

Humana Pharmacy Solutions

Pharmacy Manual

Humana Healthy Horizons in South Carolina
2026 Edition

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Introduction

Dear pharmacy:

Humana appreciates your role in delivering quality pharmacy services to our Medicaid members. This manual pertains exclusively to South Carolina members enrolled in Humana Healthy Horizons® in South Carolina 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.

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

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

- Obtain a current list of generic maximum allowable cost (MAC) pricing
- Send email inquiries directly to Humana
- View news bulletins and link to news alerts
- Find member eligibility regarding a member's prescription drug plan, effective date and type of plan
- View claims a member has filled with 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 obtain access, please visit **Humana.com/Logon** and follow the on-screen instructions under "Don't have an account?" to create your account. 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 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 Customer Care

To obtain general Medicaid plan information:

866-432-0001 (TTY: 711)

Monday – Friday, 8 a.m. – 8 p.m., Eastern time

Humana Clinical Pharmacy Review (HCPR)

To submit prior authorization requests:

- Obtain forms at **Provider.Humana.com/pharmacy-resources/prior-authorizations** or submit your request electronically by visiting www.covermymeds.com/epa/humana.
- Submit request by fax to **877-486-2621**.
- Call HCPR at **800-555-CLIN (2546)**, Monday – Friday, 8 a.m. – 8 p.m., Eastern time.

Humana Pharmacy Solutions® Network Contracting

Pharmacy contract requests

Email: PharmacyContractRequest@humana.com

Fax number: **866-449-5380**

Phone number: **888-204-8349**, Monday – Friday, 8 a.m. – 5 p.m., Eastern time

Humana Ethics Help Line

877-5-THE-KEY (584-3539), 24 hours a day, seven days a week

Humana Healthy Horizons in South Carolina pharmacy help desk

844-918-0109, 24 hours a day, seven days a week

Humana's pharmacist website

Visit **Provider.Humana.com/pharmacy-resources** 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

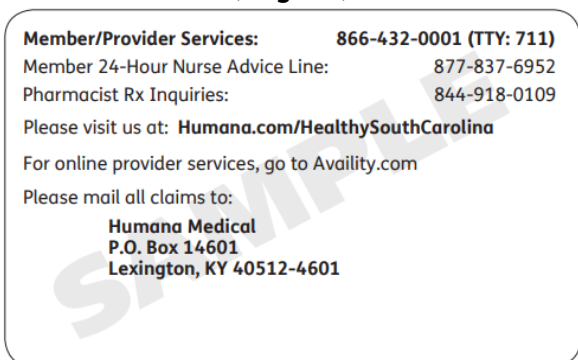
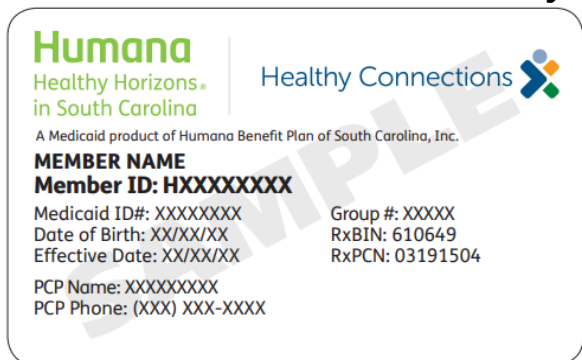
Provider.Humana.com/pharmacy-resources/manuals-forms

Eligibility verification

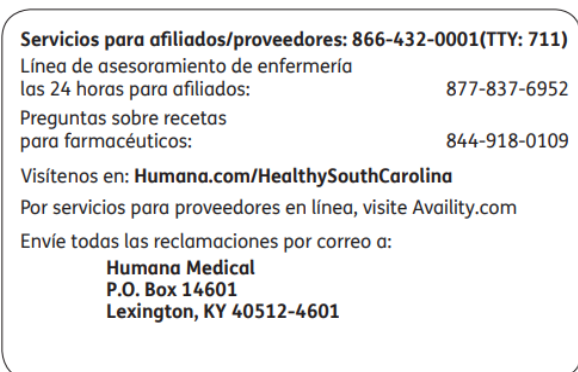
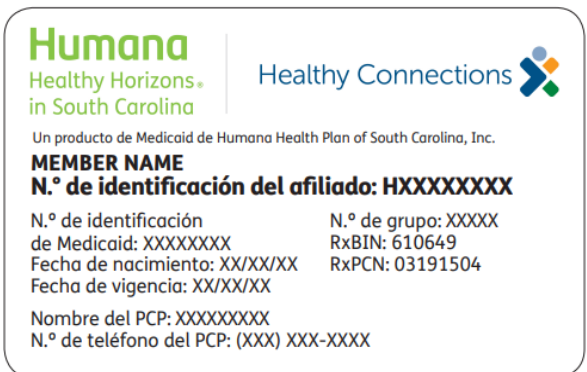
Humana member ID cards

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

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



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



Note: These images meet 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 appear in the “Humana member ID cards” section above.

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

Coordination of benefits

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

- Some prescription products not covered under Medicare Part D

- Some over-the-counter (OTC) products

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

Excluded prescription 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 prescription drug coverage for South Carolina:

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

Additional information is available at www.medicaid.gov/medicaid/prescription-drugs/medicaid-drug-policy-laws-regulations-and-federal-register-notice/index.html.

Drug coverage

Drug Lists

Humana Healthy Horizons provides coverage of medically necessary medications, both prescription and select OTC medications, when prescribed by licensed providers in the state. The Comprehensive Drug List (CDL) includes the state's Preferred Drug List (PDL). Additional prescription drug coverage and criteria outside of the state's PDL is developed and maintained by Humana's Pharmacy and Therapeutics Committee, which consists of providers and pharmacists. The CDL is a list of covered medications on the member's benefit and identifies drug utilization management requirements, such as prior authorization, quantity limits and step therapy.

CDLs are updated regularly. To view the current CDL for Humana Healthy Horizons Medicaid-eligible members, visit Provider.Humana.com/pharmacy-resources/tools/humana-drug-lists.

Utilization management

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

- **Prior authorization (PA):** Humana's Pharmacy and Therapeutics Committee reviews medications based on safety, efficacy and clinical benefit and may make additions or deletions to the list of prescription drugs requiring PA. Certain medications may need to be approved by the member's plan to be covered.
- **Step therapy:** Plans that are subject to step therapy as a component of Humana's standard drug utilization review (DUR) program require the member to utilize medications commonly considered first-line before using medications considered second-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 prescription 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.

Coverage determinations

Prescribers may request coverage determinations, such as medication prior authorization, step therapy, quantity limits and medication exceptions, by faxing the request to HCPR at **877-486-2621**. A prescriber can submit the request electronically by visiting www.covermymeds.com/epa/humana.

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

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

The prescriber quick reference guide can be found at [https://assets.humana.com/is/content/humana/Prescriber Quick Reference Guidepdf](https://assets.humana.com/is/content/humana/Prescriber%20Quick%20Reference%20Guide.pdf).

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

72-hour emergency fill

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

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

General claims procedures

Submitting pharmacy claims

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

The pharmacy may not submit test claims. Test claims are claims submissions used to confirm patient eligibility or to determine the existence of any coverage restrictions or requirements and/or the maximum amount of reimbursement.

Bank Identification Numbers and Processor Control Numbers

The Bank Identification Number (BIN) and Processor Control Number (PCN) are:

Plan	BIN	PCN
Humana Healthy Horizons in South Carolina	610649	03191504

Prescription origin code requirements

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

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

Value	Value type
1	Written
2	Telephone
3	Electronic
4	Fax
5	Situations for which a new prescription number needs to be created from an existing valid prescription, such as traditional transfers, intrachain transfers, file buys and software upgrades/migrations. This value is also the appropriate value for “pharmacy dispensing,” when applicable, such as 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 the sales tax, please email PharmacyPricingReview@humana.com.

Timely submission of claims

Claims must be submitted on the date of service (DOS). There are special circumstances under which a pharmacy may submit claims after the DOS, including the following:

- Resolution of **coordination of benefits** issues requiring claims reversal and rebilling to appropriate payers for Medicare Part D, which have 36 months for submission
- **Subrogation** claims, which have 36 months for submission
- **POS Medicaid** claims, which have 365 days from DOS for submission

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

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

Please contact 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.

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. In these cases, the LTC pharmacy requesting such an exception must complete, sign and date the LTC appeal form for untimely filing.

Here is a link to the form, which will provide a list of permitted exceptions along with how to submit the form for consideration:

[https://assets.humana.com/is/content/humana/LTC Appeal Form for Untimely Filingpdf.](https://assets.humana.com/is/content/humana/LTC%20Appeal%20Form%20for%20Untimely%20Filing.pdf)

Humana-specific SS&C Health payer sheets

Pharmacists can find the pharmacy payer sheet (D.0 Medicaid) 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.”

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

NCPDP error code	NCPDP error code description	Free-form messaging	Applicable SCC
56	Nonmatched prescriber ID	Prescriber ID submitted not found. If validated, submit applicable SCC.	42
42	The 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	The 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	The 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	The 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	The prescriber ID qualifier value is not supported.	Prescriber Type 1 is required. Foreign prescriber ID is not allowed.	N/A

619	The prescriber Type 1 NPI is required.	Type 2 NPI submitted – Type 1 NPI required (for Humana Medical Plan)	N/A
6Z	The provider is not eligible to perform services/dispense product.	The provider is ineligible to perform the service.	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 comply with all applicable laws, rules and regulations.

DAW codes for multisource brand drugs

Claims will be denied if a DAW code is not entered or if the DAW code of “0” is entered when a multisource 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 multisource brand drug to be generic.

Value	Value type
0	No product selection indicated
1	Substitution not allowed by prescriber
5	Substitution allowed — brand drug is dispensed as generic
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 reviews or DUR safety edits at the point of service to assist pharmacies in identifying and addressing potentially inappropriate or unsafe prescription drug therapy before dispensing. These safety edits can present as a message, soft reject or hard reject and may include, but are not limited to, the following:

DUR type	Pharmacy information	Example
Drug–drug interactions	This interaction identifies possible adverse interactions between the submitted medication and other medications in the patient’s prescription history.	Selective serotonin reuptake inhibitors/monoamine oxidase inhibitors
Drug–age interaction	This interaction identifies safety risk related to the use of specific medication for the patient’s age.	Adderall for children younger than 6 years old
Drug–disease interaction	This 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 only apply for commercial and Medicaid when applicable.	Makena
Maximum dose	This interaction 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	This interaction identifies patients at greater risk of overdose or inappropriate opioid utilization. Dosing greater than 50 mg MED per day will trigger this error code.	MS Contin 30 mg twice daily plus Percocet 10/325 mg two tablets every eight hours as needed
MED* overuse	This interaction 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	This interaction 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	This interaction 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) (including concurrent opioid and benzodiazepine use)	DD: Drug-drug interaction	DE: Dosing evaluation M0: Prescriber consulted MP: Patient will be monitored PE: Patient education/instruction PO: Patient consulted RO: Pharmacist consulted other source SW: Literature search/review	1A: Filled as is, false positive 1B: Filled prescription as is 1D: Filled with different directions 1F: Filled with different quantity 1G: Filled with prescriber approval 4A: Prescribed with acknowledgments 4B: 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*	Cumulative morphine equivalent dose exceeds limits	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 of nonhospice 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 SW: Literature search/review	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	1A: Filled as is, false positive

			MP: Patient will be monitored PE: Patient education/instruction PO: Patient consulted RO: Pharmacist consulted other source SW: Literature search/review	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
AG: Exceeds opioid initial fill limits 925: Initial fill days' supply exceeds limit	Days' supply limitation for product/service	MX: Excessive duration	M0: Prescriber consulted PH: Patient medication history RO: Pharmacist consulted other source	1G: Filled with prescriber approval 4B: Dispensed, palliative care 4D: Dispensed, cancer treatment 4J: Dispensed, patient is not opioid naïve 4K: Prescriber specialty exemption-oncology of nonhospice palliative care 4L: Prescriber specialty exemption-hospice

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

Submitting claims for 340B medications

When dispensing medications acquired under the 340B Program, as such terms are defined by the Centers for Medicare & Medicaid Services (CMS), pharmacies must utilize an SCC (42Ø-DK) field with a value of 20 or the most current NCPDP standard for identification of 340B medications.

Pharmacies may be required to complete a contract addendum with Humana to be eligible to dispense 340B medications under the agreement with Humana.

Vaccine administration

The program covers administration expenses associated with the injection of vaccines covered by the plan. Pharmacists in Humana-participating pharmacies may administer the vaccines if allowed by South Carolina state law.

Submitting claims for vaccine administration

To submit claims for both the prescription 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.

Vaccines for children

Pharmacies are required to enroll in the Vaccines for Children (VFC) Program for vaccine administration to eligible Humana Healthy Horizons members younger than 19 years old. The VFC Program is a federally funded program that provides vaccines at no cost to children who might not otherwise be vaccinated because of their inability to pay.

Vaccines may be obtained at no cost through the Statewide Immunization Online Network (SIMON) from the South Carolina Immunization Operations Section for Humana Healthy Horizons members younger than 19 years old.

To enroll in the VFC program, pharmacy providers should email scvfc@dph.sc.gov and must register for SIMON at <https://dph.sc.gov/professionals/simon>.

Humana will pay pharmacies an administration fee for administering one of the VFC Program pediatric vaccines to eligible Humana Healthy Horizons members. To receive payment of the administration fee, pharmacies must submit a claim with the NCPDP fields populated (as shown in the following table):

Field number	NCPDP field name	Required vaccine administration information for processing
440-E5	Professional Service Code	MA (Medication Administration)
438-E3	Incentive Amount Submitted	≥ \$0.01 (submit administration fee)
412-DC	Dispensing Fee Submitted	≥ \$0.01 (submit dispensing fee)
426-DQ	Usual and Customary Charge	> \$0.00
423-DN	Basis of Cost Determination	15 (free product or no associated cost)

Note: Pharmacies must be enrolled in the VFC Program to administer vaccines to eligible members and order the vaccines from that program at no cost. For additional information, please visit <https://dph.sc.gov/professionals/simon/vfc-vaccine-management-information>.

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 prescription drugs found to be written outside of a prescriber’s prescribing authority (according to the DEA) will be rejected with the following error message: “Plan’s prescriber database indicates associated DEA to submitted prescriber ID does not allow this DEA drug class.”

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

Clarification of federal requirements—Schedule II drugs

Humana would like to remind pharmacies of the importance of monitoring pharmacy claims for accuracy and complying with federal and state laws, rules and regulations. This is especially

important when filling prescriptions and submitting claims for partial fills of Schedule II drugs. In accordance with the Pharmacy Provider Agreement, 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 prescription drug. Schedule II drugs have a high potential for abuse, have an accepted medical use (including severe restrictions) and may lead to severe psychological or physical dependence if abused. Pursuant to 21 CFR § 1306.12(a), Schedule II prescription drugs may not be refilled.

Pharmacies should take appropriate steps to confirm (including verifying with the prescriber, when necessary) that controlled substances, including Schedule II drugs, are being filled only in accordance with federal and state law. This includes preventing refills and partial fills of Schedule II drugs that are not allowable under the Controlled Substances Act.

Submitting CII claims

CMS ruling CMS-0055-F mandates that a valid Quantity Prescribed (NCPDP field 460-ET) is submitted on all federally designated Controlled Substance 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](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](https://www.humana.com/provider/pharmacy-resources/manuals-forms). See the “Pharmacy resources” tab under “Manuals and forms.”

Lock-In Program

The Lock-In Program is designed for individuals enrolled in Humana Healthy Horizons who need help managing their use of prescription medications. It is intended to limit overuse of benefits and reduce unnecessary costs to Medicaid while providing an appropriate level of care for the member.

Humana Healthy Horizons members who meet the program criteria are locked into one specific pharmacy location. The lock-in program is required by the South Carolina Department of Health and Human Services.

Humana Healthy Horizons monitors claims activity for signs of misuse or abuse in accordance with state and federal laws. Quarterly reports are generated by the Division of Program Integrity, which reviews all Medicaid members' claims for a six-month period.

The report is reviewed for 20 different weighted criteria as established by the Division of Program Integrity. Based on criteria met, a score is assigned that is used in identifying members for the

Statewide Pharmacy Lock-In Program (SPLIP). In addition, members may be reviewed for the SPLIP based on data mining of pharmacy and medical claims data to identify recipients who have an excess of medication fills.

Members who obtained two or more controlled substance medications from two or more prescribers and utilized two or more pharmacies within 180 days and have a documented diagnosis of narcotic poisoning or prescription drug abuse within the last 365 days will be reviewed for the lock-in program. Prescribers within the same practice are counted as a single prescriber. Pharmacies with multiple locations that share real-time data are counted as one pharmacy. Members identified for the lock-in program receive written notification from Humana Healthy Horizons, along with the designated lock-in pharmacy's information and the member's right to appeal the plan's decision.

Members are initially locked in for a total of two years, during which members can request a change from their designated lock-in pharmacy upon approval. Members will be notified as to whether the request for the change has been approved or denied. If a member should transfer between MCOs, the member will remain in the SPLIP program continuously, regardless of Medicaid eligibility. Following the member's two-year enrollment, the member's future claims are monitored. If the member meets the established criteria, the member will be reenrolled in the SPLIP.

Excluded from enrollment in the lock-in program are:

- Members in hospice and those who are no longer Medicaid eligible
- Members younger than 14 years old
- Members currently in a lock-in program
- Members with sickle cell disease (International Classification of Diseases, 10th Revision [ICD-10] codes D57.00–D57.1, D57.20–D57.219 and D57.4–D57.819)
- Members enrolled in both Medicaid and Medicare

Members identified for the lock-in program receive written notification from Humana Healthy Horizons, along with the designated lock-in pharmacy's information and the member's right to appeal the plan's decision.

In the event of an emergency override by the pharmacy, the member will be given a three-day (72-hour) supply of the medication. If the medication is not in stock, an override of up to a 30-day supply will be approved with a coordinating pharmacy of the member's choice that can supply the medication.

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

- Call **833-410-2496**, 8 a.m. – 5:30 p.m., Eastern time. After-hours, please leave a voicemail with the member name, member ID number, case number, contact phone number and a detailed description of your request.
- Fax: **502-996-8184**
- Email: CPORM@humana.com

Continuity of care

Continuity of care policy

This policy applies to prescribed medications that are subject to certain limitations, such as prescription drugs not listed on the CDL and prescription drugs requiring prior authorization, step

therapy or quantity limit. This policy helps by providing a temporary supply to members who have limited ability to receive their prescribed drug therapy. For new members, Humana will cover a temporary supply as indicated in the chart below, including for out-of-network pharmacies. If the member presents a prescription written for less than the days' supply allowed, Humana will allow multiple fills to provide up to the total days' supply of medication allowed.

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

Continuity of care will not work under the following conditions:

- Medicaid-excluded prescription drugs
- Safety edits
- Eligibility criteria are not met

Program	Total days' supply allowed	Total days allowed for transition
Humana Healthy Horizons in South Carolina	90	90

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

Humana requires all pharmacies to submit the patient residence code (NCPDP field 384-4X) and pharmacy service type (NCPDP field 147-U7) on all claims. Claims submitted with a missing or invalid code will be rejected at the POS. The tables below list valid patient residence codes and pharmacy service types.

Patient residence codes	Description
0	Not specified
1	Home
3	Nursing facility
4	Assisted living facility
6	Group home
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 for a managed Medicaid plan with a missing or invalid patient residence code, the claim will reject with NCPDP error code 4X and return the following message: **Missing/Invalid Patient Residence Code.**

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

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

Combination pharmacies

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

Home infusion billing procedure

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

Compound claims

Submitting compound claims

The pharmacy must submit the correct amount with corresponding accurate quantities and days’ supply calculations based on a valid prescription for the member. The pharmacy must submit all

ingredients that make up a compound drug on the same claim. The most expensive ingredient will display at the claim level. Edits are returned for each ingredient based on the member's benefits. 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 Medicaid-excluded ingredient contained in the compound.

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

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

Pharmacy audit and compliance

Pharmacy audit program

Humana maintains a pharmacy audit program to:

- Help ensure the validity and accuracy of pharmacy claims for its clients (including CMS and state agencies overseeing a program for Medicaid-eligible 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 prescription 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 or dispensing an incorrect drug
- Billing the wrong member or an incorrect provider
- Using an NCPDP/NPI number inappropriately
- Invalid pharmacy service type submitted or invalid patient residence code submitted
- Calculating the days' supply incorrectly or 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 LTC 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 has a process in place to conduct a pharmacy compliance program audit at Humana’s discretion to assure 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 a plan administered by Humana are subject to compliance program audits that may occur on an ad-hoc basis. Humana notifies a pharmacy of its intent to audit and provides specific directions regarding the process. If an audit identifies deficiencies, a corrective action plan is issued. Humana works with the pharmacy to ensure the deficiencies are remediated in a timely manner and 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 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-administered plans and products that have a pharmacy benefit. All organizations supporting any of the products Humana administers are required to have a comprehensive plan to detect, correct and prevent FWA 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, then 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

Pharmacies may use their own materials 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 Policy.pdf](https://assets.humana.com/is/content/humana/Compliance%20Policy.pdf)
- Humana Ethics Every Day for Contracted Healthcare Providers and Third Parties: [https://assets.humana.com/is/content/humana/Ethics Every Day.pdf](https://assets.humana.com/is/content/humana/Ethics%20Every%20Day.pdf)

Note: The Humana materials alone may not be used to meet the FWA training requirement. However, a pharmacy may use these documents to supplement or integrate within your 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 retained 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 Healthy Horizons members or Humana, the pharmacy must report it to Humana, along with actions taken by the pharmacy to address the violation.

Methods to report suspected or detected fraud, waste and abuse and/or noncompliance

Humana expects all organizations supporting Humana to provide 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:** A person with a concern is allowed to submit 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 and 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/legal/fraud-waste-and-abuse](https://www.humana.com/legal/fraud-waste-and-abuse)**.

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 that may be outlined in the contract
- Mandatory retraining
- Formal, written corrective action plan(s) tracked to closure
- Reporting the violation and action(s) taken by Humana Reporting 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 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 are also expected to:

- Promote to those supporting Humana the available methods for reporting compliance and FWA concerns and the nonretaliation 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 by email.
 - It is not sufficient to post information only within a facility and not share it by 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 nonintimidation and nonretaliation.

Standards of conduct/ethics

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

- Your organization must require employees, management, governing body members and those with whom the pharmacy contracts to support its contractual obligations with Humana's Medicaid products to review and attest to compliance with the pharmacy's standards of conduct document upon hire or contract and annually thereafter.
- If a 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](https://assets.humana.com/is/content/humana/Ethics%20Every%20Day.pdf)**.
- 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 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 agency (contracting Humana for Medicaid plan administration) of an entity with a location outside of the U.S. 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 government contract may have prohibitions related to the offshoring of information.
- **Establishment, documentation and communication of effective compliance policies:** Your organization must have policies and procedures in place for preventing and detecting 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 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 (i.e., 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 it contracts 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 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 Medicaid products can be found in Humana’s Compliance Policy at [https://assets.humana.com/is/content/humana/Compliance Policypdf](https://assets.humana.com/is/content/humana/CompliancePolicypdf).

Additional, required compliance education and training

Network pharmacies supporting Humana Healthy Horizons must also educate those employed or contracted to perform a function in support of the plan in multiple ways, as noted below:

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

Note: *Humana documents, or documents that are materially similar, can be used to meet the compliance policy and standards of conduct requirements. These materials are available at Provider.Humana.com/pharmacy-resources/manuals-forms.*
- Conduct training on understanding and addressing FWA via material developed or adopted by the pharmacy.

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

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

Note: Humana will notify a pharmacy if an organization-level attestation must be submitted

to certify compliance with these additional requirements.

Additional guidance related to compliance program requirements 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 may change, Humana reserves the right to require additional or different compliance program training or components, although it strives not to make midyear changes.

Humana pharmacy credentialing

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

- Pharmacy's state licensure information
- Pharmacy's DEA licensure information
- Signed and dated attestation stating the pharmacy is free of sanctions imposed by federal, state and local authorities
- Copy of current professional liability insurance coverage that meets or exceeds a minimum requirement of \$1 million in aggregate
- Pharmacy's NCPDP number
- Medicaid ID number for South Carolina

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

Mail-order pharmacy providers must be licensed by the appropriate state board. Additionally, a special nonresident South Carolina permit number is required for all out-of-state providers. Such permits are issued by the Board of Pharmacy under the South Carolina Department of Labor, Licensing and Regulation. Information is available at <https://www.llr.sc.gov/bop/>.

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 it 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 it 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 with a Medicaid component. 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 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://assets.humana.com/is/content/humana/Pharmacy%20Pricing%20Review%20Request%20Excel%20File_Portal
- 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 contact Humana and speak to a representative regarding its request at **888-204-8349**, Monday – Friday, 8 a.m. – 5 p.m., Eastern time, for retail. The following must be included in the request:

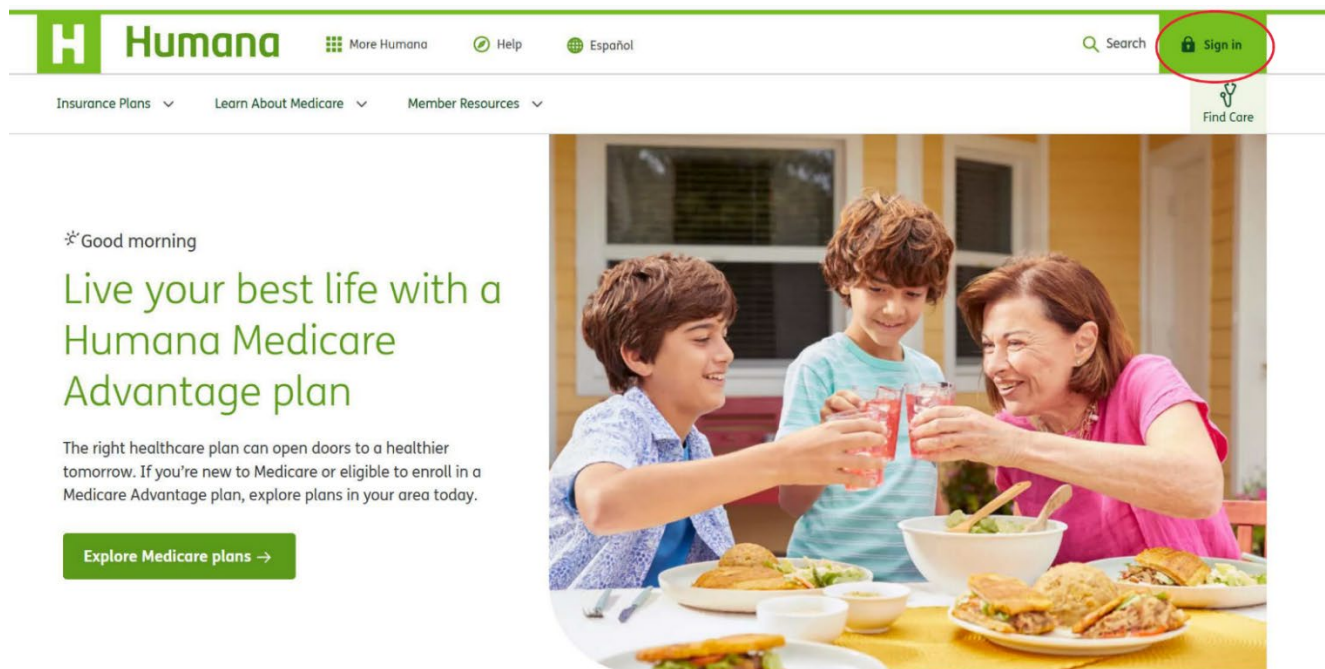
- Pharmacy name, address and NCPDP
- PCN
- Prescription number
- Prescription drug name and strength
- Prescription drug NDC
- Date of initial fill and quantity of fill

- Relevant documentation that supports the MAC is below the cost available to the pharmacy and any other supporting documentation as needed

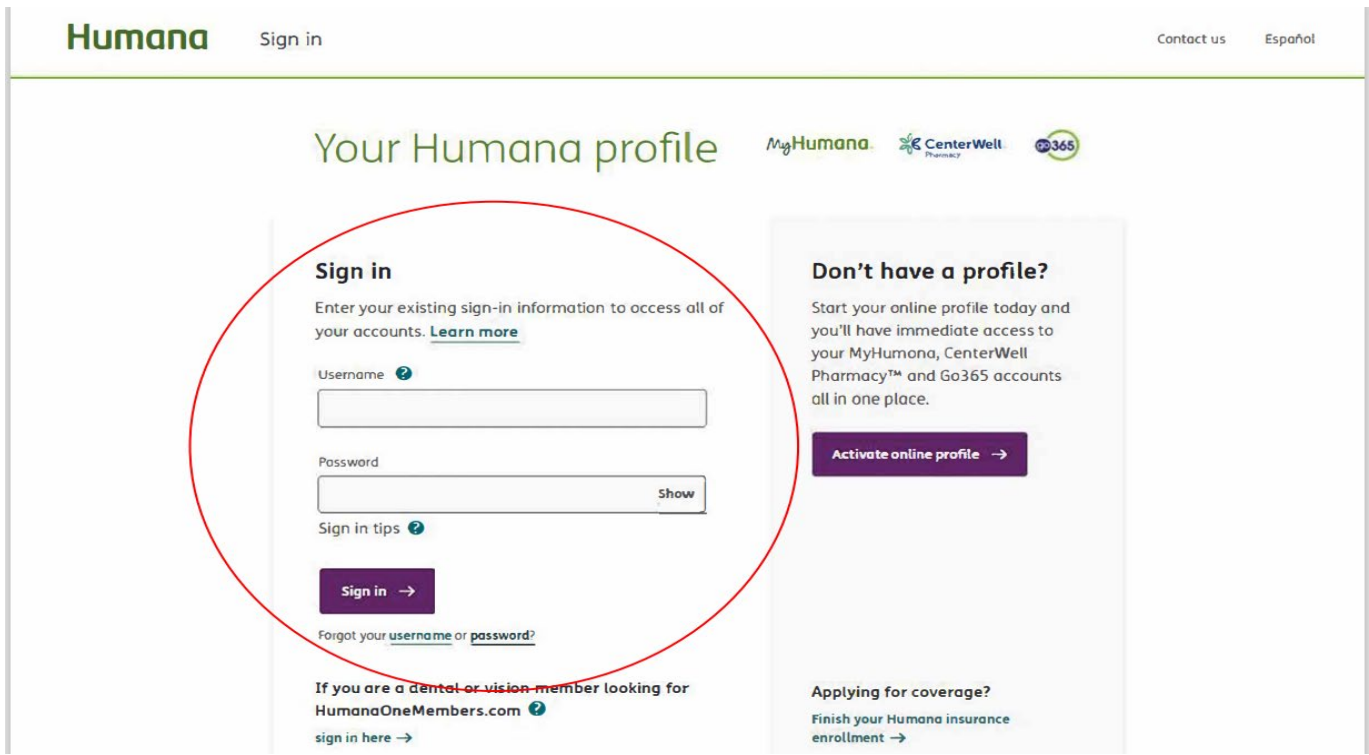
Humana will respond to the network pharmacy’s request within five business days of receipt by Humana. In the event the MAC appeal is denied, Humana will provide the reason for the denial and will identify an NDC for the prescription drug product at or below the current MAC price. If the MAC request is 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 and are subject to change.

Pharmacy maximum allowable cost list location

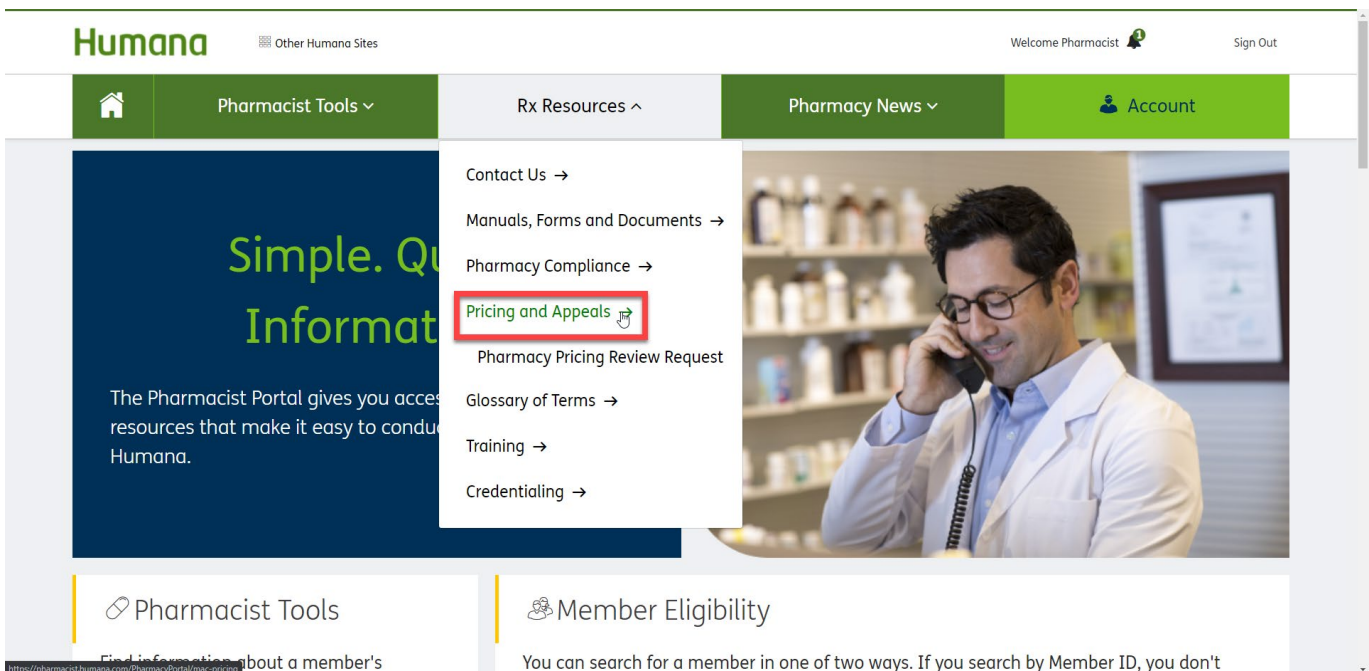
When network pharmacies need to locate the current MAC list, they can follow the steps below at **Humana.com**. They will see the screen below. Select the “**Sign in**” button located on the top right corner of the screen.



The pharmacy will then enter the username and password that it set up at the time it contracted with Humana. If the pharmacy is unsure of its username and password, it should contact the pharmacy contracting team at PharmacyContracting@humana.com and ask to have the pharmacy's 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 the pharmacy chooses will show as download only or load on the page.

A network pharmacy with a pricing dispute should follow the steps below to submit a pricing review form to Humana.

- 1) Select **“Pharmacy Pricing Review Request”** in the upper right corner.

The screenshot shows the Humana Pharmacist Portal interface. At the top, there is a navigation bar with the Humana logo, 'Other Humana Sites', 'Welcome Pharmacist', and 'Sign Out'. Below this is a secondary navigation bar with 'Pharmacist Tools', 'Rx Resources', 'Pharmacy News', and 'Account'. The main content area is titled 'Pricing and Appeals' and includes an 'Export Excel File' button and a purple button labeled 'Pharmacy Pricing Review Request' which is highlighted with a red box. The form below contains several input fields: 'Source List' (a dropdown menu), 'Date of Fill' (a date picker), 'Include inactive price records' (a checkbox), 'Generic Code Number (GCN)', 'NDC Number', and 'Drug Name' (all text input fields), and a 'Search' button.

- 2) The pharmacy must complete all fields in the form below and return it to Humana by selecting the **“Submit”** button located in the bottom right corner of the form to initiate the dispute process.

The screenshot shows the 'Pharmacy Pricing Review Request' form. At the top, there is a breadcrumb trail: 'Pharmacist Portal / Rx Resources / Pharmacy Pricing Review Request'. The form title is 'Pharmacy Pricing Review Request'. Below the title, there is a note: 'For multiple pricing review requests, please download [excel file](#) and email to pharmacypricingreview@humana.com'. The form contains several input fields: 'Pharmacy Name' (text input), 'Pharmacy NCPDP' (text input), 'Phone Number' (text input), 'Fax Number' (text input), 'Email Address' (text input), 'Rx Number' (text input), 'Drug Name' (text input), 'BIN' (text input), 'PCN' (text input), 'Date of Service' (date picker), 'Drug NDC' (text input), and 'Is this a Hospice claim?' (radio buttons for Yes and No). There is also an 'Add Attachment' section with a 'Choose File' button and 'No file chosen' text. A 'Comments' field is located at the bottom left. At the bottom right, there is a 'Cancel' button and a purple 'Submit' button which is highlighted with a red box.

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

Pharmacy's process for filing a complaint

SS&C Health system issues

All pharmacies contracted with Humana are encouraged to contact the Humana Healthy Horizons in South Carolina pharmacy help desk at **844-918-0109**, 24 hours a day, seven days a week, for questions or complaints related to a system issue or claims transaction. SS&C Health has a dedicated telephone support unit that provides guidance for calls related to pharmacy claims. All issues that cannot be addressed or resolved by SS&C Health are forwarded to the Pharmacy Networks department for research and resolution at **888-204-8349**.

Pharmacy initiative inquiries

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

Member complaint system

The section below is from the member grievance and appeal procedure as set forth in the Humana Member Handbook. This information is provided to the pharmacy so that the pharmacy may assist members in this process if they request assistance. Please contact your 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 recipients can file a grievance at any time. Grievances can be submitted using either method provided below.

- The member can submit written grievances to:
Humana Healthy Horizons in South Carolina
Grievance and Appeal Department
P.O. Box 14546
Lexington, KY 40512-4546
- Fax: **800-949-2961**
- For verbal grievances, the member can call Customer Service at **866-432-0001 (TTY: 711)**, Monday – Friday, 8 a.m. – 8 p.m., Eastern time.

Member appeals

The member, prescriber or member representative may submit an expedited or standard appeal in writing within 60 calendar days of the date of the denial notice. Options for submitting the appeal:

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

Humana Healthy Horizons in South Carolina
Grievance and Appeal Department
P.O. Box 14546
Lexington, KY 40512-4546

Fax: **800-949-2961**

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

If the member is requesting an expedited appeal or is unable to write an appeal, oral appeals are accepted. Medicaid members may ask for an appeal by calling Customer Service at **866-432-0001 (TTY: 711)**.

For all members, their healthcare provider, pharmacist or someone else can make an appeal on their behalf. However, an Appointment of Representative form must be completed. This form provides permission for another person to act on behalf of the member.

To obtain an Appointment of Representative form, the member can call Customer Care and ask for one or 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 grievance and/or appeal and inform them of Humana's decision. If the member has questions concerning the grievance or appeal, direct them to the Humana Member Handbook or contact Humana using the number on the back of their member ID card.