



Prescription drug fraud can be a costly problem for health plans. The author describes common abuses and recommends steps plan sponsors can take to identify fraud and stop it from happening.

Finding and Preventing Prescription Drug Fraud



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benefits

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It seems that a day does not go by without prescription drug fraud making the headlines. Consider these stories:

- The city of Kermit, West Virginia is seeking to recoup the costs of dealing with opioid abuse and is suing out-of-state drug distributors.¹
- A former university trustee pleads guilty to tax evasion charges for prescribing painkillers without a legitimate medical purpose.²
- An Amherst, New York doctor is sentenced for fraud for writing more than 200 illegal painkiller prescriptions and will spend two years in prison.³

As these examples illustrate, fraud is committed at many levels and often by those we expect to be ethical, making it all the more difficult to detect. While many plan sponsors rely on pharmacy benefit managers (PBMs) to help them prevent prescription drug fraud, there are actions that plan sponsors, as fiduciaries, should take to ensure that their plans and participants don't fall victim.

Defining Prescription Drug Fraud

The National Health Care Anti-Fraud Association in 2009 estimated that annual health care fraud costs as much as \$234 billion. *Prescription drug fraud* can be defined as any unlawful act that involves a prescription drug and is performed for financial gain. A wide range of activities qualify under this broad definition: drug diversion within a hospital, pharmacists submitting fake prescriptions or physicians writing prescriptions for patients not under their care.

Drug diversion, which is when medi-

cal personnel (physicians, pharmacists, nurses or other medical personnel) steal drugs for their own use or to sell illegally, is on the rise. The International Health Facility Diversion Association estimates that 37,000 health care professionals are impaired in the United States on a daily basis from drugs stolen from their place of employment.⁴

Prescription drug fraud comes under the purview of state and federal laws, as well as Employee Retirement Income Security Act (ERISA) regulations. Pharmacies and PBMs also are contractually obligated to not commit fraud. Violators of these laws face potential significant jail time (e.g., up to 20 years for medical identity fraud) and may be required to make restitution. Perpetrators who work in the health care industry, such as pharmacists and physicians, also may temporarily or permanently lose their license to practice.

Federal laws that encompass prescription drug fraud include the False Claims Act, wire and mail fraud statutes, the Health Care Fraud Statute and theft or embezzlement of health care statutes. The False Claims Act, for example, provides a civil penalty of between \$5,000 and \$10,000 for each count (i.e., each claim processed) plus three times the amount of damages to government programs because of the action. The Civil Monetary Penalties Law provides penalties of \$10,000 per item or service—so for every fraudulent claim processed, the perpetrator could receive a penalty far in excess of the actual claim amount or a simple one-for-one damage restitution order.

In addition to laws, each state has licensing regulations governing health care professionals that include provisions against fraud.

Why Prescription Drug Fraud Happens

The regulation or lack of regulation of pharmacy technicians can be a factor in prescription drug fraud. For example, most states require a pharmacy to be owned and operated by a pharmacist, but Florida (one of the most notorious states for prescription drug fraud) allows pharmacy technicians to own a pharmacy if they pay \$105 and complete a two-week course. Adding to the ripe conditions for fraud is that south Florida has the highest density of Medicare and Medicaid recipients in the U.S.

Several states, including New York, Pennsylvania, Wisconsin, Delaware, Colorado and Hawaii, do not regulate pharmacy technicians. In these states, a convicted felon (with a conviction of possession or distribution of controlled substances, for example) can work behind the counter with unfettered access to medications. These vital assistants perform many routine functions within the pharmacy but also are given a wide range of discretion. They have the potential to greatly harm patients, since technicians mix compounds and place the appropriate drugs in the vial for patients.

Many prescription drug fraud schemes involve medical identity theft, which can be costly. According to think tank Ponemon Institute, a medical identity theft incident costs patients an average of \$22,000 and affects 1.85 million Americans.⁵

How Fraud Happens

Phantom Prescriptions

In a 2014 case, a California medical clinic wrote thousands of fraudulent prescriptions for antipsychotic medications for fictional patients, according

to a statement from the U.S. Attorney's Office (these fake prescriptions are commonly referred to as *phantom prescriptions*). The company then bought back the drugs for a nominal fee and diverted them to the black market to sell to other pharmacies.⁶

Institutional Fraud

Another example of prescription drug fraud involves *institutional fraud* (fraud perpetrated by the industry itself: drug companies, mail-order facilities, pharmacy chains and PBMs). In one recent case, a drug manufacturer was accused of hiding its relationship with a network of mail-order pharmacies that solicited physicians and overrode plan design. The mail-order chain helped the pharmaceutical company artificially increase its revenue by bending account rules in a channel stuffing scheme⁷ and used coupons to increase sales and to forgive copays.⁸

A lawsuit against the manufacturer claimed it was:

- Actively changing codes on prescriptions to ensure that the prescriptions would be filled with its own drug rather than a generic equivalent
- Using false pharmacy identification information to bill payers/PBMs for prescriptions in order to fraudulently bypass payers' denials of claims for reimbursement
- Submitting prescription renewals for reimbursement and falsely representing to payers/PBMs that patients had requested renewals of their prescriptions when no such request had been made
- Waiving patient copays through manufacturer coupons or otherwise to remove patients' incentive to seek out cheaper drugs
- Using affiliate pharmacies within its "enterprise" to enable the mail-order pharmacies to indirectly operate in states where it had been denied a license.⁹

What Plan Sponsors Should Do

There are efforts within the health care industry to combat fraud. For example, more than 40 health insurance agencies have formed the Medical Identity Fraud Alliance to fight medical identity theft.¹⁰ Plan sponsors, however, should undertake their own efforts to detect and prevent prescription drug fraud.

Discuss Fraud With the PBM

Plan sponsors should first talk with their PBMs about fraudulent claims and find out what policies and procedures

the PBM has for auditing and prosecuting fraud. Most PBMs have some type of fraud program, but they may not be strong enough or might fail to find the fraud until after the claims have been paid.

Some PBM fraud programs may send auditors to a small number of pharmacies to determine if the pharmacy has the proper paperwork (e.g., prescription order and signature log). If the pharmacy does not have the proper records, even if the prescription was ordered by a prescriber and the patient requested/received the prescription, the claim is reversed, and the plan sponsor may or may not be credited for the claim.¹¹

These procedures, however, are recordkeeping investigations rather than true fraud investigations. Many of the auditors may have little or no law enforcement/private investigation experience and may not properly prepare a case for prosecution. They also may lack the legal authority to investigate a pharmacy, since many states require any person who investigates claims and who does not work for an insurance company, or investigates *beyond the claim* (meaning investigating ownership or finances of a pharmacy), to be a licensed private investigator.¹²

Obtain and Review Claims Data

A significant spike in claims—either from a particular pharmacy or provider or a specific therapeutic class (such as *compound drugs*) can be a warning sign for fraudulent claims. Compound drugs are medications that are mixed together and that are not commercially available. Compounding a drug is perfectly legal (a) if it is medication that is not commercially available in the formulation needed by the patient and

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Education

Visit www.ifebp.org/benefitbits to watch a video of Susan Hayes discussing pharmacy fraud.

Fraud Prevention Institute for Employee Benefit Plans

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From the Bookstore

Pharmacy Benefits: Plan Design and Management

F. Randy Vogenberg. International Foundation. 2011.

Visit www.ifebp.org/books.asp?6962 for more information.

takeaways

- Health care fraud, including prescription drug fraud, is estimated to cost as much as \$234 billion annually in the United States.
- *Phantom prescriptions*—prescriptions for fictional patients—are a common prescription drug fraud scheme.
- Plan sponsors should talk with their pharmacy benefit manager (PBM) to find out what policies and procedures the PBM has for auditing and prosecuting fraud.
- Warning signs for fraud include a significant spike in claims from a particular pharmacy or for a specific therapeutic class of drugs. A big increase in prescriptions for opioids also should raise a red flag.
- Plan sponsors should educate participants about fraud, including how to protect their medical identity and the penalties for committing fraud. Providing participants with an annual pharmacy benefits statement will help keep them on the lookout for fraud.

(b) only if the volume is under 5% of a pharmacy's overall prescription volume. If over 5%, the pharmacy must be registered with its state board of pharmacy, and if over 30%, the state board must conduct annual inspections. Compound drug claims should represent less than one half of 1% of overall volume. If compound drugs are more than one half of 1% of claims, it may mean a pharmacy is submitting compound bulk products that are clinically ineffective or dangerous. It is illegal for a pharmacy to submit a claim for a product that is commercially available or not approved by the U.S. Food and Drug Administration.¹³

Opioid abuse is on the rise in the U.S. and represents another area where plan sponsors can focus their attention. Opioids should be used on a long-term basis (more than six weeks) only for diagnoses such as cancer. If opioid use is increasing, but the plan participant population does not have a significant number of cancer patients, it may be a sign of fraud. A review of line item data can help detect an opioid problem by revealing whether the patient has been on the drug for more than six months, does not have a cancer diagnosis or is

not under the care of a pain management specialist or orthopedic surgeon. Many summary reports from PBMs may mask the issue because generic opioids are very inexpensive and may never bubble up to the top drugs on any cost report. For example, 120 5 mg tablets of oxycodone can be purchased at Walmart for \$18.58, a relatively inexpensive prescription compared with other drugs.¹⁴ However, those same 120 tablets can sell for \$80 a pill, or \$9,600, on the black market.¹⁵

Claims also should be reviewed for inappropriate relationships. In order for many fraudulent claim schemes to work, the pharmacy and physician must work together. The physician must typically write the phantom prescription and the pharmacist must “dispense” the prescription (although there is no dispensing, simply adjudication to collect funds). If a review of data reveals that a single physician has many of his or her prescriptions dispensed at a single pharmacy or vice versa, there may be an issue of coconspiracy of health care fraud occurring.

Claims should be reviewed for use of pharmacies outside of the plan sponsor's

geographic area. It is rare that a member in Illinois, for example, will travel to New York to simply obtain a prescription at a New York pharmacy, especially if the physician is also in Illinois.

Educate Members About Fraud

It's much less likely for a plan to fall victim to fraud if plan members are diligent about their medical identity information. Inform members that their medical identity (carrier identification number, name, date of birth, address) should be held in the strictest confidence. In today's environment, providers should never ask for a Social Security number. Plan sponsors should make members aware that it is a federal crime for anyone other than the provider, insurance company or PBM to ask for their medical identity. The sale of medical identity occurs daily, and a simple online search of Craigslist or other websites reveals that a list of medical identities can easily be procured for \$50.

Plan sponsors should warn participants that they risk termination from the medical and pharmacy benefit plan (or termination of employment) as well as prosecution if they are caught selling their identity. Plan participants also should be informed that selling prescription drugs obtained under the pharmacy benefit program is illegal and subject to prosecution.

Send an Annual Pharmacy Benefits Statement

Many members are unaware that their medical identity has been compromised. This can happen when a health care provider staff member (or the provider itself) sells the identity or uses the identity to submit fraudulent claims. In addition, dependents can

commit medical identity fraud without the primary cardholder's knowledge.

An annual statement that includes all of the prescription drugs dispensed on behalf of members will at least inform them of the specific drugs that have been dispensed under their identity. A strong statement about fraud should be included on the statement, as well as an anonymous hotline number to call to report fraud (often provided by medical carriers and PBMs).

Notify Legal Counsel

Plan sponsors that suspect fraud should immediately notify legal counsel. The plan attorney (whether in-house or external counsel) realizes plan sponsors have a fiduciary responsibility to the plan participants to not pay for fraudulent prescriptions. The legal counsel may then hire an investigation firm outside of the PBM to obtain evidence to pursue legal action. This firm should have the computer programming skills to use statistical modeling on claims data to detect fraud.¹⁶ The firm should then be able to supplement the results of the statistical analysis with good old "gumshoe" investigation work that drills down into the problem and, in counsel with plan attorneys, works toward a solution that may or may not involve prosecution and/or a settlement that involves restitution.

Conclusion

Prescription drug fraud is now a fact of life that frequently makes the headlines. Perpetrators of these crimes, punishable through federal, state and regulatory agencies, range from low-level fraudsters to pillars of society such as university trustees, physicians and pharmacists. Rather than relying on others, plan sponsors, through legal counsel, should take matters into their own hands and make sure their claims and assets are properly monitored. 📍

Endnotes

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