

PONCA TRIBE OF NEBRASKA
Contract Health Service Program

ALTERNATE RESOURCE LETTER

Date: ____/____/____

The information that has been provided to the CHS Office indicates that you may be qualified for an alternate resource. Pursuant to IHS regulations, 42 CFR Part C, attached, you are required to make a good faith effort to apply for and complete an application for alternate resources. You must provide this facility with a copy of the alternate resource program's eligibility determination.

THE APPLICATION PROCESS REQUIRES YOU TO DO THE FOLLOWING:

- () A. You must contact _____
to make an application, schedule an appointment and attend the appointment as scheduled.
- () B. You will need to bring the following documentation to the appointment:

You might also have to provide the alternate resource program with additional documentation specifically requested prior to or during your appointment.
- () C. The CHS office will provide/assist you in obtaining transportation for you to attend your scheduled appointment. Please contact _____ for more information.

IF YOU ARE UNABLE TO APPLY FOR AN ALTERNATE RESOURCE OR ARE HAVING DIFFICULTY APPLYING, THE CHS OFFICE IS AVAILABLE TO ASSIST YOU. PLEASE CONTACT _____ FOR ASSISTANCE. IF AN ALTERNATE RESOURCE APPLICATION IS NOT COMPLETED, OR IF YOU DO NOT CONTACT THE CHS OFFICE FOR ASSISTANCE IN COMPLETING AN APPLICATION WITHIN 30 DAYS OF THE DATE OF THIS NOTICE, A CHS DENIAL LETTER WILL BE ISSUED.

Sincerely,

Contract Health Services

PONCA TRIBE OF NEBRASKA CONTRACT HEALTH SERVICES

Release of Medical Information

In order for the Ponca Tribe of Nebraska to process claims on your behalf, we will need you to sign the release statement below:

AUTHORIZATION TO RELEASE MEDICAL INFORMATION
<p>I authorize any physician, medical practitioner, hospital, clinic, veterans administration facility, other medical or medically-related facility, insurance or reinsuring company, Social Services, General Assistance, the Medical Information Bureau, Inc., or Consumer Reporting Agency having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or my minor children and any other non-medical information of me or my minor children to give to the Ponca Tribe of Nebraska or their legal representative, any and all such information.</p> <p>I understand the information obtained by Use of the authorization will be used by the Ponca Tribe of Nebraska to determine eligibility for benefits under an existing health Contract. Any information obtained will not be released by the Ponca Tribe of Nebraska to any person or organization.</p> <p>I know that I may request to receive a copy of this authorization. I agree that a photographic copy of this authorization shall be as valid as the original. I agree that this authorization shall be valid until revoked.</p>

NAME		P.I.N.	
SIGNATURE		DATE	-----/-----/-----

Ponca Contract Health Services (CHS) Summary of Services

CHS funds are used to supplement and complement other health care resources available to eligible Indian people. Because Indian Health Service (IHS) programs are not fully funded, the CHS program must rely on specific regulations relating to eligibility, notification, residency, and a medical priority rating system. IHS is designated as the payor of last resort meaning that all other available alternate resources must first be used before payment is expected. These mechanisms enhance the IHS to stretch the limited CHS dollars and designed to extend services to more members.

Ponca Tribe of Nebraska offers its members limited routine services. As for specialized care, the member/provider must submit the referral and all pertinent information to the Contract Health Department so that a determination can be made in regards to approval or denial of such referral.

Please note: Services cannot be approved or authorized until the CHS office has received the above information. You will also be asked to update your client information on a yearly basis (or as needed). If your update reflects a new address, you will be requested to provide proof of residency.

Coverage: (All ages)

- Maximum of two primary medical (family physician) visits per year
- Specialized services
- Vision services **(See Vision Care Policy)**
- Emergency services
- Prescriptions
 - CHS will cover prescriptions following an emergency visit
 - CHS will cover prescriptions before and after surgeries
 - CHS will cover prescriptions following an inpatient stay
- NOTE:* There is no coverage on refills
- Dental services
 - One initial or periodic oral exam per year
 - ❖ Includes x-ray, prophylaxis, fluoride and sealants
 - ❖ Amalgam Restorations/Composite Restorations (fillings)
- Emergency Dental services **(See Emergency Dental Policy)**
 - CHS will cover prescriptions after an emergency dental visit
- Yearly Required Physicals (18 & under for grades K-12)
 - Includes all needed immunizations and series

Coverage: (Elderly 65 and over) * **See Elderly Care Plan as there are special guidelines to this plan**

- Primary Care Medical Services
 - Prescription services
- NOTE:* Elderly are eligible for all services listed above regardless of their coverage

To be eligible for the Elderly Care Plan where you have unlimited access to your primary care physician, you must have Medicare Part B or Insurance. To be eligible for unlimited access for prescriptions you must have Medicare Part D or Insurance coverage for prescriptions. The elderly must be denied from Medicaid and must provide proof of such denial. If you do not have Medicare Part B/D or Insurance, you are not eligible for the elderly care plan. It is the members' decision as to whether or not they want to participate in this program as CHS cannot require that a member pay out of pocket to meet an alternate resource.

Disabled: Prescription co-payment coverage only if the member is covered by Medicaid and/or Medicare because of disability. - Proof will be requested)

MEDICAL SERVICES

IHS ALLOWABLE SERVICES – INCLUSIONS, EXCLUSIONS, AND LIMITATIONS OF THE CHS PROGRAM

1. Contingent upon the current level of funding the following services, though not exhaustive, may be covered under the CHS program:
 - a. Physician services
 - b. Inpatient hospital services
 - c. Outpatient medical/surgical services including emergency room services at free-standing ambulatory or hospital based locations
 - d. Outpatient evaluative and crisis intervention mental health services
 - e. Medical service for substance abuse
 - f. Diagnostic laboratory and diagnostic and therapeutic radiologic services
 - g. Home health services, if within medical priorities (e.g., a cancer patient can be treated at home more cost effectively than being admitted to the hospital for treatment)
 - h. Preventive health services
 - i. Skilled nursing home services as defined by Medicare regulations
 - j. Optometry services
 - k. Dental services
 - l. Physical medicine and rehabilitative services within medical priorities
 - m. Prescription drugs
 - n. Chiropractic services, for subluxation of the spine as demonstrated by x-ray, when specifically ordered by a physician.
 - o. Acupuncture services when provided by a physician
 - p. Autopsies when ordered by an IHS physician for clinical purposes only
 - q. Services provided in accordance with a Federal court order
 - r. Prosthetic devices
 - s. Medical Laboratory and x-ray
 - t. Podiatry services
 - u. Transportation and per diem for patient

- v. Transportation and per diem for escort for patients who are unable to travel without assistance (e.g., children and handicapped adults)
- w. Extended care facilities, refer to Exhibit IX, 25.2M in the IHS Manual

2. The following services, though not exhaustive, are specifically excluded:

- a. Services and supplies that are not necessary for the diagnosis and treatment of a covered illness or injury
- b. Custodial care
- c. Domiciliary care
- d. Intermediate nursing home care
- e. Services and supplies for which the Indian person has no legal obligation to pay or for which no charge would be made if the individual were not eligible for IHS
- f. Services or supplies furnished by local, State, or other Federal programs
- g. Abortions as prescribed by regulations at 42 CFR, Subpart F
- h. Naturopaths
- i. Burials including other related funeral expenses
- j. Housekeeper and companion services
- k. Personal comfort and/or convenience items such as beauty and barber services, radio, telephone, and television
- l. Services to persons in the custody of local, State, and Federal law enforcement agencies
- m. Services or costs related to deceased persons who are “dead upon arrival” at contract facilities. It is not appropriate to deny ambulance charges for treatment en route to an IHS or contract facility unless the patient has been pronounced dead at the scene by appropriate medical personnel

**INDIAN HEALTH SERVICES MEDICAL PRIORITIES
CONTRACT HEALTH SERVICES MEDICAL CARE**

PART ONE – APPLICATION OF IHS MEDICAL PRIORITIES

PART TWO – DESCRIPTION OF MEDICAL PRIORITY LEVELS

- I. EMERGENT/ACUTELY URGENT CARE SERVICES
- II. ACUTE PRIMARY AND PREVENTIVE CARE SERVICES
- III. CHRONIC PRIMARY AND SECONDARY CARE SERVICES
- IV. CHRONIC TERTIARY CARE SERVICES
- V. EXCLUDED SERVICES

APPENDIX I: EXAMPLES OF DIAGNOSES THAT USUALLY REQUIRE
EMERGENT/ACUTELY URGENT CARE SERVICES

APPENDIX II: EXCLUDED SERVICES

- A. COSMETIC SERVICES
- B. EXPERIMENTAL AND OTHER EXCLUDED SERVICES

PART THREE – TYPES OF IHS/TRIBAL FACILITIES

TYPES OF IHS/TRIBAL FACILITIES – DESCRIPTION

LEVELS OF DIRECT/CHS CARE PROVIDED BY IHS FACILITIES – TABLE

DATE: June, 1993

PART ONE – APPLICATION OF IHS MEDICAL PRIORITIES

GENERAL

The Indian Health Services (IHS) Medical Priorities will be reviewed annually. Any changes in the definitions, categories, or excluded procedures list will be distributed to all Areas by the office of Health Programs (OHP).

Each IHS Area will develop Area Medical Priorities that are consistent with IHS Medical Priorities. Each Area will submit copies of their respective contract health services (CHS) medical priorities list to Headquarters CHS Branch, each time they are updated.

Each Area shall integrate their medical priorities with annual spending plans, since the availability of funds determines the level of medical care that can be provided. It is expected that each service unit will have actively functioning CHS management committees to develop and implement spending plans and authorize payment for CHS referrals in compliance with Area Medical Priorities.

When reviewing appeals and issuing final opinions on CHS care that has been denied because of medical priorities list. Where conflict exists, IHS Medical Priorities will take precedence.

Patients and providers will not be issued a payment denial letter for “lack of funds.” If the care required is not within medical priorities, and the patient is otherwise eligible for CHS, the denial letter shall explain that payment for care is denied because it is not within medical priorities.

REQUESTS FOR PAYMENT WITHOUT PRIOR AUTHORIZATION

When emergency care is performed in non-IHS facilities without prior authorization, a review of the patient’s eligibility status, compliance with notification requirements, and clinical information must be performed prior to approving CHS payment. Payment should be authorized only for those cases falling within established medical priorities, and meeting all other CHS requirements.

The condition of the patient and manner in which the patient presented for care should be taken into account. The decision to approve or deny payment should not be based solely on the final diagnosis.

LEVEL II SERVICES – PREVENTIVE

The IHS requires a high priority for preventive health care services. Level II services are distinguished from emergency care, sophisticated diagnostic procedures, treatment of acute conditions, and care primarily intended for symptomatic relief or chronic maintenance.

Most services listed as Level II are available at IHS direct care facilities. When these services are purchased using CHS funding, it is usually requested by an IHS or tribal service unit with no direct care capabilities. In addition, IHS direct care facilities may, at times, find it necessary to purchase or defer these types of services, if they are unable to directly provide for all their patient’s preventive health care needs.

ELECTIVE REFERRALS INITATED BY IHS PROVIDERS

When patients are referred for elective procedures, consultation, outpatient care, or inpatient care, payment for eligible patients should be authorized only when the care required is medically necessary and falls within established medical priorities. All referrals will be reviewed and approved in a prescribed manner.

The condition of the patient at the time of the referral will influence the ultimate determination of Level III and IV services. In order to determine whether or not the needed care is within established medical priorities, the following questions should be considered:

1. What is the rate of determination of the patient's condition (is the needed service deferrable or non-deferrable)?
2. What will be the potential morbidity of the patient, if the desired care is not rendered (are there any uncertain, but potentially grave outcomes?)
3. What is the expected benefit from the evaluation or treatment (will the care result in a cure or improvement)?
4. Is the procedure experimental or purely cosmetic (is the requested service on the excluded list)?

Controversial types of therapy shall have a rigorous review by the CHS committee. Services such as disc surgery, hysterectomies, tonsillectomies and adenoidectomies, portacaval shunts, obesity surgery, etc., may necessitate a second opinion process established by the Area Chief Medical Officer.

In general, authorization should be made for only one visit at a time, or for a prescribed number of visits. If additional procedures or care are required, the medical priority of the follow up request may be different. Patients should be asked to return for another referral.

EXCLUDED SERVICES

Level V (excluded services) includes cosmetic procedures (see Part Two, (V.A) and procedures excluded from authorization for CHs payment (see Part Two, V.B). The OHP will review the list on an annual basis and notify Area CMOs of any addition or deletions. The list is based upon the Medicare Coverage Issuance Manual; the first intermediary will not pay a claim for a potentially cosmetic procedures listed in Appendix II.A unless approval is received from the CMO. This may be granted if one of the listed procedures, normally considered cosmetic, is necessary for proper mechanical function or psychological reason.

Payment for excluded procedures listed in Appendix II.B will not be paid by the fiscal intermediary, unless a formal exception has been granted by the OHP (see IHS Circular 93-03, "Cosmetic and Experimental Procedures Review").

PART TWO – DESCRIPTION OF MEDICAL PRIORITY LEVELS

I. EMERGENT/ACUTELY URGENT CARE SERVICES

Definition: Diagnostic or therapeutic services that are necessary to prevent the immediate death or serious impairment of the health of the individual, and which, because of the threat to the life or health of the individual, necessitate the use of the most accessible health care available and capable of furnishing such services. Diagnosis and treatment of injuries or medical conditions that, if left untreated would result in uncertain but potentially grave outcomes.

Categories of Services Include (random order):

- 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 dialysis, 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 perinatal care
- Neonatal care

See Appendix I for examples of specific diagnoses.

II. PREVENTIVE CARE SERVICES

Definition: Primary health care that is aimed at the prevention of disease or disability. This includes services 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). Level II services are available at most IHS facilities.

Categories of Services Included (random order):

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

III. PRIMARY AND SECONDARY CARE SERVICES

Definition: Inpatient and outpatient care services that involve the treatment of prevalent illnesses or conditions that have a significant impact on morbidity and mortality. This involves treatment for conditions that may be delayed without progressive loss of function or risk of life, limb, or sense. It includes services that may not be available at many IHS facilities and/or may require specialty consultation.

Categories of Services Included (random order):

- 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
- Diagnostic evaluations for non-acute conditions
- Specialized medications not available at IHS facility, when no suitable alternative exists

IV. CHRONIC TERTIARY AND EXTENDED CARE SERVICES

Definition: Inpatient and outpatient care services that (1) 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 tertiary care facilities. These services are not readily available from direct care IHS facilities. Careful case management by the service unit CHS committee is a requirement, as is monitoring by the area CMO or his/her designee. Depending on cost, the referral may require concurrence by the CMO.

Categories of Services Included (random order):

- Rehabilitation care
- Skilled nursing home care
- Highly specialized medical services/procedures
- Restorative orthopedic and plastic surgery
- Other specialized elective surgery such as obesity surgery
- Elective open cardiac surgery
- Organ transplantation (Health Care Financing Administration (HCFA) approved transplants only)
- Care provided under the direction of an advance directive

V. EXCLUDED SERVICES

Definition: Services and procedures that are considered purely cosmetic in nature, experimental or investigational, or have no proven medical benefit.

- A. Cosmetic Procedures – Payment for certain cosmetic procedures may be authorized if these services are necessary for proper mechanical function or psychological reasons. Approval from the CMO is required.
- B. Experimental and Other Excluded Services – Payment is not authorized, unless a formal exception is grant by OHP.

The list of therapies and procedures classified as potentially cosmetic in nature, experimental, or excluded will be reviewed and updated on an annual basis.

Categories of Excluded Services:

- All purely cosmetic (not reconstructive) plastic surgery
- Procedures listed as experimental by HCFA
- Procedures for which there is no proven medical benefit – procedures listed as “Not Covered” in the Medicare Coverage Issuance Manual, Section 27.200
- Extended care nursing homes (intermediate or custodial care)
- Alternate medical care (e.g., homeopathy, acupuncture, chemical endarterectomy, naturopathy)

See Appendix II.A for listing of procedures that are considered to be potentially cosmetic in nature, and Appendix II.B for listing of procedures considered to be experimental or otherwise excluded from coverage.

APPENDIX I.

LEVEL I PRIORITY: EXAMPLES OF DIAGNOSES THAT USUALLY REQUIRE
EMERGENCY/ACUTELY URGENT CARE SERVICES
(NOT AN ALL INCLUSIVE LIST)

Airway obstruction	Hernia, strangulated or ruptured
Abscess	Hypercalcemia
Amputation, traumatic	Hypertension, crisis or emergency
Anaphylaxis	
Appendicitis	Lacerations
Arrhythmia	
Asthma, acute	Meningitis
	Menorrhagia, profuses
Burns	Migraine, acute attacks
	Musculoskeletal trauma, acute
Cholecystitis, acute	Myocardial ischemia, acute
Coma	Myocardial infarctions
Concussion	
Congestive heart failure, decompensated	Obstetrical emergencies
Dehydration, severe	Pancreatitis
Delirium tremens	Pelvic inflammatory disease
Diabetic ketoacidosis	Peritonitis
Drowning, near	Pneumonia
	Pneumothorax
Embolism, cerebral or peripheral	Poisoning
Encephalitis	Premature infant
Epididymitis, acute	Pulmonary embolism
Epiglottitis	Pulmonary edema
Eye diseases, acute	Puncture of stab wounds
Eye injuries	
	Rape, alleged examination
Flail chest	Renal lithiasis, acute
Fractures	Renal failure, acute
	Respiratory failure
Glomerulonephritis, acute	
Gunshot wounds	Sepsis
	Shock
Head injury	Spinal column injuries
Heat exhaustion and prostration	Suicide attempt
Hemoptysis	
Hemorrhage	Urinary retention, obstruction
Hepatic encephalopathy	

APPENDIX II.

LEVEL V.A.: COSMETIC PROCEDURES

HCPCS – HCFA

HCPCS

T1110 Argon Laser Treatment for Congenital Hemangiomas
T1111 Topical Chemotherapy (Total Face and/or Neck)
T1951 Mastectomy for Gynecomastia
T1958 Mastectomy, Subcutaneous with Delayed Prosthetic Implant
T1975 Removal of Mammary Implant Material
T1976 Reconstruction of Nipple and/or Areola
T2100 Revision (Release of Scar Contracture) of Breast, Following Mammoplasty
T6520 Blepharoptosis Repair
11920 Tattooing
11950 Subcutaneous Injection of “Filling” Material (i.e. Collagen)
11960 Insertion of Tissue Expanders
15780 Dermabrasion
15786 Abrasion
15790 Chemical Peel
15810 Salabrasion
15820 Rhytidectomy
15831 Excision Excessive Skin and Subcutaneous Tissue (Including Lipectomy)
15876 Suction Assisted Lipectomy
17340 Cryotherapy for Acne
17380 Electrolysis Epilation
19316 Mastopexy
19318 Reduction Mammoplasty
19324 Augmentation Mammoplasty
19360 Breast Reconstruction
21100 Application of Halo Type Appliance for Maxillofacial Fixation
21110 Application of Interdental Fixation Devica for Condition other than Fracture of Dislocation
12244 Reconstruction of Midface
21193 Reconstruction of Mandibular Ramus
21208 Osteoplasty of Facial Bone
21210 Bone Graft to Nasal, Maxillary and Malar Areas
21230 Cartilage Graft to Face, Chin, Nose or Ear
21430 Treatment of Craniofacial Separation
21497 Interdental Wiring for Conditions other than Fractures
30400 Rhinoplasty
40500 Vermilionectomy
40530 Resection of Lip
40820 Destruction of Lesion of Scar
41830 Gingivectomy
67914 Repair of Ectropion
67924 Blepharoplasty

LEVEL V.B.: EXPERIMENTAL (INVESTIGATIONAL) AND OR EXCLUDED PROCEDURES NOT COVERED BY THE CHS PROGRAM

ICD-9-CM: International classification of Diseases, 9th Edition, Clinical Modification

MCE: Medicare Code Editor (3M Software Version of HCFA Sanctioned Non-covered Codes)

OCE: Outpatient Code Editor (3M Software Version of HCFA Sanctioned Non-covered Outpatient Codes)

Sec. #: Medicare Manual Reference

ICD-9-CM

1175 Radial Keratotomy (Sec. 35-54)
 3928 Extracranial-Intracranial Bypass (Sec. 35-37)
 4493 Insert Gastric Bubble (Sec. 35-86 and MCE)
 5051 Auxiliary Liver Transplant (MCE)
 5796 Implant Bladder Stimulator (Sec. 65-11 and MCE)
 5797 Replace Bladder Stimulator (MCE)

HCPCS

J9219 Laetrile (Sec. 45-10)
 M0075 Cellular Therapy (Fresh Cell) (Sec. 35-5)
 M0300 IV Chelation Therapy (Chemical Endarterectomy) (Sec. 35-64)
 S9019 Human Tumor Stem Cell Assay (Sec. 50-41)
 S9025 Omnicardiogram/Cardiointegram (Sec. 50-47)
 W0050 Acupuncture (Sec 3508)
 15775 Punch Graft for Hair Transplant
 20975 Invasive Electrical Bone Growth Stimulation (Sec 35-48 with criteria)
 20976 Percutaneous Electrical Bone Growth Stimulation (Sec 35048 with criteria)
 33935 Heart-Lung Transplant
 36260 Insertion of Implantable Infusion Pump (Sec. 60-14 with criteria)
 36520 Therapeutic Apheresis (Sec. 35-60 with criteria)
 38230 Bone Marrow Harvesting for Transplantation (Sec. 35-30 with criteria)
 43844 Gastric By-Pass for Morbid Obesity (Sec. 35-40 with criteria)
 44131 Intestinal By-Pass for Morbid Obesity (Sec. 35-33)
 48160 Pancreatectomy with Transplant (Sec. 35-82)
 54660 Insertion of Testicular Prosthesis (Sec. 35-61)
 55970 Intersex Surgery Male to Female (Sec. 35-61)
 55972 In-vitro Fertilization
 55980 Intersex Surgery Female to Male (Sec. 35-61)
 58970 Follicular Puncture for Oocyte Retrieval
 58972 Culture and Fertilization of Oocyte
 58974 Embryo Transfer
 58976 Gamete or Zygote Intrafallopian Transfer, Any Method
 61855 Implantation of Neurostimulator Electrodes (Sec. 35-20, 65-8)
 63650 Percutaneous Implantation of Neurostimulator
 64550 TENS (Sec. 35-46, 45-19 with criteria)
 65760 Keratomileusis (Sec. 35-64)
 65765 Keratophakia (Sec. 35-54)
 68771 Radial Keratotomy/Keratoplasty (Sec. 35-54)
 69090 Ear Piercing

69399 Tinnitus Masking (Sec 35-63)
69930 Cochlear Device Implantation (Sec. 65-14 with criteria; both IHS and Medicare have criteria)
77600 Hyperthermia (Sec. 35-27 with criteria)
78330 Bone Density Study (Sec. 50-44 with criteria)
90900 Biofeedback (Sec. 35-27 with criteria)
91032 Esophageal Acid Reflux Testing (Sec. 35-83)
92286 Corneal Endothelial Microscopy (Sec. 50-38 with criteria)
93720 Plethysmography (Sec. 50-6 with criteria)
93784 Ambulatory Blood Pressure Monitoring (Sec. 50-42)
95828 Polysomnography (Sec. 60-17)
99180 Hyperbaric Oxygen Therapy (Sec. 35-10 with criteria)

OTHER

No code Artificial Hearts (Sec. 65-15)
No code Colonic Irrigation (Sec. 35-1)
No code Cytotoxic Food testing (Sec. 50-2)
No code Electric Aversion Therapy (Sec. 35-23.1)
No code Electro-sleep Therapy (Sec. 35-18)
No code Electrotherapy for Facial Nerve Palsy (Sec. 35-72)
No code External Counter-pulsation (Sec. 35-74)
No code Food Allergy Testing and Treatment
No code Gastric Freezing (Sec. 35-65)
No code Hair Analysis (Sec. 50-24)
No code Electric Nerve Stimulation for Monitoring Dysfunction (Sec. 35-20)
No code Challenge Ingestion Food Testing (Sec. 50-22 with criteria)
No code Heat Treatment for Pulmonary Conditions
No code Hemodialysis for treatment of Schizophrenia (Sec. 35-51)
No code Human Tumor Stem Cell Drug Sensitivity Assays (sec. 50-42)
No code Intestinal Transplantation
No code Intravenous Histamine Therapy (Sec. 35-19)
No code Joint and Ligament Sclerosing Therapy (Sec. 35-13)
No code Portable Hand Held X-Ray Instruments
No code Prolotherapy (Sec. 35-13)
No code Pulmonary Embolectomy, Transvenous (catheter) (Sec. 35-55)
No code Thermogenic Therapy (Sec. 35-6)
No code Tattoo Removal

PART THREE – TYPES OF IHS/TRIBAL FACILITIES

BACKGROUND:

Because funding levels, geographic access, health conditions, local health resources, and third party coverage vary to a great extent among IHS Areas and service units, each Area must maintain an Area medical priority document consistent with the IHS guidelines. In a review of the existing facilities in the IHS and the application of these guidelines, the following descriptive narrative and matrix was developed for the purpose of information.

A – Limited Acute Care Hospital Based Service Unit

A primary care hospital staffed primarily by family physicians, with 24-hour emergency room services. Provides no inpatient surgery services. Limited obstetrical services; may or may not perform on-site deliveries. Limited pediatrics and internal medicine coverage

Ex: Winnebago Service Unit (Winnebago Hospital)

B – Outpatient Health Center Based Service Unit

No IHS/Tribal hospital within service unit. General complement of outpatient services. Staffed by family physicians, open 5 or more days per week.

Ex: Omaha Service Unit (Carl T. Curtis Health Center)
Santee Service Unit (Santee Sioux Tribe Health Center)
Ponca Service Unit (Fred LeRoy Health & Wellness Center)
Nebraska Urban Indian Center (Lincoln & Omaha locations)

LEVELS OF DIRECT/CHS CARE PROVIDED BY FACILITY TYPE

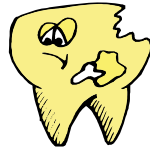
<u>Facility Type</u>	<u>Level of Services Provided In-house</u>	<u>Level of Services Provided by CHS Funding</u>
A	I, II, III, (IV)	I Yes – when direct care services at IHS facility not available or accessible III Depending on funding level, if services not available at IHS facility IV Depending on funding level
B	I, II, (III)	I Yes – when direct care services at IHS facility not available or accessible III Depending on funding level, if services not available at IHS facility IV Depending on funding level
C	II, (I), (III)	I Yes III Depending on funding level, if services not available at IHS facility IV Depending on funding level
D	II, (III)	I Yes III Depending on funding level, if services not available at IHS facility IV Depending on funding level
E	NONE	I Yes II Depending on funding level III Depending on funding level IV Depending on funding level

*Priority levels in parentheses indicate limited availability

**Level V not funded by any facility

PONCA TRIBE OF NEBRASKA CONTRACT HEALTH SERVICES

Emergency Dental Procedure



The CHS program will assist with emergency dental care **ONLY WHEN THE CLIENT CAN NOT IMMEDIATELY** receive services at an IHS facility.

Emergency Care

Emergency care is intended to relieve pain caused by an acute condition until your primary dentist can see you. Your emergency care benefit does not include procedures that may be required but are not necessary for the relief of pain. For example, root canals and crowns may be necessary treatments but are not covered under emergency care benefits. If you have an emergency that involves extensive accidental or traumatic injury to your teeth or mouth, or that affects your ability to breathe or swallow, you should contact your medical physician.

Emergency Dental Service

Emergency dental services are limited to procedures done in a dentist's office, dental clinic, or other comparable facility, to evaluate and stabilize dental conditions of a recent onset and severity accompanied by excessive bleeding, severe pain, or acute infection that would lead a layperson with average knowledge of dentistry to believe that immediate care is needed. A specific example would be a toothache that caused you severe pain.

Emergency dental services are those services necessary for the relief of acute conditions. Services include all necessary laboratory & preoperative work including examination, radiographs and appropriate anesthesia (local, general, sedative) for optimal management of the emergency.

Emergency Dental Procedure:

1. Client must first attempt to be seen at an IHS facility.
2. If unable to be seen at an IHS facility, client must contact the CHS department for authorization if during business hours, if after hours, you are required to call within 72 hours.
3. Client must have a serious dental problem. Emergency dental services shall include but not limited to the following:
 - Procedures necessary to control bleeding, relieve pain, and eliminate acute infection
 - Operative procedures that are required to prevent imminent loss of teeth

- Treatment of injuries to the teeth or supporting structures (please note that severe trauma to teeth and gums should be evaluated by an emergency physician)
4. The emergency dental appointment should only be utilized to alleviate the serious dental condition requiring such service. Once emergent care is received and the condition is stabilized, follow-up care will require services to be performed at the IHS dental facility or at your primary dental office (non-payable by CHS).
 5. If the patient is seen at an emergency dental facility, and it is determined that the visit does not meet our emergency criteria, the patient will be liable for all charges incurred.
 6. If the client has repeatedly missed dental appointments at the IHS facility, and has come to the point of an emergency, the patient will be responsible for all charges incurred.

PONCA TRIBE OF NEBRASKA
CONTRACT HEALTH SERVICES

Ponca Dental Service Policy

The procedures classified under primary care are those that prevent the onset of oral disease. The coverage of services is as follows:

- Initial or periodic oral examination
- Bitewing and/or panoramic radiographs
- Adult prophylaxis (routine or difficult)
- Child prophylaxis (not a toothbrush prophylaxis)
- Topical fluoride
- Sealants by tooth or quadrant
- Amalgam restorations
- Composite restorations

IHS ALLOWABLE DENTAL SERVICES

LEVEL I – EMERGENCY CARE

Emergency dental services are those that are necessary to relieve or control acute oral conditions such as: serious bleeding, a potentially life-threatening difficulty, maxillofacial fractures, swelling and severe pain, or other signs of oral infection. Other conditions that the patient may determine to require urgent attention are also classified as Level I care (e.g., prosthetic repairs). Procedures commonly reported are listed below:

- Emergency (limited) examination
- One or more periapical radiographs
- Simple extractions
- Temporary or sedative restoration
- Re-cement crowns or bridges
- Prosthetic repairs and adjustments
- Endodontic access preparation
- Drain oral abscess
- Reduction of jaw fractures

LEVEL II – PRIMARY DENTAL CARE

The procedures classified under primary care are those that prevent the onset of oral disease. Clinical services to individual patients and community-based preventive services or activities are included in Level II care. The primary care services most frequently provided are:

Clinical services:

- Preventive plan and education to promote “self-care”
- Adult prophylaxis (routine or difficult)
- Child prophylaxis (not a toothbrush prophylaxis)
- Topical fluoride
- Sealants by tooth or quadrant
- Periodontal maintenance (recall) procedures
- Athletic mouth guard

Community-based services

- Water fluoridation activities
- Group health education/health promotion activities
- Supplemental fluoride program status during current month

LEVEL III – SECONDARY DENTAL CARE

Level III services are those deemed necessary for routine diagnosis and primary treatment to control the early stages of disease. This level also includes the treatment of certain advanced conditions that are limited in scope (e.g., anterior endodontic, stainless steel crowns). The procedures generally are not highly complex in nature and often more than one of these services can be completed in one appointment. The Level III procedures commonly report includes the following:

- Initial or periodic oral exam
- Bitewing and/or panoramic radiographs
- Diagnostic casts
- Space maintainer
- Amalgam restorations (1, 2, 3 surface)
- Composite restoration (1, 2, 3 surface)
- Stainless steel crowns (primary teeth only)
- Therapeutic pulpotomy (primary teeth only)
- Anterior endodontic (one canal)
- Periodontal scaling/rooting planing (for 4-6 mm pockets)
- Biopsy, excision of lesion

LEVEL IV – LIMITED REHABILITATION

Rehabilitative care is that which restores oral structure to an improved condition and form. Limited Rehabilitation is defined by the IHS as those dental procedures that involve more advanced disease conditions and are more complex and costly to provide than Level III care in controlling disease and restoring function.

The following Level IV services are those most frequently utilized:

- Complex amalgam (4 or more surfaces)
- Cast on-lays or crowns with or without porcelain
- Post and core restoration
- Crown buildups
- Acid etch (Maryland) bridge
- Bicuspid Endodontic (two canals)
- Apicoectomy/Retrograde Filling
- Gingival flap with root planing/curettage of deep pockets
- Denture reline (laboratory)
- Limited/Interceptive Orthodontics

LEVEL V – REHABILITATION

The dental services classified into this level are rehabilitative procedures that require more clinical chair time, additional knowledge and skill of the care provider, and usually greater expense than the limited rehabilitative services listed under Level IV care. Level V services usually require multiple appointments to complete and they are usually associated with a rehabilitative plan for the entire mouth.

These Level V services generally require a substantial patient contribution (co-payment) to cover professional fees in dental insurance programs. The IHS does have the authority to charge dental fees to Indian beneficiaries. The Level V services most frequently needed are:

- Molar endodontic (3 or more canals)
- Periodontal surgery in deep pockets (6+ mm)
- Complete and partial dentures
- Denture rebase (laboratory)
- Fixed bridgework (retainers and pontics)
- Surgical extractions (impactions)
- Analgesia (e.g., nitrous oxide)

LEVEL VI – COMPLEX REHABILITATION

Level VI includes those services that usually require more time, skill, and cost than the rehabilitative procedures classified under Levels IV and V. A substantial portion of patients may require referral to specialists for complex rehabilitative treatment; however, referrals must be justified by special circumstances that warrant the associated higher costs. Level VI services may not predictably improve the overall prognosis for many patients. Thus, careful patient selection is a critical factor in the provision of Level VI care. Complex rehabilitation includes the following procedures:

- Cephalometric of TMJ radiographs
- Occlusal adjustment (complete)
- Periodontal Surgery
 - Osseous of soft tissue grafts
 - Repositioning flaps
- Over-dentures
- Consultation
- Precision attachment prosthetics
- Comprehensive Orthodontics (class I, II, or III)
 - Occlusal analysis
 - Fixed appliances (usually full-bonding)
 - Post-treatment stabilization
- Surgical Extractions (bony impactions)
- Unusual and complex oral surgery
- Maxillofacial prosthetics
- I-V sedation, general anesthesia

PONCA TRIBE OF NEBRASKA

Contract Health Services

EYE CARE POLICY

FREQUENCY OF EXAMINATION:

The frequency of examination shall be determined by the individual needs of the patient. When going to an Ophthalmologist a referral is necessary from an Optometrist or physician.

An Optometrist is a professional concerned with the examination of the eyes and related structure to determine the presence of vision problems, eye disorders, and diseases such as diabetes, detached retina etc. An Ophthalmologist is one who is a specialist in the area of correcting the disease found and performs surgery when necessary.

A. Children (through age of 18) should be screened and/or examined each year.

- Children are eligible for an eye exam every 12 months from their last date of service
- Children are eligible for lenses every 12 months from their last date of service.
- Children are eligible for a new frame every 12 months from their last date of service.

B. Adults should be screened every two years.

- Adults are eligible for an eye exam every 24 months from their last date of service
- Adults are eligible for lenses every 24 months from their last date of service.
- Adults are eligible for a new frame every 24 months from their last date of service.

C. Elderly age 65 and over should be screened every year.

- Elderly are eligible for an eye exam every 12 months from their last date of service
- Elderly are eligible for lenses every 12 months from their last date of service.
- Elderly are eligible for a new frame every 12 months from their last date of service.

D. More frequent examinations are encouraged when:

- Signs or symptoms of acute or chronic eye disease/conditions are apparent;
- Instructed by a doctor to return for a specific reason, such as diabetes, follow-up exam or amblyopia therapy;
- Written referral from a doctor, nurse, or school screening.

E. Eligibility for vision care services will be based on the actual date of service of your last routine exam.

NON-COVERED ITEMS:

- A. No tints will be provided except where therapeutically indicated
- B. No monogrammed lenses
- C. No other purely cosmetic items (for example: scratch cote)
- D. No contact lenses (patient will be responsible for the difference between basic exam charges versus a contact exam fee)

FEE SCHEDULE:

- A. \$250.00 allotment for single vision (exam, frame and lenses)
- B. \$300.00 allotment for bifocal vision (exam, frame and lenses)
- C. \$350.00 allotment for trifocal vision (exam, frame and lenses)

REPAIRS/REPLACEMENTS:

- A. In the case of repairs, CHS will pay up to \$50.00 toward any necessary repairs. The patient is required to submit a letter from the vision provider stating an estimate cost for the repair. The repair coverage may only be used one (1) time during each eligible period (i.e. children/elderly-yearly, adults-once every two years)
- B. In the case of replacement, CHS will pay up to \$100.00 toward the replacement of glasses. The patient will need to submit a letter from the vision provider stating that the glasses are non-repairable and must be replaced. The replacement coverage can only be used one (1) time during each eligible period (i.e. children/elderly-yearly, adults-once every two years)

ALTERNATE RESOURCES:

The Contract Health Service program is a payor of last resort; therefore, all alternate resources must be exhausted before authorization of Contract Health Services benefits.

If the client has Vision Insurance through their employer, they are **REQUIRED** to utilize this resource first. The Contract Health Service program will pick up the difference between the Insurance payment and the fee schedule allotment.

**PONCA TRIBE OF NEBRASKA
CONTRACT HEALTH SERVICES**

CHS ELDERLY CARE PLAN

The CHS program offers additional benefits to those Ponca Tribal members who are age 65 and over who meet the following criteria:

QUALIFICATIONS:

You must be age 65 & over

- All alternate resources will be exhausted before authorization of services (i.e. Medicare, Medicaid or Insurance) If denied from Medicaid, you must submit the denial letter to the CHS office.
- If you choose not to take out Medicare Part B (physician services) or Part D (prescription benefits), you will not be eligible for primary care or prescription benefits through CHS. You will be referred to an IHS facility for these services.
- For those members who have private Insurance, CHS will pay for deductibles and co-pays/co-insurance.
- You are eligible for those services that are offered to all members regardless of your coverage. For example, if you do not have Medicare Part D (prescription drug coverage) and you access the emergency room for a life threatening illness and require medication, CHS WILL cover your medication on a one time basis only.

Important Notice: Medicare beneficiaries are penalized 10% each year for Part B and 1% each month for Part D if they opt not to enroll into Part B/D at the time they become eligible for the benefits.

Disabled

- Prescription co-payment coverage only if the member is covered by Medicaid and/or Medicare because of disability. (Proof will be requested)

SERVICES:**Medical**

- May utilize a local (non-IHS) provider, CHS will cover the cost of the deductible and co-payments after Medicare has paid their portion
- If member has both Medicare and Private Insurance, CHS will cover the cost of the deductible and co-payments after Medicare and Private Insurance has paid their portion

Prescriptions

- If prescribed medication from a local provider, CHS will cover the cost of the medication after the member's primary resource. This will include deductible or co-pays
- CHS requires that generic brands be utilized when available, and that the member makes every effort to obtain a cost effective medication

An elder with Original Medicare Part A and Part B in 2009, will receive the following benefits:

Part A (Hospital Insurance)

- Most people do not pay a monthly Part A premium because they or a spouse has 40 or more quarters of Medicare-covered employment.
- You pay up to \$443.00 each month if you don't get **Premium-free** Part A.
- Pays for inpatient hospital, skilled nursing facility, and some home health care. For each benefit period Medicare pays all covered costs except the Medicare Part A deductible (2009=\$1068) during the first 60 days and coinsurance amounts for hospital stays that last beyond 60 days and no more than 150 days.

Inpatient facility

- A total of \$1068 for a hospital stay of 1-60 days
- \$267 per day for days 61-90 of a hospital stay
- \$534 per day for days 91-150 of a hospital stay
- All costs for each day beyond 150 days (“**Lifetime reserve days**” are 60 extra days of coverage you can use in your lifetime. In 2009, you pay \$534.00 per day during these 60 days of coverage.)

Skilled nursing facility

- \$0 for the first 20 days each benefit period
- \$133.50 per day for days 21 through 100 each benefit period
- All costs for each day after day 100 in the benefit period

Part B (Medical Insurance)

- Premium \$ 96.40 (Deducted from elderly Social Security Check)
- Deductible is \$135.00 per year

Medicare recipient pays 20% of the Medicare approved amount for services after the deductible has been met (i.e. If the provider charges \$60.00 for the service, Medicare has contracted with the provider to accept a Medicare approved amount which lowers the cost significantly, so in this case, instead of paying 20% of 60.00, you will only pay 20% of the contracted amount. Within this same example, if the approved amount is adjusted to a \$32.00 charge, you will only pay \$6.40. Contract Health Services would then pay \$6.40 instead of \$60.00).

- Covers Medicare eligible physician services, outpatient hospital services, certain home health services, durable medical equipment

Referred Services Information Guide

If you are a member of the **Ponca Tribe** and have been **referred** to a specialist, you must contact the Contract Health Service (CHS) program to determine your eligibility and to obtain authorization for payment of service(s).

Procedure is as follows:

1. The member is responsible for submitting the referral to the CHS office. You may have the provider submit the referral but it is strongly encouraged that you follow-up with CHS to see if it was received.
2. The referral will be reviewed by the CHS Dept. and a determination will be made in regards to eligibility and whether or not the referral for payment of services is approved or denied.
3. If approved, notification will be relayed to the member either by phone or mail. It is at this time, an appointment can be scheduled.
4. Member is required to contact CHS with their scheduled appointment date. Once the appointment is obtained, CHS Staff will complete a medical purchase order that notifies the provider(s) that payment for services has been authorized. If you cancel or reschedule your appointment, please notify the CHS office so that we can change the information within our system.
5. Authorization is good for 1 visit only. A purchase order covers only one appointment date. You will need a purchase order for each and every visit. Please contact CHS if additional services are needed.

If you fail to follow the above process, you will be held responsible for all charges incurred. Thank you in advance for your cooperation and if you have any questions, please contact us. Thank you!

Contract Health Services Staff

Thomas Wright II, CHS Clerk
Tina Villalpando, Contract Health Specialist

1800 Syracuse Ave.
Norfolk, NE 68701
Office Line # 402-371-8834
Toll Free # 1-800-405-0365
Fax # 402-371-0176

Health Resource Advocate

Toni Hoffman, HRA

2602 J. Street
Omaha, NE 68107
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Fax # 402-734-5708

PONCA TRIBE OF NEBRASKA CONTRACT HEALTH SERVICE PROGRAM

PURCHASE ORDER (P.O.) NOTICE

DATE _____

Please indicate status of P.O.	
#	_____
<input type="checkbox"/>	Patient was a no show or cancelled appointment
<input type="checkbox"/>	No Charge
<input type="checkbox"/>	Patient was not seen by our facility on this date
<input type="checkbox"/>	Alternate Resource paid 100%
<input type="checkbox"/>	P.O. not located, please send a duplicate form
	Attn: _____
<input type="checkbox"/>	Other _____

On ____/____/____ we mailed/client took a Purchase Order (P.O.) covering services on ____/____/____, for _____.

To date, the completed P.O. has not been submitted for payment. Please complete and return this form so that this account may be cleared from our records. If we do not receive a response, the obligation for these services will be cancelled.

If the form has been misplaced or the account has been covered by some other resource, please advise us so that appropriate action may be taken.

Sincerely,

PTON Contract Health Service Program

**OBJECT CLASS AND COST CENTER CODES
FOR IHS CONTRACT HEALTH SERVICE DOCUMENTS**

OBJECT CLASS CODE	DESCRIPTION	PIGGYBACK WORKLOAD UNIT	APPLICABLE COST CENTERS
21.85	Patient and Escort Travel: Includes travel and related costs, e.g.; lodging, meals, etc.	One Way Passengers	226, 326, 526, 533, 826
25.2A	Medical Lab Services – Outpatient Non-IHS: Includes laboratory cost for outpatients at contract facilities. If pathologist and lab fees are invoiced together use 25.2A. Excludes pathologist professional fee invoiced separately (use 25.4D)	Number of Test	574, 874
25.2B	Medical Lab Services – Inpatient and Outpatient IHS: Includes all laboratory costs for inpatients and outpatient at IHS facilities referred to contract facilities. Excludes pathologist professional fee invoiced separately (use 25. 4C).	Number of Test	251, 351
25.2D	Dental Lab Services: Includes dental prosthetic fabrication services provided by dental laboratories Excludes any dentist professional fee (use 25. 4E).	Number of Services	268, 368, 568, 868
25.2F	Federal Hospitalization: Includes inpatient services in Department of Defense, VA, or other Federal hospital.	Number of Patient Days	573, 873
25.2G	Non-Federal Hospitalization: Includes inpatient services in a non-Federal hospital	Number of Patient Days	533, 573, 575 873
25.2H	X-Ray Services – Outpatient non-IHS: Includes X-Ray services for outpatients at contract facilities. If radiologist and facility fees are involved together use 25.2.H. Excludes radiologist professional fee invoiced separately (use 25.4D).	Number of X-Rays	574, 874
25.2J	X-Ray Services – Inpatient & Outpatient IHS: Includes all radiology costs for inpatients and outpatients at IHS facilities referred to contract facilities. Excludes radiologist professional fee invoiced separately (use 25.4C).	Number of X-Rays	250, 350
25.2L	Hospital Outpatient: Includes ambulatory care services at contract hospitals other than emergency room services. Includes instance where an IHS physician uses a non-IHS facility to perform a procedure and there is a facility charge. If hospital outpatient and physician services are billed together, use 25.4D. Excludes any physician professional fee (use 25.4D).	Number of Patient Visits	574, 874

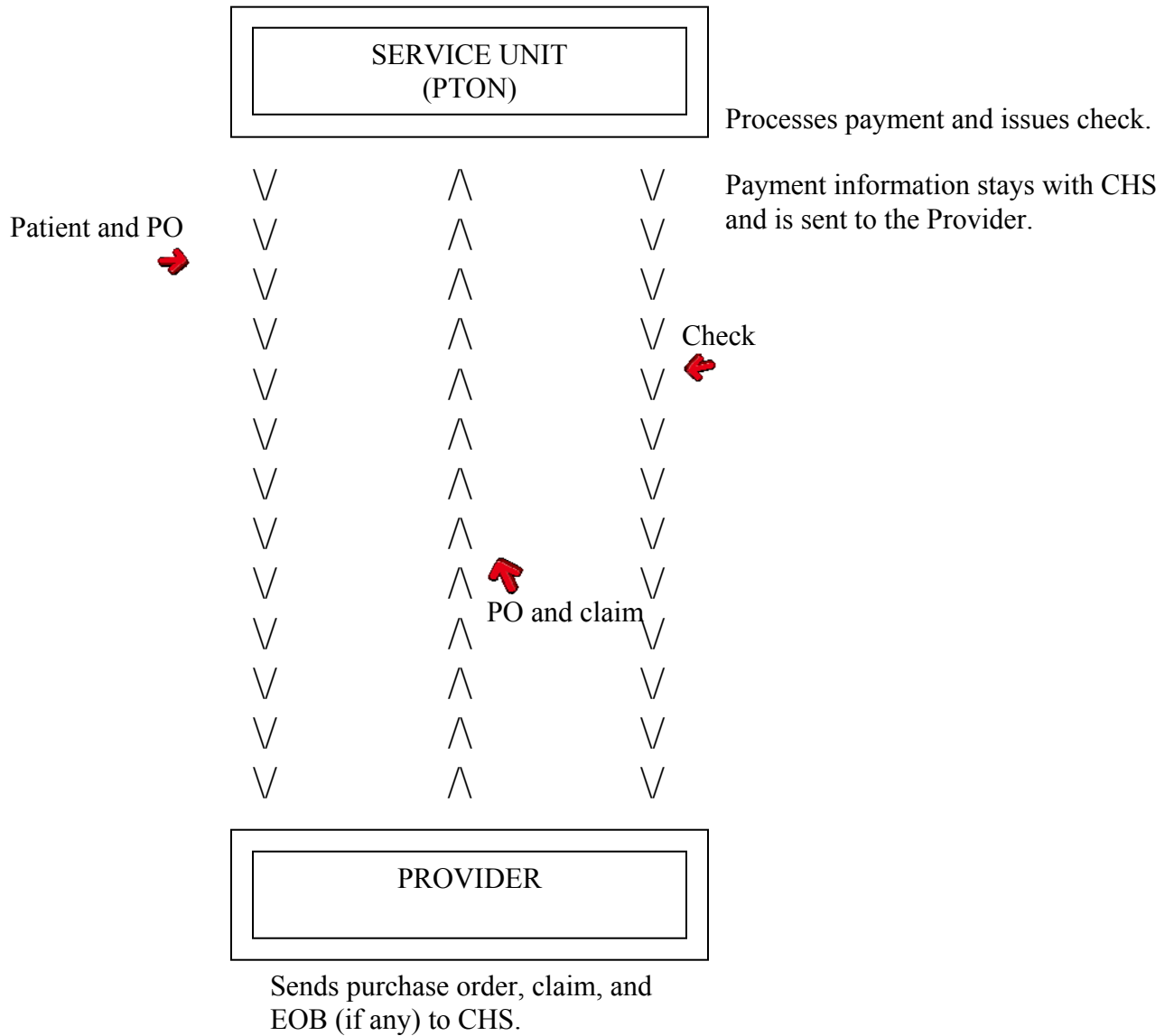
OBJECT CLASS CODE	DESCRIPTION	PIGGYBACK WORKLOAD UNIT	APPLICABLE COST CENTERS
25.2M	Extended Care Facilities: Includes rehabilitation, skilled nursing facilities, psychiatric inpatient facilities, and psychiatric inpatient care in an acute facility exceeding 30 days. Excludes any physician fee. (use 25.4B)	Number of Patient Days	575, 875
25.2Q	Emergency Room Services: Includes non-IHS hospital emergency room services. Includes any ER physician fees whether combined or billed separately.	Number of Patient Visits	574, 874
25.2S	Physical Therapy Services: Includes all contract physical therapy services visits invoiced separately. Excludes all physician professional fees (use 25.4D).	Number of Patient Services	235, 240, 246, 258, 346, 358, 574, 874
25.2Z	All other: Includes direct operations of Federal programs by contract.		574, 575
25.4Z	Physician – Inpatient IHS Facility: Includes contract physician services for patients hospitalized in IHS facilities. Includes radiologist and pathologist professional fees invoiced separately.	Number of Visits	235 through 245, 250, 251, 254, 255, 261
25.4B	Physician – Inpatient Non-IHS Facility: Includes all physician services for patient hospitalized in non-IHS facilities. Includes radiologist and pathologist professional fees invoiced separately. <u>Distinguishes physician visits to extended care facilities by using cost center 575.</u>	Number of Visits	533, 573, 575, 873, 875
25.4C	Physician – Outpatient IHS Facility: Includes all contract physician services for outpatients in IHS services for outpatients in IHS facilities. Includes radiologist professional fees invoiced separately.	Number of Patient Visits	233, 246, 248, 250, 251, 346, 348, 350, 351
25.4D	Physician – Outpatient Non-IHS Facility: Includes all contract physician services for outpatients in non-IHS facilities/physician offices. Includes radiologists and pathologists professional fees invoiced separately. includes combined hospital outpatient visit and physician services. Excludes emergency room visits billed separately (use 25.2Q). Excludes physician visits to skilled nursing facilities (use 25.4B).	Number of Patient Visits	533, 574, 575, 874
25.4E	Dentists: Includes all services provided by dentists to inpatients and outpatients. Includes combined dental laboratory costs and dental services. Use 25.2D for laboratory services billed separately.	Number of Patients	268, 368, 568, 573, 868
25.4G	Fee Basis Specialists – IHS Facility: Includes all consultant services <u>other than physicians</u> . Examples are nurse anesthetists, audiologists, speech therapies and podiatrists (cost centers 268 and 368).	Number of Consultant Visits	235 through 271, 346 through 371 216

OBJECT CLASS CODE	DESCRIPTION	PIGGYBACK WORKLOAD UNIT	APPLICABLE COST CENTERS
25.4J	Fee Basis Specialist- Non-IHS Facility: Includes all consultant services in non-IHS facilities <u>other than physicians</u> . Examples are nurse anesthetists, audiologists, podiatrists, and dental hygienists.	Number of Consultant Visits	533, 568, 573, 574, 575, 868, 873, 874, 875
25.4L	Refractions – IHS/Non-IHS Facilities: Eye and visions exams only, not for injuries or other medical reasons, by ophthalmologists and optometrists.	Number of Refractions	243, 267, 367, 574, 874
25.4V	Federal Hospital Outpatient: Includes outpatient services in Department of Defense, VA, or other Federal hospital.	Number of Patient Visits	574, 874
25.82	Tribal Health Services Operations	None	868, 873-875, 883-885
25.84	Other Tribal Contracts	None	826, 885, 886,
25.85	Tribal Indirect Cost	None	826, 868, 873-875, 883-885
26.11	Drugs, Medicine, Blood, Blood Productions: Includes blood, derivatives, prescriptions, and professional fee for prescriptions filled.	Number of Prescriptions	220, 251, 320, 533, 573, 574, 575, 873, 874, 875
26.3A	Consumable Medical and Surgical Supplies: Includes medical and surgical supplies. Examples are dressings, bandages, catheters	Number of Orders Filled	233, 242, 255, 268, 333, 368, 533, 568, 573, 574, 575, 868, 873, 874, 8750
26.3G	Non-consumable Medical and Surgical Supplies: Includes rental and purchase of wheelchairs, apnea monitors, oxygen tanks, beds, etc.	Number of Devices	242, 245, 246, 346, 573, 574, 575, 873, 874, 875
26.3K	Eyeglasses: Includes eyeglasses and repairs to eyeglasses. If glasses are billed with the professional fee use 26.3K.	Number of Eyeglasses	267, 367, 574, 874
26.3L	Hearing Aids: Includes costs of hearing aid devices and repairs to hearing aids.	Number of Devices	235, 240, 246, 260, 346, 360, 574, 874
43.19	Interest		All
81.16	Allowance		All

OBJECT CLASS CODE	DESCRIPTION	PIGGYBACK WORKLOAD UNIT	APPLICABLE COST CENTERS
DELETION OF CODES			
BEFORE	AFTER		
FY92			
23.44	26.3G		
25.2C	25.2B		
25.2R	25.2G		
25.2K	25.2J		
25.4H	25.2L		
25.4K	25.2M		
25.4M	25.4C/D		
25.4P	25.4A/B		
26.18	26.11		
26.3D	26.3A/G		
26.3H	26.3A/G		
61.23	NONE		
26.61	26.11		
22.41	FREIGHT EXPENSE – USE APPROPRIATE OBJECT CLASS CODE FOR WHAT WAS SHIPPED		
25.2N	NONE		
25.4P	NONE		
25.4R	NONE		
26.3H	NONE		
26.36	NONE		
25.49	NONE		

CHS FLOW CHART

Start: Authorizes care, creates a
PO and obligates funds



PATIENT'S PERMANENT AREA OF RECORD
SEVERAL EXAMPLES TO CLARIFY THE CONCEPT

1. For example, the permanent area of record for a Navajo who was born and raised in Tuba City, Arizona, and has been living in Phoenix, Arizona, for 2 years would be Phoenix, Arizona. Therefore, the Phoenix Indian Medical Center (PIMC) would not contact Tuba City Service Unit because the patient would not be eligible for CHS through the Tuba City Service Unit.
2. The permanent area of record for a Navajo who was born and raised in Tuba City, Arizona, who continues to live in Tuba City and is visiting in Phoenix, Arizona, for one week, would be Tuba City, Arizona. This patient would continue to be eligible for CHS through the Tuba City Service Unit.
3. The permanent area of record for a Navajo who has been living in Washington D.C. for two years would be Washington D.C. If the Navajo whose permanent area of record is Washington D.C., is visiting Phoenix, Arizona, for one week, and obtains emergency treatment at PIMC prior to being referred to a non-IHS facility, there is no IHS service unit for PIMC to contact. Since the patient living in Washington D.C., is not eligible for CHS, there is no need for PIMC to contact any other service units. No IHS service unit should authorize payment for CHS because the patient is not eligible for CHS.
4. An infant, whose parents were members of the Rosebud Sioux Tribe, was living on the Rosebud reservation when the parents were killed in a car accident. The Tribal court assumed custody of the child and placed him with a foster family that lived outside of the Contract Health Service Delivery Area for the Tribe and the Tribal court maintained continued jurisdiction over the child. The child was a ward of the Tribal court and assumed the residency where the Tribal court sits during his foster home placement. After the child was living with the foster family for 300 days he became very sick and required high priority medical care. His permanent area of record is the Rosebud Service Unit and he is eligible for CHS.

PONCA TRIBE OF NEBRASKA CONTRACT HEALTH SERVICES

CLIENT RESPONSIBILITIES

The Ponca Tribe of Nebraska has been authorized by Indian Health Services to administer Contract Health Services (CHS) for enrolled Ponca members living in the service areas of Madison, Douglas, Lancaster, Boyd, Sarpy, Burt, Platte, Stanton, Holt, Hall, Wayne, and Knox Counties of Nebraska, Charles Mix County of South Dakota and Woodbury or Pottawattomie Counties of Iowa.

To ensure that the Ponca Tribal Health Department maintains compliance with federal regulations under Indian Health Services, we are providing you with a list of your responsibilities as a Tribal Contract Health Service user.

1. **Pre-authorization MUST be obtained from the CHS Department at least 48 hours prior to obtaining medical services, which are non-emergent.** If the referral/services are approved and prior authorization is not obtained by notifying CHS of the date of your scheduled appointment, payment through CHS will be denied and the member will assume full financial responsibility. If you cancel or reschedule your appointment(s) you will need to notify the CHS program or you will be held liable for all charges incurred. If advance notification is not given, the member may be asked to reschedule their appointment.
2. **The CHS Department must be notified within 72 hours of a medical emergency.** Medical emergencies are considered a sudden illness after physician's office hours or a hospitalization. A review of the physician's records will occur following an emergency. If the service was not of an emergent nature, CHS payment may be denied. Denial in payment will also occur if the CHS Department is not notified within the 72 hours.
3. **No payment through CHS will be made until all other alternate resources have been exhausted.** The CHS department will determine if the member may be eligible for payment through other sources and will refer the member for application. Failure to apply will result in denial of payment through CHS.
4. **If it is your responsibility to file your insurance claims, you must file within two weeks of the date of service.** If payment is denied due to a lapse in time from filing with your insurance company, payment can not be made by CHS.
5. Payment will not be made through CHS until the member submits all explanation of benefits from their insurance company.
6. Prior to receiving medical services through a specialist, the member must obtain a referral from a physician and provide the referral and all pertinent information to the CHS department for review. The member will be notified as to whether or not the referral is approved or denied.
7. **Payment is not guaranteed upon receipt of a purchase order from the CHS Department.** Payment is only guaranteed after services are rendered and the service is within the PTON's approved levels of care and funding availability.

I acknowledge that I have reviewed and understand my responsibilities with the CHS Department.

CLIENT SIGNATURE

_____/_____/_____
DATE

CHS DEPARTMENT SIGNATURE

_____/_____/_____
DATE

PONCA TRIBE OF NEBRASKA CONTRACT HEALTH SERVICES

REFERRAL NOTIFICATION

Patient Name

Provider Name

Date of Birth: ____/____/____

Date of Referral: ____/____/____

The Contract Health Service (CHS) program has received a referral on the above named client. The client has/should been/be referred to _____

After further review, the CHS program has made the following decision based on the information provided:

A. _____ Referral submitted has been denied as:

- (1) _____ Client is not eligible for CHS Benefits.
- (2) _____ Inadequate information to properly evaluate this case.
(Please submit additional documentation/justification of the medical necessity such as a letter from the physician or medical notes, etc.)
- (3) _____ Treatment requested is not a covered service by CHS program policy.
- (4) _____ Other: _____

B. _____ Referral has been approved

(Client is REQUIRED to pre-notify the CHS Program of the date of their scheduled appointment.)

(The client is REQUIRED to contact the CHS program for prior approval if follow-up appointments, additional treatments or surgery is necessary).

A referral is not an implication that the CHS program will authorize payment for the cost of the care to be provided. CHS will ONLY assume financial responsibility for referrals if the patient is eligible under the Contract Health Service (CHS) regulations. Patients who are ineligible under the CHS regulations will be financially responsible for the medical costs incurred from a referral.

The basic criteria for determination is if the person is enrolled with the Ponca Tribe of Nebraska and resides in the Contract Health Service Delivery Area. The CHS program is a payor of last resort; and will refer members to make alternate resource applications when deemed appropriate.

I certify that the decision stated above is according to the rules and regulations of the Ponca Tribe of Nebraska Contract Health Service Program.

Contract Health Service Program

_____/_____/_____
Date

PONCA TRIBE OF NEBRASKA CONTRACT HEALTH SERVICES

PONCA CHS HIGHER EDUCATION STUDENT POLICY

PURPOSE: Define procedure and criteria for higher education students are reviewed, reported and identified for continued CHS coverage while in full-time student status.

DEFINITION: Higher education students in full-time student status

POLICY: Student must be a permanent resident within one of the Ponca Contract Health Service Delivery Areas immediately prior to becoming a full-time student. Below is a list of required information for the CHS program to use to make a determination on continued CHS coverage for the student (and family if they accompany/reside with the student).

PROCEDURES:

- A. Patient must provide the following information:
 1. Full name(s) and dates of birth of student & family members who are living with the student (while at school)
 2. Present address and new mailing address (while at school)
 3. Date of move to new address
 4. Letter from college stating full-time (12+ semester hours) or part time status
 - i. Each semester: letter from college on full-time status
 5. If vocational school – letter from school stating full-time status
 - i. Each semester: letter from school on full-time status
 6. List of medical coverage resources with copy of card

An information sheet is attached as a handout to each student (See Summary of Services).

- B. Information will be provided to the student on:
 1. Non-emergency notification requirements and who to contact
 2. Emergency notification requirements and who to contact
 3. Care at IHS that should be completed prior to or during vacations
- C. CHS coverage will not continue for students who do not provide the required information or do not abide by section (A).
- D. Service Unit is required to maintain a student health file using a log and form letters (see attachment).
- E. Service Unit will determine what type of care will be approved while student is away (this could be for non-emergency needs) do to transportation restrictions.

**PONCA TRIBE OF NEBRASKA
CONTRACT HEALTH SERVICES**

**Ponca CHS Higher Education
Student Response Letter**

____/____/____

The information you submitted has been reviewed. You are NOT eligible for the CHS Student Health Program because: _____

If you have other information that you identify as appropriate for our CHS office to review and re-evaluate your student status, please provide them to the following address:

Ponca Tribe of Nebraska
Attn: Contract Health Services
1800 Syracuse Ave.
Norfolk, NE 68701
Ph. No.: (402) 371-8834
Ph. No.: (800) 405-0365
Fax No.: (402) 371-0176

Thank you for your cooperation. If you have any additional questions, please call. Thank you.

Sincerely,

Contract Health Service Department

**PONCA TRIBE OF NEBRASKA
CONTRACT HEALTH SERVICES**

**Ponca CHS Higher Education
Eligible Student Response Letter**

_____/_____/_____

The information you submitted has been reviewed. You are ELIGIBLE for the CHS Student Health Program.

As a reminder you are REQUIRED to adhere to the following:

- 1. Each semester: if at a college a letter from college stating your full-time or part-time status
- 2. Each semester: if a vocational school - letter from school stating status
- 3. Non-emergency care: obtain prior approval before care is received
- 4. Emergency care: notify Ponca CHS within 72 hours after care is received
- 5. Obtain care that is available at an IHS prior to going to school (self and family members) or obtain this care on vacation or breaks from school. This type of care may range from dental, routine check-ups, medications, eye care etc.

Contact Information for Ponca Tribe of Nebraska Contract Health Services

Ponca Tribe of Nebraska
Attn: Contract Health Services
1800 Syracuse Ave.
Norfolk, NE 68701
Ph. No.: (402) 371-8834
Ph. No.: (800) 405-0365
Fax No.: (402) 371-0176

Thank you for your cooperation. If you have any additional questions, please call.

Sincerely,

Contract Health Service Department

PONCA TRIBE OF NEBRASKA
TRIBAL HEALTH DEPARTMENT
P.O. BOX 160
Niobrara, NE 68760
(402) 857-3341 Fax: (402) 857-3771

CONTRACT HEALTH SERVICE DENIAL FORM

TO:	DATE	
	PATIENT	
TO:	PROVIDER	
	DATE OF SERVICE	
	AMOUNT OF CLAIM	

We have been requested to authorize payment for health services provided to the above-named. The Ponca Tribe of Nebraska (PTON) Tribal Health Department, pursuant to the guidelines, rules and regulations established by the Indian Health Service, **cannot** assume responsibility for these charges because:

- () 1. Prior approval **was not** obtained from a PTON Health Department authorizing official for this NON-EMERGENCY service.
- () 2. Approval **was not** obtained from a PTON Contract Health Department authorizing official within 72 hours following receipt of this EMERGENCY SERVICE.
- () 3. You have an alternate resource, namely, _____ to provide these services. This is in accordance with the attached policy.
- () 4. You are not eligible for Contract Health Services in accordance with 42 CFR 36.23 (See attached).
- () 5. Other _____

If you disagree with the above decision you may obtain a reconsideration of this denial by submitting a written appeal to the signer of this letter.

1ST LEVEL APPEAL
PONCA TRIBE OF NEBRASKA
Tribal Health Director
P.O. BOX 160

30-DAY DEADLINE ____ / ____ / ____ Niobrara, NE 68760 **TRACKING #** _____

ANY APPEAL OF THIS DECISION MUST BE IN WRITING AND RECEIVED BY THE ABOVE DENIAL DEADLINE DATE. THIS PROCEDURE ALLOWS RECIPIENTS THIRTY (30) DAYS IN WHICH TO APPEAL.

TRIBAL HEALTH DIRECTOR

____ / ____ / ____
DATE

**PONCA TRIBE OF NEBRASKA
TRIBAL HEALTH DEPARTMENT
P.O. BOX 160
Niobrara, NE 68760
(402) 857-3341 Fax: (402) 857-3771**

CONTRACT HEALTH SERVICE APPEAL RESPONSE FORM

TO:	DATE	
	PATIENT	
TO:	PROVIDER	
	DATE OF SERVICE	
	AMOUNT OF CLAIM	

The Ponca Tribe of Nebraska Tribal Health Department is acknowledging receipt of your written appeal pertaining to the above health services. The following decision has been determined:

_____ The Ponca Tribe of Nebraska (PTON) Tribal Health Department, pursuant to the guidelines, rules and regulations established by the Indian Health Service, has determined that the information submitted represents sufficient information to **OVERTURN** your denial. The Contract Health Service program will be instructed to authorize payment of the above health service.

_____ The Ponca Tribe of Nebraska (PTON) Tribal Health Department, pursuant to the guidelines, rules and regulations established by the Indian Health Service, has determined that the information submitted does not represent sufficient information to overturn your denial; therefore your denial is being **UPHELD**.

_____ Denial **UPHELD** as the appeal was not submitted in writing within the 30-day deadline.
30-day deadline ____/____/____

Explanation/Justification:

If no additional supporting information is to be submitted, you may appeal this decision by setting forth the grounds supporting the request to: 2ND LEVEL APPEAL

Area Director
Aberdeen Area Indian Health Service- Federal Building
115 4th Avenue Southwest
Aberdeen, South Dakota 57401

ANY APPEAL OF THIS DECISION MUST BE MADE WITHIN THIRTY (30) DAYS FROM DATE OF RECEIPT OF THIS LETTER

Tribal Health Director

____/____/____
Date