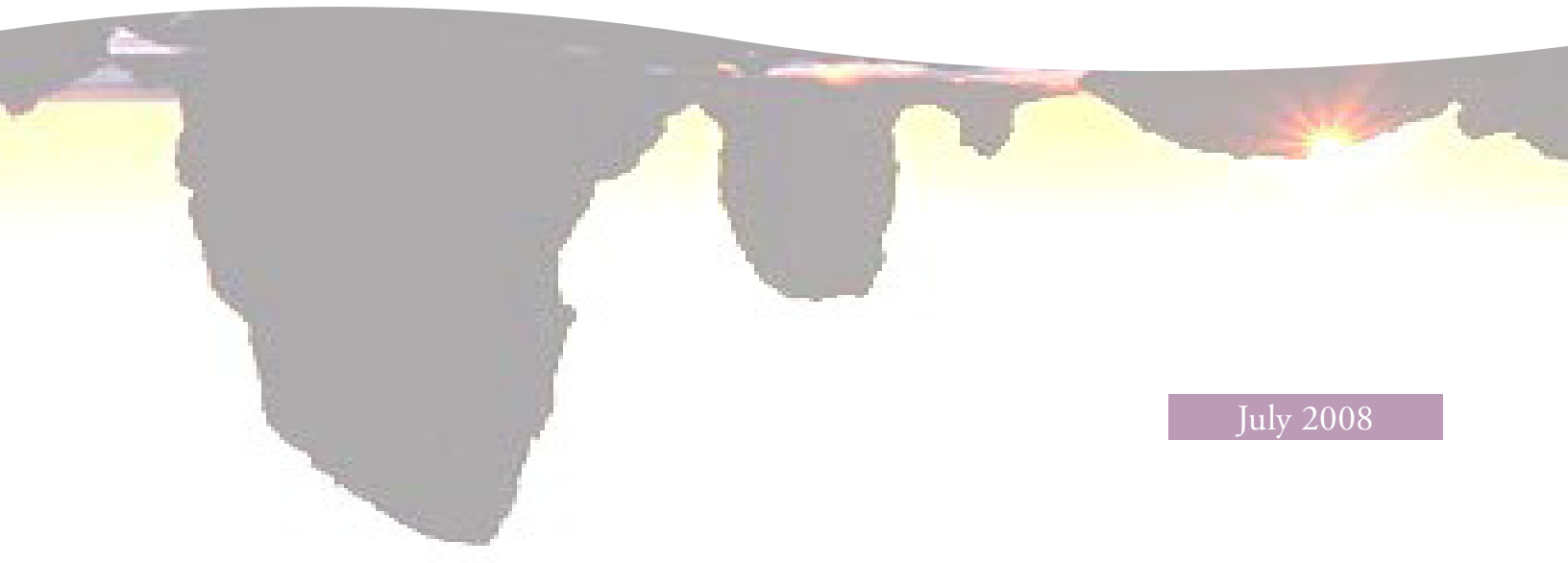
DMAP Worker Guide XI

Client Rights and Responsibilities

- Billing of clients...2
- Health care complaint process...3
- Hearings...4



July 2008

Client Rights and Responsibilities

Clients who receive medical assistance (a.k.a. Medicaid or Oregon Health Plan) have specific rights and responsibilities:

- The Rights and Responsibilities section is part of a client's application for medical assistance. Clients are asked to sign this form to be sure they are aware of their rights.
- Part of a client's rights involves billing. The Division of Medical Assistance Programs (DMAP) has very specific rules for billing clients.
- Clients also have grievance rights and rights to a hearing under administrative rules.
- Plans must have a complaint process for clients.

Billing of clients — General Rules 410-120-1280 and 410-141-0420

A provider must not seek payment from a medical assistance client or any financially responsible relative or representative of that individual for any service covered by Medicaid except under the circumstances described below.

- The health service or item is not covered by a DMAP program. The client must be informed in writing in advance of the receipt of the specific service that is not covered, the estimated cost of the service, and that the client or the client's family is or may be financially responsible for payment for the specific services.
- The client is not eligible for medical assistance at the time the service(s) or item(s) were provided, and is not made eligible retroactively.
- The charge is for a copayment when a client is required to make a copayment as outlined in DMAP General Rules 410-120-1230.
- The client did not tell the provider that he/she had medical coverage from DMAP either at the time the service was provided or subsequent to the provision of the service and, as a result, the provider could not bill DMAP in accordance with the Timely Submission of Claims rule. The provider must document attempts to obtain information from the client on potential medical assistance coverage.
- The client did not tell the provider that he/she had medical assistance coverage prior to the delivery of the service, the service required authorization prior to the delivery of the service, and DMAP staff will not retroactively authorize.
- The client did not tell the provider that he/she had other insurance coverage and the third party insurer will not make payment because of lack of timeliness or lack of prior authorization. DMAP will not make payment on a service which would have been covered by another insurer if the client had informed the provider in a timely manner of the other insurance.
- A Third Party Resource makes payments directly to the client for medical services.

  NOTE: Indian Health Services or Tribal Health Clinics are not Third Party Resources and are the payor of last resort.

- The provider is not enrolled with the DMAP.
- The client entered into a payment arrangement before or at the time service was provided. The provider must document the payment terms and client acceptance of the terms under which treatment is being provided and payment responsibility before the service is provided.

NOTE: If clients report that they are receiving bills for a covered Medicaid service, branch staff should ask the client if they have told the provider that they have medical assistance coverage.

If the provider is aware of the client's medical assistance coverage through DMAP, but still bills the client, fax copies of the bills to DMAP Client Services Unit 503-945-6898 or mail the copies to:

DMAP, Attention CSU Billing
500 Summer St NE, E-49
Salem, OR 97301-1079

Health care complaint processes OHP Rules 410-141-0260 and 410-141-0261

There will be times when clients are not satisfied with a health care decision made by their providers or their managed health care plan.

All clients may seek assistance with health care concerns or complaints through DMAP's Client Advisory Services Unit. Clients may call the unit toll-free at 1-800-273-0557. Clients may also use the OHP 3001 Complaint Form to submit a complaint in writing to the Client Advisory Services Unit. This form is especially useful if the client wants to attach backup documentation such as a denial of service or bills from providers. A copy of the OHP 3001 form is contained in this section.

Clients in managed health care plans should be encouraged to use the complaint process outlined below:

- Talk to the Primary Care Provider. The client should ask the physician or other provider to attempt to resolve the problem.
- Contact the plan's customer service representative. The plan's telephone number is on the client's monthly DMAP Medical Care Identification. Clients may also use the OHP 3001 Complaint Form to register complaints with a managed care plan.

  Clients over 65 and those with disabilities can also seek help from their plan's Exceptional Needs Care Coordinator (ENCC), who can be reached at the same telephone number.
- Ask for a Review by the plan. If the decision is unsatisfactory, the client can request a review of the decision by the managed care plan's board of directors, quality assurance committee, or other responsible party. The plan must respond in writing within 30 days.

Hearings

General Rules OAR 410-120-1860
OHP (managed care rules, OAR 410-141-0262; 410-141-0264

Managed care plan clients

Clients enrolled in a managed care plan that have been denied a service may appeal the decision through their plan and/or request an administrative hearing through DMAP. Clients should follow the instructions on the Notice of Action (initial decision notice) to initiate the appeal process through their plan and/or request an administrative hearing through DMAP within 45 days from the date of the decision notice.

If the client chooses to file an appeal the managed care plan will complete the appeal process and send the client a Notice of Appeal Resolution stating the plan's decision. If the client is not satisfied with the outcome, they may then elect to follow the instructions on the Notice of Appeal Resolution to request an administrative hearing with DMAP within 45 days from the date of the decision notice.

Fee-for-service clients

OHP clients who are fee-for-service (also known as "open card"), may request an administrative hearing through DMAP at the time they receive the decision notice. Clients have 45 days from the date of the decision notice to request an administrative hearing.

Submitting the DHS 443 to DMAP Hearings Unit

Managed care plan clients

Please ensure that the client has fully completed the DHS 443. Ask the client for a copy of the Notice of Action or the Notice of Appeal Resolution (decision notices) from the managed care plan to include with the DHS 443. If they do not have a copy, please forward the DHS 443 to DMAP.

Fee-for-service clients

Please ensure that the client has fully completed the DHS 443. Ask the client for a copy of the decision notice to include with the DHS 443. If they do not have a copy, please forward the DHS 443 to DMAP.

Please forward the DHS 443 to DMAP immediately, as the hearing process timelines have been shortened.

Forward all DMAP hearing requests, with attachments, to:

Division of Medical Assistance Programs
Hearings Unit
500 Summer St. NE, E-49
Salem, OR 97301-1079