Finance and Business Workshop

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TRAUMA CENTER Association of America ADVOCACY • FINANCE • OPERATIONS

Welcome
March 1, 2022
Valerie Rinkle

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Scope of Workshop

- What is Trauma and Why is it Special?
- Understanding Roles and Responsibilities
- Reporting trauma services on claims
- Establishing charges for trauma response
- Improving reimbursement for trauma
- Other financial strategies
- Claim examples - appendix

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What is Trauma and Why is it Special?

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Unique to Trauma Care

- Focus on the system and performance improvement in care delivery and outcomes
- Regionalized care & specialized services
- Higher level of resources required by the hospital for care and readiness
- Program staff to monitor and implement performance improvement and patient safety
- Additional costs other facilities don't incur related to readiness (ex. OR capability 24h/day, radiology staffing and other ancillary services that have higher capability and availability)
- Increased standby/call pay for physicians
  - Specialty Physicians
  - Reduced resident's hours
- Increased trauma related knowledge and experience

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Trauma- A Multidisciplinary Sport

Trauma on-call Physician Specialties
(Level Dependent)

Trauma Surgery
Anesthesia
Ob/Gyn Surgery
Cardiac Surgery
Hand Surgery
Plastic Surgery
Oral Maxillofacial Surgery
ENT
Neurosurgery
Pediatric Surgery
Ophthalmology
Thoracic Surgery
Orthopedic Surgery
Critical Care Medicine
Radiology
Nephrology

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Trauma- A Multidisciplinary Sport

Common required resource examples (level dependent)

- Additional training for providers and nurses
- 24h staffing of all departments
- 24h capability of various services
- Research, injury prevention, outreach
- Structured Performance Improvement and Safety Programs
- Program staff - manager, injury prevention, registrars
- Dedicated, trained staff to trauma care

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Hospital Resources and Trauma Activation Response Teams

- Dependent on Level of Activation, Hospital Resources (Level of Center) & Activation Policies
- May include all or some of the following:
  - ED Provider (MD or APP)
  - ED trauma trained nursing staff
  - Trauma Surgeon and APP
  - Lab
  - RT
  - Radiology
  - Anesthesia
  - OR Crew
  - Chaplain
  - Surgical Specialties
  - CT/IR/MRI on immediate stand by
  - Radiologists in house
  - Security
  - Blood Bank

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Understanding Roles & Responsibilities

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Identify Key Players in Your Organization's Financial & Trauma Village

Financial:
- CDM Coordinator
- Payer Contracting Director
- Revenue Cycle
- Revenue Integrity
- Compliance Officer

Clinical:
- Trauma Medical Director
- Trauma Program Manager
- Director of Trauma

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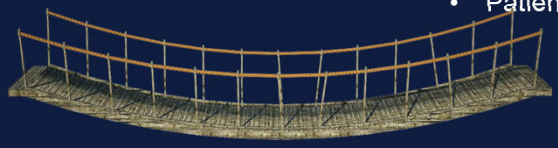
Communication: Appreciate the Language

Finance Language
- P & L
- Margin
- Contribution Margin
- ROI
- Business Plan

Clinical Language
- Response Team
- Activation Criteria
- Trauma Bay
- CT
- CT Tray
- Patients



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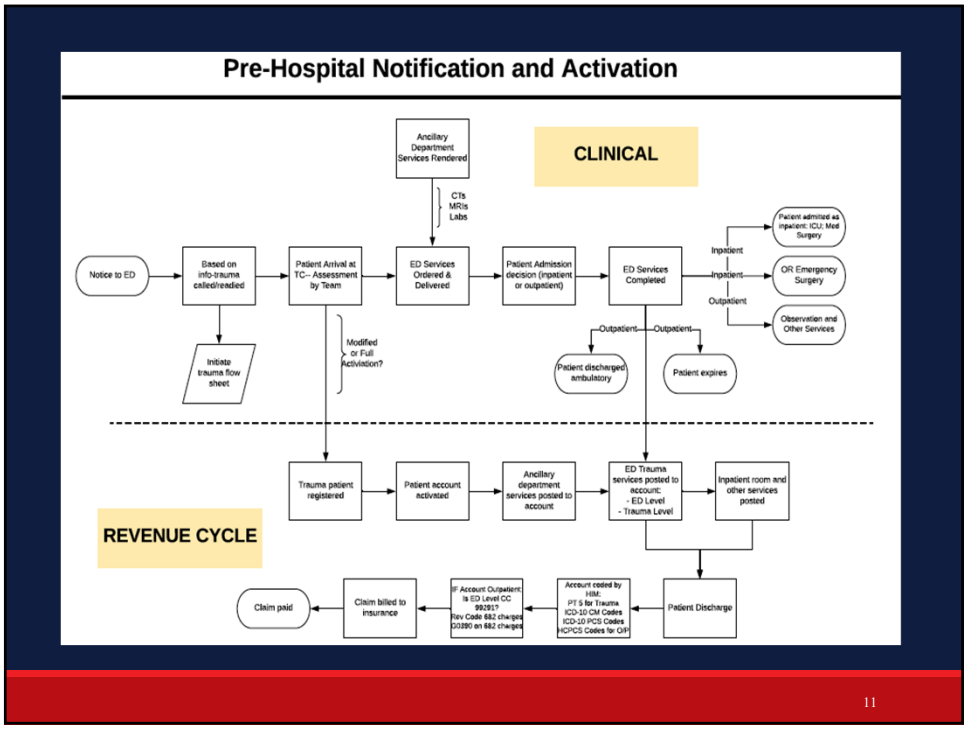
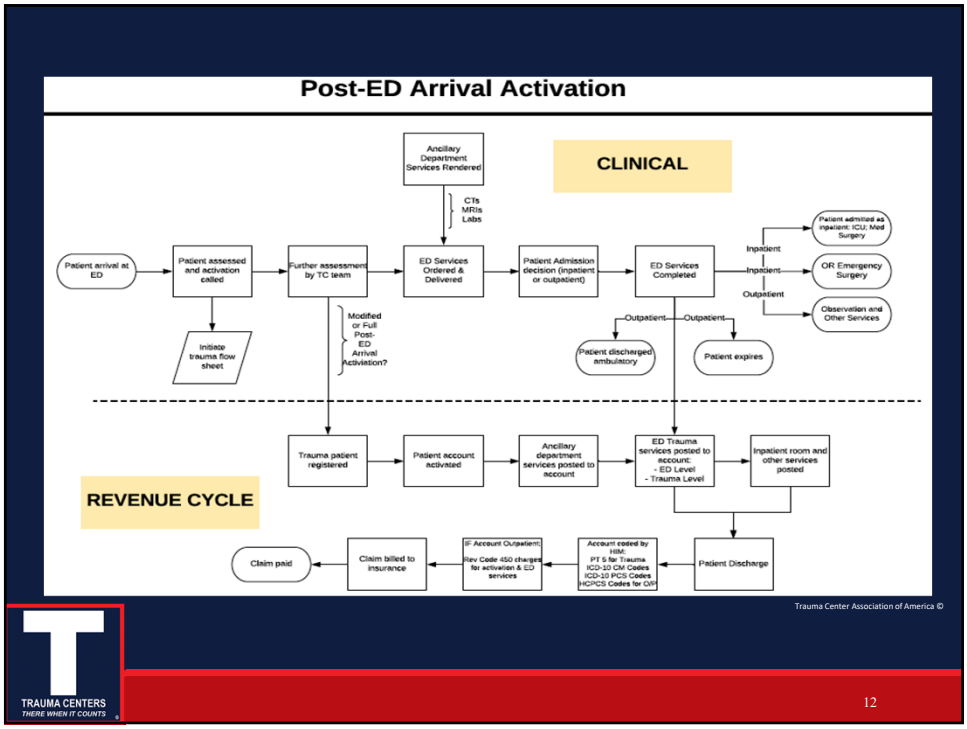

Pre-Hospital Notification and Activation
CLINICAL
Ancillary Department Services Rendered
CTs
MRIs
Labs
Notice to ED
Based on info-trauma called/readied
Patient Arrival at TC-- Assessment by Team
ED Services Ordered & Delivered
Patient Admission decision (inpatient or outpatient)
ED Services Completed
Inpatient
Inpatient
Outpatient
Patient admitted as inpatient: ICU; Med Surgery
OR Emergency Surgery
Observation and Other Services
Outpatient
Outpatient
Patient discharged ambulatory
Patient expires
Initiate trauma flow sheet
Modified or Full Activation?
REVENUE CYCLE
Trauma patient registered
Patient account activated
Ancillary department services posted to account
ED Trauma services posted to account: - ED Level - Trauma Level
Inpatient room and other services posted
Patient Discharge
Account coded by HIM: PT S for Trauma ICD-10 CM Codes ICD-10 PCS Codes HCPCS Codes for O/P
IF Account Outpatient: Is ED Level CC 99291? Rev Code 682 charges G0390 on 682 charges
Claim billed to insurance
Claim paid
11


Post-ED Arrival Activation
CLINICAL
Ancillary Department Services Rendered
CTs
MRIs
Labs
Patient arrival at ED
Patient assessed and activation called
Further assessment by TC team
ED Services Ordered & Delivered
Patient Admission decision (inpatient or outpatient)
ED Services Completed
Inpatient
Inpatient
Outpatient
Patient admitted as inpatient: ICU; Med Surgery
OR Emergency Surgery
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Account coded by HIM: PT S for Trauma ICD-10 CM Codes ICD-10 PCS Codes HCPCS Codes for O/P
IF Account Outpatient: Rev Code 450 charges for activation & ED services
Claim billed to insurance
Claim paid
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Whose Job Is It?

- To bridge the clinical and financial
- To verify to clinical managers that revenue and expense is correctly accounted in the GL
- To verify clinical services are properly reported on inpatient and outpatient claims pursuant to HIPAA
- To provide a feedback loop to clinical management that their services are paid by payers as expected versus experiencing delays or denials and what their role is to correct root causes of delays or denials

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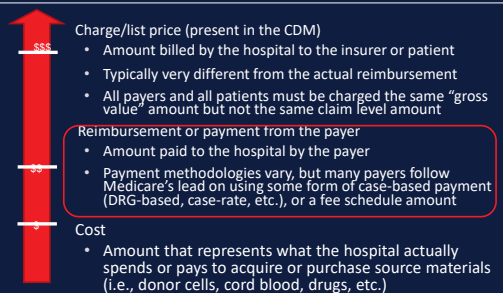
Who needs to understand this key concept?



Charge/list price (present in the CDM)

- Amount billed by the hospital to the insurer or patient
- Typically very different from the actual reimbursement
- All payers and all patients must be charged the same "gross value" amount but not the same claim level amount

Reimbursement or payment from the payer

- Amount paid to the hospital by the payer
- Payment methodologies vary, but many payers follow Medicare's lead on using some form of case-based payment (DRG-based, case-rate, etc.), or a fee schedule amount

Cost

- Amount that represents what the hospital actually spends or pays to acquire or purchase source materials (i.e., donor cells, cord blood, drugs, etc.)

Example: A hospital purchases drugs from the manufacturer, applies a mark-up to represent it's internal handling and overhead costs, and reports this higher dollar amount as the charge on its claim to the payer, who then pays (reimburses) the hospital according to its methodology or contract provisions. The difference between the "charge" and what is "reimbursed" is deemed a contractual allowance and written off by the hospital

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Important Revenue Concepts for Clinical Management to Understand

Eligibility and Coverage

- Covers the setting, services for specific indications (exists for transplant)
- Commercial payers may have additional requirements, like requesting prior authorization
- Medicare may have national or local coverage determinations (NCDs/LCDs for radiation therapy)

Claims with Charges & Codes

- Diagnosis Codes: ICD-10-CM for coverage & also reimbursement depending on payer and method
- Procedure Codes: ICD-10-PCS Inpatient; CPT/HCPCS: Physician/Outpatient Facility
- Revenue Codes: Represent what departments perform services

Payment

Hospitals submit correctly coded claims to the payer for payment of covered services; payers use software to check for coverage (Ex: Medicare Code Editor may have edits based on language from an NCD or LCD where procedures are checked against covered diagnoses)

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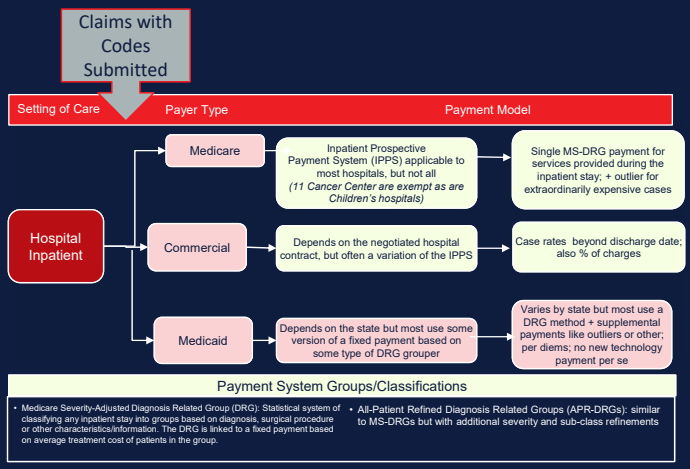
Do you know margin of these payers for trauma?



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DRG's (IPPS) and Trauma – blunt and not good for analysis!

Diagnosis ICD 10 codes

Surgical Procedures ICD10 procedure codes

Comorbidities & Complication

Age, sex and discharge status

DRG

Trauma patients don't go into several at same time- but there is not ONE DRG or one area they may land in (Ortho/Neuro/vent/other)

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Do you know proportion and margin of these payers for outpatient trauma?

Claims with Codes Submitted

Setting of Care	Payer Type	Payment Model
Hospital Outpatient	Medicare	Outpatient Prospective Payment System (OPPS) applicable to most hospitals → CPT services grouped into Ambulatory Payment Classifications or APCs + outlier for extraordinarily expensive cases
	Commercial	Depends on the negotiated hospital contract, but often a variation of the OPPS and/or fee schedules → Lower of charge or payment rate often applies
	Medicaid	Depends on the state but most use some version of a fixed payment based on some type of APC grouper → Varies by state but most use a APC and/or fee schedule method or eAPGs

Payment System Groups/Classifications

- Ambulatory Payment Classifications (APCs): System of classifying any similar outpatient services into groups based on common hospital cost and clinical characteristics/information. The APC is based on average treatment cost of services in the group. Many ancillary services are not paid separately
- Episode Ambulatory Payment Groups (eAPGs): similar to APCs but with different refinements and groups

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Reporting Trauma Services on Claims

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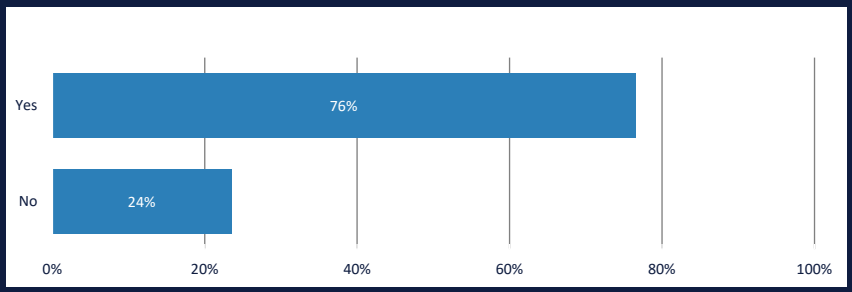
Survey Results:

Do you know your fee structure for your facility's trauma activation charges?



Why Trauma Response Charges ?

- Hospitals represent the cost of services furnished to patients with charges
- Charges are defined – they must be consistently related to the resources and uniformly applied to all patients – inpatient or outpatient, Medicare or other payers
- Trauma care involves additional resources for the trauma services furnished to patients – it is different than ED and different than the OR or the room charge
- Trauma patients receive an intensive level of evaluation by numerous coordinated staff
- Hospitals ensure that trauma physicians meet higher requirements than general medical staff
  - Response, education & participation
- Charges must always be supported with medical record documentation

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All Types of Separately Billable Trauma Care Services

- Emergency Medical Services (EMS) transport from accident to nearest hospital
  - Must validate/justify transport to a more distant hospital due to medical necessity/level of care requirements. Paid under CMS' ambulance fee schedule. *Not discussed here.*
- ED, Trauma Surgeon & Professional Services of other treating physician and non-physician practitioners rendered to patients and paid via the Medicare Physician Fee Schedule (MPFS). *Not discussed here*.
  - No separate professional payment for stand-by or on-call, but may be claimed as facility expense in the hospital cost report
- Hospital Services – Inpatient and Outpatient
  - ED visits including Critical Care and Trauma Activations
  - Hospital services for inpatient and outpatient surgeries and other diagnostic and therapeutic services

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CMS Requires Hospitals Establish Charges to Capture Costs of Care

- CMS Defines Charges PRM1 Section 2202.4 "Charges refer to the regular rates established by the provider for services rendered to both beneficiaries and to other paying patients. Charges should be related consistently to the cost of the services and uniformly applied to all patients whether inpatient or outpatient."
- PRM1 Section 2203 - "each facility should have an established charge structure which is applied uniformly to each patient as services are furnished to the patient and which is reasonably and consistently related to the cost of providing the services"
- The service = trauma response
- The service = trauma management of trauma patient ICU stay
- Trauma patients with and without pre-hospital arrival notification have the same costs for activations as those with pre-hospital notification

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Foundational to all Claims

- HIPAA laws that govern:
- Claim formats – electronic
- Code sets – diagnoses and procedures
- Data sets required for claims
- All payers and providers must adhere to HIPAA transaction code set laws – reporting services is expected to be standard, coverage and payment differs by payer and benefit plans and negotiated contracts!!
- Important!! Payers use Medicare reimbursement rules to deny reporting of charges pursuant to HIPAA to avoid outlier/stop loss payments on all types of accounts, but this will occur often on trauma cases!!

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Establish Trauma Team Response Levels & Fees

Full Response

- Minimal requirements by designating/verifying body for calling
- Highest level of Activation Criteria (usually physiologic criteria)
- Response time usually required (<15 min)
- Full hospital team
  - Trauma Surgeon and EM Physician
  - Defined by policy and center resources
  - Likely OR notification

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Establish Trauma Team Response Levels & Fees

Partial Response

- Requirements by designating/verifying body for calling (often mechanistic)
- Response time may be longer (<30 min)
- Smaller hospital team
  - Trauma Surgeon/APP & EM Physician/APP
  - Defined by policy and center resources

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Establish Trauma Team Response Levels & Fees

ED Trauma Evaluation

- Often single system injuries with traumatic MOI
- May be trauma transfers from non-trauma or lower-level centers that do not meet higher activation criteria
- Must be an ***activation*** based on criteria and response, not just an evaluation to admit, discharge or when results are back
- Can be a small trauma trained team
  - Trauma Surgeon, Resident or APP
  - Trauma Credentialed Nurse
  - Ancillary staff as indicated- team defined by policy and center resources

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Activation Charge(s) = Response Fees

In addition to the clinical resources responding to activations, should include direct program expenses inclusive of/but not limited to:

- TPM salary and benefits
- Registrar salary and benefits
- Certification fees
- Continuing education
- Research (depending on level)
- On-call fees for physicians (do not include things reimbursed with professional fees)
- On-call/OT fees for team members (depends on team member composition for full or partial activations)
- Mark-up for indirect/overhead following hospital policies

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Documentation to Support Charges

- Effective design of documentation templates are key
  - Trauma flow sheet – time of pre-hospital notification and by who (e.g., EMS, clinician at facility, home health aide)
  - Time of arrival, mode of arrival
  - Activation/Response level – Full or modified and time of activation, time of team response and whether pre or post arrival activation
  - Vital signs from interfaced physiological monitoring equipment – frequency matters (e.g., every 2 minutes tapering to longer intervals upon stabilization of patient)
  - Procedures and interventions (e.g., arterial draw, intubation, additional IV access)
- Ensure charge capture staff and coders understand the templates
- Evaluate completeness and consistency of documentation with staff using actual case reviews

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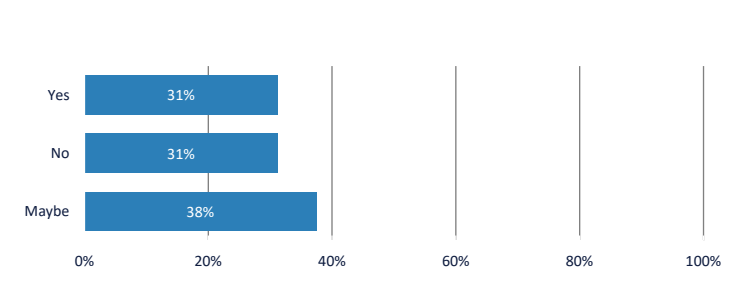
Survey Results:

As part of the registration process for trauma patients, is there a process to ensure trauma patients are registered as "type 5" in field locator 14 (FL 14)?



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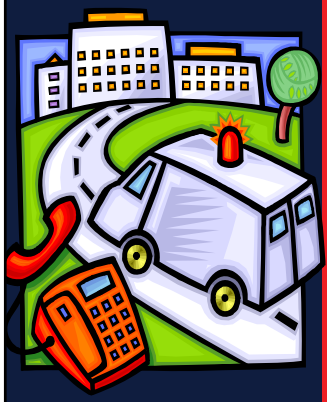
NUBC Code - Type of Admission/Visit
FL14, Patient Type 5
"Trauma"



Form Locator or Field Locator (FL)

- Term for the fields on the claim forms (UB-04/837I).

Visit/Admission Types: Emergent(1), Urgent (2), Elective (3), Newborn (4) and Trauma (5)

Differentiates trauma patient from others on the claim for their entire course of care

Enables trauma access to or the ability to query the patient accounting system and

- Track P/L by payor, zip code, county
- Get comparison LOS and other cost/charge data

Trauma Charges on Hospital Claims

- Requirements for claims is part of HIPAA
- NUBC as the HIPAA-authorized entity regarding rules for hospital claims established the pre-arrival notification trauma response (activation) revenue codes on October, 1, 2002
- Revenue code series 068x is reserved for trauma team response (activation) with pre-arrival notification

NUBC **Revenue Codes Applicable for Trauma**

068X - Trauma Response Code

0450 - ED Service Code

0208 - Trauma ICU Accommodation Code

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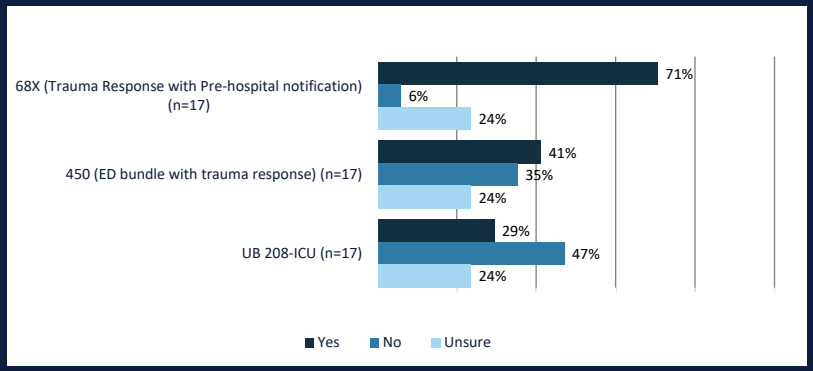
Survey Results:
Do you charge the following?



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NUBC Requirements for Trauma Charges

- Verified and/or designated trauma center
- Revenue Category 068X is used for patients for whom a trauma activation occurred with pre-arrival notification
  - A trauma team activation/response is a "Notification of key hospital personnel in response to triage information from pre-hospital caregivers in advance of the patient's arrival."
- Review and/or update trauma team response policy and procedure
- Revenue Category 068X must be used in conjunction with FL 14 Type of Admission/Visit code 05 ("Trauma Center").

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Pre-Arrival Notice

- Not exclusively EMS
- Can include
  - Airmedical
  - Referring Hospital
  - Police
  - Fire
  - Urgent Care
  - Referring Physician or PA, ANP
  - Clinic
- All except family, friends, squeal of tires on ambulance ramp

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NUBC Requirements for Trauma Charges

- Patients who are dropped off or arrive without notification cannot be charged for activations under 068X.
- Should be classified as trauma under FL 14, Type 5 per NUBC instructions
- Because patients receive the same trauma response service, per PRM1 definition of charges, the response fee must be charged and the next most appropriate revenue code to report on the claim is the ED revenue code (0450)

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Report Applicable 068x Code based on Trauma Level Designation

068x is the Trauma Response Code

"x" relates to level of Trauma Center designation/verification

- 681 = Level I
- 682 = Level II
- 683 = Level III
- 684 = Level IV
- 689 = Levels beyond IV- Specific to state

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Trauma Activations without Pre-Arrival Notification

Drop off/Drive By and Walk-in

- Use revenue code 0450 for the trauma activation/response charge and also bill the ED Visit Charge (99285-99291)
- If it is an outpatient claim, sum the activation charge together with the ED visit charge
  - **99291** (ED patient w/o trauma Activation)
  - **99291** + Trauma Evaluation
  - **99291** + Partial Trauma Team Activation
  - **99291** + Full Trauma Team Activation

Charge is sum of both charges on outpatient claims

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ED Visit and Procedure Charges are Separate from Trauma Charges

The ED charges its services separate from trauma and NUBC notes "*if trauma activation occurs, there will normally be both a 045x and a 068x revenue code reported*"

When the patient meets the definition of critical care for the ED visit charge, then there is a unique HCPCS code for trauma to be used when the trauma patient remains an outpatient = G0390.

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Trauma Response -Outpatient Payment (death or transfer)

- CMS created HCPCS code G0390 with the description **Trauma response team associated with hospital critical care service** (HCPCS 99291)
  - 99291 Same Day of Service
    - Requires 30 minutes Critical Care Time
    - Physician and/or staff count unless at same time
- CMS created APC **Trauma response with Critical Care** with a national payment rate
  - Need to code 68X + G0390 + HCPCS 99291

Note – 068x can be billed on outpatient claim w/o a HCPCS code, but payers incorrectly deny

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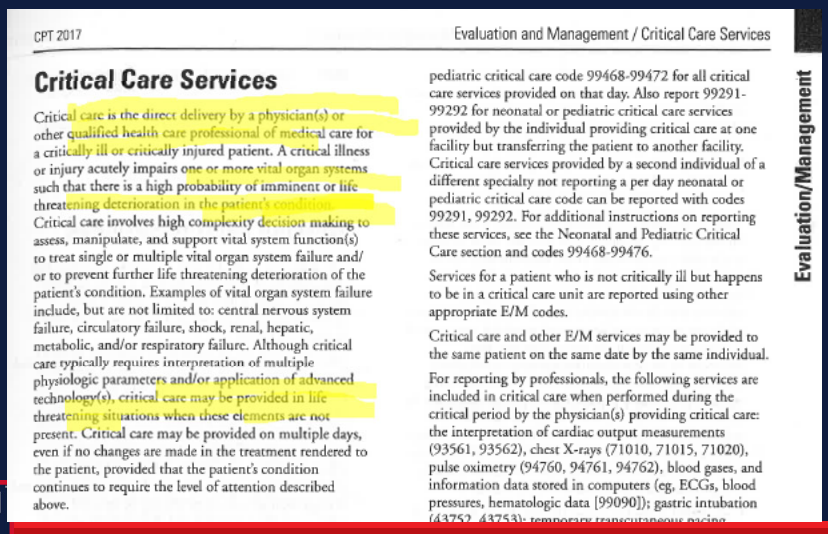
Critical Care Services



CPT 2017 Evaluation and Management / Critical Care Services

Critical Care Services

Critical care is the direct delivery by a physician(s) or other qualified health care professional of medical care for a critically ill or critically injured patient. A critical illness or injury acutely impairs one or more vital organ systems such that there is a high probability of imminent or life threatening deterioration in the patient's condition. Critical care involves high complexity decision making to assess, manipulate, and support vital system function(s) to treat single or multiple vital organ system failure and/or to prevent further life threatening deterioration of the patient's condition. Examples of vital organ system failure include, but are not limited to: central nervous system failure, circulatory failure, shock, renal, hepatic, metabolic, and/or respiratory failure. Although critical care typically requires interpretation of multiple physiologic parameters and/or application of advanced technology(s), critical care may be provided in life threatening situations when these elements are not present. Critical care may be provided on multiple days, even if no changes are made in the treatment rendered to the patient, provided that the patient's condition continues to require the level of attention described above.

pediatric critical care code 99468-99472 for all critical care services provided on that day. Also report 99291-99292 for neonatal or pediatric critical care services provided by the individual providing critical care at one facility but transferring the patient to another facility. Critical care services provided by a second individual of a different specialty not reporting a per day neonatal or pediatric critical care code can be reported with codes 99291, 99292. For additional instructions on reporting these services, see the Neonatal and Pediatric Critical Care section and codes 99468-99476.

Services for a patient who is not critically ill but happens to be in a critical care unit are reported using other appropriate E/M codes.

Critical care and other E/M services may be provided to the same patient on the same date by the same individual.

For reporting by professionals, the following services are included in critical care when performed during the critical period by the physician(s) providing critical care: the interpretation of cardiac output measurements (93561, 93562), chest X-rays (71010, 71015, 71020), pulse oximetry (94760, 94761, 94762), blood gases, and information data stored in computers (eg, ECGs, blood pressures, hematologic data [99090]); gastric intubation (43752, 43753); temporary transcutaneous pacing

Evaluation/Management

Assigning G0390

- Hospitals have several options to assign HCPCS G0390 with the 068x charges when the ED visit is a critical care 99291 visit.
  - Option #1: Have HIM Coders assign G0390 to 068x charges only when 99291 for critical care is also coded. Ensure the G0390 populates the claim for same day of service.
  - Option #2: Put G0390 into the charge master with the 068x charge as a hardcoded HCPCS code. Write electronic claim logic to remove G0390 if 99291 is not also present for same day of service. **[Best practice option]**
  - Option #3: Build two trauma activation charges at the same price, one with G0390 to be billed when critical care HCPCS 99291 is assigned on same day of service and a second without G0390 to be billed when no critical care is assigned.

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Key Points!

AHA & NUBC Compliant

- Revenue Category 068X does not replace UB 0450
- Revenue Category 068X is not limited to admitted patients
- UB 0450 only used for trauma activations without Pre-Arrival Notification
- CMS payments increase or decrease based on 068X data

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What is ICU revenue code 0208?

- ICU Accommodation Code for trauma patients admitted to the ICU to be used instead of generic 200 or 201
- The room rate can be higher than typical ICU room charge
- Charged for the daily ICU room charge when the patient received a trauma activation response – either with pre-arrival notification or not – and is managed throughout the ICU stay by the hospital trauma program staff

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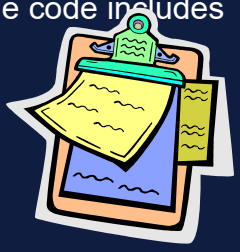
Trauma Revenue Code 0208 for ICU

Documentation to support the revenue code includes a trauma note



Covers higher resource use

- Case Management
- Nutrition, PT, OT
- Social Services, Clergy
- Rehabilitation

Take base charge + additional cost = 0208 charge

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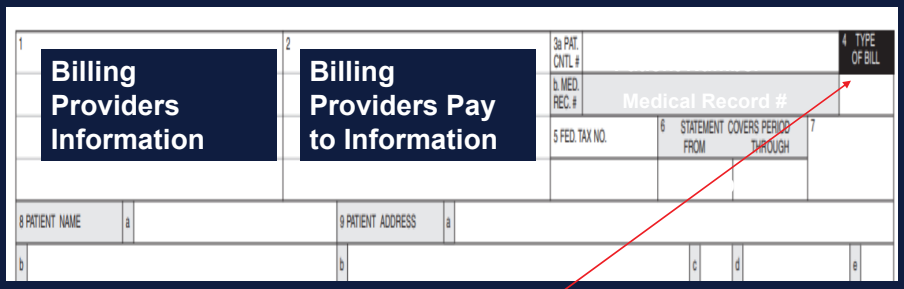
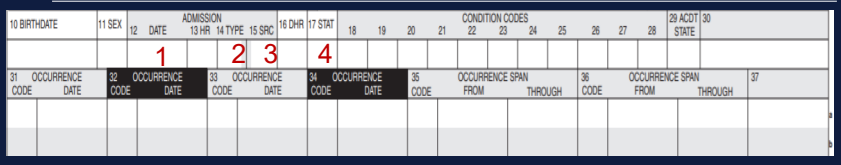
Claim Review

Important Trauma Data on Hospital Claims



Form locator (FL) 4: Type of bill
0111 Hospital Inpatient including Medicare Part A
0117 Inpatient Bill with revisions
0131 Hospital Outpatient

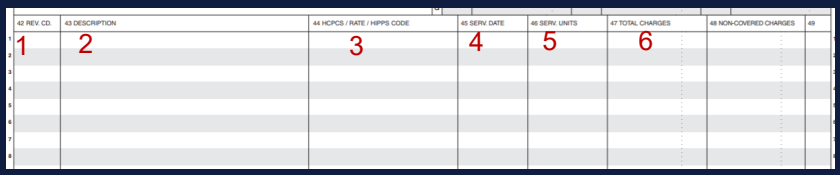
Important Trauma Data on Hospital Claims



FL 12 Admission dates- would not be filled out if outpatient chart (1)
FL 14 Type 1 is emergency patient, 5 is trauma (2)
FL 15 Point of admission: Physician referral, emergency room, transfer in etc (3)
FL 17 Discharge status: Different codes can be found at below website (4)

http://www.alphacm.net/mcsuniversity/documents/general/UB-04_2007.pdf 49

Important Trauma Data on Hospital Claims



FL 42 Revenue codes from NUBC manual (1)
FL 43 Description of code (2)
FL 44 HCPCS (Healthcare Common Procedure Coding System) (3)
FL 45 Service Dates (4)
FL 46 Service Units (5)
FL 47 Total Charges (6)

50

Verification of all fields necessary

- FL 14, Type 5 – if patient receives a trauma team response regardless of the mode of arrival
- 68x – if patient receives a trauma team response with pre-hospital notification
  - G0390 if patient receives critical care
- Documentation is key to assisting coders
  - Provide information to reflect the severity of the injury
  - "Critical Care time: _ _ _ provided

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Trauma Billing Summary

- Unique trauma transaction codes are defined
- CMS definition of hospital charges applies to all trauma responses
- Hospitals are obligated to report services on claims reported to payers
- Therefore, is this an opportunity to…
  - Define a new cost and/or revenue center
  - Improve fiscal reports for trauma and better quantify margin
  - Track patient outcomes and expense for data to support commercial payer contract negotiations

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Common TPM FAQs on Trauma Response Charging

- Do I charge for a full or partial charge if I upgrade an TA?
- Do I charge for a full or partial charge if I downgrade an TA?
- Do I need to have trauma provider involvement to charge an activation/response?
- Do I charge the TA fee if after workup a non-trauma diagnosis is made?
- Patient is a full activation/response, over triaged do I charge the full response charge?
- How does the bill get triggered for the UB 208 code?
- Can I bill for both hospitals in the same system if both have the same billing ID number?

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Establishing Charges for Trauma Response

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What is the best method to establish charges?

- Check the charge amounts for activations from other trauma centers at the same certification level
- Use a multiple of CMS' outpatient payment rate
- Charges are already defined in the CDM, so we will continue to increase them with our annual price increase

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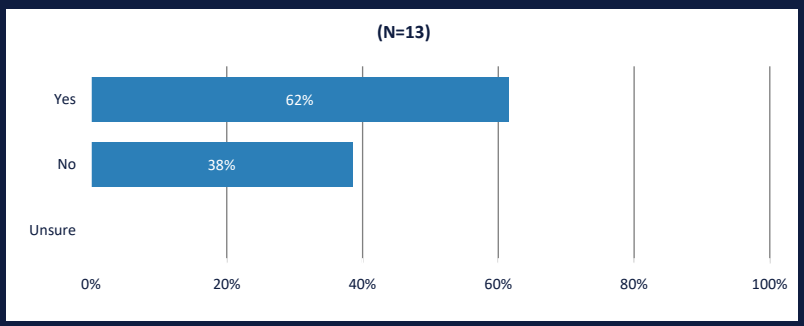
Survey Results:

Do you have a process or cadence to review costs associated with trauma activations and revise trauma activation fees as indicated?



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Review of Hospital's Posted Prices for Trauma – aka Price Transparency

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Do you have a pricing policy?

- Expense based items
- Services furnished
- Purchased services

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How charges impact payment

- The hospital cost report involves reporting annual expenses by major service line, such as lab, pharmacy, emergency department, nursing, supplies, intensive care, etc.
- Where is trauma? Is it its' own cost center or included in ED or over in the medical school or medical group?
- How are hospital administrative and overhead expense allocated to trauma?
- Where is it reported in the cost report?

- Total annual hospital cost is compared to total patient care charges; a comparison is also made for each service department
  - This comparison is expressed as mathematical ratio called the "cost-to-charge ratio" (CCR)
  - CCRs are used by Medicare to compute outlier and develop future payments and in developing future payment rates

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Obtaining Reimbursement for Trauma

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Reimbursement is the last step

- Accurate or improved reimbursement is impossible if services are not accurately reported on claims
- Data often needs to be tracked over 2-3 years to build a compelling case to a commercial payer
- Recent government designation as a trauma center may be sufficient to negotiate with a payer

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Start with PI to Improve Trauma Reimbursement

Establish a Trauma PI Team with the following suggested members:

Admissions, ED Manager, Trauma Coordinator/Manager, ED charge capture, Coding Supervisor, Billing Manager, Revenue Integrity & Denials Manager, and Administration

Determine Data Entry Points
Monitor Data and Charge Accuracy
Audit Charts for Compliance

PI for Trauma Finances (Cont.)

Develop the scope for the PI Team:

- Determine Revenue Cycle Data Entry Points applicable to trauma charges and codes on claims
- Monitor Data and Charge Accuracy
- Audit Charts for Compliance

Determine Data Entry Points

- Patient Type (FL 14)
  - Registration, Admitting, Unit Secretary
  - Add Trauma Center Patient Type 5
- 68x Charges
  - ED: Full, Partial, and Evaluation Trauma Team
  - Trauma Program: ALL Charges
- 208 Trauma Critical Care
  - FL14, Type 5 patients admitted to Critical Care (any bed)

Monitor Data & Charge Accuracy

- Patient Type 5 – Hospital-wide Process
- Trauma Response Levels Entered
  - Still charge 0450 ED level of service
  - 068X does not require a HCPCS or CPT code
- Monitor and Correct charges entered for patient type and level of service
  - Does trauma have access to finance system?
  - Does trauma get regular reports?

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Pull Charts, Itemized Statements & UB04s for Complete Review:

- Field Activation accounts
- Intra-Hospital Activation accounts
- ED Critical Care accounts
- Patient Type 5 accounts
- Trauma patients admitted to ICU
- Confirm Medical Record Documentation

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Develop a Trauma Program Financial Dashboard

Suggestions:

- TA by levels, total charges and revenue
- Overall Volume as reported in registry
- Admits, Transfers in/out, Discharges
- Average LOS by age and ISS
- Average ICU LOS by age and ISS
- Case Mix Index
- Number of cases paid, in progress, in denials
- Charge capture days and compared to hospital goals
- Cost per case
- Number of TA billed vs activation number

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Financial Data from the Registry

Your registry is a great source of information

- Clinical: ISS, LOS, procedures
- Administrative: Volume, payer, injury data

When comparing to finance data, keep in mind definitions – the data dictionary for the registry may or may not match how the EHR or RCM system defines things

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Stand-alone vs. System Considerations

Independent Hospital	Part of a System/Network
May be a third party	Finance may be offsite
Finance team may be onsite	Rules may be different if systems crosses state lines
	May have uniform billing
	May have 2 hospital under same billing number

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Common Barriers to Overcome

- Belief that charging for 68X will cause red flags with insurance carriers
- Not wanting to charge patients for “extra things”
- Why charge if we don't get paid?
- Networking activation charges the same regardless of level of TC
- Resistance from finance department
- Lack of knowledge in finance department to trauma billing
- Small volume so why bother to charge
- Charge capture and documentation
- Access to financial information
- Getting trauma department visible on organizational chart

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Common Barriers to Overcome (cont.)

- We do not charge any fees for trauma visits.
- We have a great partnership with finance, but we have an opportunity to increase our trauma activation fees. We are currently charging about $15,000 less than surrounding areas. We are working on a plan to increase those charges.
- Difficulty identifying trauma patients in the system.
- We do not specifically focus on trauma and cost associated with it. We need to focus on carve outs
- Large percentage are uninsured
- Most trauma accounts are covered by a third-party liability payer, rather than a medical insurance payer. The turnaround to approve and remit payment can be improved.
- Reimbursement due to being a government entity.
- Integration with a system

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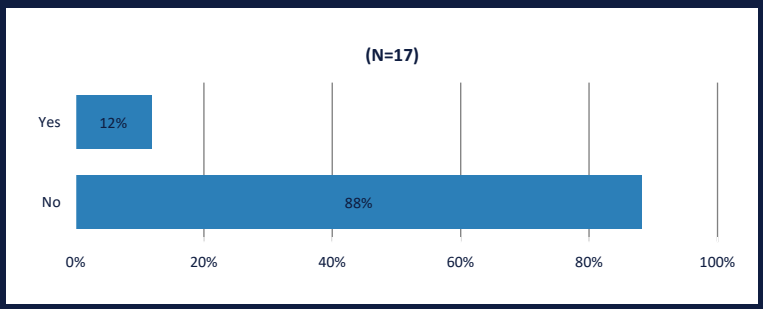
Survey Results:

Do you know your current denial rate for insurance claims?



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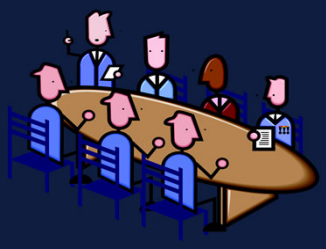
Multidisciplinary Review Team to Review Denials Know your Payors and Contracts "Out-of-Network"

Incorporate No Surprises Act Protections



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Track Denials

Technical denials for claim fields billed in error should enable billing department staff to correct and resubmit

Clinical denials should be reported to the Trauma PI Committee

- Trend denials and develop appeal templates
- Include appeal nurses to audit charges and medical record for accuracy and draft appeal letters – ensure there are no errors
- Involve medical staff in signing letters and adding clinical emphasis regarding medical need

- Be aware of the applicability of unique laws for trauma cases such as those discussed on next two slides

Intoxicated and/or Substance Abuse Patients

Uniform Accident and Sickness Policy Provision Law (UPPL)

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Hoag Memorial Hospital vs. Managed Care Administrators

9th Circuit Court held that… when plan administrators or insurance companies verify coverage to a third party health care provider, they create an independent obligation to pay for service reasonably rendered in reliance on the verification.

Overrides UPPL

Providers should not render immediately following registration and always document coverage verification

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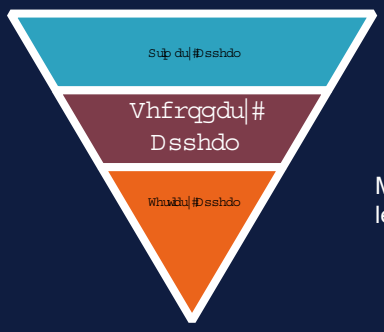
Each Payer has a Specified Number of Appeals Allowed and Timeframes to Meet



Medicare has 5 levels of appeal

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Contract Negotiations

- Contracting department should lead – educate them on unique benefits and expense of trauma programs
- Single case agreements can be negotiated
- Language is as important as the rate terms
- Involve the payer's decision maker and use experts in your hospital for requested changes
- Have leadership pre-define parameters for contracts

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Important Concepts for Contracting

Trauma is a Special Service uniquely recognized in code sets for medical insurance

- Non-trauma hospitals do not have the direct costs or overhead required of a trauma centers
- Patients are directed to Trauma Centers by statute, rule or designation/verification not insurance or preference
- Full services 24/7 are not available at other non-trauma centers: subspecialists, OR, CT
- Centers cannot manage expense as with other elective service lines (e.g., patients are not pre-selected)

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Suggested Carve-Out Provisions for Improved Payment

- Use trauma code set as the means to identify trauma patients for better payment
- Best practice is to agree to better case payment for any claim, inpatient or outpatient, with type of visit/admission of "5" for trauma
- Can be payment based on percent of charges or % increase to case rates/per diem rates or different outlier/stop loss thresholds or a combination of these tactics
- Can also include 068x charges and 0208 charges, but not every trauma patient will have these charges, so best to use type of visit/admission "5"

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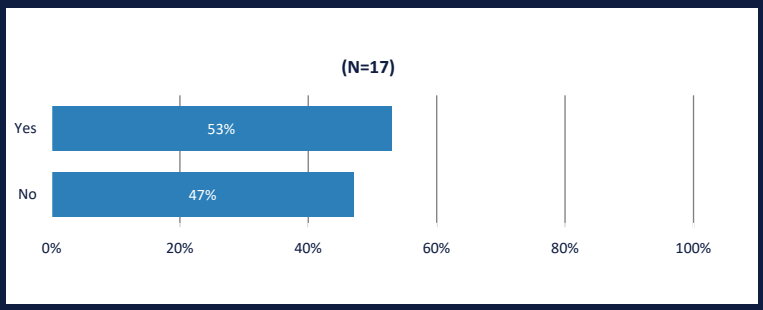
Survey Results:

Does the Trauma Program have an assigned finance/budget liaison to assist with optimization of revenue opportunities for the trauma?



Other Trauma Financial Strategies

- Optimizing documentation to improve billing for HB and PB
- Managing efficient care
- Contracts for professional trauma services

Trauma Finance Strategies Review

- Review of contracting and use of carve-outs where possible
- Managing Denials
- Convening a Trauma PI Committee keeps all departments in your facility on the same page
- Advocacy for future reimbursement

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Trauma Financial Strategies –the Big Picture

- Managing Length of Stay (LOS) for inpatient and observation is increasingly important
- Managing quality, safety, and satisfaction with care increasingly affects reimbursement for care

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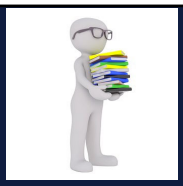
Next Steps- Homework



- Evaluate your current trauma cost structure
- Clinical should make friends with your financial team & visa versa
- Get access to and understand your P&L
- Establish a trauma finance PI committee
- Treat trauma finance like PI
- Develop a financial dashboard

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TCAA Resources

ADVANCED TRAUMA CENTER FINANCE & BUSINESS COURSE — Advanced Business & Finance Course 4.20.22

TRAUMA CENTER FINANCE & BUSINESS COURSE — Basic Business & Finance Course 4.27.22

TRAUMA CENTER Finance Consultation Visit — Finance Consultation Visits

Variety of resources on website for TCAA Members

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https://www.traumacenters.org/

Claim Example – Outpatient with Pre-Hospital Notification

Claim Example – Itemized Charges			
Critical Care	0450	99291	1,500
Field Full TTA/Response	068x	G0390	7,500
Claim			
ED	0450	99291	1,500
Trauma Activation/Response	068x	G0390	7,500

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Claim Example – Inpatient with Pre-Hospital Notification

Claim Example – Itemized Charges			
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Field Full TTA/Response	068x	G0390	7,500
Claim			
ED	0450		1,500
Trauma Activation/Response	068x		7,500

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Claim Example – Outpatient with No Pre-Hospital Notification

Claim Example – Itemized Charges			
Critical Care	0450	99291	1,500
Field Full TTA/Response	0450		7,500
Claim			
ED & TTR	0450	99291	9000

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Claim Example – Inpatient with No Pre-Hospital Notification

Claim Example – Itemized Charges			
Critical Care	0450	99291	1,500
Field Full TTA/Response	0450		7,500
Claim			
ED & TTR	0450		9000

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Evaluation Link

Please take a few minutes to evaluate the workshop

https://survey.sogosurvey.com/r/3.1.22GA

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