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BY CORTNEY

SIERRA COUNTY

INDIGENT HEALTH CARE ORDINANCE NO. 23-006

PASSED: 12/19/2023

EFFECTIVE: 30 days

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BY CORTNEY

SIERRA COUNTY
ORDINANCE NO. 23-006

AN ORDINANCE CONCERNING INDIGENT HOSPITAL CLAIMS TO REPLACE ALL ORDINANCES AND RESOLUTIONS PREVIOUSLY ADOPTED BY THE BOARD OF COUNTY COMMISSIONERS, SIERRA COUNTY, NEW MEXICO

WHEREAS, the Board of County Commissioners of Sierra County, New Mexico, is required by law to sit as the Sierra County Indigent Hospital Claims Board for the purpose of administering the Indigent Hospital and County Health Care Act, NMSA 1978, Sections 27-5-1 to 27-5-18 (1965, as amended through 2004), and adopting Rules and Regulations for the processing of said claims; and,

WHEREAS, the Sierra County Indigent Hospital Claims Board has seen the need to adopt Rules and Regulations for the processing of Indigent Hospital Claims; and,

WHEREAS, the Sierra County Indigent Hospital Claims Board desires to establish a maximum income for any individual who may seek to claim benefits under the Indigent Hospital Claims Act from Sierra County.

NOW, THEREFORE, BE IT ORDAINED by the Sierra County Board of Commissioners as follows:

SECTION 1 – GENERAL PROVISIONS

1.1 Title. This Ordinance shall be known and may be cited as the "Sierra County Indigent Hospital/Health Care (IHC) Ordinance" and shall be referred to herein as the IHC Ordinance.

1.2 Authority. This Ordinance is created pursuant to the Indigent Hospital Claims and County Health Care Act, Section 27-5-1 NMSA 1978 et seq.

1.3 Purpose. The purpose of this ordinance is to assist the indigent residents of Sierra County to obtain health care. To further this goal, the County has adopted this ordinance which recognized the County's responsibility to assist indigents in paying for health care.

1.4 Interpretation. The County Manager shall interpret the meaning of the provisions of this Ordinance. Whenever any provision of this Ordinance conflicts with other laws, rules, regulations or ordinances, the more restrictive shall govern.

1.5 Approval of Claims by the IHC Board. All IHC Claims paid to eligible recipients shall be approved by the Board of County Commissioners, sitting as the IHC Board.

1.6 Decision in Writing. The IHC Board shall state in writing the reasons for their decision to approve or disapprove any claim.

1.7 Administrative Expenses. In accordance with Section 27-5-1 NMSA 1978, a percentage of funds received by the County shall be reserved and budgeted for administrative expenses. The funds budgeted as administrative expenses shall not be available for payments of IHC Claims.

1.8 Claims Subrogation. The IHC Board is permitted to recover costs and payments in accordance with Section 27-5-14 and 27-5-15 NMSA 1978.

1.9 Open Meetings. The IHC Board shall conduct their meetings in accordance with the Open Meetings Act. Section 10-15-1 NMSA 1978.

1.10 Appendices. The schedules attached to this Ordinance as appendices may be revised, modified or amended by resolution of the Board of County Commissioners.

1.11 Amendments. Amendments to this Ordinance shall be approved by the IHC Board at a public hearing after providing notice of the public hearing in accordance with New Mexico State Statutes.

1.12 Severability. It is the intent of the governing body that the sections, paragraphs, sentences, clauses and phrases of this Ordinance are severable, and if any phrase, clause, sentence, paragraph or section of the Ordinance shall be determined to be invalid for any reason, such invalidity shall not affect any of the remaining phrases, clauses, sentences, paragraphs and sections of the Ordinance.

SECTION II – DEFINITIONS

The following terms are defined to be used for the purpose of this ordinance, regardless of common usage of such terms, or usage for other purposes.

CLAIM: Billing statements for an episode of illness, injury or other medical treatment as deemed necessary to an indigent patient.

CLAIMANT: A person who makes a claim for IHC assistance for medical services he or she received.

CLAIMANT'S AGENT: The individual authorized to provide consent for treatment of the claimant as specified in the New Mexico Hospital Association Legal Handbook.

CLAIMANT'S REPRESENTATIVE: The provider or individual that is authorized by the claimant or the claimant's agent to submit a Formal Application on behalf of the claimant.

CO-INSURANCE DAYS: The total sum of money the patient is expected to pay as per co-insurance days which usually the sixty-first (61st) through the ninetieth (90th) day in each benefit period for which the patient pays the required amount per day himself. The reserve period from the ninetieth (90th) day through the one hundred fiftieth (150th) day for which the patient pays the required amount per day. This reserve period is only sixth (60) days in the patient's lifetime.
Definition is subject to change and will be applicable as defined in the Medicare Manual.

ELECTIVE SURGERY OR TREATMENT: Non-emergency hospital surgery or treatment, as recommended by physician(s). This treatment is not medically necessary to the patient's health or well-being, but can be requested by the patient.

EMPLOYED OR CONTRACTED: A physician that is employed by or contracts with a medical provider or provides services which are billed by the medical provider for the provider on routine, normal or regular basis.

EMERGENCY: Medical care required for a serious medical condition resulting from injury or illness that arises suddenly and required immediate care and treatment to avoid jeopardy to the life or health of an individual.

HOME HEALTH AGENCY: A profit or non-profit organization which provides Skilled Nursing Care, Physical Therapy, Speech or Occupational Therapy, Home Health Aide, medical supplies and prescribed medication to an indigent patient. This organization is required to be certified and licensed by Medicare and the State of New Mexico.

HOSPICE SERVICES: An organization which provides care for the terminally ill patient which is licensed and certified by Medicare and the State of New Mexico.. These services include physicians' services, skilled nursing care, physical and speech therapy, pastoral care, medically necessary prescribed medication related to terminal care, equipment, intravenous and other supplies.

INDIGENT: "Indigent" is based on the definition of "indigent patient" pursuant to NMSA 27-5-4, Paragraph C, that defines indigent patient as persons to whom an ambulance service, a hospital or medical provider determined to be eligible under the provisions of the ordinance has provided medical care or ambulance transportation and who can normally support himself and his dependents on present income and liquid assets available to him but, taking into consideration this income and those assets and his requirement for other necessities of life for himself and his dependents, is unable to pay the cost of such medical services. The policy of the IHC Board, established by the rules and regulations of this ordinance pursuant to NMSA 27-5-6, Paragraph C, specifies the provisions and criteria for determining which persons are qualified indigent persons and therefore eligible to receive IHC assistance, consistent with the above referenced statutory provision, that are deemed necessary to carry out the provisions of the Indigent Hospital and Health Care Act. The IHC Board has permitted the use of the Sierra County IHC Income Schedule as a tool to be used to determine the income for an individual or family.

LIQUID ASSETS: Assets that can quickly or easily be converted to cash (bank accounts, CD's, marketable securities, etc.).

MEDICALLY INDIGENT: An individual that needs medical care or treatment, but due to their individual circumstances are financially unable to pay the cost of such treatment. An individual that earns up to 150% of the Federal Poverty Guidelines is medically indigent for the purposes of this Ordinance.

MEDICAL PROVIDER: Any general or limited care certified hospital, institution or agency that is properly licensed and certified to provide medical services, and may be

eligible to receive IHC reimbursement for medical services based on the provisions specified in this ordinance.

NON-EMERGENCY SURGERY OR TREATMENT: The treatment or surgical procedure that is not for an emergency condition, but is medically necessary to the well being of the patient. This treatment is eligible for assistance.

NON-EMERGENCY TRANSPORTATION: The transporting of indigent patients by a non-emergency vehicle. This type of transport does not require any medical treatment to be rendered to the patient, unless as otherwise specified in the provider agreement with the Department of Transportation.

OUTPATIENT HOSPITAL SERVICES: Hospital sponsored ambulatory care service for medical or surgical treatment of one or more organizational units, or components thereof, of the hospital, that are under the responsibility of the hospital and through which non-emergency health services are provided to patients who do not need to remain the hospital overnight as defined in the JCAH Manual. Outpatient services are provided by Home Health Agencies, Hospice Providers, and Community Health Centers.

PRENATAL SERVICES: A patient uses the same process and making an application with the County. The Indigent Hospital/Health Care Office pre-approves the eligible patient for services within three (3) days of receiving the application.

PRIMARY HEALTH CARE: Means the first level of basic or general health care for an individual's health needs, including medical and dental diagnostic and treatment services, prescribed medication, referrals and supportive services. All dental services must be provided in coordination with primary medical services. Primary medical services are those provided as part of general family practice, obstetrics, gynecology, pediatrics, general surgery, or general internal medicine.

PRO-RATA FORMULA: Approval or payment of ICH claims when different hospital or ambulance providers are involved in the treatment of a patient will be based on a percentage of the charges pro-rated to the amount of total claims submitted within a ninety (90) day period from the beginning date of the treatment. The Pro-Rated percentage of all claims will be calculated from each provider and will be paid their percentage of the determined yearly maximum limit per claim.

Section III – IHC Eligibility Provision

3.1 Individuals Eligible for IHC Assistance. Individuals are eligible for IHC assistance if (1) they qualify as medically indigent; and (2) they have been residents of Sierra County for at least ninety (90) days.

3.2 Individuals Not Eligible for IHC Assistance. Individuals are not eligible for assistance if (1) they are eligible for medical assistance from the NM Human Services Department as specified in Section 27-5-3 NMSA 1978; (2) do not qualify as medically indigent; (3) do not meet the residency requirements; or (4) individuals under the age of 18, unless the individual is married or emancipated.

3.3 Residency Requirements. All eligible individuals must be residents of Sierra County for at least ninety (90) days prior to receiving medical services. Claimants must provide proof of residency such as : (1) A copy of Sierra County Driver's License/Picture I.D; (2) A notarized Proof of Residency form completed by a non-related landlord or individual verifying that the patient has resided in Sierra County for at least ninety (90) days; (3) voter registration; (4) payment receipt of a utility bill, rental agreement, etc. College students attending college outside of the County shall be considered primary residents of Sierra County.

3.4 Medically Indigent Persons Eligibility. In addition to residency requirements, a claimant is qualified as medically indigent and eligible to receive IHC assistance if the person or the person's spouse or dependent, is determined under the provisions of this Ordinance to be unable to pay for eligible medical treatment or care that has been received after the individual has attempted to make payment and has exhausted all other financial resources for such payment ot the extent possible, taking in consideration the person's income and family's size based on the following provisions and criteria;

A. Basic Eligible Annual Income Criteria. In order to be qualified as medically indigent and eligible for IHC assistance, a claimant's annual household income as determined in Paragraph 3.4C of this Section, shall not be greater than 150% of the Federal Income Guidelines.

B. Payment by Claimant. Once claimant is deemed as eligible, the claimant, claimant's spouse and/or dependent(s) must agree to exhaust every financial resource of the family, to the extent possible, to make payment(s) of their medical bills. This includes all insurance or other programs or funding assistance available to the claimant. Claimants are eligible to receive IHC assistance for insurance deductibles, Medicare deductibles, co-insurance days or co-insurance pay.

C. Determination of Annual Income. The income indicated on claimant's most recent Federal or State income tax return will be accepted as the claimant's annual income, unless the claimant's income has changed due to a loss of a job, a substantial decrease or increase to income. In these circumstances, the current monthly income shall be taken into consideration in order to determine eligibility. Pay stubs or some other form may be used to verify this change to income. The claimant is required to provide a complete Federal or State income tax return, the claimant is required to complete a notarized tax waiver form with an attached copy of the claimant's social security card.

(1) Claimants that own their business must additionally submit a Profit and Loss Statement prepared by a CPA in order to be considered for IHC funding.

(2) IHC Income. The County utilizes the Federal Poverty Guidelines as a measure for eligibility, and allows the IHC staff to use the adjusted gross income based on the number of individuals in a house hold or

family. An expectant mother's unborn child will be included in determining the family or household eligibility.

(3) Child support payments will be considered in determining the annual income of claimant.

(4) Medical Garnishments will be a deduction for establishing household income.

(5) Medical Spend Down: Claimants annual income may be reduced by the amount of regular payments made to medical providers within the previous twelve (12) months, if the payments are for services that were not covered by this policy.

D. Assets. A household that has liquid assets in the amount of $20,000 or less and an individual which has liquid assets in the amount of $10,000 or less will be eligible for indigent health care claims assistance.

3.5 Medical Providers Eligible for IHC Approval or Reimbursement.

1. A general or limited hospital licensed by the Department of Health, whether owned by a political subdivision, not-for-profit or for-profit corporation, or a licensed out-of-state hospital, approved by the Department of Health, where treatment provided is necessary for the proper care of an indigent patient when that care is not available in an in-state hospital.

2. An in-state home health agency licensed and certified by Medicare and the State of New Mexico.

3. An in-state hospice which is licensed and certified by Medicare and the State of New Mexico.

4. An in-state ambulance provider.

5. Behavioral health providers eligible medical care and treatment services as specified by this Ordinance.

6. Licensed Medical Doctor, Osteopathic Physician, Dentist, Optometrist or Expanded Practice Nurse who provides emergency services in a hospital to an Indigent patient.

Only the above-listed medical providers are eligible for IHC reimbursements.

3.6 Medical Treatment Eligibility and Payment. Eligible persons may receive IHC assistance for medical care and treatment received from an eligible medical provider as listed in Section 3.5. Whenever insurance or Medicare payments exceed the established payment percentage, or limit, no approval of payment will be made. Should the insurance or Medicare payment fall below the determined annual percentage, the applicant may be assisted with the remaining balance. In circumstances where there are multiple providers and the medical expenses will reach

the maximum limitation amount, the Pro-Rata formula will be used to calculate the amount of reimbursement to each medical provider. IHC claims will be based on the order that expenses for treatment are incurred up to the maximum. Payment will be made in the order claims are approved by the IHC Board.

A. Claim Eligibility and Limitations for IHC Approvals or Payment. The Indigent Hospital and Health Care Act Section 27-5-1 (NMSA 1978) limits approvals or payments to "actual costs" for hospital care normally consisting of general medical treatment, and shall not exceed the determined established annual limits per patient and providers as set forth by the IHC Board in Appendix 1. Application for IHC payment may be submitted after the treatment is complete, or after the billing or the treatment is received.

(1) Ambulance transportation – These services are allowed based upon the expense incurred to include the care and transport of a patient to the "nearest" general or limited hospital. Claims that reach the maximum allowed policy limit may be subject to the Pro-Rata payment formula whenever there are multiple providers.

(2) Home Health Services – These services are allowed based on the actual need of the patient. Services include supplies, skilled nursing services, home health aids, prescribed medication, physical therapy, occupational and speech therapy. These services should be provided as deemed necessary for the patient's care and reimbursed to the provider at the rates specified on the provider agreement. The total sum of IHC payments shall be considered as a separate expense above any other medical claim limits and shall be limited to the established annual limit per patient. Services must be provided by a contracted home health provider licensed and certified by Medicare and the State of New Mexico. The total payments to a contracted home health service provider shall not exceed the established annual limit as determined by the IHC Board.

(3) Hospice Care Service – These services are allowed based on the actual need of the patient. The total sum of IHC payments for these services shall be considered as a separate expense form the other medical claim limits. The total sum of IHC payments for these services shall be considered as a separate expense from the other medical claim limits. The total sum of IHC payments for these services shall be considered as a separate expense from the other medical claim limits. The total sum of payment shall not exceed the established annual limit per patient. The total payment to a contracted Hospice provider shall not exceed the established annual limit as determined by the IHC Board.

(4) Mental Health Services – One claim per fiscal year will be permitted or psychiatric treatment services rendered by a contracted behavioral health care provider. One treatment for attempted suicide will also be permitted within the same fiscal year. The combination of both of these treatments will not exceed the determined policy limit for approval or payment as set fort by the IHC Board.

(5) Pregnancy-related Claims – One or more obstetrical deliveries or pregnancy-related illnesses shall not exceed the established fiscal year claim limit for each eligible individual. This includes the cost of the prenatal care clinic, delivery charges, and possibly the payment of the newborn charge.

(6) Substance Abuse - IHC approval or payment is available for only one inpatient substance abuse claim when deemed medically necessary, as well as unlimited outpatient substance abuse claims. However, the sum of both inpatient and outpatient treatment cannot exceed the policy limit. Also, the total sum of all IHC payments to any approved behavioral health care provider shall not exceed the established annual limit per provider.

(7) Primary Care Services - Primary care services are provided to individuals for the basic or general health care needs of the patient.

(8) Physicians - A licensed medical doctor, certified registered nurse anesthetist, certified nurse practitioner, osteopathic physician, dentist, optometrist or expanded practice nurse when providing emergency services, as determined by the IHC Administrator, in a hospital to an indigent patient; or a licensed medical doctor or osteopathic physician, dentist, optometrist or expanded practice nurse when providing services in an outpatient setting, as determined by the IHC Administrator, to an indigent patient with life threatening illness or disability.

(9) Other services. The IHC Administrator may allow other services which will benefit all indigent patients as deemed necessary.

B. Claims Not Eligible for Payment. The following claims are not eligible for payment: (1) hospital elective surgery or treatment; (2) nursing home care; (3) medical social worker; (4) nutrition counseling; and (5) primary care co-pays and prescription co-pays.

3.7 Detainees. Individuals arrested by the Sierra County Sheriff's Office and/or detained by Sierra County shall be considered medically indigent for the purpose of this Ordinance.

SECTION IV – APPLICATION FOR IHC ASSISTANCE.

4.1 IHC Application Provisions. The provisions of this Section are required in order for an application to be accepted and considered by the County for IHC assistance.

4.2 Applicant Cooperation. Failure of applicant's cooperation in providing the County authorization to obtain information is grounds for denial of application.

4.3 Application Submissions. An application may be submitted after treatment is complete or after the billing for the treatment is received.

4.4 Acceptance of IHC Applications. The County, at its discretion, may refuse to accept any application that does not include all required information or documents requested by the County.

4.5 Application Verification. Formal applications shall include but not be limited to the following:

A. Name, address and other personal identification of the patient/claimant as deemed appropriate by the County.

B. Name of patient/claimant, agency, medical provider, or other representative submitting the application. If other than the patient, the application shall include specific authorization in writing, signed by the claimant, or the patient's agent if the patient is unable to sign, that the representative is authorized to submit the application on their behalf.

C. Proof of residency to include Sierra County Driver's License/Picture I.D., voter registration, and/or other information as deemed necessary by the County to verify residency requirements.

D. Proof of income to include Federal or State tax returns, pay stubs, and/or other information as deemed necessary by the County to verify annual income and availability of assets. If the claimant does not file a current return, a notarized tax waiver form must be completed. The claimant will be required to provide a copy of his or her social security card along with the tax waiver form.

E. The claimant must not be eligible for Medicaid or other assistance provided by the State of New Mexico Human Services Department, unless a written denial from Medicaid for financial ineligibility is received and submitted with the IHC Application.

F. Evidence to verify that all other sources of payment such as insurance, Medicare, Medicaid etc. will make payment or that a pay source is not available due to patient's ineligibility or due to the provider's failure to submit a claim to the appropriate agency, which resulted in a denial to the payee.

G. Itemized bills which include the treating diagnosis of all charges submitted for IHC approval or payment that have been billed by an eligible medical provider. These billings will be based on provisions of Section 4 of this Ordinance. Claims with multiple providers may be held open for sixty (60) days in order for all providers to submit their bills. Payments will be based on the pro-rata formula.

4.6 Application Deadline. A formal application with the required documentation, must be submitted to the County IHC office no later than ninety (90) days from the first date medical treatment or services were received. Claims received after the ninety (90) day deadline will not be considered for payment, unless the County IHC Administrator determines that an exception can be made due to extraordinary circumstances.

A. The applicant will have ninety (90) days in which to file with the medical provider that rendered services. The claimant must provide the necessary

documentation to this provider unless the medical provider is located outside the County. In this circumstance, the applicant must return the completed application to the County IHC office.
If the additional requested information is not received within the allotted time, the claim will be closed. Once the claim is complete, the claim will be approved at the next scheduled monthly IHC Board meeting.

B. All approved applications will be considered complete and current for one (1) year from the date in which the application is executed.
Any claims received after an application is approved, the provider will be expected to complete a supplemental claim form. The notarized supplement form must be signed by the adult patient to authorize the medical provide to release necessary information to process the claim. After the time limit has expired for the current application, a new application will be requested with all required documentation attached.

C. When a patient is covered by insurance, Medicare or another pay source, the ninety (90) day claim limit will begin with the date that the pay source made the first payment on the claim. In circumstances in which a denial has been received by the provider, the ninety (90) day limit will revert to the original date of the denial.

4.7 Application Confidentiality. All information regarding the claimant shall be kept strictly confidential.

SECTION V. – PROVISION FOR IHC APPROVAL OR REIMBURSEMENT TO MEIDCAL PROVIDERS

5.1 Reimbursement To Medical Providers. Approvals or reimbursement of IHC funds by the County shall be made to eligible medical providers based on seventy seven percent (77%) of the actual billed charges or one hundred percent (100%) of the Medicaid rate, whichever is the lessor thereof, for eligible treatment not to exceed the established claim limit, except that approvals or reimbursement of IHC funds by the County shall be made to eligible medical providers based of the entire of the actual billed charges or one hundred percent (100%) of the Medicaid rate, whichever is the lessor thereof, for eligible treatment of individuals committed to the custody of the Sierra County Detention Center. Charges shall be submitted on itemized bills with the treating diagnosis form the medical provide(s). The charges for such services shall not exceed the normal charges to other patients. Approvals or reimbursements will be made to medical providers after obtaining authorization from the IHC Board.

5.2 Overcharges. Any medical provider found to be overcharging or billing greater than the normal charges to other patients for itemized services reimbursed by IHC payment is in violation of the provisions of this Ordinance. The IHC Board may, at its discretion, reduce the IHC payment of billed charges to a percentage between 20% and 65% of billed charges. The reduced percentage of payment may be assessed for any length of period up to twelve (12) months. The provider shall be given the opportunity to provide its justification and documentation to the County prior to such action being implemented. The County may, at its discretion, hire an independent

auditor paid for by the medical provider to determine overcharges. Medical providers shall provide to the County or its representative all information requested to verify charges.

5.3 Reimbursement Limited to Available Funds. Outstanding IHC claims that have been approved by the IHC Board will be paid by the County to each eligible medical provider with available Indigent Fund revenues that have been received by the County. Payment will be made based on the order of approved claims by the IHC Board. If revenues are all exhausted or encumbered, the outstanding claims will be paid based upon: (1) the order of approval by the IHC Board; (2) current complete claims; and (3) aging claims which have been completed.

5.4 Withholding of IHC Payments. IHC payments shall be withheld pending the disposition of medical payments form other possible sources, such as insurance, workers' compensation, or State and Federal funding that may cover the expenses. Upon evidence that the other possible sources will not make payment, IHC funds may be approved for payment consistent with the provisions of this Ordinance.

5.5 Screening and Collections By Providers. The medical provider is required to screen all potential IHC Claimants and determine if the claimant will have a remaining balance, a reasonable payment schedule will be made.

5.6 Claims, Preparation, and Verification by Providers. The medical provider shall assist the claimant in correctly and accurately preparing the formal application to be submitted to the County, and shall use all resources available to screen and verify the information submitted by the claimant for a final decision by the IHC Board.

5.7 Disclosure by Medical Providers. Medical providers shall provide to the County reports, financial statements, random samples of paid bills or other information deemed necessary by the IHC Board or its representatives.

5.8 Limitation for Collection by Provider. The medical provider is required to write off ninety percent (90%) of the remaining balance. The medical provider shall not pursue collection of a service whenever the provider is at fault in not submitting the patient's charges within the ninety (90) day filing limit and the patient has cooperated and submitted all documents necessary to process their claim.

5.9 Agreement between County and Provider. All medical providers that are eligible for approval or reimbursement of IHC funds shall enter into an agreement with the County agreeing to abide by all provisions of this Ordinance prior to receiving any IHC funds. The medical provider shall submit copies of their state license and annual certification as part of this ongoing agreement. The IHC office should receive a copy of the renewed certification annually.

SECTION VI – APPEALS

6.1 County IHC Board or IHC Administrator. Any person or medical provider who is adversely affected by a decision of the IHC Administrator may appeal that decision to the IHC Board within (15) days after the date of the action of the County IHC

Administrator. The IHC Board shall hear the appeal and render a decision in writing within sixty (60) days after receiving the Notice of Appeal.

6.2 IHC Board. Any person or medical provider who is adversely affected by a decision of the IHC Board may appeal that decision to the District Court within thirty (30) days of the action of the Board.

SECTION VII – PENALTIES

7.1 Criminal Penalties. Any person or medical provider who intentionally violates the provision of this ordinance shall be punished by a fine not to exceed Three Hundred Dollars ($300.00) or imprisonment in the County Detention Center of not more than ninety (90) days, or both, in accordance with Section 4-37-3 NMSA 1978. In addition, the person or medical provider will be required to reimburse or credit the fund.

SECTION VIII – REPEALER

8.1 The rules contained herein replace and supersede all previously issued rules, resolutions, regulations and ordinances applicable to the subject matter that is covered in this Ordinance, including without limitation, Sierra County Ordinance 10-004.

APPROVED, ADOPTED, AND PASSED on this 21st day of November, 2023.

TRAVIS DAY, CHAIR

JAMES PAXON, VICE-CHAIR

HANK HOPKINS, COMMISSIONER

ATTEST BY:

SHELLY TRUJILLO, COUNTY CLERK

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BY CORTNEY

APPENDIX I
INDIGENT HOSPITAL/HEALTH CARE CLAIM LIMITS

POLICY LIMIT	MEDICAL SERVICES	TYPE OF CARE
$15,000*	Hospital ———	General medical treatment, or acute services care. Services may be out-patient or in-patient treatment. Includes the cost of cancer treatment
$2,500	Ambulance	Ambulance transportation *by ground or air* to nearest facility.
$2,500	Mental and Suicidal Treatment	This care is limited to one treatment each as deemed necessary for the patient. The combination of both of these treatments shall not exceed the fiscal year limit.
$ 3,000	Substance Abuse Treatment	This care is limited to only one in-patient treatment; however, patient treatment is unlimited as long as the sum of both in-patient and out-patient treatment does not exceed the established policy limit. Provider is limited to $30,000 per fiscal year.
$ 2,500	Home Health Care	Medical care and treatment as deemed necessary for the patient each fiscal year in accordance with Section 3.5. (2). Evidence to verify is required. Contracted provider is limited to $20,000 per fiscal year.
$ 2,500	Hospice Care	Medical care and treatment as deemed necessary for the care of the patient. Each contracted provider will be limited to $20,000 per fiscal year.
$2,500	Prenatal & Maternity Related Service	A lifetime of three pregnancies will be allowed per client. The fiscal year limit will include the cost for prenatal care, obstetric charges, newborn charges** and miscarriages. Provider limit will not exceed $20,000 in any fiscal year.
$2,500	ER Physicians	Reimburse for medical care administered, as determined by the board, on emergency basis only at a Hospital, at Medicaid fee-for-service rates. Contracted providers limited to $20,000 per fiscal year.

*Services that will exceed the annual claim limit will be pro-rated for reimbursement to each medical provider which rendered the patient's treatment or care.

**Newborn charges which incur complications and will exceed the established mother's limit will be established as a separate claim.

Note: The approved limits indicated on this appendix are subject to change each fiscal year based on the amount of the Indigent Fund Revenues received.