No. 07-1158
Criminal

UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

UNITED STATES OF AMERICA,

Plaintiff and Appellee,

vs.

SOSAEOLEISAH REFERT,
a/k/a Sosaeoleisah C. Bluespruce,
a/k/a Leisah Bluespruce, a/k/a Lisa Refert,

Defendant and Appellant.

Appeal from the United States District Court
for the District of South Dakota
Southern Division

The Honorable Lawrence L. Piersol
United States District Court Judge

APPELLEE'S BRIEF

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SUMMARY OF THE CASE AND WAIVER OF ORAL ARGUMENT

A United States District Court jury for the District of South Dakota found Lisa Refert guilty of one count of health care fraud in violation of 18 U.S.C. § 1347 and four counts of making false claims in violation of 18 U.S.C. § 287.

In this appeal, Refert raises four issues: (1) Whether the district court committed plain error by not instructing the jury on the eligibility requirements for free Indian Health Service medical services; (2) Whether sufficient evidence was presented to support Refert's convictions on two false claims counts arising from emergency room visits; (3) Whether the court committed plain error by including in the restitution order the cost of services provided during emergency room visits; and (4) Whether the court committed plain error in ordering that two of the supervised release terms be served consecutively.

The United States believes that the facts and legal arguments are adequately presented in the briefs and record. Accordingly, the Government does not request oral argument but does requests equal time to respond to any oral argument granted to the appellant in this case.

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JURISDICTIONAL STATEMENT

Lisa Refert appeals a final district court judgment in a criminal case. The district court had jurisdiction over this case by virtue of 18 U.S.C. §§ 287 and 1347. The district court's judgment was entered on January 17, 2007. CR 6-11. Refert filed a timely notice appeal on January 10, 2007. CR 12.[1] This Court has appellate jurisdiction under the provisions of 28 U.S.C. § 1291.

STATEMENT OF THE ISSUES

I.

WHETHER THE DISTRICT COURT COMMITTED PLAIN ERROR BY NOT INSTRUCTING THE JURY ON THE ELIGIBILITY REQUIREMENTS FOR FREE MEDICAL SERVICES AT AN INDIAN HEALTH SERVICE MEDICAL FACILITY.

United States v. Patient Transfer Service, Inc. 413 F.3d 734 (8th Cir. 2005)
United States v. Peterson, 223 F.3d 756 (8th Cir. 2000)
United States v. Blecker, 657 F.2d 629 (4th Cir. 1981)
United States v. Adler, 623 F.2d 1287 (8th Cir. 1980)

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[1] References to the Clerk's record with be cited as "CR" followed by the relevant number. Docket entries will be cited as "DE" followed by the relevant number. References to the trial and sentencing transcripts will be cited as "TR" and "ST" followed by the appropriate page reference. References to the Appellant's Brief will be cited as "AB" followed by the specific page number.

II.

WHETHER SUFFICIENT EVIDENCE WAS PRESENTED TO SUPPORT REFERT'S CONVICTIONS ON TWO FALSE CLAIMS COUNTS ARISING FROM EMERGENCY ROOM VISITS.

United States v. Patient Transfer Service, Inc. 413 F.3d 734 (8th Cir. 2005)
United States v. Peterson, 223 F.3d 756 (8th Cir. 2000)
United States v. Blecker, 657 F.2d 629 (4th Cir. 1981)

III.

WHETHER THE DISTRICT COURT COMMITTED PLAIN ERROR BY INCLUDING IN THE RESTITUTION ORDER THE COST OF SERVICES PROVIDED DURING EMERGENCY ROOM VISITS.

United States v. Senty-Haugen, 449 F.3d 862 (8th Cir. 2006)
United States v. Piggie, 303 F.3d 923 (8th Cir. 2002)
United States v. Akbani, 151 F.3d 774 (8th Cir. 1998)

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WHETHER THE DISTRICT COURT COMMITTED PLAIN ERROR IN ORDERING THAT TWO OF THE SUPERVISED RELEASE TERMS BE SERVED CONSECUTIVELY.

United States v. Gullickson, 982 F.2d 1231 (8th Cir. 1993)
United States v. Ravoy, 994 F.2d 1332 (8th Cir. 1993)
United States v. Ashland, Inc., 356 F.3d 871 (8th Cir. 2004)

STATEMENT OF THE CASE

On August 18, 2005, an Indictment was filed in the United States District Court for the District of South Dakota charging Lisa Refert[2] with one count of health care fraud in violation of 18 U.S.C. § 1347 and four counts of making a false claim in violation of 18 U.S.C. § 287. CR 1-3. A jury trial commenced on September 7, 2006 before United States District Court Judge Charles B. Kornmann. TT 6. On September 8, 2006, the jury found Refert guilty on all counts. CR 4-5. Refert filed a post-trial motion for judgment of acquittal with alternative motion for new trial. These motions were denied by the district court in an Order and Opinion filed January 3, 2007. DE 96. On January 17, 2007, Refert was sentenced to serve 3 months in custody, ordered to serve 3 years of supervised release on each count with 2 counts to run consecutively, and ordered to make restitution of $8,689.45. CR 6-11.

STATEMENT OF THE FACTS

On 88 occasions, Refert obtained free medical services from the Indian Health Service (IHS) by falsely representing that she was an enrolled member of the

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[2] The defendant in the Indictment was named as Sosaeoleisah C. Refert a/k/a Sosaeoleisah C. Bluespruce, a/k/a Leisah Bluespruce, a/k/a Lisa Refert. The district court found that the defendant had never produced documents demonstrating a legal name change and, therefore, in this brief the United States will refer to the defendant/appellant, as the court did at the sentencing hearing, by the name on her birth certificate – Lisa Refert.

Northern Cheyenne Tribe with 3/4-degree of Indian blood. When questioned about her eligibility, Refert provided multiple explanations of her Indian heritage and indicated she had documents that established her tribal enrollment. However, her promises to provide those to investigators went unfulfilled. Instead, the over-whelming weight of the evidence produced at trial demonstrated that Refert is not an enrolled member of any of tribe and that she was not otherwise eligible to receive free medical care from IHS facilities.

The Indian Health Service is an agency within the Department of Health and Human Services which provides limited medical services to eligible American Indian and Alaskan Native People. TT 24; Exh. 1. The operational budget for IHS comes through discretionary funding from Congress. *Id.* Currently, IHS is funded at 50 percent of actual documented need. TT 24. Services are provided only to eligible persons who meet the criteria for the program.[3] Nancy Davis, the Deputy Area Director for IHS, testified that in order to be eligible for direct health care benefits, an individual must "demonstrate tribal or Bureau of Indian Affairs documentation of Indian descent." TT 27. This generally means that the person is an enrolled member of a federally recognized tribe, is able to prove descendancy through a member of a

[3] The role of Indian Health Service and its funding limitations were generally discussed by the Supreme Court in *Lincoln v. Vigil*, 508 U.S. 185 (1993).

federally recognized tribe, or is recognized in the community as an Indian. TT 28. Ms. Davis testified that the general eligibility requirements were summarized in Exhibit 1, which is a resource document utilized by IHS to explain sources of funding and eligibility requirements. TT 26; Add. 1-9. Code of Federal Regulations provisions regarding eligibility for IHS services (42 C.F.R. §§ 136.11-136.14) were also introduced at trial. TT 56; Exh. B; Add. 10-11. Davis explained that it is the patient's burden to provide documentation to IHS establishing that they meet the eligibility requirements. TT 28. She also testified that the Bureau of Indian Affairs and the tribes maintain enrollment records which are commonly used by patients to prove eligibility. A tribe may also by resolution notify IHS that the patient is regarded as an Indian within the community. TT 56.

Refert moved to Eagle Butte, South Dakota, in early 1998 after she was hired by the Cheyenne River Sioux Tribe as the Chief Tribal Judge. TT 68-69, 72-73. In her job application, Refert claimed that she was born in Wyoming and was a member of the Northern Cheyenne Tribe. TT 69. The Northern Cheyenne Tribe has its headquarters in Lame Deer, Montana, and is not affiliated with the Cheyenne River Sioux Tribe.

Sometime in early 1998, Refert presented herself to the IHS facility in Eagle Butte, South Dakota, and requested free medical services, claiming to be eligible

because she was an enrolled member of the Northern Cheyenne Tribe. On at least two occasions, she completed IHS paperwork in which she represented that she was enrolled with the Northern Cheyenne Tribe. TT 36-38; Exh 16. In the same documents, Refert claimed to have 3/4-degree of Indian blood. *Id.* On one form, she stated that her father was Chester Bluespruce and that his place of birth was Sheridan, Wyoming. On the other form she indicated that her father was Chet Bluespruce and that he was born in Lame Deer, Montana. On both forms she listed Edna Refert of New York as her mother. *Id.* From 1998 to 2003, Refert obtained free medical services from IHS on at least 88 occasions by leading officials to believe she was an enrolled member of a federally recognized tribe and, therefore, eligible for free medical services. TT 60.

Medical and billing records concerning Refert's visits to the IHS facility in Eagle Butte were introduced into evidence at trial. TT 146-153; Exh. 17, 27. These included documentation of the four visits that formed the basis of the specific false claim counts – Counts 2-5 of the Indictment. TT 151; Exh. 27. Lisa Schlosser, the Business Manager for IHS, testified that during the time Refert was a Cheyenne River Sioux Tribe employee, the documents listed her as having insurance. However, Schlosser explained that the Tribe was in fact self insured and that under IHS

protocol, IHS did not bill the Tribe for services provided to Indian employees. TT 153-158, 163-164.

In 2001, questions began to arise as to whether Refert was in fact a member of any Indian tribe. During a meeting with the Tribal Council on November 1, 2001, Refert was asked whether she was in fact a Native American. TT 74. A transcript of those proceedings was introduced at trial. TT 74; Exh. 7. Refert told the Tribal Council that she had been a member of the Northern Cheyenne Tribe since birth. She also claimed she had given documentation proving this to IHS and to the Tribe. TT 75-76.

Tom Van Norman, the Tribe's senior attorney, then began to investigate Refert's claims. He reviewed Refert's tribal personnel file looking for any documents supporting her claim of tribal enrollment and found none. TT 76. He then contacted IHS, requesting officials to review their files to see whether Refert, as she had claimed to the Council, had submitted documents that proved her tribal enrollment. No documents were found. Van Norman also corresponded with several tribes from across the county to determine if Refert was an enrolled member. In his inquiries, he referenced the multiple names that Refert had used over the years. All replied that they had no such person on their tribal rolls. TT 76-82.

In October 2003, IHS officials sent Refert a letter informing her that, based upon their determination, she had never provided the documentation necessary to establish her eligibility for services. The letter further indicated IHS would no longer provide her with health care services unless she within 60 days provided the necessary documentation or requested a hearing. TT 32-33; Exh 2. Refert never submitted the documentation and never requested a hearing. TT 33.

At this time, Etheleen Jewett was working as the Administrative Officer at the Eagle Butte IHS facility. Jewett was familiar with Refert because Refert had previously done some legal work for her family. TT 138-139. Refert met with Jewett after she had received the letter from IHS. Jewett discussed the appeal process with Refert. Refert told Jewett she had her tribal enrollment documents at home and would provide them to Jewett. Refert never produced the documents. TT 140.

Following the October 2003 letter, this matter was referred to the Department of Health and Human Services – Office of Inspector General. TT 97-98. Special Agent Corey Dumdei interviewed Refert at her residence in Lantry, South Dakota, on October 14, 2004. Dumdei informed Refert that he was there to hear her side of the story. He told her he was investigating whether she in fact was an enrolled tribal member and thus eligible for free IHS medical services. TT 99-100. Refert told Dumdei that she was born in Wyoming and that her name at birth was Sosaeoleisah

Bluespruce. TT 100. She claimed that her father was Chester Bluespruce, III, and that her mother was Edna Refert. TT 101. When asked if whether she was an enrolled member of any tribe, Refert responded that she was enrolled through her mother with the Northern Cheyenne Tribe in Montana. *Id.* Refert also claimed to be eligible for enrollment in the Northern Cheyenne Tribe through her grandfather, Chester Bluespruce I (sic). *Id.* Refert further stated that she was eligible to be enrolled with the Onondaga Nation in New York through her mother, claiming that her mother was an enrolled member of that tribe. TT 102.

This information was inconsistent with what Refert had previously presented to the Social Security Administration. Agent Dumdei, prior to interviewing Refert, had obtained documents from a name change request that Refert had submitted to Social Security in 2001. In that request, Refert listed her place of birth as Long Branch, New Jersey. She listed her father's name as Richard Refert and her mother's maiden name as Edna Van Steenburg. TT 104-105; Exh. 18. During the interview, Dumdei confronted Refert with this information. Refert attempted to explain away the inconsistencies by stating that her parents went through a "rough divorce." TT 106. She said her mother moved back to New Jersey after the divorce and took back her maiden name, which she claimed was Refert. TT 107. During this interview, Refert also claimed that her mother had at one time attempted to enroll Refert in the

Onondaga Nation of New York. TT 107. Refert told Dumdei she had a tribal identification card or certificate of Indian blood document somewhere in her residence and promised to provide those to Dumdei after she located them. TT 108. She also claimed that she had previously provided a copy of this document to Etheleen Jewett, the Administrative Officer of the IHS facility in Eagle Butte. After the interview, Dumdei met with Ms. Jewett. They reviewed Refert's file at IHS and found no such document. TT 108.

Near the conclusion of the interview, Refert told Dumdei that the person she claimed to be her father, Chester Bluespruce, could be listed on the Northern Cheyenne rolls under the last name of Blue Earth. She also mentioned that she had some affiliation with the Southern Cheyenne Tribe in Oklahoma, claiming that she and her brothers received approximately $7,500 per year in royalty payments from trust land in Oklahoma. TT 109.

On numerous occasions after the October 2004 interview, Agent Dumdei contacted Refert to see if she had located the enrollment documents that she had promised to provide him. Despite repeated assurances from Refert that she had these documents, none were ever produced. TT 110.

Agent Dumdei uncovered numerous documents that demonstrated Refert was born in New Jersey, that she was not of Native American descent, and that she was

not an enrolled member of any recognized Indian Tribe. Dumdei obtained Refert's birth certificate, which established that she was born in Long Branch, New Jersey, on December 14, 1962 . TT 113; Exh. 9. Her father is listed at Richard Refert, and her mother's maiden name is listed as Edna Van Steenburg. The race for both parents is listed as white. However, other documents revealed that Refert had been adopted by her parents. The adoption papers from Monmouth County Court in New Jersey list the same date of birth and indicate that the natural mother's name is Karen Edith Skrivanek. TT 120; Exh. 15. Agent Dumdei was able to determine that the birth mother now goes by the name of Karen Worth. *Id.*

Armed with this and other information regarding Refert's parents, Agent Dumdei then contacted officials with the various tribes referenced by Refert to determine whether Refert, or anyone who was a parent or claimed parent of Refert, was on the tribal rolls. TT 113-136. It was discovered that no one with the various names used by Refert or her parents had ever been enrolled with any of these tribes.

At trial, Refert testified that she had "always known" Chester Bluespruce was her father but that she did not remember much about her childhood. TT 199-200. She indicated that her claim to be 3/4-Indian blood was based on her mother being an Onondaga and her father who was a full blood. TT 225. Refert testified that her father was deceased but that an uncle was still living. She explained that the uncle

was unavailable to testify because he was "moving cows." TT 223. Refert claimed that the case against her was all a part of a tribal political vendetta that started when she was removed from her position as tribal judge. TT 206. Despite the evidence to the contrary, Refert maintained that she had documents proving that she was a member of the Northern Cheyenne Tribe and that she had submitted them to IHS. TT 205. She also claimed that an assistant of hers had found these documents in Refert's trailer home and had sent copies of them to Agent Dumdei. TT 211.

No documents were ever produced by Refert before or at trial establishing her tribal membership. The enrollment officer from the Northern Cheyenne Tribe testified that no person with any of the name variations used or submitted by Refert as her name or her parents' names was or had been an enrolled member of that tribe. TT 172-184; Exh. 6, 26. The enrollment officer further stated that members of her tribe do not have names such as Blue Earth or Blue Spruce. TT 178, 185.

SUMMARY OF THE ARGUMENT

The district court did not commit plain error by not instructing the jury on the eligibility criteria to receive free medical services from Indian Health Service. The court's instructions were sufficient when considered as a whole because they adequately apprised the jury of the elements of the offenses charged in the Indictment and the government's burden of proof. Refert committed the crimes of health care

fraud and making false claims by falsely representing, with intent to deceive, that she was eligible for free IHS medical services and by specifically claiming she was an enrolled member of the Northern Cheyenne Tribe with 3/4-Indian blood. IHS officials relied on these representations in initially providing free care and in continuing to provide services to her until they were alerted that she was not a member of any tribe. At no time did Refert represent to IHS that she was entitled to free services based upon any other eligibility criteria and, therefore, any question regarding possibly being eligible on the basis of being "regarded as" an Indian in the community was not relevant to the charges contained in the Indictment.

Sufficient evidence was presented to support the two false claims convictions that arose from separate emergency room visits (Counts 2 and 4). IHS provided free services to Refert on those two occasions based on her false representations that she was an enrolled tribal member with 3/4-Indian blood. IHS regulations do provide that "[i]n case of emergency, as an act of humanity" services can be provided to individuals who are not eligible for free care. However, these services are not provided free of charge, and IHS is authorized to seek reimbursement for its costs. Refert was not billed for the services because IHS relied on her false representations that she was an enrolled tribal member. Refert, therefore, was properly convicted of making a false claim to the United States for these two occasions. Correspondingly,

properly included the cost of Refert's visits to the IHS emergency room in the restitution order.

The United States concedes that the district court improperly ordered that two of the terms of supervised release be served consecutively. This Court has previously held in *United States v. Gullickson*, 982 F.2d 1231, 1235 (8th Cir. 1993), that under the provisions of 18 U.S.C. § 3642(e), terms of supervised release on multiple counts of conviction must be ordered to run concurrently. The United States, therefore, suggests that this Court modify the judgment without remand and direct that all the terms of supervised be served concurrently. *See United States v. Ashland, Inc.*, 356 F.3d 871, 875 (8th Cir. 2004).

ARGUMENT

I.

THERE WAS NO PLAIN ERROR IN THE DISTRICT COURT NOT INSTRUCTING THE JURY ON ELIGIBILITY REQUIREMENTS FOR FREE IHS MEDICAL SERVICES.

A. Standard of review.

Refert did not ask the district court to instruct the jury on eligibility requirements for free IHS medical services and did not object to the court's instructions on the elements of the offense. This issue, therefore, can only be reviewed under the

plain error standard. *United States v. Falcon*, 477 F.3d 573, 577 (8th Cir. 2007); *United States v. Headbird*, 461 F.3d 1074, 1079 (8th Cir. 2006).

B. The court's instructions, when considered as a whole, properly instructed the jury on the elements of the offenses charged in the Indictment.

This Court has generally held that jury instructions are acceptable if, taken as a whole, they adequately apprise the jury of the essential elements of the offenses charged and the burden of proof required of the government. *United States v. Youngman*, 481 F.3d 1015 (8th Cir. 2007). In this case, the district court's instruction fully set forth the elements of the offenses charged in the Indictment – health care fraud in violation 18 U.S.C. § 1347, and false claims in violation of 18 U.S.C. § 287.

In order to convict Refert of health care fraud under 18 U.S.C. § 1347, the government was required to prove beyond a reasonable doubt that Refert knowingly and willfully executed, or attempted to execute, a scheme or artifice: (1) to defraud any health care benefit program; or (2) to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program in connection with the delivery of or payment for health care benefits, items, or services. *United States v. Boesen*, 2007 WL 1531415, No. 06-3290 (8th Cir. May 29, 2007). The trial court in this case properly explained these elements to the jury in Instruction 9. It utilized

Eighth Circuit Pattern Jury Instruction § 6.18.287 in explaining the elements of the false claim charges in violation of 18 U.S.C. § 287 in Instructions 10-14. The elements of the § 287 count were listed as:

> 1. On or about [_____], the defendant made or presented to the United States Department of Health and Human Services, Indian Health Service, a claim in the form of payment for health care benefits, items, or services, upon and against the Department of Health and Human Services, Indian Health Service, a department and agency of the United States.
>
> 2. The claim was false, fictitious, or fraudulent in that the defendant knew she was not eligible to receive health care benefits, items, or services paid for by Indian Health Service.
>
> 3. The defendant knew the claim was false, fictitious, or fraudulent.
>
> 4. The false, fictitious, or fraudulent claim was material to the Department of Health and Human Services, Indian Health Service.

CR 69 (Instruction 10).

The government's burden of proof was properly explained in the court's Instructions 3 and 4. The instructions as a whole, therefore, clearly set forth the elements of the crime alleged and government's burden of proof. Refert did not object to these instructions and did not submit any proposed instructions on elements of the charged offenses.

Refert argues in her brief that it was incumbent for the court to instruct on "the law regarding eligibility" for IHS services. App. Brief 13. She claims that conflicting information was provided to the jury regarding eligibility and that the jury could have rendered its verdicts based upon a misunderstanding of the eligibility requirements. *Id.*

This argument overlooks the specific question presented by the Indictment. The jury's inquiry was confined to determining whether Refert had unlawfully misled IHS officials into believing she was eligible for free medical services – not whether there was an alternate theoretical basis for eligibility. Refert's argument incorrectly suggests that the jury should have undertaken its own de novo review of her eligibility for IHS services under any and all criteria.

The record demonstrates, however, that Refert's sole basis for eligibility was her claim that she was an enrolled member of the Northern Cheyenne Tribe with 3/4-Indian blood. These representations were the "false and fraudulent pretenses" which formed the basis for the health care fraud violation alleged in Count 1 of the Indictment and the "false and fraudulent" claims underlying the false claims violations in Counts 2-5.

A somewhat similar argument was presented to this Court in *United States v. Patient Transfer Service, Inc.* 413 F.3d 734, 741 (8th Cir. 2005). In that case, some

of the charges involved double billing for ambulance transports when two patients were hauled at the same time. The defendant submitted claim forms to Medicare, falsely representing two separate single-patient transports. On appeal, the defendant argued that no regulation expressly prohibited this double billing and that conflicting information been given to Medicare providers on the practice. This Court upheld the convictions, noting that even if the regulations were not clear, the defendant had falsely represented that each transport was for a single patient. *Id.* *See also United States v. Peterson*, 223 F.3d 756, 762 (8th Cir. 2000).

In *United States v. Blecker*, 657 F.2d 629, 634 (4th Cir. 1981), the court found that a violation of 18 U.S.C. § 847 may be based simply on proof that the defendant knowingly submitted a false claim. It noted that it is not a defense that the government "got its money's worth" for false invoices submitted for consultant services. The offense is committed when the defendant knowingly submits false information to the agency which may induce the agency to act. *United States v. Adler*, 623 F.2d 1287, 1291 (8th Cir. 1980); *Boushea v. United States*, 173 F.2d 131, 135 (8th Cir. 1949).

Refert represented to IHS in the forms that she filled out that she was eligible based upon her tribal enrollment and her 3/4-Indian blood. IHS relied on these representations when they provided her services. The statements were false. It does

not matter whether Refert was possibly eligible under some other criteria, because she never represented to IHS that she was eligible on any other ground, and IHS did not act to provide services based upon some other basis for eligibility.

It is also important to note that no credible evidence was presented to the jury that would have allowed the jury to find under any standard that Refert was "regarded as" an Indian in the community in which she lived. The only witness that presented any testimony on this topic was Georgianne Dupris, a friend of Refert who had worked for her. It was Dupris who Refert claimed mailed the documents to Agent Dumdei that were never received. Dupris' testimony at trial was completed discredited. On cross-examination, her testimony was inconsistent with an affidavit that Refert had typed up for her to sign just a week before. TT 249-254. Even with this witness, all that Refert presented on the topic of whether she was "regarded as" an Indian in the community was a simple "yes she is" response. TT 249. No supportive evidence was presented on the other factors listed in 42 C.F.R. § 136.12(a)(2),such as ownership of trust land.[4] In fact, the evidence that was before

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[4] Generally, an individual may be regarded as within the scope of the Indian health and medical service program if he/she is regarded as an Indian by the community in which he/she lives as evidenced by such factors as tribal membership, enrollment, residence on tax-exempt land, ownership of restricted property, active participation in

(continued...)

the jury did not support the conclusion that Refert was "regarded as" an Indian in the community. She is not an enrolled member of any tribe. She could not demonstrate that she had any Indian blood. Her only direct involvement in tribal affairs was when she was a tribal judge and that appointment, in part, was based on her false claim of tribal enrollment.

II.

SUFFICIENT EVIDENCE WAS PRESENTED TO SUPPORT THE CONVICTIONS ON COUNTS 2 AND 4 WHICH INVOLVED SERVICES PROVIDED THROUGH THE IHS FACILITY EMERGENCY ROOM.

A. Standard of review.

Refert did not present this argument to the district court in her motion for judgment of acquittal that was made at the conclusion of the government's evidence. TT 189-190. She also failed to raise it in her post-trial motions for judgment of acquittal and new trial. DE 72. This issue, therefore, can only be reviewed for plain error. *United States v. Selwyn*, 398 F.3d 1064, 1066 (8th Cir. 2005).

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[4](...continued)

> tribal affairs, or other relevant factors in keeping with general Bureau of Indian Affairs practices in the jurisdiction.

B. The fact that Refert was treated in the emergency room at the IHS facility during the two visits which formed the basis for the charges in Counts 2 and 4 does not affect the validity of the convictions.

Two of the false claims counts (Counts 2 and 4) involved incidents when Refert was seen at the emergency room at the IHS facility in Eagle Butte. Exhibit 27 contained the specific medical records for the four visits which formed the basis for Counts 2-5. Count 2 involved a March 24, 2002 visit. On that day, Refert presented herself to the emergency room at 8:00 a.m complaining of a chronic headache. She was given a prescription and discharged at 8:10 a.m. Count 4 flowed from a July 27, 2003 visit to the emergency room. Refert arrived at 2:53 a.m. complaining she needed an inhaler and described cold-like symptoms. She was diagnosed as having bronchitis, given medications, and discharged at 3:08 a.m.

Refert argues in her brief that the convictions for these counts should be reversed because IHS is required to treat "anybody on an emergency basis." App. Brief 16. Refert is apparently referring to 42 C.F.R. § 136.14, which provides:

> (a) In case of an emergency, as an act of humanity, individuals not eligible under § 136.12 may be provided temporary care and treatment in Service facilities.
>
> (b) Charging ineligible individuals. Where the Service Unit Director determines that an ineligible individual is able to defray the cost of care and treatment, the individual shall be charged at rates approved by the Assistant Secretary for Health and Surgeon General published in the

> Federal Register. Reimbursement from third-party payors may be arranged by the patient or by the Service on behalf of the patient.

Refert's argument fails for several apparent reasons. First, as noted previously, the basis for the false claim charges was Refert's representations to IHS. She claimed she was an enrolled tribal member with 3/4-Indian blood and, therefore, entitled to free medical services. *See Patient Transfer Services, Inc.*, 413 F.3d at 741; *Peterson*, 223 F.3d at 762; *Blecker*, 657 F.2d at 634. Refert never represented to IHS that she should be cared for because she was in need of emergency services.

Second, the two visits in Counts 2 and 4 can hardly be considered cases "of an emergency" where IHS provided services "as an act of humanity" as described in the regulation. These were visits where Refert just showed up at the emergency room, more as an apparent matter of convenience for her rather than medical necessity.

Lastly, even when emergency medical services are provided under this provision, they are not free. The Service Unit Director is authorized to bill patients who have the ability to pay. That was not done here, however, because Refert had represented herself to be an enrolled tribal member entitled to free medical services. Counts 2 and 4 of the Indictment specifically alleged that Refert's claim was false because she was aware that she was not eligible "to receive health care benefits, items and services, paid for by Indian Health Service." (Emphasis added.)

III.

THE DISTRICT COURT DID NOT COMMIT PLAIN ERROR BY INCLUDING IN THE RESTITUTION ORDER THE AMOUNTS RELATED TO EMERGENCY SERVICES.

A. Standard of review.

Refert failed to raise, either in her objections to the presentence report or at sentencing, any argument regarding the inclusion of emergency room services in the restitution order and, therefore, this argument is only reviewed for plain error. *United States v. Piggie*, 303 F.3d 923, 928 (8th Cir. 2002).

B. Refert was not entitled to free emergency services and, therefore, the amounts attributable to those visits were properly included in the court's restitution order.

Government agencies that are victims of offenses involving fraud and deceit are entitled to restitution under the Mandatory Victims Restitution Act. 18 U.S.C. §§ 3663, et seq. *United States v. Senty-Haugen*, 449 F.3d 862, 865 (8th Cir. 2006). Sentencing courts have wide discretion in determining the appropriate amount of restitution, especially in cases, such as here, where the defendant does not object to the amount of restitution at the sentencing hearing. *United States v. Akbani*, 151 F.3d 774, 779 (8th Cir. 1998). In this case, the district court properly included as a loss to the victim the cost of the services provided. *See Piggie*, 303 F.3d at 927.

Refert restates her argument regarding Counts 2 and 4 which involved emergency room services and claims the court should not have included in the restitution amount any of the costs related to the times Refert received services at the emergency room of the IHS facility in Eagle Butte. As demonstrated previously, non-eligible individuals are not entitled to free medical services from IHS even under true emergency situations. Refert obtained these services without being charged for them by making false representations to IHS.

IV.

UNDER THIS COURT'S HOLDING IN *UNITED STATES v. GULLICKSON*, REFERT'S SENTENCE SHOULD BE MODIFIED BY THIS COURT TO ORDER THAT ALL TERMS OF SUPERVISED RELEASE RUN CONCURRENTLY.

A. Standard of review.

Refert did not object to this portion of her sentence at the sentencing hearing and did not file any motion under Fed. R. Crim. P. 35 requesting that the sentence be corrected. This issue, therefore, is reviewed under the plain error standard. *United States v. Ristine*, 335 F.3d 692, 694 (8th Cir. 2003).

B. Refert's terms of supervised release on her five counts of conviction should run concurrently.

At the sentencing hearing, the district court, after indicating that it wanted to make sure that restitution was paid in full, ordered that two of the three-year terms of

supervised release be served consecutively. ST 121. The written judgment also directs that two of the three-year terms are to run consecutively. DE 102. The court's sentence in this regard was contrary to this Court's holding in *United States v. Gullickson*, 982 F.2d 1231, 1235 (8th Cir. 1993).

In *Gullickson*, this Court found that under the provisions of 18 U.S.C. § 3624(e), terms of supervised release on multiple counts of conviction must be ordered to run concurrently.[5] In *United States v. Ravoy*, 994 F.2d 1332, 1337 (8th Cir. 1993), this Court reaffirmed its holding in *Gullickson*, stating that the statute "unambiguously states that terms of supervised release on multiple convictions are to run concurrently." Other courts have reached the same conclusion. *See United States v. Herndandez-Guevara*, 162 F.3d 863, 877 (5th Cir. 1998); *United States v. Bailey*, 76 F.3d 320, 323 (10th Cir. 1996).

The United States concedes that the portion of the district court's sentence which directs that two of the three-year terms of supervised are to be served consecutively is plain error, and the judgment needs to be corrected. The United

---

[5] (e) **Supervision after release.** – The term of supervised release commences on the day the person is released from imprisonment and runs concurrently with any Federal, State, or local term of probation or supervised release or parole for another offense to which the person is subject or becomes subject during the term of supervised release. . . .

States suggests that the sentence can be modified by this Court without a remand under 28 U.S.C. § 2106.[6] In *United States v. Ashland, Inc.*, 356 F.3d 871, 875 (8th Cir. 2004), this Court found that an appellate court could modify the judgment before it under the authority vested in it under this statute. This would avoid any waste of resources which would result from directing a resentencing hearing where the parties would be required to appear simply to change one line of the judgment.

CONCLUSION

Accordingly, and based upon the foregoing, the Government respectfully requests that this Court affirm Refert's conviction and modify the Judgment to reflect that all terms of supervised release are to run concurrently.

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[6] The Supreme Court or any other court of appellate jurisdiction may affirm, modify, vacate, set aside or reverse any judgment, decree, or order of a court lawfully brought before it for review, and may remand the cause and direct the entry of such appropriate judgment, decree, or order, or require such further proceedings to be had as may be just under the circumstances.

Respectfully submitted this 3rd day of July, 2007.

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CERTIFICATE OF COMPLIANCE

I hereby certify that this brief was prepared using Corel WordPerfect 12 and is 30 pages or less in proportional spacing in 14-pt. type and is therefore in compliance with Fed. R. App. P. 32(a)(7). I further certify that I have provided to the Court and to each party separately represented by counsel a CD containing the full text of the brief. The CDs have been scanned for viruses using Trend Micro OfficeScan Corporate Edition 6.5 and are virus free.

DENNIS R. HOLMES
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CERTIFICATE OF SERVICE

The undersigned hereby certifies that service of the foregoing brief was made upon the Appellant by mailing by first class mail, postage prepaid, two true and correct copies thereof and one CD containing the brief to Appellant and her attorney of record at their respective post office addresses as shown, on this 3rd day of July, 2007:

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ADDENDUM

ABERDEEN AREA OFFICE OF RESOURCE MANAGEMENT

BUSINESS OFFICE
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605-226-7575

ADDENDUM 1

INDIAN HEALTH CARE
SERVICES AND ELIGIBILITY INFORMATION

This document is intended to help individuals understand the regulations, policies, and procedures regarding the provision of health care services to American Indian and Alaskan Native (AI/AN) People. There are three health care systems that provide care to AI/AN People, the Indian Health Services (IHS), the Tribal Programs (contract and compact with the Federal Government) and the Urban Clinics. In addition, it is acknowledged that individual AI/AN Tribes determine enrollment criteria for each Tribe.

OVERVIEW

- The IHS is an agency of the United States within the Department of Health and Human Services.
- The IHS is funded by annual appropriations of the U.S. Congress.
- The **funding is discretionary** and serves over 1.5 million American Indians and Alaskan Natives (AI/AN) throughout the U.S.
- The funding to care for eligible AI/AN people is about 50 % of the actual need
- By virtue of funding source, the IHS **is neither an insurance plan nor an entitlement program and there is no universal benefit package.**

Medicare is an example of a Federal Government entitlement program. There is a universal benefit package for specific people (as defined by Medicare).

- Some Tribes contract or compact with the Federal Government/IHS and provide the health care.
- Some AI/AN People receive care in Urban Clinics, which receives partial funding from the Federal Government/IHS. See the section specific to Urban Clinics.
- The IHS and Tribal Facilities provide two types of health services: direct and indirect. Eligibility requirements for both types of care are discussed herein.

Direct services are those provided **within** IHS or tribal facilities.

Indirect services are those **outside of the facility,** purchased and provided in the private sector; this care is known as Contract Health Services (CHS).

- Urban Clinics do not receive CHS funding.

Because of funding limitations, IHS cannot guarantee that funds will be available to pay for all services. Contract Health Services funds are intended to help pay for health care when no other sources of health care payment are available, or to supplement other alternate resources (e.g., Medicaid). This enables the IHS to stretch the limited funds and to provide more health care for the AI/AN people.

Payments for health care outside an IHS facility can only be authorized by a CHS authorizing official. No one else can authorize payment. The CHS payments are authorized based on guidelines and eligibility criteria.

DIRECT HEALTH CARE SERVICES

Direct health care refers to health services provided at IHS or tribally operated hospitals, clinics, and health stations.

A person is eligible for direct health care if she/he meets one of the following criteria:

- Demonstrates **tribal** or **Bureau of Indian Affairs documentation** of **Indian descent**.
- Is an Indian of Canadian or Mexican origin who resides in the US and is an enrolled member or descendent of an American federally recognized tribe or (proof required).
- Is a non-Indian woman pregnant with an eligible male Indian's child for the duration of her pregnancy (usually through postpartum) for pregnancy related care. (Marriage license required). In a non-married situation, an Indian man must acknowledge paternity in written form and notarized. (Proof required)
- If a non-Indian member of an eligible Indian's household and the Medical-Officer-in-Charge determine that services are necessary to control a public health hazard of an acute infectious disease.
- Non-Indian member of an eligible Indian's household up to 19 years of age. (Adopted, foster child, or step-child). (Proof required)

Indian Health Service facilities comply with Emergency Medical Treatment and Active Labor Act (EMTALA) therefore in the case of an Indian Health Service hospital emergency department, if any individual (whether or not eligible for care by the Indian Health Service)presents to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition (TITLE 42, Chapter 7, Subchapter XVIII, Part D § 1395dd).

THIRD PARTY REIMBURSEMENTS

Due to limited appropriations and high unmet health care needs, in 1976 Congress extended the Indian Health Service the authority to bill for services that have been provided at the Indian Health Service. However, to be able to exercise the authority, facilities must earn and retain certification and/or accreditation from one of the certifying bodies:

- Certification from Centers of Medicare and Medicaid Services (formerly Health Care Financing Administration)
- Joint Commission on Accreditation of Healthcare Organizations
- Accreditation Association for Ambulatory Health Care

Indian Health Service facilities are precluded from billing health insurance plans that are Tribally Funded Self-Insurance.

- Medicare and Medicaid reimbursements received for services provided in a federally owned or leased facility belong to the Indian Health Service.

- Reimbursements from Medicare and Medicaid are to be used to maintain accreditation/certification status.

- Any person who is not eligible for services will be billed for the services provided.

CONTRACT HEALTH SERVICES

Contract health services are provided by private doctors and hospitals; providers under contract must be utilized if at all possible. The CHS program is used when:

- No tribal or direct care facility exists.
- The IHS direct care facility is not capable of providing the required care.
- A patient's alternate resource is not sufficient to cover the entire cost of the required care.

  An Indian is eligible for CHS if she/he is eligible for direct health care services and lives on a federally recognized Indian reservation. An Indian living off the reservation must meet additional criteria to be eligible for CHS.

- The patient's home reservation must be part of or touch the county in which he/she lives. This is called the contract health services delivery area (CHSDA).

OR

- The patient must have close social and economic ties (by marriage, full time employment or by tribal certification) to a tribe whose reservation is in the CHSDA.

OR

- The patient must be away from his/her CHSDA only because he/she is a full-time student, foster child, or transient (e.g. migratory/seasonal worker), or must have left his/her CHSDA less than 180 days ago.

  Other eligibility circumstances:

- A non-Indian woman pregnant with the child of a male Indian eligible for CHS.
- A non-Indian member of the household of an Indian who is eligible for CHS, if the Medical-Officer-in-Charge determines that services are necessary to control a public health hazard.

EMTALA Medical Screening Examinations (MSE) are not Priority I care. Therefore if the care required is Emergent and is considered a Priority I by the individual CHS Committee, payment for the MSE will be included in the payment of care for a CHS eligible Indian patient.

ALTERNATE RESOURCES

Authorities for use of Alternate Resources:

- Indian Health Care Improvement Act (IHCIA) Title IV permits Medicare and Medicaid payments to the Indian Health Service
- Public Law 100-713-Title II, IHCIA Section 206 permits private insurance to both IHS and tribally owned and operated facilities
- Social Security Act- Section 1905 permits Medicare and Medicaid payments to tribally owned and operated facilities

Alternate Resources definition- Alternate Resources are health care funding sources other than the Indian Health Service or tribal programs that are available and accessible to an individual. Alternate Resources include, but are not limited to, Medicare, Medicaid, Veterans Administration, private health insurance, vocational rehabilitation, workmen's compensation, vehicle insurance (medical coverage) and state programs.

An individual is not required to expend personal resources, sell valuables or property to qualify for alternate resources.

Application is a requirement. An individual must apply for alternate resources if there is a reasonable indication that the person maybe eligible for these resources.

Failure to apply for and/or use an alternate resource will result in a CHS denial of payment.

Using an alternate resource does not disqualify an eligible Indian from receiving direct health care services. The IHS will bill the alternate resource for payment.
Some examples of alternate resources:

- Medicare Part A, Part B and Part D
- Medicaid- Examples: Arizona: Health Care Cost Containment System, California: Medi-Cal
- Private Insurance
- Civilian Health and Medical Program of the Uniformed Services
- Veteran's benefits (ChampVA)
- Crippled Children's Services
- Tribally-funded Self Insurance (for CHS purposes only; IHS may not bill)
- Auto Insurance (liability)
- Workmen's Compensation
- State Vocational Rehabilitation
- State Maternal and Child Health Programs
- Examples: State- Children's Health Insurance Program
  Arizona: Newborn Intensive Care Program
  California: Child Health and Disability Prevention Program
- Another Indian Health Service facility

Students whose education grants include funds for health services will be expected to use the grant funds to purchase available student health insurance.

Indian Health Service cannot request an individual to spend personal funds to purchase an alternate resource, such as:

- **Medicare Part B** and **Part D** requires patient to pay a monthly premium
- Indian Health Service cannot pay Medicare Part B or Part D premiums
- Two ways premiums may be paid:

A) Qualified Medicare Beneficiaries- this is a State Medicaid program
   - Application is required

1) Income guidelines must be met
- With application approval State Medicaid will pay
  1) Medicare Part B premiums
  2) Provide Medicaid coverage for the patient

B) A tribe may contract for a grant to pay Medicare Part B premiums for
- Patients who meet the grant proposal requirements
- Who are eligible for Qualified Medicare Beneficiaries

• **Medicaid Spend Down** (or patient liability) - some states require the patient (not IHS or the tribe) to pay up to a specific dollar amount before Medicaid will pay

• **Health Insurance**- requires the patient to pay a premium

Tribally Funded Self-Insurance: Tribes have the option to have a group policy with an insurance company.
- Tribally Funded Self- Insurance is not a Contract Health Service alternate resource
- Indian Health Service cannot bill Tribally Funded Self-Insurance for direct care that is provided in an IHS facility

Other Insurance: Life Insurance or Supplemental Income/Indemnity or Compensation Income Insurance is not considered an alternate resource. These types of insurance are for personal benefit only. They cannot be billed nor can the patient be asked or requested to pay part of their medical expenses with the money collected from these types of insurance. However, the patient has the choice.
- Example: A CHS eligible patient has Supplemental Income Insurance and is referred by IHS/Tribal Program. Contract Health Services cannot require the patient to pay for the medical care but the patient may choose to pay part of the medical bill by sending a personal check to the medical provider. This is acceptable because it is the patient's choice.

Often these alternate resources can pay for a source of health care service that the IHS is unable to provide because of funding limitations.

BENEFITS – INCLUSION, EXCLUSIONS & LIMITATIONS

The Contract Health Services Program guidelines determine which services can and cannot be paid for.

Due to limited funding to access CHS it is necessary to abide by the Medical Priorities of Care. Presently, only Priority I (emergent, saving of life and limb) is being authorized.

In general, if funding is not limited **CHS *MAY* Pay** for:
- Physician and other health professional services
- Inpatient and out patient hospital services
- Patient and escort services
- Other authorized support services for eligible AI/persons.

- Provided there are sufficient funds to meet higher levels of care, skilled nursing home services, as defined by Medicare regulations, may be paid.

The **CHS *DOES NOT* PAY** for:

- Services or supplies that are not necessary for the diagnosis and treatment of a covered illness or injury
- Services and supplies for which the patient has no legal obligation to pay or for which no charge would be made if the individual was not eligible for CHS
- Services or supplies furnished by local, State or other Federal programs, including care for individuals incarcerated by law enforcement agencies
- Naturopaths
- Burials
- Personal comfort and /or convenience items
- Sterilization's that do not meet IHS regulations
- EMTALA Medical Screening Examinations

PAYMENT DENIALS

The most common reasons for Contract Health Services denials are:

- Lack of appropriate documentation of Indian descent.
- Residency off a reservation or outside a Contract Health Services Delivery Area.
- The patient fails to obtain prior approval within 72 hours for an emergency service.
- The patient fails to apply for potential or established alternate resources or to use such resources.
- A diagnosed medical problem is not within established medical priorities.

Remember

It is important to remember:

- Only the CHS Program Officer or CEO/Service Unit Director can authorize payment for off-site care.
- Physicians and other health care professionals **CANNOT** authorize payment for care.

The IHS/CHS Program is discretionally funded annually by the U.S. Congress.

- By virtue of the funding source, the IHS is neither an insurance plan nor an entitlement program and there is no universal benefit package.
- The IHS cannot guarantee that funds will be available for all services needed by the AI/AN people.

PATIENTS RIGHTS & RESPONSIBILITIES

It is the patient's responsibility to register with his/her local IHS Hospital, clinic or tribal program. Through registration, eligibility for direct care and CHS is determined as well as any/all potential or established alternate resources are identified. The patient has to provide documentation that will prove that she/he is an AI/AN descent, and may be asked to verify residency.

Notification Requirements:

The elderly and disabled may need assistance.

The individual requiring CHS (or his/her proxy) **must obtain prior** approval from an IHS authorizing official for non-emergency services. Non-emergencies are routine and preventive medical services.

For emergency services, the individual (or his/her proxy) **must notify** the IHS authorizing official **within 72 hours** of the initiation of services. An emergency is a **Priority I** condition that represents and immediate threat of loss of life, limb or special sense (vision, hearing, etc.)

On October 29, 1992, Section 406 of Public Law (P.L.) 102-573 extended the 72-hour emergency notification requirement described above to 30 days for elderly and disabled Native Americans after admission to a non-IHS facility or after the beginning of treatment.

CARE & TREATMENT OF MINORS

Legal Definition of a minor patient, an infant or person under the age of legal competence. This age is established by statute in many States. Where no State statute exists, 18 are considered the age of majority.

State laws and Federal court case law establish certain conditions that may be treated without parental consent of a minor patient. However, in most instances it is better to obtain consent of both patient and parent.

Although age is frequently looked upon as the sole criterion for ability to give legal consent for treatment, the effect of marriage, maturity, and emancipation must also be considered.

Actual care and treatment of minors. A parent or guardian of any minor or the legal guardian of any individual who has been declared incompetent due to physical or mental incapacity by a court of competent jurisdiction is authorized to act on behalf of a subject individual. An individual authorized to act on behalf of a minor or legally incompetent individual will be viewed as if he/she were the subject individual with exception of total access to the record. A parent or guardian will furnish verification of identity as required in 45 CFR.

Consent for Operation and Treatment in Cases of minor.
Parents or Guardian: Operations on minor children shall be lawfully authorized by the parent or if there is no parent, by court appointed legal guardian.

- If a minor patient is at an age of reason (can understand the nature of the procedure and why it is to be performed), his/her consent should be obtained.
- Where parents are divorced, consent for procedure in the case of a minor is a matter of state law. In the absence of State law prohibition or a court order on one of the natural parents, the other natural parent is equally the next of kin of the minor child and as such has a right to consent to medical procedures. However, the consent of the custodial parent should be obtained when possible or practical.

- The minor has a guardian appointed by the court to manage his/her affairs if he/her has no parents or the parents have been deprived of the child's custody or control by the court.
- Permission of adult siblings of a minor may not substitute for the permission of the parent. In emergencies, policies regarding emergency cases would prevail and the written permission of the adult sibling should be obtained in the absence of the next of kin or court appointed guardian.
- Laws of States are generally consistent with Federal regulations and case law in allowing treatment of minors for certain conditions, such as Sexually Transmitted Disease, drug addiction, alcoholism, birth control, and OB care without parental consent. However, where conflict exists, the issue should be referred to your Regional Attorney.

Definition of Emancipated Minors: Mature minors earning their own livelihood and retaining their earnings are emancipated. The term emancipated, as used with reference to the parent-child relationship, involves an entire surrender of the right to the care, custody, and earnings of such child as well as a renunciation of parental duties. Emancipation may be expressed, implied, or granted by court petition.

- Mature minors earning their own livelihood and retaining their earnings may consent to surgical procedures.
- Whenever possible, the signed consent of the parent should also be obtained. Unsuccessful efforts should be documented within the patient's medical record.
- Parental control ceases upon the marriage of a minor, whether married with or without the consent of the parents.
- Since marriage emancipates the female minor, she has the same right to consent to a medical procedure as does her husband. The husband's or parent's consent is not needed for an operation which she has authorized. Minor parents may consent to treatment of their children.

§ 136.2 Purpose of the regulations.

The regulations in this part establish general principles and program requirements for carrying out the Indian health programs.

§ 136.3 Administrative instructions.

The service periodically issues administrative instructions to its officers and employees, which are primarily found in the *Indian Health Service Manual* and the Area Office and program office supplements. These instructions are operating procedures to assist officers and employees in carrying out their responsibilities, and are not regulations establishing program requirements which are binding upon members of the general public.

Subpart B—What Services Are Available and Who Is Eligible To Receive Care?

SOURCE: 64 FR 58319, Oct. 28, 1999, unless otherwise noted. Redesignated at 67 FR 35342, May 17, 2002.

§ 136.11 Services available.

(a) *Type of services that may be available.* Services for the Indian community served by the local facilities and program may include hospital and medical care, dental care, public health nursing and preventive care (including immunizations), and health examination of special groups such as school children.

(b) *Where services are available.* Available services will be provided at hospitals and clinics of the Service, and at contract facilities (including tribal facilities under contract with the Service).

(c) *Determination of what services are available.* The Service does not provide the same health services in each area served. The services provided to any particular Indian community will depend upon the facilities and services available from sources other than the Service and the financial and personnel resources made available to the Service.

§ 136.12 Persons to whom services will be provided.

(a) *In general.* Services will be made available, as medically indicated, to persons of Indian descent belonging to the Indian community served by the local facilities and program. Services will also be made available, as medically indicated, to a non-Indian woman pregnant with an eligible Indian's child but only during the period of her pregnancy through postpartum (generally about 6 weeks after delivery). In cases where the woman is not married to the eligible Indian under applicable state or tribal law, paternity must be acknowledged in writing by the Indian or determined by order of a court of competent jurisdiction. The Service will also provide medically indicated services to non-Indian members of an eligible Indian's household if the medical officer in charge determines that this is necessary to control acute infectious disease or a public health hazard.

(2) Generally, an individual may be regarded as within the scope of the Indian health and medical service program if he/she is regarded as an Indian by the community in which he/she lives as evidenced by such factors as tribal membership, enrollment, residence on tax-exempt land, ownership of restricted property, active participation in tribal affairs, or other relevant factors in keeping with general Bureau of Indian Affairs practices in the jurisdiction.

(b) *Doubtful cases.* (1) In case of doubt as to whether an individual applying for care is within the scope of the program, the medical officer in charge shall obtain from the appropriate BIA officials in the jurisdiction information that is pertinent to his/her determination of the individual's continuing relationship to the Indian population group served by the local program.

(2) If the applicant's condition is such that immediate care and treatment are necessary, services shall be provided pending identification as an Indian beneficiary.

(c) *Priorities when funds, facilities, or personnel are insufficient to provide the indicated volume of services.* Priorities for care and treatment, as among individuals who are within the scope of the program, will be determined on the

ADDENDUM 10

basis of relative medical need and access to other arrangements for obtaining the necessary care.

§ 136.13 [Reserved]

§ 136.14 Care and treatment of ineligible individuals.

(a) In case of an emergency, as an act of humanity, individuals not eligible under § 136.12 may be provided temporary care and treatment in Service facilities.

(b) Charging ineligible individuals. Where the Service Unit Director determines that an ineligible individual is able to defray the cost of care and treatment, the individual shall be charged at rates approved by the Assistant Secretary for Health and Surgeon General published in the FEDERAL REGISTER. Reimbursement from third-party payors may be arranged by the patient or by the Service on behalf of the patient.

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

Subpart C—Contract Health Services

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

§ 136.21 Definitions.

(a) *Alternate resources* is defined in § 136.61 of subpart G of this part.

(b) *Appropriate ordering official* means, unless otherwise specified by contract with the health care facility or provider, the ordering official for the contract health service delivery area in which the individual requesting contract health services or on whose behalf the services are requested, resides.

(c) *Area Director* means the Director of an Indian Health Service Area designated for purposes of administration of Indian Health Service programs.

(d) *Contract health service delivery area means* the geographic area within which contract health services will be made available by the IHS to members of an identified Indian community who reside in the area, subject to the provisions of this subpart.

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

(f) *Emergency* means any medical condition for which immediate medical attention is necessary to prevent the death or serious impairment of the health of an individual.

(g) *Indian tribe* means any Indian tribe, band, nation, group, Pueblo, or community, including any Alaska Native village or Native group, which is federally recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

(h) *Program Director* means the Director of an Indian Health Service "program area" designated for the purposes of administration of Indian Health Service programs.

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

(j) *Secretary* means the Secretary of Health and Human Services to whom the authority involved has been delegated.

(k) *Service* means the Indian Health Service.

(l) *Service Unit Director* means the Director of an Indian Health Service "Service unit area" designated for purposes of administration of Indian Health Service programs.

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

§ 136.22 Establishment of contract health service delivery areas.

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

(1) The State of Alaska;

(2) The State of Nevada;

(3) the State of Oklahoma;