PCMA
PHARMACEUTICAL CARE MANAGEMENT ASSOCIATION

"Prompt Payment" Mandates Would Raise Costs Due to Pharmacy Fraud, Waste, and Abuse

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To assess the potential impact of accelerated payment cycles on the ability of Part D plans to prevent unnecessary payments for prescription claims involving pharmacy fraud, waste, and abuse, PCMA conducted structured interviews with more than a dozen industry experts responsible for pharmacy audits, fraud investigations, payment recoveries, and pharmacy network contracts. Unless otherwise noted, the findings summarized below represent the consensus viewpoint of those interviewed.

Major Findings:

- **Pharmacy Fraud, Waste, and Abuse Is Costly:** Approximately 1 percent of prescription costs are likely due to fraud, waste, or abuse. This amounts to hundreds of millions of dollars in unnecessary costs for the Medicare Part D program and its beneficiaries.

- **Part D Plans Use Advanced Techniques to Combat Fraud, Waste, and Abuse:** Part D plans use sophisticated software and auditing techniques to identify problematic prescription claims. Most plans screen for fraud, waste, and abuse both before and after a claim is paid. Problem claims can often be detected automatically, but auditors must then analyze the claims and often contact the pharmacy, doctor, or patient for additional information to determine if fraud, waste, or abuse has occurred.

- **Problem Claims Can Be Caught Prior to Payment:** Typical examples of fraud, waste, and abuse detected prior to a claim being paid include prescription claims submitted with the improper quantity, improper days supply, improper coding, duplicative claims, and other irregularities.

- **"Prompt Payment" Mandates Would Increase Costs:** Accelerated payment cycles would make it difficult or impossible to complete some fraud, waste, and abuse detection efforts that currently occur prior to payments being made. While the majority of payments made on claims involving fraud, waste, or abuse can eventually be recovered, this can be difficult, time intensive, and, in some cases, impossible. This results in increased costs.

- **Independent Pharmacies Tend to be More Vulnerable to Fraud than Large Chain Pharmacies:** Unlike independent pharmacies, large chains have centralized billing operations with sophisticated accountability systems in place.

Detailed Survey Findings:

1. *Approximately what percent of prescription claims are fraud, waste, and abuse?*

   While estimates vary, most experts suggest that approximately 1 percent of prescription claims involve fraud, waste, or abuse. The majority of these claims are simple but sometimes substantial errors, which constitutes waste. The remainder is either fraud, where claims are intentionally falsified by the pharmacy or patient, or abuse, where the patient seeks to obtain unnecessary prescriptions due to addiction or other causes.

2. *Has the ability to detect pharmacy fraud, waste, and abuse increased, decreased, or remained the same over the past ten years?*

   Due to advances in computer software technology and auditing techniques, the ability to detect fraud, waste, and abuse has increased over the past decade.

3. *In general, are pharmacy fraud schemes becoming more sophisticated and difficult to detect?*

   In general, pharmacy fraud schemes are becoming more sophisticated as criminals adapt to advancing detection techniques. While fraud—especially false information that could be interpreted as a simple error—continues to constitute the vast majority of problem claims, advanced schemes have emerged as third party reimbursement for prescriptions has expanded.

   For example, during the Medicare Part D enrollment period, clever criminals started "pop up" pharmacies to take advantage of temporary reimbursement rules in place for consumers transitioning from Medicaid drug coverage to Part D drug coverage. Because prescription claims for these consumers had to be processed and paid immediately—regardless of whether or not the pharmacy was in an established network—the door was opened for criminals to open "pop up" pharmacies in order to file fraudulent high-dollar claims. These "pop up" pharmacies were only detected after CMS determined that the claims were bad. By the time plans attempted to recover payments, the "pop up" pharmacies had closed.

   "Pop up" pharmacies and other fraud schemes are not limited to government programs and the risk of such sophisticated schemes continues.

4. *What percentage of overall prescription drug costs result from fraud, waste, and abuse?*

   Pharmacy fraud, waste, and abuse accounts for about 1 percent of prescription drug costs, according to several experts. Precise estimates are difficult because the full extent of undetected fraud, waste, and abuse is unknown.

5. *How is pharmacy fraud, waste, and abuse generally detected?*

Part D plans detect pharmacy fraud, waste, and abuse by screening and auditing prescription claims for common errors, irregular information, and suspicious patterns over time. Claims are compared with historical information as well as claims submitted by similarly situated pharmacies. Substantial changes in the volume of claims or the dollar amount of claims from particular pharmacies can indicate fraudulent activity.

After sophisticated computer algorithms have identified potential problems, teams of auditors then analyze and investigate as necessary. Part D plans typically conduct pre-payment reviews as claims are received and a perform retrospective "field audits" at select pharmacy locations based on claims the pharmacy has submitted during the previous year.

Independent pharmacies tend to be more vulnerable to fraud than large chain pharmacies. Unlike independent pharmacies, large chains have centralized billing operations with sophisticated accountability systems in place.

6. *What types of potential fraud, waste, and abuse can generally be detected prior to a claim being paid?*

Typical fraud, waste, and abuse detected prior to a claim being paid includes prescription claims submitted with the improper quantity, improper days supply, improper coding, duplicative claims, and other irregularities. Some of these problems involve human error, some involve fraud.

7. *Are non-automated processes involved in detecting suspect billing patterns and determining if fraud has occurred? If so, describe:*

Pre-payment reviews start with computer algorithms flagging potential problems among the hundreds of thousands of prescription claims received by Part D plans each day. Auditors must then analyze the claims and often contact the pharmacy, doctor, or patient for additional information to determine if fraud, waste, or abuse has occurred.

8. *Would accelerated payment cycles reduce the ability to fight fraud, waste, and abuse?*

Accelerated payment cycles would make it difficult or impossible to complete some fraud, waste, and abuse detection efforts that currently occur prior to payments being made.

9. *If payment has been made on a claim subsequently found to involve fraud, waste, or abuse, how likely is it that such payments will be recovered?*

   While the majority of payments made on claims involving fraud, waste, or abuse can be recovered, this can be difficult, time intensive, or, in some cases, impossible. Recoveries are typically made against future claims—a process that can take months depending on the dollar amount of the problem claim and the dollar volume of future claims from the pharmacy. In the case of high-dollar claims improperly submitted by "pop up" pharmacies shortly before the store closes down, recovery is virtually impossible.