

# Oklahoma State Department of Health Trauma Fund Review

## Final Report

June 6, 2012





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# 1. EXECUTIVE SUMMARY

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## 1. EXECUTIVE SUMMARY

Between October 2011 and March 2012 Public Consulting Group, Inc. (PCG) conducted a review of claims submitted to the Oklahoma State Department of Health (OSDH) Trauma Fund (“the Fund”) to determine the level of compliance with Fund regulations. All claims reviewed were claims for services provided during calendar year 2009. The specific regulations may be found in the state of Oklahoma Administrative Code (OAC) 310:669. These regulations provide guidance to providers who submit claims to the Fund and define the criteria that must be met, both clinically and financially, to receive reimbursement through the Fund’s bi-annual disbursement. As a payer specifically for trauma-related injuries, the Fund’s regulations require certain levels of injury severity for reimbursement and, as an uncompensated care funding source, providers are required to pursue all other potential payers before submitting a claim to the Fund.

Three specific types of providers may submit claims to the Fund: Hospitals, Physicians, and Emergency Medical Service (EMS) providers. As such, PCG performed onsite reviews for claims submitted of a selected sample from each provider type. The Fund disbursed \$25,680,066 to eligible providers submitting valid claims for services performed during 2009. PCG first selected a total of 100 providers to conduct onsite reviews. The selection methodology is described in detail below, but essentially PCG first selected the largest providers in terms of dollar amounts of Fund disbursement and then selected a random number of providers across the spectrum of Fund disbursement dollar values. After selecting the providers, PCG employed RAT-STATS, a sampling technology tool approved by the United States Department of Health & Human Services Office of Inspector General, to select a representative sample of claims at each provider. In total, PCG reviewed 2,825 claims. The breakdown by provider type was as follows:

<b>Provider Type</b>	<b>Total Number of Providers Receiving Reimbursement</b>	<b>Total Dollar Value of Fund Disbursement</b>	<b>Total Number of Providers Reviewed</b>	<b>Total Dollar Value of Reviewed Providers’ Disbursement</b>
<b>Hospital</b>	71	\$21,130,144	36	\$20,381,961
<b>Physician</b>	447	\$2,998,651	44	\$2,736,506
<b>EMS</b>	57	\$1,551,271	20	\$1,406,692
<b>Total</b>	<b>575</b>	<b>\$25,680,066</b>	<b>100</b>	<b>\$24,525,159</b>

### ***Review Preparation***

PCG met with OSDH staff in May 2011 to develop a protocol for each reviewed provider type. While there are aspects of the regulations at OAC 310:669 which are uniform across all provider types, there are also elements that are specific to each provider type. PCG reviewed the regulations with OSDH staff to gain an understanding of the particular challenges posed by reviewing each type of provider. Following that meeting, PCG revised the review protocol for each provider type and submitted to OSDH for approval.

On August 31, 2011, OSDH notified all Fund providers that PCG had been hired to perform a review of selected providers who submitted claims for services rendered during calendar year 2009. Approximately two (2) weeks before a provider site visit, PCG sent notification via certified mail informing providers that an onsite review was scheduled and requesting specific documentation (e.g., patient accounting records and service notes) related to the selected claims. On the day of the visit, PCG conducted entrance conferences to explain the reason for the visit, our approach for reviewing documentation, and the timeline for our submission of a report to OSDH. Our reviewers also offered to engage in an exit conference following our reviews to discuss general findings and give providers the opportunity to ask questions regarding specific claims that were found to be non-compliant.

### ***Hospital Reviews***

PCG performed reviews at a total of thirty-six (36) hospitals receiving reimbursement from the Fund for 2009 claims. Our review included twenty (20) of the top twenty-five (25) hospitals in terms of dollar value of claims and sixteen additional hospitals chosen at random. PCG reviewed a total of 1,170 hospital claims accounting for \$17,613,642 in claimed uncompensated trauma care.

PCG concluded that there was a very high level of compliance with the Fund's regulations related to the clinical aspects of a claim's eligibility. Of the \$17,613,642 in hospital claims PCG reviewed, PCG found just 0.8 percent of claimed uncompensated trauma care did not fully adhere to the Fund's clinical criteria. Given the Fund's extensive employment of the Trauma Fund Registry to "screen" cases into the Fund, it is intuitive that there would be a high level of clinical compliance. In order for a claim to be deemed eligible for reimbursement, certain objective criteria, like an admission to a hospital of at least forty-eight (48) hours and the ICD-9 code, have already been data entered by hospital staff. 98.6 percent of the reviewed number of claims (representing 0.8 percent of claimed uncompensated trauma care) featured service notes which supported the information submitted through the Trauma Registry.

However, the rate of compliance with the financial regulations was lower. Of the \$17,613,642 in hospital claims PCG reviewed, PCG found 7.5 percent of claimed uncompensated trauma care did not fully comply with the Fund's financial criteria. Hospital billing offices were generally compliant before the submission of claims to the Fund, appropriately reducing claim amounts by received payments in 95.8 percent of the claims reviewed and executing "reasonable" collection efforts in 100 percent of these cases.

PCG identified \$207,256 of patient and third party payments which were not deducted from uncompensated trauma care claims *prior to* submission to the Trauma Fund, as mandated by OAC 310:669-5-2. Hospitals were less compliant, however, in remitting patient and third party payments received after the submission of uncompensated trauma care claims, as required by OAC 310:669-5-4-c. PCG found \$1,102,850 in patient and third party payments which should have been (at least in part) remitted back to the Trauma Fund because they were received by the hospital after the hospital's submission of uncompensated trauma care claims. This trend was particularly evident at hospitals with higher designations of trauma care. This is typical because those providers generally treat the most severe cases which often receive payment from non-traditional healthcare payers (e.g., automobile insurers) after lengthy periods of negotiation or, in some cases, litigation. PCG's report includes recommendations that OSDH may implement to mitigate these issues.

In total, PCG's clinical and financial review of uncompensated trauma care claimed by hospitals found 176 claims, or 15.0 percent of the 1,170 reviewed claims, which failed to fully comply with the Fund's eligibility criteria outlined in OAC 310:669. The 176 noncompliant claims PCG identified represented \$1,467,687 dollars in claimed uncompensated trauma care, or approximately \$956,448 in Trauma Fund disbursement.

### ***Physician Reviews***

PCG performed reviews at a total of forty-four (44) physician groups receiving reimbursement from the Fund for 2009 claims. Our review included all of the top ten physician groups in terms of dollar value of claims, a random selection of ten (10) physician groups ranked eleven (11) through twenty-five (25), and a random selection of twenty-four (24) additional physician groups ranked twenty-six (26) or higher in the dollar value of claims submitted to the Trauma Fund. In total, PCG reviewed 1,207 physician claims accounting for \$445,394 in claimed uncompensated trauma care.

Physician groups demonstrated a very high level of compliance with the Fund's clinical and financial criteria, as PCG identified just \$4,415, or 0.9 percent of the dollar value of reviewed claims, as failing to adhere to eligibility criteria for Trauma Fund payment. Of the 1,207 physician claims reviewed, PCG identified just twenty-three (23) claims as noncompliant. However, specialty physicians such as those performing radiology or anesthesia services often had medical records which were limited to their specific procedure(s), requiring these providers to rely on hospital confirmation that their claims were in compliance with the Fund's criteria that the patient remain in the hospital for forty-eight (48) hours, be admitted to the operating room or intensive care unit, or be transferred from a lower to a higher level trauma facility.

PCG found that 1.9 percent of the reviewed number of physician claims (regardless of dollar value), accounting for \$4,415 in Trauma Fund payments, failed to adhere to the Fund's eligibility criteria outlined in OAC 310:669.

### ***EMS Reviews***

PCG performed reviews at a total of twenty (20) EMS groups receiving reimbursement from the Fund for services rendered in calendar year 2009. Our review included all of the top ten (10) EMS providers offering air services and all of the top ten (10) EMS providers offering ground services; each in terms of the dollar amount of Fund distribution. In total, PCG reviewed 448 EMS claims accounting for \$1,186,965 in claimed uncompensated trauma care.

While EMS providers were generally compliant with Fund eligibility criteria, PCG identified eighty-four (84) claims, representing \$149,648 in Trauma Fund payments, which failed to fully comply with the Trauma Fund's eligibility criteria. PCG also found variability across providers in the completion of the Fund's claim form. Because the Fund's claim form contains only a single Medicare allowable mileage rate field for each EMS provider run, ground providers were unable to differentiate between the rural mileage premium applied to the first seventeen (17) miles of a loaded run and the lower mileage rate applied to any additional miles traveled. This resulted in ground providers overstating the value of their uncompensated trauma care on thirty (30) of the claims reviewed by PCG, representing \$2,827 in Trauma Fund overpayment.

Seven (7) of the twenty (20) EMS providers PCG reviewed failed to cite specific, acceptable eligibility criteria (i.e., #1-15 of OAC 310:669-5-1-f) in the 'Trauma Criteria' field on the EMS Trauma Fund claim form, despite the fact that in nearly every case their medical records supported the trauma designation for each claim. Affected EMS providers often cited non-medical terminology such as "motor vehicle accident" as proof of trauma.

### ***Summary Findings***

In total, PCG found that 10.0 percent of reviewed 2009 uncompensated trauma care claims submitted by hospitals, physicians, and EMS providers failed to comply with the Trauma Fund's eligibility criteria as stated in OAC 310:669. PCG identified 283 claims which failed to meet the Trauma Fund's eligibility criteria, representing \$1,110,511 in incorrect Trauma Fund payments, as follows:

	<b>Hospitals</b>	<b>Physicians</b>	<b>EMS</b>	<b>Total</b>
<b>Reviewed Claims</b>	1,170	1,207	448	<b>2,825</b>
<b>Noncompliant Claims</b>	176	23	84	<b>283</b>
<b>Unsupported TF Payments</b>	\$956,448	\$4,415	\$149,648	<b>\$1,110,511</b>

### ***Conclusions***

Provider reviews play a critical role in ensuring that hospitals, physicians and EMS providers continue to operate in compliance with Trauma Fund regulations. PCG's review of 2,825 uncompensated trauma care claims at 100 providers across the state of Oklahoma found that more than ten (10) percent of the reviewed uncompensated trauma care claims did not adhere to Fund' eligibility criteria, resulting in \$1.1 million in potentially erroneous Trauma Fund payments.

PCG's onsite review found that providers are generally operating in good faith in submitting claims for Trauma Fund reimbursement but that there are compliance issues which are largely identifiable and, more importantly, preventable. Healthcare reimbursement is increasingly complex regardless of who the payer is and the Trauma Fund is no exception. The regulations governing reimbursement through the Fund are typical of healthcare reimbursement requirements and effectively demonstrate *what* needs to be done but, in many cases, do not explain *how* certain situations should be handled. The most obvious example of this in PCG's experience with the Fund is the issue of third party payment after submission of a claim to the Fund. Our review illustrated that this is the single biggest risk factor facing the Fund and the biggest challenge for providers who submit claims for reimbursement. The regulations clearly stipulate that these payments should be remitted back to the Fund but do not clearly state how the remittance amount should be calculated.. The Fund is one of many payers a provider partners

with and each one has unique requirements. PCG's experience with healthcare payers and providers across the country has taught us that a collaborative approach is the best approach and that both the payer and provider can take steps to create such an arrangement. PCG believes that this risk can be significantly mitigated through improved communication between the Fund and providers to verify payments from past claim periods.

Trauma Fund providers have a responsibility to understand the regulations of the Trauma Fund just as they have the responsibility to understand private payers' policies. The state government of Oklahoma established the Fund to compensate providers for a portion of the cost of providing care to the underinsured and the uninsured and that carries with it significant responsibilities for providers. PCG also concludes that OSDH can take certain steps to improve the compliance rate of Trauma Fund providers and by implementing fairly simple modifications, improve its role as a steward of public funds. By specifying Fund disbursement at the claim level through the use of an explanation of benefits-type document, providing provider outreach and education on remitting collected funds, revisiting past paid claims each year to identify additional collections providers may have received, and incorporating quality and automation controls into the claim submission and payment process, OSDH can enhance the integrity of the claiming and reimbursement system.

As more providers begin to utilize the Trauma Fund to supplement uncompensated trauma care, ensuring accuracy and eliminating erroneous payments will become increasingly important. The recommendations PCG has provided in this report can serve as a framework for the necessary next steps that will ensure continued support for trauma providers and high quality service provision to the underinsured and the uninsured.

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## 2. BACKGROUND AND UNDERSTANDING

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## ***2. BACKGROUND AND UNDERSTANDING***

### ***2.1 Purpose of Procurement***

Senate Bill 290 established the Trauma Care Assistance Revolving Fund (Trauma Fund) in 1999. This Bill authorized reimbursement for uncompensated costs associated with trauma care provided by recognized trauma facilities and emergency medical service (EMS) providers. In 2004, House Bill 1554 added physicians as a provider type eligible for reimbursement from the Trauma Fund. Today, eligible EMS, hospital and physician groups may be qualified for reimbursement from the Trauma Fund for cases meeting the trauma clinical criteria outlined in Oklahoma Administrative Code (OAC) 310:669. Providers submit claims to the Trauma Fund administrators, the Oklahoma State Department of Health (OSDH), on a bi-annual basis in a standard spreadsheet format. The claims are reviewed by OSDH staff to verify that they are in compliance with the Trauma Fund eligibility criteria.

In May 2011 Public Consulting Group, Inc (PCG) was awarded a contract to review and examine the accuracy of a sample of claims submitted by physicians, hospitals, and EMS providers to the Trauma Fund. PCG has reviewed a statistically valid sample of claims from thirty-six (36) hospitals, forty-four (44) physician groups, and twenty (20) EMS providers throughout the State of Oklahoma.

### ***2.2 Scope of Work***

On behalf of OSDH, PCG performed financial and clinical reviews of selected claims from hospitals, physician groups and EMS providers to determine whether:

- The service met Trauma Fund eligibility criteria as outlined in OAC 310:669.
- The amount of the service charges and the Trauma Fund claims are both supported by patient service delivery records, medical records, patient accounting records and the OSDH claim form.
- Billing for the service was performed and communicated to the patient and any potentially liable third parties.
- All collections and adjustments associated with the service were accurately calculated and communicated to the Trauma Fund.

Specifically, PCG reviewed the service delivery, medical, billing and patient accounting records associated with each claim to ensure claims were accurately billed and in compliance with the

Trauma Fund's eligibility criteria found in OAC 310:669. The key questions that PCG's review sought to verify are listed in the following table:

<i>Clinical Review</i>	<i>Financial Review</i>
<ul style="list-style-type: none"> <li>▪ <i>Was the service provided?</i></li> <li>▪ <i>Did the service take place within thirty (30) days of injury?</i></li> <li>▪ <i>Do medical records support the trauma designation according to OAC 310:669?</i></li> <li>▪ <i>Do medical records support all claimed diagnosis and/or procedure codes?</i></li> <li>▪ <i>Do medical records support all charges?</i></li> <li>▪ <i>Was the Trauma Fund claim form accurately completed?</i></li> <li>▪ <i>Was there any identifiable intentional irregularities or fraud?</i></li> </ul>	<ul style="list-style-type: none"> <li>▪ <i>Were all charges accurately calculated?</i></li> <li>▪ <i>Are all charges supported by patient accounting and billing records?</i></li> <li>▪ <i>Were reasonable collection efforts directed at the patient? At any potentially liable insurers?</i></li> <li>▪ <i>Are all collections accounted for on the Trauma Fund claim form?</i></li> <li>▪ <i>Was other revenue received after the claim was submitted to the Trauma Fund?</i></li> <li>▪ <i>Did the patient have insurance?</i></li> <li>▪ <i>Was there any identifiable intentional irregularities or fraud?</i></li> </ul>

**NOTE:** *Claims were not reviewed for medical necessity.*

PCG prepared a detailed review protocol document which was approved by OSDH staff for each provider type and applied a uniform standard to all claims during the review. Providers were notified approximately 2 weeks prior to their scheduled onsite visits using a standard data request form. It is important to note that findings were based on the documentation provided and PCG would recommend following any due process policies and procedures before acting upon (e.g., recovering payment) recommendations provided in the report. It is possible that documentation exists beyond that which was reviewed that would mitigate or nullify an individual finding.

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## 3. HOSPITALS

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### 3. HOSPITALS

#### 3.1 Hospital Audit Methodology

PCG employed stratified sampling to select thirty-six (36) of the eighty-six (86) hospital providers who submitted claims to the Trauma Fund for uncompensated trauma care performed during 2009. The selected providers accounted for 96.5 percent of the dollar value of hospital claims submitted to the Trauma Fund for uncompensated trauma care performed in 2009. For each hospital selected, PCG reviewed a statistically valid sample of Trauma Fund claims for clinical and financial compliance with the Trauma Fund regulations outlined in Oklahoma Administrative Code (OAC) 310:669. In total, PCG reviewed 1,170 hospital claims submitted to the Trauma Fund for services performed in 2009.

##### 3.1.1 Hospital Provider Selection

PCG selected hospital providers using stratified sampling based on the Fund's distribution for the two periods from January 1, 2009 through June 30, 2009 and July 1, 2009 through December 31, 2009. PCG's three (3) strata are as follows:

- Strata 1: Top 10 hospitals (based on dollar value of Fund distribution)
- Strata 2: Random sample of 10 hospitals ranked 11-25 in Fund distribution
- Strata 3: Random sample of 16 hospitals ranked 26-75 in Fund distribution

For each strata, PCG employed the RAT-STATS's Random Number Generator tool to generate random numbers, which, when compared with the Fund Distribution Rank (#), allowed us to randomly identify which hospitals would be selected for inclusion in our review. The results of this random selection are as follows. Please note: Because all of the top ten (10) ranked hospitals are to be reviewed, PCG did not apply the Random Number Generator for Strata 1.

##### *Selected Providers, Strata 1:*

<i>Fund Distribution Rank (#)</i>	<i>Provider</i>	<i>% of Fund Distribution at Selected Provider</i>	<i>Cum % of Distribution at Selected Providers</i>
1	OU Medical Center	42.9%	42.9%
2	St John Medical Center	15.3%	58.2%
3	Saint Francis Hospital	11.1%	69.3%
4	Integris Baptist Medical Center, Inc	6.8%	76.1%
5	Comanche County Memorial Hospital	6.1%	82.2%



6	Hillcrest Medical Center	2.9%	85.1%
7	Norman Regional Hospital	2.8%	87.9%
8	Integris Southwest Medical Center	2.1%	90.0%
9	Mercy Health Center	0.9%	90.9%
10	Mercy Memorial Health Center	0.9%	91.8%

***Selected Providers, Strata 2:***

<i>Fund Distribution Rank (#)</i>	<i>Provider</i>	<i>% of Fund Distribution at Selected Provider</i>	<i>Cum % of Distribution at Selected Providers</i>
12	Jackson County Memorial Hospital	0.6%	92.4%
13	Jane Phillips Medical Center	0.6%	93.0%
15	St. Mary's Regional Medical Center	0.5%	93.5%
16	Valley View Regional Hospital	0.5%	93.9%
18	Integris Bass Baptist Health Center	0.4%	94.3%
19	Unity Health Center	0.3%	94.7%
20	Duncan Regional Hospital	0.3%	95.0%
23	OSU Medical Center	0.2%	95.2%
24	Medical Center of Southeastern Oklahoma	0.2%	95.4%
25	Muskogee Regional Medical Center	0.2%	95.6%

***Selected Providers, Strata 3:***

<i>Fund Distribution Rank (#)</i>	<i>Provider</i>	<i>% of Fund Distribution at Selected Provider</i>	<i>Cum % of Distribution at Selected Providers</i>
28	Grady Memorial Hospital	0.1%	95.7%
31	Deaconess Hospital	0.1%	95.8%
32	Integris Mayes County Medical Center	0.1%	95.9%
34	McCurtain Memorial Hospital	0.1%	96.0%
35	Southcrest Hospital	0.1%	96.1%
40	Atoka Memorial Hospital	0.1%	96.2%
41	Park View Hospital	0.1%	96.2%
43	Integris Baptist Regional Health Center	0.1%	96.3%
46	Eastern Oklahoma Medical Center	0.0%	96.3%
49	Craig General Hospital	0.0%	96.4%
55	Share Memorial Hospital	0.0%	96.4%
58	Purcell Municipal Hospital	0.0%	96.4%
64	Johnston Memorial Hospital	0.0%	96.4%
69	Perry Memorial Hospital	0.0%	96.4%
71	Jane Phillips Nowata Health Center	0.0%	96.5%
73	Healdton Mercy Hospital Corporation	0.0%	96.5%

PCG's random selection of thirty-six (36) hospital providers ensured that our statistically valid review covers providers representing 96.5 percent of the Fund's 2009 distribution to hospitals.

### 3.1.2 Hospital Claim Selection

A hospital claim is defined as any single entry into the Trauma Registry. For each of the top ten (10) specific hospital providers selected for review, PCG identified four (4) statistically viable strata of each provider's claims, based on dollar volumes, for example:

- Strata 1: Claims  $\geq$  \$100,000
- Strata 2: Claims  $<$  \$100,000 and  $\geq$  \$50,000
- Strata 3: Claims  $<$  \$50,000 and  $\geq$  \$25,000
- Strata 4: Claims  $<$  \$25,000

Because of the smaller number of claims from the ten (10) providers to be audited from Strata 2, PCG identified two (2) strata of each provider's claims, for example:

- Strata 1: Claims  $\geq$  \$2,000
- Strata 2: Claims  $<$  \$2,000

Because of the even smaller number of claims from the sixteen (16) providers to be audited from Strata 3, PCG reviewed either ten (10) claims or 100 percent of that providers claims.

The differing number of strata used to randomly select claims did not affect the statistical validity of the sampling as the claims reviewed in a particular strata was only representative of those claims whose dollar value in Fund distribution falls between the parameters of said strata.

For each strata in the top twenty-five (25) ranked (based on dollar value of the Fund distribution) selected providers' claims, PCG used RAT-STATS to produce stratified variable sample size determinations representing a degree of precision of +/- 5 percent at a confidence interval of at least a 95 percent, ensuring that the sample size of claims selected for our audit was representative of the universe of claims within each strata. For smaller providers ranked between twenty-five (25) and seventy-six (76), PCG randomly selected ten (10) claims or all of the provider's claims, reviewing the smaller number of the two.

After PCG identified the sample sizes of claims for each provider and within each provider strata, PCG assigned each claim a number sequentially based on the dollar volume of the claim. Using the RAT-STATS's tool, PCG generated random numbers within each strata, which, when

compared with the assigned claim numbers allowed us to randomly identify which claims for each provider, and within each strata, were selected for inclusion in our audit.

### **3.1.3 Hospital Claims Review**

Approximately two (2) weeks prior to an onsite hospital visit, PCG notified the provider via certified mail, introducing the audit, asking the provider to prepare for our visit and indicating what types of documents PCG would be reviewing. Once onsite, PCG began the reviews with an onsite entrance conference to briefly explain the process. During this entrance conference, PCG discussed the audit objectives, provider and claims selection methodology and documentation and data elements to be reviewed and answered any questions providers had.

PCG reviewed the clinical, service delivery, billing and patient accounting records associated with each claim to determine whether claims met the eligibility criteria for Trauma Fund reimbursement. PCG reviewed the medical records associated with each claim to confirm that the service was provided, met Fund eligibility criteria, took place within thirty (30) days of injury, and supported the charge amount. PCG reviewed the patient accounting and billing records associated with each claim to determine the accuracy of charges, whether charges were supported by patient accounting records, whether reasonable collection efforts were made to recover funds from both the patient and/or any liable third parties, and whether charges were reduced by any collections.

### ***3.2 Hospital Findings***

PCG found that the majority of hospital claims submitted to the Trauma Fund were appropriately supported by medical and patient accounting records and met the Fund's eligibility criteria outlined in OAC 669:310. However, PCG identified a number of general and hospital-specific issues, as detailed in the following sections.

#### **3.2.1 Hospital Financial Issues**

PCG reviewed the patient accounting and billing records associated with each claim to determine the accuracy of charges, whether charges were supported by patient accounting records, whether reasonable collection efforts were made to recover funds from both the patient and/or any liable third parties, and whether charges were reduced by any collections. PCG's review of 1,170 claims at thirty-six (36) hospitals revealed the following general financial issues:

- In some cases providers had collected funds from third parties after Trauma Fund payment but had not remitted these collections back to the Trauma Fund.
- In some cases providers had not reduced the amount of their claims by the amount of collections they had received prior to the claims' submission.
- In some cases there appeared to be inconsistencies in the type of contractual adjustments included in the calculation of Trauma Fund claim amounts.
- In some cases patient charges, but not uncompensated trauma care claim amounts, were reduced or eliminated as a result of uninsured discounts or Crime Victims eligibility. These discounts reduced or eliminated the amount of funds hospitals attempted to collect from patients which resulted in higher Trauma Fund claim amounts.
- In some cases hospitals included physician charges in their calculation of uncompensated trauma care claims but failed to reduce these claims by third party physician payments.
- In some cases providers wrote off claims to charity care, Crime Victims or bad debt while still seeking reimbursement from the Trauma Fund.
- In some cases hospitals continued to bill patients after receiving Trauma Fund payment.
- In some cases collection attempts were halted once partial payment had been received from third party insurers. After partial payment was received hospitals would bill the remainder to the Trauma Fund without attempting further collections.

- In some cases liable automobile insurance companies were not followed-up with to obtain payment.

### 3.2.2 Hospital Clinical Issues

PCG reviewed the medical, service delivery, billing and patient accounting records associated with each claim to determine whether claims met the eligibility criteria for Trauma Fund reimbursement. PCG reviewed the medical records associated with each claim to confirm that the service was provided, met Fund eligibility criteria, took place within thirty (30) days of injury, and supported the charge amount. PCG's review of 1,170 claims at thirty-six (36) hospitals identified the following general clinical issues:

- In some cases diagnosis/ICD-9 codes did not fall within the Trauma Fund's eligibility range of 800.0 to 959.9 and in some case provider diagnosis codes did not match the diagnosis codes listed in the Trauma Registry.
- In some cases medical records did not support the Trauma Fund's criteria that the patient remain in the hospital for at least forty-eight (48) hours, be sent from a lower to a higher level of trauma care, be sent directly to the operating room or intensive care unit, be pronounced dead, or be suffering from traumatic oral-maxillo-facial or hand injuries.
- PCG identified two (2) cases where services were provided to a patient who had an injury resulting from a pre-existing condition, which is an exclusionary condition per OAC 310:669-5-1(e).

### 3.3.3 Hospital Review Results

In total, PCG audited 1,170 claims at thirty-six (36) hospitals receiving uncompensated trauma care compensation to determine compliance with the Trauma Fund's eligibility criteria found in OAC 310:669. Our review yielded the following hospital-specific findings:

- PCG identified 176 uncompensated trauma care claims, or 15.0 percent of the reviewed number of claims, which did not comply with Trauma Fund eligibility criteria.
- PCG identified \$1,467,687 dollars in Trauma Fund claims, representing approximately \$956,448 in Trauma Fund payments, which did not comply with Fund eligibility criteria.

- PCG identified \$207,256 of patient and third party payments hospitals received prior to claim submission which should have reduced the amount of uncompensated trauma care reported to the Trauma Fund.
- PCG identified \$1,102,850 in patient and third party payments made which should have been remitted back to the Trauma Fund because they took place after the hospital's submission of uncompensated trauma.
- The average Trauma Fund hospital reimbursement rate for 2009 uncompensated trauma care claims was 62.6 percent. Mercy Health Center received just 35.2 percent of the value of their Trauma Fund claims, however.

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## 4. PHYSICIANS

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## 4. PHYSICIANS

### 4.1 Physician Audit Methodology

PCG employed stratified sampling to select forty-four (44) physician groups who submitted claims to the Trauma Fund for 2009 claims. The selected providers accounted for 91.2 percent of the Trauma Fund's physician distribution for 2009 claims. For each physician group selected, PCG reviewed a statistically valid sample of Trauma Fund claims for clinical and financial compliance with the Trauma Fund regulations outlined in Oklahoma Administrative Code (OAC) 310:669. In total, PCG reviewed 1,207 physician claims submitted to the Trauma Fund for uncompensated trauma care performed in 2009.

#### 4.1.1 Physician Provider Selection

PCG selected physician group providers using stratified sampling based on the claimed uncompensated trauma care amounts submitted by each group. PCG's three (3) strata are as follows:

- Strata 1: Top 10 physicians (based on the amount of claimed uncompensated trauma care submitted to the Trauma Fund)
- Strata 2: Random sample of 10 physicians ranked 11-25 in physician claims
- Strata 3: Random sample of 24 physicians ranked 26 or higher in physician claims

For each strata, PCG employed RAT-STATS's Random Number Generator tool to generate random numbers, which, when compared with the Fund Distribution Rank (#), allowed PCG to randomly identify which physician providers would be selected for inclusion in our audit. The results of this random selection are as follows. Please note: Because all of the top ten (10) ranked physicians are to be audited, PCG did not need to use the Random Number Generator for Strata 1.

#### *Selected Providers, Strata 1:*

<i>Fund Distribution Rank (#)</i>	<i>Provider</i>	<i>% of Total Physician Claims at Selected Provider</i>	<i>Cum % of Total Physician Claims at Selected Provider</i>
1	OU Physicians	48.5%	48.5%
2	Surgery, Inc.	7.3%	55.8%
3	Orthopedic & Trauma Services of Oklahoma	4.8%	60.6%



4	St. John Physicians, Inc.	4.1%	64.8%
5	Morningstar Emergency Physicians, PLLC	3.2%	67.9%
6	Radiology Consultants of Tulsa, Inc	2.6%	70.5%
7	J Michael McGee	2.5%	73.1%
8	Tulsa Orthopedic Trauma Specialists	2.4%	75.5%
9	Warren Clinic, Inc	2.4%	77.8%
10	Surgical Specialists of Oklahoma, PLLC	2.1%	79.9%

***Selected Providers, Strata 2:***

<i>Fund Distribution Rank (#)</i>	<i>Provider</i>	<i>% of Total Physician Claims at Selected Provider</i>	<i>Cum % of Total Physician Claims at Selected Provider</i>
11	Surgical Associates, Inc.	1.8%	81.7%
13	Tulsa Radiology Associates, Inc.	1.4%	83.1%
14	Care Communications LLC	1.2%	84.3%
15	Tulsa Bone & Joint Associates	1.2%	85.5%
16	Utica Plastic Surgery, Inc.	0.8%	86.3%
19	St. John Emergency Physicians, Inc.	0.7%	87.0%
21	Central States Orthopedic Specialists, Inc.	0.6%	87.7%
22	Northwest Anesthesia, PC	0.6%	88.3%
23	Associated Anesthesiologists, Inc.	0.6%	88.9%
25	Neurosurgical Specialists of Tulsa	0.5%	89.4%

***Selected Providers, Strata 3:***

<i>Fund Distribution Rank (#)</i>	<i>Provider</i>	<i>% of Total Physician Claims at Selected Provider</i>	<i>Cum % of Total Physician Claims at Selected Provider</i>
27	NRHS Radiology Associates	0.4%	89.8%
28	Orthopaedic and Sports Medicine Center	0.4%	90.2%
30	Southwest Orthopaedics & Reconstructive Specialist	0.4%	90.6%
32	Eastern Oklahoma Orthopedic Center, Inc.	0.3%	90.9%
35	Diagnostic Imaging Associates, Inc	0.3%	91.2%
37	Neuroscience Specialists, PC	0.3%	91.4%
38	Gary L Decker	0.2%	91.7%
42	NRHS Intensivist Physicians	0.2%	91.8%
43	Ortho Oklahoma, PC	0.2%	92.0%
45	Orthopedic Associates	0.1%	92.1%
48	Eastern OK Ear, Nose & Throat	0.1%	92.2%
52	OK Center for Ortho Excellence	0.1%	92.3%
53	GR Group	0.1%	92.4%

56	Memorial Medical Group Emergency Physicians	0.1%	92.4%
60	Oklahoma Cardiovascular Surgeons	0.0%	92.5%
62	Berry E. Winn, MD PLLC	0.0%	92.5%
65	Purcell Emergency, PLLC	0.0%	92.6%
67	Mason Lawrence	0.0%	92.6%
70	Joe Voto, MD	0.0%	92.6%
73	T. Fazili, M.D. PC	0.0%	92.6%
74	Matthew Stanfield, MD, PC	0.0%	92.6%
77	Tulsa X-Ray Lab, Inc.	0.0%	92.6%
78	Lester L. Cowden	0.0%	92.6%
81	Caple Spence, MD	0.0%	92.6%

PCG's random selection of forty-four (44) physician providers ensured that our statistically valid audit covered providers representing 91.3 percent of the Fund's 2009 distribution to physicians.

#### 4.1.2 Physician Claim Selection

A physician claim was defined as a single line item on the Physician Claim Form.

For each selected provider ranked in the top twenty-five (25) based on Fund distribution, PCG determined four (4) strata of each provider's claims, based on dollar volumes, for example:

- Strata 1: Claims  $\geq$  \$2,000
- Strata 2: Claims  $<$  \$2,000 and  $\geq$  \$1,000
- Strata 3: Claims  $<$  \$1,000 and  $\geq$  \$500
- Strata 4: Claims  $<$  \$500

Because of the high number of small dollar value claims (e.g.,  $<$  \$10 claims) and to ensure that our resources were effectively allocated, PCG did not include physician claims under \$50 in our sampling.

For each strata in the top twenty-five (25) ranked (based on physician claim amounts) selected providers' claims, PCG used RAT-STATS to produce stratified variable sample size determinations representing a degree of precision of +/- 5 percent at a confidence interval of at least a 95 percent, ensuring that the sample size of claims selected for our audit was representative of the universe of claims within each strata. For smaller providers ranked higher

than twenty-five (25), PCG randomly selected ten (10) claims or all of that provider's claims, reviewing the smaller number of the two. In total, PCG's physician claims selection methodology resulted in the review of 1,207 claims at forty-four (44) physician providers.

#### **4.1.3 Physician Claims Review**

Approximately two (2) weeks prior to an onsite physician visit, PCG notified the provider via certified mail, introducing the audit, asking the provider to prepare for our visit and indicating what types of documents PCG would be reviewing. Once onsite, PCG began the reviews with an onsite entrance conference to briefly explain the process. During this entrance conference, PCG discussed the audit objectives, provider and claims selection methodology and documentation and data elements to be reviewed and answered any questions providers had.

PCG reviewed the medical, service delivery, billing and patient accounting records associated with each claim to determine whether claims met the eligibility criteria for Trauma Fund reimbursement. PCG reviewed the medical records associated with each claim to confirm that the service was provided, met Fund eligibility criteria, took place within thirty (30) days of injury, and supported the charge amount. PCG reviewed the patient accounting and billing records associated with each claim to determine the accuracy of charges, whether charges were supported by patient accounting records, whether reasonable collection efforts were made to recover funds from both the patient and/or any liable third parties, and whether charges were reduced by any collections.

## **4.2 Physician Findings**

PCG found that the majority of physician claims submitted to the Trauma Fund were appropriately supported by medical and patient accounting records and met the Fund's eligibility criteria outlined in OAC 669:310. However, PCG identified a number of general and physician-specific issues as detailed in the following sections.

### **4.2.1 Physician Financial Issues**

PCG reviewed the patient accounting and billing records associated with each claim to determine the accuracy of charges, whether charges were supported by patient accounting records, whether reasonable collection efforts were made to recover funds from both the patient and/or any liable third parties, and whether charges were reduced by any collections. PCG's review of 1,207 claims at forty-four (44) physician groups revealed the following general financial issues:

- In some cases physician billing systems credited third party payments only to patient accounts, rather than to specific procedures/charges, which limited providers' ability to determine whether collections had been made on a specific claimed procedure.
- In some cases patient charges, but not uncompensated trauma care claim amounts, were reduced because of uninsured discounts and/or Crime Victims eligibility. As a result, patient charges were eliminated and collection attempts were stopped but the original charges were still billed to the Trauma Fund.
- In some cases providers had collected funds from third parties after Trauma Fund payment but had not remitted these collections back to the Trauma Fund.
- In some cases providers had not reduced the amount of their uncompensated care claims by the amount of collections they had received prior to the claims' submission.
- In some cases physicians continued to bill patients after receiving Trauma Fund payment.
- In some cases liable automobile insurance companies were not followed-up with to obtain payment.

### **4.2.2 Physician Clinical Issues**

PCG reviewed the medical, service delivery, billing and patient accounting records associated with each claim to determine whether claims met the eligibility criteria for Trauma Fund

reimbursement. PCG reviewed the medical records associated with each claim to confirm that the service was provided, met Fund eligibility criteria, took place within thirty (30) days of injury, and supported the charge amount. PCG's review of 1,207 claims at forty-four (44) physician groups revealed the following general clinical issues:

- In some cases the Trauma Fund's physician claims data had incorrect procedure (i.e., CPT) codes, which had resulted in an incorrect allocation of Fund reimbursement.
- In some cases specialty physicians (e.g., radiologists) were unable to produce thorough service delivery records due to the specialized nature of their procedure(s); making it difficult to identify the provider's compliance with certain Trauma Fund criteria such as the length of a patient's hospital stay.
- In some cases physician documentation was incomplete (e.g., missing discharge date, date of injury, insurance liability, etc.) because they were depending on hospitals to fully document care and determine trauma eligibility.
- In some cases patient diagnosis/ICD-9 codes did not fall within the Trauma Fund's eligibility range of 800.0 to 959.9 and in some case provider diagnosis codes did not match the diagnosis codes listed in the Trauma Registry.

#### **4.3.3 Physician Audit Results**

PCG audited 1,207 claims at forty-four (44) physician groups receiving uncompensated trauma care compensation to determine compliance with the Trauma Fund's eligibility criteria found in OAC 310:669. Our review yielded the following physician-specific findings:

- PCG identified twenty-three (23) uncompensated trauma care claims, or 1.9 percent of the total number of reviewed number of claims, which did not comply with Fund eligibility criteria.
- PCG identified \$4,415 in Trauma Fund payments for claims which did not fully comply with Fund eligibility criteria.
- PCG identified twenty-eight (28) claims featuring incorrect procedure codes causing an incorrect allocation of Trauma Fund reimbursement for each claim.

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## 5. EMERGENCY MEDICAL SERVICES (EMS)

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## 5. EMERGENCY MEDICAL SERVICES (EMS)

### 5.1 EMS Audit Methodology

PCG employed stratified sampling to select twenty (20) EMS providers who submitted claims to the Trauma Fund for 2009 claims. The selected providers accounted for 58.0 percent of the Trauma Fund's EMS distribution for 2009 claims. For each EMS provider selected, PCG reviewed a sample of Trauma Fund claims for clinical and financial compliance with the Trauma Fund regulations outlined in Oklahoma Administrative Code (OAC) 310:669. In total, PCG reviewed 448 EMS claims submitted to the Trauma Fund for uncompensated trauma care performed for 2009 claims.

#### 5.1.1 EMS Provider Selection

PCG selected twenty (20) EMS providers based on the type of EMS provider (i.e., air or ground) and the Fund's distribution dollar amount, as follows:

- Strata 1: Top 10 EMS air providers (based on Fund distribution)
- Strata 2: Top 10 EMS ground providers (based on Fund distribution)

PCG has selected the following EMS providers based on the dollar amount of fund distribution.

#### *Selected Providers, Strata 1:*

<i>Fund Distributi on Rank (#) - Air</i>	<i>Provider</i>	<i>% of Total Physician Claims at Selected Provider</i>	<i>Cum % of Total Physician Claims at Selected Provider</i>
1	Air Evac EMS - 398 McAlester	7.0%	7.0%
2	Ballard Aviation - 423 Ardmore (until 8/24/09)	5.5%	12.5%
3	EagleMed LLC-446 Ardmore (after 8/24/09)	5.0%	17.5%
4	AirEvac Lifeteam-412 Elk City	5.0%	22.5%
5	Tulsa Life Flight	4.5%	27.0%
6	Ballard Aviation - 418 Hugo OK/EagleMed LLC-446 Hugo	5.6%	32.6%

7	Air Evac EMS - 397 Claremore OK	4.3%	36.9%
8	AirEvac Lifeteam-433 Muskogee	4.3%	41.1%
9	Ballard Aviation - 382 Tahlequah OK (until 8/24/09)	3.9%	45.0%
10	Medi Flight of Oklahoma LLC	3.9%	48.9%

***Selected Providers, Strata 2:***

<b><i>Fund Distributi on Rank (#) - Ground</i></b>	<b><i>Provider</i></b>	<b><i>% of Total Physician Claims at Selected Provider</i></b>	<b><i>Cum % of Total Physician Claims at Selected Provider</i></b>
1	EMSA - West Division	3.3%	52.1%
2	EMSA - East Division	1.5%	53.7%
3	REACT EMS	1.1%	54.8%
4	McCurtain County EMS	0.6%	55.4%
5	Stilwell EMS/Ambulance Service	0.6%	56.0%
6	EMSSTAT - Norman Regional Hospital	0.5%	56.6%
7	Parkview EMS (Mercy El Reno)	0.5%	57.1%
8	Mayes Emergency Services Trust Authority (MESTA)	0.5%	57.5%
9	Chickasha Fire EMS, City of	0.3%	57.8%
10	Stillwater EMS, City of	0.2%	58.0%

PCG's selection of twenty (20) EMS providers will ensure our audit covers EMS providers representing 90.7 percent of the Fund's 2009 distribution.

**5.1.2 EMS Claim Selection**

An EMS claim is defined as a single line item on OSDH's EMS Claim Form.

For each selected EMS provider, PCG reviewed thirty (30) or 100 percent of the provider's claims. In total, PCG's EMS claims selection methodology resulted in the review of 448 Fund claims at twenty (20) EMS providers.

### **5.1.3 EMS Claims Review**

Approximately two (2) weeks prior to an onsite EMS provider visit, PCG notified the provider via certified mail, introducing the audit, asking the provider to prepare for our visit and indicating what types of documents PCG would be reviewing. Once onsite, PCG began the reviews with an onsite entrance conference to briefly explain the process. During this entrance conference, PCG discussed the audit objectives, provider and claims selection methodology and documentation and data elements to be reviewed and answered any questions providers had.

PCG reviewed the run reports and medical, service delivery, billing and patient accounting records associated with each claim to determine whether claims met the eligibility criteria for Trauma Fund reimbursement. PCG reviewed the medical records associated with each claim to confirm that the service was provided, met Fund eligibility criteria, took place within thirty (30) days of injury, and supported the charge amount. PCG reviewed the patient accounting and billing records associated with each claim to determine the accuracy of charges, whether charges were supported by patient accounting records, whether reasonable collection efforts were made to recover funds from both the patient and/or any liable third parties, and whether charges were reduced by any collections.

## **5.2 EMS Findings**

PCG found that the majority of EMS claims submitted to the Trauma Fund were appropriately supported by medical and patient accounting records and met the Fund's eligibility criteria outlined in OAC 669:310. However, PCG identified a number of general and EMS-specific issues, as detailed in the following sections.

### **5.2.1 EMS Financial Issues**

PCG reviewed the patient accounting and billing records associated with each claim to determine the accuracy of charges, whether charges were supported by patient accounting records, whether reasonable collection efforts were made to recover funds from both the patient and/or any liable third parties, and whether charges were reduced by any collections. PCG's review of 448 claims at twenty (20) EMS providers identified the following general financial issues:

- In some cases the Medicare mileage and procedure rates were incorrectly based on rural, rather than urban, pick-up locations which resulted in higher uncompensated trauma care claims.
- In some cases EMS ground providers inconsistently applied the Medicare allowable rural mileage rate to loaded miles past the 17<sup>th</sup> mile. Because the Trauma Fund's EMS claim form contains only a single "MCR allowable Mileage Rate (\$)" field for each EMS provider run, providers were unable to claim separate mileage rates for runs longer than seventeen (17) miles.
- In some cases collection attempts were discontinued once partial payment was received from third party insurers, resulting in the remainder of the outstanding charges being billed to the Trauma Fund.
- In some cases providers had collected funds from third parties after Trauma Fund payment but had not remitted these collections back to the Trauma Fund.
- In some cases providers had not reduced the amount of their uncompensated care claims by the amount of collections they had received prior to the claims' submission.
- In some cases there appeared to be inconsistencies in the type of contractual adjustments included in the calculation of uncompensated trauma care claim amounts.
- In some cases liable automobile insurance companies were not followed-up with to obtain payment.

### 5.2.2 EMS Clinical Issues

PCG reviewed the medical, service delivery, billing and patient accounting records associated with each claim to determine whether claims met the eligibility criteria for Trauma Fund reimbursement. PCG reviewed the medical records associated with each claim to confirm that the service was provided met Fund eligibility criteria and supported the charge amount. PCG's review of 448 claims at twenty (20) EMS providers revealed the following general clinical issues:

- In some cases providers failed to cite specific, acceptable clinical criteria (i.e., #1-15 from OAC 310:669-5-1-f) in the 'Trauma Criteria' field on the EMS Trauma Fund claim form.
- In one (1) case EMS medical documentation did not fully support the acceptable EMS clinical eligibility criteria outlined in OAC 310:669-5-1-f.

### 5.3.3 EMS Audit Results

PCG reviewed 448 claims at twenty (20) providers receiving uncompensated trauma care reimbursement to determine compliance with the Trauma Fund's eligibility criteria found in OAC 310:669. Our review yielded the following specific findings:

- PCG identified eighty-four (84) uncompensated trauma care claims, or 18.8 percent of the reviewed number of claims, which did not fully comply with Fund's eligibility criteria.
- PCG identified \$149,648 of uncompensated trauma care for claims which did not fully comply with Fund's eligibility criteria.
- PCG identified \$6,945 of uncompensated trauma care claims which did not meet the Fund's clinical criteria.
- PCG identified \$143,153 of uncompensated trauma care claims which did not meet the Fund's financial criteria.
- PCG identified \$15,507 of patient and third party payments which should have been deducted from uncompensated trauma care claims prior to submission to the Trauma Fund and \$67,724 in patient and third party payments made which should have been remitted back to the Trauma Fund because they took place after the provider's submission of uncompensated trauma.

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## 6. SUMMARY FINDINGS AND RECOMMENDATIONS

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## 6. SUMMARY FINDINGS AND RECOMMENDATIONS

On behalf of OSDH, PCG performed a financial and clinical review of selected claims from hospitals, physician groups and EMS providers to determine whether Trauma Fund disbursements made by OSDH were supported by clinical and financial documentation. While in its role as administrator of the Trauma Fund OSDH has put effective safeguards in place to prevent inappropriate billing, PCG has identified several steps that the Fund, in concert with the provider community, may wish to consider implementing in an effort to improve the Fund's administration and quality control, as follows.

The summary of findings and recommendations to management are included in a separate report.

***Finding #1: Trauma Fund payment documentation lacks detail which, providers noted, makes it difficult for providers to identify which claims have been reimbursed.***

When eligible providers receive a bi-annual lump sum payment for claims submitted to the Trauma Fund they are unable to determine which of their claims the Trauma Fund accepted and how much the Trauma Fund has disbursed for each accepted claim. Because of this, providers cannot accurately trace Fund payment back to specific claims and upon receiving additional collections from patients or third parties, are unable to calculate how much should be remitted back to the Trauma Fund.

**Recommendation:** With each provider payment the Trauma Fund should include a document similar to the Explanation of Benefits document provided by other payers which shows at a claim level what is included in the disbursed amount.

***Finding #2: Trauma Fund remittance policies and procedures are not clearly defined.***

Providers commented on the lack of clear, specific guidance on how to remit funds collected from either patients or third parties after they have already submitted uncompensated trauma care claims. OAC 310:669, 5-4 (c) states that "*Any additional monies received from other sources of funding for a case that was reimbursed by the Trauma Fund must be returned to the Fund and applied towards future disbursements.*" However, Fund regulations do not outline how providers should calculate remittance amounts (e.g., when partial remittances may be required), how these amounts should be remitted, or when this should take place.

**Recommendation:** Amend regulations or produce and distribute a provider manual or other reference materials which include sample claim amendment/remittance calculation examples. Provide provider staff training on the proper handling of late third party payments.

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***Finding #3: OSDH does not have a system in place to re-check previously reimbursed claims to identify any patient or third party payments which may have been received following each provider's original submission of uncompensated trauma care claims.***

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PCG found \$1,171,936 in unreported patient and third party payments received by providers after their submission of uncompensated trauma care claims. While OAC 310:669 mandates that these funds should be remitted back to the Trauma Fund, OSDH does not have adequate quality control measures in place to identify late payments which should be remitted back to the Fund.

**Recommendation:** Require providers to review claims paid by the Trauma Fund in past periods and to disclose payments received on those cases. If payments were received, providers should supply the Fund with the amount and date of payment and if no payments were received relating to prior period claims, providers should attest to that.

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***Finding #4: OSDH has not clearly defined "reasonable collection efforts", and as a result, providers are inconsistent in their attempts to collect payment prior to submitting uncompensated trauma care claims.***

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While PCG found that 100 percent of reviewed providers attempted to collect payment from either the patient, insurance company, or both. However, collection efforts often stopped once partial payment was received, with the difference being billed to the Trauma Fund. In other cases, providers sometimes wrote off uncompensated trauma care as bad debt while continuing to attempt collection from the Trauma Fund and patients.

**Recommendation:** Amend language in regulations that define "reasonable collection" efforts so that uniform requirements for collections from third parties and patients are met before seeking reimbursement from the Trauma Fund.

**Recommendation:** Require providers to submit automobile insurance coverage denials with motor vehicle accident-related claims.

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***Finding #6: EMS providers' calculation of Medicare mileage and procedure rates were incorrectly based on rural, rather than urban, pick-up locations which resulted in higher uncompensated trauma care claims.***

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PCG found thirty (30) uncompensated trauma care claims submitted by EMS providers where the Medicare allowable mileage rate (as determined by the pick-up zip code) was incorrectly identified as the rural rate, rather than the less expensive urban rate.

**Recommendation:** Require EMS providers to enter the pick-up location zip code on the Trauma Fund's EMS claim form.

***Finding #7: When completing the EMS claim form, providers inconsistently applied the Medicare allowable rural mileage rate to loaded miles past the 17<sup>th</sup> mile.***

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PCG identified thirty-one (31) Trauma Fund claims where the Medicare allowable rural mileage rate was applied to loaded miles past the 17<sup>th</sup> mile. However, the Trauma Fund's EMS claim form contains only a single "MCR allowable Mileage Rate (\$)" field for each EMS provider run, which prevents providers from claiming separate mileage rates for runs longer than seventeen (17) miles.

**Recommendation:** Modify the Trauma Fund's EMS claim form to allow EMS ground providers to enter a secondary rural mileage rate for runs longer than seventeen (17) miles.

***Finding #8: Trauma Fund claims data lacked the quality controls necessary to guarantee correct procedure codes and to ensure the application of the cost-to-charge ratio.***

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In the calculation of Comanche County Memorial Hospital's uncompensated trauma care claims between January and June of 2009, the mandatory cost-to-charge ratio was not applied and Comanche's claims for this period and were credited to be \$1.9 million, when the accurate uncompensated trauma amount was less than \$400,000. While the Trauma Fund identified this error in 2011, the lack of automated quality assurance measures in the claim acceptance process leaves the Trauma Fund vulnerable to future overpayments.

**Recommendation:** Modify the provider claim submission process to include additional quality control checks and automated calculations.

***Finding #9: Physician and EMS documentation is often incomplete (e.g., discharge date, date of injury, insurance liability, etc.) because they are depending on hospitals to fully document care and determine trauma eligibility.***

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Specialty physicians, such as those performing radiology or anesthesia services, often had medical records which were limited to their specific procedure(s), forcing these providers to rely on hospital confirmation that their claims were in compliance with the Fund's criteria that the

patient remain in the hospital for forty-eight (48) hours, be admitted to the operating room or intensive care unit, or be transferred from a lower to a higher level trauma facility.

**Recommendation:** Customize trauma eligibility requirements to each specific provider type to ensure applicability with each provider type's services.

***Finding #10: Availability of Trauma Fund reimbursement will become limited as an increasing number of providers submit an increasing number of uncompensated trauma care claims each year.***

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Many states with similar funds for emergent care restrict the pool of available resources to those who are uninsured (i.e., no insurance coverage). The Trauma Fund, however, allows claims to be submitted for reimbursement even when providers have already been partially compensated from other payers, such as Medicare or Medicaid (i.e., the "underinsured").

**Recommendation:** Consider limiting Trauma Fund payments to only truly uncompensated care by not allowing providers receiving partial payment from third parties such as Medicare or Medicaid to bill the difference to the Trauma Fund.

