**REVIEWER:** Click or tap here to enter text.

**SECONDARY REVIEWER (if applicable):**Click or tap here to enter text.

**TERTIARY REVIEWER (if applicable):**Click or tap here to enter text.

**TYPE OF REVIEW:**

**FFS:** **ACO:** Choose an item. **ACO** **Requesting Data from DOH** **Referral**

**Initial Annual Targeted Follow-up Alert Audit Frequency Acuity**

**REVIEW START DATE:** Click or tap to enter a date. **REVIEW COMPLETED DATE:** Click or tap to enter a date.

**REVIEW DATE SPAN:** Click or tap here to enter text.

**MEMBER DEMOGRAPHICS:
Date of Birth:** Click or tap to enter a date.

**Institution:** Click or tap here to enter text.

**City:** Click or tap here to enter text.

**Age:** Click or tap here to enter text.

**Rural:** Choose an item. **Program Category:** Choose an item.

**Surveillance Report Date:** Click or tap to enter a date.

**ACO or Referral Requester:** Click or tap here to enter text.

**Date of Request:** Click or tap to enter a date.
**Other: Copy and Paste original referral or ACO request below when applicable and/or available:**

**I - CRITERIA SUMMARY:**

1. # Providers
2. # Pharmacies
3. # Abuse Potential Prescribers (Highest in a 2-month period)
4. # Abuse Potential Prescriptions (Highest in a 2-month period)
5. # Non-Emergent ED visits

**II - ADDITIONAL INFORMATION:**

# Unique Abuse Potential Prescribers (Per review period)

# Unique Abuse Potential Prescriptions (Per review period)

# Unique occurrences of concurrent prescribing of abuse potential medications

Other:

**III- MENTAL HEALTH: *Please notify PCP of current mental health prescriptions, if applicable.***

Mental health provider(s)/prescriber(s):

Mental health prescription(s):

**IV- DECISION:** Choose an item.Click or tap here to enter text.

**\*IF RESTRICTED, IT IS *MANDATORY* TO LIST THE FOLLOWING:**

- **Date and time of PCP approval was received:**
**- Provider (PCP) approval contact name:**
**- Provider (PCP) approval contact number:**
**- Name of provider(s)/prescriber(s) who will be listed on the restricted member’s case:**

See Restriction Files for further information.

**V. CRITERIA WORKSHEET:**

1. **PROVIDERS: ≥ 4 WITHIN 12 MONTHS TARGETED REVIEW** [ ]

**PRIMARY CARE PROVIDER(S):**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **#**  | **Provider Name** | **Taxonomy/Specialty** | **Provider Affiliation** | **Dx** | **Comments** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

**SPECIALIST(S)/SECONDARY PROVIDER(S):**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **#**  | **Provider Name** | **Taxonomy/Specialty** | **Provider Affiliation** | **Dx** | **Comments**  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

1. **PHARMACIES: ≥ 4 WITHIN 12 MONTHS TARGETED REVIEW** [ ]

**ALL PHARMACIES WITH PAID CLAIMS FOR SCHEDULED DRUGS DURING THE REVIEW PERIOD (NOT INCLUDING DOPL INFORMATION):**

|  |  |  |  |
| --- | --- | --- | --- |
| **#** | **Pharmacy Name** | **Location** | **Comments as needed** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **#**  | **Pharmacy Name** | **Location** | **Comments as needed** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**DOPL: (LIST NAMES OF PHARMACIES USED FOR SCHEDULED DRUGS THAT ARE IN ADDITION TO THE PHARMACIES LISTED IN THE TABLE ABOVE.)**

1. **PRESCRIBERS: ≥ 3 WITHIN 2 CONSECUTIVE MONTHS TARGETED REVIEW** [ ]

**ALL PRESCRIBERS OF ABUSE POTENTIAL MEDICATIONS DURING THE REVIEW PERIOD (NOT INCLUDING DOPL INFORMATION):**

1-

2-

3-

**PAID CLAIMS: List a consecutive 2-month period with the highest number of prescribers during the review period.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Months** | **Prescriber Name** | **Taxonomy** | **Prescriber Affiliation** | **Comment (include services provided)** |
|  |  |  |  |  |
|  |  |  |  |  |

Number of additional 2 consecutive month periods where criteria is met: Click or tap here to enter text.

**ALL PRESCRIBERS OF ABUSE POTENTIAL MEDICATIONS DURING THE REVIEW PERIOD ON THE DOPL REPORT THAT ARE IN ADDITION TO PAID CLAIMS:**

1-

2-

3-

**DOPL: List a consecutive 2-month period with the highest number of prescribers found on DOPL that are in addition to the Paid Claims**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Months** | **Prescriber Name** | **Taxonomy** | **Prescriber Affiliation** | **Comment (include services provided)** |
|  |  |  |  |  |

Number of additional 2 consecutive month periods where criteria is met: Click or tap here to enter text.

1. **PRESCRIPTIONS: ≥ 6 WITHIN 2 CONSECUTIVE MONTHS TARGETED REVIEW** [ ]

**LIST ALL ABUSE POTENTIAL MEDICATIONS WITH PAID CLAIMS DURING THE REVIEW PERIOD (NOT INCLUDING DOPL INFORMATION):**

1-

2-

3-

**PAID CLAIMS:** **List 2 consecutive month period with highest number of prescriptions for abuse potential medications**

|  |  |  |  |
| --- | --- | --- | --- |
| **Months** | **Rx** | **Maintenance Rx (check if yes)** | **Comments** |
|  |  |  |  |

Number of additional 2 consecutive month periods where criteria is met: Click or tap here to enter text.

**LIST ALL ABUSE POTENTIAL MEDICATIONS DURING THE REVIEW PERIOD ON THE DOPL IN ADDITION TO PAID CLAIMS:**
1-

2-

3-

**DOPL:** **List 2 consecutive month periods with the highest # of prescriptions for abuse potential medications found on DOPL in addition to Paid Claims**

|  |  |  |  |
| --- | --- | --- | --- |
| **Months** | **Rx** | **Maintenance Rx (check if yes)** | **Comments** |
|  |  |  |  |

Number of additional 2 consecutive month periods where criteria is met: Click or tap here to enter text.

**CHECK FOR CONCURRENTLY PRESCRIBED SCHEDULED DRUGS WRITTEN BY DIFFERENT PRESCRIBERS:** [ ]

Comments regarding concurrent prescriptions (List drugs and dates of concurrency, as needed for clarity): Click or tap here to enter text.

1. **ED VISITS: ≥ 5 NON-EMERGENT WITHIN 12 MONTHS TARGETED REVIEW** [ ]

**# NON-EMERGENT:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **#** | **Date** | **Facility** | **Dx** | **Dx/CPT Code** | **Rx/Comments** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

**# EMERGENT:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **#** | **Date** | **Facility** | **Dx** | **Dx/CPT Code** | **Rx/Comments** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

 Total # of visits: Click or tap here to enter text.

**EVALUATION AND SUMMARY:**

**PRE-REVIEW CRITERIA (BASELINE DATA FROM PREVIOUS REVIEW OR SURs REPORT):** (A-E): A       (≥4) B        (≥4) C        (≥3) D        (≥6) E        (≥5) N/A \_\_\_

**POST-REVIEW CRITERIA (RAW DATA WITHOUT ANALYSIS):** A        (≥4) B       (≥4) C        (≥3) D        (≥6) E        (≥5)

Explain any differences between (a) and (d) using **CRITERIA F** in SOP RES008. For any number recorded in (d), which meets or exceeds criteria threshold the member is enrolled in the Restriction Program

1. **CRITERIA A PROVIDERS:** **≥ 4 WITHIN 12 MONTHS** N/A [ ]

The number was \_\_\_. Applying Criteria F, the number has been refined to \_\_\_ due to:

Choose an item.

*Briefly explain why data was refined: (i.e. 5 PCPs. D Jones PA affiliated with Dr. Smith = 4)*

 Click or tap here to enter text.

1. **CRITERIA B PHARMACIES:** **≥ 4 WITHIN 12 MONTHS**  N/A [ ]

The number was \_\_\_. Applying Criteria F, the number has been refined to \_\_\_ due to:

Choose an item.

*Briefly explain why data was refined: (i.e. 4 Pharmacies, U of U hospital pharmacy used for discharged meds = 3)*

Click or tap here to enter text.

1. **CRITERIA C PRESCRIBERS**: **≥ 3 WITHIN 2 CONSECUTIVE MONTHS** N/A [ ]

The number was \_\_\_. Applying Criteria F, the number has been refined to \_\_\_ due to:

Choose an item.

*Briefly explain why data was refined: (i.e. 3 prescribers. Dr. Smith is affiliated with Dr. Jones = 2)*

Click or tap here to enter text.

1. **CRITERIA D PRESCRIPTIONS**: **≥ 6 WITHIN 2 CONSECUTIVE MONTHS** N/A [ ]

The number was \_\_\_. Applying Criteria F, the number has been refined to \_\_\_ due to:

Choose an item.

*Briefly explain why data was refined: (8 meds; 4 recurring meds each month are maintenance meds =1)*

Click or tap here to enter text.

1. **CRITERIA E NON-EMERGENT ED VISITS: ≥ 5 NON-EMERGENT WITHIN 12 MONTHS** N/A [ ]

The number was \_\_\_. Applying Criteria F, the number has been refined to \_\_\_ due to:

Choose an item.

*Briefly explain why data was refined: (i.e. 5 non-emergent ED visits; one was for chest pain =4)*

Click or tap here to enter text.

***The numbers listed above are the numbers that the DOH has provided to the ACO in the past. These numbers are transcribed to the first page of this review template. If the result exceeds the threshold for any one of the criteria, then the member is enrolled in the Restriction Program.***

**TARGETED REVIEW ATTESTATION:** I have reviewed member utilization in an effort to assure no extenuating diagnosis or circumstances are found in claims data that would clinically explain or justify current overutilization [ ]  Explain if needed: Click or tap here to enter text.

**FINAL RESULT: LIST THE FINAL VALUE (NUMBER) AND CHECK “MET” OR “NOT MET” FOR EACH CRITERION (A-E) BELOW**

**A    (≥4)** [ ]  **MET** [ ]  **NOT MET** Click or tap here to enter text.

**B     (≥4)** [ ]  **MET** [ ]  **NOT MET** Click or tap here to enter text.

**C     (≥3)** [ ]  **MET** [ ]  **NOT MET** Click or tap here to enter text.

**D     (≥6)** [ ]  **MET** [ ]  **NOT MET** Click or tap here to enter text.

**E      (≥5)** [ ]  **MET** [ ]  **NOT MET** Click or tap here to enter text.

**DECISION (this section is only required to be completed by DHHS Restriction):**

[ ]  **Information sent to ACO for ACO consideration of appropriateness of member’s enrollment in the Restriction Program**

[ ]  **Enroll in Restriction Program:**

Attempt member contact (date and time)

 Comment: Click or tap here to enter text.

 Comment: Click or tap here to enter text.

 Comment: Click or tap here to enter text.

[ ]  Educated member regarding specific Restriction Program Criteria:

[ ]  Educated member regarding general Medicaid utilization appropriateness:

[ ]  Discussed choice of PCP and pharmacy:

[ ]  **Restriction enrollment continues based on annual review:**

 Attempt member contact (date and time)

 Comment: Click or tap here to enter text.

 Comment: Click or tap here to enter text.

 Comment: Click or tap here to enter text.

[ ]  Educated member regarding specific Restriction Program Criteria where member continues to meet criteria:

[ ]  Educated member regarding general Medicaid utilization appropriateness:

[ ]  Discussed possible need for different choice of PCP and pharmacy due to address change (if needed):

 [ ]  Co-ordinated services with PMHP so the member has help obtaining services (as needed or possible)

 [ ]  Observed and responded to any changes of address that may require a change of pharmacy and/or PCP

[ ]  **Restriction enrollment discontinued based on annual review:**

Attempted member contact Choose an item.

Comment: Click or tap here to enter text.

Disenrollment from Restriction letter sent Choose an item.

[ ]  **Secondary Review alert** Click or tap to enter a date. **(Month/Year)**

[ ]  Educated member regarding specific Restriction Program Criteria:
[ ]  Educated member regarding general Medicaid utilization appropriateness:

[ ]  **Not Enrolled in Restriction Program:**
 [ ]  Educated member regarding general Medicaid utilization appropriateness:

[ ]  **Audit**

[ ]  **Audit Source:** Choose an item.Click or tap here to enter text.[ ]  **State and ACO in Agreement:**[ ]  **State and ACO not in Agreement:**

[ ]  **Describe the resolution of non-agreement:** Click or tap here to enter text.

 **ACO Case Management Plan:**