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## HAWAII ADMINISTRATIVE RULES

### TITLE 17

#### DEPARTMENT OF HUMAN SERVICES

##### SUBTITLE 12

###### MED-QUEST DIVISION

###### CHAPTER 1741

###### UTILIZATION CONTROL

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Historical Notes: Chapter 17-1741 is based  
substantially upon chapter 17-1350. [Eff 6/29/92;  
R 08/01/94 ]

§17-1741-1 Purpose. This chapter shall implement  
the State Plan requirements for a statewide  
surveillance and utilization control program and a  
fraud detection and investigation program.  
[Eff 08/01/94 ] (Auth: HRS §346-14; 42 C.F.R.  
§§430.10, 431.10) (Imp: 42 C.F.R. §§455.1, 456.3,  
456.4)

§17-1741-2 REPEALED. [R 09/30/13]

§17-1741-3 Surveillance and utilization review.  
To safeguard against unnecessary or inappropriate use  
of services under the medical assistance program,  
excess payments and to assess the quality of those  
services, the department shall:

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- (1) Conduct post payment reviews and audits of a statistically significant sampling of provider claims;
- (2) Compare provider and recipient utilization of services to establish statistical models of average provider and recipient utilization patterns;
- (3) Select for review those providers and recipients with exceptional utilization patterns; and
- (4) Take necessary remedial measures and corrective action to ensure the effectiveness of the program. [Eff 08/01/94 ] (Auth: HRS §346-14; 42 C.F.R. §§430.10, 431.10, 456.1) (Imp: 42 C.F.R. §§456.1, 456.3-456.6, 456.22, 456.23)

### §17-1741-4 Provider over-utilization or abuse.

- (a) If the findings of the review indicate possible abuse, the department shall conduct a full investigation.
- (b) In the event that the department is unable to determine whether the actions of a provider constitute improper medical practice, the department requests an opinion of the Hawaii Medical Association peer review committee.
- (c) When incorrect practices result in overpayment, the department shall:
  - (1) Notify the provider of any aberrances;
  - (2) Request the provider to take corrective action; and
  - (3) Establish a monitoring program of the provider's medicaid practice to ensure corrective measures have been introduced.
- (d) Any overpayment made by the medical assistance program shall require repayment by the provider. Payment on the provider's pending claims may be withheld in part or in whole to be applied to the overpayments previously made to the provider by the medical assistance program. [Eff 08/01/94 ] (Auth: HRS §346-14; 42 C.F.R. §§431.10, 456.12) (Imp: 42 C.F.R. §§455.13, 455.14, 455.15, 455.16)

§17-1741-5 Referrals to the medicaid investigations division. Referrals shall include all cases of suspected provider fraud and complaints

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alleging abuse or neglect of patients in health care facilities including misappropriation of patient's private funds in such facilities. [Eff 08/01/94 ]  
(Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 C.F.R. §§455.13, 455.15)

### §17-1741-6 Recipient over-utilization or abuse.

(a) Freedom of choice in selecting health care providers shall not include the expedient utilization or over-utilization of the community's health care providers and supplies.

(b) When a recipient over-utilizes medical services, the department shall request the recipient's voluntary cooperation in curbing abusive utilization practices and shall monitor the recipient's case for no less than six months.

(c) When a recipient has been shown to be over-utilizing controlled drugs with multiple prescriptions filled at more than one pharmacy and written by multiple prescribers, the department shall require the recipient to choose one primary care physician and one pharmacy to be the only approved providers of usual care. The department also reserves the right to ask the recipient to choose another provider if the physician is known to the department to be over-prescribing medications or medical services. Refer to section 17-1741-7 for specific details regarding restrictions.

(d) When a recipient has been determined to be using excessive medical services provided by multiple physicians, the department may assist the recipient in receiving appropriate coordinated care. As a result, the department shall ask the recipient to choose one primary care provider to coordinate all usual services for the recipient and make referrals to other providers, as needed. Refer to section 17-1741-7 for specific details regarding restrictions. [Eff 08/01/94; am 07/06/99 ] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 C.F.R. §§456.3, 456.23)

§17-1741-7 Restriction. (a) If over-utilization or abuse continues, the recipient shall be administratively restricted for no less than twenty-four months to a primary care physician who is:

(1) Of the client's choice;

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- (2) Willing to provide and coordinate services to the client; and
  - (3) Certified by the department to participate in the medical assistance program.
- (b) A recipient who over-utilizes services which are provided by psychotherapists, pharmacies and dentists shall also be restricted to those providers if necessary, to further curb recipient abuse.
- (c) The individual who is restricted shall be afforded advance notice and appeals process.
- (d) Emergency medical services shall not require the referral, assistance, or approval of the designated primary care physician.
- (e) The restricted recipient shall receive a medical authorization card bearing the designated primary care physician until:
- (1) Responsibility for care is transferred to another physician;
  - (2) The recipient requests a change in the primary care physicians and the department and the affected physician concurs; or
  - (3) Control is no longer considered necessary by the designated primary care physician and the department's medical consultant concurs.
- (f) If a recipient fails to select a primary care physician within thirty days following receipt of notice of medical service restrictions, the department shall select a physician who is in good standing with the medical program.
- (g) When a physician willing to participate as the primary care physician cannot be found, the department's medical consultant shall provide prior approval for all health service required by the restricted recipient with the exception of emergency care.
- (h) The designated physician shall:
- (1) Provide and coordinate all medical services to the client, except for emergency services;
  - (2) Make referrals for other needed health services; and
  - (3) Inform the department when the designated physician is no longer able to provide medical services to the recipient.
- (i) A recipient shall continue to be restricted to a designated provider(s) until:
- (1) There is documented evidence of that individual's compliance for at least one full year; and

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(2) The primary care physician and the department's medical consultant concur.

(j) When the decision is made to continue restriction, the recipient shall be afforded advance notice and the appeals process.

(k) The recipient whose restriction has been terminated shall be monitored for no less than twenty-four months and placed back on restriction if there is evidence of recurrent over-utilization or abuse of medicaid services during that period.

[Eff 08/01/94 ] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 C.F.R. §§456.3, 456.23)