Benefits Monitoring Program (BMP)

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1. What is the Benefits Monitoring Program?

State and federal regulations require the Medicaid program to conduct surveillance and benefits utilization review to ensure the appropriate amount, scope, and duration of medically necessary services are being provided to program beneficiaries. The Benefit Monitoring Program (BMP) is in place to closely monitor program usage and to identify beneficiaries who may be potentially over utilizing or misusing their Medicaid services and benefits.

2. What is the purpose of the Benefits Monitoring Program?

- Promote quality health care;
- Promote patient safety through reduction of drug interaction and/or possible drug abuse, and duplication of medical services;
- Identify beneficiaries whose utilization patterns appear to be overutilization and/or misutilization of their Medicaid benefits;
- Analyze individual beneficiary health service utilization data;
- Improve beneficiary utilization of Medicaid services through educational contacts and monitoring;
- Improve the continuity of care and service coordination to prevent fragmentation of services; **(revised 10/1/13)** and
- Assure that beneficiaries are receiving health care services which are medically necessary and supported by evidence-based practices, thereby curtailing unnecessary costs to the program.

3. Functions of the Benefits Monitoring Program:

- Identifies beneficiaries who appear to be overusing and/or misusing covered services
- Evaluates utilization of covered services to determine whether the services are appropriate to a beneficiary's medical condition(s)
- Educates beneficiaries regarding appropriate utilization
- Monitors utilization patterns and institutes interventions to optimize program effectiveness

A. **Fraud** - The beneficiary is suspected, or has been convicted, of fraud for any one or more of the following:
    - Selling or purchasing products/pharmaceuticals obtained through Medicaid.
    - Altering prescriptions to obtain medical services, products or pharmaceuticals.
    - Stealing prescriptions/pads; provider impersonation.
    - Using another individual's identity, or allowing another individual to use your identity, to obtain medical services, products or pharmaceuticals.

B. **Misutilization of Emergency Department Services** - Criteria include but are not limited to the following:
    - More than three emergency department visits in one quarter.
    - Repeated emergency department visits with no follow-up with a primary care (or Specialist when appropriate) physician.
    - More than one outpatient hospital emergency department facility used in a quarter.
    - Repeated emergency department visits for non-emergent conditions.

C. **Misutilization of Pharmacy Services**- Criteria includes but is not limited to the following:
    - Utilizing more than three different pharmacies in one quarter.
    - Aberrant utilization patterns for drug categories listed in section 8.3 over a one-year period.
    - Obtaining more than 5 prescriptions for drug categories listed in section 8.3 of this chapter in one quarter (including emergency prescriptions).

D. **Misutilization of Physician Services** - Criteria include but are not limited to the following:
    - Utilizing more than one physician/physician extender in different practices to obtain duplicate or similar services for the same or similar health condition
    - Utilizing more than one physician/physician extender in different practices to obtain duplicate prescriptions for a drug(s) listed in the Drug Categories subsection of this chapter. (E.g. two prescriptions for Vicodin/hydrocodone written by different providers within an overlapping timeframe).
    - Utilizing covered services to obtain prescriptions for drugs subject to abuse and paying cash to obtain the drugs.

MDCH considers the following drug categories as having high potential for abuse:

- Narcotic Analgesics
- Barbiturates
- Sedative-Hypnotic, Non-Barbiturates
- Central Nervous System Stimulants/Anti-Narcoleptics
- Anti-Anxieties
- Amphetamines
- Skeletal Muscle Relaxants

6. Assigned Providers

The BMP may assign beneficiaries to specific providers. BMP Authorized Providers that may be
assigned include but are not limited to the following:

- Specific primary care physician
- Specific pharmacy
- Specific outpatient hospital
- Specific specialist physician(s)
- Specific group practice

7. All Providers Responsibility

Eligibility must be verified before providing service. BMP enrollees are indicated on the CHAMPS Eligibility Inquiry response as additional information. If the BMP Provider Restriction Indicator is "Y", the hyperlink will be activated. The hyperlink will open the BMP Restrictions page which contains BMP Authorized Provider information. If there is no provider listed, the beneficiary is restricted only by the pharmaceutical refill tolerance for that date of service. **CHAMPS BMP Authorized Provider information is only available for beneficiaries enrolled in FFS and for beneficiaries enrolled in a MHP receiving services carved out of the MHP benefit. For services provided by a MHP to a beneficiary enrolled in BMP, authorized provider information must be obtained from the MHP.**

FFS reimbursement for BMP enrollees is limited to exempt services, services provided by an active BMP Authorized Provider per the beneficiary's eligibility file, and services provided by a referred provider when all of the following are present:

- The beneficiary was referred by an active BMP Authorized Provider; and
- The referred provider has a current Benefits Monitoring Program Referral (form

MSA-1302) from the BMP Authorized Provider. Rendering (and referring when applicable) provider NPI numbers are required on claim submissions.

The monthly case management fee is ***only*** **paid** for beneficiaries with Fee-for-Service Medicaid eligibility. The state of Michigan does not offer case management services that are available with Medicaid Health Plan membership.

8. Referrals for BMP Enrollees

The BMP Authorized Primary Care Provider must complete the MSA-1302 form when referring a restricted beneficiary to other specialist providers. This form applies to beneficiaries with Medicaid FFS program eligibility. Providers must be BMP Authorized Providers in the CHAMPS system in order for prescriptions for drugs subject to abuse to be processed for payment by MDCH.

9. Discharge from BMP Authorized Provider

It is the responsibility of the BMP Authorized Provider to notify the Department in the event that a beneficiary in the BMP is discharged from their practice. The MSA-1302 form may be submitted to the BMP with a referral to a new provider. The Reason for Referral and Authorization, section 4 on the form, should state “discharged”; additional details may be included. General practice standards should be followed with regard to patient notification. A copy of the written notice to the beneficiary should be included when notifying the Department.

10. Changes in Enrollment

A beneficiary enrolled in the BMP will remain in the BMP for the minimum time period regardless of any change in enrollment status (e.g. change from fee-for-service to managed care; break in eligibility, incarceration, etc.). When a beneficiary in the BMP has a change in enrollment, responsibility for monitoring the beneficiary moves from the Department to the MHP or vice versa. When a beneficiary has a break or change in eligibility that disrupts historical data collection and review, upon regaining full Medicaid eligibility, the beneficiary will by default remain in BMP and periodic review will depend on availability of sufficient utilization data.