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HOUSE BILL NO. 198

Offered January 13, 2010
Prefiled January 7, 2010

A BILL to amend and reenact § 38.2-4319 of the Code of Virginia and to amend the Code of Virginia by adding a section numbered 38.2-3407.9:04, relating to pharmacy benefits; audits and claims review.

Patron—Ware, R.L.

Referred to Committee on Commerce and Labor

Be it enacted by the General Assembly of Virginia:

1. That § 38.2-4319 of the Code of Virginia is amended and reenacted and that the Code of Virginia is amended by adding a section numbered 38.2-3407.9:04 as follows:

§ 38.2-3407.9:04. Pharmacy benefits; audits and appeals.

A. As used in this section:

"Audit" includes any audit conducted by a carrier or its pharmacy benefits administrator, on the premises of the participating pharmacy provider or by other means, to determine whether the participating pharmacy provider has complied with any term of the provider contract.

"Carrier" and "provider contract" have the same meaning ascribed thereto in subsection A of § 38.2-3407.15.

B. Any contract between a carrier and its pharmacy benefits administrator, pursuant to which the pharmacy benefits administrator has the right or obligation to conduct audits of participating pharmacy providers, shall:

1. Comply with the requirements of this section; and

2. Include and describe all audit procedures to be utilized by the pharmacy benefits administrator and state that updated audit procedures shall be delivered to all participating pharmacy providers at least 30 days prior to the effective date of any substantive change in such audit procedures.

C. Any provider contract between a carrier and a participating pharmacy provider or its contracting agent, pursuant to which the carrier has the right or obligation to conduct an audit of the participating pharmacy provider, shall:

1. Comply with the requirements of this section; and

2. Include and describe all audit procedures to be utilized by the carrier and state that updated audit procedures shall be delivered to all participating pharmacy providers at least 30 days prior to the effective date of any substantive change in such audit procedures.

D. Audit procedures with respect to any contract subject to this section shall include, but shall not be limited to, the following:

1. No audit shall occur unless the participating pharmacy provider received written notice of the audit, including information sufficient for the participating pharmacy provider to identify the specific items and procedures to be audited, by first-class mail, at least 15 days prior to the date of the audit, and the participating pharmacy shall be afforded at least 30 days in which to provide any information requested prior to or during the course of the audit;

2. No audit may occur during the first five calendar days of a month without the consent of the participating pharmacy provider;

3. The same audit standards and rules shall be applied to all participating pharmacy providers;

4. The auditor shall retain or employ a licensed pharmacist to assist the auditor if any aspect of the audit requires the clinical or professional judgment of a pharmacist, and such pharmacist shall sign the final report on any audit in which he has participated;

5. Any legal prescription may be used to validate claims in connection with prescriptions for, or refills of, a controlled substance as defined in § 54.1-3401;

6. Claims adjudicated more than 12 months prior to the date of the audit may not be audited;

7. Preliminary audit reports shall be delivered to the participating pharmacy provider within six months of the date of the audit, with reasonable extensions for good cause permitted;

8. The participating pharmacy provider shall be afforded at least 30 days from its receipt of a preliminary audit report, with reasonable extensions for good cause permitted, to respond to the preliminary audit report;

9. Final audit reports shall be delivered to the participating pharmacy provider within six months of its receipt of the preliminary audit report or within six months of the date of the completion of any review requested by the participating pharmacy provider, whichever occurs later;

10. Overpayments and underpayments shall be determined solely on the basis of claims actually audited and may not be mathematically derived from the number of patients with similar diagnoses, the number of similar prescriptions, the number of refills for similar medications, or any other method of extrapolation;

11. Calculations of overpayments shall not include dispensing fees;

12. The amount of any recovery or setoff from a participating pharmacy provider by a carrier or its pharmacy benefits administrator shall not exceed the amount of documented overpayments for claims actually audited;

13. Any interest charged to a participating pharmacy provider by a carrier or its pharmacy benefits administrator shall not start to accrue until the later of:

a. The date of delivery of the final audit report; or

b. The date of delivery of the response to the review permitted pursuant to subsection E;

14. No recovery or setoff for any overpayment or denial of a claim shall occur until 60 days after the date the final audit report is delivered to the participating pharmacy provider, except that a carrier or its pharmacy benefits administrator may waive this requirement if the amount of the overpayment identified by the audit exceeds $25,000;

15. Payments due to a participating pharmacy provider for the underpayment of any claims shall be made within 60 days of the date the final audit report is delivered to the participating pharmacy provider;

16. Audit requirements may be waived by the carrier or its pharmacy benefits administrator if either possesses direct evidence, and not mere suspicion, of fraud or misrepresentation by the participating pharmacy provider; and

17. If a carrier or its pharmacy benefits administrator independently determines during an audit or claims review process or at any other time that any claims were underpaid, full payment for such claims shall be made to the participating pharmacy provider within 14 days of the determination.

E. Any contract made subject to this section as provided in subsection B or C shall include and describe a claims review process and state that updated claims review procedures shall be delivered to each participating pharmacy provider at least 30 days prior to the effective date of any substantive change in such review procedures. A claims review process shall include the following procedures:

1. The participating pharmacy provider may request, via electronic means, review of any alleged underpayment within 12 months of the adjudication of the claim; and

2. The participating pharmacy provider shall be given written notice of the review decision within three months of the date the review request is received by the carrier or its pharmacy benefits administrator.

F. This section shall apply to contracts between a carrier and its pharmacy benefits administrator or a carrier and a participating pharmacy provider or its contracting agent that are entered into, amended, extended, or renewed on or after January 1, 2011.

§ 38.2-4319. Statutory construction and relationship to other laws.

A. No provisions of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-100, 38.2-136, 38.2-200, 38.2-203, 38.2-209 through 38.2-213, 38.2-216, 38.2-218 through 38.2-225, 38.2-229, 38.2-232, 38.2-305, 38.2-316, 38.2-322, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, Chapter 9 (§ 38.2-900 et seq.), §§ 38.2-1016.1 through 38.2-1023, 38.2-1057, Article 2 (§ 38.2-1306.2 et seq.), § 38.2-1306.1, § 38.2-1315.1, Articles 3.1 (§ 38.2-1316.1 et seq.), 4 (§ 38.2-1317 et seq.) and 5 (§ 38.2-1322 et seq.) of Chapter 13, Articles 1 (§ 38.2-1400 et seq.) and 2 (§ 38.2-1412 et seq.) of Chapter 14, §§ 38.2-1800 through 38.2-1836, 38.2-3401, 38.2-3405, 38.2-3405.1, 38.2-3407.2 through 38.2-3407.6:1, 38.2-3407.9 through 38.2-3407.16, 38.2-3411.2, 38.2-3411.3, 38.2-3411.4, 38.2-3412.1:01, 38.2-3414.1, 38.2-3418.1 through 38.2-3418.15, 38.2-3419.1, 38.2-3430.1 through 38.2-3437, 38.2-3500, subdivision 13 of § 38.2-3503, subdivision 8 of § 38.2-3504, §§ 38.2-3514.1, 38.2-3514.2, 38.2-3522.1 through 38.2-3523.4, 38.2-3525, 38.2-3540.1, 38.2-3541.1, 38.2-3542, 38.2-3543.2, Article 5 (§ 38.2-3551 et seq.) of Chapter 35, Chapter 52 (§ 38.2-5200 et seq.), Chapter 55 (§ 38.2-5500 et seq.), Chapter 58 (§ 38.2-5800 et seq.) and § 38.2-5903 of this title shall be applicable to any health maintenance organization granted a license under this chapter. This chapter shall not apply to an insurer or health services plan licensed and regulated in conformance with the insurance laws or Chapter 42 (§ 38.2-4200 et seq.) of this title except with respect to the activities of its health maintenance organization.

B. For plans administered by the Department of Medical Assistance Services that provide benefits pursuant to Title XIX or Title XXI of the Social Security Act, as amended, no provisions of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-100, 38.2-136, 38.2-200, 38.2-203, 38.2-209 through 38.2-213, 38.2-216, 38.2-218 through 38.2-225, 38.2-229, 38.2-232, 38.2-322, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, Chapter 9 (§ 38.2-900 et seq.), §§ 38.2-1016.1 through 38.2-1023, 38.2-1057, § 38.2-1306.1, Article 2 (§ 38.2-1306.2 et seq.), § 38.2-1315.1, Articles 3.1 (§ 38.2-1316.1 et seq.), 4 (§ 38.2-1317 et

seq.) and 5 (§ 38.2-1322 et seq.) of Chapter 13, Articles 1 (§ 38.2-1400 et seq.) and 2 (§ 38.2-1412 et seq.) of Chapter 14, §§ 38.2-3401, 38.2-3405, 38.2-3407.2 through 38.2-3407.5, 38.2-3407.6 and 38.2-3407.6:1, 38.2-3407.9, 38.2-3407.9:01, ~~and~~ 38.2-3407.9:02, *and 38.2-3407.9:04,* subdivisions 1, 2, and 3 of subsection F of § 38.2-3407.10, 38.2-3407.11, 38.2-3407.11:3, 38.2-3407.13, 38.2-3407.13:1, and 38.2-3407.14, 38.2-3411.2, 38.2-3418.1, 38.2-3418.2, 38.2-3419.1, 38.2-3430.1 through 38.2-3437, 38.2-3500, subdivision 13 of § 38.2-3503, subdivision 8 of § 38.2-3504, §§ 38.2-3514.1, 38.2-3514.2, 38.2-3522.1 through 38.2-3523.4, 38.2-3525, 38.2-3540.1, 38.2-3542, 38.2-3543.2, Chapter 52 (§ 38.2-5200 et seq.), Chapter 55 (§ 38.2-5500 et seq.), Chapter 58 (§ 38.2-5800 et seq.) and § 38.2-5903 shall be applicable to any health maintenance organization granted a license under this chapter. This chapter shall not apply to an insurer or health services plan licensed and regulated in conformance with the insurance laws or Chapter 42 (§ 38.2-4200 et seq.) of this title except with respect to the activities of its health maintenance organization.

C. Solicitation of enrollees by a licensed health maintenance organization or by its representatives shall not be construed to violate any provisions of law relating to solicitation or advertising by health professionals.

D. A licensed health maintenance organization shall not be deemed to be engaged in the unlawful practice of medicine. All health care providers associated with a health maintenance organization shall be subject to all provisions of law.

E. Notwithstanding the definition of an eligible employee as set forth in § 38.2-3431, a health maintenance organization providing health care plans pursuant to § 38.2-3431 shall not be required to offer coverage to or accept applications from an employee who does not reside within the health maintenance organization's service area.

F. For purposes of applying this section, "insurer" when used in a section cited in subsections A and B of this section shall be construed to mean and include "health maintenance organizations" unless the section cited clearly applies to health maintenance organizations without such construction.