Title 23: Division of Medicaid

Part 300: Appeals

Chapter 1: Appeals

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.

Title 23: Division of Medicaid

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~~Part 300~~ Chapter 1: Appeals

Rule 1.4: Provider Peer Review Protocol

C. 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.

D. 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 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 1.4: 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~~