Humana Pharmacy Solutions

Pharmacy Manual

Humana Healthy Horizons in Florida

2024 Edition

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Introduction

Dear pharmacy:

Humana appreciates your role in delivering quality pharmacy services to our members. This manual pertains exclusively to Florida members enrolled with Humana Healthy Horizons® in Florida in a state-managed Medicaid plan and is an extension of your organization's agreement. It is intended to assist your staff in processing prescription claims for those members and outline Humana compliance program requirements for your organization.

Medicaid
Medicaid is a program run by federal and state governments that helps people with limited income pay for medical costs and, if qualified, long-term services and support, 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 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.

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

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

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

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

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

The Florida Medicaid program is implementing a new system through which Medicaid members will receive services. This program is called the Statewide Medicaid Managed Care Managed Medical Assistance program. The Managed Medical Assistance (MMA) program is composed of several types of managed care plans:

- Health maintenance organizations (HMOs)
- Provider service networks
- Children's Medical Services Network

Most Medicaid recipients must enroll in the MMA program.

The following individuals are **not** required to enroll (although they may enroll if they choose to):

- Medicaid recipients who have other creditable healthcare coverage, excluding Medicare
- People eligible for refugee assistance
- Medicaid recipients who are residents of a developmental disability center
- Medicaid recipients enrolled in the developmental disabilities home- and community-based services
- Waiver or Medicaid recipients waiting for waiver services

To be a participating provider, a pharmacy must be a Medicaid-registered provider who provides services in one of the following regions:

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

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

The Florida MMA program will focus on four key objectives to support successful implementation:

1. Preserving continuity of care
2. Requiring sufficient and accurate networks, under contract and taking patients, as well as allowing for an informed choice of plans for recipients and the ability to make appointments
3. Paying providers fully and promptly to preclude provider cash flow or payroll issues and to

give providers ample opportunity to learn and understand the plan's prior authorization procedures

4. Coordinating with the Choice Counseling call center and website operated by the agency's contracted enrollment broker

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 your pharmacy has difficulty registering, send an email to **PharmacyContracting@humana.com**. Please include the pharmacy name, NPI, pharmacy contact name and contact phone number.

We hope your pharmacy finds 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
800-865-8715
For refill-too-soon overrides and prior authorization status

Humana Customer Care
To obtain general Medicaid plan information:
800-477-6931 (TTY: 711)
Monday – Friday, 8 a.m. – 8 p.m., Eastern time

Humana Clinical Pharmacy Review (HCPR)
To submit prior authorization requests:
- Obtain forms at **Humana.com/PA** or submit requests electronically by visiting www.covermymeds.com/epa/humana**.**
- Submit request by fax to **877-486-2621.**
- Call HCPR at **800-555-CLIN (2546).**

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

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

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

SS&C Health
866-211-9459

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.

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

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

Rights and responsibilities

Pharmacy responsibilities

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

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

Member rights and responsibilities

Member rights

- A member has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.
- A member has the right to a prompt and reasonable response to questions and requests.
- A member has the right to know who is providing medical services and who is responsible for his or her care.
- A member has the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand.
- A member has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.
- A member has the right to know what rules and regulations apply to his or her conduct.

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

- A member has privacy rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This is a federal law that protects a member's health information. These rights are important for a member to know. The member can exercise these rights, ask questions about them and file a complaint if the member thinks his or her rights are being denied or his or her health information isn't being protected.
- A member has a right to receive a copy of the pharmacy's Notice of Privacy Practices that explains these rights as well as how the pharmacy uses and discloses their protected health information.
- A member has the right to receive information from his or her healthcare provider concerning diagnosis, planned course of treatment, alternatives, risks and prognosis.
- A member has the right to participate in decisions regarding his or her healthcare, including the right to refuse treatment except as otherwise provided by law.
- A member has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.
- A member who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the healthcare provider or healthcare facility accepts the Medicare assignment rate.
- A member has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
- A member has the right to receive a copy of a reasonably clear and understandable itemized bill and, upon request, to have the charges explained.
- A member has the right to request and receive a copy of his or her medical records, and request that they be amended or corrected.
- A member has the right to be furnished healthcare services in accordance with federal and state regulations.
- A member has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, disability or source of payment.
- A member has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- A member has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.
- A member has the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- The state must ensure that each member is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the health plan and its providers or the state agency treat the member.
- A member has the right to express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the healthcare provider or healthcare facility which served the member and to the appropriate state licensing agency.

Member responsibilities

- A member is responsible for providing to the healthcare provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications and other matters relating to his or her health.
- A member is responsible for reporting unexpected changes in his or her condition to the healthcare provider.

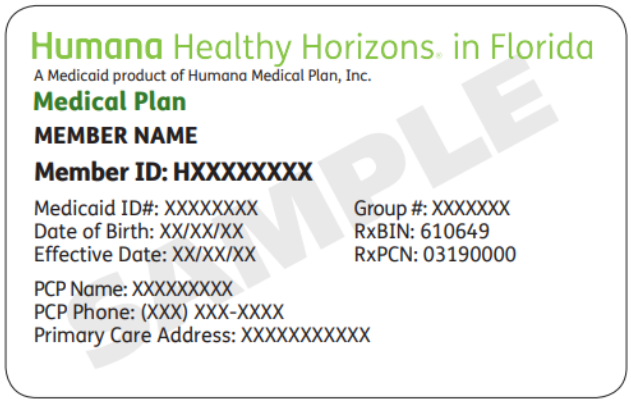
- A member is responsible for reporting to the healthcare provider whether he or she understands a possible course of action and what is expected of him or her.
- A member is responsible for following the treatment plan recommended by the healthcare provider.
- A member is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the healthcare provider or healthcare facility.
- A member is responsible for his or her actions if he or she refuses treatment or does not follow the healthcare provider's instructions.
- A member is responsible for ensuring the financial obligations of his or her healthcare are fulfilled as promptly as possible.
- A member is responsible for following healthcare facility rules and regulations affecting patient care and conduct.

Eligibility verification

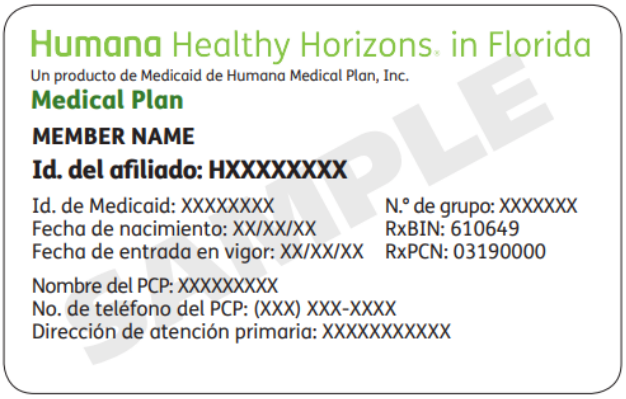
Humana member identification (ID) cards

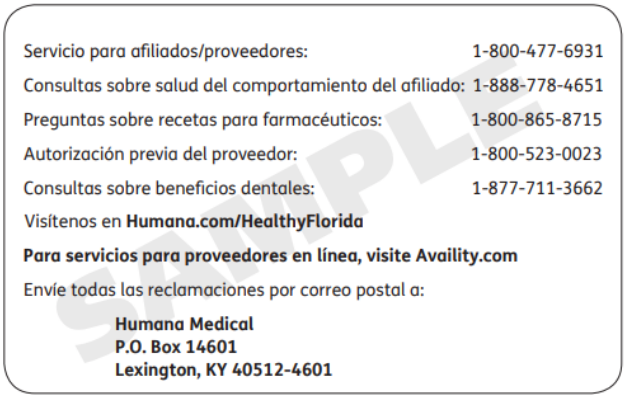
The following are examples of the ID cards pharmacy employees may see from Humana members.

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

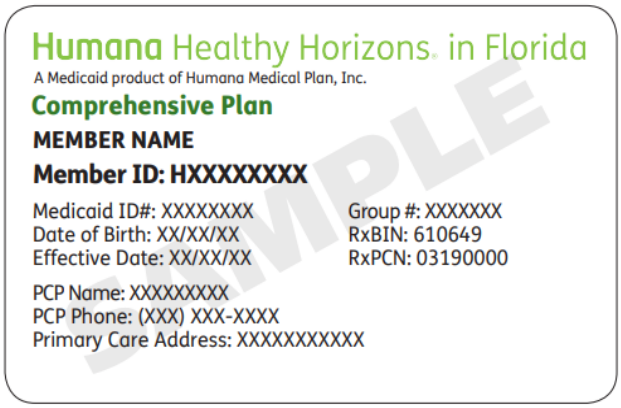


Card for a member with Humana Healthy Horizons in Florida (Spanish)

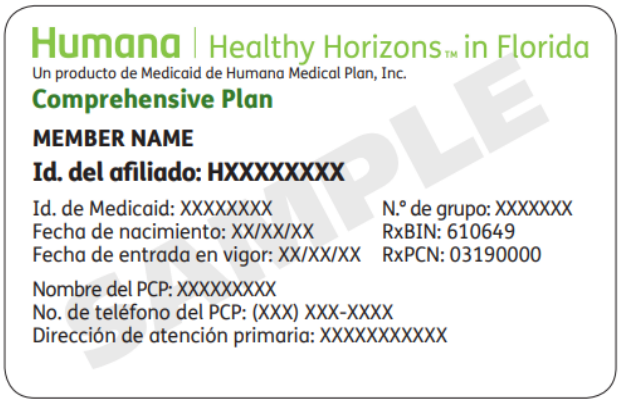


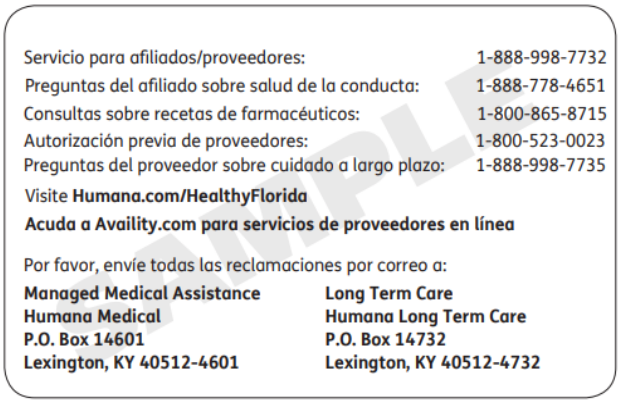


Card for a member with Florida Comprehensive (COMP) English



Card for a member with Florida Comprehensive (COMP) 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 provided 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 Humana's 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 members 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 Florida Medicaid program:
Each state has the option to cover medications specifically excluded under section 1927 (d)(2) of the Social Security Act.

Listed is some of the excluded drug coverage for the state of Florida:

- Drugs for which the manufacturer has not entered into a federal rebate agreement
- Drugs used for anorexia, weight loss or weight gain
- Drugs used to promote fertility
- Drugs used for cosmetic purposes or hair growth
- Drugs used for the symptomatic relief of cough or colds

Drug coverage

Drug Lists

Humana Healthy Horizons provides coverage of medically necessary medications, both prescription and select OTC medications, when prescribed by licensed providers in the state. Humana administers the AHCA's Preferred Drug List (PDL), which indicates the preferred and nonpreferred status of covered drugs on the member's benefit. The PDL also identifies drug utilization management requirements, such as prior authorization, quantity limits and step therapy.

PDLs are updated regularly. To view the current PDL for Florida Medicaid eligible members, go to **Humana.com/DrugLists**.

For the Florida MMA program, all drugs are limited to a 34-day supply with the exception of certain maintenance medications that are allowed a 100-day supply. For a list of the 100-day supply maintenance medications, visit www.ahca.myflorida.com/medicaid/prescribed_drug/information.shtml and select "100 Day Supply Maintenance Meds."

For the Florida MMA program, some services are excluded. This includes hemophilia products (prescriber factor replacement products) to members diagnosed with hemophilia through AHCA's hemophilia disease management program. For more information, visit www.ahca.myflorida.com/medicaid/policy_and_quality/quality/fee-for-service/hemophilia.shtml.

Utilization management (UM)

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

- **Prior authorization (PA):** Humana's Pharmacy and Therapeutics Committee reviews medications based on safety, efficacy and clinical benefit and may make additions or deletions to the list of drugs requiring PA.
- **Step therapy:** Plans that are subject to step therapy as a component of Humana's standard DUR program require the member to use 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. 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 the HCPR team.

Please note: Utilization management criteria can be found at www.ahca.myflorida.com/medicaid/prescribed_drug/drug_criteria.shtml.

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**. The request may be submitted electronically by visiting 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 the link here: **https://Apps.Humana.com/Marketing/Documents.asp?q=QChm%2fH%2b%2b1IiOcQ5lgbWwpA%3d%3d.**

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

72-hour emergency fill

Pharmacies can provide a 72-hour emergency fill for a drug requiring PA at the point of sale (POS) when the PA has not been completed and the pharmacist believes the patient's health would be in serious jeopardy if he or she does not receive the medication.

If a pharmacy receives a denied Humana claim for a PA edit when the PA has not been completed (and the pharmacist believes the patient's health would be jeopardized), initiate the "Emergency 72 Hour Fill" process by entering submission clarification code (SCC) = '65' and Day Supply = '3'. The pharmacist should then fill the prescription for a three-day supply.

The Humana member will have no copayment. Applicable fees will be applied when the remainder of the prescription is filled.

Beneficiaries eligible for the Low-Income Subsidy (LIS)

All members enrolled in a dual-demonstration plan should be eligible for, and have, Medicare's 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 paying for premiums, deductibles or cost shares related to their Medicare drug plans. Some people automatically qualify for this subsidy and do not need to apply; Medicare mails a letter to these individuals.

Sometimes a member believes he or she qualifies for the LIS and is paying an incorrect cost-sharing amount for their prescription. To address these situations, Humana has established a process that allows the member to provide the best-available evidence of 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 Medicaid card with the name and an eligibility date that falls between July 1 and Dec. 31 of the previous calendar year
- One of the following letters from the Social Security Administration (SSA) showing Extra Help status: "Important Information" letter, award letter, "Notice of Change" or "Notice of Action"
- A copy of a state document that confirms active Medicaid status and is dated July 1

through Dec. 31 of the previous calendar year

- A screen print from the state Medicaid system showing Medicaid status on a date that falls between July 1 and Dec. 31 of the previous calendar year
- A printout from the state electronic enrollment file or any other state documentation showing Medicaid status on a date that falls between July 1 and Dec. 31 of the previous calendar year
- A letter from SSA showing the individual receives Supplemental Security Income (SSI)
- A remittance from a medical or nursing facility showing Medicaid payment for a full calendar month of care for the individual between July 1 and Dec. 31 of the previous calendar year
- A copy of a state document that confirms Medicaid payment on behalf of the individual to a medical or nursing facility for a full calendar month between July 1 and Dec. 31 of the previous calendar year
- A screen print from the state Medicaid system showing the individual's institutional status based on at least a full calendar month's stay for Medicaid payment purposes. The stay must fall between July 1 and Dec. 31 of the previous calendar year.

Please note this proof must be confirmed by a pharmacist and must show the individual's eligibility took effect on or before the date the prescription was filled. If the member is not found in SS&C Health (formerly known as DST Pharmacy Solutions), the pharmacist may call the Humana pharmacy help desk at **800-865-8715** and select option **2** to add a recently enrolled Medicare Part D member to the SS&C Health claim-processing system using the quick-activation process. The LIS also can be added during the quick-activation process (if applicable).

To initiate a quick activation, the following information will be needed:

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

If the pharmacist can verify proof of Extra Help from the member, the member is showing eligible in SS&C Health and a call has been made to Humana to have the member's Medicare LIS status updated, the member must follow up by mailing the proof to Humana at the following address within 30 days:
Humana
P.O. Box 14168
Lexington, KY 40512-4168

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

If a member wishes to apply for the Medicare LIS, the member should call SSA at **800-772-1213**, Monday – Friday, 8 a.m. – 7 p.m.

Best-available evidence for LTC residents
Pharmacists who have evidence that the cost-share responsibility of a Humana Medicare-Medicaid member residing in an LTC facility should be different from that shown on adjudicated claims may provide applicable evidence to Humana regarding the member's LIS status.

Inquiries regarding member LIS levels may be directed to Humana at **800-281-6918**. Pharmacists who have evidence that the member cost share on claims for a Medicare-Medicaid member is incorrect and should reflect a different LIS level are asked to call this number as well.

General claims procedures

Submitting pharmacy claims

All participating pharmacies must comply with the National Council for Prescription Drug Programs (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
Humana Healthy Horizons in Florida	610649	03190000

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 POS 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 is also the appropriate value for "pharmacy dispensing," when applicable, such as over the counter, 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

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.

The member's address is not a required element for the claim to process unless the medication is shipped. The member's address should be added to where the medication is 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).

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
- Subrogation claims, which have 36 months for submission
- Medicaid claims, which have 480 days for submission

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.

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 recognizes the need for 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/Provider/Pharmacy-Resources**. Look for the "Pharmacy manuals and forms" link. The payer sheet can be found at the following link:

- Medicaid plans: Use commercial/Medicaid D.0 payer sheet (under the heading "Payer sheets") **Humana.com/Provider/Pharmacy-Resources/Manuals-Forms**

Prescriber National Provider Identifier (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 POS 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 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	Nonmatched 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, 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.	Type 2 NPI submitted—Type 1 NPI required (for Humana Medical Plan)	N/A

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

Dispense-as-written (DAW) codes

Humana recognizes the NCPDP standard 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.

Florida Medicaid MMA 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 PDL to identify the AHCA preferred brand drugs.

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 implements concurrent reviews or DUR 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 they may include, but are not limited to, the following:

DUR type	Pharmacy information	Example
Drug–drug interactions	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 patient's age.	Adderall for age younger than 6
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 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.	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 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	This drug interacts with 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**	Cumulative morphine equivalent dose exceeds limits	HD: High dose	M0: Prescriber consulted DE: Dosing evaluation DP: Dosage evaluated	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 4K: Prescriber specialty exemption – oncology or non-hospice palliative care 4L: Prescriber specialty exemption – hospice
AG: Day supply limitation for product/ service Florida Statute 456.44(5)(a) Prescription Supply Limits	Days' supply limitation for product/service	MX: Excessive duration	M0: Prescriber consulted	3A: Will only override DEA Class II, short acting drug, for less than eight days' supply 4B: Dispensed, palliative care 4D: Filled, cancer treatment 4C: Dispensed, hospice 4E: Dispensed, chronic pain 4K: Prescriber specialty exemption oncology or non-hospice palliative care 4L: Prescriber specialty exemption - hospice

NCPDP error code	NCPDP description	Reason for service	Professional service	Result of service
AG: Exceeds opioid initial fill limits 925: Initial fill days' supply exceeds limit	Days' supply limitation for product/service	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 or non-hospice palliative care 4L: Prescriber specialty exemption - hospice

** 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 the Centers for Medicare & Medicaid Services (CMS), pharmacies must utilize an SCC (42Ø-DK) field with a value of 20 or the most current NCPDP standard for identification of 340B medications. For Florida Medicaid providers: The value of 20 along with a value of nine should be used for the SCC (42Ø-DK) field. Pharmacies may be required to complete a contract addendum with Humana to be eligible to dispense 340B medications under the agreement with Humana.

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 Florida 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 will also state: "Validation of active DEA schedule required. If validated, submit applicable SCC."

Clarification of federal requirements – Schedule II drugs

Humana would like to remind pharmacies of the importance of monitoring pharmacy claims for accuracy and complying with federal and state laws, rules and regulations. This is especially important when filling prescriptions and submitting claims for refills and partial fills

of Schedule II drugs. In accordance with the 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, a pharmacy 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 opioids and other controlled substances, Humana employs several POS edits.

Please visit the following link for information on current guidance on edits and overrides: **Humana.com/Provider/Pharmacy-Resources/Manuals-Forms**. See the “Pharmacy resources” tab under “Manuals and forms.”

Controlled substance limitations for Florida Medicaid MMA

CII-CV edits

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

Limitations on controlled substance prescribing (Florida Statute 456.44(5)(a) Prescription Supply Limits)

In accordance with this legislation “Limitations on controlled substances prescribing,” as enacted by the state of Florida and guidance issued by AHCA, regulations apply to Medicaid members when opioid pain medications are prescribed for acute pain and days’ supply is limited as follows:

- Schedule II: limit to no more than a three-day supply for acute pain
- Schedule III, IV and V: limit to no more than a 14-day supply

For more information, visit **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 when it is compromised due to excessive use of prescription drugs. When Humana receives a referral on a member with an allegation of potential prescription drug misuse, 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 the lock-in program 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 misuse within the last 365 days.
- The member violated a pain management agreement/contract with a 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.

The member will be restricted to one retail pharmacy and, if needed, one specialty pharmacy while in the program.

If the member chooses to use another pharmacy, the member must complete and submit the request on the Request for Reconsideration form attached to the notification letter by Humana.

If your pharmacy or the member has questions, contact Humana in one of the following ways:

- Call **855-330-8054**, Monday – Friday, 8 a.m. – 5:30 p.m., Eastern time. After hours, please leave a voicemail with the member name, member ID number, case number, contact phone number and a detailed description of the request.
- Fax**: 502-996-8184**
- Email**: CPORM@humana.com**

Continuity of care

Continuity of care policy

This policy applies to prescribed drugs that are subject to certain limitations, such as drugs not listed on the PDL and drugs requiring prior authorization, step therapy or quantity limit. Continuation of care does not cover the generic versions of medications that are considered the plan's preferred brands (as indicated by the Florida AHCA). 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 for each program 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 days allowed for transition
FL MMA	**60**	**60**

Long-term care (LTC)

LTC pharmacy information

Humana recognizes the unique operational model and services provided by the pharmacies in 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 members in institutional settings. While most of the needs of LTC pharmacies 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 POS. 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. 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.
- 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

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 members).
- 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 and 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
- Calculating the days' supply incorrectly
- Using a 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 and 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 to verify claims information. LTC pharmacies are required to have signed prescribers' orders available for review during 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 containing 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 LTC 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 Medicaid 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 works with the pharmacy to ensure the deficiencies are remediated in a timely manner and that there is a sufficient process and policy in place to prevent recurrence.

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

In accordance with Florida Statute § 409.912(16) and AHCA guidance, a psychotropic consent form must be on file with the dispensing pharmacy for any pediatric patient (younger than 13). A parent or legal guardian must complete the consent form. The referring physician must document the consent of a parent or guardian in the child's medical record and provide the pharmacy with a signed attestation of this consent with each new prescription. Humana Pharmacy Solutions, which provides pharmacy benefit management services to the Humana Medical Plan, intends to cooperate with Florida Medicaid by assisting pharmacies in complying with this law.

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

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

Once the pharmacist confirms the consent form accompanies the prescription, the following PPS overrides can be used:

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

Humana Pharmacy Solutions' audit program may ask the pharmacy to provide a copy of the informed consent form to ensure network pharmacies are receiving and retaining the form for their records. If pharmacies do not provide the informed consent form or the form provided is not complete, it may result in a full claim reversal and financial recovery.

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**). This includes FWA committed by Humana employees, contracted pharmacy providers or those supporting the pharmacy providers' contractual obligations to Humana or its 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, reported or suspected noncompliance or fraudulent activity.
2. Take additional action as necessary.
3. Report the matter when appropriate to the impacted regulatory, federal or state agencies for further action and investigation.

Humana is an administrator of Medicaid products that have a pharmacy benefit. All organizations supporting any products Humana administers are required to have a comprehensive plan to detect, correct and prevent 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 Humana's plan administration
- 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
Your pharmacy may use its own material to meet the FWA training requirement or adopt another organization's training material on the topic. However, Humana also offers content on this topic in the following documents:

Humana Compliance Policy for Contracted Healthcare Providers and Third Parties:
https://Apps.Humana.com/Marketing/Documents.asp?q=kaOUjtwlbGCAf367eB0Z7Q%3d%3d

Humana Ethics Every Day for Contracted Healthcare Providers and Third Parties:
https://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, your pharmacy may use these documents to supplement or integrate within your 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 applicable government agencies overseeing Medicaid programs reserve the right to conduct oversight of 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

All pharmacy employees and subcontractors who 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 matters 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, seven days a week. Callers may remain anonymous. Humana takes great efforts to keep information confidential.

Those reporting suspected activities are protected from retaliation by 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 of the phone methods above are available 24 hours a day and allow callers to remain anonymous. Humana requests that those who report ethics concerns and desire to remain anonymous 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: 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 any 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 law enforcement agencies or a state agency that has contracted Humana to administer a Medicaid product

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 found 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.

Depending on the specifics of a case, a state agency and/or CMS 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 a government agency.

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 or facilities, such as on an intranet site and/or via email 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 (i.e., remotely or within a home).

- Reinforce Humana's policy of nonintimidation and non-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 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 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 may be used. A copy can be accessed, printed and downloaded by visiting the link here: **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.
- Remove any person or party identified on an exclusion list above from any work, or access to information or data, related directly or indirectly to Humana's support of a state-administered program, such as Medicaid, or any federal healthcare program, such as Medicare.
- 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, report findings to Humana's SIU 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 employed or contracted by these non-Humana organizations 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 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 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.

- **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 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:
    - Humana may need to notify the Florida AHCA of an entity with a location outside of the United States or a U.S. territory that receives, processes, transfers or stores in oral, written or electronic form protected health information of a Medicaid member for an individual who also is eligible for Medicare.
    - AHCA may limit or prohibit plan member information from being stored, accessed or shared offshore
- **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 (who was trained, when, how and with what materials).
- **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, 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 it contracts with to support obligations to Humana.
- **Assurance:** Complying with Humana requests to provide assurance related to the pharmacy's compliance program.

The above are examples of 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 the link here:
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 Medicaid products can be found in Humana's compliance policy at **https://Apps.Humana.com/Marketing/Documents.asp?q=kaOUjtwlbGCAf367eB0Z7Q%3d%3d.** For training questions that are not addressed in this manual, please send an email to **HumanaPharmacyCompliance@humana.com.**

Compliance training and assurance expectations, attestation requirements
Humana reserves the right to request documentation and/or a certification that certain compliance program requirements and training are in place to meet government contract obligations. When an attestation is required depends on multiple factors, such as government contract expectations and corresponding Humana compliance program oversight activities.

For example, Humana requires an annual, organization-level attestation from network pharmacies supporting Humana Healthy Horizons in Florida to assure processes are in place to:

- Conduct Medicaid topic-specific training of those employed or contracted to perform a function in support of the plan
- Cultural competency
- Health, safety and welfare of plan members
- Medicaid pharmacy orientation and provider training

Training materials on the above-listed topics are available at **Humana.com/Provider/Pharmacy-Resources/Manuals-Forms**. Instructions on how to provide confirmation of adherence to the above training requirements, when necessary and applicable, are listed in the attestation form found on the above website.

Since compliance education material is refreshed at least each calendar year to assist pharmacies in meeting these requirements, pharmacies are required to:

- Complete the assigned attestation annually.
- Submit the attestation to Humana within 30 days of notification each calendar year.

Additional, required compliance program education and training
Network pharmacies supporting Humana Healthy Horizons in Florida also must educate those employed or contracted to perform a function in support of the plan in multiple ways, as noted below:

- Providing the following to those contracted or employed to support Humana:
  - Compliance policy or policies that outline compliance program requirements
  - Standards of conduct

  Note: 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.

- Conducting training on understanding and addressing FWA via material developed or adopted by the pharmacy

  Note: In the case of non-employees, pharmacies may collect attestations from them (in lieu of conducting their FWA training) to confirm they are receiving FWA training elsewhere.

Frequency and timing of the above is outlined in Humana's compliance policy, which is available at **Humana.com/Provider/Pharmacy-Resources/Manuals-Forms.**

Note: Humana will notify a pharmacy if an organization-level attestation must be submitted to certify compliance with these additional requirements.
Additional guidance related to compliance program requirements are listed on Humana's website in the compliance requirements FAQ for pharmacies at the link here: **https://Apps.Humana.com/Marketing/Documents.asp?q=uhZ%2bjqKP1UP%2bQ1pmcyu86Q%3d%3d.**

Please note: As requirements of government contracts, regulations and/or Humana's compliance program 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
Required compliance information instructions, located at **https://Apps.Humana.com/Marketing/Documents.asp?q=nR%2fWvra3yhHlXLdxGzCwGg%3d%3d,** 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 to 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. 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 coverage that meets or exceeds a minimum requirement of $1 million in aggregate
- Pharmacy's NCPDP number
- Active Florida Medicaid provider ID

Pharmacies that do not meet Humana's required standards, which include 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, 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 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 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 to 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 are prohibited from having any financial relationship related 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
- 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 or parties from supporting Humana business with a Medicaid component. Humana reserves the right to request information and data to ascertain ongoing compliance with these provisions.

Complaint system

Pharmacy's pricing dispute process

Network pharmacies have the right to submit a request to appeal, investigate or dispute the MAC reimbursement amount to Humana within 90 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 Pharmacist Portal.

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

https://Apps.Humana.com/Marketing/Documents.asp?file=2661815
*Note: 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. The following must be included in the request:

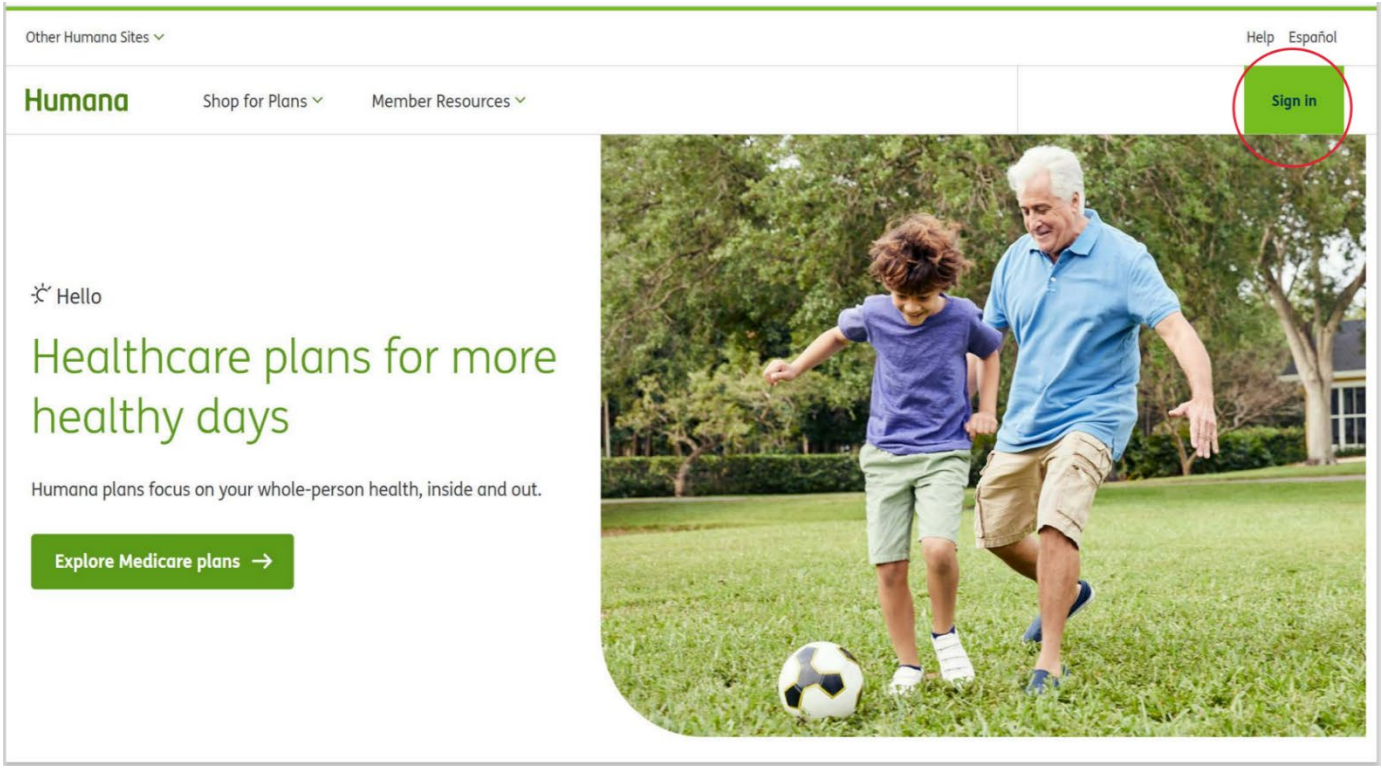
- Pharmacy name
- Pharmacy address
- Pharmacy NCPDP
- PCN
- Rx number
- Drug name
- Drug strength
- Drug NDC
- Date of initial fill
- Quantity of fill
- Relevant documentation that supports the MAC is below the cost available to the pharmacy
- Any other supporting documentation as needed

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.

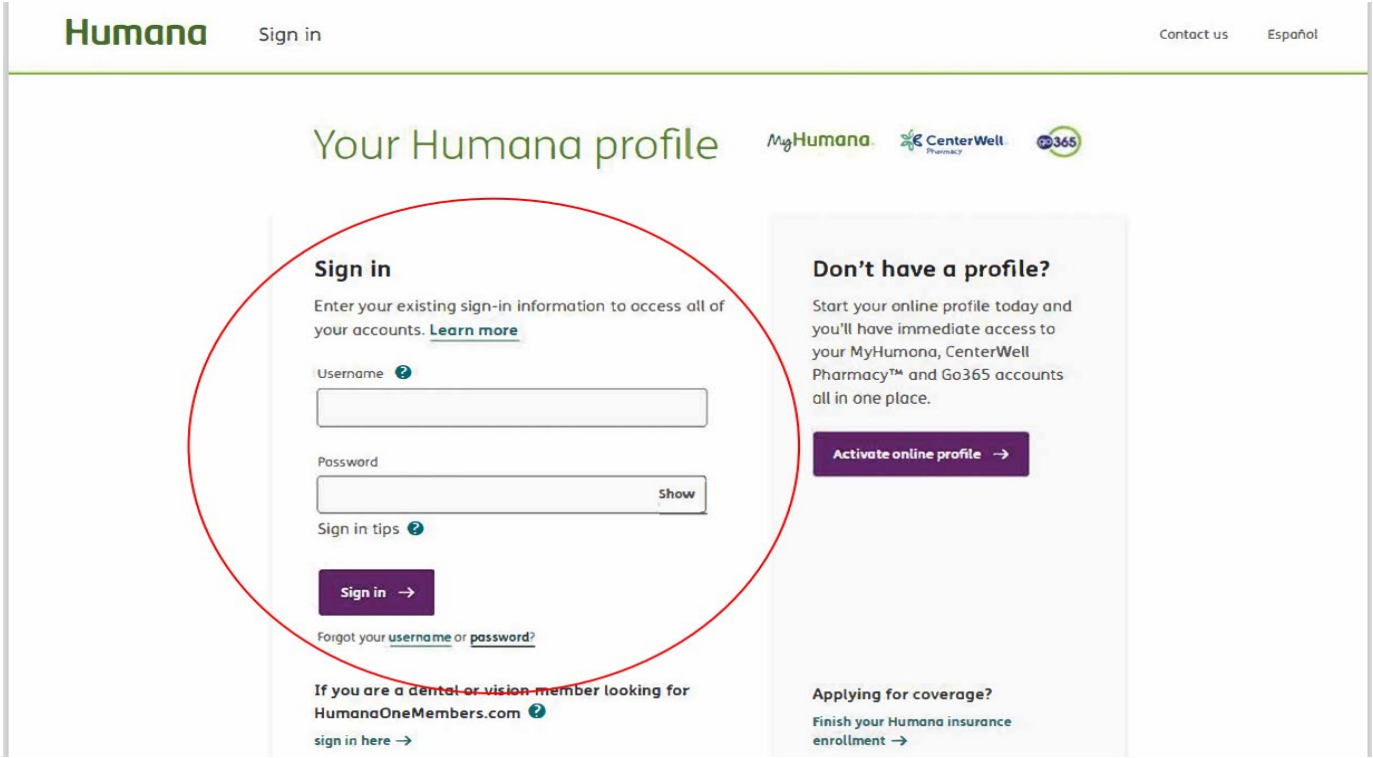
Please note: Timelines may vary state to state and are subject to change.

Pharmacy maximum allowable cost (MAC) list location

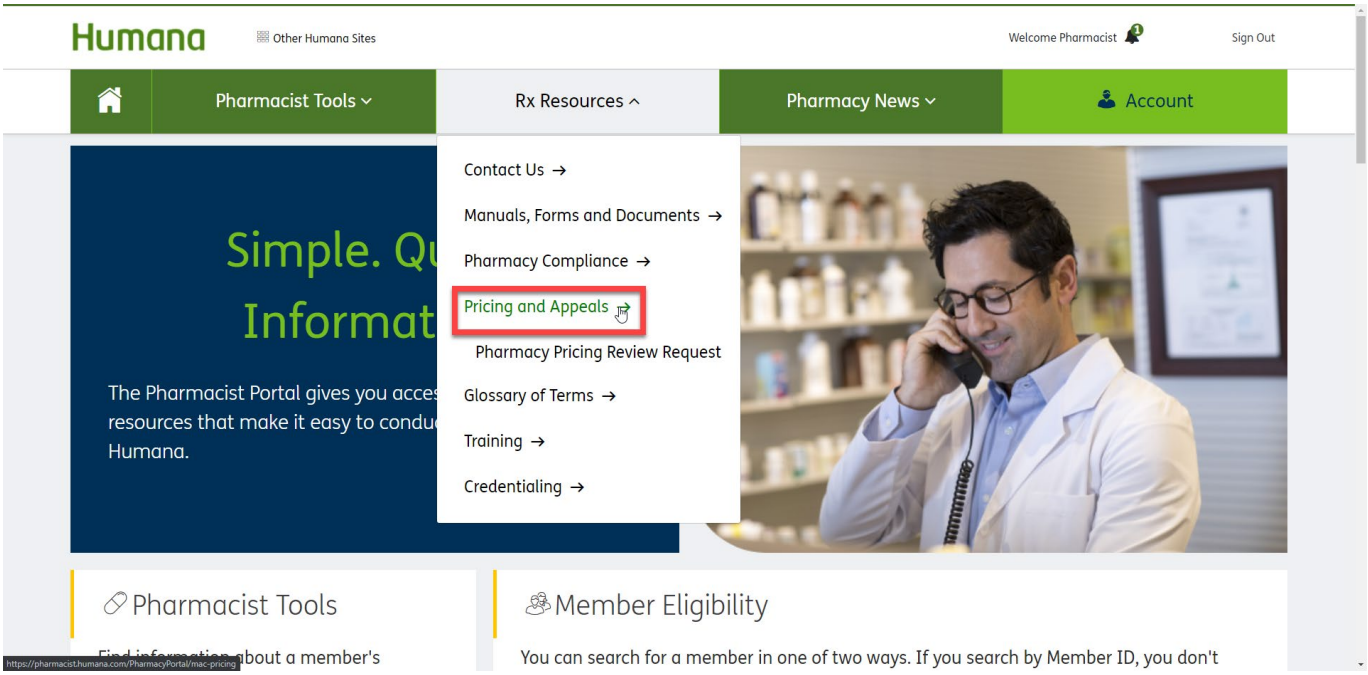
When network pharmacies need to locate the current MAC list, they can follow the steps below at **Humana.com**. They will see the screen below. Select the "Sign in" button at the top right corner of the screen.



The pharmacy will then enter the username and password it set up when 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.

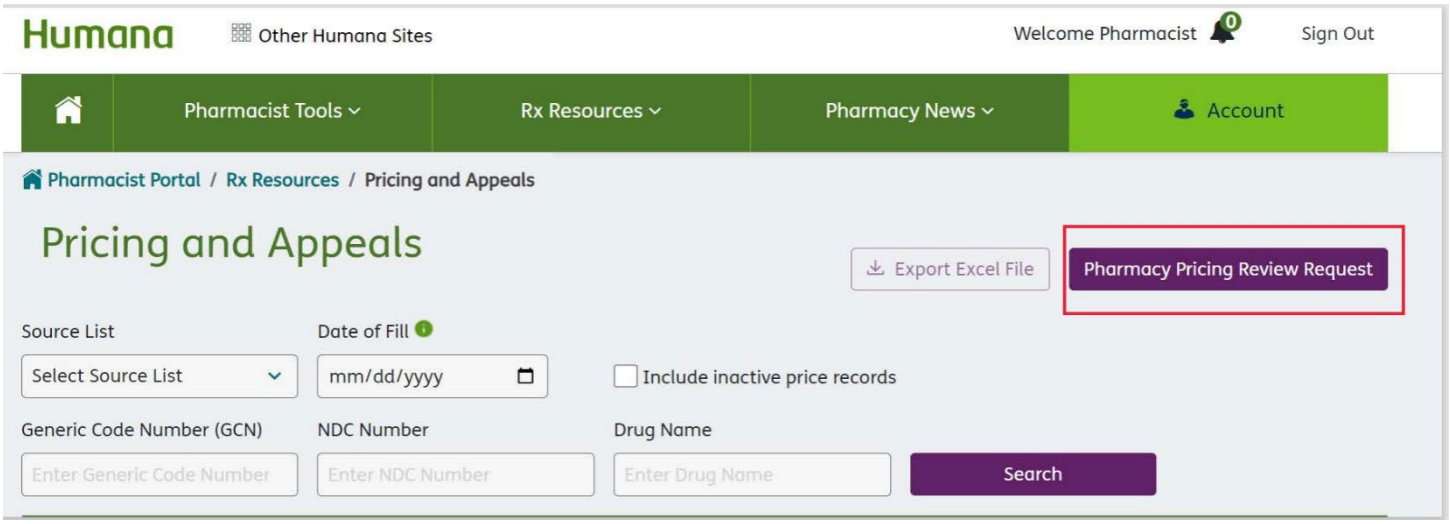


For the current MAC list applicable to the NPI the pharmacy used to register its account, which includes recent updates, select the "Pricing and Appeals" link:



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 your pharmacy chooses will show as download only or 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 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 **866-211-9459** for questions or complaints 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 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**.

Member complaint system

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

Member grievances
Medicaid members can file a grievance at any time. Grievances can be submitted using any of the methods provided below:

- The member can submit written grievances via mail to:
  Humana Healthy Horizons in Florida
  Grievance and Appeal Department
  P.O. Box 14546
  Lexington, KY 40512-4546
- Fax: **800-949-2961**
- For verbal grievances, the member can call Customer Service at **800-477-6931 (TTY: 711)**. Humana is available Monday – Friday, 8 a.m. – 8 p.m., Eastern time.

Member appeals
The member, prescriber or member representative may submit an appeal in writing within 60 calendar days of the date of the denial notice. 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 at:
  Humana Healthy Horizons in Florida
  Grievance and Appeal Department
  P.O. Box 14546
  Lexington, KY 40512-4546
- Fax: **800-949-2961**

Please include the member's name, address, Humana ID number, reason for the appeal and any supporting documents.

If the member is requesting an expedited appeal or is unable to write an appeal, oral appeals are accepted. Medicaid members may ask for an appeal by calling Customer Service at **800-477-6931 (TTY: 711)**. Humana is available Monday – Friday, 8 a.m. – 8 p.m., Eastern time.

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

To obtain an Appointment of Representative form, the member can call Customer Care and ask for one, or the member can visit Humana's website at **Humana.com/Medicaid/Florida-Medicaid/Member-Support/Documents-Forms**.

If the appeal comes from someone besides the member, Humana must receive the completed Appointment of Representative form or other appropriate documentation, such as power of attorney, before Humana can review the appeal.

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