DEPARTMENT OF HEALTH & HUMAN SERVICES **Office of Inspector General**

Washington, D.C. 20201

July 29, 2011

TO: Donald M. Berwick, M.D.
Administrator
Centers for Medicare & Medicaid Services

FROM: /Lori S. Pilcher/
Acting Deputy Inspector General for Audit Services

SUBJECT: Review of Arkansas Medicaid Prescription Drug Claims for the Quarter Ended December 31, 2008 (A-06-09-00093)

Attached, for your information, is an advance copy of our final report on Arkansas Medicaid prescription drug claims for the quarter ended December 31, 2008. We will issue this report to the Arkansas Department of Human Services within 5 business days.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact Brian P. Ritchie, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through email at Brian.Ritchie@oig.hhs.gov or Patricia Wheeler, Regional Inspector General for Audit Services, at (214) 767-8414 or through email at Trish.Wheeler@oig.hhs.gov. Please refer to report number A-06-09-00093.

Attachment

DEPARTMENT OF HEALTH & HUMAN SERVICES **Office of Inspector General**

Office of Audit Services, Region VI
1100 Commerce Street, Room 632
Dallas, TX 75242

August 2, 2011

Report Number: A-06-09-00093

Mr. Eugene Gessow
Division Director
Division of Medical Services
Department of Human Services
Donaghey Plaza South
P. O. Box 1437, Slot S401
Little Rock, AR 72203-1437

Dear Mr. Gessow:

Enclosed is the U.S. Department of Health & Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of Arkansas Medicaid Prescription Drug Claims for the Quarter Ended December 31, 2008*. We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at http://oig.hhs.gov.

If you have any questions or comments about this report, please do not hesitate to call me at (214) 767-8414 or contact Paul Chesser, Audit Manager, at (501) 225-8114 or through email at Paul.Chesser@oig.hhs.gov. Please refer to report number A-06-09-00093 in all correspondence.

Sincerely,

/Patricia Wheeler/
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Ms. Jackie Garner
Consortium Administrator
Consortium for Medicaid and Children's Health Operations
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, IL 60601

Department of Health & Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF ARKANSAS MEDICAID PRESCRIPTION DRUG CLAIMS FOR THE QUARTER ENDED DECEMBER 31, 2008

Daniel R. Levinson
Inspector General

August 2011
A-06-09-00093

Office of Inspector General

http://oig.hhs.gov

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health & Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC

at http://oig.hhs.gov

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site.

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

Pursuant to Title XIX of the Social Security Act, the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements. Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (CMS-64 report), summarizes, by category of service, actual Medicaid expenditures for each quarter and is used by CMS to reimburse States for the Federal share of Medicaid expenditures.

The American Recovery and Reinvestment Act of 2009 (the Recovery Act), P.L. No. 111-5, enacted February 17, 2009, provided, among other initiatives, fiscal relief to States to protect and maintain State Medicaid programs in a period of economic downturn. For the recession adjustment period (October 1, 2008, through December 31, 2010), the Recovery Act provided approximately $87 billion in additional Medicaid funding based on temporary increases in States' Federal medical assistance percentages (FMAP). The Federal Government pays its share of a State's medical assistance expenditures under Medicaid based on the FMAP, which varies depending on that State's relative per capita income.

In Arkansas, the Department of Human Services (the State agency) administers the Medicaid program. Medically necessary pharmaceutical services are included in Medicaid coverage. These services are provided by pharmacies, which obtain reimbursement from the State pursuant to Federal and State regulations. The claims for prescribed drugs were included in the temporary increases in States' FMAPs. Arkansas' FMAP increased from 72.81 percent to 79.14 percent, an increase of 6.33 percent, for the quarter ended December 31, 2008.

OBJECTIVES

Our objectives were to determine whether (1) the State agency's claim for Federal reimbursement of Medicaid outpatient drug expenditures on the CMS-64 report was supported by actual recorded expenditures and (2) the expenditures were supported by pharmacy records.

SUMMARY OF FINDINGS

For the quarter ended December 31, 2008, the State agency's claim for Federal reimbursement of Medicaid outpatient drug expenditures on the CMS-64 report was supported by actual recorded expenditures. In addition, pharmacy records supported 774 of the 800 sampled claims. Of the 26 unsupported claims, 11 were unsupported because the drug or quantity dispensed was not authorized, 11 because the original prescription had expired, 2 because the pharmacies could not locate the prescriptions, and 2 because the prescriptions did not authorize refills. Based on our sample results, we estimated that the State agency reimbursed pharmacies $1.7 million for Medicaid outpatient drug claims that were not supported by pharmacy records for the quarter

ended December 31, 2008. In addition, 127 prescriptions were not written on tamper-resistant pads as required by Federal statute, and the pharmacies did not document verification of those prescriptions with the prescribing practitioners in accordance with CMS guidance.

PHARMACY COMMENTS

Pharmacies generally concurred with our findings, described corrective actions, and stated that they would work with the State agency to resolve issues related to the audit. However, pharmacy representatives stated that although they understood the importance of the tamper-resistance requirement, its implementation places an undue burden on the pharmacies. The pharmacy representatives also said that there are no consequences for physicians who use prescription pads that do not comply with Federal tamper-resistance requirements.

RECOMMENDATIONS

We recommend that the State agency:

- work with the pharmacies to determine the proper resolution for the 26 unsupported claims,
- remind pharmacies of CMS guidance to verify prescriptions that do not comply with Federal tamper-resistance requirements,
- remind physicians of the Federal tamper-resistance requirements for prescriptions, and
- strengthen its review process to ensure that payments are made only for drugs that are supported by appropriate records.

STATE AGENCY COMMENTS

The State agency described actions it had taken and stated that all findings had been turned over to the State Program Integrity Unit for further action. The State agency's comments are included in their entirety as Appendix D.

TABLE OF CONTENTS

Page

INTRODUCTION 1

BACKGROUND 1
Medicaid Program 1
Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program 1
Temporary Increases in Federal Medical Assistance Percentages 1

OBJECTIVES, SCOPE, AND METHODOLOGY 2
Objectives 2
Scope 2
Methodology 2

FINDINGS AND RECOMMENDATIONS 3

FEDERAL AND STATE REQUIREMENTS 3

CLAIMS NOT SUPPORTED 4
Incorrect Dispensing 4
Expired Prescriptions 4
Missing Prescriptions 5
Unauthorized Refills 5

TAMPER-RESISTANCE REQUIREMENT NOT FOLLOWED 5

PHARMACY COMMENTS 5

RECOMMENDATIONS 5

STATE AGENCY COMMENTS 6

APPENDIXES

A: SAMPLE DESIGN AND METHODOLOGY

B: SAMPLE RESULTS AND ESTIMATES

C: SUMMARY OF UNSUPPORTED CLAIMS BY PHARMACY

D: STATE AGENCY COMMENTS

INTRODUCTION

BACKGROUND

Medicaid Program

Pursuant to Title XIX of the Social Security Act, the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements. Pursuant to section 1905(b) of the Social Security Act, the Federal Government pays its share of a State's medical assistance expenditures under Medicaid based on the Federal medical assistance percentage (FMAP), which varies depending on the State's relative per capita income.

In Arkansas, the Department of Human Services (the State agency) administers the Medicaid program. Medically necessary pharmaceutical services are included in Medicaid coverage. These services are provided by pharmacies, which obtain reimbursement from the State pursuant to Federal and State regulations.

Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program

Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (CMS-64 report), summarizes, by category of service, actual Medicaid expenditures for each quarter and is used by CMS to reimburse States for the Federal share of Medicaid expenditures. The amounts reported on the CMS-64 report and its attachments must be actual expenditures with supporting documentation. The expenditures must be readily reviewable, compiled, and available at the time the claim is filed.

CMS considers claims developed through sampling (other than under an approved cost allocation or administrative claiming plan), projections, or other estimating techniques to be estimates, which are not allowable.

Temporary Increases in Federal Medical Assistance Percentages

The American Recovery and Reinvestment Act of 2009 (the Recovery Act), P.L. No. 111-5, enacted February 17, 2009, provided, among other initiatives, fiscal relief to States to protect and maintain State Medicaid programs in a period of economic downturn. For the recession adjustment period (October 1, 2008, through December 31, 2010), the Recovery Act provided approximately $87 billion in additional Medicaid funding based on temporary increases in States' FMAPs. Arkansas' FMAP increased from 72.81 percent to 79.14 percent, an increase of 6.33 percent, for the quarter ended December 31, 2008. Section 5000 of the Recovery Act provided these increases to help avert cuts in health care provider payment rates, benefits, or services and to prevent changes in income eligibility requirements that would reduce the number

of individuals eligible for Medicaid. The claims for prescribed drugs were included in the temporary increases in States' FMAPs.

OBJECTIVES, SCOPE, AND METHODOLOGY

Objectives

Our objectives were to determine whether (1) the State agency's claim for Federal reimbursement of Medicaid outpatient drug expenditures on the CMS-64 report was supported by actual recorded expenditures and (2) the expenditures were supported by pharmacy records.

Scope

The State agency claimed Medicaid expenditures totaling $838 million ($665 million Federal share) for the quarter ended December 31, 2008. Our review covered one line item on the CMS-64 report, "Prescribed Drugs," which totaled $84 million.

We limited our review to Medicaid outpatient drug claims with amounts greater than zero, pharmacies with quarterly claims totaling $20,000 or more, and pharmacies that were not under investigation by the State agency or other Federal authorities. Our review covered 688 pharmacies and 1,177,230 claims that totaled $83,533,525 ($5,287,672 in Recovery Act funds).

We limited our review of supporting documentation to the records maintained at each pharmacy. We did not review physician medical records or obtain confirmations from prescribing physicians or beneficiaries.

Our objective did not require an understanding or assessment of the complete internal control structure at the State agency or the pharmacies. We limited our internal control review at the State agency to obtaining an understanding of the procedures used in reconciling Medicaid drug expenditures to claim data, and we limited our review at the pharmacies to obtaining an understanding of the procedures that the pharmacies used to receive, dispense, and document prescriptions.

We conducted our fieldwork at eight pharmacies located throughout Arkansas in December 2009 and January and April 2010.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal and State requirements;

- obtained Medicaid prescription claim data and CMS-64 report data from the State agency and reconciled the claim data to the expenditures reported on the CMS-64 report;

- selected, as detailed in Appendix A, a 2-stage sample, randomly selecting 8 pharmacies and then randomly selecting and reviewing 100 claims from each of the pharmacies;

- interviewed the pharmacies' staff regarding procedures for receiving, dispensing, and documenting prescriptions;

- reviewed the original prescription for each sampled claim;

- estimated, as shown in Appendix B, the total value of unsupported claims in the sampling frame; and

- summarized, as shown in Appendix C, the unsupported claims by pharmacy.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

FINDINGS AND RECOMMENDATIONS

For the quarter ended December 31, 2008, the State agency's claim for Federal reimbursement of Medicaid outpatient drug expenditures on the CMS-64 report was supported by actual recorded expenditures. In addition, pharmacy records supported 774 of the 800 sampled claims. Of the 26 unsupported claims, 11 were unsupported because the drug or quantity dispensed was not authorized, 11 because the original prescription had expired, 2 because the pharmacies could not locate the prescriptions, and 2 because the prescriptions did not authorize refills. Based on our sample results, we estimated that the State agency reimbursed pharmacies $1.7 million for Medicaid outpatient drug claims that were not supported by pharmacy records for the quarter ended December 31, 2008. (See Appendix B for our sample results and estimates.) In addition, 127 prescriptions were not written on tamper-resistant pads as required by Federal statute, and the pharmacies did not document verification of those prescriptions with the prescribing practitioners in accordance with CMS guidance.

FEDERAL AND STATE REQUIREMENTS

The *Arkansas Medicaid Pharmacy Provider Manual* (the provider manual),[1] section II 211.000, states: "Prescription drugs are covered by the Arkansas Medicaid Program pursuant to an order from an authorized prescriber." The Arkansas Pharmacy Practice Act, section 17-92-101(17), defines a prescription as an order for medicine usually written by a physician containing the name and quantity of the desired substance with instructions to the pharmacist for its preparation.

The provider manual, section II 213.200, states: "Refills are reimbursable under the Arkansas Medicaid Pharmacy Program only if they are specifically authorized on the original prescription

[1] Codified at 016 06 CARR 035 (2011).

or if authorized by the physician at a later date and recorded by the pharmacist on the original prescription when refilled." It further states: "In no event is any prescription to be refilled more than five (5) times or beyond six (6) months after the date of the original issue. Renewals or continuation of drug therapy beyond six months requires another original prescription."

Section II 221.000 of the provider manual states that pharmacy providers furnishing any Medicaid-covered service must maintain prescriptions in a manner that makes them readily retrievable for at least 5 years. It further states that pharmacy providers must immediately furnish these records to the U.S. Department of Health & Human Services when requested.

Pursuant to section 1903(i)(23) of the Social Security Act, effective April 1, 2008, payment shall not be made for covered outpatient drugs unless the prescriptions are written on a tamper-resistant pad. This requirement applies only to written or printed prescriptions and not to prescriptions that are transmitted from the prescriber to the pharmacy verbally, by fax, or through an e-prescription. Guidance issued by CMS, the CMS Medicaid Tamper Resistant Prescription Law – Pharmacist FACT SHEET (the Fact Sheet), stated that the requirement for tamper-resistant pads would be implemented in two phases. Phase one, effective April 1, 2008, required States to meet one of three specific tamper-resistance characteristics. Phase two, effective October 1, 2008, required compliance with all three characteristics. For prescriptions not meeting the tamper-resistance requirement, the Fact Sheet stated that the pharmacist could request verification of the prescription from the prescribing practitioner and document the verification or fill the prescription on an emergency basis and obtain documentation within 72 hours.

CLAIMS NOT SUPPORTED

Incorrect Dispensing

Eleven claims from four pharmacies were for drugs that were incorrectly dispensed. Dispensing errors included dispensing a larger quantity of the drug than was authorized, dispensing an additional active ingredient that was not authorized, and dispensing an extended-release form of the authorized drug. The most common response given by pharmacy representatives was that the prescriptions were for drugs that came in prefilled sizes (e.g., a 15-gram tube, a 20-milliliter bottle) that the pharmacies did not have in stock. The pharmacies attributed the other errors to clerical mistakes or did not know why the errors occurred.

Expired Prescriptions

Eleven claims from three pharmacies were for prescriptions filled more than 6 months after the original date on the prescriptions. Pharmacy representatives stated that they reviewed the number of refills remaining when determining whether a prescription was still valid or that they relied on the State agency to reject a claim if the prescription was expired.

Missing Prescriptions

One pharmacy was not able to locate the prescriptions for two of the claims in our sample. The pharmacy representative stated that the prescriptions had been misplaced.

Unauthorized Refills

Two claims at one pharmacy were for prescriptions that were refilled without documented physician authorizations. The prescriptions indicated "No Refills." A pharmacy representative stated that the prescriptions were refilled because of clerical errors.

TAMPER-RESISTANCE REQUIREMENT NOT FOLLOWED

Of the 363 written prescriptions in our sample (435 prescriptions were transmitted verbally, faxed, or e-prescribed, and 2 prescriptions were missing), 127 were on forms that did not contain all 3 tamper-resistance characteristics. However, 112 of these 127 prescriptions met the phase one requirement. Additionally, the pharmacies did not document verification with the prescribing practitioner for any of the 127 prescriptions. Although evidence indicated that the 127 claims were adequately supported by the prescriptions, the use of tamper-resistant forms would have decreased the risk of a fraudulent prescription being filled.

PHARMACY COMMENTS

Pharmacies generally concurred with our findings, described corrective actions, and stated that they would work with the State agency to resolve issues related to the audit. However, pharmacy representatives stated that although they understood the importance of the tamper-resistance requirement, its implementation places an undue burden on the pharmacies. The pharmacy representatives also said that there are no consequences for physicians who use prescription pads that do not comply with Federal tamper-resistance requirements.

RECOMMENDATIONS

We recommend that the State agency:

- work with the pharmacies to determine the proper resolution for the 26 unsupported claims,
- remind pharmacies of CMS guidance to verify prescriptions that do not comply with Federal tamper-resistance requirements,
- remind physicians of the Federal tamper-resistance requirements for prescriptions, and
- strengthen its review process to ensure that payments are made only for drugs that are supported by appropriate records.

STATE AGENCY COMMENTS

The State agency described actions it had taken and stated that all findings had been turned over to the State Program Integrity Unit for further action. The State agency's comments are included in their entirety as Appendix D.

APPENDIXES

APPENDIX A: SAMPLE DESIGN AND METHODOLOGY

POPULATION

The population consisted of Medicaid outpatient drug claims paid by the Department of Human Services (the State agency) to pharmacies, excluding claims for zero dollars and negative adjustments, during the period October 1 through December 31, 2008.

SAMPLING FRAME

The State agency provided two electronic files listing paid Medicaid outpatient drug claims. We excluded one of the files, as well as payouts, voids, recoupments, and zero-dollar and negative adjustment claims. We also removed all claims for pharmacies with total reimbursement of less than $20,000 during our audit period, leaving 1,184,250 claims at 692 pharmacies that totaled $85,636,746. Finally, we removed claims for pharmacies that were under investigation by the State agency or other Federal authorities, leaving us a sampling frame of 688 pharmacies with 1,177,230 claims that totaled $83,533,525.

SAMPLE UNIT

The sample unit was a paid Medicaid outpatient drug claim.

SAMPLE DESIGN

We used a two-stage random sample. We randomly selected 8 pharmacies and then randomly selected 100 claims from each of these 8 pharmacies.

SAMPLE SIZE

We selected 800 Medicaid outpatient drug claims, 100 from each of the 8 pharmacies.

SOURCE OF RANDOM NUMBERS

We generated the random numbers using Office of Inspector General, Office of Audit Services, statistical software.

METHOD OF SELECTING SAMPLE ITEMS

We consecutively numbered the pharmacies in the sampling frame from 1 to 688. After generating eight random numbers, we selected the corresponding frame items.

We consecutively numbered the claims in the sampling frame for each of the pharmacies from 1 to the maximum number of claims paid to that pharmacy. After generating 100 random numbers for each of the pharmacies, we selected the corresponding frame items.

APPENDIX B: SAMPLE RESULTS AND ESTIMATES

Sample Results

Frame Size	Value of Frame	Sample Size	Value of Sample	Number of Unsupported Claims	Value of Unsupported Claims
1,177,230	$83,533,525	800	$57,392	26	$1,881

Estimates

(*Limits calculated for a 90-percent confidence interval)*

	Value of Unsupported Records
Point estimate	$1,660,106
Lower limit	(409,362)
Upper limit	3,729,574

APPENDIX C: SUMMARY OF UNSUPPORTED CLAIMS BY PHARMACY

Pharmacy	Incorrect Dispensing	Expired Prescriptions	Missing Prescriptions	Unauthorized Refills	Not Tamper Resistant
A	1				16
B	4			2	24
C	4	3			11
D					7
E	2		2		21
F		2			13
G					16
H		6			19
Total	**11**	**11**	**2**	**2**	**127**

APPENDIX D: STATE AGENCY COMMENTS

Arkansas Department of Human Services
Division of Medical Services
P.O. Box 1437, S415
Little Rock, AR 72203-1437
501-683-4120 □ 501-683-4124 (Fax) □ 501-682-6789 (TDD)

May 12, 2011

Common Identification Number: A-06-09-00093

Patricia Wheeler
Regional Inspector General
for Audit Services
Office of Inspector General
Office of Audit Services
1100 Commerce, Room 632
Dallas, TX 75242

Dear Ms. Wheeler:

We have received the copies of the Department of Health and Human Services, Office of Inspector General, Office of Audit Services' draft report of the "*Review of Arkansas Medicaid Prescription Drug Claims for the Quarter Ending December 31, 2008.*

Once the state obtained the actual claim level detail to contact the providers, we were able to determine that in some instances of Incorrect Dispensing there were factors that were within the scope of dispensing. In all cases, pharmacies were instructed to address these issues with staff.

Expired Prescriptions is being addressed by the State in having a system edit implemented to disallow claims to pay past 6 months from the original fill.

As it related to the Federal tamper proof requirement, which encompassed the bulk of the findings, was conducted at the time of implementation of the second phase requiring all three tamper proof elements. A solution indicated by the pharmacies is that they would reaffirm with staff on the process of contacting physicians for verification when a non tamper proof form was submitted for a prescription.

A meeting was held with the local OIG and the state related to the audit. Missing Prescriptions and Unauthorized fills as well as *all* findings were turned over to the State Program Integrity Unit for any further action..

If you have further questions please feel free to contact me at (501) 683-4120.

Sincerely,

Suzette Bridges

Suzette Bridges, PD
Director, Pharmacy Program
Arkansas Medicaid

cc: Eugene Gessow, Director of Division of Medical Services
Paul Chesser, Audit Manager, Office of Inspector General