

RESTRICTION PROGRAM

IDENTIFYING EFFECTIVE UTILIZATION OF
MEDICAID RESOURCES



Department of Health
& Human Services

WHY

FEDERAL AUTHORITY – 42 CFR 431.54

“**42 CFR 431.54(e)** states that a Medicaid agency may restrict a beneficiary for a reasonable period of time to obtain Medicaid services from designated providers only if the beneficiary has utilized Medicaid services at a frequency or amount that is not medically necessary.”

STATE RULE AUTHORITY – R414-29-3

“If a Medicaid agency finds that a beneficiary has utilized Medicaid services at a frequency or amount that is not medically necessary, as determined in accordance with utilization guidelines established by the State, the agency may restrict that beneficiary for a reasonable period of time to obtain Medicaid services from designated providers only.”

WHO

- SURS 011

A surveillance report run in Quicksight which identifies **all** Medicaid beneficiaries who meet one or more of the five utilization criteria identified in State Rule R414-29-3 over the period of 12 months of eligibility.

Additionally, the report provides a frequency parameter which identifies beneficiaries with short term eligibility but high utilization and an acuity parameter which identifies beneficiaries who meet more than one criteria.

This report is used to identify beneficiaries who require a review of Medicaid claims to determine if utilization is appropriate.

HOW

- SURS 017

A surveillance report run in Quicksight on **individual** beneficiaries identifying utilization of Medicaid services using paid and denied claims in the Prism database.

The report enumerates claims based on the five criteria listed in state rule.

- SURS 101

A surveillance report run in Quicksight on **individual** beneficiaries identifying prescriptions paid by Medicaid

- DOPL REPORT

A report run from the State DOPL database listing all prescriptions of scheduled medications (abuse potential) filled by an individual

USED TO IDENTIFY CASH PAYMENTS FOR MEDICAID COVERED SERVICES

STATE CRITERIA (BY THE NUMBERS)

STATE RULE R414-29-3

(1) The department may enroll a member in the Restriction Program if the beneficiary meets one or more of the following restriction criteria within the most recent 12 months of Medicaid eligibility:

- (a) accesses **four** or more non-affiliated PCPs and specialists (appropriate specialists are counted as 1)
- (b) accesses **four** or more pharmacies for the purchase of abuse potential medications (each pharmacy counted individually)
- (c) accesses **three** or more non-affiliated providers who prescribe abuse potential medications in a consecutive two-month period
- (d) accesses **six** or more prescriptions for abuse potential medications in a consecutive two-month period (monthly maintenance medications are counted as 1)
- (e) accesses emergency department services for **five** or more non-emergent emergency department visits (based on the State Emergency Diagnosis list)

STATE CRITERIA (ADDITIONAL CONSIDERATIONS)

- (f) fills **concurrent prescriptions** for abuse potential medications of the same DEA class, written by different prescribers;
- (g) **pays cash** for Medicaid-covered services; or

(2) The department shall also consider the following when determining whether to place a member in the Restriction Program:

- (a) the beneficiary's diagnoses and **medical necessity** (tech dependent, cancer, accident, surgery)
- (b) the beneficiary's **concurrent prescribers** of abuse potential medications (are both prescribers aware of the prescribing patterns)
- (c) the beneficiary's **geographic location** and potential of limited access to care in rural areas (availability of urgent care facilities)
- (d) the beneficiary's right to seek a **second opinion**

REVIEW PROCESS

- Through detailed analysis of utilization, discussion with providers and discussion with the beneficiary a decision is made regarding the appropriate use of Medicaid benefits.
- If it is determined that the beneficiary is overutilizing Medicaid benefits enrollment in the Restriction program occurs. A Primary Care Provider agrees to provide a medical home and authorize any additional specialty providers as needed. A pharmacy is assigned to fill all prescriptions.
- The restriction care manager monitors the beneficiary throughout the year and assists in addressing any issues with the beneficiary's care including consultation with providers.
- During the eleventh month of enrollment in the Restriction program utilization reports are run for that time period and an analysis of utilization over the past 11.5 months is completed. If the beneficiary has worked within the program by seeing assigned providers, using Medicaid appropriately and working within the State guidelines, the Restriction is closed. If the beneficiary continues to meet criteria enrollment in the Restriction Program continues for another 12 months.

MANAGEMENT PROCESS

- **The department may only pay claims for services provided by the assigned PCP, prescriptions written by the assigned PCP, and prescriptions filled by the assigned pharmacy unless:**
 - (a) services were provided upon **referral** from the assigned PCP;
 - (b) prescribers were **authorized** as assigned prescribers by the assigned PCP;
 - (c) services were provided by an emergency department (prescriptions for abuse potential medications must be approved by the assigned PCP)
 - (d) services and resulting prescriptions were provided in a hospital **inpatient** setting;
 - (e) services were provided by an urgent care center (prescriptions for abuse potential medications must be approved by the assigned PCP)
 - (f) services were provided by Medicaid-enrolled providers not licensed to prescribe medications, such as behavioral health counselors or physical therapists.

AVAILABILITY OF CARE

- **The Emergency Medical Treatment and Labor Act (EMTALA), enacted in 1986, requires nearly all U.S. hospitals with emergency departments to provide a medical screening exam and stabilizing treatment to anyone seeking emergency care, regardless of insurance, citizenship, or ability to pay.**
- Restriction does not prevent a beneficiary from accessing care from an Emergency Room but does require PCP approval for the payment of abuse potential medications by Medicaid.

OVERSIGHT

- **MONTHLY MCO AUDITS**

The Restriction Team at DHHS performs monthly audits of a percentage of MCO reviews to verify accuracy and continuity of review results and restriction assignments

- **ANNUAL CMS DRUG UTILIZATION REVIEW (DUR) REPORT (FEDERAL)**

Section 1927(g)(3)(D) of the Social Security Act (the Act) requires each state to submit an annual report on the operation of its Medicaid Drug Utilization Review (DUR) program.

- **ANNUAL STATE AUDIT**

The restriction team receives an annual request for approximately 45 FFS reviews for audit by the State Auditors Office.

Thanks!



**Department of Health
& Human Services**