Chapter 15

Restricted Recipient Program

NOTE: *Please review the following details 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 details 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 (DHS) 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 medical services or medications 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 are placed in the RRP for a period of 24 months of enrollment in a Minnesota Health Care Program (MHCP). During this period of time a 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 are reviewed and may continue 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, South Country staff conducts a full investigation.
- South Country may contact the member to address the behavior leading to the review
- 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 South Country medical director reviews 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.

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 RRP are enrolled for an additional 36 months.
- The RRP is universal and stays in place regardless of whether a recipient:
    - Changes health plans;
    - Moves from fee-for-service to a health plan; or
    - Moves from the health plan to fee-for-service.
- South Country provides a member who is to be placed in the RRP 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 RRP 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.
        - Although members in the RRP are assigned to a specific hospital, members may access care at the nearest hospital if experiencing a medical emergency.
    - 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 as the primary care provider by the recipient.
- 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 designated 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 RRP 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 RRP. 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 the date of service. South Country will enter an authorization and fax an authorization letter to the

specialist. If South Country does not have a referral for the specialist from the primary care provider or the medical claim is submitted without the authorization number, 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.

Emergency Care

- A newly restricted recipient is assigned to a designated hospital which must include emergency care. The primary hospital should accept recipients who are transferring from a non-designated hospital. Due to staffing, capacity or other reasons, the designated hospital may not be able to accept a transfer.
- South Country pays for all emergency services at the member's designated hospital. This includes treatment that may be necessary to ensure, within a reasonable medical probability, that no material deterioration of the patient's condition is likely to result from or occur during discharge or transfer of the patient to another facility.
- Hospitals are required to follow the Emergency Medical Treatment & Labor Act (EMTALA). For more information on EMTALA, go to Emergency Medical Treatment & Labor Act (EMTALA) | CMS. EMTALA guarantees access to emergency medical services for individuals who present to a hospital emergency department regardless of their ability to pay. Any individual who presents to a hospital emergency department must be screened by qualified medical personnel to determine the presence or absence of an emergency medical condition. Hospitals are required to make sure patients are provided with stabilizing treatment, within their capabilities, before they can initiate a transfer to another hospital or medical facility or before they can discharge a patient.
- Under the Minnesota law pertaining to medical assistance payments, "Emergency" means 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. Minn. R. 9505.0175, subp. 11.
- When emergency health services are provided to a restricted recipient, the service is eligible for payment if the service provided meets the definition of an "emergency" as above. Minn. R. 9505.2238, subp. 4.

Emergency Care at Non-Designated Hospitals

- Hospital admissions must follow medical protocols (i.e., EMTALA) to care for the recipient if there is clear treatment and admission need, such as a life-threatening injury or illness or level of care not available at the designated hospital. The emergency department is not required to stabilize and request transfer to the designated hospital when a recipient will be placed in an inpatient status.
- Hospitals are charged with the responsibility of verifying Minnesota Health Care eligibility, including whether the individual is in the RRP, by accessing MNITS.
- Referrals to a non-designated hospital emergency department are not accepted. The RRP referral process is not the appropriate mechanism for paying an emergency department claim or any corresponding prescriptions. Review of a hospital emergency department claim must follow both State and Federal law, including the Emergency Medical Treatment & Labor Act (EMTALA).

- Claims automatically deny when care is received from the non-designated hospital provider. When “emergency health services” are provided to a restricted recipient, the service is eligible for payment. Providers are required to provide documentation of the emergency circumstances in support of payment for the emergency service claim. See Minn. R. 9505.2238, subp. 4.
- South Country has a claim reconsideration process (appeal process) in place to review claims for emergency services for proper payment.
- The medical record review will be completed by South Country's clinical review specialist.

Case Management

- South County Health Alliance assigns a case member from the behavioral health team to all members who are enrolled in the RRP. South County Health Alliance notifies the primary care provider and member of the name and contact information of the RRP case manager. The role of the case manager is to:
    - Assist the member in following the RRP 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
    - 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 the initial 90 days in the RRP, 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 if the restriction continues.

- If the member has been compliant with the RRP requirements, South Country will notify the primary care provider and member that the RRP will end.
    - 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.

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).