Chapter 15

Restricted Recipient Program

NOTE: *Please review the following detail for specific processes and expectations with South Country Health Alliance (South Country). South Country may vary from the MHCP Manual and Minnesota Department of Human Services Guidelines. For additional detail on this chapter, please go to the Minnesota Health Care Programs Provider Manual at* MHCP Provider Manual.

Billing Information – Please review the South Country Provider Manual Chapter 4 Provider Billing for general billing processes and procedures.

Program Overview

The Restricted Recipient Program (RRP) is a program developed by the Minnesota Department of Human Services for recipients who have failed to comply with the requirements within the Minnesota Rule 9505.2165. Placement in the RRP does not apply to services in long term care facilities and/or members covered by Medicare.

The RRP identifies members who have used services at a frequency or amount that is not medically necessary and may be deemed as abusing the system and/or accessing medical services that are potentially harmful to the recipient.

Initially, members may be placed in the RRP for a period of 24 months of enrollment to a Minnesota Health Care Program (MHCP). During this period of time the member's health services will be limited to a designated primary care provider, one clinic, one pharmacy and one hospital, except in an emergency service need. After the initial 24 months of restriction, members will be reviewed and may be continued in the RRP for an additional 36 months. The Department of Human Services may place a member in the RRP for the conduct regarding use of Personal Care Assistance under Minnesota Rules 9505.2165. When appropriate, South Country Health Alliance will coordinate the RRP with DHS.

Misuse of Medical Services

Abuse of medical services is defined by the Department of Human Services as the use of health services that result in unnecessary costs to the programs or in reimbursements for services that are not medically necessary.

Members' behavior is based on MN Rule 9505-2165 subp. 2 Part B

- Obtaining equipment, supplies, drugs, or health services that are in excess of program limitations or that are not medically necessary and that are paid for through the program.
- Obtaining duplicate or comparable services for the same health condition from a multiple number of vendors, such as going to multiple pharmacies or physicians. Duplicate or comparable services do not include an additional opinion that is medically necessary for the diagnosis, evaluation, or assessment of the recipient's condition or required under program rules, or a service provided by a school district as specified in the recipient's individualized education plan under Minnesota Statutes, section 256B.0625, subdivision 26.
- Continuing to engage in abusive practices after receiving a written warning.
- Altering or duplicating the medical identification card for the purpose of obtaining additional health services or aiding another person to obtain such services.
- Using a medical identification card belonging to another person.

- Using an identification card to assist an unauthorized individual in obtaining a health service for which a program is billed.
- Duplicating or altering prescriptions.
- Misrepresenting material facts as to physical symptoms for the purpose of obtaining equipment, supplies, health services, or drugs.
- Furnishing incorrect eligibility status or information to a vendor.
- Furnishing false information to a vendor in connection with health services previously rendered to the recipient which were billed to a program.
- Obtaining health services by false pretenses.
- Repeatedly obtaining health services that are potentially harmful to the recipient.
- Repeatedly obtaining emergency room health services for nonemergency care.
- Repeatedly using medical transportation to obtain health services from providers located outside the local trade area when health services appropriate to the recipient's physical or mental health needs can be obtained inside the local trade area. For purposes of this sub-item, "local trade area" has the meaning given in part 9505.0175, subpart 22; or
- Repeatedly arranging for services and then canceling services in order to circumvent the spend-down requirement.

For restricted members who are reviewed at the end of the restriction period:

- Obtaining medical services from a physician without an authorization from the recipient's designated primary care provider when restricted;
- Obtaining emergency room services for nonemergency care;
- Obtaining prescriptions from a pharmacy other than the designated pharmacy when restricted; and
- Obtaining health services from a non-designated provider when the recipient has been required to designate a provider.

Member Identification

Members will be identified for the RRP through various mechanisms including, but not limited to:

- Analysis of medical and pharmacy claims data;
- Referral from South Country contracted providers including practitioners, pharmacies, county public health and human service agencies;
- Referral from South Country third party administrator (TPA) and South Country staff;
- Members who refuse care coordination or case management;
- Members identified by another managed care organization or DHS; and
- Behaviors by a member that could be deemed as abuse.

Review of Referred Members

- Prior to placing a member in the RRP, a full investigation will be conducted by RRP staff.
- South Country may contact the member to address the behavior leading to the recommendation.

- South Country staff may also refer members to appropriate health counseling services to correct inappropriate or dangerous use of health services.
- The RRP review may include documentation, utilization data, review of the Prescription Monitoring Board data, and communication with involved providers and correlating medical records when appropriate. Identified situations must be supported by documentation.
- South Country staff will prepare a case summary for review by the medical director.
- The case summary will include any recommendations for restriction. The South Country Medical Director will review the case for approval of the member's placement in the RRP or may recommend continuing to monitor the member.
- For members who are being monitored, data will be pulled and reviewed at least every 3 months for review.

Placement in RRP

- The time period a member is initially placed on restriction is 24 months of enrollment in a MHCP. Months during which the member is not enrolled in a MHCP do not count toward the 24-month total. Individuals who continue in the Restricted Recipient Program will be enrolled for an additional 36 months.
- The Restricted Recipient Program is universal and stays in place regardless of whether a recipient:
    - Changes health plans;
    - Moves from fee-for-service to a health plan; and
    - Moves from the health plan to fee-for-service.
- South Country provides a member who is to be placed on restriction with a 30-day written notice that complies with DHS contract requirements. The notice will include:
    - Explanation that placement in the RRP will not result in loss of eligibility for Medicaid;
    - Explanation that placement in the RRP will not result in a denial, reduction or termination of benefits;
    - A 30-day notification period prior to the effective date of the proposed sanction;
    - Factual basis of the allegations against the member;
    - Requirements of the Restricted Recipient Program including choosing a designated primary care provider, clinic, hospital, and pharmacy by completing the Provider Selection Form;
        - If the recipient fails to choose providers, South Country will assign the member's providers based on considerations of geographic proximity, the recipient’s prior experience with a specific provider, and the provider's willingness to provide health care services.
    - The rights of the member to appeal placement in the RRP with South Country and the process to appeal to the State Fair Hearing at the Department of Human Services; and
    - The member has the right to appeal the decision under Minnesota Statutes, section 256.045 and part 9505.0130.

Provider Responsibilities

- Any physician, nurse practitioner or physician's assistant enrolled as a general practitioner, internal medicine, pediatric, or family practice provider may be selected by the recipient as his or her primary care provider.
- Providers designated to act as a primary care provider for a restricted member are contacted and notified of the requirements of that role as specified in the Restricted Recipient Program Brochure.
- Primary care providers are notified in writing of a member's restricted status, a list of the member's restricted providers and of the designated RRP case manager. The Restricted Recipient Case Manager also sends a Managed Care Referral form and an RRP program brochure.
- Primary care providers are responsible to coordinate patient care and may authorize specialists or other providers to also provide medical services to members by completing a Managed Care Referral Form (found on the Provider tab of the South Country website) and faxing the form to South Country at 507-431-6329.
    - Upon receiving the referral, South Country will process the referral and issue an authorization number. An authorization letter will be sent to the referred provider. The authorization number must be submitted with all claims for the RRP member for that specialist. Claims lacking the authorization number will be denied.
- Referrals are required for all providers who prescribe medications.
- Members in the Restricted Recipient program do not need referrals for the following providers:
    - Mental health providers unless the provider will be prescribing medications, i.e.: Psychiatrist or Psychiatric Nurse;
    - Dental providers or oral surgeons unless the provider will be prescribing medications;
    - Chiropractors/acupuncturists;
    - Optometrists;
    - Physical and occupational therapists;
    - Laboratory services;
    - Home care and community based services;
    - Vision services; and
    - Substance use disorder treatment including opioid use disorder treatment when provided at an opioid treatment program (methadone clinic).

Non-Designated Providers

- Providers can access a member's restricted eligibility by accessing the Department of Human Services MN-ITS system which indicates a member's eligibility status and participation in the Restricted Recipient Program. Verify MHCP Eligibility for all recipients. The phone eligibility verification system, Metro (651) 282-5354 or out-state 1-800-657-3613, and MN-ITS both provide a member's restricted status and the providers to whom the recipient is restricted.
- To access care at a specialist or other provider, a member must obtain a referral from their primary care provider within 90 days of service.

- If the medical service provided was not an emergency and South Country does not have a referral from the primary care provider, the claim will deny.
- Providers who are not designated providers and who have treated recipients may request reconsideration of their claims. To request reconsideration, the provider must complete the Provider Appeal Form on South Country's Provider Portal and submit the medical records for the denied claims.
- If a member accesses care at a hospital emergency department at a hospital other than their authorized hospital for the Restricted Recipient program, the medical claim will be denied unless the medical diagnosis meets emergency criteria or is authorized by the medical director,
    - If the care provided was in response to an urgent medical emergency, the provider or member may appeal the denial. An emergency is defined by Minnesota rule 9505.0175 as: a condition including labor and delivery that if not immediately diagnosed and treated could cause a person serious physical or mental disability, continuation of severe pain, or death.

- Any change in service authorization or denial of a claim from a non-designated provider requires a denial, termination, or reduction (DTR) notice to the recipient and the provider.

Case Management

- South County Health Alliance members who are enrolled in the Restricted Recipient Program are assigned a case manager from the behavioral health team. South County Health Alliance notifies the primary care provider and member of the name and contact information of the Restricted Recipient Program case manager. The role of the case manager is to:
    - Assist the member in following the Restricted Recipient Program guidelines;
    - Coordinate referrals from the primary care provider;
    - Support the primary care provider’s plan of care;
    - Update any change of providers in the appropriate systems, including the Department of Human Services system;
    - Assist the member in meeting their health care needs and facilitate access to appropriate services; and
    - Serve as a resource to the primary care provider.

Changing Providers

- Restricted recipients may change primary care providers if:
    - The current provider is no longer able to provide medical care;
    - The recipient moves more than forty miles from their current provider;
    - The provider and member agree that a change would be in the member’s best interest;
    - South Country determines that the member’s primary care provider cannot manage the member’s health care needs; and
    - A primary care provider can dismiss a member from their practice by providing written notification to the member, faxing the notification to South Country Health

Alliance and continuing to provide care for 30 days to allow the member to establish care with a new provider.

- After 90 days of restriction, members are allowed two primary care provider changes per year for reasons other than those listed.

Removal from the restriction

- Two months prior to the end of their restriction period, South Country staff will review the member's medical and pharmacy claims during the restriction period. If the member has not been compliant with the program, the member's restriction will continue for an additional 36 months. The primary care provider and the member will be notified that the restriction will continue.
- If the member has been compliant with the Restricted Recipient Program requirements, the member will be moved from the active list to the watch list. Claims will be reviewed at 3 months and if appropriate, again at 6 months.
    - The restriction lock-in the South Country internal system and in the Department of Human Services system will terminate after the initial period of 24 months unless South Country extends the restriction for an additional 36 months due to non-compliance.
    - South Country staff will notify the claims payer when a member's restriction is extended.

Additional Resources

If you have questions regarding the Restricted Recipient Program, call South Country Health Alliance at 1-866-567-7242 or call the MRRP hotline at (651) 431-2648 or 1-800-657-3674.

Authority for the universal restriction:

- 42 CFR section 438;
- Minnesota Rules parts 9505-2160 and 9505.2165; and
- Contracts between DHS and each MCO.

Authority for sharing of information between DHS and the MCOs and between the MCOs:

- HIPAA (45 CFR sections 164.5010, 164.502, 164.506);
- Medical Records Act (Minnesota Statutes 144.335); and
- Minnesota Data Practices Act (Minnesota Statutes section 13.46).