PURCHASED/REFERRED CARE (PRC) MISSION STATEMENT

The Shingle Springs Health & Wellness Center (SSHWC) offers a full range of health services and Purchase/Referred Care is one of them. Through PRC, we cover services that are not provided at the SSHWC. The PRC program is funded annually by the US Congress. It is not an entitlement program nor is it an insurance program. That is, PRC cannot guarantee that funds are always available.

PRC 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 PRC to maximize funds so that we are able to provide a wider range of health care to as many American Indian/Alaska Native people as possible.

Payments for health care can only be authorized by a PRC Ordering Official. No one else can authorize payments. PRC 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.

Purchase/Referred Care is health services provided at the expense of the Indian Health Service through the SSHWC to public or private medical or hospital facilities. These services are in addition to those services provided at an IHS facility. PRC is a supplement to other third-party reimbursement services.

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.

Overview of the PRC Program

This guideline is to be used for the effective management of the SSHWC Purchased/Referred Care Program.

PRC Eligibility Requirements:

- Must be a registered patient (active user) of SSHWC as defined on page 13 "Requested Documentation" of this policy.
- Patient must provide proof of eligibility as defined on page 11 of this policy.
- Patient must have a current referral from SSHWC as defined on Exhibit 2-L. A referral is a request for health services, not a guarantee of payment; AND
- The PRC program is the payer of last resort (42 CFR 136.61) for persons defined as eligible for PRC. All alternate resources and entitlements must be used before PRC funds can be utilized as defined on page 14 of this policy.

PRC funds may be used when:

- The services are unavailable at the SSHWC;
- All other alternate resources are exhausted;
- The patient and the services meet all requirements of these policies;
- The services are medically indicated;
- The services are within the Levels of Care currently funded by the SSHWC; AND
- Funds are, in fact, available.

All services requested will be reviewed by the PRC department and the PRC Review Committee before payment approval is made to ensure all eligibility requirements have been met.

Table of Contents

1.1 **PURPOSE**

To define and establish policies, procedures, and guidance for the effective management of the SSHWC Purchased/Referred Care (PRC) Program.

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

To clarify and explain PRC 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 136.21 through

136.25. 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/Alaska Native patients.

1.2 **ACRONYMS**

SSHWC-Shingle Springs Health and Wellness Center

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 RPMS Commitment Register

IHCIA – Indian Health Care Improvement Act

IHS – Indian Health Services

PRC – Purchased/Referred Care

PRCDA – Purchased/Referred Care Delivery Area

SSBMI – Shingle Springs Band of Miwok Indians

1.3 **DEFINITIONS** (Also, See 42 CFR 136.102)

Alternate Resources – The available and accessible IHS and Tribal health facilities and those non-IHS healthcare resources. 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 PRC payment.

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 Services – Now known as Purchased/Referred Care.

PRC Review Committee: Purchased/Referred Care Committee, the staff, physician, dental representative, Health Board representative, Finance Manager, Executive Director, or any other pertinent personnel assigned to hold bi-monthly meetings in order to review PRC cases ensure all requirements have been met before payment authorization is made.

Purchased/ Referred Care – Previously known as Contract Health Services. Purchased/Referred Care is any health service that is: a) delivered based on a referral by, or at the expense of, an Indian health program; and b) provided by a public or private medical provider or hospital that is not a provider or hospital of the Indian Health Program

Purchased/Referred Care Services Eligible Person – Previously known as 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 the United States (U.S.) on a reservation located within a PRC delivery area; resides within a PRC delivery area and is either a member of the tribe or tribes located on that reservation; or maintains close economic and social ties with that tribe or tribes.

Purchased/Referred Care to Support Direct Care – PRC may fund a specialist to come to the SSHWC to provide services to PRC eligible patients. Examples of direct care services that cannot be reimbursed with PRC 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 PRC 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 136.24 (b)(1)(c).

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

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

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 United States 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 PRC department based on the best information available, with the appeals procedure process as a protector of the individual's rights.

Purchased/Referred Care Delivery Area – The PRCDA means the geographic area within which PRC services will be made available by the SSHWC to members of an identified Indian community who reside in the area, subject to the provisions of 42 CFR Part 136 Subpart C.

Tribal Health Director – The Director of a tribally operated program, or his/her designee, authorized to make decisions on payment of PRC 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 PRC program.

1.4 USES OF PRC

The PRC 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 Tribally Operated Program or 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 PRC

Tribally Operated Program – 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 PRC by following the medical priority guidelines that are approved by the SSHWC Health Board.

(3) Process all requests for PRC including the issuance of purchase orders within SSBMI signing authority, determination of alternate resource availability, and maintenance of PRC related financial records.

(4) Ensure program/budget control and effective utilization of PRC at the tribal level.

(5) Work closely with appropriate tribal staff in identifying the need for PRC and in negotiating contracts with hospitals, clinical services, dentists, and other health care providers.

(6) Conduct managed care activities through and established PRC managed care committee

that reviews and monitors PRC referrals and emergency cases.

(7) Monitor and prepare CHEF cases according to high-cost case management guidelines.

1.6 PURCHASES/REFERRED CARE DELIVERY AREA

A. Purchased/Referred Care Delivery Area – SSHWC personnel should understand that residence within a PRCDA by a person who is within the scope of the Indian health program, as set forth in 42 C.F.R. § 136.12, creates no legal entitlement to PRC but only potential eligibility for services.

B. Services Needed But Not Available - Services needed but not available at an IHS or Tribal facility are provided under the PRC program depending on the availability of funds, the person's relative medical priority and the actual availability and accessibility of alternate resources in accordance with the regulations.

C. Established Purchased/Referred Care Delivery Area – The PRCDA for the Shingle Springs Health & Wellness Center is El Dorado County.

1.7 PERSON TO WHOM PRC WILL BE PROVIDED

A. There is no authority to provide payment for services under the PRC program unless funds are, in fact, available.

B. When funds are insufficient to provide the volume of PRC services indicated as needed by the population residing in the PRCDA, priorities for services shall be determined on the basis of relative medical need.

C. The PRC funds are limited to services that are medically indicated. See Exhibits 2-A and 2B for services that may be included and those specifically excluded.

D. The PRC funds may not be expended for services that are reasonable accessible and available at the SSHWC.

(1) The determination as to the SSHWC being "reasonable accessible and available" is a 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 SSHWC to provide the necessary service.

c. The level of funding available to provide PRC.

d. Distance from the SSHWC.

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

a. The PRC funds may be authorized for an emergency to 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 Director may consult with available SSHWC Medical Director, medical staff, or contract providers in order to arrive at the administrative decision.

(i) Medical and dental priorities (Exhibits 2-A, 2-B) 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 professionals.

(ii) Final decision as to classification of medical services as "emergency" will be based on review by a tribal physician or by documented medical history.

b. Services for an acute condition (urgent but not emergent) may be provided through PRC funds when the nature of the medical need of the patient, as determined by a SSHWC professional, can best be met by using a contract facility and sufficient PRC 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 PRC when the tribal health director has determined that sufficient PRC funds are available for this priority of medical service.

E. <u>The PRC funds may be expended for services to individuals treated in a SSHWC facility to the extent that the individual is eligible for PRC</u>. However, 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 or orthopedic clinics) provided within the facility are permitted when patients are under the direct supervision of an SSHWC physician or a contract physician practicing under the auspice (authority) of the SSHWC. For example, PRC funds may be used to pay for a contract specialist to see PRC eligible patents at the SSHWC.

F. Eligibility

Eligibility for PRC is governed by 42 C.F.R. § 136.23. The PRC program is not an entitlement program and thus, when funds are insufficient to provide the volume of PRC needed, services shall be determined on the basis of relative medical need in accordance with established medical priorities [42 C.F.R. § 136.23(e)]. To be eligible for PRC, individuals must:

(1) be eligible for direct care as defined in 42 C.F.R. § 136.12; and

(2) reside within El Dorado County; or

(3) be a student or transient:

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

(i) College (undergraduate and graduate) vocational, technical, or other academic education. The SU where the student was eligible for PRC prior to leaving for school is responsible for the student. While the student is on a scheduled break or vacation, the student's PRC permanent area of residence is responsible for payment of PRC services.

(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 PRCDA. Persons, who leave the PRCDA in which they are eligible for PRC, and are neither students nor transients, will be eligible for PRC for a period not to exceed 180 days from his/her last PRC authorized date of service.

(5) Other Eligibility Consideration

a. Indians adopted by non-Indian parents must meet all PRC requirements to be eligible for care (e.g., reside in PRCDA).

b. Foster/Custodial Children – Indian children who are placed in foster care outside a PRCDA by order of a court of competent jurisdiction and who are eligible for PRC at the time of the court order shall continue to be eligible for PRC 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.

d. A non-Indian woman pregnant with an eligible Indian's child who resides within the PRCDA is eligible for PRC during pregnancy through postpartum (usually 6 weeks). If unmarried, such a woman is eligible for PRC 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.

Once the child is born the family will have up to six months for the newborn to become eligible for direct care, to continue receiving PRC services. The child should register as soon as possible to be PRC eligible.

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

G. Requested Documentation

(1) In order to initially open a chart with PRC, the following documentation is needed:

a. Must have a current Medical Department registration packet on file

b. Social security card

c. Proof (enrollment card or enrollment office verification) 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

(i) A Purchased/Referred Care Proof of Residency form will be completed for each applicant. The signed/verified form (see exhibit 2-G) with requested documents will constitute proof of residency.

(2) The following documentation will be requested when applicable (may include, but not limited to):

a. Alternate resource information

(i) Private insurance card

(ii) Medi-Cal determination letter

(iii) Medicare card

- Part A
- Part B
- Part C
- Part D
- Supplemental, if any

b. For proof of pregnancy:

(i) If married to a non-Indian woman, a Marriage certificate to eligible tribal member.

(ii) If not married to a non-Indian 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) Medical charts are updated on an annual basis. PRC Coordinators will facilitate the annual update for PRC eligible patients including proof of residency, as needed, to assist patients in maintaining PRC eligibility. The annual update is a required component of continued PRC eligibility.

H. Priorities of PRC –

(1) Because the IHS resources are insufficient to meet all the needs of the Indian people served, regulations at Code of Federal Regulations, at Title 42, section 136.23(e), priorities for contract health services require that medical priorities be established governing authorization of PRC. Tribal programs are required to follow IHS regulations and the SSHWC will utilize the IHS Priorities Levels. See Manual Exhibits 2-A and 2-B for priority list.

I. Payer of Last Resort – 42 CFR 136.61

(1) The IHS is payer of last resort of persons defined as eligible for PRC under these regulations, notwithstanding any State or local law or regulation to the contrary.

(2) Accordingly, the SSHWC will not be responsible for or authorize payment for PRC 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 PRC or other health services, from the IHS or IHS programs.

(3) The payer of last resort rule does not represent a change in the PRC program

requirements. The PRC office must first determine whether the patient applying is eligible pursuant to 42 CFR 136.12 and 136.23. In addition, the PRC office must determine that the medical services requested for payment from PRC funds are within medical priorities. The PRC program is not an entitlement program and thus, when funds are insufficient to provide the volume of PRC needed, priorities for service shall be determined on the basis of relative medical need (42 CFR 136.23(e) (1986)).

(4) Upon application by a patient for PRC, the PRC office must:

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

GUIDELINE: Initially, the PRC office should make a determination based upon reasonable inquiry whether the patient applying for PRC 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. Patients who, upon reasonable inquiry, are potentially eligible for alternate resources are required to apply for such resources. The patients should not automatically be denied PRC 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: SSHWC 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 Exhibit 2-H.)

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 SSHWC should include in its written notice that if a patient is unable to apply or is having difficulty applying for alternate resources, the PRC office will assist with the application process.

The SSHWC should include with the written notice an authorization to release and an assignment of rights form for the patient to sign and return to PRC. These forms authorize the SSHWC to obtain information from the alternate resources program files and allows the SSHWC to intervene on the patient's behalf to ensure completion of the application (Exhibit 2-I).

The PRC office may assist the patient in completing an alternate resource application prior to an illness or injury. This policy should be encouraged; however, the SSHWC should not deny PRC funds for an individual's failure to apply prior to medical need. The PRC 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 PRC 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 PRC eligible, the Tribe should pay the Tribal Member'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.

(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 PRC eligible Indian patient.

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

SSHWC will provide a written notice to patients that if an alternate resource application is not completed, or if the patient does not contact the PRC office for assistance in completing the application within 30 days of the date of the notice, then a PRC 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 PRC file is well documented with attempts to assist the applicant, the PRC office will issue a PRC denial to the patient and a copy should be forwarded to the provider.

Second, SSHWC will not pay the referred provider when the provider fails to follow alternate resource procedures, such as not notifying the program within its time constraints. SSHWC 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, SSHWC will not be responsible for the medical bill, even if the Indian patient is otherwise PRC eligible.

SSHWC should inform non-IHS providers (i.e., non-IHS facilities and practitioners providing medical services to IHS beneficiaries) of the PRC 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. SSHWC should inform providers that: (1) an SSHWC does not constitute a representation of eligibility under the PRC program; (2) SSHWC 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 SSHWC shall be promptly notified of any payment received; and (5) SSHWC will reject claims where the provider fails to investigate other party liability.

a. The use of alternate resources is mandated by IHS' Payer 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 alternate resource, requires the denial of eligibility for PRC.

    (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 (i.e. Medi-Cal), 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.

J. Higher Education Student Policy

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

Student/Patient must provide the following information:

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) 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 SSHWC that should be completed prior to or during vacations

(3) PRC coverage will not continue for students who do not provide the required information or do not abide by section 1 of this policy. 180 day rule applies (see section 1.7(E)(3)(iii))

1.8 AUTHORIZATION FOR PRC

A. Notification requirement, as described in the Federal Register of August 4, 1978, and contained specifically in 42 CFR 136.24, 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 PRC ordering official to the medical care provider.

(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 PRC 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 PRC 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 PRC 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 PRC 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 PRCDA.

B. Payment shall be in accordance with the provisions of the contract or purchase order and other provisions put forward in the Tribe's payment policy.

C. 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 PRCDA. Individuals under treatment for an acute condition shall remain eligible as long as the acute medical condition exists.

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

(1) Indian people affected by the PRC program must be kept aware of policies on administrative requirements for approval of PRC payment for services, and the title(s) of the person(s) who will be notified when PRC is required. This notification will include at least publication on official social media and/or tribal newsletters and posting of notices on bulletin boards in patient areas of the SSHWC facility. 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 SSHWC.

(2) The PRC eligible person being referred from the SSHWC will be notified at referral time of his/her eligibility status for PRC. In cases where determination of eligibility cannot be made before referral, the individual will be notified in writing that the SSHWC may not be responsible for bills incurred. See Manual Exhibit 2-G.

E. PRC Authorization Numbering System.

A uniform numbering system has been developed to use when issuing IHS-43/64 purchase documents.

(1) The number has four components and consists of 9 digits

(2) The four components are: 0 000 00000.

(3) The first digit of the first component is the last digit of the fiscal year being charged for the services. Example: Fiscal Year 1998 is 8.

(4) The second component is an alpha code to identify the Area. The alpha code for the California area is "L".

(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 PRC Authorization Process, Flow Chart – The flow of a PRC purchase order form initial request through processing and closeout is diagramed in Manual Exhibit 2-M. Many aspects of PRC and other activities are incorporated in this general flow. The flow chart provides a general description of the process.

1.9 PAYMENT DENIALS AND APPEALS

If a medical provider reasonably thinks that the SSHWC is a party to payment for services provided to an eligible patients, and if the patient is denied PRC, both the patient and the provider must be notified in writing of the denial with a statement containing all the reasons for the denial, (see Exhibit 2-D) and that within 30 days the applicant (See 42 CFR 136.25 Reconsiderations and Appeals):

A. Denial Notice. A PRC denial notice must inform the patient/beneficiary/applicant that within 30 days from receiving the notice, the patient/beneficiary/applicant.

(1) May request a reconsideration of the denial by the SSHWC Executive Director. However, the appeal must provide additional information not previously submitted.

(2) If the claim is denied by the Executive Director, an appeal may be made to the Chairperson of the Health Board. The appeal to the Health Board must be in writing and include supporting documentation showing that the patient has complied with every part of this policy. The Health Board chairperson shall decide whether sufficient documentation has been submitted in order for the appeal to be reviewed by the Health Board. The Health Board shall meet within thirty (30) days of receipt of the appeal to consider the circumstances of the case. The Health Board shall notify the patient, in writing, within five (5) working days after the meeting. The identity of the patient shall remain anonymous during the Health Board appeal process. There shall be no appeal available past the Health Board; decisions of the Health Board shall be final.

B. Failure to Follow Appeals Procedures. If the patient/beneficiary/applicant fails to follow these procedures, the request for reconsideration or an appeal may be denied. A written Notice of Denial will be sent to the patient/beneficiary/applicant stating there are no further appeal rights.

1.10 APPEALS RECORDS

A. The SSHWC Executive Director or his/her designee is administratively responsible for creating and maintaining a file on each denial of PRC.

B. The appeal file shall contain: all denial letters, all briefing memorandums prepared in connection with any recommendation to the Tribal Health Director or Area or Program Director regarding such denial; all correspondences to the SSHWC PRC 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 Health Board shall constitute final administrative action.

1.11 CONTROL OF FUNDS

A. The PRC Commitment Registers will be maintained. The PRC Commitment Register must contain the following minimum information

(1) Authorization Number

(2) Provider Name

(3) Patient Identification Number

(4) Date of Service

(5) Allowance Amount

B. Commitment Register. The RPMS CHS/MIS application is a commitment register when issuing authorizations at referral or committee approval. A summary of the PRC fund balance shall be provided to the SSHWC Executive Director and the PRC Committee at least once a month.

C. 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

SSHWC has established follow-up system for all authorizations that have not been completed and returned within 90 days of issuance.

1.13 RECONCILIATION OF COMMITMENT REGISTER

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

1.14 DATA REPORTING

The appropriate workload and fiscal codes will be entered into the data system, as specified in the Federal Register, January 20, 1994, Vol. 59, No. 13, 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

CHEF funds cover the IHS portion of medical expenses for catastrophic illness and events falling within the SSHWC responsibility after the yearly maximum is reached by the tribal clinic.

(1) PRC staff will notify the California Area Office (CAO) Purchased Referred/Care Officer in writing of the following:

i. Potential catastrophic cases: Cases that have the possibility of reaching the threshold cost.

ii. Actual catastrophic cases: Cases that are obligated in the amount of the threshold or more.

iii. PRC Eligibility and use of Alternate Resources Requirements apply.

Submit the following information via secure email service:

(1) Patients name

(2) Diagnosis/procedures

(3) Admitting hospital

(4) Possible case cost

(5) Type/possible alternate resources

When the obligation reaches the threshold amount a completed CHEF Reimbursement Request and Catastrophic Illness/Event codes form will be completed sent to the CAO.

1.16 **MEDICAL AND DENTAL PRIORITIES**

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

B. Dental Priorities

See Exhibit 2-B.

1.17 **DEFERRED SERVICES**

A. Recording and Reporting: The reporting formats and guidelines for deferred services accrued and deferred services expenditures are sent to the SSHWC by IHS Area Office on an annual basis.

B. Guidelines for recording and reporting on deferred services are found in the IHS Manual 2-3.20.

1.18 "**PRC MANAGED CARE"** There shall be an active PRC or managed care review committee to review PRC referrals and emergency cases and monitor the referral and expenditure of PRC funds. See Exhibit 2-H, "PRC Committee and Prohibition Letter."

A. PRC Meeting Notes

(1) Writing notes will be created for each PRC Committee meeting

(2) A committee member will record committee comments, medical priority and ranking information.

(3) PRC meeting notes will summarize decisions made and will note if recusal occurred

B. Referral Tracking

(1) Referrals will be tracked using methodology that includes the disposition of each referral request

(2) A clear record will be maintained including reasons for referral, approval or denial, and communication with patients and providers.

C. Communication

(1) A designated committee member will communicate approval/denial decisions to PRC staff for management of referrals, issuance of purchase orders, denials, deferrals, and notifications requirements.

D. Record Maintenance

(1) PRC Committee records, notes and lists will be created, used, and stored/maintained and made available for review as appropriate.

(2) Committee meeting records including agenda, attendance, minutes, and notes will be created, maintained, and stored in a confidential manner.

(3) PRC Committee records will be retained for six years.

(4) Records will be made available in accordance with HIPAA regulations.