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U.S. Department of Health and Human Services
Indian Health Service
The Federal Health Program for American Indians and Alaska Natives

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Contract Health Service (CHS) Data Quality Work Group



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CHS 101

- Overview of the Contract Health Service (CHS)
- Who is Eligible for CHS?
- What Data is Collected for CHS-and Why?
- CHS Authorization Process Flow [PDF-76KB]
- Where is CHS Data Stored?

Overview of the Contract Health Service (CHS)

The Indian Health Service (IHS) provides two types of services: (1) direct healthcare services delivered by an IHS facility (e.g. clinic, hospital), or (2) contract health services (CHS) delivered by a non-IHS facility or provider through contracts with the IHS. CHS are provided principally for members of federally recognized tribes who reside on or near the reservation established for the local tribe(s) in geographic areas called contract health service delivery areas (CHSDAs). The eligibility requirements are stricter for CHS than they are for direct healthcare.¹ <http://www.ihs.gov/generalweb/helpcenter/customerservices.chsda.asp>

CHS funds are used in situations where: (1) no IHS direct-care facility exists, (2) the direct-care element is incapable of providing the required emergency and/or specialty care, (3) the direct-care element has an overflow of medical care workload, and (4) to supplement alternate resources. The IHS purchases the needed basic healthcare services from private local and community healthcare providers that include:

- Hospital care
- Physician services
- Outpatient care
- Laboratory
- Dental
- Radiology
- Pharmacy
- Transportation services (e.g. ground and air ambulance)

The CHS program supports the provision of care in IHS and tribally operated facilities by contracting healthcare services that would otherwise not be available.

The CHS program is administered through twelve IHS Area Offices that consist of 155 IHS and tribally operated service units. The facilities include two major IHS-operated medical centers and one tribally operated medical center; however, most of the IHS and tribally operated facilities are small rural community hospitals and health centers that provide basic primary care services. Because not all tribes have access to IHS or tribally operated facilities, healthcare services are limited and there is an increasing demand for CHS to access needed healthcare. With the increasing costs of pharmaceuticals and medical

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care, as well as the growing population, there is a high demand from all Areas on the CHS program to provide needed healthcare.

The IHS fiscal intermediary (FI) contract with Blue Cross/Blue Shield of New Mexico provides a mechanism of payment for services purchased in the private sector and ensures that payments are made accurately and timely according to contractual requirements and maintains a centralized medical and dental claims reimbursement system. The FI process functions within the CHS program and the IHS payment policy and meets the standards of the medical industry. In addition to providing payments to vendors, the FI provides program support services that collects, compiles, and organizes workload and financial data, as well as generating statistical reports to the IHS that support the administration of CHS programs.² [CHS FY2004 Budget Request:

http://www.ihs.gov/AdminMngrResources/budget/downloads/fy_2004/ihs-65_contract_health_service.doc [DOC]]

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Who is Eligible for CHS?

To be eligible for CHS, an individual must meet the eligibility requirements as defined by Code of Federal Regulations (CFR) Title 42, Section 36.21 through 36.25, and Indian Health Services, Part 2, Chapter 3, "Contract Health Services" dated January 5, 1993. These federal regulations are available at local Area IHS health centers and hospitals. There are five eligibility factors, which must be met by every person needing and applying for CHS assistance. The eligibility factors are:

1. An individual must be of Indian descent and belong to the Indian community, which may be verified by tribal descendancy or census number. A non-Indian woman pregnant with an eligible Indian's child is eligible for CHS during pregnancy through post partum (usually six weeks).
2. An individual must reside within his/her Tribal Contract Health Service Delivery Area (CHSDA). The Tribal CHSDA encompasses the Reservation, trust land, and the counties that border the reservation. The following individuals also must meet the residency requirements:
 - Students who are temporarily absent from his/her CHSDA during full-time attendance of boarding school, college, vocational, technical, and other academic education. The coverage ceases 180 days after completing the study.
 - A person who is temporarily absent from his/her CHSDA due to travel, employment, etc. Eligibility ceases after 180 days.
 - Children placed in foster care outside of the CHSDA by court order.
 - Other Indian persons who maintain "close social and economic ties" with the Tribe.
3. CHS funds are limited to medical or dental services considered medically necessary and listed within the established Area IHS medical/dental priorities. A copy of the Area IHS medical/dental priorities is available at the local IHS health centers and hospitals.
4. An individual must apply for and use all alternate resources that are available and accessible, such as Medicare A and B, state Medicaid, state or other federal health program, private insurance, etc. The IHS is the "payor of last resort" of persons defined as eligible for CHS, notwithstanding any state or local law or regulation to

the contrary. The IHS facility is also considered a resource, and therefore, the CHS funds may not be expended for services reasonably accessible and available at IHS facilities.

5. The federal regulations require proper notification of the appropriate IHS official before CHS assistance is authorized. In "non-emergency" cases, the patient, or an individual or agency acting on behalf of the patient, or the medical provider must notify the respective IHS CHS specialists or Chief Executive Officer prior to the provision of medical care and service in a non-IHS facility. In "emergency" cases, the same party(ies) mentioned above must notify the respective official(s) within 72 hours after the beginning of the treatment or after admission to a non-IHS facility. For an elderly or disabled person, the notification period may be extended from 72 hours to 30 days in emergency situation.

To be eligible for CHS, an individual must meet all five eligibility factors listed above. A referral by an IHS physician to a non-IHS provider does not automatically qualify a patient for CHS. The IHS is not obligated to pay for medical or dental services under the CHS program unless funds are available and authorized. Therefore, it is important that every person needing CHS assistance—the patient, patient's family or significant others, or non-IHS providers (physicians and/or hospitals)—promptly notify and receive approval from appropriate IHS officials.³ [Public Information on Contract Health Service Program: <http://www.ihs.gov/generalweb/webcomponents/documents/nldb/648-200104190848529.doc> [DOC-KB]. For additional information on CHS eligibility, please refer to the IHS Manual, Part 2, Chapter 3-Contract Health Services, Section 2-3.7 or access the following URL: <http://www.ihs.gov/publicinfo/publications/ihsmanual/part2/pt2chapt3/pt2chtp3.htm>]

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What Data is Collected for CHS-and Why?

The following categories of CHS data are collected:

- Chart facility code
- Chart number
- CHS paid amount
- Date of service
- Patient identifiers
- Primary diagnosis code (ICD9)
- Primary APC Recode
- Provider affiliation code
- Provider disc code
- Vendor TP code

The issue of accurate CHS data is vital to Areas and Tribes: CHS data are used to produce user population data. The Division of Facilities Planning and Construction is dependent on user population information to determine Area and Tribal funding allocation.

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Where is CHS Data Stored?

CHS/MIS

CHS data are stored primarily in the Contract Health Service/Management Information System (CHS/MIS)-a facility-based automated document and fiscal management system for the IHS CHS Program. The CHS/MIS is a fully integrated component of the Resource Patient Management System (RPMS) and uses the shared data files for patients and vendors. The system generates authorizations for CHS payment and maintains an up-to-date commitment register for all current obligations and paid CHS funds. All federally

operated facilities use this application for capturing and storing their CHS data. In addition, tribally operated facility using the services of the CHS Fiscal Intermediary (CHS FI) are required to use CHS/MIS for capturing and storing CHS data. Tribally operated facilities that do not use the services of the CHS FI may choose the CHS/MIS or some other application for capturing and storing data.

In this context, CHS data are referred to as purchase orders (PO). The purchase orders remain open in the system until they are:

- closed,
- partially cancelled,
- or completely cancelled.

A closed purchase order indicates that final payment has been made to the CHS provider and final payment has been posted to the purchase order in CHS/MIS.

Purchase orders are partially cancelled when the cost is overestimated and the obligation funds need to be corrected.⁴ *[Example-Partially Canceled Purchase Order:*

A purchase order was issued for an office visit with an estimated cost of \$75.00. Before the CHS FI paid the vendor, it was discovered the patient had private insurance, therefore the CHS cost is only the co-pay of \$15.00, necessitating a partial cancel of \$60.00.]

When the partial cancel is complete, it restores funds from the Federal/local budget accounting system back to the CHS program, making it available for other uses.

A purchase order created in error would be completely canceled.

CHS FI

CHS data are also stored in the Indian Health Service Claims Processing System (IHSCPS). For federal and tribal sites using the services of the CHS FI, electronic data exports are made from the CHS/MIS to the CHS FI. The exports contain new purchase orders needing payment. The FI loads this data into its application-the Indian Health Service Claims Processing System. The FI also receives a hardcopy of the purchase order and claim from the CHS provider.

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TITLE 42--PUBLIC HEALTH

CHAPTER I--PUBLIC HEALTH SERVICE, DEPARTMENT OF HEALTH AND HUMAN SERVICES

PART 136_INDIAN HEALTH--Table of Contents

Subpart C_Contract Health Services

Sec. 136.21 Definitions.

Source: 64 FR 58320, Oct. 28, 1999, unless otherwise noted.
Redesignated at 67 FR 35342, May 17, 2002.

- (a) Alternate resources is defined in Sec. 136.61 of subpart G of this part.
- (b) Appropriate ordering official means, unless otherwise specified by contract with the health care facility or provider, the ordering official for the contract health service delivery area in which the individual requesting contract health services or on whose behalf the services are requested, resides.
- (c) Area Director means the Director of an Indian Health Service Area designated for purposes of administration of Indian Health Service programs.
- (d) Contract health service delivery area means the geographic area within which contract health services will be made available by the IHS to members of an identified Indian community who reside in the area, subject to the provisions of this subpart.
- (e) Contract health services means health services provided at the expense of the Indian Health Service from public or private medical or hospital facilities other than those of the Service.
- (f) Emergency means any medical condition for which immediate medical attention is necessary to prevent the death or serious impairment of the health of an individual.
- (g) Indian tribe means any Indian tribe, band, nation, group, Pueblo, or community, including any Alaska Native village or Native group, which is federally recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.
- (h) Program Director means the Director of an Indian Health Service "program area" designated for the purposes of administration of Indian Health Service programs.
- (i) Reservation means any federally recognized Indian tribe's reservation, Pueblo, or colony, including former reservations in Oklahoma, Alaska Native regions established pursuant to the Alaska Native Claims Settlement Act (43 U.S.C. 1601 et seq.), and Indian allotments.
- (j) Secretary means the Secretary of Health and Human Services to whom the authority involved has been delegated.
- (k) Service means the Indian Health Service.

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(1) Service Unit Director means the Director of an Indian Health Service ``Service unit area'' designated for purposes of administration of Indian Health Service programs.

[64 FR 58320, Oct. 28, 1999. Redesignated and amended at 67 FR 35342, May 17, 2002]

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TITLE 42--PUBLIC HEALTH

CHAPTER I--PUBLIC HEALTH SERVICE, DEPARTMENT OF HEALTH AND HUMAN SERVICES

PART 136_INDIAN HEALTH--Table of Contents

Subpart C_Contract Health Services

Sec. 136.22 Establishment of contract health service delivery areas.

(a) In accordance with the congressional intention that funds appropriated for the general support of the health program of the Indian Health Service be used to provide health services for Indians who live on or near Indian reservations, contract health service delivery areas are established as follows:

- (1) The State of Alaska;
- (2) The State of Nevada;
- (3) the State of Oklahoma;

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(4) Chippewa, Mackinac, Luce, Alger, Schoolcraft, Delta, and Marquette Counties in the State of Michigan;

(5) Clark, Eau Claire, Jackson, La Crosse, Monroe, Vernon, Crawford, Shawano, Marathon, Wood, Juneau, Adams, Columbia, and Sauk Counties in the State of Wisconsin and Houston County in the State of Minnesota;

(6) With respect to all other reservations within the funded scope of the Indian health program, the contract health services delivery area shall consist of a county which includes all or part of a reservation, and any county or counties which have a common boundary with the reservation.

(b) The Secretary may from time to time, redesignate areas or communities within the United States as appropriate for inclusion or exclusion from a contract health service delivery area after consultation with the tribal governing body or bodies on those reservations included within the contract health service delivery area. The Secretary will take the following criteria into consideration:

- (1) The number of Indians residing in the area proposed to be so included or excluded;
- (2) Whether the tribal governing body has determined that Indians residing in the area near the reservation are socially and economically affiliated with the tribe;
- (3) The geographic proximity to the reservation of the area whose inclusion or exclusion is being considered; and
- (4) The level of funding which would be available for the provision of contract health services.

(c) Any redesignation under paragraph (b) of this section shall be made in accordance with the procedures of the Administrative Procedure Act (5 U.S.C. 553).

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CHAPTER I--PUBLIC HEALTH SERVICE, DEPARTMENT OF HEALTH AND HUMAN SERVICES

PART 136_INDIAN HEALTH--Table of Contents

Subpart C_Contract Health Services

Sec. 136.23 Persons to whom contract health services will be provided.

(a) In general. To the extent that resources permit, and subject to the provisions of this subpart, contract health services will be made available as medically indicated, when necessary health services by an Indian Health Service facility are not reasonably accessible or available, to persons described in and in accordance with Sec. 136.12 of this part if those persons:

(1) Reside within the United States and on a reservation located within a contract health service delivery area; or

(2) Do not reside on a reservation but reside within a contract health service delivery area and:

(i) Are members of the tribe or tribes located on that reservation or of the tribe or tribes for which the reservation was established; or
(ii) Maintain close economic and social ties with that tribe or tribes.

(b) Students and transients. Subject to the provisions of this subpart, contract health services will be made available to students and transients who would be eligible for contract health services at the place of their permanent residence within a contract health service delivery area, but are temporarily absent from their residence as follows:

(1) Student--during their full-time attendance at programs of vocational, technical, or academic education, including normal school breaks (such as vacations, semester or other scheduled breaks occurring during their attendance) and for a period not to exceed 180 days after the completion of the course of study.

(2) Transients (persons who are in travel or are temporarily employed, such as seasonal or migratory workers) during their absence.

(c) Other persons outside the contract health service delivery area. Persons who leave the contract health service delivery area in which they are eligible for contract health service and are neither students nor transients will be eligible for contract health service for a period not to exceed 180 days from such departure.

(d) Foster children. Indian children who are placed in foster care outside a contract health service delivery area by order of a court of competent jurisdiction and who were eligible for contract health services at the time of the court order shall continue to be eligible for contract health services while in foster care.

(e) Priorities for contract health services. When funds are insufficient to provide the volume of contract health services indicated as needed by the

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population residing in a contract health service delivery area, priorities for service shall be determined on the basis of relative medical need.

(f) Alternate resources. The term "alternate resources" is defined in Sec. 136.61(c) of Subpart G of this part.

[64 FR 58319, Oct. 28, 1999. Redesignated and amended at 67 FR 35342, May 17, 2002]

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TITLE 42--PUBLIC HEALTH

CHAPTER I--PUBLIC HEALTH SERVICE, DEPARTMENT OF HEALTH AND HUMAN SERVICES

PART 136_INDIAN HEALTH--Table of Contents

Subpart C_Contract Health Services

Sec. 136.24 Authorization for contract health services.

(a) No payment will be made for medical care and services obtained from non-Service providers or in non-Service facilities unless the applicable requirements of paragraphs (b) and (c) of this section have been met and a purchase order for the care and services has been issued by the appropriate ordering official to the medical care provider.

(b) In nonemergency cases, a sick or disabled Indian, an individual or agency acting on behalf of the Indian, or the medical care provider shall, prior to the provision of medical care and services notify the appropriate ordering official of the need for services and supply information that the ordering official deems necessary to determine the relative medical need for the services and the individual's eligibility. The requirement for notice prior to providing medical care and services under this paragraph may be waived by the ordering official if:

- (1) Such notice and information are provided within 72 hours after the beginning of treatment or admission to a health care facility; and
- (2) The ordering official determines that giving of notice prior to obtaining the medical care and services was impracticable or that other good cause exists for the failure to provide prior notice.

(c) In emergency cases, a sick or disabled Indian, or an individual or agency acting on behalf of the Indian, or the medical care provider shall within 72 hours after the beginning of treatment for the condition or after admission to a health care facility notify the appropriate ordering official of the fact of the admission or treatment, together with information necessary to determine the relative medical need for the services and the eligibility of the Indian for the services. The 72-hour period may be extended if the ordering official determines that notification within the prescribed period was impracticable or that other good cause exists for the failure to comply.

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TITLE 42--PUBLIC HEALTH

CHAPTER I--PUBLIC HEALTH SERVICE, DEPARTMENT OF HEALTH AND HUMAN SERVICES

PART 136_INDIAN HEALTH--Table of Contents

Subpart C_Contract Health Services

Sec. 136.25 Reconsideration and appeals.

(a) Any person to whom contract health services are denied shall be notified of the denial in writing together with a statement of the reason for the denial. The notice shall advise the applicant for contract health services that within 30 days from the receipt of the notice the applicant:

(1) May obtain a reconsideration by the appropriate Service Unit Director of the original denial if the applicant submits additional supporting information not previously submitted; or

(2) If no additional information is submitted, may appeal the original denial by the Service Unit Director to the appropriate Area or program director. A request for reconsideration or appeal shall be in writing and shall set forth the grounds supporting the request or appeal.

(b) If the original decision is affirmed on reconsideration, the applicant shall be so notified in writing and advised that an appeal may be taken to the Area or program director within 30 days of receipt of the notice of the reconsidered decision. The appeal shall be in writing and shall set forth the grounds supporting the appeal.

(c) If the original or reconsidered decision is affirmed on appeal by the Area or program director, the applicant shall be so notified in writing and advised that a further appeal may be taken to the Director, Indian Health Service, within 30 days of receipt of the notice. The appeal shall be in writing and shall set the grounds supporting the appeal. The decision of the Director, Indian Health Service, shall constitute final administrative action.

Subpart D [Reserved]

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2-3.1 PURPOSE

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

To delegate to the greatest degree possible, within the limits of available funds, authority for the operation of the CHS Program to Area Directors and the Service Unit Directors, (SUD)

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

To further explain the Code of Federal Regulations Title 42, Sections 36.21 through 36.25. However, this manual should not be cited as authority for making decisions on eligibility or payment denials. The CFR is the proper citation for correspondence to providers and American Indian and Alaska Native patients.

2-3.2 ACRONYMS

CFR - Code of Federal Regulations
 CHEF - Catastrophic Health Emergency Fund
 CHS - Contract Health Services
 CHSDA - Contract Health Service Delivery Area
 CHS/MIS - Contract Health Services/Management Information System, the CHS Commitment Register
 CDSR - Core Data Set Requirement
 FMCRA - Federal Medical Care Recovery Act
 FMFIA - Federal Managers' Financial Integrity Act
 FI - Fiscal Intermediary
 IHCIA - Indian Health Care Improvement Act
 IHS - Indian Health Service
 P.L. - Public Law
 PRO - Peer Review Organization
 SU - Service Unit
 SUD - Service Unit Director
 U.S.C. - United States Code

2-3.3

DEFINITIONS (Also, See 42 CFR 36.21, 1986)

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

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

Area Director - The Director of an IHS Area designated for purposes of administration on IHS programs.

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

Contract Health Service Delivery Area - The geographic areas within which CHS will be made available by the IHS. (Reference Federal Register, vol. 49, No. 6, 1984)

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

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

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

Contract Health Services to Support Direct Care - These are provided within an IHS facility when the patient is under direct supervision of an IHS physician or a contract physician practicing under the

auspices (or authority) of the IHS facility. Examples of direct care services that cannot be reimbursed with CHS funds are on-call hours, after hours or weekend pay, and holiday coverage. (e.g., for x-ray, laboratory, pharmacy).

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

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

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

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

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

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

Service - The Indian Health Service.

Service Unit Director - The Director of an IHS service unit designated for purposes of administration of IHS programs.

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

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

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

2-3.4 USES OF CHS

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

1-3.5 RESPONSIBILITIES FOR ADMINISTRATION OF CHS

A. Headquarters.

- (1) Establish general policies regarding the administration of the CHS program in the IHS.
- (2) Establish standards of performance for Area, SU, and Fiscal Intermediary (FI) operations of CHS.
- (3) Assess the performance of the CHS program at Area, SU, and FI against established standards.
- (4) Assess long-term purpose and direction of the CHS program to ensure maximum effectiveness of the program in meeting the health needs of Indian people.
- (5) Develop long-term plans and objectives for the future development of the CHS program.
- (6) Provide staff assistance to Area Offices in matters of general policies and procedures.
- (7) Prepare budget justification for the total CHS program.
- (8) Allocate funds through the Division of Resources Management to Area Directors.
- (9) Promptly and appropriately respond to appeals of denials of CHS by IHS Area Offices.
- (10) Provide guidance in the establishment of medical priorities.
- (11) Provide project officer services for the FI contract and all FI evaluation projects.
- (12) Respond to congressional questions and requests for information from the CHS program.
- (13) Centrally manage the Catastrophic Health Emergency Fund (CHEF).
- (14) Establish general guidelines and policies for applying managed care practices and CHS quality assurance activities in the Areas/SUs.
- (15) Responsible for establishing and implementing a Management Control System for the CHS function that conforms to the requirements of the Federal Managers' Financial Integrity Act (FMFIA), Section 2 (31 U.S.C. 3512 (b)), and IHS policies and procedures cited in the Indian Health Manual, Part 5, Chapter 16, "Management Control Systems."

B. Area Offices.

- (1) Within regulations, policies, procedures, and budget, develop and establish policies and methods for the direction, control, review, and evaluation of the Area and SU CHS programs.
- (2) Establish medical priorities for the care of eligible Indian people that will most effectively meet their needs within the funds available.
- (3) Maintain records for planning and for controlling funds and furnish reports to Headquarters as required.
- (4) Coordinate the Area CHS program to allocate an equitable share of funds among the SUs.
- (5) Establish contracts in cooperation with SUDs for needed services with hospitals, clinics, physicians, dentists, and others in accordance with the Area policies and established regulations, the CHS payment policy of June 30, 1986, and policy and procedures established in the Indian Health Manual, Part 5, Chapter 5, Section 13, "Acquisition of Health Care Services." Provide assistance to P.L. 93-638 programs with these activities as requested/required.
- (6) Coordinate appropriate contract activities with the Contracting Officer.
- (7) Periodically review and evaluate the services provided under contract to ensure quality and effectiveness. In carrying out this responsibility, Areas are encouraged

- to utilize the services of one or more peer review organizations established under P.L. 92-603, Social Security Amendments of 1972.
- (8) Act on appeals of SU denials, whether issued by a SUD or a comparable official for P.L. 93-638 operated CHS programs, promptly and appropriately.
- (9) Monitor the CHEF cases submitted by the Area SUs or P.L. 93-638 operated CHS programs.
- (10) Establish general guidelines and policies for applying managed care practices and CHS quality assurance activities in the Areas/SUs.
- (11) Responsible for internal controls related to the FMFIA.

C. Service Units/Tribally Operated Programs.

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

2-3.6

ESTABLISHMENT OF CHSDAs

A. CHSDAs

- (1) The approved CHSDAs are specified in 42 CFR 36.22, and may be changed only in accordance with the Administrative Procedures Act (5 U.S.C. 553).
- (2) Established CHSDAs are identified below:
 - a. The State of Alaska.
 - b. The State of Nevada.
 - c. The State of Oklahoma.
 - d. Chippewa, Mackinac, Luce, Alger, Schoolcraft, Delta, and Marquette Counties in the State of Michigan.
 - e. Clark, Eau Claire, Jackson, Lacrosse, Monroe, Vernon, Crawford, Shawano, Marathon, Wood, Juneau, Adams, Columbia, and Sauk Counties in the State of Wisconsin, and Houston County in the State of Minnesota.
 - f. The State of California, excluding the counties of Alameda, Contra Costa, Los Angeles, Marin, Orange, Sacramento, San Francisco, San Mateo, Santa Cruz, Kern, Merced, Monterey, Napa, San Benito, San Joaquin, San Luis Obispo, Santa Cruz, Solano, Stanislaus, and Ventura.
 - g. With respect to all other reservations, within the funded scope of the Indian health program, the CHSDA consists of a county that includes all or part of a reservation, and any county or counties that have a common boundary with the reservation.
 - h. In addition, the Congress statutorily creates or redesignates CHSDAs through legislative enactments such as appropriations, restoration and/or

recognition acts, public laws, etc. This information is distributed through public issuances as necessary.

B. Redesignation of CHSDAs.

- (1) Request for redesignation of CHSDAs may be initiated by the tribal group(s) affected, or by IHS, after participation with the affected tribal group(s).
- (2) All requests for redesignation must provide the following information:
 - a. The estimated number of Indian people who will be included and/or excluded for eligibility of CHS.
 - b. The tribal governing body's designation of the categories of Indian people to be included and/or excluded from eligibility for CHS; i.e., (1) members of the tribe who live near the reservation; (2) Indian people who are not members of the tribe but have close economic and social ties with the tribe. Please note that redesignation of CHSDAs may not result in the exclusion of Indian people eligible under 42 CFR 36.23(a)(1), i.e., reservation residents. Generally, it is expected that an expansion in the CHSDA will not exceed counties that border the current CHSDA. All CHSDAs must be within the U.S.
 - c. The estimated costs of including additional Indian people in the CHSDA as determined in accordance with the IHS resource allocation guidelines currently in effect.
 - d. The impact of the change in the CHSDA on the level of CHS being provided to eligible Indian people in the original CHSDA.
 - e. The justification for the change in the CHSDA. The justification may include criteria used in establishing the CHSDA for the States of Oklahoma, Nevada, Michigan, and Minnesota outlined in 42 CFR 36, page 34650, items 10, 11, and 12, but are not limited to these criteria.
- (3) Submission of a Proposed CHSDA Change
 - a. The Area will analyze the proposal outlining positive and negative features, and will recommend acceptance or rejection over the signature of the Area Director to the Director, IHS. Proposal for change in a CHSDA will be submitted to Headquarters, Attention: Chief, CHS Branch, for appropriate action.
 - b. The CHS Branch will review the request for redesignation of the CHSDA, and apply the criteria outlined in Paragraph 2 above to the information submitted to support the request.
 - c. After review, the CHS Branch shall make findings as to whether the criteria has been met and recommend whether the request for redesignation should be granted.
- (4) The regulations at 42 C.F.R. -36.22(b) state that after consultation with the tribal governing body or bodies of those reservations included in the CHSDA, the Secretary may 'from time to time, redesignate areas within the United States for inclusion in or exclusion from a CHSDA. Consultation with the affected tribe(s) occurs during the review of the request for redesignation, but the IHS publishes as well a notice with requests for comments as part of the consultation process.
 - a. If after determining that a redesignation of a tribe's CHSDA should be made, the IHS shall publish a notice with request for comments in the Federal Register advising the public that the IHS proposes to redesignate a particular tribe's CHSDA.
 - b. The notice with request for comments shall include:
 - (i) The proposed action and the background information sufficient to provide the public an explanation for the agency's decision.

- (ii) A statement as to the date when comments must be received. There must be at least a 30-day "comment" period from date of publication of the notice.
 - (iii) Reference to the legal authority and the name and address of the public official to whom comments should be addressed.
- (5) Effective Date of CHSDA Change.

After a review of any comments received by the IHS after publication of its notice with request for comments, and after determining that the tribe's CHSDA should still be redesignated, the IHS shall publish a final notice advising the public that the IHS is redesignating a particular tribe's CHSDA.

The change in the CHSDA will be effective on the date of the final notice in the Federal Register.

- (6) Counties may be added to a tribe's CHSDA by operation of the CHS regulations when (a) the IHS inadvertently or mistakenly omitted the county from the tribe's CHSDA list; or (b) the tribe's reservation was expanded or created by a proclamation issued by the Secretary of Interior or by congressional statute, e.g., Federal recognition of a tribe. Under these circumstances, the notice and comment process described above, in paragraphs (2) through (5), is not necessary. Instead, a memorandum from the IHS Director is mailed to the respective IHS Area Director regarding the action resulting in a correction to, or expansion or creation of, the tribe's CHSDA with instructions to the Area Director to contact the tribe with this information.

2-3.7 PERSONS TO WHOM CHS WILL BE PROVIDED

- A. There is no authority to provide payment for services under the CHS program unless funds are, in fact, available.
- B. The CHS funds are limited to services that are medically indicated. See Exhibit 2-3-A for services that may be included and those specifically excluded.
- C. The CHS may not be expended for services that are reasonably accessible and available at IHS facilities.
 - (1) The determination as to an IHS/tribal facility being, "reasonably accessible and available" is a service unit/tribal health director decision based on the following criteria:
 - a. Determination of the actual medical condition of the patient, i.e., emergent, urgent, or routine.
 - b. The ability of the IHS/tribal facility to provide the necessary service.
 - c. The level of funding available to provide CHS.
 - d. Distance from the IHS/tribal facility.
 - (2) The following guidelines will be used in applying the above, criteria:
 - a. The CHS funds may be authorized for an emergency to the extent that the contract facility was the nearest available provider capable of providing the necessary services and the patient's condition dictated that he/she be transported to the nearest hospital. There must be a compelling reason to believe, upon review of the medical record and assessment of the patient's situation, that without immediate medical treatment an individual's life or limb would have been endangered.

Tribal Health Directors may consult with available IHS Chief Medical

Officers, medical staff, or contract providers in order to arrive at an administrative decision.

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

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

E. Eligibility.

To be eligible for CHS, an individual must:

- (1) Reside within the U.S. and on a reservation located within a CHSDA; or
- (2) Reside within the U.S., and
 - a. within a CHSDA, and
 - b. be a member of the tribe or tribes located on that reservation or maintain close economic and social ties with such tribe or tribes.

The basis for determining close economic and social ties are established by:

- (i) employment with a tribe whose reservation is located within a CHSDA in which the applicant lives;
- (ii) marriage to, or being a 'child of (see Section 2-3.7 (5)e, below), an eligible member of the tribe or

- (iii) determination by the tribe, including certification from the tribe or tribes near where they live that they have close economic and social ties with the tribe whose reservation is located within a CHSDA in which the applicant lives.
- (3) An Indian claiming eligibility for CHS has the responsibility to furnish the SUD or the tribal program with documentation to substantiate the claim.
- (4) Be a student or transient.
 - a. Boarding School Students CHS is provided during their full-time attendance, by the Area where the boarding school is located, while the student is in attendance at all Bureau of Indian Affairs (BIA) boarding schools, including the following BIA off reservation schools: Flandreau Indian School, Moody County, South Dakota; Wahpeton Indian School, Richland County, -North Dakota; Sherman Indian High School, Riverside County, California; Maricopa County, Arizona; Riverside Indian School, Caddo County, Oklahoma; and Chemawa Indian School, Marion County, Oregon. Boarding school students can receive CHS whether or not they resided in a CHSDA before attending the school.

While the student is on a scheduled break or vacation, the student's CHS permanent area of residence is responsible for payment of CHS services.
 - b. The CHS will be made available to students and transients who would be eligible or CHS at the place of their permanent residence within a CHSDA, but who are temporarily absent from their residence, as follows:
 - (i) College (undergraduate and graduate) vocational, technical, or other academic education. The SU where the student was eligible for CHS prior to leaving for school is responsible for the student. While the student is on a scheduled break or vacation, the student's CHS permanent area of residence is responsible for payment of CHS services.
 - (ii) Transients (persons who are in travel or are temporarily employed, such as seasonal or migratory workers), during their absence from their place of residence.
 - (iii) Other persons outside the CHSDA. Persons who leave the CHSDA in which they are eligible for CHS, and are neither students nor transients, will be eligible for CHS for a period not to exceed 180 days from such departure.
- (5) Other Eligibility Considerations:
 - a. An Indian is not required to be a citizen of the U.S. to be eligible for CHS. The Indian (e.g., Canadian or Mexican) must reside in the U.S. and be a member of a tribe whose traditional land is divided by the Canadian border (i.e., St. Regis Mohawk, Blackfeet) or Mexican border (i.e. Tohono O'Odham).
 - b. Section 709(b) of the Indian Health Care Improvement Act, until such time as any subsequent law may otherwise provide, states that the following California Indians shall be eligible for health services provided by the Service:
 - (1) any member of a federally recognized Indian tribe; (2) any descendent of an Indian who was residing in California on June 1, 1852, but only if such descendent - (A) is living in California, (B) is a member

of the Indian community served by a local program of the Service, and (C) is regarded as an Indian by the community in which the descendent lives; (3) any Indian who holds trust interests in public domain, national forest, or Indian reservation allotments in California; and (4) any Indian in California who is listed on the plans for distribution of assets of California rancherias and reservations under the Act of August 18, 1958 (72 STAT. 619), and any descendent of such an Indian. Section 709(c) states that nothing in this Section may be construed as expanding the eligibility of California Indians for health services provided by the Service beyond the scope of eligibility for such health services that applied on May 1, 1986.

- c. Indians adopted by non-Indian parents must meet all CHS requirements to be eligible for care (e.g., reside in a CHSDA).
- d. Foster/Custodial Children - Indian children who are placed in foster care outside a CHSDA by order of a court of competent jurisdiction and who were eligible for CHS at the time of the court order shall continue to be eligible for CHS while in foster care.
- e. Section 813 of the Indian Health Care Improvement Act, P.L. 94-437, as amended, states in part: "(a)(1) Any individual who (A) has not attained 19 years of age, (B) is the natural or adopted child, step-child, foster-child, legal ward, or orphan of an eligible Indian, and (C) is not otherwise eligible for the health services provided by the Service, shall be provided by the Service on the same basis and subject to the same rules that " apply to eligible Indians until such individual attains 19 years of age. (2) Any spouse of an eligible Indian who is not an Indian, or who is of Indian descent but not otherwise eligible for the health services provided by the Service, shall be eligible for such health services if all of such spouses are made eligible, as a class, by an appropriate resolution of the governing body of the Indian tribe of the eligible Indian."
- f. A non-Indian woman pregnant with an eligible Indian's child who resides within a CHSDA is eligible for CHS during pregnancy through post partum (usually 6 weeks). If unmarried, such a woman is eligible for CHS if an eligible Indian male states in writing that he is the father of the unborn child or such is determined by order of a court of competent jurisdiction. This will ensure health services to the unborn Indian child.
- g. A non-Indian member of an eligible Indian's household who resides within a CHSDA is eligible for CHS if the medical officer in charge determines that services are necessary to control a public health hazard or an acute infectious disease, which constitutes a public health hazard.

F. Priorities for CHS.

- (1) Regulations permit the establishment of priorities based on relative medical need when funds are insufficient to provide the volume of CHS indicated as needed by the population residing in a CHSDA. The IHS medical priorities are found in Section 2-3.17. Tribal programs are required to follow IHS regulations and can utilize Section 2-3.17 priorities as guidelines.
 - a. Area-wide priorities should be established to ensure an equivalent level of services in all SUs, taking into consideration the availability and accessibility of IHS/tribal facilities, the population being served, the relative cost of services, and the availability of alternate resources.

- b. Priorities established to limit services, whether on an Area-wide or SU basis, shall be made known to the Indian population being served through publication in local community and/or tribal newspapers and posting of notices on bulletin boards in patient areas of IHS/tribal facilities.

G. Payor of Last Resort - 42 CFR 36.61

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

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

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

GUIDELINE: The IHS should provide the patient with a written notice that explains the patient's need to make a "good faith" application to the alternate resource program. The notice should include information such as the need to schedule and attend scheduled appointments, the necessary documentation to bring to the appointments, and availability of transportation to appointments. (See sample written notice, Appendix 2-3-A.)

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

process.

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

The Area/SU should include with the written notice an authorization to release and an assignment of rights form for the patient to sign and return to CHS. These forms authorize the IHS to obtain information from the alternate resource program files and allows IHS to intervene on the patient's behalf to ensure completion of the application. (See Appendix 2-3-B.)

In some areas, the CHS offices or social services assist the patient in completing an alternate resource application prior to an illness or injury. This policy should be encouraged; however, the IHS should not deny CHS funds for an individual's failure to apply prior to medical need. This issue is most relevant in those States that have a limited retroactive eligibility rule such as Arizona where Arizona Health Care Cost Containment System has a 48-hour retroactive eligibility rule.

Some CHS offices obtain the signatures of individuals acknowledging that they are not eligible for CHS, e.g., not residing within the CHSDA. This policy should continue with an additional requirement that when the CHS office determines an individual is not CHS eligible, the CHS office should assist the individual in completing the alternate resource application.

Each CHS office should document attempts to assist patients in applying for or completing an alternate resource application. Documentation of assistance for application to the alternate resource program is necessary to support a decision whether to authorize payment of CHS funds.

(5)

Completed Application To Alternate Resource Program.

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

If a completed application to an alternate resource program results in a denial for a McNabb-type reason (the program denied because of an alternate resource-type rule of its own or based on a policy that IHS should pay for on-reservation Indians), the IHS will pay the bill and report the case to the regional attorney.

Under the old regulations, a completed alternate resource application was not required when the file was well documented that an application to the alternate resource program would prove futile. An application to the alternate resource

program was determined to be futile when the program had an alternate resource-type rule of its own or a policy that IHS should pay because the patient was Indian. In these instances, the CHS office paid the Indian patient's medical bills, under protest.

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

(6)

Failure To Follow Alternate Resource Procedures

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

First, when the patient willfully or intentionally fails to apply or fails to complete an alternate resource application. If IHS does not require its beneficiaries, in "good faith," to apply for and complete an alternate resource application, the alternate resource rule will have little effect on conserving contract health funds.

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

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

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

The SU should inform non-IHS providers (i.e., non-IHS facilities and practitioners providing medical services to IHS beneficiaries) of the CHS

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

- a. The use of alternate resources is mandated by IHS Payor of Last Resort Rule, 42 C.F.R. 36.61 [1990].
 - (i) An individual is required to apply for an alternate resource if there is reasonable indication that the individual may be eligible for the alternate resource.
 - (ii) Refusal to apply for alternate resources when there is a reasonable possibility that one exists, or refusal to use an alternate resource, requires the denial of eligibility for CHS.
 - (iii) An individual is not required to expend personal resources for health services to meet alternate resource eligibility or to sell valuables or property to become eligible for alternate resources.

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

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

2-3.8 AUTHORIZATION FOR CHS

- A. Notification requirements as described in the Federal Register of August 4, 1978, and contained specifically in 42 CFR 36.24, will be followed, including but not limited to:
 - (1) No payment will be-made for medical care and services obtained from non-

- service providers or in non-service facilities unless the requirements listed below have been met and a purchase order for the care and services has been issued by the appropriate IHS ordering official to the medical care provider.
- (2) In non-emergency cases, an eligible Indian, an eligible non-Indian, [or] an individual or agency acting on behalf of this person, or the medical care provider shall, prior to the provision of medical care and services, notify the appropriate IHS ordering official of the need for services and supply information that the ordering official deems necessary to determine the relative medical need for the services and the individual's eligibility. The requirement for notice prior to providing medical care and services under this paragraph may be waived by the ordering official if the ordering official determines that giving of notice prior to obtaining the medical care and services was impracticable or that other good cause exists for the failure to provide prior notice.
 - (3) In emergency cases, an eligible Indian, an eligible non-Indian, an individual or agency acting on behalf of this person, or the medical care provider shall, within 72 hours after the beginning of treatment for the condition or after admission to a health care facility, notify the appropriate IHS ordering official of the admission or treatment and provide information to determine the relative medical need for the services. The 72-hour period may be extended if the ordering official determines that notification within the prescribed period was impracticable or that other good cause exists for the failure to comply.
 - (4) Section 406 Of P.L. 94-437, as amended, allows the elderly and disabled 30 days to notify the IHS of emergency medical care received from non-IHS medical providers or at non-IHS medical facilities. The following definitions for elderly Indian and disabled Indian are to be used until further defined and published in the Federal Register.

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

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

Notification requirements apply to all categories of eligible persons including students, transients, and persons who leave the CHSDA.

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

For the purpose of this section of the manual a patient's permanent area of record

is defined as the area where the patient currently resides unless an exception applies such as the patient has moved to attend a University full time. (See examples of clarification of the concept, Manual Exhibit 2-3-I.)

- C. Payment shall be in accordance with the provisions of the contract or purchase order and other provisions put forward in the payment policy.
- D. Persons Under Treatment at the Expiration of 180-Day Eligibility Period.

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

This does not include continued treatment of chronic conditions, or for example, obstetrical deliveries that occur after 180-Days.

- E. Responsibility to Notify Indian Community of Requirements for Authorization.
 - (1) Indian people affected by the CHS program must be kept aware of policies on administrative requirements for approval of CHS payment for services, and the title(s) of the person(s) who will be notified when CHS is required. This notification will include at least publication in local community and/or tribal newspapers and posting of notices on bulletin boards in patient areas if the IHS facilities. Changes in local policies or administrative requirements will be published and posted as outlined above including notification to vendors commonly used by Indian people who may or may not have contracts with IHS.
 - (2) The Indian person being referred from an IHS/tribal facility will be notified at referral time of his/her eligibility status for CHS. In cases where determination of eligibility cannot be made before referral, the individual will be notified in writing that the IHS/tribe may not be responsible for bills incurred. See Exhibit 2-3-C.
- F. CHS Authorization Numbering System.

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

- (1) The number has four components and consists of 10 digits.
- (2) The four components are 00 0 00 00000.
- (3) The first digit of the first component is always 0, followed by the last digit of the fiscal year being charged for the services. Example: Fiscal Year 1998 is 08.
- (4) The second component is an alpha code to identify the Area. The alpha codes are:

Aberdeen	C	Navajo	N
Alaska	A	Oklahoma	O
Albuquerque	Q	Phoenix	X
Bemidji	D	Portland	P
Billings	B	Tucson	S
California	L	Nashville	U

- (5) The third component consists of the two digit fiscal code that identifies the facility being charged for the services. The digits are standard location code as used in the Fiscal Accounting System.
- (6) The fourth component has five digits and is sequential number for the documents to be charged to each issuing facility. These numbers will begin each fiscal year

with 00001 and continue sequentially for the year. Supplemental authorizations, if necessary, will be numbered with the original numbers plus a suffix of S-1, S-2, etc.

- (7) The CHS Authorization Process, Flowchart - The flow of a CHS purchase order for from initial request through processing and closeout is diagramed in Exhibit 2-3-H. Many aspects of CHS and other activities are incorporated in this general flow. The flow chart provides a general description of the process.

2-3.9

PAYMENT DENIALS

- A. If a person is denied CHS, or when a medical provider may reasonably think that IHS is a party to payment, both the patient and the provider must be notified in writing of the denial with a statement containing all the reasons for the denial. Refer to the CHS/Management Information System manual (version 2.0) denial package. The notice must inform the applicant that within 30 days from the receipt of the notice the applicant:
- (1) May request a reconsideration by the appropriate SUD/Tribal Health Director and that a request for reconsideration must contain additional information not previously submitted.
 - (2) In accordance with Section D may appeal the original denial by the SUD/Tribal Health Director to the appropriate Area Director, if there is no additional information on which to base reconsideration.

Appeals may be submitted by providers. The provider will be considered as acting on behalf of the patient. A response must be made to the provider and a courtesy copy of such response is provided to the patient.

- B. When on appeal, the Area Director upholds the denial, the applicant must be notified in writing of the denial and that an appeal may be submitted in writing to the Director, IHS within 30 days.
- C. If the claimant fails to follow procedures, the request for reconsideration of an appeal may be denied. A written Notice of Denial will be sent to the claimant.
- D. The IHS appeals process applies to IHS administered CHS programs and to Title I and III programs that have negotiated and incorporated into their funding agreements that the IHS appeals procedures will be utilized.
 - (1) The CHS regulations currently in effect at 42 CFR 36.25 (1986) only allow three levels of appeal: (a) request for reconsideration of the appeal by the SUD/Tribal Health Director or other individual or group designated by the tribe, (b) appeal to the Area Director, and (c) final administrative appeal to the Director, IHS.

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

- (2) Title I and III programs that have negotiated and incorporated into their funding agreement that the IHS appeals procedures will be utilized agree to the following terms and conditions:
 - a. The Area Director and the Director, IHS utilizes the IHS', not tribal criteria and interpretations, to adjudicate claims. The IHS utilizes its

- b. medical priorities and policies to adjudicate IHS CHS claims. The Title I or III program shall provide necessary documentation required for claims adjudication. Depending on the nature of the claim, documentation such as medical records, date of notification, papers pertaining to residency, etc., could be required.
 - c. The IHS reviews the appeals from Title I and III programs without assuming any fiscal responsibility. When an Area Director, or the Director, IHS, issues a determination overturning the tribal denial of payment authorization, it is the responsibility of the tribe not the IHS to pay the bill.
 - d. The tribe must have left sufficient funds with the IHS before either an Area Director or the Director, IHS, may adjudicate a claim. It is not sufficient to have it negotiated and incorporated into a tribe's funding agreement that the IHS appeals procedures will be utilized without withholding sufficient funds to pay for the costs to operate the appeals process for a tribe.
- (3) Denials of CHS payment by Title I and Title III programs that do not utilize the IHS appeals mechanism may not be appealed to an Area Director or the Director, IHS. Tribes that have assumed the CHS appeals function are required to provide administrative procedures pursuant to the Indian Civil Rights Act of 1968 (25 U.S.C. 1301 et seq.). The office of the General Counsel (OGC) had advised that Title I and Title III health programs must make eligibility determinations in accordance with the IHS eligibility regulations in the Code of Federal Regulations (CFR), Title 42, Part 36. However, there are provisions of the IHS eligibility regulations that are subject to interpretation and the tribes are not required to interpret particular words in the regulations in the same way as the IHS. For example, tribes and tribal organizations may have a different definition of "close economic and social ties" for contract health service eligibility (See 42 CFR 36.23.). Thus, eligibility determinations will be made by the individual tribal contractors and compactors consistent with the IHS eligibility regulations at 42 CFR Part 36. Under P.L. 93-638, as amended, individuals who are dissatisfied with tribal determinations of eligibility must pursue tribal administrative remedies. Issues that need to be considered by tribes in the development of appeals policies and procedures include: (1) development of a formal appeals procedure and levels; (2) establishment of clear program policies concerning eligibility, priorities, referrals, and notification of all parties, and (3) protection of individual rights to due process.

2-3.10 APPEALS RECORDS

- A. The SUD, or his/her designee, is administratively responsible for creating and maintaining a file on each denial of CHS.
- B. The appeal file shall contain: all denial letters, all briefing memorandums prepared in connection with any recommendation to the SUD or Area Director regarding such denial; all correspondence to IHS from claimant or claimant's representative; any other relevant correspondence, maps, bills, or receipts; records of telephone calls to or from claimant or claimant's representative; correspondence relative to any inquiry (i.e., congressional, State official, etc.) made on behalf of the claimant; and pertinent correspondence relative to prior appeal by the same claimant.
- C. Tribal organizations that operate a facility and/or CHS programs pursuant to P.L. 93-638, as amended, and such contract includes carrying out the supervisory and administrative

- duties of the SUD, the designated tribal official shall have the same duties and responsibilities as the SUD.
- D. Area Directors, or their designees, are responsible for: (a) establishing individual alphabetical patient appeals files that contain all documentation in chronological order for all appeals, and (b) for forwarding copies of appeals files to Headquarters upon request.
 - E. Area Director, or their designees, should not routinely forward informational copies of all denials to the Headquarters CHS office.
 - F. The Headquarters CHS office is the focal point for processing all CHS appeals to the Director, IHS. All appeal files received by IHS Headquarters are screened in the CHS office to ensure that all required correspondence is included in chronological order.
 - G. The Principal CHS Consultant, Headquarters, or his/her representative, analyzes the issues contained in the appeal and processes the appeal to the extent issues can be handled within established policy.
 - H. Each appeal record/file will be maintained for a period of 6 years and 3 months after the IHS CHS appeals process has been exhausted. This time period will allow sufficient time should the patient utilize the civil court process.
 - I. Appeals that involve questions of medical judgment, are referred to a physician in the Office of Public Health for review.
 - J. Appeals that involve questions that may require a legal opinion are reviewed by staff in the Division of Regulatory and Legal Affairs (DRLA), Office of Management Support, prior to being forwarded to the OGC by the DRLA.
 - K. The decision of the Director, IHS, shall constitute final administrative action.
 - L. The IHS/Executive Secretariat will fax incoming controlled correspondence to the appropriate Area(s). Each CHS officer will analyze the correspondence and submit all necessary documentation to Headquarters so that the CHS Branch, Headquarters, will be able to prepare a response. If there were no appeals to the Area Office or SUD, the CHS Branch is to be so notified. Copies of all determinations issued within the Area are to be submitted to the CHS Branch. If an appeal(s) was submitted to either the SUD or Area Director and the SUD or Area Director has not issued a determination, a status report is to be submitted to support the actions that have been taken.

2-3.11 CONTROL OF FUNDS

- A. The CHS Commitment Registers will be maintained at each authorizing location. The CHS Commitment Register must contain the following minimum information:
 - (1) Date of Authorization
 - (2) Authorization Number
 - (3) Provider Name
 - (4) Patient Name
 - (5) Date of Service
 - (6) Allowance Amount
 - (7) Estimated Cost of Service
 - (8) Balance of Funds
- B. Exhibit 2-3-E provides the recommended format for a Commitment Register that meets the above minimum requirements.
- C. The Commitment Register is to be submitted to the Area Financial Management Office at least once a month. A summary of the CHS fund balance shall be provided to the SUD/Tribal Health Director and the Clinical Director/CHS Committee at least-once a month.
- D. An entry will be made on the Commitment Register for each obligation of funds, or modification of obligation of funds. The entries will be made daily to reflect the services

authorized that working day. Entries should not be delayed beyond 3 working days from the date of referral or notification of services provided.

2-3.12 FOLLOWUP OF OUTSTANDING AUTHORIZATIONS

Each SU will establish a followup system for all authorizations that have not been completed and returned within 90 days of issuance. Exhibit 2-3-D is a recommended form letter for use in these followups.

2-3.13 RECONCILIATION OF COMMITMENT REGISTER

The CHS Commitment Register (CHS/MIS) will be reconciled with the official Financial Management Report, SHR 424, each month of the fiscal year. The recommended procedures for reconciliation of the Commitment Register are provided in Exhibit 2-3-F.

2-3.14 DATE REPORTING

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

2-3.15 CATASTROPHIC HEALTH EMERGENCY FUND

A.

Background.

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

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

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

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

B. governing the CHEF program.
General Policy.

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

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

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

C. Cost Threshold

- (1) The CHEF threshold is adjusted according to CHEF experience, within the range established by law. Language in P.L. 102-573 requires that the Secretary shall establish the threshold cost at not less than \$15,000 or not more than \$25,000 for 1993. The threshold for subsequent years is based on the percentage increase of the expenditures for all urban consumers.
- (2) The cost threshold includes only those costs remaining after payment has been made by Federal, State, Local, private health insurance, or other applicable alternate resources.

3.16 FISCAL INTERMEDIARY

A. Purpose The purpose of the Fiscal Intermediary (FI) is to operate a nationwide centralized medical and dental claims processing and payment system; to collect, compile, and organize workload and financial data; and to provide statistical and financial reports to the IHS in administration of its CHS program. The FI pays the following object class codes:

Object Class Code	Description
21.85	Patient and Escort Travel: Includes travel and related costs, e.g., lodging, meals, etc.
25.2A	Medical Lab Services-Outpatient Non-IHS: Includes laboratory costs for outpatients at contract facilities. If pathologists and lab fees are invoiced together use 25.2A. Excludes pathologist professional fee invoiced separately (use 25.4D).
25.2B	Medical Lab Services-Inpatient and Outpatient Facility: Includes all laboratory costs for inpatients and outpatient at IHS facilities referred to contract facilities. Excludes pathologist professional fee invoiced separately (use 25.4C).
25.2D	Dental Laboratory - Includes dental prosthetic fabrication services provided by dental laboratories. <u>Excludes</u> any dentist professional fee (see 25.4E).
25.2G	Non-Federal Hospitalization - Includes inpatient services in non-Federal hospitals.
25.2H	X-ray services-Outpatient Non-IHS: Includes X-ray services for outpatients at contract facilities. If radiologist and facility fees are invoiced together, use 25.2H. Excludes radiologist professional fee invoiced separately (use 25.4D).
25.2J	X-ray Services-Inpatient and Outpatient IHS: Includes all radiology costs for inpatients and outpatients at IHS facilities referred to contract facilities.

- 25.2L Excludes radiologist professional fee invoiced separately (use 25.4C).
Hospital Outpatient - Includes ambulatory services at contract hospitals other than emergency room services. Excludes any physician professional fee billed separately. (See 25.4D)
- 25.2Q Emergency Room (ER) Services - Includes non-IHS hospital ER services. Includes any ER physician fees whether combined or billed separately.
- 25.2R Dialysis - Contract Hospital Inpatient Services. (FY 1991 and prior FYs only.)
- 25.2S Physical Therapy Services: Includes all contract therapy services invoiced separately. Excludes all physician professional fees (use 25.4D.)
- 25.4A Physician-Inpatient-IHS Facility: Includes contract physician services for patients hospitalized in IHS facilities. Includes radiologist and pathologist professional fees invoiced separately.
- 25.4B Physician Inpatient - Non IHS facility - Includes all physician services for patients hospitalized in non-IHS facilities.
- 25.4C Physician-Outpatient-IHS-Facility: Includes all contract physician services for outpatients in IHS facilities. Includes radiologist and pathologist professional fees invoiced separately.
- 25.4D Physician Outpatient - Non-IHS Facility - Includes all physician services for outpatients in non-IHS facilities and physician offices.
- 25.4E Dentists - Includes all services provided by dentists to inpatients and outpatients. Includes combined dental laboratory costs and dental services.
- 25.4G Fee Basis Specialist-IHS Facility: Includes all consultant services other than physicians. Examples are nurse anesthetists, audiologists, speech therapists, podiatrists, and dental hygienists (cost centers 268 and 368).
- 25.4J Fee Basis Specialist-Non-IHS Facility: Includes all consultant services in non-IHS facilities other than physicians. Examples are: Nurse anesthetists, audiologists, dental hygienists, and podiatrists.
- 25.4L Refractions - IHS/Non-IHS Facility - Eye and vision exams only, not for injuries or other medical reasons, by ophthalmologists and optometrists.
- 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).
- 25.4M Dialysis - Physician Outpatient and Inpatient services in IHS; or
- 25.4P Non-IHS Facility. (FY 1991 and prior FYs only.)
- 26.3A Consumable Medical and Surgical Supplies: Includes medical, dental, and surgical supplies. Examples are dressings, bandages, and catheters.
- 26.3G Non-consumable Medical and Surgical Supplies: Includes rental and purchase of Wheelchairs, apnea monitors, oxygen tanks, beds, etc.
- 26.3K Eyeglasses: Includes eyeglasses and repair to eyeglasses. If eyeglasses are billed with the professional fee use 26.3K.
- 26.3L Hearing Aids: Includes costs of hearing aid devices and repairs to hearing aids.
- 43.19 Interest

B.

Authority

The authority for a fiscal agent is contained in P.L. 99-272, the Consolidated Omnibus Budget Reconciliation Act of 1985, Section 17003:

"...provides authority for the Secretary of the Department of Health and Human Services to contract with fiscal agents to perform claims payment, processing and audit functions with respect to services purchased on a contract basis by the Public Health Service. . . Fiscal agents must either be entities which could qualify as carriers for Medicare purposes, or

Indian tribes or tribal organizations acting under Indian Self-Determination Act Contracts. While the fiscal agents need not be Medicare carriers, they must meet the same requirements as Medicare carriers regarding efficiency and effectiveness of operations, surety bonds, and financial controls."

C. FI Operations

For FI operations information refer to "FI Reference Manual" for IHS/CHS, dated September, 1995. The FI Reference Manual is updated to reflect changes or incorporate information on an as-needed basis.

D. Accessing the FI Data System

The IHS is mandated to protect patients' medical information from all security risks. Changes to the FI data system allowing access to data and the ability to communicate through local area networks shall include provisions to ensure patient confidentiality. Ensuring compliance with the Privacy Act and confidentiality requirements is the responsibility of each Area CHSO. Each IHS employee, unless otherwise authorized, is responsible for limiting access to patient medical information to the business of patient care as defined in the IHS mission statement. The following steps provide necessary guidance in accessing the FI data system:

- (1) Access to FI data is accomplished through computer log-on to the IHS Intranet at Headquarters West in Albuquerque, New Mexico.
- (2) The staff involved with the Intranet at Headquarters West and the data system at New Mexico Blue Cross Blue Shield (NMBCBS) are responsible for ensuring that the systems are secure. Firewalls at each location guard against unauthorized access.
- (3) Procedures must be developed and implemented at each IHS site to ensure that Intranet access to the FI data system is revoked when employees leave CHS employment. Employee access to the FI data system can be revoked for a violation of the security requirements. Access may be revoked for reasons other than a violation of the security requirements if requested by IHS Officials.

The FI staff members are required to sign a code of conduct documenting their responsibility to adhere to the Privacy Act.

- (4) The FI violators of the code of conduct will be terminated from employment. Each authorized user of the FI data system will have an individual sign-on and password assigned. It is the responsibility of each user to keep this information confidential. Access must be revoked if the sign-on and password are shared with other staff members regardless of the purpose.
- (5) Training will be provided by IHS and FI staff via teleconferencing for new users. Training will also be provided to current staff as changes and enhancements occur.
- (6) Problems or incidents must be reported to the Area CHSO.

E. Procedures. In order for access to the FI data system to be granted, the following procedures must be followed:

- (1) Requests. Area CHSOs should submit the form found in Manual Exhibit 2-3-J to the FI Project Officer. The CHSO must verify that a confidentiality statement is on file and that privacy act training/orientation has been given to each CHS employee before access to the FI data system is granted.
- (2) Approval. Only the FI Project Officer may approve or deny the requests for CHS data access. When requests are denied, the reasons are documented and returned

to the Area CHSO. Copies of the approved requests will be returned to the respective Area and copies faxed to the FI.

- (3) Access Set-up. The FI staff will receive approved requests and will assign sign-on and passwords.
- (4) Access Training. The FI staff is responsible for contacting the CHS employee granted access to the FI data system with their assigned sign-on and password. The FI staff will provide a practical orientation and ongoing user support for new users via teleconferencing.
- (5) Access Log. The FI staff will maintain a log of all users of the FI data system. Reports will be sent to the FI Project Officer designated by the IHS as requested.
- (6) Other Reports. The FI staff will provide reports to the FI Project Officer as requested. These reports include information about the types of information accessed (i.e., providers) and how often the information is requested.

2-3.17 MEDICAL and DENTAL PRIORITIES

A. Medical Priorities.

The application of medical priorities is necessary to ensure that appropriated IHS/CHS funds are adequate to provide services that are authorized in accordance with IHS approved policies and procedures. See Manual Exhibit 2-3-A.

B. Dental Priorities.

See Manual Exhibit 2-3-B.

2-3.18 DEFERRED SERVICES

Guidelines for recording and reporting on deferred services are:

A. Cases reported as deferred services must meet these criteria:

- (1) The patient must have accessed the IHS health care system during the FY reporting period. Although there will be no carry over in reporting deferred services from one year to the next, the SU has the option to pay for care deferred in a prior FY.
- (2) The service deferred must be elective (i.e., "deferrable"), not emergent/urgent. Denials for payment of care received that were not within medical priorities are reported through the denial reporting process, not as a deferrable service.
- (3) The service required cannot be accessible/available to the patient in the IHS direct system (care provided directly in IHS clinics or facilities, not CHS care) within the usual and customary treatment and referral patterns.
- (4) The service deferred must be within IHS medical priorities. Items listed in the IHS medical priorities as procedures that IHS will not pay for cannot be reported as a deferrable service.

B. The reporting formats and guidelines for deferred services accrued and deferred services expenditures are sent to the Areas on an annual basis.

2-3.19 CHS "MANAGED CARE"

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

- A. There shall be an active CHS Committee to review CHS referrals and emergency cases. Membership should include, at a minimum, the Clinical Director, Director of Nurses or Clinical Manager (or other primary care provider), Utilization Review Nurse (if stated), Administrative Officer, and the CHS Specialist. Meetings must be held at least once a week to determine the appropriateness of referral requests for expenditure of CHS funds.
 Note: Committee members who are related to patients, for whom an inquiry is being made, must excuse themselves from case discussion and decisions. The record of the meeting must reflect the reason that the employee excused himself/herself from the case. The employee with procurement authority must not sign the purchase/delivery order for patients to whom she/he is related.
- B. The Committee will consider the following criteria, at a minimum, for CHS cases:
 - (1) The care must be within medical priorities.
 - (2) Funds must be available.
 - (3) The requested service must not be available in an IHS/tribal facility.
 - (4) The patient must be CHS eligible.
 - (5) The referral shall be made to the appropriate provider based on cost/quality factors, or an exception justified.
 - (6) For review of emergency cases, the care provided shall be verified as an emergency situation.
 - (7) Care must not be deferred for cases where full reimbursement is available.
- C. The minutes of each Committee meeting will be maintained to accurately reflect the determination of each case.
- D. The Committee will monitor high cost cases (greater than \$10,000), including the progress of each case, according to current Area guidelines for high cost case management.

2-3.20

PROMPT RESPONSE TO PROVIDER NOTIFICATION OF CLAIM "5-DAY" RULE

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

Section 220 states - -

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

9

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
PUBLIC HEALTH SERVICE

Acoma-Canoncito-Laguna Hospital
PO Box 130
San Fidel, New Mexico 87049
(505) 552-5300

May 27, 2005

Mr. Gary Collins
Suite 400
201 3rd St NW
Albuquerque, NM 87102

RE: Contract Care Program

Dear Mr. Collins:

Our basic contract care program is for the purchase of care for eligible Indians, when that care is not available in our Service Unit. The program consists of two parts. The first part is the ranking of the relative medical need (priorities attached) and the verification of eligibility.

When one of our medical staff writes a referral for care to be provided outside our Service Unit, the medical workup is reviewed by the Clinical Director and assigned a priority (I, II, or III). That information is then given to our contract Care section where eligibility, correct addresses and phone numbers are collected.

Because we have limited funding we are currently only paying for Priority I cases. When patients are assigned a Priority I on the referral, we make appointments for them, issue the purchase orders and assist them in keeping their appointments. If patients have sufficient third party resources to cover the medical charges, we also help them with the appointments. For those who are not considered a Priority I, they are written a denial letter, with clear instructions on how to appeal the decision.

The Contract Care program has often been accused of refusing care to people. The program is intended to be a payor and not a provider of care.

I hope this information helps.

Sincerely,

Bill Thorne
Bill Thorne, Jr.
CEO

Attachment
CHS Priorities

EXHIBIT 9



DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Albuquerque Area Indian Health Service
5300 Homestead Rd, NE
Albuquerque, New Mexico 87110

Date: January 15, 2004

To: Chief Executive Officers, AAHS
Administrative Officers, AAHS
Clinical Directors, AAHS
CHS Coordinators, AAHS

From: Chief Medical Officer
Albuquerque Area Indian Health Service

Subject: Contract Health Service Medical Priorities -- FY 2004

PRIORITY ONE

Services which are required to prevent immediate death or serious impairments:

- A. Obstetric and Pediatric Emergencies
- B. Medical Emergencies
- C. Eye Emergencies
- D. Psychiatric Emergencies - up to 14 days
- E. Dental Emergencies
- F. Renal Replacement Therapy (includes transplant)
- G. Emergency Transportation
- H. Surgical Emergencies: Includes Orthopedic, Gynecological
- I. Extra depth shoes with custom-molded inserts for diabetics that meet the following criteria:
 - a) loss of protective sensation OR
 - b) history of ischemic or pressure ulcers or amputation or recurrent callus with micro-hemorrhage OR
 - c) Significant foot deformity
- J. ENT Surgery required when immediate threat to development of speech language or hearing is documented.
- K. Gynecological Tubal Ligation.

PRIORITY TWO

Services for potentially life-threatening/severe handicapping condition; maintenance of JCAHC accreditation.

- A. Laboratory/Radiology/Nuclear Medicine not available on site including screening mammography.
- B. Specialty Consultation: For acute care diagnosis, cancer, high risk OB, etc.
- C. Backfill for positions: Lab, X-ray, Pharmacy, Physicians, Nursing.
- D. Psychiatric ambulatory and inpatient services.
- E. Non-emergency elective surgery.

- F. Podiatry services - high risk medical.
- G. Prosthetics and appliances.

PRIORITY THREE

Services which contribute to better patient functioning, but not necessarily to prevent death or serious impairment:

- A. Patient rehabilitation (residual resources).
- B. Specialty consultation when less than Priority #2
- C. Hearing Aids
- D. Podiatry/Orthopedics - less than Priority #2.
- E. Allergy Services
- F. Preventative Medicine/Health Promotion Activities
- G. Orthodontic Services

PRIORITY FOUR

- A. Long-term residential psychiatric care
- B. Rehabilitation surgery
- C. Non-emergency transportation
- D. Elective surgery cosmetic

Should you have any questions, please contact the Area Contract Health Services Program at 505-248-4553.

Ervin Lewis, M.D.
Ervin Lewis, M.D.

cc: Director, AAHS
Executive Officer, AAHS
Director, DCSS, CHS, AAHS

10

Y. P. AYALA CI MACILIMAN
MD

November 22, 2004

To: Mr. Bill Thorne Jr.,
CEO ACL Hospital

From: Acoma-Canoncito-Laguna Health Board

Re: Resignation of Dr. Stephen Ryter, Administrative Director
Acoma-Canoncito-Laguna Hospital

Reference ACL Health Board memo of November 18, 2004, regarding Dr. Ryter and his willingness to resign, as Administrative Director, effective immediately from ACL Hospital.

The Health Board meeting of November 19, 2004 provided a vote of "No Confidence" as indicated by the membership's majority vote of 7 no confidence votes and 1 abstention.

The Health Board's vote of no confidence, in Dr. Ryter, is *final* and is requesting his immediate resignation due to the following failings at ACL Hospital:

Unable to provide leadership and direction.

Unable to recruit and retain physicians effectively.

Unable to provide orientation to staff, tribal members, health board members and the tribal leadership on relevant health care issues.

Unable to familiarize self with the cultural, social, political, geographic, demographic, economic and epidemiological characteristics of the assigned communities.

The Acoma-Canoncito-Laguna Health Board Members awaits your immediate action in providing us with Dr. Ryter's letter of resignation, no later than, 4:00 P.M., November 23, 2004.

Sincerely,

Acoma-Canoncito-Laguna
Health Board Membership

cc: file

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**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL
OFFICE OF INVESTIGATIONS
REPORT OF INTERVIEW**

Dr. Stephen R. Ryter was interviewed on June 9, 2005, by Special Agent Gary Collins. After being advised of the nature of the interview and the identity of the Special Agent, Dr. Stephen R. Ryter provided the following information, in substance:

NAME: Dr. Stephen Roy Ryter

DOB:

SSN:

HOME ADDRESS:

PHONE:

E-MAIL:

- Dr. Ryter has been a practicing doctor for 40 years as a pediatrician.
- Previously to being employed with the Acoma-Canoncioto-Laguna (ACL) Service Unit, Dr. Ryter was employed with Cimarron Health Plan of Albuquerque, New Mexico as the Chief Medical Officer from October 1997 to April 2003. According to Dr. Ryter his contract was not renewed in order to save money.
- Dr. Ryter was employed with ACL service unit as the Clinical Director from November 2003 to April 2005. Dr. Ryter's primary duties, while the Clinical Director, were to supervise the medical staff.
- According to Dr. Ryter the Clinical Director position at ACL has not been filled.
- Dr. Ryter stated the ACL Service Unit is a facility that has no surgical capabilities and has few medical resources. When patients need further care that ACL cannot provide, they were referred to a contract health program. To qualify for this program they first must be an Indian Health Service beneficiary, they have to be a member of the tribe, or be related to a member of the tribe, and usually have to live on the reservation. At this time Dr. Ryter indicated the eligibility requirements for this program are outlined in the IHS Manual located on the web site under the contract health section.

Interview Conducted on June 9, 2005 At Santa Fe Indian Hospital
By Gary Collins SA Phone Number (505) 346-2546
Date Prepared June 14, 2005 By Gary Collins Case Number 6-05-00237-9

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- According to Dr. Ryter the process for referral starts when the patient needs further care and they are then forwarded to the Contract Health Division (CHD) of the ACL Service Unit. The CHD then determines eligibility then the patient file is forwarded to the ACL Clinical Director to see what medical priority is to be given to the patient's condition. The guidelines provided by the IHS Rockville, MD Office are used to an extent in determining priority, but the Clinical Director determines the final priority level to be assigned to the patient's condition. After the priority has been determined the patient file goes back to CHD, all priority 1's are then authorized for further treatment by a contract health facility to be paid for by ACL if funding is available. If additional money remains at the end of the year lower priority patients may have the contract services paid for. Dr. Ryter emphasized all patient who need further care are referred, but usually only the priority 1's services are paid by ACL. The other lower priority cases usually have to pay for further care on their own.

- Dr. Ryter indicated if patients don't fit into the priority 1 category, CHD automatically generates a letter that is sent to the patient explaining further health services will not be paid for by ACL. The patient then has the right to appeal this decision to the Chief Executive Officer of ACL. If this appeal process fails the patient can then appeal to the area office, and then finally to IHS Headquarters in Rockville, MD, for a final appeal.

- According to Dr. Ryter the ACL Clinical Director has the initial determination of priority, but not the final decision due to the appeals process.

- During Dr. Ryter's employment as the Clinical Director at the ACL Service Unit, Dr. Zimmerman was employed as a staff physician. Dr. Zimmerman's duties while employed as a staff physician would be to see patients at the ACL Service Unit and to enter his notes of the examination into the Referred Care Information System (RCIS).

- Dr. Ryter stated after Dr. Zimmerman entered his notes into RCIS this information was forward to CHD and then forwarded on to the Clinical Director for prioritization.

- At this time S/A Collins gave Dr. Ryter a list of patients Dr. Zimmerman mentioned in his complaint for denial of services.

Below is a list of the above patients and Dr. Ryter's explanation why these patients were not given priority 1 status.

According to Dr. Ryter the patient had terminal lung cancer the only further care that could be given was medication to make patient more comfortable. Dr. Ryter stated this is not considered an emergency due to the terminal status of patient. Dr. Ryter indicated to appeal the case for possible payment.

Dr. Ryter stated that according to the notes this was a referral for a scheduled Endoscopic Retrograde Cholepancreatography, and this is a non-emergency and does not fit into priority 1.

Dr. Ryter was unable to explain why this patient was not a priority 1, due to a lack of information in the patient notes.

Schedule dates for evaluation provided by Dr. Zimmerman show a low priority.

According to notes [redacted] needed a thyroid scan to be scheduled 7-14 days from referral, Dr. Ryter indicated low priority due to length of scheduling.

Dermatology consultation for possible skin cancer, according to Dr. Ryter low priority because cancer had yet to be determined and patient was Medicare eligible.

Possible prostate cancer, again cancer had not yet been determined so a low priority. Dr. Ryter indicated according to the notes this was appealed and changed to a priority 1.

According to Dr. Ryter this patient was given a low priority by another Dr. filling in for him while he was on vacation.

- Dr. Ryter then explained the denials after June 2004, when the ACL Service Unit was re-accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Dr. Ryter indicated JCAHO has no influence on reviews or referrals of the ACL Service Unit CHD. According to Dr. Ryter in July of 2004, ACL was operating in a 4-5 million deficit, and contract health was a large portion of this deficit. Acting CEO Joe Moquino, Administrative Officer Barbara Felipe, and Clinical Director Dr. Ryter determined they would have to start prioritizing many former priority 1's to priority 2's to save money.

- According to Dr. Ryter Dr. Zimmerman filed the denial of services claim after he was fired by Dr. Ryter. Dr. Ryter indicated Dr. Zimmerman was fired due to numerous complaints by staff. In addition Dr. Ryter stated Dr. Zimmerman's writing was unreadable by himself and other staff members. Dr. Ryter believes this occurred sometime in July 2004.

- According to Dr. Ryter pressure was put on the CEO of ACL to fire him by the ACL Health Board due to tribal politics and mainly because they felt he was purposefully denying patients further health care. This resulted in a vote of "No Confidence" by the ACL Health Board on November 19, 2004.

- Dr. Ryter was re-assigned in April of 2005, to appease the ACL politics and personality conflicts. At this time Dr. Ryter provided a signed copy of his transfer letter, this letter can be found in the electronic case file under the following serial number: 031 605002379 **Dr. Ryter Transfer Letter 061505.**

- According to Dr. Ryter in April 2005, after the decision to have him transferred he was awarded an IHS Director National Award for his accomplishments at the ACL Service Unit.

At this time S/A Collins ended the interview and indicated he would contact Dr. Ryter is further information is needed.

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DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Albuquerque Area Indian Health Service
5300 Homestead Road, N.E.
Albuquerque, New Mexico 87110

APR 01 2005

Dr. Stephen Ryter, MD
Albuquerque Area
5300 Homestead Road, NE
Albuquerque, New Mexico 87110

Dear Dr. Ryter:

This is notice that I am directing a change in your duty station from Acoma-Canoncito-Laguna Service Unit, Acoma, New Mexico, to Santa Fe Service Unit, Santa Fe, New Mexico. Your duties will change to Medical Officer (Pediatrics), GS-602-15. A change in duty station does not constitute filling a vacancy.

This reason for this assignment is based on the Acoma-Canoncito-Laguna Tribes' request to move you out of the ACL Service Unit. In making my decision, I have considered the needs of the Area as well as your qualifications. Your skills and knowledge base will enhance the services to be provided at this location and will serve to accomplish the mission of the Indian Health Service (IHS). This assignment will have the least possible adverse impact on you and your career.

There will be no loss in grade or pay. Since you are not being reassigned outside the commuting area, you will not be entitled to severance pay or relocation expenses. There are no government quarters available at the Santa Fe Service Unit.

You are directed to report for duty for permanent assignment to Medical Officer (Pediatrics) not later than 8:00 a.m. on Monday, April 4, 2005. Please be advised that failure to report as directed could place you in an absent without leave (AWOL) status and will lead to disciplinary or adverse action up to and including removal.

You have the right to file a grievance under the HIS Administrative Grievance System. A grievance must be submitted in writing to me. (Copy enclosed)

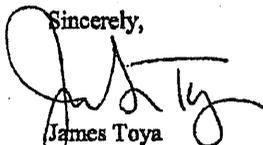
You have the right to file a discrimination complaint within the Department under the provisions of 29 CFR 1614 if you think this action is based on discrimination due to race, color, religion, handicap, national origin, age, sex, or sexual orientation. To initiate the EEO process, you must contact an EEO counselor with 45 calendar days upon receipt of this letter. You may contact Marla Jones, Albuquerque Area Office, (505) 248-4620.

Please keep in mind that submission of a grievance or EEO complaint will not stay the change in duty station. You still must report as described above.

Page 2, Directed Reassignment/SRyter

Please acknowledge receipt of this letter by signing and dating the receipt copy in the space indicated and return it to me immediately. Your signature does not mean that you agree with this letter but merely shows that you received it.

Sincerely,



James Toya
Area Director

Enclosure

cc: Receipt Copy

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**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL
OFFICE OF INVESTIGATIONS
REPORT OF INTERVIEW**

Joseph A. Moquino was interviewed on June 23, 2005, by Special Agent Gary Collins. After being advised of the nature of the interview and the identity of the Special Agent, Joseph A. Moquino provided the following information, in substance:

NAME: Joseph A. Moquino

DOB: :

SSN:

ADDRESS:

PHONE:

- Mr. Moquino was employed as the Chief Executive Officer (CEO) of the IHS Acoma-Canoncito-Laguna (ACL) Service Unit from October 8, 2003, to July 31, 2004. Mr. Moquino's duties while employed as the CEO of the ACL Service were to monitor all ACL Service Unit activities. According to Mr. Moquino he was hired temporarily until the ACL could find a permanent CEO.

- Mr. Moquino was employed during the employment of both Dr. Stephen Ryter (Clinical Director of the ACL Service Unit) and Dr. Mark Zimmerman (Inpatient Physician at ACL Service Unit)

- According to Mr. Moquino the ACL Service Unit is a general medical facility for the Indian Health Service (IHS). They have basic medical capabilities and refer patients to contractors when they cannot provide the services the patient needs.

- Mr. Moquino indicated patients would arrive at the clinic with scheduled appointments or would come in on a walk in basis. A doctor at ACL Service Unit would then see the patient and document the patient's condition. The doctor then determines if the patient can be treated at the ACL Service Unit or if the patient needed to be referred to contractor for further treatment. Once the doctor had documented the patient file it would then go to Contract Health Division (CHD) and then forwarded to the ACL Service Unit Clinical Director. The Clinical Director then determines what priority (1-4) the patient fits in. Priority 1 patients are considered in a life threatening condition, these patients are referred to a contractor and the services are paid for by the ACL Service Unit.

Interview Conducted on <u>June 23, 2005</u>	At <u>Albuquerque Field Office via phone</u>
By <u>Gary Collins</u>	SA Phone Number <u>(505) 346-2546</u>
Date Prepared <u>June 23, 2005</u>	By <u>Gary Collins</u> Case Number <u>6-05-00237-9</u>

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Priority 2-4 would then be put on a list and may be re-prioritized when funds were determined available.

- According to Mr. Moquino if patients are not initially put in Priority 1, an appeal process is in place for the patient to be re-prioritized. If a patient is not put in a Priority 1 after their first evaluation they can appeal the decision and the ACL Service Unit Medical Staff will re-evaluate the decision. If a Priority 1 is still not given, the patient can then appeal to the IHS Albuquerque Area Office, then Rockville, MD, for a final determination of priority.

- According to Mr. Moquino prioritization by the ACL Service Unit is driven by funding. This is why all Priority 1 patients are referred for further services and others must wait to see if additional funds exist.

- Mr. Moquino indicated Dr. Ryter did not deny patients who needed further services while he was employed as the CEO of the ACL Service Unit. Mr. Moquino further stated Dr. Ryter was an excellent clinical director and was not aware of any problems between he and the ACL Service Unit staff.

- Mr. Moquino stated Dr. Mark Zimmerman was hired as the inpatient physician, but Dr. Zimmerman did not like this position. Dr. Ryter and Mr. Moquino decided to move Dr. Zimmerman to the Diabetes Clinic. Dr. Zimmerman then refused to provide adequate services to the patients, mainly he would not examine the patient's feet. According to Mr. Moquino Dr. Zimmerman also had numerous problems working the ACL Service Unit staff. Due these factors Mr. Moquino had Dr. Ryter assess Dr. Zimmerman to determine if he was able to meet the standards of his position. Due to the assessment conducted by Dr. Ryter Mr. Moquino terminated Dr. Zimmerman.

- According to Mr. Moquino he consulted with IHS Area Albuquerque Personnel Office to make sure the proper procedures in the termination of Dr. Zimmerman were followed. Mr. Moquino believes that all the procedures were followed and Dr. Zimmerman was properly terminated.

- Mr. Moquino indicated the ACL Health Board only has the power to recommend terminations of ACL Service Unit employees and they cannot terminate any government employee on their own.

- Mr. Moquino was not employed with the ACL Service Unit when they were re-accredited by the Joint Commission on Accreditation of Health Organizations, or when a vote of "No Confidence" was rendered against Dr. Ryter by the ACL Health Board.

At this time S/A Collins ended the interview and indicated he would contact Mr. Moquino if additional information is needed.

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**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL
OFFICE OF INVESTIGATIONS
REPORT OF INTERVIEW**

Dr. Mark Zimmerman was interviewed on June 29, 2005, by Special Agent Gary Collins. After being advised of the nature of the interview and the identity of the Special Agent, Dr. Mark Zimmerman provided the following information, in substance:

Dr. Zimmerman's Attorney Cheri McCracken was present during the interview and the interview was conducted at her office.

NAME: Mark Zimmerman

DOB:

SSN:

ADDRESS:

PHONE:

- Dr. Zimmerman has been a practicing physician for over 31 years.
- Dr. Zimmerman is currently employed as a Home Visiting Physician for Care Level Management located at 2525 E. Indian School Road, Phoenix, AZ 85016. Dr. Zimmerman has been employed with Care Level Management for 2 months.
- Prior to being employed for Care Level Management Dr. Zimmerman was employed a prison clinical physician for the State of New Mexico. Dr. Zimmerman was employed with State of New Mexico prison system for approximately 6 weeks.
- Dr. Zimmerman was unemployed from December 2004 until April 2005.
- From October 2003 to October 2004, Dr. Zimmerman was employed as an inpatient physician with the IHS Acoma-Canoncito-Laguna (ACL) Service Unit. Dr. Zimmerman's duties while employed with the ACL Service Unit were to examine walk in patients, patients with appointments, patients admitted to the ACL Service Unit, and patients who were transported to the ACL Service Unit.

Interview Conducted on	<u>June 29, 2005</u>	At	<u>2402 N. 24th St., Phoenix, AZ 85008</u>
By	<u>Gary Collins</u>	SA Phone Number	<u>(505) 346-2546</u>
Date Prepared	<u>July 5, 2005</u>	By	<u>Gary Collins</u> Case Number <u>6-05-00237-9</u>

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- When Dr. Zimmerman examined the patients he would enter the examination information into an electronic format. This information would be sent to Contract Health Division (CHD) then forwarded to the ACL Service Unit Clinical Director. The Clinical Director during Dr. Zimmerman's was Dr. Stephen Ryter and the CEO William Thorn. Dr. Ryter and Mr. Thorn would then prioritize the condition of the patient. CHD would contact the patient after they had been prioritized. If a patient was a Priority 1, they would be contacted directly by CHD and the patient would be scheduled an appointment with the contract hospital or doctor. If the patient was not a Priority 1 CHD would contact them via written letter. According to Dr. Zimmerman the letter explained to the patient they could appeal to the ACL Service Unit in an attempt to be re-prioritized. Dr. Zimmerman was unaware of any appeals process beyond this point.

- Dr. Zimmerman believes his patients were not given Priority 1 status because Dr. Ryter had a personality conflict with him. Dr. Zimmerman indicated he examined patients who were very ill, and believes they deserved to be Priority 1, and have their further care paid by the ACL Service Unit.

- Dr. Zimmerman stated the at the time when some of his patients were not given Priority 1 status the ACL Service Unit was running in a 2-3 million dollar deficit. Dr. Zimmerman did admit that some of the patients did not receive care paid by the ACL Service Unit because of financial problems.

- Dr. Zimmerman believes all the patients who needed immediate emergency assistance received the proper care. Dr. Zimmerman indicated that most terminal cancer patients were given Priority 1 status. Dr. Zimmerman indicated patients who were terminally ill, such as liver transplants and terminal lung cancer patients did not receive Priority 1 status.

- Dr. Zimmerman gave patient _____ as an example. _____ had terminal lung cancer and the ACL Service Unit refused to treat the patient due to cost and the disease was incurable. Dr. Zimmerman indicated _____ appealed the decision and was eventually given Priority 1 status.

- S/A Collins showed Dr. Zimmerman a copy of his complaint with a list of the patients. Dr. Zimmerman was unable to give any additional information or articulate why these patients should have been given Priority 1 status, beyond the fact they were sick and needed to be cared for. Dr. Zimmerman indicated the listed patients did not have any immediate life threatening conditions.

- Dr. Zimmerman was unable to clearly explain what the priority classifications were and what patient conditions fit into what priority.

- According to Dr. Zimmerman at no time did he file a formal complaint with the ACL Service Unit or with any other government agency regarding his current allegations until after he was terminated. Dr. Zimmerman admitted he was not the only doctor who's patients were not given Priority 1 status.

- Dr. Zimmerman stated that during the re-accreditation process by the Joint Commission on Accreditation of Health Organizations (JCAHO) he was sent to various clinics that were out of the office. Dr. Zimmerman feels this was done to re-assure he would not cause any problems because the ACL Service Unit was at the end of the fiscal year and money was a big issue.

- Dr. Zimmerman indicated the financial issues and the JCAHO re-accreditation of the ACL Service Unit were at or near the same time when patients were being denied services. Dr. Zimmerman feels the increased denials after the re-accreditation could be due to there not being any immediate pressure to be re-accredited.

- Dr. Zimmerman believes he was terminated due to a personality conflict with the Clinical Director Stephen Ryter. According to Dr. Zimmerman he was given a verbal reprimand on May 11, 2004, for unprofessional conduct, but never received a negative evaluation while employed with the ACL Service Unit.

At this time S/A Collins terminated the interview and indicated he would contact Dr. Zimmerman's attorney if any additional information is needed.

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DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service
Albuquerque Area Indian Health Service
5300 Homestead Road, N.E.
Albuquerque, New Mexico 87110

DATE: JUN 23 2005

TO: Special Agent, OIG
Office of Investigations

FROM: Human Resources Specialist
Division of Human Resources

SUBJECT: Status of Clinical Director Position, Acoma-Canoncito-Laguna Service Unit

This is in response to your request for information concerning the status of the vacant Clinical Director position [Supervisory Medical Officer (General Practice-Administration), GS-602-15] located at Acoma-Canoncito-Laguna Service Unit, Acoma, New Mexico.

On June 21, 2005, I telephoned William Thorne, Chief Executive Officer, to follow-up and obtain the information you requested. Mr. Thorne indicated that the position is currently vacant, although Alan Walker, PA, has been temporarily assigned as the Acting Clinical Director (see attached e-mail). Mr. Thorne also indicated that recruitment for the Clinical Director position [Supervisory Medical Officer (General Practice-Administration), GS-602-15] is on hold until seven (7) vacant Medical Officer staff positions are filled. He anticipates that it will take at least six (6) months or longer to fill these vacancies.

You may contact me at (505) 248-4515 if you have any questions.

Ernestine Overfield
Ernestine Overfield

Attachment

16

**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL
OFFICE OF INVESTIGATIONS
REPORT OF INTERVIEW**

William Thorne Jr. was interviewed on July 6, 2005, by Special Agent Gary Collins. After being advised of the nature of the interview and the identity of the Special Agent, William Thorne Jr. provided the following information, in substance:

NAME: William Thorne Jr.

DOB:

SSN:

ADDRESS:

PHONE:

- Mr. Thorne has been employed as the Chief Executive Officer (CEO) for the IHS Acoma-Canoncito-Laguna (ACL) Service Unit since August 2004 until present.
- Mr. Thorne was employed as the CEO for the Potawapmia Nation Health Service Unit in Shawnee, Oklahoma from August 2000 to August 2004.
- While employed as the CEO for the ACL Service Unit Mr. Thorn was in charge of both, Dr. Stephen Ryter (Clinical Director) and Dr. Mark Zimmerman (Inpatient Physician).
- According to Mr. Thorn ACL Service Unit patients arrive at the facility by ambulance, by appointment, or by urgent care. Some of these arriving individuals will be admitted as inpatients if further care is needed and the ACL Service Unit can provide this care. Mr. Thorne stated the ACL Service Unit is small healthcare facility and has a maximum of 15 patient beds.
- Once the patient arrives at the ACL Service Unit general biographical and physical information is taken, then the patient is given a basic physical examination usually given by a nurse then a physician performs a full examination.
- If patient needs further care that the ACL Service Unit cannot provide, usually the doctor will enter their notes into a computer system and they will be forwarded to the Contract Health Division (CHD). CHD will then send this information to the Clinical Director to be prioritized into category 1,2, or 3. According to Mr. Thorne these priority guidelines are established by the Albuquerque, New Mexico Area Office. Mr. Thorne provide S/A Collins a copy of these guidelines on June 6,

Interview Conducted on <u>July 6, 2005</u>	At <u>Albuquerque Field Office (Telephonic)</u>
By <u>Gary Collins</u>	SA Phone Number <u>(505) 346-2546</u>
Date Prepared <u>July 7, 2005</u>	By <u>Gary Collins</u> Case Number <u>6-05-00237-9</u>

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OI-3 (7/2002)

EXHIBIT 16

2005, these guidelines can be found in the electronic case file under serial number 008 605002379
ACL Current Patient Referral Policy 060605

- Mr. Thorne stated in 2004 approximately 1,500 patients were sent denials for various reasons, such as; patient has alternate resources, condition not a medical priority, patient lives outside geographic area of reservation, patient did not contact the ACL Service Unit within 72 hours after receiving outside care, or receiving outside care when the ACL Service Unit could have provided services. According to Mr. Thorne the ACL Service Unit is considered the payer of last resort when the patient has no other options.
- Mr. Thorne stated Priority 1 patients are considered a high priority for payment as long as they do not fit into one of the automatic denial categories. If patient comes in with emergency needs they are referred immediately, the lower priorities are usually sent a denial letter outlining the appeals process.
- Due to financial obligations a patient with a low priority category will be referred, but the ACL Service Unit will not pay for the services. According to Mr. Thorne all patients with immediate emergency needs are referred and the services are paid for by the ACL Service Unit. If funds are not available the services will be paid at a later date when funds become available.
- According to Mr. Thorne all the doctors at the ACL Service Unit follow the same guidelines. The patient can immediately appeal to the ACL Service Unit if given a low priority. If they are not given a higher priority or they feel their medical services should be paid by the ACL Service Unit they can then appeal to the IHS Albuquerque, New Mexico Area Office and then to the IHS Rockville, Maryland office. According to Mr. Thorne occasionally patients will skip some of the initial appeals process and appeal to a higher office.
- Mr. Thorne indicated he was not employed with the ACL Service Unit during the re-accreditation process by the Joint Commission on Accreditation of Health Organizations (JCAHO) and had no information regarding the re-accreditation.
- Mr. Thorne stated he deferred to be involved in the termination of Dr. Zimmerman and let Dr. Ryter handle the matter. He only evaluated the information given to him by Dr. Ryter and supported his decision. According to Mr. Thorne Dr. Zimmerman had numerous deficiencies and failed to comply with basic hospital needs. In addition Dr. Zimmerman had a difficult time getting along with ACL Service Unit staff members and was combative toward management.
- Mr. Thorne indicated it would be difficult to target a certain doctor and not refer their patients for services with all of the guidelines and checks in place.
- Mr. Thorne indicated he did not have any problems with Dr. Ryter and he received positive evaluations. Mr. Thorne believes that the ACL Health Board gave Dr. Ryter a vote of "No Confidence" due to political reasons. When Dr. Ryter was hired some of the ACL Health Board members wanted to hire a different individual for the Clinical Director position even though Dr. Ryter was ranked #1. In an effort to appease the political tension Mr. Thorne decided to transfer Dr. Ryter to the Sante Fe Indian Hospital, not due to problems with Dr. Ryter.

- Mr. Thorne indicated the ACL Health Board only has the ability to make recommendations for termination of ACL Service Unit employees, but they do not have the authority to terminate any federal employee. All federal employee terminations are handled by the IHS Albuquerque, New Mexico Area Office.

- During the interview Mr. Thorne provide S/A Collins with a copy of a denial of service letter that is sent to ACL Service Unit patients and a copy of the 2004 denials issued by the ACL Service Unit. A copy of these documents can be found in the electronic case file under the following serial numbers:

046 605002379 Denial Letter Example 070705

047 605002379 2004 Reasons for Denial and Statistics 070705

In addition S/A Collins provided a list of patients to Mr. Thorne that Dr. Zimmerman listed in his complaint who should have had their treatment paid by the ACL Service Unit. Mr. Thorne indicated he would have the patient files reviewed and provide an explanation of why the patients were not referred for further treatment to be paid for by the ACL Service Unit. Below is a list of the patients provided by S/A Collins:

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Jul 01, 2005

UNM HOSPITAL/BCMC
P.O. BOX 369
ALBUQUERQUE NM 87103

The following letter was sent to the patient for denial of services:

Document number: 053-0ACL-1590

TO: [REDACTED]

Re: Patient: [REDACTED] CHART: [REDACTED] HOSPITAL
Contract Health Services request for services on [REDACTED]
Date request received: [REDACTED]
Provider of services: UNM HOSPITAL/BCMC
Provider of services: UNIVERSITY PHYSICIAN ASSOC.

Dear [REDACTED],

We have been requested to authorize payment for services received from the above provider(s). Regretfully, we must advise you the Indian Health Service (IHS) will not pay for charges for the following reason(s):

Care Not Within Medical Priority
The medical care you received is not within the CHS medical priorities. Medical priorities must be established when funding is limited. [Per 42 Code of Federal Regulations 36.23(e) (1986)].

Primary Denial Comments:
The IHS referral submitted by AIM was deemed not to be within ACL's medical priority. At this time ACL is within medical priority I's.

If you have additional information that may be helpful in reconsidering our decision, please submit, in writing, within 30 days of receipt of this letter to:

FRANCIS DARRIN, JR. SHIJE

053-0ACL-1590
Page 2

WILLIAM THORNE, JR.
PO BOX 130
SAN FIDEL, NM 87049
505-552-5300

If you do not have additional information, you may appeal in writing,
within 30 days of receipt of this letter:

James L. Toya, Area Director
5300 Homestead Rd NE
Albuquerque, NM 87110
505-248-4500

Sincerely,

WILLIAM THORNE, JR.
PO BOX 130
SAN FIDEL, NM 87049
505-552-5300

18

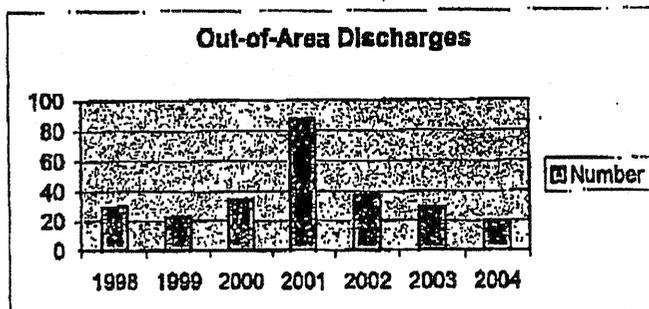
various reasons. The most common reason was that the patient had access to alternative resources, which under Federal law are primary payors before the Service Unit. Even with the continuation of paying only medical priority I cases, funding may be short again this year. The Health Board, working with the Medical Staff is going through a review of the priorities to make sure they reflect the local needs.

Reasons for denial for FY 2004 are as follows:

<u>Reason</u>	<u># denials</u>
Alternative resource available	1,021
Care not within priority	296
Lives outside CHS area	189
No 72 hour notification	84
IHS facility available	46
Eligibility not established	14
No prior approval-non emergency	7
No 30 day notification (elderly)	5

V. OUT OF SERVICE AREA PATIENTS

We are still gathering the statistics for the outpatient figures. However we have taken the initiative to draft a policy giving priority to service unit residents for appointment scheduling. We hope to have the draft sent to the Area Office for their review by December 1, 2005. Below is the inpatient trend for out of area patients.



19



Date/Time

Reason for Denial

Referral was denied, but returned. - RCIS # 4417.

- Priority I

- Priority II

*Referral was denied, pt wanted appt + pd balance. RCIS # [redacted]
pt obtained another referral RCIS # 309 and this was approved.

- Priority II

- Priority II

Referral denied medical priority - RCIS # 5165

Referral denied medical priority - RCIS # 4504

**Pt. obtained another referral & was approved for these services. See RCIS # 1166.*



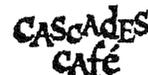
La Cantina
Mexican Grill
Lunch & Dinner
Center of the Main Building



**DIFFERENT
POINTE
OF VIEW**
French-Italian-
Mediterranean Cuisine
Evening Dining
Top of the Mountain



Pointe In Type
Contemporary Grille
& Tavern
Breakfast, Lunch & Dinner
North End of the Resort



**CASCADES
CAFÉ**
Poolside Light Bites
& Cool Libations
Lunch
At The Falls

20



U.S. Department of Justice

United States Attorney
District of New Mexico

Post Office Box 607
Albuquerque, New Mexico 87103

505/346-7274
FAX 505/346-6886

August 19, 2005

Special Agent Gary Collins
DHHS - Office of Inspector General
201 3rd Street NW, Suite 400
Albuquerque, New Mexico 87102

RE: Dr. Stephen Ryter
OI File# 6-05-00237-9

Dear Mr. Collins:

I have reviewed the 94-page report of investigation concerning Dr. Ryter. Based on the information contained therein, I am unable to identify evidence of a federal criminal violation. I am, therefore, returning the report to you. Should you or your agency develop further information you wish this office to consider, please do not hesitate to contact us.

Sincerely,

DAVID C. IGLESIAS
United States Attorney

Mary L. Higgins
MARY L. HIGGINS
Assistant United States Attorney

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EXHIBIT 20

U.S. OFFICE OF
SPECIAL COUNSEL
WASHINGTON, D.C.

2006 JAN 17 PM 2:45

10960 N. 67th Avenue #94
Glendale, AZ 85304
January 14, 2006

Malia M. Paslawski
Attorney, Disclosure Unit
U.S. Office of Special Counsel
1730 M Street, N.W. Suite 300
Washington, D.C. 20036-4505

Subj: OSC File No. DI-05-1145

Dear Ms. Paslawski,

Thank you for sending the report from the Honorable Michael Leavitt, Secretary of HHS. Due to my moving to Peoria, AZ (Glendale, AZ P.O.) your packet was not received until 12/30/05. I appreciate all the effort you put into my whistleblower disclosure. Thank you for extending the time in which I can respond, to January 20. Since speaking to you January 3, I have changed my mind and decided to go ahead and sign a release for public disclosure. When discussing patients' denied services, I have used only patient initials to protect their privacy.

Several comments would be in order. HHS IG Special Agent Gary Collins never interviewed any of the physicians I worked with at ACL Indian Hospital/Clinics to substantiate denial of care, nor did he interview the ACL Indian Health Service Unit Contract Svcs. Supervisor responsible for carrying out the decisions made at the ACL Service Unit (Susie Analla). Mrs. Analla vociferously advocated for Tribal members denied necessary Priority One services by Dr. Ryter (Exhibit One). Mrs. Analla's name and physician names were given to Mr. Collins when he interviewed me at my attorney's office in Phoenix, AZ. Furthermore Mr. Collins did not request interviews with the (3) Tribal leaders of the ACL Svc. Unit; the two Governors (or their Lt. Governors) of Acoma & Laguna Pueblos and the Navajo Chapter President (or his surrogate) of To'hajiilee-Canoncito, who knew first hand of the denial of services to their Tribal members mentioned in my Complaint. Mr. Collins merely interviewed the Agency administrators involved, who had already collectively discussed their strategy in my case (See the enclosed identical testimonials of Mr. Thorne & Mr. Moquino used in the Agency's MSPB presentation).

In regard to the Contract Svcs. Priorities-Exhibit 9, the Office of the IG did not read the categories carefully. The Office of the IG (not being medically trained) failed to note that Priority Two (B) "Specialty Consultation: For acute care diagnosis, cancer, high risk OB" is INCORRECTLY CLASSIFIED AS PRIORITY TWO, AND SHOULD BE PRIORITY ONE, ON A CASE BY CASE BASIS. (B) stands out as incongruent with the other categories of Priority Two. Dr. Ryter relished the fact (pg. 3 Exhibit 11) that JCAHO had no jurisdiction over the priority categories/decisions that affected patients' continuity of care and lives! Exhibit 8 2-3.9 (A) (2) states that "appeals may be submitted by a provider. The provider will be considered as acting in behalf of the patient. A response must be made to the provider and courtesy copy of such response is provided to the patient." Multiple appeals through RCIS and by email were disregarded by Dr. Ryter (priority remained as Priority Two without explanation) despite regulation requiring him to respond to such entreaties.

The patients revealed in my Complaint fit category Priority Two (B) and a competent and compassionate Medical Director would know that these patients were Priority One. Of the (8) patients listed in my Complaint, (3) of Dr. Ryter's Priority Two's were overturned by his superiors. Dr. Ryter's poor judgment and lack of training in adult medicine made decision making difficult for him. He ignored the advice of his internal medicine staff physicians or failed to appreciate the complexity and the need for timely action in regard to illness. (page 3 Exhibit 11). Cancer was regularly determined to be Priority Two even when palliative therapies were available to provide quality of life/amelioration of suffering (the case of patient R.P.). Dr. Ryter had the audacity to deny patients with expectant cancer referral services, saying that their cancer was not yet proven! (the cases of N.P. and D.C.). He failed to review wrong decisions of his acting Medical Director (the case of T.F.). Dr. Ryter's lack of familiarity with tests done on adult patients is evident by his denial of priority one for radioactive iodine uptake calculations for the determination of radioactive iodine therapy for hyperthyroidism (the case of L.S.) and his failure to see the need for arterial evaluation in a patient with claudication requiring removal of a suspicious skin lesion on the arterially insufficient limb (the case of L.O.). Patient S.C. with end stage liver disease requiring liver transplantation was given Priority Two because Dr. Ryter did not empathize with the patient's deteriorating plight despite well documented chart evidence of failure to respond to lesser measures. Patient E.C. with an impacted common bile duct gallstone needed only an outpatient procedure (ERCP) to unblock her bile duct and remedy her progressing liver damage but Priority Two was never changed to Priority One. Special Agent Collins omitted interviewing Dr. Ryter/ Mr. Thorne about Dr. Ryter's memorandum denying access to care and relief of symptoms for a dying patient (the case of patient D.A). The (case of patient D.A.) was submitted and accepted by the Office of Special Counsel and was forwarded to the Office of the IG. It is incredulous that the HHS IG would find that the above patients received the "proper care and that the appeals process was used appropriately" (Page 6 of the Report).

In the IG Report there is no mention of Mr. Thorne's 10/04 memo to the ACL Staff; Subject: Contract Care priorities. "There may be discussion about setting social priorities such as giving priority to keeping working adults in the workforce". The email response to Mr. Thorne's memo by Dr. Makowski, ACL Chief of Behavioral Svcs. shows Dr. Makowski's outrage. Dr. Makowski's email and the existence of Mr. Thorne's original email was brought to the attention of Special Agent Collins and a copy should have been forwarded to him by my attorney. Did Mr. Collins ever make the same effort to get Mr. Thorne's original email as he did Ms. Siow-Rodriguez's ACL Hospital Board Minutes? If not, why not? I have enclosed a copy of Dr. Makowski's email response for the record.

In their testimonies, the ACL and Albuquerque Area administrators have the audacity to say that Dr. Ryter was an able administrator and that he was removed as ACL Medical Director for political reasons, yet they make no positive and reassuring comments about Dr. Ryter's competence as a physician to make life/death/health decisions that impact Native Americans. It is clear from Mr. Toya's April 2005 letter (Exhibit 12) relieving Dr. Ryter of his duties as ACL Medical Director and reassigning him to Santa Fe Svc. Unit as Staff Pediatrician that he expected Dr. Ryter to step up to the plate and be an able and dedicated physician to the care needs of the pediatric population of the Sante Fe Svc. Unit. Instead Dr. Ryter resigned his position from the Sante Fe Svc. Unit in June 2005. If the IG felt it was not enough that the ACL Tribal Health Board voted to terminate Dr. Ryter's contract during probation on sensitivity and competency grounds (Exhibit 10) then had Special Agent Collins interviewed the physicians of the ACL Service Unit he would have discovered that Dr. Ryter was given full clinical privileges only on a technicality. The ACL Medical Staff did not value Dr. Ryter's clinical abilities (he had not practiced Pediatric Medicine for 8 yrs.) nor did they accept his denial of Native American contract services. When the ACL Medical Staff finally voted him full privileges in 12/04-1/05 the (5) abstentions outnumbered the (4) yea votes in favor but the Medical Staff Bylaws did not allow abstentions to negate the yea votes and he was given full clinical

January 14, 2006

privileges. Hardly an endorsement for a Hospital Clinical Director hand-selected and supported by the Albuquerque Area CEO. Can anyone be that naïve to believe that Dr. Ryter's 17 month ride as ACL Medical Director was anything other than an Albuquerque Area directed debt reducing slash and burn program targeting ACL Clinical Staff and necessary clinical services advocated by these clinicians. Two physicians resigned, one Health Service Corps physical therapist transferred, and one additional physician was silenced by being unjustly terminated during probation for raising the issue of denial of care as being equivalent to malpractice. And did Special Agent Collins try to locate the named Native Americans whose contract services were denied to see what had become of them?

Sincerely,



Mark Zimmerman, M.D.

Purley, Penny

Subject: FW: contract care priorities

-----Original Message-----

From: Makowski, Teresa

Sent: Tuesday, November 02, 2004 2:23 PM

To: Thorne, Bill

Cc: Ryter, Stephen; Analla, Susie; Felipe, Barbara; ACL - MEDICAL STAFF; ACL - BEHAVIORAL HEALTH

Subject: contract care priorities

I must speak out on something that I find very disturbing in your memo of 10/21/04 re: contract care priorities. The statement that "there may be discussion about setting social priorities such as giving priority to keeping working adults in the workforce" makes me shudder. It smacks of social engineering and diminishes the value of human life. I do not believe that a life that so-called "contributes to society" is more valuable than any other. Would you deny care to the mentally retarded since they are unable to work? It denegrates the dignity of the elderly, a value which I thought was sacred to the Native American. It reminds me of the tenets of the Nazi regime where human life was categorized by order of value, and disposed of accordingly. I absolutely cannot believe that this is even being considered. I must speak my mind on this issue, and will continue to do so.

Thank you for hearing me.

Teresa Makowski, PhD

11/9/04

**UNITED STATES OF AMERICA
MERIT SYSTEM PROTECTION BOARD
DENVER FIELD OFFICE**

**MARK ZIMMERMAN, M.D.
APPELLANT**

vs.

**DOCKET NUMBER
DE-1221-05-0311-W-1**

**DEPARTMENT OF HEALTH AND
HUMAN SERVICES,
AGENCY**

AFFIDAVIT OF WILLIAM THORNE

1. William Thorne, am the present Chief Executive Officer (CEO) of the Acoma Canoncito Laguna Service Unit (ACL), part of the Albuquerque Area Indian Health Service (Area). I began serving in this capacity commencing August, 2004, after the previous Acting CEO, Mr. Joe Moquino, left.

2. During my tenure as CEO, I was the first line supervisor of Dr. Stephen Ryter during his tenure as the ACL Clinical Director. During the period of his probationary status of employment with the Indian Health Service (Agency) which he served under me, I was responsible for preparing his efficiency ratings and, if applicable, would have been responsible for taking any disciplinary action against him, and/or terminating him from service during his probationary period.

3. One of Dr. Ryter's duties was to establish priority of care categories for ACL's expenditure of its contract health services funds (CHS). He performed this duty in compliance with the existing CHS policy that Area had distributed to its service units, and which had been authorized by the then Area Chief Medical Officer, Ervin Lewis, M.D. (deceased). He did not apply the policy in an arbitrary or capricious manner, but only after consultation with all relevant federal and tribal entities, whose opinions were properly solicited.

Dr. Ryter's prioritization of CHS was vetted through the ACL Resource Management Committee (RMC), a standing committee which has been operational

V-1

for many years at ACL. The RMC is comprised of the ACL CEO, the Administrative Officer, the CHS Director, the Clinical Director, the Case Management Director, and representatives from the departments of Behavioral Health, Substance Abuse and Health Benefits Coordination. It meets on a weekly basis and reviews cases, the CHS financial status and CHS cases which come before it for reconsideration of denial of CHS authorization. Dr. Ryter's participation on this committee in his capacity as Clinical Director was exemplary.

4. At no time during his probationary period was Dr. Ryter in jeopardy and/or otherwise at any risk of discipline and/or termination from service with the federal government. Dr. Ryter fulfilled the requirements of his position description in very satisfactory manner.

Further Affiant sayeth not."

DATED: August 5, 2005

William Thorne
WILLIAM THORNE

SIGNED AND SWORN TO before me, a notary public in and for Bernalillo County, New Mexico.



C. Divina Valle Stern
NOTARY PUBLIC

V.2

**UNITED STATES OF AMERICA
MERIT SYSTEM PROTECTION BOARD
DENVER FIELD OFFICE**

**MARK ZIMMERMAN, M.D.
APPELLANT**

vs.

**DOCKET NUMBER
DE-1221-05-0311-W-1**

**DEPARTMENT OF HEALTH AND
HUMAN SERVICES,
AGENCY**

AFFIDAVIT OF JOSEPH MOQUINO

I, Joseph Moquino, residing at 11817 Phoenix Avenue, NE, Albuquerque, NM 87112, being of sound mind and over the age of 18 years, do affy as follows:

"1. I was the Acting Chief Executive Officer (CEO) of the Acoma Canonicito Laguna Service Unit (ACL), part of the Albuquerque Area Indian Health Service (Area). I served in this capacity from October 8, 2003 until approximately July 31, 2004.

2. During my tenure as Acting CEO, I was the first line supervisor of Dr. Stephen Ryter during his tenure as the ACT Clinical Director. At all times during Dr. Ryter's probationary status of employment with the Indian Health Service (Agency), I was responsible for preparing his efficiency ratings and, if applicable, would have been responsible for taking any disciplinary action against him, and/or terminating him from service during his probationary period.

3. One of Dr. Ryter's duties was to establish priority of care categories for ACL's expenditure of its contract health services funds (CHS). He performed this duty in compliance with the existing CHS policy that Area had distributed to its service units, and which had been authorized by the then Area Chief Medical Officer, Ervin Lewis, M.D. (deceased). He did not apply the policy in an arbitrary or capricious manner, but only after consultation with all relevant federal and tribal entities, whose opinions were properly solicited.

1

V. 3

4. At no time during his probationary period was Dr. Ryter in jeopardy and/or otherwise at any risk of discipline and/or termination from service with the federal government. Dr. Ryter fulfilled the requirements of his position description in very satisfactory manner.

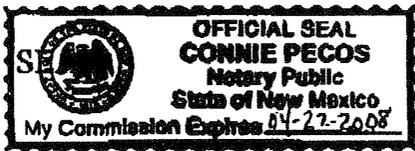
Further Affiant sayeth not."

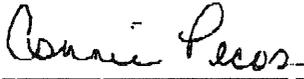
DATED: August 5, 2005



JOSEPH MOQUINO

SIGNED AND SWORN TO before me, a notary public in and for Bernalillo County, New Mexico.





NOTARY PUBLIC

V.4