welcome to

Demystifying the Part D Audit: Internal Auditing & Monitoring

CAREKINESIS
State-of-the-Art Medication Management

GCATMeds
Trusted by organizations nationwide as the authority on PACE pharmacy.
4 Sites

14 States

26 Clients

50 Centers

5000 Participants
The Medication Process in PACE is very complex...

CareKinesis helps to:

- **Reduce** Medication-Related Risk
- **Improve** Access
- **Optimize** Quality Metrics
- **Enhance** Participant & Staff Satisfaction
- **Assure** Compliance with Part D
EireneRx shared medication platform, e-prescribing

Dedicated geriatric-trained pharmacists

Dispensing and adherence packaging

PACE Medication Risk Mitigation™ Tools

Unique understanding of participants’ needs
Now, please welcome

Matthew Zimmerman
from Capstone Performance Systems
Demystifying the Part D Audit
Internal Auditing and Monitoring

Presented by Matt Zimmerman
Risk Adjustment Consultant
Capstone Performance Systems
Objectives

1. Part D Requirements for Internal Monitoring and Auditing
2. Implementing and Testing your Internal Monitoring and Auditing Work plan
3. Little-Known Work Plan Elements that Relate to Part D
4. Care Kinesis Compliance and Part D Resources
Background on Health Care Compliance

Monitoring and Auditing in Health Care
Beginnings of Monitoring and Auditing in Health Care

- The Office of the Inspector General (OIG) estimates the cost to taxpayers resulting from Fraud Waste and Abuse in the Medicare system to be in the billions (with a B) annually.

In fact, as a result of increased health care fraud investigations approximately $6.9 billion was recovered in FY2012 by the OIG.
Beginnings of Monitoring and Auditing in Health Care

- OIG has been at the forefront of fighting waste, fraud, and abuse in Medicare, Medicaid and more than 300 other HHS programs for more than 30 years," said Inspector General Daniel R. Levinson in a congressional speech in late 2012.
- The OIG budget is small in comparison to what they recover. Their budget in FY2013 was only $85 million.
- With this kind of return on investment the Government is quite likely to increase their activities surrounding detecting and preventing fraud waste and abuse.
Background on Health Care Compliance

- Plans should ask this question. Do we want to be part of the problem or part of the solution?
  - Developing an effective Monitoring and Auditing program is a solution to detect and repair any risks associated with health care compliance.
Plans that do not support this effort will live with the constant reminder that their Medicare payment may be at risk.

Plans that have a robust Monitoring and Auditing work plan can feel secure that they are utilizing the Medicare dollar to its fullest and have little concern about audits.
The Office of the Inspector General (OIG) defines the essential elements for an effective compliance plan in the federal register.

- These **guiding principles** were addressed way back in 1999. Perhaps even much earlier, but this 15 year old reference still holds true.

  A. Implement written policies, procedures and standards of conduct
  B. Designate a Compliance officer and Compliance committee
  C. Conduct effective training and education
  D. Develop effective lines of communication
  E. Enforce standards through well publicized disciplinary guidelines
  F. Conduct internal monitoring and auditing
  G. Respond promptly to detected offences, develop corrective action and reporting to the Government.
The OIG goes on to explain the overall benefits of a Compliance Plan. This guidance is 6 years before Medicare Part D, but still valid and ironically similar to today’s OIG advice for Part D.

COMPLIANCE BENEFITS INCLUDE:

- Formulation of effective internal controls to assure compliance with Federal regulations and internal guidelines
- Improved communication with enrollees (participants)
- The ability to respond more quickly and accurately react to employee’s operational compliance concerns.
COMPLIANCE BENEFITS INCLUDE:

- A concrete demonstration to employees and the community at large of a strong commitment to honest and responsible corporate conduct.
- The ability to monitor and assess employee and contractor behavior as it relates to fraud and abuse.
- Improved (clinical and non-clinical) quality of care and service delivery.
- Improved assessment tools that could affect many organization departments.
- Creation of an environment that encourages employees to report potential problems.
- Procedures that allow prompt and through investigation of possible misconduct.
So with what we just discussed we now understand the Federal government has been and will continue perusing fraud waste and abuse and this effort will continue for years to come.

Overall, plans with an effective compliance strategy will be better positioned for success.
Required Elements for Internal Monitoring and Auditing
Now let’s narrow our focus to further define an Effective Part D Internal Monitoring and Auditing work plan.

DEFINITIONS:

- **Monitoring**: Regular reviews performed as part of normal operations, to confirm ongoing compliance.

- **Auditing**: Formal reviews of compliance, with particular set of standards (policies and procedures, laws and regulations) used as base measures.

Distinction here would be monitoring is a routine process and auditing is a focused process used to verify the accuracy of plan monitoring activities.
Part D Compliance Elements

- Monitoring and auditing activities are needed to detect and prevent the following in your Plan:
  - **Fraud**: An intentional act of deception, misrepresentation, or concealment in order to gain something of value.
  - **Waste**: Over-utilization of services (not caused by negligent actions) or the misuse of resources.
  - **Abuse**: Excessive or improper use of services or actions that is inconsistent with acceptable business or medical practices. Refers to incidents that although not fraudulent, may directly or indirectly cause financial loss.
  - All of our Part D policy (existing and to be developed) should focus on monitoring and auditing with an eye on the prevention of fraud waste and abuse.
For today’s Part D plans there is some required reading to understand the overall effort CMS requires for effective Internal Monitoring and Auditing.

- CMS/Prescription Drug Benefit Manual - Chapter 9 – Compliance Program Guidelines (01.11.13)
- CMS/PACE Program manuals Chapter 15 – Organization Monitoring and Auditing. (06.09.11)
When you read these guidelines it’s confusing for PACE to define responsibility since requirements are so different than MA-PD plans.

While certain provisions regarding Medicare Part D are waived others are not.

Further, the PACE chapter for Organization Auditing and Monitoring only mentions Part D - 3 times. These 3 mentions distill down to infer PACE plans are required to:

- have staff available in pre-audit activities to answer Part D questions
- again during the CMS audit
- Then overall, staff must be available to answer questions regarding the 9 Part D audit elements.
The reason for this confusion is Part D guidelines for PACE fall back on the larger Part D requirements.

From the Prescription Drug Benefit Manual Chapter 9 it defines the PACE responsibilities for Part D as follows. At least it’s clearer!

These compliance program guidelines apply fully to the prescription drug benefit programs of sections 1833 and 1876 Cost Plans. In addition, these compliance program guidelines apply to the prescription drug benefit programs of Program of All-Inclusive Care for the Elderly (PACE) plans only with respect to those portions of this chapter that pertain to Elements 6 and 7, which are embodied in 42 C.F.R. 423 §§504(b)(4)(vi)(F) and (G) respectively. These compliance program guidelines do not apply to the PACE plans or to sections 1833 and 1876 Cost Plans that do not have a prescription drug benefit program. However, given the Office of Inspector General (OIG) guidance promoting compliance programs for all sponsors, CMS strongly encourages sponsors to voluntarily develop and implement effective compliance programs.
CMS Chapters on Compliance

- Again the OIG is everywhere warning plans about development and implementation of effective compliance programs for Part D.
- The best advice here is for plans to have an overall compliance plan that focuses on detecting fraud waste and abuse. Specifically, for Part D effort and attention should be aimed at the following:
  - Element 6 = Effective System for Routine Monitoring, Auditing and Identification of Compliance Risks
  - Element 7 = Procedures and Systems for prompt response to Compliance issues.
2013 Compliance Guidelines

- Chapter 9 from the Prescription drug benefit manual updated January 2013. CMS defines mandatory Compliance program guidelines that look quite similar to what we just discussed from the OIG in 99’.

- Below are highlights today:
  - Written Policies, Procedures and standards of conduct
  - Compliance officer, Compliance committee and high level oversight
  - Effective training and education
  - Effective lines of communication
  - Well publicized disciplinary standards
  - Effective system for routine monitoring and identification of compliance risks
  - Procedures and system for prompt response to compliance issues.

All Streamlined, but with the exact same message.
Monitoring and Auditing for PACE Plans

- Unfortunately, CMS does not fully lay out the requirements of an acceptable monitoring and auditing program for PACE.
- Their best advice for monitoring and auditing is as follows:
  - In order for this to be effective a plans compliance program must be fully implemented, and should be tailored to each plans unique organization, operations and circumstances.
The best plan for a robust internal monitoring and auditing program would be to do the following:

- Define your overall compliance plan for Part D, just like the OIG recommends.
- Develop internal monitoring and auditing work plan processes for each and every element that relates to Part D.
  
  Focus on elements of Part D that could create waste or effect Participant rights and expectations.
- The more elements included in your work plan for Part D the better.

This is especially important considering CMS only defined 9 audit elements, but the OIG knows there are more. It’s logical to assume in the coming years CMS will expand the requirement for PACE plans.
Implementing and Testing your Internal Monitoring and Auditing Work Plan
Internal Monitoring and Auditing: Work Plan Elements

Now we have a framework with which to identify what CMS is looking for in the area of Internal Monitoring and Auditing. What elements are logical to include in your work plan?

- The monitoring activities and audits to be performed. - What?
- Audit/Monitoring Schedules including start and end dates. When?
- Audit methodology How?
- Necessary resources
- Types of audits, (individual or summary) Where?
- Person(s) responsible Who?
- Interim and Final audit report due date(s) to compliance officer
- Follow up activities from findings.
Consider starting or updating your existing Part D compliance plan by mapping out areas of risk, low and high and define in standard work plan format.

- Break it down into smaller units using SMOT or SMART processes to further define work plan with a consistent approach.
  - **SMOT** – Strengths, Weaknesses, Opportunities and Threats
  - **SMART** – Specific, Measurable, Achievable, Relevant and Time Bound

- Simple steps yield big impact. Define your approach in a monthly master compliance spreadsheet.
To start the 9 Part D audit elements need to be in your Part D work plan. Let’s review those.

ER13 – Confirmation of enrollment for members of Employer group/Union receiving employer subsidy.

- The PO must meet CMS requirements for obtaining a confirmation of the intent to enroll from any individual who attempts to enroll in the plan, but whose enrollment is conditionally rejected by CMS due to a detected match indicating that the beneficiary may have existing Employer or Union drug coverage.
ER13 – Employer or Union Drug Coverage

- For this element plans should document the monthly enrollment process and any exceptions in full. Review and document who enrolled and if there were any conditional rejections for employer group/union coverage.
- Any rejections from CMS regarding potential employer group/union coverage must be taken seriously and require immediate follow up. Simply overriding this edit and enrolling a participant will cause a loss of the other coverage.
ER13 – Employer or Union Drug Coverage

- Document required discussions and correspondence sent to participants regarding a conditional rejection due to employer group/union coverage.
- Plans must have confirmation/documentation from the participant if the conditional rejection is going to be overridden in the CMS system.
- Plans should consider adding a form to the enrollment agreement process to address this issue up front with potential participants.
PR02 – Use of SSN/HICN on Participant Identification Cards

- The PO must use a number other than a participant’s Social Security Number (SSN) or Healthcare Insurance Claim Number (HICN) on participant identification cards.
  - This element is quite straightforward. In the audit, plans will have to demonstrate to CMS that they are not utilizing the SSN or HICN on ID cards.
  - Plans must have a policy to address what is or is not permitted on the participant ID card.
  - Generally, plans only add a name, possibly a date of birth, and a medical record ID number on the ID card.
CB03 – TrOOP Status and Mid-Year Enrollment Changes

- The PO must facilitate the transfer of a participant’s gross covered drug spend (GCDS) and true out-of-pocket (TrOOP) balance to the appropriate party upon the participant’s enrollment in, or disenrollment from, the plan during the coverage year.
- To PACE plans this audit element initially seems unnecessary since co-payments and deductibles are not collected from participants by agreement.
- However, this element is #1 in audit deficiencies.
Plans are required to develop policy and procedure documenting their process to notify disenrolling plan participants of their True Out of Pocket Costs (TrOOP).

This process is critical when a participant disenrolls from PACE into another Medicare Advantage plan. The TrOOP letter from the PACE plan will position the participant correctly in the Part D benefit after PACE. If done correctly and timely your disenrolled participants will be able to assimilate into their new plan without issue for Part D at least.
All enrolling participants from another Medicare Advantage plan must provide that Plans TrOOP letter to the PACE plan.

Basically this required letter from their old provider is an assessment where the PPT is in the TrOOP benefit.

If a participant disenrolls, both the prior plan and your plan TrOOP balances are combined in an effort to correctly assess the Part D benefit.
What’s in a TrOOP letter?

- CMS defines a standard format and it must include an estimation of Gross Covered Drug Spend. (both from the former and existing plan)
- Using the PACE TrOOP Calculator define where the Participant is at in the TrOOP benefit when they disenroll.
- Updated fully by March of the following year with any changes to TrOOP balances.

Plans should track all TrOOP letters sent out in a master spreadsheet. Track items like:

- Gross Covered Drug Spend (GCDS) – amounts
- When letter was sent to disenrolled PPT (requirement is seven (7) days from acknowledgement of disenrollments)
- The master spreadsheet is your internal monitoring and auditing documentation.
CL02 – Linking Medicare Parts A and B Data

- CL02 – Requirements for Submitting Prescription Drug Event Data and Data Elements needed to Link Medicare Parts A, B and D Data.
- The PO must submit claims data that can be linked at the individual level to Medicare Parts A and B data.
- For PACE plans this means we are reviewing our Prescription Drug Event (PDE) data and not submitting Part D PDE data when Medicare Part A or B would otherwise be primary.
For example, when a participant is inpatient hospital all prescriptions filled are considered Part A. If the PACE plan did not notify their contracted pharmacy of the Part A stay any fills, routine or otherwise, during this time are Part A and not submittable as Part D.

- This element really attempts to address prescription waste and accurately define Part D benefits for PACE plans.
Essentially, Medicare is trying to sort ALL eligible prescriptions into the right bucket based on place of service.

- Part A – Inpatient benefits
- Part B – Physician benefits
- Part D – Pharmacy benefits

Plans should document that their monthly listing of Inpatient service participants do not have Part D prescriptions during their inpatient stay.

Any review for accuracy here should be documented, generally with each PDE batch generated.
The PO has a detailed claims adjudication process including flow charts, claims management, data capture and claims data retrieval processes.

For this element it depends on how PDE data is captured.

One goal is to define how PDE data is generated.

Some plans have a detailed process for submitting PDE data; others rely on a 3rd party submitter or PBM to send their PDE data.
CL03 – Processing Systems

- Regardless of the method each plan must have a detailed process in place and documented.

- Once a policy is in place routine audits should determine if the process is effective.
  - For instance, your policy may state that your plan will submit all PDE data on the first day of each month detailing the prior month. If it does your internal monitoring and auditing process must document that all PDE data for the selected date range was submitted and when.

- Most PACE plans utilize this element to demonstrate that all PDE data has been submitted in a timely fashion.
Additionally, CMS utilizes this element to determine if the Plans contracted entities are effective as well.

- Plans will want to coordinate with their contracted Pharmacy, 3rd party submitter or PBM and generate a statement discussing their internal claims adjudication process.
  - Discuss emergency procedures, backup of data, scalability of systems, policy guidelines and set clear expectations.

- This element has evolved a bit over the years. Demonstrating the PDE process at the Plan level and Contractor Level is a good process to demonstrate compliance with this element.
PA01 — Certification of Monthly Enrollment and Payment Data

- Certification of Monthly Enrollment and Payment Data relating to CMS payment

- Payments to a PO are conditioned upon its submittal and certification of enrollment, disenrollment, and change transactions to CMS each month. The PO must submit reconciled enrollment/payment reports and signed attestation forms to CMS within 45 days of data availability.
Upon first inspection it may appear that this element has nothing to do with Part D.

The goal of this element is for plans to assess the accuracy of the prospective Medicare payment for all Medicare Parts A, B, C & D.

Before signing an enrollment and payment attestation plans must detail all actions taken to ensure the Medicare payment is accurate and correct.
PA01 – Certification of Payment

- Plans should detail all payment reconciliation activities and retroactive changes that are, or going to be, requested.
- Details of all adjustments should be maintained in a master spreadsheet tracking when requested and verified accurate in future payments.
- This step is important to ensure CMS is paying Part D expenses in accordance with the Part D bid/contract.
- Additionally, it’s a good opportunity to tell CMS what issues exist within the payment.
The PO must adhere to CMS guidance for adopting and maintaining current, written policies and procedures that address all applicable Part D statutes, regulations, and program requirements. These policies and procedures must articulate the specific procedures personnel should follow when performing their duties.

This element is the Plans opportunity to demonstrate its commitment to compliance for CMS in all areas Part D.
All Policy and Procedure that relates to Part D should be addressed or bundled in this audit element.

- (think all-inclusive)

Your detailed Part D work plan lives here along with routine monitoring schedules and audit results.
CP02 – Comprehensive Fraud Waste and Abuse Plan

- The PO must have and implement a compliance plan that includes a comprehensive plan to detect, correct, and prevent fraud, waste, and abuse.

- This element is a plans opportunity to ‘live’ their generic Fraud, Waste & Abuse policy.

- Every plan has one, but plans that stand out as exceptional in a CMS audit will have numerous supporting policy and procedure linked to the larger FWA policy.

- From the view of CMS this will demonstrate plan commitment to reviewing PDE data and the larger Part D process for accuracy and effectiveness.
Fraud Waste and Abuse (FWA) plays the leading role in an effective Monitoring and Auditing plan and in the larger corporate compliance plan.

When developing FWA procedures the data must be considered. By developing a consistent data review strategy the items below can be eliminated.

- Billing for services not rendered
- Overcharging for services or supplies
- Double billing that creates duplicate

Additional items for this review that your contracted pharmacy can assist with will be discussed in depth by Care Kinesis in a few minutes.
The PO must have and implement a compliance plan that includes procedures for effective internal monitoring and auditing.

The PO must have and implement a compliance plan that includes procedures to ensure a prompt response to detected offenses relating to the Part D portion of the PO’s contract, and must conduct a timely, reasonable inquiry upon discovery of evidence of misconduct related to payment or delivery of prescription drug items or services under the contract. The PO must also develop and conduct appropriate corrective actions in response to identified violations.

More to follow on this element from Care Kinesis
Beyond the Audit: Other Work Plan Elements that will give your Part D compliance plan a boost
Beyond the Audit: items discussed here are additional opportunities to address Part D compliance through internal monitoring and auditing.

- Generally, the data required for additional review is available directly from CMS or an internal process already in place.
- If not, it’s likely that your contracted pharmacy, PBM or 3rd party submitter can help.
Other elements to consider in our overall Part D monitoring and auditing work plan.

- PDE submission timeliness monitoring
- Plan to Plan payment review process
- Direct and Indirect Remuneration (DIR) tracking (rebates and incentives)
- PDE Attestations: ensure all data is submitted timely accurately and consistently.
Other Items to Monitor

- Finally, there are elements that relate to Part D, but upon first inspection may not appear to.
  - Monthly Enrollment and Disenrollment accuracy monitoring
    - Tracking the effectiveness and accuracy of all enrollments and disenrollments processed.
    - Maintain a spreadsheet documenting successful enrollments and turnaround time for the unsuccessful ones and the steps taken to correct them.
Other Items to Monitor

- **Coordination of benefit reviews** (ECRS and Annually)
  - Routinely document COB reviews of your MMR.
  - If Medicare Secondary Payer (MSP) instance is in play on the MMR at least annually survey coverage.
  - Utilize the Electronic Correspondence Referral System (ECRS) to further understand COB instances listed in CMS reports.
  - The end goal is to define the process to mitigate any payment reductions due to an instance of Medicare Secondary Payer (MSP) and utilize to the extent possible any potential other insurance that exists for your enrolled participants.
Other Items to Monitor

- **HPMS Memo Tracking Tool** to demonstrate adherence to new CMS regulations
- Develop process to document how HPMS memos are addressed within your organization
- Maintain a tracking spreadsheet detailing when memos are received, who they were forwarded to for review and when any issues or required action was addressed or resolved.

- **New to Medicare Validation Process** (60 day notice)
  - Develop a process to review potential Medicare eligibility.
  - Document when advanced notice was sent to effected participants.
Other Items to Monitor

- **Medicaid Pending (Plan Benefit Package) Validation**
  - If your plan enrolls a participant pending Medicaid eligibility the Part D plan benefit package must be accurately assessed at enrollment and upon Medicaid eligibility.
  - Fortunately, there are very few plans that deal with this process.
  - Document process from start to finish.

- **Daily Transaction Reply Report (DTRR) Review**
  - Develop process to ensure DTRR files are being reviewed and acted upon. The DTRR report is the primary mechanism for CMS to report to Plans any changes to participant data within the CMS system.
  - Track all changes from start to finish to ensure accuracy
  - Consider including estimates of financial impact
Other Items to Monitor

- **Submission of Risk Adjustment Data**
  - It seems upon first inspection that risk adjustment data would not apply to Part D, but it does.
  - Maintaining and improving your Part D risk score is just as important as Part C.
  - Reviewing and auditing risk adjustment batches for consistent submission of accurate and complete data is critical.

- **Unintentional disenrollment from PACE**
  - Occasionally an existing participant will disenroll from the PACE plan accidentally.
  - When this happens Plans must have a defined process to address retro enrollment to avoid missed payments
  - Document and track these instances in a master monitoring and auditing spreadsheet.
Other Items to Monitor

- **Formulary Review Process** (if needed)
  - Most PACE plans do not have a formulary to define their prescription benefit, but if you do you will need a policy and procedure to administer your formulary.

- **Medication Therapy Management Programs** (if applicable)

- **Rebate Allocation Tracking** (if applicable)
Other Items to Monitor

- **First Tier, Downstream, Related Entities (FDR)**
  - Plans should routinely monitor the billing accuracy of contracted providers
    - Include monitoring for possible overbilling.
    - Monitor for services billed and not rendered.
  - The process to routinely review providers usually starts with comparing invoices for a period of time against prior authorizations for accuracy.
    - Any resulting discrepancies would be part of your routine spreadsheets documenting your reviews and resolutions.
  - Include all follow up and possibly amounts recovered or validated during your routine reviews
Care Kinesis has a dependable and intuitive system already in place to help Plans with their monitoring and auditing activities for numerous Part D work plan elements.

These files and systems are readily available and offered as part of your existing contract.
Care Kinesis Compliance and Part D Resources

- Items here should relate directly to Part D work plan activities.
- Executive Report
  - Generic Utilization Rates
- Drug Utilization Monitoring
  - Top 25 by dispense and cost
  - Top 25 by participant
- Prescription Drug Event Reporting
  - All inclusive Rx listing
  - Compare vs. PDE return file.
- Overutilization monitoring system (OMS)
- FWA - Rx monitoring from script to delivery receipt
- Ad Hoc
With Monitoring and Auditing gaining the increased attention and focus of the OIG & CMS it’s safe to say that all Plans will need to pay special attention to this requirement.

Now I would like to introduce:

- Mike Ristagno
CareKinesis Tools
For Monitoring and Auditing

Mike Ristagno, PharmD, MBA
SrVP Client Services
Agenda

• Illustrate CareKinesis tools
• Suggest various ways to monitor and audit
• Review performance improvement initiatives
• Share additional available resources
Business Intelligence Reports

• Online Report Portal
  – Web-accessible
  – Participant Dispense Data
  – Extensive Filtering Capabilities
  – Export to Excel
  – Custom Reports Available
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Executive Report

[Diagram of report portal and content]

[Table with data]

Member Summary

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<tbody>
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<td>Utilizing Member Months</td>
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<td>1,995</td>
<td>1,793</td>
<td>1,914</td>
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<td>100.0%</td>
<td>100.0%</td>
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Dispenses Summary

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</thead>
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<td>1,995</td>
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Cost Summary

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</thead>
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Internal Monitoring and Auditing

CareKinesis Report Portal

1. Explore different folders such as CareKinesis, Client, etc.
2. Select the Patient Totals option to view total charges.
3. Filter the Patient Totals by date periods and view the total charges for each patient.
### PDE (Prescription Drug Event)

#### CareKinesis Report Portal

- **View**
  - Expand All
  - Collapse All
  - Client
    - Billing_PDE
    - Billing Detail
    - Executive Report
    - Patient Totals
    - PDE
    - Top 25 Drugs (by cost)
    - Top 25 Drugs (by dispensing)
    - Top 25 Participants by Cost
  - Clinical
    - Discontinued Medications
    - FWA Prescription Tracking
    - New Medications
    - Patients
  - User FAQs
    - Exporting to Excel
    - Troubleshooting - Report not running

#### PDE Details

- **Patient Last Name**:
- **Prescribes Last Name**:
- **Drug Name**:
- **Date of Service (start)**: 1/1/2011
- **Date of Service (end)**: 2/26/2014
- **Billing Month**: 2013-11

#### Patient Information Table

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<th>Social Security Number</th>
<th>Medicare Number</th>
<th>Date of Birth</th>
<th>Gender</th>
<th>Date of Service</th>
<th>Rx Number</th>
<th>NDC</th>
<th>Drug Name</th>
<th>Pharmacy Qualifier</th>
<th>Pharmacy Number</th>
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<th>Dispensing Site</th>
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<td>A123456789</td>
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Top 25 Drugs by Cost
A closer look at Advair dispenses
Top 25 Drugs by Dispense

CareKinesis Report Portal

Top 25 Drugs (by cost)

Provider: All
Plan: All
Period: Nov-13
Dispense Date From: 12/31/2010
Dispense Date To: 02/10/2014
Prescription Type: All

Top 25 Drugs (by cost)

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<td>COMBIVENT RESPIMAT INHAL SPRAY</td>
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Reviewing Prescription Claims

CareKinesis Report Portal

1. Click on "Billing Detail" to view prescription claims.
2. Select "Plan" as "All Plans" or a specific plan.
3. Choose "Dispense Type" as "All Types" or a specific type.
4. Enter "Patient Last Name", "Prescriber Last Name", or "Drug Name" to filter.
5. Set the date range for "Date of Service (start)" and "Date of Service (end)."

The table below displays details such as plan, participant name, insurance type, date, RX number, dispense type, drug name, and NDC number.
Audit by Participant

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<th>Patient Last Name</th>
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<th>Rx Number</th>
<th>NDC</th>
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<td>456-78-90</td>
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## FWA Prescription Tracking

### CareKinesis Report Portal

#### 1. FWA Prescription Tracking

#### 2. FWA Prescription Tracking Table

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<td>60.0</td>
<td>2096488</td>
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<td>2014-02-05</td>
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<tr>
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<td>299.647</td>
<td>7</td>
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<td>2096488</td>
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<td>2014-02-05</td>
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<tr>
<td>crystalline topical (crystalline topical) 100000unitig Powder</td>
<td>15</td>
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<td>299.647</td>
<td>15</td>
<td>2014-02-05</td>
<td>30.0</td>
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<td>LORazepam (LORazepam) 0.5mg Tablet</td>
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<td>2014-02-05</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Severe winter weather is causing delays and disruptions across the U.S. Learn More

FedEx Tracking

A new level of delivery convenience has arrived.

Ship (P/U) date: Tues 2/11/2014 6:46 pm
Moorestown, NJ US

Actual delivery: Wed 2/12/2014 10:37 am

Delivered
Signed for by: [Signature]

Travel History

- Date/Time       Activity                Location
- 2/12/2014 - Wednesday
  10:37 am        Delivered
  8:49 am         On FedEx vehicle for delivery
  8:48 am         At local FedEx facility

FWA (cont)
Additional Resources

EireneRx Help

Please use the sidebar links on the right to submit bug reports

Thank you for visiting the EireneRx Support center. We offer several different support methods, such as email, phone, and web based forms. If you are experiencing technical difficulties please fill out a bug report.

Support Resources

Morphine Equivalent Dosing Calculator

Partner Resources
Partner Resources

- CK Audit Documents
- CK Presentations & Tools
- Training Resources

CK Audit Documents
- CK Pharmacy License- NJ
- CK Pharmacy License- CO
- CK Certificate of Insurance (COI)
- DEA Certificate
- FWA Compliance Program
- CMS Part D Audit Worksheet
- FWA Attestation - Jan 2014

CK Presentations & Tools
- Care Transitions Slides (August 2013)
- New Oral Anticoagulants Slides (April 2013)
- Food-Drug Interactions Slides (January 2013)
- Adherence Slides (June 2013)

Training Resources
QA Reporting

• Number of Quality Assurance Events by quarter classified by type of event
• Total Events/Month is compared to Total Number of Dispenses to calculate medication error rate
• Graphs included for:
  – Reported QA Event Distribution
  – Customer Service Event Distribution by Type
  – Total Reported Events by Month
  – Medication Error Distribution by Type
Performance Improvement

• CareKinesi develops an annual client-focused performance improvement made available for clients to participate and include as a part of their performance improvement initiatives.

The current initiatives include:

– Medication Reconciliation
– Medication Adherence
– Hospitalization Initiative
Medicare Part D
Overutilization Monitoring System (OMS)

• As part of a focused CMS initiative, Part D sponsors and beneficiaries are being monitored for potential overutilization of opioids and acetaminophen.

• Metric: Beneficiaries who may be taking more than 4 grams of acetaminophen per day for more than 30 days.

• Metric: Excluding patients with cancer or receiving hospice care, beneficiaries whose daily morphine equivalent (MED) is greater than 120mg for at least 90 consecutive days, AND who used more than 3 prescribers and more than 3 pharmacies. - Must meet all 3 criteria to be flagged.

• Recent EireneRx enhancements included a Morphine Equivalent Dosing Calculator tool at point of prescribing.
Morphine Equivalent Calculator

Morphine Equivalent Dosing (MED) Calculator

Opioid Meds

<table>
<thead>
<tr>
<th>Opioid</th>
<th>Daily Dosage</th>
<th>Morphine Equivalent</th>
<th>Remove</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hydrocodone (oral)</td>
<td>50</td>
<td>50 (mg/day)</td>
<td>Remove</td>
</tr>
<tr>
<td>Short-Acting Less Potent (Schedule III/IV)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fentanyl mcg/hr (Transdermal)</td>
<td>25</td>
<td>60 (mg/day)</td>
<td>Remove</td>
</tr>
<tr>
<td>Long-Acting High Potent (Schedule II)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Codeine (oral)</td>
<td>90</td>
<td>13.5 (mg/day)</td>
<td>Remove</td>
</tr>
<tr>
<td>Short-Acting High Potent (Schedule II)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total MED: 123.5 mg/day
Custom Reports

• Custom reports including economic, clinical, and humanistic outcome reports are available upon request.
• CareKinesis continues to develop and launch reports as identified through client interaction.
• Clients, please contact your CareKinesis Client Liaison for training
Thank you!

Questions?