Demonstrating Fiscal Viability Toolkit

Prepared for
the Council of Accredited Trauma Centers
August 2015
# The Hospital & Healthsystem Association of Pennsylvania

**Demonstrating Fiscal Viability Toolkit**  
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OVERVIEW

Financial pressure on Pennsylvania hospitals continues to increase with government funding cuts, lower private insurance reimbursement rates, and cuts in funding for physician education and research.

Trauma center requirements are costly and, traditionally, patients tend to be underinsured. The non-traditional nature of the structure of trauma programs makes financial analysis difficult, causing many to be unable to examine their full financial reimbursement and impact.

Some trauma programs that have undertaken a full analysis have found that the trauma program is financially beneficial to its hospitals, or they have found opportunities to make improvements.

With increasing financial challenges at every hospital, it is vital for trauma programs to be able to show profitability to the hospital administration. Doing so can guarantee the survival of the program, and assist in gaining the resources needed to maintain a quality program with good outcomes.

This toolkit will discuss methods to evaluate and improve the financial performance of Pennsylvania trauma centers, and includes speaking points to justify the analysis needed for this review.

You will find that there are a number of billing opportunities for injured patients, however it is key that trauma program leadership work closely with legal, finance, and compliance departments to develop an agreed-upon overarching strategy for billing and reimbursement.
TRAUMA POPULATION

In order to thoroughly analyze the financial health of a trauma program, all patients that the trauma program oversees must be included. The Pennsylvania Trauma Systems Foundation (PTSF) standards and other documents support the concept that the trauma program is responsible for overseeing the quality of care for all admitted injured patients, injury deaths, and transfers. They also define the trauma population that must be part of the trauma registry.

Supporting PTSF standards include:

**Standard V:**

The Trauma Program Medical Director, in conjunction with the hospital’s medical governing board or body and, in collaboration with the Trauma Program Coordinator, will have the oversight authority for all trauma patients, administrative authority, and responsibility for the trauma program to affect all aspects of trauma care including:

- Recommending or removing trauma team privileges
- Cooperating with nursing administration to support the nursing needs of the trauma program
- Developing treatment protocols
- Coordinating the performance improvement and patient safety peer-review process
- Correcting deficiencies in the trauma care or excluding from trauma call those team members who do not meet criteria
- Participating in the budgetary process for the trauma program

**Standard XXXIII:**

The goals of the Trauma Performance Improvement and Patient Safety (PIPS) Program are to monitor the process and outcome of patient care, to ensure the quality and timely provision of such care, to improve the knowledge and skills of trauma care providers, and to provide the institutional structure and organization to promote performance improvement and patient safety.

**Standard XV:**

The institution will maintain a trauma registry.

Data must be submitted to the National Trauma Data Bank.

The Pennsylvania Trauma Outcome Study (PTOS) Patient Inclusion Criteria, accessed April, 2014, states that all patients treated for a diagnosis of trauma (ICD-9-CM injury codes 800–995 except 930–939.9) that meet a list of additional criteria will be included in the trauma registry.
Speaking Points

During discussions with hospital administration and finance department staff, trauma program leadership most likely will need to describe the trauma program and justify the inclusion of all admitted patients who are injured in the definition of trauma patients.

The following are speaking points that may be helpful in these discussions:

- Trauma programs consist of a trauma medical director, trauma program manager, and additional supporting staff

- Responsibility as a trauma center includes the continuum of care from pre-hospital care, emergency care, and in-hospital care through to discharge and, at times, encompasses post-discharge care

- Trauma program responsibility, based on the PTSF standards, includes:
  - Oversight and, in some cases, participation in clinical care
  - Performance improvement (PI) of the entire population of trauma patients
  - Internal and external trauma education
  - Injury prevention
  - Trauma registry
  - In many cases, trauma research

- Some of the trauma program responsibilities constitute fixed costs, however others—including clinical care, PI, and trauma registry—vary according to the patient volume

- Trauma program responsibility is maintained regardless of the actual admitting service of the injured patient

- The inclusive trauma patient population contains all patients admitted for a diagnosis of trauma (ICD-9-CM injury codes 800–995 except 930–939.9) and emergency department patients that die or are transferred to a trauma center with the same diagnosis

- To measure the true financial impact of the trauma program, analysis must be performed on the inclusive population of trauma patients
OBTAINING A HOSPITAL FINANCIAL ANALYSIS

The trauma registry is ideal for obtaining a hospital financial analysis, as it can provide a very clean and complete set of all patients whose charges should be credited to the trauma service line.

- The necessary information varies, but typically name, a patient identifier like medical record (MR) number or account number, date of birth, and Social Security number are all that are needed. A timeframe is selected, and the central hospital financial group should easily be able to extract:
  - Total charges
  - Reimbursements
  - Net revenue
  - Payor mix
  - Denials for that population

- Depending on the institution, it also may be possible to further subdivide this information by service line (trauma/general surgery, orthopedics, neurosurgery, etc.) but, in many instances, the most impressive information is aggregate.

- Targets vary widely based on payor mix, but blunt trauma centers often can generate $2,500–$3,500/patient in net profits for the institution on the facility side billing.

This data should be generated at least yearly and presented to department and hospital leadership. It is critical to recognize that many trauma providers will not generate enough income to offset their salaries, but this is more than compensated for by the facility side revenue and should, therefore, be presented to leadership as a total, if possible.
IMPROVING TRAUMA FINANCES

After you have acquired an analysis of the full trauma population, there are a number of areas that should be examined to improve reimbursements. The following sections cover some of these, and provide references to learn more.

Trauma Activation Billing

Planning and Set up

- The National Uniform Billing Committee (NUBC) has set up Revenue Code 068X for patients in which there is a trauma activation with pre-notification of patient’s arrival
  - 068X is the Trauma Response Code for pre-notification
  - “X” relates to level of trauma center designation/verification

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<tr>
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- The Centers for Medicare & Medicaid Services (CMS) states, “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 service.”

- Define your Trauma Activation Levels
  - Full—Complete team response including trauma surgeon
  - Partial—Team comprised of emergency department physician, trauma fellow/resident if teaching facility, radiology
  - Evaluation—do not to use trauma consult, as this may cause bills to be denied

- Meet with emergency department registration staff to verify that trauma patients are billed as FL 14 Type 5
  - FL 14 is a Universal Billing (UB) code to identify the patient priority as a trauma patient and is required for inpatients and recommended for outpatients
  - This field also contains numeric code (type) to identify patient type

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Meet with finance and billing staff to establish activation fee amounts
  o Each trauma center establishes its own trauma activation fee
    ▪ Full Activation can range from $3,000 to $30,000, depending upon location
    ▪ Partial Activation usually is at 50 percent of the Full Activation, but best at 67 percent
    ▪ Evaluation usually is at 30 percent to 50 percent of the Full Activation, dependent upon the amount on which the Partial Activation charge is set
  o The amount should be based on the resources and equipment that is on standby for the trauma patient as listed in your hospital policy
    ▪ Trauma surgeon
    ▪ Operating room team
    ▪ Blood bank
    ▪ Trauma bay
    ▪ CT scanner
    ▪ Social worker or chaplain support staff that responds to the activations

Trauma Activation Denials

- It is important to conduct audits regularly for
  o Correct identification of patient and level charge
  o Timely entry of activation charge
  o Denials

- Report errors in data entry to appropriate personnel as a PI indicator

- Drill down on reasons for denials
  o If an insurance carrier does not accept the trauma activation charge
    ▪ A letter should be drafted to address resources required and cost associated to maintain trauma center level
    ▪ May need to work with contracts department and develop a contract with the insurance carrier to carve out trauma-specific reimbursement

- Identify an individual to dispute denials. The trauma program manager can be well-suited for this function; they can address the care that is required for the patient and the resources required to maintain trauma accreditation

- Consider having ongoing trauma/finance meetings. This will allow the trauma program manager to educate another individual to dispute appeals, if the program manager’s workload does not allow them to manage denials on a routine basis. In addition, it will allow personnel who work in the contracts department to understand the resources required to operate a trauma center, allowing them to better develop a fair contract.

- Report denial/appeal success rate ratios as a PI indicator
Important Points to Remember

- The chief financial officer, and staff in the contracts department and insurance companies will need to be educated about the resources required to maintain 24-hour resource availability
- Patience and frequent contact with departments can provide you a go-to person for information you are requesting
- Set up a Trauma Finance Committee to discuss the formal process for trauma charging, billing, and denial management
- Establish who will be responsible for inputting trauma activation charges
- Establish who will receive the revenue from the billing

Trauma Physician Billing Optimization

- The physician/provider (nurse practitioner, physician assistant) production is considered separately from the charges submitted by the hospital or facility, and are on the order of one-tenth of the hospital charges
- The provider charges and hospital charges may be managed by separate groups or a central billing/coding area, depending on the local institution, and are addressed below

Provider Production Optimization

- Charge capture is essential, as the individual charges in the trauma program largely are generated from Evaluation and Management (E&M), and not necessarily procedural billing (ICU charges, daily rounds, admissions, clinics, etc.)
- The system will have to be individualized by institution, but the keys are templating and standardization
  - Templates should be developed for an electronic medical record (EMR), written chart, or dictation that allows as much “check-boxing” as possible for the key components (defined by CMS, discussed separately) and used by all team members for every patient contact. Institutional compliance offices should be involved in the development of such standards to ensure facility buy-in
  - Physician charges typically are reimbursed at a higher rate than extender (nurse practitioner/physician assistant) charges, but if independent submission by extenders would allow upcoding a level, it may be worthwhile to consider this as an option
  - Often there are practice/documentation variances between providers, and the use of the templates should be encouraged to prevent frequent denials related to simple matters such as lack of attestation, omission of review of systems, etc.
Monitoring the timeliness of charge submissions on a regular basis is encouraged, even if it must be done manually for each provider. Making this information known throughout the group can help encourage timely submissions, with a goal of less than 48 hours from charge generation to charge submission.

Common E&M errors include minimizing admission coding (only a percentage will be true ICU coding, but higher level admission codes based on time spent in the trauma bay/radiography review/etc. are easily justified), failing to use discharge codes, missing tobacco/alcohol cessation evaluation/counseling, not upcoding for work done with a patient subsequent to daily rounds, and omitting the time notation from ICU charges.

Procedural billing for common operations should be reviewed to allow inclusion of minor procedures which often go uncharged (laceration closure in the emergency department, central line placement, etc.) and to encourage inclusive coding for operating room procedures (lysis of adhesions, drainage of abdominal/retroperitoneal abscess, tissue debridement, wound vac placement, etc.)

**Obtaining Provider Production Data**

- This is most easily obtained by looking at the total production by provider (who must be identified individually and not as a collective group to track this successfully). However, the evolution of the American College of Surgeons’ (ACS) model has complicated this somewhat as the production between trauma, emergency general surgery, and elective general surgery can be difficult to separate.

- The trauma registry data can be used to provide a list of patients cared for by the provider group, and to compare to a billing charge summary for each provider to separate trauma from other charges. But, this can be time-consuming, as the two systems may function primarily based on different identifiers.

- Demonstration of total value to the physician group or facility is most clearly done by using total provider production (i.e., not separating the components of an ACS model), and at least one physician in the group should have administrative or “read only” access to the actual charge program software to evaluate production at least monthly for the group.
Managing Denials (Provider and Facility)

The provider charges and hospital charges may be managed by separate groups or a central billing/coding area, depending on the local institution. Denial of charges may be similarly separated and challenged.

- Denials should be assessed at least twice yearly and fall grossly into two categories. This information should be obtainable using the same clean patient dataset provided by the trauma registry that was previously mentioned.

- **Provider denials** typically are often secondary for one of two reasons:
  - Inadequate documentation (or inadequate submission of documentation)
  - For billing purposes, trauma physicians often are considered one group rather than individuals, which prevents separate charges for related diagnoses in the same day by different people.
    - This can be circumvented if one charge is an increased level of care (i.e. transfer to an ICU and subsequent management), one is clearly procedural, or if the total work is grouped into a single higher level charge (although it still can only be submitted under one provider). However, a letter detailing that may have to be written. Generating a few stock letters stating those occurrences is worthwhile, and can then be tailored by the denial management group, as needed.

- **Facility denials** often are due to inadequate documentation or submission thereof. It is not uncommon to have significant denials due to system/clerical errors (wrong patient address, incorrect insurance billed, etc.)

An overall goal of five percent for denials is ideal (after resubmission/correction), but is sometimes a challenge to reach. Recall that this is separate from billing losses from unfunded patients, and reflects only those with a payor.

- If documentation exists but is not submitted, the director of the billing/denials group or the hospital finance office/Chief Financial Officer should be shown that information and their staff corrected. In paper or hybrid medical records, and due to the labor-intensive nature of extracting that information, this is not uncommon.
- If documentation does not exist or is incomplete, this should be analyzed on a per-provider basis to demonstrate outliers that can then be counseled. If multiple providers are involved, this suggests that the use of a template (see Trauma Physician Billing Optimization) is inadequate and should be revised.
- The system itself should be scrutinized and automated as much as possible to limit simple errors (name spelling, addresses, policy number) and to limit charge lag. Some accounts may not be payable after as little as 30 days, so automation is a key to success.
Payor mix losses (i.e., unfunded/self-pay) are not a denial per se, but a breakdown of the mix also can be generated using the trauma registry dataset. In the era of geriatric trauma and falls, many centers can demonstrate a favorable shift in payor mix during recent years. This is worth highlighting to administration, who still often perceives it as far inferior to other lines. (This may be true in more urban or high-penetrating rate centers and, obviously, that information should be used accordingly.)

Additional Front End Billing Processes

There are a number of additional actions that a trauma center can take at the time of patient care to improve billing and reimbursement:

- Proactive Registration
  - Bedside registration in trauma bay: once the patient is medically cleared by the trauma team, the registration process can begin immediately. This is very helpful for patients who may be at risk for leaving against medical advice
  - If registration cannot be done in the trauma bay, it should start as soon as possible at the bedside in-house
  - Rapid registration can facilitate a concurrent billing process in which the patient is billed while still in-house (can be done only for physician charges). This is particularly advantageous for patients with a long length of stay

- Active social work, case management, or pastoral care programs can assist in the development of initiatives to optimize financial reimbursement for the uninsured by beginning Medicaid Assistance applications and assisting with patient identification. This also can help reduce length of stay by providing a payor means for placement/rehab

- Physician Documentation
  - Correct documentation is vital for many billing processes
  - Timely physician dictations of procedures, op notes, and clinic visits, along with timely chart closure will assist with reducing lost charge capture or denied reimbursement
  - Documentation of preexisting conditions, especially UTI, CLABSI, Pneumonia and Decubitus Ulcer upon admission, will optimize payment
  - Physician education, monitoring, and positive reinforcement is beneficial
  - Developing provider report cards with stats from various databases like trauma registry, Pennsylvania Outcomes and Performance Improvement Measurement System (POPIMS), hospital financials, and OR/procedural databases can increase provider compliance by providing incentives based on performance

- Pennsylvania Medicaid Adjudication
  - In cases of uninsured patients, a claim can be dropped within six months of care
  - The hospital has 180 days to get the application and precertification into the state, and then drop the claim within six months for timely filing
Creating a hospital-wide system to allow patients to make financial arrangements and obtain a “payment pass” will allow for follow-up care such as labs, imaging, and provider visits for an agreed-upon timeframe. For example, trauma centers are obligated to care for trauma emergencies regardless of the patient’s insurance status.

Often times, a “John Doe” MR number is assigned to allow the patient access to hospital systems and care. Upon discharge, the patient is instructed to follow up with a financial planner to assist the patient with obtaining episodic care for follow-up clinic appointments and imaging related to that admission. This allows the financial office another opportunity to verify insurance status, begin Medical Assistance applications, or provide the patient with a time-limited pass to follow-up care.

Carve Outs

**Hospital Side:** The hospital can charge for a trauma activation if pre-notification was obtained and documented and an activation code assigned.

**Professional Side:** There currently is no professional procedure code for a Trauma Activation. Practices may choose to assign a visit code instead of an alert code since one does not exist, such as 99223, 99233, or 99255. [http://bulletin.facs.org/2013/06/em-codes-for-trauma-care/](http://bulletin.facs.org/2013/06/em-codes-for-trauma-care/)

**ADDITIONAL BILLING OPPORTUNITIES**

There are a number of billing opportunities for injured patients, however it is most important for the trauma program leadership to work closely with its legal, finance, and compliance departments to develop an agreed-upon strategy for billing. Reimbursement opportunities to consider include:

- **Trauma Stabilization Act Funds**
  - Funds divided among trauma centers based on proportion of self-pay and Medical Assistance patients
  - Numbers are validated annually through querying contacts in the trauma programs
  - Funds are received annually from the Department of Human Services in one lump sum

- **Crime Victims Fund**
  - Pays for hospital and physician reimbursement
  - $35,000 cap
  - Will pay 70 percent of charges
  - Funds also will be given to caregivers of the crime victim
- **Worker’s Compensation Act**
  - Allows accredited trauma centers to be exempt from payment caps provided by the worker’s compensation act
  - Compensates all physicians who treat the patient
  - Payment at 113 percent of Medicare cap
  - Bill and collect 100 percent with no exhaustion

- **Auto Insurance Act 6**
  - Patients in a motor vehicle crash
  - First come, first serve (If patient is transferred in and the outside hospital drops the charge first and utilizes all accessible funds, the second institution will not be awarded any additional payments)
  - Bill and collect 100 percent up to the exhaustion of the policy
  - Typically, payment is capped at 110 percent of Medicare reimbursement. This restriction does not apply to trauma centers
  - Only for patients admitted as a trauma alert
  - Payment for all services

- **Legal Cases**
  - Many trauma victims pursue legal cases and receive compensation
  - Results of these cases are on the public record, minus payouts
  - In these cases, it usually is up to the hospital to proactively track and pursue reimbursement

- **Advanced Practitioner Billing**
  - Must be employed by the physician practice—and not the hospital—to capture billing charges

- **Critical Care Billing for Physicians**
  - Can be billed in the trauma bay if the patient stayed in the bay 30 minutes or more
  - Physician documentation must reflect the care that was provided
IMPORTANT LAWS

- **Emergency Medical Treatment & Labor Act** (EMTALA)
- Affordable Care Act
  - The patient needs to be insured at the time of injury as insurance is not retroactive
  - Arraigned prisoners now are covered by the federal government
  - Retro-adjudication bill back to the original date of service. For example, if case management begins the Medical Assistance process and Medical Assistance is accepted after the patient is discharged, the hospital will be eligible for reimbursement for all of the charges acquired during the hospital stay
  - Before the 15th of each month, the hospital must apply for assistance so that coverage will start the 1st of the following month. If you apply after the 15th of the month you must wait until the 1st of the following month
  - Reimbursement is driven by quality and patient satisfaction

REFERENCES

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- Trauma Center Maturation, Quantification of Process and Outcome, Peitzman, Courcoulas, Stinson, Udekwu, Biliar and Harbecht Annals of Surgery 999
- Trauma Center Downstream Revenue: The Impact of Incremental Patients with in a Health System Taheri, Maggio, Dougherty, Neil, Fetyko, Harkins, Butz Jn of Trauma 2007, 62: 615-621

RESOURCES

The Trauma Center Association of America is a fee-based organization that provides its members with information about operations, finance, and trauma systems. [http://www.traumacenters.org/](http://www.traumacenters.org/)