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.