Humana Pharmacy Solutions Pharmacy Manual

2016 edition

2118ALL0916

Table of contents

Introduction....3

Submitting pharmacy claims....4
Prescription origin code requirements....4
Eligibility verification....5
Prescriber NPI submission....6
Drug formularies....7
Utilization management....7
Step therapy....8
Quantity limits....8
Dispense as written (DAW) codes....8
Identification (ID) cards....9
Humana Access® Visa® debit card....11
Medicare pharmacy claims....13
Medicare Part B vs. Part D billing....13
Humana processing of Medicare drug exclusions....14
Medicare vaccine administration....15

Medicare coverage determinations....15
Exceptions to plan coverage for Medicare members....15
Retail and long-term-care transition policy....16
Beneficiaries eligible for the Low-Income Subsidy (LIS)....17
2016 Low-Income Subsidy chart....18
Long-term-care short cycle dispensing (appropriate dispensing)....20
Long-term-care attestation....21
Home infusion billing procedures — Medicare claims....22
Limited Income Newly Eligible Transition program....22
Medication therapy management program....23

Pharmacy audit program....23
Fraud, waste and abuse (FWA) and compliance program requirements....24
Standards of conduct/ethics....25
Humana pharmacy compliance....26
Humana Pharmacy credentialing....28

Conflicts of interest....28
Appendix A: Related resources....29
Appendix B: Medicare Prescription Drug Coverage and Your Rights....30

Introduction

Humana appreciates your participation in its pharmacy network and your role in delivering quality pharmacy services to our members. This manual is intended to assist your pharmacy staff in processing prescription claims for Humana plans.

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 Medicare, commercial and Limited Income Newly Eligible Transition (NET) program payer sheets for the required fields to submit prescription claims electronically to Humana. In your pharmacy provider agreement, you'll find network participation requirements.

To view Humana formularies for Medicare and commercial members, go to **Humana.com/druglists**.

The Humana Pharmacists 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 member's prescription prior authorization status.

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 any difficulties registering, send an email to **hpsnetworks@humana.com**. Please include the pharmacy name, National Provider Identifier (NPI), pharmacy contact name and contact phone number.

Documents such as Humana payer sheets, the Humana Pharmacy Audit Guide, Limited Income NET documents and pharmacy news bulletins are available on our public website **(Humana.com/pharmacists)** for your convenience.

We hope that you find this manual informative, and we thank you again for your participation in the Humana pharmacy provider network. If you have comments about this manual or suggestions for next year's edition, please send them to **hpsnetworks@Humana.com.**

Submitting pharmacy claims

All participating pharmacies must comply with NCPDP transaction standards for pharmacy drug claims, coordination of benefits and related pharmacy services.

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

Plan	BIN	PCN
Non-Medicare	610649	03190000
Medicare Prescription Drug Plans (please submit with the member ID located on the member's ID card)	015581	03200000
Medicare Advantage Plans	610649	03200004
Medicare's Limited Income NET program	015599	05440000

For information regarding CarePlus BIN and PCN, see the CarePlus supplement to the Humana pharmacy manual found at **http://apps.humana.com/marketing/documents.asp?file=2618785.**

Prescription origin code requirements

Humana requires the prescription origin code (NCPDP Telecommunications Standard D.0 field 419-DJ) to be populated on all prescriptions. All claims submitted will be denied at the point of sale if this code is not populated. If the pharmacist is not able to populate these values within the pharmacy's practice management system, the pharmacist should contact the pharmacy's current software vendor for assistance. Argus is not able to override this edit.

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

Value	Value type
00	Original dispensing — the first dispensing
01-99	Refill number — number of the replenishment

All new prescriptions must contain one of the following numeric values:

Value	Value type
1	Written
2	Telephone
3	Electronic
4	Fax
5	Situations for which a new Rx number needs to be created from an existing valid prescription such as traditional transfers, intra-chain transfers, file buys and software upgrades/migrations. This value is also the appropriate value for "pharmacy dispensing," when applicable, such as over-the-counter, Plan B, established protocols, pharmacists' authority to prescribe, etc.

Eligibility verification

Cardholder ID

Pharmacies should submit the Humana member ID number in the "Cardholder ID" field whenever possible. This number can be found on the member's Humana ID card. Sample card images can be seen on pages 9 through 11 of this manual.

- For commercial claims, Humana also allows the submission of the member's Social Security number in the cardholder ID field. The commercial claim will adjudicate with the Social Security number if the member provided this number to Humana at the time of enrollment. In addition, pharmacies may call our help desk at **1-800-865-8715** (option 3) and provide the member's name and date of birth to obtain the Humana member ID.
- For Limited Income NET program claims, the Medicare health insurance claim number (HICN) may be submitted in the cardholder ID field.
- For Medicare members who don't have their Humana ID number, pharmacies may use the automated eligibility verification described below or submit an E1 query.

Person code

A person code (also known as dependent or relationship code) is required for commercial plans, but it is not required for Medicare plans. The person code field is a two-digit numeric entry; a single-digit numeric entry will result in a rejection.

Medicare automated eligibility-verification system

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 address (including city, state and ZIP code)
- Member telephone number
- Member date of birth
- Member gender
- Medicare ID number (nine digits and one alpha character)
- Plan name (Humana Gold Plus HMO, Humana Walmart Preferred RX PDP, HumanaChoice PPO, etc.)
- Plan option/Contract-plan benefit package (e.g., S5884-032, H1806-001, R5826-002)

Humana-specific Argus payer sheets

Pharmacists can find applicable commercial and Medicare pharmacy payer sheets at **Humana.com/pharmacists**. Look for the "Manuals & forms" link. Direct links to the payer sheets are as follows:

- Commercial D.0 sheet: **http://apps.humana.com/marketing/documents.asp?file=2295826**

- Medicare D.0 sheet: **http://apps.humana.com/marketing/documents.asp?file=2295839**
- Limited Income NET sheet**:** **http://apps.humana.com/marketing/documents.asp?file=2295852**

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 and the Illinois Integrated Care Program (ICP) Medicaid plan. Claims submitted without a valid and active Type 1 NPI will be rejected at the point of sale. 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.

NCPDP error code	NCPDP error code description	Free-form messaging	Applicable SCC
56	Non-matched prescriber ID	Prescriber ID submitted not found. If validated, submit applicable SCC.	42
42	Plan's prescriber database indicates the prescriber ID submitted is inactive or is not found or is expired	Prescriber ID not active. If validated, submit applicable SCC.	42
43	Plan's prescriber database indicates the associated United States Drug Enforcement Agency (DEA) number for submitted prescriber ID is inactive or expired	Validation of active DEA status required. If validated, submit applicable SCC.	43
44	Plan's prescriber database indicates the associated DEA to submitted prescriber ID is not found	Validation of active DEA for prescription required. If validated, submit applicable SCC.	43 or 45
46	Plan's prescriber database indicates associated DEA to submitted prescriber ID does not allow this drug DEA schedule	Validation of active DEA schedule required. If validated, submit applicable SCC.	46
543	Prescriber ID qualifier value not supported	Prescriber Type 1 required. Foreign prescriber ID not allowed.	N/A
619	Prescriber Type 1 NPI required	Type 2 NPI submitted — type 1 NPI Required (for FL MMA & IL ICP) and Claim not covered due to Medicare Part D active valid prescriber NPI requirement (for Part D claims)	N/A

The pharmacy NPI field must contain accurate information identifying the pharmacy for each claim submitted. The pharmacy NPI must be submitted in NCPDP field 201-B1 (service provider ID) with the qualifier "01" in NCPDP field 202-B2 (service provider ID qualifier). The prescriber NPI must also be submitted in NCPDP field 411-DB (prescriber ID) with the qualifier "01" in NCPDP field 466-EZ (prescriber ID qualifier).

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 to confirm 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 compliance 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 (with severe restrictions) and may cause severe psychological or physical dependence if abused. Pursuant to 21 CFR § 1306.12(a), Schedule II prescription drugs may not be refilled. However, 21 CFR § 1306.13(b) provides that Schedule II drugs for patients residing in a long-term-care facility and for the terminally ill may be partially filled as long as the total quantity dispensed does not exceed the total quantity prescribed. Under this provision, Schedule II prescriptions for these patients are valid for a period not to exceed 60 days from the issue date. In addition, pursuant to 21 CFR § 1306.11(a), Schedule II drugs may not be dispensed without a practitioner’s written prescription.

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.

Drug formularies

Humana manages numerous formularies for the many prescription benefit plans it offers. You can view details of these formularies at **Humana.com/druglists**. Noteworthy annual changes to Humana’s Medicare and commercial formularies are announced in the fall of each year. You can find these announcements on the Medicaid provider “What’s New” page at **https://www.humana.com/pharmacy/pharmacists/news/alerts**.

Formulary lists are developed and maintained by a medical committee consisting of doctors 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

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

For information on prior authorizations, visit **Humana.com/PA.** Prescribers may fax prior authorization requests to Humana Clinical Pharmacy Review (HCPR) at **1-877-486-2621**. For questions, contact HCPR at **1-800-555-CLIN** (**1-800-555-2546**) between 8 a.m. and 6 p.m. local time, Monday through Friday. Requests for Puerto Rico members can be submitted via phone at **1-866-488-5991** or can be faxed to **1-855-681-8650**.

Step therapy

Humana's Medicare and commercial plans are subject to step therapy protocols as a component of Humana's standard drug utilization review (DUR) program. Step therapy protocols require the member to utilize medications commonly considered first-line before using medications considered second- or third-line. These protocols promote established national treatment guidelines and assist in promoting safe, cost-effective medication therapy.

Prescribers with requests related to step therapy requirements should fax them to HCPR at **1-877-486-2621**. Requests should be submitted on the applicable form found at **Humana.com/PA**. Prescribers or pharmacists with questions may contact HCPR at **1-800-555-CLIN** (**1-800-555-2546**). Requests for Puerto Rico members can be submitted via phone at **1-866-488-5991** or can be faxed to **1-855-681-8650**.

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 helps members obtain the optimal dose required for treating their conditions.

If a member's medical condition warrants an additional quantity, the pharmacist should ask the prescriber to submit a request to HCPR. Requests can be submitted by phone at **1-800-555-CLIN** (**1-800-555-2546**) between 8 a.m. and 6 p.m. local time, Monday through Friday. Fax requests should be submitted on the applicable form found at **Humana.com/PA** and sent to **1-877-486-2621**. Requests for Puerto Rico members can be submitted via phone at **1-866-488-5991** or can be faxed to **1-855-681-8650**.

While awaiting clinical review, the pharmacist may:

- Dispense up to the quantity limitation to meet the member's immediate needs. Secondary messaging will provide dosage limit guidelines.
- Inform the prescriber directly that the pharmacist has given the member medication to meet the member's immediate needs.
- Inform the member that the drug in question has a quantity limit and that the pharmacist has given the member an amount to meet his/her immediate needs. Mention that a larger quantity will be available if the prescriber receives clinical approval from HCPR.

If approval is received for a larger quantity, the pharmacist should reverse and resubmit the claim with the appropriate quantity.

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. On a prescription submitted with a DAW code other than zero, the reason for the selected code must be documented and must be in compliance with all applicable laws, rules and regulations.

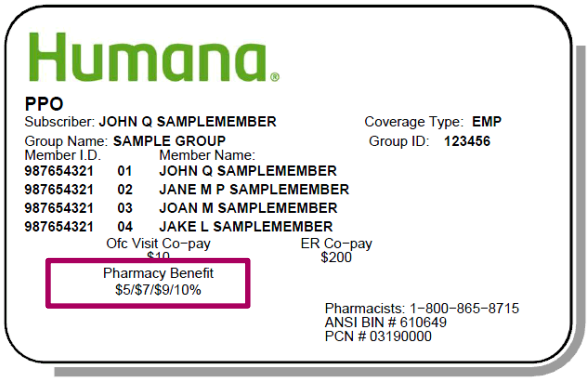
Value	Value type
0	No product selection indicated

1	Substitution not allowed by prescriber
2	Substitution allowed — patient requested product dispensed
3	Substitution allowed — pharmacist selected product dispensed
4	Substitution allowed — generic not in stock
5	Substitution allowed — brand drug is dispensed as generic
6	Override
7	Substitution not allowed — brand drug is mandated by law
8	Substitution allowed — generic drug not available in marketplace
9	Other

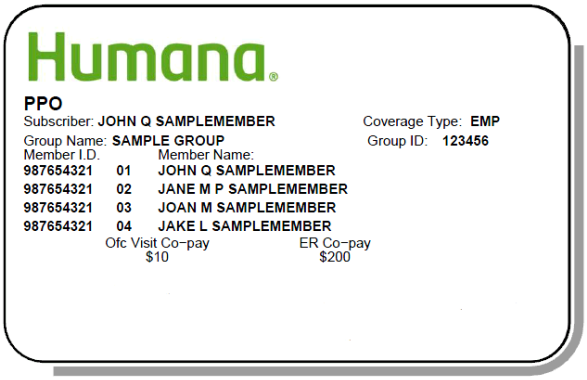
Identification (ID) cards

The following are examples of the ID cards that pharmacy employees may see from Humana members.

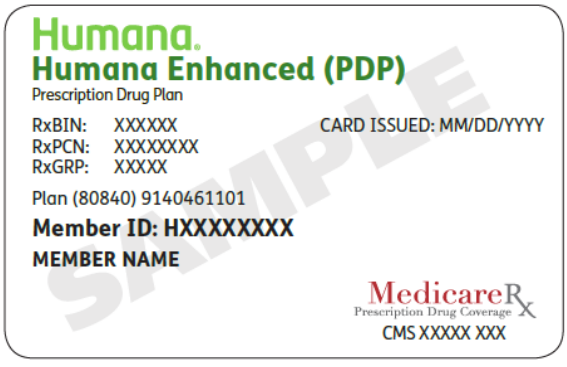
Card for a commercial member with pharmacy coverage



Card for a commercial member without pharmacy coverage

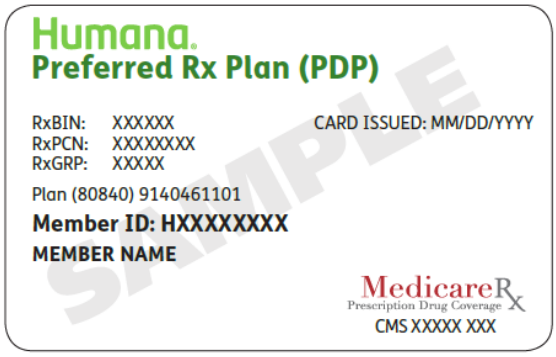


Card for a Medicare member with a Prescription Drug Plan (PDP) – Part D ONLY

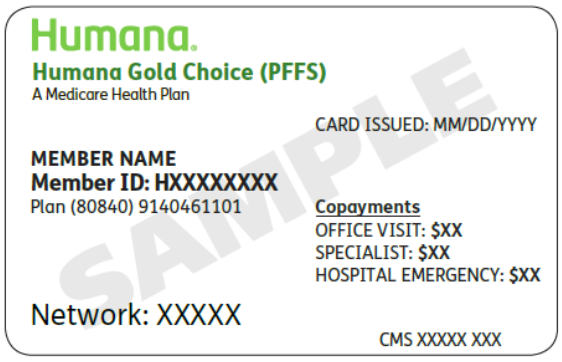


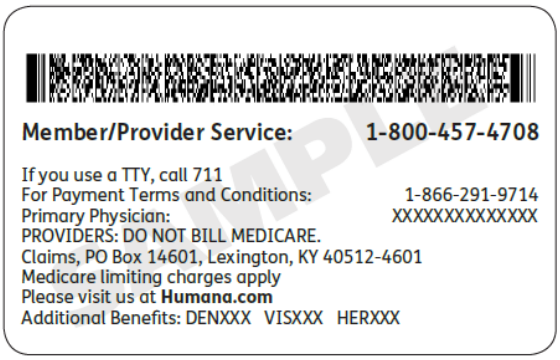
The member's plan designation is located under the Humana logo.

Card for a Medicare member with a (or the) Humana Preferred Rx Plan (PDP)



Card for a member with Medicare Advantage Prescription Drug Coverage (MAPD) (Parts A, B, D)



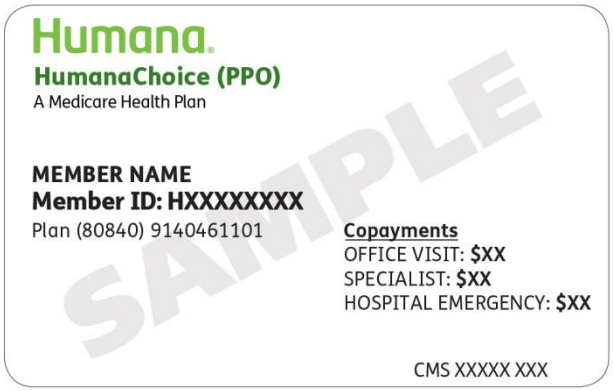


Humana Medicare Advantage-only plans

Some beneficiaries continue to participate in a Medicare Advantage-only plan (without the prescription benefit). Humana's coverage for these beneficiaries includes a benefit for Part B drugs. Note that the BIN and PCN are not supplied on the identification cards. Please process claims for these members under BIN 610649 and PCN 03200004. Beneficiaries with this plan may present a card similar to the cards below.

Card for a member with health maintenance organization (HMO) Medicare Advantage-only plan – Parts A and B

Card for a member with preferred provider organization (PPO)
Medicare Advantage-only plan – Parts A and B



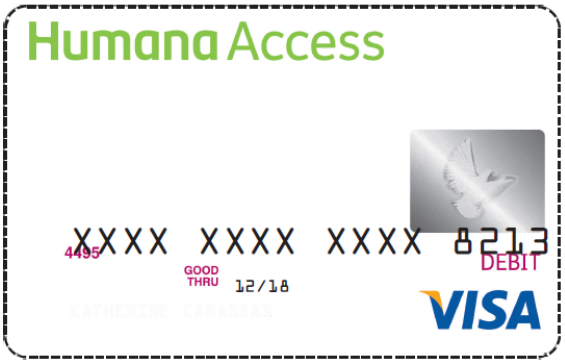
Humana Access® Visa® debit card

The Humana Access Visa debit card is designed to make health care payment transactions easier for members, pharmacists and other health care providers. This card enables commercial members who have selected a health savings account (HSA), personal care account (PCA) and/or a health care flexible spending account (FSA) to deduct applicable copayments and other covered out-of-pocket expenses directly from these accounts when using health-care-related merchants.

There are two types of cards:

1. **Combined ID and Visa card**: Some Humana members will have a Humana Access card that will be used as their identification card and as a debit/credit card for payment of specific medical expenses. This is a sample of the combined ID and Humana Access card:

2. **Stand-alone Humana Access card for members with Humana FSA plans**: This is not a medical ID card. It only gives members access to FSA funds. Some members may have separate medical insurance ID cards, and some members who carry the stand-alone Visa may not have Humana medical coverage. This is a sample of the stand-alone Humana Access card:



Please note:

- Humana members may carry both types of Humana Access cards.
- Only the subscriber's name appears on the card.

If it is necessary to make a copy of the Humana Access card, please mark out the Visa account number on the copy to prevent fraud.

Completing transactions with the Humana Access card

The following criteria must be met to successfully complete a transaction:

- A member must be enrolled in a Humana spending account.
- The member must activate the card.
- For an FSA or PCA, the amount charged must be an exact match to the member's prescription cost share.

Please note these additional tips:

- Pharmacy providers may always select the "credit" option and process the transaction with the member's signature.
- Payments with the Humana Access card may be processed like a credit card, requiring only a signature, or as a debit transaction using the member's preassigned personal identification number (PIN). Members who don't know their PIN can log in to their MyHumana account to retrieve it or call **1-800-604-6228** to have it mailed to them.
- The card cannot be used in conjunction with coupons or other discounts because an exact match of the subscriber's prescription drug copayment is required.

Reasons for declines

Humana Access card transactions usually process successfully. When a card is declined, the failed transaction may be due to one of the following reasons:

- **Insufficient funds**
- **No substantiation match** – the prescription amount must match the transaction amount
- **Invalid merchant** – not health-care-related
- **Inactive card** – member never called to activate
- **Member not eligible** – the member's plan does not allow prescriptions to be purchased with the card

In these instances, members should pay for their prescriptions and submit a paper claim form for reimbursement to Humana. Members may contact spending account administration at **1-800-604-6228** for information about reimbursement. Assistance is available from 8 a.m. to 7 p.m. Central time on weekdays.

Medicare pharmacy claims

A member could have separate Medicare Part B and Part D plans with Humana. In those instances, the pharmacist will receive a rejection for Part B-covered items and services from Humana's Part D plan. In order to process the claim under the member's Humana Part B plan, the pharmacist should resubmit the claim with the appropriate BIN/PCN combination. All member information, such as the cardholder ID, remains the same. If there are problems, pharmacists may call Humana Medicare customer service at **1-800-281-6918** (option 1) for assistance.

Medicare Part B vs. Part D billing

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 considers most drugs that meet the CMS definition of a Part D drug and are dispensed at a retail pharmacy to be covered under Medicare Part D. Humana also considers most drugs administered incidental to a physician service to be covered 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 plans cover the following drugs (this is not an all-inclusive list):

- Most 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.

In order for a drug to be included in the Part D benefit, the product must satisfy the definition of a Part D drug and not otherwise be excluded. A Part D drug must be regulated by the U.S. Food and Drug Administration (FDA) as a drug, biological or vaccine.

PDPs 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 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.

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.

For information about prior drug authorization for CarePlus members, see the CarePlus supplement to the Humana pharmacy manual found at **http://apps.humana.com/marketing/documents.asp?file=2618785.**

Humana processing of Medicare drug exclusions

For Medicare PDP members, Humana will process claims for excluded drugs in the following manner:

- **Medicare Part B drugs:** Rejection with a message that says "Bill Part B Carrier"
- **Medicare Part D drugs, including over-the-counter drugs:** Process through the member benefit **unless** the member is eligible for a low-income subsidy or the member has other secondary insurance, in which case the claim will be rejected.

Pharmacists who are not receiving these messages should check with their chain headquarters or their software vendor. Humana is sending this message, but the pharmacy's headquarters or software vendor may choose not to display messages on claims that successfully adjudicate.

For information regarding CarePlus plans' exclusions, see the CarePlus supplement to the Humana pharmacy manual found at **CarePlusHealthPlans.com.**

Medicare vaccine administration

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 state law.

Submitting claims for vaccine administration

To submit claims for **both** the drug and the administration, the pharmacy must bill a value greater than zero in the incentive amount submitted field (438-E3) and submit a professional service code of "MA" in field 44Ø-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 a value greater than zero in the

incentive amount submitted field (438-E3). The pharmacy must also submit a professional service code of "MA" in field 44Ø-E5.

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

Medicare coverage determinations

Medicare members, appointed or authorized representatives and prescribers have the right to ask Humana to make a decision regarding the coverage of a drug, reimbursement for a drug purchased out-of-pocket or reimbursement for a drug purchased at an out-of-network pharmacy.

Members, appointed or authorized representatives and prescribers can request an expedited **coverage determination** if the member's health would be placed in jeopardy by waiting the standard 72 hours for a decision. However, requests for payment or reimbursement cannot be expedited.

Members, appointed or authorized representatives and prescribers may request a coverage determination or expedited coverage determination by faxing the request to HCPR at **1-877-486-2621**. Requests for Puerto Rico members can be submitted via phone at **1-866-488-5991** or can be faxed to **1-855-681-8650**. For questions, contact HCPR at **1-800-555-CLIN** (**1-800-555-2546**). More information and applicable forms are available at **Humana.com/Rxtools**. Choose the link under "Coverage determinations."

For information about the CarePlus coverage determination review process, see the CarePlus supplement to the Humana pharmacy manual found at **http://apps.humana.com/marketing/documents.asp?file=2618785.**

Exceptions to plan coverage for Medicare members

Medicare members can ask Humana to make an exception to its coverage rules; however, the request must be supported by the member's prescriber in a supporting statement. Members may submit several types of exception requests, including the following:

- 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)
- Request for a higher level of coverage for a drug. For example, if a drug is considered a tier 4 nonpreferred drug, the member can ask that it be covered as a tier 3 preferred drug instead. (This results in a lower copayment for the member.)

A member may request an expedited exception if his or her health would be placed in jeopardy by waiting the standard 72 hours for a decision.

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/Rxtools**. Select the "Exceptions and Appeals" link to locate the form. Prescribers or pharmacists with questions may contact HCPR at **1-800-555-CLIN** (**1-800-555-2546**). Requests for Puerto Rico members can be submitted via phone at **1-866-488-5991** or can be faxed to **1-855-681-8650**.

Retail and long-term-care transition policy

This policy applies to prescribed medications that are subject to certain limitations, such as nonformulary drugs and drugs requiring prior authorization or step therapy. This policy helps members who have limited ability to receive their prescribed drug therapy by providing them with a temporary supply. For new and re-enrolling members, Humana will cover one temporary 30-day supply of a Part D-covered drug within the first 90 days of eligibility when the prescription is filled at a network pharmacy. If the member presents a prescription written for less than 30 days, Humana will allow multiple fills to provide up to a total of 30 days of medication.

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 30-day supply gives the member time to talk to his/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.

Pharmacists will need to enter the PAC that is returned on the rejected claim response in order for the claim to process consistently with the transition policy. See the table below.

Transition type	PAC	Free-form text message to pharmacy
Initial Eligibility Period LTC	41000	LTC TRAN BFT USE PAC 41000
Emergency Fill LTC	42000	LTC EMERGENCY FILL USE PAC 42000
Level of Care Change LTC	43000	LOC CHANGE LTC USE PAC 43000
Retroactive Eligibility LTC	44000	LTC RETRO ELIG BENEFIT USE PAC 44000

PACs will not work under the following conditions:

- CMS-excluded drug
- Medicare Part B drug
- Drug requires a Medicare Part B vs. D determination and therefore is required to go through the standard prior authorization process
- Initial transition eligibility criteria are not met

Level-of-care changes

Throughout the plan year, members may have a change in their treatment setting 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 stay (where payments include all pharmacy charges) and who now need to use their Part D plan benefit
- 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 Humana's nonformulary, step therapy, quantity limitations and clinical prior authorization requirements. A PAC will not be required to process the first claim in the retail setting.

In the long-term-care (LTC) setting, a PAC will be provided in the messaging to the pharmacy upon receipt of a denied claim that is eligible for a transition fill. This PAC will allow the claim to be processed and paid. There will also be messaging for eligible retail and LTC transition claims indicating the drugs' 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, Part D excluded drugs, Part B drugs or Medicare Part B vs. D determinations.

Beneficiaries eligible for the 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 plan. Some people automatically qualify for this subsidy and don't need to apply. Medicare mails a letter to these individuals. The pharmacist may use the pharmacist self-service center website (registration required; see page 3) to view the member's LIS status.

Sometimes a member believes he or she has qualified for the low-income subsidy and is paying an incorrect cost-sharing amount for his or her prescription. To address these situations, our plan has established a process that allows the member to provide to us 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" letter or "Notice of Action" letter
- A copy of a state document that confirms active Medicaid status and is dated between July 1 and Dec. 31 of the previous calendar year
- A screen print from the state Medicaid system showing Medicaid status on a date that falls between July 1 and Dec. 31 of the previous calendar year
- A printout from the state electronic enrollment file or any other state documentation showing Medicaid status on a date that falls between July 1 and Dec. 31 of the previous calendar year
- A letter from SSA showing the individual receives Supplemental Security Income
- A remittance from a medical or nursing facility showing Medicaid payment for a full calendar month of care for the individual between July 1 and Dec. 31 of the previous calendar year
- A copy of a state document that confirms Medicaid payment on behalf of the individual to a medical or nursing facility for a full calendar month between July 1 and Dec. 31 of the previous calendar year
- A screen print from the state Medicaid system showing the individual's institutional status based on at least a full calendar month's stay for Medicaid payment purposes; the stay must fall between July 1 and

Dec. 31 of the previous calendar year

Please note this proof must be confirmed by a pharmacist and must show the individual's eligibility took effect on or before the date the prescription was filled. The pharmacist may contact the Humana pharmacy help desk at 1-800-865-8715 and choose option 2 to add a recently enrolled Medicare Part D member to the Argus claim-processing system using the quick-activation process.

If the pharmacist can verify proof of Extra Help from the member and a call has been made to Humana to have the member's Medicare Low-Income-Subsidy 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 service at **1-800-281-6918** between 8 a.m. and 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 the Social Security Administration at **1-800-772-1213** between 7 a.m. and 7 p.m. local time, Monday through Friday.

Best-available evidence for long-term-care residents

Pharmacists who have evidence that the cost-share responsibility of a Humana Medicare member residing in a long-term-care facility should be different than 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 **Humana.com/pharmacists**. Choose the "Manuals & Forms" link under the "Rx resources" heading to download this document.

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 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 3).

For information about CarePlus' policy on best available evidence for LIS status, see the CarePlus supplement to the Humana pharmacy manual found at **http://apps.humana.com/marketing/documents.asp?file=2618785**.

2016 Low-Income Subsidy chart

Categories	Resource limits	Deductible, if applicable	Cost share up to $4,850 out-of-pocket limit	Copayment above out-of-pocket limit	Medicare subsidy of Part D premium
Institutionalized full-benefit dual eligible	N/A	N/A	$0 copay	$0 copay	100 percent
Full subsidy — full-benefit dual eligible below or equal to 100 percent of federal poverty level (FPL)	N/A	N/A	$1.20 for generic or preferred multi-source drug; $3.60 for any other drug	$0 copay	100 percent
Full subsidy – full- benefit dual eligible greater than 100 percent of FPL	N/A	N/A	$2.95 for generic or preferred multi-source drug; $7.40 for any other drug	$0 copay	100 percent
Full subsidy — nonfull-	Resources/assets	N/A	$2.95 for generic or	$0 copay	100 percent

benefit dual eligible w/ resource limits below 135 percent of FPL	below or equal to $8,780 (individual) or $13,930 (couple)		preferred multi-source drug; $7.40 for any other drug		
Partial subsidy below 150 percent of FPL	Resources/assets greater than $8,780 – $13,640 for an individual or $13,930 - $27,250 for a couple	$74	15 percent coinsurance	$2.95 for generic or preferred multi-source drug; $7.40 for any other drug	25 to 100 percent, depending on level of Extra Help

Note: Resource/asset limits displayed include $1,500 per person for burial expense.

Long-term-care pharmacy information

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

LTC claim processing guidelines

CMS requires all retail and mail-order 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.

Patient residence codes	Description
0	Not specified; other patient residence not identified below
1	Home
3	Nursing facility
4	Assisted living facility
6	Group home
9	Intermediate care facility
11	Hospice

If the pharmacy submits a Part D 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 Part D 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"**

Pharmacy service types	Description
1	Community/retail pharmacy services
2	Compounding pharmacy services
3	Home infusion therapy provider services
4	Institutional pharmacy services

5	Long-term-care pharmacy services
6	Mail-order pharmacy services
7	Managed care organization pharmacy services
8	Specialty care pharmacy services
99	Other

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

Nebulizer solutions covered under Part D for LTC residents

In order for Humana's claims-processing system to recognize that a claim for inhalation solutions, such as albuterol (to be used in nebulizers, not the metered-dose inhalers), is for a 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 in order to comply with CMS Part D requirements related to appropriate dispensing for brand, oral, solid medications in the long-term-care 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, non-oral, 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) in order 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 fails to include both an appropriate submission clarification code and special package indicator.

- **NCPDP reject code 597:** "LTC Dispensing Type Does Not Support The Packaging Type"

- **NCPDP reject code 612:** "LTC Appropriate Dispensing Invalid Submission Clarification Code (SCC) Combination"

Combination pharmacies

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

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:

Applicable member copayment (31-day)	$31
Days' supply submitted on the claim	14
Prorated copayment	$14
Calculated daily copayment	$1

Long-term-care attestation

Humana reimburses its contracted LTC pharmacy providers 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 pharmacy providers' 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. Your cost-share collection practices should be guided by the following principles:

1. **Your practice:** We request that you attest that your general practice consists of (i) not collecting LIS or suspected LIS member cost-share, (ii) deferring collection and (iii) accepting health plan remittance that is in compliance with the terms of the member's benefit plan as payment in full.

2. **Notification:** As a Humana-contracted network LTC pharmacy provider, you agree to notify Humana within 30 calendar days of any changes to this attestation of LIS cost-share collection practices for LIS-eligible beneficiaries.

Please contact Humana at 1-888-204-8349 if you have not submitted your cost-share collection practices. This attestation is collected in accordance with the requirements of applicable CMS regulations and instructions. Representatives are available to assist you from Monday through Friday from 8 a.m. to 11 p.m. Eastern time.

Home infusion billing procedures — Medicare claims

In order for Humana to recognize a claim from a home infusion provider and to reimburse accordingly, three fields require a specific entry during claims processing.

Field description	NCPDP field number	Entry for home infusion therapy
Place of service	307-C7	01
Patient residence	384-4X	01
Pharmacy service type	147-U7	03

Each of these fields requires an entry of a **two-digit** number (not a single-digit number). If a pharmacy's software system has a drop-down menu for the place of service, patient residence or pharmacy service type code, the pharmacist will need to verify that it is a two-digit field. If a single-digit number is entered, the system will default to "00," and the pharmacy will not be reimbursed in accordance with its contractual agreement with Humana.

Limited Income Newly Eligible Transition program

Humana administers the Limited Income Newly Eligible Transition (Limited Income NET) program on behalf of CMS. The program is designed to provide drug coverage for low-income beneficiaries who are currently without coverage.

Limited Income NET allows individuals with both Medicare and Medicaid who are not yet enrolled in a Medicare Part D Prescription Drug Plan to be automatically enrolled in a Part D plan at the pharmacy. The program also covers individuals who have been automatically assigned to the Limited Income NET contract (contract ID X0001). Once an individual is determined to be eligible, depending on the individual's eligibility effective date, claims can be submitted for up to 36 months of retroactive coverage.

Four specific groups qualify for Limited Income NET:

- Full-benefit, dual-eligible beneficiaries (those who have Medicare and full Medicaid benefits)
- Social Security Income (SSI)-only beneficiaries (those who have Medicare and receive Supplemental SSI but do not have Medicaid)
- Partial-benefit, dual-eligible beneficiaries (those who have Medicare and qualify for a Medicare Savings Program but not full Medicaid)
- Low-Income Subsidy (LIS) awardees (those who have been awarded the LIS through the Social Security Administration)

Humana asks its contracted providers to be alert for patients who may be eligible for the program. Beneficiaries can access the Limited Income NET program in three ways:

1. CMS can automatically assign individuals to the Limited Income NET program. These beneficiaries typically have retroactive eligibility and have past claims that they ask the pharmacy to submit to the Limited Income NET program.
2. A beneficiary may present a prescription at the pharmacy and become enrolled at the point of sale.

3. Beneficiaries may submit receipts for their out-of-pocket payments for prescriptions to Humana as the Limited Income NET administrator and, upon verification of eligibility, become enrolled in the program. Beneficiaries who have a claim more than 30 days old that is rejected for no eligibility at the pharmacy should call 1-800-783-1307 for an eligibility determination. This line is open 24 hours a day.

For more information on the program, visit **Humana.com/LINET.**

Medication Therapy Management 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 your pharmacy is interested in providing MTM services to Humana members, please visit **OutcomesMTM.com** to learn more.

Pharmacy audit program

Humana maintains a pharmacy audit program to:

- Help ensure the validity and accuracy of pharmacy claims for our clients (including CMS)
- Help ensure compliance with the provider agreement between Humana and our 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 day supply incorrectly
- Using a dispense-as-written code incorrectly
- Overbilling quantities
- Failing to retain/provide 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/pharmacists**, then select "Manuals & forms."

LTC pharmacy audits

Humana has the right to audit an LTC pharmacy provider'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/pharmacists**, then select "Manuals & forms."

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 (available at **Humana.com/fraud**), as committed by Humana employees, contracted providers, those supporting their contractual obligations to Humana, members, customers, vendors, contractors and/or other business entities. The company 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 and a Medicare Part D Prescription Drug Plan sponsor. 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.

FWA prevention training

Every Humana-contracted entity supporting Humana's Medicare and/or Medicaid products is responsible for providing FWA prevention and detection training to its employees and contractors who administer, deliver or support federal health care program benefits or services and for providing certification of training completion.

Humana-contracted entities must maintain FWA training records, including the time, attendance, topic, certificate of completion (if applicable) and test scores for any tests administered, for 11 years (or longer, if required by state law). Humana has adopted training content published by CMS as a resource for meeting this requirement. To access the CMS material, please visit **Humana.com/fraud** and look for "Fraud, Waste and Abuse Training and General Compliance Training."

Humana and CMS reserve the right to audit your pharmacy to assess its commitment to FWA requirements, including requests CMS makes of Humana that require your pharmacy to provide documentation.

Reporting methods for suspected or detected FWA and/or noncompliance

Pharmacy providers should report suspected fraudulent activities by calling the Humana Special Investigation Unit (SIU) at **1-800-614-4126**. This 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.

Additional information about SIU and Humana's efforts to address FWA can be found at Humana.com/fraud.

Once SIU performs its initial investigation, it will refer the case to law enforcement and/or regulatory agencies, as appropriate.
Pharmacy providers, their employees and subcontractors may also report concerns and information related to FWA or noncompliance with this manual and/or Humana's compliance policy via these options:

By phone:

- Humana Special Investigations Hotline (voice messaging system): **1-800-614-4126** (available 24 hours a day; callers may remain anonymous)
- Humana Ethics Help Line: **1-877-5-THE-KEY** (**1-877-584-3539**) (available 24 hours a day)

Fax: **1-920-339-3613**
Email: siureferrals@humana.com
Mail: Humana, Special Investigations Unit, 1100 Employers Blvd., Green Bay, WI 54344
Ethics Help Line reporting website: **https://ethicshelpline.tnwreports.com**

Confidential follow-up to check on the status of an investigation is available. Humana requests that if a reporter desires to remain anonymous, he/she provide enough information to allow Humana to investigate the issue.

Humana has a zero-tolerance policy for 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
- Corrective action plan(s)
- Reporting of the conduct to the appropriate external entity(ies), such as CMS, a CMS designee and law enforcement agencies

Every Humana-contracted entity must have disciplinary standards and take appropriate action upon discovery of FWA or actions likely to lead to FWA.

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 CMS contract.

Standards of conduct/ethics

Every Humana-contracted entity must ensure its business performs the following actions and, upon Humana's request, provide certification of these actions:

- Employees, management, governing body members and those the entity contracts to support
- contractual obligations to Humana's Medicare and/or Medicaid products are required to review and
- attest to comply with the entity's standards of conduct document upon hire or contract and annually
- thereafter. If the contracted entity 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. To obtain a copy, please visit **Humana.com/fraud**.

- Employees, management and governing body members must sign a conflict of interest document upon hire/contract and annually thereafter. If disclosures on the conflict of interest form become inaccurate or incomplete because of a change in circumstances, the organization should immediately complete and submit a new form, detailing the change.

- 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, upon hire/contract and monthly thereafter to verify those who assist in the administration or delivery of federal health care program benefits are not included on such lists.

- Remove any person identified on an exclusion list above from any work related directly or indirectly to any federal health care program. Take appropriate corrective actions and report findings to Humana's Special Investigation Unit at **1-800-614-4126**.

Humana pharmacy compliance

CMS and Humana's Medicaid contracts mandate that all those contracted with Humana or Humana subsidiaries to provide or support health care services for Humana's Medicare and/or dual Medicare-Medicaid members, including pharmacies, complete compliance program requirements.

The information below is provided to help health care providers complete these requirements:

Frequently Asked Questions and Answers
This document provides additional information regarding the compliance requirements and Web access.

http://apps.humana.com/marketing/documents.asp?file=1827553

Humana's compliance program requirements for contracted pharmacy providers also include, but are not limited to:

1. Monitoring and auditing the compliance of subcontractors that provide services or support related to administrative or health care services provided to a member of a Humana Medicare Advantage or Prescription Drug Plan.
2. Obtaining approval from Humana for relationships with downstream entities. 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.
3. Having policies and procedures in place for preventing, detecting, correcting and reporting FWA, including, but not limited to:

a. Requiring employees and subcontractors to report suspected and/or detected FWA
b. Safeguarding Humana's confidential and proprietary information
c. Providing accurate and timely information/data in the regular course of business

4. Cooperating fully with any investigation of alleged, suspected or detected violation of the manual, Humana policies and procedures, applicable state or federal laws or regulations and/or remedial actions.
5. Publicizing disciplinary standards to employees and subcontractors.
6. Providing Humana with assurance related to pharmacies' compliance programs upon request.
   Please refer to Humana's compliance policy at Humana.com/fraud, as it includes an overview of the seven elements of an effective compliance program.

Humana requires completion of compliance program training and refreshes it at least each calendar year to assist you in meeting these and related requirements. Please complete the training as soon as possible within each calendar year by following the instructions below.

Your training will include review of at least the following materials available at **Humana.com/fraud**:

- Humana's compliance policy (the definitive source of Humana's compliance program requirements);
- Humana's standards of conduct

- Fraud waste and abuse training* and general compliance training.

* If you are enrolled in the Medicare program or accredited as a durable medical equipment prosthetics, orthotics and supplies supplier, you are deemed to be already compliant with the FWA training requirement and do not need to complete the FWA training. Instead, you may record your deemed status on a Humana attestation form. You must still complete the compliance policy, standards of conduct and general compliance components of the requirements.

Additionally, Humana requires that all pharmacy entities participating in plans for dual Medicare-Medicaid beneficiaries and/or Medicaid beneficiaries, including those contracted with subsidiaries, complete additional training that may cover any or all of the following topics**:

- Cultural competency
- Health, safety and welfare education
- Medicaid pharmacy provider
- Humana orientation.

These trainings are available at **humana.com/pharmacy/pharmacists/manuals-forms**.
** The number of trainings may vary by state where Humana offers these plans. Humana clarifies this in its attestation form that must be completed and returned to Humana.

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.

If you have training questions that are not addressed in this manual please send an email to **HumanaPharmacyCompliance@humana.com**.

Humana.com instructions

This document covers how to complete the compliance requirements on Humana.com, how to register on Humana.com, how to create a new user, how to assign the compliance business function to another user and how to update an organization's tax identification number (TIN):
http://apps.humana.com/marketing/documents.asp?file=1827566

If your organization is unable to register on Humana.com, refer to the following document: Compliance requirements for health care providers who are unable to register
http://apps.humana.com/marketing/documents.asp?file=1827579

Humana pharmacy credentialing

URAC requires all network pharmacies to be credentialed at the time of contracting 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, as well as the following:

- Pharmacy state licensure information
- Pharmacy U.S. Drug Enforcement Agency (DEA) licensure information
- Nonsanction attestation
- Copy of current professional liability insurance (PLI) coverage that meets or exceeds a minimum requirement of $1 million in aggregate

Participating pharmacies that fail to meet Humana's required standards will be removed from Humana's pharmacy network.

Conflicts of interest

All entities and individuals supporting Humana business are required to avoid conflicts of interest. Pharmacy providers 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 procurement, transaction or business dealing. This prohibition includes, but is not limited to, a pharmacy provider offering or providing consulting, employment or similar positions to any Humana employee involved with Humana procurement or to that employee's family members or significant others.

Humana pharmacy providers are required to obtain 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 health care program benefits or services.

All pharmacy providers 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.

Pharmacy providers are prohibited from having any financial relationship relating to the delivery of or billing for items or services covered under a federal health care 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 health care 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 health care 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 health care program in a manner that is inconsistent with professional standards or norms in the local community.
- Pharmacy providers 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.

Appendix A: Related resources

Humana pharmacy help desk	For refill-too-soon overrides and prior authorization status, call **1-800-865-8715**, and press 2. For other claims-processing questions, press "3."
Humana Medicare customer service	**1-800-281-6918** 8 a.m. to 8 p.m. local time 7 days a week ********** TTY: **711** 7 a.m. to 7 p.m. Monday through Friday ********** Puerto Rico: **1-800-256-3316**
Humana Clinical Pharmacy Review (HCPR)	**1-800-555-CLIN** (**1-800-555-2546**) U.S. fax: **1-877-486-2621** Puerto Rico HCPR phone: **1-866-488-5991** Puerto Rico HCPR fax: **1-855-681-8650**
Humana Pharmacy Solutions network contracting	Fax: **1-877-650-2334** Email: pharmacycontracting@humana.com and/or hpsnetworks@Humana.com
Humana Ethics Help Line	**1-877-5-THE-KEY** (**1-877-584-3539**)
Argus reconciliation line	**1-866-211-9459**
Humana's pharmacist website	Visit **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

For important phone numbers and website information for CarePlus, see the CarePlus supplement to the Humana pharmacy manual found at **http://apps.humana.com/marketing/documents.asp?file=2618785**.

Appendix B: Medicare Prescription Drug Coverage and Your Rights

CMS requires network pharmacies to post the "Medicare Prescription Drug Coverage and Your Rights" notice within the pharmacy or to distribute it 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. Humana has provided a copy of this notice on the following page.

CMS requires that LTC pharmacies send the "Medicare Prescription Drug Coverage and Your Rights" notice to the location in the LTC facility designated to accept such notices. If the LTC pharmacy is on site, it must deliver the notice to the location in the facility designated to accept such notices.

Please post this notice in a location that is easily seen by your customers.

OMB Approval No. 0938-0975

Enrollee's Name: _____ (optional)
Drug and Prescription Number: _____ (optional)

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 nonpreferred drug and you want the plan to cover the drug at the 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.
4. 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 nonpreferred 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.

Form CMS-10147

Número de OMB 0938-0975

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 (un copago más bajo).

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 1800-MEDICARE.