MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

December 20, 2005 Corrected

MEMORANDUM

TO: CUSTODIANS OF MEDICAID SERVICES MANUALS

FROM: JOHN A. LIVERATTI, CHIEF, COMPLIANCE

SUBJECT: MEDICAID SERVICES MANUAL CHANGES

BACKGROUND AND EXPLANATION

The Medicaid Chapter that covers Hearings has redefined a definition and changed some policies to simplify and clarify its meaning to recipients and to providers.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL 42/05	
CHAPTER 3100 HEARINGS	
Sec. 3102.4 Authorized Representative	
Added: A written and signed request sent to Nevada Medicaid, to allow representation by a designated person as their legal representative is required. The request would include the designated person's name and relationship to the requestor.	
3104.13 (3) (a) Copying the Hearing Record	Deletion of the current sentence.
Added: The requestor may secure a copy of the tape recording and/or transcript of a Fair Hearing by written request to the Department of Administration. Please note that the requestor shall be invoiced from the Department of Administration for this service and the requestor is responsible for the payment of these records.	

3105: Medicaid Services Hearing Procedures Providers	Deletion of three commas from this sentence to allow for easier reading and understanding.
3105.1. 2: Date of Request Replace 30 days to 90 days	Deletion of hearing request date from 30 days.

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3100 INTRODUCTION

The Division of Health Care Financing and Policy may make available a fair hearing process to any Medicaid or Nevada Check Up recipient who disagrees with any action resulting in the reduction, suspension, termination, denial or denial-in-art of a Medicaid service. Also, any recipient who makes a request for a service and believes the request was not acted upon with reasonable promptness by Medicaid and/or the health plan may request a fair hearing.

Nevada Medicaid makes available a fair hearing process whereby providers request a hearing for an adverse action taken by the Division which affects the provider's participation in the Medicaid program, reimbursement for services rendered to eligible Medicaid recipients or recoupments.

All Medicaid policies and requirements (such as prior authorization, etc.) are the same for Nevada Check Up, with the exception of the four areas where Medicaid and Nevada Check Up policies differ as documented in Chapter 3700.

3101 REGULATORY AUTHORITY

3101.1 The fair hearing process for recipients is a mandated service. The citation denoting the right to a hearing is found in 42 Code of Federal Regulations (CFR), §431, Subpart E. In addition, the citation denoting the appeals procedure for nursing facilities (NF) and intermediate care facility for the mentally retarded (ICF/MR) is found in 42 CFR §431, Subpart D.

3101.2 The fair hearing process for providers is cited at NRS Chapter 422.306 – Hearing to review action taken against provider of services under state plan for Medicaid regulations; appeal of final decision.

3102 DEFINITIONS

3102.1 ACTION

An ACTION is a termination, suspension, reduction or denial of Medicaid eligibility or covered services. An action also means determinations by skilled nursing facilities and nursing facilities to transfer or discharge residents and adverse determinations made by a State with regard to the pre-admission screening and resident review (PASARR II) requirements of Section 1919(e)(7) of the Social Security Act. It includes changes in type or amount of services or a change in level of care.

3102.2 ADVANCE NOTICE OF ACTION

A written notice must be mailed by Medicaid to the individual when Medicaid or the health plan propose to take an ACTION, as defined in 3102.1, at least 10 days before the DATE OF ACTION. ADVANCE NOTICE and NOTICE OF DECISION may be used interchangeably.

3102.3 ADVERSE DETERMINATION

Adverse determination means a determination made in accordance with sections 1919(b)(3)(f) or 1919(e)(7)(B) of the Act that the individual does not require the level of services provided by a nursing facility or that the individual does or does not require specialized services.

3102.4 AUTHORIZED REPRESENTATIVE

An authorized representative is an individual who has been designated by a recipient as having authority to act on behalf of the recipient. A written and signed request sent to Nevada Medicaid, to allow representation by a designated person as their legal representative. The request would include the designated person's name and relationship to the requestor.

3102.5 BURDEN OF PROOF

At a fair hearing, the recipient or provider must establish by a preponderance of the evidence that the agency's denial of the request was not correct. Except where otherwise established by law or regulation, in fair hearings concerning the termination, reduction or suspension of medical assistance previously received by a recipient, the agency must establish by a preponderance of the evidence that its actions were correct.

Preponderance of the evidence is that evidence which, in light of the record as a whole, leads the hearing officer to believe that the finding is more likely to be true than not true. Except where otherwise established by law or regulation, in provider fair hearings concerning claims,

recoupments, suspension, non-renewals or terminations, the agency must establish by a preponderance of the evidence that its actions were correct.

3102.6 CONTENTS OF NOTICE

A notice must contain the following information:

1. A statement of what action the State, or nursing facility intends to take;

2. The reasons for the intended action;

3. The specific regulations that support, or the change in Federal or State law that requires the action;

4. An explanation of:

   a. The individual's right to request an evidentiary hearing if one is available, or a State agency hearing; or
   b. In cases of an action based on a change in law, the circumstances under which a hearing will be granted; and

5. An explanation of the circumstances under which services are continued if a hearing is requested.

3102.7 DATE OF ACTION

Is the intended date on which a termination, suspension, reduction, transfer or discharge becomes effective. It also means the date of the determination made by a State with regard to the preadmission screening and annual resident review (PASARR) requirements of Section 1919(e)(7) of the Social Security Act.

3102.8 EXCEPTION TO ADVANCE NOTICE

Pursuant to 42 CFR §431.213, the agency may mail a notice not later than the date of action if:

1. The agency has factual information confirming the death of a recipient;

2. The agency receives a clear written statement signed by a recipient that:

   a. He/She no longer wishes services; or
   b. Gives information that requires termination or reduction of services and indicates that he/she understands that this must be the result of supplying that information.

3. The recipient has been admitted to an institution where he/she is ineligible under the plan for further services;
4. The recipient's whereabouts are unknown and the post office returns agency mail directed to him/her indicating no forwarding address (see §431.231(d) of this subpart for the procedure if the recipient's whereabouts become known);

5. The agency establishes the fact that the recipient has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth;

6. A change in the level of medical care is prescribed by the recipient's physician;

7. The notice involves an adverse determination made with regard to the preadmission screening requirements of section 1919(e)(7) of the Act; or

8. The date of action will occur in less than 10 days, in accordance with §483.12(a)(5)(ii), which provides exceptions to the 30 days notice requirements of §483.12(a)(5)(i).

Pursuant to 42 CFR §431.214, the agency may shorten the period of advance notice to 5 days before the date of action if:

1. The agency has facts indicating that action should be taken because of probable fraud by the recipient; and

2. The facts have been verified, if possible, through secondary sources.

3102.9 HEARING

A hearing is an orderly, readily available proceeding before a hearing officer, which provides for an impartial process to determine the correctness of an agency action. Recipients and Medicaid providers are afforded an opportunity for a hearing in certain circumstances and when requested in a timely manner. An agency action or adverse determination made against a recipient's request for service or payment as well as a determination against a provider that terminates or may provide the opportunity for a hearing.

3102.10 HEARING OFFICER

The hearing officer is an impartial fact-finder who may or may not be an employee of the Division of Health Care Financing and Policy (DHCFP). The hearing officer is an individual who has not been directly involved in the investigation or initial determination of the action in question.

It is the hearing officer's responsibility to:

1. Notify the parties regarding the date, time and place of the hearing;
2. Receive verbal testimony and documentary evidence from the recipient, provider and agency representatives;

3. Make a complete record of the hearing proceedings;

4. Control the hearing and exclude irrelevant information;

5. Make a decision based on program policy and the evidence presented; and

6. Notify the parties of the decision and the right to seek judicial review.

3102.11 HEARING PREPARATION MEETING (HPM)

Within ten (10) calendar days of a request for a hearing, the responsible office (district office or central office) contacts the claimant to offer to schedule a hearing preparation meeting (HPM) with agency staff to discuss the action being contested. The purpose is to provide an opportunity to the recipient or provider to ensure he understands the reason for the action which is the subject of the hearing request and to possibly resolve the matter. Every effort is made to reconcile the disagreement without the necessity of a hearing. The right to a hearing is not affected by attendance at a hearing preparation meeting. The recipient may bring legal counsel, a friend, or other spokesman to the conference and present information to show that the proposed action is incorrect. The provider may bring legal counsel.

It is important the hearing preparation meeting be held at the earliest possible date, but no later than twenty-one (21) working days after receipt of the hearing request. Rescheduling of a HPM should be kept to a maximum of two (2), assuring completion by the required due date. Rescheduling at the recipient or provider request is allowed if "good cause" is substantiated. Good cause is defined as a factor(s) beyond the recipient or provider's control such as illness or an unavoidable absence from their area.

The hearing preparation meeting may be conducted via telephone.

3102.12 PROGRAM POLICY

Program policy refers to all relevant doctrine including federal regulations, Nevada Revised Statute, Medicaid State Plan, Medicaid Services Manual, Policy News and Bulletins and Medicaid's interpretation of its policy.

3102.13 RECIPIENT

A person who receives benefits pursuant to the Medicaid State Plan.

3102.14 REQUEST FOR HEARING

A clear, written request from either a provider or Medicaid recipient to the Division for a hearing relating to a sanction and/or adverse determination. In the case of a provider sanction or adverse determination, it is a request made after all Division remedies have been exhausted by the provider.

3103 POLICY

3103.1 Pursuant to 42 CFR at 431 Subpart E, Nevada Medicaid will provide an opportunity for a fair hearing to any person whose claim for assistance is denied or not acted upon promptly.

Pursuant to NRS Chapter 422.306, Nevada Medicaid will provide an opportunity for a fair hearing to review an adverse action taken against a provider of services.

Nevada Medicaid provides the Fair Hearing process pursuant to Section 3104 and 3105 of this Chapter.

3104 MEDICAID SERVICES HEARING PROCEDURES – RECIPIENTS

3104.1 REQUEST FOR A MEDICAID SERVICES HEARING

1. Who May Request

A recipient or his authorized representative may request a hearing in writing.

2. Date of Request

The date of the request for a hearing is the date the request is received by the Medicaid office. This request must be received by the Medicaid office within 90 calendar days from the date the Medicaid Notice of Decision was mailed unless a recipient or provider of fee for service can substantiate "good cause" for not doing so. Good cause may include such reasons as an illness or extended absence from the area which prevented a timely response. When the deadline falls on a weekend or holiday, the deadline is extended to the next working day.

The request for hearing must contain the recipient's name, address, Medicaid number and the name and address of the authorized representative, if applicable.

3. Subject Matter

The agency must grant an opportunity for a hearing to:

a. A recipient who requests it because his request for services is denied;
b. A recipient who requests it because his request for services is not acted upon with reasonable promptness;
c. A recipient who requests it because he believes the agency has taken an ACTION erroneously;
d. Any resident of a nursing facility who believes the facility erroneously determined that he must be transferred or discharged;
e. Any recipient who requests it because he believes the State has made an erroneous determination with regard to the preadmission screening and annual resident review (PASARR) as outlined in Section 1917(e)(7) of the Social Security Act.

This includes an adverse determination that the recipient does not require specialized services as defined in 42 CFR §431.201; 431.206 and 431.220 as determined by a PASARR.

Pursuant to 42 CFR §204, the state will provide a system for a resident of a Nursing Facility (NF) to appeal a notice from the NF of intent to discharge or transfer the resident.

Upon receipt of the discharge notice, the resident may request a fair hearing in writing by submitting a letter to Nevada Medicaid. Nevada Medicaid will inform the Department of Administration of the resident's request for a fair hearing. Nevada Medicaid does not take an adverse action against the resident; rather the facility takes the action via the discharge. Nevada Medicaid is not a party to the action.

3104.2 DISPOSITION OF A MEDICAID FAIR HEARING REQUEST

1. Dismissal of a Hearing Request Upon:

   a. Withdrawal of a Hearing Request
   A recipient may withdraw the request for a hearing at any time before a decision is rendered. Notification of the request for withdrawal will be submitted to the hearing officer who will dismiss the hearing request. The hearing officer will dismiss the hearing request upon receipt of the request to withdraw.

   b. Abandonment of a Hearing Request
   A hearing is considered abandoned and may be dismissed by the hearing officer when the recipient fails to appear for a scheduled hearing after having been properly notified. The recipient's request for hearing is considered abandoned unless they submit to the hearing officer substantiation for good cause for failing to appear. The hearing officer must receive the substantiation within ten (10) calendar days of the date of the scheduled hearing.

   c. Agency Action
   Medicaid may reverse its notice of decision at any time during the hearing process. If a Medicaid reversal occurs, a report shall be submitted by the person conducting the review detailing the reason(s) for the reversal if a fair hearing has been calendared. The report must be forwarded to the hearing officer within five (5) business days following the reversal decision date or review date if a fair hearing has been scheduled. The hearing officer notifies the recipient the request for hearing is dismissed because Medicaid will not take action or has reversed the decision.

2. Denial of a Hearing Request

   A hearing need not be granted when:
   a. The sole issue is a Federal or State law requiring an automatic change adversely affecting some or all recipients;
   b. The request is not received timely (see Section 3104.1b);
   c. The agency and/or health plan has not taken any ACTION affecting the recipient, nor made an ADVERSE DETERMINATION, nor denied a request for services, nor failed to act upon the request within reasonable promptness;
   d. A recipient is not Medicaid eligible, except for PASRR determinations.

3104. 3 HEARING NOTIFICATION, SCHEDULING, AND LOCATION

1. Notice of Hearing

The hearing officer must notify the recipient, appropriate office (local and/or central) and if applicable, the health plan, by mail as to the time, date and place the hearing has been scheduled. Recipients are given at least ten (10) calendar days advance notice of the scheduled hearing unless the recipient specifically requests a hearing in a shorter period of time based on an emergency.

At the discretion of the hearing officer, a hearing may be postponed if requested by the appropriate Medicaid office (local or central), Health Plan, recipient, or counsel of either party.

If the recipient requests a postponement, the number of days postponed will extend the decision due date by an equal number of days.

2. Hearings by Telephone

Either party may request that the hearing be conducted via telephone conference. If a telephone hearing is held, the following procedures apply:

a. The hearing officer can hold teleconferences from the assigned Hearing Office. Medicaid representative(s), and/or health plan representative(s) must be at the location designated in the scheduling letter.
b. The recipient is advised at the time the hearing is scheduled that all other policies and procedures relative to hearings and program requirements still apply.
c. The hearing officer may request Medicaid and the recipient to provide copies of any evidence or exhibits to be presented during the hearing to the hearing officer and the other parties prior to a scheduled telephone hearing. This does not preclude additional information from being presented during the hearing, or if requested, after the close of the hearing.
d. All telephone hearings must be tape recorded by the hearing officer over the telephone. This recording is the official record.

3104.4 PROGRAM PARTICIPATION PENDING A HEARING DECISION

1 Recovery

If Medicaid services are continued until a decision is rendered, such cost of services are subject to recovery by Medicaid if the agency's action is sustained or the hearing request is withdrawn by the recipient.

2 Maintaining Medicaid Services

If the agency mails the notice as required, and the recipient requests a hearing before the DATE OF ACTION, Medicaid will not terminate or reduce services until a decision is rendered after the hearing unless:

a. The hearing officer makes a determination the sole issue is one of Federal or State law or policy and the agency promptly informs the recipient in writing that services are to be terminated or reduced pending the hearing decision; or,
b. The recipient requests in writing that benefits not be continued pending a hearing decision; or
c. The request for hearing is denied or dismissed.

3. Reinstating Medicaid Services

a. Discretionary: When a recipient requests a hearing no more than the 10th calendar day after the DATE OF ACTION, the agency may reinstate benefits if requested by the recipient. The reinstated services will continue until a hearing decision is rendered unless, at the hearing, it is determined that the sole issue is one of Federal or State law or policy.
b. Mandatory: The agency must reinstate and continue services until a decision is rendered after a hearing if:
    1. Action is taken without the required advance notice;
    2. The agency mails the 10-day or 5-day notice as required under 42 CFR §431.211 or 42 CFR §431.214, and the recipient requests a hearing before the date of action, the agency may not terminate or reduce services until a decision is rendered after the hearing unless:
        a. It is determined that the sole issue is one of Federal or State law or policy; and
        b. The agency promptly informs the recipient in writing that services are to be terminated or reduced pending the hearing decision.

3104.5 HEARING PARTICIPATION

1. Attendance

Attendance at a hearing is limited to those directly concerned; namely, the hearing officer, recipient(s), and/or their witnesses, counsel or authorized representative(s), interpreter, witnesses and representatives of Medicaid, and if applicable, representatives from the health plan. Counsel for the agency and/or health plan may also attend as necessary.

Nevada Medicaid assures the availability for recipients, their authorized representatives and witnesses of necessary transportation to and from the hearing.

2. Group Hearings

A series of recipient requests for a hearing may be consolidated upon agreement of all parties by conducting a single group hearing in cases in which the sole issue involved is one of State and/or Federal law, regulation or policy.

3104.6 PREPARATION/PRESENTATION

1. Agency/Health Plan

It is the responsibility of the agency and/or health plan representative to be present at the hearing, in person or telephonically, and to provide testimony and/or evidence regarding the agency's and/or health plan's action. This includes the organization of oral and written evidence and preparation of a "BASIS OF ACTION" summary substantiating the decision to be presented at the hearing. This summary becomes part of the record at the end of the hearing.

2. Recipient

a. Before the date of the hearing and during the hearing the recipient may examine and request copies of their own case information. Authorized representatives must provide a current signed release from the recipient to permit release of records. Nevada Medicaid and/or health plan will provide the copies free of charge. The recipient shall not have access to confidential information.

b. It is the responsibility of the recipient to provide testimony and/or evidence in support of his position either in person or telephonically. If the hearing involves a legal issue only, the recipient's presence, in person or telephonically, is not necessary. Testimony can be provided by a representative.

Recipients are allowed to bring witnesses and submit evidence to establish all pertinent facts and circumstances relative to the issue and to present arguments without undue interference. They are also allowed to question or refute any testimony or evidence and confront and cross-examine adverse witnesses. New evidence not previously provided to Medicaid or health plan, but which is believed to have a bearing on the action taken, should be provided to Medicaid prior to the hearing when possible for evaluation and any necessary action.

c. Recipients are given a copy of all evidence presented at the hearing by Medicaid.

3104.7 CONDUCT OF HEARING

1. Control

The hearing officer controls the hearing and ensures only relevant issues are considered. Disrespectful language or contemptuous conduct, refusal to comply with directions, or continued use of dilatory tactics by any person at the hearing constitutes grounds for immediate exclusion of such person from the hearing by the hearing officer and the hearing decision will be based on evidence submitted. A tape recorder must be used by the hearing officer to record hearing proceedings. The hearing officer's Transcripts of Evidence constitutes the sole official record.

2. Opening the Hearing

At the opening of the hearing, the hearing officer must:

a. Introduce himself;
b. Explain the reason for the hearing and the role of the hearing officer;
c. Assure all persons in attendance at the hearing are identified by name and purpose of attendance;
d. Advise all persons in attendance that the hearing is being tape-recorded.

3. Testimony and Evidence

Nevada Rules of Evidence do not apply in the hearing. The hearing officer:

a. Excludes irrelevant, immaterial or unduly repetitious evidence;
b. Provides the parties an opportunity to present their case, to present witnesses, introduce evidence and cross-examine witnesses and examine evidence; and
c. Collects and logs relevant evidence exhibits.

4. Closing the Hearing

At the close of the hearing, the hearing officer advises persons in attendance:

a. When a decision is expected to be made;
b. That the decision will be made based on program policy and exclusively on the testimony and evidence presented at the hearing; and
c. The parties will be advised in writing by certified mail of the decision.

5. Administering Oaths

Testimony under oath may be required at the discretion of the hearing officer.

3104.8 ACTION ON INCORRECT NOTICE OF DECISION FOR PAYMENT AUTHORIZATION REQUEST (NOD)

1. If, prior to the hearing, it becomes apparent the recipient has received an incorrect Notice of Decision for Prior Authorization Request from Medicaid or the health plan, a corrected notice must be sent to the recipient if the proposed action remains unchanged.

2. If, after a hearing has begun, it becomes apparent the recipient received an incorrect Notice of Decision for Prior Authorization Request (i.e., the notice quotes incorrect factual and legal reason(s) or omits additional factual and legal reason(s) pertinent to the issue), the hearing officer shall offer the recipient the choice of either accepting the incorrect notice, with the necessary corrections noted for the record and continuing with the hearing; or setting the hearing to a later date to allow Medicaid or the health plan time to prepare and serve the corrected NOD.

3104.9 SUBMISSION OF ADDITIONAL EVIDENCE

During a hearing, additional evidence related to the hearing issue may be submitted. The hearing officer, recipient, Medicaid or health plan may request additional evidence be submitted which is not available at the hearing. The hearing officer may:

1. Recess the hearing if additional evidence has been submitted, to allow for review by the recipient, Medicaid or health plan; or

2. Continue the hearing to a later date and order further investigation or request either party to review or produce the additional evidence; or

3. Close the hearing, but hold the record open to permit submission of any additional evidence.

3104.10 MEDICAL ISSUES

When the hearing involves medical issues such as those concerning a diagnosis or an examining physician's report, the hearing officer may require an additional medical assessment other than that of the person involved in making the original assessment. The request is directed to Nevada Medicaid or the health plan for evaluation and follow-up. Any additional assessment determined to be necessary is obtained at Medicaid or health plan expense. The hearing may be held open for a specified length of time pending receipt of such requested information. This additional assessment must be made part of the record.

3104.11 HEARING DECISION

The hearing officer's decision must be in writing and comply with Nevada Medicaid's program policy. The decision is based exclusively on evidence introduced at the hearing. Changed physical or social factors following the Medicaid or health plan action being appealed cannot be considered in rendering the hearing decision.

1. Basis

Decisions by the hearing officer shall:

a. Be based exclusively on the evidence introduced at the hearing;
b. Comply with applicable regulations in effect at the time of the agency's or health plan's action;
c. Summarize the findings of fact;
d. Identify and cite supporting evidence and regulation;
e. Be submitted in written format, to the Deputy Administrator, Medicaid or his designee.

2. Appeal is Denied

Denied decisions are adverse to the recipient. When the appeal is denied, the hearing officer will notify Medicaid or the health plan and the recipient of his right to judicial review.

Recipient withdrawals and abandonments are equivalent to a denied appeal. Medicaid may institute recovery procedures against the recipient to recoup the cost of any services furnished by Medicaid.

3. Appeal is Sustained

Sustained decisions are favorable to the recipient. Medicaid or the health plan must take corrective action promptly, retroactive to the date an incorrect action was taken. If appropriate, the agency must provide for admission or readmission of a recipient to a facility if the hearing decision is favorable to the recipient or if Medicaid decides in the recipient's favor before the hearing.

4. Decision Due Date

Within ninety (90) calendar days after the date of the request for a hearing has been received by the Medicaid office, the recipient, and the Hearings Unit must be notified of the Hearing Officer's decision specifying the factual and legal reasons for the decision and identifying the supporting evidence relied upon to reach the decision. A copy of the

decision must be delivered by certified mail to each party and to his attorney or other authorized representative.

The time period for a hearing decision may be extended for a period equal to the total delay if the recipient requests a delay or postponement of the hearing proceedings and waives his right to have a decision rendered within 90 days after the date of the request for a hearing.

3104.12 RIGHT TO APPEAL HEARING DECISION

The decision of the hearing officer is final. The hearing decision may be appealed by any party, within ninety (90) days after the date on which the written notice of decision is mailed, to the appropriate District Court of the State of Nevada. The day after the mailing is the first day of the 90-day period.

3104.13 HEARING RECORDS

1. Content

A hearing record is maintained by Medicaid or its designee. The record consists of all papers and requests filed in the proceeding, the transcript or recording of testimony and exhibits, or an official report containing the substance of what happened at the hearing, all exhibits received or considered, and the decision letter.

2. Retention of Hearing Record

Administrative hearing files and taped recordings must be retained no less than six (6) years from the date the hearing decision was rendered.

If a hearing decision is appealed, the hearing record must be retained until the court action is resolved or the designated retention period, whichever is later.

3. Copying the Hearing Record

Copies of the Hearing Record are made as follows:

a. The requestor may secure a copy of the tape recording and/or transcript of a Fair Hearing by written request to the Department of Administration. Please note that the requestor shall be invoiced from the Department of Administration for this service and the requestor is responsible for the payment of these records.

b. An official typed transcription of the tape recording of the hearing is prepared for the District Court and recipient when a hearing decision is appealed. Within 90 days after the service of the petition for judicial review, Medicaid or its designee

shall transmit to the court the original or a certified copy of the entire record of the proceeding under review, including, without limitation, a transcript of the evidence resulting in the final decision of the hearing officer.

* The requested tape recording and/or transcript is free of charge to the recipient, but not to a provider, only in the event that the recipient appeals to District Court.

3105 MEDICAID SERVICES HEARING PROCEDURES – PROVIDERS

All references in Medicaid Services Manual Section 3105 to Medicaid Services Manual Section 3104, indicate that the procedures that apply to recipients shall also apply to providers except as otherwise provided for in Medicaid Services Manual Section 3105.

3105.1 REQUEST FOR A MEDICAID SERVICES HEARING

1. Who May Request

A provider who disagrees with the result of the Fiscal Agent's provider appeal process regarding a claim, suspension, lockout, recoupment, termination or renewal issue.

The hearing officer shall insure the provider has followed any internal grievance process available through the QIO-like vendor prior to a Nevada Medicaid Fair Hearing.

2. Date of Request

The date of request for a hearing is the date the request is received by the Medicaid office. This request must be received by the Medicaid office within 90 calendar days from the date of Medicaid's Notice of Decision issued by First Health Services Corporation unless the provider can substantiate "good cause" for not doing so. When the deadline falls on a weekend or holiday, the deadline is extended to the next working day.

The request for a hearing must be submitted to Nevada Medicaid in writing.

The hearing request should include a copy of the letter from the Fiscal Agent indicating the decision to uphold denied or disputed claims, recoupment, suspension, lockout, renewal or termination of the provider number. The request for hearing must contain the provider name, address, and provider number if available.

3105.2 DISPOSITION OF A MEDICAID SERVICES HEARING REQUEST

1. Dismissal of a Hearing Request Upon:

a. Withdrawal of a Hearing Request
Reference Medicaid Services Manual Chapter 3100, Section 3104.2

b. Abandonment of a Hearing Request
Reference Medicaid Services Manual Chapter 3100, Section 3104.2

c. Agency Action
Reference Medicaid Services Manual Chapter 3100, Section 3104.2

2. Denial of a Hearing Request

A hearing need not be granted when:

a. The sole issue is a Federal suspension or ban of regulation at the Federal level effecting providers.
b. The request is not received timely (see Section 3105.1b)

3105.3 HEARING NOTIFICATION, SCHEDULING AND LOCATION

Reference Medicaid Services Manual Chapter 3100, Section 3104.3

3105.4 HEARING PARTICIPATION

Reference Medicaid Services Manual Chapter 3100, Section 3104.5

3105.5 PREPARATION/PRESENTATION

Reference Medicaid Services Manual Chapter 3100, Section 3104.6

3105.6 CONDUCT OF HEARING

Reference Medicaid Services Manual Chapter 3100, Section 3104.7

3105.7 SUBMISSION OF ADDITIONAL EVIDENCE

Reference Medicaid Services Manual Chapter 3100, Section 3104.9

3105.8 HEARING DECISION

Reference Medicaid Services Manual Chapter 3100, Section 3104.11

3105.9 RIGHT TO APPEAL HEARING DECISION

Reference NRS 422.306

3105.10 HEARING RECORDS

Reference NRS 442.306