TIME AND DATE: April 24–25, 1985, 9:00 a.m.

PLACE: Federal Building, South Auditorium, 915 Second Avenue, Seattle, Washington.

MATTERS TO BE CONSIDERED:

- Council Decision on Draft Load Forecasts
- Staff Presentation on the Status of Resource Portfolio Analysis
- Staff Presentation on Institutional Arrangements Issue Paper
- Council Decision on Use of Non-Firm Power (Including the Interruptibility of the Direct Service Industries)
- Public Comment on Proposed Council Intertie Access Policy Issue Paper
- Public Comment on Out-of-Region Imports/Exports Issue Paper
- Staff Presentation and Public Comment on Re-Evaluation of the Model Conservation Standards Issue Paper
- Staff Presentation on Potential and Achieveable Conservation Issue Paper
- Council Decision on Cost and Availability of Generating Resources
- Staff Presentation on Lost Opportunity Resources
- Public Comment on Research, Development and Demonstration of Promising Resources
- Council Business

Public comment will follow each item.

FOR FURTHER INFORMATION CONTACT: Ms. Bess Wong, (503) 222–5161.

Edward Sheets,

Executive Director.

[FR Doc. 85–9282 Filed 4–15–85; 8:45 am]

BILLING CODE 0000–00–M

5

SECURITIES AND EXCHANGE COMMISSION

Notice is hereby given pursuant to the provisions of the Government in the Sunshine Act, Pub. L. 94–409, that the Securities and Exchange Commission will hold the following meetings during the week of April 22, 1985.

An open meeting will be held on Tuesday, April, 23, 1985, at 2:30 p.m., in Room 1C30, followed by a closed meeting.

The Commissioners, Counsel to the Commissioners, the Secretary of the Commission, and recording secretaries will attend the closed meeting. Certain staff members who are responsible for the calendared matters may be present.

The General Counsel of the Commission, or his designee, has certified that, in his opinion, the items to be considered at the closed meeting may be considered pursuant to one or more to the exemptions set forth in 5 U.S.C. 552b(c) (4), (8), (9) (A) and (10) and 17 CFR 200.402)(a)(4), (8), (9)(i) and (10).

Commissioner Cox, as duty officer, voted to consider the items listed for the closed meeting in closed session.

The subject matter of the open meeting scheduled for Tuesday, April 23, 1985, at 2:30 p.m., will be:

1. Consideration of whether to approve under section 210(b) of the Investment Advisers Act of 1940 a program to share information with state securities officials regarding Commission adviser examinations. For further information, please contact Gene A. Gohlke at (202) 272–2024.

2. Consideration of whether to propose for public comment a revised Form ADV under the Investment Advisers Act of 1940 which would make the investment adviser registration application form a uniform form for use by both the commission and the states. For further information, please contact Mary Podesta at (202) 272–2107.

3. Consideration of whether to issue a release proposing for public comment revisions to Form BD, other related technical changes, and amendments to the broker-dealer successor rules, to reduce the regulatory burden on broker-dealers by revising the disciplinary question to remove duplicative information requirements and narrow the scope of that question, by clarifying the information required to be disclosed on the schedules, by making the information requested under Rule 17a-3 of the Securities Exchange Act of 1934 conform to that requiring in the revised Form U–4, and by amending the broker-dealer successor rules to allow a broker-dealer to file an amendment to Form BD rather than a complete Form BD. For further information, please contact Valerie Golden at (202) 272–2848.

4. Consideration of an amendment to Rule (b)(2) of the Commission's Conduct Regulation, 17 CFR 200.734–3(b)(2). For further information, please contact Myrna Siegel at (202) 272–2430.

5. Consideration of whether to adopt two new registration forms, Forms S–4 (for all registrants) and F–4 (for certain foreign private issuers) to be used for the registration of securities in connection with merger proxies and exchange Patricia B. Magee at (202) 272–2589 (re Form S–4) or Martin L. Meyrowitz at (202) 272–3250 (re Form F–4).

6. Consideration of whether to issue a release proposing technical amendments to Rule 3A–02 of Regulation S–X, "Consolidated financial statements of the registrant and its subsidiaries." For further information, please contact Dorothy Walker at (202) 272–7343.

(This item was previously noticed in 50 FR 14192, April 10, 1985)

The subject matter of the closed meeting scheduled for Tuesday, April 23, 1985, following the 2:30 p.m. open meeting, will be:

Formal orders of investigation.
Settlement of administrative proceedings of an enforcement nature.
Institution of administrative proceedings of an enforcement nature.
Institution of injunctive actions.
Opinion.

At times changes in commission priorities require alterations in the scheduling of meeting items. For further information and to ascertain what, if any, matters have been added, deleted or postponed, please contact: Angela Hall at (202) 272–3085.

April 15, 1985.

Shirley E. Hollis,

Assistant Secretary.

[FR Doc. 85–9382 Filed 4–15–85 3:45 pm]

BILLING CODE 8010–10–M

federal register

Wednesday
April 17, 1985

Part II

Department of the Interior

Bureau of Indian Affairs

List of Indian Estates Affected by Old Age Assistance Claims; Notice

DEPARTMENT OF THE INTERIOR

Bureau of Indian Affairs

List of Indian Estates Affected by Old Age Assistance Claims

ACTION: Notice of Reimbursement.

This notice is published in the exercise of authority delegated by the Secretary of the Interior to the Deputy Assistant Secretary—Indian Affairs by 209 DM 8.

SUMMARY: This notice lists all Indian trust estates identified by the Department of the Interior, from which unauthorized disbursements were made by the Secretary of the Interior to States, or political subdivisions thereof, as reimbursement for old age assistance provided to deceased Indians before death in violation of Federal laws. This notice is required by section 4(a) of the Old Age Assistance Claims Settlement Act of October 19, 1984, Pub. L. 98–500.

DATE: This notice establishes that tribes, bands, groups and individual Indians shall have until October 14, 1985, to submit to the Secretary of the Interior, through the proper Area Office, the names of any additional trust estates from which unauthorized disbursements were made and which are not contained in this list.

FOR FURTHER INFORMATION CONTACT:

Aberdeen Area Director, Bureau of Indian Affairs, 115 4th Avenue, S.E. Aberdeen, South Dakota 57401, Telephone: (605) 225–0250;

Albuquerque Area Director, Bureau of Indian Affairs, 5301 Central Avenue, N.E., P.O. Box 8327, Albuquerque, New Mexico 87198, Telephone: (505) 766–3170;

Anadarko Area Director, Bureau of Indian Affairs, Federal Building, P.O. Box 368, Anadarko, Oklahoma 73005, Telephone: (405) 247–6673;

Billings Area Director, Bureau of Indian Affairs, 316 North 26th Street, Billings, Montana 59101, Telephone: (406) 657–6315;

Eastern Area Director, Bureau of Indian Affairs, 1951 Constitution Avenue, N.W., Washington, D.C. 20245, Telephone: (703) 235–2571;

Juneau Area Director, Bureau of Indian Affairs, Federal Building, P.O. Box 3–8000, Juneau, Alaska 99802, Telephone: (907) 586–7177;

Minneapolis Area Director, Bureau of Indian Affairs, Chamber of Commerce Building, 15 South Fifth Street, 10th Floor, Minneapolis, Minnesota 55402, Telephone: (612) 349–3631;

Muskogee Area Director, Bureau of Indian Affairs, Old Federal Building, Muskogee, Oklahoma 74401, Telephone: (918) 687–2295;

Navajo Area Director, Bureau of Indian Affairs, P.O. Box M., Window Rock, Arizona 86515, Telephone: (602) 871–5151;

Phoenix Area Director, Bureau of Indian Affairs, 3030 North Central, P.O. Box 7007, Phoenix, Arizona 85011, Telephone: (602) 241–2305;

Portland Area Director, Bureau of Indian Affairs, 1425 Irving Street, N.E., Portland, Oregon 97208, Telephone: (503) 231–6702; and

Sacramento Area Director, Bureau of Indian Affairs, 2800 Cottage Way, Sacramento, California 95825, Telephone: (916) 484–4682.

SUPPLEMENTARY INFORMATION: The Old Age Assistance Claims Settlement Act, Pub. L. 98–500, authorizes and directs the Secretary of the Interior to pay entitled individuals their portions of any unauthorized disbursement made from the trust estate of a deceased Indian to a State, or a political subdivision thereof, as reimbursement for old age assistance provided to the deceased Indian before death in violation of Federal laws governing Indian trust property. The Secretary of the Interior is further directed to search the records of the Department of the Interior to identify individuals who are entitled to payment, and to ascertain the amount of the unauthorized disbursement to which each of the individuals would be entitled. Any payment under the Act shall include simple interest at a rate of five percent per annum from the date on which such unauthorized disbursement was made from the trust estate of the deceased Indian. No payments shall be made with respect to any unauthorized disbursement from the trust estate of a deceased Indian if the total amount of such unauthorized disbursement was less than $50.

This notice lists all Indian trust estates, identified by the Department of the Interior, from which unauthorized disbursements were made for the purpose of reimbursement for old age assistance. Copies of the Old Age Assistance Claims Settlement Act, Pub. L. 98–500, and this document are being provided to all federally acknowledged Indian tribes.

Indian tribes, bands, groups and individual Indians have 180 days, or until October 14, 1985, to submit to the appropriate area Office, in writing, the names of any additional qualified estates not listed in this document. (See the **FOR FURTHER INFORMATION CONTACT** section of this document for the names, addresses and telephone numbers of the Area Offices.) The name of any additional qualified estate submitted to an Area Office must be accompanied by: (1) The name and tribal affiliation of the Indian decedent, (2) the date and number of the Departmental probate order determining heirs of the trust estate, and (3) evidence that a payment was made from the trust estate of the decedent as reimbursement for old age assistance. Within 30 days after the expiration of the 180-day period, the Secretary of the Interior will publish in the **Federal Register** a supplemental list identifying those additional qualified estates submitted to Area Offices by tribes, bands, groups and individual Indians.

The payment and acceptance of any claim, after its determination in accordance with the Act, shall be a full discharge to the United States and any State, or political subdivision thereof, of all claims and demands touching any of the matters involved in the controversy.

Because of the numerous estates listed in the document, this notice may be subject to technical clarification or change.

John W. Fritz,

Deputy Assistant Secretary—Indian Affairs.

Instruction Sheet

Each estate from which an unauthorized payment was made has been assigned a nine or ten character issue number (a letter followed by eight or nine numbers). The first six characters identify a specific Bureau of Indian Affairs Area Office, Agency Office and tribe. The last three or four characters represent the specific numbers assigned to that estate from which an unauthorized payment was made. For example, A013400001 indicates:

A01—Aberdeen Area Office/Cheyenne River Agency
340—Cheyenne River Sioux Tribe
0001—Estate number one

To locate an estate, begin with the Table of Contents which lists each affected tribe (grouped by Area Office and Agency) and the pages where the estates for individuals affiliated with such tribe can be found. The list of estates has been reproduced by photographing two pages of the list to each **Federal Register** page. The page number referred to in the Table of Contents is located at the top center above the name of the Area Office and is not the five digit **Federal Register** page number located on the outer portion of each page.

If a tribe is not listed in the Table of Contents, no estate was identified for any individual affiliated with such tribe.

Each page of estates contains five columns of information under the

headings: Issue Number, Decedent Name, Decedent ID, $ Allowed, $ Paid.

Issue Number: The nine or ten character code (explained above) which identifies the Area Office/Agency/Tribe/and specific number assigned to that estate.

Decedent Name: The name of the deceased Indian whose Departmental records contain evidence that an unauthorized payment was made from his/her trust estate as reimbursement for old age assistance.

Decedent ID: The decedent's identification number. This number usually coincides with the decedent's allotment number, tribal enrollment number, or, in their absence, a number assigned by the Bureau of Indian Affairs.

$ Allowed: The amount of money, cited in the decedent's probate order, which was allowed as a claim to be paid from the decedent's trust estate as reimbursement to the State, or political subdivision thereof, for old age assistance. This figure appears in the list as an indication that the Departmental records contain evidence that some money was actually paid from the decedent's trust estate as reimbursement for old age assistance.

$ Paid: The amount of money actually paiid (the amount of the unauthorized disbursement) from the decedent's trust estate as reimbursement to the State, or political subdivision thereof, for old age assistance. This figure is supported by evidence appearing in Departmental records. Where the Departmental records contain evidence that money was paid from the decedent's trust estate as reimbursement for old age assistance, but the exact amount is not known, the word UNKNOWN appears in this column; further research is needed to ascertain such amount. Those amounts ascertained after this list is published will appear on the supplementary list of estates to be published in the **Federal Register** 30 days after the expiration of the aforementioned 180-day period

If, after locating an estate on the list, you desire further information, call or write the Area Office under which the estate is listed. The names, addresses, and telephone numbers for all Area Offices are contained in the **FOR FURTHER INFORMATION CONTACT** section of this document. Be sure to include the complete issue number in any correspondence with the Bureau of Indian Affairs Area or Agency Office. It is important to remember that additional qualified estates must be submitted in writing, together with evidence of the unauthorized disbursement, to the appropriate Area Office within 180 days of the publication of this document.

BILLING CODE 4310-02-M

TABLE OF CONTENTS

ABERDEEN AREA

ISSUE NUMBER	NAME OF DECEDENT	DECEDENT ID	$ALLOWED	$PAID
A00-007-0084	JONES ELLEN (WILSON)	42	671.50	UNKNOWN
A00-007-0094	HUAPAPI NANCY (WEST)	56	667.50	UNKNOWN
A00-007-0131	THOMAS LOVEJOY	NB6137	2,664.00	UNKNOWN
A00-007-0132	JOHN A. LOVEJOY	U425	457.50	UNKNOWN
A00-007-0133	MINNIE LAWRENCE	U249	27.00	UNKNOWN
A01-340-0001	CIRCLE EAGLE WILLIAM (FOUR)	1408	3,343.00	UNKNOWN
A01-340-0002	LONE HORSE PETER	1610	695.68	638.38
A01-340-0005	YELLOW SHIELD KNIFE NELLIE	2114	250.00	250.00
A01-340-0006	TOP OF THE LODGE JESSIE (EAGLE)	2022	269.00	269.00
A01-340-0007	LITTLE CROW GEORGE	1394	2,847.00	2,663.78
A01-340-0008	LEAR MOLLIE	1526	776.00	738.15
A01-340-0009	LITTLE WOUNDED JAMES	1441	969.50	556.94
A01-340-0010	LINDLEY LIZZIE M.	1924	82.50	82.50
A01-340-0011	WALKS RUNNING RATTLE CLARA	2136	21.00	21.00
A01-340-0012	WHITE WOLF THOMAS	1756	696.00	692.00
A01-340-0013	JAMES AFRAID OF LIGHTENING	1259	650.00	435.00
A01-340-0014	DOG ARM ABRAHAM	1155	866.00	79.54
A01-340-0015	PAPIN CHARLES (GABE)	324	628.00	483.83
A01-340-0016	MARSHALL THOMAS	1751	2,811.50	2,811.50
A01-340-0017	RICH LOUISE MARCELLE	1158	364.00	UNKNOWN
A01-340-0018	FIELDER TWO SPEARS ANNIE	1904	1,447.08	1,447.08
A01-340-0019	FOX LOUISE (BRIDGET CURELY)	1720	737.50	326.61
A01-340-0020	HAWK THAT DARES SOLOMON	16	487.50	487.50
A01-340-0021	BLACK CHICKEN SOPHIA	121	1,395.00	1,395.00
A01-340-0022	RED HEAD NELLIE	564	3,508.50	1,527.48
A01-340-0023	GETS OFF IDA	2495	5.00	5.00
A01-340-0024	DROPS AT A DISTANCE JESSIE	2551	446.50	446.50
A01-340-0025	COUNTING MARY	2196	5.00	5.00
A01-340-0026	CHARGER NELLIE	2660	4,000.00	4,000.00
A01-340-0027	RED BIRD MARY ALICE	2157	1,133.00	222.97
A01-340-0028	DUCHENEAUX JENNIE	2664	1,900.00	1,900.00
A01-340-0029	CONDON JOSEPHINE	1295	18.44	18.44
A01-340-0030	LAFFERTY BERT C.	870	5.00	5.00
A01-340-0031	MARROWBONE JOSEPH (LITTLE HAWK)	1548	46.00	46.00
A01-340-0032	TALKS GEORGE	1578	328.20	328.20
A01-340-0033	BEAR EAGLE FLORA	1414	4,754.00	4,754.00
A01-340-0034	BALD HEAD EMMA	1631	34.07	34.07
A01-340-0035	HOLLOW HORN JOHN	1752	2,971.00	2,971.00
A01-340-0036	BAZIL CLAYMORE	906	5.00	5.00
A01-340-0037	BLACK HORSE CHARLES	987	2,282.36	2,282.36
A01-340-0038	SWIFT EAGLE ALICE	1188	733.50	682.09
A01-340-0039	COUNTING DANIEL	1452	846.00	UNKNOWN
A01-340-0040	HIGH BEAR AMY	855	1,322.00	1,322.00
A01-340-0041	OWL KING JONAS	1146	2,591.00	55.46
A01-340-0042	GOOD HOOP	1592	5.00	5.00
A01-340-0043	STRAIGH HEAD ROBERT	1551	1,319.00	1,319.00
A01-340-0044	CURLEY KENTON	1203	510.70	306.36
A01-340-0045	CLAYMORE EMMA	2810	850.00	21.72
A01-340-0046	JENISE BERT	2044	100.00	100.00
A01-340-0047	GRASPING EAGLE CARRIE	1789	891.68	81.99
A01-340-0048	RED DOG LUCY	3057	1,674.50	1,674.50
A01-340-0049	CLAYMORE MARY	3116	430.00	430.00
A01-340-0050	WHITE EAGLE EMILY	2756	1,449.50	1,449.50
A01-340-0051	LONE EAGLE MARTHA	3033	369.00	368.00
A01-340-0052	ROAN BEAR SOPHIA	1935	597.10	280.85
A01-340-0053	KILLS TWO PAUL	174	911.73	911.73
A01-340-0054	CANE HARRY	1491	2,235.00	2,235.00
A01-340-0055	BLACKBIRD TAIL HENRY	1276	1,386.00	1,086.22
A01-340-0056	BLUE COAT PHILIP	1339	325.33	325.33
A01-340-0057	SWAN RICHARD	1391	241.20	40.34
A01-340-0058	BLACK HAWK JOHN	1387	49.00	38.89
A01-340-0059	RIVERS WILLIAM	24	2,139.00	1,335.05
A01-340-0061	BLACK EAGLE JUSTIN	1540	823.00	823.00
A01-340-0062	CROW ASA	1009	861.00	861.00
A01-340-0063	CHARGIN EAGLE THOMAS	1118	48.00	48.00
A01-340-0064	GARTER JOSEPH	570	620.50	620.50
A01-340-0065	POOR BUFFALO JESSIE	676	142.67	133.70
A01-340-0066	CECELIA CHARGING HAWK	472	3,382.00	217.00
A01-340-0067	LITTLE CROW GEORGE MRS.	685	720.00	720.00
A01-340-0068	JOHNSON FRED	459	16.81	16.81
A01-340-0069	BLACK BODY ANGELINE	2699	107.50	107.50
A01-340-0070	LEBEAU JULIA	2705	22.00	22.00
A01-340-0071	WARRIOR LOUISA	2547	630.30	630.30
A01-340-0072	CLAYMORE SOPHIA	2554	5.00	5.00
A01-340-0073	IRON LIGHTNING ROSE	2180	220.00	220.00

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ABERDEEN AREA

ISSUE NUMBER	NAME OF DECEDENT	DECEDENT ID	$ALLOWED	$PAID
A01-340-0074	POOR BUFFALO LUCY	2198	3,289.00	3,289.00
A01-340-0075	FIRST HAWK ALICE	2714	2,412.79	456.70
A01-340-0076	CURLEY LOUISA	2460	18.09	18.09
A01-340-0077	BEAR EAGLE GEORGE	1633	4,390.00	988.38
A01-340-0078	WHITE FEATHER GEORGE	1637	1,200.00	1,200.00
A01-340-0079	SMOKY WOMAN REBECCA	1632	269.50	12.79
A01-340-0080	CREEK WALTER DANIEL	1742	681.50	681.50
A01-340-0081	BRUGUIER AMBROSE	1884	5.00	5.00
A01-340-0082	SWIFT BEAR THOMAS	1479	15.75	15.75
A01-340-0083	ROBERTS JENNIE	1287	140.34	140.34
A01-340-0084	WHITE CROW EAGLE KATE	859	1,736.00	911.72
A01-340-0085	BLACK EAGLE GRACE	1379	1,466.50	1,466.00
A01-340-0086	SWAN WILLIE	1424	45.99	45.99
A01-340-0087	ELK HEAD PHILLIP	1561	575.00	542.72
A01-340-0088	BULL MAN MARY	1293	484.00	126.55
A01-340-0089	HIGH EAGLE AMOS	32	2,282.00	1,838.63
A01-340-0090	CARTER CATHERINE	617	23.24	16.47
A01-340-0091	ANNIE BLACKCOAT	1939	10.00	10.00
A01-340-0092	BLACKMAN NELLIE	3024	173.50	173.50
A01-340-0093	SPOTTED HORSE MRS. JOHN	2099	209.50	209.50
A01-340-0094	PETER ONE SKUNK	2959	709.50	709.50
A01-340-0095	KISS IN THE WOODS SOPHIA	2385	8.90	8.90
A01-340-0096	BEAR EAGLE ANNIE	3023	1,000.00	999.47
A01-340-0097	GROUSE RUNNING ANNIE	2426	275.00	161.62
A01-340-0098	EAGLE BODY AMOS	2354	1,744.50	350.00
A01-340-0099	BLACK EAGLE LOUISE	2086	748.00	748.00
A01-340-0100	WHITE HAWK JOHN	1500	70.50	70.50
A01-340-0101	LONG LOG MARY	2582	18.00	14.32
A01-340-0102	DUPRIS EMILY	2358	4.41	4.41
A01-340-0103	DUCHENEAUX VICTOR SR.	44	5.00	5.00
A01-340-0104	LAUNDREAUX JOSEPHINE	198	2,097.43	2,097.43
A01-340-0105	STANDING ELK MATHEW	1247	256.50	256.50
A01-340-0106	VEO CHARLES	281	38.50	38.50
A01-340-0107	JEWETT LILLIE #2 (HIS HORSE)	2203	35.00	35.00
A01-340-0108	TWO CROW MILES	1329	504.00	504.00
A01-340-0109	HIGH EAGLE ROSE	2208	30.00	30.00
A01-340-0110	LIVERMONT MILLIE	1971	83.33	83.33
A01-340-0111	MOUND PHILLIP	516	86.00	86.00
A01-340-0112	RAISED HIM ABRAHAM	581	741.00	313.52
A01-340-0113	LAPPABEE RICHARD	654	68.06	68.06
A01-340-0114	ROAN BEAR EDWARD	322	4,814.00	4,814.00
A01-340-0115	AFRAID OF THE BEAR MAGGIE	341	241.16	241.16
A01-340-0116	WOODS HARRY F.C.	796	1,136.50	450.00
A01-340-0117	HOWARD PHILIP	790	9.75	9.75
A01-340-0118	FIRST HAWK ALICE	2714	2,412.79	456.20
A01-340-0119	TWO CROW MAUDE	960	424.00	424.00
A01-340-0121	WEST ALLEN	932	241.86	241.86
A01-340-0122	HOLY BULL PETER	1111	783.50	670.29
A01-340-0123	HEAD OF BUCK ELK ELIAS	1467	663.00	663.00
A01-340-0124	LEMS HIS HORSE WALLACE	269	2,724.50	138.64
A01-340-0125	FIRST HAWK PAUL	2716	399.00	399.00
A01-340-0126	CRANE PRETTY VOICE	2936	585.00	585.00
A01-340-0127	SPOTTED BIRD JESSE	3143	899.50	899.50
A01-340-0128	BUCK DENNIS	813	187.50	187.50
A01-340-0129	CHASHING HAWK HANNAH	2443	626.00	626.00
A01-340-0130	BENOIST CORA	3060	79.00	79.00
A01-340-0131	RED BIRD ISABELLE	2099	552.50	237.03
A01-340-0132	BLUE ARM CHARLES	1372	325.00	325.00
A01-340-0133	WALKING CRANE JOSEPH	13	1,759.43	1,253.63
A01-340-0134	FISHGUTS WILLIAM	983	115.00	115.00
A01-340-0135	WHITE DOG NELLIE	1845	747.00	747.00
A01-340-0136	GROUSE RUNNING	1110	192.00	192.00
A01-340-0137	IRON MOCCASIN MOSES	357	25.00	25.00
A01-340-0138	FIELDER RICHARD	804	308.70	308.70
A01-340-0140	BULL EAGLE JACK	1211	77.95	77.95
A01-340-0141	WALKING HUNTER SIMON	751	132.74	132.74
A01-340-0142	WHITE HORSE JAMES	296	239.00	239.00
A01-340-0143	CLOWY AMOS	677	92.75	92.75
A01-340-0144	BAD WARRIOR ELI	638	2,982.00	7.44
A01-340-0145	BEAR SHIELD SOPHIA	1824	30.34	30.34
A01-340-0146	STAMP PETER (STANDING ELK)	1428	1,115.50	1,115.50
A01-340-0147	RED HEAD JOHN	563	29.74	29.74
A01-340-0148	BROWN TWO FOR FOLLOW HIM MRS.	1071	36.46	36.46
A01-340-0149	MRS. HOLY GOOD WOMAN	112	879.50	600.00
A01-340-0150	RUNNING RAFFLE	590	1,123.00	540.00

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ABERDEEN AREA

ISSUE NUMBER	NAME OF DECEDENT	DECEDENT ID	$ALLOWED	$PAID
A01-340-0151	POOR ELK ANNIE	1322	1,596.50	1,596.50
A01-340-0152	FOX THOMAS	3090	740.25	326.61
A01-340-0153	LEE HENRY	401	3,820.00	479.63
A01-340-0154	RICE EDWARD	85	935.00	686.56
A01-340-0155	MARSHALL IDA	877	149.50	149.50
A01-340-0156	TRAVERSIE ETTA	768	94.30	94.30
A01-340-0157	BOTTOM SHOULDER JOHN	587	531.50	531.50
A01-340-0158	IRON BIRD GEORGE	777	2,895.00	379.84
A01-340-0159	ON THE TREE GEORGE	550	1,339.00	700.00
A01-340-0160	HALF RED MAGGIE	3051	3,103.00	803.48
A01-340-0162	MARY OAKES POWELL	2894	6,104.00	145.36
A01-340-0163	HORSE WOMAN	2264	407.50	407.50
A01-340-0164	FOOL DOG	2101	334.22	334.22
A01-340-0165	ALBERT OWL KING	1142	1,732.50	1,732.50
A01-340-0166	JOHN DID NOT GO HOME	1092	933.00	314.14
A01-340-0167	LOUIS POSEY MORAN	925	1,916.00	815.51
A01-340-0168	EMMA DUNN	921	116.40	116.40
A01-340-0169	FRANK IRON HAWK	1066	1,043.50	1,043.50
A01-340-0170	MAGGIE RED HORSE	1165	36.00	36.00
A01-340-0171	NELLIE KILLS THEM FIRST	2944	400.00	400.00
A01-340-0172	EUGENE WHITNEY	136	545.50	545.50
A01-340-0173	HORACE TWO LANCE	256	2,483.50	2,483.50
A01-340-0174	GEORGE LANDREAUX	187	1,337.50	1,337.50
A01-340-0175	ALBERT SAND	235	1,177.00	1,177.00
A01-340-0176	ROUSSEAU JULIA	2312	10.00	10.00
A01-340-0177	LITTLE WOUNDED DELIA	2336	860.50	556.94
A01-340-0178	KNIFE CHARLES	1584	692.33	692.33
A01-340-0179	MARROWBONE DAVID	1570	35.00	35.00
A01-340-0180	BROWN WOLF PHILIP	1070	582.00	69.21
A01-340-0181	BATTLING RIB LOUIS	985	784.25	321.95
A01-340-0182	HAS WATER ELIZABETH	2697	3,893.50	2,105.14
A01-340-0183	MAKES IT LONG JONAH	1244	1,105.00	476.26
A01-340-0184	CANE KATE MRS.	2371	564.04	564.04
A01-340-0185	EAGLE CHASING RAY MRS.	2167	324.50	261.59
A01-340-0186	KINSMAN HARRY	838	355.00	355.00
A01-340-3185	HIGH BACK	2292	983.00	983.00
A01-340-3186	JOBE HOLY BULL	1152	520.95	520.95
A04-301-0072	PEPPERMINT	954	768.00	768.00
A04-301-0073	STAR DORA (GOUGH)	920	1,013.00	1,013.00
A04-301-0074	ANTELOPE WOMAN	1129	869.00	869.00
A04-301-0075	LEAD WOMAN	1176	1,463.00	1,463.00
A04-301-0076	ALEX SAGE	797	90.00	90.00
A04-301-0077	MRS. ENEMY DOG JUNEBERRIES	1466	2,302.00	2,302.00
A04-301-0078	JOHN WHITE BODY SR.	950	405.00	405.00
A04-301-0079	GEORGE MARSHALL	116	1,304.21	1,304.21
A04-301-0080	ERNEST WILKINSON SR.	817	718.00	718.00
A04-301-0081	ALICE FOX	822	520.00	520.00
A04-301-0083	FOUR DANCES	132	419.00	419.00
A04-301-0084	CROW CARRIE	345	1,379.00	1,379.00
A04-301-0085	BLUE BLANKET	63	220.00	220.00
A04-301-0086	GERTRUDE BLACK HAWK	408	234.00	234.00
A04-301-0088	STELLA HOWLING WOLF	905	688.00	683.00
A04-301-0089	GEORGE BATEMAN	764	210.00	210.00
A04-301-0090	FANNIE SITTING BEAR	903	272.00	272.00
A04-301-0091	MARTIN FOX	147	2,619.00	2,619.00
A04-301-0092	ALLEN SMITH	294	1,470.00	1,470.00
A04-301-0093	BLACK MEDICINE (LITTLE OWL	720	352.40	221.39
A04-301-0094	MARY NAGLE WALKER FREDERICKS	212 275A	332.19	332.00
A04-301-0095	GRINNELL CHARLES	190	925.00	901.45
A04-301-0096	FRED FOX SR.	950	3,353.00	466.89
A04-301-0097	BAKER JAMES	565	2,291.00	2,291.00
A04-301-0098	PERKINS ELI	642	1,068.00	1,068.00
A04-301-0099	WORA PAINTE	904	1,426.00	1,426.00
A04-301-0100	FLOYD MONTCLAIR	332	1,208.00	67.50
A04-301-0101	SNOW BIRD	327	2,917.00	418.99
A04-301-0209	BLUE BLANKET FOUR DANCES	63 410A	22.00	22.00
A05-303-0100	BRAIN EUGENE	356	2,959.00	774.27
A05-303-0101	COURT IGNATIUS	433	155.41	UNKNOWN
A05-303-0102	BLACK TIGER AGNES	492	3,495.00	1,955.67
A05-303-0103	PEOPLES WILFRED	U-2670	9,092.00	1,062.74
A05-303-0104	WAKANSAN NANCY (GUY)	NA	267.15	UNKNOWN
A05-303-0105	KEEBLE VICTORIA (ONE BEAR)	169	1,432.00	702.28
A05-303-0106	DANCE EAGLE ROSALIE	194	3,490.00	1,043.90
A05-303-0107	LONGIE ANTHONY (LANGER)	187	4,983.00	201.40
A05-303-0108	EHLUND LOUISA (LANGER)	189	191.00	191.00

ISSUE NUMBER	NAME OF DECEDENT	DECEDENT ID	$ALLOWED	$PAID
AOS-303-0109	AIKINICAPI ANTHONY	193	429.99	429.99
AOS-303-0160	TURNING EAGLE (SIPTO JOHSON)	90	65.00	65.00
AOS-303-0161	HERRICK LOUIS	148	588.00	588.00
AOS-303-0162	GOURD HEAD PHILOMENE	405	659.00	659.00
AOS-303-0163	HOPKINS ANTHONY	500-A	458.00	458.00
AOS-303-0164	TOMAHAWK THOMAS	569	3,012.00	3,012.00
AOS-303-0165	CASKE ALBERT	386	444.00	444.00
AOS-303-0166	YOUNG ADELE (LAMBOR)	185	108.49	108.49
AOS-303-0167	BROWN JOSEPHINE	905	1,652.00	1,652.00
AOS-303-0168	HOLYAHDIHEKA (FALLING GRAY)	856	929.00	929.00
AOS-303-0169	BROWN CLARA (MOON)	979	480.00	480.00
AOS-303-0170	TWO HEARTS MARY (KING)	1169	288.00	288.00
AOS-303-0171	STANDING JAMES	1120	176.41	176.41
AOS-303-0172	HIGH ELK ANNIE	1062	194.95	194.95
AOS-303-0173	BLACKSMITH MARY	U1169	1,266.00	1,266.00
AOS-303-0174	MCKAY LUKE B.	27	4,900.00	1,310.89
AOS-303-0175	FALLING CLOUD RACHEL	59	1,772.00	1,009.59
AOS-303-0176	MATOHIN JOSEPH	106	2,614.00	1,356.24
AOS-303-0177	JOHNSON MARGARET	143	3,377.00	86.85
AOS-303-0178	LONGIE FRANCIS	300	3,394.00	2,463.47
AOS-303-0179	CROW ONE BEAR MARTHA	495	1,922.00	1,838.32
AOS-303-0180	PEOPLES THOMAS	536	1,481.06	1,481.06
AOS-303-0181	LAWRENCE CHARLES	548	3,551.00	610.71
AOS-303-0182	CASKE FREDERICK	593	940.00	674.54
AOS-303-0183	PEOPLES CECELIA	291	4,336.00	1,970.58
AOS-303-0184	WAANTAN ELIZA	225	672.00	512.53
AOS-303-0185	GREYWIND JOSEPH	637	3,092.00	802.63
AOS-303-0186	MEAD MICHAEL	234	78.89	78.89
AOS-303-0187	WHITE HEAD NANCY	919	1,511.31	674.39
AOS-303-0188	LONG HORN MAGGIE	1144	492.00	400.60
AOS-303-0189	TAMAHPIYATOWIN WABIDE	U87	2,970.98	2,641.50
AOS-303-0190	LITTLE ADELE (LONGIE)	859	2,494.00	149.03
AOS-303-0191	WAKAKSAN JOSEPH A.	127	3,989.00	1,712.85
AOS-303-0192	MCKAYMARY LOUISE	991	431.56	399.15
AOS-303-0193	JAMES JULIA (IRISH)	679	1,091.47	357.88
AOS-303-0194	RAINBOW CARRIE	691	3,945.00	493.26
AOS-303-0195	ROSS JULIA	706	1,112.00	1,112.00
AOS-303-0196	ALBERT JOSEPH	77	6,601.00	122.32
AOS-303-0197	WAKASAN KATE (LAWRENCE)	98	7,757.25	261.84
AOS-303-0198	MERRICK JOSEPH	150	4,041.00	662.64
AOS-303-0199	BUISSON HENRY	319	34.39	31.50
AOS-303-0200	EUGENE BRAIN	356	2,959.00	774.27
AOS-303-0201	IGNATIUS COURT	413	155.41	UNKNOWN
AOS-303-0202	AGNES BLACK TIGER	492	3,495.00	1,955.67
AOS-303-0203	WILFRED PEOPLES	534	8,092.00	1,062.74
AOS-303-0204	NANCY GUY WAKAKSAN	509	439.50	UNKNOWN
AOS-303-0205	VICTORIA ONE BEAR KEEBLE	169	1,685.00	702.28
AOS-303-0206	ROSALIE DANCE EAGLE	184	3,480.00	1,043.90
AOS-303-0207	ANTHONY LANSER LONGIE	187	3,863.00	204.40
AOS-303-0208	LOUISA LANSER EMLUND	189	191.00	191.00
AOS-303-0209	EUGENE HIGH ELK	594	30.00	30.00
AOS-303-0210	STAIGHT NANCY	996	1,994.00	1,994.00
AOS-303-0211	BLACK WILLIAM	278	227.00	227.00
AOS-303-0212	CAVANAUGH WALTER	270	521.00	440.10
AOS-303-0214	PAHMANI PAUL	450	3,160.00	95.00
AOS-303-0215	DUNN RUPERT	641	3,563.00	490.20
AOS-303-0216	IRON HAWK ANNIE	638	2,203.00	321.59
AOS-303-0217	DOUGLAS STEVEN	244	742.00	53.75
AOS-303-0218	LANGER ISABELLE	998	1,494.00	1,035.91
AOS-303-0219	JACKSON JOSEPH	812	2,234.00	UNKNOWN
AOS-303-0220	AGNES MYRICK MERRICK	779	2,166.00	1,350.37
AOS-303-0221	SMITH MARY (HOPKINS)	1145	5,874.00	286.74
AOS-303-0222	IRON HEART JOSEPH	1177	5,603.92	97.35
AOS-303-0223	BLACK CLOUD LOUISA	689	952.88	952.18
AOS-303-0224	FALLING CLOUD FRANK	1102	1,403.98	UNKNOWN
AOS-303-0225	YOUNG GEORGE	1135	323.20	UNKNOWN
AOS-303-0226	PEOPLES PETER	H-2868	3,116.00	321.00
AOS-303-0227	YOUNG PETER	42	4,897.00	UNKNOWN
AOS-303-0229	BIG TRACK ANNIE	1197	14.14	14.14
AOS-303-0230	LITTLE JOSEPH	H-2479	23.00	23.00
AOS-303-0231	HEAD WINONA	1024	387.99	220.31
AOS-303-0232	BEGAR MARY JANE	NA	1,926.00	1,449.15
AOS-303-0233	FOX SOLOMON	65	924.25	648.55
AOS-303-0234	WANTAN MOSES	H-2795	1,887.00	888.67
AOS-303-0235	GRAY PAUL SR.	856	929.00	929.00

ISSUE NUMBER	NAME OF DECEDENT	DECEDENT ID	$ALLOWED	$PAID
AOS-303-0236	BEGAR LEO	18	1,968.00	915.15
AOS-303-0237	LAWRENCE CEDINA	1143	2,885.00	1,250.28
AOS-303-0238	LAHNER ANTHONY	H-2515	476.00	383.55
AOS-303-0239	LEAF WILLIAM	354	3,843.00	147.58
AOS-303-0240	ABRAHAM JACOB	809	150.00	150.00
AOS-303-0242	DEMERCE JAMES	322	304.73	304.73
AOS-303-0243	LAURENCE FRED	543	478.15	69.98
AOS-303-0244	KEYA JOSEPH	461	228.00	228.00
AOS-303-0245	SMITH LAURA (LAHNES)	H-2593	244.00	141.50
AOS-303-0296	ANTHONY AIKINICAPI	193	430.00	429.99
AOS-344-0001	ROAN EAGLE BESSIE	2584	1,897.32	173.12
AOS-344-0002	THUNDER CLUB PAUL	6591	1,138.05	955.28
AOS-344-0003	POOR ELK CLARINDA	10145	892.24	892.24
AOS-344-0004	IRON HAWK HOMER	4533	2,200.00	2,200.00
AOS-344-0005	STAND UP JULIA	2509	61.64	61.64
AOS-344-0006	JONES NANCY (YOUNG BEAR)	1907	458.50	458.50
AOS-344-0007	BOUILLARD JENNIE	6175	184.50	184.50
AOS-344-0008	SISSONETTE JOSEPH	3094	700.00	700.00
AOS-344-0009	MAGPIE PAUL (WHITE)	6182	1,687.00	1,687.00
AOS-344-0010	BROWN EAR NOSE GEORGE	6196	1,012.00	1,012.00
AOS-344-0011	LITTLE WOLF BESSIE	2420	2,320.00	606.13
AOS-344-0012	STIRK ANTHONY	2405	50.00	50.00
AOS-344-0013	HERON HIGH	5997	1,014.41	1,014.41
AOS-344-0014	RANDALL ROBERT	4531	618.00	284.44
AOS-344-0015	LITTLE DOG	6150	359.00	359.00
AOS-344-0016	FOOLISH WOMEN LEONARD	2854	319.55	319.55
AOS-344-0017	LITTLE FINGER JENNIE	2850	1,374.80	1,374.80
AOS-344-0018	TEN FINGERS ELLA	3815	419.00	419.00
AOS-344-0019	LIVING OUTSIDE ISABELLE	2982	629.90	629.90
AOS-344-0020	NOT HELP HIM JENNIE	2945	613.50	613.50
AOS-344-0021	RATTLING CHASE JOHN	2861	1,855.60	1,855.60
AOS-344-0022	LAYS HARD MILLIE	5930	447.25	447.25
AOS-344-0023	BELT LEVI	5896	160.00	160.00
AOS-344-0024	LITTLE SOLDIER AMELIA	6596	584.00	584.00
AOS-344-0025	GOOD VOICE IRON CHARLES	7954	1,450.00	44.14
AOS-344-0026	LITTLE BEAR JENNIE	9015	568.00	568.00
AOS-344-0027	COMES OUT JENNIE	4371	1,208.50	1,208.50
AOS-344-0028	VALANDRY VETAL	2460	5.00	5.00
AOS-344-0029	BLACK CROW AUSTIN	2373	1,379.50	1,379.50
AOS-344-0030	TWO STICKS HATTIE	2361	1,228.38	1,228.38
AOS-344-0031	WHITE BIRD JAMES	6570	1,533.00	415.94
AOS-344-0032	NOSE	6556	1,499.00	1,499.00
AOS-344-0033	DON'T THINK MARY	6641	278.00	278.00
AOS-344-0034	BLACK HAIR CATHERINE	6535	457.50	457.50
AOS-344-0035	THUNDER HAWK THOMAS	1890	3,487.50	3,487.50
AOS-344-0036	SMITH JULIA	1874	95.50	95.50
AOS-344-0037	YELLOW BOY JOSEPHINE	5899	125.00	125.00
AOS-344-0038	LITTLE SOLDIER HENRY	6203	1,816.50	1,816.50
AOS-344-0039	IRON HAWK	6445	2,546.98	2,546.98
AOS-344-0040	RUMP BONE	6450	31.50	31.50
AOS-344-0041	TWO STICKS THOMAS	2360	649.00	649.00
AOS-344-0042	CLINCHER GEORGE	4365	501.00	501.00
AOS-344-0043	BONE NECKLACE	9214	954.36	954.36
AOS-344-0044	HER HORSES	1879	600.00	600.00
AOS-344-0045	STABBER JULIA	6691	140.00	140.00
AOS-344-0046	LOUD VOICE HAWK MARY	6527	1,881.00	1,881.00
AOS-344-0047	POOR BEAR LIZZIE	4393	84.00	84.00
AOS-344-0048	LITTLE WAR BONNETT JESSIE	6528	2,869.16	1,738.92
AOS-344-0049	CHARGING CROW WILLIAM	2091	1,328.15	1,328.15
AOS-344-0050	CHARGING CROW NANCY	2092	46.50	46.50
AOS-344-0051	BITTERS PATRICK	2042	255.15	255.15
AOS-344-0052	JARVIS GRACE	6501	659.92	487.65
AOS-344-0053	CROOKED EYES THOMAS	2314	841.00	841.00
AOS-344-0054	SUSIE MERRIVAL	3592	1,600.00	131.00
AOS-344-0055	BENJAMIN RICHARD	2333	200.00	200.00
AOS-344-0056	ROUSSEAU JOSEPH	2338	237.90	237.90
AOS-344-0057	BULL KNIFE GEORGE	1894	900.68	900.68
AOS-344-0058	SWALLOW IDA	3536	116.92	116.92
AOS-344-0059	NO TWO HORNS HILDA	3271	1,420.00	1,420.00
AOS-344-0060	WHETSTONE JOSEPH	597	2,200.50	2,200.50
AOS-344-0061	BLUFFINS BEAR SOPHIA	2313	1,898.85	1,898.85
AOS-344-0062	EAGLE BEAR	611	284.40	284.40
AOS-344-0063	WHISTLER JULIAN	4301	133.39	133.39
AOS-344-0064	LITTLE SOLDIER NANCY	4294	1,892.45	1,892.45
AOS-344-0065	BLACK BEAR HARRY	4284	351.50	351.50

ISSUE NUMBER	NAME OF DECEDENT	DECEDENT ID	$ALLOWED	$PAID
AO6-344-0066	WOODEN GUN ALBERT	4219	12.00	12.00
AO6-344-0067	YELLOW SHIRT STELLA	6438	552.80	552.80
AO6-344-0068	BACK SIMON	6507	492.00	492.00
AO6-344-0069	LITTLE WAR BONNETT PETER	6517	608.46	608.46
AO6-344-0070	SAHOVIA JAMES	4362	2,074.30	360.08
AO6-344-0071	LONG COMMANDER JOHN	4345	321.60	321.60
AO6-344-0072	USES BOW JULIA	2112	384.45	384.45
AO6-344-0073	BLACK BEAR	5298	1,003.20	1,003.20
AO6-344-0074	LITTLE KILLER JOHN	2047	149.10	149.10
AO6-344-0075	CHIEF BEAR WILLIAM	2001	718.90	718.90
AO6-344-0076	RANDALL WILLIAM	2037	5.00	5.00
AO6-344-0077	SHORT BULL JESSIE	4347	648.56	648.50
AO6-344-0078	EAGLE FOX MARY	4337	90.00	90.00
AO6-344-0079	LAST HORSE JOSEPH	2053	1,141.55	1,141.55
AO6-344-0080	SURROUNDED IN WOODS	2029	582.00	582.00
AO6-344-0081	SCOUT JASPER	1122	2,594.50	2,594.50
AO6-344-0082	BLACK BEAR EMMA	2299	1,018.20	1,018.20
AO6-344-0083	YOUNG IDA	2513	111.72	111.72
AO6-344-0084	SPIDER MACK	544	168.50	168.50
AO6-344-0085	TWISS ADELIA	2142	50.00	50.00
AO6-344-0086	HAWK WING LUKE	2165	558.23	558.23
AO6-344-0087	RED BREACH BEAR MILDRED	6430	355.00	355.00
AO6-344-0088	WEANS ALICE	2246	5.00	5.00
AO6-344-0089	FIRE THUNDER MARY	6427	921.89	921.89
AO6-344-0090	EAGLE PIPE	601	10.00	10.00
AO6-344-0091	BULL KNIFE MARY	2116	954.50	954.00
AO6-344-0092	FAST HORSE ANNA	2237	1,103.50	1,103.50
AO6-344-0093	LINSMAN CHARLES	2089	1,595.50	1,595.00
AO6-344-0095	RANDALL SUSIE	2038	209.22	209.22
AO6-344-0096	JUMPING BULL	4356	679.00	679.00
AO6-344-0097	YOUNG BEAR RACHEL	2250	266.25	226.25
AO6-344-0098	SWALLOW HATTIE	2161	13.75	13.75
AO6-344-0099	POOR BEAR ALBERT	2115	510.40	510.40
AO6-344-0100	BLACK EYES ANNIE	2105	237.50	237.50
AO6-344-0102	BAD WOUND ROBERT	2066	281.00	281.00
AO6-344-0103	CLINCHER LIZZIE	4366	1,244.00	1,244.00
AO6-344-0104	BELT FRANK	3274	578.50	578.50
AO6-344-0105	KINDLE BEN	3150	2,154.30	208.81
AO6-344-0106	LITTLE BULL MABEL	10793	874.50	874.50
AO6-344-0107	SMITH ALICE	2379	341.05	34.20
AO6-344-0108	STANDING BEAR DAVID	2415	540.00	540.00
AO6-344-0109	GOODMAN JANICE	9780	48.00	48.00
AO6-344-0110	BIG HEAD BRAVE JOHN	4170	1,759.00	1,759.00
AO6-344-0111	GAY NANCY	4179	555.50	555.50
AO6-344-0112	KILLS THE CHIEF JULIE	7812	1,527.85	1,527.85
AO6-344-0113	STANDS NELLIE	7813	399.21	399.21
AO6-344-0114	WHITE WHIRLWIND SUSIE	7811	1,451.00	1,451.00
AO6-344-0115	EAGLE HAWK AGNES	7614	406.84	406.84
AO6-344-0116	STINKING BEAR IDA	6411	1,733.00	1,733.00
AO6-344-0117	RED BEAR SUSIE	6610	1,319.00	1,319.00
AO6-344-0118	RED BEAR JOSEPH	6609	2,733.00	1,865.30
AO6-344-0119	BROKEN LEG LUCY	1862	790.50	790.50
AO6-344-0121	BLACK CROW JULIA	2374	559.50	559.20
AO6-344-0122	WAR BONNETT JOSEPH	2380	451.00	451.00
AO6-344-0123	EAGLE HAWK JOSEPH	3107	513.54	513.54
AO6-344-0124	PALMER LAURA	3791	460.60	460.60
AO6-344-0125	FROM AMONG THEM	3141	1,201.37	1,178.92
AO6-344-0126	COMES FROM AMONG THEM DONALD	3140	649.50	649.50
AO6-344-0127	NOT FAT EDNA	3112	2,905.90	2,905.90
AO6-344-0128	DOG CHIEF MARY	6461	589.73	589.73
AO6-344-0129	BROKEN NOSE FOX	6529	564.40	564.40
AO6-344-0130	HIGH CAT LEE	4582	150.00	150.00
AO6-344-0131	SHIELD LOUIS	957	44.00	44.00
AO6-344-0132	RUNS FOR HILL	1145	647.20	647.20
AO6-344-0133	YELLOW BEAR MARY	1043	423.00	423.00
AO6-344-0134	WHITE EAGLE ROBERT	1026	955.55	955.55
AO6-344-0135	WHIRLWIND	1024	302.50	302.50
AO6-344-0136	CONQUERING BEAR ABE	1014	406.50	406.50
AO6-344-0137	BLACK BEAR JOHN	998	957.55	957.55
AO6-344-0138	LARAPEE NANCY	479	1,818.50	1,818.50
AO6-344-0139	KILLS ENEMY CHARLES	951	1,211.43	1,211.43
AO6-344-0140	FIRE THUNER WILLIAM	943	1,113.00	1,113.00
AO6-344-0141	WHITE THUNDER HARRISON	503	81.00	81.00
AO6-344-0142	WHITE BRINGS ELLA	898	266.91	91.22
AO6-344-0143	STABBER THOMAS	526	1,680.00	1,680.00

ISSUE NUMBER	NAME OF DECEDENT	DECEDENT ID	$ALLOWED	$PAID
AO6-344-0144	BRINGS WHITE ANNIE	897	1,685.00	1,464.65
AO6-344-0145	WHITE BULL # 2	452	152.95	152.95
AO6-344-0146	ADAMS JOHN	459	1,007.50	1,007.50
AO6-344-0147	YOUNG VICTOR	2519	6,582.50	27.21
AO6-344-0148	HE DOG LUCY	3105	26.00	26.00
AO6-344-0149	WEASEL BEAR CHARLES	3065	1,272.50	1,272.50
AO6-344-0150	GARCIA LENA	8052	810.95	810.95
AO6-344-0151	IRON BULL ANNIE	9014	3,624.00	1,876.68
AO6-344-0152	WHITE HORSE GROVER	8039	599.50	599.50
AO6-344-0153	KATE ROMERO	9029	365.28	365.00
AO6-344-0154	GOOD HORSE BOB	8010	209.03	209.03
AO6-344-0155	GETS THERE FIRST SUSAN	7946	80.30	UNKNOWN
AO6-344-0156	POURIER JOSIE	7692	700.00	700.00
AO6-344-0157	PACKED JACOB	3746	1,397.00	1,397.00
AO6-344-0158	PROTECTOR ISAAC	962	591.50	363.31
AO6-344-0159	CHASES IN MORNING STANLEY	911	388.50	386.50
AO6-344-0160	SITTING UP ESTHER	1911	54.00	54.00
AO6-344-0161	WHITE WOMAN	1940	772.00	772.00
AO6-344-0162	FASTWOLF JENNIE	1926	1,199.50	1,199.50
AO6-344-0163	FIRE THUNDER MARY	1944	20.00	20.00
AO6-344-0164	RAIN BOW	2451	596.20	586.20
AO6-344-0165	YOUNG LOUISA	2524	216.80	79.78
AO6-344-0166	BETTLEYOUN JOSEPHINE	2181	5.00	5.00
AO6-344-0167	SWIMMER JOHN	2635	1,391.29	1,381.29
AO6-344-0168	YELLOW HORSE JOSEPH	2607	932.72	932.72
AO6-344-0169	GOOD BUFFALO FRANK	5945	777.56	457.31
AO6-344-0171	KILLS THE CHIEF	6016	990.40	990.40
AO6-344-0172	YOUNG SOLDIER MILLIE	3838	360.30	360.30
AO6-344-0173	HOLLOW HORN FANNIE	3815	393.94	393.94
AO6-344-0174	WESTETH WILLIAM	2632	509.14	509.14
AO6-344-0175	BROOKS CHARLES	2599	50.00	50.00
AO6-344-0176	SITTING EAGLE ALBERT	1425	1,967.99	1,967.99
AO6-344-0177	WOUNDED HEAD BROOKS	1687	462.00	462.00
AO6-344-0178	CHEYENNE EFFIE	3064	903.48	903.48
AO6-344-0179	WHITE HAWK MATTIE	3049	852.03	852.03
AO6-344-0180	HORSE BESSIE	3045	1,366.60	326.08
AO6-344-0181	BISSONETTE JOHN	3027	350.00	350.00
AO6-344-0182	BLACK ELK NICK	3021	747.00	747.00
AO6-344-0183	SHOULDER MARY	5623	785.00	785.00
AO6-344-0184	POURIER JOSEPHINE	2609	88.00	88.00
AO6-344-0185	BIRD EAGLE AUSTIN	1166	2,773.05	2,773.05
AO6-344-0186	STANDING SOLDIER HENRY	2604	1,380.14	1,380.14
AO6-344-0187	BLUE HORSE OWNER MINNIE	3160	2,600.00	395.35
AO6-344-0188	AROUND HIM HOWARD	1956	300.00	300.00
AO6-344-0189	FIRE THUNDER LOUISA	1950	11.00	11.00
AO6-344-0190	SPOTTED CROW EDWARD	3722	945.50	945.50
AO6-344-0191	COW HORN	2660	126.00	126.00
AO6-344-0192	RED EAGLE ANNIE	3719	295.00	295.00
AO6-344-0193	CLOSE GEORGE	5199	841.00	841.00
AO6-344-0194	HOLY ELK LIZZIE	1908	984.00	984.00
AO6-344-0195	PLENTY HORSES LIZZIE	3284	949.50	949.50
AO6-344-0196	HOWES CAMP	1918	1,985.00	1,985.00
AO6-344-0197	BLACK HORSE JAMES	3431	50.00	50.00
AO6-344-0198	ARAPAHOE LUCY	5145	945.50	945.50
AO6-344-0199	LAMONT MARY	5157	5.00	5.00
AO6-344-0200	KILLS CLOSE TO LODGE BERT	5049	2,377.90	2,377.90
AO6-344-0201	LITTLE KNIFE LOUISA (RED EYES)	5837	427.00	427.00
AO6-344-0202	JEALOUS OF HIM LOUISA	5684	645.00	645.00
AO6-344-0203	LOOKING CLOUD NANCY	5780	217.70	217.70
AO6-344-0204	DANA LONE WOLF	4889	2,659.30	2,659.30
AO6-344-0205	OWNS MANY HORSES WILLIAM	4892	1,442.90	1,442.90
AO6-344-0206	SHORT BEAR MILLIE	5370	735.50	735.50
AO6-344-0207	KILLS ON HORSE BACK JAMES	2775	3,687.10	1,398.74
AO6-344-0208	EAGLE LOUSE JOHN	3411	2,917.30	174.07
AO6-344-0209	CLIFFORD JOHN H.	2672	795.00	573.99
AO6-344-0210	CLOSE FEATHER	5933	2,310.00	2,310.00
AO6-344-0211	GILLESPIE ROBERT	3250	457.26	457.26
AO6-344-0212	CANE WOMAN	5903	333.00	333.00
AO6-344-0213	MARY ROUGH FEATHER	5942	250.00	250.00
AO6-344-0214	LITTLE COMMANDER CECELIA	5916	1,515.25	1,515.25
AO6-344-0215	YELLOW BOY	246	395.10	395.10
AO6-344-0216	KILLS CLOSE TO LODGE MOLLIE	5050	357.96	357.96
AO6-344-0217	POOR ELK ELIZABETH	3273	1,096.00	1,096.00
AO6-344-0218	LONE WOLF NATHAN	3951	678.50	678.50
AO6-344-0219	HOLY CLOUD JULIA	4193	532.57	532.57

ISSUE NUMBER	NAME OF DECEDENT	DECEDENT ID	$ALLOWED	$PAID
AQ6-344-0220	PRETTY EAGLE MARY	5037	173.08	173.08
AQ6-344-0221	HORSE ROBERT	4998	1,887.90	1,887.90
AQ6-344-0222	WATER MAGGIE	4926	1,918.70	1,918.70
AQ6-344-0223	BLACK BEAR EDWARD	1433	1,381.00	1,381.00
AQ6-344-0224	GOES IN CENTER JOHN	5768	5.00	5.00
AQ6-344-0225	HIGH HORSE ANNA	5746	503.40	503.40
AQ6-344-0226	PLUME HOBART	5716	2,515.00	2,515.00
AQ6-344-0227	FLYING HORSE HOWARD	5048	797.50	797.50
AQ6-344-0228	RED OWL JESSIE	3941	966.20	966.20
AQ6-344-0229	SPOTTED EAGLE	4260	325.48	325.48
AQ6-344-0230	MORRISON LUCY	4251	948.25	948.25
AQ6-344-0231	ELK BOY JOSEPH	4418	944.67	944.67
AQ6-344-0232	ADAMS ALEX	345	781.85	781.85
AQ6-344-0233	HAWKINS JAMES	4612	5.00	5.00
AQ6-344-0234	STANDS PETER	3303	434.30	434.30
AQ6-344-0235	BETTELYOUN LIZZIE	4701	24.00	24.00
AQ6-344-0236	RED HORSE	4112	987.50	987.45
AQ6-344-0237	FAST WOLF JOHN	1981	3,833.00	3,234.04
AQ6-344-0238	FIGHTS BEAR	178	843.43	843.43
AQ6-344-0239	KILLS IN WATER SAMUEL	234	494.55	494.55
AQ6-344-0240	JEALOUS OF HIM OSCAR	32	197.50	197.50
AQ6-344-0241	LOOKING ELK SILVIA	5-3153	1,489.50	1,489.50
AQ6-344-0242	LAYS BEAR MARY	3240	1,200.00	1,200.00
AQ6-344-0243	RED PAINT LOUIS	3355	24.88	24.88
AQ6-344-0244	LOOKING HORSE ROSA	3458	840.00	840.00
AQ6-344-0245	KNIFE LUCY	4033	1,229.50	325.70
AQ6-344-0246	MEANS FANNIE (FAST HORSE)	4078	1,837.10	1,837.10
AQ6-344-0247	TWISS LIZZIE	2923	35.00	35.00
AQ6-344-0248	STANDING SOLDIER WILLIAM JR.	282	595.01	595.01
AQ6-344-0249	BIG CROW SUSIE	261	493.12	493.12
AQ6-344-0250	SMOKE EMMA	4921	546.00	546.00
AQ6-344-0251	MAKES OVER	2823	183.00	183.00
AQ6-344-0252	LITTLE ELK JEROME	3831	158.00	158.00
AQ6-344-0253	SMITH JEANETTE	2736	606.00	606.00
AQ6-344-0254	JAMES LOCYE	3951	143.45	143.00
AQ6-344-0255	RED ELK PHILLIP	5618	1,200.00	UNKNOWN
AQ6-344-0256	RED SHIRT ELLEN	6045	1,957.00	1,957.00
AQ6-344-0257	GOINGS FRANK	2591	355.14	355.14
AQ6-344-0258	TIBBITTS WILLIAM	2572	1,050.84	1,050.84
AQ6-344-0259	YELLOW WOLF CHARLES	5113	1,393.20	1,393.20
AQ6-344-0260	SHORT BEAR SILAS	5363	1,170.50	1,170.50
AQ6-344-0261	HOLLOW HORN HAR SUSIE	4751	560.10	560.10
AQ6-344-0262	LOCATION (KILLS REE)	3931	560.00	560.00
AQ6-344-0263	HEART MAN THOMAS	3497	1.00	1.00
AQ6-344-0264	KILLS A HUNDRED SUSIE	3492	70.00	70.00
AQ6-344-0265	TWO BULLS MARY	3471	1,280.50	1,280.50
AQ6-344-0266	GOES AFTER FANNIE	3018	1,159.16	1,159.16
AQ6-344-0267	TWO BULLS AMOS	2452	1,773.59	1,297.99
AQ6-344-0268	YELLOW THUNDER THOMAS	1382	689.90	689.90
AQ6-344-0269	JARIS MOLLIE	1783	75.41	75.41
AQ6-344-0270	HOLLOWHEAD JOHNSON	1749	2,186.50	2,186.50
AQ6-344-0271	FIRE PLACE WILLIAM	4128	699.50	699.50
AQ6-344-0272	LITTLE CLOUD MILLIE	4124	666.36	666.36
AQ6-344-0273	TWIN FREE	4115	1,237.00	1,237.00
AQ6-344-0274	GHOST BEAR WILLIAM	30	60.00	60.00
AQ6-344-0275	PAIN ON HIP CHARLES	1727	148.94	148.94
AQ6-344-0276	YAMATON HELEN	1744	779.90	599.77
AQ6-344-0277	WHITE DRESS LIZZIE	4092	1,042.50	1,042.50
AQ6-344-0278	PEMICAN	2986	2,936.00	2,936.00
AQ6-344-0279	TYON LUCY	3424	346.75	346.75
AQ6-344-0280	WALKS UNDER GROUND JACOB	1477	1,195.24	1,195.24
AQ6-344-0281	WALKING HAIL	3152	228.60	228.60
AQ6-344-0282	BLUE LEG GEORGE	1950	975.44	975.44
AQ6-344-0283	BROWN DAVID	4221	2,164.00	2,164.00
AQ6-344-0284	WEIVER HARRY	4226	1,107.68	1,107.68
AQ6-344-0285	IRON BEAR ALEC	677	1,283.10	440.90
AQ6-344-0286	BROWN EYES LOUIS	650	1,540.00	548.58
AQ6-344-0287	ROCK CHARLES	693	238.38	78.32
AQ6-344-0288	GOOD VOICE IRON CHARLES	2984	1,450.00	44.14
AQ6-344-0289	YAMATON SALLIE	1159	560.86	560.86
AQ6-344-0291	CUNY ANGELINE	5116	611.00	611.00
AQ6-344-0290	TWISS WILLIAM	2924	894.70	894.70
AQ6-344-0292	O'ROURKE LIZZIE	2917	75.00	75.00
AQ6-344-0293	PRAYS TO HER	5330	675.99	392.99
AQ6-344-0294	YELLOW BUG	5276	480.05	480.05

ISSUE NUMBER	NAME OF DECEDENT	DECEDENT ID	$ALLOWED	$PAID
AQ6-344-0296	LONG SOLDIER ALBERT	1791	2,071.10	2,071.10
AQ6-344-0297	LIP GEORGE	3906	362.37	22.00
AQ6-344-0298	SOPHIA FILLS THE PIPE	3445	10.00	10.00
AQ6-344-0299	RED PAINT EDNA	6076	462.00	462.00
AQ6-344-0300	MORRISETTE LUCY	6102	10.00	10.00
AQ6-344-0301	FOOLS CROW	1435	2,029.09	2,029.09
AQ6-344-0302	ONE BEAR SAMUEL	1428	66.00	66.00
AQ6-344-0303	KILLS PLENTY	1513	108.50	108.50
AQ6-344-0304	HERNANDEZ REYS	1410	257.50	257.50
AQ6-344-0305	EAGLE ELK	6051	1,157.05	1,157.05
AQ6-344-0306	WOUNDED HORSE JULIA	2899	457.03	457.03
AQ6-344-0307	CUNY CHARLES	2907	5.00	5.00
AQ6-344-0308	LITTLE DOG RUTH	2952	1,723.00	1,723.00
AQ6-344-0310	EAGLE TAIL FEATHER STELLA	4110	293.65	293.65
AQ6-344-0309	RUNS AGAINST SOPHIA	2975	1141.90	1141.90
AQ6-344-0311	NESTETH MABLE	6045	399.00	399.00
AQ6-344-0312	GOOD WEASEL ETTA	6358	23.00	23.00
AQ6-344-0313	BREAST JOHN	4195	1,446.00	1,446.00
AQ6-344-0314	LONG WARRIOR ELLA	4093	697.38	697.38
AQ6-344-0315	BREAST LUCY	4239	743.38	743.38
AQ6-344-0316	TWISS FRANK	724	43.50	43.50
AQ6-344-0317	YOUNG BEAR MARTIN	295	48.00	48.00
AQ6-344-0318	PABLO ALEX	353	130.00	2.91
AQ6-344-0319	RED BOW ANNIE	6231	907.50	907.50
AQ6-344-0320	LITTLE HORSE ISAAC	632	1,255.50	1,255.50
AQ6-344-0321	BEAR SHIELD NANCY	5541	937.38	937.38
AQ6-344-0322	YELLOW HAWK WZ	3960	946.38	946.38
AQ6-344-0323	YOUMAN ALICE (BETTLEYOUN)	4073	41.76	41.76
AQ6-344-0324	BETWEEN LODGES LUCY	3461	1,545.50	1,545.50
AQ6-344-0325	DILLION EMILY (STANDING BEAR)	4511	854.33	854.33
AQ6-344-0326	STOVER EDWARD	4436	30.00	30.00
AQ6-344-0327	LONG WARRIOR JOHNSON	4039	2,603.58	2,603.58
AQ6-344-0328	KILLS ABOVE	1246	1,347.05	1,347.05
AQ6-344-0329	ROMERO PHILIP	3991	10.00	10.00
AQ6-344-0330	FOOL HEAD JULIA	6010	509.00	509.00
AQ6-344-0331	JONES JOHN	3747	419.00	419.00
AQ6-344-0332	ELLA LABEAUX	2978	323.04	323.04
AQ6-344-0334	RANDALL ALICE	1991	1,449.00	1,449.00
AQ6-344-0335	CHIEF BEAR WILLIAM	2001	218.98	218.98
AQ6-344-0336	CHIEF BEAR SUSIE	2002	176.50	176.50
AQ6-344-0337	LITTLE SOLDIER HARRY	6394	1,940.80	1,940.80
AQ6-344-0338	CHARGES ENEMY JAMES	6393	97.01	97.01
AQ6-344-0339	LONG SHANK	1969	308.50	308.50
AQ6-344-0340	RATTLING HAWK	4310	10.00	10.00
AQ6-344-0341	SPIDER BACKBONE JULIA	6260	1,030.15	622.42
AQ6-344-0342	NESTETH DAVID	6357	39.93	39.93
AQ6-344-0343	POOR BEAR BESSIE (TWO ELK)	4221	470.00	69.23
AQ6-344-0344	ELIZABETH FLOOD	2954	159.98	159.98
AQ6-344-0345	JOSEPH HIGH EAGLE	3454	2462.00	2462.00
AQ6-344-0346	FOURTER JOHN	2137	1.00	1.00
AQ6-344-0347	TWIN RUBEN	4113	1,204.26	1,204.26
AQ6-344-0348	FEATHERMAN JOHN	1230	901.38	438.98
AQ6-344-0349	WHITE WHIRLWIND GILBERT	1237	1,099.72	1,098.00
AQ6-344-0350	SHOT AT JAMES	4015	190.00	190.00
AQ6-344-0351	HOLY TRACY	4007	641.50	641.50
AQ6-344-0352	LITTLE IRON WILLIAM ARNOLD	4931	255.00	255.00
AQ6-344-0353	DAMMON JULIA	3568	2.00	2.00
AQ6-344-0354	AMERICA HORSE DAWSON	43	1,124.50	1,124.50
AQ6-344-0355	MAKES SHINE OLIVER	255	463.50	463.50
AQ6-344-0356	RUNNING BEAR ALBERT	148	389.00	389.00
AQ6-344-0357	RANDALL SALLIE	1849	2,498.40	2,498.40
AQ6-344-0358	OLD HORSE JOSIE	1223	43.91	43.91
AQ6-344-0359	FIRE THUNDER	3024	90.00	90.00
AQ6-344-0360	CEDAR FACE WILLIAM	2044	362.00	362.00
AQ6-344-0361	BULL BEAR REIE	1697	1,294.50	1,294.50
AQ6-344-0362	HARD TO HIT	1716	311.50	311.50
AQ6-344-0363	STEALS HORSES THOMAS	1683	915.83	915.83
AQ6-344-0364	RED PAINT ROGER	3163	403.38	403.38
AQ6-344-0365	RED WITH BLOOD (WEASA)	6424	200.00	200.00
AQ6-344-0366	IRON HEART JOSEPHINE	5135	600.00	600.00
AQ6-344-0367	POOR BEAR PHILIP	5114	1,994.81	1,630.81
AQ6-344-0368	HOLY HAND	1463	765.50	765.50
AQ6-344-0369	HUPSPETH LILLIE	3264	1,592.65	1,592.65
AQ6-344-0370	WAR BONNETT NI	3954	1.00	1.00
AQ6-344-0371	BRAVE HEART JOHN	3174	2,075.00	388.74

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ABERDEEN AREA

ISSUE NUMBER	NAME OF DECEDENT	DECEDENT ID	$ALLOWED	$PAID
A06-344-0372	BRAVEHEART JOSEPH	3177	1,645.00	1,477.72
A06-344-0373	LONG BULL JOHN	5083	460.55	460.55
A06-344-0374	BRINGS WHITE	5085	370.50	370.50
A06-344-0375	HOLY HORSE SUSIE	5086	352.50	352.50
A06-344-0376	BAD HEART BULL DOLLIE	3232	1,970.50	1,970.50
A06-344-0377	SWALLOW OLIVER	3241	400.00	400.00
A06-344-0378	HER DOOR MARY	6111	55.00	55.00
A06-344-0379	SLEEP BETSY	6085	1,661.10	1,661.10
A06-344-0380	LONE WOMAN	2647	378.50	378.50
A06-344-0381	KING MARY	2648	870.50	870.50
A06-344-0382	SHOULDER JAMES	3898	618.50	618.50
A06-344-0383	SMOKE WOMAN	3337	671.20	671.20
A06-344-0384	BAD BEAR NELLIE	3346	334.50	334.50
A06-344-0385	GAY WILLIAM	1321	1,100.00	8.03
A06-344-0386	FAST WOLF THOMAS	1925	690.50	690.50
A06-344-0387	BRINGS HIM BACK HENRY	3264	24.00	24.00
A06-344-0388	PULLIAM LUCINDA	3632	1,426.00	1,426.00
A06-344-0389	FILLS THE PIPE SILAS	3444	793.29	793.29
A06-344-0390	MEANS GEORGE	3959	388.00	349.55
A06-344-0391	ELK BOY MARY	4419	1,514.80	447.64
A06-344-0392	RUNS BETWEEN	6029	690.50	690.00
A06-344-0393	RICHARDS EVA	4694	1,494.50	1,494.50
A06-344-0394	PARTS HIS HAIR EPHRIM	1387	1,611.00	1,611.00
A06-344-0395	SIX FEATHERS JOHN	4622	413.50	413.50
A06-344-0398	BIG HAWK PETER	1192	356.20	356.20
A06-344-0400	WALKS OUT	3295	1,023.15	1,023.15
A06-344-0401	STAR COMES OUT LIZZIE	3348	1,079.98	1,079.98
A06-344-0402	SITS POOR FRANK	2807	1,700.00	67.30
A06-344-0403	MEXICAN MILLIE	2803	781.50	781.50
A06-344-0404	RUNSON MAR	3645	609.50	609.50
A06-344-0405	GARNETTE CHARLES	3734	125.00	19.76
A06-344-0406	RED EYES MOLLIE	7818	939.50	939.50
A06-344-0407	BAD YELLOW HAIR JOSEPH	8056	5.00	5.00
A06-344-0408	SIOUX BOB HENRY	7891	600.00	600.00
A06-344-0409	AROUND HIM VICTORIA	1967	1,500.00	1,500.00
A06-344-0410	HIS ROAN HORSE	636	274.00	274.00
A06-344-0411	WHITE MOUSE CHARLIE	366	49.50	49.50
A06-344-0412	KNIGHT JOSEPH	399	439.00	247.47
A06-344-0413	BEARD ALICE	3642	664.00	276.98
A06-344-0414	PRETTY BIRD JOHN	2890	759.50	759.50
A06-344-0415	MOSSEAU LOUIS JR.	1956	94.00	94.00
A06-344-0416	LAKOTA ALEXANDER	3016	595.00	412.53
A06-344-0417	QUIVER FANNIE	4207	498.50	498.50
A06-344-0418	BACKBONE SPIDER	6259	2,868.45	2,868.45
A06-344-0419	WALKS OUT EUREKA	6237	131.25	131.25
A06-344-0422	PLENTY WOUNDS	421	892.00	892.00
A06-344-0423	RED HORSE MARY	2823	183.00	183.00
A06-344-0424	BREAST SILAS	4204	2,194.00	2,194.00
A06-344-0425	APPLE ROSA	3579	181.50	181.50
A06-344-0426	EAGLE HEART	1429	519.50	519.50
A06-344-0427	SWARD LOUISA	4161	399.00	399.00
A06-344-0428	SOUND SLEEPER JOSEPH	4144	316.30	316.30
A06-344-0429	WHITE COW KILLER EMMA	4194	867.90	867.90
A06-344-0430	GETS THERE FIRST GEORGE	1490	505.50	505.50
A06-344-0431	LAYS HARD FRANK	1523	778.70	778.70
A06-344-0432	FEATHER MARY	1535	888.50	888.50
A06-344-0433	LEFT HAND JESSIE	5013	693.00	693.00
A06-344-0434	LITTLE BEAR HENRY	7891	1,748.00	1,748.00
A06-344-0436	LONG BULL MARY	4549	4,050.50	2,112.37
A06-344-0437	TALL NOAH	4414	290.50	290.50
A06-344-0438	KILLS AT LARGE BERTHA	3421	275.50	275.50
A06-344-0440	LEDEAUX BESSIE	3942	825.50	825.50
A06-344-0441	RANDALL CHARLES SR.	4559	138.78	138.78
A06-344-0442	RICHARD ALFRED	4673	103.88	103.88
A06-344-0443	TURNING HOLY HENRY	4558	34.25	34.25
A06-344-0444	YELLOW HAWK ELLEN	3927	465.93	465.93
A06-344-0445	KILLS BEE JOHN	3532	1,288.00	1,288.00
A06-344-0446	RUNNING HAWK HARRY	4910	929.43	929.43
A06-344-0447	SHANGREAUX LIZZIE	3596	236.50	236.50
A06-344-0449	GOOD SOLDIER RICHARD	2869	1,746.19	1,746.19
A06-344-0450	GOOD SOLDIER CORA	2870	945.50	945.50
A06-344-0451	BELT	2871	358.00	358.00
A06-344-0452	TWO TWO ALEXANDER	198	200.00	200.00
A06-344-0453	ALLMAN LOUISE	207	71.50	71.50
A06-344-0454	TURNING HEART PHILOMENA	5937	222.50	222.50

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ABERDEEN AREA

ISSUE NUMBER	NAME OF DECEDENT	DECEDENT ID	$ALLOWED	$PAID
A06-344-0455	LONG HORN	4339	318.20	318.20
A06-344-0456	QUIVER THOMAS	4309	574.50	574.50
A06-344-0457	LONG SKUNK MILLIE	1970	258.50	258.50
A06-344-0458	HORN CHIPS	1975	317.00	317.00
A06-344-0459	PLENTY WOUNDS IDA	8059	1,149.11	1,149.11
A06-344-0460	LITTLE BOY CECILA	7968	504.40	504.40
A06-344-0461	BLACK FEATHER WASHINGTON	3013	2,315.40	1,303.71
A06-344-0462	BEAR COMES OUT	3011	154.30	154.30
A06-344-0463	RANDALL ANTOINE	1807	756.70	739.28
A06-344-0464	DEON WILLIAM	5591	5.00	5.00
A06-344-0465	UNDERSTANDING CROW	5329	1,612.00	1,612.00
A06-344-0466	SHORT BULL THOMAS	5580	3,172.50	901.02
A06-344-0467	RANDALL GEORGE	5557	3,150.00	3,150.00
A06-344-0468	SHOT TO PIECES ANNIE	5586	69.00	69.00
A06-344-0469	YELLOW HORSE WOMAN	2987	239.87	239.87
A06-344-0470	WHITE COW BULL	6476	772.50	772.50
A06-344-0471	SALWAY ALEX	5233	378.90	378.90
A06-344-0472	HOLY BEAR LUCY	5216	1,907.50	1,907.50
A06-344-0473	HAT SALLIE	2866	351.50	351.50
A06-344-0474	PRETTY WOMAN	5944	280.90	280.90
A06-344-0475	GOOD VOICE CROW	3633	236.00	236.00
A06-344-0476	WHITE BELLY MATTIE	3494	368.00	368.00
A06-344-0477	NO FAT ROSA (DREAMER)	4027	400.00	400.00
A06-344-0478	BULLMAN SALLIE	3674	968.88	968.88
A06-344-0479	LITTLE BOY RACHAEL	3992	826.50	826.50
A06-344-0480	ECOFFEY ALICE	5451	377.90	377.90
A06-344-0481	GOOD SHIELD OLIVER	742	1,578.94	1,578.94
A06-344-0482	BLACK BEAR THOMAS	726	598.50	598.50
A06-344-0483	PARTS HIS HAIR MAGGIE	778	455.00	455.00
A06-344-0484	KILLS CROW INDIAN	789	1,783.00	1,783.00
A06-344-0485	LITTLE ELK JOHN	668	1,449.32	1,449.32
A06-344-0486	JONES CHARLES	2696	817.55	817.55
A06-344-0487	AFRAID OF HAWK MABEL	2781	763.00	763.00
A06-344-0488	EAGLE SHIRT WILLIAM	5998	2,115.00	2,114.90
A06-344-0489	STANDING SOLDIER PHILLIP	3554	218.00	218.00
A06-344-0490	HAWK	3253	1,476.60	1,476.60
A06-344-0491	HOLLOW WOOD MOLLIE	3267	2,503.95	1,096.53
A06-344-0492	PLENTY HORSES	1828	41.83	41.83
A06-344-0493	WHITE BEAR JENNIE	1793	175.50	175.50
A06-344-0494	SPOTTED SNAKE	3497	640.90	640.90
A06-344-0495	RUNS WITH THEM MINNIE	6115	261.50	261.50
A06-344-0496	MILK HATTIE	4554	2,244.00	2,244.00
A06-344-1462	MAGGIE RED CROW	6905	934.10	934.10
A06-344-1463	NANCY AMERICAN HORSE	6774	771.29	771.29
A06-344-1464	FELIX LITTLE BALD EAGLE	953	2,650.00	35.37
A06-344-1465	GEORGE MOUNTAIN SHEEP	3501	949.50	949.50
A06-344-1466	ROSA HOLLOW HORN	3458	840.00	840.00
A06-344-1467	LIZZIE PROTECTOR	6452	1,117.50	543.37
A06-344-1468	JOHN APPLE SR.	3579	46.20	46.20
A06-344-1469	YELLOW HORSE WOMAN CHASE	2987	239.97	239.97
A06-344-1470	EMMA BROWN EARS	7215	2,635.00	2,635.00
A06-344-1473	PETER CRIER	4235	270.00	270.00
A06-344-1474	MILLIE TWIN SCRATCHER	4116	1,300.00	1,300.00
A06-344-1475	AMOS RED OWL	1324	66.50	66.50
A06-344-1476	JEFFERSON KING YELLOW SHIRT	925	686.68	686.68
A06-344-1477	JOHN MONROE	2318	30.57	30.57
A06-344-1478	ESTHER BRAVE HEART	7640	435.72	263.36
A06-344-1479	JAMES TWO TWO	263	751.00	751.00
A07-345-0001	BIG MISSOURI	2	732.50	732.50
A07-345-0002	KNIFE SCABBARD OR HORN CLOUD	2533	811.42	811.42
A07-345-0003	YELLOW HAIR WOMAN	2541.5	300.00	300.00
A07-345-0004	DUBRAY JENNIE	2337.5	563.12	563.12
A07-345-0005	KILLS HER ENEMY JOE	2325	3,299.75	3,279.75
A07-345-0006	RATTLING HORSE JOHN	2321	357.50	357.50
A07-345-0007	GOOD VOICE WOMAN	2250	260.58	260.58
A07-345-0008	HER GOOD HORSE	2247.5	900.00	900.00
A07-345-0009	AFRAID OF EAGLE	1335	336.82	336.82
A07-345-0011	STANDS FOR THEM JAMES	2118	248.22	248.22
A07-345-0012	RED HAWK FRANK	1553	909.98	909.98
A07-345-0013	DAY PATTY	4019	345.50	286.81
A07-345-0014	BLACK MOUNTAIN ALICE	3802	132.50	126.34
A07-345-0015	EAGLE FACE ONE BATTLE	4131	748.50	748.50
A07-345-0016	PRETTY VOICE EAGLE MOLLIE	4196.5	627.90	627.90
A07-345-0018	DORIAN PHILLIP	107	6,905.00	159.25
A07-345-0019	LITTLE CROW NELLIE	95.5	436.90	436.90

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ABERDEEN AREA

ISSUE NUMBER	NAME OF DECEDENT	DECEDENT ID	$ALLOWED	$PAID
A07-345-0020	LAROCHE EMMA DRAPPEAU	6489	966.00	966.00
A07-345-0021	CROW DOG JOHN	5400	229.50	229.50
A07-345-0022	BLACK BEAR ANNIE	5140	414.08	414.08
A07-345-0023	GOOD BOY	5904	534.34	534.34
A07-345-0024	BLACK CROW MAY JACK	5357	33.00	33.00
A07-345-0026	COMLET MARY MCGHEE	6481	197.50	197.50
A07-345-0027	DRAPPEAU LEON	6498	1,124.00	1,124.00
A07-345-0028	HUNTS HORSES BELLE	6076	817.00	817.00
A07-345-0029	SCATTERS THEM MARY	6043	583.00	583.00
A07-345-0030	WHITE CROW BRAVE HAWK	3723.5	59.62	59.62
A07-345-0031	WHITE PIPE WARD	2935	538.13	538.13
A07-345-0032	BEAR DOCTOR MOSES S	80	4,296.50	82.60
A07-345-0033	BLANKETT PAUL	3727	1,529.10	1,529.10
A07-345-0034	BULL NANCY	3739	1,153.91	1,153.91
A07-345-0035	RED STAR LUCY	3757.5	744.00	744.00
A07-345-0036	NO LEAD OR BIRD ANNIE	3694	491.50	491.50
A07-345-0037	RED GOOSE JOHN	3709	235.64	235.64
A07-345-0038	WHITE LANCE JOSEPH HOWARD	3697	1,613.50	1,613.50
A07-345-0039	CROW GOOD VOICE WILLIAM	3692	192.00	192.00
A07-345-0040	LONG WOMAN NELLIE	2904	854.00	854.00
A07-345-0041	YELLOW CANE FAST BULL SUSIE	3751	454.00	362.38
A07-345-0042	HAIL WOMAN EMILY	3335	206.73	206.73
A07-345-0044	WHITE LANCE JOSEPH JESSE	2955	2,690.00	2,690.00
A07-345-0045	FACE CHARLES	2932	240.30	240.30
A07-345-0046	COFFEE NO. 2	3646	911.50	911.50
A07-345-0047	BONE SHIRT DAVID	3639	149.50	149.50
A07-345-0048	YELLOW ELK JOHN	3638	187.23	108.53
A07-345-0049	GOOD BIRD	2886	319.92	319.92
A07-345-0050	SWIFT CROCKERY BENJAMIN	2938	648.00	648.00
A07-345-0051	WHITE BUFFALO LIZZIE	2929	3,848.00	3,848.00
A07-345-0052	EAGLE BIRD WILLIAM	3656	1,819.50	1,819.50
A07-345-0053	BONE SHIRT SUSAN YELLOW BULL	3678	77.00	77.00
A07-345-0054	OWNS THE FIRE THOMAS	3798	307.05	307.05
A07-345-0055	GOES AMONG AMOS	3709	904.50	904.42
A07-345-0056	WHITE BIRD SAMUEL	2907	80.00	80.00
A07-345-0057	YELLOW HAWK DORA HIGH DOG	2754	993.00	993.00
A07-345-0059	MOLLIE EAGLE HORN	390	185.00	185.00
A07-345-0060	UNDER THE WATER THRINE JOHN	998	90.00	90.00
A07-345-0061	JACKSON EDWARD	921	8.66	8.66
A07-345-0062	QUICK BEAR MARY	527.5	179.55	170.55
A07-345-0063	MENARD GEORGE	MA	189.50	189.50
A07-345-0064	PAWNEE MARY	723.5	64.20	62.20
A07-345-0065	CORTIER GEORGE	497	131.40	131.40
A07-345-0066	BROKEN LEG LIZZIE	600	72.17	72.17
A07-345-0067	PIPE BOYD JOHN	899	200.00	200.00
A07-345-0068	BRAVE BOY GEORGE	852	200.00	200.00
A07-345-0069	BRAVE BOY MILLIE MARY	853.5	350.00	350.00
A07-345-0070	BUCKMAN PHILLIP FELIOLD AGE	325	200.00	200.00
A07-345-0071	IRON SHELL PETER	1749	28.26	28.26
A07-345-0072	EAGLE DOG LENA	1729	227.50	227.50
A07-345-0073	BRAVE BIRD STEVEN	1653	5.00	5.00
A07-345-0074	WHITE BEAR AMY	1550	172.80	172.80
A07-345-0075	RED SHIRT NELLIE	1528.5	127.50	127.50
A07-345-0076	MEIS ANNIE HER HOLY COMES BLUE CANE	1460	81.81	81.81
A07-345-0077	BORDEAUX SUSAN	195	80.00	80.00
A07-345-0078	SINGING WOMAN	1780.5	710.40	678.58
A07-345-0079	LITTLE THUNDER FRANK	1951	10.19	10.19
A07-345-0081	WALKER ANNIE	1285.5	37.35	37.35
A07-345-0082	BROKEN LEG JENNIE	1903.5	2,769.00	2,769.00
A07-345-0083	CHESTER BROKEN LEG	1903	709.68	700.68
A07-345-0084	HORNED EAGLE FRANK	1333	371.50	371.50
A07-345-0085	DILLON GEORGE	436	797.50	796.70
A07-345-0086	GOOD BREAST JOHN	1101	542.00	542.00
A07-345-0087	IRON BOY EDWARD	1415	700.00	700.00
A07-345-0088	STONE CYRUS	1637	715.93	715.83
A07-345-0089	MOORE CHARLES	1491	415.85	415.85
A07-345-0090	NO HEART CHARLES	1493	932.00	932.00
A07-345-0091	MAKES GOOD FRANCIS	1842	400.00	400.00
A07-345-0092	GREYHOUND JENNIE FAST DOG	921	589.50	589.50
A07-345-0093	GREYHOUND WILLIAM	922	629.40	629.40
A07-345-0095	ARCOREN JOSEPHINE	1193.5	1,449.13	1,449.13
A07-345-0096	HORNS HARRIS LEON	937	3,342.50	412.89
A07-345-0097	RATTLING WOMAN	1152.5	57.70	57.70
A07-345-0098	BRONCHO BILL HARRY	1159	1,402.50	1,402.50
A07-345-0099	BLACK BUFFALO KATE	1017	2,918.20	2,918.20

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ABERDEEN AREA

ISSUE NUMBER	NAME OF DECEDENT	DECEDENT ID	$ALLOWED	$PAID
A07-345-0100	EAGLE FEATHER HATTIE	899	2,703.00	2,703.00
A07-345-0101	BEAR LOOKS BEHIND JACK ISAAC	698	1,765.50	1,765.50
A07-345-0102	PRATT HENRY	816	1,140.00	1,140.00
A07-345-0103	BIGLER JOHN	650	2,302.00	2,302.00
A07-345-0104	FAST HORSE JACOB	866	1,219.55	1,219.55
A07-345-0105	CUMLEY SHIELD GRACE	163.5	904.77	736.49
A07-345-0106	ANDREWS JAMES	2038	2,054.00	2,054.00
A07-345-0107	WALKING EAGLE WILLIAM	1098	644.50	644.50
A07-345-0108	LITTLE ELK SADIE BIG CROW	1834	1,020.50	1,020.50
A07-345-0109	MAKES ROOM FOR THEM LUCY WOUNDED	1692.5	591.60	591.60
A07-345-0110	RED CROW SARAH	1702.5	355.00	355.00
A07-345-0111	YELLOW EYES AMOS	1594	1,089.00	1,089.00
A07-345-0112	MOCCASIN AMOS	1392	1,622.00	1,622.00
A07-345-0113	SHIELDS NORRIS	163	2,605.55	2,605.55
A07-345-0114	LENNIE METCALF	489	489.50	236.00
A07-345-0115	FLY JAW MILLIE	536	3,492.50	473.34
A07-345-0116	IRON SHOOTER CECELIA	310	4,333.00	1,088.40
A07-345-0117	YELLOW FOX JESSIE	100.5	933.15	825.56
A07-345-0119	WINTER PHILLIP	301	3,965.50	1,761.89
A07-345-0119	PRUE SADIE	283	3,142.00	1,045.11
A07-345-0120	DILLON MARY CUTFOOT JONES	481	3,454.50	25.46
A07-345-0121	WRIGHT EMMA CORDIER	476	1,053.00	40.06
A07-345-0122	IRON HEART JAMES	451	4,894.50	1,694.69
A07-345-0123	HAWK LUKE	401	5,727.10	1,744.50
A07-345-0124	MORAN IDA GARY	397	2,486.00	66.70
A07-345-0125	STANDS AND LOOKS BACK MILLIE	159.5	723.50	723.50
A07-345-0126	YELLOW FACE LUKE	244	594.80	594.80
A07-345-0127	GARNEAUX JOSEPH	324	31.05	31.04
A07-345-0128	MCLEAN ADDIE (LARVIE)	371	3,213.50	114.02
A07-345-0129	ROAN EAGLE LIZZIE	161.5	408.90	408.90
A07-345-0130	GARNEAUX KATE	380.5	236.68	1.88
A07-345-0132	PLENTY HORSES JOSEPH	4001	2,681.00	2,681.00
A07-345-0133	NIGHT PIPE ANDREW	176	4,992.00	873.00
A07-345-0134	IRON SHOOTER CHARGER	156	1,751.00	90.18
A07-345-0135	FIREHEART JOSEPH	3987	789.00	789.00
A07-345-0136	LITTLE CROW STELLA	3814	590.50	590.50
A07-345-0137	STRANGER HORSE EDWARD	129	5,622.00	174.77
A07-345-0138	PHUE MILLIE NICHOLAS	121.5	6,491.75	1,136.68
A07-345-0139	SLEEPING BEAR FRANK	3989	5,214.00	363.09
A07-345-0140	SCISSORS ROSE E	5A	5,245.00	522.39
A07-345-0141	HIT HIM RUNNING MARY	3952	5,105.00	20.86
A07-345-0142	WHITE COW GIRL RICH ELIZABETH	6026	3,721.50	107.47
A07-345-0143	GIROUX LOUIS	1534	42.27	42.27
A07-345-0144	BLACK BULL JENNIE	1475	15.74	15.74
A07-345-0145	CHARGING CLOUD KATE	667	3,233.50	2,710.34
A07-345-0146	RED FACE WOMAN ELLA	935	300.00	225.66
A07-345-0147	STONE ARROW MARK	957	5,458.50	427.71
A07-345-0148	DUBRAY LOUISA FLOOD	1469.5	15.50	15.50
A07-345-0149	LITTLE ELK GEORGE	1587	853.70	70.89
A07-345-0150	MOUSE RICHARD	684	7,616.20	522.43
A07-345-0151	WHITE JAMES	1422	788.00	788.00
A07-345-0152	RUNNING HORSE RUSSELL	1299	2,384.50	543.13
A07-345-0153	HIGH PINE DAVID	1330	1,793.83	814.29
A07-345-0154	AFRAID OF EAGLE MAGGIE	1356	135.00	135.00
A07-345-0155	THIN ELK SOPHIE	1340	3,163.50	842.19
A07-345-0156	GALLINEAUX EMMA	1386.5	6,193.50	116.06
A07-345-0157	LITTLE BALD EAGLE DINAH (GARY)	394	3,793.00	392.26
A07-345-0158	CURTIS FELIOLD AGE	1586	106.71	106.62
A07-345-0159	WHITE WING EMMA	1585	2,579.00	1,768.39
A07-345-0160	SIDE HILL AMOS	1582	940.95	250.66
A07-345-0161	BLACK CROW CLINTON	1283	4,608.00	942.55
A07-345-0162	BLACK CROW ARRON	1282	1,554.00	330.93
A07-345-0163	POINTS AT HIM ALBERT	1234	1,764.00	1,571.70
A07-345-0164	EAGLE ELK BUSHEL	1214.5	400.00	399.95
A07-345-0165	EAGLE ELK JESSE	1214	400.00	400.00
A07-345-0166	METCALF LOUIS WILLIAM	1207	3,545.00	16.05
A07-345-0167	BEAR LOOKS BEHIND SOPHIA	697.5	246.60	246.60
A07-345-0168	BORDEAUX ELLEN	713	4,076.00	671.63
A07-345-0169	KILLS THE ENEMY COLD PAUL	1232	616.78	616.78
A07-345-0170	DOG SOLDIER LOUIE	201	7,811.50	265.29
A07-345-0171	WEEDS FATHER	2029	232.23	UNKNOWN
A07-345-0172	EAGLE BEAR EMMET	2024	4,218.50	598.30
A07-345-0173	NEW HAIRED HORSE STAMPEDE	1953	69.92	69.92
A07-345-0174	OWNS THE BATTLE ELLEN	1980.5	4,626.50	450.42
A07-345-0175	HENRY QUICK BEAR	1983	347.00	345.97

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ABERDEEN AREA

ISSUE NUMBER	NAME OF DECEDENT	DECEDENT ID	$ALLOWED	$PAID
A07-345-0176	LOOKING WHITE BENJAMIN	2013	4,793.00	1,260.50
A07-345-0177	BIG BELLE	2018.5	228.43	228.43
A07-345-0178	WHITE BUFFALO CHIEF EMMA	1617	1,887.50	1,003.68
A07-345-0179	GUN HAMMER AMY	995	336.50	37.78
A07-345-0180	GUN HAMMER THEODORE	993	570.73	267.20
A07-345-0182	OWNS THE BATTLE ANTHONY	3715	2,760.50	724.95
A07-345-0183	BLACK BEAR ROSA MOCCASIN	3782	2,944.00	520.99
A07-345-0184	BLACK BEAR CHARLES	3781	195.83	195.83
A07-345-0185	BULL NATION CONRAD	4761	2,646.50	20.37
A07-345-0186	HOLY WHITE WOMAN	4128.5	21.40	21.40
A07-345-0187	BEAR JULIAN FIRE HEART	4139	718.00	718.00
A07-345-0188	GOOD JOSEPH	4122	507.90	344.23
A07-345-0189	RED GOOD ROAD	4122.5	18.79	18.79
A07-345-0190	SLIDES OFF JAMES	4089	4,351.51	3,252.11
A07-345-0191	BEAR SHIELD ANNA RUTH	4067	3,080.50	141.70
A07-345-0192	RATTLING HAWK	4034	854.70	854.70
A07-345-0193	BIG CROW JOHN OR JOSEPH	4073	987.00	729.66
A07-345-0194	CRAZY BULL JULIA WALKER (RED HORSE)	1816	5.00	5.00
A07-345-0195	RUNS ABOVE LOUIS OR GOOD DAY	1829	1,349.50	1,154.53
A07-345-0196	LITTLE ELK FRANK	1840	3,610.50	1,033.16
A07-345-0197	RED LAME OMAHA LIZZIE	1966.5	219.00	219.00
A07-345-0198	FLOWER BRAVE BROWN LEAF	1597.5	3,888.40	195.08
A07-345-0199	LANCE WILLIAM (YELLOW)	930	294.00	294.00
A07-345-0200	YELLOW ROBE WILLIAM	1902	501.45	356.72
A07-345-0201	MCLEAN JOHN MOORE	1592	400.00	336.55
A07-345-0202	LEFT HAND BULL PETER	1744	945.34	944.84
A07-345-0203	SCOTT TITUS	1753	36.60	36.60
A07-345-0204	EAGLEMAN ALFRED	1781	3,787.00	633.48
A07-345-0205	WALKING BULL ALICE	4046.5	5,078.75	2,343.89
A07-345-0206	NOT GOOD CHARLES	1800	826.85	826.85
A07-345-0207	CLOUDMAN LOUISE RED EYE	997	3,052.50	474.58
A07-345-0208	HORN COMES OUT JULIA	924.5	542.50	542.50
A07-345-0209	SWIFT HAWK JOSEPH	1710	3,229.50	1,964.85
A07-345-0210	CHARGE ON HIM HARRY	1723	976.50	976.50
A07-345-0211	BRIDGEMAN THOMAS	1728	2,855.00	350.04
A07-345-0212	LEFT HAND BULL JACOB	1740	172.50	172.50
A07-345-0213	LEFT HAND BULL LAWRENCE	1743	271.30	271.30
A07-345-0214	LITTLE EAGLE JOSEPHINE	1527.5	10.25	10.25
A07-345-0215	BORDEAUX CHARLES	564	7,441.00	594.66
A07-345-0216	EAGLE DOG LEVI	1094	3,787.50	54.11
A07-345-0217	ON THE GROUND MARY	1144	217.00	217.00
A07-345-0219	KNOCKS ADOLPH	1161	431.50	431.50
A07-345-0221	HIS BLUE HORSE CONRAD	2243	273.15	273.15
A07-345-0222	BROKEN LEG SAMUEL	2202	3,200.40	453.30
A07-345-0223	GRANT WILLIAM JOSEPH	2181	3,520.00	460.08
A07-345-0224	ROBERTS ANGELINE (LARVIE)	2177	4,807.00	293.27
A07-345-0226	RUNNING BIRD ARTHUR	2168	1,522.85	1,392.35
A07-345-0227	BLACK SPOTTED HORSE JOSEPH	2937	3,442.50	2,196.03
A07-345-0228	STANDING BULL OWEN	3791	2,954.00	206.79
A07-345-0229	MAID OWNS THE FIRE LUCY	3798.5	3,657.53	746.09
A07-345-0230	PRETTY BOY FIRE BELLE	2150	5,158.42	649.50
A07-345-0231	WALKING BULL THOMAS	2800	688.30	688.30
A07-345-0232	CRAZY BULL MARY LITTLE GUERUE	2781	1,500.00	23.47
A07-345-0233	YELLOW WOODEN SAMUEL DAVID	2491	877.15	875.25
A07-345-0234	LARVIE BENJAMIN	2425	2,018.50	743.04
A07-345-0235	PONY BERTIE	3780	2,872.50	879.62
A07-345-0236	HER NATION ALICE	2414	3,611.50	675.90
A07-345-0237	CROOKED FOOT EDWARD	2772	3,546.00	2,329.20
A07-345-0238	WHITE BIRD JOHN	2222	571.50	571.50
A07-345-0239	BUFFALO LONE WOLF WILLARD	2924	402.00	299.69
A07-345-0240	CASE KNIFE DAVID	3242	4,193.00	55.09
A07-345-0241	RED BLANKET SALLIE HAIL BLACK CROW	3245	1,945.50	531.96
A07-345-0242	HER PRETTY DOOR OR CROOKED FOOT	2801	279.00	279.00
A07-345-0243	JONES HUGH	2767	115.12	115.12
A07-345-0244	YELLOW EAGLE CLAY	2293	2,704.50	1,856.00
A07-345-0245	GETTING AROUND LIZZIE GETTING ALONG	2365	11.95	11.95
A07-345-0246	CROW JOHN OR TAYLOR	2324	701.90	701.90
A07-345-0247	LONG ELK WILLIAM	2721	616.00	616.00
A07-345-0248	KING JACK	2694	231.50	231.50
A07-345-0249	WHITE CROW LIZZIE (KING)	2298	2,969.50	1,218.75
A07-345-0250	DUBRAY JOHN BOYD	2438	1,307.00	40.00
A07-345-0251	DUBRAY MARY	2354.5	1,015.00	989.41
A07-345-0252	WRIGHT THOMAS	2357	352.00	95.94
A07-345-0253	MURRAY STEPHEN	2090	4,501.50	38.76
A07-345-0254	STANDS FOR THEM CORA	2079	623.52	623.52

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ISSUE NUMBER	NAME OF DECEDENT	DECEDENT ID	$ALLOWED	$PAID
A07-345-0255	BEAR SHIELD WILLIAM DEAFT	2072	455.00	455.00
A07-345-0256	CHARGING BEAR WHITE COW	2049.5	695.25	695.25
A07-345-0257	HORNED ANTELOPE CHARLES	2043	1,901.00	1,535.05
A07-345-0258	BLACK BULL PHILLIP	2048	613.50	297.97
A07-345-0259	KILLS AT NIGHT RICHARD	2130	4,338.30	507.02
A07-345-0260	GERRY ROSE (LARVIE)	1606	721.58	721.58
A07-345-0261	EAGLE CHIEF LEVI	1615	2,973.00	1,439.19
A07-345-0262	FORGETS NOTHING	2035	27.41	27.41
A07-345-0263	WILLIAMS MOLLIE (SKUNK)	2040	1,911.50	514.78
A07-345-0264	DIDIER JULIA (WHITE WOMAN)	1992	1,228.50	695.61
A07-345-0265	RUNNING HORSE BENJAMIN	1635	663.23	663.23
A07-345-0266	LITTLE BULL PETER	1662	274.00	274.00
A07-345-0267	HORSE LOOKING HENRY	1694	338.00	338.00
A07-345-0268	MAKES ROOM FOR THEM MARTIN	1692	3,774.40	1,059.09
A07-345-0269	KILLS THE ENEMY LUCILLE	3495	470.00	56.81
A07-345-0270	BEAR LOOKS BEHIND PETER	3603	990.00	890.00
A07-345-0271	SAWAT NANCY	3659	3,083.50	633.76
A07-345-0272	BORDEAUX ARTHUR	3326	2,111.50	360.33
A07-345-0273	NEVER MISSES A SHOT MAUDE	3337	834.00	834.00
A07-345-0274	NOT AFRAID FRANCES	3343	392.52	392.52
A07-345-0275	PRETTY VOICE	2682	245.50	245.50
A07-345-0276	MOCCASIN FACE LUKE	3347	894.40	548.29
A07-345-0277	PLUM MAN CHARLES	2541	701.93	179.87
A07-345-0278	STANDING BULL JACOB	2985	4,093.00	365.39
A07-345-0279	LEVER CHARLES	2667	860.00	860.00
A07-345-0280	BEAR HEELS CHARLES	2539	4,047.50	790.35
A07-345-0281	COLOMBE DAVID	2556	1,722.50	848.22
A07-345-0282	BEAR WILLIAM	3230	18.20	18.20
A07-345-0283	CROW HEAD PETER (THOMPSON)	2553	2,718.00	6.75
A07-345-0284	BROKEN LEG CLARA (FARMER)	1901	38.00	38.00
A07-345-0285	IRON DEER IDA (MCCLOSKEY)	412.5	29.17	29.17
A07-345-0286	BORDEAUX JOHN	710	6,148.60	1,379.55
A07-345-0287	DESERA JOSEPHINE	543.5	5.00	5.00
A07-345-0288	WOOLEY HAIR FRED	590	199.50	199.50
A07-345-0289	GREASE STELLA (SPOTTED ELK)	880	2,995.00	61.84
A07-345-0290	WHITE BUFFALO WOMAN	885.5	139.00	1.45
A07-345-0291	MEDICINE PIPE LOUISE	14.5	149.00	149.00
A07-345-0292	IYOTTE JOSEPH JAMES	901	1,760.00	295.92
A07-345-0293	BAD HAND HARRY	4012	1,430.00	1,059.91
A07-345-0294	CLAIRMONT JESSE	18	1,928.50	408.76
A07-345-0295	WHITE WASH IRON SHOOTER ALICE	153	4,077.50	384.88
A07-345-0296	JULIA HIGH PIPE	3991	3,419.00	986.02
A07-345-0297	MARY STANDS KILLS ENEMY COLD	1232.5	2,626.30	2,538.72
A07-345-0298	JOSEPH SNOW FLY	906	813.00	284.44
A07-345-0300	MINNIE USES HER WORDS	2074	1,749.00	UNKNOWN
A07-345-0301	GLADYS HOLY PIPE FAST HORSE	967	5,066.00	2,817.01
A07-345-0302	HARRY MORAN	812	1,104.50	25.73
A07-345-0303	WHITE MOUSE	1561	450.00	450.00
A07-345-0304	WILLIAM THUNDER HAWK	1943	168.00	168.00
A07-345-0305	LUCY TWO TEETH OR END	1366	1,349.10	1,349.10
A07-345-0306	LOUIS YELLOW ROBE	1905	17.86	17.86
A07-345-0307	JOSEPH FRIGHTENED	1950	980.00	980.00
A07-345-0308	REBECCA HOLY EYES	1973.5	442.78	442.78
A07-345-0309	RICHARD FORGETS NOTHING	2036	578.00	578.00
A07-345-0310	ALBERT BLACK MOUNTAIN SHEEP	3803	626.50	391.06
A07-345-0311	JOSEPH JACKSON	919	10.00	10.00
A07-345-0312	JOSEPHINE BIG TAIL YELLOW	188.5	679.95	679.95
A07-345-0313	ALLEN YELLOW BEAR	993	609.53	609.53
A07-345-0314	LOUISE ROGERS TWO HEART	1048.5	400.00	400.00
A07-345-0315	WILLIAM BRIDGEMAN	1070	455.95	455.84
A07-345-0900	JOSHUA ROAN EAGLE	16	351.27	351.27
A07-345-0901	NELLIE NANCY SMELLS GOOD	457.5	435.00	435.00
A07-345-0902	JOSEPH THUNDER	2641	172.96	172.96
A07-345-0903	RATTLING WOMAN	2590	132.45	132.45
A07-345-0904	FRANK WHITE LARK	2657	504.96	504.96
A07-345-0906	JOHN DU BRAY	2354	5.00	5.00
A07-345-0907	OGLALA FOOT	2209.5	421.00	421.00
A07-345-0908	HENRY DIDIER	2374	451.00	451.00
A07-345-0909	HERMAN CROOKED FOOT	2650	4,860.50	4,860.30
A07-345-0910	WALLACE HIGH DOG	2645	3,710.20	3,710.20
A07-345-0911	HARRY WHITE WING	2478	834.57	834.57
A07-345-0912	CECELIA SCOUT WHITE LANCE EAGLE DOG	2492	993.55	993.55
A07-345-0913	JOSEPHINE LITTLE BULL LOOKING ELK	2509	2,611.00	2,611.00
A07-345-0915	GEORGE EAGLEMAN	1996	448.50	410.34
A07-345-0916	LUCY ELK SKY OR PLENTY BEAR	2086	25.95	25.95

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ISSUE NUMBER	NAME OF DECEDENT	DECEDENT ID	$ALLOWED	$PAID
A07-345-0917	JOSEPH HORNED ANTELOPE	2042	872.80	872.80
A07-345-0918	FANNIE NIGHT CHASE(STRANGER HORSE)	2125	849.90	702.51
A07-345-0919	RICHARD LARVIE	2056	621.60	621.60
A07-345-0920	MARY LARVIE HILL	2175.5	1,174.75	1,174.75
A07-345-0921	SOPHIA RUNS CLOSE TO VILLAGE	2182.5	500.00	500.00
A07-345-0922	MAGGIE WHITE HORSE ROGERS CLAIRMONT	2199	198.00	198.00
A07-345-0923	WILLIAM BROWN	2536	56.50	56.50
A07-345-0924	PAUL BEAR HEELS	2540	1,760.50	1,760.50
A07-345-0925	ANDREW RED BLANKET	2544	591.60	591.60
A07-345-0926	MAGGIE WHITE YELLOW CLOUD	936.5	175.00	175.00
A07-345-0927	JESSE ROSS	2562	100.00	100.00
A07-345-0928	ESTELLA GOOD DAY HAWK TRACK	2595	457.00	457.00
A07-345-0929	ELIZABETH ELIZA OWNS THE WAR	2633.5	932.50	932.50
A07-345-0930	CURTIS FORKED TAIL	2623	1,342.00	1,342.00
A07-345-0931	ACQUILLA BIG HEART	2751	1,448.14	1,448.14
A07-345-0932	SUSAN RINGING SHLD/BARBED ARRW SPIK	105.5	354.01	237.39
A07-345-0933	ESTHER DORIAN BROKEN ROPE	407	43.00	43.00
A07-345-0934	JOHN COBER	475	395.20	395.20
A07-345-0935	JOSEPH WHITE BUFFALO	760	374.25	74.25
A07-345-0936	BENJAMIN BEAUVAIS JR.	484	47.84	47.84
A07-345-0937	EMMA RED HORSE OR TURNING HAWK	773.5	732.20	732.20
A07-345-0938	MARTHA NEVER MISSES A SHOT	1251	471.88	471.88
A07-345-0939	ALEXANDER TURNING HAWK	773	103.12	103.12
A07-345-0940	JOHN LAYS ON HIS BELLY	1247	513.77	513.77
A07-345-0941	LUCY LITTLE TAIL	1134	28.10	28.10
A08-346-0001	IRVING FRANK	822	3,013.00	3,013.00
A08-346-0002	PROVOST IDA	1061	400.00	400.00
A08-346-0003	NECKLACE SAMUEL BAKER	139	497.70	497.70
A08-346-0004	YELLOW-BROWN CANE	1234	170.00	170.00
A08-346-0005	BULL MARY EUGENE	865	334.50	334.50
A08-346-0006	PRIMEAU ROSE	996	60.00	60.00
A08-346-0007	JOHNSTON HERBERT	50-15	633.50	295.22
A08-346-0008	LOWE JULIA WELLS	524	36.55	36.55
A08-346-0009	BION JOSEPH ISAAC	1434	525.00	525.00
A08-346-0010	COURNOYER ANNIE	236	460.60	460.60
A08-346-0011	COOK LIZZIE HOPE	74	26.04	26.04
A08-346-0012	KUTSNA ANNA	397	1,481.50	1,481.50
A08-346-0013	WAHCANUNKA MARTIN	1026	373.50	373.50
A08-346-0015	NIMROD WINNIE ASHES	616	5,149.50	830.17
A08-346-0016	LAROCHE LOUISA	756	375.00	375.00
A08-346-0017	THUNDER HORSE GEORGE MARSHALL	488	422.50	422.50
A08-346-0018	BENNE JENNETTE MANY DOGS	988	1,001.82	1,001.82
A08-346-0019	HIGH ROCK EUGENE	1343	1,402.00	61.61
A08-346-0020	GOODTALKER LOUISA	318	363.75	363.75
A08-346-0021	PRETTY VOICE CROW SUSIE	941	597.50	597.22
A08-346-0022	FIELDER EMMA STANDING BULL	129	511.00	511.00
A08-346-0023	LITTLE OWL SARAH WALTERS	1358	48.00	48.00
A08-346-0024	YELLOW HAIR MARIE SWEENEY	780	5,113.20	92.23
A08-346-0025	WOOD CHARLES (HENAKE)	471	477.50	477.30
A08-346-0026	WILLIAMS PETER (HEPANNA)	923	563.00	241.50
A08-346-0027	WILLIAMS JAMES SR. (SANICHA)	949	6,793.00	915.79
A08-346-0028	PATTERSON RACHEL	681	48.00	49.00
A08-346-0029	THORNTON CORA COLLINS	608	6,294.00	1,520.74
A08-346-0030	STRICKER GEORGE	820	507.30	507.30
A08-346-0031	SPOTTED EAGLE ROBERT	1184	125.00	125.00
A08-346-0032	SHONK ADA WOOD	1131	3,902.00	48.25
A08-346-0033	REDLIGHTENING MARION LOUISE	970	4,931.00	101.70
A08-346-0034	HOMER REDLIGHTENING	1265	661.00	UNKNOWN
A08-346-0035	NASSER EMMA WAHPEZI-WIN	476	101.00	101.00
A08-346-0036	REE HCARLES LONGEAR	84	5,761.00	675.61
A08-346-0037	RED HORSE ELIZA ARTHUR	303	3.25	3.25
A08-346-0038	PROVOST WILLIAM	391	418.90	178.00
A08-346-0039	ORSON PACKARD	1002	157.50	83.00
A08-346-0040	OMAHA ISAAC	246	427.50	166.52
A08-346-0041	LAGRANDE MARRY SITTING CLOUD	1174	594.00	593.96
A08-346-0042	LAGRANDE PHILBRICK BENJAMIN	1399	168.00	168.00
A08-346-0043	JUMPING THUNDER DAVID	179	115.07	115.07
A08-346-0044	JANDREAU JULIA LONGEAR	83	1,235.00	UNKNOWN
A08-346-0045	IRVING HOWARD	927	1,301.00	1,134.31
A08-346-0046	IRONHAWK CHARLES	972	3,758.50	337.82
A08-346-0048	GRAYHAWK SOPHIA M.	257	227.50	227.50
A08-346-0049	GRAY JOHN	257	758.57	758.57
A08-346-0050	GRAY ALICE	59	1,974.00	399.43
A08-346-0051	GOODTALKER ALBERT	90	3,899.50	965.65
A08-346-0052	GASSMAN WILLIAM	991	43.50	43.50

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ABERDEEN AREA

ISSUE NUMBER	NAME OF DECEDENT	DECEDENT ID	$ALLOWED	$PAID
A08-346-0053	GASSMAN SAMUEL	1429	4,746.50	776.20
A08-346-0055	FLYING HAWK EDWARD	930	1,655.50	1,655.50
A08-346-0056	COOK MARY HAWK EAGLE	273	2,063.00	965.00
A08-346-0057	FELIX CHARLES	1371	1,045.48	1,030.16
A08-346-0058	DRAPEAU LOUIS	1181	1,754.00	1,754.00
A08-346-0059	CHINN HENRY	573	243.00	243.00
A08-346-0061	BLAINE STEPHEN	1086	1,287.00	1,287.00
A08-346-0062	BLAINE JAMES G.	1083	471.90	471.90
A08-346-0063	BATES THOMAS W.	224	1,099.50	1,041.88
A08-346-0064	PATTERSON ANNIE RAINBOW	542	2,354.00	20.00
A08-346-0065	BLACKMOON MAGGIE	409	2,922.00	1,701.05
A08-346-0066	SPOTTED EAGLE-ZINA WILLIAM	181	7,424.00	229.83
A08-346-0067	RUMNEY ANNIE MATO HAKE	675	524.50	UNKNOWN
A08-346-0068	STINGER FRANK PEE	564	1,130.50	UNKNOWN
A08-346-0069	ASHES SUSAN FEATHER	1069	353.50	UNKNOWN
A09-347-0001	KEEBLE ISAAC	1249	742.63	378.84
A09-347-0002	PAUL ADAM	95	618.35	618.35
A09-347-0003	STANDFAST THOMAS	948	2,083.16	2,083.16
A09-347-0004	GOODBIRD AMOS	889	939.60	421.36
A09-347-0005	BIRD SUSAN	932	3,381.62	408.26
A09-347-0006	THOMAS HEMINGER	656	913.50	257.00
A09-347-0007	CECELIA HILL	368	2,884.00	1,533.00
A09-347-0008	BEAR MARY	573	1,356.34	416.98
A09-347-0009	STAFFORD CECELIA (BARTLETT)	606	1,464.93	338.31
A09-347-0010	REDEARTH EMMA	632	4,473.90	165.16
A09-347-0011	GRAY SAMUEL	423	978.00	643.10
A09-347-0012	GRANT JENNIE	15	218.82	198.00
A09-347-0013	DEMARIAS MARY (WILLIAMS)	950	1,047.50	634.67
A09-347-0014	AMOS MARY	48	1,732.65	971.09
A09-347-0015	RENVILL SAMUEL	1004	4,443.50	752.28
A09-347-0016	ONEROAD CHARLES	396	5,662.35	142.37
A09-347-0017	WICITEMAZA LOUISA	397	649.38	646.38
A09-347-0018	WHITE KING ELLA	416	4,227.63	538.53
A09-347-0019	HOPKINS SAMUEL	435	2,932.00	210.44
A09-347-0020	WILLIAMS EDWARD R.	38	1,614.00	1,414.56
A09-347-0021	DEMARRIAS JOHN	754	4,129.50	247.75
A09-347-0022	DEMARRIAS NARCISSE	755	2,994.10	229.35
A09-347-0023	WILLIAMS JOHN (SUNKA)	757	5,270.50	297.47
A09-347-0024	ST. JOHN MOSES	790	2,091.00	466.19
A09-347-0025	ROBERTSON HELEN (DUGGAN)	232	945.00	32.44
A09-347-0026	PHILIP LOUIS	152	2,512.50	262.50
A09-347-0027	BAFSE SARAH (RENVILLE)	1081	2,048.50	1,292.62
A09-347-0028	BEAR JOHN	634	843.00	843.00
A09-347-0029	BIRD ALVIN	A90517	50.00	50.00
A09-347-0031	CROSS NANCY	469	406.50	406.50
A09-347-0033	DUMARCE BAPTISTE JR.	675	119.50	119.50
A09-347-0034	ENOCH JAMES	498	891.00	891.00
A09-347-0035	FOSTER MARY	447	555.50	550.50
A09-347-0036	FRENIER AMOS	236	2,092.50	1,346.45
A09-347-0037	FRENIER BAPTISTE	359	1,829.00	1,829.00
A09-347-0038	GILBERT AMOS	1046	240.00	240.00
A09-347-0039	GRAHAM ZENAS	NE-842	750.00	750.00
A09-347-0040	HAYES DANIEL	323	496.00	496.00
A09-347-0041	JOHNSON JOHN W.	551	56.00	56.00
A09-347-0042	KEEBLE JOHN	1299	1,439.30	1,439.30
A09-347-0043	LALELLE PETER	1236	301.00	301.00
A09-347-0044	LAEROUX ALBERT	114	30.15	30.00
A09-347-0045	LAFROMBOISE MOSES	190	2,382.50	2,382.50
A09-347-0046	CAMPBELL LUCY (LOVEJOY)	166	5,684.01	264.66
A09-347-0047	QUINN CHARLES	640	9.17	9.17
A09-347-0048	RENVILLE DAVID	1008	7.23	7.23
A09-347-0049	RENVILLE MASON	2159	100.00	100.00
A09-347-0050	ROBERTSON WILLIAM M.	1093	105.36	105.36
A09-347-0051	ROGERS JOSEPH	952	110.00	105.93
A09-347-0053	SHEPHERD HANNAH T.	314	54.25	54.25
A09-347-0054	STANDFAST CATHERINE	512	199.94	199.94
A09-347-0055	WAKEMAN SOLOMAN	291	312.00	312.00
A09-347-0056	WHITE RAYMOND CLEMENT	451	584.50	684.50
A09-347-0057	CRAWFORD ABRAHAM	1000	1,711.50	539.33
A09-347-0058	RENVILLE ROSE RICE	1304	8,619.00	UNKNOWN
A09-347-0059	SHEPHERD MINNIE LAURENCE	502	27.00	27.00
A09-347-0060	WEATHERSTON WILLIAM M.	1390	1,796.00	59.00
A09-347-0061	WHITE ELIZABETH	348	86.03	86.03
A09-347-0062	SPICER MARY (LOVEJOY)	159	966.00	966.00
A09-347-0419	HANNAH BARKER REDEARTH	456	2,269.00	848.21

ISSUE NUMBER	NAME OF DECEDENT	DECEDENT ID	$ALLOWED	$PAID
A09-347-0420	AGNES FLUTE	1003	1,668.00	909.04
A10-302-0001	MANY HORSES CECELIA	3669	1,623.20	1,623.20
A10-302-0002	BRUSH HORNS EMMA	3664	17.23	17.23
A10-302-0003	WATER LOUISA	3658	594.50	594.50
A10-302-0004	EAGLEBOY MRS.	3653	1,011.00	1,011.00
A10-302-0006	CHASE ALONE JOSEPHINE	3645	3,590.00	UNKNOWN
A10-302-0009	NO HEART	3602	616.50	63.00
A10-302-0010	IRON NECKLACE LOUISA	3599	2,509.50	1,749.38
A10-302-0011	LONGBULL SADIE	3597	4,334.50	45.35
A10-302-0013	AGUILA FEATHER EARRINGS	3577	287.50	189.00
A10-302-0014	PRETTY ELK SARAH	3486	877.00	397.19
A10-302-0015	WALKS IN THE WIND JULIA	3460	821.00	821.00
A10-302-0016	CHASING HAWK ELIZABETH	3367	1,447.55	1,447.55
A10-302-0017	LONG BULL JENNIE	3359	73.01	73.01
A10-302-0018	RED BIRD	3264	1,237.00	1,237.00
A10-302-0019	EASTMORSE LOUISA	3240	262.00	262.00
A10-302-0020	EAGLE BOY MRS.	3389	1,263.00	1,262.50
A10-302-0021	VILLAGE CENTER JULIA	3366	921.50	921.50
A10-302-0022	RED TOMAHAWK FRANCES	3276	1,490.00	668.90
A10-302-0023	HAND MAUD	3189	1,932.50	1,932.50
A10-302-0024	GRINDSTONE STELLA OR LOUELLA	3174	1,102.69	1,102.69
A10-302-0025	WHITE HORSE AGNES	3168	380.00	380.00
A10-302-0026	WHITE EAGLE TASINA	3164	2,786.90	1,312.08
A10-302-0027	MRS. EDWARD TAKES THE SHIELD	3574	618.00	UNKNOWN
A10-302-0028	JOSEPH EAGLEMAN	2647	174.00	174.00
A10-302-0029	WHITESELL JOHN	651	69.83	69.83
A10-302-0030	WALKING ELK MARK	703	212.50	212.50
A10-302-0031	IRON WING PAUL	31	1,038.00	1,039.00
A10-302-0032	CROW FEATHER FRANCIS	905	1,116.00	1,116.00
A10-302-0033	FEATHER EARRINGS MORRIS	809	1,747.00	915.19
A10-302-0034	BADGER JOVITA	827	702.00	609.45
A10-302-0035	LEFT HAND VERMUND (HAND)	850	1,641.50	UNKNOWN
A10-302-0036	JORDAN ANNIE	959	1,189.50	1,189.50
A10-302-0037	WHITEBULL	869	1,169.00	738.03
A10-302-0038	KILLS PRETTY ENEMY LEO	1024	1,113.75	1,006.27
A10-302-0039	LOOKING HORSE LOUIS	1026	2,200.50	523.04
A10-302-0040	USES HIS ARROWS GUIBERT	1029	312.00	312.00
A10-302-0041	MANY ELKS LUKE	1034	66.09	66.00
A10-302-0042	TAKE THE GUN REUBEN	1039	4,790.50	1,088.09
A10-302-0043	MALE BEAR LUKE	1062	1,031.00	1,021.00
A10-302-0044	SUNKAWAKBLI JOHN (DOG EAGLE)	1057	531.00	531.00
A10-302-0045	KILLS AT NIGHT SAMUEL	1061	375.00	375.00
A10-302-0046	ELK JOHNSON (BROWN EAGLE)	1072	4,937.50	UNKNOWN
A10-302-0047	KILLS CROW INDIAN JOHN	1077	3,783.00	778.81
A10-302-0049	EAGLE BOY GROVER	1213	460.00	460.00
A10-302-0050	ROSEBUD JOSEPH	1214	15.48	15.48
A10-302-0051	LITTLE BEAR JOHN	1243	85.00	85.00
A10-302-0052	PRAYS TO HIM LAWRENCE	1274	424.00	424.00
A10-302-0053	OTTER ROBE JOSEPH	1332	1,260.00	1,059.47
A10-302-0054	WHITE COAT FREDERICK	1334	351.00	351.00
A10-302-0055	HAS HORNS JENNIE	1339	1,616.90	1,616.90
A10-302-0056	WHITE PAW FRANCIS	1350	186.00	UNKNOWN
A10-302-0058	MIDDLE BULL PAUL	1406	1,565.00	140.20
A10-302-0059	AGARD LOUIS	1420	413.50	196.19
A10-302-0060	GRAYEAGLE GABRIEL MRS.	1473	779.00	748.35
A10-302-0061	CEDAR BOY JAMES	1480	1,000.00	990.00
A10-302-0062	FLYING HORSE ANTHONY	1493	401.59	401.59
A10-302-0063	KILLS HAWK ROBERT	1500	430.00	430.00
A10-302-0064	TWO FACE JOSEPH	1501	2,823.50	2,550.56
A10-302-0065	ANTELOPE HERBERT (ALBERT)	1510	2,002.00	591.60
A10-302-0066	MAKES TROUBLE AUGUSTUS	1526	383.00	383.00
A10-302-0067	ELK NATION LOUIS	1535	282.00	164.87
A10-302-0068	MARSHALL CHARLES (SR.)	1548	10.00	10.00
A10-302-0069	GAYTON AMY	1725	387.30	387.30
A10-302-0070	LECOMPTE EDWARD	2	787.44	302.92
A10-302-0071	RED HORSE VIRGIL	26	4,030.50	4,030.50
A10-302-0072	IRON CLOUD SARAH	29	2,249.00	2,249.00
A10-302-0073	LONG BULL PAUL	40	194.50	194.50
A10-302-0074	LONG BULL DOMINICK	41	459.55	443.78
A10-302-0075	CHASE ALONE PETER (WEBSTER)	45	291.50	291.50
A10-302-0076	SWIFT CLOUD MARTIN	46	768.00	768.00
A10-302-0077	WHITE EAGLE SAM	54	186.90	113.88
A10-302-0078	HORSE THIEF AMOS	73	1,032.50	376.54
A10-302-0079	DISTRIBUTE JOHN (END OF CLOUD)	82	55.50	55.50
A10-302-0080	SHOOT THE BEAR MAURICE	102	816.50	816.50

ISSUE NUMBER	NAME OF DECEDENT	DECEDENT ID	$ALLOWED	$PAID
A10-302-0081	END OF CLOUD IGNATIUS	103	1,305.00	614.62
A10-302-0082	STANDING BEAR SAM HOWARD	154	424.00	424.00
A10-302-0083	CADOTTE JOHN J. (SR.)	173	1,684.50	1,144.23
A10-302-0084	YELLOW PROTEUS	195	611.95	611.95
A10-302-0085	KICKING BEAR THOMAS (G. V. BULL)	209	210.00	210.00
A10-302-0086	LITTLEMOON HENRY	213	360.50	UNKNOWN
A10-302-0087	EAGLE SAMUEL OR FRANCIS	220	4,288.50	2,992.52
A10-302-0088	BONECLUB MAUDE (TAKES THE GUN)	235	3,819.00	UNKNOWN
A10-302-0089	RAWHIDE GUS	259	28.50	UNKNOWN
A10-302-0090	TAYLOR MOLLIE MARSH	276	10.00	10.00
A10-302-0091	TAKE THE GUN LOUIS (GUNNER)	297	1,531.35	431.12
A10-302-0092	RED HAWK JOHN	305	5.00	5.00
A10-302-0093	RED HORSE ANNIE DAVIS	320	224.60	224.60
A10-302-0094	BLOODY KNIFE EMMA HOWARD	344	1,393.50	331.13
A10-302-0095	LOOKING BACK CHARLES	366	1,187.00	1,187.00
A10-302-0096	HAS HORNS OWENS	376	3,145.00	2,978.56
A10-302-0097	TWO KILL JOSEPH	398	1,953.50	995.61
A10-302-0099	THUNDERSHIELD ELLA	415	921.50	798.06
A10-302-0100	THUNDERSHIELD JOSEPH	418	1,754.00	1,659.33
A10-302-0101	LAFROMBOISE FRANK	420	70.00	70.00
A10-302-0102	GRINDSTONE STANTON	480	245.00	245.00
A10-302-0103	GRINDSTONE PAUL	517	113.58	UNKNOWN
A10-302-0104	WATERS ISADORE	619	932.50	932.50
A10-302-0105	WHITESELL CHARLES	556	745.00	UNKNOWN
A10-302-0106	DOG LOUIS (SR.)	570	1,735.35	1,735.35
A10-302-0107	WALKING ELK FRANCES	591	3,260.00	2,655.50
A10-302-0108	END OF HORN WILLIAM	109	2,570.00	2,507.00
A10-302-0109	HER GOOD HORSE	602	50.00	50.00
A10-302-0110	MANY HORSES FRANCIS	605	1,226.50	1,226.50
A10-302-0112	IRONHORN CHARLES JR.	622	60.00	60.00
A10-302-0113	IRON HORSE CHARLES	623	40.00	40.00
A10-302-0114	RED FISH JAMES	641	721.50	UNKNOWN
A10-302-0115	FROWIN REEL	658	2,069.30	717.32
A10-302-0116	KILLS CROW INDIAN JULIA	3122	3,196.50	1,505.09
A10-302-0117	EAGLE ON HIGH ALMA	3165	447.00	447.00
A10-302-0118	TAKES THE GUN HANNAH	3253	126.00	126.00
A10-302-0121	DOG EAGLE JOHN (MRS.)	3299	387.00	387.00
A10-302-0122	SCHOLASTICS (MRS. BOBTAIL BULL)	3302	730.50	730.50
A10-302-0123	SHOT AT CATHERINE (MRS. LEO)	3304	219.00	219.00
A10-302-0125	MANY DEEDS STANTON MRS.	3334	160.00	43.93
A10-302-0124	FROWN MAN MARY	3337	107.00	107.00
A10-302-0127	KILLS CROW YNDIAN JULIA (MIDDLE)	3338	1,057.50	1,057.50
A10-302-0128	SPOTTED BEAR JULIA	3339	30.00	30.00
A10-302-0129	WHITETEMPLE FANNIE	3348	471.00	471.00
A10-302-0130	WHITE COAT HELEN	3371	5,050.70	2,124.55
A10-302-0131	PINE NANCY	3375	3,462.50	3,462.05
A10-302-0132	EAGLE FEATHER AUGUSTINE	3380	1,261.50	974.55
A10-302-0133	CARRY MOCCASIN MARTHA	3388	984.30	284.37
A10-302-0134	CLAYMORE ANTOINE	3393	1,063.50	1,063.50
A10-302-0135	ONE BULL OR WAHNIOMNILUTA	3398	393.00	393.00
A10-302-0136	HAWK BERE OR TAWACINWASTEWIN	3401	1,846.72	373.93
A10-302-0137	CROSS WILLIAM	3409	410.50	410.50
A10-302-0139	ARCHAMBAULT SAM MRS.	3410	459.00	459.00
A10-302-0139	OLD BULL OR KANTOTAWIN	3421	551.50	445.55
A10-302-0140	WHITE SHIELD LOTTIE OR WICIGNA	3422	2,256.50	1,326.10
A10-302-0141	HAWK EAGLE SAMUEL MRS.	3432	1,514.00	1,514.00
A10-302-0142	HOKA AGNES	3456	1,448.00	673.82
A10-302-0143	WALKS QUIETLY OR CATAKUIN	3471	60.00	47.16
A10-302-0144	GOOD VOICE ELK	3474	216.00	216.00
A10-302-0145	SPOTTED HORSE THERESA	3484	1,736.50	1,736.50
A10-302-0146	HOLY WHITE MAN SARAH	3485	95.00	91.77
A10-302-0148	SPOTTED HORSE FELL	440	1,243.50	1,243.50
A10-302-0149	EAGLE HORN PAUL ALLEN	491	460.50	460.50
A10-302-0150	BEAR SOLDIER GEORGE (CHARLES)	542	504.00	504.00
A10-302-0151	BLACK BEAR WILLIAM (WALTER)	593	386.00	386.00
A10-302-0152	ROUGH SURFACE SAMUEL	717	1,009.50	999.55
A10-302-0153	FIRECLOUD JOSEPH SR.	750	5,534.40	600.00
A10-302-0154	LONGSTEPS BERNADINE	757	2,560.50	2,199.89
A10-302-0155	DRIVER GARFIELD	901	1,693.00	73.87
A10-302-0156	FIRE CLOUD ALFRED	938	403.50	403.50
A10-302-0157	WHITEHORSE LOUIS	954	2,300.00	2,300.00
A10-302-0158	SHOT AT LEO	960	555.00	555.00
A10-302-0159	HOMEKTE LAWRENCE	986	699.00	192.42
A10-302-0160	ONE BULL HENRY	990	453.00	453.00
A10-302-0161	CROSS JULIA (MRS. WILLIAM)	3132	2,204.00	1,612.09

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ISSUE NUMBER	NAME OF DECEDENT	DECEDENT ID	$ALLOWED	$PAID
A10-302-0162	BEAR AT BAY JULIA	1018	598.50	598.50
A10-302-0163	YELLOW EARRINGS THOMAS	1502	4,715.00	2,456.35
A10-302-0164	ANTELOPE EDWIN OR EDWARD	1509	3,637.00	3,196.39
A10-302-0165	HONA GEORGE	1581	1,382.50	799.99
A10-302-0166	IRON BULL MARTIN	2368	1,516.00	UNKNOWN
A10-302-0167	VERMILLION CHARLES	2954	400.42	168.59
A10-302-0168	SHOOTER EDWARD	2982	1,026.50	928.00
A10-302-0169	JOHN ELK	2988	1,113.92	211.00
A10-302-0170	HIGH CAT BERTHA (MRS PAUL)	3027	541.50	541.50
A10-302-0171	IRON LAVATTA ANNIE	3392	116.00	116.00
A10-302-0172	MAKES TROUBLE CANOPA (ANNIE)	3391	601.50	601.50
A10-302-0173	DOG EAGLE JAMES	3838	431.15	431.15
A10-302-0174	SHOOT STRAW THOMAS	3871	3,792.05	1,925.73
A10-302-0175	INDUSTRIOUS LAWRENCE (PAUL)	3980	702.00	464.25
A10-302-0176	LONG BULL LIZZIE (SWIMMER)	4284	1,238.00	1,238.00
A10-302-0178	WEARS HORNS NELLIE	4597	3,034.00	1,379.27
A10-302-0179	DUNCA ELLEN	2933	2,237.77	2,232.77
A10-302-0181	YELLOW EARRINGS HARRIET	2922	1,659.50	1,657.84
A10-302-0182	FAST HORSE JOSEPH	2937	400.30	302.37
A10-302-0184	WHITE HORSE THOMAS	350	501.00	316.80
A10-302-0185	ERNEST TWO RUNS	459	730.50	593.08
A10-302-0186	LAWRENCE MAGPIE EAGLE	774	2,974.00	795.65
A10-302-0188	CRAZY BEAR	2052	55.00	55.00
A10-302-0189	RED PHEASANT SAM MRS.	3082	12.00	12.00
A10-302-0190	SHOT THE BEAR MAGGIE	3413	292.00	292.00
A10-302-0191	LONEMAN MARY	3445	11.00	11.00
A10-302-0192	WARRIOR LEAN MRS. OR WINCINCALA	2239	286.92	210.59
A10-302-0193	GOODIRON JOSEPH T.	2673	2,514.00	492.05
A10-302-0194	RED FOX CHARLES	2637	1,344.00	1,098.11
A10-302-0195	HUFF NELLIE (MORAIN)	2591	5,189.00	UNKNOWN
A10-302-0196	LANIGAN MAMIE (MELVIN)	2555	4,499.00	262.41
A10-302-0197	RUNS THE HOOPE AGNES	2549	837.00	837.00
A10-302-0198	HALSEY LOUIS	2474	224.00	224.00
A10-302-0199	ONE HORN DORA (PRETTY BEAR)	2470	359.00	359.00
A10-302-0200	COLD HAND CLEMENT	2450	5.00	5.00
A10-302-0201	OWNS MEDICINE HENRY	2419	199.02	199.02
A10-302-0202	BIG SHIELD PIUS	2415	615.00	615.00
A10-302-0203	WALKING CLOUD CHARLES	2403	314.96	185.47
A10-302-0204	SHIELD NECKLACE LEO	3403	49.00	UNKNOWN
A10-302-0205	RAMSEY CHARLES	2389	5,259.00	986.95
A10-302-0206	HUFF JOSEPH	2335	3,862.46	UNKNOWN
A10-302-0207	COLD HAND DANIEL	2312	952.00	13.94
A10-302-0208	NELSON EAGLE BOY	2281	359.00	359.00
A10-302-0209	EAGLE STAFF CHARLES	2274	2,541.00	2,541.00
A10-302-0210	IRELAND ANDREW	2260	82.50	UNKNOWN
A10-302-0211	MANY HORSES FRANCIS	2254	3,615.00	2,123.81
A10-302-0212	CHASE IN THE WOODS	2253	178.00	178.00
A10-302-0213	IRONSHIELD BERNARD	2250	490.00	490.00
A10-302-0214	SHOOT THE BUFFALO LUKE	2247	1,082.99	431.37
A10-302-0215	BLACKBEAR CHARLES OR SMUTTY BEAR	2221	3,660.00	1,920.89
A10-302-0216	WHITE LIGHTNING JOE	2190	1,076.00	477.76
A10-302-0217	BRAVE BULL CLAUDE	2189	789.07	789.06
A10-302-0218	RUNS THE MIDDLE MRS.	2160	768.00	768.00
A10-302-0219	COMES LAST THOMAS (EHAKAKU)	2159	197.00	UNKNOWN
A10-302-0220	LITTLE CROW JOHN	2063	5,128.00	1,272.90
A10-302-0221	CRAZY WALKING PAUL	2062	4,990.00	151.03
A10-302-0222	GOOD BOY OSCAR	2051	70.00	70.00
A10-302-0223	ALL YELLOW JAMES	2020	1,681.00	1,652.16
A10-302-0224	BUCKLEY JOHN	2012	349.00	UNKNOWN
A10-302-0225	BLACK HOOP BENEDICT	1998	1,447.00	1,447.00
A10-302-0226	LOVE JOY MARY (SMITH)	1996	1,147.00	407.60
A10-302-0227	BIG BOY MARY (TWO SHIELDS)	1976	363.00	363.00
A10-302-0228	YELLOW HAMMER EDWARD	1964	2,914.00	1,310.58
A10-302-0229	HAS TRICKS MARY	1944	815.00	215.79
A10-302-0230	HAS TRICKS JEROME	1943	4,241.00	423.25
A10-302-0231	DWARF CLAUDE	1929	3,506.00	946.29
A10-302-0232	SIAKA CLARENCE	1996	944.00	944.00
A10-302-0234	STANDING SOLDIER LOUISE	1864	287.00	287.00
A10-302-0235	CASKE DAVID SR.	1921	326.00	326.00
A10-302-0236	NO HEART ALBERT SR.	1746	72.90	72.90
A10-302-0237	CHARGING EAGLE JOHN	1739	342.00	342.00
A10-302-0238	WHITE BIRD PHILLIP	1730	97.59	97.59
A10-302-0239	TWIN JOSEPH SR.	1635	1,274.00	1,274.00
A10-302-0240	JORDON JACOB	1612	160.00	160.00
A10-302-0241	FORTE EMMA (BRUGIER)	1095	159.51	159.51

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ISSUE NUMBER	NAME OF DECEDENT	DECEDENT ID	$ALLOWED	$PAID
A10-302-0242	STRIPED CLOUD LOUISA (LONEMAN)	802	3,307.00	31.67
A10-302-0243	STRIPED CLOUD CECELIA (BULLHEAD)	801	224.00	10.00
A10-302-0244	HALSEY SAMUEL	793	3,911.00	366.05
A10-302-0245	HALSEY JOSEPHINE (SILK)	788	4,585.00	46.11
A10-302-0246	HALSEY JACOB	786	5,997.00	UNKNOWN
A10-302-0247	BLACK CLOUD FELIX	620	771.50	355.91
A10-302-0248	WHITESELL JOHN	551	42.95	42.95
A10-302-0249	KILLS THE ENEMY MORY OR TOKAKTA	106	1,042.00	585.21
A10-302-0250	GRASS TWIN EMMA	3544	1,490.00	1,490.00
A10-302-0251	WALKER LUCY	3540	439.00	439.00
A10-302-0252	DIFFERENT TAIL (GOOD GENERATION)	3512	724.32	724.32
A10-302-0253	GAYTON MAGGIE	3467	334.95	136.46
A10-302-0254	LAFROMBOISE SALLY BAIN	3452	1,154.56	662.96
A10-302-0255	YELLOW LODGE ELLA	3240	2,124.00	2,124.00
A10-302-0256	YELLOW HAMMER FLORIA	3226	2,549.00	1,593.16
A10-302-0257	BUFFALO BOY JOSEPHINE	3208	2,638.00	2,638.00
A10-302-0258	EAGLE STAFF MRS. (CHIEF WOMAN)	3199	369.49	310.86
A10-302-0259	BEAR PAW JULIA	3129	58.92	58.92
A10-302-0260	TRACKWIDER MARGARET	3143	48.00	48.00
A10-302-0261	JOSEPH RED BEAR	1010	2,204.00	1,612.09
A10-302-0262	GOODIRON LUCILLE	3094	2,518.00	UNKNOWN
A10-302-0263	YOUNG BEAR BESSIE.	3092	4,690.00	1,238.93
A10-302-0264	IRONROAD MARY	3090	304.00	304.00
A10-302-0265	SEE THE BEAR REBECCA	3084	279.00	279.00
A10-302-0266	TAKES THE HAT CATHERINE	3066	222.00	214.00
A10-302-0267	LOANS HIM ARROWS MRS. OR GRAY HORNS	3063	2,702.00	698.43
A10-302-0268	AZURE HENRY	2959	502.65	104.90
A10-302-0269	WHITE TWIN WILLIAM	2755	4,008.00	1,200.48
A10-302-0271	IRONBOULDER JOHN JACK	2616	8,290.00	UNKNOWN
A10-302-0272	MOLASH MANDY (BUCKLEY)	2542	968.00	243.41
A10-302-0273	NO TWO HORNS JOSEPH	2367	424.00	424.00
A10-302-0274	IRONROAD ANDREW	2330	346.00	346.00
A10-302-0276	LEAN WARRIOR	2275	1,102.00	1,102.00
A10-302-0277	BEARS HEART EUGENE	2269	314.45	314.45
A10-302-0278	SHOOTS THE ENEMY JOSEPHINE	2265	1,101.00	1,101.00
A10-302-0279	USES HIS ARROW BEDE	2119	526.00	526.00
A10-302-0280	FOOL BEAR CHARLES SR.	2115	2,923.00	397.64
A10-302-0281	PRETTY BEAR JOHN	2111	4,999.00	UNKNOWN
A10-302-0282	SWIFT EAGLE ELI (WALKER)	2099	4,359.00	2,813.47
A10-302-0283	GOOD CROW AMOS	2094	1,521.00	1,521.00
A10-302-0284	KING SAMUEL	2093	121.07	83.88
A10-302-0285	KEEPSEAGLE LOUISA	2049	2,395.00	1,394.98
A10-302-0286	LAFROMBOISE LUCY (BROUGHT PLENTY)	1981	1,256.00	1,256.00
A10-302-0287	TIOKASIN RICHARD	1594	2,744.00	51.60
A10-302-0288	CALLOUS LEG AMOS	1679	1,940.00	1,940.00
A10-302-0289	STRIPED CLOUD FRANCIS	1642	1,953.00	552.37
A10-302-0290	CHASE RED HORSE	1629	3,172.00	1,231.57
A10-302-0291	ANTELOPE EMMA	1590	3,037.00	3,037.00
A10-302-0292	WHITE HORSE SEBASTIAN	1579	402.00	UNKNOWN
A10-302-0293	SILK JOHN SR.	966	221.91	39.98
A10-302-0295	ALKIRE JAMES	541	3,040.00	23.89
A10-302-0297	BRISTLING SOPHIE (MRS LUCAS)	3057	2,535.00	2,535.00
A10-302-0298	VAULTER MATILDA	3059	3,511.00	3,511.00
A10-302-0299	IRONROAD HELEN	3111	1,205.00	631.98
A10-302-0300	BLACKTONGUE VICTORIA	3116	1,878.00	1,878.00
A10-302-0301	MANY HORSES MARY	3125	2,768.00	995.57
A10-302-0302	BULL BEAR JULIA	3149	216.00	122.19
A10-302-0303	BLUEBOY CLARA (WICISA)	3155	1,499.00	1,499.00
A10-302-0304	WHITE TWIN MARY	3225	3,636.00	UNKNOWN
A10-302-0305	KIDDER JENNIE MRS.	3229	234.00	234.00
A10-302-0306	SWIFT HAWK ANNA	3237	750.00	750.00
A10-302-0307	COTTONWOOD LAURA	3237	4,545.00	302.95
A10-302-0308	HIGH DOG STELLA	3498	550.00	550.00
A10-302-0309	YELLOW BIRD MRS. (COLD HAND)	3523	99.00	99.00
A10-302-0310	YELLOW ELK MARY	3537	1,141.00	1,141.00
A10-302-0311	BRINGS WATER EMMA	3541	374.44	374.44
A10-302-0312	GRAYBULL ISABELLE	3563	2,268.00	1,930.54
A10-302-0313	AZURE MARY (LONGIE)	3659	5,493.00	UNKNOWN
A10-302-0314	FOLLOWS THE ROAD	3561	351.00	351.00
A10-302-0315	SHELLTRACK MARY (GOOD WOMAN)	3562	2,126.00	938.77
A10-302-0316	WHITE ABBIE (GAYTON)	3673	897.00	65.52
A10-302-0317	IRELAND ANDREW MRS.	3489	1,461.00	1,461.00
A10-302-0318	IRON BULL HARRIET	3692	105.00	105.00
A10-302-0319	FAST HORSE JANE	3707	153.00	153.00
A10-302-0320	WALKING THUNDER JOSEPHINE	3720	2,591.00	2,591.00

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ISSUE NUMBER	NAME OF DECEDENT	DECEDENT ID	$ALLOWED	$PAID
A10-302-0321	BRINGS THEM MRS.	3726	2,470.00	2,470.00
A10-302-0322	ELK EDWARD MRS.	3734	234.76	234.71
A10-302-0323	FOUR YELLOW LODGE THERESA	3765	1,030.00	1,030.00
A10-302-0324	BEAR BOY,PETER	2560	41.50	41.50
A10-302-0325	WHITE EAGLE JEROME	2197	198.00	198.00
A10-302-0326	IRONWOOD IGNATIUS	2301	776.66	353.27
A10-302-0327	IRON SHIELD HENRY	2412	182.00	182.00
A10-302-0329	BULL BEAR FRANK	2791	1,591.59	980.70
A10-302-0330	KATE TIOKEVIN	3040	443.00	UNKNOWN
A10-302-0331	MRS. NAPA BEARSHEART	3239	2,783.00	184.76
A10-302-1132	HENRY KILLS ALIVE	397	2,173.00	1,992.37
A10-302-1133	CHESTER CARRY MOCCASIN	455	698.00	270.01
A10-302-1134	THOMAS EAGLE SHIELD	3574	10.00	10.00
A10-302-1135	MRS.MAUD LEFT HAND	3199	1,932.50	UNKNOWN
A11-304-0002	JOHN KAKENOWASH	116	105.00	2.91
A11-304-0003	MARY RISING SUN	155	1,410.56	909.22
A11-304-0005	ALLERY JOSEPH	235	1,746.00	1,077.00
A11-304-0006	AZURE ALEXANDER	295	249.48	235.02
A11-304-0007	AZURE EMILY	303	100.00	2.08
A11-304-0008	AZURE ELIE	319	5,013.49	1,774.57
A11-304-0009	AZURE BERGER (GRAVELIN)	320	7,974.20	1,135.50
A11-304-0010	AZURE JOSEPH	386	2,899.00	382.64
A11-304-0011	BELGARDE VIRGINIA	450	487.50	487.50
A11-304-0012	BELGARDE JACQUES	471	450.00	UNKNOWN
A11-304-0013	BELGARDE VIGINIA (DUCHAIN)	499	3,520.00	1.00
A11-304-0014	AZURE MARY (BELGARDE)	498	1,114.13	1,114.13
A11-304-0015	BERCIER MARIE ROSE	561	231.99	13.00
A11-304-0016	CHAMPAGNE MARIE	740	3,310.00	1,785.91
A11-304-0017	CHARETTE SIMON	755	3,276.00	486.00
A11-304-0018	NORMAN DAUPHINAIS	787	4,549.50	88.46
A11-304-0019	DELORME PATRICE	1012	563.56	563.56
A11-304-0020	DUCEPT CELINA (WILKIE)	1081	1,083.11	400.77
A11-304-0021	ENNO MARY CELINA	1139	258.49	258.68
A11-304-0022	ENNO MARIE TISTIS (AZURE)	1137	7,032.00	1.65
A11-304-0023	FAGUANT JULIA (LAFOUNTAIN)	1147	4,930.00	118.93
A11-304-0024	GORDON	1240	5,017.00	2.47
A11-304-0025	GOURNEAU JOSEPH JR.	1253	3,405.00	527.93
A11-304-0026	GOURNEAU LEANDER SR.	1265	70.00	70.00
A11-304-0027	LAVENDURE LARASE VANDAL	M303	53.33	53.33
A11-304-0028	GRANT CHARLES	1316	450.00	216.00
A11-304-0029	GRANT SARAH JANE (MCCLOUD)	1320	232.26	232.26
A11-304-0030	GRANT JOHN B.	1327	270.00	270.00
A11-304-0031	GRANT MARY	M22	9,280.00	558.33
A11-304-0032	GRANT WILLIAM	1355	1,210.00	610.82
A11-304-0033	HOULE WILLIAM JOHN	1447	990.00	23.91
A11-304-0034	HOULE JOSEPH	1451	402.89	80.00
A11-304-0035	JACQUEMART PETER	1472	176.00	176.00
A11-304-0036	JEANOTTE PATRICE	1491	4,878.00	88.50
A11-304-0037	JEROME FREDRICK	1509	4,348.00	162.08
A11-304-0038	LAFROMBOISE PATRICK	1644	649.76	627.09
A11-304-0039	LAFROMBOISE MARIE ROSE	1673	8,881.00	942.39
A11-304-0040	LAFROMBOISE PATRICE	1693	4,867.00	83.87
A11-304-0041	LAIRILLE CLEMENCE	1759	151.40	4.32
A11-304-0042	LAVALLIE FRANCIS	1789	6,750.00	320.97
A11-304-0043	LAVALLIE ELIZA (HOULE)	1790	572.00	572.00
A11-304-0044	LAVENDURE ISADORE	1812	230.00	230.00
A11-304-0045	LAVENDURE WILLIAM	1831	975.09	289.06
A11-304-0046	LEDEAUX ANTOINE	1869	881.71	23.06
A11-304-0047	LENOIR MICHAEL	1894	971.93	971.93
A11-304-0048	CECILIA MALATERRE	1930	10,292.19	42.00
A11-304-0049	MALATERRE JOHN	1931	2,584.00	46.35
A11-304-0050	MALATERRE EDWARD	1940	3,400.00	145.84
A11-304-0051	MALATERRE JOSEPH	1943	2,729.00	222.54
A11-304-0052	MALATERRE NAPOLEON	1947	8,629.41	395.22
A11-304-0053	MALATERRE PHILLIP	1949	4,635.47	484.16
A11-304-0054	AZURE MARY	1959	7,217.00	44.90
A11-304-0055	MASON JOSEPH	2005	2,822.00	398.42
A11-304-0056	MCCLOUD MARGARET	2026	1,765.00	1,765.00
A11-304-0057	MCGILLIS STARR (RECTOR)	2050	8.00	8.00
A11-304-0058	MONTREUIL FRANCOIS	2071	528.00	350.78
A11-304-0059	MORIN ALEXANDER	2094	403.29	403.29
A11-304-0060	MORIN ISADORE	2136	432.00	432.00
A11-304-0061	NADEAU JOSEPH	2179	199.05	199.05
A11-304-0062	PAGE JOHN B.	2212	7,008.00	274.07
A11-304-0063	PAGE EDGAR	2216	7,401.00	199.91

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ISSUE NUMBER	NAME OF DECEDENT	DECEDENT ID	$ALLOWED	$PAID
A11-304-0064	PAGE JOSETTE	2219	7,485.00	302.39
A11-304-0065	PARISIEN JUSTINE CLAUDE	2235	5,168.00	1,392.39
A11-304-0066	PATNAUDE SAMPSON	2246	870.91	870.91
A11-304-0067	ANTOINE PAUL	2269	620.60	620.60
A11-304-0068	PAYS PIERRE	2275	401.00	401.00
A11-304-0069	PELTIER BARTHALOMEW	2297	7,156.00	175.03
A11-304-0070	PERRINTEAU LARASE (LAPIERRE)	2325	3,344.00	13.83
A11-304-0071	POITRA ALFRED	2350	5,748.20	60.28
A11-304-0072	POITRA CHARLES (NO. 1)	2356	916.40	585.90
A11-304-0073	FOUGHTY ADELINE (POITRA)	2358	4,136.00	129.00
A11-304-0074	POITRA CHARLES (NO.3)	2365	1,480.59	1,480.59
A11-304-0075	PAGE JUDITH	2437	5,713.00	8.00
A11-304-0076	ROUSSIN EUSTACHE	2515	475.00	475.00
A11-304-0077	SMITH CHARLES	2554	121.45	121.45
A11-304-0078	SMITH ARTHUR	2578	2,996.00	106.50
A11-304-0079	ST.ARNAUD JOHN B.	2582	3,130.73	21.50
A11-304-0080	ST.ARNAUD JULIA B.	2583	5,899.45	34.59
A11-304-0081	ST.CLAIR ROBERT	2593	900.00	54.46
A11-304-0082	ST.GERMAINE ROSE	2602	5,373.00	558.37
A11-304-0083	ST.PIERRE MARTIN	2617	3,577.00	3,137.33
A11-304-0084	THOMAS MARGARET (HERMAN)	2660	1,106.00	1.97
A11-304-0085	THOMAS WILLIAM J.	2662	2,328.00	53.98
A11-304-0086	TURCOTTE MARGARET	2685	380.00	159.03
A11-304-0087	VIVIER NAPOLEON	2740	4,933.57	356.55
A11-304-0088	VIVIER ALEXANDER	2746	427.00	98.11
A11-304-0089	WARREN MARY DIONNE	2776	464.00	464.00
A11-304-0090	WILKIE JOSEPHINE (LAVENDURE)	2787	235.22	235.22
A11-304-0091	GRANDBOIS LOUISE (BELGARDE)	512	361.17	361.17
A11-304-0092	LONDIE LOUIS	1749	1,358.00	219.38
A11-304-0093	REFLECTING MAN MAGGIE	8	2,345.00	645.00
A11-304-0094	TOBINES MIKE MRS. (ENWEAS GIRL)	27	469.00	468.00
A11-304-0095	OSKINE	134	252.00	252.00
A11-304-0096	REFLECTING MAN JOHN	149	1,478.00	1,478.00
A11-304-0097	BELGARDE ANTOINE JR.	456	101.50	101.50
A11-304-0098	BONNEAU VICTORIA	579	52.28	52.28
A11-304-0099	MORIN MARYJUSTINE	711	1,202.93	1,202.93
A11-304-0100	DAUPHINAIS JOHN B.	784	294.00	294.00
A11-304-0101	DAUPHINAIS DAVID	798	1,516.00	1,516.00
A11-304-0102	DECOTEAU LAROSE (CHAMPAGNE)	901	3,183.00	1,191.07
A11-304-0103	DEJARLAIS LOUIS	957	5,074.00	3,648.00
A11-304-0104	TURCOTTE MARY LOUISE	968	3,961.00	2,893.56
A11-304-0106	LANDRY MARGARET	1723	111.74	111.74
A11-304-0107	LAFOUNTAIN SARAH (PRIMEAUX)	2467	185.00	73.66
A11-304-0108	VIVIER VIRGINIA	2745	699.73	699.73
A11-304-0109	WILKIE ALBERT	2786	8.00	8.00
A11-304-0110	POTTINEAU MIKE	3290	352.00	352.00
A11-304-0111	BERCIER FRANCOIS	5537	606.30	606.30
A11-304-0112	BRELAND ALEX SR.	5726	6,911.00	179.23
A11-304-0113	DEMONTIGNY AMBROSE	6320	3,604.00	347.63
A11-304-0114	GRANT VIRGINIA	6998	901.00	900.00
A11-304-0115	LAFONTAIN ELIZABETH	7513	3,448.71	49.90
A11-304-0116	LATTERGRASS SARAH DIONNE	7847	238.95	238.95
A11-304-0117	BERCIER ANTOINE	11640	782.00	526.36
A11-304-0118	BELGARDE ADELE MARY	1194	6,022.50	109.62
A11-304-0119	GRANDBOIS DAVID	1286	132.00	UNKNOWN
A11-304-0239	WILLIAM ALLERY	227	992.45	360.47
A11-304-0240	GRANDBOIS LOUISE F. DESJARLAIS	512	361.17	361.17
A11-304-0241	PRIMRE MARY ALPHONSIN	465	777.93	17.55
A11-304-0242	BONNELL LOUIS	680	615.17	532.50
A11-304-0243	DELORME LOUIS	1019	790.00	54.35
A11-304-0244	GRANDBOIS DAVID	1286	132.00	2.23
A11-304-0245	LA FOUNTAIN PIERRE	1619	4,195.72	UNKNOWN
A11-304-0246	LA FOUNTAIN ISABEL DELORMAIS	1620	2,710.00	UNKNOWN
A11-304-0247	MARTELL MARY ROSE GLADUE	2003	910.36	910.36
A11-304-0248	MORIN ANASTASIA GLADUE	2111	265.05	265.05
A11-304-0249	MORIN ISADORE	2136	432.00	432.00
A11-304-0250	MORIN MARIE BEAUCHMAN	2155	33.33	33.33
A11-304-0251	POITRA JOSEPH ALFRED	2390	312.33	99.73
A11-304-0252	PREMEAU MARY JUSTINE	2469	225.85	225.85
A11-304-0253	ALLERY MARY LENORE	51270	163.92	163.92
A11-304-0254	WILKIE PAULINE ALLARD	09905	567.00	UNKNOWN
A13-390-0315	MITCHELL THOMAS	259	1,349.00	952.57
A13-390-0316	HARLAN RUEBEN	354	1,349.00	952.57
A13-390-0317	BLACK LUCY	433	2,478.37	343.58
A13-390-0318	PORTER PHILLIP	750	576.00	38.97

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ISSUE NUMBER	NAME OF DECEDENT	DECEDENT ID	$ALLOWED	$PAID
A13-380-0319	DICK JOSEPH	46-0	782.32	289.22
A13-380-0320	SHERIDAN JULIA (WHITE H.)	141-N	4,324.65	373.66
A13-380-0322	LASLEY JOHN	461	3,957.01	1,246.56
A13-380-0323	WILLIAM WEBSTER CAYOU	845-0180-N	2,561.92	1,835.00
A13-380-0324	SOLOMON HARRY	363	2,407.43	2,407.43
A13-380-0325	CANBY DAVID	811	709.05	UNKNOWN
A13-382-0134	JOHNSON JOSEPH (HAIMES)	470	450.00	447.97
A13-382-0135	HOFFMAN SARAH	350	225.00	225.00
A13-382-0136	REDWING MARY ALLEN	793	198.95	198.95
A13-382-0137	ST. CLAIRE ELIZABETH	131	3,517.50	1,417.19
A13-382-0138	FLANDREAU NANCY (WEST)	456	667.50	619.50
A13-382-0140	BARKER CHARLES	382	1,714.00	1,714.00
A13-383-0112	LIEB JEANETTE (RICE)	168	213.95	213.95
A13-383-0113	WHITE LEO C.	1170	576.00	39.97
A13-383-0114	HENSLEY MARTHA (HENRY)	41	1,141.72	1,071.27
A13-383-0115	MCKEE ANSON	271	669.40	620.00
A13-383-0116	WHITE GROVER	942	1,222.99	1,222.99
A13-383-0117	LAMERE MARGUERETTE (KITTLE)	826	350.39	211.06
A13-383-0118	CLAY JOHN	643	2,812.22	981.12
A13-383-0119	OWENS MARY (HOUGHTON)	217	1,135.20	730.86
A13-383-0120	WHITE JAMES	941	2,179.43	439.05
A13-383-0121	CROSBY JOHN SR.	282	3,439.40	234.14
A13-383-0122	HUMPHREY HOMER	279	3,304.71	477.96
A13-383-0123	WOLF DANIEL	573	5,124.09	326.09
A14-342-0001	BLAKE JENNIE	1163	361.50	90.04
A14-342-0002	TWO ARROWS LULA	579	4,739.50	1,126.34
A14-342-0003	WILLIAMS EUNICE	701	4,502.00	880.50
A14-342-0004	WALKER WILLIAM	18,	1,419.17	1,283.10
A14-342-0005	WHITE THOMAS	625	1,400.00	1,380.00
A14-342-0006	SAUL THOMAS	279	3,687.93	543.07
A14-342-0007	SKUNK GREGORY	1486	317.92	176.73
A14-342-0009	OWN ELIZABETH (ASHLEY)	720	816.00	516.61
A14-342-0010	PARKHURST JOSEPHINE (LODGE)	353	812.50	812.50
A14-342-0011	KEEBLE MAGGIE	361	926.00	896.00
A14-342-0012	WHITE MOUSE	367	7.30	7.30
A14-342-0013	WOUNDED KNEE PETER MRS. (SUSAN)	393	1,892.79	1,892.79
A14-342-0014	BIG EAGLE LEVI	290	3,514.05	2,906.28
A14-342-0015	MUSKRAT WALLCE (ASHLEY)	292	217.26	100.00
A14-342-0016	BIG EAGLE SARAH	296	1,067.75	1,067.75
A14-342-0017	WOOD PILER BLISS LEN	300	3,268.50	860.28
A14-342-0018	MEDICINE CROW	32	322.37	322.37
A14-342-0019	PLAYS WITH IRON	107	216.00	216.00
A14-342-0020	DRIFTING GOOSE LENA	123	503.50	503.50
A14-342-0021	IRVING JOSEPH	205	147.00	147.00
A14-342-0022	WHITE JAMES	208	409.41	409.41
A14-342-0023	ODD FACE GEORGE	250	187.50	187.50
A14-342-0024	OLDEST CHILD LUKE	254	186.95	186.95
A14-342-0025	EAR JOHN	270	256.67	256.67
A14-342-0026	FLUERY ROSE	274	317.50	210.24
A14-342-0027	CHUNKY WOMAN LOUISA	1219	205.75	205.75
A14-342-0028	HOWE SOPHIA	552	543.00	543.00
A14-342-0029	STANDING CLOUD AGNES	529	920.00	920.00
A14-342-0030	ST. JOHN JOSEPH	547	1,323.93	1,089.91
A14-342-0031	AGARD ANNA (WOMAN)	549	318.50	318.50
A14-342-0032	FIRE CLOUD JAMES	555	67.80	67.80
A14-342-0033	FIRE CLOUD THOMAS	567	328.20	328.20
A14-342-0034	MEDICINE CROW NELLIE	591	312.57	312.57
A14-342-0035	SHIELD AMOS	611	3,939.50	1,045.07
A14-342-0036	FOUR EAGLE BELLE	617	382.50	382.50
A14-342-0037	BARRY MARY	622	5,725.00	385.28
A14-342-0038	TREMBLING BLISS MAUD	313	1,552.00	1,552.00
A14-342-0039	SANTEE OLIVER	317	2,465.00	196.86
A14-342-0040	COMES UP FROM DIRT	332	28.35	28.35
A14-342-0041	NOBLE WOMAN MARY	337	1,081.50	1,081.50
A14-342-0042	CLARK SALLIE	344	1,244.00	1,052.32
A14-342-0043	LODGE MELVIN	352	4,006.50	1,074.28
A14-342-0044	ARROW WANDA	715	487.00	487.00
A14-342-0045	GOOD EAGLE MARY (PRATT)	736	339.00	339.00
A14-342-0046	STRONG BLANKET	786	2,128.80	2,128.98
A14-342-0047	RUNNING BEAR FLORENCE	809	5,699.00	2,784.19
A14-342-0048	WILBER MINNIE	810	234.40	234.40
A14-342-0049	JACOBS HENRY	900	1,673.50	1,673.50
A14-342-0050	THOMAS ROSS	946	512.00	512.00
A14-342-0051	STEP EMILY	950	336.00	336.00
A14-342-0052	ROSS PHILLIP	913	543.95	35.00

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ABERDEEN AREA

ISSUE NUMBER	NAME OF DECEDENT	DECEDENT ID	$ALLOWED	$PAID
A14-342-0053	SHIELDS GRACE	663	793.50	450.34
A14-342-0054	OLD MAN CORA	677	351.50	351.50
A14-342-0055	BADGER JOHN	695	262.80	262.80
A14-342-0056	WHITE MOUSE EMMA	452	190.00	190.00
A14-342-0057	LITTLE EAGLE EDWARD	404	119.39	119.39
A14-342-0058	IRON NELLIE (SHIELD HELEN)	410	1,833.40	1,225.36
A14-342-0059	SMELLS THE EARTH	423	262.59	262.59
A14-342-0060	THRUST BENJAMIN	461	35.30	35.30
A14-342-0061	SURROUNDED JENNIE	470	3,389.00	428.05
A14-342-0062	MIDDLE TENT JOHN	511	390.00	390.00
A14-342-0063	HOWE GEORGE	764	693.75	693.75
A14-342-0064	BIG EAGLE SAMUEL	297	645.75	645.75
A14-342-0065	SAMUEL FLUERY	813	969.00	150.00
A14-342-0066	FIRETAIL LOUIS	591	3,266.50	126.00
A14-342-0067	STEP EMILY	950	336.00	336.00
A14-342-0068	FLUERY WILLIAM	844	3,373.50	1,461.38
A14-342-0069	SHORT BEAR SUSAN	660	513.05	513.05
A14-342-0070	WHITE MARY	644	255.00	255.00
A14-342-0071	BARRY CATHERKINE	622	3,193.50	1,830.91
A14-342-0072	JENNYS PETER	770	267.50	267.50
A14-342-0074	WALKING CRANE JOSEPH	1254	1,117.84	1,117.84
A15-343-0001	MCDONALD THOMAS	550	59.90	25.48
A15-343-0002	MEDICINE BIRD SAMUEL	64	4,229.00	2,571.01
A15-343-0003	SMALL DANIEL	110	4,775.95	1,163.64
A15-343-0004	LONG TURNKEY CHARLES	430	5,002.00	1,641.66
A15-343-0005	GOOD FACE HENRY	246	4,782.00	1,036.35
A15-343-0006	GRASS ROPE DANIEL	308	3,969.50	496.39
A15-343-0007	THOMPSON JOSEPH	15	2,840.50	789.60
A15-343-0009	ANNIE LA ROCHE	292	2,830.50	UNKNOWN
A15-343-0010	DRIVING HAWK	292	2,830.50	1,710.59
A15-343-0011	SWIFT HAWK JOSEPH EUGENE	21	4,810.50	1,094.42
A15-343-0012	IRON HAWK ROSIE	101	3,423.00	1,521.82
A15-343-0013	ESTES RUEBEN	509	5,715.50	551.69
A15-343-0014	THOMPSON MAR	16	295.20	295.20
A15-343-0015	TWO HAWK PETER	130	20.00	20.00
A15-343-0017	QUILT DANIEL	393	1,395.00	1,395.00
A15-343-0018	TOMPKINS ESTER	306	1,771.45	53.10
A15-343-0019	TOMPKINS GEORGE	305	793.99	354.05
A15-343-0020	BYRNES JAMES	183	660.00	660.00
A15-343-0021	HIGH ELK SAMUEL	355	459.50	459.50
A15-343-0022	FORKED BUTTE MAR	26	799.50	522.11
A15-343-0023	YELLOW GEORGE	27	586.00	586.00
A15-343-0024	FALLIS GROVER	55	5.00	5.00
A15-343-0025	YELLOW HELEN	259	3,334.50	630.73
A15-343-0026	FIRECLOUD JOHN	201	476.37	5.00
A15-343-0027	WALKING WOMAN	309	112.34	112.34
A15-343-0028	LEGGS SOPHIA	12	1,980.00	1,980.00
A15-343-0099	MARGARET SPOTTED BULL	479	616.00	123.50
A15-343-0100	GEORGE YELLOW	27	5.00	5.00

ANADARKO AREA

ISSUE NUMBER	NAME OF DECEDENT	DECEDENT ID	$ALLOWED	$PAID
B04-860-0155	ROSELLA GREEN	860N21-72	7,423.51	UNKNOWN
B04-861-0150	RACHEL MASQUAT DELACRUZ	7	265.71	84.90
B04-861-0151	DUDLEY MASQUAH	50	82.50	82.50
B04-861-0152	ROSA POTTOE WILLIAMS	91	330.00	330.00
B04-862-0132	MARTHA JACKSON	119	320.40	320.40
B04-862-0133	ALBERT J MASQUAT	136	2,277.52	189.98
B04-862-0134	WE ZAH	214	371.18	UNKNOWN
B04-862-0135	JOE TURTLE	211	1,962.56	UNKNOWN
B04-862-0136	ALICE WAHWASSUCK	208	533.48	77.43
B04-862-0137	PANASKA CHAPEAKOSHEKOKE	171	1,345.00	UNKNOWN
B04-862-0138	MARIE PEWAMO	380	592.31	UNKNOWN
B04-862-0139	FRED GREEMORE	446	3,756.30	UNKNOWN
B04-862-0140	MEXICO NORHACKUM	492	37.24	UNKNOWN
B04-862-0141	PO K TO	503	1,208.98	UNKNOWN
B04-862-0142	MAGGIE LINK	558	3,035.47	UNKNOWN
B04-862-0143	FRANCES K SHOPTEESE	590	2,649.50	UNKNOWN
B04-862-0144	JOHN WAHWASHOQUAH	654	491.70	UNKNOWN
B04-862-0145	THERESA THOMPSON GREEMORE	679	2,956.75	UNKNOWN
B04-862-0146	MAGGIE WHITEFISH BARNEY	715	105.00	UNKNOWN
B04-862-0147	SUSAN LECLAIR	728	1,665.49	50.00

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ANADARKO AREA

ISSUE NUMBER	NAME OF DECEDENT	DECEDENT ID	$ALLOWED	$PAID
B04-862-0148	WILLIE SHEKOME NESS	739	142.53	UNKNOWN
B04-862-0149	SQUA SE ZHICK	740	615.00	615.00
B04-862-0154	JOHN COOK	434N40-56	861.00	861.00
B04-863-0153	THOMAS GREEN	4	964.50	590.27

BILLINGS AREA

ISSUE NUMBER	NAME OF DECEDENT	DECEDENT ID	$ALLOWED	$PAID
C51-201-0028	GEORGE BULLCHILD	1731	312.00	UNKNOWN
C51-201-0029	PETERWHITEMAN	484	958.00	UNKNOWN
C51-201-0030	MARY OLDROCK	2498	282.00	UNKNOWN
C51-201-0031	PETER BLACKFACE GRANT	884	4,574.00	UNKNOWN
C51-201-0032	AGNES ROSE	316	5,044.25	UNKNOWN
C51-201-0033	DOUBLE BULLWOMN.AFTER.BUFFALO	1089	226.00	226.00
C51-201-0034	ARROWTOPKNOT	1732	190.00	190.00
C51-201-0035	RAGGEDMAN BEARMEDICINE	2012	110.00	110.00
C51-201-0036	VIRGINIA BILLEDEAUX	1945	492.87	UNKNOWN
C51-201-0037	DRESSEDLIKEAWOMAN/BLACKBULL	1201	5,059.00	1,613.94
C51-201-0038	FRED BLACKMAN	993	413.26	87.95
C51-201-0039	BLACKWEASEL	984	135.00	135.00
C51-201-0040	PERCY BULLCHILD	256	1,160.00	1,160.00
C51-201-0041	BARNEY CALFBOSSRIBS	324	2,942.50	2,942.50
C51-201-0042	EMMA CALFROBE	199	240.00	240.00
C51-201-0043	MARY CHEWINGBLACKBONES	791	2,205.00	1,110.53
C51-201-0044	VICTOR CHIEFCOWARD	257	3,954.00	739.68
C51-201-0045	THOMAS DAWSON	1016	5,371.00	80.84
C51-201-0046	GEORGE DOGTAKINGGUN	1301	2,378.00	2,378.00
C51-201-0047	HERMAN DUSTYBULL	1762	543.00	UNKNOWN
C51-201-0048	GRETCHEN DUVALL	1354	376.00	376.00
C51-201-0049	PETER EAGLE	111	1,477.50	1,477.50
C51-201-0050	ELKYELLSINTHEWATERBEARCHIEF	786	195.00	195.00
C51-201-0051	UNDERBEAVERFLINTSMOKER	56	3,027.25	UNKNOWN
C51-201-0052	CECILE YOUNGMANCHIEF	1236	1,743.20	1,743.20
C51-201-0053	DIRTYFACEWHITEMAN	1354	539.40	539.40
C51-201-0054	ADAM WHITEMAN	429	2,337.00	122.13
C51-201-0055	MARY SHORTYWHITEGRASS	1406	1,115.46	1,115.46
C51-201-0056	THOMAS VIELLE	1675	2,960.00	871.12
C51-201-0057	SUSAN VIELLE	116	315.00	315.00
C51-201-0058	MARY WHITESHIELDVIELLE	1159	2,965.90	822.29
C51-201-0059	JOSEPHINE NEQUETTE	1935	1,092.00	371.60
C51-201-0060	MIDDLERIDER	999	2,522.40	2,522.40
C51-201-0061	MIDDLEPERSONWOCOAT	839	1,333.20	1,333.20
C51-201-0062	BAPTISTE MERCIER	1710	350.40	UNKNOWN
C51-201-0063	MILLIE MAGEE	637	402.32	UNKNOWN
C51-201-0064	ALBERT MADPLUME	279	1,792.00	1,792.00
C51-201-0065	PETER LUKIN	1607	135.00	135.00
C51-201-0066	TURTLE	1224	567.00	567.00
C51-201-0067	ANNIE TATSEY	24	2,005.25	1,594.91
C51-201-0068	FRONTSTRIKE TAKESGUNUP	1060	195.00	195.00
C51-201-0069	CHARLES POWELL	1787	922.79	UNKNOWN
C51-201-0070	JOSEPH OLLINGER	96	3,564.00	1,634.26
C51-201-0071	OLD ROCK	352	867.75	867.75
C51-201-0072	TIM NORUMMER	1393	2,073.72	2,073.72
C51-201-0073	WALLACE NIGHTGUN	1040	2,083.00	1,121.73
C51-201-0074	GEORGE HORN	123	651.00	651.00
C51-201-0075	MANYPIPES HOMEGUN	1916	2,461.00	1,490.96
C51-201-0076	HOMEGUN	1915	2,393.00	2,393.00
C51-201-0077	HENRY HAGAN	617	303.00	96.93
C51-201-0078	EMMA LAST STAR	1931	152.00	152.00
C51-201-0079	IRENE GOSS	1395	658.42	110.28
C51-201-0080	JAMES HOUSEMAN	2221	140.39	140.39
C51-201-0081	GOODMEDICINEPIPELAZYBOY	1499	519.40	519.40
C51-201-0082	GREENGRASSBULL	1373	3,123.80	3,123.80
C51-201-0083	GOODLEADERWOMAN HEAVYGUN	332	503.00	503.00
C51-201-0084	GOINGAFTERWATERSHORTROBE	1422	1,257.20	UNKNOWN
C51-201-0085	MIKEBADOLDMAN	436	4,293.00	933.94
C51-201-0086	ISABELLE BEARMEDICINE	1079	765.00	765.00
C51-201-0087	WEASELHEAD	1738	1,526.20	1,526.20
C51-201-0088	MINNIE WALTER	431	1,488.00	UNKNOWN
C51-201-0089	JOHN WAGNER	2195	1,006.27	1,006.27
C51-201-0090	JAPPY TAKESGUNONTOP	1743	495.80	495.80
C51-201-0091	MARGARET SPANISH	658	418.20	418.20
C51-201-0092	MARY SHORTY	1430	2,824.00	UNKNOWN

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BILLINGS AREA

ISSUE NUMBER	NAME OF DECEDENT	DECEDENT ID	$ALLOWED	$PAID
C51-201-0093	SHORTFACE	1794	3,034.40	1,307.04
C51-201-0094	SHOOTSFIRST	1432	240.00	240.00
C51-201-0095	RUSHESALONE RUNNINGFISHER	896	1,188.00	1,188.00
C51-201-0096	JOHN MORGAN	774	2,996.62	1,506.49
C51-201-0103	JOHN MESTAS	3124	1,170.00	426.20
C51-201-0104	CECILE CRE MEDICINEEAGLE HEAD	547	4,000.00	1,323.57
C51-201-0105	FRANK GUARDIPEE	2370	585.00	585.00
C51-201-0106	PETER MARCEAU	142	3,391.50	2,253.04
C51-201-0107	MARY WAGNER	2196	631.00	UNKNOWN
C51-201-0108	FRANK MOUNTAIN CHIEF	213	870.00	861.67
C51-201-0109	MINNIE DUSTYBULL GUARDIPEE	1723	4,045.00	4,045.00
C51-201-0110	BAPTISTE WEST WOLF	1107	3,263.00	UNKNOWN
C51-201-0111	JOSEPH YOUNGEAGLE	1769	591.80	91.11
C51-201-0112	JOSEPH WHITEGRASS	1405	2,065.28	1,032.28
C51-201-0113	HAIRY COAT	964	560.70	UNKNOWN
C51-201-1427	JEANETTE CALFROBE	193	2,424.00	1,301.14
C51-201-1428	JOHN MOUNTAIN CHIEF	223	44.00	44.00
C51-201-1429	JOHN P. CROFF	261	610.21	610.21
C51-201-1430	LOUISE CROFF	262	1,648.00	184.58
C51-201-1431	WILLIAM ROSE	318	796.00	UNKNOWN
C51-201-1432	MARY HEAVYGUN	335	1,267.00	1,267.00
C51-201-1433	MINNIE AIMSBACK	359	2,158.00	2,158.00
C51-201-1434	SWEETGRASSWOMAN GREENGRASSBULL	423	594.80	120.61
C51-201-1435	NIGHTHAWKFACE IRONEATER	453	757.75	757.75
C51-201-1436	CHARLES JUNEAU	466	540.00	21.71
C51-201-1437	JOHN DUCKHEAD	467	467.00	467.00
C51-201-1438	NETTIE RACINE	519	93.00	93.00
C51-201-1439	THOMAS RUNNINGRABBIT	536	258.00	UNKNOWN
C51-201-1440	MONROE ARNOUX	742	510.00	510.00
C51-201-1441	JOSEPH WOLFTAIL	727	1,741.00	UNKNOWN
C51-201-1442	WILLIAM TAILFEATHERS	801	238.00	UNKNOWN
C51-201-1443	WIPESHISEYES	998	70.00	70.00
C51-201-1444	CUTSDIFFERENT LITTLEPLUME	942	2,611.40	2,611.40
C51-201-1445	LOUIS LITTLEPLUME	945	1,466.00	UNKNOWN
C51-201-1446	FANNIE BLOOD	974	548.00	548.00
C51-201-1447	JOHN GOODGUN	987	3,178.00	3,178.00
C51-201-1448	ANNIE MIDDLERIDER	992	172.00	172.00
C51-201-1449	JOHN OLDCHIEF	1014	1,518.00	1,518.00
C51-201-1450	PETER AFTERBUFFALO	1084	175.00	175.00
C51-201-1451	CUTNOSE AFTERBUFFALO	1095	890.90	890.90
C51-201-1452	SAM MIDDLECALF	1114	4,421.00	1,912.24
C51-201-1453	MINNIE LABRECHE	1156	908.00	908.00
C51-201-1454	CROWEYES	1179	653.00	653.00
C51-201-1455	JOSEPHINE TURTLE	1199	2,054.00	2,054.00
C51-201-1456	ELLEN LONECHIEF	1209	632.11	UNKNOWN
C51-201-1458	ANNIE SPOTTEDBEAR	1271	498.30	498.30
C51-201-1459	SWIMSUNDER	1341	2,096.60	2,096.60
C51-201-1460	LOUIS CHAMPAGNE	1355	468.30	468.30
C51-201-1461	JAMES EARRINGS	1445	165.00	165.00
C51-201-1462	GENEVA CUTFINGER	1451	3,283.00	1,915.60
C51-201-1463	LAZYBOY	1520	2,366.40	2,366.40
C51-201-1464	JOSEPHINE GRANT	1619	728.95	728.95
C51-201-1465	CECILE YELLOWKIDNEY	1663	769.40	769.40
C51-201-1466	DANIEL LONECHIEF #1	1207	6,200.90	5,295.26
C51-201-1467	RIDESATTHEDOOR	1647	1,069.00	1,069.00
C51-201-1468	MARY KIPP #3	1702	2,436.00	2,169.70
C51-201-1469	CHARLES DUSTYBULL	1722	2,175.00	2,175.00
C51-201-1470	PHILLIP ARROWTOPKNOT	1734	2,953.00	440.24
C51-201-1471	MARGARET CROFF	1772	865.00	865.00
C51-201-1472	MARY POWELL	1795	285.00	285.00
C51-201-1473	JOHN GALBREATH	1888	201.00	201.00
C51-201-1474	ROBERT MANYHIDES	1909	3,470.00	UNKNOWN
C51-201-1475	PAUL HOMEGUN	1917	2,200.00	1,393.57
C51-201-1476	JAMES HOMEGUN	1930	986.00	UNKNOWN
C51-201-1477	MARY NEQUETTE	1935	420.00	420.00
C51-201-1478	EDWARD DOUBLERUNNER	1954	328.99	328.99
C51-201-1479	JOHN GROUND	2026	4,403.00	2,025.15
C51-201-1480	DORA DENNIS	2088	1,025.00	UNKNOWN
C51-201-1481	CECELIA MCKELVEY	2181	83.76	83.76
C51-201-1482	WILLIAM HENKEL	2219	1,075.00	UNKNOWN
C51-201-1483	ANNA FISHER	2314	1,542.00	69.21
C51-201-1484	VICTORY BEFORETIME WARBONNETT	2315	985.00	985.00
C51-201-1485	CAROLINE HENKEL	2653	3,838.00	UNKNOWN
C51-201-1486	FRANK J. BASTIEN	2698	3,573.00	113.04
C51-201-1487	CLARA SCHMIDT	3303	2,398.00	980.79

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BILLINGS AREA

ISSUE NUMBER	NAME OF DECEDENT	DECEDENT ID	$ALLOWED	$PAID
051-201-1488	FRANK CHOATE	99	2,148.20	UNKNOWN
051-201-1489	JOSEPH CALFROBE	188	657.00	UNKNOWN
051-201-1490	HOLLARSATNIGHT BISPEAVER	201 1/2	4,642.00	UNKNOWN
051-201-1491	THOMAS SPOTTEDEAGLE	232	5,070.00	1,787.89
051-201-1492	FRANK RACINE	518	4,458.00	UNKNOWN
051-201-1493	HENRY MAIN	696	68.21	UNKNOWN
051-201-1494	MARY GALLINEAUX	734	4,486.00	UNKNOWN
051-201-1495	IRENE RUNNINGFISHER	905	2,200.00	UNKNOWN
051-201-1496	MUDHEAD	954	364.90	UNKNOWN
051-201-1497	JULIA POWELL	1154	2,909.99	UNKNOWN
051-201-1498	GEORGE CROFF	1775	28.31	UNKNOWN
051-201-1499	ANNIE POWELL	1787 1/2	220.00	UNKNOWN
051-201-1500	CHARLES DELANEY	2089	5,560.00	UNKNOWN
051-201-1501	WILBERT MORGAN	2415	126.66	UNKNOWN
051-201-1502	MILLIE DOUGLAS	2438	22.10	22.10
051-201-1503	MAGGIE ROSE MARCEAU	143	5,337.00	UNKNOWN
052-202-0052	SMELL CHILD	825	1,816.00	1,816.00
052-202-0053	TAKES ENEMY	1	1,061.00	UNKNOWN
052-202-0054	LUCY HILL TURNSBACKPLENTY	1931	1,011.00	1,011.00
052-202-0055	ELKIN STANDSOVERBULL	2114	992.00	UNKNOWN
052-202-0056	JOSEPHINE GOODHORSE HILL	282	144.00	144.00
052-202-0057	OTTO BEARCLOUD	1542	1,624.00	UNKNOWN
052-202-0058	JOSEPHINE SHANE WHITECLOUD BEARDRD	1705A	2,266.00	UNKNOWN
052-202-0059	OLIVER LIONSHOWS	1892	2,311.00	UNKNOWN
052-202-0060	ROSE DREAMER BEARCLOUD	2234	108.00	108.00
052-202-0061	CHARLES ROBINSON	347	4,204.00	UNKNOWN
052-202-0062	OLIVE RECORDBLADE VENNE	99	1,136.00	UNKNOWN
052-202-0063	WILLIAM SHANE SR	155	1,693.00	UNKNOWN
052-202-0064	AUSTIN LIONSHOWS	2190	1,295.00	178.59
052-202-0065	DORA RECORD WHITEMAN	98	700.00	UNKNOWN
052-202-0066	STANLEY RIDESHORSE	1753	3,263.00	1,622.07
052-202-0067	TAKESHORSESONTHEPRAIRIE	2070	522.00	522.00
052-202-0068	WOMANONTOPOFTHEMOUNTAIN	1097	1,953.00	1,953.00
052-202-0069	BERNARD OLDCOYOTE	2031	225.00	225.00
052-202-0070	YELLOWBIRD	1310	532.00	UNKNOWN
052-202-0071	BEATRICE SACO	592	1,055.00	444.83
052-202-0072	RALPH SACO	591	939.00	345.75
052-202-0073	WESLEY MILLIKEN	1468A	495.00	495.00
052-202-0074	MEDICINE OLD COYOTE	2030	36.00	36.00
052-202-0075	THE WOMANMEDICINETOP	574	315.00	315.00
052-202-0076	MRS. JACOB WOODSTICK	2362	1,001.00	1,001.00
052-202-0077	JACKSON STEWART	966	3,320.00	1,060.74
052-202-0078	SARAH W PEASE	1317	2,380.00	393.53
052-202-0079	PLAYS WITH HIMSELF	1226	1,333.00	1,333.00
052-202-0080	FRANK BETHUNE	2303	119.00	119.00
052-202-0081	OLD CRANE	1954	422.75	UNKNOWN
052-202-0082	MOUNTAIN SHEEP	1091	391.75	UNKNOWN
052-202-0083	JOSEPHINE LAFORGE	1214	110.00	110.00
052-202-0084	KATIE DREAMER LODGEPOLE	1943	251.00	251.00
052-202-0085	ROSE PETERS	1289	1,396.25	UNKNOWN
052-202-0086	SITS DOWN	2033	222.00	222.00
052-202-0087	PLENTY HAWK	1747	333.00	266.62
052-202-0088	HARVEY BIG LAKE	4021	234.00	UNKNOWN
052-202-0089	HARRY MEDICINE ROCK ABOVE	1798	345.00	UNKNOWN
055-204-0038	KILLED IN LINE LITTLE SHIELD	136	130.00	130.00
055-204-0039	ROUND HEAD	29	460.25	460.25
055-204-0040	CHIEF WOMAN	1144	499.25	499.25
055-204-0041	FIRSTKILLHEADDRESS	28	446.25	446.25
055-204-0042	JOHN SHORTMAN	25	535.25	535.25
055-204-0043	DANCING DOG MOCCASIN	469	757.25	757.25
055-204-0044	BULL CAP	865	819.50	819.50
055-204-0045	FOUR NATIONS STRIKE	1146	655.25	655.25
055-204-0046	STANDING CHIEF	508	687.25	687.25
055-204-0047	JAMES SNOW 1	85	675.50	675.50
055-204-0048	STANDING BEAR	1142	490.50	490.50
055-204-0049	RAISING DAY	314	956.50	956.50
055-204-0050	PAUL MEDICINE BOY	447	320.00	320.00
055-204-0051	LAME CHICKEN	617	1,004.25	1,004.25
055-204-0052	LOOKING WALKING	394	552.25	552.25
055-204-0053	BELKNAP FOX	207	862.50	862.50
055-204-0054	BULL HEAD	564	695.25	695.25
055-204-0055	SINDEN	295	1,374.19	1,374.19
055-204-0056	LOUIS SPEAKSTHUNDER	781	584.00	584.00
055-204-0057	SPEAK THUNDER	779	942.25	942.25
055-204-0058	LARGWINGS MEDCLK	744	1,582.25	1,582.25

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BILLINGS AREA

ISSUE NUMBER	NAME OF DECEDENT	DECEDENT ID	$ALLOWED	$PAID
055-204-0059	KILLEDINTHEBRUSH	594	1,394.25	1,394.25
055-204-0060	TURN TOES	912	946.25	946.25
055-204-0061	LOUIS STRIKE	470	1,095.25	1,095.25
055-204-0062	TAKES THE BOW	49	1,052.25	1,052.25
055-204-0063	HOLY TREE	670	675.26	675.26
055-204-0064	CHARLES J BUCKMAN	101	1,059.57	1,059.57
055-204-0065	ATTACKS	712	1,617.70	1,617.70
055-204-0066	TAKESAPRISONER WARRIOR	544	949.40	949.40
055-204-0067	THE GIRL	991	651.73	651.73
055-204-0068	MEDICINEROBE	597	1,350.62	1,350.62
055-204-0069	AMY BLACKBEAR WHITE	1081	1,026.00	249.47
055-204-0070	IRON MAN 1	92	1,719.25	1,719.25
055-204-0071	MRS J P DORRITY	1169	1,820.75	1,820.75
055-204-0072	GROWINGWHITEWOMAN	392	1,349.84	1,349.84
055-204-0073	RETURNING HUNTER	673	1,497.25	1,497.25
055-204-0074	MARK FISH GUTS	501	1,379.05	1,094.54
055-204-0075	HIRAM FACING	425	1,826.60	1,826.60
055-204-0076	ONE WOMAN BUCK	230	832.25	832.25
055-204-0077	WIND CHIEF	241	1,122.20	680.44
055-204-0078	EMMA TRAIL LODGE	416	1,681.00	1,681.00
055-204-0079	FELICITAS TWO KILL	822	2,239.00	2,239.00
055-204-0080	GEORGE ROCK	535	5,235.09	2,235.00
055-204-0081	BROWN BEAR WOMAN	535	3,040.10	2,453.89
055-204-0082	SAM KING	171	1,210.50	1,210.50
055-204-0083	JULIA SHADE	420	3,216.00	3,216.00
055-204-0084	CARTER SNAKE	60	4,336.25	2,456.50
055-204-0085	BOB TAILBEAR	141	5,003.00	857.60
055-204-0086	JULIA TURCOTTE	155	544.00	544.00
055-204-0087	MARY MATT HAWLEY	1072	2,899.53	809.24
055-204-0088	HERBERT SOLDIER	750	954.00	562.54
055-204-0089	THERESA BLACKBULL LONGFOX	791	2,777.00	2,777.00
055-204-0090	THE BOY	557	2,576.25	2,576.25
055-204-0091	DEAF WOMAN	247	611.01	265.09
055-204-0092	MARY KIPKALDEI	835	559.25	559.25
055-204-0093	CAROLIEN BIG BEAVER	923	6,353.50	4,392.82
055-204-0094	EFFIE TALKSDIFFERENT	492	1,040.77	218.44
055-204-0095	JOHN SAMBORN	842	703.50	703.50
055-204-0096	FIRST CHIEF	363	3,943.64	1,372.26
055-204-0097	PAUL SLEEPINGBEAR	24	1,075.00	211.71
055-204-0098	ALOYSIUS CHANDLER	1	4,449.00	3,904.58
055-204-0099	RUSSELL YOUNG	1054	323.00	323.00
055-204-0100	GERTRUDE HAWLEY	110	1,678.00	643.71
055-204-0101	FRANK WHEELER	295	3,615.00	724.19
055-204-0102	WOUNDED FOOT	290	7,490.25	209.96
055-204-0103	HELEN EARTHPOW	429	4,522.00	617.85
055-204-0104	FRED V LONDE	1059	3,846.00	3,846.00
055-204-0105	PETER METAN	580	316.00	UNKNOWN
055-204-0106	SPIRIT BOY	633	1,369.98	1,369.98
055-204-0107	LESLIE KILLEAGLE	887	5,202.00	1,202.00
055-204-0108	WILLIAM KILLEAGLE	999	1,670.00	UNKNOWN
055-204-0037	LIGHTENING WOMAN BEARNOSE	54	101.50	101.50
056-206-0038	SAMUEL ALLISON	11	2,305.25	UNKNOWN
056-206-0039	BESS HIS OWN	59	1,568.25	1,568.25
056-206-0040	HANNAH BOUSHIELDS	92	125.00	UNKNOWN
056-206-0041	SAMUEL CONGER	185	2,288.00	UNKNOWN
056-206-0042	ROSE CHASER CLEVELAND	141	1,698.00	UNKNOWN
056-206-0043	SOPHIA BURSHIA	145	126.25	UNKNOWN
056-206-0044	JOSEPH CLOUD HAIL	173	614.50	614.50
056-206-0045	FANNIE CONGER	186	160.00	160.00
056-206-0046	COUNTER	204	439.75	UNKNOWN
056-206-0047	GOODHAND CROW	215	878.75	UNKNOWN
056-206-0048	GOOD WEST DRUM	280	3,589.75	UNKNOWN
056-206-0049	MABEL C DUPREE	290	864.20	UNKNOWN
056-206-0050	HUGH EAGLEBEAR	305	153.74	124.45
056-206-0051	GOODWOMAN EAGLEMAN	303	240.00	240.00
056-206-0052	JOHN FOOTE	338	130.50	UNKNOWN
056-206-0053	MARY FOOTE	339	3,045.00	3,045.00
056-206-0054	ALBERT FOOTE	349	1,635.07	UNKNOWN
056-206-0055	SANTEE IRON RING	450	709.00	351.81
056-206-0056	EUNICE GRAY BEAR	379	120.00	120.00
056-206-0057	MILLS SPOTTED	492	1,367.25	1,367.25
056-206-0058	EDWARD LAMBERT	511	242.00	242.00
056-206-0059	LITTIE LAMBERT	518	876.25	876.25
056-206-0060	LEWIS L. LAVAITA	549	1,000.00	931.94
056-206-0061	LUCY LONE DOG	571	150.00	150.00

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BILLINGS AREA

ISSUE NUMBER	NAME OF DECEDENT	DECEDENT ID	$ALLOWED	$PAID
C56-206-0062	FRANK LONGEE	574	581.90	UNKNOWN
C56-206-0063	ELLA LONGEE	575	1,102.00	UNKNOWN
C56-206-0064	WILBUR LOVES HIM	594	195.00	195.00
C56-206-0065	JOHN LONGTREE #1	597	1,473.92	1,473.92
C56-206-0066	MEDICINE EAGLE	636	137.50	UNKNOWN
C56-206-0067	JAMES MELBOURNE #1	648	325.50	325.50
C56-206-0069	RATTLING IRON	727	156.75	156.75
C56-206-0070	MAT RING	803	1,325.00	1,325.00
C56-206-0071	RAY SCOTT	836	156.00	156.00
C56-206-0072	SCOUT	840	1,792.85	1,792.85
C56-206-0073	FOUR CLOUD SHARP EYES	848	1,267.12	1,239.77
C56-206-0074	RED BIRD SHARP EYES	854	713.00	713.00
C56-206-0075	CHARLES TAKES THEM	931	2,532.50	2,532.50
C56-206-0076	SHADOW TAKES THEM	932	66.00	UNKNOWN
C56-206-0077	WILLIS TAYLOR	937	3,319.00	3,319.00
C56-206-0079	ELLEN TURNING PINE	961	646.00	646.00
C56-206-0080	SUSAN TWO FACE SMALL	970	3,208.00	3,208.00
C56-206-0081	FRED WALKING EAGLE	980	4,247.00	516.92
C56-206-0082	JAMES WALKING EAGLE	993	1,565.07	UNKNOWN
C56-206-0083	JOHN WHITEHAWK	1034	3,171.50	3,171.50
C56-206-0084	OWL SHIELD WOMAN	1039	320.00	320.00
C56-206-0085	MARIANNA WHITEHAWK	1045	363.00	UNKNOWN
C56-206-0086	YELLOW HAWK	1081	1,069.72	1,069.72
C56-206-0087	SKEDANA YOUNGMAN	1091	1,796.50	1,796.50
C56-206-0088	CHESTER ARTHUR	1129	248.00	248.00
C56-206-0089	BAD HAWK ADAM	1132	1,107.00	1,107.00
C56-206-0090	BEARCUB	1142	369.00	369.00
C56-206-0091	JAMES BEAR HILL	1147	156.00	156.00
C56-206-0093	HER BLANKET BEARSKIN	1173	209.00	209.00
C56-206-0094	GOOD BLACKBACK	1183	1,195.25	1,195.25
C56-206-0095	ALLEN CLANCY	1238	817.00	817.00
C56-206-0096	WALTER CLARK #1	1244	1,500.00	UNKNOWN
C56-206-0097	CLAUDE BIRD #1	1251	157.00	157.00
C56-206-0098	CLOUD	1257	7,195.00	7,195.00
C56-206-0099	GEORGE CONNORS #1	1264	200.00	180.25
C56-206-0100	GRAY MANE CRAZY BULL	1277	303.50	303.50
C56-206-0101	USES JAW DIGS THE GROUND	1290	891.50	UNKNOWN
C56-206-0102	THOMAS DUCK	1291	547.00	461.95
C56-206-0103	MARGARET LAPLANTE	1300	973.50	973.50
C56-206-0104	THOMAS FIRE MOON #1	1319	357.25	357.25
C56-206-0105	HAIL FISK ROSEBUD	1326	2,072.52	1,763.42
C56-206-0106	EUGENE GRANDCHAMP #1	1369	[illegible]	[illegible]
C56-206-0107	NANCY GROWING THUNDER	1379	3,629.50	3,629.50
C56-206-0108	HATCHET WOMAN	1399	235.00	UNKNOWN
C56-206-0109	WING WOMAN KNAPP	1443	513.50	UNKNOWN
C56-206-0110	CHARLES LAMBERT #1	1450	407.00	407.00
C56-206-0111	CAROLINE LAROCQUE	1458	530.94	UNKNOWN
C56-206-0112	JACKSON LOOKING	1484	156.00	156.00
C56-206-0113	JOHN LONG FOX	1499	1,997.26	1,997.26
C56-206-0114	SPOTTED BLANKET LUCKY	1495	323.00	323.00
C56-206-0115	MAKES CLOUD FIGHTER	1506	456.00	456.00
C56-206-0116	JOSEPH MARTIN	1514	3,667.50	UNKNOWN
C56-206-0117	MEDICINE HEAD NIGHT	1560	537.25	537.25
C56-206-0118	REDFEATHER #2	1591	1,206.50	582.04
C56-206-0119	JOSEPH ROSEBUD	1620	2,040.46	2,040.46
C56-206-0120	STEPHEN STANDING	1677	6,034.50	723.43
C56-206-0121	POINTING IRON	1741	3,396.00	3,396.00
C56-206-0122	RALEIGH FOUR STAR	1839	2,420.00	UNKNOWN
C56-206-0123	NELLIE KING	2026	4,233.75	UNKNOWN
C56-206-0124	GILBERT WALKER	2037	98.00	98.00
C56-206-0125	PEARL STANDING	2176	1,212.00	UNKNOWN
C56-206-0126	BRANCH WOMAN THUNDER HORSE	2802	717.50	717.50
C56-206-0127	HELEN SILVER	2803	290.00	290.00
C56-206-0128	TWO BONNETS HIGH BACK	2805	4,343.00	UNKNOWN
C56-206-0129	BLANCHE HEBDOOR	40	526.25	526.25
C56-206-0131	ROBERT BUCK ELK	120	430.00	UNKNOWN
C56-206-0132	GOOD HOWLING BIG FOOT	185	317.75	UNKNOWN
C56-206-0133	WALKING CLOUD HALF RED	384	323.32	UNKNOWN
C56-206-0135	HOWARD IRON LEGGINGS	445	190.94	UNKNOWN
C56-206-0136	NANCY MUSKRAT	629	50.00	UNKNOWN
C56-206-0137	JOHNSON PORCUPINE QUILLS	709	1,500.00	1,500.00
C56-206-0138	RED	751	1,424.00	1,424.00
C56-206-0139	AGNES RED BOY	911	1,958.50	UNKNOWN
C56-206-0140	AUDREY SHIELDS	954	4,991.00	UNKNOWN
C56-206-0141	HENRY SHIELDS	954	499.75	499.75

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ISSUE NUMBER	NAME OF DECEDENT	DECEDENT ID	$ALLOWED	$PAID
C56-206-0142	GOOD CLOUD EAGLE BEAR	956	660.50	660.50
C56-206-0144	WHITE SHIELD	1062	1,033.75	UNKNOWN
C56-206-0145	ROSE ADAMS YELLOW EAGLE	1102	1,425.00	401.07
C56-206-0146	CHARLES BLACK DOG	1154	429.00	UNKNOWN
C56-206-0147	TESSA BLOUNT	1191	1,044.00	1,044.00
C56-206-0148	GEORGE BLUE TALK	1197	490.00	490.00
C56-206-0149	CHASING HAWK	1236	1,495.89	99.99
C56-206-0150	VICTORIA BIRD	1252	2,265.00	2,265.00
C56-206-0151	CRAZY BULL #2	1276	501.50	501.50
C56-206-0152	EAGLE FEATHER #2	1293	204.50	204.50
C56-206-0153	THE GIRL EAGLEFEATHER	1294	559.50	559.50
C56-206-0154	BEDFORD FORREST SR.	1345	60.00	60.00
C56-206-0155	LODGEPOLE FOUR STAR	1352	1,317.50	UNKNOWN
C56-206-0156	HARVEY HAMILTON	1388	2,245.00	2,245.00
C56-206-0157	MARY HAMMOND MATHEWS	1394	230.00	230.00
C56-206-0158	THOMAS HANCOCK	1395	318.00	UNKNOWN
C56-206-0159	STONEWALL JACKSON #1	1438	2,243.00	2,243.00
C56-206-0160	LAST	1547	1,104.50	1,104.50
C56-206-0161	WHITEWOMAN ONE CLAW	1562	371.00	UNKNOWN
C56-206-0162	JIM OLD ROCK	1563	395.00	UNKNOWN
C56-206-0163	CHARLES PARNELL	1574	327.00	UNKNOWN
C56-206-0164	RED DOG THUNDERINGWOMAN	1594	755.50	UNKNOWN
C56-206-0165	JAMES ROBERTS	1615	1,062.50	UNKNOWN
C56-206-0166	RUNS THROUGH	1622	2,952.60	2,952.60
C56-206-0167	WHITEMAN	1727	782.50	782.50
C56-206-0168	NECK WALKING BULL	1745	145.00	UNKNOWN
C56-206-0169	JOHN HUNTER	1863	75.00	UNKNOWN
C56-206-0170	SAMUEL SMALL	1991	5,247.50	1,937.81
C56-206-0171	SUSIE MYRICK	2006	3,561.00	2,612.74
C56-206-0172	JOHN LEFT HAND THUNDER	534	730.00	UNKNOWN
C56-206-0173	ROBERT WAR CLUB	998	1,024.00	1,024.00
C56-206-0174	JESSIE WETSIT BEAR SKIN	1718	2,089.00	UNKNOWN
C56-206-0180	GOOD NIGHT DOG WASHINGTON	66	519.00	519.00
C57-207-0040	MARGARET RISINGSUN	20	1,939.00	UNKNOWN
C57-207-0041	AUSTIN AMERICANHORSE	5	5,068.00	UNKNOWN
C57-207-0042	WALTER ANT	23	910.00	910.00
C57-207-0043	HELEN ANT	24	4,168.00	UNKNOWN
C57-207-0044	MINNIE BEARQUIVER	49	3,559.07	946.16
C57-207-0045	MARTHA PUNCH REDWATER	SHAW49	673.80	UNKNOWN
C57-207-0046	LAURA BOXELDER	59	1,059.50	1,059.50
C57-207-0047	DAVID BEAVERHEART	61	803.00	803.00
C57-207-0048	WHITE BIGFOOT	93	130.00	UNKNOWN
C57-207-0049	WINTON BIGLEG	112	2,967.00	UNKNOWN
C57-207-0050	SAMUEL BIGNOSE	116	1,743.31	183.99
C57-207-0051	PAUL BLACKBEE	144	238.97	UNKNOWN
C57-207-0053	ELLEN BRADY	170	408.69	408.69
C57-207-0054	JOSEPH BROWNBIRD	187	407.41	UNKNOWN
C57-207-0055	ANNA BROWNBIRD	198	591.84	UNKNOWN
C57-207-0056	MINNIE CLUBFOOT	216	280.63	UNKNOWN
C57-207-0057	JENNIE CRAZYMULE	244	614.00	564.00
C57-207-0058	SARAH CRAZYMULE	246	973.19	UNKNOWN
C57-207-0059	THERESA COOK	251	911.94	UNKNOWN
C57-207-0060	ROSA CROOK	252	470.04	470.04
C57-207-0061	DAVID DEAFY	261	1,592.72	UNKNOWN
C57-207-0062	JOHN DIVESBACKWARDS	265	1,230.00	UNKNOWN
C57-207-0063	BESSIE DULL KNIFE	274	694.50	UNKNOWN
C57-207-0064	JACOB EAGLEFEATHERS	280	649.50	649.50
C57-207-0065	PERRY EASTMAN	293	575.00	UNKNOWN
C57-207-0066	EDGAR FIGHTINGBEAR	308	1,410.00	1,327.44
C57-207-0067	OTIS FINGERS	316	627.15	627.15
C57-207-0068	PETER FIRECROW	318	300.00	UNKNOWN
C57-207-0069	EUGENE FISHER	322	425.00	UNKNOWN
C57-207-0070	KITTY BELLE SPANG FISHER	323	1,159.00	31.40
C57-207-0071	CALLEUS FISHER	328	1,951.97	UNKNOWN
C57-207-0072	MYRA FLYING	342	724.50	90.50
C57-207-0073	THOMAS FLYING	347	1,226.00	979.55
C57-207-0074	NELLIE WHITEFROG FLYING	349	1,769.30	UNKNOWN
C57-207-0075	EDWARD GRAY	366	3,133.50	562.57
C57-207-0076	NELLIE GRAY	367	3,916.00	UNKNOWN
C57-207-0077	BRYAN J. HARRIS	412	262.00	UNKNOWN
C57-207-0078	ROSE ALICE HAIRLESSBEARHART	421	1,590.00	UNKNOWN
C57-207-0079	CHARLES HEADSWIFT	422	440.56	213.00
C57-207-0080	HERBERT HOLLOWBREAST	438	7,540.00	UNKNOWN
C57-207-0081	THOMAS HORSEROADS	450	995.00	956.93
C57-207-0082	CORA KILLSNIGHT	477	394.50	394.50

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ISSUE NUMBER	NAME OF DECEDENT	DECEDENT ID	$ALLOWED	$PAID
C57-207-0083	CHARLES KILLSNIGHT	480	1,098.00	UNKNOWN
C57-207-0084	ROSA BLACKMED. LONEWOLF KLSNIT	487	1,387.00	378.46
C57-207-0085	HUGH KILLSNIGHT	497	184.00	184.00
C57-207-0086	STANLEY LAMEWOMAN	524	1,438.00	UNKNOWN
C57-207-0087	AUGUSTA LAMEWOMAN	525	1,439.50	327.48
C57-207-0088	FRED LASTBULL	532	1,375.08	54.94
C57-207-0089	ARTIE LIMBERHAND	546	5,511.00	772.22
C57-207-0090	VICTOR LITTLECHIEF	569	1,731.00	UNKNOWN
C57-207-0091	DORA LITTLEHAWK	576	3,636.25	UNKNOWN
C57-207-0092	MILTON LITTLEWHITEMAN	613	4,104.00	99.72
C57-207-0093	ROSA LITTLEWHITEMAN	616	2,123.39	694.79
C57-207-0094	FRANK LITTLEWOLF	633	2,747.67	440.55
C57-207-0095	WILLIAM LITTLEWOLF	642	4,803.00	UNKNOWN
C57-207-0096	MAY WOMANLEGGINS LITTLEWOLF	643	958.00	UNKNOWN
C57-207-0097	ANNA MEDICINE	708	25.35	25.35
C57-207-0098	NELSON MEDICINE BIRD	711	2,834.00	UNKNOWN
C57-207-0099	BASIL MEDICINEELK	724	4,494.00	UNKNOWN
C57-207-0100	JENNIE EGLFTHS MDCELK WLKSLAST	726	4,021.98	UNKNOWN
C57-207-0101	JOHN MEDICINEFLYING	732	405.00	405.00
C57-207-0102	JOHN MEDICINETOP	739	5,284.72	697.64
C57-207-0103	JOSIE MERRITT	746	292.50	292.50
C57-207-0104	DANIEL OLDBULL	760	5,636.80	UNKNOWN
C57-207-0105	NORA WALKSEASTPINE	779	1,554.00	UNKNOWN
C57-207-0106	NORA BIGNOSEPINE	785	1,612.00	UNKNOWN
C57-207-0107	ALBERT MAGPIE	699	2,912.00	UNKNOWN
C57-207-0108	NANCY SLEEPINGWOLFREDBEADS	805	3,242.80	UNKNOWN
C57-207-0109	SUSIE REDBEADSHARDGROUND	806	232.00	UNKNOWN
C57-207-0110	TEDDY REDCHERRIES	823	1,806.00	1,339.81
C57-207-0111	JAMES REDFOX	834	780.90	UNKNOWN
C57-207-0112	HENRY REDNECK	840	3,163.00	UNKNOWN
C57-207-0113	PAUL REDNOSE	851	156.00	156.00
C57-207-0114	LUCY REDNOSE	852	822.72	UNKNOWN
C57-207-0115	NORA NICETALKER	955	1,168.00	1,168.00
C57-207-0116	JOHN SANDCRANE	963	346.49	346.49
C57-207-0117	HENRY MEDICINEBULL SANDCRANE	966	5,208.00	234.91
C57-207-0118	JOHN SEMINOLE	980	1,323.93	210.45
C57-207-0119	CHARLES SITTINGMAN	1034	1,747.90	UNKNOWN
C57-207-0120	BLANCHE SHEBEARSMITHSIOUX	1046	567.00	414.72
C57-207-0121	MAY BLACKBEE-STAR	1125	1,741.56	UNKNOWN
C57-207-0122	JOHN STRANGEOWL	1128	529.50	529.50
C57-207-0123	GERTIE STRANGEOWL	1129	529.50	529.50
C57-207-0124	MICHAEL SUNBEAR	1136	695.00	47.69
C57-207-0125	LENA SUNROADS	1139	500.00	UNKNOWN
C57-207-0126	DAVID SUNROADS	1140	1,998.00	UNKNOWN
C57-207-0127	HENRY SWEETMEDICINE	1152	654.00	UNKNOWN
C57-207-0128	NELLIE TANGLEHORNELK	1179	304.80	UNKNOWN
C57-207-0129	CHARLES EUGNE TANGLEYELLOWHAIR	1183	825.00	409.94
C57-207-0130	FANNIE HARDROBE TEETH	1192	827.00	UNKNOWN
C57-207-0131	BESSIEBIGBEAVERTWIN	1211	3,365.00	UNKNOWN
C57-207-0132	PETER TWOBIRDS	1214	1,820.00	UNKNOWN
C57-207-0133	LENORA ARAPAHOECHIEF	1215	5,198.00	UNKNOWN
C57-207-0134	CLARA TWOFEATHERS	1222	570.80	152.72
C57-207-0135	WILLIAM TWOMOONS	1226	1,385.00	1,385.00
C57-207-0136	CHARLES WALKINGBEAR	1232	137.00	137.00
C57-207-0137	JENNIE WALKINGBEAR	1233	769.50	769.50
C57-207-0138	ADOLPH WALKSNICE	1247	211.34	211.34
C57-207-0139	LENA WHITEBIRD	1282	462.90	UNKNOWN
C57-207-0140	LEO LEONARD WHITECRANE	1288	2,422.00	UNKNOWN
C57-207-0141	MAGGIE WHITEDIRT	1293	126.00	126.00
C57-207-0142	HUGH WHITEMOON	1307	2,729.77	482.10
C57-207-0143	DALLAS WOLFBLACK	1347	2,431.00	UNKNOWN
C57-207-0144	PAUL WOLFCHUM	1359	2,508.00	UNKNOWN
C57-207-0145	CHESTER WOODENTHIGH	1398	1,944.44	227.53
C57-207-0146	DAVIS WOODENEYE	1414	2,962.54	208.86
C57-207-0147	ROBERT YELLOWNOSE	1434	1,440.90	UNKNOWN
C57-207-0148	JOHN (BEANS) YOUNGBIRD	1455	5,878.32	781.01
C57-207-0149	ANDREW ANDY LARANCE	N5027	252.00	UNKNOWN

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ISSUE NUMBER	NAME OF DECEDENT	DECEDENT ID	$ALLOWED	$PAID
F53-404-0041	WM. JOHNSON	37	983.10	300.87
F53-405-0033	TOM DRIFT	139	672.50	672.50

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ISSUE NUMBER	NAME OF DECEDENT	DECEDENT ID	$ALLOWED	$PAID
F53-405-0034	WM. O. COFFEY	118	90.41	90.41
F53-405-0035	RIGHT DOMEY	83	10,341.53	928.19
F53-405-0036	CHARLES GOODSKY	120	279.00	279.00
F53-405-0037	JESSIE DRIFT SOREYES	148	2,921.66	2,921.66
F53-405-0038	JOHN WAKWESON	125	1,000.00	1,000.00
F53-405-0039	MRS. CHARLES GOODSKY	121	1,150.00	1,150.00
F53-405-0040	MAISH KOW WAY WE DUNG	224	2,955.92	944.00
F53-405-0041	WISH E BAH KAH MIG OKE	424	1,007.00	1,007.00
F53-405-0042	WAY NAH E QUAY	493	120.00	120.00
F53-405-0043	CHARLES F. GESHICK	494	50.00	50.00
F53-405-0156	LOUISA W. WOOD	MD03067	919.00	368.59
F53-406-0011	MAY MIN WAUM DAH YAUSH EKE	496	343.50	343.50
F53-407-0229	PAISH KE WAY KE SHIG OKE	799	999.00	999.00
F53-407-0230	JAMES BURGESS	1119	1,154.63	1,154.63
F53-407-0231	LUCY CARIBOO LOUIS	GP 137	1,004.38	358.93
F53-407-0238	DORA STURGEON	363	1,000.00	1,000.00
F53-407-0240	MAGGIE MCCABE BURING	732	2,906.90	672.78
F53-407-0241	TOM LEE	1209	4,961.34	43.20
F53-407-0243	MRS. JOHN JACKSON	1599	900.00	417.06
F53-407-0244	MRS. JOHN FINEDAY	979	4,857.50	1,666.44
F53-407-0247	AY ME WAUSH	362	100.00	100.00
F53-407-0248	JOHN WOOD	1612	3,002.00	2,210.26
F53-407-0249	JOHN WHITECLOUD	1519	1,197.00	1,197.00
F53-407-0250	ROBERT A. BLAKELY	255	5,289.94	432.52
F53-407-0251	JOHN MINK	949	127.54	127.54
F53-407-0252	WAY MAH TIG OSH E QUAY	15	4,857.50	1,855.84
F53-407-0254	MARY JANE RICE	4960	140.30	140.30
F53-407-0256	QUAY QUAY CUP	1024	3,414.00	2,884.27
F53-407-0257	MRS. CHARLES RABBIT	778	1,004.55	1,004.55
F53-407-0258	MARY DRUMBEATER	721	1,606.23	1,371.75
F53-407-0259	BOB MOSOMO	1046	1,290.48	100.00
F53-407-0260	MRS. BOB MOSOMO	1047	861.00	453.00
F53-407-0261	ROBERT JOHNSON	1073	4,741.00	2,705.44
F53-407-0266	ANNA JACKSON	134	7,281.44	133.33
F53-407-0268	OSCAR WHITEFEATHER	409N4260	2,115.09	376.25
F53-407-0269	JAMES BROUILLARD	ND03064	365.00	365.00
F53-407-0270	MARY NADEAU MORRIS	409N4069	1,281.00	1,166.97
F53-407-0271	MARY SPRUCE FISHER	GP194	4,366.01	311.11
F53-407-0272	MICHAEL FLATT	GP 234	8,514.57	168.19
F53-407-0273	ANGUS LESAGE	ND03066	3,379.20	196.63
F53-407-0274	THERESA MORRISON	GP 91	7,093.40	515.91
F53-407-0858	JOHN JOSEPH BEDEAU	1342	240.00	240.00
F53-407-0954	JENNIE BEAULIEU	995	1,105.93	542.60
F53-407-0955	MRS. JOHN MINK	1230	252.15	252.15
F53-408-0496	CHARLES CASSAWAY	2047	115.25	115.25
F53-408-0702	MARY LEQUIER	2055	100.00	100.00
F53-408-1956	MAGGIE PETERSON SQUIRREL	5169	787.30	357.63
F55-430-0088	MARY S. GREEN BRESETTE	132	651.50	451.50
F55-430-0089	DAVID MARKSMAN	4	3,328.15	160.40
F55-430-0090	CHARLOTTE MESSENGER	38	434.00	434.00
F55-431-0095	MARY HOMESKY LARSON BAKER	28	8,598.99	765.00
F55-431-0096	WILLIAM BILLY BOY	5	1,886.50	1,886.50
F55-431-0097	ESTHER JAMES NAVIOSH MARTIN	N4050	1,146.75	44.45
F55-432-0049	AGNES BLUESKY DOUD	U2159	665.00	665.00
F55-432-0050	MAGGIE LINK	U2548	385.00	385.00
F55-432-0051	MAGGIE LINK	U2548	1,949.50	1,286.93
F55-434-0004	WILLIAM KESHICK	N4124	1,432.75	1,195.98
F55-436-0001	JOHN A. LAUREW	N5614	966.54	162.21
F55-439-0097	SNIDER PEAR	19	90.00	90.00
F55-439-0107	DAN BEARHEART	R3995	573.50	573.50
F55-439-0108	EMMA BLOWSNAKE GOODBEAR MIKE	N5253	1,138.51	1,138.51
F55-439-0109	HENRY THUNDER	R3477	815.95	653.45

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ISSUE NUMBER	NAME OF DECEDENT	DECEDENT ID	$ALLOWED	$PAID
P03-101-0260	LUCY JIM TIMENTWA	S-1111	158.40	158.40
P03-101-0305	RUTH A. PARADIS CAIN	S-606	118.47	118.47
P03-101-0306	ANNIE JIM (WASH-WE)	S-988	71.02	71.02
P03-101-0307	ELIZA LAWSON	S-1784	552.64	552.64
P03-101-0309	WILLIAM SKOLASKIN	S-1729	1,680.03	85.33
P03-101-0310	KIST SOCULA	S-333	211.46	211.46
P03-101-0311	GEORGE TILLETSON	C-114	255.29	255.29

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ISSUE NUMBER	NAME OF DECEDENT	DECEDENT ID	$ALLOWED	$PAID
P03-101-0315	ALICE ANTONIA WILLIAMS	NONE	88.93	88.93
P03-101-0317	LUCY JAMES	S-226	180.52	180.52
P04-180-0033	DOLLY PAT JOHNNY	NONE	1,008.00	1,008.00
P04-180-0034	JULIA GRANT (HOLBROOK)	569	1,000.00	1,000.00
P04-180-0036	MINNIE Y. LE SIEUR	91	680.00	680.00
P04-180-0038	EMRY POCATELLO	1654	446.00	446.00
P04-180-0039	SSEDOYAH SOYOUMA WOODABOGAN	228	575.00	575.00
P04-180-0040	MOOOZAH TINDORE	12	768.00	768.00
P04-180-0041	SEODA JOHNSON WARJACK	903	411.00	411.00
P05-181-0102	BASIL PEONE	484	65.60	65.60
P05-182-0071	ANDREW RED DUCK	539	707.00	250.31
P05-181-0005	PIERRE ENEAS CHIQUI	76	632.00	632.00
P06-117-0029	LIZZIE JOHNSON	456	50.00	50.00
P06-117-0032	LUCY AGNES FITZPATRICK	1796	1,115.32	1,115.32
P06-117-0033	WALTER FITZPATRICK	1557	2,685.00	2,685.00
P06-117-0035	JACK WARD	1406	122.61	122.61
P06-120-0012	HENRY R. ALLEN	5075-A	12.18	2.15
P07-143-0030	JOSEPH WILD BILL THOMPSON	688	498.00	498.00
P09-145-0021	SALLY STACONA WILLIAMS	259	39.00	39.00
P10-109-0024	CHARLES JERRY	NONE	564.66	564.66
P10-109-0025	HENRY BILL HAMILTON	NONE	23.07	23.07
P10-130-0011	JOHN MIKE	13844	623.43	209.81
P11-124-0040	WYSOOKIE WYNOOKIE	2846	248.76	248.76
P11-124-0041	TOMMY THOMPSON	NONE	4,526.21	3,045.68
P11-124-0042	BILL (KOMSH) ANNISON TELASET	199	515.28	515.28
P11-124-0043	ELIZABETH POLLOCK CROW	1829	43.16	43.16
P11-124-0044	JOHN WHIZ	3110	271.50	271.50
P11-124-0045	THOMAS K. YALLUP	2476	245.00	245.00
P11-124-0048	ANNAHAT LALLASHUTE	1093	528.58	528.58
P11-124-0049	GEORGE SAM (TEMALOLES)	210	442.42	442.42
P11-124-0050	JAMES UMTUCK	1677	139.99	139.99
P11-124-0051	WILLIAM YALLUP	U366	802.48	802.48
P11-124-0055	MARY UMTUCH	1490	280.00	280.00
P12-102-0016	LUCY SOLOMON THOMAS	304	125.96	125.96
P13-203-0020	LOUIS COURVILLE JR.	68	900.00	785.99
P13-203-0021	EMILY FINLEY COURVILLE	69	730.00	730.00
P13-203-0022	MARY ASHLEY	99	180.00	180.00
P13-203-0024	WILLIAM ASHLEY	91	376.66	64.77
P13-203-0025	MARY ANN LA ROSE	111	1,125.00	1,125.00
P13-203-0027	HENRY B. CHALWAIN	231	67.47	67.27
P13-203-0028	THERESE S. FELSMAN	246	229.60	24.75
P13-203-0029	LOMAH MATT	292	486.81	486.81
P13-203-0030	JULE MATT	311	887.57	79.00
P13-203-0031	AGNES LUMPRY ANTOINE	360	1,297.00	143.39
P13-203-0032	(FRANK) PELASSIE COCOWEE	357	239.97	239.97
P13-203-0033	MELANE COCOWEE	368	399.00	399.00
P13-203-0035	JOHN W. FINLEY	419	996.00	996.00
P13-203-0036	MARY INMEE QUEQUESAH	441	395.20	395.20
P13-203-0037	JOSEPH SELPSTU	576	914.00	914.00
P13-203-0038	FELIX GENDRON	579	180.00	180.00
P13-203-0039	LUCY FINLEY CUNMAH	596	540.96	540.96
P13-203-0040	THERESE SELOW LUMPRY ASHLEY	648	1,551.40	671.40
P13-203-0042	HENRY MINESINGER	665	93.57	93.57
P13-203-0043	EDWARD GIBSON LACOURSE	715	3,295.22	1,621.81
P13-203-0044	EDWARD LOZEAU	746	1,028.64	1,028.64
P13-203-0046	MARY BIGJOHN	834	506.00	506.00
P13-203-0047	PHILIP ENEAS PIERRE	878	977.00	977.00
P13-203-0048	MARTIN CHESHESUE	884	2,081.00	2,081.00
P13-203-0049	THERESE MICHEL	887	1,861.00	1,861.00
P13-203-0050	ALEXANDER CALOWAHCAN (BEAVERHEAD)	903	1,566.40	1,566.40
P13-203-0051	MARY CATHERINE WOODCOCK	982	1,175.16	1,175.16
P13-203-0052	BAPTISTE FINLEY	1212	5,355.68	3,754.79
P13-203-0053	LOUISE FINLEY	1218	767.00	767.00
P13-203-0054	WILLIAM FINLEY	1219	3,934.00	3,664.06
P13-203-0055	JOHN GABE LUMPRY	1259	21.00	21.00
P13-203-0056	MARY LUMPRY VANDERBURG	1271	1,130.00	1,130.00
P13-203-0058	CECILLE CHARLO VANDERBURG	1284	2,873.00	2,759.79
P13-203-0059	JOSEPH FINLEY	1287	496.00	496.00
P13-203-0060	CARRIE COUTURE	1491	165.00	26.94
P13-203-0061	ANTOINE BARNABY	1486	838.19	480.24
P13-203-0062	JOHN CHARLEY	1501	1,015.00	1,015.00
P13-203-0063	MARY LOUIE	1561	1,227.00	1,227.00
P13-203-0064	PETER CAYE	2112	3,656.00	1,870.83
P13-203-0065	JOHN DELAWARE	1023	4,057.00	1,453.25
P13-203-0066	MARY WOODCOCK (CAYE)	1035	544.40	544.40

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ISSUE NUMBER	NAME OF DECEDENT	DECEDENT ID	$ALLOWED	$PAID
P13-203-0067	ISAAC PLANT	1042	1,058.00	488.66
P13-203-0068	ALEXANDER ASHLEY	1077	4,174.30	1,165.04
P13-203-0069	JOHN ASHLEY	1082	3,014.26	3,014.26
P13-203-0070	JOSEPH TALLMAN	1095	300.00	300.00
P13-203-0071	JOHN HOULE JR.	1132	1,504.00	1,163.67
P13-203-0072	CECILLIA SLOAN	1177	44.38	44.38
P13-203-0073	ANTOINE FELIX	1330	1,051.00	1,051.00
P13-203-0074	CECILLE FELIX	1331	1,419.00	785.12
P13-203-0075	JOSEPH POKERJIM	1537	998.00	998.00
P13-203-0076	CATHERINE POKERJIM	1541	258.00	258.00
P13-203-0077	PALCATNAH (PAUL) CHARLO	1554	92.39	13.66
P13-203-0078	MARTINE VANDERBURG SIWAHSAH	1558	904.17	904.17
P13-203-0080	MARY COOPER PIERRE YOSTSWEE	1586	3,100.00	2,882.25
P13-203-0081	MARY LOUISE PIERRE (NICOLAI)	1600	154.00	154.00
P13-203-0082	MOSES BIGSAM	1615	152.00	152.00
P13-203-0083	ISABEL WHITECOYOTE (BIGHAWK)	1619	240.00	240.00
P13-203-0084	GUS WHITE	1630	1,092.49	1,092.49
P13-203-0085	SUSAN FISHER VINSON	1637	3,635.00	743.01
P13-203-0086	LOUISE TOOOEL-PARKER-STOCKTAH	1642	884.00	884.00
P13-203-0087	MARY RATTLESNAKE	1727	925.44	925.44
P13-203-0088	ANTOINE STASSOO	1898	1,500.00	1,500.00
P13-203-0089	FRANK BEAUVAIS	1904	1,234.00	1,234.00
P13-203-0090	MARY LUCIER BEAUVAIS	1907	659.00	659.00
P13-203-0091	ROSETTE BIGBEAR	1951	828.92	828.92
P13-203-0092	ENEAS PAUL KOOSTAHTAH	2003	887.00	40.84
P13-203-0093	SUSETTE ISAAC KOOSTAHTAH	2005	2,967.00	2,796.57
P13-203-0094	ANTOINE JULIAN	2010	891.00	891.00
P13-203-0095	JOSEPH ONICKANILSEET	2015	150.00	150.00
P13-203-0096	ISABEL PIERRE	2022	703.24	703.24
P13-203-0097	JOHN KALLOWAT	2074	597.00	597.00
P13-203-0098	JOSEPHINE ENEAS YOUSTAH	2150	3,945.33	1,953.55
P13-203-0099	LOUISE BIGCRANE QUINTAH	2166	1,399.00	1,399.00
P13-203-0100	THERESE PLUFF	2229	846.79	846.79
P13-203-0101	SUSAN BULLROBE	2250	2,920.00	2,920.00
P13-203-0103	MADELINE PAIN CHARLEY	2294	3,769.00	3,531.96
P13-203-0104	MARY SUSTEEL SELPAH	2307	120.00	120.00
P13-203-0105	LOUIE ENEAS SCULKAH	2316	700.00	700.00
P13-203-0106	JOHN COCOWAH	2324	135.00	110.25
P13-203-0107	ANN CHESDOLLAY	2393	462.00	462.00
P13-203-0108	ANNIE RILEY	2449	393.76	393.76
P13-203-0109	MARY SMALLMOUTH CHAGALTHMAKMA	2457	476.00	476.00
P13-203-0419	SEYMOUR ANDREW KUNUCKAH	2017	301.40	124.49
P13-203-0420	ANDREW TOOMAH	2053	775.34	775.34
P13-203-0421	LOUIE KAHTLAGO	2104	1,838.00	1,335.23
P13-203-0422	MARY KUNUCKAH	2072	700.00	700.00
P13-203-0423	PHILIP KALLOWAT	2076	427.00	427.00
P13-203-0424	NICHOLAI GRAVELLE	2115	305.00	305.00
P13-203-0425	MARY PACHE	2106	186.40	186.40
P13-203-0426	SAHKALE (FINLEY) LEFTHAND	2141	55.00	55.00
P13-203-0427	MADALINE LEFTHAND	2140	917.45	917.45
P13-203-0428	ROSALIE MICHEL	2126	1,222.00	1,222.00
P13-203-0429	ANN MATHIAS (CHIEFHAT)	2153	282.00	282.00
P13-203-0430	JOSEPH WILSON (SPOKANE JOE)	2143	422.64	422.64
P13-203-0431	ANTOINE LA ROSE	110	390.00	390.00
P13-203-0432	ALEXANDER HOMINETO	2187	539.00	539.00
P13-203-0433	SUSAN MOICHAH	2219	100.00	100.00
P13-203-0434	LASSAW STASSO	2240	1,348.37	1,038.52
P13-203-0435	PHILOMENE FINLEY	619	143.00	143.00
P13-203-0436	ALEXANDER JOSEPH	687	550.00	550.00
P13-203-0437	JANE MICHEL-TELLIER-FINLEY	786	10.62	10.62
P13-203-1463	MARY ANN ENEAS FINLEY	434	829.60	829.60

[FR Doc. 85-8518 Filed 4-16-85; 8:45 am]

BILLING CODE 4310-02-C

federal register

Wednesday
April 17, 1985

Part III

Department of Health and Human Services

Health Care Financing Administration

42 CFR Parts 400 et al.

Medicare and Medicaid Programs; Peer Review Organizations; Final Rules

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 400, 405, 412, 431, 433, 456, 460, 462, and 466

[HSQ-108-F]

Medicare and Medicaid Programs; Utilization and Quality Control Peer Review Organization (PRO): Assumption of Medicare Review Functions and Coordination With Medicaid

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Final rule.

SUMMARY: This rule describes the review functions to be performed by a utilization and quality control peer review organization (PRO). It outlines the relationships that will be established among PROs, Medicare fiscal intermidiaries and carriers, providers, practitioners, and beneficiaries when a PRO assumes its review responsibilities. It also describes the relationship that should exist between PROs and State Medicaid agencies that contract with PROs to perform review.

This rule implements portions of the following statutes:

- Peer Review Improvement Act of 1982 (Title I, Subtitle C of the Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. 97-248)
- Social Security Amendments of 1983 (Pub. L. 98-21)
- Deficit Reduction Act of 1984 (Pub. L. 98-369).

EFFECTIVE DATE: These regulations are effective May 17, 1985 except for the following:

(1) Section 466.78(a) that specifies that each hospital have a written contract with a PRO is effective June 17, 1985.

(2) Sections 412.44, 431.630, 456.654, 466.70, 466.72, 466.74, 466.78, 466.80 and 466.94 contain information collection requirements with which the public is not required to comply until the Executive Office of Management and Budget (EOMB) approves these requirements. See section VI of the preamble for a discussion of information collection.

FOR FURTHER INFORMATION CONTACT: Mary Kay Terry, (301) 594-7910.

SUPPLEMENTARY INFORMATION:

I. Background

The Peer Review Improvement Act of 1982 (Title I, Subtitle C of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), Pub. L. 97-248) amended Part B of Title XI of the Social Security Act (Act) by establishing the Utilization and Quality Control Peer Review Organization (PRO) program. This program, when fully implemented, will replace the existing Professional Standards Review Organization (PSRO) program. The responsibilities that PROs are assuming are similar to those now exercised by PSROs. PROs will review health care services funded under Title XVIII of the Act (Medicare) to determine whether those services are reasonable, medically necessary, furnished in the appropriate setting, and are of a quality which meets professionally recognized standards. Congress created the PRO program in order to redirect, simplify and enhance the cost-effectivensess and efficiency of the peer review of services reimbursed by Medicare.

The Social Security Amendments of 1983 established a prospective payment system for Medicare and amended section 1866(a)(1)(F) of the Act to specify that hospitals seeking reimbursement under the prospective payment system must enter into agreements with PROs by specified dates to review the following:

- The validity of diagnostic and procedural information supplied by the provider.
- The completeness, adequacy, and quality of care provided.
- The appropriateness of admissions and discharges.
- The appropriateness of care provided or proposed to be provided for which payment is sought on an "outlier" basis under the prospective payment system.

In addition, the amendments added section 1886(f)(2) of the Act to specify that the Secretary may deny payment or require the hospital to take corrective action if a PRO provides the Secretary with documentation that a hospital has circumvented the prospective payment system through unnecessary admissions or other practices.

The Deficit Reduction Act of 1984 (DRA) revised the provisions of the Social Security Amendments to require that all hospitals, not just those receiving payment under the prospective payment system, must maintain an agreement with a PRO. Effective November 15, 1984, all hospitals must have an agreement with a PRO as a condition of payment under Medicare.

The DRA amendments permit the Secretary to enter into contracts with entities or affiliated entities (other than self-insured employers) that directly or indirectly make payments to a provider or practitioner on or after November 15, 1984 if there is no other available entity. Section 1153(b)(2)(A) of the Act, as amended, clarifies that the Secretary can contract with this type of entity if the entity does not have more than one member of the governing board being affiliated through management, ownership or common control with a health maintenance organization or competitive medical plan which is an "eligible organization" as defined in section 1876(b) of the Act.

In addition, Congress modified the restriction in section 1153(b)(3) of the Act. The Secretary may now contract with an organization that has no more than 20 percent of the members of its governing board affiliated with health care facilities or associations of facilities through management, ownership or common control.

In June of 1984, HCFA began awarding contracts to PROs. On July 17, 1984, we published a proposed rule (NPRM) which describes the PROs' review responsibilities and the PROs' relationships with other PROs, fiscal intermediaries, carriers, providers, beneficiaries, and State Medicaid agencies (49 FR 29026). Seventy-eight items of corresponsence were received from the public. The provisions of the proposed rule, the comments we received and the changes that we made in response to those comments, as well as additional changes, are discussed below.

II. Provisions of the Proposed Regulations

A. PRO Implementation and Functions Under Medicare

The NPRM specified that HCFA would award contracts to PROs and further specified the procedures for notifying facilities to be reviewed by the PRO, State survey agencies, Medicare fiscal intermediaries and carriers, and the public about the PRO contract and the schedule for the implementation of review. The NPRM proposed general requirements for a PRO's assumption of review.

The NPRM included the specific dates by which health care facilities would be required to enter into an agreement with a PRO. As discussed in section I, above, these requirements have been revised by DRA.

The proposed regulations would have required PROs to negotiate memoranda of understanding with Medicare fiscal intermediaries and carriers that delineate the responsibilities of each party and provide for the exchange of data, notification of review determinations, and any other pertinent procedures. The NPRM proposed that any of the duties and functions of a PRO

for which a PRO has not assumed responsibility under its contract with HCFA must be performed in the manner and to the extent otherwise provided for under the Act.

The proposal specified that a PRO determination under 42 CFR Part 466 would be an initial determination that is final and binding unless it is reconsidered or revised in accordance with appeal procedures in 42 CFR Part 473, Subpart B. Final regulations for Part 473 are included elsewhere in this issue of the **Federal Register.**

The proposal described the correlation of the Title XI and Title XVIII functions of the PRO. A PRO's review determination with regard to reasonableness, medical necessity, and appropriateness of placement at an acute level of care would replace the utilization review activities required of health care institutions under sections 1861(e)(6), 1861(j)(8) and (j)(12), 1861(k) and 1865 of the Act. However, a PRO's review determination would not supersede HCFA's authority to enforce the coverage provisions of the statute. For example, although a service may have been medically necessary, it might be a service that is not covered under Medicare.

In order for a PRO to carry out its review functions, we proposed that a PRO be authorized to examine the operations and records of facilities that are pertinent to services provided to Medicare beneficiaries. A PRO would be permitted to examine the records of non-Medicare patients only if authorized to do so by the facility or practitioner or by HCFA under sections 1815 and 1833 of the Act.

We proposed that PRO review would differ from the current PSRO review with regard to requirements for the annotation of claims. PSROs were required to annotate all Medicare claims from health care facilities under their review to indicate whether the claims are approved for payment or denied. Because that procedure has been administratively cumbersome and ineffective, we proposed that PROs would not annotate every claim, but only those made for additional payment for an "outlier" case, those cases subject to preadmission review and those other claims that are denied.

The proposed regulations described the procedures a PRO must follow in making an initial denial determination. Before a PRO issues an initial denial determination, the proposed regulations would have required that the PRO afford the provider and the patient's attending physician (or other attending health care practitioner) the opportunity to discuss with the PRO physician advisor any proposed denial determination and the bases for that determination. The proposal also described the content of the notice and the procedures for notifying the patient or the patient's representative, the attending physician, the Medicare fiscal intermediary or carrier, and the facility.

The proposed rule specified that the PRO review period is generally within one year of the date that the claim containing the item or service was submitted to the Medicare fiscal intermediary or carrier. A PRO determination could be reopened and revised by the PRO within four years of the date that the claim was submitted to the Medicare fiscal intermediary or carrier if additional information is received on the patient's condition or if an error had been made. The proposed rule stated that a PRO determination could be reopened or revised at any time if it was obtained through fraud or a similar abusive practice.

The NPRM proposed qualifications for the PRO reviewers. Generally, the services ordered or furnished by a doctor of medicine, osteopathy or dentistry may be denied only by another doctor of medicine, osteopathy or dentistry, respectively, who has active admitting privileges at one or more hospitals in the PRO area.

The NPRM specified that a PRO would be required to negotiate with HCFA concerning the use of national or regional norms for conducting review to achieve the objectives set forth in the PRO contract. A PRO would also be required to establish written criteria and standards to be used in the conduct of review.

The NPRM proposed that a PRO, in order to achieve economical and efficient review, would be required to coordinate activities (including the exchange of information) among Medicare fiscal intermediaries and carriers, other PROs, and other public or private review organizations as appropriate.

B. PRO Relationships With Medicaid

The NPRM specified that, as with PSRO requirements, when a State contracts with a PRO for medical or utilization review, the State must submit a plan amendment to the Regional Office for approval. The proposed rule specified that the State plan would assure that the contract with the PRO satisfied certain requirements. Again, as with current PSRO policy, a State that contracts with a PRO will be eligible for Federal financial participation (FFP) at 75 percent for funds expended for the performance of medical and utilization review under the contract. If a State fails to make a satisfactory showing that it has an effective utilization control program (42 CFR 456.650), the reduction in FFP would not apply to facilities where either PSRO or PRO review is being conducted under an approved contract.

Under the proposed regulations, if a State contracts with a PRO, the medical and utilization requirements would be deemed to be met. However, the physician certification requirements and plan of care requirements would not be deemed met through an approved PRO contract. The proposed regulations added the requirement that the State agency, in its quarterly report that indicates that the State meets utilization requirements, must include facilities in which a PRO is performing review. As specified in the NPRM, the State agency's report for a quarter would have to include the dates a PRO was responsible for review in a facility for which a showing that the State met utilization requirements for recipients would otherwise have had to been made. More specific details of the proposal can be found in the document published on July 17.

III. Discussion of Comments

Note: We have made references within this preamble and regulations text to prospective payment regulations (previously §§ 405.470 through 405.477) that were redesignated under a new Part 412 on March 29, 1985 (50 FR 12740). References to these sections in the preamble of this document give both old and new citations for the benefit of the reader.

The majority of the comments we received on the proposed rule were from PSROs, hospitals, hospital associations, business groups and national medical organizations. The comments and our responses are set forth below and are grouped by subject area:

A. Statutory Provisions (§ 466.70)

Comment: One commenter noted that the proposed § 466.70(c) that would allow PROs to make payment determinations based on the completeness, adequacy and quality of care is not consistent with the PRO statute that only allows PROs to review services, not deny payment, based on these issues. Another commenter believed the regulations should not require the PRO to perform any duties in addition to those imposed by the statute.

Response: We agree with the first comment and have revised § 466.70(c), now redesignated as paragraph (d), to remove the reference to a PRO making a payment determination based on the completeness, adequacy and quality of care. We have deleted the reference to a

PRO making payment determinations based on quality contained in the definition of "Review responsibility" (§ 466.1). We have also removed the reference to a PRO making a payment determination based on changes resulting from DRG validations. As revised, the section provides that PROs will make payment determinations based on the reasonableness and medical necessity of services and the appropriateness of the acute care setting. Regarding the second comment, the Secretary has the authority, under section 1154(a)(8) of the Act, to issue regulations to implement the PRO program. We believe that all of the PRO activities required by these regulations are required by statute (sections 1154, 1866(a)(1)(F), 1886(f)(2) of the Act) and are necessary for an effective peer review program.

B. Notification of Designation and Implementation of Review (§ 466.72)

Comment: One commenter suggested that the PRO's notification that it is assuming review should include a list of the facilities to be under review. Another commenter believed that facilities should get a detailed explanation of the review process within 10 days of the signing of the PRO contract.

Response: Section 466.72(b)(2) of the proposed regulations specifies that the PRO will publish a notice in at least one local newspaper listing each facility to be under review. HCFA has also published newspaper notices announcing the award of individual PRO contracts. However, PROs are still required to issue a more detailed newspaper notice listing each facility under review and stating when and where their review plan is available for public inspection. Regarding the second comment, the regulations at § 466.72(b)(1) require that the hospital receive written notification of the date and manner by which the PRO will implement review. In addition, regulations at § 466.76 require a PRO to discuss the PRO's review process with the hospital. Also, the PRO's review plan is available at the PRO office for public inspection (§ 466.72(b)(2)). Therefore, we believe that the regulations contain adequate provisions to assure that hospitals are fully aware of the PRO's review procedures.

C. General Requirements for PROs (§ 466.74)

Comment: Fifteen commenters disagreed with the proposed regulations that specify that a PRO must not subcontract with a facility to conduct review activities that would affect payment. The commenters stated that this prohibition is unfair, inefficient, ineffective and costly and recommended deleting this section and replacing it with criteria for delegation. A national medical organization believed the PRO should be allowed to subcontract with members of the medical staff who are not employees of the hospital and who do not have an ownership interest in the hospital.

Response: Although the PRO statute does not specifically prohibit PROs from subcontracting review responsibilities to facilities, we believe that subcontracting review responsibilities to hospitals would compromise the intent of Congress that there be no financial conflict of interest. Since 1981, Social Security Act legislation has reflected a clear departure from delegated hospital review. The Omnibus Reconciliation Act of 1981 removed the requirement that PSRO review be delegated and allowed PSROs discretion about whether or not to delegate review. TEFRA continued and strengthened this trend away from hospital delegation by limiting PRO subcontracting of review to those instances where the PRO finds that the provider will effectively and efficiently review itself. The Social Security Amendments of 1983 created the prospective payment system, where payment is based on a single review decision that affects payment for an entire hospital stay rather than multiple decisions that affect smaller units of payment over the course of a hospital stay. This, together with the Congressional concern expressed in the TEFRA legislation that there be no financial conflict of interest in PRO review, leads us to conclude that subcontracting any review that affects Medicare payment under the prospective payment system not be allowed. We also believe this prohibition should apply to non-PPS hospitals. The majority of PRO review is conducted retrospectively, after the patient has left the hospital. If a hospital were given the responsibility to conduct PRO review, it would therefore be asked to review and deny care, the cost of which it has already incurred. We consider this an extreme conflict of interest. Therefore, we are retaining the prohibition against subcontracting any review except quality review in this final rule.

Comment: Two commenters expressed concern about the requirement that the PRO make it contract primary to all other activities and believed this may interfere with PRO contracts for private review.

Response: Section 1154(b)(11) of the Act encourages PROs to engage in private review activities, but only to the extent feasible and appropriate. The intent of this provision of the regulations is that Medicare review not be compromised by any other PRO contract activities.

Comment: One commenter questioned whether PROs will compile statistics to determine a provider's favorable presumption status under section 1879 of the Act and whether the PRO will be required to notify the provider of its waiver status.

Response: We have included in § 466.74(e) provisions for circumstances when PROs are required to compile statistics to determine a provider's favorable presumption status using the criteria contained in § 405.332(b) and notify the provider of its status. Instructions concerning these compilations will be included in administrative guidelines.

Comment: One commenter believed the regulations should reflect the PRO's responsibility for confirming the accuracy of a hospital patient's discharge destination.

Response: We believe that the specific obligations of an individual PRO should be contained in that PRO's individual contract with HCFA rather than in regulations. Therefore, we are not revising the final rule as a result of this comment.

D. Cooperation with Health Care Facilities (§ 466.76)

Comment: Three commenters believed the 30 day timeframe for implementing review makes it very difficult for PROs to fully discuss their review plans with facilities. Another commenter requested that the regulations specify how a PRO must cooperate with facilities.

Response: We believe it is essential that a PRO begin its review activities as soon as possible after its contract is signed. In fact, we encouraged organizations that submitted proposals for PRO contracts to provide evidence that they had initiated discussions with facilities or associations of facilities in their area. Thus, we believe the 30 day timeframe is adequate for the discussion of review plans with facilities. Regarding the second comment, the individual agreements between PROs and facilities will detail the relationship between the two organizations.

E. Responsibilities of Health Care Facilities (§ 466.78)

Comment: A hospital representative questioned whether the hospital's Medicare payment would be in jeopardy

if the hospital did not have a contract with a PRO by October 1, 1984. The representative noted that there is no designated PRO for the area.

Response: As described in the preamble, the DRA amendments revised the date by which a hospital must have an agreement with a PRO. That date is now November 15, 1984. We note that there are now PROs in each geographic area.

Comments: Twenty-four commenters objected to the requirement in the proposed regulations (§ 466.78(b)(2)) that hospitals photocopy and deliver pertinent information to the PRO because it would increase hospitals' operating costs. The commenters further stated that the PRO should be required to conduct onsite reviews at the hospital whenever possible. The commenters also suggested that the regulations impose some limitations on the volume of material a PRO can request from a hospital and that they ensure the confidentiality of the records. Another commenter requested that the regulations specify that the PRO can request pre-admission records of tests in addition to the post-admission record.

Response: We believe it is important that PROs have adequate access to medical records to enable them to carry out required activities. This includes the right to request and receive copies as they deem necessary, including preadmission test records. In some cases, this will mean that the PRO will request hospitals to photocopy specific medical records and mail them to the PRO.

The prospective payment rates are computed according to the provisions of the law and are also based on the best available data at the time of computation.

Administrative costs are included in the Federal and hospital specific portions of prospective payments by virtue of their being incurred and reported by hospitals for the years that represent the data bases for the prospective payment system.

Prior to the use of PROs, review of inpatient hospital services was carried out either at the hospital or offsite. Offsite review sometimes required that the hospital mail patient records to Medicare fiscal intermediaries. These costs were subsumed in the hospital's administrative costs which in turn were reflected in Medicare cost reimbursement. Costs related to such activites are accounted for, in some measure, in the prospective payment base rates.

We also believe that the fiscal benefits of PRO review will compensate for any such increased costs. For example, in many cases, PRO's preadmission review activities will protect hospitals from retrospective denials. Thus, there will be trade-offs between a hospital's cost of providing medical records to a PRO and the PRO's performance of review, that, in many cases, may assist hospitals in avoiding unnecessary expenditures.

We agree that the confidentiality of copied records is important and we plan to publish final regulations concerning PRO's protection of photocopied records as separate regulations.

Comment: One commenter questioned why the proposed rule did not contain provisions to satisfy the requirements under Section 1815(b) and 1861(w)(2) of the Act that specify that a hospital, as a condition of payment under Medicare, is obligated to pay a PRO an amount reasonably incurred by the PRO in conducting review activities at that hospital.

Response: Section 1153(c)(8) of the Act provides that reimbursement of PROs will be made in accordance with the terms of their contract with the Secretary. HCFA's policy in negotiating the terms of the PRO contracts has been that PROs will receive reimbursement directly from HCFA. This policy, which is in accordance with section 1153(c)(8) of the Act, eliminates the need for regulations that would specify that HCFA pay a hospital which in turn would pay a PRO for the conduct of review.

Comment: Many Commenters believed that hospitals should not be held financially liable for cases subject to preadmission review. The commenters believe that the PRO should be required to perform review in a timely manner and the beneficiary should be financially liable if the hospital notifies the beneficiary that services would not be covered. The commenters believed that the policy in the regulations is contrary to the limitation of liability provisions in section 1879 of the Act. Another commenter requested that we explain the difference between preadmission review and preadmission certification.

Response: We agree with the commenters that HCFA should not assign financial liability to providers in preadmission review cases in which both the patient and provider have knowledge that the proposed admission is medically unnecessary, unreasonable or inappropriate. Therefore, we have deleted this provision from § 466.78(b)(6) of the final rule. In accordance with section 1879(c) of the Act, if both the provider and beneficiary have knowledge that the proposed admission will not be covered by Medicare, HCFA will not pay the bill and settlement will be between the hospital and the beneficiary. We are retaining the requirement that a facility agree to accept financial liability if (1) the facility has been notified by the PRO of the admission categories that are subject to preadmission review and certification; (2) the required PRO review has not been performed; (3) the facility admits the patient; and (4) subsequent PRO review finds the admission to be medically unnecessary, unreasonable or inappropriate. However, we are revising § 466.78(b)(6) to state that a hospital is not automatically liable if, in accordance with its agreement with the PRO, it makes a timely request for preadmission review and the PRO does not review the case. The agreements between the hospital and the PRO will contain specific details regarding the PRO preadmission review process including the timing of the request for PRO review and the PRO's response.

Regarding the request for clarification on the difference between preadmission review and preadmission certification, preadmission review is the process for determining, for payment purposes, the reasonableness, medical necessity and appropriateness of placement at an acute level of care. Preadmission certification is a favorable determination, transmitted to the hospital and the fiscal intermediary, approving of the patient's admission for payment purposes. We have included definitions of these two terms in § 466.1 of this final rule.

Comment: One State government suggested that the beneficiary should be informed of the reconsideration and appeals process at the time of admission. However, other commenters believed that we should eliminate the requirement that the beneficiary be informed by the hospital at the time of admission about PRO review because it would harm the patient and because the commenters believe it is the responsibility of the Government to inform the beneficiary.

Response: We believe it is important that Medicare beneficiaries be informed about the PRO review process at admission and the § 466.78 of these regulations adequately ensures that beneficiaries are aware of that process. We believe that the hospital can most effectively and efficiently provide this information to the beneficiary at the time of admission. Also, additional detailed information concerning PRO reconsiderations will be made available to beneficiaries by the PRO whenever a PRO denial determination is issued.

Comment: One commenter believed the regulations should specify that the hospital will provide space to the PRO for its review functions in accordance with other demands on the hospital for space.

Response: In their agreement, the PRO and the facility should work out an arrangement that provides the PRO with adequate space to perform its review functions while not placing a hardship on the facility.

F. Coordination with Medicare Fiscal Intermediaries and Carriers (§ 466.80)

Comment: Two commenters questioned whether the agreement between the PRO and the Medicare fiscal intermediaries or carriers has to be approved by HCFA before review can begin because this could delay implementation of review. The commenters believed that we should establish timeframes for submission of the agreements to HCFA and for approval by HCFA.

Response: The regulations require that the agreements must be approved by HCFA before the PRO begins to make review determinations. Because PRO contracts will be signed at different times, each PRO contract will contain a timeframe that is adequate for the PRO and the fiscal intermediary or carrier to reach an agreement. Therefore, we are retaining this provision in § 466.80(c) of the final regulations. We do not believe that more rigid timeframes would necessarily facilitate the negotiation process. Also, every organization that submitted a proposal for a PRO contract was asked to provide a draft agreement and to verify that it had initiated discussions with the appropriate fiscal intermediary. It is our intention that all PRO contracts be awarded in sufficient time for agreements to be signed by the November 15th deadline.

G. Continuation of Functions (§ 466.82)

Comment: One commenter asked who is responsible for certain review activities once a PRO contract is effective. Specifically, the commenter asked who is responsible for review activities not initiated or not completed by the fiscal intermediary or former PSRO for Medicare hospital admissions occurring before the effective date of the PRO contract. Another commenter believed that § 466.82 dealing with the continuation of functions is unnecessary because, as of November 15, all hospitals will have review contracts with PROs.

Response: The pro is responsible for all review activities specified in its contract with HCFA. In most cases, these contracts include the completion of any PSRO activity. We believe that § 466. 82 is still necessary because fiscal intermediaries must, in the unlikely event that a PRO contract terminates before a new contract is signed, be responsible for these review functions. The fiscal interemediary will also be responsible for any review function that the PRO has not yet assumed, but which it may assume at some future time.

Comment: Two commenters believed that the fiscal intermediaries should not be making determinations on medical necessity, reasonableness, or level of care. Another commenter believed that the PRO should use norms of care, not HCFA coverage policy, in making review determinations. One commenter believed the regulations appear to state that PRO review determinations are final and binding, but believed that all cases should be subject to appeal.

Response: In responses for the first comment, the regulations at § 466.85 provide that, if a PRO has assumed review responsibility, the PRO, in fact, is responsible for making determinations based on medical necessity, reasonableness and level of care. However, the fiscal intermediary will continue to make coverage determinations on other bases, including whether the service is a statutorily excluded service. It is bound, for payment purposes, by a PRO determination with respect to a medical necessity issue. Regarding the last comment, PRO initial denial determinations are final and binding, subject to appeal under 42 CFR Part 473. Final regulations for Part 473 are published elsewhere in this issue of the **Federal Register.**

Comment: One commenter believed that the regulations should state that the PRO's determination about whether outpatient or other inpatient care is appropriate must be consistent with medical care in the community and must take into consideration the availability and accessibility of care to the patient.

Response: Although we basically agree with the commenters, we do not believe the regulations should address these specific issues. In developing their review criteria, PROs must take into consideration the appropriate medical care in the community.

Comment: Two commenters objected to the need for hospitals to reinstate physician certification. The commenters believed that this will be an administrative burden on hospitals.

Response: The PRO statute does not contain the provision included in the PSRO statute at 1156(d)(1)(B) of the Act that permitted the use of PSRO review to meet the physician certification requirements of the Act. Therefore, to be consistent with the PRO statute, we are retaining this provision for the final rule.

H. PRO Access to Non-Medicare Patient Records (§ 466.88)

Comment: Thirty-five commenters argued that the proposed regulations regarding a PRO's access to the medical records of non-Medicare patients (§ 466.88(b)) are contrary to the provisions of the statute. Section 1866(a)(1)(E) of the Act requires a hospital to release these records to a PRO for its conduct of review under a contract with a private or public agency. As written, the proposed regulations would allow a hospital to deny the PRO access to the medical records of non-Medicare patients. One commenter also questioned whether the working aged are considered Medicare patients when Medicare is not the primary payor.

Response: We agree with the commenters and are revising § 466.88(b) to provide that a PRO may obtain non-Medicare patient records relating to review performed under a non-Medicare PRO contract, if authorized by the patient under State law. This includes records of the working aged and beneficiaries who are dually entitled under Titles XVIII and XIX. However, when these beneficiaries are receiving Medicare services, all Medicare review rules apply. A PRO may also obtain non-Medicare patient records in accordance with its quality review responsibilities under the Act, only if authorized by the institution or practitioner.

Quality review is an integral and essential element of the PRO statute. Section 1154(a)(1)(B) of the Act specifies that any PRO must (in accordance with its contract with the Secretary) perform review to determine whether the quality of care provided to Medicare beneficiaries meets professionally recognized standards of health care. This PRO requirement represents the continuation of a peer review function mandated by the Medicare statute over the past ten years. In section 1154(a)(8), the Congress provides the same process for PROs as it had for earlier Medicare peer review for prescribing the way in which quality review would be performed by PROs, namely, regulations of the Secretary. Furthermore, the provisions of section 1154(a)(7)(D) and (a)(9) direct PROs, in a way similar to earlier peer review organizations, to inspect facilities and collect information necessary to carry out PRO review functions, including quality review. Section 1866(a)(1)(E) imposes a similar obligation on Medicare providers to release patient care data to PROs for

review purposes including the conduct of Medicare quality review. Taken together, these provisions give statutory authority to PROs to conduct quality review in the same manner as conducted by previous Medicare peer review organizations.

The quality review process consists of screening patient care information to identify and verify quality problems in addition to conducting quality review studies. A quality review study is an assessment conducted by or for a PRO of a patient care problem for the purpose or improving the patient care of some or all providers or practitioners in the PRO area through peer analysis, intervention, and resolution of the problem and follow-up.

While the problem studied must affect Medicare patients, it usually affects other patients as well, especially in the context of acute inpatient care. This is because quality problems relate to the way in which care is delivered (i.e., the behavior of a provider or practitioner). In some of these cases, a problem can be adequately addressed for Medicare patients only by addressing the problem for all patients in an acute care setting.

This means that in some quality review studies a PRO must review both Medicare and non-Medicare patient records in order to resolve the problem for Medicare patients. For example, a Medicare quality review study may seek to analyze and resolve a problem in the use of prophylatic antibotics in certain operations which, when not used, increase the rate of infections post-operatively. However, for individual providers or specific practitioners, the frequency of certain operations for Medicare patients may be too low to draw reliable conclusions about the proper use of these antibiotics by that practitioner or in that provider on a timely basis (i.e., it may take a year of data collection for Medicare patients only). In contrast, the frequency for these operations performed on all patients may be adequate to permit timely and reliable assessment of the problem (i.e., within one to three months) and permit more rapid problem resolution for Medicare patients.

Also, physican and hospital-wide studies encourage general resolution of problems through the alteration of area practice patterns. This benefits both Medicare and non-Medicare patients and assures more substantive and longer lasting improvement in a problem than could have been achieved by focusing only on Medicare patients.

I. Examination of the Operation and Records of Facilities (§ 466.88)

Comment: Several commenters believed that PROs should only examine hospital information and charges for outlier cases and those other items required by law. Other commenters felt the language in § 466.88 is vague and requires PROs to duplicate fiscal intermediary efforts. Other commenters requested that we specify what aspects of a hospital's operation a PRO can examine and that PROs should be required to submit results of inspections in writing to the facility. Another commenter noted that the proposed regulations that allow a PRO to examine a hospital's operation in order to determine a hospital's capability to perform review should refer specifically to quality review, as this is the only review that may be delegated to a hospital. Another commenter questioned whether the facility may have access to PRO records.

Response: We believe that the regulations are consistent with the statute, which gives PROs the authority to inspect facilities and records of health care facilities and providers for the purpose of carrying out their responsibilities as specified in the Act. PROs may require hospital charge information for many types of review, such as ancillary services or quality review of inappropriate utilization. We have, however, deleted the reference to cost information from § 466.88(a) because we do not anticipate a need by PROs for this information in carrying out their statutory and contractual responsibilities. PRO review does not duplicate fiscal intermediary review because the functions of each are coordinated as described in § 466.88 of these regulations. For example, only PROs will make determinations based on medical necessity, reasonableness and appropriateness of inpatient care. Only fiscal intermediaries will make coverage determinations on services excluded by statute. The results of PRO review will be made known to hospitals in accordance with provisions that will be included in 42 CFR Part 476. We agree with the comment that the reference to the capability of the facility to perform review should refer specifically to quality review, and we have revised § 466.88(a)(3) accordingly.

J. Lack of Cooperation by a Health Care Facility or Practitioner (§ 466.90)

Comment: Some commenters questioned whether, if a PRO denies a claim because the hospital did not submit requested information, the hospital can then submit the information and request a reconsideration. Two commenters believed that the proposed regulations at § 466.90 are vague and requested definitions and clarifications.

Response: If a PRO denies a claim because a hospital did not submit requested information, the hospital may request a reopening of the case after submitting the requested information in accordance with regulations in 42 CFR Part 473. Final regulations for Part 473 are also published in this issue of the **Federal Register.** We are not making any significant changes to § 466.90 because we believe that the terms used in the section have been defined or explained elswhere in the text of the regulations.

K. Opportunity to Discuss Proposed Initial Denial Determination (§ 466.93)

Comment: Seven commenters recommended that we revise the proposed requirement that a PRO afford an opportunity for the provider and physician (or other attending health care practitioner) to discuss a proposed initial denial determination with the PRO physician advisor. The commenters believed that this requirement should not apply when a retrospective review is performed by the PRO after the patient is discharged from the hospital because it would result in an increased administrative burden to the PRO and would be impossible to implement. One commenter also suggested that if retrospective review is performed, an exit interview should be furnished to the hospital upon request. Another commenter questioned whether there is a need for both the provider and practitioner to discuss the proposed denial.

Response: Section 1154(a)(3) of the Act requires the PRO to afford an opportunity to the provider and practitioner to discuss any initial denial determination. In addition, our proposed rule would increase review flexibility and reduce the costs of issuing unnecessary denials or conducting reconsiderations by providing an opporutnity for discussion to both provider and practitioner prior to issuing a denial. We believe this is a more efficient and less cumbersome procedure than exit interviews or retrospective denials alone.

Comment: A hospital association suggested that the PRO should be required to notify the provider and the physician of the proposed denial within 24 hours of the denial decision. Another commenter recommended that the provider and physician be given 24-hours to respond to the PRO's notification.

Response: We do not believe it would be appropriate for the regulations to require a 24-hour limit for notification of the provider and practitioner or for their response. However, in their individual agreements with PROs, hospitals may wish to negotiate these types of provisions.

L. Notice of PRO Initial Denial Determination (§ 466.94)

Comment: Several commenters objected to the proposed requirements that the content of a PRO's notification to a patient of an initial denial determination be the same as that used to notify the practitioner or provider. The commenter argued that, since in most cases the patient would not be liable for payment, it is inappropriate to include the same amount of detail that would be given to the practitioner or provider. Another commenter believed the notice to the patient should only be issued after all local appeals are completed.

Response: Section 1154(a)(3) of the Act specifically requires that the PRO promptly notify the practitioner, provider, patient and payment agency of the denial decision. The Act does not specify that the patient should receive a less detailed notice than the other parties. Therefore, we believe it appropriate that the patient be fully informed and receive the same notice as the other parties and at the same time. Also, in order to appeal a denial determination, a patient must receive timely notice of the denial.

Comment: Three commenters believed that the regulations should contain the specific requirements for the content and format of the denial notice in order to ensure that the notices are understandable, complete, written in plain English, and clearly represent the nature of the PRO's decision. The commenters believed the PRO and the hospital should negotiate the wording of the notice.

Response: We believe the wording of the denial notice is the responsibility of the PRO and should not be subject to negotiation with the hospital. We do agree with the commenters that the regulations should contain specific requirements for the content of the denial notices and we have included appropriate language in § 466.94 of the final rule. Also, we will be monitoring PRO denial notices to ensure that they can be understood by all parties and do not cause unnecessarily adverse reactions among the recipients.

Comment: One commenter believed the regulations should not limit when a patient's representative can be involved.

Response: We believe the regulations adequately provide for the protection of the patient and the inclusion of a patient representative, when appropriate.

Comment: One commenter pointed out that since Saturday and Sunday are not always working days, it might take three days for the delivery of a denial notice. The commenter also questioned what "prompt written notice" to the fiscal intermediary would be and suggested it be the same timeframe as the issuance of the notice to the other parties.

Response: We agree with the commenter and have revised the proposed § 466.94(c) (this is § 466.94(a)(2) in the final rule) to specify that the time periods for delivery of the notices are all in terms of "working" days, rather than calendar days. We have also revised the timeframe for the notice to the fiscal intermediary to be the same as the notice to the other parties. We have also added timeframes for the notice to the practitioner and provider regarding changes as a result of a PRO's DRG validation.

M. Review Period and Reopening of Denial Determinations (§ 466.96)

Comment: Three commenters suggested that a PRO should not have more than 120 days to deny payment, rather than the one year generally specified in the regulations. Another commenter suggested that the proposed § 466.96(b) that would allow denial determinations to be made within four years of the date of the claim for service should be deleted because all reviews should be completed within one year.

Response: We believe the timeframes specified in the regulations are appropriate because they are similar to other Medicare review time limits at § 405.750(b)(2). To assure the efficiency of the review process, we are limiting to one year the time period during which a PRO may on its own make or reopen an initial denial determination or a change as a result of a DRG validation. In addition, we are revising § 466.96 to allow up to four years for an initial determination change or a change as a result of a DRG validation to be made, reconsidered or revised as described in the regulations. We have deleted the proposed requirement that these actions first be approved by the HCFA Regional Administrator.

N. Reviewer Qualifications and Participation (§ 466.98)

Comment: Several commenters believed that doctors of medicine (M.D.s) and osteopathy (D.O.s) should be allowed to review each others' care. Other commenters suggested that specialists be able to request review by another specialist in the same discipline. Another commenter was concerned that only appropriately qualified medical record personnel perform DRG validation. Another commenter believed the regulations should prohibit a person from performing review who is connected with a facility that is in competition with the facility under review. Also, one commenter suggested that any physician who receives compensation from a hospital should be prohibited from performing review. Another commenter believed the role of the non-physician in the review process should be detailed in the regulations.

Response: We believe it is the intent of the statute and the most effective method of peer review, for M.D.s to review M.D.s, and D.O.s to review D.O.s. We have, however, made an exception to this rule when the appropriate peer is not available to perform the review. Although the suggestions of the commenters regarding review by specialists may have merit, we do not believe these requirements should be included in regulations. However, we have revised the regulations to require that changes as a result of DRG validations be made by a physician and that individuals with training and experience in ICD–9–CM coding must review the technical coding issues. Additionally, the final regulations in Part 473 published elsewhere in this issue of the Federal Register do require that the reconsideration reviewer be a professional peer of the practitioner under review. Regarding the next two comments, we do not believe it is appropriate to include these limitations on the qualifications of reviewers. We believe that the regulations adequately protect against a conflict of interest and that further restrictions are not necessary. Regarding the last comment, we believe that § 466.102 adequately addresses the role of non-physicians in the review process.

O. Use of Norms and Criteria (§ 466.100)

Comment: Several commenters believed that the regulations do not reflect the Congressional intent that PROs use local norms, taking into consideration national norms. Other commenters expressed concern that the PRO may be discriminatory in applying different criteria to different locations and facilities. Other commenters suggested that the PRO be required to describe to the hospital how it arrived at the numbers of procedures selected for preadmission review. Another commenter believed the PRO should be required to make available to the

hospital the criteria, norms and standards used in review. Another commenter suggested that the regulations specify the body of knowledge to be used to determine national norms.

Response: Section 1153(c)(7) requires that negotiated PRO contracts include specifications for use of regional or national norms for setting contract objectives and performing review functions. Norms are statistical values used to establish standards of care and PRO objectives. In contrast to these norms, section 1154(a)(6) of the Act specifies that in their review PROs must use professionally developed norms based upon typical patterns of practice within the PRO area. These are in fact review criteria which are developed by each PRO. Criteria may reflect special circumstances in the PRO area. Regarding the last comment, the PRO agreement with the hospital should contain the specifics for exchange of data, including review criteria.

P. Coordination of Activities

Comment: One commenter suggested that PRO's should be allowed to exchange only aggregate data and that the regulations should preclude disclosure and redisclosure of unauthorized information. Another commenter suggested that the information should be exchanged only with those who have a financial interest in the case.

Response: The exchange of data is governed by the PROs review responsibilities as set forth in section 1154 of the Act. In some cases, the data may be aggregated, but in other cases may contain more detailed information. Regulations governing the acquisition, disclosure and redisclosure of PRO data will be contained in 42 CFR Part 476 and will be published in the **Federal Register.**

Q. HMOs

Comment: Two commenters suggested that HMO patients be exempted from review because the HMO receives a prospective payment and the HMO already has an incentive to provide efficient care.

Response: The statute does not exclude HMO patients from PRO medical review. We believe that PRO review is important because the quality of care is a critical issue for HMO and other patients treated on a capitated payment basis. Therefore, we are not revising the final rule to exempt HMO patients from PRO review.

R. Hospital Issued Denial Notice

Comment: One commenter suggested that the regulations provide that a patient be entitled to an expedited review of the hospital's denial notice and that the hospital be required to notify the patient of appeal rights before the notice is issued. Another commenter questioned whether the provisions of § 466.78(b)(4) are in conflict with a hospital's right to issue denials because that section would require that hospitals issue denials only in accordance with their agreement with the PRO.

Response: Regulations concerning the timing and review of hospital-issued denial notices are contained in § 412.42(c)(3) (previously § 405.472(b)(1)(iii)(C)). Therefore, we are revising § 466.78(b)(4) to specify that when a hospital has issued a written determination in accordance with § 412.42(c)(3) that a beneficiary no longer requires inpatient hospital care, it must submit a copy of its determination to the PRO within 3 working days.

S. Impact

Comment: Four commenters believed that the impact analysis that appeared in the NPRM was incorrect in stating that the regulations will not have an annual effect of $100 million.

Response: In the Impact Analysis of this final rule, we have included a voluntary regulatory impact and regulatory flexibility analysis. The analysis acknowledges that a substantial number of facilities, practitioners and beneficiaries will be affected by implementing the PRO program. However, for the following reasons, we believe that the annual impact will not be significant, nor will it meet the $100 million threshold criterion. The reasons we cite are: (1) The primary impact results from Congressional intent and from the individual PRO contracts; (2) the incremental differences between most PRO and previous peer review activities are not significant; and (3) the effect of PRO activities may not be the primary cause of these impacts. The influence of other factors like the prospective payment system and other third-party payor review efforts to reduce unnecessary admissions and procedures, may have a greater impact on costs than the effects of the PRO activity.

T. Objectives

Comment: Several commenters expressed concern that the objectives are, in fact, quotas and that they could have a negative impact on quality. Another commenter was concerned that setting unrealistic objectives will erode PRO credibility with the medical community. Some commenters were concerned that PROs would be held accountable for their contract objectives even though circumstances beyond their control prevented them from accomplishing their objectives.

Response: While PROs have negotiated specific contract objectives in accordance with requirements contained in section 1153(c)(7) of the Act, these objectives are targets, or quotas. We recognize that there are circumstances under which the objectives may need to be modified. For example, quality objectives would be modified if data developed during the course of the contract demonstrates that the problem targeted is not as severe as previously thought, or if the PRO identifies a different problem of greater importance. Utilization objectives would be modified as a result of demographic shifts (for example, an influx of Medicare beneficiaries into the PRO service area), the effects of new technology, etc.

This approach will allow us to be responsive should circumstances for the PRO change significantly, while also retaining the accountability and performance incentives built into a specified, outcome-oriented contract. In addition, we will periodically review all PRO required review activities to evaluate their appropriateness and cost effectiveness.

U. Medicaid Provisions

Comment: One commenter objected to the provision that reimburses a State at 75 percent when they contract with a PRO to perform medical and utilization review, but only 50 percent when they contract with any other organization. Another commenter questioned what the reimbursement will be for those States with superior utilization review systems waivers granted under 42 CFR 456.505, currently reimbursed at 75 percent.

Response: Sections 1903(a) (2) and (7) of the Act provide that States will be reimbursed at 75 percent for the cost of utilization review activities performed by a PRO under contract with a State or by State employees but only 50 percent for review performed by others under a contract. Under section 1903(a)(2) of the Act, States that have been granted superior systems waivers to perform utilization review activities can be reimbursed at 75 percent for those activities performed by State employees.

Comment: One commenter pointed out that we had an incorrect cross-reference in § 431.630(b).

Response: We agree and have corrected the cross-reference in the regulations text.

V. Definitions

Comment: One commenter pointed out that the definition of grace days conflicts with 42 CFR 405.472. which requires 2 graces days after termination of benefits.

Response: Grace days as used in our proposed definition at 42 CFR 466.1 and as defined in 42 CFR 405.330 refer to additional days of Medicare payment (not more than 2 days) that a PRO or fiscal intermediary may, at its discretion, provide to arrange for post discharge care. In contrast, the provisions at § 412.42(c) (previously § 405.472(b)) describe when a hospital may begin to charge a beneficiary for services provided during a stay otherwise covered by a DRG payment. These provisions do not provide for additional Medicare payment but do specify when a hospital may charge the beneficiary (i.e., the day after the second day after the issuance of a hosptial denial notice). Therefore, we believe our explanation of grace days is appropriate. We note that we are deleting the definition of grace days that was in our proposed § 466.1 because we did not specificially refer to grace days elsewhere in the proposed rule. We have, however, included our explanation of the term at § 466.70(d). We also note that we are changing our explanation of grace days. We previously stated that PROs may grant grace days for the purpose of arranging for post discharge care when neither the provider nor the patient knew or could reasonably be expected to have known that Medicare payment for the service would not be made. In accordance with section 1154(a)(2)(B) of the Act, we have revised our explanation to refer only to the provider's lack of knowledge regarding coverage of services.

Comment: Two commenters believed that the definition of "active staff privileges" is unduly restrictive. Many practitioners, such as psychologists, have privileges to practice independently in the hospital, but do not have admitting privileges. One commenter suggested that the definition include practitioners who are authorized to perform diagnostic services in a facility on a regular basis.

Response: The PRO program is a medical peer review program. To achieve true peer review, we believe it is essential that any PRO reviewing physician be actively practicing his or her profession which includes admitting patients to acute care hospitals.

Comment: One commenter questioned why the definitions of "length of stay norms" and "length of stay projections" only refer to PSROs. The commenter believes these definitions should also apply to PRO outlier reviews.

Response: We have revised these definitions to apply to both PSROs and PROs. PROs will be performing length-of-stay review in both non-PPs and specialty hospitals.

Comment: One commenter suggested that the definition of "quality review study" should include the element of follow-up to the problems identified to ensure that they are corrected.

Response: We agree with the commenter, and have added the element of follow-up to the definition of "quality review study".

Comment: One commenter suggested that the regulations should include a definition of "criteria".

Response: The definition of "criteria" is already contained in § 466.1. The definition did not appear in the July 17th **Federal Register** publication because the definition is unchanged from that contained in current regulations.

IV. Final Regulations

Based on the comments received and other considerations, we are making the following changes to the proposed rule. We also have made technical changes to the proposed regulations to correct drafting errors and to simplify and clarify certain sections.

A. Statutory Provisions

In the proposed § 466.70(a), we are replacing the reference to specific legislation with the important statutory cites relating to PRO review responsibilities. We are revising the proposed § 466.70(b) that is redesignated as § 466.70(c) to include the requirement that PROs make determinations as to whether a hospital has misrepresented admission or discharge information or has unnecessarily admitted patients to a hospital. This conforms to existing regulations at § 412.48 (previously § 405.472(e)). We are revising the proposed § 466.70(c) that is redesignated as § 466.70(d) to conform to section 1154 of the Act that specifies that a PRO cannot make payment determinations based on the quality of care. Additionally, in § 466.70(d), we are specifying that PROs may grant grace days. In accordance with section 1154(a)(2)(B) of the Act, we refer only to the provider's (and not the patient's) lack of knowledge regarding coverage of services.

B. General Requirements for the Assumption of Review

We are revising § 466.74(e) to require that PROs compile statistics to determine a provider's favorable presumption status and notify the provider of its status.

C. Responsibilities of Health Care Facilities

We are revising § 466.78(a) to conform to section 1866(a)(1)(F) of the Act as revised by the DRA to require that effective November 15, 1984, all hospitals seeking payment under Medicare must maintain an agreement with a PRO. We also are specifying that the agreement must be in writing. In order to allow time for these agreements to be established, we are specifying that this provision is effective June 17, 1985 rather than May 17, 1985 which is the effective date for the other provisions of this rule.

We are revising the proposed § 466.78(b) to specify that when a health care facility has issued a written determination in accordance with regulations at § 412.42(c)(3) (previously § 405.472(b)(1)(iii)(C)), it must submit a copy of its determination to the PRO within 3 working days. We are revising § 466.78(b)(5) that requires a facility to assure that each case subject to preadmission review has been approved by the PRO before admission. We are adding the alternative that the facility assure that a timely request for the PRO preadmission review has been made. In § 466.78(b)(6), we have deleted the proposed provisions that would have assigned financial liability to a hospital in cases in which both the patient and the provider had knowlege that a proposed admission was medically unnecessary, unreasonable or inappropriate. We are also adding a provision to state that a facility is not automatically liable if, in accordance with its agreement with the PRO, it makes a timely request for preadmission review and the PRO does not review the case. This type of case is subject to retrospective prepayment review.

D. Coordination with Medicare Fiscal Intermediaries and Carriers

For consistency, we are changing the references to an "MOU" in this section to "agreement". We are also adding language in § 466.80(b) to provide that the PRO inform intermediaries and carriers of changes that result from DRG validations and the revisions that result from the review of these changes. In § 466.80(e) that specifies that an intermediary will not make payment unit it receives notice that the PRO has

approved the admission, we are specifying that the PRO's approval will be after a preadmission or retrospective review.

E. Initial Denial Determinations

We are revising the proposed § 466.83 to include a clarification of what constitutes an initial denial determination. We are redesignating the proposed § 466.84 as § 466.85 and adding a new § 466.84 to explain that changes as a result of DRG validations may be reviewed by a PRO in accordance with 42 CFR Part 473. The newly designated § 466.85 is revised to specify that both PRO initial denial determinations and changes as a result of DRG validations are final and binding unless reconsidered, reviewed and revised in accordance with Part 473. We note that we have made changes in several other sections of the proposed regulations in order to include the PRO review activity regarding DRG validation.

F. Correlation of Functions

We are revising the format of the proposed § 466.86 for clarity. In some cases, we are changing the citations of the statute to the appropriate citations of the regulations. In § 466.86(a)(1)(iv), we are clarifying that PRO determinations regarding the appropriateness of the setting are conclusive for payment purposes. Additionally, we are revising and adding the proposed § 466.92(b) to § 466.86 of the final rule because both sections concern coverage determinations.

G. Examination of the Operation and Records of Facilities

We are revising § 466.88(a) and (c) to delete the requirement that facilities permit a PRO to examine their cost information. We are revising § 466.88(a)(1) that lists certain PRO functions for which a facility must provide the PRO access to its records and operations. We are specifying that PRO access is not limited to the functions listed. We also are revising the proposed § 466.88(a)(3) to specify that a facility must permit a PRO to examine its operation and records to evaluate the facility's capability to perform quality review. We are revising the proposed § 466.88(b) that previously permitted a PRO to have access to non-Medicare records only if authorized by a facility or practitioner. We are now stating that a PRO may examine these records if: (1) The records relate to review performed under a non-Medicare contract and if authorized by the patient in accordance with State law, or (2) necessary to perform quality review functions and if authorized by the facility or practitioner.

H. General Requirements for PRO Review

We are deleting the proposed § 466.92(a) regarding certain coverage issues that are involved in making a determination of the appropriateness of care. We are deleting this provision because the regulations contain a similar statement in § 466.86(c) that the Medicare fiscal intermediaries and carriers are not precluded from applying Medicare coverage policy rules. Additionally, we are adding the language contained in the proposed § 466.92(b) to § 466.86(c) since these sections are related and should be grouped together.

I. Notice of PRO Initial Denial Determination or Changes as a Result of a DRG Validation

We are revising the format of the proposed § 466.94 for clarity. In § 466.94(a) of this final rule, we discuss specific requirements for initial denial determination notices, including the parties to be notified and the timing of the notice. We are adding a requirement to this paragraph that PROs must document that the patient and facility receive notice of the initial denial determination in cases of preadmission review. We are clarifying that the time periods for the delivery of the notices are in terms of "working" days.

Also, we are adding a new paragraph (b) to include specific requirements for notice of changes as a result of DRG validations. We are including in this final rule at § 466.94(c) a requirement that PRO determination and DRG change notices be understandable and written in plain English.

Finally, we are revising § 466.94(d) and (e) to require that PROs notify payors of changes as a result of DRG validations and to expand the record retention requirements to include a record of these changes.

J. Review Period and Reopening of Determinations

We are revising the proposed § 466.96 for clarity and to include requirements for the review and reopening of changes as a result of DRG validations. We are limiting the time period to one year in which a PRO may make an initial denial determination or a change resulting from a DRG validation on its own. We are deleting the requirement in the proposed § 466.96(b) that denial determinations made after one year but within 4 years be approved by the HCFA Regional Administrator. Instead, we are requiring that HCFA evaluate on a case-by-case basis whether the PRO will be permitted to make an initial denial determination or change as a result of DRG validation after the one year review period but within 4 years. In evaluating whether the PRO may make an initial denial determination or change DRGs, within the 4 year period, HCFA will assess whether the potential benefits of the review activity are justified in terms of the administrative burden on HCFA. We are also adding a provision stating that if there is an error on the face of the evidence, an initial denial determination or change as a result of a DRG validation may be reopened after one year but within four years. We inadvertently omitted this in our proposed rule but had included it in the proposed regulations for 42 CFR Part 473 concerning PRO reconsiderations and appeals (49 FR 29041). We note that the provision allowing PROs to review, at anytime, claims involving fraud or abuse, includes claims that may not have been previously reviewed by the PRO or those that were reviewed but were not denied by the PRO.

K. Reviewer Qualification and Participation

In § 466.98, we are adding a new paragraph (c) and redesignating the proposed paragraph (c) as (d). The new provision clarifies that decisions about procedural and diagnostic information must be made by physicians. However, (OIG) technical coding issues must be reviewed by individuals with training and experience in ICD–9–CM coding. This change conforms to regulations in Part 473 that are published elsewhere in this issue of the **Federal Register.**

L. Definitions

We are making several changes to the definitions located at § 466.1 as follows:

- We are deleting the proposed definition of "annotation" because we had previously deleted the reference to this term in the regulations text.
- We are revising and moving the definition of "area" to § 400.200 that contains definitions for terms used throughout 42 CFR Chapter IV.
- We are deleting the reference to PSROs in the definition of "concurrent review" so that the definition applies to both PSROs and PROs.
- We are deleting the definition of "denial" because we have added further explanations of denials in §§ 466.84 and 466.85.
- We are revising the definition of "DRG" for clarity.
- We are deleting the defintion of "grace days" because we did not specifically refer to grace days in the

proposed rule. We note, however, that we are adding a provision at § 466.70(d) that states that PROs may grant grace days and explain the term.

- We are deleting the definition of "health care service" because this term is self-explanatory.
- We are deleting the reference to PSROs in the definitions of "length-of-stay norms" and "length-of-stay projections" so that the definitions apply to both PSROs and PROs.
- We are revising the definition of "non-facility organization" for purposes of clarity and to specify that it does not include entities that are owned by one or more associations of health care facilities. This requirement is specified in section 1153(b)(3) of the Act and we inadvertently omitted it from our proposal.
- We are adding the definitions of "preadmission certification", "preadmission review" and "preprocedure review".
- We are deleting the definition of "PRO" because it appears in § 400.200 that contains definitions that are used throughout 42 CFR Chapter IV.
- We are deleting the proposed definition of "provider" because this term has been defined in § 400.202. Since the definition we proposed included suppliers, we are making specific reference to suppliers where applicable in the regulations text.
- We are revising the definition of "quality review study" to limit it to the quality review studies conducted by or for a PRO for a patient care problem. We are also including an element of follow-up to the definition.
- We are revising the definition of "review responsibility" to delete an incorrect reference to a PRO's payment determination based on the quality of health care. We are also adding language to clarify that PRO decisions regarding changes as a result of DRG validations are conclusive.
- We are deleting the definition of "Utilization and Quality Control Peer Review Organization" because it is being added to the definitions in § 400.200 by anothe final rule published elsewhere in this issue of the **Federal Register** regarding the acquisition, protection and disclosure of PRO information.

We also are deleting the definitions of "area" and "PRO" in § 460.1. We are also deleting the definition of "PRO" in § 462.2 (that we are redesignating as § 462.1). These definitions are being deleted because they appear in 42 CFR Part 400 that is the general definition section for 42 CFR Chapter IV.

We are revising the definition of "payor organization" in the newly redesignated § 462.1 to conform with section 1153(b)(2)(A) as amended by DRA.

M. Other Technical and Conforming Changes

We are revising Part 405, Subpart G that contains the reconsideration and appeals procedures for Medicare Part A services. Specifically, we are revising § 405.704 that lists actions that are initial determinations to cross-reference Parts 466 and 473 regarding initial and reconsidered determinations made by a PSRO or PRO.

We are revising § 412.44 (previously § 405.472(c)) regarding medical review requirements for hospitals under the prospective payment system to more accurately reflect a PRO's review responsibilities. As revised, this section is consistent with the description of PROs' responsibilities in § 466.70(c)(4), (5), (6), and (7).

We are revising § 412.82(b) (previously § 405.475(c)(2)) to provide that a medical review entity (for example, a PRO) grants grace days for day outliers under the prospective payment system for inpatient hospital care.

We are deleting references to PSROs in § 431.630 regarding the coordination of Medicaid with peer review organizations to conform to section 1902(d) of the Act.

In § 456.2 concerning States contracting with PSROs, we are deleting a cross-reference to § 431.630 since we are no longer referring to PSROs in that section in accordance with section 1902(D) of the Act.

Again, in accordance with section 1902(d) of the Act, we are deleting the cross-reference to § 431.630 in § 456.650. We also are revising the language in the proposed § 456.650(c)(3) for consistency with paragraph (c)(2). We are deleting the proposed § 456.652(d) that would have implemented a penalty provision for States, contracting with PSROs or PROs, if the State failed to submit a quarterly showing that it met physician certification, recertification and plan of care requirements. The DRA amendments which deleted sections 1903(g)(1)(A) and (B) of the Act, removed the penalty provision for those States not meeting these patient care requirements. Instead, the patient care requirements are now included under the State plan requirements located at section 1902(a)(44) of the Act.

We will not require that States, after they have entered into a contract with a PSRO or PRO, to submit quarterly showings that they meet the patient care requirements except for the first quarter following the effective date of the contract. This will serve as notification to us to exclude that State or those particular facilities from our validation reviews. As specified in the proposed § 456.654(a)(5) and now in § 456.654(a)(4), if a facility is being reviewed by a PRO, the State need only list the date the PRO assumed review authority on the quarterly showing for that facility. However, a quarterly showing will continue to be required for any facility not being reviewed by a PRO or for any level of care that is still being reviewed by the State.

We are amending 42 CFR Part 462 regarding peer review organizations to establish a new Subpart A to include the definitions located at § 462.2. We are redesignating this section as § 462.1. Also in Part 462, we are making changes to §§ 462.102, 462.103 and 462.105 for clarity. We are revising § 462.105 to conform to section 1153(b)(3)(B) of the Act that defines an entity affiliated with a health care facility or association of facilities. We are further revising §§ 462.105 and 462.106 to conform to section 1153(b)(2)(A) that permits Medicare fiscal intermediaries to serve as PROs effective November 15, 1984. We are deleting the text at § 462.107(d)(2) because it duplicates the provisions contained in § 462.106.

V. Impact Analyses

A. Introduction

Executive Order 12291 requires us to prepare and publish a regulatory impact analysis for any regulations that are likely to have an annual effect on the economy of $100 million or more, cause a major increase in costs or prices, or have a significant adverse effect on competition, employment, investment, productivity, or innovation. In addition, the Regulatory Flexibility Act, Pub. L. 96–354, requires us to prepare and publish a regulatory flexibility analysis for regulations unless the Secretary certifies that the regulations will not have a significant economic impact on a substantial number of small entities. Under both the Executive Order and the Regulatory Flexibility Act, such analyses must, when prepared, show that the agency issuing the regulations has examined alternatives that might minimize an unnecessary burden or otherwise ensure that the regulations are cost-effective.

In the Impact Analysis section of the proposed rule published on July 17, 1984, we stated that the effects of the regulation were not significant to the point of requiring a regulatory impact analysis or a regulatory flexibility analysis. However, after further review

of our proposed policies and as a result of substantive issues raised by the public commenters, we have decided to include a voluntary regulatory impact and regulatory flexibility analysis in this final rule. This analysis focuses primarily on the nature of the incremental differences between the PRO and PSRO programs and also on the impact of these differences on certain affected parties (e.g., the Federal government, hospitals, physicians, beneficiaries and recipients). Together with several specific comments noted in the preamble, the following discussion constitutes a voluntary analysis of this final rule.

B. Background

Since the inception of the Medicare program in 1965, and the Medicaid program in 1967, Utilization review has been an ongoing activity to assure that Federally reimbursed health care was furnished only when medically necessary. The Social Security Amendments of 1972 established the PSRO program to assure that the health services and items for which Federal payment is made conformed to appropriate professional standards and were delivered in the most efficient and economical manner possible. The Peer Review Improvement Act of 1982 focused on ". . . promoting effective, efficient, economical delivery of health care services and promoting the quality of services of the type for which payment may be made under this title . . ." (Congressional Record—August 17, 1982, page H6185). Thus, throughout the history of the Medicare and Medicaid programs, utilization and peer review strategies have been maintained to safeguard program expenditures and the quality of services and items provided to programs beneficiaries.

C. PROs and PSROs—Differences and Similarities

As noted in the background discussion in the NPRM, there are differences and similarities between the PSRO and PRO programs. A general discussion of these points will focus on significant distinctions between these programs and the effect these differences have on affected parties.

There are notable differences between the two programs. They include:

- PROs are expected to achieve specific, outcome oriented measurable objectives. PSROs emphasized the process of review.
- The funding mechanism (PRO contracts *vs.* PSRO grants) and length of the agreement (2-year PRO contracts *vs.* 1-year PSRO grants).
- The responsibilities of PROs to monitor potential utilization and quality problems inherent in the prospective payment system (increased admissions, multiple transfers, early discharges, procedure coding abuse). PSRO review was not strongly focused on outcomes or system impact.

The similarities between the PRO and PSRO programs include:

- Safeguarding Medicare and Medicaid funds from unnecessary and inappropriate expenditures.
- Using various initiatives to educate physician and hospital staff regarding more effective, efficient and economical ways to provide health care services to program beneficiaries.
- Conducting medical reviews by peers.

In this analysis, we are focusing on the impact of the provisions in the rule that are new or modifications to the current peer review effort. In particular, we will examine the effects of the PROs' assumption of review on hospitals under the prospective payment system and for all other facilities, practitioners, and beneficiaries.

D. The Nature of Estimated Impacts Resulting from this Final Rule

In discussing the expected impacts (benefits, costs and behavioral changes) resulting from the final rule, several contraints limit our ability to determine the nature and extent of the impacts. First, PRO efforts are related to the purpose and goals of the prospective payment system. The prospective payment system endeavors to change hospital behavior through financial incentives under Medicare. The PROs act as a safeguard to assure that, as certain behavorial changes occur in response to prospective payment system incentives, program abuses do not occur to adversely affect beneficiaries or the Medicare program. Therefore, it will be difficult to differentiate clearly the impact of PRO efforts from those of the prospective payment system.

A second consideration is that States, other third-party payors and numerous business health care coalitions are also examining the behavior of hospitals and practitioners in hopes of reducing unnecessary and inappropriate expenditures and services. Their efforts, which in some case are the result of PROs' initiatives through private contractual arrangements, will also serve to reduce unnecessary and inappropriate admissions and services. While we view these efforts as beneficial in nature, they must be considered in determining the nature and extent of the effect of this final rule.

Finally, we believe that much of the impact of the PRO program results from the intent of Congress, as expressed in the statute, rather than from this final rule.

For these reasons we believe that the impact of these regulations, as distinct from the total impact of the PRO program, will not be singularly significant. However, apart from these considerations, it is certain that a substantial number of hospitals, practitioners, beneficiaries, recipients and other parties, including the Federal government, will be directly or indirectly affected by this final rule.

E. Impacts on Affected Parties

1. *Medicare and Medicaid Programs.* As discussed in the Background section of this analysis, utilization and peer review programs have long been an integral part of both the Medicare and Medicaid programs. These medical review efforts have been safeguards over Federal expenditures for health care services and items furnished to Medicare and Medicaid beneficiaries. We believe that the PRO program will continue to assure that Federal funds will be spent only for necessary, reasonable and appropriate services and items and that beneficiaries will receive quality care.

To realize the continued safeguarding of Federal program expenditures and the provision of quality care, $339 million will be spent on the two-year PRO contracts for the period from the fourth quarter FY 1984 through the third quarter of FY 1986. Investing these Federal funds will enable the PROs to meet their individual contract objectives (admission, quality of care and utilization goals), and will result in certain dollar benefits to the government in excess of total contract costs. Also, we believe that by reducing inappropriate utilization, more Federal funds would be freed to provide needed care for a greater number of beneficiaries and recipients. Futhermore, reducing unnecessary utilization will lessen possible health complications and deaths that at times result from unnecessary admissions and inappropriate procedures. Thus, we believe that the Federal government will realize benefits of greater value than its expenditures in its effort to safeguard Federal Medicare and Medicaid program expenditures.

2. *Beneficiaries and Recipients.* Two issues of concern for Medicare beneficiaries and Medicaid recipients are the cost of health care, particularly out-of-pocket expenses, and the quality of care received from providers.

suppliers, and practitioners. As a result of PROs achieving their contractual objectives, we believe that beneficiaries and recipients will continue to receive necessary, reasonable and appropriate services and items. Beneficiaries, in particular, will be protected by PRO review from potential abuses that may result from the actions some providers may take in response to the incentives established by the prospective payment system (unnecessary increased admissions, inappropriate readmissions and unnecessary transfers to providers and units excluded from the prospective payment system.) Recipients in States operating under a cost reimbursement methodology will also benefit from the review activities of the PROs that will prevent unnecessary admissions and shortening lengths of stay. In both cases, individuals should save the out-of-pocket expenses (deductibles and coinsurance payment) related to unnecessary admissions, readmissions, transfers and lengths of stay.

In some instances, the impact of PRO review will be to change the site of service from inpatient to outpatient care. In these cases, the beneficiary would avoid paying the inpatient deductible amount ($400 in 1985), but would pay the amount of the outpatient deductible and coinsurance. To the extent that the sum of the out-of-pocket expense for the Part B services is less than the Part A deductible, the beneficiary will incur less personal liability than if the service was performed in an inpatient setting.

Regarding the quality of care issue, we believe that beneficiaries and recipients will benefit from the peer review efforts of the PROs. In particular, we note that individual beneficiaries and recipients will be advantaged by the reduction in the number of inappropriate or unnecessary admissions or procedures; by the anticipated outcomes of certain required review activities; and by the achievement of overall PRO objectives aimed at significant improvement in patient quality care. For example, we expect PROs will reduce avoidable deaths and complications after surgery. To the extent that PROs can achieve these quality goals, beneficiaries will benefit from the PROs' efforts.

Therefore, in summary, beneficiaries and recipients can anticipate beneficial outcomes in several respects, especially reduced personal expenditures, avoidance of unnecessary or inappropriate health services, and avoidance of unnecessary death and complications. We qualify this conclusion by noting that some beneficiaries could incur additional personal expenses under Part B if the site of care is changed from inpatient to an outpatient setting.

3. *Health Care Facilities.* Many of the public comments received on the proposed rule were from hospitals raising issues related to the impact of this rule on their operations. We are responding to many of these issues in the comment and response portion of the preamble. We also address in the preamble issues raised about other responsibilities and functions of health care facilities.

Earier in this analysis, we discussed the difficulties encountered in estimating precisely the impact of this rule. We noted that the requirements of the PRO statute itself have an impact on facilities; that in many respects the incremental differences between the impact of the PSRO program and the PRO program are not significant; and that the influence of the prospective payment system and the efforts of other third-party payors will also affect facilities.

However, even given these qualifications, we can identify several areas of potential impact that may result from implementing the PRO program. In summary, they include:

- A potential increase in reporting, recordkeeping and photocopying burdens that were not specifically part of the prospective payment rate calculations. As explained earlier in the preamble, collection of this information is necessary for PROs to make determinations that the items and services provided by a facility are necessary and appropriate.
- A reduction in expected Medicare payments to health care facilities. Some facilities, especially hospitals, can minimize the impact of potential payment denials, by ensuring that admissions are medically necessary and appropriate.
- Changes in behavior regarding the numbers and types of admissions. We believe that these changes will result from reductions in unnecessary and inappropriate admissions and procedures. Many other behavioral changes will result from the financial incentives of the prospective payment system that will be reinforced by PRO activity.

We believe that many of these costs and additional burdens will be offset by identifiable benefits to the facilities. For example, by providing PROs with needed medical record information for the PROs' conduct of preadmission review, in many cases hospitals will avoid the more burdensome retrospective denial process.

In summation, we believe that all health care facilities will benefit from PRO activity, particularly in light of the increasing fiscal constraints that are affecting many facilities. We believe that PRO initiatives will be effective in reducing some operating expenses that would otherwise be spent on unnecessary or inappropriate services.

4. *Physicians.* In recent years, variations in physicians' hospital admission and procedure rates have come under particular examination for their influence on the cost and quality of health care. Recent studies identify several primary causes for these variations and conclude that they may occur because of "practice style" (Wennberg, *HEALTH AFFAIRS*, Summer 1984), "reliance on the opinions of peers" (Eddy, *HEALTH AFFAIRS*, Summer 1984), or "provider efficiency" (McClure, *HEALTH AFFAIRS*, Summer 1984).

The conclusion reached from these and other investigations is that variations in physician behavior may unnecessarily drive up health care costs and cause needless complications and even deaths. Historically, PSROs provided a peer review mechanism to examine the impact of physician decisions related to items in the general course of treatment, the appropriateness of the setting, and the length of an inpatient's stay. In many respects, PRO activities will also focus on similar concerns.

We received a number of public comments concerning the impact of PRO initiatives on physicians. In our responses, we consider some of the potential impacts resulting from provisions like the examination of practitioner records and the necessity for the cooperation of practitioners in the conduct of PRO reviews. However, it is difficult to isolate the impact of PRO activities alone on affected physicians. One reason is that the prospective payment system itself is causing significant direct and indirect changes in physician practice styles and behaviors (for example, in terms of admissions and decisions about elective surgery). Also, other third-party payor activities seek to influence physicians' practice styles. The combined effect of these initiatives is to provide physicians with economic incentives to alter their practice styles in order to reduce unnecessary expenditures while preserving the quality of health care.

However, we can cite several examples of potential impacts on affected physicians resulting from the PRO program. First, the change from local peer review (PSRO) to statewide

peer review (PRO) by expanding the geographic scope of reviewers, may contribute to a decrease in local practice variations within a State. Second, physicians may realize some reduction in Medicare revenues as the result of a PRO's decision concerning the necessity of an admission or the efficacy of a procedure. However, we believe that in most cases, overall reductions in physician income will not be significant because the majority will practice in accordance with accepted norms thereby avoiding the risk of payment denials.

In summary, we believe that PRO activities will affect many physicians. However, through the educational efforts of individual PROs, we believe that unnecessary admissions and procedures will be reduced. This in turn would lead to reduction in the number of denials for submitted claims and the accompanying administrative burdens associated with processing denied claims.

F. Conclusion

In the introduction to this analysis, we stated that we are performing a voluntary regulatory impact and flexibility analysis. This decision results from a further examination of the effects of our proposed policies and because of the number of public comments received on several substantive issues. We conclude that a substantial number of health care facilities, beneficiaries, recipients and physicians are affected by the PRO program. However, we believe that the impact directly attributable to these final regulations is not significant for three reasons:

- The primary impact results from the requirements of the PRO statute itself.
- The incremental differences between most PRO and previous peer review activities are not significant.
- The effect of PRO activities may not be the primary cause of these impacts. Other factors, such as the prospective payment system and other third-party payor review efforts, may have a greater impact than the PRO activities.

For the reasons noted above, we have determined that this final rule does not meet the threshold criteria set forth in Executive Order 12291. Furthermore, we have determined, and the Secretary certifies, that this final rule will not have a significant effect on a substantial number of small entities under the Regulatory Flexibility Act of 1980.

VI. Information Collection Requirements

Sections 412.44 (previously 405.472), 431.630, 456.654, 466.70, 466.72, 466.74, 466.78, 466.80 and 466.94 of this rule contain information collection requirements. They are subject to review by the Office of Management and Budget (OMB) under the Paperwork Reduction Act of 1980 (44 U.S.C. 3507). The public is not required to comply with the information collection requirements until OMB approves these requirements under section 3507 of the Paperwork Reduction Act of 1980. Comments on this requirement should be sent directly to the Office of Information and Regulatory Affairs, OMB, New Executive Office Building, Washington, D.C., Attention: Faye Iudicello. A notice will be published in the **Federal Register** when approval is obtained.

VII. Waiver of Proposed Rulemaking

The Administrative Procedure Act (5 U.S.C. 553) requires us to publish a general notice of proposed rulemaking in the **Federal Register**, and afford prior public comment on proposed rules. Such notice includes a statement of the time, place, and nature of rulemaking proceedings, reference to the legal authority under which the rule is proposed, and the terms or substance of the proposed rule or a description of the subjects and issues involved. However, this requirement does not apply when an agency finds good cause that such a notice-and-comment procedure is impracticable, unnecessary, or contrary to the public interest, and incorporates a statement of the finding and its reasons in the rules issued.

These final rules include revisions to conform the regulations to sections 2315(d), 2334 and 2347 of the Deficit Reduction Act of 1984. Because these conforming changes do not involve significant discretion or the addition of significant procedure or detail for implementation, we believe that there is good cause to waive a proposed rulemaking as unnecessary. Furthermore, the changes made to conform the regulations to the DRA amendments are less stringent than existing regulations. Therefore, it is also in the public interest to waive the proposed rulemaking.

VIII. List of Subjects

42 CFR Part 400

Definitions, OMB control numbers.

42 CFR Part 405

Administrative practice and procedure, Certification of compliance, Clinics, Contracts (Agreements), End-Stage Renal Disease (ESRD), Health care, Health facilities, Health maintenance organizations (HMO), Health professions, Health suppliers, Home health agencies, Hospitals, Inpatients, Kidney diseases, Laboratories, Medicare, Nursing homes, Onsite surveys, Outpatient providers, Reporting and recordkeeping requirements, Rural areas, X-rays.

42 CFR Part 431

Administrative practice and procedure, Contracts (Agreements), Fair hearings, Federal financial participation, Grant-in-Aid program—health, Health facilities, Health maintenance organizations (HMO), Indians, Information (Disclosure), Medicaid, Mental health centers, Prepaid health plans, Privacy, Quality control, Reporting and recordkeeping requirements.

42 CFR Part 433

Administrative practice and procedure, Assignment of Rights, Claims, Contracts (Agreements), Cost allocation, Federal financial participation, Federal matching provision, Grant-in-Aid program—health, Mechanized Claims Processing and Information Retrieval Systems, Medicaid, State fiscal administration, Third party liability.

42 CFR Part 456

Administrative practice and procedure, Grant-in-Aid program—health, Health facilities, Medicaid, Mental health centers, Nursing homes, Penalties, Reporting and recordkeeping requirements, Utilization control, Utilization review.

42 CFR Part 460

Health care, Health professions, Hospitals, Physicians, Professional Standards Review Organizations (PSRO).

42 CFR Part 462

Grant-in-Aid program—health, Health care, Professional Standards Review Organizations (PSRO).

42 CFR Part 466

Appeals, Delegation, Denials, Grant-in-Aid program—health, Health care, Health facilities, Health professions, Hospitals, Hospital review, Norms/criteria/standards, Physicians, Professional Standards Review Organizations (PSRO), Reconsiderations, Utilization and Quality Control Peer Review Organizations (PRO).

42 CFR Chapter IV is amended as set forth below:

I. The table of contents is amended by revising the title of Part 466 as follows:

CHAPTER IV—HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES

* * * * *

SUBCHAPTER D—PEER REVIEW ORGANIZATIONS

* * * * *

Part 466—Utilization and Quality Control Review

* * * * *

PART 400—INTRODUCTIONS; DEFINITIONS

The authority citation for Part 400 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh) and 44 U.S.C. Chapter 35.

II. Section 400.200 is amended by adding in alphabetical order, the definition of "Area" to read as follows:

§ 400.200 General definitions.

* * * * *

"Area" means the geographical area within the boundaries of a State or a State or other jurisdiction designated as constitution an area with respect to which a Professional Standards Review Organization or a Utilization and Quality Control Peer Review Organization has been or may be designated.

* * * * *

PART 405—FEDERAL HEALTH INSURANCE FOR THE AGED AND DISABLED

III. Part 405 is amended as follows:

A. The authority citation for Subpart C is revised to read as follows:

Authority: Secs. 1102, 1154(a)(2)(B), 1815, 1833, 1842, 1862, 1866, 1870, 1871, and 1879 of the Social Security Act (42 U.S.C. 1302, 1320c-3(a)(2)(B), 1395g, 1395l, 1395u, 1395y, 1395cc, 1395gg, 1395hh, 1395pp), and 31 U.S.C. 3711.

B. In Subpart C, § 405.330 is amended by revising paragraph (b) to read as follows:

§ 405.300 Payment for certain nonreimbursable expenses.

* * * * *

(b) Payment may be made under this provision for not more than 2 days for inpatient hospital services, post-hospital, SNF care, or home health services (as defined in §§ 409.10, 409.20, and 409.40, respectively) when the fiscal intermediary or PRO determines that additional time is required in order to arrange for post discharge care, and when the additional care is furnished after whichever of the following days is the earlier:

(1) The day on which the individual, to whom the services were furnished, has been determined, under § 405.332(a), to have knowledge, actual or imputed, that those services were excluded from coverage by reason of § 405.310(g) or § 405.310(k); or

(2) The day on which the provider of the services, has been determined, under § 405.332(b), to have knowledge, actual or imputed, that the services were excluded from coverage as custodial care (§ 405.310(g)) or as not reasonable and necessary (§ 405.310(k)).

C. The authority citation for Subpart G continues to read as follows:

Authority: Secs. 1102, 1154, 1155, 1869(b), 1871, 1872 and 1879 of the Social Security Act (42 U.S.C. 1302, 1320c, 1395ff(b), 1395hh, 1395ii and 1395pp).

In § 405.704(b), the introductory paragraph is reprinted, and paragraphs (b)(11) and (b)(12) are revised to read as follows:

§ 405.704 Actions which are initial determinations.

* * * * *

(b) *Requests for payment by or on behalf of individuals.* An initial determination with respect to an individual includes any determination made on the basis of a request for payment by or on behalf of the individual under Part A of Medicare, including a determination with respect to:

* * * * *

(11) The medical necessity of services (See Parts 466 and 473 of this chapter for provisions pertaining to initial and reconsidered determinations made by a PSRO or PRO.);

(12) When services are excluded from coverage as custodial care (§ 405.310(g)) or as not reasonable and necessary (§ 405.310(k)), whether the individual or the provider of services who furnished the services, or both, knew or could reasonably have been expected to know that the services were excluded from coverage (see § 405.332); and

* * * * *

PART 412—PROSPECTIVE PAYMENT SYSTEM FOR INPATIENT HOSPITAL SERVICES

The authority citation for Part 412 continues to read as follows:

Authority: Secs. 1102, 1871 and 1886 of the Social Security Act (42 U.S.C. 1302, 1395hh, 1395ww).

IV. Part 412 is amended as follows:

A. In § 412.44, the introductory language is reprinted without change for the convenience of the reader, paragraph (a) is revised and redesignated as paragraph (b), a new paragraph (a) is added, paragraphs (b) and (c) are redesignated as (c) and (d), and a new paragraph (e) is added. As revised § 412.44 reads as follows:

§ 412.44 Medical review requirements: Admissions and quality review.

Beginning on November 15, 1984, a hospital must have an agreement with a Utilization and Quality Control Peer Review Organization (PRO) to have the PRO review, on an ongoing basis, the following:

(a) The medical necessity, reasonableness and appropriateness of hospital admissions and discharges.

(b) The medical necessity, reasonableness and appropriateness of inpatient hospital care for which additional payment is sought under the outlier provisions of §§412.82 and 412.84 of this chapter.

(c) The validity of the hospital's diagnostic and procedural information.

(d) The completeness, adequacy, and quality of the services furnished in the hospital.

(e) Other medical or other practices with respect to beneficiaries or billing for services furnished to beneficiaries.

B. Section 412.82 is amended by revising paragraph (b) to read as follows:

§ 412.82 Payment for extended length of stay cases (day outliers).

* * * * *

(b) The medical review entity (that is, a PSRO, PRO, or intermediary) must review and approve to the extent require by HCFA—

(1) The medical necessity and appropriateness of the admission and outlier services in the context of the entire stay;

(2) The validity of the diagnostic and procedural coding; and

(3) The granting of grace days.

PART 431—STATE ORGANIZATION AND GENERAL ADMINISTRATION

The authority citation for Part 431 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act, (42 U.S.C. 1302), unless otherwise noted.

V. Part 431 is amended as follows:

A. The table of contents for Part 431 is amended by revising the title of § 431.630 to read as follows:

* * * * *

Supbart M—Relations With Other Agencies

* * * * *

431.630 Coordination of Medicaid with PROs.

* * * * *

B. In § 431.630, the editorial note is removed and the section is revised to read as follows:

§ 431.630 Coordination of Medicaid with PROs.

(a) The State plan may provide for the review of Medicaid services through a contract with a PRO designated under Part 462 of this chapter. Medicaid requirements for medical and utilization review are deemed to be met for those services or providers subject to review under the contract.

(b) The State plan must provide that the contract with the PRO—

(1) Meets the requirements of § 434.6(a) of this part;

(2) Includes a monitoring and evaluation plan by which the State ensures satisfactory performance by the PRO;

(3) Identifies the services and providers subject to PRO review;

(4) Ensures that the review activities performed by the PRO are not inconsistent with PRO review activities of Medicare services and includes a description of whether and to what extent PRO determinations will be considered conclusive for Medicaid payment purposes.

PART 433—STATE FISCAL ADMINISTRATION

VI. Part 433 is amended as follows:

A. The authority citation for Part 433 is revised to read as follows:

Authority: Secs. 1102, 1902(a)(25), 1903(a)(3), 1903(d)(2), 1903(d)(5), 1903(o), 1903(p), and 1912 of the Social Security Act (42 U.S.C. 1302, 1396a(a)(25), 1396b(a)(3), 1396b(d)(2), 1396b(d)(5), 1396b(o), 1396b(p), and 1396(k), unless otherwise noted.

B. Section 433.15 is amended by revising paragraph (b)(6)(i) to read as follows:

§ 433.15 Rates of FFP for administration.

* * * * *

(b) *Activities and rates.*

* * * * *

(6)(i) Funds expended for the performance of medical and utilization review by a PRO under a contract entered into under section 1902(d) of the Act: 75 percent (section 1903(a)(3)(C) of the Act).

* * * * *

PART 456—UTILIZATION CONTROL

The authority citation for Part 456 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act, 49 Stat. 647 (42 U.S.C. 1302).

VII. Part 456 is amended as follows:

A. Section 456.2 is amended by revising paragraph (b) to read as follows:

§ 456.2 State plan requirements.

* * * * *

(b) These requirements may be met by the agency by:

(1) Assuming direct responsibility for assuring that the requirements of this Part are met:

(2) Deeming, if the agency contracts with a PSRO designated under Part 462 of this chapter; or

(3) Deeming of medical and utilization review requirements if the agency contracts with a PRO to perform that review, which in the case of inpatient acute care review will also serve as the initial determination for PRO medical necessity and appropriateness review for patients who are dually entitled to benefits under Medicare and Medicaid.

* * * * *

B. Section 456.650(c) is revised to read as follows:

§ 456.650 Basis, purpose and scope.

* * * * *

(c) *Scope.* The reductions required by this subpart do not apply to—

(1) Services provided under a contract with a health maintenance organization;

(2) Facilities in which a PSRO is performing review under contract with the Medicaid agency, but only until a contract is awarded in the area to a PRO; or

(3) Facilities in which a PRO is performing medical and utilization reviews under contract with the Medicaid agency in accordance with § 431.630 of this chapter.

C. In § 456.654(a), the introductory language is reprinted; paragraph (a)(4) is revised to include requirements for PRO reviews; paragraph (a)(6) is amended to change "as" to "an" and "provided" to "provider"; and paragraph (a)(7) is amended to change "facility and" to "facility that". The revised § 456.654(a)(4) reads as follows:

§ 456.654 Requirements for content of showings and procedures for submittal.

(a) An agency's showing for a quarter must—

* * * * *

(4) If review has been contracted to a PRO under § 431.630 of this chapter or to a PSRO, list the date the PRO or PSRO contracted for review.

* * * * *

PART 460—AREA DESIGNATIONS

The authority citation for Part 460 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act, 42 U.S.C. 1302. Subpart A is also issued under sec. 150 of Pub. L. 97-248, 42 U.S.C. 1320c note. Subpart B is also issued under secs. 1151 and 1153 of the Social Security Act, 42 U.S.C. 1320c and 1320c-2.

§ 460.1 [Amended]

VIII. Section 460.1 is amended by removing the definitions of "Area" and "PRO".

IX. Part 462 is amended as follows:

A. The table of contents is revised to reflect the establishment of a new Subpart A—General Provisions, to include the current § 462.2 which is redesignated as § 462.1; the redesignation of the current Subpart A as Subpart B to include the current § 462.1 which is redesignated as § 462.2 and the current §§ 462.3–462.16; the redesignation of the current Subpart B as Subpart C to include the current §§ 462.100–462.107; and the revision of the authority citation to read as follows:

PART 462—PEER REVIEW ORGANIZATIONS

Subpart A—General Provisions

Sec.
462.1 Definitions.

Subpart B—PSRO

462.2 Scope and applicability.
462.3 Eligibility for grants.
462.4 Requirements for designation as a priority PSRO.
462.5 Requirements for designation as an alternate PSRO.
462.6 Application requirements for conditional designation.
462.7 [Reserved]
462.8 Conditional designation as a PSRO.
462.9 [Reserved]
462.10 Limitation on period of conditional designation.
462.11 Duration, renewal and voluntary termination or nonrenewal of grants.
462.12 Involuntary termination of non-renewal or grants.
462.13 Use of grant funds.
462.14 Publications and copyrights.
462.15 Applicability of 45 CFR Part 74.
462.16 Additional terms and conditions.

Subpart C—Utilization and Quality Control Peer Review Organizations

462.100 Scope and applicability.
462.101 Eligibility requirements for PRO contracts.
462.102 Eligibility of physician-sponsored organizations.
462.103 Eligibility of physician-access organizations.
462.104 Requirements for demonstrating ability to perform review.
462.105 Prohibition against contracting with health care facilities.
462.106 Prohibition against contracting with payor organizations.
462.107 PRO contract award.

Authority: Sec. 1102 of the Social Security Act, 42 U.S.C. 1302. Subpart B is also issued under sec. 150 of Pub. L. 97-248 U.S.C. 1320c note. Subpart C is also issued under secs. 1152 and 1153 of the Social Security Act, U.S.C. 1320c and 1320-2.

B. The current Subparts A and B are redesignated as Subparts B and C, respectively.

C. 1. A new Subpart A—General Provisions is established to include the current § 462.2 which is redesignated as § 462.1.

2. The newly designated § 462.1 is amended by removing the definition of "PRO" and by revising the definition of "Payor organization" to read as follows:

§ 462.1 Definitions.

* * * * *

"Payor organization" means any organization, other than a self-insured employer, which makes payments directly or indirectly to health care practitioners or providers whose health care services are reviewed by the organization or would be reviewed by the organization if it entered into a PRO contract. "Payor organization" also means any organization which is affiliated with any entity which makes payments as described above, by virtue of the organization having two or more governing body members who are also either governing body members, officers, partners, 5 percent or more owners or managing employees in a health maintenance organization or competitive medical plan.

* * * * *

§ 462.1 [Redesignated as § 462.2]

D. The newly designated Subpart B is amended by redesignating the current § 462.1 as § 462.2.

E. The newly designated Subpart C is amended as follows:

1. Section 462.102 is amended by revising paragraph (a) to read as follows:

§ 462.102 Eligibility of physician-sponsored organizations.

(a) In order to be eligible for designation as a physician-sponsored PRO, an organization must meet the following conditions:

(1) Be composed of a substantial number of the licensed doctors of medicine and osteopathy practicing medicine or surgery in the review area and who are representative of the physicians practicing in the area.

(2) Not be a health care facility, health care facility association, or health care facility affiliate, as specified in § 462.105.

* * * * *

2. Sections 462.103, 462.105, and 462.106 are revised to read as follows:

§ 462.103 Eligibility of physician-access organizations.

(a) In order to be eligible for designation as a physician-access PRO, an organization must meet the following conditions:

(1) Have available to it, by arrangement or otherwise, the services of a sufficient number of licensed doctors of medicine or osteopathy practicing medicine or surgery in the review area to assure adequate peer review of the services provided by the various medical specialties and subspecialties.

(2) Not be a health care facility, health care facility association, or health care facility affiliate, as specified in § 462.105.

(b) An organization meets the requirements of paragraph (a)(1) of this section if it demonstrates—

(1) That it has available to it at least one physician in every generally recognized specialty; and

(2) The existence of an arrangement or arrangements with physicians under which the physicians would conduct review for the organization.

* * * * *

§ 462.105 Prohibition against contracting with health care facilities.

(a) *Basic rule.* Except as permitted under paragraph (b) of this section, the following are not eligible for PRO contracts:

(1) A health care facility in the PRO area.

(2) An association of health care facilities in the PRO area.

(3) A health care facility affiliate; that is, an organization in which more than 20 percent of the members of the governing body are also either a governing body member, officer, partner, five percent or more owner, or managing employee in a health care facility or association of health care facilities in the PRO area.

(b) *Exceptions.* Effective November 15, 1984, the prohibition stated in paragraph (a) of this section will not apply to a payor organization if HCFA determines under § 462.106 that there is no other eligible organization available.

(c) *Subcontracting.* A PRO must not subcontract with a facility to conduct any review activities except for the review of the quality of care.

§ 462.106 Prohibition against contracting with payor organizations.

Payor organizations are not eligible to become PROs for the area in which they make payments until November 15, 1984. If no PRO contract for an area is awarded before November 15, 1984, a payor organization will be determined eligible by HCFA, if an eligible organization that is not a payor organization is unavailable at that time. HCFA may determine the unavailability of nonpayor organizations based on the lack of response to an appropriate Request for Proposal.

3. In § 462.107, the introductory language is reprinted, and paragraph (d) is revised to read as follows:

§ 462.107 PRO contract award.

HCFA, in awarding PRO contracts, will take the following actions—

* * * * *

(d) Subject to the limitations established by §§ 462.105 and 462.106, award the contract for the given PRO area to the selected organization for a period of two years.

X. Part 466 is amended as set forth below:

A. The title of Part 466 is revised to read as set forth below.

B. The table of contents is amended to reflect the revision of Subpart A—"General Provisions" to include only current § 466.2, which is redesignated as § 466.1, the revision of the title and contents of Subpart B—PSRO Review, to include current § 466.1 which is redesignated as § 466.2 and current §§ 466.3 through 466.63 with center headings, the removal of the headings of Subparts D and E and the revision of the heading of Subpart C. As revised, the table of contents reads as follows:

PART 466—UTILIZATION AND QUALITY CONTROL REVIEW

Subpart A—General Provisions

Subpart B—PSRO Review

General

Authority: Sec. 1102 of the Social Security Act, 42 U.S.C. 1302. Subpart B is also issued under sec. 150 of Pub. L. 97-248, 42 U.S.C. 1320c note. Subpart C is also issued under secs. 1151-1163, and 1868(a) of the Social Security Act, 42 U.S.C. 1320c-1320c-12, and 1395cc(a).

C. Section 466.1 is redesignated as § 466.3 and § 466.2 is redesignated as § 466.1.

D. Newly designated § 466.1 is amended by removing definitions of "Act", "HCFA", "Health care service", "National Council", "Other Attending Health Care Practitioner" and "Secretary" and revising the definitions of "Active staff privileges", "Admission review", "Concurrent quality assurance", "Concurrent review", "Continued stay review", "Delegated Hospital", "Length-of-stay norms", "Length-of-stay projection", Non-delegated hospital", "Norm", "Physician", "Quality Review Study", "Skilled nursing facility (SNF)", "Working day", and adding in alphabetical order, the definitions of "Diagnosis-Related Group (DRG)", "DRG Validation", "Five Percent or more owner", "Health care facility or facility", "Non-facility organization", "Outliers", "Practitioner," "Preadmission certification," "Preadmission review," "Preprocedure review," "PRO review", "Retrospective review", "Review responsibility", "State survey agency," and "Subcontractor" as follows:

§ 466.1 Definitions.

Active staff privileges means: (a) That a physician is authorized on a regular, rather than infrequent or courtesy, basis: (1) To order the admission of patients to a facility; (2) to perform diagnostic services in a facility; or (3) to care for and treat patients in a facility; or (b) that a health care practitioner other than a physician is authorized on a regular, rather than infrequent or courtesy, basis to order the admission of patients to a facility.

Admission review means a review and determination by a PSRO or a PRO of the medical necessity and appropriateness of a patient's admission to a specific facility.

* * * * *

Concurrent quality assurance means a form of PSRO review that focuses on the quality of health services furnished to individual patients, and is performed while the patient is in the hospital.

Concurrent review means a review and determination that is focused on the necessity and appropriateness of inpatient hospital services and is performed while the patient is in the hospital. It includes admission review, continued stay review and, when appropriate, procedure review.

Continued stay review means PSRO or PRO review that is performed after admission review and during a patient's hospitalization to determine the medical necessity and appropriateness of continuing the patient's stay at a hospital level of care.

* * * * *

Delegated hospital means a hospital to which PSRO review functions are delegated under Subpart B.

Diagnosis related group (DRG) means a system for classifying inpatient hospital discharges. DRGs are used for purposes of determining payment to hospitals for inpatient hospital services under the Medicare prospective payment system.

DRG validation means a part of the prospective payment system in which a PRO validates that DRG assignments are based on the correct diagnostic and procedural information.

Five percent or more owner means a person (including, where appropriate, a corporation) who:

(a) Has an ownership interest of 5 percent or more;

(b) Has an indirect ownership interest equal to 5 percent or more;

(c) Has a combination of direct and indirect ownership interests (the possession of equity in the capital, the stock, or the profits of an entity) equal to five percent or more; or

(d) Is the owner of an interest of five percent or more in any obligation secured by an entity, if the interest equals at least five percent of the value of the property or assets of the entity.

* * * * *

Health care facility or *facility* means an organization involved in the delivery of health care services for which reimbursement may be made in whole or in part under Title XVIII of the Act.

* * * * *

Length-of-stay norms means established statistical measures of average lengths of stay for patients of similar age and diagnosis or condition.

Length-of-stay projection means a criterion that defines the time at which patients of similar age and diagnosis or condition would be expected to be ready for discharge.

* * * * *

Non-facility organization means a corporate entity that (1) is not a health care facility; (2) is not a 5 percent or more owner of a facility; and (3) is not owned by one or more health care facilities or association of facilities in the PRO area.

Nondelegated hospital means a hospital in which the PSRO conducts review activities using its own review procedures, and to which it has not delegated review activities under Part 466, Subpart B of this chapter.

Norm means a pattern of performance in the delivery of health care services that is typical for a specified group.

Outliers means those cases that have either an extremely long length of stay or extraordinarily high costs when compared to most discharges classified in the same DRG.

* * * * *

Physician means a doctor of medicine or osteopathy or another individual who is authorized under State or Federal law to practice medicine and surgery, or osteopathy. This includes medical officers in American Samoa, the Northern Mariana Islands, and the Trust Territory of the Pacific Islands.

Practitioner means an individual credentialed within a recognized health care discipline and involved in providing the services of that discipline to patients.

* * * * *

Preadmission certification means a favorable determination, transmitted to the hospital and the fiscal intermediary, approving the patient's admission for payment purposes.

Preadmission review means review prior to a patient's admission to a hospital to determine, for payment purposes, the reasonableness, medical necessity and appropriateness of placement at an acute level of care.

Preprocedure review means review of a surgical or other invasive procedure prior to the conduct of the procedure.

PRO review means review performed in fulfillment of a contract with HCFA, either by the PRO or its subcontractors.

* * * * *

Quality review study means an assessment conducted by or for a PRO of a patient care problem for the purpose of improving patient care through peer analysis, intervention, resolution of the problem and follow-up.

Retrospective review means review that is conducted after services are provided to a patient. The review is focused on determining the appropriateness, necessity, quality, and reasonableness of health care services provided.

* * * * *

Review responsibility means (1) the responsibility of the PRO to perform review functions prescribed under Part B of Title XI of the Act and the Social Security Amendments of 1983 (Pub. L. No. 98-21) and the regulations of this part; (2) the responsibility to fulfill the terms and meet the objectives set forth in the negotiated contract between HCFA and the PRO; and (3) the authority of a PRO to make conclusive initial denial determinations regarding the medical necessity and appropriateness of health care and changes as a result of DRG validations.

Skilled nursing facility (SNF) means a health care institution or distinct part of an institution that (a) is primarily engaged in providing skilled nursing care or rehabilitative services to injured, disabled, or sick persons, and (b) has an agreement to participate in Medicare or Medicaid or both, and (c) is not a Christian Science sanatorium operated or listed and certified by the First Church of Christ Scientist, Boston, Massachusetts.

* * * * *

State survey agency means an agency performing provider surveys in accordance with an agreement under § 405.685 of this chapter.

"Subcontractor" means a facility or a non-facility organization under contract with a PRO to perform PRO review functions.

Working day means any one of at least five days of each week (excluding, at the option of each PSRO or PRO, legal holidays) on which the necessary personnel are available to perform review.

Subparts B through E—[Amended]

E. The headings for Subparts C, D, and E are removed, and §§ 466.30 through 466.63 are incorporated into Subpart B. Subpart B is amended by revising the title to read "PSRO Review", including the newly redesignated § 466.2 and incorporating therein current §§ 466.3 through 466.63, and adding center headings as follows: Center heading "Delegated Review" is added immediately before § 466.30, center heading "Norms, Criteria, and Standards for Review" is added immediately before § 466.50 and center heading "Financing of Review Activities" is added immediately before § 466.60.

F. Subpart C consisting of §§ 466.70 through 466.104 is added to read as follows:

Subpart C—Review Responsibilities of Utilization and Quality Control Peer Review Organizations (PROs)

General Provisions

§ 466.70 Statutory bases, applicability and provisions.

(a) *Statutory basis.* Sections 1154, 1866(a)(1)(F) and 1886(f)(2) of the Act require that a PRO review those services furnished by physicians, other health care professionals, providers and suppliers as specified in its contract with the Secretary.

(b) *Applicability.* The regulations in this subpart apply to review conducted by a PRO and its subcontractors.

(c) *Scope of PRO review.* In its review, the PRO must determine (in accordance with the terms of its contract)—

(1) Whether the services are or were reasonable and medically necessary for the diagnosis and treatment of illness or injury or to improve functioning of a malformed body member, or (with respect to pneumococcal vaccine) for prevention of illness or (in the case of hospice care) for the palliation and management of terminal illness;

(2) Whether the quality of the services meets professionally recognized standards of health care;

(3) Whether those services furnished or proposed to be furnished on an inpatient basis could, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient health care facility of a different type;

(4) Through DRG validation, the validity of diagnostic and procedural information supplied by the hospital;

(5) The completeness, adequacy and quality of hospital care provided;

(6) The medical necessity, reasonableness and appropriateness of hospital admissions and discharges;

(7) The medical necessity, reasonableness and appropriateness of inpatient hospital care for which additional payment is sought under the outlier provisions of §§ 412.82 and 412.84 of this chapter; and

(8) Whether a hospital has misrepresented admission or discharge information or has taken an action that results in—

(i) The unnecessary admission of an individual entitled to benefits under Part A;

(ii) Unnecessary multiple admissions of an individual; or

(iii) Other inappropriate medical or other practices with respect to beneficiaries or billing for services furnished to beneficiaries.

(d) *Payment determinations.* On the basis of the review specified under paragraphs (c) (1), (3), (6) and (7), and (8) of this section, the PRO must determine whether payment may be made for these services. A PRO may grant a period of not more than two days (grace days) for the purpose of arranging post discharge care when the provider did not know or could not reasonably be expected to have known that payment for the service(s) would not be made under the Medicare program as specified in § 405.330(b).

(e) *Other duties and functions.* (1) The PRO must review at least a random sample of hospital discharges each quarter and submit new diagnostic and procedural information to the Medicare fiscal intermediary or carrier if it determines that the information submitted by the hospital was incorrect.

(2) The PRO must also perform other duties, functions, and responsibilities as required by HCFA.

§ 466.72 Notification of PRO designation and implementation of review.

(a) *Notice of HCFA's decision.* HCFA sends written notification of a PRO contract award to the State survey agency and Medicare fiscal intermediaries and carriers. The notification includes the effective dates of the PRO contract and specifies the area and types of health care facilities to be reviewed by the PRO. The PRO must make a similar notification when review responsibilities are subcontracted.

(b) *Notification to health care facilities and the public.* As specified in its contract with HCFA, the PRO must—

(1) Provide to each health care facility scheduled to come under review, a timely written notice that specifies the date and manner in which the PRO proposes to implement review, and the information to be furnished by the facility to each Medicare beneficiary upon admission as specified in § 466.78(b)(3) of this part.

(2) Publish, in at least one local newspaper of general circulation in the PRO area, a notice that states the date the PRO will assume review responsibilities and lists each area health care facility to be under review. The PRO must indicate that its plan for the review of health care services as approved in its contract with HCFA is available for public inspection in the PRO's business office and give the address, telephone number and usual hours of business.

§ 466.74 General requirements for the assumption of review.

(a) A PRO must assume review responsibility in accordance with the schedule, functions and negotiated objectives specified in its contract with HCFA.

(b) A PRO must notify the appropriate Medicare fiscal intermediary or carrier of its assumption of review in specific health care facilities no later than five working days after the day that review is assumed in the facility.

(c) A PRO must maintain and make available for public inspection at its principal business office—

(1) A copy of each agreement with Medicare fiscal intermediaries and carrier;

(2) A copy of its currently approved review plan that includes the PRO's method for implementing review; and

(3) Copies of all subcontracts for the conduct of review.

(d) A PRO must not subcontract with a facility to conduct any review activities except for the review of the quality of care. The PRO may subcontract with a non-facility organization to conduct review in a facility.

(e) If required by HCFA, a PRO is responsible for compiling statistics based on the criteria contained in § 405.332 of this chapter and making limitation of liability determinations on excluded coverage of certain services that are made under section 1879 of the Act. If required by HCFA, PROs must also notify a provider of these determinations. These determinations and further appeals are governed by the reconsideration and appeals procedures in Part 405, Subpart G of this chapter for Medicare Part A related determinations and Part 405, Subpart H of this chapter for Medicare Part B related determinations.

(f) A PRO must make its responsibilities under its contract with HCFA, primary to all other interests and activities that the PRO undertakes.

§ 466.76 Cooperation with health care facilities.

Before implementation of review, a PRO must make a good faith effort to discuss the PRO's administrative and review procedures with each involved health care facility.

§ 466.78 Responsibilities of health care facilities.

(a) Beginning November 15, 1984, every hospital seeking payment for services provided to Medicare beneficiaries must maintain a written agreement with a PRO operating in the area in which the hospital is located. These agreements must provide for the PRO review specified in § 466.70(c).

(b) *Cooperation with PROs.* Health care facilities that submit Medicare claims must cooperate in the assumption and conduct of PRO review. Facilities must—

(1) Allocate adequate space to the PRO for its conduct of review at the times the PRO is conducting review.

(2) Provide patient care data and other pertinent data to the PRO at the time the PRO is collecting review information that is required for the PRO to make its determinations. When review is performed away from the facility, the facility must photocopy and deliver to the PRO, without charge, all required information within 30 days of a request. When the PRO does post-admission, preprocedure review, the facility must provide the necessary information before the procedure is performed, unless it must be performed on an emergency basis.

(3) Inform Medicare beneficiaries at the time of admission, in writing, that the care for which Medicare payment is sought will be subject to PRO review and indicate the potential outcomes of that review. Furnishing this information to the patient does not constitute notice, under § 405.332(a) of this chapter, that can support a finding that the beneficiary knew the services were not covered.

(4) When the facility has issued a written determination in accordance with § 412.42(c)(3) of this chapter that a beneficiary no longer requries inpatient hospital care, it must submit a copy of its determination to the PRO within 3 working days.

(5) Assure, in accordance with the provisions of its agreement with the PRO, that each case subject to preadmission review has been reviewed and approved by the PRO before admission to the hospital or a timely request has been made for PRO review.

(6)(i) Agree to accept financial liability for any admission subject to preadmission review that was not reviewed by the PRO and is subsequently determined to be inappropriate or not medically necessary.

(ii) The provisions of paragraph (b)(6)(i) of this section do not apply if a facility, in accordance with its agreement with a PRO, makes a timely request for preadmission review and the PRO does not review the case timely. Cases of this type are subject to retrospective prepayment review under paragraph (b)(7) of this section.

(7) Agree that, if the hospital admits a case subject to preadmission review without certification, the case must receive retrospective prepayment review, according to the review priority established by the PRO.

§ 466.80 Coordination with Medicare fiscal intermediaries and carriers.

(a) *Procedures for agreements.* The Medicare fiscal intermediary or carrier must have a written agreement with the PRO. The PRO must take the initiative with the fiscal intermediary or carrier in developing the agreement. The following steps must be taken in developing the agreement.

(1) The PRO and the fiscal intermediary or carrier must negotiate in good faith in an effort to reach written agreement. If they cannot reach agreement, HCFA will assist them in resolving matters in dispute.

(2) The PRO must incorporate its administrative procedures into an agreement with the fiscal intermediary or carrier and obtain approval from HCFA, before it makes conclusive determinations for the Medicare program, unless HCFA finds that the fiscal intermediary or carrier has—

(i) Refused to negotiate in good faith or in a timely manner, or

(ii) Insisted on including in the agreement, provisions that are outside the scope of its authority under the Act.

(b) *Content of agreement.* The agreement must include procedures for—

(1) Informing the appropriate Medicare fiscal intermediaries and carriers of—

(i) Changes as a result of DRG validations and revisions as a result of the review of these changes; and

(ii) Initial denial determinations and revisions of these determinations as a result of ——— reconsideration and all approvals and denials with respect to cases subject to preadmission review and outlier claims in hospitals under a prospective payment system for health care services and items;

(2) Exchanging data or information;

(3) Modifying the procedures when additional review responsibility is authorized by HCFA; and

(4) Any other matters that are necessary for the coordination of functions.

(c) *Action of HCFA.* (1) Within the time specified in its contract, the PRO must submit to HCFA for approval its agreement with the Medicare fiscal intermediaries carriers, and if an agreement has not been established, the PRO's proposed administrative procedures, including any comments by the Medicare fiscal intermediaries and carriers.

(2) If HCFA approves the agreement or the administrative procedures (after a finding by HCFA as specified in paragraph (a)(2) of this section), the PRO may begin to make determinations under its contract with HCFA.

(3) If HCFA disapproves the agreement or procedures, it will—

(i) Notify the PRO and the appropriate fiscal agents in writing, stating the reasons for disapproval; and

(ii) Require the PRO and fiscal intermediary or carrier to revise its agreements or procedures.

(d) *Modification of agreements.* Agreements or procedures may be modified, with HCFA's approval—

(1) Through a revised agreement with the fiscal intermediary or carrier, or

(2) In the case of procedures, by the PRO, after providing opportunity for comment by the fiscal intermediary or carrier.

(e) *Role of the fiscal intermediary.* (1) The fiscal intermediary will not pay any claims for those cases which are subject to preadmission review by the PRO, until it receives notice that the PRO has approved the admission after preadmission or retrospective review.

(2) A PRO's determination that an admission is medically necessary is not a guarantee of payment by the fiscal intermediary. Medicare coverage requirements must also be applied.

§ 466.82 Continuation of functions not assumed by PROs.

Any of the duties and functions under Part B of Title XI of the Act for which a PRO has not assumed responsibility under its contract with HCFA must be performed in the manner and to the extent otherwise provided for under the Act or in regulations.

§ 466.83 Initial denial determinations.

A determination by a PRO that the health care services furnished or proposed to be furnished to a patient are not medically necessary, are not reasonable, or are not at the appropriate level of care, is an initial denial determination and is appealable under Part 473 of this chapter.

§ 466.84 Changes as a result of DRG validation.

A provider or practitioner may obtain a review by a PRO under Part 473 of this chapter for changes in diagnostic and procedural coding that resulted in a change in DRG assignment as a result of PRO validation activities.

§ 466.85 Conclusive effect of PRO initial denial determinations and changes as a result of DRG validations.

A PRO initial denial determination or change as a result of DRG validation is final and binding unless, in accordance with the procedures in Part 473—

(a) The initial denial determination is reconsidered and revised; or

(b) The change as a result of DRG validation is reviewed and revised.

§ 466.86 Correlation of Title XI functions with Title XVIII functions.

(a) *Payment determinations.*

(1) PRO initial denial determinations under this part with regard to the reasonableness, medical necessity, and appropriateness of placement at an acute level of patient care as are also conclusive for payment purposes with regard to the following medical issues:

(i) Whether inpatient care furnished in a psychiatric or tuberculosis hospital meets the requirements of § 405.1629 of this chapter.

(ii) Whether payment for inpatient hospital or SNF care beyond 20 consecutive days is precluded under § 489.50 of this chapter because of failure to perform review of long-stay cases.

(iii) Whether the care furnished was custodial care or care not reasonable and necessary and, as such, excluded under § 405.310(g) or § 405.310(k) of this chapter.

(iv) Whether the care was appropriately furnished in the inpatient or outpatient setting.

(2) Reviews with respect to determinations listed in paragraph (a)(1) of this section must not be conducted, for purposes of payment, by Medicare fiscal intermediaries or carriers except as outlined in paragraph (c) of this section.

(3) PROs make determinations as to the appropriateness of the location in which procedures are performed. A procedure may be medically necessary but denied if the PRO determines that it could, consistent with the provision of appropriate medical care, be effectively provided more economically on an outpatient basis or in an inpatient health care facility of a different type.

(4) PRO determinations as to whether the provider and the beneficiary knew or could reasonably be expected to have known that the services described in paragraph (a)(1) of this section were excluded are also conclusive for payment purposes.

(b) *Utilization review activities.* PRO review activities to determine whether inpatient hospital or SNF care services

are reasonable and medically necessary and are furnished at the appropriate level of care fulfill the utilization review requirements set forth in §§ 405.1035, 405.1042, and 405.1137 of this chapter.

(c) *Coverage.* Nothing in paragraphs (a) (1) and (3) of this section will be construed as precluding HCFA or a Medicare fiscal intermediary or carrier, in the proper exercise of its duties and functions, from reviewing claims to determine:

(1) In the case of items or services not reviewed by a PRO, whether they meet coverage requirements of Title XVIII relating to medical necessity, reasonableness, or appropriateness of placement at an acute level of patient. However, if a coverage determination pertains to medical necessity, reasonableness, or appropriateness of placement at an acute level of patient care, the fiscal intermediary or carrier must use a PRO to make a determination on those issues if a PRO is conducting review in the area and must abide by the PRO's determination.

(2) Whether any claim meets coverage requirements of Title XVIII relating to issues other than medical necessity, reasonableness or appropriateness of placement at an acute level of patient care.

(d) *Payment.* Medicare fiscal intermediaries and carriers are not precluded from making payment determinations with regard to coverage determinations made under paragraph (c) of this section.

(e) *Survey, compliance and assistance activities.* PRO review and monitoring activities fulfill the requirements for compliance and assistance activities of State survey agencies under section 1864(a) with respect to sections 1861(e)(6), 1861(j)(8), 1861(j)(12), and 1861(k) of the Act, and activities required of intermediaries and carriers under §§ 421.100(d) and 421.200(f) of this chapter.

(f) *Appeals.* The requirements and procedures for PRO review of changes as a result of DRG validation and the reconsideration, hearing and judicial review of PRO initial denial determinations are set forth in Part 473 of this chapter.

§ 466.88 Examination of the operation and records of health care facilities and practitioners.

(a) *Authorization to examine records.* A facility claiming Medicare payment must permit a PRO or its subcontractor to examine its operation and records (including information on charges) that are pertinent to health care services furnished to Medicare beneficiaries and are necessary for the PRO or its subcontractor to—

(1) Perform review functions including, but not limited to—

(i) DRG validation;

(ii) Outlier review in facilities under a prospective payment system; and

(iii) Implementation of corrective action and fraud and abuse prevention activities;

(2) Evaluate cases that have been identified as deviating from the PRO norms and criteria, or standards; and

(3) Evaluate the capability of the facility to perform quality review functions under a subcontract with the PRO.

(b) *Limitations on access to records.* A PRO has access to the records of non-Medicare patients if—

(1) The records relate to review performed under a non-Medicare PRO contract and if authorized by those patients in accordance with State law; or

(2) The PRO needs the records to perform its quality review responsibilities under the Act and receives authorization from the facility or practitioner.

(c) *Conditions of examination.* When examining a facility's operation or records the PRO must—

(1) Examine only those operations and records (including information on charges) required to fulfill the purposes of paragraph (a) of this section;

(2) Cooperate with agencies responsible for other examination functions under Federal or Federally assisted programs in order to minimize duplication of effort;

(3) Conduct the examinations during reasonable hours; and

(4) Maintain in its principal office written records of the results of the examination of the facility.

§ 466.90 Lack of cooperation by a health care facility or practitioner.

(a) If a health care facility or practitioner refuses to allow a PRO to enter and perform the duties and functions required under its contract with HCFA, the PRO may—

(1) Determine that the health care facility or practitioner has failed to comply with the requirements of § 474.30(c) of this chapter and report the matter to the HHS Inspector General; or

(2) Issue initial denial determinations for those claims it is unable to review, make the determination that financial liability will be assigned to the health care facility, and report the matter to the HHS Inspector General.

(b) If a PRO provides a facility with sufficient notice and a reasonable amount of time to respond to a request for information about a claim, and if the facility does not respond in a timely manner, PRO will deny the claim.

§ 466.93 Opportunity to discuss proposed initial denial determination and changes as a result of a DRG validation.

Before a PRO reaches an initial denial determination or makes a change as a result of a DRG validation, it must—

(a) Promptly notify the provider or supplier and the patient's attending physician (or other attending health care practitioner) of the proposed determination or DRG change; and

(b) Afford an opportunity for the provider or supplier and the physician (or other attending health care practitioner) to discuss the matter with the PRO physician advisor and to explain the nature of the patient's need for health care services, including all factors which preclude treatment of the patient as an outpatient or in an alternative level of inpatient care.

§ 466.94 Notice of PRO initial denial determination and changes as a result of a DRG validation.

(a) *Notice of initial denial determination*—(1) *Parties to be notified.* A PRO must provide written notice of an initial denial determination to—

(i) The patient, or if the patient is expected to be unable to comprehend the notice, the patient's next of kin, guardian or other representative or sponsor;

(ii) The attending physician, or other attending health care practitioner;

(iii) The facility; and

(iv) The fiscal intermediary or carrier.

(2) *Timing of the notice.* The notice must be delivered to beneficiaries in the facility or mailed to those no longer in the facility, within the following time periods—

(i) For admission, on the first working day after the initial denial determination;

(ii) For continued stay (e.g., outliers in facilities under a prospective payment system), by the first working day after the initial denial determination if the beneficiary is still in the facility, and within 3 working days if the beneficiary has been discharged;

(iii) For preprocedure review, before the procedure is performed;

(iv) For preadmission review, before admission;

(v) If identification as a Medicare program patient has been delayed, within three working days of identification;

(vi) For retrospective review, (excluding DRG validation and post procedure review), within 3 working

days of the initial denial determination; and

(vii) For post-procedure review, within 3 working days of the initial denial determination.

(3) *Preadmission review.* In the case of preadmission review, the PRO must document that the patient and the facility received notice of the initial denial determination.

(b) *Notice of changes as a result of a DRG validation.* The PRO must notify the provider and practitioner of changes to procedural and diagnostic information that result in a change of DRG assignment, within 30 days of the PRO's decision.

(c) *Content of the notice.* The notice must be understandable and written in plain English and must contain—

(1) The reason for the initial denial determination or change as a result of the DRG validation;

(2) For day outliers in hospitals, the date on which the stay or services in the facility will not be approved as being reasonable and medically necessary or appropriate to the patients' health care needs;

(3) A statement informing each party or his or her representative of the right to request in accordance with the provisions of Part 473, Subpart B of this chapter—

(i) Review of a change resulting from DRG validation; or

(ii) Reconsideration of the initial denial determination;

(4) The locations for filing a request for reconsideration or review and the time period within which a request must be filed;

(5) A statement about who is liable for payment of the denied services under section 1879 of the Act; and

(6) A statement concerning the duties and functions of the PRO under the Act.

(d) *Notice to payers.* The PRO must provide prompt written notice of an initial denial determination or changes as a result of a DRG validation to the Medicare fiscal intermediary or carrier within the same time periods as the notices to the other parties.

(e) *Record of initial denial determination and changes as a result of a DRG validation.* (1) The PRO must document and preserve a record of all initial denial determinations and changes as a result of DRG validations for six years from the date the services in question were provided.

(2) The documentary record must include—

(i) The detailed basis for the initial denial determination or changes as a result of a DRG validation; and

(ii) A copy of the determination or change in DRG notices sent to all parties and identification of each party and the date on which the notice was mailed or delivered.

§ 466.96 Review period and reopening of initial denial determinations and changes as a result of DRG validation.

(a) *General timeframe.* A PRO or its subcontractor—

(1) Within one year of the date of the claim containing the service in question, may review and deny payment; and

(2) Within one year of the date of its decision, may reopen an initial denial determination or a change as a result of a DRG validation.

(b) *Extended timeframes.* (1) An initial denial determination or change as a result of a DRG validation may be made after one year but within four years of the date of the claim containing the service in question, if HCFA approves.

(2) A reopening of an initial denial determination or change as a result of a DRG validation may be made after one year but within four years of the date of the PRO's decision if—

(i) Additional information is received on the patient's condition;

(ii) Reviewer error occurred in interpretation or application of Medicare coverage policy or review criteria;

(iii) There is an error apparent on the face of the evidence upon which the initial denial or DRG validation was based; or

(iv) There is a clerical error in the statement of the initial denial determination or change as a result of a DRG validation.

(c) *Fraud and abuse.* (i) A PRO or its subcontractor may review and deny payment anytime there is a finding that the claim for service involves fraud or a similar abusive practice that does not support a finding of fraud.

(ii) An initial denial determination or change as a result of a DRG validation may be reopened and revised anytime there is a finding that it was obtained through fraud or a similar abusive practice that does not support a finding of fraud.

§ 466.98 Reviewer qualifications and participation.

(a) *Peer review by physician.* (1) Except as provided in paragraph (a)(2) of this section, each person who makes an initial denial determination about services furnished or proposed to be furnished by a licensed doctor of medicine or osteopathy or by a doctor of dentistry must be respectively another licensed doctor of medicine or osteopathy or of dentistry with active staff privileges in one or more hospitals in the PRO area.

(2) If a PRO determines that peers are not available to make initial denial determinations, a doctor of medicine or osteopathy may make denial determinations for services ordered or performed by a doctor in any of the three specialties.

(3) For purposes of paragraph (a)(1) of this section, individuals authorized to practice medicine in American Samoa, the Northern Mariana Islands, and the Trust Territory of the Pacific Islands as "medical officers" may make determinations on care ordered or furnished by their peers but not on care ordered or furnished by licensed doctors of medicine or osteopathy.

(b) *Peer review by health care practitioners other than physicians.* Health care practitioners other than physicians may review services furnished by other practitioners in the same professional field.

(c) *DRG validation review.* Decisions about procedural and diagnostic information must be made by physicians. Technical coding issues must be reviewed by individuals with training and experience in ICD–9–CM coding.

(d) *Persons excluded from review.* (1) A person may not review health care services or make initial denial determinations or changes as a result of DRG validations if he or she, or a member of his or her family—

(i) Participated in developing or executing the beneficiary's treatment plan;

(ii) Is a member of the beneficiary's family; or

(iii) Is a governing body member, officer, partner, 5 percent or more owner, or managing employee in the health care facility where the services were or are to be furnished.

(2) A member of a reviewer's family is a spouse (other than a spouse who is legally separated under a decree of divorce or separate maintenance), child (including a legally adopted child), grandchild, parent, or grandparent.

§ 466.100 Use of norms and criteria.

(a) *Use of norms.* As specified in its contract, a PRO must use national, or where appropriate, regional norms in conducting review to achieve PRO contract objectives. However, with regard to determining the number of procedures selected for preadmission review, a PRO must use national admission norms.

(b) *Use of criteria.* In assessing the need for and appropriateness of an inpatient health care facility stay, a PRO must apply criteria to determine—

(1) The necessity for facility admission and continued stay (in cases of day outliers in hospitals under prospective payment);

(2) The necessity for surgery and other invasive diagnostic and therapeutic procedures; or

(3) The appropriateness of providing services at a particular health care facility or at a particular level of care. The PRO must determine whether the beneficiary requires the level of care received or whether a lower and less costly level of care would be equally effective.

(c) *Establishment of criteria and standards.* For the conduct of review a PRO must—

(1) Establish written criteria based upon typical patterns of practice in the PRO area, or use national criteria where appropriate; and

(2) Establish written criteria and standards to be used in conducting quality review studies.

(d) *Variant criteria and standards.* A PRO may establish specific criteria and standards to be applied to certain locations and facilities in the PRO area if the PRO determines that—

(1) The patterns of practice in those locations and facilities are substantially different from patterns in the remainder of the PRO area; and

(2) There is a reasonable basis for the difference which makes the variation appropriate.

§ 466.102 Involvement of health care practitioners other than physicians.

(a) *Basic requirement.* Except as provided in paragraph (b) of this section, a PRO must meet the following requirements:

(1) Consult with the peers of the practitioners who furnish the services under review of the PRO review care and services delivered by health care practitioners other than physicians.

(2) Assure that in determinations regarding medical necessity of services or the quality of the services they furnish, these practitioners are involved in—

(i) Developing PRO criteria and standards;

(ii) Selecting norms to be used; and

(iii) Developing review mechanisms for care furnished by their peers.

(3) Ensure that an initial denial determination or a change as a result of DRG validation of services provided by a health care practitioner other than a physician is made by a physician only after consultation with a peer of that practitioner. Initial denial determinations and changes as a result of DRG validations must be made only by a physician or dentist.

(b) *Exception.* The requirements of paragraph (a) of this section do not apply if—

(i) The PRO has been unable to obtain a roster of peer practitioners available to perform review; or

(ii) The practitioners are precluded from performing review because they participated in the treatment of the patient, the patient is a relative, or the practitioners have a financial interest in the health care facility as described in § 466.98(d).

(c) *Peer involvement in quality review studies:* Practitioners must be involved in the design of quality review studies, development of criteria, and actual conduct of studies involving their peers.

(d) *Consultation with practitioners other than physicians.* To the extent practicable, a PRO must consult with nurses and other professional health care practitioners (other than physicians defined in 1861(r) (1) and (2) of the Act) and with representatives of institutional and noninstitutional providers and suppliers with respect to the PRO's responsibility for review.

§ 466.104 Coordination of activities.

In order to achieve efficient and economical review, a PRO must coordinate its activities (including information exchanges) with the activities of—

(a) Medicare fiscal intermediaries and carriers;

(b) Other PROs; and

(c) Other public or private review organizations as may be appropriate.

(Catalog of Federal Domestic Assistance Program No. 13.714, Medical Assistance Program; No 13.773, Medical—Hospital Insurance; No. 13.774, Medicare—Supplementary Medical Insurance)

Dated: December 17, 1984.

Carolyne K. Davis,

Administrator, Health Care Financing Administration.

Approved: January 28, 1985.

Margaret M. Heckler,

Secretary.

[FR Doc. 85-9000 Filed 4-11-85; 2:42 pm]

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42 CFR Parts 405, 420, 474 and 489

[HSQ-109-F]

Medicare Program; Utilization and Quality Control Peer Review Organizations—Imposition of Sanctions on Health Care Practitioners and Providers of Health Care Services

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Final rule.

SUMMARY: This final rule implements the portion of the Peer Review Improvement Act of 1982 that imposes certain obligations on health care practitioners and other persons who provide health care services to Medicare beneficiaries. The rule also: (1) Establishes sanctions that the Secretary may impose for violations of the obligations; (2) imposes certain responsibilities on utilization and quality control peer review organizations; and (3) provides that an exclusion sanction will automatically become effective if the Secretary fails to act within a 120-day review period.

EFFECTIVE DATE: May 17, 1985. However, peer review organizations are not required to comply with the information collection requirements contained in §§ 474.36(b), 474.38(b), 474.38(c), 474.39(b), 474.40(b), and 474.40(c) until they are approved by the Office of Management and Budget. (See section VI.C. of the preamble for a discussion of the information collection requirements.)

FOR FURTHER INFORMATION CONTACT:

Anthony J. Tirone (HCFA)—(PRO process), (301) 594-9208.

William M. Libercci (OIG)—(Department process), (301) 594-5035.

SUPPLEMENTARY INFORMATION:

I. Background

The Peer Review Improvement Act of 1982 (Title I, Subtitle C of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA, Pub. L. 97-248)) amended Part B of Title XI of the Social Security Act by establishing the Utilization and Quality Control Peer Review Organization (PRO) program. The PRO legislation, enacted on September 3, 1982, seeks to redirect, simplify, and enhance the cost-effectiveness of the peer review program under Medicare.

Section 143 of TEFRA amends sections 1151 through 1163 of the Social Security Act (the Act). As amended, section 1156 of the Act imposes certain obligations upon health care practitioners and other persons who furnish or order services under Medicare. Section 1156 of the Act also provides for sanctions if the Secretary determines that the obligations were not met. These sanctions are recommended to the Secretary by PROs that contract with the Secretary. PROs have the responsibility to determine whether practitioners and other persons are complying with their obligations under the statute. Based upon the PRO recommendations, the Secretary is authorized, by statute, to exclude practitioners or other persons from the

Medicare program or, in lieu of exclusion, require payment of a monetary penalty as a condition of continued eligibility to receive reimbursement under the program.

II. Discussion of Proposed Rule

On April 18, 1984, we published a proposed rule to implement section 1156 of the Act (49 FR 15233). Briefly, the major provisions of the proposal were as follows:

A. PRO Review Process

We proposed to require PROs to review activities of practitioners and other persons who furnish or order health care services or items and, when warranted, make determinations that obligations were violated and that corrective action is needed.

Under the proposal, when a practitioner or other person fails to comply substantially with an obligation in a substantial number of cases, or violates an obligation in a gross and flagrant manner, the PRO must report the violation to the Secretary. The Office of the Inspector General (OIG), Department of Health and Human Services, would act as the Secretary's designee.

The proposal detailed the procedures the PRO must follow in giving notice to the practitioner or other person and providing an opportunity for discussion before making a final determination that a practitioner or other person has violated an obligation. If, after following those procedures, the PRO still determines that a violation has occurred, the PRO would send its report and recommendations to the OIG.

The OIG would review the PRO report and either agree or disagree with the PRO's recommendations. If the OIG agrees with the PRO determination, it could exclude the practitioner or other person from the Medicare program, or in lieu of exclusion, require payment of a monetary penalty as a condition for continued participation in the program.

As provided in section 1156(b)(1) of the Act and our proposal, an exclusion would automatically become effective 120 days after a PRO recommendation for exclusion is received by the OIG, unless the OIG specifically rejects the recommendation. This provision *would not* apply to recommendations for a monetary penalty.

B. Effect of an Exclusion

Under the proposed rule, payment under Medicare would not be made to a practitioner or other person who has been excluded from the program for services or items furnished on or after the effective date of the exclusion. Also, payment would not be made for services or items *ordered* by an excluded practitioner or other person. Further details of our proposal, and the rationale for the proposed policies may be found in the preamble to the April 18 document.

III. Analysis and Response to Comments

We received comments on the proposed rule from 52 commenters including individuals, hospitals, medical societies, hospital and other professional associations, and professional standards review organizations (PSROs). These comments and our responses to them are discussed below.

A. Comment Period

Comment: Some commenters believe that the comment period for the proposed regulations was too short. They stated that 30 days was not enough to address all the issues and implications adequately. The commenters also suggested that the deadline for PRO contracts be revised from October 1, 1984 to January 1, 1985 to allow more time for review and comment.

Response: We believe 30 days was adequate time for commenters to address the proposal. The comment period was limited to 30 days to allow HCFA ample time to review, analyze, and incorporate pertinent comments into the final rule. The initial date mandated by Congress for the implementation of the PRO program was October 1, 1984. The implementation date was subsequently extended to November 15, 1984 by the Deficit Reduction Act of 1984 (Pub. L. 98-369).

B. Definitions (§ 474.0(b))

Comment: One of the obligations of a health care practitioner or other person who furnishes or orders health care services under Medicare, is to assure that those services are furnished economically (proposed § 474.30(a)). The proposed rule stated that *economically* meant that services were provided at the least expensive, medically appropriate type of setting or level of care.

A few commenters suggested revisions to the definition of the term *economically*, stating that although a physician may agree that services could be provided at a lower level of care, that lower level may not exist or be available. In addition, commenters stated that the longer and more complicated inpatient stays should not be arbitrarily terminated because less intensive services could be given in another setting. They believe that, in many cases, the continuity and completion of the patient care plan would be disrupted by such a move.

Other related comments on termination of stays cited the serious stress a patient could suffer, time wasted in the patient's physical transfer and transfer of medical records, and the adjustment problems the patient could have becoming familiar with new staff for a very short period of time.

Some commenters also suggested that the definition of *economically* should require transfer of a patient to another setting only when the new setting can actually take care of the patient. These commenters recommended that the definition be related to the availability of alternative settings or levels or care.

Response: We agree with the recommendation to revise the definition of *economically* and have added the word *available* to the definition. Thus, the requirement at § 474.30(a) that the practitioner provide services economically, means that the services must be provided at the least expensive, medically appropriate type of setting or level of care available. "Available", for this purpose, relates to the availability of alternative settings or levels of care with certain limitations (§ 405.1627). For example, if a patient no longer requires acute hospital care but could receive treatment, covered under Medicare, in a skilled nursing facility and there is no bed available to the patient, that continued stay in the hospital would be considered covered care. However, if a patient no longer needs an acute inpatient level of care but requires home health care services, any continued inpatient stay would not be considered covered care even though the necessary home health care services are not available. Consideration of alternatives by the PROs in no way implies any modification of current coverage policy.

Comment: One commenter believes that the definition of *economically* ignores the special needs of patients in rehabilitation hospitals and that the interpretation of the term *least expensive, medically appropriate type of setting or level of care* could cause significant problems. Another commenter stated that the proposed definition of *economically* could create the impression that the PRO or the physician is to make a comparative cost determination between institutional and other types of services. The commenter believes that this aspect should be clarified.

Response: The term *least expensive, medically appropriate* does not imply that a patient should be placed in or transferred to a facility or level of care

because the cost of the services needed is lower than in another similar facility (or level of care). The definition of *economically* for the final rule reads "least expensive, medically appropriate type of setting or level of care available". We believe this modified definition also addresses concerns related to special needs of patients in all types of settings.

Comment: Several commenters noted that the regulations do not define the criteria that PROs will utilize when making a determination that a practitioner or other person has (1) failed substantially to comply with any obligation in a substantial number of cases, or (2) grossly and flagrantly violated any obligation in one or more instances (§ 474.34(c)). Some commenters also stated that no definitions were given for *substantial* or *gross and flagrant* in the proposed rule. The commenters stated that without definitions, the interpretations will vary from one locality to another and even within a particular PRO area. The commenters believe that this will lead to inconsistent application of sanctions.

Response: We are not specifying the criteria for determining violations of the statutory obligations contained in section 1156(a) of the Act and § 474.30 of these final regulations. The PROs have responsibility for the review of the professional activities of practitioners or other persons. In rendering medical judgments, the PROs must apply, as principal points of evaluation and review, professionally developed norms of care, diagnosis, and treatment based on typical patterns of practice within the geographic area served by the organization. We agree with part of the comments and have added definitions for what will be considered *gross and flagrant* and *substantial* violations (§ 474.0(b)).

We have differentiated between substantial violation and gross and flagrant by interpreting the language used by the statute. Substantial violation in a substantial number of cases means a pattern of care has been provided that is inappropriate, unnecessary or does not meet the recognized professional standards of care or is not supported by the necessary documentation of care as required by the PRO. Gross and flagrant violation means a violation of an obligation has occurred in one or more instances which presents an imminent danger to health, safety or well being of a Medicare beneficiary or places the beneficiary unnecessarily in high risk situations.

Comment: One commenter suggests that the definition for Statewide Council be deleted because Statewide Councils do not apply to the PRO program and are no longer operational in the PSRO program.

Response: We agree and have deleted the definition for Statewide Council.

C. Obligations of Practitioners or Other Persons (§ 474.30)

Comment: One commenter believes that the practitioner's or other person's obligation to assure that services are of a quality that meet professionally recognized standards of health care (proposed § 474.30(b)) could be a problem. The commenter states that a PRO may not be qualified to define these standards. Similarly, one commenter states that the proposed sanction process imposes the judgment of non-professionals on medical professionals without due process of law. A third commenter wants us to ensure that the sanction process is objective. This commenter is concerned that the proposed regulations could result in reviewers who are not familiar with certain procedures making arbitrary determinations of violations.

Response: The requirements and criteria for determining the capability of a PRO to perform medical review were specified in the request for proposal for PRO contracts. As part of the requirements, a PRO must have sufficient physician resources to conduct all required review activities. This requirement assures adequate peer review. The process followed in developing a sanction case under this regulation is very similar to the process used under the PSRO program. These procedures have been tested in court and found to be constitutionally sound.

Comment: Proposed § 474.30(c) stated that practitioners or other persons who furnish or order health care services under Medicare would be obligated to assure that the services are supported by evidence of medical necessity and quality in the form and fashion that the reviewing PRO may reasonably require. Some commenters believe that § 474.30(c) is not consistent with the related provision in the statute (section 1156(a)(3) of the Act). These commenters stated that this paragraph would require a hospital to substantiate its compliance with pre-admission or pre-procedure review requirements. They noted, however, that the request for proposal for PROs sent out by HCFA indicates that no review function except quality review studies will be delegated to a hospital by the PRO. The commenters believe, in essence, that the proposed rule would require hospitals to develop a system to comply with a review activity that only the PRO is supposed to conduct.

Some commenters believe that the practitioner's or other person's obligation to comply with pre-admission or pre-procedure review requirements allows PROs to exercise a broad authority not supported by statute. They recommend that the reference to pre-admission and pre-procedure reviews be deleted from § 474.30(c). One commenter suggested that the pre-admission and pre-procedure reviews cited in § 474.30(c) should be performed on a delegated basis because this method would be the most cost-effective.

Response: The commenters are correct when they point out that no pre-admission or pre-procedure review activity will be delegated to hospitals and only the PROs will conduct this type of review. However, the intent of the requirement was misunderstood by the commenters and only needs to be clarified here. A PRO may require that practitioners or other persons follow certain procedures to enable the PRO to conduct this type of review, and all practitioners or other persons must comply. Hospitals must develop procedures to ensure that categories of patients subject to pre-admission review are, in fact, reviewed before admission. A violation of these procedures could result in a sanction. At its discretion, a PRO could request evidence of compliance with its review procedures to assure that a practitioner or other person is meeting the obligations imposed by section 1156(a) of the Act. Therefore, we do not believe that any changes are required in § 474.30(c).

Comment: Many commenters believe that PROs should not be provided with copies of medical records at the expense of the practitioner or other person (§ 474.30(c)). They stated that this provision shifts substantial unreimbursed costs to the practitioner or other person, causing an undue financial burden. One commenter noted that under the prospective payment system, the high non-reimbursable costs for retrieving, copying, and transporting records will result in higher charges to private pay patients.

Response: We believe it is important that PROs have adequate access to medical records to enable them to carry out required activities. This includes the right to request and receive copies as they deem necessary. In some cases, this will mean that the PRO will request hospitals to photocopy specific medical records and mail them to PRO. However, the cost of photocopying records is a hospital operating cost and,

as such, is covered by the DRG prospective payments.

The prospective payment rates are computed according to the provisions of the law and are also based on the best available data at the time of the computation. Administrative costs are included in the Federal and hospital specific portions of prospective payments by virtue of being incurred and reported by hospitals for the years that represent the data bases for the prospective payment system.

Prior to the use of PROs, review of inpatient hospital services was carried out either at the hospital or offsite. Offsite review sometimes required that the hospital mail patient records to Medicare fiscal intermediaries. These costs were subsumed in the hospital's administrative costs that in turn were reflected in Medicare cost reimbursement calculations. Costs related to such activities are accounted for, in some measure, in the prospective payment base rates.

We also believe that the fiscal benefits of PRO review will compensate for any such increased costs. For example, in many cases, PROs' pre-admission review activities will protect hospitals from many retrospective denials. Thus, there will be trade-offs between hospitals' costs of providing medical records to PROs and PROs' performance of review that in many cases, may assist hospitals in avoiding unnecessary expenditures.

Accordingly, we are not changing this section of the regulations.

D. Sanctions (§ 474.32)

Comment: One commenter stated that § 474.32(b) does not completely reflect the Act's provisions and limitations in section 11256(b)(3). The commenter believes that although the proposed rule reflects the fact that monetary penalties are to be imposed in lieu of exclusion and are limited to an amount not in excess of the cost of improper or unnecessary services, the proposed rule does not indicate that monetary penalties can be imposed only when "such acts or conduct involved the provision or ordering . . . of health care services which were medically improper or unnecessary."

Response: We agree and have modified § 474.32(b) to specifically state that penalty is only available in cases of unnecessary or improper services.

Comment: One commenter recommends that the time for payment of a monetary assessment be extended from six months to one year since the amount of the penalty may be substantial.

Response: We believe six months is a sufficient period of time for payment of any monetary assessment. The practitioner or other person will have an option of taking six months to pay the monetary assessment or having it deducted from any sums the Federal Government owes the practitioner or other person. We believe the six month period is appropriate given the basis for determining the amount of the penalty and the need to adequately monitor its enforcement.

Comment: One commenter states that HCFA should promote a means of coordinating sanction activity between the Medicare and Medicaid programs.

Response: We agree and are coordinating sanction activity to the extent that legislation allows notification to State agencies when sanctions are being imposed on practitioners and other persons participating in the Medicare program.

E. PRO Responsibilities (§ 474.34)

Comment: A commenter recommends that the regulations be amended to provide a means of accommodating the practitioner's or other person's comments prior to the PRO's identification of a violation. The commenter stated that before a PRO identifies a violation, the PRO should be required to speak with the practitioner or other person to obtain his or her view of the facts and to see if a mutually satisfactory resolution could be reached.

Response: We agree with the comments but have not accepted the recommendation to revise the proposed rule because the requirements suggested are beyond the scope of the regulations and have already been included in the peer review plan of the PRO. A PRO must use all appropriate mechanisms of review and intervention to resolve adverse situations and assure compliance with the statutory obligations prior to using the sanction procedures specified in these final regulations. The sanction process is viewed as a measure of last resort in the peer review program. We believe that the broad scope of the basic responsibilities addressed in § 474.34(a) applies to the requirement of resolving situations before using the sanction procedures under this final rule.

Comment: Proposed § 474.34(e) requires the PRO to deny Medicare payment for services or items ordered by an excluded practitioner or other person when the PRO identifies such services or items and reports the findings to HCFA. One commenter stated that it will be almost impossible for a PRO to identify items or services ordered by an excluded practitioner from another area or State, given the present state-of-the-art for tracking excluded practitioners. The commenter suggested that § 474.34(e) be modified to recognize this difficulty.

Response: We have not changed this section because we believe that the provisions requiring that notice of sanction be provided to the PRO who originated the sanction report and PROs in adjacent areas (as defined in § 474.52(e) (1) and (2)) reduce the potential difficulty that may be encountered by a PRO in identifying services or items ordered by an excluded practitioner. Section 474.34(e) does not require a tracking mechanism for an excluded practitioner outside the jurisdiction of a PRO. However, PROs are statewide organizations and are expected to conduct statewide monitoring. The OIG's internal procedures requiring monthly notice of sanctioned individuals to every State and PRO could facilitate the identification of an out-of-State practitioner who could be furnishing services in another State.

F. Action of Identification of a Violation (§ 474.36)

Comment: One commenter stated that § 474.36(b), concerning PRO action if the PRO determines that a violation is a substantial failure to comply in a substantial number of cases, should require the PRO to send the practitioner or other person a written initial notice when the PRO identifies the violation.

Response: We agree with this comment and have clarified the section to require the PRO to send a written notice when a substantial violation is identified.

Comment: One commenter believes that a summary of the information used by the PRO in arriving at its determination (which is supplied to the practitioner or other person at the time a violation is identified) is insufficient to support action by the PRO at that time. The commenter believes that the practitioner or other person would be unable to respond properly to the PRO's allegations, unless detailed supporting material were provided at the time of notice.

Response: We believe the summary information that the PRO provides with the written notice at the time a substantial violation is identified is adequate. This summary must be complete enough to advise the physician or other person of the issues involved and to identify the significant information on cases used in determining the violation. Section 474.38(b) requires the PRO to provide a

copy of all the material used by the PRO if it is determined that a violation has, in fact, occurred.

G. PRO Determination of a Violation (§ 474.39)

Comment: The proposed regulations allow a practitioner or other person 20 or 30 days to respond to PRO notices during different stages of the sanction process (§§ 474.36(b)(6), 474.38(b)(5), and 474.39(b)(2)). Various commenters stated that 20 or 30 days is not enough time for a reasonable reply. One commenter also noted that the failure of a PRO to release notices in a timely manner and potential delays in the postal system could limit the available time even more. The commenters suggested that: (1) The time frames be extended by 10 or 15 days, (2) practitioners or other persons be given 20 to 30 days to reply from the date the PRO notification is *received*, and (3) only work days be considered in the time frames.

Response: Sections 474.36(b)(6), 474.38(b)(5), and 474.39(b)(2) have been modified to incorporate the suggestion that practitioners or other persons be given 20 or 30 days, as specified, to reply from the date the PRO notification is received. The date of receipt is presumed to be five days after the date on the notice, unless there is a reasonable showing to the contrary. We are not further extending these timeframes for the final rule. These timeframes have been extended already from the time allowed under the previous sanction regulations. Extending the timeframes any longer would prolong an already lengthy process. We believe that the time allowed is adequate for a practitioner or other person to respond.

Comment: We proposed that if the issue concerning the PRO's determination of a violation is not resolved to the PRO's satisfaction, the PRO would submit its report and recommendation to the OIG, and the practitioner or other person would have 30 days to submit additional material to the OIG. One commenter recommends that the proposal be revised to allow the OIG to accept information beyond the proposed 30-day period if the practitioner or other person has exercised diligence in providing or obtaining information, and acceptance of the information could materially affect the outcome of the case.

Response: We believe the time limits specified in the regulations are sufficient for the practitioner or other person to submit additional material to the OIG. Additionally, in view of the statutory mandate that the Secretary act within 120 days of the receipt of a PRO recommendation for exclusion, the granting of any additional time in which to submit additional information would interfere with the OIG responsibility in this regard.

H. PRO Report to OIG (§ 474.40)

Comment: One commenter states that the language contained in § 474.40(c)(4) was merely repetitive of the language in the statute and requested a more thorough explanation as to how a "finding" could be made as to whether a practitioner or other person is unable or unwilling substantially to comply with his or her obligations.

Response: We have changed the word "finding" to "recommendation" in § 474.40(c)(4). Section 1156(b) of the Act requires the Secretary, rather than the PRO, to make the determination before invoking a sanction, that the practitioner or other person is unable or unwilling substantially to comply with the statutory obligations. We have not specified the information that the PRO must use in making its recommendation in the final regulation. The PROs are responsible for determining in each situation the information that would best support their recommendation. For example, the PRO could base its recommendation on the experience the PRO has had with the particular practitioner as well as any other information considered relevant by the PRO.

I. Basis for Recommended Sanction (§ 474.41)

Comment: Proposed § 474.41 contains the various considerations on which the PRO would base its recommendations for a specific type of sanction. A commenter stated that two of the listed considerations were duplicative, and that we should require consideration of the availability of alternative sources of services in the community.

Response: The repetition was due to a typographical error that has been corrected in these final regulations. The proposal should have required, in place of the duplication, a consideration of the deterrent value of the sanction. Also, the commenter's request concerning alternative sources of services in the community has been accepted. However, as discussed in section III.B. of this preamble, consideration of alternatives by the PROs in no way implies any modification of current coverage policy.

J. Review of PRO Report by the OIG (§ 474.42)

Comment: One commenter suggests that § 474.42(b) should be revised to expand the bases for OIG review of a PRO's report and recommendations to include, in the case of evidentiary violations, whether the PRO's procedures and demands for documentation in the cases at issue were reasonable and necessary to performance of its duties under the Act.

Response: We believe the requirement contained at § 474.42(b)(1) that the OIG determine whether the PRO is following its procedures is sufficient to substantiate whether the PRO's actions were reasonable and necessary.

Comment: One commenter noted that paragraphs (d) through (f) of § 474.42 were incorrectly designated since paragraph (c) was omitted.

Response: Appropriate redesignations have been made to correct the typographical error.

Comment: One commenter stated that § 474.42(e) (2) and (3) (redesignated in this final rule as paragraphs (d) (2) and (3)) were not clear as to how the type and severity of offense would be classified and weighed in the OIG's sanction determination.

Response: We believe the present language adequately advises the reader of the manner in which the OIG determines the appropriateness of any sanction. Identical language was found in former § 474.10, relating to HCFA's deliberations concerning the imposition of a sanction following the receipt of a PSRO report.

Comment: Many commenters disagree with the automatic imposition of an exclusion if the OIG (acting as the Secretary's designee) does not act within the 120-day review period (proposed § 474.42(f)). These commenters believe that this is an arbitrary intrusion into the Secretary's discretionary role that fails to consider special circumstances that may arise. The commenters want some action required by the OIG before an exclusion could be effective. One commenter stated that the automatic exclusion is inappropriate because action by the OIG *is* required to reinstate a practitioner or other person in the Medicare program.

Response: We are unable to accept these comments because the 120-day provision for the automatic implementation of an exclusion is required by section 1156(b)(1)(B) of the Act. However, if an exclusion sanction becomes effective because a decision was not made within 120 days, the OIG will complete the review of the case and issue a notice to the practitioner or other person affirming or modifying the PRO recommendation. We would note that proposed § 474.42(f) has been

redesignated as § 474.42(e) in this final rule.

Comment: Several comments were received concerning the imposition of a monetary penalty in lieu of an exclusion. Specifically, the proposed rule states that the 120-day provision for automatic imposition does not apply to the recommendations for a monetary penalty. Commenters requested specific language to reflect the appropriate handling of monetary penalty recommendations, specifying the action that OIG will take in these cases.

Response: We have modified the section pertaining to the automatic imposition of an exclusion to accommodate the comments. We have also added a new paragraph (§ 474.42(f)) relating to monetary penalty recommendations to address the comments.

K. Notice of Sanction (§ 474.52)

Comment: In the case of an exclusion under the proposed rule, the OIG would specify the earliest date on which it would accept a request for reinstatement. One commenter believes that the OIG should consider reinstatement of a practitioner without inflexible time limits when to do so would serve the interest of patients and the program.

Response: Under current HCFA regulations in 42 CFR Part 420—Program Integrity, § 420.132, Criteria for Action on Request for Reinstatement, provides that reinstatement will not be granted unless it is reasonably certain that the violations that led to exclusion will not be repeated. Statutory authority is given to the Secretary to exclude either permanently or for such period as may be determined. By excluding for a specific period of time, the practitioner or other person will have sufficient time to improve his or her medical practice or services and to demonstrate to the Secretary that the violations that led to exclusion will not recur. Furthermore, allowing reinstatment prior to the period specified by the Secretary would mitigate against the effect of imposing a sanction. To permit the practitioner or other person to apply for reinstatement when the practitioner or other persons believes that he or she is ready to be reinstated would be totally unmanageable and would not be of benefit to the program. This could allow the person to apply one week after the effective date.

Comment: Many commenters are concerned that the new regulations do not adequately address the administrative appeals process available to a practitioner or other person who receives a sanction notice from the OIG.

Response: Several modifications have been made to accommodate these concerns. We have added a new paragraph (g) to § 474.52 to specify that the OIG's determination and notice of sanction under these regulations constitute an "initial determination" and a "notice of initial determination" for purposes of the administrative appeals process. These initial determinations are not subject to reconsideration. Instead, if dissatisfied with an initial determination, a practitioner or other person must request a hearing. We have revised § 474.56 to clarify that the OIG's determination that the basis for the exclusion no longer exists and that there is reasonable assurance that the problems will not recur must be made in accordance with 42 CFR 420.130–420.136. We have also revised § 474.58 to clarify that a practitioner or other persons dissatisfied with the OIG's determination or an automatic exclusion sanction is entitled to a hearing before an Administrative Law Judge and may also request a review of that decision by the Appeals Council in accordance with 42 CFR 405.1530 through 405.1595 of this chapter.

Comment: Many commenters strongly believe that, since hospitals and other health care providers could potentially be held liable for services ordered by the sanctioned practitioner, the OIG should notify hospitals and other health care providers where the sanctioned practitioner may be practicing.

Response: We agree, in part, with these comments, and have added a requirement to § 474.52(e)(5) that notifications be given to the hospital where the sanctioned individual's case originated and where the individual currently has privileges, if known.

L. Effect of an Exclusion on Medicare Payments and Services (§ 474.54)

Comment: Many commenters noted that under § 474.54(a)(2) providers will not be paid for items or services ordered by the excluded practitioner or other person even though the provider may not be aware of the exclusion. These commenters believe that a provider (especially the institutions where the practitioner practices) must get adequate notice of sanction if the provider is going to be held liable in this manner. The commenters stated that the provision, as proposed, imposes an undue financial burden on providers because they will not be aware of particular sanctions.

Response: As previously noted, we will notify the hospital where the sanctioned individual's case originated and where the individual currently has visting privileges, if known.

Comment: We proposed to continue payment for inpatient hospital or skilled nursing services for 30 days after the effective date of an exclusion, for services furnished to a beneficiary who was admitted before the effective date of the exclusion. One commenter questioned why the length of stay should be determined by a sanction when a patient's admission is found to be medically necessary and appropriate (§ 474.54(b)(1)). This commenter noted that the prospective payment system already has sufficient remedies for lengths of stay and total costs that exceed the designated limits. The commenter believes that the hospitals should receive payment for items and services covered by the Medicare program and found by the PRO to be provided appropriately, regardless of the relationship of the length of stay to the effective date of the sanction.

Response: This is a statutory requirement contained in section 1866(b)(3) of the Act, and we cannot revise that policy in § 474.54(b)(1). Although we received no comments related to the payment exception for home health services or items, we have modified § 474.54(b)(2) to reflect a recent change to the Act that was contained in section 2348 of the Deficit Reduction Act of 1984 (Pub. L. 98–369). That statutory revision amended section 1866(b)(4) of the Act to permit payment for home health services or items furnished under a plan established before the effective date of exclusion to be available for services or items furnished up to 30 days after the effective date.

M. Hearings and Appeals (§ 474.58)

Many commenters are concerned about the hearings and appeals that woud be available under the proposed regulations. The following comments illustrate these concerns.

Comments:

- The proposed sanction process deprives practitioners or other persons of their constitutionally guaranteed right to legal counsel and judicial proceedings prior to the imposition of a sanction.
- An individual practitioner's reputation in the community could be irreparably damaged by an incorrect finding and publication of a sanction. All alleged violators should be accorded the right to a full, fair, and impartial evidentiary hearing prior to the imposition of a sanction and public disclosure. Publication of a sanction should be postponed until appeals are

completed, or until the time to appeal has expired.

• There is no opportunity to appeal a substantive error during the period that the OIG is reviewing the PRO's determination.

• Sections 474.36 and 474.38 of the proposed regulations (PRO identification and determination of a violation) should be revised. The regulations do not provide for an evidentiary hearing, permit the alleged violator to cross-examine witnesses or call witnesses in its defense, nor provide for an objective forum to judge the PRO's determination. Under the proposed regulations, the PRO would determine that a violation exists and then would judge whether or not the determination is correct.

• The practitioner or other person should have at least as much time to develop its documentation as the PRO took in preparing the determination of a violation.

• The regulations preclude any meaningful administrative review. Proposed § 474.52 provides that a sanction would be effective 15 days after the practitioner or other person is notified. A sanction could be entered, imposed, publicized, and implemented before the practitioner or other person has had any hearing and before there has been any opportunity to be heard by an independent forum. The regulations should provide that a sanction will not go into effect before a provider has had an opportunity to exhaust administrative review rights and not until one month after any petition for judicial review is filed.

• The regulations should require the PRO to provide the practitioner or other person with the actual information used by the PRO to determine that a violation exists. The summary of information (§ 474.36(b)(7)) required in the proposed regulations is not sufficient for a practitioner or other person to prepare an adequate defense.

• The regulations do not provide the practitioner or other person with a hearing before the OIG. While § 474.39(b)(2) grants the right to submit additional material to the OIG, it does not allow critical activities such as the right to cross-examine and probe the data upon which the PRO has relied.

Response: We do not agree that a formal hearing is required before implementation of a sanction.

Section 1156(c) of the Act provides for a hearing and judicial review as provided in section 205(b) and (g) of the Act, respectively. In accordance with these sections, the hearing and judicial review of administrative determinations do not occur before the decision is implemented.

Provision has been made in the regulations for an opportunity for the practitioner or other person to submit additional documentary evidence or written argument to the OIG before any sanction is imposed. This information must be submitted within 30 days from the date of receipt of final notice of a violation (§ 474.39(b)). We believe that the two opportunities to meet with the PRO in the case of a substantial violation (one opportunity in a gross and flagrant situation) before a final determination of a violation is made, and the opportunity to submit additional written argument or evidence to the OIG prior to its determination, along with the opportunity for an evidentiary hearing and judicial review after the implementation of a sanction, fully satisfy the due process standards as set forth by the United States Supreme Court in *Matthews v. Eldridge*, 424 U.S. 319 (1976).

In the *Eldridge* case, the Supreme Court made clear that due process does not require a full evidentiary pretermination hearing. The Court in the *Eldridge* case set forth three factors to be evaluated in deriving specific requirements of due process for a given situation:

(a) The private interest involved;

(b) The reliability of the process in making correct determinations and the probable value of additional safeguards; and

(c) The government's interest, including the fiscal and administrative burdens of additional safeguards (424 U.S. at 335).

The private interest here concerns practitioners' or providers' abilities to furnish services for which payment may be made under the Medicare program. Continued access to Medicare funds is not a prerequisite for the practitioner or provider continuing to furnish health care services to patients but concerns the physicians' access to one group of potential customers for their services. The government's interest, on the other hand, is not only fiscal but also the health and safety of individuals who are eligible for Medicare benefits.

In our view, the meeting with the PRO before it files a sanction report, and then the opportunity to provide additional written evidence or argument to the OIG before a determination is made, assures a high degree of reliability for the OIG's actions and safeguards against the erroneous imposition of a sanction.

We believe that requiring a full evidentiary hearing prior to the OIG's actions would not only be contrary to the Act but would adversely affect the health and safety of individuals. It also would add to the OIG's administrative and fiscal burdens by precluding prompt action and by allowing the continuation of benefit payments pending a conclusion of the hearing, without adding significantly to the reliability of the OIG's decision.

IV. Summary of Changes to the Proposed Rule

The following summary of regulations changes is provided for the reader's reference.

1. Section 405.1502

• We have added a new paragraph (f) to specify that the determination and notice of sanction under the PRO program is one of the initial determinations made by the Secretary.

2. Section 405.1503

• This section has been revised to distinguish between the notification procedures for initial determinations under the PRO sanction process and the notification procedures for other types of initial determinations.

3. Section 420.115(c)

• This paragraph has been revised to reflect a recent statutory change contained in section 2348 of Pub. L. 98–369. The statutory change provides that Medicare payment may be made for certain services furnished up to 30 days after the date of termination from the Medicare program.

4. Section 420.126(e)

• This paragraph has also been revised to reflect the recent statutory change contained in section 2348 of Pub. L. 98–369. The statutory change provides that Medicare payment may be made for certain services furnished up to 30 days after the date of termination from the Medicare program.

5. Section 474.0(a)

• The reference to Statewide Councils has been deleted from paragraph (a)(2).

6. Section 474.0(b)

• The definition of *economically* has been revised to clarify that the appropriate level of care is a level of care that is actually available.

• A definition for *gross and flagrant violation* has been added.

• A definition for *substantial violation* has been added.

• The definition for *Statewide Council* has been deleted.

• The definitions for *PRO* and *PSRO* have been deleted because the terms are already defined in Part 400, § 400.200 General definitions.

7. Section 474.36(b)

• The term *substantial failure to comply* has been changed to read *a substantial violation in a substantial number of cases.*

• We have clarified that the PRO's notice to the practitioner or other person must be in writing.

8. Sections 474.36(b)(6), 474.38(b)(5), and 474.39(b)(2)

• These sections have been revised to specify that the practitioner's or other person's time to respond to the PRO notice begins on the date the PRO notice is received. Further, the date of the receipt is presumed to be 5 days after the date on the notice, unless there is a reasonable showing to the contrary.

9. Section 474.40(c)(4)

• The word *finding* has been changed to *recommendation* to clarify that the PRO makes a recommendation and not a determination concerning the practitioner's or other person's ability to comply with an obligation that was violated.

10. Section 474.41

• The typographical error in paragraph (c) of the proposed rule has been corrected by adding the statement originally intended.

• A new paragraph (e) has been added to recognize that a PRO must consider the availability of alternative sources of service in the community when deciding whether to recommend a sanction.

• Paragraph (e) of the proposed rule has been redesignated as paragraph (f) in this final rule.

11. Section 474.42

• To correct a typographical error in the proposed rule, paragraphs (d), (e), and (f) have been redesignated as paragraphs (c), (d), and (e), respectively.

• Paragraph (e) has been revised to clarify the provisions concerning an automatic exclusion sanction.

• A new paragraph (f) has been added to clarify the provisions concerning a monetary penalty.

12. Section 474.52

• Paragraph (e)(5) has been revised to clarify that a notice of sanction will be provided to the hospital where the sanctioned individual has privileges and to the hospital where the case originated, if known.

• Paragraph (f) of the proposed rule has been revised to clarify the notification procedures when an automatic exclusion sanction is involved.

• A new paragraph (g) has been added to clarify that the determination and notice of sanction constitute an initial determination and a notice of initial determination for purposes of administrative appeals procedures.

13. Section 474.54(b)

• This paragraph has been revised as required by section 2348 of Pub. L. 98–369. The statute provides that Medicare payment may be made for certain services furnished up to 30 days after the date of termination from the Medicare program.

14. Section 474.56(a)

• This paragraph has been revised to clarify that the OIG must comply with §§ 420.130 through 420.136 when deciding whether an exclusion sanction should be terminated.

15. Section 474.58(a)

• This paragraph was revised to clarify the practitioner's or other person's appeal rights.

16. Section 489.55

• This section was also revised to reflect a change contained in section 2348 of Pub. L. 98–369. The statutory change provides that Medicare payment may be made for certain services furnished up to 30 days after the date of termination from the Medicare program.

17. Miscellaneous changes

• We have made numerous minor editorial and technical revisions to clarify and correct the language in the regulations and to provide easier reading. All regulations sections contain one or more of these types of revisions.

18. Conforming changes

• Sections 405.1504, 405.1530, and 405.1531 have been revised to include a cross-reference to new § 405.1502(f).

V. Waiver of Notice of Proposed Rulemaking for Certain Sections

The revisions in §§ 420.115(c), 420.126(e), 474.54(b), and 489.55 are conforming changes made necessary by section 2348 of Pub. L. 98–369. This statutory provision became effective on July 18, 1984, the date of enactment of Pub. L. 98–369. Our conforming changes are being issued as part of this final rule because the effective date of the provision was statutorily mandated and because the provision itself is self-implementing.

The conforming changes do not expand upon the statutory provision, but merely paraphrase it. Accordingly, we find that a notice of proposed rulemaking for the conforming changes would be impractical and unnecessary, and find good cause to waive it.

VI. Impact Analyses

A. Executive Order 12291

Executive Order 12291 requires that a regulatory impact analysis be performed for any "major" regulation; that is, a regulation that will result in an economic impact of $100 million or more, or a regulation that meets other criteria specified in section 1(b) of the Order.

Under these final regulations, a PRO can recommend certain sanctions to the OIG when a practitioner or other person fails to meet obligations specified at section 1156(a) of the Act.

The PRO can recommend exclusion or, in lieu of exclusion, the assessment of a monetary penalty. An exclusion will become effective automatically 120 days after a PRO submits a recommendation for exclusion to the OIG, if a decision is not made within the 120-day period. This does not represent a major change from our current sanction activities. Although these regulations will expedite the review and completion of sanction cases, the incremental impact of these regulations will be negligible.

In this final rule, we are also clarifying and revising certain provisions of the proposed rule to accommodate questions and issues raised by numerous commenters. Taken as a whole, these changes are not significant departures from our current policies and procedures. Therefore, we have determined that a regulatory impact analysis is not required because these regulations do not meet the criteria for a "major" regulation.

B. Regulatory Flexibility Act

We do not expect these regulations to cause a significant incremental increase in our sanction activity. Historically, we have imposed administrative sanctions only in particularly abusive situations. Therefore, we believe that these sanction regulations will affect relatively few practitioners or other persons. Accordingly, we have determined that these regulations will not result in a significant impact on a substantial number of providers and practitioners.

Therefore, the Secretary certifies under 5 U.S.C. 605(b), as enacted by the Regulatory Flexibility Act of 1980 (Pub. L. 96–354), that these regulations will not result in a significant impact on a substantial number of small entities.

C. Reporting and Recordkeeping Requirements

Sections 474.36(b), 474.38(b), 474.38(c), 474.39(b), 474.40(b), and 474.40(c) contain information collection requirements to which PROs must adhere. We are submitting the requirements in these regulations to the Office of Management and Budget (OMB) for review under the requirements of the Paperwork Reduction Act of 1980 (Pub. L. 96-511). PROs are not required to comply with these information collection requirements until OMB approves them. Comments on these requirements should be sent directly to the Office of Information and Regulatory Affairs, OMB, New Executive Office Building, Washington, D.C., Attention: Fay Iudicello. A notice will be published in the Federal Register when approval is obtained.

VII. LIST OF SUBJECTS

42 CFR Part 405

Administrative practice and procedure, Certification of compliance, Clinics, Cost-based reimbursement, Contracts (Agreements), End-Stage Renal Disease (ESRD), Health care, Health facilities, Health maintenance organizations (HMO), Health professions, Health suppliers, Home health agencies, Hospitals, Inpatients, Kidney diseases, Laboratories, Medicare, Nursing homes, Onsite surveys, Outpatient providers, Reasonable charges, Reporting and recordkeeping requirements, Rural areas, Prospective payment system, X-rays.

42 CFR Part 420

Abuse, Administrative practice and procedure, Contracts (Agreements), Conviction, Convicted, Courts, Exclusion, Fraud, Health care, Health facilities, Health maintenance organizations (HMO), Health professions, Health suppliers, Information (Disclosure), Lawyers, Medicaid, Medicare, Penalties, Professional Standards Review Organizations (PSRO), Reporting and recordkeeping requirements, Supervision.

42 CFR Part 474

Health care, Health professions, Penalties, Professional Standards Review Organization (PSRO), Reporting and recordkeeping requirements, Sanctions, and Utilization and Quality Control Peer Review Organization (PRO).

42 CFR Part 489

Clinics, Health care, Health facilities, Medicare, Provider Agreements, Rural health clinics, Termination procedures.

42 CFR Chapter IV is amended as set forth below:

PART 405—FEDERAL HEALTH INSURANCE FOR THE AGED AND DISABLED

A. Part 405 is amended as follows:

1. The authority citation for Subpart O is revised to read as follows:

Authority: Secs. 1102, 1866, 1869, 1871, and 1872 of the Social Security Act; 42 U.S.C. 1302, 1395cc, 1395ff, 1395hh, and 1395ii, unless otherwise noted.

2. The introductory paragraph for § 405.1502 is reprinted unchanged and the section is amended by adding a new paragraph (f) to read as follows:

§ 405.1502 Initial determinations.

The Secretary will make findings setting forth the pertinent facts and conclusions, and an initial determination with respect to:

* * * * *

(f) The determination and notice of sanction provided for in §§ 474.52(a) and 474.52(g) of this chapter.

3. Section 405.1503 is revised to read as follows:

§ 405.1503 Notice of initial determinations.

A written notice of an initial determination as specified in paragraphs (a) through (f) of § 405.1502 will—

(a) Be mailed to the concerned provider, supplier, or practitioner; and

(b) Include the basis or reasons for the determination, and information concerning appeal rights. (See § 405.1510 concerning the right to a reconsideration, if applicable, and § 405.1530 concerning the right to a hearing.)

4. Section 405.1504 is revised by adding a cross-reference to § 405.1502(f) to read as follows:

§ 405.1504 Effect of initial determination.

The initial determination shall be final and binding upon the parties to the determination unless: (a) It is revised (see § 405.1519); (b) in the case of a determination described in § 405.1502 (a), (b)(1), or (d)(1), it is reconsidered in accordance with § 405.1514; or (c) in the case of a determination described in § 405.1502 (b)(2), (c), (d)(2), (e), or (f), a request for a hearing is filed and the initial determination is reversed.

5. Section 405.1530 is revised by adding a cross-reference to § 405.1502(f) to read as follows:

§ 405.1530 Hearing: Right to hearing.

After an initial and reconsidered determination described in §§ 405.1502 (a), (b)(1), (d)(1), and 405.1514, or after an initial determination described in § 405.1502 (b)(2), (c), (d)(2), (e), or (f); or after a revised determination described in § 405.1519, an institution, agency, clinic, laboratory, portable X-ray supplier, ambulatory surgical center, end-stage renal disease treatment facility, or person shall be entitled to a hearing with respect to such determination, if such person or the representative of the institution, agency, clinic, laboratory, portable X-ray supplier, ambulatory surgical center, end-stage renal disease treatment facility, or person files a written request for hearing as provided in § 405.1531.

6. Section 405.1531(a) is revised by adding a cross-reference to § 405.1502(f) to read as follows:

§ 405.1531 Filing a request for a hearing; time and manner of filing.

(a) The request for a hearing shall be made in writing, signed by the person, or a proper official of the institution, agency, clinic, laboratory, portable X-ray supplier, ambulatory surgical center, or end-stage renal disease treatment facility concerned and filed at an office of the Department of Health and Human Services, or with a presiding officer of the Appeals Council of the Office of Hearings and Appeals. The request must be filed within 60 days after the date notice of an initial determination provided for in § 405.1502 (b)(2), (c), (d)(2), (e), or (f); or a reconsidered or revised determination, is received by the institution, agency, clinic, laboratory, portable X-ray supplier, ambulatory surgical center, end-stage renal disease treatment facility, or person (see §§ 405.1503, 405.1516, and 405.1520), except where the time is extended for "good cause" (see § 405.1569). For purposes of this section, the date of receipt of notice of the initial, reconsidered or revised determination shall be presumed to be 5 days after the date of such notice, unless there is a reasonable showing to the contrary.

* * * * *

PART 420—PROGRAM INTEGRITY

B. Part 420 is amended as follows:

1. The authority citation for Part 420 continues to read as follows:

Authority: Secs. 1102, 1862(d) (1), (2), (3), and (4), 1862(e), 1866(b) (2)(D), (E), and (F), 1871, 1902(a)(39), and 1903(i)(2) of the Social Security Act (42 U.S.C. 1302, 1395y(d), 1395cc, 1395hh, 1396a, and 1396b, unless otherwise noted).

2. Section 420.115(c) is revised to read as follows:

§ 420.115 Effect of exclusion.

* * * * *

(c) *Exceptions.* Payment is available for up to 30 days after the effective date of exclusion for—

(1) Inpatient hospital services or posthospital skilled nursing facility care services furnished to a beneficiary who was admitted to a hospital or a SNF before the effective date of exclusion; and

(2) Home health services furnished under a plan established before the effective date of exclusion.

3. Section 420.126(e) is revised to read as follows:

§ 420.126 Effect of suspension.

* * * * *

(e) *Exceptions.* Payment is available for up to 30 days after the effective date of the suspension for—

(1) Inpatient hospital services or posthospital skilled nursing facility care furnished to a beneficiary who was admitted to a hospital or a SNF before the effective date of the suspension; and

(2) Home health services furnished under a plan established before the effective date of the suspension.

PART 474—IMPOSITION OF SANCTIONS ON HEALTH CARE PRACTITIONERS AND PROVIDERS OF HEALTH CARE SERVICES

C. Part 474 is amended as follows:

1. The table of contents and the authority statement are revised to read as follows:

Subpart A—General Provisions

Sec.
474.0 Scope and definitions.

Subpart B—Sanctions Under the PSRO Program

474.1 Statutory obligations of practitioners and providers.
474.2 Sanctions.
474.3 PSRO responsibilities.
474.4 Action on potential violation.
474.5 Factors in PSRO determination of a violation.
474.6 Basis for recommended sanction.
474.7 Notice and review of PSRO determination of violation.
474.8 PSRO report to the Statewide Council or to HCFA.
474.9 Role and functions of the Statewide Council.
474.10 Action by HCFA on receipt of the report.
474.14 Effective dates of exclusion.
474.15 Reinstatement after exclusion.
474.17 Right to judicial review.

Subpart C—Sanctions under the PRO Program: General Provisions

474.30 Statutory obligations of practitioners and other persons.
474.32 Sanctions.

Subpart D—PRO Responsibilities

474.34 Basic responsibilities.
474.36 Action on identification of a violation.
474.38 Action on determination of a violation.
474.39 Final PRO determination of a violation.
474.40 PRO report to OIG.
474.41 Basis for recommended sanction.

Subpart E—OIG Responsibilities

474.42 Acknowledgment and review of report.
474.52 Notice of sanction.

Subpart F—Effect and Duration of Exclusion

474.54 Effect of an exclusion on Medicare payments and services.
474.56 Reinstatement after exclusion.

Subpart G—Appeals

474.58 Appeal rights.

Authority: Section 1102 of the Social Security Act, 42 U.S.C. 1302. Subpart B is also issued under sec. 150 of Pub. L. 97-248, 42 U.S.C. 1320c note. Subparts C through G are also issued under sec. 1156 of the Social Security Act, 42 U.S.C. 1320c—5.

2. A new Subpart A entitled "General Provisions" is established to include the current § 474.0.

3. Section 474.0 is revised to read as follows:

§ 474.0 Scope and definitions.

(a) *Scope.*

This part implements section 150 of Pub. L. 97-248 (PSROs) and section 1156 of the Act (PROs) by—

(1) Setting forth certain obligations imposed on practitioners and providers of services under Medicare;

(2) Establishing criteria and procedures for the reports required from PSROs and PROs when there is failure to meet those obligations;

(3) Specifying the policies and procedures for making determinations on violations and imposing sanctions; and

(4) Defining the procedures for appeals by the affected party and the procedures for reinstatements.

(b) *Definitions.* As used in this part, unless the context indicates otherwise:

"Economically" means that services are provided at the least expensive, medically appropriate type of setting or level of care available.

"Exclusion" means that items or services furnished or ordered by a specified health care practitioner, provider, or other person during a specified period are not reimbursed under Medicare.

"Gross and flagrant violation" means a violation of an obligation has occurred in one or more instances which presents an imminent danger to the health, safety or well-being of a Medicare beneficiary or places the beneficiary unnecessarily in high-risk situations.

"Health care services" or "Services" means services or items for which payment may be made (in whole or in part) under the Medicare program.

"Obligation" means any of the obligations specified at section 1156(a) of the Act.

"OIG" stands for the Office of the Inspector General, Department of Health and Human Services.

"Other person" means a hospital or other health care facility, an organization, or an agency that furnishes health care services for which payment may be made under the Medicare program.

"Physician" means a doctor of medicine or osteopathy or another individual who is authorized under State or Federal law to practice medicine and surgery or osteopathy.

"Practitioner" means a physician or other health care professional licensed under State law to practice his or her profession.

"PRO area" means the geographic area subject to review by a particular PRO.

"Provider" means a hospital or other health care facility, agency, or organization.

"PSRO area" means the geographic area subject to review by a particular PSRO.

"Sanction" means an exclusion or monetary penalty that the Secretary may impose on a practitioner or other person as a result of a recommendation from a PRO.

"Substantial violation in a substantial number of cases" means a pattern of care has been provided that is inappropriate, unnecessary, or does not meet recognized professional standards of care, or is not supported by the necessary documentation of care as required by the PRO.

4. A new Subpart B entitled "Sanctions Under the PSRO Program" is established to include current §§ 474.1-474.17.

5. New Subparts C through G are added to read as follows:

Subpart C—Sanctions Under the PRO Program: General Provisions

§ 474.30 Statutory obligations of practitioners and other persons.

It is the obligation of any health care practitioner or other person who furnishes or orders health care services that may be reimbursed under Medicare, to ensure, to the extent of his or her authority, that those services are—

(a) Furnished economically and only when and to the extent medically necessary;

(b) Of a quality that meets professionally recognized standards of health care; and

(c) Supported by evidence of the medical necessity and quality of the services in the form and fashion that the reviewing PRO may reasonably require (including copies of the necessary documentation and evidence of compliance with pre-admission or pre-procedure review requirements to ensure that the practitioner or other person is meeting the obligations imposed by section 1156(a) of the Act.

§ 474.32 Sanctions.

In addition to any other sanction provided under law, a practitioner or other person may be—

(a) Excluded from Medicare; or

(b) In lieu of exclusion and as a condition for continued participation in Medicare, if the violation involved the provision or ordering of health care services that were medically improper or unnecessary, required to pay an amount not in excess of the cost of the improper or unnecessary services that were furnished or ordered. The practitioner or other person will be required either to pay the monetary assessment within 6 months of the date of notice or have it deducted from any sums the Federal Government owes the practitioner or other person.

Subpart D—PRO Responsibilities

§ 474.34 Basic responsibilities.

(a) The PRO must use its authority or influence to enlist the support of other professional or government agencies to ensure that each practitioner or other person complies with the obligations specified in § 474.30.

(b) The PRO must identify situations where the obligations specified in § 474.30 are violated and afford the practitioner or other person reasonable notice and opportunity for discussion in accordance with §§ 474.36 and 474.38.

(c) The PRO must submit a report to the OIG after the notice and opportunity provided under paragraph (b) of this section, if the PRO determines that the practitioner or other person has—

(1) Failed substantially to comply with any obligation in a substantial number of cases; or

(2) Grossly and flagrantly violated any obligation in one or more instances.

(d) The PRO report to the OIG must comply with the provisions of § 474.40.

(e) The PRO must deny services or items ordered by an excluded practitioner or other person when the PRO identifies the services or items and reports the findings to HCFA.

§ 474.36 Action on identification of a violation.

When a PRO identifies a violation, it must determine the nature of the violation.

(a) If the PRO determines the violation as one that is gross and flagrant, it must proceed in accordance with § 474.38.

(b) If the PRO determines the violation as a substantial violation in a substantial number of cases it must send the practitioner or other person a written initial notice of the identification of a violation containing the following information:

(1) The obligation involved.

(2) The situation, circumstances, or activity that resulted in a violation.

(3) The authority and responsibility of the PRO to report violations of obligations.

(4) At the discretion of the PRO, a suggested method for correcting the situation and a time period for corrective action.

(5) The sanction that the PRO could recommend to the OIG if the violation continues.

(6) An invitation to submit additional information to or discuss the problem with respresentatives of the PRO within 20 days of receipt of the notice. The date of receipt is presumed to be five days after the date on the notice, unless there is a reasonable showing to the contrary.

(7) A summary of the information used by the PRO in arriving at its determination of a violation of an obligation.

§ 474.38 Action on determination of a violation.

(a) *Written notice.* The PRO must give written notice to the practitioner or other person if it determines that—

(1) A substantial violation has occurred in a substantial number of cases; or

(2) A violation is gross and flagrant in one or more cases.

(b) *Contents.* The notice must contain the following information:

(1) The determination of a violation.

(2) The obligation violated.

(3) The basis for the determination.

(4) The sanction the PRO will recommend to the OIG.

(5) The right of the practitioner or other person to submit to the PRO within 30 days of receipt of the notice, additional information or a written request for a meeting with the PRO to review and discuss the determination, or both. The date of receipt is presumed to be five days after the date on the notice, unless there is a reasonable showing to the contrary.

(6) A copy of the material used by the PRO in arriving at its determination.

(c) *Review of PRO determination.*

(1) The PRO may, on the basis of additional information received, affirm, modify, or reverse its determination.

(2) The PRO must give written notice to the practitioner or other person, of any action it takes as a result of the additional information received, as specified in § 474.39.

§ 474.39 Final PRO determination of a violation.

If the issue is not resolved to the PRO's satisfaction as specified in § 474.38(c), the PRO must—

(a) Submit its report and recommendation to the OIG; and

(b) Send the affected practitioner or other person a concurrent final notice, with a copy of the PRO report that is being forwarded to the OIG, advising that—

(1) The PRO recommendation has been submitted to the OIG;

(2) The practitioner or other person has 30 days from receipt of this final notice to submit any additional material to the OIG at its central office location. The date of receipt is presumed to be five days after the date on the notice, unless there is a reasonable showing to the contrary; and

(3) Due to the 120-day statutory requirement specified at § 474.42(e), the period for submitting additional information will not be extended and any material received by the OIG after the 30-day period will not be considered.

§ 474.40 PRO report to OIG.

(a) *Manner of reporting* . If the PRO determines that a substantial violation has occurred in a substantial number of cases or that a gross and flagrant violation has occurred, it must submit a report and recommendation to the OIG at the regional office with jurisdiction.

(b) *Content of report.* The PRO report must include the following information—

(1) Identification of the practitioner or other persons and when applicable, the

name of the director, administrator, or owner of the entity involved;

(2) The type of health care services involved;

(3) A description of each failure to comply with an obligation, including specific dates, places, circumstances, and any other relevant facts;

(4) Pertinent documentary evidence;

(5) Copies of written correspondence and written summaries of oral exchanges with the practitioner or other person regarding the violation;

(6) The PRO's determination that an obligation under section 1156(a) of the Act has been violated and that the violation is substantial and has occurred in a substantial number of cases or is gross and flagrant;

(7) The professional qualifications of the PRO's reviewers; and

(8) The PRO's sanction recommendation.

(c) *PRO Recommendation.* The PRO must specify in its report—

(1) The sanction recommended;

(2) The amount of the monetary penalty recommended, if applicable;

(3) The period of exclusion recommended, if applicable; and

(4) A recommendation as to whether the practitioner or other person is unable or unwilling substantially to comply with the obligation that was violated.

§ 474.41 Basis for recommended sanction.

The PRO's specific recommendation must be based on a consideration of—

(a) The type of offense involved;

(b) The severity of the offense;

(c) The deterrent value;

(d) The practitioners's or other person's previous sanction record;

(e) The availability of alternative sources of services in the community; and

(f) Any other factors that the PRO considers relevant (for example, the duration of the problem).

Subpart E—OIG Responsibilities

§ 474.42 Acknowledgement and review of report.

(a) *Acknowledgement.* The OIG will inform the PRO of the date it received the PRO's report and recommendation.

(b) *Review.* The OIG will review the PRO report and recommendation to determine whether—

(1) The PRO is following its procedures;

(2) A violation has occurred; and

(3) The practitioner or other person has demonstrated an unwillingness or lack of ability substantially to comply with an obligation.

(c) *Rejection of the PRO recommendation.* If the OIG decides that a sanction is not warranted, it will notify the PRO that recommended the sanction and the affected practitioner or other person that the recommendation is rejected.

(d) *Decision of sanction.* If the OIG decides that a violation of obligations has occurred, it will determine the appropriate sanction by considering—

(1) The recommendation of the PRO;

(2) The type of offense;

(3) The severity of the offense;

(4) The previous sanction record of the practitioner or other person;

(5) The availability of alternative sources of services in the community;

(6) Any prior problems the Medicare carrier or intermediary has had with the practitioner or other person;

(7) Whether the practitioner or other person is unable or unwilling to comply substantially with the obligations; and

(8) Any other matters relevant to the particular case.

(e) *Exclusion sanction.* If the PRO submits a recommendation for exclusion to the OIG, and a determination is not made by the 120th day after actual receipt by the OIG, the exclusion sanction recommended will become effective and the OIG will provide notice in accordance with § 474.52(f).

(f) *Monetary penalty.* If the PRO recommendation is to assess a monetary penalty, the 120-day provision does not apply and the OIG will provide notice in accordance with § 474.52 (a) through (e).

§ 474.52 Notice of sanction.

(a) The OIG notifies the practitioner or other person of the adverse determination and of the sanction to be imposed.

(b) The sanction is effective 15 days from the date of receipt of the notice. The date of receipt is presumed to be 5 days after the date on the notice, unless there is a reasonable showing to the contrary.

(c) The notice specifies—

(1) The legal and factual basis for the determination;

(2) The sanction to be imposed;

(3) The effective date and, if appropriate, the duration of the exclusion;

(4) The appeal rights of the practitioner or other person; and

(5) In the case of exclusion, the earliest date on which the OIG will accept a request for reinstatement.

(d) The OIG notifies the public by publishing in a newspaper of general circulation in the PRO area a notice that identifies the sanctioned practitioner or other person, the obligation that has been violated, the sanction imposed and, if the sanction is exclusion, the effective date and duration.

(e) Notice of the sanction is also provided to the following entities as appropriate:

(1) The PRO that originated the sanction report.

(2) PROs in adjacent areas.

(3) State Medicaid fraud control units and State licensing bodies.

(4) Appropriate Medicare contractors and State agencies.

(5) Hospitals, including the hospital where the sanctioned individual's case originated and where the individual currently has privileges, if known; skilled nursing facitilies, home health agencies, and health maintenance organizations (HMOs).

(6) Medical societies and other professional organizations.

(7) Medicare carriers and intermediaries, health care prepayment plans, and other affected agencies and organizations.

(f) If an exclusion sanction is effected because a decision was not made within 120 days after receipt of the PRO recommendation, notification is as follows:

(1) The OIG notifies the practitioner or other person that the exclusion from the Medicare program is effective 15 days from the date the notice is received by the practitioner or other person. The date of receipt is presumed to be five days after the date on the notice, unless there is a reasonable showing to the contrary.

(2) Notice of the sanction is also provided as specified in paragraph (e) of this section.

(3) As soon as possible after the 120th day, the OIG will issue a notice to the practitioner or other person affirming the PRO recommendation or modifying the recommendation based on the OIG's review of the case.

(g) The determination and notice of sanction provided for in this section constitute an "initial determination" and a "notice of initial determination" for purposes of the administrative appeals procedures specified in Part 405, Subpart O of this chapter concerning determinations and appeals procedures for providers and suppliers.

Subpart F—Effect and Duration of Exclusion

§ 474.54 Effect of an exclusion on Medicare payments and services.

(a) *General provisions.* Except as provided under paragraphs (b) and (c) of this section—

(1) Payment will not be made under Medicare to an excluded practitioner or other person for services or items furnished or ordered during the period of exclusion;

(2) Payment will not be made under Medicare to any provider for services or items ordered by an excluded practitioner or other person when the order was a necessary precondition for payment under Medicare; and

(3) Assignment of a beneficiary's claim for services or items furnished or ordered by an excluded practitioner or other person on or after the effective date of exclusion will not be valid.

(b) *Exceptions.* Payment is available for services or items provided up to 30 days after the effective date of an exclusion for—

(1) Inpatient hosptial or skilled nursing services or items furnished to a beneficiary who was admitted before the effective date of the exclusion; and

(2) Home health services or items furnished under a plan established before the effective date of the exclusion.

(c) *Denial of payments to beneficiaries.* If a beneficiary submits claims for services or items furnished or ordered by an excluded practitioner or other person on or after the effective date of exclusion—

(1) HCFA pays the first claim submitted and immediately gives the beneficiary notice of the exclusion; and

(2) The beneficiary's right to payment extends to services or items furnished or ordered up to 15 days after the date on the notice.

(d) *Effective date of termination of provider agreement.* The effective date of termination of a Medicare provider agreement is determined in accordance with §§ 489.53 and 489.55 of this chapter.

§ 474.56 Reinstatement after exclusion.

Exclusion will remain in effect until—

(a) The OIG determines, in accordance with §§ 420.130 through 420.136 of this chapter, that the basis for the exclusion no longer exists and there is reasonable assurance that the problems will not recur, or

(b) The OIG's determination to exclude is reversed by a hearing decision.

Subpart G—Appeals

§ 474.58 Appeal rights.

(a) *Right to administrative review.*

(1) A practitioner or other person dissatisfied with an OIG determination or an exclusion that results from a determination not being made within 120 days is entitled to a hearing before an Administrative Law Judge and may also request a review of that decision by the Appeals Council in accordance with §§ 405.1530 through 405.1595 of this chapter.

(2) Due to the 120-day statutory requirement specified at § 474.42(e) of this part, the following limitations apply:

(i) The period for submitting additional information will be not be extended.

(ii) Any material received by the OIG after the 30-day period allowed, will not be considered and will not be subject to review by the Administrative Law Judge and the Appeals Council.

(3) OIG's determination continues in effect unless reversed by a hearing decision.

(b) *Right to judicial review.* Any practitioner or other person dissatisfied with a decision of the Appeals Council or an administrative law judge (if a request for Appeals Council review is denied), may file a civil action in accordance with the provisions of section 205(g) of the Act.

PART 489—PROVIDER AGREEMENTS UNDER MEDICARE

D. Part 489 is amended as follows:

1. The authority citation for Part 489 continues to read as follows:

Authority: Secs. 1102, 1861, 1864, 1866, and 1871 of the Social Security Act (42 U.S.C. 1302, 1395x, 1395aa, 1395cc, and 1395hh).

2. Section 489.55 is revised to read as follows:

§ 489.55 Exceptions to effective date of termination.

Payment is available for up to 30 days after the effective date of termination for—

(a) Inpatient hospital services (including inpatient psychiatric hospital services) and posthospital extended care services furnished to a beneficiary who was admitted before the effective date of termination; and

(b) Home health services furnished under a plan established before the effective date of termination.[1]

(Catalog of Federal Domestic Assistance Programs, No. 13.773, Medicare—Hospital Insurance and No. 13.774, Medicare—Supplementary Medical Insurance)

[1] For terminations before July 18, 1984, payment was available through the calendar year in which the termination was effective.

Dated: December 11, 1984.

Carolyne K. Davis,

Administrator, Health Care Financing Administration.

R.P. Kusserow,

Inspector General, Department of Health and Human Services.

Approved: January 28, 1985.

Margaret M. Heckler,

Secretary.

[FR Doc. 85-9001 Filed 4-11-85; 2:42 pm]

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42 CFR Parts 400 and 476

[HSQ-110-F]

Medicare Program; Acquisition, Protection, and Disclosure of Utilization and Quality Control Peer Review Organization (PRO) Information

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Final rule.

SUMMARY: These regulations govern the acquisition, protection, and disclosure of information obtained or generated by Utilization and Quality Control Peer Review Organization (PROs). The Peer Review Improvement Act of 1982 authorizes PROs to acquire information necessary to fulfill their duties and functions, places limits on disclosure of PRO information, and establishes penalties for unauthorized disclosure. These regulations implement the PROs' statutory right of access to necessary information and set forth their responsibilities to assure that information once acquired is adequately safeguarded and disclosed only for proper purposes.

EFFECTIVE DATE: The regulations are effective May 17, 1985.

Sections 476.105, 476.116, and 476.134 of this rule contain information collection requirements with which the public is not required to comply until the Executive Office of Management and Budget (EOMB) approves these requirements. (See section VI. of the preamble for a discussion of information collection.)

FOR FURTHER INFORMATION CONTACT: Mary K. Terry, (301) 594-7910.

SUPPLEMENTARY INFORMATION:

I. Legislative History

The Peer Review Improvement Act of 1982 (Title I, Subtitle C of the Tax Equity and Fiscal Responsibility Act of 1982 (Pub. L. 97-248)) amended Part B of Title XI of the Social Security Act (Act) to establish the Utilization and Quality