The Scottish Government
Health Finance Directorate

Chief Executives and Directors of Finance
NHS Health Boards

The Scottish Government
Riaghaltas na h-Alba

Dear Colleague

REVISED PAYMENT VERIFICATION PROTOCOLS – GENERAL DENTAL SERVICES, PRIMARY MEDICAL SERVICES, GENERAL OPHTHALMIC SERVICES, PHARMACEUTICAL SERVICES

The attached document updates and supersedes the guidance on payment verification procedures contained in DL (2016) 11 and outlines the arrangements for payment verification for 2016-17.

BACKGROUND

This revision includes the following main changes:

Dental

The revision for 2017-18 has introduced a flowchart demonstrating guidelines for payment verification reviews, and a paragraph relating to the recovery of overpayments.

Medical

The revision for 2017-18 reflects the continuing development of the GP contract. Sections relating to the Quality & Outcomes Framework and the Organisational Core Standard have been removed.

Ophthalmic

The revision for 2017-18 has resulted in the introduction of a paragraph relating to IT System Security.

DL (2017) 11

22 May 2017

Addresses

For action
Chief Executives and Directors of Finance, NHS Boards

Chief Executive, NHS National Services Scotland

For information
Chief Executives and Directors of Finance, Special Health Boards

Auditor General

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Pharmacy

The revision for 2017-18 has resulted in no changes to the protocol.

ACTION

Chief Executives are asked to:

- note the revised protocol and ensure that relevant staff within their Boards are familiar with this;
- share the protocol with FHS contractors;
- ensure that their Audit Committee have sight of the protocol;
- work with Practitioner Services in ensuring the implementation of the protocol;
- note that contractors must retain evidence to substantiate the validity of payments and, where this cannot be found, any fees paid may be recovered; and
- note that tri-partite discussion should take place between Practitioner Services, NHSScotland Counter Fraud Services and the relevant NHS Board where a concern relating to potential fraud arises in the course of payment verification, and that, where a tri-partite meeting is deemed necessary, this should take place within 2 weeks of the simultaneous notification of the concern to the Board and NHSScotland Counter Fraud Services by Practitioner Services.

Where an FHS practitioner refuses to co-operate in the payment verification process, he or she may be in breach of his/her contract or terms of service. In such cases, NHS Boards are asked to take appropriate action.

FURTHER INFORMATION

Further information is available from David Knowles, Director, Practitioner & Counter Fraud Services, NHS National Services Scotland:

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Yours faithfully,

Christine McLaughlin
Director of Health Finance

Payment Verification Protocols

Payment Verification Programme for 2017-18

TABLE OF CONTENTS

Introduction……. 2
Contractor Checking…… 2
Risk Assessment…….. 3
Reporting to NHS Boards…… 3
Countering Fraud…….. 4
Adjustment to Payments……. 4
Dental Payments……..……..…...Annex I
Medical Payments……..……Annex II
Ophthalmic Payments…….……..……Annex III
Pharmaceutical Payments……..…….Annex IV

Introduction

1.1 As the accountable bodies for FHS spend, NHS Boards are required to ensure that the payments made to contractors on their behalf are timely, accurate and valid.

1.2 With respect to the validity of the payments, as far as possible claims will be verified by pre-payment checks. The checking process will be enhanced by a programme of post-payment verification, across all contractor groups – Dentists, GPs, Optometrists and Community Pharmacists.

1.3 Accountability for carrying out payment verification ultimately rests with NHS Boards. Whilst the majority of payment verification will be undertaken by Practitioner Services (in accordance with the Partnership Agreement between Practitioner Services and the NHS Boards) there may be instances where it is more appropriate for payment verification to be undertaken by the NHS Board. Consequently, there is an onus on Practitioner Services and NHS Boards to agree the annual payment verification programme.

1.4 It is vital that a consistent approach is taken to PV across the contractor streams and this paper outlines the ways in which this matter will be taken forward across the various payment streams.

1.5 The verification process across all contractor streams relies, amongst other things, on the accuracy of CHI. Further details in relation to the verification of CHI data is detailed within Annex II, Medical Payments.

1.6 These requirements have been produced following consultation with representatives from NHS Health Boards, Practitioner Services and Audit Scotland and reflect the outcome of a comprehensive risk assessment process. The payment verification processes will be subject to regular review in respect of performance and contractual changes.

1.7 Payment verification of the exemption/remission status of patients (Patient Checking) is dealt with within a Partnership Agreement between Counter Fraud Services and the NHS Boards.

Contractor Checking

Ophthalmic, Pharmaceutical and Dental Payments

2.1 It is intended that payment verification checks will take place on 4 levels:

2.2 **Level 1:** Routine pre-payment checking procedures carried out by PSD staff, including automated pre-payment checking by Optix/MIDAS/DCVP, with reference to the Community Health Index (CHI) where appropriate.

2.3 **Level 2:** PV Teams will undertake a trend analysis and monthly/quarterly sample testing, where:

- the results of level 1 checks indicate that this would be beneficial;

- the results of statistical trend analysis indicate a need for further investigation; and
- the formal assessment of the level of risk associated with a particular payment category indicates a need for more detailed testing.

2.4 **Level 3:** PV Teams will, as appropriate, undertake extended sample testing, send out patient letters, or conduct targeted inspection of clinical records in order to pursue the outcome of any claims identified at Levels 1 and/or 2 as requiring further investigation.

2.5 **Level 4:** PV Teams will undertake a random assessment of claims, which may require an inspection of clinical records and/or patient examination.

GMS Payments

2.6 Due to the different nature of the GMS contract, payment verification will use various techniques such as:

- validation of data quality;
- checking of source documentation and activity monitoring. The purpose of this is to reduce the requirement to access patient medical records during practice visits; and
- payment verification practice visits.

Inspection of Clinical Records

2.7 Inspection of clinical records may or may not necessitate a practice visit, depending on the contractor type and also on the implementation of PV protocols at a local NHS Board level. The methodology of actual practice visits is detailed further in Appendix A of the Medical and Ophthalmic Annexes.

Risk Assessment

3.1 In order to ensure that maximum use is made of the finite resources available for payment verification, it is imperative that PV work is targeted at the areas of highest risk. Risk matrices have been developed and applied to facilitate the appropriate risk assessment of the payment areas and targeted use of payment verification resources.

3.2 In order to ensure that these risk matrices continue to reflect both the materiality of, and the risks relating to, all contractor payment types, it is intended that the application of the risk assessment methodology will be subject to annual review. This review will be undertaken by the appropriate PV Contractor Group, and shall be subject to approval by the PV Governance Group.

Reporting to NHS Boards

4.1 NHS Boards also require assurance on the level of payment verification checking carried out in their respective areas, in relation to the guidance set out in this document.

4.2 In order to support this, the Practitioner Services PV teams will produce quarterly reports for each of the contractor streams, providing information on the

level of checking carried out in each NHS Board area and highlighting any specific issues of interest.

4.3 In addition, for all categories of payments, it is important that any matters of concern arising from the payment verification work undertaken are acted upon quickly and appropriately. In such circumstances the procedure noted at Section 6 below will be followed.

Countering Fraud

5.1 NHS Scotland Counter Fraud Services has the responsibility of working with others to prevent, detect and investigate fraud against any part of the NHS in Scotland. Under the Scottish Government's Strategy to Combat NHS Fraud in Scotland, everyone within NHS Scotland has a part to play in reducing losses to fraud and, to increase deterrence, effective sanctions will be applied to all fraudsters. Professional bodies representing all FHS Practitioners have signed a counter fraud charter with CFS, committing their members to assist in reducing fraud against NHS Scotland.

5.2 Where Practitioner Services or an NHS Board, through the application of their internal control systems, pre or post-payment, identify irregularities which could potentially be fraud, they shall make their concerns known to CFS. Where necessary, tri-partite discussion will be held to determine the best way forward in accordance with the Counter Fraud Strategy, and the NHS Board/CFS Partnership Agreement.

Adjustment to Payments

6.1 All proposals to make additional payments or to seek recoveries of overpayments from contractors as a result of PV investigations will be the subject of discussion and agreement between Practitioner Services and the relevant NHS Board. Although any recovery is officially in the name of the NHS Board and any formal action to recovery will have to be taken in their name, it is important that recoveries are affected by Practitioner Services through the Practitioner Services payment processes. This will ensure that all such adjustments are recorded in the payment systems and that any consequential adjustments for other payments (such as pension deductions) take account of the adjustment.

Annex I – Dental Payments

TABLE OF CONTENTS

Introduction 2
Capitation & Continuing Care 3
Items of Service 4
Allowances 5
Appendix A – Examination of Patients – Scottish Dental Reference Service (SDRS) 6

Introduction

The following sections detail the payment verification requirements for General Dental Services (GDS).

It should be noted that Practitioner Services (Dental) operates under the aegis of the Scottish Dental Practice Board (SDPB) whose powers are set out in statutory legislation. The role of Practitioner Services Dental, as agents of the Scottish Dental Practice Board, is to attest that care and treatment proposed or provided under GDS is appropriate having undertaken a risk versus benefit analysis. Where appropriate, the outputs from this clinical governance process will inform the verification of payments.

Dental, unlike the other contractor streams within Practitioner Services, have a responsibility regarding Clinical Governance. And if they become aware of any significant clinical issues during the course of an investigation notification will be discussed with the relevant NHS Board at the earliest opportunity for agreement to be reached on whether a referral to the GDC is appropriate

Practitioner Services (Dental) operates a computerised payments system (MIDAS) as well as an optical character recognition system (iDent), both of which undertake extensive pre-payment validation on dental payment claims. Electronic Data Interchange (EDI) is accepted by MIDAS and the checks noted below apply equally to scanned paper claim input and data fed through EDI.

Retention of Evidence

Practices are required to retain evidence to substantiate the validity of payments. The requirement for this evidence will be in accordance with the NHS (GDS) (Scotland) Regulations 2010, the Statement of Dental Remuneration (SDR) and the Scottish Dental Practice Board Regulations 1997, para 10(2). The Scottish Government Records Management: NHS Code of Practice (Scotland) Version 2.1 also provides a schedule listing the retention period for financial records in NHS Scotland. This specifies six years plus the current year as minimum retention period for most financial records. For the avoidance of doubt this would relate to any information used to support NHS payments to dental practitioners.

Where evidence to substantiate the validity of payments cannot be found, any fees paid will be recovered.

Capitation & Continuing Care

Capitation and continuing care payments are based on the numbers and ages of the patients registered with the dentist. These details are gathered when dental claim forms are submitted and payment will continue unless the patient registers with another dentist, dies, embarks (has left the United Kingdom) or is de-registered by the dentist.

Payment verification checking takes place on 4 levels as follows:

Level 1 will comprise 100% checking of:

- claim forms by MIDAS/iDENT – to ensure all mandatory information is present
- patient existence/status by matching to CHI
- validation against the SDR
- duplication on MIDAS

Level 2 will comprise trend analysis of claims, including, but not limited to:

- number of registrations by contractor
- registrations by contractor that are unmatched to CHI
- registrations by contractor with no IOS claims

Level 3 checking will be undertaken as appropriate where the outcome of the above analysis proves unsatisfactory or inconclusive. This may include:

- patient letters
- sampling of patient records and associated documentation
- liaison with private capitation scheme providers to establish registration status

Level 4 will comprise of a percentage of unmatched registrations (where an IOS claim has been made) being included in the random examinations of patients by the Scottish Dental Reference Service (SDRS) as per Appendix A.

Outputs:

Quarterly PV report detailing:

- Results and status of checking process
- Any necessary recommendations, actions and recoveries(as per Appendix B)

Items of Service

Payment verification checking takes place on 4 levels as follows:

Level 1 will comprise 100% checking of:

- claim forms by MIDAS/iDENT – to ensure all mandatory information is present
- patient existence/status by matching to CHI
- validation against the SDR and any provisos or time limits that apply, including tooth specific validation where appropriate for specific items of service.
- duplication on MIDAS
- the patient's date of birth for age exemption
- checking the total value of the claim and applying prior approval as appropriate

Prior Approval - claims with values in excess of the prior approval limit require to be submitted for checking before treatment is carried out. These are assessed for both clinical and financial appropriateness.

Level 2 will comprise risk driven trend analysis of claims, including, but not limited to:

- individual and combinations of item of service claims
- items claimed where the patient does not pay the statutory charge
- level of earnings
- cost per case and throughput

Level 3 checking will be undertaken as appropriate where the outcome of the above analysis proves unsatisfactory or inconclusive. This may include:

- patient letters
- sampling of patient records and associated documentation
- applying the "special prior approval" process or the "prior approval by targeting" regulation
- referral of patients to the SDRS to confirm that treatment proposed or claimed was in accordance with the SDR in compliance with the NHS (GDS)(Scotland) Regulations 2010
- further investigation as a result of adverse outcome of SDRS examination.

Level 4 will involve the SDRS examining a sample of patients, chosen at random, from every NHS dentist to confirm that treatment claimed was in accordance with the Statement of Dental Remuneration in compliance with the NHS (GDS) (Scotland) Regulations 2010.

Any practitioner who receives an unsatisfactory report from the SDRS in relation to the validity or standard of treatment provided to the patient is automatically referred to the NHS Board for consideration.

Outputs:

Quarterly PV report detailing:

- Results and status of checking process
- Details of information used to verify service provision
- Any necessary recommendations, actions and recoveries(as per Appendix B)
- SDRS reports

Allowances

Allowances are based on existing data held within MIDAS (e.g. General Dental Practice Allowance and Commitment Payment) or they are the subject of separate claims submitted by the dentist or practice.

Level 1 will comprise 100% checking of:

- mandatory information and supporting documentation is present
- validation against the SDR and any provisos or time limits that apply
- duplication on MIDAS

Outputs:

Quarterly PV report detailing:

- Results and status of checking process
- Any necessary recommendations, actions and recoveries(as per Appendix B)

Appendix A – Examination of Patients – Scottish Dental Reference Service (SDRS)

1 Background

1.1 One of the methods of verifying payments made under General Dental Services (GDS) arrangements is to examine patients. This service is carried out by a Dental Reference Officer (DRO) employed by the SDRS. The DRO inspects patients' mouths before extensive work is carried out, or after they have received treatment.

1.2 All patients receiving treatment under GDS sign to say that they agree to be examined by a dental reference officer if necessary.

2 Selection of Patients

2.2 Every year a number of patients from every NHS dentist are invited to attend the SDRS. Patients may also be invited to attend where the application of risk assessment or trend analysis in relation to claims received from practitioners suggests that this would be appropriate.

2.3 Practitioners are advised about appointment timings for their patients and are permitted to attend the examination.

3 SDRS Reports

3.1 Once a practitioners patients have been examined, a report is produced which details DRO's opinion of the clinical care and treatment/clinical treatment proposals, and any concerns relating to possible clerical errors, mis-claims or regulatory concerns.

3.2 Clerical errors, mis-claims or regulatory concerns are classified in a SDRS report as follows:

Administrative (i) m: possible mis-claim e.g. claiming the wrong code

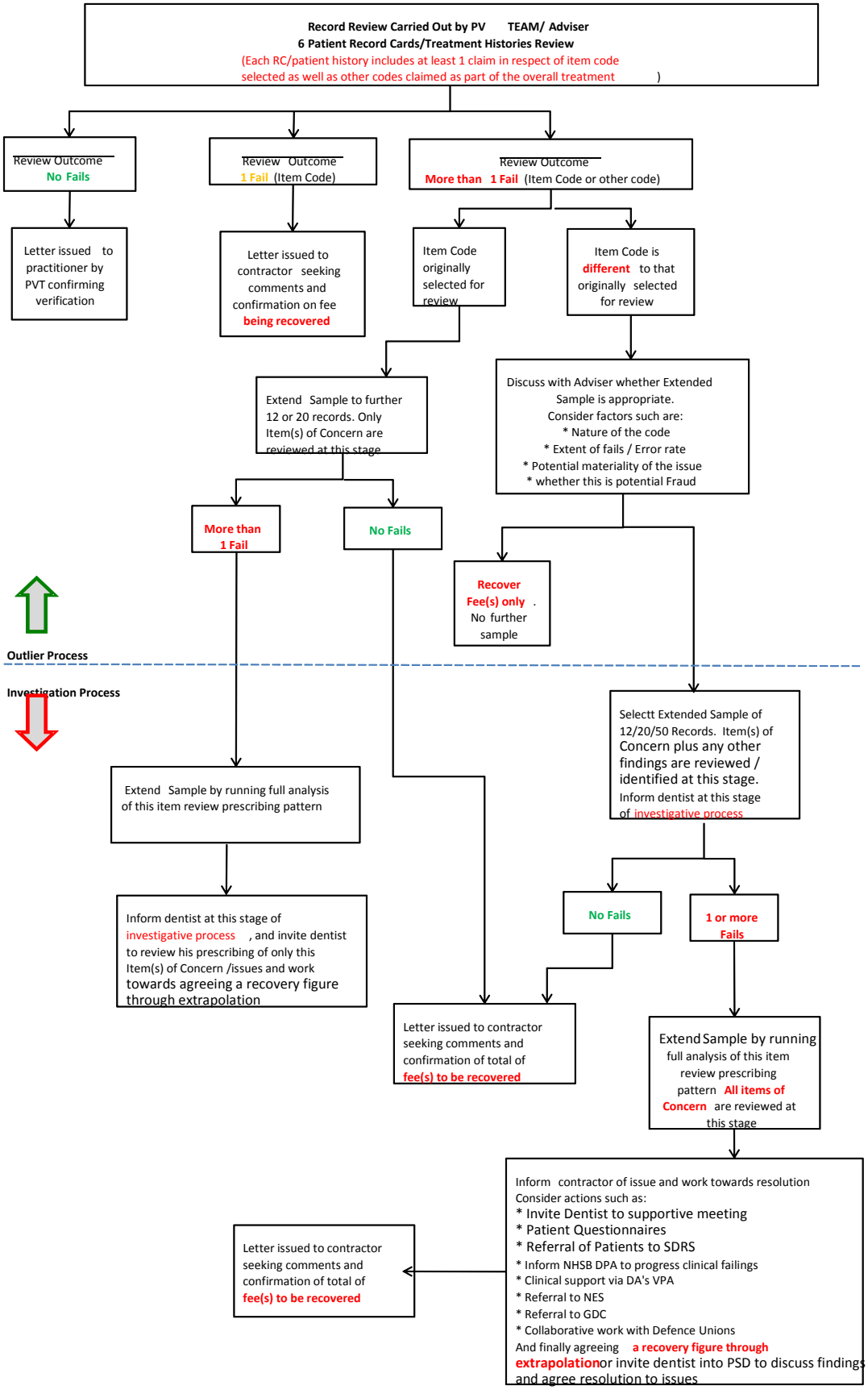
Administrative (i) c: possible clerical error e.g. mixing an upper and lower or left and right on the charting of a restoration

Administrative (i) r: possible regulatory error e.g. claiming an amalgam on the occlusal surface of a premolar when a composite was provided

Administrative P: possible violation or avoidance of Prior Approval Regulations/requirements.

3.3 The code assigned to the examination by the DRO will determine the course of action to be taken. This may include no further action, further patient examinations, discussion with or referral to the NHS Board, or in some cases a tri-partite meeting between Practitioner Services, the NHS Boards and Counter Fraud Services.

Appendix B - FLOWCHART DEMONSTRATING GUIDELINES FOR PAYMENT VERIFICATION REVIEWS



Recovery of Overpayments

Under Regulation 25(1) of the National Health Service (General Dental Services (Scotland) Regulations 2010, Practitioner Services (as the Agency) will draw to the attention of the dentist payments which they consider have been made in circumstances in which they are not due and therefore proceed to makes recoveries by any means possible.

Extrapolation to the entire population is used to make recoveries where a high number of systematic errors are identified from either the original or extended sample of record cards and item of service claims tested. This aims to keep the administrative burden to a minimum from both the practitioner and practitioner services.

Annex II – Medical Payments

TABLE OF CONTENTS

Introduction 2
Payment Verification for Global Sum 3
Payment Verification of Core Standard Payment 6
Payment Verification for Temporary Patient Adjustment (TPA) 7
Payment Verification for Additional Services 8
Payment Verification for Payments for a Specific Purpose 9
Payment Verification for Section 17c Contract 10
Payment Verification for Seniority 11
Payment Verification for Enhanced Services 12
GP Practice System Security 13

Introduction

The following sections detail the payment verification requirements for Primary Medical Services for the 2017/18 financial year.

The verification arrangements outlined will require local negotiation between NHS Boards and Practitioner Services on implementation. This should ensure that a consistent approach is taken to payment verification irrespective of who performs it.

Each of the three Practitioner Services Regional Offices supports a dedicated Medical PV team to undertake the required payment verification work. These teams work in close co-operation with their respective NHS Boards and colleagues in the other Medical departments to ensure co-ordination in payment verification and related activities.

Retention of Evidence

Practices are required to retain evidence to substantiate the validity of payments relating to the GMS Contract. The requirement for this evidence will be in line with that detailed in the Contract, in the Statement of Financial Entitlements or in locally negotiated contract documentation. It is particularly important to retain evidence that is generated by the running of a computer generated search, as this provides the most reliable means of supplying data, that fully reconciles with the claim submitted should practices be required to do so. Scottish Government Records Management: NHS Code of Practice (Scotland) Version 2.1 provides a schedule listing the retention period for financial records in NHS Scotland. This specifies six years plus the current year as minimum retention period for most financial records. For the avoidance of doubt this would relate to any information used to support a payment to the GP Practice.

Where evidence to substantiate the validity of payments cannot be found, any fees paid will be recovered.

Data Protection

PCA (M)(2005) 10, Confidentiality & Disclosure of Information Code of Practice, illustrates the circumstances under which disclosure of patient identifiable data may be made in relation to checking entitlement to payments and management of health services. The guidance contained in this document is consistent with this code of practice.

The practice visit protocol, contained as Appendix A in this document, pays particular attention to minimising the use of identifiable personal data in the payment verification process. The use of clinical input is recommended to streamline the process, provide professional consistency, and limit the amount of investigation necessary in validating service provision.

Premises and IT Costs

Expenditure on premises and IT will be met through each Board’s internal payment systems and as such will be subject to probity checks through the Board's normal control processes. There is therefore no payment verification required. Where Practitioner Services are required to make payments on behalf of NHS Boards these will be checked for correct authorisation.

Payment Verification for Global Sum

METHOD

The Global Sum is the payment to GP Contractors for delivering essential and additional services.

A GP Practice's global sum allocation is dependent on their share of the Scottish workload, based on a number of weighting factors (reference Annexe B, Scottish Allocation Formula, GMS Statement of Financial Entitlements).

The accuracy of the Global Sum is dependent upon the data held on the Community Health Index (CHI).

The verification of the data held on the CHI is achieved in a number of ways. Although the intent of these control and verification processes is primarily focussed on the accuracy of patient data for health administration purposes, assurance can be taken from the existence and application of many of these controls for payment verification purposes.

The following controls and processes are used to verify GP Practice Population List Size and weighting factors:

System/Process Generated Controls

- All new patient registrations transferred electronically via PARTNERS to the Community Health Index (CHI) are subject to an auto-matching process against existing CHI records. If a patient cannot be auto-matched further information is requested from the GP Practice so that positive patient identification can be ensured.
- All patient addresses transferred by PARTNERS to CHI are subject to an auto-post coding process to ensure validity of address within the Health Board Area.
- All deceased patients are automatically deducted from the GP Practice on CHI using an interface file from NHS Central Register (information being derived from General Register of Scotland). Patients registering elsewhere in the UK are deducted from the GP Practice on CHI following matching by NHS Central Register.
- Patients are automatically deducted from GP Practice on registration with another GP Practice in Scotland.
- All patients confirmed as no longer residing at an address are removed on CHI and automatically deducted from GP Practice lists via PARTNERS.
- Quarterly archiving of GP Practice systems and generation of PARTNERS reports ensures that all patient transactions (acceptances and deductions) have been completed by the GP Practice.
- All patients whose address is an exact match with a Care Home address will automatically have a Care Home indicator inserted on CHI.
- Where new patient registrations are not transferred by PARTNERS manual scrutiny of registration forms is undertaken.
- Registration Teams check unmatched patients (without CHI number) to NHS Central Register database to ensure positive patient identification.

Random Checking

- Validation on patient data for a minimum of 10% of GP Practices annually via Patient Information Comparison Test (PICT) to ensure that patient data on CHI and on GP systems match. The following fields can be validated:

  1. Date of Birth and Sex differences
  2. Name differences
  3. Unmatched patients
  4. Patients on CHI but not on practice system
  5. Patients who have left the practice
  6. GP Reference differences
  7. Address differences
  8. Possible duplicates
  9. Missing CHI Postcodes
  10. Mileage differences

Targeted Checking

- Manual scrutiny of registration forms where there is concern regarding the quality of registration data submitted via PARTNERS.

- Data Quality work which contributes to the removal of patients from CHI:
  1. UK and Scottish Duplicate Patient matching exercises to ensure that patients are only registered with one GP Practice.
  2. Bi-annual short term residency checks on patients such as, Students, c/o Addresses, Holiday Parks, or Immigrant status.
  3. Annual checks on patients aged over 100.
  4. Quarterly checks on Care Home Residents.
  5. All mail to patients that is returned in post is followed up with the GP Practice and where appropriate patients are removed from CHI and from the GP Practice list.

- Validation on patient data via PiCT for capitation dispute, data quality concerns or system migration (fields as above).

Payment Verification Practice Visit

- Where patient registration data is submitted via PARTNERS the Payment Verification visiting team will check a sample of recent transactions to ensure that General Practice Registration Form (GPR) has been completed and retained by the practice electronically as verification of the registration.

Trend Analysis

- Monitoring of levels of the following using the Quarterly Summary Totals report by Health Board Area:
  1. Capitation Totals by age/sex bands
  2. Patients in Care Homes registered with the practice in the last 12 months
  3. Patients in Care Homes registered with the practice more than 12 months ago
  4. All other patients registered with the practice in the last 12 months
  5. All other patients registered with the practice more than 12 months ago
  6. Number of Dispensing Patients
  7. Number of Mileage patients

- Monitoring of levels of the following through Key Performance Indicators using the Quarterly Summary Run:
  1. Number of new registrations in CHI in quarter
  2. Number of patients removed from CHI as deceased

- Number of patients removed from CHI as moved out of Health Board Area.
- Pre-Payment checking of quarterly payments being authorised by GP Practice on the value of the Global Sum Payment to ensure that variances no more than +/- 5% of the value of the previous quarter.

OUTPUTS:

- A Global Sum Verification Report will be generated on a quarterly basis.

  The report will detail the results of the checking and any actions taken as a result of the checks and provide recommendations to the Health Board.

Payment Verification of Core Standard Payment

In 2016-17 the remaining 659 QOF points were merged with the clinical and organisational core standard payments to create a single Core Standard Payment.

The decision on whether or not it is appropriate to provide a particular service to a patient in these areas is taken by the practice, usually in conjunction with the patient, and is based on clinical judgement rather than simply whether the action was previously required to achieve a QOF indicator.

There will be no specific payment verification arrangements aligned to the Core Standard Payment.

If it appears that there is a systematic failure to provide any of the transferred services, this may require recourse to a formal review of the clinical decision making recorded within the patient file. This process is not part of payment verification.

Payment Verification for Temporary Patient Adjustment (TPA)

METHOD
To verify that the payment of the TPA is appropriate the following checks will be undertaken:

- Random sampling of GP Practice records for evidence of service provision at practice visit.
- Complaint logs will be reviewed annually to identify complaints, or a pattern of complaints, that could indicate a lack of service provision. If an absence of service is found, this should be subject to further investigation, and if necessary further action taken.
- Where concerns exist over an absence of provision of service, a practice may be asked to demonstrate their process of recording instances where treatment of a temporary patient(s) has been refused.

The incorrect registration of temporary patients as permanent patients will be checked as part of the payment verification for Global Sum.

OUTPUTS:

- Number of records checked at practice visit and results.
- Record of check made to complaint logs.
- Any necessary recommendations, actions and recoveries.

Payment Verification for Additional Services

METHOD
To verify that these services are being provided one or more of the following verification techniques will be undertaken as applicable:

- Practice Visit – the purpose of which is to examine a percentage of patient records. Records to be reviewed will be selected at random. See Appendix A.
- Analysis of anonymised practice prescribing information.
- Review of practice activity information including national call/recall systems.

OUTPUTS:

- Number of records checked at practice visit and results.
- Details of information used to verify service provision.
- Any necessary recommendations, actions and recoveries.

Payment Verification for Payments for a Specific Purpose

METHOD
To verify that these payments are valid, one or more of the following verification techniques will be undertaken as applicable:

- Confirmation of adherence to entitlement criteria as per the relevant section of the Statement of Financial Entitlements (SFE) are met
- Confirmation that all relevant conditions of payment as per the relevant section of the SFE are met
- Analysis of outlier detail

Immunisations

METHOD
To verify that these services are being provided, one or more of the following verification techniques will be undertaken as applicable:

- Practice Visit – the purpose of which is to examine a percentage of patient records. Records to be reviewed will be selected at random. See Appendix A.
- Analysis of anonymised practice prescribing information.
- Review of practice activity information including national call/recall systems.

OUTPUTS:

- Numbers and values of payments made by practice type and practice.
- Any specific matters arising in the processing of payments.
- Number of records checked at practice visits and results.
- Details of information used to verify service provision.
- Any necessary recommendations, actions and recoveries.

Payment Verification for Section 17c Contract

METHOD
Payments to practices holding section 17c contracts are split into two streams:

- Payments that map to those received by section 17j practices.
- Payments that are specific to their section 17c contract.

Payments that map to those received by section 17j practices are subject to the payment verification processes outlined elsewhere in this document.

To verify that payments specific to a section 17c contract are appropriate, these practices will be subject to NHS Boards' contract monitoring processes which may involve:

- NHS Board quarterly review.
- Analysis of practice produced statistics which demonstrate contract compliance.
- Reviewing as appropriate section 17c contracts against other/new funding streams to identify and adjust any duplication of payment.
- Practice Visit – the purpose of which is to examine a percentage of patient records. Records to be reviewed will be selected at random. See Appendix A.

OUTPUTS:

- Number of records checked at practice visit and results.
- Details of information used to verify service provision.
- Any necessary recommendations, actions and recoveries.
- As per agreed local monitoring process.

Payment Verification for Seniority

METHOD

To verify that new claims for Seniority payments are valid, checks will be undertaken, prior to payment, as follows:

- Reasonableness of claim – to check appropriateness of dates against information on form seems appropriate - General Medical Council (GMC) registration date, NHS service start date.
- check for length of service.
- check eligibility of breaks in service.
- where applicable check with Scottish Government (SG) for eligibility of non-NHS Service.

OUTPUTS:

- details of new claimants received in quarter and level of seniority.
- results and status of checking process.

Payment Verification for Enhanced Services

INTRODUCTION

The method and output sections below provide generic guidance for the payment verification of all Enhanced Services.

METHOD

To verify that these services are being provided the relevant specification for the service must be obtained. The practice's compliance against this specification will be verified by one or more of the following techniques:

- Practice Visit – the purpose of which is to examine a percentage of patient records. Records to be reviewed will be selected at random. (See Appendix A). Verification may also include the inspection of written evidence retained outwith the patient record and a review of the underlying systems and processes that a practice has in place.
- Analysis of anonymised practice prescribing information.
- Analysis of GP Practice activity information.
- Discussion of GP Practice policies and procedures.
- Confirmation letters/surveys to patients.
- Review of Complaints log.
- Discussion of how Extended Hours service was planned and organised. Checks to provide evidence that the service is being provided, (e.g. check that the correct additional consultation time is being provided via the appointment system, notification of service availability to patients - practice leaflet, posters, etc.)

OUTPUTS:

- Results and status of checking process.
- Details of information used to verify service provision.
- Any necessary recommendations, actions and recoveries.

GP Practice System Security

Payment verification practice visits comprehensively utilise data held within GP clinical systems, and it is therefore necessary to seek assurance that there are no issues regarding the reliability or the integrity of the systems that hold this data.

NHS Boards are responsible for the purchase, maintenance, upgrade and running costs of integrated IM&T systems for GP Practices, as well as for telecommunications links within the NHS. Within each NHS Board area, assurances will be obtained that appropriate measures are in place to ensure the integrity of the data held within each GP Practice's clinical system.

In obtaining this level of assurance, consideration will be given to the following areas:

- an established policy on System Security should exist that all practices have access to and have agreed to abide by;
- administrator access to the system should only be used when performing relevant duties;
- a comprehensive backup routine should exist, backup logs should be examined on a regular basis with issues being resolved where appropriate, and appropriate storage of backup media should occur; and
- Up to date anti-virus software should be installed, and be working satisfactorily.

In addition, confirmation will be sought during a practice visit that users have a unique login to the GP clinical system, that they keep their password confidential, and that they will log off when they are no longer using the system.

OUTPUTS:

- Any necessary recommendations and actions.

Annex III – Ophthalmic Payments

TABLE OF CONTENTS

Introduction 2
GOS 1 Primary Eye Examination Claim 3
GOS 1 Supplementary Eye Examinations 4
GOS 1 Domiciliary Visits 5
GOS 3 Spectacle Vouchers 6
GOS 4 Repair/Replacement Voucher 7
IT System Security 8
Appendix A – Inspection of Ophthalmic Records and Practice Visits 9

Introduction

The following sections detail the payment verification requirements for General Ophthalmic Services (GOS).

Practitioner Services (Ophthalmic) operate a scanning and optical character recognition system (iDENT) and a computerised payment system (OPTIX) both of which undertake extensive pre-payment validation on ophthalmic payment claims.

Retention of Evidence

Practices are required to retain evidence to substantiate the validity of payments. The requirement for this evidence will be in accordance with the NHS (GOS) (Scotland) Regulations 2010. The Scottish Government Records Management: NHS Code of Practice (Scotland) Version 2.1 also provides a schedule listing the retention period for financial records in NHS Scotland. This specifies six years plus the current year as minimum retention period for most financial records. For the avoidance of doubt this would relate to any information used to support NHS payments to ophthalmic practitioners.

Where evidence to substantiate the validity of payments cannot be found, any fees paid will be recovered.

GOS 1 Primary Eye Examination Claim

Primary Eye Examination payments are based on claims made by contractors for undertaking examinations to test sight and identify signs of eye disease. Claims are submitted on the GOS 1 form or submitted electronically.

Payment verification checking takes place on 4 levels as follows:

Level 1 will comprise 100% checking of:

- claim forms by OPTIX/iDENT – to ensure all mandatory information is present validation against the GOS regulations and any provisos or time limits that apply
- duplication on OPTIX
- the patient's date of birth for age exemption
- checking the total value of the claim

Level 2 will comprise random sampling of claims including, but not limited to:

- examination of record cards and associated documentation to establish that they comply with the minimum data set as laid down in " The Statement"
- Check on number of primary examinations conducted in a day

Level 3 checking will be undertaken as appropriate where the outcome of the above analysis proves unsatisfactory or inconclusive. This may include:

- patient letters
- further sampling of record cards and associated documentation
- the carrying out of practice visits as per Appendix A

Level 4 checking will be undertaken as follows:

- the carrying out of practice visits as per Appendix A

Outputs:

Quarterly PV report detailing:

- Results and status of checking process
- Details of information used to verify service provision
- Any necessary recommendations, actions and recoveries

Further to the completion of a practice visit, a report will be produced which details the following:

- Information used to verify service provision
- Number of records checked and results
- Any necessary recommendations, actions and recoveries
- Level of assurance gained

GOS 1 Supplementary Eye Examinations

Supplementary Eye Examination (SEE) payments are based on claims made by contractors where the patient presents and requires an examination prior to the minimum Primary Eye Examination frequency. Claims are submitted on the GOS 1 form or submitted electronically.

Level 1 will comprise 100% checking of:

- claim forms by OPTIX/iDENT – to ensure all mandatory information is present validation against the GOS regulations and any provisos or time limits that apply
- duplication on OPTIX
- checking the total value of the claim

Level 2 will comprise risk driven trend analysis of claims, including, but not limited to:

- Individual and combinations of different SEE code types
- number of SEE

Level 3 checking will be undertaken as appropriate where the outcome of the above analysis proves unsatisfactory or inconclusive. This may include:

- patient letters
- sampling of patient records and associated documentation
- the carrying out of practice visits as per Appendix A

Level 4 checking will be undertaken as follows:

- the carrying out of practice visits as per Appendix A

Outputs:

Quarterly PV report detailing:

- Results and status of checking process
- Details of information used to verify service provision
- Any necessary recommendations, actions and recoveries

Further to the completion of a practice visit, a report will be produced which details the following:

- Information used to verify service provision
- Number of records checked and results
- Any necessary recommendations, actions and recoveries
- Level of assurance gained

GOS 1 Domiciliary Visits

Domiciliary visits are claimed in respect of a patient who is eligible for a GOS eye examination and who is unable to leave the place where they normally reside unaccompanied (for reasons of physical or mental ill health or disability) to attend a practice. Claims are made as an accompaniment to a GOS 1 PEE or SEE claim.

Payment verification checking takes place on 4 levels as follows:

Level 1 will comprise 100% checking of:

- claim forms by OPTIX/iDENT – to ensure all mandatory information is present

Level 2 will comprise random sampling of claims including, but not limited to:

- examination of record cards and associated documentation

Level 3 checking will be undertaken as appropriate where the outcome of the above analysis proves unsatisfactory or inconclusive. This may include:

- patient letters
- sampling of patient records and associated documentation
- the carrying out of practice visits as per Appendix A

Level 4 checking will be undertaken as follows:

- the carrying out of practice visits as per Appendix A

Outputs:

Quarterly PV report detailing:

- Results and status of checking process
- Details of information used to verify service provision
- Any necessary recommendations, actions and recoveries

Further to the completion of a practice visit, a report will be produced which details the following:

- Information used to verify service provision
- Number of records checked and results
- Any necessary recommendations, actions and recoveries
- Level of assurance gained

GOS 3 Spectacle Vouchers

Spectacle Vouchers are issued by contractors to patients who are eligible for help with costs towards glasses or contact lenses. Claims are submitted on the GOS 3 form or submitted electronically. The GOS 3 voucher may contain a number of payment elements including the voucher value (based on the prescription) and supplementary items such as Prisms, Tints, Small Glasses and Complex Lenses.

Level 1 will comprise 100% checking of:

- claim forms by OPTIX/iDENT – to ensure all mandatory information is present
- validation against the NHS (Optical Charges & Payments) (Scotland) Regulations 1998 and any provisos or time limits that apply
- duplication on OPTIX
- the patient's date of birth for age exemption
- checking the total value of the claim

Level 2 will comprise risk driven trend analysis of claims, including, but not limited to:

- ratio of GOS3 claims to total eye examination claims

Level 3 checking will be undertaken as appropriate where the outcome of the above analysis proves unsatisfactory or inconclusive. This may include:

- patient letters
- sampling of patient records and associated documentation
- the carrying out of practice visits as per Appendix A
- for glasses that have not yet been collected, verification that the prescription corresponds to that which is being claimed for

Level 4 checking will be undertaken as follows:

- the carrying out of practice visits as per Appendix A
- for glasses that have not yet been collected, verification that the prescription corresponds to that which is being claimed for

Outputs:

Quarterly PV report detailing:

- Results and status of checking process
- Details of information used to verify service provision
- Any necessary recommendations, actions and recoveries

Further to the completion of a practice visit, a report will be produced which details the following:

- Information used to verify service provision
- Number of records checked and results
- Any necessary recommendations, actions and recoveries
- Level of assurance gained

GOS 4 Repair/Replacement Voucher

Repair and replacement vouchers are issued by contractors, primarily in respect of patients under 16 year of age, whose spectacles have suffered damage or been lost and require either to be repaired or replaced. Claims are submitted on the GOS 4 form.

Level 1 will comprise 100% checking of:

- claim forms by OPTIX/iDENT – to ensure all mandatory information is present
- validation against the NHS (Optical Charges & Payments) (Scotland) Regulations 1998 and any provisos or time limits that apply
- duplication on OPTIX
- the patient's date of birth for age exemption
- checking the total value of the claim

Level 2 will comprise random sampling of claims including, but not limited to:

- examination of record cards and associated documentation

Level 3 checking will be undertaken as appropriate where the outcome of the above analysis proves unsatisfactory or inconclusive. This may include:

- patient letters
- sampling of patient records and associated documentation
- the carrying out of practice visits as per Appendix A

Level 4 checking will be undertaken as follows:

- the carrying out of practice visits as per Appendix A

Outputs:

Quarterly PV report detailing:

- Results and status of checking process
- Details of information used to verify service provision
- Any necessary recommendations, actions and recoveries

Further to the completion of a practice visit, a report will be produced which details the following:

- Information used to verify service provision
- Number of records checked and results
- Any necessary recommendations, actions and recoveries
- Level of assurance gained

IT System Security

Payment verification practice visits comprehensively utilise data held within ophthalmic clinical systems, and it is therefore necessary to seek assurance that there are no issues regarding the reliability or the integrity of the systems that hold this data.

Contractors are responsible for the purchase, maintenance, upgrade and running costs of integrated IM&T systems for their practices, as well as for telecommunications links within the NHS. Within each NHS Board area, assurances will be obtained as part of the premises inspection programme that appropriate measures are in place to ensure the integrity of the data held within each ophthalmic practice's clinical system.

In obtaining this level of assurance, consideration will be given to the following areas:

- That the practice has current registration with the Information Commissioner's Office regarding Data Protection
- an established policy on System Security should exist that all employees have access to and have agreed to abide by;
- administrator access to the system should only be used when performing relevant duties;
- a comprehensive backup routine should exist and appropriate storage of backup media should occur; and
- all staff utilising the VPN connection comply with of the Acceptable User Policy in place in their Health Board

In addition, confirmation will be sought during a practice visit that users have a unique login to the ophthalmic clinical system, that they keep their password confidential, and that they will log off when they are no longer using the system.

OUTPUTS:

- Any necessary recommendations and actions.

Appendix A – Inspection of Ophthalmic Records and Practice Visits

1. Background

1.1 One of the methods of verifying payments made under General Ophthalmic Services (GOS) arrangements is to examine patient records. It has been agreed that these checks may be carried out during practice visits. During these visits a selection of records will be examined looking at a range of items of service.

1.2 These records will usually be paper based though cross-checking may be required with any relevant electronically held information, as well as with order books and appointment diaries.

2. Selection of Practices

2.1 Practitioner Services staff will conduct these visits on either a random basis with regard to the risk matrix and the quota of record card checks to be carried out for that particular NHS Board, or where the application of risk assessment or trend analysis suggests that this would be appropriate.

2.2 Practitioner Services and NHS Boards will jointly agree the selection of practices. In the case of those visits carried out as part of random sampling, consideration will be given to avoiding the selection of any practices that have recently been in receipt of a Practice Inspection or routine record card check. It is for the NHS Board to determine the level of assurance it requires from the payment verification process.

2.3 Contractors will be advised of when the visit will take place and the reason therefor.

2.4 The contractor will be given at least four weeks' notice of the intention to carry out a visit. Every effort will be made to carry out the visit at a mutually convenient time, including giving consideration to visits 'out of hours' where that is feasible.

2.5 In the event that a contractor fails to give access to patient records then the NHS Board will be alerted so that the contractor may be warned that he or she may be subject to a referral for NHS disciplinary procedures.

3. Selection of Records

3.1 In advance of the visit, a number of claims will be identified for examination. Practitioner Services will extract this information from the OPTIX system and cross reference this to the Community Health Index (CHI).

3.2 Practitioner Services will examine record cards from recent visits by patients, though this will be dependent on the 'items of service' being checked and the throughput of the practice.

3.3 The total number of patient records identified for examination would not normally exceed that which it is practical to review in a two to three hour session. This timeframe may however vary, particularly where records are held centrally.

3.4 The numbers of records selected for each 'item of service' as part of the random practice visit will be determined by a risk methodology, thus ensuring that a minimum threshold is achieved for the number of records that are accessed for the purposes of verification. For visits concentrating on specific areas, the volume of checks will be determined by the specific circumstances and in consultation with the relevant NHS Board.

3.5 During the visit, Practitioner Services staff may take copies of a sample of the patient records they have checked, either by photocopying, photographing or by electronic scanning. This will support instances where there is a need for clarification on any matter that cannot be resolved during the practice visit.

3.6 Once the practice visit is completed, the outcome agreed and no further audit is required, the copies of the patient records will be destroyed.

4. Visiting Team

4.1 The team visiting the practice may comprise representatives from both Practitioner Services and the NHS Board. An Optometrist, who is independent to the practice, may also attend.

4.2 As all members of the visiting team are NHS staff/contractors, they are contractually obliged to respect patient and business confidentiality and are bound by the NHS code of practice.

4.3 Should they so desire, the relevant NHS Board may undertake a visit at the same time as the visiting team. This may be of particular assistance if locally run schemes are to be verified by the NHS Board during the visit. In these cases, all of the purposes of the visit will be made clear to the contractor before the visit is made.

5. Examining the Patient Record Cards

5.1 The visiting team should be afforded sufficient space and time to examine the patient record cards to ascertain whether evidence exists to verify that payments made to the contractor were appropriate.

5.2 The audit should be carried out in a private, non-public area of the practice where patient confidentiality can be observed, and issues can be discussed where necessary out-with the earshot of patients.

5.3 A member of the practice staff should be available to assist with the location of evidence, if required.

5.4 It is recommended good practice that, where the visiting team is accessing electronic records, the contractor grants access to the computer system via a 'read only' account.

6. Concluding the Visit

6.1 Where the visit has identified issues, these will be discussed with the practice with a view to resolving them. The independent optometrist may assist these discussions by providing advice and guidance in relation to clinical matters.

6.2 In instances where resolution of these issues is achieved, the visit may then be concluded, and the practice advised of the following:

- Which payments were verified, and which payments were not;

- Whether an extended sample of clinical records require to be examined/further investigation carried out;
- What actions the practice is required to take as a result of the visit;
- Whether recoveries require to be made as a result of the visit, and the terms according to which they will be made.

6.3 These discussions, and the agreements reached will form the basis of the draft practice visit report.

6.4 Where the discussions with the practice do not resolve the visiting team's concerns, no further dialogue will take place and the matter will be reported to the NHS Board and (if appropriate) to Counter Fraud Services simultaneously.

6.5 Practitioner Services do not have any remit regarding Clinical Governance. If, however, they become aware of any significant clinical issues during the course of the visit, these will be referred on to the relevant NHS Board at the earliest opportunity, for them to take forward through the appropriate channels.

7. Practice Visit Report

7.1 The report should be drafted as soon as possible following the visit. It should be noted that practice visit reports may be made available under Freedom of Information requests, subject to individual request consideration and report content.

7.2 In instances where the visit highlighted no areas of significant concern, a draft report will be sent to the contractor for confirmation of factual accuracy.

7.3 Once the contents have been agreed by the contractor, a copy of the final report will be sent to the contractor and the NHS Board, with a copy being retained by Practitioner Services.

7.4 In order to facilitate the equitable assessment of contractors, the conclusions resulting from a visit, and any further action required, will be clearly and consistently shown in all final reports. In order to facilitate this, the report will contain one of the following four summary conclusions:

1. High level of assurance gained – no recommendations/actions necessary

2. Adequate level of assurance gained – no significant recommendations/actions necessary

3. Limited level of assurance gained – key recommendations/actions made – re testing required following implementation of recommendations

4. Inadequate level of assurance gained - issues escalated to appropriate authority for consideration of further action

7.5 In instances where the visit has highlighted significant areas of concern, a report will not be sent to the contractor until the tri-partite meeting between Practitioner Services, the NHS Boards and Counter Fraud Services has taken place, and their agreement reached as to the appropriate course of action.

Annex IV – Pharmaceutical Payments

TABLE OF CONTENTS

Introduction 2
Minor Ailments Service 3
Chronic Medication Service 4
Gluten Free Food Service (GFF) 5
Acute Medication Service 6
Public Health Service - Emergency Hormonal Contraception 7
Public Health Service – Nicotine Replacement 8
Locally Negotiated Payments 9
Out of Pocket Expenses 9
Stock Orders 10
Other Contractor Types 16
Appendix A – Level 1 Checks 13
Appendix B – Random Sampling 14

Introduction

The following sections detail the payment verification requirements for General Pharmaceutical Services (GPS).

Practitioner Services (Pharmacy) operates a scanning and optical character recognition system and a computerised payment system (DCVP) both of which undertake extensive pre-payment validation on pharmaceutical payment claims from pharmacies, dispensing doctors, stoma suppliers and appliance suppliers.

Retention of Evidence

Practices are required to retain evidence to substantiate the validity of payments. The requirement for this evidence will be in accordance with the General Pharmaceutical regulations. The Scottish Government Records Management: NHS Code of Practice (Scotland) Version 2.1 also provides a schedule listing the retention period for financial records in NHS Scotland. This specifies six years plus the current year as minimum retention period for most financial records. For the avoidance of doubt this would relate to any information used to support NHS payments to pharmacies, dispensing doctors, stoma suppliers and appliance suppliers.

Where evidence to substantiate the validity of payments cannot be found, any monies paid will be recovered.

Minor Ailments Service

Minor Ailments Service Payments are based on a GP referral and on the provision of consultation, prescribing (within a permitted range) and dispensing services to eligible patients. Patients must be registered with a Scottish GP Practice and pharmacy to receive the service. The pharmacy receives payment for capitation and reimbursement for any drugs dispensed. Registrations and claims are made on form CP2.

Payment verification checking takes place on 4 levels as follows:

Level 1 will comprise 100% checking of:

- Patients against CHI for existence and eligibility.
- Other checks as detailed in Appendix A.

Level 2 will comprise risk driven trend analysis of claims, including, but not limited to:

- Registration activity.
- Claim activity.
- Random letters to patients to confirm provision of service.

Level 3 checking will be undertaken as appropriate where the outcome of the above analysis proves unsatisfactory or inconclusive. This may include:

- Targeted letters to patients to confirm provision of service.
- Sampling of patient medication records and associated documentation.

Level 4 checking will be undertaken as follows:

- Random sampling as outlined in Appendix B.

Outputs:

Quarterly PV report detailing:

- Results and status of checking process
- Any necessary recommendations, actions and recoveries

Chronic Medication Service

Chronic Medication Service payments relate to the provision of services to patients with ongoing long term medical conditions. This includes the assessment and planning of the patient's pharmaceutical care needs and the establishment of a shared care element, which allows the GP to produce a serial prescription to be dispensed at appropriate intervals. Patients must be registered with a Scottish GP Practice and pharmacy to receive the service. The pharmacy receives payment for capitation and reimbursement for any drugs dispensed. Registrations and claims are made on form CP3.

Payment verification checking takes place on 4 levels as follows:

Level 1 will comprise 100% checking of:

- Patients against CHI for existence and eligibility.
- Claims forms by the Patient Registration System – to ensure all mandatory information is present.
- Other checks as detailed in Appendix A.

Level 2 will comprise risk driven trend analysis of claims, including, but not limited to:

- Registration activity.
- Claim activity.
- Random letters to patients to confirm provision of service.

Level 3 checking will be undertaken as appropriate where the outcome of the above analysis proves unsatisfactory or inconclusive. This may include:

- Targeted letters to patients to confirm provision of service.
- Sampling of patient medication records and associated documentation.

Level 4 checking will be undertaken as follows:

- Random sampling as outlined in Appendix B.

Outputs:

Quarterly PV report detailing:

- Results and status of checking process
- Any necessary recommendations, actions and recoveries

Gluten Free Food Service (GFF)

Gluten Free Food Service payments are based on claims submitted for services to patients with a diagnosis of coeliac disease or dermatitis herpetiformis. The service allows patients to order and receive gluten free food from their pharmacy without the need to go through their GP. Claims are made via submission of a CPUS form.

Payment verification checking takes place on 4 levels as follows:

Level 1 will comprise 100% checking of:

- Patients against CHI for existence and eligibility.
- Other checks as detailed in Appendix A.

Level 2 will comprise risk driven trend analysis of claims, including, but not limited to:

- Claim activity.
- Random letters to patients to confirm provision of service.

Level 3 checking will be undertaken as appropriate where the outcome of the above analysis proves unsatisfactory or inconclusive. This may include:

- Targeted letters to patients to confirm provision of service.
- Sampling of patient medication records and associated documentation.
- Review of the GP letter of authority.

Level 4 checking will be undertaken as follows:

- Random sampling as outlined in Appendix B.

Outputs:

Quarterly PV report detailing:

- Results and status of checking process
- Any necessary recommendations, actions and recoveries

Acute Medication Service

The Acute Medication Service (AMS) allows the Electronic Transfer of Prescriptions (ETP) and supports the provision of pharmaceutical care services for acute episodes of care and any associated counselling and advice.

Payment verification checking takes place on 4 levels as follows:

Level 1 will comprise 100% checking as detailed in Appendix A.

Level 2 will comprise risk driven trend analysis of claims, including, but not limited to:

- Claim activity.
- Random letters to patients to confirm provision of service.

Level 3 checking will be undertaken as appropriate where the outcome of the above analysis proves unsatisfactory or inconclusive. This may include:

- Targeted letters to patients to confirm provision of service.
- Sampling of patient medication records and associated documentation.

Level 4 checking will be undertaken as follows:

- Random sampling as outlined in Appendix B.

Outputs:

Quarterly PV report detailing:

- Results and status of checking process
- Any necessary recommendations, actions and recoveries

Public Health Service - Emergency Hormonal Contraception

This service provides, where clinically indicated, a free supply of emergency hormonal contraception (EHC). The service is available to any female client aged 13 years or over.

Payment verification checking takes place on 4 levels as follows:

Level 1 will comprise 100% checking as detailed in Appendix A.

Level 2 will comprise risk driven trend analysis of claims, including, but not limited to:

- Claim activity.

Level 3 checking will be undertaken as appropriate where the outcome of the above analysis proves unsatisfactory or inconclusive. This may include:

- Sampling of patient medication records and associated documentation.

Level 4 checking will be undertaken as follows:

- Random sampling as outlined in Appendix B.

Outputs:

Quarterly PV report detailing:

- Results and status of checking process
- Any necessary recommendations, actions and recoveries

Public Health Service – Nicotine Replacement

This service supports the provision of extended access through the NHS, including the provision of advice and smoking cessation products, in order to help smokers successfully stop smoking as part of the Public Health Service (PHS) element of the community pharmacy contract.

Payment verification checking takes place on 4 levels as follows:

Level 1 will comprise 100% checking of:

- Patients against CHI for existence and eligibility.
- Claim forms by the Patient Registration System – to identify concurrency.
- Other checks as detailed in Appendix A.

Level 2 will comprise risk driven trend analysis of claims, including, but not limited to:

- Claim activity.

Level 3 checking will be undertaken as appropriate where the outcome of the above analysis proves unsatisfactory or inconclusive. This may include:

- Targeted letters to patients to confirm provision of service.
- Sampling of patient medication records and associated documentation.

Level 4 checking will be undertaken as follows:

- Random sampling as outlined in Appendix B.

Outputs:

Quarterly PV report detailing:

- Results and status of checking process
- Any necessary recommendations, actions and recoveries

Locally Negotiated Payments

Locally Negotiated Payments will be covered by the NHS Boards' internal and external audit processes and the NSS service audit process.

Out of Pocket Expenses

Community Pharmacies can claim reasonable Reimbursements for Out of Pocket Expenses for certain items, excluding any items in parts 2 – 7 and 9 of the Scottish Drug Tariff.

Payment verification checking takes place on 4 levels as follows:

Level 1 will comprise 100% checking of:

- System validation against set claim criteria.
- Other checks as detailed in Appendix A.

Level 2 will comprise risk driven trend analysis of claims, including, but not limited to:

- Claim activity.

Level 3 checking will be undertaken as appropriate where the outcome of the above analysis proves unsatisfactory or inconclusive. This may include:

- Targeted letters to contractors to request supporting documentation.

Level 4 checking will be undertaken as follows:

- Random sampling as outlined in Appendix B.

Outputs:

Quarterly PV report detailing:

- Results and status of checking process
- Any necessary recommendations, actions and recoveries

Stock Orders

Stock Order Forms (GP10A) should only be used for treatments that are required for immediate use by patients following an un-planned intervention in the GP practice.

Payment verification checking takes place on 4 levels as follows:

Level 1 will comprise 100% checking of:

- System validation against set claim criteria.
- Other checks as detailed in Appendix A.

Level 2 will comprise risk driven trend analysis of claims, including, but not limited to:

- Claim activity.

Level 3 checking will be undertaken as appropriate where the outcome of the above analysis proves unsatisfactory or inconclusive. This may include:

- Targeted letters to GP practices to confirm receipt of items.

Level 4 checking will be undertaken as follows:

- Random letters to GP practices to confirm receipt of items.

Outputs:

Quarterly PV report detailing:

- Results and status of checking process
- Any necessary recommendations, actions and recoveries

Other Contractor Types - Dispensing Doctors

Dispensing GP practices exist in those areas of Scotland where the population density is considered too low to support a pharmacy.

Payment verification checking takes place on 4 levels as follows:

Level 1 will comprise 100% checking as detailed in Appendix A.

Level 2 will comprise risk driven trend analysis of claims, including, but not limited to:

- Claim activity.
- Random letters to patients to confirm provision of service.

Level 3 checking will be undertaken as appropriate where the outcome of the above analysis proves unsatisfactory or inconclusive. This may include:

- Targeted letters to patients to confirm provision of service.

Level 4 checking will be undertaken as follows:

- Random sampling as outlined in Appendix B.

Outputs:

Quarterly PV report detailing:

- Results and status of checking process
- Any necessary recommendations, actions and recoveries

Other Contractor Types - Appliance/Stoma Suppliers

Appliance/Stoma Suppliers are reimbursed for the provision of specialist products to Scottish patients.

Payment verification checking takes place on 4 levels as follows:

Level 1 will comprise 100% checking as detailed in Appendix A.

Level 2 will comprise risk driven trend analysis of claims, including, but not limited to:

- Claim activity.
- Random letters to patients to confirm provision of service.

Level 3 checking will be undertaken as appropriate where the outcome of the above analysis proves unsatisfactory or inconclusive. This may include:

- Targeted letters to patients to confirm provision of service.

Level 4 checking will be undertaken as follows:

- Random sampling as outlined in Appendix B.

Outputs:

Quarterly PV report detailing:

- Results and status of checking process
- Any necessary recommendations, actions and recoveries

Appendix A – Level 1 Checks

P&CFS will automatically carry out 100% level 1 checking on the following:

a) All Foreign Forms & Items.
b) All Urgent Fees.
c) All High Value Items above a fixed amount.
d) All Low Value Items, below £0.02
e) All Dummy Items with Over-ride prices.
f) All Out of Pocket claims.
g) All Rejected Items.
h) All Pay & Report Items.
i) Any Unusual Fees above a fixed amount.
j) Any items set for Ambiguity Check.
k) Any Invalid CHI No.
l) All Instalments claimed above a fixed amount.
m) All invalid formulary items, against form type, prescriber type and dispenser type.
n) Any Quantity Limit Exceeded - limits set at item level on EVADIS.
o) Random Check of manually processed items.

The checks will be applied to the various service areas as follows:

- Minor Ailments Service. – b, c, d ,e, g, h, i, j, k, l, m, n, o
- Chronic Medication Service. - b, c, d, e, g, h, j, k, l, m ,n, o
- Gluten Free Food Service (GFF) - a, b, c, d, e, g, h, j, k, l, m, n, o
- Acute Medication Service. - a, b, c, d, e, g, h, i, j, k, l, m, n, o
- Public Health Service – Emergency Hormonal Contraception. - b, c, d, e, g, h, i, j, k, l, m, n, o
- Public Health Service – Nicotine Replacement - b, c, d, e, g, h, i, j, k, l, m, n, o
- Out of Pocket Expenses. – f
- Stock Orders. - c, d, e, g, h, j, m, n, o
- Dispensing Doctors - b, c, d, e, g, h, j, l, m, n, o
- Appliance/Stoma Suppliers - a, b, c, d, e, g, h, i, j, k, l, m, n, o

Appendix B – Random Sampling

1. Background

1.1 One of the methods of verifying payments made under General Pharmaceutical Services (GPS) arrangements is to examine patient records as part of random sampling. During random sampling a selection of records will be examined looking at a range of claim/payment types.

2. Selection of Pharmacies

2.1 Practitioner Services will select the pharmacies to be included as part of the random sample. Pharmacies which have been selected within the previous five years random sampling will be excluded.

2.2 The level of this check will result in a minimum of 1% of all pharmacies across Scotland having records inspected annually and will involve the confirmation of a sample of claims across selected payment categories.

3. Selection of Records

3.1 The size of the sample undertaken will be based on statistical strata using the number of claims submitted by the pharmacy.

4. Examination of Patient Medication Records

4.1 The claims/payments included within the sample will be checked against the details contained within the respective patient medication records from the pharmacy.