

POLICY AND PROCEDURE

DEPARTMENT: Medical Management	DOCUMENT NAME: Restricted Services (Member Lock-In) Program
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APPROVED DATE:	RETIRED:
EFFECTIVE DATE: 01/17	REVIEWED/REVISED:
PRODUCT TYPE: Medicaid	REFERENCE NUMBER: NE.CM.18

SCOPE:

Medical Management, Quality, Provider, Compliance, Pharmacy and Member Service Departments

PURPOSE:

To describe the Member Restricted Services/Lock-In Program.

POLICY:

Plan will establish and maintain a procedure for the Restricted Services (hereafter referred to as Member Lock-In) Program in accordance with all applicable contract, state and federal laws (including 471 NAC 2 concerning restricted services).

This program addresses Member abuse or over utilization of services, including physician, pharmacy and outpatient hospital services.

Lock-In is a mechanism for restricting members to a specific provider and/or a specific pharmacy, prescribing and/or hospital, while not prohibiting the member from receiving medically necessary services as follow: ER care for medical emergencies; PCP referrals for services beyond his/her scope; and other covered service providers who offer services other than physician and pharmacy benefits.

If a member with a lock-in status is unable to obtain care or services from his/her restricted services provider(s) due to extenuating services, the Plan will authorize necessary exceptions on a case-by-case basis.

PROCEDURE:

The Plan investigates members who through UR, provider or MLTC referral are identified as misusing program benefits. If the investigation shows evidence that abuse or overutilization of services has occurred, the member may be locked-in as outlined below. The Plan will so inform the MLTC of this lock-in status. Plan implements a lock-in status code in the system for the member and has the ability to communicate this status to MLTC and other Plans, as appropriate.

I. Identification and Criteria for Medical and Pharmacy Services Lock-In

The Plan may initiate the lock-in process for a member if, in one consecutive 180 calendar day period, the member is identified with one of the following markers:

- Received services from at least five (5) different providers;

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- The member's pharmacy profile has the number of prescriptions for controlled substances exceeding 10% of the total number of prescriptions per month;
- Member transferred to Plan from a previous Managed Care Organization (MCO) lock-in program or referred by State. Member will be locked in the system for twenty four (24) months from the "Date of the original Lock In date or last evaluation of Lock-In (as applicable) as reported by Plan or State.
- Prescriptions written on stolen, forged or altered prescription blank; or
- Prescribed medications do not correlate with the Member's medical condition, as identified by his/her Primary Care Provider (PCP), or ICD-10 code from encounter data; or
- Member tends to have prescriptions filled at multiple pharmacies, and/or pharmacies out of the Member or Provider's local area; or
- Member receives two or more Controlled Substances per month prescribed by two (2) or more physicians, or were dispensed at two (2) or more pharmacies; or
- Member has a diagnosis of narcotic poisoning or drug abuse on file; or

A member shall be locked in to one of the categories of Lock In as outlined below.

II. Identification and Criteria for Non-Emergency Hospital Services

The Plan may initiate the lock-in process, for a member if, in one consecutive 180 calendar day period of eligibility the member is identified as having had three (3) hospital emergency department visits.

III. Categories of Lock In

A member shall be locked into one of the following categories:

- **Category 1: One Pharmacy-** Member chooses one (1) pharmacy. Payment is approved only for prescriptions filled at the selected pharmacy. Other services are not restricted
- **Category 2: One primary physician and one pharmacy-** Member chooses one primary physician and one pharmacy
- **Category 3: One primary physician, one pharmacy, and one hospital-** Member chooses one primary physician, one pharmacy, and one hospital for outpatient services. Inpatient hospital admissions are exempt.
- **Category 4: One prescribing physician and one pharmacy-** Member chooses one prescribing physician and one pharmacy. Only

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prescriptions authorized by the prescribing physician and dispensed by the pharmacy will be approved for payment. However, this category allows the member to visit other physicians without restriction.

- **Category 5: All Medical Services-** member selects one primary physician, one prescribing physician, one pharmacy and one hospital where all medical services will be rendered. Only these providers will be authorized for payment.

NOTE: The provider chosen as the lock-in provider must be the provider who is the member's primary care physician (PCP). The choice of provider(s) may be changed at any time upon demonstration by the member of good cause. The member is allowed to change the provider(s) every three months without demonstration of good cause.

IV. Lock-In Process:

The Plan conducts retrospective UR to identify the potential need for restricted services for a member, in addition to requests by network providers for a review of utilization patterns by a member. The review is conducted on a quarterly basis to identify members who utilized services at a frequency or amount which meets utilization criteria. If criteria are met, the member shall be restricted to receiving services from designated providers as indicated. The member is initially locked-in for a twenty four (24) month period. Following this twenty four (24) month period, utilization review for this member is conducted at twenty four (24) month intervals to determine the member's continued need for the program.

A Plan care manager reviews, documents, and manages the clinical needs of a member, collaborate with the enrollment broker, pharmacy division to ensure the coordination of restricted services. The Plan maintains documentation of all activities associated with member lock-in including network providers who requested a review by the Plan.

A. Medical and Pharmacy Services

Once a member has been identified for lock-in, the Plan shall send a written notification of lock-in status and enroll the member in the program as outlined below.

The written notification sent to the member shall include:

- The reason for enrolling the member in the lock-in program;
- A description of the lock-in program;

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- The effective date of lock-in program enrollment;
- Notification that member shall select a provider(s) of identified services.
- Notification that if the member does not select a provider within XX days of the date of the letter, providers will be selected for him/her.
 - In this case, follow up letter identifying member's designated providers with contact information;
- Information relating to the member's right to a hearing as outlined in this policy; and
- Contact information of an individual who may be contacted in writing or by telephone for information relating to the lock-in program.

Except for a member who requests a hearing relating to a Plan lock-in determination, the Plan shall enroll the member in the lock-in program within ninety (90) days of sending the written notification. Member has ninety (90) days from date of the notice to request hearing.

When a member has selected (or the Plan has designated for non-response by member) provider(s) for a lock-in period, the Plan designated staff reach out to selected providers to ensure their willingness to act as a Lock-In Provider to the member (assuring that all standards, including distance, admitting privileges, prescriber requirements are fulfilled).

The Plan designee documents the lock-in status, category and selected providers in the clinical documentation system and reaches out to the Plan contracted medical service vendors as necessary to ensure this is noted within their clinical documentation system. The Plan Pharmacist communicates the pharmacy and prescriber information to the contracted Pharmacy Benefits Management Company to initiate the lock-in.

Once enrolled, the lock-in member shall be restricted to receiving covered services from designated providers as appropriate by category of lock in.

The Plan designee will provide the Plan Eligibility Specialist with the following information via CRM:

- Member's Name,
- Medicaid ID (or other ID),
- DOB,
- Effective date of lock in
- Name of the provider(s) or facility and
- Category of the lock-in program

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Initially, the restrictions shall be maintained for twenty four (24) months. Following this period, utilization review for this member is conducted at twenty four (24) month intervals to determine the member's continued need for the program.

B. Hospital Services

When applicable, a facility is assigned as a lock-in hospital for outpatient services upon the member selection of the facility. The Plan will educate both the member and the assigned PCP on eligible services and proper use of ER as well as the proper use of services. The use of a non-lock in facility for outpatient services during a hospital lock-in period will be denied and considered a non-covered benefit with the exception of inpatient and/or emergent care.

The Plan designee documents the lock-in status in the clinical documentation system, notifies the State (as applicable) and reaches out to the Plan contracted medical service vendors as necessary to ensure this is noted.

C. Lock-In Notification

The Plan shall send a written notification of lock-in status; and enroll the member in the program as outlined below.

The written notification sent to the member shall include:

- The reason for enrolling the member in the lock-in program;
- A description of the lock-in program;
- The effective date of lock-in program enrollment;
- Identification of the member's designated providers
- Information relating to the member's right to a hearing as outlined in this policy; and
- Contact information of an individual who may be contacted in writing or by telephone for information relating to the lock-in program.

Except for a member who requests a hearing relating to a Plan lock-in determination, the Plan shall enroll the member in the lock-in program within thirty (30) days of sending the written notification

Once enrolled, the lock-in member shall be restricted to receiving covered services from designated providers depending on category of Lock-In.

Initially, the restrictions shall be maintained for at least twenty four (24) months. Following this period, utilization review for this member is conducted at twenty

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four (24) month intervals to determine the member's continued need for the program.

The Plan designee will provide the Plan Eligibility Specialist with the following information via CRM:

- Member's Name,
- Medicaid ID (or other ID)
- DOB,
- Date to make the Lock in Effective
- Name of the provider(s) or facility and
- version of the lock-in program
 - Medical
 - Pharmacy

V. Change of Lock-In Primary Provider

The choice of provider(s) may be changed at any time upon demonstration by the client of good cause which is determined by the Utilization Management Committee (UMC). The client is allowed to change the provider every three months without demonstration of good cause. Client must submit request using the "Recipient Choice of Provider Agreement". All requests for change must be directed to the UMC.

VI. Members Right to Appeal or State Fair Hearing Regarding Lock-In:

A member who is notified of a Plan decision to enroll or maintain enrollment of the member in the lock-in program shall have the right to request a Plan appeal or Hearing as follows.

- (1) The subject of the appeal or hearing shall be limited to whether or not the Plan had sufficient evidence to support the Plans decision.
- (2) A request for an appeal or Hearing shall be:
 - (a) In writing;
 - (b) Mailed to the Plan; and
 - (c) Received by the Plan or the department within ninety (90) calendar days from the date that the notice of lock-in was received by the recipient.
- (3) If the member is requesting a hearing, the request for a hearing shall be received by the agency within ninety (90) calendar days from the date that the notice was received by the recipient.
- (4) If a request for an appeal or hearing which meets the criteria established in subsection (3) of this section is:

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- (a) Received by the Plan or department within ten (10) calendar days from the date that the recipient received a notice of lock-in status, the lock-in action shall be delayed until an appeal or fair hearing has occurred; or
 - (b) Not received by the Plan or department within ten (10) calendar days from the date that the recipient received a notice of lock-in status, the lock-in action shall not be delayed.
- (5) A fair hearing shall be held in accordance with State policy, rules and regulations.

VII. Review and Notification to Members Regarding Lock-In Status:

Member shall remain in Lock-in after the 24 month initial period, after the 24 month period, utilization is re-evaluated. The Plan shall provide the lock-in member with a written notification, which shall include:

1. Findings of a utilization review; and
2. A decision to maintain enrollment in or discharge the member from the lock-in program.

VIII. Updating the System: Removing Member from Lock-In Status:

If after review the member is removed from lock-in, the Plan designee will provide the Plan Eligibility Specialist with the following information via CRM:

- Member's Name,
- Medicaid ID (or other ID),
- DOB,
- Date to terminate the Lock in
- Name of the provider(s) or facility and
- Category of the lock-in program to terminate

The Plan designee documents the lock-in status in the clinical documentation system and reaches out to the Plan contracted medical service vendors as necessary to ensure this is noted. The case management designee notifies the Plan Pharmacist of the change in lock-in status. The Plan Pharmacist communicates this to the contracted Pharmacy Benefits Management Company to terminate the lock-in.

IX. Reporting:

The MCO will submit a monthly report, in a manner and format to be specified by MLTC, of the status of all members participating in a restriction program.

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REFERENCES

Contract Section Restricted Services

ATTACHMENTS

DEFINITIONS:

Restricted Services- a mechanism for restricting Medicaid recipients to a specific physician and/or a specific pharmacy provider. The restricted services mechanism cannot prohibit the recipient from receiving services from providers who offer services other than physician and pharmacy benefits.

REVISION LOG

REVISION	DATE

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in Compliance 360, Centene's P&P management software, is considered equivalent to a physical signature.

VP Medical Management _____ Approval on File _____

Director Medical Management _____ Approval on File _____