



ADMINISTRATIVE RULES OF MONTANA



37.86.5303 PASSPORT TO HEALTH'S TEAM CARE PROGRAM

- (1) A recipient may be subject to restrictions on, or prior approval for, physician related services, pharmacy services or any other services covered by the medicaid program if the department determines that the recipient's utilization of service is excessive, inappropriate, or fraudulent with respect to medical need.
- (2) The restrictions described in (1) may be imposed if any of the following events occur:
 - (a) the recipient seeks medical services that are not medically necessary;
 - (b) there is multiple provider usage that results in the receipt of unnecessary services;
 - (c) there is repeated use of emergency rooms for routine medical services;
 - (d) there is unwarranted multiple pharmacy usage, indicated by the use of more than three pharmacies, that results in the receipt of unnecessary prescriptions;
 - (e) there is admission of or conviction for forgery of medicaid drug prescriptions by the recipient; or
 - (f) the recipient utilizes a medicaid card in any unlawful or fraudulent manner.
- (3) The department will use payment records, reports from medical consultants, provider referrals or other pertinent recipient or service information, to determine if recipient overutilization, or other abuses, have occurred.
- (4) A recipient's restriction does not apply to other members of the household.
- (5) Restriction of medicaid services may include limiting a recipient to a designated provider or providers or requiring the recipient to obtain department approval to receive non-emergent services. A recipient with restricted services is participating in the team care program. Medicaid payment for medical services provided to a team care participant will only be made to the recipient's designated provider(s) except:
 - (a) when emergency services, as defined at ARM 37.82.102(11) , are required;
 - (b) when the designated provider refers the recipient to another provider; or
 - (c) when the department approved the service prior to performance.
- (6) A recipient restricted to the team care program is required to participate in the passport to health program set forth in this subchapter unless the recipient is ineligible, as that term is defined in ARM 37.86.5102.

- (7) A recipient whose medical service usage meets the criteria for restriction listed in (2) , but who is ineligible for the passport to health program for the reasons listed in ARM 37.86.5102, may be required to participate in the team care program. A recipient living in a nursing home or institutional setting or a recipient whose eligibility period is only retroactive cannot be required to participate in either the passport for health or the team care programs.
- (8) The department will notify a recipient in writing at least 10 days prior to the date of the intended action restricting medical services paid by the medicaid program.
- (9) The department will determine the provider type to which the recipient is restricted (pharmacy, physical health provider or both) . The recipient will have an opportunity to choose the recipient's primary care provider and pharmacy unless:
 - (a) the department determines that the selected provider has been sanctioned by the department in accordance with ARM 37.85.501;
 - (b) the designated review organization has determined that the selected provider has not properly managed the medical care of a recipient who has been restricted; or
 - (c) the selected provider will not accept the recipient as a patient.
- (10) The recipient will have 10 days from the date of notification of restriction by the department to choose a primary care provider and a pharmacy provider. If the recipient does not choose a primary care provider and a pharmacy provider within 10 days, a primary care provider and a pharmacy will be selected for the recipient. If the department is unable to obtain a primary provider for the restricted recipient, all non-emergency services must be prior authorized by the department.
- (11) A restricted recipient may request a change of provider. The request must be in writing and submitted to the department for approval. Provider changes will not be approved unless the department determines that there is good cause for the requested provider change. The department will have 30 days to take action on the request.
- (12) The department will review all restricted recipients annually unless the recipient's medical service usage indicates an earlier review should occur. Restriction may be continued if:
 - (a) the department determines the recipient's use of services has remained excessive or unnecessary. Examples of excessive or unnecessary usage include, but are not limited to, those listed in (2) ;
 - (b) the designated provider recommends, with supporting rationale, that the recipient should remain restricted; or
 - (c) the recipient has received or attempted to receive medicaid services not authorized under the restricted card program.
- (13) A recipient aggrieved by an adverse departmental action under this rule may request a fair hearing in accordance with ARM 37.5.304, 37.5.305, 37.5.307, 37.5.310, 37.5.311, 37.5.313, 37.5.316, 37.5.318, 37.5.322, 37.5.325, 37.5.328, 37.5.331, 37.5.334 and 37.5.337.

Authorizing statute(s): Sec. 53-6-113, MCA

Implementing statute(s): Sec. 53-6-104 and 53-6-113, MCA



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History: NEW, 2004 MAR p. 1624, Eff. 7/23/04.