Humana Pharmacy Solutions

Pharmacy Manual

Medicare and Commercial

2024 Edition

294903ALLL0823 GHHJT9NEN

Table of contents

Introduction

Dear pharmacy:

Humana appreciates your role in delivering quality pharmacy services to our members. This manual is an extension of your organization's agreement and is intended to assist pharmacy staff in processing prescription claims for Humana plans and outline Humana Compliance Program requirements for your organization.

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 (LI NET) Program payer sheets. For CarePlus payer sheets, please visit the CarePlus Pharmacy Resources page at CarePlusHealthPlans.com/CarePlus-Providers/Pharmacy-Resources. In the Pharmacy Provider Agreement, you will find network participation requirements.

To view Humana Drug Lists for Medicare and commercial members, go to **Humana.com/DrugLists**. CarePlus Drug Lists are located at **CarePlusHealthPlans.com/CarePlus-Providers/Pharmacy-Resources.**

Pharmacist Portal

The Humana Pharmacist Portal provides a secure online resource where pharmacists can:

- Obtain a current list of generic MAC pricing.
- Send email inquiries directly to Humana.
- View news bulletins and link to news alerts.
- Find member eligibility regarding a member's prescription drug plan, effective date and type of plan.
- View claims a member has filled at your pharmacy.
- Check the status of a drug requiring prior authorization for a member.

This resource is available to any pharmacy contracted with Humana and is provided free of charge. To gain access, visit **Humana.com/Logon**, choose "Activate online account" and select registration type. If you have difficulty registering, send an email to **PharmacyContracting@humana.com.** Please include the pharmacy name, NPI, pharmacy contact name and contact phone number.

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 Pharmacia serves nearly 500 hospice providers and more than 130,000 patients nationally, helping to reduce pharmacy costs through a clinically driven model that enables home delivery of pharmaceuticals. Enclara Pharmacia has access to a network of more than 62,000 local pharmacies, including more than 7,000 retail pharmacies, institutional pharmacies and Enclara Pharmacia's own mail-order fulfillment centers.

How to join our network

If you are not already part of our network, we welcome you. If you would like to join, please complete the Pharmacy Contract Request Form at **https://Apps.Humana.com/Marketing/Documents.asp?q=9Mf%2fwxRucPzrJbILBCCHgA%3d%3d**.

Please send completed forms to **PharmacyContracting@humana.com.**

We hope you find this manual informative, and we thank you again for your participation in the Humana pharmacy provider network.

Sincerely,

The Humana Pharmacy Network team

Contact information

Pharmacy help desk
800-865-8715
For refill-too-soon overrides and prior authorization status

CarePlus Pharmacy help desk
1-866-315-7587
Fax: **1-800-310-9071**

Humana Medicare Customer Care
800-281-6918 (TTY: 711)
Daily, 8 a.m. – 8 p.m.
Puerto Rico: **800-256-3316**
Monday – Friday, 7 a.m. – 7 p.m.

CarePlus Member Services
1-800-794-5907 (TTY: 711)
Daily, 8 a.m. – 8 p.m. (Oct. 1–March. 31)
Monday – Friday, 8 a.m. – 8 p.m. (Apr. 1–Sept. 30)

LI NET
800-783-1307 (TTY: 711)
Monday – Friday, 8 a.m. – 7 p.m., Eastern time

Humana Clinical Pharmacy Review (HCPR)
800-555-CLIN (2546)
U.S. fax: **877-486-2621**
Puerto Rico HCPR phone number: **866-488-5991**
Puerto Rico HCPR fax number: **855-681-8650**

CarePlus Pharmacy Utilization Management Unit
Phone: **1-866-315-7587**
Fax: **1-800-310-9071**

Humana Pharmacy Solutions® Network Contracting
Pharmacy contract requests
Email: **PharmacyContractRequest@humana.com**
Fax: **866-449-5380**
Phone: **888-204-8349**

Enclara Pharmacia
Pharmacy Claims Help Desk
Phone: **866-597-3589**, 24 hours a day, seven days a week
Claim rejections and general plan coverage questions, including prior authorizations and eligibility
Email: **PharmacyClaims@enclarapharmacia.com**

MAC Appeals department
Email only: **PharmacyPricingReview@humana.com**
Pharmacy reimbursement questions or concerns

Rx Quality Program
Email: **RxQualityProgram@humana.com**
Fax: **844-330-8892**

Humana Ethics Help Line
Phone: **877-5-THE-KEY (584-3539)**

SS&C Health
Phone: **866-211-9459**

CarePlus Technical Help Call Center (SS&C Health)
Phone: **1-800-865-4034**

Humana's pharmacist website
Visit **Humana.com/Pharmacists** to access payer sheets, pharmacy news bulletins, the Humana Pharmacy Solutions Audit and Claim Review Guide and many other resources.

Visit **CarePlusHealthPlans.com/CarePlus-Providers/Pharmacy-Resources** for CarePlus payer sheets and other resources.

Pharmacist Portal self-service website assistance
Email: **PharmacyContracting@humana.com**

Pharmacy compliance information website
Humana.com/Provider/Pharmacy-Resources/Manuals-Forms

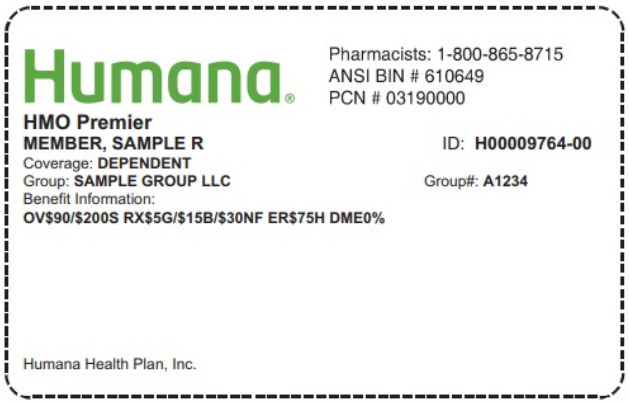
Eligibility verification

Humana member identification (ID) cards

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

Commercial member cards:

Health maintenance organization (HMO) Premier


Humana

Pharmacists: 1-800-865-8715
ANSI BIN # 610649
PCN # 03190000

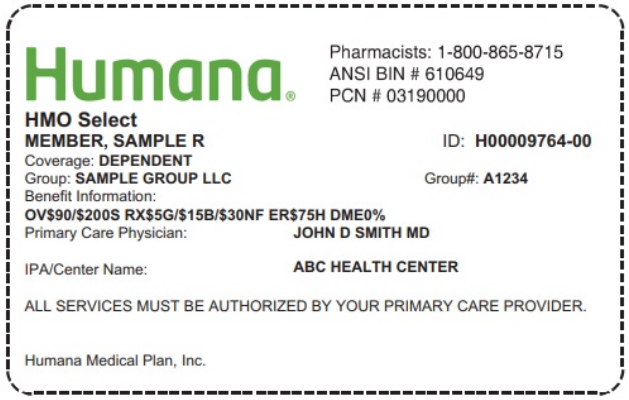
HMO Premier
MEMBER, SAMPLE R ID: **H00009764-00**
Coverage: **DEPENDENT**
Group: **SAMPLE GROUP LLC** Group#: **A1234**
Benefit Information:
OV$90/$200S RX$5G/$15B/$30NF ER$75H DME0%

Humana Health Plan, Inc.


Out of network services are not covered. **Card Issued: 11/09/2022**
In Plan Deductible/In Plan Out of Pocket Max
DED $225/$675
COINS $4000
Members: Amounts displayed are not inclusive of all plan member cost sharing.
Log into Humana.com or call Member/Provider Services for plan specifics.
Member/Provider Service: 1-800-448-6262
Nationwide Virtual Doctor 24/7: doctorondemand.com
Go365 Customer Service: 1-888-443-7942

Humana Claims
P.O. Box 14601
Lexington, KY 40512-4601 Payor ID: 61101

HMO Select


Humana

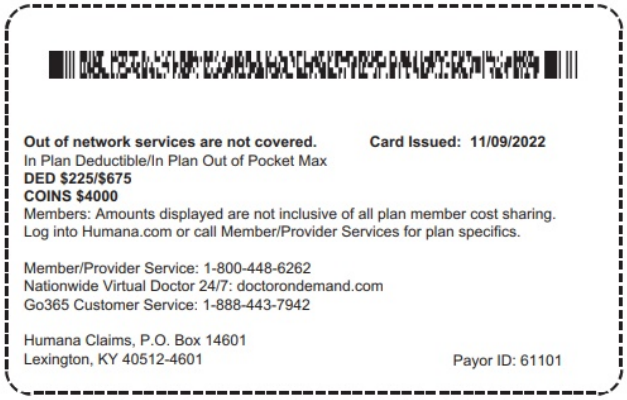
Pharmacists: 1-800-865-8715
ANSI BIN # 610649
PCN # 03190000

HMO Select
MEMBER, SAMPLE R ID: **H00009764-00**
Coverage: **DEPENDENT**
Group: **SAMPLE GROUP LLC** Group#: **A1234**
Benefit Information:
OV$90/$200S RX$5G/$15B/$30NF ER$75H DME0%
Primary Care Physician: **JOHN D SMITH MD**

IPA/Center Name: **ABC HEALTH CENTER**

ALL SERVICES MUST BE AUTHORIZED BY YOUR PRIMARY CARE PROVIDER.

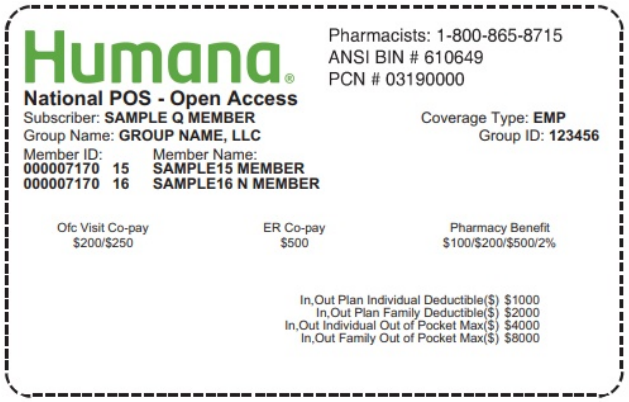
Humana Medical Plan, Inc.


Out of network services are not covered. **Card Issued: 11/09/2022**
In Plan Deductible/In Plan Out of Pocket Max
DED $225/$675
COINS $4000
Members: Amounts displayed are not inclusive of all plan member cost sharing.
Log into Humana.com or call Member/Provider Services for plan specifics.

Member/Provider Service: 1-800-448-6262
Nationwide Virtual Doctor 24/7: doctorondemand.com
Go365 Customer Service: 1-888-443-7942

Humana Claims, P.O. Box 14601
Lexington, KY 40512-4601 Payor ID: 61101

National Point of Service – Open Access


Humana

Pharmacists: 1-800-865-8715
ANSI BIN # 610649
PCN # 03190000

National POS - Open Access
Subscriber: **SAMPLE Q MEMBER** Coverage Type: **EMP**
Group Name: **GROUP NAME, LLC** Group ID: **123456**

Member ID:	Member Name:
000007170 15	**SAMPLE15 MEMBER**
000007170 16	**SAMPLE16 N MEMBER**

Ofc Visit Co-pay	ER Co-pay	Pharmacy Benefit
$200/$250	$500	$100/$200/$500/2%

In,Out Plan Individual Deductible($) $1000
In,Out Plan Family Deductible($) $2000
In,Out Individual Out of Pocket Max($) $4000
In,Out Family Out of Pocket Max($) $8000


Member/Provider Service: 1-866-427-7478
Go365 Customer Service: 1-888-443-7942

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

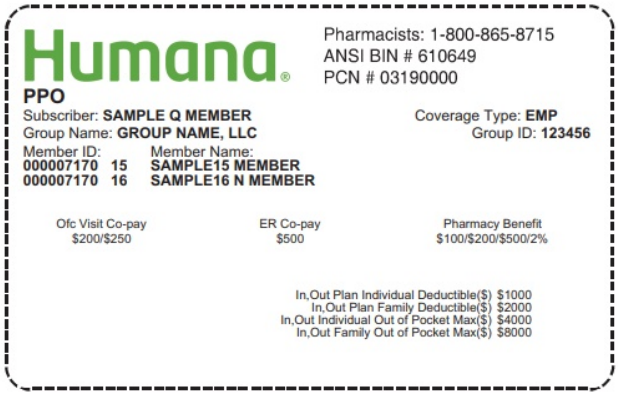
Nationwide Virtual Doctor 24/7: doctorondemand.com

Members: Amounts displayed are not inclusive of all plan member cost sharing.
Log into Humana.com or call Member/Provider Services for plan specifics.

Humana Health Plan, Inc. and Humana Insurance Company
Payor ID: 61101 **Card Issued: 11/08/2022**

ChoiceCare NETWORK QualCare GHI network access

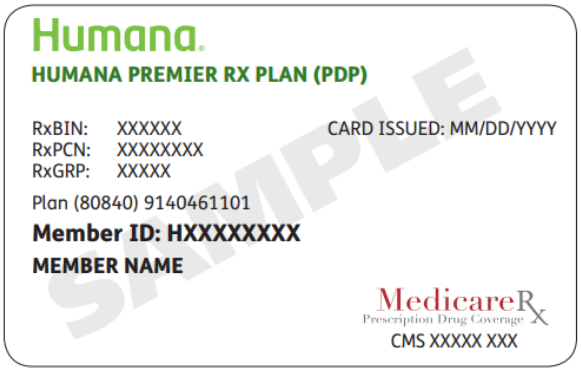
Preferred provider organization (PPO)

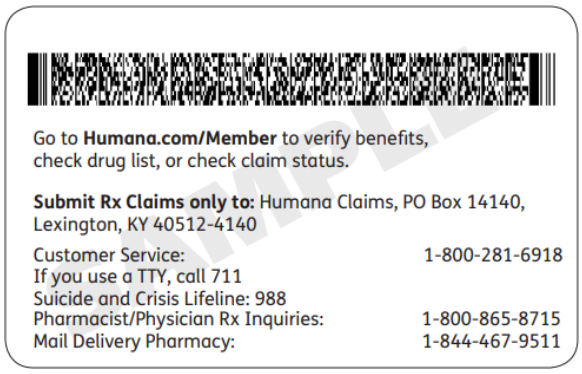


Medicare member cards:

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

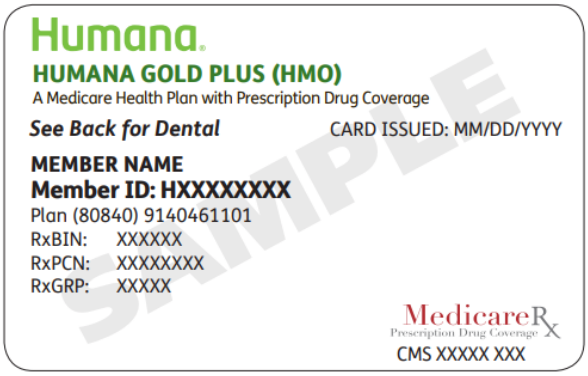
Individual PDP Premier Rx

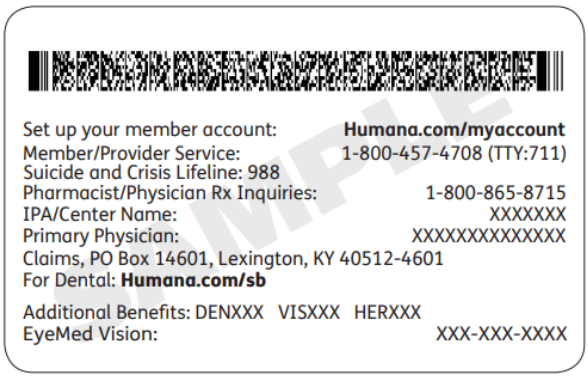




Card for a member with HMO with Medicare Advantage prescription drug (MAPD) coverage – Parts A, B and D

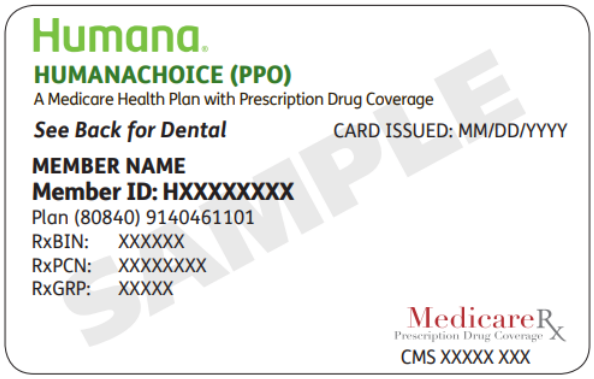
Individual MAPD HMO

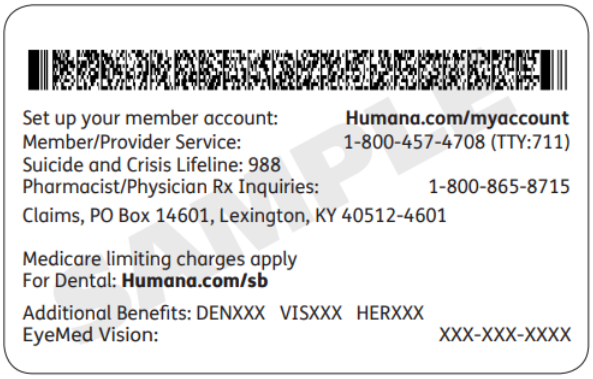




Card for a member with PPO with MAPD coverage – Parts A, B and D

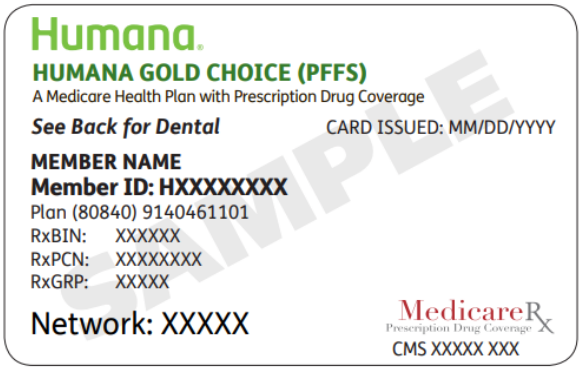
Individual MAPD PPO





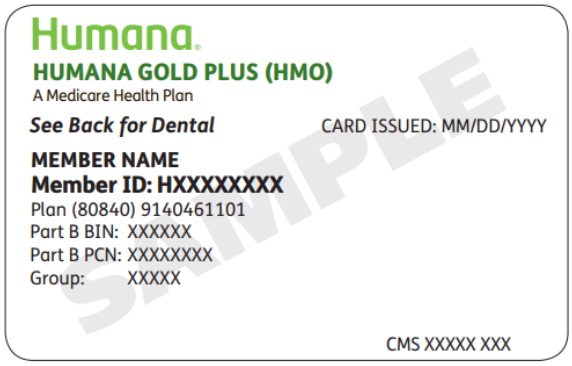
Card for a member with private fee-for-service (PFFS) with MAPD coverage – Parts A, B and D

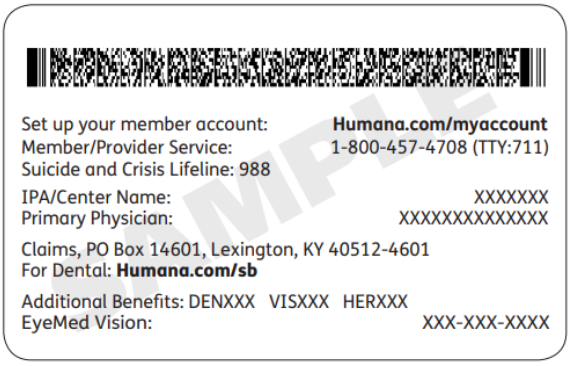
Individual MAPD PFFS



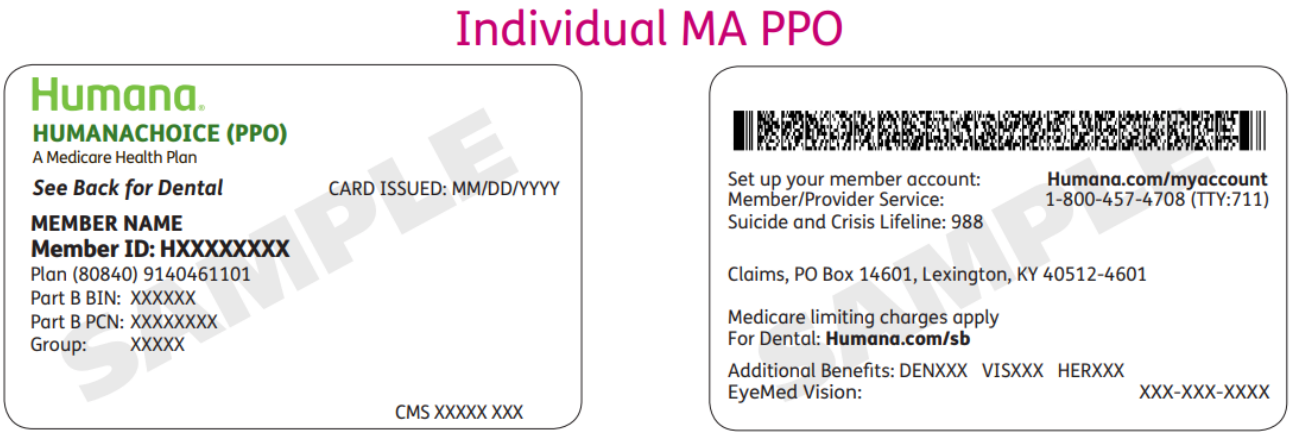
Card for a member with HMO with MA-only coverage – Parts A and B

Individual MA HMO

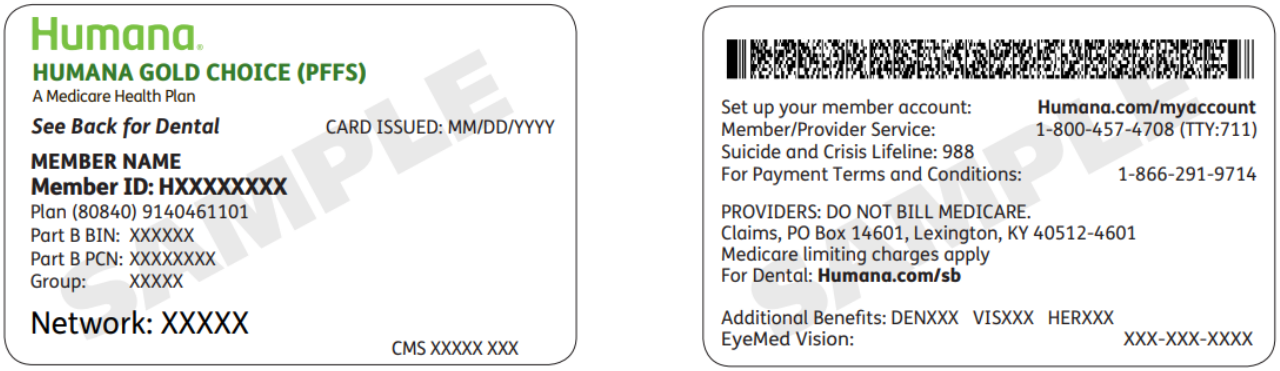




Card for a member with PPO with MA-only coverage – Parts A and B



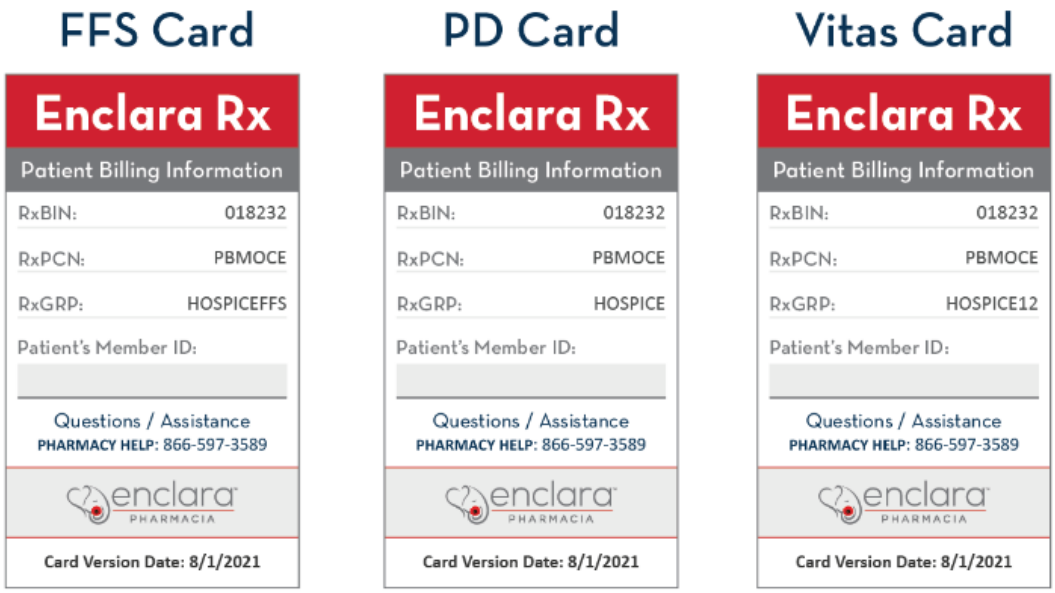
Card for a member with PFFS with MA-only coverage – Parts A and B



Note: These images meet compliance/Centers for Medicare & Medicaid Services (CMS) guidelines and could be subject to change at any time. Notification will be communicated if compliance guidelines change.

Enclara member identification cards

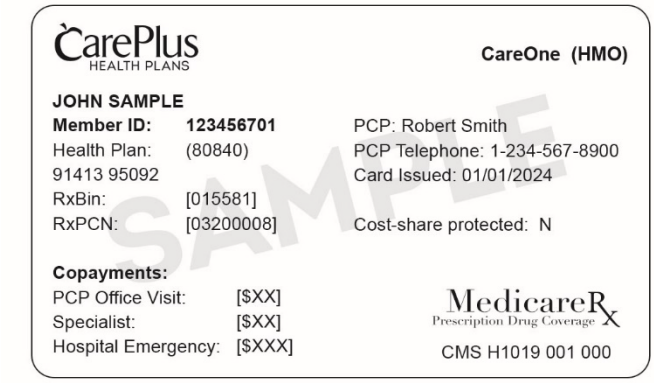
The following are examples of the ID cards pharmacy employees may see from Enclara members:



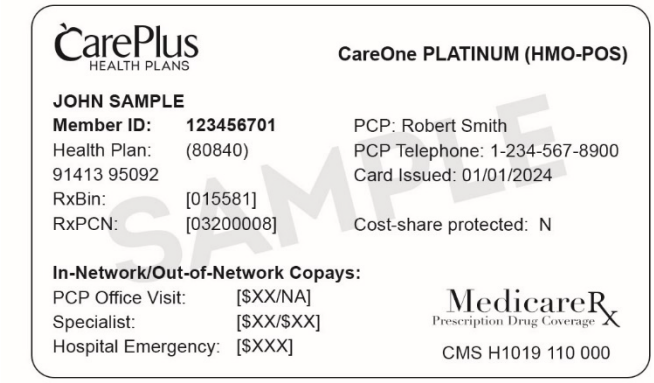
CarePlus member identification cards

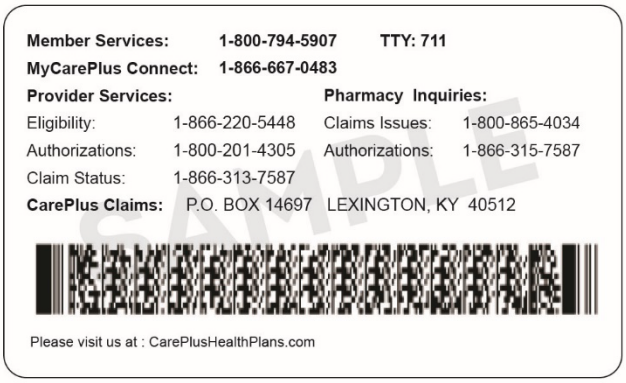
The following are examples of the ID cards pharmacy employees may see from CarePlus MAPD and MA-only members:

Card for a member with HMO with MAPD coverage – Parts A, B and D

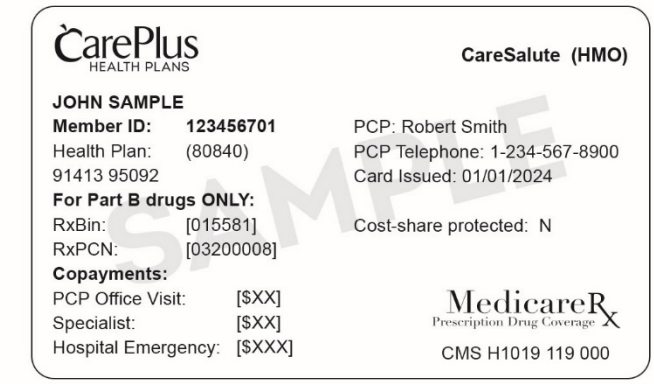


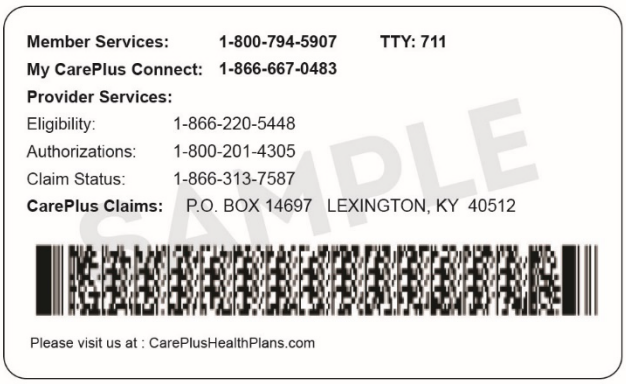
Card for a member with HMO-POS with MAPD coverage – Parts A, B and D



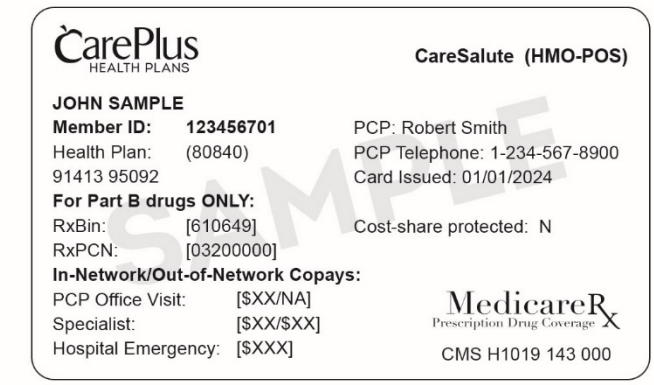


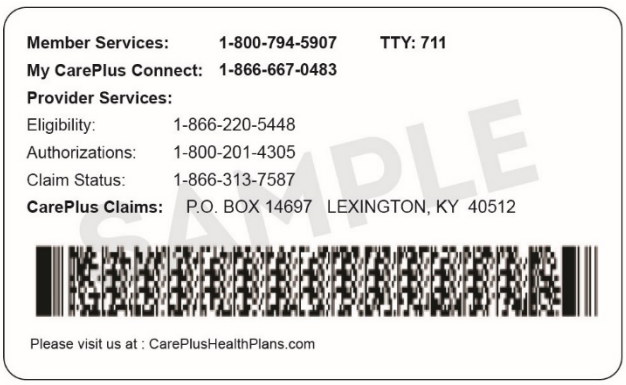
Card for a member with HMO with MA-only coverage – Parts A and B





Card for a member with HMO-POS with MA-only coverage – Parts A and B





Cardholder ID

Pharmacies should submit the Humana and/or CarePlus member ID number in the "Cardholder ID" field whenever possible. This number can be found on the Humana and/or CarePlus member's ID card. Sample card images are shown in previous sections "Humana member identification (ID) cards" and "CarePlus 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 the Humana pharmacy 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 LI NET claims, the Medicare Beneficiary Identifier (MBI) may be submitted in the Cardholder ID field.

For Medicare members who do not have their Humana member ID number, pharmacies should call the pharmacy help desk at **800-865-8715** or submit an E1 query.

For CarePlus Medicare members who do not have their CarePlus ID number, pharmacies should call the CarePlus Pharmacy Utilization Management Unit at **1-866-315-7587.**

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 and/or CarePlus 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 A: Medicare Prescription Drug Coverage and Your Rights" on page 50 of this manual.

Members, prescribers and appointed or authorized representatives can request an expedited coverage determination if the member's health would be jeopardized 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**. Requests for CarePlus members can be faxed to **1-800-310-9071**.

For LI NET-specific requests, please fax to **855-605-6385**. Requests also can be submitted by phone at **800-783-1307**. For questions, call LI NET at **800-783-1307**.

More information and applicable forms are available at:

- **Humana.com/Provider/Pharmacy-Resources/Tools** (choose the link under "Coverage determinations")
- **CarePlusHealthPlans.com/CarePlus-Providers/Pharmacy-Resources**

Beneficiaries eligible for the Low-Income Subsidy (LIS)

Medicare's LIS (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 that helps pay 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.

Sometimes a member believes he or she has qualified for LIS and is paying an incorrect cost-share amount for his or her prescription(s). 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
- 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 call 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 also can 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 within 30 days to the following address:

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

For additional assistance, the member may call Humana Customer Care at **800-281-6918**, 8 a.m. – 8 p.m., Eastern time.

If a member wishes to apply for the Medicare LIS, he or she should call the Social Security Administration at **800-772-1213**, Monday – Friday, 8 a.m. – 7 p.m.

CarePlus
The pharmacist may call the CarePlus Pharmacy Utilization Management Unit at **1-866-315-7587.** Once the Extra Help eligibility information is updated at the pharmacy, the member must mail the proof within 30 days to the following address to maintain the correct copayment level:

CarePlus Health Plans
Attn: Member Services Department
P.O. Box 277810
Miramar, FL 33027

For assistance with Extra Help concerns, members may call CarePlus Member Services at

1-800-794-5907 (TTY: 711), 8 a.m. – 8 p.m., daily (Oct. 1–March 31) and Monday – Friday (April 1–Sep. 30), Eastern time. Members may leave a voicemail after hours, Saturdays, Sundays and holidays. Humana will return the call within one business day.

Best-available evidence for long-term care (LTC) residents

Medicare 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:

- 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
- 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
- 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
- Effective as of a date specified by the secretary, but no earlier than Jan. 1, 2017, a copy of:
    - 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
    - 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
    - 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
    - Other documentation provided by the state showing HCBS eligibility status during a month after June of the previous calendar year
    - 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 an LTC facility should be different from that shown on adjudicated claims may provide applicable evidence to Humana regarding the member's LIS status. Pharmacists may submit appropriate evidence to Humana by utilizing the "Long-Term Care Appeal for Untimely Filing" form at **https://Apps.Humana.com/Marketing/Documents.asp?q=y6nu1BgevSGJhMcNrtXcIQ%3d%3d**.

Inquiries regarding member LIS levels may be directed to Humana at **800-281-6918**. Pharmacists who have evidence the member's 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.

For CarePlus members, pharmacists may call 1-866-315-7587, Monday – Friday, 8 a.m. to 8 p.m., Eastern time, to provide applicable evidence regarding the member's LIS status.

2024 LIS chart – "Extra Help" for members

Categories	LIS level	Resource limits	Deductible	Cost share up to OOP limit ($8,400)	Copayment above OOP limit ($8,400)	Subsidy % Part D premium
Full subsidy – full benefit dual eligible greater than 100% and 150% Federal Poverty Level (FPL)	1	N/A – individual deemed Medicaid eligible	$0	$4.50 generic/preferred multi-source drug or biosimilar; $11.20 for any other drug	$0	100%
Full subsidy – non-full benefit dual eligible at or below 150% FPL	1	Resources/assets below or equal to $17,220 (single); $34,360 (married)	$0	$4.50 generic/preferred multi-source drug or biosimilar; $11.20 for any other drug	$0	100%
Full subsidy – full benefit dual eligible below or equal to 100% FPL	2	N/A – individual deemed Medicaid eligible	$0	$1.55 generic/preferred multi-source drug or biosimilar; $4.60 for any other drug	$0	100%
Institutionalized full benefit dual eligible	3	N/A – individual deemed Medicaid eligible	$0	$0 copay	$0	100%

Notes:

- Resource/asset limits displayed include $1,500 per person for burial expenses.
- 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.
- Effective Jan. 1, 2024, members who received partial LIS will receive full LIS due to the Inflation Reduction Act.

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**. For CarePlus Drug Lists, please visit **CarePlusHealthPlans.com/CarePlus-Providers/Pharmacy-Resources**.

Drug Lists are developed and maintained by Humana's Pharmacy and Therapeutics Committee, which consists 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 and/or CarePlus 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 and/or CarePlus' Drug List
- Request that Humana and/or CarePlus 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 non-preferred drug, the member can ask that it be covered as a Tier 3 preferred brand-name 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 jeopardized 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**. For CarePlus members, requests can be faxed to **1-800-310-9071**. To submit a request, complete a coverage determination form found at **Humana.com/Provider/Pharmacy-Resources/Prior-Authorizations**. For a CarePlus coverage determination form, visit **CarePlusHealthPlans.com/CarePlus-Providers/Pharmacy-Resources**. Prescribers or pharmacists with questions may call HCPR at **800-555-CLIN (2546)**. Requests for Puerto Rico members can be submitted via phone to **866-488-5991** or can be faxed to **855-681-8650**. For CarePlus, prescribers or pharmacists with questions may call CarePlus Pharmacy Utilization Management Unit at **1-866-315-7587**.

Reference "Appendix A: Medicare Prescription Drug Coverage and Your Rights" on page 50 of this manual.

Please note: Humana and CarePlus do 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 or CarePlus' standard 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:** Quantity limits are implemented for various classes of medications to facilitate the appropriate, approved label use of these agents. Humana believes 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 and/or the CarePlus Pharmacy Utilization Management Unit.

Please note: Humana and CarePlus do 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: **Apps.Humana.com/Marketing/Documents.asp?q=QChm%2fH%2b%2b1IiOcQ5lgbWwpA%3d%3d**.

Prescribers in Puerto Rico can use the quick reference guide at **Apps.Humana.com/Marketing/Documents.asp?q=KrMR0r9TH4Lv19U4zyeNSg%3d%3d**.

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

For CarePlus members, prescribers can visit **CarePlusHealthPlans.com/Members/Drug-Coverage-Determination**. Prescribers or pharmacists with questions may call the CarePlus Pharmacy Utilization Management Unit at **1-866-315-7587,** Monday – Friday, 8 a.m. to 8 p.m., Eastern time.

General claims procedures

Submitting pharmacy claims

All participating pharmacies must comply with the 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 plan (Part D)* Use this if the member has a MAPD or PDP plan.	015581	03200000
Medicare Advantage (MA) plans (Part B only)* Use this if the member has an MA-only plan.	610649	03200004
LI NET	015599	05440000
CarePlus MAPD plans	015581	03200008
CarePlus MA-only plans	610469	03200000

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

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

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.

All new prescriptions must contain one of the following numeric values:

Value	Value type
1	Written
2	Telephone
3	Electronic
4	Fax
5	Situations for which a new prescription number needs to be created from an existing valid prescription, such as traditional transfers, intrachain transfers, file buys and software upgrades/migrations. This value also is the appropriate value for "pharmacy dispensing," when applicable, such as OTC, Plan B, established protocols, pharmacists' authority to prescribe, etc.

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.

The member's address is not a required element for the claim to process unless the medication is being shipped. The member's address should be added to where the medication is being shipped. The pharmacy should enter the following information in the appropriate NCPDP field for the shipping tax to apply: Pharmacy Service type is 03 (HIT), 05 (LTC), 6 (MO) or 8 (Specialty).

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 the pharmacy has 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 LTC pharmacy services. Additionally, there are special circumstances under which a pharmacy may submit claims after the DOS, including the following:

- Resolution of coordination of benefits issues requiring claims reversal and rebilling to appropriate payers for Medicare Part D, which have 36 months for submission
- LI NET claims (Please reference the "Timely Filing Limits" on the LI NET Payer Sheets at **Apps.Humana.com/Marketing/Documents.asp?q=pRwj6AN%2fILbcLuGYsH%2bHSQ%3d%3d**.)
- Subrogation claims, which have 36 months for submission
- Fully insured commercial claims, which have 480 days from DOS for submission
- Medicare claims, which have until March 31 of the year following the DOS

Attempting to adjudicate a POS transaction after the claims submission deadline may result in a reject

with the message “Claim too old” (NCPDP reject 81). This includes:

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

Please call the Humana pharmacy help desk at **800-865-8715** for claims processing questions. This line is staffed 24 hours a day, seven days a week. For CarePlus claims processing questions, call the CarePlus Pharmacy Utilization Management Unit at **1-866-315-7587.**

Please note: This does not apply to claims for LIS members who were retroactively enrolled.

LTC appeals for untimely filing
As set forth in 42 C.F.R § 423.505(b)(20), LTC pharmacy claims must be submitted for eligible persons no later than 90 days from the DOS. Humana and CarePlus recognize the need to make exceptions 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:
https://Apps.Humana.com/Marketing/Documents.asp?q=y6nu1BgevSGJhMcNrtXcIQ%3d%3d.

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.0 sheet:
  https://Apps.Humana.com/Marketing/Documents.asp?q=FA%2f7ArlFlgliIZ9n2NZT1A%3d%3d
- Medicare D.0 sheet:
  https://Apps.Humana.com/Marketing/Documents.asp?q=tMtRgGL3q5LywAy3LN2kQw%3d%3d
- LI NET sheet:
  Apps.Humana.com/Marketing/Documents.asp?q=pRwj6AN%2fILbcLuGYsH%2bHSQ%3d%3d

CarePlus SS&C Health payer sheets

Pharmacists can find applicable CarePlus pharmacy payer sheets at **CarePlusHealthPlans.com/CarePlus-Providers/Pharmacy-Resources**.

Enclara SS&C Health payer sheet

Pharmacists can find the Enclara payer sheet at **Humana.com/Pharmacists**. Look for the “Pharmacy manuals and forms” link. The direct link to the payer sheet is **https://Apps.Humana.com/Marketing/Documents.asp?file=4298385.**

Prescriber National Provider Identifier (NPI) submission

Humana and CarePlus require 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 (i.e., 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 a 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 U.S. Drug Enforcement Administration (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 and CarePlus recognize the NCPDP standard 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.

DAW codes for multi-source brand drugs

Claims will be denied if a DAW code is not entered or if the DAW code of "0" is entered when a multi-source brand drug is dispensed. The SS&C error code of "100" will show with the following message: "DRUG MULTSRCE – DISP Generic or Enter DAW Code." A DAW code of "5" must be entered if the pharmacy considers the multi-source brand drug to be generic.

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

Humana and CarePlus implement concurrent reviews or safety edits at the point of service to assist pharmacies in identifying and addressing potentially inappropriate or unsafe drug therapy before dispensing. These safety edits can present as a message, soft reject or hard reject and include, but are not limited to, the following:

DUR type	Pharmacy information	Example
Drug–drug interaction	Identifies possible adverse interactions between the submitted medication and other medications in the patient's prescription history.	Selective serotonin reuptake inhibitors/monoamine oxidase inhibitors
Drug–disease interaction	Identifies safety risk when an active medication is contraindicated for a patient's disease state. Disease may be inferred or identified via medical claims history.	Amphetamines — cardiomyopathy
Drug–age interaction	Identifies safety risk related to use of specific medication for the 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 30 mg twice daily plus Percocet 10/325 mg two tablets every eight hours as needed.
MED* overuse (commercial only)	Identifies patients at greater risk of overdose or inappropriate opioid utilization. For commercial, dosing greater than 250 mg MED per day.	MS Contin 100 mg three times daily

Opioid naïve	Identifies patients that have not filled an opioid medication within the past 108 days. A seven days or less supply of opioid medication limit will apply to these patients.	hydrocodone/acetaminophen 5/325 mg supply for 8 days
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 within a therapeutic class of active medications with overlapping claims in the patient's prescription history.	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." If the pharmacy approves the prescription fill, the rejection can be overridden utilizing the appropriate professional and results code from the following list:

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 M0: Prescriber consulted MP: Patient will be monitored PE: Patient educated P0: Patient consulted R0: 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
70: DUR reject error	The drug interacts with the patient's disease state	DC: Drug disease	DE: Dosing evaluation M0: Prescriber consulted MP: Patient will be monitored PE: Patient educated P0: Patient consulted R0: 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

NCPDP error code	NCPDP description	Reason for service	Professional service	Result of service
88: DUR reject error	This drug may duplicate current patient therapy	TD: Therapeutic duplication	M0: Prescriber consulted PE: Patient educated P0: Patient consulted R0: 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**	Limits cumulative morphine milligram equivalent (MME) daily dosage across all opioid prescriptions to a lower threshold between 90 MME and 200 MME	HD: High dose	M0: Prescriber consulted DE: Dosing evaluation DP: Dosage evaluated	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 4K: Prescriber specialty exemption-oncology of non-hospice palliative care 4L: Prescriber specialty exemption-hospice
88: DUR reject error 922: Morphine equivalent dose exceeds limit**	Limits cumulative MME daily dosage across all opioid prescriptions to an upper threshold of greater than 200 MME	ER: Overuse	M0: Prescriber consulted	4B: Filled, palliative care 4L: Prescriber specialty exemption-hospice

NCPDP error code	NCPDP description	Reason for service	Professional service	Result of service
88: DUR reject error	Concurrent opioid and benzodiazepine use	AT: Additive toxicity	DE: Dosing evaluation M0: Prescriber consulted MP: Patient will be monitored PE: Patient educated P0: Patient consulted R0: Pharmacist consulted other source SW: Literature search/review	1F: Filled with different quantity 1G: Filled with prescriber approval 4A: Prescribed with acknowledgments 4B: Filled, palliative care 4D: Filled, cancer treatment
COMMERCIAL ONLY AG: Exceeds opioid initial fill limits 925: Initial fill days' supply exceeds limit	Opioid naïve – seven days supply limit (18 and over) Pediatric opioid naïve limit – Three to seven days supply can be overridden for eligible exemptions Override using eligible ICD-10 codes if a patient has an appropriate exemption (i.e., sickle cell disease, cancer, palliative care, hospice) Initial fill is limited to less than 50 MME per day	MX: Excessive duration	M0: Prescriber consulted PH: Patient medication history R0: Pharmacist consulted other source	1G: Filled with prescriber approval 4B: Filled, palliative care 4D: Filled, cancer treatment 4J: Dispensed, patient is not opioid naïve 4K: Prescriber specialty exemption-oncology of non-hospice palliative care 4L: Prescriber specialty exemption-hospice
MEDICARE ONLY AG: Exceeds opioid initial fill limits 925: Initial fill days' supply exceeds limit	Opioid naïve – seven days supply limit Override using eligible ICD-10 codes if a patient has an appropriate exemption (i.e. sickle cell disease, cancer, palliative care, hospice, chronic pain management diagnosis [G89, M25, M47, M50, M51, M54] – for Medicare only)	Not applicable	Not applicable	Not applicable

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

Submitting 340B medications

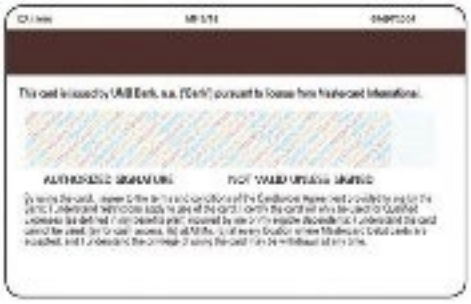
When dispensing medications acquired under the 340B program (as such terms are defined by CMS), pharmacies must utilize a SCC (42Ø-DK) field with a value of 20, or they must use the most current NCPDP standard for identification of 340B medications (unless prohibited by law). Humana may require pharmacies to complete a contract addendum to dispense 340B medications under the pharmacy agreement.

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 exactly match the member's prescription cost.
- **Over-the-counter (OTC) healthcare items:** Most employers allow qualified OTC healthcare items to be reimbursed. Internal Revenue Service (IRS)-qualified OTC items include pain relievers and allergy medicines but not vitamins or supplements. OTC items no longer require a prescription to be eligible for reimbursement. Menstrual supplies and personal protective equipment 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/Page/Home** to locate 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 the page. Select "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.

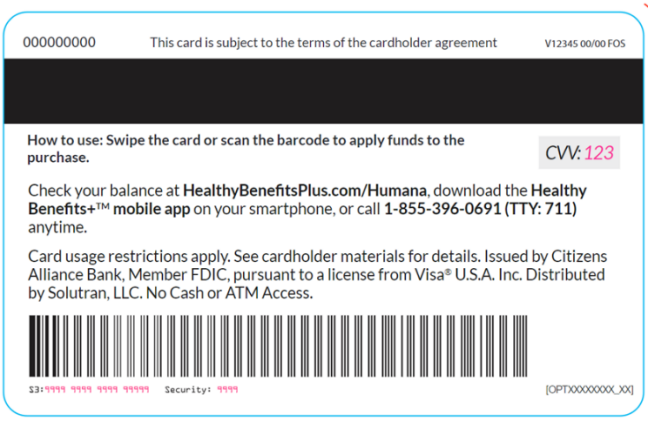
Reasons for declines
Humana Access card transactions usually process successfully. When a transaction is declined, it may be due to one of the following reasons:

- **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 call Humana's spending account administration at **800-604-6228 (TTY: 711)** for information about reimbursement. Assistance is available Monday – Friday, 8 a.m. – 7 p.m., Eastern time.

Humana Spending Account Card

The Humana Spending Account card provides a monthly Healthy Options allowance, monthly or quarterly OTC allowance and annual Humana Flex allowance for Medicare members. Please visit **HealthyBenefitsPlus.com/Humana** or call **855-396-0691 (TTY: 711)** anytime for complete program details. This is a sample of a Humana Spending Account card.



Controlled substances

Controlled substance claims

During claims adjudication, Humana and CarePlus attempt 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 and CarePlus 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://Apps.Humana.com/Marketing/Documents.asp?q=lbX%2flIaqxhxA%2bedS6wPj%2fg%3d%3d.

Point-of-sale (POS) edits and overrides

To support state and federal regulations regarding opioid and other controlled substances, Humana and CarePlus employ several POS edits.

For information on current guidance on edits and overrides, visit **Humana.com/Provider/Pharmacy-Resources/Manuals-Forms**, then select the “Pharmacy resources” tab under “Manuals and forms.”

Medicare claims coverage

Medicare Part B vs. Part D coverage

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 and CarePlus cover 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 (if they are administered in a physician's office from a physician's supply)

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
- Physician-administered injectable drugs (if they are dispensed from a retail pharmacy)
- 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 Medicare 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 and CarePlus follow the CMS coverage guidelines. To assist in making the appropriate determination for Part B or Part D coverage and payment, Humana and CarePlus may require prior authorization. To request prior authorization when required, members, prescribers and appointed or authorized representatives should call HCPR at **800-555-CLIN (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**. For CarePlus members, requests can be submitted via phone to **1-866-315-7587** or can be faxed **to 1-800-310-9071.**

Please note: Humana and CarePlus do 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 Medicare Part B or Part D coverage cannot be made, a fax form requesting more information may be sent to the prescriber.

Prohibition on balance billing cost-share-protected members
As a reminder, CMS guidelines and state Medicaid guidelines prohibit Medicare-contracted providers from collecting cost share for Medicare-covered services, including Part B services provided at the POS from members who are protected by the state from cost sharing. This includes some Humana MA and Dual Eligible Special Needs Plan members.

Cost-share-protected members have no legal obligation to make further payment to a provider for Medicare Part B-covered medications and/or 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 and/or 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 can 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 and CarePlus-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 44Ø-E5.

To submit a claim for the administration fee only, the pharmacy must submit the National Drug Code (NDC) for the drug administered, submit a value of zero in the ingredient cost field and a value greater than zero in the incentive amount submitted field (438-E3). The pharmacy also must submit a professional service code of "MA" in field 44Ø-E5.

Influenza, pneumococcal and hepatitis B vaccines are not covered under the Medicare Part D program. However, they are a covered benefit for members who have Humana and CarePlus 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 OTC drugs:** Process through the member benefit unless the member is eligible for LIS 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.

Medicare continuity of care

Retail and LTC transition policy
This policy applies to prescribed drugs 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 reenrolling members who are at a retail pharmacy, receive prescriptions through mail order or are in an LTC facility, Humana and CarePlus 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, as applicable. Humana and CarePlus will cover a 30-day supply for members at a retail or mail-order pharmacy and a 31-day supply for members in LTC facilities. If the member presents a prescription written for less than the days' supply allowed, Humana and CarePlus will allow multiple fills to provide up to the total days' supply of medication allowed. For members who have more than 108 days of claims history, Humana and CarePlus 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 and CarePlus 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 and CarePlus will allow multiple fills to provide up to a total of 31 days of a Medicare Part D-covered drug when the prescription is filled at the network pharmacy.

Humana and CarePlus 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 and CarePlus 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, for example:

- CMS-excluded drug
- Medicare Part B drug
- Drugs that require a Medicare Part B vs. Part 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 to standard Medicare Part A and Part B coverage
- Members who are discharged from chronic psychiatric hospitals with highly individualized drug regimens

For these changes in treatment settings, Humana and CarePlus will cover up to a 31-day temporary

supply of a Part D-covered drug when the prescription is filled at an in-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 and CarePlus 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 and CarePlus Drug Lists or 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 Medicare Part D use, Part B drugs, CMS-excluded drugs or Medicare Part B vs. Part D determinations.

When a claim is processed under the transition benefit, a free-form message will return, indicating that the claim was 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)

LTC pharmacy information

Humana and CarePlus recognize the unique operational model and services provided by the pharmacies in their LTC 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 and CarePlus members in institutional settings. While most of the needs 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/CarePlus-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 Medicare 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 and CarePlus' claims-processing system to recognize a claim for inhalation solutions—such as albuterol (to be used in nebulizers, not metered-dose inhalers)—is for an LTC facility resident, the claim should be submitted with a patient residence code of 03 or 09. If this patient residence code is not submitted with the claim, the claim will be rejected.

LTC short-cycle dispensing

Humana and CarePlus have implemented POS 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 and CarePlus apply 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 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 and CarePlus' appropriate dispensing requirements and do not undergo this editing. In accordance with CMS guidance, Humana and CarePlus consider a product "brand" or "generic" according to the FDA's approval. Brands are drugs receiving new drug application approval; generics receive abbreviated new drug application 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 and CarePlus payer sheets 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 POS system will calculate and prorate any member copayment that is applicable to the claim, according to the member's Medicare 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

LTC attestation

Humana reimburses contracted LTC pharmacies for cost-share amounts related to retroactive subsidy level changes for eligible LIS 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 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 complies 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 call 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.

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:
  - MAPD plans: All covered Medicare Part D drugs should be billed through the member's Humana or CarePlus pharmacy benefit using the applicable BIN/PCN. All covered Part B drugs, supplies and nursing should be billed through the member's Humana or CarePlus medical benefit.
  - PDP-only plans: All covered Medicare Part D drugs should be billed through the member's Humana pharmacy benefit using the applicable BIN/PCN.
  - MA-only plans: All covered Medicare Part B drugs, supplies and nursing should be billed through the member's Humana or CarePlus 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. A 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 SCC 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 Medicare 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
- 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

Nonformulary compound (Medicare only)

Medicare Part D multi-ingredient prescription compound medications (with the exception of IV parenteral 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:
    - Product not on Formulary
    - NF Compound

NCPDP SCC 08 cannot be used to override the nonformulary compound rejection.

When this error message is returned, as with any non-covered drug, explain to the member that his or her prescriber can submit a request for an exception by calling HCPR at **800-555-CLIN (2546)**. In Puerto Rico, the prescriber can call **866-488-5991**. For CarePlus members, call the CarePlus Pharmacy Utilization Management Unit at **1-866-315-7587.**

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 and CarePlus' MTM program utilizes a variety of resources, such as telephone-based and pharmacy-based consultation services, for ambulatory and institutional beneficiaries.

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

Humana and CarePlus have contracted with a vendor to assist in providing MTM services. If a pharmacy is interested in providing MTM services to Humana and CarePlus members, it can visit **www.getoutcomes.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- eligible beneficiaries
- Help ensure compliance with the provider agreement between Humana, its network pharmacies and this manual
- 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, as well as the pharmacy's compliance program.

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/NPI number inappropriately
- Invalid pharmacy service type submitted
- Invalid patient residence code submitted
- Calculating the day's supply incorrectly
- Using a DAW code incorrectly
- Overbilling quantities
- Not retaining/providing the hard copy of prescriptions or a signature log/delivery manifest
- Claims paid to the incorrect benefit

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 and Health Insurance Portability and Accountability Act of 1996 (HIPAA)-compliant manner with respect for patients and pharmacy staff. To access the Humana Pharmacy Solutions Audit and Claim Review Guide, please visit **Humana.com/Provider/Pharmacy-Resources/Manuals-Forms** and select the "Audit guide, claim form and other materials" tab.

LTC 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 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/Manuals-Forms** and select the "Audit guide, claim form and other materials" tab.

Compliance program audits

Humana maintains a pharmacy compliance program audit to ensure compliance with this manual, government requirements and corresponding compliance and standards of conduct material. Entities contracted with Humana or a Humana-related entity ("Humana") that support Humana's Medicare products are subject to compliance program audits that may occur on an ad hoc basis. Humana notifies a pharmacy of its intent to audit and provides specific directions regarding the process. If an audit identifies deficiencies, a corrective action plan is issued. Humana then works with the pharmacy to ensure the deficiencies are remediated in a timely manner and to ensure there is a sufficient process and policy in place to prevent recurrence.

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

Policy statement

Humana and CarePlus do 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**), as committed by Humana and CarePlus employees; contracted pharmacy providers or those supporting the providers' contractual obligations to Humana and CarePlus; members; customers; vendors; contractors; and/or other business entities. In addition to Humana-administered plans and products that have a pharmacy benefit for Medicare-eligible beneficiaries, Humana is an administrator of Medicaid products that have a pharmacy benefit. All organizations supporting any of the products Humana administers are required to have a comprehensive plan to detect, correct and prevent FWA. Humana is committed to:

1. Investigate any identified or reported suspected noncompliance or fraudulent activity;
2. Take additional action as necessary; and
3. Report the matter (when appropriate) to the impacted regulatory, federal or state agencies for further action and investigation.

Humana is an MA organization, a Medicare Part D PDP sponsor and an administrator of Medicaid products that have a pharmacy benefit. All such organizations supporting any of these products Humana administers are required to have a comprehensive plan to detect FWA. Humana has such a plan.

Training to combat FWA
Every Humana-contracted entity supporting Humana's products is responsible for:

- Providing FWA prevention, detection and correction training to its employees who administer, deliver or support federal healthcare program benefits or services
- Providing FWA prevention, detection and correction training to its contractors who administer, deliver or support Humana's plan administration, or notifying them that they must conduct such training
- Tracking adherence to the training obligation and understanding of and compliance with the requirements outlined in the FWA training materials

Material to use
A pharmacy may use its own material to meet the FWA training requirement or adopt another organization's training on the topic. Humana also offers content on this topic in the following documents:

- Humana Compliance Policy for Contracted Healthcare Providers and Third Parties **Apps.Humana.com/Marketing/Documents.asp?q=kaOUjtwlbGCAf367eB0Z7Q%3d%3d**
- Humana Ethics Every Day for Contracted Healthcare Providers and Third Parties **Apps.Humana.com/Marketing/Documents.asp?q=PxY%2fgulHDJm74ctVrMWa6Q%3d%3d**

Note: The Humana materials alone may not be used to meet the FWA training requirement. However, a pharmacy may use these documents to supplement or integrate within their FWA training.

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 conduct oversight of 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

All pharmacy employees and subcontractors that support the pharmacy's contract with Humana must report suspected or detected fraudulent or noncompliant activities using one of the reporting methods provided by the pharmacy. When the subject of the reported activities impacts a plan administered by Humana, the pharmacy must report the matter and the actions taken by the pharmacy to Humana.

Humana offers multiple options to report concerns. 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**.

Humana makes the following reporting options available:

Phone:

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

Both phone methods above are available 24 hours a day and allow callers to remain anonymous. Humana requests those who report ethics concerns and desire to remain anonymous to provide enough information to allow Humana to investigate the issue.

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: www.ethicshelpline.com

Note: When using a Humana option to report a concern, confidential follow-up to check on the status of an investigation is available.

If a contracted pharmacy elects to offer any reporting option(s) instead of, or in addition to, those Humana makes available, the pharmacy still must do the following in a timely manner: Relay to Humana reports that could impact Humana or its members and outline the action(s) taken.

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 or entities, such as CMS, a CMS designee,

a state agency where Humana administers a Medicaid product or law enforcement agencies

Note: All employees, managers, governing body members and any party with whom a pharmacy contracts to support a Humana contract are required to report suspected FWA or violations of Humana's standards of conduct or compliance policy (available at **Humana.com/Provider/Pharmacy-Resources/Manuals-Forms**). Those identified as not reporting a corresponding matter that is determined to have adversely impacted Humana shall be confirmed as being in violation of Humana requirements and be 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 available methods for reporting compliance and FWA concerns and the non-retaliation policy. Examples of how to achieve this include posters, mouse pads, key cards and other prominent displays within a pharmacy's facility, such as on an intranet site and/or via email sent to those performing a function in support of Humana.
    - It is not sufficient to post information only within a facility and not share it via email and/or a pharmacy intranet site when any person needing the information works outside of the facility (e.g., remotely or within a home).
- 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 adopt or have its own written standards of conduct that are materially similar to Humana's written standards of conduct, then Humana's standards of conduct document can be used. A copy can be accessed, printed and downloaded by visiting **https://Apps.Humana.com/Marketing/Documents.asp?q=PxY%2fgulHDJm74ctVrMWa6Q%3d%3d**
- Conduct the following for all new employees, management, governing body members and contracted individuals prior to hire/contract and monthly thereafter when they are designated to assist in the administration or delivery of federal healthcare program benefits in support of a Humana contract: Review the separate exclusion lists of the Office of Inspector General and General Services Administration's System for Award Management.
- Retain evidence of the exclusion screening for 11 years (or longer, as required by state law). Note: If a contract with Humana is terminated, the screening evidence must be retained for a minimum of 10 years after the termination date.
- Take appropriate corrective actions for standards of conduct violations and, when FWA is involved, please 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 by these non-Humana organizations 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 include, but are not limited to:

- **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 MA plan, Medicare PDP or a Medicaid plan administered by Humana. This is conducted from both operational and compliance perspectives and includes exclusion screenings of all individuals and contracted entities that support Humana Medicare products.
- **Immediate notification to Humana of the 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 and where or how data is processed, transferred, stored or accessed.
- **Prior approval from Humana before moving forward with or modifying 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 from transmitting, processing, accessing or storing related information offshore.
    - Humana may need to notify CMS of any entity with a location outside of the United States or a U.S. territory that receives, processes, transfers, stores or accesses in oral, written or electronic form protected health information of a Medicare member for an individual who is also eligible for Medicaid.
- **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:
    - Requiring employees, board members 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**). Any suspected and confirmed instances of ethical, compliance or FWA violations must be reported to Humana.
    - Safeguarding Humana's confidential and proprietary information and plan members' protected personal and health information
    - Providing accurate and timely information/data in the regular course of business
    - Monitoring and auditing activities
    - Upholding disciplinary standards
- **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 requirement 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).

- **Cooperation:** Cooperating fully with Humana for any compliance-related requests and any government entity audits or 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.
- **Communication:** Publicizing methods for how to report suspected violations of Humana policies and government regulations and corresponding disciplinary standards to employees, volunteers, board members and subcontractors.
- **Disciplinary standards:** Having established disciplinary standards in place that are carried out when violations are committed by the pharmacy provider, its employees or those the provider contracts with to support obligations to Humana.
- **Assurance:** Complying with Humana requests to provide assurance related to the pharmacy's compliance program.

The examples above are ways to implement an effective 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?q=kaOUjtwlbGCAf367eB0Z7Q%3d%3d**.

Frequently asked questions
Humana makes a guidance document publicly available online that includes frequently asked questions and additional information regarding the compliance requirements at: **https://Apps.Humana.com/Marketing/Documents.asp?q=uhZ%2bjqKP1UP%2bQ1pmcyu86Q%3d%3d**.

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?q=kaOUjtwlbGCAf367eB0Z7Q%3d%3d**.

If a pharmacy also supports Humana Medicaid business, additional compliance requirements apply. 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**.

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

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** and include information on:

- Training on general compliance
- Training on understanding and addressing FWA

Your organization may develop or adopt other material to meet these last two requirements.

Timing of individuals to meet the above requirements is upon hire/contract and annually thereafter.

Compliance assurance
Humana reserves the right to request documentation as assurance that certain compliance program requirements and training are in place to meet government contract obligations.

If an attestation is required:

- It is based on multiple factors, such as government contract expectations and corresponding Humana compliance program oversight activities.
- It will be for an organization-level attestation from a network pharmacy supporting any plan Humana administers for Medicare-eligible beneficiaries.

Humana will notify the pharmacy if an attestation must be submitted.

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 **https://Apps.Humana.com/Marketing/Documents.asp?q=uhZ%2bjqKP1UP%2bQ1pmcyu86Q%3d%3d**.

Please note: 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 Required Compliance Information instructions, located at **https://Apps.Humana.com/Marketing/Documents.asp?q=nR%2fWvra3yhHlXLdxGzCwGg%3d%3d%20,** cover how to:

- Complete the compliance requirements at **Humana.com**
- Register at **Humana.com**
- Create a new user record
- Assign the compliance business function to another user
- Update an organization's Tax Identification Number

Humana pharmacy credentialing

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

- Pharmacy state licensure information
- Pharmacy DEA licensure information and/or DEA controlled dangerous substances 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 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, 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:

- Obtain certifications of conflicts of interest or the possible absence of conflicts of interest from all providers and those they employ or contract to support Humana business
- 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 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 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 would violate comparable state law
- 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

A violation of this prohibition could result in Humana terminating a pharmacy provider contract or requiring the provider to remove any applicable employed or contracted party from supporting Humana business. 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, Medicaid and hospice

Network pharmacies have the right to submit a request to appeal, investigate or dispute the MAC reimbursement amount to Humana within 60 calendar days of the initial claim. The pharmacy may submit its request to appeal, investigate or dispute MAC pricing in writing to Humana by fax at **855-381-1332** or by email at **PharmacyPricingReview@humana.com.** Please submit the request using one of the Humana Pricing Review Request files below, which also are available on the Humana.com Pharmacist Portal.

- File for multiple requests (download this Excel file): **https://Apps.Humana.com/Marketing/Documents.asp?file=4212377**
- Pharmacy Pricing Review Request**:** **https://Apps.Humana.com/Marketing/Documents.asp?file=2661815**

Please email **PharmacyPricingReview@humana.com** to request the file if it cannot be downloaded.

The pharmacy can call Humana and speak to a representative regarding its request at **888-204-8349** for retail claims or **866-597-3589** for hospice claims. The following must be included in the request:

- Pharmacy name
- Pharmacy address
- Pharmacy NCPDP
- PCN

- Rx number
- 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 an NDC 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 call the SS&C Health help desk at **866-211-9459** (or **1-800-865-4034** for CarePlus) for any question or complaint related to a system issue or claims transaction. SS&C Health 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 Health are forwarded to the Pharmacy Networks Department for research and resolution at **888-204-8349**.

Pharmacy initiative inquiries
Humana has a dedicated 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**.

Member complaint system

The section below is taken from Humana's member grievance and appeal procedure as set forth in the Member Handbook. This information is provided so that the pharmacist may assist Humana members in this process if they request assistance. Please contact the pharmacy network contracting representative if the pharmacy has questions about this process.

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

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

Grievance and Appeal
P.O. Box 14546
Lexington, KY 40512-4546
Fax: **888-556-2128**

Members also can call Customer Service at the toll-free number on the back of the member ID card. Puerto Rico members may call **866-773-5959**. For members with speech or hearing impairments who

use a TTY, call **711**. Hours of operation are daily, 5 a.m. – 8 p.m., Eastern time.

Medicare member grievances
Medicare member 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 member to call Customer Service at **800-457-4708**. For members with speech or hearing impairments who use a TTY, call **711**. Hours of operation are Monday – Friday, 8 a.m. – 8 p.m., Eastern time.

A member should include his or her name, address, telephone number, Humana member ID number, the reason for the grievance and any supporting documents. Humana will investigate the grievance and inform the member of the resolution.

Medicare member appeals
The Medicare member, prescriber or member 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 at **Humana.com** and either fax or mail it to Humana. Please include the member's name, address, Humana member ID number, reason for the appeal and any supporting documents. Humana will investigate the appeal and inform the member of the decision. If the member is unable to write an appeal, oral appeals will be accepted.
- For written appeals, Medicare members 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 members can file online requests at this link:
Resolutions.Humana.com/Grievances-Appeals-Forms/Member-Info

For all members, the physician, prescriber or member representative can make the appeal on behalf of the member. The Appointment of Representative form, or an equivalent written notice that includes the same required information in the Appointment of Representative form, must be completed. This form provides permission for another person to act on behalf of the member.

To locate an Appointment of Representative form, the member can call Customer Care and ask for one or visit Humana's website at **Humana.com/Individual-And-Family-Support/Tools/Member-Forms**. Medicare members also can access to form through the Medicare website at **www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf**.

- If the appeal comes from someone besides the member, Humana must receive the completed Appointment of Representative form before Humana 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 member has questions concerning a grievance or appeal, direct him or her to the Member Handbook or call Humana using the number on the back of the member ID card.

CarePlus member appeals
The first level of appeal is a redetermination. Standard redeterminations should be submitted in writing, and expedited redeterminations can be requested verbally or in writing. Both types of redeterminations must be submitted within 60 calendar days from the date of the notice of CarePlus' initial decision.

Send requests to:
CarePlus Health Plans Inc.
Attn: Grievance and Appeals
P.O. Box 277810
Miramar, FL 33027
or
Attn: Grievance and Appeals Department
Fax: **1-800-956-4288**

CarePlus can extend the 60-day time frame for filing a redetermination request if the member has a valid reason for missing the deadline. For a standard redetermination, CarePlus will review the appeal and issue written notification of its decision to the member within seven calendar days after receiving the request. An expedited redetermination can be requested by the member, his or her physician or prescriber, or the member's appointed representative if they believe that waiting for a standard decision (seven days) could seriously jeopardize the member's life, health or ability to regain maximum function. CarePlus will automatically expedite a redetermination if the request is filed by the member's physician or prescriber, or if the member has a supporting statement from his or her physician or prescriber indicating why the redetermination must be processed expeditiously.

If the member asks for an expedited redetermination on his or her own without the prescriber's support, CarePlus will decide if his or her health requires an expedited redetermination. To file an expedited redetermination, the member, member-appointed representative or physician may call CarePlus Member Services at **1-800-794-5907 (TTY: 711)**. The request also may be faxed to **1-800-956-4288**. An expedited redetermination will be decided as expeditiously as the member's health condition requires, but no later than 72 hours from receipt of the request if CarePlus finds that the redetermination should be handled as an expedited request.

Price source and maximum allowable cost (MAC) information

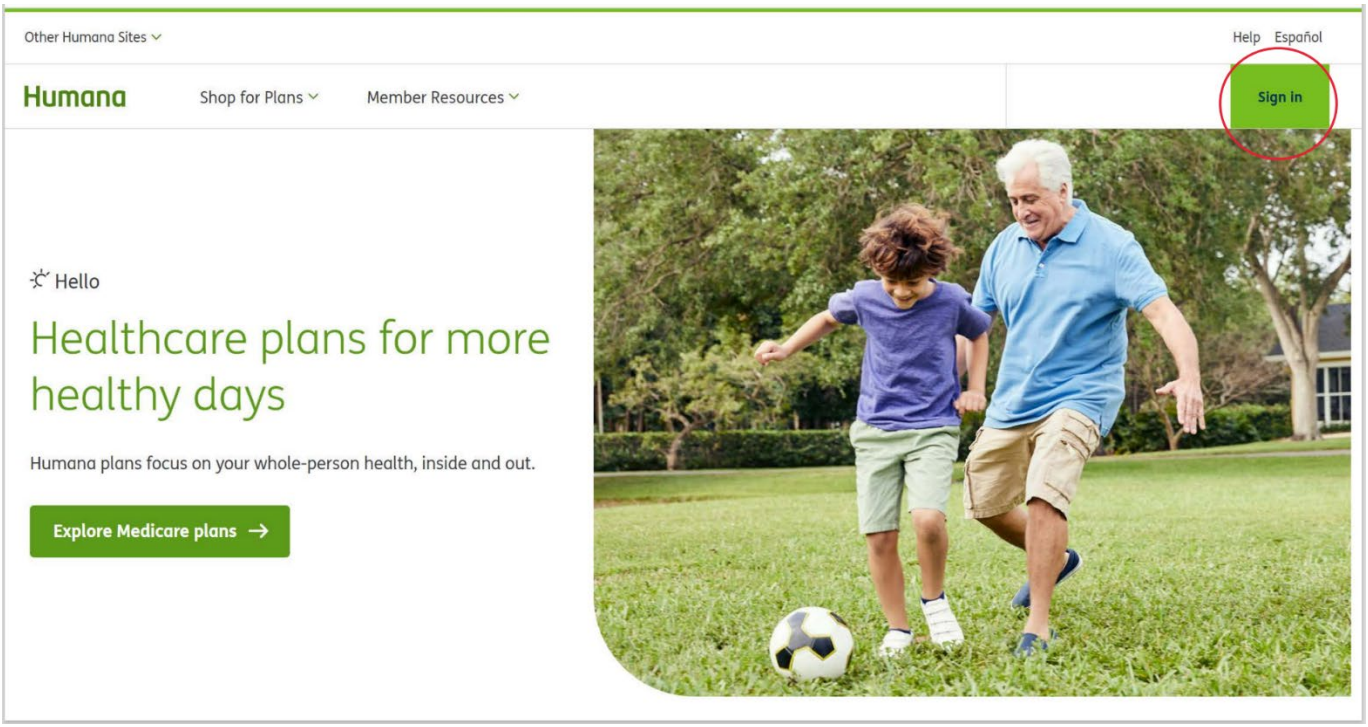
Price source

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

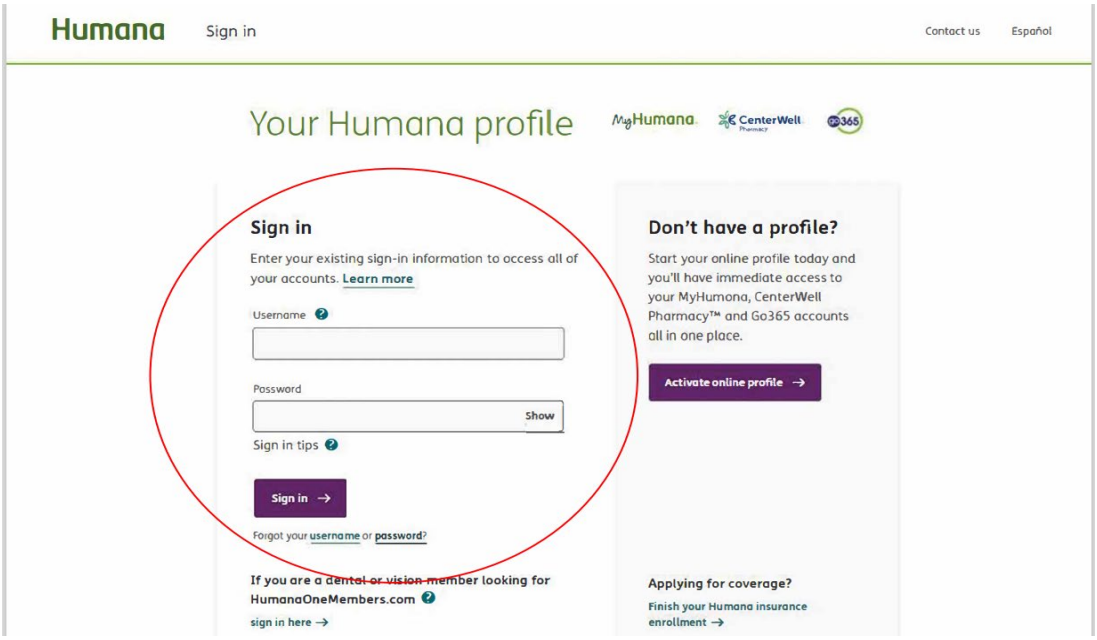
The national drug pricing source used to determine the wholesale acquisition cost of a prescription drug that is not included on the MAC list is First Databank.

Pharmacy MAC list location

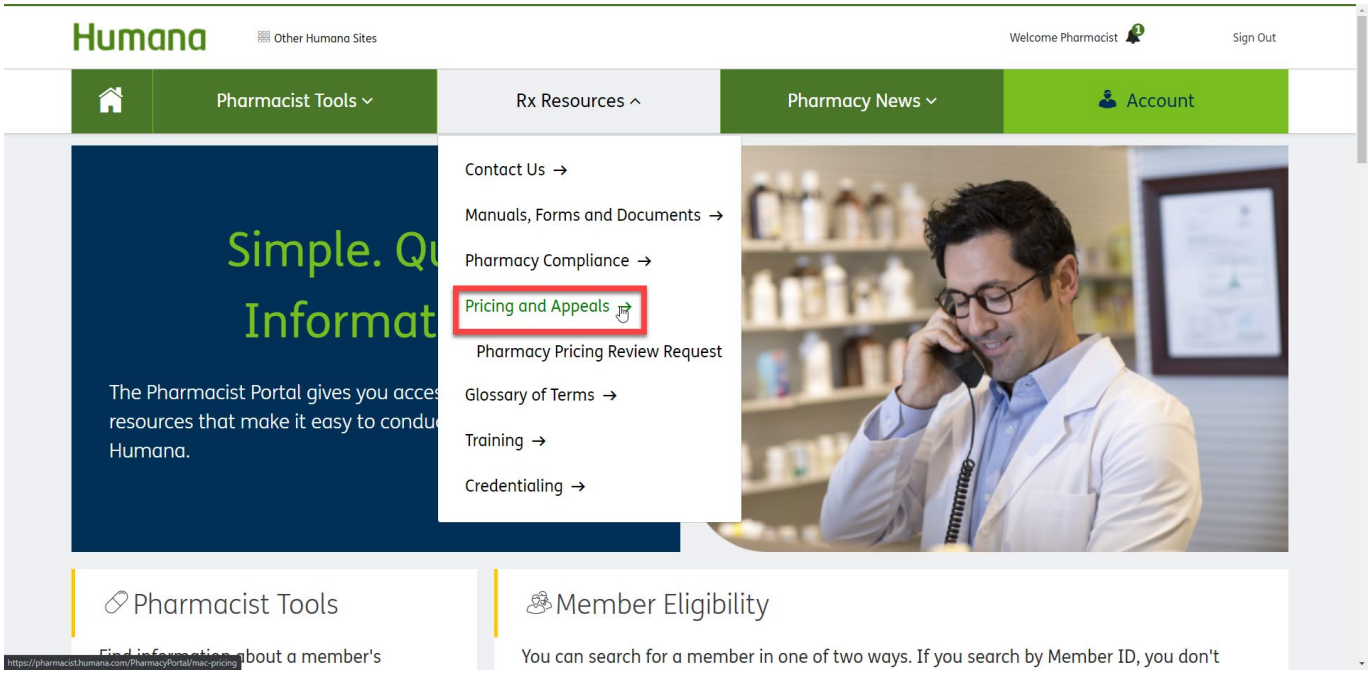
When network pharmacies need to locate the current MAC list, they can follow the steps below at **Humana.com**. They will see the screen below. Select the "Sign in" button located on the top right corner of the screen.



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 email the pharmacy contracting team at **PharmacyContracting@humana.com** and ask to have the pharmacy's online portal account reset.

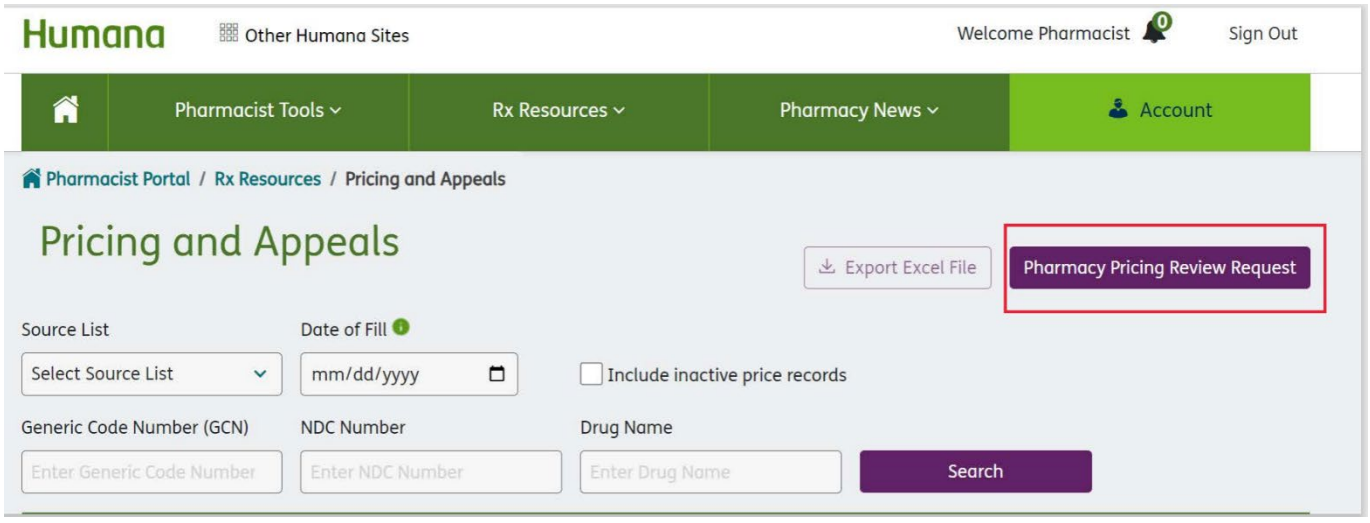


For the current MAC list applicable to the NPI the pharmacy used to register its account, which includes recent updates, select the "Pricing and Appeals" link:



Once the pharmacy selects that link, a MAC search box will appear. Close the box and select the appropriate list from the drop-down menu. The list chosen 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. Select “Pharmacy Pricing Review Request” in the upper right corner.



The pharmacy must complete all fields in the form and return it to Humana by selecting 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 by fax or email of the results of the dispute within five business days from the date the form was received.

Limited Income NET (LI NET) Program

LI NET is a Medicare program that provides immediate prescription coverage for Medicare beneficiaries who qualify for Medicaid or Extra Help and have no prescription drug coverage.

Please keep these details about LI NET in mind:

- Qualifying patients must be eligible for Medicare Part D and Medicaid, Extra Help or Supplemental Security Income.
- The program provides immediate prescription coverage at the pharmacy; enrollment is processed by claim submission.
- There are limited pharmacy network restrictions.
- There are no premiums.
- Coverage usually lasts about two months.
- Retroactive reimbursement may be available for out-of-pocket expenses.

Beneficiaries are enrolled in the LI NET program in one of four ways:

- Automatically enrolled: periodic enrollments by CMS
- Point of sale: enrollment by claim submission
- Retroactive: reimbursement request
- LI NET enrollment form: **https://Apps.Humana.com/Marketing/Documents.asp?file=3603210**

Confirming eligibility

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

E1 results	Status	Action
Contract ID X0001	Patient currently enrolled in LI NET	Submit claim to LI NET using 4 Rx data
No plan information LICS/Extra Help = YES	Patient may be eligible for LI NET—not yet enrolled	Submit claim to LI NET using 4 Rx data
No plan information LICS/Extra Help = NO	Patient not eligible for LI NET	Refer patient to 800-MEDICARE (633-4227)
Plan BIN/PCN number	Patient is enrolled in a Medicare Part D plan	Submit claim to plan using 4 Rx data
Plan phone number	Patient is enrolled in a Medicare Part D plan/issues	Call phone number provided

Claim submission information

Please submit electronic pharmacy claims with the following information:

BIN	PCN	Group ID	Cardholder ID	Optional field: Patient ID
015599	05440000	May be left blank	Medicare number	Medicaid ID or Social Security number

How a beneficiary can request retroactive reimbursement:

- Complete the Direct Member Reimbursement form at **Humana.com/LI NET.**
- Attach a copy of receipt or printout from the pharmacy and proof of payment.
- Mail or fax completed form with receipt to:
  LI NET
  P.O. Box 14310
  Lexington, KY 40512-4310
  Fax: **877-210-5592**

Questions

For help and information, please call the LI NET help desk at **800-783-1307**.

Appendix A: 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. Information is available at: **https://www.cms.gov/Medicare/Appeals-and-Grievances/MedPrescriptDrugApplGriev/PlanNoticesAndDocuments.**

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.

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 OMB Approval No. 0938-0975 (Expires: 02/28/2025)

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 0938-0829. El tiempo necesario para responder esta recopilación de información es de aproximadamente 10 minutos 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, Mail Stop C4-26-05, 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 Número de OMB 0938-0972 (Expiración: 02/28/2025)

Appendix B: State Fraud Warning Statements

Any person who, with intent to defraud or knowing that they are facilitating a fraud against an insurer, submits an application or files a false or deceptive statement may be subject to prosecution of fraud.

By providing these notices, neither Humana nor its subsidiaries imply that they are authorized to write insurance in all 50 states.

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof.

Alaska: A person who knowingly and with intent to injure, defraud or deceive an insurance company or files a claim containing false, incomplete or misleading information may be prosecuted under state law.

Arizona: For your protection, Arizona law requires the following statement to appear on/with this form. Any person who knowingly presents a false or fraudulent claim for payment of loss is subject to criminal and civil penalties. The authorization shall remain in effect for the term of your coverage. You or your designated representative is entitled to receive a copy of this claim form.

Arkansas: Any person who knowingly presents a false or fraudulent claim for payment for a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California: For your protection, California law requires the following to appear on/with this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Delaware: Any Person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Hawaii: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Idaho: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony.

Indiana: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Kansas: Any person who with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be subject to prosecution for fraud and guilty of insurance fraud as determined by a court of law.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Louisiana: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines.

Maine: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland: Any person who knowingly OR willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly OR willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon: Any person who knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or, (2) conceals for the purpose of misleading, information concerning any material fact, may have committed a fraudulent insurance act.

Pennsylvania: Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand ($5,000) and not more than ten thousand ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

Rhode Island: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Tennessee: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Texas: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Utah: Any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits, or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state prison.

Virginia: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

Washington: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.