AN ACT

relating to procedures for certain audits of pharmacists and pharmacies.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. Chapter 1369, Insurance Code, is amended by adding Subchapter F to read as follows:

SUBCHAPTER F. AUDITS OF PHARMACISTS AND PHARMACIES

Sec. 1369.251. DEFINITIONS. In this subchapter:

(1) "Desk audit" means an audit conducted by a health benefit plan issuer or pharmacy benefit manager at a location other than the location of the pharmacist or pharmacy. The term includes an audit performed at the offices of the plan issuer or pharmacy benefit manager during which the pharmacist or pharmacy provides requested documents for review by hard copy or by microfiche, disk, or other electronic media. The term does not include a review conducted not later than the third business day after the date a claim is adjudicated provided recoupment is not demanded.

(2) "Extrapolation" means a mathematical process or technique used by a health benefit plan issuer or pharmacy benefit manager that administers pharmacy claims for a health benefit plan issuer in the audit of a pharmacy or pharmacist to estimate audit results or findings for a larger batch or group of claims not reviewed by the plan issuer or pharmacy benefit manager.

(3) "Health benefit plan" means a plan that provides

benefits for medical, surgical, or other treatment expenses incurred as a result of a health condition, a mental health condition, an accident, sickness, or substance abuse, including:

(A) an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is issued by:

(i) an insurance company;

(ii) a group hospital service corporation operating under Chapter 842;

(iii) a health maintenance organization operating under Chapter 843;

(iv) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844;

(v) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846;

(vi) a stipulated premium company operating under Chapter 884;

(vii) a fraternal benefit society operating under Chapter 885;

(viii) a Lloyd's plan operating under Chapter 941; or

(ix) an exchange operating under Chapter 942;

(B) a small employer health benefit plan written under Chapter 1501; or

(C) a health benefit plan issued under Chapter 1551, 1575, 1579, or 1601.

(4) "On-site audit" means an audit that is conducted at:

(A) the location of the pharmacist or pharmacy; or

(B) another location at which the records under review are stored.

(5) "Pharmacy benefit manager" has the meaning assigned by Section 4151.151.

Sec. 1369.252. EXCEPTIONS TO APPLICABILITY OF SUBCHAPTER. This subchapter does not apply to an issuer or provider of health benefits under or a pharmacy benefit manager administering pharmacy benefits under:

(1) the state Medicaid program;

(2) the federal Medicare program;

(3) the state child health plan or health benefits plan for children under Chapter 62 or 63, Health and Safety Code;

(4) the TRICARE military health system;

(5) a workers' compensation insurance policy or other form of providing medical benefits under Title 5, Labor Code; or

(6) a self-funded health benefit plan as defined by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.).

Sec. 1369.253. CONFLICT WITH OTHER LAWS. If there is a conflict between this subchapter and a provision of Chapter 843 or 1301 related to a pharmacy benefit manager, this subchapter

prevails.

Sec. 1369.254. AUDIT OF PHARMACIST OR PHARMACY; NOTICE; GENERAL PROVISIONS. (a) Except as provided by Subsection (d), a health benefit plan issuer or pharmacy benefit manager that performs an on-site audit under this subchapter of a pharmacist or pharmacy shall provide the pharmacist or pharmacy reasonable notice of the audit and accommodate the pharmacist's or pharmacy's schedule to the greatest extent possible. The notice required under this subsection must be in writing and must be sent by a means that allows tracking of delivery to the pharmacist or pharmacy not later than the 14th day before the date on which the on-site audit is scheduled to occur.

(b) Not later than the seventh day after the date a pharmacist or pharmacy receives notice under Subsection (a), the pharmacist or pharmacy may request that an on-site audit be rescheduled to a mutually convenient date. The request must be reasonably granted.

(c) Unless the pharmacist or pharmacy consents in writing, a health benefit plan issuer or pharmacy benefit manager may not schedule or have an on-site audit conducted:

(1) except as provided by Subsection (d), before the 14th day after the date the pharmacist or pharmacy receives notice under Subsection (a), if applicable;

(2) more than twice annually in connection with a particular payor; or

(3) during the first five calendar days of January and December.

(d) A health benefit plan issuer or pharmacy benefit manager is not required to provide notice before conducting an audit if, after reviewing claims data, written or oral statements of pharmacy staff, wholesalers, or others, or other investigative information, including patient referrals, anonymous reports, or postings on Internet websites, the plan issuer or pharmacy benefit manager suspects the pharmacist or pharmacy subject to the audit committed fraud or made an intentional misrepresentation related to the pharmacy business. The pharmacist or pharmacy may not request that the audit be rescheduled under Subsection (b).

(e) A pharmacist or pharmacy may be required to submit documents in response to a desk audit not earlier than the 20th day after the date the health benefit plan issuer or pharmacy benefit manager requests the documents.

(f) A contract between a pharmacist or pharmacy and a health benefit plan issuer or pharmacy benefit manager must state detailed audit procedures. If a health benefit plan issuer or pharmacy benefit manager proposes a change to the audit procedures for an on-site audit or a desk audit, the plan issuer or pharmacy benefit manager must notify the pharmacist or pharmacy in writing of a change in an audit procedure not later than the 60th day before the effective date of the change.

(g) The list of the claims subject to an on-site audit must be provided in the notice under Subsection (a) to the pharmacist or pharmacy and must identify the claims only by the prescription numbers or a date range for prescriptions subject to the audit. The last two digits of the prescription numbers provided may be

omitted.

(h) If the health benefit plan issuer or pharmacy benefit manager in an on-site audit or a desk audit applies random sampling procedures to select claims for audit, the sample size may not be greater than 300 individual prescription claims.

Sec. 1369.255. COMPLETION OF AUDIT. An audit of a claim under Section 1369.254 must be completed on or before the one-year anniversary of the date the claim is received by the health benefit plan issuer or pharmacy benefit manager.

Sec. 1369.256. AUDIT REQUIRING PROFESSIONAL JUDGMENT. A health benefit plan issuer or pharmacy benefit manager that conducts an on-site audit or a desk audit involving a pharmacist's clinical or professional judgment must conduct the audit in consultation with a licensed pharmacist.

Sec. 1369.257. ACCESS TO PHARMACY AREA. A health benefit plan issuer or pharmacy benefit manager that conducts an on-site audit may not enter the pharmacy area unless escorted by an individual authorized by the pharmacist or pharmacy.

Sec. 1369.258. VALIDATION USING CERTAIN RECORDS AUTHORIZED. A pharmacist or pharmacy that is being audited may:

(1) validate a prescription, refill of a prescription, or change in a prescription with a prescription that complies with applicable federal laws and regulations and state laws and rules adopted under Section 554.051, Occupations Code; and

(2) validate the delivery of a prescription with a written record of a hospital, physician, or other authorized practitioner of the healing arts.

Sec. 1369.259. CALCULATION OF RECOUPMENT; USE OF EXTRAPOLATION PROHIBITED. (a) A health benefit plan issuer or pharmacy benefit manager may not calculate the amount of a recoupment based on:

(1) an absence of documentation the pharmacist or pharmacy is not required by applicable federal laws and regulations and state laws and rules to maintain; or

(2) an error that does not result in actual financial harm to the patient or enrollee, the health benefit plan issuer, or the pharmacy benefit manager.

(b) A health benefit plan issuer or pharmacy benefit manager may not require extrapolation audits as a condition of participation in a contract, network, or program for a pharmacist or pharmacy.

(c) A health benefit plan issuer or pharmacy benefit manager may not use extrapolation to complete an on-site audit or a desk audit of a pharmacist or pharmacy. Notwithstanding Subsection (a)(2), the amount of a recoupment must be based on the actual overpayment or underpayment and may not be based on an extrapolation.

(d) A health benefit plan issuer or pharmacy benefit manager may not include a dispensing fee amount in the calculation of an overpayment unless:

(1) the fee was a duplicate charge;

(2) the prescription for which the fee was charged:

(A) was not dispensed; or

(B) was dispensed:

(i) without the prescriber's authorization;

(ii) to the wrong patient; or

(iii) with the wrong instructions; or

(3) the wrong drug was dispensed.

Sec. 1369.260. CLERICAL OR RECORDKEEPING ERROR; FRAUD ALLEGATION. (a) An unintentional clerical or recordkeeping error, such as a typographical error, scrivener's error, or computer error, found during an on-site audit or a desk audit:

(1) is not prima facie evidence of fraud or intentional misrepresentation; and

(2) may not be the basis of a recoupment unless the error results in actual financial harm to a patient or enrollee, health benefit plan issuer, or pharmacy benefit manager.

(b) If the health benefit plan issuer or pharmacy benefit manager alleges that the pharmacist or pharmacy committed fraud or intentional misrepresentation described by Subsection (a), the health benefit plan issuer or pharmacy benefit manager must state the allegation in the final audit report required by Section 1369.264.

(c) After an audit is initiated, a pharmacist or pharmacy may resubmit a claim described by Subsection (a) if the deadline for submission of a claim under Section 843.337 or 1301.102 has not expired.

Sec. 1369.261. ACCESS TO PREVIOUS AUDIT REPORTS; UNIFORM AUDIT STANDARDS. (a) Except as provided by Subsection (b), a health benefit plan issuer or pharmacy benefit manager may have access to an audit report of a pharmacist or pharmacy only if the

report was prepared in connection with an audit conducted by the health benefit plan issuer or pharmacy benefit manager.

(b) A health benefit plan issuer or pharmacy benefit manager may have access to audit reports other than the reports described by Subsection (a) if, after reviewing claims data, written or oral statements of pharmacy staff, wholesalers, or others, or other investigative information, including patient referrals, anonymous reports, or postings on Internet websites, the plan issuer or the pharmacy benefit manager suspects the audited pharmacist or pharmacy committed fraud or made an intentional misrepresentation related to the pharmacy business.

(c) An auditor must conduct an on-site audit or a desk audit of similarly situated pharmacists or pharmacies under the same audit standards.

Sec. 1369.262. COMPENSATION OF AUDITOR. An individual performing an on-site audit or a desk audit may not directly or indirectly receive compensation based on a percentage of the amount recovered as a result of the audit.

Sec. 1369.263. CONCLUSION OF AUDIT; SUMMARY; PRELIMINARY AUDIT REPORT. (a) At the conclusion of an on-site audit or a desk audit, the health benefit plan issuer or pharmacy benefit manager shall:

(1) provide to the pharmacist or pharmacy a summary of the audit findings; and

(2) allow the pharmacist or pharmacy to respond to questions and alleged discrepancies, if any, and comment on and clarify the findings.

(b) Not later than the 60th day after the date the audit is concluded, the health benefit plan issuer or pharmacy benefit manager shall send by a means that allows tracking of delivery to the pharmacist or pharmacy a preliminary audit report stating the results of the audit and a list identifying documentation, if any, required to resolve discrepancies, if any, found as a result of the audit.

(c) The pharmacist or pharmacy may, by providing documentation or otherwise, challenge a result or remedy a discrepancy stated in the preliminary audit report not later than the 30th day after the date the pharmacist or pharmacy receives the report.

(d) The pharmacist or pharmacy may request an extension to provide documentation supporting a challenge. The request shall be reasonably granted. A health benefit plan issuer or pharmacy benefit manager that grants an extension is not subject to the deadline to send the final audit report under Section 1369.264.

Sec. 1369.264. FINAL AUDIT REPORT. Not later than the 120th day after the date the pharmacist or pharmacy receives a preliminary audit report under Section 1369.263, the health benefit plan issuer or pharmacy benefit manager shall send by a means that allows tracking of delivery to the pharmacist or pharmacy a final audit report that states:

(1) the audit results after review of the documentation submitted by the pharmacist or pharmacy in response to the preliminary audit report; and

(2) the audit results, including a description of all

alleged discrepancies and explanations for and the amount of recoupments claimed after consideration of the pharmacist's or pharmacy's response to the preliminary audit report.

Sec. 1369.265. CERTAIN AUDITS EXEMPT FROM DEADLINES. A health benefit plan issuer or pharmacy benefit manager is not subject to the deadlines for sending a report under Sections 1369.263 and 1369.264 if, after reviewing claims data, written or oral statements of pharmacy staff, wholesalers, or others, or other investigative information, including patient referrals, anonymous reports, or postings on Internet websites, the plan issuer or pharmacy benefit manager suspects the audited pharmacist or pharmacy committed fraud or made an intentional misrepresentation related to the pharmacy business.

Sec. 1369.266. RECOUPMENT AND INTEREST CHARGED AFTER AUDIT. (a) If an audit under this subchapter is conducted, the health benefit plan issuer or pharmacy benefit manager:

(1) may recoup from the pharmacist or pharmacy an amount based only on a final audit report; and

(2) may not accrue or assess interest on an amount due until the date the pharmacist or pharmacy receives the final audit report under Section 1369.264.

(b) The limitations on recoupment and interest accrual or assessment under Subsection (a) do not apply to a health benefit plan issuer or pharmacy benefit manager that, after reviewing claims data, written or oral statements of pharmacy staff, wholesalers, or others, or other investigative information, including patient referrals, anonymous reports, or postings on

Internet websites, suspects the audited pharmacist or pharmacy committed fraud or made an intentional misrepresentation related to the pharmacy business.

Sec. 1369.267. WAIVER PROHIBITED. The provisions of this subchapter may not be waived, voided, or nullified by contract.

Sec. 1369.268. REMEDIES NOT EXCLUSIVE. This subchapter may not be construed to waive a remedy at law available to a pharmacist or pharmacy.

Sec. 1369.269. ENFORCEMENT; RULES. The commissioner may enforce this subchapter and adopt and enforce reasonable rules necessary to accomplish the purposes of this subchapter.

Sec. 1369.270. LEGISLATIVE DECLARATION. Except as provided by Section 1369.252, it is the intent of the legislature that the requirements contained in this subchapter regarding the audit of claims to providers who are pharmacists or pharmacies apply to all health benefit plan issuers and pharmacy benefit managers unless otherwise prohibited by federal law.

SECTION 2. Section 1301.001, Insurance Code, as amended by Chapters 288 (H.B. 1772) and 798 (H.B. 2292), Acts of the 82nd Legislature, Regular Session, 2011, is amended by reenacting and amending Subdivision (1) and reenacting Subdivision (1-a) to read as follows:

(1) "Exclusive provider benefit plan" means a benefit plan in which an insurer excludes benefits to an insured for some or all services, other than emergency care services required under Section 1301.155, provided by a physician or health care provider who is not a preferred provider. [~~"Extrapolation" means a~~

~~mathematical process or technique used by an insurer or pharmacy benefit manager that administers pharmacy claims for an insurer in the audit of a pharmacy or pharmacist to estimate audit results or findings for a larger batch or group of claims not reviewed by the insurer or pharmacy benefit manager.~~]

(1-a) "Health care provider" means a practitioner, institutional provider, or other person or organization that furnishes health care services and that is licensed or otherwise authorized to practice in this state. The term includes a pharmacist and a pharmacy. The term does not include a physician.

SECTION 3. The following provisions of the Insurance Code are repealed:

(1) Section 843.002(9-a);

(2) Section 843.3401; and

(3) Section 1301.1041.

SECTION 4. The changes in law made by this Act apply only to contracts between a pharmacist or pharmacy and a health benefit plan issuer or pharmacy benefit manager executed or renewed, and audits conducted under those contracts, on or after the effective date of this Act. Contracts entered into or renewed, and audits conducted under those contracts, before the effective date of this Act are governed by the law in effect immediately before the effective date of this Act, and that law is continued in effect for that purpose.

SECTION 5. This Act takes effect September 1, 2013.

President of the Senate

Speaker of the House

I certify that H.B. No. 1358 was passed by the House on May 2, 2013, by the following vote: Yeas 141, Nays 0, 2 present, not voting.

Chief Clerk of the House

I certify that H.B. No. 1358 was passed by the Senate on May 20, 2013, by the following vote: Yeas 31, Nays 0.

Secretary of the Senate

APPROVED: _____

Date

_____

Governor