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Introduction

Dear pharmacy,

Humana appreciates your role in delivering quality pharmacy services to our Medicaid members. This manual pertains exclusively to Kentucky Humana members enrolled in Humana Health Plan Inc., to assist pharmacy staff in processing prescription claims for Humana plans.

Medicaid
Medicaid is a program run by the federal and state governments that helps people with limited income pay for medical costs and, if qualified, long-term services and supports, such as nursing homes and home- and community-based waiver services. Each state decides what counts as income and who qualifies for Medicaid. States also decide what services are covered and how much they cost.

By contracting with various types of managed care organizations (MCO) to deliver Medicaid program healthcare services to their beneficiaries, states can reduce Medicaid program costs and better manage utilization of health services. Improvement in health plan performance, healthcare quality and outcomes are key objectives of Medicaid managed care. Some states are implementing a range of initiatives to coordinate and integrate care beyond traditional managed care. These initiatives are focused on improving care for populations with chronic and complex conditions, aligning payment incentives with performance goals and building in accountability for high-quality care.

The Humana pharmacist self-service center provides a secure online resource where pharmacists can:

- View Humana member eligibility information
- Research Humana member benefit design information
- View paid and rejected claims
- View a Humana member’s prescription prior authorization status
- Obtain a current list of generic maximum allowable cost (MAC) pricing

This resource is available to any pharmacy contracted with Humana and is provided free of charge. To gain access, visit Humana.com/Pharmacists and select “Register for self-service.” If you have difficulty registering, send an email to hpsnetworks@humana.com. Please include the pharmacy name, National Provider Identifier (NPI), pharmacy contact name and contact phone number. We hope that you find this manual informative. Thank you for your participation in the Humana pharmacy provider network.

Sincerely,

The Humana Pharmacy Network Team
## Contact information

<table>
<thead>
<tr>
<th>Service</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pharmacy help desk</strong></td>
<td>For refill-too-soon overrides and prior authorization status, call <strong>1-800-865-8715</strong> and follow the prompts.</td>
</tr>
<tr>
<td><strong>Humana Customer Care</strong></td>
<td>To obtain general Medicaid plan information: <strong>1-800-477-6931 (TTY: 711)</strong> 8 a.m. – 8 p.m., seven days a week</td>
</tr>
</tbody>
</table>
| **Humana Clinical Pharmacy Review (HCPR)** | To submit prior authorization requests:  
  - Obtain forms at [Humana.com/PA](http://Humana.com/PA) or submit your request electronically by going to [www.covermymeds.com/epa/humana](http://www.covermymeds.com/epa/humana)  
  - Submit request by fax to **1-877-486-2621**  
  - Call HCPR at **1-800-555-CLIN** (**1-800-555-2546**) |
| **Humana Specialty Pharmacy**        | **1-800-486-2668 (TTY: 711)**  
  Available Monday – Friday, 8 a.m. – 8 p.m., Eastern time; Saturday, 8 a.m. – 6 p.m., Eastern time |
| **Humana Pharmacy Solutions network contracting** | Pharmacy contract requests  
  Email: PharmacyContractRequest@humana.com  
  Fax: **1-866-449-5380** |
| **Humana Ethics Help Line**          | **1-877-5-THE-KEY (1-877-584-3539)**                                        |
| **Humana's pharmacist website**      | Visit [Humana.com/Pharmacists](http://Humana.com/Pharmacists) to access payer sheets, pharmacy news bulletins, the Humana Pharmacy Audit Guide and many other resources. |
| **Pharmacist self-service website assistance** | Email: hpsnetworks@humana.com |
Eligibility verification

Humana member identification (ID) cards

The following is an example of the ID card that pharmacy employees may see from Humana members.

Card for a member with Kentucky Medicaid (English)

Note: This image meets state/compliance guidelines and could be subject to change at any time. Notification will be communicated if compliance guidelines change.

Card for a member with Kentucky Medicaid (Spanish)

Note: This image meets state/compliance guidelines and could be subject to change at any time. Notification will be communicated if compliance guidelines change.

Cardholder ID

Pharmacies should submit the Humana member ID number in the “Cardholder ID” field whenever possible. This number can be found on the Humana member’s ID card. Sample card images are shown in the section above, “Humana member identification (ID) cards.”

For Medicaid claims, Humana allows the cardholder ID to be submitted with the Medicaid ID, the Humana ID number or the Social Security number. In addition, pharmacies may call our help desk at 1-800-865-8715, select option 3 and provide the member’s name and date of birth to obtain the Humana member ID.

Coordination of benefits

Effective Jan. 1, 2006, Medicaid enrollees who are entitled to receive Medicare benefits under Part A or Part B no longer receive their pharmacy benefits under their state Medicaid agency, except for drugs
that are not covered under Medicare Part D. Medicaid will not pay for drugs for beneficiaries who have both Medicare and Medicaid (dual eligible) with the exception of:

- Some prescription products that are not covered under Part D
- Some over-the-counter (OTC) products

Medicaid does not reimburse for Medicare Part D drug copayment or for prescriptions not covered due to the Medicare Part D coverage gap. Medicaid will not pay any deductibles or coinsurance for drugs covered by Medicare Part D. However, Medicaid will pay for coinsurance for drugs covered by Medicare Part B.

**Excluded drug coverage by state Medicaid program:**

Each state has the option to cover medications specifically excluded under the Social Security Act section 1927 (d)(2). Listed is some of the excluded drug coverage for the state of Kentucky:

- Drugs for which the manufacturer has not entered into a Federal Rebate Agreement
- Drugs when used for anorexia, weight loss or weight gain
- Drugs when used to promote fertility
- Drugs when used for cosmetic purposes or hair growth
- Drugs when used for symptomatic relief of cough and colds

Additional information is available at [www.medicaid.gov/medicaid/prescription-drugs/excluded-drug-coverage/index.html](http://www.medicaid.gov/medicaid/prescription-drugs/excluded-drug-coverage/index.html).

**Drug coverage**

**Drug Lists**

Humana Health Plan Inc. provides coverage of medically necessary medications, both prescription and select over-the-counter drugs, when prescribed by licensed providers in the state. The Preferred Drug List (PDL) is developed and maintained by Humana’s Pharmacy and Therapeutics Committee consisting of physicians and pharmacists. The PDL indicates the preferred and nonpreferred status of covered drugs on the enrollee’s benefit, as well as identifies drug utilization management requirements, such as prior authorization, quantity limits and step therapy.

Preferred drug lists are updated regularly. To view the current PDL for Kentucky Medicaid eligible members, go to [Humana.com/DrugLists](http://Humana.com/DrugLists).

**Utilization management (UM)**

Certain prescriptions must undergo a criteria-based approval process prior to coverage decision.

- **Prior authorization (PA):** Humana’s Pharmacy and Therapeutics Committee reviews medications based on safety, efficacy and clinical benefit and may make additions or deletions to the list of drugs requiring PA. Certain medications may need to be approved by the member’s plan to be covered.

- **Step therapy:** Plans that are subject to step therapy as a component of Humana’s standard drug utilization review (DUR) program require the member to utilize medications commonly considered first-line before using medications considered second- or third-line. These requirements promote established national treatment guidelines and assist in promoting safe, cost-effective medication therapy.
• **Quantity limits:** Humana has implemented quantity limits for various classes of drugs to facilitate the appropriate, approved label use of these agents. We believe this program helps members obtain the optimal dose required for treating their conditions. If a member’s medical condition warrants an additional quantity, the pharmacist should ask the prescriber to submit a request to HCPR.

**Coverage determinations**
Prescribers may request coverage determinations, such as medication prior authorization, step therapy, quantity limits and medication exceptions, by faxing the request to HCPR at **1-877-486-2621**. Forms can be obtained at [Humana.com/PA](http://Humana.com/PA) or submit the request electronically by going to [www.covermymeds.com/epa/humana](http://www.covermymeds.com/epa/humana).

The coverage determination decision will be made within 24 hours after complete information is received from the prescriber.

**Please note:** Humana does not accept requests for coverage determinations directly from pharmacies. The prescriber must initiate the request.


Prescribers or pharmacists with questions may contact HCPR at **1-800-555-CLIN (1-800-555-2546)**.

**Copayments**
If the member is subject to a copayment, the following information applies:

- **Generic drugs:** $1 copay for a monthly supply
- **Brand drugs:** $4 copay for a monthly supply
- **Products in the following classes are exceptions to the brand/generic rules and will have $1 copays:**
  - Atypical antipsychotics
  - Long-acting injectable antipsychotics
- **Products in the following classes are exceptions to the brand/generic rules and will have $0 copays**
  - Contraceptives for family planning
  - Tobacco cessation
- **Diabetes supplies will have exceptions to the brand/generic rules and will have copays as follows:**
  - Blood glucose meters: $0
- **For pediatric patients, the copay for most medications is $0 for a month supply.**

**Beneficiaries deemed below Federal Poverty Level**
In accordance with federal regulations [42 U.S.C. § 447.52], Medicaid members who are at or below 100% of the Federal Poverty Level (FPL) and cannot afford their copay may not be denied services. Pharmacy services may be denied for failure of member to pay cost-sharing amounts under the following criteria:

- The denial of services follows the current business practice the provider uses for all patients, and
- The member’s income is above 100% of the FPL

To identify whether a member’s income is at or below 100% of the FPL, the message “MEMBER IS AT OR BELOW 100% FPL” will be returned.

Additionally, Kentucky regulation [HB 200] requires that a Medicaid beneficiary presenting with a condition that could result in harm if left untreated shall be dispensed a 72-hour emergency supply of
a prescribed drug regardless of ability to afford copayment. For products dispensed in any special packaging that may not be broken, the minimum full quantity to last 72 hours should be dispensed. Partial fills of C-II substances are allowed for non-terminally ill patients who are not residents of long-term care facilities [905 KAR 55:095]. In the event a patient requests a partial fill of a C-II medication, additional dispensing shall not continue beyond 30 days. Only one dispensing fee shall be paid for both the emergency supply and remainder of the prescription. To remain in compliance with Federal Poverty Level requirements, pharmacies should take the following actions:

1) If the member is at or below 100% of FPL and reports an inability to pay, pharmacy services must be provided.
2) If the member is above 100% of FPL and reports an inability to pay, the pharmacy must dispense a 72-hour emergency supply if the condition could result in harm if left untreated.

General claims procedures

Submitting pharmacy claims
All participating pharmacies must comply with NCPDP transaction standards for pharmacy drug claims, coordination of benefits and related pharmacy services. Prior to submitting a claim, the pharmacy must have a valid prescription on file.

Humana requires the prescriber to be enrolled in the Kentucky Medicaid Program. Claims submitted for a prescriber not enrolled in the Kentucky Medicaid Program will be rejected at the point of sale with the following error message: “Prescriber not Enrolled in State Medicaid Program.”

The pharmacy may not submit test claims. Test claims are claims submissions used to confirm patient eligibility or to determine the existence of any coverage restrictions or requirements and/or the maximum amount of reimbursement.

Bank Identification Numbers (BIN) and Processor Control Numbers (PCN)

<table>
<thead>
<tr>
<th>Plan</th>
<th>BIN</th>
<th>PCN</th>
</tr>
</thead>
<tbody>
<tr>
<td>KY Medicaid</td>
<td>610649</td>
<td>03191501</td>
</tr>
</tbody>
</table>

Prescription origin code requirements
Humana requires the prescription origin code (NCPDP Telecommunications Standard D.0 field 419-DJ) to be included on all prescriptions. All claims submitted will be denied at the point of sale if this code is not included. If the pharmacist is not able to include this code within the pharmacy’s practice management system, the pharmacist should contact the pharmacy’s current software vendor for assistance. SS&C Health (formerly known as DST Pharmacy Solutions) claims processing is not able to override this edit.

Prescriptions, including refills, must contain the fill number according to the following chart:

<table>
<thead>
<tr>
<th>Value</th>
<th>Value type</th>
</tr>
</thead>
<tbody>
<tr>
<td>00</td>
<td>Original dispensing—the first dispensing</td>
</tr>
<tr>
<td>01–99</td>
<td>Refill number—number of the replenishment</td>
</tr>
</tbody>
</table>
All new prescriptions must contain one of the following numeric values:

<table>
<thead>
<tr>
<th>Value</th>
<th>Value type</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Written</td>
</tr>
<tr>
<td>2</td>
<td>Telephone</td>
</tr>
<tr>
<td>3</td>
<td>Electronic</td>
</tr>
<tr>
<td>4</td>
<td>Fax</td>
</tr>
<tr>
<td>5</td>
<td>Situations for which a new prescription number needs to be created from an existing valid prescription, such as traditional transfers, intrachain transfers, file buys and software upgrades/migrations. This value is also the appropriate value for “pharmacy dispensing,” when applicable, such as over the counter, Plan B, established protocols, pharmacists’ authority to prescribe, etc.</td>
</tr>
</tbody>
</table>

**Sales tax**
The sales tax should be submitted as value equal to the percentage of the usual and customary charge that equates to the applicable sales tax rate. The pharmacist must enter a tax amount in NCPDP field 482-GE. If this field is left blank, no sales tax will be calculated.

If you have questions about sales tax, please email PharmacyPricingReview@humana.com.

**Timely submission of claims**
Claims must be submitted on the date of service (DOS). Notwithstanding the foregoing, pharmacies have at least 30, but not more than 90, days from the DOS to submit claims for long-term care pharmacy services. Additionally, there are special circumstances under which a pharmacy may submit claims after the date of service, including the following:
- Resolution of **coordination of benefits** issues requiring claims reversal and rebilling to appropriate payers for Medicare Part D
- **LINET** claims (please reference the “Timely Filing Limits” on the LINET payer sheets available at apps.humana.com/marketing/documents.asp?file=2295852)
- **Subrogation** claims, which have 36 months for submission
- **Commercial** claims, which have 480 days from DOS for submission

Attempting to adjudicate a POS transaction after the claims submission deadline may result in a reject with the message “Claims too old” (NCPDP reject 81). This includes:
- POS payments, reversals and/or adjustments
- Universal claim form claims for payment and reversals

Please contact the Humana pharmacy help desk at **1-800-865-8715** for claims processing questions. This line is staffed 24 hours a day.

**Please note:** This does not apply to claims for low-income subsidy members who were retroactively enrolled.
LTC appeals for untimely filing
As set forth in 42 C.F.R § 423.S0S(b)(20), long-term care (LTC) pharmacy claims must be submitted for eligible persons no later than 90 days from the DOS. Humana recognizes the need for exceptions to be made when claims cannot be submitted in this time frame. In these cases, the LTC pharmacy requesting such an exception must complete, sign and date the LTC appeal form for untimely filing.

Here is a link to the form, which will provide a list of permitted exceptions along with how to submit the form for consideration: apps.humana.com/marketing/documents.asp?file=2322905.

Humana-specific SS&C Health payer sheets
Pharmacists can find applicable Medicaid and Medicare pharmacy payer sheets at Humana.com/provider/pharmacy-resources. Look for the “Pharmacy manuals and forms” link. Direct links to the payer sheets are as follows:
- Medicaid plans: Use commercial D.0 payer sheet (under the heading “Payer sheet”) Humana.com/provider/pharmacy-resources/manuals-forms.

Prescriber NPI submission
Humana requires the use of a valid and accurate Type 1 (also known as “individual”) prescriber NPI on all electronic transactions. Claims submitted without a valid and active Type 1 NPI will be rejected at the point of sale with the following error message: “Prescriber Type 1 NPI required.”

In addition, the error codes listed below will display in the free-form messaging returned to pharmacies. If the pharmacy believes it has received one of these codes in error (e.g., the NPI submitted is an active, valid, individual NPI number), the pharmacy may override the hard edit with the applicable submission clarification code (SCC). Claims processed with an SCC may be subject to post-adjudication validation review.

<table>
<thead>
<tr>
<th>NCPDP error code</th>
<th>NCPDP error code description</th>
<th>Free-form messaging</th>
<th>Applicable SCC</th>
</tr>
</thead>
<tbody>
<tr>
<td>56</td>
<td>Non-matched prescriber ID.</td>
<td>Prescriber ID submitted not found. If validated, submit applicable SCC.</td>
<td>42</td>
</tr>
<tr>
<td>42</td>
<td>Plan’s prescriber database indicates the prescriber ID submitted is inactive or is not found or is expired.</td>
<td>Prescriber ID not active. If validated, submit applicable SCC.</td>
<td>42</td>
</tr>
<tr>
<td>43</td>
<td>Plan’s prescriber database indicates the associated United States Drug Enforcement Agency (DEA) number for submitted prescriber ID is inactive or expired.</td>
<td>Validation of active DEA status required. If validated, submit applicable SCC.</td>
<td>43</td>
</tr>
<tr>
<td>44</td>
<td>Plan’s prescriber database indicates the associated DEA to submitted prescriber ID is not found.</td>
<td>Validation of active DEA for prescription required. If validated, submit applicable SCC.</td>
<td>43 or 45</td>
</tr>
<tr>
<td>46</td>
<td>Plan’s prescriber database indicates associated DEA to submitted prescriber ID does not allow this drug DEA schedule.</td>
<td>Validation of active DEA schedule required. If validated, submit applicable SCC.</td>
<td>46</td>
</tr>
<tr>
<td>543</td>
<td>Prescriber ID qualifier value not</td>
<td>Prescriber Type 1 required. Foreign</td>
<td>N/A</td>
</tr>
</tbody>
</table>
The pharmacy NPI field must contain accurate information identifying the pharmacy for each claim submitted. The pharmacy NPI must be submitted in NCPDP field 201-B1 (service provider ID) with the qualifier “01” in NCPDP field 202-B2 (service provider ID qualifier). The prescriber NPI must also be submitted in NCPDP field 411-DB (prescriber ID) with the qualifier “01” in NCPDP field 466-EZ (prescriber ID qualifier).

**Dispense-as-written (DAW) codes**

Humana recognizes the NCPDP standard dispense-as-written (DAW) codes. Prescriptions with a DAW request must designate the DAW product selection code (NCPDP field 408-D8) on the submitted claim. For a prescription submitted with a DAW code other than zero, the reason for the selected code must be documented and comply with all applicable laws, rules and regulations.

Kentucky Medicaid has certain preferred brand drugs when the brand drug is on the formulary and the generic is not. This may require the pharmacy to use DAW 9 when submitting a claim. Please refer to the Preferred Drug List to identify the preferred brand drugs.

<table>
<thead>
<tr>
<th>Value</th>
<th>Value type</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No product selection indicated</td>
</tr>
<tr>
<td>1</td>
<td>Substitution not allowed by prescriber</td>
</tr>
<tr>
<td>2</td>
<td>Substitution allowed—patient requested product dispensed</td>
</tr>
<tr>
<td>3</td>
<td>Substitution allowed—pharmacist selected product dispensed</td>
</tr>
<tr>
<td>4</td>
<td>Substitution allowed—generic not in stock</td>
</tr>
<tr>
<td>5</td>
<td>Substitution allowed—brand drug is dispensed as generic</td>
</tr>
<tr>
<td>6</td>
<td>Override</td>
</tr>
<tr>
<td>7</td>
<td>Substitution not allowed—brand drug is mandated by law</td>
</tr>
<tr>
<td>8</td>
<td>Substitution allowed—generic drug not available in marketplace</td>
</tr>
<tr>
<td>9</td>
<td>Substitution allowed by prescriber but plan requests brand-patient’s plan requested brand product to be dispensed</td>
</tr>
</tbody>
</table>

**Drug utilization review (DUR) safety edits**

<table>
<thead>
<tr>
<th>DUR type</th>
<th>Pharmacy information</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug – drug interactions</td>
<td>Identifies significant interaction with active medication in patient history, including medication name.</td>
<td>Selective serotonin reuptake inhibitors/monoamine oxidase inhibitors</td>
</tr>
<tr>
<td>Drug – age interaction</td>
<td>Identifies safety risk related to use of specific medication for patient’s age.</td>
<td>Adderall for age younger than 6</td>
</tr>
<tr>
<td>------------------------</td>
<td>---------------------------------------------------------------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td>Drug – disease interaction</td>
<td>Identifies safety risk when medication is contraindicated for a patient’s disease state. Disease may be inferred or identified via medical claims.</td>
<td>Disease: Congenital long QT syndrome</td>
</tr>
<tr>
<td>Drug – gender interaction</td>
<td>Alert of safety risk related to use of specific medication for reported gender. <strong>Note:</strong> Gender edits only apply for commercial and Medicaid when applicable</td>
<td>Makena</td>
</tr>
<tr>
<td>Maximum dose</td>
<td>Identifies safety risk when dosage exceeds First Data Bank (FDB) maximum adult daily dose. Ratio of exceeding FDB maximum dosing is specific to the medication.</td>
<td>Digoxin daily dose greater than 500 mcg</td>
</tr>
<tr>
<td>MED* high dose</td>
<td>Identifies patients at greater risk of overdose or inappropriate opioid utilization. Dosing greater than 100 mg MED per day will trigger this error code.</td>
<td>MS contin 30 mg twice daily plus Percocet 5/325 two tablets every four hours as needed</td>
</tr>
<tr>
<td>MED* overuse</td>
<td>Identifies patients at greater risk of overdose or inappropriate opioid utilization. Dosing greater than 250 mg MED per day and/or more than four providers and more than four pharmacies.</td>
<td>MS contin 100 mg three times daily</td>
</tr>
<tr>
<td>Plan limitations exceeded: accumulation</td>
<td>Identifies the potential for an overdose resulting in single or multiple medications and cumulative doses that exceed safe daily maximums.</td>
<td>Acetaminophen dose greater than 4 grams per day</td>
</tr>
<tr>
<td>Therapeutic duplication</td>
<td>Identifies duplication with active medication in patient history, including medication name.</td>
<td>Two prescriptions for different angiotensin receptor blockers</td>
</tr>
</tbody>
</table>

*MED—Morphine equivalent dosing

**Soft reject DUR**

Select DUR safety alerts may be addressed at the retail pharmacy. Upon receipt of these rejects, pharmacists should apply clinical judgment to review the alert, recommend therapy changes or override the alert when clinically appropriate. Message on claim denials will indicate “Soft Reject: Payer allows DUR/PPS code override.”

<table>
<thead>
<tr>
<th>NCPDP error code</th>
<th>NCPDP description</th>
<th>Reason for service</th>
<th>Professional service</th>
<th>Result of service</th>
</tr>
</thead>
<tbody>
<tr>
<td>88: DUR reject error</td>
<td>This drug interacts with patient’s other drug(s)</td>
<td>DD: Drug interaction</td>
<td>DE: Dosing evaluation MO: Prescriber consulted MP: Patient will be monitored PE: Patient educated PO: Patient consulted RO: Pharmacist consulted other source SW: Literature search/review</td>
<td>1A: Filled as is, false positive 1B: Filled prescription as is 1D: Filled with different directions 1F: Filled with different quantity 1G: Filled with prescriber approval 4A: Prescribed with acknowledgments 4B: Filled, palliative care 4D: Filled, cancer treatment</td>
</tr>
</tbody>
</table>
**Note 922 can apply to single claim or cumulative claim MED limits for opioids**

**Submitting claims for 340B medications**
When dispensing medications acquired under the 340B Program, as such terms are defined by CMS, pharmacies must utilize a submission clarification code (420-DK) field with a value of 20, or the most current NCPDP standard for identification of 340B medications. Pharmacies may be required to complete a contract addendum with Humana to be eligible to dispense 340B medications under the agreement with Humana.

**Vaccine administration**
The program covers administration associated with the injection of shingles, influenza and pneumococcal vaccines. Pharmacists in Humana-participating pharmacies may administer the vaccines if allowed by Kentucky state law.
Submitting claims for vaccine administration
To submit claims for the drug and the administration, the pharmacy must bill a value greater than zero in the incentive amount submitted field (438-E3) and submit professional service code “MA” in field 440-E5.

Controlled substance claims
During claims adjudication, Humana attempts to confirm the validity of the prescriber ID submitted on controlled substance (schedule II-V) claims and that the controlled substance is within the prescriber’s scope of practice. Claims for drugs found to be written outside of a prescriber’s prescribing authority (according to the DEA) will be rejected with the following error message: “Plan’s prescriber database indicates associated DEA to submitted prescriber ID does not allow this DEA drug class.”

The free-form message on the claim will also state: “Validation of active DEA schedule required. If validated, submit applicable SCC.”

Clarification of federal requirements—Schedule II drugs
Humana would like to remind pharmacies of the importance of monitoring pharmacy claims for accuracy and complying with federal and state laws, rules and regulations. This is especially important when filling prescriptions and submitting claims for refills and partial fills of Schedule II drugs. In accordance with your pharmacies agreement, Humana requires its pharmacies to comply with all federal and state laws, rules and regulations pertaining to the dispensing of medications.

The Controlled Substances Act established five schedules, which are based on medical use acceptance and the potential for abuse of a substance or drug. Schedule II drugs have a high potential for abuse, have an accepted medical use (including severe restrictions) and may lead to severe psychological or physical dependence if abused. Pursuant to 21 CFR § 1306.12(a), Schedule II prescription drugs may not be refilled.

Pharmacies should take appropriate steps to confirm (including verifying with the prescriber, when necessary) that controlled substances, including Schedule II drugs, are being filled only in accordance with federal and state law. This includes preventing refills and partial fills of Schedule II drugs that are not allowable under the Controlled Substances Act.

Point-of-sale (POS) edits and overrides
To support state and federal regulations regarding opioid and other controlled substances, Humana employs several point-of-sale edits.

Follow the link provided for information on current guidance on edits and overrides: Humana.com/provider/pharmacy-resources/manuals-forms, then select “Controlled Substances” tab under “Manuals and forms.”

Lock-in program
Humana’s lock-in program is designed to care for member safety due to excessive use of prescription drugs. When Humana receives a referral on a member with an allegation of potential prescription drug abuse, a thorough review is conducted. Prior to completing the pharmacy restriction process, Humana would have already conducted a review on the member and made the determination that the member should be restricted to a particular pharmacy.
Prior to restriction, Humana will reach out to the pharmacy to confirm lock-in at that site. A minimum selection criterion must be met to restrict a Medicaid member to one particular pharmacy. One of the following criteria must be met:

- The member obtained three or more controlled-substance prescriptions from three or more pharmacies written by three or more different prescribers within 180 days.
- The member has been convicted of fraud through unauthorized sale or transfer of a pharmaceutical product funded by Medicaid.
- The member utilized more than 10 different controlled-substance prescribers in 90 days.
- The member obtained two or more controlled-substance prescriptions written by two or more different prescribers who have utilized two or more pharmacies within 180 days AND has a documented diagnosis of narcotic poisoning or drug abuse within the last 365 days.
- The member violated a pain management agreement/contract with his/her prescriber.

Excluded recipients include patients with sickle cell disease and/or cancer, recipients residing in institutionalized settings and recipients enrolled with Medicare.

**Exception:** This limitation does not apply to emergency services and care provided to the recipient in a hospital emergency department.

If the member chooses to use another pharmacy, he or she must complete and submit the request on the Request for Reconsideration form attached to the notification letter by Humana. Members are reviewed during the lock-in program and annually to determine if they still qualify for the lock-in status. After the first 12 months in the lock-in program, the member is given a six-month window during which he or she is not restricted and re-reviewed for lock-in status. After the six-month period, if the member qualifies for lock-in status, he or she will remain locked for two years at the chosen pharmacy.

If you or the member have questions, please feel free to contact Humana in one of the following ways:

- Call **1-855-330-8054**, from 7 a.m. to 4:30 p.m., Central time. After hours, please leave a voicemail with the member name, member ID number, case number, contact phone number and a detailed description of your request.
- Fax **1-855-729-9290**.
- Email **PharmacyClaimAuditAndReview@humana.com**.

## Continuity of care

### Retail and long-term care (LTC) transition policy

This policy applies to prescribed medications that are subject to certain limitations, such as drugs not listed on the preferred drug list and drugs requiring prior authorization, step therapy or quantity limit. This policy helps by providing a temporary supply to members who have limited ability to receive their prescribed drug therapy. For new and re-enrolling members who are at a retail pharmacy or in a long-term care facility, Humana will cover a temporary supply as indicated in the chart below. If the member presents a prescription written for less than the days’ supply allowed, Humana will allow multiple fills to provide up to the total days’ supply of medication allowed.

Humana will indicate that a prescription is a transition fill in the message field of the paid claim response. The pharmacist should communicate this information to the member. Providing a temporary supply gives the member time to talk to his or her prescriber to decide if an alternative drug is
appropriate or to request an exception or prior authorization. Humana will not pay for additional refills of temporary supply drugs until an exception or prior authorization has been obtained.

Transition will not work under the following conditions:

- Medicaid-excluded drugs
- Safety edits
- Initial transition eligibility criteria are not met
- Drugs that require a diagnosis to determine medically accepted indication

<table>
<thead>
<tr>
<th>Program</th>
<th>Retail—Total days’ supply allowed</th>
<th>Retail—Total time period allowed for transition</th>
<th>LTC—Total days’ supply allowed</th>
<th>LTC—Total time period allowed for transition</th>
</tr>
</thead>
<tbody>
<tr>
<td>KY Medicaid</td>
<td>90</td>
<td>90</td>
<td>30</td>
<td>30</td>
</tr>
</tbody>
</table>

Long-term care (LTC)

Long-term care pharmacy information

Humana recognizes the unique operational model and services provided by the pharmacies in its long-term care network. Whether the scope of the pharmacy’s services to LTC facilities is predominantly institutional or part of the mix of services offered by a retail pharmacy, the following resources provide policies and direction for services to Humana members in institutional settings. While most of the needs that LTC pharmacies have are covered by the materials in the main portion of this manual, the following addresses some of the unique features of the LTC pharmacy network.

LTC claims-processing guidelines

Humana requires all pharmacies to submit the patient residence code (NCPDP field 384-4X) and pharmacy service type (NCPDP field 147-U7) on all claims. Claims submitted with a missing or invalid code will be rejected at the point of sale. The tables below list valid patient residence codes and pharmacy service types.

<table>
<thead>
<tr>
<th>Patient residence codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Not specified</td>
</tr>
<tr>
<td>1</td>
<td>Home</td>
</tr>
<tr>
<td>3</td>
<td>Nursing facility</td>
</tr>
<tr>
<td>4</td>
<td>Assisted living facility</td>
</tr>
<tr>
<td>6</td>
<td>Group home</td>
</tr>
<tr>
<td>9</td>
<td>Intermediate care facility/mentally retarded*</td>
</tr>
<tr>
<td>11</td>
<td>Hospice</td>
</tr>
</tbody>
</table>

*Pharmacy code only. This is not Humana-approved language.
If the pharmacy submits a claim for a managed Medicaid plan with a missing or invalid patient residence code, the claim will reject with NCPDP error code 4X and return the following message: **Missing/Invalid Patient Residence Code.**

<table>
<thead>
<tr>
<th>Pharmacy service types</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Community/retail pharmacy services</td>
</tr>
<tr>
<td>2</td>
<td>Compounding pharmacy services</td>
</tr>
<tr>
<td>3</td>
<td>Home infusion therapy provider services</td>
</tr>
<tr>
<td>4</td>
<td>Institutional pharmacy services</td>
</tr>
<tr>
<td>5</td>
<td>Long-term care pharmacy services</td>
</tr>
<tr>
<td>6</td>
<td>Mail-order pharmacy services</td>
</tr>
<tr>
<td>7</td>
<td>Managed care organization pharmacy services</td>
</tr>
<tr>
<td>8</td>
<td>Specialty care pharmacy services</td>
</tr>
<tr>
<td>99</td>
<td>Other</td>
</tr>
</tbody>
</table>

If the pharmacy submits a claim with a missing or invalid pharmacy service type, the claim will reject with NCPDP error code U7 and return the following message: **Missing/Invalid Pharmacy Service Type.**

**Rejections**

If an LTC pharmacy submits a claim for a brand, oral solid medication that is subject to the appropriate dispensing requirement, it must contain valid information in all the appropriate fields (as indicated previously for appropriate dispensing and on the Humana payer sheet for all claims) to be processed. If an LTC pharmacy does not submit the required fields, one of the following messages will be returned to the pharmacy with the claim rejection:

- **NCPDP reject code 613:** “The Packaging Methodology or Dispensing Frequency is Missing or Inappropriate for LTC Short Cycle.” This rejection is returned if the pharmacy submits an LTC claim but does not include both an appropriate submission clarification code and special package indicator.
- **NCPDP reject code 597:** “LTC Dispensing Type Does Not Support the Packaging Type.”
- **NCPDP reject code 612:** “LTC Appropriate Dispensing Invalid Submission Clarification Code (SCC) Combination.”

**Combination pharmacies**

Some pharmacies participate in Humana’s pharmacy network under multiple service types. For example, a pharmacy may maintain a traditional community (ambulatory) pharmacy with a storefront that serves walk-in customers, while also serving members residing in an institutional setting. When submitting claims, these pharmacies should be sure to include the LTC-appropriate dispensing fields that are required on LTC claims. Otherwise, the claim will process as a “retail” claim and bypass the appropriate dispensing edits.
Home infusion billing procedure

Home infusion drug claims are billed through the member's medical benefit.

Compound claims

**Submitting compound claims**
The pharmacy must submit the correct amount with corresponding accurate quantities and days’ supply calculations based on a valid prescription for the member. The pharmacy must submit all ingredients that make up a compound drug on the same claim. The most expensive ingredient will display at the claim level. Edits are returned for each ingredient based on the member’s benefits. Submission clarification code (SCC) of 08 can be submitted on the claim when a pharmacy accepts reimbursement for approved ingredients only.

- A free-form message will return to the pharmacy when a submission clarification code of 08 can be submitted.
- Pharmacies are prohibited from balance billing the beneficiary for the cost of any Medicaid-excluded ingredient contained in the compound.

The pharmacy shall not attempt to circumvent a plan’s benefit design or engage in inappropriate billing practices of compound drugs. Such practices include, but are not limited to:

- Submitting test claims for a compound drug;
- Submitting a claim multiple times with variations in the ingredients, ingredient cost, dispensing fees, quantity amount and/or days’ supply to obtain the highest reimbursement possible;
- Resubmitting rejected compound prescription ingredients as individual, noncompounded ingredients; and
- Submitting partial fills or multiple claims for fills that are less than a 30-day supply to avoid coverage limitations or gain additional reimbursement or copayment amounts.

Medication Therapy Management (MTM) program

Medication Therapy Management (MTM) is a program that seeks to enhance a member’s medication therapy and to minimize adverse drug reactions. Humana’s MTM program utilizes a variety of resources, such as telephone-based and pharmacy-based consultation services, for ambulatory and institutional beneficiaries.

Humana works with community pharmacies to provide eligible Medicaid members with a series of face-to-face MTM consultations at their local pharmacies.

Humana has contracted with a vendor to assist in providing MTM services. If a pharmacy is interested in providing MTM services to Humana members, it can visit [www.outcomesMTM.com](http://www.outcomesMTM.com) to learn more.
Pharmacy audit and compliance

Pharmacy audit program

Humana maintains a pharmacy audit program to:

• Help ensure the validity and accuracy of pharmacy claims for its clients (including CMS and state agencies overseeing a program for Medicaid eligibles)
• Help ensure compliance with the provider agreement between Humana and its network pharmacies
• Educate network pharmacies regarding proper submission and documentation of pharmacy claims

According to the pharmacy provider agreement between Humana and its network pharmacies, Humana, any third-party auditor designated by Humana or any government agency allowed by law is permitted to conduct audits of any and all pharmacy books, records and prescription files related to services rendered to members.

Claim-specific audit objectives include, but are not limited to, correction of the following errors:

- Dispensing unauthorized, early or excessive refills
- Dispensing an incorrect drug
- Billing the wrong member
- Billing an incorrect physician
- Using an NCPDP/National Provider Identifier (NPI) number inappropriately
- Calculating the days’ supply incorrectly
- Using a dispense-as-written (DAW) code incorrectly
- Overbilling quantities
- Not retaining/providing the hard copy of prescriptions or a signature log/delivery manifest

Humana notifies pharmacies of its intent to audit and provides specific directions regarding the process. Humana’s on-site audits are conducted in a professional, Health Insurance Portability and Accountability Act (HIPAA)-compliant manner, with respect for patients and pharmacy staff. To access the Humana Pharmacy Audit Guide, please visit Humana.com/provider/pharmacy-resources, then select “Explore guides, forms and resources” found under “Pharmacy manuals and forms.”

LTC pharmacy audits

Humana has the right to audit an LTC pharmacy’s books, records, prescription files and signature logs for the purpose of verifying claims information. LTC pharmacies are required to have signed prescribers’ orders available for review for an audit. These orders may be in the form of traditional signed prescriptions, copies of signed prescribers’ orders from the member’s medical chart or other documentation that contains all required elements of a prescription.

Time to retrieve these documents will be considered as part of Humana’s audit requirements. LTC pharmacies should have a signature log or patient receipt, a delivery manifest, a copy of a medication administration record (MAR) that shows the prescription was administered, and the name and signature of the person who administered the medication, along with the date and time the medication was given. To access the Long-Term Care Pharmacy Documentation Guidelines, please visit Humana.com/Provider/Pharmacy-Resources, then select “Explore guides, forms and resources” found under “Pharmacy manuals and forms.”

Compliance program audits

Humana-contracted entities supporting Humana’s Medicaid products are subject to Compliance Program audits that may occur on an ad hoc basis. Humana notifies pharmacies of its intent to audit and provides specific directions regarding the process. If an audit identifies deficiencies, a correction
action plan is issued and Humana works with the pharmacy provider to ensure the deficiencies are remediated.

**Fraud, waste and abuse (FWA) and compliance program requirements**

**Policy statement**
Humana does not tolerate fraudulent activity or actions in violation of its standards of conduct or compliance policy (both available at [Humana.com/Fraud](http://Humana.com/Fraud)), as committed by Humana employees, contracted providers, those supporting their contractual obligations to Humana, members, customers, vendors, contractors and/or other business entities. Humana will investigate any suspected noncompliance or fraudulent activity and will report it to the appropriate regulatory, federal or state agencies for further action and investigation, as appropriate.

Humana is a Medicare Advantage organization, a Medicare Part D prescription drug plan sponsor and administrator of Medicaid products that have a pharmacy benefit. All such organizations are required to have a comprehensive plan to detect, correct and prevent fraud, waste and abuse, and Humana has such a plan.

**Training to combat FWA**
Every Humana-contracted entity supporting Humana’s Medicare and/or Medicaid products is responsible for:

- Providing FWA prevention, detection and correction training to its employees and contractors who administer, deliver or support federal healthcare program benefits or services; and
- Confirming adherence to the training obligation, as well as understanding of and compliance with the requirements outlined in the training materials.

**Material to use**
Your pharmacy may use its own material to meet the FWA training requirement or another training. However, Humana offers content on this topic in the following documents that together contain basic corresponding FWA content that your pharmacy may use to supplement your FWA training.


**Training records**
Humana-contracted entities must maintain FWA training records, including the completion date, attendance, topic, certificate of completion (if applicable) and test scores for all tests administered, for 11 years (or longer, if required by state law).

**Additional assurance**
Humana and CMS reserve the right to audit contracted pharmacies to assess their commitment to FWA training requirements, including requests CMS makes of Humana that require these pharmacies to provide corresponding documentation.
Requirement to report suspected or detected FWA and/or noncompliance

The pharmacy and all of its employees and subcontractors that support the pharmacy's contract with Humana must report suspected fraudulent or noncompliant activities to Humana. The person reporting information may relay concerns via multiple options.

The most expedient manner is by calling the Humana Special Investigation Unit (SIU) at 1-800-614-4126. This toll-free hotline is available 24 hours a day, and callers may remain anonymous. Humana takes great efforts to keep information confidential.

Those reporting suspected activities are protected from retaliation according to the whistleblower provision in 31 U.S.C. § 3730(h) of the False Claims Act.

Once SIU performs its initial investigation, it will refer the case to law enforcement and/or regulatory agencies, as appropriate. Additional information about SIU and Humana's efforts to address FWA can be found at Humana.com/Fraud.

The following reporting options are available:

**Phone:**
- Humana Special Investigations Hotline (voice messaging system):
  1-800-614-4126
- Humana Ethics Help Line:
  1-877-5-THE-KEY (1-877-584-3539)
Both of the phone methods are available 24 hours a day and allow callers to remain anonymous.*

**Fax:** 920-339-3613
**Email:** siureferrals@humana.com or ethics@humana.com

**Mail:**
Humana, Special Investigations Unit
1100 Employers Blvd.
Green Bay, WI 54344

**Ethics Help Line reporting website:**
ethicshelpline.com

*Humana requests that if a person reporting an ethics concern desires to remain anonymous, he/she provide enough information to allow Humana to investigate the issue.

**Note:** Confidential follow-up to check on the status of an investigation is available.

Prohibition against intimidation or retaliation

Humana has a zero-tolerance policy for the intimidation of or retaliation or retribution against any person who is aware of and, in good faith, reports suspected misconduct or participates in an investigation of it.

Disciplinary standards

Humana may take any or all of the following actions related to FWA or violations of Humana's standards of conduct:
- Oral or written warnings or reprimands
- Termination(s) of employment or contract
- Other measures that may be outlined in the contract
- Mandatory retraining
- Formal, written corrective action plan(s) tracked to closure
- Reporting of the conduct to the appropriate external entity(ies), such as CMS, a CMS designee, a state agency where Humana administers a Medicaid product or law enforcement agencies
Note: If an employee, manager, governing body member or any party with whom a pharmacy contracts to support a Humana contract, does not report suspected FWA or violations of Humana’s standards of conduct or compliance policy (available at Humana.com/provider/pharmacy-resources/manuals-forms), it is considered a violation of Humana requirements and is subject to any or all of the above disciplinary actions.

Every Humana-contracted entity must have disciplinary standards and take appropriate action upon discovery of FWA and violations of Humana’s standards of conduct or compliance policy or actions likely to lead to FWA or the above-referenced violations.

In addition, depending on the specifics of a case, CMS may elect to exclude anyone involved in an FWA violation from participating in federal procurement opportunities, including work in support of any contract Humana has with CMS.

Corresponding expectations
Pharmacy providers are also expected to:

• Widely publicize both the available Humana methods for reporting compliance and FWA concerns and the nonretaliation policy throughout their facilities (examples include: posters, mouse pads, key cards and other prominent displays); and
• Reinforce Humana’s policy of nonintimidation and nonretaliation.

Standards of conduct/ethics
Every Humana-contracted entity must routinely perform the following actions and, upon Humana’s request, provide certification of these actions:

• Employees, management, governing body members and those with whom the pharmacy contracts to support pharmacy’s contractual obligations to Humana’s Medicaid products are required to review and attest to compliance with the pharmacy’s standards of conduct document upon hire or contract and annually thereafter. If the contracted pharmacy does not have its own written standards of conduct or if those standards are not materially similar to Humana’s standards of conduct, then it may use Humana’s standards of conduct. A copy can be accessed, printed and downloaded by visiting apps.Humana.com/marketing/documents.asp?file=1112774.
• Review the Office of Inspector General (OIG) and General Services Administration (GSA) exclusion lists for all new employees, management, governing body members and contracted individuals or entities, prior to hire/contract and monthly thereafter to verify those who assist in the administration or delivery of federal healthcare program benefits in support of a Humana contract are not included on such lists. This includes retaining evidence of the exclusion screening for 11 years (or longer, as required by state law).
• Remove any person identified on an exclusion list above from any work related directly or indirectly to Humana’s support of any federal healthcare program, such as Medicare, or a state-administered program like Medicaid.
• Take appropriate corrective actions for standards of conduct violations and, when fraud, waste or abuse is involved, report findings to Humana’s Special Investigation Unit at 1-800-614-4126.

CMS and Humana’s Medicaid contracts mandate that all those contracted with Humana or Humana subsidiaries—and those they employ or contract, to provide or support healthcare services for Humana’s Medicare, Medicaid and/or dual Medicare-Medicaid members, including pharmacies—complete compliance program requirements.
Compliance program requirements

The information below is provided to help the pharmacy and those with whom they contract or employ to support Humana business confirm their compliance programs have the necessary elements to be effective.

Humana’s compliance program requirements for contracted pharmacies also include, but are not limited to:

1. **Oversight:** Monitoring and auditing the compliance of employees and subcontractors that provide services and/or perform any support functions related to administrative or healthcare services provided to a member of a Humana Medicare Advantage plan, Medicare prescription drug plan or a Medicaid plan administered by Humana. This is conducted from both an operational perspective and through exclusion screening of all individuals and contracted entities that support Humana Medicare and/or Medicaid products.

2. **Offshore subcontracting notification:** Obtaining prior approval from Humana for relationships that would support the pharmacy provider’s contractual obligations to Humana. In addition, note that Humana must notify CMS of any location outside of the United States or a United States territory that receives, processes, transfers, stores or accesses Medicare member protected health information in oral, written or electronic form. Therefore, Humana must be notified immediately of prospective offshore arrangements, including desired changes or additions to existing relationships or offshore locations. No offshore contract that would support the pharmacy provider’s contractual obligations to Humana should be executed until Humana has been notified.

3. **Establishment, documentation and communication of effective compliance policies:** Having policies and procedures in place for preventing and detecting suspected FWA, then correcting and reporting identified instances, as well as other aspects of noncompliance, including, but not limited to:
   a. Requiring employees and subcontractors to report suspected and/or detected FWA and suspected violations of Humana's compliance policy or standards of conduct (those documents are available at Humana.com/provider/pharmacy-resources/manuals-forms). Any validated instances of ethical, compliance or FWA violations must be reported to Humana.
   b. Safeguarding Humana's confidential and proprietary information, as well as plan members’ protected personal and health information.
   c. Providing accurate and timely information/data in the regular course of business.
   d. Monitoring and auditing activities.
   e. Upholding disciplinary standards.

4. **Training:** Ensuring that all required compliance program training is completed not simply by the compliance contact at the pharmacy, but also by those supporting the pharmacy’s contractual obligations to Humana. Where applicable, operational training must be conducted. This includes having a tracking method in place to provide evidence of these efforts upon request; e.g., who was trained, when, how and with what material(s).

5. **Cooperation:** Cooperating fully with Humana and/or government entity investigations of an alleged, suspected or detected violation of this manual, Humana policies and procedures, applicable state or federal laws or regulations and/or remedial actions.

6. **Communication:** Publicizing methods for reporting suspected violations of Humana policies and government regulations, as well as corresponding disciplinary standards to employees, volunteers, board members and subcontractors.

7. **Disciplinary standards:** Having established disciplinary standards in place that are carried out when violations are committed by the pharmacy provider, its employees or those it contracts to support obligations to Humana.
8. **Assurance:** Complying with Humana requests to provide assurance related to the pharmacy entity’s compliance program.

For an overview of the seven elements of an effective compliance program, please refer to Humana’s compliance policy at apps.humana.com/marketing/documents.asp?file=1827514.

**Frequently asked questions**
Humana makes a guidance document that includes frequently asked questions (apps.humana.com/marketing/documents.asp?file=2621125) publicly available online with additional information regarding the compliance requirements.

Further compliance program requirements information for pharmacies supporting Humana’s Medicare and/or Medicaid products can be found in Humana’s compliance policy at apps.humana.com/marketing/documents.asp?file=1827514.

For training questions that are not addressed in this manual, please send an email to HumanaPharmacyCompliance@humana.com.

**When a compliance attestation is required**
Humana reserves the right to request documentation as assurance that certain compliance program requirements and training are in place. However, Humana only requires a compliance attestation when it pertains to Medicaid training for pharmacies supporting one or more plans administered by Humana for Medicaid beneficiaries. Compliance education material is refreshed at least each calendar year to assist pharmacies in meeting these and related requirements. Pharmacies are required to complete the Medicaid training attestation annually and must submit it within 30 days of notification each calendar year. Corresponding instructions are listed in the compliance requirements FAQ for pharmacies at apps.humana.com/marketing/documents.asp?file=2621125.

**Required compliance program training**
The following must be provided to those contracted or employed to support a Humana contract for a Medicare and/or Medicaid product that Humana is ultimately responsible for administering:

- Compliance policy that outlines compliance program requirements;
- Standard of conduct; and
- Training on understanding and addressing fraud, waste and abuse (FWA) using your pharmacy’s material or another training.

Humana documents, or documents that are materially similar, may be used to meet the compliance policy and standards of conduct requirements. These materials are available at Humana.com/provider/pharmacy-resources/manuals-forms.

Additionally, Humana’s government contracts for plans administered for dual Medicare-Medicaid beneficiaries and/or Medicaid beneficiaries require that all pharmacies participating in any of those plans, including those contracted with Humana subsidiaries, complete additional training that may cover any or all of the following topics:*  
- Cultural competency;
- Health, safety and welfare of plan members;
- Medicaid pharmacy provider; and
- Humana orientation for pharmacies
These above-listed documents are available at Humana.com/provider/pharmacy-resources/manuals-forms.

Instructions on how to provide confirmation of adherence to these requirements, when necessary and applicable, are listed in the Notification of Compliance Requirement document found at the above website.

Please note that as requirements of Humana may change, Humana reserves the right to require additional or different compliance program training or components, although it strives not to make midyear changes.

*The number of Medicaid trainings may vary by state where Humana offers these plans and may include state-specific or pharmacy-specific versions. Humana clarifies variances through the combination of information outlined in its Medicaid training attestation form that applicable pharmacies must be complete and return to Humana via the training documents at the above website.

**Humana.com instructions**
The document at apps.humana.com/marketing/documents.asp?file=1827566 covers how to:
- Complete the compliance requirements at Humana.com;
- Register at Humana.com;
- Create a new user; and
- Assign the compliance business function to another user, and update an organization’s tax identification number (TIN).

**Humana pharmacy credentialing**
Humana requires all network pharmacies to be credentialed and as well as to be recredentialed every three years. The recredentialing request is sent to the pharmacy via fax and requires the pharmacy to return a recredentialing application, which includes:
- Pharmacy state licensure information
- Pharmacy U.S. Drug Enforcement Agency (DEA) licensure information
- No sanction attestation
- Copy of current professional liability insurance (PLI) coverage that meets or exceeds a minimum requirement of $1 million in aggregate

Pharmacies that do not meet Humana’s required standards, which includes having an active state Medicaid ID and not being listed on the applicable state exclusion list or on the federal exclusion lists, will be removed from Humana’s pharmacy network.

**Conflicts of interest**
All entities and individuals supporting Humana are required to avoid conflicts of interest. Pharmacies should never offer or provide, directly or indirectly, anything of value—including cash, bribes or kickbacks—to any Humana employee, contractor, representative, agent or customer or any government official in connection with any Humana Solutions procurement, transaction or business dealing. This prohibition includes, but is not limited to, a pharmacy provider offering or providing consulting, employment or similar positions to any Humana employee involved with Humana procurement or to that employee’s family members or significant others.

Pharmacies are required to obtain and sign a conflict of interest statement from all employees and subcontractors within 90 days of hire or contract and annually thereafter. This statement certifies that the employee or downstream entity is free from any conflict of interest for administering or delivering federal healthcare program benefits or services.
All pharmacies are required to review potential conflicts of interest and either remove the conflict or, if appropriate, request approval from Humana to continue work despite the conflict.

Humana reserves the right to obtain certifications of the absence of conflicts of interest from all providers and to require that certain conflicts be removed or that the applicable employee(s) and/or downstream entities be removed from supporting Humana.

Pharmacies are prohibited from having any financial relationship relating to the delivery of or billing for items or services covered under a federal healthcare program that:

• Would violate the federal Stark Law, 42 U.S.C. § 1395nn, if items or services delivered in connection with the relationship were billed to a federal healthcare program, or that would violate comparable state law;
• Would violate the federal Anti-Kickback Statute, 42 U.S.C. § 1320a-7b, if items or services delivered in connection with the relationship were billed to a federal healthcare program, or that would violate comparable state law; or
• In the judgment of Humana, could reasonably be expected to influence a provider to utilize or bill for items or services covered under a federal healthcare program in a manner that is inconsistent with professional standards or norms in the local community.

Pharmacies are subject to termination by Humana for violating this prohibition. Humana reserves the right to request information and data to ascertain ongoing compliance with these provisions.

**Complaint system**

**Pricing dispute process**

Network pharmacies have the right to submit a request to appeal, investigate or dispute the maximum allowable cost (MAC) reimbursement amount to Humana within 60 calendar days of the initial claim. The pharmacy may submit its request to appeal, investigate or dispute maximum allowable cost pricing in writing to Humana by fax 1-855-381-1332 or email PharmacyPricingReview@humana.com. The pharmacy may contact Humana at 1-888-204-8349 to speak to a representative regarding its request. All of the following must be included in the request:

- Pharmacy name
- Pharmacy address
- Pharmacy NPI
- Drug name
- Drug strength
- Drug NDC
- Date of initial fill
- Quantity of fill
- Relevant documentation that supports the MAC is below the cost available to the pharmacy
- Any other supporting documentation as needed

Humana will respond to the network pharmacy’s request within five business days of receipt by Humana. In the event the MAC appeal is denied, Humana will provide the reason for the denial and will identify a national drug code(s) for the drug product at or below the current MAC price. If the MAC request is approved, Humana will make an adjustment to the MAC price to the date of the disputed claim(s). The pharmacy is responsible for the resubmission of the claim and for collecting and/or
refunding any copayment amount.

Please note: Timelines may vary state to state and are subject to change.

Pharmacy MAC list location
When network pharmacies need to locate the current MAC list, they can follow the steps below at Humana.com. They will see the screen below. Click the “Sign in” located on the top right corner of the screen.

The pharmacy will then enter the username and password that it set up at the time it contracted with Humana. If the pharmacy is unsure of its username and password, it should contact the pharmacy contracting team at PharmacyContracting@humana.com and ask to have the pharmacy's web portal account reset.
For the current MAC list applicable to the NPI the pharmacy used to register its account, which includes recent updates, click on the blue “MAC Pricing” link on the right side of the screen.

Once the pharmacy clicks that link, the page shown below opens in a new tab. This is the current MAC list that is applicable to the NPI that the pharmacy used to register its account.
To save this MAC list as a PDF, hover the cursor over the bottom middle part of the screen and click on the disk icon on the far left of the gray pop-up box, then follow the prompt.

As you scroll through the listing (via web or PDF), you will notice that some lines have been highlighted in yellow (see below). This indicates that the drug’s pricing was changed as a result of a MAC appeal. The highlighted row is the updated price that was the result of an appeal.

**Pricing review form location**
A network pharmacy with a pricing dispute should follow the steps below to submit a pricing review form to Humana. Go to Humana.com/provider/pharmacy-resources/manuals-forms, then select “Network request forms” under “Manuals and forms.”
The pharmacy must complete all fields in the attached form and return it to Humana via fax at 1-855-381-1332 or email PharmacyPricingReview@humana.com to initiate the dispute process.

When the form is received, Humana will begin the research process and inform the pharmacy via fax or email of the results of the dispute within five business days from the date the form was received.

### Pharmacy’s process for filing a complaint

#### Pharmacy complaints and disputes

**SS&C Health system issues**
All pharmacies contracted with Humana are encouraged to contact the SS&C Health help desk at 1-800-865-8715 for any question or complaint related to a system issue or claims transaction. SS&C has a dedicated telephone support unit that provides guidance for calls related to pharmacy claims. All issues that cannot be addressed or resolved by SS&C are forwarded to the Pharmacy Networks Department for research and resolution.

**Pharmacy initiative inquiries**
Humana has a dedicated pharmacy telephone support unit that provides support for pharmacy inquiries and complaints related to specific corporate pharmacy management initiatives. Any specific initiative question that cannot be answered by the HCPR telephone support unit is forwarded to the Pharmacy Networks Department for research and resolution at 1-888-204-8349.

#### Enrollee complaint system

The section below is taken from Humana’s enrollee grievance and appeal procedure as set forth in the Humana Member Handbook. This information is provided to you so that you may assist Humana enrollees in this process, if they request your assistance. Please contact your contracting representative if you have questions about this process.

Humana has representatives who handle complaints, which include all enrollee grievances and appeals. A special set of records is kept with the reason, date and results. Humana keeps these records in the central office.

**Kentucky Medicaid enrollee grievances**
Medicaid enrollees can file grievance at any time. Grievances can be submitted using either method provided below.
The enrollee can submit written grievances to:

- **Humana Medical Plan Inc.**
  P.O. Box 14546
  Lexington, KY 40512-4546
- **Fax:** 1-800-949-2961

For verbal grievances, the enrollee can call Customer Service at 1-800-477-6931 (TTY: 711). We are available Monday – Friday, from 8 a.m. – 8 p.m., Eastern time.

**Kentucky Medicaid enrollee appeals**

The enrollee, prescriber or enrollee representative may submit an appeal in writing within 60 calendar days of the date of the denial notice received from Humana. Options for submitting the appeal (redetermination request):

- Download a copy of the appeal form provided on [Humana.com](http://Humana.com) and either fax or mail it to Humana:
  Humana Medical Plan Inc.
  P.O. Box 14546
  Lexington, KY 40512-4546.
  Include your name, address, Humana ID number, reason for the appeal and any supporting documents.
- For expedited requests, you can fax to 1-855-336-6220.

If the enrollee is unable to write an appeal, oral appeals are accepted.

- Medicaid enrollees may ask for an appeal by calling Customer Service 1-800-477-6931 (TTY: 711). We are available Monday – Friday, from 8 a.m. – 8 p.m., Eastern time.
- Using their MyHumana login, Medicare Part D enrollees can file online requests through [Humana.com](http://apps.humana.com/webdetermination/authentication.aspx?sysid=f1ed49c9-9f67-489e-ac80-ee54c3575570)

For all enrollees, the physician, prescriber or someone else can make the appeal in behalf of the enrollee. The Appointment of Representative form must be completed. This form provides permission for another person to act for the enrollee.

To get an Appointment of Representative form, the enrollee can call Customer Care and ask for one or Humana’s website at [Humana.com/individual-and-family-support/tools/member-forms](http://Humana.com/individual-and-family-support/tools/member-forms).

If the appeal comes from someone besides the enrollee, we usually must receive the completed Appointment of Representative form, or other appropriate documentation such as Power of Attorney (POA), before we can review the appeal.

**Resolution for grievance and appeals**

We will investigate the enrollee’s appeal and inform them of our decision. If the enrollee has questions concerning their grievance or appeal, direct him or her to the Member Handbook or contact Humana using the number on the back of their ID card.
Medicare’s Limited Income NET Program (LINET)

Medicare’s Limited Income NET Program, or LINET, is a CMS demonstration program administered by Humana that provides temporary prescription coverage for Medicare beneficiaries who qualify for low-income subsidy (LIS), sometimes called “Extra Help,” and have no prescription coverage.

To qualify for LINET, the beneficiary must be eligible for Medicare Part D and be eligible for one of the following:

- Medicaid
- LIS
- Supplemental Security Income (SSI)
- Medicare Savings Program (MSP)

Beneficiaries who are unsure if they qualify for a low-income program can be referred to Kentucky health insurance assistance programs (SHIPs) for assistance. SHIPs counselors can be reached at 1-877-839-2675.

Enrollment methods

Beneficiaries are enrolled in LINET in one of three ways:

- **Auto-enrollment**: Auto-enrolled by CMS; beneficiary will receive a temporary prescription card with instructions
- **Point of sale**: Immediate enrollment at the pharmacy counter through claim submission
- **Direct member reimbursement**: Upon beneficiary’s submission of a request for reimbursement for out-of-pocket expenses

Confirming eligibility

LINET eligibility can be confirmed by submitting an E1 query (Eligibility Transaction).

### E1 Query

<table>
<thead>
<tr>
<th>E1 results</th>
<th>Status</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contract ID X0001</td>
<td>Patient currently enrolled in LINET</td>
<td>Submit claim to LINET using 4 Rx data</td>
</tr>
<tr>
<td>No plan information LICS/LIS = YES</td>
<td>Patient may be eligible for LINET—not yet enrolled</td>
<td>Submit claim to LINET using 4 Rx data</td>
</tr>
<tr>
<td>No plan information LICS/LIS = NO</td>
<td>Patient not eligible for LINET</td>
<td>Refer patient to 1-800-MEDICARE</td>
</tr>
<tr>
<td>Plan BIN/PCN #</td>
<td>Patient is enrolled in a Part D plan</td>
<td>Submit claim to plan using 4 Rx data</td>
</tr>
<tr>
<td>Plan phone number</td>
<td>Patient is enrolled in a Part D plan/issues</td>
<td>Call phone number provided</td>
</tr>
</tbody>
</table>

**How to submit an LINET claim**

Electronic pharmacy claims should be submitted with the following information:

<table>
<thead>
<tr>
<th>BIN</th>
<th>PCN</th>
<th>Group ID</th>
<th>Cardholder ID</th>
<th>Optional field: Patient ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>015599</td>
<td>05440000</td>
<td>May be left blank</td>
<td>Medicare claim number or Medicare number</td>
<td>Medicaid or Social Security number</td>
</tr>
</tbody>
</table>
What if my patient paid out of pocket for medications?

Beneficiaries who paid out of pocket for medications may be eligible for reimbursement. The beneficiary can take the following steps to request reimbursement:

1. Complete the LINET direct member reimbursement form (DMR) located in the LINET “Welcome Letter” or found online at apps.Humana.com/marketing/documents.asp?file=2830217.
2. Attach a copy of receipt or printout from the pharmacy showing member payment.
3. Mail or fax completed form and receipt information to:
   Medicare’s Limited Income NET Program
   P.O. Box 14310
   Lexington, KY 40512-14310
   Fax: 1-877-210-5592

For more information, visit Humana.com/LINET or call the LINET help desk at 1-800-783-1307.