INAPPROPRIATE SITE INQUIRY LETTER (FOLLOW-UP INQUIRY)

Current Date

Contact Full Name
Respondent Names
Contact Mailing Address

RE: Complainant Names , INQUIRER
Insured Names , INSURED
OID FILE NUMBER: Case Tracking ID
To View Attachment Password = PBM2020

To Whom It May Concern:

The Oklahoma Insurance Department (OID) has received an inquiry or inquiries regarding Pharmacy Benefit Manager (PBM), [NAME OF PBM], hereinafter "PBM" or "your company." OID is in receipt of your company's response to OID's initial inquiry and requests for information and/or documentation. Having reviewed your company's response, OID has some follow-up inquiries that we request your company address and respond to.

Title 36 O.S.§6965 (C) requires that your company provide the OID with an adequate response to this inquiry within thirty (30) days from the date of this inquiry. Your company's response should be delivered electronically to the OID at PBMcomplaints@oid.ok.gov. Please review this correspondence and the corresponding complaint(s) and advise our office of your response and position in this matter. Please include the OID file number/SBS tracking number with your response. This will ensure that we associate the record(s) of the complaint(s) with the appropriate entity.

We also request that you provide a specific contact person who will be handling this matter, along with their direct telephone number and email address.

In addition to your company's position in this matter, please provide its full and complete answers to the following questions and requests:

1. Why was this claim denied? Explain why the product/service requested was not appropriate for this site.
2. Did PBM provide the customer with a list of sites that were appropriate & where the claim could be approved/adjudicated (i.e. a list of contracted providers)? Or did PBM direct customer to a list of providers that could fill the claim?

a. If the customer was provided a list, provide OID with the list customer was provided with or directed to.
b. If customer was directed to the list, provide the directions as provided to the customer as well as a copy of the list customer was directed to (as of the date customer was directed).

3. Did PBM provide any person or entity, other than the customer, with a list of sites that were appropriate & where the claim could be approved/adjudicated (i.e. a list of contracted providers)? Or did PBM direct any person or entity, other than the customer, to a list of providers that could fill the claim?
    a. If yes, who was that person/entity and why was that person/entity provided with or directed to the list of contracted providers? (For example, did PBM expect the non-approved pharmacy to provide that information to the customer?)
    b. If the person/entity, other than the customer, was provided a list, provide OID with the list provided.
    c. If the person/entity, other than the customer, was directed to a list, provide the directions as provided to the person/entity as well as a copy of the list the person/entity was directed to (as of the date directed).
4. Provide OID with a list of approved providers (preferred & non-preferred) where customer's claim could have been filled/approved on the same date. Denote each provider's status as "preferred" or "non-preferred" on the claim date.
5. Are any of the approved providers on this list owned by or a subsidiary of PBM? If yes, identify this/these provider(s) and the relationship between PBM and the provider(s).
6. Is PBM owned by or a subsidiary of any of the approved providers on this list? If yes, identify this/these provider(s) and the relationship between PBM and the provider(s).
7. Within 6 months of (before or after) the date of the claim, did the pharmacy where the claim was denied request and/or apply to be contracted with PBM as a preferred or non-preferred provider?
    a. If yes, provide OID with the corresponding documents.
    b. If yes, what was the outcome? Provide documentation.
    c. If the pharmacy's request/application to be a contracted provider was denied, why was it denied?
8. Within 6 months of (before or after) the date of the claim, have any other providers, not on PBM's list of contracted providers, requested and/or applied to be contracted with PBM as a preferred or non-preferred pharmacy?
    a. If yes, identify each requesting/applying provider.
    b. If yes, what was the outcome? Provide documentation.
9. What are PBM's credentialing requirements for a pharmacy to become an "in-network preferred provider" and an "in-network non-preferred provider?"
    a. If the pharmacy where the claim(s) was denied subsequently requested/applied to be contracted with PBM as a preferred or non-preferred provider, were the credentialing requirements the same at that time? If no, provide the credentialling requirements at that time.
10. Does PBM have any cost-sharing agreements or provide any rebates, discounts, reduction in copay or copay amounts, or any other incentives to any of the pharmacies in Oklahoma with which it is contracted?

    a. If yes, which pharmacies? Describe the rebates, discounts, or other incentives provided.
11. Do any of PBM's contracts with any of its in-network provider(s) in Oklahoma include any provision(s) related to discounts, cost-sharing, reduction or potential reduction in copay amount, or the number of copays to individuals.
    a. If yes, supply OID with a complete unredacted copy of the contract(s).
12. Provide any and all documentation in further support of your responses to the questions above.

Thank you in advance for your assistance and timely response. This department looks forward to working with you in resolving this matter.

Sincerely,

Investigator #1 Signature

Investigator Names

Investigator Titles

Investigator Emails

(918) 295-3716

Enclosure