



Oklahoma State Department of Health

2015 Trauma Fund Audit

Final Report

November 30, 2015

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TABLE OF CONTENTS

1. EXECUTIVE SUMMARY7

2. OBJECTIVES11

3. METHODOLOGY13

4. FINDINGS22

4.1 Hospital Reviews23

4.2 Physician Reviews25

4.3 EMS Reviews27

5. HOSPITAL REHABILITATION ANALYSIS29

Independent Accountant's Report On Applying Agreed-Upon Prodecures

1. Executive Summary
2. Objectives
3. Methodology
4. Findings
5. Hospital Rehabilitation Analysis



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

Oklahoma State Department of Health and Trauma Fund Management:

We have performed the procedures enumerated in the following report presented by Muret CPA, PLLC in conjunction with Public Consulting Group, 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, 2011; 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 sufficiency of these procedures is solely the responsibility of those parties specified in the report. Consequently, we make no representation regarding the sufficiency of the procedures described below either for the purpose for which this report has been requested or for any other purpose.

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 financial statement audit, the objective of which would be the expression of an opinion on a full set of financial statements. 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 20, 2015

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 May 2015 to conduct a review of 2011 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 May 2015 and November 2015 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 2015 review of Trauma Fund claims included a review of the 15 largest hospitals, 5 largest physician groups, and 10 largest (5 ground and 5 air) EMS providers, based on the dollar value of approved uncompensated care claims submitted by each provider for claim period January 1, 2011 to December 31, 2011. 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 10 additional EMS providers. Muret-PCG reviewed 50 percent of paid Trauma Fund claims for hospitals and 30 percent of physician groups and EMS providers for services delivered during calendar year 2011.

The Muret-PCG Team's review included a sample of 92.4 percent of the paid Trauma Fund claims for services delivered during 2011:

Provider Type	# Providers Receiving Fund Disbursement	\$ Fund Disbursement	# Providers Reviewed	Reviewed Providers' \$ Fund Disbursements
Hospital	80	\$19,601,300	25	\$18,899,104
Physician	68	\$3,935,652	15	\$3,112,222
EMS	54	\$1,345,175	20	\$982,160
Total	202	\$24,882,127	60	\$22,993,486

Findings

The Muret-PCG review found that 6.3 percent of reviewed 2011 uncompensated trauma care claims 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 \$132.11 in Fund overpayments. In total, Muret-PCG identified 650 claims which failed to meet the Trauma Fund's eligibility criteria, representing \$1,362,618 in Trauma Fund overpayments, detailed as follows:

	Hospital	Physician	EMS	Total
Reviewed Fund Payments	\$9,636,126	\$3,112,222	\$982,160	\$13,730,508
Reviewed Claims	1,400	8,636	278	10,314
Noncompliant Claims	206	385	59	650
Fund Overpayments	\$1,291,098	\$50,009	\$21,511	\$1,362,618
Fund Overpayments Per Reviewed Claim	\$922.21	\$5.79	\$77.38	\$132.11

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 \$4.1 million in unreported provider collections, \$659,083 of which were received prior to the provider submitting their uncompensated care claims to the Fund, as follows:

	# Reviewed Claims	\$ Collections Received Prior to Deadline	\$ Collections Received After Deadline	Total \$ Unreported Collections	\$ Unreported Collections Per Reviewed Claim
Hospital	1,400	\$612,354	\$3,445,679	\$4,058,033	\$2,898.60
Physician	8,636	\$38,016	\$15,086	\$53,102	\$6.15
EMS	278	\$8,713	\$14,976	\$23,689	\$85.21

	# Reviewed Claims	\$ Collections Received Prior to Deadline	\$ Collections Received After Deadline	Total \$ Unreported Collections	\$ Unreported Collections Per Reviewed Claim
Total	10,314	\$659,083	\$3,475,741	\$4,134,824	\$400.89

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 an 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 May 2015 to conduct a review of 2011 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 July 2015 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 July 2015.

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 2011 uncompensated care. The 15 largest hospitals, 5 largest physician groups and 10 largest EMS (5 ground and 5 air) 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 60 providers, including onsite reviews of the 5 largest physician groups, based on the dollar value of approved uncompensated care claims submitted by each provider for claim period January 1, 2011 to December 31, 2011, and desk reviews of the 15 largest hospitals and 10 largest EMS providers (5 ground and 5 air) as well as random selections of 10 additional hospital providers, 10 additional physician groups, and 10 additional EMS (5 ground and 5 air) providers, as follow:

Provider Type	# Providers Receiving Fund Disbursement	\$ Fund Disbursement	# Providers Reviewed	\$ Reviewed Providers' Fund Disbursements
Hospital	80	\$19,601,300	25	\$18,899,104
Physician	68	\$3,935,652	15	\$3,112,222
EMS	54	\$1,345,175	20	\$982,160
Total	202	\$24,882,127	60	\$22,993,486

The following providers were included in the Muret-PCG review of 2011 uncompensated care claims:

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Selected Hospital Providers

\$ Uncompensated Claims Rank (#)	Provider	\$2011 TF Payment	% 2011 Hospital Disbursement at Selected Provider
1	OU Medical Center	\$9,049,973	46.2%
2	St John Medical Center	\$3,318,601	16.9%
3	Saint Francis Hospital	\$2,443,178	12.5%
4	Integris Baptist Medical Center, Inc.	\$1,413,167	7.2%
5	Hillcrest Medical Center	\$596,539	3.0%
6	St. Anthony OKC	\$391,192	2.0%
7	Integris Southwest Medical Center	\$318,177	1.6%
8	Mercy Health Center - OKC	\$262,561	1.3%
9	Norman Regional Hospital - Moore	\$220,649	1.1%
10	Comanche County Memorial Hospital	\$215,670	1.1%
11	Mercy Memorial Health Center - Ardmore	\$125,767	0.6%
12	Deaconess Hospital	\$133,770	0.7%
13	Jane Phillips Medical Center	\$109,863	0.6%
14	Jackson County Memorial Hospital	\$103,853	0.5%
15	Muskogee Regional Medical Center	\$77,119	0.4%
22	St. John Sapulpa	\$30,832	0.2%
27	St. Mary's Regional Medical Center	\$28,046	0.1%
31	Claremore Regional Hospital	\$20,476	0.1%
34	St. John Owasso	\$17,083	0.1%
43	Memorial Hospital - Stilwell	\$7,945	0.0%
48	St. John Broken Arrow	\$6,812	0.0%
56	Newman Memorial Hospital	\$5,453	0.0%
71	Holdenville General Hospital	\$1,076	0.0%
75	Watonga Municipal Hospital	\$916	0.0%
78	Beaver County Memorial Hospital	\$385	0.0%

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Selected Physician Providers

\$ Uncompensated Claims Rank (#)	Provider	\$2011 TF Payment	% 2011 Hospital Disbursement at Selected Provider
1	OU Physicians	\$2,000,617	50.8%
2	Surgery, Inc.	\$364,186	9.3%
3	Care Communications LLC	\$208,038	5.3%
4	Orthopedic & Trauma Services of Oklahoma	\$177,370	4.5%
5	St. John Physicians, Inc.	\$155,947	4.0%
6	Tulsa Radiology Associates, Inc.	\$104,882	2.7%
16	Associated Anesthesiologists, Inc.	\$27,853	0.7%
18	Comanche County Healthcare Corporation	\$22,593	0.6%
21	Neurosurgical Specialists of Tulsa	\$16,972	0.4%
22	Emergency Services of Oklahoma, PC	\$16,226	0.4%
31	Radiology Associates, LLC	\$7,686	0.2%
34	Green Country Emergency Physicians of Tulsa	\$6,819	0.2%
54	Okmulgee Emergency PLLC	\$1,421	0.0%
56	OSU Med Center Patient Services	\$1,009	0.0%
62	Radiological Services, Inc.	\$603	0.0%

Selected EMS (Air) Providers

\$ Uncompensated Claims Rank (#)	Provider	\$2011 TF Payment	% 2011 Hospital Disbursement at Selected Provider
1	EagleMed 446 - Rotor Wing	\$263,989	19.6%
2	Rocky Mountain Holdings, LLC	\$146,246	10.9%
3	AirEvac Lifeteam 398 - McAlester	\$93,599	7.0%
4	EagleMed 418 - Hugo	\$66,239	5.0%
5	AirEvac Lifeteam 428 - TX	\$74,587	5.5%
6	AirEvac Lifeteam 412 - Elk City	\$79,461	6.0%
11	EagleMed 367 - Stillwater	\$36,784	2.7%
12	AirEvac Lifeteam 401 - Lawton	\$42,700	3.2%
14	AirEvac Lifeteam 399 - Cushing	\$32,482	2.4%
15	EagleMed 382 - Tahlequah	\$26,114	2.0%

Selected EMS (Ground) Providers

\$ Uncompensated Claims Rank (#)	Provider	\$2011 TF Payment	% 2011 Hospital Disbursement at Selected Provider
1	EMSA - West	\$46,908	3.5%
2	EMSA - East	\$27,091	2.0%
3	REACT EMS	\$17,325	1.3%
4	McCurtain County EMS	\$9,001	0.7%
5	EMSStat	\$6,268	0.5%
6	Mayes Emergency Services Trust Authority (MESTA)	\$5,673	0.4%
11	LifeNet	\$2,698	0.2%
13	Mercy Hospital – El Reno	\$3,184	0.2%
22	Sinor EMS – Sayre	\$898	0.1%
26	Choctaw County EMS, LLC	\$913	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 11,306 claims from 60 providers for inclusion in the 2015 Trauma Fund Review.

Provider Communications

In June 2015, 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 four 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 conducted a follow-up telephone call reminding the provider of the review and extending the document submission deadline an additional five days.

Approximately 1 week after each provider review was completed, Muret-PCG schedule a preliminary audit findings telephone call with the provider. During this call, providers were encouraged to provide any additional documents that were needed, clarify any discrepancies, and informed that the final Tentative Notice of Overpayment would be mailed in approximately 1 week. 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-five (25) hospitals, fifteen (15) physician groups, and 20 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.

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

Hospital Review Protocol Summary
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?
Did the patient receive rehabilitation services while in the hospital?
How many days did the patient receive rehabilitation services?
What were the uncompensated care and actual hospital costs associated with rehabilitation services?

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

Physician Review Protocol Summary
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:

EMS Audit Protocol Summary
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 • 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 6.3 percent of reviewed 2011 uncompensated trauma care claims 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 \$132.11 in Fund overpayments. In total, Muret-PCG identified 650 claims which failed to meet the Trauma Fund's eligibility criteria, representing \$1,362,618 in Trauma Fund overpayments, detailed as follows:

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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 \$4.1 million in unreported provider collections, \$659,083 of which were received prior to the provider submitting their uncompensated care claims to the Fund, as follows.

	# Reviewed Claims	\$ Collections Received Prior to Deadline	\$ Collections Received After Deadline	Total \$ Unreported Collections	Unreported Collections Per Reviewed Claim
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Physician	8,636	\$38,016	\$15,086	\$53,102	\$6.15
EMS	278	\$8,713	\$14,976	\$23,689	\$85.21
Total	10,314	\$659,083	\$3,475,741	\$4,134,824	\$400.89

4.1 Hospital Reviews

Muret-PCG performed reviews of a total of twenty-five hospitals receiving reimbursement from the Fund for 2011 claims. Our initial review included the top fifteen hospitals based on the approved value of uncompensated care claims for 2011, and included an additional ten hospitals chosen at random. All twenty-five hospital providers were desk reviews whereby the providers submitted supporting documents via the OSDH Trauma Fund Audit Web Portal. Muret-PCG reviewed a total of 1,400 hospital claims in the initial audit accounting for \$9,636,126 in Trauma Fund disbursements and identified 206 ineligible claims, or 14.7 percent of reviewed claims, totaling \$1,291,098 in Trauma Fund overpayments. Muret-PCG identified \$33,509 of uncompensated trauma care claims which did not meet the Fund's clinical criteria and \$2,341,657 of uncompensated trauma care claims which did not meet the Fund's financial criteria.

Hospital Results

2011 Reviewed \$ Hospital Payments	# Reviewed Claims	Noncompliance Rate	\$ Overpayments	\$ Overpayments per Reviewed Claim
\$9,636,126	1,400	14.7%	\$1,291,098	\$922.21

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 1,400 hospital claims Muret-PCG reviewed, 7 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 1,400 hospital claims Muret-PCG reviewed, Muret-PCG found 122 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 \$612,354 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 \$3,445,678 in additional collections providers received after the claim submission deadlines. In total, Muret-PCG discovered \$4,058,032 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.

Date of Service	Submission Deadline	# Reviewed Claims	# Collections Received Prior to Deadline	\$ Collections Received Prior to Deadline	# Collections Received After Deadline	\$ Collections Received After Deadline
1/2011 – 6/2011	6/1/2012	675	18	\$174,812	40	\$1,031,983
7/2011 – 12/2011	12/1/2012	725	19	\$437,542	45	\$2,413,696
Total		1,400	38	\$612,354	85	\$3,445,679

In total, Muret-PCG's clinical and financial review of uncompensated trauma care claimed by hospitals found 206 claims, or 14.7%, of the 1,400 reviewed claims, which failed to fully comply with the Fund's eligibility criteria outlined in OAC 310:669. The 206 total noncompliant claims Muret-PCG identified represented \$4,750,332 in claimed uncompensated trauma care, or \$1,291,098 in Trauma Fund overpayments.

4.2 Physician Reviews

Muret-PCG performed reviews of a total of fifteen physician groups receiving reimbursement from the Fund for 2011 claims. Our review included the top five physician groups based on the approved value of uncompensated care claims for 2011, and included an additional ten physician groups chosen at random. The five largest physician groups had an onsite review performed, while the remaining ten providers were desk reviews whereby the providers submitted supporting documents via the OSDH Trauma Fund Audit Web Portal. Muret-PCG reviewed a total of 8,636 physician claims, accounting for \$3,112,222 in Trauma Fund disbursements, and identified 385 ineligible claims totaling \$50,009 in Trauma Fund overpayments. Muret-PCG did not identify any trauma care claims which did not meet the Fund's clinical criteria. Muret-PCG identified \$50,009 of uncompensated trauma care claims which did not meet the Fund's financial criteria.

Physician Results

2011 \$ Physician Payments	# Reviewed Claims	Noncompliance Rate	\$ Overpayments Identified	\$ Overpayments per Reviewed Claim
\$3,112,222	8,636	4.5%	\$50,009	\$5.79

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 8,636 reviewed physician claims, Muret-PCG was not able to identify any noncompliant claims as stipulated in OAC 311:669.

Similar to Muret-PCG's hospital findings, the most significant area of physician noncompliance was unreported collections by providers. Of the 8,636 physician claims Muret-PCG reviewed, Muret-PCG found 277 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 \$38,016 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 \$15,086 in additional collections providers received after the claim submission deadlines. In total, Muret-PCG discovered \$53,102 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.

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Date of Service	Submission Deadline	# Reviewed Claims	# Collections Received Prior to Deadline	\$ Collections Received Prior to Deadline	# Collections Received After Deadline	\$ Collections Received After Deadline
1/2011 – 6/2011	6/1/2012	3,752	157	\$19,208	15	\$4,270
7/2011 – 12/2011	12/1/2012	4,884	69	\$18,808	36	\$10,816
Total		8,636	226	\$38,016	51	\$15,086

In total, Muret-PCG's clinical and financial review of uncompensated trauma care claimed by physicians found 385 claims, or 4.5%, of the 8,636 reviewed claims, which failed to fully comply with the Fund's eligibility criteria outlined in OAC 310:669. The 385 total noncompliant claims Muret-PCG identified represents \$50,009 in Trauma Fund overpayments.

4.3 EMS Reviews

Muret-PCG performed reviews of a total of twenty EMS providers receiving reimbursement from the Fund for 2011 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 2011, and also included an additional ten EMS providers chosen at random. All twenty EMS providers were conducted as desk reviews whereby the providers submitted supporting documents via the OSDH Trauma Fund Audit Web Portal. Muret-PCG reviewed a total of 278 EMS claims, accounting for \$982,160 in Trauma Fund payments and identified 59 noncompliant claims totaling \$21,511 in Trauma Fund overpayments. Muret-PCG identified \$35,872 of uncompensated trauma care claims which did not meet the Fund's financial criteria.

EMS Results

2011 \$ EMS Payments	# Reviewed Claims	Noncompliance Rate	\$ Overpayments Identified	\$ Overpayments per Reviewed Claim
\$982,160	278	21.2%	\$21,511	\$77.38

While EMS providers were generally compliant with Fund eligibility criteria, Muret-PCG identified 59 claims which failed to fully comply with the Trauma Fund's eligibility criteria. Within these 59 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 \$5,216 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 \$19,029 in additional collections providers received after the claim submission deadlines. In total, Muret-PCG discovered \$23,689 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.

Date of Service	Submission Deadline	# Reviewed Claims	# Collections Received Prior to Deadline	\$ Collections Received Prior to Deadline	# Collections Received After Deadline	\$ Collections Received After Deadline
1/2011 – 6/2011	6/1/2012	147	2	\$812	3	\$4,934
7/2011 – 12/2011	12/1/2012	131	5	\$7,901	9	\$10,042
Total		278	7	\$8,713	12	\$14,976

In total, Muret-PCG's clinical and financial review of uncompensated trauma care claimed by EMS providers found 59 claims, or 21.2%, of the 278 reviewed claims, which failed to fully comply with the Fund's eligibility criteria outlined in OAC 310:669. The 59 total noncompliant claims Muret-PCG identified represented \$36,105 in claimed uncompensated trauma care, or \$21,511 in Trauma Fund overpayments.

5. Hospital Rehabilitation Analysis

5. HOSPITAL REHABILITATION ANALYSIS

In 2015, Muret CPA was tasked with quantifying the financial impact of hospital rehabilitation stays on Trauma Fund disbursements. Muret's goal was to isolate those patients who received rehabilitation services - including physical, occupational, and therapeutic rehabilitation – during inpatient hospital stays which were subsequently billed to the Trauma Fund. The Muret Team then identified those hospital charges which should be considered rehabilitation charges. Our audit findings related to the cost of the Trauma Fund paying for rehabilitation-related services can be summarized as follows.

- Muret-PCG identified 780 hospital patients of the initial 1,400 hospital claims we audited who received rehabilitation services during the hospital stays covered by the Trauma Fund;
- Muret-PCG's audit of Fund-approved claims identified \$10,156,049 in Actual Hospital Charges associated with rehabilitation services/procedures;
- Muret-PCG calculated that 7.6 percent of Actual Hospital Charges supplemented by the Trauma Fund are generated from rehabilitation services by comparing the actual hospital charges from the providers we audited (\$133,958,239) with the Actual Hospital Charges from rehabilitation services we discovered (\$10,156,049);
- Muret-PCG calculated the average ratio of Actual Hospital Charges to Trauma Fund Hospital payments to be 7.4 percent based on the fact that in 2011 the Fund paid a total of \$19,601,487 for claims corresponding with a total of \$265,963,189 in Actual Hospital Charges; and
- Therefore, Muret-PCG concludes that \$20,213,202 (or 7.6 percent) of the \$265,963,189 in 2011 Actual Hospital Charges were for rehabilitation-related services and that this \$20,213,202 in Actual Hospital Charges represents approximately \$1,495,777 (or 7.4 percent) in Trauma Fund payments made for rehabilitation services.

The following tables illustrates our estimates:

1. Ratio of rehabilitation-related charges vs. actual hospital charges:

\$ Actual Hospital Charges from Audited Patients	\$ Rehab-Related Actual Hospital Charges from Audited Patients	Rehab-Related Actual Hospital Charges / Actual Hospital Charges from Audited Patients Ratio
\$133,958,239	\$10,156,049	7.6%

2. Ratio of actual hospital charges vs. hospital payments:

Total 2011 Actual Hospital Charges from All TF Patients	Total 2011 TF Hospital Payments	2011 TF Hospital Payments / Actual Hospital Charges Ratio
\$265,963,189	\$19,601,487	7.4%

3. Calculation of hospital payments for rehabilitation-related services:

Total 2011 Actual Hospital Charges from All TF Patients	Rehab-Related Actual Hospital Charges / Actual Hospital Charges Ratio	2011 Rehab-Related Actual Hospital Charges from All TF Patients	2011 TF Hospital Payments / Actual Hospital Charges Ratio	2011 TF Payments for Rehab-Related Services
\$265,963,189	7.6%	\$20,213,202	7.4%	\$1,495,777

Results by provider are as follows:

Provider Name	# Audited Patients (initial)	Audited Patients Receiving Rehab Services	Actual Hospital Costs for Audited Patients' Rehab Services	Est. TF Payment for Audited Patients' Rehab Services	# Patient Days Including Rehab*
Beaver County Memorial Hospital	2	0	\$0	\$0	0
Claremore Regional Hospital (Permanently Closed) / Hillcrest Hospital Claremore	14	0	\$0	\$0	0
Comanche County Memorial Hospital	35	20	\$166,811	\$12,344	126
Deaconess Hospital	21	7	\$72,795	\$5,387	22
Hillcrest Medical Center	42	26	\$380,204	\$28,135	222
Holdenville General Hospital	1	0	\$0	\$0	0
Integrus Baptist Medical Center	102	63	\$164,306	\$12,159	619
Integrus Southwest Medical Center	48	27	\$35,104	\$2,598	82
Jackson County Memorial Hospital	21	7	\$37,029	\$2,740	36
Jane Phillips Medical Center	35	15	\$62,134	\$4,598	73
Memorial Hospital - Stilwell	10	0	\$0	\$0	0
Mercy Health Center - OKC	36	26	\$71,128	\$5,263	76
Mercy Memorial Health Center - Ardmore	38	5	\$30,894	\$2,286	37
Muskogee Regional Medical Center (d/b/a Eastar Health System)	27	1	\$11,433	\$846	10
Newman Memorial Hospital	3	0	\$0	\$0	0
Norman Regional Hospital - Moore	48	4	\$5,278	\$391	7
OU Medical Center (OUMC)	407	279	\$8,690,926	\$643,129	Unable to determine
St. Anthony OKC	37	10	\$30,451	\$2,253	63
St. Francis Hospital	221	152	\$204,287	\$15,117	782
St. John Broken Arrow	7	0	\$0	\$0	0

Provider Name	# Audited Patients (initial)	Audited Patients Receiving Rehab Services	Actual Hospital Costs for Audited Patients' Rehab Services	Est. TF Payment for Audited Patients' Rehab Services	# Patient Days Including Rehab*
St. John Medical Center	207	134	\$186,681	\$13,814	640
St. John Owasso	13	0	\$0	\$0	0
St. John Sapulpa	13	0	\$0	\$0	0
St. Marys Regional Medical Center	10	4	\$6,589	\$488	8
Watonga Municipal Hospital (Now managed by Mercy Hospital Watonga)	2	0	\$0	\$0	0
Total	1,400	780	\$10,156,049	\$751,548	2,803

*Because of inconclusive and/or ambiguous documentation, PCG was unable to accurately differentiate each acute care day from each rehabilitation day. As a result, we have omitted this determination from our analysis and have only indicated the number of days during which the patient appeared to have received at least one rehabilitation-related service or procedure.

In total, Muret-PCG identified 780 claims, or 55.7% of the total number of initial audited hospital claims, in which the provider records indicated that the patient received rehabilitation services during his or her stay in the hospital. These claims, valued at over \$10 million in actual hospital charges, represent an estimated \$1.5 million in 2011 Trauma Fund payments.

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