

PONCA TRIBE OF NEBRASKA *CONTRACT HEALTH SERVICES*



POLICIES AND PROCEDURES MANUAL

CONTRACT HEALTH SERVICES

PONCA TRIBE OF NEBRASKA
CONTRACT HEALTH SERVICES

MISSION STATEMENT

IHS offers a full range of health services and contract health services is one of them. Through CHS, we cover services that are not provided at an IHS facility. The CHS program is funded annually by the US Congress. It is NOT AN ENTITLEMENT PROGRAM nor is it an Insurance program. That is, CHS cannot guarantee that funds are always available.

CHS funds are intended to help pay for care where no other sources of health care payments are available, or to supplement other alternate resources after they have been exhausted. The use of alternate resources allows CHS to maximize funds so that we are able to provide a wider range of health care to as many tribal members as possible.

Payments for health care can only be authorized by a CHS ordering official. No one else can authorize payments. CHS payments are authorized through a process using federal guidelines and eligibility criteria.

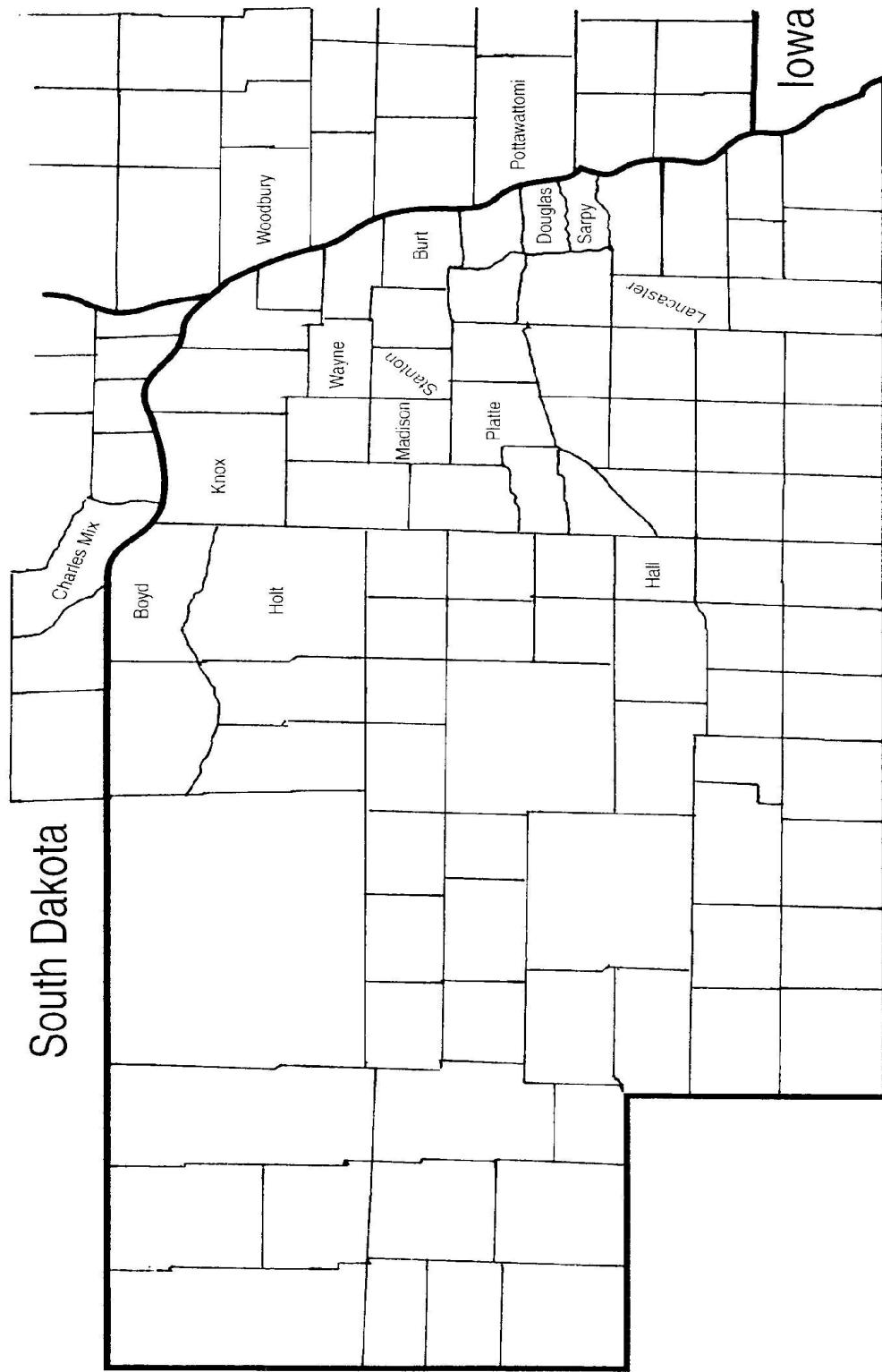
The Tribal Health Director is responsible for providing leadership, direction, and effectiveness in meeting the program goals and objectives. Additionally, the Director ensures that the program provides quality, cost-effective/efficient services that preserve the rights of the clients.

Contract Health Services are health services provided at the expense of the Indian Health Service through the Ponca Tribe of Nebraska from public or private medical or hospital facilities. These services are in addition to those services provided at an IHS facility. Contract Health Services is a supplement to other third-party reimbursement services.

Eligibility for services are limited to those individuals who are enrolled members of the Ponca Tribe of Nebraska; reside within one of the fifteen counties (Boyd, Burt, Douglas, Hall, Holt, Knox, Lancaster, Madison, Platte, Sarpy, Stanton, and Wayne Counties of Nebraska, Pottawatomie and Woodbury Counties of Iowa, and Charles Mix of South Dakota) which comprise the Ponca Tribe of Nebraska's Service Delivery Area (CHSDA).

In carrying out this mission, program staff will abide by all applicable policies/procedures and rules/regulations of all federal, tribal, state, or other regulatory authorities.

Ponca Service Delivery Areas



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1.1 **PURPOSE**

To define and establish policies, procedures, and guidance for the effective management of the Ponca Tribe of Nebraska's Indian Health Service (IHS) Contract Health Services (CHS) Program.

To delegate to the greatest degree possible, within the limits of available funds, authority for the operation of the CHS Program to the Tribal Health Director.

To clarify and explain CHS policies and procedures for Public Law (P.L.) 93-638, the Indian Self-Determination and Education Assistance Act, contractors, when applicable.

To further explain the Code of Federal Regulations (CFR), Title 42, Sections 36.21 through 36.25. However, neither this manual nor the IHS manual should not be cited as authority for making decisions on eligibility or payment denials, the CFR is the proper citation for correspondence to providers and American Indian and Alaska Native patients.

1.2 **ACRONYMS**

CFR – Code of Federal Regulations

CHEF – Catastrophic Health Emergency Fund

CHS – Contract Health Services

CHSDA – Contract Health Service Delivery Area

CHS/MIS – Contract Health Services/Management Information System, the CHS
Commitment Register

CDSR – Core Data Set Requirement

FMCRA – Federal Medical Care Recovery Act

FMFIA – Federal Managers' Financial Integrity Act

FI – Fiscal Intermediary

IHCIA – Indian Health Care Improvement Act

IHS – Indian Health Services

P.L. – Public Law

PRO – Peer Review Organization

SU – Service Unit

SUD – Service Unit Director

THD – Tribal Health Director

U.S.C. – United States Code

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1.3 **DEFINITIONS** (Also, See 42 CFR 36.31, 1986)

Alternate Resources – Health care resources other than those of the IHS. Such resources include health care providers and institutions, and health care programs for the payment of health services including but not limited to programs under Titles XVIII and XIX of the Social Security Act (i.e., Medicare & Medicaid), State and local health care programs and private insurance

Appropriate Ordering Official – The person, with documented procurement authority, who signs the purchase order authorizing CHS payment.

Area Director – The Director of an IHS Area designate for purposes of administration of IHS program.

Catastrophic Health Emergency Fund – The fund to cover the IHS portion of medical expenses for catastrophic illnesses and events falling within IHS responsibility.

Contract Health Service Delivery Area – The geographic areas within which CHS will be made available by the IHS.
(Reference Federal Register, Vol. 49. No. 6, 6, 1986)

Contract Health Services – Health services provided at the expense of the IHS from other public or private providers (e.g. dentists, physicians, hospitals).

Contract Health Services Eligible Person – A person of Indian descent belonging to the Indian community served by the local IHS facilities and program who resides within a Contract Health Service Delivery Area (CHSDA); or resides within a CHSDA and either is a member of the tribe or tribes located on that reservation; or maintains close economic and social ties with the tribe or tribes.

The definition of eligibility for CHS shall be consistent with Sec. 2-3.7 (E) infra. If there is a misunderstanding, Sec. 1.7 (E) (2) will prevail to resolve the issue.

Contract Health Services to Support Direct Care – These are provided within an IHS facility when the patient is under direct supervision of an IHS physician or a contract physician practicing under the auspices (or authority) of the IHS facility. Examples of direct care services that cannot be reimbursed with CHS funds are on-call hours, after hours or weekend pay, and holiday coverage (e.g., for x-ray, laboratory, pharmacy).

Disabled Indian – an Indian who has a physical or mental condition that reasonably prevents him/her from notifying the CHS within 72 hours of his/her receipt of emergency medical care or services from a non-service provider or facility as required by 42 CFR 36.24 (c) [1986].

Elderly Indian – an Indian who is 65 years of age or older.

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Emergency – Any medical condition for which immediate medical attention is necessary to prevent the death or serious impairment of the health of an individual.

Fiscal Intermediary – The fiscal agent contracted by IHS to provide and implement a system to process CHS medical and dental claims for payment, if contracted with the Ponca Tribe.

Indian Tribe – Any Indian tribe, band, nation, group, pueblo, or community, including any Alaska Native village or Native group, which is federally recognized as eligible for the special programs and services provided by the U.S. to Indians, because of their status as Indians.

Reservation – Any federally recognized Indian tribe’s reservation, pueblo, or colony, including former reservations in Oklahoma, Alaska Native regions established pursuant to the Alaska Native Claims Settlement Act (43 U.S.C. 1601 et seq.), and Indian allotments.

Residence – In general usage, a person “resides” where he or she lives and makes his or her home as evidenced by acceptable proof of residency. In practice, these concepts can be very involved. Determinations will be made by the CHS department based on the best information available, with the appeals procedure process as a protector of the individual’s rights.

Secretary – The Secretary of Health and Human Services and any other officer or employee of the Department to whom the authority involved has been delegated.

Service – The Indian Health Service.

Service Delivery Area – The counties that make up the Ponca Tribe of Nebraska’s service area.

Tribal Health Director – The Director of a tribally operated program, or his/her designee, authorized to make decisions on payment of CHS funds pursuant to a P.L. 93-638 contract.

Tribal Member – A person who is an enrolled descendent of a tribe, or is granted tribal membership by some other criteria in the tribal constitution.

Tribally Operated Program – A program operated by a tribe or tribal organization that has contracted under P.L. 93-638 to provide a CHS program.

1.4 **USES OF CHS**

The CHS funds are used to supplement and complement other health care resources available to eligible Indian people. The funds are utilized in situations where: (1) no IHS direct care facility exists, (2) the direct care element is incapable of providing required emergency and/or specialty care, (3) the direct care element has an overflow of medical care workload, and (4) supplementation of alternate resources (i.e. Medicare, private insurance) is required to provide comprehensive care to eligible Indian people.

1.5 **RESPONSIBILITIES FOR ADMINISTRATION OF CHS**

A. Service Unit/Tribally Operated Programs –

The Tribal Health Director or his/her designee shall be responsible for ensuring the following requirements are met:

- (1) Determine whether an individual requesting services is eligible within established guidelines.
- (2) Provide CHS by following the medical priority guidelines that are consistent with the Aberdeen Area and IHS Headquarters medical priorities.
- (3) Process all requests for CHS including the issuance of purchase orders, determination of alternate resource availability, and maintenance of all financial records.
- (4) Ensure program/budget control and effective utilization of CHS at the tribal level.
- (5) Work closely with appropriate tribal staff in identifying the need for CHS and in negotiating contracts with hospitals, clinical services, dentists, and other health care providers.
- (6) Conduct managed care activities through an established CHS managed care committee that reviews and monitors CHS referrals and emergency cases.
- (7) Monitor and prepare CHEF cases according to high cost case management guidelines.
- (8) Ensure that procedures and policies comply with the Federal Managers Financial Integrity Act of 1982 (FMFIA).

1.6 **ESTABLISHMENT OF CHSDA**

A. CHSDA –

- (1) The approved CHSDAs are specified in 42 CFR 36.22, and may be changed only in accordance with the Administrative Procedures Act (5 U.S.C. 553).
- (2) Established CHSDAs are identified below:

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- a. The Congress statutorily creates or redesignates CHSDAs through legislative enactment such as appropriations, restoration and/or recognition acts, public laws, etc. This information is distributed through public issuances as necessary.
- b. The Ponca Tribe of Nebraska's CHSDA is comprised of the following counties: Boyd, Burt, Douglas, Hall, Holt, Knox, Lancaster, Madison, Platte, Sarpy, Stanton, and Wayne of Nebraska, Pottawatomie and Woodbury of Iowa, and Charles Mix of South Dakota.

(3) Re-designation of CHSDAs –

- a. See IHS Manual for more information

B. Submission of a Proposed CHSDA Change –

- (1) See IHS Manual for more information

1.7 **PERSON TO WHOM CHS WILL BE PROVIDED**

- A. There is no authority to provide payment for services under the CHS program unless funds are, in fact, available.
- B. The CHS funds are limited to services that are medically indicated. See Exhibits 2-A, 2-B, 2-C, and 2-D for services that may be included and those specifically excluded.
- C. The CHS funds may not be expended for services that are reasonable accessible and available at Indian Health Service facilities.
 - (1) The determination as to an IHS/tribal facility being “reasonable accessible and available” is a service unit/tribal health director decision based on the following criteria:
 - a. Determination of the actual medical condition of the patient, i.e., emergent, urgent, or routine.
 - b. The ability of the IHS/tribal facility to provide the necessary service.
 - c. The level of funding available to provide CHS.
 - d. Distance from the IHS/tribal facility.

- (2) The following guidelines will be used in applying the above criteria:

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- a. The CHS funds may be authorized for an emergency to the extent that the contract facility was the nearest available provider capable of providing the necessary services and the patient's condition dictated that he/she be transported to the nearest hospital. There must be compelling reason to believe, upon review of the medical record and assessment of the patient's situation that without immediate medical treatment an individual's life or limb would be endangered.

Tribal Health Directors may consult with available IHS Chief Medical Officers, medical staff, or contract providers in order to arrive at the administrative decision.

- (i) Medical and dental priorities (Exhibits 2-A, 2-B, 2-C, AND 2-D) include a list of diagnostic categories that have been administratively determined to be emergencies. This list is not all inclusive and other conditions may be included as an emergency when so determined by qualified IHS professionals.
 - (ii) Final decision as to classification of medical services as "emergency" will be based on review by an IHS/tribal physician or by documented medical history.
- b. Services for an acute condition (urgent but not emergent) may be provided through CHS funds when the nature of the medical need of the patient, as determined by an IHS professional, can best be met by using a contract facility and sufficient CHS funds are available for this level of service.
- c. Routine health services (neither emergent nor urgent) should ordinarily be provided by IHS staff and facilities. Routine health services may be through CHS when the THD has determined that sufficient CHS funds are available for this priority of medical service. As a general rule, routine health services will not be provided through CHS when and IHS facility capable of providing these services is within 90 minutes one-way surface transportation time from the person's place of residence until the level of IHS funding permits a less restrictive guideline.
- (3) Each SU must develop a SU policy, with tribal participation, on the availability and accessibility of IHS facilities. The policy will be posted and published to maximize knowledge among the American Indian and Alaska Native populations served.

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D. The CHS funds may be expended for services to individuals treated in an IHS/tribal facility to the extent that the individual is eligible for direct care services. However, hospitals and clinic funds shall be used to support direct care whenever possible. The payment of costs for “contract to support direct care” services (e.g., prenatal, podiatry, or orthopedic clinics) provided within the facility are permitted when patients are under the direct supervision of an IHS/tribal physician or a contract physician practicing under the auspice (authority) of the IHS/tribal facility. Services in a non-IHS direct or tribal facility are not included unless the patient meets CHS eligibility criteria of 42 CFR 36.23, “Persons to whom contract health services will be provided.”

E. Eligibility –

To be eligible for CHS, an individual must:

- (1) Reside within the U.S. and on/in one of the fifteen service area counties of the Ponca Tribe of Nebraska’s CHSDA. The Ponca’s CHSDA is comprised of the following counties: Boyd, Burt, Douglas, Hall, Holt, Knox, Lancaster, Madison, Platte, Sarpy, Stanton, and Wayne of Nebraska, Pottawatomie and Woodbury of Iowa, and Charles Mix of South Dakota.
- (2) Must be an enrolled member of the Ponca Tribe of Nebraska, and must provide proof of enrollment.
- (3) An Indian claiming eligibility for CHS has the responsibility to furnish the SUD for the tribal program with documentation to substantiate the claim.
- (4) Be a student or transient.
 - a. Boarding School Students—CHS is provided during their full-time attendance, by the Ponca Tribe of Nebraska. While the student is in attendance at all Bureau of Indian Affairs (BIA) boarding schools, including BIA off reservation schools. (See IHS Manual for a list of BIA off reservation schools.) Boarding school students can receive CHS whether or not they resided in a CHSDA before attending the school.

While the student is on scheduled break or vacation, the student’s CHS permanent area of residence is responsible for payment of CHS services.

- b. The CHS will be made available to students and transients who would be eligible for CHS at the place of their permanent residence within a CHSDA, but who are temporarily absent from the residence, as follows:

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- (i) College (undergraduate and graduate) vocational, technical, or other academic education. The SU where the student was eligible for CHS prior to leaving for school is responsible for the student. While the student is on a scheduled break or vacation, the student's CHS permanent area of residence is responsible for payment of CHS services. See Section 1.7I.
 - (ii) Transient (persons who are in travel or are temporarily employed, such as seasonal or migratory workers), during their absence from their place of residence.
 - (iii) Other persons outside the CHSDA. Persons, who leave the CHSDA in which they are eligible for CHS, and are neither students nor transients, will be eligible for CHS for a period not to exceed 180 days from his/her last CHS authorized date of service.
- (5) Other Eligibility Consideration
- a. Indians adopted by non-Indian parents must meet all CHS requirements to be eligible for care (e.g., reside in a CHSDA).
 - b. Foster/Custodial Children – Indian children who are placed in foster care outside a CHSDA by order of a court of competent jurisdiction and who are eligible for CHS at the time of the court order shall continue to be eligible for CHS while in foster care.
 - c. Section 813 of the Indian Health Care Improvement Act, P.L. 94-437, as amended, states in part: “(a) (1) Any individual who—(A) has not attained 19 years of age, (B) is the natural or adopted child, step-child, foster-child, legal ward, or orphan of an eligible Indian, and (C) is not otherwise eligible for the health services provided by the Service, shall be provided by the Service on the same basis and subject to the same rules that apply to eligible Indians until such individual attains 19 years of age. (2) Any spouse of an eligible Indian who is not an Indian, or who is of Indian descent but not otherwise eligible for the health services provided by the Service, shall be eligible for such health services if all of such spouses are made eligible as a class, by an appropriate resolution of the governing body of the Ponca tribe of the eligible Indian.
 - d. A non-Indian woman pregnant with an eligible Indian's child who resides within a CHSDA is eligible for CHS during pregnancy through

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post partum (usually 6 weeks). If unmarried, such a woman is eligible for CHS if an eligible Indian male state in writing, through a notarized paternity affidavit, that he is the father of the unborn child or such is determined by order of a court of competent jurisdiction. This will ensure health services to the unborn Indian child.

- e. A non-Indian member of an eligible Indian's household who resides within the Ponca CHSDA is eligible for CHS if the medical officer in charge determines that services are necessary to control a public health hazard or an acute infectious disease, which constitutes a public health hazard.

F. Requested Documentation

- (1) In order to initially open a medical chart with CHS, the following documentation is needed:
 - a. Completed CHS Client Intake Packet
 - b. Social security card
 - c. Proof (enrollment paper) of being a member or descendent of a member (parent(s) or grandparent(s) enrollment papers, birth certificates, etc.) to show lineage.
 - d. Proof of residency (Must provide one of the following.)
 - (i) Rent Agreement, Utility bill, Copy of Medicaid determination letter, statement from employer showing proof of employment and dates employed with address verification, or a check stub indicating the address or
 - (ii) P.O. Box Receipt: A street address must be listed on receipt or
 - (iii) Notarized Letter: If living with a family member, relative, or friend, they must submit a notarized letter stating you do reside with them permanently and the date you started living at that residence.
- (2) The following documentation will be requested when applicable (may include, but not limited to):
 - a. Alternate resource information

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- (i) Private insurance card
 - (ii) Medicaid determination letter
 - (iii) Medicare card
 - Part A
 - Part B
 - Part D
 - Supplemental, if any
- b. For proof of pregnancy:
- (i) If married to a non-Ponca tribal woman, a Marriage certificate to eligible tribal member.
 - (ii) If not married to a non-Ponca tribal woman, a notarized paternity affidavit.
- c. For proof of name change:
- (i) Marriage certificate or
 - (ii) Social security card listing new legal name or
 - (iii) Divorce paper or other legal documents
- (3) CHS client charts will be updated on an annual basis. The annual update due date will be one calendar year from the date the client signed his/her previous packet. An annual update will consist of a completed client intake packet and any necessary information that will show the change for the client (i.e. proof of residency, proof of insurance). Clients will be given up to three notices to update his/her file with the requested information. On the third and final notice issued, services will not be authorized until the client submits the requested information.
- a. Any client files that are over two years outdated will not be eligible for services until the file is updated.

G. Priorities of CHS –

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- (1) Regulations permit the establishment of priorities based on relative medical need when funds are insufficient to provide the volume of CHS indicated as needed by the population residing in a CHSDA. See Manual Exhibit 2-A for priority list. Tribal programs are required to follow IHS regulations and can utilize Section 1.17 priorities as guidelines.
 - a. Area-wide priorities should be established to ensure an equivalent level of services in all SUs, taking into consideration the availability and accessibility of IHS/tribal facilities, the population being served, the relative cost of services, and the availability of alternate resources.
 - b. Priorities established to limit services, whether on an Area-wide or SU basis, shall be made known to the Indian population being served through publication in local community and/or tribal newsletters and posting of notices on bulletin boards in patient areas of IHS/tribal facilities.

H. Payor of Last Resort – 42 CFR 36.61

- (1) The IHS is payor of last resort of persons defined as eligible for CHS under these regulations, notwithstanding any State or local law or regulation to the contrary.
- (2) Accordingly, the Ponca Tribe of Nebraska will not be responsible for or authorize payment for CHS to the extent that:
 - a. the Indian is eligible for alternate resources, or
 - b. the Indian would be eligible for alternate resources if he/she were to apply for them, or
 - c. The Indian would be eligible for alternate resources under state or local law or regulation but for the Indian's eligibility for CHS or other health services, from the IHS or IHS programs.
- (3) The payor of last resort rule does not represent a change in the CHS program requirements. The CHS office must first determine whether the patient applying is eligible pursuant to 42 CFR 36.12 and 36.23 (1986). In addition, the CHS office must determine that the medical services requested for payment from CHS funds are within medical priorities. The CHS program is not an entitlement program and thus, when funds are insufficient to provide the volume of CHS needed, priorities for service shall be determined on the basis of relative medical need (42 CFR 36.23(e) (1986)).
- (4) Upon application by a Ponca patient for CHS, the CHS offices must:

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- a. Determine upon reasonable inquiry, whether the patient is potentially eligible for alternate resources.

GUIDELINE: Initially, the Ponca Tribe should make a determination based upon reasonable inquiry whether the Ponca patient applying for CHS is potentially eligible for alternate resources. Reasonable inquiry consists of ascertaining the patient's household size, income, and applying alternate resource program standards to the patient's information. Only Ponca patients who, upon reasonable inquiry, are potentially eligible for alternate resources are required to apply for such resources. The Ponca patients should not automatically be denied CHS benefits simply because of the possibility they might be eligible for an alternate resource.

- b. Advise the patient of the need to apply for alternate resources.

GUIDELINE: The Ponca Tribe should provide the patient with a written notice that explains the patient's need to make a "good faith" application to the alternate resource program. The notice should include information such as the need to schedule and attend scheduled appointments, the necessary documentation to bring to the appointments, and availability of transportation to appointments. (See Appendix 1-A.)

- c. Assist the patient in applying, especially where it is evident that the patient is unable to apply or is having difficulty with the application process.

GUIDELINE: The Ponca Tribe should include in its written notice that if a patient is unable to apply or is having difficulty applying for alternate resources, the CHS office or the tribe's social services department will assist with the application process.

The Ponca Tribe should include with the written notice an authorization to release and an assignment of rights form for the patient to sign and return to CHS. These forms authorize the Ponca Tribe to obtain information from the alternate resources program files and allows the Ponca Tribe to intervene on the patient's behalf to ensure completion of the application (Appendix 1-B).

The CHS office or tribe's social services department may assist the patient in completing an alternate resource application prior to an illness or injury. This policy should be encouraged; however, the Ponca Tribe should not deny CHS funds for an individual's failure to apply prior to medical need.

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The Ponca Tribe's CHS office will document attempts to assist patients in applying for or completing an alternate resource application. Documentation of assistance for application to the alternate resource program is necessary to support a decision whether to authorize payment of CHS funds.

(5) Completed Application To Alternate Resource Program.

If a completed application to the alternate resource program results in denial of payment of the Indian's medical bill and the Indian is otherwise CHS eligible, the Ponca Tribe should pay the Indian's medical bill if the alternate resource program denied payment for a valid reason such as: over income eligibility standards or non-resident of the county; i.e., the Indian is determined non-eligible for the same reasons that a non-Indian would be determined non-eligible.

Pursuant to the new rule as codified at 42 CFR 36.61, the IHS will no longer pay the Indian patient's medical bills under protest in regards to a McNabb-type denial from an alternate resource. It is essential that the Indian patient make application to the alternate resource program even if the program denies payment of medical bills because IHS is considered an alternate resource. The IHS clarified its alternate resource rule to specifically designate the IHS payor of last resort, notwithstanding a State or local rule to the contrary. Thus, the IHS will deny payment of the medical bill pursuant to its payor of last resort rule, and inform the medical provider that payment must be sought from the alternate resource program.

(6) Failure To Follow Alternate Resource Procedures

There are two instances when IHS will not pay the provider for medical bills incurred by an otherwise CHS eligible Indian patient.

First instance is when the patient willfully or intentionally fails to apply or fails to complete an alternate resource application. The Ponca Tribe does require its beneficiaries, in "good faith," to apply for and a complete an alternate resource application.

This policy is supported by the 9th Circuit decision in McNabb, supra. The court interpreted the IHS policy of requiring a patient to first make application to the alternate resource program as "serving a legitimate government goal of efficient distribution of limited resources." The court recognized the fact that contract care funds are limited and thus application to an alternate resource program results in more Federal funds being available to meet the needs of other Indians.

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The Ponca Tribe will provide a written notice to patients that if an alternate resource application is not completed, or if the patient does not contact the CHS office for assistance in completing the application within 30 days of the date of the notice, then a CHS denial letter will be issued. If an alternate resource program issues a denial because the applicant failed to apply or failed to complete the application and the CHS file is well documented with attempts to assist the (1.7G continued) applicant, the CHS office will issue a CHS denial to the patient and a copy should be forwarded to the provider.

Second, the Ponca Tribe will not pay the provider when the provider fails to follow alternate resource procedures, such as not notifying the program within its time constraints. The Ponca Tribe trust responsibilities include requiring the providers to maximize the availability of alternate resources. Thus, if the provider is not able to receive payment from an alternate resource program because of the provider's failure to follow proper procedures, the Ponca Tribe will not be responsible for the medical bill, even if the Indian patient is otherwise CHS eligible.

The Ponca Tribe should inform non-IHS providers (i.e., non-IHS facilities and practitioners providing medical services to IHS beneficiaries) of the CHS eligibility criteria and requirements. Such information can be provided through terms in a contract with the provider, by separate notice upon referral of a patient to the provider, or by general notification to a provider when there are continuous referrals of patients to that same provider. The Ponca Tribe should inform providers that: (1) an IHS and a non-IHS referral does not constitute a representation of eligibility under the CHS program; (2) the Ponca Tribe expects the provider to apply for alternate resources as it would for its non-Indian patients; (3) the provider must investigate with each patient, his or her eligibility for alternate resources and should assist the patient in completing necessary application forms; (4) if an alternate resource is available, its use is required and the Ponca Tribe shall be promptly notified of any payment received; and (5) the Ponca Tribe will reject claims where the provider fails to investigate other party liability.

- a. The use of alternate resources is mandated by IHS' Payor of Last Resort Rule, 42 C.F.R. 36.61 (1990).
 - (i) An individual is required to apply for an alternate resource if there is reasonable indication that the individual may be eligible for the alternate resource.
 - (ii) Refusal to apply for alternate resources when there is a reasonable possibility that one exists, or refusal to use an

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alternate resource, requires the denial of eligibility for CHS.

- (iii) An individual is not required to expend personal resources for health services to meet alternate resources eligibility or to sell valuables or property to become eligible for alternate resources.

Examples of alternate resources are those resources, including IHS/tribal facilities that are available and accessible to an individual. Alternate resources would include, but not be limited to, Medicare, Medicaid, vocational rehabilitation, Veterans Administration, Crippled Children's programs, private insurance, and State programs.

(7) Other Alternate Resources Information

- a. Students whose grant includes funds for health services shall be required to use the grant funds to purchase available student health insurance.
- b. When an alternate resource is identified that will require the IHS/tribal program to pay a portion of the medical care costs, the appropriate IHS forms (IHS-43, 57, or 64) will be processed immediately to obligate the funds for the estimated balance, after alternate resource payment, with corresponding distribution of the form. In these situations, the IHS forms (IHS-43, 57, or 64) must clearly indicate that payment will not be processed unless and until the provider has billed and received payment from the alternate resource. It is proper and necessary to require either an explanation of benefits (EOB), or in cases of denial from the alternate resource, a copy of the denial notice for the record.

I. Higher Education Student Policy

- (1) To define procedure and criteria for higher education students are reviewed, reported and identified for continued CHS coverage while in full-time status. Student must be a permanent resident within the (fifteen) 15 counties service areas boundaries immediately prior to becoming a full-time student. Below is a list of required information for the CHS program to use to make a determination on continued CHS coverage for the student (and family if they accompany/reside with the student).

Student/patient must provide the following information:

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- a. Full name(s) and dates of birth of student & family members who are living with the student (while at school).
- b. Present address and new mailing address (while at school).
- c. Date of move to new address.
- d. Letter from college stating full-time (12+ semester hours) or part time (6-11 semester hours) status.
 - (i) Each semester: letter from college on full-time or part-time status
- e. If vocational school- letter from school on full time status
 - (i) Each semester: letter from school on full-time status
- f. List of medical coverage resources with copy of card.

An information sheet is attached as a handout to each student.

(2) Information will be provided to the student on:

- a. Non-emergency notification requirements and who to contact
- b. Emergency notification requirements and who to contact
- c. Care at IHS that should be completed prior to or during vacations

(3) CHS coverage will not continue for students who do not provide the required information or do not abide by section 1 of this policy.

(4) The Ponca Tribe is required to maintain a student health file using a log and form letters. (See CHS Higher Education Student Policy Exhibit 2-M.)

1.8 **AUTHORIZATION FOR CHS**

A. Notification requirement, as described in the Federal Register of August 4, 1978, and contained specifically in 42 CFR 36.24, will be followed, including but not limited to:

- (1) No payment will be made for medical care and services obtained from non-service providers or in non-service facilities unless the requirements listed below have been met and a purchase order for the care and services has been issued by the appropriate CHS ordering official to the medical care provider.

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- (2) In non-emergency cases. An eligible Indian, and eligible non-Indian, (or) an individual or agency acting on behalf of this person, or the medical care provider shall, at least 48 hours prior to the provision of medical care and services, notify the appropriate CHS ordering official of the need for services and supply information that the ordering official deems necessary to determine the relative medical need for the services and the individual's eligibility. The requirement for notice prior to providing medical care and services under this paragraph may be waived by the ordering official if the ordering official determines that giving of notice prior to obtaining the medical care and services was impracticable or that other good cause exists for the failure to provide prior notice.
- a. In regards to specialty service follow-up appointments, specialized testing and any other non-emergency visits, where there will be a charge, the client must have the doctor requesting follow-ups/testing submit justification for the service at least 48 hours prior to the provision of medical care and service. Acceptable justification includes, but is not limited to: referral, medical records, physician orders, and dictated notes.
- (3) In emergency cases, an eligible Indian, and eligible non-Indian, an individual or agency acting on behalf of this person, or the medical care provider shall, within 72 hours after the beginning of treatment for the condition or after admission to a health care facility, notify the appropriate CHS ordering official of the admission or treatment and provide information to determine the relative medical need for the services. The 72 hour period may be extended if the ordering official determines that notification within the prescribed period was impracticable or that other good cause exists for the failure to comply.
- (4) Section 406 of P.L. 94-437, as amended, allows the elderly and disabled 30 days to notify CHS of emergency medical care received from non-IHS medical providers or at non-IHS medical facilities. The following definitions for elderly Indian and disabled Indian are to be used until further defined and published in the Federal Register.

An elderly Indian means an Indian who is 65 years of age or older.

A disabled Indian is an Indian who has a physical or mental condition that reasonably prevents him/her from providing or cooperating in obtaining the information necessary to notify the CHS of his/her receipt of emergency care or services from a non-service provider or facility within 72 hours after the non-service provider began to deliver the care.

Notification requirements apply to all categories of eligible person(s) including students, transients, and person(s) who leave the CHSDA.

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B. Authorization for CHS to students, transients, and persons who leave the CHSDA will be the responsibility of the SU from which the person left except:

- (1) When the individual is eligible for CHS in his/her current place of residence.
- (2) If a CHS eligible patient presents to a CHS Area/SU other than the permanent Area/SU for direct care and requires CHS, the Area/SU will contact the patients' Area of record for instruction for disposition of the patient. Payment for CHS is the responsibility of the patient's permanent Area of record, to the extent of regulation, when notification is provided prior to the authorization and/or provision of CHS services by another IHS Area. If the patient's Area of record is not notified prior to the referral or within 72 hours for emergencies, the referring SU is responsible for payment. These guidelines do not preclude formal arrangement for fund transfers within or among Areas to provide CHS for patients from other service units.

For the purpose of this section of the manual a patient's permanent area of record is defined as the area where the patient currently resides unless an exception applies such as the patient has moved to attend a University full time. (See examples of clarification of the concept, Manual Exhibit 2-J)

C. Payment shall be in accordance with the provisions of the contract or purchase order and other provisions put forward in the IHS payment policy.

D. Persons Under Treatment at the Expiration of 180-Day Eligibility Period.

Individuals under treatment for a condition that may be deferred to a later date will cease to be eligible at the expiration of the 180-day period after leaving their CHSDA. Individuals under treatment for an acute condition shall remain eligible as long as the acute medical condition exists.

E. Responsibility to Notify Indian Community of Requirements for Authorization.

- (1) Indian people affected by the CHS program must be kept aware of policies on administrative requirements for approval of CHS payment for services, and the title(s) of the person(s) who will be notified when CHS is required. This notification will include at least publication in local community and/or tribal newsletters and posting of notices on bulletin boards in patient areas of the IHS facilities. Changes in local policies or administrative requirements will be published and posted as outlined above including notification to vendors commonly used by Indian people who may or may not have contracts with IHS.
- (2) The Indian person being referred from an IHS/tribal facility will be notified at referral time of his/her eligibility status for CHS. In cases where determination of eligibility cannot be made before referral, the individual will be notified in writing

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that the IHS/tribe may not be responsible for bills incurred. See Manual Exhibit 2-E.

F. CHS Authorization Numbering System.

A uniform numbering system has been developed to use when issuing IHS-43/64 purchase documents. The use of this system will preclude two or more facilities from using the same document number and will assist in identifying the Area and facility.

- (1) The number has four components and consists of 10 digits
- (2) The four components are: 00 0 00 00000.
- (3) The first digit of the first component is always 0, followed by the last digit of the fiscal year being charged for the services. Example: Fiscal Year 1998 is 08.
- (4) The second component is an alpha code to identify the Area. The alpha code for the Aberdeen area is "C". See the IHS Manual for other area alpha codes.
- (5) The third component consists of the two digit fiscal code that identifies the facility being charged for the services. The digits are the standard location code as used in the Fiscal Accounting System.
- (6) The fourth component has five digits and is the sequential number for the documents to be charged to each fiscal year with 00001 and continue sequentially for the year. Supplemental authorizations, if necessary, will be numbered with the original numbers plus a suffix of S-1, S-2, etc.
- (7) The CHS Authorization Process, Flow Chart – The flow of a CHS purchase order form initial request through processing and closeout is diagramed in Manual Exhibit 2-I. Many aspects of CHS and other activities are incorporated in this general flow. The flow chart provides a general description of the process.

1.9 **PAYMENT DENIALS**

A. If a person is denied CHS, or when a medical provider may reasonably think Ponca Tribe CHS is a party to payment, both the patient and the provider shall be notified in writing of the denial (see Exhibit 2-N) with a statement containing all the reasons for denial and that within 30 days the applicant:

- (1) If you disagree with the decision to deny, you may obtain a reconsideration of the denial by submitting a written appeal to the Tribal Health Director. The Tribal Health Director will review and respond (in writing) to the appeal within 30 days (see Exhibit 2-O).

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- (2) In accordance with Section D, the Indian may appeal the original denial by the Tribal Health Director to the Aberdeen Area Director, if the Tribal Health Director upholds the original denial.

Appeals may be submitted by providers, who will be considered as acting on behalf of the patient. A response will be sent to the provider with a courtesy copy to the patient.

- B. When, on appeal, the Aberdeen Area Director upholds the denial, the applicant must be notified in writing of the denial and that an appeal may be submitted in writing to the Director of IHS, within 30 days.
- C. If the claimant fails to follow procedures, the request for reconsideration of an appeal may be denied. A written Notice of Denial will be sent to the claimant.
- D. The IHS appeals process applies to the IHS administered CHS programs and to Title I and III programs that have negotiated and incorporated into their funding agreements that the IHS appeals procedures will be utilized.

- (1) The CHS regulations currently in effect at 42 CFR 36.25 (1986) only allow three levels of appeal: (1st) request for reconsideration of the appeal by the Tribal Health Director or other individual or group designated by the tribe, (2nd) appeal to the Aberdeen Area Director, and (3rd) final administrative appeal to the Director of IHS.

Tribal contractors that have decided to utilize the IHS appeals process are required to operate their program in accordance with IHS regulations. Tribes may not reduce the level of appeals. A tribe cannot require a claimant to submit an additional appeal not provided in the regulations. However, a tribe may have a request for reconsideration submitted to the CHS office (e.g., Tribal Health Director) that issued the denial or to a committee of the tribe. The committee of the tribe would fulfill the role of Tribal Health Director and thus, the process would be consistent with the scheme provided in the CHS regulations.

- (2) Title I and III programs that have negotiated and incorporated into their funding agreement that the IHS appeals procedure will be utilized agree to the following terms and conditions:
- i. The Aberdeen Area Director and the Director of IHS utilizes the IHS', not tribal criteria and interpretations, to adjudicate claims. The IHS utilizes its medical priorities and policies to adjudicate IHS CHS claims.
 - ii. The Title I and III program shall provide necessary documentation required for claims adjudication. Depending on the nature of the claim,

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documentation such as medical records, date of notification, papers pertaining to residency, etc., could be required.

- iii. The IHS reviews the appeals from Title I and III programs without assuming any fiscal responsibility. When the Aberdeen Area Director, or the Director of IHS, issues a determination overturning the tribal denial of payment authorization, it is the responsibility of the tribe, not the IHS, to pay the bill.
- iv. The tribe must have left sufficient funds with the IHS before either the Aberdeen Area Director or the Director of IHS, may adjudicate a claim. It is not sufficient to have it negotiated and incorporated into a tribe's funding agreement that the IHS appeals procedure will be utilized without withholding sufficient funds to pay for the costs to operate the appeals process for the tribe.

1.10 **APPEALS RECORDS**

- A. The Tribal Health Director or his/her designee is administratively responsible for creating and maintaining a file on each denial of CHS.
- B. The appeal file shall contain: all denial letters, all briefing memorandums prepared in connection with any recommendation to the Tribal Health Director or Aberdeen Area Director regarding such denial; all correspondences to the Ponca Tribe CHS from the claimant or the claimant's representative; any other relevant correspondence, maps, bills, or receipts; records of telephone calls to or from claimant or claimant's representative to any inquiry (i.e., congressional, State official, etc.) made on behalf of the claimant; and any pertinent correspondences relative to any prior appeal by the same claimant.
- C. Each appeal file will be maintained for a period of 6 years and 3 months after the appeal process has been exhausted. This time period allows sufficient time should the patient utilize the civil court process.
- D. The decision of the IHS Director shall constitute final administrative action.
- E. The IHS/Executive Secretariat will fax incoming controlled correspondence to the Aberdeen Area office. Each CHS office will analyze the correspondence and submit all necessary documentation to Headquarters so that the CHS Branch, Headquarters, will be able to prepare a response. If there were no appeals to the Aberdeen Area office or THD, the CHS Branch is to be so notified. Copies of all determinations issued within the Aberdeen Area are to be submitted to the CHS Branch. If an appeal(s) was submitted to either the THD or Aberdeen Area Director and the THD or Aberdeen Area Director has not issued a determination, a status report is to be submitted to support the actions that have been taken.

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1.11 CONTROL OF FUNDS

- A. The CHS Commitment Registers will be maintained at each authorizing location. The CHS Commitment Register must contain the following minimum information
- (1) Authorization Number
 - (2) Provider Name
 - (3) Patient PIN
 - (4) Date of Service
 - (5) Allowance Amount
- B. Exhibit 2-G provides the recommended format for a Commitment Register that meets the above minimum requirements.
- C. The Commitment Register is to be submitted to the Area Financial Management Office at least once a month. A summary of the CHS fund balance shall be provided to the Tribal Health Director and the CHS Committee at least once a month.
- D. An entry will be made on the Commitment Register for each obligation of funds, or modifications of obligation of funds. The entries will be made daily to reflect the services authorized that working day. Entries should not be delayed beyond 3 working days from the date of referral or notification of services provided.

1.12 FOLLOWUP OF OUTSTANDING AUTHORIZATIONS

Ponca Tribe has established follow-up system for all authorizations that have not been completed and returned within 90 days of issuance. Exhibit 2-F is the form used for these follow-ups.

1.13 RECONCILIATION OF COMMITMENT REGISTER

The Commitment Register will be reconciled each month of the fiscal year.

1.14 DATA REPORTING

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The appropriate workload and fiscal codes will be entered into the data system, as specified in the Federal Register, Vol. 55, No. 152, Core Data Set Requirements (CDSR).

1.15 CATASTROPHIC HEALTH EMERGENCY FUND

A. Background

The fiscal year (FY) 1987 Appropriation Act for the IHS, P.L. 99-591, established the CHEF solely for the purpose of meeting the extraordinary medical costs associated with the treatment of victims of disasters or catastrophic illnesses who are within the responsibility of IHS.

The FY 1987 Act appropriated \$10 million. The Act directed that the CHEF shall not be allocated, apportioned, or delegated on a SU, Area Office, or any other basis. In FY 1990, as authorized by P.L. 100-713, the amendments to P.L. 94-437 (November 23, 1988), the Congress increased the CHEF appropriation to \$12 million. Effective FY 1993, the Federal Medical Care Recovery Act (FMCRA) funds were returned directly to the SUs, pursuant to Section 207 of the Amendments to the Indian Health Care Improvement Act and are no longer added to the CHEF as they were in the past.

The term “Catastrophic Illness” refers to conditions that are costly by virtue of the intensity and/or duration of their treatment. Cancer, burns, high-risk births, cardiac disease, end-stage renal disease, strokes, trauma-related cases such as automobile accidents and gunshot wounds, and some mental disorders are examples of conditions that frequently require multiple or prolonged hospital stays and extensive treatment after discharge.

Public Law 100-713 authorized the CHEF as a new program and required the IHS to publish regulations governing the program. Further amendments to P.L. 94-437 (P.L. 102-573, October 29, 1992) changed the calculation and level of the CHEF threshold. While regulations are being developed, Headquarters CHEF Guidelines serve as interim policy governing the CHEF program.

B. General Policy

The resources of CHEF will be expended according to the basic requirements of the CHS program, and will be made available to partially reimburse IHS direct and tribally contracted programs for expenditures on patients who incur extraordinary medical costs.

Obligations against the CHEF in excess of \$50,000 will be made only in cases where local management documents that it would be medically and fiscally inappropriate to transfer the patient to an IHS, tribal or less costly contract provider.

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Requirements for alternate resources shall be met before reimbursement can be expected from the CHEF. The CHEF reimbursements shall be applied only to cases that have been reviewed and approved by the CHEF Manager; any amounts not used because of payments by alternate resources or cancellations shall be returned to the Headquarters CHEF account. For specific details on the CHEF, reference the most recent CHEF guidelines.

C. Cost Threshold

- (1) The CHEF threshold is adjusted according to CHEF experience, within the range established by law. Language in P.L. 102-573 requires that the Secretary shall establish the threshold cost at no less than \$15,000 or not more than \$25,000 for 1993. The threshold for subsequent years is based on the percentage increase of the consumer price index, medical care expenditures for all urban consumers.
- (2) The cost threshold includes only those costs remaining after payment has been made by Federal, State, local, private health insurance, or other applicable alternate resources.

1.16 FISCAL INTERMEDIARY

See IHS Manual (Section 2-3.16)

1.17 MEDICAL AND DENTAL PRIORITIES

A. Medical Priorities

The application of medical priorities is necessary to ensure that appropriated IHS/CHS funds are adequate to provide services that are authorized in accordance with IHS approved policies and procedures. See Manual Exhibit 2-A.

B. Dental Priorities

See Manual Exhibit 2-B.

1.18 DEFERRED SERVICES

See IHS Manual (Section 2-3.18)

1.19 CHS "MANAGED CARE"

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All SUs will maintain the following elements to review and monitor the referral and expenditure of CHS funds:

- A. The Ponca Tribe is currently in the process of establishing and implementing a CHS Committee.

See IHS Manual for information (Section 2-3.19.)

1.20 PROMPT RESPONSE TO PROVIDER NOTIFICATION OF CLAIM CHS “5-DAY”
RULE

The amendment of the Indian Health Care Improvement Act, Section 220 of P.L. 102-573, directs the CHS program to issue a purchase order or denial within five (5) days of notification of a claim.

Section 220 states –

- A. The Service shall respond to a notification of a claim by a provider of a contract care service with either an individual purchase order or a denial of the claim within 5 working days after the receipt of such notification.
- B. If the Service fails to respond to a notification of a claim in accordance with subsection (1), the Service shall accept as valid the claim submitted by the provider of a contract care service.
- C. The Service shall pay a completed contract care service claim within 30 days after completion of the claim. If a patient is potentially eligible for an alternate resource, issue a denial and advise and assist the patient in the application process.

1.21 VICTIMS OF CRIME ACT

The Victims of Crime Act of 1984, Title 42, Chapter 112 U.S.C., established a crime victim compensation program. The program is operated by the Federal Government and provides compensation to criminal violence victims and survivors of criminal violence, including drunk driving and domestic violence for medical expenses attributable to a physical injury resulting from a compensable crime, and for certain other expenses. Accordingly the IHS CHS program must pay for care provided to eligible AI/ANs before the crime victim compensation program pays; consequently, the crime victim compensation program is an exception to the IHS payer of last resort policy.