

Humana Pharmacy Solutions

Pharmacy Manual

Humana Healthy Horizons in Virginia
2026 Edition

Humana
Healthy Horizons.
in Virginia



CardinalCare
Virginia's Medicaid Program

774603VA0326 VAHL5HWEN

Table of contents

Introduction	4
Contact information	5
Eligibility verification	6
Humana member identification cards	6
Cardholder ID	7
Coordination of benefits	7
Drug coverage	8
Drug Lists	8
Utilization management	8
Coverage determinations	8
72-hour emergency fill	9
Copayments	9
General claims procedures	9
Submitting pharmacy claims	9
Bank Identification Numbers and Processor Control Numbers The Bank Identification Number (BIN) and Processor Control Number (PCN) for Humana Healthy Horizons in Virginia is below:	9
Prescription origin code requirements	9
Fill number	10
Sales tax	10
Timely submission of claims	10
Humana-specific SS&C Health payer sheets	11
Prescriber National Provider Identifier (NPI) submission	11
Dispense-as-written codes	12
Drug utilization review safety edits	12
Soft reject drug utilization review	13
Submitting claims for 340B medications	15
Vaccine administration	15
Vaccines for Children Program	15
Controlled substance claims	16
Clarification of federal requirements—Schedule II drugs	16
Submitting CII claims	17
Point-of-sale edits and overrides	17
Patient Utilization Management and Safety Program	17
Continuity of care	18
Continuity of care policy	18
Long-term care	18
Long-term care pharmacy information	18
Long-term care claims-processing guidelines	18
Home infusion billing procedure	19
Compound claims	20
Submitting compound claims	20
Pharmacy audit and compliance	20
Pharmacy audit program	20
Long-term care pharmacy audits	21
Compliance program oversight	21

Fraud, waste and abuse and compliance program requirements	21
Requirement to report suspected or detected FWA and/or noncompliance	22
Prohibition against intimidation or retaliation	23
Disciplinary standards	23
Corresponding expectations	24
Standards of conducts/ethics	24
Compliance program requirements	25
Humana pharmacy credentialing	27
Conflicts of interest	27
Complaint system	28
Pharmacy's pricing dispute process	28
Pharmacy maximum allowable cost list location	29
Pharmacy's process for filing a complaint	31
Member complaint system	31

Introduction

Dear pharmacy:

Humana appreciates your role in delivering quality pharmacy services to our Medicaid members. This manual pertains exclusively to Virginia members enrolled in Humana Healthy Horizons® in Virginia 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 operated 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 entities 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 links 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 (PA) for a member

This resource is available to any pharmacy contracted with Humana and is provided free of charge. To gain access, visit **Account.Humana.com/**, select "Activate online account" and choose 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 for your participation in the Humana pharmacy provider network.

Sincerely,

The Humana Pharmacy Solutions® Network team

Contact information

Pharmacy help desk

800-865-8715, 24 hours a day, seven days a week
(for refill-too-soon overrides and PA status)

Humana Customer Care

To obtain general Medicaid plan information:
844-881-4482 (TTY: 711), daily, 8 a.m. – 8 p.m., Eastern time

Humana Clinical Pharmacy Review (HCPR)

To submit PA requests:

- Obtain forms at **Provider.Humana.com/pharmacy-resources/prior-authorizations** or submit your request electronically by visiting www.covermymeds.health/prior-authorization-forms/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 Virginia pharmacy help desk

844-918-0115, 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 identification cards


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

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

Humana Healthy Horizons. in Virginia
A Medicaid product of Humana WI Health Org. Ins. Corp

MEMBER NAME
MEMBER ID: HXXXXXXXXX
Medicaid ID#: XXXXXXXX
Effective Date: XX/XX/XX

RxGRP: VAM01
RxBIN: 610649
RxPCN: 03191507



CardinalCare
Virginia's Medicaid Program

In case of emergency, call 911 or go to the closest emergency room.
After treatment, call your PCP within 24-hours or as soon as possible.

Member/Provider Services: 844-881-4482 (TTY: 711)
Member Transportation Services: 877-718-4215
Clinical Triage Line BH/ARTS Crisis, Nurse Line: 888-445-8714
Member Dental Program: 888-912-3456
Pharmacy Rx Inquiries: 844-918-0115
Please visit us at: Humana.com/HealthyVirginia
To connect with Virginia Medicaid visit: dmas.virginia.gov
For online provider services, go to Availity.com
Please mail all claims to:
Humana Medical
P.O. Box 14359
Lexington, KY 40512-4359

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

Humana Healthy Horizons. in Virginia
Un producto de Medicaid de Humana WI Health Org. Ins. Corp.

NOMBRE DEL AFILIADO
IDENTIFICACIÓN DEL AFILIADO: HXXXXXXXXX
N.º de Identificación de Medicaid: XXXXXXXX
Fecha de Vigencia: XX/XX/XX

RxGRP: VAM01
RxBIN: 610649
RxPCN: 03191507



CardinalCare
Virginia's Medicaid Program

En caso de emergencia, llame al 911 o diríjase a la sala de emergencias más cercana.
Luego del tratamiento, llame a su médico de cuidado primario (PCP, por sus siglas en inglés) dentro de las 24 horas o tan pronto como pueda.

Servicios para Afiliados/Proveedores: 844-881-4482 (TTY: 711)
Servicios de Transporte para Afiliados: 877-718-4215
Línea de Triage Clínico para Crisis de Salud Conductual/Servicios de Tratamiento de Adicción y Recuperación (BH/ARTS), Línea de Enfermería: 888-445-8714
Programa Dental para Afiliados: 888-912-3456
Preguntas sobre Recetas de Farmacia: 844-918-0115
Visítenos en: es-www.humana.com/HealthyVirginia
Para comunicarse con Medicaid de Virginia, visite: dmas.virginia.gov
Para servicios para proveedores en línea, diríjase a Availity.com
Envíe todas las reclamaciones por correo postal a:
Humana Medical
P.O. Box 14359
Lexington, KY 40512-4359

Card for a Family Access to Medical Insurance Security Plan (FAMIS) member with Humana Healthy Horizons in Virginia (English)


FAMIS is Virginia's health insurance program for children who meet the following qualifications:

- Under 19 years old
- Uninsured
- Live in Virginia
- Live in families that meet income rules
- United States citizens or lawfully residing immigrants

Humana Healthy Horizons. in Virginia
 A Medicaid product of Humana WI Health Org. Ins. Corp

FAMIS
MEMBER NAME
MEMBER ID: HXXXXXXXXX
 Medicaid ID#: XXXXXXXX
 Effective Date: XX/XX/XX

RxGRP: VAM01
 RxBIN: 610649
 RxPCN: 03191507



CardinalCare
 Virginia's Medicaid Program

In case of emergency, call 911 or go to the closest emergency room.
 After treatment, call your PCP within 24-hours or as soon as possible.

Member/Provider Services: 844-881-4482 (TTY: 711)
 Member Transportation Services: 877-718-4215
 Clinical Triage Line BH/ARTS Crisis, Nurse Line: 888-445-8714
 Member Dental Program: 888-912-3456
 Pharmacy Rx Inquiries: 844-918-0115
 Please visit us at: Humana.com/HealthyVirginia
 To connect with Virginia Medicaid visit: dmas.virginia.gov
 For online provider services, go to Availity.com
 Please mail all claims to:
Humana Medical
P.O. Box 14359
Lexington, KY 40512-4359

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

Humana Healthy Horizons. in Virginia
 Un producto de Medicaid de Humana WI Health Org. Ins. Corp.

NOMBRE DEL AFILIADO
IDENTIFICACIÓN DEL AFILIADO: HXXXXXXXXX
 N.º de Identificación de Medicaid: XXXXXXXX
 Fecha de Vigencia: XX/XX/XX

RxGRP: VAM01
 RxBIN: 610649
 RxPCN: 03191507



CardinalCare
 Virginia's Medicaid Program

En caso de emergencia, llame al 911 o diríjase a la sala de emergencias más cercana.
 Luego del tratamiento, llame a su médico de cuidado primario (PCP, por sus siglas en inglés) dentro de las 24 horas o tan pronto como pueda.

Servicios para Afiliados/Proveedores: 844-881-4482 (TTY: 711)
 Servicios de Transporte para Afiliados: 877-718-4215
 Línea de Triage Clínico para Crisis de Salud Conductual/Servicios de Tratamiento de Adicción y Recuperación (BH/ARTS), Línea de Enfermería: 888-445-8714
 Programa Dental para Afiliados: 888-912-3456
 Preguntas sobre Recetas de Farmacia: 844-918-0115
 Visítenos en: es-www.humana.com/HealthyVirginia
 Para comunicarse con Medicaid de Virginia, visite: dmas.virginia.gov
 Para servicios para proveedores en línea, diríjase a Availity.com
 Envíe todas las reclamaciones por correo postal a:
Humana Medical
P.O. Box 14359
Lexington, KY 40512-4359

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

Cardholder ID

Pharmacies should submit the Medicaid 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 identification cards” section above.

For Medicaid claims, Humana allows the cardholder ID to be submitted with the member’s Medicaid ID or their 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 Medicaid ID.

Coordination of benefits

Effective Jan. 1, 2006, Medicaid members who are entitled to receive Medicare benefits under Part A or Part B no longer receive their pharmacy benefits under their state Medicaid agency, except for 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 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 prescription drugs specifically excluded under section 1927 (d)(2) of the Social Security Act.

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

- 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 Preferred Drug List (PDL) is developed and maintained by the Medicaid Drug Utilization Review Board in Virginia, which consists of providers and pharmacists. The PDL indicates the preferred and nonpreferred status of covered medications on the member's benefit and identifies prescription drug utilization management requirements, such as PA, quantity limits and step therapy.

PDLs are updated regularly. To view changes and the current PDL for Humana Healthy Horizons Medicaid-eligible members, please visit

Provider.Humana.com/pharmacy-resources/tools/humana-drug-lists.

Utilization management

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

- **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 prescription drugs 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 and approved label use of these prescription drugs. 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 PA, 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.health/prior-authorization-forms/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 may 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. For unit-of-use prescription drugs (inhalers, eye drops, insulin, etc.), the entire unit should be dispensed for the 72-hour supply.

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.

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

Copayments

There are no cost-sharing obligations (coinsurance, deductibles or copayments) for prescription drugs for Humana Healthy Horizons in Virginia members.

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) for Humana Healthy Horizons in Virginia is below:

Plan	BIN	PCN
Humana Healthy Horizons in Virginia	610649	03191507

Prescription origin code requirements

Humana requires the prescription origin code (NCPDP Telecommunications Standard D.0 field 419-DJ) to be included on all new 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 Long-term Care (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). There are special circumstances under which a pharmacy may submit claims after the DOS, including the following:

- Coordination of benefits (COB) resolutions that necessitate claim reversals and subsequent rebilling to the correct payer are subject to the timely filing applicable to POS claims.
- **Subrogation** claims, which have 36 months for submission
- **POS** claims, reversals (B2 transactions) and adjustments (B3 transactions), 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 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.

Humana-specific SS&C Health payer sheets

Pharmacists can find the pharmacy payer sheet (D.O Medicaid) at Provider.Humana.com/pharmacy-resources/manuals-forms.

Prescriber National Provider Identifier (NPI) submission

Humana requires the use of a valid and accurate Type 1 (also known as “individual”) prescriber NPI on all electronic transactions. Claims submitted without a valid and active Type 1 NPI will be rejected at the POS with the following error message: “Prescriber Type 1 NPI required.”

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

NCPDP error code	NCPDP error code description	Free-form messaging	Applicable SCC
56	Nonmatched prescriber ID	Prescriber ID submitted not found. If validated, submit applicable SCC.	42
42	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 United States Drug Enforcement Administration (DEA) number for the 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 prescription 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 required. The 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.	Provider ineligible to perform 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.

Medicaid has certain preferred brand-name medications when the brand-name medication is on the formulary and the generic is not. This may require the pharmacy to use DAW 9 when submitting a claim. Please refer to the PDL to identify the preferred brand-name medications.

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

DUR type	Pharmacy information	Example
Drug–drug interactions	This DUR type 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 DUR type identifies safety risk related to the use of a specific medication for a patient’s age.	Revatio for patients younger than one years old.
Drug–disease interaction	This DUR type 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

Maximum dose	This DUR type identifies safety risk when the dosage exceeds the First Databank (FDB) maximum adult daily dose. The ratio of exceeding FDB maximum dosing is specific to the medication.	digoxin daily dose greater than 500 mcg
MED* high dose	This DUR type identifies patients at greater risk of overdose or inappropriate opioid utilization. Dosing greater than 90 mg MED per day will trigger this error code.	MS Contin 30 mg twice daily plus Percocet 10/325 mg two tablets every eight hours as needed
MED* overuse	This DUR type identifies patients at greater risk of overdose or inappropriate opioid utilization (dosing greater than 90 mg MED per day).	MS Contin 50 mg twice daily
Plan limitations exceeded: accumulation	This DUR type identifies the potential for an overdose resulting in single or multiple medications and cumulative doses that exceed safe daily maximums	acetaminophen dose greater than four grams per day
Therapeutic duplication	This DUR type 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 codes from the following list:

NCPDP error code	NCPDP description	Reason for service	Professional service	Result of service
88: DUR reject error	This prescription drug interacts with the patient's other drug(s).	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 prescription drug may duplicate current patient therapy.	TD: Therapeutic duplication	M0: Prescriber consulted PE: Patient education/instruction	1A: Filled as is, false positive 1B: Filled prescription as is

			PO: Patient consulted RO: Pharmacist consulted other source SW: Literature search/review TH: Therapeutic product interchange	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 or nonhospice palliative care 4L: Prescriber specialty exemption hospice
88: DUR reject error	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

70: DUR reject error	This prescription drug interacts with the patient's disease state.	DC: Drug disease	DE: Dosing evaluation M0: Prescriber consulted MP: Patient will be monitored PE: Patient education/instruction PO: 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
----------------------	--	------------------	---	--

† 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 associated with the injection of vaccines covered by the plan. Pharmacists in Humana-participating pharmacies can administer the vaccines if allowed by Virginia state law.

Submitting claims for vaccine administration

To submit claims for 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 Program

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

Vaccines can be obtained at no cost through the Virginia Department of Health, Division of Immunization for Humana Healthy Horizons in Virginia members younger than 19 years old.

To enroll in the VVFC program, pharmacy providers can call **804-864-8055**. Providers can also visit www.vdh.virginia.gov/immunization/ to select the program of interest from the navigation options and print the provider agreement form.

All pharmacy providers are required to upload vaccine administration information into the statewide immunization registry database, Virginia Immunization Information System (VIIS), for both public and private stock within 30 days of administration. To set up access to VIIS, please review the enrollment website at www.vdh.virginia.gov/immunization/viis.

Humana will pay pharmacies an administration fee for administering one of the VVFC program pediatric vaccines to eligible Humana Healthy Horizons in Virginia 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 VVFC program to administer vaccines to eligible members and order the vaccines from that program at no cost. For additional information, please visit www.vdh.virginia.gov/immunization/vvfc/.

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 refills and partial fills of Schedule II prescription 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 prescription 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 (verifying with the prescriber as necessary) that controlled substances, including Schedule II prescription drugs, are being filled only in accordance with federal and state law. This includes preventing refills and partial fills of Schedule II prescription drugs that are not allowable under the Controlled Substances Act.

Submitting CII claims

CMS ruling CMS-0055-F mandates that a valid Quantity Prescribed (NCPDP field 460-ET) is submitted on all federally designated controlled substance level II (CII) prescription 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. Please see the “Pharmacy resources” tab under “Manuals and forms.”

Patient Utilization Management and Safety Program

The Patient Utilization Management and Safety (PUMS) Program is designed for individuals enrolled in Humana Healthy Horizons in Virginia who need care coordination. It is intended to limit overuse of benefits and reduce unnecessary costs to Medicaid while providing an appropriate level of care for the member.

Members who meet the program criteria may be limited to providers and/or a pharmacy on a case-by-case basis (and/or a referral to utilization management or a case coordinator). Humana Healthy Horizons members receive written notification stating that they meet the criteria for PUMS and need to respond within 15 days of receiving the notification letter to choose a pharmacy and provider to receive services. If a response is not received within 15 days, selections will be made for the Humana Healthy Horizons member.

The member will receive a letter that provides the following information:

- Name of the designated provider and/or pharmacy
- Instructions for requesting a change to the designated pharmacy and/or provider
- Reason for restriction
- Effective date of program enrollment
- Length of limitation
- Rights to appeal the decision
- Emergency after-hours prescriptions

Members diagnosed with cancer, enrolled in hospice, enrolled in both Medicaid and Medicare programs, and individuals 14 years old or younger are exempt from PUMS.

If you or the member have questions, please feel free to contact Humana Healthy Horizons in Virginia in one of the following ways:

- Phone number: **833-410-2496 (TTY: 711)**, Monday – Friday, 8 a.m. – 5:30 p.m., Eastern time (After-hours, please leave a voicemail with the member name, member ID number, contact phone number and a detailed description of your request.)
- Fax number: **502-996-8184**
- Email: CPORM@humana.com

Continuity of care

Continuity of care policy

This policy applies to prescribed drugs that are subject to certain limitations, such as prescription drugs not listed on the PDL and prescription drugs requiring PA, 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 his or her prescriber and decide if an alternative prescription drug is appropriate or request an exception or PA. Humana will not pay for additional refills of temporary supply drugs until an exception or PA 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 Virginia	60	60

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
9	Intermediate care facility/mentally retarded [‡]
11	Hospice

[‡] Pharmacy code only. This is not Humana-approved language.

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

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

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

Combination pharmacies

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

Home infusion billing procedure

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

Compound claims

Submitting compound claims

The pharmacy must submit the correct amount with corresponding accurate quantities and days' supply calculations based on a valid prescription for the member. The pharmacy must submit all ingredients that make up a compound drug on the same claim. The most expensive ingredient will display at the claim level. Edits are returned for each ingredient based on the member's benefits. 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 members
- Help ensure compliance with the provider agreement between Humana, its network pharmacies and this manual
- Help ensure compliance with federal and state laws/regulations and drug-specific requirements
- Educate network pharmacies regarding proper submission and documentation of pharmacy claims

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

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

- Dispensing unauthorized, early or excessive refills or dispensing an incorrect prescription drug
- Billing the wrong member or billing an incorrect provider
- Using an NCPDP/NPI number inappropriately
- Submitting an invalid pharmacy service type or invalid patient residence code
- Calculating the days' supply incorrectly or using a DAW code incorrectly
- Overbilling quantities or not retaining/providing the hard copy of prescriptions or a signature log/delivery manifest
- Submitting claims 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**, scroll down to "Manuals and 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 an audit review. 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, scroll down to "Manuals and forms," and select the "Audit guide, claim form and other materials" tab.

Compliance program oversight

Humana maintains a compliance program that includes oversight of pharmacies 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 Humana's Medicaid products are subject to ongoing monitoring of pharmacies' compliance programs, as well as audits that may occur on an ad hoc basis. Humana notifies a pharmacy of monitoring activities that require timely responses and its intent to audit and provides specific directions regarding the oversight process. If an oversight activity 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 available at **Provider.Humana.com/pharmacy-resources/manuals-forms**) that are 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. In addition to Humana-administered plans and products that have a pharmacy benefit for Medicare-eligible beneficiaries, Humana is an administrator of Medicaid products that have a pharmacy benefit. All organizations supporting any of the products Humana administers are required to have a comprehensive plan to detect, correct and prevent fraud, waste and abuse (FWA). Humana is committed to:

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

Humana is an administrator of Medicaid products that have a pharmacy benefit. All such organizations supporting any of these products Humana administers are required to have a comprehensive plan to detect, correct and prevent FWA. Humana has such a plan.

Training to combat FWA

Every Humana-contracted entity supporting Humana's products is responsible for:

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

Material to use

Pharmacies may use their own materials to meet the FWA training requirement or adopt another organization's training material on the topic. 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
- Humana Ethics Every Day for Contracted Healthcare Providers and Third Parties:
https://assets.humana.com/is/content/humana/Ethics_Every_Day.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, including the completion date, attendance, topic, certificate of completion (if applicable) and test scores for all tests administered for 11 years (or longer, if required by state law).

Additional assurance

Humana and applicable government agencies overseeing Medicaid programs reserve the right to conduct oversight of contracted pharmacies to assess their commitment to FWA training requirements, including requests that require these pharmacies to provide corresponding documentation.

Requirement to report suspected or detected FWA and/or noncompliance

All pharmacy employees and subcontractors who support the pharmacy's contract with Humana for Humana Healthy Horizons, as well as governing body members (e.g., Board of Directors), must report suspected or detected fraudulent or noncompliant activities that pertain to Humana Healthy Horizons in Virginia by using one of the reporting methods provided by the pharmacy. When the subject of the reported activities impacts Humana Healthy Horizons and/or plan members, the pharmacy must report to Humana the matters and the actions taken by the pharmacy.

Humana offers multiple options to report concerns. The most expedient manner is by calling the Humana Special Investigation Unit (SIU) at **800-614-4126 (TTY: 711)**, 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 makes the following reporting options available:

Phone:

- Humana Special Investigations Hotline (voice messaging system):
800-614-4126 (TTY: 711)
- Humana Ethics Help Line:
877-5-THE-KEY (584-3539)

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

Fax number: **920-339-2005**

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:

<https://secure.ethicspoint.com/domain/media/en/gui/60750/index.html>

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

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

Prohibition against intimidation or retaliation

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

Disciplinary standards

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

- Oral or written warnings or reprimands
- Termination(s) of employment or contract
- Requirement for select individuals to be removed from supporting Humana business
- Mandatory retraining
- Formal, written corrective action plan(s) tracked to closure
- Reporting of the conduct to the appropriate external entity or entities, such as law enforcement agencies or a state agency that has contracted Humana to administer a Medicaid product
- Other measures that may be outlined in the contract

Note: The above disciplinary actions are not limited to those with direct violations. Such actions can also be imposed on those identified as not reporting awareness of a plan or action of another who was later determined to have committed FWA or a violation of Humana's standards of conduct or compliance policy (available at [Provider.Humana.com/pharmacy-resources/manuals-forms](https://www.humana.com/provider/humana.com/pharmacy-resources/manuals-forms)). The rationale is the inaction resulted in unnecessary risk for the pharmacy, plan members and Humana and could have subsequently contributed to any of the following: the violation that was committed by someone else and/or more severe, extensive or continued violations (and even monetary loss).

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

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

Corresponding expectations

Pharmacies are also expected to widely communicate the following:

- Available method(s) 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 regular (quarterly) emails to those performing a function in support of Humana.
 - 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 (i.e., remotely or within a home).
- Humana's policy of nonintimidation and nonretaliation

Standards of conducts/ethics

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

- Require employees, management, governing body members and those with whom the pharmacy contracts to support the pharmacy's contractual obligations to Humana's Medicaid products to review and attest to compliance with the pharmacy's standards of conduct document upon hire or contract and annually thereafter
 - If the contracted pharmacy does not adopt or have its own written standards of conduct that are materially similar to Humana's written standards of conduct, then Humana's standards of conduct document may be used. A copy can be accessed, printed and downloaded by visiting the link here:
[https://assets.humana.com/is/content/humana/Ethics Every Daypdf](https://assets.humana.com/is/content/humana/Ethics%20Every%20Day.pdf).
- Conduct the following for all new employees, management, governing body members and contracted individuals prior to hire/contract and monthly thereafter when they are designated to assist in the administration or delivery of federal healthcare program benefits in support of a Humana contract
 - Review the separate exclusion lists of the Office of Inspector General and General Services Administration's System for Award Management
- Remove any person or party identified on an exclusion list above from any work, or access to information or data, related directly or indirectly to Humana's support of a state-administered program, such as Medicaid, or any federal healthcare program, such as Medicare:
 - Notify Humana when the person/party had access to information pertaining to Humana Healthy Horizons in Virginia and/or was supporting Humana Healthy Horizons in Virginia
- Retain evidence of the exclusion screening for 11 years (or longer, if required by state law)

- Note: If a contract with Humana is terminated, the screening evidence must be retained for a minimum of 10 years after the termination date.
- Take appropriate corrective actions for standards of conduct violations and, when FWA is involved, report findings to Humana’s SIU at **800-614-4126 (TTY: 711)**

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 and 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 supporting Humana Healthy Horizons in Virginia include, but are not limited to:

- **No offshoring of members’ protected health information (PHI):** This is a requirement from the Virginia Department of Medical Assistance Services (DMAS).
- **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 Humana Healthy Horizons in Virginia. This is conducted from both operational and compliance perspectives and includes exclusion screening of all individuals and contracted entities that support Humana Healthy Horizons in Virginia.
- **Immediate notification to Humana of your organization’s intentions to utilize offshore resources in meeting any obligation to Humana which does not involve member PHI:** 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 that does not involve member PHI.**
- **Establishment, documentation and communication of effective compliance policies:** Your organization must have policies and procedures in place for preventing and detecting suspected FWA and/or nonadherence with compliance policies and/or standards of conduct, then correcting and reporting identified instances. These policies must include, but not be limited to:
 - Requiring employees, board members and subcontractors to report suspected and/or detected FWA and suspected violations of Humana’s compliance policy or standards of conduct
 - Those documents are available at **Provider.Humana.com/pharmacy-resources/manuals-forms**.
 - Requiring the reporting to Humana of any confirmed instances of ethical, compliance and/or FWA violations (and the action(s) taken)
 - 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 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, including who was identified as needing training, what training method was used, training status and materials used.

- **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 widely communicate methods for how to report suspected violations of Humana policies, government regulations and corresponding disciplinary standards to employees, volunteers, board members and subcontractors.
- **Disciplinary standards:** Your organization must have established disciplinary standards in place that are carried out when violations are committed by the pharmacy provider, its employees or those it contracts to support obligations to Humana.
- **Assurance:** Your organization must comply with Humana requests to provide assurance related to the pharmacy's compliance program.

These requirements are examples of ways to implement an effective compliance program. For an overview of the seven elements of an effective compliance program, please refer to Humana's compliance policy at the link here:

[https://assets.humana.com/is/content/humana/Compliance Policy.pdf](https://assets.humana.com/is/content/humana/Compliance%20Policy.pdf).

FAQ

Humana makes a guidance document publicly available online that includes FAQ and additional information regarding the compliance requirements at

https://assets.humana.com/is/content/humana/GCHJ9HTEN_FAQ.pdf.

Further compliance program requirements information for pharmacies supporting Humana's Medicaid products can be found in Humana's compliance policy at

[https://assets.humana.com/is/content/humana/Compliance Policy.pdf](https://assets.humana.com/is/content/humana/Compliance%20Policy.pdf).

Compliance training and assurance expectations, attestation requirements

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

Additional, required compliance education and training

Network pharmacies supporting Humana Healthy Horizons must also educate those employed and contracted to perform a function in support of the plan. The ways of meeting this requirement are noted below:

- Providing content on the following to those contracted and/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.*

- Conducting 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, or, in lieu of conducting their FWA training, their employer can confirm they are receiving FWA training elsewhere.*

Frequency and timing of the above is upon contract/hire and annually thereafter, according to 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 are listed 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 to be recredentialed at least every three years. The recredentialed request is sent to the pharmacy by fax or email and requires the pharmacy to return a recredentialed 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

Pharmacies that do not meet Humana's required standards, which include having an active state Medicaid ID and not being listed on any 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 in the state the pharmacy is physically located. Additionally, nonresident pharmacies must be registered with the Virginia Board of Pharmacy prior to shipping, mailing or delivering into the state of Virginia. Nonresident pharmacy registration information is available at <https://www.dhp.virginia.gov/Boards/Pharmacy>.

Conflicts of interest

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

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

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

Humana reserves the right to:

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

Pharmacies and those they employ or contract are prohibited from having any financial relationship 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
- Could reasonably be expected by Humana to influence a provider to utilize or bill for items or services covered under a federal healthcare program in a manner that is inconsistent with professional standards or norms in the local community

A violation of this prohibition could result in Humana terminating a pharmacy provider contract or requiring the provider to remove any applicable employed or contracted party or parties from supporting Humana Healthy Horizons in Virginia. Humana reserves the right to request information and data to ascertain ongoing compliance with these provisions.

Complaint system

Pharmacy's pricing dispute process

Network pharmacies have the right to submit a request to appeal, investigate or dispute the MAC reimbursement amount to Humana within 14 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 Pharmacy 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.

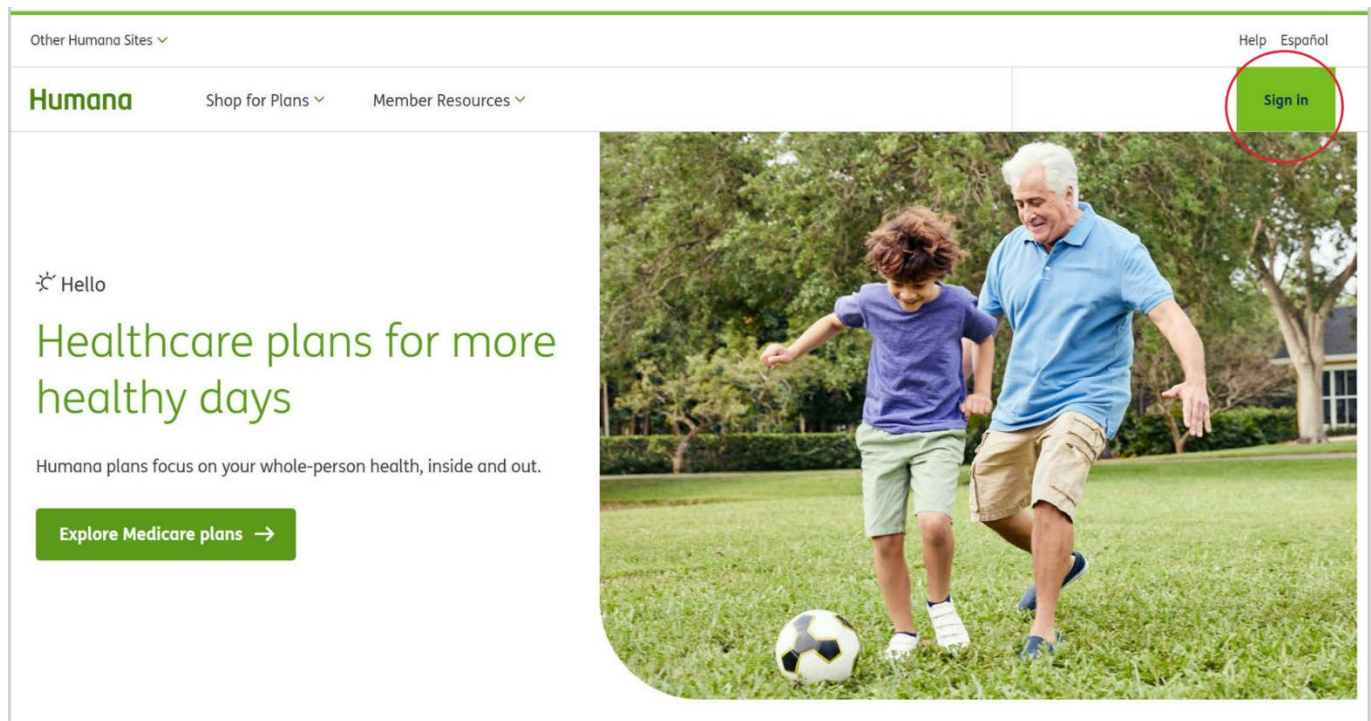
The pharmacy can call Humana and speak to a representative regarding its request at **888-204-8349** for retail. The following must be included in the request:

- Pharmacy name, address and NCPDP number
- PCN
- Prescription number
- Prescription drug name and strength
- National Drug Code (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)

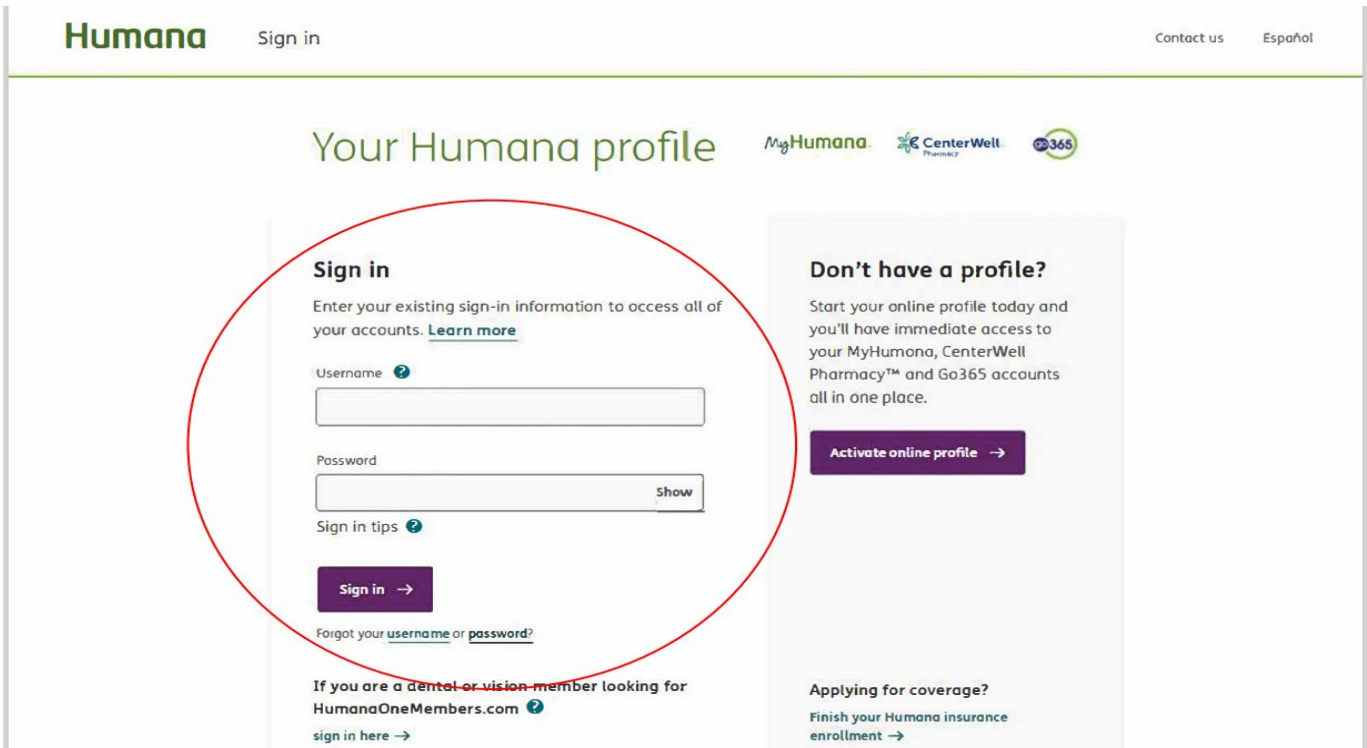
Humana will respond to the network pharmacy’s request within five business days of receipt by Humana. In the event the MAC appeal is denied, Humana will provide the reason for the denial and will identify an NDC for the prescription drug product at or below the current MAC price. If the MAC request is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

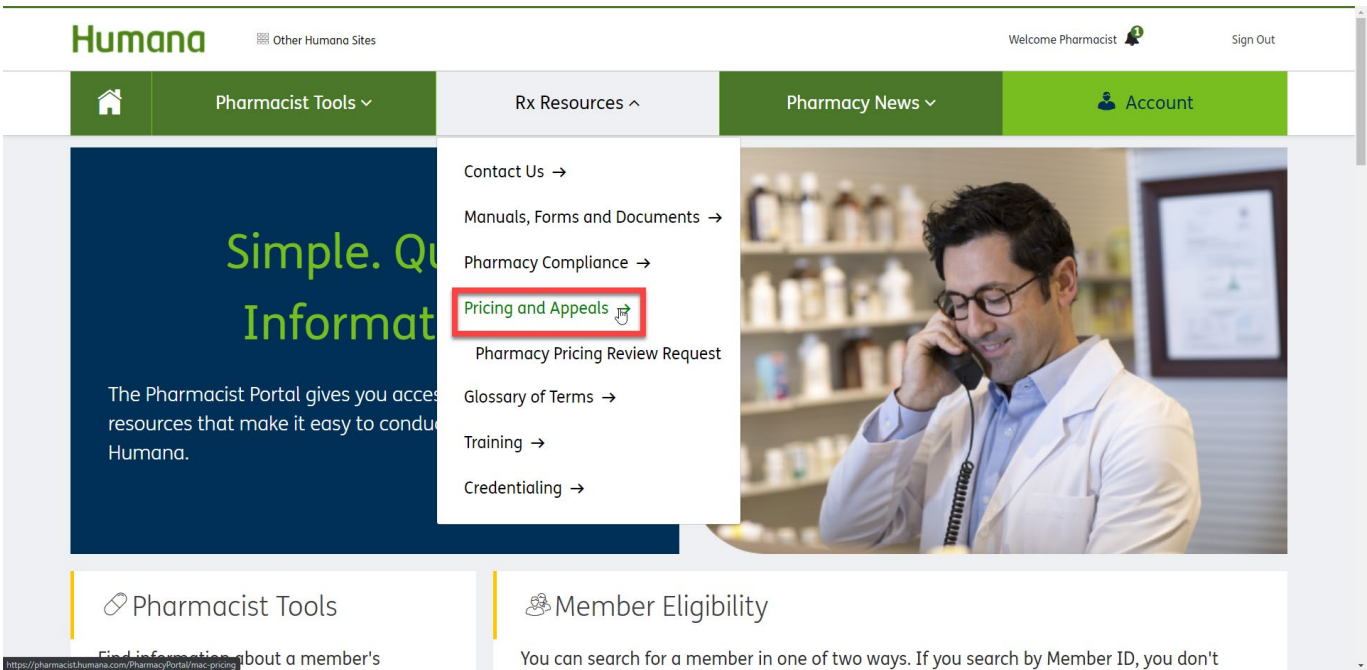
When network pharmacies need to locate the current MAC list, they can follow the steps below at **Humana.com**. They will see the screen below. Select the “Sign in” button located on the top right corner of the screen.



The pharmacy will then enter the username and password 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 the pharmacy chooses will show as download only or will load on the page.

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

The screenshot shows the Humana Pharmacist Portal interface. At the top, there is a navigation bar with '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 a breadcrumb trail: 'Pharmacist Portal / Rx Resources / Pricing and Appeals'. There is an 'Export Excel File' button and a 'Pharmacy Pricing Review Request' button highlighted with a red box. The form contains several input fields: 'Source List' (dropdown), 'Date of Fill' (calendar), 'Generic Code Number (GCN)', 'NDC Number', and 'Drug Name'. There is also a checkbox for 'Include inactive price records' and a 'Search' button.

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

When the form is received, Humana will begin the research process and inform the pharmacy by fax or email of the results of the dispute within five business days of 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 Humana Healthy Horizons in Virginia pharmacy help desk at **844-918-0115** 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, which is set forth in the Humana Member Handbook. This information is provided to the pharmacy so the pharmacy may assist members in this process if they request your 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 Virginia
Grievance and Appeals Department
P.O. Box 14163
Lexington, KY 40512-4163
Fax: **800-949-2961**

- For verbal grievances, the member can call customer service at **844-881-4482 (TTY: 711)**, daily, 8 a.m. – 8 p.m., Eastern time.

Member appeals

The member, provider 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 Virginia
Grievance and Appeals Department
P.O. Box 14163
Lexington, KY 40512-4163
Fax: **800-949-2961**

Please include the member's name, address, Medicaid 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 **844-881-4482 (TTY: 711)**, daily, 8 a.m. – 8 p.m., Eastern time.

For all members, their 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 for the member.

To obtain an Appointment of Representative form, the member can call Humana Customer Care and ask for one or visit Humana's website at **Humana.com/member/documents-and-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 grievance and appeals

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