NEW YORK STATE
DEPARTMENT OF SOCIAL SERVICES
40 NORTH PEARL STREET, ALBANY, NEW YORK 12243

CESAR A. PERALES
Commissioner

[An Administrative Directive is a written communication to local Social Services Districts providing directions to be followed in the administration of public assistance and care programs.]

ADMINISTRATIVE DIRECTIVE

TRANSMITTAL NO.: 83 ADM-23
[Medical Assistance]

TO: Commissioners of Social Services

SUBJECT: Recipient Restriction Program

DATE: May 23, 1983

SUGGESTED DISTRIBUTION:
All Medical Assistance Staff
All Public Assistance Staff
All Accounting Staff

CONTACT PERSON: Any questions concerning this release should be directed to your county's contact person in the Recipient Activities Unit or Mr. Richard Johnson at 1-800-342-3715, extension 3-5989.

I. PURPOSE

The purpose of this Administrative Directive is to advise local agencies of changes in the Recipient Restriction Program which have been made since the release of 80-ADM-93.

II. BACKGROUND

80-ADM-93 introduced to local districts the Recipient Restriction Program, which was developed to identify and control inappropriate, unnecessary, or excessive use of medical services, drugs and supplies covered under Medicaid. According to 42 CFR § 431.54(e), "if a Medicaid agency finds that a recipient has utilized Medicaid services or items 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 recipient for a reasonable period of time to obtain Medicaid services or items only from designated providers."

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Social Services Law and Other Legal References	Bulletin/Chapter Reference	Miscellaneous Reference
80 ADM-93		18 NYCRR 360.16 18 NYCRR 383.5 18 NYCRR 358 18 NYCRR 505.1	SSA 1902(a)(23); 42 CFR 431.51 42 CFR 431.54		Omnibus Budget Reconciliation Act of 1981 (Pub.L. 97-35) 81 ADM-55

For this purpose, DMA Program Analysis and Utilization Review (PAUR) formerly Surveillance and Utilization Review (SUR) staff developed guidelines and conditions for restriction (see Attachment A) based on the professional medical/health care expertise and Medicaid program experience in New York State. These guidelines form the basis for each recommendation made by State PAUR staff to local districts concerning restriction of a Medical Assistance recipient to a primary medical provider.

In addition to the guidelines, exception criteria are used in a process of computer screening for specified levels of usage of medical services, drugs and supplies. Commonly abused services (e.g. certain drugs, office visits) are included in this screening to identify those persons whose utilization will be reviewed by medical health care professionals.

If a local district would like PAUR to include other specific exception criteria in computer screening for that county for the purpose of uncovering individuals engaged in a type of abuse thought to be a problem in that county, the local agency should contact the county contact person in the Recipient Activities and Tracking Unit of PAUR to discuss the feasibility of including the requested exception criteria in computer screening for that county.

III. PROGRAM IMPLICATIONS

This directive will clarify standards and procedures of the Recipient Restriction Program.

IV. REQUIRED ACTION

A. Change of Initial Restriction Period

In 80-ADM-93 a period of restriction was discussed without specifying the length of restriction. It had been Department policy that restrictions would last for a period of 18 months. This release modifies this policy to a period of restriction of 15 months. Please note that all restrictions in excess of 15 months have been lifted, so that all initial restrictions now should run for a period not in excess of 15 months.

B. Implementation Procedures

Upon receipt of a recommendation from State PAUR staff to restrict a recipient to a primary medical provider(s), implementation will proceed as follows:

1. Notice of Intent

A "Notice of Intent to Restrict Medical Assistance Identification Card" shall be sent to the recipient. This notice must conform to the guidelines contained in 81-ADM-55 and must include the following information:

a. date restriction will begin

b. effect and scope of restriction

c. reason for the restriction (attachment of summary pages from the Recipient Information Package)

d. recipient's right to fair hearing

e. instructions for requesting a fair hearing in compliance with 18 NYCRR 358 including the right to receive aid continuing where such a request is made prior to the effective date of the intended action

f. right of the recipient to select a primary provider within two (2) weeks of the date of the "Notice of Intent to Restrict"

g. right of the local agency to select a primary provider for the recipient if he/she fails to select a primary provider within the two (2) week time limit

h. right of the recipient to change providers every three months, or sooner for good cause shown

i. right to a conference with a local agency staff person to discuss the reason for and effect of the intended restriction

j. right of the recipient to present at the conference an explanation and submit documentation to support the medical necessity of the utilization documented in the Recipient Information Packet

k. name and phone number of the person to contact to arrange a conference

l. the fact that a conference does not suspend the date on which the restriction will become effective as stated in the 'Notice of Intent to Restrict" and, further, that the conference neither takes the place of nor abridges the recipient's right to a fair hearing

m. the right of the recipient to examine his/her case record.

2. Conference With Recipient

The conference can be utilized to achieve the following goals:

a. provide the recipient with an opportunity to explain his/her utilization of Medical Assistance and submit any evidence which may be used to support his/her explanation

b. provide the local agency with an opportunity to explain the restriction program and how it can benefit the recipient through increased coordination of the medical care they receive and, in this way, attempt to gain the voluntary cooperation of the recipient

c. avoid unnecessary fair hearings which are time consuming for both state and local staff

d. expedite the selection of a primary provider by the recipient

e. provide the recipient the opportunity to have answered any questions he/she may have concerning the restriction program.

Upon completion of a conference with a recipient, the local agency must inform the recipient in writing of the outcome of the conference and, if the final decision is to restrict, provide instructions on how to obtain a fair hearing and re-state the recipient's right to select his/her primary provider(s).

Notation must be made in the case record of the date, outcome, and notification of the recipient of the result of the conference.

3. Reversal or Change of PAUR Recommendation for Administrative Reason

After conference with the recipient or receipt of additional information not available through claim history, the local agency may decide to change or reverse the recommendation to restrict received from State PAUR staff. This decision can be based on administrative necessity arising from situations such as a case closing, institutionalization of the recipient, inability to locate a primary provider of the type recommended, or other restrictions on a recipient's medical benefits such as participation in an HMO or case management program. Documentation of the reason for the change or reversal of the recommendation from PAUR must be noted in the case record. These changes or reversals should be reported to the Recipient Activities and Tracking Unit of PAUR. The only situation where restriction types can be changed is when a physician restriction is recommended, and the agency cannot find any Medicaid physician to accept primary provider status for the recipient. In that case the physician restriction can be changed to a clinic restriction.

4. Reversal or Change of PAUR Recommendation for Medical Reasons

If, after conference with the recipient, or receipt of additional information the local agency decides to change or reverse the PAUR recommendation, and this is done for medical reasons, the change or reversal must be supported in the following manner:

a. case decision must be signed by the local agency's Medical Director or a consulting physician having no vested interest in the case

b. verification of documentation should be such that it ensures that any treating physician who submits a statement verifying the medical necessity of the services, drugs, and supplies received by the recipient is fully aware of all the services, drugs, and supplies documented in the RIP

c. this documentation and summary must be forwarded to the Recipient Activities and Tracking Unit of PAUR within thirty (30) days of the date on which the decision to change or reverse the PAUR recommendation is made.

The above procedures must be followed when a recommendation is changed or reversed at any point in the restriction process. Medical Review and Recipient Activities staff of the Recipient Units of PAUR are available for consultation with local agency staff concerning problematic cases and can be reached by calling 1-800-342-3715, extension 4-6866 and asking for the county contact person.

5. Contacting Primary Providers

When a primary provider is selected by either the recipient or the local agency, a local staff person must contact the provider to explain the Recipient Restriction Program and solicit the provider's cooperation. If the provider agrees to be the primary provider for the recipient, written notice must be sent to the provider and recipient confirming the date on which the restriction will begin.

6. Entering Restriction on WMS/IREF

Data entry of restriction codes via WMS should proceed as outlined in the Forms and Procedures Manual, beginning on page III-C-3 and the Recipient Restriction Procedural Manual section entitled "Instructions for Use of MA Restriction Codes." Questions concerning WMS input should be directed to the county contact person in the Recipient Activities and Tracking Unit of PAUR. Input of restriction codes in New York City will be by monthly update tape prepared by staff of the New York City Medical Assistance Program.

C. Post-Restriction Review

Prior to the end of the initial fifteen (15) month restriction period, State PAUR staff will review each restricted recipient's utilization while restricted and send the local agency a recommendation to either terminate or continue the restriction.

If a restriction is to be continued, a new "Notice of Intent to Restrict" with appropriate fair hearing language must be sent to the recipient.

If the recipient disagrees with the decision to continue the restriction, he/she shall be afforded the same rights to administrative redress as afforded him/her at the time of the initial restriction. The recipient must be notified in writing of these rights.

V. Effective Date

This Administrative Directive is effective December 20, 1982.

Robert C. Osborne
Deputy Commissioner
Division of Medical Assistance

Attachments

NEW YORK STATE DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL ASSISTANCE
BUREAU OF PROGRAM ANALYSIS AND UTILIZATION REVIEW

Utilization Review Procedures for the Recipient Restriction Program

1. Initial Identification of Possible Misutilization[1]

The following utilization standards[2], expressed as exception criteria, are used to identify recipients who appear to have engaged in misutilization of certain ambulatory care services. A recipient who exceeds one or more of the criteria within the most current six months available for review will be considered for possible inclusion in the Recipient Restriction Program, but only after a multi-level professional review is performed utilizing the guidelines in Part 2.

Please note that the exception criteria (values and time periods) may be modified on a quarterly basis in order to comply with HCFA SURS performance standards which require that exception criteria be routinely updated to identify potential misuse or abuse, and to meet program needs. The criteria are also modified to reflect changes in covered services/drugs by the New York State Medical Assistance Program, as well as to identify misuse of services in other areas (e.g. psychiatric services, clinic specialty services, different drugs or drug groupings).

Exception Criteria	Description	Exception Value	
		1 Mo.	3 Mos.
# Different Ambulatory Care Providers	The # of Different Physicians, Pharmacies and Clinics Used	5	7
# Emergency Room Visits	The # of Visits to Hospital Based and Free-Standing Clinic Emergency Rooms	3	6
# Days Supply Prescription Drugs	The Total # of Days Supply of Prescription Drugs Prescribed	120	360
# Days Supply of Valium	The Total # of Days Supply of the Controlled Substance Valium that was Prescribed	60	180
# Days Supply of Elavil	The Total # of Days Supply of the Drug Elavil that was Prescribed	60	180
# Days Supply Drugs for the Relief of Pain	The Total # of Days Supply of the Therapeutic Category of Drugs Used for the Relief of Pain	60	180

Exception Criteria	Description	Exception Value 1 Mo.	Exception Value 3 Mos.
# Days Supply Central Nervous System Drugs	The Total # of Days Supply of the Therapeutic Category of Drugs that act on the Central Nervous System	60	180
# Days Supply of Darvon, Dolene and/or Propoxyphene	The Total # of Days Supply of the Drugs, Darvon, Dolene and Propoxyphene that were Prescribed	60	180

2. Guidelines for Recommending a Restriction

A recipient who exceeds one or more of the exception criteria of medical assistance usage or is referred[3] is subject to a multi-level professional analysis and review by the Medical Review Team to determine whether restriction should be recommended to the local social services district. Only a recipient who appears to have met one or more of the following conditions during the most current 15 months available for review may be recommended for restriction.

In using the guidelines, the professional judgement of the Medical Review Team is applied to each case review. Use of professional judgement includes but is not limited to:

a) identifying potential hazards to the health of the recipient arising from the conditions specified in the guidelines.

b) identifying instances in which the misutilization of services appears to be physician generated. In such instances the Review Team will refer the physician to the appropriate agency for quality of care review and/or administrative or criminal action rather than recommending a physician restriction.

c) identifying instances where the recipient may have met one of the conditions specified below, but it appears that it was an isolated instance or occurrence, or it appears that there was a legitimate reason for the utilization cited. In these instances a restriction will not be recommended.

d) recommending the type of restriction which will have the optimal effect on controlling the misutilization arising from the conditions specified in the guidelines. No pharmacy restriction will be recommended unless the recipient has received duplicative medications or excessive drugs or contraindicated (conflicting) drugs.

3. **Conditions for Restriction:**

a) Duplicative Medications - recipient has received two or more similarly acting drugs during overlapping time periods. The drugs, if taken together, may result in a significant drug interaction(s) or adverse reaction(s) which may be harmful to the recipient.

b) Duplicative Medical Care - recipient has received services from two or more physicians and/or clinics for the same or similar problems or conditions in an overlapping time frame.

c) Excessive Drugs - recipient has received a greater than necessary quantity of the same drug for the time period specified.

d) Contraindicated Care (Conflicting Care) - recipient has received drugs and/or medical care which may be inadvisable for the treatment of the medical condition or such treatment may significantly conflict with other treatment being rendered by another provider.

NOTES

[1] Misutilization means the use of medical assistance in excess of, or inappropriate to, the particular medical needs of the recipient.

[2] The utilization standards are established by the Medical Review Team of the Department of which consists of licensed pharmacists, physicians and registered nurses. The standards are established on the basis of the Medical Review Team's professional expertise as well as Medicaid program experience in New York State and other states with restriction programs.

[3] An unsolicited written referral from an identified provider, health agency or government agency indicating potential misuse of services by a recipient may also lead to inclusion in the Recipient Restriction Program, but only after misuse is confirmed via medical review using the guidelines cited in Part 2.