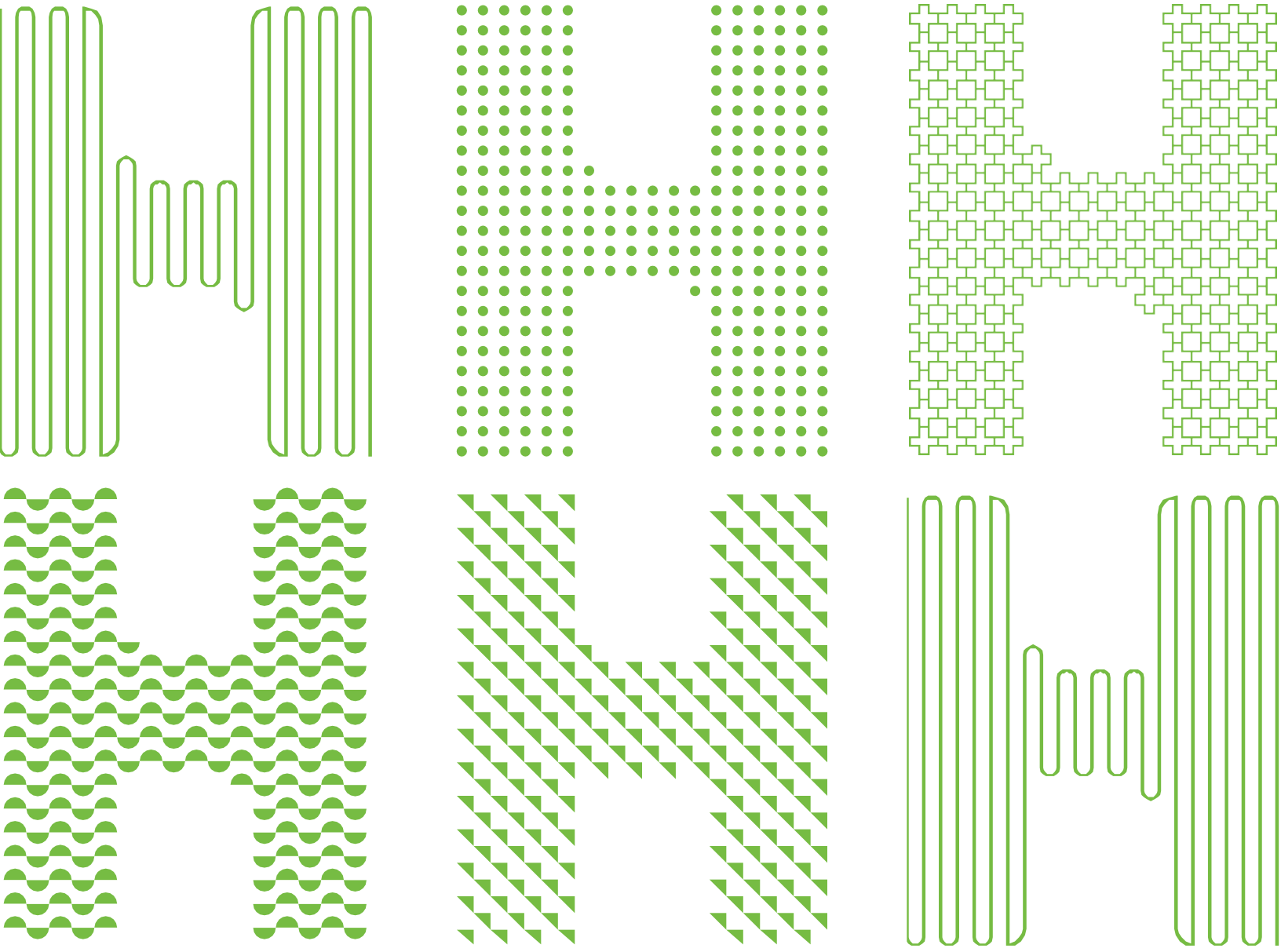
Humana Pharmacy Solutions Audit and Claim Review Guide



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Introduction

This Humana Pharmacy Solutions Audit and Claim Review Guide explains Humana Pharmacy Solutions' (HPS) audit and claim review processes.

HPS maintains a pharmacy audit and claim review program:

1. To ensure that claims submitted by network pharmacies match network pharmacy records;
2. To ensure that network pharmacies are maintaining proper documentation to support the claims submitted to Humana as required by the Pharmacy Provider Agreement (Agreement) between HPS and network pharmacies, and applicable state and federal laws, rules, regulations and guidance, including guidance from the Centers for Medicare & Medicaid Services (CMS); and
3. To educate network pharmacies about proper submission and documentation of pharmacy claims.

1. Overview

HPS conducts three types of pharmacy audits: desktop, on-site and government-directed, and two types of claim reviews: pre-pay claim validation and overpayment reviews. Pre-pay claim validation reviews and government-directed audits generally are conducted for a small number of claims. Desktop and on-site audits generally are conducted for a large number of claims.

HPS contracts with third-party audit vendors (each, an "Auditor") to perform desktop and on-site audits and overpayment reviews. Pharmacies should reference their audit letters for the appropriate audit contacts for questions or concerns. HPS reviews all audit appeals. HPS may not have access to audits performed by a third-party audit vendor until the pharmacy has received a final audit results letter and is eligible to appeal the final results.

2. Audit and claim review types and processes

2.1 Desktop audits

If HPS selects a pharmacy for a desktop audit, the Auditor will send an audit notification letter asking the pharmacy to provide the documentation identified in the letter for the claims listed on the claims report enclosed with the audit notification letter. The audit notification letter will include a copy of the Humana Pharmacy Solutions Audit Discrepancy Code List (DCL), which describes the types of discrepancies that may be found during an audit. Please refer to the external comments on the note sheet report for full details regarding any issues or concerns found.

The pharmacy must provide the documentation no later than the due date set forth in the audit notification letter. See Section 4 of this guide for more information regarding documentation requirements. The Auditor will review the documentation submitted by such date to validate the pharmacy's claim submission(s) and billing accuracy and to determine if there are any discrepancies. The Auditor also reviews the pharmacy's compliance with laws, regulations, rules or other requirements as required by the Agreement and Humana Pharmacy Solutions pharmacy manual(s). (To download a copy of the pharmacy manuals, visit **Humana.com/pharmacists** and select the "Explore guides, forms and resources" link

under “Pharmacy manuals and forms.” To request a paper copy of a pharmacy manual, call the Humana Pharmacy Networks Customer Service Center at **888-204-8349**.)

2.1.1 Extensions

If a pharmacy needs to request additional time to supply requested documentation, the pharmacy may contact the Auditor via the methods listed in the audit notification letter. The pharmacy must request the extension prior to the due date set forth in the audit notification letter. The Auditor will not grant a pharmacy’s request for an extension after the due date set forth in the audit notification letter has passed. Only one extension for the life of the audit is allotted. Therefore, if the pharmacy does not request a due date extension for the initial audit, the pharmacy may request a due date extension for the initial audit results review, if needed. The pharmacy may request the Auditor to provide an email confirmation of the new due date.

2.1.2 Submitting documentation for desktop audits

The pharmacy may submit documentation to the Auditor via certified U.S. Postal Service mail, FedEx, United Parcel Service or another traceable shipping method. The pharmacy may request to send documentation electronically as a single PDF via secure methods. All documents intended for review should be submitted at the same time using the same delivery method. If the pharmacy has concerns regarding the submission of documentation, the pharmacy should contact the Auditor via the communication methods outlined in the audit notification letter.

2.1.3 Initial documentation review

After reviewing all of the documentation submitted by the pharmacy by the due date, the Auditor will send the pharmacy an initial audit results letter. The initial audit results letter will notify the pharmacy that the pharmacy may contest the initial audit results and will include a copy of the DCL and a note sheet report or pharmacy audit report. The note sheet report includes claim review outcomes, any discrepancies found and any other notes for each claim. The pharmacy should review the note sheet report for information pertaining to the findings.

2.1.4 Failure to respond

If a pharmacy does not respond by the due date set forth in the audit notification letter (or if an extension is granted, the extended due date), the Auditor will send an “initial failure-to-respond” letter to the pharmacy. The “initial failure–to-respond” letter will describe the steps the pharmacy must take to avoid full claim reversal.

If documentation:	**Penalty assessed will be:**
Is postmarked after the initial due date set forth in the audit notification letter (or if an extension is granted, the extended due date)	25% of the total value of the audited claims (failure-to-respond penalty is capped at $10,000 for the audit as a whole)
Is provided after receipt of an “initial failure-to-respond letter” and postmarked by the post-audit due date set forth in the “initial failure-to-respond” letter (or if an extension is granted, the extended due date)	25% of the total value of the audited claims (failure-to-respond penalty is capped at $10,000 for the audit as a whole)

Is postmarked after the post-audit due date set forth in the initial failure-to-respond letter (or if an extension is granted, the extended due date)	100% of the total value of the audited claims

2.1.5 Initial audit result reviews

The initial audit results letter (or, if applicable, the initial failure-to-respond letter) will provide a due date for the pharmacy to submit any documents the pharmacy wishes to be reviewed before the audit is finalized. HPS provides the initial audit results review window so that the pharmacy can supply additional documentation to mitigate discrepancies marked on claims. The pharmacy must submit the documentation outlined in the DCL to mitigate discrepancies. The Auditor will review documentation postmarked by the due date set forth in the initial audit results letter (or, if applicable, the initial failure-to-respond letter) and determine if any discrepancies can be removed.

When the initial audit results review is complete, the Auditor will send the pharmacy a final audit results letter.

2.1.6 Audit appeals

The pharmacy may appeal the final audit results. The pharmacy must use the pharmacy audit appeal form enclosed with the final results letter, explain why the pharmacy disagrees with the audit findings for each claim deemed discrepant and provide mitigating documentation as outlined on the DCL.

Audit appeals must submitted to the HPS Audit Appeals Committee via certified U.S. Postal Service mail, FedEx, United Parcel Service or another traceable shipping method. Appeals must be postmarked within 37 days of the date of the final audit results letter. If the appeal is not postmarked by this date, the audit will be considered closed and the adjustment process (outlined in Section 3 of this guide) will begin.

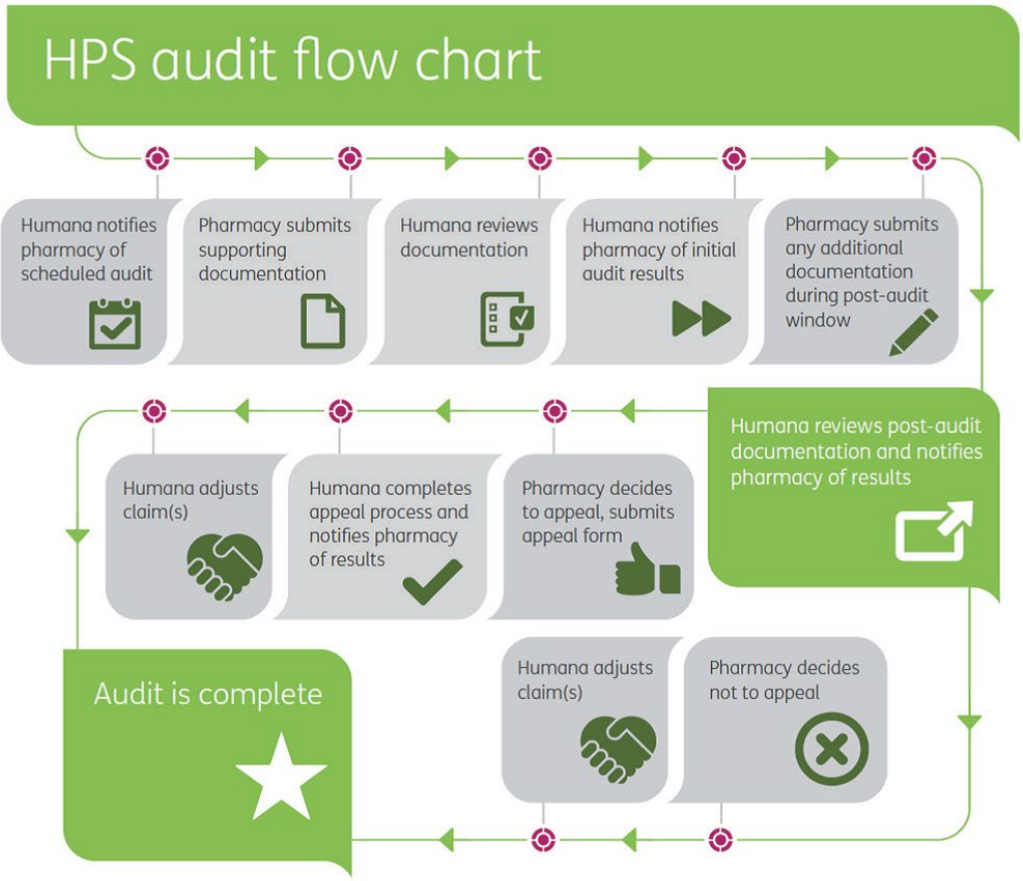
After the HPS Audit Appeals Committee has reviewed the appeal, the pharmacy will receive an appeal results letter with the committee's decision. Any pharmacy that submits an appeal after the appeal due date will receive a letter informing the pharmacy that the appeal window has expired.

2.2 On-site audits

An on-site audit is conducted at the pharmacy and generally will include a review of 150 claims. Refills associated with the audited claims may be included in the on-site audit. A pharmacy selected for an on-site audit will receive an audit notification letter that specifies the date of the audit visit, the date range of claims being audited and the Auditor's contact information. If the pharmacy would like to reschedule the on-site audit, the pharmacy must submit a request to reschedule the audit within seven calendar days from the date of the on-site audit notification letter. The Auditor will decide whether to approve or reject the pharmacy's request to reschedule. The Auditor will contact the pharmacy approximately seven calendar days before the audit to answer questions and supply additional information the pharmacy needs to prepare for the audit. If a pharmacy does not comply with an on-site audit, the pharmacy may be assessed a penalty equal to the total value of the audited claims or be subject to other disciplinary action, including, but not limited to, a corrective action and/or termination from the HPS pharmacy network(s).

HPS strongly recommends that the pharmacy designate an individual (e.g., pharmacist, manager or technician) to assist the Auditor. The pharmacy must provide the Auditor with hard copies of prescriptions, signature logs and other documents requested by the Auditor. See Section 4 of this guide for more information regarding documentation requirements. Any documentation not received on-site will be considered missing. The pharmacy also must provide the Auditor a clean workspace away from the dispensing area to keep from disrupting pharmacy practice. All documentation must be collected within eyesight of the Auditor, or the Auditor may not accept it. In addition to claim-specific documentation, the Auditor may review pharmacy procedures, licensure information and other information to determine compliance with specific sections of the Agreement and applicable rules, laws and regulations.

After reviewing all submitted documentation, the Auditor will send the pharmacy an initial audit results letter. See the initial audit review results and audit appeals processes described in Section 2.1.5 and 2.1.6 of this guide, respectively, for available post-initial audit review and appeal processes.



2.3 Pre-pay claim validation reviews

HPS also randomly conducts pre-pay claim validation reviews. HPS may contact the pharmacy by phone, fax and/or email to verify claim(s) submission, and HPS may ask the pharmacy to correct claim billing. In some circumstances, HPS may ask the pharmacy to fax prescription hard copies for verification. If a pharmacy does not comply with a pre-pay request, HPS may initiate a desktop or on-site audit. In addition, the pharmacy may be contacted by phone, fax and/or email to assist with rejected claim(s) submissions to ensure the claim is adjudicated appropriately.

2.4 Overpayment reviews

Generally, an overpayment review is a review of claims that may have been paid in error. Many overpayment reviews are conducted based on CMS requirements that Part D plan sponsors ensure claim accuracy. In some cases, information is needed to verify whether a claim should have been paid under Medicare Part A, Part B or Part D. Sometimes this information is not available at the time of initial claim adjudication, so a retrospective review is required to determine which benefit the claim should be paid under and the appropriate payer. An overpayment review may include, but is not limited to, review of:

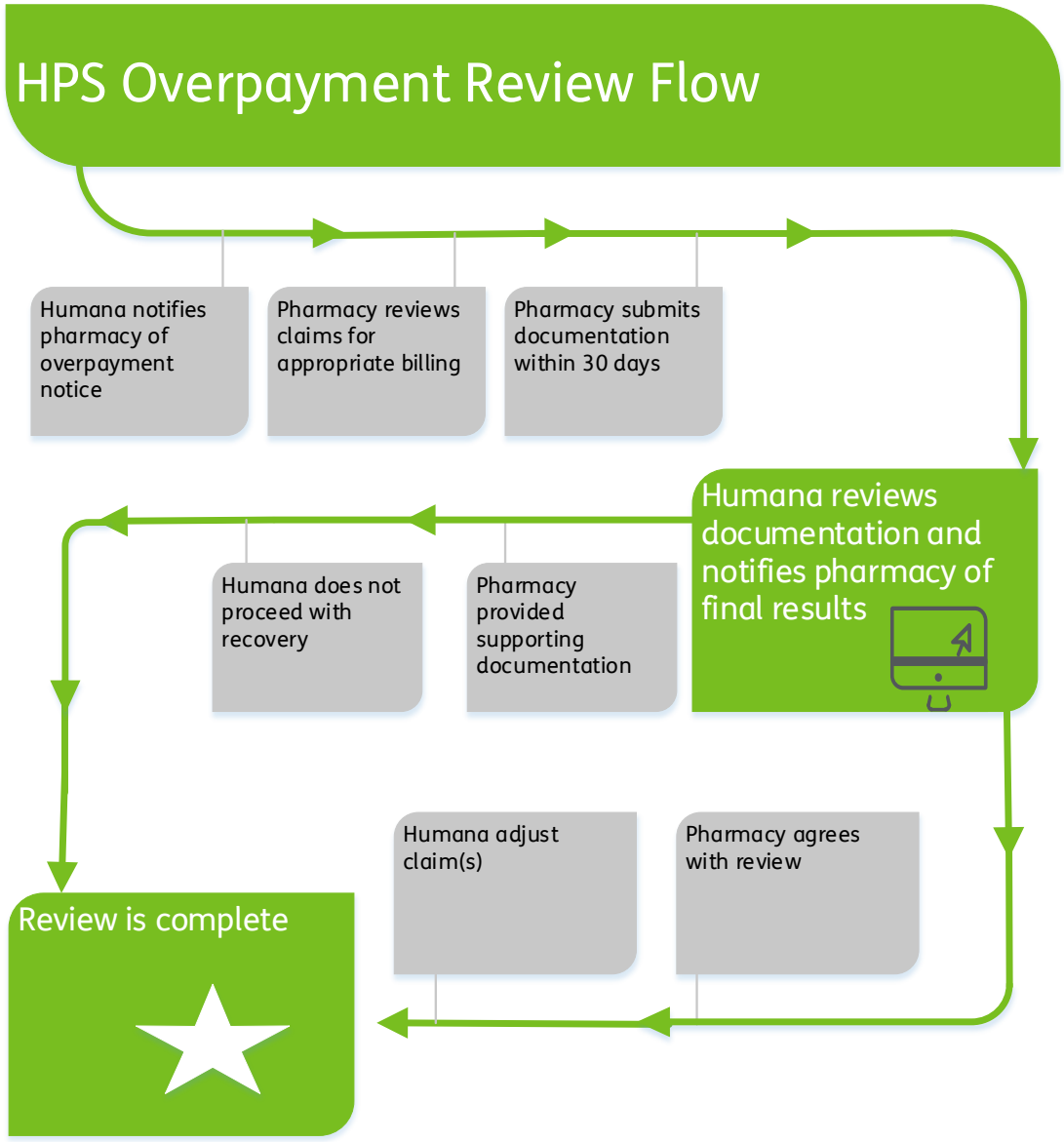
- Immunosuppressive drug claims paid in error under Part D for members who have received a kidney or other transplant
- Claims paid in error under Part D for prescription drug plan (PDP) and Medicare Advantage prescription drug plan (MAPD) members who were in a long-term care facility during a Part A hospital stay
- Insulin claims paid in error under Part D for PDP members receiving insulin through a pump (Insulin claims for PDP members receiving insulin through a pump should be paid under Part B per CMS benefit guidelines.)

In other cases, HPS internal claim analysis or a CMS rejection of a prescription drug event (PDE) can indicate that a pharmacy submitted a claim containing invalid elements of information. These claims must be corrected, and the pharmacy is required to provide the information HPS needs to correct them. This type of overpayment review includes, but is not limited to, a review of:

- Claims submitted with an invalid or inaccurate prescriber identifier number
- Claims submitted with the wrong Humana member identification number
- Claims submitted with invalid or inaccurate National Drug Codes
- Claims submitted with invalid or inaccurate pharmacy service types and/or patient resident codes
- Claims paid as primary insurer in error
- Claims paid after a member's plan is terminated
- Claims paid under the incorrect benefit

When a claim has been identified as erroneous in an overpayment review, the Auditor will send the pharmacy or facility a letter asking the pharmacy/facility to verify that the claim was submitted in error. The pharmacy/facility also will be asked to reverse the claim in its system and to rebill the claim under the appropriate drug benefit or with the correct claim-record values, if the pharmacy's dispensing software system allows the correction and the claim's submission window has not expired. If the pharmacy/facility believes the claim was correctly billed, it has 30 calendar days from the date of the notice to dispute the findings and submit supporting documentation. See Section 4 of this guide for more information

regarding documentation requirements. The Auditor will review any responses submitted by the due date and determine if any claim was paid in error. If the pharmacy does not respond within the allotted 30 days, claims identified as erroneous through the overpayment review will be adjusted in accordance with Section 3 of this guide.



2.5 Government-directed audits

HPS may initiate an audit request to the pharmacy for prescription documentation review on behalf of a government agency, including CMS. Humana may receive these requests from a third-party auditor designated by the government agency. These requests may require the pharmacy to provide HPS with copies of prescription hard-copy documentation and proof of delivery, in addition to any other documentation that the government agency or its designee requires. See Section 4 of this guide for more information regarding documentation requirements.

For questions regarding a government-directed audit, pharmacies can call **502-476-5900** or email pharmacyauditcmsrequests@humana.com.

3. Adjustments

The adjustment process will begin after the audit or claim review is closed. When an audit or claim review is closed depends on the type of audit or claim review.

Discrepant claim recovery amounts listed in an audit results letter are estimates based on the claim paid amount at the time of the pharmacy's claim submission. The pharmacy letter may list the entire claim paid amount as the estimated chargeback on claims that require adjudication until the claim adjustment has occurred.

Actual recovery amounts will not be known until the claim adjustments occur. HPS will communicate actual recovery amounts through the pharmacy's remittance advice statement. HPS will deduct audit recovery amounts from future payments to the pharmacy until the audit recovery amounts have been collected in full. If HPS is unable to offset from future payments, HPS will notify the pharmacy and the pharmacy must pay HPS the amount owed by the date set forth in the notice to the pharmacy.

4. Audit and overpayment review documentation requirements

4.1 Retail pharmacy documentation requirements

HPS recognizes that, while retail pharmacies operate in a generally consistent manner, some practices may vary from location to location. If you are uncertain whether the pharmacy's documentation matches the requirements listed below, please contact the Auditor via a communication method outlined in the letter sent to the pharmacy.

4.1.1 Retail hard copies

The pharmacy must submit, at minimum, a copy of the front and back (copy of the back sticker) of audited prescriptions. The documentation must include the following information or claims will be considered discrepant:

- Patient's name
- Date of prescription issuance
- Name, strength and dosage form (if applicable) of the drug prescribed
- Directions for use (or the maximum daily dosage allowed by the prescriber)
- Quantity prescribed
- Number of refills authorized
- Prescriber's name
- Prescriber's Drug Enforcement Agency (DEA) registration number (for scheduled
- medications)
- Prescriber's signature or, in the case of a phone-in prescription order, the full name of the individual from whom the pharmacist received the prescription order
- The unique prescription identifier (prescription number)

Additional documentation may be required based on circumstances. If needed, it will be requested from the pharmacy.

4.1.2 Retail signature log elements

HPS requires, at minimum, the following data elements on all signature logs, as well as any additional information required by law:

- Date of fill
- Prescription number
- Signature of the member (or member's representative)
- Date of pickup or delivery

4.1.3 Retail electronic prescription requirements

The pharmacy must be able to accept electronically submitted prescriptions from prescribers in National Council for Prescription Drug Programs (NCPDP) version 10.6 (Prescriber/Pharmacist Interface SCRIPT Standard, Implementation Guide) or the most current NCPDP format. For claims submitted to HPS' claims processor/administrator, the pharmacy is required to populate NCPDP field 419-DJ with prescription origin code 3 for all electronically submitted prescriptions.

4.2 Long-term care (LTC) pharmacies

HPS recognizes that LTC pharmacies operate differently than their retail counterparts. These requirements are intended to capture as many variations in acceptable practices as possible. If you are uncertain if the pharmacy's documentation matches the requirements listed below, please contact the Auditor via a communication method outlined in the letter sent to the pharmacy.

4.2.1 LTC hard copies

If a single hard-copy prescription does not contain all the elements required for an audit, the pharmacy should submit a combination of documents that constitute a full hard-copy prescription. For further guidance, consult HPS' "Long-Term Care Pharmacy Documentation Guidelines." To access them, visit **Humana.com/provider/pharmacy-resources/manuals-forms**. These guidelines can help pharmacies provide valid documentation for LTC pharmacy audits.

4.2.2 LTC signature log elements

HPS recognizes that most LTC pharmacies do not maintain patient signature logs. If an LTC pharmacy does provide a signature log for audit, and the log meets the requirements for a retail pharmacy log, HPS will accept the signature log as valid documentation. If no signature log is available, HPS requires documentation that clearly shows the member received the medication. Examples of acceptable documentation may include a signed facility delivery sheet/manifest or medication administration record (MAR). For further guidance, consult **Humana.com/provider/pharmacy-resources/manuals-forms**.

4.2.3 Emergency kit (E-kit) fill requirements

HPS recognizes that the use of E-kits and unscheduled medication pulls are necessary under certain circumstances for LTC pharmacies. The standard of practice for E-kit utilization varies across pharmacies. In general, E-kit documentation can be any combination of reports or documents that link together and display all required elements of a prescription order including prescriber signature and directions. E-kit submissions can

be clarified with the appropriate use of submission clarification codes on the claim. Where possible, please identify on the document submission if the claim is an E-kit fill.

4.3 Documentation requirements for scheduled medications

Prescriptions for scheduled medications must adhere to state and federal laws and regulations as well as any requirements outlined by governing bodies regarding stipulations particular to individual treatment methods and uses.

4.3.1 Electronic prescriptions for scheduled medications

Pharmacy systems must comply with DEA requirements for electronic prescribing of controlled substances. Pharmacy systems that accept electronically prescribed prescriptions for scheduled medications must retain the digital signatures received. Pharmacies also must validate the DEA registration of a prescriber from whom an electronic prescription is received when there is reason to suspect fraud.

4.3.2 Medications for treatment of opioid dependency

Medications used for the treatment of opioid dependency require special licensure of the prescriber as well as notation on the prescription hard copy. These medications can be used for multiple purposes, but in the event of use for treatment of opioid dependency prescriptions must contain all required elements.

4.4 Signature log elements for mail-order pharmacy providers

HPS requires, at minimum, the following data elements for all mail-order pharmacy services, as well as any additional information required by law:

- Date of pickup from pharmacy
- Name of carrier
- Tracking number, as well as documentation tying the tracking number to the audited prescription (Note: Multiple documents may be required to show link.)
- Date of delivery to member (or member's representative)
- Signature of the member (or member's representative), if required by law

If this information is stored on several different documents, there must be a clear and direct connection between all elements that links the documents to the single claim being audited.

4.5 Additional documentation

HPS has the right to request additional documentation for auditing purposes. Such documentation could include, but is not limited to:

- Purchase invoices and reports
- Credentialing documentation
- Training documentation
- Employee documentation

Humana will review additional forms of mitigating documentation if required by state laws governing audits of pharmacies, unless the state law is preempted or otherwise inapplicable.

5. Administrative penalties

HPS may assess a $5 administrative penalty to correct certain claim values listed in the sections below. Pharmacies should reference the DCL enclosed with audit letters for this information.

5.1 Quantity/days' supply

The quantity prescribed by the prescriber should be dispensed with the correct days' supply, and documentation of such dispensing should be submitted to HPS. If the prescription is written for a quantity of one, the pharmacy should dispense the smallest commercially available product for eye drops, inhalers and topical agents. If the pharmacy dispensed a larger package size, it should document an appropriate reason on the hard-copy prescription or on another readily retrievable medium.

The pharmacy must clarify the appropriate designation on the hard-copy prescription for products that can be written in various quantities (i.e., box, pen, mL, month). This clarification may be included via the prescriber's original notation or notes from the pharmacy via a readily retrievable medium regarding clarification in compliance with applicable laws and guidelines.

5.2 Origin codes

The pharmacy must submit a valid prescription origin code for every prescription and populate the prescription origin code with the approved values below:

1 = Written
2 = Telephone
3 = Electronic
4 = Facsimile
5 = Other/Transfer

5.3 Package sizes

The package size dispensed by the pharmacy must adhere to the prescription directions. If the proper package size is not in stock, HPS expects the pharmacy to dispense a smaller package size or order and dispense the proper package size within 24 hours. However, if the member's condition is such that the member must have the medication immediately, the pharmacy may dispense a larger package than called for on the prescription.

5.4 Patient residence codes

The pharmacy must submit a valid prescription patient residence code for every prescription and populate the patient residence code with the approved values below:

0 = Not specified
1 = Home
2 = Skilled nursing facility
3 = Nursing facility
4 = Assisted living facility
5 = Custodial care facility
6 = Group home
7 = Inpatient psychiatric facility

8 = Psychiatric facility
9 = Intermediate care facility
10 = Residential substance-abuse treatment facility
11 = Hospice
12 = Psychiatric residential treatment facility
13 = Comprehensive inpatient rehabilitation facility
14 = Homeless shelter
15 = Correctional institution

5.5 Pharmacy service types

The pharmacy must submit a valid prescription pharmacy service type for every prescription and populate the pharmacy service type with the approved values below:

1 = Community/retail
2 = Compounding
3 = Home-infusion therapy provider
4 = Institutional
5 = Long-term care
6 = Mail-order pharmacy
7 = Managed care organization
8 = Specialty care
9 = Not used
10 = Not used
99 = Other

5.6 Dispense as written (DAW)

The pharmacy must utilize appropriate DAW codes for claim submission based on what the prescriber or pharmacy documented on the hard copy or by the pharmacy's notation regarding the patient request and/or plan requirements/product availability in the marketplace. The pharmacy must notate any prescription submitted with a DAW code 1 designation by the provider requiring brand name. Generally, for any DAW submission other than zero, the prescription must contain documentation as to the reason for the submission and comply with all applicable laws, rules and regulations.

5.7 Prescriber ID

The pharmacy must submit a prescriber's correct National Provider Identifier (NPI) for each claim submitted.

The prescriber ID on the claim must match the prescriber ID of the prescriber who authorized and signed the prescription according to state laws and requirements.

5.8 As directed/as needed (PRN)

All prescriptions must include specific, calculable directions. HPS prohibits using the dosing instruction "as directed" except for dosage packs. For drugs that may fluctuate in dosage, the pharmacy must use a maximum or "up to" daily dose to calculate the appropriate days' supply and document this maximum on the hard-copy prescription.

5.9 Insulin

The pharmacy must submit claims for the correct quantity and days' supply based on the number of units per day. Since insulin doses vary, the pharmacy may use a maximum daily dose to calculate the quantity and days' supply and may be provided on the hard copy. The maximum daily dose should be documented on the hard-copy prescription and provided during an audit. (Note: "Per sliding scale" by itself is not an acceptable direction for a hard-copy prescription.)

HPS does not require pharmacies to break a package or box of insulin pens. HPS has days' supply plan limitations and recognizes that one box may exceed the plan limitation. The pharmacy should dispense the plan's maximum days' supply in this scenario and monitor future fills to ensure that members are not receiving refills too soon. Monitoring is necessary because the days' supply submitted may be less than the actual days' supply that the insulin may last.

5.10 Inhalers

In most cases, claims for inhalers should cite the manufacturer's indicated metric decimal quantity, not the number of inhalations for the given inhaler.

5.11 Kits

In most cases, the pharmacy should bill kits by the number of kits dispensed at the time of fill, not by the number of units in the kit. HPS retrieves information for kits from First Databank to determine the appropriate billing units.

5.12 Injections

The standard of practice for billing injections is by the number of mL dispensed, not by the number of injections or bottles dispensed. HPS retrieves information for injections from First Databank to determine the appropriate billing units.

5.13 Topical agents

The pharmacy should document the affected area that the topical agents are applied to on the hard-copy prescription or another readily retrievable medium, unless the smallest commercially available package is dispensed.

5.14 Ophthalmic/otic solutions

HPS calculates solutions as having 20 drops per milliliter (mL), unless otherwise indicated by the manufacturer. The pharmacy should submit all ophthalmic/otic claims based on the 20 drops per mL guideline and adjusted to the proper quantity and days' supply based on the directions provided on the hard-copy prescription.

5.15 Ophthalmic/otic suspensions

HPS calculates suspensions as having 15 drops per milliliter (mL), unless otherwise indicated by the manufacturer. The pharmacy should submit all claims for ophthalmic/otic suspensions based on the 15 drops per mL guideline and adjusted to the proper quantity and days' supply based on the directions provided on the hard-copy prescription.

5.16 Compounds

The cost of a compound should not exceed the contract rate of the covered ingredients used. Upon audit, HPS will require the pharmacy to provide a compound worksheet for each compound. The compound worksheet will include the National Drug Code (NDC) and quantity. All compound prescriptions must be submitted with the appropriate National Council for Prescription Drug Programs (NCPDP) compound code. (Note: Multiple pieces of documentation related to compounds may be required.)

5.17 Changes to prescriptions

Any change in a prescription element must be documented and submitted appropriately with the originally requested documentation and all other documentation related to the hard-copy prescription. This change in a prescription includes any change notated in the computer system.

5.18 Reversals

HPS requires pharmacies to reverse prescriptions not picked up within 15 business days. Claims selected for desktop or on-site audits will be reviewed for this concern and a corresponding discrepancy code will be applied as necessary.

5.19 Risk Evaluation and Mitigation Strategy (REMS) program

Medications with special and specific U.S. Food and Drug Administration (FDA) guidelines must be dispensed in accordance with the FDA's guidelines.

5.20 Prescriber and member statement requirements

HPS requires pharmacies to submit a prescriber statement on a Humana uniform prescriber statement with all the required fields populated. The uniform prescriber statement can be found on **Humana.com/provider** and will be included with the initial audit results and final audit results letters.

A member statement must be a new document and contain all of the following information to be considered as valid mitigating documentation:

- Member name
- Medication name or prescription number(s)
- Date(s) of service
- Member's signature (or patient representative's signature)
- Date the member signed the statement (different than the date of service)

If medication is delivered to a facility, documentation submitted to HPS must include the following information:

- Member name
- Prescription number(s) or medication name(s)
- Date(s) of service
- Facility to which it was delivered and date of delivery
- Signature of the person who received the delivery
- Date the facility signed the statement (different than the date of service)

6. Frequently asked questions (FAQ)

Desktop and on-site FAQ

1. **Q: Why is my pharmacy being audited?**
   A: HPS routinely audits pharmacies in its network.

2. **Q: How will my pharmacy be notified of a desktop or on-site audit?**
   A: HPS will notify all pharmacies via traditional mail (United Parcel Service or certified mail). If you prefer to be notified via email, we can send letters via secure message. To notify HPS of your notification preference, please send an email to pharmacyaudit@humana.com.

3. **Q: How should my documents for a desktop audit be organized?**
   A: Documents for desktop audits must be copies of the original documents with no staples or clips applied to the pages. Do not send original hard copies, as they may not be returned to the pharmacy. All pages that pertain to a single claim (hard copy, signature log, etc.) should be grouped together in the document set.

4. **Q: What can my pharmacy do to prepare for an on-site audit?**
   A: The pharmacy should have all documentation from the previous 18 months readily retrievable. The Auditor will supply the masked book list seven to 10 days before the audit. The masked book list is a list of prescriptions without the ending numbers. The prescription books associated with these prescriptions should be organized in numerical order prior to the audit. Refer to Section 2.2 of this guide for more information about on-site audits.

5. **Q: What documentation should my pharmacy submit for a desktop or on-site audit?**
   A: Documentation requirements vary depending on the audit and pharmacy type. Refer to Section 4 of this guide for more information.

6. **Q: Can HPS give my pharmacy an exact list, before the on-site audit, of the prescriptions to be audited?**
   A: No. To ensure the audit's integrity, the Auditor will not supply a list of exact prescriptions until the date of the audit.

7. **Q: Should my pharmacy have a staff member assist the on-site Auditor?**
   A: Yes. Having a staff member assist the on-site Auditor will ensure the Auditor can access all needed documentation.

8. **Q: How can my pharmacy request a deadline extension?**
   A: HPS expects pharmacies to submit all documentation by the due date set forth in the letter. However, HPS will review requests for deadline extensions if they are received before the deadline has passed. HPS retains sole discretion to approve or disapprove a deadline extension request. Refer to Section 2.1.1 of this guide for more information.

9. **Q: During a desktop or on-site audit, can my pharmacy correct claims being audited?**
   A: If your pharmacy's system permits and/or HPS' timely filing window has not expired, the pharmacy may correct the claim. Therefore, if the pharmacy tries to reverse and reprocess the claim and fails, HPS will not be responsible for readjudication errors. For this reason, pharmacies are encouraged to let HPS correct claims. If the pharmacy does not correct the claim, HPS will process any adjustment to audited claims based on the audit's final outcome.

10. **Q: If a compound prescription is being reviewed, what should my pharmacy submit?**
    A: In addition to hard-copy documentation, submit a compound worksheet that includes each ingredient's quantity and National Drug Code (NDC) used in the compound. Refer to Section 5.16 of this guide for more information.

11. **Q: How is reimbursement for compound prescriptions calculated?**
    A: Reimbursement for a compound prescription is calculated using each covered ingredient's quantity and contract rate.

12. **Q: Can the Auditor assist me with a question about a claim that is not included in the audit?**
    A: The Auditor may be able to provide general guidance, but the Auditor will not be able to adjudicate claims on the pharmacy's behalf.

13. **Q: My pharmacy provides delivery and drive-thru service to patients/members. For these patients/members, rather than make the patients sign a signature log, we write "mailed," "delivery" or "drive-thru" to show the pharmacy delivered the prescription. Is this practice acceptable?**
    A: No. This practice does not confirm that a member received the medication. Please refer to Sections 4.1.2, 4.2.2 and 4.4 of this guide for more information.

14. **Q: To whom should the pharmacy send documentation for a desktop or on-site audit?**
    A: The pharmacy should reference its audit letter for the appropriate method of documentation submission.

    For Humana desktop audits (does not include Conduent audits):
    Mail via traceable method to:
    ATTN: Humana Pharmacy Audit Department
    P.O. Box 14164
    Lexington, KY 40512-4164

    For CMS desktop audits:
    - Mail to: 515 W. Market St.; Louisville, KY 40202
    - Fax to: **855-700-5109**
    - Secure email to: Pharmacyauditcmsrequests@humana.com

15. **Q: When can my pharmacy expect to receive a results letter?**
    A: HPS strives to review audit materials promptly. Results letters are typically sent within 30–60 days of receiving the pharmacy's documentation. If the pharmacy does

not respond within the audit window, the next letter will be sent approximately 14 days after the deadline.

16. **Q: For what type of discrepancy can the pharmacy supply additional documentation during the post-audit window?**
    A: The DCL will identify this information. Please note that additional documentation submission is not a guarantee the discrepancy will be removed. For questions or concerns, please contact the Auditor using a communication method set forth in the letter.

17. **Q: How can a pharmacy obtain a copy of the Humana Pharmacy Solutions DCL?**
    A: Visit **Humana.com/provider/pharmacy-resources/manuals-forms**. A copy of the DCL also will be included with most audit letters.

18. **Q: What type of discrepancy can a pharmacy appeal?**
    A: The pharmacy can appeal any claim marked discrepant, as long as the pharmacy uses a pharmacy audit appeal form and follows the guidelines in Section 2.1.6 of this guide. HPS will review all audit appeal documentation submitted and will follow the DCL when determining audit decisions. Pharmacies should reference the DCL for acceptable mitigating documentation.

19. **Q: How can I obtain a copy of the pharmacy audit appeal form the pharmacy needs to appeal the audit findings?**
    A: The audit appeal form will be included with the final results letter. If the pharmacy needs another copy of the audit appeal form, please call **502-580-3232** or email pharmacyaudit@humana.com to request a copy of the form.

20. **Q: Who reviews the pharmacy's appeal?**
    A: The HPS Audit Appeals Committee reviews all appeals submitted.

21. **Q: How long does the pharmacy have to file an appeal?**
    A: All appeals must be submitted on a pharmacy audit appeal form and postmarked by the due date provided on the final results letter.

22. **Q: What is the difference between the post-audit window and the appeal window?**
    A: The post-audit window opens after the initial audit results letter is sent. The appeal window opens after the Auditor sends the final results letter. These two windows provide the pharmacy with a new due date to mitigate a discrepancy by submitting additional documentation and explanations. Please reference the documentation listed in the "mitigating documentation" column on the DCL, available at **Humana.com/provider/pharmacy-resources/manuals-forms**.

23. **Q: Will my pharmacy receive an estimated recovery amount with my audit results?**
    A: Yes. If discrepancies are found during the audit, the pharmacy will receive an estimated chargeback amount for each discrepant claim on the note sheet report. The final amount cannot be calculated until the claims have gone through the adjustment process. This amount will appear on the pharmacy's remittance advice statement.

24. **Q: How and when will applicable recoupments and penalties take place?**
    A: Recoupments and penalties generally occur within 30 calendar days of the audit's closing or within 30 days of an appeal's conclusion. Recoupments and penalties will be deducted from future claims payments. If HPS is unable to offset from future payments, the pharmacy must pay HPS the amount owed within 30 calendar days from the date of HPS' written notice to the pharmacy.

25. **Q: Whom should I contact if I have questions about my desktop audit or on-site audit?**
    A: The appropriate contact will depend on the audit type. Phone lines are direct to voicemail with calls being returned within five business days. HPS will respond to all email inquiries within five business days.
    - For desktop audits, call **502-580-3232** or send an email to pharmacyaudit@humana.com.
    - For CMS audits, call **502-476-5900** or send an email to pharmacycmsrequests@humana.com.
    - For Conduent audits, call **800-742-7638** or email pharmacyaudit@conduent.com.
    - For audit appeals, call **502-476-3508** or send an email to pharmacyauditappeals@humana.com.

Pre-pay claim validation FAQ

26. **Q: During a pre-pay claim validation review, can the pharmacy correct the claim(s) being audited?**
    A: Yes. Pharmacies are encouraged to reverse and correctly reprocess discrepant claims at the time of the call.

27. **Q: During a pre-pay claim validation review, what documentation should the pharmacy submit?**
    A: The fax/email will include a report of claims in question requesting copies of the prescriptions and/or any supporting documentation.

28. **Q: Who should the pharmacy contact if the pharmacy has questions about the pre-pay claim validation review?**
    A: Call **502-580-3085**.

29. **Q: To whom should the pharmacy send documentation for a pre-pay claim validation review?**
    A: Email Rxprepayclaimvalidation@humana.com or fax **833-900-1023**.

Overpayment review FAQ

30. **Q: Who should the pharmacy contact if the pharmacy has questions about an overpayment review?**
    A: Call **502-476-9400** or email pharmacyauditcompliance@humana.com.

31. **Q: To whom should the pharmacy send documentation for an overpayment review?**
    A: Mail via traceable method to:
        ATTN: Humana Pharmacy Audit Department
        P.O. Box 14164
        Lexington, KY 40512-4164
    Email to: Pharmacyauditcompliance@humana.com
    Fax to: **502-301-5667**