DEPARTMENT OF COMMUNITY HEALTH

MEDICAL SERVICES ADMINISTRATION

MONITORING AND CONTROLLING RECIPIENT USE OF MEDICAL ASSISTANCE PROGRAM SERVICES

(By authority conferred on the department of social services by sections 6 and 10 of Act No. 280 of the Public Acts of 1939, as amended, being SS400.6 and 400.10 of the Michigan Compiled Laws)

R 400.7391 Definitions.

Rule 1. As used in these rules:

(a) "Department" means the department of social services.

(b) "Enrollment with a primary provider" means the procedure by which a recipient is restricted to a single provider or group of providers to receive the nonemergency services available under the medical assistance program.

(c) "Medicaid management information system" means the mechanized medical claims processing and information retrieval system used by the department.

(d) "Medical assistance program" means the department's program to provide for medical assistance established by section 105 of Act No. 280 of the Public Acts of 1939, as amended, being S400.105 of the Michigan Compiled Laws, and title 19 of the federal social security act, 42 U.S.C. S1396 et seq.

(e) "Medical emergency" means any condition for which a delay in treatment may result in the recipient's death or the permanent impairment of the recipient's health.

(f) "Misutilization" means the use of medical assistance in excess of, or inappropriate to, the particular medical needs of the recipient, as determined by the department through investigation and analysis. Initial indicators of possible misutilization in light of a recipient's medical condition shall include unusually frequent physician, pharmacy or emergency room encounters, frequent use of ambulances, and unusually frequent acquisition of drugs, especially those with addictive properties.

(g) "Prior authorization" means the procedure by which the department approves, in advance, the provision of a specific service or group of services to be covered under the medical assistance program.

(h) "Program to control utilization" means a program in which a recipient, who has been found to engage in misutilization, is placed to allow the department to monitor and assure the medical necessity of services for that recipient. The program may include, singularly or in combination, prior authorization, enrollment with a primary provider, counseling, or referral to other agencies.

(i) "Provider" means an individual, firm, corporation, association, agency, institution, or other legal entity which has been approved to provide medical assistance to a recipient pursuant to the medical assistance program.

(j) "Recipient" means an individual eligible to receive medical assistance through the department.

History: 1981 AACS.

R 400.7392 Monitoring and analysis of a recipient's pattern of utilization.

Rule 2. (1) A recipient's use of medical assistance shall be monitored through the medicaid management information system. When a recipient's use of medical assistance exceeds utilization measurements in use by the department in 1 or more categories, or when information available to the department indicates possible misutilization, the recorded pattern of utilization of medical assistance program services by the recipient may be examined to determine whether the recipient shall be considered for placement in a program to control utilization.

(2) The department shall use analysis, investigation and medical review to determine whether the use of medical assistance is appropriate to the recipient's medical condition.

History: 1981 AACS.

R 400.7393 Notification to recipient of findings; recipient's response; possible departmental actions.

Rule 3. (1) When analysis indicates that a recipient may be misutilizing medical assistance, the recipient shall be advised of the findings in writing, and shall be requested in writing to meet and discuss his or her use of medical assistance with a representative of the department. This notice shall also indicate the possible recipient control actions of the department and the consequences to the recipient of not responding. The recipient shall have 10 days from the date of notice to the recipient to respond to the written request to discuss his or her use of medical assistance.

(2) If no response is received from the recipient by the department within 10 days, 1 or more of the following actions may be taken:

(a) The department may send the medical assistance card of a recipient to its appropriate local county office in any of the following situations:

(i) If, in the judgment of the department, the recipient requires counseling to change patterns of utilization.

(ii) If the recipient does not respond to written requests to discuss the recipient's use of medical assistance.

(iii) If the recipient does not cooperate with the department's efforts to investigate the recipient's use of services or to place the recipient in a program to control utilization.

The department shall require the recipient to obtain the card in person if at all feasible.

(b) The department may enroll the recipient in a program to control utilization. The department shall notify the recipient when enrollment is made and explain in the notification any procedures to be followed.

(c) If, after follow up on the initial notification of the consequences of failure to cooperate, the recipient refuses to cooperate or demonstrates an inability to cooperate with the department, the department may enroll the recipient in a program to control utilization and select the type of control or controls to be used.

(3) If a response is received, a meeting to discuss the findings shall take place. As a result of the meeting, 1 of the following shall result:

(a) The department may enroll the recipient in a program to control utilization. The recipient may participate in the selection of the type of control best suited for his or her needs.

(b) The recipient, as a result of the meeting, may have demonstrated to the department appropriate program utilization and may not be enrolled in a program to control utilization.

History: 1981 AACS.

R 400.7394 Program to control utilization.

Rule 4. The department may take 1 or more of the following actions as part of a program to control utilization:

(a) The department may enroll the recipient in a counseling program with the recipient's consent. The counseling shall be directed at locating appropriate medical care or instructing the recipient in ways to adjust the use of medical assistance to a level appropriate to the recipient's particular medical needs.

(b) The department may refer the recipient with the recipient's consent to other agencies whenever the department determines that misutilization may be related to such problems as mental illness or substance abuse. Referral agencies include, but are not limited to, community mental health services, substance abuse services and protective services. The department shall safeguard the confidentiality of the recipient's records in all referrals made pursuant to this subrule by obtaining a signed authorization from the recipient.

(c) The department may use prior authorization procedures to monitor and reduce a recipient's misutilization of services. The department shall issue a specially designated medical assistance card which shall inform providers that all designated services for the recipient, except those related to medical emergencies or referrals, require prior authorization by the department in order to assure reimbursement by the department. The department shall review the need for continued issuance of the special card at least once every 90 days. The department shall issue the card for as long as the department considers it to be an effective measure to control utilization.

(d) The department may use enrollment with a primary provider to monitor and reduce a recipient's misutilization of services. The recipient may select the provider or providers to whom he or she will be restricted. If the department has reason to suspect that the selected primary provider will not contribute to a reduction in utilization, the recipient shall select another provider. If the recipient refuses to make a selection, the department shall make the selection. Only providers who agree to work with restricted recipients shall have recipients enrolled with them. The department shall issue a specially designated medical assistance card which shall indicate that only those physician services rendered by the primary provider, except services related to medical emergencies or referrals, shall be reimbursed by the department. The department shall review the enrollment at

least once every 90 days, although the recipient may request a change in the primary provider at any time. The recipient's request for a change in primary provider will be considered in light of the recipient's past and current utilization and will be adjudicated in the best interest of the recipient and the department. The recipient shall be informed in writing on the basis for any department disapproval of a provider change request. The enrollment shall be continued for as long as the department considers it to be an effective measure to control utilization. Recipients shall be disenrolled from enrollment with a primary provider if the primary provider recommends disenrollment and the department approves.

History: 1981 AACS.

R 400.7395 Scope of rules; confidentiality.

Rule 5. (1) Nothing in these rules shall be construed to prohibit the department, as part of its responsibility for medical assistance program administration, from doing any of the following:

(a) A review of any recipient's utilization of medical assistance program services.

(b) An investigation of any findings made during a review through discussions with any of the following:

(i) The recipient or with other individuals directly involved.

(ii) A provider licensed to render such care.

(2) The identity of a recipient who is enrolled in a program to control utilization shall not be disclosed to any provider except one who is evaluating or treating or agrees to evaluate or treat that recipient.

History: 1981 AACS.

R 400.7396 Referrals to the office of inspector general.

Rule 6. The department's office of inspector general shall be informed when there is evidence of possible fraud by a recipient.

History: 1981 AACS.

R 400.7397 Right of appeal.

Rule 7. Any written notice to the recipient which is part of the program to control utilization shall include reference to the recipient's right to appeal any action of the department taken pursuant to these rules, including the denial of a request for a change in the primary provider. The appeal process shall conform to R 400.901 to R 400.922, except that action related to recipient placement in a program to control utilization shall not be considered a suspension, reduction, discontinuance or termination of medical assistance under subrule 5 of R 400.904.

History: 1981 AACS.