Humana Pharmacy Solutions®

Pharmacy Manual

Medicaid and Dual Medicare-Medicaid
2019 Edition

Humana®

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Introduction

Humana appreciates your participation in our pharmacy network and your role in delivering quality pharmacy services to our members.

This manual pertains exclusively to Humana members enrolled in a state-managed Medicaid program or a Medicare-Medicaid dual demonstration program, and it is intended to assist your pharmacy staff in processing prescription claims. The current plans for these Humana programs are:

Humana Gold Plus® Integrated

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

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

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

Medicare

Medicare is the federal health insurance program for:

- People 65 years old or older
- Some people under age 65 with certain disabilities
- People with end-stage renal disease (kidney failure)

Medicaid

Medicaid is a program run by the federal and state governments that helps people with limited income pay for medical costs and, if qualified, long-term services and supports, such as nursing homes and home- and community-based waiver services. It covers some extra services and drugs that Medicare doesn't pay for. Each state decides what counts as income and who qualifies for Medicaid. States also decide what services are covered and how much they cost.

Florida Medicaid Plan

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

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

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

Humana's obligations under the contract include, but are not limited to:
- Maintaining a quality improvement program aimed at improving the quality of member outcomes.
- Maintaining quality management and utilization management programs.
- Furnishing AHCA with data as required under the contract and as may be required in additional ad hoc requests.
- Collecting and submitting encounter data in the format and in the time frames specified by AHCA.

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

The Florida Medicaid program is implementing a new system through which Medicaid enrollees will receive services. This program is called the Statewide Medicaid Managed Care Managed Medical Assistance program. The Managed Medical Assistance (MMA) program is composed of several types of managed care plans:
- Health maintenance organizations
- Provider service networks
- Children's Medical Services Network

Most Medicaid recipients must enroll in the MMA program.

The following individuals are NOT required to enroll, although they may enroll if they choose to:
- Medicaid recipients who have other creditable healthcare coverage, excluding Medicare
- Persons eligible for refugee assistance
- Medicaid recipients who are residents of a developmental disability center
- Medicaid recipients enrolled in the developmental disabilities home- and community-based services
- Waiver or Medicaid recipients waiting for waiver services

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

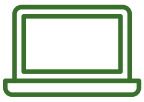
Florida's MMA program is designed to implement a statewide managed care delivery system that will improve outcomes, improve consumer satisfaction, and reduce and control costs.

The Florida MMA program will focus on four key objectives to support successful implementation:
1. Preserving continuity of care.
2. Requiring sufficient and accurate networks under contract and taking patients, allowing for an informed choice of plans for recipients and the ability to make appointments.
3. Paying providers fully and promptly to preclude provider cash flow or payroll issues, and to give providers ample opportunity to learn and understand the plan's prior authorization procedures.
4. Coordinating with the Choice Counseling Call Center and website operated by the agency's contracted enrollment broker.

Processing requirements may vary by plan, and online claims adjudication and messaging reflect the most current benefits. Please refer to Humana's National Council for Prescription Drug Programs (NCPDP) Version D.0 commercial and Medicare 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.

The Humana Pharmacist Self-Service Center provides a secure online resource where pharmacists can:

- View Humana member eligibility information
- Research Humana member benefit design information
- View paid and rejected claims
- View Humana members' prescription prior authorization status



This resource is available to any pharmacy contracted with Humana and is provided free of charge. To gain access, visit **Humana.com/Pharmacists** and select "Register for self-service." If you have difficulty registering, send an email to **hpsnetworks@humana.com**. Please include the pharmacy name, National Provider Identifier (NPI), pharmacy contact name and contact phone number.

Information about Medication Therapy Management, manuals and forms, and the LINET program is available on our public website **Humana.com/Pharmacists**, for your convenience.

We hope that you find this manual informative. Thank you again for your participation in the Humana pharmacy provider network.

Sincerely,

The Humana Pharmacy Network Team

Provider responsibilities

Pharmacy network providers are responsible for the provision of **pharmacy services,** which may include retail pharmacy services, long-term care pharmacy services and home infusion pharmacy services as defined below:

- **Retail pharmacy services** means those prescription drug and allied services and/or supplies normally provided by participating pharmacies to the general public in the ordinary course of pharmacy business to members at retail pharmacies.
- **Long-term care pharmacy services (LTC pharmacy services)** means those prescription drug and allied services and/or supplies normally provided by participating pharmacies in the ordinary course of pharmacy business to members residing in LTC and/or assisted living facilities.
- **Home infusion pharmacy services (home infusion pharmacy services)** means those prescription drug and allied services and/or supplies normally provided by participating pharmacies in the ordinary course of pharmacy business to members residing in their homes or ambulatory infusion suites where allowed by law.

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

1. Provider shall comply with all applicable aspects of the Hernandez Settlement Agreement ("HSA"). An HSA situation arises when a member who is a Medicaid recipient attempts to fill a prescription at a participating pharmacy location and is unable to receive his/her prescription as a result of:[1]
   (1) An unreasonable delay in filling the prescription;
   (2) A denial of the prescription;
   (3) The reduction of a prescribed good or service; and/or
   (4) The termination of a prescription
2. Provider shall post signs in both English and Spanish in a conspicuous location advising members who are Medicaid recipients that if a claim for covered drugs is initially rejected, provider shall provide pamphlets in English and Spanish that will inform the member of the reason the claim was rejected and the phone number to the HSA ombudsman.[2] Pamphlets and signs are available at: **http://ahca.myflorida.com/Medicaid/Prescribed_Drug/multi_source.shtml.**
3. If the denied prescription is for a timely refill, and it is otherwise valid, provider must provide the member with a three-day temporary supply unless the attempt to refill is early; the rejection is due to an error that only the pharmacist can correct; there are clinical issues that must be resolved; the individual is not eligible for Medicaid; or there would be a medical danger, in the pharmacist's professional judgment, if a temporary supply is dispensed.[2]
4. If provider fails any aspect of an HSA survey, provider agrees to undergo mandatory training within six months and then be reevaluated within one month of the HSA training to ensure that provider is in compliance with the HSA.[3]

Member rights and responsibilities

Member rights

1. A member has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity and with protection of his or her need for privacy.
2. A member has the right to a prompt and reasonable response to questions and requests.
3. A member has the right to know who is providing medical services and who is responsible for his or her care.
4. A member has the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand.

[1]Florida Medicaid Health Plan Model Contract Attachment II – Core Contract Provisions, Section VII.E.2.a.
[2]Letter from Christine Osterlund, Deputy Secretary for Medicaid Operations, Florida Agency for Health Care Administration to all Medicaid pharmacy providers. (undated)
[3]Florida Medicaid Health Plan Model Contract Attachment II – Core Contract Provisions, Section VIII.C.3.d.

5. A member has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.
6. A member has the right to know what rules and regulations apply to his or her conduct.
7. A member has privacy rights under the Health Insurance Portability and Accountability Act (HIPAA). This is a federal law that protects a member's health information. These rights are important for a member to know. The member can exercise these rights, ask questions about them and file a complaint if the member thinks their rights are being denied or their health information isn't being protected.
8. A member has the right to be given by the healthcare provider information concerning diagnosis, planned course of treatment, alternatives, risks and prognosis.
9. A member has the right to participate in decisions regarding his or her healthcare, including the right to refuse treatment except as otherwise provided by law.
10. A member has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.
11. A member who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the healthcare provider or healthcare facility accepts the Medicare assignment rate.
12. A member has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
13. A member has the right to receive a copy of a reasonably clear and understandable itemized bill and, upon request, to have the charges explained.
14. A member has the right to request and receive a copy of his or her medical records, and request that they be amended or corrected.
15. A member has the right to be furnished healthcare services in accordance with federal and state regulations.
16. A member has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap or source of payment.
17. A member has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
18. A member has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.
19. A member has the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
20. The state must ensure that each enrollee is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the health plan and its providers or the state agency treat the enrollee.
21. A member has the right to express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the healthcare provider or healthcare facility which served him or her and to the appropriate state licensing agency.

Member responsibilities

1. A member is responsible for providing to the healthcare provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications and other matters relating to his or her health.
2. A member is responsible for reporting unexpected changes in his or her condition to the healthcare provider.
3. A member is responsible for reporting to the healthcare provider whether he or she understands a possible course of action and what is expected of him or her.
4. A member is responsible for following the treatment plan recommended by the healthcare provider.
5. A member is responsible for keeping appointments, and when he or she is unable to do so for any reason, for notifying the healthcare provider or healthcare facility.
6. A member is responsible for his or her actions if he or she refuses treatment or does not follow the healthcare provider's instructions.
7. A member is responsible for ensuring that the financial obligations of his or her healthcare are fulfilled as promptly as possible.
8. A member is responsible for following healthcare facility rules and regulations affecting patient care and conduct.

Submitting pharmacy claims

All participating pharmacies must comply with NCPDP transaction standards for pharmacy drug claims, coordination of benefits and related pharmacy services. Prior to submitting a claim, the pharmacy must have a valid prescription on file.

The pharmacy may not submit test claims. Test claims are claims submissions used to confirm patient eligibility or to determine the existence of any coverage restrictions or requirements and/or the maximum amount of reimbursement.

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

Plan	BIN	PCN
Medicare-Medicaid dual eligible	015581	03200000
Medicaid plans	610649	03190000

Submitting compound claims

- The pharmacy must submit the correct amount with corresponding accurate quantities and days' supply calculations based on a valid prescription for the member.
- The pharmacy must submit all ingredients that make up a compound drug on the same claim.
- The most expensive ingredient will display at the claim level.
- Edits are returned for each ingredient based on the member's benefits.
- Submission clarification code (SCC) of 08 can be submitted on the claim when a pharmacy accepts reimbursement for approved ingredients only.
  - A free-form message will return to the pharmacy when a submission clarification code of 08 can be submitted.
  - Per CMS guidance, pharmacies are prohibited from balance billing the beneficiary for the cost of any non-Part D ingredient contained in the Part D compound.

The pharmacy shall not attempt to circumvent a plan's benefit design or engage in inappropriate billing practices of compound drugs. Such practices include, but are not limited to:

- Submitting test claims for a compound drug;
- Submitting a claim multiple times with variations in the ingredients, ingredient cost, dispensing fees, quantity amount and/or days' supply to obtain the highest reimbursement possible;
- Resubmitting rejected compound prescription ingredients as individual, noncompounded ingredients; and
- Submitting partial fills or multiple claims for fills that are less than a 30-day supply to avoid coverage limitations or gain additional reimbursement or copayment amounts.

Submitting claims for 340B medications

When dispensing medications purchased under Section 340B of the Public Health Service Act, providers should utilize a submission clarification code (42Ø-DK) field with a value of 20, or the most current NCPDP standard for identification of 340B medications. For Florida Medicaid providers: The value of 20 along with a value of 9 should be used for the submission clarification code (42Ø-DK) field. Pharmacies may be required to complete a contract addendum with Humana to be eligible to dispense 340B medications under the agreement with Humana.

Prescription origin code requirements

Humana requires the prescription origin code (NCPDP Telecommunications Standard D.0 field 419-DJ) to be included on all prescriptions. All claims submitted will be denied at the point of sale if this code is not included. If the pharmacist is not able to include this code within the pharmacy's practice management system, the pharmacist should contact the pharmacy's current software vendor for assistance. DST Pharmacy Solutions 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 prescription number needs to be created from an existing valid prescription, such as traditional transfers, intrachain transfers, file buys and software upgrades/migrations. This value is also the appropriate value for "pharmacy dispensing," when applicable, such as over-the-counter, Plan B, established protocols, pharmacists' authority to prescribe, etc.

Enrollee complaint system

The section below is taken from Humana's enrollee grievance and appeal procedure as set forth in the Humana Member Handbook. This information is provided to you so that you may assist Humana enrollees in this process, if they request your assistance. Please contact your provider contracting representative if you have questions about this process.

Humana has representatives who handle complaints, which include all enrollee grievances and appeals. A special set of records is kept with the reason, date and results. Humana keeps these records in the central office.

Medicare-Medicaid dual enrollee grievances

Grievances must be filed within 60 days of the occurrence. Direct written grievance to:

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

When filing a verbal grievance direct the enrollee to the appropriate phone number as it applies.

- Medicaid Dual enrollees call **1-800-787-3311**. For enrollees with speech or hearing impairment who use a TTY, call **711**. Hours are on Monday – Friday, 8 a.m. – 8 p.m. Central time.
- For all other enrollees, a grievance can be provided by calling Customer Service. For additional help filling out the form, the enrollee can call Customer Service toll-free at the number on the back of their ID card. Puerto Rico enrollees, call **1-866-773-5959**. For enrollees with speech or hearing impairment who use a TTY, call **711**. Our hours are 5 a.m. to 8 p.m. Eastern time, seven days a week.

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

Florida Medicaid enrollee grievances

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

- The enrollee can submit written grievances to:
  Humana Medical Plan, Inc.
  P.O. Box 14546
  Lexington, KY 40512-4546
  Fax: 1-800-949-2961
- For verbal grievances, the enrollee can call Customer Service at **1-800-477-6931 (TTY: 711).** We're available Monday – Friday, from 8 a.m. – 8 p.m. Eastern time.

Medicaid, Medicaid-Dual and Florida Medicaid enrollee appeals

Enrollee, prescriber or enrollee representative may submit an appeal in writing within 60 calendar days of the date of the denial notice received from Humana. Options for submitting the appeal (redetermination request):

- Download a copy of the appeal form provided on Humana.com and either fax or mail it to Humana. Include your name, address, Humana ID number, reason for the appeal and any supporting documents.
  Humana Medical Plan, Inc.
  P.O. Box 14546
  Lexington, KY 40512-4546
- For expedited requests you can fax to **1-855-336-6220.**

If the enrollee is unable to write an appeal, oral appeals are accepted.

- Medicare-Medicaid Dual enrollees may ask for an appeal by calling Customer Service at **1-800-787-3311**. We are available Monday-Friday, from 8 a.m. – 8 p.m. Central time.
- Medicaid enrollees may ask for an appeal by calling Customer Service **1-800-477-6931 (TTY: 711)**. We're available Monday – Friday, from 8 a.m. – 8 p.m. Eastern time.
- Using their MyHumana login, Medicare Part D enrollees can file online requests through **Humana.com**
  https://apps.Humana.com/webdetermination/authentication.aspx?sysid=f1ed49c9-9f67-489e-ac80-ee54c3575570

For all enrollees, the physician, prescriber or someone else can make the appeal in behalf of the enrollee. The Appointment of Representative form must be completed. This form provides permission for another person to act for the enrollee.

To get an Appointment of Representative form, the enrollee can call Customer Care and ask for one, or visit the Medicare website at **https://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf**: or Humana's website at **https://www.Humana.com/individual-and-family-support/tools/member-forms**.

- If the appeal comes from someone besides the enrollee, we usually must receive the completed Appointment of Representative form before we can review the appeal.
- Note that under the Medicare program, the physician or other provider can file an appeal without the Appointment of Representative form.

Resolution for grievance and appeals

We'll investigate the enrollee's appeal and inform them of our decision. If the enrollee has questions in regard to their grievance or appeal, direct them to the Member Handbook or contact Humana using the number on the back of their ID card.

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 Humana member's ID card. Sample card images are shown on page 19 of this manual.

- For Medicaid claims, Humana allows the cardholder ID to be submitted with the Medicaid ID, the Humana ID number or the Social Security number. In addition, pharmacies may call our help desk at **1-800-865-8715,** select option 3 and provide the member's name and date of birth to obtain the Humana member ID.
- For Medicare-Medicaid dual eligible members who do not have their Humana ID numbers, pharmacies may use the automated eligibility verification described below or submit an E1 query.

Medicare automated eligibility-verification system (for Medicare-Medicaid dual demonstration plans only)

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

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

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

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

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

Humana-specific DST Pharmacy Solutions payer sheets

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

- Medicaid plans: Use commercial D.0 payer sheet (under the heading "Payer sheet") **apps.Humana.com/marketing/documents.asp?file=2295826**
- Medicare-Medicaid dual demonstration plans: Use Medicare D.0 payer sheet (under the heading "Payer sheet") **apps.Humana.com/marketing/documents.asp?file=2295839**

Prescriber NPI submission

Humana requires the use of a valid and accurate Type 1 (also known as "individual") prescriber NPI on all electronic transactions. This requirement also applies to Humana's Florida Managed Medical Assistance (MMA) Medicaid plan. Claims submitted without a valid and active Type 1 NPI will be rejected at the point of sale with the following error message: "Prescriber Type 1 NPI required."

In addition, the error codes listed below will display in the free-form messaging returned to pharmacies. If the pharmacy believes it has received one of these codes in error (e.g., the NPI submitted is an active, valid, individual NPI number), the pharmacy may override the hard edit with the applicable submission clarification code (SCC). Claims processed with an SCC may be subject to post-adjudication validation review.

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 Humana Medical Plan) 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 complying with federal and state laws, rules and regulations. This is especially important when filling prescriptions and submitting claims for refills and partial fills of Schedule II drugs. In accordance with your pharmacy provider agreement, Humana requires its pharmacies to comply with all federal and state laws, rules and regulations pertaining to the dispensing of medications. Further, as of July 22, 2016, a prescription for Schedule II may be partially filled if it meets the following requirements:

1. It is not prohibited by state law;
2. The prescription is written and filled according to federal and state law (including DEA regulations);
3. The partial is requested by the patient or the practitioner who wrote the prescription; and
4. The total quantity dispensed in all partial fillings does not exceed the total quantity prescribed.

The Controlled Substances Act established five schedules, which are based on medical use acceptance and the potential for abuse of a substance or drug. Schedule II drugs have a high potential for abuse, have an accepted medical use (including severe restrictions) and may lead to severe psychological or physical dependence if abused. Pursuant to 21 CFR § 1306.12(a), Schedule II prescription drugs may not be refilled. 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 except in an emergency.

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.

Controlled substance limitations for Florida Medicaid MMA

In an effort to reduce doctor-shopping behaviors, an edit on narcotic prescriptions defined as federal controlled substances, schedule II-V, has been installed to limit six CII-CV prescriptions per month for oncology and sickle cell patients. Patients with any condition other than cancer or sickle cell are limited to four CII-CV prescriptions per month. For more information visit:
ahca.myflorida.com/medicaid/prescribed_drug/drug_criteria_pdf/CII-V_Edit_Override_Criteria.pdf.

Please note: Humana does not accept requests for coverage determination directly from pharmacies. They must be initiated by the member or prescriber.

Drug Lists

Humana manages numerous Drug Lists for the many prescription benefit plans it offers. Pharmacies can view details of these Drug Lists at **Humana.com/DrugLists**. Noteworthy annual changes to Humana's Medicare and Medicaid Drug Lists are announced in the fall of each year.

Drug 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.

To view Humana Drug Lists for Medicaid members, go to **Humana.com/DrugLists**.

To view Humana Drug Lists for Medicare-Medicaid dual eligible members in Illinois, go to **Humana.com/Medicare/Medicaid-dual/Illinois/Pharmacy/**.

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

For the Florida MMA program, some services are excluded. This includes hemophilia products (prescriber factor replacement products) to members diagnosed with hemophilia through the Agency for Health Care Administration's (AHCA) hemophilia disease management program. For more information, visit: **www.fdhc.state.fl.us/medicaid/Policy_and_Quality/Quality/fee-for-service/hemophilia.shtml**.

Utilization management (UM)

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

Prior authorization

Prior authorization encourages appropriate medication use by allowing coverage only when certain coverage determination requirements have been met.

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 Florida Medicaid MMA, Humana follows the AHCA formulary and criteria.

For more information, visit **Humana.com/PA**. Please have the prescribing provider fax the request for coverage determination form to Humana Clinical Pharmacy Review (HCPR) at **1-877-486-2621**. For questions, contact HCPR at **1-800-555-CLIN (1-800-555-2546)**. For guidance and requirements on the PA submission process, please visit **apps.Humana.com/marketing/documents.asp?file=1372774.**

Step therapy protocol

Humana's 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.

For Florida Medicaid MMA, Humana follows the AHCA Drug List and step therapy criteria.

For information on step therapy, visit **Humana.com/PA**. Please have the prescribing provider fax the prior authorization request to HCPR at **1-877-486-2621.** For questions, contact HCPR at **1-800-555-CLIN (1-800-555-2546).**

Quantity limits

Humana has implemented quantity limits for various classes of drugs to facilitate the appropriate, approved label use of these agents. We believe this program helps members obtain the optimal dose required for treating their conditions.

For Florida Medicaid MMA, Humana follows the AHCA Drug List and quantity limits criteria.

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)**, Monday – Friday, 8 a.m. – 6 p.m. Fax requests should be submitted on the requests for coverage determination form found at **Humana.com/PA** and sent to **1-877-486-2621**.

Please note: Humana does not accept requests for coverage determination directly from pharmacies. They must be initiated by the member or prescriber.

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 that the pharmacist has given the member medication to meet the member's immediate needs.

- Inform the member that the drug he/she is receiving 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. For 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.

Florida Medicaid MMA has certain preferred brand drugs when the brand drug is formulary and the generic is not. This may require the pharmacy to use DAW 6 when submitting a claim. Please refer to the Drug List to identify the AHCA preferred brand drugs.

Drug utilization review (DUR) safety edits

DUR type	Pharmacy information	Example
Plan limitations exceeded: accumulation	Identifies the potential for an overdose resulting in single or multiple medications and cumulative doses that exceed safe daily maximums.	Acetaminophen dose greater than 4 grams per day
Therapeutic duplication	Identifies duplication with active medication in patient history, including medication name.	Two prescriptions for different angiotensin receptor blockers
Drug – drug interactions	Identifies significant interaction with active medication in patient history, including medication name.	Selective serotonin reuptake inhibitors/monoamine oxidase inhibitors
Drug – age interaction	Identifies safety risk related to use of specific medication for patient's age.	Adderall for age younger than 6
Drug – disease interaction	Identifies safety risk when medication is contraindicated for a patient's disease state. Disease may be inferred or identified via medical claims.	Disease: Congenital long QT syndrome
Drug – gender interaction	Alert of safety risk related to use of specific medication for reported gender.	Makena
Maximum dose	Identifies safety risk when dosage exceeds First Data Bank (FDB) maximum adult daily dose. Ratio of exceeding FDB maximum dosing is specific to the medication.	Digoxin daily dose greater than 500 mcg
MED* high dose	Identifies patients at greater risk of overdose or inappropriate opioid utilization. Dosing greater than 100 mg MED per day will trigger this error code.	MS Contin 30 mg twice daily plus Percocet 5/325 two tablets every four hours as needed
MED* overuse	Identifies patients at greater risk of overdose or inappropriate opioid utilization. Dosing greater than 250 mg MED per day and/or more than four providers and four or more pharmacies will trigger this error code.	MS Contin 100 mg three times daily

*MED – Morphine equivalent dosing

Soft reject DUR

Select DUR safety alerts may be addressed at the retail pharmacy. Upon receipt of these rejects, pharmacists should apply clinical judgment to review the alert, recommend therapy changes or override the alert when clinically appropriate. Message on claim denials will indicate "Soft Reject: Payer allows DUR/PPS code override."

NCPDP error code	NCPDP description	Reason for service	Professional service	Result of service
88: DUR reject error	This drug interacts with patient's other drug(s)	DD: Drug interaction	DE: Dosing evaluation MO: Prescriber consulted MP: Patient will be monitored PE: Patient educated PO: Patient consulted RO: Pharmacist consulted other source SW: Literature search/review	1A: Filled as is, false positive 1B: Filled prescription as is 1D: Filled with different directions 1F: Filled with different quantity 1G: Filled with prescriber approval 4A: Prescribed with acknowledgments 4B: Filled, palliative care 4D: Filled, cancer treatment
88: DUR reject error	This drug may duplicate current patient therapy	TD: Therapeutic duplication	MO: Prescriber consulted PE: Patient educated PO: Patient consulted RO: Pharmacist consulted other source SW: Literature search/review TH: Therapeutic product interchange	1A: Filled as is, false positive 1B: Filled prescription as is 1D: Filled with different directions 1F: Filled with different quantity 1G: Filled with prescriber approval 4A: Prescribed with acknowledgments 4B: Filled, palliative care 4D: Filled, cancer treatment
88: DUR reject error 922: Morphine equivalent dose exceeds limit**	Cumulative morphine equivalent dose exceeds limits	HD: High dose	MO: Prescriber consulted	1B: Filled prescription as is 1D: Filled with different directions 1F: Filled with different quantity 1G: Filled with prescriber approval 3D: Regimen changed 3E: Therapy changed 4A: Prescribed with acknowledgments 4B: Filled, palliative care 4D: Filled, cancer treatment
AG: Exceeds opioid initial fill limits 925: Initial fill days' supply exceeds limit	Days' supply limitation for product/service	MX: Excessive duration	MO: Prescriber consulted PH: Patient medication history RO: Pharmacist consulted other source	4B: Filled, palliative care 4D: Filled, cancer treatment 4J: Dispensed, patient is not opioid naive

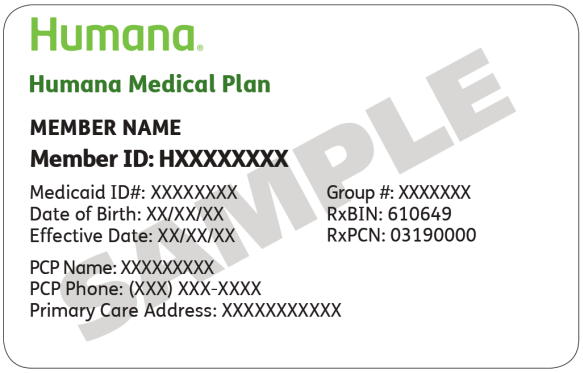
** Note 922 can apply to single claim or cumulative claim MED limits for opioids.

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
10	Drug utilization review (DUR) safety edits table, as well as soft reject DUR section, above

Humana member identification (ID) cards

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

Card for a member with FL MMA English


Humana.

Humana Medical Plan

MEMBER NAME

Member ID: HXXXXXXXX

Medicaid ID#: XXXXXXXX
Date of Birth: XX/XX/XX
Effective Date: XX/XX/XX

Group #: XXXXXXX
RxBIN: 610649
RxPCN: 03190000

PCP Name: XXXXXXXXX
PCP Phone: (XXX) XXX-XXXX
Primary Care Address: XXXXXXXXXXX

SAMPLE


Member/Provider Service: 1-800-477-6931
Member Behavioral Health Inquiries: 1-888-778-4651
Pharmacist Rx Inquiries: 1-800-865-8715
Provider Prior Authorization: 1-800-523-0023

For online provider services, go to [www.availity.com]

Please mail all claims to:

Humana Medical
P.O. Box 14601
Lexington, KY 40512-4601

SAMPLE

Card for a member with FL MMA Spanish


Humana.

Humana Medical Plan

MEMBER NAME

Id. del afiliado: HXXXXXXXX

Id. de Medicaid: XXXXXXXX
Fecha de nacimiento: XX/XX/XX
Fecha de entrada en vigor: XX/XX/XX

N.° de grupo: XXXXXXX
RxBIN: 610649
RxPCN: 03190000

Nombre del PCP: XXXXXXXXX
No. de teléfono del PCP: (XXX) XXX-XXXX
Dirección de atención primaria: XXXXXXXXXXX

SAMPLE


Servicio para afiliados/proveedores: 1-800-477-6931
Preguntas del afiliado sobre salud de la conducta: 1-888-778-4651
Consultas sobre recetas de farmacéuticos: 1-800-865-8715
Autorización previa de proveedores: 1-800-523-0023

Acuda a [www.availity.com] para servicios de proveedores en línea

Por favor, envíe todas las reclamaciones por correo a:

Humana Medical
P.O. Box 14601
Lexington, KY 40512-4601

SAMPLE

Card for a member with FL COMP English


Humana.

Humana Comprehensive Plan

MEMBER NAME

Member ID: HXXXXXXXX

Medicaid ID#: XXXXXXXX
Date of Birth: XX/XX/XX
Effective Date: XX/XX/XX

Group #: XXXXXXX
RxBIN: 610649
RxPCN: 03190000

PCP Name: XXXXXXXXX
PCP Phone: (XXX) XXX-XXXX
Primary Care Address: XXXXXXXXXXX

SAMPLE


Member/Provider Service: 1-888-998-7732
Member Behavioral Health Inquiries: 1-888-778-4651
Pharmacist Rx Inquiries: 1-800-865-8715
Provider Prior Authorization: 1-800-523-0023
Provider Long-Term Care Inquiries: 1-888-998-7735

For online provider services, go to [www.availity.com]

Please mail all claims to:

Managed Medical Assistance
Humana Medical
P.O. Box 14601
Lexington, KY 40512-4601

Long Term Care
Humana Long Term Care
P.O. Box 14732
Lexington, KY 40512-4732

SAMPLE

Card for a member with FL COMP Spanish


Humana.

Humana Comprehensive Plan

MEMBER NAME

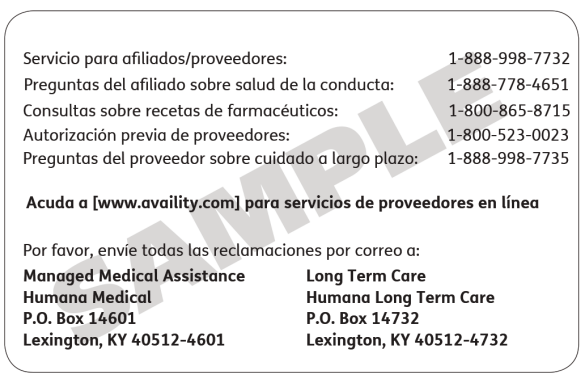
Id. del afiliado: HXXXXXXXX

Id. de Medicaid: XXXXXXXX
Fecha de nacimiento: XX/XX/XX
Fecha de entrada en vigor: XX/XX/XX

N.° de grupo: XXXXXXX
RxBIN: 610649
RxPCN: 03190000

Nombre del PCP: XXXXXXXXX
No. de teléfono del PCP: (XXX) XXX-XXXX
Dirección de atención primaria: XXXXXXXXXXX

SAMPLE


Servicio para afiliados/proveedores: 1-888-998-7732
Preguntas del afiliado sobre salud de la conducta: 1-888-778-4651
Consultas sobre recetas de farmacéuticos: 1-800-865-8715
Autorización previa de proveedores: 1-800-523-0023
Preguntas del proveedor sobre cuidado a largo plazo: 1-888-998-7735

Acuda a [www.availity.com] para servicios de proveedores en línea

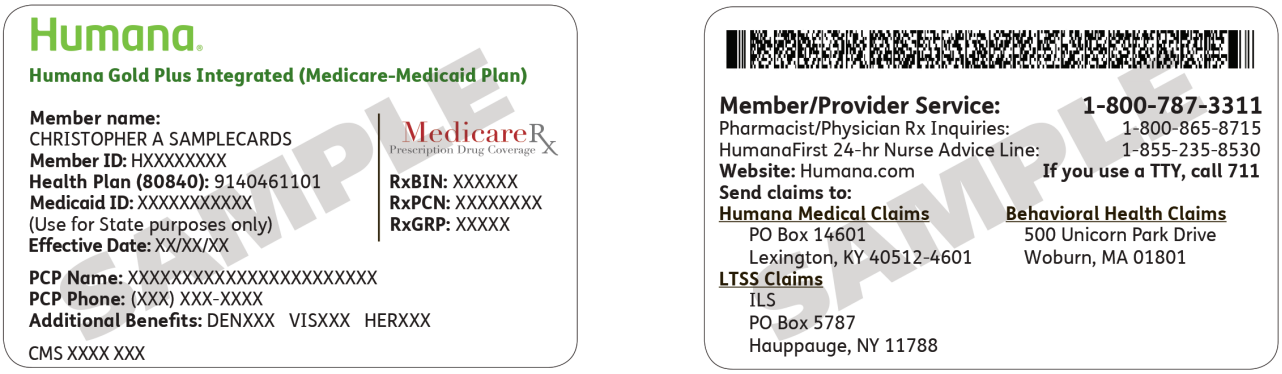
Por favor, envíe todas las reclamaciones por correo a:

Managed Medical Assistance
Humana Medical
P.O. Box 14601
Lexington, KY 40512-4601

Long Term Care
Humana Long Term Care
P.O. Box 14732
Lexington, KY 40512-4732

SAMPLE

Card for a member with Individual MAPD IL MMAI HMO



Note: As of today, this PDF meets state/compliance guidelines and could be subject to change at any time. Notification will be communicated if compliance guidelines change.

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 covers most drugs that meet the CMS definition of a Part D drug and are dispensed at a retail pharmacy under Medicare Part D. Humana also covers most drugs administered incidentally to a physician service under Medicare Part B. For members who have both a Part B plan and a Part D plan, the following guidelines apply.

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

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

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

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

In order for a drug to be included in the Part D benefit, it must satisfy the definition of a Part D drug and not otherwise be excluded. 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 the CMS coverage guidelines. To assist in making the appropriate determination for Part B or Part D coverage and payment, Humana may require prior authorization. To request prior authorization when required, members, prescribers and appointed or authorized representatives should contact HCPR at **1-800-555-CLIN (1-800-555-2546)**. The caller should be prepared to answer questions related to the prescribed drug. These questions are used to help determine coverage and payment as either Part B or Part D.

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.

Please note: Humana does not accept prior authorization requests directly from pharmacies. They must be initiated by the member or prescriber.

Prohibition on balance billing cost-share-protected members

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

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

Process for filing a complaint

Pharmacy complaints and disputes

Humana corporate management provides and promotes numerous strategies when addressing complaints and/or disputes from pharmacies, based on issue type:

DST System Issues

All pharmacies contracted with Humana are encouraged to contact the DST Help Desk at **1-800-865-8715** for any question or complaint related to a system issue or claims transaction. DST has a dedicated telephone support unit that provides guidance for calls related to pharmacy claims. All issues that cannot be addressed or resolved by DST are forwarded to the Pharmacy Networks Department for research and resolution.

Pharmacy Initiative Inquiries

Humana has a dedicated pharmacy HCPR telephone support unit that provides support for pharmacy inquiries and complaints related to specific corporate pharmacy management initiatives. Any specific initiative question that cannot be answered by the HCPR telephone support unit is forwarded to the Pharmacy Networks Department for research and resolution. PH: **1-888-204-8349.**

For provider complaints from providers providing services to Florida Medicaid enrollees concerning non-pricing/non-claims issues, Humana shall:

a. Allow 45 days to file a written complaint for issues that are not about claims.
b. Within three business days of receipt of complaint, notify the pharmacy (verbally or in writing) that the complaint has been received and the expected date of resolution.

c. Document why a complaint is unresolved if not resolved within 15 days of receipt and every 15 days thereafter until such complaint is resolved.
d. Resolve all complaints within 90 days of receipt and provide written notice of the disposition and the basis of resolution within three days of resolution.
e. Humana shall include its provider complaint system policies and procedures in the Humana provider handbook (ie: Provider Manual).
f. Distribute the provider complaint system policies and procedures to nonparticipating providers upon request. Humana may submit a summary of the policies and procedures, if the summary includes information about how the provider may access the full policies and procedures. The summary shall also detail how the provider can request a hard copy from Humana at no charge.
g. Humana shall report provider complaints as specified in Section XVI, Reporting Requirements, and the Managed Care Plan Report Guide.

Pricing dispute process for Medicare and Medicaid

Network pharmacies have the right to submit a request to appeal, investigate or dispute the maximum allowable cost (MAC) reimbursement amount to Humana within 90 calendar days of the initial claim. The pharmacy may submit its request to appeal, investigate or dispute maximum allowable cost pricing in writing to Humana by fax **1-855-381-1332** or email **pharmacypricingreview@humana.com**. The pharmacy may contact Humana at **1-888-204-8349** to speak to a representative regarding its request. All of the following must be included in the request:

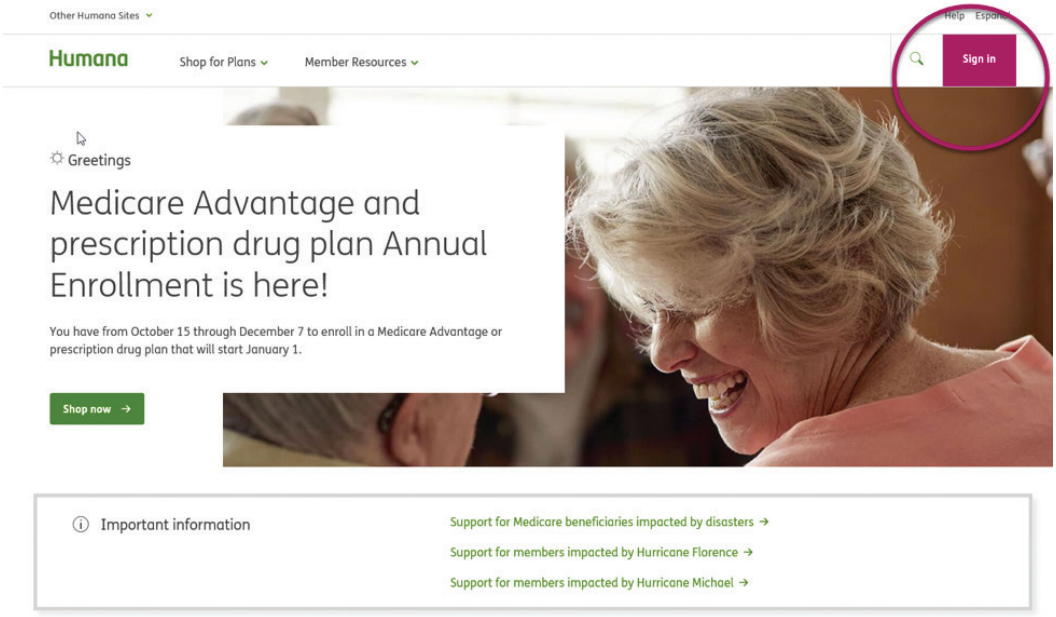
- Pharmacy name;
- Pharmacy address;
- Pharmacy NPI;
- Drug name;
- Drug strength;
- Drug NDC;
- Date of initial fill;
- Quantity of fill;
- Relevant documentation that supports the MAC is below the cost available to the pharmacy;
- Any other supporting documentation as needed.

Humana will respond to the network pharmacy's request within five business days of receipt by Humana. In the event the MAC appeal is denied, Humana will provide the reason for the denial and will identify a national drug code(s) for the drug product at or below the current MAC price. If the MAC request is approved, Humana will make an adjustment to the MAC price to the date of the disputed claim(s). The pharmacy is responsible for the resubmission of the claim and for collecting and/or refunding any copayment amount.

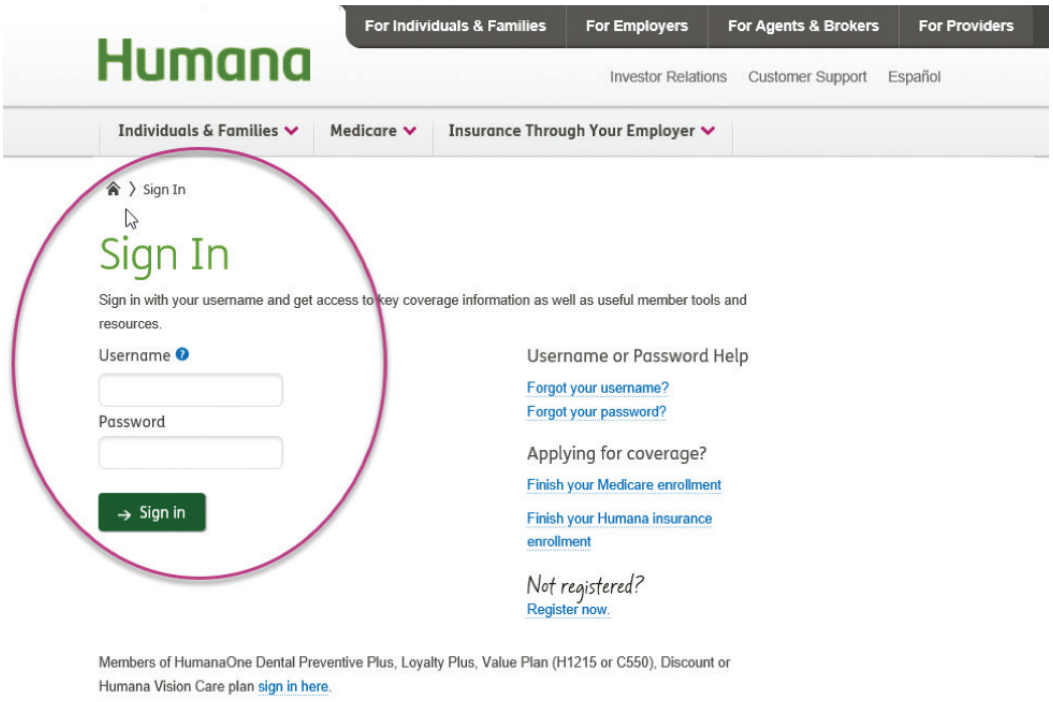
Please note: Timelines may vary state to state and are subject to change.

Pharmacy MAC list location

When network pharmacies need to locate the current MAC list, they can follow the steps below at **Humana.com**. They will see the screen below.



Click the "Sign in" button. The drop-down menu that is shown below will appear. The pharmacy will then enter the username and password that it set up at the time it contracted with Humana. If the pharmacy is unsure of its username and password, it should contact the pharmacy contracting team at **pharmacycontracting@humana.com** and ask to have the pharmacy's web portal account reset.



For the pricing dispute form, click on the **Manuals and forms** link on the right side of the screen.

Once the pharmacy clicks that link, the page shown below opens in a new tab. This is the current MAC list that is applicable to the NPI that the pharmacy used to register its account.

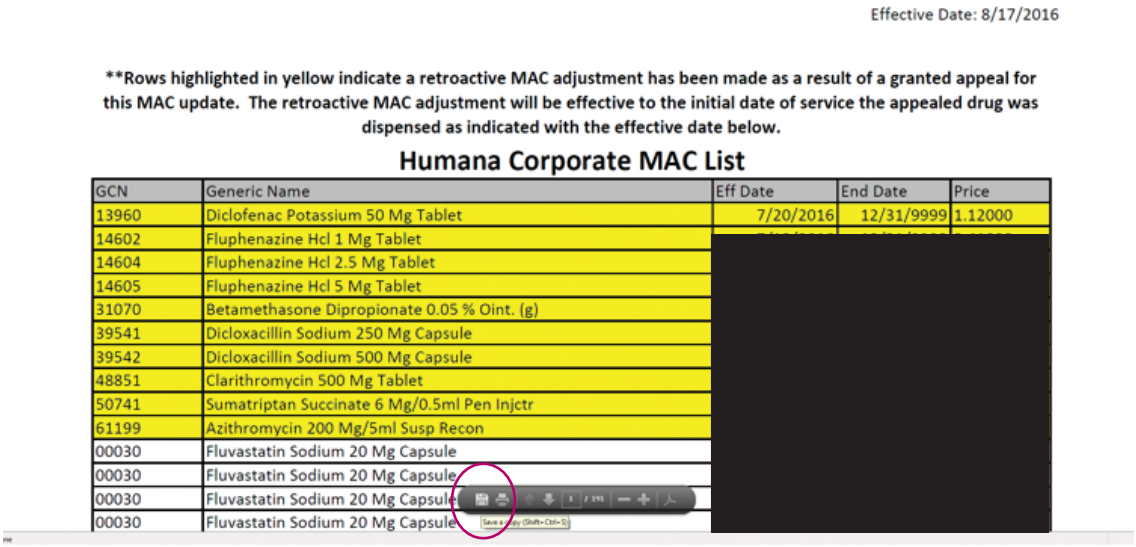
Effective Date: 8/17/2016

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

Humana Corporate MAC List

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

To save this MAC list as a PDF, hover the cursor over the bottom middle part of the screen and click on the disk icon on the far left of the gray pop-up box, then follow the prompt.



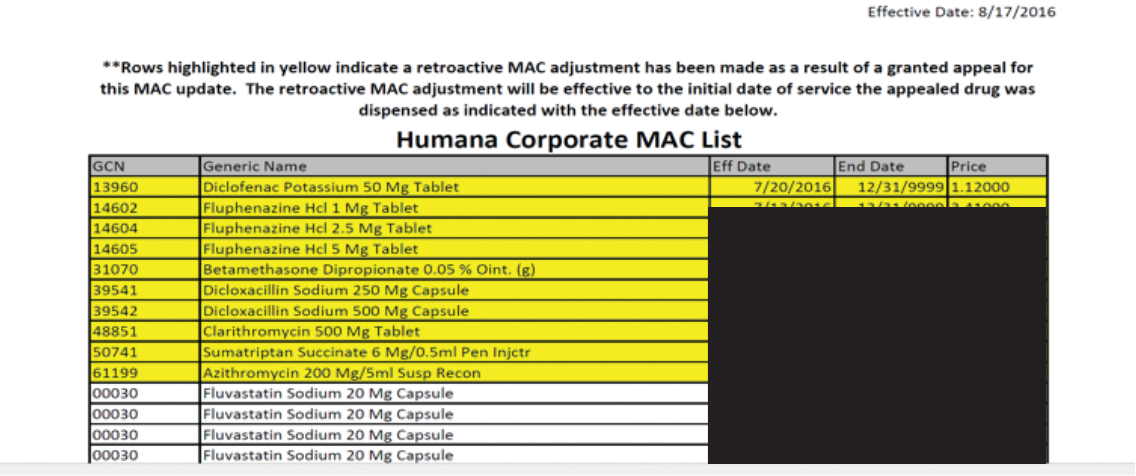
Effective Date: 8/17/2016

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

Humana Corporate MAC List

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

The lines highlighted in yellow indicate that the drug's pricing was changed as a result of a MAC appeal. The highlighted row is the updated price that was the result of an appeal.



Effective Date: 8/17/2016

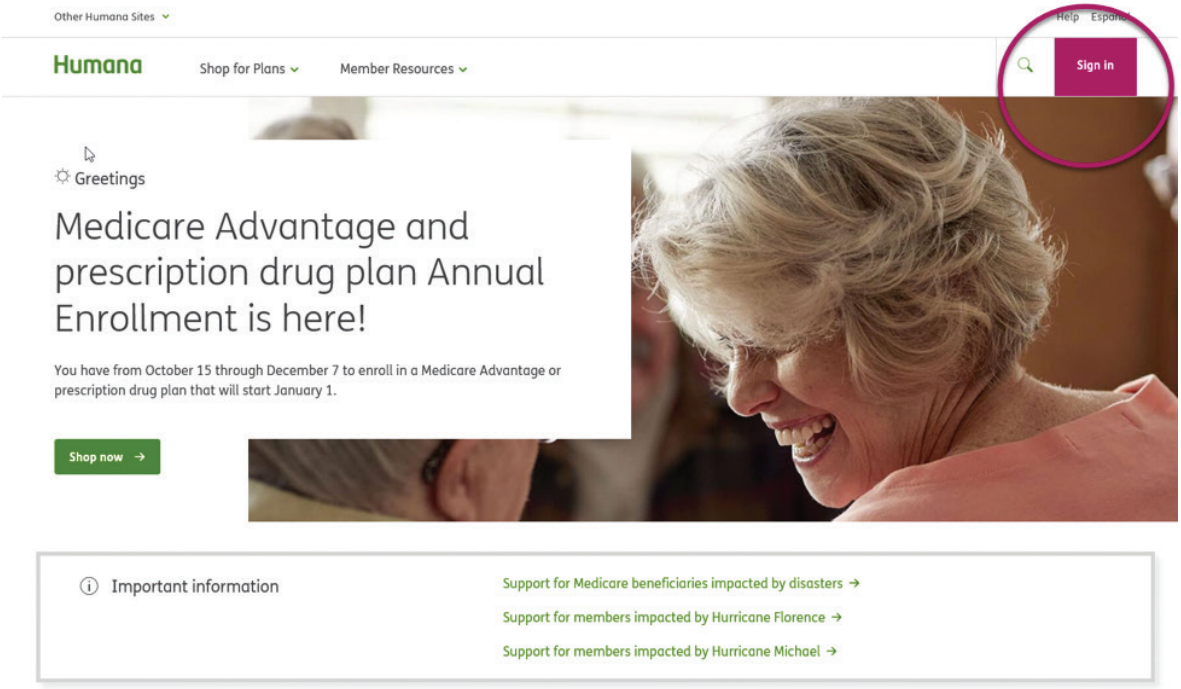
**Rows highlighted in yellow indicate a retroactive MAC adjustment has been made as a result of a granted appeal for this MAC update. The retroactive MAC adjustment will be effective to the initial date of service the appealed drug was dispensed as indicated with the effective date below.

Humana Corporate MAC List

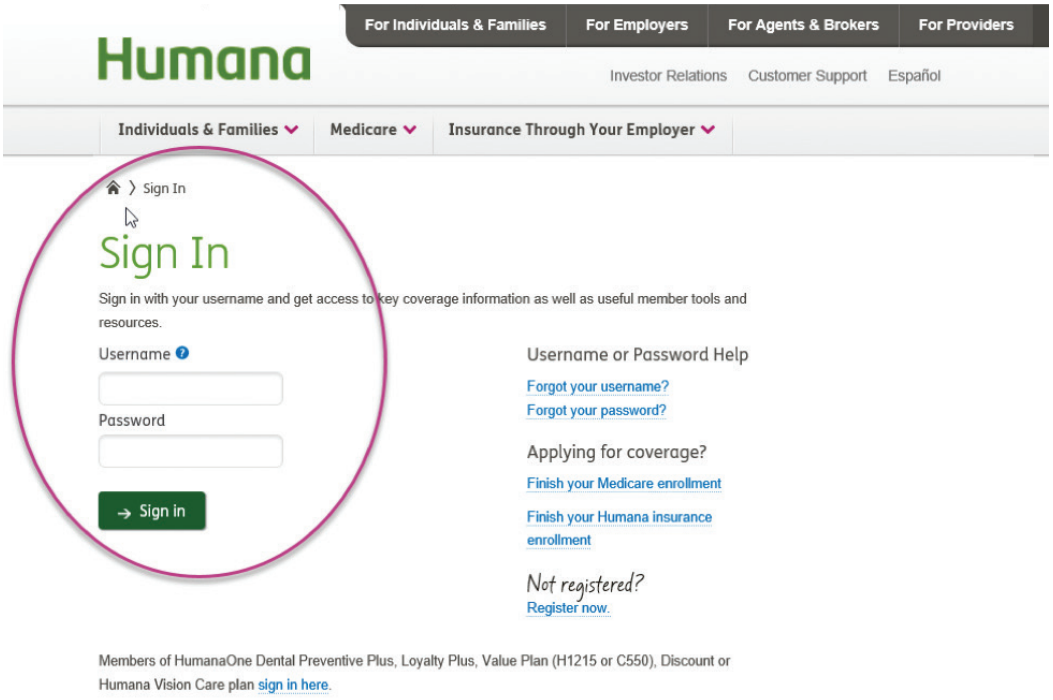
GCN	Generic Name	Eff Date	End Date	Price
13960	Diclofenac Potassium 50 Mg Tablet	7/20/2016	12/31/9999	1.12000
14602	Fluphenazine Hcl 1 Mg Tablet			
14604	Fluphenazine Hcl 2.5 Mg Tablet			
14605	Fluphenazine Hcl 5 Mg Tablet			
31070	Betamethasone Dipropionate 0.05 % Oint. (g)			
39541	Dicloxacillin Sodium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

Pricing review form location

A network pharmacy with a pricing dispute should follow the steps below in order to submit a pricing review form to Humana. Go to **Humana.com** and click the "Sign in" button.



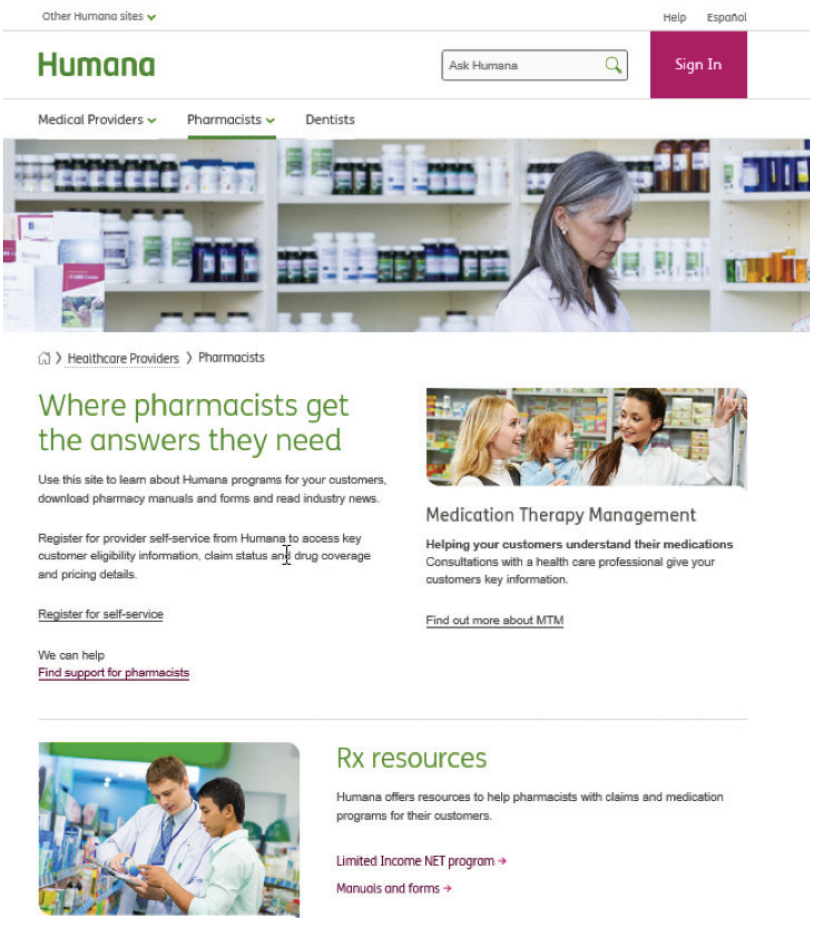
The drop-down menu that is shown below appears. The pharmacy will then enter the username and password that it set up at the time it contracted with Humana. If the pharmacy is unsure of its username and password, it should contact the pharmacy contracting team at **pharmacycontracting@humana.com** and ask them to have the pharmacy's web portal account reset.



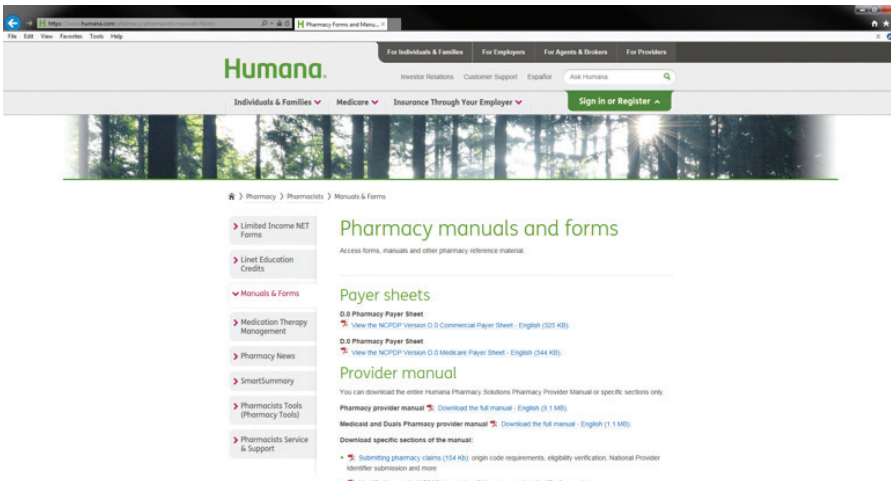
Pricing dispute form

Click on the **Manuals and forms** link on the right side of the screen.

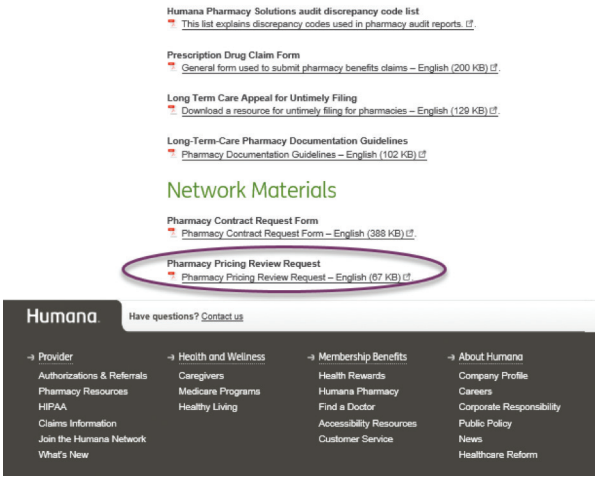
Scroll about halfway down the screen to the **Rx resources** section, and click on the **Manuals and forms** button.



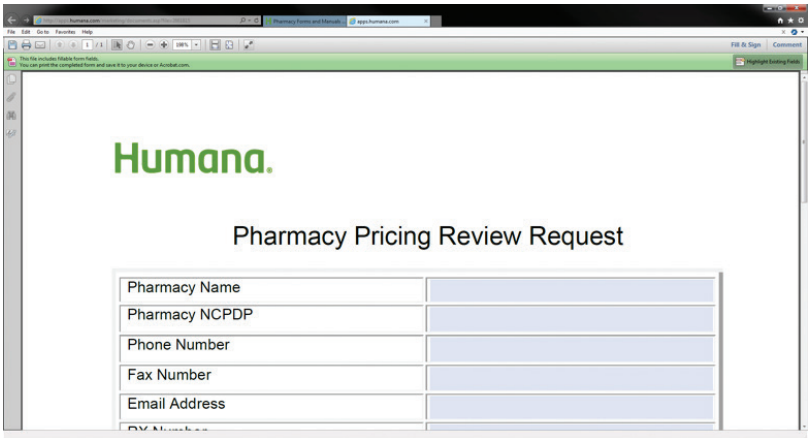
Once the pharmacy clicks on the **Manuals and forms** button, it will be redirected to a new page, similar to the screen below.



Scroll to the bottom of the page to the Network Materials section and click on the **Pharmacy Pricing Review Request–English** document.



The pharmacy must complete all fields in the attached form and return it to Humana via fax at **1-855-381-1332** or email **pharmacypricingreview@humana.com** to initiate the dispute process.



When the form is received, Humana will begin the research process and inform the pharmacy via fax or email of the results of the dispute within five business days from the date the form was received.

Humana processing of Medicare drug exclusions

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

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

Managed Medicaid plans:

Many Medicare Part D-excluded drugs and OTC drugs are payable under Medicaid plans. Some drug categories are excluded under Medicaid plans. Check the applicable Drug List for more information.

Coordination of benefits (for Medicaid programs only)

Excluded drug coverage by state Medicaid program:
Effective Jan. 1, 2006, Medicaid enrollees who are entitled to receive Medicare benefits under Part A or Part B no longer receive their pharmacy benefits under their state Medicaid agency, except for drugs that are not covered under Medicare Part D. Each state has the option to cover these drugs for their Medicaid beneficiaries who also have Medicare coverage, and each state has a list of excluded drugs. Please note this does not apply to the territories. Additional information is available at:
https://www.medicaid.gov/medicaid/prescription-drugs/excluded-drug-coverage/index.html.

If recipients enroll in Medicare Part D, they should compare drug plans prior to choosing one. Doing so will allow recipients to see which drug plans cover the prescription medications they take; how much coverage they offer; the cost of deductibles, copayments and the monthly premium; and which pharmacies they can use with each plan. To learn more, visit the Medicare website.

Prescriptions that are eligible for coverage through the Part D Medicare program for Medicare-Medicaid dual-eligible members are not covered by Medicaid. Under section 1927(d)(2) of the Act, some drugs excluded from Part D may be billed to Medicaid. Medicaid will not pay for drugs for beneficiaries who have both Medicare and Medicaid (dual eligible) with the exception of:

- Prescription products that are not covered under Part D
- OTC products

Medicaid does not reimburse for Medicare Part D drug copayment or for prescriptions not covered due to the Medicare Part D coverage gap. Medicaid will not pay any deductibles or coinsurance for drugs covered by Medicare Part D.

Vaccine administration

Medicare-Medicaid dual demonstrations

The Medicare Part D program covers administration associated with the injection of Part D vaccines. Pharmacists in Humana-participating pharmacies may administer the vaccines if allowed by state law.

Submitting claims for vaccine administration

To submit claims for the drug and the administration, the pharmacy must bill a value greater than zero in the incentive amount submitted field (438-E3) and submit professional service code “MA” in field 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 bill a value greater than zero in the incentive amount submitted field (438-E3). The pharmacy also must submit a professional service code of "MA" in field 44Ø-E5.

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

Managed Medicaid plans

The program covers administration associated with the injection of shingles, influenza and pneumococcal vaccines. Pharmacists in Humana-participating pharmacies may administer the vaccines if allowed by state law.

Submitting claims for vaccine administration

To submit claims for the drug and the administration, the pharmacy must bill a value greater than zero in the incentive amount submitted field (438-E3) and submit professional service code "MA" in field 44Ø-E5.

Coverage determinations

Medicare-Medicaid dual demonstrations

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**. 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,** and scroll down to **Medicare coverage determination form.**

Managed Medicaid plans

Managed Medicaid 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' prescribers may request a coverage determination by faxing the request to HCPR at **1-877-486-2621**. For questions, contact HCPR at **1-800-555-CLIN (1-800-555-2546)**. The coverage determination decision will be made within 24 hours after complete information is received from the prescriber. However, requests for payment or reimbursement have a different time frame.

Exceptions to plan coverage for Medicare members

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

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

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

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 to **1-866-488-5991** or can be faxed to **1-855-681-8650**.

Please note: Humana does not accept prior authorization requests directly from pharmacies. They must be initiated by the member or prescriber.

Retail and long-term care (LTC) transition policy

This policy applies to prescribed medications that are subject to certain limitations, such as drugs not listed on the Drug List and drugs requiring prior authorization, step therapy or quantity limit. This policy helps members who have limited ability to receive their prescribed drug therapy by providing them with a temporary supply. For new and re-enrolling members who are at a retail pharmacy or in a long-term care facility, Humana will cover a temporary supply as indicated for each program in the chart below. If the member presents a prescription written for less than the days' supply allowed, Humana will allow multiple fills to provide up to the total days' supply of medication allowed.

Humana will indicate that a prescription is a transition fill in the message field of the paid claim response. The pharmacist should communicate this information to the member. Providing a temporary supply gives the member time to talk to his/her prescriber to decide if an alternative drug is appropriate or to request an exception or prior authorization. Humana will not pay for additional refills of temporary supply drugs until an exception or prior authorization has been obtained.

Transition will not work under the following conditions:

- CMS-excluded drug
- Medicare Part B drug
- Drugs that require a Medicare Part B vs. D determination and therefore are required to go through the standard prior authorization process
- Drugs that require a diagnosis to determine medically accepted Part D use safety edits
- Initial transition eligibility criteria are not met

Program	Retail–Total days' supply allowed	Retail–Total time period allowed for transition	LTC–Total days' supply allowed	LTC–Total time period allowed for transition
IL MMAI	30	90	31 per fill 98 total days' supply	90
FL MMA	60	60	60	60

Level-of-care changes (for Medicare-Medicaid dual demonstrations only)

Throughout the plan year, members may have changes in their treatment settings due to the level of care they require. Such transitions include:

- Members who are discharged from a hospital or skilled nursing facility to a home setting
- Members who are admitted to a hospital or skilled nursing facility from a home setting
- Members who transfer from one skilled nursing facility to another and are serviced by a different pharmacy
- Members who end their skilled nursing facility Medicare Part A stays (where payments include all pharmacy charges) and who now need to use their Part D plan benefits
- Members who give up hospice status and revert back to standard Medicare Part A and B coverage
- Members who are discharged from chronic psychiatric hospitals with highly individualized drug regimens

For these changes in treatment settings, Humana will cover up to a 30-day temporary supply of a Part D-covered drug

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

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

There also will be messaging for eligible retail and LTC transition claims indicating 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)

All members enrolled in a dual demonstration should be eligible for, and have, Medicare's low-income subsidy (LIS).

Medicare's low-income subsidy (also known as "Extra Help") assists people who have limited income and resources with their prescription drug costs. People who qualify for this program receive assistance paying for premiums, deductibles or cost-shares related to their Medicare drug plans. Some people automatically qualify for this subsidy and do not need to apply. Medicare mails a letter to these individuals. The pharmacist may use the pharmacist self-service center website (registration required; see page 1) to view the member's LIS status.

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

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

Please note this proof must be confirmed by a pharmacist and must show the individual's eligibility took effect on or before the date the prescription was filled. If the member is not found in DST Pharmacy Solutions, the pharmacist may contact the Humana pharmacy help desk at **1-800-865-8715**, and select option 2 to add a recently enrolled Medicare Part D member to the DST Pharmacy Solutions claim-processing system using the quick-activation process. (See Eligibility Verification section for quick-activation requirements.)

The LIS can also be added during the quick-activation process if applicable.

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

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

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

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

Best available evidence for long-term care residents

Pharmacists who have evidence that the cost-share responsibility of a Humana Medicare-Medicaid member residing in an LTC facility should be different from that shown on adjudicated claims may provide applicable evidence to Humana regarding the member's LIS status. Pharmacists may submit appropriate evidence to Humana by utilizing the "Long-term Care Access to Care" form available at **Humana.com/Pharmacists**. Choose the **Manuals and 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-Medicaid member are incorrect and should reflect a different LIS level are asked to call this number as well. Member-specific LIS levels may be viewed on the pharmacist self-service center website (registration required; see page 1).

Long-term care pharmacy information

Humana recognizes the unique operational model and services provided by the pharmacies in its long-term care network. Whether the scope of the pharmacy's services to LTC facilities is predominantly institutional or part of the mix of services offered by a retail pharmacy, the following resources provide policies and direction for services to Humana members in institutional settings. While most of the needs that LTC 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 claims-processing guidelines

CMS requires all pharmacies to submit the patient residence code (NCPDP field 384-4X) and pharmacy service type (NCPDP field 147-U7) on all Medicare Part D claims. Additionally, Humana has the same requirement for any claim submitted for a managed Medicaid plan. 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
1	Home
3	Nursing facility
4	Assisted living facility
6	Group home

Patient residence codes	Description
9	Intermediate care facility/mentally retarded*
11	Hospice

*Pharmacy code only. This is not Humana approved language.

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

If the pharmacy submits a claim for a Managed Medicaid plan with a missing or invalid patient residence code, the claim will reject with NCPDP error code 4X and return the following message: **Missing/Invalid Patient Residence Code.**

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 or claim for a Managed Medicaid plan with a missing or invalid pharmacy service type, the claim will reject with NCPDP error code U7 and return the following message: **Missing/Invalid Pharmacy Service Type.**

Nebulizer solutions covered under Part D for LTC residents

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

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

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

Submission requirements

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

- **Patient residence** (NCPDP field 384-4X)–This field communicates where the patient resides. Several values are used in this field to communicate LTC, but Humana applies appropriate dispensing requirements only to claims submitted with a patient residence code of 03 (nursing facility).
- **Pharmacy service type** (NCPDP field 147-U7)–This field communicates the type of service being performed by a pharmacy when different contractual terms exist between a payer and the pharmacy or when benefits are based upon the type of service performed.
- **Submission clarification code** (NCPDP field 420-DK)–This field is used to identify the dispensing frequency used by the pharmacy (e.g., every 14 days, every seven days, etc.).
- **Special packaging indicator** (NCPDP field 429-DT)–This field is used in appropriate dispensing to identify the type of packaging used in dispensing the medication.

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

Rejections

If an LTC pharmacy submits a claim for a brand, oral solid medication that is subject to the appropriate dispensing requirement, it must contain valid information in all the appropriate fields (as indicated previously for appropriate dispensing and on the Humana payer sheet for all claims) 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 does not include both an appropriate submission clarification code and special package indicator.
- **NCPDP reject code 597:** "LTC Dispensing Type Does Not Support The Packaging Type."
- **NCPDP reject code 612:** "LTC Appropriate Dispensing Invalid Submission Clarification Code (SCC) Combination."

Combination pharmacies

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

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. The pharmacy's cost-share collection practices should be guided by the following principles:

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

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

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

Home infusion billing procedures

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
Therapeutic duplication	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.

Medicare's Limited Income Newly Eligible Transition (LINET) program

Medicare's Limited Income NET Program, or LINET, is a CMS demonstration program administered by Humana that provides temporary prescription coverage for Medicare beneficiaries who qualify for low-income subsidy (LIS), sometimes called "Extra Help," and have no prescription coverage.

To qualify for LINET, the beneficiary must be eligible for Medicare and be eligible for one of the following:

- Medicaid
- LIS
- Supplemental Security Income (SSI)
- Medicare Savings Program (MSP)

Beneficiaries who are unsure if they qualify for a low-income program can be referred to their state health insurance assistance programs (SHIPs) for assistance. SHIPs counselors can be reached at **1-877-839-2675**.

Beneficiaries are enrolled in LINET in one of three ways:

- Auto-enrollment – Most beneficiaries are auto-enrolled by CMS and receive a temporary prescription card with instructions
- Point of sale – Immediate enrollment at the pharmacy counter through claim submission
- Direct member reimbursement – Beneficiary submits request for reimbursement for out-of-pocket expenses

How to submit an LINET claim

1. Submit an E1 query to Medicare's online eligibility query system.
   a. If the E1 query returns BIN/PCN, submit the claim to the appropriate Part D plan.
   b. If the E1 query returns a contract ID and help-desk numbers, contact that Medicare Part D plan for the 4Rx data.
   c. If the E1 query returns a telephone number for Contract ID "X0001," the patient is enrolled in the Medicare's Limited Income NET Program. Use the 4Rx data located below.
   d. If the query does not return plan enrollment, go to step 2.
2. Verify eligibility for Medicaid or low-income subsidy (LIS).
3. Submit the claim using the following 4Rx data:
   - BIN: 015599
   - PCN: 05440000
   - Group ID: May be left blank
   - Cardholder ID: Medicare claim number (include letters)
   - Patient ID (optional) – Medicaid ID or Social Security number

What if my patient paid out of pocket for medications?

Beneficiaries who paid out of pocket for medications may be eligible for reimbursement. The beneficiary can take the following steps to request reimbursement:

1. Complete the LINET direct member reimbursement form (DMR) located in the LINET "Welcome Letter" or found online at **apps.Humana.com/marketing/documents.asp?file=2830217**.
2. Attach a copy of receipt or printout from the pharmacy showing member payment.
3. Mail or fax completed form and receipt information to:

Medicare's Limited Income NET Program
P.O. Box 14310
Lexington, KY 40202-14310

Fax: **1-877-210-5592**

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

Medication Therapy Management (MTM) program (for Medicare-Medicaid dual demonstrations only)

Medication Therapy Management (MTM) is a program that seeks to enhance a member's medication therapy and to minimize adverse drug reactions. Humana's MTM program utilizes a variety of resources, such as telephone-based and pharmacy-based consultation services, for ambulatory and institutional beneficiaries.

Humana works with community pharmacies to provide eligible Medicare members with a series of face-to-face MTM consultations at their local pharmacies.

Humana has contracted with a vendor to assist in providing MTM services. If a pharmacy is interested in providing MTM services to Humana members, it can visit **www.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 its clients (including CMS)
- Help ensure compliance with the provider agreement between Humana and its network pharmacies
- Educate network pharmacies regarding proper submission and documentation of pharmacy claims

According to the pharmacy provider agreement between Humana and its network pharmacies, Humana, any third-party auditor designated by Humana or any government agency allowed by law is permitted to conduct audits of any and all pharmacy books, records and prescription files related to services rendered to members.

Claim-specific audit objectives include, but are not limited to, correction of the following errors:

- Dispensing unauthorized, early or excessive refills
- Dispensing an incorrect drug
- Billing the wrong member
- Billing an incorrect physician
- Using an NCPDP/National Provider Identifier (NPI) number inappropriately
- Calculating the days' supply incorrectly
- Using a dispense-as-written code incorrectly
- Overbilling quantities
- Not retaining/providing the hard copy of prescriptions or a signature log/delivery manifest

Humana notifies pharmacies of its intent to audit and provides specific directions regarding the process. Humana's on-site audits are conducted in a professional, Health Insurance Portability and Accountability Act (HIPAA)-compliant manner, with respect for patients and pharmacy staff. To access the Humana Pharmacy Audit Guide, please visit **Humana.com/Pharmacists**, then select **Manuals and 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 and forms**.

Humana's policy on informed consent for psychotherapeutic medication (for Florida MMA Medicaid only)

The state of Florida has instituted the following legislation, Florida Statute 409.912(13). Florida Medicaid Agency for Health Care Administration (AHCA) requires a psychotropic consent form to be on file with the dispensing pharmacy for any pediatric patient (less than 13 years of age). A documented consent form must be completed by a parent or guardian. The referring physician must file the consent of a parent or guardian in the medical record and a copy of the consent must accompany each new prescription. Humana Pharmacy Solutions, which administers the Humana Medical Plan, intends to cooperate with Florida Medicaid by assisting pharmacies in complying with this regulation.

When a psychotropic medication prescription is being filled for a pediatric patient who is less than 13 years of age, the claim will reject with NCPDP error code 60 and return the following message: Age Limit-drug excluded product/service not covered for patient age. Free form message will indicate: Informed consent request use PPS override.

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

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

Value	Value type
ED	Patient education/instruction
M0	Prescriber consulted
4A	Prescriber acknowledgements

Hernandez settlement agreement (for Florida MMA Medicaid only)

Florida Medicaid healthcare providers (including pharmacies serving Humana Medical Plan members) must meet all requirements set forth in the Hernandez settlement agreement. If you are not familiar with the agreement and its requirements, additional information is available at:
www.fdhc.state.fl.us/medicaid/prescribed_drug/multi_source.shtml.

Multisource brand drug policy (for Florida MMA Medicaid only)

If a patient's prescription was not covered because there is a generic, the prescribing physician believes the patient has had a bad reaction to the generic or the brand drug is otherwise medically necessary, the prescriber must fill out and submit a prior authorization fax form, along with supporting documentation of step therapy and/or adverse reaction. This form can be submitted only by a Medicaid recipient's prescribing physician.

For information on prior authorizations, visit **Humana.com/PA.** Please have the prescribing provider fax the prior authorization request to Humana Clinical Pharmacy Review (HCPR) at **1-877-486-2621.** For questions, contact HCPR at **1-800-555-CLIN (1-800-555-2546).**

Fraud, waste and abuse (FWA) and compliance program requirements

Policy statement

Humana does not tolerate fraudulent activity or actions in violation of its standards of conduct or compliance policy (both available at **Humana.com/Fraud**), as committed by Humana employees, contracted providers, those supporting their contractual obligations to Humana, members, customers, vendors, contractors and/or other business entities. Humana will investigate any suspected noncompliance or fraudulent activity and will report it to the appropriate regulatory, federal or state agencies for further action and investigation, as appropriate.

Humana is a Medicare Advantage organization, a Medicare Part D prescription drug plan sponsor and administrator of Medicaid products that have a pharmacy benefit. All such organizations are required to have a comprehensive plan to detect, correct and prevent fraud, waste and abuse, and Humana has such a plan.

Training to combat FWA

Every Humana-contracted entity supporting Humana's Medicare and/or Medicaid products is responsible for:

- Providing FWA prevention, detection and correction training to its employees and contractors who administer, deliver or support federal healthcare program benefits or services; and
- Confirming adherence to the training obligation, as well as understanding of and compliance with the requirements outlined in the training materials.

Material to use

Your organization may use its own material to meet the FWA training requirement or another training. However, Humana offers content on this topic in the following documents that together contain corresponding FWA content that your organization may use to supplement the FWA training or within it:

Humana Compliance Policy for Contracted Health Care Providers and Business Partners (http://apps.Humana.com/marketing/documents.asp?file=1827514)

Humana Ethics Every Day for Contracted Health Care Providers and Business Partners (http://apps.Humana.com/marketing/documents.asp?file=1112774)

Training records

Humana-contracted entities must maintain FWA training records, including the time, attendance, topic, certificate of completion (if applicable) and test scores for all tests administered, for 11 years (or longer, if required by state law).

Additional assurance

Humana and CMS reserve the right to audit contracted pharmacies to assess their commitment to FWA training requirements, including requests CMS makes of Humana that require these pharmacies to provide corresponding documentation.

Requirement to report suspected or detected FWA and/or noncompliance

Pharmacy providers and all they employ and contract to support a contract with Humana must report suspected fraudulent or noncompliant activities to Humana. The person reporting information may relay concerns via multiple options.

The most expedient manner is by calling the Humana Special Investigation Unit (SIU) at **1-800-614-4126**. This toll-free hotline is available 24 hours a day, and callers may remain anonymous. Humana takes great efforts to keep information confidential.

Those reporting suspected activities are protected from retaliation according to the whistleblower provision in 31 U.S.C. 3730(h) of the False Claims Act.

Once SIU performs its initial investigation, it will refer the case to law enforcement and/or regulatory agencies, as appropriate. Additional information about SIU and Humana's efforts to address FWA can be found at **Humana.com/Fraud**.

The following reporting options are available:

Phone:

- Humana Special Investigations Hotline (voice messaging system): **1-800-614-4126**
- Humana Ethics Help Line: **1-877-5-THE-KEY (1-877-584-3539)**

Both the above phone methods are available 24 hours a day and allow for callers to remain anonymous.*

Fax:

1-920-339-3613

Email:

siureferrals@humana.com or **ethics@humana.com**

Mail:

Humana, Special Investigations Unit 1100 Employers Blvd.
Green Bay, WI 54344

Ethics Help Line reporting website:

ethicshelpline.tnwreports.com

*Humana requests that if a person reporting an ethics concern desires to remain anonymous, he/she provide enough information to allow Humana to investigate the issue.

NOTE: Confidential follow-up to check on the status of an investigation is available.

Prohibition against intimidation or retaliation

Humana has a zero-tolerance policy for the intimidation of or retaliation or retribution against any person who is aware of and, in good faith, reports suspected misconduct or participates in an investigation of it.

Disciplinary standards

Humana may take any or all of the following actions related to FWA or violations of Humana's standards of conduct:

- Oral or written warnings or reprimands
- Termination(s) of employment or contract
- Other measures that may be outlined in the contract
- Mandatory retraining
- Formal, written corrective action plan(s) tracked to closure
- Reporting of the conduct to the appropriate external entity(ies), such as CMS, a CMS designee, a state agency where Humana administers a Medicaid product or law enforcement agencies

NOTE: If a pharmacist, or any party a contracted pharmacy provider entity employs or contracts to support a Humana contract, does not report suspected FWA or violations of Humana's standards of conduct or compliance policy (available at **Humana.com/pharmacy/pharmacists/manuals-forms**), it is considered a violation of Humana requirements and is subject to any or all of the above disciplinary actions.

Every Humana-contracted entity must have disciplinary standards and take appropriate action upon discovery of FWA and violations of Humana's standards of conduct or compliance policy or actions likely to lead to FWA or the above-referenced violations.

In addition, depending on the specifics of a case, CMS may elect to exclude anyone involved in an FWA violation from participating in federal procurement opportunities, including work in support of any contract Humana has with CMS.

Corresponding expectations

Pharmacy providers are also expected to:

- Widely publicize both the available Humana methods for reporting compliance and FWA concerns and the non-retaliation policy throughout their facilities (examples include: posters, mouse pads, key cards and other prominent displays); and
- Reinforce Humana's policy of nonintimidation and nonretaliation.

Standards of conduct/ethics

Every Humana-contracted entity must routinely perform the following actions and, upon Humana's request, provide certification of these actions:

- Employees, management, governing body members and those the entity contracts to support contractual obligations to Humana's Medicare and/or Medicaid products are required to review and attest to compliance 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. A copy can be accessed, printed and downloaded by visiting **apps.Humana.com/marketing/documents.asp?file=1112774**.
- Review the Office of Inspector General (OIG) and General Services Administration (GSA) exclusion lists for all new employees, management, governing body members and contracted individuals or entities, upon hire/contract and monthly thereafter to verify those who assist in the administration or delivery of federal healthcare program benefits in support of a Humana contract are not included on such lists.
- Remove any person identified on an exclusion list above from any work related directly or indirectly to Humana's support of any federal healthcare program, such as Medicare, or a state-administered program like Medicaid.
- Take appropriate corrective actions for standards of conduct violations and, when fraud, waste or abuse is involved, report findings to Humana's Special Investigation Unit at **1-800-614-4126**.

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

Compliance program requirements

The information below is provided to help the above-listed pharmacy providers confirm their compliance programs have the necessary elements to be effective.

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

1. Oversight: Monitoring and auditing the compliance of employees and subcontractors that provide services and/or perform any support functions related to administrative or healthcare services provided to a member of a Humana Medicare Advantage plan, Medicare prescription drug plan or a Medicaid plan administered by Humana. This is conducted from both an operational perspective and through exclusion screening of all individuals and contracted entities that support Humana Medicare and/or Medicaid products.
2. Offshore subcontracting notification: Obtaining approval from Humana for relationships that would support the pharmacy provider's contractual obligations to Humana. In addition, note that Humana must notify CMS of any location outside of the United States or a United States territory that receives, processes, transfers, stores or accesses Medicare member protected health information in oral, written or electronic form. Therefore, Humana must be notified in a timely manner of prospective offshore arrangements, including desired changes or additions to existing relationships or offshore locations.
3. Establishment, documentation and communication of effective compliance policies: Having policies and procedures in place for preventing and detecting suspected FWA, then correcting and reporting identified instances, as well as other aspects of noncompliance, including, but not limited to:
   a. Requiring employees and subcontractors to report suspected and/or detected FWA and suspected violations of Humana's compliance policy or standards of conduct (those documents are available at **Humana.com/pharmacy/pharmacists/manuals-forms**).
   b. Safeguarding Humana's confidential and proprietary information, as well as plan members' protected personal and health information.
   c. Providing accurate and timely information/data in the regular course of business.
   d. Monitoring and auditing activities.
   e. Upholding disciplinary standards.

4. Training: Ensuring that all required compliance program training is completed not simply by the compliance contact at the organization, but by those supporting the organization's contractual obligations to Humana employees and subcontractors. Where applicable, operational training must be conducted. This includes having a tracking method in place to provide evidence of these efforts upon request; e.g., who was trained, when, how and with what material(s).
5. Cooperation: Cooperating fully with Humana and/or government entity investigations of an alleged, suspected or detected violation of this manual, Humana policies and procedures, applicable state or federal laws or regulations and/or remedial actions.
6. Communication: Publicizing methods for reporting suspected violations of Humana policies and government regulations, as well as corresponding disciplinary standards to employees, volunteers, board members and subcontractors.
7. Disciplinary standards: Having established disciplinary standards in place that are carried out when violations are committed by the pharmacy provider, its employees or those it contracts to support obligations to Humana.
8. Assurance: Complying with Humana requests to provide assurance related to the pharmacy entity's compliance program.

Please refer to Humana's compliance policy at **apps.Humana.com/marketing/documents.asp?file=1827514**, as it includes an overview of the eight elements of an effective compliance program.

Frequently asked questions

Humana makes a guidance document (**apps.Humana.com/marketing/documents.asp?file=2621125**) publicly available online with additional information regarding the compliance requirements.

Further compliance program requirements information for pharmacies supporting Humana's Medicare and/or Medicaid products can be found in Humana's compliance policy at **apps.Humana.com/marketing/documents.asp?file=1827514**.

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

When an attestation is required

Humana reserves the right to request documentation as assurance that certain compliance program requirements and training are in place, yet the only attestation required pertains to Medicaid training for pharmacies supporting one or more plans administered by Humana for Medicaid beneficiaries. Compliance education material is refreshed at least each calendar year to assist pharmacies in meeting these and related requirements. Pharmacies required to complete the Medicaid training attestation must complete it within 30 days of notification each calendar year. The attestation(s) and method(s) for completion vary based on whether Medicare and/or Medicaid products are supported. Corresponding instructions are listed in the compliance requirements FAQ for pharmacy providers at **apps.Humana.com/marketing/documents.asp?file=2621125**.

Required compliance program training

The following must be provided to those contracted or employed to support a Humana contract for a Medicare and/or Medicaid product that Humana is ultimately responsible for administering:

- Compliance policy that outlines compliance program requirements;
- Standards of conduct; and
- Training on understanding and addressing fraud, waste and abuse (FWA) using your organization's material or another training.

Humana documents, or documents that are materially similar, may be used to meet the compliance policy and standards of conduct requirements. Instructions on how to provide confirmation, when necessary and applicable, is listed in the Notification of Compliance Requirement document found at **Humana.com/pharmacy/pharmacists/manuals-forms**. Humana's documents also are available at the same website.

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

- Cultural competency;
- Health, safety and welfare of plan members;
- Medicaid pharmacy provider; and
- Humana orientation.

These above-listed documents are available at **Humana.com/pharmacy/pharmacists/manuals-forms**.

Please note that as requirements of Humana may change, Humana reserves the right to require additional or different compliance program training or components, although it strives not to make midyear changes.

*The number of Medicaid trainings may vary by state where Humana offers these plans and may include state-specific or pharmacy-specific versions. Humana clarifies variances through the combination of information outlined in its Medicaid training attestation form that applicable pharmacies must be complete and return to Humana via the training documents at the above website.

Humana.com instructions

The document at **apps.Humana.com/marketing/documents.asp?file=1827566** covers how to:

- Complete the compliance requirements at **Humana.com**;
- Register at **Humana.com**;
- Create a new user; and
- Assign the compliance business function to another user, and update an organization's tax identification number (TIN).

If an organization is unable to register at **Humana.com**, it can refer to the document "Compliance Requirements for Health Care Providers Who Are Unable to Register" at **apps.Humana.com/marketing/documents.asp?file=1827579**.

Humana pharmacy credentialing

Humana Pharmacy Solutions 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
- No sanction attestation
- Copy of current professional liability insurance (PLI) coverage that meets or exceeds a minimum requirement of $1 million in aggregate

Participating pharmacies that do not meet Humana Pharmacy Solutions' required standards will be removed from Humana Pharmacy Solutions' pharmacy network.

Conflicts of interest

All entities and individuals supporting Humana 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 Solutions 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 and sign a conflict of interest statement from all employees and subcontractors within 90 days of hire or contract and annually thereafter. This statement certifies that the employee or downstream entity is free from any conflict of interest for administering or delivering federal healthcare program benefits or services.

All 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 healthcare program that:

- Would violate the federal Stark Law, 42 U.S.C. § 1395nn, if items or services delivered in connection with the relationship were billed to a federal healthcare program, or that would violate comparable state law;
- Would violate the federal Anti-Kickback Statute, 42 U.S.C. § 1320a-7b, if items or services delivered in connection with the relationship were billed to a federal healthcare program, or that would violate comparable state law; or
- In the judgment of Humana, could reasonably be expected to influence a provider to utilize or bill for items or services covered under a federal healthcare program in a manner that is inconsistent with professional standards or norms in the local community.

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 help desk	For prior authorization status, call **1-800-865-8715**, and select option 2. For other claims-processing questions, select option 3.
Humana Customer Care	**1-800-477-6931 (TTY: 711)** 8 a.m. – 8 p.m., seven days a week
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	Pharmacy contract requests Email: **pharmacycontractrequest@humana.com** Fax: **1-866-449-5380** Quality programs Email: **RxQualityProgram@humana.com** Fax: **1-844-330-8892**
Humana Ethics Help Line	**1-877-5-THE-KEY (1-877-584-3539)**
DST Pharmacy Solutions	**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**

Appendix B: Medicare Prescription Drug Coverage and Your Rights

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

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

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

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

OMB Approval No. 0938-0975

Enrollee's name _____ (optional)

Drug and prescription number _____ (optional)

Medicare Prescription Drug Coverage and Your 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 "Drug List";
- 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 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 drug not covered by the plan 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 (1-800-633-4227)**, 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 **1-800-MEDICARE (1-800-633-4227).**

Formulario de CMS-10147-Spanish

Medicare and Medicaid Reports and Other Documents

Prohibition on Balance Billing Dually Eligible Individuals Enrolled in the Qualified Medicare Beneficiary (QMB) Program, ¶65,239, Centers for Medicare and Medicaid Services, (Feb. 1, 2016)

¶65,239. MLN Matters, No. SE1128, Feb. 1, 2016.

Department of Health and Human Services

Centers for Medicare & Medicaid Services

MLN Matters® Number: SE1128

Revised related change request (CR) #: N/A

Related CR release date: N/A

Effective date: N/A

Related CR transmittal #: N/A

Implementation date: N/A

Prohibition on Balance Billing Dually Eligible Individuals Enrolled in the Qualified Medicare Beneficiary (QMB) Program

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

Provider types affected

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

Stop–What Medicare providers need to know

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

Caution–What Medicaid providers need to know

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

Go–What Medicare providers need to know

Refer to the Background and Additional Information Sections of this article for further details and resources about this guidance. All Medicare providers should be aware of the federal balance billing law and policies regarding QMB individuals. Medicare providers should contact the Medicaid Agency in the states in which they practice to learn about ways to identify QMB patients in their states and procedures applicable to Medicaid reimbursement for their Medicare cost-sharing. Medicare Advantage providers also may contact the MA plan for more information. Finally, all Medicare providers should ensure that their billing software and administrative state exempt QMB individuals from Medicare cost-sharing billing and related collection efforts.

Background

This article provides CMS guidance to Medicare providers to help them avoid inappropriately billing QMBs for Medicare cost-share, including deductibles, coinsurance and copayments. This practice is known as "balance billing."

Balance billing of QMBs is prohibited by federal law

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

Inappropriate balance billing persists

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

QMB eligibility and benefits

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

Additional information

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

Document history

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

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