Curbing Prescription Drug Abuse With Patient Review and Restriction Programs

Learning from Medicaid agencies

Appendix A

Methodology

Information for the chartbook was collected via a survey (see Page 2 here) consisting of approximately 30 questions on patient review and restriction (PRR) program characteristics, structures, and outcomes, as well as a literature review of publicly available sources, including state Medicaid websites, regulations, administrative codes, and provider manuals (see pages 8-16 for a full list of sources consulted). The survey was emailed to all 50 states, the District of Columbia, and Puerto Rico. Pharmacy managers, program integrity directors, or other staff closely involved in the administration of the PRR were provided with the survey between Sept. 14 and Nov. 13, 2015. Respondents were given the option of completing the survey via SurveyMonkey, an online tool, or using a Microsoft Word document version. Forty-three states (including the District and Puerto Rico) responded. Of these, 38 states (including the District) operate a PRR in Medicaid fee-for-service (FFS). The survey focused on PRR programs in FFS; however, information was collected on whether states administered Medicaid managed care PRRs. The data collected from the survey was self-reported.

Survey Questions

1. In what state does your Medicaid program operate?
2. How many beneficiaries are enrolled in your state's Medicaid program (both fee-for-service [FFS] and managed care)? How many beneficiaries in the state's Medicaid population are in managed care only?
3. Does your state Medicaid FFS program currently operate a Patient Review and Restriction (PRR), or lock-in, program for controlled substances?

   ❍ Yes

   ❍ No*

   * **If no, please only answer Question 4 and Questions 30-35.**

4. Do your state's Medicaid managed care plans operate PRRs?

   ❍ Yes*

   ❍ No

   ❍ Not sure

   ❍ My state does not currently operate Medicaid managed care plans

   * **If yes, please answer Question 5 (unless you answered no to Question 3). Otherwise, please skip to Question 6.**

5. Are the Medicaid managed care plans required to follow the same program structure as the FFS PRR?

   ❍ Yes

   ❍ No*

   ❍ Not sure

   * **If no, please answer Question 6. Otherwise, skip to Question 7.**

6. Please elaborate on why Medicaid managed care plans **are not required** to follow the same program structure as the FFS PRR.

For the remaining questions, please answer with regard to your FFS PRR (if your FFS and managed care PRRs differ).

7. What year did your PRR program begin operation?
8. To which of the following providers are PRR enrollees restricted? *Please select all that apply.*

   ❍ Pharmacy

   ❍ Prescriber

   ❍ Hospital

   ❍ Other *(please elaborate)*

9. For patients not identified through referral, how frequently are beneficiaries identified for potential enrollment in the PRR through proactive claims data analysis?

   ❍ Monthly

   ❍ Quarterly

   ❍ Annually

   ❍ Rolling/Ongoing

   ❍ Other *(please elaborate)*

10. Which of the following criteria are used to identify beneficiaries for enrollment in the PRR? *Please select all that apply.*

    ❍ Obtaining/filling a certain number of controlled substance prescriptions over a specified time period

    ❍ Obtaining/filling a certain number of other prescriptions over a specified time period

    ❍ Utilizing a certain number of pharmacies to obtain controlled substances over a specified time period

    ❍ Visiting a certain number of prescribers to obtain controlled substances over a specified time period

    ❍ Visiting a certain number of emergency rooms over a specified time period

    ❍ Obtaining a certain number of controlled substances in the same therapeutic class over a specified time period

    ❍ Referral/recommendation

    ❍ Other *(please elaborate)*

11. Which type of personnel most frequently performs the internal clinical review once the beneficiary has been initially identified for PRR enrollment based on the criteria defined in the previous question?

    ❍ Physician

    ❍ Pharmacist

    ❍ Registered Nurse

    ❍ Social Worker

    ❍ Nurse Practitioner

    ❍ Physician Assistant

    ❍ Other *(please elaborate)*

12. What is the initial process for selecting assigned pharmacies and/or prescribers for beneficiaries?

    ❍ Beneficiaries submit preferences for pharmacies and/or prescribers

    ❍ Beneficiaries are presented with pharmacy and/or prescribers options from which to select

    ❍ The state chooses beneficiaries' most frequently visited pharmacies and/or prescribers with the option for beneficiaries to change selections

    ❍ The state chooses pharmacies and/or prescribers with beneficiaries able to change selections under limited circumstances

    ❍ Other *(please elaborate)*

13. Which of the following entities are notified when a beneficiary has been assigned to them? *Please select all that apply.*

    ❍ Pharmacies

    ❍ Prescribers

    ❍ Neither

    ❍ Other *(please elaborate)*

14. Since the inception of the PRR program, what percentage of beneficiaries needed to be re-enrolled after being released from the program?

    ❍ _____ percent (number that have been released and re-enrolled divided by the number that have been released) *(Numerical responses only)*

    ❍ Not measured

    ❍ Not sure

15. Does your PRR program have access to the state's Prescription Drug Monitoring Program (PDMP) database?

    ❍ Yes*

    ❍ No

    *** If yes, please answer Question 16, otherwise skip to Question 17.**

16. How is the PDMP used in the PRR program? *Please select all that apply.*

    ❍ To monitor cash transactions

    ❍ To obtain historical information on filled prescriptions to identify at-risk beneficiaries

    ❍ Other *(please elaborate)*

17. Which DEA schedules or other drug classes does the PRR address? *Please select all that apply.*

    ❍ Schedule II controlled substances

    ❍ Schedule III controlled substances

    ❍ Schedule IV controlled substances

    ❍ All controlled substances

    ❍ Non-controlled substances identified as frequently subject to abuse

18. Does your state exclude certain beneficiaries from enrollment in a PRR based on diagnosis or other criteria?

    ❍ Yes*

    ❍ No

    *** If yes, please answer Question 19, otherwise skip to Question 20.**

19. What patient types are automatically excluded from enrollment? *Please select all that apply.*

- ❍ Cancer patients
- ❍ Hospice patients
- ❍ Beneficiaries in long-term care
- ❍ Beneficiaries in skilled nursing facilities
- ❍ Minors
- ❍ None
- ❍ Other *(please elaborate)*

20. What services does the PRR program provide to enrolled beneficiaries? *Please select all that apply.*

- ❍ General information on substance abuse
- ❍ Referrals for substance abuse treatment
- ❍ Referrals to pain specialists
- ❍ Case management services
- ❍ Other (please elaborate)
- ❍ None of these services are offered

21. How many full time equivalent (FTE) positions are involved in the administrative, clinical, and data analytics aspects of the PRR?

- ❍ Administrative FTEs: _____
- ❍ Clinical FTEs: _____
- ❍ Data analyst FTEs: _____

22. What is the estimated annual operating cost of the PRR program for fiscal year 2014? *(Numerical responses only)*

23. How many total beneficiaries are currently enrolled in the PRR? Please include beneficiaries enrolled in the FFS and managed Medicaid programs. *(Numerical responses only)*

24. How many of these beneficiaries are currently in managed care?

- ❍ _____ *(Numerical responses only)*
- ❍ Not sure
- ❍ N/A

25. What is the estimated percentage of beneficiaries in the PRR that are: *(must total 100%)*

- ❍ Male: _____ % *(Numerical responses only)*
- ❍ Female: _____ % *(Numerical responses only)*

26. Regarding the process of beneficiaries appealing PRR enrollment, for calendar year 2014, please provide:

    ❍ The number of beneficiaries that appealed enrollment into the Medicaid FFS PRR: _____

    ❍ The number of FFS appeals that were ruled in favor of the beneficiary: _____

    ❍ The number of beneficiaries that appealed enrollment into Medicaid managed care PRRs: _____

    ❍ The number of managed care appeals that were ruled in favor of the beneficiary: _____

27. What is the estimated percentage of beneficiaries in the PRR that are ages: *(must total 100%)*

    ❍ Under 25: _____ % *(Numerical responses only)*

    ❍ 26-44: _____ % *(Numerical responses only)*

    ❍ 45-64: _____ % *(Numerical responses only)*

    ❍ 65 and above: _____ % *(Numerical responses only)*

28. What outcomes data or evidence do you have that documents the effectiveness or cost impact of your PRR program? *Please select all that apply.*

    ❍ Decreases in the number of prescribers visited per enrollee

    ❍ Decreases in the number of pharmacies visited per enrollee

    ❍ Decreases in the number of prescriptions/controlled substances obtained per enrollee

    ❍ Decreases in emergency room visits per enrollee

    ❍ Decreases in prescription opioid overdose deaths

    ❍ Overall cost savings

    ❍ Other

    ❍ Outcomes have not been assessed*

    *** Unless you chose "outcomes have not been assessed," please answer Question 29.**

29. Do you have evaluations you would be willing to share? Please provide specific outcomes data or links to reports that document these program outcomes. Please also provide the year in which the outcomes data were reported. *In cases where the data are not available via a link to a public domain, please e-mail the report to Jennifer Welch (JWelch@pewtrusts.org).*

30. Does your state Medicaid program have mechanisms, other than a PRR, in place to prevent potential abuse of controlled substances or other prescription drugs? *Please select all that apply.*

    - ❍ Educational materials for beneficiaries on controlled substances prone to misuse, abuse, or addiction
    - ❍ Educational programs/training for prescribers of controlled substances
    - ❍ Pain management prescribing guidelines
    - ❍ Point-of-sale system edit requirements
    - ❍ Prior authorizations or quantity limits
    - ❍ None
    - ❍ Other *(please elaborate)*

31. Which of the above mechanisms, including PRRs, do you see as most effective? *Please explain.*

32. Please rank the following potential barriers to operating an effective PRR program where 5 is the greatest barrier and 1 is the smallest. *Each ranking can only be used once.*

	Rank
i. Cost associated with operating the program	
ii. Staff and time commitment	
iii. Lack of evidence of effectiveness and return on investment	
iv. Inability to review cash transactions	
v. Prescribers/pharmacies do not want to accept PRR patients	

Literature Review Sources

Alaska

Alaska Administrative Code 7 AAC 105.600 (2015): Restriction of recipient's choice of providers, http://www.legis.state.ak.us/basis/aac.asp#7.105.600

Alaska Medicaid Recipient Services Recipient Handbook (2015), http://dhss.alaska.gov/dhcs/Documents/PDF/Recipient-Handbook.pdf

Alaska Medicaid Care Management Program Outreach Brochure, http://manuals.medicaidalaska.com/docs/dnld/Flyer_Care_Management_Program_Outreach_Brochure.pdf

Arkansas

Arkansas Medicaid Provider Manual, Section 123.400: Beneficiary Lock-In (2015), https://www.medicaid.state.ar.us/Download/provider/provdocs/Manuals/SectionI/Section_I.doc

Arkansas Medicaid Manual, Section 105: Recipient Lock-In (2002), http://www.sos.arkansas.gov/rulesRegs/Arkansas%20Register/2002/jan_2002/016.06.02-003.pdf

Colorado

Code of Colorado Regulations 10 CCR 2505-10 8.000: Medical Assistance (2007), http://www.sos.state.co.us/CCR/GenerateRulePdf.do?ruleVersionId=6237&fileName=10%20CCR%202505-10%208.000

"Client Overutilization Program," Colorado Medicaid website, https://www.colorado.gov/pacific/hcpf/client-overutilization-program

Connecticut

"Pharmacy Information," Connecticut Department of Social Services website (2016), https://www.ctdssmap.com/CTPortal/Pharmacy%20Information/tabId/65/Default.aspx

Connecticut Medical Assistance Pharmacy Program Drug Utilization Review Program DUR Board meeting minutes (2012), https://www.ctdssmap.com/CTPortal/Portals/0/StaticContent/Publications/June_12_Minutes.pdf

Connecticut Medical Assistance Pharmacy Program Drug Utilization Review Program DUR Board meeting minutes (2010), https://www.ctdssmap.com/CTPortal/Portals/0/StaticContent/Publications/June_10_Minutes.pdf

Delaware

Delaware Medicaid Program Provider Policy Manual, 1.32: Restricted "Lock-In" Clients (Fee for Service/Non-Managed Care) (2016), http://www.dmap.state.de.us/downloads/manuals/General.Policy.Manual.pdf

District of Columbia

D.C. Municipal Regulations and D.C. Register, Rule 29-2712: Pharmacy Lock-In Program (2012), http://dcregs.dc.gov/Gateway/RuleHome.aspx?RuleNumber=29-2712

Georgia

Georgia Medicaid Provider Manual, Part II Policies and Procedures for Pharmacy Services (2016), https://www.mmis.georgia.gov/portal/Portals/0/StaticContent/Public/ALL/HANDBOOKS/January%202016%2004-01-2016%20190054.pdf

Peach State Health Plan Provider Office Manual (2013), http://www.pshpgeorgia.com/files/2011/12/PSHP-Provider-Manual-March-2013.pdf?4608b1

Hawaii

Hawaii Medicaid Provider Manual, Chapter 19: Pharmacy Services (2011), http://www.med-quest.us/PDFs/Provider%20Manual/PMChp1911.pdf

Idaho

Idaho Administrative Code IDAPA 16.03.09: Medicaid Basic Plan Benefits (2007), http://adminrules.idaho.gov/rules/current/16/0309.pdf

Idaho Medicaid Management Information System Provider Handbook, Section 2.3.6: Participant Program Abuse/Lock-In Program (2016), https://www.idmedicaid.com/General%20Information/General%20Provider%20and%20Participant%20Information.pdf

Illinois

Illinois Administrative Code Title 89, Chapter 1b, Section 120.80: Recipient Restriction Program (2013), http://www.ilga.gov/commission/jcar/admincode/089/089001200E00800R.html

Illinois Medicaid Handbook for Providers of Medical Services Chapter 100: General Policy and Procedures (2009), http://www.hfs.illinois.gov/assets/100.pdf

Indiana

Indiana Medicaid Right Choices Program Policy Manual (2015), http://www.indianamedicaid.com/media/80075/right%20choices%20program%20policy%20manual.pdf

Iowa

Iowa Administrative Code 441—75.30(249A): Member lock-in (2015), https://www.legis.iowa.gov/docs/ACO/agency/05-27-2015.441.pdf

Iowa Department of Human Services Informational Letter No. 1029 Re: Lock-In Program Reminders (2011), http://dhs.iowa.gov/sites/default/files/1029%20Lock-in%20Program%20Reminders.pdf

Iowa Department of Human Services, "Iowa Medicaid Enterprise : Iowa Medicaid Managed Care Programs" (2012), http://dhs.iowa.gov/sites/default/files/Managed%20Care%202012.pdf

Iowa Medicaid Integrity Program, Iowa Comprehensive Program Integrity Review Final Report (2008), https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/downloads/iacompfy08pireviewfinalreport.pdf

"Iowa Medicaid Care Management Programs," Iowa Medicaid website, http://dhs.iowa.gov/ime/providers/tools-trainings-and-services/medicaid-initiatives/care-management

Kansas

Kansas Medicaid Provider Manual, Section 2400: Program Integrity (2014), https://www.kmap-state-ks.us/Documents/Content/Provider%20Manuals/Gen%20benefits_12112014_14177.pdf

Kansas Health Policy Authority Office of the Inspector General, "A Performance Audit of KHPA's Medicaid Pharmacy Program" (2010), http://www.kdheks.gov/hcf/oig/download/Medicaid_Pharmacy_Program_11162010.pdf

Kentucky

Kentucky Administrative Regulation KAR 1:677. Medicaid Recipient Lock-In Program (2010), http://www.lrc.state.ky.us/kar/907/001/677.htm

Kentucky Medicaid's Recipient Lock-In Program Performance Audit (1997), http://apps.auditor.ky.gov/Public/Audit_Reports/Archive/medicaid_Lock_In.pdf

"Kentucky Lock-In Program (KLIP)," CareSource website (2015), https://www.caresource.com/providers/kentucky/medicaid/member-care/kentucky-lock-in-program-klip/

Louisiana

Louisiana Medicaid Pharmacy Benefits Management Services Manual, Medicaid Recipient Eligibility (2005), http://www.lamedicaid.com/provweb1/Providermanuals/manuals/PHARMACY/PHARMACY.pdf

"Lock-In Program," Louisiana Medicaid website, http://www.lamedicaid.com/provweb1/about_medicaid/lock-in.htm

Louisiana Medicaid Eligibility Manual (2008), http://new.dhh.louisiana.gov/assets/medicaid/MedicaidEligibilityPolicy/N-0000.pdf

Maine

MaineCare Benefits Manual, Chapter IV, Restriction Plans (2010), http://www.maine.gov/sos/cec/rules/10/ch101.htm

Maryland

Code of Maryland Regulations 10.09.75.00-10.09.75.05 and 10.09.75.9999, http://www.dsd.state.md.us/comar/SubtitleSearch.aspx?search=10.09.75

Maryland Medicaid Pharmacy Program Advisory (2011), https://mmcp.dhmh.maryland.gov/pap/docs/Advisory_94.pdf

Massachusetts

Massachusetts Medicaid Provider Manual Series, Pharmacy Manual (2008), http://www.mass.gov/eohhs/docs/masshealth/regs-provider/regs-pharmacy.pdf

Massachusetts Medicaid Pharmacy Bulletin 72 Re: Controlled Substances Management Program (2003), http://www.mass.gov/eohhs/docs/masshealth/bull-2003/phm-72.pdf

Massachusetts Medicaid Review of Controls Over Pharmacy Claims (2013), http://www.mass.gov/auditor/docs/audits/2013/201213743c2.pdf

"MassHealth Controlled Substances Management Program," Massachusetts Medicaid website, http://www.mass.gov/eohhs/provider/insurance/masshealth/pharmacy/controlled-substances-management-prog.html

Michigan

Michigan Medicaid Provider Manual, Section 8: Benefits Monitoring Program (2016), http://www.mdch.state.mi.us/dch-medicaid/manuals/medicaidprovidermanual.pdf

Minnesota

Minnesota Administrative Rule 9505.2238: Placement in Restricted Recipient Program (2008), https://www.revisor.mn.gov/rules/?id=9505.2238&keyword_type=all&keyword=restricted+recipient

Minnesota Administrative Rule 9505.2165: Definitions (2013), https://www.revisor.mn.gov/rules/?id=9505.2165

"Minnesota Restricted Recipient Program," Minnesota Department of Human Services website (2014), http://mn.gov/dhs/general-public/office-of-inspector-general/minnesota-restricted-recipient-program/

"Health Care Programs and Services Overview," Minnesota Department of Human Services website (2015), http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_008922#P59_4371

Minnesota Restricted Recipient Program brochure, https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6752-ENG

Mississippi

Mississippi Administrative Code Title 23, Part 302, Beneficiary Health Management, http://www.medicaid.ms.gov/wp-content/uploads/2014/01/Admin-Code-Part-302.pdf

Mississippi Medicaid Provider Reference Guide for Part 214 Pharmacy Services (2014), https://www.medicaid.ms.gov/wp-content/uploads/2014/01/Provider-Reference-Guide-214.pdf

Mississippi Medicaid Provider Policy Manual (2006), http://mdah.state.ms.us/arrec/digital_archives/series/files/34/pdf/723.pdf

Missouri

Missouri Code of State Regulations 13 CSR 70-4.070: Title XIX Recipient Lock-In Program (2015), http://www.sos.mo.gov/cmsimages/adrules/csr/current/13csr/13c70-4.pdf

Montana

Montana Medicaid Team Care Fact Sheet (2013), Member Handbook (2010), and General Information and FAQs (2013), http://medicaidprovider.mt.gov/teamcare

Nebraska

Nebraska Administrative Code 471 NAC 2-004: Client Lock-In (2015), http://www.sos.ne.gov/rules-and-regs/regsearch/Rules/Health_and_Human_Services_System/Title-471/Chapter-02.pdf

Nevada

Nevada Medicaid Services Manual (2015), http://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Resources/AdminSupport/Manuals/Medicaid_Services_Manual_Complete.pdf

Nevada Medicaid Provider Web Announcement: Pharmacy Lock-In Program Implemented (2008), https://www.medicaid.nv.gov/Downloads/provider/web_announcement_228_111408.pdf

New Hampshire

New Hampshire Code of Administrative Rules Chapter He-W 500 Part He-W 506 Medicaid Managed Care (2013), http://www.dhhs.state.nh.us/oos/aru/documents/hew506certified.pdf

New Hampshire Medicaid Care Management Program Addenda, http://www.dhhs.nh.gov/ombp/caremgt/documents/addendum1cm01.pdf

New Jersey

New Jersey Medicaid Fraud Division Work Plan, Calendar Year 2014, http://nj.gov/comptroller/divisions/medicaid/plans/

New York

New York Recipient Restriction Program Policy for Health Home Care Managers: Recipient Restriction Program (2014), http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/rfp_final_7.15.14.pdf

New York State Medicaid Update (2011), http://www.health.ny.gov/health_care/medicaid/program/update/2011/2011-06.htm#dat

New York Recipient Restriction Program Policy for Health Home Care Managers: Health Homes of Upstate New York (2014), http://www.carecoordination.org/documents/RecipientRestrictionProgramPolicyForHealthHomeCareManagers.pdf

HealthFirst Restricted Recipient Program Frequently Asked Questions (2011), http://assets.healthfirst.org/api/pdf?id=pdf_f465fa8acf&key=3357396596f942dfa77053cd2a4e4216c67bf854

North Carolina

North Carolina Division of Medical Assistance Outpatient Pharmacy Medicaid and Health Choice Clinical Coverage Policy No. 9 (2015), https://ncdma.s3.amazonaws.com/s3fs-public/documents/files/9.pdf

North Carolina Medicaid Pharmacy Newsletter No. 184 (2010), http://www2.ncdhhs.gov/DMA/pharmnews/0710pharm.pdf

North Carolina Department of Health and Human Services, "Curbing Prescription Drug Abuse in Medicaid, Joint Legislative Health Care Oversight Committee" (2010), http://www.ncleg.net/documentsites/Committees/JLHCOC/2010%20Interim%20Committee%20Meetings/October%2012,%202010/Lisa%20Weeks.pdf

North Carolina Administrative Code 10A NCAC 22F .0704 Recipient Management Lock-In System, http://reports.oah.state.nc.us/ncac/title%2010a%20-%20health%20and%20human%20services/chapter%2022%20-%20medical%20assistance%20eligibility/subchapter%20f/10a%20ncac%2022f%20.0704.pdf

North Dakota

North Dakota Medicaid General Information for Providers (2012), http://www.nd.gov/dhs/services/medicalserv/medicaid/docs/gen-info-providers.pdf

North Dakota's Coordinated Services Program brochure (2011), https://www.nd.gov/dhs/services/medicalserv/medicaid/docs/csp-brochure.pdf

Ohio

Ohio Administrative Code 5160-20-01 Coordinated Services Program (2012), http://codes.ohio.gov/oac/5160-20-01

Ohio Administrative Code 5101:6-2-40 State Hearings: Coordinated Services Program State Hearing and Notice Requirements (2014), http://codes.ohio.gov/oac/5101:6-2-40

Oklahoma

"Pharmacy Lock-In Program," Oklahoma Health Care Authority website, http://www.okhca.org/providers.aspx?id=8738

Oklahoma Health Care Authority, "SoonerCare Lock-In Program" (n.d.), https://www.okhca.org/WorkArea/DownloadAsset.aspx?id=10414

Oklahoma Health Care Authority news release: "OHCA Adds New Measure To Combat Public Crisis Of Prescription Drug Abuse" (2014), http://www.okhca.org/about.aspx?id=15752

Oklahoma Administrative Code 317:30-3-14 Freedom of Choice, https://www.okhca.org/xPolicyPart.aspx?id=538&chapter=30&subchapter=3&part=1&title=GENERAL%20SCOPE%20AND%20ADMINISTRATION

Oregon

Oregon State Plan Under Title XIX of the Social Security Act Medical Assistance Program (2012), http://www.oregon.gov/oha/healthplan/DataReportsDocs/Medicaid%20State%20Plan%20Attachment%204.10A%20through%204.42A.pdf

Pennsylvania

Pennsylvania PROMISe Provider Handbook NCPDP 5.1 Pharmacy Billing (2015), http://www.dpw.state.pa.us/cs/groups/webcontent/documents/document/s_001851.pdf

"Bureau of Program Integrity," Pennsylvania Department of Human Services website, http://www.dhs.pa.gov/learnaboutdhs/dhsorganization/officeofadministration/bpi/index.htm

Pennsylvania PROMISe Provider Handbook 837 Institutional/UB-04 Claim Form (2015), http://www.dpw.state.pa.us/cs/groups/webcontent/documents/form/s_001848.pdf

Pennsylvania Administrative Code 1101.91 Recipient Misutilization and Abuse, http://www.pacode.com/secure/data/055/chapter1101/s1101.91.html.

Pennsylvania Medical Assistance Manual Chapter 1121, Pharmaceutical Services (n.d.), http://www.dpw.state.pa.us/cs/groups/webcontent/documents/document/p_012076.pdf

Rhode Island

"Pharmacy Lock-In Program," Rhode Island Executive Office of Health and Human Services website, http://www.eohhs.ri.gov/ProvidersPartners/ProviderManualsGuidelines/MedicaidProviderManual/Pharmacy/PharmacyLock-InProgram.aspx

Rhode Island Executive Office of Health and Human Services Drug Utilization Review Board meeting minutes (2011), http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/dur_dec11.pdf

Medicaid Executive Summary—FFY 2011 DUR Report for Fee for Service Pharmacy Programs—State by State (2011), http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Prescription-Drugs/Downloads/DURSurvey2011-StateXIIExecutiveSummarySurvey01152013.pdf

Rhode Island Executive Office of Health and Human Services Drug Utilization Review Board meeting minutes (2012), http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/dur_sept12.pdf

South Carolina

"The Centers for Medicare & Medicaid Services' Medicaid Integrity Program: South Carolina Comprehensive Program Integrity Review," (2011), http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/SCfy11.pdf

South Carolina Healthy Connections Provider Manual: Medicaid Program Integrity (2016), https://www.scdhhs.gov/internet/pdf/manuals/Nursing/Manual.pdf

Tennessee

Tennessee Department of Finance and Administration Bureau of TennCare, Medicaid Chapter 1200-13-13 (2005), http://share.tn.gov/sos/rules_archived/1200/1200-13/1200-13-13.20050907.pdf

Amendment to Tennessee Department of Finance and Administration Bureau of TennCare, Medicaid Chapter 1200-13-13 (2013), http://regs.cqstatetrack.com/info/get_text?action_id=534992&text_id=536741&type=action_text.

Texas

Texas Administrative Code Title 1, Part 15, Chapter 354, Subchapter K Medicaid Recipient Utilization Review and Control, http://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=5&ti=1&pt=15&ch=354&sch=K&rl=Y

Navitus Health Solutions, "ACAP Pharmacy Presentation: Texas Experience With Limited Pharmacy Carve-In" (2014), http://www.communityplans.net/portals/0/meetings/14ceosummit/petersonjune2014.pdf

Letter from Joy Sparks, Deputy Counsel, Office of Inspector General to Health and Human Services Commission Council Re: Agenda Item No. 6.c.: Medicaid Lock-In (2012), http://www.hhsc.state.tx.us/news/meetings/past/2012/council/6c-112912.pdf

Texas Medicaid Provider Procedures Manual: Vol. 1, Section 4.4.2 Client Lock-in Program (2016), http://www.tmhp.com/TMPPM/TMPPM_Living_Manual_Current/Vol1_04_Client_Eligibility.pdf

Utah

"Restriction Program," Utah Department of Health Medicaid website, https://medicaid.utah.gov/restriction-program

"Hearings," Utah Department of Health Medicaid website, https://medicaid.utah.gov/hearings

Utah Administrative Code Rule R410-14. Administrative Hearing Procedures (2016), http://www.rules.utah.gov/publicat/code/r410/r410-014.htm

UHealthPlan Medicaid Restriction Program Guidelines (2013), http://uhealthplan.utah.edu/pdf/Medicaid%20Restriction%20Program.pdf

Vermont

Department of Vermont Health Access "Team Care" (2012), http://dvha.vermont.gov/for-consumers/team-care-power-point-presentation-ii.ppt

Vermont Medicaid Provider Manual, Section 10.3.51 Team Care Program (2016), https://www.vtmedicaid.com/Downloads/manuals.html

Virginia

Virginia Administrative Code 12VAC30-130-810: Client Medical Management Program for Individuals, http://leg1.state.va.us/cgi-bin/legp504.exe?000+reg+12VAC30-130-810

Washington

Washington Administrative Code WAC 182-501-0135 Patient Review and Coordination (PRC), http://apps.leg.wa.gov/WAC/default.aspx?cite=182-501-0135

Washington Division of Healthcare Services "Patient Review and Coordination Program For Medical Assistance Clients Who Need Assistance In Appropriate Use of Services" (2009), http://c.ymcdn.com/sites/www.safestates.org/resource/resmgr/imported/Patient%20Review%20Coordination%20program6.pdf

"Patient Review and Coordination Program," Washington State Health Care Authority website, http://www.hca.wa.gov/medicaid/prr/pages/index.aspx

West Virginia

West Virginia Medicaid Lock-In Criteria (2014), http://www.dhhr.wv.gov/bms/BMS%20Pharmacy/Documents/DUR/WVLock_InUpdate.pdf

UniCare Health Plans of West Virginia "Provider Training: Managed Care Pharmacy Benefits, West Virginia Medicaid" (2013), http://www.unicare.com/provider/noapplication/plansbenefits/medical/notertiary/pw_e198384.pdf?refer=chpproviderunicare

West Virginia Bureau for Medical Services Provider Manual, Chapter 518: Pharmacy Services (2015), http://www.dhhr.wv.gov/bms/Pages/Chapter-518-Pharmacy-Services.aspx

West Virginia Family Health Member Handbook (2015), http://www.wvfh.com/members/member-handbook

West Virginia Bureau for Medical Services DUR Capsules: West Virginia Medicaid Lock-In Program (August 2014), http://www.dhhr.wv.gov/bms/BMS%20Pharmacy/DUR/Pages/DUR-Newsletters.aspx

Wisconsin

Wisconsin BadgerCare Plus and Medicaid Physician Handbook: Pharmacy Services Lock-In Program, https://www.forwardhealth.wi.gov/WIPortal/Online%20Handbooks/Print/tabid/154/Default.aspx?ia=1&p=1&sa=50&s=6&c=39&nt=Pharmacy+Services+Lock-In+Program (login required)

Wisconsin Administrative Code DHS 104.02: Recipient duties (2008), http://docs.legis.wisconsin.gov/code/admin_code/dhs/101/104/02

Wisconsin ForwardHealth Update: Changes to the Pharmacy Services Lock-In Program (2011), https://www.forwardhealth.wi.gov/kw/pdf/2011-04.pdf

Wyoming

Wyoming Medicaid Pharmacy Lock-In Program Referral Form, www.health.wyo.gov/Media.aspx?mediaId=13206

"Program Integrity/Lock-in," Wyoming Department of Health website, http://www.wymedicaid.org/lockin

"Pharmacy Services," Wyoming Department of Health website, http://health.wyo.gov/healthcarefin/pharmacy/index.html

Appendix B

Program Criteria Used to Identify At-Risk Patients for PRR Enrollment

State	Criteria
Alabama	Information not available
Alaska	**One of the following:** • Referral indicating that the recipient has used a medical item or service at a frequency or amount that is not medically necessary • The recipient receives prescriptions from one or more providers for medication in total average daily doses that exceed those recommended in *Drug Facts and Comparisons*, 2007 edition. • The recipient, in at least three consecutive months, uses a medical item or service with a frequency that exceeds two standard deviations from the arithmetic mean of the frequency of use of the medical item or service by recipients of medical assistance programs administered by the department who have used the medical item or service as shown in the department's most recent statistical analysis of usage of that medical item or service
Arizona	Information not available
Arkansas	Utilization of pharmacy services at a frequency or amount that is not medically necessary, as determined by a computerized algorithm and a clinical review process.
California	No FFS PRR
Colorado	**Any of the following in a 3-month period:** • ≥ 16 prescriptions • ≥ 3 pharmacies • ≥ 3 drugs in the same therapeutic category • Excessive ER visits • Referral or analysis indicates possible over-utilization
Connecticut	The Retrospective Drug Utilization Review (RetroDUR) program collects and analyzes claims data against predetermined, DUR Board approved criteria to identify and correct client misuse. Through input from RetroDUR, providers, and the medical audit division, the contractor identifies certain clients who demonstrate the potential to abuse or misuse prescription drugs.
Delaware	Engaging in abusive or fraudulent practices such as over-utilization of emergency room services or prescription drugs, lending a Medical Assistance card to an unauthorized person, etc.
District of Columbia	When an individual misuses drugs in excess of the customary dosage for the proper treatment of the given diagnosis or misuses multiple drugs in a manner that can be medically harmful. These criteria include: • ≥3 controlled substance prescriptions per month • ≥3 prescribers for controlled substances within the last 90 days • ≥10 prescriptions per month • ≥3 pharmacies used per month
Florida	No FFS PRR

State	Criteria
Georgia	**The following criteria are utilized in the recommendation for pharmacy lock-in:** • Drug therapy must correlate with either the primary or secondary diagnosis in the Department's claims data; if not it is the member's responsibility to have the prescribing physician submit the member's complete medical record • Initial complaint indicates the member is suspected of drug abuse or fraudulent activities (forged prescriptions, borrowed ID cards, etc.) • The member has filled prescriptions at more than two pharmacies/month or more than five pharmacies/year. If greater, the address of the member should have changed • The member has received more than three controlled substances/month • The number of prescriptions for controlled substances filled by the member (this includes all drugs with abuse potential) exceeds 10% of the total number of prescriptions filled by the member • The member was seen in the hospital emergency room more than twice per year. If greater, the recorded diagnosis should be consistent with an emergency medical condition • The member received duplicate therapy from different physicians • The member received prescriptions from pharmacies or visited physicians located outside the member's county of residence • The member purchased drugs of abuse without utilizing their Medicaid prescription benefits • The member has a diagnosis of narcotic poisoning or drug abuse • The member has previously been in one of the Care Management Organization's lock-in programs • The member is taking >120 mg morphine sulfate equivalents per day. Studies show patients receiving 100 mg/d or more have an 8.9-fold increase in overdose risk and a 1.8% annual overdose rate
Hawaii	Clients who are over-utilizing controlled substances or who are receiving unusually extensive medical services from multiple providers.
Idaho	**No specific criteria, but the following may be considered:** • Unnecessary use of providers or Medicaid services, including excessive provider visits • Recommendation from a medical professional or the recipient's primary care physician that the recipient has demonstrated abusive patterns and would benefit from the lock-in program • Frequent use of emergency room facilities for non-emergent conditions • Use of multiple providers • Use of multiple controlled substances • Use of multiple prescribing physicians and/or pharmacies • Overlapping prescription drugs with the same therapeutic class • Drug abuse and/or drug withdrawal diagnosis • Drug-seeking behavior as identified by a medical professional • Use of drugs or other Medicaid services determined to be abusive by the Department's medical or pharmacy consultant

State	Criteria
Illinois	The Department determines if recipients are unnecessarily utilizing medical services based on statistical norms and the medical judgment of individual practitioners and/or pharmacists or other providers. The medical necessity of Medicaid recipients' medical services is determined using the recipients' diagnoses and/or medical conditions or use in such a manner as to constitute an abuse of medical privileges or Program services. Based on this determination, the Department will make the decision to restrict a recipient to one or more primary provider types. The primary source of identification is the Surveillance and Utilization Review Subsystem (SURS) of the Medicaid Management Information System (MMIS). On an ongoing basis, SURS analyzes the Medicaid population, determines medical usage per recipient, and identifies recipients with usages in excess of the established norm of recipients in the same category of assistance and similar demographic areas. Secondary sources of identification include incoming referrals, such as referrals from medical providers, law enforcement officials or members of the general public. All referrals are reviewed and analyzed. Recipients found to have loaned or altered their medical cards for the purpose of obtaining medical benefits for which they or other persons are not legitimately entitled; falsely represented medical coverage; found in possession of blank or forged prescription pads; or who knowingly assisted providers in rendering excessive services or defrauding the Medical Assistance Program will be restricted.
Indiana	**Identification can come from a variety of sources, including:** • Statistical analysis databases – The Right Choices Program (RCP) Administrator creates reports to review the cost and utilization data of its members. The Indiana Health Coverage Programs contractors may also supply information to the RCP Administrator regarding the member's utilization of services. • Referrals to the RCP Administrator – Any person or source may contact the RCP Administrator on suspicion of overuse or misuse of services by a member. Referral sources may include the Family and Social Services Administration (FSSA), state and local law enforcement agencies, the FSSA's Division of Family Resources, pharmacies, physician offices, hospitals, and emergency rooms. Referrals may be made by telephone, mail, or email. The RCP Administrator's designated department must complete the RCP screening process within 60 calendar days of receiving a referral. Typical referral reasons include over-utilization of Medicaid services, such as multiple visits to the ER, doctor shopping, frequent dismissals by doctors, or polypharmacy. In addition, referrals are made when Medicaid members are suspected of activities such as drug abuse or dependence or prescription forgery and selling drugs, supplies, or equipment obtained through Medicaid. Referrals are made when members pay cash for Medicaid covered services which would exceed predetermined standards as outlined in 42 CFR 456.709 • Data mining techniques identifying: number of prescribers, number of primary medical provider (PMP) changes, number of ER visits, number of pharmacies used • Review of: number of physicians visited; distance to physician from the member's home; number of prescriptions; diagnoses with a focus on the medical necessity of all services provided to a member; county-by-county analysis with predetermined review factors, such as ER and volume indicators; member ranking report, such as a ranked report of members based on cost or diagnosis; number of inpatient stays; inpatient length of stay; number of PMP and specialist visits; the RCP Administrator's designated predictive modeling tools, such as statistical analysis, algorithms, and aggregate data from the predictive modeling tool, assist with identifying members for further review
Iowa	Overuse of services is defined as receipt of treatments, drugs, medical supplies or other Medicaid benefits from one or multiple providers of service in an amount, duration, or scope in excess of that which would reasonably be expected to result in a medical or health benefit to the patient. Determination of overuse of service is based on utilization data generated by the Surveillance and Utilization Review Subsystem of the Medicaid Management Information System (MMIS). The system employs an exception-reporting technique to identify the members most likely to be program overutilizers by reporting cases in which the utilization exceeds the statistical average. In addition, referrals can be made when utilization data generated by the MMIS reflect that utilization of Medicaid member outpatient visits to physicians, advanced registered nurse practitioners, federally qualified health centers, rural health centers, other clinics, and emergency rooms exceed 24 visits in any 12-month period.

State	Criteria
Kansas	The fiscal agent's Surveillance and Utilization Review Subsystem (SURS) team uses the Multiple Prescriber or Multiple Pharmacy reports to identify consumers for lock-in. The Multiple Prescriber Report identifies consumers who obtain prescriptions from three or more prescribers per month and the Multiple Pharmacy Report identifies consumers who fill prescriptions at three or more pharmacies per month. On some occasions, consumers can be referred for the lock-in program because of a review initiated by the Threshold Report, which is used mostly for therapeutic management and identifies consumers who received 15 or more drug classes or generic code numbers in one month.
Kentucky	**If in two consecutive 180-calendar-day periods, the recipient:** • Received services from at least five different providers; received at least 10 different prescription drugs; and received prescriptions from at least three different pharmacies; or • Had at least four different hospital emergency department visits for a condition that was not an emergency medical condition; or received services from at least three different hospital emergency departments for a condition that was not an emergency medical condition
Louisiana	Recipients who have shown a consistent pattern of misuse of program benefits, taking the form of either overuse or unwise use of program benefits, are programmatically identified and may be placed in lock-in. Also, potential lock-in recipients may be identified by the Bureau of Health Services Financing (BHSF) Pharmacy Benefits Management personnel, Surveillance Utilization Review Subsystem personnel, concerned providers or concerned citizens. The decision to lock in a particular recipient rests with the Pharmacy Benefits Management Section of BHSF.
Maine	**Full Restriction:** Over-utilization in any two of the core provider types. **Partial Lock-in:** Over-utilization of one or more types of health care providers but the standard of a Full Restriction is not met. **Prescriber Lock-In:** Over-utilization of one or more types of prescriptions. The Member Review Team may designate multiple prescribers for the member for differing types of prescriptions. **Pharmaceutical Restriction:** Over-utilization in one or more drug categories. Medical necessity is determined by the following (not an exhaustive list): unusually frequent utilization of health care services; inappropriate or excessive acquisition of drugs, especially drugs with addictive properties such as tranquilizers, psychostimulants, narcotic analgesics, non-narcotic analgesics, sedative barbiturates and sedative non-barbiturates; and duplicated services or prescriptions for the same or similar conditions.
Maryland	**Abuse exists if an enrollee:** • Utilizes an inappropriate type of provider for care • Utilizes an appropriate type of provider but at an inappropriate service rate • Utilizes an appropriate provider but distorts or fails to disclose pertinent medical information • Utilizes a managed care organization card in an inappropriate manner • Engages in Medicaid fraud as defined under COMAR 10.09.24.14

State	Criteria
Massachusetts	**MassHealth members who meet one of the following criteria:** • Members who MassHealth determines use excessive quantities of prescribed drugs. For purposes of 130 CMR 406.442, "excessive quantities of prescribed drugs" is defined as 11 or more prescriptions, including original fill and refills, of one or more controlled substances from Schedule II, III, or IV over a three-month period, obtained from four or more prescribers or filled by four or more pharmacies; or • Members who were enrolled in the Controlled Substance Management Program of a MassHealth-contracted managed care organization at the time the member disenrolled from the managed care organization. When the MassHealth agency enrolls a member in the Controlled Substance Management Program it notifies the member accordingly
Michigan	**When any of the following criteria are present:** • Suspicion or conviction of fraud for one or more of the following: selling or purchasing products/ pharmaceuticals obtained through Medicaid; altering prescriptions to obtain medical services, products, or pharmaceuticals; stealing prescriptions/pads or provider impersonation; using another individual's identity to obtain medical services, products or pharmaceuticals. • Misutilizing emergency department services, such as: more than three emergency department visits in one quarter; repeated emergency department visits with no follow-up with a primary care provider or specialist when appropriate; more than one outpatient hospital emergency department facility in one quarter; repeated emergency department visits for non-emergent conditions. • Misutilizing pharmacy services, such as: utilizing more than three different pharmacies in one quarter; aberrant utilization patterns for drug categories listed in the Drug Categories subsection of the Medicaid Provider Manual over a one-year period; obtaining more than five prescriptions for drug categories listed in the Drug Categories mentioned above in one quarter (including emergency prescriptions); utilizing multiple prescribing providers for drug categories listed in the Drug Categories mentioned above, including when prescribing providers provide services to the beneficiary as a private pay patient (e.g., beneficiary pays cash for office visits while using the Medicaid pharmacy benefit to obtain prescriptions). • Misutilizing physician services, such as: utilizing more than one physician/physician extender in different practices to obtain duplicate or similar services for the same or similar health condition; utilizing more than one physician/physician extender in different practices to obtain duplicate prescriptions for a drug(s) listed in the Drug Categories mentioned above (e.g., two prescriptions for Vicodin/hydrocodone written by different providers within an overlapping time frame); utilizing covered services to obtain prescriptions for drugs subject to abuse and paying cash to obtain the drugs.
Minnesota	**The use of health services that results in unnecessary costs to programs, or in reimbursements for services that are not medically necessary. The following practices are deemed to be abuse:** • 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 a 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 as required under program rules, or a service provided by a school district as specified in the recipient's individualized education program under Minnesota Statutes, section 256B.0625, subdivision 26 • Continuing to engage in practices that are abusive of the program after receiving the department's written warning that the conduct must cease • Altering or duplicating the medical identification card for the purpose of obtaining additional health services billed to the program or aiding another person to obtain such services *Continued on next page*

State	Criteria
Minnesota (continued)	• Using a medical identification card that belongs to another person • Using the medical 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 subitem, "local trade area" has the meaning given in part 9505.0175, subpart 22 • Repeatedly arranging for services and then canceling services in order to circumvent the spenddown requirement • Obtaining medical services from a physician without a referral from the recipient's designated primary care provider • Obtaining emergency room services for nonemergency care • Obtaining prescriptions from a pharmacy other than the designated pharmacy • Obtaining health services from a nondesignated provider when the recipient has been required to designate a provider
Mississippi	Utilizing Medicaid services at a frequency or amount that is not medically necessary, as determined in accordance with utilization guidelines established by the State.
Missouri	Misutilization of medical services is defined as the act of seeking or obtaining medical services, or both, from a number of like providers and in quantities that exceed the levels considered medically necessary by current medical practices, standards and policies of the Missouri Title XIX Medicaid Program. **If any of the following occurs, the recipient will be referred to the Division of Investigation:** • Lending Medicaid ID to non-eligible persons • Submitting forged documents to providers for medical benefits or services • Seeking excessive or unnecessary medical care (for things like drugs, office visits, eyeglasses, dentures, etc.) • Utilizing multiple medical providers • Refusing to submit to or failing a urine or blood screen for opioid or opioid-like controlled substances covered by Medicaid while engaged in a pain or substance abuse treatment regimen

State	Criteria
Montana	Targets members with a history of using Medicaid or Healthy Montana Kids Plus services at an amount or frequency that is not medically necessary. Members are chosen for the program through information gathered from claims, drug utilization review referrals, and provider referrals. Members identified through claims information are also approved for Team Care enrollment by their primary care provider. The program is for members who use more medical services than the average member, indicating that the member needs assistance in learning the appropriate way to use Medicaid benefits.
Nebraska	Misutilization of medical assistance services based on determination of abuse or overutilization.
Nevada	The recipient has filled ≥ 10 controlled substance prescriptions in the past 60-day period, AND One of the following: utilized more than one pharmacy in the past 60-day period; utilized more than three physicians in the past 60-day period; utilized the ER for receiving controlled substances; been diagnosed with a drug dependency-related condition; the dispensed quantity per prescription of controlled substances appears excessive by the clinical review team; or has other noted drug-seeking behaviors
New Hampshire	**Any three of the following:** • 3 or more pharmacies used by a recipient within 90 days • 3 or more physicians prescribing within 90 days • 2 or more ER visits within 90 days, or exceeds the ER and physician visit service limits as outlined in He-W 530.03 • 100 units per prescription per 7-day supply • 3 or more medications prescribed of the same drug class within 90 days • Same or similar drug obtained within 2 days from different pharmacies
New Jersey	**A recipient who:** • Receives prescription drugs on two or more occasions in excess of what any one prescriber would intend • Presents a forged prescription • Alters a prescription • Uses multiple physicians and/or pharmacies, or • Is referred to the Special Status Unit by an investigative unit for possible abuse
New Mexico	No FFS PRR
New York	• Medical reasons: receipt of health care services or supplies that are duplicative, excessive, contraindicated, or conflicting • Nonmedical reasons: forged prescriptions or fiscal orders, the possession of multiple Medicaid cards, card loaning and/or sharing, and the selling of drugs or other supplies obtained from Medicaid

State	Criteria

North Carolina	**If any one of the following are met:**
	• Any one or more of the following:
	  • Benzodiazepines and certain anxiolytics: > 6 claims in 2 consecutive months
	  • Opiates: > 6 claims in 2 consecutive months
	• Receiving prescriptions for opiates and/or benzodiazepines and certain anxiolytics from > 3 prescribers in 2 consecutive months
	• Referral from a provider, the state Division of Medical Assistance, or Community Care of North Carolina

North Dakota	Parameters include, but are not limited to: use of multiple providers and clinics; early prescription refills and usage of multiple pharmacy providers; use of ER services for other than emergent care; and/or prescription use that is excessive or potentially threatening to the health of the recipient as indicated by multiple prescribing providers, use of multiple controlled drugs, or overlapping prescriptions with counterproductive therapeutic value.
Ohio	No FFS PRR
Oklahoma	Must meet 3 out of 8 criteria to be locked-in: increased number of ER visits; increased number of unique pharmacies; increased number of prescribers/physicians; increased number of days' supply of narcotics, anxiolytics, antidepressants, etc.; diagnosis of drug dependency or related diagnosis; increased number of hospital discharges; information from previous reviews; safety concerns noted in profile.
Oregon	Criteria include, but are not limited to: use of three or more pharmacies in six months; using multiple prescribers to obtain the same or comparable drugs; or exhibiting patterns of drug misuse.
Pennsylvania	The review procedures identify recipients or families that are receiving excessive or unnecessary treatment, diagnostic services, drugs, medical supplies, or other services by visiting numerous practitioners.
Puerto Rico	No FFS PRR
Rhode Island	The Department selects recipients who have a documented history of obtaining excessive or inappropriate prescribed drugs under the Medicaid program. Excessive utilization of prescription medications will be determined from published current medical and pharmacological references to include *Physician Desk Reference* published by Medical Economics Company and the *Pharmacological Basis of Therapeutics* published by MacMillan Company. As of 2011, patients: receiving more than 120 days' supply of controlled substances over the previous 60 days were reviewed; using methadone with another opioid; using Suboxone with another opioid; using ≥ 3 pharmacies for controlled substances in the prior month; using short acting narcotic agents for a long period of time.
South Carolina	Problematic patient utilization indicators, such as: use of multiple pharmacies and/or prescribers; any history of prior misutilization, such as abusive, duplicative, or wasteful utilization practices; utilization patterns that deviate from peer group comparisons; duplication and inappropriate use of controlled substances or psychotropic drugs; contraindications suggesting potential harm to the patient; drug-seeking behaviors.

State	Criteria
South Dakota	No FFS PRR
Tennessee	The following enrollees are appropriate for lock-in: any enrollee who has been identified by the TennCare Office of Inspector General as having been convicted of TennCare fraud or a drug-related offense; any enrollee who has used buprenorphine/naloxone (Suboxone) or buprenorphine (Subutex) for office-based opioid addiction treatment within the previous six (6) months; any enrollee who has been arrested for TennCare fraud; any enrollee who has been arrested for a drug-related offense; any enrollee who has obtained multiple controlled substance prescriptions over a 90-day period that meet one of the following conditions: (i) The prescriptions were filled at three (3) or more pharmacies and written by three (3) or more prescribers, (ii) The prescriptions were filled at one (1) or more targeted pharmacies and written by two (2) or more prescribers, (iii) The prescriptions were filled at two (2) or more targeted pharmacies and written by one (1) or more prescribers, (iv) The prescriptions were filled at one (1) or more targeted pharmacies and written by one (1) or more targeted prescribers, (v) The prescriptions were filled at two (2) or more pharmacies and written during three (3) or more emergency room visits.
Texas	The client received duplicative, excessive, contraindicated, or conflicting health-care services, including drugs, or a review indicates abuse, misuse, or fraudulent actions related to Medicaid benefits and services. "Excessive use or overuse" is defined as exceeding what is usual, medically necessary or customary use of Medicaid services and benefits. It is also defined as, but not limited to, the following: (A) receipt of Medicaid benefits or services from one or multiple providers of service in an amount, duration, or scope in excess of which would reasonably be expected to result in a medical or health benefit to the patient; or (B) use exceeding the standards and criteria for utilization of outpatient drugs or products, as listed in the compendia and peer reviewed medical literature and/or criteria and standards approved by the Texas Medicaid Drug Utilization Review Board. Misuse is defined as using incorrectly, misapplying, or illegally using Medicaid benefits or services. Also, seeking or obtaining medical services from a number of like providers and in quantities that exceed the levels considered medically necessary by current medical practices, standards and policies.
Utah	One or more of the following over a 12-month period: four or more primary care providers, non-affiliated, in a maximum of 12 eligible months, and/or four or more specialists seen outside a normal range of utilization; four or more pharmacies in a maximum of 12 eligible months; three or more providers (non-affiliated) prescribing abuse-potential medications; six or more prescriptions filled for abuse-potential medications; five or more non-emergent ED visits in 12 months. And/Or In a consecutive two-month period: three or more providers, non-affiliated, prescribing abuse-potential medications; six or more prescriptions filled for abuse-potential medications.
Vermont	Noncompliance with narcotics contract; duplicate services received from more than 2 providers and/or pharmacies; high emergency department usage; emergency department visits at multiple hospitals; pill counts demonstrate inappropriate utilization; arrest, conviction or on probation for selling drugs; altered or forged prescriptions.

State	Criteria
Virginia	Utilizing services at a frequency or amount that results in a level of utilization or a pattern of services which is not medically necessary or which exceeds the thresholds established in these regulations. **These activities or patterns or levels of utilization include but are not limited to:** • Exceeding 200 percent of the maximum therapeutic dosage of the same drug or multiple drugs in the same therapeutic class for a period exceeding four weeks • Two occurrences of filling prescriptions for the same drugs two or more times on the same or the subsequent day • Utilizing services from three or more prescribers and three or more dispensing pharmacies in a three-month period • Receiving more than 24 prescriptions in a three-month period • Receiving more than 12 psychotropic prescriptions or more than 12 analgesic prescriptions or more than 12 prescriptions for controlled drugs with potential for abuse in a three-month period • Exceeding the maximum therapeutic dosage of the same drug or multiple drugs in the same therapeutic class for a period exceeding four weeks. In addition, such drugs must be prescribed by two or more practitioners • Receiving two or more drugs, duplicative in nature or potentially addictive (even within acceptable therapeutic levels), dispensed by more than one pharmacy or prescribed by more than one practitioner for a period exceeding four weeks • Utilizing three or more different physicians of the same type or specialty in a three-month period for treatment of the same or similar conditions • Two or more occurrences of seeing two or more physicians of the same type or specialty on the same or subsequent day for the same or similar diagnosis • Duplicative, excessive, or contraindicated utilization of medications, medical supplies, or appliances dispensed by or prescribed by more than one provider for the time period specified by the Department of Medical Assistance Services (DMAS) • Duplicative, excessive, or contraindicated utilization of medical visits, procedures, or diagnostic tests from more than one provider for the time period specified by DMAS • Use of emergency hospital services for three or more emergency room visits for nonemergency care during a three-month period • One or more providers recommends restriction for medical management because the recipient has demonstrated inappropriate utilization practices • A pattern of noncompliance that is inconsistent with sound fiscal or medical practices. Noncompliance is characterized by, but not limited to: (1) failure to disclose to a provider any treatment or services provided by another provider, (2) failure to follow a drug regimen or other recommended treatment, (3) requests for medical services or medications which are not medically necessary, (4) excessive use of transportation services, or (5) use of transportation services with no corresponding medical services • One or more documented occurrences of use of the eligibility card to obtain drugs under false pretenses, which includes, but is not limited to the purchase or attempt to purchase drugs via a forged or altered prescription • One or more documented occurrences of card-sharing • One or more documented occurrences of alteration of the recipient eligibility card

State	Criteria
Washington	• If any 2 or more of the following occurs in a 90-day period in the last 12 months: received services from four or more different providers, including physicians, advanced registered nurse practitioners, and physician assistants, not located in the same clinic or practice; had prescriptions filled by four or more different pharmacies; received 10 or more prescriptions; had prescriptions written by four or more different prescribers not located in the same clinic or practice; received similar services in the same day not located in the same clinic or practice; had 10 or more office visits. • If any one of the following occurs in a 90-day period in the last 12 months: made two or more emergency department visits; exhibits "at-risk" usage patterns; made repeated and documented efforts to seek health care services that are not medically necessary; was counseled at least once by a health care provider, or an agency or managed care organization staff member with clinical oversight, about the appropriate use of health care services • If the client received prescriptions for controlled substances from two or more different prescribers not located in the same clinic or practice in any one month within the 90-day review period OR • If the client has either a medical history or billing history, or both, that demonstrates a pattern of the following at any time in the previous 12 months: using health care services in a manner that is duplicative, excessive, or contraindicated; seeking conflicting health care services, drugs, or supplies that are not within acceptable medical practice; being on substance abuse programs such as the Alcohol and Drug Abuse Treatment and Support Act
West Virginia	• Suboxone: Therapy in the past 30 days – Automatic lock-in • High Average Daily Dose: ≥ 120 morphine milligram equivalents per day over the past 90 days • Overutilization: Filling of ≥ 7 claims for all controlled substances in the past 60 days • Doctor Shopping: ≥ 3 prescribers OR ≥ 3 pharmacies writing/filling claims for any controlled substance in the past 60 days • Use with a History of Dependence: Any use of a controlled substance in the past 60 days with at least 2 occurrences of a medical claim for substance abuse or dependence in the past 720 days • Use with a History of Poisoning/Overdose: Any use of a controlled substance in the past 60 days with at least 1 occurrence of a medical claim for controlled substance overdose in the past 720 days • "Frequent Flyer": ≥ 3 emergency department visits in the last 60 days

State	Criteria
Wisconsin	**"Abuses or misuses" includes, but is not limited to:** • Altering or duplicating the medical assistance (MA) in any manner • Permitting the use of the MA card by any unauthorized individual for the purpose of obtaining health care through MA • Using an MA card that belongs to another recipient • Using the MA card to obtain any covered service for another individual • Duplicating or altering prescriptions • Knowingly misrepresenting material facts as to medical symptoms for the purpose of obtaining any covered service • Knowingly furnishing incorrect eligibility status or other information to a provider • Knowingly furnishing false information to a provider in connection with health care previously rendered which the recipient has obtained and for which MA has been billed • Knowingly obtaining health care in excess of established program limitations, or knowingly obtaining health care which is clearly not medically necessary • Knowingly obtaining duplicate services from more than one provider for the same health care condition, excluding confirmation of diagnosis or a second opinion on surgery • Otherwise obtaining health care by false pretenses
Wyoming	Any recipient who receives controlled substance prescriptions from two (2) or more prescribers and utilizes two (2) or more pharmacies within a designated time period.

Appendix C

Clinical Review Process

State	Clinical Review Process
Alabama	Information not available
Alaska	The department conducts an individualized clinical review of the recipient's medical and billing history to determine how the recipient has used the disputed medical item or service and whether that usage was medically necessary. A qualified health care professional must conduct the review. The reviewer considers: (1) the recipient's age; (2) the recipient's diagnosis; (3) complications of the recipient's medical conditions; (4) the recipient's chronic illnesses; (5) the number of different physicians and hospitals used by the recipient; and (6) the type of medical care received by the recipient.
Arizona	Information not available
Arkansas	Overutilization is determined by a computerized algorithm and clinical review process.
California	No FFS PRR
Colorado	Once the department identifies a client who meets the criteria, a post-payment review of documented information may be initiated, which includes but is not limited to Medicaid Management Information System reports, billing invoices, investigative reports, and medical record reviews. Potential lock-in client usage is reviewed on a quarterly basis.
Connecticut	The Retrospective Drug Utilization Review (RetroDUR) program collects and analyzes claims data against predetermined, drug utilization review (DUR) Board-approved criteria. Through RetroDUR, provider, and the medical audit division's input, the contractor identifies clients who demonstrate potential abuse or misuse.
Delaware	Information not available
District of Columbia	The Department of Health Care Finance uses the drug utilization guidelines established by the Drug Utilization Review Board. The guidelines require a monthly report from the Medicaid Management Information System to determine when a beneficiary may be at risk of exceeding the customarily prescribed dosages or utilization. Evaluation patterns may include review by the Department staff of electronic or paper records of claims submitted for prescriptions.
Florida	No FFS PRR
Georgia	The Division's Program Integrity Unit determines the need for lock-in based on the established criteria.
Hawaii	Providers are requested to assist the Medicaid program in identifying cases of drug misuse or overutilization.
Idaho	The Department reviews recipients to determine if services are being utilized at a frequency or amount that results in a level of utilization or a pattern of services which is not medically necessary. Evaluation of utilization patterns can include, but is not limited to, review by the Department staff of medical records and/or computerized reports generated by the Department reflecting claims submitted for physician visits, drugs/prescriptions, outpatient and emergency room visits, lab and/or diagnostic procedures, hospital admissions, and referrals.

State	Clinical Review Process
Illinois	The primary source of identification is the Surveillance and Utilization Review Subsystem (SURS) of the Medicaid Management Information System. SURS analyzes the Medicaid population and determines medical usage per recipient and will identify recipients with usages in excess of the established norm of recipients in the same category of assistance and like demographic areas. Secondary sources of identification are incoming referrals from places like medical providers, law enforcement officials, or members of the general public. Once identified, medical usage based on diagnoses and/or medical condition for the preceding 24 months is reviewed. Medical Assistance Consultants and licensed individual practitioners and/or pharmacists will determine if the recipient should be restricted.
Indiana	Identification of members eligible for the Right Choices Program (RCP) can come from statistical analysis databases (the RCP Administrator creates reports to review the cost and utilization data of its members. The Indiana Health Coverage Programs contractors may also supply information to the RCP Administrator regarding the member's utilization of services), referrals to the RCP Administrator (the RCP Administrator's designated department must complete the RCP screening process within 60 calendar days of receiving a referral), or data mining techniques (patterns of member utilization can be aggregated from the RCP Administrator's applicable data source, such as the Medicaid Management Information Systems). Any member who meets or exceeds the thresholds in at least one of the four utilization criteria groups is placed in the RCP.
Iowa	Determination of overuse of service is based on utilization data generated by the Surveillance and Utilization Review Subsystem (SURS) of the Medicaid Management Information System (MMIS). The system employs an exception-reporting technique to identify the members most likely to be program overutilizers by reporting cases in which the utilization exceeds the statistical average. In addition to referrals from the SURS, referrals for utilization review can be made when utilization data generated by the MMIS reflects overutilization. An investigation process of Medicaid members to be subject to a review of overutilization is conducted to determine if actual overutilization exists by verifying that the information reported by the computer system is valid and is also based on professional medical judgment. Medical judgments are made by physicians, pharmacists, nurses and other health professionals either employed by, under contract to, or as consultants for the department. These medical judgments are made by the health professionals on the basis of the body of knowledge each has acquired which meets the standards necessary for licensure or certification under the Iowa licensing statutes for the particular health discipline.
Kansas	Fiscal agent Surveillance and Utilization Review Subsystem (SURS) staff conducts beneficiary reviews through a review of Medicaid claim history and the Multiple Prescriber or Multiple Pharmacy Reports. Once identified, the beneficiary's records are reviewed by a utilization review nurse. Direct lock-in can be initiated without a beneficiary review when confirmed abuse has been identified.
Kentucky	The department accepts complaints of fraud and abuse and it can also review data available to it to determine potential fraud and abuse without a complaint. Utilization review includes a review of claims from the MMIS or a Kentucky All Schedule Prescription Electronic Reporting (Kentucky's prescription drug monitoring program) report to see if the recipient meets criteria.
Louisiana	The DUR Committee looks at usage and one of the following identifies recipients: Bureau of Health Services Financing (BHSF) Pharmacy Benefits Management personnel, Surveillance and Utilization Review Subsystem (SURS) personnel, concerned providers, or concerned citizens. The decision to lock in a particular recipient rests with the Pharmacy Benefits Management Section of BHSF.

State	Clinical Review Process
Maine	The Member Review Team determines medical necessity of beneficiary usage through investigation and analysis of the medical record and claims history. The Member Review Team consists of, at a minimum, a physician, registered nurse or social worker, and Program Integrity representative. The Team may also include other consultants, such as a pharmacist and/or a representative from the Health Care Management unit of MaineCare services. Members who are suspected of obtaining health care services that are not medically necessary may be identified by a referral or computer generated reports that flag members who may be over-utilizing or inappropriately using health care services. Following identification, the Program Integrity Unit may analyze the individual's past six months in regards to reimbursed health services, review clinical record, or communicate with key providers.
Maryland	Cases may be reviewed utilizing statistical reports, outside complaints, referrals from other agencies, or other appropriate sources. If the alleged or noted behavior is one of the types listed in the criteria, all relevant and available information is forwarded to a medical professional employee of the managed care organization for medical review. The medical reviewer considers all relevant and available information including managed care organization payment records and information secured from interviews, if conducted, in making a decision. If appropriate, the medical reviewer may obtain records from other sources, including providers of medical services.
Massachusetts	MassHealth reviews paid pharmacy claims data.
Michigan	Enrollment in the Benefits Monitoring Program is determined after review of the beneficiary's usage of medical services.
Minnesota	For every referral received, the program opens a case and review. The program also has a few computer-generated reports where they look for outliers of ER use, recipients in methadone clinics, recipients receiving 10 controlled substances from 5 or more providers and 4 or more pharmacies, etc.
Mississippi	Criteria are determined based on utilization guidelines established by the state. The program closely monitors program usage and identifies beneficiaries.
Missouri	The Division of Medical Services, Surveillance and Utilization Review Subsystem Unit reviews all suspect or potential cases of lock-in. The unit's professional staff will initiate lock-in procedures after utilization review of documented services indicate misutilization of Title XIX services, benefits, or both.
Montana	Members are chosen for the program through information gathered from claims, drug utilization review (DUR) referrals, and provider referrals. The DUR board, which is made up of doctors, a mid-level practitioner, and pharmacists, performs pharmacy reviews of Medicaid's pharmacy claims. Health Improvement Program care managers can make suggestions for referrals, as well.
Nebraska	Clients are investigated through utilization review, provider referral, or local office referral. The department's Utilization Review Committee makes the decision to lock in.
Nevada	The Division of Health Care Financing and Policy looks at the number of controlled substances prescriptions filled in 60 days to identify recipients. If that number is 10 or more, then each recipient is further reviewed for the other criteria. The program conducts a claims check history and data analysis.

State	Clinical Review Process
New Hampshire	Surveillance and Utilization Review Subsystem reviews drug/medical history profiles for beneficiaries and investigates provider referrals of possible recipient overutilization. Each month a report is generated to identify Medicaid recipients who meet the criteria for lock-in as recommended by the Pharmacy Therapy Advisory Committee and approved by the Department of Health and Human Services. Each recipient is then further reviewed for medical conditions that might justify the necessity for their overutilization. If a recipient is identified as meeting one criterion, he or she will be monitored every three months. If a recipient is identified as meeting two criteria, a warning letter is sent. If a recipient meets three criteria, the lock-in process will be initiated. Lock-in will occur once the time for appeal has expired.
New Jersey	The Medicaid Fraud Division reviews the list of locked-in recipients to ensure they were appropriately determined to be locked in.
New Mexico	No FFS PRR
New York	Information not available
North Carolina	Program Integrity conducts audits to ensure compliance. Program criteria are approved by the North Carolina Physician Advisory Group and are supported by the Controlled Substances Task Force. If a provider referral is made for lock-in program, then clinical grounds must be met.
North Dakota	The Surveillance and Utilization Review Subsystem analyst initiates a review of services utilized by Medicaid recipients. The reviews are referred to the Medicaid medical review team consisting of a physician, pharmacist, and/or nurse. The Medicaid medical review team determines if a recipient could benefit from enrollment in the Coordinated Services Program.
Ohio	No FFS PRR
Oklahoma	Beneficiaries can be referred by physicians, pharmacies, caseworkers, or Oklahoma Health Care Authority staff members. After a member is referred, certain information is reviewed, including pharmacy claims, hospital/emergency room claims, physician claims, history of diagnoses, and the number of pharmacies visited and their specialties.
Oregon	The Oregon drug utilization review (DUR)/Pharmacy and Therapeutics Committee develops standards to be used in retrospective and prospective drug utilization review in a manner that ensures that such criteria and standards are based on the compendia, relevant guidelines obtained from professional groups through consensus-driven processes, the experience of practitioners with expertise in drug therapy, and data and experience obtained from DUR program operations. At least quarterly, the program runs a query that identifies all clients meeting the program criteria. A pharmacist reviews those clients to determine which, if any, would likely benefit from the program.
Pennsylvania	Providers notify their County Assistance Office or the Office of Administration's Bureau of Program Integrity if they have reason to believe that a recipient is misutilizing or abusing Medical Assistance (MA) services or may be defrauding the MA Program. In addition, the department has established procedures for reviewing recipient utilization of MA services.
Puerto Rico	No FFS PRR
Rhode Island	Information not available

State	Clinical Review Process
South Carolina	The Bureau of Compliance and Program Review staff in the Department of Recipient Utilization review beneficiary profiles to identify beneficiaries who meet the criteria.
South Dakota	No FFS PRR
Tennessee	A clinical pharmacist from our pharmacy benefit management vendor reviews each beneficiary's profile, and he or she has the ability to make a judgment call as to whether any activity involving multiple controlled substances and multiple providers could be justified. For example, if the enrollee suffers from metastatic cancer or from crisis episodes of sickle cell disease, he or she may meet the criteria for legitimate reasons. Some of these enrollees are eventually placed on lock-in, and some are not but may be monitored periodically.
Texas	After analysis through the neural network component of the Medicaid Fraud and Abuse Detection System, qualified medical personnel validate the initial identification and determine candidates for lock-in status.
Utah	Reports are generated from the Surveillance and Utilization Review Subsystem (SURS) computer subsystem. SURS reports display details regarding members with excessive use based on criteria that are suggestive of over-utilization. Reviews evaluating recipients for restriction are also performed at the request of providers who call with concerns about specific members who may or may not have been captured on a SURS report. Once a member is displayed on the SURS report, acuity of possible over-utilization is determined by how many of each of the criteria a member meets and/or the numbers of times the member has met any one single criterion. Members are reviewed in order of acuity score. After acuity scores are assigned, a thorough review of claims data is performed to differentiate members who meet criteria due to purposeful abuse (such as drug seeking or using the emergency department for primary care), members needing education regarding appropriate use of the Medicaid system, and members who have specific circumstances or diagnoses that would temporarily create an exception to being enrolled in the Lock-in Program.
Vermont	Clinicians compile documentation based on the criteria and then present the case in a peer review format with clinicians from various disciplines (the majority are licensed). The peer review team discusses the case, looking at potential for more appropriate or concurrent referrals to other Medicaid programs as well as involvement in other programs, and then makes a recommendation regarding enrollment.
Virginia	The Department of Medical Assistance Services identifies recipients for review from computerized reports such as, but not limited to, Recipient Surveillance and Utilization Review Subsystem (SURS), or by referrals from agencies, health care professionals, or other individuals. Evaluation of utilization patterns can include, but is not limited to, review by the department staff of medical records or computerized reports generated by the department reflecting claims submitted for physician visits, drugs/prescriptions, outpatient and emergency room visits, lab and diagnostic procedures, hospital admissions, and referrals. Abusive activities are investigated and, if appropriate, the recipient is reviewed for restriction. Recipients demonstrating questionable patterns of utilization or exceeding reasonable levels of utilization are reviewed for restriction.
Washington	Clients are selected for program review when either a usage review report indicates that the client meets the criteria or medical providers, social service agencies, or other concerned parties have provided direct referrals to the agency or managed care organization (or both). When a client is selected for review, the agency or managed care organization staff, with clinical oversight, review the client's medical history, billing history, or both to determine if the client has used health care services at a frequency or amount that is not medically necessary.

State	Clinical Review Process
West Virginia	The Retrospective Drug Utilization Review Committee reviews member profiles monthly that have been selected because of therapeutic criteria exceptions, including potential overutilization of controlled substances. The Retrospective Drug Utilization Committee is a subcommittee of the West Virginia Drug Utilization Review Board. Criteria for lock-in are reviewed and approved by the Drug Utilization Review Board and Retrospective Drug Utilization Review Committee.
Wisconsin	Referrals for lock-in are received from retrospective drug utilization review, physicians, pharmacists, other providers, and through automated surveillance methods. Once a referral is received, six months of pharmacy claims and diagnoses data are reviewed.
Wyoming	The prescription and diagnosis history of the patient is reviewed to look for drug-seeking behavior. The program also reviews for cancer to exclude those patients from lock-in. The program requests a prescription drug monitoring program report from the Board of Pharmacy if there are further questions that can be answered by looking for cash payments.

Appendix D

Patient Review Process for Release From the Program

State	Patient Review Process for Release From the Program
Alabama	Information not available
Alaska	The department will review the restriction annually. If the department determines that the restriction should extend beyond 12 months of eligibility, the department will provide the recipient notice and an opportunity for a new fair hearing.
Arizona	Information not available
Arkansas	The restriction will be removed after demonstration by the beneficiary that the abusive situation has been corrected.
California	No FFS PRR
Colorado	Reviewed quarterly
Connecticut	Reviewed annually
Delaware	A restricted client's case is reviewed within one year to decide if his/her restriction should be continued or lifted. If the restricted status is not lifted, the lock-in is continued for an additional 24 months.
District of Columbia	A restriction may be required for a reasonable amount of time, not to exceed twelve (12) months. Subsequent restrictions are not imposed until after a review by the Drug Utilization Review Board has concluded.
Florida	No FFS PRR
Georgia	At the conclusion of the lock-in period, the member's usage is reevaluated to determine whether restrictions should continue.
Hawaii	Information not available
Idaho	Cases are reviewed at the end of the predetermined program length, at which point lock-in may be extended for an additional period. If a recipient continues to abuse and/or overutilize items or services after being identified for lock-in, the department may terminate medical assistance benefits for a specified period as determined by the department.
Illinois	The department reevaluates the recipient's medical usage after four full quarters to determine whether the recipient continues to receive medical services that are not medically necessary. This review must come no later than 18 months after the initial restriction date. If the recipient is still receiving medical services that are not medically necessary, the restriction is continued for an additional period of eight full quarters. The department obtains a complete copy of the recipient's medical record from the primary provider type, which is reviewed by the medical assistant consultant. The final determination comes from a licensed individual practitioner to determine if the medical services received were medically necessary.
Indiana	Thirty to 60 days before the projected end of the member's enrollment in the program, the program administrator's staff reviews the member's case to determine the outcome of his or her performance in the program. To remove a member from the program, the program administrator convenes a multidisciplinary Exit Care Conference. The case is evaluated to determine the member's readiness for removal from the program, therapeutic situations or circumstances that may be present, and conditions that may contribute to the member's return to inappropriate utilization once removed from the program.

State	Patient Review Process for Release From the Program
Iowa	Information not available
Kansas	Three months before the end of the lock-in program, fiscal agent Surveillance and Utilization Review Subsystem (SURS) staff conducts a review to determine whether the beneficiary's behavior regarding use of prescription medicine improved. If improvement is noted, the beneficiary is removed from the program; otherwise he or she is placed on extended lock-in. SURS staff conducts another review six to 12 months after a beneficiary is removed from lock-in as a means to monitor behavior.
Kentucky	The patient's designated primary care provider participates in the periodic utilization review. After the initial 24-month period of lock-in enrollment, the department conducts a utilization review at 12-month intervals to measure the effectiveness of the program and to determine if the recipient should continue to be enrolled. The department then sends the recipient the findings of the utilization review.
Louisiana	Enrolled lock-in recipient cases are re-reviewed on a periodic basis, currently every 24 months. Previously, the review period was nine months but it was extended to one year and then to two years.
Maine	During the period of enrollment in the Restriction Plan, the Program Integrity Unit will supervise and monitor utilization patterns of restricted members and analyze computer-generated profiles of the member's health care services reimbursed under MaineCare. The member is contacted by the Program Integrity Unit periodically to verify that his or her medical needs are being met. The member's records, claims data and national standards are reviewed annually.
Maryland	Managed care organizations submit monthly lists of enrollees who have been locked in. After an initial enrollment, the enrollee is reviewed. If he/she is found to have abused managed care organization benefits for a second time, they are locked in for another 12 months. After that time period, he/she is reviewed again. If again he/she is found to abuse managed care organization benefits, he/she will be locked in for 24 more months. An enrollee subsequently found to have abused managed care organization benefits will be extended for another 18 months.
Massachusetts	MassHealth periodically reviews the member's drug utilization on its own initiative or upon the member's request, but no earlier than 12 months after the date of enrollment. If, after such review, the MassHealth agency determines that the member has not used excessive quantities of prescribed drugs for at least that 12-month period, the MassHealth agency will disenroll the member from the Controlled Substance Management Program and the member will no longer be subject to the restrictions of the program.
Michigan	Utilization of medical services and drugs is routinely monitored and the effectiveness of program interventions is evaluated. The department reviews each case at least once every 24 months.
Minnesota	After an initial 24-month period of eligibility in the program, the Department may renew the recipient's placement for an additional 36 months by sending written notice. The recipient will remain in the program pending the resolution of an appeal of the placement renewal. If the recipient's placement is not renewed, the recipient will be notified.
Mississippi	Beneficiaries receive ongoing reviews to monitor pattern of care. Beneficiaries who have received a utilization review within the past year are not eligible for re-review for another 12 months.
Missouri	After the initial 12 month lock-in period, but no longer than 24 months after being locked in, the Surveillance and Utilization Review Subsystem Unit professional staff will review the case and continue the recipient on lock-in if review of documented services indicates continuing misutilization. The lock-in period will again be for a minimum of 12 months and a maximum of 24 months before another review is conducted.
Montana	After the initial term of enrollment, Medicaid will review the beneficiary's medical history to decide if he or she would benefit from staying in Team Care.

State	Patient Review Process for Release From the Program
Nebraska	The Utilization Review Committee, or its designee, will review the client's lock-in status every 24 months for the continued appropriateness of the lock-in. Lock-in status will be continued, changed, or removed based on the following: use of controlled substances, carisoprodol, tramadol, or other drug(s) with abuse potential; early prescription refills, as defined in the drug claim processing system; use of drugs that are known to interact with other drugs, diseases, conditions, or foods; use of medications indicating multiple medical conditions with complex medication regimens; patient safety, including use of medication(s) with narrow therapeutic index; abuse or overuse of medical services; history of drug abuse, medication-seeking behavior, noncompliance, emergency room overuse or abuse; coverage by Medicaid of services from non-lock-in providers in nonemergency situations; report(s) of obtaining Medicaid coverable drugs by paying cash; or other similar reasons. The client or the client's primary physician may request a review of the client's lock-in status once a year in addition to the biennial review.
Nevada	Information not available
New Hampshire	Six months following the end of the lock-in period, recipients are re-reviewed to determine if they continue to meet criteria for remaining in the program. If two criteria are met, a letter of warning is sent with a three-month follow-up. If three or more criteria are met, the recipient is locked in for an additional two years.
New Jersey	The continued need for lock-in is periodically evaluated at least every two years.
New Mexico	No FFS PRR
New York	The State Medical Review Team or a managed care organization review team and/or committee reviews patients for abuse.
North Carolina	Beneficiaries will be removed from the program after the enrollment period is up if they no longer meet the identification criteria. Beneficiaries who continue to meet the criteria will be locked in for a subsequent year. Once released from the lock-in program, prescription claims will continue to be monitored. Should a beneficiary meet the criteria again after being released from the program, they will be re-identified for the lock-in program.
North Dakota	After 18 months in the program, the recipient can request consideration for removal. The request for medical review must be in writing, must explain the reasons for requesting removal, and must include any supporting documentation.
Ohio	No FFS PRR
Oklahoma	After the initial 24-month enrollment, authority employees re-evaluate whether the member should stay in the program. Members are locked in for one year at a time after that.
Oregon	Information not available
Pennsylvania	Restrictions are removed after a period of five years if improvement in use of services is demonstrated.
Puerto Rico	No FFS PRR
Rhode Island	If, after review of the recipient's drug-usage profile, it is determined by the Medicaid Pharmacy Lock-In Program that restriction of the recipient to the primary pharmacy is no longer appropriate, the restriction will be removed. Such review will not take place prior to 15 months from the date of enrollment.

State	Patient Review Process for Release From the Program
South Carolina	Utilization in the lock-in program is monitored on a monthly basis from the time a beneficiary is placed in the program. The Department of Health and Human Services staff monitors utilization through pre- and post-lock-in comparisons.
South Dakota	No FFS PRR
Tennessee	All enrollees get a chance to be unlocked once a year through a re-review process. Re-reviews take place each month. In addition, in January there is a "cleanup" that queries every lock-in patient who has only one prescriber and one pharmacy for three months and no cash transactions (pulled from the prescription drug monitoring program) and reviews their files. To be unlocked, beneficiaries must have six months of using just one prescriber and one pharmacy and have no cash transactions. Those who are convicted of fraud, waste, and abuse will always have a lock-in status.
Texas	The Health and Human Services Commission will review and determine whether to continue a recipient's lock-in status prior to the end of a lock-in period. Clients are removed from lock-in status at the end of the specified limitation period if their use of medical services no longer meets the criteria for lock-in status. A medical review also may be initiated at the client or provider's request.
Utah	Recipients are restricted for the initial period of one year with a review of use scheduled for the end of the year period to determine whether or not to continue the recipient in the program. Program staff reviews borderline cases at given intervals after the member's case is found to be "borderline" in order to determine whether use has dropped or restriction should be implemented.
Vermont	Discharge is not automatic, but the beneficiary may request to be taken out of Team Care.
Virginia	During the restriction period, the Department of Medical Assistance Services monitors recipients' utilization at least every 12 months and follows up with the recipient to promote appropriate utilization patterns. The department reviews recipients' utilization prior to the end of the restriction period to determine restriction termination or continuation. Restriction is extended for 36 months if the recipient still meets criteria or has not complied with procedures for referrals in the absence of a medical emergency. If one or more of the designated providers recommends continued restriction, the beneficiary will continue to be locked in.
Washington	The agency or managed care organization reviews a client's use of health care services prior to the end of each program placement period (24-month initial period, 36 months for second placement, 72 months for each placement after that) using the same criteria as the initial review. The client can be removed if he or she successfully completes a treatment program or maintains appropriate use of health care services for six consecutive months after the date the treatment ends.
West Virginia	At the end of the 12-month period, the Retrospective Drug Utilization Committee reviews the member's prescription profile to determine whether enrollment should be continued for another 12 months. Members who are enrolled in the program for management of Suboxone utilization who discontinue Suboxone therapy will continue to be enrolled until their scheduled annual enrollment review. The members' Suboxone doctor may submit a request to the RetroDUR Committee, asking for an early review to release a member from enrollment once Suboxone therapy has been discontinued, provided the member meets no other criteria.
Wisconsin	Members remain enrolled in the program for two years and are continuously monitored for their prescription drug usage. At the end of the two-year enrollment period, an assessment is made to determine if the member should continue enrollment.
Wyoming	Patients are reviewed by the program manager six months after enrollment. Each patient is referred to case management, which performs ongoing review while the patient is enrolled.

For further information, please visit:

pewtrusts.org/prescription-drug-abuse

Contact: Erin Davis, communications
Email: edavis@pewtrusts.org
Project website: pewtrusts.org/prescription-drug-abuse