1. INTRODUCTION
Effective July 1, 2000, the United States Public Health Services/Navajo Area Indian Health Service (IHS) and Presbyterian Medical Services (PMS) of Santa Fe entered into a contract pursuant to which PMS administers health care claims for a specific population of Native Americans residing in a designated service area around Cuba, New Mexico. This program is managed in part by the PMS Checkerboard Area Health System (CAHS) located in Cuba, New Mexico.

This manual details procedures that are required of health care providers (“Participating Providers”) who seek to be reimbursed by PMS and/or IHS for provision of health care services to certain IHS beneficiaries.

2. COVERED POPULATION
The Native American population covered by this contract is part of the population served by the Crownpoint IHS Service Unit and is identified as IHS beneficiaries residing within defined chapter boundaries and portions of communities which may include: (1) Counselor, Ojo Encino and Torreon Chapters; (2) Star Lake, Cuba, Rincon Marcus and Tinian Communities; and (3) designated area southeast of Lybrook School. Such IHS beneficiaries are referred to herein as the “Covered Members.”

3. SUMMARY OF BENEFITS
Reimbursement to participating partners covers the provision of medically necessary health care services to Covered Members, including inpatient services with support services, emergency medical services, outpatient specialty services & diagnostic services, in accordance to IHS Priority 1.

4. **IHS PAYOR OF LAST RESORT**

The IHS is the “payor of last resort” for Covered Members, notwithstanding any State or Local law or regulation to the contrary.

A. IHS is a residual resource and not an entitlement program. As a result, neither PMS nor IHS will pay for services provided to a Covered Member if the Covered Member is (1) eligible for alternate payment resource (e.g., Medicare, Medicaid, private health insurance, worker’s compensation, etc.); or (2) would be eligible for an alternate payment resource under State or local law or regulation if he/she were not an IHS beneficiary.

B. When a Covered Member is potentially eligible for an alternative payment resource, Participating Providers are responsible for assisting the Covered Member in completing application forms necessary to obtain such payment resources. In addition, it is the Participating Provider’s responsibility to bill all applicable alternate payment resources.

5. **CARE COORDINATION**

A. Purpose

The purpose of the IHS Contract Health Care Coordination Program is to provide a framework to monitor and manage the use of patient care resources. The Care Coordination Program actively promotes the most efficient delivery of patient care services while maintaining a level of quality in keeping with professionally recognized standards. On behalf of IHS, PMS/CAHS conducts Care Coordination for patients who have IHS as their Primary Payor.

The primary objective of the Care Coordination Program is to facilitate the most appropriate use of resources for each patient based on clinical needs. Care Coordination provides an on-going evaluation of service appropriateness throughout the treatment process. This process begins prior to treatment and continues through the course of treatment.

1. All non-emergent services require prior authorization from PMS. This process is necessary to assure payment for services rendered.

2. **Prior to Treatment**, care coordination involves referral of treatment modalities to available resources and level of care which may be appropriate to meet patient’s immediate needs and to provide continuing care.

3. **During and After Treatment**, care coordination entails reviewing each patient’s clinical treatment information; promoting timely and efficient patient care services and ongoing continued care; discharge planning and aftercare follow-up with the patient, his/her family or guardians; and the involved inpatient/outpatient treatment for Native Americans residing within the defined Chapter boundaries and portions of the communities.

4. **Discharge Planning** - Discharge Planning assistance can be coordinated through the IHS care coordination team, who will work with all appropriate CAHS staff to assist in care coordination and planning.

B. **Prior Authorization**

1. Requesting Prior Authorization (PA) - All non-emergent services require prior authorization.
a. Requests for PA are to be directed to PMS/CAHS Claims Coordinator. Emergency medical services do not initially require PA but notification requirements apply. Notification to PMS/CAHS must be made within 72 hours for all non-emergent services. After notification, if the Covered Member receiving emergency services requires emergent inpatient care, the provider facility will notify PMS/CAHS Claims Coordinator. The Claims Coordinator can be reached at (575) 289-3291. Only services that have been prior authorized, using PMS/CAHS Diagnostic, Specialty and Coordinated Care form, will be considered for payment.

The PMS/CAHS Claims Coordinator is available Monday-Friday from 8am to 5pm. If the PMS/CAHS Claims Coordinator is not available, or if you send the request after hours, please fax Prior Authorization requests to 575-289-2320.

**PMS/CAHS DIAGNOSTIC, SPECIALTY AND COODINATED CARE FORM**

The PMS/CAHS Diagnostic, Specialty and Coordinated Care form is used to request Prior Authorization for all non-emergent services requested for Covered Members. The following fields are required in order for this claim to be considered for approval:

- **BOX 1** APPOINTMENT DATE AND TIME
- **BOX 2** FACILITY TO WHICH PATIENT IS BEING REFERRED
- **BOX 3** FACILITY PHONE #
- **BOX 4** FACILITY ADDRESS – INCLUDING ZIP CODE
- **BOX 5** PATIENT NAME
- **BOX 6** PATIENT GENDER
- **BOX 7** DATE OF BIRTH
- **BOX 8** MEDICAL RECORD NUMBER – REFERRING FACILITY #
- **BOX 9** MAILING ADDRESS
- **BOX 10** PATIENT PHONE # - IF APPLICABLE
- **BOX 11** TRIBAL AFFILIATION AND CIB # (IF AVAILABLE)
- **BOX 12** COMMUNITY/CHAPTER WHERE PATIENT RESIDES
- **BOX 13** EMERGENCY CONTACT & PHONE #
- **BOX 14** TYPE OF SPECIALTY
- **BOX 15** REASON FOR REFERRAL
- **BOX 16** PRIORITY OF REQUEST (PRC PRIORITY IS IN HOUSE FOR CAHS)
- **BOX 17** DIAGNOSIS
- **BOX 18** REFERRING PROVIDER – NAME AND CREDENTIALS
- **BOX 19** SPECIALTY PROVIDER NAME – NAME AND CREDENTIALS
- **BOX 20** CAHS STAFF MEMBER WHO AUTHORIZED REFERRAL
- **BOX 21** AUTHORIZATION # GIVEN BY CAHS STAFF MEMBER
b. A service may be authorized as a result of the prior authorization process. If it is approved, an authorization letter will be mailed to the Participating Provider at that time. However, if an authorization cannot be issued as a result of failure to meet criteria, the Participating Provider will be asked for additional information, if appropriate. If denial occurs, a letter will be issued stating the reason for denial.

(See Attachments A)

C. 72-Hour Notification Requirement

1. In non-emergency cases, a sick or disabled Covered Member, or any individual or agency acting on behalf of the Covered Member, or the Participating Provider shall, PRIOR TO THE PROVISION OF ANY MEDICAL CARE AND SERVICES, notify PMS/CAHS IHS Claims Management office of the need for services and the individual’s eligibility by faxing the notification for to the IHS Claims Coordination fax number – (575)289-2320.

The PMS/CAHS Contractor 72 hour Emergency Notification and Prior Authorization Request Form is all emergency room visits and for services requested as a result of emergency room visits, and for all hospitalizations for Covered Members. The following fields are required in order for this claim to be considered for approval:

- BOX 1 PATIENT NAME
- BOX 2 PATIENT SOCIAL SECURITY NUMBER
- BOX 3 PATIENT ADDRESS
- BOX 4 PATIENT DATE OF BIRTH
- BOX 5 PATIENT COMMUNITY OF RESIDENCE
- BOX 6 PATIENT DATE OF EMERGENCY ROOM VISIT OR ADMISSION
- BOX 7 PATIENT DISCHARGE DATE
- BOX 8 PATIENT INSURANCE PAYOR TYPE – IHS ONLY
- BOX 9 PATIENT INSURANCE PAYOR TYPE – MEDICARE, SPECIFICALLY
- BOX 10 PATIENT INSURANCE PAYOR TYPE – 3RD PARTY INSURER
- BOX 11 PATIENT INSURANCE PAYOR TYPE – MEDICAID, SPECIFICALLY
- BOX 12 DATE OF AUTHORIZATION REQUEST
- BOX 13 DATE PAYOR TYPE VERIFIED
- BOX 14 FACILITY CONTACT PERSON, FOR QUESTIONS
- BOX 15 FACILITY CONTACT PHONE #
- BOX 16 FACILITY CONTACT E-MAIL ADDRESS
- BOX 17 EMERGENCY ROOM HOSPITAL NAME
D. **Referral Process**

Prior Authorization must be obtained by the Participating Provider for referral of Covered Members to other health care providers. (The Covered Member is to be returned to the Participating Provider as soon as medically appropriate for monitoring of progress.) **This requirement includes referral to radiology programs.**

1. The referring Participating Provider is to complete, date and sign (signature stamp is acceptable) the Presbyterian Medical Services/CAHS Referral Form to Checkerboard Area Health System Claims Coordinator. If obtaining prior authorization by telephone, the Participating Provider is to write the Claims Coordinator’s name or authorization number and date in the space provided on the form.
E. Utilization Review
Utilization Review (UR) is performed through Presbyterian Medical Service’s utilization Review Team.

1. Utilization Review Team
The Utilization Review Team follows Covered Members through regular telephone review with Participating Provider staff. Length of stay may be extended or decreased according to Covered Members’ progress. Transfer of Covered Members to IHS hospitals may be coordinated by PMS/CAHS UR Team if long term hospitalization is required and patient condition will allow the transfer.

2. Length of Stay Reconsideration
PMS has established mechanisms for hospitals to request further days of stay. This request may be verbal or written. Additional documentation or information may be requested by the PMS/CAHS Utilization Review Team or Administrator in order to increase length of stay.

3. Retrospective Claims Review
Retrospective review is conducted by the PMS/CAHS Utilization Review Team and/or Administrator. All claims submitted by providers are reviewed to make sure the services being billed are covered and are medically necessary. Claims meeting the criteria are processed for payment. Denial letters are sent to provider for claims not meeting contract criteria.

BILLING FOR SERVICES

A. ACCEPTABLE CLAIM FORMS
PMS/CAHS requires all providers to use one of two forms when submitting claims for payment:

1. A current HCFA 1500 billing form is used when submitting claims for all professional services, including ancillary services and professional services rendered in a hospital setting. The current HCFA 1500 is the one dated (02/12).

2. A UB04 CMS1450 billing form is used when submitting hospital facility charges for inpatient and outpatient services.

PMS will not process claims received on any other type of claim form.

B. COMPLETING A HCFA 1500
When filing a claim on HCFA 1500, there are certain fields on the form that are required to be completed. Listed in this section are the required field numbers, along with explanations. The number of the field corresponds with the field number on the HCFA 1500 claim form.

HCFA 1500 FORM (02/12 VERSION)
The HCFA 1500 form is used to bill professional services provided to Covered Members. The following fields are required in order for this claim to be considered a clean claim:

BOX 1      PROGRAM
BOX 1a     INSURED’S ID NUMBER
The **UB04 CMS 1450** will be used to bill facility services provided. The following fields are **required** in order for this claim to be considered a clean claim:

- **BOX 1** PROVIDER NAME, ADDRESS AND TELEPHONE NUMBER
- **BOX 3A** PATIENT CONTROL NUMBER
- **BOX 3B** MEDICAL RECORDS #
- **BOX 4** TYPE OF BILL
- **BOX 5** FEDERAL TAX ID NUMBER
- **BOX 6** STATEMENT COVERS PERIOD
- **BOX 8A** PATIENT NAME
- **BOX 9A-E** PATIENT ADDRESS
- **BOX 10** PATIENT BIRTHDATE
- **BOX 11** PATIENT GENDER
- **BOX 12** ADMISSION/START OF CARE DATE
- **BOX 13** ADMISSIONS HOUR
- **BOX 14** TYPE OF ADMISSION
- **BOX 15** SOURCE OF ADMISSION
- **BOX 16** DISCHARGE HOUR
- **BOX 17** PATIENT STATUS
- **BOX 18-28** CONDITION CODES
- **BOX 38** RESPONSIBLE PARTY NAME AND ADDRESS
- **BOX 42** REVENUE CODE
D. **CLAIM SUBMISSIONS REQUIREMENTS**

PMS requires that Participating Providers initially submit claims for payment within ninety (90) days from date of service. A “clean claim” is defined as one that can be processed (adjudicated) without obtaining additional information from the provider of service or from a third party.

*Failure to adhere to this requirement will result in the denial of your claims. In order to assure proof of timely filing please: Fax claims to 575-289-2320 with a coversheet listing claims; or mail claims certified return receipt to address below – include a cover sheet listing claims or scan claims and e-mail them to rena.castillo@pmsnm.org with a copy to teresa.woodfill@pmsnm.org*

These methods will be the only accepted proof of timely filing.
You are required to submit claims for all services rendered.

Please mail new claims to:

PMS Central Billing Office
Attention: IHS Claims
6000 Uptown Blvd. Ste 400
Albuquerque, NM 87110
(877) 222-4521

E. RESUBMITTING A CLAIM

If you feel your claim has not been properly processed, PMS/CAHS has set up a procedure to help you resolve those issues and resubmit your claim.

Although you may have met the initial ninety (90) day claim submission requirement, you have ninety (90) additional days from the date of adjudication to resubmit your claim for adjustment.

If you want to resubmit a claim, you must do the following:

1. Make a copy of your claim
2. Make a copy of the remittance advice.
3. Make a notation on the claim the remittance advice explaining why you are resubmitting the claim and clearly indicate any corrections you have made. Please sign and date your notation and provide Presbyterian Medical Services with a telephone number should we need to contact you.

Mail the claim and all attachments to:

PMS Central Billing Office
Attention: IHS Claims
6000 Uptown Blvd. Ste 400
Albuquerque, NM 87110
(877) 222-4521

The original 90 day submission requirements must be met in order to re-submit a corrected claim.

F. APPEAL OF A DENIED OF CLAIM

If you want to appeal the denial of a claim, you can do so within 30 days of the date of the denial letter. To have a denied claim reconsidered for payment, please do the following:

1. Make a copy of the claim and the letter of denial.
2. Make a copy of proof of timely filing, proof of patient residence, or any other supporting data that will assist in the reconsideration.
3. Send a memo or note justifying why you are appealing the denial. Please sign and date your request and include a telephone number should we need to contact you.
4. Mail the claim and all attachments to:

PMS/CAHS
Attention: Administrator
P.O. Box 638
Cuba, NM 87013

5. You will receive notification of the appeals decision within ten (10) working days.
If your appeal is denied by the Administrator, you may request further reconsideration by sending the above information the CAHS Region Director at:

PMS/CAHS
Attention: Region Director
P.O. Box 638
Cuba, NM 87013

G. THIRD PARY RESOURCES- SECONDARY PAYOR
By law, IHS is always the payor of last resort for Native Americans. Therefore, you must bill all third party resources and obtain an explanation of benefits from any other third party resource prior to billing PMS and/or IHS.

Once you receive the EOB from the alternate payor, you can then complete the appropriate claim form, and attach the EOB to that claim form and submit it to:

PMS Central Billing Office
Attention: IHS Claims
6000 Uptown Blvd. Ste 400
Albuquerque, NM 87110
(877) 222-4521

You have 90 days from the date of primary payment to submit your claim and the EOB. Claims for services submitted without EOB will be denied.

6. GRIEVANCE AND COMPLAINT PROCESS
A complaint or grievance may be filed by a Participating Provider if there is dissatisfaction with any aspect of the PMS/CAHS claims administration. This includes, but is not limited to: service, utilization management and claims processing. Disagreements that exist between you and PMS/CAHS such as denial letters and authorizations of services are handled through the process described in Section 5.F.

To file a complaint or grievance, the Participating Provider may follow these steps:

A. Contact the PMS/CAHS Claims Processing Coordinator at (575)289-3291 or you may submit a written complaint to:

PMS/CAHS Administrator
P.O. Box 638
Cuba, NM 87013

B. If your complaint is not resolved to your satisfaction, you may request a formal view. This review will be conducted by the CAHS Administrator, Region Director and/or PMS, Director of Operational Support. Please send this request, listing your complaint, in writing and mail this and any other additional information to PMS/CAHS Administrator, at the above address. You will receive notification within ten (10) working days acknowledging the receipt of your request and a decision regarding your request within thirty (30) days.

7. COMMITTEES
A. Utilization Review Team
The IHS Claims Coordinator and Administrator meet on a weekly basis, more frequently if needed, to discuss in-patient/discharge needs of PMS/CAHS patients. CAHS Region Director and/or PMS/Director of Operational Support may be included in person, by telephone or by e-mail. The PMS Vice President of Clinical Affairs participates in the Utilization Review Team when there are questions regarding clinical decisions or Priority 1 determination.

8. CREDENTIALING
PMS/CAHS deems credentialing status to a practitioner that can provide evidence that they have been credentialed by a JCAHO or NCQA accredited organization, when requested. If unable to provide this evidence, you will be subject to additional documentation.
# PMS/CHECKERBOARD AREA HEALTH CENTER (CAHS)
## Diagnostic, Specialty and Coordinated Care Form

### CAHS PATIENT REFERRAL

<table>
<thead>
<tr>
<th>FACILITY REFERRED TO:</th>
<th>APPOINTMENT DATE:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>TIME:</td>
</tr>
</tbody>
</table>

| FACILITY PHONE NUMBER: | |
|------------------------||

| FACILITY ADDRESS: | |
|-------------------||

<table>
<thead>
<tr>
<th>PATIENT NAME:</th>
<th>SEX:</th>
<th>DOB:</th>
<th>CHART #:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>MAILING ADDRESS:</th>
<th>PHONE #:</th>
<th>TRIBAL AFFILIATION:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>COMMUNITY/CHAPTER:</th>
<th>EMERGENCY CONTACT &amp; PHONE #:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>SPECIALTY REFERRED TO:</th>
<th>SCHEDULING PRIORITY:</th>
<th>PRC PRIORITY:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ 24 Hrs</td>
<td>□ 1</td>
</tr>
<tr>
<td></td>
<td>□ 1-3 Weeks</td>
<td>□ 2</td>
</tr>
<tr>
<td></td>
<td>□ &gt; 1 Month</td>
<td>□ 3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>REASON FOR REFERRAL:</th>
</tr>
</thead>
</table>

### Diagnosis:

### Referring Provider:

### Specialty Provider Name:

---

**Authorized by:** ___________________________  **Authorization #:** ___________________________

**PMS/CAHS USE ONLY**

- **PRIVATE INSURANCE:**
  - □ A
  - □ B

- **MEDICAID FFS**
  - □ ID#: ___________________________

- **MGD CARE MEDICAID**
  - □ PHP
  - □ MOLINA
  - □ BCBS
  - □ UHC
  - □ ID#: ___________________________

- **PMS/CAHS PRIMARY PAYOR**
- **PMS/CAHS SECONDARY PAYOR**

**PMS/CAHS Claims Submission**

Attention: Rena Castillo, IHS Claims Coordinator
renacastillo@pmsnm.org
Box 638 Cuba, NM 87013
289-3291 (575) 289-2320 (fax)

**Additional Follow-Up Authorizations**

<table>
<thead>
<tr>
<th>Authorization #</th>
<th># of Visits Approved</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
PMS/CAHS CONTRACTOR
72hour EMERGENCY NOTIFICATION AND PRIOR AUTHORIZATION REQUEST FORM

Patient: ___________________________ Soc. Sec. #: ___________________________
Address: __________________________ Date of Birth: __________________________
Community of Residence: __________________________ Admit Date: ____________ Discharge date: __________________________
Payor Type: IHS only __________________________ Medicare __________________________ 3rd Party __________________________ Medicaid __________________________
Date of Authorization Request: __________________________ Payor Type Verification Date: __________________________
Facility Contact Person: Name __________________________ Phone #: __________________________ E-mail __________________________

SECTION 1. EMERGENCY HOSPITALIZATION (Requires 72hour notification by fax to 575-289-2320)

What Hospital: __________________________
Hospital Address: __________________________
Hospital Phone #: __________________________ Fax #: __________________________
Diagnosis: __________________________ Diagnosis (ICD-9) Code: __________________________
Mode of Emergency transport: Ambulance _____ Helicopter _____ Fixed Wing _____ Unknown _____

Confirm Receipt of Notification date __________________________ Verified Patient covered by PMS/IHS Contract _____ Y _____ N
Approval Authorization #: __________________________

SECTION 2. HOSPITALIZATION PRIOR AUTHORIZATION (Required for all non-emergent hospitalizations)

Hospitalization – What Hospital: __________________________
Hospital Address: __________________________
Hospital Phone #: __________________________ Fax #: __________________________
Diagnosis: __________________________ Diagnosis (ICD-9) Code: __________________________
Approved _____ Denied _____ Reason for denial __________________________ Denied by __________________________
Approval Authorization #: __________________________

Authorization approval is always pending receipt of Medicaid Approval or Denial

Follow up Information: Please provide PMS/CAHS with clinical summary for patient’s PCP.