med should ensure that any changes in the quantity dispensed from the quantity prescribed are authorized by the prescribing physician and documented prior to dispensing.

[3] 22 Tex. Admin. Code § 291.34(b)(5)(A) (Mar. 13, 2012), and 22 Tex. Admin. Code § 291.34(b)(6)(A) (Sept. 8, 2013 through June 12, 2016).

Management Response

The OIG Audit Division presented the audit results, issues, and recommendations to Best Med in a draft report on May 28, 2019, and requested that it provide management responses to the recommendations no later than June 18, 2019. As of the date of this report, Best Med had not provided those responses.

Overpayments to Best Med

Overpayments identified for the sample of claims were used to calculate an error rate, which was applied to the population of all claims using extrapolation. See Appendix A for the sampling and extrapolation methodology.

Recovery of Extrapolated Overpayments

The population included in this audit consists of 12,171 fee-for-service VDP claims from September 1, 2013, through August 31, 2016, for which HHSC paid Best Med $1,144,018.10. A statistically valid sample was selected that included 120 claims, for which HHSC paid Best Med $140,141.22. These exceptions are detailed in the following issues.

Issue 1	$6,534.80
Issue 2	$8,332.99
Issue 3	$777.08
Issue 4	$0.00
Issue 5	$30.07
Total	$15,674.94

The estimated overpayment amount was calculated by extrapolating the dollar value of the errors across the entire population. By extrapolating the results to the entire population of claims within the scope of the audit, OIG determined that the exceptions represented an overpayment for the population of $96,892.92. The overpayment was calculated using the lower limit of a two-sided 80 percent confidence interval.

Recommendation 6

Best Med should return the overpayment amount of $96,892.92 to the State of Texas.

Management Response

The OIG Audit Division presented the audit results, issues, and recommendations to Best Med in a draft report on May 28, 2019, and requested that it provide management responses to the recommendations no later than June 18, 2019. As of the date of this report, Best Med had not provided those responses.

CONCLUSION

Best Med complied with TAC and contract provisions related to refills, controlled substances, and acquisition cost. IT general controls were adequate, and the data used to form audit conclusions was reliable.

There were exceptions related to claims validity, NDC usage, and quantity. Best Med did not bill VDP properly, or comply with other contractual or TAC requirements, for 18 of the 120 claims tested. The 18 claims with exceptions resulted in overpayments of $15,674.94 subject to extrapolation and recoupment. The total amount due to the State of Texas is $96,892.92.

In addition, Best Med did not retain invoice documentation for 119 of the 120 claims in the sample. Best Med's not maintaining invoices did not invalidate the authorization for dispensed medications. Of the 119 claims, 91 may be subject to the assessment of penalties.

The OIG Audit Division offered recommendations to Best Med, which, if implemented, will correct deficiencies in compliance with state guidelines.

The OIG Audit Division thanks management and staff at Best Med for their cooperation and assistance during this audit.

Appendix A: Sampling and Extrapolation Methodology

Statistical Sampling

The OIG Data and Technology Division provided data for testing. It was administratively infeasible to review every claim in the population; therefore, the OIG Audit Division selected a sample of 120 claims to test. The following query parameters are provided for replication purposes.

One item detailed query was run in the Xerox Pharmacy Claims Data Warehouse using the Texas VDP PBM Universe table. The data set included only fee-for-service paid claims for the audit scope.

Query Result Objects field names included:

Prescription Number	Last Name (client)
First Name (client)	Participant ID
Drug Name	Drug Strength
Quantity	Days Supply
Nbr of Refills Authorized	Refill Number
Date of Service	Date Prescribed
Date Paid	Total Reimbursed Amount
DAW Code	NDC
Drug Class Code	Client Mailing Address Line 1
Birth Date (client)	Compound Code
DEA Code	Basis of Cost Determination
Basis of Reimbursement	Basis of Reimbursement Descr.
Prescriber ID	NPI (prescriber)
Prescriber Name	Batch Doc. Type Code
Group ID (client)	Tx Status Code
TPL Amt	Pharmacy ID
TCN	Pharmacy Name
Claim Line Number	Unlimited Drug Indicator
Allowed Ingredient Amount	Dispensing Fee Amount

Query Filters Included:

- Date of Service (between 09/01/2013 and 08/31/2016)
- TX Status Code (equal to PD)
- Batch Doc. Type Code (equal to A;C)
- Group ID (equal to V)
- Pharmacy ID (equal to 1740283811)
- TPL Amt Less than or Equal to (0)

Extrapolation

OIG provided Best Med with an extrapolation detail file at the same time as the draft audit report. The extrapolation detail file contains information about the data and methods used to determine the overpayment in sufficient detail so the extrapolation results may be demonstrated to be statistically valid and are fully reproducible.

The extrapolation detail file contains the (a) population of claims, (b) sample frame, including sample size determination, (c) seed value for random number generation, (d) extrapolation validation, and (e) results printout from the RAT-STATS software. The population used for extrapolation included in this audit consists of refill claims with dispensing dates between September 1, 2013, and August 31, 2016. The estimated overpayment amount of $96,892.92 was calculated by extrapolating the dollar value of the errors in the sample, identified in Appendix B, across the population from which the sample was selected. The overpayment was calculated using the lower limit of a two-sided 80 percent confidence interval.

Best Med has been kept apprised of all aspects of the audit process, and has been provided multiple opportunities to provide relevant documentation and information in order to ensure audit issues are accurate.

Opportunities to provide relevant documentation extended to the draft audit report stage. The draft audit report stage is the final opportunity for Best Med to provide additional relevant documentation, including sufficient evidence that would support the removal of identified errors on which the identified overpayment in this report is based. Errors occurring in September 2013 were removed based on records retention requirements at the draft audit stage, the overpayment amount was recalculated and a new extrapolation is provided with the final audit report.

The Texas Legislature has recognized HHSC OIG's authority to utilize a peer reviewed sampling and extrapolation process. HHSC OIG has formally adopted RAT-STATS software as the statistical software to be utilized for the extrapolation process, to be consistent with the Office of Inspector General for the United States Department of Health and Human Services. The Association of Inspectors General concluded a peer review of this process on January 7, 2016, and opined that OIG met all relevant policies, procedures, and AIG standards for the period under review.

Appendix B: Claims Subject to Extrapolation

The table below provides details about the claims filed and paid in error for the following issues discussed in the report.

Issue 1: Missing Supporting Documentation
Issue 2: Incorrect Prescriber Identification Numbers
Issue 3: Incorrect Prescription Issuance Date
Issue 4: Missing Medication Invoice
Issue 5: Incorrect Medication Quantities (dispensing fee)

Sample Number	Prescription Number	Fill Date	Issue Number	Overpayment Amount
12	[redacted]	10/6/2013	3	$ 321.82
18		10/24/2013	5	9.09
21		10/22/2013	2	1,742.29
32		1/2/2014	1	314.92
33		1/7/2014	1	82.39
46		2/28/2014	1	4,797.10
53		5/12/2014	2, 4	26.54
55		5/14/2014	5	6.97
57		6/4/2014	5	14.01
58		5/21/2014	1	10.91
67		7/11/2014	1	394.87
69		7/18/2014	2	509.20
77		11/14/2013	3	317.78
85		10/26/2014	2	267.47
86		10/11/2014	2	5,787.49
106		2/19/2015	3	121.78
114		4/11/2016	1	934.61
119		6/2/2016	3	15.70
Total				$15,674.94

Source: OIG Audit Division

Appendix C: Claims Subject to Administrative Penalty

The following errors identified in the following issue may constitute proper bases for assessing penalties:

Issue 4: Missing Medication Invoice

Sample Number	Prescription Number	Fill Date
13	[redacted]	10/8/2013
14		10/8/2013
15		10/20/2013
16		10/22/2013
17		10/22/2013
19		10/27/2013
20		10/29/2013
22		11/10/2013
23		11/11/2013
24		11/12/2013
25		11/19/2013
26		11/22/2013
27		11/25/2013
28		11/27/2013
29		12/4/2013
30		12/10/2013
31		12/20/2013
34		1/11/2014
35		1/14/2014
36		1/21/2014
37		1/21/2014
38		1/26/2014
39		11/13/2013
40		1/28/2014
41		1/28/2014
42		1/28/2014
43		1/30/2014
44		2/12/2014
45		2/25/2014
47		3/7/2014
48		3/25/2014
49		3/27/2014
50		11/15/2013

Sample Number	Prescription Number	Fill Date
51	[redacted]	4/13/2014
52		4/29/2014
54		5/12/2014
56		5/23/2014
59		6/15/2014
60		4/24/2014
61		5/22/2014
62		5/26/2014
63		7/8/2014
64		7/8/2014
65		7/2/2014
66		7/9/2014
68		7/18/2014
70		7/22/2014
71		7/25/2014
72		7/26/2014
73		8/16/2014
74		8/21/2014
75		8/23/2014
76		9/3/2014
78		9/9/2014
79		9/10/2014
80		9/16/2014
81		9/28/2014
82		10/19/2014
83		10/24/2014
84		10/25/2014
87		11/4/2014
88		11/8/2014
89		11/13/2014
90		11/13/2014
91		11/16/2014
92		11/18/2014
93		11/19/2014
94		11/25/2014
95		12/28/2014
96		12/29/2014
97		12/30/2014
98		1/7/2015
99		1/10/2015

Sample Number	Prescription Number	Fill Date
100	[redacted]	1/16/2015
101		1/17/2015
102		1/12/2015
103		1/23/2015
104		1/25/2015
105		2/15/2015
107		2/21/2015
108		2/22/2015
109		10/8/2014
110		2/24/2015
111		3/6/2015
112		1/12/2015
113		7/7/2015
115		3/8/2016
116		5/2/2016
117		4/26/2016
118		8/3/2016
120		8/16/2016

Source: OIG Audit Division

Appendix D: Report Team and Distribution

Report Team

OIG staff members who contributed to this audit report include:

- Kacy J. VerColen, CPA, Audit Director
- Lisa Kanette Blomberg, CPA, Audit Manager
- Maria M. Johnson, CFE, Audit Project Manager
- Jesus Vega, CIGA, Senior Auditor
- TiAnna Riddick, Associate Auditor
- Mo Brantley, Senior Audit Operations Analyst

OIG Support

- Rolando Delgado, Data Intelligence Analyst

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- Stephanie Muth, State Medicaid Director, Medicaid and CHIP Services
- Katherine Scheib, Deputy Associate Commissioner, Medicaid and CHIP Services
- Gina Marie Muniz, Director, Vendor Drug Program, Medicaid and CHIP Services
- Priscilla Parrilla, Director, Pharmacy Operations, Vendor Drug Program

- Robin Agnew, Director, Cross Coordination and Pharmacy Benefit Oversight, Vendor Drug Program
- Kimberly Royal, Manager, Contract Compliance and Performance Management, Medicaid and CHIP Services

Best Med

- Joe Riley, Owner and Pharmacist-in-Charge
- Hilton Wise, Co-Owner

Appendix E: OIG Mission and Contact Information

The mission of OIG is to prevent, detect, and deter fraud, waste, and abuse through the audit, investigation, and inspection of federal and state taxpayer dollars used in the provision and delivery of health and human services in Texas. The senior leadership guiding the fulfillment of OIG's mission and statutory responsibility includes:

- Sylvia Hernandez Kauffman, Inspector General
- Susan Biles, Chief of Staff
- Dirk Johnson, Chief Counsel
- Christine Maldonado, Chief of Operations and Workforce Leadership
- Olga Rodriguez, Chief of Strategy and Audit
- Quinton Arnold, Chief of Inspections and Investigations
- Steve Johnson, Interim Chief of Medicaid Program Integrity
- Tony Owens, Deputy IG for Third Party Recoveries
- David Griffith, Deputy IG for Audit
- Alan Scantlen, Deputy IG for Data and Technology
- Lizet Hinojosa, Deputy IG for Benefits Program Integrity
- Judy Hoffman-Knobloch, Assistant Deputy IG for Medical Services

To Obtain Copies of OIG Reports

- OIG website: https://oig.hhsc.texas.gov

To Report Fraud, Waste, and Abuse in Texas HHS Programs

- Online: https://oig.hhsc.texas.gov/report-fraud
- Phone: 1-800-436-6184

To Contact OIG

- Email: OIGCommunications@hhsc.state.tx.us
- Mail: Texas Health and Human Services Commission
  Office of Inspector General
  P.O. Box 85200
  Austin, Texas 78708-5200
- Phone: 512-491-2000