Medicare Part B vs. Part D billing

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

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

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

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

- Most prescription drugs
- Insulin (excludes insulin used in a pump)
- Insulin supplies, such as standard and needle-free syringes, needles, gauze, alcohol swabs and insulin pens
- Most vaccines (product and administration); exceptions include flu and pneumonia vaccines, Hepatitis B vaccines (when they meet the CMS coverage 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) drips or push injection. (Examples include, but are not limited to, intramuscular drugs, antibiotics, parenteral nutrition,immunoglobulin and other infused drugs.)

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

PDPs cover Part D drugs, MA plans cover Part B drugs, and MAPD plans cover both Part B and Part D drugs. The coverage determination for Part B or Part D coverage is based upon the 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.

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 formulary 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: **http://www.medicaid.gov/medicaid-chip-program-Information/by-topics/benefits/prescription-drugs/excluded-drug-coverage.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 medicines 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 any drugs for beneficiaries who have both Medicare and Medicaid (dual eligible) with the exception of:

- Prescription products that are not covered under Part D
- Over the counter (OTC) products

Medicaid does not reimburse for Medicare Part D drug copayment or for prescriptions not covered due to the Medicare Part D coverage gap. Medicaid will not pay any deductibles and 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 a professional service code of "MA" in field 44Ø-E5.

To submit a claim for the **administration fee only**, the pharmacy must submit the National Drug Code (NDC) for the drug administered, submit a value of zero in the ingredient cost field and 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 the Part B coverage with Humana.

Managed Medicaid plans:

The program covers administration associated with the injection of shingles, influenza and pneumococcal vaccines participating in the Medicaid Drug Rebate Program. 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 a professional service code of "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 "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, appointed or authorized representatives and 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 members

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

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

For Medicaid-Medicare dual demonstrations only, a member may request an expedited exception if his or her health would be placed in jeopardy by waiting the standard 72 hours for a decision. For Medicaid plans, the exception decision will be made within 24 hours after the complete information is received from the prescriber.

Members, prescribers and appointed or authorized representatives can request an exception or an expedited exception by faxing the request to Humana Clinical Pharmacy Review at **1-877-486-2621**. To do this, **complete the coverage determination form** found at **Humana.com/Rxtools**. Prescribers or pharmacists with questions may contact HCPR at **1-800-555-CLIN** (**1-800-555-2546**).

Retail and long-term-care transition policy

This policy applies to prescribed medications that are subject to certain limitations, such as nonformulary drugs and drugs requiring prior authorization or step therapy. This policy helps members who have limited ability to receive their prescribed drug therapy by providing them with a temporary supply. For new and re-enrolling members, Humana will cover 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.

Program	Retail – Totals 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	98
VA CCC	30	90	31	98

FL MMA	60	60	60	60
IL ICP	30	90	30	90

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 discharged from chronic psychiatric hospitals with highly individualized drug regimens

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

The transition policy applies only to Humana's nonformulary, step therapy, quantity limitations and clinical prior authorization requirements. A prior authorization code will not be required to process the first claim in the retail setting.

In the long-term-care (LTC) setting, a prior authorization code will be provided in the messaging to the pharmacy upon receipt of a denied claim that is eligible for a transition fill. This prior authorization code will allow the claim to be processed and paid. There also will be messaging for eligible retail and LTC transition claims indicating the drug's transition status.

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