

## Accessing Contract Health Services of the XXXXXXXXXXXX (Facility Name)

### What are contract health services?

Health care purchased by the Indian Health Service (I.H.S.) for eligible Indians from non I.H.S. providers and facilities when direct services of appropriate types are not available or accessible.

The facility is required to operate within appropriated funds. There is no authority to provide payment for services under the C.H.S. program unless funds are, in fact, available at the time the patient is referred for care. Contract funds are a finite congressional appropriation that can not be increased with local funding.

Payor of Last Resort. The I.H.S. will not be responsible for or authorize payment for contract health services (C.H.S.) to the extent that:

- The Indian is eligible for alternate resources
- The Indian would be eligible for alternate resources if he or she were to apply for them.

The Contract Health Services program is not an Entitlement Program or an Insurance program and is managed at the local level but must adhere to national regulations.

### Uses of Contract Health Services Funds

- C.H.S. funds are used to supplement and compliment other health care resources available to eligible Indian people.
- The funds are utilized in situations where:
  1. No I.H.S. direct care facility exists
  2. The direct care element is incapable of providing required emergency specialty care
  3. The direct care element has an overflow of medical care workload
- Funds are used to provide health care consistent with established Contract Health Services medical priorities
- Contract Health Services are limited to services that are medically indicated within the established C.H.S. medical priorities.
- Because C.H.S. funds are limited by FINITE annual appropriation, and because some C.H.S. medically indicated emergency room contacts are not within established and funded medical priorities, some emergency room contacts cannot be paid with C.H.S. funds.

### Emergency Room Contacts

- In emergency room cases, an eligible patient, 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, notify the Service Unit of the Treatment

and provide information to determine the relative medical need for the services. Elderly person(s) have 30 days to notify the S.U. of emergency care received.

- Prior to admission of an eligible patient to a non-Indian Health Service facility, the XXXXXXXX Service Unit physician on call is to be notified. This is to determine if the eligible patient can be cared for at the local I.H.S. facility.
- The Contract Health Services review committee must review all emergency room contacts. Prior to review supporting documentation must be received from the medical care provider.

## REVIEW OF REQUESTS

- The Contract Health Service Review Committee (CHSRC) reviews all C.H.S requests, referrals and emergency room contacts with attached medical information, received during the week. These requests are reviewed for the severity of illness and level or intensity of clinical care.
- Requests are reviewed and categorized in accordance with established medical priorities and then are ranked in accordance with relative medical need with in the medical priorities.
- Review and ranking of all requests are based solely upon relative medical need.
- The CHSRC reviews for medical priority only.
- The CHSRC does not “APPROVE” payment.
- After ranking of request, C.H.S. staff obligates funds (issue purchase orders) in sequence of the highest to the lowest ranking and ONLY to the extent of resources available for the review period.
- Available funding level for the review period is determined by prorating the service units’ quarterly funding level into a weekly spending plan.

### Eligibility for Contract Health Services

- The patient must be a member of the Tribe or Tribes served by the XXXXXXXX Service Unit and live on the reservation served by the XXXXXX Service Unit or within the Contract Health Services Delivery Area for that reservation.
- A non-Indian woman pregnant with an eligible Indian’s child who resides within the contract health service delivery area is eligible during pregnancy.
- Be a full time student that is eligible for CHS from the XXXXXX Service Unit.
- A patient claiming eligibility for CHS has the responsibility to furnish the service unit with documentation to substantiate the claim

### Access to CHS is through:

- Referral by the service unit clinical staff
- Emergency contacts

### Referral

The patient presents to the service unit clinical staff and referral is written for medically indicated care.

While service unit physicians must refer patients for medically indicated care, a referral does not authorize payment for the medical care delivered. Approval of the referral must be provided by Contract Health Services and a purchased order issued before the care can be provided. This includes referrals for medical services which cannot be provided directly through the existing Indian Health Service health care facilities.

Funds are limited by finite annual appropriation and some CHS medically indicated referrals are not within established and funded medical priorities, some referrals and funded medical priorities, some referrals cannot be paid with CHS funds.

## EMERGENCY CONTACT

In emergency cases, an eligible patient 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, notify the service unit of the treatment and provide information to determine the relative medical need for the services. Elderly patients have 30 days to notify the Service Unit.

PRIOR to admission of an eligible patient to a non Indian health service facility, the XXXXXX Service Unit physician on call is to be notified.

All emergency room contacts (call-ins) must be reviewed by the contract health services review committee. Prior to review supporting documentation must be received from the medical care provider. Funds are limited by FINITE annual appropriation and some CHS medically indicated call-ins are not within established and funded medical priorities, some call-ins cannot be paid with CHS funds.

## ALTERNATE RESOURCES

The use of alternate resources is mandated by the Indian Health Service Payor of Last Resort Rule, 42 C.F.R. 36.61 [1990]

- 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.
- 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 Contract Health Services.

## FAILURE TO FOLLOW ALTERNATE RESOURCE PROCEDURES

There are two instances when Indian Health Service will not pay the provider for medical bills incurred by an otherwise C.H.S. eligible patient.

1. When the patient willfully or intentionally fails to apply or fails to complete an alternate resource application.

2. The Indian Health Service will not pay the provider when the provider fails to follow alternate resource procedures.

Alternate resources include, but not limited to, programs under titles 18 and 19 of the Social Security Act (i.e., Medicare, Medicaid), State and local health care programs and private insurance.

## THE APPEAL PROCESS

When a person is denied CHS, or when a medical provider may reasonably think that Indian Health Service is a party to payment, both the patient and the provider are notified in writing of the denial. The denial notice informs the patient and provider that within 30 days from the receipt of the notice the applicant:

1. May request reconsideration by the service unit director. That request for reconsideration (appeal) must contain additional information not previously submitted.
2. Denials from the service unit director may be appealed to the XXXXXXXX Area director.
3. Providers may submit appeals. The provider is considered as acting on behalf of the patient.
4. When the area director upholds the denial, the patient/provider is notified in writing. An appeal may be submitted in writing to the director, Indian Health Service, within 30 days.
5. If the claimant fails to follow procedures, the request for reconsideration of an appeal may be denied.

## MEDICARE LIKE RATES FOR HOSPITAL PROVIDERS

Section 506 of the Medicare Modernization Act entitles Indian Health Programs to pay Medicare-like rates to Medicare-Participating hospitals for patients that receive hospital services outside of the Indian Health Service (IHS) direct care facilities.

CMS issued a notice to the Medicare Fiscal Intermediaries (FIs) and Part A and Part B Medicare Administrative Contractors (A/B MACs), of an IHS clarification of its methodology for coordination of benefits with other payors under Section 506, to a manner similar to the Medicare Secondary Payor (MSP) Program.

The IHS total payment amounts to providers for services provided under this provision, including applicable cost-sharing, will not exceed the Medicare-like rate in accordance with the regulation.

Example 1:

The primary payor(s) total paid is an amount equal to or greater than the Medicare-like rate; no additional payment will be made by the IHS.

Example 2:

The primary payor(s) total paid amount is less than the Medicare-like rate; the difference is the amount available for the patient liability.

2.a. If the patient liability is greater than the amount available, the payment will be only that portion which is available.

2.b. If the patient liability amount is less than the amount available, the payment will be up to but not more than the patient liability amount.

**You may not bill the patient for the balance.**

NOTE: Medicare-like rates applies to hospital facility services only.

## HOW TO PROCESS A CLAIM

In order to have your claims processed timely, accurately and without delays, please review the following tips with your staff a purchase order is received by the vendor

- Prior to filing the claim with Blue Cross and Blue Shield of New Mexico. The claim must be filed with all alternate resources.
- After receiving all Explanation of Benefits (EOB's) from the alternate resources:
  1. Attach the EOB and or denial and appropriate UB or HCFA form to the original purchase order. Then send to Blue Cross and Blue Shield of New Mexico. The patient and provider on the claim must match the information on the purchase order.
  2. Attach copies of the EOB and or denial and appropriate HCFA form to the first copy of the purchase order and send this to the XXXXXX Facility Contract Health Services Department.
  3. Keep the vender copy of the purchase order with the copies of the EOB, Denial and Appropriate UB or HCFA form for your files.
- Submitting copies of purchase orders and filing late charges result in payment delays.

## DETAILS FOR CLAIMS PROCESSING

### Introduction

This section describes claims processing requirements for patient-specific and non-patient-specific claims. For a patient-specific claim, the FI receives, enters and reports information specific to that patient. For a non-patient-specific claim, invoices are used in lieu of claim forms to bill for items such as clinic days in an IHS facility.

Payment delays may occur if necessary data is missing or invalid. The FI makes every effort to enter all claims received. Sometimes such claims can be entered into the system but pend until necessary information is obtained through a telephone call or letter. Some claims are returned to the Service Unit or the provider before entry to obtain critical missing information.

To ensure that claims can be processed as accurately and timely as possible, claims must meet minimum requirements. These requirements also allow accurate processing and statistical reporting to IHS Headquarters.

## **Claim Receipt**

### Mailing Address

To ensure that claims are processed promptly without unnecessary delays, please send claims to:

**IHS/CHS FI**  
**P.O. Box 13509**  
**Albuquerque, New Mexico 87192-3509**

### Priority Processing

The FI is very careful not to prioritize standard items that are sent via priority mail or fax, or directed to someone's attention. This would unfairly delay one customer's request for another's. All claims are subject to the IHS/CHS FI contract standard of completing 95% of clean claims within 21 calendar days.

The FI understands that there may be circumstances that require priority handling, and those are handled on a case-by-case basis. Please continue faxing CHEF cases, claims in collection, and any claims with extenuating circumstances. Before faxing them, discuss these claims with the Customer Service (CS) Supervisor so the claims are identified for priority processing, and send the fax to the attention of the CS Supervisor. For any questions, please contact a CS representative at (800) 225-0241.

## **Electronic Media Claims (EMC)**

### Description

Providers may submit Electronic Media Claims (EMC) to the FI, which can speed up the claim payment process and prevent manual entry of claims. The FI is able to accept institutional, professional, and dental electronic claim transmissions in the HIPAA standard transaction set (837) format.

For information on electronic transmission of claims, the provider can call FI Customer Service at (800) 225-0241 and ask for System Coordination.

### Requirements

Currently, the following information is required to match EMCs to Purchase Delivery Orders (PDOs):

- PDO number
- Health Record Number (HRN)
- Facility Code

### Possible Delays

Processing delays may occur when EMCs contain incomplete, inaccurate, or missing information, including:

- If an EMC is received without an HRN, the claim rejects back to the provider to take appropriate action.
- If the FI has not received an electronic or paper PDO, the EMC pends until the PDO is received. Paper PDOs are required unless the claim is Master Delivery Order Listing (MDOL) or unless the requirement for a paper PDO has been waived.
- If EMCs are submitted but do not meet EMC edit criteria, the claim is returned to the provider via an EMC Transmittal Report. These claims can be retransmitted to the FI after the problem is resolved, or paper copies may be submitted.
- EMCs accepted by the FI can still pend for any of the routine claim processing edits. The provider, Tribe, Service Unit and/or Area Office are notified of any EMCs pending, using the same procedures as for paper claims.
- If alternate resources are involved with a claim, the EMC pends until the provider mails or faxes a copy of the alternate resource's EOB to the FI.

#### Procedure

If a provider is interested in submitting claims electronically to the FI, please direct the provider to contact the FI's customer service department at (800) 225-0241 and ask for the Systems Coordination.

### **Electronic Interfaces for Providers for Funds Transfer**

#### Electronic Funds Transfer

An Electronic Funds Transfer (EFT) allows providers to have payments directly deposited into their bank account rather than having a check mailed to their location. This avoids mail delivery delays. If this option is chosen, a provider receives credit for the check amount the second business day after payment is processed at the FI. A provider can choose EFT and receive either a paper or electronic detail of remittance.

#### Detail of Remittance

A Detail of Remittance (DOR) accompanies each payment to a provider, and displays patient, claim, and payment calculation information. Checks and DORs are dated with the date they are mailed, which is the day the claim is counted as paid.

DORs are also sent to providers when there is not an accompanying payment. In this case, the DOR includes information about why services were rejected for payment, and any applicable instructions to the provider regarding resubmission.

The Detail of Remittance is available in a HIPAA-compliant electronic format at the request of the provider. Electronic DORs (eDOR) enable payments to be posted automatically. The eDOR has the same itemization of payments as the paper DOR. The payment reasons are HIPAA-mandated codes. A provider can choose to receive eDORs even if claims are submitted via

paper. Receiving an eDOR is a direct file transfer with no manual intervention, and can reduce the potential of provider posting errors.

## **Electronic Interfaces for Providers for Inquiry and Responses**

### Electronic Inquiry & Response

Electronic inquiry allows providers to submit claims status inquiries electronically to the FI. If received by 6:00pm MST/MDT, an electronic response is sent back the same day with three possible outcomes:

- Claim payment information-paid date, check number, and payment amount.
- Claim pending information with applicable pend reason.
- Claim cannot be identified in the FI system with the information submitted (this response will recommend the provider call IF customer service).

This functionality allows providers to submit multiple inquiries in the same transmission. The inquiry must be in the HIPAA-mandated format.

### How to get started

If a provider is interested in EFT, receiving DORs electronically, and/or electronic inquiry, please direct the provider to contact the FI's customer service department at (800) 225-0241 and ask for Systems Coordination.

## **Facility and Professional Claims**

### Description

Providers submit patient-specific facility and professional charges on CMS 1450 and CMS 1500 claim forms:

- Patient name and address
- Patient date of birth
- Provider name and address
- Provider's EIN and applicable suffix
- Dates of service for billed charges
- Diagnosis codes
- HCPCS or revenue codes, or a detailed description of services provided if an existing code is not available
- Billed amount per service rendered
- Number of units for each service rendered
- Bill type, admit date and discharge status code on inpatient facility charges.
- Alternate resource information (and EOB from alternate resource, if appropriate)

Please note the following additional requirements:

- Claim must have PDO attached, unless approved for MDOL, or unless the requirement for a paper PDO has been waived.
- For MDOLs, the correct PDO number must be on the claim.
- Patient information (name, DOB, etc.) must match patient name on PDO.
- Provider name and EIN on claim must match PDO
- Claim and PDO must be legible.
- Providers do not need to send copies of medical records unless requested.
- Use current/appropriate provider contract # for dates of service.
- Dates on claim must match authorized dates on PDO.
- PDOs can only be used once, except for blankets.
- Blankets PDOs must be for same provider (EIN/suffix).
- Patient-specific claims filed with blanket PDOs require itemized charges and patient's community, county, and tribe on the claim.

## **Additional Charges**

### Description

Occasionally a provider has additional charges that were not included when the claim was originally submitted and processed. IHS has instructed the FI that the issuing Service Unit of Tribe must approve the charges prior to the FI processing them for payment. Therefore, the FI will send a letter to the Service Unit or Tribe with the claim and the PDO attached, requesting approval for payment. If the Service Unit or Tribe issues a new PO for the claim or the Tribe reopens the original the original PO, the FI will process the claim for the additional charges.

## **Claim Coding**

### Introduction

Various types of codes are required on the claim from so the FI can pay services according to IHS contracts and provide detailed statistical and clinical reporting to IHS program managers. These codes are also used for utilization and post-payment editing.

Processing delays may occur when codes are missing or invalid. In many instances, these claims must be returned to the provider or a telephone call made to obtain the missing/correct codes. To ensure that claims are processed as timely as possible and to avoid returned claims, providers should submit all applicable codes as described below.

### ICD-9-CM Codes

There are two kinds of ICD-9-CM codes: diagnosis and procedure. Diagnosis Codes describe a patient's medical condition or symptoms. Procedure Codes describe medical or surgical procedures performed during the billing period listed on the claim form.

## HCPCS Codes

HCPCS codes are a national coding system developed by the Centers for Medicare and Medicaid Services (CMS) for the Medicare program. It consists of three levels, which are integrated into the payment calculation process for Medicare methodology pricing.

Level 1 Codes are Current Procedural Terminology (CPT) codes developed by the American Medical Association to identify professional services. They comprise 80 percent of the HCPCS codes.

Level 2 Codes are nationally assigned five-position alphanumeric codes, used for professional services or supplies and equipment that are identified by CPT.

Level 3 Codes (local codes) allow Medicare carriers and insurance companies to develop codes for use in their service areas. These codes are for services not specifically identified in Level 1 or 2. The FI uses Level 3 codes when processing certain types of invoices to ensure consistent reporting of these procedures.

## Revenue Codes

Revenue codes were developed by the National Uniform Billing Committee for use by Medicare. These codes identify the type of facility charges being billed. CMS 1450 claim forms display these codes for both inpatient and outpatient charges.

## **Returned PDOs, Claims, & Invoices**

### Description

The FI makes every effort to process all PDOs and claims received. Telephone calls are made to providers, Service Units, or Tribes to obtain information whenever possible. However, PDOs and claims (or invoices) may be returned to the Service Unit, Area Office, Tribe or the provider if data is missing, invalid or does not match information in the FI system.

### Responding to Returns

When a PDO and/or claim is returned, a cover letter is attached that informs the recipient of the reason (s) the documents were returned and/or request additional information if appropriate. Return letters may list several possible reasons for returns, but only the item(s) marked with an (X) require a response (see example following the matrix).

If a response is requested on a PDO or claim returned to your office by the FI, please return the FI cover letter with your response. Make sure that:

- Any changes to the PDO are initialed by an authorized IHS/CHS representative. Example: MA, IHS/CHS, 5/2/08.
- All information that was requested is attached and legible.

## **Provider Identification Numbers**

### Description

The FI currently uses the EIN or SSN of a provider as the provider identification number. EINs, also referred to as TINs, are assigned by the federal government to partnerships, associations, and corporations for tax purposes. This number links the provider with payment and contract information in the FI system.

### National Provider Identifiers

The Centers for Medicare and Medicaid Services (CMS) has adopted the National Provider Identifier (NPI) as the standard unique identifier for health care providers to use in electronic filing and processing health care claims and other transactions.

The EINs or SSNs currently used as provider identification numbers will be tied to the NPI as mandated by the Health Insurance Portability and Accountability Act (HIPAA) for electronic processing. Providers who do not request or use an NPI as allowed by HIPAA will be assigned an ID number by the FI.

Providers filing standard transactions (HIPAA electronic formats) must use the NPI on all electronic transactions.

### Medicare ID numbers for Hospitals

CMS currently uses a 6-position numeric or alpha numeric designation for participating hospitals. The format identifies various types of care and/or reimbursement methods used by Medicare. These numbers will also be used by the FI system to access the appropriate pricing methodology for processing claims at Medicare-like rates. The FI has requested that IHS require providers to include their Medicare ID number when submitting claims, as they do with claims being submitted to Medicare.

## **Provider IRS Forms**

### W-9 Forms

A W-9 form is an Internal Revenue Service (IRS) form completed by the provider to verify the provider's legal entity name and tax or SSN used to file with the IRS. This information is captured on the FI's legal entity file and is reported to the IRS on the provider's 1099 form.

The FI sends W-9s to all new providers who are added to the FI's provider database. A new provider's claims are pended until the W-9 is completed returned.

Established providers receive W-9 requests as files are updated and it is noted that they have not previously submitted a W-9 form. For established providers, claims are pended if the W-9 is not returned after the second request. The Area Office receives copies of second request letters.

Claims pending while awaiting a W-9 form are not eligible for interest payment because the provider has not submitted all the required information for processing the claim. If the W-9 form is not returned to the FI within 60 days of the original request, claims are rejected on an interim basis.

## 1099 Reports

A 1099 report is an IRS informational document sent in January of each year to providers whose annual claim payments exceed the IRS designated amount. The 1099 informs providers of the amount reported to the IRS as income payments.

## DATA UNIVERSAL NUMBER SYSTEM

The federal government requires that all applicants for Federal grants and cooperative agreements with the exception of individuals other than sole proprietors have a DUNS number. (See policy at: [http://www.omb.gov/grants\\_docs](http://www.omb.gov/grants_docs) ). The federal government will use the DUNS number to better identify related organizations that are receiving funding under grants and cooperative agreements, and to provide consistent name and address data for electronic grant application systems.

### **Data Universal Number System (DUNS) Number**

- The Data Universal Numbering System (DUNS) number is unique nine-digit identification number provided by Dun & Bradstreet (D&B).
- The DUNS Number is site-specific. Therefore, each distinct physical location of an entity (such as branches, divisions, and headquarters) may be assigned a DUNS number. Organizations should try and keep DUNS numbers to a minimum. In many instances, a central DUNS number with a DUNS number for each major division/department/agency that applies for a grant may be sufficient.
- In order to provide on-the-spot DUNS number assignment, the requestor should do this by telephone. (See telephone number below).

### **Obtaining a DUNS Number**

- You should verify that you have a DUNS number or take the steps needed to obtain one as soon as possible, if there is a possibility you will be applying for future Federal grants or cooperative agreements. There is no need to wait until you are submitting a particular application.

- If you already have a DUNS number. If you, as the entity applying for a Federal grant or cooperative agreement, previously obtained a DUNS number in connection with the Federal acquisition process or requested or had one assigned to you for another purpose, you should use that number on all of your applications. It is not necessary to request another DUNS number from D&B. You may request D&B to supply a family-tree report of the DUNS numbers associated with your organization. Organizations should work with D&B to ensure the right information is on the report. Organizations should not establish new numbers, but use existing numbers and update/validate the information associated with the number.
- If you are not sure if you have a DUNS number. Call D&B using the toll-free number, 1-866-705-5711 and indicate that you are a Federal grant applicant/prospective applicant. D&B will tell you if you already have a number. If you do not have a DUNS number, D&B will ask you to provide the information listed below and will immediately assign you a number, free of charge.
- If you know you do not have a DUNS number. Call D&B using the toll-free number, 1-866-705-5711 and indicate that you are a Federal grant applicant/prospective applicant. D&B will ask you to provide the information listed below and will immediately assign you a number, free of charge.

### **Managing Your DUNS Number**

- D&B periodically contacts organizations with DUNS numbers to verify that their information is current. Organizations with multiple DUNS numbers may request a free family tree listing from D&B to help determine what branches/divisions have numbers and whether the information is current. Please call the dedicated toll-free DUNS Number request line at 1-866-705-5711 to request your family tree.
- D&B recommends that organizations with multiple DUNS numbers have a single point of contact for controlling DUNS number requests to ensure that the appropriate branches/divisions have DUNS numbers for Federal purposes.
- As a result of obtaining a DUNS number you have the option to be included on D&B's marketing list that is sold to other companies. If you do not want your organization included on this marketing list, request to be de-listed from D&B's marketing file when you are speaking with a D&B representative during your DUNS number telephone application.

Obtaining a DUNS number is absolutely Free for all entities doing business with the Federal government. This includes grant and cooperative agreement applicants/prospective applicants and Federal contractors. Be certain that you identify yourself as a Federal grant applicant/prospective applicant.

### **To Obtain Your DUNS Number**

- Please call the dedicated toll-free DUNS Number request line for Federal grant and cooperative agreement applicants or prospective grant applicants at:

## 1-866-705-5711

The number is staffed from 8 a.m. to 6 p.m. (local time of the caller when calling from within the continental United States) Calls placed to the above number outside of those hours will receive a recorded message requesting the caller to call back between the operating hours.

- The process to request number takes about 5-10 minutes
- A DUNS number will be assigned at the conclusion of the call.
- You will need to provide the following information:
- Legal Name
- Headquarters name and address for your organization
- Doing business as (DBA) or other name by which your organization is commonly known or recognized
- Physical Address, City, State and Zip Code
- Mailing Address (is separate from Headquarters and/or physical address)
- Telephone Number
- Contact Name and Title
- Number of Employees at your physical location

### System for Award Management (SAM)

Since October 1, 2003, it is federally mandated that any organization wishing to do business with the federal government under a FAR-based contract must be registered in SAM before being awarded a contract. For more information please visit the website: [www.sam.gov](http://www.sam.gov).

### DEFINITIONS

ALTERNATE RESOURCES – Health care resources available for patients, other than the Indian Health Service. 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 18 and 19 of the Social Security Act (i.e., Medicare, Medicaid), State and local health care programs and private insurance.

CONTRACT HEALTH SERVICE DELIVERY AREA (CHSDA) – The geographic areas within which Contract Health Services will be made available by the Indian Health Service.

CONTRACT HEALTH SERVICES (CHS) – Health services provided at the expense of the Indian Health Service from other public or private providers.

CONTRACT HEALTH SERVICES ELIGIBLE PERSON – A person of Indian descent belonging to the Indian community served by the local Indian Health Service facilities and who resides within a Contract Health Service delivery Area, (CHSDA)

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 (FI) – The fiscal agent contracted by Indian Health to provide and implement a system to process CHS medical claims for payment.

MEDICAL PRIORITIES - Because funding levels, geographic access, health conditions, local health resources, and third-party coverage vary to a great extent among Indian Health Service (IHS) Areas and service units, each Area must maintain an Area medical priorities list consistent with the IHS guidelines. Tribally managed programs that elect to follow IHS regulations may utilize the IHS medical priorities as a guideline. The range from: Level I service – Emergent or acutely urgent care services are diagnostic or therapeutic services that are necessary to prevent the immediate death or serious impairment of the health of the individual. To level V services - Excluded Services. Excluded services are services and procedures that are considered purely cosmetic in nature, experimental or investigational, or have no proven medical benefit. The list of therapies and procedures classified as potentially cosmetic in nature, experimental, or excluded will be reviewed and updated on an annual basis.

### Questions and Answers for common CHS issues

**QUESTION:** Why are Indian descendants not eligible for CHS off the reservation?

**Answer:** Indian descendants residing off the reservation may be eligible if they meet certain conditions. Pursuant to 42 C.F.R. 136.23 (a)(2)(i) and (ii), if not residing on the reservation such individuals must live within the CHSDA and (1) be members of the tribe(s) located on the associated reservation or (2) "maintain close economic and social ties with that tribe or tribes."

Also see 42 C.F.R.136.23(b) related to students and transients, and 42 C.F.R.136.23(d) for foster children placed off the reservation.

**QUESTION:** If 136.12 is mentioned in 136.23, does this mean Indians eligible for direct care are also automatically eligible for CHS?

**Answer:** No. In order to receive CHS, Indian beneficiaries must also meet the CHS eligibility requirements of 42 C.F.R. 136.23, 136.24 and 136.61.

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**QUESTION:** Why do Indian patients have to apply for Alternate Resources?

**Answer:** This is required by 42 C.F.R. 136.61, Payor of last resort. Approval of CHS payment for services is considered after all other Alternate Resources (AR) are applied. Any patient who is potentially eligible is required to apply for the alternate resource.

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**QUESTION:** If an Indian patient is eligible for CHS, why are some of my medical bills being paid and others not?

**Answer:** Each visit to a non-IHS health care provider and the associated medical bill is distinct and must be examined individually to determine CHS eligibility. All CHS requirements must be met for each episode (treatment) of care. A patient must meet residency, notification, medical priority of care and use of

alternate resources requirements of 42 CFR 136.23, 136.24 and 136.61 in order to be eligible for CHS. Example: If a CHS authorization is issued, IHS will pay the first medical treatment. Follow up care or additional medical care is to be done at the nearest accessible IHS or tribal facility; or will require approval with a new CHS authorization. If this process is not followed, the patient may be responsible for the expense.

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**QUESTION:** If an IHS doctor refers an Indian patient to a specialist, why are they being held responsible for the bill?

**Answer:** Referrals are not a guarantee for payment. Referral is a recommendation for treatment/test only. The CHS program must review the referral to make the determination for IHS approval of payment. All CHS eligibility requirements must also be met. See 42 C.F.R. 136.23, 136.24 and 42 CFR 136.61.

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**QUESTION:** If a student/transient is covered under CHS, are the student/transient's dependents also covered?

**Answer:** Yes, dependents may be covered for CHS up to 180 days if they were eligible for CHS at their original (home) CHSDA. See 42 C.F.R. 136.23(c). Continued CHS eligibility is not a requirement after 180 days.

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**QUESTION:** Where in the regulation does it state IHS has to follow medical priorities?

**Answer:** See 42 C.F.R. 136.23(e), Priorities for contract health services.

**QUESTION:** Children in foster care are eligible for CHS, but are they provided health care for all medical priorities, or only what the program is operating at?

**Answer:** Foster children are eligible on the same basis as other eligible Indians, including meeting the same standards for medical priority. See section 813(a)(1) of IHClA.

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**QUESTION:** Can non-Indians be eligible for CHS?

**Answer:** Yes, but only for three classes of non-Indians. These include (1) non-Indian women pregnant with an eligible Indian's child during pregnancy through postpartum (42 C.F.R. 136.12(a)); (2) non-Indians under 19 who are the natural, adopted, step-child, foster-child, legal ward, or orphan of an eligible Indian, section 813(a)(1) of IHClA); and (3) non-Indian spouses of eligible Indians if all such spouses are made eligible through a tribal resolution, section 813(a)(2) of IHClA).

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**QUESTION:** What does Social, Economic Ties mean, 42 C.F.R. 136.23(a)(2)(ii)?

**Answer:** Close social and economic ties are determined by the governing body, or designee, of the local Tribe. The IHS considers employees of the Tribe and spouses and children of eligible members of the Tribe to have close social and economic ties. The determination of eligibility applies if all individuals with the same circumstances are made eligible through a tribal resolution.

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**QUESTION:** Can a tribe decrease or increase their CHSDA?

**Answer:** Yes, but they must follow certain procedures (see 42 CFR 136.22(b)). Funding may not increase if the CHSDA expands, however it may decrease if the CHSDA is reduced.

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**QUESTION:** If an Indian moves from one federally recognized reservation to another federally recognized reservation, does the 180-day rule apply?

**Answer:** See 42 C.F.R. 136.23(a)(1) and (2). The 180-day rule applies until the client establishes residency and becomes eligible in another CHSDA.

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**QUESTION:** How does a CHS Program determine if a client has established residency? Does the program rely on program policy or tribal policy when it comes to determining residency on a reservation?

**Answer:** Residency is determined by **both** the physical presence of an individual in a location combined with the intent of the individual to remain there **permanently**.

**QUESTION:** Can a CEO or Tribal Health Director determine Social, Economic Ties, or is this strictly a Tribal function?

**Answer:** This is a tribal function. However, this determination can be delegated by the relevant Tribe(s) to the CEO or Tribal Health Director.