ARTICLE 18.

PHARMACY AUDIT RIGHTS

SECTION 38-71-1810. Pharmacy audit rights.

Section effective January 1, 2013.

(A) For the purposes of this article:

(1) "Insurer" means an entity that provides health insurance coverage in this State as defined in Section 38-71-670(7) and Section 38-71-840(16).

(2) "Responsible party" means the entity responsible for payment of claims for health care services other than:

(a) the individual to whom the health care services were rendered; or

(b) that individual's guardian or legal representative.

(3) "Audit" means an evaluation, investigation, or review of claims paid to a pharmacy that takes place at the pharmacy location and does not include review of claims or claims payments that an insurer conducts as a normal course of business.

(4) "Abuse" means any practice that:

(a)(i) is inconsistent with sound fiscal or business practices; or

(ii) fails to meet professionally recognized standards for pharmacy services; and

(b) directly or indirectly causes financial loss to a responsible party.

(B) If a managed care organization, insurer, third-party payor, or any entity that represents a responsible party conducts an audit of the records of a pharmacy, then, with respect to this audit, the pharmacy has a right to:

(1) have at least fourteen days' advance notice of the initial audit for each audit cycle with no audit to be initiated or scheduled during the first five days of any month without the express consent of the pharmacy, which shall cooperate with the auditor to establish an alternate date if the audit would fall within the excluded days;

(2) have an audit that involves clinical judgment be conducted with a pharmacist who is licensed and employed by or working under contract with the auditing entity;

(3) not have clerical or record-keeping errors, including typographical errors, scrivener's errors and computer errors, on a required document or record considered fraudulent in

the absence of any other evidence; however, the provisions of this item do not prohibit recoupment of fraudulent payments;

(4) have, if required under the terms of the contract with the auditing entity, the auditing entity to provide the pharmacy, upon request, all records related to the audit in an electronic format or contained in digital media;

(5) have the properly documented records of a hospital or of a person authorized to prescribe controlled substances for the purpose of providing medical or pharmaceutical care for their patients transmitted by any means of communication approved by the auditing entity in order to validate a pharmacy record with respect to a prescription or refill for a controlled substance or narcotic drug pursuant to federal and state regulations;

(6) have a projection of an overpayment or underpayment based on either the number of patients served with a similar diagnosis or the number of similar prescription orders or refills for similar drugs; however, the provisions of this item do not prohibit recoupments of actual overpayments unless the projection for overpayment or underpayment is part of a settlement by the pharmacy;

(7) be free of recoupments based on either of the following subitems unless defined within the billing, submission, or audit requirements set forth in the pharmacy provider manual not inconsistent with current State Board of Pharmacy Regulations, except for cases of Food and Drug Administration regulation or drug manufacturer safety programs in accordance with federal or state regulations:

(a) documentation requirements in addition to, or exceeding requirements for, creating or maintaining documentation prescribed by the State Board of Pharmacy;

(b) a requirement that a pharmacy or pharmacist perform a professional duty in addition to, or exceeding, professional duties prescribed by the State Board of Pharmacy unless otherwise agreed to by contract with the auditing entity;

(8) be subject, so long as a claim is made within the contractual claim submission time period, to recoupment only following the correction of a claim and to have recoupment limited to amounts paid in excess of amounts payable under the corrected claim unless a prescription error occurs. For purposes of this subsection, a prescription error includes, but is not limited to, wrong drug, wrong strength, wrong dose, or wrong patient;

(9) be subject to reversals of approval, except for Medicare claims, for drug, prescriber, or patient eligibility upon adjudication of a claim only in cases in which the pharmacy obtained the adjudication by fraud or misrepresentation of claim elements;

(10) be audited under the same standards and parameters as other similarly situated pharmacies audited by the same entity;

(11) have at least thirty days following receipt of the preliminary audit report to produce documentation to address any discrepancy found during an audit;

(12) have the period covered by an audit limited to twenty-four months from the date a claim was submitted to, or adjudicated by, a managed care organization, an insurer, a third-party payor, or an entity that represents responsible parties, unless a longer period is permitted by or under federal law;

(13) have the preliminary audit report delivered to the pharmacy within one hundred twenty days after conclusion of the audit;

(14) have a final audit report delivered to the pharmacy within ninety days after the end of the appeals period; and

(15) not have the accounting practice of extrapolation used in calculating recoupments or penalties for audits, unless otherwise required by federal requirements or federal plans.

(C) Notwithstanding Section 38-71-1840, the auditing entity shall provide the pharmacy, if requested, a masked list that provides a prescription number range the auditing entity is seeking to audit.

HISTORY: 2012 Act No. 250, Section 1, eff January 1, 2013.

SECTION 38-71-1820. Appeals process; dismissal; copy of audit findings.

< Section effective January 1, 2013. >

(A) Each entity that conducts an audit of a pharmacy shall establish an appeals process under which a pharmacy may appeal an unfavorable preliminary audit report to the entity.

(B) If, following the appeal, the entity finds that an unfavorable audit report or any portion of the unfavorable audit report is unsubstantiated, the entity shall dismiss the unsubstantiated portion of the audit report without any further proceedings.

(C) Each entity conducting an audit shall provide a copy, if required under the terms of the contract with the responsible party, of the audit findings to the plan sponsor after completion of any appeals process.

HISTORY: 2012 Act No. 250, Section 1, eff January 1, 2013.

SECTION 38-71-1830. Recoupment.

< Section effective January 1, 2013. >

(A) Recoupments of any funds disputed on the basis of an audit must occur only after final internal disposition of the audit, including the appeals process as provided for in Section 38-71-1820, unless fraud or misrepresentation is reasonably suspected.

(B) Recoupment on an audit must be refunded to the responsible party as contractually agreed upon by the parties involved in the audit.

(C) The entity conducting the audit may charge or assess the responsible party, directly or indirectly, based on amounts recouped if both of the following conditions are met:

(1) the responsible party or payor and the entity conducting the audit have entered into a contract that explicitly states the percentage charge or assessment to the responsible party; and

(2) a commission or other payment to an agent or employee of the entity conducting the audit is not based, directly or indirectly, on amounts recouped.

HISTORY: 2012 Act No. 250, Section 1, eff January 1, 2013.

SECTION 38-71-1840. Exemptions.

< Section effective January 1, 2013. >

The provisions of this article do not apply to an audit, review, or investigation:

(1) that involves alleged insurance fraud or abuse, Medicare fraud or abuse, or other fraud or misrepresentation; or

(2) conducted by or on the behalf of the Department of Health and Human Services in the performance of its duties in administering Medicaid under Titles XIX and XXI of the Social Security Act.

HISTORY: 2012 Act No. 250, Section 1, effective January 1, 2013.