TITLE 317: OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 2. GRIEVANCE PROCEDURES AND PROCESS

317:2-1-1. Purpose

The purpose of this Chapter is to describe the different types of grievances addressed by the Oklahoma Health Care Authority (OHCA). The rules explain the step by step processes that must be followed by a party seeking redress from the OHCA. All hearings on eligibility issues for ~~recipients~~ members are conducted by the Oklahoma Department of Human Services, and are not contained in this Chapter. Hearings will not be granted when the sole issue to be determined is a Federal or State law requiring an automatic change adversely affecting some or all ~~recipients~~ members.

317:2-1-2. Appeals

(a) **Member Process Overview.**

(1) The appeals process allows a member to appeal a decision which adversely affects their rights. Examples are decisions involving medical services, prior authorizations for medical services, or discrimination complaints.

(2) In order to file an appeal, the member files a LD-1 form within 20 days of the triggering event. The triggering event occurs at the time when the Appellant (Appellant is the person who files a grievance) knew or should have known of such condition or circumstance for appeal~~)~~.

(3) If the LD-1 form is not received within 20 days of the triggering event, OHCA sends the Appellant a letter stating the appeal will not be heard because it is untimely. In the case of tax warrant intercept appeals, if the LD-1 form is not received within 30 days of written notice sent by OHCA according to Title 68 O.S. § 205.2, OHCA sends the Appellant a letter stating the appeal will not be heard because it is untimely.

(4) If the LD-1 form is not completely filled out and necessary documentation not included, then the appeal will not be heard.

(5) The staff advises the Appellant that if there is a need for assistance in reading or completing the grievance form that arrangements will be made.

(6) Upon receipt of the member's appeal, a fair hearing before the Administrative Law Judge (ALJ) will be scheduled. The member will be notified in writing of the date and time for this procedure. The member must appear at this hearing and it is conducted according to ~~Section~~ OAC 317:2-1-5. The ALJ's decision may be appealed to the ~~CEO~~ Chief Executive Officer of

the OHCA, which is a record review at which the parties do not appear (Section OAC 317:2-1-13).

(7) Member appeals are ~~to be~~ ordinarily decided within 90 days from the date OHCA receives the member's timely request for a fair hearing unless the member waives this requirement. [Title 42 ~~U.S.C.~~ CFR Section 431.244(f)]

(8) Tax warrant intercept appeals will be heard directly by the ALJ. A decision ~~will be~~ is normally rendered by the ALJ within 20 days of the hearing before the ALJ.

(b) **Provider Process Overview.**

(1) The proceedings as described in this Section contain the hearing process for those appeals filed by providers. These appeals encompass all subject matter cases contained in OAC 317:2-1-2(c)(2).

(2) All provider appeals are initially heard by the OHCA Administrative Law Judge under OAC 317:2-1-2(c)(2).

(A) The Appellant (Appellant is the provider who files a grievance) files an LD form requesting a grievance hearing within 20 days of the triggering event. The triggering event occurs at the time when the Appellant knew or should have known of such condition or circumstance for appeal. (LD-2 forms are for provider grievances and LD-3 forms are for nursing home wage enhancement grievances.)

(B) If the LD form is not received within 20 days of the triggering event, OHCA sends the Appellant a letter stating the appeal will not be heard because it is untimely.

(C) The staff advises the Appellant that if there is a need for assistance in reading or completing the grievance form that arrangements will be made.

(D) A decision will be rendered by the ALJ ordinarily within 45 days of the close of all evidence in the case.

(E) The Administrative Law Judge's decision is appealable to OHCA's CEO under OAC 317:2-1-13.

(c) **ALJ jurisdiction.** The administrative law judge has jurisdiction of the following matters:

(1) Member Appeals:

(A) Discrimination complaints regarding the Medicaid program;

(B) Appeals which relate to the scope of services, covered services, complaints regarding service or care, enrollment, disenrollment, and reenrollment in the SoonerCare Program;

(C) Fee for Service appeals regarding the furnishing of services, including prior authorizations;

(D) Appeals which relate to the tax warrant intercept system through the Oklahoma Health Care Authority. Tax warrant intercept appeals will be heard directly by the

ALJ. A decision will be rendered by the Administrative Law Judge within 20 days of the hearing before the ALJ;

(E) Complaints regarding the possible violation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA); ~~and~~

(F) Proposed administrative sanction appeals pursuant to OAC 317:35-13-7. Proposed administrative sanction appeals will be heard directly by the ALJ. A decision by the ALJ will ordinarily be rendered within 20 days of the hearing before the ALJ. This is the final and only appeals process for proposed administrative sanctions; and

(2) Provider Appeals:

(A) Whether Pre-admission Screening and Resident Review (PASRR) was completed as required by law;

(B) Denial of request to disenroll member from provider's SoonerCare Choice panel;

(C) Appeals by Long Term Care facilities for nonpayment of wage enhancements, determinations of overpayment or underpayment of wage enhancements, and administrative penalty determinations as a result of findings made under OAC 317:30-5-131.2(b)(5), (e)(8), and (e)(12);

(D) Petitions for Rulemaking;

(E) Appeals of insureds participating in Insure Oklahoma/ O-EPIC which are authorized by OAC 317:45-9-8(a);

(F) Appeals to the decision made by the Business Contracts manager related to Purchasing as found at OAC 317:10-1-5 and other appeal rights granted by contract;

(G) Drug rebate appeals;

(H) Nursing home contracts which are terminated, denied, or non-renewed; and

(I) Proposed administrative sanction appeals pursuant to OAC ~~317:35 13 7~~ 317:30-3-19. Proposed administrative sanction appeals will be heard directly by the ALJ. A decision will normally be rendered by the ALJ within 20 days of the hearing before the ALJ. This is the final and only appeals process for proposed administrative sanctions.

Administrative Law Judge.

(1) Hearings will be conducted in an informal manner without formal rules of evidence or procedure.

(2) No party is required to be represented by an attorney. Members may represent themselves or authorize another party to represent them. A person or entity desiring to represent a member must provide documentation of the consent of the member to be represented by that person or entity. An appeal will be rejected without documentation of representation. Individuals

appearing for corporate entities will be deemed to be authorized to represent the corporation in a hearing.

(3) The docket clerk will send the Appellant and any other necessary party notice which states the hearing location, date, and time.

(4) The OHCA Administrative Law Judge or designee may:

(A) Rule on any requests for extension of time;

(B) Hold pre-hearing conferences to settle, simplify, or identify issues in a proceeding or to consider other matters that may end in the expeditious disposition of the proceeding;

(C) Require the parties to state their positions concerning the various issues in the proceeding;

(D) Require the parties to produce for examination those relevant witnesses and documents under their control;

(E) Rule on motions and other procedural items;

(F) Regulate the course of the hearing and conduct of the participants;

(G) Establish time limits for the submission of motions or memoranda;

(H) Impose appropriate sanctions against any person failing to obey an order of the ALJ or authorized under the rules in this Chapter which may include:

(i) Refusing to allow the person to assert or oppose designated claims or defenses, or prohibiting that person from introducing designated matters in evidence;

(ii) Excluding all testimony of an unresponsive or evasive witness; or

(iii) Expelling the person from further participation in the hearing;

(I) Take official notice of any material fact not appearing as evidence in the record, if the fact is among traditional matters of judicial notice;

(J) Administer oaths or affirmations;

(K) Determine the location of the hearing;

(L) Allow either party to request that the hearing be recorded by a court reporter with costs to be borne by the requesting party. The original of such transcription, if ordered, will be given to the ALJ with a copy to be given to the requesting party;

(M) Recess and reconvene the hearing;

(N) Set and/or limit the time frame of the hearing;

(O) Reconsider or rehear a matter for good cause shown; and

(P) Send a copy of the decision by the ALJ to both parties outlining their rights to appeal the decision. The decision letter need not contain findings of fact or conclusions of law.

(5) The burden of proof during the hearing will be upon the Appellant and the ALJ will decide the case based upon a preponderance of evidence standard as defined by the Oklahoma Supreme Court. Parties who fail to appear at a hearing, after notification of said hearing date, will have their cases dismissed for failure to prosecute.

(6) Parties may file preliminary motions in the case. Any such motions must be filed within 15 calendar days prior to the hearing date. Response to preliminary motions must be made within 7 calendar days of the date the motion is filed with OHCA. Preliminary motions will be ruled upon 3 days prior to the hearing date.

(7) In any case in which a member requests a continuance, OHCA will not be prejudiced to complete the case within 90 days.

317:2-1-6. Other grievance procedures and processes

Other grievance procedures and processes include those set out in OAC 317:2-1-7 [~~Surveillance, Utilization and Review System (SURS) and~~ Program Integrity Audits/Reviews Appeals]; OAC 317:2-1-8 (Nursing Home Provider Contract Appeals); OAC 317:2-1-9 [OHCA's Designated Agent's Appeal Process for ~~Behavioral Health~~ QIO Services]; OAC 317:2-1-10(Drug Rebate Appeal Process); OAC 317:2-1-11 [Medicaid Drug Utilization Review Board (DUR) Appeal Process]; and OAC 317:2-1-12 (For Cause Provider Contract Suspension/Termination Appeals Process).

317:2-1-7. ~~Surveillance, Utilization and Review System (SURS) and~~ Program Integrity ~~Audits/Reviews appeals~~

All ~~SURS and~~ Program Integrity Audits/Reviews appeals are made to the State ~~Medicaid~~ SoonerCare Director.

(1) If a provider disagrees with a decision of ~~the SURS or~~ Program Integrity ~~Audit/Review~~ including statewide surveillance and utilization control program appeals, which has determined that the provider has received an overpayment, the provider may appeal, within 20 days of the date of that decision to the State Medicaid Director.

(2) The appeal from the ~~SURS or~~ Program Integrity ~~Audit/Review~~ decision will be commenced by the receipt of a letter from the appellant provider. The letter must set out with specificity, the overpayment decision to which the provider objects along with the grounds for appeal. The letter should explain in detail, the factual and/or legal basis for disagreement with the allegedly erroneous decision. The letter should also include all relevant exhibits the provider believes necessary to decide the appeal.

(3) Upon receipt of the appeal by the docket clerk, the matter will be docketed for the next meeting of the Medical Advisory Committee (MAC). Any appeal received less than four weeks

before a scheduled MAC meeting will be set for the following MAC meeting.

(4) The appeal will be forwarded to the OHCA Legal Services Division by the docket clerk for distribution to the members of the subcommittee and for preparation of the OHCA's case. A subcommittee of the MAC will be formed and render a recommendation to the State Medicaid Director.

(5) At the discretion of the MAC, witnesses may be called and information may be solicited from any party by letter, telephonic communication, fax, or other means. The subcommittee may request that members of the Authority be present during their consideration of the appeal. Members of the ~~Authority's~~ OHCA's Legal Division may be asked to answer legal questions regarding the appeal.

(6) The subcommittee will issue a recommendation regarding the appeal, in writing, within 30 days of the hearing. An exception to the 30 day rule will apply in cases where the subcommittee sets the case over until its next scheduled meeting in order to gather additional evidence. The written recommendation will list the members of the subcommittee who participated in the decision. In cases where an appeal must be continued, the subcommittee will issue a letter within 30 days of the initial hearing to inform the appellant of the continuance.

(7) The recommendation, after being formalized, will be sent to the docket clerk for review by the State Medicaid Director. The State Medicaid Director will ordinarily issue a decision regarding the appeal within 60 days of the docket clerk's receipt of the recommendation from the MAC. The decision will be issued to the appellant or his/her authorized agent.

(8) If the provider is dissatisfied with the Medicaid Director's decision, it may be appealed to the CEO under OAC 317:2-1-13.

317:2-1-8. Nursing home provider contract appeals

This Section explains the appeal process to be accorded all nursing home providers whose contracts are terminated, denied or non-renewed. No procedure is afforded a nursing facility whose contract is limited in any other fashion.

(1) If a nursing home provider's contract is terminated, non-renewed or denied prior to the action's effective date, the provider will be afforded an informal reconsideration in accordance with ~~42 C.F.R. 431.154~~ 42 C.F.R. 421.153.

(2) The notice of termination, non-renewal or, denial of contract will include the findings it was based upon. The letter will be sent by certified mail to the provider.

(3) The provider will have ~~20~~ 60 days to respond to the notice unless there is a finding of immediate jeopardy or a

determination that the facility's SoonerCare certification has been cancelled prior to 60 days. The response should outline the reasons why the ~~Authority's~~ OHCA's decision to terminate, non-renew, or deny the contract is wrong. The response by the provider must include a detailed position addressing the findings set out in the ~~Authority's~~ OHCA's letter. ~~The provider may request an extension of the 20 day limit if "good cause" exists that prevents the provider from refuting the findings in 20 days. A finding of "good cause" is in OHCA's discretion.~~ In the event that less than a 60 day notice is provided for either reason stated above, the provider will be afforded a notice in as much time before decertification as possible.

(4) Based upon the provider's response, the ~~Authority~~ OHCA will affirm or deny the notice of non-renewal, termination or denial.

~~(5) If the Oklahoma Health Care Authority affirms the notice of termination, non renewal, or denial or the provider files no timely response, the effective date will pass and upon affirmation of the notice, the process described in OAC 317:2-1-2(b), and 317:2-1-2(c)(2) and 317:2-1-5(b) will apply.~~

~~(6) The hearing afforded the provider after the effective date will satisfy the requirements of 42 C.F.R. 431.153.~~

~~(7) If the facility is a skilled nursing facility, the facility will receive a notice as required by 42 C.F.R. 431.153(d)(1) and (2).~~

317:2-1-9. OHCA's Designated Agent's appeal process for ~~Behavioral Health services~~ QIO Decisions

~~This Section explains the administrative processes available to providers who have reviews completed by OHCA's Quality Improvement Organization (QIO).~~ The OHCA's Quality Improvement Organization (QIO) ~~The QIO~~ conducts an administrative process for those providers it reviews. The process afforded providers by QIO is the only administrative remedy available to providers. The decision issued by the QIO is considered by the OHCA to be a final administrative determination. The final QIO determination is not appealable to the OHCA for any further administrative hearings. After the QIO'S decision, OHCA will recoup the monies paid the provider related to the review.

317:2-1-10. Drug Rebate appeal process

The purpose of this Section is to afford a process to both the manufacturer and the state to administratively resolve drug rebate discrepancies. These rules anticipate discrepancies between the manufacturer and OHCA which would require the manufacturer to pay a higher rebate or a lower rebate. These regulations provide a mechanism for both informal dispute resolution of drug rebate discrepancies between the manufacturer

and OHCA and a mechanism for appeals of drug rebate discrepancies between the manufacturer and OHCA.

(1) The process begins at the end of each calendar quarter when the ~~Authority will mail~~ OHCA mails a copy of the State's past quarter's utilization data to the manufacturer. Utilization data and a billing for rebates will be mailed to the manufacturer within 60 days after the end of each quarter. It is this data which dictates the application of the federal drug rebate formula.

(2) Within 30 days from the date utilization data is sent to the manufacturer, the manufacturer may edit state data and resolve data inconsistencies with the state. The manufacturer may utilize telephone conferences, letters and any other mechanism to resolve data inconsistencies in mutual agreement with the state.

(3) Within 30 days after the utilization data is mailed to the manufacturer, the manufacturer may:

(A) pay the same amount as billed by the state with the quarterly utilization date;

(B) pay an amount which differs from the amount billed by the state with the utilization data and send disputed data information;

(C) pay nothing and send no disputed data information;

(D) pay nothing and send disputed data information.

(4) In the event the state receives the rebate amount billed by the 30th day, the dispute ends.

(5) If after 30 days one of the following events occurs, the state will acknowledge the receipt of the correspondence and review the disputed data:

(A) the receipt of an amount lower than that billed to the manufacturer;

(B) the receipt of disputed data.

(6) In the event no disputed data is received and no payment is received, interest will be computed in accordance with the provisions of federal law found at 42 U.S.C. Section 1396b(d)(5) and will be compounded upon the amount billed from 38 days after the date utilization data is sent.

(7) In the event a lower amount than billed is paid or in the event disputed data is sent, and no money is received, interest will be computed in accordance with 42 U.S.C. Section 1396b(d)(5) and will be computed from 38 days from the date utilization data is sent to the manufacturer.

(8) Within 70 days from the date utilization data is sent to the manufacturer, the state will make its final informal review of the disputed data. OHCA will mail a second notice to the manufacturer which will include:

(A) receipt of the rebate, if any;

(B) receipt of the dispute;
(C) a statement regarding the interest amount; and
(D) a statement regarding the appeal rights of the manufacturer with a copy of the appeal form.

(9) Within 90 days of the date utilization data is sent to the manufacturer or within 20 days of the date a second notice is mailed to the manufacturer, whichever is sooner, the state or the manufacturer may request a hearing to administratively resolve the matter.

(10) The administrative appeal of drug rebate discrepancies includes:

(A) The appeal process will begin by the filing of a form LD-2 by the manufacturer or OHCA.

(B) The process afforded the parties will be the process found at ~~OAC 317:2-1-5(b). The process provided by~~ OAC 317:2-1-2(b) and (c) ~~will also apply to these hearings~~.

(C) With respect to the computation of interest, interest will continue to be computed from the 38 day based upon the policy contained in the informal dispute resolution rules above.

(D) The ALJ's decision will constitute the final administrative decision of the OHCA.

(E) If the decision of the ALJ affirms the decision of OHCA in whole or in part, ~~paymnent~~ payment from the manufacturer must be made within 30 days of the decision. If the decision of the ALJ reverses the decision of the OHCA, the OHCA will make such credit or action within 30 days of the decision of the ALJ.

(F) The nonpayment of the rebate by the manufacturer within 30 days after the ALJ's decision will be reported to the Centers for Medicare and Medicaid Services and may be the basis of an exclusion action by the OHCA.

317:2-1-11. Medicaid Drug Utilization Review Board (DUR) appeal process

This Section explains the appeal process, pursuant to 63 O.S. §5030.3~~(8)~~(B)(Supp. 1999), accorded any ~~part~~ party aggrieved by a decision of the OHCA Board or Administrator (CEO) concerning a proposed recommendation of the Medicaid Drug Utilization Review Board (DUR).

(1) The aggrieved party may appeal pursuant to OAC 317:2-1-2 et seq. OHCA Appeals).

(2) The Board finds that the prescription of Title 63 O.S. § 5030.3(B) is somewhat contradictory with the functions of the DUR Board. More specifically, in most instances, the DUR Board suggests policies that must be rule made. Rules promulgated by the OHCA Board do not lend to an "individual proceeding notice" as contemplated by Article II of the

Oklahoma Administrative Procedures Act, specifically, Title 75 O.S. §309. Thus, in instances where the OHCA Board promulgates rules as a result of policy recommendations by the DUR Board, this Board will consider a party aggrieved by these rules to have filed a Petition for Rulemaking under 75 O.S. §305. In making this interpretation of 63 O.S. §5030.1, the Board will not enforce the last sentence of ~~74~~ 75 O.S. §305. In making this interpretation, the Board finds that it is taking two somewhat conflicting provisions, and combining them to effectuate the intent of the legislature - to provide a hearing to those aggrieved by recommendations by the DUR Board and accepted by the OHCA Board.

(3) In instances where the DUR Board makes a recommendation accepted by the Board against an individual provider [for example, a recommendation under ~~42 U.S.C. §1396a8(g)(3)(c)(iii)(IV)~~] 42 U.S.C. 1396r-8(g)(3)(C)(iii)(IV), OHCA will provide an individual proceeding under the Oklahoma Administrative Procedures Act.

(4) In any appeal under (1) and (2) of this subsection, the OHCA Board delegates the OHCA ALJ to preside over the above hearing and present the Board with proposed findings of fact and conclusions of law in accordance with Article II of the Administrative Procedures Act. The OHCA Board may accept the ALJ's written decision, reject it, or amend the recommendations.

(5) Appeals filed pursuant to (1) and (2) of this subsection, will be made within 20 days of the OHCA Board's acceptance of the recommendation by the DUR Board.

(6) After Proposed Findings of Fact and Conclusions of Law are presented to the OHCA Board, the Board will have a period of 120 days to issue a final administrative order.

(7) The Agency's Legal Services Division will construct a form called the LD-3, which will be used for parties to file an action under (1) and (2) of this subsection.

317:2-1-12 For Cause provider contract suspension/termination appeals process

This Section explains the appeals process for providers whose ~~Medicaid~~ SoonerCare contracts have been suspended/terminated by the OHCA for cause. Those providers whose contracts have been affected by other OHCA actions cannot request an appeal of those measures. Contracts terminated or suspended for cause are either timed terminations(30, 60,or 90 day) or immediate terminations /suspensions. Subsections (1) and (2) apply to timed terminations/suspensions and subsection (3) applies to immediate terminations.

(1) **Procedure for suspending/terminating provider's contract.**

(A) **Notice of proposed suspension or termination.** The OHCA will provide notice to the medical services provider of the proposed suspension or termination of provider contract. The written notice of suspension/termination will state:

(i) the reasons for the proposed suspension/termination;

(ii) the date upon which the suspension/termination will be effective; and

(iii) a statement that the medical services provider has a right to review prior to the suspension/termination of the provider's contract (refer to subparagraph (B) of this paragraph).

(B) **Right to review prior to suspension/termination of provider contract.** Before the medical services provider's contract is suspended or terminated, the OHCA will give the medical services provider the opportunity to submit documents and written arguments against the suspension/termination of the provider's contract.

(C) **Notice of suspension or termination.**

(i) After the review of the medical services provider's written response, the OHCA will make a final administrative decision subject to a post-suspension or termination hearing.

(ii) After the review of the medical services provider's written response, the OHCA will make a final administrative decision subject to a post-sanction hearing. Should the OHCA decide not to suspend or terminate the provider's contract, the medical services provider will be notified of the reasons for the decision.

(iii) Should the OHCA make a decision to suspend or terminate the medical services provider's contract, the OHCA will send a notice stating:

(I) the reasons for the decision;

(II) the effective date of the suspension or termination of the contract;

(III) the medical services provider's right to request a post-suspension or termination hearing; and

~~(IV) the earliest date in which the agency will accept a request for reinstatement; and~~

(V) the requirements and procedures for reinstatement.

(2) **Post-suspension/termination hearing.** After the effective date of the suspension or termination of the provider's contract, the medical services provider is entitled to receive a post-suspension or termination hearing. The hearing committee for the OHCA will be comprised of three members of the OHCA and two other members as appointed. The

representative who investigated the case will not be a representative if an investigation was initiated or completed.

(A) After the provider's request for the post-suspension/termination hearing is made, a hearing date will be established. A certified letter will be sent to the provider giving notification of the hearing date and naming the contact person. The contact person will answer procedural questions about the hearing.

(B) Ten days prior to the hearing, the medical services provider will submit a brief written statement detailing the evidence which will be presented by the provider at the hearing. Such statement must detail the facts which will be refuted by the provider. The purpose of the hearing will be limited to issues raised in the letter of suspension or termination as the cause of suspending or terminating the provider contract.

(C) The provider may be represented by an authorized representative, with documentation to that effect, at the informal hearing and/or the provider may present testimony himself or herself and have witnesses present.

(D) At the conclusion of the hearing, a decision will be made by the Hearing Committee. The provider will be notified in writing of the decision within 20 days of the final day of the hearing. The decision letter will constitute the agency's final decision regarding the matter.

(3) **Notice of immediate suspension or termination**. The process below will be followed in the event of an immediate suspension or termination:

(A) A notice described in section (1)(A) will be sent to the provider, except there is no right to review prior to an immediate termination or suspension.

(B) A post suspension termination review will be conducted in accordance with section (2) above.

317:2-1-13. Appeal to the Chief Executive Officer

An appeal to the Chief Executive Officer (CEO) of the Oklahoma Health Care Authority includes:

(1) Within 20 days of decisions made pursuant to provider or ~~SURS/~~Program Integrity Audits/Reviews appeals found at this Chapter, either party may appeal a decision to the CEO of the ~~Authority~~ OHCA. Such appeal will be commenced by a letter or fax received by the CEO within 20 days of the receipt of the prior decision made by the ALJ or Medicaid Director. The appeal will concisely and fully explain the reasons for the request. No new evidence may be presented to the CEO. Evidence presented must be confined to the records below.

(2) Appeals to the CEO under ~~recipient~~ member proceedings will be commenced by a letter received no later than 10 days of the receipt of the decision by the ALJ. Should the appellant request a transcription to prosecute its appeal to the CEO, the appellant will be required to execute a waiver relieving the OHCA from completing its fair process hearing within 90 days.

(3) For provider and ~~SURS/~~Program Integrity Audits/Reviews proceedings, the CEO will ordinarily have 90 days from receipt of the appeal to render a written decision.

(4) For ~~recipient~~ member proceedings, the CEO will ordinarily have 30 days from receipt of the appeal to render a written decision.

(5) The only appeal for proposed provider or member administrative sanctions is before the ALJ and the ALJ decision is not appealable to the CEO.