12. AUDIT OF CLAIMS

12.1 OVERVIEW

This section has been included to provide an overview of NLPDP Provider Audit practices, policies, and procedures.

Providers are entitled to payment for eligible claims. The purpose of auditing a Provider's claims is to verify that items were paid in accordance with the *Pharmaceutical Services Act*, its regulations and the billing policies set out in the NLPDP Provider Guide.

Audit is based primarily on the prescription and other documentation requirements. In cases where requirements are specified in the Provider Guide but do not appear in the prescription, associated hard copy and/or documentation, recoveries may occur.

There are five main audit activities

1) Claims Monitoring
2) Desk Audit
3) Claims Intervention Program
4) Preliminary Audit, and
5) Comprehensive On-Site Audit.

To determine what audit activities are required, several audit factors may be considered. These include, but are not limited to, such items as patterns of servicing; information supplied by beneficiaries and other individuals.
The Audit Services Division of the Department of Health and Community Services may collaborate and consult with the Pharmaceutical Services Division of the Department of Health and Community Services with respect to audit activities and audit recoveries.

The following description of the NLPDP Audit Program covers general claims audit procedures. There may be adaptations to these procedures at times to allow for specific circumstances of individual audits.

12.2 NLPDP PROVIDER AUDIT PROGRAM ACTIVITIES

12.2.1 COMPLAINTS OR VOLUNTARY INFORMATION

Complaints may be received regarding the billing or pattern of practice of a Provider from a number of sources (e.g. beneficiaries, physicians, other Providers). These complaints are

reviewed in conjunction with all available information. Documentation or other information may be requested from the Provider. Review of the information may require further audit activity.

12.2.2 AUDITS OF TARGETED ITEMS

Targeted activities may occur when claims appear to be subject to widespread misinterpretation or incorrect billing. These audits are an important means by which policies and definitions may be clarified, reviewed, and improved.

12.2.3 CLAIMS ANALYSIS

Billing data is regularly compiled, summarized and reviewed to present a comparative picture of service patterns of pharmacies. Whenever service volume significantly exceeds area or provincial averages or when practice patterns are otherwise anomalous, such cases will be investigated and may result in the commencement of an audit which may begin in either the Preliminary or Comprehensive Stage.

12.2.4 BENEFICIARY UTILIZATION AUDITS

During the investigation of a beneficiary who is flagged for high levels of utilization, issues may arise regarding the billing or documentation practices of the Prescriber(s) and/or Provider(s). These issues are analysed and may require further audit activity.

12.2.5 CLAIMS MONITORING SYSTEM (CMS)

CMS is an automated claims selection program designed to continually monitor the integrity of claims billed to the NLPDP. Non-compliant submissions may require further audit activity.

Providers will be mailed a letter requesting copies of 3 to 15 sampled prescriptions and associated documentation to be supplied on or before the date noted in the letter. In most cases a confirmation letter will also be mailed to the Beneficiary requesting verification of billing details. In some cases, a confirmation letter may also be sent to the Prescriber.

Audit Services will review the submitted documents to determine if claims were billed in accordance with the Provider Guide. Providers will be notified of the results of this review.

CMS is designed to help Providers be aware of the elements required to substantiate NLPDP

billings, resulting in fewer comprehensive audits. CMS offers feedback and communication to Providers with regard to acceptable NLPDP billing practices.

12.2.6 DESK AUDIT

Audit Services routinely conducts desk audits of claims billed to the NLPDP. As part of this activity, Providers may be asked to provide copies of required documentation. Requests are made in writing and the Provider is asked to supply the information on or before the date noted in the letter. Normally, a sample of 100 claims or less related to the billing issue are selected for review.

Beneficiaries and/or Prescribers may be contacted to confirm aspects of the billing(s). All available information is reviewed and the Provider is advised in writing of any applicable claim cancellations or adjustments. In the event that the requested information is not provided, all associated claims will be considered not validated and payment will be recovered. Significant findings of a desk audit may require further audit activity.

12.2.7 PRELIMINARY AUDIT

As a result of any one or more of the preceding audit activities, a preliminary audit may be commenced. Normally, a sample of 100 claims or less related to the billing issue are selected for review. Providers will be asked to provide their records by mail, fax, and email or for on-site scanning to substantiate their claims. Beneficiaries and/or Prescribers may be contacted to confirm aspects of the billing(s).

Where audit findings reveal misbilling of 5% or less of the total number of claims reviewed, the audit is closed and the provider is notified of the findings of the audit. For these minor billing errors, appropriate adjustments are completed. Significant (greater than 5%) billing errors may require further audit activity.

12.2.8 COMPREHENSIVE ON-SITE AUDIT

As a result of any one or more of the preceding audit activities, a comprehensive on-site audit may be commenced. The initial audit period is generally one year prior to the most current month and may extend up to a maximum of two years. This would occur where claims selected for the audit sample have associated claims which could originate as much as one year prior to the selected claim. The audit sample size will be such that a statistically valid assessment of the provider's billing practices can be determined. Providers will be requested to make copies of their records available to be scanned on-site by audit staff. Information will be reviewed for adherence to the Provider Guide.

During the on-site audit, auditors may request interviews with the Provider and/or staff to obtain clarifications and further information. Beneficiaries and/or Prescribers may be contacted to confirm aspects of the billing(s).

Upon review, where documentation combined with any other supporting information substantiates the Provider's billings, the audit is closed and the Provider is notified in writing of the audit findings and of no further action to be taken at that time. In cases where less than 5% misbilling is determined, a direct recovery (claims adjustment) is made and the Provider is notified in writing and provided instructions on proper billing procedures for claim submissions. In cases of significant misbilling (greater than 5%), the Provider is notified in writing and the findings are extrapolated over the population of claims paid during the period from which the sample was drawn.

When extrapolation is used, the review of sampled claims will determine the error rate for the sample selected and this error rate will be projected to the entire population of applicable claims for the audit period. Accepted statistical concepts state that repeated randomly selected samples of the same size from the population of claims billed will produce an error rate within a range 95% of the time. The upper and lower limit of the range of expected values is known as the confidence interval. The confidence interval will vary with each audit because it is the result of a calculation which is determined by the error rate, sample size and population.

Extrapolation of the findings from the reviewed sample will be applied over the applicable claims for a Provider where the lower level of the confidence interval exceeds five percent. For example, if the achieved precision level was 9.50% +/- 2.50% with a 95% confidence level, then the lower value of this achieved precision is 7.00%, and since this is higher than the 5% threshold extrapolation may be used.

Claims deemed unacceptable may be recovered either in part or in full. For example, a partial recovery may include recovery of the professional fee only (in cases of split prescriptions) or recovery of the product cost (for the excess quantity billed) when the quantity of drugs dispensed exceeds the quantity prescribed. In addition, a variety of factors influence the amount paid per claim, such as varying unit prices or third party insurance. As a result, the extrapolation is based on the dollar figure of the billing errors identified, the sample and the population.

12.2.8 PROVIDER INTERVIEW

Before the information obtained in the comprehensive on-site stage of the audit is finalized or presented to the Pharmaceutical Audit Review Committee (PARC), the Provider under audit may be contacted by phone or requested to attend a Provider Interview. During this interview, issues identified during the course of the audit are disclosed. Providers are offered the opportunity to respond to these issues by providing explanations and further information.

12.2.9 CLAIMS INTERVENTION PROGRAM (CIP)

If potential problems with a particular Provider's billings have been identified, that Provider may be entered into the CIP.

CIP is designed to prevent the incorrect submission of claims and to ensure that Providers are continuously aware of the elements required to substantiate billings. Providers with questionable billing patterns or practices are identified and their claims are reviewed on a regular on-going basis. The Provider will remain in the program until it is determined that their billings are in order.

12.2.10 PHARMACEUTICAL AUDIT REVIEW COMMITTEE (PARC)

As part of the review of information gathered during the on-site audit and the subsequent Provider interview, Audit Services may decide to refer the audit findings to the PARC for professional review and recommendations.

This Committee is constituted under Section 8 of the *Pharmaceutical Services Regulations*. Matters reviewed by the Committee and its deliberations are held in confidence. Presentations to the Committee will not include any identifying information.

This Committee has the ability to recommend amendments to audit findings to the Minister of the Department of Health and Community Services with appropriate justification.

Audit Services will inform the Provider of his/her right to make a written submission to be presented to the PARC for consideration.

PARC must abide by all applicable legislation, Program policies, and applicable agreements between the Pharmacists' Association of Newfoundland and Labrador (PANL) and the Government.

12.2.11 NOTIFICATION OF RECOVERIES

Where it has been determined that billings have been submitted contrary to the *Pharmaceutical Services Act*, its regulations and/or the Provider Guide, the Provider is sent a notification of audit findings.

The notification letter details the findings of the audit, the resulting recovery calculations, and the options available under the *Pharmaceutical Services Act*.

The Provider (or a representative) is provided the opportunity to submit a written

representation to Audit Services regarding the matters raised in the notification letter. In this written representation, the Provider (or a representative) may elect to avail of options under the *Pharmaceutical Services Act*, specifically the Alternate Dispute Resolution Process and/or the Audit Appeal Board.

12.2.12 ALTERNATE DISPUTE RESOLUTION (ADR) PROCESS

Alternate Dispute Resolution is a process for resolving issues identified during the audit.

The ADR process is intended to encourage a cooperative climate, achieve fair and appropriate settlements, and to avoid the financial and procedural costs associated with formal court proceedings. In this process, attempts are made to negotiate a settlement which is satisfactory to both parties.

As outlined in the notification letter, ADR must be requested by the Provider within fifteen (15) days from the date of the notification letter. The ADR Process shall be completed in no more than thirty (30) days after it has been requested, or within another period that the parties may agree to in writing. The outcome of ADR is subject to the provisions of the *Financial Administration Act* RSNL 1990 cF-8.

In the event that a settlement is reached, any adjustments to the recovery amount will be made accordingly. The audit will then proceed to the recovery stage as part of the ADR agreement. The Provider will waive the right to appeal the audit findings to the Audit Appeal Board.

If a mutually acceptable agreement is not reached the process will proceed to either recovery or a hearing before the Audit Appeal Board.

12.2.13 HEARING BY AUDIT APPEAL BOARD

Within thirty (30) days of receiving the notification letter to proceed with a recovery, the Provider (or a representative) may make a written representation of his or her position and request a hearing before an Audit Appeal Board.

Within thirty (30) days of hearing the appeal, the Audit Appeal Board will confirm, set aside or vary the audit findings. The Board's decision must be consistent with the *Pharmaceutical Services Act* and its Regulations.

A party may appeal the decision of the Audit Appeal Board to the court.

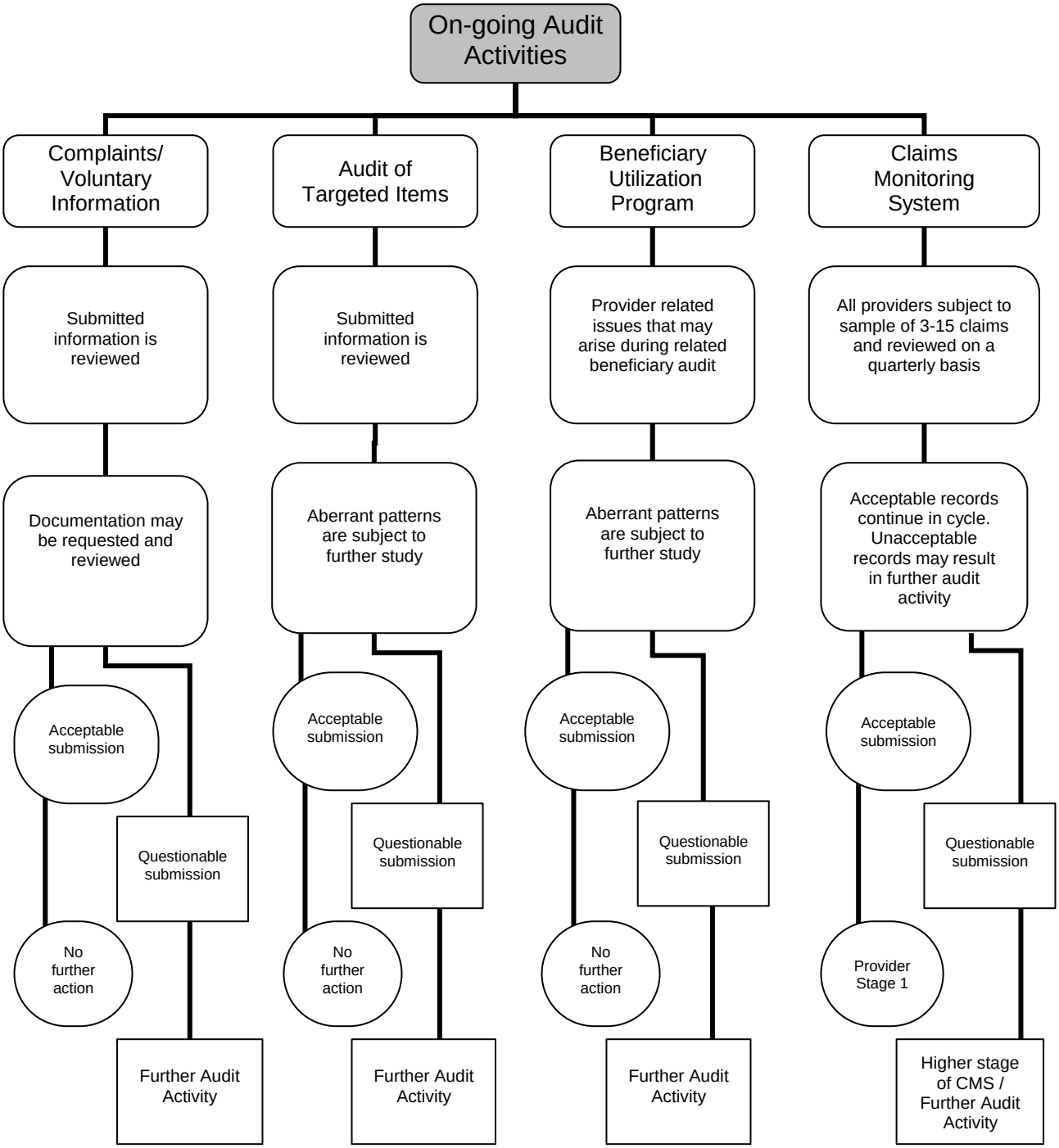
12.3 NLPDP PROVIDER AUDIT FLOW CHARTS

The following flow charts have been prepared in an attempt to present pictorially in a logical sequence, the various steps and actions which are generally followed in relation to audits of Provider claims.

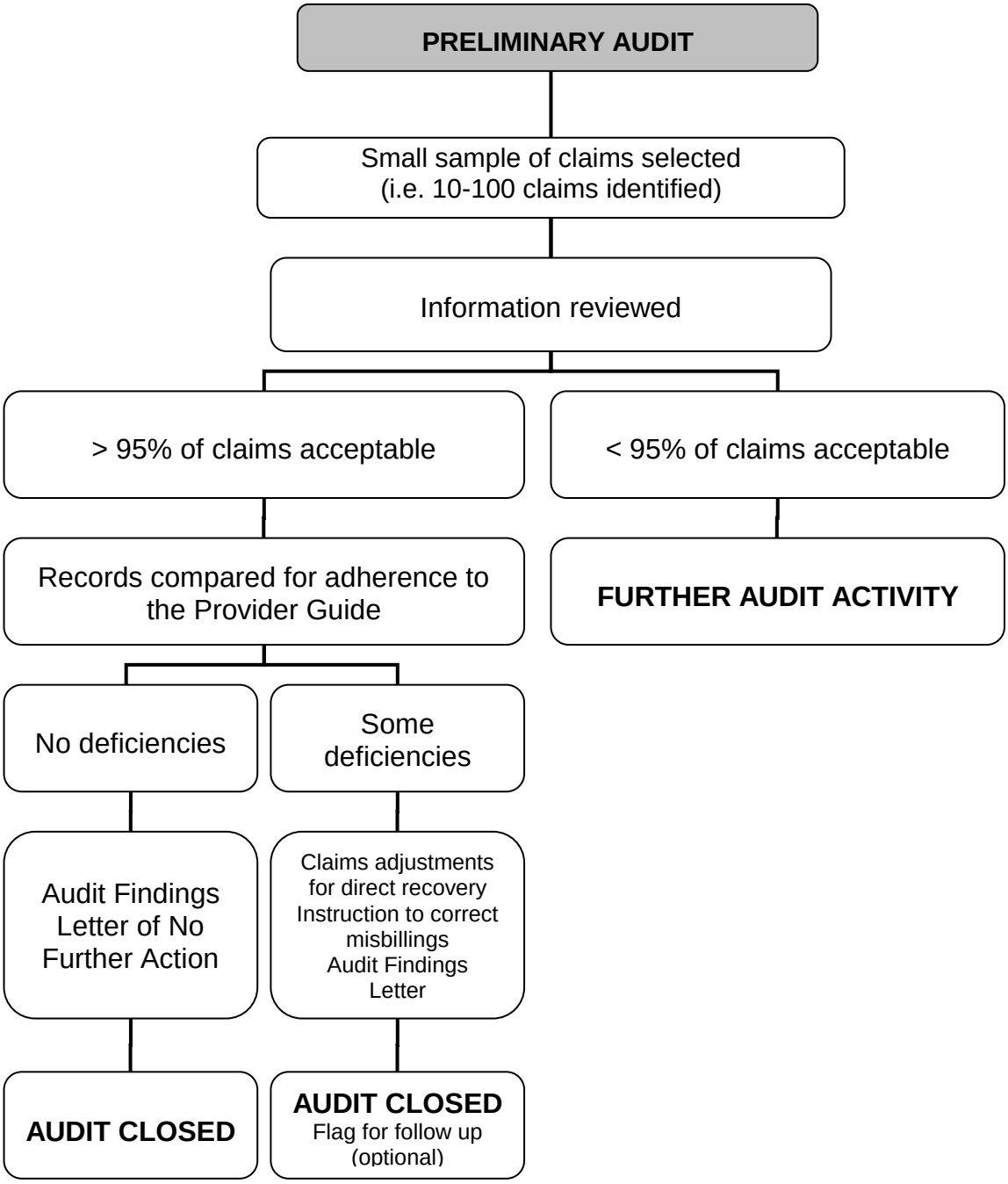
NLPDP Provider Audit Program

1. **ON-GOING AUDIT ACTIVITIES**
2. **PRELIMINARY AUDIT**
3. **COMPREHENSIVE ON-SITE AUDIT**
4. **PROVIDER INTERVIEW**
5. **CLAIMS INTERVENTION PROGRAM (CIP)**
6. **PHARMACEUTICAL AUDIT REVIEW COMMITTEE (PARC)**
7. **NOTIFICATION**
8. **ALTERNATE DISPUTE RESOLUTION (ADR)**
9. **HEARING BY AUDIT APPEAL BOARD**
10. **APPEAL TO SUPREME COURT**

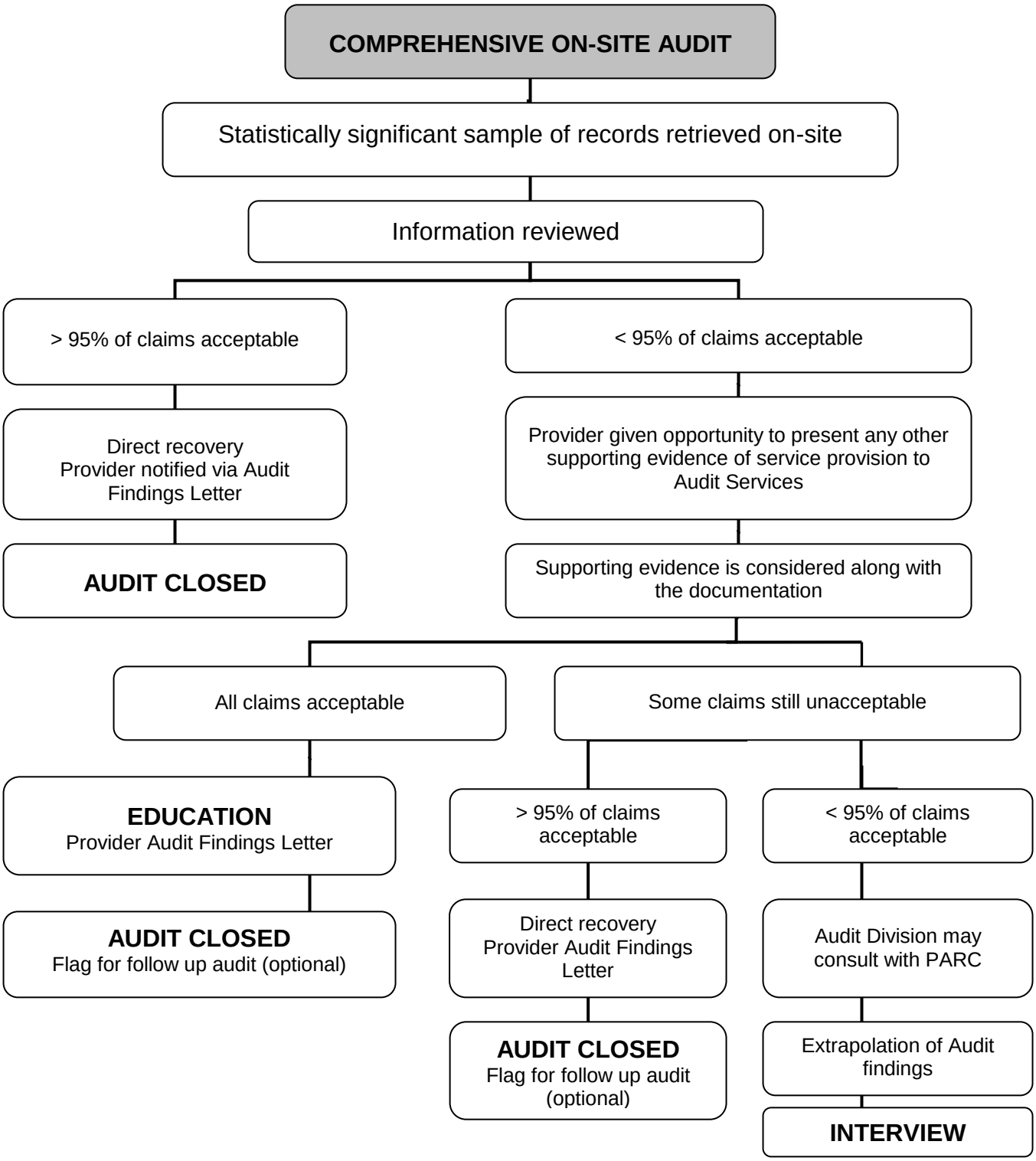
12.3.1 ON-GOING AUDIT ACTIVITIES



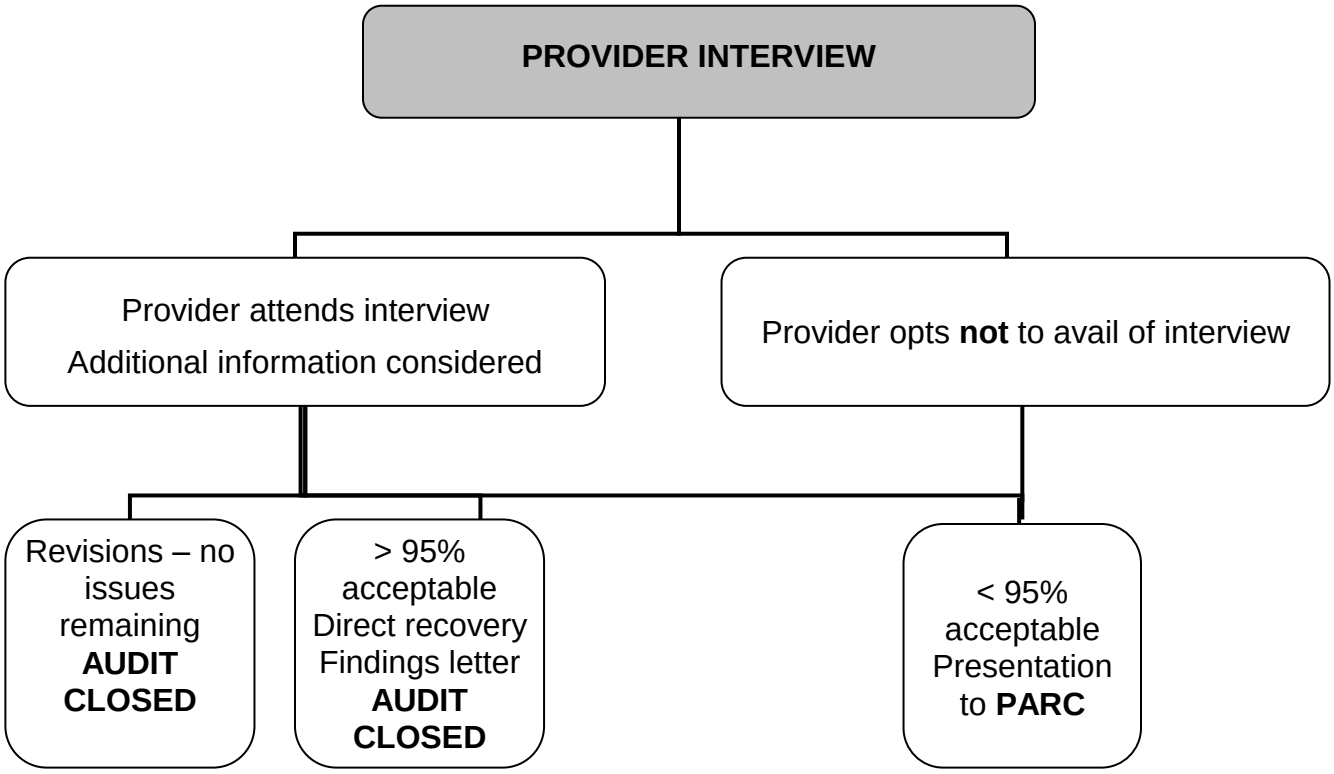
12.3.2 PRELIMINARY AUDIT



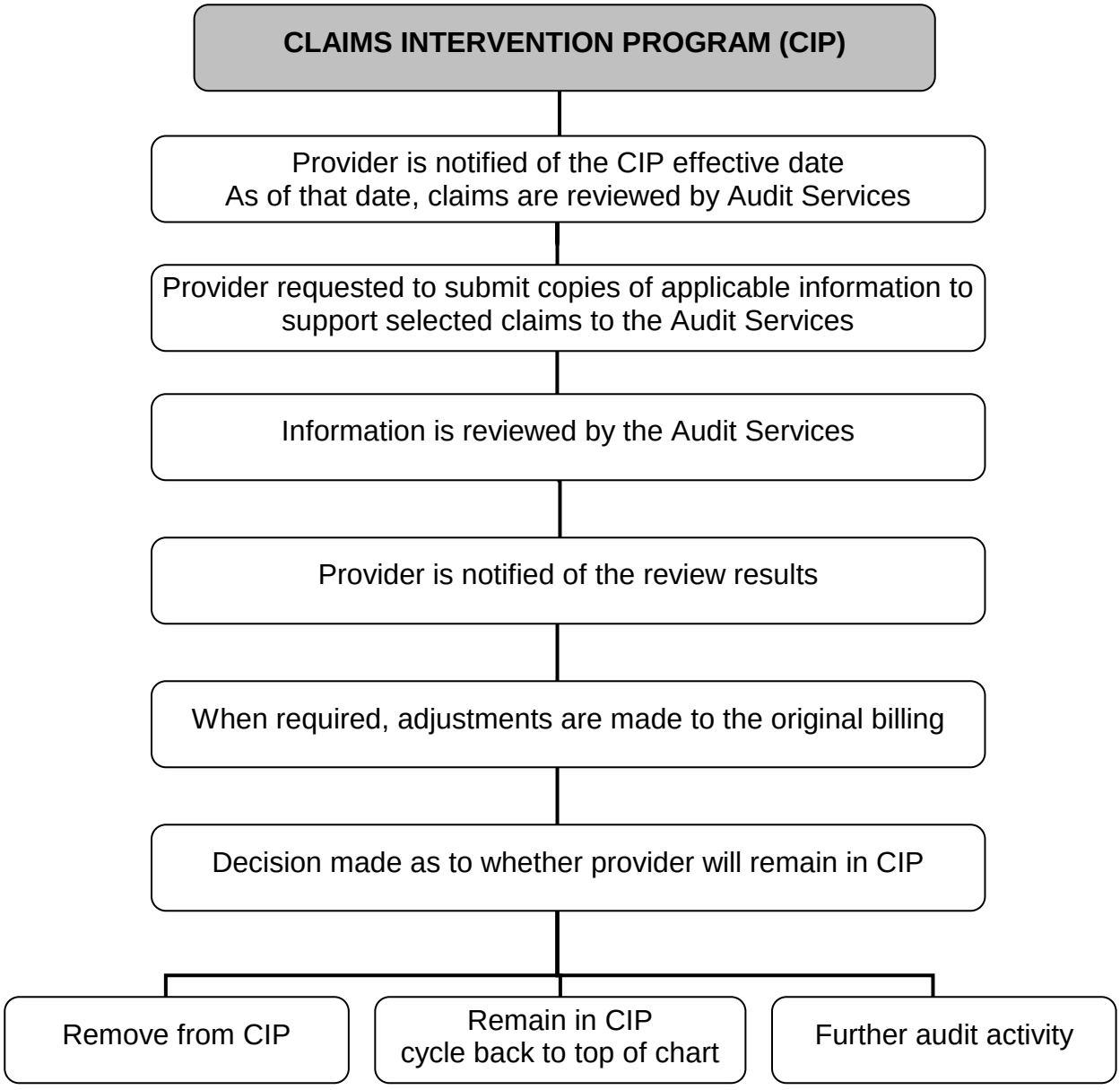
12.3.3 COMPREHENSIVE ON-SITE STAGE



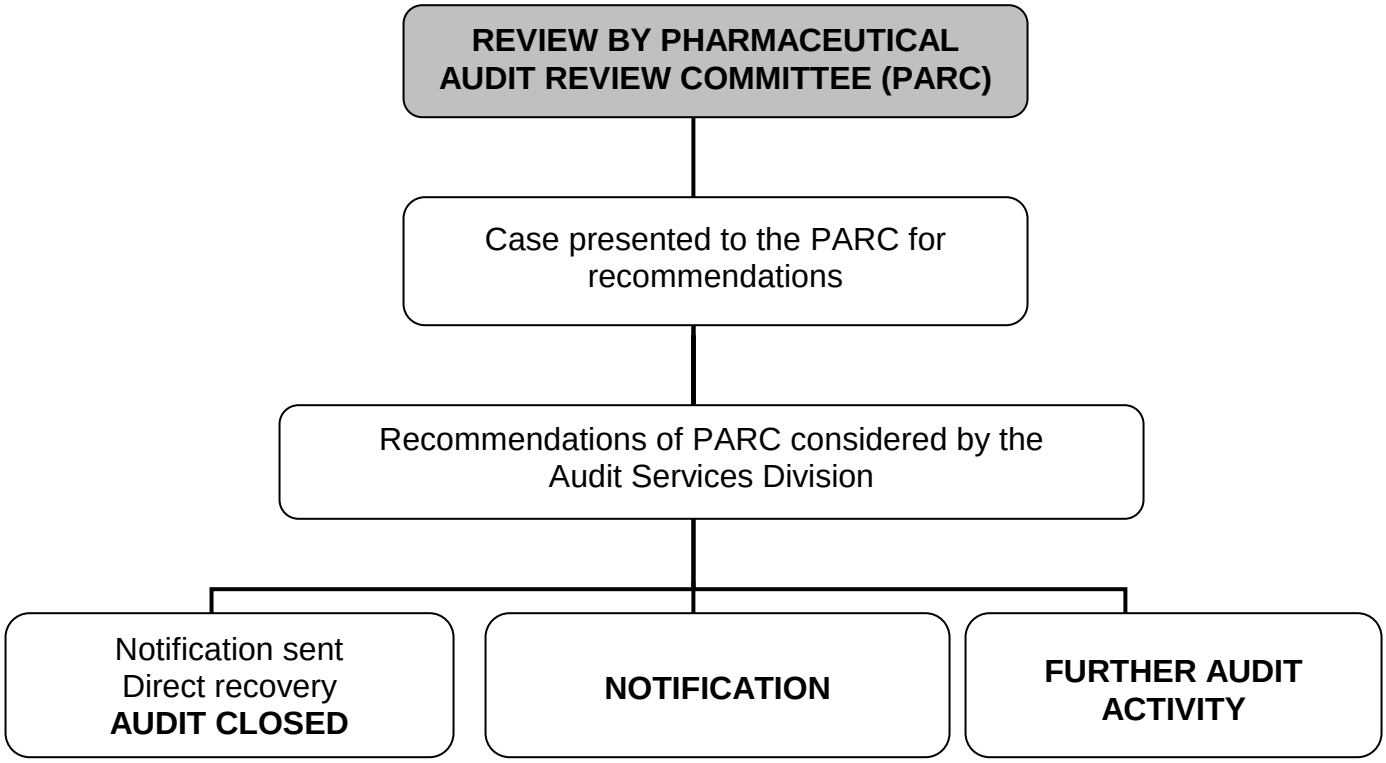
12.3.4 PROVIDER INTERVIEW



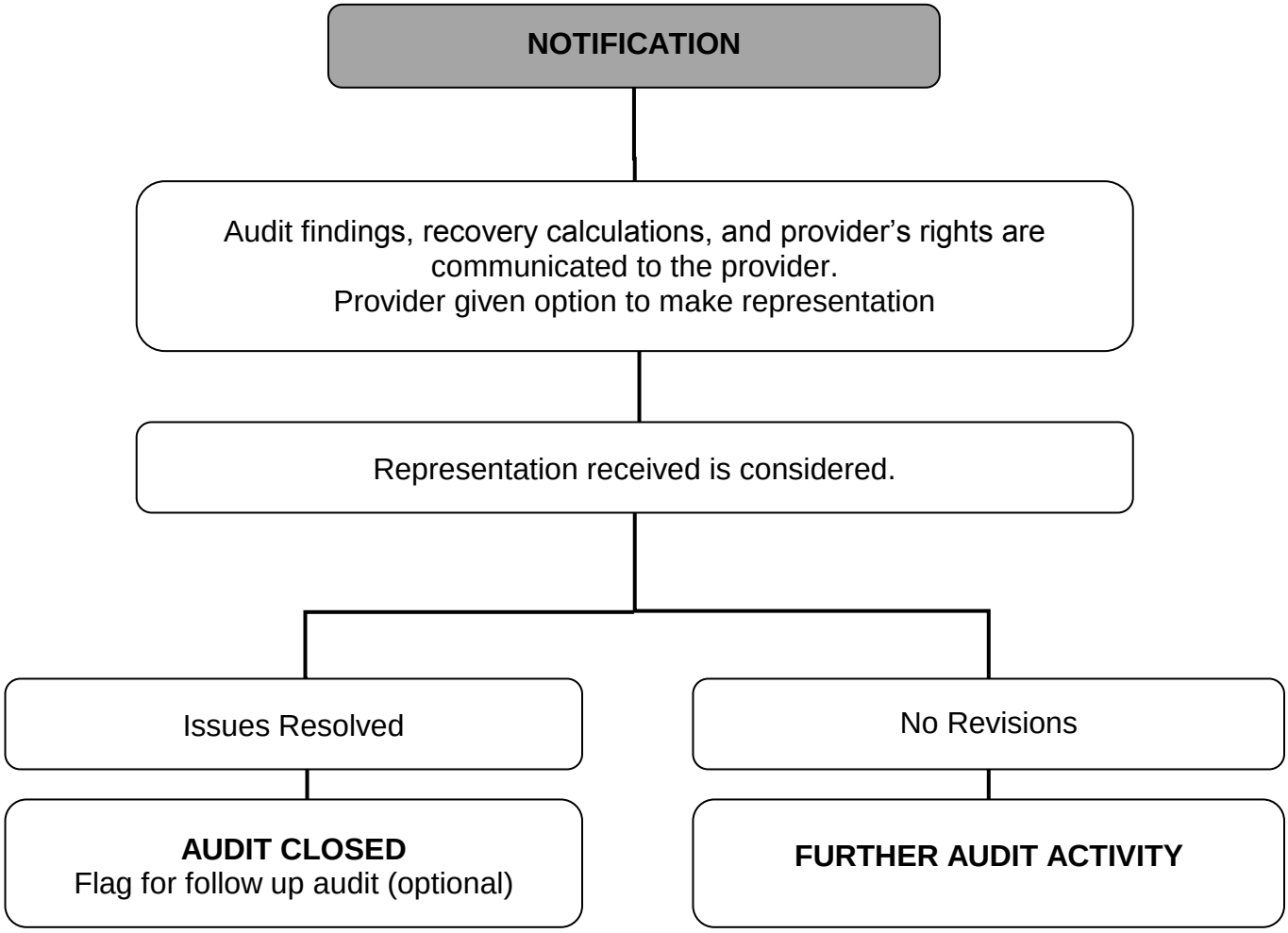
12.3.5 CLAIMS INTERVENTION PROGRAM (CIP)



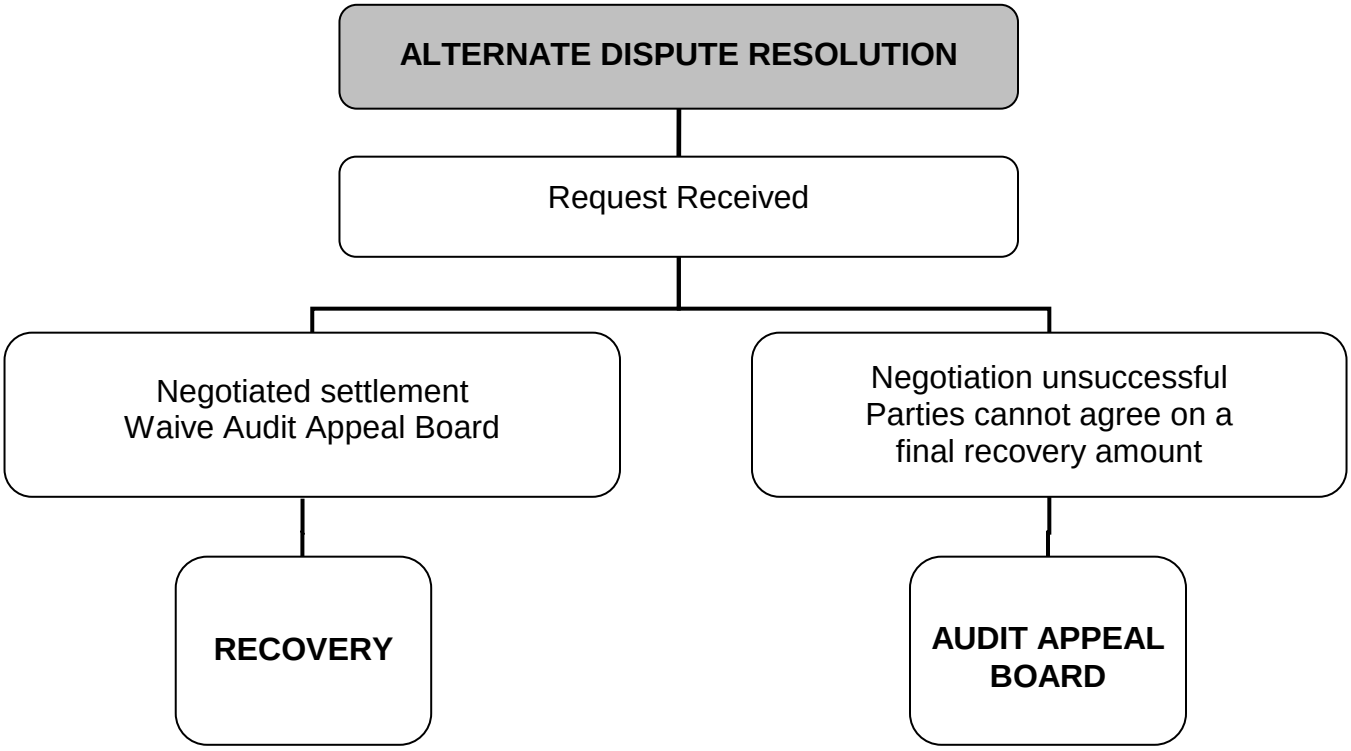
12.3.6 PHARMACEUTICAL AUDIT REVIEW COMMITTEE (PARC)



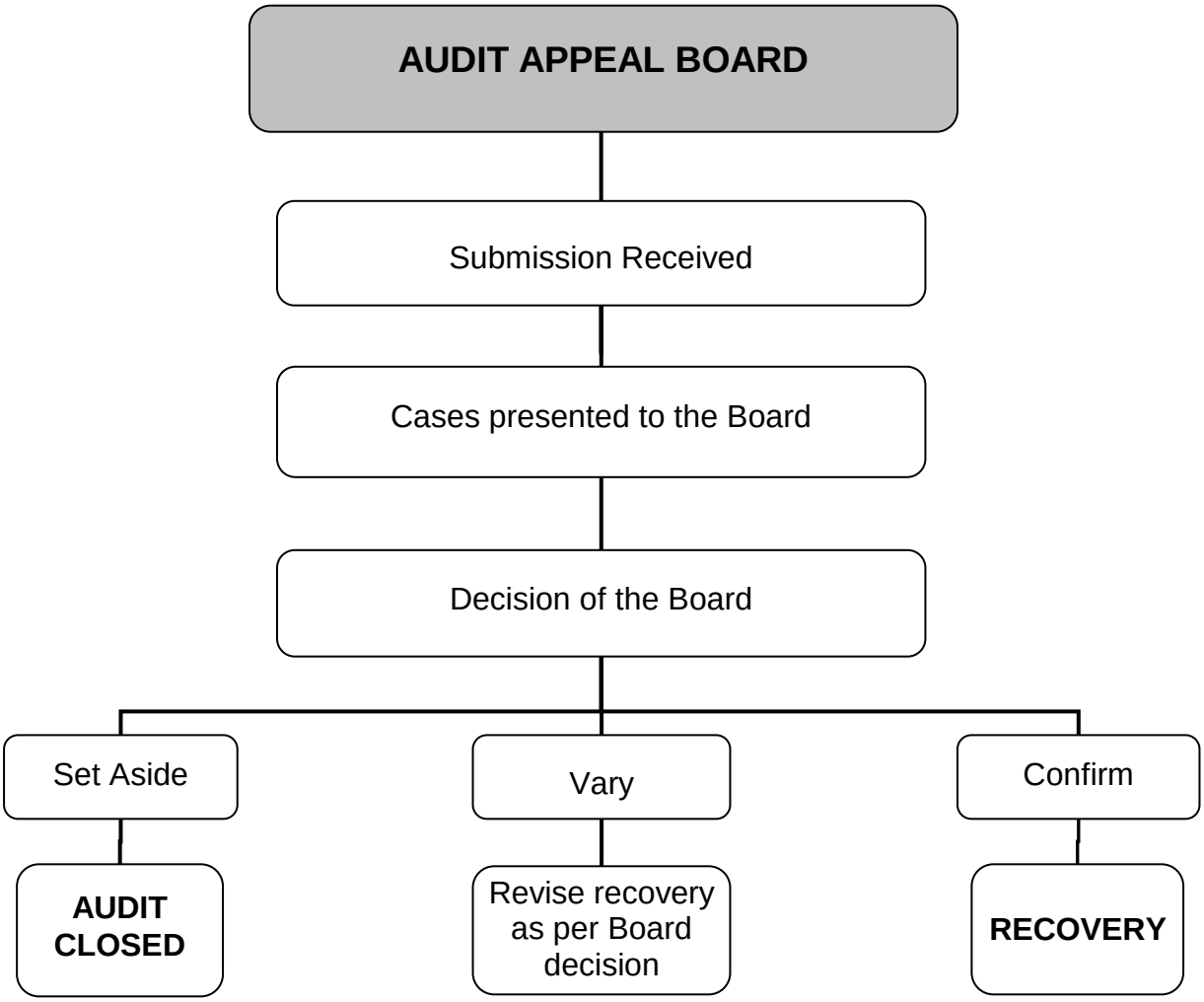
12.3.7 NOTIFICATION



12.3.8 ALTERNATE DISPUTE RESOLUTION (ADR)



12.3.9 HEARING BY AUDIT REVIEW BOARD



12.4 NLPDP AUDIT RECOVERY PROCEDURES

The following is a list of the most common billing issues identified during audits of NLPDP claims. The purpose of this list is to illustrate the nature of the possible recovery action which may be taken based on audit findings. Please refer to the referenced Provider Guide Section for further clarification.

GUIDE SECTION	
Audit Findings	**Action**
10.3 Compound Preparations	
Incomplete or missing compound documentation requirements	Recovery of the professional fee paid for original and any refills
Non-Benefit items billed under the compound DIN 00999997	Recovery of the total amount paid for original and any refills
Compound ingredients determined to be overbilled	Recovery of excess amount paid
10.8 Documentation Requirements	
Patient's first name or surname missing	Recovery of the total amount paid for original and any refills
No patient name indicated	Recovery of the total amount paid for original and any refills
Drug name not indicated	Recovery of the total amount paid for original and any refills
No drug strength indicated where multiple strengths exist	Recovery of the total amount paid for original and any refills
No quantity or dosage directions indicated for drug prescribed	(i) If no quantity and no dosage directions indicated, recover total amount paid for original and any refills. (ii) Unless the quantity claimed is the only size manufactured and the package format is such that it cannot be divided (e.g., inhalers, insulins, and ophthalmic/otic products) recover professional fee paid for original and any refills.
Authorized signature of prescriber not present on written prescription	Recovery of the total amount paid for original and any refills
Missing prescription(s) in a sample containing greater than 100 original	

prescriptions: (i) One or two prescriptions (ii) Three or more prescriptions	 (i) Recovery of the professional fee paid for original and any refills (ii) Recovery of the total amount paid for original and any refills
10.9 Expiry of a Prescription	
Claim(s) billed greater than one year from the date the prescription was originally written or ordered, except in cases authorized by Medication Management	Recovery of the total amount paid for any claims billed past the expiry date.
10.10 Interchangeability of Medications	
Drug interchange not authorized under Section 10.10 of the NLPDP Provider Guide or the Prescriber	Recovery of the total amount paid for original and any refills
10.12 Multiple Billings	
Multiple Billings submitted, same patient, same DIN, same day except for compounds	Recovery of the total amount paid for excess billing(s)
10.16 Days' Supply Policy	
Claims identified as being billed in a smaller quantity than prescribed (with the exception of Customized Patient Drug Packing)	Recovery of excess professional fee(s)
Medication(s) required to be filled to a maximum of 30 days without documentation supporting a reasonable rationale.	Recovery of excess product cost
10.18 Quantities – Pre-Packaged Drugs	
Quantity billed is not equal to the nearest reasonable package size.	Recovery of the excess product cost
10.20 Refills in Excess of that Authorized	
Refills in excess of that authorized except in cases authorized by medication management	Recovery of total amount paid for excess refills
10.23 Tamper Resistant Prescription Drug Pad (TRPP) Program	
Incomplete or missing TRPP requirements	Recovery of the total amount paid for

	original and any refills
10.25 Refusal to Fill	
Incomplete or missing Refusal to Fill documentation requirements	Recovery of the refusal to fill professional fee paid
10.26 Prescribing by Pharmacists	
Incomplete or missing documentation as per requirements for Prescribing by Pharmacists	If the pharmacist is authorized to Prescribe - Recovery of the medication management professional fee paid If the pharmacist is not authorized to Prescribe – Recovery of the total amount paid for original and any refills