Humana Pharmacy Solutions

Pharmacy Manual

Illinois Dual-Demonstration Medicaid

2025 Edition

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Table of contents

Introduction

Dear pharmacy:

Humana appreciates your role in delivering quality pharmacy services to our members. This manual pertains exclusively to Illinois members enrolled with Humana 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 the federal government and state governments that helps people with limited income pay for medical costs and, if qualified, long-term services and supports, such as nursing homes and home- and community-based 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.

Medicare
Medicare is the federal health insurance program for:
- People 65 or older
- Some people under 65 with certain disabilities
- People with end-stage renal disease (kidney failure)

Current Medicaid Humana program available:

Humana Gold Plus® Integrated Medicare-Medicaid is a Medicare-Medicaid plan. A Medicare-Medicaid plan is an organization made up of physicians, hospitals, pharmacies, providers of long-term services and supports, and other providers. It also has care coordinators and care teams to help patients manage all their providers and services. They all work together to provide the care the patient needs.

Humana Gold Plus Integrated was approved by the state of Illinois and the Centers for Medicare & Medicaid Services (CMS) to provide the patient services as part of the Medicare-Medicaid Alignment Initiative (MMAI).

MMAI is a demonstration program jointly run by Illinois and the federal government to provide better healthcare for people who have both Medicare and Medicaid. Under this demonstration, the state and federal governments want to test new ways to improve how patients get their Medicare and Medicaid healthcare services.

Processing requirements may vary by plan, and online claims adjudication and messaging reflect the most current benefits. Please refer to Humana's National Council for Prescription Drug Programs (NCPDP) Version D.0 commercial/Medicaid and Medicare program payer sheets for the required fields to submit prescription claims electronically to Humana. In your Pharmacy Provider Agreement, you will find network participation requirements.

The **Humana Pharmacist Portal** provides a secure online resource where pharmacists can:
- Obtain a current list of generic maximum allowable cost (MAC) pricing
- Send email inquiries directly to Humana
- View news bulletins and link to news alerts
- 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 prescription drug requiring prior authorization for a member

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

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

Sincerely,

The Humana Pharmacy Network team

Contact information

Pharmacy help desk
800-865-8715
24 hours a day, 7 days a week
For refill-too-soon overrides and prior authorization status

Humana Medicare Customer Care
800-281-6918 (TTY: 711)
Daily, 8 a.m. – 8 p.m.

Humana Medicaid Customer Care
To obtain general Medicaid plan information:
800-787-3311 (TTY: 711)
Monday – Friday, 8 a.m. – 8 p.m., Central time
Please note that our automated phone system may answer your call after hours, during weekends and on holidays. Please leave your name and telephone number and Humana will call you back by the end of the next business day. The call is free. Visit **MyHumana.com** for 24-hour access to information, such as claims history, eligibility and the Humana Drug List. The member also can use the physician finder and receive health news and information.

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 requests 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 number: **866-449-5380**
Phone number: **888-204-8349**

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
Provider.Humana.com/pharmacy-resources/manuals-forms

Pharmacy enrollment requirements

Pharmacies must be enrolled as both Medicare and Medicaid providers and in the Healthcare and Family Services (HFS) Medical Program to provide covered services under the Illinois MMAI plan.

To comply with federal regulation 42 CFR Part 455 Subpart E – Provider Screening and Enrollment, Illinois has an electronic provider enrollment system. The web-based system is known as Illinois Medicaid Program Advanced Cloud Technology (IMPACT).

The following information is required for enrollment in IMPACT:

- NPI
- Certified W-9 on file with the comptroller
- Renewal of professional certifications or licensures
- Valid primary email
- Internet browser equivalent to Internet Explorer 8 or a more recent browser

Pharmacy providers can enroll online at impact.illinois.gov.

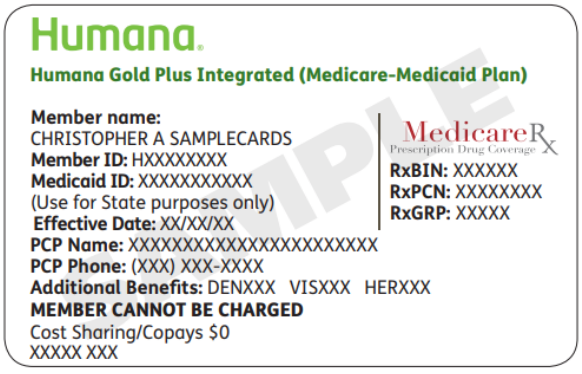
For additional information, please visit https://hfs.illinois.gov/impact/aboutimpact.html or email IMPACT.help@illinois.gov with questions.

Eligibility verification

Humana member ID cards

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

Card for a member with Individual Medicare Advantage prescription drug (MAPD) plan IL MMAI health maintenance organization (HMO)



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

Cardholder ID

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

- For Medicare-Medicaid dual-eligible members who do not have their Humana member ID numbers, pharmacies may submit an E1 query.

Coordination of benefits

(for Medicaid programs only)

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

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

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

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

Listed below is some of the excluded drug coverage for the state of Illinois:

- Drugs when used for anorexia, weight loss or weight gain
- Drugs when used to promote fertility
- Drugs when used for cosmetic purposes or hair growth

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

Drug coverage

Drug Lists

Humana manages numerous Drug Lists for the many prescription benefit plans it offers. Pharmacies can view details of these Drug Lists at **Humana.com/DrugLists**.

Drug Lists are developed and maintained by Humana's Pharmacy and Therapeutics Committee, which consists of physicians and pharmacists. Members' drug coverage varies by plan. Certain drugs may have coverage limitations based on duration or dosage or may require preapproval. Humana may add drugs to the list, change drugs on the list or remove drugs from the list at any time, which could affect the amount the member pays for prescription drugs.

For information about the prescription medicine covered for Medicare-Medicaid dual-eligible members in Illinois, go to the Prescription Drug Guide at
Humana.com/Medicaid/Illinois-Gold-Plus-Integrated/Coverage/Pharmacy.

Utilization Management

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

- **Prior authorization:** 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 prior authorization.
- **Step therapy:** Plans that are subject to step therapy as a component of Humana's standard drug utilization review (DUR) program require the member to utilize medications commonly considered first-line before using medications considered second-line 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 HCPR.

Exceptions to plan coverage for Medicare members

Medicare members can ask Humana to make an exception to its coverage rules; however, the request must include a supporting statement from the member's prescriber. Members may submit several types of exception requests, including:

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

An expedited decision should be requested if the member's health would be jeopardized by waiting the standard 72 hours for a decision.

Coverage determinations/exceptions

Members, prescribers and appointed or authorized representatives can request an exception or an expedited exception by submitting the request electronically by going to www.covermymeds.com/epa/humana**.**

Exception requests can include the following:

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

Please note:

- Humana does not accept prior authorization requests directly from pharmacies. The prescriber must initiate the request.
- Members can ask Humana to make an exception to its coverage rules; however, the request must include a supporting statement from the member's prescriber.

The coverage determination decision will be made within 72 hours after complete information is received from the prescriber. An expedited decision should be requested if the member's health would be jeopardized by waiting the standard 72 hours for a decision. The request will be reviewed within 24 hours.

The prescriber quick reference guide can be found at **https://assets.humana.com/is/content/humana/Prescriber Quick Reference Guidepdf.**

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

Beneficiaries eligible for the Low-Income Subsidy

All members enrolled in a dual-demonstration plan should be eligible for and have Medicare's Low-Income Subsidy (LIS). Medicare's LIS, also known as "Extra Help," assists people who have limited income and resources with their prescription drug costs. People who qualify for this program receive assistance 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.

General claims procedures

Submitting pharmacy claims

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

The pharmacy may not submit test claims. Test claims are claim 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
Medicare-Medicaid dual eligible	015581	03200000

Prescription origin code requirements

Humana requires the prescription origin code (NCPDP Telecommunications Standard D.0 field 419-DJ) to be included on all prescriptions. All claims submitted will be denied at the point of sale (POS) if this code is not included. If the pharmacist is unable to include this code within the pharmacy's practice management system, the pharmacist should contact the pharmacy's current software vendor for assistance. SS&C Health is not able to override this edit.

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

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

Fill number

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

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

Sales tax

The sales tax should be submitted as a value equal to the percentage of the usual and customary

charge that equates to the applicable sales tax rate. The pharmacist must enter a tax amount in NCPDP field 482-GE. If this field is left blank, no sales tax will be calculated.

The member's address is not a required element for the claim to process unless the medication is being shipped. The member's address should be added to where the medication is being shipped. The pharmacy should enter the following information in the appropriate NCPDP field for the shipping tax to apply: Pharmacy Service type is 03 Home Infusion Therapy (HIT), 05 (LTC), 6 Mail Order (MO) or 8 (Specialty). If you have questions about sales tax, please email **PharmacyPricingReview@humana.com**.

Timely submission of claims

Claims must be submitted on the date of service (DOS). Notwithstanding the foregoing, pharmacies have at least 30, but not more than 90, days from the DOS to submit claims for long-term care (LTC) pharmacy services. Additionally, there are special circumstances under which a pharmacy can 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
- POS claims, which have 480 days from DOS for submission
- POS claim reversals (B2 transactions), which have 480 days for submission
- POS claim adjustments (B3 transactions), which have 480 days for submission

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

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

Please 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.S0S(b)(20), LTC pharmacy claims must be submitted for eligible persons no later than 90 days from the DOS. Humana recognizes the need to make exceptions when claims cannot be submitted in this time frame. For those 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://assets.humana.com/is/content/humana/LTC Appeal Form for Untimely Filingpdf**.

Humana-specific SS&C Health payer sheets

Pharmacists can find applicable Medicaid and Medicare pharmacy payer sheets at **Provider.Humana.com/pharmacy-resources/manuals-forms**.

Prescriber National Provider Identifier 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." The Illinois Department of Healthcare and Family Services mandates all submitted prescribers on claims also must be enrolled in the IMPACT system. This requirement applies to any drug not covered under Medicare Part D and any drug in Tier 3 or Tier 4. For additional information regarding prescriber enrollment

requirements, please visit www.illinois.gov/hfs/impact/pages/providerenrollment.aspx.

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

NCPDP error code	NCPDP error code description	Free-form messaging	Applicable SCC
56	Non-matched prescriber ID	Prescriber ID submitted not found. If validated, submit applicable SCC.	42
42	Plan's prescriber database indicates the prescriber ID submitted is inactive or is not found or is expired.	Prescriber ID not active. If validated, submit applicable SCC.	42
43	Plan's prescriber database indicates the associated 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) and claim not covered due to Medicare Part D active valid prescriber NPI requirement (for Part D claims).	N/A
889	Prescriber not enrolled in state Medicaid program.	Use PAC 911911 for disaster claims.	N/A

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

Humana recognizes the NCPDP standard dispense-as-written (DAW) codes. Prescriptions with a DAW request must designate the DAW product selection code (NCPDP field 408-D8) on the submitted claim. For a prescription submitted with a DAW code other than zero, the reason for the selected code must be documented and must comply with all applicable laws, rules and regulations. Humana may prefer a brand-name drug. If a brand-name drug is on the formulary and the generic is not, the pharmacy may use DAW 9 when submitting a claim.

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 safety edits

Humana implements concurrent review 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 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–age interaction	Identifies safety risk related to use of specific medication for patient's age	Adderall for age younger than 6
Drug–disease interaction	Identifies safety risk when an active medication is contraindicated for a patient's disease state. The disease may be inferred or identified via medical claims.	Amphetamines – cardiomyopathy
Drug–gender interaction	Alert of safety risk related to use of specific medication for reported gender **Note:** Gender edits apply only for commercial and Medicaid when applicable.	Makena

Maximum dose	Identifies safety risk when dosage exceeds First Databank (FDB) maximum adult daily dose (ratio of exceeding FDB maximum dosing is specific to the medication)	Digoxin daily dose greater than 500 mcg
MED* high dose	Identifies patients at greater risk of overdose or inappropriate opioid utilization (dosing greater than 90 mg MED per day will trigger this error code)	MS Contin 30 mg twice daily plus Percocet 10/325 two tablets every four 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 drug utilization review

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. The 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-drug interaction	DE: Dosing evaluation M0: Prescriber consulted MP: Patient will be monitored PE: Patient education/instruction 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: Dispensed, palliative care 4D: Dispensed, 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 education/instruction P0: Patient consulted R0: Pharmacist	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

			consulted other source SW: Literature search/review	4B: Dispensed, palliative care 4D: Dispensed, cancer treatment
88: DUR reject error	This drug may duplicate current patient therapy	TD: Therapeutic duplication	M0: Prescriber consulted PE: Patient education/instruction 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: Dispensed, palliative care 4D: Dispensed, cancer treatment
88: DUR reject error 922: Morphine equivalent dose exceeds limit*	Limits cumulative morphine milligram equivalent (MME) daily dosage across all opioid prescriptions to a lower threshold between 90 MME and 200 MME	HD: High dose	M0: Prescriber consulted DE: Dosing evaluation DP: Dosage evaluated	1B: Filled prescription as is 1D: Filled with different directions 1F: Filled with different quantity 1G: Filled with prescriber approval 4A: Prescribed with acknowledgments 4B: Dispensed, palliative care 4D: Dispensed, cancer treatment 4K: Prescriber specialty exemption-oncology or non-hospice palliative care 4L: Prescriber specialty exemption-hospice
88: DUR reject error 922: Morphine equivalent dose exceeds limit*	Limits cumulative MME daily dosage across all opioid prescriptions to an upper threshold of greater than 200 MME	ER: Overuse	M0: Prescriber consulted	4B: Dispensed, palliative care 4L: Prescriber specialty exemption-hospice
88: DUR reject error	Concurrent opioid and benzodiazepine use	AT: Additive toxicity	DE: Dosing evaluation M0: Prescriber consulted MP: Patient will be monitored PE: Patient education/instruction P0: Patient consulted R0: Pharmacist consulted other source	1F: Filled with different quantity 1G: Filled with prescriber approval 4A: Prescribed with acknowledgments 4B: Dispensed, palliative care 4D: Dispensed, cancer treatment

			SW: Literature search/review	
AG: Exceeds opioid initial fill limits 925: Initial fill days' supply exceeds limit	Opioid naïve – seven days' supply limit Override using eligible ICD-10 codes if a patient has an appropriate exemption (e.g., sickle cell disease, cancer, palliative care, hospice, chronic pain management diagnosis [G89, M25, M47, M50, M51, M54])	Not applicable	Not applicable	Not applicable

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

Submitting claims for 340B medications

When dispensing medications purchased under Section 340B of the Public Health Service Act, pharmacies should utilize an SCC (42Ø-DK) field with a value of 20 or the most current NCPDP standard for identification of 340B medications. Pharmacies may be required to complete a contract addendum with Humana to be eligible to dispense 340B medications under the agreement with Humana.

Vaccine administration

Medicare-Medicaid dual demonstrations

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

Submitting claims for vaccine administration

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

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

Influenza, pneumococcal and hepatitis B vaccines are not covered under the Medicare Part D program. However, they are a covered benefit for members with a dual-demonstration plan under Part B coverage with Humana.

Controlled substance claims

During claims adjudication, Humana attempts to confirm the validity of the prescriber ID submitted on controlled substance (schedule II–V) claims and that the controlled substance is within the

prescriber's scope of practice. Claims for drugs found to be written outside of a prescriber's prescribing authority (according to the DEA) will be rejected with the following error message: "Plan's prescriber database indicates associated DEA to submitted prescriber ID does not allow this DEA drug class." The free-form message on the claim also will state: "Validation of active DEA schedule required. If validated, submit applicable SCC."

Clarification of federal requirements – Schedule II drugs

Humana would like to remind pharmacies of the importance of monitoring pharmacy claims for accuracy and complying with federal and state laws, rules and regulations. This is especially important when filling prescriptions and submitting claims for refills and partial fills of Schedule II drugs. In accordance with 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 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 Schedule II (CII) drug claims. This impacts pharmacy claim data submission, processor adjudication edits to validate the Quantity Prescribed and payer sheet updates to include the Quantity Prescribed field.

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

Access this CII claim bulletin for additional information:
https://assets.humana.com/is/content/humana/CII Claims Submission Requirements_Update_09_24_2020pdf

Point-of-sale edits and overrides

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

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

Medicare claims coverage and procedures

Medicare Part B vs. Part D coverage

CMS makes a distinction between prescription drugs that are covered under Medicare Part B and those covered under Medicare Part D. These distinctions help pharmacists determine the appropriate insurance carrier to bill. In general, Humana covers most drugs that meet the CMS definition of a Part

D drug and are dispensed at a retail pharmacy under Medicare Part D and most drugs administered incidentally to a physician service under Medicare Part B. For members who have both a Part B plan and a Part D plan, the following guidelines apply.

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

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

Medicare Part D covers the following drugs (not an all-inclusive list):

- Most outpatient prescription drugs
- Insulin (excludes insulin used in a pump)
- Insulin supplies, such as standard and needle-free syringes, needles, gauze, alcohol swabs, and insulin pens
- Most vaccines (product and administration); exceptions include flu and pneumonia vaccines, hepatitis B vaccines (when they meet the CMS requirements for Part B coverage) and vaccines used for the treatment of an injury or illness (e.g., tetanus vaccine)
- Prescription-based smoking cessation products
- Injectable drugs that may be self-administered
- Injectable or infusible drugs administered in the home setting and not covered by Medicare Part A or Part B
- Infusion drugs not covered under Part B and administered in the home via intravenous drip or push injection; examples include, but are not limited to, intramuscular drugs, antibiotics, parenteral nutrition, immunoglobulin and other infused drugs

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

Prescription drug plans cover Part D drugs, Medicare Advantage (MA) plans cover Part B drugs and MAPD plans cover both Part B and Part D drugs. The determination for Part B or Part D coverage is based upon CMS coverage guidelines. A drug claim will never be eligible for coverage under Medicare Part B and Part D simultaneously.

Humana follows the CMS coverage guidelines. To assist in making the appropriate determination for Part B or Part D coverage and payment, Humana may require prior authorization. To request prior authorization when required, members, prescribers, and appointed or authorized representatives should call HCPR at **800-555-CLIN (2546)**. The caller should be prepared to answer questions related to the prescribed drug. These questions are used to help determine coverage and payment as either Medicare Part B or Part D.

Please note: Humana does not accept prior authorization requests directly from pharmacies. The member or prescriber must initiate the request. If insufficient or incomplete information is received and the determination of Part B or Part D coverage cannot be made, a fax form requesting more

information can be sent to the prescriber.

Prohibition on balance billing cost-share-protected members

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

Cost-share-protected members have no legal obligation to make further payment to a provider for Medicare Part B-covered medications/supplies. Balances should be billed to Medicaid as the secondary payer, following Medicaid guidelines for claim submission. The cost share cannot be collected from the member. Per CMS guidelines, if a full or partial balance remains after billing Medicaid, or if the provider is unable to bill Medicaid, the provider is still required to dispense the medication/supply without balance billing the member. Providers who inappropriately bill cost-share-protected members may be subject to sanctions, as established in Section 1902(n)(3)(C) of the Social Security Act.

Humana processing of drug exclusions

Medicare-Medicaid dual demonstrations:
All prescription drug claims should be submitted to Humana for processing. For the dual-demonstration plans, some Medicare Part D-excluded drugs and OTC drugs are payable under the Medicaid portion of the benefit. The tiers on dual-demonstration plans are as follows:

- Tier 1 drugs are generic drugs.
- Tier 2 drugs are brand-name drugs.
- Tier 3 drugs are Medicare-excluded drugs covered by Medicaid.
- Tier 4 drugs are OTC drugs covered by Medicaid.

Continuity of care

Retail and long-term care transition policy

This policy applies to prescribed drugs that are subject to certain limitations, such as drugs not listed on the Humana Drug List and drugs requiring prior authorization, step therapy or quantity limit. This policy helps members who have limited ability to receive their prescribed drug therapy by providing them with a temporary supply. For new and reenrolling members who are at a retail pharmacy or in an LTC facility, Humana will cover a temporary supply as indicated in the chart below. If the member presents a prescription written for less than the days' supply allowed, Humana will allow multiple fills to provide up to the total days' supply of medication allowed. For members who have more than 108 days of claims history, Humana will look back 180 days from the member effective date, or the beginning of the current plan year, for prior utilization of the drug when claims history is available. For members who are LTC residents, but past the first 90 days of eligibility, Humana will cover a 31-day supply unless the prescription is written for less. In that case, Humana will allow multiple fills to provide up to a total of 31 days of a Medicare Part D-covered drug when the prescription is filled at a network pharmacy.

Humana will indicate that a prescription is a transition fill in the message field of the paid claim response. The pharmacist should communicate this information to the member. Providing a temporary supply gives the member time to talk to their 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.

Transition will not work under the following conditions:

- CMS-excluded drug
- Medicare Part B drug
- Drugs that require a Medicare Part B vs. Part D determination and therefore are required to go through the standard prior authorization process
- Drugs that require a diagnosis to determine medically accepted Part D use
- Safety edits
- Initial transition eligibility criteria are not met

Program	Retail – total days' supply allowed	Retail – total days allowed for transition	LTC – total days' supply allowed	LTC – total time period allowed for transition
IL MMAI	30	90	31	90

Level-of-care changes (for Medicare-Medicaid dual demonstrations only)

Throughout the plan year, members may have changes in their treatment settings due to the level of care they require. Such transitions include:

- Members who are discharged from a hospital or skilled nursing facility to a home setting
- Members who are admitted to a hospital or skilled nursing facility from a home setting
- Members who transfer from one skilled nursing facility to another and are serviced by a different pharmacy
- Members who end their skilled nursing facility Medicare Part A stays (where payments include all pharmacy charges) and who now need to use their Part D plan benefits
- Members who give up hospice status and revert to standard Medicare Part A and Part B coverage
- Members who are discharged from chronic psychiatric hospitals with highly individualized drug regimens

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

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

When a claim is processed under the transition benefit, a free-form message will return, indicating that the claim was paid under the member's transition benefit. There also will be messaging for eligible retail and LTC transition claims indicating the drug's transition status.

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

Long-term care

Long-term care pharmacy information

Humana recognizes the unique operational model and services provided by the pharmacies in its 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.

Long-term care claims-processing guidelines

CMS requires all pharmacies to submit the patient residence code (NCPDP field 384-4X) and pharmacy service type (NCPDP field 147-U7) on all Medicare Part D claims. Claims submitted with a missing or invalid code will be rejected at the 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
8	Psychiatric facility
9	Intermediate care facility/mentally retarded*
11	Hospice
15	Correctional institution

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

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

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

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

If the pharmacy submits a Medicare Part D claim or claim for a managed Medicaid plan with a missing or invalid pharmacy service type, the claim will reject with NCPDP error code U7 and return the following message: **Missing/Invalid Pharmacy Service Type**.

Nebulizer solutions covered under Part D for LTC residents

For Humana's claims-processing system to recognize that a claim for inhalation solutions, such as

albuterol (to be used in nebulizers, not metered-dose inhalers), is for an LTC facility resident, the claim should be submitted with a patient residence code of 03 or 04. If this patient residence code is not submitted with the claim, the claim will be rejected.

Long-term care short-cycle dispensing

(appropriate dispensing)

Humana has implemented POS claims processing logic to comply with CMS Part D requirements related to appropriate dispensing for brand, oral, solid medications in the LTC pharmacy setting.

Submission requirements

LTC pharmacies submitting claims for brand, oral, solid medications that are subject to appropriate dispensing requirements must submit the following fields for proper claim adjudication:

- **Patient residence (NCPDP field 384-4X):** This field communicates where the patient resides. Several values are used in this field to communicate LTC, but Humana applies appropriate dispensing requirements only to claims submitted with a patient residence code of 03 (nursing facility).
- **Pharmacy service type (NCPDP field 147-U7):** This field communicates the type of service being performed by a pharmacy when different contractual terms exist between a payer and the pharmacy or when benefits are based upon the type of service performed.
- **Submission clarification code (NCPDP field 420-DK):** This field is used to identify the dispensing frequency used by the pharmacy (e.g., every 14 days, every seven days, etc.)
- **Special packaging indicator (NCPDP field 429-DT):** This field is used in appropriate dispensing to identify the type of packaging used in dispensing the medication.

Claims submitted by LTC pharmacies for generic, nonoral, solid medications (e.g., topical creams, lotions, etc.) and unbreakable packages (physically unbreakable or FDA-labeled to be dispensed in the manufacturer's packaging) are excluded from Humana's appropriate dispensing requirements and do not undergo this editing. In accordance with CMS guidance, Humana considers a product "brand" or "generic" according to the FDA's approval. Brands are prescription drugs receiving new drug application approval; generics receive abbreviated new drug application approval.

Rejections

If an LTC pharmacy submits a claim for a brand, oral, solid medication that is subject to the appropriate dispensing requirement, it must contain valid information in all the appropriate fields (as indicated previously for appropriate dispensing and on the Humana payer sheet for all claims) to be processed. If an LTC pharmacy does not submit the required fields, one of the following messages will be returned to the pharmacy with the claim rejection:

- **NCPDP reject code 613:** "The Packaging Methodology or Dispensing Frequency is Missing or Inappropriate for LTC Short Cycle." (This rejection is returned if the pharmacy submits an LTC claim but does not include both an appropriate SCC and special package indicator.)
- **NCPDP reject code 597:** "LTC Dispensing Type Does Not Support the Packaging Type."
- **NCPDP reject code 612:** "LTC Appropriate Dispensing Invalid Submission Clarification Code (SCC) Combination."

Combination pharmacies

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

appropriate dispensing edits.

Copayments
When an LTC-appropriate dispensing claim successfully meets the required elements (i.e., additional fields that must be submitted are present and valid) and is otherwise appropriately payable (i.e., no other edits apply), then Humana's POS system will calculate and prorate any member copayment that is applicable to the claim, according to the member's Medicare Part D benefit. Below is an example of Humana's proration procedure:

Applicable member copayment (31-day)	$31
Days' supply submitted on the claim	14
Prorated copayment	$14
Calculated daily copayment	$1

Long-term care attestation

Humana reimburses its contracted LTC pharmacies for cost-share amounts related to retroactive subsidy level changes for eligible LIS Medicare Part D beneficiaries who meet the CMS definition of institutionalized individuals ("member") per Medicare Part D guidance. Humana understands that LTC pharmacies' general practice is not to collect cost-sharing amounts from LIS or suspected LIS members or their responsible parties, but to defer collection until the member's health plan remits payment of the cost share directly. Applicable law prohibits waiving cost-sharing charges for Medicare beneficiaries, except under certain stated and limited circumstances. The pharmacy's cost-share collection practices should be guided by the following principles:

- **Pharmacy practice:** Humana requests the pharmacy attests its general practice consists of not collecting LIS or suspected LIS member cost share, deferring collection, and accepting health plan remittance that complies with the terms of the member's benefit plan as payment in full.
- **Notification:** As a contracted network LTC pharmacy, the pharmacy agrees to notify Humana within 30 calendar days of changes to this attestation of LIS cost-share collection practices for LIS-eligible beneficiaries.
- **List of participating pharmacies:** As a Humana network LTC pharmacy, the pharmacy also agrees to provide a current list of participating pharmacies, which shall be authorized to use and shall use the NCPDP number. The pharmacy understands and agrees that those participating pharmacies are included in, and subject to, the terms of this attestation.

If the pharmacy does not provide this complete and signed attestation, it will affect its ability to contract with Humana as a participating Humana provider and may result in sanctions, up to and including termination of a future Pharmacy Provider Agreement.

Please call Humana at **888-204-8349** if the pharmacy's cost-share collection practices have not been submitted. This attestation is collected in accordance with the requirements of applicable CMS regulations and instructions.

Home infusion billing procedure

All covered Medicare Part D drugs should be billed through the member's Humana pharmacy benefit

manager using the applicable BIN/PCN. All covered Part B drugs, supplies and nursing should be billed through the member's Humana 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. An 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 an SCC of 08 can be submitted.
- Pharmacies are prohibited from balance billing the beneficiary for the cost of any excluded ingredient contained in the compound.

The pharmacy shall not attempt to circumvent a plan's benefit design or engage in inappropriate billing practices of compound drugs. Such practices include, but are not limited to:

- Submitting test claims for a compound drug
- Submitting a claim multiple times with variations in the ingredients, ingredient cost, dispensing fees, quantity amount and/or days' supply to obtain the highest reimbursement possible
- Resubmitting rejected compound prescription ingredients as individual, noncompounded ingredients
- Submitting partial fills, or multiple claims for fills that are less than a 30-day supply, to avoid coverage limitations or gain additional reimbursement or copayment amounts

Medication Therapy Management Program

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

Humana works with internal and external pharmacists to provide telephonic MTM services.

Pharmacy audit and compliance

Pharmacy audit program

Humana maintains a pharmacy audit program to:

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

According to the Pharmacy Provider Agreement between Humana and its network pharmacies, Humana, any third-party auditor designated by Humana or any government agency allowed by law is

permitted to conduct audits of any and all pharmacy books, records and prescription files related to services rendered to members, as well as the pharmacy's compliance program.

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

- Dispensing unauthorized, early or excessive refills
- Dispensing an incorrect drug
- Billing the wrong member
- Billing an incorrect physician
- Using an NCPDP/NPI number inappropriately
- Invalid pharmacy service type submitted
- Invalid patient residence code submitted
- Calculating the days' supply incorrectly
- Using a DAW code incorrectly
- Overbilling quantities
- Not retaining/providing the hard copy of prescriptions or a signature log/delivery manifest
- Claims paid to the incorrect benefit

Humana notifies pharmacies of its intent to audit and provides specific directions regarding the process. Humana's on-site audits are conducted in a professional and Health Insurance Portability and Accountability Act of 1996 (HIPAA)-compliant manner with respect for patients and pharmacy staff. To access the Humana Pharmacy Solutions Audit and Claim Review Guide, please visit **Provider.Humana.com/pharmacy-resources/manuals-forms** and select the "Audit guide, claim form and other materials" tab.

Long-term care pharmacy audits

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

Time to retrieve these documents will be considered as part of Humana's audit requirements. LTC pharmacies should have a signature log or patient receipt, a delivery manifest, a copy of a Medication Administration Record that shows the prescription was administered, and the name and signature of the person who administered the medication, along with the date and time the medication was given. To access the long-term care pharmacy documentation guidelines, please visit **Provider.Humana.com/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 Gold Plus Integrated Medicare-Medicaid are subject to compliance program audits that may occur on an ad hoc basis. Humana notifies a pharmacy of its intent to audit and provides specific directions regarding the process. If an audit identifies deficiencies, a corrective action plan is issued. Humana then works with the pharmacy to ensure the deficiencies are remediated in a timely manner and to ensure there is a sufficient process and policy in place to prevent recurrence.

Fraud, waste and abuse 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 documents are available at **Provider.Humana.com/pharmacy-resources/manuals-forms.**) This includes fraud, waste and abuse (FWA) and noncompliance as committed by Humana employees, contracted pharmacy providers or those supporting the pharmacy providers' contractual obligations to Humana, members, customers, vendors, contractors and/or other business entities for Humana Gold Plus Integrated Medicare-Medicaid. All organizations supporting any of the products Humana administers are required to have a comprehensive plan to detect, correct and prevent FWA and noncompliance. This includes sharing Humana's commitment to:

- Investigate any identified, reported or suspected noncompliance or fraudulent activity
- Take additional action as necessary
- Report the matter when appropriate to the impacted regulatory, federal or state agencies for further action and investigation

Note: When your organization confirms there was an ethics, compliance or fraud violation that does or could impact Humana, your organization must report it to Humana. This includes relaying the disciplinary action(s) taken and what measures were revised or put in place to minimize and/or prevent future issues.

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
- Offering FWA prevention, detection and correction training to its contractors who administer, deliver or support Humana's plan administration, and/or notifying them that they must conduct such training
- Tracking adherence to the training obligation of those taking or offering the training

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

- Humana Compliance Policy for Contracted Healthcare Providers and Third Parties: **https://assets.humana.com/is/content/humana/Compliance Policypdf**
- Humana Ethics Every Day for Contracted Healthcare Providers and Third Parties: **https://assets.humana.com/is/content/humana/Ethics Every Daypdf**

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

Training records
Humana-contracted entities must maintain FWA training records. This includes the completion date, attendance, topic, certificate of completion (if applicable) and scores for all administered knowledge checks and, when applicable, attestations assuring others conducted and/or received such training elsewhere. Records must be kept 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 fraud, waste and abuse 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.

When there is a confirmed violation and it does or could impact Humana Gold Plus Integrated Medicare-Medicaid members, the pharmacy must report it to Humana, along with the actions taken to address the violation.

Methods to report suspected or detected fraud, waste and abuse and/or noncompliance
Humana expects all organizations supporting Humana to offer at least a reporting method not offered by Humana. Why? Your organization is best equipped to handle an initial review involving someone your organization designates to support Humana business so corresponding action can be taken in the timeliest manner. Also, any reports to Humana that do not pertain to Humana business are not in scope for Humana, which means they must not be reported to Humana.

Required features

- **Intake neutrality:** Those receiving the reports are employed by a separate and independent company or an area that does not have the same leadership of the one making a report.
- **Anonymous reporting:** Allow a person with a concern to make an anonymous report.
- **Information gathering:** Please ensure sufficient information is asked and/or collected to investigate.
- **Status update:** Regardless of reporting method used, the individual submitting a report must receive a confidential identification number that will allow for follow-up on the status of the issue reported, along with a recommended follow-up date.

Reporting method options
Humana makes available multiple options to report concerns, which serve as examples to mirror or to supplement the reporting method(s) your organization offers.

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

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

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

Humana also offers the Humana Ethics Help Line, **877-5-THE-KEY (584-3539)**, which is staffed by non-Humana personnel employed by a separate and independent company. This method is also available 24 hours a day, seven days a week and allows callers to remain anonymous.

Other reporting options:

- **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**

Your organization must also share the following commitments:

Prohibition against intimidation or retaliation
Your organization must have 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
Your organization can 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 outlined in the contract
- Mandatory retraining
- Formal, written corrective action plan(s) tracked to closure
- Reporting the violation and action(s) taken to Humana
- Reporting 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

Failure to report
Any individual or entity identified as not reporting a corresponding matter that is determined to have adversely impacted Humana shall be confirmed as being in violation of Humana requirements and will be subject to any or all of the above disciplinary actions.

Government action for an FWA violation
Depending on the specifics of a case, a state agency and/or CMS may elect to take action. This could mean excluding any individual or entity involved in an FWA violation from participating in government procurement opportunities, including work in support of any contract Humana has with a government agency and/or taking other legal action.

Corresponding expectations

Pharmacies also are expected to:

- Promote to those supporting Humana the available methods for reporting compliance and FWA concerns and the non-retaliation policy:
  - Examples of how to achieve this include posters, mouse pads, key cards and other prominent displays within a pharmacy's facility, such as on an intranet site and/or via email.
  - It is not sufficient to post information only within a facility and not share it via email and/or a pharmacy intranet site when any person needing the information works outside of the facility (e.g., remotely or within a home).
- Reinforce Humana's policy of non-intimidation 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:

- Your organization must require employees, management, governing body members and those with whom the pharmacy contracts to support the pharmacy's contractual obligations to Humana's Medicare and/or Medicaid products to review and attest to compliance with the pharmacy's standards of conduct document upon hire or contract and annually thereafter.
- If the contracted pharmacy does not have its own written standards of conduct that are materially similar to Humana's written standards of conduct, or does not adopt them from another organization, then Humana's standards of conduct document may be used. A copy can be accessed, printed and downloaded by visiting **https://assets.humana.com/is/content/humana/Ethics Every Daypdf.**
- Your organization must 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.
- Your organization must 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.
- Your organization must 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.
- Your organization must 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 met 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:** Your organization must monitor and audit 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 plan administered by Humana. This is conducted from both operational and compliance perspectives and includes an exclusion screening of all individuals and contracted entities that support Humana.
- **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 a state of Illinois agency (contracting Humana for administration of a plan with Medicaid-eligible beneficiaries) of an entity with a location outside of the United States or a U.S. territory that receives, processes, transfers, stores or accesses, in oral, written or electronic form, protected health information of a Medicaid member for an individual who is also eligible for Medicare.

- A state of Illinois agency may limit or prohibit plan member information from being stored, accessed or shared offshore.

- **Establishment, documentation and communication of effective compliance policies:** Your organization must have policies and procedures in place for preventing and detecting suspected ethics, compliance and FWA violations, 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 detected ethics, compliance and FWA violations of Humana's Compliance Policy or standards of conduct. (Those documents are available at **Provider.Humana.com/pharmacy-resources/manuals-forms.**) Any suspected and confirmed instances of ethical, compliance or FWA violations must be reported to Humana.
  - Reporting to Humana the ethics, compliance and FWA violations that impact Humana
  - Safeguarding both 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:** Your organization must ensure 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).
- **Disciplinary standards:** Your organization must establish disciplinary standards that are carried out when violations are committed by the pharmacy provider, its employees or those the pharmacy provider contracts with to support obligations to Humana.
- **Cooperation:** Your organization must cooperate 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:** Your organization must promote methods for how to report suspected violations of Humana policies, government regulations and corresponding disciplinary standards to employees, volunteers, board members and subcontractors.
- **Assurance:** Your organization must comply with Humana requests to provide assurance related to the pharmacy's compliance program.

FAQs

Humana makes a guidance document publicly available online that includes FAQs and additional information regarding the compliance requirements at **https://assets.humana.com/is/content/humana/GCHJ9HTEN_FAQpdf.**

More information on the seven elements of an effective compliance program and compliance program requirements for pharmacies supporting Humana's Medicare and/or Medicaid products can be found in Humana's Compliance Policy at **https://assets.humana.com/is/content/humana/Compliance Policypdf.**

Compliance training assurance expectations and 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 Gold Plus Integrated to ensure processes are in place to conduct Medicaid topic-

specific training of those employed or contracted to perform a function in support of the plan. Training topics include:

- 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 **Provider.Humana.com/pharmacy-resources/manuals-forms**. Instructions on how to provide confirmation of adherence to the above training requirements, when necessary and applicable, are listed on the above website.

Additional, required compliance education and training
Network pharmacies supporting Humana Gold Plus Integrated must also 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
  *(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 **Provider.Humana.com/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 the FWA training.*

Frequency and timing of the above is outlined in Humana's Compliance Policy, which is available on Humana's website at **Provider.Humana.com/pharmacy-resources/manuals-forms**.

Note: Humana will notify the pharmacy if an organization-level attestation must be submitted to certify compliance with these additional requirements.

Since compliance education material is refreshed at least each calendar year to assist pharmacies in meeting these and other related requirements, pharmacies are required to complete the assigned attestations annually, and they must submit the attestations to Humana within 30 days of notification each calendar year.

Additional guidance related to compliance program requirements is located on Humana's website in the compliance requirements FAQ for pharmacies at **https://assets.humana.com/is/content/humana/GCHJ9HTEN_FAQpdf.**

Please note: As requirements of government contracts, regulations and/or Humana's compliance program can change, Humana reserves the right to require additional or different compliance program training or components, although it strives not to make midyear changes.

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 by fax and requires the pharmacy to return a recredentialing application, which includes:

- Pharmacy state licensure information
- Pharmacy 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 Illinois Medicaid provider ID

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

Pharmacies enrolled in the IMPACT system will be considered fully credentialed and/or recredentialed by the Illinois Medicaid Program. They will not be subject to additional credentialing or recredentialing activities for Humana's MMAI network.

Conflicts of interest

All entities and individuals supporting Humana are required to avoid conflicts of interest that could compromise the completion or integrity of work to be performed in support of Humana.

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

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

Pharmacies 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.

A violation of these prohibitions 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. Humana reserves the right to request information and data to ascertain ongoing compliance with these provisions.

Proactive steps to address conflicts of interest

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.

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 either lists any possible conflict(s) or certifies the employee or downstream entity is free from any conflict of interest for administering or delivering federal healthcare program benefits or services.

Humana reserves the right to:

- Obtain certifications of the conflicts of interest, or the possible absence of conflicts of interest, from all providers
- Require that certain conflicts be removed
- Require that the applicable employee(s) and/or downstream entities be removed from supporting Humana

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

- File for multiple requests (download this Excel file): **https://aempublish.humana.com/content/dam/finished-pieces/miscellaneous-finished-pieces/humana/pharmacy/contracting/portal-documents/Pharmacy%20Pricing%20Review%20Request%20Excel%20File_Portal.xlsx**
- Pharmacy Pricing Review Request**:** **https://assets.humana.com/is/content/humana/Pharmacy Pricing Review Request Formpdf**

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:

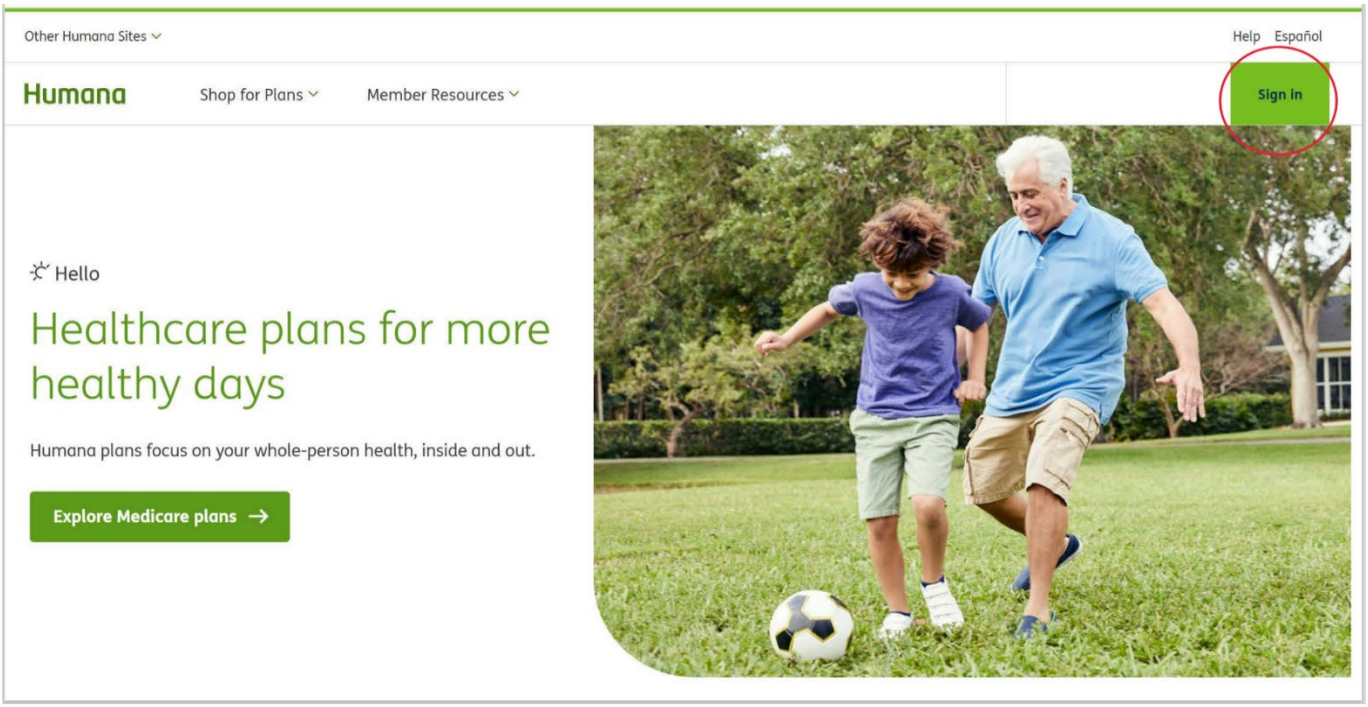
- Pharmacy name
- Pharmacy address
- Pharmacy NCPDP
- PCN
- Prescription number
- Drug name
- Drug strength
- Drug NDC
- Date of initial fill
- Quantity of fill
- Relevant documentation that supports the MAC is below the cost available to the pharmacy
- Any other supporting documentation (as needed)

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.

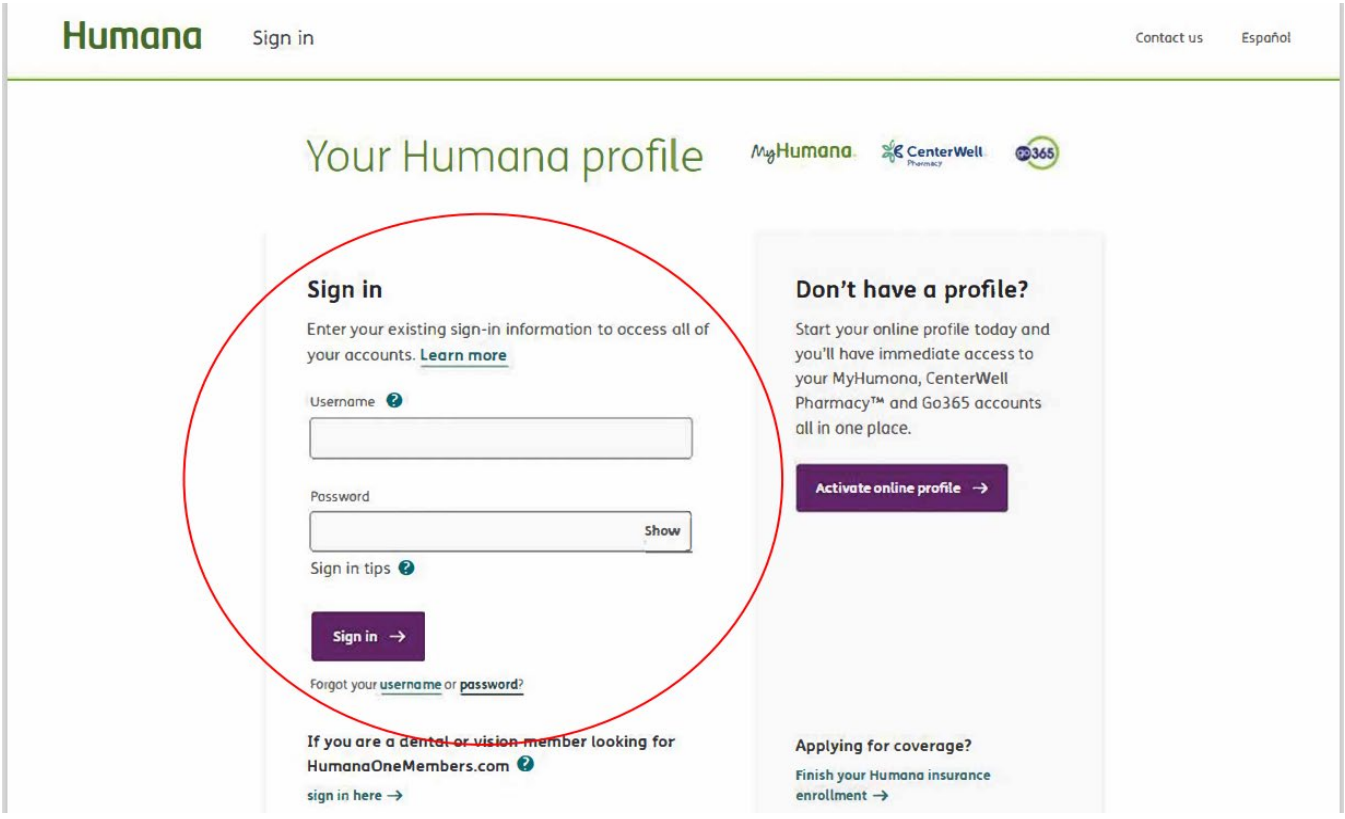
Please note: Timelines may vary state to state and are subject to change.

Pharmacy maximum allowable cost list location

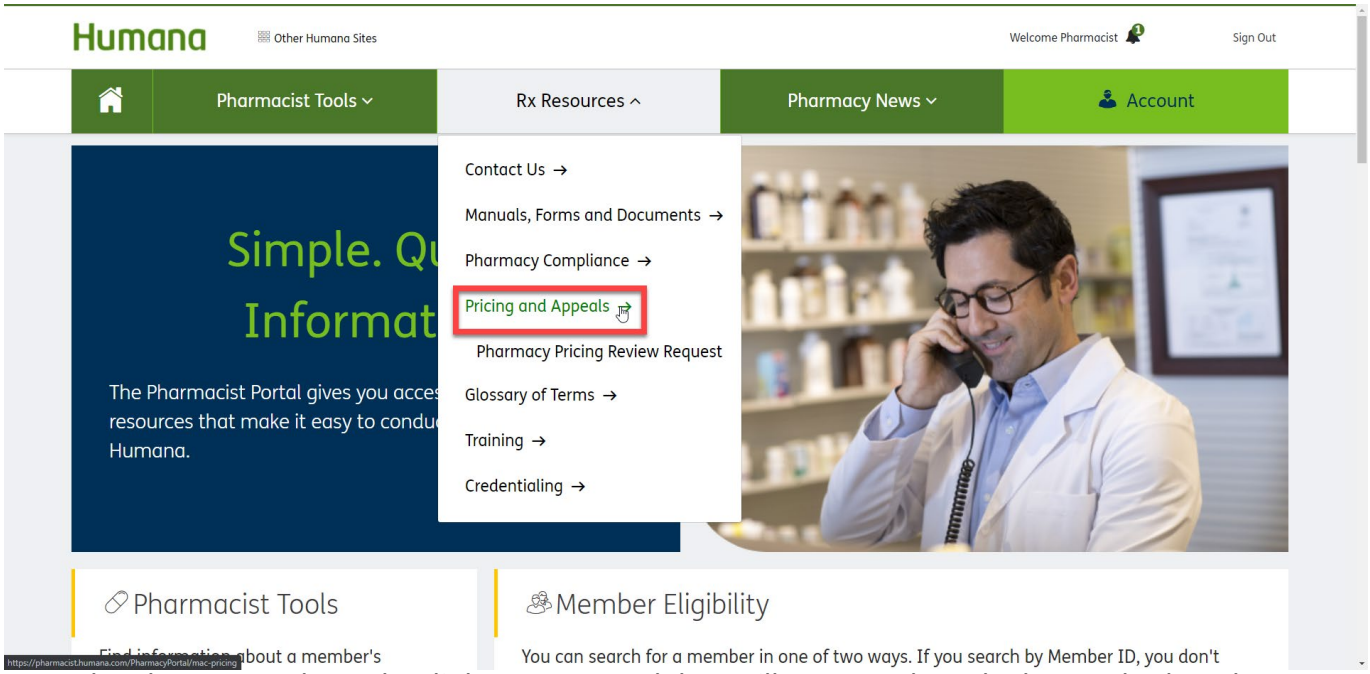
When network pharmacies need to locate the current MAC list, they can follow the steps below at **Humana.com**. They will see the screen below. Select the "**Sign in**" button located on the top right corner of the screen.



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

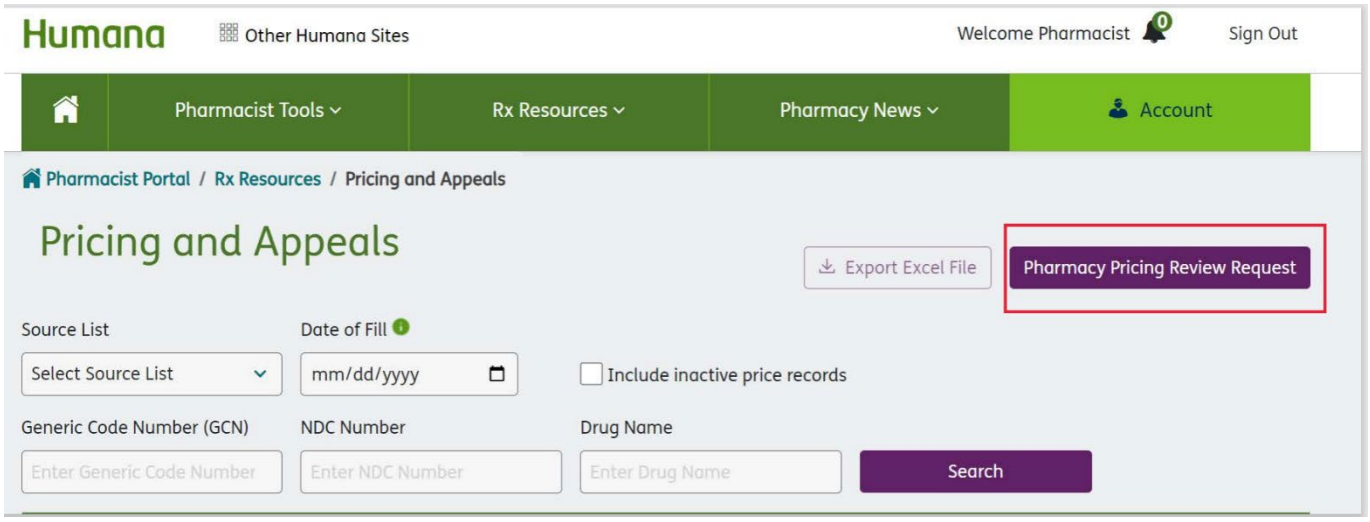


For the current MAC list applicable to the NPI the pharmacy used to register its account, which includes recent updates, select the **"Pricing and Appeals"** link:



Once the pharmacy selects that link, a MAC search box will appear. Close the box and select the appropriate list from the drop-down menu. The list you choose 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 located in the bottom right corner of the form to initiate the dispute process.

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

Pharmacy's process for filing a complaint

SS&C Health system issues
All pharmacies contracted with Humana are encouraged to call 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 HCPR telephone support unit that provides support for pharmacy inquiries and complaints related to specific corporate pharmacy management initiatives. Any specific initiative question that cannot be answered by the HCPR telephone support unit is forwarded to the Pharmacy Networks department for research and resolution at **888-204-8349**.

Member complaint system

The section below is taken from Humana's member grievance and appeal procedure as set forth in the Humana Member Handbook. This information is provided to pharmacies so they can assist Humana members in this process if they request assistance. Please contact the pharmacy network contracting representative if you have 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. Humana keeps these records in the central office.

Member grievances
Medicaid beneficiaries can file a grievance at any time. Grievances can be submitted using either method provided below. The member can submit written grievances to:

Humana Inc.
Grievances and Appeals Department
P.O. Box 14546
Lexington, KY 40512-4546
Fax: 800-949-2961

For verbal grievances, the member can call Customer Service at **800-787-3311 (TTY: 711)**. Humana is available Monday – Friday, 8 a.m. – 8 p.m., Central time. The automated phone system may answer member calls after hours, during weekends and on holidays. Members can leave their name and telephone number and Humana will call them back by the end of the next business day. The call is free. Visit **MyHumana.com** for 24-hour access to information, such as claims history, eligibility and Humana's Drug List. Members also can use the physician finder to find health news and information.

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

Member appeals
The member, prescriber or member representative may submit an expedited or standard appeal in writing within 65 calendar days of the date of the denial notice.

At a glance: How to make a Level 1 appeal
The member, member's physician or member representative can submit a request in writing and mail

or fax it to us. The member can also ask for an appeal by calling us.

- The member can ask for an appeal within 65 calendar days of the decision they are appealing. If the member misses the deadline for a good reason, they may still appeal.
- If a member appeals because Humana told the member that a Medicaid service they currently receive will be changed or stopped, the member has 10 calendar days to appeal if they want to keep receiving that Medicaid service while the appeal is processing.

Options for submitting the appeal (redetermination request):

- The member can download a copy of the appeal form provided at **Humana.com** and either fax or mail it to Humana:

  Humana Medical Plan Inc.
  Grievances and Appeals Department
  P.O. Box 14546
  Lexington, KY 40512-4546
  Fax: 800-949-2961
  (The member should include their name, address, Humana member ID number, reason for the appeal and any supporting documents.)

If the member requests an expedited appeal or is unable to write an appeal, oral appeals are accepted.

- Medicare-Medicaid dual members may ask for an appeal by calling Customer Service at **800-787-3311**. Humana is available Monday – Friday, 8 a.m. – 8 p.m., Central time.
- Using their MyHumana login, Medicare Part D members can file online requests using this link: **Resolutions.Humana.com/Grievances-Appeals-Forms/Member-Info.**

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

To receive an Appointment of Representative form, the member can call Customer Care and ask for one or visit Humana's website at **Humana.com/Individual-And-Family-Support/Tools/Member-Forms.**

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

Appendix: Medicare Prescription Drug Coverage and Your Rights

CMS requires network pharmacies to distribute the “Medicare Prescription Drug Coverage and Your Rights” notice to beneficiaries. This notice advises Medicare beneficiaries of their rights to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist.

Printing the pharmacy notice on prescription label stock or an integrated prescription receipt is permitted, so long as the notice is provided in at least 12-point font. Electronic distribution of the notice is permitted if the enrollee or the enrollee’s appointed representative has provided an email address and has indicated a preference for that method of communication.

Home Infusion Pharmacies must distribute the “Medicare Prescription Drug Coverage and Your Rights” notice to enrollee electronically, by fax, in person or by first-class mail as expeditiously as the enrollee’s health condition requires, but no later than 72 hours from the pharmacy’s receipt of the original transaction response indicating the claim is not covered by Part D.

CMS requires that LTC pharmacies contact the prescriber or an appropriate staff person at the LTC facility to resolve the matter. If the matter cannot be resolved the pharmacy must provide an appropriate staff person at the LTC facility, enrollee’s representative, prescriber or the enrollee the “Medicare Prescription Drug Coverage and Your Rights” notice as expeditiously as the enrollee’s health condition requires, but no later than 72 hours from the pharmacy’s receipt of the original transaction response indicating the claim is not covered by Part D.

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

Enrollee name:_____(optional)

Drug and prescription number:_____(optional)

Medicare Drug Coverage and Your Rights

You have the right to ask for a coverage determination from your Medicare drug plan to provide or pay for a drug you think should be covered, provided, or continued. You also have the right to ask for a special type of coverage determination called an **"exception"** if you:

- Need a drug that's not on your plan's list of covered drugs
- Believe a coverage rule (like prior authorization or a quantity limit) shouldn't apply to you for medical reasons
- Need to take a non-preferred drug and you want the plan to cover the drug at a preferred drug price

How to ask for a coverage determination

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

Be ready to tell your Medicare drug plan:

- The name of the prescription drug, including dose and strength (if known)
- The name of the pharmacy that tried to fill the prescription
- The date you tried to fill the prescription
- If you ask for an exception, your prescriber will need to explain why you need the off-formulary or non-preferred drug, or why a coverage rule shouldn't apply to you

Your Medicare drug plan will send you a written decision. If coverage isn't approved and you disagree with this decision, you have the right to appeal. The plan's notice will explain why coverage was denied and how to ask for an appeal.

Get help and more information

Look at your plan materials or call 1-800-MEDICARE (1-800-633-4227) for more information about how to ask for a coverage determination. TTY users can call 1-877-486-2048. For help contacting your plan, call 1-800-MEDICARE.

To get this form in an accessible format (like large print, Braille, or audio) contact your Medicare drug plan. You also have the right to file a complaint if you feel

you've been discriminated against. Visit Medicare.gov/about-us/accessibility-nondiscrimination-notice, or call 1-800-MEDICARE (1-800-633-4227) for more information. TTY users can call 1-877-486-2048.

PRA Disclosure Statement According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0975. This information collection is used to provide notice to enrollees about how to contact their Part D plan to request a coverage determination. The time required to complete this information collection is estimated to average 1 minute per response, including the time to review instructions, search existing data resources, gather the data needed, to review and complete the information collection. This information collection is required under § 423.562(a)(3) and an associated regulatory provision at § 423.128(b)(7)(iii). If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Nombre del afiliado:_____(opcional)

Medicamento y número de receta:_____(opcional)

Cobertura de medicamentos de Medicare y sus derechos

Tiene derecho a solicitar una determinación de cobertura a su plan de medicamentos de Medicare para que le proporcionen o paguen un medicamento que usted cree que debe cubrirse, proporcionarse o continuarse. También tiene derecho a solicitar un tipo especial de determinación de cobertura llamada **"excepción"** si usted:

- Necesita un medicamento que no figura en la lista de medicamentos cubiertos de su plan.
- Considera que una norma de cobertura (como una autorización previa o un límite de cantidad) no debería aplicarse en su caso por razones médicas.
- Necesita tomar un medicamento no preferido y desea que el plan cubra el medicamento al precio de uno preferido.

Cómo solicitar una determinación de cobertura

Para solicitar una determinación de cobertura, usted o su médico pueden llamar al número de teléfono gratuito de su plan de medicamentos de Medicare que se indica en el reverso de su tarjeta de miembro del plan, o ir a la página web de su plan. Puede solicitar una decisión acelerada (en 24 horas) si su salud puede verse gravemente perjudicada por la espera de hasta 72 horas.

Esté preparado para informar a su plan de medicamentos de Medicare:

- El nombre del medicamento recetado, incluida la dosis y la potencia (si se conocen)
- El nombre de la farmacia en la que intentó surtir la receta
- La fecha en que intentó surtir la receta
- Si solicita una excepción, el médico deberá explicar por qué necesita un medicamento fuera del formulario o no preferido, o por qué no se le debe aplicar una norma de cobertura.

Su plan de medicamentos de Medicare le enviará una decisión por escrito. Si no se aprueba la cobertura y usted no está de acuerdo con esta decisión, tiene derecho a apelar. El aviso del plan le explicará por qué le denegaron la cobertura y cómo solicitar una apelación.

Obtenga ayuda y más información

Consulte los materiales de su plan o llame al 1-800-MEDICARE (1-800-633-4227) para obtener más información sobre cómo solicitar una determinación de cobertura. Los usuarios de TTY pueden llamar al 1-877-486-2048. Si necesita

ayuda para comunicarse con su plan, llame al 1-800-MEDICARE.

Para obtener este formulario en un formato accesible (como letra grande, Braille o audio) comuníquese con su plan de medicamentos de Medicare. También tiene derecho a presentar una queja si considera que se le ha discriminado. Visite Medicare.gov/about-us/accessibility-nondiscrimination-notice, o llame al 1-800-MEDICARE (1-800-633-4227) para solicitar más información. Los usuarios de TTY pueden llamar al 1-877-486-2048.

Declaración sobre la Ley para la Reducción de Trámites De acuerdo con la Ley para la Reducción de Trámites (PRA) de 1995, ninguna persona está obligada a responder una recopilación de información a menos que esta muestre un número de control válido de la Oficina de Administración y Presupuesto (OMB). Se trata de una encuesta nacional que se realizará entre consumidores que actualmente tienen seguro médico a través del Mercado de Seguros Médicos o que no tienen seguro, y entre personas que actualmente tienen Medicare. La encuesta está diseñada para examinar la confianza en la toma de decisiones de atención médica, la confianza en la capacidad de comprender conceptos clave de los seguros médicos, el conocimiento de los seguros médicos y la toma de decisiones sobre los seguros médicos específicamente en relación con el Mercado de Seguros Médicos y Medicare. Las respuestas de las secciones de confianza y conocimiento de los seguros médicos se utilizarán para darnos una idea de cómo la educación sobre los seguros médicos afecta las decisiones sobre estos. El número de control válido de la OMB para esta recopilación de información es 0938-0975. El tiempo necesario para completar esta recopilación de información voluntaria y no confidencial es de aproximadamente 1 minuto en promedio por encuesta, incluido el tiempo para revisar las instrucciones, buscar fuentes de datos existentes, reunir los datos necesarios, y completar y revisar la recopilación de información. Si tiene preguntas sobre la precisión de los tiempos estimados o sugerencias para mejorar este formulario, escriba a: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Medicare and Medicaid reports and other documents

Prohibition Billing Dually Eligible Individuals Enrolled in the Qualified Medicare Beneficiary (QMB) Program
MLN Matters, No. SE1128, June 26, 2018

Department of Health and Human Services

Centers for Medicare & Medicaid Services MLN Matters® Number: SE1128
Revised related change request (CR) #: N/A
Related CR release date: N/A

Effective date: N/A
Related CR transmittal #: N/A
Implementation date: N/A

Prohibition on Balance Billing Dually Eligible Individuals Enrolled in the QMB Program
Note: This information was revised on June 26, 2018, to clarify the description of the QMB program. It also adds that starting July 2018 the Medicare Summary Notice (MSN) is another way for providers to verify the QMB status of beneficiaries for Medicare Fee-For-Service (FFS) claims. All other information remains the same.

Provider types affected

This information pertains to all Medicare providers and suppliers, including pharmacies that serve beneficiaries enrolled in original Medicare or a Medicare Advantage (MA) plan.

What Medicare providers need to know

This information from the Centers for Medicare & Medicaid Services (CMS) reminds **all Medicare providers and suppliers, including pharmacies, that they may not bill beneficiaries enrolled in the QMB program for Medicare cost-sharing**. Medicare beneficiaries enrolled in the QMB program have no legal obligation to pay Medicare Part A or Part B deductibles, coinsurance, or copays for any Medicare-covered items and services.

Refer to the Background and Additional Information Sections for further details and resources about this guidance. All Medicare providers should be aware of the federal balance billing law and policies regarding QMB individuals. Medicare providers should contact the Medicaid Agency in the states in which they practice to learn about ways to identify QMB patients in their states and procedures applicable to Medicaid reimbursement for their Medicare cost sharing. Medicare Advantage providers also may contact the MA plan for more information. Finally, all Medicare providers should ensure that their billing software and administrative state exempt QMB individuals from Medicare cost sharing billing and related collection efforts.

What Medicaid providers need to know

The QMB program is a state Medicaid benefit that covers Medicare deductibles, coinsurance and copayments, subject to state. (States may limit their liability to providers for Medicare deductibles, coinsurance and copayments under certain circumstances.) Medicare providers may not balance bill QMB individuals for Medicare cost sharing, regardless of whether the state reimburses providers for the full Medicare cost sharing amounts. Further, all original Medicare and MA providers—not only those that accept Medicaid—must refrain from charging QMB individuals for Medicare cost sharing. Providers who inappropriately balance bill QMB individuals are subject to sanctions.

Background

All Original Medicare and MA providers and suppliers—–not only those that accept Medicaid—–must not charge individuals enrolled in the QMB program for Medicare cost-sharing. Providers who inappropriately bill individuals enrolled in QMB are subject to sanctions. Providers and suppliers may bill State Medicaid programs for these costs, but States can limit Medicare cost-sharing payments under certain circumstances.

Billing of Qualified Medicare Beneficiaries is prohibited by federal law

Federal law bars Medicare providers and suppliers from billing an individual enrolled in the QMB program for Medicare Part A and Part B cost-sharing under any circumstances (see Sections

1902(n)(3)(B), 1902(n)(3)(C), 1905(p)(3), 1866(a)(1)(A), and 1848(g)(3)(A) of the Social Security Act [the Act]). The QMB program provides Medicaid coverage of Medicare Part A and Part B premiums and cost sharing to low-income Medicare beneficiaries. QMB is an eligibility category under the Medicare Savings Programs. In 2016, 7.5 million individuals (more than one out of eight beneficiaries) were enrolled in the QMB program.

Providers and suppliers may bill State Medicaid agencies for Medicare cost-sharing amounts. However, as permitted by Federal law, States can limit Medicare cost-sharing payments, under certain circumstances. Regardless, persons enrolled in the QMB program have no legal liability to pay Medicare providers for Medicare Part A or Part B cost-sharing. Medicare providers who do not follow these billing prohibitions are violating their Medicare Provider Agreement and may be subject to sanctions (see Sections 1902(n)(3)(C), 1905(p)(3), 1866(a)(1)(A), and 1848(g)(3)(A) of the Act).

Inappropriate balance billing persists

Despite Federal law, providers and suppliers continue to improperly bill individuals enrolled in the QMB program. Many beneficiaries are unaware of the billing restrictions (or concerned about undermining provider relationships) and simply pay the cost-sharing amounts. Others may experience undue distress when unpaid bills are referred to collection agencies. For more information, refer to **Access to Care Issues Among Qualified Medicare Beneficiaries (QMB), Centers for Medicare & Medicaid Services July 2015.**

Ways to promote compliance with QMB billing rules

Take the following steps to ensure compliance with QMB billing prohibitions:

1. Establish processes to routinely identify the QMB status of Medicare beneficiaries prior to billing for items and services. Use the Medicare 270/271 HETS data provided to Medicare providers, suppliers, and their authorized billing agents (including clearinghouses and third party vendors) (effective November 2017) to verify a beneficiary's QMB status and exemption from cost-sharing charges. Ask your third party eligibility-verification vendors how their products reflect the new QMB information from HETS. For more information, visit the **HETS** website at https://www.cms.gov/data-research/cms-information-technology/hipaa-eligibility-transaction-system.
    - In July 2018, CMS will reintroduce QMB information in the Medicare RA that Original Medicare providers and suppliers can use to identify the QMB status of beneficiaries. Refer to the Additional Information section below for educational materials on recent changes that impact RAs for Medicare FFS QMB claims.
    - MA providers and suppliers should also contact the MA plan to learn the best way to identify the QMB status of plan members both before and after claims submission.
    - Providers and suppliers may also verify beneficiaries' QMB status through automated Medicaid eligibility-verification systems in the State in which the person is a resident or by asking beneficiaries for other proof, such as their Medicaid identification card, MSN (starting July 2018) or other documentation of their QMB status.
2. Ensure that billing procedures and third-party vendors exempt individuals enrolled in the QMB program from Medicare charges and that you remedy billing problems should they occur. If you have erroneously billed individuals enrolled in the QMB program, recall the charges (including referrals to collection agencies) and refund the invalid charges they paid.
3. Determine the billing processes that apply to seeking payment for Medicare cost-sharing from the States in which the beneficiaries you serve reside. Different processes may apply to Original Medicare and MA services provided to individuals enrolled in the QMB program. For Original Medicare claims, nearly all States have electronic crossover processes through the Medicare Benefits Coordination & Recovery Center (BCRC) to automatically receive Medicare-adjudicated claims.

- If a claim is automatically crossed over to another payer, such as Medicaid, it is customarily noted on the Medicare RA.
- States require all providers, including Medicare providers, to enroll in their Medicaid system for provider claims review, processing, and issuance of the Medicaid RA. Providers should contact the State Medicaid Agency for additional information regarding Medicaid provider enrollment.

QMB eligibility and benefits

Dual eligibility	Eligibility criteria	Benefits
Qualified Medicare Beneficiary (QMB only)	• Resources cannot exceed $9,660 for single individual or $14,470 in 2025 for an individual living with a spouse and no other dependents.* • Income cannot exceed $1,325/month-individual; $1,783/month-couple in 2025* **Note:** These guidelines are a part of the federal Medicare Advantage (Part C) floor. Under Section 1902 (r)(2) of the Social Security Act, states can effectively raise these limits above these baseline federal standards. *Rev 04_04_2025	Medicaid Pays Medicare Part A and B premiums, deductibles, coinsurance and copays to the extent required by the State Medicaid. • Exempts beneficiaries from Medicare cost sharing charges • The state may choose to pay the Medicare Advantage Part C premium.
QMB Plus	• Meets all of the standards for QMB eligibility as described above, but also meets the financial criteria for full Medicaid coverage.	Provides all benefits available to QMBs, as well as all benefits available under the state plan to a fully eligible Medicaid recipient.

Additional information

For more information on this process, refer to Section HI 00801.140 of the **Social Security Administration Program Operations Manual System** - https://secure.ssa.gov/apps10/poms.nsf/lnx/0600801140.

For more information about dual eligibles under Medicare and Medicaid, please visit and refer to **Dual Eligible Beneficiaries Under Medicare and Medicaid**. For general Medicaid information, please visit **medicaid.gov**.