MISSISSIPPI DIVISION OF
MEDICAID

Administrative Code

Title 23: Medicaid
Part 300
Appeals

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Rule 1.1: Authority to Conduct Appeals

Title 23, Part 300 of the Mississippi Division of Medicaid's Administrative Code establishes procedures applicable to Appeals and Fair Hearings conducted by the Mississippi Division of Medicaid pursuant to 42 C.F.R. Part 431 Subpart E, 42 C.F.R. Part 438 Subpart F, 42 C.F.R. Part 455 Subpart E, Miss. Code Ann. §§ 43-13-116, 43-13-117, and 43-13-121.

Source: 42 C.F.R. Part 431 Subpart E; 42 C.F.R. Part 438 Subpart F; 42 C.F.R. Part 455 Subpart E; Miss. Code Ann. §§ 43-13-116, 43-13-117, 43-13-121.

History: New Rule eff. 03/01/2023.

Rule 1.2: Categories of Appeals

A. The Division of Medicaid provides an appeal process for applicants, beneficiaries, and providers.

B. Appeals for Fee-for-Service (FFS) Applicants, Beneficiaries, and Providers

1. An applicant or beneficiary, or an applicant/beneficiary's representative wishing to appeal a Reconsideration decision originating from FFS Medicaid must file the appeal directly with the Division of Medicaid, following rules and procedures stated in Part 300, Chapter 2.

2. A provider wishing to appeal a Final Agency Action originating from FFS Medicaid must file the appeal directly with the Division of Medicaid, following rules and procedures stated in Part 300, Chapter 3.

C. Appeals for MississippiCAN (MSCAN) Beneficiaries and Providers

Beneficiaries and providers must exhaust all appeals with the coordinated care organizations (CCOs) prior to requesting a fair and/or administrative hearing with the Division of Medicaid.

D. Appeals for Waiver Beneficiaries Receiving Medicaid Services Through Other State Agencies.

1. Appeal Procedure for Waivers Administered by the Mississippi Department of Rehabilitative Services (MDRS) are covered under Part 300, Chapter 2, Rule 2.22.A. MDRS administers benefits for the following waivers:

a) Independent Living (IL) Waiver, and

b) Traumatic Brain Injury/Spinal Cord Injury (TBI/SCI) Waiver.

2. Appeal Procedures for Waivers Administered by the Mississippi Department of Mental Health (DMH) are covered under Part 300, Chapter 2, Rule 2.22.B. DMH administers the Intellectual Disabilities/Developmental Disabilities (ID/DD) Waiver.

Source: 42 C.F.R. Part 431 Subpart E; 42 C.F.R. Part 438 Subpart F; 42 C.F.R. Part 431 Subpart E; Miss. Code Ann. §§ 43-13-116, 43-13-117, and 43-13-121.

History: New Rule eff. 03/01/2023.

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: Authority for Applicant and Beneficiary Appeals

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.

Source: 42 C.F.R. Part 431 Subpart E; Miss. Code Ann. §§ 43-13-116, 43-13-117, 43-13-121.

History: Renamed and revised eff. 03/01/2023.

Rule 2.2: Definitions

The Division of Medicaid defines:

A. Case Record as all documents relevant to the administration of an appeal, including but not limited to all correspondence, applications, medical records and decisions, and past appeals.

B. Course of Treatment as a planned program of one or more services or supplies.

C. Grievance as an expression of dissatisfaction submitted orally or in writing about any matter, including but not limited to the quality of services provided, rudeness from a Division of

Medicaid employee, unfair treatment, or failure to respect the applicant or beneficiary's rights.

D. Local Hearing or Reconsideration as a hearing held at the Division of Medicaid Regional Office from which the decision the applicant or beneficiary wishes to appeal was generated.

E. State Hearing or Fair Hearing as an orderly, but informal meeting in which an applicant or beneficiary or his/her representative is afforded an opportunity to address an impartial hearing officer for the purpose of presenting oral testimony and/or evidence of the individual's entitlement to medical assistance and services.

1. The applicant or beneficiary has the right of confrontation and cross-examination.

2. A fair hearing is a de novo hearing which means the determination process starts over from the beginning. A new determination of the applicant or beneficiary'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.

3. This hearing is conducted by the Division of Medicaid's Central Office.

F. Hearing Officer as the presiding officer appointed by the Executive Director or the Executive Director's designee to conduct administrative hearings within the guidelines stated in this chapter. The Hearing Officer may:

1. Issue subpoenas,

2. Administer oaths,

3. Compel attendance and testimony of witnesses,

4. Require the production of books, papers, documents, and other evidence required,

5. Take depositions,

6. Preserve and enforce order during the administrative hearing,

7. Call informal, status, or pre-hearing conferences,

8. Invite stipulations between the parties, and

9. Do all things conformable to law and Medicaid regulations that may be necessary to enable the Hearing Officer to effectively perform the Hearing Officer's duties.

G. A legal representative or representative as the applicant or beneficiary's authorized representative, an attorney retained to represent the applicant or beneficiary, a paralegal

representative with a legal aid service, the parent of a minor child if the beneficiary or appellant is a child, a legal guardian or conservator or an individual with power of attorney for the applicant or beneficiary.

1. The applicant or beneficiary may be represented by anyone they designate.

2. If the applicant or beneficiary elects to be represented by someone other than a legal representative, they must designate the person in writing.

3. If a person, other than a legal representative, states that the applicant or beneficiary has designated them as the applicant or beneficiary's representative, and the individual has not provided written verification to this effect, the regional office will ask the individual to obtain written designation from the applicant or beneficiary.

H. Final Decision as the decision rendered by the Executive Director at the end of the hearing process, subject to appeal only through judicial review.

I. Judicial Review as the relief available to an applicant or beneficiary after the Division of Medicaid has rendered its final decision. Final decisions by the Division of Medicaid may be appealed to the court of proper jurisdiction for Judicial Review.

J. Advance Notice Period as the time in which the Division of Medicaid must send a notice before the date of an action, except when advance notice is impossible, or in cases of probable fraud.

K. Adverse Action as a decision rendered by the Division of Medicaid denying or reducing an applicant or beneficiary's coverage or desired treatment. An applicant or beneficiary will receive written notice of an adverse action and be able to file for an appeal after receipt of this notice.

Source: 42 C.F.R. Part 431 Subpart E; Miss. Code Ann. §§ 43-13-116, 43-13-117, and 43-13-121.

History: Renamed and revised eff. 03/01/2023.

Rule 2.3: Appeal Rights of Applicants and Beneficiaries

A. The Division of Medicaid provides an opportunity to contest any adverse decisions through an appeal and fair hearing process, and notifies applicants, beneficiaries and/or their legal representatives of their Medicaid appeal rights. The following categories have appeal processes through the Division of Medicaid:

1. Fee-for-service (FFS) beneficiaries,

2. Beneficiaries enrolled in a coordinated care organization (CCO),

3. Beneficiaries enrolled in a Medicaid waiver,

4. Beneficiaries who are subject to a proposed transfer or discharge from a long-term care facility or nursing facility,

5. Individuals who are adversely affected by the pre-admission screening or the annual resident review, and

6. Any other Medicaid applicants or beneficiaries not enumerated herein.

B. The Division of Medicaid's informal dispute and appeal process has four (4) levels:

1. Grievance,

2. Local Hearing,

3. State Hearing, also referred to as Fair Hearing, and

4. Judicial Review.

C. A hearing request made prior to any adverse action being taken will not be accepted.

D. The Division of Medicaid is not required to grant a hearing if the sole issue is a federal or state law requiring an automatic change adversely affecting some or all beneficiaries.

E. At the time of any action affecting an applicant or beneficiary's claim for assistance, the applicant or beneficiary must be:

1. Informed of the right to a hearing,

2. Notified of the method by which to obtain a hearing, and

3. Informed of the right to self-representation at the hearing or to be represented by an authorized person such as an attorney, relative, friend, or other spokesperson.

Source: 42 C.F.R. Part 431 Subpart E; Miss. Code Ann. §§ 43-13-116, 43-13-117, 43-13-121.

History: Renamed and revised eff. 03/01/2023, New Rule moved from Miss. Admin. Code Part 100 eff. 07/01/2020.

Rule 2.4: Types of Hearings

A. The applicant or beneficiary, or their representative may request to present an appeal through a local hearing, a state hearing, or both.

B. There are two instances in which a local hearing is not permitted, and the applicant or beneficiary must request relief directly through a state hearing. These are:

1. A disability or blindness denial, or termination, or

2. A level of care denial or termination for an applicant or beneficiary in the Katie Beckett category of eligibility.

C. 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: 42 C.F.R. Part 431 Subpart E; Miss. Code Ann. §§ 43-13-116, 43-13-117, 43-13-121.

History: Revised eff. 07/01/2025; Revised eff. 03/01/2023; New Rule moved from Miss. Admin. Code Part 100 eff. 07/01/2020.

Rule 2.5: Applicant Appeals

Appeals regarding eligibility must be filed with the agency through which the applicant/beneficiary first applied. Agencies include:

A. Mississippi Division of Medicaid,

1. The Mississippi Division of Medicaid is responsible for making eligibility determinations for the following groups:

   a) Families,

   b) Children,

   c) Pregnant Women, and

   d) Aged, blind and disabled individuals who do not qualify for Social Security Income.

2. If the Division of Medicaid determines that an applicant is ineligible for Medicaid, and the applicant disagrees with the decision, the applicant may request a local and/or state hearing by contacting the Regional Office that made the decision or by contacting the Division of Medicaid Central Office.

3. Hearing requests must be made within thirty (30) days of the date of the letter providing notice of the adverse action to deny, terminate or reduce Medicaid benefits. All adverse action notices issued to applicants contain their appeal rights and explain how to request a hearing.

B. Social Security Agency (SSA),

The SSA 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. Applicants/beneficiaries whose entitlement to SSI is terminated also lose Medicaid eligibility. Appeals of SSI decisions must be made through the SSA.

C. The Mississippi Department of Child Protection Services (MDCPS).

1. The Mississippi Department of Child Protection Services (MDCPS) is the State agency charged with the responsibility of determining Medicaid eligibility for foster children in the custody of MDCPS.

2. In the event MDCPS denies, terminates or reduces the Medicaid benefits of a foster child, the Division of Medicaid is the agency responsible for handling the appeals of such adverse actions.

Source: 42 C.F.R. Part 431 Subpart E; Miss. Code Ann. §§ 43-13-116, 43-13-117, and 43-13-121.

History: Renamed and revised eff. 03/01/2023.

Rule 2.6: Beneficiary Appeals

A. The Division of Medicaid provides beneficiaries the opportunity to request a fair hearing in order to appeal decisions of:

1. Eligibility,

2. Denial,

3. Termination,

4. Suspension, or

5. 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 the beneficiary's legal representative must request a hearing within thirty (30) days of the notice of adverse action. See Part 300, Chapter 2, Rule 2.7, All Hearing Requests, for more information.

C. The Division of Medicaid is not required to grant a 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 appeal process.

E. The Division of Medicaid may deny or dismiss a request for any hearing if the beneficiary and/or legal representative:

1. Withdraws the request in writing, or

2. Fails to appear at a scheduled hearing without good cause.

F. The case shall be heard by an impartial hearing officer.

G. At the Hearing Officer's discretion, 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 the beneficiary's 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: 42 C.F.R. Part 431 Subpart E; Miss. Code Ann. §§ 43-13-116, 43-13-117, 43-13-121.

History: Renamed and revised eff. 03/01/2023.

Rule 2.7 All Hearing Requests

A. All hearing requests may initially be written, oral, or made in-person at a regional office.

B. Written Hearing Requests

1. A simple statement requesting a hearing that is signed by the applicant/beneficiary or the applicant/beneficiary's legal representative is sufficient.

2. The written request may be mailed to the regional office or central office. If the letter does not specify the type of hearing desired, a Medicaid 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.

3. If the hearing involves an issue that requires that a state hearing be held or if a state hearing is requested, the request will be forwarded to the Office of Administrative Appeals.

C. When an oral request is made, the regional office specialist will fill out a DOM 350, Request for Local Hearing, or DOM 352, Request for State Hearing, on the applicant or beneficiary's behalf and begin the Hearing Request process.

D. Hearing Requests Made in Person

1. The applicant/beneficiary may come to the regional office or meet with a Medicaid specialist in person to request a hearing. The specialist must determine what level of hearing, local or state, is desired.

2. If a state level hearing is required as noted in Part 300, Chapter 2, Rule 2.4, this will be explained to the applicant/beneficiary. Otherwise, if the applicant/beneficiary is unsure of the type hearing desired, the Medicaid 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.

3. The Medicaid specialist will assist the applicant/beneficiary in completing the appropriate form, DOM 350, Request for Local Hearing, or DOM 352, Request for State Hearing, whichever is applicable. If a state hearing is required or requested, the specialist can assist in mailing the request to state office or the applicant/beneficiary may choose to mail it himself/herself.

Source: 42 C.F.R. Part 431 Subpart E; Miss. Code Ann. §§ 43-13-116, 43-13-117, 43-13-121.

History: Renamed and revised eff. 03/01/2023, New Rule moved from Miss. Admin. Code Part 100 eff. 07/01/2020.

Rule 2.8: Time Limit For Filing A Hearing Request

A. The applicant or beneficiary has thirty (30) days from the postmark date of the appropriate notice to request either a local or state hearing. This thirty (30) day filing period may be extended if the applicant or beneficiary can show good cause, as determined by the Division of Medicaid, for not filing within thirty (30) days.

B. When good cause is shown, a late hearing request may be accepted, provided the facts in the case remain the same.

C. If good cause for filing a request beyond thirty (30) days does not exist, a hearing request will not be accepted.

D. If the applicant or beneficiary wishes to have his/her eligibility reconsidered after this period, s/he may reapply.

Source: 42 C.F.R. Part 431 Subpart E; Miss. Code Ann. §§ 43-13-116, 43-13-117, 43-13-121.

History: Renamed and revised eff. 03/01/2023, New Rule moved from Miss. Admin. Code Part 100 eff. 07/01/2020.

Rule 2.9: 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.

Source: 42 C.F.R. Part 431 Subpart E; Miss. Code Ann. §§ 43-13-116, 43-13-117, and 43-13-121.

History: Renamed and revised eff. 03/01/2023; New Rule moved from Miss. Admin. Code Part 100 eff. 07/01/2020.

Rule 2.10: Scheduling the Hearing

A. When a local hearing is requested, the regional office will notify the applicant/beneficiary or representative in writing of the time and date of the local hearing.

B. When a state hearing is requested, the hearing officer assigned to the case will notify the applicant/beneficiary or representative in writing of the time and date of the state hearing.

C. The notice scheduling the time and date of a state or local hearing must be mailed to the applicant or beneficiary 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: 42 C.F.R. Part 431 Subpart E; Miss. Code Ann. §§ 43-13-116, 43-13-117, 43-13-121.

History: Renamed and revised eff. 03/01/2023, New Rule moved from Miss. Admin. Code Part 100 eff. 07/01/2020.

Rule 2.11: Attendance at the Hearing

A. A state or local hearing is not open to the public. Persons attending the hearing will attend for the purpose of:

1. Giving information on behalf of the applicant or beneficiary,

2. Rendering the applicant or beneficiary assistance in some other way, or

3. To represent the Division of Medicaid.

B. All persons attending the hearing will be asked to give information pertinent to the issues under consideration.

Source: 42 C.F.R. Part 431 Subpart E; Miss. Code Ann. §§ 43-13-116, 43-13-117, 43-13-121.

History: Renamed and revised eff. 03/01/2023, New Rule moved from Miss. Admin. Code Part 100 eff. 07/01/2020.

Rule 2.12: Withdrawn or Abandoned Hearings

A. Withdrawal of a request for hearing must be in writing and submitted by:

1. The applicant/beneficiary, or

2. The applicant/beneficiary's representative, and

3. Bear the applicant/beneficiary's signature or the representative's signature.

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.

C. A hearing request will be considered abandoned if the applicant/beneficiary or representative:

1. Fails to appear, or

2. Is unavailable for a scheduled hearing without good cause.

D. If no one is available for a hearing, the appropriate office will notify the applicant or beneficiary 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: 42 C.F.R. Part 431 Subpart E; Miss. Code Ann. §§ 43-13-116, 43-13-117, 43-13-121.

History: Renamed and revised eff. 03/01/2023, New Rule moved from Miss. Admin. Code Part 100 eff. 07/01/2020.

Rule 2.13: Rights of the Applicant/Beneficiary During the Hearing Process

The applicant/beneficiary or his/her representative has the following rights in connection with a local or state hearing:

A. The right to examine the contents of the case record at a reasonable time before the date of the hearing and during the hearing. In cases of eligibility appeals, the beneficiary will be mailed a copy of the case file by the Division,

B. The right to have legal representation at the hearing, and to bring witnesses,

C. The right to produce documentary evidence and establish all pertinent facts and circumstances concerning eligibility, and

D. 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: 42 C.F.R. Part 431 Subpart E, Miss. Code Ann. §§ 43-13-116, 43-13-117, 43-13-121.

History: Renamed and revised eff. 03/01/2023.

Rule 2.14: Local Hearing Requests

A. A local hearing request will ordinarily be filed in the regional office responsible for the adverse decision or delay in action.

B. An applicant or beneficiary who has moved to another regional office's jurisdiction at the time the appeal is made may submit an appeal in the regional office serving the applicant or beneficiary's current county of residence. The hearing officer may request the participation of staff in the regional office where the action was originally taken if necessary or advisable.

Source: 42 C.F.R. Part 431 Subpart E; Miss. Code Ann. §§ 43-13-116, 43-13-117, 43-13-121.

History: Renamed and revised eff. 03/01/2023, New Rule moved from Miss. Admin. Code Part 100 eff. 07/01/2020.

Rule 2.15: Local Hearing Procedure

A. The purpose of a local hearing is to provide an informal proceeding to allow the applicant/beneficiary or representative to:

1. Present new or additional information;

2. Question the action taken on the applicant/beneficiary's case, and

3. Hear an explanation of eligibility requirements as they pertain to the applicant/beneficiary's situation.

B. The regional office is responsible for:

1. Completing a supervisory review of the action under appeal,

2. Preparing the state hearing record,

3. All activities involved in the local hearing process, and

4. Taking appropriate action on the case at the end of the hearing process.

C. Local Hearing Requirements.

1. 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 applicant/beneficiary will be allowed time to obtain additional information or request an attorney, relative or friend to attend the hearing and give evidence.

2. A local hearing must not be scheduled without giving five (5) days advance notice to the applicant/beneficiary unless the applicant/beneficiary waives advance notice time.

3. The regional office staff member who conducts the hearing cannot be one who has participated in determining eligibility or directed the decision.

D. After the Local Hearing.

1. When a decision has been reached, the regional office must notify the applicant/beneficiary of the decision in writing and advise the applicant/beneficiary of his/her right to request a state hearing.

2. The local hearing officer will prepare a summary of the local hearing. The summary serves the same purpose as a transcript and is filed in the case record. The summary must be included as part of the state hearing record when the applicant/beneficiary requests a state hearing after an adverse local hearing decision. The summary must contain sufficient information to enable the state hearing officer to have a clear understanding of what transpired during the local hearing.

3. When the local hearing decision is unfavorable to the applicant/beneficiary, the new effective date of closure or reduced benefits must be included on the notification of 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.

Source: 42 C.F.R. Part 431 Subpart E; Miss. Code Ann. §§ 43-13-116, 43-13-117, 43-13-121.

History: Renamed and revised eff. 03/01/2023, New Rule moved from Miss. Admin. Code Part 100 eff. 07/01/2020.

Rule 2.16: State Hearing Requests After Adverse Local Decision

A. The applicant or beneficiary has the right to appeal a local hearing decision by requesting a state hearing; however, the state hearing request must be made within fifteen (15) days of the postmark 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 (15^{th}) day after the local hearing notice is mailed.

B. 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: 42 C.F.R. Part 431 Subpart E; Miss. Code Ann. §§ 43-13-116, 43-13-117, 43-13-121.

History: Renamed and revised eff. 03/01/2023, New Rule moved from Miss. Admin. Code Part 100 eff. 07/01/2020.

Rule 2.17: State Hearing Requests for Appeals that Must Originate as a State Hearing

A. Disability or Blindness Denials.

1. An appeal related to a disability or blindness denial must be resolved through a state hearing. Procedures for filing a state hearing appeal are detailed in Rules 2.5 through 2.8 of this chapter and should be followed.

2. After the state hearing, the hearing officer will forward all medical information to the Disability Determination Service (DDS) 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.

3. The DDS decision is final and binding on the Division of Medicaid.

B. Level of Care Denials or Terminations for an applicant or beneficiary in the Katie Beckett category of eligibility.

1. An appeal related to level of care denials or terminations for the Katie Beckett category of eligibility must be resolved through a state hearing. Procedures for filing a state hearing appeal are detailed in Rules 2.5 through 2.8 of this chapter and should be followed.

2. The final decision of the hearing officer must be based on oral and written evidence, testimony, exhibits and other supporting documents that were discussed at the hearing. The decision cannot be based on any material, oral or written, not available to and discussed with the beneficiary/applicant or representative.

3. 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 that governs the recommendation.

4. The Executive Director of the Division of Medicaid, upon review of the recommendation, proceedings and the record, may:

   a) Sustain the recommendation of the hearing officer,

   b) Reject the recommendation,

   c) 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, or

   d) Amend the recommendation and adopt the remainder.

5. 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 applicant/beneficiary or representative 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.

6. The decision of the Executive Director of the Division of Medicaid is final and binding. The applicant/beneficiary is entitled to seek judicial review in a court of appropriate jurisdiction.

7. Should the applicant/beneficiary file an appeal of an issue that has already been adjudicated without a change in circumstances or agency rule, the appeal will be dismissed as untimely, and the applicant/beneficiary will be notified in writing by the office to which the appeal was made (be it the Regional Office or the Central Office) explaining that the appeal cannot be honored. If the applicant/beneficiary's circumstances or agency rule have changed, the applicant/beneficiary will be advised to file a new application.

Source: 42 C.F.R. Part 431 Subpart E; Miss. Code Ann. §§ 43-13-116, 43-13-117, 43-13-121.

History: Revised eff. 07/01/2025; Renamed and revised eff. 03/01/2023; New Rule moved from Miss. Admin. Code Part 100 eff. 08/01/2020.

Rule 2.18: State Hearing Procedure

A. A state hearing is assigned to an impartial hearing officer. The hearing officer has not been involved in any way with the action or decision prior to being assigned the appeal at the state level. The hearing officer:

   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 applicant/beneficiary upon request,

      b) The reason for the hearing, i.e., the action taken by the regional office which prompted the appeal,

      c) The applicant/beneficiary's rights, and

      d) The purpose of the hearing.

B. The case record must be available for review by the applicant/representative or representative before, during and/or after the state hearing.

C. The final hearing decision will be rendered by the Executive Director of the Mississippi Division of Medicaid based on the facts discussed at the hearing and the applicant/beneficiary or representative will be notified in writing of this decision.

D. All persons representing the applicant/beneficiary and those representing the Division 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. If the time at which the information will be obtained is not known, the hearing officer will reach an agreement

with the applicant/beneficiary and any persons attending on the applicant/beneficiary's 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 applicant/beneficiary's circumstances that will result in an adverse action other than the issue currently under appeal, the applicant/beneficiary must be notified in writing. Adverse action notice requirements 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 applicant/beneficiary may choose to have the new adverse action issue incorporated into the current appeal. To do so, the applicant/beneficiary must first request an appeal as detailed in Rules 2.5 through 2.8 of this chapter. 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. The hearing may have to be rescheduled to allow the applicant/beneficiary time to prepare for the hearing.

2. Change Discovered During the State Hearing. If the change in circumstances is discovered during the state 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 applicant/beneficiary 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. After the State Hearing.

1. The final decision of the hearing officer must be based on oral and written evidence, testimony, exhibits and other supporting documents that were discussed at the hearing. The decision cannot be based on any material, oral or written, not available to and discussed with the beneficiary/applicant.

2. 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 that governs the recommendation.

3. The Executive Director of the Division of Medicaid, upon review of the recommendation, proceedings and the record, may:

a) Sustain the recommendation of the hearing officer,

b) Reject the recommendation,

c) Amend and adopt the recommendation, or

d) 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.

4. 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 applicant/beneficiary 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.

5. The decision of the Executive Director of the Division of Medicaid is final and binding. The applicant/beneficiary is entitled to seek judicial review in a court of appropriate jurisdiction.

H. Should the applicant/beneficiary file an appeal of an issue that has already been adjudicated without a change in circumstances or agency rule, the appeal will be dismissed as untimely, and the applicant/beneficiary will be notified in writing by the office to which the appeal was made explaining that the appeal cannot be honored. If the applicant/beneficiary's circumstances or agency rule have changed, the applicant/beneficiary will be advised to file a new application.

Source: 42 C.F.R. Part 431 Subpart E; Miss. Code Ann. §§ 43-13-116, 43-13-117, 43-13-121.

History: Renamed and revised eff. 03/01/2023, New Rule moved from Miss. Admin. Code Part 100 eff. 07/01/2020.

Rule 2.19: Appeal By Both Members Of A Couple

A. One or both members of a couple may file a hearing request either jointly or separately when they are denied benefits and that denial arises from the same issue.

B. If a joint hearing is held, both members of the couple may present evidence at the hearing, and the agency's decision will apply to both individuals.

C. If both members of the couple file a hearing request, two hearings will be registered. The hearings will be conducted on the same day and in the same place, either consecutively or jointly, according to the wishes of the couple. If they wish for only one of them to attend the joint hearing, that is allowed.

Source: 42 C.F.R. Part 431 Subpart E; Miss. Code Ann. §§ 43-13-116, 43-13-117, 43-13-121.

History: Renamed and revised eff. 03/01/2023, New Rule moved from Miss. Admin. Code Part 100 eff. 07/01/2020.

Rule 2.20: Group Hearings

A. A group hearing can be held for multiple applicants or beneficiaries 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 a single law or agency rule common to all members of the group.

2. The applicants or beneficiaries may request a group hearing when the only issue involved is a single law or agency rule common to all members of the group.

B. In all group hearings, whether initiated by the Division of Medicaid or by the applicants or beneficiaries, the policies governing fair hearings must be followed.

1. Each individual applicant or beneficiary in a group hearing must be permitted to present his/her own case and be represented by his own lawyer or withdraw from the group hearing and have his/her appeal heard individually.

2. As in individual hearings, the hearing will be conducted on the issue being appealed, and each applicant or beneficiary is expected to keep his/her testimony within a reasonable time as a matter of consideration to the other clients involved.

Source: 42 C.F.R. Part 431 Subpart E; Miss. Code Ann. §§ 43-13-116, 43-13-117, and 43-13-121.

History: Renamed and revised eff. 03/01/2023, New Rule moved from Miss. Admin. Code Part 100 eff. 07/01/2020.

Rule 2.21: Continuation of Benefits

When an applicant/beneficiary 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, if a timely request is filed.

A. Timely Request for Continuation of Benefits.

1. To determine if the request for continuation of benefits is timely, the request must be received by the regional office within ten (10) days from the notice date of the adverse action.

2. 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.

1. The applicant/beneficiary may request a state hearing if the local hearing is adverse.

2. If benefits have been continued pending the local hearing, then benefits will continue pending a state hearing decision as long as 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.

1. When the final hearing decision is adverse to the applicant or beneficiary, the Medicaid specialist will terminate or reduce the continued benefits using the original reason for the adverse action.

2. A second (2^{nd}) Notice of Adverse Action is not required.

D. When an adverse action is ultimately upheld, the Division of Medicaid has the right to initiate recovery procedures against the applicant or beneficiary to recoup the cost of any medical services furnished the applicant or beneficiary, to the extent they were furnished solely based on the provision for continuation of benefits.

Source: 42 C.F.R. Part 431 Subpart E; Miss. Code Ann. §§ 43-13-116, 43-13-117, 43-13-121.

History: Renamed and revised eff. 03/01/2023.

Rule 2.22: Appeals for Waiver Beneficiaries Receiving Medicaid Services

A. Appeal Procedure for Waivers Administered by the Mississippi Department of Rehabilitative Services (MDRS).

1. MDRS administers benefits for the following waivers:

a) Independent Living (IL) Waiver, and

b) Traumatic Brain Injury/Spinal Cord Injury (TBI/SCI) Waiver,

2. A Case Manager sends a Notice of Action (NOA) to a beneficiary via certified mail informing the beneficiary that benefits have been denied.

a) The beneficiary/beneficiary's representative may request to present an appeal within thirty (30) days. This appeal request may ask for a local hearing, state hearing, or both.

b) The beneficiary/beneficiary's representative may choose to represent themselves or designate another representative in writing.

3. Local Hearing

a) For the IL and TBI/SCI, local hearings will be conducted by MDRS. MDRS will issue a determination within thirty (30) days of the initial request.

b) If the beneficiary/beneficiary's representative is dissatisfied with the of the local level determination for any of the waivers listed, the beneficiary/beneficiary's representative may request a state hearing with the Division of Medicaid through the methods described in Part 300, Chapter 2, Rule 2.16: State Hearing Requests After Adverse Local Decision. Requests must be made within fifteen (15) days of the adverse decision.

4. State Hearing

a) State hearings are conducted by the Division of Medicaid.

b) The beneficiary/beneficiary's representative may either:

1) Request a state hearing at the beginning of the appeal process, or

2) Request a state hearing within fifteen (15) days after receiving a local level determination with which the beneficiary/beneficiary's representative is dissatisfied.

(a) For beneficiaries receiving services through the Traumatic Brain Injury/Spinal Cord Injury Waiver, the request must be made within fifteen (15) days from the date the determination letter was mailed.

(b) For beneficiaries receiving services through the Independent Living Waiver, the request must be made within fifteen (15) days from the date the letter was received.

c) State hearings for wavier beneficiaries will be conducted in the same manner as state hearings for all Division of Medicaid beneficiaries who request a state hearing, as described in Part 300, Chapter 2, Rule 2.18 of this Title.

d) The Division will issue a determination within ninety (90) days of the hearing request. Both the Division and MDRS will inform the beneficiary/beneficiary's representative of the decision in writing. This decision is final and not appealable to MDRS or the Division of Medicaid.

B. Appeal Procedures for Waivers Administered by the Mississippi Department of Mental Health (DMH).

1. DMH administers the Intellectual Disabilities/Developmental Disabilities (ID/DD) Waiver.

2. At any point in the DMH appeal process, the beneficiary/beneficiary's representative may request a state hearing through the Division of Medicaid.

3. Beneficiaries are notified of level of care (LOC) or eligibility denials within ten (10) days

of the denial of eligibility for the LOC. The beneficiary has thirty (30) days from the date of the notice to submit an appeal to the Director of the Bureau of Intellectual Disabilities/Disabilities (BIDD). Appeals must be submitted in writing.

4. During the appeal process, contested services that were already in place must remain in place, unless the decision is for immediate termination due to possible adverse circumstances to the beneficiary.

5. The BIDD Director will respond in writing within thirty (30) days of receipt of the appeal. If more information is needed, the BIDD Director may request additional information before making a decision and extend the thirty (30) day timeline.

6. If the beneficiary/beneficiary's representative is dissatisfied with the BIDD Director's decision, the beneficiary/beneficiary's representative may appeal to the Executive Director of DMH in writing by the date noted in the decision letter. Appeals must be submitted in writing.

7. The Executive Director of DMH will respond in writing within thirty (30) days of receipt of the appeal. If more information is needed, the Executive Director of DMH may request additional information before making a decision and extend the thirty (30) day timeline.

8. If the beneficiary/beneficiary's representative is dissatisfied with the Executive Director of DMH's decision, the beneficiary/beneficiary's representative may appeal to the Executive Director of Medicaid for a state hearing in writing within thirty (30) days of receiving notification of the decision.

9. State Hearing

    a) State hearings are conducted by the Division of Medicaid.

    b) The beneficiary/beneficiary's representative may either:

        1) Request a state hearing at any point in the appeal process, or

        2) Request a state hearing within thirty (30) days after receiving a local level determination with which the beneficiary/beneficiary's representative is dissatisfied.

    c) State hearings for waiver beneficiaries will be conducted in the same manner as state hearings for all Division of Medicaid beneficiaries who request a state hearing, as described in Part 300, Chapter 2, Rule 2.18 of this Title.

    d) The Division will issue a determination within ninety (90) days of the hearing request and inform the beneficiary/beneficiary's representative and DMH of the decision in writing.

e) If the beneficiary/beneficiary's representative is dissatisfied with Division of Medicaid's decision, the beneficiary/beneficiary's representative may seek relief in a court of proper jurisdiction.

C. Appeal Procedures for Waivers Administered by the Mississippi Division of Medicaid.

1. The Division of Medicaid administers the following waivers:

a) Elderly and Disabled (ED) Waiver, and

b) Assisted Living (AL) Waiver.

2. A Case Manager sends a Notice of Action (NOA) to a beneficiary via certified mail informing the beneficiary that benefits have been denied.

a) The beneficiary/beneficiary's representative may request to present an appeal within thirty (30) days of the date of the denial notice. This appeal request may ask for a state hearing.

b) The beneficiary/beneficiary's representative may choose to represent themselves or designate another representative in writing.

3. State Hearing

a) State hearings are conducted by the Division of Medicaid, Office of Appeals.

b) State hearings for waiver beneficiaries will be conducted in the same manner as state hearings for all Division of Medicaid beneficiaries who request a state hearing, as described in Part 300, Chapter 2, Rule 2.18 of this Title.

c) The Division will issue a determination within ninety (90) days of the hearing request. The Division will inform the beneficiary/beneficiary's representative of the decision in writing. If the person/legal guarding determines the need for further redress, he/she may seek relief in a court of appropriate jurisdiction.

Source: 42 C.F.R. Part 431 Subpart E; 42 C.F.R. Part 438 Subpart F; 42 C.F.R. Part 431 Subpart E; Miss. Code Ann. §§ 43-13-116, 43-13-117, 43-13-121.

History: New Rule eff. 03/01/2023.

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.

Chapter 3: Provider Appeals

Rule 3.1: Authority for Provider Appeals

The Mississippi Division of Medicaid conducts provider hearings for the following reasons:

A. The provider is dissatisfied with a Final Agency Action of the Division of Medicaid relating to:

1. Disallowances,

2. Withholding of funds resulting from overpayments,

3. Suspension of payments as a result of an audit, review or investigation,

4. Termination of a provider agreement as a result of an audit, review or investigation,

5. Suspension of provider participation as a result of an audit, review or investigation,

6. Matters relating to payment rates if not previously considered by the Division of Medicaid under Public Notice or Public Hearing Procedures,

7. Breach of provider agreement,

8. Provider disqualification,

9. Any other matter that the Division of Medicaid deems appropriate in its sole discretion at request of a party.

B. 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.

Source: 42 C.F.R. Part 455 Subpart E; Miss. Code. Ann. § 43-13-121.

History: Renamed and revised eff. 03/01/2023.

Rule 3.2: Definitions

The Division of Medicaid defines:

A. Administrative Hearing as a trial-like proceeding before the Division of Medicaid at which evidence and testimony may be offered.

B. Hearing Officer as the presiding officer appointed by the Executive Director or the Executive Director's designee to conduct administrative hearings within the guidelines stated in this chapter. The Hearing Officer may:

   1. Issue subpoenas,

   2. Administer oaths,

   3. Compel attendance and testimony of witnesses,

   4. Require the production of books, papers, documents, and other evidence required,

   5. Take depositions solely for the purposes of preserving testimony for the purposes of the administrative hearing,

   6. Preserve and enforce order during the administrative hearing,

   7. Call informal, status, or pre-hearing conferences, including for the purposes of handling procedural matters,

   8. Invite stipulations between the parties,

   9. Do all things conformable to law and Medicaid regulations that may be necessary to enable the Hearing Officer to effectively discharge the Hearing Officer's duties,

   10. State that exact costs, including but not limited to cost of the Hearing Officer, court reporter, attorney's fees, third-party medical review, and any other cost borne by the Division in preparing for and conducting the hearing, be assessed to a losing provider as part of the recommendation to the Executive Director, and

   11. Include the recommendation to the Executive Director that the Provider be terminated in cases of egregious behavior, such as fraud, waste, and abuse, and that the Provider be reported to HHS.

C. Final Agency Action as the decision rendered by the Division regarding matters as defined under Rule 3.1.A of this Chapter to which the Provider may file an appeal with the Division.

D. Final Decision as the decision rendered by the Division's Executive Director after the completion of the Division's appeal process.

Source: 42 C.F.R. Part 455 Subpart E; Miss. Code. Ann. § 43-13-121.

History: Renamed and revised eff. 03/01/2023.

Rule 3.3: Pre-Hearing Procedure

A. Within thirty (30) calendar days after a Final Agency Action has been made, the provider may request a formal administrative hearing.

B. Appeal requests must:

1. Be written,

2. Explain the facts that support the provider's position,

3. Supply reasons the provider purports to have complied with the Medicaid regulations,

4. Include any available documentation supporting the provider's request, and

5. Be timely and proper.

a) Appeals that are not both timely and proper are not subject to review and will not be considered by the agency.

b) The only exception to the timeliness requirement is when a provider can show good cause for late filing. The Executive Director of the Division of Medicaid or the Executive Director's designee will decide whether the provider has submitted good cause.

C. The Office of Appeals will notify the provider of approval or denial to take the appeal.

D. The Executive Director or designee 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 waived if both parties agree.

Source: 42 C.F.R. Part 455 Subpart E; Miss. Code. Ann. § 43-13-121.

History: Renamed and revised eff. 03/01/2023.

Rule 3.4: Hearing Procedure

A. The administrative hearing shall be conducted in an informal manner but consistent with courtroom practices and procedures.

B. Location of Hearing.

1. The administrative hearing will be held at the Division of Medicaid's central office, unless otherwise designated.

2. Hearings may be held telephonically upon agreement of the parties and if approved by the Hearing Officer.

C. Provider's Rights. The provider may, at the provider's discretion:

1. Be assisted and represented by counsel,

2. Examine any evidence or witnesses presented at the administrative hearing, and

3. Present evidence and witnesses.

D. Witnesses and Evidence.

1. All witnesses shall be sworn in prior to testifying. False statements under oath are subject to applicable state and federal laws regarding perjury.

2. 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, including but not limited to rulings about the pertinence, relevance, or redundancy of evidence.

E. Hearing Record. The Division of Medicaid will provide a court reporter and/or a tape recorder to make an accurate record of the administrative hearing procedures.

Source: 42 C.F.R. Part 455 Subpart E; Miss. Code. Ann. § 43-13-121.

History: Renamed and revised eff. 03/01/2023.

Rule 3.5: After the Hearing

A. After the hearing has concluded, the Hearing Officer shall issue a recommendation with respect to the Final Agency Action. The standard of review to be applied by the Hearing Officer is whether the Final Agency Action was:

1. Unsupported by substantial evidence,

2. Arbitrary and capricious,

3. Beyond the power of the administrative agency to make, or

4. Violated the complaining party's statutory or constitutional rights.

B. The Hearing Officer may recommend upholding the Final Agency Action in whole or in part; reversing it in whole in part; or recommend sending it back to DOM for reconsideration.

C. The Executive Director of the Division of Medicaid, upon a review of the proceedings and the recommendation of the Hearing Officer, will issue a Final Decision. The Executive Director may adopt the recommendation of the Hearing Officer, amend the recommendation of the Hearing Officer and adopt that as the Final Decision, or remand the matter back for reconsideration. The Executive Director may assess all or any part of the costs of the administrative hearing to the provider if the provider is not the prevailing party on any or all of the issues subject to the provider's appeal. The Executive Director may grant sanctions at the Executive Director's discretion or at the recommendation of the Hearing Officer.

Source: 42 C.F.R. Part 455 Subpart E; Miss. Code. Ann. §43-13-121.

History: Renamed and revised eff. 03/01/2023.

Rule 3.6: Post-Decision Relief

A. Appeal of a final administrative decision must be filed in a court of proper jurisdiction within sixty (60) days from the date of notice. The Final Decision will be mailed to the provider by certified mail sent to the proper address of the provider on file with the Division of Medicaid.

B. Providers filing a judicial appeal must post both an appeal bond and a supersedeas bond in the court of proper jurisdiction.

C. Failure by a provider to either timely file a judicial appeal or secure the requisite bonds will serve as ground for dismissal for failure to comply with all administrative procedural requirements for appeal.

Source: 42 C.F.R. Part 455 Subpart E; Miss. Code. Ann. §§ 11-51-31, 43-13-121.

History: Renamed and revised eff. 03/01/2023.

Rule 3.7: Consolidation Requested by a Provider or the Division

A. A provider or the Division may request a consolidated hearing when two or more matters arise from the same fact pattern or involve the same issue of law. The administrative Hearing Officer may grant or deny a party's request for consolidation.

B. The Hearing Officer must take into account adjudication deadlines for each appeal and may require a requesting party to waive the adjudication deadline associated with one or more appeals if consolidation otherwise prevents the Hearing Officer from deciding all of the appeals at issue within their respective deadlines.

C. Notice of a consolidated hearing will be included in the notice of hearing.

D. After a Consolidated Hearing, the Hearing Officer may render either:

1. A consolidated decision and record, or

2. A separate decision and record on each appeal. If a separate decision and record on each appeal is made, the Hearing Officer is responsible for making sure that any materials, including documents, evidence and testimony, relevant to multiple issues are included in each hearing record as appropriate.

Source: 42 C.F.R. Part 455 Subpart E; Miss. Code. Ann. § 43-13-121.

History: New rule eff. 03/01/2023.

Rule 3.8: All Other Matters Not Defined

Any matter involving a provider requiring an administrative hearing or an appeal not otherwise defined within these rules will be allowed as outlined in this chapter. If specific time frames of the matter relating to the requesting, granting, and concluding of the hearing are contrary to the time frames as set out in the general administrative procedures above, those specific time frames will govern over the time frames set out in this chapter.

Source: 42 C.F.R. Part 431 Subpart E; Miss. Code Ann. § 43-13-121.

History: New Rule eff. 03/01/2023.

Chapter 4: Claim Denials

Rule 4.1. Definitions

A. Administrative Review for a Denied Claim is defined as a review of a claim denied for timely filing that is conducted by the Division's Office of Provider Solutions.

B. Final Administrative Decision is defined as the final decision regarding an Administrative Review for a Claim made by the Division's Office of Provider Solutions, acting as the designee of the Executive Director. This decision may be appealed to the court of proper jurisdiction for Judicial Review.

C. Fiscal Agent is defined as the agency, under contract with the Division of Medicaid, for the purpose of disbursing funds to providers of services under the Medicaid program. The fiscal agent collects eligibility and payment information from agencies administering Medicaid and processes the information for payment to providers.

D. Fiscal Agent Error is defined as an error made by the Division's Fiscal Agent in the

administration of the services it has been contracted by the Division to perform.

E. Provider Billing Error is defined as an error made by a Provider in the submission of a claim, including failure to obtain prior authorization, claims made for services and/or providers not covered, duplicate services, other insurance and/or incorrect beneficiary identification.

F. Timely filing period is defined as three hundred and sixty-five (365) days from the date of service.

G. Timely processing period is defined as three hundred and sixty-five (365) from the date the claim is filed.

Source: 42 C.F.R. § 447.45; Miss. Code Ann. §§ 43-13-113, 43-13-117, 43-13-121.

History: New Rule eff. 03/01/2023.

Rule 4.2 Errors Made within the Timely Processing Period

A. The Provider may not seek relief from the Division for a claim denied due to an error within the timely processing period until the provider exhausts the applicable process for the type of error as detailed below.

1. Fiscal Agent Error

a) When a claim is denied due to Fiscal Agent Error(s) within the timely processing period, the provider must notify the fiscal agent to correct the error.

b) If the Fiscal Agent does not correct the error within the timely processing period, the provider may contact Division of Medicaid Office of Provider Solutions within ninety (90) days of the end of the timely processing period for an Administrative Review for the Denied Claim.

2. Provider Billing Errors

a) Claims submitted within the timely filing period that deny due to a Provider Billing Error(s) may be resubmitted to the Fiscal Agent within the timely processing period.

b) Claims submitted outside of the timely filing period will only be reviewed if the requirements listed in Part 200, Rule 1.6 are met. The Division has discretion to grant or refuse an Administrative Review for a Denied Claim.

c) Denial of a request for an Administrative Review for a Denied Claim is the Division's Final Administrative Decision.

d) If the Division does grant a request for Administrative Review of a Denied Claim, the Division of Medicaid's Office of Provider Solutions will render the Division's Final Administrative Decision.

3. Providers may not appeal the technical denial of a claim for failure to timely obtain a prior authorization.

B. Claims Denied for Untimeliness

1. Providers may request an Administrative Review for a claim denied for untimeliness within ninety (90) calendar days of the denial of a claim when:

a) The provider is unable to meet the timely filing requirement due to retroactive beneficiary eligibility and has:

1) Received prior authorization, if required, from the Utilization Management/Quality Improvement Organization (UM/QIO) within ninety (90) days of the system add date of the eligibility determination, and

2) Filed the claim within ninety (90) days of the system add date of the eligibility determination,

b) The Division of Medicaid adjusts claims after timely filing and timely processing deadlines have expired,

c) A Medicare crossover claim has been filed within one hundred eighty (180) calendar days from the Medicare paid date and the provider is dissatisfied with the disposition of the Medicaid claim, or

d) The Fiscal Agent's untimeliness decision was incorrect.

2. Requests for an Administrative Review for a Denied Claim must include:

a) Documentation of timely filing or documentation that the provider was unable to file the claim timely due to the beneficiary's retroactive eligibility;

b) Documentation that explains the facts that support the provider's position as to how the denied claim meets one (1) or more of the requirements in Miss. Admin. Code, Title 23, Part 300, Rule 4.1.B. and the reasons the provider believes the Provider complied with Medicaid regulations;

c) A new claim submission for the claim in question; and

d) Any other documentation as required or requested by the Division of Medicaid.

3. Requests for an Administrative Review for a claim adjusted after the expiration of timely filing must include:

    a) A copy of the Remittance Advice that includes the claim adjustment;

    b) Documentation supporting the Provider's position that the claim meets one (1) or more of the requirements of Rule 4.1.C. of this Chapter;

    c) A new claim submission for the subject claim; and

    d) Any other documentation as required and/or requested by the Division.

C. Medical necessity

1. Providers may request a reconsideration when a claim is denied due to failure to meet medical necessity requirements by submitting the required documentation to the fiscal agent within ninety (90) days of the denial.

2. If the provider is not satisfied with the fiscal agent's medical necessity determination, the provider may request, in writing, an administrative hearing with the Division of Medicaid within ninety (90) days of the receipt of the fiscal agent's medical necessity determination through the appeal process as described in Rule 3.1 of this Part.

Source: Miss. Code Ann. §§ 43-13-113, 43-13-117, 43-13-121.

History: New Rule eff. 03/01/2023