



RxPreferred Pharmacy Audits and Appeals Policy and Procedure – Provider Auditing Guidelines

Purpose:

Provide guidelines for pharmacies for audits and appeals of pharmacy audit findings resulting from RxPreferred Benefits auditor data review and claims selection for identification of potential fraud, waste and abuse (FWA) and/or non-compliance with the RxPreferred Benefits Pharmacy Network agreement/s.

Definitions:

Abuse includes actions that may, directly or indirectly, result in unnecessary costs, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are not medically necessary.

Adjudication is the process of completing all validity, process, and file edits necessary to prepare a claim for final payment or denial. It occurs in real-time and processes a prescription claims based on plan parameters and eligibility. Messages back to the pharmacy indicate payment parameters, plan edits, etc.

Audit is a formal review of processes to ensure pharmacy procedures are consistent with regulatory and contractual agreements. Audit types include desk top, onsite, pre-pay claims review and investigational.

Controlled Substances are drug products (Schedule I-V) and chemicals identified in the Controlled Substances Act, Title II and Title III of the Comprehensive Drug Abuse Prevention and Control Act of 1970. This law is a consolidation of numerous laws regulating the manufacture and distribution of narcotics, stimulants, depressants, hallucinogens, anabolic steroids, and chemicals used in the illicit production of controlled substances.

Desk Top Audit is an in-house retrospective audit done on adjudicated claims. It is sometimes referred to as Documentation and Verification (D&V) Audit.

Discrepancies are claims that appear to have unusual or potentially abusive, wasteful or fraudulent elements (e.g., quantity, days supply).

Documentation and Verification Audit (D&V) is an in-house retrospective audit done on adjudicated claims. It is sometimes referred to as a desktop audit.

Flags are the audit query edits used to pull claims for D&V and onsite audits. They are the RxPreferred Benefits proprietary indicators for potential fraud, waste and abuse and should be used as guides for marking claims.

Fraud is knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program to obtain (by means of false representations) any of the money or property owned by, or under custody or control of, any health care benefit program.

Investigational Audit is more extensive than a desk or onsite audit the process for this type of audit may vary depending on the situation being researched and/or the requestor of the research

Onsite audit is when an RxPreferred Benefits auditor schedules an appointment and goes onsite at the pharmacy. During the visit the auditor will review adjudicated claims against the original prescription, verify policies and procedures and do a brief interview with the pharmacist-in-charge. The auditor completes a report that identifies any issues, concerns or prescription discrepancies.

Pre-pay Claims Review is an audit of adjudicated claims prior to payment. The goal of the review is to identify claims with discrepancies such as quantity or excessive dosage and resolve concerns prior to payment. Claims are not adjusted, reversed or stopped at POS during pre-pay claims review. Waste is the over-utilization, misuse or squandering of resources (product or services) resulting in unnecessary costs.

Waste is generally not considered to be caused by criminally negligent actions rather it relates to mismanagement, inappropriate actions or oversight.

Guidelines:

Pre-payment Claim Review

1. The adjudicated claims are run through approximately 20 algorithms. The algorithms score or “flag” the claims with suspicious attributes and/or inappropriately submitted claims.
2. An auditor will contact pharmacies with discrepancies via phone or fax requesting the prescriber instructions for dispensed medication(s).
3. The auditor will strive to work with the pharmacy to correct the claims prior to payment processing.
4. The pre-payment claims review does not stop the claim. Therefore there is no disruption at the Point of-Service (POS). The pre-payment review algorithms reflect frequent typing errors (input errors) by pharmacists or pharmacy technicians that appear on approved claims.

Desk Audit

1. Data review and claim selection is a combination of electronic and manual procedures to identify potential cases of pharmacy error and/or fraud, waste and abuse. 100% of claims are subject to audit.
 - a. Claims selected may go back up to 18 months. Average is six (6) to nine (9) months.
 - b. Claims for desk audit are selected based on a combination of the flags, high dollar, duplicate claims and comparison with like claims, etc. Claims with discrepancies may result in a request for documentation.
 - c. Claims for onsite audit are selected based on desk audit results, Client input, member complaints and the RxPreferred Benefits proprietary Pharmacy Report Card. The Report Card reviews include, but are not limited to, DAW, compound percent, high dollar, numbers of prescriptions, member numbers, etc.

2. Request for documentation is sent to the pharmacy. Response is requested in 14 days. Documentation may be provided by fax, mail or e-mail. The documentation MUST include the audit number and auditor's name as listed on the audit letter. Appropriate documentation includes the following:

- a. Legible copy of original prescription (front and back)
- b. Telephone prescriptions must include all prescription information including date, drug, strength, quantity, days' supply, directions to the member, member information (date of birth), prescriber information, etc.
- c. Scanned copy of original prescription
- d. Electronic prescription or electronic medical record with transaction notes, date and time stamp
- e. Prescriber letter, medical record/physician orders or medical order (Prescriber letter must be on letterhead)
- f. Proof of pick-up or delivery of the prescription (fill or refill)
 1. Delivery log with signature or delivery time stamp
 2. Signature log

For the following pharmacies additional prescription information is required –

1. Long-term care pharmacies must also provide the medication order sheet from the facility requesting the refill with appropriate date and signature.
2. Compounding pharmacies must provide the compound "recipe" with the NDCs and quantity for each NDC used in the compound, use by date and storage instructions.
3. Home Infusion, intravenous (IV) pharmacies must provide turnaround time when requested by an auditor.

The following are NOT considered appropriate documentation:

- Pharmacy print screen of the prescription is not valid for an RxPreferred Benefits audit or for a CMS Validation Audit request.
- A prescription label.
- Telephone prescriptions without appropriate documentation (Member name, date-of-birth, prescriber's name, date of request, etc.).
- Transfer prescription without appropriate information (contact store information, date, directions, refills remaining, date, etc.).
- Prescriptions without directions to the patient/member. "As directed" is not acceptable EXCEPT in sliding scale insulin orders or with certain fertility products.

3. The auditor will review the documentation received. The auditor may ask for more information. A report is sent to the pharmacy via fax, e-mail or mail with the audit findings.

- a. If the documentation is accepted, the pharmacy will be notified by letter upon audit close.
- b. If the documentation is not accepted, the pharmacy will be notified that the claim/s may be reversed or adjusted depending on the discrepancy identified.
- c. If the auditor asks for more information, the pharmacy may be given up to 10 days to respond. The 10 days grace period is dependent on the discrepancy identified.

The following are NOT considered appropriate claims and will be adjusted or reversed:

- Infusion or vaccine claims identified as compound claims that are “mixed” or prepared by a home care provider or LTC home associate.
- Claims with incorrect prescriber identifiers.
- Claims with inappropriate use of Dispense as Written (DAW) codes.
- Claims with incorrect locator codes.

4. Pharmacies wishing to appeal audit findings have 30 days from the date of the audit close letter to appeal and to provide new or revised documentation. State laws may vary.

5. If the documentation is not received, the pharmacy will be notified by letter at audit close that the claim/s will be reversed or adjusted depending on the situation. The pharmacy may also be fined \$500 (See RxPreferred Benefits’ Pharmacy Network Policies and Procedures.)

6. Missing or undocumented prescriptions will be reversed.

Onsite Audit

1. Pharmacies are selected for onsite audit based on information received from clients or members, contractual requirements, standard network compliance and oversight.

2. The pharmacy will receive a letter approximately 15 to 30 days prior to the audit date. The letter will provide the following:

- a. Name and contact information for the assigned auditor.
- b. Date of the audit
- c. Date range of the hardcopy prescription review
- d. List of documents to be available for review on the day of the audit:
 - i. Written policies and procedures in regards to patient health information, fraud, waste, and abuse prevention, handling medication errors, return to stock policy, and the management of Controlled Substances.

- ii. Credentialing documents - DEA License, State License, Liability Insurance Certificate, Pharmacist in Charge (PIC) License and Board of Equalization Permit (CA Stores Only).
 - iii. Original prescriptions, signature logs and other documentation for/about the prescriptions.
3. One week, five (5) business days, before the onsite audit, the pharmacy will receive a masked list of prescriptions to be reviewed onsite. The pharmacy should begin pulling the appropriate records in preparation for the audit.
 4. On the day of the audit, the auditor will work with the pharmacy staff to make sure there is no disruption of the pharmacy work flow.
 5. The audit will last approximately three (3) hours. The pharmacy is given a preliminary report of the onsite and the claims discrepancies at the conclusion of the audit.
 6. Desk Audit items 1-3 discussed above also apply to onsite audits.
 7. During the observation portion of the audit, the Auditor will review the premises, stock availability, and other site-specific elements as may be identified by RxPreferred Benefits or regulatory agencies as necessary to ensure the safety of plan members and proper required activities and notifications. Observations may include, but are not limited to the following:
 - a. Review of the items listed in 2.d.;
 - b. Confirm Patient Counseling area;
 - c. Operational practices (eg., error reporting, HIPAA training, return to stock policy);
 - d. Physical hazards (ie., wheelchair accessibility);
 - e. Required posters, etc. are available.
 8. Pharmacies wishing to appeal audit findings have 30 days from the date of the audit close letter to appeal and to provide new or revised documentation. State laws may vary.

Appeal Process

1. The pharmacy may appeal the decision of the auditor within 30 days from the date of the audit close letter. For onsite audits it is 30 days from the day of the audit or as arranged with the onsite auditor. Time allowed may vary by State Law.
2. The pharmacy must e-mail, to info@rxpreferred.com, a letter stating their desire to appeal and the reason for the appeal. The letter must include the appropriate documentation to support their appeal. The audit number and the auditor's name must also be included in the appeal documentation. Phone calls are not accepted as documentation of the pharmacy's desire to appeal.
3. The auditor in charge of the audit will review appeals. The pharmacy will be notified of the results of the appeal within 30 to 45 days.

4. Appeals of an appeal (second appeals) will be handled on an individual basis based on the claim contents, appeal documentation, etc. These appeals will be reviewed by a Senior Auditor and/or the Director. State laws may impact second appeals.

5. Any unresolved audit appeals will be documented and presented to the Client. State laws may vary.

6. For purposes of state law in reference to preliminary audit reports and final audit reports, the following shall apply: regardless of audit type, the audit close letter is considered a preliminary audit report. The result of initial appeal shall be considered a final audit report, which may be appealed pursuant to the procedure hereinabove.

Important information:

- CMS directed audits – PDE or claims – may follow a different timeline and documentation requirement list.
- Pharmacies non-compliant with RxPreferred Benefits agreements or nonresponsive or uncooperative with the audit process may be reported to the RxPreferred Benefits Credentialing Committee. The Committee may recommend a penalty fee, corrective action plan, suspension or removal from the network.
- RxPreferred Benefits may adjust claims with common package size or quantity errors that may be the result of keying errors by the pharmacy. These claims will appear on the final letter and on the 835 file. Obvious, overbilled quantities may not be appealed.
- It is RxPreferred Benefits' goal to close onsite audits in approximately 60 days from date of audit. Depending on the circumstances and the findings, it may take less or more time to complete the audit close.
- It is RxPreferred Benefits' goal to close desk audits in approximately 90 days. Depending on the circumstances and the findings, it may take less or more time to complete the close of the audit.
- In the event there are conflicts between this guideline and state specific laws, to the extent required, state specific laws shall control and such laws shall be incorporated herein by reference.

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Responsible Department: Legal

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