Office of Inspector General

Health and Human Services Commission

Stuart W. Bowen Jr., Inspector General

Performance Audit Report

Maritime Pharmacy

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EXECUTIVE SUMMARY

The Health and Human Services Commission (HHSC), Inspector General (IG) Audit Division, has completed its performance audit of Maritime Pharmacy (Vendor), contract number 144914, as specified in the Texas Administrative Code (TAC), Title 1, Part 15, Chapter 354, Subchapter F, Division 5, Section 354.1891.

Objectives

The objectives of the audit were to determine if the Vendor billed accurately the Texas Medicaid Vendor Drug Program (VDP) and complied with contractual requirements and the TAC rules.

Background

As part of the Texas Medical Assistance Program operated in accordance with the Title XIX of the Social Security Act, the VDP provides statewide outpatient pharmaceutical services to eligible recipients. Pharmaceutical services include the preparation, packaging, compounding, and labeling of covered legend and nonlegend drugs that appear in the latest revision of the Texas Drug Code Index. Contracted pharmacies and pharmacists provide the pharmaceutical services and submit claims for reimbursement to the HHSC through an electronic adjudication system. Payments made to the Vendor during the audit period reviewed totaled $2,252,880.28.

Summary of Scope and Methodology

The engagement covered the period of September 1, 2009 through February 29, 2012 and included obtaining an understanding of internal controls limited to the objectives described above. Additionally, IG examined pharmacy prescriptions, daily logs, and other applicable accounting records that supported the claims submitted for reimbursement. For sampling methodology, see Appendix B.

IG conducted this performance audit in accordance with Generally Accepted Government Auditing Standards. Those standards require that IG plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for the findings and conclusions based on our audit objectives. IG believes the evidence obtained provides the basis for our findings and conclusions.

Conclusions

The Vendor accurately billed the Texas Medicaid Vendor Drug Program (VDP) and complied with contractual requirements and the TAC rules.

DETAILED FINDINGS

Invalid Claims: Missing Prescriptions For Three Claims

Prescription records were unavailable to support three claims. Vendor did not maintain prescriptions for three claims. Dispensing medication without a prescription does not comply with established guidelines and results in an overpayment of Medicaid funds. Texas Administrative Code Title 1. Part 15, Chapter 354, Subchapter F, division 4 Rule §354.1863 states: "(a) Payment for pharmaceuticals can be made only when these pharmaceuticals are prescribed by a practitioner licensed to prescribe legend drugs. (b) The pharmacist must ensure that the original prescription conforms to the Texas State Board of Pharmacy rules concerning the records to be maintained by a pharmacy. A signed prescription must be maintained in the dispenser's file and available for audit at any reasonable time."

Recommendation
Vendor should ensure that prescriptions are maintained as required by Texas Administrative Code.

Management's Response
No written response was provided by Vendor. The Vendor only provided copies of documentation related to the prescriptions in question.

Auditor's Follow-Up Comment
The IG reviewed the documents provided. The submitted documentation did not resolve the missing prescriptions. The finding remains unchanged.

Quantity Errors: Unauthorized Quantity Increase For Four Claims

Vendor increased the prescribed quantity for four claims without documented authorization from the prescribing physician. Changes to medication quantities by anyone other than the prescriber or designee are unauthorized and ineligible for payment. The Vendor received overpayments for the unauthorized additional quantities. Texas Administrative Code Title 1. Part 15, Chapter 354, Subchapter F, division 6 Rule 354.1901 states: "b) Providers must dispense the quantity prescribed or ordered by the prescriber except as limited by the policies and procedures described in the Commission's Pharmacy Provider Handbook..."

Recommendation
Vendor should dispense quantity prescribed by physician or document authorized quantity changes as required by Texas Administrative Code.

Management's Response
No written response was provided by Vendor. The Vendor only provided copies of documentation related to the prescriptions in question.

Auditor's Follow-Up Comment
The IG reviewed the documents provided. Vendor submitted attestations from the Prescribing Physician that did not address nor approve of the increase in quantity prescribed. The finding remains unchanged.

Billing Errors: No Supporting Invoice For Five Claims

Vendor dispensed medication that could not be supported by invoice supporting purchase of medication for five claims. The missing invoices prevented verification that dispensed medications met the packaging and pricing requirements set forth by the Vendor Drug Program, resulting in overpayments to the Vendor. Texas Health and Human Services Commission, Title XIX Vendor Drug Program Pharmacy Provider Contract states "H. 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: 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."

Recommendation
Vendor should maintain records including invoices supporting medication purchases.

Management's Response
No written response was provided by Vendor. The Vendor only provided copies of documentation related to the prescriptions in question.

Auditor's Follow-Up Comment
The IG reviewed the documents provided. Vendor submitted one invoice that addressed one prescription in question resulting in the dispensing fee only being withheld. One invoice submitted did not match the National Drug Code number of the prescription in question. One invoice was dated more than one year before the prescription in question. One invoice along with invoice information provided on site did not indicate adequate supplies of medication to support medication dispensed. There was no invoice submitted for the remaining prescription in question. The finding remains unchanged with the exception of one prescription being reduced to the dispensing fee.

APPENDICES

APPENDIX A

OBJECTIVES, SCOPE, AND METHODOLOGY

Objectives

The objectives of the audit were to determine if the Vendor accurately billed the Texas Medicaid VDP and complied with contractual requirements and the TAC rules.

Scope

The engagement covered the period of September 1, 2009 through February 29, 2012. During the engagement, IG did not review all internal controls. IG limited the internal control review to the objectives described above.

Methodology

An engagement letter was issued to the Vendor outlining the understanding of the IG with respect to the audit of paid claims submitted by the Vendor for reimbursement. To obtain an understanding of the Vendor's internal controls, an internal control questionnaire was completed and observations were made throughout the audit. Additionally, IG examined prescriptions, daily logs, and other applicable accounting records that supported the claims submitted for reimbursement. Professional judgment was exercised in planning, executing, and reporting the results of our audit.

Audit Criteria

- Texas Administrative Code, Title 1, Part 15, Chapter 354, Subchapter F, Divisions 1 through 7, Sections 354.1801 through 354.1928; Chapter 355, Subchapter J, Division 28
- Texas Vendor Drug Contract for Maritime Pharmacy
- Vendor Drug Program Pharmacy Provider Handbook, March 1, 2006
- Texas Drug Code Index
- Texas State Board of Pharmacy rules and regulations
- Health and Safety Code, Title 6, Subtitle C, Chapter 481, Subchapter A
- Revisions and updates to the aforementioned materials and information
- Notices or bulletins issued by the VDP concerning Medicaid pharmaceutical drug benefits

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Other Information

Fieldwork was conducted from October 27, 2014 through November 18, 2014.

APPENDIX B

SAMPLING METHODOLOGY

Summary of Sample Methodology

IG used statistically valid random sampling to determine the extent to which the Vendor correctly billed the VDP for Medicaid prescription claims. IG conducted its sampling methodology in accordance with guidance from CMS Medicare Program Integrity Manual Chapter 8 - Administrative Actions and Statistical Sampling for Overpayment Estimates and guidance issued by the American Institute of Certified Public Accountants and Statements on Auditing Standards (SAS), Number 39. In order to ensure proper evaluation of the entire population, IG divided the population into three groups, a population for low dollar transactions, a population for medium dollar transactions, and a population for high dollar transactions. The low and medium populations were then split into 13 strata. Sample sizes were calculated for each stratum in the low and medium population groups. In any stratum containing only a single sample item, extrapolation was excluded for that stratum and any errors were calculated on a dollar-for-dollar basis to determine the final extrapolated recoupment amount owed. To determine the final extrapolated recoupment amount owed by the Vendor, IG utilized RAT-STATs Stratified Variable Appraisal functionality to evaluate the results of the low and medium samples. The results for the low, medium, and high dollar populations can be found in Tables A, B, and C respectively.

Sample Results

To achieve valid sampling results, the population was separated into low, medium, and high dollar claims. To determine the dollar value of billing errors, IG tested 266 claims, of which 12 constituted findings. Of the 266 claims, 153 were low dollar, 110 were medium dollar, and 3 were high dollar. The low and medium dollar claims were selected for testing based on statistically valid random sampling. Of the 12 findings, four were from the low dollar claims, eight were from the medium dollar claims, and zero from the high dollar claims. The findings for low dollar and medium dollar claims were categorized in two parts, a dollar-for-dollar population and an extrapolated population. The findings for high dollar claims were tested only on a dollar-for-dollar basis. The low dollar tested claims consisted of 3 dollar-for-dollar tested claims from the dollar-for-dollar population and 150 randomly sampled claims from the extrapolated population. The medium dollar tested claims consisted of 2 dollar-for-dollar tested claim from the dollar-for-dollar population and 108 randomly sampled claims from the extrapolated population. The high dollar tested claims consisted of 3 dollar-for-dollar tested claims from the dollar-for-dollar population. The total recoupment amount for the low dollar sample was calculated to be $4,068, the medium dollar sample totaled $3,063.47, and the high dollar sample totaled $0.00, for a total combined recoupment amount of $7,131.47 (Table A, B, and C).

During the engagement, IG identified the following instances of noncompliance for the claims:

Finding Type	Low Dollar Findings	Medium Dollar Findings	Total Findings
Invalid Claim			
Missing Prescription	0	3	3
Quantity Error			
Unauthorized Quantity Increase	0	4	4
Billing Error			
No Supporting Invoice	4	1	5
Total	4	8	12

See the Detailed Findings section of this report for details.

Sampling Frame

The sampling frame (population) was the Vendor's claims paid by the HHSC that had a "Date of Service" in the audit period of September 1, 2009 through February 29, 2012. The low dollar sample frame consisted of all paid claims less than or equal to $249.59. The medium dollar sample frame consisted of all paid claims greater than $249.59 and less than or equal to $777.68. The high dollar sample frame consisted of all paid claims greater in amount than $777.68

Sample Unit

The sample unit was a paid claim. A paid claim is a prescription dispensed to a Medicaid recipient by a contracted Vendor or Pharmacist for which the HHSC paid the Vendor, and the "Date of Service" was in the audit period of September 1, 2009 through February 29, 2012.

Table A

Total Population Paid and Recoupment Statistics (Low Dollar)

Total Paid Dollar Amount in Extrapolation Population	$1,795,307.14
Total Paid Dollar Amount in Dollar-For-Dollar Population	$343,229.74
Total Population Paid Dollar Amount	**$2,138,536.88**
Total Recoupment Amount from Extrapolation Population Using RAT-STATs 2007 Stratified Variable Appraisal (Calculated at lower limit of 90% confidence interval)	$4,068.00
Total Recoupment Amount from Dollar-For-Dollar Population	$0.00
Total Population Recoupment Amount	**$4,068.00**

Table B

Total Population Paid and Recoupment Statistics (Medium Dollar)

Total Paid Dollar Amount in Extrapolation Population	$108,014.87
Total Paid Dollar Amount in Dollar-For-Dollar Population	$3,482.67
Total Population Paid Dollar Amount	**$111,497.54**
Total Recoupment Amount from Extrapolation Population Using RAT-STATs 2007 Stratified Variable Appraisal (Calculated at lower limit of 90% confidence interval)	$2,422.00
Total Recoupment Amount from Dollar-For-Dollar Population	$641.47
Total Population Recoupment Amount	**$3,063.47**

Table C

Total Population Paid and Recoupment Statistics (High Dollar)

Total Paid Dollar Amount in Dollar-For-Dollar Population	$2,845.86
Total Population Paid Dollar Amount	**$2,845.86**
Total Recoupment Amount from Dollar-For-Dollar Population	$0.00
Total Population Recoupment Amount	**$0.00**

Please note: Additional details regarding the samples and extrapolations will be provided upon request.

APPENDIX C

Schedule of Findings
Maritime Pharmacy
Vendor Number: 144914
Over/Under Payments for Low Dollar Claims

Client Number	Prescription Number	Fill Date	Amount Paid	Audited Cost	Over/(Under) Payments	Comments
[redacted]	[redacted]	[redacted]	$10.95	$0.00	$10.95	No Supporting Invoice
[redacted]	[redacted]	[redacted]	9.75	0.00	9.75	No Supporting Invoice
[redacted]	[redacted]	[redacted]	14.12	0.00	14.12	No Supporting Invoice
[redacted]	[redacted]	[redacted]	10.88	3.17	7.71	No Supporting Invoice*
		Sub Total	$45.70	$3.17	$42.53	
		Total	$45.70	$3.17	$42.53	

*Dispensing Fee Withheld

Schedule of Findings
Maritime Pharmacy
Vendor Number: 144914
Over/Under Payments for Medium Dollar Claims

Client Number	Prescription Number	Fill Date	Amount Paid	Audited Cost	Over/(Under) Payments	Comments
[redacted]	[redacted]	[redacted]	$372.70	$129.34	$243.36	Unauthorized Quantity Increase
[redacted]	[redacted]	[redacted]	372.70	129.34	243.36	Unauthorized Quantity Increase
[redacted]	[redacted]	[redacted]	317.39	162.01	155.38	Unauthorized Quantity Increase
[redacted]	[redacted]	[redacted]	279.50	143.51	135.99	Unauthorized Quantity Increase
		Sub Total	$1,342.29	$564.20	$778.09	
[redacted]	[redacted]	[redacted]	$641.47	0.00	$641.47	Missing Prescription
[redacted]	[redacted]	[redacted]	276.93	0.00	276.93	Missing Prescription
[redacted]	[redacted]	[redacted]	276.93	0.00	276.93	Missing Prescription
		Sub Total	$1,195.33	$0.00	$1,195.33	
[redacted]	[redacted]	[redacted]	$380.05	0.00	$380.05	No Supporting Invoice
		Sub Total	$380.05	0.00	$380.05	
		Total	$2,917.67	$564.20	$2,353.47	

APPENDIX D

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