TEXAS HEALTH AND HUMAN SERVICES COMMISSION

OFFICE OF INSPECTOR GENERAL

AUDIT OF PREMIER CARE PHARMACY SERVICES

A Texas Vendor Drug Program Provider

July 31, 2018

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WHY THE OIG CONDUCTED THIS AUDIT

The Texas Vendor Drug Program (VDP) provides statewide access to covered outpatient drugs for individuals enrolled in Medicaid, the Children's Health Insurance Program, the Children with Special Health Care Needs program, the Healthy Texas Women program, and the Kidney Health Care program.

The objectives of this audit were to determine whether Premier Care Pharmacy Services (Premier Care) (a) properly billed VDP for Medicaid claims submitted and (b) complied with selected contractual and Texas Administrative Code (TAC) requirements.

Premier Care processed 9,693 Texas Medicaid claims for prescriptions through VDP during the audit period of March 1, 2012, through February 28, 2015. Premier Care received reimbursements of more than $34 million from Texas Medicaid as the result of these claims.

WHAT THE OIG RECOMMENDS

Premier Care should obtain the prescriber's authorization for any changes in the quantity dispensed from the quantity prescribed. The dispensing fees associated with these claims are $658.61 and are subject to recovery.

After extrapolating the exceptions, the OIG determined that Premier Care owes the State of Texas $10,497.00.

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

WHAT THE OIG FOUND

Premier Care did not bill VDP properly, or comply with other contractual or TAC requirements, for 9 of 86 claims tested.

The OIG Audit Division tested Premier Care's compliance with contractual and TAC requirements in seven 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, (f) warehouse billing, and (g) acquisition cost. This report details results, issues, and recommendations in those areas, when applicable, and the results of limited testing of information technology (IT) general controls.

The testing resulted in no findings related to claims validity, NDC usage, refills, controlled substances, warehouse billing, or acquisition cost. Based on the results of the IT general controls review, the data provided was considered sufficiently reliable for the purposes of this audit. There were exceptions related to quantity errors, as detailed below.

Auditors identified nine exceptions in which Premier Care dispensed a different quantity of medication than was ordered by the prescribing physician without obtaining authorization for the change in quantity. The dollar value of the prescription exceptions totaled $31,673.33. The OIG determined the amount owed is $10,497.00, which represents extrapolated dispensing fees, after considering the following.

In general practice and with approval of the Texas State Board of Pharmacy (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."

VDP has indicated it will review the Pharmacy Board rule change, once made, and consider whether any guidance to VDP providers or VDP rule changes are needed.

The OIG Audit Division reviewed Premier Care's management response and participated in meetings involving Premier Care and VDP staff to discuss the findings. Since the errors result from a violation of VDP rules, OIG determined the finding should remain in the report.

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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 Premier Care Pharmacy Services (Premier Care), a Texas Vendor Drug Program (VDP) provider, vendor number 145532.

Objectives and Scope

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

The audit scope included all initial fill claims for the period from March 1, 2012, through February 28, 2015, and a review of relevant activities, internal controls, and IT general controls through the end of fieldwork in June 2017.

Background

VDP provides statewide access to covered outpatient drugs for individuals enrolled in Medicaid, the Children's Health Insurance Program (CHIP), the Children with Special Health Care Needs program, the Healthy Texas Women program, and the Kidney Health Care program.

Premier Care, a retail pharmacy located in Austin, Texas, operates under license number 24038 from the Texas State Board of Pharmacy (Pharmacy Board). Premier Care processed 9,693 Medicaid claims for prescriptions through VDP during the audit period, for which it received reimbursements of more than $34 million.

The OIG Audit Division conducted the audit in accordance with generally accepted government auditing standards issued by the Comptroller General of the United States. Unless otherwise described, any year that is referenced is the state fiscal year, which covers the period from September 1 through August 31.

The OIG Audit Division presented preliminary audit results, issues, and recommendations to Premier Care in a draft report on November 10, 2017. Premier Care provided responses to the audit finding and additional documentation Premier Care believed would remove the current finding, and proposed an action plan to address the situation going forward. These responses are included after Recommendation 1.

The OIG Audit Division reviewed the additional documentation provided by Premier Care and determined the finding should remain in the report. The errors

identified in the finding resulted from a violation of TAC, and the additional documentation failed to demonstrate that the violation had not occurred.

AUDIT RESULTS

VDP pharmacy providers must follow TAC and contract provisions when filling, dispensing, and billing for prescriptions. The Pharmacy Board and VDP rules require prescriptions to include specific elements to be valid. The OIG Audit Division tested Premier Care's compliance in seven 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, (f) warehouse billing, and (g) acquisition cost. This report details results, issues, and recommendations in those areas, when applicable, and the results of limited testing of information technology (IT) general controls, performed to determine whether data used to form audit conclusions was reliable.

The OIG Audit Division obtained claims data for testing from the Xerox Pharmacy Claims Data Warehouse using the Texas VDP PBM Universe table, which contains all pharmacy claims information. The data request was for Medicaid fee-for-service only paid claims for the audit period. Given the total number of claims submitted by Premier Care, the OIG Audit Division determined it would be administratively infeasible to review every claim in the population. The OIG Audit Division therefore selected a statistically valid random sample of 86 claims to test. The OIG Audit Division visited the pharmacy to review the records during March 2017.

The testing resulted in no findings related to claims validity, NDC usage, refills, controlled substances, warehouse billing, or acquisition cost, and there were no findings related to IT general controls. There were exceptions related to quantity errors.

QUANTITY

VDP participating pharmacies are contractually required to maintain documents to support Medicaid claims. VDP participating pharmacies are also contractually required to follow Pharmacy Board rules and regulations, VDP rules and regulations, and Title 3 of the Texas Occupations Code as applicable and in effect at the time service is provided.[1] 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. Quantity changes made to comply with Medicaid limitations for reimbursement purposes do not override the pharmacist's obligation to obtain the prescribers authorization for quantity changes.

[1] Vendor Drug Program Pharmacy Provider Contract #145532, Part 3 (M)(11) (Mar. 2006).

Finding 1: Medication Was Dispensed in Quantities Other Than Prescribed

Premier Care dispensed a different quantity of medication than was ordered by the prescribing physician for 9 of 86 claims tested. VDP was billed and paid $31,673.33 for these claims.

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."[2]

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 Premier Care did not follow TAC or VDP rules when processing the nine 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.

VDP has indicated it will review the Pharmacy Board rule change, once made, and consider whether any guidance to VDP providers or VDP rule changes are needed. Claim details related to this finding are listed in Appendix C.

Recommendation 1

Premier Care should ensure that all claims are supported and fully documented, and that any changes in the quantity dispensed from the quantity prescribed are authorized from the prescribing physician and adequately documented prior to dispensing. The dispensing fees associated with these claims are $658.61 and are subject to recovery.

[2] 1 Tex. Admin. Code § 354.1901(b) (June 19, 2003, through May 14, 2016), 22 Tex. Admin. Code § 291.34(b)(5)(A) (Nov. 24, 2011, through Sept. 7, 2013), and 22 Tex. Admin. Code § 291.34(b)(6)(A) (Sept. 8, 2013, through June 11, 2014).

After extrapolating, the OIG determined that the exceptions represented an overpayment of $10,497, which Premier Care should repay to the State of Texas. See Appendix B for the sampling and extrapolation methodology.

Management Response

Action Plan

Recommendation 1 directs that "Premier Care should ensure that all claims are supported and fully documented, and that any changes in the quantity dispensed from the quantity prescribed are authorized from the prescribing physician and adequately documented prior to dispensing. The dispensing fees associated with these claims are $658.61 and are subject to recovery." Recommendation 1 goes on to extrapolate the dispensing fees to calculate an alleged overpayment of $10,497.

Premier Kids Care, Inc. DBA Premier Care (PKC) welcomes the reduction in alleged overpayment from the preliminary report, but any payment by PKC of the revised alleged overpayment amount is not an admission of liability and should not be characterized as such. PKC does not agree that the OIG should recoup dispensing fees on the nine alleged audit exceptions, or that the dispensing fees connected therewith should be extrapolated. Communications with the Texas State Board of Pharmacy, and subsequent communications issued to the pharmacy community by Vendor Drug indicate that the process followed by PKC is allowed by the Texas State Board of Pharmacy, and that VDP's process is "unclear."

In its original response to the Draft Report dated November 30, 2017, PKC stated that it has always filled prescriptions consistent with the physician's instruction, but also in a manner that would properly process the claims within the benefits limits of the VDP software system. In fact, PKC reported that it was routinely directed by VDP personnel to meet both physician directives and VDP benefits limitations, and PKC contends that it did so regarding the claims in the audit. As noted in this response, the "written prescription vs. benefits limitation" issue flagged by the OIG remains a lingering concern today, but it is a benefits payment processing issue, not a prescription problem.

We appreciated OIG's participation at the April 2018 meeting with Vendor Drug. As you are aware, Vendor Drug acknowledged that the provider helpline sponsored by Vendor Drug did advise providers to go ahead and back down the quantities on a 90 day prescription (for example) so that the IT payment would process appropriately, rather than requiring that the pharmacy provider recontact the prescribing physician—a process acknowledged by all to be unworkable, and, as PKC pointed out, could also put Medicaid beneficiaries at risk of harm and at full risk of disparate treatment when compared with Texas Medicaid managed care (MCO) beneficiaries, since all of the providers serving MCO beneficiaries routinely approve the process already used by PKC.

However, in an effort to address the OIG audit results while ensuring that patients' continuity of care is not affected, PKC will immediately take these steps to dispense medication through the Vendor Drug portal:

1. *PKC will load all prescriptions into its Pharmacy Management Software exactly as written by the physician. If the patient agrees to receive the prescription as written, PKC will then attempt to adjudicate the prescription as it is written.*

2. *If the patient requests that the prescription be filled in quantities less than that prescribed, or if the claim is rejected, PKC will call VDP. If it is determined that the claim should be "backed down" or "dispensed in a smaller quantity" in order to be approved, PKC will follow the instructions of the VDP representative.*

3. *On the call, the Pharmacist or Pharmacy Technician shall receive and note the following information in the patient's pharmacy record: the date of and reference number of the call to VDP, the name of the VDP representative taking the call, and the instruction from the VDP representative stating what action should be taken on the claim.*

Once documented in the patient's pharmacy record, the PKC Pharmacist shall change the prescription in the patient's profile to ensure the patient receives the correct number of refills going forward.

We appreciate the acknowledgement by all agencies involved that the Texas State Board of Pharmacy already permits a pharmacy to back down a prescription to smaller dispensing units without prescriber or patient prior authorization.

Responsible Managers

Director of Operations will be in charge to oversee that this process is implemented.

Corporate Compliance Officer and Auditing RPh will assist in training, perform random audits to ensure compliance of new implemented processes.

PKC PIC will ensure when RX's are entered into QS1 that they match how the MDO prescribed the prescription.

Target Implementation Date

PKC will begin the process laid out in this response by July 15, 2018 to allow for adequate training. Please share this response with Vendor Drug, so that Vendor Drug is apprised of PKC's implementation of its recommended approach.

Auditor Comment

VDP rules require pharmacies to follow the Pharmacy Board rules as those rules are written in TAC. VDP also requires pharmacies to submit Medicaid claims consistent with the information contained on a written prescription, including the quantity notated on the prescription. If the claim is rejected, the pharmacy should call the HHS Pharmacy Benefits Access Help Desk (Help Desk) to discuss the specific claim and receive instruction on how to submit the claim to receive payment.

According to VDP system records, Premier Care submitted one of the nine claims to reflect the written prescription. The claim rejected, and Premier Care contacted the Help Desk. The Help Desk indicated that the claim would process if the quantity on the prescription was reduced to no more than a one-month supply, and submitted as three separate claims to equal a three-month supply. Premier Care submitted another claim that rejected, but did not call the Help Desk.

For the seven other prescriptions, Premier Care reduced the quantities to no more than a one-month supply and submitted three separate claims for each three-month supply prescription, without submitting a claim for the original prescription quantity and without calling the Help Desk.

The guidance given by the Help Desk to reduce the quantity was intended to assist Premier Care in addressing the claims that failed to process. However, Premier Care should ensure, when making changes that allow a claim to process, that it continues to comply with TAC, which requires quantity changes to be approved by the prescribing physician.

CONCLUSION

The OIG Audit Division completed an audit of Premier Care. The audit evaluated Premier Care to determine whether it properly billed VDP and complied with contractual and TAC requirements. The OIG Audit Division evaluated IT general controls to determine whether data used for audit testing was reliable. The OIG Audit Division conducted site visits in March, May, and June 2017.

Premier Care did not bill VDP properly, or comply with other contractual or TAC requirements, for 9 of 86 claims. Based on the results of the IT general controls testing, the data was sufficiently reliable for the purposes of the audit.

In all nine exceptions noted, Premier Care dispensed medication in a quantity less than that ordered by the prescribing physician. The Pharmacy Board accepts this general practice by pharmacists, however, the VDP program requires pharmacies to follow the TAC rules as written. The OIG determined the recoupable amount is dispensing fees extrapolated to the population tested. Premier Care owes the State of Texas $10,497.

The OIG Audit Division offered recommendations to Premier Care which, if implemented, will correct deficiencies in compliance with contractual and TAC requirements.

The OIG Audit Division thanks management and staff at Premier Care, including its corporate management team, for their cooperation and assistance during this audit.

Appendix A: Objective, Scope, and Methodology

Objectives

The objectives of this audit were to determine whether Premier Care (a) properly billed VDP for Medicaid claims submitted and (b) complied with contractual and TAC requirements.

Scope

The audit scope included all initial fill claims the period from March 1, 2012, through February 28, 2015, and a review of relevant activities, internal controls, and IT general controls through the end of fieldwork in June 2017.

Methodology

To accomplish the audit objectives, the OIG Audit Division collected information for this audit through discussions and interviews with Premier Care management and staff and by reviewing:

- Supporting documentation for a sample of all initial fill claims billed to VDP during the audit scope
- Policies and procedures of Premier Care
- Premier Care IT general controls

The OIG Audit Division issued an engagement letter on March 16, 2017, to Premier Care providing information about the upcoming audit, and conducted fieldwork at the Austin, Texas, facility from May 15, 2017, through May 19, 2017. While on site, the OIG Audit Division interviewed responsible personnel, evaluated internal controls and the facility, and reviewed relevant documents related to sampled claims billed to VDP.

Auditors did not remove original records from the Premier Care premises. During fieldwork, auditors requested additional documents, which Premier Care provided.

Criteria

The OIG Audit Division used the following criteria to evaluate the information provided:

- 21 C.F.R. § 1311.200(f) (2010)
- 1 Tex. Admin. Code § 354.1901(b) (2003 through 2016)
- 22 Tex. Admin. Code § 291.34(b)(5)(A) (2011 through 2013) and 22 Tex. Admin. Code § 291.34(b)(6)(A) (2013 through 2014)
- Vendor Drug Program Pharmacy Provider Contract #145532 (2006)

Auditing Standards

Generally Accepted Government Auditing 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.

Appendix B: Sampling and Extrapolation Methodology

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 random sample of 86 claims to test. The following query parameters are provided for replication purposes.

A line item detailed query was run in the Xerox Pharmacy Claims Data Warehouse using the Texas VDP PBM Universe table. The data pull was for fee-for-service only paid claims for the audit scope and did not include refills.

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 Refils 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

Query Filters Included:

- Date of Service (between 03/01/2012 and 02/28/2015)
- TX Status Code (equal to PD)
- Batch Doc. Type Code (equal to C)
- Group ID (equal to V)
- Pharmacy ID (equal to 1447321674)

The OIG provided Premier Care 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 included in this audit consists of claims for initial fill claims with dispensing dates between March 1, 2012, and February 28, 2015. The estimated overpayment amount of $10,497 was calculated by extrapolating the dispensing fee dollar value of the errors as identified in Appendix C across the population for this audit at the time of the draft report. The overpayment was calculated using the lower limit of a two-sided 80 percent confidence interval.

Premier Care 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 findings are accurate.

Opportunities to provide relevant documentation extend to the draft audit report stage. The draft audit report stage is the final opportunity for Premier Care 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. If errors are removed based on sufficient additional evidence being provided at the draft audit stage, the overpayment amount is recalculated and a new extrapolation is provided with the final audit report. If Premier Care does not provide additional documentation sufficient to remove an identified error, as part of its management response to the draft report, then the audit report is finalized.

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 HHSC OIG met all relevant policies, procedures, and AIG standards for the period under review.

Appendix C: Prescriptions Paid in Error

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

Finding 1. Medication was dispensed in quantities other than prescribed

Prescription Number	Fill Date	Finding Number	Amount Paid	Dispensing Fee
[redacted]	7/16/2012	1	$ 1,566.55	$ 37.20
	2/11/2013	1	10,926.23	200.00
	1/14/2013	1	1,281.93	31.62
	7/29/2013	1	1,269.02	31.37
	9/25/2013	1	4,991.92	104.34
	11/15/2013	1	1,269.01	31.37
	12/30/2013	1	1,707.03	39.95
	12/27/2013	1	3,201.70	69.25
	11/4/2014	1	5,459.94	113.51

Source: OIG Audit Division

Appendix D: Report Team and Distribution

Report Team

The OIG staff members who contributed to this audit report include:

- Kacy J. VerColen, CPA, Audit Director
- Kanette Blomberg, CPA, CIGA, Audit Manager
- Jerry Ethridge, CIA, CGAP, CRMA, Audit Project Manager
- Melissa Stice Larson, CIA, CISA, CFE, HCISPP, IT Audit Manager
- Amy Behrens, MBA, CIA, CIPP, IT Audit Project Manager
- Carol Barnes, CIGA, Staff Auditor
- Adebukola Salawu, MBA, CIGA, Staff Auditor
- Mo Brantley, Senior Audit Operations Analyst

OIG Support

- Rolando Delgado, Data Intelligence Analyst
- Katie Reyes, Data Intelligence Analyst

Report Distribution

Health and Human Services

- Cecile Erwin Young, Acting Executive Commissioner
- Kara Crawford, Chief of Staff
- Victoria Ford, Chief Policy Officer
- Karen Ray, Chief Counsel
- Karin Hill, Director of Internal Audit
- Enrique Marquez, Chief Program and Services Officer, Medical and Social Services Division
- 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 and Contract Oversight, Vendor Drug Program
- Robin Agnew, Manager, Vendor Drug Program, Medicaid and CHIP Services
- Kimberly Royal, Manager, Contract Compliance and Performance Management, Medicaid and CHIP Services
- Lisa Cruz Hidrogo, Special Projects Manager, Medicaid and CHIP Services

Premier Care

- Mickey Benson, Director of Operations
- Brian Dalton, Compliance Officer
- Lindsey Carreker, Director of Sales
- Phoung Pham, Director of Pharmacy

Appendix E: OIG Mission and Contact Information

The mission of the 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
- Anita D'Souza, Chief of Staff and Chief Counsel
- Olga Rodriguez, Chief Strategy Officer
- Christine Maldonado, Chief of Operations and Workforce Leadership
- Brian Klozik, Deputy IG for Medicaid Program Integrity
- Lizet Hinojosa, Deputy IG for General Investigations
- David Griffith, Deputy IG for Audit
- Quinton Arnold, Deputy IG for Inspections and Interim Deputy IG for Investigations
- Alan Scantlen, Deputy IG for Data and Technology
- Judy Hoffman-Knobloch, Assistant Deputy IG for Medical Services

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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 the OIG

- Email: OIGCommunications@hhsc.state.tx.us
- Mail: Texas Health and Human Services Commission
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  P.O. Box 85200
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