

Frequently asked questions and answers for pharmacy providers

The purpose of Medicare's Limited Income Newly Eligible Transition (NET) Program is to ensure individuals with Medicare's low-income subsidy (LIS), or "extra help," who are not yet enrolled in a Part D prescription drug plan are still able to obtain immediate prescription drug coverage.

Medicare's Limited Income NET Program also provides retroactive coverage for new "dual eligibles" – those individuals who are eligible for both Medicare and Medicaid or Medicare and Supplemental Security Income. Medicare automatically enrolls these individuals into Medicare's Limited Income NET Program with an effective date retroactive to the start of their full benefit dual status or their last enrollment in a Medicare Part D plan, whichever is later. These individuals are covered by the program temporarily while Medicare enrolls them into a standard Medicare Part D plan for the future.

Humana administers Medicare's Limited Income NET Program on behalf of the Centers for Medicare & Medicaid Services (CMS).

This document answers some frequently asked questions about Medicare's Limited Income NET Program. It supplements the following documents, which you can find at **[Humana.com/LINET](https://www.humana.com/LINET)**:

- Medicare's Limited Income NET Program payer sheet.
- Medicare's Limited Income NET Program "Four Steps for Pharmacy Providers" document.

If your question is not addressed in the following pages, please call Medicare's Limited Income NET Program help desk at 1-800-783-1307. This line is open from 8 a.m. to 8 p.m. local time each day. For assistance, pharmacists should press option 1, physicians/prescribers should press option 2 and beneficiaries or other callers should press option 3.

About eligibility

1. How can I verify a beneficiary's Medicare eligibility?

A pharmacist can verify eligibility for Medicare Parts A and/or B or enrollment in a Part D plan by submitting an electronic eligibility transaction (E1 query) to Medicare's online eligibility system, called the true out-of-pocket (TrOOP) facilitator.

Other offline ways to check for Medicare parts A and B eligibility are:

- Ask to see a Medicare (red, white and blue) card as shown in the sample below.



- Ask to see a Medicare summary notice (MSN).
- Call Medicare at 1-800-633-4227 (available 24 hours a day).

2. How can pharmacies verify a beneficiary's eligibility for Medicaid or the low-income subsidy (LIS)?

Note: Such verification should be performed prior to submitting the Medicare's Limited Income NET Program claim.

In accordance with CMS' best available evidence (BAE) policy, the following are considered acceptable forms of evidence to establish the beneficiary's eligibility for Medicaid or LIS:

- A copy of the beneficiary's Medicaid card that includes the beneficiary's name and an eligibility date in effect after June of the previous calendar year.
- A copy of a state document that confirms active Medicaid status in effect between July 1 and Dec. 31 of the previous calendar year.
- A printout from the state electronic enrollment file showing Medicaid status in effect between July 1 and Dec. 31 of the previous calendar year.
- A screen-print from the state's Medicaid systems showing Medicaid status in effect between July 1 and Dec. 31 of the previous calendar year.
- Other documentation provided by the state showing Medicaid status between July 1 and Dec. 31 of the previous calendar year.
- A letter from the Social Security Administration (SSA) showing that the individual receives Supplemental Security Income (SSI).

For individuals who are not deemed eligible, but who apply for and are awarded the LIS by the Social Security Administration, a copy of one of the following letters will suffice as verification of the individual's eligibility for the LIS:

- SSA award letter.
- SSA Notice of Change, indicating an award increase.
- SSA Notice of Planned Action, indicating an award reduction.
- SSA Notice of Important Information, indicating no change to the beneficiary's award.

3. Can the evidence of eligibility be faxed to Medicare's Limited Income NET Program?

Yes, all evidence of eligibility, including BAE, can be faxed to Medicare's Limited Income NET Program at 1-877-210-5592.

4. What happens if a beneficiary is found to be ineligible after a claim is paid under Medicare's Limited Income NET Program?

The beneficiary will be billed for the cost of the pharmacy claim if he or she is later found to be ineligible. The pharmacy is encouraged to perform all possible steps to verify the beneficiary's eligibility for Medicaid or LIS at the point of sale (POS).

5. What is the beneficiary evidence of eligibility letter and who receives it?

The evidence of eligibility letter is sent to beneficiaries if Medicare's Limited Income NET Program is unable to validate their eligibility for the program after a claim has been paid. This letter is sent to the beneficiary to allow him/her the opportunity to provide evidence of eligibility for either Medicaid or "extra help."

6. What is the process if the beneficiary is out of medication?

If the beneficiary has two days or less of medication left (or new pharmacy), he/she might qualify for an immediate need. The pharmacist will need to complete the fax form request and fax it to **1-502-580-6644**. Once the request has been received and validated, the pharmacy will receive a call back within 24 hours to process the immediate need request.

7. Why should pharmacy providers be aware of this process, and how can they support it?

A beneficiary may come to you and ask for assistance because of a letter he or she received from Medicare's Limited Income NET Program. The letter may have been generated by the claim(s) that you submitted on his or her behalf. You can support the process by submitting the proof of eligibility to Medicare's Limited Income NET Program.

About claims submission

8. What bank identification number (BIN) and processor control number (PCN) do I use to submit a Limited Income NET claim?

The BIN is 015599. The PCN is 05440000. Other key fields are:

- Group ID: May be left blank.
- Cardholder ID: The Medicare Beneficiary Identifier (MBI) on the Medicare card (include letters).
- Patient ID (Optional): Medicaid ID or Social Security number.

9. What are the timely filing requirements for Medicare's Limited Income NET claims submission?

For individuals **already enrolled** in Medicare's Limited Income NET Program, there are generally no timely filing limits on claims incurred during periods of enrollment. The only exceptions are:

- Prior authorization is required for claims submitted more than 36 months after the date of service, even during the period of Limited Income NET Program enrollment (call us at 1-800-783-1307 for details).
- After disenrollment from Medicare's Limited Income NET Program, request for payment must be submitted within **180 days after** the date of disenrollment.

For individuals **not** already enrolled in Medicare's Limited Income NET Program, generally claims must be filed within 30 days following the date of service, depending on the beneficiary's LIS status. Dual eligibles may have claims covered up to 36 months in the past for eligible periods, but you must first contact Medicare's Limited Income NET Program help desk at 1-800-783-1307 for an immediate eligibility determination. If the beneficiary is determined to be a full-benefit dual eligible or SSI-only beneficiary on the date of service, you will be able to submit the claim online. If the LIS status is not present in CMS' systems at the point of sale, claims must be filed within seven days following the date of service.

10. Do I have to submit claims to Medicaid and receive a denial before submitting a claim to Medicare's Limited Income NET Program?

No. Prior to submitting a claim to Medicare's Limited Income NET Program, you should attempt to verify the beneficiary's Medicaid or LIS eligibility in accordance with the CMS BAE policy (see answer to question 2).

11. How many days' supply of a medication can a beneficiary receive if the claim processes under the Limited Income NET Program?

Beneficiaries who have their LIS status documented in CMS' systems may receive up to a 60 day supply of medication. Hepatitis C and Opioid medications are limited to a 30 day supply. Beneficiaries who do not have their LIS status documented in CMS' system may only receive up to a 34-day supply of a prescription drug (or the lowest unit dose package allowed if the smallest exceeds a 34-day supply). This policy also applies to eye drops, creams, ointments, inhalers, etc.

12. What do I do if the drug is in unit dose packaging and exceeds the days' supply limit?

You should call Medicare's Limited Income NET Program help desk at 1-800-783-1307 for an override.

13. What happens when a claim is paid by both Medicare's Limited Income NET Program and another Part D plan?

This should only occur in rare instances. Medicare's Limited Income NET Program will contact the other Part D plan to reconcile the claim.

14. After a beneficiary is enrolled in a permanent Part D plan, where do I submit his/her claims?

The preferred method to determine where to submit **any** Medicare Part D claim is to submit an electronic eligibility verification query using your pharmacy system (E1 transaction to Medicare's enrollment/eligibility system). This query provides a response indicating where to submit the claim. You can also ask for the beneficiary's Medicare Part D Plan ID card, which will indicate where to submit a claim. If neither of these options is available, call Medicare's Limited Income NET Program help desk at 1-800-783-1307.

15. What happens to claims submitted with invalid data?

There are front-end edits in place to ensure that certain types of invalid data will cause a claim rejection at the point of sale, such as an invalid Medicare ID number. Other types of invalid data, such as name, date of birth or gender, that do not match data associated with a particular Medicare ID number may not cause a claim rejection at the POS, but they will be detected upon back-end processing and will need to be reconciled. Reconciliation may include follow-up with the pharmacy provider to obtain valid data. The claim may then be reprocessed. If an invalid Medicaid ID number is submitted, the claim will not be rejected at the POS, but the beneficiary may be determined ineligible for Medicaid and be responsible for the cost of the claim.

16. Last week I successfully processed a claim through Medicare's Limited Income NET Program for a customer, but today, claims for this patient will not process. Why did this happen?

Generally, one of the following two situations would cause this:

1. The beneficiary was not enrolled in a Part D plan or the plan enrollment was not yet present in CMS' systems last week; this week, the Part D plan enrollment is present. In this case, you would receive the 4Rx enrollment information for the other Part D plan in the rejection.
2. Medicare's Limited Income NET Program could not determine Medicaid or LIS eligibility at the POS last week, and upon back-end verification with state systems, the beneficiary was determined to be ineligible for Medicaid or LIS. In this case, Medicare's Limited Income NET Program does not allow further POS claims until the beneficiary provides proof of Medicaid or LIS eligibility. If the beneficiary has proof of eligibility, call Medicare's Limited Income NET Program at 1-800-783-1307 for information on how to submit it.

About plan enrollment

17. After a beneficiary has claims processed under Medicare's Limited Income NET Program, how quickly will that beneficiary be enrolled into a Part D plan?

Within three days of claim submission, the beneficiary is automatically enrolled into Medicare's Limited Income NET Program for current coverage and, at the same time, prospectively enrolled into a standard Part D plan with an effective date two months in the future. For example, a Medicare Limited Income NET claim submitted on Jan. 14 would trigger an enrollment into Medicare's Limited Income NET program for January and February and an enrollment into a standard Part D plan effective March 1.

18. What drugs are covered in Medicare's Limited Income NET Program?

Medicare's Limited Income NET Program has an open formulary. However, drugs that are excluded from Medicare Part D coverage by law also will be excluded from this program.

19. Who pays the pharmacy claim if the beneficiary is currently eligible for Medicaid but is not eligible for Medicare until the following month?

If the beneficiary is not eligible for Medicare until the following month, Medicaid remains the payer until Medicare Part D eligibility becomes effective.

20. What happens when a beneficiary's copayment changes?

Humana will internally reverse and reprocess previous claims to adjust the copayment level, resulting in either a refund or bill for the difference to the beneficiary, pharmacy or other payer (as appropriate per CMS guidance). Pharmacies are generally not affected by this process unless they are a long-term-care pharmacy that has indicated it is holding the member's cost-share. Future claims will be processed at the appropriate copayment levels.

21. How are formulary discrepancies resolved for reversed Medicare's Limited Income NET claims that must be submitted to another payer because the beneficiary was later determined to have been enrolled in another Part D plan on the date of service and, thus, ineligible for Medicare's Limited Income NET?

This should not be an issue (see question 10). However, all Part D plans have submitted a first-fill transition policy of at least 31 days; therefore, claims for nonformulary drugs will be covered by the plan of record during the first 31 days of enrollment. CMS has provided additional guidance on this policy in Chapter 6 of the Medicare Prescription Drug Benefit Manual in section 30.4. The chapter is accessible on the CMS website at

<http://www.cms.gov/PrescriptionDrugCovContra/Downloads/Chapter6.pdf>.