Chapter 28 Section 2

Beneficiary Prescription Monitoring Program (PMP)

For the purpose of this section, the term "contractor" applies to the Managed Care Support (MCS) contractor.

1.0 SCOPE

1.1 This PMP is a quarterly review of all beneficiaries who received prescriptions using TRICARE benefits. 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 contractors shall designate a "reviewer". The reviewer shall be a contractor's Chief Medical Officer (CMO) or a person approved by the CMO. The reviewer shall have the appropriate credentials to review all types of claims. The reviewer shall review individuals on the quarterly list and make determinations based upon the beneficiaries' entire profile regardless of individual providers seen over the duration of the report. The reviewer shall 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 shall necessitate the contractor to develop a support plan. A support plan may be restrictions only or include case management, pain management, behavioral health, or any other contractually available services. If the plan includes restrictions, the contractor shall notify the TRICARE Pharmacy (TPharm) contractor and the TPharm contractor shall begin the process outlined in paragraph 3.2.

2.0 INITIAL REVIEW AND SUPPORT SERVICES

2.1 Each quarter, the TPharm contractor shall generate for each of the contractors, a list of all beneficiaries surpassing the current established parameters, to include the use of opioid potentiators. The parameters are based upon pharmacy's commercial best practices for identifying potential Substance Use Disorder (SUD) and doctor shopping. These parameters may evolve and are not made publicly available. The TPharm contractor shall communicate the parameters to the Government and identify when changes are necessary. The data provided to the contractors shall be divided into subsets based upon beneficiary's Primary Care Manager (PCM) assignment (Prime or TRICARE Plus) or region location (e.g., residential address of Select beneficiaries). The data shall be arranged in a two tiered report. One section shall be a summary of individuals included for the quarter and one page shall be claim level detail for the past 180 days. The report shall contain the latest status (see paragraph 2.5) reported by the contractor. The list shall also identify how many times within the past five years each beneficiary has been identified on the report. The report shall be sent to the contractors for medical review.

2.2 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 Medical contractor and shall be provided a medical review by the contractor as received to determine final status. These shall be given priority over the quarterly list and may be counted towards the minimum 20 cases per quarter (see paragraph 2.4).

2.3 The contractors 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 shall coordinate cases that need assistance from the Military Treatment Facilities (MTFs).

2.4 The contractor shall prioritize and review a minimum of 20 beneficiary cases per quarter from the quarterly list. See paragraph 2.5 for responses, and paragraph 2.6 for responses that count towards the minimum review.

2.5 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

2.6 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, Contract Data Requirements List (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 shall 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.

3.0 RESTRICTIONS

3.1 Based upon 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 shall send letters to the beneficiary. The beneficiary shall be asked to provide their primary provider preference and emergency room preference per guidelines in paragraph 3.2.1. 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 3.1.1) is implemented unless the contractor chooses to specify more stringent restrictions. See paragraphs 3.1.1 to 3.1.3 for available restriction options.

Note: The TPharm contractor system shall have 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.

3.1.1 Default Restriction Program For Purchased Care

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

3.1.1.2 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.

3.1.2 Default Restriction Program For MTF

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

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

3.1.3 Highest Level Of Restriction Available

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

3.2 To Add Beneficiary Restrictions

3.2.1 The contractor and TPharm contractor shall develop a process to communicate the determinations. The contractor shall notify the TPharm contractor regarding which beneficiaries to add to the restriction program. Notifications to the TPharm contractor to add restrictions may occur as the reviews are completed. The contractor may communicate with the TPharm contractor at any time during the review process. Upon notification, the TPharm contractor shall then start the following two letter process to refine the detail on the restrictions:

3.2.1.1 The TPharm contractor shall send a letter to the beneficiary explaining the program and medical review results. The letter shall 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 shall be provided to the appropriate contractor with jurisdiction to oversee compliance.

3.2.1.2 A notification letter shall 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 providers do not receive letters.

3.2.2 The beneficiary shall be given 14 calendar days from the date the notification letter is sent to respond with their selected options. The beneficiary shall be notified in the initial letter that no payment shall 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 shall remain in 100% prepay status review and shall 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.

3.2.3 Once the beneficiary has made the appropriate selections, the beneficiary may request a re-review for previously pended or denied claims. The beneficiary may also request a list of all pended or denied claims. The beneficiary requests are not required to be in writing. The contractor shall note the date requested and complete the review(s) within 30 days. A request for re-review shall be forwarded to the other participating contractor within 24 hours to fulfill the request.

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

3.3 While restricted, the beneficiary may need 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 shall provide in the initial notification letter an email address and phone number to support those needs. This information shall 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 shall send the information to the originating contractor for authorization to override.

3.4 To remove a beneficiary from restrictions:

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

3.4.2 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 shall notify the contractor and the beneficiary shall be removed from the program within 30 days unless the contractor indicates otherwise. The contractor may request to maintain the restriction.

3.4.3 The contractor shall provide written notification to the beneficiary of the results. If the result is removal from the program, the letter shall identify the date of removal. If the result is the not to remove, the letter shall identify the next date a review may be requested. A courtesy copy of the result shall be provided to the Government's TPharm points of contact.

4.0 RE-REVIEWS TIMELINES

4.1 The beneficiary shall 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 shall have 90 days from the date of the original notification letter (paragraph 3.2.1.2) to request an initial re-review. The contractor shall respond to the beneficiary's request for a re-review within 30 days. If there is no initial request for a re-review, the procedures in paragraph 4.2 are applicable. Being placed on the PMP restriction program is not appealable but claims denied due to restrictions in place may be appealable.

4.2 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 shall forward within 24 hours to the appropriate contractor for medical review. The contractor shall respond to the beneficiary on annual reviews within 30 days.

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

4.4 If a beneficiary needs assistance with MTF-based restrictions, the TPharm contractor shall facilitate a resolution with the appropriate MTF site. The MTF has final say whether they will re-review the case. Requirements in paragraph 4.1 do not apply to the MTF.

5.0 REPORTS

5.1 Monitoring Reports

5.1.1 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 requests, compliance with restrictions, etc.). A copy of this report shall be provided to the respective contractor and MTF. (For details refer to DD Form 1423, CDRL, located in Section J of the applicable contract.)

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

5.2 Summary Reports

5.2.1 The contractor (excluding MTFs) 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.)

5.2.2 The TPharm contractor shall provide a monthly report to the Government office (Managed Care Support Program Section (MCSPS), program office (i.e., dental), or MTF) a list of 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 shall be provided to the contractor for their region.

5.2.2.1 Contractors with physician portals shall 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 Health Insurance Portability and Accountability Act (HIPAA) Privacy standards, HIPAA Electronic Transaction standards, and any other applicable Federal regulations.

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

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