



MISSISSIPPI DIVISION OF  
**MEDICAID**

## Administrative Code

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Title 23: Medicaid  
Part 300  
Appeals

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**Title 23: Division of Medicaid**

**Part 300: Appeals**

**Part 300 Chapter 1: Appeals**

*Rule 1.1: Administrative Hearings for Providers*

- A. According to the provisions of Section 43-13-121 of the Mississippi Code of 1972, as amended, and the applicable federal statutes and regulations, administrative hearings shall be available to providers of services participating in the Mississippi Medicaid Program. These hearings are for providers who are dissatisfied with a decision of the Division of Medicaid relating to disallowances, withholding of funds, refusals in the renewal of a provider agreement, terminations of provider agreements, suspensions of provider participation or matters relating to payment rates or reimbursement if not previously considered by the Division of Medicaid under Public Notice or Public Hearing Procedures. Administrative hearings are also available for providers who are terminated or denied enrollment for any of the reasons set forth in 42 C.F.R. § 455.416.
- B. The procedures for conducting provider administrative hearings shall be as follows:
1. Within thirty (30) calendar days after an agency decision has been made, the provider may request a formal administrative hearing. The request must be in writing and must explain the facts that support the provider's position and the reasons the provider believes he/she has complied with Medicaid regulations. Any available documentation supporting the provider's statement should be attached to the written request.
    - a) If the decision of the Division of Medicaid involves the disqualification of a provider, the Executive Director of the Division of Medicaid may suspend payments to the provider beginning with the date the provider is advised in writing the reasons for the suspension.
    - b) Unless the Division of Medicaid receives a timely and proper request for an administrative hearing from the provider, the agency decision shall not be subject to review. If the issue involves disqualification of the provider, the findings shall be final and binding unless the provider can submit documented good cause for not requesting an administrative hearing within the time and manner described above. The Executive Director of the Division of Medicaid or his/her designee will decide whether the provider has submitted documented good cause.
  2. The Executive Director of the Division of Medicaid shall notify the provider in writing by certified, return receipt mail at least thirty (30) days in advance of the date that the matter has been set for an administrative hearing. This notice period may be shortened if both parties agree.
  3. The Executive Director of the Division of Medicaid will designate a hearing officer on

behalf of the Division of Medicaid to preside over the administrative hearings conducted within the guidelines stated below:

- a) The hearing officer shall have the power to issue subpoenas, to administer oaths, to compel the attendance and testimony of witnesses, to require the production of books, papers, documents, and other evidence as required to take depositions, to preserve and enforce order during the administrative hearing, and to do all things conformable to law and Medicaid regulations which may be necessary to enable him/her to effectively discharge his/her duties as hearing officer.
  - b) The hearing officer shall be authorized to call informal, status, or pre-hearing conferences and to invite stipulations by and between the parties. The administrative hearing shall be held at the Division of Medicaid's main office, unless otherwise designated.
4. The provider may, at his/her discretion, be assisted and represented by counsel, examine any evidence or witnesses presented at the administrative hearing, and present evidence and witnesses of his/her own. All witnesses shall be sworn in prior to testifying. Any presentations made or evidence presented at the administrative hearing pursuant to these rules and procedures are subject to the judgment of the hearing officer that said presentations or evidence are pertinent or relevant to the case and are not redundant in nature.
  5. The Division of Medicaid will provide a court reporter and/or a tape recorder to make an accurate record of the administrative hearing procedures. The administrative hearing shall be conducted in an informal manner but consistent with courtroom practices and procedures.
  6. After all witnesses have been heard and all evidence has been presented, the hearing officer shall, as soon as possible, but not more than sixty (60) days, review the evidence and record of the proceedings and, based on the facts as he/she determines them to be, prepare a written summary of his/her findings and make a written recommendation to the Executive Director of action to be taken by the Division of Medicaid. This could include, but is not limited to, one or more of the following:
    - a) Evidence presented did not, in his/her opinion, substantiate the agency decision and that no action should be taken against the provider. If the case involves issues of reimbursement, that it either be recommitted to the appropriate Medicaid staff for further consideration based on the documentation or evidence presented during the course of the administrative hearing; or recommended to the Executive Director that the matter be administratively reconsidered.
    - b) Evidence presented was, in his/her opinion, sufficient to substantiate the agency decision. If the matter relates to the possible suspension or probation of a provider or the refusal to renew a provider agreement, then the hearing officer may recommend appropriate action that might include, but is not limited to, one or more of the

following:

- 1) That the provider be required within sixty (60) days from receipt of the final administrative decision to refund the amount determined to be due the Division of Medicaid, plus any interest allowable under state law, and that if the provider refuses to make full restitution, proper civil recovery action be taken.
  - 2) That the provider be suspended as a provider of Medicaid services for a specified period of time with a follow-up review to be made to determine if the suspension is to be lifted.
  - 3) That the provider be placed on probation for a specified period of time with proper monitoring of the provider's Medicaid activities to be conducted during the period of probation to determine if the probation should be lifted or if further sanctions are warranted.
- c) Evidence presented was, in his/her opinion, sufficient to substantiate the agency decision. If the matter relates to the disqualification of a provider or the refusal to renew a provider agreement, then the hearing officer may recommend that the provider be disqualified as a provider of Medicaid services.
7. The recommendations of the hearing officer shall be in writing and shall contain findings of fact and a determination of the issues presented. The recommendation of the hearing officer in this form shall be submitted to the Executive Director of the Division of Medicaid for further review and decision.
  8. The Executive Director of the Division of Medicaid, upon a review of the proceedings and the recommendation of the hearing officer, shall issue a final administrative decision. The Executive Director may sustain and adopt the recommendations of the hearing officer, reject the same and have a decision prepared based on the record, or remand the matter to the hearing officer to take additional testimony and evidence. In the last instance, the hearing officer thereafter shall submit to the Executive Director of the Division of Medicaid a new recommendation.
  9. If the case does not involve a reimbursement issue and the Executive Director concludes that the provider shall be disqualified or substantiates the declination of the agency to renew a provider agreement with the provider, the provider may be disqualified at the direction of the Executive Director of the Division of Medicaid. Should the Executive Director disqualify a provider, all claims held in abeyance will be handled according to the directive of the Division of Medicaid. Payment will not be allowed toward any claims submitted by said provider for services rendered on or after the date of disqualification. The Executive Director may disqualify a provider permanently or for such other period as the Executive Director may deem proper, and the decision of the Executive Director is final, subject only to judicial review by the courts. The Executive Director may assess all or any part of the costs of the administrative hearing to the provider if the provider is unsuccessful in overturning the agency decision or the final

administrative decision, if appealed to a court of proper jurisdiction.

10. Any specific matter or grievance necessitating an administrative hearing or an appeal not otherwise provided under agency rules shall be afforded under the Administrative Hearing Procedures for Providers as outlined in this section. If the specific time frames of such a unique matter relating to the requesting, granting, and concluding of the hearing is contrary to the time frames as set out in the general administrative procedures above, the specific time frames will then govern over the time frames as set out within these procedures.
11. Appeal of a final administrative decision must be filed in a court of proper jurisdiction within sixty (60) days after the date that the Division of Medicaid has notified the provider by certified mail sent to the proper address of the provider on file with the Division of Medicaid and the provider has signed for the certified mail notice, or sixty (60) days after the date of the final decision if the provider does not sign for the certified mail notice.

Source: 42 C.F.R. § 455.422; Miss. Code Ann. § 43-13-121.

History: Revised eff. 10/01/2016; Revised eff. 11/01/2013.

*Rule 1.2: Administrative Hearings - Eligibility Decisions*

- A. The Mississippi Medicaid Law governing the administration of medical assistance makes provision under Section 43-13-116 of the Mississippi Code of 1972, as amended, for fair and impartial hearings in full implementation of the Federal statutory and regulatory requirements. Any person whose claim for assistance is denied or not acted upon promptly may request a hearing from the Division of Medicaid, if the Division of Medicaid is the determining agency.
- B. The Social Security Administration is the Federal agency charged with the responsibility of determining who is eligible for Supplemental Income (SSI). In Mississippi, individuals who are eligible for SSI are automatically eligible for Medicaid. Applicants who are denied SSI are also denied Medicaid. Beneficiaries whose entitlement to SSI is terminated also lose Medicaid. These individuals denied or terminated from SSI may apply for Medical Assistance Only provided the application qualifies under one (1) of the Medicaid only coverage groups covered by the Medicaid regional offices.
- C. If an SSI applicant or beneficiary disagrees with the decision to deny or terminate SSI benefits, the individual must contact the Social Security office that issued the adverse decision. A request for a hearing must be made with the Social Security Administration when the issue to be determined is SSI benefits and automatic Medicaid eligibility.
- D. The Division of Medicaid is the State agency charged with the responsibility of determining Medicaid eligibility for families, children, pregnant women and aged, blind and disabled individuals who do not qualify for SSI. If an applicant's application for Medicaid as

determined by the Division of Medicaid is disapproved or a decision is made to terminate or reduce a beneficiary's benefits under any Division of Medicaid program, and he/she disagrees with the decision, the individual may request a local and/or state hearing by contacting the Regional Office that made the decision or by contacting the Division of Medicaid State Office. Hearing requests must be made in writing within thirty (30) days of the adverse action to deny, terminate or reduce Medicaid benefits. All adverse action notices issued to applicants or beneficiaries contain their appeal rights and explain how to request a hearing.

- E. The Department of Human Services (DHS) is the State agency charged with the responsibility of determining Medicaid eligibility for foster children in the custody of DHS. In the event DHS denies, terminates or reduces the Medicaid benefits of a foster child, DHS is the agency responsible for handling the appeals of such adverse actions.

Source: Miss. Code Ann. § 43-13-121

*Rule 1.3: Administrative Hearings for Beneficiaries*

- A. In accordance with Section 43-13-116 of the Mississippi Code of 1972, as amended, and 42 CFR 431.200 et. seq., the Division of Medicaid provides beneficiaries the opportunity to request a fair hearing in order to appeal decisions of denial, termination, suspension or reduction of Medicaid covered services.
- B. If a decision is made to reduce, deny, suspend or terminate covered services provided to a Medicaid beneficiary, and the beneficiary disagrees with the decision, the beneficiary and/or his/her legal representative must request a hearing in writing within thirty (30) days of the notice of adverse action.
- C. The Division of Medicaid is not required to grant an administrative hearing if the sole issue is a federal or state law requiring an automatic change adversely affecting some or all beneficiaries.
- D. When an ongoing course of treatment is at issue, services will be maintained at the previous level during the appeals process.
- E. The Division of Medicaid may deny or dismiss a request for a hearing if the beneficiary and/or legal representative withdraws the request in writing or fails to appear at a scheduled hearing without good cause.
- F. The case shall be heard by an impartial hearing officer employed by or on contract with the Division of Medicaid. Hearing officers will be individuals with appropriate expertise and who have not been involved in any way with the action or decision on appeal in the case.
- G. When feasible the case will be evaluated by an appropriate independent review professional in the same or a similar specialty as would typically manage the case being reviewed, or another healthcare professional. In no case shall the review professional have been involved

in the initial adverse determination.

- H. Before the hearing, the beneficiary and/or his or her legal representative will be provided a copy of the case file that will be used at the hearing in support of the adverse decision.
- I. The hearing will be held by telephone unless, at the hearing officer's discretion, it is determined that an in-person hearing is necessary.
- J. The final hearing decision shall be rendered by the Executive Director of the Division of Medicaid based solely on the evidence produced at the hearing and the case record. The Division of Medicaid must take final administrative action on a hearing within ninety (90) days from the date the initial appeal request was received.

Source: Miss. Code Ann. § 43-13-121

*Rule 1.4: Provider Peer Review Protocol*

A. The Division of Medicaid defines:

- 1. Administrative Hearing as a trial-like proceeding before the Division of Medicaid at which evidence and testimony may be offered.
- 2. Corrective Action Plan (CAP) as documentation for implementing activities structured to remedy a problem which includes a specific time frame for the remedy to be implemented and what will happen if the problem is not resolved. [Refer to Miss. Admin. Code Part 305]
- 3. Demand Letter as notification that a provider is required to refund improper payments.
- 4. Peer Review as a retrospective review of medical records by the Division of Medicaid's Utilization Review/Quality Improvement Organization (UM/QIO) to assess if:
  - a) Services and items were reasonable and medically necessary;
  - b) The quality of services met professionally recognized standards of health care;
  - c) The beneficiary received the appropriate health care in a safe, appropriate and cost-effective setting based on the beneficiary's diagnosis and severity of the symptoms;
  - d) Services were provided economically and only when and to the extent they were medically necessary; and
  - e) The utilization billing and coding practices and/or overall utilization patterns of a provider for beneficiaries being reviewed are appropriate.
- 5. Peer Review Consultant as the medical reviewer in a comparable specialty as the

healthcare practitioner or a certified professional coder (CPC) when appropriate.

6. Reconsideration Review as an impartial review of the case by a Peer Review Consultant not involved in the initial Peer Consultant Review determination.
- B. Mississippi Medicaid providers have the following obligations and must ensure that the services or items are:
1. Provided economically and only when and to the extent they are medically necessary,
  2. Of a quality that meets professionally recognized standards of health care,
  3. Supported by the appropriate documentation of medical necessity and quality,
  4. Provided when no other effective and more conservative or substantially less costly treatment, service and/or setting are available,
  5. Not solely for the convenience of the beneficiary or the family, or for the convenience of the provider, and/or
  6. Not primarily custodial care unless custodial care is a covered service.
- C. Providers with a possible violation of one (1) or more of the obligations listed in Miss. Admin. Code Part 300, Rule 1.4.A. are referred to the fee-for-service (FFS) Utilization Management/Quality Improvement Organization (UM/QIO) to perform a peer consultant review that consists of the following four (4) levels:
1. Level I - Peer Review,
  2. Level II - Request for Reconsideration Review,
  3. Level III - Administrative Hearing, and
  4. Level IV - Sanctions.
- D. All correspondence regarding findings, decisions or other documents pertaining to Peer Reviews will be sent to the provider by certified mail, restricted delivery, return receipt requested.
- E. Level I Peer Review proceeds as follows:
1. A Peer Review Consultant is selected by the Medical Director of the UM/QIO, or designee, when a referral is received from the Division of Medicaid.
    - a) The selection process of the Peer Review Consultant ensures that the Peer Review Consultant practices in a comparable specialty as the provider and that the Peer

Review Consultant's objectivity and judgment will not be affected by personal bias for or against the subject provider or by direct economic competition or cooperation with the provider.

- b) The Division of Medicaid will provide records relevant to the possible violation to the Peer Review Consultant.

2. Peer Review Consultant findings consist of one (1) of the following:

- a) No violation of obligations.

- 1) The Division of Medicaid is notified in writing by the UM/QIO Contract Administrator of the findings, action recommended, the records relied upon to make the recommendation, and the Peer Review Consultant's notes.
- 2) The Division of Medicaid will make a final decision based on the Peer Review Consultant's recommendation, and the provider will be notified.

- b) A potential violation of obligations.

- 1) The Division of Medicaid is notified in writing by the UM/QIO Contract Administrator of the findings, action recommended, the records relied upon to make the recommendation, and the Peer Review Consultant's notes.
- 2) The Division of Medicaid's Program Integrity Office Director, or designee, will notify the provider of the findings of the Peer Review Consultant.
- 3) The provider must submit a written statement to the Division of Medicaid within thirty (30) calendar days of receipt of the findings notification indicating whether the provider agrees or disagrees with the findings.
- 4) If the provider agrees with the findings, the Division of Medicaid will send a Demand Letter and a Corrective Action Plan (CAP).

- (a) The provider must sign and return the CAP within ten (10) business days after receipt of the Demand Letter and CAP.

- (b) The CAP will include at a minimum:

- (1) The specific obligations violated,
- (2) The specific elements of the CAP that address correction of the behavior that led to the violation(s),
- (3) The duration of the CAP which must be greater than ninety (90) calendar days, and

- (4) The means by which compliance with the CAP will be monitored and assessed.
  - (c) If the provider fails to submit the signed CAP to the Division of Medicaid within (10) business days after receipt of the Demand Letter and CAP, a sanction may be imposed on the provider.
  - (d) The UM/QIO Medical Director, or designee, and the Peer Review Consultant will monitor the signed CAP.
  - (e) Within thirty (30) calendar days of the receipt of a completed CAP, the Peer Review Consultant will determine if the provider complied with the CAP and whether or not the CAP was effective.
  - (f) If the CAP was effective and the provider has met all obligations, the Division of Medicaid will notify the provider that the review is closed.
  - (g) If the CAP was not effective and the provider is deemed to be continuing to violate obligations, the provider is subject to a sanction.
- 4) If the provider disagrees with the findings of the Peer Review Consultant, the provider may request a Reconsideration Review.
- c) A gross and flagrant violation of obligation such that the life and welfare of the provider's beneficiaries are in jeopardy, the provider is subject to immediate suspension.

F. Level II Reconsideration Review is as follows:

1. The provider may submit a request for a Level II Reconsideration Review to the Division of Medicaid within thirty (30) calendar days of receipt of the Level I findings notification.
2. The Reconsideration Review request must include the reason for the request, pertinent medical documentation, or other information to justify the need for reconsideration.
3. The UM/QIO will select a different Peer Review Consultant, who practices in a comparable specialty, to obtain a second opinion.
4. The Reconsideration Review will include the findings of the initial Peer Review Consultant.
5. The Division of Medicaid is notified in writing by the UM/QIO Contract Administrator of the findings, action recommended, the records relied upon to make the recommendation, and the Peer Review Consultant's notes.

6. The Division of Medicaid will notify the provider of the results of the Reconsideration Review which will be one (1) of the following:
  - a) No violation of obligations and the review is closed, or
  - b) Violation of obligations affirmed and a Demand Letter and CAP are sent to the provider.
7. If the provider disagrees with the findings of the Reconsideration Review, the provider may request a Level III Administrative Hearing. [Refer to Miss. Admin. Code Part 300, 1.4.G.]
8. If the provider does not request an Administrative Hearing, the Division of Medicaid will proceed with the appropriate administrative action outlined in the Demand Letter.

G. Level III Administrative Hearings are conducted as outlined in Miss. Admin. Code Part 300.

H. Level IV Sanction is as follows:

1. The Executive Director of the Division of Medicaid, upon review of the record, proceedings, and recommendation of the Division of Medicaid Administrative Hearing Officer and/or Peer Review Consultant, will render a final written decision whether or not to impose sanctions, which may include disqualification from the Medicaid program for a limited period or permanently
2. The Executive Director of the Division of Medicaid will notify the provider of the intent to impose a sanction by sending a notice containing the following:
  - a) The authority and responsibility afforded the Division of Medicaid under Miss. Code Ann. Section 43-13-121;
  - b) The obligation(s) violated;
  - c) The situation, circumstance, or activity that resulted in the violation;
  - d) A summary of the information used in arriving at the determination to initiate sanction; and
  - e) Notice that the Division of Medicaid will impose the sanction(s) within thirty (30) calendar days of the date of provider's receipt of the notice unless the provider requests an Administrative Hearing within thirty (30) calendar days of the receipt of the notice.
3. The Executive Director may assess all or any part of the cost of implementing the sanction protocol to the provider.

4. The Executive Director's decision is a final administrative decision.

Source: 42 U.S.C. Section 1320c *et seq.*; 42. C.F.R. § 455 Subpart A; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 01/01/2020.

*Rule 1.5: Review for Medical Necessity and/or Independent Verification and Validation (IV&V)*

- A. Inpatient hospital providers may request an Administrative Appeal when the provider is dissatisfied with final administrative decisions of the Division of Medicaid relating to disallowances as a result of a review for medical necessity or Independent Verification and Validation (IV&V) decision described in Miss. Admin. Code Part 202, Rule 1.18.A.
- B. Inpatient hospital providers must comply with the appeal provisions in Miss. Admin. Code Part 300, Rule 1.1.

Source: Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: New eff. 09/01/2014.

**Chapter 2: Beneficiary Right to Appeal and Fair Hearing**

*Rule 2.1: Appeal Rights*

- A. At the time of any action affecting an applicant or recipient's claim for assistance, the applicant or recipient must be:
  - 1. Informed of his right to a fair hearing;
  - 2. Notified of the method by which he may obtain a hearing, and
  - 3. Informed of his right to represent himself at the hearing or to be represented by an authorized person such as an attorney, relative, friend, or other spokesperson.
- B. The agency must grant the opportunity for a fair hearing to any applicant or recipient who requests it because his claim for medical assistance is denied or not acted upon with reasonable promptness or because he believes that the agency has taken an action erroneously. A hearing request made in connection with a rebuttal prior to any adverse action being taken will not be accepted. The agency need not grant a hearing when the sole issue is a federal or state law requiring an automatic change which adversely affects some or all recipients.

Source: 42 C.F.R. § 431.205.

History: New Rule moved from Miss. Admin. Code Part 100 eff. 08/01/2020.

*Rule 2.2: Notification Regarding Appeal Rights*

- A. If an interview is conducted, the right to appeal must be discussed with the applicant/recipient. In addition, individuals are notified of appeal rights by statements included on the ABD and FCC application forms and on all notices. A hearings pamphlet is included with adverse action notices informing clients of the right to appeal and providing other information about the hearings process. These pamphlets are also available for distribution in regional offices.

Source: 42 C.F.R. § 431.210; Miss. Code Ann. § 43-13-121.

History: New Rule moved from Miss. Admin. Code Part 100 eff. 08/01/2020.

*Rule 2.3: Hearings Defined*

- A. A fair hearing is an orderly, but informal meeting in which a client or his representative is afforded an opportunity to address an impartial hearing officer for the purpose of presenting oral testimony and/or evidence of his entitlement to medical assistance and services.
- B. The applicant or recipient has the right of confrontation and cross-examination as described further in this section.
- C. A fair hearing is a de novo hearing which means it starts over from the beginning. A new determination of the client's eligibility is made based on all the evidence that can be secured, without regard to whether the evidence was available at the time the regional office took action. Thus, the process is not essentially different from a determination of eligibility.

Source: 42 CFR § 431.201.

History: New Rule moved from Miss. Admin. Code Part 100 eff. 08/01/2020.

*Rule 2.4: Types of Hearings*

- A. The client or his representative may request to present an appeal through a local-level hearing, a state-level hearing, or both. In an attempt to resolve issues at the lowest level possible, offices should encourage clients to request a local hearing first. The only exception to requesting a local hearing is when the issue under appeal involves disability, blindness or level of care. Therefore, the actions below which involve medical decisions cannot be addressed in a local hearing. A state hearing must be requested for:
1. A disability or blindness denial, or termination, or
  2. A level of care denial or termination for a Disabled Child Living at Home.

B. Local and/or state level hearings will be held by telephone unless, at the discretion of the hearing officer, it is determined that an in-person hearing is necessary.

Source: Miss. Code Ann. § 43-13-116.

History: New Rule moved from Miss. Admin. Code Part 100 eff. 08/01/2020.

*Rule 2.5: Handling Local Hearing Requests*

A. An appeal will ordinarily be filed in the regional office responsible for the adverse decision or delay in action. If the client has moved to another regional office's jurisdiction at the time the appeal is made, it is possible for the regional office serving the client's current county of residence to act for the former regional office. However, the hearing officer may request the participation of staff in the regional office where the action was originally taken if necessary or advisable.

Source: Miss. Code Ann. § 43-13-116.

History: New Rule moved from Miss. Admin. Code Part 100 eff. 08/01/2020.

*Rule 2.6: Representation*

A. The request for a state or local hearing must be made in writing by the client or his legal representative.

B. "Legal representative" includes the client's authorized representative, an attorney retained to represent the client, a paralegal representative with a legal aid service, the parent of a minor child (if the client is a child), a legal guardian or conservator or an individual with power of attorney for the client.

C. The client may be represented by anyone he designates. If the client elects to be represented by someone other than a legal representative, he must designate the person in writing. If a person, other than a legal representative, states that the client has designated him as the client's representative and the client has not provided written verification to this effect, the regional office will ask the person to obtain written designation from the client.

Source: 42 C.F.R. § 431.206.

History: New Rule moved from Miss. Admin. Code Part 100 eff. 08/01/2020.

*Rule 2.7 Oral Hearing Requests*

A. An oral request for a hearing must be put in written form. When an oral request is made, the specialist will inform the client that the request must be put in a letter or signed statement and mailed to the regional office or the specialist will mail the appropriate hearing request form, i.e., DOM 350, Request for Local Hearing, or DOM 352, Request for State Hearing, to the

client for signature and return.

- B. A hearing will not be scheduled until a written request is received by either the regional or state office.

Source: Miss. Code Ann. § 43-13-116.

History: New Rule moved from Miss. Admin. Code Part 100 eff. 08/01/2020.

*Rule 2.8: Written Hearing Requests*

- A. A simple statement requesting a hearing that is signed by the client or his legal representative is sufficient; however, if possible, the client should state the reason for the request.
- B. The written request may be mailed to the regional office or state office. If the letter does not specify the type of hearing desired, the specialist will contact the person making the request to determine whether a local or a state hearing is being requested. If contact cannot be made within three (3) days of receipt of the hearing request, the regional office will assume a local hearing is requested and schedule accordingly.
- C. If the hearing involves a medical decision, which requires that a state hearing be held or if a state hearing is requested, the request will be forward to the Bureau of Appeals.

Source: 42 C.F.R. § 431.201.

History: New Rule moved from Miss. Admin. Code Part 100 eff. 08/01/2020.

*Rule 2.9: Hearing Requests Made In Person*

- A. The client may come to the regional office or meet with a specialist in person to request a hearing. The specialist must first determine what level of hearing, local or state, is desired.
- B. If a state level hearing is required because the hearing request is based on a medical decision, this will be explained to the client. Otherwise, if the client is unsure of the type hearing desired, the specialist will explain the difference between the two levels of appeal and explain a state hearing may still be available if the local hearing decision is not favorable. The specialist will assist the client in completing the appropriate form, DOM-350 or DOM 352, whichever is applicable. If a state hearing is required or requested, the specialist can assist in mailing the request to state office or the client may choose to mail it himself.

Source: Miss. Code Ann. § 43-13-116.

History: New Rule moved from Miss. Admin. Code Part 100 eff. 08/01/2020.

*Rule 2.10: Appeal By Both Members Of A Couple*

- A. When both members of an eligible couple wish to dispute the action or inaction of the regional office that affects both applications and cases similarly and arose from the same issue, one or both members may file the request for a hearing. The couple will be assured that both may present evidence at the hearing and that the agency's decision will be applicable to both.
- B. If both file a hearing request, two hearings will be registered, but they will be conducted on the same day and in the same place, either consecutively or jointly, according to the wishes of the couple. If it is their wish for only one of them to attend the hearing, this is permissible.

Source: Miss. Code Ann. § 43-13-116.

History: New Rule moved from Miss. Admin. Code Part 100 eff. 08/01/2020.

*Rule 2.11: Time Limit For Filing A Hearing Request*

- A. The client has thirty (30) days from the date the appropriate notice is mailed to request either a local or state hearing. This thirty (30) day filing period may be extended if the client can show good cause for not filing within thirty (30) days.
- B. Good cause includes, but may not be limited to, illness, failure to receive the notice, being out of state, or some other reasonable explanation. If good cause can be shown, a late hearing request may be accepted, provided the facts in the case remain the same. However, if a client's circumstances have changed or if good cause for filing a request beyond thirty (30) days does not exist, a hearing request will not be accepted. If the client wishes to have his eligibility reconsidered, he may reapply.

Source: Miss. Code Ann. § 43-13-116.

History: New Rule moved from Miss. Admin. Code Part 100 eff. 08/01/2020.

*Rule 2.12: Timeframe for Holding Local or State Hearings*

The Division of Medicaid must take final administrative action on a hearing, whether state and/or local, within ninety (90) days of the date of the initial request for a hearing. Although regulations allow ninety (90) days, the agency will make every effort to hold hearings promptly and render decisions in a shorter timeframe.

Source: Miss. Code Ann. § 43-13-116.

History: New Rule moved from Miss. Admin. Code Part 100 eff. 08/01/2020.

*Rule 2.13: Scheduling the Hearing*

- A. If a local hearing is requested the regional office will notify the client or representative in writing of the time and date of the local hearing. If a state hearing is requested, the hearing

facilitator assigned to the case will notify the appropriate person in writing of the time and date of the state hearing. The notice scheduling the time and date of a state or local hearing must be mailed to the client at least five (5) days before the day the hearing is scheduled. A hearing pamphlet will be included with the letter scheduling either a local or state hearing.

Source: Miss. Code Ann. § 43-13-116.

History: New Rule moved from Miss. Admin. Code Part 100 eff. 08/01/2020.

*Rule 2.14: Attendance at the Hearing*

A state or local hearing is not open to the public. All persons attending the hearing will attend for the purpose of giving information on behalf of the claimant or rendering him assistance in some other way, or for the purpose of representing the Division of Medicaid. All persons attending the hearing will be asked to give information pertinent to the issues under consideration.

Source: Miss. Code Ann. § 43-13-116.

History: New Rule moved from Miss. Admin. Code Part 100 eff. 08/01/2020.

*Rule 2.15: Withdrawn or Abandoned Hearings*

- A. The hearing process is initiated by a written request and can be terminated only by a written statement in which the client or representative withdraws the request for a hearing.
- B. A state or local hearing request may be withdrawn at any time prior to the scheduled hearing or after the hearing is held, but before a decision is rendered. As indicated, the withdrawal must be in writing and signed by the client or representative.
- C. A hearing request will be considered abandoned if the client or representative fails to appear or is unavailable for a scheduled hearing without good cause. If no one is available for a hearing, the appropriate office will notify the client in writing that the hearing is dismissed unless good cause is shown for not attending. Following failure to appear for a hearing, the proposed adverse action will be taken on the case if the action is not already in effect.

Source: Miss. Code Ann. § 43-13-116.

History: New Rule moved from Miss. Admin. Code Part 100 eff. 08/01/2020.

*Rule 2.16: Rights of the Client*

The client or his representative has the following rights in connection with a local or state hearing:

- A. The right to examine at a reasonable time before the date of the hearing and during the hearing the contents of the applicant or recipient's case record. The right to have legal

representation at the hearing and to bring witnesses.

- B. The right to produce documentary evidence and establish all pertinent facts and circumstances concerning eligibility.
- C. The right to present an argument without undue interference and to question or refute testimony or evidence, including an opportunity to confront and cross-examine adverse witnesses.

Source: Miss. Code Ann. § 43-13-116.

History: New Rule moved from Miss. Admin. Code Part 100 eff. 08/01/2020.

*Rule 2.17: Group Hearings*

- A. A group hearing can be held for a number of clients under the following circumstances:
  - 1. The Division of Medicaid may consolidate the cases and conduct a single group hearing when the only issue involved is one of a single law or agency rule.
  - 2. The clients may request a group hearing when there is one issue of agency rule common to all of them.
- B. In all group hearings, whether initiated by the Division of Medicaid or by the clients, the policies governing fair hearings must be followed.
  - 1. Each individual client in a group hearing must be permitted to present his own case and be represented by his own lawyer or withdraw from the group hearing and have his appeal heard individually.
  - 2. As in individual hearings, the hearing will be conducted on the issue being appealed, and each client is expected to keep his testimony within a reasonable time as a matter of consideration to the other clients involved.

Source: Miss. Code Ann. § 43-13-116.

History: New Rule moved from Miss. Admin. Code Part 100 eff. 08/01/2020.

*Rule 2.18: SSI Recipients*

- A. In Mississippi, persons who are eligible for SSI are automatically eligible for Medicaid. If an SSI applicant or recipient disagrees with the decision to deny or terminate SSI benefits, the individual must contact the Social Security Office which issued the adverse action.
- B. Social Security handles appeals when the issue is SSI benefits and automatic Medicaid eligibility.

Source: Miss. Code Ann. § 43-13-116.

History: New Rule moved from Miss. Admin. Code Part 100 eff. 08/01/2020.

*Rule 2.19: Continuation of Benefits*

If a client or representative requests a hearing within the advance notice period, benefits must be continued or reinstated to the benefit level in effect prior to the planned adverse action.

- A. **Timely Request for Continuation of Benefits.** To determine if the request for continuation of benefits is timely, the request must be received by the regional office within twelve (12) days from the notice date. This twelve (12) day period includes the ten (10) day adverse action period plus two (2) days mailing time. If a hearing is requested by telephone, the client must be advised to put the request in writing prior to the end of the specified period. Any hearing requested or dated after this period will not be accepted as a timely request for continuation of benefits.
- B. **Continuation of Benefits When Local Decision is Adverse.** The client may request a state hearing if the local hearing is adverse. If benefits have been continued pending the local hearing, then benefits will continue pending a state hearing decision provided the request for the state hearing is made within fifteen (15) days of the date on the Notice of Local Hearing Decision.
- C. **Agency Action Upheld in Final Hearing Decision.** When the final hearing decision is adverse to the client, the specialist will terminate or reduce the continued benefits using the original reason for the adverse action. A second (2nd) Notice of Adverse Action is not required.
- D. **The Division of Medicaid has the right to initiate recovery procedures against the client to recoup the cost of any medical services furnished the client under Medicaid and CHIP premiums paid by the Division of Medicaid on behalf of CHIP children, to the extent they were furnished solely based on the provision for continuation of benefits.**

Source: Miss. Code Ann. § 43-13-116.

History: New Rule moved from Miss. Admin. Code Part 100 eff. 08/01/2020.

*Rule 2.20: Local Hearings*

- A. The regional office is responsible for completing a supervisory review of the action under appeal and for preparing the state hearing record. The office is responsible for all activities involved in the local hearing process and for taking appropriate action on the case at the end of the hearing process. The purpose of a local hearing is to provide an informal proceeding to allow the client or representative to:
  - 1. Present new or additional information;

2. Question the action taken on the client's case, and
  3. Hear an explanation of eligibility requirements as they pertain to the client's situation.
- B. When a request for a local hearing is received, the local hearing will be scheduled no later than twenty (20) days after receipt of the request. The client will be allowed time to obtain additional information or request an attorney, relative or friend to attend the hearing and give evidence. A local hearing must not be scheduled without giving five (5) days advance notice to the client unless the client waives advance notice time.
  - C. The regional office staff member who conducts the hearing must be one who has not participated in determining eligibility or directed the decision.
  - D. After a local hearing is held, the person who conducted the hearing will prepare a summary of the hearing procedure. The summary serves the same purpose as a transcript and is filed in the case record. The summary of the local hearing must be included as part of the state hearing record when the client requests a state hearing after an adverse local hearing decision. The local hearing summary must contain sufficient information to enable the state hearing officer to have a clear understanding of what transpired during the local hearing.
  - E. When a decision has been reached, the client must be notified of the decision and advised of the right to request a state hearing.
  - F. If the local hearing decision is unfavorable to the clients, the new effective date of closure or reduced benefits must be included on the notification if continuation of benefits applied during the hearing process. The new effective date of closure or reduced benefits must include an effective date at the end of the fifteen (15) day advance notice period. A second (2nd ) Notice of Adverse Action is not required;
  - G. However, if a state hearing is subsequently requested within the fifteen (15) day advance notice period and continuation of benefits is applicable, the state office will notify the client of the new effective date of closure, reduced benefits or other revised eligibility dates in the state hearing decision letter.
  - H. Any corrective action that is required must be taken as a result of a local or state hearing decision rendered in the client's favor or for processing the originally-planned action on the case that was the basis for the appeal and continuation of benefits applied pending the hearing decision.

Source: Miss. Code Ann. § 43-13-116.

History: New Rule moved from Miss. Admin. Code Part 100 eff. 08/01/2020.

*Rule 2.21: State Hearing After Adverse Local Decision*

- A. The client has the right to appeal a local hearing decision by requesting a state hearing; however, the state hearing request must be made in writing within fifteen (15) days of the mailing date of the local hearing decision. This means the state hearing request must be received by the regional office or state office on or before the fifteenth (15th) day after the local hearing notice is mailed.
- B. If the state hearing request is made orally, then the claimant must be informed that the request must be put into writing and received within the allotted fifteen (15) day time period. If benefits have been continued pending the local hearing decision, then benefits will continue throughout the fifteen (15) day advance notice period when the local hearing decision is adverse.
- C. If a state hearing is requested timely within the fifteen (15) day period, then benefits will continue pending the outcome of the state hearing. State hearings requested after the fifteen (15) day advance notice period for the local hearing will not be accepted unless the thirty (30) day period for filing a hearing request has not expired because the local hearing was held early in the thirty (30) day period and there is time remaining.

Source: Miss. Code Ann. § 43-13-116.

History: New Rule moved from Miss. Admin. Code Part 100 eff. 08/01/2020.

*Rule 2.22: State Hearings*

- A. A state hearing is assigned to an impartial hearing officer. Impartial means the hearing officer has not been involved in any way with the action or decision under appeal who
  - 1. Reviews the local office's action;
  - 2. Schedules the hearing;
  - 3. Holds the hearing and provides the following explanations to those in attendance:
    - a) The hearing will be recorded and a copy of the recording made available to the client upon request.
    - b) The reason for the hearing, i.e., the action taken by the regional office which prompted the appeal.
    - c) The client's rights and the purpose of the hearing.
- B. The actual case record must be available for review by the client or representative before, during or after the state hearing.
- C. The final hearing decision will be rendered by the Executive Director of the Mississippi Division of Medicaid on the basis of the facts discussed at the hearing and the claimant will

be notified in writing of this decision.

- D. All persons representing the claimant and those representing the regional office will have the opportunity to state all facts pertinent to the appeal.
- E. If additional information is determined to be needed during the state hearing, the hearing officer may recess or continue the hearing as follows:
  - 1. Recessing the Hearing. If additional information is needed and this information is readily available, the hearing officer will recess the hearing for the time required to obtain the facts.
  - 2. Continuing the Hearing. If the information needed is not readily available, the hearing officer will continue the hearing to a suitable later date. If the time at which the information will be obtained is known, the hearing officer, before adjourning the original hearing, will set the time and place for the continued hearing at the earliest possible date, notifying the principals that there will be no further notice. The hearing officer will reach an agreement with the client and any persons attending on his behalf about bringing the needed information to the continued hearing. The hearing cannot be extended beyond the time limit for completion of a hearing.
- F. If the regional office becomes aware of a change in the client's circumstances which will result in an adverse action other than the issue currently under appeal, the client must be notified in writing. Adverse action notice requirements, i.e., ten (10) day notice plus two (2) days mailing time, must be met and action taken as follows:
  - 1. Change Discovered Prior to State Hearing. If the state hearing has not yet been held, the client may choose to have the new adverse action issue incorporated into the current appeal; however, the client must first request an appeal in the usual manner. If the new hearing request is filed in time for the issue to be considered in the current hearing process, the regional office will notify the hearing officer of the additional issue under appeal. In this instance, the hearing may have to be rescheduled to allow the client time to prepare for the hearing.
  - 2. Change Discovered During the State Hearing. If the change in circumstances is discovered during the actual hearing, the hearing officer will recess the hearing and notify the regional office to send the appropriate ten (10) day notice. The hearing will be reconvened after the adverse action notice is mailed and the advance notice period has expired. The client may choose to include the new issue in the hearing when it is reconvened. The hearing will be reconvened following the usual procedure for setting the time and place.
- G. When the issue under appeal is disability or blindness, a review by DDS is required. After the hearing, the hearing officer will forward all medical information to the Disability Determination Service for reconsideration. A review team consisting of medical staff who were not involved in any way with the original decision will review the medical information

and hearing transcript and give a decision on the disability or blindness factor. The DDS decision is final and binding on the agency.

- H. After the hearing, the final decision of the hearing officer must be based on oral and written evidence, testimony, exhibits and other supporting documents which were discussed at the hearing. The decision cannot be based on any material, oral or written, not available to and discussed with the claimant. Following the hearing, the hearing officer will make a written recommendation of the decision to be rendered as a result of the hearing. The recommendation, which becomes part of the state hearing record, will cite the appropriate rule which governs the recommendation.
- I. The Executive Director of the Division of Medicaid, upon review of the recommendation, proceedings and the record may sustain the recommendation of the hearing officer, reject the recommendation or remand the matter to the hearing officer for additional testimony and evidence, in which case the hearing officer will submit a new recommendation to the Executive Director after the additional action has been taken.
- J. The decision letter will specify any action to be taken by the agency and any revised eligibility dates. If the decision is adverse and continuation of benefits is applicable, the claimant will be notified of the new effective date of reduction or termination of benefits or services, which will be fifteen (15) days from the date of the notice of decision.
- K. The decision of the Executive Director of the Division of Medicaid is final and binding. The client is entitled to seek judicial review in a court of appropriate jurisdiction. Should the client file an appeal the second time without a change in circumstances or agency rule, the client will be notified in writing by the appropriate office explaining that the appeal cannot be honored. If the client's circumstances or agency rule have changed, the client will be advised to file a new application.

Source: Miss. Code Ann. § 43-13-116.

History: New Rule moved from Miss. Admin. Code Part 100 eff. 08/01/2020.

*Rule 2.23: CHIP Agency Errors*

- A. The Division of Medicaid is responsible for ensuring payment for eligible beneficiaries. Providing timely CHIP benefits is a special concern because, unlike Medicaid, the CHIP effective dates are determined relative to monthly processing deadlines which do not allow the regional office to take retroactive or corrective action when an error is discovered for a prior month.
- B. When CHIP agency errors occur, resolution comes through a local or state hearing request.
- C. If a fair hearing is requested on a CHIP termination or denial and agency error was not involved, the procedures described previously in this section will be followed based on the type of hearing requested, i.e., local or state.

Source: Miss. Code Ann. § 41-86-3.

History: New Rule moved from Miss. Admin. Code Part 100 eff. 08/01/2020.