Chapter 28 Section 1

# Prescription Monitoring Program (PMP)

Revision: C-58, September 20, 2019

## 1.0 SCOPE

**1.1** The prescription monitoring program is a quarterly review of all beneficiaries who received prescriptions using TRICARE benefits. The program below applies to the regional contractors and TRICARE Pharmacy (TPharm) contractor. Uniformed Services Family Health Plan (USFHP), Dental, TRICARE for Life (TFL), Veterans Health Administration (VHA), or overseas contractors are excluded from quarterly reporting but may be contacted as necessary to resolve non-routine cases such as a beneficiary who is seeing multiple dentists or a beneficiary assigned to overseas contractor who is obtaining large volumes of prescriptions within TPharm contractor's jurisdiction. Military Treatment Facilities/Enhanced Multi-Service Markets (MTFs/eMSMs) will receive data of persons for whom the MTF is (or acts as) a Primary Care Manager (PCM), but are not required to participate in this program (for details refer to DD Form 1423, Contract Data Requirements List (CDRL), located in Section J of the applicable contract). Any contractor or MTF/eMSM may use the restriction portion of the program at their discretion. The goal of the program is to identify beneficiaries who may need additional medical assistance by providing knowledge of resources and maintaining compliance with the guidelines described within 32 CFR 199.4.

**1.2** The prescription monitoring program performs automated review using predefined algorithms to identify beneficiaries with a higher use of controlled substances (Schedule II-V) than parameter thresholds. Other non-controlled substances maybe included if they are known to be combined with Schedule II-V for purposes of substance abuse. The results will be sent to the appropriate contractor based on beneficiary's PCM assignment (Prime) or location (Select) for review.

**1.3** The contractors shall designate a "reviewer". The reviewer can be a contractor's Chief Medical Officer (CMO) or a person approved by the CMO. The reviewer should have the appropriate credentials to review all types of claims. The reviewer is responsible for reviewing individuals on the quarterly list and making determinations based on the beneficiaries' entire profile regardless of individual providers seen over the duration of the report. The reviewer will conduct a medical review of the patient history to validate utilization with medical diagnosis and appropriateness of care. The level of review necessary is the breadth and depth needed to make an accurate determination. It may include claims review, record review, or any other relevant information as necessary to make an accurate determination. Any inconsistencies with utilization and medical diagnosis and/or over-utilization concerns for medical diagnosis noted by the reviewer will necessitate the contractor to develop a support plan. A support plan could be restrictions only or include case management, pain management, behavioral health, or any other contractually available services. If the plan includes restrictions, the contractor will notify the TPharm contractor and the TPharm contractor will begin the process outlined in paragraph 5.2.

**1.4** All communication and coordination will comply with Health Insurance Portability and Accountability Act (HIPAA) standards.

## 2.0 BACKGROUND

**2.1** The 32 CFR 199.4(e)(11) states that:

> "TRICARE benefits cannot be authorized to support or maintain an existing or potential drug abuse situation whether or not the drugs (under other circumstances) are eligible for benefit consideration and whether or not obtained by legal means. Drugs, including the substitution of a therapeutic drug with addictive potential for a drug of addiction, prescribed to beneficiaries undergoing medically supervised treatment for a Substance Use Disorder (SUD) as authorized under paragraph (e)(4)(ii) of this section are not considered to be in support of, or to maintain, an existing or potential drug abuse situation and are allowed."
>
> This does not preclude payment for medically necessary services.

**2.2** Both contractors and the TPharm contractor are responsible for implementing utilization control and quality measures designed to identify possible drug abuse situations. Each contractor is responsible for screening all claims within their system for medication line items that show potential over-utilization and irrational prescribing of drugs, and to subject any such cases to an extensive review to establish the necessity for the drugs and their appropriateness on the basis of diagnosis or definitive symptoms. This program is to supplement the objective of the Code of Federal Regulations (CFR) language and not meant to be the sole means of utilization control.

## 3.0 INITIAL REVIEW AND SUPPORT SERVICES

**3.1** Each quarter, the TPharm contractor shall generate for each of the contractors, a list of all beneficiaries surpassing the current established parameters. The parameters are based on pharmacy's commercial best practices for identifying potential fraud and abuse. These parameters are constantly evolving and not made publicly available. The TPharm contractor will be responsible for communicating the parameters to the Government and identifying when changes are necessary. The data provided to the contractor will be divided into subsets based on beneficiary's PCM assignment (Prime or TRICARE Plus) or region location (e.g., residential address of Select beneficiaries). The data will be arranged in a two tiered report. One section will be a summary of individuals included for the quarter and one page will be claim level detail for the past 180 days. The report will contain the latest status (see paragraph 3.3) reported by the contractor. The list will also identify how many times within the past five years each beneficiary has been identified on the report. The report is sent to the contractor for medical review.

**3.2** During the quarter, if concerns about controlled substance use are identified by other entities such as private providers (physician, nurse practitioners, etc.) or reviewers in the course of business, the TPharm contractor shall refer the identified beneficiaries to the appropriate contractor. Individuals identified by clinicians shall be put on 100% prepayment review by the TPharm contractor and must be provided a medical review by the contractor as received to determine final status. These should be given priority over the quarterly list and may be counted towards the minimum 20 cases per quarter.

**3.3** The contractor shall coordinate efforts with other TRICARE contractors as needed (change in PCMs, change in regions) to ensure the beneficiary's care is appropriately managed and benefits are not being abused. The TPharm contractor will coordinate cases that need assistance from the MTF/ eMSM.

**3.4** The contractor shall prioritize and review a minimum of 20 beneficiary cases per quarter from the quarterly list. See paragraph 3.5 for responses, and paragraph 3.6 for responses that count towards the minimum review.

**3.5** At a minimum, each contractor shall review the data generated on the quarterly report and provide a response in the following manner:

- No Action (diagnosis supports utilization)
- Support plan with restrictions
- Support plan without restrictions
- Restrictions Only
- Further monitoring needed
- Not Reviewed

**3.6** Each beneficiary documented as no action, support plan with or without restriction, restrictions only count towards for cases reviewed. The contractors shall provide responses within 60 days after receiving the TPharm report identifying at-risk beneficiaries and upload to the Performance Assessment Tracker (PAT) tool (for details refer to DD Form 1423, CDRL, located in Section J of the applicable contract) and provide a courtesy copy to the Government's designated pharmacy point of contact. The responses will be used by the TPharm contractor in generating a new report for the next quarter and be documented on future reports for trending across quarters.

## 4.0 SUSPENSION, DENIAL, AND RECOUPMENT OF CLAIMS

**4.1** 32 CFR 199.4(e)(11)(iv) states:

> "(A) When a possible drug abuse situation is identified, all claims for drugs for that specific beneficiary or provider will be suspended pending the results of a review.
>
> (B) If the review determines that a drug abuse situation does in fact exist, all drug claims held in suspense will be denied.
>
> (C) If the record indicates previously paid drug benefits, the prior claims for that beneficiary or provider will be reopened and the circumstances involved reviewed to determine whether or not drug abuse also existed at the time the earlier claims were adjudicated. If drug abuse is later ascertained, benefit payments made previously will be considered to have been extended in error and the amounts so paid recouped.
>
> (D) Inpatient stays primarily for the purpose of obtaining drugs and any other services and supplies related to drug abuse also are excluded."

**4.2** It is not the intent of the program to restrict care for non-chronic pain related drugs or services since those do not create a potential abuse situation. The contractor shall develop evidence-based criteria, incorporating national standards of care for identifying diagnoses and/or protocols for

medically necessary services, in an effort to clearly determine non-drug seeking behavior and pay claims appropriately for non-drug seeking behavior.

## 5.0 RESTRICTIONS

**5.1** Based on the outcome of the review, the contractor may place the beneficiary on restrictions. In cases where restrictions are appropriate and the TPharm contractor has been notified, the TPharm contractor will send letters to the beneficiary. The beneficiary will be asked to provide their primary provider preference and emergency room preference per guidelines in paragraph 5.2.1. The contractor does not need to pick specifics (individual providers, individual drugs, or emergency room) of the restrictions, but may designate at that level if deemed appropriate. The default option (paragraph 5.1.1) is implemented unless the contractor chooses to specify more stringent restrictions. See paragraphs 5.1.1 to 5.1.3 for available restriction options.

**Note:** The TPharm contractor system has adjudication edits in place to prevent multiple fills with overlapping days' supply at the same or multiple pharmacies; therefore, pharmacy restrictions are not necessary but may be added when appropriate.

### 5.1.1 Default Restriction Program For Purchased Care

**5.1.1.1** Restrict pharmacy claim reimbursement for controlled drugs and specific non-control drugs (e.g., antidepressants, antipsychotics, muscle relaxants, etc.) to cover only those prescriptions written by a beneficiary's designated provider(s).

**5.1.1.2** The default drug restriction list is Schedule II-IV drugs but when necessary may include other drugs. For example, when a previously unscheduled drug is under review for categorization of scheduling, it may be added to the list during the interim between the Drug Enforcement Agency's (DEA's) Notice of intent to schedule and the "effective date" of scheduling.

### 5.1.2 Default Restriction Program For MTF/eMSM

**5.1.2.1** Deny access to drugs from retail and mail order sources and narrow access to include only specific MTF/eMSM pharmacy(ies). The MTF/eMSM may designate a purchased care venue and/or provider for drug(s) not carried at the MTF/eMSM.

**5.1.2.2** This function may also be chosen by the beneficiary who wants to fill their prescriptions solely at the MTF/eMSM regardless of their PCM assignment. The narrow access would not allow them to fill prescriptions at retail or mail order venues.

### 5.1.3 Highest Level Of Restriction Available

Restrict all pharmacy claims (not only Schedule II-V). Only those prescriptions written by designated provider(s) will be processed.

## 5.2 To Add Beneficiary Restrictions

**5.2.1** The contractor and TPharm contractor will develop a process to communicate the determinations. The contractor will notify the TPharm contractor regarding which beneficiaries to add to the restriction program. Notifications to the TPharm contractor to add restriction can occur as the

reviews are completed. Communication does not have to wait until the minimum cases are reviewed or the due date for report responses. Upon notification, the TPharm contractor will then start the following two letter process to refine the detail on the restrictions:

**5.2.1.1** The TPharm contractor will send a letter to the beneficiary explaining the program and medical review results. The letter will ask the beneficiary to select a single provider for pain management and a primary emergency department.

- Additional providers may be added by beneficiary request and Government concurrence.

- The emergency department choice will be provided to the appropriate contractor with jurisdiction to oversee compliance.

**5.2.1.2** A notification letter will be sent to all individual commercial providers that prescribed to the beneficiary in the past 180 days. The letter explains the concern of over utilization, asks for confirmation of prescribing, and notification of future restrictions. Individual MTF/eMSM providers do not receive letters.

**5.2.2** The beneficiary will be given 14 calendar days from the date the notification letter is sent to respond with their selected options. The beneficiary will be notified in the initial letter that no payment will be made after 14 days on Schedule II-V drugs or medical service claims associated with obtaining those drugs until selections are made. A beneficiary who chooses not to participate will remain in 100% prepay status review and will be responsible for the costs of medical services and pharmaceuticals (not to include claims where the contractor has established medical necessity) until selections have been provided. The beneficiary may respond in writing (fax, email, or letter) or may call the designated phone number in the notification letter to provide the selections.

**5.2.3** Once the beneficiary has made the appropriate selections, a re-review can be requested by the beneficiary for previously pended or denied claims. The beneficiary can request a list of all pended or denied claims. The beneficiary request does not have to be in writing. The contractor must note date requested and complete the review in 30 days. A request for re-review will be forwarded to the other participating contractor within 24 hours to fulfill the request.

**Note:** Due to the real time environment, pharmacy claims cannot be pended. Therefore, any previous claims that were subject to 100% copay can be re-reviewed based on additional information and re-processed if necessary. An appeal is only necessary for claims that have been re- reviewed and denied payment.

**5.3** While restricted, the beneficiary may find it necessary to request overrides due to emergent need (illness while traveling) or changing circumstances (moved, provider retired, etc.). The beneficiary may request a temporary override (emergent need) or permanent change. The TPharm contractor will provide in the initial notification letter an email address and phone number to support those needs. This information will also be made available on the TPharm contractor's web site. If the beneficiary requests more than two overrides/changes during a six month period, the TPharm contractor will send the information to the originating contractor for authorization to override.

**5.4** To remove a beneficiary from restrictions:

**5.4.1** A case manager, physician, or other provider can make the request based on change in clinical condition. This request will be reviewed by the originating contractor for concurrence. The contractor shall respond in seven calendar days. The requestor will be notified of the results by originating contractor of the restriction. If the request is received by the TPharm contractor they will forward within 24 hours of receiving to the contractor for resolution.

**5.4.2** The TPharm contractor shall monitor the Morphine Equivalent Dose (MED) for opioid based restrictions. When the TPharm contractor detects that the MED has dropped below 30mg for 180 consecutive days, the TPharm contractor will notify contractor and the beneficiary will be removed from program in 30 days unless the contractor indicates otherwise. The contractor may request to maintain the restriction.

**5.4.3** The contractor will provide written notification to beneficiary of the results. If the result is removal from the program, the letter will identify the date of removal. If the result is the not to remove, the letter will identify the next date a review can be requested. A courtesy copy of the result will be provided to the Government's TPharm point of contacts.

## 6.0 RE-REVIEWS TIMELINES

**6.1** The beneficiary is to be offered an opportunity to request a re-review of the initial decision to restrict the beneficiary and informed that his/her attending provider(s) may discuss the case with the reviewer. The beneficiary will have 90 days from the date of the original notification letter (paragraph 5.2.1.2) to request an initial re-review and the contractor has 30 days to respond to the beneficiary's request for a re-review. If there is no initial request for a re-review, the procedures in paragraph 6.2 are applicable. Being placed on the PMP restriction program is not appealable but claims denied due to restrictions in place may be appealable.

**6.2** The beneficiary may request an annual review or anytime they have documentation from their provider about a clinical condition which substantiates utilization. If the request goes to the TPharm contractor, they will forward within 24 hours to the appropriate contractor for medical review. The contractor has 30 days to respond to the beneficiary on annual reviews.

**6.3** As appropriate, the requirement for 100% prepayment review or restrictions may be removed in the face of new or updated information about the beneficiaries' clinical condition.

**6.4** If a beneficiary needs assistance with MTF/eMSM based restrictions, the TPharm contractor will facilitate a resolution with the appropriate MTF/eMSM site. The MTF/eMSM has final say whether they will re- review the case. Requirements in paragraph 6.1 do not apply to the MTF/eMSM.

## 7.0 POTENTIAL FRAUD

The contractor and TPharm contractor shall not submit these cases to the Defense Health Agency (DHA) Program Integrity (PI) office unless potential fraud is identified, such as altered prescriptions or drug receipts, or aberrant prescribing patterns by the provider. When appropriate, the contractor and TPharm contractor shall develop the case as stated in Chapter 13.

## 8.0 REPORTS

In addition to the quarterly reports, the following reports will be generated to support the

program.

## 8.1 Monitoring Reports

**8.1.1** TPharm contractor shall provide to the Government a quarterly activity report on individuals currently restricted which includes date restricted, restrictions in place, source of restriction, and any other notes necessary for monitoring compliance (number of emergent override request, compliance with restrictions, etc.). A copy of this report will be provided to the respective contractor and MTF/eMSM. (For details refer to DD Form 1423, CDRL, located in Section J of the applicable contract.)

**8.1.2** The TPharm contractor shall provide a monthly report at summary level to the MTFs/ eMSMs detailing MTF/eMSM prescribers that write for restricted beneficiaries that are not assigned to them or MTF/eMSM prescribers writing a high volume of Schedule II-V prescriptions. The TPharm contractor will also provide summary stats for MTF/eMSM pharmacies that bypass restriction requirements and dispense a prescription. The TPharm contractor will support the MTF/eMSM by providing detail reports when requested. (For details refer to DD Form 1423, CDRL, located in Section J of the applicable contract.)

## 8.2 Summary Reports

**8.2.1** The contractor (excluding MTFs/eMSMs) shall provide to the Government an annual summary status report of all beneficiaries currently in the restriction program and summary of the case history to include summary of the clinical review, the support services being provided, beneficiary restrictions, and beneficiary compliance. (For details refer to DD Form 1423, CDRL, located in Section J of the applicable contract.)

**8.2.2** The TPharm contractor shall provide a monthly report to the Government office (TRICARE Regional Office (TRO), program office (i.e., dental), or MTF/eMSM) a list beneficiaries to whom restrictions have been applied in their area. (For details refer to DD Form 1423, CDRL, located in Section J of the applicable contract.) A courtesy copy will be provided to the contractor for their region.

**8.2.2.1** Contractors with physician portals will be required to maintain a searchable database of patients currently on restriction in their secured website and make available to their network providers. These physician portals shall be compliant with HIPAA Privacy standards, HIPAA Electronic Transaction standards, and any other applicable Federal regulations.

**8.2.2.2** Prior to initial posting, the contractor will provide a preview of the location and validate the site has appropriate access restrictions.

- END -