# Table of contents

**Introduction** ................................................................................................................................. 4

**Contact information** ..................................................................................................................... 6

**Eligibility verification** ..................................................................................................................... 7
  - Humana member identification (ID) cards ..................................................................................... 7
  - Cardholder ID ................................................................................................................................. 7
  - Medicare automated eligibility-verification system (for Medicare-Medicaid dual demonstration plans only) ........................................................................................................................................... 7
  - Coordination of benefits ................................................................................................................. 8

**Drug coverage** ................................................................................................................................ 8
  - Drug Lists ......................................................................................................................................... 8
  - Utilization management (UM) .......................................................................................................... 9
  - Exceptions to plan coverage for Medicare members ....................................................................... 9
  - Coverage determinations/exceptions ............................................................................................. 9
  - Beneficiaries eligible for the low-income subsidy (LIS) ................................................................ 10

**General claims procedures** ........................................................................................................... 11
  - Submitting pharmacy claims ......................................................................................................... 11
  - Bank Identification Numbers (BIN) and Processor Control Numbers (PCN) ......................... 11
  - Prescription origin code requirements .......................................................................................... 11
  - Sales tax .......................................................................................................................................... 12
  - Timely submission of claims .......................................................................................................... 12
  - Humana-specific SS&C Health payer sheets .................................................................................. 13
  - Prescriber NPI submission ............................................................................................................. 13
  - Dispense-as-written (DAW) codes ................................................................................................. 14
  - Drug utilization review (DUR) safety edits ..................................................................................... 14
  - Soft reject DUR .............................................................................................................................. 15
  - Submitting claims for 340B medications ....................................................................................... 17
  - Vaccine administration ................................................................................................................... 17

**Controlled substance claims** .......................................................................................................... 17
  - Clarification of federal requirements – Schedule II drugs ............................................................... 17
  - Point-of-sale (POS) edits and overrides ......................................................................................... 18

**Medicare claims coverage and procedures** .................................................................................... 18
  - Medicare Part B vs. Part D coverage ............................................................................................. 18
  - Prohibition on balance billing cost-share-protected members ...................................................... 19
  - Humana processing of drug exclusions ......................................................................................... 20

**Continuity of care** ............................................................................................................................ 20
  - Retail and long-term care (LTC) transition policy ......................................................................... 20

**Long-term care (LTC)** ..................................................................................................................... 21
  - Long-term care pharmacy information .......................................................................................... 21
  - Level-of-care changes (for Medicare-Medicaid dual demonstrations only) ................................ 21
  - LTC claims-processing guidelines .................................................................................................. 21
  - Long-term care short-cycle dispensing .......................................................................................... 23
  - Long-term care attestation ............................................................................................................. 24

**Home infusion billing procedure** .................................................................................................. 25

**Compound claims** .......................................................................................................................... 25
  - Submitting compound claims ...................................................................................................... 25
Introduction

Dear pharmacy,

Humana appreciates your role in delivering quality pharmacy services to our members. This manual pertains exclusively to Illinois 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 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.

**Medicare**
Medicare is the federal health insurance program for:
- People 65 years old or older
- Some people under age 65 with certain disabilities
- People with end-stage renal disease (kidney failure)

**Current Medicaid Humana program available:**

**Humana Gold Plus® Integrated** is a Medicare-Medicaid plan. A Medicare-Medicaid plan is an organization made up of physicians, hospitals, pharmacies, providers of long-term services and supports, and other providers. It also has care coordinators and care teams to help patients manage all their providers and services. They all work together to provide the care the patient needs.

Humana Gold Plus Integrated was approved by the state of Illinois and the Centers for Medicare & Medicaid Services (CMS) to provide the patient services as part of the Medicare-Medicaid Alignment Initiative.

The Medicare-Medicaid Alignment Initiative is a demonstration program jointly run by Illinois and the federal government to provide better healthcare for people who have both Medicare and Medicaid. Under this demonstration, the state and federal governments want to test new ways to improve how patients get their Medicare and Medicaid healthcare services.

Processing requirements may vary by plan, and online claims adjudication and messaging reflect the most current benefits. Please refer to Humana’s National Council for Prescription Drug Programs (NCPDP) Version D.0 commercial/Medicaid and Medicare program payer sheets for the required fields to submit prescription claims electronically to Humana. In your pharmacy provider agreement, you will find network participation requirements.

**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 again for your participation in the Humana pharmacy provider network.

Sincerely,

The Humana Pharmacy Network Team
# Contact information

<table>
<thead>
<tr>
<th><strong>Pharmacy help desk</strong></th>
<th>For refill-too-soon overrides and prior authorization status, call <strong>1-800-865-8715</strong> and follow the prompts.</th>
</tr>
</thead>
</table>
| **Humana Medicare Customer Care** | 1-800-281-6918 (TTY: 711)  
8 a.m. – 8 p.m., seven days a week  
7 a.m. – 7 p.m., Monday – Friday |
| **Humana Customer Care** | To obtain general Medicaid plan information:  
**1-800-477-6931 (TTY: 711)**  
8 a.m. – 8 p.m., seven days a week |
| **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](https://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)** |
| **SS&C Health (formerly known as DST Pharmacy Solutions)** | **1-866-211-9459** |
| **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 |
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 Individual MAPD IL MMAI HMO

Note: This PDF 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 “Humana member identification (ID) cards” section above.

• For Medicare-Medicaid dual-eligible members who do not have their Humana member ID numbers, pharmacies may use the automated eligibility verification described below or submit an E1 query.
• For LINET claims, the Medicare Beneficiary Identifier (MBI) may be submitted in the Cardholder ID field.

Medicare automated eligibility-verification system (for Medicare-Medicaid dual demonstration plans only)
Humana provides an automated eligibility-verification system for Medicare members as an alternative to the NCPDP D.0 E1 transmission to RelayHealth. The Humana tool is available at no cost to pharmacies. Pharmacy employees can contact the Humana pharmacy help desk at 1-800-865-8715 and select option 2 to access this feature. Please have the following information available:

• Pharmacy NCPDP number
• Member Social Security number
• Member date of birth

If the member is not found, the pharmacy employee can assist the member further by contacting the Humana pharmacy help desk at 1-800-865-8715 to initiate a quick activation. This should allow the pharmacy to submit the claim online.

The following information will be needed for the quick-activation process:

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

**Coordination of benefits**
(for Medicaid programs only)

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 Illinois:

• 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

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 manages numerous Drug Lists for the many prescription benefit plans it offers. Pharmacies can view details of these Drug Lists at [Humana.com/DrugLists](http://Humana.com/DrugLists). Noteworthy annual changes to Humana’s Medicare and Medicaid Drug Lists are announced in the fall of each year. Pharmacies can find these announcements at [Humana.com/provider/news/pharmacy-news](http://Humana.com/provider/news/pharmacy-news).

Drug Lists are developed and maintained by Humana’s Pharmacy and Therapeutics Committee consisting of physicians and pharmacists. Members’ drug coverage varies by plan. Certain drugs may have coverage limitations based on duration or dosage or may require preapproval. Humana may add drugs to the list, change drugs on the list or remove drugs from the list at any time, which could affect the amount the member pays for prescription drugs.

Utilization management (UM)

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

Exceptions to plan coverage for Medicare members

Medicare members can ask Humana to make an exception to its coverage rules; however, the request must include a supporting statement from the member’s prescriber. Members may submit several types of exception requests, including:

- Request for a drug to be covered, even if it is not on Humana’s Drug List
- Request that Humana waive coverage restrictions or limits on a drug (e.g., prior authorization, step therapy, dispensing-limit restrictions)

An expedited decision should be requested if the member’s health would be placed in jeopardy by waiting the standard 72 hours for a decision.

Coverage determinations/exceptions

Members, prescribers and appointed or authorized representatives can request an exception or an expedited exception by faxing the request to HCPR at 1-877-486-2621. To do this, complete a coverage determination form found at Humana.com/PA or submit the request electronically by going to www.covermymeds.com/epa/humana.

Please note: Humana does not accept prior authorization requests directly from pharmacies. The member or prescriber must initiate the request.

The coverage determination decision will be made within 72 hours after complete information is received from the prescriber. An expedited decision should be requested if the member’s health would be placed in jeopardy by waiting the standard 72 hours for a decision; it will be reviewed within 24 hours.

Please note: Members can ask Humana to make an exception to its coverage rules; however, the request must include a supporting statement from the member’s prescriber.


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 5) 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 the 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. (See “Medicare automated eligibility-verification system” section for quick-activation requirements.) The LIS can also be added during the quick-activation process, if applicable.

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, daily, 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 a long-term care (LTC) facility should be different from that shown on adjudicated claims may provide applicable evidence to Humana regarding the member’s LIS status. Pharmacists may submit appropriate evidence to Humana by utilizing the “Long-Term Care Appeal for Untimely Filing” form available at [http://apps.humana.com/marketing/documents.asp?file=2322905](http://apps.humana.com/marketing/documents.asp?file=2322905).

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 5).

**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>Medicare-Medicaid dual eligible</td>
<td>015581</td>
<td>03200000</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 also is 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
- **Subrogation** claims, which have 36 months for submission
- **Administrative services only (ASO) 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 §423.505(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.

Humana-specific SS&C Health payer sheets
Pharmacists can find applicable Medicaid and Medicare pharmacy payer sheets at Humana.com/provider/pharmacy-resources. Select the “Pharmacist manuals and forms” link.

Prescriber NPI submission
Humana requires the use of a valid and accurate Type 1 (also known as “individual”) prescriber NPI on all electronic transactions. This requirement also applies to Humana’s Florida Managed Medical Assistance (MMA) Medicaid plan. 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 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>
</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.

Humana may prefer a brand drug. If a brand drug is on the formulary and the generic is not, the pharmacy may use DAW 9 when submitting a claim.

<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>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.</td>
<td>Makena</td>
</tr>
<tr>
<td></td>
<td><strong>Note:</strong> Gender edits apply only for commercial and Medicaid when applicable.</td>
<td></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>
<tr>
<td>88: DUR reject error</td>
<td>This drug may duplicate current patient therapy</td>
<td>TD: Therapeutic duplication</td>
<td>MO: Prescriber consulted PE: Patient educated PO: Patient consulted RO: Pharmacist consulted other source SW: Literature search/review TH: Therapeutic product interchange</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>
<tr>
<td>88: DUR reject error 922: Morphine equivalent dose exceeds limits **</td>
<td>Cumulative morphine equivalent dose exceeds limits</td>
<td>HD: High dose</td>
<td>MO: Prescriber consulted</td>
<td>1B: Filled prescription as is 1D: Filled with different directions 1F: Filled with different quantity 1G: Filled with prescriber approval 3D: Regimen changed 3E: Therapy changed 4A: Prescribed with acknowledgments 4B: Filled, palliative care 4D: Filled, cancer treatment</td>
</tr>
</tbody>
</table>
AG: Exceeds opioid initial fill limits
925: Initial fill days’ supply exceeds limit

Days' supply limitation for product/service

MX: Excessive duration

MO: Prescriber consulted

PH: Patient medication history

RO: Pharmacist consulted other source

1G: Filled with prescriber approval

4B: Filled, palliative care

4D: Filled, cancer treatment

4J: Dispensed, patient is not opioid naive

**Note 922 can apply to single claim or cumulative claim MED limits for opioids

Submitting claims for 340B medications

When dispensing medications purchased under Section 340B of the Public Health Service Act, providers should 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

Medicare-Medicaid dual demonstrations

The Medicare Part D program covers administration associated with the injection of Part D vaccines. Pharmacists in Humana-participating pharmacies may administer the vaccines if allowed by Illinois 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. To submit a claim for the administration fee only, the pharmacy must submit the national drug code (NDC) for the drug administered, submit a value of zero in the ingredient cost field and bill a value greater than zero in the incentive amount submitted field (438-E3). The pharmacy also must submit a professional service code of “MA” in field 440-E5.

Influenza, pneumococcal and hepatitis B vaccines are not covered under the Part D program. However, they are a covered benefit for members with a dual demonstration under Part B coverage with Humana.

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.”

**Medicare claims coverage and procedures**

**Medicare Part B vs. Part D coverage**

The Centers for Medicare & Medicaid Services (CMS) makes a distinction between drugs that are covered under Medicare Part B and those covered under Medicare Part D. These distinctions help pharmacists determine the appropriate insurance carrier to bill. In general, Humana covers most drugs that meet the CMS definition of a Part D drug and are dispensed at a retail pharmacy under Medicare Part D, and most drugs administered incidentally to a physician service under Medicare Part B. For members who have both a Part B plan and a Part D plan, the following guidelines apply.

**Medicare Part B covers the following drugs** (this is not an all-inclusive list):

- Oral immunosuppressive drugs secondary to a Medicare-approved transplant
- Oral antiemetic drugs for the first 48 hours after chemotherapy
- Inhalation drugs delivered through a nebulizer with the service location being the patient’s home
- Diabetic testing supplies, such as blood glucose meters, test strips and lancets
- Certain drugs administered in the home setting that require the use of an infusion pump, such as certain antifungal or antiviral drugs and pain medications
- Flu and pneumonia vaccines
- Insulin used in a pump
- Physician-administered injectable drugs

**Medicare Part D covers the following drugs** (this is not an all-inclusive list):

- Most outpatient prescription drugs
- Insulin (excludes insulin used in a pump)
• Insulin supplies, such as standard and needle-free syringes, needles, gauze, alcohol swabs and insulin pens
• Most vaccines (product and administration); exceptions include flu and pneumonia vaccines, hepatitis B vaccines (when they meet the CMS requirements for Part B coverage) and vaccines used for the treatment of an injury or illness (e.g., tetanus vaccine)
• Prescription-based smoking cessation products
• Injectable drugs that may be self-administered
• Injectable or infusible drugs administered in the home setting and not covered by Medicare Part A or Part B
• Infusion drugs not covered under Part B and administered in the home via intravenous (IV) drip or push injection; examples include, but are not limited to, intramuscular drugs, antibiotics, parenteral nutrition, immunoglobulin and other infused drugs

For a drug to be included in the Part D benefit, it must satisfy the definition of a Part D drug and not otherwise be excluded. The U.S. Food and Drug Administration (FDA) must regulate a Part D drug as a drug, biological or vaccine.

Prescription drug plans cover Part D drugs, MA plans cover Part B drugs, and MAPD plans cover both Part B and Part D drugs. The coverage determination for Part B or Part D coverage is based upon CMS coverage guidelines. A drug claim will never be eligible for coverage under Part B and Part D simultaneously.

Humana follows the CMS coverage guidelines. To assist in making the appropriate determination for Part B or Part D coverage and payment, Humana may require prior authorization. To request prior authorization when required, members, prescribers and appointed or authorized representatives should contact HCPR at 1-800-555-CLIN (1-800-555-2546). The caller should be prepared to answer questions related to the prescribed drug. These questions are used to help determine coverage and payment as either Part B or Part D.

Please note: Humana does not accept prior authorization requests directly from pharmacies. The member or prescriber must initiate the request.

If insufficient or incomplete information is received and the determination of Part B or Part D coverage cannot be made, a fax form requesting more information may be sent to the prescriber.

Prohibition on balance billing cost-share-protected members

As a reminder, CMS guidelines and state Medicaid guidelines prohibit Medicare-contracted providers from collecting cost-share for Medicare-covered services, including Part B services provided at the point of sale from members who are protected by the state from cost-sharing. This includes some Humana Medicare Advantage and Dual Eligible Special Needs Plan (D-SNP) members.

Cost-share-protected members have no legal obligation to make further payment to a provider for Part B-covered medications/supplies. Balances should be billed to Medicaid as the secondary payer, following Medicaid guidelines for claim submission. The cost-share cannot be collected from the member. Per CMS guidelines, if a full or partial balance remains after billing Medicaid, or if the provider is unable to bill Medicaid, the provider is still required to dispense the medication/supply without balance billing the member. Providers who inappropriately bill cost-share-protected patients may be subject to sanctions as established in Section 1902(n)(3)(C) of the Social Security Act.
Humana processing of drug exclusions
Medicare-Medicaid dual demonstrations:

All drug claims should be submitted to Humana for processing. For the dual-demonstration plans, some Medicare Part D-excluded drugs and over-the-counter (OTC) drugs are payable under the Medicaid portion of the benefit. The tiers on dual-demonstration plans are as follows:

- Tier 1 drugs are generic drugs.
- Tier 2 drugs are brand-name drugs.
- Tier 3 drugs are Medicare-excluded drugs covered by Medicaid.
- Tier 4 drugs are OTC drugs covered by Medicaid.

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 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. For members who are long-term care residents, but past the first 90 days of eligibility, Humana will cover a 31-day supply unless the prescription is written for less. In that case, Humana will allow multiple fills to provide up to a total of 31 days of a Part D-covered drug when the prescription is filled at a network pharmacy.

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:

- CMS-excluded drug
- Medicare Part B drug
- Drugs that require a Medicare Part B vs. D determination and therefore are required to go through the standard prior authorization process
- Drugs that require a diagnosis to determine medically accepted Part D use
- Safety edits
- 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>IL MMAI</td>
<td>30</td>
<td>90</td>
<td>31</td>
<td>90</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 predominately 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.

Level-of-care changes (for Medicare–Medicaid dual demonstrations only)
Throughout the plan year, members may have changes in their treatment settings due to the level of care they require. Such transitions include:
- Members who are discharged from a hospital or skilled nursing facility to a home setting
- Members who are admitted to a hospital or skilled nursing facility from a home setting
- Members who transfer from one skilled nursing facility to another and are serviced by a different pharmacy
- Members who end their skilled nursing facility Medicare Part A stays (where payments include all pharmacy charges) and who now need to use their Part D plan benefits
- Members who give up hospice status and revert back to standard Medicare Part A and B coverage
- Members who are discharged from chronic psychiatric hospitals with highly individualized drug regimens

For these changes in treatment settings, Humana will cover up to a 31-day temporary supply of a Part D-covered drug when the prescription is filled at a network pharmacy. If members change treatment settings multiple times within the same month, they may have to request an exception or prior authorization and receive approval for continued coverage of their drug. Humana will review these requests for continuation of therapy on a case-by-case basis when members are stabilized on drug regimens that, if altered, are known to have risks.

The transition policy applies only to drugs not on Humana’s Drug List, step therapy, quantity limitations and clinical prior authorization requirements.

There also will be messaging for eligible retail and LTC transition claims indicating the drug’s transition status.

This message should be communicated to the member so he or she can talk with the prescribing provider before the next refill. The transition policy does not apply to safety edits, drugs requiring a diagnosis to determine accepted Part D use, Part B drugs, CMS excluded drugs or Medicare Part B vs. D determinations.

LTC claims-processing guidelines
CMS requires all pharmacies to submit the patient residence code (NCPDP field 384-4X) and pharmacy service type (NCPDP field 147-U7) on all Medicare Part D 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 with a missing patient residence code, the claim will reject with NCPDP reject code 4X and return the following message: **Missing/Invalid Patient Residence Code**.

If the pharmacy submits a claim with an invalid patient residence code, the claim will reject with NCPDP reject code 4Y and return the following message: **Patient residence not supported**.

<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 Part D claim or claim for a managed Medicaid plan 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**.

**Nebulizer solutions covered under Part D for LTC residents**
For Humana's claims-processing system to recognize that a claim for inhalation solutions—such as albuterol (to be used in nebulizers, not metered-dose inhalers)—is for an LTC facility resident, the claim should be submitted with a patient residence code of 03 or 04. If this patient residence code is not
submitted with the claim, the claim will be rejected.

**Long-term care short-cycle dispensing**  
(appropriate dispensing)

Humana has implemented point-of-sale claims processing logic to comply with CMS Part D requirements related to appropriate dispensing for brand, oral solid medications in the LTC pharmacy setting.

**Submission requirements**

LTC pharmacies submitting claims for brand, oral solid medications that are subject to appropriate dispensing requirements must submit the following fields for proper claim adjudication:

- **Patient residence (NCPDP field 384-4X)** – This field communicates where the patient resides. Several values are used in this field to communicate LTC, but Humana applies appropriate dispensing requirements only to claims submitted with a patient residence code of 03 (nursing facility).

- **Pharmacy service type (NCPDP field 147-U7)** – This field communicates the type of service being performed by a pharmacy when different contractual terms exist between a payer and the pharmacy or when benefits are based upon the type of service performed.

- **Submission clarification code (NCPDP field 420-DK)** – This field is used to identify the dispensing frequency used by the pharmacy (e.g., every 14 days, every seven days, etc.).

- **Special packaging indicator (NCPDP field 429-DT)** – This field is used in appropriate dispensing to identify the type of packaging used in dispensing the medication.

Claims submitted by LTC pharmacies for generic, nonoral solid medications (e.g., topical creams, lotions, etc.) and unbreakable packages (physically unbreakable or FDA-labeled to be dispensed in the manufacturer’s packaging) are excluded from Humana’s appropriate dispensing requirements and do not undergo this editing. In accordance with CMS guidance, Humana considers a product “brand” or “generic” according to the FDA’s approval. Brands are drugs receiving new drug application (NDA) approval; generics receive abbreviated new drug application (ANDA) approval.

**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 must 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.

Copayments
When an LTC-appropriate dispensing claim successfully meets the required elements (i.e., additional fields that must be submitted are present and valid) and is otherwise appropriately payable (i.e., no other edits apply), then Humana’s point-of-sale system will calculate and prorate any member copayment that is applicable to the claim according to the member’s Part D benefit. Below is an example of Humana’s proration procedure:

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applicable member copayment (31-day)</td>
<td>$31</td>
</tr>
<tr>
<td>Days’ supply submitted on the claim</td>
<td>$14</td>
</tr>
<tr>
<td>Prorated copayment</td>
<td>$14</td>
</tr>
<tr>
<td>Calculated daily copayment</td>
<td>$1</td>
</tr>
</tbody>
</table>

Long-term care attestation
Humana reimburses its contracted LTC pharmacies for cost-share amounts related to retroactive subsidy level changes for eligible low-income subsidy Medicare Part D beneficiaries who meet the CMS definition of institutionalized individuals (“member”) per Medicare Part D guidance. Humana understands that LTC pharmacies’ general practice is not to collect cost-sharing amounts from LIS or suspected LIS members or their responsible party but to defer collection until the member’s health plan remits payment of the cost-share directly. Applicable law prohibits waiving cost-sharing charges for Medicare beneficiaries, except under certain stated limited circumstances. The pharmacy’s cost-share collection practices should be guided by the following principles:

1. **Pharmacy practice:** Humana requests that the pharmacy attests that its general practice consists of (i) not collecting LIS or suspected LIS member cost-share, (ii) deferring collection and (iii) accepting health plan remittance that complies with the terms of the member’s benefit plan as payment in full.
2. **Notification:** As a contracted network LTC pharmacy, the pharmacy agrees to notify Humana within 30 calendar days of changes to this attestation of LIS cost-share collection practices for LIS-eligible beneficiaries.
3. **List of participating pharmacies:** As a Humana network LTC pharmacy, the pharmacy also agrees to provide a current list of participating pharmacies, which shall be authorized to use and shall use the National Council for Prescription Drug Programs (NCPDP) number. It understands and agrees that those participating pharmacies are included in, and subject to, the terms of this attestation.

If the pharmacy does not provide this complete and signed attestation, it will affect its ability to contract with Humana as a participating Humana provider and may result in sanctions, up to and including termination of a future Pharmacy Provider Agreement.

Please contact Humana at **1-888-204-8349** if the pharmacy’s cost-share collection practices have not been submitted. This attestation is collected in accordance with the requirements of applicable CMS regulations and instructions. Representatives are available to assist Monday – Friday, 8 a.m. – 11 p.m., Eastern time.
Home infusion billing procedure

All covered Part D drugs should be billed through the member’s Humana pharmacy benefit (PBM) using the applicable BIN/PCN. All covered Part B drugs, supplies, and nursing should be billed through the member’s Humana 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 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 Medicare 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, the pharmacy can visit 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 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 the link under “Pharmacy manuals and forms.”

Long-term care 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 the link under “Pharmacy manuals and forms.”
Compliance program audits
Humana-contracted entities supporting Humana’s Medicare and/or 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/provider/pharmacy-resources/manuals-forms), 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 or within it:
• Humana Ethics Every Day for Contracted Healthcare Providers and Third Parties https://apps.humana.com/marketing/documents.asp?file=1112774

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 who 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

Both of the above 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 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](http://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 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 the pharmacy’s contractual obligations to Humana’s Medicare and/or 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](http://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 to 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 who 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 and grants approval.

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 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 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’s compliance program.

For an overview of the seven elements of an effective compliance program, please refer to Humana’s compliance policy at https://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 requires a compliance attestation only when it pertains 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/policies outlining compliance program requirements;
- Standards 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.
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](apps.humana.com/marketing/documents.asp?file=1827566) covers how to:

- Complete the compliance requirements at [Humana.com](https://www.humana.com);
- Register at [Humana.com](https://www.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 during the initial contracting process and 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 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 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.

**Rows highlighted in yellow indicate a retroactive MAC adjustment has been made as a result of a granted appeal for this MAC update. The retroactive MAC adjustment will be effective to the initial date of service the appealed drug was dispensed as indicated with the effective date below.**

### Humana Corporate MAC List

<table>
<thead>
<tr>
<th>GCN</th>
<th>Generic Name</th>
<th>Eff Date</th>
<th>End Date</th>
<th>Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>13960</td>
<td>Diclofenac Potassium 50 Mg Tablet</td>
<td>7/20/2016</td>
<td>12/31/9999</td>
<td>1.12000</td>
</tr>
<tr>
<td>14602</td>
<td>Fluphenazine Hcl 1 Mg Tablet</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14604</td>
<td>Fluphenazine Hcl 2.5 Mg Tablet</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14605</td>
<td>Fluphenazine Hcl 5 Mg Tablet</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>31070</td>
<td>Betamethasone Dipropionate 0.05 % Oint. (g)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>39541</td>
<td>Dicloxacillin Sodium 250 Mg Capsule</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>39542</td>
<td>Dicloxacillin Sodium 500 Mg Capsule</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>48851</td>
<td>Clarithromycin 500 Mg Tablet</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>50741</td>
<td>Sumatriptan Succinate 6 Mg/0.5ml Pen injctr</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>61199</td>
<td>Azithromycin 200 Mg/5ml Susp Recon</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>00030</td>
<td>Fluvastatin Sodium 20 Mg Capsule</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>00030</td>
<td>Fluvastatin Sodium 20 Mg Capsule</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>00030</td>
<td>Fluvastatin Sodium 20 Mg Capsule</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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 above). 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](http://Humana.com/provider/pharmacy-resources/manuals-forms), then select “Network request forms” under “Manuals and forms.”

**Manuals and forms**

<table>
<thead>
<tr>
<th>Provider manuals</th>
<th>Controlled Substances</th>
<th>Medicaid training resources</th>
<th>Audit guide, claim form and...</th>
<th>Network request forms</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pharmacy Contract Request Form</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Pharmacy pricing review request</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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 HCPR 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 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.

Enrollee grievances
Grievances must be filed within 60 days of the occurrence. Written grievances can be submitted to:

Humana Inc.
Attn: Grievances and Appeals
P.O. Box 14546
Lexington, KY 40512-4546

When filing a verbal grievance, direct the enrollee to call 1-800-787-3311. For enrollees with speech or hearing impairment who use a TTY, call 711. We are available Monday – Friday, 8 a.m. – 8 p.m., Central time.

The enrollee should include his or her name, address, telephone number, Humana ID number, the reason for the grievance and any supporting documents. Humana will investigate the grievance and inform the enrollee of the decision.

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.

- Medicare-Medicaid dual enrollees may ask for an appeal by calling Customer Service at 1-800-787-3311. We are available Monday – Friday, 8 a.m. – 8 p.m., Central 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.

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 grievance and appeals
We will investigate the enrollee’s appeal and inform him or her of our decision. If the enrollee has questions concerning the grievance or appeal, direct him or her to the Member Handbook or contact Humana using the number on the back of his or her 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 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).

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:

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](http://Humana.com/LINET) or call the LINET help desk at **1-800-783-1307**.
Appendix: Medicare Prescription Drug Coverage and Your Rights

CMS requires network pharmacies to distribute the “Medicare Prescription Drug Coverage and Your Rights” notice to beneficiaries. This notice advises Medicare beneficiaries of their rights to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist.

Printing the pharmacy notice on prescription label stock or an integrated prescription receipt is permitted, so long as the notice is provided in at least 12-point font. Electronic distribution of the notice is permitted if the enrollee or the enrollee's appointed representative has provided an email address and has indicated a preference for that method of communication.

Home Infusion Pharmacies must distribute the “Medicare Prescription Drug Coverage and Your Rights” notice to enrollee electronically, by fax, in person or by first-class mail as expeditiously as the enrollee’s health condition requires, but no later than 72 hours from the pharmacy’s receipt of the original transaction response indicating the claim is not covered by Part D.

CMS requires that LTC pharmacies contact the prescriber or an appropriate staff person at the LTC facility to resolve the matter. If the matter cannot be resolved the pharmacy must provide an appropriate staff person at the LTC facility, enrollee’s representative, prescriber or the enrollee the “Medicare Prescription Drug Coverage and Your Rights” notice as expeditiously as the enrollee’s health condition requires, but no later than 72 hours from the pharmacy’s receipt of the original transaction response indicating the claim is not covered by Part D.

Note: If the enrollee is a self-pay resident and the pharmacy cannot fill the prescription under the Part D benefit, the pharmacy must, upon receipt of the transaction response, fax or otherwise deliver the notice to the enrollee, enrollee’s representative, prescriber or an appropriate staff person at the LTC facility. After distribution of the notice, the LTC pharmacy should continue to work with the prescriber or facility to resolve the matter and ensure the resident receives the needed medication or an appropriate substitute.
Medicare Prescription Drug Coverage and Your Rights

Your Medicare rights

You have the right to request a coverage determination from your Medicare drug plan if you disagree with information provided by the pharmacy. You also have the right to request a special type of coverage determination called an “exception” if you believe:

- you need a drug that is not on your drug plan’s list of covered drugs. The list of covered drugs is called a “formulary;”
- a coverage rule (such as prior authorization or a quantity limit) should not apply to you for medical reasons; or
- you need to take a non-preferred drug and you want the plan to cover the drug at a preferred drug price.

What you need to do

You or your prescriber can contact your Medicare drug plan to ask for a coverage determination by calling the plan’s toll-free phone number on the back of your plan membership card, or by going to your plan’s website. You or your prescriber can request an expedited (24 hour) decision if your health could be seriously harmed by waiting up to 72 hours for a decision. Be ready to tell your Medicare drug plan:

1. The name of the prescription drug that was not filled. Include the dose and strength, if known.
2. The name of the pharmacy that attempted to fill your prescription.
3. The date you attempted to fill your prescription.

If you ask for an exception, your prescriber will need to provide your drug plan with a statement explaining why you need the off-formulary or non-preferred drug or why a coverage rule should not apply to you.

Your Medicare drug plan will provide you with a written decision. If coverage is not approved, the plan’s notice will explain why coverage was denied and how to request an appeal if you disagree with the plan’s decision.

Refer to your plan materials or call 1-800-MEDICARE for more information.

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concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

CMS does not discriminate in its programs and activities: To request this form in an accessible format (e.g., Braille, Large Print, Audio CD) contact your Medicare Drug Plan. If you need assistance contacting your plan, call: 1-800-MEDICARE.

Form CMS-10147
02/28/2020

OMB Approval No. 0938-0975 (Expires: 02/28/2020)
Nombre del beneficiario: _______________________________ (opcional)

Número de receta y de medicamento: _____________________ (opcional)

La cobertura de Medicare de las recetas médicas y sus derechos

Sus derechos si tiene Medicare

Usted tiene el derecho de solicitar una determinación de cobertura de su plan Medicare de recetas médicas si está en desacuerdo con la información proporcionada por la farmacia. También tiene el derecho de solicitar una determinación de cobertura especial conocida como “excepción” si piensa que:

- Necesita un medicamento que no está en la lista de su plan. A la lista de medicamentos cubiertos se le conoce como “formulario”.
- Una regla de cobertura (como la autorización previa o un límite de cantidad) no debe aplicarse debido a su problema médico; o
- Necesita tomar un medicamento no preferido y usted quiere que su plan lo cubra al precio de un medicamento preferido.

Lo qué necesita hacer

Usted o la persona que le ha recetado el medicamento pueden pedirle al plan una determinación de cobertura, llamando al número gratis que aparece en la parte de atrás de la tarjeta del plan, o visitando el sitio web del plan. Usted o su médico puede pedir una determinación acelerada (24 horas) si su salud pudiera estar en peligro si tiene que esperar 72 horas para obtener la respuesta. Usted tendrá que informarle al plan:

1. El nombre del medicamento que no pudo obtener, la dosis y concentración si lo sabe.
2. El nombre de la farmacia donde intentó obtener el medicamento.
3. La fecha en que intentó obtenerlo.
4. Si solicita una excepción, el médico que lo recetó tiene que enviarle a su plan una declaración explicándole el motivo por el cual usted necesita el medicamento que no está en el formulario, el medicamento no preferido o no se debe aplicar una regla de cobertura a usted.

Su plan Medicare de medicamentos recetados le comunicará su decisión por escrito. Si no aprueban la cobertura, la carta del plan le explicará el motivo y cómo apelar la decisión si no está de acuerdo.

- Si desea más información, consulte los materiales del plan o llame al 1-800-MEDICARE.

Declaración sobre la Ley para la Reducción de Trámites De acuerdo con la Ley para la Reducción de Trámites de 1995 (PRA en inglés), las personas no están obligadas a responder una recopilación de información a menos que se exhiba un número de control de la oficina de Gerencia y Presupuesto (OMB en inglés) válido. El número de control OMB válido para esta recopilación de información es 0938-0972. El tiempo necesario para responder esta recopilación de información es de aproximadamente 1 minuto por respuesta, incluido el tiempo para revisar instrucciones, buscar fuentes de datos existentes, reunir los datos necesarios y completar y revisar la recopilación de información. Si tiene preguntas sobre la precisión de los tiempos estimados o sugerencias para mejorar este formulario, escriba a: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

CMS no discrimina en sus programas y actividades. Para solicitar esta publicación en un formato alternativo, llame al 1-800-MEDICARE o envíe un correo electrónico a: AltFormat@cms.hhs.gov.
Medicare and Medicaid reports and other documents
Prohibition on Balance Billing Dually Eligible Individuals Enrolled in the Qualified Medicare Beneficiary (QMB) Program,
¶65,239, Centers for Medicare and Medicaid Services, (Feb. 1, 2016)

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Prohibition on Balance Billing Dually Eligible Individuals Enrolled in the QMB Program

Note: This article was revised on Feb. 4, 2016, to include updated information for 2016 and a correction to the second sentence in paragraph 2 under Important Clarifications Concerning QMB Balance Billing Law on page 3. All other information is the same.

Provider types affected
This article pertains to all Medicare physicians, providers and suppliers, including those serving beneficiaries enrolled in original Medicare or a Medicare Advantage plan.

Stop—What Medicare providers need to know
This Special Edition MLN Matters® Article from the Centers for Medicare & Medicaid Services (CMS) reminds all Medicare providers that they may not bill beneficiaries enrolled in the QMB program for Medicare cost-sharing (such charges are known as “balance billing”). QMB is a Medicare Savings Program that exempts Medicare beneficiaries from Medicare cost sharing liability.

Caution—What Medicaid providers need to know
The QMB program is a state Medicaid benefit that covers Medicare deductibles, coinsurance and copayments, subject to state. (States may limit their liability to providers for Medicare deductibles, coinsurance and copayments under certain circumstances.) Medicare providers may not balance bill QMB individuals for Medicare cost sharing, regardless of whether the state reimburses providers for the full Medicare cost sharing amounts. Further, all original Medicare and MA providers—not only those that accept Medicaid—must refrain from charging QMB individuals for Medicare cost sharing. Providers who inappropriately balance bill QMB individuals are subject to sanctions.

Go—What Medicare providers need to know
Refer to the Background and Additional Information Sections of this article for further details and resources about this guidance. All Medicare providers should be aware of the federal balance billing law and policies regarding QMB individuals. Medicare providers should contact the Medicaid Agency in the states in which they practice to learn about ways to identify QMB patients in their states and procedures applicable to Medicaid reimbursement for their Medicare cost sharing. Medicare Advantage providers also may contact the MA plan for more information. Finally, all Medicare providers should ensure that their billing software and administrative state exempt QMB individuals from Medicare cost sharing billing and related collection efforts.
Background
This article provides CMS guidance to Medicare providers to help them avoid inappropriately billing QMBs for Medicare cost-share, including deductibles, coinsurance and copayments. This practice is known as “balance billing.”

Balance billing of QMBs is prohibited by federal law
Federal law bars Medicare providers from balance billing a QMB beneficiary under any circumstance. See Section 1902(n)(3)(B) of the Social Security Act, as modified by Section 4714 of the Balanced Budget Act of 1997. (Please note, this section of the Act is available at www.ssa.gov/OP_Home/ssact/title19/1902.htm on the internet.) QMB is a Medicaid program for Medicare beneficiaries that exempts them from liability for Medicare cost sharing. State Medicaid programs may pay providers for Medicare deductibles, coinsurance and copayments. However, as permitted by federal law, states can limit provider reimbursement for Medicare cost sharing under certain circumstances. See the chart at the end of this article for more information about the QMB benefit. Medicare providers must accept the Medicare payment and Medicaid payment (if any) as payment in full for services rendered to a QMB beneficiary. Medicare providers who violate these billing prohibitions are violating their Medicare Provider Agreement and may be subject to sanctions. (See Sections 1902(n)(3)(C); 1905(p)(3); 1866(a)(1)(A); 1848(g)(3)(A) of the Social Security Act.)

Inappropriate balance billing persists
Despite federal law, erroneous balance billing of QMB individuals persists. Many beneficiaries are unaware of the billing restrictions (or concerned about undermining provider relationships) and simply pay the cost sharing amounts. Others may experience undue distress when unpaid bills are referred to collection agencies. See Access to Care Issues Among Qualified Medicare Beneficiaries (QMB), Centers for Medicare & Medicaid Services July 2015 at www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination-Medicare-Medicaid-Coordination-Office/Downloads/Access_to_Care_Issues_Among_Qualified_Medicare_Beneficiaries.pdf on the CMS website.

Important clarifications concerning QMB balance billing law
Be aware of the following policy clarifications to ensure compliance with QMB balance billing requirements. First, know that all Original Medicare and MA providers—not only those that accept Medicaid—must abide by the balance billing prohibitions.

In addition, QMB individuals retain their protection from balance billing when they cross state lines to receive care. Providers cannot charge QMB individuals even if the patient’s QMB benefit is provided by a different state than the state in which care is rendered.

Finally, note that QMBs cannot choose to “waive” their QMB status and pay Medicare cost sharing. The federal statute referenced above supersedes Section 3490.14 of the “State Medicaid Manual,” which is no longer in effect.

Ways to improve processes related to QMBs
Proactive steps to identify QMB individuals and to communicate with state Medicaid agencies (and Medicare Advantage plans if applicable), can promote compliance with QMB balance billing prohibitions.

1. Determine effective means to identify QMB individuals among patients. Find out what cards are issued to QMB individuals and ask all patients if they have them. Learn how to query state systems to verify QMB enrollment among patients. Medicare Advantage providers can contact the plan to determine how to identify the plan’s QMB enrollees.
2. Discern what billing processes apply to seek reimbursement for Medicare cost sharing from the states in which providers operate. Different processes may apply to Original Medicare and MA services provided to QMB beneficiaries. For Original Medicare claims, nearly all states have electronic crossover processes through the Medicare Benefits Coordination & Recovery Center (BCRC) to automatically receive Medicare-adjudicated claims.

- If a claim is automatically crossed over to another payer, such as Medicaid, it is customarily noted on the Medicare Remittance Advice.
- Understand the processes used to request reimbursement for Medicare cost sharing amounts if they are owed by the state. Providers may need to complete a State Provider Registration Process and be entered into the state payment system to bill the state.

3. Make sure that billing software and administrative state exempt QMB individuals from Medicare cost sharing billing and related collection efforts.

**QMB eligibility and benefits**

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<thead>
<tr>
<th>Dual eligibility</th>
<th>Eligibility criteria</th>
<th>Benefits</th>
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<tr>
<td>Qualified Medicare Beneficiary (QMB only)</td>
<td>Resources cannot exceed $7,280 for single individual or $10,930 in 2015 for an individual living with a spouse and no other dependents.</td>
<td>Medicaid Pays Medicare Part A and B premiums, deductibles, coinsurance and copays to the extent required by the State Medicaid.</td>
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<td>Income cannot exceed 100% of the Federal Poverty Level (FPL) +$20 ($1,001/month–Individual $1,348/month–Couple in 2015.</td>
<td>• Exempts beneficiaries from Medicare cost sharing charges</td>
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<td>Note: These guidelines are a part of the federal Medicare Advantage (Part C) floor. Under Section 1902 (r)(2) of the Social Security Act, states can effectively raise these limits above these baseline federal standards.</td>
<td>• The state may choose to pay the Medicare Advantage Part C premium.</td>
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<td>QMB Plus</td>
<td>Meets all of the standards for QMB eligibility as described above, but also meets the financial criteria for full Medicaid coverage.</td>
<td>Provides all benefits available to QMBs, as well as all benefits available under the state plan to a fully eligible Medicaid recipient.</td>
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**Additional information**

For more information about dual eligible categories and benefits, please visit [www.medicare.gov/Publications/Pubs/pdf/10126.pdf](http://www.medicare.gov/Publications/Pubs/pdf/10126.pdf) on the internet. Also, for more information about QMBs and other individuals who are dually eligible to receive Medicare and Medicaid benefits, please refer to the Medicare Learning Network® publication titled “Medicaid Coverage of Medicare Beneficiaries (Dual Eligibles),” which is available on the CMS website. For general Medicaid information, please visit the Medicaid webpage at [www.medicaid.gov/index.html](http://www.medicaid.gov/index.html) on the CMS website.
## Document history

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<tr>
<th>Date of change</th>
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<tr>
<td>Feb. 1, 2016</td>
<td>The article was revised to include updated information for 2016 and a clarifying note regarding eligibility criteria in the table on page 4.</td>
</tr>
<tr>
<td>Feb. 4, 2016</td>
<td>The article was revised on Feb. 4, 2016, to include updated information for 2016 and a correction to the second sentence in paragraph 2 under Important Clarifications Concerning QMB Balance Billing Law on page 3.</td>
</tr>
<tr>
<td>March 28, 2016</td>
<td>The article was revised to change the name of the Coordination of Benefits Contractor (COBC) to Benefits Coordination &amp; Recovery Center (BCRC).</td>
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