**Section 120.80 Recipient Restriction Program**

a) Effective July 1, 2012, the Recipient Restriction Program (RRP) shall identify recipients who unnecessarily utilize medical services. When the Department determines, on the basis of statistical norms and the medical judgment of individual practitioners and/or pharmacists, or other providers, that a Medicaid recipient has received medical services that are not medically necessary based on the recipient's diagnoses and/or medical condition or conditions or in such a manner as to constitute an abuse of medical privileges or Program services, the decision to restrict a recipient to one or more primary provider types will be made. For purposes of this Section, "primary provider type" means an individual practitioner in any of the following licensed or certified health care professions: physician, optometrist, chiropractor, pharmacist, dentist, any advanced practice nurse, registered nurse, licensed practical nurse, genetic counselor, physical therapist, podiatrist, speech therapist, psychologist, audiologist, occupational therapist or physician assistant. A primary provider type also means a business entity, partnership or group practice comprised of or employing any of the individual practitioners listed in this subsection (a). A primary provider type can also mean any of the following: hospice provider, home health agency, transportation provider, community health agency, imaging service, optical company, optician, optometrist, independent laboratory, clinical social worker, Department of Human Services-Division of Alcohol and Substance Abuse provider, durable medical equipment provider, provider of medical equipment and supplies, case management provider, behavioral health professional provider, a provider of services authorized under a federal Medicaid waiver, or any other provider of medical assistance programs authorized under the Illinois Public Aid Code or its administrative rules. The RRP applies to all medical assistance programs administered by the Department, with the exception of full risk Managed Care Organizations (MCO).

b) Primary and Secondary Sources of Recipient Identification

1) The primary source of recipient identification shall be 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 will identify recipients with usages in excess of the established norm of recipients in the same category of assistance and like demographic areas.

2) Secondary sources of identification shall be incoming referrals, such as referrals from medical providers, law enforcement officials or members of the general public. All referrals shall be 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 shall be restricted.

c) Once a recipient is identified, medical usage based on diagnoses and/or medical condition for the preceding 24 months shall be reviewed. Medical Assistance Consultants and licensed individual practitioners and/or pharmacists will determine if the recipient should be restricted due to the medical services received being not medically necessary. The Department shall initially designate, without regard to choice, a primary provider type or types (type). The Department's designation shall remain in effect for the entire period of the restriction unless the recipient changes this designation pursuant to subsection (f) of this Section. Each recipient to be restricted will be notified in writing. This notice will also contain a statement relating to the medical necessity of services consistent with the findings of the professional consultants; a statement advising the recipient of his or her right to appeal; and a toll-free number to call for information.

d) Department Designated Primary Provider Type

1) The Department will select the applicable primary provider type in reasonable geographical proximity to the recipient's home to serve as the recipient's primary provider type.

2) The primary provider type must be a properly enrolled Medicaid provider in good standing with the Department, properly licensed and credentialed and willing to serve as a primary provider type.

3) If a primary care provider is selected as the primary provider type, he or she shall be a medical doctor or doctor of osteopathy licensed to practice medicine in all of its branches or a clinic enrolled to provide primary care.

e) Types of Services Provided or Authorized

1) Once restricted, the Recipient Eligibility Verification (REV) system shall display information regarding the primary provider type. REV will also display information that emergency services will not be restricted.

2) If restricted to a primary care provider, the primary care provider must provide or authorize the following non-emergency ambulatory care services for the restricted recipient before the Department will render payment for the services:

A) Clinic

B) Laboratory

C) Outpatient Hospital

D) Pharmacy

E) Physician

3) If restricted to a primary care pharmacy, the primary care pharmacy must supply all prescriptions for the restricted recipient. Authorization to obtain non-emergency prescriptions from any other source will only be approved when a specific item is not part of the primary care pharmacy's inventory and cannot be acquired through the primary care pharmacy.

4) If restricted to a primary care dentist, the primary care dentist must provide or authorize all dental services for the restricted recipient before the Department will render payment for the dental services.

5) If restricted to a primary care podiatrist, the primary care podiatrist must provide or authorize all podiatric services for the restricted recipient before the Department will render payment for the podiatric services.

6) If restricted to a primary durable medical equipment provider, the primary durable medical equipment provider must supply all medical supplies for the restricted recipient. Authorization to obtain medical supplies from any other source will only be approved when a specific item is not part of the primary durable medical equipment provider's inventory and cannot be acquired through the primary durable medical equipment provider.

7) Other covered services may be provided by a qualified provider in the Department's Medical Program.

f) Changing the Designated Primary Provider Type

1) The recipient may change the Department's initial designation of a primary provider type once without cause. The request for change must be submitted to the Department in writing. The Department, by notice, shall inform the recipient how to request a change in primary provider type.

2) The recipient may change his or her designated provider for cause if one of the following circumstances is verified:

A) Change of recipient's residence from the geographical area of the primary provider type;

B) Change in the recipient's medical condition that the primary provider type is unable to treat or refer to another provider;

C) Death of the primary provider type;

D) Disenrollment of the primary provider type from the Medical Assistance Program; and

E) Notice from the primary provider type that he, she or it will no longer serve as the primary provider type.

3) The Department will notify the recipient in writing if the primary provider type has disenrolled as a provider of Medicaid services or if the provider notifies the Department of his, her or its unwillingness to continue to serve as the recipient's primary provider type.

4) Changes in designated primary provider type shall be processed effective with the earliest possible date reflected on the eligibility file.

5) For the designated primary provider type, the Department will determine if the requested change meets the criteria in subsection (d) of this Section.

g) Length of Restriction

1) Once recipients are restricted they remain in restriction for a minimum of four full quarters. If restricted recipients transfer to a different assistance unit, the restriction will be processed to follow the recipient. If a restricted recipient becomes inactive and is subsequently reactivated, the restriction will be reactivated until such time as four full quarters have elapsed.

2) Reevaluation of the Recipient's Medical Usage

A) When a recipient has had his or her medical card restricted for four full quarters, the Department shall reevaluate the recipient's medical usage to determine whether the recipient continues to receive medical services that are not medically necessary. The Department shall evaluate each case not later than eighteen months after the effective date of restriction. If the recipient is still receiving medical services that are not medically necessary, the restriction shall be continued for an additional period of eight full quarters. This additional period of eight full quarters shall begin with the first month immediately following the end of the first four full quarter restriction period. If the recipient no longer is receiving medical services that are not medically necessary, the restriction shall be discontinued. A "quarter", for purposes of this Section, shall be defined as one of the following three-month periods of time: January-March, April-June, July-September or October-December.

B) If necessary to determine if medical services that are not medically necessary are still being received, the Department shall obtain a complete copy of the recipient's medical record from the primary provider type. The medical record will be reviewed by the Medical Assistant Consultant with a final determination by a licensed individual practitioner to determine if the medical services received were medically necessary.

C) If the decision is to release the recipient from restriction, such release will be processed effective with the earliest possible date reflected on the eligibility file.

D) If the services are determined to be medically unnecessary, the recipient will be notified in writing of the continued restriction. The Department may designate a different individual provider type. The criteria in subsection (d) of this Section shall apply. This notice will also contain a statement relating to the medical necessity of services consistent with the findings of the professional consultants; a statement advising the recipient of his or her right to appeal; and a toll-free number to call for information.

3) If the restriction is continued, a review will be conducted in accordance with subsection (g)(2) of this Section, subsequent to the additional eight quarter period.

4) A recipient who has been restricted under this Section, is released and then is restricted under this Section a subsequent time, shall be restricted for a period of eight full quarters. Subsequent to this eight quarter period, a review will be conducted in accordance with subsection (g)(2) of this Section.

h) Recipients have the right to appeal inclusion in the program. (See 89 Ill. Adm. Code 102.80 through 102.84.)

i) Any recipient in the RRP who subsequently enrolls in a full risk MCO will be released from the RRP.

(Source: Amended at 37 Ill. Reg. 10208, effective June 27, 2013)