Revenue Operations Manual

Part 2

Patient Registration

Version 1.0

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Department of Health & Human Services
Indian Health Service
Business Office
Part 2. Patient Registration

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1. Overview of Patient Registration

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1.1 About the Revenue Operations Manual

The Indian Health Service Revenue Operations Manual provides a system-wide reference resource for all Indian, Tribal, and Urban (I/T/U) facilities across the United States, to assist any and all staff with any function related to business operation procedures and processes.

1.1.1 Revenue Operations Manual Objectives

- Provide standardized policies, procedures, and guidelines for the Business Office related functions of IHS facilities.
- Capture accurate coding for all procedures and services to maximize reimbursement for each facility.
- Provide on-line, via the IHS Intranet, reference material subdivided by department and function that is accessible to all facilities.
- Share innovative concepts and creative approaches to Business Office functions across all the Area offices and facilities.
- Promote a more collaborative internal working environment throughout all of IHS.
- Foster and promote continuous quality improvement standards, which when implemented and monitored on a day-to-day basis, will ensure the highest quality of service at each level of the Business Office operation.

1.1.2 Revenue Operations Manual Contents

The Revenue Operations Manual is divided into the following five (5) parts:

- **Part 1 Administrative Roles and Responsibilities** contains
  - Overview of revenue operations
  - Laws, acts, and regulations affecting health care
  - IHS laws, regulations, and policies
  - Health Insurance Portability and Accountability Act (HIPAA)
  - Business Office Management and Staff
  - Business Office Quality Process Improvement and Compliance

- **Part 2 Patient Registration** contains:
  - Overview of patient registration
  - Patient eligibility, rights, and grievances
  - Direct care and contract health services
  - Registration, discharge, and transfer
- Third-party coverage
- Scheduling appointments
- Benefit coordinator

- **Part 3 Coding** contains:
  - Overview of coding
  - Medical record documentation
  - Coding guidelines
  - Data entry

- **Part 4 Billing** contains:
  - Overview of billing
  - Hard copy vs. electronic claims processing
  - Billing Medicare
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- **Part 5 Accounts Management** contains:
  - Overview of accounts management
  - Electronic deposits and Remittance Advices
  - Processing zero pays
  - Creating payment batches
  - Processing payments and adjustments
  - Reconciliation of credit/negative balances
  - Collections
  - Collection strategies
  - Rejections and appeals

Each part and chapter of the manual is designed to address a specific area, department, or function. A part may also contain one or more appendices of topic-related reference materials.

This manual also includes:

- Acronym dictionary
- Glossary
1.1.3 Accessing the Revenue Operations Manual

The *Revenue Operations Manual* is available for downloading, viewing, and printing at this website:

http://www.ihs.gov/NonMedicalPrograms/BusinessOffice/index.cfm?module=rom

1.2 About Patient Registration

The Registration staff gathers and enters the required patient visit information, and promotes positive public relations to increase community trust in the facility.

The Registration function creates the patient record and patient identification system for future record storage and ensures the clinic’s data integrity. Incomplete and/or inaccurate collection of information and disposition of the patient will adversely affect other departments by delaying various processes and creating more manual interventions (re-works) by the Business Office and Health Information Management (HIM).

The process of submitting claims electronically demands complete and accurate collection of information by registration to ensure timely and accurate billing. HIM also depends on patient registration to prevent potential duplication of patient records.

Although a particular patient may visit the facility every month, that patient’s insurance, demographic, and employment information may change. Each visit presents an opportunity to verify and update facility records. The same information must be gathered from patients seeking emergency services; however, the timing and techniques may differ. Friends and family often accompany the patient and are good resources in completing the registration process.

For information related to tracking Registration performance, see Part 1, Chapter 7, “Business Office Quality Process Improvement.”
1.3 IHS National Registration Policy and Procedures

1.3.1 Policy

All individuals seeking care or services from an IHS facility must be registered primarily through the IHS Resource Patient Management System (RPMS) Patient Registration application, or in a limited manner through the Scheduling application.

1.3.2 Procedures

- All patients will be registered using the policy set by the facility.
  - Requests will be made for enrollment or descendancy verification.
  - All fields will be completed using the coded information in the current IHS Standard Code Book.
  - Initial Contract Health Service (CHS) eligibility and third party resources will be documented and appropriate letters will be signed by the individual.
- Third Party eligibility will be updated per encounter, as necessary, that conform to the facilities policies.
- An initial interview will be conducted in a courteous and confidential manner before the patient is seen by a provider.
- When a patient has been entered/updated in the RPMS system, an entry on the Notes page in the Registration Editor of the Patient Registration application needs to be documented as to when the patient was last updated and by whom.
- Patient’s eligibility for services must be proven and accepted. If a patient does not provide adequate proof of eligibility, the patient’s classification will be non-Indian “ineligible” until such proof has been provided.
- Designated staff will establish the registration record in RPMS system.
- Designated staff at each clinic or facility will be assigned to update the selected areas of the registration record.
- Menu options to view or edit should be based on the user’s need-to-know, as determined by their job responsibilities. This is also called “Role-Based Access.”
- Registration staff is responsible for identifying and sequencing the primary, secondary, and tertiary insurer and updating this information into the RPMS Patient Registration application for each encounter.
• A stamped “signature on file” can be used in place of the patient’s actual signature, provided the clinic has a signed authorization on file to bill Medicare for covered services. The “signature on file” must be updated on a yearly basis.

For an example of the Application for Medical Services (Form 58), see Part 2, Appendix A.

1.4 Customer Service

Customer Service is defined as an approach to interacting with people that respects and values each person. As applied to IHS patients, the goals of customer service are to achieve optimum results and contribute to improving one’s health. Essentially, customer service infers – “Treat people the way you would like to be treated if you were sick and seeking health services or having a health-related problem that needs fixing.”

Registration offers the health care facility many opportunities to score public relations points and these individuals are often the very first contact the patient has for obtaining needed health care in order to get well. With a good impression, the registration process will flow with ease. Patients will feel comfortable giving the clinic staff information, confident they are dealing with a professional. A bad impression makes patients leery of staff’s ability.

Several suggestions include:

• Communicate effectively. Be natural. Use words patients can understand. Be careful of technical jargon that may be unfamiliar to patients. Take the time to answer questions.

• Train staff in the registration process and make sure procedures are being followed. Let staff help develop the procedures. That way, they will be more likely to follow them.

• Help patients with directions to other parts of the clinic

• Make patients aware if the physician’s schedule is behind

• Assist patients by making appointments for multiple services on the same day

• Contact patients who missed appointments, find out the reason, and reschedule

• Treat patients with dignity and respect

• Address and respond to patient complaints
• Obtain interpreter, if needed
• Address all patient’s complaints and/or obtain assistance
• Kindly remind patients to bring in correct records, reports

In most patient contacts, there will not be a problem and the registration process will go smoothly. However, when there is a problem,
• Allow the customer to vent or state the problem from his/her point of view.
• Try to understand what the patient is saying – listen first, so you will know what the problem is. This will help when you try to “fix it.”
• Restate the problem back to the patient. “If I heard you correctly, (restate the problem). Do I have the problem right?” This validates the patient complaint.
• Make an apology – “I am sorry” - regardless if the patient is right or wrong.

The goal is to solve the problem for the patient and prevent it from occurring again. Everybody wins when the problem is taken care of quickly, using good customer service strategies.
• Fix the problem if it is within your control. If you need extra help, ask your supervisor.
• If the problem cannot be fixed or it will take awhile, tell the patient what you plan to do about the problem in the future. “We will keep an eye on this situation.”

1.5 Telephone Etiquette

Whether answering the phone or making phone calls, proper etiquette is essential. This will assist each person at the facility to maintain a certain level of professionalism when using the telephone. Proper etiquette leaves callers with a favorable impression of you and your department. You will also find that others treat you with more respect and are willing to go out of their way to assist you if you use proper etiquette.


1.5.1 Basic Telephone Procedures

**Remember:** Etiquette is a very important element of a professional atmosphere, and phrases such as "thank you" and "please" are essential.

- Make sure to answer before the third ring.
- Use a greeting that is going to give the caller the impression that we are professional and pleasant; for example, “[Department name], may I help you?”
- If you are currently on one line and another line rings:
  - Tell the first caller to "Please hold."
  - Place caller on hold.
  - Answer the ringing line saying, "[Department name]--please hold."
  - Place second caller on hold.
  - Return to first caller and complete the call.
  - Go back to the second caller.
  - Say, "Thank you for holding, may I help you?"

**Note:** Sometimes you will have many lines ringing all at once. Please remember to write down the names of the calls waiting so you avoid asking who the caller is holding for more than once.

1.5.2 Answering Calls for your Department

**Remember:** You may be the first and only contact a person may have with your department, and that first impression will stay with the caller long after the call is completed.

- Answer promptly (before the third ring, if possible).
- Before picking up the receiver, discontinue any other conversation or activity (e.g., eating, chewing gum, typing, etc) that can be heard by the calling party.
- Speak clearly and distinctly in a pleasant tone of voice.
- Use the Hold button when leaving the line so that the caller does not accidentally hear conversations being held nearby.
- When transferring a call, be sure to explain to the caller that you are doing so and where you are transferring them.
- If the caller has reached the wrong department, be courteous. Sometimes they have been transferred all over campus with a simple question. If possible, attempt to find out where they should call/to whom they should speak. They will greatly appreciate it.
1.5.3 Taking Telephone Messages

- Be prepared with pen and message slip when you answer the phone.
- When taking messages be sure to ask for:
  - Caller's name (ask for the correct spelling)
  - Caller's phone number (including area code) and/or extension
- Repeat the message to the caller.
- Fill in the date, time, and your initials.
- Place the message slip in the called party's inbox or in a conspicuous place in their office, such as their chair.
- If you can transfer the caller to voicemail instead of taking a paper message, don't forget to ask, "Would you like me to transfer you to _____'s voicemail?" Do not assume that the caller would rather go to voicemail. Always ask first.

1.5.4 Handling Rude or Impatient Callers

- Stay calm. Try to remain diplomatic and polite. Getting angry will only make them angrier.
- Always show willingness to resolve the problem or conflict.
- Try to think like the caller. Remember, their problems and concerns are important.
- (Non-supervisory staff) If the caller persists, offer to have your supervisor talk to the caller or call him/her back.
# 2. Patient Eligibility, Rights & Grievances

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2.1 Patient Eligibility Criteria

A person may be regarded as eligible for services of the IHS Program if he/she is not otherwise excluded by provision of law, and meets the criteria set forth below:

- Is of American Indian and/or Alaska Native descent as evidenced by one or more of the following factors:
  - Is regarded by the community in which he lives as an American Indian and/or Alaska Native;
  - Is a member, enrolled or otherwise, of an American Indian or Alaska Native Tribe or Group under Federal supervision;
  - Beneficiary resides on tax-exempt land or owns restricted property;
  - Actively participates in tribal affairs;
  - Any other reasonable factor indicative of Indian descent;
- Is a non-Indian member of an eligible Indian’s household and 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 (e.g., TB, HIV, Hepatitis).

Eligibility regulations are defined in the Code of Federal Regulations (CFR 42, 36 & 36A).

2.2 Other Eligible Categories of Patients

2.2.1 Commissioned Corp and Dependent Eligibility Criteria

The following identified Commissioned Corp groups may be provided direct care that is within the scope of services provided by that facility.

- Active commissioned officers
- Active commissioned officer dependents
- Retired commissioned officers
- Retired commissioned officer dependents

Any referrals to providers outside of the IHS must follow the referral policies of TRICARE, which provides coverage for Commission Officers and their dependents. The IHS will bill TRICARE for payment of services rendered to Commissioned Officers and their dependents.
2.2.2 Non-Indian Federal Employees (PHS Field Employees)

Non-Indian Federal employees are eligible for emergency treatment for on-the-job injuries.

At remote facilities Non-Indian Federal employees are eligible for medical services as defined in Public law 90-174 amended Section 324 of the Public Health Service Act, as follows:

“The Secretary is authorized to provide medical, surgical, and dental treatment and hospitalization and optometric care for Federal employees (as defined in section 8901(1) of title.5 of the United States 80 Stat. 600. Code) and their dependents at remote medical facilities of the Public Health Service where such care and treatment are not otherwise available. . . .”

The following facilities are designated as remote facilities.

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At a remote medical facility the Service is authorized to provide medical, surgical, and dental treatment and hospitalization and optometric care for Federal employees and their dependents that reside or work within a 30-mile radius of the remote facility.

The remote facility may also provide such services to Federal employees and their dependents, who reside or work outside of the 30-mile radius of the remote facility, AND

• who would otherwise be required to travel a greater distance from their residence or place of employment to the remote facility, or
• for whom transportation for private care is greater than the distance from their residence or place of employment to the remote facility, or
• for whom transportation for private care from their place of residence or employment is unavailable, hazardous, protracted, or unreasonably expensive, due to unfavorable factors such as unpaved or mountainous winding road or toll bridges and roads or adverse weather conditions.

The applicant will establish his status as a Federal employee to the satisfaction of the Service Unit Director.

The Service Unit Director is authorized to establish limitations and priorities for furnishing medical care to Federal employees and their dependents, as dictated by the primary mission of circumstances related to the provision of medical care

The Service unit Director of a remote station or his designee may deny treatment of care to Federal employees and their dependents

• who cannot establish their status to the satisfaction of the Service Unit Director, OR
• who cannot establish that they must otherwise travel at least thirty miles for private health services, or
• for whom transportation for private care is unavailable, hazardous, protracted, or unreasonably expensive due to unfavorable factors such as unusual climatic conditions, un-surfaced or mountainous winding roads, or toll bridges and roads.

A written notice of such denial will be given and a copy of each notice of denial will be retained at the remote facility.

2.2.3 Other Eligibility Considerations

An Indian is not required to be a citizen of the U.S. to be eligible for contract health services (CHS). The Indian (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 (e.g., St. Regis Mohawk, Blackfeet) or Mexican border (e.g., Tohono O'Odham).

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;

For a list of eligible tribes, see the Federal Register, Part II Department of the Interior, Bureau of Indian Affairs, Volume 70/No. 226/November 25, 2005/Notices: “Indian Entities Recognized and Eligible to Receive Services from the United States Bureau of Indian Affairs.” To view this notice in text or PDF format, go to this website, http://www.access.gpo.gov/su_docs/fedreg/a051125c.html and scroll to Indian Affairs Bureau.

(2) any descendant of an Indian who was residing in California on June 1, 1852, but only if such descendant is

(A) living in California,

(B) a member of the Indian community served by a local program of the Service, and

(C) regarded as an Indian by the community in which the descendant 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 descendant of such an Indian. Section 709 (c) [which] 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.

Indians adopted by non-Indian parents must meet all CHS requirements to be eligible for care, that is, reside in a Contract Health Services Delivery Area (CHSDA).

**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.

Section 813 of the Indian Health Care Improvement Act, P.L. 94-437, as amended, states in part:

(a) (I) 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.”

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 the 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.
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.

**Note:** Indian people, who are eligible for tribal membership but who do not wish to exercise their membership eligibility for whatever personal reasons they may have, are free to make this choice. However, it is the responsibility of these individuals to provide the necessary eligibility information to receive ongoing services at IHS. The IHS can assist with this process by providing information on the requirements to document tribal enrollment or descendancy.

### 2.3 Determination of the Degree of Indian or Alaska Native Blood

A Certificate of Degree of Indian or Alaska Native Blood (CDIB), or proof of eligibility document, certifies that an individual possesses a specific degree of Indian blood of a federally recognized Indian tribe(s). A Tribe or Bureau of Indian Affairs official issues the CDIB. The Certificate is issued to establish the individual’s eligibility for those programs and services based on their status as American Indians and Alaska Natives.

#### 2.3.1 Computation of the Degree of Indian Blood

The degree of Indian blood is computed from lineal ancestors of Indian blood, who were enrolled with a federally recognized Indian tribe or whose names appear on the designated base rolls of a federally recognized Indian Tribe.

To calculate your total Indian blood degree, add together your blood degree obtained from your birth mother and your blood degree obtained from your proven birth father.

**Examples:**
- One-half of the Indian blood is obtained from each of your birth parents
- One-half of the Indian blood is from your birth mother.
If your grandmother was full blood, your mother obtained one-half Indian blood from your grandmother; and if your mother obtained no Indian blood through her father, you obtain only one-fourth Indian blood from your mother.

- One-half of the Indian blood is obtained from your birth father.

If you were born out of wedlock, then you obtain one-half of the Indian blood from your birth father only if his identity is proven.

**Note:** An adoptive parent is not a lineal ancestor and blood degree cannot be derived from an adoptive parent.

To determine a child’s degree of Indian blood, see Part 2, Appendix B, Blood Quantum Formula (Excel spreadsheet), in which you enter the blood quantum of the parents and it calculates the child’s degree of Indian blood.

### 2.3.2 Obtaining a Certificate of Degree of Indian or Alaska Native Blood

Requirements include the following:

- The relationship to an enrolled member(s) of a federally recognized Indian tribe must be demonstrated.

- The maiden names of all women listed on the Request for CDIB must be documented.

- A certified copy of a Birth Certificate is required.

- If a parent is not enrolled with a federally recognized Indian tribe, a certified copy of that parent’s Birth or Death Certificate is required.

- In the case of adoption, the degree of Indian blood of the natural (birth) parent must be proven.

Contact your local Tribal agency to obtain a Certificate of Degree of Indian Blood (CDIB) and specific requirements.
2.4 Patient Rights and Grievances

2.4.1 IHS Policy

Each Indian health Service Area will develop and promulgate a written statement of patient rights. Such statements of patient rights should be developed in cooperation with the Area Indian Health Boards and must have their concurrence.

At the minimum, these statements must include an affirmation of the patient’s rights to:
- Services, within their availability or capability of being provided
- Considerate and respectful treatment
- Privacy and confidentiality of medical information
- Information on his or her condition, including the right to give or withhold consent for treatment, referral, or transfer
- Continuity of care and information regarding what health services are available, and where and how they may be obtained
- Knowledge of hospital rules and regulations applying to patient conduct
- Access to an established patient grievance procedure
- Selection of an interpreter when requested and available

Each Area will have in place a mechanism to insure that patient grievances are given full and fair consideration to the highest level of appeal. The Area’s grievance procedure will include a provision that a designated grievance committee exist at each Service Unit. This committee may be the local Indian Health Board, or it may be another group or committee that includes Indian representatives and has been approved for this purpose by the local tribal government and Service Unit Administration.

Ultimate appeal at the local level will be to the Service Unit Director, who must initiate an investigation and provide a written reply, both within specified periods of time. Unresolved complaints may then be appealed to Area Health Board and/or the Area Director. Final decisions will be made by the Area Director.
The Area will insure that each Service Unit has a positive mechanism for disseminating information on patient rights and the grievance process. At the minimum, written explanations of the grievance process and patient rights must be

- Posted prominently in the waiting areas of all IHS facilities.
- Periodically distributed to the community.
- Included in the orientation process for all new IHS staff.

2.4.2 Example of Patients’ Rights Statement

Each patient has a right to

- **Access to Care**
  
  Individuals shall be accorded impartial access to treatment or accommodations that are available or medically indicated regardless of race, creed, sex, national origin, or sources for payment of care.

- **Respect and Dignity**
  
  The patient has the right to considerate, respectful care at all times and under all circumstances, with recognition of his or her personal dignity.

- **Privacy and Confidentiality**
  
  The patient has the right, within the law, to personal and informational privacy, as follows:
  
  - To refuse to talk with or see anyone not officially connected with the hospital/clinic, including visitor or persons officially connected with the hospital/clinic but not directly involved in his or her care
  - To wear appropriate personal clothing and symbolic items, as long as they do not interfere with diagnostic procedures or treatment
  - To be interviewed and examined in surroundings designed to ensure reasonable visual and auditory physical examination, treatment, or procedure performed by a health professional of the opposite sex, and the right not to remain disrobed any longer than is required for accomplishing the medical purpose for which the patient was asked to disrobe.
  - To expect that any discussion or consultation involving his or her case will be conducted discreetly and that individuals not directly involved in his or her care will not be present without the patient’s permission.
– To have his or her medical record read only by individuals directly involved in his or her treatment, or in the monitoring of its quality. Other individuals can only read the patient’s medical record on his or her written authorization or that of his or her legally authorized representative.
– To expect all communications and other records pertaining to his or her care, including the source of payment for any treatment, to be treated as confidential.
– To request a transfer to another room if another patient or a visitor in the room is unreasonably disturbing the patient by any actions.
– To be placed in protective privacy when considered necessary for personal safety.

• Personal Safety

The patient has the right to expect reasonable safety insofar as the hospital practices and environment are concerned.

• Identity

The patient has the right to know the identity and professional status of individuals providing service to him or her and to know which provider or other practitioner is primarily responsible for his or her care. This includes the patient’s right to know the existence of any professional relationship among individuals who are treating him or her, as well as the relationship to any other health care or educational institutions involved in the patient’s care. Participation by patients in clinical training programs or in the gathering of data for research purposes should be voluntary.

• Information

The patient has the right to obtain from the practitioner responsible for coordinating his or her care, complete and current information concerning the patient’s diagnosis (to the degree known), treatment, and any know prognosis. This information should be communicated in terms that the patient can reasonably be expected to understand. When it is not medically advisable to give such information to the patient, the information should be made available to a legally authorized individual.

• Communication

The patient has the right of access to people outside the hospital by means of visitors and by oral and written communication. When the patient does not speak or understand the language of the community, he or she should have access to an interpreter.
3. Direct Care and Contract Health Services

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3.1 **Direct Care Services**

A person may be regarded as within the scope of the Indian Health Program if he/she is not otherwise excluded by provision of law and is of American Indian and/or Alaska Native descent, as evidenced by the specific criteria stated in Section 2.2 of CFR 42, 36 & 36A.

3.1.1 **Direct Care Policy**

It is the policy of the Indian Health Service (IHS) to insure that needed health services are available to each person who is eligible for the IHS Program. The IHS is primarily responsible for:

- Providing all direct services available at an IHS facility to any eligible person
- Verifying and entering alternate resources, which include Medicare, Medicaid, Private Insurance, State Children’s Health Insurance Program, SSI, and other State, Federal, and private sources.
- Coordinating services to all persons within the scope of the Indian Health Program from existing sources.
- Identifying and determining whether or not the eligible person may be eligible for an alternate resource, which include County, State or Federal programs, such as Medicaid, State Children’s Health Insurance Program (SCHIP); Medicare, Veterans Administration Hospital, U.S. Army, Air Force, Navy, Public Health Service Hospitals, and others; official or voluntary health Organizations; employee health insurance; accident insurance; or others.
- Billing all third-party payers and recording revenue in compliance with the Accounts Receivable policy.

3.1.2 **Provision of Direct Care Services**

- Medical care and treatment services including hospitalization are provided as available in IHS facilities or on a referral basis for eligible persons in accordance with the Contract Health Program funding and priorities.
- The preventive and health promotion services at all facilities shall be made available to all persons within the scope of the Indian Health Program. As part of such service, those persons who are able and willing to utilize local Indian Health Service community preventive health services will be encouraged to do so.
• When care from a Contract Health Service vendor is necessary, by Law IHS must first use alternate resources, if they are available. If an alternate resource may be available, IHS is required to refer the patient to make application for the resource, for example, Medicaid. Based on the determination, a decision will be made whether or not IHS will make a contract health services (CHS) payment. Also, the patient must provide proof of private insurance.

In the event the individual’s condition is such that immediate care and treatment are necessary, services may be provided pending determination of whether or not the individual is within the scope of the program and whether or not he is within priority. In these cases, a medical referral is made without authorization for payment.

If a patient is not CHS eligible, IHS still has the obligation to initiate a referral to a non-IHS facility or provider. In such cases IHS is not obligated to make payment to the non-IHS facility or provider; the patient is responsible for the payment.

• When alternate resources are available to the patient, the Service will require use of such services prior to authorizing any IHS resources, and will maintain relationships with agencies to facilitate the utilization of those resources. Every effort should be made to make the most effective use of alternate resources, including other Federal medical facilities whenever appropriate.

• The cost of medical and related health services for persons in the custody of (non-Indian) law enforcement agencies is not the responsibility of the IHS, but is the responsibility of that particular agency.

### 3.1.3 Denial of Direct Care Services

The CEO or his designee may deny services to persons who according to his determination do not meet the eligibility criteria of the IHS program.

**Note:** If a non-eligible patient presents for emergency care, appropriate triage and assessment services will be provided according to the EMTALA Regulation.
3.2 Contract Health Services (CHS)

Contract Health Services (CHS) are provided by referral providers outside the IHS direct care system. Determination of Eligibility for the CHS program is the responsibility of the CHS staff. This program is has its own set of Laws, regulations and policies. For more information, go to this website:


3.2.1 Contract Health Services Policy

If the patient requires services outside of IHS and the alternate resource cannot or will not provide the necessary assistance, the Service may provide it by referral, based on the CHS medical priorities and funding.

Eligible persons, within the scope of the Indian Health program in one area, will be provided available medical and/or other related direct services by any other IHS facility in which they may require health services. For services provided outside IHS direct care, the authorization or denial of contract Health services shall be the responsibility of the Service Unit /facility in which the services are rendered. The Area in which the services are rendered shall apply the same policies and have the same notification requirements for persons from other Areas as are applied to those persons within the Area.

3.2.2 Provision of Contract Health Services (CHS)

All direct services available at any IHS facility will be provided as needed to any eligible person. Services needed but not available as direct service at the facility will be provided through the Contract Health Service Program, depending on:

- the person’s medical need as determined by a physician whenever possible
- the actual availability and accessibility of alternate resources
- the financial resources available to the service facility at that time
- CHS program eligibility, medical priorities, and funding

Contract Health services are divided into five levels of services, based on medical priority, as discussed in Part 2, Chapter 3, Section 3.3, “CHS Medical Priority Criteria.”
3.2.3 Denial of Contract Health Services

The CEO or his designee may deny services to persons, who according to his determination, do not meet the eligibility criteria of the IHS program. When the services are denied, a written notice of such denial will be given to the person. Such written notice will include:

- The basis for denial, listing the specific circumstances and facts upon which the priority decision was made
- The name of the CEO or of his designated representative
- The statement, “If you have any information which may affect this decision, you may appeal this decision with a copy of this letter for reconsideration by the Area Director.”

A copy of each notice of denial will be retained at the IHS facility, preferably in the person’s case folder, and a copy will be forwarded to the Area office.

3.3 CHS Medical Priority Criteria

Contract Health Services (CHS) are divided by medical priority into five levels of services:

- Level I – Emergent/Acutely Urgent Care Services
- Level II – Preventive Care Service
- Level III – Primary Secondary Care Services
- Level IV – Chronic Tertiary and Extended Care Services
- Level V – Excluded Services

Detailed information related to CHS medical priority is located in the Indian Health Manual, Part 2 - Services to Indians and Others; Chapter 2 Contract Health Services, Section 3.17, “Medical and Dental Priorities,” which is available at this website:

http://www.ihs.gov/PublicInfo/Publications/IHSManual/Part2/pt2chapt3/pt2chpt3.htm#17
3.3.1 **Level I – Emergent/Acutely Urgent Care Services**

Emergency and/or acutely urgent care services include those diagnostic or therapeutic services that are necessary to prevent the immediate death or serious impairment of the health of the individual, and which because of the threat to the life or health to the individual, necessitate the use of the most accessible health care that is available and capable of furnishing such services. Also included are diagnosis and treatment of injuries or medical conditions that, if left untreated, would result in uncertain but potentially grave outcomes.

Categories of service include:

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

3.3.2 **Level II – Preventive Care Service**

Preventive care service includes primary health care that is aimed at the prevention of disease or disability. This includes services proven effective in avoiding the occurrence of a disease (primary prevention) and services proven effective in mitigating the consequences of an illness or condition (secondary prevention). Level II services are available at most IHS facilities.

Categories of service include:

- Routine prenatal care
- Non-urgent preventive ambulatory care (primary prevention)
- Screening for known disease entities (secondary prevention)
- Screening mammograms
- Public Health interventions
3.3.3 Level III – Primary Secondary Care Services

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

Categories of services include:
- Scheduled ambulatory services for non-emergent conditions
- Specialty consultations in surgery, medicine, obstetrics, gynecology, pediatrics, ophthalmology, ENT, orthopedics, and dermatology
- Elective, routine surgeries that have a significant impact on morbidity and mortality
- Diagnostic evaluations for non-acute conditions
- Specialized medications not available at IHS facility, when no suitable alternative exists

3.3.4 Level IV – Chronic Tertiary and Extended Care Services

Chronic tertiary and extended care services are those inpatient and outpatient care services that (1) are not essential for initial/emergent diagnosis or therapy, (2) have less impact on mortality than morbidity, or (3) are high cost, elective, and often require tertiary care facilities. These services are not readily available from direct care IHS facilities.

Careful case management by the service unit CHS committee is a requirement, as is monitoring by the Area Chief Medical Officer (CMO), or his/her designee. Depending on cost, the referral may require concurrence by the CMO.

Categories of service include:
- Rehabilitation care
- Skilled nursing home care
- Highly specialized medical services/procedures
- Restorative orthopedic and plastic surgery
- Elective open cardiac surgery
- Organ transplantation (HCFA/CMS approved transplants only)
- Care provided under the direction of an advance directive

### 3.3.5 Level V – Excluded Services

Excluded services and procedures that are considered purely cosmetic in nature, are experimental or investigational, or have no proven medical benefit.

- **Cosmetic procedures** – Payment for certain cosmetic procedures may be authorized if these services are necessary for proper mechanical function or psychological reasons. Approval from the CMO is required.

- **Experimental and other excluded services** – Payment is not authorized, unless a formal exception is granted by the Office of Public Health (OPH).

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**Note:** Limitations of funds, facilities, or staff may result in different levels of direct services available at IHS facilities.
4. **Registration, Discharge, and Transfer**

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4.1 About the Medical Record

As stated in the *Indian Health Manual* (3-3.2), the medical record is:

- The chronological documentation of health care and medical treatment given to a patient by professional members of the health care team. It is an accurate, prompt recording of their observations, including relevant information about the patient, the patient's progress, and the results of the treatment.

- The means by which physicians, nurses, and allied health professionals who plan and conduct the care and treatment of the individual patient communicate.

- A legal document that benefits the patient, the physician, and the health care program.

- A tool for training members of the medical and paramedical professions, and for conducting medical research. It is also the primary means of evaluating the quality and appropriateness of medical care rendered.

- The source document for statistical use in research, planning, and budgeting.

- The original source document for any-financial activity involving patient care. Primary examples are the use of medical records in audits of third party collections by outside payers; and in internal audits to verify allocation processes and to develop and maintain cost management programs and cost management systems.

For more information on the medical record, see the *Indian Health Manual*, Part 3, “Professional Services, Chapter 3, “Medical Records,” which is available at this website:

4.1.1 Medical Record Number

As defined in the *Indian Health Manual* (3-3.9B):

“Unit Number: A unique unit number shall be assigned to each patient’s record upon initial registration; whether outpatient, inpatient, newborn, emergency patient, community health patient, or contract health service beneficiary. This number is used to identify the patient’s record and all material filed therein. Reissue of a number is strictly prohibited because of the interactive nature of IHS data systems.”

4.1.2 Medical Record Chart/Folder

Each Medical Record established will have the following forms imprinted or laser labels with patient identifying information on each form prior to delivery of the record to the designated clinic.

- Ambulatory Care Record Brief
- IHS Ambulatory and Inpatient (if facility is ambu and inpt) divider tabs
- PCC Health Summary
- Immunization Record, IHS-216 (optional if entering immunizations at point of care and facility has eliminated the Immunization Record form)
- Radiology consultation report
- Disclosure accounting record, IHS-505 (optional) facilities either manually or electronically account for disclosures via Release of Information (ROI) software
- Authorization to furnish Information/Assignment of Benefits
- Acknowledgement of Receipt of IHS Notice of Privacy Practices

The medical record will be identified with

- patient name – Last, First, and Middle Initial – (this should be the legal name, e.g., Rebecca, not “Becky,” William, not “Bill”) on top
- medical record number (terminal digit) on the side and top tab along with the back of the chart cover
- year of activity stamp or label
- Allergy (sensitivity) sticker, if applicable

These are the only authorized items allowed on the outside of the chart/folder.
4.2 Temporary Medical Record Number Assignments

Temporary numbers ("T" numbers) are usually assigned to individuals who are
- walk-ins without a previous medical record number,
- emergencies,
- newborns, or
- transfers to the clinic that do not have an existing medical record number.

In order to treat that patient on the date they present, a temporary number is issued to the patient chart.

Temporary numbers are also issued to patients who call in for an appointment and are not registered (new patients).

A temporary number is issued from the Patient Mini-Registration option in the RPMS Scheduling application. This will be used only after a thorough search of the record is done to avoid duplication.

The RPMS Patient Registration application considers anyone with a temporary chart number to be an incomplete record and will issue a message to Registration. After reviewing the report of temporary chart numbers from RPMS, a new, permanent medical record number from the next available number on the Number Control Log should be assigned and the information updated in the system.

4.2.1 Clean Up Process for Temporary Medical Record Numbers

Assigning a permanent chart number should be done as soon as possible, since temporary chart numbers are not exported to the National Patient Information Reporting System (NPIRS).

- Identify the patient records that contain a temporary chart number.
  - Go to the Patient Registration Reports Menu (REG > PTRG > RPT).
  - Access the Print Patient with TEMPORARY CHART NUMBERS (TEM) option.
  - Print a list of patients that have a temporary chart number.

Temporary chart numbers are identified as a “TNNNNNN” where the “NNNNNN” is a temporary number usually beginning with 00001.
• Compare the patient entry on the TEM report to the Patient Registration database.
  – Use the **SCAN the patient files** option (REG > PTRG > SCA), and check against:
    • Active patients
    • Inactive or deceased patients
    • Patient charts at other locations in the same database
  – Check if the patient may be a duplicate in the system by comparing:
    • Social Security numbers
    • Date of birth
    • Mother’s maiden name
    • Current Community

• If the patient is identified as a unique entry, ensure that the mandatory fields in the patient’s record are completed, and then request a new Health Record Number from Medical Records (or whoever assigns the HRNs).

• If the patient is identified as a duplicate entry, it is easier to print a face sheet of the duplicate patient entry (usually it is the one that has the temporary chart number) and merge the two entries together.

  This is a manual process, comparing fields from one chart entry to the other and transferring data to the correct patient. When moving the data is completed, the staff can inactivate (INA) the duplicate chart. An additional step could be to change the name (NAM) on the duplicate chart, and then proceed to inactivate it.

**Note:** All visit information associated to the duplicate chart number will need to be reassigned to the permanent chart number in RPMS.

Notify the appropriate departments of the chart number reassignment.
4.3 Master Patient Index (MPI)

A permanent, current Master Patient Index (MPI) shall be maintained by each facility. This alphabetical index of patients is a key to the identity and location of the medical record. It may be contained in a computer system (RPMS), but a hard copy control index must also be maintained.

Information on the patient index card shall be as detailed as needed. The index cards shall be filed alphabetically by the last name. For a name change, a cross-index file shall be made. The unit number of the original registration shall be recorded on the cross-index card. (The majority of facilities still type or print this card from Patient Registration Menu. Usually the Kardex equipment that holds the card is located in the HIM Department.)

The MPI is also used to find inactive patients who were treated at the facility but never registered. The original number should then be used and a new chart established.

With the implementation of the Electronic Health Record at IHS clinics and hospitals, a hard copy or paper medical record must be established and maintained until the IHS-EHR is approved and accepted by the National Archives and Records Administration (N.A.R.A.).

4.4 Name/Birth Date Change Requests

4.4.1 Name Change

On request from the patient, a name will be changed on the medical record of the patient after valid document(s) have been presented:

- Birth certificate
- Marriage license
- Court order/Divorce decree stating the name change

A name change/correction request form will be completed. For an example of this form see Part 2, Appendix C, Name Change/Date-of-Birth Correction Request Form.

Patient demographic information updates will be completed to reflect the name change for Assignment of Benefits form and HIPAA Acknowledgement of Receipt of the Notice of Privacy Practices (NPP). Changing the name will not update the insurance eligibility information.
A copy of the Ambulatory Care Record Brief (face sheet) will be printed and attached to the change request form with the supporting documents.

Name changes must be made directly into the RPMS Patient Registration application. Changes, whether for the manual or electronic medical record, are identical. The name must also be changed on the actual Medical Record chart and corresponding identification media (labels, embossed cards, etc.).

4.4.2 Birth Date Change

On request from the patient, the date of birth on the medical record will be changed after a state copy of the birth certificate, driver’s license, or other acceptable documentation is presented. Patients will be informed that the change will take place within a day. Documentation will be maintained in the patient account files.

If the patient’s date of birth in the third party payor eligibility files is different than the existing or corrected date of birth in the patient demographics information, the patient should notify his/her third party payor of the change to his/her date of birth.

Note: Never change the demographic date of birth to match the third party payor date of birth.

A birth date correction request form will be completed. For an example of this form see Part 2, Appendix C, Name Change/Date-of-Birth Correction Request Form.

4.5 New Patient Registration

All patients must be registered in the RPMS Patient Registration application before care is rendered, with the exception of emergency services. On subsequent encounters, each patient’s demographic and third party information must be updated.

- Upon completion of the triage process and/or check-in at the clinic, the patient will be directed to the Patient Registration area for the establishment of the Medical Record.

- Patient registration staff will thoroughly scan the RPMS database using the SCAN/ALL option, to search for an exiting file to avoid duplication of the medical record file.
• The patient will be added to the RPMS database using the Patient Registration “ADD a new patient” option.

• A new medical record number will be assigned from the “Number Control Log” Form, IHS-209, if no existing file is found. This number is used to identify the patient’s record and all material filed therein.

• The patient’s file will be completed and all documents verified, including: Social Security Card, Birth Certificates, Identification Cards, and Certificate of Tribal Enrollment. Verification will be documented in the Registration Editor.

• It is very important to verify the patient’s eligibility in a federally recognized tribe by reviewing their Certificate Degree of Indian Blood (CDIB) with the list in the Code of Federal Regulations. To insure this, patients will be informed to bring in all missing documents on their next visit.

• The following forms and signatures will need to be completed:
  – Assignment of Benefits
  – Acknowledgement of Receipt of the Notice of Privacy Practices
  – Notification to provide proof of Tribal enrollment if valid document is not present
  – Medicare Secondary Payor (MSP) Questionnaire (for Medicare patients only)

• Any other information that cannot be entered on any page needs to be entered on the Notes page of the Patient Registration application.

• The following fields in the RPMS Patient Registration application must be completed for exporting purposes.

<table>
<thead>
<tr>
<th>Patient Registration Field Name</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registering Facility Code</td>
<td></td>
</tr>
<tr>
<td>Chart/Health Record Number</td>
<td></td>
</tr>
<tr>
<td>First Name</td>
<td>Required if no Middle Name is provided</td>
</tr>
<tr>
<td>Middle Name</td>
<td>Required if no First Name is provided</td>
</tr>
<tr>
<td>Last Name</td>
<td></td>
</tr>
<tr>
<td>Birth Date</td>
<td></td>
</tr>
<tr>
<td>Gender Code</td>
<td></td>
</tr>
<tr>
<td>Social Security Number</td>
<td></td>
</tr>
<tr>
<td>Beneficiary Classification Code</td>
<td></td>
</tr>
</tbody>
</table>
• On completion of the interview, Patient Registration staff will assemble the documents into the medical record.

• The patient will be directed to the clinic.

### 4.6 Established Patient Registration

Demographic and third party information must be updated at each encounter. The patient registration staff will update demographic information and collect all third-party information during the update process, when a patient is seeking medical services.

<table>
<thead>
<tr>
<th>Form</th>
<th>Signature Update Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assignment of Benefits and Release of Information</td>
<td>annually</td>
</tr>
<tr>
<td>The HIPAA Acknowledgement Form</td>
<td>required once after April, 2003</td>
</tr>
<tr>
<td>When the patient reaches the age of majority, 18 years, or has a</td>
<td></td>
</tr>
<tr>
<td>name change due to divorce/marriage or court name change, then an</td>
<td></td>
</tr>
<tr>
<td>other Acknowledgement Form should be signed and filed in the record</td>
<td></td>
</tr>
</tbody>
</table>

Signatures and updates need to be completed on the following forms:

- Assignment of Benefits and Release of Information (annually)
- The HIPAA Acknowledgement Form (required once after April, 2003)

When the patient reaches the age of majority, 18 years, or has a name change due to divorce/marriage or court name change, then another Acknowledgement Form should be signed and filed in the record.

- Medicare Secondary payor (MSP) Questionnaire (every inpatient stay or every 90 days). This does not apply to a Free Standing Facility.

- Notification to provide proof of Tribal membership (completed only if no valid documentation has been presented), if applicable.
4.7 **Non-Beneficiary Registration**

It is very important for the Registration staff to obtain identifying demographic and insurance related information on any non-beneficiary patient. Depending on the patient’s condition, all of this information should be recorded prior to him or her seeing the provider. However, if the situation is an emergency, the information can be obtained before the patient is ready to leave the facility (see Part 2, Chapter 4, Section 4.16, “Non-Beneficiary Exit and Collection Process.”)

The following information should be obtained:

- Copy of the insurance card back and front
- Copy of valid driver license
- Completed Patient Registration form. Form will be utilized at the discretion of the facilities.
- Demographic information to include home address and telephone number
- Name and telephone number of nearest relative not living in the same household
- Name and telephone number of an emergency contact
- Name of attending provider
- Name of guarantor
- Collection of deductible or co-payments by check, cash, or credit card
- Collection of total charge by check, cash, or credit card, if the patient has no insurance
- Any other identifying information
- A superbill (or charge ticket) and PCC form should be placed in the chart for use by the nurse or provider.
- After the visit the superbill should be given to the exit clerk.
- The exit clerk should charge out the superbill, collect any final monies due, or develop a payment agreement with the patient
- The superbill will be attached to the claim and filed in the patient account financial folder for future reference

After the visit, the services and procedures data need to be entered into the RPMS PCC application by the end of the day and sent to Billing immediately.
4.8 Commissioned Officers and Dependents Registration

Prior to care being rendered, all Commissioned Officers and their dependents must be registered in the RPMS Patient Registration application. On subsequent visits, each patient’s demographic and third party information must be updated.

- Patient Registration staff will obtain a current copy of the Commissioned Officer’s
  - Identification card
  - Driver’s license
  - Social Security card
  - Insurance card(s), front and back

  The copies of these documents go to Precertification, marked “Commissioned Officer or Dependent.”

- Demographic information will include
  - Current home address
  - Working telephone number.
  - Name and telephone number of nearest non-household relative

- Assignment of Benefits signed.
- Notice of Privacy Practices signed.
- Medicare Secondary Payor (MSP) Questionnaire signed (if applicable).
- Advance Directive and Patient Rights will be addressed and entered in the Notes page of the RPMS Patient Registration application.
- A new medical record file number will be issued from the “Number Control Log,” if no existing file is found.
- When a chart is established for a Commission Officer or Dependent, the chart identification will be “Commission Officer” and will indicate “Non-Beneficiary-IHS.”

- Patient Registration staff will update the RPMS Patient Registration application as follows:

  **Page 1:** Eligibility = Direct

  **Page 2:** Classification = Commission Officer or Dependent of Commission Officer
• Patient Registration staff will call the Medical Affairs Branch to verify that the patient is enlisted with Commissioned Corp.

• Patient Registration staff will update the Notes page of the RPMS Patient Registration application with the status of “Commissioned Officer” or “Dependent of Commissioned Officer.”

4.9 Scheduled Patient Registration

4.9.1 Centralized Registration for Scheduled Patients

Patients who have an appointment will report to the Central Registration area on arrival at the clinic.

• Patients will be checked in using the RPMS Scheduling application, and the patient’s name will be checked-off on the printed daily schedule.

• The patient will be sent to the designated clinic for their clinical appointment.

• All mandatory fields must be updated for demographic and insurance information in the RPMS Patient Registration application at each encounter.

• Eligibility for insurance will be verified at each encounter.

4.9.2 Decentralized Registration for Scheduled Patients

For decentralized registration, patients who have appointments at any clinic within the facility will report to their designated clinic.

• Patients will be checked in using the RPMS Scheduling application, and the patient’s name will be checked-off on the printed daily schedule.

• The patient will be sent to the designated clinic for their clinical appointment.

• All mandatory fields must be updated for demographic and insurance information in the RPMS Patient Registration application at each encounter.

• Eligibility for insurance will be verified at each encounter.
4.10 Unscheduled Walk-in Registration

All unscheduled walk-in patients seeking health care must go through the Triage process. On completion of the Triage process, the patient(s) will be directed to Patient Registration. The regular registration process will be followed with the documentation of necessary forms if needed.

4.11 Inpatient Admissions Registration

All patients requiring hospitalization must be registered prior to or at the time of admission through the Admitting Office. The admitting clerk will interview the patient/family member for updated demographic and third party information, process all inpatient forms with signatures, and issue identification bands for the patient. This process should be completed within the timeline specified by the facility’s policy.

A copy of the Clinical Record Brief, along with the Admission Call-In/Check-Off List, could be used to assure that all required information is obtained during the admission process. For an example of the Admission Call-In/Check-Off List, see Part 2, Appendix D.

4.12 Scheduled Inpatient Admission Procedure (Adult, Pediatric)

**Note:** As defined by current IHS policy, the Minimum Age for an Adult is 15 years.

It is the responsibility of the Admitting Section to ensure that all patients admitted as an inpatient status are updated in the RPMS Patient Registration application and the RPMS Admitting, Discharge and Transfer application.

When a provider determines that a patient will be admitted as an inpatient, it is important that the data is entered in both the RPMS Patient Registration and Admission, Discharge and Transfer applications in a timely manner. This information is used by other clinical departments and other RPMS applications, and the timeliness and accuracy of the data are important for optimum patient care.
When a patient is to be admitted, the hospital staff should refer the patient or family members to the Admitting section either for a personal interview, or if the patient is already admitted, the Admitting clerk should be notified of the location of the patient or family member.

A copy of the Clinical Record Brief, along with the Admission Call-In/Check-Off List, could be used to assure that all required information is obtained during the admission process. For an example of the Admission Call-In/Check-Off List, see Part 2, Appendix D.

4.12.1 Procedure for Patient Admission - RPMS Patient Registration

Once Admitting is notified, the following steps should be performed.

**Note:** If the Admission is scheduled, some of these steps can be performed during pre-admission of the patient.

1. Ensure a doctor’s order is on file and verify the inpatient admitting status of the patient.

2. Interview the patient and/or representative and update the demographic information and the third party eligibility information in the RPMS Patient Registration application.

3. If the patient is 18 years or older, ask the patient or family member if the patient has an Advanced Directive. If not, provide the patient with the pamphlet that has initial information. If the patient requests more information, notify the appropriate department to follow-up with the patient.

4. Provide the patient with the hospital pamphlet on the “Patient Bill of Rights” If the patient is a minor, give the pamphlet to the parent/guardian/legal representative of the minor.

5. Have the patient/parent/legal representative sign the inpatient consent form for medical treatment, if required.

6. If available, stamp or label the identifying information on the patient armband and attach the armband to the patient.

7. If the patient has third party coverage, have the patient and/or representative sign an Assignment of Benefits form.
8. If the patient is on Medicare, have the patient or family member complete a Medicare Secondary Payor form.

9. If the patient is on Medicare, have the patient and/or representative sign the “Important Message for Medicare” form.

   The original form will be given to the patient and a copy will be filed in the medical record.

10. If the patient has Private Insurance, notify the Private Insurance plan of the patient’s admission status within the 72-hour time frame.

11. Submit the admitting information to the Utilization Review Coordinator. The Utilization Review Coordinator will call the Insurance Company to provide the necessary clinical information and to obtain a Pre-Certification or Prior Authorization number. This number will be entered in the RPMS Patient Registration application.

12. If the patient is a non-beneficiary Medicare patient, provide the Advanced Beneficiary Notification (ABN) rules and have the patient sign the appropriate documents.

   For more information about ABNs, go to this website:


### 4.12.2 Entering Patient Data in RPMS Admission/Discharge/Transfer (ADT)

The RPMS Admission/Discharge/Transfer (ADT) application enables the hospital to enter and track specific clinical information on patients while they have inpatient status at the facility. The RPMS laboratory, radiology, pharmacy and other applications utilize the patient information entered in the ADT application.

1. The Admitting clerk will enter the data in the RPMS Admission/Discharge/Transfer (ADT) application.

   The following information is required:
   - Patient name or Chart number or Date of birth or Social Security Number
   - Admit Date and Time
• Yes or No to prompt: “Does patient wish to be excluded from the Hospital Directory?”

• Admit Ward and Bed Number

• Admit provider (may enter Referring physician (word text), Admitting and Attending Provider (may be the same provider)

• Admit to Treating Specialty (e.g., General Medicine)

• Admit diagnosis

• Type of Admit (Direct, Referral, or Transfer)

• Admit Source (UB 92 equivalent)

2. After the data is entered, print the Inpatient Clinical Record Brief (IHS-44).

3. Accumulate all of the forms related to this admission and file the forms in the Medical Record located on the ward.

4. File the IHS-44 form in the inpatient medical record on the inpatient unit.

5. Provide a copy of the IHS-44 form to the Benefit Coordinator and the Utilization Review Coordinator.

4.13 Newborn Admission Procedure

Newborn admissions use the same procedure as the scheduled inpatient admission procedure for adult and pediatric patients. By reviewing the OB Clinic appointment list, the Admitting clerk can identify future newborn admissions.

A copy of the Clinical Record Brief, along with the Admission Call-In/Check-Off List, could be used to assure that all required information is obtained during the admission process. For an example of the Admission Call-In/Check-Off List, see Part 2, Appendix D.

For pre-admission, the Admitting clerk will complete the following tasks prior to admission:

1. Obtain current demographic information and enter the data in the RPMS Patient Registration application.

2. Identify Alternate Resource information and enter the data in the RPMS Patient Registration application.
3. Provide the new parent a packet for obtaining the birth certificate, which contains detailed information on what will be needed to submit for the birth certificate.

On notification of an admission, the Admitting clerk will

- Follow the same steps as identified in the Adult and Pediatric General Admission instructions.
- Obtain and process the necessary information for the birth certificate, or provide the information to the Health Information Management department for processing.
- Provide the parent with an application for a Social Security number. If the patient is a newborn, file a copy of the Parent’s Certificate of Indian Blood documentation in the newborn’s medical record.

4.14 Observation Bed Admission Procedure

An observation bed is defined as the use of a bed and periodic monitoring by the hospital’s nursing or other ancillary staff, which are reasonable and necessary to evaluate an outpatient’s condition, to determine the need for possible inpatient admission.

The same registration process is used to gather specific data on demographic and insurance information for the Registration application as identified in Part 2, Chapter 4, Section 4.12, “Scheduled Inpatient Admission Procedure (Adult, Pediatric).”

Due to the nature of the patient’s condition, this information often must be obtained from the family or from the patient during their stay in the observation bed, before they leave the hospital, or after they are admitted.

The guidelines state that patients may stay in an observation bed for up to 23 hours of care. Additionally, the following guidelines apply:

- When a patient arrives at the facility (generally via the Emergency Department), observation services may be reasonable and necessary to evaluate the medical conditions, to determine the need for a possible admission to the hospital as an inpatient.
- Documentation in the patient's medical record must support the medical necessity of the observation service.
• An inpatient's status may not be retroactively changed to observation/outpatient status.

The physician's intent to admit the patient at the time the patient entered the facility is the controlling factor. That intent cannot be retroactively changed. Hospitals must not substitute outpatient observation services for medically appropriate inpatient admissions, nor may outpatient observation services follow a medically appropriate hospital inpatient admission.

4.15 Discharge and Transfer Processes

A provider, a nurse, the patient, or a family member may request that the patient be transferred from one place to another, one treating specialty to another, one ward to another, or one bed to another. However, the Admitting Office needs to be contacted about the request for a room change and approval sought from the attending physician based on level of acuity. A patient room change impacts the census reporting and needs to be actively coordinated and documented via ADT, Nursing, and the Admitting office.

Transfers may also occur from one facility to another facility. The admitting office staff needs to coordinate the transfer with their counterpart in the other facility. In addition, the attending physician should document in the medical record the reason or medical necessity of the transfer.

The Admitting section should be informed of a potential discharge by Nursing. This will enable the Admitting staff to make specific bed assignments for other incoming patients.

4.15.1 Other Discharges

An inpatient discharge is the end of an inpatient hospitalization. The end of a hospitalization can occur by

• Order of the physician,
• Against medical advice (AMA),
• Other types of irregular discharge, such as absent over leave (AOL), absent without leave (AWOL),
• Transfer to another medical facility, or
• Death.
Patients, who are AOL or AWOL, are considered discharged at the time they actually leave the hospital.

These patients may be at risk for adverse health outcomes and/or subsequent admissions. When this situation occurs, each facility needs to thoroughly document the medical record with

- provider discussions with the patient
- reason why the patient chose to leave the facility
- whether any education was provided to the patient prior to departure

In addition, the appropriate medical records forms need to be assigned, noting the patient’s desire to leave.

### 4.16 Non-Beneficiary Exit and Collection Process

When a patient is ready to leave the facility, several business processes need to be completed, if they were not been completed during the check-in process.

- Insurance cards need to be copied front and back and should be verified before the patient’s departure.
- Demographic and telephone information on the patient, including family members, should be maintained in the Notes section of the RPMS Patient Registration application, giving Billing several resources for follow-up, if necessary.
- Identify the guarantor, who is financially responsible for services rendered.
- Deductibles and Coinsurance payments should be collected.
- For non-insured patients, payment should be collected before the patient exits the facility.
- If the patient does not have the funding, then a payment plan should be established.
4.17 Reconciliation of RPMS Admission/Discharge/Transfer Statistics

It is the responsibility of the Admitting clerk to ensure the information entered in the RPMS Admission/Discharge/Transfer application is accurate. To verify that this information is accurate, the Admitting clerk will check the Nurses Daily Census report.

All RPMS Admission/Discharge/Transfer data must match the Nurses Daily Census report data, as well as the inpatient service to which each patient is assigned. The reconciliation of admissions, discharges, and transfers should be completed on a daily basis.

On the first business day of the month, the IHS-202 report is printed from the RPMS Admissions/Discharge/Transfer application for signature by the Chief Executive Officer. The report is filed on site, and the data is submitted to the Area Office on a pre-established schedule.
5. Third Party Coverage

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5.1 About Medicaid and Medicare

In 1965, the Social Security Act established both Medicare and Medicaid. Medicare was a responsibility of the Social Security Administration (SSA), while Federal assistance to the State Medicaid programs was administered by Social and Rehabilitation Service (SRS). SSA and SRS were agencies in the Department of Health, Education, and Welfare (HEW).

In 1977, the Health Care Financing Administration (HCFA) was created in HEW to effectively coordinate Medicare and Medicaid. In 1980 HEW was divided into the Department of Education and the Department of Health and Human Services (HHS). In 2001, HCFA was renamed the Centers for Medicare & Medicaid Services (CMS).

5.2 Medicaid

Medicaid (Title XIX of the Federal Social Security Act) is a program that pays for medical assistance for certain individuals and families with low incomes and resources. This program became law in 1965 and is jointly funded by Federal and State governments (including the District of Columbia and the Territories) to assist states in providing medical and long-term care assistance to people who meet certain eligibility criteria. Medicaid is the largest source of funding for medical and health-related services for people with limited income.

For a description of eligibility criteria, see Part 2, Chapter 7, Section 7.5, “Medicaid Eligibility and Application.”

The Federal statute identifies over 25 different eligibility categories for which federal funds are available; however, each state has its own plan and all 23 eligibility categories may not be utilized. These statutory categories can be classified into five broad coverage groups: children, pregnant women, adults in families with dependent children, individuals with disabilities, and individuals 65 or over.

Utilizing broad national guidelines, each state has the right to establish its own eligibility standard; determine the type, amount, duration, and scope of services; set the rate of payment for services; and administer the program. Thus, Medicaid guidelines vary from state to state. Currently, 37 states have medically needy programs.
All states provide community Long Term Care services for individuals who are Medicaid eligible and qualify for institutional care.

All state plans must be approved by CMS prior to adoption. State plans include how IHS and Tribal facilities are reimbursed.

5.2.1 Covered Medicaid Benefits

Most Medicaid programs pay for medically necessary health services furnished by medical providers who participate in Medicaid. Medicaid covers a range of medical services, including traditional acute care services, transportation, physician services, home health care, durable medical equipment, and medical supplies. Medicaid also covers services which are medically necessary for the diagnosis and/or treatment of illnesses, injuries, or conditions of recipients.

The following services are typically covered by Medicaid:

- Inpatient hospital (excluding inpatient services in institutions for mental disease)
- Outpatient hospital including Federally Qualified Health Centers (FQHCs), and if permitted under state law, rural health clinic and other ambulatory services provided by a rural health clinic which are otherwise included under states’ plans.
- Other laboratory and x-ray services
- Certified pediatric and family nurse licensed practitioners
- Nursing facility services for beneficiaries, age 21 and older
- Early and periodic screening, diagnosis, and treatment (EPSDT) for children under age 21
- Family planning services and supplies
- Physicians’ services
- Medical and surgical services of a dentist
- Home health services, including
  - Intermittent or part-time nursing services
  - Home health aides
  - Medical supplies and appliances for use in the home
- Nurse mid-wife services
5. Third Party Coverage

5.2.2 Examples of Non-covered Medicaid Services

Note: This is a representative list of non-covered services. Each facility or clinic needs to check with their State Medicaid office to verify what services are covered or not covered in their particular state.

- Broken or missed appointments
- Services furnished by contractors, organizations, or individuals which are not the billing provider
- Cosmetic services and surgeries prescribed or used for aesthetic purposes only
- Dental services performed for aesthetic or cosmetic purposes only
- Separate charges for kits, films, supplies, or other material used in the performance of diagnostic imaging or therapeutic radiology services
- Durable medical equipment and medical supplies that are not primarily and customarily for a therapeutic purpose and are generally used for comfort or convenience purposes
- Literature, booklets, and other educational materials
- Experimental or investigational services
- Routine foot care, such as removal of corns or calluses
- Hair or nail analysis
- Laboratory specimen handling, mailing, or collection fees
- Methadone drug treatment
- Post-mortem examinations
- Pregnancy termination
- Oral, topical, optic, or ophthalmic preparations dispensed to recipients by the clinic
- Services by providers not covered by Medicaid
- Reproductive health services
- Visits to pick up prescriptions or telephone consultations
- Routine physical examinations
- Screening services that are not used to make a diagnosis
- Vision eyewear
- Hearing aids
• Homeopathic therapy
• Chiropractic services
• Acupuncture used for medical management of acute or chronic pain, or as an anesthetic
• Services not covered by Medicare

5.2.3 State Children’s Health Insurance Program (SCHIP)

As part of the Balanced Budget Act of 1997, Congress created Title XXI, the State Children’s Health Insurance Program (SCHIP) to address the growing problem of children without health insurance. SCHIP was designed as a Federal/State partnership, similar to Medicaid, with the goal of expanding health insurance to children up to age 19, whose families earn too much money to be eligible for Medicaid but not enough money to purchase private insurance. SCHIP is the single largest expansion of health insurance coverage for children since the initiation of Medicaid in the mid-1960s.

SCHIP is designed to provide coverage to “targeted low-income children”. A “targeted low-income child” is one who resides in a family with income below 200% of the Federal Poverty level (FPL) or whose family has an income 50% higher than the state’s Medicaid eligibility threshold. Some states have expanded SCHIP eligibility beyond the 200% FPL limit, and others are covering entire families, not just the children.

Ineligible children are those children who are
• covered under a group health plan or under health insurance coverage.
• members of a family that is eligible for state employee insurance based on employment with a public agency.
• residing in an Institution for Mental Disease.
• eligible for Medicaid coverage.

SCHIP offers three options:

1) Use SCHIP funds to expand Medicaid eligibility to children who previously did not qualify for the program.

2) Design a separate children’s health insurance program entirely separate from Medicaid.

3) Combine both the Medicaid and separate program options.
If a state elects to establish an expanded Medicaid program using SCHIP, the eligibility rules of Medicaid apply and the services provided mirror the Medicaid services of that state. For a separate child health program, the states have the option of determining the level of coverage.

### 5.2.4 Medicaid Managed Care

Currently, 48 states offer some form of managed care. Since 1992, states have utilized federal Medicaid waivers to increase enrollment in managed care and to develop other innovative changes to their Medicaid programs. Several states have used the resulting savings from managed care enrollment to expand the number of individuals covered by Medicaid and/or the number of services covered under their programs.

States may also apply for waivers of Medicaid rules to test innovative approaches to benefits, services, eligibility, program payments, and service delivery. State demonstration projects are frequently aimed at saving money to allow states to extend Medicaid coverage to additional low-income and uninsured people.

Since January 1993, comprehensive health care reform demonstration waivers have been approved for 18 states. In addition, HHS has approved requests from 19 states for Medicaid waivers as part of larger welfare reform projects, as well as 25 local Medicaid demonstration projects. When fully implemented, these demonstration projects will extend health coverage to 2.2 million parents and children who otherwise would be uninsured.

The Medicaid Managed Care program allows the States greater flexibility to amend their State plan to require certain categories of Medicaid beneficiaries to enroll in managed care entities without obtaining waivers.

For more information on Medicaid Managed Care, go to this website:

[http://www.cms.hhs.gov/MedicaidManagCare/](http://www.cms.hhs.gov/MedicaidManagCare/)

### 5.3 Medicare

Medicare is a national health care program covering

- individuals 65 and older,
- individuals under 65 who are disabled, and
- individuals with end stage renal disease (ESRD).
Medicare, like Medicaid, pays for medically necessary health services furnished by medical providers.

The Indian Health Service authorizes private physicians and privately owned hospitals and nursing homes to provide treatment to Indians and their dependents under contractual arrangements with the Division of Indian Health. Contract health services via Contract Health Services (CHS) are provided when IHS facilities and clinics either do not offer the level of care or the specialty service.

When CHS providers or facilities are used, Medicare is the primary payor and IHS is secondary payor.

5.4 Medicare Part A

Medicare Part A (Title XVIII of the Social Security Act) is the hospital insurance that pays for inpatient hospital services, skilled nursing facility services, home health care, and hospice care.

Most individuals become entitled to Medicare Part A when they reach the age of 65 and are also eligible for monthly social security retirement or survivor benefits or railroad retirement benefits. Individuals age 65 or over who are not entitled to Part A because they do not meet these conditions, may enroll in the Part A program if they pay a monthly premium.

Medicare Part A is also available to individuals under age 65 if they are entitled to (1) social security or railroad retirement disability benefits, or (2) have end-stage renal disease.

The Fiscal Intermediary (FI) for IHS is Trailblazers. Tribes have the option of using Trailblazers or another FI, such as Federally Qualified Health Center (FQHC), Rural Health Center, or billing the local Medicare Part B.

5.4.1 Covered Benefits, Medicare Part A

Inpatient Medicare (Part A) covers the following services furnished to an inpatient of a participating hospital or, in case of emergency services, to an inpatient of a qualified hospital:

- Medicare Part A inpatient services are paid based on Diagnosis Related Groups (DRGs).
- Room and Board – A semi-private room or a private room (if medically necessary), and the Intensive Care Unit (ICU) if the level of care requires this type of patient services
• Nursing services and other related services
• Use of hospital facility
• Operating room charges
• Drugs furnished by the hospital
• Laboratory tests
• X-ray and other radiology services
• Medical supplies, such as casts and splints
• Use of appliances and equipment furnished by the hospital, such as wheelchairs, crutches, canes, etc.
• Physical, speech, or occupational therapy
• Medical social services
• Respiratory Therapy
• Inpatient hospital stays for rehabilitation care
• Inpatient psychiatric hospital services
• Observation room
• Emergency room
• Transportation services, including transport by ambulance

5.4.2 Non Covered Services, Medicare Part A

Inpatient Medicare hospital Part A services do not cover:
• Post-hospital Skilled Nursing care furnished by a hospital, or a critical access hospital that has a swing-bed approval
• Nursing facility services that may be furnished as a Medicaid service in a swing-bed hospital that has approval to furnish nursing facility services
• Physician services that meet the requirements for payment on a fee scheduled basis
• Physician assistant services
• Nurse practitioner and clinical nurse specialist services
• Certified nurse mid-wife services
• Qualified psychologist

The beneficiary is responsible for a cash deductible for each benefit period and a coinsurance amount that equals one-quarter of the inpatient deductible amount from the 61st to the 90th day of an inpatient admission. The beneficiary may also elect to use the 60 lifetime reserve days with a coinsurance amount that equals one-half of the inpatient deductible.
5.4.3 **Lifetime Reserve Days**

Each beneficiary has a lifetime reserve of 60 additional days of inpatient hospital services available after he/she has used 90 days (60 full and 30 coinsurance) of inpatient hospital services in a spell of illness. Depending on the situation, the patient may elect not to use his lifetime reserve days.

Such situations would include:

- The average daily charge for covered services furnished during a lifetime reserve billing period is equal to or less than the coinsurance amount for lifetime reserve days; *and*
  - The hospital is reimbursed on a cost reimbursement basis; *or*
  - The hospital is reimbursed under the prospective payment system and lifetime reserve days are needed to pay for all or part of the outlier days.

- For the non-outlier portion of a stay in a hospital reimbursed under the prospective payment system, if the beneficiary has one or more regular (non-lifetime reserve) days remaining in the benefit period upon admission to the hospital.

- The beneficiary has no regular days available at the time of admission to a hospital reimbursed under the prospective payment system and the total charges for which the beneficiary would be liable if he/she does not use lifetime reserve days are equal to or less than the sum of the coinsurance amounts of the lifetime reserve days needed for the stay.

**Note:** For hospital reimbursed under the prospective payment system, if a patient has one or more regular benefits (non-lifetime reserve, i.e., coinsurance days) days remaining in the benefit period upon entering the hospital, Medicare will pay the entire PPS amount of the non-outlier days. Therefore, it would not benefit the patient to utilize his lifetime reserve days.

For patients utilizing 25 coinsurance days and who remain in the hospital over the 30-day coinsurance threshold and enter into lifetime reserve days, the hospital must inform the patient. It is the patient’s decision on electing to use the lifetime reserve days.
A retroactive election not to use the lifetime reserve days must be filed within 90 days following the beneficiary’s discharge from the hospital, unless benefits are available from a third-party payor to pay for the services, and the hospital agrees to the retroactive election. In those cases, the beneficiary may file an election not to use the lifetime reserve days later than 90 days following discharge.

5.4.4 Benefit Period

The term **benefit period** is defined as the period of time for measuring the use of hospital insurance benefits. It is a period of consecutive days during which covered services furnished to a patient can be paid for by the hospital insurance plan.

The **first day of the benefit period** is when a patient is furnished inpatient hospital or skilled nursing facility services by an approved provider after entitlement to hospital insurance begins. From the date of discharge from any inpatient or swing-bed stay, the time will begin to accrue for the first day of a new benefit period. A transfer from one hospital to another is not considered a discharge, even if the transfer is considered a discharge under PPS. Also, a leave of absence is not considered a discharge from the hospital.

The **end of the benefit period** is when a beneficiary has not been an inpatient of a hospital or a swing-bed facility for sixty (60) consecutive days. At this time, the benefits will be renewed for full and coinsurance days only.

To calculate the sixty (60) consecutive days, begin counting with the day the individual was discharged. A benefit period cannot end while a beneficiary is an inpatient of a skilled nursing facility (SNF) where the SNF is defined as a facility which is primarily engaged in providing skilled nursing care and related services to residents who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.

Examples of Benefit Period:

**Example 1:** Mrs. Smith enters the hospital on July 5 and is discharged on July 15. In this example, Mrs. Smith has used 10 days of her first benefit period. Mrs. Smith is not hospitalized until again until December 15. Since more than sixty days elapsed between her hospital days, she begins a **new** benefit period and will be obligated to pay the hospital deductible.
**Example 2:** Mrs. Smith enters the hospital on August 14 and is discharged on August 24. Like the first example, Mrs. Smith has used 10 days of her first benefit period. However, Mrs. Smith is readmitted to the hospital on September 20. Since fewer than sixty days have elapsed between hospital days, Mrs. Smith is still in her first benefit period and will not be required to pay another deductible. In essence, the admission on September 20 is actually the eleventh day used in her first benefit period. Mrs. Smith will not begin a new benefit period until she is out of the hospital and/or SNF for more than sixty consecutive days.

### 5.5 Medicare Part B

Medicare Part B is a voluntary program and provides the medical insurance that covers doctor’s services, outpatient hospital services, durable medical equipment, and medical services and supplies not covered under Part A. The program is financed from premium payments by the enrollees or by states under the Medicaid program.

Because Medicare Part B is separate and distinct from Medicare Part A, it is possible for a person to enroll without being entitled to monthly social security or railroad retirement benefits or even receive Part A benefits.

For a provider to be paid under Medicare, the provider must voluntarily participate with Medicare via a written agreement and accept assignment, and the level of care received by the patient must be medically necessary. Assignment means that the provider agrees to accept the Medicare approved amount for each service as payment in full. If the provider does not want to participate, he must revoke his agreement in writing to all carriers with whom he/she has filed an agreement.

Most of Medicare Part B physician services are paid based on a physician fee schedule. There is an annual deductible and a 20% coinsurance for covered medical expenses. However, Indian Health Service providers do not collect this amount from the American Indian/Alaskan Native beneficiaries.

For emergency situations, the patient may be seen in a non-participating hospital.
5.5.1 Covered Services, Medicare Part B

Examples of covered services under Part B include:

- Physician’s services, including surgery, consultation, office and institutional calls, and services and supplies furnished incident to a physician’s professional service
- Physician’s services are paid based on Part B fee schedule.
- Outpatient hospital services furnished incident to physicians’ services
- Outpatient diagnostic services furnished by a hospital/clinic
- Outpatient physical therapy, outpatient occupational therapy, outpatient speech-language pathology services (clinic based only)
- Diagnostic x-ray tests, laboratory tests, and other diagnostic tests
- X-ray, radium and radioactive isotope therapy
- Surgical dressings, and splints, casts, and other devices used for reduction of fractures and dislocations
- Rental or purchase of durable medical equipment in the home
- Ambulance service
- Prosthetic devices, other than dental, which replace all or part of an internal body organ
- Leg, arm, back and neck braces, and artificial legs, arms, and eyes; includes adjustments, repairs, and replacements
- Certain medical supplies used in connection with home dialysis delivery systems
- Rural Health Clinic (RHC) services
- Ambulatory surgical center (ASC) services
- Screening mammography services
- Screening pap smears and pelvic exams
- Screening glaucoma services
- Influenza, pneumococcal pneumonia, and hepatitis B vaccines
- Colorectal screening
- Bone mass measurements
- Diabetes self-management services
- Prostate screening
- Home health visits after all covered Part A visits have been used
5.5.2 *Non-covered Services, Medicare Part B*

Examples of non-covered Medicare Part B services are:

- Services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member
- Routine foot care in general is excluded, except some particular foot care is covered.
- Items or services which neither the beneficiary nor any other person or organization has a legal obligation to pay for or provide. This would include services furnished gratuitously or provided free.
- Some providers waive their charges for individuals of limited means, but they also expect to be paid where the patient has insurance which covers the items or services they furnish. In such a situation because it is clear that a patient would be charged if insured, a legal obligation to pay exists and benefits are payable for services rendered to patients with medical insurance, if the provider customarily bills all insured patients – not just Medicare patients – even though non-insured patients are not charged.
- Other primary insurance to Medicare
- Items and services furnished, paid, or authorized by Federal, State, or Local government entities
- Services resulting from war
- Personal comfort items that do not contribute meaningfully to the treatment of an illness or injury, or the functioning of a malformed body member
- Routine physical checkups; eyeglasses, contact lenses, and eye examinations for the purpose of prescribing, fitting, or changing eyeglasses; eye refractions by whatever practitioner and for whatever purpose performed; hearing aids and examinations for hearing aids; and immunizations (unless for the latter the immunization relates to the treatment of any injury or direct exposure to a disease)
- Custodial care
- Cosmetic surgery that is related to improving appearance
- Charges of immediate relatives of the patient
- Dental services that include care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth.
5.5.3 Services “Incident to” Diagnosis or Treatment

Services such as lab and x-ray and other services can be paid to IHS under the “incident to” interpretation of Medicare Part B reimbursement. This is interpreted as being integral and part of the provider’s professional services in the course of diagnosing or treating the patient’s illness or injury. The orders must be written by the provider and needs to be under the auspice and direction or the provider. For the latter, this is interpreted as “the provider has ordered the test, is available at the clinic for discussion, and will review the results”. It is also interpreted as “the provider may issue standing orders for the nurse in that the nurse can order the tests and the provider will review the result.”

5.6 Medicare/Medicaid Dual Eligibles

Medicare provides two basic coverages:

- Part A, which pays for hospitalization costs
- Part B, which pays for physician services, lab and x-ray services, durable medical equipment, and outpatient and other services

Dual eligibles are those individuals who are entitled to Medicare Part A and/or Part B, and are eligible for some form of Medicaid benefit.

Note: For the most current information, please go to this website: [http://www.cms.hhs.gov/DualEligible/](http://www.cms.hhs.gov/DualEligible/)

These are the various categories of individuals, who collectively are known as dual eligibles

- **Qualified Medicare Beneficiary (QMB) without other Medicaid (QMB only)**
  - Entitled to Medicare Part A
  - Income of 100% Federal poverty level (FPL) or less
  - Resources do not exceed twice the limit for SSI eligibility
  - Not otherwise eligible for full Medicaid

Medicaid pays their Medicare Part A premiums, if any; Medicare Part B premiums; and, to the extent consistent with the Medicaid State plan, Medicare deductibles and coinsurance for Medicare services provided by Medicare providers. Federal financial participation (FFP) equals the Federal medical assistance percentage (FMAP).
• **QMB with full Medicaid (QMB plus)**
  - Entitled to Medicare Part A
  - Income of 100% FPL or less
  - Resources do not exceed twice the limit for SSI eligibility
  - Eligible for Medicaid benefits

  Medicaid pays their Medicare Part A premiums, if any; Medicare Part B premiums; and, to the extent consistent with the Medicaid State plan, Medicare deductibles and coinsurance, and provides full Medicaid benefits. FFP equals FMAP.

• **Specified Low-Income Medicare Beneficiary (SLMB) without other Medicaid (SLMB Only)**
  - Entitled to Medicare Part A
  - Income greater than 100% but less than 120% FPL
  - Resources do not exceed twice the limit for SSI eligibility
  - Not otherwise eligible for Medicaid

  Medicaid pays their Medicare Part B premiums only. FFP equals FMAP.

• **SLMB with full Medicaid (SLMB Plus)**
  - Entitled to Medicare Part A
  - Income greater than 100% but less than 120% PPL
  - Resources do not exceed twice the limit for SSI eligibility
  - Eligible for full Medicaid benefits

  Medicaid pays their Medicare Part B premiums and provides full Medicaid benefits. FFP equals FMAP.

• **Qualified Disabled and Working Individual (QDWI)**
  - Lost Medicare Part A benefits due to returning to work, but eligible to enroll in and purchase Medicare part A
  - Income of 200% FPL or less
  - Resources do not exceed twice the limit for SSI eligibility
  - Not otherwise eligible for Medicaid.

  Medicaid pays their Medicare Part B premiums only. FFP equals FMAP at 100%.
• **Qualifying Individual (2) (QI-1)**

This group is effective 1/1/98-12/31/02. There is an annual cap on the amount of money available, which may limit the number of individuals in the group.

- Entitled to Medicare Part A
- Income of at least 135% but less than 175% FPL
- Resources do not exceed twice the limit for SSI eligibility
- Not otherwise eligible for Medicaid.

Medicaid pays only a portion of their Part B premiums. FFP equals FMAP at 100%.

• **Medicaid Only Dual Eligibles (Non QMB, SLMB, QDWI, QI-1)**

Typically, these individuals need to spend down to qualify for Medicaid or to fall into a Medicaid eligibility poverty group that exceeds the limits listed.

- Entitled to Medicare Part A and/or Part B
- Eligible for full Medicaid benefits
- Not eligible for Medicaid as a QMB, SLMB, QDWI, QI-1

Medicaid provides full Medicaid benefits and pays for Medicaid services provided by Medicaid providers, but Medicaid will only pay for services also covered by Medicare if the Medicaid payment rate is higher than the amount paid by Medicare, and within this limit, will only pay to the extent necessary to pay the beneficiary’s Medicare cost-sharing liability.

Payment by Medicaid of Medicare Part B premiums is a State option; however, States may not receive FFP for Medicaid services also covered by Medicare Part B for certain individuals who could have been covered under Medicare Part B had they been enrolled. FFP equals FMAP.

5.7 **Medicare Advantage, Part C**

The Medicare Advantage program replaced the Medicare+Choice (M+C) program under Medicare Part C. Under this program, Medicare pays a set amount of money for a Medicare patient’s care every month to a private health plan that manages Medicare coverage for its members. In most Medicare Advantage Coordinated Care plans, there are doctors and hospitals that join the plan, called the plan’s network. Most of the care required is obtained from the doctors within the network, and referrals are required for services outside of the network.
5.7.1 Medicare Advantage Prescription Drug Plan (MA-PD)

Individuals enrolled in a Medicare Advantage Coordinated Care Plan also can receive their prescription drug coverage through the Medicare Advantage Prescription Drug (MA-PD) plan. The drugs are covered as long as the prescription is filled at one of the plan pharmacies or through the network’s mail-order pharmacy.

Drugs purchased outside of the network can be obtained, but at an additional cost. For certain prescription drugs, additional requirements for coverage or limits on coverage are applied. Both brand-name drugs and generic drugs are included in the formulary, and the formulary is updated at least monthly.

For additional information on MA-PD plans, as related to the Medicare Prescription Drug Plan, Part D, see Part 2, Chapter 5, Section 5.9, “Medicare Prescription Drug Plan (Part D).”

5.8 Medicare Managed Care

Managed care plans serve Medicare beneficiaries through three types of contracts:
- risk
- cost
- health care prepayment plans (HCPPs)

All plans receive a monthly payment from the Medicare program.

In general, an individual is eligible to elect a Medicare Managed Care plan when each of the following requirements is met.

- The individual is entitled to Medicare Part A and enrolled in Part B, provided that he/she will be entitled to receive services under Medicare Part A and Part B as of the effective date of coverage under the plan.
- The individual has not been medically determined to have ESRD prior to completing the enrollment form.
- The individual permanently resides in the service area of the Medicare Managed Care plan. A temporary move into the Medicare Managed Care plan’s service area does not enable the individual to elect the Managed Care coverage.
• The individual or his/her legal representative has completed an enrollment election and it includes all the information required to process the enrollment or meets alternative conditions for enrollment specified by CMS.

• The individual is fully informed of and agrees to abide by the rules of the Medicare Managed Care organization that were provided during the election process, and

• The individual makes the election during the election period.

The individual can still be covered under the spouse’s health benefit plan; however, the rules for coordination will apply.

For more information on the Medicare Managed Care program, go to this website: [www.cms.hhs.gov/manuals](http://www.cms.hhs.gov/manuals).

Go to the Internet-only Manuals (IOMs) webpage, and then select publication 100-16, *Medicare Managed Care Manual*, Chapter 2, “Enrollment and Disenrollment.”

### 5.8.1 Risk Plans

Risk plans are paid a per capita premium set at approximately 95 percent of the projected average expenses for fee-for-service beneficiaries in a given county. Risk plans assume full financial risk for all care provided to Medicare beneficiaries. Risk plans must provide all Medicare-covered services, and most plans offer additional services, such as prescription drugs and eyeglasses.

With the exception of emergency and out-of-area urgent care, members of risk plans must receive all of their care through the plan. However, as of January 1, 1996, risk plans can provide an out-of-network option that, subject to certain conditions, allows beneficiaries to go to providers who are not part of the plan.

Since 1992, enrollment in risk plans has more than tripled to 5.3 million. Currently, 88 percent of Medicare beneficiaries in managed care are in risk plans. As of January 1998, risk plans made up 322 of the 427 managed care plans participating in Medicare.
5.8.2 Cost Plans

Cost plans are paid a pre-determined monthly amount per beneficiary based on a total estimated budget. Adjustments to that payment are made at the end of the year for any variations from the budget. Cost plans must provide all Medicare-covered services but do not provide the additional services that some risk plans offer.

Beneficiaries can also obtain Medicare-covered services outside the plan without limitation. When a beneficiary goes outside the plan, Medicare pays its traditional share of those costs and the beneficiary pays Medicare's coinsurance and deductibles.

5.8.3 Health Care Prepayment Plans (HCPPs)

Health Care Prepayment Plans (HCPPs) are paid in a similar manner as cost plans but only cover part of the Medicare benefit application. HCPPs do not cover Medicare Part A services (inpatient hospital care, skilled nursing, hospice, and some home health care), but some do arrange for services and may file Part A claims for their members.

5.9 Medicare Prescription Drug Plan (Part D)

As of January 1, 2006, Medicare offers a new prescription drug coverage, Part D. This prescription drug coverage can benefit American Indians and Alaska Natives (AI/AN) who pay for their prescriptions at retail pharmacies, as well as those who receive medications at no cost at IHS Tribal or Urban Indian programs (I/T/U).

Initial open enrollment began November 15, 2005 and runs for six months, ending May 15, 2006. In later years, open enrollment will run from November 15 to December 31, with enrollment effective January 1 of the following year. After beneficiaries choose a PDP, they will generally remain enrolled for the year.

Everyone with Medicare and Railroad Retirement is eligible for this coverage by joining an approved prescription drug plan (PDP) or a Medicare Advantage Drug Plan (MA-PD). All plans are required to offer basic drug coverage. However, drug plans and Medicare Advantage plans can separately offer enhanced coverage for an additional premium.
The program has an “opt-in” rule, which means that with limited exceptions, beneficiaries will need to make an affirmative statement to sign up for the drug beneficiary plan by filling out an enrollment form of an approved plan.

Generally, the two main options for how beneficiaries receive their drug benefit are:

- Those who wish to remain in traditional Medicare may elect to join a stand-alone prescription drug plan (PDP) that adds drug benefits to regular Medicare coverage.
- Those who wish to receive their entire medical and drug benefits from one source can join a Medicare Advantage (MA) plan, like an HMO, and chose an MA prescription drug plan (MA-PD plan), which will provide an integrated benefit covering their hospital, physician, and drug costs.

By participating in Medicare Part D, beneficiaries may help both themselves and their community.

- Individuals who pay for some or all medications at retail pharmacies may reduce their out-of-pocket costs paid to the retail pharmacy.
- Individuals who receive medications at no cost from an I/T/U site can benefit their community by enrolling in a drug plan; thus allowing the I/T/U site to bill the drug plan for reimbursement of part or all of the cost of the medications. The reimbursement funds can then be used to purchase other medications or services that benefit members of the community.

The categories of Medicare eligibles in the IHS system are:

- Medicare A Only
- Medicare B Only
- Medicare A&B Only
- Medicare A and Medicaid
- Medicare B and Medicaid
- Medicare A&B and Medicaid
- Medicare A and Private Insurance (PI)
- Medicare B and PI
- Medicare A&B and PI
- Medicaid/PI and Medicare A
- Medicaid/PI and Medicare B
- Medicaid/PI and Medicare A&B

A Summary of 3RD Party Resources report is located the RPMS Patient Registration Application.
The patient should be advised of his or her options to enroll in a PDP.

- Dual eligibles – those patients with Medicare and Medicaid – must choose a plan or they will be automatically enrolled in a plan. (IHS will not bill Medicaid but will bill the PDP).
- Patients currently on private insurance must review their plan to see if it is as good as the new Medicare benefit.
- Patients who do not have current drug coverage will need to choose a plan.

The drug plans charge members a monthly premium to participate in the plan. Individuals who qualify for both Medicare and Medicaid are eligible for a premium subsidy.

The patient may qualify for a

- Full premium subsidy, also known as Extra Help, if income is below 135 percent of the Federal Poverty Level (FPLL) with few assets
- Partial premium subsidy, if income is over 135 and under 150 percent of the FPL.

Either the local I/T/U site or the Social Security Administration will help individuals with the application process.

5.10 **Railroad Retirement**

The Railroad Retirement program is a Federal Insurance program similar to Social Security for workers in the railroad industry. The provisions of the Railroad Retirement Act provided for a system of coordination and financial exchange between the Railroad Retirement Program and the Social Security Program.

Like the Social Security program, the Railroad Retirement provides retirement, disability, and survivors' benefits under rules approximately the same as for Social Security. There is also a supplemental retirement annuity and, for some people, the possibility of collecting both Railroad Retirement and Social Security benefits.
Railroad Retirement number has either six or eight digits. Beneficiaries are indicated by a letter prefix.

<table>
<thead>
<tr>
<th>Prefix</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Retired railroad worker (&quot;Annuitant&quot;)</td>
</tr>
<tr>
<td>MA</td>
<td>Spouse of an annuitant</td>
</tr>
<tr>
<td>WA</td>
<td>Widow or widower (of an annuitant) who is 60 or over</td>
</tr>
<tr>
<td>WCA</td>
<td>Widow of a child in her care, or child along (on annuitant)</td>
</tr>
<tr>
<td>PA</td>
<td>Parent of a deceased annuitant</td>
</tr>
<tr>
<td>JA</td>
<td>Survivor &quot;joint annuitant&quot;; an employee who is receiving a reduced annuity in order to guarantee payment to his widow</td>
</tr>
<tr>
<td>WD</td>
<td>Widow or widower (of an employee) who is 60 or over</td>
</tr>
<tr>
<td>WCD</td>
<td>Widow with a child in her care, or a child alone (of an employee)</td>
</tr>
<tr>
<td>PD</td>
<td>Parent of a deceased employee</td>
</tr>
<tr>
<td>H</td>
<td>Retired worker on a pension</td>
</tr>
<tr>
<td>MH</td>
<td>Spouse of a pensioner</td>
</tr>
<tr>
<td>WH</td>
<td>Widow or widower of pensioner</td>
</tr>
<tr>
<td>WCH</td>
<td>Widow with a child in her care or a child alone (of a pensioner)</td>
</tr>
<tr>
<td>PH</td>
<td>Parent of a deceased pensioner</td>
</tr>
</tbody>
</table>

### 5.11 Private Insurance

Private health insurance is a mechanism for people to protect themselves from the potentially extreme financial costs of medical care if they become severely ill, ensuring that they have access to health care when they need it. Private health insurance is provided primarily through benefit plans sponsored by employers. People without access to employer-sponsored insurance may obtain health insurance on their own, usually through the individual health insurance market.

Private health insurance provides health care benefits to an individual through a for-profit or not-for-profit insurance company or corporation. Private insurance covers almost every aspect of health care: hospital, surgical, medical, major medical, disability and mental health. A typical policy pays after the subscriber meets an initial calendar year deductible and a predetermined coinsurance amount.

Private health insurance is provided primarily by two different types of entities:
- State-licensed health insuring organizations
- Self-funded health benefit plans.
5.11.1 State-Licensed Health Insuring Organizations

The state-licensed health insuring organizations, as the name implies, are organized and regulated under state law. There are three primary types:

- **Commercial health Insurers**

  These are sometimes called indemnity insurers and are generally organized like stock companies or as mutual insurance companies. An example is Aetna.

- **Blue Cross and Blue Shield Plans**

  Many of these were organized as not-for-profit organizations under special state laws by state hospital and state medical associations. Blue Cross and Blue Shield Plans operate and are regulated in a similar manner to commercial insurers, although in a few states Blue Cross and Blue Shield plans continue to have special requirements to accept applicants for health insurance on a more lenient basis than is applied to other type of insurers.

- **Health Maintenance Organizations (HMOs)**

  These are usually licensed under special state laws that recognize that they tightly integrate health insurance with the provision of health care. HMOs operate as insurers (meaning they spread health care costs across the people enrolled in the HMO) and as health care providers (meaning they directly provider or arrange for the necessary health care for their enrollees). An example is Kaiser.

5.11.2 Self-Funded Employee Health Benefit Plans

Self-funded employee health benefit plans operate under Federal law and are health benefit arrangements sponsored by employers, employee organizations, or a combination of the two. Under a self-funded arrangement, the plan sponsor retains the responsibility to pay directly for health care services of the plan’s participants.

In most cases, the sponsors of self-funded health plans contract with one or more third parties to administer the plans. The contracts are sometimes with entities that specialize in administering benefit plans, called third-party administrators. In other cases, sponsors contract with health insurers or HMOs for administrative services.
5.11.3 Typical Examples of Covered Services

- Office and clinic exams, procedures, and treatment
- In-hospital admissions and related services
- Emergency room care primarily related to a medical or accidental injury
- Surgical procedures in the office, clinic, hospital, or ambulatory surgery center
- Chiropractors
- OB care, including pre and post natal
- Lab, x-ray, and pharmacy
- Medical equipment and supplies
- Physical, Occupational, and Speech therapy
- Vision care
- Dental care
- Hospice care
- Defined list of preventive care

5.12 Managed Care

Managed care is a broad term and encompasses many different types of organizations, payment mechanisms, review mechanisms, and collaborations. Managed care is sometimes used as a general term for the activity of organizing doctors, hospitals, and other providers into groups, to enhance the quality and cost-effectiveness of health care.

Managed Care includes systems and techniques used to control the use and the cost of health care services. It also includes a review of medical necessity, incentives to use certain providers, and case management. Managed care techniques are most often practiced by organizations and professionals which assume risk for a defined population (e.g., health maintenance organizations), but this is not always the case.

Managed care has effectively formed a "go-between" brokerage or 3rd party arrangement by existing as the gatekeeper between payers and providers and patients.

Managed Care Organizations (MCOs) are entities that seek to manage health care. Generally, this involves contracting with health care providers to deliver health care services on a capitated (per-member per-month) basis.
Examples of MCOs include

- Health Maintenance Organizations (HMO)
- Preferred Provider Organizations (PPO)
- Point of Service (POS)
- Exclusive Provider Organization (EPO)
- Provider Health Organization (PHO)
- Integrated Delivery System (IDS)
- Accountable Health Plan (AHP)
- Independent Practice Association (IPA)

Usually, a managed care organization is the entity which manages risk, contracts with providers, is paid by employers or patient groups, or handles claims processing. Arrangements often involve a defined delivery system of providers with some form of contractual arrangement with the plan.

A Managed Care Plan is a health plan that uses managed care arrangements and has a defined system of selected providers that contract with the plan. Managed care plans contract with providers to render health care services to members for a predetermined, discounted fee.

Under a Managed Care Plan, health coverage providers seek to influence the treatment decisions of health care providers through a variety of techniques, including financial incentives, development of treatment protocols, prior authorization of certain services, and dissemination of information on provider practice relative to norms or best practices.

Managed care health insurance is generally cheaper for employers because utilization requirements are stricter than private insurance plans. Enrollees have a financial incentive to use participating providers that agree to furnish a broad range of services to them.

### 5.13 Dental Insurance

Medical insurance is designed primarily to cover the costs of diagnosing, treating, and curing serious illnesses. This process may involve a primary care physician and multiple specialists, a variety of tests performed by doctors and laboratories, multiple procedures, and masses of medications.

Dental insurance works differently. Most dental coverage is designed to ensure that the patient receives regular preventative care. High quality dental care rarely requires the complex, multiple resources often required by medical care. A thorough examination by the dentist and a set of x-rays are all it usually takes to diagnose a problem.
Dental care is provided by a general practitioner – dentist – and may require services of a dental specialist. Because most dental disease is preventable, dental benefit plans are structured to encourage patients to get the regular, routine care that are vital to preventing and diagnosing the onset of serious disease.

Most dental benefit plans require patients to assume a greater portion of the costs for treatment of dental disease than for preventive procedures. By placing an emphasis on prevention and by covering regular teeth cleaning and check-ups, millions of dollars are saved each year in dental care costs.

There are two types of dental compensation plans:

- **Indemnity Plans**
  
  An indemnity plan pays the dentist on a traditional fee-for-service basis. A monthly premium is paid by the patient or employer to the insurance carrier which directly reimburses the dentist for the services provided. Usually insurance companies pay between 50 percent and 80 percent of the dentist’s fee for covered services.

  These plans often have a pre-determined deductible, a dollar amount which varies from plan to plan. Indemnity plans can limit the amount of services covered within a given year and can pay the dentist based on a variety of fee schedules.

- **Direct Reimbursement Plan**
  
  Under this self-funded plan, an employer or company sponsor pays for dental care with its own funds, rather than paying premiums to an insurance company. The plan may limit the amount of dollars an employee can spend on dental care within a given year, but often places no limit on services provided.

Regardless of the dental benefit plan, there are several different types of third-party insurers:

- **Dental Service Corporations**
  
  Dental service corporations are not-for-profit organizations that negotiate and administer contracts for dental care to individuals or specific groups. Examples include Delta Dental Plan and Blue Cross/blue Shield Plans.
• **Insurance Carriers**

Insurance carriers are for-profit companies that underwrite the financial risk of and process payment claims for the dental services. Carriers contract with individuals or patient groups to offer a variety of dental benefit packages, including fee-for-service and managed care plans.

• **Self-Funded Insurers**

Self-funded insurers are companies who use their own funds to underwrite the expense of providing dental care to their employees.

### 5.13.1 Examples of Typical Dental Coverages

Typical *preventive* dental treatments that are covered include:

- Initial oral and recall examinations
- Complete x-ray survey and bite-wing x-rays
- Prophylaxis or teeth cleaning
- Topical fluoride treatment

Typical *corrective* dental treatments covered, where most plans will cover 70 or 80 percent of the treatment, include:

- Restorative care
- Endodontics
- Oral surgery
- Periodontics
- Crowns

Prosthodontics – denture and bridge related services – are also included.

Dental insurance is designed to help get care at a reasonable cost. Because each person’s oral health is different, costs can vary widely. To control dental cost, most plans will limit the amount of care you can receive in a given year. This is done by placing a dollar “cap” or limit on the amount of benefits you receive or by restricting the number or type of services that are covered. Some plans may specifically exclude certain services or treatments.
5.14 **Pharmacy**

Benefits for prescription drugs can be included in the medical insurance application or be provided by a separate Pharmacy Benefit Manager (PBM) through Aetna, Express Scripts, Medco, Pay Prescriptions, PCS, Blue Cross and Blue Shield, Cardinal or others.

Most of the drugs covered by the pharmacy insurers are listed on a preferred drug list or formulary, subject to applicable limits and conditions. Formularies include both brand-name and generic drugs that have been approved by the Food and Drug Administration (FDA) as safe and effective.

Most drugs listed on the preferred drug list are subject to manufacturer volume discount arrangements under which the applicable insurance company receives financial consideration. In addition, drugs on the formulary represent an important therapeutic advance or are clinically equivalent and possibly more cost-effective than other drugs not on the preferred drug list.

Generic drugs must contain the same active ingredients in the same amounts as their brand-name counterparts. The same rigorous FDA quality and safety reviews apply to generic and brand-name drugs; however, generic drugs may help lower the health care expenses for patients.

Several of the pharmacy insurers require pre-certification. It is designed to help encourage appropriate use of certain drugs in accordance with current medical findings, FDA-approved manufacturer labeling information, and cost and manufacturer rebate arrangements.

Registration staff must remember to ask each patient if they have pharmacy insurance, and whether it is part of the coverage in the medical plan or is through a separate insurer.

5.15 **CHAMPUS/TRICARE**

The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), now called TRICARE, is for members of the military and their families. TRICARE covers active duty and retired service members from any of the seven services: Army, Air Force, Navy, Marine Corps, Coast Guard, Public Health Service, or National Oceanic and Atmospheric Administration. In addition, spouses and unmarried children remain eligible for services under TRICARE even when the parents are divorced or remarry. Eligibility for children usually terminates at age 21 except if the child is a full time student or incapable of self support.
TRICARE also covers:

- Reservists and their dependents that have been called to active duty for 31 consecutive days
- Retired military service members and their spouses

Attaining Medicare eligibility does not mean beneficiaries lose eligibility for TRICARE, for example:

- Beneficiaries who become eligible for Medicare Part A on the basis of age and purchase Medicare Part B continue to be eligible for TRICARE, secondary to Medicare.
- Family members of active duty service members who are also eligible for Medicare for any reason retain eligibility for TRICARE whether or not they purchase Medicare Part B.
- Beneficiaries under 65 who are entitled to Medicare Part A because of disability or end stage renal disease and have purchased Medicare Part B retain their eligibility for TRICARE until they turn 65, when they become only eligible for TRICARE for Life (a Medicare-wraparound coverage).

For more information, go to this website:

http://tricare.osd.mil.

5.16 Workman’s (Worker’s) Compensation

Workman’s Compensation is an insurance offered by the state to employers, to cover risk-related work accidents and injuries. The laws regarding Workman’s Compensation are state-specific and vary regarding coverage, reporting, and benefit waiting periods.

Employers are responsible for premiums and maintenance. The injured employee has a right to compensation for 100% of medical expenses.

Providers must provide a form to the Workman’s Compensation office within a stipulated period of time. Each clinic or facility should check with their local office to understand the time requirement.

Workman’s compensation is the primary coverage when there is an on-the-job injury and no other insurer is liable. The insurance company of the employer should be called to verify coverage. Notations should be made in the RPMS Patient Registration application, page 8, to indicate date, name, and approval.
When the carrier of the employee’s work-related injury is notified, the carrier will:

- Determine the compensability of the injury
- Provide an authorized doctor
- Pay for all authorized medically necessary care and treatment related to the injury
- Authorize treatment for doctor’s visits, physical therapy, prescription drugs, hospitalization, medical tests, prosthesis, and travel.

### 5.17 Third Party Liability

Liability cases involve traffic and other accidents where third-party insurance may cover a patient’s treatment. In such cases the patient’s insurer is responsible for covering the claim and later can seek reimbursement from the responsible party’s insurer.

Patients may say someone else is responsible for their bill and that therefore their insurance information is not needed, but registration staff should explain that they must document every insurer that may be involved.

A provider is under no obligation to wait for appeal activity or legal action to be paid in liability cases. For more detailed information, see the Federal Medical Care Recovery Act (FMCRA) policy at this website:

[http://www.ihs.gov/PublicInfo/Publications/IHSManual/Circulars/Circ06/Circ06_02/circ06_02.htm](http://www.ihs.gov/PublicInfo/Publications/IHSManual/Circulars/Circ06/Circ06_02/circ06_02.htm)

### 5.18 Grant Programs

Research and grant dollars can be made available to the clinic to cover health-related research activities that would not have been available otherwise. As an example, the National Institute of Health (NIH) provides research grants and funding to programs that will reimburse the clinic for services, equipment, supplies, facility and administrative cost, publications, consultant fees, renovations, and other items.
5.19 Medicare Secondary Payer (MSP)

Medicare Secondary Payer (MSP) is the term used by Medicare when Medicare is not responsible for paying first. Most private insurance companies refer to MSP as “Coordination of Benefits”.

By Federal law, Medicare is secondary payor to a variety of government and private insurance benefit plans. Medicare should be viewed as the secondary payor when a beneficiary can reasonably be expected to receive medical benefits through one or more of the following means:

- An employer Group Health plan for working age beneficiaries
- A large Group Health Plan for disable beneficiaries
- Beneficiaries eligible for End State Renal Disease (ESRD)
- Liability/Automobile medical or no-fault insurance
- The Veterans Administration (VA)
- A Workers’ Compensation (WC) plan
- The Federal Black Lung program

Any conditional primary payment(s) made by Medicare for services related to a third-party liability injury is subject to recovery.

The facility should submit the MSP information to the intermediary using condition and occurrence codes on the claim. After initial payment from the primary insurer, the clinic should submit a copy of the explanation of benefits (EOB) or rejection notice from the carrier with all appropriate MSP information to the designated carrier. Information related to the billing process and coordination of benefits is discussed further in Part 4, Billing of this manual.

For Trailblazers:

- Inpatient – an MSP needs to be obtained on every admission.
- Outpatient – an MSP needs to be obtained every 90 days.

If different Fiscal Intermediary is used, verify if there are different requirements for updating the MSP.

Data from the MSP form may be entered into the RPMS Patient Registration application and retrieved at a later time, if needed for auditing purposes.

For more information on MSP, go to this website: http://www.cms.hhs.gov/COBGeneralInformation/
5.20 Tribal Self Insurance

Typically, a self-insurance plan involves payment of funds by a Tribe or Tribal organization into a liability pool. The Tribe or Tribal organization bears all the financial risk for the occurrence of a particular event, such as health care costs for tribal employees. When the particular event occurs, payment is made from the liability pool or from other tribal resources.

Under this type of arrangement, Section 206(f) of the Indian Health Care Improvement Act (INCIA), P.L. 94-437, 25U.S.C. 1621e(f) prohibits the IHS from seeking a right of recovery when the health services it has provided to an eligible patient are covered by a self-insured health plan funded by a Tribe or Tribal organization. Consistent with Congressional intent not to burden Tribal resources, the agency has made a determination that tribal-funded, self-insured health plans are not to be considered alternate resources for purposes of the IHS payor of last resort rule. Thus, if a Tribal self-insurance plan exercises an exclusionary clause prohibiting payments to the IHS, then the IHS will not consider that healthcare plan an alternate resource. Subject to the availability of funds, the IHS will authorize CHS funds for payment of services otherwise covered by such a Tribal self-insurance plan, if the services are eligible for payment under the IHS regulations and no other alternate resources exist, subject to the availability of funds.

5.21 Verifying Third Party Insurance Coverage

5.21.1 Verifying Medicaid Insurance

A current copy of the state Medicaid card needs to be obtained from the patient and the information will be entered in the RPMS Patient Registration database. If there are discrepancies on the name and/or date of birth, the patient will need to correct these discrepancies with the state Medicaid office.

In addition, if the Medicaid card indicates an incorrect birth date or name, the name appearing on the card must be used until the state corrects the information on the Medicaid card.

If the discrepancy occurs on the facility records, the patient will need to furnish the required documentation to make the necessary changes/corrections.
To verify Medicaid, follow these steps:

1. Obtain copy of the patient’s Medicaid card.

2. Speak to a representative at the state Medicaid program, or utilize on-line verification.

3. Identify the patient by providing his/her social security or Medicaid identification number to the representative.

4. Update eligibility information for date of service.

5. Enter patient data on Page 4 and Page 8 of the RPMS Patient Registration application.

5.21.2 Verifying Medicare Parts A and B Eligibility

A copy of the Medicare card needs to be obtained from the patient and the information will be entered in the RPMS Patient Registration application.

Any discrepancies must be corrected by the patient with the Social Security Office. If the discrepancy occurs in the facility’s records, the patient will need to furnish the required documentation to make the necessary changes/corrections.

To verify Medicare A and B, follow these steps:

1. Obtain copy of the patient’s Medicare card.

2. Speak to a representative at the Medicare Part A provider line.

3. Identify the patient by giving the Health Insurance Claim Number (HICN) – provide number, suffix, date of birth and gender – to the representative.

For current HICNs, go to this website:

http://www.cms.hhs.gov/Manuals/

Go to the Internet-only Manuals (IOMs) webpage. The HIC number suffixes are listed in publication 100-01, Medicare General Information, Eligibility, and Entitlement Manual, Chapter 2, “Hospital Insurance and Supplementary Medical Insurance.”
4. Eligibility is given at time of verification – information given is effective date, primary or secondary or coverage terminated.

5. Enter patient data on Page 4 and Page 8 of the RPMS Patient Registration application.

5.21.3 Verifying Private Insurance

For new patients to the facility or when insurance coverage has changed, the Registration staff needs to

• Obtain the insurance card.
• Xerox both sides of card.
• File the copy.

The Xeroxed copy of the insurance card will be verified with the insurance company (electronically or via a telephone call) by the Registration staff, Benefit Coordinator, or a Pre-Certification clerk. All verifications will be entered into the patient’s file in the RPMS Patient Registration application.

To verify private insurance coverage, follow these steps:

1. Obtain copy of private insurance card.
2. Call or check on-line the private insurer listed on card and check Page 8 of the RPMS Patient Registration application to ensure that the insurer’s telephone number is the same.
3. Verify the following information:
   – policy number
   – person class code
   – group number
   – name
   – date of birth
   – billing address
4. Determine if there is a separate insurer for pharmacy, mental health, or dental.
5. Update the Notes page in the RPMS Patient Registration application.
6. Check the Patient Third Party Eligibility section in the RPMS Patient Registration application to verify accurate demographic and third party information.
7. Document all information in the patient’s **Third Party Eligibility** information section of the **RPMS Patient Registration** application to include policyholder, billing address, telephone number, pre-certification number, filing limit, and benefit information.

8. Document the insurance representative’s name and date of verification.

### 5.22 Prior Authorization Process

Prior Authorization, also called pre-certification or pre-authorization, is the process by which the insurer evaluates the medical necessity of the proposed hospital stay and certain outpatient services, the number of days that are required to treat the condition, services for mental conditions or substance abuse, and even certain drugs.

The Prior Authorization process involves the hospital or provider contacting the plan, usually within 24 hours prior to admission. After providing the patient’s name, identification number, birth date, reason for hospitalization, name and phone number of provider, and number of planned days in the hospital, the insurer will approve the days of confinement for the care of the patient’s condition. Written confirmation usually follows.

For emergency admissions, the provider or hospital must call the insurer within two business days following the day of admission, even if the patient has been discharged from the hospital.

Not all insurers require Prior Authorization; however, the clinic and/or Billing should be aware of those that do require this process. If Prior Authorization is required but not performed by the clinic, the admission or the outpatient services will not be reimbursed.

**Note:** For approving a stay, extending an admission for additional days, or approving an outpatient clinic visit, the pre-certification number can be documented in the RPMS Patient Registration application.
5.22.1 **Inpatient Prior Authorization Procedure**

**Note:** Prior authorization for weekends and holidays is completed the next business day. Follow each payor’s criteria.

The Admission and Discharge sheet generated from the RPMS Admission/Discharge/Transfer (ADT) application will be used to verify all inpatient third-party information. If data was obtained during the pre-op visit, this information will be found in the patient’s file of RPMS.

1. An admission/discharge summary report will be printed-out and used as a guide to check all inpatient admissions to determine whether the patient has any alternate resources. If the patient has any alternate resources, verification of coverage will be completed and pre-authorization will also be obtained, if required.

2. The verification/admit clerk will use the following information when calling in for verification and authorization:
   - Admission date
   - Admission time
   - Admitting diagnosis (ICD9)
   - Admitting physician (facility address, facility telephone and physician specialty)
   - Patient Name
   - Date of birth
   - Name of insurance policy holder and policy number
   - Name of Third Party Private insurance
   - Name of Facility/Address/Telephone number (Federal Tax Identification Number)

3. The verification/admit clerk will update all pertinent information in the **Third Party Eligibility** section of the **RPMS Patient Registration** application.

4. The Utilization Review personnel will be notified. The authorization number is utilized for billing purposes once the patient is discharged from the facility.

5. The Utilization Review Case Management personnel will receive notification via their assigned pager regarding the identified patient as having medical health insurance.
6. The UR personnel will document such information as authorization number, review nurse, inpatient unit, treatment plan medications, and other related information on an established worksheet.

The facility may want to establish a worksheet for recording this information.

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**Note:** For approving a stay, extending an admission for additional days, or approving an outpatient clinic visit, the pre-certification number can be documented in the RPMS Patient Registration application.

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### 5.22.2 Outpatient Prior Authorization Procedure

All outpatient cases will be verified and authorized on the pre-operative visit, with the exception of emergency cases.

1. The verification/admit clerk will use the following information when calling in for verification and authorization:
   - Preoperative date
   - Day surgery date
   - Diagnosis (ICD-9)
   - Surgical procedures (CPT)
   - Other services, such as rehab, PT with date range of services
   - Name of physician and specialty
   - Patient Name
   - Date of Birth
   - Name of insurance policy holder and policy number, copied front and back
   - Name of Third Party Private insurance
   - Name of facility, address, telephone number (Federal Tax Identification Number)

   The verification/admit clerk will document this information which will be routed to the Utilization Review personnel for follow up. The authorization number is utilized for billing purpose once the patient is discharged from the facility.

2. The verification/admit clerk will update all pertinent information in the **Third Party Eligibility** section of the **RPMS Patient Registration** application.
3. The Utilization Review Case Management personnel will receive notification regarding the identified patient as having medical health insurance. The information such as an authorization number, review, nurse, past medical history, treatment plan, and medications should be recorded on a form.

**Note:** For approving an outpatient clinic visit, the pre-certification number can be documented in the RPMS Patient Registration application.

### 5.23 Patient Referral to the Benefit Coordinator

The Registration staff needs to have a defined process in place for referring patients to the Patient Benefit Coordinator. Details of this process are described in Part 2, Chapter 7, “Benefit Coordinator.” In addition, Registration staff needs to understand who potentially may qualify for alternate resources and make sure these individuals are appropriately referred to, as well as, meet the Benefit Coordinator.

Patients can be referred to the Patient Benefit Coordinator using the RPMS Patient Registration application, which notifies the Benefit Coordinator. The information provided will include the patient’s name and medical record number.
6. Scheduling Appointments

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6.1 About Scheduling Appointments

The purpose of scheduling appointments, utilizing the RPMS Scheduling application, is to:

- Distribute workload as evenly as possible for the providers and nurses.
- Reduce unnecessary wait times.
- Encourage continuity of care.
- Improve the patient-provider relationship.
- Assure timely follow-up of patients with chronic diseases.

Whenever possible, patients will be offered their choice of several dates and times to better assure compliance and customer satisfaction.

6.2 Appointment Scheduling Process

- If appointment scheduling is centralized, patients will be directed to the Appointment Scheduling clerk for a future appointment.

- If appointment scheduling can be made directly with each clinic, the patients can either schedule an appointment directly in person or call the Appointment clerk directly.

- If the clinic has restrictions which require a referral form from a primary care provider or approval of the staff of the clinic, the clerk or other person entering the data into RPMS should first obtain the authorization according to the clinic’s appointment policy.

- The appointment clerk will access the RPMS Scheduling application using his or her assigned access codes and current RPMS codes for the clinic.

- The clerk will offer several times and dates for the clinic or specific provider and allow the patient to select one that is convenient.

Although not all clinics have a future open schedule, and many clinics do not provide options to the patient, allowing the patient to select an appointment is preferred because it encourages participation and endorsement from the patient.

- The clerk will enter the patient’s name or chart number into the requested opening.
If the patient is physically present, the clerk will print the patient an appointment slip confirming the date and time of the appointment. If the appointment is being handled by mail, a copy of the appointment slip will be mailed to the patient.

### 6.3 Exceptions to the Standard Scheduling Process

<table>
<thead>
<tr>
<th>If . . .</th>
<th>Then . . .</th>
</tr>
</thead>
<tbody>
<tr>
<td>the clinic cannot locate a chart number for the patient,</td>
<td>The clerk should contact Patient Registration to check for an inactive record or a temporary medical record number.</td>
</tr>
<tr>
<td>a patient is being asked to return to the clinic within the next two work days,</td>
<td>The chart should be with the appointment charts. The appointment should be entered into the computer.</td>
</tr>
<tr>
<td>the patient has never been to the facility before,</td>
<td>The patient should be advised to come to the clinic one hour before the scheduled time of the appointment with the required documents, to have a chart prepared.</td>
</tr>
<tr>
<td>during the appointment process, the clerk is advised that the patient’s chart is inactive and stored at the Federal Record Center (FRC),</td>
<td>The chart will be reactivated in the RPMS Patient Registration menu, if the patient is physically present at the time the appointment is made.</td>
</tr>
<tr>
<td>the patient is not present,</td>
<td>The patient will be advised to come one hour early for the appointment. The patient should be directed to Registration and inform Patient Registration that their chart is inactive.</td>
</tr>
<tr>
<td>the physician needs the inactive record,</td>
<td>The chart can be retrieved from the Federal Record Center, based on rules of your local archive center.</td>
</tr>
</tbody>
</table>

### 6.4 Preventing “Did Not Keep Appointments” (DNKA)

Although some missed appointments are unavoidable due to a lack of dependable transportation, telephones, or inclement weather, “Did Not Keep Appointment” (DNKA) is a major cause of inefficiency in clinic operations.
Suggestions to reduce DNKAs include:

- Offering the patient a selection of times when the appointment is made initially.

- Encouraging the patient to call to make a change in their appointment, if events make it impractical to attend. It is easier to reschedule a patient and then schedule a new or walk-in patient for that time in the day’s schedule.

In addition, a telephone number for the appointment clerk should be provided to the patient when the appointment is rescheduled. The message should state:

“If you cannot keep your appointment, please call us at _______ to let us know so we can schedule someone else in that time and give you a better time.”

- Making a courtesy “appointment reminder” telephone call one day prior to the scheduled appointment.

- Establishing a system for reviewing charts of patients who did not keep their appointments for that day. The person responsible for reviewing the charts may be the provider or nurse with whom the patient had the appointment.

Although the appointment clerk has a role in preparing the paperwork, making appointments, and following up on decisions, the actual decision as to what action is to be taken rests with the professional staff member. The provider may decide to:

- Take no action and have the patient return at an unspecified future time.

- Schedule a new appointment with a reminder notice to the patient of the date and time.

- Refer a Public Health Nurse or Community health Representative to check on the status of the patient.

- Initiate a verbal dialogue with the patient.

A notation should be placed in the medical record or a note should be entered into the Electronic Health Record (EHR), that the patient did not keep their appointment. This should be signed by the provider or nurse.
# 7. Benefit Coordinator

## Contents

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7.1 About the Benefit Coordinator

The Benefit Coordinator identifies patients who are eligible for alternate resources such as Medicaid, Medicare, private insurance, and others. This includes

- determining if the patient qualifies for alternate resources,
- assisting the patient with completion of the application, and
- following up with the insurer to assure the coverage.

Besides identifying patients who are eligible for alternate resources, another Benefit Coordinator function is to maximize and enhance patient care through increased revenue from other insurers. Because the Indian Health Service (IHS) may not be able to provide coverage for certain health services, the funds from alternate resources can be utilized in place of Contract Health Services (CHS).

To accomplish the essential activities related to this position, the Benefit Coordinator needs to be on-site and available during the clinic hours of operation.

The Benefit Coordinator needs to maintain statistics daily, monthly, and quarterly of enrollments, approvals/denials of applications, verification, and updating of the RPMS and overall assistance of patients with benefits. These reports need to be submitted to the business office manager or supervisor.

These are the overall responsibilities of the Benefit Coordinator:

- Advocate on behalf of patients with all alternate resource activities.
- Effectively educate patients on alternate resources.
- Effectively utilize or maximize enrollment of patients into an alternate resource program.
- Effectively interview patients to determine eligibility and make appropriate referrals for benefits.
- Work closely with Patient Registration and Contract Health Services in screening potential patients who are eligible for alternate resources.
- Abide by the Privacy Act of 1974 to maintain confidentiality of all records.
- Follow up on pending applications with appropriate alternate resource agencies.
• Make home visits to gather pertinent information/documents from client/patients to complete the application process.

• Monitor and update change in coverage and/or rate code per encounter.

For information related to Benefit Coordinator performance tracking and quality assurance, see Part 1, Chapter 7, “Business Office Quality Process Improvement.”

### 7.2 Outpatient Identification and Verification Process

The process for identifying and verifying alternate resources for outpatient services are:

• Review the scheduled patients either the evening before or morning of, to assess potential patients for referral to the Benefit Coordinator.
  – Have the Registration staff refer any potential patients to the Benefit coordinator’s office.

• For walk-in patients, cross-train the Registration staff on eligibility requirements for alternate resources that may be available.
  – Have the Registration staff refer any potential patients to the Benefit coordinator’s office.

• Screen and/or interview patients by face-to-face contact or telephone contact.

• Obtain the following information:
  – Demographics, including date of birth (DOB), social security number, home mailing address
  – Insurance information, if any
  – Income information

• Verify eligibility:

<table>
<thead>
<tr>
<th>If the patient . . .</th>
<th>Do this:</th>
</tr>
</thead>
<tbody>
<tr>
<td>is 65 or over,</td>
<td>Contact the Social Security Administration (SSA) for a Medicare update.</td>
</tr>
<tr>
<td></td>
<td>Determine if the patient has any private insurance prescription drug coverage.</td>
</tr>
<tr>
<td>worked for the railroad,</td>
<td>Contact the Medicare Railroad Retirement Office for Railroad Medicare.</td>
</tr>
</tbody>
</table>
If the patient . . . | Do this:
--- | ---
has no insurance, or has/had Medicaid coverage, | Contact the automated state Medicaid Voice Response System, call the Medicaid fiscal agent eligibility help desk, or verify eligibility via the Internet connection with the state Medicaid.

is disabled, | Contact the Social Security Administration to determine if the patient has Supplemental Social Security (SSI).

has had military service, | Contact the local Veterans Administration (VA) office to determine if he/she has VA benefits

(or spouse) is employed and has the company’s insurance, | Contact the private insurer eligibility or verification staff person for private insurance validation.

is elderly and/or blind, physically disabled, or has developmental disabilities, | Contact the Social Security Administration

- Enter insurance updates into the **Resource Patient Management System (RPMS) Patient Registration** application or **Patient Information Management System (PIMS)**, such as any new insurance information, or changes in date of birth or social security number.
  - Benefit Coordinator notes can be entered in the Benefits Coordination section of the RPMS Patient Registration Editor.

### 7.3 Eligibility Verification

The Benefit Coordinator, Registration staff, and Contract Health Services verify insurance as part of their daily business processes using the same data base, where the

- Benefit Coordinator verifies new insurance eligibility.
- Registration staff verifies existing or changed insurance.
- Contract Health Services verifies insurance to determine if any coverage should pay before contract health dollars are used.
The process of verifying insurance varies by state and insurer. The verification process can include an automated telephone response system, Internet on-line verification, or a direct telephone call to speak with a customer service representative at the insurance company.

### 7.3.1 State Medicaid/SCHIP Verification

1. Use the existing automated toll-free telephone voice response system, OR contact the existing eligibility help desk representative, OR use the Internet Online verification system.

2. Verify eligibility coverage for the past three months.

3. Update eligibility information in the third party eligibility section of RPMS Patient Registration application.

4. Make notation in the Notes section of the RPMS Patient Registration application

### 7.3.2 Social Security Income (SSI) Disability Verification

1. Use the toll-free automated voice response telephone system, OR contact the existing eligibility help desk representative, OR use the Internet Online verification system.

   a. Verify eligibility for the past three months.

   b. Make notation in the Notes section of the RPMS Patient Registration application, “Medicare Verification.”

2. Call the local Social Security Administration Office.

   a. Verify eligibility coverage for patient’s name, date of birth, Medicare identification number, and effective coverage dates for Part A and/or Part B.

   b. Update eligibility information in the third party eligibility section of the RPMS Patient Registration application.

   c. Make notation in the Notes section of the RPMS Patient Registration application.
7.3.3 **Private Insurance Verification**

1. Copy the insurance card.

2. Contact the private insurance customer service representative directly.

3. Update eligibility information in the third party eligibility section of the RPMS Patient Registration application.

4. Make notation in the Notes section of the RPMS Patient Registration application.

7.4 **Inpatient Identification and Verification Process**

This is process for identifying and verifying alternate resources for inpatient services are:

1. Before interviewing the patient in the patient room, print the Admission/Discharge Sheet (listed under the ADT Menu report option).
   a. At the ADT Menu prompt, type RM (Reports Menus).
   b. At the RM Menu prompt, type IRM (Inpatient Reports Menu).
   c. At the IRM Menu prompt, type PMI (Patient Movement Listing) from.
   d. In PMI, specify the date of service.
   e. Print a summary of the report.
   f. Return to the RM Menu and select the DAS (Print A sheets by admit date) option, and print out the half sheets (Clinical Record Brief) of each admitted patient for a specific date of service.
   g. Go to the RPMS Patient Registration application (or PIMS) and review Pages 4-8 and Page 11 for alternate resource information.
   h. Indicate any significant findings on the Clinical Record Brief.

2. Go to the ADT Menus and select the PI (Patient Inquiry) option to locate the patient’s room number.
3. Interview the patient.

4. If the insurance information is not voluntarily provided, call the employer of the responsible party to obtain this information.

7.5 Medicaid Eligibility and Application

7.5.1 Medicaid Eligibility

Each state has the discretion as to which groups their Medicaid programs will cover and the financial criteria for Medicaid eligibility. Examples of Medicaid eligibility groups are:

- Low income families with children who meet certain of the eligibility requirements in the State’s Aid to Families with Dependent Children (AFDC) plan in effect on July 16, 1996
- Supplemental Security Income (SSI) recipients to include aged, blind, and disabled individuals which were in place in the State’s approved Medicaid plan as of January 1, 1972
- Infants born to Medicaid-eligible pregnant women. Medicaid eligibility must continue throughout the first year of life, so long as the infant remains in the mother’s household and she remains eligible.
- Children under age 6 and pregnant women whose family income is at or below 133 percent of the Federal poverty level – set by each state. States are required to extend Medicaid eligibility until age 19 to all children born after September 30, 1983 in families with incomes at or below the Federal poverty level. Once eligibility is established, pregnant women remain eligible for Medicaid through the end of the calendar month in which the 60th day after the end of the pregnancy falls, regardless of any changes in family income.
- Recipients of adoption assistance and foster care under Title IV-E of the Social Security Act.
- Certain Medicare beneficiaries
- Special protected groups who may keep Medicaid for a period of time, such as a person who loses SSI payments due to earnings from work or increase in Social Security benefits.
States also have the option to provide Medicaid coverage for other “categorically needy” groups. Such coverage needs to be verified by the state. Here are some examples:

- Infants up to age one and pregnant women not covered under mandatory rules whose family income is below 185 percent of the Federal poverty level (the percentage is set by each State).
- Optional targeted low income children.
- Certain aged, blind, or disable adults who have incomes above those requiring mandatory coverage, but are below the Federal poverty level.
- Children under age 21 who meet income and resources requirements for AFDC but are not eligible for ADFC.
- Institutionalized individuals with income and resources below specified limits.
- Persons who would be eligible if institutionalized but are receiving care under home and community-based services waivers.
- Recipients of State supplementary payments.
- TB-infected persons who would be financially eligible for Medicaid at the SSI level.
- Low-income, uninsured women screened and diagnosed through a Center for Disease Control and Prevention’s Breast and Cervical Cancer Early Detection Program and determined to be in need of treatment for breast and cervical cancer.

### 7.5.2 Medicaid Eligibility Dates

Coverage may start retroactive to any or all of the three months prior to the application, if the individual would have been eligible during the retroactive period. Coverage generally stops at the end of the month in which a person’s circumstances change.

### 7.5.3 Relationship and Coordination between Medicaid and Medicare

Medicare Part A covers the hospital insurance and Part B covers the medical insurance. Medicare beneficiaries who have low income and limited resources may receive help paying for their out-of-pocket medical expenses from their State Medicaid program.
If a person is eligible for full Medicaid coverage, Medicare will pay first and the difference will be paid by Medicaid up to the Medicare allowable limit. Medicaid also covers additional services such as nursing facility care beyond the 100 day limit covered by Medicare, prescription drugs not covered by Medicare Part D, eyeglasses and hearing aids.

Qualified Medicare Beneficiaries (QMB) with resources at or below twice the standard allowed under the SSI program and income exceeding the QMB level, but less than 120% of the Federal Poverty Level (FPL) do not have to pay the monthly Medicare Part B premiums.

Qualifying individuals that are not otherwise eligible for full Medicaid benefits and with resources at or below twice the standard allowed under the SSI program will get help with all or a small part of their monthly Medicare Part B premiums, depending on whether their income exceeds the SLMB level but is less than 135% of the FPL.

Medicaid can pay Medicare premiums for Part A, Part B, and Part D deductibles and coinsurance for Qualified Medicare Beneficiaries (QMB) – individuals whose income is at or below 100% of the Federal poverty level and whose resources are at or below the standard allowed under SSI.

Medicaid can also pay the Medicare Part A premiums for certain disabled individuals who lose Medicare coverage because of work. These individuals have income below 200% of the Federal poverty level and resources that are no more than twice the standard allowed under SSI.

### 7.5.4 Medicaid Presumptive Eligibility

The Omnibus Budget Reconciliation Act provides for payment of ambulatory prenatal care to pregnant women during a presumptive eligibility period before they have formally applied for Medicaid. Women qualify for presumptive eligibility if:

- Pregnancy has been medically verified.
- Patient verifies social security number.
- Family income does not exceed 133% of the Federal poverty guidelines.
- There is not a presumptive eligibility in existence for this current pregnancy.
- An application form has been completed.
The following providers can qualify for presumptive eligibility:

- Title X family planning clinics through State Department of Health
- City/County Health Departments
- Peri-natal projects through State Health Departments
- Title V of the Indian Health Care Improvement Act
- WIC program through State Department of Health
- Other health care clinics within individual states, such as migrant health services or rural health clinics
- Indian Health Service or a health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act

Covered services under presumptive eligibility (hospital services are not covered) include:

- Provider, nurse practitioner or nurse midwife services
- Laboratory and radiology
- Dental
- Optometry
- Podiatry
- Speech, physical or occupational therapy
- Durable medical equipment
- Audiology and related services
- Counseling services
- Prescription drugs
- Transportation
- Family planning

7.5.5 Temporary Medicaid Number for Newborn

This is process for obtaining a temporary newborn number for State Medicaid. Check your state’s guidelines for newborn enrollment process.

1. Call or e-mail the appropriate Income Support Division Office.

2. Provide the following information:
   - Name of newborn
   - Date of birth for newborn
   - Gender of newborn
   - Mother’s name
   - Mother’s social security number
3. Enter the Temporary Newborn Number in the **RPMS Patient Registration** application on **Page 4**, and enter notations on **Page 8**.


### 7.5.6 Permanent Medicaid Number for Newborn

This is the process for obtaining a permanent Medicaid number for the newborn:

1. Call the State Medicaid Newborn Notification or Inquiry Line.

2. Provide the applicable newborn information
   - Clinic’s name and provider number
   - Mother’s name
   - Mother’s Medicaid number or Social Security Number
   - Mother’s date of birth
   - Name of newborn
   - Date of birth for newborn
   - Gender of newborn
   - Gestational age of newborn
   - Weight in grams of newborn
   - Type of delivery for newborn – normal or C-section
   - APGAR score of newborn

3. Enter the newborn’s Medicaid number in the **RPMS Patient Registration** application on **Page 4**, and enter notations on **Page 8**.

4. Notify the Billing Department and Contract Health Services of the newborn’s permanent Medicaid number.

### 7.5.7 State Medicaid Application Process

This is the procedure for the application process for State Medicaid:

1. Have the patient complete the appropriate state Medicaid application form and/or presumptive eligibility form:
   - adult patient or spouse without insurance coverage
   - for uncovered children under 19 years of age
   - for pregnant women and their newborns
   - for women who want family planning

2. Interview the patient and/or family members.
3. Complete the state Medicaid application and instruct the patient regarding documents needed and patient rights
   - Copy of birth certificate and/or certificate of Indian blood
   - Proof of state residency
   - Citizenship or immigration status:
     - Copies of both sides of the citizenship or immigration documents. Non-citizens must provide copies of any Immigration and Naturalization Services (INS) cards or letters.
   - Social Security Number
     - Validate the social security number with state and Federal agencies to verify if the patient has Medicare and to determine income status (earned or unearned).
     - If the patient does not have a social security number, assist the patient in applying for one.
   - Wages
     - Copies of check stubs or statement from employer showing gross earnings last month and this month for those individuals listed on the state Medicaid application.
   - Self-employment
     - Copies of current Federal tax forms.
     - Proof of business income and expenses for the last calendar month. Proof of business income includes records, journals, or financial statements that show the amount and date received; proof of business expenses including receipts, bills, or canceled checks that include date, amount, and type of expense.
   - Child Support
     - Copies of the court order or child support payment history.
   - Other Income
     - Proof of any income, such as Social Security Administration, Veterans Administration, Railroad Retirement, or disability income.
   - Health Insurance
     - Copies of insurance identification cards.
   - Daycare
     - Proof of amount billed for child care or care of an incapacitated adult.
7.5.8 Enrollment in Medicaid Managed Care Plans

1. If the patient is not locked into the Medicaid plan for one year, then have the patient complete the Native American Opt Out form.

2. Have patient sign the Opt Out form.

3. Attach a copy of the Patient’s Certificate of Indian Blood (CIB).

4. Fax the Opt Out form and CIB to the Native American Opt Out office or, depending on the state, the patient may have to call the customer representative and request formally a health plan change to IHS.

5. Update the change in plans in the RPMS Patient Registration application on Page 4, and enter an update note on Page 8.
7.5.9 **Follow-up Procedures for Pending Medicaid Applications**

Follow up with patients and alternate resources can be done via home or site visits, telephone calls, or letters.

1. Send a follow-up letter to the patient informing him/her to bring in the pending verification documents.

2. Make follow-up telephone calls with the appropriate agency on a set schedule.

3. Document all follow-up conversations in the **RPMS Patient Registration** application on **Page 8**.
**Application for Medical Services**

**IHS Medical Facility**

**SECTION A  PATIENT DEMOGRAPHIC INFORMATION**

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Name:</td>
<td>[LAST] [FIRST] [MIDDLE INITIAL]</td>
</tr>
<tr>
<td>Patient Sex:</td>
<td>[ ] MALE [ ] FEMALE</td>
</tr>
<tr>
<td>Other Names Used:</td>
<td></td>
</tr>
<tr>
<td>Date of Birth:</td>
<td></td>
</tr>
<tr>
<td>Place of Birth:</td>
<td></td>
</tr>
<tr>
<td>Social Security#</td>
<td></td>
</tr>
<tr>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td>City:</td>
<td></td>
</tr>
<tr>
<td>State:</td>
<td></td>
</tr>
<tr>
<td>Zipcode:</td>
<td></td>
</tr>
<tr>
<td>Religion:</td>
<td></td>
</tr>
<tr>
<td>Community Name:</td>
<td></td>
</tr>
<tr>
<td>How long have you lived at this address?:</td>
<td></td>
</tr>
<tr>
<td>Is this on a Reservation?:</td>
<td></td>
</tr>
<tr>
<td>Marital Status:</td>
<td>[ ] Single [ ] Married [ ] Widower [ ] Divorced [ ] Significant Other</td>
</tr>
<tr>
<td>Home Phone#:</td>
<td></td>
</tr>
<tr>
<td>Cell or Message Phone#:</td>
<td></td>
</tr>
<tr>
<td>Which Reservation?:</td>
<td></td>
</tr>
</tbody>
</table>

**SECTION B  PATIENT TRIBAL INFORMATION**

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you: [ ] Enrolled Tribal Member</td>
<td>Tribe Name:</td>
</tr>
<tr>
<td>[ ] Enrollment is Pending</td>
<td>Agency enrolled at:</td>
</tr>
<tr>
<td>[ ] A decedent of an Enrolled Member</td>
<td>Enrollment/Census #:</td>
</tr>
<tr>
<td>Father's Name:</td>
<td></td>
</tr>
<tr>
<td>[Last] [First] [Middle Initial] Date of Birth: Place of Birth:</td>
<td></td>
</tr>
<tr>
<td>Father's Tribal Affiliation?:</td>
<td>Economic Status:</td>
</tr>
<tr>
<td>Mother's Maiden Name:</td>
<td></td>
</tr>
<tr>
<td>[Last] [First] [Middle Initial] Date of Birth: Place of Birth:</td>
<td></td>
</tr>
<tr>
<td>Mother's Tribal Affiliation?:</td>
<td></td>
</tr>
<tr>
<td>Enrollment/Census#:</td>
<td>Economic Status:</td>
</tr>
<tr>
<td>Date of Death:</td>
<td></td>
</tr>
</tbody>
</table>

**SECTION C  EMPLOYMENT INFORMATION**

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you employed: [ ] Yes [ ] No</td>
<td>Employer Name:</td>
</tr>
<tr>
<td>If No, how long?</td>
<td>How long with employer?</td>
</tr>
<tr>
<td>Do you receive:</td>
<td>Employer Phone#:</td>
</tr>
<tr>
<td>Do you receive:</td>
<td></td>
</tr>
<tr>
<td>Are you a Student? [ ] Yes [ ] No</td>
<td></td>
</tr>
<tr>
<td>[ ] Full-time [ ] Part-time</td>
<td></td>
</tr>
<tr>
<td>If yes, where?</td>
<td></td>
</tr>
<tr>
<td>How long?</td>
<td></td>
</tr>
<tr>
<td>Do you receive:</td>
<td></td>
</tr>
<tr>
<td>Do you receive:</td>
<td></td>
</tr>
</tbody>
</table>

**SECTION D  SPOUSE/SIGNIFICANT OTHER INFORMATION**

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse/Significant Other Name:</td>
<td>Date of Birth:</td>
</tr>
<tr>
<td></td>
<td>SSN:</td>
</tr>
<tr>
<td>Is Spouse/Significant Other employed? [ ]</td>
<td></td>
</tr>
<tr>
<td>Yes [ ] No</td>
<td></td>
</tr>
<tr>
<td>Employer Name:</td>
<td></td>
</tr>
<tr>
<td>How long have they been with this Employer?</td>
<td>Their Employer Phone#:</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td>City:</td>
<td></td>
</tr>
<tr>
<td>State:</td>
<td></td>
</tr>
<tr>
<td>Zipcode:</td>
<td></td>
</tr>
</tbody>
</table>

**SECTION E  MILITARY SERVICE**

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Were you ever in any Military Service?</td>
<td>If YES, which Branch?</td>
</tr>
<tr>
<td>[ ] Yes [ ] No</td>
<td>Claim#</td>
</tr>
<tr>
<td>Entry Date:</td>
<td></td>
</tr>
<tr>
<td>Separation Date</td>
<td></td>
</tr>
<tr>
<td>Does Spouse/Significant Other receive:</td>
<td></td>
</tr>
</tbody>
</table>

I certify that the information provided on this form is true to the best of my knowledge.

________________________________________  ______________________________________
Signature                                             Date
# Application for Medical Services

## SECTION F  CONTACT INFORMATION

<table>
<thead>
<tr>
<th>Person who can be contacted in the event of an emergency:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td>Relationship:</td>
</tr>
<tr>
<td>Address:</td>
<td>City:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Next of Kin (Different from your Emergency Contact above)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td>Relationship:</td>
</tr>
<tr>
<td>Address:</td>
<td>City:</td>
</tr>
</tbody>
</table>

## SECTION G  ALTERNATE RESOURCE INFORMATION

### MEDICARE PROGRAM

<table>
<thead>
<tr>
<th>Do you currently have Medicare?</th>
<th>Medicare Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] Yes [ ] No</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Are you currently 65 years or older?</th>
<th>Are you disabled?</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] Yes [ ] No [ ] Yes [ ] No</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>AHCCCS or Out-of State MEDICAID Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you currently enrolled with the Arizona AHCCCS Program? If yes, please give Health Plan Name:</td>
</tr>
<tr>
<td>[ ] Yes [ ] No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If you are not enrolled in the Arizona AHCCCS Program, are you enrolled in another state?</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] Yes [ ] No State: __________</td>
</tr>
</tbody>
</table>

### PRIVATE INSURANCE

<table>
<thead>
<tr>
<th>Are you covered under a Private Insurance Plan?</th>
<th>If yes, what is the name of your insurance?</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] Yes [ ] No</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Who is the primary insured (policy holder)?</th>
<th>Their Social Security Number:</th>
<th>Date of Birth:</th>
</tr>
</thead>
</table>

## SECTION H  TRIBAL VERIFICATION (If applicable)

The Indian Patient identified above is receiving or has requested medical treatment at this IHS Facility. The Application for Medical Services Form has been completed and outlines facts relative to the patient status. Verification of this patient as a beneficiary of the PHS Indian Health Service Program falling within the priority of service established for your Service Unit is requested. This can be done by completing the lower part of this form. Your prompt reply will be appreciated.

[Please complete one of the options below]

<table>
<thead>
<tr>
<th>Option</th>
<th>[ ] Check if applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Option 1 Enrolled</td>
<td>(above named) with the date of birth of ____________________ is listed as a member of our tribe, with an enrollment/census number of ____________________, and is ______________________ (1/4, 1/2, 4/4) degree of ____________________________ Indian Blood.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Option 2 Descendent</th>
<th>(Tribe).</th>
</tr>
</thead>
<tbody>
<tr>
<td>I hereby certify that ___________________________________ parent of ______________________ as shown by Birth Certificate, is listed on our rolls with the number ______________________ and is ______________________ (1/4, 1/2, 4/4) degree of ____________________________ (Tribe).</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Option 3 Not Eligible</th>
<th>[ ] Check if applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Our agency does not show record of this applicant as being a member of the Tribe/Agency, nor is there evidence showing descendancy of this applicant. At this time, we ARE NOT acknowledging enrollment or descendancy of this applicant.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Verification</th>
<th>[ ] Check if applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>I hereby certify that I am authorized by the ______________________ tribe to make the above enrollment determination and that the above is true and correct.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date</th>
<th>Signature</th>
<th>Print Name &amp; Title</th>
</tr>
</thead>
</table>

Lori Aguilar, Chief, Patient Business Services
Phoenix Indian Medical Center

Form 58 Revised: 05/2002

Revised: 05/2002
B. Indian Blood Quantum Formula

The degree of Indian blood is computed from lineal ancestors of Indian blood, who were enrolled with a federally recognized Indian tribe or whose names appear on the designated base rolls of a federally recognized Indian Tribe.

To calculate your total Indian blood degree, add together your blood degree obtained from your birth mother and your blood degree obtained from your proven birth father.

To determine a child’s degree of Indian blood, use the Blood Quantum Formula (Microsoft Excel spreadsheet), in which you enter the blood quantum of the parents and it calculates the child’s degree of Indian blood.

To download Appendix B:

1. Go to the IHS Revenue Operations Manual website:
   http://www.ihs.gov/NonMedicalPrograms/BusinessOffice/index.cfm?module=rom

2. In the right panel, click Part 2 - Patient Registration.

3. In the right panel of the next webpage, click Chapter 1. Overview of Patient Registration.

4. In the table locate B. Indian Blood Quantum Formula and click xls in the “Other” column.

5. In the File Download dialog box, click Save to save a copy of the Excel spreadsheet on your local computer.
Name Change/Date-of-Birth Correction Request

PATIENT NAME __________________________________________ GIMC# ____________

UPDATE COMPLETED _____ (Y/N)   AOB/PA COMPLETED _____ (Y/N)   (Attach Face Sheet)

RECEIVED BY __________________________________________ DATE ____________

CORRECTION OF NAME

_____ Birth Certificate   _____ Court Order

NAME CHANGE DUE TO MARRIAGE

_____ Marriage License   _____ Family Profile Card

NAME CHANGE DUE TO DIVORCE

_____ Divorce Decree   _____ Court Order

DATE OF BIRTH CORRECTION

_____ Birth Certificate

Completed by __________________________________________ Date ____________

Document sent to THC by __________________________________________ Date ____________

Comments/Problems:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
ADMISSION CALL-IN/CHECK OFF LIST

DATE __________________ TIME _________________ CALLER’S NAME ____________________________________

PT NAME _____________________________________________ CHART # ________________ WARD ____________

SERVICE ___________________ DX _________________________________________________________________________

ADMIT TYPE: DIRECT/REFERRAL/TRANSFER __________________ ADMITTING PROVIDER _________________________

CALL REC’D AND ENTERED IN ADT BY ___________________ @ ___________________ & GIVEN TO ADMIT CLERK

NEWBORN ADMIT ONLY: MOTHER’S NAME __________________ CHART # ___________________

***********************************************************************************************************

CONFIRMATION OF ADMISSION

ADMIT TIME ___________________ OBSERVATION ADMIT? (Y/N) ___________ FULL ADMIT? (Y/N) ___________

***********************************************************************************************************

INITIAL ON COMPLETION

_____ THIRD PARTY VERIFICATION COMPLETED AND UPDATED ON PAGE 4 AND 8. ATTACH PRINTOUTS.

_____ PATIENT INTERVIEWED, UPDATE COMPLETED IN PT REGISTRATION DATABASE, PAGES 1 TO 9. ALL NOTES ON PAGE 8 UPDATED.

_____ VALUABLES COLLECTED & DEPOSITED. IF NONE, WAIVER IMPLEMENTED.

_____ IMPLEMENTED ADVANCE DIRECTIVE. REFERRAL MADE FOR ADVANCE DIRECTIVE PER REQUEST.

_____ SIGNATURES/THUMBPRINTS OBTAINED ON INPATIENT CONSENT FORM.

_____ HIS 912-1 COMPLETED FOR OBJECTION FOR INPATIENT DIRECTORY, IF APPLICABLE.

_____ MSP (MEDICARE SECONDARY PAYOR) FORM COMPLETED W/ SIGNATURES.

_____ “MESSAGE FROM MEDICARE” COMPLETED W/ SIGNATURES AND UPDATED ON PAGE 9. ATTACH COPY.

_____ PRE-CERT CALLED IN TO PAYOR, IF APPLICABLE. See Health Plan sheet for AZ. These plans need pre-authorizations.

_____ AUTHORIZATION NUMBER ___________________; (VERY IMPORTANT TO AVOID DENIAL) INFO NOTED ON PAGE 8.

_____ UPDATE COMPLETED IN PATIENT REGISTRATION DATABASE, PAGES 1 TO 9. ALL NOTES ON PAGE 8 UPDATED.

_____ NEWBORN ADMITS: RECORDED IN BIRTH LOG AND NUMBER CONTROL LOG CHECKED OFF.

_____ DR’S ORDERS HAVE BEEN CHECKED FOR ADMIT TYPE, SERVICE/PROVIDER AND CORRECT DX’S.

_____ FORMS PRINTED (2) 44’S, (1) FACE SHEET, ADDRESSOGRAPH CARD, (1) LOCATOR CARD, ID BAND MADE.

DISTRIBUTION: (1) 44 CENSUS, FILE LOCATOR (file room) REMAINING FORMS ➔ ADMIT PACKET (SEE BELOW)

_____ ADMISSION COMPLETED AND PACKET DELIVERED TO WARD BY ___________________ @ ___________________.

(ADMIT PACKET: 44 (Clinical Record Brief), 45 (Face sheet), addressograph card, armband, forms w/ signatures)

_____ PATIENT NOT INTERVIEWED. FACESHEET, 44, ARMABND, ADDRESSOGRAPH CARD DELIVERED TO WARD BY

_____@_____. (STATE REASON (S) BELOW) SUBMIT COPY OF COVER SHEET WITH 44 FOR INPATIENT CENSUS.

PROBLEMS/CONCERNS: (PLEASE INDICATE DATE/TIME & INITIALS)

____________________________________________________________________________________________________________

____________________________________________________________________________________________________________

____________________________________________________________________________________________________________

____________________________________________________________________________________________________________

____________________________________________________________________________________________________________

____________________________________________________________________________________________________________

____________________________________________________________________________________________________________

____________________________________________________________________________________________________________

Revised Aug 2005/fc