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.