



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: Healthcare Practitioner Peer Review Protocol*

- A. Health care practitioners and any other persons, including institutions, that provide health care services or items for which payment may be made, in whole or in part, by the Division of Medicaid have certain obligations as set forth in Title XI of the Social Security Act (U.S.C. Section 1320c *et seq.*) and Mississippi State Law (Miss. Code Ann. Section 43-13-121) that must be met. These obligations are to 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, and
  - 3. Supported by the appropriate documentation of medical necessity and quality.
- B. When the Division of Medicaid has identified, by data analysis and other means, a possible violation by a health care practitioner of one (1) or more of these obligations, the matter will be referred to the Medicaid Utilization Management/ Quality Improvement Organization (UM/QIO) required by contract to carry out a proper peer investigation and review. Special accommodations will be made to consider the protocol for the various health care practitioner roles. As the case moves through Level I of the process, the UM/QIO will report its status to the Division of Medicaid at least monthly.
- C. This protocol employs three levels of due process:
  - 1. Level I - Peer review panel considerations and actions,
  - 2. Level II - Division of Medicaid administrative hearing, and
  - 3. Level III - Division of Medicaid sanctions.
- D. Progress to Level III is contingent upon recommendations adverse to the subject health care

practitioner at Levels I and II as well as the failure of the subject health care practitioner to successfully carry out a corrective action plan, if one is recommended at Level I.

#### E. Peer Review Panel Considerations and Actions

1. Panel Selection - When a referral is received from the Division of Medicaid, the Medical Director of the UM/QIO, or his/her designee will select a panel of at least three (3) health care practitioners, at least one (1) of whom practices in the same class group as the subject health care practitioner. Selection of the peer review panel members will be done in such a way as to ensure that their objectivity and judgment will not be affected by personal bias for or against the subject health care practitioner or by direct economic competition or cooperation with the subject health care practitioner. The Division of Medicaid will make records relevant to the possible violation available to the Peer Review Panel.
2. Peer Review and Preliminary Deliberation - Following their review of the relevant records, the Peer Review Panel will meet, either in person or by conference call, to deliberate on the matter. Minutes of the meeting will be taken and documented in the case record. The Peer Review Panel must complete this process within thirty (30) to sixty (60) calendar days of the receipt of the records by the Medical Director of the UM/QIO.
3. Peer Review Findings
  - a) If the Peer Review Panel determines that there has been no violation of obligations, it will notify the Division of Medicaid UM/QIO Contract Administrator, in writing, of that finding and recommend that no action be taken. The records relied upon to make the recommendation, as well as the minutes of the Peer Review Panel meeting, will accompany the written recommendation. The Division of Medicaid will make a final decision, within not more than fourteen (14) working days of its receipt of the recommendation, and so inform the UM/QIO. The Division of Medicaid may accept the recommendation, take other action on the case, or return the case to the UM/QIO for further action, as specified by the Division of Medicaid.
  - b) If the Peer Review Panel finds a potential violation of obligations, it will present that preliminary finding to the Medical Director of the UM/QIO, or his/her designee who will notify the health care practitioner by certified mail, restricted delivery, return receipt requested, of the preliminary finding of the Peer Review Panel and of the right of the health care practitioner to a conference with the Peer Review Panel to address this matter.
  - c) If the Peer Review Panel finds violations that arise to the level of gross and flagrant, such that the life and welfare of the health care practitioner's patients are in jeopardy, it will immediately relay its finding to the UM/QIO Medical Director, or his/her designee who will recommend to the Executive Director of Division of Medicaid that the health care practitioner be immediately suspended from the Medicaid program.

Based upon this recommendation, the Executive Director of the Division of Medicaid may take such action as deemed appropriate and notify the health care practitioner. The procedures set forth herein in Section II will be followed.

4. Peer Review Panel Conference with the Healthcare Practitioner

a) Notification of Conference

1) The letter giving notice of potential violation will:

- i) Set forth the specific preliminary finding of potential violation or violations,
- ii) Instruct the health care practitioner to attend a Peer Review Panel conference, which will be set no later than thirty (30) days after the letter date, in order to present his or her position on the matters at issue,
- iii) Inform the health care practitioner that he or she may have an attorney present for advisory purposes only but that the health care practitioner will make all presentations and representations,
- iv) Instruct the health care practitioner to provide the Peer Review Panel with any information in support of the health care practitioner's position no later than ten (10) days prior to the conference in order to allow time for its proper study,
- v) Convey a copy of this protocol,
- vi) Provide notice that, at the conference, the Peer Review Panel will consider all relevant information, whether provided by the Division of Medicaid or by the health care practitioner, prior to making its final recommendation on the matter, and
- vii) Provide notice that, although the conference will be informal, it will be carried out in an orderly manner and minutes will be kept to provide a proper record.

b) Conduct of the Conference

- 1) The Peer Review Panel will either select one (1) of its members to preside at the conference or invite the Medical Director of the UM/QIO, or his/her designee to do so. If the Medical Director or his/her designee does preside, he or she will not participate in the Panel's deliberation. The potential violation or violations will be explained to the health care practitioner as well as the reasons why the Peer Review Panel has come to make its preliminary finding. The health care practitioner will then be afforded reasonable opportunity to present information in support of his or her position.

- 2) After all information has been presented, the health care practitioner will be excused from the Conference, and the Peer Review Panel will deliberate and render its findings and recommendation based upon a thorough review of the clinical records and of the information presented at the conference.
- c) Outcome of the Conference
- 1) If the Peer Review Panel finds that the health care practitioner has not violated any obligations, it will report that finding and its recommendation in writing to the Medical Director of the UM/QIO, or his/her designee, who will convey that written recommendation to the Division of Medicaid UM/QIO Contract Administrator. The records relied upon to make the recommendation, as well as the minutes of the Peer Panel Conference with the health care practitioner, will accompany the written recommendation. The Division of Medicaid will make a final decision within not more than fourteen (14) working days of its receipt of the recommendation and so inform the UM/QIO. The Division of Medicaid may accept the recommendation, may take other action on the case, or return the case to the UM/QIO for further action, as specified by the Division of Medicaid. The UM/QIO will inform the health care practitioner, as directed by the Division of Medicaid, if it is determined to close the case.
  - 2) If the Peer Review Panel determines that the health care practitioner has violated one or more Division of Medicaid obligations, it will formulate a corrective action plan (CAP) and recommend it to the Division of Medicaid's UM/QIO Contract Administrator within ten (10) days following the conference. The CAP will list the specific obligations violated; the specific elements of the CAP which will address correction of the behavior which led to the violation(s); the duration of the CAP which is a minimum of ninety (90) days; and the means by which compliance with the CAP will be monitored and assessed. Upon the Division of Medicaid's approval, within not more than fourteen (14) working days of its receipt of the CAP, the UM/QIO will notify the health care practitioner of the CAP by certified mail, restricted delivery, return receipt requested.
  - 3) The health care practitioner will be required to sign the CAP and return it within ten (10) days to the Peer Review Panel. If the health care practitioner fails to submit the signed CAP, the Peer Review Panel will immediately recommend to the Executive Director of the Division of Medicaid that a sanction be imposed on the health care practitioner. The procedures set forth in Level II will be followed.
  - 4) The UM/QIO Medical Director, or his/her designee and the Peer Review Panel will monitor the signed CAP. After the CAP has been completed, all information subject to being monitored, including, but not limited to medical service claims history, copies of patient records, files, and charts will be obtained by the Division of Medicaid Bureau of Program Integrity and submitted to the Peer Review Panel for review. Within thirty (30) days of the receipt of such information from the Division of Medicaid, the Peer Review Panel will meet to determine whether or

not the health care practitioner complied with the CAP and whether the CAP was effective. Minutes will be kept of the meeting.

- 5) If the CAP was effective and the health care practitioner is now meeting all obligations, the Peer Review Panel will provide a written recommendation to the Division of Medicaid's UM/QIO Contract Administrator that the peer review process has been completed and the identified violation(s) corrected and resolved. The records relied upon to make the recommendation, as well as the minutes of the Peer Panel meeting, will accompany the written recommendation. The Division of Medicaid will make a final decision within not more than fourteen (14) working days of its receipt of the recommendation and so inform the UM/QIO. The Division of Medicaid may accept the recommendation, take other action on the case, or return the case to the UM/QIO for further action, as specified by the Division of Medicaid. The UM/QIO will inform the health care practitioner, as directed by the Division of Medicaid, if it is determined to close the case, by certified mail, restricted delivery, return receipt requested.
- 6) If the CAP was not effective and the health care practitioner, as noted in the minutes of the meeting, is still deemed to be violating obligations, the Peer Review Panel will, by a motion approved by a majority of its members, recommend to the Executive Director of the Division of Medicaid that a sanction be imposed. The full and complete record relied upon to make the recommendation and the minutes of the Peer Panel will be submitted to the Executive Director of the Division of Medicaid within fifteen (15) days of the Peer Review Panel's recommendation for sanction.

#### F. Level II Division of Medicaid Administrative Hearing

##### 1. Notice of Sanction

- a) Upon receipt of the Peer Review Panel's recommendation to sanction, the Executive Director of the Division of Medicaid may send notice to the health care practitioner, by certified mail, restricted delivery, return receipt requested of the Executive Director's intent to impose a sanction for violation of obligations. The Notice will contain the following:
  - 1) The obligation(s) violated,
  - 2) The situation, circumstance, or activity that resulted in the violation,
  - 3) The authority and responsibility afforded the Division of Medicaid under Miss. Code Ann. Section 43-13-121,
  - 4) A summary of the information used in arriving at the determination to initiate sanction, and

- 5) Notice that the Division of Medicaid will impose the recommended sanction within thirty (30) days of the date of health care practitioner's receipt of the notice letter unless the health care practitioner requests an administrative hearing within these thirty (30) days.
2. Administrative Hearing Panel - If the health care practitioner requests an administrative hearing, the hearing will be administered in accordance with the procedures outlined in Part 300, Chapter 1, Rule 1.1.
- G. Level III Division of Medicaid Sanction - The Executive Director of the Division of Medicaid, upon review of the record, proceedings, and recommendation of the Division of Medicaid Administrative Hearing Officer, will render a final written decision whether or not to impose sanctions, which may include disqualification from participation in the Medicaid program. The Executive Director may disqualify the health care practitioner for a limited period or permanently. The Executive Director's decision is a final administrative decision. The Executive Director may assess all or any part of the cost of implementing this sanction protocol to the health care practitioner.

Source: Miss. Code Ann. § 43-13-121

*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.