HB2017

LRB09710463RPM50700b

97TH GENERAL ASSEMBLY

State of Illinois

2011 and 2012

HB2017

by Rep. Franco Coladipietro

SYNOPSIS AS INTRODUCED:

215 ILCS 5/512-3	from Ch. 73, par. 1065.59-3
215 ILCS 5/512-7	from Ch. 73, par. 1065.59-7

Amends the Illinois Insurance Code. Makes changes in the provision concerning definitions. Provides that when an on-site audit or a desk audit of the records of a pharmacy is conducted by any entity, the audit shall be conducted in accordance with certain criteria. Provides that the auditing entity, administrator, or its representative must provide the pharmacy with a written report of the audit and comply with certain requirements. Sets forth provisions concerning appeals processes, accounting practices, and applicability.

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A BILL FOR

AN ACT concerning insurance.

Be it enacted by the People of the State of Illinois, represented in the General Assembly:

Section 5. The Illinois Insurance Code is amended by changing Sections 512-3 and 512-7 as follows:

(215 ILCS 5/512-3) (from Ch. 73, par. 1065.59-3)

Sec. 512-3. Definitions. For the purposes of this Article, unless the context otherwise requires, the terms defined in this Article have the meanings ascribed to them herein:

(a) "Third party prescription program" or "program" means any system of providing for the reimbursement of pharmaceutical services and prescription drug products offered or operated in this State under a contractual arrangement or agreement between a provider of such services and another party who is not the consumer of those services and products. Such programs may include, but need not be limited to, employee benefit plans whereby a consumer receives prescription drugs or other pharmaceutical services and those services are paid for by an agent of the employer or others.

(b) "Third party program administrator" or "administrator" or "entity" means any pharmacy benefits manager or person, business, or other entity that performs pharmacy benefits management. The terms include a person or auditing entity

acting for a pharmacy benefits manager in a contractual or employment relationship in the performance of pharmacy benefits management for a managed care company or nonprofit hospital or the services of a pharmacy benefits administrator, medical service organization, insurance company, third-party payor, person, partnership or corporation who issues or causes to be issued any payment or reimbursement to a provider for services rendered pursuant to a third party prescription program, but does not include the Director of Healthcare and Family Services or any agent authorized by the Director to reimburse a provider of services rendered pursuant to a program of which the Department of Healthcare and Family Services is the third party.

(Source: P.A. 95-331, eff. 8-21-07.)

(215 ILCS 5/512-7) (from Ch. 73, par. 1065.59-7)

Sec. 512-7. Contractual provisions.

(a) Any agreement or contract entered into in this State between the administrator of a program and a pharmacy shall include a statement of the method and amount of reimbursement to the pharmacy for services rendered to persons enrolled in the program, the frequency of payment by the program administrator to the pharmacy for those services, and a method for the adjudication of complaints and the settlement of disputes between the contracting parties.

(b)(1) A program shall provide an annual period of at least

30 days during which any pharmacy licensed under the Pharmacy Practice Act may elect to participate in the program under the program terms for at least one year.

(2) If compliance with the requirements of this subsection (b) would impair any provision of a contract between a program and any other person, and if the contract provision was in existence before January 1, 1990, then immediately after the expiration of those contract provisions the program shall comply with the requirements of this subsection (b).

(3) This subsection (b) does not apply if:

(A) the program administrator is a licensed health maintenance organization that owns or controls a pharmacy and that enters into an agreement or contract with that pharmacy in accordance with subsection (a); or

(B) the program administrator is a licensed health maintenance organization that is owned or controlled by another entity that also owns or controls a pharmacy, and the administrator enters into an agreement or contract with that pharmacy in accordance with subsection (a).

(4) This subsection (b) shall be inoperative after October 31, 1992.

(c) The program administrator shall cause to be issued an identification card to each person enrolled in the program. The

identification card shall include:

(1) the name of the individual enrolled in the program; and

(2) an expiration date if required under the contractual arrangement or agreement between a provider of pharmaceutical services and prescription drug products and the third party prescription program administrator.

(d) Notwithstanding any other law, when an on-site audit or a desk audit of the records of a pharmacy is conducted by any entity, the audit shall be conducted in accordance with the following criteria:

(1) no entity shall conduct an on-site audit or a desk audit at a particular pharmacy more than once annually; however, this paragraph (1) shall not apply when an entity must return to a pharmacy to complete an audit already in progress, there is suspected or previously identified history of errors, or inappropriate or illegal activity that the entity has brought to the attention of the pharmacy owner or corporate headquarters of the pharmacy;

(2) the entity conducting the on-site audit or desk audit must give the pharmacy written notice, delivered by certified mail to the owner of the pharmacy, at least 2 weeks prior to conducting the initial on-site audit for each audit cycle and must describe in exact detail the records to be examined;

(3) the entity conducting the on-site audit or desk

audit shall not exceed 4 hours in duration and shall not interfere with the delivery of pharmacist services to any patient, and shall utilize every effort to minimize inconvenience and disruption to pharmacy operations during the audit process; on-site audits shall review no more than 100 unique prescription numbers during an initial audit;

(4) any audit that involves clinical or professional judgment must be conducted by or in consultation with a pharmacist licensed in this 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;

(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 overpayment to the pharmacy shall invoke a recoupment of dispensing fees only, such as the

medications were legally dispensed and received by a valid patient under order of a valid prescription and previously authorized for payment by the entity;

(9) each pharmacy shall be audited under the same standards, parameters, and frequency 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, nonprofit hospital or medical service organization, insurance company, third-party payor, pharmacy benefit manager, health program administered by a department of the State, or any entity that represents such companies, groups, or departments;

(11) no audit may be initiated or scheduled during the first 7 calendar days of any month, or during peak holiday seasons, due to the high volume of prescriptions filled in the pharmacy during that time unless otherwise consented to by the pharmacy;

(12) the firm or entity conducting the on-site audit or desk audit on behalf of the plan provider or pharmacy benefits manager may not receive compensation payments based on a formula calculated on the amount recovered;

(13) any necessary or legally required information may appear on the front or back or affixed to the prescription to be deemed legally valid, along with any accepted

electronic records to the extent permitted by law; and

(14) when a valid prescription is in force, auditors may not seek recoupment for claims that exceeded face value of prescription or similar claims when a duly authorized prescription is in force and permitted under law.

(e) The auditing entity, administrator, or its representative described in subsection (d) of this Section 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 along with a written copy of the formal appeals process to each pharmacy that is being audited;

(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, whichever is later;

(4) the audit report must be signed and shall 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;

(6) interest shall not accrue during the audit period;

(7) each administrator or its representative conducting an audit shall provide a copy of the final audit report, after completion of any review process, to the both the pharmacy and the plan sponsor; and

(8) the auditing entity shall conduct an exit interview at the close of the audit, at a time agreed to by the pharmacy, which shall provide the following: (i) response to questions from the auditing entity; (ii) review and comment on the initial finding of the auditing entity; and (iii) additional documentation to clarify the initial findings of the auditing entity.

(f) Appeal processes pursuant to this Section shall comport with the following provisions:

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

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

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

further action.

(g) Notwithstanding any other provision in this Code, the administrator conducting the audit pursuant to subsections (d) and (e) of this Section shall not use the accounting practice of extrapolation in calculating recoupments or penalties for audits.

As used in this Section, "accounting practice of extrapolation" means an audit of a sample of prescription drug benefit claims submitted by a pharmacy to the administrator conducting the audit that is then used to estimate audit results for a larger batch or group of claims not reviewed by the auditor.

(h) The audit criteria set forth in this Section shall apply only to audits of claims for services provided and claims submitted for payment after the effective date of this amendatory Act of the 97th General Assembly and all criteria of the audit standards must be set forth in law and criteria more restrictive than Illinois law shall not be permitted nor used as principles of audit.

(i) This Section shall not apply to any investigative audit conducted by or on behalf of a State agency that involves fraud, willful misrepresentation, or abuse, including, without limitation, investigative audits or any other statutory provision that authorizes investigations relating to insurance fraud.

(Source: P.A. 95-689, eff. 10-29-07.)