Introduction to the Purchased/Referred Care (PRC) & Catastrophic Health Emergency Fund (CHEF) Programs

Indian Health Service

Salena Nicole Massey
Program Analyst
Portland Area Office

Ed Chasing Hawk
Management Analyst
IHS Headquarters

Objective

By the end of this session, participants will be able to:

- Describe the basic principles of the PRC program
- Identify key PRC eligibility requirements
- Explain the role of alternate resources and medical priorities
- Recognize basic PRC authorization, payment, denial, and appeal processes
- Learn the basics of creating and submitting a CHEF case for reimbursement.

What is Purchased/Referred Care (PRC)?

From 42 CFR Part 136:

"Contract Health Services means health services provided at the expense of the Indian Health Service from public or private medical or hospital facilities other than those of the service."*

***The Consolidated Appropriation Act of 2014 renamed the Contract Health Services (CHS) program to the Purchased/Referred Care (PRC) program. All policies and practices remain the same.

IHS Direct Care (42 CFR§136.12)

Indian Descent: A person requesting ***IHS Direct Care Services**** must provide proof of enrolled membership; or proof that he/she descends from an enrolled member, of a federally recognized tribe (42 CFR 136.12). PRC eligibility begins with the eligibility for Direct Care services.

services available onsite at an IHS or Tribal Health Facility.

There are 575 U.S. Federally Recognized Tribes (as of August 2026)

Tribes are recognized by Federal recognition statute or through the Bureau of Indian Affairs (BIA) administrative recognition process.

Patient Registration

PRC eligibility begins with Direct Care eligibility. Accurate and current patient registration information is essential to determining eligibility, coordinating referrals, and processing PRC payments.

- **Demographic & Contact Information:** Verify mailing and physical addresses, telephones numbers, emergency contacts, and other demographic information at each visits.
- **Tribal Documentation:** Maintain Tribal enrolment and/or descendant documentation required for Direct Care eligibility.
- **Alternate Resources:** Update private insurance, Medicare, Medicaid, and other Alternate Resource (AR) information. PRC is a payor of last resort.
- **Verification:** Verify Alternate Resource information using available systems, portals, and other resources.
- **Other Documentation:** Obtain additional information required by IHS such as assignment of benefits.

Keep your information up to date

PLEASE HELP US KEEP YOUR INFORMATION UP TO DATE

We will ask you to verify your information at EVERY VISIT.

Even if nothing has changed, please confirm that your information is still correct.

WHY DO WE ASK? Accurate information helps us provide your care, contact you when needed, and process Purchased/Referred Care (PRC) referrals.

What We Will Ask You to Verify

1. **ADDRESS**
   Mailing address for health, appointment, and PRC referral information. We also need your physical residence location for PRC referral purposes.
2. **PHONE NUMBER**
   A current number so IHS can contact you about important health information, lab results, appointments, or information from private-sector health care providers.
3. **HEALTH INSURANCE**
   Current private insurance, Medicare, or Medicaid information. Incorrect or outdated information may delay PRC payment.
4. **TRIBAL ENROLLMENT**
   If needed, we may ask you to provide enrollment information or sign a Release of Information so we can obtain it from your Tribe.
5. **OTHER INFORMATION**
   We may also ask you to verify employment, emergency contact, and other demographic information.

"EVERYTHING IS THE SAME."

That is okay! We still need you to confirm your information at each visit.

Thank you for your patience and cooperation with our Patient Registration staff.

Keeping your information current helps prevent unnecessary delays with your care and PRC services.

Residency (42 CFR §136.23)

To be PRC eligible, an applicant must be a member **or** a descendant of an enrolled member of a federally recognized tribe; and reside on a reservation, or;
If not residing on a reservation, must reside within a PRC Delivery Area (PRCDA); and:

- Are members of the tribe(s) located on that reservation; or

  Maintain close economic and social ties with that tribe.

  "Residence: Where a person lives and makes his or her home as evidenced by acceptable proof of residency or acceptable proof established by the Service Unit." Persons claiming PRC eligibility have the responsibility to furnish documentation to substantiate the claim.

- Proof of Residency Policy and/or **IHS-976 form**..
  https://www.hhs.gov/sites/default/files/ihs- 976.pdf

- PRCDA: consists of a county which includes all or part of a reservation, and any county or counties which have a common boundary with the reservation.

Illustration/Example of a PRCDA on the next slides…

Illustration of a current PRCDA

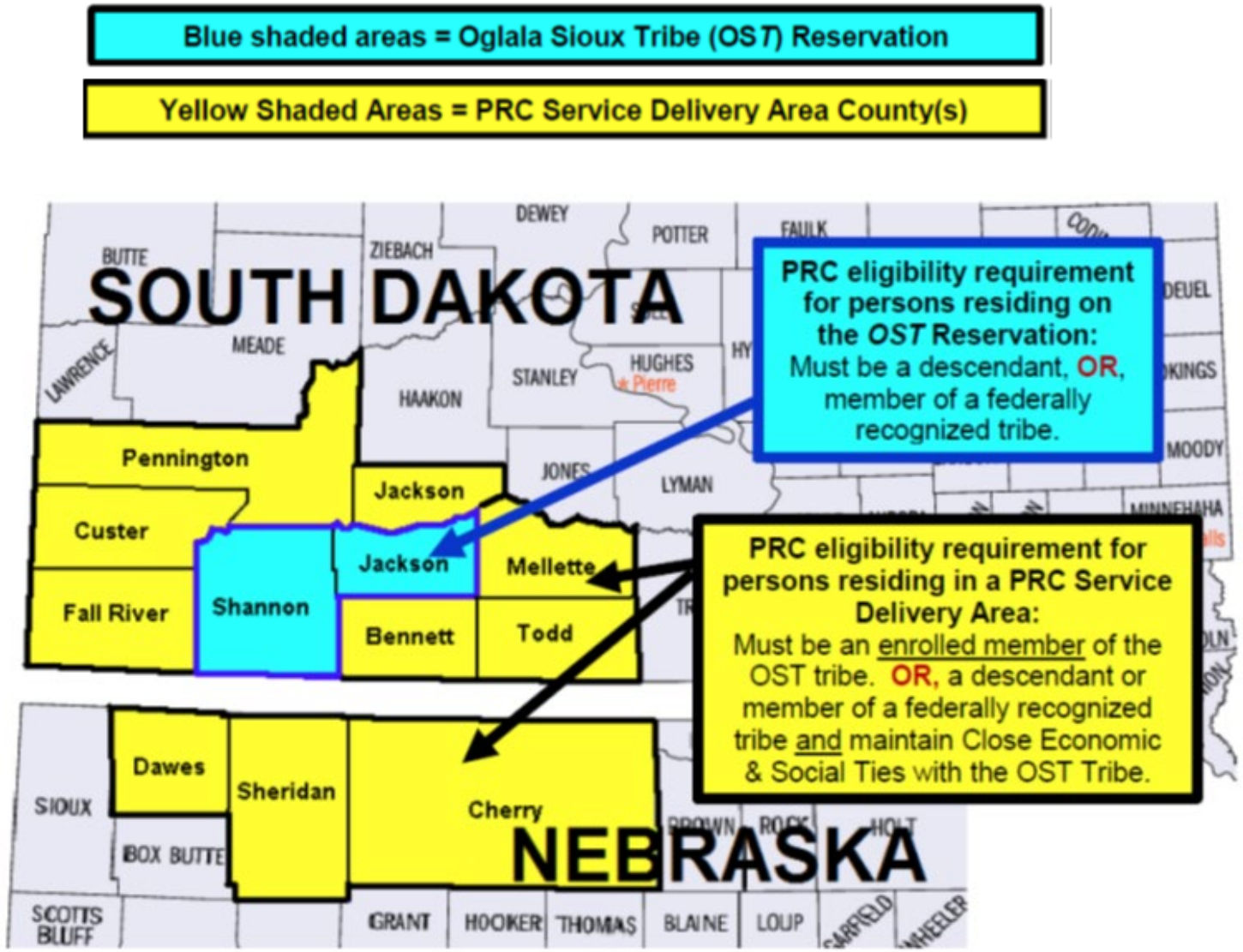
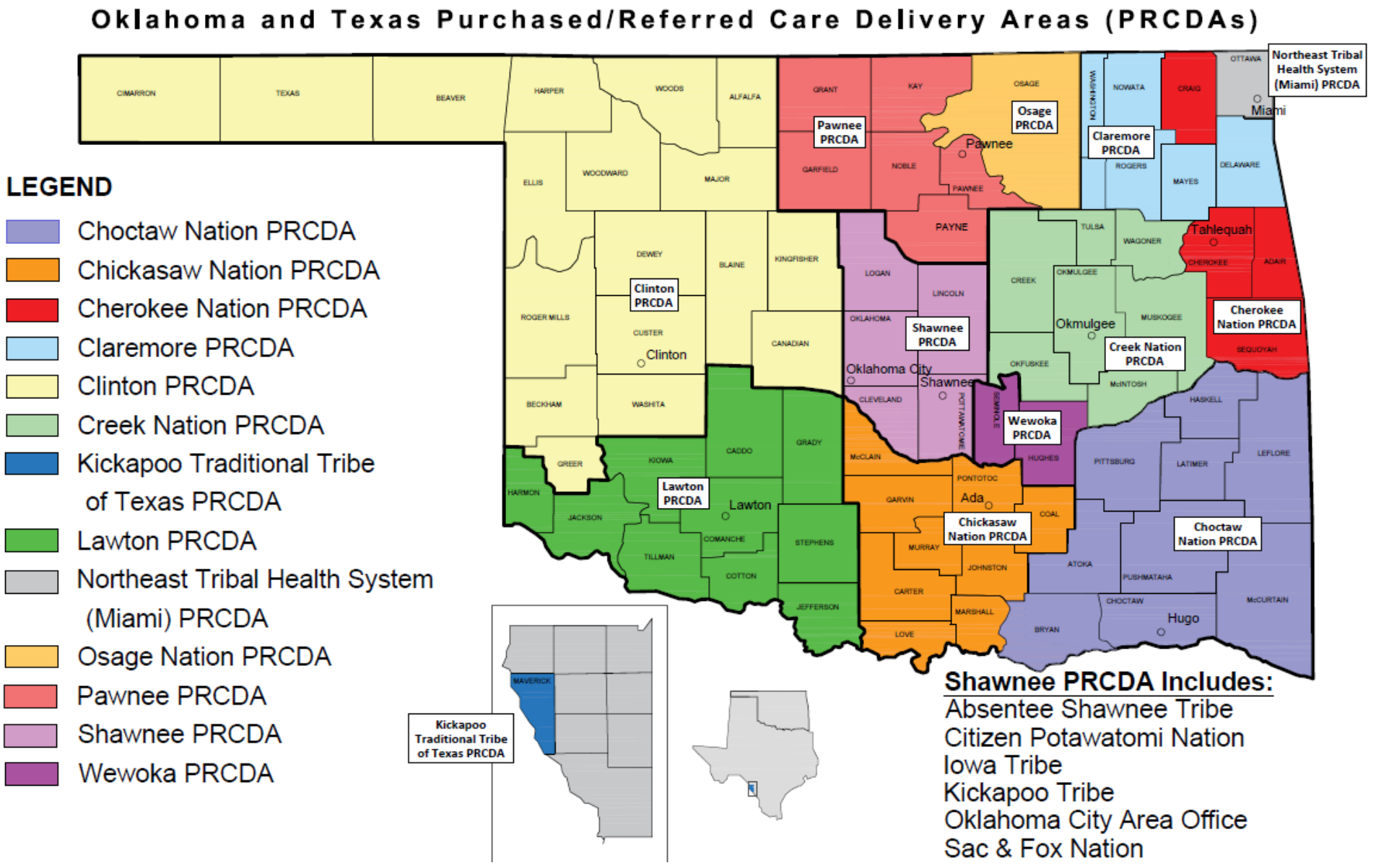
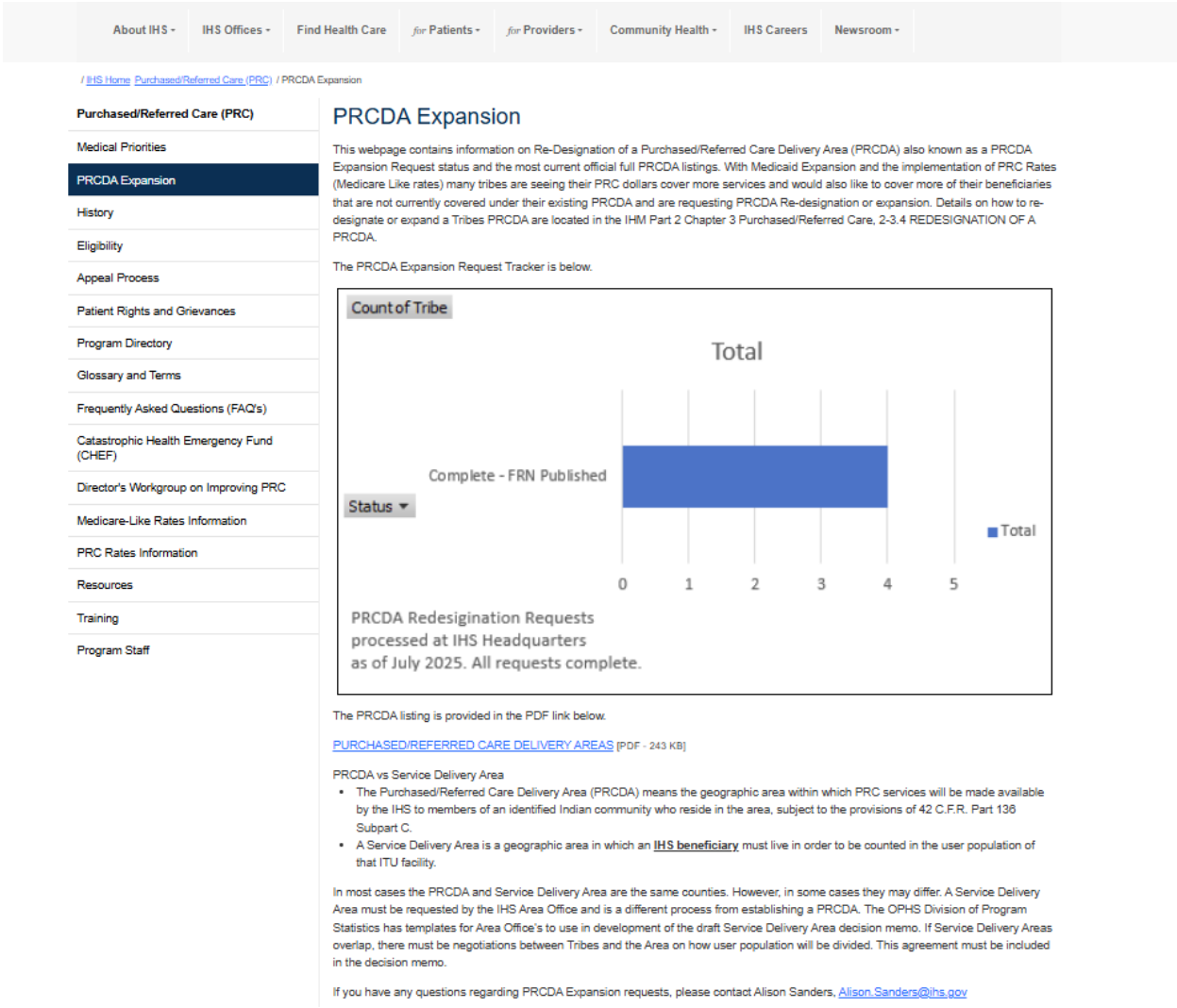


Illustration of a current PRCDA



PRCDA Expansion Website

[PRCDA Expansion | Purchased/Referred Care (PRC) (ihs.gov)](https://www.ihs.gov/prc/prcda-expansion/)
https://www.ihs.gov/prc/prcda-expansion/



About IHS | IHS Offices | Find Health Care | for Patients | for Providers | Community Health | IHS Careers | Newsroom

/ IHS Home / Purchased/Referred Care (PRC) / PRCDA Expansion

Purchased/Referred Care (PRC)

- Medical Priorities
- PRCDA Expansion
- History
- Eligibility
- Appeal Process
- Patient Rights and Grievances
- Program Directory
- Glossary and Terms
- Frequently Asked Questions (FAQ's)
- Catastrophic Health Emergency Fund (CHEF)
- Director's Workgroup on Improving PRC
- Medicare-Like Rates Information
- PRC Rates Information
- Resources
- Training
- Program Staff

PRCDA Expansion

This webpage contains information on Re-Designation of a Purchased/Referred Care Delivery Area (PRCDA) also known as a PRCDA Expansion Request status and the most current official full PRCDA listings. With Medicaid Expansion and the implementation of PRC Rates (Medicare Like rates) many tribes are seeing their PRC dollars cover more services and would also like to cover more of their beneficiaries that are not currently covered under their existing PRCDA and are requesting PRCDA Re-designation or expansion. Details on how to re-designate or expand a Tribes PRCDA are located in the IHM Part 2 Chapter 3 Purchased/Referred Care, 2-3.4 REDESIGNATION OF A PRCDA.

The PRCDA Expansion Request Tracker is below.

The PRCDA listing is provided in the PDF link below.

PURCHASED/REFERRED CARE DELIVERY AREAS [PDF - 243 KB]

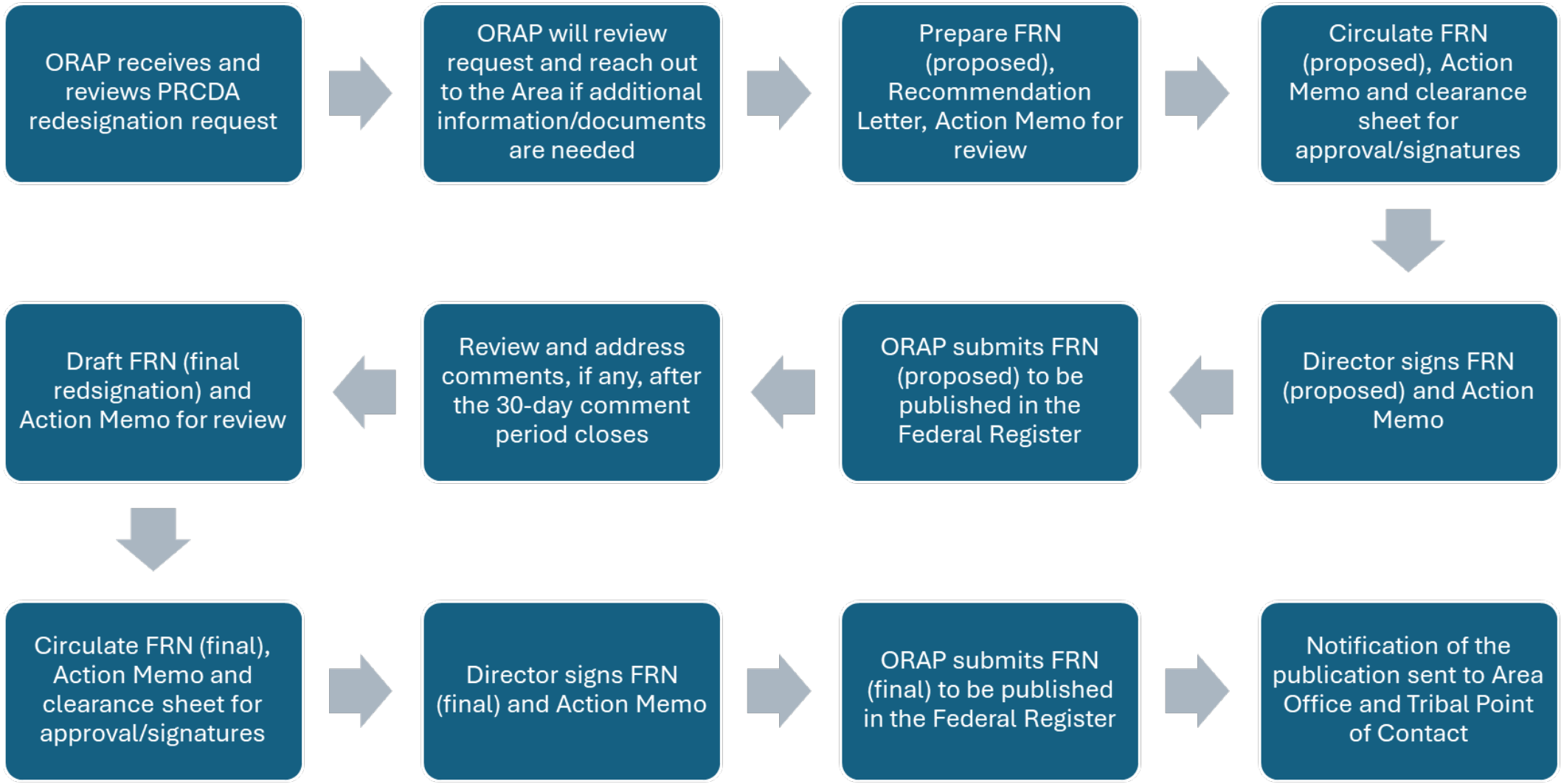
PRCDA vs Service Delivery Area

- The Purchased/Referred Care Delivery Area (PRCDA) means the geographic area within which PRC services will be made available by the IHS to members of an identified Indian community who reside in the area, subject to the provisions of 42 C.F.R. Part 136 Subpart C.
- A Service Delivery Area is a geographic area in which an **IHS beneficiary** must live in order to be counted in the user population of that ITU facility.

In most cases the PRCDA and Service Delivery Area are the same counties. However, in some cases they may differ. A Service Delivery Area must be requested by the IHS Area Office and is a different process from establishing a PRCDA. The OPHS Division of Program Statistics has templates for Area Office's to use in development of the draft Service Delivery Area decision memo. If Service Delivery Areas overlap, there must be negotiations between Tribes and the Area on how user population will be divided. This agreement must be included in the decision memo.

If you have any questions regarding PRCDA Expansion requests, please contact Alison Sanders, Alison.Sanders@ihs.gov

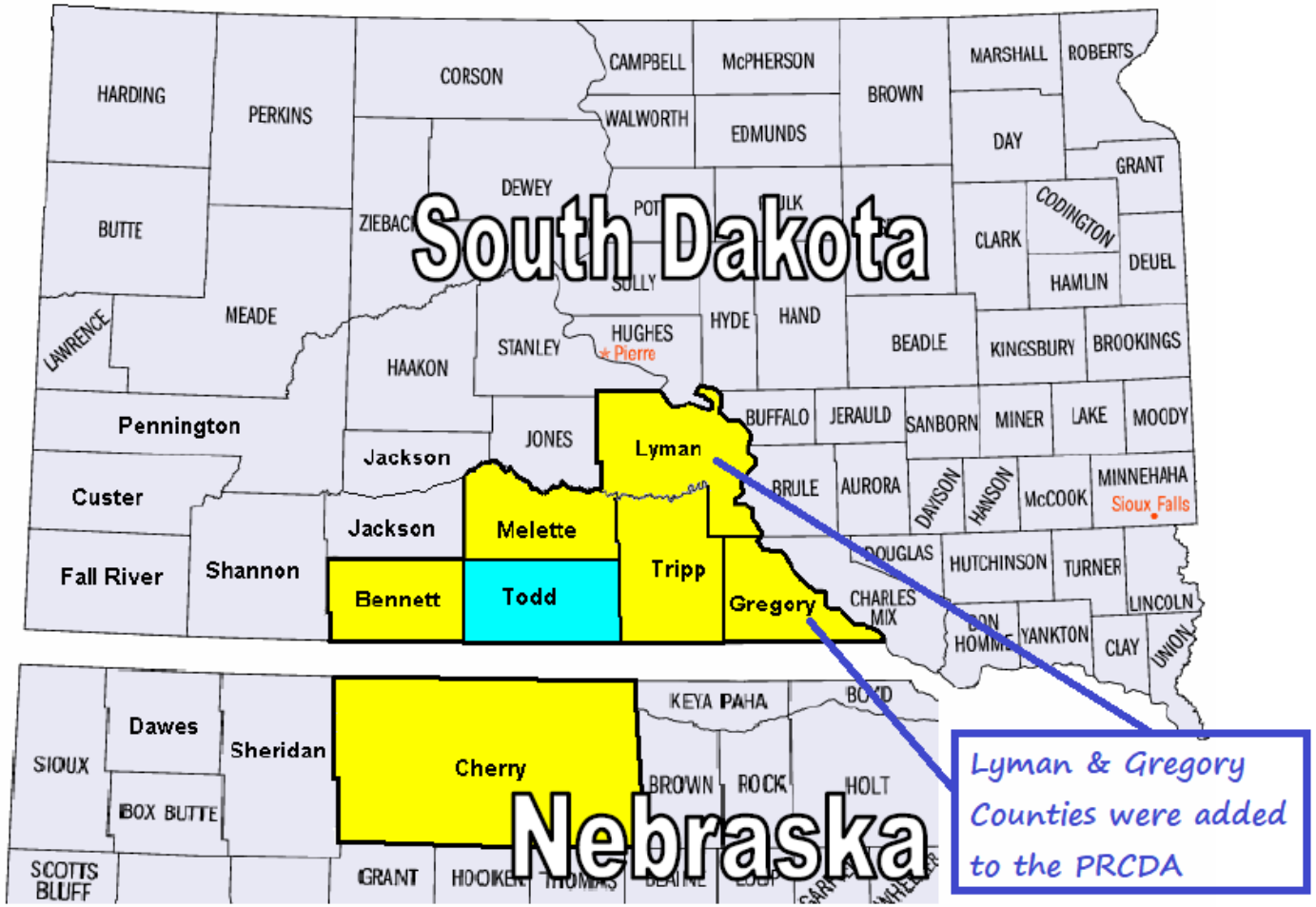
PRCDA Redesignation Request at HQ



Rosebud IHS Hospital

(Rosebud Sioux Tribe)

Contract Health Service Delivery Area (CHSDA)



Current process does allow for requests to expand PRCDA's. Rosebud Sioux Tribe utilized the process to add additional counties to their PRCDA, **however, additional funds were not included.**

Alternate Resources (42 CFR §136.61)

42 CFR §136.61 establishes IHS as the "Payor of Last Resort".

Alternate Resources means health care resources other than those of the IHS. Such resources include Medicare, Medicaid, Private Health Insurance, and State or local health care. IHS is the Payor of Last Resort for approved PRC referrals.

IHS will not be responsible for or authorize payment for PRC to the extent that:

The person would be eligible for Alternate Resources if he/she were to apply for them (not required to expend personal resources).

"REASONABLE INQUIRY" compare pt. income, etc. to Medicaid guidelines and if potentially eligible, IHS may require them to apply.

IHS Policy: *"...patients should not automatically be denied [PRC] benefits simply because of the possibility they might be eligible for an alternate resource".* IHS must do a Reasonable Inquiry prior to denial of a PRC referral.

Students/Transients (42 CFR §136.23)

Students and Transients*

- PRC may be available to students and transients who would be eligible for PRC at the place of their permanent residence within a PRCDA but are temporarily absent from their residence.
  - **Transients:** PRC eligible persons who are temporarily employed, such as seasonal or migratory workers, during their absence.
  - **Students:** During full-time attendance at programs of vocational, technical, or academic education, including high school students. In addition, persons who leave a location (in which they were PRC eligible) may be eligible for PRC for a period of 180 days from such departure.

Students & Transients must still comply with all other PRC eligibility requirements.

*Refer to 42 CFR 136.23(b), (1) and (2) for student and transient definition(s).

Other PRC Eligible Persons

- Non-Indian woman pregnant with an eligible Indian's child – duration of pregnancy & up to 6 weeks postpartum. (proof required)
- Non-Indian member of an eligible Indian's household for public health hazard.
- Adopted, foster & step-children up to 19 years of age (IHCIA)

Must still comply with all other PRC requirements

PRC Review Committee

Review, prioritize, and manage PRC referrals within available resources

PURPOSE

- Review and prioritize PRC referrals
- Monitor PRC expenditures and high-cost cases
- Determine the level of care the Service Unit can authorize

REFERRAL REVIEW

- Medical staff assign medical priority and rank referrals
- Administrative staff authorize by ranking and available funds
- All requests are Approved or Denied
- Routine referral prioritization may be delegated

COMMITTEE & FUNDING

- Meets at least weekly with clinical, administrative, PRC, and other appropriate staff
- Minutes are maintained for tracking and audit purposes
- Weekly spending limit = fiscal year funding ÷ 52 weeks

PRC funds are managed throughout the fiscal year to maintain a consistent level of available care.

Medical Priorities (CFR §136.23)

42 CFR §136.23(e): When funds are insufficient to provide the volume of PRC indicated as needed by the population residing in a PRC Delivery Area, priorities for services shall be determined on the basis of relative medical need.

Medical Priority: PRC medical priorities are typically determined by IHS providers.

Routine Referrals: Prioritization may be delegated to a Nurse Case Manager to expedite processing

Updated Priorities: PRC medical priorities were updated January 2024

Medicare Like Rates (42 CFR §136 Subpart D)

42 CFR, Subpart D, §136.30 – Limitation on charges for services furnished by Medicare-Participating (in-patient) hospitals to Indians.

- Requires Medicare participating hospitals that provide inpatient hospital services to accept Medicare-Like Rates (MLR) as payment in full when delivering services to PRC eligible patients who are referred to them by programs funded by the IHS.
- MLR for IHS/Federal Facilities is determined by the IHS Fiscal Intermediary, Blue Cross Blue Shield of NM.
  - Tribally Operated PRC programs may contract with the IHS FI or purchase their own software to calculate the MLR. (MLR PPS pricer is available for free at cms.gov)
- Became effective July 5, 2007

"PRC Rates" (42 CFR §136, Subpart I)

The General Accounting Office (GAO), conducted a study and in April 2013 released a report recommending congress cap IHS PRC payments for physician and non-hospital services at rates comparable to other federal programs.

- NPRM published in the Federal Register (FR) December 5, 2014, extended to February 4, 2015, to allow for a 60-day comment period. Final rule published in FR on March 21, 2016, IHS addressed all comments in the preamble of the final rule.
- Effective date is May 20, 2016, IHS programs must implement no later than March 21, 2017. Tribes have the option to Opt-In to the rule and implement immediately or when they are fully able to implement the rule.

For medical services not previously covered by MLR. Described as payment for physicians and other health care professional services, associated with hospital and non-hospital-based care.

42 CFR Part 136, Subpart I – Limitation on Charges for Health Care Professional Services and Non-Hospital-Based Care.

- §136.203 – Payment for provider and supplier services purchased by Indian health programs.
  - Services covered are, but not limited to: Outpatient care, Physicians, Laboratory, Dialysis, Radiology, Pharmacy, and Transportation services.
- **3 Tier payment system**, 1) Contract, 2) Medicare Fee Schedule, 3) 65% of billed charges.

PRC Denials (42 CFR §136.25)

Persons to whom PRC is denied must be notified of the denial in writing.

DENIAL REASONS IN RPMS/CHSMIS

Notification	**Medical Priority**	**IHS Available**
Alternate Resource Available	**Indian Descent / Membership**	**Residency**

PRC programs should ensure all applicable denial reasons are identified and applied.

A written denial begins the reconsideration and appeals process.

Reconsideration & Appeals (42 CFR §136.25)

A written request for reconsideration must be submitted within 30 days of receipt of the denial.



Tribal contractors are not required to utilize the IHS appeals process, however, pursuant to 25 U.S.C. § 5324(g) and 25 U.S.C. § 5397(e), a Tribe must provide a written appeals process that is functionally equivalent to the process in 42 C.F.R. § 136.25.

Catastrophic Health Emergency Fund (CHEF)

Purpose:

- The CHEF program was established to help meet the extraordinary medical costs associated with the treatment of victims of disaster and/or catastrophic illnesses. The CHEF is a reimbursement program for Purchased/Referred Care (PRC) programs operated by IHS and Tribal Health programs.

What is CHEF?

- The fund was created by Congress to **reimburse** medical expenses incurred for catastrophic illnesses and events falling within the PRC payment responsibility of IHS after a threshold cost has been met. The cost threshold for FY 2025 is **$19,095** and must first be met before reimbursements can be requested from the CHEF. First in/First out basis.
- In accordance with the CHEF regulations that became effective on October 29, 2024, the annual CHEF threshold will increase by the Consumer Price Index (CPI) for all urban consumers.
- Electronic CHEF Application (ECA), mandatory for IHS/federal sites and available to Tribal PRC Programs.

CHEF Program Requirements

- The applicable CHEF threshold must be met before reimbursement can be considered
  - FY 2024 threshold: $19,000
  - FY 2025 threshold: $19,095
  - FY 2026 threshold: $19,630
- **Alternate Resources:** CHEF reimbursement cannot be made until all alternate resources for which the patient is eligible have been exhausted.
- **Cost Reimbursement:** CHEF reimburses IHS and Tribal PRC programs; it does not make the initial payment to vendors or providers.
- **First In, First Out (FIFO):** Complete CHEF requests are processed in order received, subject to availability of funds

CHEF Program Requirement (continued)

- **CHEF Budget:** CHEF is funded at approximately $54 million annually. Annual Threshold: The CHEF threshold is adjusted annually based on the medical care expenditure category of the Consumer Price Index (CPI) and published in the *Federal Register*. The FY 2026 threshold is $19,630.
- **Electronic CHEF Application (ECA):** All Federal PRC programs are required to use ECA. Tribal programs are being encouraged to use ECA. Tribal Programs: If a Tribal program is not yet set up to use ECA, the Area Office will enter and submit the CHEF case into ECA on the program's behalf.
- **SDTS Update:** Effective June 1, 2026, SDTS cases should be submitted to the Area PRC Officer through SDTS. Cases should no longer be submitted directly to Headquarters and must instead be routed through the Area Office.

CHEF Procedures & Guidelines

- Patients (Tribal & Federal) must meet PRC eligibility requirements and treatment must be authorized for payment.
- CHEF is intended to shield IHS and Tribal PRC operations from financial disruption caused by the intensity of high-cost catastrophic illnesses and/or events. Examples of catastrophic illnesses include: cardiac disease, cancer, dialysis, burns, alcohol and opioid dependence, high-risk births, end-stage renal disease, strokes, trauma-related causes such as automobile accidents, or gunshot wounds, and some mental disorders.
- The Indian Health Care Improvement Act (IHCIA) section 202 provides that a Service Unit shall not be eligible for reimbursement from the CHEF program until its cost of treating any victim of a catastrophic illness or event has reached a certain threshold

CHEF Procedures & Guidelines

- The request must indicate if charges were billed at Medicare-Like Rates, PRC Rates, Negotiated Rates or Billed Charges.
- Priorities of care and treatment for health care services will be determined on the basis of relative medical need. IHS National medical priorities will be used unless approved Area and Tribal medical priorities are provided to the Division of Contract Care and the Headquarters CHEF Team.
- All health care services must be within identified medical priorities of the IHS at all levels.
- CHEF is not intended to be used to expand or change medical priorities.

CHEF Procedures & Guidelines

- Inpatient care is based on consecutive days from the initial date of admission up to 90 days after the date of discharge. If there is a reoccurrence more than 90 days after discharge, a new threshold is applied.
- Inpatient cases require a discharge summary and History & Physical documentation to support Medicare-Like Rate (MLR) claims.
- Chronic care is based on 90-day episodes with exceptions for ongoing cancer treatment (not surveillance) and renal dialysis.
- Outpatient and/or chronic care is based on 90-day increments.
- All CHEF cases must have a specific primary ICD-10-CM diagnostic/procedure code and CHEF code consistent with the case.

CHEF Procedures & Guidelines

- Ongoing CHEF cases may qualify for an advance payment of 50 percent reimbursement and fully completed cases may qualify for 100 percent reimbursement.
- Cases submitted for 100 percent reimbursement must have complete disbursements from all Medical Purchase Orders (MPO) with official paid dates.
- All cases must include claims (CMS claim forms) that were submitted for payment with proof of PRC payment. Examples include: EOB (Explanation of Benefits) and payment checks.

CHEF Procedures & Guidelines

- **IHS is the payor of last resort.** Available and accessible alternate resources must be used before CHEF reimbursement.
- **Alternate resources** include Federal, State, local, and private sources of health care reimbursement, such as Medicare, Medicaid, and private insurance.
- CHEF cannot reimburse expenses paid by an alternate resource.
- A patient is considered eligible for an alternate resource when the patient is eligible **o**r would be eligible if they applied.
- **Document the outcome.** The FY 2026 procedures require alternate resources to be billed before CHEF reimbursement and require their use or payment to be documented.

Payor of Last Resort Regulation

- To ensure compliance with the requirement for the use of alternate resources, Service Unit Directors and their Tribal counterparts will be required to follow PRC rules and regulations governing such procedures. Funds expended for medical cases later reimbursed by alternate resources must be returned to the facility program account.
- An individual must apply for and exhaust all alternate resources that are available and accessible.
- The IHS facility is also considered a resource, and therefore, the PRC funds may not be expended for services reasonably accessible and available at IHS facilities. When a IHS facility capable of providing these services is within ninety minutes (90) minutes one-way surface transportation time from the person's place of residence to the nearest IHS facility.

Electronic CHEF Application (ECA)

- **What is ECA?** A paperless application used to identify, document, track, and submit CHEF reimbursement requests.
- **Purpose:** ECA streamlines the CHEF workflow and documentation needed to submit a complete reimbursement request.
- **Implementation:** IHS implemented the Electronic CHEF Application on May 1, 2019.
- **Federal PRC Programs:** Use of ECA is mandatory.
- **Tribal PRC Programs:** Tribal programs are encouraged to use ECA. Tribal programs that are not yet set up in ECA can send their cases to the Area Office for entry into ECA.

Electronic CHEF Application (ECA)

- Key benefits of using the ECA:
- Paperless process: The ECA automates the workflow for submitting applications, eliminating the need for paper documentation
- Efficiency: Using the ECA is a user-friendly and efficient process that results in fewer errors and rejections of applications
- Tracking and reporting: The application provides a centralized location for tracking cases and generating reports, offering self-service capabilities
- All required signatures are captured
- Tracks the place in line (the queue)

Recoveries

- In the event that a PRC program has been reimbursed by the CHEF for an episode of care and that same episode of care becomes eligible for and is paid by any Federal, state, local, or private source (including third-party insurance), the PRC program shall return all the CHEF funds received for that episode of care to the CHEF at the IHS Headquarters. Recoveries will be used to fund current year approved cases.

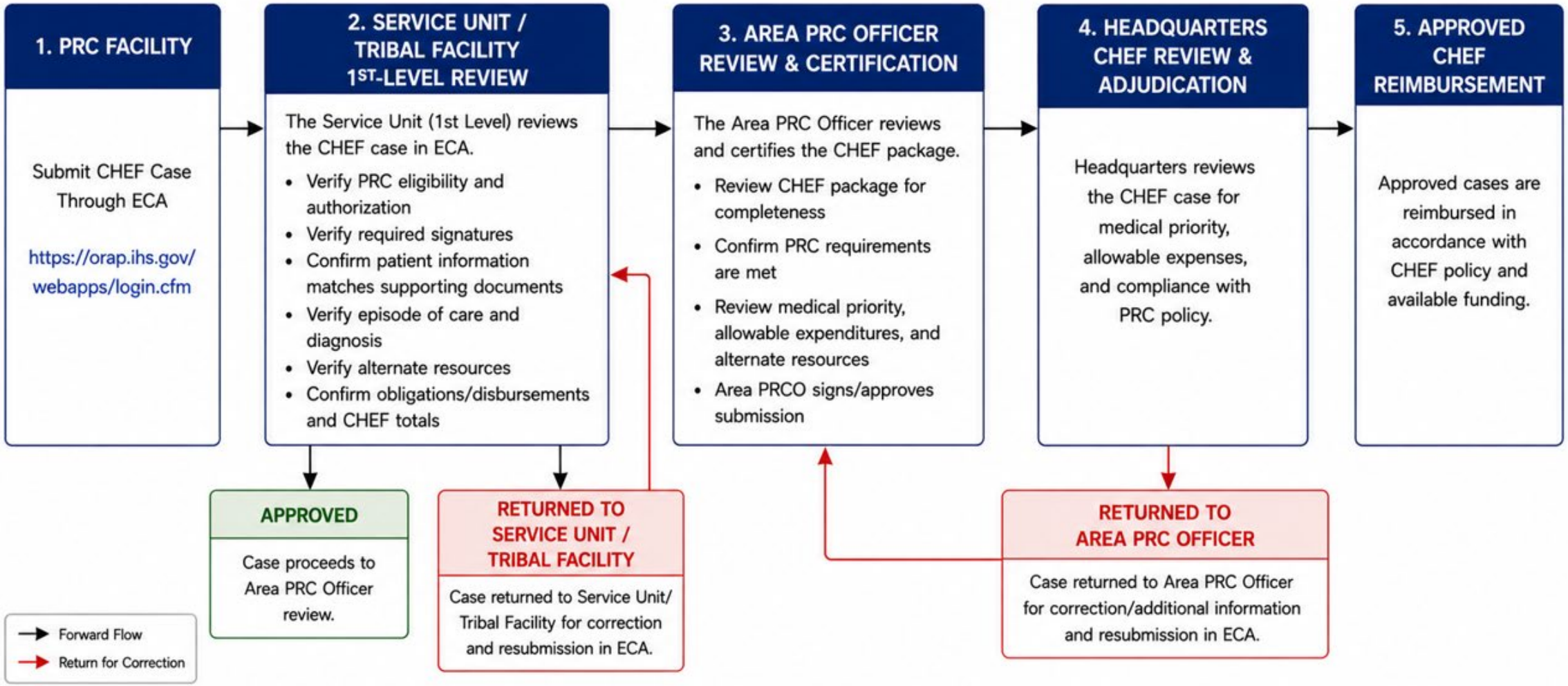
Recoveries (cont.)

- The following are instances when Advances are not used and need to be returned to the Headquarters CHEF Fund:
- The final costs did not meet the threshold amount; this occurs when the obligations are overestimated and the final costs are below the threshold amount.
- If canceled obligations cause the final cost to be less than the threshold amount.
- Unanticipated payment(s) received by alternate resource(s).
- Notify the Area Office to begin the recovery process.
- Recoveries will be used to fund current-year cases.

Submission Process Overview

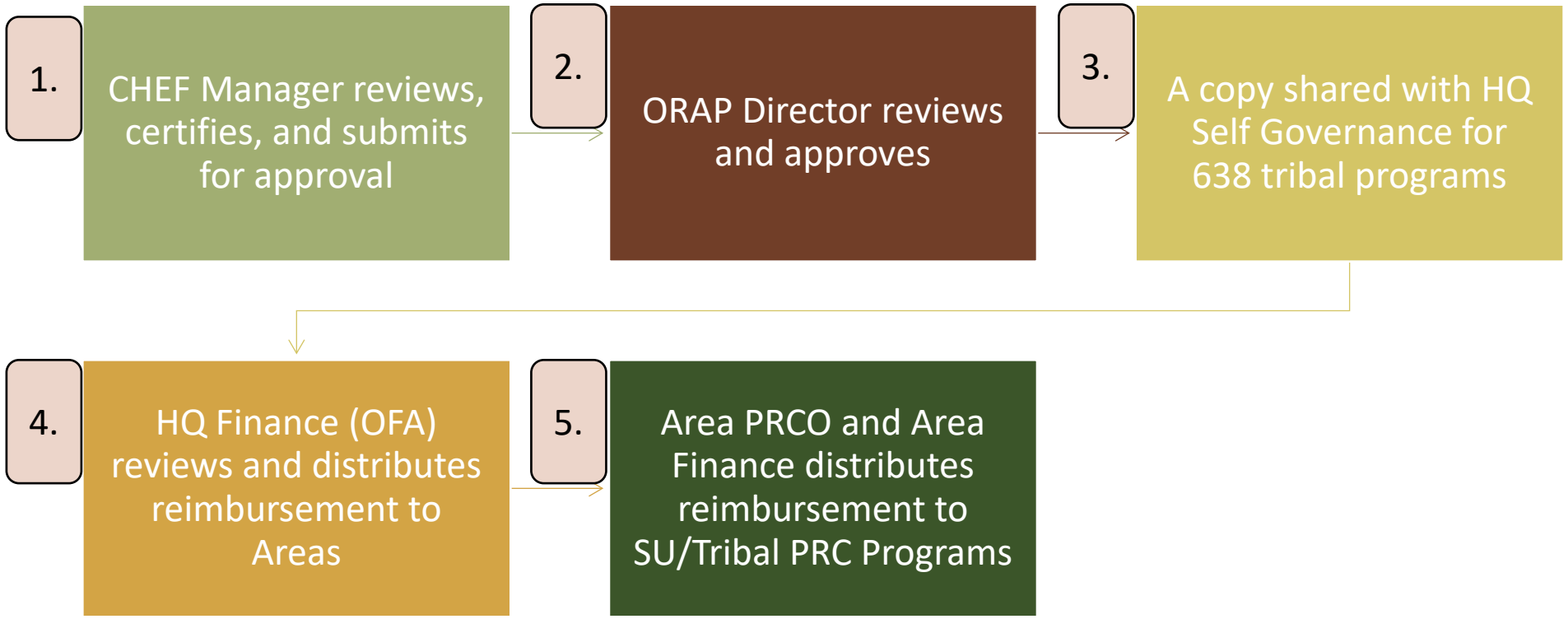
- Amendment: Adjustment to distribution from Headquarters.
- Supplement: Additional PDOs have been issued since the initial CHEF submission.
- Federal – The CHEF Reimbursement Request Summary Sheet form with a new Referred Care Information System (RCIS) display or the PO document disbursement (DOCD) and progress notes if an ongoing case such as End Stage Renal Disease (ESRD) or Oncology.
- Tribal – Resource and Patient Management System (RPMS) user sites should include CHEF Reimbursement Request Summary sheet with RCIS display or the PO document disbursement (DOCD) and progress notes for ongoing cases. Sites not using RPMS should include the CHEF Reimbursement Request Summary sheet with new claims and copies of checks and/or cancelled checks.

CHEF Submission Process Overview



HQ Process Overview

Review, approval, and funds transfer process



Denied cases will be returned to the Area

CHEF Reconsideration and Appeals

- **Written Denial:** If CHEF reimbursement is denied, the Service Unit will receive written notice stating the reason for denial.
- **Reconsideration:** A written request for reconsideration may be submitted to the Division of Contract Care within 40 business days of receiving the denial.
- **Supporting Documentation:** The reconsideration request should include corrections or additional documentation needed to address the denial, or documentation showing why the original decision was incorrect.
- **Deemed Denial:** If the CHEF Program Manager does not make a decision within 180 calendar days of receipt, the Service Unit may choose to appeal the case as a deemed denial.
- **Final Appeal:** If the denial is upheld on reconsideration, a written appeal may be submitted to the Director, Indian Health Service, within 40 business days. The Director's decision constitutes final administrative action

Submission Process Overview

- 50 % Submission

Submission of CHEF cases prior to final payment for all purchase orders

Requirement to close out cases once all purchase orders are paid

Catastrophic Health Emergency Fund 50% Reimbursement eRequest - Summary Sheet FY 2018

1. AREA:	2. ORDERING FACILITY:	3. CHEF NUMBER:	4. PATIENT NAME:	5. DATE OF BIRTH:	6. SEX:
OKLAHOMA	CLAREMORE HOSPITAL	18-OK-189	LastName, FirstName Middle	mm/dd/yyyy (99)	U

7. TRIBE:	8. ICD CODE	9. CATASTROPHIC CODE:	10. TRAUMA CODE:	11. MEDICAL PRIORITY:	12. ALT RESOURCE:
CHEROKEE NATION, OK (022)	C15	3.0	N	I	PEND

13. CONTRACT RATE:	14. EPISODE OF CARE:
YES	03/06/2018-06/03/2018 (90 d)

15. PROVIDER	16. DATE OF SERVICE	17. PDO NO.	18. OBLIGATION AMT	19. DISBURSEMENT AMT	20. DATE PAID
OK CANCER SPECIALISTS	03/06/2018	8O1104388	$2,500.00	[redacted]	[redacted]
OK CANCER SPECIALISTS	03/13/2018	8O1103824	$200.00	[redacted]	[redacted]
OK CANCER SPECIALISTS	04/03/2018	8O1103829	$200.00	[redacted]	[redacted]
OK CANCER SPECIALISTS	05/22/2018	8O1103825	$2,000.00	[redacted]	[redacted]
OK CANCER SPECIALISTS	05/22/2018	7O1109615	$2,000.00	[redacted]	[redacted]
OK CANCER SPECIALISTS	06/01/2018	8O1103826	$10,000.00	[redacted]	[redacted]
OK CANCER SPECIALISTS	06/01/2018	7O1109616	$10,000.00	[redacted]	[redacted]
ST. JOHN MEDICAL CENTE	06/18/2018	8O1104127	$4,000.00	[redacted]	[redacted]
ST JOHN PHYSICIANS INC	06/18/2018	8O1104128	$1,000.00	[redacted]	[redacted]
ST JOHN ANES SERVICES	06/18/2018	8O1104129	$500.00	[redacted]	[redacted]
21.		TOTAL IHS COST	$52,700.00	[redacted]	[redacted]
22.		LESS THRESHOLD	-$25,000.00	[redacted]	[redacted]
23.		NET ELIGIBLE FROM FUND	$27,700.00	[redacted]	[redacted]
24a.		ADVANCE: INCOMPLETE 50%	$13,850.00	[redacted]	[redacted]
24b.		REIMBURSEMENT: COMPLETE 100%	N/A	[redacted]	[redacted]
25.		LESS PREVIOUS ADVANCE/REIMBURSEMENT	$0.00	[redacted]	[redacted]
26.		TOTAL REQUEST	$13,850.00	[redacted]	[redacted]

By signing this form, I certify our program has fully utilized alternate resources and the Medicare like rates (MLR) (Section 506 or MMA). I understand this case will be submitted to the IHS fiscal intermediary (FI) for review, at no cost to our program. If after the FI assessment, it has been determined that the initial CHEF reimbursement exceeded the MLR review level the CHEF program will recall the amounts over the MLR through the appropriate process. Additionally I certify the information and costs listed are associated with this catastropic event and that case management has been performed.

27. ADMINISTRATOR	DATE	28. CASE MANAGER	DATE	29. AREA CERTIFICATION	DATE
E-sig/GEORGE VALLIERE, CEO	07/13/2018	E-sig/Bobbie Moran	07/13/2018		

30. AREA PRC APPROVAL	DATE	31. 42. CFR SEC. 136 met	DATE	32. REMARKS: (50% request)
		YES	07/13/2018	Area/Facilty Request ID: 18-OK-011-044

Submission Process Overview

- 100 % Submission
- All purchase orders have been final paid, and all alternate resources have been exhausted.

Catastrophic Health Emergency Fund 100% Reimbursement eRequest - Summary Sheet FY 2018

1. AREA:	2. ORDERING FACILITY:	3. CHEF NUMBER:	4. PATIENT NAME:	5. DATE OF BIRTH:	6. SEX:
OKLAHOMA	CLAREMORE HOSPITAL	18-OK-190	LastName, FirstName Middle	mm/dd/yyyy (99)	U

7. TRIBE:	8. ICD CODE	9. CATASTROPHIC CODE:	10. TRAUMA CODE:	11. MEDICAL PRIORITY:	12. ALT RESOURCE:
CHEROKEE NATION, OK (022)	R47.01	22.2	N	I	NO

13. CONTRACT RATE:	14. EPISODE OF CARE:	
YES	02/16/2018-06/10/2018 (115 d)	NOT CATEGORICALLY ELIGIBLE FOR MEDICAID

15. PROVIDER	16. DATE OF SERVICE	17. PDO NO.	18. OBLIGATION AMT	19. DISBURSEMENT AMT	20. DATE PAID
ST. JOHN MEDICAL CENTE (43)	02/16/2018-03/12/2018	8O1103264	[redacted]	$106,034.05	05/23/2018
ST JOHN PHYSICIANS INC	02/16/2018	8O1103265	[redacted]	$21,440.91	05/24/2018
ST JOHN ANES SERVICES	02/16/2018	8O1103266	[redacted]	OPEN	
TULSA RADIOLOGY ASSOCI	02/16/2018	8O1103267	[redacted]	OPEN	
REGIONAL MEDICAL LABOR	02/16/2018	8O1103268	[redacted]	OPEN	

21.	TOTAL IHS COST	$127,474.96	[redacted]
22.	LESS THRESHOLD	-$25,000.00	[redacted]
23.	NET ELIGIBLE FROM FUND	$102,475.00	[redacted]
24a.	ADVANCE: INCOMPLETE 50%	N/A	[redacted]
24b.	REIMBURSEMENT: COMPLETE 100%	102475.00	[redacted]
25.	LESS PREVIOUS ADVANCE/REIMBURSEMENT	$0.00	[redacted]
26.	TOTAL REQUEST	$102,475.00	[redacted]

By signing this form, I certify our program has fully utilized alternate resources and the Medicare like rates (MLR) (Section 506 or MMA). I understand this case will be submitted to the IHS fiscal intermediary (FI) for review, at no cost to our program. If after the FI assessment, it has been determined that the initial CHEF reimbursement exceeded the MLR review level the CHEF program will recall the amounts over the MLR through the appropriate process. Additionally I certify the information and costs listed are associated with this catastropic event and that case management has been performed.

27. ADMINISTRATOR	DATE	28. CASE MANAGER	DATE	29. AREA CERTIFICATION	DATE
E-sig/GEORGE VALLIERE, CEO	07/13/2018	E-sig/Bobbie Moran	07/13/2018		

30. AREA PRC APPROVAL	DATE	31. 42. CFR SEC. 136 met	DATE	32. REMARKS: (100% request)
		YES	07/13/2018	Area/Facilty Request ID: 18-OK-011-045

Common CHEF Errors

- **Incorrect ICD-10-CM Code**
  Primary diagnosis/code does not match the medical documentation.
- **Services Outside the Episode of Care**
  Dates of service or purchase orders fall outside the applicable **90-day episode of care**.
- **Referral Documentation Does Not Match**
  Referral/authorization does not support the **provider, diagnosis, dates of service, or purchase orders** submitted for reimbursement.
- **Invalid Alternate Resource Screening**
  Screening is missing, outdated, incomplete, or does not adequately document the patient's alternate-resource status.
- **Bottom takeaway:**
  Before submission, make sure the Diagnosis → Referral → Episode of Care → Purchase Orders → Payment → Alternate Resources all align.

CHEF Case Scenario 1

Patient: PRC-eligible patient receiving ongoing specialty care
FY 2026 CHEF threshold: $19,630
Total eligible PRC costs: $38,500
Medicaid: Patient was screened and determined **over income**
Medicare: Not eligible
Private insurance: None
Other alternate resources: None identified
Documentation: Medicaid screening/eligibility documentation showing the patient is over income is included in the CHEF case.

Is the alternate resource requirement adequately documented?

A. No — the patient must apply for Medicaid anyway
B. Yes — if the over-income determination is supported by appropriate documentation
C. No — every CHEF patient must have an alternate resource
D. Yes — simply writing "over income" on the Summary Sheet is enough

ANSWER B: The FY 2026 CHEF Checklist specifically addresses this situation: when a patient is screened as ineligible for Medicaid and is not required to apply, the submission should include **supporting documentation explaining why**, including examples such as **over income, not disabled, or no children**

CHEF Case Scenario 2

Patient: PRC-eligible patient
Diagnosis: Acute cardiac condition
Hospital admission: October 10, 2025
Discharge: October 15, 2025
CHEF episode of care: October 10, 2025 through **January 13, 2026**
FY 2026 threshold: $19,630
The CHEF case includes:
Inpatient hospital PO — **$31,000**
Cardiology follow-up on November 20 — **$2,800**
Related diagnostic testing on December 18 — **$3,500**
Cardiology services on February 12, 2026 **— $6,500**

Should the February 12 date of service be included in the original CHEF case?
A. Yes — because the diagnosis is the same
B. Yes — because the original case already exceeded $19,630
C. No — the services occurred more than 90 days after discharge
D. Yes — as long as the same provider treated the patient

ANSWER C: For inpatient care, the FY 2026 CHEF procedures define the episode based on consecutive days from the initial admission through 90 days after discharge. If there is a recurrence more than 90 days after discharge, a new threshold is applied

CHEF Case Scenario 3

Patient: PRC-eligible patient
FY 2026 CHEF threshold: $19,630
Alternate resources: Screened and documented; none available

Date of Service	Provider/Service	Primary Diagnosis	PO	PRC Payment
11/03/2025	Hospital – Inpatient Admission	Cardiac Condition	PO-101	$14,500
11/18/2025	Cardiology Follow-up	Cardiac Condition	PO-102	$4,000
12/08/2025	Cardiac Diagnostic Testing	Cardiac Condition	PO-103	$3,500
12/15/2025	Emergency Department	Orthopedic Injury	PO-104	$7,500
12/22/2025	Orthopedic Specialist	Orthopedic Injury	PO-105	$6,000
01/12/2026	Physical Therapy	Orthopedic Injury	PO-106	$4,000

Cardiac costs: $22,000
Orthopedic costs: $17,500
Total PRC payments: $39,500

CHEF Case Scenario 4

Can all $39,500 in PRC payments be combined into one CHEF case because the services occurred close together and were paid during FY 2026?

A. Yes — all services occurred during the same fiscal year
B. Yes — the combined payments exceed $19,630
C. No — the costs represent different diagnoses/episodes of care
D. Yes — because the same PRC program paid all six POs

Answer: C — No

The two conditions should **not be combined simply to meet the CHEF threshold**.
The FY 2026 procedures require CHEF treatment to relate to the **primary diagnosis identified in Box 8**, and a new CHEF case number is required for each episode of care

Key Takeaways

- **PRC requirements still apply.** Verify patient eligibility, authorization, medical priority, allowable expenditures, and alternate resources.
- **One CHEF case should support one primary diagnosis and episode of care.** The ICD-10-CM code, referral, dates of service, purchase orders, medical records, and payments should all align.
- **Know the episode of care.** Review dates carefully and do not include unrelated services or services outside the applicable episode.
- **Alternate resources must be screened and documented.** “No alternate resources” should be supported by appropriate documentation.
- **Submit a complete and accurate case.** Missing or inconsistent information can result in a case being returned and losing its original place in the queue.
- **Review before submission:** Diagnosis → Referral → Episode of Care → Purchase Orders → Payment → Alternate Resources should all tell the same story.

Questions



Contact

Edwin C. Chasing Hawk, Management Analyst
IHS Headquarters
Office of Resource Access & Partnership (ORAP)
Division of Contract Care (DCC)
Edwin.ChasingHawk@ihs.gov

Salena Nicole Massey
Program Analyst
Portland Area Office
Salena.Massey@ihs.gov


INDIAN HEALTH SERVICE
PHS · 1955 ·