

ARTICLE XLV PHARMACY BENEFIT MANAGER

In addition to all other applicable sections of the Mississippi Code of 1972, ARTICLE XLV of the Mississippi Board of Pharmacy Regulation pertains specifically to Pharmacy Benefit Managers.

1. DEFINITIONS

- A. "Board" means the State Board of Pharmacy.
- B. "Commissioner" means the Mississippi Commissioner of Insurance.
- C. "Day" means a calendar day, unless otherwise defined or limited.
- D. "Electronic claim" means the transmission of data for purposes of payment of covered prescription drugs, other products and supplies, and pharmacist services in an electronic data format specified by a pharmacy benefit manager and approved by the department.
- E. "Electronic adjudication" means the process of electronically receiving, reviewing and accepting or rejecting an electronic claim.
- F. "Enrollee" means an individual who has been enrolled in a pharmacy benefit management plan.
- G. "Health insurance plan" means benefits consisting of prescription drugs, other products and supplies, and pharmacist services provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as prescription drugs, other products and supplies, and pharmacist services under any hospital or medical service policy or certificate, hospital or medical service plan contract, preferred provider organization agreement, or health maintenance organization contract offered by a health insurance issuer, unless preempted as an employee benefit plan under the Employee Retirement Income Security Act of 1974. However, "health insurance coverage" shall not include benefits due under the workers compensation laws of this or any other state.
- H. "Pharmacy benefit manager" means a business that administers the prescription drug/device portion of pharmacy benefit management plans or health insurance plans on behalf of plan sponsors, insurance companies, unions and health maintenance organizations. For purposes of Sections 73-21-151 through 73-21-159, a "pharmacy benefit manager" shall not include an insurance company that provides an integrated health benefit plan and that does not separately contract for pharmacy benefit management services. The pharmacy benefit manager of the Mississippi State and School Employees Health Insurance Plan or the Mississippi Division of Medicaid or its contractors when performing services for the Division of Medicaid shall not be subject to Sections 73-21-151 through 73-21-159 because of those activities, but, if they are conducting business as a pharmacy benefit manager other than with those agencies,

they shall be subject to Sections 73-21-151 through 73-21-159 for those activities only.

- I. "Pharmacy benefit management plan" means an arrangement for the delivery of pharmaceutical services in which a pharmacy benefit manager undertakes to administer the payment or reimbursement of any of the costs of pharmacist's services for an enrollee on a prepaid or insured basis which (i) contains one or more incentive arrangements intended to influence the cost or level of pharmaceutical services between the plan sponsor and one or more pharmacies with respect to the delivery of pharmacist's services; and (ii) requires or creates benefit payment differential incentives for enrollees to use under contract with the pharmacy benefit manager. A pharmacy benefit management plan does not mean any employee welfare benefit plan if preempted by the Employee Retirement Income Security Act of 1974, which is self-insured or self-funded, the Mississippi State and School Employees Health Insurance Plan or the programs operated by the Mississippi Division of Medicaid.
- J. "Pharmacist", "pharmacist services" and "pharmacy" or "pharmacies" shall have the same definitions as provided in Section 73-21-73.
- K. "Uniform claim form" means a form prescribed by rule by the State Board of Pharmacy, provided however that, for purposes of Sections 73-21-151 through 73-21-159, the board shall adopt the same definition or rule where the State Department of Insurance has adopted a rule covering the same type of claim. The board may modify the terminology of the rule and form when necessary to comply with the provisions of Sections 73-21-151 through 73-21-159.
- L. "Plan sponsors" means the employers, insurance companies, unions and health maintenance organizations that contract with a pharmacy benefit manager for delivery of prescription services.

2. LICENSE REQUIRED BEFORE CONDUCTING BUSINESS AS PHARMACY BENEFIT MANAGER; PHARMACY BENEFIT MANAGERS TO FILE CERTAIN FINANCIAL STATEMENTS WITH STATE BOARD OF PHARMACY; TIME PERIOD FOR FILING STATEMENTS

- A. Before beginning to do business as a pharmacy benefit manager, a pharmacy benefit manager shall obtain a license from the board. To obtain a license, the applicant shall submit an application to the board on a form prescribed by the board.
 - a. Contents of Application shall include:
 - i. The identity of the pharmacy benefits manager and any company or organization controlling the operation of the pharmacy benefits manager, including the name, business address, and contact person, for the pharmacy benefit manager and the controlling entity.
 - ii. A "Certificate of Good Standing" from the Mississippi Secretary of State and, if applicable, a Mississippi "Certificate of Existence".
 - iii. In the case of pharmacy benefit managers domiciled out of the State of

Mississippi, a certificate that the pharmacy benefits manager, company or organization is in good standing in the state of domicile or organization.

- iv. A report of the details of any suspension, sanction, penalty or other disciplinary action relating to the pharmacy benefits manager, controlling company or organization, in the State of Mississippi or any other state, territory or country.
- v. The pharmacy benefit manager shall report all previous and future data security breaches and HIPAA security breaches.
- vi. The name and address of the agent of record or for services of process for the pharmacy benefit manager in Mississippi.
- vii. A list of the pharmacy benefit manager's principal owners.
- viii. The geographical services area of the pharmacy benefit manager.
- ix. A list of all entities on whose behalf the pharmacy benefit manager has contracts or agreements to provide pharmacy benefit services.
- x. The number of total enrollees or lives served under all of the pharmacy benefit manager's contracts or agreements in Mississippi and nationwide.
- xi. A contingency plan describing how contracted pharmacy benefit services will be provided in the event of insolvency of the pharmacy benefit manager.
- xii. The most recently concluded fiscal year-end financial statements for the pharmacy benefit manager and its controlling company or organization, which statements have been audited by an independent certified public accountant (CPA) under U.S. generally accepted accounting principles (GAAP).
- xiii. The names and addresses of the public accounting firm and internal accountant(s) preparing or assisting in the preparation of such financial statements.
- xiv. A certificate signed by the Chief Executive Officer of the pharmacy benefit manager attesting to the accuracy of the information contained in the filing.
- xv. The Pharmacy Benefit Manager license shall be an annually renewable license expiring on January 1st of each calendar year.
- xvi. A non-refundable license fee of \$500.00 must accompany each application for the application to be considered complete.
- xvii. 'Pro rata' pharmacy benefit manager licenses are not allowed by the Board.
- xviii. A completed application for renewal of a Pharmacy Benefit Manager license must be received at the offices of the Board no later than December 31st annually.
- xix. In the event that a pharmacy benefit manager license renewal is received after December 31st, a \$500.00 late fee will be assessed and payment must be received by the Board before a license will be issued.
- xx. A monetary penalty of \$1000.00 per day may be imposed upon any Pharmacy Benefit Manager that practices or conducts business in the

State of Mississippi without a license.

- B. Each pharmacy benefit manager providing pharmacy management benefit plans in this state shall file a statement with the board annually by March 1 or within sixty (60) days of the end of its fiscal year if not a calendar year. The statement shall be verified by at least two (2) principal officers and shall cover the preceding calendar year or the immediately preceding fiscal year of the pharmacy benefit manager.
- C. The statement shall be on forms prescribed by the board and shall include:
 - a. A financial statement of the organization, including its balance sheet and income statement for the preceding year; and
 - b. Any other information relating to the operations of the pharmacy benefit manager required by the board under this section.

However, no pharmacy benefit manager shall be required to disclose proprietary information of any kind to the board.

- D. If the pharmacy benefit manager is audited annually by an independent certified public accountant, a copy of the certified audit report shall be filed annually with the board by June 30 or within thirty (30) days of the report being final.
- E. The board may extend the time prescribed for any pharmacy benefit manager for filing annual statements or other reports or exhibits of any kind for good cause shown. However, the board shall not extend the time for filing annual statements beyond sixty (60) days after the time prescribed by subsection (1) of this section. The board may waive the requirements for filing financial information for the pharmacy benefit manager if an affiliate of the pharmacy benefit manager is already required to file such information under current law with the Commissioner of Insurance and allow the pharmacy benefit manager to file a copy of documents containing such information with the board in lieu of the statement required by this section.
- F. The expense of administering this section shall be assessed annually by the board against all pharmacy benefit managers operating in this state.

3. FINANCIAL EXAMINATION OF PHARMACY BENEFIT MANAGER

- A. In lieu of or in addition to making its own financial examination of a pharmacy benefit manager, the board may accept the report of a financial examination of other persons responsible for the pharmacy benefit manager under the laws of another state certified by the applicable official of such other state.
- B. The board shall coordinate financial examinations of a pharmacy benefit manager that provides pharmacy management benefit plans in this state to ensure an appropriate level of regulatory oversight and to avoid any undue duplication of effort or regulation.

The pharmacy benefit manager being examined shall pay the cost of the examination. The cost of the examination shall be deposited in a special fund that shall provide all expenses for the licensing, supervision and examination of all pharmacy benefit managers subject to regulation under Sections 73-21-71 through 73-21-129 and Sections 73-21-151 through 73-21-159.

- C. The board may provide a copy of the financial examination to the person or entity that provides or operates the health insurance plan or to a pharmacist or pharmacy.
- D. The board is authorized to hire independent financial consultants to conduct financial examinations of a pharmacy benefit manager and to expend funds collected under this section to pay the costs of such examinations.

4. CLEAN CLAIM

Most current nationally recognized reference price to be used in calculation of reimbursement for prescription drugs and other products and supplies; updating of reference price; time period for payment of benefits; "clean claim" defined; compliance; penalties

- A. Reimbursement under a contract to a pharmacist or pharmacy for prescription drugs and other products and supplies that is calculated according to a formula that uses a nationally recognized reference in the pricing calculation shall use the most current nationally recognized reference price or amount in the actual or constructive possession of the pharmacy benefit manager, its agent, or any other party responsible for reimbursement for prescription drugs and other products and supplies on the date of electronic adjudication or on the date of service shown on the nonelectronic claim.
- B. Pharmacy benefit managers, their agents and other parties responsible for reimbursement for prescription drugs and other products and supplies shall be required to update the nationally recognized reference prices or amounts used for calculation of reimbursement for prescription drugs and other products and supplies no less than every three (3) business days.
- C. All benefits payable under a pharmacy benefit management plan shall be paid within fifteen (15) days after receipt of due written proof of a clean claim where claims are submitted electronically, and shall be paid within thirty-five (35) days after receipt of due written proof of a clean claim where claims are submitted in paper format. Benefits due under the plan and claims are overdue if not paid within fifteen (15) days or thirty-five (35) days, whichever is applicable, after the pharmacy benefit manager receives a clean claim containing necessary information essential for the pharmacy benefit manager to administer preexisting condition, coordination of benefits and subrogation provisions under the plan sponsor's health insurance plan. A "clean claim" means a claim received by any pharmacy benefit manager for adjudication and which requires no further information, adjustment or alteration by the pharmacist or pharmacies or the insured in order to be processed and paid by the pharmacy benefit manager. A claim is

clean if it has no defect or impropriety, including any lack of substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under this subsection. A clean claim includes resubmitted claims with previously identified deficiencies corrected.

- D. A clean claim does not include any of the following:
- (a) A duplicate claim, which means an original claim and its duplicate when the duplicate is filed within thirty (30) days of the original claim;
 - (b) Claims which are submitted fraudulently or that are based upon material misrepresentations;
 - (c) Claims that require information essential for the pharmacy benefit manager to administer preexisting condition, coordination of benefits or subrogation provisions under the plan sponsor's health insurance plan; or
 - (d) Claims submitted by a pharmacist or pharmacy more than thirty (30) days after the date of service; if the pharmacist or pharmacy does not submit the claim on behalf of the insured, then a claim is not clean when submitted more than thirty (30) days after the date of billing by the pharmacist or pharmacy to the insured.
- E. Not later than fifteen (15) days after the date the pharmacy benefit manager actually receives an electronic claim, the pharmacy benefit manager shall pay the appropriate benefit in full, or any portion of the claim that is clean, and notify the pharmacist or pharmacy (where the claim is owed to the pharmacist or pharmacy) of the reasons why the claim or portion thereof is not clean and will not be paid and what substantiating documentation and information is required to adjudicate the claim as clean. Not later than thirty-five (35) days after the date the pharmacy benefit manager actually receives a paper claim, the pharmacy benefit manager shall pay the appropriate benefit in full, or any portion of the claim that is clean, and notify the pharmacist or pharmacy (where the claim is owed to the pharmacist or pharmacy) of the reasons why the claim or portion thereof is not clean and will not be paid and what substantiating documentation and information is required to adjudicate the claim as clean. Any claim or portion thereof resubmitted with the supporting documentation and information requested by the pharmacy benefit manager shall be paid within twenty (20) days after receipt.
- F. If the board finds that any pharmacy benefit manager, agent or other party responsible for reimbursement for prescription drugs and other products and supplies has not paid ninety-five percent (95%) of clean claims as defined in subsection (3) of this section received from all pharmacies in a calendar quarter, he shall be subject to administrative penalty of not more than Twenty-five Thousand Dollars (\$ 25,000.00) to be assessed by the State Board of Pharmacy.
- G. Examinations to determine compliance with this subsection may be conducted by the board. The board may contract with qualified impartial outside sources to assist in examinations to determine compliance. The expenses of any such examinations shall be paid by the pharmacy benefit manager examined.

- H. Nothing in the provisions of this section shall require a pharmacy benefit manager to pay claims that are not covered under the terms of a contract or policy of accident and sickness insurance or prepaid coverage.
- I. If the claim is not denied for valid and proper reasons by the end of the applicable time period prescribed in this provision, the pharmacy benefit manager must pay the pharmacy (where the claim is owed to the pharmacy) or the patient (where the claim is owed to a patient) interest on accrued benefits at the rate of one and one-half percent (1- 1/2%) per month accruing from the day after payment was due on the amount of the benefits that remain unpaid until the claim is finally settled or adjudicated. Whenever interest due pursuant to this provision is less than One Dollar (\$ 1.00), such amount shall be credited to the account of the person or entity to whom such amount is owed.
- J. Any pharmacy benefit manager and a pharmacy may enter into an express written agreement containing timely claim payment provisions which differ from, but are at least as stringent as, the provisions set forth under subsection (3) of this section, and in such case, the provisions of the written agreement shall govern the timely payment of claims by the pharmacy benefit manager to the pharmacy. If the express written agreement is silent as to any interest penalty where claims are not paid in accordance with the agreement, the interest penalty provision of subsection (4)(c) of this section shall apply.
- K. The State Board of Pharmacy may adopt rules and regulations necessary to ensure compliance with this subsection.

5. AUDIT

I. DEFINITIONS:

- A. "Entity" means a pharmacy benefit manager, a managed care company, a health plan sponsor, an insurance company, a third-party payor, or any company, group or agent that represents or is engaged by those entities.
- B. "Health insurance plan" means benefits consisting of prescription drugs, other products and supplies, and pharmacist services provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as prescription drugs, other products and supplies, and pharmacist services under any hospital or medical service policy or certificate, hospital or medical service plan contract, preferred provider organization agreement, or health maintenance organization contract offered by a health insurance issuer.
- C. "Individual prescription" means the original prescription for a drug signed by the prescriber, and excludes refills referenced on the prescription.
- D. "Pharmacy benefit manager" means a business that administers the prescription drug/device portion of pharmacy benefit management plans or health insurance plans on behalf of plan sponsors, insurance companies, unions and health maintenance organizations. Pharmacy benefit managers may also provide some, all, but may not be

limited to, the following services either directly or through outsourcing or contracts with other entities:

- (i) Adjudicate drug claims or any portion of the transaction.
- (ii) Contract with retail and mail pharmacy networks.
- (iii) Establish payment levels for pharmacies.
- (iv) Develop formulary or drug list of covered therapies.
- (v) Provide benefit design consultation.
- (vi) Manage cost and utilization trends.
- (vii) Contract for manufacturer rebates.
- (viii) Provide fee-based clinical services to improve member care.
- (ix) Third-party administration.

- E. "Pharmacy benefit management plan" means an arrangement for the delivery of pharmacist's services in which a pharmacy benefit manager undertakes to administer the payment or reimbursement of any of the costs of pharmacist's services for an enrollee on a prepaid or insured basis that (i) contains one or more incentive arrangements intended to influence the cost or level of pharmacist's services between the plan sponsor and one or more pharmacies with respect to the delivery of pharmacist's services; and (ii) requires or creates benefit payment differential incentives for enrollees to use under contract with the pharmacy benefit manager.
- F. "Pharmacist," "pharmacist services" and "pharmacy" or "pharmacies" shall have the same definitions as provided in Section 73-21-73.

Sections 73-21-175 through 73-21-189 shall apply to any audit of the records of a pharmacy conducted by a managed care company, nonprofit hospital or medical service organization, insurance company, third-party payor, pharmacy benefit manager, a health program administered by a department of the state or any entity that represents those companies, groups, or department.

II. Audit procedures; written report; report requirements

A. The entity conducting an audit shall follow these procedures:

- i. The pharmacy contract must identify and describe in detail the audit procedures;
- ii. The entity conducting the on-site audit must give the pharmacy written notice at least two (2) weeks before conducting the initial on-site audit for each audit cycle, and the pharmacy shall have at least fourteen (14) days to respond to any desk audit requirements;
- iii. The entity conducting the on-site or desk audit shall not interfere with the delivery of pharmacist services to a patient and shall utilize every effort to minimize inconvenience and disruption to pharmacy operations during the audit process;

- iv. Any audit that involves clinical or professional judgment must be conducted by or in consultation with a pharmacist;
- v. Any clerical or record-keeping error, such as a typographical error, scrivener's error, or computer error, regarding a required document or record shall not constitute fraud; however, those claims may be subject to recoupment. No such claim shall be subject to criminal penalties without proof of intent to commit fraud;
- vi. 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;
- vii. A finding of an overpayment or an underpayment may 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, except that recoupment shall be based on the actual overpayment or underpayment;
- viii. A finding of an overpayment shall not include the dispensing fee amount unless a prescription was not dispensed;
- ix. Each pharmacy shall be audited under the same standards and parameters as other similarly situated pharmacies audited by the entity;
- x. The period covered by an audit may not exceed two (2) years 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, a health program administered by a department of the state or any entity that represents those companies, groups, or department;
- xi. An audit may not be initiated or scheduled during the first five (5) calendar days of any month due to the high volume of prescriptions filled in the pharmacy during that time unless otherwise consented to by the pharmacy;
- xii. Any prescription that complies with state law and rule requirements may be used to validate claims in connection with prescriptions, refills or changes in prescriptions;
- xiii. An exit interview that provides a pharmacy with an opportunity to respond to questions and comment on and clarify findings must be conducted at the end of an audit. The time of the interview must be agreed to by the pharmacy;
- xiv. Unless superseded by state or federal law, auditors shall only have access to previous audit reports on a particular pharmacy conducted by the auditing entity for the same pharmacy benefits manager, health plan or insurer. An auditing vendor contracting with multiple pharmacy benefits managers or health insurance plans shall not use audit reports or other information gained from an audit on a particular pharmacy to conduct another audit for a different pharmacy benefits manager or health insurance plan;
- xv. The parameters of an audit must comply with consumer-oriented parameters based on manufacturer listings or recommendations for the following:
 - (a) The day supply for eyedrops must be calculated so that the consumer pays only one (1) thirty-day copayment if the bottle of eyedrops is intended by the manufacturer to be a thirty-day supply;

- (b) The day supply for insulin must be calculated so that the highest dose prescribed is used to determine the day supply and consumer copayment;
- xvi. The day supply for a topical product must be determined by the judgment of the pharmacist based upon the treated area;
- xvii. (a) Where an audit is for a specifically identified problem that has been disclosed to the pharmacy, the audit shall be limited to claims that are identified by prescription number;
(b) For an audit other than described in subparagraph (a) of this paragraph , an audit shall be limited to one hundred (100) individual prescriptions that have been randomly selected;
(c) If an audit reveals the necessity for a review of additional claims, the audit shall be conducted on site;
(d) Except for audits initiated under paragraph (a) of this subsection, an entity shall not initiate an audit of a pharmacy more than one (1) time in any quarter;
- xviii. A recoupment shall not be based on:
 - (a) Documentation requirements in addition to or exceeding requirements for creating or maintaining documentation prescribed by the State Board of Pharmacy; or
 - (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;
- xiv. Except for Medicare claims, approval of drug, prescriber or patient eligibility upon adjudication of a claim shall not be reversed unless the pharmacy or pharmacist obtained the adjudication by fraud or misrepresentation of claim elements; and
- xv. 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.

III. The entity must provide the pharmacy with a written report of the audit and comply with the following requirements:

- A. The preliminary audit report must be delivered to the pharmacy within one hundred twenty (120) days after conclusion of the audit, with a reasonable extension to be granted upon request;
- B. A pharmacy shall be allowed at least thirty (30) days following receipt of the preliminary audit report in which to produce documentation to address any discrepancy found during the audit, with a reasonable extension to be granted upon request;
- C. A final audit report shall be delivered to the pharmacy within one hundred eighty (180) days after receipt of the preliminary audit report or final appeal, as provided for in Section 73-21-185, whichever is later;
- D. The audit report must be signed by the auditor;

- E. Recoupments of any disputed funds, or repayment of funds to the entity by the pharmacy if permitted pursuant to contractual agreement, shall occur after final internal disposition of the audit, including the appeals process as set forth in Section 73-21-185. If the identified discrepancy for an individual audit exceeds Twenty-five Thousand Dollars (\$ 25,000.00), future payments in excess of that amount to the pharmacy may be withheld pending finalization of the audit;
- F. Interest shall not accrue during the audit period; and
- G. Each entity conducting an audit shall provide a copy of the final audit report, after completion of any review process, to the plan sponsor.

IV. Appeals; dismissal of audit report; mediation of unresolved issues

- A. Each entity conducting an audit shall establish a written 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 thereof is unsubstantiated, the entity shall dismiss the audit report or that portion without the necessity of any further action.
- C. If, following the appeal, any of the issues raised in the appeal are not resolved to the satisfaction of either party, that party may ask for mediation of those unresolved issues. A certified mediator shall be chosen by agreement of the parties from the Court Annexed Mediators List maintained by the Mississippi Supreme Court.

V. Use of extrapolation in calculating recoupments or penalties prohibited:

Notwithstanding any other provision in Sections 73-21-175 through 73-21-189, the entity conducting the audit shall not use the accounting practice of extrapolation in calculating recoupments or penalties for audits. An extrapolation audit means an audit of a sample of prescription drug benefit claims submitted by a pharmacy to the entity conducting the audit that is then used to estimate audit results for a larger batch or group of claims not reviewed by the auditor.

VI. Limitation of applicability of Sections 73-21-175 through 73-21-189

Sections 73-21-175 through 73-21-189 do not apply to any audit, review or investigation that involves alleged fraud, willful misrepresentation or abuse.

VII. Penalty for noncompliance:

- A. The State Board of Pharmacy may impose a monetary penalty on pharmacy benefit managers for noncompliance with the provisions of the Pharmacy Audit Integrity Act,

Sections 73-21-175 through 73-21-189, in amounts of not less than One Thousand Dollars (\$ 1,000.00) per violation and not more than Twenty-five Thousand Dollars (\$ 25,000.00) per violation. The board shall prepare a record entered upon its minutes which states the basic facts upon which the monetary penalty was imposed. Any penalty collected under this subsection (1) shall be deposited into the special fund of the board.

- B. The board may assess a monetary penalty for those reasonable costs that are expended by the board in the investigation and conduct of a proceeding if the board imposes a monetary penalty under subsection (1) of this section. A monetary penalty assessed and levied under this section shall be paid to the board by the licensee, registrant or permit holder upon the expiration of the period allowed for appeal of those penalties under Section 73-21-101, or may be paid sooner if the licensee, registrant or permit holder elects. Money collected by the board under this subsection (2) shall be deposited to the credit of the special fund of the board.

When payment of a monetary penalty assessed and levied by the board against a licensee, registrant or permit holder in accordance with this section is not paid by the licensee, registrant or permit holder when due under this section, the board shall have the power to institute and maintain proceedings in its name for enforcement of payment in the chancery court of the county and judicial district of residence of the licensee, registrant or permit holder, or if the licensee, registrant or permit holder is a nonresident of the State of Mississippi, in the Chancery Court of the First Judicial District of Hinds County, Mississippi. When those proceedings are instituted, the board shall certify the record of its proceedings, together with all documents and evidence, to the chancery court and the matter shall be heard in due course by the court, which shall review the record and make its determination thereon in accordance with the provisions of Section 73-21-101. The hearing on the matter may, in the discretion of the chancellor, be tried