HAWAII ADMINISTRATIVE RULES

TITLE 17

DEPARTMENT OF HUMAN SERVICES

SUBTITLE 12 MED-QUEST DIVISION

CHAPTER 1736

PROVIDER PROVISIONS

Subchapter 1 Free Choice of Providers

Subchapter 2 Providers of the Fee for Service Program

Historical Note: Subchapter 1 is based substantially upon Title 17, chapter 17-1302 [Eff 6/29/92; R 08/01/94], Subchapter 2 is based substantially upon Title 17, chapter 17-1320 [Eff 6/29/92; am 9/3/93; R 08/01/94], Subchapter 3 is based substantially upon Title 17, chapter 17-1321, Hawaii Administrative Rules. [Eff 6/29/92; R 08/01/94]

SUBCHAPTER 1

FREE CHOICE OF PROVIDERS

§17-1736-1 Purpose. The purpose of this chapter shall be to set forth conditions on the free choice of providers in the fee for services component under the medical assistance program. [Eff 08/01/94] (Auth: HRS §346-14) (Imp: HRS §346-14)

§17-1736-2 Definitions. For the purpose of this chapter:

"Department" means the state department of human services.

"Freedom of choice" means the right to elect a qualified participating provider of health care services.

"Pre-paid health benefits" means health benefits available through a current health plan.

"Provider" means an individual or entity which furnishes items or services for which payment is claimed through the State medical assistance program. [Eff 08/01/94] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: HRS §346-14)

§17-1736-3 Right to free choice of providers of medical services. (a) A client shall have freedom to choose health care providers certified by the department to participate in the medical assistance program.

(b) Freedom of choice includes the right to seek medical services elsewhere within the State when physician recommended care is not available or readily accessible.

(c) Medical care and services shall be provided on the client's home island unless otherwise recommended by the client's physician.

(d) A client who decides on the services of a clinic shall be considered as having exercised the client's right to choose a provider, even though a physician may be assigned to the client by the clinic under the clinic's normal practices. [Eff 08/01/94] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 C.F.R. §431.51)

§17-1736-4 Medical care resources affecting freedom of choice. (a) A client who has pre-paid or earned health benefits shall utilize these benefits before utilizing medical assistance payments.

(b) A client may be encouraged but shall not be required to utilize public and private health resources available to groups meeting financial and eligibility standards. [Eff 08/01/94] (Auth: HRS §346-14) (Imp: 42 C.F.R. §433.135)

§17-1736-5 to §17-1736-10 (Reserved).

SUBCHAPTER 2

PROVIDERS OF THE FEE FOR SERVICE PROGRAM

§17-1736-11 Purpose. The purpose of this chapter is to establish conditions for provider participation in the fee for service component of Hawaii's medical assistance program. The provisions of this chapter govern provider applications and procedures for approval or denial of those applications, the requirements to be met by a provider before that person or organization is certified or denied provider status, and the requirements that providers keep records to participate in the program. Also described are procedures to be used for suspension or termination of providers from the Hawaii medical assistance program. [Eff 08/01/94] (Auth: HRS §346-14) (Imp: 42 C.F.R. §431.10)

§17-1736-12 Definitions. For the purpose of this subchapter:

"Abuse" means to put to a wrong or improper use the health care services available under the Hawaii medical assistance program. It includes, but is not limited to, providing or receiving health care services where no medical need exists, providing or receiving health care services where the recipient is not legally entitled to medicaid, providing or receiving service in excess of that medically needed by the recipient, presenting a claim for services not provided, or presenting a claim for services in excess of those actually provided or needed. Abuse may exist where the provider or recipient acts negligently, or recklessly.

"Fraud" means the knowing and willful making or causing a making by any person in the medical assistance program of any false statement or representation of the material fact in any application for benefits or payment for furnishing services or supplies, or for the purpose of obtaining greater compensation than the person is legally entitled to, or for obtaining authorization for furnishing services or supplies. If any of the conditions above exist, then there is fraud whether or not any payment is actually

received from the Hawaii medical assistance program. For purposes of this chapter, fraud may exist whether or not judgment has been made by a court of this State having jurisdiction over criminal matters.

"DHHS" means the United States Department of Health and Human Services.

"Medical assistance program" includes, but is not limited to, medicaid and all medical services provided to clients.

"Pharmacy provider" means every place, shop, or store where drugs are dispensed or sold at retail; or where physicians' prescriptions or drug preparations are compounded. It is an entity fully licensed and registered under all county, state, and federal laws. It is under the supervision of a registered pharmacist.

"Physician providers" means persons licensed by the State to practice medicine or osteopathy and approved as a provider of Hawaii's medical assistance program.

"Provider" means an individual or entity which furnishes health care goods or services such as those authorized for payment under the Hawaii medical assistance program. It covers all persons or entities validly licensed or permitted to provide health care services. Providers shall be certified by the Hawaii medical assistance program.

"QMB" or "Qualified Medicare Beneficiaries" means eligible recipients entitled to medicare Part A, with incomes not exceeding one hundred per cent of the official federal poverty line, and resources not exceeding twice the SSI resource limit, for which medicaid shall pay medicare cost-sharing expenses.

"QMB only provider" means a provider of QMB services that is not certified to participate in the medicaid program.

"Suspension" means exclusion of a provider from participation in the Hawaii medical assistance program by withdrawing the provider's certification for a specified period of time. At the conclusion of the times specified in the suspension, the suspension expires and certified provider status resumes without further action.

"Termination" means exclusion of a provider from participation in the Hawaii medical assistance program by withdrawing the provider's approval. Termination is not for a specified period of time and absent provider application for approval, remains permanent.

"Title XX" means Title XX of the Social Security

Act (42 U.S.C. §1397). [Eff 08/01/94] (Auth: HRS §346-14) (Imp: 42 C.F.R. §431.10; Pub. L. No. 100-360 §301)

§17-1736-13 Application for provider participation. (a) Any provider who wishes to provide care, goods, or services to receive reimbursement from the Hawaii medical assistance program, shall apply in writing to the med-QUEST division of DHS. The provider shall, at the request of the DHS med-QUEST administrator, supply all information requested concerning the provider's education and qualifications as a provider, financial status of the provider's practice, background history of the provider, and if the provider is required to maintain a license, the status of that license. The DHS med-QUEST administrator shall, in the administrator's sound discretion, have the right to approve or deny any application for certification as a provider under the Hawaii medical assistance program. If a provider is denied certification by the DHS med-QUEST administrator, the provider may request a fair hearing as provided by section 17-1736-33. Application forms to request certified provider status shall be furnished by the DHS med-QUEST administration.

(b) Except for providers exempted in subsections (c) and (d), all providers participating or applying to participate in Hawaii's medical assistance program shall have a current and valid written agreement or contract on file with DHS. Failure to maintain such a contract shall constitute grounds for suspension, termination, or withholding payment of claims submitted under the Hawaii medical assistance program until a current and valid written agreement is signed and on file with DHS.

(c) A provider outside of the State of Hawaii who furnishes goods and services authorized to be provided under the Hawaii medical assistance program to eligible Hawaii residents visiting in that state and urgently requiring care and services shall be exempt from the certification requirement so long as that provider is properly licensed to provide health care services in accordance with the laws of the provider's home state, and the provider is certified by Medicaid in the provider's home state to furnish the health care services actually rendered.

(d) Provider outside of the State of Hawaii who satisfy the requirements of subsection (c) also furnish services not available in Hawaii to eligible Hawaii residents as long as that provider obtains prior oral or written authorization from the DHS med-QUEST division's medical consultant prior to providing the goods, care, and services that the provider deems necessary. The medical consultant granting the prior authorization shall immediately reduce the substance of the authorization into writing and mail a copy to the out-of-state provider.

(e) Pharmacy providers who are the exclusive suppliers of prescribed drugs and supplies to a long term care facility shall apply for a separate provider agreement and provider number for each facility served as described in subsection (a). [Eff 08/01/94; am 03/30/96; am 02/10/97] (Auth: HRS §346-14) (Imp: 42 C.F.R. §§431.51, 447.15)

§17-1736-14 Approval or denial of provider application and notification. (a) DHS, upon finding that a provider applicant meets the requirements for participation in the medicaid program, shall promptly notify the person or entity in writing of the department's approval of the provider's application. The department shall arrange with its fiscal agent to issue to the new provider:

(1) A provider code number and instructions regarding the use of that number;
(2) A provider manual complete with all letter updates; and
(3) Notification of federal and state penalties for fraud.

(b) The department shall promptly notify any applicant in writing who does not meet all the requirements for participation. The notice shall state the reasons for the department's denial of the application. The notice shall inform the provider of the provider's right to a fair hearing. The department's fair hearing procedure as provided in subchapter 3 shall be utilized if a hearing is requested. [Eff 08/01/94] (Auth: HRS §346-14) (Imp: 42 C.F.R. §§431.51, 455.22)

§17-1736-15 Requirements for participation in the program by providers. (a) Except for payments authorized to out-of-state providers in emergency

situations and to Qualified Medicare Beneficiaries (QMB) only providers, or as authorized under section 17-1736-13, payments under the medical assistance program for goods, care, and services shall be made only to providers approved by DHS to participate in the Hawaii medical assistance program.

(b) An individual, institution, or organization shall meet all of the following requirements in order to become and retain eligibility as a provider under the medical assistance program:

(1) The provider shall be licensed or approved as follows:

(A) The provider, if an individual, shall be licensed to practice the provider's profession in accord with state law. Permits, temporary licenses, provisional licenses, expired or unrenewed licenses, or any form of license or permit which requires supervision of the licensee shall not serve to qualify the licensee as an approved provider of service under the Hawaii medical assistance program;

(B) The provider, if a medical or health related institution, shall be certified by the state department of health under applicable public health rules of the state and standards of the federal government; or

(C) The provider of any other health care services shall comply with standards and all licensure, certification and other requirements as applicable;

(2) The provider shall comply with the non-discrimination provisions of Title VI of the Civil Rights Act of 1964 (42 U.S.C. §2000d) by not discriminating against program beneficiaries on the basis of race, color, national origin, or mental or physical handicap; and

(3) The provider shall accept medicaid's established rates of payments whether based on DHS's fee schedule, negotiated rate, reasonable cost reimbursement, or other adopted rates, whichever is applicable, as payment in full for goods, care, or services furnished. The provider shall not require any participation in payment by the medicaid recipient for goods, care, or services

furnished by the provider. The provider shall not demand or receive any additional payment from any medicaid recipient with the exception of the department's proviso for cost sharing of medical care costs. [Eff 08/01/94] (Auth: HRS §346-14) (Imp: HRS §346-59; 42 C.F.R. §447.15; Pub. L. No. 100-360 §301)

§17-1736-16 Provider requirements regarding advance directives. (a) Hospitals, hospices, nursing homes, health maintenance organizations, and other health care facilities that receive funds from medicare or medicaid are required by law (Pub. L. No. 101-508 and chapter 327D, HRS) to have in place a mechanism for advising patients of their legal rights and options for refusing or accepting treatment if they are or become incapacitated.

(b) Providers must offer written information as well as summaries of pertinent institutional policies to all adult patients regarding their rights under State laws to accept or refuse treatment and to make advance directives.

(1) An advance directive is a document that is written in advance of an incapacitating illness that state a patient's choices about treatment, or name someone to make such choices, if the patient becomes unable to make decisions.

(2) Through advance directives such as living wills and durable powers of attorney for health care, patients will be able to make legally valid decisions about their future medical treatment.

(3) The patient's medical record must be documented to indicate whether the patient has an advance directive.

(c) Institutions may not discriminate against or condition care provided to a patient on the basis of whether the patient has, or has not, executed an advance directive.

(d) Institutions must provide (individually or with others) education to staff and community regarding issues associated with advance directives.

[Eff 08/01/94] (Auth: HRS §346-14, 42 U.S.C. §1396 a(w)) (Imp: HRS §327D)

§17-1736-17 Record keeping requirements for providers. (a) In order to determine the correct amount of medicaid program payments due to any provider, and to protect the medicaid program from fraud and abuse, the DHS's representative, agent, investigative and recovery service, the fiscal agent, and the medicaid fraud control unit of the attorney general's office shall have the right to examine, inspect, copy, and if necessary, seize all records of a provider pertaining to medicaid patients which are necessary to fully disclose the type and extent of health care services or supplies provided to eligible medicaid recipients. The provider, for a period of three calendar years, shall maintain thorough records of medicaid patients, including but not limited to the following:

(1) Billings and account ledgers;
(2) Records of patient appointments;
(3) Patient history forms, medical records, diagnosis, and orders prescribed and treatment plans;
(4) Records of requests for and results of tests and examinations ordered or furnished;
(5) Records of prescriptions, medications, assistive devices, or appliances prescribed, ordered, or furnished; and
(6) All records which are necessary to justify the amount of claims for payment which are determined by cost reimbursement or a similar basis, including billing documents showing the cost of services or supplies provided to the recipient.

(b) A provider shall make these records available to any duly authorized DHS representative or agent, including the DHS investigative and recovery service, a representative of the fiscal agent, and any representative of the medicaid fraud control unit. These records shall be made available at the provider's place of business during normal business hours or upon agreement of the provider and appropriate representatives of the state at any other mutually convenient time or place.

(c) In addition to those records required to be maintained in accordance with subsection (b), institutional providers shall also make available to the agencies specified in subsection (b) records of receipts and disbursements of patient trust funds by the provider, including ledger accounts reflecting

credits, debits and balances for each recipient.

(d) The records described in subsections (a) and (b) shall be maintained for a period not less than three calendar years. For purposes of this section, a record shall not be counted as three calendar years old until the last entry made in that record is three years old.

(e) All records obtained by the state agency, the investigative and recovery service, the fiscal agent or the medicaid fraud control unit, pursuant to this section, shall be maintained in safe keeping and may be used for auditing, scientific examination and writing analysis, photocopying, or testing in any other way, so long as that test does not significantly alter, damage, or destroy the record taken. Records which are not undergoing examination or testing as defined in this subsection and are not intended to be used as evidence in a judicial or administrative hearing by the State shall be immediately returned to the provider.

(f) Cost report files of an institutional provider shall contain the following information:

(1) Reimbursable cost;

(2) Cost finding schedules; and

(3) Other financial and statistical data to support reimbursable cost, including:

(A) Employment records;

(B) Work shift and schedules; and

(C) Payroll records of all institutional personnel, owners, and corporate officers. [Eff 08/01/94] (Auth: HRS §346-14) (Imp: HRS §346-40)

§17-1736-18 <u>Confidential communications and disclosure requirements for physician and psychologist providers.</u> (a) There is no privilege under this section in any administrative proceeding where the:

(1) Competency;

(2) Practitioner's license;

(3) Provider status; or

(4) Practice;

of the physician is an issue, including fair hearing criminal cases involving fraud, or civil cases involving over-payment under the medicaid program. However, the identifying data of a patient whose records are admitted into evidence at an administrative hearing shall be kept confidential among the parties to

the hearing unless waived by the patient. The administrative agency, board, or commission may close its proceedings to the public to protect a patient's confidentiality.

(b) The DHS director may require providers of health care goods and services, including physicians and psychotherapists, to seek written authorization from the med-QUEST administration to provide care, goods, or services to medicaid patients. A provider's request for authorization shall include:

(1) The patient's name;
(2) A diagnosis of the patient's psychiatric, physical, or psychological condition;
(3) Whether or not the patient can work, either part-time or full-time;
(4) The number of times the patient has seen the provider over a given prior period;
(5) The number of future visits the doctor anticipates needing in order to properly treat the patient;
(6) Information on whether the patient is working and if so, whether on a full-time or part-time basis; and
(7) Any other information requested by the med-QUEST division which properly relates to the patient's present or prior condition or appropriate care to be rendered to the patient.

(c) For purposes of this section, confidential communication shall consist only of the statements made between a physician or psychologist and a patient during a therapy session. The provider's diagnosis, finding, and treatment plan shall not be considered confidential communications.

(d) Whenever a provider refuses to disclose unprivileged information to the med-QUEST division, then payment of claims for which the information is lacking may, at the discretion of the director, be denied, or if payment is already made, recovery may be initiated by the department. [Eff 08/01/94] (Auth: HRS §346-14) (Imp: 42 C.F.R. §431.10)

§17-1736-19 <u>Disclosure by providers and their fiscal agents of information concerning provider's ownership and control</u>. (a) Providers shall disclose to the med-QUEST division the following information

upon request:

(1) The name and address of each person with an ownership or controlling interest in the provider;

(2) The name, address, and ownership or controlling interest which the provider may have in any other entity which also has certification as a provider under the Hawaii medical assistance program or the medicare program;

(3) The name of any business, either in the State or elsewhere, whether incorporated or not, in which the provider has a financial or management interest and which is itself a supplier of medical goods, care, or services to any provider certified under the medical assistance program;

(4) The name of any business either in the State or elsewhere, whether incorporated or not, in which a blood relative of an individual provider has a financial or management interest and which is itself a supplier of medical goods, care, or services to any provider certified under the medical assistance program;

(5) The name of any blood relatives or in-laws of an individual provider who have a financial or management interest in any business concern which is itself a supplier of medical goods, care, or services to any provider certified under the Hawaii medical assistance program; and

(6) The name of any blood relative or in-laws of an individual provider who is also a provider certified under the medical assistance program.

(b) The provider shall upon discovery of any information required by subsection (a), immediately notify the med-QUEST division in writing of the information required to be provided.

(c) If the DHS director, as a result of any of the information provided pursuant to subsection (a), determines in the director's sound discretion that a conflict of interest exists based upon a relationship revealed by a provider pursuant to the requirements of subsection (a), then the DHS director may withdraw certification of the provider until the relationship which creates the conflict of interest is terminated.

(d) Failure by any provider to reveal the existence of any relationship specified in subsection (a) shall be grounds for suspension or termination of that provider's certification under the medical assistance program. [Eff 08/01/94] (Auth: HRS §346-14) (Imp: 42 C.F.R. §455.104)

§17-1736-20 Provider requirements prior to certification. (a) Prior to certification as a provider under the medical assistance program, a provider must submit to the department full and complete information about:

(1) The ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the twelve month period ending on the date that certification is requested; and

(2) Any significant business transactions between the provider and any supplier of services or goods wholly owned, or between the provider and any subcontractor during the five year period ending on the date of the request for certification.

(b) The information required by subsection (a) must be provided within thirty-five days of the date of any request by the secretary of DHHS or the medicaid agency of the State. [Eff 08/01/94] (Auth: HRS §346-14) (Imp: 42 C.F.R. §455.105)

§17-1736-21 Disclosure by providers of information on persons convicted of crimes. (a) The provider shall disclose to DHS the identity of any person who has an ownership or controlling interest in the provider, or who is an agent, managing employee, or employee of the provider and who has been convicted of a criminal offense relating to that person's involvement in the medical assistance program, medicare, or any Title XX service program since the start of those programs.

(b) DHS shall notify DHHS immediately of any disclosures made pursuant to subsection (a).

(c) DHS may refuse to enter into or renew an agreement with a provider if a person with ownership or controlling interest in that provider, or an agent or managing employee of that provider is a person who has been convicted of a criminal offense relating to the

person's involvement in a program established under the medical assistance program, medicare, or any Title XX program.

(d) DHS may refuse to enter into or may terminate a provider agreement if the full and accurate disclosure requirements under this section are not met by the provider. [Eff 08/01/94] (Auth: HRS §346-14) (Imp: 42 C.F.R. §455.106)

§17-1736-22 Cause for suspension or termination of providers. DHS may suspend or terminate a provider from the medical assistance program based upon any one or combination of reasons established in section 17-1736-33(c). [Eff 08/01/94] (Auth: HRS §346-14) (Imp: 42 C.F.R. §455.13)

§17-1736-23 Suspension or termination. (a) The decision to suspend or terminate a provider from participation in the medical assistance program and the duration of any suspension shall be made by the DHS director.

(b) The duration of the suspension imposed by the DHS director shall be conditioned upon the seriousness of the infraction but shall not exceed a period of five years.

(c) The DHS director shall suspend or terminate any provider in the medical assistance program who has been suspended or terminated from the medicare program. Suspension or termination from the medical assistance program if based upon suspension from the medicare program shall be at least under the same conditions and for the same period of time as the suspension from the medicare program. The DHS director may determine that more stringent action under the medical assistance program than was taken under the medicare program is justified. In that event, the director shall take such steps as the director deems appropriate subject to the provisions of subchapter 3.

(d) The DHS director shall suspend or terminate any provider in the medical assistance program whose license, certification, authorization or permit to practice is not current or has been suspended, revoked, or restricted by a state or federal government, court, or agency.

(e) A provider who has terminated from the medical assistance program for a violation may not

petition the director for reinstatement to the program for a period of five years at which time reinstatement may be permitted by the director, if justified, provided that at the time reinstatement is requested that no medicare sanctions remain applicable.

(f) All legal actions, both civil and criminal, against providers certified under the medicaid program shall be handled by the State's medicaid fraud control unit.

(g) Actions for suspension or termination of a provider may be initiated or continued even though a provider voluntarily withdraws from the program. The procedures for determining whether suspension or termination are appropriate and the length of time shall be governed by this subchapter and subchapter 3. [Eff 08/01/94] (Auth: HRS §346-14) (Imp: 42 C.F.R. §§455.16, 455.21)

§17-1736-24 Notification and effective date of suspension or termination of provider certification. (a) The provider shall be informed by certified mail of DHS's intent to suspend or terminate the provider's participation as a medical assistance provider. The notice shall include the following:

(1) The reasons for the action;

(2) If the action is a suspension, the duration of the suspension;

(3) The provider's rights to request an administrative review, and to be represented at the provider's own expense by legal counsel or a designated representative at the administrative hearing provided for by subchapter 3; and

(4) The effective date of the suspension or termination.

(b) A suspension or termination of a provider's certification in the medical assistance program shall be effective thirty calendar days following the mailing of DHS's notice of intent to suspend or terminate, except a suspension or termination based on section 17-1736-23(d) which shall be effective from the date of license, certification, authorization, or permit suspension or revocation.

(c) DHS shall notify DHHS whenever a state or federal court convicts a provider for a criminal office relating to the medical assistance program. This notice shall be sent within fifteen days of the time

that DHS learns of the conviction. [Eff 08/01/94; am 01/29/96] (Auth: HRS §346-14) (Imp: 42 C.F.R. §455.212)

§§17-1736-25 to 17-1736-30 (Reserved).

SUBCHAPTER 3

ADMINISTRATIVE PROCEEDINGS FOR PROVIDER REVIEW

§17-1736-31 Purpose. The purpose of this chapter shall be to establish provisions for a provider's right to review and hearing following any administrative decision made by the DHS which directly and adversely affects the rights of that provider or the reimbursement claimed under the medical assistance program. [Eff 08/01/94] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: HRS §346-14; 42 C.F.R. §§431.10, 455.12)

§17-1736-32 Definitions. As used in this subchapter:

"Abuse" means to put to a wrong or improper use the health care services available under the Hawaii medical assistance program. It includes, but is not limited to, providing or receiving health care services where no medical need exists, providing or receiving health care services where the recipient is not legally entitled to medicaid, providing or receiving services in excess of that medically needed by the recipient, presenting a claim for services not provided, or presenting a claim for services in excess of those actually provided or needed. Abuse may exist where the provider or recipient acts negligently or recklessly.

"Determination" means the amount of reimbursement due to a provider under the medicaid program as summarized on the notice of program reimbursement (NPR) or notice of PPS rate.

"DHHS" means the United States Department of Health and Human Services.

"Fraud" means the knowing and willful making, or causing to make, by any person in the medical assistance program of any false statement or representation of material fact in any application for benefits or payment for furnishing services or supplies, or for the purpose of obtaining greater

compensation than the person is legally entitled to, or for obtaining authorization for furnishing services or supplies. If any of the conditions stated above exist, when there is fraud whether or not any payment is actually received from the Hawaii medical assistance program. For purposes of this subchapter, fraud may exist whether or not a judgment has been made by a court of this State having jurisdiction over criminal matters.

"Medical assistance program" includes, but is not limited to, medicaid and all medical services provided to clients under the general assistance category.

"PPS rate" means the prospective payment system annual rate assigned each medicaid institutional provider.

"Provider" means an individual or entity which furnishes health care goods or services such as those authorized for payment under the Hawaii medical assistance program. It covers all persons or entities validly licensed or permitted to provide health care services. Providers shall be certified by the Hawaii medical assistance program.

"Suspension" means exclusion of a provider from participation in the Hawaii medical assistance program by withdrawing the provider's certification for a specified period of time. At the conclusion of the time specified in the suspension, the suspension expires and certified provider status resumes without further action.

"Termination" means an exclusion of a provider from participation in the Hawaii medical assistance program by withdrawing the provider's certification. Termination is not for a specified period of time and absent provider application for certification, remains permanent. [Eff 08/01/94] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: HRS §346-14; 42 C.F.R. §431.10)

§17-1736-33 Providers' right to review. (a) A provider may request an administrative hearing following the department's administrative decision to do any one of the following:

(1) Withhold, terminate, or suspend a provider's certification to participate in the medical assistance program;

(2) Withhold payment of claims as a result of audit or investigation;

(3) Recover money claimed to have been overpaid to the provider by medicaid; or

(4) Impose remedies established in section 17-1736-40 for nursing facilities that do not meet the requirements of participation.

(b) Any notice of intent to do any of the actions specified in subsection (a) shall be sent to the provider by certified mail. The provider shall have thirty days from the date that notification is mailed to request in writing an administrative hearing. There shall be no required format for the provider's written request for an administrative hearing, though the provider must clearly state that the provider requests an administrative hearing. At the time the provider requests an administrative hearing, the provider shall include with the request all documents and written evidence that the provider wishes to be considered at the hearing. Where a provider makes a timely request for an administrative hearing, the provider shall not be terminated or suspended until the hearing has been held and a decision has been rendered.

(c) DHS may suspend or terminate a provider from the medicaid program for one or more of the following reasons:

(1) Failure by the provider to maintain with DHS a signed agreement identifying the terms and conditions under which the provider may participate in the Hawaii medical assistance program;

(2) Refusal or failure by the provider to make available at the provider's place of business or at an appropriate location, either during normal business hours, or at the mutual convenience of the parties, immediate access to all records and all diagnostic devices required to be maintained by section 346-40(b), HRS;

(3) Refusal or failure by a provider without reasonable justification to keep those adequate written records necessary to disclose fully the type and extent of health care, service,s or supplies provided to medicaid recipients as provided by section 346-40(a) and (c), HRS;

(4) Revocation or suspension of the provider's license, certification, authorization, or permit to practice or provide service in the provider's health care specialty by a state

or federal government, court, or agency;

(5) Failure to maintain a current and valid license, certification, or permit to practice the provider's profession;

(6) A criminal complaint against the provider, indictment by grand jury, or information about or conviction of the provider by a state or federal court for an offense involving the provider's participation in the medicaid program. A criminal complaint against the provider, indictment, or information may remain the basis for a suspension or termination by the department even though the complaint, information, or indictment results in acquittal;

(7) Any fraud against the medicaid program or abuse of health care services as defined in this section;

(8) A determination by a peer review organization that the provider has failed to provide adequate quality services to medicaid recipients as judged against accepted medical community standards in Hawaii;

(9) Any intentional failure to repay overpayments made by the medicaid program to the provider; or

(10) Any effort by the provider to interfere with, hinder, or stop an investigation by any state or federal agency into fraud or abuse in the medicaid program.

(d) During the period of time from the notice of suspension or termination until the department orders a decision after administrative hearing, payment on any claims of the provider requesting review shall, at the med-QUEST administrator's discretion, be withheld pending the hearing officer's final determination. If the administrative hearing officer upholds suspension or termination, decides that the contested claim shall not be paid, or renders a decision denying the provider's appeal, then the provider claims for which payment was withheld shall not be paid. If, after the administrative hearing, the hearing officer overturns a provider's suspension or termination, decides that any contested claims shall be paid, or renders a favorable decision on the provider's appeal, then the provider claims for which payment was withheld shall be paid.

(e) A provider may request an administrative hearing only after an administrative decision by the

department is made against that provider. There shall be no right of hearing for class actions on the part of other providers and there shall be no right to administrative hearing for the purpose of obtaining advisory opinions. [Eff 08/01/94] (Auth: HRS §346-14; 42 C.F.R §431.10) (Imp: HRS §§346-14, 346-40; 42 C.F.R. §§431.10, 455.13)

§17-1736-34 Limitation of the right to review. A provider shall not have a right to an administrative hearing if:

(1) The provider fails to request in writing a fair hearing from the med-QUEST administrator of DHS within the time specified in section 17-1736-33(b);

(2) The administrative action is one of suspension or termination, based upon a final administrative decision of a state or federal agency withdrawing the license, certification, authorization, or permit of the provider to practice or furnish the health care specialty for which the provider is certified under the Hawaii medical assistance program; or

(3) The administrative action is for suspension or termination and is based upon a state or federal court conviction of the provider of an offense involving fraud or abuse relating to the medicaid program. [Eff 08/01/94] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 C.F.R. §§431.10, 455.16)

§17-1736-35 Appearance by representatives of the provider and the department. (a) In all matters involving an administrative hearing, a provider may represent him or herself or be represented by an attorney or other person. A provider shall not have a right to legal counsel appointed at state expense. If the provider is represented by another person, that person's name, address, and telephone number shall be provided to the DHS med-QUEST administrator and to the hearing officer prior to the administrative hearing.

(b) Upon receipt of the name of the provider's representative, the med-QUEST administrator shall provide to that representative, the name, address, and

telephone number of the department's representative. [Eff 08/01/94] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: HRS §91-9; 42 C.F.R. §455.13)

§17-1736-36 Forms for papers. An original and two copies of all papers filed in any proceeding under this chapter shall be filed with the department, shall be typewritten on one side only, and be on 8½ by 13 inch white paper. Documents shall bear on the first page the title of the proceeding at the top of the page, together with any administrative or court number assigned to the hearing, and the signatures of the party or the party's representative. [Eff 08/01/94] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: HRS §346-14; 42 C.F.R. §431.10)

§17-1736-37 Notice, service, and proof of service. (a) All papers, notices, and other documents shall be served by the party offering them upon all other parties to the proceeding. Proof of service upon the parties shall be filed with the DHS.

(b) Service of process may be accomplished in any manner permitted by law. The department shall serve the provider in person or by mail. If the provider is represented by an attorney or other person, service upon that attorney or other person shall be sufficient.

(c) Proof of service of any document shall be by certificate of attorney, affidavit, or acknowledgment.

(d) Where written notice is required by this chapter, notice shall be considered effective on the date of mailing. [Eff 08/01/94] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: HRS §91-9; 42 C.F.R. §455.13)

§17-1736-38 Notice of formal hearing; notice of decision. (a) The department shall notify any provider, who is entitled to an administrative hearing in accordance with section 17-1736-34 of the scheduled date and location of the administrative hearing. Such notice shall be in writing and mailed to the provider no fewer than thirty calendar days before the scheduled date of hearing.

(b) The department shall notify any provider who has received an administrative hearing of the hearing officer's decision by mailing a written copy of the

decision within fourteen calendar days of the date of the decision. [Eff 08/01/94] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: HRS §§91-9, 91-9.5; 42 C.F.R. §455.13)

§17-1736-39 Conduct of hearing. (a) The hearing shall be conducted by an impartial hearing officer appointed by the DHS director. Prior to conducting the hearing, the hearing officer shall become familiar with sections 84-1 to 84-19, HRS, and the published opinions of the state ethics commission and determine that participation as an administrative hearing officer will create no conflicts of interest or ethical violations.

(b) Testimony shall be taken only on oath or affirmation and such testimony shall be subject to sections 710-1060, 710-1061, and 710-1062, HRS.

(c) Each party may:

(1) Call and examine witnesses;

(2) Introduce exhibits into evidence;

(3) Cross-examine witnesses called by the other party;

(4) Object to the presentation of any evidence deemed by the party to be not properly admitted;

(5) Present rebuttal evidence to the opposing party's case-in-chief; and

(6) Present an opening statement to the hearing officer prior to the taking of evidence, and a closing argument to the hearing officer at the conclusion of the taking of evidence.

(d) The hearing officer shall not require strict adherence to any rules of evidence. The hearing officer shall admit all evidence including, but not limited to, testimony, documents, photographs, opinions, objects, or diagrams, so long as that evidence has any tendency to make the existence of any fact of consequence to the hearing more or less probable than it would be without the evidence. The hearing officer may, in the hearing officer's discretion, allow the presentation or hearsay evidence, allow cross-examination beyond the scope of direct examination, and allow the party calling a witness to cross-examine or impeach that witness. Rulings on evidence made by the administrative hearing officer shall be in the officer's discretion and not subject to appeal.

(e) The hearing officer may ask questions of any

witness or request production of further evidence by any party to the hearing.

(f) The administrative hearing officer shall have discretion to exclude irrelevant, immaterial, or unduly repetitious evidence as provided in section 91-10(1), HRS.

(g) In administrative hearings, the provider shall have the burden of proof, including the burden of producing evidence as well as the burden of persuasion. The amount of proof necessary to prevail shall be a preponderance of the evidence in accordance with section 91-10(5), HRS. [Eff 08/01/94] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: HRS §91-10; 42 C.F.R. §455.13)

§17-1736-40 Witnesses andsubpoenas. (a) Each party to the administrative hearing shall arrange for the presence of its witnesses at the hearing.

(b) The DHS director hereby designates the hearing officer as a representative of the director, empowered to conduct a hearing. Any party to the administrative hearing may request of the hearing officer a subpoena to compel the attendance of a witness or the production of books, papers, documents, or other objects deemed relevant to the investigation, except that no subpoena shall affect any privilege established by law. Each subpoena shall be signed by the administrative hearing officer who at any point in the proceedings may, on the hearing officer's own motion, subpoena witnesses, books, papers, documents, correspondence, memoranda, or other records in furtherance of the administrative hearing.

(c) Applications for subpoenas for the production by a witness of books, papers, documents, correspondence, memoranda, or other written records, shall be made by affidavit to the hearing officer and shall contain:

(1) The name and address of the organization upon whom the subpoena is to be served;

(2) A description of the documents, papers, books, correspondence, memoranda, photographs, or other written records that are desired;

(3) A statement by the affiant that to the best of the affiant's knowledge and belief, the person to be subpoenaed has information about or possesses the documents, papers, books,

correspondence, memoranda, photographs, or other objects that the subpoena seeks; and

(4) The basis for the affiant's belief that the person or organization has information about or possesses the documents, papers, books, correspondence, memoranda, photographs, or other objects that the subpoena seeks.

(d) Each party to the administrative hearing shall arrange for the service of all subpoenas issued on its behalf. A copy of the affidavit in support of the issuance of the subpoena shall be served along with the subpoena.

(e) All witnesses who are summoned to an administrative hearing by subpoena may claim witness fees and mileage allowance at the same rate established for witnesses in the circuit court of the first circuit of the State.

(f) The parties shall bear their own costs. [Eff 08/01/94] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: HRS §§92-16, 346-13; 42 C.F.R. §455.13)

§17-1736-41 Amendments. (a) If during the course of the hearing, evidence taken reveals that the provider was involved with conduct which would properly be the basis for suspension, termination, or other administrative sanction, and which was not alleged by the State as grounds for suspension, termination, or other administrative sanction, the State, at the discretion of the hearing officer, may amend its allegations to conform with the evidence.

(b) If, during the course of an administrative hearing, it becomes apparent to either party or to the administrative hearing officer that an absent party should be joined or afforded the opportunity to make an appearance, then the State, at the discretion of the hearing officer, may amend its allegations to include the additional party, or if appropriate, substitute the additional party for the present provider.

(c) Where allegations are amended pursuant to subsection (a), or parties are added or substituted pursuant to subsection (b), the administrative hearing shall be continued for the length of time the hearing officer deems appropriate to afford any additional party notice and to afford any existing or additional party a chance to address additional allegations.

(d) Notice of amendments or substitutions shall be mailed in writing to the last known address of each

party affected by the amendment or substitution. [Eff 08/01/94] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: HRS §346-14; 42 C.F.R. 455.13)

§17-1736-42 Continuances or further hearings. (a) At any time during the administrative hearing, if the hearing officer determines that the hearing shall be held at another time or at any other locations in the State, the hearing officer, at the hearing officer's discretion or on the motion of any party, may continue the hearing.

(b) If the hearing officer determines at any point in the hearing that it is necessary to seek additional evidence, the hearing officer may continue the hearing to a later date and seek additional evidence, or direct one or both parties to seek further evidence, provided that the hearing officer shall furnish written justification on the record for any continuance under this section lasting in excess of thirty days. Failure of either party to provide additional evidence as directed by the hearing officer shall not be used as the sole basis for an adverse decision against that party on the issues presented at the hearing. In the event that further evidence is not produced as directed, the hearing officer shall proceed to a decision based upon the entirety of the evidence presented at the hearing.

(c) Written notice of the time and place of any continued or additional hearings shall be given in accordance with section 17-1736-37, except that when a continuance or additional hearing to a certain date is ordered during a hearing, then oral notice of the time and place of the hearing shall be sufficient for all parties present at the hearing. [Eff 08/01/94] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: HRS §346-14; 42 C.F.R. §455.13)

§17-1736-43 Record of hearing. A verbatim record of all portions of the hearing shall be made. The record may be in the form of a transcript of verbatim shorthand, or by an audio or video recording, provided that in the event any party to the hearing notifies the hearing officer in writing of an intent to file exceptions to the hearing officer's findings of fact as provided in section 91-11, HRS, or if any party appeals an agency decision, as provided in section 91-14, HRS,

a verbatim written transcript shall be prepared. [Eff 08/01/94] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: HRS §91-9; 42 C.F.R. §455.13)

§17-1736-44 Decision of the hearing officer. (a) At the conclusion of the evidence and arguments by the parties, the hearing officer shall declare the hearing to be closed, at which time each party shall have thirty calendar days, not counting the day that the hearing is closed, to present written proposed findings of fact.

(b) At the conclusion of the thirty day period prescribed in subsection (a), the hearing officer shall have sixty calendar days to prepare a written decision accompanied by separate findings of fact, conclusions of law, and basis for findings. The hearing officer, if clarification of any evidence or any proposed finding of fact is desired, may reconvene the hearing to clarify the existing evidence. The period of time during which the hearing has been reconvened shall toll the time within which the hearing officer is required to prepare the written decision.

(c) The hearing officer shall not have informal, unrecorded conversations with any party concerning the case. All discussions concerning the evidence shall be at sessions of record with all parties to the hearing present except to the extent those discussions are required for the disposition of ex parte matters authorized by law. [Eff 08/01/94] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: HRS §§91-12, 91-13; 42 C.F.R. §§455.13, 455.16)

§17-1736-45 Dismissal upon failure to appear at hearings. (a) If, after timely, proper written notice, a provider fails to appear at a scheduled hearing, the hearing officer may issue a written dismissal of the provider's request for an administrative hearing, which shall be mailed to each party with notice to the provider that the provider may request written consideration.

(b) In order to request written consideration, the provider shall, within ten days of the mailing of written dismissal, appeal to the hearing officer in writing showing good cause for the provider's failure to appear at the hearing. The hearing officer may, in the hearing officer's sound discretion, either sustain

the dismissal, or reinstate the hearing with proper written notice to parties. In the event that the hearing officer sustains the dismissal, the hearing officer shall provide a written dismissal order including the circumstances upon which the dismissal is based. [Eff 08/01/94] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: HRS §346-14; 42 C.F.R. §§455.13, 455.16)

§17-1736-46 Administrative appeal to the director. (a) In the event of a decision adverse to the provider, a copy of the order and decision shall be served upon all parties pursuant to section 17-1736-37. The provider shall have ten calendar days following the date of mailing of the order and decision to file written exceptions and present written argument to the DHS director.

(b) The director shall have thirty calendar days following the receipt of written exceptions and argument to decide the appeal. The director's decision on the appeal must be based upon the applicable rules and the facts as established in the record, provided that the director may communicate with the hearing officer while deciding the appeal. The director may sustain or reverse the decision and order of the the hearing officer and in either event, shall within thirty calendar days, mail the decision on appeal to all parties. The decision of the hearing officer and any appeal made to the DHS director shall be subject to judicial review as provided in section 91-14, HRS. [Eff 08/01/94] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: HRS §346-14; 42 C.F.R. §§455.13, 455.16)

§§17-1736-47 to 17-1736-56 (Reserved).

§17-1736-57 Determination of medicaid reimbursement for hospital and institutional providers. The provider shall be notified of the reimbursement determination (NPR) and notice of PPS rate through the fiscal agent. The notices shall be sent to the provider by certified mail. [Eff 08/01/94] (Auth: HRS §346-14; 42 C.F.R. §431-10) (Imp: 42 C.F.R. §431.10)

§17-1736-58 Hospital and institutional provider's right to review. (a) A provider may request an administrative hearing if it is dissatisfied with the department's determination of medicaid reimbursement:

(1) Following any request for rate reconsideration determination under PPS; or

(2) Following the issuance of an NPR under cost reimbursement; and

(3) The amount in dispute is at least $1,000.

(b) A written request for administrative hearing must be received by the department within ninety days from the date of the rate reconsideration determination or NPR as provided in subsection (a) and shall refer to that specific notification.

(c) The provider's request for an administrative hearing shall include the following:

(1) Individual adjustment items and the specific reimbursement issue and the dollar amount entailed;

(2) The reasons for the disagreement;

(3) Any material or evidence the provider considers necessary to support its position; and

(4) The notice with which the provider disagrees.

(d) A group of providers may request an administrative hearing if the issue involves a common question of fact or interpretation, and the amount in controversy is in the aggregate of $50,000 or more. [Eff 08/01/94] (Auth: HRS §346-14) (Imp: 42 C.F.R. §447.258)

§17-1736-59 Limitation of the right to review for hospital and institutional providers. A provider shall not have the right to an administrative hearing as provided under this subchapter if:

(1) The provisions of section 17-1736-58 are not met; or

(2) The administrative hearing concerns the following:

(A) A determination of non-payment for items or services provided a recipient but which are not covered by the medicaid program;

(B) The constitutionality of the law, rules, or medicaid reimbursement methodology;

(C) Issues not addressed on the NPR or in the notice of rate reconsideration

determination;
(D) Issues related to DHHS rules or policies; or
(E) Issues not addressed in the Hawaii Administrative Rules. [Eff 08/01/94] (Auth: HRS §346-14) (Imp: 42 C.F.R. §447.258)

§17-1736-60 Appearance by representatives of hospital and institutional providers and the department. (a) In all matters involving an administrative hearing, a provider may choose representation by itself or by an attorney or other person. A provider shall not have a right to legal counsel appointed at state expense.

(b) If the provider is represented by another person, that person's name, address, and telephone number shall be provided to the DHS med-QUEST administrator prior to the administrative hearing.

(c) Upon receipt of the name of the provider's representative, the med-QUEST administrator shall provide to that representative, the name, address, and telephone number of the department's representative. [Eff 08/01/94] (Auth: HRS §346-14) (Imp: 42 C.F.R. §447.258)

§17-1736-61 Forms for papers for hospital and institutional providers. An original and two copies of all papers filed in any proceeding under this subchapter shall be filed with the department and shall be typewritten on one side only. [Eff 08/01/94] (Auth: HRS §346-14) (Imp: HRS §91.9; 42 C.F.R. §447.258)

§17-1736-62 Notice, service, and proof of service for hospital and institutional providers. (a) All papers, notices, and other documents shall be served by the party offering them upon all other parties to the proceeding. Proof of service upon the parties shall be filed with the DHS.

(b) Service of process may be accomplished by any manner permitted by law. The department shall serve the provider in person or by mail. If the provider is represented by an attorney or other person, service upon that attorney or other person shall be sufficient.

(c) Proof of service of any document shall be by certificate of attorney, affidavit, or acknowledgement.

(d) Where written notice is required by these rules, notice shall be considered effective on the date of mailing. [Eff 08/01/94] (Auth: HRS §346-14) (Imp: HRS §91.9; 42 C.F.R. §447.258)

§17-1736-63 Notice of formal hearing; notice of results of formal hearing for hospital and institutional providers. (a) The department shall notify any provider who is entitled to an administrative hearing of the scheduled date and location of the administrative hearing. The notice shall be in writing and mailed to the provider not less than thirty calendar days before the scheduled date of hearing.

(b) The department shall notify by mail any provider who has received an administrative hearing of the hearing officer's decision. [Eff 08/01/94] (Auth: HRS §346-14) (Imp: HRS §91.9; 42 C.F.R. §447.258)

§17-1736-64 Waiver of the right for oral hearing for hospital and institutional providers. (a) A provider may request that the hearing officer base the decision solely upon the documentary evidence submitted for the record without an oral hearing or appearance by either party. The request may be made at any time before or during the hearing. A waiver of an oral hearing is valid only if all parties agree with the request and if it is approved by the hearing officer.

(b) Approval of the request shall rest exclusively with the hearing officer.

(c) Where a request has been made and approved, the parties shall file with the hearing officer a written waiver of their right to a personal appearance before the hearing officer. The waiver may be withdrawn by any party with adequate notice to the opposing party and to the hearing officer as specified in section 17-1736-63.

(d) Once a waiver has been withdrawn, as provided in subsection (c), the hearing officer shall promptly notify all parties of the withdrawal and the need for an oral hearing. The hearing shall be held within one hundred eighty calendar days following the date of withdrawal of the waiver. [Eff 08/01/94] (Auth: HRS §346-14) (Imp: HRS §91.9; 42 C.F.R. §447.258)

§17-1736-65 Prehearing conference for hospital and institutional providers. (a) At any time before the actual formal hearing as specified in section 17-1736-64 or 17-1736-66, a prehearing conference may be held to clarify the issues under dispute.

(b) The conference shall be informal in nature, and a record as described in section 17-1736-71 shall not be required.

(c) The decision to have, or to not have a prehearing conference shall rest solely with the hearing officer. The decision shall not be subject to appeal.

(d) The decision to record or not record the prehearing conference shall rest solely with the hearing officer. The decision shall not be subject to appeal.

(e) At the sole discretion of the hearing officer, a prehearing order regarding the proceedings may be issued. The order shall control the subsequent course of the evidentiary hearing unless modified at the hearing to prevent manifest injustice. The prehearing order regarding the proceedings shall not be subject to appeal. [Eff 08/01/94] (Auth: HRS §346-14) (Imp: HRS §91.9; 42 C.F.R. §447.258)

§17-1736-66 Conduct of hearing for hospital and institutional providers. (a) The hearing shall be conducted by an impartial hearing officer appointed by the DHS director. Before conducting the hearing, the hearing officer shall become familiar with sections 84-1 to 84-19, HRS, and the published opinions of the State's ethics commission and determine that participation as an administrative hearing officer shall not create conflicts of interest or ethical violations.

(b) Testimony shall be taken only on oath or affirmation and the testimony shall be subject to sections 710-1060, 710-1061, and 710-1062, HRS.

(c) Each party may:

(1) Call and examine witnesses;

(2) Introduce exhibits into evidence;

(3) Cross-examine witnesses called by the other party;

(4) Object to the presentation of any evidence deemed by the party to be not properly admitted;

(5) Present rebuttal evidence to the opposing

party's case-in-chief; and

(6) Present an opening statement to the hearing officer before the taking of evidence, and a closing argument to the hearing officer at the conclusion of the taking of evidence.

(d) The hearing officer shall not require strict adherence to any rules of evidence. The hearing officer shall admit all evidence having any bearing on the hearing including, but not limited to, testimony, documents, photographs, opinions, objects, or diagrams. The hearing officer may allow the presentation of hearsay evidence, allow cross-examination beyond the scope of direct examination, and allow the party calling a witness to cross-examine or impeach that witness. Rulings on evidence made by the administrative hearing officer shall not be subject to appeal.

(e) The hearing officer may ask questions of any witness or request production of evidence by any party to the hearing.

(f) The administrative hearing officer may exclude irrelevant, immaterial, or unduly repetitious evidence as provided in section 91-10(1), HRS.

(g) In administrative hearings, the provider shall have the burden of proof, including the burden of producing evidence as well as the burden of persuasion. The amount of proof necessary to prevail shall be a preponderance of the evidence in accordance with section 91-10(5), HRS. [Eff 08/01/94] (Auth: HRS §346-14) (Imp: HRS §91.10; 42 C.F.R. §447.258)

§17-1736-67 Prehearing discovery for hospital and institutional providers. Any party may request data from any other party to the proceeding. If the requested party does not respond within fifteen calendar days of the request, the requesting party may notify the hearing officer. Upon notice, the hearing officer shall allow the requested party fifteen calendar days to state why the requested data was not furnished. If inadequate or no response is received, the hearing officer may take one of the following actions:

(1) Subpoena the requested data under section 17-1736-68;

(2) Issue an order that the matters regarding which the request was made or any designated facts shall be taken to be established for

the purposes of the hearing in accordance with the claim of the requesting party;

(3) Issue an order prohibiting the non-compliant party from supporting or opposing designated claims or defenses, or prohibiting that party from introducing designated matters in evidence; or

(4) Issue an order continuing or suspending further proceedings in the provider's request for review until the requested data is furnished as provided for in section 17-1736-70.

(5) The hearing officer, on the application of one of the parties, shall have the authority to determine that the request is unduly burdensome. [Eff 08/01/94] (Auth: HRS §346-14) (Imp: HRS §91.10; 42 C.F.R. §447.258)

§17-1736-68 Witnesses and subpoenas for hospital and institutional providers. (a) Each party to the administrative hearing shall arrange for the presence of its witnesses at the hearing.

(b) The DHS director shall designate the hearing officer as a representative of the director and empowered to conduct a hearing. Any party to the administrative hearing may request of the hearing officer a subpoena to compel the attendance of a witness or the production of books, papers, documents, or other objects deemed relevant to the investigation, except that no subpoena shall affect any privilege established by law. Each subpoena shall be signed by the administrative hearing officer who at any point in the proceedings may, subpoena witnesses, books, papers, documents, correspondence, memoranda, or other records in furtherance of the administrative hearing.

(c) Applications for subpoenas for the production by a witness of books, papers, documents, correspondence, memoranda, or other written records, shall be made by affidavit to the hearing officer and shall contain all of the following:

(1) The name and address of the person or organization upon whom the subpoena is to be served;

(2) A description of the documents, papers, books, correspondence, memoranda,

photographs, or other written records that are desired;

(3) A statement by the affiant that to the best of the affiant's knowledge and belief, the person to be subpoenaed has information about or possesses the documents, papers, books, correspondence, memoranda, photographs, or other objects that the subpoena seeks; and

(4) The basis for the affiant's belief that the person or organization has information about or possesses the documents, papers, books, correspondence, memoranda, photographs, or other objects that the subpoena seeks.

(d) Each party to the administrative hearing shall arrange for the service of all subpoenas issued on its behalf. A copy of the affidavit in support of the issuance of the subpoena shall be served along with the subpoena.

(e) All witnesses who are summoned to an administrative hearing by subpoena may claim witness fees and mileage allowance at the same rate established for witnesses in the circuit court of the first circuit of the State.

(f) The parties shall bear their own costs. [Eff 08/01/94] (Auth: HRS §346-14) (Imp: 42 C.F.R. §447.258)

§17-1736-69 Amendments for hospital and institutional providers. (a) If, subsequent to the provider's request for hearing under section 17-1736-58(b), the provider identifies further issues with which it disagrees, the provider, with notice to the opposing party and to the hearing officer, may include those issues in the appeal. The provider shall only amend the appeal if the initial request was made in accordance with section 17-1736-58, and the additional issues are not excluded as specified in section 17-1736-59. The provider shall not amend the appeal following the close of the formal hearing. Final determination of the right to amend shall be at the sole discretion of the hearing officer.

(b) Where the issues are amended pursuant to subsection (a), the administrative hearing process shall be continued for a length of time as the hearing office deems appropriate to afford all parties notice and a chance to examine and address the additional issues.

(c) Notice of amendments shall be served in accordance with section 17-1736-62. [Eff 08/01/94] (Auth: HRS §346-14) (Imp: 42 C.F.R. §447.258)

§17-1736-70 Continuances or further hearings for hospital and institutional providers. (a) At any time during the administrative hearing, if the hearing officer determines that the hearing shall be held at another time or at any other location in the State, the hearing officer shall have discretion to continue the hearing.

(b) If the hearing officer determines at any point in the hearing that it is necessary to seek additional evidence, the hearing may be continued at a later date or one or both parties may be directed to seek further evidence, provided the hearing officer furnish written justification on the record for any continuance under this section lasting in excess of thirty days. Failure of either party to provide additional evidence as directed by the hearing officer shall not be used as the sole basis for an adverse decision against that party on the issues presented at the hearing. In the event that further evidence is not produced as directed, the hearing office shall proceed to a decision based upon the entirety of the evidence presented at the hearing.

(c) Written notice of the time and place of any continued or additional hearings shall be given in accordance with section 17-1736-63, except when a continuance or additional hearing to a certain date is ordered during a hearing, then oral notice of the time and place of the hearing shall be sufficient for all parties present at the hearing. [Eff 08/01/94] (Auth: HRS §346-14) (Imp: 42 C.F.R. §447.258)

§17-1736-71 Record of hearing for hospital and institutional providers. A verbatim record of all portions of the hearing shall be made. The record may be in the form of a transcript of verbatim shorthand, or by an audio or video recording. If any party to the hearing notifies the hearing officer in writing of an intent to file exceptions to the hearing officer's findings of fact as provided in section 91-11, HRS, or if a party appeals an agency decision, as provided in section 91-14, HRS, a verbatim written transcript shall

be prepared. [Eff 08/01/94] (Auth: HRS §346-14) (Imp: HRS §91; 42 C.F.R. §447.258)

§17-1736-72 Decision of the hearing officer for hospital and institutional providers. (a) At the conclusion of the evidence and argument by the parties, the hearing officer shall declare the hearing closed, at which time each party shall have thirty calendar days, not counting the day that the hearing is closed, to present written proposed findings of fact.

(b) At the conclusion of the thirty day period prescribed in subsection (a), the hearing officer shall have sixty calendar days to prepare a written decision accompanied by separate findings of fact, conclusions of law, and basis for findings. The hearing officer, if clarification of any evidence or any proposed finding of fact is desired, may reconvene the hearing to clarify the existing evidence. The period of time during which the hearing has been reconvened shall toll the time within which the hearing officer is required to prepare the written decision.

(c) The hearing officer shall not have informal, unrecorded conversations with any party concerning the case. All discussions concerning the evidence shall be at sessions of record with all parties to the hearing present, except to the extent those discussions are required for the disposition of ex parte matters authorized by law. [Eff 08/01/94] (Auth: HRS §346-14) (Imp: HRS §§91-12, 91-13; 42 C.F.R §447.258)

§17-1736-73 Dismissal upon failure to appear at hearings for hospital and institutional providers. (a) If, after timely, proper written notice, a provider fails to appear at a scheduled hearing, the hearing officer may issue a written dismissal of the provider's request for an administrative hearing, which shall be mailed to each party with notice that the provider may request written consideration.

(b) In order to request written consideration, the provider shall, within ten days of the mailing of written dismissal, appeal to the hearing officer in writing showing good cause for the provider's failure to appear at the hearing. At the sole discretion of the hearing officer, the hearing officer may either sustain the dismissal or reinstate the hearing with proper written notice to parties. If the hearing

officer sustains the dismissal, the hearing officer shall provide a written dismissal order including the circumstances upon which the dismissal is based. [Eff 08/01/94] (Auth: HRS §346-14) (Imp: 42 C.F.R. §447.258)

§17-1736-74 Administrative review by the director for hospital and institutional providers. (a) The DHS director shall have the authority to review the hearing officer's written decision. The review may take place following issuance of the decision as specified in section 17-1736-63.

(b) The director shall have thirty calendar days following the date of the hearing officer's decision to mail notice of review to the parties of the director's intention to review the decision. The director's review shall be based upon the applicable rules and the facts as established in the record, provided that the director may communicate with the hearing officer during the review.

(c) The director may sustain, reverse, modify, or remand the decision of the hearing officer and in any event shall mail notice of his intention to review within thirty calendar days following the date of the hearing officer's decision.

(d) The director's decision shall be mailed to all parties within thirty days following the notice of review.

(e) The decision of the hearing officer and DHS director shall be subject to judicial review as provided in section 91-14, HRS. [Eff 08/01/94] (Auth: HRS §346-14) (Imp: 42 C.F.R. §447.258)

§17-1736-75 Reopenings for hospital and institutional providers. (a) A hearing officer may reopen a decision at any time within three years after the date of the decision.

(b) Notice shall be given to all parties of the hearing officer's intent to reopen and the reasons therefore.

(c) The decision to reopen, or not to reopen rests solely with the hearing officer and shall not be subject to appeal.

(d) The three years time limit shall be waived if the reopening is due to evidence of fraud. [Eff 08/01/94] (Auth: HRS §346-14) (Imp: 42 C.F.R §447.258)