

SUMMARY OF PROMPT PAY & AUDIT STANDARDS BILL

- The bill relates to the payment of claims to pharmacists and pharmacies. Specifically, it amends the Texas Insurance Code in regard to prompt payment and audit standards affecting pharmacist and pharmacy providers.
- This bill amends Chapters 843, 1213, and 1301 of the Texas Insurance Code.
- Chapter 843 governs Health Maintenance Organizations.
- Chapter 1213 governs Electronic Health Care Transactions.
- Chapter 1301 governs Preferred Provider Benefit Plans.
- This bill affects the following three (3) entities that pay claims to pharmacists and pharmacy providers:
 - 1) Health Maintenance Organizations (hereafter “HMOs”);
 - 2) Preferred Maintenance Organizations (hereafter “PPOs”); and
 - 3) those entities that contract with HMOs or PPOs to process or pay claims, provide health care services to enrollees or issue verifications or preauthorizations, namely pharmacy benefit managers (“PBMs”). This bill ensures applicability to PBMs with specific, unambiguous language.**
- This bill provides for a deadline for action on all prescription claims not later than the 21st day after the date the entity receives a clean claim from a pharmacist or pharmacy provider in a nonelectronic format or the 18th day after the date the entity affirmatively adjudicates a pharmacist or pharmacy claim that is electronically submitted.
- Within the required time frame (21 or 18 days depending on the form of the claim), the entity must make a determination in regard to the claim. The determination must be that the claim falls into one of the following (3) categories:
 - 1) The entire claim is payable; thus, the entity must pay the total amount of the claim via electronic funds transfer (hereafter “EFT”);
 - 2) A portion of the claims is payable; thus, the entity must pay the payable portion of the claim via EFT, and notify the pharmacist or pharmacy in writing why the remaining portion of the claim will not be paid; or
 - 3) The entire claim is not payable; thus, the entity must notify the pharmacist or pharmacy in writing why the claim will not be paid.

- This bill defines the term “extrapolation” and prohibits the utilization of extrapolation calculations or practices in the completion of audits of pharmacists or pharmacy providers.
- This bill requires the auditing entity to accommodate the pharmacist or pharmacy provider’s schedule to the greatest extent and provide reasonable notice when scheduling the field or on-site portion of an audit. This language is taken from the Texas Administrative Code’s authority regarding Medicaid audits of pharmacists and pharmacies. The notice shall be in writing and sent via certified mail not less than fifteen (15) days prior to the date of the field or on-site portion of the audit.
- This bill contains a legislative declaration, stating that it is the intent of the legislature that the requirements contained in this bill apply to all HMOs, PPOs and PBMs, unless otherwise prohibited by law—thus avoiding the potential invalidity of the law due to any later Employee Retirement Income Security Act (“ERISA”) challenges.
- This bill requires that PBMs also must comply with existing law governing health benefit plans, which provides that health benefit plans may not directly or indirectly charge or hold a health care professional, health care facility, or person enrolled in a health benefit plan responsible for a fee for the adjudication of a claim.
- This bill would take effect September 1, 2011.