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
Prescription Drug Fraud

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.

Why Prescription Drug Fraud Happens

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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 scheme\(^7\) 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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(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 card-holder’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. 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 lower-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**

7. Channel stuffing is the business practice used when a company or a sales force within a company inflates its sales figures by forcing more products through a distribution channel than the channel is capable of selling to the world at large.
13. The Food and Drug Administration Modernization Act specifically prohibits compounding commercially available products, Section 503A; 21 USC Section 503A.

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She has more than 35 years of experience in the health care consulting and management industry. Hayes has a B.S. degree in criminal justice from Northeastern Illinois University and a master’s degree in criminology from Boston University. She is a certified registered pharmacy technician in Illinois and is accredited as a health care fraud investigator by the National Health Care Anti-Fraud Association.