Title 23: Division of Medicaid

Part 300: Appeals

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.

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Source: 42 C.F.R. § 455.422; Miss. Code Ann. § 43-13-121.~~; 42 C.F.R. § 455.416.~~

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