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Introduction

Dear pharmacy,

Humana appreciates your role in delivering quality pharmacy services to our members. This manual pertains exclusively to Florida members enrolled with Humana in a state-managed Medicaid plan and is intended to assist your pharmacy staff in processing prescription claims for those members.

Medicaid

Medicaid is a program run by federal and state governments that helps people with limited income pay for medical costs and, if qualified, long-term services and support, 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.

Florida Medicaid Plan

Florida has offered Medicaid services since 1970. Medicaid provides healthcare coverage for income-eligible children, seniors, disabled adults and pregnant women. It is funded by both the state and federal governments and includes both capitated health plans as well as fee-for-service coverage. The Agency for Health Care Administration (AHCA) is responsible for administering the Medicaid program and will administer contracts, monitor health plan performance and provide oversight in all aspects of health plan operations. The state has sole authority for determining eligibility for Medicaid and whether Medicaid recipients are required to enroll in, may volunteer to enroll in, may not enroll in a Medicaid health plan or are subject to annual enrollment.

The 2011 Florida Legislature passed House Bill 7107 (creating part IV of Chapter 409, F.S.) to establish the Florida Medicaid program as a statewide, integrated managed care program for all covered services. This program is referred to as statewide Medicaid managed care (SMMC).

In entering into a contract with AHCA to provide services to Medicaid beneficiaries, Humana has agreed to comply with the provisions of the Medicaid contract (the “contract”) as well as with all applicable agency rules relating to the contract and the applicable provisions in the Florida Medicaid handbooks (“handbooks”).

Humana’s obligations under the contract include, but are not limited to:

- Maintaining a quality improvement program aimed at improving the quality of member outcomes
- Maintaining quality management and utilization management programs
- Furnishing AHCA with data as required under the contract and as may be required in additional ad hoc requests
- Collecting and submitting encounter data in the format and in the time frames specified by AHCA

In signing this contract, Humana has been authorized to take whatever steps are necessary to ensure
that providers are recognized by the state Medicaid program, including its Choice Counseling/enrollment broker contractor(s) as a participating provider of Humana. In addition, Humana has the responsibility to ensure providers’ submission of encounter data is accepted by the Florida Medicaid Management Information Systems (MMIS) and/or the state’s encounter data warehouse.

The Florida Medicaid program is implementing a new system through which Medicaid enrollees will receive services. This program is called the Statewide Medicaid Managed Care Managed Medical Assistance program. The Managed Medical Assistance (MMA) program is composed of several types of managed care plans:

- Health maintenance organizations
- Provider service networks
- Children’s Medical Services Network

Most Medicaid recipients must enroll in the MMA program.

The following individuals are NOT required to enroll, although they may enroll if they choose to.

- Medicaid recipients who have other creditable healthcare coverage, excluding Medicare
- Persons eligible for refugee assistance
- Medicaid recipients who are residents of a developmental disability center
- Medicaid recipients enrolled in the developmental disabilities home- and community-based services
- Waiver or Medicaid recipients waiting for waiver services

To be a participating provider, you must be a Medicaid-registered provider who provides services in one of the following regions:

- Region 1: Escambia, Okaloosa, Santa Rosa and Walton counties
- Region 2: Bay, Calhoun, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Taylor, Wakulla and Washington counties
- Region 3: Alachua, Bradford, Citrus, Columbia, Dixie, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Putnam, Sumter, Suwannee and Union counties
- Region 4: Baker, Clay, Duval, Flagler, Nassau, St. Johns and Volusia counties
- Region 5: Pasco and Pinellas counties
- Region 6: Hardee, Highlands, Hillsborough, Manatee and Polk counties
- Region 7: Brevard, Orange, Osceola and Seminole counties
- Region 8: Charlotte, Collier, DeSoto, Glades, Hendry, Lee and Sarasota counties
- Region 9: Indian River, Martin, Okeechobee, Palm Beach and St. Lucie counties
- Region 10: Broward County
- Region 11: Miami-Dade and Monroe counties

Florida’s MMA program is designed to implement a statewide-managed care delivery system that will improve outcomes, improve consumer satisfaction, and reduce and control costs.

The Florida MMA program will focus on four key objectives to support successful implementation:

1. Preserving continuity of care
2. Requiring sufficient and accurate networks under contract and taking patients, allowing for an informed choice of plans for recipients and the ability to make appointments
3. Paying providers fully and promptly to preclude provider cash flow or payroll issues and to give providers ample opportunity to learn and understand the plan’s prior authorization procedures
4. Coordinating with the Choice Counseling Call Center and website operated by the agency’s contracted enrollment broker
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 Humana members’ 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>Details</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](https://www.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](https://www.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                                                                           |
Rights and responsibilities

Pharmacy responsibilities

Participating pharmacies are required to provide covered services in accordance with applicable laws, regulations and requirements as set forth by AHCA, including:

1. The pharmacy shall comply with all applicable aspects of the Hernandez Settlement Agreement (“HSA”). An HSA situation arises when a member who is a Medicaid recipient attempts to fill a prescription at a participating pharmacy location and is unable to receive his or her prescription as a result of:
   (1) An unreasonable delay in filling the prescription;
   (2) A denial of the prescription;
   (3) The reduction of a prescribed good or service; and/or
   (4) The termination of a prescription.

2. The pharmacy shall post signs in both English and Spanish in a conspicuous location advising members who are Medicaid recipients that if a claim for covered drugs is initially rejected, provider shall provide pamphlets in English and Spanish that will inform the member of the reason the claim was rejected and the phone number to the HSA ombudsman. Pamphlets and signs are available at: [http://ahca.myflorida.com/Medicaid/Prescribed_Drug/multi_source.shtml](http://ahca.myflorida.com/Medicaid/Prescribed_Drug/multi_source.shtml).

3. If the denied prescription is for a timely refill, and it is otherwise valid, the pharmacy must provide the member with a three-day temporary supply unless the attempt to refill is early; the rejection is due to an error that only the pharmacist can correct; there are clinical issues that must be resolved; the individual is not eligible for Medicaid; or there would be a medical danger, in the pharmacist’s professional judgment, if a temporary supply is dispensed.

4. If the pharmacy fails any aspect of an HSA survey, the pharmacy agrees to undergo mandatory training within six months and then be reevaluated within one month of the HSA training to ensure that the pharmacy complies with the HSA.

Member rights and responsibilities

Member rights

1. A member has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity and with protection of his or her need for privacy.

2. A member has the right to a prompt and reasonable response to questions and requests.

3. A member has the right to know who is providing medical services and who is responsible for his or her care.

4. A member has the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the member’s condition and ability to understand.

5. A member has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.

6. A member has the right to know what rules and regulations apply to his or her conduct.

---


2 Letter from Christine Osterlund, Deputy Secretary for Medicaid Operations, Florida Agency for Health Care Administration to all Medicaid pharmacy providers. (undated)

7. A member has privacy rights under the Health Insurance Portability and Accountability Act (HIPAA). This is a federal law that protects a member’s health information. These rights are important for a member to know. The member can exercise these rights, ask questions about them and file a complaint if the member thinks their rights are being denied or their health information isn’t being protected.

8. A member has the right to be given by the healthcare provider information concerning diagnosis, planned course of treatment, alternatives, risks and prognosis.

9. A member has the right to participate in decisions regarding his or her healthcare, including the right to refuse treatment except as otherwise provided by law.

10. A member has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.

11. A member who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the healthcare provider or healthcare facility accepts the Medicare assignment rate.

12. A member has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.

13. A member has the right to receive a copy of a reasonably clear and understandable itemized bill and, upon request, to have the charges explained.

14. A member has the right to request and receive a copy of his or her medical records, and request that they be amended or corrected.

15. A member has the right to be furnished healthcare services in accordance with federal and state regulations.

16. A member has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap or source of payment.

17. A member has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.

18. A member has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.

19. A member has the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.

20. The state must ensure that each enrollee is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the health plan and its providers or the state agency treat the enrollee.

21. A member has the right to express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the healthcare provider or healthcare facility which served the member and to the appropriate state licensing agency.

**Member responsibilities**

1. A member is responsible for providing to the healthcare provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications and other matters relating to his or her health.

2. A member is responsible for reporting unexpected changes in his or her condition to the healthcare provider.

3. A member is responsible for reporting to the healthcare provider whether he or she understands a possible course of action and what is expected of him or her.

4. A member is responsible for following the treatment plan recommended by the healthcare provider.

5. A member is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the healthcare provider or healthcare facility.
6. A member is responsible for his or her actions if he or she refuses treatment or does not follow the healthcare provider’s instructions.

7. A member is responsible for ensuring that the financial obligations of his or her healthcare are fulfilled as promptly as possible.

8. A member is responsible for following healthcare facility rules and regulations affecting patient care and conduct.

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 FL MMA English

Card for a member with FL MMA Spanish

Card for a member with FL COMP English
Card for a member with FL COMP Spanish

Note: These images meet 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 provided 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 Florida 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 Florida:
- 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 the symptomatic relief of cough or colds

Additional information is available at www.medicaid.gov/medicaid/prescription-drugs/excluded-drug-coverage/index.html.
Drug coverage

Drug Lists
Humana Medical Plan provides coverage of medically necessary medications, both prescription and select over-the-counter drugs, when prescribed by licensed providers in the state. Humana administers the Agency for Health Care Administration’s (AHCA) Preferred Drug List (PDL), which indicates the preferred and nonpreferred status of covered drugs on the enrollee’s benefit. The PDL also 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 Florida Medicaid eligible members, go to Humana.com/DrugLists.

For the Florida MMA program, all drugs are limited to a 34-day supply with the exception of certain maintenance medications that are allowed a 100-day supply. For a list of the 100-day supply maintenance medications, visit: https://ahca.myflorida.com/medicaid/Prescribed_Drug/information.shtml. Select “100 Day Supply Maintenance Meds.”

For the Florida MMA program, some services are excluded. This includes hemophilia products (prescriber factor replacement products) to members diagnosed with hemophilia through AHCA’s hemophilia disease management program. For more information, visit: https://ahca.myflorida.com/medicaid/Policy_and_Quality/Quality/fee-for-service/hemophilia.shtml.

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.
- **Step therapy:** Plans that are subject to step therapy as a component of Humana’s standard drug utilization (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 the Humana Clinical Pharmacy Review (HCPR) team.

Please note: Utilization management criteria can be found at https://ahca.myflorida.com/Medicaid/Prescribed_Drug/drug_criteria.shtml.

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 or submit the request electronically by going to 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 member or prescriber must initiate the request.

The prescriber quick reference guide can be found at apps.humana.com/marketing/documents.asp?file=1372774.

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

**Beneficiaries eligible for the low-income subsidy (LIS)**

All members enrolled in a dual demonstration should be eligible for, and have, Medicare's low-income subsidy (LIS). Medicare's low-income subsidy (also known as “Extra Help”) assists people who have limited income and resources with their prescription drug costs. People who qualify for this program receive assistance paying for premiums, deductibles or cost-shares related to their Medicare drug plans. Some people automatically qualify for this subsidy and do not need to apply; Medicare mails a letter to these individuals. The pharmacist may use the pharmacist self-service center website (registration required; see page 6) to view the member's LIS status.

Sometimes a member believes he or she is qualified for the low-income subsidy and is paying an incorrect cost-sharing amount for his or her prescription. To address these situations, Humana has established a process that allows the member to provide the best-available evidence (BAE) of his or her proper cost-share level. At the pharmacy, a member can show proof of Extra Help by providing any of the following:

- A copy of his or her Medicaid card with his or her name and an eligibility date that falls between July 1 and Dec. 31 of the previous calendar year
- One of the following letters from the Social Security Administration (SSA) showing Extra Help status: “Important Information” letter, award letter, “Notice of Change” or “Notice of Action”
- A copy of a state document that confirms active Medicaid status and is dated July 1 through Dec. 31 of the previous calendar year
- A screen print from the state Medicaid system showing Medicaid status on a date that falls between July 1 and Dec. 31 of the previous calendar year
- A printout from the state electronic enrollment file or any other state documentation showing Medicaid status on a date that falls between July 1 and Dec. 31 of the previous calendar year
- A letter from SSA showing the individual receives Supplemental Security Income
- A remittance from a medical or nursing facility showing Medicaid payment for a full calendar month of care for the individual between July 1 and Dec. 31 of the previous calendar year
- A copy of a state document that confirms Medicaid payment on behalf of the individual to a medical or nursing facility for a full calendar month between July 1 and Dec. 31 of the previous calendar year
- A screen print from the state Medicaid system showing the individual’s institutional status based on at least a full calendar month's stay for Medicaid payment purposes; the stay must fall between July 1 and Dec. 31 of the previous calendar year

Please note this proof must be confirmed by a pharmacist and must show the individual's eligibility took effect on or before the date the prescription was filled. If the member is not found in SS&C Health (formerly known as DST Pharmacy Solutions), the pharmacist may contact the Humana pharmacy help desk at 1-800-865-8715 and select option 2 to add a recently enrolled Medicare Part D member to the SS&C Health claim-processing system using the quick-activation process. The LIS also can be added
during the quick-activation process, if applicable.

To initiate a quick activation, the following information will be needed:

- Member first name and last name
- Member address (including city, state and ZIP code)
- Member telephone number
- Member date of birth
- Member gender
- Medicare ID number (nine digits and one alpha character)
- Plan name (Humana Gold Plus Integrated, A Commonwealth Coordinated Care Plan; and Humana Gold Plus Integrated [Medicare-Medicaid Plan])
- Plan option/Contract-plan benefit package (e.g., H0336_001)

If the pharmacist can verify proof of Extra Help from the member, the member is showing eligible in SS&C Health and a call has been made to Humana to have the member’s Medicare LIS status updated, the member must follow up by mailing the proof to Humana at the following address within 30 days:

Humana
P.O. Box 14168
Lexington, KY 40512-4168

The member may contact Humana Customer Care at 1-800-281-6918, 8 a.m. – 8 p.m., Eastern time, for additional assistance.

If a member wishes to apply for the Medicare low-income subsidy, he or she should contact SSA at 1-800-772-1213, Monday – Friday, 7 a.m. – 7 p.m.

**Best available evidence for long-term care residents**
Pharmacists who have evidence that the cost-share responsibility of a Humana Medicare-Medicaid member residing in an LTC facility should be different from that shown on adjudicated claims may provide applicable evidence to Humana regarding the member’s LIS status.

Inquiries regarding member LIS levels may be directed to Humana at 1-800-281-6918. Pharmacists who have evidence that the member cost-share on claims for a Medicare-Medicaid member are incorrect and should reflect a different LIS level are asked to call this number as well. Member-specific LIS levels may be viewed on the pharmacist self-service center website (registration required; see page 6).

**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.

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>FL Medicaid</td>
<td>610649</td>
<td>03190000</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>
</tbody>
</table>
| 5     | 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.

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.

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


• **Subrogation** claims, which have 36 months 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 § 423.505(b)(20), long-term-care (LTC) pharmacy claims must be submitted for eligible persons no later than 90 days from the date of service. 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: [http://apps.humana.com/marketing/documents.asp?file=2322905](http://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](http://www.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](http://www.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>Nonmatched 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, is not found or is expired.</td>
<td>Prescriber ID not active. If validated, submit applicable SCC.</td>
<td>42</td>
</tr>
<tr>
<td>NCPDP error code</td>
<td>NCPDP error code description</td>
<td>Free-form messaging</td>
<td>Applicable SCC</td>
</tr>
<tr>
<td>-----------------</td>
<td>-----------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------</td>
<td>---------------</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 supported.</td>
<td>Prescriber Type 1 required. Foreign prescriber ID not allowed.</td>
<td>N/A</td>
</tr>
<tr>
<td>619</td>
<td>Prescriber Type 1 NPI required.</td>
<td>Type 2 NPI submitted—Type 1 NPI required (for Humana Medical Plan) and claim not covered due to Medicare Part D active valid prescriber NPI requirement (for Part D claims).</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 also must 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 must comply with all applicable laws, rules and regulations.

Florida Medicaid MMA 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 AHCA preferred brand drugs.
## 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>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>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</td>
</tr>
<tr>
<td><strong>88: DUR reject error</strong></td>
<td><strong>This drug may duplicate current patient therapy</strong></td>
<td><strong>TD: Therapeutic duplication</strong></td>
<td><strong>MO: Prescriber consulted</strong></td>
<td></td>
</tr>
<tr>
<td>--------------------------</td>
<td>-----------------------------------------------</td>
<td>-------------------------------</td>
<td>---------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>PE: Patient educated</strong></td>
<td><strong>PO: Patient consulted</strong></td>
<td><strong>RO: Pharmacist consulted other source</strong></td>
<td><strong>SW: Literature search/review</strong></td>
<td></td>
</tr>
<tr>
<td><strong>TH: Therapeutic product interchange</strong></td>
<td><strong>1A: Filled as is, false positive</strong></td>
<td><strong>1B: Filled prescription as is</strong></td>
<td><strong>1D: Filled with different directions</strong></td>
<td></td>
</tr>
<tr>
<td><strong>1F: Filled with different quantity</strong></td>
<td><strong>1G: Filled with prescriber approval</strong></td>
<td><strong>4A: Prescribed with acknowledgments</strong></td>
<td><strong>4B: Filled, palliative care</strong></td>
<td></td>
</tr>
<tr>
<td><strong>4D: Filled, cancer treatment</strong></td>
<td><strong>1B: Filled prescription as is</strong></td>
<td><strong>1D: Filled with different directions</strong></td>
<td><strong>1F: Filled with different quantity</strong></td>
<td></td>
</tr>
<tr>
<td><strong>1G: Filled with prescriber approval</strong></td>
<td><strong>4A: Prescribed with acknowledgments</strong></td>
<td><strong>4B: Filled, palliative care</strong></td>
<td><strong>4D: Filled, cancer treatment</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>AG: Exceeds opioid initial fill limits</strong></th>
<th><strong>925: Initial fill days’ supply exceeds limit</strong></th>
<th><strong>Days’ supply limitation for product/service</strong></th>
<th><strong>MX: Excessive duration</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MO: Prescriber consulted</strong></td>
<td><strong>PH: Patient medication history</strong></td>
<td><strong>RO: Pharmacist consulted other source</strong></td>
<td><strong>4B: Filled, palliative care</strong></td>
</tr>
<tr>
<td><strong>4D: Filled, cancer treatment</strong></td>
<td><strong>4J: Dispensed, patient is not opioid naive</strong></td>
<td><strong>4D: Filled, cancer treatment</strong></td>
<td><strong>4J: Dispensed, patient is not opioid naive</strong></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 (42Ø-DK) field with a value of 20, or the most current NCPDP standard for identification of 340B medications. For Florida Medicaid providers: The value of 20 along with a value of nine should be used for the submission clarification code (42Ø-DK) field. 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 Florida 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 pharmacy provider 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.

Please visit the following link for information on current guidance on edits and overrides: Humana.com/provider/pharmacy-resources/manuals-forms. See the “Controlled substances” tab under “Manuals and forms.”

**Controlled substance limitations for Florida Medicaid MMA**

**CII−CV edits**
In an effort to reduce doctor-shopping behaviors, an edit on narcotic prescriptions defined as federal controlled substances, schedule II−V, has been installed to limit six CII−CV prescriptions per month for oncology and sickle cell patients. Patients with any condition other than cancer or sickle cell are limited to four
Limitations on controlled substance prescribing (House Bill 21)
In accordance with House Bill 21 “Limitations on controlled substances prescribing” as enacted by the state of Florida and guidance issued by AHCA, regulations apply to Medicaid members when opioid pain medications are prescribed for acute pain and days’ supply is limited as follows:

- Schedule II: limit to no more than a three-day supply for acute pain
- Schedule III, IV and V: limit to no more than a 14-day supply

For more information, visit: Humana.com/provider/pharmacy-resources/manuals-forms. See the “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 or 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:
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 members who have limited ability to receive their prescribed drug therapy by providing them with a temporary supply. For new and reenrolling members who are at a retail pharmacy or in a long-term care facility, Humana will cover a temporary supply as indicated for each program 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
• Drugs that require a diagnosis to determine medically accepted indication
• Initial transition eligibility criteria are not met

<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>FL MMA</td>
<td>60</td>
<td>60</td>
<td>60</td>
<td>60</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 of 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.

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 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 to verify 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 to ensure the deficiencies are remediated.

**Humana’s policy on informed consent for psychotherapeutic medication (for Florida MMA Medicaid only)**
In accordance with Florida Statute § 409.912(16) and AHCA guidance, a psychotropic consent form must be on file with the dispensing pharmacy for any pediatric patient (younger than 13). A parent or legal guardian must complete the consent form. The referring physician must document the consent of a parent or guardian in the child’s medical record and provide the pharmacy with a signed attestation of this consent with each new prescription. Humana Pharmacy Solutions, which provides pharmacy benefit management services to the Humana Medical Plan, intends to cooperate with Florida Medicaid by assisting pharmacies in complying with this law.
When a psychotropic medication prescription is being filled for a pediatric patient who is younger than 13, the claim will reject with NCPDP error code 60 and return the following message: Age Limit-drug excluded product/service not covered for patient age. A free-form message will indicate: Informed consent request use PPS override.

- When prescriptions are received via phone or electronically prescribed, the pharmacy must obtain a completed consent form directly from the prescriber or the child’s parent or legal guardian before dispensing the medication.
- If a prescription containing refills is transferred to another pharmacy, the consent form must also be transferred.
- The completed form (hard copy or imaged) must be held for audit purposes for a minimum of six years.

Once the pharmacist confirms the consent is accompanied with the prescription, the following PPS overrides can be used:

<table>
<thead>
<tr>
<th>Value</th>
<th>Value type</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED</td>
<td>Patient education/instruction</td>
</tr>
<tr>
<td>M0</td>
<td>Prescriber consulted</td>
</tr>
<tr>
<td>4A</td>
<td>Prescriber acknowledgments</td>
</tr>
</tbody>
</table>

**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), 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

Fax: 920-339-3613

Email: siureferrals@humana.com or ethics@humana.com

  • Humana Ethics Help Line:
    1-877-5-THE-KEY (1-877-584-3539)

Ethics Help Line reporting
website: ethicshelpline.com

Mail:
Humana, Special Investigations Unit
1100 Employers Blvd.
Green Bay, WI  54344
*Humana requests that if a person reporting an ethics concern desires to remain anonymous, he or 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](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**
Pharmacies also are 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 the 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

• 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’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’s contractual obligations to
   Humana should be executed until Humana has been notified and approval has been granted.

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/pharmacy/pharmacists/manuals-forms). Any suspected and
      confirmed 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, its employees or those with whom it contracts to support its obligations to Humana.

8. Assurance: Complying with Humana requests to provide assurance related to the pharmacy’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
- 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- 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 Pharmacy Solutions procurement, transaction or business dealing. This prohibition includes, but is not limited to, a pharmacy 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 annually. 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 90 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 at 1-855-381-1332 or by email at 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” button 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

SS&C Health system issues
All pharmacies contracted with Humana are encouraged to contact the SS&C 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 (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 pharmacy network 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.

Florida Medicaid enrollee grievances
Florida Medicaid enrollees can file a grievance at any time. Grievances can be submitted using either method provided below:

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

**Florida 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 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 at 1-800-477-6931 (TTY: 711). We are available Monday – Friday, 8 a.m. – 8 p.m., Eastern time.

For all enrollees, the physician, prescriber or someone else can make the appeal on 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 visit Humana's website at [Humana.com/individual-and-family-support/tools/member-forms](https://www.humana.com/individual-and-family-support/tools/member-forms).
If the appeal comes from someone besides the enrollee, we 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 enrollee’s 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 their Florida state 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 request for reimbursement for out-of-pocket expenses

**Confirming eligibility**

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

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