310:669-5-1. Filing requirements

(a) There shall be a minimum of two filing periods annually with such filing periods to be designated by the Department. By the end of each filing period, each distribution entity requesting distribution of a pro rata share of the Trauma Care Assistance Revolving Fund shall file a report with the Commissioner for the designated filing period.

(b) Each distribution entity shall use the forms established by OAC 310:669-5-2 to report the following:

- (1) A link(s) to identify the trauma registry data;
- (2) The dollars of gross revenues for the distribution entity's trauma care bad debts;
- (3) The dollars of gross revenues for the distribution entity's trauma charity care;
- (4) The cost to charge ratio calculated using the costs and charges for all departments of a trauma facility; and
- (5) The trauma facility's specific ambulance department cost to charge ratio for a hospital-based ambulance service.

(c) Trauma reported to the trauma registry is described by one of the following:

- (1) An ICD-9 code of 800.00 to 959.9, and is limited to contacts within thirty (30) days of the injury, and is accompanied by one or more of the following events for the patient:
  - (A) An admission to a hospital of at least forty-eight (48) hours; or
  - (B) Transfer from a lower level to a higher level of trauma care for major trauma; or
  - (C) Admission to an intensive care unit; or
  - (D) Admission directly to an operating room for surgery of the head, chest, abdomen, or vascular system; or
  - (E) A declaration of dead on arrival; or
  - (F) A declaration of dead in the emergency room or elsewhere in the hospital.
  - (G) In addition to meeting the requirements at 310:669-5-1(c), each reportable case must also meet at least one of the following criteria as computed by the trauma registry software, unless the patient was declared dead on arrival to the hospital or died while in the hospital:
    - (i) Have an Abbreviated Injury Score of 3 or higher; or
    - (ii) Have an Injury Severity Score of 9 or higher; or
    - (iii) Have a Survival Probability of 0.90 or less; or
- (2) Oral-maxillo-facial injuries requiring the immediate treatment and presence of a licensed physician or licensed dentist credentialed by the hospital to perform oral-maxillo-facial surgery, with an ICD-9 code of 800.0 to 959.9 and meeting at least one of the following criteria:
  - (A) Panfacial trauma involving fractures of the zygomaticomalar complex type, or a Lefort type (I, II, or III) and a mandibular fracture. Panfacial trauma may also include multiple soft tissue injuries, lacerations, or avulsions; or
  - (B) Bilateral fracture of the mandible with flail symphyseal segment; or
  - (C) Multiple severe mandibular fractures requiring tracheostomy or intubation of greater than 24 hours; or
  - (D) Depressed zygomaticomalar complex fractures with entrapment of the inferior rectus muscle or impingement on the optic nerve bundle; or
  - (E) Facial lacerations that involve major vessels, major branches of the facial nerve, or the parotid duct; or
- (3) Traumatic injuries to the hand requiring the immediate presence and treatment by a physician credentialed by the hospital with ICD-9 codes of 800.00 to 959.9 and meeting one of the following criteria:
  - (A) Complete amputations or lacerations of the hand which result in disruption of the vascular supply to one or more digits or the entire hand; or
  - (B) Severely crushed or mangled hand injuries with associated vascular injuries, fractures and/or dislocations.

(d) Time sensitive traumatic injuries requiring immediate surgical intervention by a surgical specialist to prevent loss of life, limb, or vision, and not meeting the criteria identified in 310:669-5-1(c) may be considered for Trauma Fund Disbursement as approved by the Medical Audit Committee and the Oklahoma Trauma System Improvement and Development Advisory Council and reported to the Board of Health. Such approval shall occur periodically and shall not be effective retroactively.

(e) Cases meeting any of the following exclusionary conditions shall not be reported to the trauma registry or be eligible for reimbursement from the Fund:

- (1) Isolated orthopedic injuries to the extremities due to a same level fall;
- (2) Overexertion injuries;
- (3) Injuries resulting from a pre-existing condition such as osteoporosis or esophageal stricture;
- (4) Injuries greater than 30 days old;
- (5) Poisoning and toxic events; and
- (6) Submersion injuries.

(f) Uncompensated expenses incurred by a distribution entity associated with major trauma patients, and such trauma care has been reported to the state pre-hospital emergency medical service database and/or the state trauma registry, shall be eligible for reimbursement. Uncompensated expenses incurred for emergency transport to a trauma facility from the scene of the injury or from a lower level to a higher level of trauma care are eligible for reimbursement when the case meets one or more of the following conditions:

- (1) The extent of patient injury is verified through a hospital trauma registry as described at OAC 310:667-5-1(c), (d), and (e); or

(2) Glascow coma score equal to or less than thirteen (13) directly related to the mechanism of injury; or
(3) Signs and symptoms of respiratory compromise resulting from trauma requiring intervention; or
(4) Hemodynamic compromise from trauma resulting in decreased blood pressure; or
(5) Penetrating injury above the groin; or
(6) Amputation proximal to the wrist or ankle; or
(7) Complete amputations or lacerations of the hand which result in disruption of the vascular supply to one or more digits or the entire hand; or
(8) Severely crushed or mangled hand injuries with associated vascular injuries, fractures and/or dislocations.
(9) Paralysis resulting from traumatic injury, including pre-hospital treatment for spinal precautions based upon the signs and symptoms of neurological deficit; or
(10) Flail chest; or
(11) Two or more proximal long bone fractures (humerus and/or femur); or
(12) Open or depressed skull fracture; or
(13) Unstable pelvis; or
(14) Pediatric trauma score equal to or less than eight (8).
(15) Time sensitive traumatic injuries requiring immediate surgical intervention by a surgical specialist to prevent loss of life, limb, or vision, and not meeting the criteria identified in 310:669-5-1 (c) and approved by the Medical Audit Committee and the Oklahoma Trauma System Improvement and Development Advisory Council and reported to the Board of Health.

(g) A distribution entity shall exclude from its contractual adjustments gross revenue amounts written off as a result of governmental payors' set reimbursement rates that are not subject to negotiation by the entity. Contractual adjustment exclusions may include but are not limited to Medicare, Medicaid, and Indian Health Service reimbursement,and shall not include Workers Compensation.

(h) A free-standing ambulance service shall calculate transportation reimbursement using the Centers for Medicare and Medicaid Services reimbursement methodology in place as of the date of transportation.

(i) A physician shall calculate procedure reimbursement using the Centers for Medicare and Medicaid Services reimbursement methodology based on the appropriate procedure code.

(j) A distribution entity shall not include in uncompensated care any deductible or coinsurance that the patient fails to pay to the distribution entity unless the distribution entity has pursued reasonable collection efforts consistent with those generally used by similar entities. A distribution entity shall not include any amount it is not entitled to collect from the patient.

(k) If a trauma facility transfers a major trauma patient to another facility classified to provide a higher level of trauma care, the transfer shall be performed in accordance with the Oklahoma Triage, Transport, and Transfer Guidelines established under OAC 310:641-3-130 (b)(3). The transferring facility shall include in uncompensated care reported in accordance with OAC 310:669-5-2 only those gross revenues incurred which were necessary to provide stabilizing treatment prior to effecting an appropriate transfer. Gross revenues for inappropriate definitive diagnostic testing prior to transfer shall not be reported as uncompensated care.

[**Source:** Added at 17 Ok Reg 3465, eff 8-29-00 (emergency); Added at 18 Ok Reg 2047, eff 6-11-01; Amended at 19 Ok Reg 393, eff 11-19-01 (emergency); Amended at 19 Ok Reg 1064, eff 5-13-02; Amended at 20 Ok Reg 1665, eff 6-12-03; Amended at 21 Ok Reg 2440, eff 7-11-05; Amended at 24 Ok Reg 2025, eff 6-25-07]