Michigan Association of Health Plans Pharmacy Audit Statement of Best Practices

The Michigan Association of Health Plans (MAHP) promotes principles and guidelines of best-practices in the administration of health care goods and services. In recent years, the federal government has placed increased scrutiny upon health plans to conduct extensive audits of contracting pharmacies and pharmacy benefit managers, particularly as those activities affect federal health programs such as Medicare and Medicaid. This increased federal oversight has made the terms, "Fraud, Waste, Abuse (FWA)" commonplace within the realm of federally sponsored health programs. The federal government's emphasis on detecting and eliminating FWA within health programs promotes the integrity of the programs and decreases overall costs.

As a result of the heightened importance of compliance with federal laws and regulations, health plans must establish effective protocols to detect FWA. Part of any effective compliance program is assuring thorough and rigorous auditing of pharmacy activities. It is MAHP's intent, therefore, to promote effective health plan compliance programs that include thorough pharmacy auditing procedures, while at the same time assuring that the procedures are equitable to all contracting pharmacists and are not unduly burdensome to their businesses. This Best-Practices Statement seeks a reasonable balance between effective health plan compliance and equity in the pharmacy auditing process.

Pharmacy Auditing Guidelines

The rights and responsibilities between MAHP member plans and their participating pharmacies are specified in network pharmacy agreements. These agreements should set forth the rights of MAHP member plans to perform pharmacy audits and should describe the responsibilities of network pharmacies to consent to such audits and to assure that pharmacy activities comply with state and federal laws and regulations. This Best-Practices Statement will describe the MAHP suggestions for handling pharmacy audits.

A. Conduct of audit.

When conducting an audit, a pharmacy benefits manager should:

(1) if the audit is onsite, provide written notice to the pharmacy or pharmacist at least 2 weeks before conducting the initial onsite audit for each audit cycle; and to the greatest degree possible, the audit should not be scheduled during the first five calendar days of a month unless requested by the pharmacy or pharmacist.

(2) identification of prescriptions for desk audits should be done using algorithms that have a high likelihood of identifying a true auditable finding.

(2) employ the services of a pharmacist if the audit requires the clinical or professional judgment of a pharmacist;

(3) For purposes of validating the pharmacy record with respect to orders or refills, allow the pharmacy or pharmacist to use hospital or physician records that are:

(i) written; or
(ii) transmitted or stored electronically, including file annotations, document images, and other supporting documentation; that are date/time stamped.

(4) only audit claims submitted or adjudicated within the 2-year period immediately preceding the audit, unless a longer period is permitted under federal or State law or a longer period is warranted by special circumstances;

(5) deliver the preliminary audit report to the pharmacy or pharmacist within 120 calendar days after the completion of the audit, with reasonable extensions allowed;

(6) in accordance with section (B), allow a pharmacy or pharmacist to produce documentation to address any discrepancy found during the audit; and

(7) deliver the final audit report to the pharmacy or pharmacist:

(i) within 6 months after delivery of the preliminary audit report if the pharmacy or pharmacist does not request an internal appeal under section (B) of this section; or

(ii) within 30 days after the conclusion of the internal appeals process under section (B) if the pharmacy or pharmacist requests an internal appeal.

(8) A pharmacy benefits manager should not use the accounting practice of extrapolation to calculate overpayments or underpayments.

(9) The recoupment of a claims payment from a pharmacy or pharmacist by a pharmacy benefits manager should be based on an actual overpayment or denial of an audited claim unless the projected overpayment or denial is part of a settlement agreed to by the pharmacy or pharmacist.

(10) Notwithstanding paragraphs (8) and (9) of this section, calculation of overpayments and underpayments should be reasonable and proportional in relation to the type of errors detected. For example, a simple clerical error that has no financial effect should not be recouped and such errors should not affect the dispensing fees associated with those prescriptions.

B. Internal appeals process.

(1) A pharmacy benefits manager should establish an internal appeals process under which a pharmacy or pharmacist may appeal any disputed claim in a preliminary audit report.

(2) Under the internal appeals process, a pharmacy benefits manager should allow a pharmacy or pharmacist to request an internal appeal within 30 business days after receipt of the preliminary audit report, with reasonable extensions allowed.

(3) The pharmacy benefits manager should include in its preliminary audit report a written explanation of the internal appeals process, including the name, address, and telephone number of the person to whom an internal appeal should be addressed.

(4) The decision of the pharmacy benefits manager on an appeal of a disputed claim in a preliminary audit report by a pharmacy or pharmacist should be reflected in the final audit report.

(5) The pharmacy benefits manager should deliver the final audit report to the pharmacy or pharmacist within 30 calendar days after conclusion of the internal appeals process.

C. Timing for setoff for overpayment or remittance of underpayment.

(1) A pharmacy benefits manager should not recoup by setoff any moneys for an overpayment or denial of a claim until 30 working days after the date the final audit report has been delivered to the pharmacy or pharmacist.

(2) A pharmacy benefits manager should remit any money due to a pharmacy or pharmacist as a result of an underpayment of a claim within 30 working days after the final audit report has been delivered to the pharmacy or pharmacist.

(3) Notwithstanding the provisions of paragraph (1) of this section, a pharmacy benefits manager may withhold future payments before the date the final audit report has been delivered to the pharmacy or pharmacist if the identified discrepancy for all disputed claims in a preliminary audit report for an individual audit exceeds $20,000.

D. Exception for fraud, waste, abuse, or illegal activity.

(1) Sections A, B, and C do not apply to audits involving probable or potential fraud, waste, abuse, illegal activity, or willful misrepresentation by a pharmacy or pharmacist.