441—76.9(249A) Member lock-in. In order to promote high quality health care and to prevent harmful practices such as duplication of medical services, drug abuse or overuse, and possible drug interactions, recipients that utilize medical assistance services or items at a frequency or in an amount which is considered to be overuse of services as defined in subrule 76.9(7) may be restricted (locked-in) to receive services from a designated provider(s).

76.9(1) A lock-in or restriction shall be imposed for a minimum of 24 months with longer restrictions determined on an individual basis.

76.9(2) Provider selection. The member may select the provider(s) from which services will be received. The designated providers will be identified on the department's eligibility verification system (ELVS). Only prescriptions written or approved by the designated primary physician(s) will be reimbursed. Other providers of the restricted service will be reimbursed only under circumstances specified in subrule 76.9(3).

76.9(3) Payment will be made to provider(s) other than the designated (lock-in) provider(s) in the following instances:

a. Emergency care is required and the designated provider is not available. Emergency care is defined as care necessary to sustain life or prevent a condition which could cause physical disability.

b. The designated provider requires consultation with another provider. Reimbursement shall be made for office visits only. Prescriptions will be reimbursed only if written or approved by the primary physician(s). Referred physicians may be added to the designation as explained in subrule 76.9(5).

c. The designated provider refers the recipient to another provider. Reimbursement shall be made for office visits only. Prescriptions will be reimbursed only if written or approved by the primary physician(s). Referred physicians may be added to the designation as explained in subrule 76.9(5).

76.9(4) When the recipient fails to choose a provider(s) within 30 days of the request, the division of medical services will select the provider(s) based on previously utilized provider(s) and reasonable access for the recipient.

76.9(5) Recipients may change designated provider(s) when a change is warranted, such as when the recipient has moved, the provider no longer participates, or the provider refuses to see the patient. The worker for the recipient shall make the determination when the recipient has demonstrated that a change is warranted. Recipients may add additional providers to the original designation with approval of a health professional employed by the department for this purpose.

76.9(6) When lock-in is imposed on a recipient, timely and adequate notice shall be sent and an opportunity for a hearing given in accordance with 441—Chapter 7.

76.9(7) 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.

a. Determination of overuse of service shall be based on utilization data generated by the Surveillance and Utilization Review Subsystem of the Medicaid Management Information System. The system employs an exception reporting technique to identify the recipients most likely to be program overutilizers by reporting cases in which the utilization exceeds the statistical average.

b. In addition to referrals from the Surveillance and Utilization Review Subsystem described in paragraph *"a,"* referrals for utilization review shall be made when utilization data generated by the Medicaid Management Information System reflects that utilization of Medicaid recipient outpatient visits to physicians, advanced registered nurse practitioners, federally qualified health centers, rural health centers, other clinics, and emergency rooms exceeds 24 visits in any 12-month period. This utilization review shall not apply to Medicaid recipients who are enrolled in the MediPASS program or a health maintenance organization, or who are children under 21 years of age or residents of a nursing facility. For the purposes of this paragraph, the term "physician" does not include a psychiatrist.

c. An investigation process of Medicaid recipients determined in paragraphs *"a"* or *"b"* to be subject to a review of overutilization shall be conducted to determine if actual overutilization exists by verifying that the information reported by the computer system is valid and is also unusual based on professional medical judgment. Medical judgments shall be made by physicians, pharmacists, nurses and other health professionals either employed by, under contract to, or consultants for the department. These

medical judgments shall be 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.