

HOUSE BILL NO. 1418

Introduced by

Representatives Kasper, N. Johnson, Keiser, Vigesaa

Senators Wardner, Klein

1 A BILL for an Act to provide standards for audits of pharmacy records; and to provide a penalty.

2 **BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:**

3 **SECTION 1.**

4 **Definitions.**

5 For the purposes of this Act:

- 6 1. "Entity" means a managed care company, an insurance company, a third-party payer,
7 a pharmacy benefits manager, or any other organization that represents an insurance
8 company, a third-party payer, or a pharmacy benefits manager.
- 9 2. "Insurance company" includes any corporation, association, benefit society, exchange,
10 partnership, or individual engaged as principal in the business of insurance.
- 11 3. "Managed care company" is an entity that handles both health care and health care
12 financing.
- 13 4. "Pharmacy benefits manager" means a person that performs pharmacy benefits
14 management and includes any other person acting for such person under a
15 contractual or employment relationship in the performance of pharmacy benefits
16 management for a managed care company, nonprofit hospital or medical service
17 organization, insurance company, third-party payer, or health program administered by
18 a state agency.
- 19 5. "Third-party payer" means an organization other than the patient or health care
20 provider involved in the financing of personal health services.

21 **SECTION 2.**

22 **Pharmacy benefits manager audit - Rules.**

- 23 1. An entity conducting an audit of a pharmacy shall:

- 1 a. If conducting an onsite audit, give the pharmacy a written notice at least fourteen
2 business days before conducting an initial audit.
- 3 b. If the audit involves clinical or professional judgment, ensure the audit is
4 conducted by or in consultation with a pharmacist licensed in this state and
5 employed by or contracted with the pharmacy benefits manager or conducted by
6 the state board of pharmacy.
- 7 c. Limit the audit to no more than eighteen months from the date that the claim was
8 submitted to or adjudicated by the entity. A claim may not be reviewed that is
9 older than eighteen months from the date of the audit, unless a longer period is
10 permitted under federal law.
- 11 d. Limit the audit to no more than forty prescriptions.
- 12 e. Refrain from conducting the audit during the first seven business days of the
13 month unless otherwise consented to by the pharmacy.
- 14 f. Refrain from entering the pharmacy area where patient-specific information is
15 available and remain out of sight and hearing range of the pharmacy customers.
16 The pharmacy shall designate an area for auditors to conduct their business.
- 17 g. Allow the pharmacy to use the records, including a medication administration
18 record, of a hospital, physician, or other authorized practitioner to validate the
19 pharmacy record and delivery.
- 20 h. Allow the pharmacy to use any legal prescription, including medication
21 administration records, electronic documents, or documented telephone calls
22 from the prescriber or the prescriber's agents, to validate claims in connection
23 with prescriptions and refills or changes in prescriptions.
- 24 2. An audit may not allow a recoupment to be assessed for items on the face of a
25 prescription not required by rules adopted by the state board of pharmacy with respect
26 to patient hard copy prescription forms for controlled and uncontrolled drugs.
- 27 3. A finding of overpayment or underpayment may be based only on the actual
28 overpayment or underpayment and not on a projection based on the number of
29 patients served having a similar diagnosis or on the number of similar orders or refills
30 for similar drugs. A calculation of an overpayment may not include dispensing fees,
31 unless a prescription was not dispensed or the prescriber denied authorization. In the

- 1 case of an error that has no financial harm to the patient or plan, the pharmacy
2 benefits manager may not assess any chargeback. The entity conducting the audit
3 may not use extrapolation in calculating the recoupment or penalties for audits. Any
4 recoupment may not be deducted against future remittances and must be invoiced to
5 the pharmacy for payment. An entity performing an audit may not receive payment
6 based on a percentage of the amount recovered. Interest may not accrue during the
7 audit period, which begins with the notice of audit and ends with the final audit report.
- 8 4. A clerical or recordkeeping error may not be considered fraud, but may be subject to
9 recoupment. A person is not subject to any criminal penalty for a clerical or
10 recordkeeping error without proof of intent to commit fraud.
- 11 5. The insurance commissioner shall adopt rules establishing parameters of audits,
12 including consumer-oriented parameters based on manufacturer listings or
13 recommendations.
- 14 6. Unless an alternate price is published in a provider contract and signed by both
15 parties, the usual and customary price charged by a pharmacy for compounded
16 medications is considered to be the reimbursable cost.
- 17 7. An entity conducting an audit shall utilize the same standards and parameters in
18 auditing a pharmacy the entity uses with other similarly situated pharmacies.
- 19 8. An entity conducting an audit shall establish a written appeals process which must
20 include appeals of preliminary reports and final reports and provide that if either party
21 is not satisfied with the appeal, that party may seek mediation.
- 22 9. If during the course of an audit the auditing entity requests copies of records, the
23 pharmacy may charge the entity twenty-five cents per page to cover the cost incurred
24 to the pharmacy.

25 **SECTION 3.**

26 **Audit reports - Disclosure - Distribution of recouped funds - Review of auditor.**

- 27 1. A preliminary audit report must be delivered to the pharmacy within thirty days after
28 the conclusion of the audit.
- 29 2. A pharmacy must be allowed at least thirty days following receipt of the preliminary
30 audit to provide documentation to address any discrepancy found in the audit.

- 1 3. A final audit report must be delivered to the pharmacy within ninety days after receipt
- 2 of the preliminary audit report or final appeal, whichever is later.
- 3 4. No chargeback, recoupment, or other penalty may be assessed until the appeal
- 4 process has been exhausted and the final report issued.
- 5 5. An entity shall remit any money due to a pharmacy or pharmacist as a result of an
- 6 underpayment of a claim within thirty days after the appeals process has been
- 7 exhausted and the final audit report has been issued.
- 8 6. Unless otherwise provided by law, audit information may not be shared. An auditor
- 9 may have access to any previous audit report on a pharmacy only if the audit was
- 10 conducted by that auditing entity.
- 11 7. An auditing entity shall provide a copy of the final report to the sponsor of the plan for
- 12 which claims were included in the audit. Any funds recouped must be returned to the
- 13 plan sponsor and the copayment must be returned directly to the patient.
- 14 8. At the expense of the plan sponsor, the plan sponsor may request an audit of an
- 15 auditing entity.

16 **SECTION 4.**

17 **Applicability.**

- 18 1. This Act applies to claims adjudicated after December 31, 2010.
- 19 2. This Act does not apply to any investigative audit that involves fraud, willful
- 20 misrepresentation, or abuse, including:
 - 21 a. Insurance fraud as defined in chapter 26.1-02.1.
 - 22 b. Billing for services not furnished or supplies not provided.
 - 23 c. Billing that appears to be a deliberate application for duplicate payment for the
 - 24 same services or supplies, billing both the beneficiary and the pharmacy benefits
 - 25 manager or payer for the same service.
 - 26 d. Altering claim forms, electronic claim records, or medical documentation to obtain
 - 27 a higher payment amount.
 - 28 e. Soliciting, offering, or receiving a kickback or bribe.
 - 29 f. Participating in any scheme that involves collusion between a provider and a
 - 30 beneficiary or between a supplier and a provider which results in higher costs or
 - 31 charges to the entity.

- 1 g. Misrepresenting a date or description of services furnished or the identity of the
2 beneficiary or the individual who furnished the services.
- 3 h. Billing for a prescription without a prescription on file in a situation in which an
4 over-the-counter item is dispensed.
- 5 i. Dispensing a prescription using an out-of-date drug.
- 6 j. Billing with an incorrect national drug code or billing for a brand name when a
7 generic drug is dispensed.
- 8 k. Failing to credit the payer for a medication or a portion of a prescription that was
9 not obtained by the payer within fourteen days unless extenuating circumstances
10 exist.
- 11 l. Billing the payer a higher price than the usual and customary charge of the
12 pharmacy to the general public.
- 13 m. Billing for a product without proof that the purchaser purchased the product.
- 14 3. Any case of suspected fraud or violation of law must be reported by an auditor to the
15 licensing board.

16 **SECTION 5.**

17 **Penalty.**

18 The insurance commissioner may assess a civil penalty not exceeding ten thousand dollars
19 for any violation of this Act.