



STATE OF NEW YORK
OFFICE OF THE MEDICAID INSPECTOR GENERAL
584 Delaware Avenue
Buffalo, New York 14202

ANDREW M. CUOMO
GOVERNOR

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December 30, 2014

Medilane Pharmacy Corp.
204 Clinton Street
New York, NY 10002-7576
[REDACTED]

Final Audit Report

Audit #10-2342
Provider ID [REDACTED]

Dear [REDACTED]

This letter will serve as our final audit report of the recently completed review of payments made to Medilane Pharmacy Corp. under the New York State Medicaid Program. Since you did not respond to our draft audit report dated August 15, 2014, the findings in the final audit report are identical to those in the draft audit report.

The New York State Department of Health is responsible for the administration of the Medicaid program. As part of this responsibility, the Office of the Medicaid Inspector General (OMIG) conducts audits and reviews of various providers of Medicaid reimbursable services, equipment and supplies. These audits and reviews are directed at assessing provider compliance with applicable laws, regulations, rules and policies of the Medicaid program as set forth by the Departments of Health and Education [Titles 8, 10, and 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York (8 NYCRR, 10 NYCRR, 18 NYCRR)] and the Medicaid Management Information System (MMIS) Provider Manuals.

Pharmacy is a professional practice, which includes a number of activities that are necessary for the provision of drugs for patients as ordered by persons authorized under State law to prescribe drugs. Pharmacies, which are licensed and currently registered by the New York State Board of Pharmacy, Department of Education, may dispense drugs and other medical/surgical supplies. The pharmacy must comply with all applicable provisions of State Law including Article 137 of the Education Law, Articles 1 and 33 of the Public Health Law, and the Pharmacy Guide to Practice (Pharmacy Handbook) issued by the Department of Education. The specific standards and criteria for pharmacies are outlined in Title 10 NYCRR Parts 80 and 85.20-22 and Title 18 NYCRR Section 505.3. The MMIS Provider Manual for Pharmacy also provides program guidance for claiming Medicaid reimbursement for pharmacy services.

A review of payments to Medilane Pharmacy Corp. for pharmacy services paid by Medicaid for New York City recipients from January 1, 2005, through December 31, 2008, was recently completed. During the audit period, \$7,621,115.94 was paid for 97,455 services rendered. This review consisted of a random sample of 200 services with Medicaid payments of \$15,837.43. The purpose of this audit was to verify that: prescriptions were properly ordered by a qualified practitioner; the pharmacy had sufficient documentation to substantiate billed services; appropriate formulary codes were billed; patient related records contained the documentation required by the regulations; and claims for payment were submitted in accordance with New York State laws, Department regulations and the Provider Manuals for Pharmacy.

Medilane Pharmacy Corp.'s failure to comply with Titles 8, 10 and/or 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York (NYCRR), the MMIS Provider Manual for Pharmacy, and the Pharmacy Guide to Practice resulted in a total sample overpayment of \$4,355.03 (Exhibit I).

The following detailed findings reflect the results of our audit. This audit report incorporates consideration of any additional documentation and information presented in response to the draft audit report dated August 15, 2014. Since you did not respond to the draft audit report, the findings remain the same.

DETAILED FINDINGS

In addition to the regulations cited to support each category of audit findings, the following regulations pertain to all findings:

Regulations state: "By enrolling the provider agrees: (a) to prepare and to maintain contemporaneous records demonstrating its right to receive payment . . . and to keep for a period of six years from the date the care, services or supplies were furnished, all records necessary to disclose the nature and extent of services furnished and all information regarding claims for payment submitted by, or on behalf of, the provider . . . (e) to submit claims for payment only for services actually furnished and which were medically necessary or otherwise authorized under the Social Services Law when furnished and which were provided to eligible persons; (f) to submit claims on officially authorized claim forms in the manner specified by the department in conformance with the standards and procedures for claims submission; . . . (h) that the information provided in relation to any claim for payment shall be true, accurate and complete; and (i) to comply with the rules, regulations and official directives of the department."
18 NYCRR Section 504.3

Regulations state: "Fee-for-service providers. (1) All providers ... must prepare and maintain contemporaneous records demonstrating their right to receive payment . . . All records necessary to disclose the nature and extent of services furnished and the medical necessity therefor ... must be kept by the provider for a period of six years from the date the care, services or supplies were furnished or billed, whichever is later. (2) All information regarding claims for payment submitted by or on behalf of the provider is subject to audit for a period of six years from the date the care, services or supplies were furnished or billed, whichever is later, and must be furnished, upon request, to the department ... for audit and review."
18 NYCRR Section 517.3(b)

Regulations require that bills for medical care, services and supplies contain patient name, case number and date of service; itemization of the volume and specific types of care, services and supplies provided; the unit price and total cost of the care, services and supplies provided; and a dated certification by the provider that the care, services and supplies itemized have been in fact furnished; that the amounts listed are in fact due and owing; that such records as are necessary to disclose fully the extent of care, services and supplies provided to individuals under the New York State Medicaid program will be kept for a period of not less than six years from the date of payment; and that the

provider understands that payment and satisfaction of this claim will be from Federal, State and local public funds and that he or she may be prosecuted under applicable Federal and State laws for any false claims, statements or documents, or concealment of a material fact provided.

18 NYCRR Section 540.7(a)(1)-(3) and (8)

Regulations state: "An overpayment includes any amount not authorized to be paid under the medical assistance program, whether paid as the result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse or mistake."

18 NYCRR Section 518.1(c)

Regulations state: "Vendor payments for medical care and other items of medical assistance shall not be made unless such care or other items of assistance have been furnished on the basis of the appropriate authorization prescribed by the rules of the board and regulations of the department."

18 NYCRR Section 540.1

Regulations state: "The department may require repayment from the person submitting an incorrect or improper claim, or the person causing such claim to be submitted, or the person receiving payment for the claim."

18 NYCRR Section 518.3(a)

Regulations state: "The department may require repayment for inappropriate, improper, unnecessary or excessive care, services or supplies from the person furnishing them, or the person under whose supervision they were furnished, or the person causing them to be furnished...."

18 NYCRR Section 518.3(b)

Regulations state: "Medical care, services or supplies ordered or prescribed will be considered excessive or not medically necessary unless the medical basis and specific need for them are fully and properly documented in the client's medical record."

18 NYCRR Section 518.3(b)

1. Ordering Prescriber Conflicts with Claim Prescriber

Regulations state: "By enrolling the provider agrees...to submit claims on officially authorized claim forms in the manner specified by the department in conformance with the standards and procedures for claims submission" and "that the information provided in relation to any claim for payment shall be true, accurate and complete."

18 NYCRR Sections 504.3(f) and (h)

Regulations state: "The identity of the practitioner who ordered the...medical/surgical supply, . . . must be recorded by the provider on the claim for payment by entering in the license or MMIS provider identification number of the practitioner where indicated."

18 NYCRR Section 505.5(c)(1)

Medicaid policy requires the billing provider to complete the ordering/prescribing provider section of the claim for prescriptions from private practitioners by entering the "MMIS ID Number of the prescriber. If the prescriber is not enrolled in MMIS, enter his/her State License number . . . For orders originating in a hospital, clinic or other health care facility, the facility's MMIS ID Number may be entered only when the prescriber's MMIS ID or State License number is unavailable. When a prescription is written by an unlicensed intern or resident, the supervising physician's MMIS ID Number should be entered. If the supervising physician is not enrolled in MMIS, his/her State License number may be entered. When these numbers are unavailable, enter the facility's MMIS ID Number . . . When prescriptions have been written by a physician's assistant, the supervising physician's MMIS ID Number should be entered. If the supervisor is not enrolled in MMIS, enter his/her State License number. If these numbers are unavailable and the prescription originated in a facility, enter the facility's MMIS ID Number . . . If the MMIS ID or State License number is not on the prescription . . . it is the pharmacist's responsibility to obtain it."

Medicaid policy requires the billing provider to enter the Medicaid ID Number of the ordering/prescribing provider or, if the ordering prescriber is not enrolled in the Medicaid Program, to enter his/her license number. The supervising MD's MMIS or license number should be entered for an unlicensed intern or resident for a prescription from a facility, and the facility's Medicaid ID number may be entered **only** when the prescriber's or supervising physician's Medicaid ID or License number is unavailable. When prescriptions have been written by a Physician's Assistant, the supervising physician's Medicaid ID number or license number should be entered. [There is no provision here for entering facility MMIS ID number in absence of the supervising MD number for a prescription written by a Physician's Assistant.] If the prescribing provider is a Nurse Practitioner certified to write prescriptions, enter his/her Medicaid ID number or license number in this field. **Note: If the Medicaid ID or State License number of an authorized prescriber is not on the prescription, it is the pharmacist's responsibility to obtain it.**

In addition, if a license number is indicated, the Profession Code that identifies the ordering/prescribing provider's profession must be entered. Directions are given to obtain profession codes.

NYS Medicaid Program Pharmacy Manual Billing Guidelines Version 2005-1, Section II
NYS Medicaid Program Pharmacy Manual Billing Guidelines Version 2007-1, Section II
NYS Medicaid Program Pharmacy Manual Billing Guidelines Version 2008-1, Section II

Medicaid policy requires the billing provider to enter the Medicaid ID Number **or** the NPI of the ordering/prescribing provider. If the NPI is not known and the orderer/prescriber is not enrolled in the Medicaid program, enter his/her License number. If a license number is indicated, the Profession Code that identifies the ordering/prescribing provider's profession must be entered. For orders originating in a hospital, clinic, or other health care facility, the following rules apply: When a prescription is written by an unlicensed intern or resident, the supervising physician's Medicaid ID number, NPI or license number should be entered in this field. When prescriptions have been written by a Physician's Assistant, the supervising physician's Medicaid ID number, NPI or license number should be entered in this field. Certified Nurse Practitioners with licenses that contain six digits not preceded by the letter F can only write fiscal orders. If the prescribing provider is a Nurse Practitioner certified to write prescriptions, enter his/her Medicaid ID number, NPI or license number in this field. **Note: If the Medicaid ID, NPI or State License number of an authorized prescriber is not on the prescription, it is the pharmacist's responsibility to obtain it.**

NYS Medicaid Program Pharmacy Manual Billing Guidelines Version 2008-2, Section II
NYS Medicaid program Pharmacy Manual Billing Guidelines Version 2008-3, Section II

The Medicaid Updates provide direction on identifying the ordering prescriber on the Medicaid claim.

DOH Medicaid Update March 2004
DOH Medicaid Update October 2004
DOH Medicaid Update September 2005

The Medicaid Update identifies the State Education Department's (SED) website to obtain or verify prescriber license numbers.

DOH Medicaid Update March 2000

The Medicaid Update states that it is inappropriate to use a facility's Medicaid identification number as the ordering/referring/prescribing provider.

DOH Medicaid Update January 2008

In 55 instances pertaining to 48 patients, the ordering prescriber conflicts with the claim prescriber. This resulted in a sample overpayment of \$4,233.72 (Exhibit II).

2. Prescription/Fiscal Order Refilled More Than 180 Days After It Has Been Initiated By The Prescriber

Regulations state: "No written order for drugs may be refilled more than six months after the date of issuance. . . ." *18 NYCRR Section 505.3(d)(2)*

Medicaid policy states: "No prescription or fiscal order for a drug or supply may be refilled 180 days after it has been initiated by the prescriber."

NYS Medicaid Program Pharmacy Manual Policy Guidelines Version 2006-1, Section I

Medicaid policy states: "No prescription or fiscal order for a drug or supply may be refilled 180 days from the original date ordered."

MMIS Provider Manual for Pharmacy Version 2004-1, Section 2.2.4

In 2 instances pertaining to 2 patients, a prescription or fiscal order was refilled more than 180 days after the date initiated by the prescriber. This resulted in a sample overpayment of \$73.81 (Exhibit III).

3. Missing Prescription

Regulations state: "Drugs may be obtained only upon the written order of a practitioner, except for telephone and electronic orders for drugs filled in compliance with this section and 10 NYCRR Part 910." *18 NYCRR Section 505.3(b)(1)*

Regulations state: "When used in the context of an order for a prescription drug, the order must also meet the requirements for a prescription under section 6810 of the Education Law and 10 NYCRR Part 910." *18 NYCRR Section 505.3(b)(3)*

Regulations also state: "A pharmacy must keep on file the signed written order of the practitioner for audit by the department, or other authorized agency, for six years from the date of payment for any drug dispensed." *18 NYCRR Section 505.3(c)*

Regulations state: "All providers, who are not paid at rates or fees approved by the State Director of the Division of the Budget based upon their allowable costs of operation but who are paid in accordance with the rates, fees and schedules established by the department, must prepare and maintain contemporaneous records demonstrating their right to receive payment under the medical assistance program. All records necessary to disclose the nature and extent of services furnished and the medical necessity therefor, including any prescription or fiscal order for the service or supply, must be kept by the provider for a period of six years from the date the care, services or supplies were furnished or billed, whichever is later."

18 NYCRR Section 517.3(b)(1)

Regulations state: "Written order or fiscal order are terms which are used interchangeably in this section and refer to any original, signed written order of a practitioner including any faxed transmitted order which requests a pharmacy to provide a drug to a medical assistance recipient. All written orders and fiscal orders shall comply with the provisions of Section 21 of the Public Health Law and regulations promulgated thereunder or contained in this section including but not limited to requirements for prescribing brand necessary drugs."

18 NYCRR Section 505.3(a)(6)

In 1 instance, an original prescription was missing. This resulted in a sample overpayment of \$47.50 (Exhibit IV).

Total sample overpayments for this audit amounted to \$4,355.03.

In accordance with 18 NYCRR Part 518 which regulates the collection of overpayments, your repayment options are described below. If you decide to repay the total sample overpayment amount of \$4,355.03, one of the following repayment options must be selected within 20 days from the date of this letter:

OPTION #1: Make full payment by check or money order within 20 days of the date of the final audit report. The check should be made payable to the New York State Department of Health and be sent with the attached Remittance Advice to:

[REDACTED]
 New York State Department of Health
 Medicaid Financial Management, B.A.M.
 GNARESP Corning Tower, Room 2739
 Albany, New York 12237-0048

OPTION #2: Enter into a repayment agreement with the Office of the Medicaid Inspector General. If your repayment terms exceed 90 days from the date of the final audit report, recoveries of amounts due are subject to interest charges at the prime rate plus 2%. If the process of establishing the repayment agreement exceeds 20 days from the date of the final audit report, the OMIG will impose a 50% withhold after 20 days until the agreement is established. OMIG acceptance of the repayment agreement is based on your repaying the Medicaid overpayment as agreed. The OMIG will adjust the rate of recovery, or require payment in full, if your unpaid balance is not being repaid as agreed. In addition, if you receive an adjustment in your favor while you owe funds to the State, such adjustment will be applied against any amount owed. If you wish to enter into a repayment agreement, please contact the Bureau of Collections Management within 20 days at the following:

Bureau of Collections Management
 New York State Office of the Medicaid Inspector General
 800 North Pearl Street
 Albany, New York 12204

If you choose not to settle this audit through repayment of the total sample overpayment amount, you have the right to challenge these findings by requesting an administrative hearing. As allowed by state regulations, you must make your request for a hearing, in writing, within sixty (60) days of the date of this report to:

General Counsel
 Office of Counsel
 New York State Office of the Medicaid Inspector General
 800 North Pearl Street
 Albany, New York 12204

Questions regarding the request for a hearing should be directed to Office of Counsel at [REDACTED]

Issues you may raise shall be limited to those issues relating to determinations contained in the final audit report. Your hearing request may not address issues regarding the methodology used to determine the rate, or any issue that was raised at a proceeding to appeal a rate determination.

At the hearing you have the right to:

- a) be represented by an attorney or other representative, or to represent yourself;
- b) present witnesses and written and/or oral evidence to explain why the action taken is wrong; and
- c) cross examine witnesses of the Department of Health and/or the OMIG.

The OMIG reserves the right to conduct further reviews of your participation in the Medicaid Program, take action where appropriate, and recover monies owed through the initiation of a civil lawsuit or other legal mechanisms including but not limited to the recovery of state tax refunds pursuant to Section 206 of the Public Health Law and Section 171-f of the State Tax Law.

Should you have any questions, please contact [REDACTED]

Thank you for the cooperation and courtesy extended to our staff during this audit.

Sincerely,

[REDACTED]

Division of Medicaid Audit, Buffalo
Office of the Medicaid Inspector General

[REDACTED]
Enclosure

CERTIFIED MAIL [REDACTED]
RETURN RECEIPT REQUESTED

SAMPLING METHODOLOGY

Sampling based audits commence with a request from OMIG's auditors to OMIG's Bureau of Business Intelligence ("BBI") for a sample of provider's claims or services to audit. The audit request may limit the scope of the audit to specific services and rate codes.

All Medicaid electronic claims payment records are maintained by the Department's fiscal agent, Computer Sciences Corporation ("CSC"), in the Medicaid Management Information System ("MMIS") and are accessible to OMIG in what is known as the "data warehouse" or "Datamart." The data warehouse or Datamart contains records of all Medicaid claims submitted by a provider. Depending on the type of claim or service OMIG determines to audit, a request or "query" is made of the system and a database is generated of claims submitted by a specific provider.

BBI extracts a universe of claims from the New York State Medicaid Data Warehouse based on specifications established by Audit staff. This universe is refined into unique claims from which the sample is randomly selected (sampling frame). Since claims can be adjusted by a provider for the same service, OMIG staff refines the database to include only one unique claim number ("TCN") for each billable service. The unique claims, or sampling frame, are maintained in a file called Unique IDs.txt which contains the unique claim identifier (TCN or recipient number) and the dollar amount paid for each claim in the sample frame. The universe of claims, which is contained in an Access database, includes claim detail for each of the claims identified in UniqueIDs.txt before the claims were refined into single lines. As a result, the universe of claims includes all of the adjustments made by a provider in seeking reimbursement for a single service up to the date on which the sample and universe were extracted.

BBI runs a computer program ("the program") developed by OMIG's statistical consultant, [REDACTED]. The program resides in an application called KHSC Random Sample Generator. The program requests the input of the sampling frame file and the requested sample size. The program then utilizes a proprietary random generator ("RNG") program owned by the Oracle Corporation to generate random numbers. To receive a copy of either the random number generator program or the source code, please send a written request to the Office of Counsel, marked to the attention of "Random Number Generator" and/or "Source Code" as appropriate:

Office of Counsel
Office of the Medicaid Inspector General
800 North Pearl Street
Albany, New York 12204
[REDACTED]

The random number generator program uses Java Platform software and may be released upon written request to the above address. In order for OMIG to release the Java source code, Oracle Corporation, the owner of the Java software, requires that a Confidential Undertaking be signed by the provider and/or the provider's attorney and/or consultant/expert. The Confidential Undertaking provides for the release of the source code to signatories during the pre-hearing conference or other administrative proceeding.

The RNG program utilizes the computer's clock to select the "seed", or starting point for generating random numbers. The RNG program then generates random numbers until it has selected enough random numbers for the requested sample size. In this audit, the audit sample is 200 services. The sample size was determined in consultation with [REDACTED]

The RNG program then submits the list of random numbers selected to a number of statistical tests for apparent random numbers. If the list of selected random numbers passes the tests for apparent randomness, the program reports the results of the tests and reports the list of random numbers, in the order generated. The random numbers are kept in a file called Random.txt. The results of the three statistical tests, along with the random numbers, are kept in a file called Report.txt.

The program then uses the generated random numbers to select the appropriate records from the sampling frame and creates a file called Sample.txt. BBI staff use these files to create a table called Sample Detail. This table includes all original records as well as adjusted records for the unique claims selected as part of the sample. This Sample Detail table contains the claim samples to be reviewed during the course of the audit.

Audit staff reviews the randomly selected sample claims and makes findings of disallowed claims, if any. The disallowed amounts in the sample are then projected over the sampling frame (universe of claims) to arrive at an estimate of the mean dollars in error which is reported in the Draft Audit Report. OMIG's auditors may also calculate the lower confidence limit for a given confidence level and report this information in the Draft Audit Report.

The auditors consider all responses from a provider for each finding associated with each sample. If one finding is eliminated based on a provider response, audit staff considers the remaining findings associated with that sample. Any sample with one or more finding remaining is disallowed on audit. As a result of this, providers should respond to each category of disallowance identified for each sample in an audit.

In cases where there is more than one category of disallowance, a single sample will only be disallowed once in each audit. Samples are disallowed and extrapolated based on a hierarchy of priorities. Full disallowances are given first priority in extrapolating; findings which result in a partial disallowance are given second priority in extrapolating; and findings which are not extrapolated are given third priority in the extrapolation process.

**NEW YORK STATE
OFFICE OF THE MEDICAID INSPECTOR GENERAL
REMITTANCE ADVICE**

NAME AND ADDRESS OF AUDITEE

Medifane Pharmacy, Inc.
204 Clinton Street
New York, NY 10002

AMOUNT DUE: \$4,355.03

PROVIDER ID [REDACTED]

AUDIT #10-2342

AUDIT	<input checked="" type="checkbox"/>	PROVIDER
	<input type="checkbox"/>	RATE
	<input type="checkbox"/>	PART B
TYPE	<input type="checkbox"/>	OTHER:

CHECKLIST

1. To ensure proper credit, please enclose this form with your check.
2. Make checks payable to: *New York State Department of Health*
3. Record the Audit Number on your check.
4. Mail check to:

[REDACTED]
New York State Department of Health
Medicaid Financial Management, B.A.M.
GNARESP Corning Tower, Room 2739
File #10-2342
Albany, New York 12237-0048

Thank you for your cooperation.

MEDILANE PHARMACY CORP.
PHARMACY SERVICES AUDIT
AUDIT #10-2342
AUDIT PERIOD: 1/1/2005 to 12/31/2008

Summary of Findings

<u>Finding Description</u>	<u>Total Recipients</u>	<u>Total Services</u>	<u>Total \$ Disallowance</u>	<u>Exhibit</u>
Ordering Prescriber Conflicts with Claim Prescriber	48	55	\$4,233.72	II
Prescription/Fiscal Order Refilled More Than 180 Days After It Has Been Initiated By the Prescriber	2	2	73.81	III
Missing Prescription	1	1	47.50	IV
Total	<u>51</u>	<u>58</u>	<u>\$4,355.03</u>	

MEDILANE PHARMACY CORP

MMIS # / NPI #: [REDACTED]

Audit #: 10-2342

Ordering Prescriber Conflicts with Claim Prescriber

Sample #	Date of Service	Formulary Code	Amount Disallowed
3	03/11/05	00781183201	\$23.94
8	08/03/06	00536430605	\$12.24
12	03/14/06	00029316013	\$167.20
14	09/09/08	64764030114	\$184.24
16	08/03/05	00182616039	\$2.63
18	01/09/06	60598000101	\$51.99
20	04/03/06	64764030114	\$164.53
26	09/12/05	00006074054	\$135.89
27	03/11/05	00009026001	\$113.40
34	07/15/05	00067021407	\$91.42
38	08/23/05	64894080550	\$77.39
41	05/27/08	00456202001	\$89.18
44	05/29/07	00456132501	\$10.80
47	06/13/06	00172290880	\$5.19
48	03/21/05	59762372707	\$70.68
54	07/26/05	00071015523	\$72.52
57	04/16/07	00085113201	\$38.64
58	07/13/06	00006027554	\$98.06
59	11/25/05	53489010510	\$8.42
62	01/14/06	49884096901	\$63.66
69	10/27/08	00378181501	\$10.70
70	03/09/07	00069153068	\$53.58

MEDILANE PHARMACY CORP

MMIS # / NPI #: [REDACTED]

Audit #: 10-2342

Ordering Prescriber Conflicts with Claim Prescriber

Sample #	Date of Service	Formulary Code	Amount Disallowed
74	10/25/05	59930156001	\$8.75
75	12/28/05	00093103901	\$122.25
76	09/05/06	24385040378	\$2.60
85	08/30/05	58468002101	\$121.87
86	05/19/05	00143178701	\$25.43
87	06/30/05	58177030304	\$56.77
94	03/02/07	00182402889	\$1.95
95	04/25/06	00074679922	\$698.24
99	07/06/06	00078031534	\$123.43
102	10/19/05	00172376060	\$41.84
104	07/18/07	59762490001	\$12.19
107	11/17/05	00456132301	\$31.37
110	06/19/06	00168008031	\$9.96
112	01/20/06	67253062250	\$9.92
121	09/26/05	00093103901	\$43.75
125	11/26/08	17314585102	\$239.55
133	09/02/06	00555028605	\$57.19
139	07/25/06	00536342608	\$3.23
149	11/21/05	00066800802	\$131.66
151	06/13/06	00168025846	\$59.84
153	10/05/05	59762372707	\$36.59

MEDILANE PHARMACY CORP

MMIS # / NPI #: [REDACTED]

Audit #: 10-2342

Ordering Prescriber Conflicts with Claim Prescriber

Sample #	Date of Service	Formulary Code	Amount Disallowed
154	06/07/07	00456132001	\$8.52
162	03/17/06	00168000580	\$7.88
165	10/08/05	00603385525	\$13.81
174	12/16/05	49502067231	\$185.82
175	09/16/08	00591083960	\$87.16
178	06/24/05	00472127094	\$10.56
183	12/29/04	00093812001	\$57.26
185	04/14/07	00071015823	\$113.13
186	04/03/06	A4259	\$5.06
195	03/01/06	A4253	\$78.76
197	08/15/05	00310027510	\$261.62
200	08/30/05	00039022210	\$19.46
Total Services:	55		\$4,233.72

MEDILANE PHARMACY CORP

MMIS # / NPI #: [REDACTED]

Audit #: 10-2342

Prescription/Fiscal Order Refilled More Than 180 Days After It Has Been Initiated By the Prescriber

Sample #	Date of Service	Formulary Code	Amount Disallowed
105	01/13/05	00075150616	\$68.54
120	10/04/08	00143124810	\$5.27
Total Services:	2		\$73.81

MEDILANE PHARMACY CORP

MMIS # / NPI #: [REDACTED]

Audit #: 10-2342

Missing Prescription

Sample #	Date of Service	Formulary Code	Amount Disallowed
4	01/03/05	59930151701	\$47.50
Total Services:	<u>1</u>		<u>\$47.50</u>