**A** **BILL**

TO AMEND THE CODE OF LAWS OF SOUTH CAROLINA, 1976, BY ADDING ARTICLE 18 TO CHAPTER 71, TITLE 38 SO AS TO PROVIDE THE RIGHTS OF A PHARMACY WHEN UNDERGOING AN AUDIT CONDUCTED BY A MANAGED CARE COMPANY, INSURANCE COMPANY, THIRD‑PARTY PAYER, OR AN ENTITY RESPONSIBLE FOR PAYMENT OF CLAIMS FOR HEALTH CARE SERVICES; TO REQUIRE THE AUDITING ENTITY TO ESTABLISH AN APPEALS PROCESS; AND TO PROVIDE FOR THE RECOUPMENT OF FUNDS UNDER CERTAIN CIRCUMSTANCES.

Be it enacted by the General Assembly of the State of South Carolina:

SECTION 1. Chapter 71, Title 38 of the 1976 Code is amended by adding:

“Article 18

Pharmacy Audit Rights

“Section 38‑71‑1810. (A) As used in this section, ‘responsible party’ means the entity responsible for payment of claims for health care services other than:

(a) the individual to whom the health care services were rendered; or

(b) that individual’s guardian or legal representative.

(B) Notwithstanding any other provision of law, if a managed care company, insurance company, third‑party payer, or any entity that represents a responsible party conducts an audit of the records of a pharmacy, the pharmacy has a right to:

(1) have at least thirty days’ advance notice of the initial on‑site audit for each audit cycle with no audit to be initiated or scheduled during the first five days of any month without the express consent of the pharmacy, which shall cooperate with the auditor to establish an alternate date if the audit would fall within the excluded days;

(2) have an audit that involves clinical judgment be conducted with a pharmacist who is licensed and employed by or working under contract with the auditing entity;

(3) not have clerical or record‑keeping errors, including typographical errors, scrivener’s errors, and computer errors, on a required document or record deemed fraudulent in the absence of any other evidence; this item does not prohibit recoupment of fraudulent payments;

(4) have, if required under the terms of the contract, the auditing entity to provide the pharmacy, upon request, all records related to the audit in an electronic format or contained in digital media;

(5) have the properly documented records of a hospital or of a person authorized to prescribe controlled substances for the purpose of providing medical or pharmaceutical care for their patients transmitted by any means of communication in order to validate a pharmacy record with respect to a prescription or refill for a controlled substance or narcotic drug;

(6) have a projection of an overpayment or underpayment based on either the number of patients served with a similar diagnosis or the number of similar prescription orders or refills for similar drugs; this item does not prohibit recoupments of actual overpayments, unless the projection for overpayment or underpayment is part of a settlement by the pharmacy;

(7) have the audit limited to claims that are identified by prescription number if the purpose of the audit, prior to the initiation of the audit, is for an identified problem;

(8) have the audit limited to one hundred selected prescriptions if an audit is conducted for a reason other than described in item (7);

(9) have the audit conducted on site if the audit reveals the necessity for a review of additional claims;

(10) be subject to no more than one audit in one calendar year, unless fraud or misrepresentation is reasonably suspected, except for audits initiated for the reason described in item (7);

(11) be free of recoupments based on either of the following unless defined within the billing requirements set forth in the pharmacy provider manual not inconsistent with current State Board of Pharmacy Regulations, except for cases of Food and Drug Administration regulation or drug manufacturer safety programs:

(a) documentation requirements in addition to, or exceeding requirements for, creating or maintaining documentation prescribed by the State Board of Pharmacy;

(b) a requirement that a pharmacy or pharmacist perform a professional duty in addition to, or exceeding, professional duties prescribed by the State Board of Pharmacy;

(12) be subject to recoupment only following the correction of a claim and to have recoupment limited to amounts paid in excess of amounts payable under the corrected claim;

(13) be subject to reversals of approval, except for Medicare claims, for drug, prescriber, or patient eligibility upon adjudication of a claim only in cases in which the pharmacy obtained the adjudication by fraud or misrepresentation of claim elements;

(14) be audited under the same standards and parameters as other similarly situated pharmacies audited by the same entity;

(15) have at least 30 days following receipt of the preliminary audit report to produce documentation to address any discrepancy found during an audit;

(16) have the period covered by an audit limited to twenty‑four months from the date a claim was submitted to, or adjudicated by, a managed care company, an insurance company, a third‑party payer, or an entity that represents responsible parties, unless a longer period is permitted by a federal plan under federal law;

(17) have the preliminary audit report delivered to the pharmacy within one hundred twenty days after conclusion of the audit;

(18) have a final audit report delivered to the pharmacy within ninety days after the end of the appeals period; and

(19) not have the accounting practice of extrapolation used in calculating recoupments or penalties for audits, unless otherwise required by federal requirements or federal plans.

Section 38‑71‑1820. (A) Each entity that conducts an audit of a pharmacy shall establish an appeals process under which a pharmacy may appeal an unfavorable preliminary audit report to the entity.

(B) If, following the appeal, the entity finds that an unfavorable audit report or any portion of the unfavorable audit report is unsubstantiated, the entity shall dismiss the unsubstantiated portion of the audit report without any further proceedings.

(C) Each entity conducting an audit shall provide a copy, if required under the terms of the contract, of the audit findings to the plan sponsor after completion of any appeals process.

Section 38‑71‑1830. (A) Recoupments of any disputed funds must occur only after final internal disposition of an audit, including the appeals process as provided for in Section 38‑71‑1820, unless fraud or misrepresentation is reasonably suspected.

(B) Recoupment on an audit must be refunded to the responsible party as contractually agreed upon by the parties.

(C) The entity conducting the audit may charge or assess the responsible party, directly or indirectly, based on amounts recouped if both of the following conditions are met:

(1) the responsible party and the entity conducting the audit have entered into a contract that explicitly states the percentage charge or assessment to the responsible party; and

(2) a commission or other payment to an agent or employee of the entity conducting the audit is not based, directly or indirectly, on amounts recouped.

Section 38‑71‑1840. This article does not apply to an audit, review, or investigation that involves alleged Medicaid fraud, Medicaid abuse, insurance fraud, or other criminal fraud or misrepresentation.”

SECTION 2. If any section, subsection, paragraph, subparagraph, sentence, clause, phrase, or word of this act is for any reason held to be unconstitutional or invalid, such holding shall not affect the constitutionality or validity of the remaining portions of this act, the General Assembly hereby declaring that it would have passed this act, and each and every section, subsection, paragraph, subparagraph, sentence, clause, phrase, and word thereof, irrespective of the fact that any one or more other sections, subsections, paragraphs, subparagraphs, sentences, clauses, phrases, or words hereof may be declared to be unconstitutional, invalid, or otherwise ineffective.

SECTION 3. This act takes effect July 1, 2012.

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