DEPARTMENT OF HEALTH & HUMAN SERVICES
Public Health Service
Bemidji Area Indian Health Service

Bemidji, Minnesota

Indian Health Service Circular No. 03-05

POLICY ON HIGH RISK/HIGH COST CASE MANAGEMENT

SECTION

1. **PURPOSE**: This Circular establishes Bemidji Area Indian Health Service policy and procedures for the management of high risk/high cost care cases within the Bemidji Area.

2. **BACKGROUND**: The Catastrophic Health Emergency Fund (CHEF) was established during Fiscal Year 1987, by Public Health Law 99-591, to cover the Indian Health Service (IHS) portion of medical expenses for catastrophic illnesses and events. In 1988, the Indian Health Care Improvement Act (Public Law 100-713) established the Indian Catastrophic Health Emergency Fund (CHEF) as a new program to supplement the extraordinary medical costs associated with the treatment of eligible victims of disasters or catastrophic illnesses.

   Catastrophic illness refers to medical conditions which are costly in terms of intensity and/or duration of treatment. Some examples of catastrophic illness or events include cancer, burns, premature births, cardiovascular disease (heart attacks, stroke), end stage renal disease, organ transplants, trauma-related cases such as automobile accidents and gunshot wounds, and some mental disorders. These illnesses or events require multiple hospital stays and extensive treatment. CHEF covers the medical expenses for catastrophic illnesses and events exceeding a defined threshold, e.g., $15,000.00, and meeting IHS payment responsibilities.

   The Director, Indian Health Service, issued new revised administrative guidelines for the IHS Catastrophic Health Emergency Fund. These guidelines have been in effect since October 1, 1992.

3. **POLICY**: It is the policy of the Bemidji Area Indian Health Service that High Cost Case Management (HCCM) review shall be performed at the Bemidji Area Service Units on every high risk/high cost case which has the potential of becoming a CHEF case. The Bemidji Area highly recommends that all Tribally contracted health care programs also implement High Cost Case Management (HCCM).

HCCM review includes an array of services involving certification, monitoring, and management of a case during an episode of illness or injury. The goal is to ensure that quality care is provided at the most reasonable price possible, while also optimizing the patient's medical, personal, social and/or cultural needs.

CHEF is available to the Bemidji Area Service Units and all Tribally operated health care programs for expenditures on eligible patients who incur extraordinary medical costs. The Bemidji Area Service Units or Tribally operated health care programs shall not be eligible for reimbursement for the cost of treatment from CHEF until the cost of treating any victim of catastrophic illness or event has reached the applicable threshold cost allowable.

Before assistance can be authorized through the CHEF Program, a determination must be made that the patient is eligible for both direct and contract health care services (CHS). The Bemidji Area Service Units and all Tribally operated programs must also ensure that no payment is made from CHEF to any provider if that provider is eligible to receive payment for treatment from any other Federal, State, local, or private source of reimbursement for which the patient is eligible.

This Circular shall supplement, not replace, the 1992 Administrative Guidelines for the IHS Catastrophic Health Emergency Fund.

The Bemidji Service Units shall establish and maintain a CHS Review Committee to review all high risk/high cost CHS cases. The Bemidji Area highly recommends that all Tribally contracted health care programs establish and maintain the Tribal equivalent of a CHS review committee.

4. **DEFINITIONS**: The following definitions are applicable to this Circular:

A. Case Management – Programs that provide individualized planning, management, and review for high risk/high cost patient cases.

B. Catastrophic Health Emergency Fund (CHEF) – The funds created by Congress to cover medical expenses incurred for catastrophic illnesses and events falling within the CHS payment responsibility of the IHS.

C. Catastrophic Illness – An episode of acute medical care for a condition resulting from an illness or injury, requiring extensive treatment, which incurs major medical costs to the IHS in excess of the CHEF threshold.

D. Catastrophic Event – A situation involving one or more people who, individually or collectively, incur major medical expenses in excess of the CHEF threshold.

E. Cost Effective – A comparison that evaluates alternative choices on a cost vs. benefit basis to ascertain the optimal choice among alternatives.

F. Threshold Cost – A designated amount above which incurred medical costs will be considered for CHEF reimbursement after a review of the authorized expenses and diagnosis.

G. Episode of Care – The period of consecutive days for a discrete health condition during which reasonable and necessary medical services related to the condition occur.

H. CHEF Manager - The person designated within IHS to oversee the management of the CHEF Program.

I. CHEF Case Management – The utilization review process for an episode of catastrophic illness, whereby a patient's treatment is monitored to ensure quality care and that the most appropriate facility or cost effective rates are utilized where possible.

J. Case Manager – The primary care physician, utilization review nurse, or clinical director responsible for overseeing and monitoring the high risk/high cost care throughout the episode of care.

K. High Risk/High Cost Care – Any CHS case that actually exceeds (or may potentially exceed) a medical cost of $15,000.00.

L. High Cost Care Management (HCCM) – The process by which a CHEF case and/or other high cost/high risk case is certified and monitored during an episode of illness. The goal is to ensure quality care, cost containment, and accessibility to other health services. The process shall respect the unique needs of the patient, including personal, social, cultural, and environmental factors.

M. Quality Care – Care which conforms to accepted principles of medical science, is provided in a timely and sensitive manner, involves the patient as an informed participant, and optimizes improvement in his/her health. Quality care also makes efficient use of technology and is sufficiently documented to allow continuity, evaluation, and appropriate treatment.

N. Utilization Review – Processes which evaluate the necessity, appropriateness, and efficiency of medical services, procedures and facilities.

5. **VERIFICATION PROCESS**:

The minimum components necessary for Bemidji Area certification of High Cost Case Management (HCCM) include the verification of the following:

A. Eligibility Determination

B. Medical Priority Determination

C. Case Manager Assignment: The service unit will provide documentation of managed care discussion in regards to (HCCM) cases and identify on lead Case Manager to follow the case i.e. Clinician (Physician, Quality Assurance Nurse, Utilization Review Nurse, etc.)

(1) Pre-admission Review
(2) Quality of Care
(3) Concurrent Review of Care: The service unit will provide documentation of Management Care Team being in accordance on decision of case
(4) Discharge Planning

D. Alternate Resources Determination: Medicare, Medicaid (Title XIX), Private Insurance, Veteran status, etc.

E. Obligations: Validation and verification of accurate obligations per contract rates, etc.

F. Cost Containment

(1) Contract Usage (other sources and agreements, i.e., Veterans Administration (VA) Shared Services Agreement)
(2) Use of Centers of Excellence as appropriate
(3) Claims Processing and Monitoring

G. Program Integrity

H. Timely submission of CHEF reimbursement requests

(1) Timeliness of Obligation
(2) Timeliness of Bemidji Area Service Unit/Tribal submission to the Bemidji Area Office
(3) Timeliness of Bemidji Area submission to IHS Headquarters.

(4) Timeliness of Headquarters determination/payment.

6. **RESPONSIBILITIES**:

A. CHS Review Committee: The Committee membership should include the Clinical Director, CHS Specialist, Utilization Review Coordinator, Social Worker, and Primary Care Physician, or other appropriate staff for direct care facilities. For those facilities that only provide CHS, the committee membership should be comprised of the CHS Specialist, Case Manager or equivalent and other appropriate staff with clinical expertise.

The CHS Review Committee's responsibilities shall include:

(1) Meet once weekly; or more frequently if necessary.

(2) Verify that each high risk/high cost case meets the CHS eligibility criteria, including status of alternative resources.

(3) Certify that managed care principles are utilized by providing high quality services at the most appropriate locations from the most cost effective provider.

(4) Promote and ensure coordination among all Committee members, CHS staff, and other pertinent medical staff who are responsible for the identification, management, and/or payment of high risk/high cost cases.

(5) On a weekly basis, evaluate each CHEF case for the following:

a. Patient Data

- Review and confirm patient information, diagnosis, and anticipated length of stay at the non-IHS facility.
- Verify the charges and dates of services reported by the provider against total IHS obligations to date.
- Ensure there are adequate obligations to cover the total costs should the case NOT be funded through the CHEF program.

b. Medical Treatment Plan

- Assess the patient's medical treatment plan (for appropriateness).

- Consider the feasibility of moving the patient to an IHS or less costly contract facility.

- Monitor case on a regular basis until the patient is discharged.

- Ensure that the provider initiates discharge planning.

c. Provider Data

- Ensure the patient is referred to provider(s) who have contracts and/or agreements with the IHS.

d. Discharge Planning and Follow-up

- Ensure the non-IHS provider develops an appropriate discharge plan for the patient.

- Ensure the discharge plan is implemented by the patient, patient's family or significant others, IHS facility, or other non-IHS facility.

- Close-out the case within three (3) months after the patient is discharged from the non-IHS facility.

B. Meetings of the CHS Review Committee:

The committee should meet at least once weekly, and more frequently if necessary. The following are suggested procedures for the Committee to follow:

(1) The Clinical Director will serve as Chairperson of the Committee.

(2) The CHS Specialist(s) will be responsible for preparing and furnishing pertinent information on all high risk/high cost cases.

(3) The CHS Specialist(s) will serve as recorder, to document and maintain minutes of the CHS Review Committee meetings. The minutes should reflect the following:

a. The patient meets CHS eligibility criteria.
b. The patient's case is within medical priorities.
c. Funds are available.
d. Requested medical service is not available in IHS facility.
e. Referral to non-IHS provider is justified and appropriate.
f. The patient was fully screened for alternate resources.

g. Appropriate case management is being employed.

(4) Written minutes of each Committee meeting will be reviewed and approved by the Clinical Director (or equivalent). Copies of these minutes must be maintained at the health facility for review by higher authority if appropriate. The CHEF Fund Manager may request case files from time-to-time to audit records and verify case management.

C. Case Manager Responsibilities:

To ensure quality care, cost containment, and accessibility to other health services, the Bemidji Area Service Units must assign a case manager to every high risk/high cost case. The Case Manager must be either the primary care physician, the utilization review nurse, the clinical director, or other appropriate medical staff person. The Bemidji Area highly recommends that all Tribally contracted health care programs assign an appropriate clinical staff person as a case manager. The responsibilities of the Case Manger include:

(1) Verify the appropriateness of diagnosis, treatment plan, and initial cost estimates.

(2) Perform daily telephone rounding with the non-IHS provider(s), and monitor the patient's treatment plan and expenditures.

(3) Ensure there is appropriate discharge planning.

(4) Be responsible for presenting the case to the CHS Review Committee or Tribal equivalent on a weekly basis.

(5) Be responsible for the accurate and timely completion of the Catastrophic Case Management Check List (see Exhibit I).

D. CHS Specialist and Staff Responsibilities:

The CHS Specialists and other CHS staff are the key people in implementing, maintaining, and ensuring compliance of the policy and procedures for the management of high risk/high cost cases within the programs.
The responsibilities of these staff include:

(1) Identify and present high risk/high cost cases to the Case Review Committee or Tribal equivalent on a timely basis
(2) Maintain records on each high risk/high cost case and ensure the appropriateness and completeness of case before it is reported as a CHEF case.

(3) Obligate CHS funds for each high risk/high cost case (for which IHS is responsible) within five (5) business days after the patient is transported to a non-IHS facility.

(4) Complete the Catastrophic Health Emergency Fund (CHEF) Reimbursement Request (see Exhibit II) and submit the form to the Bemidji Area Office within thirty (30) days after the CHEF threshold has been met.

(5) Administratively, ensure the patient is referred to IHS contract provider(s), IHS Centers for Excellence, or VA facilities with Shared Services Agreements.

(6) Assist the clinical director or Tribal health professional to schedule and conduct the weekly CHS Review Committee or Tribal equivalent meetings.

(7) Ensure that every CHEF case is reconciled, updated, and closed-out within 120 days after the patient is discharged from a non-IHS facility. If a case is not closed because of pending alternate resources, submit a written request to the Bemidji Area Office CHS Program for a 60-day extension of time.

(8) If the CHEF case was paid by alternate resources or if actual disbursements are less than the CHEF advance received, and unused funds must be returned to IHS Headquarters CHEF Account. Upon notification from the Bemidji Area Service Units or Tribal Health Program, the Bemidji Area Office will process documentation necessary to return these funds.

E. Bemidji Area CHS Program Responsibilities:

The Bemidji Area Health Resource Management Specialist (CHS Officer) shall provide the organizational leadership in implementing, maintaining, and ensuring compliance of the policies and procedures as outlined within this Circular. These responsibilities include:

(1) Review and certification of all HCCM policies and procedures.
(2) Review and evaluation of all CHEF cases submitted by the Bemidji Area Service Units and all Tribal Health Programs.
(3) Assignment of an identification number to every CHEF case reported.
(4) Review of each CHEF case for appropriateness and completeness. If it is determined to be appropriate and complete, submit the case to IHS Headquarters within five (5) working days after receipt. Otherwise, return the case to the Bemidji Area Service Units or referring Tribal Health Program with pertinent instructions.

(5) For each case reviewed, the Bemidji Area CHS Officer will document any discussions with the local medical authorities regarding the medical care, diagnosis, treatment, etc., to ensure compliance with case management principles.

(6) To work with the Division of Financial Management to ensure the proper accounting of funds.

(7) To work with the Division of Extramural Awards and Agreements to ensure that contract modifications are processed for any P.L. 93-638 Tribal Programs.

(8) Provide technical assistance to the Bemidji Area Service Units and, if requested, to the Tribal Health Programs.

(9) Identify emerging issues and setbacks, and provide organizational leadership in resolving these challenges.

(10) Maintain statistical data and fund control information.

(11) Review cases which are open for more than 120 days and follow-up with the Bemidji Area Service Units and all Tribal Health Programs to ensure timely closure of these cases.

(12) Periodically perform a review of casework and management practices at the Bemidji Area Service Units and, if requested, at the Tribal Health Program.

7. **EXHIBITS**: See Attachments.

8. **EFFECTIVE DATE**: This circular shall remain in effect until cancelled or superseded.

Date: 5/14/03

Kathleen Annette, M.D.
Area Director
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EXHIBIT I

BEMIDJI AREA INDIAN HEALTH SERVICE

CATASTROPHIC CASE MANAGEMENT CHECK LIST

Facility _____ Date Completed _____

1. Medical Management

   A. Name of referring IHS/Tribal physician _____

   B. Name of case manager/primary contact person _____

   C. Case review by Program Resource Management Committee is done
   ( ) Yes ( ) No

   D. Follow-up review planned _____

   E. Initial medical diagnosis is documented on CHEF application ( ) Yes ( ) No

   F. Brief summary of intended course of treatment _____
   _____
   _____

   G. Patient/Family counseled and documented ( ) Yes ( ) No

   Comments: _____
   _____
   _____

   _____
   Physician or Case Manager

2. Contract Health Services

   A. Screening for alternate resources has been done ( ) Yes ( ) No

   B. Pre-authorization issued _____

3. Patient Care Team (check disciplines involved)

   Mental Health _____ MCH _____ PHN _____ Home Health _____

   Social Services _____ Hospice _____ CHR _____ QA Coordinator _____
   Other _____

   _____
   SUD or Tribal Health Director