§ 280-c. Pharmacy audits by pharmacy benefit managers. 1. Definitions. As used in this section, the following terms shall have the following meanings:

(a) "Pharmacy benefit manager" shall have the same meaning as in section two hundred eighty-a of this article.

(b) "Pharmacy" shall mean a pharmacy that has contracted with a pharmacy benefit manager for the provision of pharmacy services.

2. When conducting an audit of a pharmacy's records, a pharmacy benefit manager shall:

(a) not conduct an on-site audit of a pharmacy at any time during the first three calendar days of a month;

(b) notify the pharmacy or its contracting agent no later than fifteen days before the date of initial on-site audit. Such notification to the pharmacy or its contracting agent shall be in writing delivered either (i) by mail or common carrier, return receipt requested, or (ii) electronically with electronic receipt confirmation, addressed to the supervising pharmacist of record and pharmacy corporate office where applicable, at least fifteen days before the date of an initial on-site audit;

(c) limit the audit period to twenty-four months after the date a claim is submitted to or adjudicated by the pharmacy benefit manager;

(d) include in the written advance notice of an on-site audit the list of specific prescription numbers to be included in the audit that may or may not include the final two digits of the prescription numbers;

(e) use the written and verifiable records of a hospital, physician or other authorized practitioner, which are transmitted by any means of communication, to validate the pharmacy records in accordance with state and federal law;

(f) limit the number of prescriptions audited to no more than one hundred randomly selected in a twelve-month period, except in cases of fraud;

(g) provide the pharmacy or its contracting agent with a copy of the preliminary audit report within forty-five days after the conclusion of the audit;

(h) be allowed to conduct a follow-up audit on-site if a remote or desk audit reveals the necessity for a review of additional claims;

(i) in the case of invoice audits, accept as validation invoices from any wholesaler registered with the department of education from which the pharmacy has purchased prescription drugs or, in the case of durable medical equipment or sickroom supplies, invoices from an authorized distributor other than a wholesaler;

(j) provide the pharmacy or its contracting agent with the ability to provide documentation to address a discrepancy or audit finding, provided that such documentation must be received by the pharmacy benefit manager no later than the forty-fifth day after the preliminary audit report was provided to the pharmacy or its contracting agent. The pharmacy benefit manager shall consider a reasonable request from the pharmacy for an extension of time to submit documentation to address or correct any findings in the report; and

(k) provide the pharmacy or its contracting agent with the final audit report no later than sixty days after the initial audit report was provided to the pharmacy or its contracting agent.

3. Any claim that was retroactively denied for a clerical error, typographical error, scrivener's error or computer error shall be paid if the prescription was properly and correctly dispensed, unless a pattern of such errors exists, fraudulent billing is alleged or the error results in actual financial loss to the entity. A clerical error is an error that does not result in actual financial harm to the covered entity or consumer and does not include the dispensing of an incorrect dose, amount or type of medication or dispensing a prescription drug to the wrong person.

4. This section shall not apply to:

(a) audits in which suspected fraudulent activity or other intentional or willful misrepresentation is evidenced by a physical review, review of claims data or statements, or other investigative methods; or

(b) audits of claims paid for by federally funded programs; or

(c) concurrent reviews or desk audits that occur within three business days of transmission of a claim and where no chargeback or recoupment is demanded.