HCPR & MIT Medicaid Coverage Determination Policy

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Summary: Coverage Determination Medicaid Program Policy

Scope: Medicaid

Statement: This policy defines Humana's business practices for compliance with rules and regulations set forth by State and Federal regulators, State Health Care Agencies, and accreditation entities regarding the tracking, timely review, and resolution of all Medicaid requests for coverage determinations performed by Humana Clinical Pharmacy Review (HCPR) and Medical Team (MIT).

Humana has established procedures for making standard coverage determinations and expedited coverage determinations for situations in which applying the standard procedure could seriously jeopardize the member's life, health, or ability to maintain maximum function.

Coverage Determinations can be standard or expedited and include:

- A decision by Humana not to provide or pay for a drug that the member believes may be covered by the plan, including a decision not to pay because the:
  - Drug is not on the plan's formulary
  - Drug is determined not to be medically necessary
  - Drug is furnished by an out-of-network pharmacy
  - Drug is otherwise excluded from the membersplan
  - Provider is not participating in the State Medicaid program
  - Pharmacy is not participating in the State Medicaid program
- A decision by Humana concerning an exception to the plan's formulary
- A decision by Humana on whether an enrollee has, or has not, satisfied a coverage determination or other utilization management requirement.

Standard: Coverage Determination Requests

Purpose: To ensure compliance with rules and regulations set forth by the State and Federal regulators, State Health Care Agencies, and accreditation entities regarding tracking and

addressing the timely review and resolution of all enrollee requests for coverage determinations performed by Humana Clinical Pharmacy Review (HCPR) and Medical Team (MIT) .

Scope: Medicaid

Requirement: The prescribing physician or other prescriber may file an electronic, oral, or a written request for a standard or expedited coverage determination.

Representatives that are appointed by the court or who are acting in accordance with State law (court appointed guardian, person with Durable Power of Attorney, or a health care proxy, or a person designated under a health care consent statute) may also file a request for a coverage determination for a member through the prescribing physician.
Humana's compliance department has processes in place to ensure awareness of different representation requirements in each state.

The appointed representative has all of the rights and responsibilities as the member. Any notice or correspondence (s) are sent to the appointed representative instead of the member.

Standard: Hours of Operation and Availability

Purpose: To ensure compliance with rules and regulations set forth by the State and Federal regulators, State Health Care Agencies, and accreditation entities regarding tracking and addressing the timely review and resolution of all Medicaid enrollee requests for coverage determinations and the hours of operations for the Humana Clinical Pharmacy Review (HCPR) department and Medical Team (MIT) **.**

Scope: Medicaid

Requirement: Humana Clinical Pharmacy Review (HCPR) operates as a toll-free Coverage Determination Provider call center to respond to requests from physicians or other prescribers, and other providers. HCPR's toll free call center hours of operation are Monday through Friday, 8 a.m. – 8:00 p.m. local times.

A provider can reach HCPR at 1-800-555-CLIN (2546) or 1-866-461-7273 for authorization requests for medications that are administered in the office, home health, facility, or clinic. A request will be expedited, based on the enrollee's request, as indicated in the prescribing physician's or other prescriber's request, that applying the standard time frame for making a coverage determination may seriously jeopardize the enrollee's life, health, or ability to regain maximum function.

Medicaid coverage determination requests received during or after hours are resolved within 24 hours of receipt regardless of urgency.* After hour calls are answered and assisted by a 24 hour, seven day a week team of Humana nurses. This team provides instructions on the process for submitting both standard and expedited coverage determination requests. A written request is

accepted at any time by faxing the request to 1-877-486-2621. After hours staff monitor requests during non- business hours.

Standard: Medical Necessity and Exception Determinations

Purpose: To ensure compliance with rules and regulations set forth by the State and Federal regulators, State Health Care Agencies, and accreditation entities regarding tracking and addressing the timely review and resolution of all enrollee requests for coverage determinations performed by Humana Clinical Pharmacy Review (HCPR) and Medical Team (MIT) regarding Expedited and Standard coverage determinations and written notifications.

Scope: Medicaid

Requirement: Requests received for a Medicaid member may require a medical necessity determination for the service, procedure, or product. The plan performs medical necessity reviews utilizing the member's benefits, federal and state regulations, accepted medical standards, and policy statements maintained by the Florida Agency for Health Care Administration, State Medicaid programs and Humana's Clinical and Pharmacy and Therapeutics departments.

Coverage Determination

Please note the following regarding medically accepted indications: All reasonable efforts have been made to ensure consideration of medically accepted indications in this policy. Medically accepted indications are defined by CMS as those uses of a covered Part D drug that are approved under the federal Food, Drug and Cosmetic Act, or the use of which is supported by one or more citations included or approved for inclusion in any of the compendia described in section 1927(g)(1)(B)(i) of the Act. These compendia guide review of off- label and off-evidence prescribing and are subject to minimum evidence standards for each compendium.
Currently, this review includes the following references when applicable and may be subject to change per CMS or State programs:

American Hospital Formulary Service-Drug Information (AHFS-DI) National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium Truven Health Analytics Micromedex DrugDEX Elsevier/Gold Standard Clinical Pharmacology Wolters Kluwer Lexi- Drugs

Standard: Coverage Determination Notification Process

Purpose: To ensure compliance with rules and regulations set forth by the State and Federal regulators, State Health Care Agencies, and accreditation entities regarding the notification of Coverage Determination decisions.

Scope: Medicaid

Requirement: Requests received from a provider may require a medical necessity determination for the service, procedure, or product. The plan performs medical necessity review and written notifications are sent to the member and provider within 24hrs of the receipt of the review.

The notification must include:

1. Notifies the member of the decision by mail within 24 hours of receipt of request.
2. If the request is denied, the written denial notification must:
    - Use approved notice language in a readable, understandable form
    - State the specific reasons for the denial
    - Inform member of his/her right to redetermination:
    - For drug coverage denials: notice must explain the standard and expedited redetermination processes, including the member's right to, and conditions for, obtaining expedited redetermination and the rest of the appeals process.

    **An offer for a peer discussion will be provided to the prescriber when mandated by the governing regulatory bodies for the enrollee's benefits. **

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Disclaimer: Humana follows all Federal and state laws and regulations. Where more than one state is impacted by a particular issue, to allow for consistency, Humana will follow the most stringent requirement. This document is intended as a guideline. Situations may arise in which professional judgment may necessitate actions that differ from the guideline. Circumstances that justify the variation from the guideline should be noted and submitted to the appropriate business area for review and documentation. This (policy/ standard) is subject to change or termination by Humana at any time. Humana has full and final discretionary authority for its interpretation and application. This (policy/ standard) supersedes all other policies, standards, guidelines, procedures or information conflicting with it. If viewing a printed version of this document, please refer to the electronic copy maintained in Policy Source or Enterprise Solution Point to ensure no modifications have been made.

Non- Compliance: Failure to comply with any part of Humana's policies, standards, guidelines, and procedures may result in disciplinary actions up to and including termination of employment, services or relationship with Humana. In addition, state and/or federal agencies may take action in accordance with applicable laws, rules and regulations. Any unlawful act involving Humana systems or information may result in Humana turning over any and all evidence of unlawful activity to appropriate authorities. Information on handling sanctions related to noncompliance with this policy may be found in the Expectations for Competency and Contribution, and Critical Offenses policies, both of which may be found in the Policy Source site of Humana's secure intranet (Humana Self-Service).