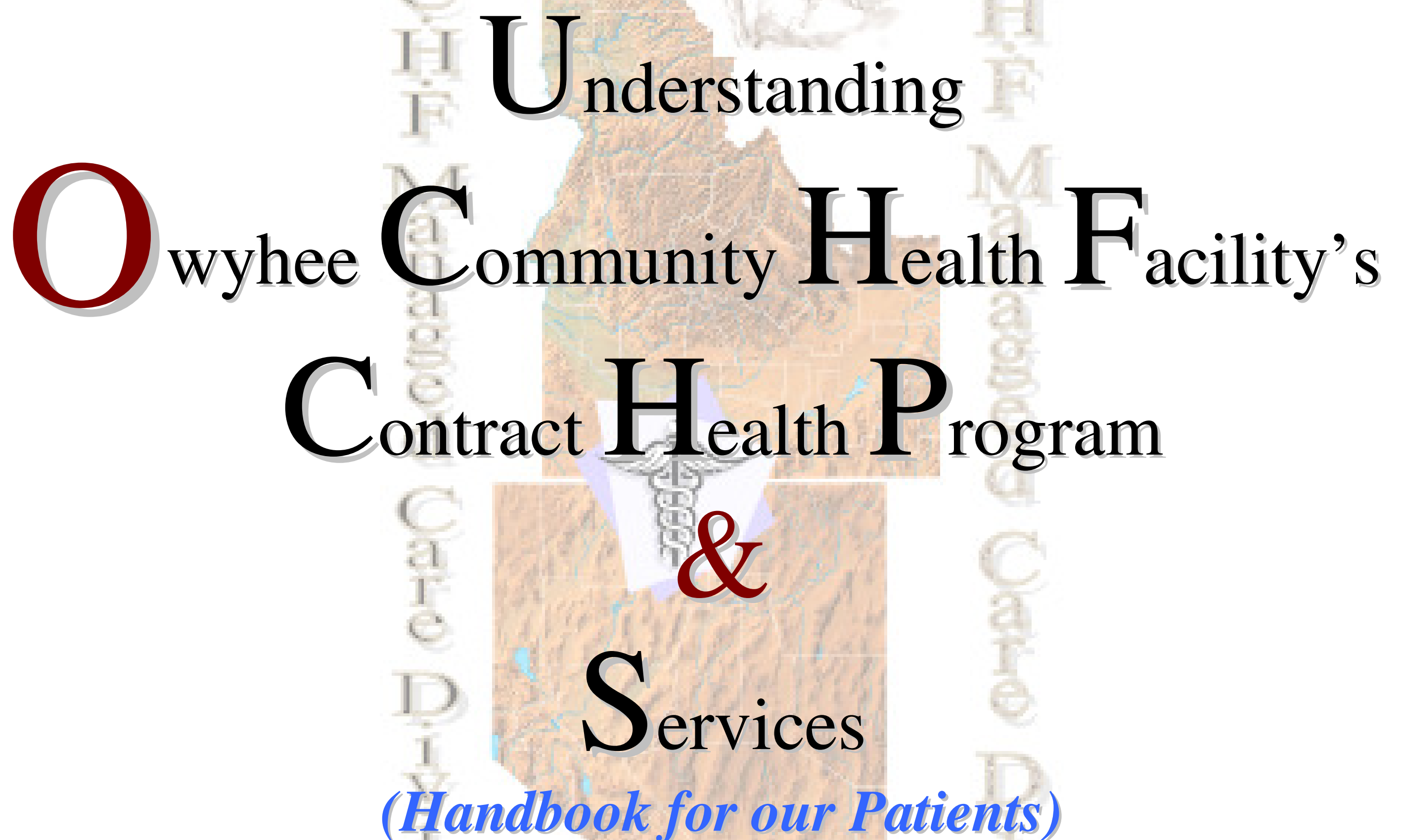
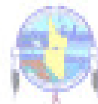
Understanding Owyhee Community Health Facility's Contract Health Program & Services

(Handbook for our Patients)



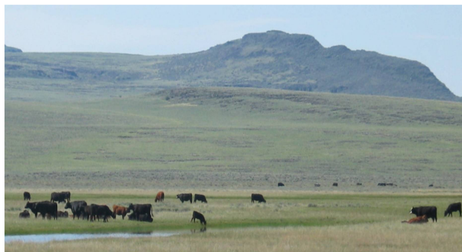


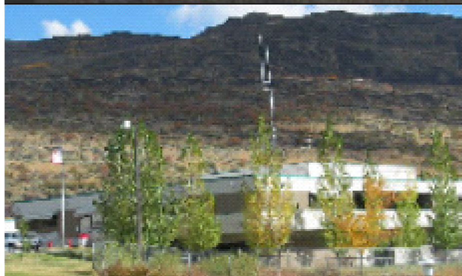
Handbook
for O.C.H.F Patients

Understanding OCHF

CONTRACT HEALTH SERVICES

TABLE OF CONTENTS





1. Introduction: What is Contract Health Service? #-3

2. Call Us #-4

3. Eligibility #-5

4. Medical Referrals #-8

5. What is OCHF's Medical Priority Basis #-10

6. Emergency Care #-12

7. Specialty Medical Services - Eye Glasses #-17

8. Specialty Medical Services - Dental Services #-18

9. Specialty Medical Services - Offsite Prescriptions #-19

10. Specialty Medical Services - Offsite Pain Management #-20

11. Specialty Medical Services – Mammogram's #-22

12. Student Education Health Program #-23

13. Denials and Appeals #-26

14. Catastrophic Health Emergency Fund #-30

15. Contract Health Service Delivery Area #-31

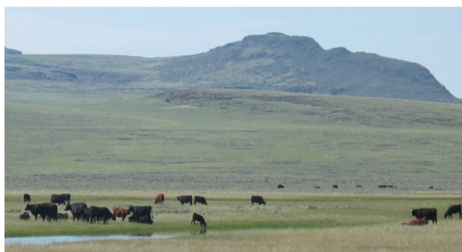
16. CHS Authorization Process Flow #-33

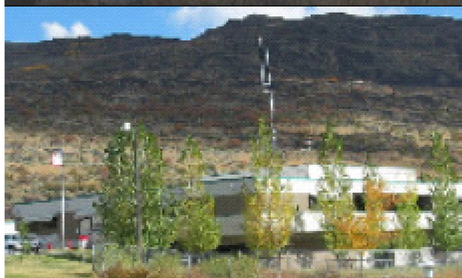
17. Managed Care Glossary and Terms #-34

STEP 1

Introduction:

What is Contract Health Services?





Owyhee Community Health Facility is a Native American operated healthcare facility of the Shoshone-Paiute tribes. The main facility is a $4 million building and the headquarters of the healthcare operation. OCHF is uniquely located 100 miles north of Elko, Nevada and 100 miles south of Mountain Home, Idaho.

OCHF provides healthcare services that range from outpatient, optometry, dental and other services that promote wellness. There are, however, some areas of health services that we cannot provide direct care to beneficiaries at our facility. In addition, there are specialized medical procedures that are routinely referred to other facilities that are not part of OCHF In order for OCHF to pay for those services, it is important that you understand your role in accessing what OCHF calls “Contract Health Service.”

Contract Health Service is services that OCHF does not directly provide at our facility. Funds are limited to pay for Contract Health Services, and guidelines in which Congress and Indian Health Service have put in place must be enforced. Many of these guidelines come directly from the federal government.

Those guidelines define those who are eligible for services and what costs are covered. If guidelines are not followed, federal regulations prevent OCHF from paying for your care.

This booklet is designed to help you understand those guidelines and your responsibilities. Thank you for taking the time to read through this handbook. We recommend you keep it handy and refer to it if you have any questions about Contract Health Services.

Owyhee Community Health Facility’s
Governing Health Board
& Management.

STEP 2

Please Call Us!

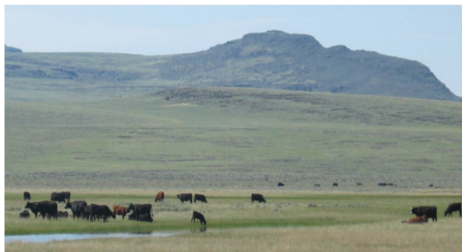
The most important thing for you to know: Call Us!

(775) 757-2403 ext. (234)

***Ms. Nammi Coons**: Business Office Specialist (Referrals)*

(775) 757-2403 ext. (235)

***Ms. Claudia Thomas:** Benefits Coordinator*



The first and perhaps the most important thing for you to understand about Contract Health Services is how important it is for you to call us if you have any questions **BEFORE** you receive services.

When you call, you can find out your eligibility and if the service you need is covered. Please don't wait until it's too late! Call first and request authorization.

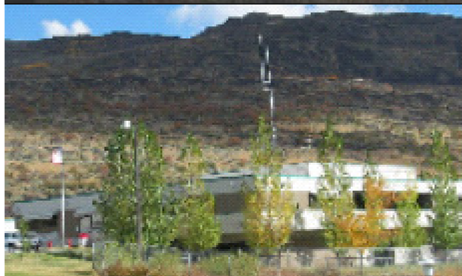
Call First for Authorization

In order for Contract Health Services to authorize payment for medical care, our OCHF physician must first authorize your referral. If the healthcare service you receive is not an emergency, authorization is required prior to the service. Please call the numbers noted on this page to talk with our Contract Health Services employees to see if payment can be authorized for your care.

Emergency Calls *(72-Hour Rule)*

If the service you receive is an emergency, Contract Health Service must be notified within 72 hours of the start of emergency services. If you are **65 years of age or older and/or disabled**, you have 30 days to notify Contract Health Service of your emergency care **(§406 of P.L 94-437, as amended).**

If you seek treatment for non-emergency services at a hospital, payment may be denied. An emergency is not defined by the location where the treatment was received and is limited to treatment. It is extremely important that you contact our offices and talk with our Contract Health Service employees.



Examples of Emergencies:

**Trouble breathing -/- **Chest Pains -/- **Bad Burns -/- **Poisoning
**High Fever in infants or children -/-
**Life-threatening accidents/injuries

STEP 3

Eligibility

Who is eligible for OCHF Contract Health Service Funds?

Not all OCHF patients are eligible for Contract Health Funds.
You must establish eligibility.

How do I establish eligibility?

To be eligible you must be:

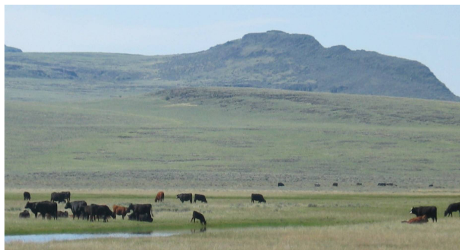
Alaskan Native and/or American Indian – To be eligible for Contract Health Services funding, you must provide proof that you are a member, or a descendent of a member, of a federally recognized tribe. (CFR), at Title 42, Section 136.21 through 136.25, and Indian Health Services, Part 2, Chapter 3, "Contract Health Services" dated January 5, 1998.

Documents accepted as proof of tribal membership or proof of Indian Blood includes:

- Certificate of Indian Blood (CIB) issued by the Bureau of Indian Affairs (BIA) or
- Certificate of Degree of Indian Blood (CDIB) issued by the Bureau of Indian Affairs, or
- Tribal enrollment card or letter of descendency issued by a federally recognized tribe

What if I do not have one of these documents?

If you do not have the paperwork or issued card, OCHF can give you an application to the Bureau of Indian Affairs (BIA) for a Certificate of Degree of Indian Blood (CDIB). Once you complete the application and mail it to the BIA office, they will send you the CDIB.

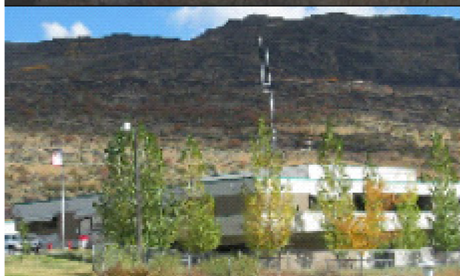


Important Notes

- Individuals may be required to pay for services if OCHF determines that the patient is not eligible or if he/she fails to provide the paperwork that proves eligibility. **"NO"** patient will be denied any medical services".
- OCHF now requires that patients provide proof of eligibility within ***90 days*** of its request and/*or on the* ***4th medical visit***.

Please Refer: OCHF Policy and Procedure for Tribal Compliance Demographic Information – OCHF Authorization of Release of Information and Liability (FORM).

- Patients are asked to show proof of eligibility before they will be scheduled for **offsite** Medical Referrals.



STEP 3 Cont.

Eligibility

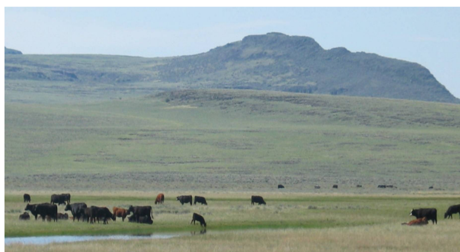
Non-Natives who are:

- Women pregnant with the child of an eligible Alaska Native or American Indian are eligible for prenatal care, delivery, and up to six weeks of post-partum care, or
- Adopted, step or foster children who are dependents of an eligible Native Parent or guardian may receive Contract Health Funding until the age of 18.

Native beneficiaries, who are requesting to prove eligibility, must present documents of residency to meet the guidelines of Contract Health Service Delivery Area (CHSDA). Three documents listed at the bottom of the page must be presented.

For those moving into the CHSDA, you must reside within the CHSDA for ***2 months or 60 days*** before residency can be established to prevent any delay of your CHS medical care. You must notify the OCHF Managed Care Office within the first 5 days of re-entering the CHSDA to allow proper linkage of time factors.

Please Refer: OCHF Policy and Procedure for Managed Care – Establishing Residency for CHSDA.



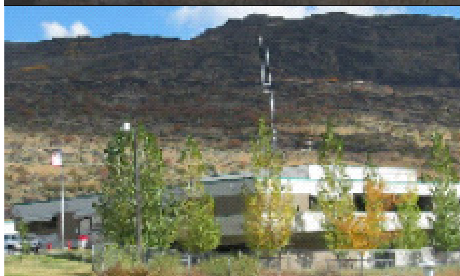
If you move outside of the CHSDA, you only remain eligible for emergency medical services for ***6 months/180 days*** from the time of moving. You must have IHS. eligibility on file with OCHF ***prior to moving.*** Those included for eligibility are Shoshone or Paiute tribal members moving outside of the area, other Indian persons who maintain "close social and economical ties" with the tribe; and transients (persons who are in travel or are temporarily employed, such as seasonal or migratory workers, during their absence).

Documentation for Proof of Eligibility Include:

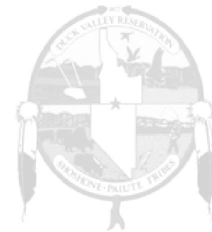
- Birth Certificate
- Two months of rent or mortgage receipts
- Social Security Card
- Student Enrollment
- Nevada/Idaho employer pay stubs 60 days Residency / 180 days Moved
- Phone/Utility bill receipts for 60 days Residency / 180 days Moved
- Nevada/Idaho voter registration date: 60 days Residency / 180 days Moved
- Nevada/Idaho driver's license or Nevada/Idaho State ID dated: 60 days Residency / 180 days Moved
- Primary Insurance Card (Private Insurance / Medicare / Medicaid)
- Permanent Fund Dividend receipt
- Tax returns
- Notarized letter from a tribal administrator
- State Application for alternative resources denial letter from state
- Other documents may be accepted upon review

Can I receive Contract Health Services funding if I haven't established eligibility?

No. Contract health funds cannot be authorized unless OCHF has been provided documentation of Indian Health Services eligibility.



STEP 3 Cont.
Eligibility



Once I have completed all eligibility requirements what happens next?

- Our Benefits Coordinator will confirm whether you meet all the requirements for the ***Direct Care Status*** under (CFR), at Title 42, Section 136.21.
- Next our Managed Care Department will confirm whether you meet all the requirements for the ***Contract Health Status*** under 42 C.F.R. §136.23, §136.24 and §136.61.

Once you have met all the necessary requirements, you will receive from the Owyhee Community Health Facility a **NEW** medical information card to use and present to all outside medical providers including hospitals in case of any Emergency Medical Care.

Each medical information card will identify you by name, and whether we the Sho-Pai Managed Care Health Program are classified as;

➢ ***Primary*** *Coverage,*

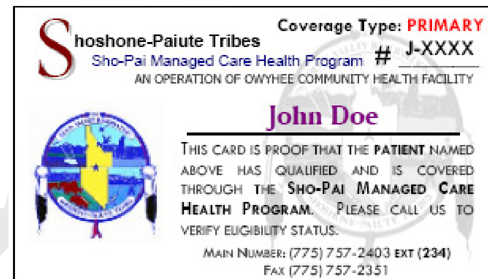
Means **NO** Alternate Resources, i.e., no 3rd party insurance, Sho-Pai Managed Care Health Program is primary coverage.

➢ ***Secondary*** *Coverage*

Means **YOU HAVE** Alternate Resources, a 3rd party insurance, which means Sho-Pai Managed Care Health Program secondary to your insurance plan.

➢ ***Tertiary*** *Coverage*

Means **YOU HAVE** Alternate Resources, two types of 3rd party insurances, which means Sho-Pai Managed Care Health Program is third to your insurance plans.



Sample of Medical Card

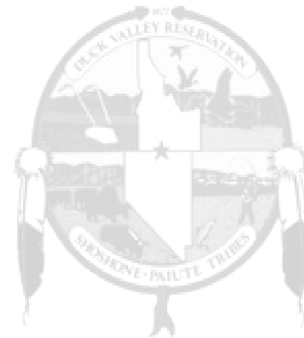
TO ALL OUT-SIDE PROVIDERS
& EMERGENCY ROOM NOTIFICATION

PRIOR AUTHORIZATION must be made for all non-emergency visits **ONLY** to outside providers if payment is requested and/or to be paid.

If you are seen in an **Emergency Room, a 72-hour notification** must be made to our office at (775) 757-2403 ext (234) or the medical claim will not be approved. Please submit Claims to:

Attention: **Sho-Pai Managed Care Health Program**
PO. Box 130 Owyhee, NV 89832

STEP 4



Medical Referrals

What is the referral process?

If OCHF is not able to perform the designated Medical Service with the boundaries of the operation and you are in need of a referral to a specialist, the referral must come from our OCHF Medical or Dental Provider. Each and every referral must be documented and/or submitted for **preauthorization**, thus receiving a confirmation/approval within a 7-day noticed timeframe from our Managed Care Committee.

The 7-Day Timeframe

Each and every referral will be reviewed and submitted to the Managed Care Committee within a 7-day timeframe. Each committee meeting is performed on a Thursday of each week. If your referral is documented on a Monday, Tuesday or Wednesday prior to the meeting of that week, the referral ***will not*** be submitted until the next designated Thursday meeting. This timeframe process will permit the following:

- Confirmation to determine if the patient meets the requirements of CHS /Direct Care 60-day/180-day rule and resides within the established service delivery area
- Confirmation to determine if the patient has insurance, Medicare, Medicaid, or Private Insurance
- If the patient does not have alternative resources, the patient will be required to meet with the OCHF Benefits Coordinator and sign the approved OCHF Offsite referral notice. This notice will explain to the patient the following: (1) level of acuity I, II, and III, which signifies a timeframe to obtain and/or apply for alternate resources.
- The patient is allowed not to participate in the alternate resource process and can ***opt out*** of the OCHF Managed Care Program. If the patient chooses to opt out of the program, all costs will be the responsibility of the patient i.e., co-payments and overall cost of the designated visit.
- If the patient chooses to participate in the alternate resource process, he/she will be required to apply for Medicaid if he/she is eligible. If the patient does not successfully complete the Medicaid application process, the referral ***will expire*** within the designated Level I, II, and III timeframe. The patient will have to re-apply for the referral all over again, thus attempting to apply for alternate resources once again.

Please Refer to: Policy and Procedure for Offsite Referrals for OCHF Patients – OCHF Application Alternate Resources (Offsite Referrals Medical Services) FORM.

STEP 4 Cont.

Medical Referrals

The OCHF Obstetrics Program

All delivering mothers are entitled to utilize the OCHF Obstetrics Program. The Managed Care Program, through the vision of the Tribal Council-Government, Governing Health Board and OCHF management, has instituted an outstanding O.B. healthcare program. The program, if utilized properly, will allow for the complete pregnancy, from the start of the program, the delivery of your child and through postpartum up to 6 weeks after the delivery. Once the mother is found to be pregnant, the medical referral is acquired that very day.

The 7-Day Timeframe

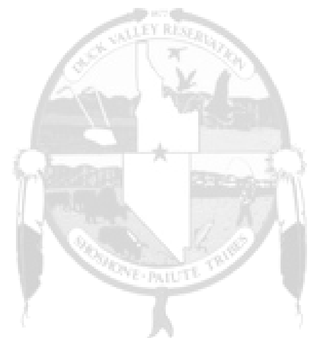
Each and every referral will be reviewed and submitted to the Managed Care Committee within a 7-day timeframe. Each committee meeting is performed on a Thursday of each week. If your referral is documented on a Monday, Tuesday or Wednesday prior to the meeting of that week, the referral ***will not*** be submitted until the next designated Thursday meeting. This timeframe process will permit the following:

- Confirmation to determine if the patient meets the requirements of CHS /Direct Care 60-day/180-day rule and resides within the established service delivery area
- Confirmation to determine if the patient has insurance, Medicare, Medicaid, or Private Insurance
- If the patient does not have alternative resources, the patient will be required to meet with the OCHF Benefits Coordinator and sign the approved OCHF Obstetrics Pregnancy Program Notice. This notice will explain to the patient that the mother is **automatically guaranteed** for the first 3 visits (90-day timeframe); this includes the 1st ultra sound for size and dates.

Please Refer to: Policy and Procedure for Managed Care Assistance CHS Timeline for OB Patients – OCHF Application Alternate Resources (OB Program) FORM.

- The patient is allowed not to participate in the alternate resource process and can ***opt out*** of the OCHF Managed Care Program. If the patient chooses to opt out of the program, all costs will be the responsibility of the patient i.e., co-payments and overall cost of the designated visit.
- If the patient chooses to participate in the alternate resource process, she will be required to apply for Medicaid if eligible. If the patient does not successfully complete the Medicaid application and/or is found to be non-compliant, the referral will change the patient's status on the ***91st day***. The patient will no longer qualify under the Managed Care Obstetrics Program under **§136.61** (payor of last resort). The patient may have to pay a sliding scale for each visit up to the delivery or until the patient has successfully applied for Medicaid or has been denied due to an overly qualified financial status.

STEP 5



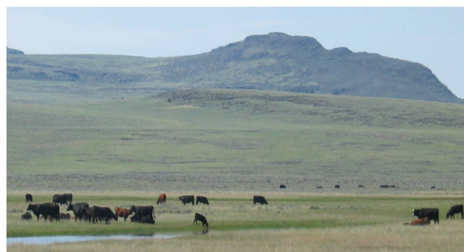
What is OCHF's Medical Priority Basis?

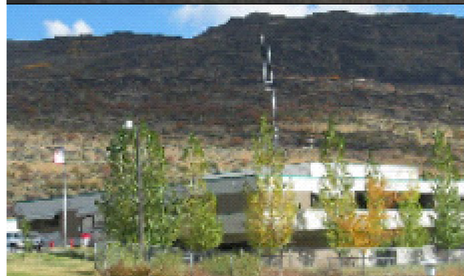
Medical Priority Basis

Owyhee Community Health Facility operates under a Priority III basis. These priorities are determined by Indian Health Operational Procedures, Managed Care -/- Contract Health Service Code of Federal Regulations, Title 42, § 136.23(e).

The interpretation of the priorities for our tribal health program is determined by consultation with our professional healthcare providers at OCHF. Any services not deemed Priority III will be added to the Deferred List at the patient's request.

Please Refer to: Policy and Procedure Managed Care Assistance for Medical Priority Classification.





Priority I

Urgent and emergent care that must be done ***within 30 days*** to preserve life, limb, function or senses. If left untreated, circumstance would result in uncertain but potentially grave outcomes.

Examples Priority I:

- ■Emergency room care for emergent/urgent medical conditions, surgical conditions or acute trauma
- ■Emergency inpatient care for emergent/urgent medical conditions, surgical conditions or acute injury
- ■Renal replacement therapy, acute and chronic
- ■Emergency psychiatric care involving suicidal persons or those who are a serious threat to themselves or others
- ■Services and procedures necessary for the evaluation of potentially life threatening illnesses or conditions
- ■Obstetrical deliveries and acute prenatal care
- ■Neonatal care

Priority II

Non-emergent care that must be ***done within 30-60 days*** but with enough time during which alternate resources can be evaluated. The patient's healthcare is amid the prevention of the disease or disability. These services include those proven effective in avoiding the occurrence of a disease (primary prevention) and services proven effective in mitigating the consequences of an illness or condition (secondary prevention) preventing the loss of life, limb or organ. This care is needed to maintain normal daily functioning.

STEP 5 Cont.

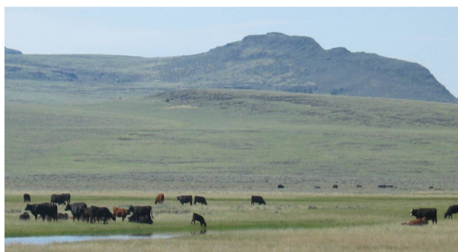
What is OCHF's Medical Priority Basis

Examples Priority II:

■Routine prenatal care
■**Non-urgent** preventive ambulatory care (primary prevention)
■Screening for known disease entities (secondary prevention)
■Screening mammograms
■Public health intervention

Priority III

Elective care that can be safely deferred for ***more than 60 days.*** Involves treatment for conditions that may be delayed without progressive loss of function or risk of life, limb, or senses. It includes services that may not be available at many IHS facilities and/or may require specialty consultations. Care can be safely postponed for more than ***60 days.***



Examples Priority III:

■Scheduled ambulatory services for non-emergent conditions
■Specialty consultations in surgery, medicine, obstetrics, gynecology, pediatrics, ophthalmology, ENT, orthopedics and dermatology
■Elective, routine surgeries that have a significant impact on morbidity and mortality
■Medically necessary acute physical rehabilitation after hospitalization for injury or illness causing disability - ***not to exceed 30-days***
■Diagnostic evaluations for non-acute conditions

Priority IV

Services that *(I) are not essential for initial/emergent diagnosis or therapy*, *(2) have less impact on mortality than morbidity, or (3) are high cost, elective, and often require specialized care facilities*. These services are considered not readily available.

Examples Priority IV:

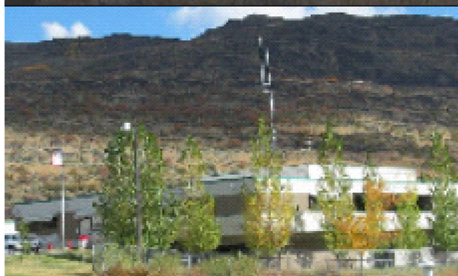
■Rehabilitation care
■Skilled nursing facility (Medicare defined)
■Highly specialized medical services/procedures
■Restorative orthopedic and plastic surgery
■Other specialized elective surgery such as obesity surgery
■Elective open cardiac surgery
■Organ transplantation (HCFA approved organs only)

Priority V

Excluded Services - Luxury procedures such as cosmetic surgery

Examples of Excluded Services - Priority V:

■All purely cosmetic (not re-constructive) plastic surgery
■Procedures defined as experimental by CMS
■Procedures for which there is no proven medical benefit - procedures listed as "Not Covered" Medicare Coverage Issuance Manual, §27,200
■Extended care nursing homes (intermediate or custodial care)
■Alternate medical practices (e.g., homeopathy, acupuncture, etc.)



STEP 6

Emergency Medical Care

Medically Necessary Services vs. Convenience

It is extremely important to note Emergency Rooms are for **"TRUE"** emergencies and not for care that could be performed at OCHF or because of convenience.

For emergency treatment or admission to a non-IHS facility, the patient or patient's representative must notify the OCHF Managed Care Program within 72 hours of the start of emergency services. If you are **65 years of age or older and/or disabled**, you have 30 days to notify Contract Health Service of your emergency care **(§406 of P.L 94-437, as amended).**

Special Notice: 72-hour notification for Emergency Room does not guarantee payment. All ER services will be reviewed by the Managed Care Committee and the OCHF providers to determine the priority level of service for approval and/or denial of your medical claim.

Emergency Room Prescription(s) Coverage

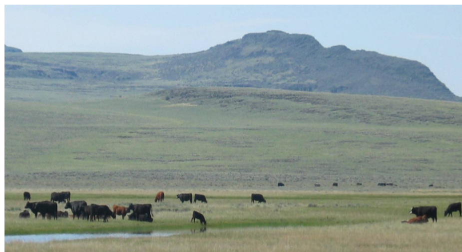
If there are medical prescriptions issued by the hospital's emergency room physician to treat your emergent condition, all medications will be covered for CHS tribal members. **NO** prescription refills are covered. You will be requested to follow up with our OCHF providers to review your emergency room visit after the fact to ensure and concur for all future medication refills.

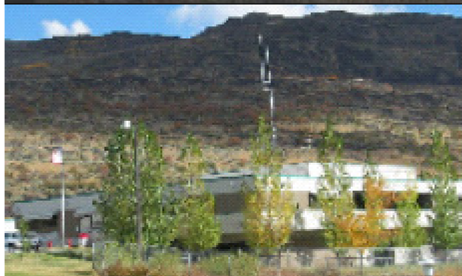
Emergency Room Requested Follow-up Visit(s)

If the Emergency Room provider requests you to follow up with "their" medical providers/specialists, OCHF must first be notified as to any pre-authorization and/or approvals. If OCHF Contract Health Service is not notified of any treatment, procedure and/or specialized service, your medical bill will be denied. These actions could ultimately affect you economically and affect your credit status.

Examples of Emergencies

- Trouble Breathing
- Chest Pain
- Bad Burns
- Poisoning
- Broken Bones
- High Fever for Infants and Children
- Life-threatening Accidents and/or Injuries

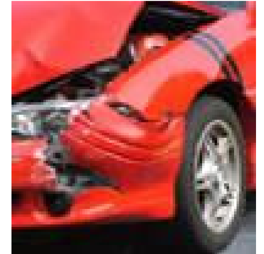




STEP 6 Cont.

Emergency Medical Care

Contract Health vs. Auto Accidents



Not only do you need to notify OCHF Contract Health Service within 72-hours for all Emergency Room visits, but if you are involved in an automobile accident, your claim will be placed on ***hold-pending status*** waiting for the outcome of your legal claim and/or status of your automobile accident.

Since **Idaho Law §49-1229** (Motor Vehicle Financial Responsibility) and **Nevada Law NRS §485.185** (Operator's Policy of Liability Insurance) requires that individuals have automobile insurance, Contract Health will not pay for injuries related to auto accidents.

CHS will request the following from you:

- Police Report
- Auto Insurance Policy Number
- HIPAA Release of Information signed to obtain information for OCHF Legal Counsel to cover any outstanding costs due to Owyhee Community Health Facility
- Legal Counsel Name and Office Telephone Number for legal claim

Contract Health vs. Workman's Comp

Not only do you need to notify OCHF Contract Health Service, within 72-hours for all Emergency Room visits, but if you are involved in a work related injury, your claim will be placed on ***hold-pending status*** waiting for the outcome of your legal claim and/or status of your Workman's Compensation Claim.

All employers are required to provide worker's compensation insurance, and Contract Health can not cover job-related injuries. It is **extremely important** that you notify your employer immediately of your injury no matter how slight. You need to comply with your employer's guidelines no matter how small your claim, otherwise, you ***may be denied due to non-compliance*** toward your employer's compensation plan. This could adversely affect you economically and your future credit status.

CHS will request the following from you:

- Copy of your C-4 Form or 1st report for work related injury
- Workman's Compensation Insurance Policy Number
- HIPAA Release of Information signed to obtain information for OCHF Legal Counsel to cover any outstanding costs due to Owyhee Community Health Facility
- Legal Counsel Name and Office Telephone Number for legal claim

STEP 6 Cont.

Emergency Medical Care

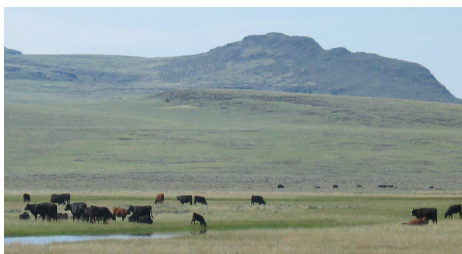
OCHF CHS Provides Ambulance & Air Flight Transport for All Emergent Needs

FIRST CALL 911!

Our Ambulance Service is provided for immediate emergency care and transport to Hospitals in Elko, Mountain Home and Boise, Idaho for emergent treatment. OCHF is under the standards and guidelines through the Emergency Department within Elko Regional Hospital.

In cases of ***immediate life-threatening circumstances,*** the OCHF Ambulance Service will call Air Life-Flight for transport for emergent medical treatment.

Our staff members are qualified and trained emergency medical technicians and are available for all Tribal and outlining communities 24 hours a day, seven days a week.



CHS will request the following from you:

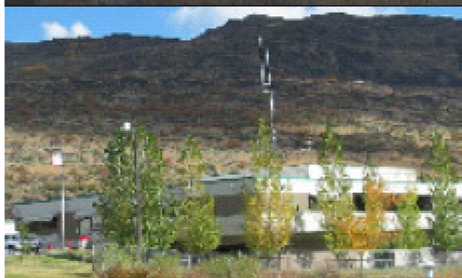
- Copy of your OCHF EMS Report.
- Receiving Agency (ER/Hospital name)
- Date of Transport, Time (72-hour rule)

Can I be covered for emergency care while I am temporarily traveling outside the Duck Valley Indian Reservation?

YES, You must notify OCHF Contract Health Service in Owyhee within 72 hours – including weekends and holidays (leave voice mail on weekends and holidays) at (775) 757-2415 after the beginning of the emergency room medical treatment. If you are too sick and disabled, a relative, friend or healthcare provider can notify Contract Health Services on your behalf. ***However, the notification is your ultimate responsibility.***

CHS medical coverage is provided for:

- Vacationers
- Tribal Members and/or Native Americans moving outside of the Duck Valley Reservation (CHSDA); 180-day maximum departure.



How can "we" help serve you and your family better to make your trip to the emergency room less stressful?

Here are a few survival tips to make your trip to an emergency room as safe as possible while reducing your out-of-pocket expenses or to help expedite your time and efforts.

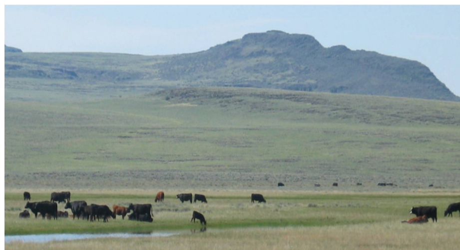
STEP 6 Cont.

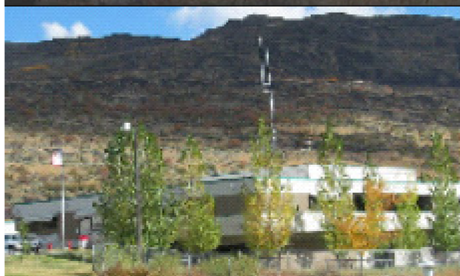
Emergency Medical Care

Emergency Room Visit - *What to Bring with You*

1. **Don't forget the folder** you created that includes all of your medical information.
2. **Bring paper and a pen** to document the treatment you received in the emergency room.

3. **Bring Comfort Items** to the emergency room - snacks, tissues, hand sanitizer, and cash for vending machines or the pay phone (most hospitals ban the use of cell phones).
4. **We recommend bringing something to read** when you go to the emergency room to help the time pass and may relieve some anxiety by taking your mind off your surroundings.





While You Wait in the Emergency Room

Chances are you will need to:

1. **Document *everything* that happens to you** in the emergency room. The most important thing you can do is to keep a detailed log of every treatment you receive, the name of the person providing that treatment, any medications given and the time you received each service.
2. **This information will be useful** to prevent any billing or treatment errors related to your emergency room visit. Please obtain the business care (or ask for a phone number) for every doctor you see in the emergency room in case your insurance company and/or managed care requests additional information. If you are not able to keep this log during your emergency room visit, ask a family member or friend to help you.
3. **Alert your insurance company and/or managed care** that you are in an emergency room to prevent any denials of your medical bill.
4. **Make sure you give your Insurance/Managed Care demographic information** to the emergency room/hospital to prevent any denials of your medical bill. This will also prevent damaging your future economic credit status.
5. **Ask to see a case worker** on duty in the emergency room or the hospital. Many people don't know that hospitals offer case management services. A case worker can be very helpful and reassuring during admittance or transfer to another hospital or when you're being discharged.

Avoid Additional Illnesses at the Emergency Room

1. Refer to the list of allergies you brought with you to the emergency room, and remind everyone who treats you.

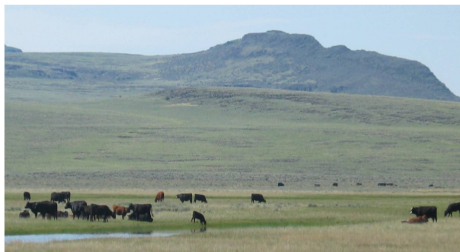
STEP 6 Cont.

Emergency Medical Care

2. When you are about to receive a new service, have that person confirm your name and your diagnosis to avoid being given the wrong treatment or medication.

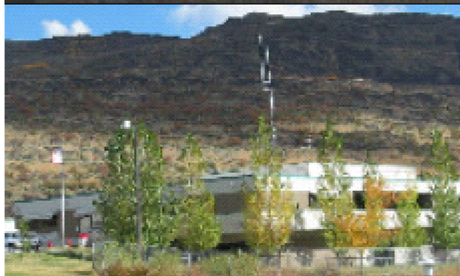
Before You Leave the Emergency Room

1. Make sure that ***you are given clear discharge instructions*** when you leave the emergency room or hospital. Read them immediately and ask questions.
2. **Ask for a copy of your emergency room report,** and ask to have an itemized copy of your medical services and charges mailed to you. Don't assume they will be sent to Owyhee Community Health Facility or your insurance company.



When You Get the Bill for Emergency Room Services?

1. **Check the bill against the log you created** while you were at the emergency room. Make sure you are not charged for services or medications you did not receive.
2. If there is an error on your emergency room bill, **write to your insurance company or present to OCHF Managed Care Department** and include a copy of the record you made of the services you received. We will try to help you or contact the hospital with the discrepancies with your information.
3. If your insurance company refuses to pay for the emergency room services or medications you received, don't be afraid to **file a claim.** According to ***Money Magazine*** when an HMO denies payment for emergency room services and a claim was filed, 90 percent of the claims were paid.



STEP 7

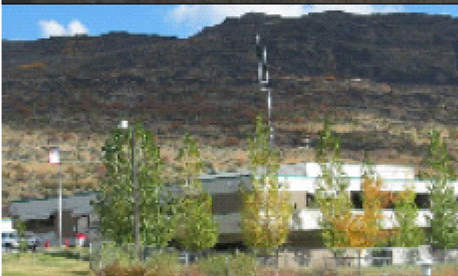
Medical Services (Vision / Eyeglasses)

The OCHF Eyeglasses Program

The OCHF's Optometry Vision/Eyeglasses Program shall be made available to all tribal members of Shoshone-Paiute Tribes and/or Native American patients that meet the CHS/Managed Care Program guidelines. It will also be the responsibility of the patient to actively participate in the financial assistance screening process.

Each eligible tribal member will be limited to ***$100.00*** for approved purchase of all new eyeglasses and ***$60.00*** for yearly eye exams per calendar year. Due to the high demand for new prescriptions, OCHF is unable to assist with eyeglass replacements or repairs.

Please Refer to: Policy and Procedure for Managed Care Assistance - Eyeglasses.



Vision – Eyeglasses eligibility is based on a *Four-Tier* process.

Tier I - Age 55 and Older

All tribal members without alternate resources and meeting the age of ***55 years of age or older*** will automatically qualify for the Owyhee Community Healthcare Facility eyeglass program.

Tier II - Diabetic and Hypertension

All tribal members without alternate resources and meeting the diagnoses classification by the Optometry Program with ***Diabetes and/or Hypertension (any age),*** will automatically qualify for the Owyhee Community Healthcare Facility eyeglass program.

Tier III - Specialized Provider Determined Medical Necessity

All tribal members without alternate resources and meeting the ***specialized diagnoses*** classification identified by the Optometry Program (i.e., specialized diagnosed with a manifestation that can only be determined by the medical provider), will automatically qualify for the Owyhee Community Healthcare Facility eyeglass program.

Tier IV - Children, High School, Full-Time College Students

Once the top three tier groups have been satisfied and/or provided for, the next tier for all tribal members without alternate resources and meeting the classification for the Optometry program will apply to the following.

i. Children in grades K-8
ii. High school students (Grades 9-12)
iii. Full-time college students
iv. All other eligible tribal members

STEP 8

Medical Specialty Services (Dental)

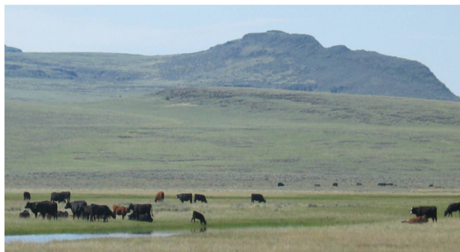
The OCHF Offsite Dental Referrals

The OCHF Dental/Offsite Referral Program is made available to all tribal members of Shoshone-Paiute Tribes and/or Native American Patients that meet the CHS/Managed Care Program guidelines. It will also be the responsibility of the patient to actively participate in the financial assistance screening process.

Notice of this special financial assistance program shall be made available where patients present and/or receive services only by the ***OCHF Dental Program***, thus meeting the required guidelines. OCHF operates under a ***Priority III*** basis. Services not deemed ***Priority III*** will be added to the Deferred List at the patient's request.

Each eligible tribal member will be limited to ***$1,500.00*** for approved offsite dental care services per calendar year. The eligibility standards for this service will be based on the payor of last resort standards, Citation CFR at Title 42 §136.61.

Please Refer to: Policy and Procedure for Managed Care Assistance for Offsite Dental Care Services.

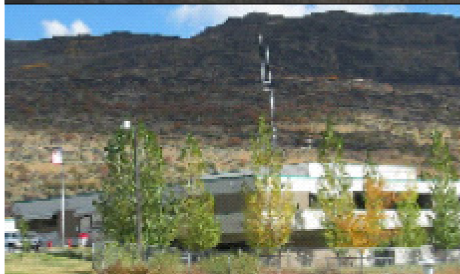


Pre-Authorization Required

All tribal members with or without alternate resources will need to meet all pre-authorization requirements. ***All dental visits*** will need an initial appointment with the OCHF dental department before ***PRIOR AUTHORIZED REFERRAL*** can be requested and submitted to OCHF Managed Care Committee (regardless of insurance coverage).

Authorization for Follow-up Visit

1. Any ***follow-up visits*** with regard to the ***initial*** referral/procedure by the referred/outside provider must have prior authorization and/or approval by OCHF medical staff. The patient must submit to facility all reports and medical information allowing the OCHF medical staff to make a suitable decision to either concur or deny any further referrals for patient care.
2. If ***follow-up care*** has been authorized by OCHF provider and assigned a proper priority level, the Managed Care Department will review his/her funding allotment for the designated year. If the funding allotment has been met, the patient will be placed on a Deferred Service List. Patient will receive a letter of confirmation when placed on the list and will be notified when funds are available.



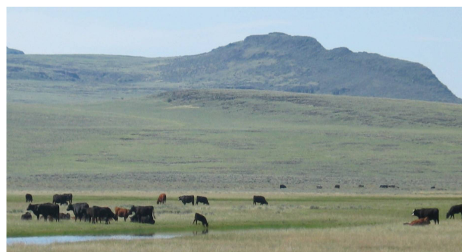
STEP 9

Medical Specialty Services (Prescriptions)

The OCHF Offsite Medical Prescriptions

This program is for OCHF's Prescription Offsite Referral Program which is made available to all tribal members of Shoshone-Paiute Tribes and/or Native American Patients that meet the CHS/Managed Care Program guidelines. It will also be the responsibility of the patient to actively participate in the financial assistance screening process.

Please Refer to: Policy and Procedure for Managed Care Assistance for Offsite Medical Prescription Services.



Pre-Authorization Required

1. All tribal members with or without alternate resources will need to meet all pre-authorization requirements. ***All Offsite Medical Prescriptions*** will need an initial appointment with the OCHF medical/dental department before ***PRIOR AUTHORIZED REFERRAL*** can be requested and submitted to OCHF Managed Care Committee (regardless of insurance coverage).

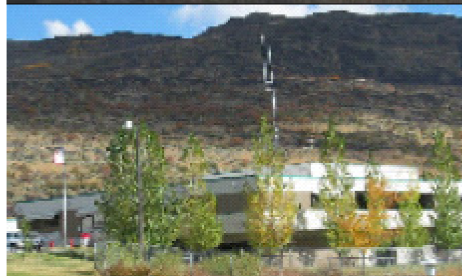
Authorization for Prescriptions

- All ***approved referred-out services*** that have connected prescriptions must have authorization to approve all medications.

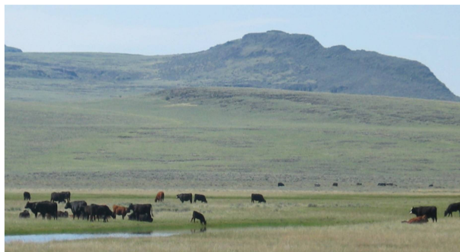
Prescribed 5-Day Medications

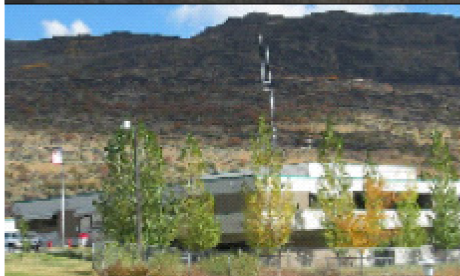
Unless otherwise approved by OCHF, if the patient is given a prescription to fill, and the patient takes medication to a pharmacy, Wal-mart, Wal-greens, etc., the pharmacist will need to contact the OCHF Managed care department for authorization.

Unless OCHF does not carry the medications, or the medications are not within its OCHF formulary and cannot be obtained within a 30-day timeframe, OCHF will authorize for a ***5-day*** prescribed filling of medications **only.** This will allow for the patient to re-enter OCHF and see our medical provider to concur with the offsite medical visit and authorized medication(s).



If OCHF is found not to have the medication in-house ***and cannot obtain the medications with the 30-day timeframe***, OCHF Managed care will authorize the requested prescription to be filled for a 30-day timeframe only. For the patient to obtain any medications for longer than 30-days, he/she must be seen by our OCHF medical providers to concur with the outside referring providers and medications requested.





STEP 10

Specialty Services (Pain Management)

The OCHF Offsite Pain Management Program

This program is for OCHF's Offsite Referrals for Pain Management Program, which is made available to all tribal members of Shoshone-Paiute Tribes and/or Native American Patients that meet the CHS/Managed Care Program guidelines. It will also be the responsibility of the patient to actively participate in the financial assistance screening process.

How Does Our Program Help You?

OCHF has established a comprehensive Pain Management Program. We will try to identify the treatable cause of your pain. Our mission is to support an effective Pain Control Program for our patients suffering from chronic or acute pain by formulating a comprehensive plan of care.

Our teams are led by OCHF medical providers in fellowship with a highly experienced and compassionate group of professionals (i.e., specialized medical programs throughout OCHF) that will help with a comprehensive approach to successfully help you manage your pain. Each patient in the OCHF Pain Management Program will receive a ***4-week*** personal evaluation to develop a course of therapy that will help make sense for you. If the ***4-week*** evaluation process indicates that you would benefit from other treatment sources, OCHF will refer you for the appropriate therapy program through our Managed Care Services.

Pre-Authorization Required

- All tribal members will need to meet all pre-authorization requirements. ***All Offsite Pain Management*** candidates will need to complete the 4-week process before ***PRIOR AUTHORIZED REFERRAL*** can be requested and submitted to OCHF Managed Care Committee (regardless of insurance coverage).

Offsite Consultation Follow-up Required

- The **1st** approved referral will be for a medical consultation with the approved OCHF Certified Pain Specialist **(ONLY)**. The patient must return to see our OCHF medical providers. After careful review of the recommended plan of care, they will either approve or deny and submit a new referral pre-authorization to continue for offsite Pain Management Services.

STEP 10 Cont.

Specialty Services (Pain Management)

Offsite Plan of Medical Care

The Referral process is to proceed to the Pain Management Committee to review, communicate and finalize the plan of care timelines with the approved Pain Management provider.

Once the plan and timelines have been approved by the Pain Management Committee the Referral will proceed to the Managed Care Committee for final approval.

Our Business Office Specialist will schedule you with an approved OCHF Certified Pain Specialist for all outpatient services, thus matching the plan of care agreed by the Offsite Provider and Pain Management Committee.

Managed Care Referral Timelines

To prevent delay for patient care, each referral will be covered for a designated timeframe. The following timelines apply:

- 2nd referral will cover a **3-month** timeframe. All the medical visits and prescriptions will be covered. These referrals must be re-authorized by our OCHF Pain Management Committee per medical compliance with program.
- 3rd referral will cover a **3-month** timeframe. All the medical visits and prescriptions will be covered. These referrals must be re-authorized by our OCHF Pain Management Committee per medical compliance with program.
- 4th referral will cover a **6-month** timeframe. All medical visits and prescriptions will be covered. These referrals must be re-authorized by the OCHF Pain Management Committee per medical compliance with program.

Special Note: All medical prescriptions for this program will be approved **ONLY** through the official OCHF Offsite Pharmacy.

Please Refer to: Policy and Procedure for Managed Care Assistance for Offsite Pain Management Program.

STEP 11

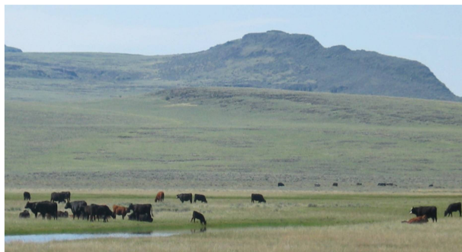
Specialty Services-(Mammogram's)

The OCHF Mammogram Program

The OCHF's Mammogram Program shall be made available and we shall encourage all women of the Shoshone-Paiute Tribes and/or Native American patients that meet the CHS/Managed Care Program guidelines to utilize the valued program. It will also be the responsibility of the patient to actively participate in the financial assistance screening process.

Each eligible tribal member without insurance will be covered for **100%** of the cost for your mobile mammogram. If you have insurance O.C.H.F will pick up the balance after your insurance has bee billed.

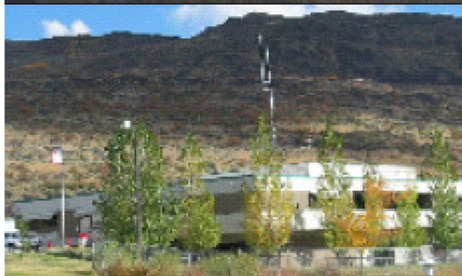
Please Refer to: Policy and Procedure for Managed Care Assistance -Mammograms



What is the process for the mammogram program?

Women wanting to be scheduled for the mammogram program should do the following;

- *Contact the O.C.H.F appointment/scheduling clerk to request an appointment with one of our O.C.H.F providers, to be examined and request a referral for your mammogram.*
- *Our medical providers will conduct a medical review, plan of care and make a referral to the O.C.H.F Mammogram program.* ***Important Note****: without a referral no procedure will be scheduled, and/or authorized for service.*
- *If the patient does not have alternative resources, the patient will be required to meet with the OCHF Benefits Coordinator and sign the approved OCHF Offsite referral notice. This notice will explain to the patient the following: (1) level of acuity I, II, and III, which signifies a timeframe to obtain and/or apply for alternate resources.*
- *The patient is allowed not to participate in the alternate resource process and can* ***opt out*** *of the OCHF Managed Care Program. If the patient chooses to opt out of the program, all costs will be the responsibility of the patient i.e., co-payments and overall cost of the designated visit.*



Please Refer to: Policy and Procedure for Offsite Referrals for OCHF Patients – OCHF Application Alternate Resources (Offsite Referrals Medical Services) FORM

.

STEP 12

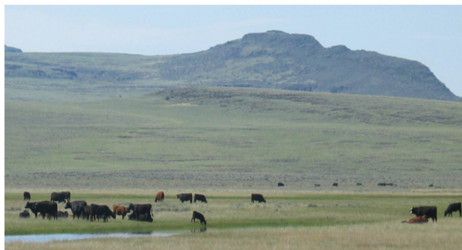
Student Health Program

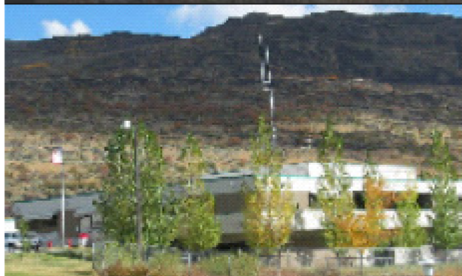
Who is eligible for the OCHF Student Contract Health Care Service Program?

Shoshone-Paiute Tribes
Sho-Pai Managed Care Health Program
AN OPERATION OF OWYHEE COMMUNITY HEALTH FACILITY
EXPIRES ON: 01/01/10
John Doe
Boise State University
THIS CARD IS PROOF THAT THE STUDENT NAMED ABOVE IS ATTENDING THE SCHOOL NOTED AND IS COVERED THROUGH THE SHO-PAI MANAGED CARE HEALTH PROGRAM. PLEASE CALL US TO VERIFY ELIGIBILITY STATUS.
MAIN NUMBER: (775) 757-2403 EXT (234)
FAX (775) 757-2351

Sample of Student Card

OCHF beneficiaries, spouses (if applicable) and/or legal dependents who temporarily leave their permanent place of residence for the sole purpose of attending programs of vocational, technical or academic study on a fulltime basis.





What is the student program process and coverage?

Students must provide the Owyhee Community Health Facility's Contract Health Care Services the following at the start of each ***semester:***

- *An official notice/document will need to be documented by your school's registrar or office of admissions to verify the student's attendance and must be documented as fulltime. Please review the OCHF Student Health Form*
- *A completed patient registration worksheet must be completed and entered by OCHF staff before approving student's program*

- *Proof of eligibility documentation for the student and all family members must be obtained before Managed Care Committee authorizes program*
- *Date of departure and intent to return to Duck Valley/Owyhee, which can be documented by airline tickets, airline boarding passes, or gas receipts if you drove to your destination*
- *Your current mailing address and phone number while attending school if OCHF Managed Care Department needs to contact you*

Students are encouraged to purchase and utilize school health insurance when available. In most cases, the benefits are excellent and the cost is minimal.

180-day Rule for Vacations, Graduation or Completion

- Student funding for healthcare includes normal breaks such as vacations for a period not to exceed 180 days after the completion of the course of study.
- Once the student has completed the course of study, if he/she chooses not to return to Owyhee/Duck Valley Indian Reservation, medical coverage is limited to emergent care for a period not to exceed 180 days.

STEP 12 Cont.

Student Health Program

What is the approval process?

Non-emergent or routine healthcare services must be authorized for payment approval ***before the receipt of medical services*** by contacting the OCHF Managed Care Service Department at (775) 757-2403 ext. 234.

Emergency care must be reported to the OCHF Managed Care Service Department within 72 hours after the beginning of the treatment including weekends and holidays (leave a voice mail on the weekends and holidays). If the person needing care is too sick or disabled, a relative, friend or the medical provider may notify the OCHF Managed Care Service Department at (775) 757-2403 ext. 234.

Dental Services must be authorized for payment approval by contacting the OCHF Managed Care Service Department ***before receipt of dental services*** by calling (775) 757-2403 ext. 234.

Prescription Services must be authorized for payment approval by contacting the OCHF Managed Care Service Department ***before receipt of any medical prescription*** for your Emergency Room, Non-Emergent dental services by calling (775) 757-2403 ext. 234.

Student and Family Healthcare Enrollments

All beneficiaries, spouses and/or legal dependents who temporarily leave their permanent place of residence for the sole purpose of attending educational programs will qualify for the OCHF student healthcare program through the 2009 spring semester.

Special Note: This program will change in regards to eligibility for the ***2009 Fall Semester.***

All beneficiaries, spouses and/or legal dependents who temporarily leave their permanent place of residence for the sole purpose of attending programs will need to qualify for this program i.e., alternate resources.

If the patient chooses to participate in the alternate resource process, he/she will need to have family members apply for Medicaid ***if they are eligible.***

If the patient does not successfully complete the Medicaid application process, the coverage for beneficiaries, spouses and/or legal dependents will not meet the standards for the Student Health Care Program. You will have to re-apply for the program for family members and attempt to apply for alternate resources once again.

Shoshone-Paiute Tribes
Sho-Pai Managed Care Health Program
AN OPERATION OF OWYHEE COMMUNITY HEALTH FACILITY
EXPIRES ON: 01/01/10
Jane Doe
University of Minnesota
THIS CARD IS PROOF THAT THE **SPOUSE** NAMED ABOVE IS COVERED AS A DEPENDENT OF OUR EDUCATIONAL **SHO-PAI MANAGED CARE HEALTH PROGRAM.** PLEASE CALL US TO VERIFY ELIGIBILITY STATUS.
MAIN NUMBER: (775) 757-2403 EXT (234)
FAX (775) 757-2351

Sample of Spouses Card

STEP 12 Cont.

Student Health Program

If the family member does not qualify do to income or is found to have alternate resources, each family member will receive an OCHF Healthcare Insurance Card to present to Emergency Rooms, Urgent Care/Medical visits, Dental visits etc.

Shoshone-Paiute Tribes
Sho-Pai Managed Care Health Program
AN OPERATION OF OWYHEE COMMUNITY HEALTH FACILITY

EXPIRES ON: 01/01/10

University of Wyoming

John J. Doe

THIS CARD IS PROOF THAT THE CHILD NAMED ABOVE IS COVERED AS A DEPENDENT OF OUR EDUCATIONAL SHO-PAI MANAGED CARE HEALTH PROGRAM. PLEASE CALL US TO VERIFY ELIGIBILITY STATUS.

MAIN NUMBER: (775) 757-2403 EXT (234)
FAX (775) 757-2351

Sample of Childs Card

Please Refer to: Policy and Procedure for Managed Care
– Student Healthcare Program for OCHF Patients
– OCHF Application for Student Healthcare Program – Form.

What is not covered for Students?

Inpatient or outpatient mental health/substance abuse treatment services.

Contract health funds will not be authorized if an Indian Health Facility or tribal health facility was open and available to provide the needed care.

TO ALL OUT-SIDE PROVIDERS
& EMERGENCY ROOM NOTIFICATION

PRIOR AUTHORIZATION must be made for all non-emergency visits ONLY to outside providers if payment is requested and/or to be paid.

If you are seen in an Emergency Room, a 72-hour notification must be made to our office at (775) 757-2403 ext (234) or the medical claim will not be approved. Please submit Claims to:

Attention: Sho-Pai Managed Care Health Program
PO. Box 130 Owyhee, NV 89832

Sample of Back of Card

This includes medical and dental services that are provided routinely through a school's health program.

Important note: Routine medical and dental needs are to be taken care of before leaving Duck Valley Indian Reservation/Owyhee Community Health Facility. Routine care includes school physicals, immunizations, vision examinations, birth control, dental care, etc.

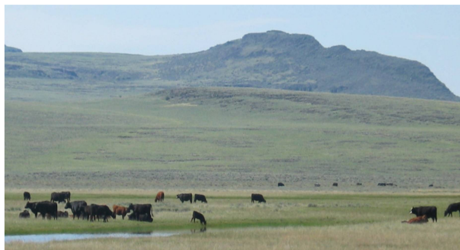
STEP 13

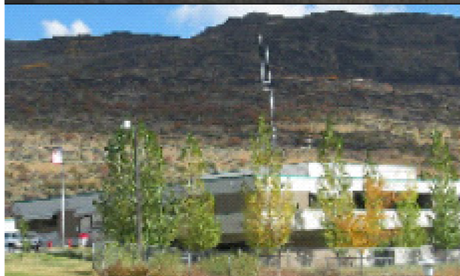
Denials and Appeal Process

What is a Denial and Appeal of Services?

A denial and appeal is a payment of services which has been requested for payment and been denied by the OCHF Managed Care/CHS program.

Each week our Managed Care Committee will meet to discuss and review all requested referrals, outstanding medical visits for payments and denials.





What is the process for the Denial and Appeal?

Each and every referral will be given complete review, research and requested approval if applicable and compliant under the payer of last resort regulations.

The regulation states: The IHS "will not be responsible for or authorized payment for Contract Health Services to the extent that the Indian is eligible for alternate resources… or the Indian would be eligible for alternate resources **were they to apply for them**." [42 CFR § 136.23 (f)]

DENIED VISITS: If the Managed Care Committee has denied your requested referral or medical bill, you will receive by certified mail the approved OCHF Denial Letter for Managed Care Program which will explain to the patient why the referral and/or medical bill has been denied.

The Most Common Reasons for Denials

- *Proof of address/residency was not provided.*
- *All patients must present their primary insurance card(s) when going to an appointment of any kind when referred through the OCHF/CHS Services. This also includes emergency room visits. Managed Care will deny payment on any bill received if the primary insurance card(s) were not presented at the time of visit.*
- *The patient did not call OCHF Managed Care within 72 hours following an emergency room service or hospital stay.*
- *The patient resides outside the OCHF service delivery area [CHSDA], and thus is ineligible for OCHF Managed Care Services. [6-Month -/- 180-Day Rule]*
- *The patient is presently visiting and/or lives within the OCHF Service Delivery Area but is covered by another CHS service delivery area. [2-Month -/- 60-Day Rule]*

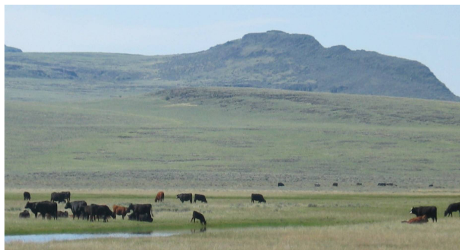
STEP 13 Cont.

Denials and Appeals

- *Request for specialty care services did not meet the level of care requirements of the Contract Health Services Program Committee at their review*
- *The patient did not sign or date referral or sign waiver document and take a copy of the referral to the appointment.*
- *The patient did not apply for potential resources or establish alternate resources or did not use the resources he/she had available.*
- *Medical Review of the patient's emergency room report did not support the necessity for using the emergency room.*

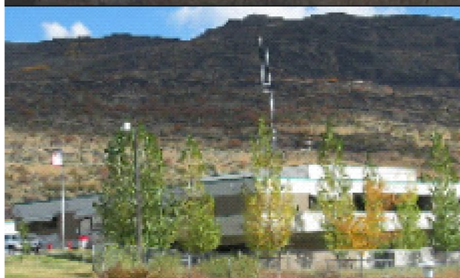
APPROVED VISITS: If the Managed Care Committee has authorized a requested referral, the patient will be given the approved OCHF Managed Care Referral Approval Notice which will explain to the patient the following:

- *The appointment time/date*
- *Reason for the referral*
- *Provider's address*
- *If your paperwork has been faxed and/or mailed to their office*
- *Whether you have third-party insurance and what type of insurance you have to present. This will help the referral provider, thereby preventing any delay in payment of your claim.*



What Should I Do if I Disagree with a CHS/Managed Care Denial Letter?

1. You should write a letter of appeal asking for your case to be reconsidered for payment.
2. This letter of appeal must be sent within ***30 days*** of receiving your denial letter.
3. The letter should state the reason you think the denial was a mistake and should include any additional information that has been previously submitted. If you wish to utilize the approved OCHF Managed Care Appeal Form, please contact our office or stop by the Managed Care Department and request a copy of the document.
4. Your letter should to be addressed to the Owyhee Community Health Facility, c/o: Tribal Health Administrator, PO Box 130, Owyhee, Nevada 89832 with a copy to the Contract Health Services Supervisor.
5. If the denial is upheld after review by the THA of OCHF and you still disagree, the next step is to appeal to the OCHF Governing Health Board. This appeal process is to be done within the next ***30 days*** of receiving your denial letter of the 1st appeal.



STEP 13 Cont.

Denials and Appeals

6. Your letter should be addressed to the Owyhee Community Health Facility, c/o: OCHF Governing Health Board, PO Box 130, Owyhee, Nevada 89832 with a copy to the Tribal Health Administrator.
7. If your denial is upheld after review by the OCHF Governing Health Board and you still disagree, the next step is to appeal to the Shoshone-Paiute Tribal Council. This appeal process is to be done within the next ***30 days*** of receiving your denial letter of the 2nd appeal. This final appeal, if upheld and/or overturned, the ruling will be final.

Please Refer to: Policy and Procedure for Managed Care Assistance for Denial on Medical Referrals.

Please Refer to: Policy and Procedure for Managed Care Assistance for Appeals Process.

Important Things Patients Really Need to Remember to Prevent Denials

1. Not everyone is eligible for OCHF Managed Care/CHS.
2. Eligibility is determined by federal regulations (eligibility criteria).
3. OCHF Managed Care/CHF has the authority to tell you if you are eligible for CHS when you get a referral from a doctor. ***Anyone else is just guessing.***
4. Just because an OCHF Doctor refers you, it does not mean CHS can pay your bills.
5. Going to a hospital ER on your own, such as St. Luke's (Boise, ID), when OCHF is open will usually result in a denial since OCHF was available.
6. When a patient receives checks for payments or partial payments of medical or dental bills from his/her insurance company and ***CASH*** the checks without applying the entire amount to the bill, OCHF Managed Care/CHS ***will not be responsible*** for any portion of that medical bill. It will be the patient's responsibility to pay for that bill.
7. **Keep your Insurance.** If you have health insurance, we can pay for your deductible and any balances after the insurance company pays, assuming you meet all requirements of our Managed Care/CHS Program. For those who have insurance, all correspondence from insurance stating what they have paid or denied must be sent to us within ***60 days*** (Private Insurance, Medicare, etc.). If you fail to comply with the requirements of your primary insurance, Managed Care/CHS may deny payment. We pay only after all alternate resources have responded.

Please Refer to: Policy and Procedure for Offsite Referrals for OCHF Patients – OCHF Application Alternate Resources (Offsite Referrals Medical Services) Form.

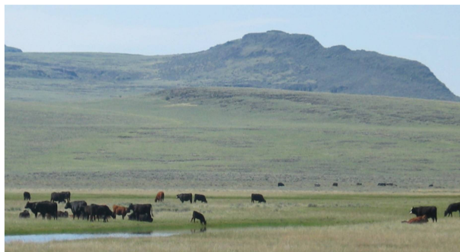
STEP 13 Cont.

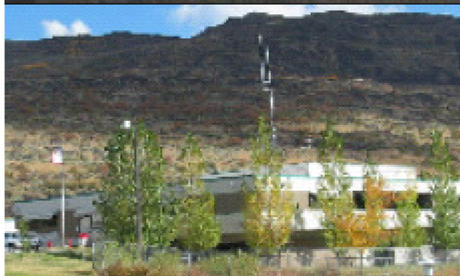
Denials and Appeals

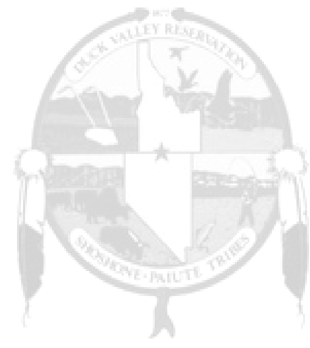
Denials due to Lack of Medical Priority - *Examples not covered:*

- Durable medical equipment to be used at home (such as wheelchairs, bedside commodes, shower chairs, hospital beds, dressings, etc.)
- Prescribed medications to be take at home
- Home healthcare and hospice
- Outpatient physical therapy (service is available at other IHS facilities)
- Allergy testing and shots
- Dermatology for skin conditions that do not threaten life or limb (such as acne or hair implants)
- Massage therapy, naturopathic therapy, biofeedback, chiropractics, acupuncture
- Cataract surgery unless it is medically approved due to severe vision loss and there are long delays having the procedure done in the IHS Facility

*OCHF has to **follow the regulations** to continue receiving CHS funds or to justify asking for more funds in the future.*







STEP 14

Catastrophic Health Emergency Fund

What is the (CHEF) program?

The fiscal year (FY) 1987 Appropriation Act for the IHS, PL 99-591, established the CHEF solely for meeting the extraordinary medical cost associated with the treatment of victims of disasters or catastrophic illness who are with the responsibility of IHS.

The term, "Catastrophic Illness" refers to conditions that are costly by virtue of the intensity and/or duration of their treatment. Here are some examples of conditions that frequently require multiple or prolonged hospital stays and extensive treatment after discharge. Examples are as follows:

- Cancer, Burns, High-risk Births, Cardiac Disease, End-stage Renal Disease, Strokes, Trauma-related Cases such as automobile accidents and gunshot wounds, some Mental Disorders

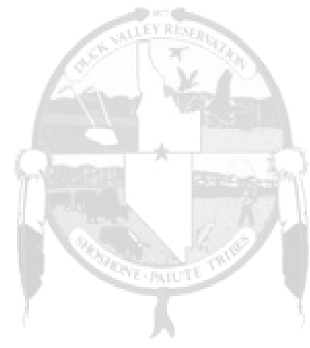
What are the Resources of CHEF?

The resources of CHEF will be expanded according to the basic requirements of the CHS program and will be made available to partially reimburse for expenditures on patients who incur extraordinary medical costs.

Requirements for alternate resources shall be met before reimbursement can be expected from the CHEF program. The CHEF reimbursements shall be applied only to cases that have been reviewed and approved by the CHS Committee, and amounts not used because of payments by alternate resources or cancellations shall be returned to the OCHF CHEF account.

This is not a guarantee that these funds will be available when your catastrophic case happens. IHS/CHS examples had six qualified CHEF cases in FY 2005. Of these cases submitted, there were only three that received additional funding which amounted to $62,851. The CHEF monies are available beginning October 1 of each fiscal year. If your case happens at the beginning of the fiscal year, CHEF funding is more likely to be approved. If your case happens in March or after, as in our case, CHEF funding may be denied as funding may not be available.

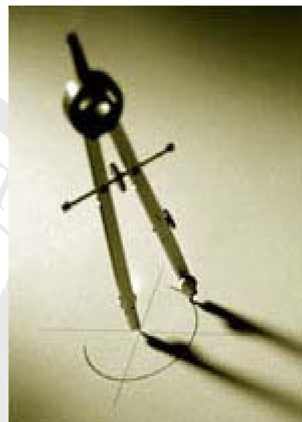
- The CHEF threshold is adjusted according to the CHEF experience within the range established by law. Once a member has exceeded medical expenses of $24,500-$25,000, threshold changes each year based on consumer price index.
- The cost threshold includes only those costs remaining after payment has been made by Federal, State, Local, and Private health insurance or other applicable alternate resources.



STEP 15

Contract Service Delivery Area

Home Care Away from Home Reservation



Two types of services are provided by Owyhee Community Health Facility: (1) Direct healthcare services which are provided at any IHS or Tribal (638) Facility, or (2) Contract health services (CHS) which are provided by a non-IHS facility or provider through contracts with the OCHF.

CHS is provided principally for members of federally recognized tribes who reside on or near the reservation established by Congress through Code of Federal Regulation (CFR) at Title 42, Part 136 Subparts A – C.

The IHS is to designate and publish as a notice in the Federal Register specific geographic areas within the United States including Indian reservations and areas surrounding those reservations as CHSDA's.

Referenced to Federal Register/Vol. 72, No. 119/Thursday, June 21, 2009/Notices

The Description of the OCHF Contract Health Service Delivery Area

For the purpose of the Federal Register, notice to revise and update the list of the CHSDA's was last published in 2007. The current eligibility regulation at 42 CFR §136.22 (a)(1)-(5) defines certain CHSDA's by designating some states as CHSDA's and certain counties within a state as a CHSDA. In addition, Section §136.22(a)(6) provides that:

With respect to all other reservations (i.e., other than those not specifically listed in 42 CFR §136.22(a)(1)-(5)) within the scope of the Indian Health Program, the CHSDA ***shall consist of the county which includes all or part of the reservation, and any county or counties which have a common boundary with the reservation.***

The counties included or excluded from the following list of CHSDA's were determined by applying the regulations at 42 CFR §136.22. The CHSDA list has been modified and updated to include the name of the tribe, with the respective reservation and counties comprising the CHSDA.

Referenced to Federal Register/Vol. 72, No. 119/Thursday, June 21, 2009/Notices

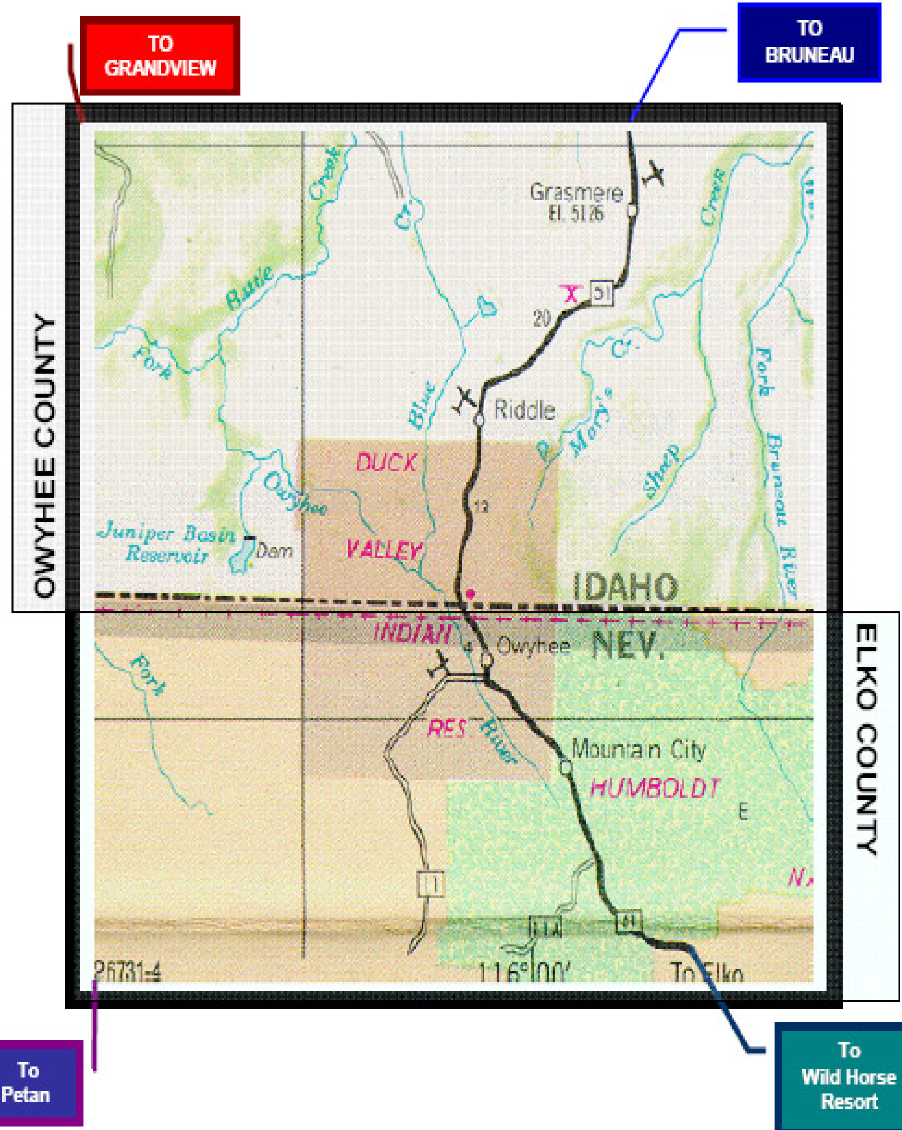
STEP 15 Cont.

Contract Service Delivery Area

Our Owyhee Community Health Facility's CHSDA

The Shoshone-Paiute Tribes of Duck Valley Reservation CHSDA is defined as follows:

- All Direct/CHS members that reside within the Shoshone-Paiute Tribes of Duck Valley Reservation CHSDA Area will encompass the designated counties of Owyhee County, ID and Elko County, NV.
- A 60-mile geographical ***boundary line*** will connect the borders of Grandview, ID, Bruneau, ID, Petan, NV and Wild Horse Resort, NV. In



STEP 16

CHS Authorization Process Flow

THE DIAGRAM ILLUSTRATES THE KEY PROCESSES involved when a patient receives authorization for CHS or whose care is deferred or denied.

PATIENT

Patient referred by OCHF providers

- **E.R VISIT (SELF-REFERRAL)** → **NOTIFY OCHF MANAGED CARE OFFICE**
- **OCHF PROVIDER REFERRAL** → **REFERRAL FORWARDED TO CHS OFFICE**

→ **7-DAY REFERRAL EXAMINATION & ELIGIBILITY REVIEW**

→ **CHS REVIEW COMMITTEE**

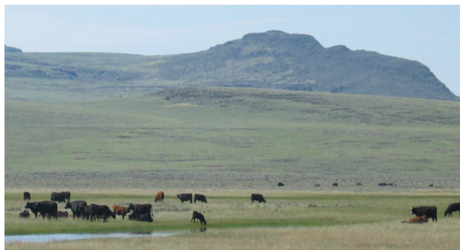
Medical Review to determine the medical or dental priority and to develop a spending plan – monthly cost assessment

- **APPROVED** → **OCHF CHECK RUN** → **PURCHASE ORDER ISSUED** → **PAYMENT MADE TO PROVIDER**
- **DEFERRED** → **DEFERRED LETTER ISSUED**
  - *Represents an unmet need; the service has not been received. Patient can receive the service and pay with own funds or can wait to see if O.C.H.F. has funds available at the end of the fiscal year.*
- **DENIED** → **DENIAL LETTER ISSUED** → **APPEAL PROCESS (1) T.H.A** → **APPEAL PROCESS (2) HEALTH BOARD** → **APPEAL PROCESS (3) TRIBAL COUNCIL**
  - *O.C.H.F. will not pay for the care*

STEP 17

Managed Care Glossary and Terms

Alternate Resources – The available and accessible IHS facilities and those non-IHS healthcare resources. Such resources include healthcare providers, institutions and healthcare programs for payment of health services including but not limited to programs under Titles XVIII and XIX of the Social Security Act, Medicare, Medicaid, state, local healthcare programs and private insurance.



Appeal – An application (as to a recognized authority) for corroboration, vindication or decision

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

Billing Statement – The amount of business done by a firm, especially a doctor's office/hospital, within a specified period of time. The total amount of the cost of services billed to a customer, usually covering medical services made or services rendered within a specified period of time

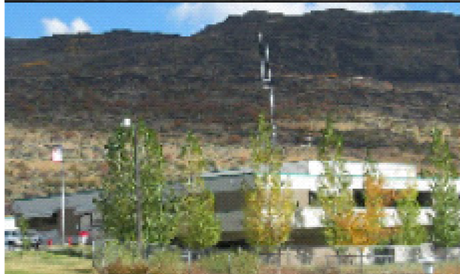
Case Management – A process by which an enrollee with a serious, complicated or chronic health condition is identified by a managed care organization and a plan of treatment is established in order to achieve optimum health in a cost-effective manner

Catastrophic Health Emergency Fund (CHEF) – The fund to cover the IHS/OCHF portion of medical expenses for catastrophic illnesses and events falling within IHS/OCHF responsibility

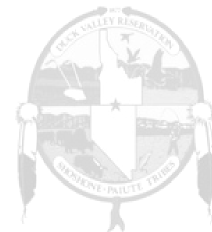
Co-Insurance – A provision in insurance policies that requires the enrollee to pay a percentage of all eligible medical expenses in excess of the deductible

Consultation – Deliberation between physicians on a case or its treatment

Contract Health Service Delivery Area (CHSDA) – Geographic area within which contract health services will be made available by the OCHF to members of an identified Indian community residing in the area (Reference Federal Register, Vol. 72, No. 119 June 21, 2007)



Contract Health Services Eligible Person – A person of Indian descent belonging to the Indian community/tribe with a Certificate of Indian Blood, proof as a member or a descendent of a Native American tribe residing within the United States on a reservation located 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 that tribe or tribes.



STEP 17 Cont.

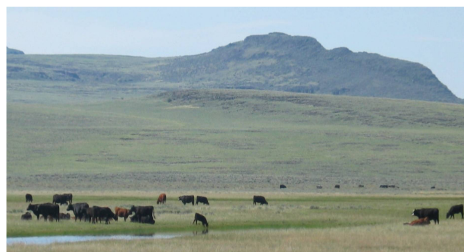
Managed Care Glossary and Terms

Contract Health Services to Support Direct Care – These are provided within an IHS/Tribal facility when the patient is under direct supervision of an IHS/Tribal physician or a contract physician practicing under the auspices (or authority) of the IHS/Tribal facility.

Co-Payment – A provision in insurance policies that requires the enrollee to pay a flat fee for certain medical services

Deductible – The portion of eligible medical expenses that the enrollee must pay before the plan will make any benefit payments

Denied – To refuse to accept as true or valid. **DENY** implies a firm refusal to accept as true, to grant or concede, or to acknowledge the existence or claims of <*denied* the charges>.



Eligibility – The established conditions as identified in the Federal Regulations that a person must meet in order to receive the healthcare services

Emergency Care – A medical emergency includes severe pain, an injury, sudden illness or suddenly worsening illness that would cause a reasonably prudent layperson to expect that delay in treatment may cause serious danger to the person's health if he/she does not get immediate medical care.

Explanation of Benefits (EOB) – Written statement to a beneficiary, from a third-party payer after a claim has been reported, indicating the benefits and charges covered or not covered by the dental benefits plan

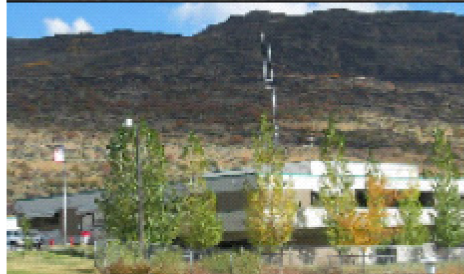
Fiscal Intermediary – The fiscal agent contracted by IHS to provide and implement a system to process CHS medical and dental claims for payment.

Follow-Up – Maintenance of contact with or examination of a person (as a patient) especially **following** treatment

Formulary – A list of prescription medications covered by an insurance plan

Global Fees – The contracted payment amount for a defined subset of services encompassing the combined technical and professional charges or payment. For diagnostic procedures, this includes both the professional and technical components which may be subject to specific billing procedures.

Independent Review – An appeal process in which a healthcare professional with no connection to an enrollee's health plan reviews a dispute whether treatment is medically necessary or experimental



In-House Referral – The **referral** of a patient by a general practitioner to another general practitioner within the same practice for a second opinion on the need for secondary care **referral**

Non-Compliant – Refusing or failing to obey

STEP 17 Cont.

Managed Care Glossary and Terms

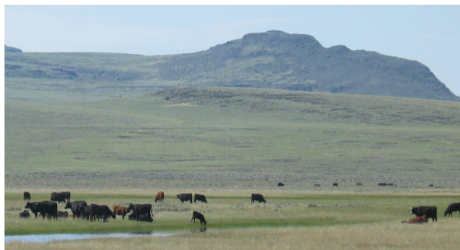
Pre-OP – Occurring before a surgical operation <*preoperative* care>

Pending – Not yet decided, being in continuance <the case is still *pending*>

Pre-authorization/Pre-certification – A provision in insurance policies that requires prior approval by a healthcare plan or by a limited service health organization for services to be covered by a plan

Primary Care Provider – A physician, such as a general practioner or internist, chosen by an individual to serve as his/her healthcare professional and capable of handling a variety of health-related problems, keeps a medical history and medical records on the individual and refers the person to specialists as needed

Primary Insurance – Coverage under an insurance policy in which the insurer is immediately liable upon the happening of a covered event



Referral – A process by which the primary care physician makes a request to a managed care/insurance plan on behalf of the enrollee to receive medical care from a nonparticipating provider or specialist

Secondary Insurance – Term utilized when referring to the presence of **insurance coverage** through two different sources at the same time. For example, a husband and wife may each have **insurance coverage** through their respective employers.

Surgery – A surgical operation or procedure, especially one involving the removal or replacement of a diseased organ or tissue

Urgent Care – Medically necessary care for an accident or illness that is needed sooner than a routine doctor's visit

72-Hour Notification – The patient or patient's representative must notify the OCHF Managed Care Program within 72 hours of the start of emergency services. If you are **65 years of age or older and/or disabled**, you have 30 days to notify Contract Health Service of your emergency care **(§406 of P.L 94-437, as amended).**