Humana Pharmacy Solutions®

Pharmacy Manual

Humana Healthy Horizons in Kentucky

2021 Edition

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Introduction

Dear pharmacy,

Humana appreciates your role in delivering quality pharmacy services to our Medicaid members. This manual pertains exclusively to Kentucky Humana members enrolled in Humana Healthy Horizons in Kentucky, to assist pharmacy staff in processing prescription claims for Humana plans.

Medicaid
Medicaid is a program run by the federal and state governments that helps people with limited income pay for medical costs and, if qualified, long-term services and supports, such as nursing homes and home- and community-based waiver services. Each state decides what counts as income and who qualifies for Medicaid. States also decide what services are covered and how much they cost.

By contracting with various types of managed care organizations (MCOs) to deliver Medicaid program healthcare services to their beneficiaries, states can reduce Medicaid program costs and better manage utilization of health services. Improvement in health plan performance, healthcare quality and outcomes are key objectives of Medicaid managed care. Some states are implementing a range of initiatives to coordinate and integrate care beyond traditional managed care. These initiatives are focused on improving care for populations with chronic and complex conditions, aligning payment incentives with performance goals and building in accountability for high-quality care.

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

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

This resource is available to any pharmacy contracted with Humana and is provided free of charge. To gain access, visit **Humana.com/logon**, choose “Register your account” and select registration type. If you have difficulty registering, send an email to **hpsnetworks@humana.com**. Please include the pharmacy name, National Provider Identifier (NPI), pharmacy contact name and contact phone number.

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

Sincerely,

The Humana Pharmacy Network Team

Contact information

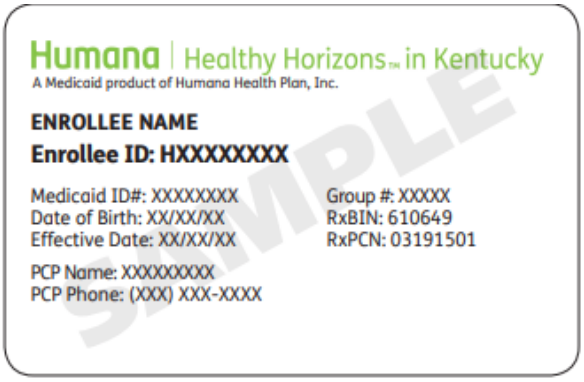
Pharmacy help desk	For refill-too-soon overrides and prior authorization status, call **800-865-8715** and follow the prompts.
Humana Customer Care	To obtain general Medicaid plan information: **800-477-6931 (TTY: 711)** 8 a.m. – 8 p.m., seven days a week
Humana Clinical Pharmacy Review (HCPR)	To submit prior authorization requests: • Obtain forms at **Humana.com/PA** or submit your request electronically by going to **www.covermymeds.com/epa/humana** • Submit request by fax to **877-486-2621** • Call HCPR at **800-555-CLIN (555-2546)**
Humana Pharmacy	**800-379-0092** Monday – Friday, 8 a.m. – 11 p.m., Eastern time; Saturday, 8 a.m. – 6:30 p.m., Eastern time **Fax: 800-379-7617**
Humana Specialty Pharmacy	**800-486-2668 (TTY: 711)** Available Monday – Friday, 8 a.m. – 8 p.m., Eastern time; Saturday, 8 a.m. – 6 p.m., Eastern time
Humana Pharmacy Solutions network contracting	Pharmacy contract requests Email: **PharmacyContractRequest@humana.com** Fax: **866-449-5380**
Humana Ethics Help Line	**877-5-THE-KEY (584-3539)**
Humana's pharmacist website	Visit **Humana.com/Pharmacists** to access payer sheets, pharmacy news bulletins, the Humana Pharmacy Audit Guide and many other resources.
Pharmacist portal website assistance	Email: **hpsnetworks@humana.com**
Pharmacy Compliance information website	**Humana.com/provider/pharmacy-resources/manuals-forms**

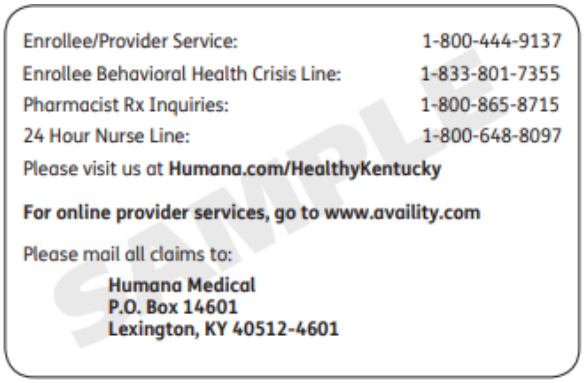
Eligibility verification

Humana member identification (ID) cards

The following is an example of the ID card that pharmacy employees may see from Humana members.

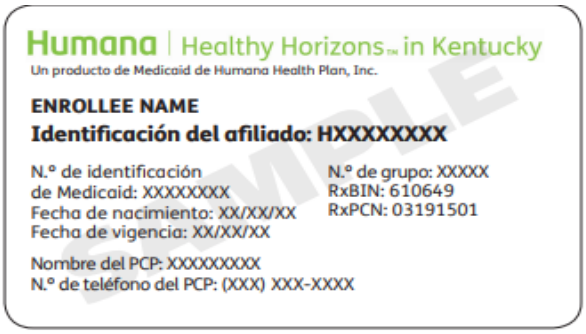
Card for a member with Humana Healthy Horizons in Kentucky (English)

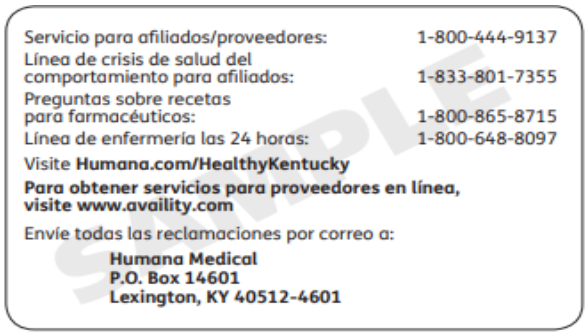




Note: These images meet state/compliance guidelines and could be subject to change at any time. Notification will be communicated if compliance guidelines change.

Card for a member with Humana Health Horizons in Kentucky (Spanish)





Note: These images meet state/compliance guidelines and could be subject to change at any time. Notification will be communicated if compliance guidelines change.

Cardholder ID

Pharmacies should submit the Humana member ID number in the "Cardholder ID" field whenever possible. This number can be found on the Humana member's ID card. Sample card images are shown in the "**Humana member identification (ID) cards**" section above.

For Medicaid claims, Humana allows the cardholder ID to be submitted with the Medicaid ID, the Humana ID number or the Social Security number. In addition, pharmacies may call our help desk at **800-865-8715**, select option **3** and provide the member's name and date of birth to obtain the Humana member ID.

Coordination of benefits

Effective Jan. 1, 2006, Medicaid enrollees who are entitled to receive Medicare benefits under Part A or Part B no longer receive their pharmacy benefits under their state Medicaid agency, except for drugs that are not covered under Medicare Part D. Medicaid will not pay for drugs for beneficiaries who have both Medicare and Medicaid (dual eligible) with the exception of:

- Some prescription products that are not covered under Part D
- Some over-the-counter (OTC) products

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

Excluded drug coverage by state Medicaid program:
Each state has the option to cover medications specifically excluded under the Social Security Act section 1927 (d)(2). Listed is some of the excluded drug coverage for the state of Kentucky:

- Drugs for which the manufacturer has not entered into a Federal Rebate Agreement
- Drugs when used for anorexia, weight loss or weight gain
- Drugs when used to promote fertility
- Drugs when used for cosmetic purposes or hair growth
- Drugs when used for symptomatic relief of cough and colds

Additional information is available at **https://www.medicaid.gov/medicaid/prescription-drugs/state-prescription-drug-resources/index.html**.

Drug coverage

Drug Lists

Humana Healthy Horizons in Kentucky provides coverage of medically necessary medications, both prescription and select over-the-counter drugs, when prescribed by licensed providers in the state. The Preferred Drug List (PDL) is mandated by the Kentucky Department for Medicaid Services Pharmacy and Therapeutic Advisory Committee. The PDL is a list of covered medications selected by Humana. The medications in the PDL are covered by Humana as long as the medication is medically necessary, the prescription is filled at a Humana network pharmacy and other plan rules are followed.

Preferred drug lists are updated regularly. To view the current PDL for Kentucky Medicaid eligible members, go to **Humana.com/DrugLists**.

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. Certain medications may need to be approved by the member's plan to be covered.
- **Step therapy:** Plans that are subject to step therapy as a component of Humana's standard drug utilization review (DUR) program require the member to utilize medications commonly considered first-line before using medications considered second- or third-line. These requirements promote established national treatment guidelines and assist in promoting safe, cost-effective medication therapy.
- **Quantity limits:** Humana has implemented quantity limits for various classes of drugs to facilitate the appropriate, approved label use of these agents. We believe this program helps members obtain the optimal dose required for treating their conditions. If a member's medical condition warrants an additional quantity, the pharmacist should ask the prescriber to submit a request to HCPR.

Coverage determinations

Prescribers may request coverage determinations, such as medication prior authorization, step therapy, quantity limits and medication exceptions, by faxing the request to HCPR at **877-486-2621**. Forms can be obtained at **Humana.com/PA** or submit the request electronically by going to **www.covermymeds.com/epa/humana**.

The coverage determination decision will be made within 24 hours after complete information is received from the prescriber.

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

The prescriber quick reference guide can be found at **apps.humana.com/marketing/documents.asp?file=1372774**.

Prescribers or pharmacists with questions may contact HCPR at **800-555-CLIN (555-2546)**.

Tamper-resistant prescriptions

In compliance with the Centers for Medicare & Medicaid Services (CMS), Kentucky Board of Pharmacy statutes and regulations (902 KAR 55:105) and to prevent Medicaid prescription fraud, we ask prescribers and pharmacies to adhere to Kentucky Medicaid tamper-resistant prescription requirements on all handwritten and hard-copy prescriptions. Excluded from this requirement are faxed, electronic and phoned prescriptions.

To be considered "tamper-resistant," prescriptions must contain one or more of the following industry-recognized features:

- Designed to prevent unauthorized copying of a completed or blank prescription form
- Designed to prevent erasure or modification of information written on the prescription by the prescriber
- Designed to prevent use of counterfeit prescription forms

Medicaid medications are reimbursable only if they include the following security features:

1. Void pantograph background screened at 5% in Pantone green shall be printed across the entire front of the prescription blank.
2. Artificial watermark placed on the backside of prescription so that it shall be seen only at a 45-degree angle. The watermark shall consist of the words "Kentucky Security Prescription" and appear horizontally in a step-and-repeated format in five lines on the back of the prescription using 12-point Helvetica bold type style.
3. Opaque Rx symbol shall appear in the upper right-hand corner, 1/8 of an inch from the top of the prescription blank and 5/16 of an inch from the right side of the prescription blank. The symbol shall be 3/4 of an inch in size and disappear if the prescription is lightened.
4. Six quantity check-off boxes printed on the form, and the following quantities shall appear and be marked:
   a. 1-24
   b. 25-49
   c. 50-74
   d. 75-100
   e. 101-150
   f. 151 and over
5. The following statement shall be printed on the bottom of the prescription blank: Prescription is void if more than one prescription is written per blank.

6. Refill options shall appear below any logo on the left side of the prescription blank in the following order: Refill NR 1, 2, 3, 4 and 5, and be marked if the prescribed drug is a schedule III, IV or V controlled substance.
7. Size of the prescription blank shall be 4 1/4 inches high and 5 1/2 inches wide.
8. A prescription shall bear the preprinted, stamped, typed or manually printed name, address and telephone number of the prescribing practitioner.
9. A prescription blank for a controlled substance shall provide space for the patient's name and address, the practitioner's signature and the practitioner's Drug Enforcement Administration (DEA) registration number.
10. A prescription blank for a controlled substance shall not contain:
    a. Advertisements on the front or back of the prescription blanks
    b. The preprinted name of a controlled substance

The written, typed or rubber-stamped name of a controlled substance until the prescription blank is signed, dated and issued to a patient.

Copayments

If the member is subject to a copayment, the following information applies:

- Generic drugs: $1 copay for a monthly supply
- Brand drugs: $4 copay for a monthly supply
- Products in the following classes are exceptions to the brand/generic rules and will have $1 copays:
    - Atypical antipsychotics
    - Long-acting injectable antipsychotics
- Products in the following classes are exceptions to the brand/generic rules and will have $0 copays
    - Contraceptives for family planning
    - Tobacco cessation
- Diabetes supplies will have exceptions to the brand/generic rules and will have copays as follows:
    - Blood glucose meters: $0
    - Additional diabetic supplies: $0
- For pediatric patients, the copay for most medications is $0 for a month supply.

Beneficiaries deemed below Federal Poverty Level

In accordance with federal regulations [42 U.S.C. § 447.52], Medicaid members who are at or below 100% of the Federal Poverty Level (FPL) and cannot afford their copay may not be denied services. Pharmacy services may be denied for failure of member to pay cost-sharing amounts under the following criteria:

- The denial of services follows the current business practice the provider uses for all patients, and
- The member's income is above 100% of the FPL

To identify whether a member's income is at or below 100% of the FPL, the message "MEMBER IS AT OR BELOW 100% FPL" will be returned.

Additionally, Kentucky regulation [HB 200] requires that a Medicaid beneficiary presenting with a condition that could result in harm if left untreated shall be dispensed a 72-hour emergency supply of a prescribed drug regardless of ability to afford copayment. For products dispensed in any special packaging that may not be broken, the minimum full quantity to last 72 hours should be dispensed. Partial fills of C-II substances are allowed for non-terminally ill patients who are not residents of long-term care facilities [905 KAR 55:095]. In the event a patient requests a partial fill of a C-II medication,

additional dispensing shall not continue beyond 30 days. Only one dispensing fee shall be paid for both the emergency supply and remainder of the prescription. To remain in compliance with Federal Poverty Level requirements, pharmacies should take the following actions:

1) If the member is at or below 100% of FPL and reports an inability to pay, pharmacy services must be provided.
2) If the member is above 100% of FPL and reports an inability to pay, the pharmacy must dispense a 72-hour emergency supply if the condition could result in harm if left untreated.

General claims procedures

Submitting pharmacy claims

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

Humana requires the prescriber to be enrolled in the Kentucky Medicaid Program. Claims submitted for a prescriber not enrolled in the Kentucky Medicaid Program will be rejected at the point of sale with the following error message: “Prescriber not Enrolled in State Medicaid Program.”

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
KY Medicaid	610649	03191501

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 (formerly known as DST Pharmacy Solutions) claims processing is not able to override this edit.

Prescriptions, including refills, must contain the fill number according to the following chart:

Value	Value type
00	Original dispensing—the first dispensing
01–99	Refill number—number of the replenishment

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

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

Sales tax

The sales tax should be submitted as 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.

If you have questions about sales tax, please email **PharmacyPricingReview@humana.com**.

Timely submission of claims

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

- Resolution of **coordination of benefits** issues requiring claims reversal and rebilling to appropriate payers for Medicare Part D
- **LINET** claims (please reference the "Timely Filing Limits" on the LINET payer sheets available at **apps.humana.com/marketing/documents.asp?file=2295852**)
- **Subrogation** claims, which have 36 months for submission
- **Commercial** claims, which have 480 days from DOS for submission

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

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

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

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

LTC appeals for untimely filing
As set forth in 42 C.F.R § 423.S0S(b)(20), long-term care (LTC) pharmacy claims must be submitted for eligible persons no later than 90 days from the DOS. Humana recognizes the need for exceptions to be made when claims cannot be submitted in this time frame. In these cases, the LTC pharmacy requesting such an exception must complete, sign and date the LTC appeal form for untimely filing.

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

Humana-specific SS&C Health payer sheets

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

- Medicaid plans: Use commercial D.0 payer sheet (under the heading "Payer sheet") **Humana.com/provider/pharmacy-resources/manuals-forms**.

Prescriber NPI submission

Humana requires the use of a valid and accurate Type 1 (also known as "individual") prescriber NPI on all electronic transactions. Claims submitted without a valid and active Type 1 NPI will be rejected at the point of sale with the following error message: "Prescriber Type 1 NPI required." The Kentucky Cabinet for Health and Family Services mandates all submitted prescribers on claims also must be enrolled with them to receive payment. This requirement applies to all claims. For additional information regarding prescriber enrollment requirements, please visit **https://chfs.ky.gov/agencies/dms/provider/Pages/providerenroll.aspx**.

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

NCPDP error code	NCPDP error code description	Free-form messaging	Applicable SCC
56	Non-matched prescriber ID.	Prescriber ID submitted not found. If validated, submit applicable SCC.	42
42	Plan's prescriber database indicates the prescriber ID submitted is inactive or is not found or is expired.	Prescriber ID not active. If validated, submit applicable SCC.	42
43	Plan's prescriber database indicates the associated United States Drug Enforcement Agency (DEA) number for submitted prescriber ID is inactive or expired.	Validation of active DEA status required. If validated, submit applicable SCC.	43
44	Plan's prescriber database indicates the associated DEA to submitted prescriber ID is not found.	Validation of active DEA for prescription required. If validated, submit applicable SCC.	43 or 45

46	Plan's prescriber database indicates associated DEA to submitted prescriber ID does not allow this drug DEA schedule.	Validation of active DEA schedule required. If validated, submit applicable SCC.	46
543	Prescriber ID qualifier value not supported.	Prescriber Type 1 required. Foreign prescriber ID not allowed.	N/A
619	Prescriber Type 1 NPI required.	Type 2 NPI submitted – Type 1 NPI required (for Humana Medical Plan) and claim not covered due to Medicare Part D active valid prescriber NPI requirement (for Part D claims).	49
889	Prescriber not enrolled in state Medicaid program.	Use PAC 911911 for disaster claims.	N/A

The pharmacy NPI field must contain accurate information identifying the pharmacy for each claim submitted. The pharmacy NPI must be submitted in NCPDP field 201-B1 (service provider ID) with the qualifier "01" in NCPDP field 202-B2 (service provider ID qualifier). The prescriber NPI must also be submitted in NCPDP field 411-DB (prescriber ID) with the qualifier "01" in NCPDP field 466-EZ (prescriber ID qualifier).

Dispense-as-written (DAW) codes

Humana recognizes the NCPDP standard dispense-as-written (DAW) codes. Prescriptions with a DAW request must designate the DAW product selection code (NCPDP field 408-D8) on the submitted claim. For a prescription submitted with a DAW code other than zero, the reason for the selected code must be documented and comply with all applicable laws, rules and regulations.

Kentucky Medicaid has certain preferred brand drugs when the brand drug is on the formulary and the generic is not. This may require the pharmacy to use DAW 9 when submitting a claim. Please refer to the Preferred Drug List to identify the preferred brand drugs.

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

Drug utilization review (DUR) safety edits

DUR type	Pharmacy information	Example
Drug – drug interactions	Identifies significant interaction with active medication in patient history, including medication name.	Selective serotonin reuptake inhibitors/monoamine oxidase inhibitors
Drug – age interaction	Identifies safety risk related to use of specific medication for patient's age.	Adderall for age younger than 6
Drug – disease interaction	Identifies safety risk when medication is contraindicated for a patient's disease state. Disease may be inferred or identified via medical claims.	Disease: Congenital long QT syndrome
Drug – gender interaction	Alert of safety risk related to use of specific medication for reported gender. **Note:** Gender edits only apply for commercial and Medicaid when applicable	Makena
Maximum dose	Identifies safety risk when dosage exceeds First Data Bank (FDB) maximum adult daily dose. Ratio of exceeding FDB maximum dosing is specific to the medication.	Digoxin daily dose greater than 500 mcg
MED* high dose	Identifies patients at greater risk of overdose or inappropriate opioid utilization. Dosing greater than 50 mg MED per day will trigger this error code.	MS contin 15 mg twice daily plus Percocet 5/325 mg two tablets every eight hours as needed
MED* overuse	Identifies patients at greater risk of overdose or inappropriate opioid utilization. Dosing greater than 250 mg MED per day and/or more than four providers and more than four pharmacies.	MS contin 100 mg three times daily
Plan limitations exceeded: accumulation	Identifies the potential for an overdose resulting in single or multiple medications and cumulative doses that exceed safe daily maximums.	Acetaminophen dose greater than 4 grams per day
Therapeutic duplication	Identifies duplication with active medication in patient history, including medication name.	Two prescriptions for different angiotensin receptor blockers

*MED—Morphine equivalent dosing

Soft reject DUR

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

NCPDP error code	NCPDP description	Reason for service	Professional service	Result of service
88: DUR reject error	This drug interacts with patient's other drug(s)	DD: Drug interaction	DE: Dosing evaluation MO: Prescriber consulted MP: Patient will be monitored	1A: Filled as is, false positive 1B: Filled prescription as is 1D: Filled with different directions

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

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

Submitting claims for 340B medications

When dispensing medications acquired under the 340B Program, as such terms are defined by CMS, pharmacies must utilize a submission clarification code (42Ø-DK) field with a value of 20, or the most current NCPDP standard for identification of 340B medications. Pharmacies may be required to complete a contract addendum with Humana to be eligible to dispense 340B medications under the agreement with Humana.

Vaccine administration

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

Submitting claims for vaccine administration

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

Controlled substance claims

During claims adjudication, Humana attempts to confirm the validity of the prescriber ID submitted on controlled substance (schedule II-V) claims and that the controlled substance is within the prescriber's scope of practice. Claims for drugs found to be written outside of a prescriber's prescribing authority (according to the DEA) will be rejected with the following error message: "Plan's prescriber database indicates associated DEA to submitted prescriber ID does not allow this DEA drug class."

The free-form message on the claim also will state: "Validation of active DEA schedule required. If validated, submit applicable SCC."

Clarification of federal requirements—Schedule II drugs

Humana would like to remind pharmacies of the importance of monitoring pharmacy claims for accuracy and complying with federal and state laws, rules and regulations. This is especially important when filling prescriptions and submitting claims for refills and partial fills of Schedule II drugs. In accordance with your pharmacy provider agreement, Humana requires its pharmacies to comply with all federal and state laws, rules and regulations pertaining to the dispensing of medications.

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 being filled only in accordance with federal and state law. This includes preventing refills and partial fills of Schedule II drugs that are not allowable under the Controlled Substances Act.

Submitting CII claims

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

updates to include the Quantity Prescribed field.

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

Access this CII claim bulletin for additional information: **https://docushare-web.apps.cf.humana.com/Marketing/docushare-app?file=4173260**

Point-of-sale (POS) edits and overrides

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

Please visit the following link for information on current guidance on edits and overrides: **Humana.com/provider/pharmacy-resources/manuals-forms**. See the "Controlled Substances" tab under "Manuals and forms."

Lock-in program

Humana's lock-in program is designed to care for member safety due to excessive use of prescription drugs. When Humana receives a referral on a member with an allegation of potential prescription drug abuse, a thorough review is conducted. Prior to completing the pharmacy restriction process, Humana would have already conducted a review on the member and made the determination that the member should be restricted to a particular pharmacy.

Prior to restriction, Humana will reach out to the pharmacy to confirm lock-in at that site.

A minimum selection criterion must be met to restrict a Medicaid member to one particular pharmacy. One of the following criteria must be met:

- The member obtained three or more controlled-substance prescriptions from three or more pharmacies written by three or more different prescribers within 180 days.
- The member has been convicted of fraud through unauthorized sale or transfer of a pharmaceutical product funded by Medicaid.
- The member utilized more than 10 different controlled-substance prescribers in 90 days.
- The member obtained two or more controlled-substance prescriptions written by two or more different prescribers who have utilized two or more pharmacies within 180 days **and** has a documented diagnosis of narcotic poisoning or drug abuse within the last 365 days.
- The member violated a pain management agreement/contract with his/her prescriber.

Excluded recipients include patients with sickle cell disease and/or cancer, recipients residing in institutionalized settings and recipients enrolled with Medicare.

Exception: This limitation does not apply to emergency services and care provided to the recipient in a hospital emergency department.

If the member chooses to use another pharmacy, he or she must complete and submit the request on the Request for Reconsideration form attached to the notification letter by Humana. Members are reviewed during the lock-in program and annually to determine if they still qualify for the lock-in status. After the first 12 months in the lock-in program, the member is given a six-month window during which he or she is not restricted and re-reviewed for lock-in status. After the six-month period, if the member qualifies for lock-in status, he or she will remain locked for two years at the chosen

pharmacy.

If you or the member have questions, contact Humana in one of the following ways:
- Call **855-330-8054**, Monday – Friday, 7 a.m. – 4:30 p.m., Central time. After hours, please leave a voicemail with the member name, member ID number, case number, contact phone number and a detailed description of your request.
- Fax **855-729-9290**.
- Email **PharmacyClaimAuditAndReview@humana.com**.

Continuity of care

Continuity of care policy

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

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

Continuity of care will not work under the following conditions:
- Medicaid-excluded drugs
- Safety edits
- Initial transition eligibility criteria are not met

Program	Total days' supply allowed	Total time period allowed for transition
KY Medicaid	30	30

Long-term care (LTC)

Long-term care pharmacy information

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

needs that LTC pharmacies have are covered by the materials in the main portion of this manual, the following addresses some of the unique features of the LTC pharmacy network.

LTC claims-processing guidelines

Humana requires all pharmacies to submit the patient residence code (NCPDP field 384-4X) and pharmacy service type (NCPDP field 147-U7) on all 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
1	Home
3	Nursing facility
4	Assisted living facility
6	Group home
9	Intermediate care facility/mentally retarded*
11	Hospice

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

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

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

If the pharmacy submits a 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**.

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

Home infusion billing procedure

Home infusion drug claims are billed through the member's medical benefit.

Compound claims

Submitting compound claims

The pharmacy must submit the correct amount with corresponding accurate quantities and days' supply calculations based on a valid prescription for the member. The pharmacy must submit all ingredients that make up a compound drug on the same claim. The most expensive ingredient will display at the claim level. Edits are returned for each ingredient based on the member's benefits. Submission clarification code (SCC) of 08 can be submitted on the claim when a pharmacy accepts reimbursement for approved ingredients only.

- A free-form message will return to the pharmacy when a submission clarification code of 08 can be submitted.
- Pharmacies are prohibited from balance billing the beneficiary for the cost of any Medicaid-excluded ingredient contained in the 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

Medication Therapy Management (MTM) program

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

Humana works with community pharmacies to provide eligible Medicaid members face-to-face and telephonic MTM consultations at their local pharmacies.

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

Pharmacy audit and compliance

Pharmacy audit program

Humana maintains a pharmacy audit program to:

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

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

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

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

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

LTC pharmacy audits

Humana has the right to audit an LTC pharmacy's books, records, prescription files and signature logs to verify claims information. LTC pharmacies are required to have signed prescribers' orders available for review for an audit. These orders may be in the form of traditional signed prescriptions, copies of signed prescribers' orders from the member's medical chart or other documentation that contains all required elements of a prescription.

Time to retrieve these documents will be considered as part of Humana's audit requirements. LTC pharmacies should have a signature log or patient receipt, a delivery manifest, a copy of a medication administration record (MAR) that shows the prescription was administered, and the name and signature of the person who administered the medication, along with the date and time the medication was given. To access the Long-Term Care Pharmacy Documentation Guidelines, please visit **Humana.com/provider/pharmacy-resources/manuals-forms** and select the "Audit guide, claim form and other materials" tab.

Compliance program audits

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

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

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

Humana is an administrator of Medicaid products that have a pharmacy benefit. All organizations supporting Humana's administration of a plan for Medicaid-eligible beneficiaries are required to have a comprehensive plan to detect, correct and prevent fraud, waste and abuse, and Humana has such a plan.

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

- Providing FWA prevention, detection and correction training to its employees and contractors who administer, deliver or support Humana's Medicaid plan administration; and
- Tracking adherence to the training obligation, as well as understanding of and compliance with the requirements outlined in the FWA training materials.

Material to use
Your pharmacy may use its own material to meet the FWA training requirement or another training. However, Humana also offers content on this topic in the following documents that your pharmacy may use to supplement your FWA training or within it.

- Humana Compliance Policy for Contracted Healthcare Providers and Third Parties **apps.Humana.com/marketing/documents.asp?file=1827514**
- Humana Ethics Every Day for Contracted Health care Providers and Third Parties **apps.Humana.com/marketing/documents.asp?file=1112774**

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

Additional assurance
Humana and applicable government agencies reserve the right to audit contracted pharmacies to assess their commitment to FWA training requirements, including requests that require these pharmacies to provide corresponding documentation.

Requirement to report suspected or detected FWA and/or noncompliance

The pharmacy and all of its employees and subcontractors that support the pharmacy's contract with Humana must report suspected fraudulent or noncompliant activities to Humana. The person reporting information may relay concerns via multiple options.

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

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

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

The following reporting options are available:

Phone:

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

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

Fax: 920-339-3613

Email: siureferrals@humana.com or ethics@humana.com

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

Ethics Help Line reporting website: ethicshelpline.com

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

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

Prohibition against intimidation or retaliation

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

Disciplinary standards

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

- Oral or written warnings or reprimands
- Termination(s) of employment or contract
- Other measures that may be outlined in the contract
- Mandatory retraining
- Formal, written corrective action plan(s) tracked to closure

- Reporting of the conduct to the appropriate external entity(ies), such as a state agency where Humana administers a Medicaid product or law enforcement agencies

Note: If an employee, manager, governing body member or any party with whom a pharmacy contracts to support a Humana contract does not report suspected FWA or violations of Humana's standards of conduct or compliance policy (available at **Humana.com/provider/pharmacy-resources/manuals-forms**), it is considered a violation of Humana requirements and is subject to any or all of the above disciplinary actions.

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

In addition, depending on the specifics of a case, CMS and/or a state agency may elect to exclude anyone involved in an FWA violation from participating in government procurement opportunities, including work in support of any contract Humana has with the government agency(s).

Corresponding expectations

Pharmacy providers are also expected to:

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

Standards of conduct/ethics

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

- Require employees, management, governing body members and those with whom the pharmacy contracts to support the pharmacy's contractual obligations to Humana's Medicaid products to review and attest to compliance with the pharmacy's standards of conduct document upon hire or contract and annually thereafter. If the contracted pharmacy does not have its own written standards of conduct or if those standards are not materially similar to Humana's standards of conduct, then it may use Humana's standards of conduct. A copy can be accessed, printed and downloaded by visiting **https://docushare-web.apps.cf.humana.com/Marketing/docushare-app?file=1112774**.
- Conduct the following for all new employees, management, governing body members and contracted individuals or entities, prior to hire/contract and monthly thereafter: Review the exclusion lists of the Office of Inspector General (OIG) and General Services Administration's System for Award Management (SAM) to verify those who assist in the administration or delivery of federal healthcare program benefits in support of a Humana contract are not included on such lists. This includes retaining evidence of the exclusion screening for 11 years (or longer, as required by state law).
- Remove any person or entity identified on an exclusion list above from any work, or access to information or data, related directly or indirectly to Humana's support of any federal healthcare program, such as Medicare, or a state-administered program like Medicaid.
- Take appropriate corrective actions for standards of conduct violations and, when fraud, waste or abuse is involved, report findings to Humana's Special Investigation Unit at **800-614-4126**.

Humana's CMS and state Medicaid contracts mandate that compliance program requirements must be

completed by all pharmacies contracted with Humana or Humana subsidiaries. This includes those they employ or contract to provide or support healthcare services for Humana's Medicare, Medicaid and/or dual Medicare-Medicaid members.

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

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

1. **Oversight:** Monitoring and auditing the compliance of employees and subcontractors that provide services and/or perform any support functions related to administrative or healthcare services provided to a member of a Humana Medicare Advantage plan, Medicare prescription drug plan or a Medicaid plan administered by Humana. This is conducted from both operational and compliance perspectives and includes exclusion screening of all individuals and contracted entities that support Humana Medicare and/or Medicaid products.
2. **Immediate notification to Humana of your organization's intentions to utilize offshore resources in meeting any obligation to Humana:** This includes new arrangements or changes to existing relationships or offshore locations, as well as where or how data is processed, transferred, stored or accessed.
3. **Prior approval from Humana before moving forward with an offshore arrangement for work in support of a Humana contract:** There are multiple reasons why: Humana may need to notify a state contracting Humana for Medicaid plan administration of an entity with a location outside of the United States or a United States territory that receives, processes, transfers, stores or accesses Medicaid member protected health information in oral, written or electronic form. A state may limit or prohibit plan member information for being stored, accessed or shared offshore. Therefore, Humana must be notified immediately of prospective offshore arrangements.
4. **Establishment, documentation and communication of effective compliance policies:** Having policies and procedures in place for preventing and detecting suspected FWA, then correcting and reporting identified instances, as well as other aspects of noncompliance, including, but not limited to:
    a. Requiring employees and subcontractors to report suspected and/or detected FWA and suspected violations of Humana's compliance policy or standards of conduct (those documents are available at **Humana.com/provider/pharmacy-resources/manuals-forms**). Any suspected and confirmed instances of ethical, compliance or FWA violations must be reported to Humana.
    b. Safeguarding Humana's confidential and proprietary information, as well as plan members' protected personal and health information.
    c. Providing accurate and timely information/data in the regular course of business.
    d. Monitoring and auditing activities.
    e. Upholding disciplinary standards.
5. **Training:** Ensuring that all required compliance program training is completed not simply by the compliance contact at the pharmacy, but also by those supporting the pharmacy's contractual obligations to Humana. Where applicable, operational training must be conducted. This includes having a tracking method in place to provide evidence of these efforts upon request; e.g., who was trained, when, how and with what material(s).

6. **Cooperation:** Cooperating fully with Humana and/or government entity investigations of an alleged, suspected or detected violation of this manual, Humana policies and procedures, applicable state or federal laws, or regulations and/or remedial actions.
7. **Communication:** Publicizing methods for reporting suspected violations of Humana policies and government regulations, as well as corresponding disciplinary standards to employees, volunteers, board members and subcontractors.
8. **Disciplinary standards:** Having established disciplinary standards in place that are carried out when violations are committed by the pharmacy provider, its employees or those it contracts to support obligations to Humana.
9. **Assurance:** Complying with Humana requests to provide assurance related to the pharmacy entity's compliance program.

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

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

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

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

When a compliance attestation is required
Humana reserves the right to request documentation as assurance that certain compliance program requirements and training are in place. However, Humana only requires a compliance attestation when it pertains to Medicaid training for pharmacies supporting one or more plans administered by Humana for Medicaid beneficiaries. Compliance education material is refreshed at least each calendar year to assist pharmacies in meeting these and related requirements. Pharmacies are required to complete the Medicaid training attestation annually and must submit it within 30 days of notification each calendar year. Corresponding instructions are listed in the compliance requirements FAQ for pharmacies at **apps.humana.com/marketing/documents.asp?file=2621125**.

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

- Compliance policy that outlines compliance program requirements
- Standard of conduct
- Training on understanding and addressing fraud, waste and abuse (FWA) that is outlined in material developed or adopted by your organization

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**.

Additionally, Humana's government contracts for plans administered for dual Medicare-Medicaid

beneficiaries and/or Medicaid beneficiaries require that all pharmacies participating in any of those plans, including those contracted with Humana subsidiaries, complete additional training that cover all of the following topics:*

- Cultural competency
- Health, safety and welfare of plan members
- Pharmacy orientation and annual provider training

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

Instructions on how to provide confirmation of adherence to these requirements, when necessary and applicable, are listed in the Notification of Compliance Requirement document found at the above website.

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

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

Humana.com instructions

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

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

Humana pharmacy credentialing

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

- Pharmacy state licensure information
- Pharmacy U.S. Drug Enforcement Agency (DEA) licensure information
- Signed and dated attestation stating the pharmacy is free of sanctions imposed by federal, state and local authorities
- Copy of current professional liability insurance (PLI) coverage that meets or exceeds a minimum requirement of $1 million in aggregate
- Pharmacy's NCPDP number
- Active Kentucky Medicaid provider ID

Pharmacies that do not meet Humana's required standards, which includes having an active state Medicaid ID and not being listed on the applicable state exclusion list or on the federal exclusion lists, will be removed from Humana's pharmacy network.

Conflicts of interest

All entities and individuals supporting Humana are required to avoid conflicts of interest. Pharmacies should never offer or provide, directly or indirectly, anything of value—including cash, bribes or kickbacks—to any Humana employee, contractor, representative, agent or customer or any government official in connection with any Humana Pharmacy Solutions procurement, transaction or business dealing. This prohibition includes, but is not limited to, a pharmacy provider offering or providing consulting, employment or similar positions to any Humana employee involved with Humana procurement or to that employee's family members or significant others.

Pharmacies are required to obtain and sign a conflict of interest statement from all employees and subcontractors within 90 days of hire or contract and annually thereafter. This statement certifies that the employee or downstream entity is free from any conflict of interest for administering or delivering federal healthcare program benefits or services.

All pharmacies are required to review potential conflicts of interest and either remove the conflict or, if appropriate, request approval from Humana to continue work despite the conflict.

Humana reserves the right to obtain certifications of the absence of conflicts of interest from all providers and to require that certain conflicts be removed or that the applicable employee(s) and/or downstream entities be removed from supporting Humana.

Pharmacies are prohibited from having any financial relationship relating to the delivery of or billing for items or services covered under a federal healthcare program that:

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

Pharmacies are subject to termination by Humana for violating this prohibition. Humana reserves the right to request information and data to ascertain ongoing compliance with these provisions.

Complaint system

Pricing dispute process

Network pharmacies have the right to submit a request to appeal, investigate or dispute the maximum allowable cost (MAC) reimbursement amount to Humana within 60 calendar days of the initial claim. The pharmacy may submit its request to appeal, investigate or dispute maximum allowable cost pricing in writing to Humana by fax at **855-381-1332** or by email at **PharmacyPricingReview@humana.com**. The pharmacy may contact Humana at **888-204-8349** to speak to a representative regarding its request. All of the following must be included in the request:

- Pharmacy name
- Pharmacy address
- Pharmacy NPI
- Drug name

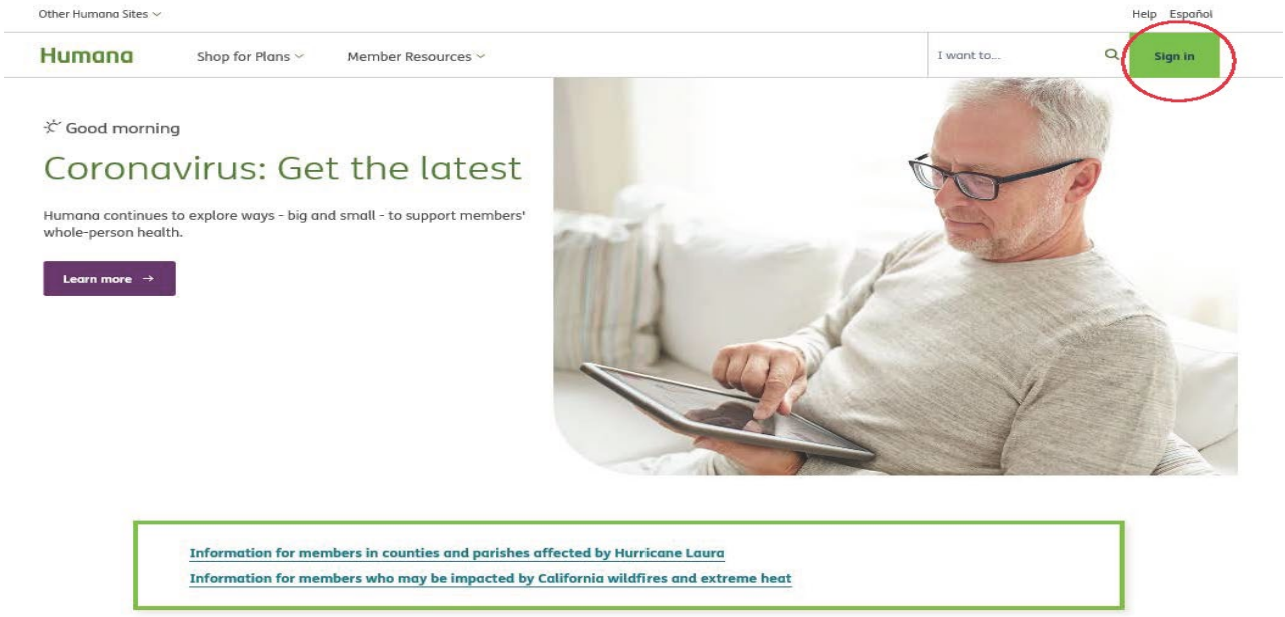
- Drug strength
- Drug NDC
- Date of initial fill
- Quantity of fill
- Relevant documentation that supports the MAC is below the cost available to the pharmacy
- Any other supporting documentation as needed

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

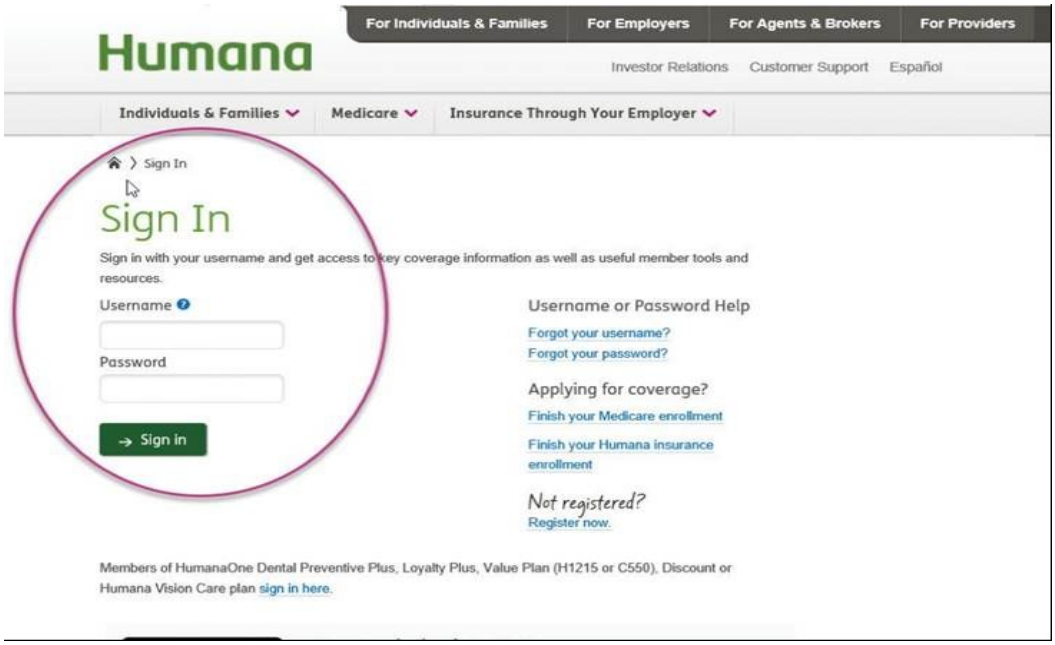
Please note: Timelines may vary state to state and are subject to change.

Pharmacy MAC list location

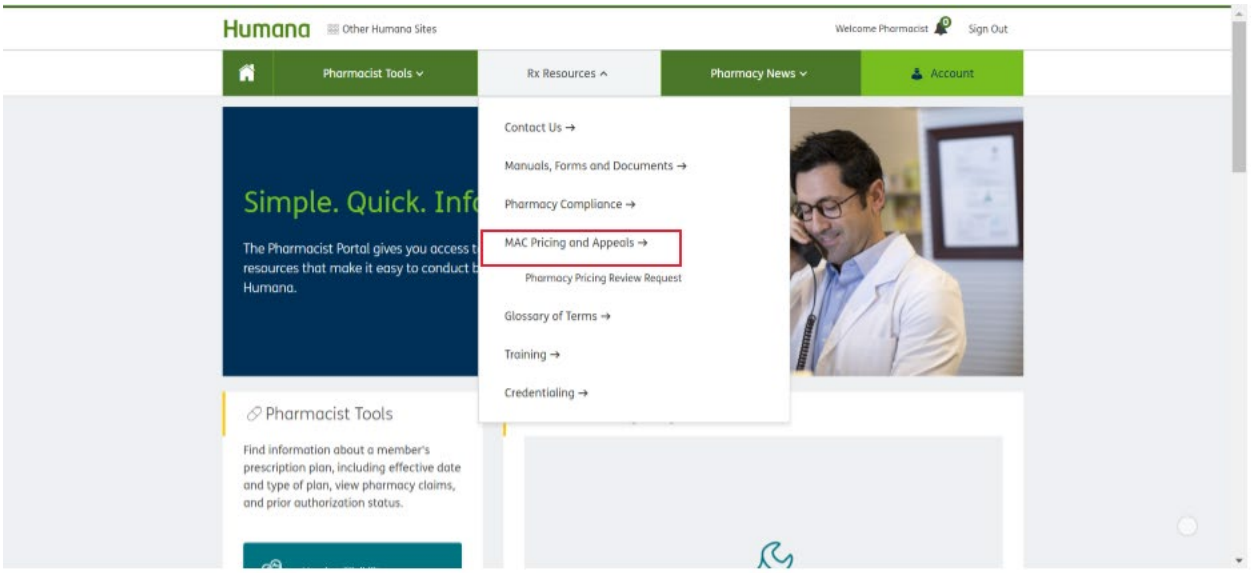
When network pharmacies need to locate the current MAC list, they can follow the steps below at **Humana.com**. They will see the screen below. Click "**Sign in**" located on the top right corner of the screen.



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



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



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

Effective Date: 9/30/2020

Please see below for any changes made to Humana's maximum allowable cost (MAC) list within the previous 60 days. Please note these changes may include any combination of additions, removals, increases and/or decreases.

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

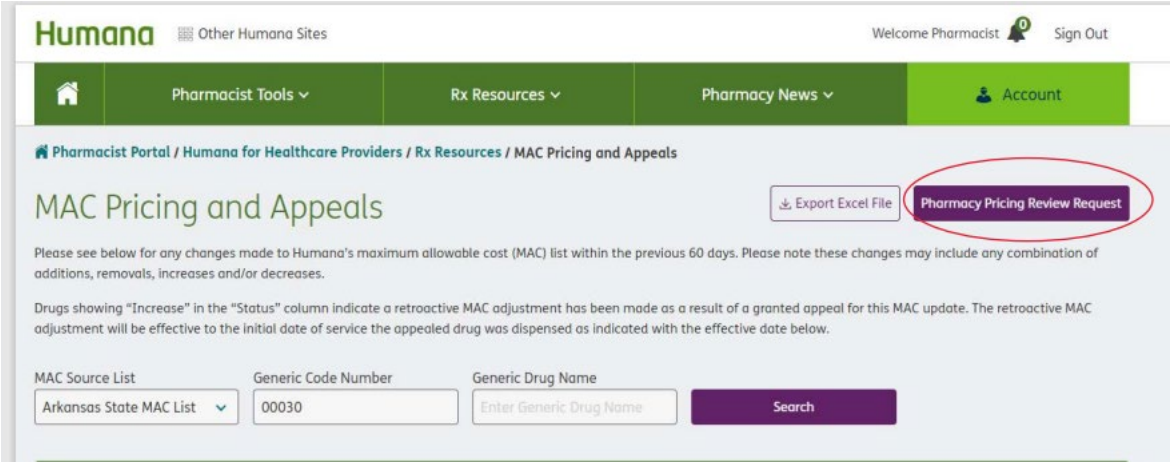
Humana MAC List Updates

GCN	Generic Name	Appeal Granted	Eff Date	Old Price	New Price	NDC	Status
17670	ORPHENADRINE ER 100 MG TA	9/28/2020			N/A	ALL	Removal
32822	TIMOLOL 0.25% GFS GEL-SOLU	9/28/2020			N/A	ALL	Removal
24735	DEXMETHYLPHENIDATE ER 20	9/14/2020			N/A	ALL	Removal
21663	Mesalamine 800 Mg Tablet Dr	9/8/2020			9.13000	ALL	Increase
49100	ITRACONAZOLE 10 MG/ML SOL	8/31/2020			1.86000	ALL	Increase
32820	TIMOLOL MALEATE 0.25% EYE	8/17/2020			N/A	ALL	Removal
14853	LOSARTAN POTASSIUM 100 MG	8/11/2020			0.28000	ALL	Increase
02390	NICARDIPINE 20 MG CAPSULE	8/11/2020			1.84000	ALL	Increase
19370	OXYBUTYNIN 5 MG/5 ML SYRU	8/11/2020			0.03000	ALL	Increase
13880	OFLOXACIN 0.3% EAR DROPS	7/27/2020			3.27000	ALL	Increase
13802	MEPROBAMATE 400 MG TABLE	7/27/2020			N/A	ALL	Removal
26781	HYDROCORTISONE 10 MG TAB	7/13/2020			N/A	ALL	Removal

As you scroll through the listing (via Excel), you will notice that some lines have been highlighted in yellow (see below). This indicates that the drug's pricing was changed as a result of a MAC appeal. The highlighted row is the updated price that was the result of an appeal.

GCN	Generic Name	Appeal Granted	Eff Date	Old Price	New Price	NDC	Status
17670	ORPHENADRINE ER 100 MG TA	9/28/2020			N/A	ALL	Removal
32822	TIMOLOL 0.25% GFS GEL-SOLU	9/28/2020			N/A	ALL	Removal
24735	DEXMETHYLPHENIDATE ER 20	9/14/2020			N/A	ALL	Removal
21663	Mesalamine 800 Mg Tablet Dr	9/8/2020			9.13000	ALL	Increase
49100	ITRACONAZOLE 10 MG/ML SOL	8/31/2020			1.86000	ALL	Increase
32820	TIMOLOL MALEATE 0.25% EYE	8/17/2020			N/A	ALL	Removal
14853	LOSARTAN POTASSIUM 100 MG	8/11/2020			0.28000	ALL	Increase
02390	NICARDIPINE 20 MG CAPSULE	8/11/2020			1.84000	ALL	Increase
19370	OXYBUTYNIN 5 MG/5 ML SYRU	8/11/2020			0.03000	ALL	Increase
13880	OFLOXACIN 0.3% EAR DROPS	7/27/2020			3.27000	ALL	Increase
13802	MEPROBAMATE 400 MG TABLE	7/27/2020			N/A	ALL	Removal
26781	HYDROCORTISONE 10 MG TAB	7/13/2020			N/A	ALL	Removal

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



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

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

Pharmacy's process for filing a complaint

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

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

Enrollee complaint system

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

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

Kentucky Medicaid enrollee grievances
Medicaid enrollees can file a grievance at any time. Grievances can be submitted using either method provided below.

The enrollee can submit written grievances to:

- **Humana Healthy Horizons in Kentucky**
  P.O. Box 14546
  Lexington, KY 40512-4546
- Fax: **800-949-2961**

For verbal grievances, the enrollee can call Customer Service at **800-444-9137 (TTY: 711)**. We are available Monday – Friday, 7 a.m. – 7 p.m., Eastern time.

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

- Download a copy of the appeal form provided on **Humana.com** and either fax or mail it to Humana:

  Humana Healthy Horizons in Kentucky
  P.O. Box 14546
  Lexington, KY 40512-4546.

  Include your name, address, Humana ID number, reason for the appeal and any supporting documents.

- For expedited requests, you can fax to **855-336-6220**.

If the enrollee is unable to write an appeal, oral appeals are accepted. Medicaid enrollees may ask for an appeal by calling Customer Service at **800-477-6931 (TTY: 711)**. We are available Monday – Friday, 7 a.m. – 7 p.m., Eastern time.

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

To get an Appointment of Representative form, the enrollee can call Customer Care and ask for one or visit Humana's website at **Humana.com/medicaid/kentucky-medicaid/enrollee-support/documents-forms**. This form must be notarized.

If the appeal comes from someone besides the enrollee, we must receive the completed Appointment of Representative form, or other appropriate documentation such as Power of Attorney (POA), before we can review the appeal.

Resolution for grievance and appeals
We will investigate the enrollee's appeal and inform them of our decision. If the enrollee has questions concerning their grievance or appeal, direct him or her to the Member Handbook or contact Humana using the number on the back of their ID card.

Medicare's Limited Income NET Program (LINET)

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

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

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

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

Enrollment methods

Beneficiaries are enrolled in LINET in one of three ways:

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

Confirming eligibility

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

E1 Query

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

How to submit an LINET claim

Electronic pharmacy claims should be submitted with the following information:

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

What if my patient paid out of pocket for medications?

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

1. Complete the LINET direct member reimbursement form (DMR) located in the LINET "Welcome Letter" or found online at **apps.Humana.com/marketing/documents.asp?file=3792139**.
2. Attach a copy of receipt or printout from the pharmacy showing member payment.
3. Mail or fax completed form and receipt information to:

   Medicare's Limited Income NET Program
   P.O. Box 14310
   Lexington, KY 40512-14310
   Fax: **877-210-5592**

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