

Division of Medicaid	New:	Date:
State of Mississippi	Revised: X	Date: -07/01/00
Provider Policy Manual	Current:	09/01/06
Section: General Policy	Section: 7.05	
	Pages: 6	
Subject: Health Care Practitioner Peer Review Protocol	Cross Reference:	

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.
3. Supported by the appropriate documentation of medical necessity and quality.

When DOM has identified, by data analysis and other means, a possible violation by a health care practitioner of one or more of these obligations, the matter will be referred to the ~~Medicaid Peer Review Organization (PRO)~~ 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 1 of the process, the ~~PRO~~ UM/QIO will report its status to DOM at least monthly.

This protocol employs three levels of due process:

Level I - Peer review panel considerations and actions

Level II - Division of Medicaid administrative hearing panel proceedings

Level III - Division of Medicaid sanctions

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.

I. Peer Review Panel Considerations and Actions

Panel Selection

When a referral is received from DOM, the Medical Director of the ~~PRO~~ UM/QIO will select a panel of at least three health care practitioners; at least one 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. DOM will make records relevant to the possible violation available to the Peer Review Panel.

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 30 to 60 calendar days of the receipt of the records by the Medical Director of the ~~PRO~~ UM/QIO.

Peer Review Findings

If the Peer Review Panel determines that there has been no violation of obligations it will notify the DOM 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. DOM will make a final decision, within not more than 14 working days of its receipt of the recommendation, and so inform the ~~PRO-UM/QIO~~. DOM may accept the recommendation, take other action on the case, or return the case to the ~~PRO-UM/QIO~~ for further action, as specified by DOM.

If the Peer Review Panel finds a potential violation of obligations, it will present that preliminary finding to the Medical Director of the ~~PRO-UM/QIO~~ 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.

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 ~~notify~~ relay its findings to the UM/QIO Medical Director ~~of the PRO~~ ~~of its finding~~, who will recommend to the Executive Director of DOM that the health care practitioner be immediately suspended from the Medicaid program. Based upon this recommendation, the Executive Director of DOM may take such action as deemed appropriate and notify the health care practitioner. The procedures set forth herein in ~~Section~~ Level II will be followed.

Peer Review Panel Conference with health care practitioner

1. Notification of Conference

The letter giving notice of potential violation will:

- Set forth the specific preliminary finding of potential violation or violations,
- Instruct the health care practitioner to attend a Peer Review Panel conference ~~with the Peer Review Panel~~, which will be set no later than 30 days after the letter date, in order to present his or her position on the matters at issue,
- 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,
- 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 10 days prior to the conference in order to allow time for its proper study,
- Convey a copy of this ~~P~~protocol,
- Provide notice that, at the conference, the Peer Review Panel will consider all relevant information, whether provided by DOM or by the health care practitioner, prior to making its final recommendation on the matter, and
- 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.

2. Conduct of the Conference

The Peer Review Panel will either select one of its members to preside at the conference or invite the Medical Director of the ~~PRO~~ UM/QIO to do so. If the Medical Director 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.

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.

3. Outcome of the Conference

- 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 ~~PRO~~ UM/QIO, who will convey that written recommendation to the DOM 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. DOM will make a final decision within not more than 14 working days of its receipt of the recommendation and so inform the ~~PRO~~ UM/QIO. DOM may accept the recommendation, may take other action on the case, or return the case to the ~~PRO~~ UM/QIO for further action, as specified by DOM. The ~~PRO~~ UM/QIO will inform the health care practitioner, as directed by DOM, if it is determined to close the case.
- If the Peer Review Panel determines that the health care practitioner has violated one or more DOM obligations, it will formulate a corrective action plan (CAP) and recommend it to DOM's UM/QIO Contract Administrator within 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—a minimum of 90 days; and the means by which compliance with the CAP will be monitored and assessed. Upon DOM's approval, within not more than 14 working days of its receipt of the CAP, the ~~PRO~~ UM/QIO will notify the health care practitioner of the CAP by certified mail, restricted delivery, return receipt requested.
- The health care practitioner will be required to sign the CAP and return it within 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 DOM that a sanction be imposed on the health care practitioner. The procedures set forth in Section Level II will be followed.
- The ~~PRO~~ UM/QIO Medical Director 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 DOM Bureau of Program Integrity and submitted to the Peer Review Panel for review. Within 30 days of the receipt of such information from DOM, 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.

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- 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 DOM 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. DOM will make a final decision within not more than 14 working days of its receipt of the recommendation and so inform the ~~PRO, UM/QIO~~ .DOM may accept the recommendation, take other action on the case, or return the case to the ~~PRO~~ for further action, as specified by DOM. ~~The PRO UM/QIO will inform the health care practitioner, as directed by DOM, if it is determined to close the case, by certified mail, restricted delivery, return receipt requested action, as specified by DOM.~~ The PRO UM/QIO will inform the health care practitioner, as directed by DOM, if it is determined to close the case, by certified mail, restricted delivery, return receipt requested.
 - 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 DOM that a sanction be imposed. The full and complete record relied upon to make the recommendation ~~as well as~~ and the minutes of the Peer Panel will be submitted to the Executive Director of DOM within 15 days of the Peer Review Panel's recommendation for sanction.

II. Division of Medicaid Administrative Hearing

Notice of Sanction

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: .

- The obligation(s) violated,
- The situation, circumstance, or activity that resulted in the violation,
- The authority and responsibility afforded DOM under Miss. Code Ann. Section 43-13-121,
- A summary of the information used in arriving at the determination to initiate sanction, and
- Notice that DOM will impose the recommended sanction within 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 30 days.

Administrative Hearing Panel

1. Appointment of the Hearing Panel and Hearing Officer

If the health care practitioner requests an administrative hearing, the Executive Director of DOM will appoint a hearing panel consisting of three health care practitioners and two members of DOM staff with appropriate Medicaid program expertise in the issues involved. The Executive Director will appoint a hearing officer from among the panel to preside over the hearing.

2. Notice of Scheduled Hearing

The hearing officer will schedule a hearing and notify the health care practitioner of the date, time, and location by certified mail, restricted delivery, return receipt requested. The notification letter will also contain the following:

- The purpose of the hearing,
- The right of the health care practitioner to be represented by an attorney,
- The right of the health care practitioner to present a reasonable number of expert witnesses to testify in support of his or her position,
- The right of the health care practitioner to present documents and information at the hearing in support of his or her position, and
- That failure to attend the hearing will result in the sanction being imposed by DOM, as set forth in the notification letter, immediately.

3. Conduct of the Hearing

The hearing will be before the DOM Administrative Hearing Panel. The hearing will be informal but orderly and will consist of sworn testimony on the record.

The DOM Hearing Panel and its Hearing Officer will control the scope, extent, and manner of questioning. The hearing will be recorded and a transcript made which will become the official hearing transcript.

Should the specialty of the health care practitioner be such that the DOM Administrative Hearing Panel feels that input from a specialist other than that of any Panel member is needed, a health care practitioner from the designated specialty may be invited to participate in the hearing.

The presiding member of the Peer Review Panel which recommended sanction will present to the Hearing Panel its finding of violation or violations; its appraisal of the medical issues which have been raised; and its assessment of either the ineffectiveness of the CAP, the health care practitioner's refusal to participate in the CAP, or the gross and flagrant nature of the violations which required immediate sanction of the health care practitioner.

Once the subject health care practitioner has presented all of his or her information and witnesses relevant to the issue(s), the hearing will be concluded. The health care practitioner will be informed that a written recommendation will be submitted to the Executive Director of DOM, who will render a final written decision, which will be mailed, certified mail, restricted delivery, return receipt requested, to the health care practitioner

III. Division of Medicaid Sanction

In notifying the Executive Director of the Division of Medicaid of its recommendation to sanction, the DOM Administrative Hearing Panel will submit the full and complete record containing all information that led to the recommendation to sanction. This record shall include:

- The name and address of the health care practitioner with his or her specialty and board certification, if applicable,

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- Copies of all notices sent to the health care practitioner within the scope of this protocol,
 - The type of health care services involved,
 - Copies of all medical records relied upon during the course of this protocol,
 - A case-by-case synopsis of the cases in question and the review determinations and recommendations made by the Peer Review Panel,
 - Copies of all correspondence, including notations of telephone conversations with the health care practitioner, throughout the course of this protocol,
 - Minutes of all Peer Review Panel meetings,
 - The transcript and exhibits of the DOM Administrative Hearing Panel hearing,
 - The Corrective Action Plan, if applicable, and the Peer Review Panel's evaluation of its effectiveness,
 - The qualifications of the Peer Review Panel and of the DOM Administrative Hearing Panel, and
 - The DOM Administrative Hearing Panel's written recommendation to sanction.

The Executive Director of DOM, upon review of the record, proceedings, and recommendation of the DOM Administrative Hearing Panel, 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.

Division of Medicaid	New:	Date:
State of Mississippi	Revised: X	Date: 07/01/00
Provider Policy Manual	Current:	09/01/06
Section: General Policy	Section: 7.07	
	Pages: 1	
Subject: Administrative Hearings - Eligibility Decisions	Cross Reference:	

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 DOM, if DOM is the determining agency.

The Social Security Administration is the Federal agency charged with the responsibility of determining who is eligible for Supplemental Income (SSI). In Mississippi, individuals who are eligible for SSI are automatically eligible for Medicaid. Applicants who are denied SSI are also denied Medicaid. Beneficiaries whose entitlement to SSI is terminated also lose Medicaid. These individuals denied or terminated from SSI may apply for Medical Assistance Only provided the application qualifies under one of the Medicaid only coverage groups covered by the Medicaid regional offices.

If an SSI applicant or beneficiary disagrees with the decision to deny or terminate SSI benefits, the individual must contact the Social Security office that issued the adverse decision. A request for a hearing must be made with the Social Security Administration when the issue to be determined is SSI benefits and automatic Medicaid eligibility.

~~The Mississippi State Department of Human Services is the State agency charged with the responsibility of determining eligibility for families and children as outlined in Section 3.01. These individuals who are eligible for assistance through DHS are automatically eligible for Medicaid. If an applicant's application for Medicaid as determined by DHS is disapproved or a decision is made to terminate a beneficiary's benefits under any DHS program, and he/she disagrees with the decision, the individual must contact the local DHS office to request a hearing. The State Department of Human Services has adopted local and State hearing procedures relating to adverse determinations of financial assistance and Medicaid eligibility for the programs they administer.~~

~~The Division of Medicaid is charged with the responsibility of determining Medicaid eligibility for certain aged, blind, and disabled individuals who are not eligible for or receiving SSI.~~

The Division of Medicaid is the State agency charged with the responsibility of determining Medicaid eligibility for families, children, pregnant women and aged, blind and disabled individuals who do not qualify for SSI. If an applicant's application for Medicaid as determined by DOM is disapproved or a decision is made to terminate or reduce a beneficiary's benefits under any DOM program, and he/she disagrees with the decision, the individual may request a local and/or state hearing by contacting the Regional Office that made the decision or by contacting the DOM State Office. Hearing requests must be made in writing within 30 days of the adverse action to deny, terminate or reduce Medicaid benefits. All adverse action notices issued to applicants or beneficiaries contain their appeal rights and explain how to request a hearing.

The Department of Human Services (DHS) is the State agency charged with the responsibility of determining Medicaid eligibility for foster children in the custody of DHS. In the event DHS denies, terminates or reduces the Medicaid benefits of a foster child, DHS is the agency responsible for handling the appeals of such adverse actions.