Claire McCaskill
Missouri State Auditor

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MEDICAID

Follow Up on Prescription Drug Oversight

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Claire McCaskill
Missouri State Auditor

YELLOW SHEET

Improvements made since last audit on oversight of Medicaid prescription drugs, but some recipients still misuse services more than a year without detection

This audit followed up prior recommendations to a 2002 audit which showed the state had inadequate controls over its Medicaid prescription drug program. Since 2002, Medicaid drug costs have doubled to $1.2 billion. This report specifically analyzed if new policies or procedures detected recipients possibly abusing the system and restricted the narcotic amounts regularly received by a recipient. The state program, run by the Department of Social Services - Division of Medical Services, has the ability to "lock-in" a potentially abusing recipient, which restricts the recipients to one prescriber and/or one pharmacy to obtain prescriptions. The lock-in program is meant to curb doctor-shopping practices to obtain excessive amounts of certain controlled substances.

New procedures are steps to curbing Oxycontin® abuse	In March 2003, division officials added computer controls requiring recipients to have certain diagnoses before approving Oxycontin® prescriptions. In addition, new controls will also deny Oxycontin® claims exceeding a recommended dosage for a 24-hour period. In April 2002, auditors reported division officials did not have procedures to restrict recipients visiting multiple physcians to obtain painkillers - specifically Oxycontin® - which is an increasingly abused drug. (See page 4)
Some recipients abused plan for years without detection	Auditors again found recipients who abused the program for a year or more without detection. Division policy allows a recipient to use four or more pharmacies and five or more physicians to obtain prescriptions before they are targeted as a potential system abuser. Auditors found division staff did not review a quarterly list of potential abuses until the data was 6 to 12 months old. One recipient visited from 5 to 16 doctors per quarter over a 21-month period. (See page 7)
Recipients not restricted if they only see multiple doctors	Auditors found division officials do not restrict recipients who obtain drugs from multiple prescribers, but just one pharmacy. Instead, division officials said they restrict recipients who do both - visit multiple prescribers and multiple pharmacies - assuming these recipients are more likely to potentially abuse the system. But auditors found a need to also consider restricting recipients visiting multiple prescribers. Auditors found examples of recipients seeing between 5 and 20 prescribers every three months. (See page 8)
Some restricted recipients not reviewed for two years	Auditors found recipients restricted to the lock-in program still received controlled substance prescriptions. For example, auditors found 45 recipients visited an average of 13 prescribers while under the lock-in program restrictions. Division officials set a standard lock-in period of two years, but do not review a recipient's activity until after the two-year period. (See page 8)

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CLAIRE McCASKILL
Missouri State Auditor

Honorable Matt Blunt, Governor
and
Gary Sherman, Director
Department of Social Services
Jefferson City, MO 65102

Medicaid prescription drug expenditures have almost doubled since fiscal year 2002 to an estimated $1.2 billion. In 2002, we reported the Department of Social Services - Division of Medical Services (division) had inadequate controls over prescription drugs. The objectives of this report include following up on our prior recommendations and to evaluate division policies and procedures to determine whether they (1) detected and prevented Medicaid recipients from visiting multiple physicians to obtain controlled substances, and (2) restricted the amount of selected controlled substances Medicaid recipients can get on a monthly basis.

The division has made improvements in the oversight of the Medicaid prescription drug program by adding staff and improving computerized controls for controlled substances. However, we found the division's procedures allowed potentially abusive recipients to misuse services for 12 months, or longer, without detection or review for restricted services. Once potentially abusive recipients' services had been restricted, the division had not reviewed these recipients for continued misuse of services until the end of the 24-month restriction period. The division also had not established adequate controls to identify whether submitted controlled substances claims had been prescribed by authorized medical practitioners.

We conducted our work in accordance with Government Auditing Standards issued by the Comptroller General of the United States. This report was prepared under the direction of Kirk Boyer, Director. Key contributors to this report included John Mollet, Michelle Holland, and Alvin Cochren.

Claire McCaskill
State Auditor

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Abbreviations

CSR	Code of State Regulations
DEA	Drug Enforcement Agency
SAO	State Auditor's Office

Improvements Made In Medicaid Prescription Drug Program Oversight, But Weaknesses Still Exist

The division has taken action to restrict hundreds of Medicaid recipients' ability to obtain controlled substances. However, we found the division's policies and procedures allowed recipients to abuse Medicaid services for 1 year or longer, before the division detected and restricted recipient access to controlled substances, and allowed some recipients to go undetected. We also found after the division restricted recipient prescription drug services, the division had not reviewed recipients to determine whether recipients continued abusing services until the end of a 24-month restriction period. The division also had not established adequate controls to ensure controlled substance prescriptions submitted for payment had been prescribed by authorized medical practitioners. This problem occurred, in part, because division policy conflicted with federal regulations.

Background

State Medicaid prescription drug expenditures increased from $730 million to $938 million (28 percent) from fiscal years 2002 through 2004. Fiscal year 2005 expenditures are estimated to reach $1.2 billion, which represents further growth of 28 percent. The number of Medicaid recipients obtaining prescription drugs increased from 468,722 in 2002 to 530,188 (an increase of 13 percent) in 2004.

State regulation[1] defines misuse of Medicaid medical services, including prescription drugs, as "the act of seeking or obtaining medical services, or both, from a number of like providers and in quantities which exceed the levels that are considered medically necessary by current medical practices, standards, and policies" of the Medicaid program. Division guidelines define excessive use of pharmacy services as a recipient (1) using multiple prescribers and four or more pharmacies during a 3-month period to obtain controlled substances, (2) alternating use of prescribers and pharmacies to obtain controlled substances, or (3) using overlapping prescriptions (refills obtained before days supply should be used) that are written by different prescribers, whether filled at the same pharmacy or different pharmacies.

The division has established an automated claims processing system to identify potential Medicaid recipients attempting to obtain unnecessary drugs. The automated system produces quarterly reports, which identify Medicaid recipients that visited five or more providers and four or more pharmacies during a previous 6-month period. These recipients are reviewed for potential lock-in to a single provider and/or a single pharmacy, who will agree to accept locked-in recipients.

State regulation defines lock-in as the method to limit or restrict a Medicaid recipient to a designated provider(s). When the designated provider is a

[1] 13 CSR 70-4.70

physician, the provider becomes the primary care physician. Payment to any other provider is limited to documented emergencies or referral from the designated provider. The lock-in period ranges from 12 months to 24 months.

Once a Medicaid recipient has been locked-in to a specified provider, the Program Integrity unit staff is to monitor the recipient's prescription drug use. These cases are not to be reviewed before the case has been locked in for 12 months, but not longer than 24 months, according to state regulations. The Program Integrity unit staff is to review questionable cases and continue the recipient on lock-in if continued misuse of Medicaid prescription drugs persist.

Prior SAO Work

We reported, in April 2002, the division had not taken adequate steps to prevent Medicaid recipients from visiting multiple physicians to obtain controlled substances, such as opiate painkillers and anti-depressants.[2] We found recipients that had obtained unrestricted amounts of opiate painkillers, specifically OxyContin®.[3] We also identified abuse could continue up to a year without recipients being locked-in to a specific physician or pharmacy. The division responded it would implement various programs to restrict further abuse of controlled substances. For example, the officials established therapeutic criteria and algorithms for the use of controlled substances, and enhanced the Program Integrity unit program for lock-in.

Although the amount spent on OxyContin® claims has increased, the division has taken steps to reduce the abuse of OxyContin®. In March 2003, the division implemented computer controls (e.g., edits) requiring certain diagnoses and/or conditions be incurred prior to approving payments for an OxyContin® claim. These conditions include cancer, opiate tolerance, and chronic nonmalignant pain. For each condition, the division has assigned a date range for the prescriptions and in some cases, non-opiate analgesics (i.e., pain killers) must be prescribed prior to the approval of OxyContin®, an opiate analgesic. The division also implemented computer edits which will deny any OxyContin® claims exceeding the recommended dosage for a 24-hour period. For instance, if a recipient is prescribed a 40 milligrams dosage of OxyContin®, any prescription which requires over eight pills per

[2] Oversight Controls in the State's Medicaid Prescription Drug Program, Report No. 2002-29, April 18, 2002.

[3] OxyContin® is a time-released tablet of the narcotic oxycodone, a Drug Enforcement Administration (DEA) Schedule II controlled substance. OxyContin® is frequently prescribed to provide relieve to patients who suffer intractable pain and is considered the drug of choice for pain management.

day (a total of 320 milligrams) will be denied. Table 1 illustrates the status of previous SAO recommendations.

Table 1: Status of Prior Recommendations

Prior recommendations	Status
1. Implement edits that will automatically deny prescriptions that result in therapeutic duplication alerts, especially for drugs from the two major therapeutic classes of controlled substances.	Not implemented[1]
2. Establish criteria for authorizing edit overrides for recipients with medical needs to obtain multiple drugs from the same therapeutic class.	Not implemented[1]
3. Establish hard edits in the Medicaid claims processing system to block payment authorization for OxyContin® prescriptions which exceed division determined utilization guidelines.	Implemented
4. Until the edit (number 3 above) is in place, identify Medicaid recipients who are obtaining OxyContin® at or above this utilization guideline and determine if there is an appropriate medical need for the drug strength and tablet quantities prescribed.	Not applicable

[1] The division did not concur with this recommendation.

Source: SAO

Scope and Methodology

To determine the extent Medicaid recipients visited multiple prescribers and pharmacies to obtain controlled substances, we analyzed all paid prescription drug claims from January 1, 2003 through August 31, 2004 (20 months), for drugs claims from the following three specific therapeutic groups (1) anti-anxiety agents such as Xanax® and Ativan®, which are Schedule IV[4] drugs under the Controlled Substances Act;[5] (2) narcotic analgesics (opiate painkillers) such as OxyContin® (Oxycodone HCL), Fentanyl, morphine, and hydrocodone, which are Schedule II[6] and III drugs under the Controlled Substances Act; and (3) and another painkiller class that includes Tramadol.

[4] Schedule IV drugs of the Controlled Substances Act have a low potential for abuse relative to Schedule III drugs. Abuse of a Schedule IV drug or other substance may lead to limited physical dependence or psychological dependence. Schedule IV drugs include Darvon®, Talwin®, Equanil®, Valium®, and Xanax®.

[5] The Controlled Substances Act places all substances regulated under existing federal law including prescriptions into one of five schedules based upon the substance's medical use, potential for abuse, and safety or dependence liability. The Act provides a mechanism for DEA and the Department of Health and Human Services to control substances through adding to a schedule or removing control of substances through rescheduling of the drug.

[6] Schedule II drugs of the Controlled Substances Act have a high potential for abuse, and are currently accepted for medical use with severe restrictions. Abuse of a Schedule II drug or other substance may lead to severe psychological or physical dependence. Schedule II drugs include hydrocodone, morphine, oxycodone, and cocaine.

To give us a better understanding of the profile of abusive recipients, we reviewed the lock-in process for detection of potential abuse, services obtained, lock-in of a physician and/or pharmacy, and final 24-month review at the end of the lock-in period. We randomly selected 146 out of 695 recipients participating in the lock-in program and reviewed each recipient's detection and services review to create a "locked in" recipient profile.

To determine whether potentially abusive recipients had been detected and whether the division's lock-in program performed effectively to reduce abuse of services, we reviewed prescription drug claims in the above three drug classes for 207 of 1,258 recipients that had visited ten or more physicians and/or used seven or more pharmacies for the period January 1, 2003 through August 31, 2004. The 207 recipients included 61 lock-in recipients and 146 recipients that had not been placed in the lock-in program. We examined claims in each of the therapeutic classes. We obtained names and addresses of physicians associated with 3,517 prescriber numbers for paid claims associated with the 207 recipients to ensure physicians in the same clinic, or same practice as other physicians that a recipient visited, had not been counted as separate prescribers. Our findings related to 207 individual recipients' claims, number of prescribers, and number of pharmacies visited; and reflect "separate" physicians visited based on this review. We reviewed a total of 15,250 claims, totaling $578,221.

We also reviewed 45 recipient claims involving analgesic narcotics that had been locked-in prior to February 1, 2004, to determine whether abusive practices had been allowed to continue after the recipients had been locked-in.[7]

Our audit relied on paid Medicaid claims data and prescriber information obtained from the division's automated Medicaid claims payment system and adhoc reports. In order to gain assurance as to the accuracy of that data, we performed data validation procedures. We assured there had been no duplications within the data and that all paid claims had been made within our audit period. We determined the paid claims data was sufficiently reliable for the purposes of this report.

We requested comments on a draft of our report from the Director of the Department of Social Services, and those comments are reprinted in

[7] This review had been completed after our request for names and addresses of physicians related to prescriber numbers had been answered. Therefore, we did not analyze the "separate" physicians in this review.

Appendix I. We performed our work between September 2004 and February 2005.

Some Recipients Abused Plan for Years Before Detection, If At All

As we reported in April 2002, Medicaid recipients continued to abuse the prescription drug program for over 12 months without being detected and reviewed for potential lock-in. Moreover, recipients who only visited multiple prescribers (physicians), but did not visit multiple pharmacies to obtain controlled substances, did so without being detected.

Division policy allows a recipient to use four or more pharmacies and five or more physicians before being identified on quarterly exception reports for review of possible abuse. That is, recipients can visit an unlimited number of different prescribing doctors to obtain controlled substances without detection, as long as they do not use four or more pharmacies to obtain their controlled substances. Division staff review quarterly report data to determine the extent Medicaid recipients had visited multiple prescribers and/or pharmacies to identify potential abusers. However, that review normally did not take place until the data was 6 to 12 months old. For example, recipients visiting multiple pharmacies and prescribers during the period October 2003 through March 2004, first showed up on the quarterly report produced on September 27, 2004—6 months later. Therefore, someone abusing services in October 2003, would not have been detected or reviewed for the lock-in program for 12 months.

We identified 52 recipients, who visited 5 or more physicians and/or four or more pharmacies to obtain controlled substances at least one quarter during the period January 2003 through August 2004. The division had taken steps to lock-in 27 of these recipients in September 2004, but not until they had abused the Medicaid program for at least 12 months during the January 2003 through August 2004.

Our review of 13 of the 27 recipients placed in the lock-in program, in September 2004, disclosed the extent they had abused the program. For example:

- One recipient visited from 5 to 16 doctors per calendar quarter (i.e., a 3-month period) for 7 quarters (21 months).
- Another three recipients visited between 5 and 19 prescribers per quarter for 5 quarters (15 months). For example, one visited 12 to 19 prescribers and 7 to 10 pharmacies.

Recipients not reviewed for lock-in also misused the program

Sixteen of the 52 recipients had not been reviewed for lock-in[8] because division personnel had not reviewed recipients that visited five or more prescribers to obtain controlled substances, but visited less than four pharmacies to obtain drugs, for the lock-in program.[9] The following examples describe the extent of the abuse of the program by 6 of the 16 we identified.

- Two recipients visited 5 or more physicians in 5 consecutive calendar quarters. One started in the second quarter of 2003 and visited between 9 and 13 prescribers a quarter through the second quarter of 2004. The other started in the third quarter of 2003, and visited between 5 and 8 prescribers a quarter through the third quarter of 2004.
- One recipient visited from 5 to 24 prescribers in 5 consecutive quarters.
- Three visited between 5 and 20 prescribers per quarter for 6 quarters, or 1½ years.

The 16 recipients had 640 controlled substances claims totaling $12,652.

Division staff said Medicaid recipients who visit multiple prescribers but do not visit multiple pharmacies, are not identified for potential lock-in, because the division believes the recipients who visit both multiple pharmacies and prescribers are the most significant abusers. Also, despite additional dedicated staff, division staff said they have been unable to review all potentially abusive recipients appearing on the quarterly exception reports. Accordingly, they said they did not have adequate staff to review additional recipients that only visited multiple prescribers.

Lock-in Recipients Not Reviewed for 24 Months

Recipients continued to obtain prescriptions for controlled substances from multiple prescribers after they had been placed in the lock-in program. For example, we found 45 recipients visited an average of 13 prescribers, and some visited as many as 41 prescribers after they had been placed in the lock-in program. These 45 recipients had been locked-in prior to February 1, 2004 and the amount of claims and number of prescribers they visited varied. However, they had 1,251 claims for opiate painkillers totaling $56,826.

State regulations require that lock-in recipients be reviewed for continuous abuse between 12 and 24 months after the date of lock-in. However, the Program Integrity unit lock-in staff created a standard lock-in period of 24

[8] Eight recipients had not been reviewed for lock-in because they were no longer eligible, in September 2004, for the Medicaid fee-for-service program. One recipient could not be locked-in to a single prescriber because the recipient was also eligible for Medicare.

[9] Unless someone referred them to the division for review.

months and do not review recipients until the 24-month lock-in period has ended. According to the Program Integrity unit supervisor, "the biennial review is a labor intensive review, similar to the time required for the initial review" and due to limited staff resources, the unit only conducts reviews of recipients 24 months after lock-in.

In responding to a draft of this report, division officials said SAO failed to recognize the two additional staff the division hired to review potentially abusive recipients, resulted in increasing the number of recipients placed in lock-in from 390 in 2002 to 1,045 in 2004. They also said the number of potentially abusive recipients identified on quarterly exception reports exceed the number of reviews the Program Integrity unit staff can review regardless if current timeframe data or data from the past 12 months are used. Our report does not assert that the Program Integrity unit should be placing more recipients in lock-in, but that the group should use more current data to place abusive recipients in lock-in before they have been allowed to abuse the program for 12 months.

Some Claims Paid Without Assurance of Valid Prescribers

Based on our review of 894 claims, we found the division paid claims with invalid prescribing doctor numbers. This weakness occurred because the division has allowed pharmacies to substitute their own number in lieu of a prescribing doctors' number. We found 46 pharmacies had submitted their Medicaid provider numbers in the data entry field reserved for the prescribing doctors' Medicaid provider numbers. Further analysis showed 153 controlled substance claims, totaling about $4,900, which pharmacies submitted Medicaid provider numbers in the data entry field reserved for the prescribers' Medicaid provider numbers. Of the 153 claims, we found 30 represented DEA Schedule II drugs, 79 represented DEA Schedule III drugs, and 44 represented DEA Schedule IV drugs. Division policy allows the pharmacy to substitute the pharmacy Medicaid provider number for the prescriber's number in the prescriber identification field, which conflicts with federal regulations requiring all prescriptions for Schedule II, III, and IV controlled substance drugs to include the prescriber's DEA registration number.[10]

Conclusions

The division made improvements to restrict the abuse of prescription drugs; however, weaknesses in procedures still existed. The division's procedures for detecting potential misuse of Medicaid prescription drug services delay review of recipient activities and have resulted in allowing recipients to

[10] Code of Federal Regulations 1306.05 states (a) "All prescriptions for controlled substances shall be dated as of, and signed on, the day when issued and shall bear the full name and address of the patient, the drug name, strength, dosage form, quantity prescribed, directions for use and the name, address and registration number of the practitioner (prescriber)."

misuse services, in some cases, a year or more before detection. In addition, division policy does not require review of recipients when excess use of only the prescriber occurs. Exception parameters need to be created to detect abuse of only one service—the prescriber or pharmacy.

Division policy did not review lock-in recipients for 24 months, which affords recipients too much time to possibly abuse the prescription program. The division's policy and practice of allowing pharmacies to use pharmacy identification numbers in lieu of prescriber numbers conflicts with federal regulations, and therefore, should not be continued for Schedule II, III, or IV drug prescription claims.

These weaknesses, individually or in combination, leaves the division vulnerable to the potential for fraud or abuse.

Recommendations

We recommend the Director of the Department of Social Services establish:

1. Procedures to detect abuse in a more timely manner by requiring quarterly exception reports to include the most recent data available.

2. Additional parameters to detect abuse of a single service without the requirement of both services being misutilized.

3. Procedures to review obtained services of locked-in recipients no later than 12 months after the recipient has been locked-in to ensure that additional services have not been abused and whether additional lock-in procedures need to be taken.

4. Claims processing controls to ensure all numbers in the prescriber field are authorized Medicaid prescribers and/or DEA numbers.

Agency Comments

See Appendix I for agency comments.

Agency Comments

MISSOURI
DEPARTMENT OF SOCIAL SERVICES

MATT BLUNT
GOVERNOR

K. Gary Sherman
DIRECTOR

P. O. BOX 1527
BROADWAY STATE OFFICE BUILDING
JEFFERSON CITY
65102-1527
TELEPHONE: 573-751-4815, FAX: 573-751-3203

RELAY MISSOURI
for hearing and speech impaired
TEXT TELEPHONE
1-800-735-2966
VOICE
1-800-735-2466

June 3, 2005

Kirk Boyer
Director of Performance Audits
Office of the State Auditor
State Capitol, Room 224
Jefferson City, MO 65101

Dear Mr. Boyer:

This is in response to your May 23, 2005 correspondence regarding the audit report entitled "Follow Up on Prescription Drug Oversight." For ease of reference, the recommendation has been repeated with the related response.

Recommendation 1: Procedures to detect abuse in a timelier manner by requiring quarterly exception reports to include the most recent data available.

Response: Beginning March 2005, the Division of Medical Services (DMS) Program Integrity Unit began using additional reports that can be run more timely and with more current data. Allowance for a timely filing lag for incurred claims is three months.

Recommendation 2: Additional parameters to detect abuse of a single service without the requirement of both services being misutilized.

Response: A March 2005 report showed that 84% of potential abuse cases met the existing pharmacy and prescribers screening criteria. It is our intention that single service of prescribers will be periodically reviewed with the outcomes tracked for determination of review benefits.

Recommendation 3: Procedures to review obtained services of locked-in recipients no later than 12 months after the recipient has been locked-in to ensure that additional services have not been abused and whether additional lock-in procedures need to be taken.

Response: To review existing cases every 12 months for possible additional abuse will decrease the number of new cases that can be opened. We believe that the policy for case review at the end of 24 months of eligibility provides adequate safeguards. However, the Program Integrity staff will look at other options to monitor the utilization of service.

Recommendation 4: Claims processing controls to ensure all numbers in the prescriber field are authorized Medicaid prescribers and/or Drug Enforcement Administration (DEA) numbers.

Response: Medicaid does check all prescriber numbers for validity, but does not authorize specific prescribers. In the rare case that a prescriber does not have a DEA number or a Medicaid provider number, pharmacies are allowed to use their own DEA number on a case-by-case basis. Validity and integrity of prescription data is reviewed on a post-payment basis. In addition, Medicaid routinely retrospectively reviews for appropriateness those pharmacy providers using their own DEA number.

In addition to the responses to the recommendations, DMS has the following comments on the text of the audit report. For ease of reference, portions of the audit report text are repeated with the DMS comment.

1) Page one of the report (letter from Auditor McCaskill to Governor Blunt), first sentence of the first paragraph states "Medicaid prescription drug expenditures have almost doubled since fiscal year 2002 to an estimated $1.2 billion."

Comment: It should be noted that enhanced fees and related pharmacy tax has contributed to the expenditures. However, more important, there has been an increase in recipient caseload which has resulted in a significant increase in expenditures.

2) Also on page one of the report, end of paragraph two, it states that, "The division also had not established adequate controls to identify whether submitted controlled substances claims had been prescribed by authorized medical practitioners."

Comment: It should be noted that DMS does screen for appropriate prescriber identification to the degree necessary for a payer of claims. It is not the responsibility of a claims payer to validate the prescriber at the level indicated by the SAO, but rather the responsibility of the dispensing pharmacy and other agencies charged with the appropriate oversight authority. The Missouri Board of Pharmacy performs annual inspections of all state pharmacies to assure that they abide by the laws governing their practice; the mission of the Missouri Bureau of Narcotics and Dangerous Drugs is to assure valid prescribing and dispensing of controlled drugs; and the DEA is the federal agency with ultimate responsibility to assure the appropriate prescribing and dispensing of drug products on a national level. In addition, the DMS Program Integrity Unit and the Attorney General's Office conduct post-payment reviews of certain providers' claims in which patient records are requested to verify the accuracy of claims billed to Medicaid.

3) Page three, first paragraph under the subheading "Background" cites the increase in prescription drug expenditures from fiscal years 2002 to 2004.

Comment: There has been a significant increase in both expenditures and number of eligibles. In fact, the expenditures are almost as much as the state's entire higher education budget. The Administration has taken steps to contain costs in this area.

4) Page five of the report, Table one, refers to previous audit recommendations. Action has been taken with regards to items one and two.

Comment: DMS would like to reference the original response to these recommendations noted as the "DSS Corrective Action." DMS indicated we were in the process of implementing a database to prospectively screen all claims for appropriateness of therapy. We have accomplished this process and apply on-line edits based upon best practices. The duplicate therapy edit is typically a soft edit (alert of potential problems to be checked by the dispensing pharmacy) to allow for appropriate duplicate therapy in many

instances of treatment. Some conditions merit duplicate therapy, such as pain control, antipsychotic treatment, and attention deficit disorder. In addition, some "hard edits" (such as early refill) have been established to control inappropriate usage, along with criteria for allowing overrides to these edits in appropriate circumstances.

5) Page nine of the report under the subheading "Some Claims Paid Without Assurance of Valid Prescribers," mentions findings that DMS paid claims with invalid prescribing doctor numbers.

Comment: In some situations, allowing a pharmacy to use their own provider number in place of the prescriber number is the only way to allow their claim to pay. This is only approved on a case-by-case basis when the pharmacy contacts DMS for assistance with processing the claim for payment. A report is reviewed retrospectively to ascertain whether this privilege has been overused, and recovery of payment has taken place when this was found. Nonetheless, it is still the pharmacy's ultimate responsibility to assure that the prescription actually originated from a valid prescriber. Again, other agencies have responsibility to enforce state and federal laws pertaining to the validity of a prescription, controlled or otherwise. The Missouri Board of Pharmacy performs an annual inspection of all state pharmacies to assure that they abide by the laws governing their practice. The mission of the Missouri Bureau of Narcotics and Dangerous Drugs is to assure valid prescribing and dispensing of controlled drugs. The DEA is the federal agency with ultimate responsibility to assure the appropriate prescribing and dispensing of drug products on a national level. In addition, the DMS Program Integrity Unit and the Attorney General's Office conduct post-payment reviews of certain providers' claims in which patient records are requested to verify the accuracy of claims billed to Medicaid. Finally, DMS makes recoveries and sanctions providers for billing invalid prescriptions as they are discovered, based upon internal audits or referral information received from other agencies' inspection findings.

6) Page 10 under "Conclusions" states that the "division's policy and practice of allowing pharmacies to use pharmacy identification numbers in lieu of prescriber numbers conflicts with federal regulations, and therefore, should not be continued for Schedule II, III, or IV drug prescription claims."

Comment: We do not believe that federal regulation pertaining to prescription drug payers requires prescriber identification on a claim in any specified format. Since the claims submitted for payment are not the actual prescriptions, the federal regulations referenced on page 10 of the report do not appear to apply.

If you have any questions please contact Q. Michael Ditmore, M.D., Interim Director, Division of Medical Services at 573/751-6922.

Sincerely,

K. Gary Sherman
Director

KGS:mjr