**R414. Health and Human Services, Integrated Healthcare.**

**R414-29. Client Review and Restriction Policy.**

**R414-29-1. Introduction and Authority.**

(1) This rule sets out the criteria and process to restrict a Medicaid member to specific Medicaid providers if the member is found to have a pattern of using Medicaid services at a frequency or amount not medically necessary.

(2) This rule implements the requirements found in 42 CFR 431.54(e) and 42 CFR 456.3.

**R414-29-2. Definitions.**

In addition to the definitions in Section R414-1-2, the following definitions apply to this rule:

(1) "Abuse potential medications" means substances listed in Schedule II-V in 21 CFR 812, Subchapter I, Part B (b)(2) through (5)(c) and Section 58-37-4.2. For purposes of the Restriction Program, this also includes regulated drugs.

(2) "Access to care" means the timely availability and adequacy of healthcare services to achieve the best health outcomes for Medicaid members.

(3) "Annual review" means a review of a restricted member's records and claims from the earlier 12 months of Medicaid eligibility and enrollment in the Restriction Program performed to determine whether the member has adhered to Restriction Program guidelines during enrollment in the Restriction Program.

(4) "Assigned pharmacy" means the pharmacy assigned by the department for a restricted member to access pharmacy services.

(5) "Assigned prescriber" means a provider authorized by a restricted member's assigned PCP to write prescriptions for the restricted member.

(6) "Assigned primary care provider" means the PCP assigned by the department as the provider responsible for coordinating a restricted member's overall health care.

(7) "Assigned provider" means provider authorized by the restricted member's assigned PCP to provide services to the member.

(8) "Concurrently prescribed" means abuse potential medications that are prescribed by different prescribers for overlapping periods.

(9) "department" means the Division of Integrated Healthcare and its contracted accountable care organizations.

(10) "Emergency department" means an area of a hospital in which emergency services are provided 24 hours a day.

(11) "Member" means a person who is determined eligible for assistance under the Medicaid program.

(12) "Non-emergent emergency department visit" means an emergency department visit, in which the medical condition does not meet the definition of emergency medical condition, and the services provided do not meet the definition of emergency service, in accordance with the definitions set forth in Section R414-1-2.

(13) "Non-affiliated" provider means a provider who has not entered into a contractual agreement with another provider to provide similar health care services. This type of provider is neither closely associated with, belongs to, nor subordinate to another provider within a provider group practice. It also means a provider who has not been designated by a principal provider to provide health care services in the temporary absence of the principal provider.

(14) "Overutilization" means to use medical services at a frequency or amount that is more than customary.

(15) "Primary care provider" or "PCP" means a physician, doctor of osteopathic medicine, nurse practitioner, or physician assistant, who provides, coordinates, or helps a patient access a necessary range of health care services.

(16) "Regulated drugs" means drugs that are monitored in the Department of Commerce Controlled Substance Database but have not been scheduled.

(17) "Restriction case" means the record of documentation on a member enrolled in the Restriction Program.

(18) "Restriction criteria" means the criteria used to place a Medicaid member in the Restriction Program, as described under Section R414-29-3.

(19) "Restricted member" means a Medicaid member who is placed in the Restriction Program.

**R414-29-3. Restriction Program.**

(1) The department may enroll a member in the Restriction Program if the member 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;

(b) accesses four or more pharmacies for the purchase of abuse potential medications;

(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;

(e) accesses emergency department services for five or more non-emergent emergency department visits;

(f) fills concurrent prescriptions for abuse potential medications, written by different prescribers;

(g) pays cash for Medicaid-covered services; or

(h) accesses concurrently prescribed abuse potential medications written by different prescribers without medical necessity or the knowledge or consent of the different prescribers.

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

(a) the member's diagnoses and medical necessity;

(b) the member's concurrent prescribers of abuse potential medications;

(c) the member's geographic location and potential of limited access to care in rural areas; and

(d) the member's right to seek a second opinion.

(3) Once a member is found to meet or exceed restriction criteria, the department shall perform an additional review to determine if overutilization of services was the result of limited access to care or medical necessity.

(4) When an individual is placed in the Restriction Program, the member shall have one assigned PCP and one assigned pharmacy.

(5) 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;

(d) services and resulting prescriptions were provided in a hospital inpatient setting;

(e) services were provided by an urgent care center; or

(f) services were provided by Medicaid-enrolled providers not licensed to prescribe medications, such as behavioral health counselors or physical therapists.

(6) Enrollment in the Restriction Program does not affect the restricted member's ability to access emergency services.

**R414-29-4. Assigned PCP and Assigned Pharmacy.**

(1) The assigned PCP and assigned pharmacy shall enroll as Medicaid providers.

(2) The restricted member's primary care provider may serve as the assigned PCP if the provider agrees to serve in that capacity and if the department approves the provider as the assigned PCP.

(3) The assigned PCP shall provide non-emergent services for the restricted member.

(4) The assigned PCP shall coordinate health care services for the restricted member, providing referrals for assigned providers and assigned prescribers as necessary.

**R414-29-5. Selection of Assigned PCP and Assigned Pharmacy.**

(1) The department shall approve an assigned PCP and assigned pharmacy for the member when the member is placed in the Restriction Program. When making this assignment, the department may consider the member's utilization history, geographic location, medical needs, transportation needs, and the quality of services available.

(2) Within 30 days of notification of placement in the Restriction Program, the restricted member may select an assigned PCP and an assigned pharmacy. The restricted member's selection of an assigned PCP and assigned pharmacy are subject to the approval of the department.

(3) Only the department may approve of any change in a assigned PCP or an assigned pharmacy.

(4) The assigned PCP and assigned pharmacy shall remain as the assigned PCP and assigned pharmacy during of the member's enrollment in the Restriction Program with the following exceptions:

(a) a member requests a change of assigned PCP or assigned pharmacy within 30 days of notification of enrollment in the Restriction Program;

(b) the assigned PCP or assigned pharmacy changes locations;

(c) the assigned PCP or assigned pharmacy discontinues or limits practice;

(d) the assigned PCP or assigned pharmacy requests a change;

(e) a member has a verified change of address, which impacts access to the assigned PCP or assigned pharmacy; or

(f) the department recommends a change when review indicates continued overutilization by a restricted member, the assigned PCP, or both.

(5) The department may require a change of assigned PCP, assigned pharmacy, assigned providers, or assigned prescribers when it determines the restricted member is not receiving appropriate care.

(6) Requests from a restricted member to change an assigned PCP or assigned pharmacy may be verbal or be in writing.

**R414-29-6. Notification of Placement in Restriction Program.**

(1) The department shall provide written notice to a Medicaid member that the department is placing the member in the Restriction Program at least 10 days before placing the member in the Restriction Program. The notice shall inform the member of:

(a) the effective date of the member's placement in the Restriction Program;

(b) the basis for the member's placement in the Restriction Program;

(c) the specific element of the restriction criteria that supports the placement of the member in the Restriction Program; and

(d) the assigned PCP and assigned pharmacy selected for the member, and known assigned providers and assigned prescribers for the member at the time of placement in the Restriction Program.

(2) The notice shall inform the member that:

(a) upon placement in the Restriction Program, the member's assigned PCP must authorize Medicaid-covered prescriptions, primary care, and specialty care services for payment to be made; and

(b) the member has the right to an administrative hearing, including appropriate forms, instructions, and information sufficient to request an administrative hearing and the time frame for requesting an administrative hearing.

**R414-29-7. Length of Restriction.**

(1) A restricted member shall remain in the Restriction Program for a total of 12 months of Medicaid eligibility. The months of eligibility need not be continuous.

(2) If a restricted member becomes ineligible for Medicaid, and subsequently reestablishes Medicaid eligibility, the department shall require the member to continue enrollment in the Restriction Program, unless the restricted member's loss of Medicaid eligibility is greater than one year.

(3) The department shall perform a review of a member's placement in the Restriction Program once the member has been enrolled in the Restriction Program for 12 months of Medicaid eligibility.

(4) The Restriction Program shall remove a restricted member if an annual review demonstrates the restricted member no longer meets the restriction criteria.

(5) The department shall inform a restricted member in writing of the member's removal from the Restriction Program.

(6) If at the time of annual review, a Medicaid member still meets the criteria for the Restriction Program, the department shall inform the restricted member of continued enrollment in the Restriction Program for an additional 12 months of Medicaid eligibility.

(7) The department shall provide notice to a Medicaid member of continuation in the Restriction Program in accordance with Section R414-29-6.

**KEY: Medicaid**

**Date of Last Change: October 28, 2024**

**Notice of Continuation: August 22, 2022**

**Authorizing, and Implemented or Interpreted Law: 26B-1-213; 26B-3-108**