MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

February 22, 2018

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: LYNNE FOSTER, CHIEF OF DIVISION COMPLIANCE \Lynne Foster\

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 3100 – HEARINGS

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 3100 – Hearings, are being proposed for consistency with the federal policy language in the Code of Federal Regulations (CFR), Title 42, Chapter IV, 431 Subpart E. Language specifying the circumstances under which a provider can request an expedited fair hearing for a recipient is proposed.

Throughout the chapter, grammar, punctuation and capitalization changes were made, duplications removed, acronyms used and standardized, and language reworded for clarity. Renumbering and re-arranging of sections was necessary.

Entities Financially Affected: All provider types are affected by this regulation.

Financial Impact on Local Government: Unknown at this time.

These changes are effective February 23, 2018.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL 03/18 Chapter 3100 - Hearings	MTL 20/17 Chapter 3100 - Hearings

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
3104.1B.1	**Medicaid Services Expedited Fair Hearing**	Added the words "(only under circumstances described below)"and "Providers may file a request only in cases where the recipient is unable to act on their own behalf, either because of physical incapacity or mental incapacity. Additional documentation may be required to demonstrate the incapacity on a case by case basis."

DIVISION OF HEALTH CARE FINANCING AND POLICY

MEDICAID SERVICES MANUAL
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HEARINGS

3100 INTRODUCTION

The Division of Health Care Financing and Policy (DHCFP) (also referred to as the "agency") makes a Fair Hearing process available to any Nevada Medicaid or Nevada Check Up (NCU) recipient who disagrees with: any action resulting in the reduction, suspension, termination, denial or denial-in-part of a Medicaid service; any recipient who makes a request for a service and believes the request was not acted upon with reasonable promptness by the DHCFP and/or the health plan. Also, the DHCFP makes available a Fair Hearing process for any Nursing Facility (NF) resident eviction.

The DHCFP makes available a Fair Hearing process whereby providers may request a hearing for any adverse action taken by the Division or its agents which affects the provider's participation in the Medicaid program, and/or reimbursement for services rendered to eligible Medicaid recipients' recoupment of overpayments or disenrollment.

For purposes of this manual section, Medicaid and NCU are referred to as Medicaid. All Medicaid policies and requirements (such as prior authorization, etc.) are the same for NCU, with the exception of three areas where Medicaid and NCU policies differ as referenced in the NCU Manual, Section 1003.6.

3101 AUTHORITY

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 and 42 CFR 457.1130 and Nevada Revised Statute (NRS) 422.276. Please see CFR §431.244 for exceptions to the Hearing decision due dates. In addition, the citation denoting the appeals procedure for NF and Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) is found in 42 CFR §431, Subpart D.

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 RESERVED

3103 POLICY

3103.1 The DHCFP provides the Fair Hearing process pursuant to Sections 3104 and 3105 of this Chapter of the Medicaid Services Manual (MSM).

3104 RECIPIENT FAIR HEARINGS

3104.1 FAIR HEARINGS

3104.1A MEDICAID SERVICES STANDARD FAIR HEARING

1. WHO MAY REQUEST

A recipient or his authorized representative may request a Standard Fair Hearing. A request for a Fair Hearing can be submitted via the internet, telephonically, in person, through other commonly available electronic means and in writing and signed by the recipient or the recipient's authorized representative.

2. DATE OF REQUEST

The date of the request for a Standard Fair Hearing is the date the request is received by the DHCFP office. The request must be received by the DHCFP office within 90 calendar days from the Notice Date, unless a recipient 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 hearing must contain the recipient's name, address, telephone number and Medicaid number as well as the name, telephone number and address of the authorized representative, if applicable.

Recipients enrolled in a Managed Care Organization (MCO) must request a Fair Hearing no later than 120 days from the date on the MCO's Notice of Decision (NOD) (Action).

3. SUBJECT MATTER

The DHCFP must grant an opportunity for a hearing to:

a. a recipient who requests it because his request for services is denied, reduced, suspended or terminated;

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 or managed health plan 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 Pre-admission Screening and Resident Review (PASRR) as outlined in Section 1917(e)(7) of the Social Security Act;

f. any recipient who is assigned (locked in) to using one pharmacy for all controlled substance prescriptions.

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 PASRR.

Pursuant to 42 CFR §483.204, the state will provide a system for a resident of a 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 via the internet, telephonically, in person, through other commonly available electronic means or by submitting the request to the DHCFP. The DHCFP will inform the Department of Administration of the residents request for a Fair Hearing. The DHCFP does not take an adverse action against the resident; rather the facility takes the action via the discharge. The DHCFP is not a party to the action.

3104.1B MEDICAID SERVICES EXPEDITED FAIR HEARING

1. WHO MAY REQUEST

A recipient, his/her authorized representative or a provider acting on a recipient's behalf (only under circumstances described below) may file for an Expedited Fair Hearing if the clinical documentation shows that the time permitted for a Standard Fair Hearing could jeopardize the individual's life, health or ability to attain, maintain or regain maximum function. The Expedited Fair Hearing request must be submitted with pertinent medical information that supports the reason for the urgent need of the expedited timeframe. Providers may file a request only in cases where the recipient is unable to act on their own behalf, either because of physical incapacity or mental incapacity. Additional documentation may be required to demonstrate the incapacity on a case by case basis. A request for an Expedited Fair Hearing can be made via the internet, telephonically, in person, through other commonly available electronic means and in writing.

2. DATE OF REQUEST

The date of the request for an Expedited Fair Hearing is the date the request is received by the DHCFP office.

The request for an Expedited Fair Hearing must contain the recipient's name, address, telephone number and Medicaid number, as well as the name, telephone number and address of the authorized representative and/or provider, if applicable, and must include all pertinent medical information that supports the reason for the urgent need of the expedited timeframe.

If the Expedited Hearing request is submitted without pertinent medical information, the Hearing request will be treated as a Standard Fair Hearing request (90-day decision). If the required documentation is submitted after the initial Expedited Hearing request is received, the timeframe for the Expedited Fair Hearing will begin the day the required pertinent medical documentation is received by the DHCFP.

3. SUBJECT MATTER

The DHCFP must grant an opportunity for an Expedited Fair Hearing to:

a. a recipient who requests it because his request for services is denied, reduced, suspended or terminated and the time permitted for a Standard Fair Hearing could jeopardize the individual's life, health or ability to attain, maintain or regain maximum function;

b. a recipient who requests it because his request for services is not acted upon with reasonable promptness and the time permitted for a Standard Fair Hearing could jeopardize the individual's life, health or ability to attain, maintain or regain maximum function;

c. a recipient who requests it because he believes the agency or managed health plan has taken an action erroneously and the time permitted for a Standard Fair Hearing could jeopardize the individual's life, health or ability to attain, maintain or regain maximum function; or

d. any resident of a NF who believes the facility erroneously determined that he must be transferred or discharged and the time permitted for a standard Fair Hearing could jeopardize the individual's life, health or ability to attain, maintain or regain maximum function;

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 PASRR.

Pursuant to 42 CFR §483.204, the state will provide a system for a resident of a 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 an Expedited Fair Hearing over the phone, electronically or in writing by submitting a letter to the DHCFP. The DHCFP will inform the Department of Administration of the resident's request for a Fair Hearing. The DHCFP does not take an adverse action against the resident; rather the facility takes the action via the discharge. The DHCFP is not a party to the action. A decision will be provided within seven working days from when the Hearing request was received.

4. EXCEPTIONS TO EXPEDITED FAIR HEARINGS

a. The agency cannot reach a decision because the recipient, authorized representative and/or provider request the delay.

b. The recipient, authorized representative and/or provider fails to take a required action such as submitting the required documentation.

c. If Medicaid services have been continued at unreduced levels per MSM Section 3104.4(C), the Expedited Fair Hearing process is not applicable and the Fair Hearing request will be treated as a Standard Fair Hearing request.

3104.2 DISPOSITION OF A FAIR HEARING REQUEST

A. DISMISSAL OF A HEARING REQUEST

A Fair Hearing request will be dismissed upon:

1. Withdrawal of a Hearing Request

A recipient may withdraw the request for a hearing at any time before a decision is rendered via phone, written submission or electronically. Notification of the request for withdrawal will be submitted to the Hearing Officer who will dismiss the hearing request. Written confirmation will be sent to the recipient regarding the withdrawal.

2. 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 10 calendar days of the date of the scheduled hearing.

3. Agency Action

Medicaid may reverse its NOD 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 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.

B. DENIAL OF A HEARING REQUEST

A hearing need not be granted when:

1. the sole issue is a Federal or State law requiring an automatic change adversely affecting some or all recipients;

2. the request is not received timely;

3. the agency and/or managed health plan has not taken any action affecting the recipient, or made an Adverse Determination, nor denied a request for services or failed to act upon the request within reasonable promptness;

4. a recipient is not Medicaid eligible, except for PASRR determinations; or

5. the primary insurance policy and access (including appeal/hearing process) has not been exhausted. As Medicaid is the payer of last resort, all remedies under other insurance must be exhausted.

3104.3 HEARING NOTIFICATION, SCHEDULING AND LOCATION

A. HEARING PREPARATION MEETING (HPM)

Within 10 calendar days of a request for a Standard Fair Hearing, the DHCFP Hearings Office shall contact the recipient to offer an HPM. The purpose is to provide the recipient an explanation of the action, which is the subject of the hearing request, and attempt to resolve the matter. Every effort is made to reconcile the disagreement without the necessity of a Fair Hearing. The right to a Fair Hearing is not affected by attendance at a HPM. The recipient may allow participation in the HPM by legal counsel, a friend or other spokesperson.

It is important the HPM be held at the earliest possible date, no later than 21 working days after receipt of a hearing request. Rescheduling of an HPM shall be kept to a maximum of two instances, assuring completion within 21 working days.

An HPM shall be conducted telephonically.

B. NOTICE OF A STANDARD FAIR HEARING

The Department of Administration Hearing Officer shall notify all parties by mail as to the time, date and place the hearing has been scheduled. Recipients are given at least 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 Fair Hearing may be postponed if requested by 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.

C. FAIR HEARINGS BY TELEPHONE

Either party may request the Fair Hearing be conducted telephonically. If a telephone hearing is held, the following procedures apply:

1. 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.

2. The Hearing Officer may request the DHCFP, the managed health plan 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.

3. All telephone hearings must be tape recorded by the Hearing Officer over the telephone. This recording is the official record.

All Expedited Fair Hearings are held telephonically due to time constraints.

3104.4 PROGRAM PARTICIPATION PENDING A HEARING DECISION

A. RECOVERY

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

B. MAINTAINING MEDICAID SERVICES

If the agency mails the notice as required, and the recipient requests a hearing before the Date of Action, the DHCFP or managed health plan will not terminate or reduce services until a decision is rendered after the hearing unless:

1. 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

2. the recipient requests in writing that benefits not be continued pending a hearing decision; or

3. the request for hearing is denied or dismissed.

C. REINSTATING MEDICAID SERVICES

1. 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.

2. Mandatory:

The agency must reinstate and continue services until a decision is rendered after a hearing if:

a. action is taken without the required advance notice;

b. 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:

1. it is determined that the sole issue is one of Federal or State law or policy; and

2. the agency promptly informs the recipient in writing that services are to be terminated or reduced pending the hearing decision.

3104.5 HEARING PARTICIPATION

A. 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 the DHCFP, and if applicable, representatives from the managed health plan. Counsel for the agency and/or managed health plan may also attend as necessary.

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

B. 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

A. AGENCY/MANAGED HEALTH PLAN

It is the responsibility of the agency and/or managed 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 managed 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.

B. RECIPIENT

1. 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. The DHCFP and/or managed health plan will provide the copies free of charge. The recipient shall not have access to confidential information.

2. It is the responsibility of the recipient to provide testimony and/or evidence in support of their 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 the DHCFP or managed health plan, but which is believed to have a bearing on the action taken, must be provided to the DHCFP prior to the hearing for evaluation and any necessary action.

3. Recipients are provided a copy of all evidence presented at the hearing by the DHCFP.

3104.7 CONDUCT OF HEARING

A. 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. The Hearing Officer shall record hearing proceedings. The Hearing Officer's Transcripts of Evidence constitutes the sole official record.

B. OPENING THE HEARING

At the opening of the hearing, the Hearing Officer shall:

1. Introduce their self;

2. Explain the reason for the hearing and the role of the Hearing Officer;

3. Assure all persons in attendance at the hearing are identified by name and purpose of attendance;

4. Advise all persons in attendance that the hearing is being tape-recorded.

C. ADMINISTERING OATHS

Testimony under oath shall be required at the discretion of the Hearing Officer.

D. TESTIMONY AND EVIDENCE

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

1. Excludes irrelevant, immaterial or unduly repetitious evidence;

2. Provides the parties an opportunity to present their case, to present witnesses, introduce evidence and cross-examine witnesses and examine evidence; and

3. Collects and logs relevant evidence exhibits.

E. CLOSING THE HEARING

At the close of the hearing, the Hearing Officer advises persons in attendance:

1. When a decision is expected to be made;

2. That the decision will be made based on program policy and exclusively on the testimony and evidence presented at the hearing; and

3. The parties will be advised in writing by certified mail of the decision.

3104.8 ACTION ON INCORRECT NOTICE OF DECISION (NOD)

A. If, prior to the hearing, it becomes apparent the recipient has received an incorrect NOD for Prior Authorization Request from the DHCFP or the managed health plan, a corrected notice must be sent to the recipient if the proposed action remains unchanged.

B. If, after a hearing has begun, it becomes apparent the recipient received an incorrect NOD 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 may 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 the DHCFP or the managed 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, the DHCFP or managed health plan may request additional evidence be submitted which is not available at the hearing.

The Hearing Officer shall:

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

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

C. 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 the

DHCFP or the managed health plan for evaluation and follow-up. Any additional assessment determined to be necessary is obtained at the DHCFP or the managed health plan's 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 Medicaid program policy. The decision is based exclusively on evidence introduced at the hearing. Changed physical or social factors following the DHCFP or managed health plan action being appealed cannot be considered in rendering the hearing decision.

A. BASIS

Decisions by the Hearing Officer shall:

1. Be based exclusively on the evidence introduced at the hearing;

2. Comply with applicable regulations in effect at the time of the agency or managed health plan's action;

3. Summarize the findings of fact;

4. Identify and cite supporting evidence and regulation;

5. Be submitted in written format, to the Deputy Administrator, the DHCFP or designee.

B. APPEAL IS DENIED

Denied decisions are adverse to the recipient. When the appeal is denied, the Hearing Officer will notify the DHCFP or the managed health plan and the recipient of the right to judicial review.

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

C. APPEAL IS SUSTAINED

Sustained decisions are favorable to the recipient. The DHCFP or the managed 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 the DHCFP decides in the recipient's favor before the hearing.

D. DECISION DUE DATE

Within 90 calendar days after the date of the request for a hearing has been received by the DHCFP 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 their 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.

Decisions on Expedited Fair Hearing requests will be made expeditiously as the recipient's health condition requires, but no later than three working days after the date the request for a hearing has been received by the DHCFP office.

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 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 RECORD

A. CONTENT

A hearing record is maintained by the Department of Administration, Hearing Office. 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.

B. RETENTION OF HEARING RECORD

Administrative hearing files and taped recordings must be retained no less than six 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.

C. COPYING THE HEARING RECORD

Copies of the Hearing Record are made as follows:

1. The requestor may secure a copy of the 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.

2. An official typed transcription of the 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, the DHCFP 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 recording and/or transcript is free of charge to the recipient in the event that the recipient appeals to District Court.

3105 MEDICAID PROVIDER HEARINGS

3105.1 REQUEST FOR A MEDICAID PROVIDER FAIR HEARING

A. WHO MAY REQUEST

A Nevada Medicaid provider may request a Fair Hearing when they disagree with an adverse determination taken against them by the agency, the Quality Improvement Organization (QIO)-like vendor/fiscal agent, managed health plan or other third-party plan or Program Administrator. An adverse determination may include, but is not limited to:

1. an outcome of the Fiscal Agent's provider appeal determination regarding a denied claim;

2. a determination to suspend payment;

3. suspension, sanction, lockout or termination;

4. recoupment of an overpayment; or

5. disenrollment or denied renewal of a provider contract

6. ineligible determination for the Incentive Payment Program for Electronic Health Record (EHR) enrollment.

The provider must exhaust any internal grievance process available through the QIO-like vendor/Fiscal Agent, managed health plan or third-party plan or Program Administrator prior to a DHCFP Fair Hearing.

B. DATE OF REQUEST

The date of request for a hearing is the date the request is received by the DHCFP Hearings Office. A request for a Fair Hearing must be received by the DHCFP Hearings Office within 90 calendar days from the date of the adverse determination notification. When a determination notification provides a specific timeframe in which a Fair Hearing may be requested, the timeframe specified in the notification is the applicable timeframe. When the deadline falls on a weekend or holiday, the deadline is extended to the next working day.

C. REQUEST FOR A FAIR HEARING

A request for a Fair Hearing must be submitted to the DHCFP Hearing Office in writing and must include the provider name, Medicaid provider number, correspondence address,

contact telephone number, the reason(s) why the provider disagrees with the determination and a copy of the determination notification from the agency, Fiscal Agent, managed health plan or third-party plan or Program Administrator. A request for a Fair Hearing must be signed by the provider or the provider's authorized representative.

3105.2 DISPOSITION OF A MEDICAID PROVIDER FAIR HEARING REQUEST

A. DISMISSAL OF A HEARING REQUEST UPON:

1. Withdrawal of a Hearing Request

A provider may withdraw a request for a Fair Hearing at any time before a decision is rendered. A request to withdraw a hearing must be submitted in writing to the Hearing Officer who may dismiss the hearing request.

2. Abandonment of a Hearing Request

A provider hearing is considered abandoned and may be dismissed by the Hearing Officer when the provider fails to appear for a scheduled hearing after having been properly notified. The provider'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 10 calendar days of the date of the scheduled hearing.

3. Agency, Fiscal Agent or Managed Health Plan Action

The agency, Fiscal Agent or managed health plan may reverse its adverse action determination at any time during the hearing process. If a determination reversal occurs, notification of the reversal must be made to the Hearing Officer, if a Fair Hearing had been scheduled. The Hearing Officer notifies the provider the request for hearing is dismissed because Medicaid, the Fiscal Agent or managed health plan will not take the action or has reversed the decision.

B. DENIAL OF A HEARING REQUEST

A hearing need not be granted when:

1. the sole issue is a Federal suspension or ban of regulation at the Federal level affecting providers.

2. the request is not received timely.

3. the provider has not exhausted the Appeal process available through the Fiscal Agent, the managed health plan or a third-party plan administrator.

3105.3 FAIR HEARING NOTIFICATION, SCHEDULING AND LOCATION

A. HEARING PREPARATION MEETING (HPM)

Nevada Medicaid Hearings Office will offer an HPM with the provider to allow an opportunity to have an informal discussion regarding the determination being disputed, and to attempt to resolve the disputed matter. A provider may refuse an HPM if they choose. The right to a Fair Hearing is not affected by attendance at an HPM. A provider may designate participation in the HPM by legal counsel or a representative.

An HPM shall be conducted telephonically.

B. NOTICE OF A FAIR HEARING

The Department of Administration Hearing Officer shall notify all parties by mail as to the date, time and location of the Fair Hearing.

At the discretion of the Hearing Officer, a Fair Hearing may be postponed if requested by either party.

C. HEARINGS BY TELEPHONE

1. A representative of each party must be in attendance at a Provider Fair Hearing.

2. The Hearing Officer may allow testimony from witnesses telephonically.

3. Telephonic testimony is recorded by the Hearing Officer and is part of the official record.

3105.4 HEARING PARTICIPATION

A. ATTENDANCE

Attendance at a hearing is limited to those directly concerned, namely the:

1. Hearing Officer;

2. provider;

3. provider’s witnesses, counsel or authorized representative(s) for the provider;

4. interpreter;

5. witnesses, counsel and representatives of Medicaid; and

6. representatives, counsel and witnesses from the managed health plan.

B. GROUP HEARINGS

At the discretion of the Hearing Officer, a series of provider requests for a hearing may be consolidated 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.

3105.5 PREPARATION/PRESENTATION

A. AGENCY/MANAGED HEALTH PLAN

1. It is the responsibility of the agency and/or managed health plan representative to be present at the Fair Hearing, unless permission has been granted prior to the Fair Hearing by the Hearing Officer to participate telephonically.

2. The agency or the managed health plan must provide testimony and/or evidence regarding the agency's and/or managed 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 Fair Hearing. This summary becomes part of the record at the conclusion of the Fair Hearing. Witness testimony may be provided telephonically at the discretion of the Hearing Officer.

3. All documents being presented at a Fair Hearing by the agency or managed health plan must be made available to the provider or representative and to the Hearing Officer at least five days prior to the Fair Hearing.

B. PROVIDER

1. It is the responsibility of the provider or representative to be present at the Fair Hearing, unless permission has been granted prior to the Fair Hearing by the Hearing Officer to participate telephonically.

2. Providers must provide testimony and/or evidence in support of their position. Testimony may be provided telephonically at the discretion of the Hearing Officer. Providers may bring witnesses and submit evidence to establish all pertinent facts and circumstances relative to the issue and to present arguments without undue interference. They may also question or refute any testimony or evidence and confront and cross-examine adverse witnesses. New evidence not previously provided to the DHCFP or the managed health plan, but which is believed to have

a bearing on the action taken, must be provided to all parties prior to the hearing for evaluation and any necessary action.

3. All documents being presented at a Fair Hearing by the provider or representative must be made available to the agency or managed health plan and to the Hearing Officer at least five days prior to the Fair Hearing.

3105.6 CONDUCT OF A FAIR HEARING

A. 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 recorder shall be used by the hearing officer to record hearing proceedings. The Hearing Officer's Transcripts of Evidence constitutes the sole official record.

B. OPENING THE HEARING

At the opening of the hearing, the Hearing Officer shall:

1. introduce their self;

2. explain the reason for the hearing and the role of the Hearing Officer;

3. assure all persons in attendance at the hearing are identified by name and purpose of attendance; and

4. advise all persons in attendance that the hearing is being recorded.

C. ADMINISTERING OATHS

Testimony under oath shall be required at the discretion of the Hearing Officer.

D. TESTIMONY AND EVIDENCE

Nevada Rules of Evidence do not apply in the hearing. The Hearing Officer shall:

1. exclude irrelevant, immaterial or unduly repetitious evidence;

2. provide the parties an opportunity to present their case, to present witnesses, introduce evidence and cross-examine witnesses and examine evidence; and

3. collect and log relevant evidence exhibits.

E. CLOSING THE HEARING

At the close of the hearing, the Hearing Officer shall advise persons in attendance:

1. when a decision is expected to be made;

2. that the decision will be made based on program policy and exclusively on the testimony and evidence presented at the hearing; and

3. the parties will be advised in writing by certified mail of the decision.

3105.7 ACTION ON INCORRECT DETERMINATION NOTICE

If the agency, fiscal agent or managed health plan recognizes an incorrect or inaccurate determination Notice has been issued, a corrected Amended Notice will be issued by the agency, Fiscal Agent or managed health plan. The action and effective date remain unchanged unless otherwise notified in the Amended Notice.

3105.8 SUBMISSION OF ADDITIONAL EVIDENCE

During a hearing, additional evidence related to the hearing issue may be submitted. The Hearing Officer, provider, the DHCFP or managed health plan may request additional evidence be submitted which is not available at the hearing. The Hearing Officer may:

A. recess the hearing if additional evidence has been submitted, to allow for review by the provider, the DHCFP or managed health plan;

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

C. close the hearing, but hold the record open to permit submission of any additional evidence.

3105.9 HEARING DECISION

The Hearing Officer's decision must be in writing and comply with Nevada Medicaid or the managed health plan's program policy. The decision is based exclusively on evidence introduced at the hearing.

A. BASIS

Decisions by the Hearing Officer shall:

1. be based exclusively on the evidence introduced at the hearing;

2. comply with applicable regulations in effect at the time of the agency's or managed health plan's action;

3. summarize the findings of fact;

4. identify and cite supporting evidence and regulation; and

5. be submitted in written format, to the Deputy Administrator, Medicaid or designee.

B. APPEAL IS DENIED

Denied decisions are adverse to the provider. When an appeal is denied, the Hearing Officer will notify the DHCFP or the managed health plan and the provider of their right to judicial review.

Provider withdrawals and abandonments are equivalent to a denied appeal. The DHCFP may institute recovery procedures against the provider to recoup the cost of any services furnished.

C. APPEAL IS SUSTAINED

Sustained decisions are favorable to the provider. The DHCFP or the managed 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 provider or if the DHCFP decides in the provider's favor before the hearing.

D. DECISION DUE DATE

Within 30 calendar days following the Fair Hearing, or the date the record is closed, whichever is later, the Hearing Officer shall issue a final Decision.

3105.10 RIGHT TO APPEAL HEARING DECISION

Reference NRS 422.306

3105.11 HEARING RECORD

Reference NRS 422.306