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Oklahoma State Department of Health

2014 Trauma Fund Audit

Final Report

November 30, 2014

Grace Pelley
Administrative Programs Manager-Trauma & Systems
Oklahoma State Department of Health
PHS-Emergency Systems



148 State Street, Tenth Floor, Boston, Massachusetts 02109
Tel. (617) 426-2026, Fax. (617) 426-4632
www.publicconsultinggroup.com



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**INDEPENDENT ACCOUNTANT'S REPORT
ON APPLYING AGREED-UPON PROCEDURES**

Oklahoma State Department of Health and Trauma Fund Management:

We have performed the procedures enumerated below, which were agreed to by Oklahoma State Department of Health (OSDH) and Trauma Fund Management (the specified parties), solely to assist you with respect to validating the integrity of the Trauma Fund Claims submitted to the OSDH Trauma Funds for the year ended December 31, 2010, in accordance with Fund disbursement regulations found in OAC 310:669. Trauma Fund management is responsible for the claims records. This agreed-upon procedures engagement was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants.

The procedures followed during this review of Trauma Fund claims were sufficient to identify compliance with Trauma Fund eligibility regulations found in OAC 310:669 and we endorse both the procedures followed and the subsequent findings detailed in the following report. However, we were not engaged to, and did not, conduct a review, the objective of which would be the expression of an opinion on the accounting records. Accordingly, we do not express such an opinion. Had we performed additional procedures, other accounting-related matters might have come to our attention that would have been reported to you.

This report is intended solely for the information and use of Oklahoma State Department of Health and Trauma Fund Management and is not intended to be and should not be used by anyone other than those specified parties.

Muret CPA, PLLC
Tulsa, Oklahoma
November 19, 2014

1. Executive Summary

1. EXECUTIVE SUMMARY

Objective

As an uncompensated care funding pool, the Oklahoma State Department of Health (OSDH) Trauma Care Assistance Revolving Fund (“Fund”) supplements the cost of uncompensated trauma care provided to under and un-insured residents by Hospital, EMS, and Physician providers. As a public health safety net, the Fund insures the continued care of some of the State’s most vulnerable residents while equitably distributing payments for traumatic services among providers across the State.

For claim periods between 2009 and 2012, the value of uncompensated care claims submitted to the Trauma Fund has grown by 22.7 percent to more than \$47.5 million, while the pool of available disbursement funds has shrunk by 5.2 percent to \$24.3 million. As managers of a Fund subject to limited growth from year-to-year, OSDH has a fiduciary responsibility to insure the growing volume of uncompensated care claims submitted to the Fund continue to be compliant with eligibility requirements found in Oklahoma Administrative Code (OAC) 310:669.

To address these challenges, OSDH engaged Muret CPA, PLLC in February 2014 to conduct a review of 2010 uncompensated care claims paid by the Fund. Muret was tasked by OSDH to perform the following specific services:

- Insure claims submitted by entities receiving reimbursement from the Fund are accurately supported by medical and financial records.
- Confirm claims are in compliance with the Fund’s reimbursement criteria outlined in OAC 310:669.
- Identify any discrepancies in submitted claims data.
- Detect any amounts collected from other sources after receiving reimbursement from the Fund.
- Provide regularly scheduled and ad-hoc reporting on review activities and results.
- Conclude with a final report detailing all findings and including process improvement recommendations and outlining potential recoupment opportunities.

Methodology

Between April 2014 and November 2014 the team of Muret CPA, PLLC (Muret) and Public Consulting Group, Inc. (PCG) conducted a review of claims submitted to the Fund to validate provider compliance with Fund eligibility requirements found in Oklahoma Administrative Code (OAC) 310:669.

The Muret-PCG Team’s 2014 review of Trauma Fund claims included a review of the 10 largest hospitals, physician groups, and EMS providers, based on the dollar value of approved uncompensated care claims submitted by each provider for claim period January 1, 2010 to December 31, 2010. To ensure that the Trauma Fund review did not ignore smaller providers or



target the same providers each year, the Muret-PCG Team also reviewed a statistically random selection of 10 additional hospital providers, 10 additional physician groups, and 5 additional EMS providers. At each selected provider, Muret-PCG reviewed 30 percent of paid Trauma Fund claims from 2010.

The Muret-PCG Team’s review included the following providers and claims:

<i>Provider Type</i>	<i>Total Number of Providers Receiving Fund Disbursement</i>	<i>Total Dollar Value of Fund Disbursement</i>	<i>Total Number of Providers Reviewed</i>	<i>Total Dollar Value of Reviewed Providers’ Fund Disbursements</i>
Hospital	83	\$20,339,217	20	\$18,703,280
Physician	67	\$3,181,740	20	\$2,782,711
EMS	64	\$2,032,621	15	\$1,494,998
Total	214	\$25,553,578	55	\$22,980,989

Findings

The Muret-PCG review found that 6.5 percent of reviewed 2010 uncompensated trauma care claims, or 10 percent of reviewed Fund payments, failed to comply with the Trauma Fund’s eligibility criteria as stated in OAC 310:669. For every reviewed claim, Muret-PCG identified an average of \$69.63 in Fund overpayments. In total, Muret-PCG identified 616 claims which failed to meet the Trauma Fund’s eligibility criteria, representing \$681,944 in Trauma Fund overpayments, detailed as follows:

	Hospitals	Physicians	EMS	Total
<i>Reviewed Fund Payments</i>	\$5,525,727	\$835,853	\$458,293	\$6,819,873
<i>Reviewed Claims</i>	833	8,723	238	9,794
<i>Noncompliant Claims</i>	70	490	56	616
<i>Fund Overpayments</i>	\$548,208	\$51,507	\$82,229	\$681,944
<i>Fund Overpayments Per Reviewed Claim</i>	\$658.11	\$5.90	\$345.50	\$69.63



The majority of Muret-PCG’s findings were related to the discovery of patient or third party payments which should have been (at least in part) either deducted from provider claims to the Fund or remitted back to the Trauma Fund after receipt of payment, as required by OAC 310:669-5-4-c. Muret-PCG discovered more than \$1.4 million in unreported provider collections, \$362,218 of which were received prior to the provider submitting their uncompensated care claims to the Fund, as follows.

	<i># Reviewed Claims</i>	<i>\$Collections Received Prior to Deadline</i>	<i>\$Collections Received After Deadline</i>	<i>Total \$Unreported Collections</i>	<i>Unreported Collections Per Reviewed Claim</i>
Hospital	833	\$248,439	\$909,679	\$1,158,118	\$1,390.30
Physician	8,723	\$36,901	\$44,599	\$81,500	\$9.34
EMS	238	\$76,878	\$114,614	\$191,492	\$804.59
Total	9,794	\$362,218	\$1,068,892	\$1,431,110	\$146.12

Recommendations

On the basis of these review findings, Muret-PCG recommends that OSDH:

- Include explanation of benefits detail with provider payments, ensuring providers have a clear understanding of which claims were paid and the value of each claim payment.
- Build and maintain a single database or portal detailing each provider’s historical claims submission, claims payment, and collections remission histories.
- Include historical claim payment details with each subsequent provider application and require providers to reconcile previously-submitted Fund payments with any collections received since the payments occurred.
- Cross-match all provider-submitted self-payment claims with Medicaid, Medicare, and TRICARE eligibility files to identify liable third party payers.
- In accordance with OAC 310:669-5-1-(j), limit uncompensated care claim amounts submitted for self-pay patients to the amount the patient would have been required to pay had the provider’s self-pay discount been applied and reduce allowable claim amounts by the amount of any charity care afforded to the patient.
- Perform additional, detailed follow-up reviews on providers demonstrating significant OAC 310:669 noncompliance.
- Draft and disseminate educational materials related to the protocols providers are to use for remitting collections, offsetting uncompensated care claim amounts by self-pay discounts and/or charity care, claiming Medicare allowable EMS mileage amounts, and screening patients for alternative insurance coverage.
- Reconsider Trauma Fund payments to patients who can obtain coverage through the online marketplaces.



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- Modify OAC 310:669 to allow the Fund to suspend and/or exclude providers consistently demonstrating high levels of noncompliance.
 - Audit a higher percentage of hospitals considering hospital fund overpayments were greater than 10 times that of physician fund overpayments and 6 times that of EMS fund overpayments.

2. Objectives

2. OBJECTIVES

Since 2009, the Trauma Fund has disbursed nearly \$150 million to eligible hospital, EMS, and physician providers qualified for uncompensated care reimbursement from the Fund for cases meeting required major trauma clinical criteria. Prior to submitting claims to the Trauma Fund, providers are required, per OAC 310:669-5-1-(j), to exhaust reasonable collection efforts and should the provider receive additional payment from either patients or third parties, to remit subsequent collections back to the Fund, per 310:669-5-4-(c). In accordance with Oklahoma Statute § 63-1-2530.9, OSDH must establish rules and procedures governing the Fund's distribution of monies to providers and ensuring information providers have submitted to the Fund is accurate and in compliance with Fund eligibility requirements OAC 310:669. Therefore, OAC 310:669-5-4 was amended in 2011, establishing the objective for engaging Muret to perform a Trauma Fund review, as follows:

- a.** A distribution entity's data originally reported to the trauma registry may be subject to review as established by law, contractual agreement, or for the facility's owners or operators to exercise fiscal and fiduciary responsibility. A State or Federal agency, a fiscal intermediary, or an independent reviewer may perform a review. The review report may also be eligible for appeal.
- b.** A distribution entity may also receive an additional collection(s) for care treated as uncompensated on a prior request for distribution report.
- c.** When a late collection(s) or a review or its appeal results in revising data filed in accordance with OAC 310:669-5-1 and 5-2, the distribution entity shall report to the Department according to Department guidelines. 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.

In accordance with this legislative requirement and to insure the integrity and equitable distribution of provider payments, OSDH engaged Muret CPA, PLLC in February 2014 to conduct a review of 2010 uncompensated care claims paid by the Fund. Muret was tasked by OSDH to perform the following specific services:

- Insure claims submitted by entities receiving reimbursement from the Fund are accurately supported by medical and financial records.
- Confirm claims are in compliance with the Fund's reimbursement criteria outlined in OAC 310:669.
- Identify any discrepancies in submitted claims data.
- Detect any amounts collected from other sources after receiving reimbursement from the Fund.
- Provide regularly scheduled and ad-hoc reporting on review activities and results.
- Conclude with a final report detailing all findings and including process improvement recommendations and outlining potential recoupment opportunities.

3. Methodology



3. METHODOLOGY

Review Preparation

The Muret-PCG team met with OSDH staff in December 2013 to develop a review protocol for each provider type. Muret-PCG reviewed Fund eligibility criteria found in OAC 310:669 and established corresponding review protocols which would effectively identify potential areas of noncompliance and/or Fund overpayment recovery opportunities. At this meeting, the Team also confirmed the appropriate protocols for selecting claims and providers for the review, communicating with providers, obtaining provider documentation, organizing cases, and sending overpayment notification. All review protocols and communications materials were approved by OSDH by February 2014.

Provider Selection

Muret-PCG subcontracted a leading statistician, Dr. Dennis Boos, to develop a statistically significant protocol for selecting providers. Per Dr. Boos’s recommendation, Muret-PCG utilized a random sampling tool, RAT-STATS, which is used by the U.S. Office of Inspector General (OIG) and has been endorsed by the Centers for Medicare and Medicaid Services (CMS). Providers were numbered sequentially according to the dollar value of approved 2010 uncompensated care. The ten largest providers were excluded from this list as they were automatically subject to review. The RAT-STATS Random Number Generator program was then used to generate a series of random numbers which were matched against the numbered list of providers to identify the providers to be subject to our review.

In total, Muret-PCG reviewed 55 providers, including onsite reviews of the 10 largest hospitals, physician groups, and EMS providers (5 largest air and 5 largest ground), based on the dollar value of approved uncompensated care claims submitted by each provider for claim period January 1, 2010 to December 31, 2010, and desk reviews of a random selection of 10 additional hospital providers, 10 additional physician groups, and 5 additional EMS providers, as follows.

<i>Provider Type</i>	<i>Total Number of Providers Receiving Fund Disbursement</i>	<i>Total Dollar Value of Fund Disbursement</i>	<i>Total Number of Providers Reviewed</i>	<i>Total Dollar Value of Reviewed Providers’ Fund Disbursements</i>
Hospital	83	\$20,339,217	20	\$18,703,280
Physician	67	\$3,181,740	20	\$2,782,711
EMS	64	\$2,032,621	15	\$1,494,998
Total	214	\$25,553,578	55	\$22,980,989



The following providers were included in the Muret-PCG review of 2010 uncompensated care claims:

Selected Hospital Providers

<i>\$ Uncompensated Claims Rank (#)</i>	<i>Provider</i>	<i>\$2010 TF Payment</i>	<i>% of 2010 Fund Hospital Disbursement at Selected Provider</i>
1	OU Medical Center	\$9,756,950	48.0%
2	St John Medical Center	\$2,913,300	14.3%
3	Saint Francis Hospital	\$2,618,391	12.9%
4	Integrus Baptist Medical Center, Inc.	\$867,683	4.3%
5	Integrus Southwest Medical Center	\$307,382	1.5%
6	Hillcrest Medical Center	\$725,974	3.6%
7	Comanche County Memorial Hospital	\$367,955	1.8%
8	Mercy Health Center	\$345,099	1.7%
9	Norman Regional Hospital	\$379,341	1.9%
10	Valley View Regional Hospital	\$179,585	0.9%
13	Mercy Memorial Health Center	\$119,919	0.6%
34	St. Francis Hospital South	\$20,285	0.1%
41	St. John Sapulpa	\$14,636	0.1%
46	Craig General Hospital	\$13,301	0.1%
48	Integrus Marshall County Medical Center	\$12,219	0.1%
64	Memorial Hospital-Stilwell	\$4,663	0.0%
68	Holdenville General Hospital	\$2,581	0.0%
72	Share Medical Center	\$1,847	0.0%
73	Memorial Hospital and Physician Group	\$1,687	0.0%
76	Edmond Medical Center	\$50,482	0.2%

Selected Physician Providers

<i>\$ Uncompensated Claims Rank (#)</i>	<i>Provider</i>	<i>\$2010 TF Payment</i>	<i>% of 2010 Fund Hospital Disbursement at Selected Provider</i>
1	OU Physicians	\$1,708,327	53.7%



2	Orthopedic & Trauma Services of Oklahoma	\$172,225	5.4%
3	Care Communications LLC	\$152,459	4.8%
4	St. John Physicians, Inc.	\$147,426	4.6%
5	Radiology Consultants of Tulsa, Inc.	\$107,831	3.4%
6	Neurological Surgery dba Neurosurgery Specialists	\$92,731	2.9%
7	Tulsa Orthopedic Trauma Specialists	\$87,683	2.8%
8	Surgery, Inc.	\$82,356	2.6%
9	Tulsa Radiology Associates, Inc.	\$106,164	3.3%
10	Emergency Medicine Physicians of Tulsa County, PLLC	\$59,314	1.9%
11	Eastern Oklahoma Orthopedic Center, Inc.	\$26,242	0.8%
14	St. John Anesthesia Services	\$16,861	0.5%
20	OU Physicians-Tulsa	\$8,652	0.3%
26	Neurological Specialists of Tulsa	\$5,470	0.2%
30	Diagnostic Imaging Associates, Inc.	\$3,400	0.1%
31	Ashton Creek Oral Surgery Suites, PLLC	\$3,820	0.1%
52	John B. Hill, DO, PC	\$590	0.0%
57	OK Center for Ortho Excellence	\$234	0.0%
58	Anderson Greenhaw, MD	\$160	0.0%
66	Okmulgee Memorial Hospital	\$766	0.0%

Selected EMS Providers

<i>\$ Uncompensated Claims Rank (#)</i>	<i>Provider</i>	<i>\$2010 TF Payment</i>	<i>% of 2010 Fund Hospital Disbursement at Selected Provider</i>
1	EagleMed LLC-446 Rotor Wing	\$ 719,634	35.4%
2	Rocky Mountain Holdings, LLC dba Tulsa Life Flight	\$ 144,858	7.1%
3	AirEvac Lifeteam-397 Claremore	\$ 139,224	6.8%
4	AirEvac Lifeteam-398 McAlester	\$ 121,581	6.0%
5	AirEvac Lifeteam-401 Lawton	\$ 114,664	5.6%
7	AirEvac Lifeteam-396 Pauls Valley	\$ 85,979	4.2%
9	EagleMed LLC-447 Fixed Wing	\$ 61,671	3.0%
13	EMSA - West Division	\$ 46,099	2.3%



18	McCurtain County EMS	\$ 18,627	0.9%
19	EMSA - East Division	\$ 15,962	0.8%
20	REACT EMS	\$ 11,721	0.6%
21	City of Chickasha Fire EMS	\$ 8,682	0.4%
32	City of Alva EMS	\$ 2,433	0.1%
44	City of Antlers EMS	\$ 1,222	0.1%
51	Sinor EMS, Inc.-Clinton	\$ 2,641	0.1%

Case and Claim Selection

Muret-PCG followed the same approach for selecting claims – or cases for hospital providers (i.e. entire patient hospital stays), employing the RAT-STATS Random Number Generator program. Each provider’s claims (or cases) were numbered from 1 to the total number of cases for that provider, also known as “n.” Considering that the sample size to be randomly sampled is “n,” the RAT-STATS Random Number Generator program was used to generate a simple random sample from the integers 1 to N. The data was separately and independently sampled with sample size equal to the larger of 30 percent of provider claims or cases to be considered (rounded up to an integer).

In total, Muret-PCG selected 9,794 claims from 55 providers for inclusion in the 2014 Trauma Fund Review.

Provider Communications

In February 2014 OSDH notified all Fund providers that Muret CPA had been hired to perform a review of selected providers who submitted claims for services rendered during calendar year 2010. In April 2014 Muret-PCG began sending providers certified letters announcing our pending reviews and the documentation that would be required.

Reviews were divided into onsite and desk reviews. Approximately three weeks before an onsite provider visit, Muret-PCG sent notification letters via certified mail informing providers of the purpose of the review, requesting documentation supporting their Trauma Fund claims, and outlining the review schedule. Muret-PCG also contacted providers by phone to schedule and confirm onsite visits. Onsite reviews occurred at the provider’s billing or physical location and consisted of an entrance conference, the review, and an exit conference to discuss preliminary findings. On the day of each provider’s onsite review, Muret-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. At the conclusion of our onsite reviews, Muret-PCG conducted an exit conference to discuss our preliminary findings and to give providers the opportunity to ask questions regarding specific claims that were found to be noncompliant. At this

time, providers were also given an opportunity to submit additional documents in the event they disagreed with any of our findings.

For desk reviews, conducted through the use of the OSDH Trauma Fund Audit Web Portal, Muret-PCG sent providers an initial letter, describing the review, requesting supporting documentation be submitted within 30 days, and instructing providers on how to access and upload documents to the Web Portal. If no provider documentation was received and/or if providers were missing documentation by the 25th day, Muret-PCG sent a Follow-Up letter reminding the provider of the review and extending the document submission deadline an additional five days. Finally, providers were contacted directly by phone to discuss document submission instructions through the Web portal and to answer any questions they might have.

Approximately 30 days after each provider review was completed, Muret-PCG mailed a Tentative Notice of Overpayment or a Perfect Audit Notice to providers documenting instances of noncompliance or the fact that our review did not identify any noncompliance, respectively. Included with the Tentative Notice of Overpayment was a detailed list of each instance of noncompliance, the associated overpayment due back to the Trauma Fund, and instructions for submitting overpayments to the Fund.

Reviews

Muret-PCG has reviewed a statistically valid sample of claims from twenty (20) hospitals, twenty (20) physician groups, and 15 EMS providers throughout the State of Oklahoma to determine whether:

- The service was provided by the provider and was related to the major trauma case that met Trauma Fund eligibility criteria.
- The diagnosis and procedure associated with the claim were supported by the provider's medical records and patient service delivery records.
- The charge amount associated with the claim was accurate and supported by the ICD-9 and /or CPT code(s).
- Billing for the service was performed and communicated to the provider's client.
- Reasonable collection efforts were conducted to recover the amount owed to the provider for services rendered. This will include verification of proper billing procedures and defining reasonable collection efforts.
- Identification of other possible liable insurers and/or 3rd party payors.
- Identification of other possible revenue received for the eligible claim after the Trauma Fund payment was made.
- Identification of provider reimbursement to the Trauma Fund of any revenue received for the eligible claim after the Trauma Fund payment was made.

Specifically, Muret-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.



Muret-PCG prepared a detailed review protocol documents for each provider type which were reviewed and approved by OSDH prior to the review and applied uniformly across all reviewed claims. Protocol summaries for each provider type are detailed as follows.

Muret-PCG’s hospital review protocol attempted to confirm the answers to the following questions:

<i>Hospital Review Protocol Summary</i>
Does length and dates of patient stay in service delivery records match length and date of claimed patient stay?
Does the name, SSN, and DOB in service delivery records match claim(s)?
Does the claimed date of service match the date of service on the service delivery records?
Was patient discharged from services after EADate and prior to DOS?
ICD-9 code between 800 and 959.9?
Which of the following events took place? <ul style="list-style-type: none"> • Hospital stay of at least 48 hours • Transfer from a lower level of trauma to a higher level of trauma care • Admission to an ICU • Admission directly to an operating room for surgery of head, chest, abdomen, or vascular system • Declaration of dead on arrival • Declaration of dead in the ER or elsewhere in the hospital • Oral-Maxillo-facial injury • Traumatic injury to the hand
Do actual charges in patient billing records match actual charges detailed in claims submitted to the Fund?
Was Cost-to-Charge ratio applied correctly?
Was Adjusted Hospital Charge accurately reduced by any collections?
Were unreported collections received prior to or after the Fund’s claim submission deadline?
Were Adjusted Hospital Charge accurately reduced by any contractual adjustments?



Were bills sent to the patient and/or other third parties?
Billed service(s) match medical records?
Billed service(s) match claimed service?
Patient have insurance on date of service?

Muret-PCG's physician review protocol attempted to confirm the answers to the following questions:

<i>Physician Review Protocol Summary</i>
Does CPT code(s) in service delivery records match claimed CPT code(s)?
Does the name, SSN, and DOB in service delivery records match claim(s)?
Does the claimed date of service match the date of service on the service delivery records?
Were service(s) provided within 30 days of date of injury?
ICD-9 code between 800 and 959.9?
Which of the following events took place? <ul style="list-style-type: none"> • Hospital stay of at least 48 hours • Transfer from a lower level of trauma to a higher level of trauma care • Admission to an ICU • Admission directly to an operating room for surgery of head, chest, abdomen, or vascular system • Declaration of dead on arrival • Declaration of dead in the ER or elsewhere in the hospital • Oral-Maxillo-facial injury • Traumatic injury to the hand
Claimed procedure (i.e. CPT code) supported by billing records?
Do actual charges in patient billing records match actual charges detailed in claims submitted to the Fund?
Were actual charges appropriately reduced to the Medicare Allowable amounts?



Were all necessary contractual adjustments accounted for?
Were Medicare Allowable amounts appropriately reduced by the amount(s) of any monies collected?
Were unreported collections received prior to or after the Fund's claim submission deadline?
Were bills sent to the patient and/or other third parties?
Billed service(s) match medical records?
Billed service(s) match claimed service?
Patient have insurance on date of service?

Muret-PCG's EMS review protocol attempted to confirm the answers to the following questions:

<i>EMS Audit Protocol Summary</i>
Was claimed transport and/or service listed in provider transport log or other documents?
Does destination in the provider documents match the claimed destination?
Does CMS Level of Service from Run Report match claimed Medicare Allowable Mileage Rate?
Does the name, SSN, and DOB in run report match claim(s)?
Does the claimed date of service match the date of service in provider records?
Was patient either (1) transported to a trauma facility from scene or injury, or (2) transported from a lower level to a higher level of trauma care?
Did Service Meet one of the following Major Trauma Criteria? <ul style="list-style-type: none"> • ICD-9 code between 800 and 959.9 and Service(s) provided on date of transport? • Glasgow coma score equal to or less than 13 directly related to the mechanism of injury • Signs and symptoms of respiratory compromise resulting from trauma requiring intervention • Hemodynamic compromise from trauma resulting in decreased blood pressure • Penetrating injury above the groin • Amputation proximal to the wrist or ankle • Complete amputations or lacerations of the hand which result in disruption of the vascular supply to one or more digits or the entire hand



<ul style="list-style-type: none"> • Severely crushed or mangled hand injuries with associated vascular injuries, fractures and/or dislocations • Paralysis resulting from traumatic injury, including prehospital treatment for spinal precautions based upon the signs and symptoms of neurological deficit • Flail chest • Two or more proximal long bone fractures (humerus and/or femur) • Open or depressed skull fracture • Unstable pelvis • Pediatric trauma score equal to or less than 8 • Time sensitive traumatic injuries requiring immediate surgical intervention by a surgical specialist to prevent loss of life, limb, or vision
Do the claimed billable miles match the mileage on the run report and/or other documents?
Was Total MCR allowable (\$) accurately reduced by any collections?
Were unreported collections received prior to or after the Fund’s claim submission deadline?
Were bills sent to the patient and/or other third parties?
Billed service(s) match medical records?
Billed service(s) match claimed service?
Patient have insurance on date of service?

All review results were entered into the OSDH Trauma Fund Audit Web Portal for QA and analysis.

4. Findings



4. FINDINGS

The Muret-PCG review found that 6.5 percent of reviewed 2010 uncompensated trauma care claims, or 10 percent of reviewed Fund payments, failed to comply with the Trauma Fund’s eligibility criteria as stated in OAC 310:669. For every reviewed claim, Muret-PCG identified an average of \$69.63 in Fund overpayments. In total, Muret-PCG identified 616 claims which failed to meet the Trauma Fund’s eligibility criteria, representing \$681,944 in Trauma Fund overpayments, detailed as follows:

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EMS	238	\$76,878	\$114,614	\$191,492	\$804.59
Total	9,794	\$362,218	\$1,068,892	\$1,431,110	\$146.12



4.1 Hospital Reviews

Muret-PCG performed reviews of a total of twenty hospitals receiving reimbursement from the Fund for 2010 claims. Our review included the top ten hospitals based on the approved value of uncompensated care claims for 2010, and included an additional ten hospitals chosen at random. The five largest hospital providers had an onsite review performed, while the remaining fifteen providers were desk reviews whereby the providers submitted supporting documents via the OSDH Trauma Fund Audit Web Portal. Muret-PCG reviewed a total of 833 hospital claims accounting for \$5,525,727 in Trauma Fund disbursements and identified 70 ineligible claims, or 8.4 percent of reviewed claims, totaling \$548,208 in Trauma Fund overpayments. Muret-PCG identified \$123,617 of uncompensated trauma care claims which did not meet the Fund’s clinical criteria and \$1,093,399 of uncompensated trauma care claims which did not meet the Fund’s financial criteria.

Hospital Results

<i>2010 \$Fund Hospital Payments</i>	<i># Reviewed Claims</i>	<i>Noncompliance Rate</i>	<i>\$Overpayments Identified</i>	<i>Identified \$Overpayments per Reviewed Claim</i>
\$20,339,217	833	8.4%	\$548,208	\$658.11

Muret-PCG concluded that there was a very high level of clinical compliance with the Fund’s regulations related to the clinical aspects of a claim’s eligibility. Of the 833 hospital claims Muret-PCG reviewed, 9 claims failed for failing to meet clinical criteria, including for the following reasons:

- In some cases primary diagnosis/ICD-9 codes did not fall within the Trauma Fund’s eligibility range of 800.0 to 959.9.
- 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.

Hospital provider compliance with the Fund’s financial eligibility criteria was considerably lower, however. Of the 833 hospital claims Muret-PCG reviewed, Muret-PCG found 61 claims featuring an unreported provider collection from another payer source for the same service that the Fund had provided previously provided payment for. Additional financial compliance issues included:

- 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 there appeared to be inconsistencies in the type of contractual adjustments included in the calculation of Trauma Fund claim amounts.
- 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 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.

Muret-PCG identified \$248,439 of unreported patient and third party payments which should have been deducted from the uncompensated care claims providers submitted due to the providers' receipt of these payments prior to their submission of the Trauma Fund claims. PCG also identified \$909,679 in additional collections providers received after the claim submission deadlines. In total, Muret-PCG discovered \$1,158,118 in patient or third party payments which should have been (at least in part) remitted to the Trauma Fund, as required by OAC 310:669-5-4-c. The chart below details this information based on the applicable claim submission deadline.

<i>Date of Service</i>	<i>Submission Deadline</i>	<i># Reviewed Claims</i>	<i># Collections Received Prior to Deadline</i>	<i>\$Collections Received Prior to Deadline</i>	<i># Collections Received After Deadline</i>	<i>\$Collections Received After Deadline</i>
1/2010 – 6/2010	6/1/2011	343	6	\$236,431	28	\$612,810
7/2010 – 12/2010	12/1/2011	490	2	\$12,008	21	\$296,869
Total		833	8	\$248,439	49	\$909,679

In total, Muret-PCG's clinical and financial review of uncompensated trauma care claimed by hospitals found 70 claims, or 8.4%, of the 833 reviewed claims, which failed to fully comply with the Fund's eligibility criteria outlined in OAC 310:669. The 70 total noncompliant claims Muret-PCG identified represented \$1,217,016 in claimed uncompensated trauma care, or \$548,208 in Trauma Fund overpayments.

4.2 Physician Reviews

Muret-PCG performed reviews of a total of twenty physician groups receiving reimbursement from the Fund for 2010 claims. Our review included the top ten physician groups based on the approved value of uncompensated care claims for 2010, and included an additional ten physician groups chosen at random. The five largest physician groups had an onsite review performed, while the remaining fifteen providers were desk reviews whereby the providers submitted supporting documents via the OSDH Trauma Fund Audit Web Portal. Muret-PCG reviewed a total of 8,723 physician claims, accounting for \$2,782,694 in Trauma Fund disbursements, and identified 490 ineligible claims totaling \$51,507 in Trauma Fund overpayments. Muret-PCG identified \$14,549



of uncompensated trauma care claims which did not meet the Fund’s clinical criteria. Muret-PCG identified \$52,738 of uncompensated trauma care claims which did not meet the Fund’s financial criteria.

Physician Results

<i>2010 \$Fund Physician Payments</i>	<i># Reviewed Claims</i>	<i>Noncompliance Rate</i>	<i>\$Overpayments Identified</i>	<i>Identified \$Overpayments per Reviewed Claim</i>
\$3,181,740	8,723	5.6%	\$51,507	\$5.90

Muret-PCG concluded that there was a very high level of clinical compliance with the Fund’s regulations related to the clinical aspects of a claim’s eligibility. Of the 8,723 reviewed physician claims, Muret-PCG identified the following clinical compliance issues:

- In some cases the provider was unable to provide supporting documentation.
- In some cases primary diagnosis/ICD-9 codes did not fall within the Trauma Fund’s eligibility range of 800.0 to 959.9.
- 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.
- Some claims could not be supported by the provider’s documentation.
- 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.

Similar to Muret-PCG’s hospital findings, the most significant area of physician noncompliance was unreported collections by providers. Of the 8,723 physician claims Muret-PCG reviewed, Muret-PCG found 362 claims featuring an unreported provider collection from another payer source for the same service that the Fund had provided previously provided payment for. In addition to unreported provider collections, PCG also identified the following financial compliance issues:

- 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 there appeared to be inconsistencies in the type of contractual adjustments included in the calculation of Trauma Fund claim amounts.
- In some cases providers wrote off claims to charity care, Crime Victims or bad debt while still seeking reimbursement from the Trauma Fund.



Muret-PCG identified \$36,901 of unreported patient and third party payments which should have been deducted from the uncompensated care claims providers submitted due to the providers' receipt of these payments prior to their submission of the Trauma Fund claims. PCG also identified \$44,599 in additional collections providers received after the claim submission deadlines. In total, Muret-PCG discovered \$81,500 in patient or third party payments which should have been (at least in part) remitted to the Trauma Fund, as required by OAC 310:669-5-4-c. The chart below details this information based on the applicable claim submission deadline.

<i>Date of Service</i>	<i>Submission Deadline</i>	<i># Reviewed Claims</i>	<i># Collections Received Prior to Deadline</i>	<i>\$Collections Received Prior to Deadline</i>	<i># Collections Received After Deadline</i>	<i>\$Collections Received After Deadline</i>
1/2010 – 6/2010	6/1/2011	3,941	121	\$15,454	138	\$37,064
7/2010 – 12/2010	12/1/2011	4,782	52	\$21,447	51	\$7,535
Total		8,723	173	\$36,901	189	\$44,599

In total, Muret-PCG's clinical and financial review of uncompensated trauma care claimed by physicians found seventy claims, or 8.4%, of the 833 reviewed claims, which failed to fully comply with the Fund's eligibility criteria outlined in OAC 310:669. The 490 total noncompliant claims Muret-PCG identified represents \$51,507 in Trauma Fund overpayments.

4.3 EMS Reviews

Muret-PCG performed reviews of a total of fifteen EMS providers receiving reimbursement from the Fund for 2010 claims. Our review included the five largest air services providers and five largest ground services providers based on the approved value of uncompensated care claims for 2010, and also included an additional five EMS providers chosen at random. The five largest EMS providers had an onsite review performed, while the remaining ten EMS providers were desk reviews whereby the providers submitted supporting documents via the OSDH Trauma Fund Audit Web Portal. Muret-PCG reviewed a total of 238 EMS claims, accounting for \$458,293 in Trauma Fund payments and identified 56 noncompliant claims totaling \$82,229 in Trauma Fund overpayments. Muret-PCG identified \$226,254 of uncompensated trauma care claims which did not meet the Fund's financial criteria.

EMS Results



<i>2010 \$Fund EMS Payments</i>	<i># Reviewed Claims</i>	<i>Noncompliance Rate</i>	<i>\$Overpayments Identified</i>	<i>Identified \$Overpayments per Reviewed Claim</i>
\$2,032,621	238	23.5%	\$82,229	\$345.50

While EMS providers were generally compliant with Fund eligibility criteria, Muret-PCG identified 56 claims which failed to fully comply with the Trauma Fund’s eligibility criteria. Within these 56 failed claims, Muret-PCG found two specific issues: the Medicare allowable urban mileage rate was incorrectly used for rural mileage runs and providers sometimes failed to report collections.

Muret-PCG identified \$76,878 of unreported patient and third party payments which should have been deducted from the uncompensated care claims providers submitted due to the providers’ receipt of these payments prior to their submission of the Trauma Fund claims. PCG also identified \$114,614 in additional collections providers received after the claim submission deadlines. In total, Muret-PCG discovered \$191,492 in patient or third party payments which should have been (at least in part) remitted to the Trauma Fund, as required by OAC 310:669-5-4-c. The chart below details this information based on the applicable claim submission deadline.

<i>Date of Service</i>	<i>Submission Deadline</i>	<i># Reviewed Claims</i>	<i># Collections Received Prior to Deadline</i>	<i>\$Collections Received Prior to Deadline</i>	<i># Collections Received After Deadline</i>	<i>\$Collections Received After Deadline</i>
1/2010 – 6/2010	6/1/2011	121	5	\$44,173	11	\$50,265
7/2010 – 12/2010	12/1/2011	117	5	\$32,705	8	\$64,349
Total		238	10	\$76,878	19	\$114,614

In total, Muret-PCG’s clinical and financial review of uncompensated trauma care claimed by EMS providers found 56 claims, or 23.5%, of the 238 reviewed claims, which failed to fully comply with the Fund’s eligibility criteria outlined in OAC 310:669. The 56 total noncompliant claims Muret-PCG identified represented \$209,546 in claimed uncompensated trauma care, or \$82,229 in Trauma Fund overpayments.

5. Recommendations

5. RECOMMENDATIONS

In order to better insure the integrity of Trauma Fund payments, educate providers on eligibility compliance, identify responsible payers, and track and reconcile unreported collections, Muret-PCG recommends that the Trauma Fund consider the following:

1. Include explanation of benefits detail with provider payments, ensuring providers have a clear understanding of which claims were paid and the value of each claim payment. Nearly every provider found to have unreported collections indicated that they were frustrated with the fact that they did not have an accurate inventory of what claims were accepted by the Trauma Fund for payment and how much the Trauma Fund paid for each of these claims. Providers would be better able to track collections, especially those received after claims were submitted to the Fund, if they received a detailed explanation of benefits document with each Trauma Fund payment.
2. Build and maintain a single database or portal detailing each provider's historical claims submission, claims payment, and collections remission histories. By maintaining a master database of Fund paid claim details, OSDH will be able to better monitor provider payments, reimbursements, and collections.
3. Include historical claim payment details with each subsequent provider application and require providers to reconcile previously-submitted Fund payments with any collections received since the payments occurred. Sending providers a running list of historical paid Trauma Fund claims and then requiring them to indicate the value of collections on any past claims – and remit these collections to the Fund - will insure that providers understand that the Fund is providing ongoing oversight and monitoring of past claims. Should future reviews discover that the provider regularly failed to acknowledge collections to the Fund, steps could be taken to sanction and/or terminate provider eligibility for Fund disbursement.
4. Cross-match all provider-submitted self-payment claims with Medicaid, Medicare, and TRICARE eligibility files to identify liable third party payers. Implementing an ongoing TPL process into the Fund's claims review protocol will insure responsible payers are billed prior to the Fund and will save the Fund's disbursement pool for those who patient charges that are truly uncompensated.
5. In accordance with OAC 310:669-5-1-(j), limit uncompensated care claim amounts submitted for self-pay patients to the amount the patient would have been required to pay had the provider's self-pay discount been applied and reduce allowable claim amounts by the amount of any charity care afforded to the patient. This statute states that "A distribution entity shall not include any amount it is not entitled to collect from the patient." If providers are qualifying patients for self-pay, Crime Victims, and/or charity care, they

are not entitled to claim uncompensated care exceeding the remaining value of the patient's care.

6. Perform additional, detailed follow-up reviews on providers demonstrating significant OAC 310:669 noncompliance. Muret-PCG's 2014 Trauma Fund review identified providers featuring significant noncompliance exceeding \$1,000 in Fund payments per reviewed claim and/or exceeding noncompliance rates greater than 25 percent. Each of these findings suggests that OSDH has an opportunity to recover additional overpayments from these providers if additional reviews were to take place. The Trauma Fund should consider incorporating follow-up reviews into future reviews to insure that seriously noncompliant providers are identified, educated, and charged for overpayments if noncompliance continues.
7. Draft and disseminate educational materials related to the protocols providers are to use for remitting collections, offsetting uncompensated care claim amounts by self-pay discounts and/or charity care, claiming Medicare allowable EMS mileage amounts, and screening patients for alternative insurance coverage. Many providers reported having a limited understanding of key Fund eligibility and claims submission protocols. EMS providers reported frustration interpreting allowable mileage claim amounts. Using the Fund's website and/or printed announcements included with provider payments to educate providers on some of the key procedural issues identified during this review will insure that future provider confusion is avoided, claims are correctly submitted, and collections are better reported and refunded.
8. Reconsider Trauma Fund payments to patients who can obtain coverage through the online marketplaces. Many patients who received health care through subsidized Trauma Fund disbursement may have qualified for, yet declined, health care insurance through the online marketplaces. In these instances, the financial burden now becomes that of the Trauma Fund. By restricting Trauma Fund reimbursement to those individuals who are either under-insured or do not qualify for reasonably affordable insurance, the Trauma Fund can channel its funds to only the most needy and disadvantaged individuals.
9. Modify OAC 310:669 to allow the Fund to suspend and/or exclude providers consistently demonstrating high levels of noncompliance. 2014's Fund audit identified certain providers demonstrating significant levels of noncompliance, exceeding 25 percent error rates and/or \$50,000 in identified Fund overpayments. These noncompliant providers failed to reimburse the Fund for thousands of dollars in payments received from third parties; much of which was received prior to submitting uncompensated care claims to the Fund. The Fund must establish the right to temporarily suspend providers from Fund disbursement participation when providers consistently fail to adhere to the Fund participation criteria outlined in OAC 310:669. Currently, providers are only held accountable for overpayments identified during Trauma Fund audits and are therefore not incentivized to take proactive steps to ensuring compliance. Additionally, because Trauma



Fund audits typically cover approximately 30 percent of paid provider claims, it is reasonable to assume that thousands of dollars in improper provider overpayments are never discovered and therefore never returned to the Fund.

10. Audit a higher percentage of hospitals considering hospital fund overpayments were over 10 times that of physician fund overpayments and 6 times that of EMS fund overpayments. Hospital overpayments per each reviewed claim were significantly higher at \$658.11 in contrast with \$5.90 and \$345.50 for physician and EMS claims, respectively. At the claim level, this equates to each reviewed hospital claim being 110 times more valuable than that of each reviewed physician claim and nearly 2 times more valuable than each reviewed EMS claim. With over 80% of Trauma Fund disbursements going to hospital providers, the audit methodology should be reconsidered and proportionally reflected in subsequent audits.