Finding the “Bad Apples”:
Case Studies of Pharmacy Fraud, Waste, and Abuse

April 2008

Approximately 1 percent of prescription drug costs result from fraud, waste, and abuse. This amounts to hundreds of millions of dollars in costs unnecessary costs for health care payors such as Medicare Part D. Wasteful pharmacy billing errors account for most of these costs, however fraud is present in a distinct minority of cases.

To find the “bad apples,” pharmacy benefit managers (PBMs) use advanced computer algorithms and auditing techniques to detect problem claims. Accelerated payment cycles would require that PBMs shift some detection and prevention efforts now accomplished prior to claims payment until after claims payment, which would make it more difficult to prevent unnecessary costs due to fraud, waste, and abuse. When a PBM detects a likely case of fraud, it will refer the issue to law enforcement authorities for further investigation and prosecution. Below are recent cases of pharmacy fraud:

Cases of Pharmacy Fraud

**Forged Prescriptions, Faked Prices, and Wrong Quantities:** An owner-pharmacist of two New York drug stores was sentenced to prison after pleading guilty to $4 million in insurance fraud involving overcharging customers, shorting prescriptions, and forging signatures to fake prescriptions. The pharmacy routinely raised co-payments without customers’ knowledge, dispensed lesser quantities than prescribed by the physician, and billed generic drugs at brand-name prices.

New York Times
August 4, 2005

“Pop Up” Pharmacy: Felony criminal charges were filed against a California “pharmacy” that fraudulently billed the state for more than $500,000 of false claims. The “pharmacy” had very few walk in customers, did not keep regular business hours, was under stocked, and carried supplies that had expired. The “pharmacy” used identities, medical records, and state Medicaid beneficiary information of patients without their permission or knowledge to submit fraudulent claims. Several patients stated that they had never been to the pharmacy or received prescriptions from their doctors.

State of California, Office of the Attorney General
June 19, 2003
**Drugs Not Dispensed:** Two brothers who owned independent pharmacies in California were convicted of fraud after billing more than $250,000 for prescription drugs that they did not dispense to consumers. The pharmacies provided prescriptions to transplant patients, but as the amount of prescribed medication used for treatment decreased, the pharmacists continued to bill for the original, higher-quantity amount, which was not dispensed to the patients.

U.S. Department of Justice
August 2005

**Selling Returned Drugs:** The owner and chief pharmacist of a Massachusetts drug store was convicted of selling more than $450,000 worth of prescriptions drugs that had either been returned by customers or were samples not intended for sale. In addition to the monetary costs of the fraud, the criminal activity left the pharmacy unable to track pills in the event of a drug recall.

U.S. Internal Revenue Service
July 10, 2007

**Phantom Prescriptions:** A California pharmacist was sentenced for defrauding health insurance companies of more than $5 million by submitting claims for prescriptions that were never written or never filled. The pharmacist obtained patient names, identifying information, and doctors’ names from prescriptions that were actually dispensed by his pharmacy, but then used the information to submit false claims to insurance companies for “phantom prescriptions.”

U.S. Internal Revenue Service
October 2006

**Drug Diversion Conspiracy:** Six pharmacists, a doctor, and five drug dealers in Texas were convicted for conspiracy to divert more than 1.7 million tablets of prescription pain killers for illicit sale and use. The $30 million scheme involved pharmacists repeatedly refilling fraudulent prescriptions that were dispensed to drug dealers.

U.S. Department of Justice
February 28, 2006

**High Dollar Claims:** A Pennsylvania pharmacist pleaded guilty of falsely claiming between $2.5 and $7 million in reimbursement costs over a four year period for high cost medications used to treat HIV/AIDS patients. The pharmacy submitted false medical information to qualify certain drugs for coverage and falsely documented sales of drugs to show that patients met eligibility requirements.

U.S. Attorney
Western District of Pennsylvania
June 18, 2007