

Humana Pharmacy Solutions®

Pharmacy Manual

Medicare and Commercial

2021 Edition

Table of contents

Introduction.....	4
Pharmacist portal	4
Rx Quality Network Program	4
How to join our network	4
Contact information.....	5
Eligibility verification.....	6
Humana member identification (ID) cards	6
Humana Medicare Advantage-only plans	7
Cardholder ID	8
Person code	8
Medicare coverage determinations.....	8
Beneficiaries eligible for the low-income subsidy (LIS)	9
Best available evidence for long-term care residents	10
2021 low-income subsidy chart.....	11
Drug coverage.....	11
Drug Lists	11
Exceptions to plan coverage for Medicare members	12
Utilization management (UM)	12
General claims procedures.....	13
Submitting pharmacy claims.....	13
Bank Identification Numbers (BIN) and Processor Control Numbers (PCN).....	13
Prescription origin code requirements	13
Fill number.....	13
Sales tax.....	14
Timely submission of claims.....	14
Humana-specific SS&C Health payer sheets.....	14
Prescriber NPI submission.....	15
Dispense-as-written (DAW) codes.....	15
Drug utilization review (DUR) safety edits	16
Soft reject DUR	17
Humana Access® Mastercard® Debit Card	18
Controlled substances.....	19
Controlled substance claims	19
Clarification of federal requirements – Schedule II drugs	20
Submitting CII claims	20
Point-of-sale (POS) edits and overrides	20
Medicare claims coverage	20
Medicare Part B vs. Part D coverage	20
Medicare Part B vs. Part D claims submission	22
Medicare vaccine administration.....	22
Humana processing of Medicare drug exclusions.....	22
Medicare continuity of care	23
Level-of-care changes	23
Long-term care (LTC).....	24
Long-term care pharmacy information	24
LTC claims-processing guidelines	24
Nebulizer solutions covered under Part D for LTC residents.....	25

Long-term care short-cycle dispensing	25
Combination pharmacies	26
Copayments	26
Long-term care attestation	26
Home infusion billing procedures.....	27
Compound claims	27
Submitting compound claims	27
Medication Therapy Management (MTM) program.....	28
Pharmacy audit and compliance	28
Pharmacy audit program	28
Long-term care pharmacy audits	29
Compliance program audits	29
Fraud, waste and abuse (FWA) and compliance program requirements	29
Requirement to report suspected or detected FWA and/or noncompliance.....	30
Prohibition against intimidation or retaliation	31
Disciplinary standards	31
Corresponding expectations.....	32
Standards of conduct/ethics.....	32
Compliance program requirements	32
Humana pharmacy credentialing	34
Conflicts of interest	35
Complaint system.....	35
Pharmacy's pricing dispute process for commercial, Medicare and Medicaid	35
Pharmacy's process for filing a complaint	36
Enrollee complaint system	36
Price source and MAC information	38
Price source	38
Pharmacy MAC list location	38
Enclara Pharmacia overview	40
Contact information for Enclara Pharmacia	40
General claims procedures	40
Member ID card examples	41
Medicare's Limited Income NET Program (LINET)	41
Enrollment methods	41
Confirming eligibility	42
How to submit an LINET claim	42
What if my patient paid out of pocket for medications?	42
Appendix A: Related resources.....	43
Appendix B: Medicare Prescription Drug Coverage and Your Rights	44

Introduction

Dear pharmacy,

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

Processing requirements may vary by plan, and online claims adjudication and messaging reflect the most current benefits. For the required fields to submit prescription claims electronically to Humana, please refer to Humana's National Council for Prescription Drug Programs (NCPDP) Version D.0 Medicare, commercial and Limited Income Newly Eligible Transition (LINET) Program payer sheets. In your pharmacy provider agreement, you will find network participation requirements.

To view Humana Drug Lists for Medicare and commercial members, go to **Humana.com/DrugLists**.

Pharmacist portal

The **Humana pharmacist portal** provides a secure online resource where pharmacists can:

- Obtain a current list of generic maximum allowable cost (MAC) pricing
- Send email inquiries directly to Humana
- View news bulletins and link to news alerts

This resource is available to any pharmacy contracted with Humana and is provided free of charge. To gain access, visit **Humana.com/logon**, choose “**Register your account**” and select registration type. 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.

Rx Quality Network Program

For information regarding the Humana Rx Quality Network Program, email **RxQualityProgram@humana.com**. 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, and we thank you again for your participation in the Humana pharmacy provider network. If you have comments about this manual or suggestions for next year's edition, please send them to **hpsnetworks@humana.com**.

Sincerely,

The Humana Pharmacy Network Team

How to join our network

If you are not already part of our network, we welcome having you in our network. If you would like to join, please complete the form at **<https://docushare-web.apps.cf.humana.com/Marketing/docushare-app?file=1090479>**.

Send completed forms to **PharmacyContractRequest@humana.com**.

Contact information

Pharmacy help desk

For refill-too-soon overrides and prior authorization status, call **800-865-8715** and follow the prompts.

Humana Medicare Customer Care

800-281-6918 (TTY: 711)

8 a.m. – 8 p.m., seven days a week

Puerto Rico: **800-256-3316**

7 a.m. – 7 p.m., Monday – Friday

Humana Clinical Pharmacy Review (HCPR)

800-555-CLIN (555-2546)

U.S. fax: **877-486-2621**

Puerto Rico HCPR phone: **866-488-5991**

Puerto Rico HCPR fax: **855-681-8650**

Humana Pharmacy Solutions network contracting

Pharmacy contract requests

Email: **PharmacyContractRequest@humana.com**

Fax: **866-449-5380**

Quality program

Email: **RxQualityProgram@humana.com**

Fax: **844-330-8892**

Humana Ethics Help Line

877-5-THE-KEY (584-3539)

SS&C Health (formerly known as DST Pharmacy Solutions)

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 portal self-service website assistance

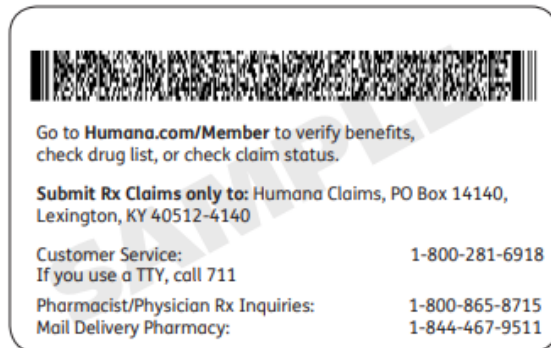
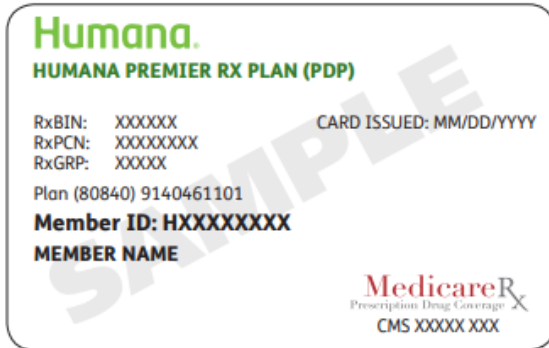
Email: **hpsnetworks@humana.com**

Eligibility verification

Humana member identification (ID) cards

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

Card for a Medicare member with a prescription drug plan (PDP) – Part D only

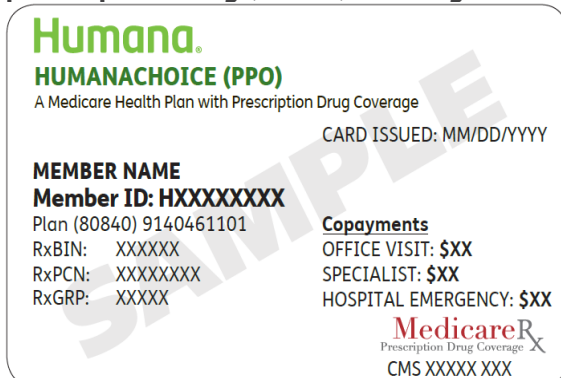


Note: This PDF meets compliance/CMS guidelines and could be subject to change at any time. Notification will be communicated if compliance guidelines change.

Card for a member with health maintenance organization (HMO) with Medicare Advantage prescription drug (MAPD) coverage – Parts A, B and D



Card for a member with preferred provider organization (PPO) with Medicare Advantage prescription drug (MAPD) coverage – Parts A, B and D



Card for a member with private-fee-for-service (PFFS) with Medicare Advantage prescription drug (MAPD) coverage – Parts A, B and D

Humana.
HUMANA GOLD CHOICE (PFFS)
 A Medicare Health Plan with Prescription Drug Coverage

CARD ISSUED: MM/DD/YYYY

MEMBER NAME
Member ID: HXXXXXXXXX
 Plan (80840) 9140461101
 RxBIN: XXXXXX
 RxPCN: XXXXXXXX
 RxGRP: XXXXX

Copayments
 OFFICE VISIT: \$XX
 SPECIALIST: \$XX
 HOSPITAL EMERGENCY: \$XX

MedicareRx
 Prescription Drug Coverage
 CMS XXXXX XXX

Network: XXXXX



Member/Provider Service: 1-800-457-4708
 If you use a TTY, call 711

For Payment, Terms and Conditions: 1-866-291-9714
 Pharmacist/Physician Rx Inquiries: 1-800-865-8715
 PROVIDERS: DO NOT BILL MEDICARE.
 Claims, PO Box 14601, Lexington, KY 40512-4601
 Medicare limiting charges apply
 Please visit us at **Humana.com** (For Dentists- **Humana.com/sb**)

Additional Benefits: DENXXX VISXXX HERXXX

Humana Medicare Advantage-only plans

Some members continue to participate in a Medicare Advantage-only plan (without the prescription benefit).

Humana's coverage for these members includes a benefit for Part B drugs. Note that the BIN and PCN are not supplied on the identification cards. Please process claims for these members under BIN 610649 and PCN 03200004. Members with this type of plan may present a card similar to the cards below.

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


Humana.
HUMANA GOLD PLUS (HMO)
 A Medicare Health Plan

CARD ISSUED: MM/DD/YYYY

MEMBER NAME
Member ID: HXXXXXXXXX
 Plan (80840) 9140461101

Copayments
 OFFICE VISIT: \$XX
 SPECIALIST: \$XX
 HOSPITAL EMERGENCY: \$XX

CMS XXXXX XXX



Member/Provider Service: 1-800-457-4708
 If you use a TTY, call 711

IPA/Center Name: XXXXXXXX
 Primary Physician: XXXXXXXXXXXXXXXX

Claims, PO Box 14601, Lexington, KY 40512-4601
 Please visit us at **Humana.com** (For Dentists- **Humana.com/sb**)

Additional Benefits: DENXXX VISXXX HERXXX

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

Humana.
HUMANACHOICE (PPO)
 A Medicare Health Plan

CARD ISSUED: MM/DD/YYYY

MEMBER NAME
Member ID: HXXXXXXXXX
 Plan (80840) 9140461101

Copayments
 OFFICE VISIT: \$XX
 SPECIALIST: \$XX
 HOSPITAL EMERGENCY: \$XX

CMS XXXXX XXX



Member/Provider Service: 1-800-457-4708
 If you use a TTY, call 711

Claims, PO Box 14601, Lexington, KY 40512-4601
 Medicare limiting charges apply
 Please visit us at **Humana.com** (For Dentists- **Humana.com/sb**)

Additional Benefits: DENXXX VISXXX HERXXX

Card for a member with private-fee-for-service (PFFS) with Medicare Advantage-only coverage – Parts A and B


Humana.
HUMANA GOLD CHOICE (PFFS)
A Medicare Health Plan

CARD ISSUED: MM/DD/YYYY

MEMBER NAME
Member ID: HXXXXXXXXX
Plan (80840) 9140461101

Copayments
OFFICE VISIT: \$XX
SPECIALIST: \$XX
HOSPITAL EMERGENCY: \$XX

Network: XXXXX
CMS XXXXX XXX



Member/Provider Service: 1-800-457-4708
If you use a TTY, call 711

For Payment Terms and Conditions: 1-866-291-9714

PROVIDERS: DO NOT BILL MEDICARE.
Claims, PO Box 14601, Lexington, KY 40512-4601
Medicare limiting charges apply
Please visit us at **Humana.com** (For Dentists- **Humana.com/sb**)
Additional Benefits: DENXXX VISXXX HERXXX

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 in a previous section, “**Humana member identification (ID) cards.**”

For commercial claims, Humana also allows the submission of the member’s Social Security number in the Cardholder ID field. The commercial claim will adjudicate with the Social Security number if the member provided this number to Humana at the time of enrollment. In addition, pharmacies may call our help desk at **800-865-8715**, choose option **3**, and provide the member’s name and date of birth to obtain the Humana member ID.

For LINET claims, the Medicare Beneficiary Identifier (MBI) may be submitted in the Cardholder ID field.

For Medicare members who do not have their Humana ID number, pharmacies may use the automated eligibility verification described on the following page or submit an E1 query.

Person code

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

Medicare coverage determinations

Medicare members or their 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. Reference Appendix B “**Medicare Prescription Drug Coverage and Your Rights**” on page 43 of this manual.

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

Members, prescribers and appointed or authorized representatives may request a coverage determination or expedited coverage determination by faxing the request to Humana at **877-486-2621**. Requests for Puerto Rico members can be faxed to **855-681-8650**.

For LINET-specific requests, please fax **855-605-6385**. Requests can also be submitted via phone at **800-783-1307**. For questions, contact LINET at **800-783-1307**. More information and applicable forms are available at **Humana.com/provider/pharmacy-resources/tools**. Choose the link under “**Coverage determinations.**”

Beneficiaries eligible for the low-income subsidy (LIS)

Medicare's low-income subsidy (also known as "Extra Help") assists people who have limited income and resources with their prescription drug costs. People who qualify for this program receive assistance paying for premiums, deductibles or cost-shares related to their Medicare drug plan. Some people automatically qualify for this subsidy and do not need to apply. Medicare mails a letter to these individuals. The pharmacist may use the pharmacist portal (registration required; see page 4) to view the member's LIS status.

Sometimes a member believes he or she has qualified for the low-income subsidy and is paying an incorrect cost-share 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 the beneficiary's Medicaid card that includes the beneficiary's name and an eligibility date during a month after June of the previous calendar year;
- A copy of a state document that confirms active Medicaid status during a month after June of the previous calendar year;
- A printout from the state electronic enrollment file showing Medicaid status during a month after June of the previous calendar year;
- A screen print from the state's Medicaid systems showing Medicaid status during a month after June of the previous calendar year;
- Other documentation provided by the state showing Medicaid status during a month after June of the previous calendar year;
- A letter from the Social Security Administration (SSA) showing that the individual receives Supplemental Security Income; or
- An application filed by deemed eligible confirming that the beneficiary is "... automatically eligible for extra help ..." (SSA publication HI 03094.605).

Please note that 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 SS&C Health's system, the pharmacist may contact the Humana pharmacy help desk at **800-865-8715** and choose option **2** to add a recently enrolled Medicare Part D member to the SS&C Health's claim-processing system using the quick-activation process. 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 SS&C Health's system 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 **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 SSA at **800-772-1213**, Monday – Friday, 7 a.m. – 7 p.m.

Best available evidence for long-term care residents

Part D sponsors are required to accept any one of the following forms of evidence from the beneficiary or the beneficiary's pharmacist, advocate, representative, family member or other individual acting on behalf of the beneficiary to establish that a beneficiary is institutionalized or—beginning on a date specified by the Secretary, but no earlier than Jan. 1, 2012—is an individual receiving home- and community-based services (HCBS) and qualifies for zero cost-sharing:

1. A remittance from the facility showing Medicaid payment for a full calendar month for that individual during a month after June of the previous calendar year;
2. A copy of a state document that confirms Medicaid payment on behalf of the individual to the facility for a full calendar month after June of the previous calendar year;
3. A screen print from the state's Medicaid systems showing the individual's institutional status based on at least a full calendar month stay for Medicaid payment purposes during a month after June of the previous calendar year;
4. Effective as of a date specified by the Secretary, but no earlier than Jan. 1, 2012, a copy of:
 - a) A state-issued Notice of Action, Notice of Determination or Notice of Enrollment that includes the beneficiary's name and HCBS eligibility date during a month after June of the previous calendar year;
 - b) A state-approved HCBS service plan that includes the beneficiary's name and effective date beginning during a month after June of the previous calendar year;
 - c) A state-issued prior authorization approval letter for HCBS that includes the beneficiary's name and effective date beginning during a month after June of the previous calendar year;
 - d) Other documentation provided by the state showing HCBS eligibility status during a month after June of the previous calendar year; or
 - e) A state-issued document, such as a remittance advice, confirming payment for HCBS, including the beneficiary's name and the dates of HCBS.

Pharmacists who have evidence that the cost-share responsibility of a Humana Medicare member residing in a long-term care 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 Appeal for Untimely Filing" form available at <http://apps.humana.com/marketing/documents.asp?file=2322905>.

Inquiries regarding member LIS levels may be directed to Humana at **800-281-6918**. Pharmacists who have evidence that the member cost-share on claims for a Medicare member is 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 portal (registration required; see page 4).

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

2021 low-income subsidy chart

Categories	LIS level	Resource limits	Deductible	Cost share up to OOP limit (\$6,550)	Copayment above OOP limit (\$6,550)	Subsidy % Part D premium
Full subsidy – full benefit dual eligible greater than 100% Federal Poverty Level (FPL)	1	N/A – individual deemed Medicaid eligible	N/A	\$3.70 generic/preferred multi-source drug; \$9.20 for any other drug	\$0 copay	100%
Full subsidy – non-full benefit dual eligible at or below 135% FPL	1	Resources/assets below or equal to \$9,360 (individual, 2020); \$14,800 (couple, 2020)	N/A	\$3.70 generic/preferred multi-source drug; \$9.20 for any other drug	\$0 copay	100%
Full subsidy – full benefit dual eligible below or equal to 100% FPL	2	N/A – individual deemed Medicaid eligible	N/A	\$1.30 generic/preferred multi-source drug; \$4 for any other drug	\$0 copay	100%
Institutionalized full benefit dual eligible	3	N/A – individual deemed Medicaid eligible	N/A	\$0 copay	\$0 copay	100%
Partial subsidy below 150% FPL	4	Resources/assets below \$14,160 (individual, 2020); \$29,160 (couple, 2020)	\$92	15% coinsurance	\$3.70 generic/preferred multi-source drug; \$9.20 for any other drug	100%
						75%
						50%
						25%

Notes:

- Resource/asset limits displayed include \$1,500 per person for burial expenses.
- Information subject to change based on CMS guidance.
- If member selects a plan with a filed deductible or cost share lower than his or her LIS amount, the member would be responsible for the lower amount.

Drug coverage

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/provider/pharmacy-resources/tools/humana-drug-lists](https://www.humana.com/provider/pharmacy-resources/tools/humana-drug-lists).

Drug Lists are developed and maintained by Humana's Pharmacy and Therapeutics Committee consisting of physicians 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. Some states and markets have specific

requirements for changes to the formulary (such as Texas, Louisiana, Illinois and Puerto Rico).

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 brand drug instead. (This may result 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 **877-486-2621**. To do this, complete a coverage determination form found at **Humana.com/provider/pharmacy-resources/prior-authorizations**. Prescribers or pharmacists with questions may contact HCPR at **800-555-CLIN (555-2546)**. Requests for Puerto Rico members can be submitted via phone to **866-488-5991** or can be faxed to **855-681-8650**.

Reference Appendix B “**Medicare Prescription Drug Coverage and Your Rights**” on page 43 of this manual.

Please note: Humana does not accept prior authorization requests directly from pharmacies. The member or prescriber must initiate the request.

Utilization management (UM)

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

- **Prior authorization (PA):** 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 PA.
- **Step therapy:** Plans that are subject to step therapy, as a component of Humana's standard drug utilization (DUR) program, require the member to utilize medications commonly considered first-line before using medications considered second- or third-line. These requirements promote established national treatment guidelines and assist in promoting safe, cost-effective medication therapy.
- **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. If a member's medical condition warrants an additional quantity, the pharmacist should ask the prescriber to submit a request to HCPR.

Please note: Humana does not accept requests for coverage determinations directly from pharmacies. The member or prescriber must initiate the request.

Prescribers can request the following for medication PA, step therapy, quantity limits and medication exceptions using the prescriber quick reference guide found at the following link:

<http://apps.humana.com/marketing/documents.asp?file=1372774>. (Puerto Rico will use quick reference guide **<http://apps.humana.com/marketing/documents.asp?file=2196233>**.)

Prescribers or pharmacists with questions may contact HCPR at **800-555-CLIN (555-2546)**. Requests for Puerto Rico members can be submitted via phone at **866-488-5991** or can be faxed to **855-681-8650**.

General claims procedures

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
Non-Medicare*	610649	03190000
Medicare prescription drug plans (PDP) (Part D)* Use this if the member has an MAPD or PDP plan.	015581	03200000
Medicare Advantage plans (Part B only)* Use this if the member has an MA-only plan.	610649	03200004
Medicare's Limited Income Newly Eligible Transition (LINET) Program	015599	05440000

*Please submit with the member ID located on the member's ID card.

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. SS&C Health is not able to override this edit.

Fill number

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

Sales tax

For states where sales tax applies, the sales tax should be submitted as a value equal to the percentage of the usual and customary charge that equates to the applicable sales tax rate. The pharmacist must enter a tax amount in NCPDP field 482-GE. If this field is left blank, no sales tax will be calculated.

To enable compliance with Louisiana state law, Louisiana pharmacies also must submit the provider fee in NCPDP field 481-HA. When applicable, payment shall be reflected in NCPDP field 558-AW. If you have questions about sales tax, please email PharmacyPricingReview@humana.com.

Timely submission of claims

Claims must be submitted on the date of service (DOS). Notwithstanding the foregoing, pharmacies have at least 30, but not more than 90, days from the DOS to submit claims for long-term care pharmacy services. Additionally, there are special circumstances under which a pharmacy may submit claims after the date of service, including the following:

- Resolution of **coordination of benefits** issues requiring claims reversal and rebilling to appropriate payers for Medicare Part D
- **LINET** claims (Please reference the “Timely Filing Limits” on the LINET Payer Sheets available at <http://apps.humana.com/marketing/documents.asp?file=2295852>.)
- **Subrogation** claims, which have 36 months for submission
- **Fully insured commercial** claims, which have 480 days from DOS for submission

Attempting to adjudicate a POS transaction after the claims submission deadline may result in a reject with the message “**Claims too old**” (NCPDP reject 81). This includes:

- POS payments, reversals and/or adjustments
- Universal claim form claims for payment and reversals

Please contact the Humana pharmacy help desk at **800-865-8715** for claims processing questions. This line is staffed 24 hours a day.

Please note: This does not apply to claims for low-income subsidy members who were retroactively enrolled.

LTC appeals for untimely filing

As set forth in 42 C.F.R § 423.S05(b)(20), long-term care pharmacy claims must be submitted for eligible persons no later than 90 days from the DOS. Humana recognizes the need for exceptions to be made when claims cannot be submitted in this time frame. In these cases, the LTC pharmacy requesting such an exception must complete, sign and date the LTC appeal form for untimely filing.

Here is a link to the form, which will provide a list of permitted exceptions along with how to submit the form for consideration: <http://apps.humana.com/marketing/documents.asp?file=2322905>.

Humana-specific SS&C Health payer sheets

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

- Commercial/Medicaid D.O sheet: apps.Humana.com/marketing/documents.asp?file=2295826
- Medicare D.O sheet: apps.Humana.com/marketing/documents.asp?file=2295839
- LINET sheet: apps.Humana.com/marketing/documents.asp?file=2295852

Prescriber NPI submission

Humana requires the use of a valid and accurate Type 1 (also known as “individual”) prescriber NPI on all electronic transactions. 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.	Claim not covered due to Medicare Part D active valid prescriber NPI requirement	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 also must be submitted in NCPDP field 411-DB (prescriber ID) with the qualifier “01” in NCPDP field 466-EZ (prescriber ID qualifier).

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 comply with all applicable laws, rules and regulations.

Value	Value type
0	No product selection indicated
1	Substitution not allowed by prescriber
2	Substitution allowed—patient requested product dispensed
3	Substitution allowed—pharmacist selected product dispensed
4	Substitution allowed—generic not in stock
5	Substitution allowed—brand drug is dispensed as generic
6	Override
7	Substitution not allowed—brand drug is mandated by law
8	Substitution allowed—generic drug not available in marketplace
9	Substitution allowed by prescriber but plan requests brand-patient's plan requested brand product to be dispensed

Drug utilization review (DUR) safety edits

DUR type	Pharmacy information	Example
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 – gender interaction	Alert of safety risk related to use of specific medication for reported gender. Note: Gender edits only apply for commercial and Medicaid when applicable	Makena
Maximum dose	Identifies safety risk when dosage exceeds First Databank (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 90 mg MED per day will trigger this error code.	MS contin 15 mg twice daily plus Percocet 5/325 mg two tablets every eight hours as needed.
MED* overuse	Identifies patients at greater risk of overdose or inappropriate opioid utilization. For commercial, dosing greater than 250 mg MED per day and/or more than four providers and more than four pharmacies.	MS contin 100 mg three times daily

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

*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	1G-Filled with prescriber approval 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.

Humana Access® Mastercard® Debit Card

The Humana Access card is designed to make healthcare payment transactions easier for members, pharmacists and other healthcare providers. This card enables commercial members who have selected a Humana health savings account (HSA), health reimbursement arrangement (HRA) and/or a flexible spending account (FSA) to deduct applicable copayments and other covered out-of-pocket expenses directly from these accounts when paying for qualified healthcare-related items and services.

There is a single debit card for all Humana Access spending accounts.

Humana Access card for members with Humana HSA, HRA and FSA plans: This card gives members access to their spending account funds. This is not a medical ID card. Humana members have a separate medical insurance ID card. This is a sample of the Humana Access card:



Completing transactions with the Humana Access card

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

- A member must be enrolled in a Humana Access spending account.
- For an FSA or HRA, the amount charged must be an exact match to the member's prescription cost.
- **Over-the-counter (OTC) healthcare items:** Most employers allow qualified OTC healthcare items to be reimbursed. IRS-qualified OTC items include pain relievers and allergy medicines, but not vitamins or supplements. **Effective Jan. 1, 2020**, OTC drugs and medications (not including vitamins or supplements) no longer require a prescription to be eligible for reimbursement. Menstrual supplies also now qualify for reimbursement. If the plan and provider's systems allow, the Humana Access card can be used to purchase OTC items.

Please note these additional tips:

- Pharmacies can always select the "credit" option and process the transaction with the member's signature.
- Provider payments with the Humana Access card may be processed like a credit card, requiring only a signature, or as a debit transaction using the member's preassigned personal identification number (PIN). Members who do not know their PIN can sign in to **HumanaAccess.com** to get it. After signing in, the member will select "**Debit Card(s)**" from the menu under his or her name located in the upper-right corner of page. Then click "**View PIN**" just above the "**Report Lost/Stolen**" button and the four-digit PIN will appear.
- The card cannot be used in conjunction with coupons or other discounts because an exact match of the member's prescription drug copayment is required.

Reasons for declines

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

- **Insufficient funds** – The member did not have enough money in his or her account to cover the full transaction amount.
- **No substantiation match** – The prescription amount must match the transaction amount.
- **Invalid merchant** – It is not a healthcare-related merchant.
- **Inactive card/nonqualified expense** – The member's new card should automatically activate the first time it is used to pay for a qualified healthcare expense, so he or she might be attempting to pay for item(s) not allowed by IRS guidelines. If the member thinks the decline is incorrect, he or she can ask the merchant for the decline code, call the number below and provide the code so Humana can research and correct it in Humana's system, if appropriate.
- **Member's benefit does not allow** – The member's plan does not allow prescriptions to be purchased with his or her spending account.

Members may contact our Customer Care Team at **800-604-6228 (TTY: 711)** for information about reimbursement. Assistance is available weekdays, 8 a.m. – 7 p.m., Eastern time.

Controlled substances

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 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 partial fills of Schedule II drugs. In accordance with the pharmacy provider agreement, participating pharmacies must comply with all federal and state laws, rules and regulations pertaining to the dispensing of medications.

The Controlled Substances Act established five schedules, which are based on medical use acceptance and the potential for abuse of a substance or drug. Schedule II drugs have a high potential for abuse, have an accepted medical use (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.

Pharmacies should take appropriate steps to confirm (including verifying with the prescriber, when necessary) that controlled substances, including Schedule II drugs, are 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.

Submitting CII claims

CMS ruling CMS-0055-F mandates that a valid Quantity Prescribed (NCPDP field 460-ET) is submitted on all federally designated Controlled Substance Level II (CII) drug claims. This impacts pharmacy claim data submission, processor adjudication edits to validate the Quantity Prescribed and payer sheet updates to include the Quantity Prescribed field.

If the field (Quantity Prescribed 460-ET) is not populated for a CII drug, you will receive NCPDP Reject Code ET. Please enter a valid Quantity Prescribed and resubmit.

Access this CII claim bulletin for additional information:

<https://docushare-web.apps.cf.humana.com/Marketing/docushare-app?file=4173260>

Point-of-sale (POS) edits and overrides

To support state and federal regulations regarding opioid and other controlled substances, Humana employs several point-of-sale edits.

For information on current guidance on edits and overrides, visit [Humana.com/provider/pharmacy-resources/manuals-forms](https://www.humana.com/provider/pharmacy-resources/manuals-forms), then select the “**Controlled Substances**” tab under “**Manuals and forms.**”

Medicare claims coverage

Medicare Part B vs. Part D coverage

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 and 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

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. The U.S. Food and Drug Administration (FDA) must regulate a Part D drug as a drug, biological or vaccine.

Prescription drug plans 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.**

If the pharmacy has any questions about appropriate Part B vs. Part D coverage, please call the number on the back of the member's ID card.

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 **800-555-CLIN (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. Requests for Puerto Rico members can be submitted via phone to **866-488-5991** or can be faxed to **855-681-8650**.

Please note: Humana does not accept prior authorization requests directly from pharmacies. The member or prescriber must initiate the request.

If insufficient or incomplete information is received and the determination of Part B or Part D coverage cannot be made, a fax form requesting more information may be sent to the prescriber.

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

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 (D-SNP) 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.

Medicare Part B vs. Part D claims submission

A member could have separate Medicare Part B and Part D plans with Humana. In those instances, the pharmacist will receive a rejection for Part B-covered items and services from Humana's Part D plan. To process the claim under the member's Humana Part B plan, the pharmacist should resubmit the claim with the appropriate BIN/PCN combination. All member information, such as the cardholder ID, remains the same. If there are problems, pharmacists may call the pharmacy help desk at **800-865-8715**.

Medicare vaccine administration

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

Submitting claims for vaccine administration

To submit claims for both the drug and the administration, the pharmacy must bill a value greater than zero in the incentive amount submitted field (438-E3) and submit professional service code "MA" in field 440-E5.

To submit a claim for the administration fee only, the pharmacy must submit the national drug code (NDC) for the drug administered, submit a value of zero in the ingredient cost field and a value greater than zero in the incentive amount submitted field (438-E3). The pharmacy also must submit a professional service code of "MA" in field 440-E5.

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

Humana processing of Medicare drug exclusions

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

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

Pharmacists who are not receiving these messages should check with their chain headquarters or their

software vendor. Humana is sending this message, but the pharmacy's headquarters or software vendor may choose not to display messages on claims that successfully adjudicate.

For information regarding CarePlus plans' exclusions, see the CarePlus supplement to the Humana pharmacy manual found at <http://apps.humana.com/marketing/documents.asp?file=2618785>.

Medicare continuity of care

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 by providing a temporary supply to members who have limited ability to receive their prescribed drug therapy. For new and re-enrolling members who are at a retail pharmacy, receive prescriptions through mail order or are in a long-term care facility, Humana will cover a temporary supply during the first 90 days of the current plan year, or during the first 90 days of the member's enrollment. Humana will cover a 30-day supply for members at a retail or mail-order pharmacy and a 31-day supply for members in long-term care facilities. 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. For members who have more than 180 days of claims history, Humana will look back 180 days from the member effective date or the beginning of the current plan year for prior utilization of the drug when claims history is available. For emergency fills for members who are LTC residents but past the first 90 days of eligibility, Humana will cover a 31-day supply (unless the prescription is written for less) while an exception or prior authorization request is being processed. In that case, Humana will allow multiple fills to provide up to a total of 31 days of a Part D-covered drug when the prescription is filled at the network pharmacy.

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 or 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.

Utilization management may be applied during a member's transition period:

- 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

Level-of-care changes

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 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 drugs not on the Humana Drug List, step therapy, quantity limitations and clinical prior authorization requirements. The transition policy does not apply to safety edits, drugs requiring a diagnosis to determine accepted Part D use, Part B drugs, CMS-excluded drugs or Medicare Part B vs. D determinations.

When a claim is processed under the transition benefit, a free-form message will return, indicating that the claim paid under the member's transition benefit.

This message should be communicated to the member to inform them they received a temporary supply of their drug and that action is needed before the next refill.

Long-term care (LTC)

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 pharmacies 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. Claims submitted with a missing or invalid code will be rejected at the point of sale. The tables below list valid patient residence codes and pharmacy service types.

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

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

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

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

Pharmacy service types	Description
1	Community/retail pharmacy services
2	Compounding pharmacy services
3	Home infusion therapy provider services
4	Institutional pharmacy services
5	Long-term care pharmacy services
6	Mail-order pharmacy services
7	Managed care organization pharmacy services
8	Specialty care pharmacy services
99	Other

If the pharmacy submits a Part D claim with a missing or invalid pharmacy service type, the claim will reject with NCPDP 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.

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

Humana has implemented point-of-sale claims processing logic 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) 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 must 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 contracted LTC pharmacies 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 pharmacies’ 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 or reducing cost-sharing charges for Medicare beneficiaries, except if (i) the waiver or reduction is not offered as part of an advertisement or solicitation; (ii) the pharmacy does not routinely waive or reduce cost-sharing amounts; and (iii) the pharmacy waives or reduces the cost-sharing amounts only after determining (and documenting) in good faith that an individual is in financial need or after failing to collect the cost-sharing amounts after making reasonable collection efforts. A pharmacy is only required to meet

the first requirement in order to reduce or waive cost sharing for LIS members. 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 contracted LTC pharmacy, 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.

Please contact Humana at **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

- For commercial/fully insured plans: All covered home infusion drugs, supplies and nursing should be billed through the member's Humana medical benefit.
- For Medicare plans:
 - Medicare Advantage prescription drug plans (MAPD): All covered Part D drugs should be billed through the member's Humana pharmacy benefit using the applicable BIN/PCN. All covered Part B drugs, supplies and nursing should be billed through the member's Humana medical benefit.
 - Prescription drug plans (PDP only): All covered Part D drugs should be billed through the member's Humana pharmacy benefit using the applicable BIN/PCN.
 - Medicare Advantage plans (MA only): All covered Part B drugs, supplies and nursing should be billed through the member's Humana medical benefit. All Part D drugs should be billed through the member's Part D drug plan.

Compound claims

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.

Non-formulary compound (Medicare only)

Medicare Part D multi-ingredient prescription compound medications (with the exception of IV parental nutrition and IV home infusion products) will be considered nonformulary and require an exception before Medicare members can fill under their Part D benefits. In these instances, Humana may reject the Part D claim for multi-ingredient compound prescriptions as follows:

1. Reject code: MR
2. Reject messages:
 1. Product not on Formulary
 2. NF Compound

NCPDP Submission Clarification Code (SCC) 08 cannot be used to override the nonformulary compound rejection.

When this error message is returned, as with any noncovered drug, explain to the member that his or her prescriber can submit a request for an exception by contacting Humana's Clinical Pharmacy Review department at 800-555-2546. In Puerto Rico, the prescriber can call 866-488-5991.

Important reminder about compound drugs for Medicare members

Because of Medicare regulations, pharmacies are prohibited from balance billing and must hold the member harmless for the cost of any non-Part D ingredient contained in the Part D compound.

Medication Therapy Management (MTM) program

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

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

Humana has contracted with a vendor to assist in providing MTM services. If a pharmacy is interested in providing MTM services to Humana members, it can visit **www.outcomesMTM.com** to learn more.

Pharmacy audit and compliance

Pharmacy audit program

Humana maintains a pharmacy audit program to:

- Help ensure the validity and accuracy of pharmacy claims for its clients (including CMS and state agencies overseeing a program for Medicaid eligibles)
- Help ensure compliance with the provider agreement between Humana and its network pharmacies
- Help ensure compliance with federal and state laws/regulations and drug specific requirements

- 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 manner, compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), with respect for patients and pharmacy staff. To access the Humana Pharmacy Audit Guide, please visit [Humana.com/provider/pharmacy-resources](https://www.humana.com/provider/pharmacy-resources), then select the link under "**Pharmacy manuals and forms.**"

Long-term care pharmacy audits

Humana has the right to audit an LTC pharmacy'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/provider/pharmacy-resources](https://www.humana.com/provider/pharmacy-resources), then select the link under "**Pharmacy manuals and forms.**"

Compliance program audits

Humana-contracted entities whose support includes Humana's Medicare products are subject to Compliance Program audits that may occur on an ad hoc basis. Humana notifies pharmacies of its intent to audit and provides specific directions regarding the process. If an audit identifies deficiencies, a correction action plan is issued and Humana works with the pharmacy provider to ensure the deficiencies are remediated.

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 (available at [Humana.com/provider/pharmacy-resources/manuals-forms](https://www.humana.com/provider/pharmacy-resources/manuals-forms)), 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 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 pharmacy may use its own material to meet the FWA training requirement or another training. Humana also offers content on this topic in the following documents that your pharmacy may use to supplement your FWA training or within it:

- Humana Compliance Policy for Contracted Healthcare Providers and Third Parties
<https://apps.humana.com/marketing/documents.asp?file=1827514>
- Humana Ethics Every Day for Contracted Healthcare Providers and Third Parties
<http://apps.humana.com/marketing/documents.asp?file=1112774>

Training records

Humana-contracted entities must maintain FWA training records, including the completion date, 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

The pharmacy and all of its employees and subcontractors that support the pharmacy's 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 **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](https://www.humana.com/Fraud).

The following reporting options are available:

Phone:

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

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

Fax: 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.com

*Humana requests that if a person reporting an ethics concern desires to remain anonymous, he or she provides 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 an employee, manager, governing body member or any party with whom a pharmacy 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/provider/pharmacy-resources/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

Pharmacies also are expected to:

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

Standards of conduct/ethics

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

- Require employees, management, governing body members and those with whom the pharmacy contracts to support the pharmacy’s contractual obligations to Humana’s Medicare products to review and attest to compliance with the pharmacy’s standards of conduct document upon hire or contract and annually thereafter. If the contracted pharmacy 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.
- Conduct the following for all new employees, management, governing body members and contracted individuals or entities, prior to hire/contract and monthly thereafter: Review the Office of Inspector General (OIG) and General Services Administration’s System for Award Management (SMA) exclusion lists 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. This includes retaining evidence of the exclusion screening for 11 years (or longer, as required by state law). If applicable, previously mentioned populations also should be screened against the state preclusion list and Medicaid exclusion list.
- Remove any person identified on an exclusion list above from any work, information or data related directly or indirectly to Humana’s support of any federal healthcare program, such as Medicare.
- 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 **800-614-4126**.

Humana’s CMS contracts mandate that compliance program requirements must be completed by all pharmacies contracted with Humana or Humana subsidiaries. This includes those pharmacies employed or contracted to provide or support healthcare services for Humana’s Medicare members.

Compliance program requirements

The information below is provided to help the pharmacy and those with whom they contract or employ to support Humana business confirm their compliance programs have the necessary elements to be effective.

Humana’s compliance program requirements for contracted pharmacies 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 operational and compliance perspectives and includes exclusion screening of all individuals and contracted entities that support Humana Medicare products.

2. **Immediate notification to Humana of your organization's intentions to utilize offshore resources in meeting any obligation to Humana.** This includes new arrangements or changes to existing relationships or offshore locations, as well as where or how data are processed, transferred, stored or accessed.
3. **Prior approval from Humana before moving forward with an offshore arrangement for work in support of a Humana contract.** There are multiple reasons why: Some government contracts prohibit or limit contracted services from being performed offshore and/or the transmission, processing, accessing or storing of related information offshore. Humana may need to notify CMS of any entity with a 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 for an individual who is eligible for Medicare. Therefore, Humana must be notified immediately of prospective offshore arrangements.
4. **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/provider/pharmacy-resources/manuals-forms](https://apps.humana.com/provider/pharmacy-resources/manuals-forms)). Any suspected and confirmed instances of ethical, compliance or FWA violations must be reported to Humana.
 - 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
5. **Training:** Ensuring that all required compliance program training is completed not simply by the compliance contact at the pharmacy, but also by those supporting the pharmacy's contractual obligations to Humana. Where applicable, operational training must be conducted. This includes having a tracking method in place to provide evidence of these efforts upon request; for example, who was trained, when, how and with what material(s).
6. **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.
7. **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.
8. **Disciplinary standards:** Having established disciplinary standards in place that are carried out when violations are committed by the pharmacy provider, its employees or those with whom it contracts to support its obligations to Humana.
9. **Assurance:** Complying with Humana requests to provide assurance related to the pharmacy's compliance program.

For an overview of the seven elements of an effective compliance program, please refer to Humana's compliance policy at <https://apps.humana.com/marketing/documents.asp?file=1827514>.

Frequently asked questions

Humana makes a guidance document publicly available online that includes frequently asked questions (<http://apps.humana.com/marketing/documents.asp?file=2621125>) and additional information regarding the compliance requirements.

Further compliance program requirements information for pharmacies supporting Humana's Medicare products can be found in Humana's compliance policy at <https://apps.humana.com/marketing/documents.asp?file=1827514>.

If your pharmacy also supports Humana Medicaid business, additional compliance requirements apply and they are outlined in the above documents.

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

When a compliance attestation is required

Humana reserves the right to request documentation as assurance that certain compliance program requirements and training are in place. Compliance education material is refreshed at least each calendar year to assist pharmacies in meeting these and related requirements. Corresponding instructions are listed in the compliance requirements FAQ for pharmacies at <http://apps.humana.com/marketing/documents.asp?file=2621125>.

Required compliance program education

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:

- Compliance policy/policies outlining compliance program requirements;
- Standards of conduct
- Training on general compliance; and
- Training on understanding and addressing fraud, waste and abuse (FWA).

Timing to meet the above requirements is within 90 days of hire/contract and annually thereafter.

Humana documents, or documents that are materially similar, may be used to meet the compliance policy and standards of conduct requirements. These materials are available at Humana.com/provider/pharmacy-resources/manuals-forms. Your organization may develop or adopt other material to meet the last two requirements above.

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.

Humana.com instructions

The document at <http://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).

Humana pharmacy credentialing

Humana requires all network pharmacies to be credentialed during the initial contracting process and recredentialed at least every three years. The recredentialed request is sent to the pharmacy via fax and requires the pharmacy to return a recredentialed application, which includes:

- Pharmacy state licensure information
- Pharmacy U.S. Drug Enforcement Agency (DEA) licensure information
- Signed and dated attestation stating the pharmacy is free of sanctions imposed by federal, state and local authorities

- Copy of current professional liability insurance (PLI) coverage that meets or exceeds a minimum requirement of \$1 million in aggregate
- Pharmacy's NCPDP number

Pharmacies that do not meet Humana's required standards will be removed from Humana's pharmacy network.

Conflicts of interest

All entities and individuals supporting Humana are required to avoid conflicts of interest. Pharmacies 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 Pharmacy 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.

Pharmacies 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 pharmacies 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:

- a) Obtain certifications of the absence of conflicts of interest from all providers and those they employ or contract to support Humana business; and
- b) Require that certain conflicts be removed or that the applicable employee(s) and/or downstream entities be removed from supporting Humana.

Pharmacies and those they employ or with whom they contract to support Humana business 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.

Pharmacies 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.

Complaint system

Pharmacy's pricing dispute process for commercial, 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 60 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 at **855-381-1332** or by email at **PharmacyPricingReview@humana.com**. The pharmacy may contact Humana at **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 adjust 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's process for filing a complaint

Pharmacy complaints and disputes

SS&C Health system issues

All pharmacies contracted with Humana are encouraged to contact the SS&C Health help desk at **800-865-8715** for any question or complaint related to a system issue or claims transaction. SS&C has a dedicated telephone support unit that provides guidance for calls related to pharmacy claims. All issues that cannot be addressed or resolved by SS&C are forwarded to the Pharmacy Networks Department for research and resolution at **888-204-8349**.

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 at **888-204-8349**.

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 pharmacy network 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.

Commercial enrollee grievances and appeals

The timeline for submitting a commercial enrollee grievance and/or appeal varies by state. Written grievances and appeals can be submitted to:

Grievances and Appeals

P.O. Box 14546

Lexington, KY 40512-4546

Fax: 888-556-2128

Enrollees can also call Customer Service toll-free at the number on the back of their ID card. Puerto Rico enrollees may call **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.

Medicare enrollee grievances

Medicare enrollee grievances must be filed within 60 days of the occurrence. Direct written grievances to:

Humana Grievances and Appeals

P.O. Box 14165

Lexington, KY 40512-4165

Fax: 800-949-2961

When filing a verbal grievance, direct the enrollee to Customer Service at **800-457-4708**. For enrollees with speech or hearing impairment who use a TTY, call **711**. Hours are Monday – Friday, 8 a.m. – 8 p.m., Eastern time (weekend hours available Oct. 15–Feb. 14 only).

Enrollee should include his or her 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 resolution.

Medicare enrollee appeals

The Medicare enrollee, prescriber or enrollee representative may submit an appeal in writing within 60 calendar days of the date the denial notice is 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 the enrollee's name, address, Humana ID number, reason for the appeal and any supporting documents. We will investigate the appeal and inform the enrollee of our decision. If the enrollee is unable to write an appeal, oral appeals will be accepted.
- For written appeals, Medicare enrollees should use the following:

Humana Grievances and Appeals

P.O. Box 14165

Lexington, KY 40512-4165

Fax: 855-251-7594

- 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 on 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 Humana's website at **Humana.com/individual-and-family-support/tools/member-forms**.

Medicare enrollees can also access through the Medicare website at

www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf.

- If the appeal comes from someone besides the enrollee, we 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

If the enrollee has questions concerning their grievance or appeal, direct him or her to the Member Handbook or contact Humana using the number on the back of their ID card.

Price source and MAC information

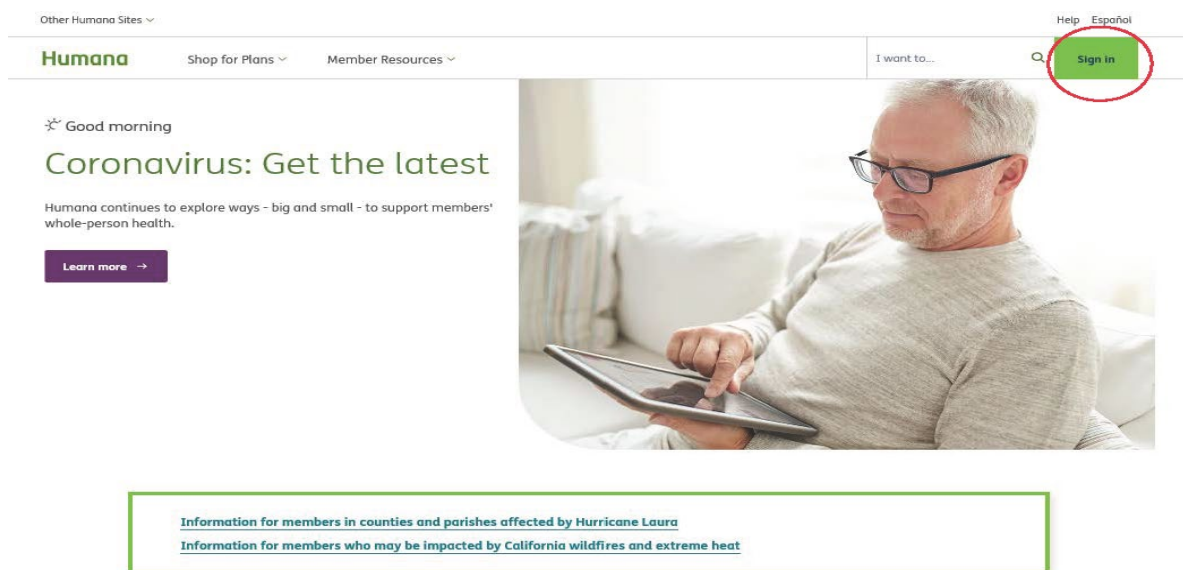
Price source

The national drug pricing source used to determine the average wholesale price of a prescription drug that is not included on the maximum allowable cost list is Medi-Span.

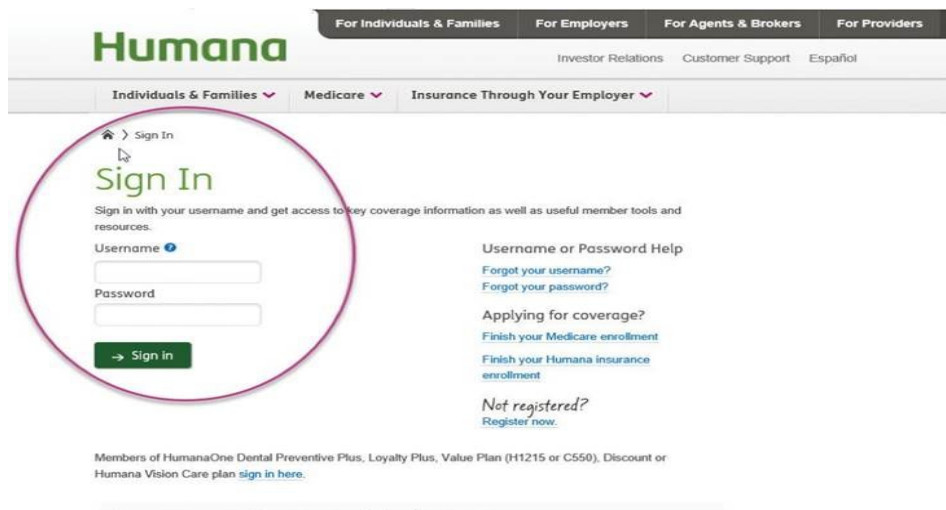
The national drug pricing source used to determine the wholesale acquisition cost of a prescription drug that is not included on the maximum allowable cost list is First Databank.

Pharmacy MAC list location

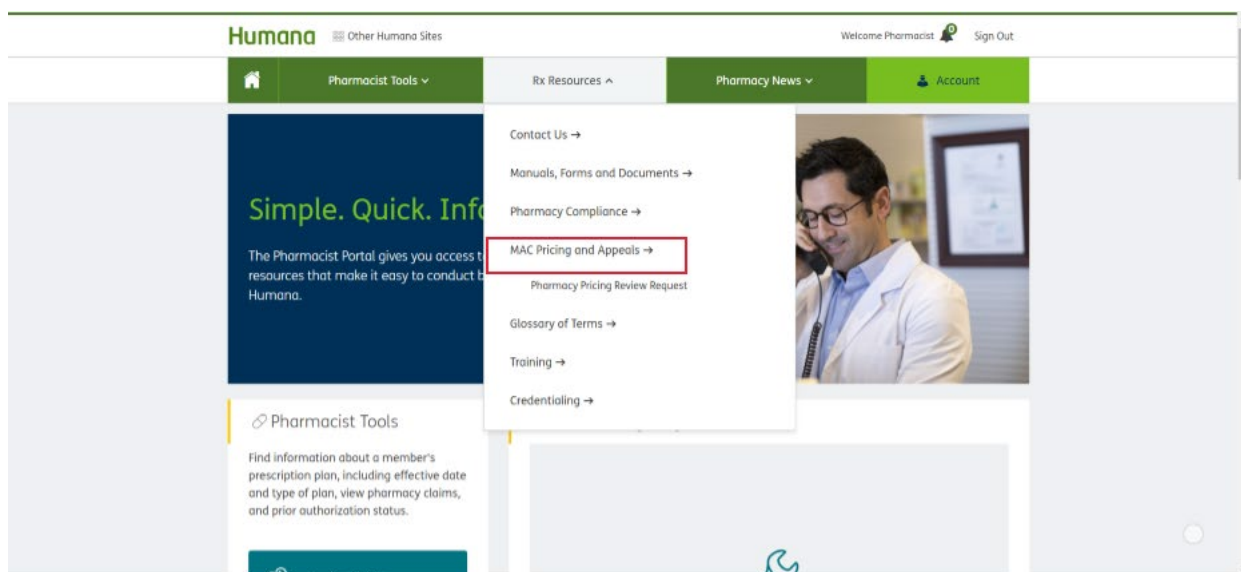
When network pharmacies need to locate the current MAC list, they can follow the steps below at **Humana.com**. They will see the screen below. Click the “**Sign in**” button located on the top right corner of the screen.



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 current MAC list applicable to the NPI the pharmacy used to register its account, which includes recent updates, click on “**MAC Pricing and Appeals**” link:



Once the pharmacy clicks that link, a MAC search box will appear. Close the box and select the appropriate list from the drop-down menu. The list you choose will show as download only or will load on the page.

A network pharmacy with a pricing dispute should follow the steps below to submit a pricing review form to Humana. Click “**Pharmacy Pricing Review Request**” in upper right corner.

The pharmacy must complete all fields in the form and return it to Humana by clicking the “**Submit**” button located in the bottom right corner of the form 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.

Enclara Pharmacia overview

Enclara Pharmacia is a national full-service pharmacy benefit manager and mail-order supplier of medications and clinical services developed specifically for the hospice and palliative care industry. Enclara serves over 400 hospice providers and 97,000 patients nationally, helping to reduce pharmacy costs through a clinically driven model that enables home delivery of pharmaceuticals, and has access to a network of over 65,000 local pharmacies, including a network of over 7,000 retail pharmacies, institutional pharmacies and Enclara’s own automated fulfillment solutions.

Contact information for Enclara Pharmacia

Enclara Pharmacia Pharmacy Claims Help Desk

- For claim rejections and general plan coverage questions, including prior authorizations and eligibility
 - Phone: **866-597-3589**, available 24 hours a day, seven days a week
 - Email: **PharmacyClaims@enclarapharmacia.com**

Enclara Pharmacia MAC Appeals Department

- For pharmacy reimbursement questions or concerns
 - Email only: **MACappeals@enclarapharmacia.com**


General claims procedures

Please see the following BINs, PCNs and groups.


Plan	BIN	PCN	Group
Enclara Hospice Fee for Service	018232	PBMOCE	HOSPICEFFS
Enclara Hospice Per Diem	018232	PBMOCE	HOSPICE
Enclara Hospice Vitas	018232	PBMOCE	HOSPICE12

Member ID card examples


FFS Card

Enclara Rx	
Patient Billing Information	
RxBIN:	018232
RxPCN:	PBMOCE
RxGRP:	HOSPICEFFS
Patient's Member ID:	
Questions / Assistance PHARMACY HELP: 866-597-3589	
	
Card Version Date: 8/1/2021	

PD Card

Enclara Rx	
Patient Billing Information	
RxBIN:	018232
RxPCN:	PBMOCE
RxGRP:	HOSPICE
Patient's Member ID:	
Questions / Assistance PHARMACY HELP: 866-597-3589	
	
Card Version Date: 8/1/2021	

Vitas Card

Enclara Rx	
Patient Billing Information	
RxBIN:	018232
RxPCN:	PBMOCE
RxGRP:	HOSPICE12
Patient's Member ID:	
Questions / Assistance PHARMACY HELP: 866-597-3589	
	
Card Version Date: 8/1/2021	

Medicare's Limited Income NET Program (LINET)

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 Part D 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 **877-839-2675**.

Enrollment methods

Beneficiaries are enrolled in LINET in one of three ways:

- **Auto-enrollment:** Auto-enrolled by CMS; beneficiary will receive a temporary prescription card with instructions
- **Point-of-sale:** Immediate enrollment at the pharmacy counter through claim submission
- **Direct member reimbursement:** Upon beneficiary's submission of a request for reimbursement for out-of-pocket expenses

Confirming eligibility

LINET eligibility can be confirmed by submitting an E1 query (Eligibility Transaction).

E1 Query

E1 results	Status	Action
Contract ID X0001	Patient currently enrolled in LINET	Submit claim to LINET using 4 Rx data
No plan information LICS/LIS = YES	Patient may be eligible for LINET—not yet enrolled	Submit claim to LINET using 4 Rx data
No plan information LICS/LIS = NO	Patient not eligible for LINET	Refer patient to 800-MEDICARE
Plan BIN/PCN #	Patient is enrolled in a Part D plan	Submit claim to plan using 4 Rx data
Plan phone number	Patient is enrolled in a Part D plan/issues	Call phone number provided

How to submit an LINET claim

Electronic pharmacy claims should be submitted with the following information:

BIN	PCN	Group ID	Cardholder ID	Optional field: Patient ID
015599	05440000	May be left blank	Medicare claim number or Medicare number	Medicaid 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 <http://apps.humana.com/marketing/documents.asp?file=3792139>.
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 40512-14310
Fax: 877-210-5592

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

Appendix A: Related resources

Pharmacy help desk	For prior authorization status, call 800-865-8715 and follow the prompts.
Humana Medicare Customer Care	<p>Humana Medicare Customer Care 800-281-6918 (TTY: 711) 8 a.m. – 8 p.m., seven days a week Puerto Rico: 800-256-3316 7 a.m. – 7 p.m., Monday – Friday</p>
Humana Clinical Pharmacy Review (HCPR)	<p>800-555-CLIN (555-2546) U.S. fax: 877-486-2621 Puerto Rico HCPR phone: 866-488-5991 Puerto Rico HCPR fax: 855-681-8650</p>
Humana Pharmacy Solutions network contracting	<p>Pharmacy contract requests Email: PharmacyContractRequest@humana.com Fax: 866-449-5380 Rx Quality Network Program Email: RxQualityProgram@humana.com Fax: 844-330-8892</p>
Humana Ethics Help Line	877-5-THE-KEY (584-3539)
SS&C Health (formerly known as DST Pharmacy Solutions)	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.

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

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.

Note: If the enrollee is a self-pay resident and the pharmacy cannot fill the prescription under the Part D benefit, the pharmacy must, upon receipt of the transaction response, fax or otherwise deliver the notice to the enrollee, enrollee’s representative, prescriber or an appropriate staff person at the LTC facility. After distribution of the notice, the LTC pharmacy should continue to work with the prescriber or facility to resolve the matter and ensure the resident receives the needed medication or an appropriate substitute.

Enrollee's Name: _____ (Optional)

Drug and Prescription Number: _____ (Optional)

Medicare Prescription Drug Coverage and Your Rights

Your Medicare rights

You **have the right to request a coverage determination** from your Medicare drug plan if you disagree with information provided by the pharmacy. You also **have the right to request a special type of coverage determination called an "exception"** if you believe:

- you need a drug that is not on your drug plan's list of covered drugs. The list of covered drugs is called a "formulary;"
- a coverage rule (such as prior authorization or a quantity limit) should not apply to you for medical reasons; or
- you need to take a non-preferred drug and you want the plan to cover the drug at a preferred drug price.

What you need to do

You or your prescriber can contact your Medicare drug plan to ask for a coverage determination by calling the plan's toll-free phone number on the back of your plan membership card, or by going to your plan's website. You or your prescriber can request an expedited (24 hour) decision if your health could be seriously harmed by waiting up to 72 hours for a decision. Be ready to tell your Medicare drug plan:

1. The name of the prescription drug that was not filled. Include the dose and strength, if known.
2. The name of the pharmacy that attempted to fill your prescription.
3. The date you attempted to fill your prescription.
4. If you ask for an exception, your prescriber will need to provide your drug plan with a statement explaining why you need the off-formulary or non-preferred drug or why a coverage rule should not apply to you.

Your Medicare drug plan will provide you with a written decision. If coverage is not approved, the plan's notice will explain why coverage was denied and how to request an appeal if you disagree with the plan's decision.

Refer to your plan materials or call 1-800-Medicare for more information.

PRA Disclosure Statement According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this collection is 0938-0975. The time required to complete this information collection is estimated to average 1 minute per response, including the time to review instructions, search existing data resources, and gather the data needed, and complete and review the information collection. If you have any comments

concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

CMS does not discriminate in its programs and activities: To request this form in an accessible format (e.g., Braille, Large Print, Audio CD) contact your Medicare Drug Plan. If you need assistance contacting your plan, call: 1-800-MEDICARE.

Form CMS -10147
02/28/2021)

OMB Approval No. 0938-0975 (Expires:

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.

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.

Declaración sobre la Ley para la Reducción de Trámites De acuerdo con la Ley para la Reducción de Trámites de 1995 (PRA en inglés), las personas no están obligadas a responder una recopilación de información a menos que se exhiba un número de control de la oficina de Gerencia y Presupuesto (OMB en inglés) válido. El número de control OMB válido para esta recopilación de información es 0938-0972. El tiempo necesario para responder esta recopilación de información es de aproximadamente 1 minuto por respuesta, incluido el tiempo para revisar instrucciones, buscar fuentes de datos existentes, reunir los datos necesarios y completar y revisar la recopilación de información. Si tiene preguntas sobre la precisión de los tiempos estimados o sugerencias para mejorar este formulario, escriba a: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

CMS no discrimina en sus programas y actividades. Para solicitar esta publicación en un formato alternativo, llame al 1-800-MEDICARE o envíe un correo electrónico a:
AltFormat@cms.hhs.gov.

Formulario de CMS-10147-Spanish
02/28/2021)

Número de OMB 0938-0972 (Expiración: