

The Pharmacy Audit Integrity Act

Section 1. Title.

This Act shall be known as 'The Pharmacy Audit Integrity Act.'

Section 2. Purpose and Intent.

The purpose of this Act is to establish minimum and uniform standards and criteria for the audit of pharmacy records by or on behalf of certain entities.

Section 3. Definitions.

For purposes of this Act:

“Pharmacy Benefits Manager” or “PBM” means a person, business or other entity that performs pharmacy benefits management. The term includes a person or entity acting for a PBM in a contractual or employment relationship in the performance of pharmacy benefits management for a managed care company, non profit hospital or medical service organization, insurance company, third-party payor, a health program administered by a Department of the State.

Section 4. Applicability and Scope.

This Act shall apply to any audit of the records of a pharmacy conducted by a managed care company, non profit hospital or medical service organization, insurance company, third-party payor, pharmacy benefit manager, a health program administered by a Department of the State or any entity that represents such companies, groups, or department.

Section 5. Procedures for conducting and reporting an audit.

A. The entity conducting an audit shall follow these procedures:

- (1) The pharmacy contract must identify and describe in detail the audit procedures;
- (2) The entity conducting the on-site audit must give the pharmacy written notice at least two weeks prior to conducting the initial on-site audit for each audit cycle;
- (3) The entity conducting the on-site audit shall not interfere with the delivery of pharmacist services to a patient and shall utilize every effort to minimize inconvenience and disruption to pharmacy operations during the audit process;
- (4) Any audit which involves clinical or professional judgment must be conducted by or in consultation with a pharmacist licensed in the state;
- (5) Any clerical or record-keeping error, such as a typographical error, scrivener's error, or computer error, regarding a required document or record does not

constitute fraud; however, such claims may be subject to recoupment. No such claim shall be subject to criminal penalties without proof of intent to commit fraud;

- (6) A pharmacy may use the records of a hospital, physician, or other authorized practitioner of the healing arts for drugs or medicinal supplies written or transmitted by any means of communication for purposes of validating the pharmacy record with respect to orders or refills of a legend or narcotic drug;
- (7) A finding of an overpayment or underpayment must be based on the actual overpayment or underpayment and may not be a projection based on the number of patients served having a similar diagnosis or on the number of similar orders or refills for similar drugs;
- (8) A finding of an overpayment shall not include the dispensing fee amount;
- (9) Each pharmacy shall be audited under the same standards and parameters as other similarly situated pharmacies audited by the entity;
- (10) The period covered by an audit may not exceed one year from the date the claim was submitted to or adjudicated by a managed care company, non profit hospital or medical service organization, insurance company, third-party payor, pharmacy benefit manager, a health program administered by a Department of the State or any entity that represents such companies, groups, or department;
- (11) An audit may not be initiated or scheduled during the first seven calendar days of any month due to the high volume of prescriptions filled in the pharmacy during that time unless otherwise consented to by the pharmacy; and
- (12) The auditing company may not receive payment based on a percentage of the amount recovered.

B. The entity must provide the pharmacy with a written report of the audit and comply with the following requirements:

- (1) The preliminary audit report must be delivered to the pharmacy within 90 days after conclusion of the audit;
- (2) A pharmacy shall be allowed at least 60 days following receipt of the preliminary audit report in which to produce documentation to address any discrepancy found during the audit;
- (3) A final audit report shall be delivered to the pharmacy within 120 days after receipt of the preliminary audit report or final appeal, as provided for in Section 6 of this Code section, whichever is later;
- (4) The audit report must be signed and include the signature of any pharmacist participating in the audit;
- (5) Any recoupments of disputed funds shall only occur after final internal disposition of the audit, including the appeals process as set forth in Section 6 of this Code section;
- (6) Interest shall not accrue during the audit period; and
- (7) Each entity conducting an audit shall provide a copy of the final audit report, after completion of any review process, to the plan sponsor.

Section 6. Appeal Process.

(1) The National Council for Prescription Drug Programs (“NCPDP”) or any other recognized national industry standard shall be used to evaluate claims submission and product size disputes.

(2) Each entity conducting an audit shall establish a written appeals process under which a pharmacy may appeal an unfavorable preliminary audit report to the entity.

(3) If, following the appeal, the entity finds that an unfavorable audit report or any portion thereof is unsubstantiated, the entity shall dismiss the audit report or said portion without the necessity of any further action.

Section 7. Extrapolation Audits.

Notwithstanding any other provision in this Act, the entity conducting the audit shall not use the accounting practice of extrapolation in calculating recoupments or penalties for audits. An extrapolation audit means an audit of a sample of prescription drug benefit claims submitted by a pharmacy to the entity conducting the audit that is then used to estimate audit results for a larger batch or group of claims not reviewed by the auditor.

Section 8. Applicability of other laws and regulations.

A. The audit criteria set forth in this Act shall apply only to audits of claims for services provided and claims submitted for payment after (insert date).

B. This Code section shall not apply to any investigative audit conducted by or on behalf of a state agency which involves fraud, willful misrepresentation, or abuse including without limitation investigative audits or any other statutory provision which authorizes investigations relating to insurance fraud.