310:669-5-2. Report forms

(a) Each trauma facility shall detail eligible trauma cases, cross-reference report components, detail and summarize uncompensated care, and report the facility's cost to charge ratio on a "Hospital Claim Form" that includes the following:

(1) Demographic data downloaded from the trauma registry including:

(A) Creation number of the Trauma registry entry;

(B) Patient's Social Security Number, if available;

(C) Medical record number for the trauma facility;

(D) Patient's date of arrival at the trauma facility in the format mm/dd/yyyy;

(E) Patient last name;

(F) Patient first name; and

(G) Patient date of birth in the format mm/dd/yyyy, if available

(2) Financial Information from the trauma registry and/or the financial records of the trauma facility and cross-references and calculations including:

(A) Total hospital charges as reported in the trauma registry;

(B) Total collections as reported in the trauma registry;

(C) Total hospital gross revenues as reported in the trauma facility's financial records;

(D) The cost to charge ratio for all departments of the facility in place as of the patient's date of arrival at the trauma facility;

(E) Adjusted hospital gross revenues calculated by multiplying the figure in C of this paragraph by the ratio in D of this paragraph;

(F) Actual total collection for the patient's services as of the date the "Hospital Claim Form" is prepared by the trauma facility;

(G) Contractual adjustments pertinent to the trauma services received by the patient;

(H) The trauma facility's uncompensated care services for the patient calculated by subtracting the figures in items F of this paragraph and G of this paragraph from the calculated amount in E of this paragraph.

(b) Each free-standing ambulance service shall detail eligible trauma cases, detail and summarize uncompensated care on an "EMS Claim Form" that includes the following:

(1) Demographic data extracted from the run report including:

(A) Run report number or lithocode;

(B) Transported person's Social Security Number, if available;

(C) Transported person's last name;

(D) Transported person's first name;

(E) Transported person's date of birth in the format mm/dd/yyyy, if available;

(F) Transported person's pickup date in the format mm/dd/yyyy;

(G) The name of the delivered to facility; and

(H)

(I) The Glascow Coma Score and trauma criteria as reported on the run report, or information using such other uniform trauma reporting standards as the Department determines are reasonable and necessary to accurately classify each trauma case.

(2) Financial information from the free-standing ambulance financial records of the ambulance service including:

(A) Total reimbursement using the Medicare allowed reimbursement or other methodology in place on the date of transportation;

(B) Actual total collections for the transported person's services as of the date the "Free Standing Ambulance Service Revolving Fund Distribution Request Form" is prepared by the trauma facility;

(C) Contractual adjustments pertinent to the transportation services received by the transported person;

(D) The free-standing ambulance services uncompensated care for the transported person calculated by subtracting the figures in items (B) of this paragraph and (C) of this paragraph from the amount in (A) of this paragraph.

(c) Each hospital-based ambulance service shall, at a minimum, detail eligible trauma cases and summarize uncompensated care in a format approved by the Department which includes the following:

(1) Demographic data extracted from the run report including:

(A) Run report number or lithocode;

(B) Transported person's Social Security Number, if available;

(C) Transported person's last name;

(D) Transported person's first name;

(E) Transported person's date of birth in the format mm/dd/yyyy, if available;

(F) Transported person's pickup date in the format mm/dd/yyyy;

(G) The name of the delivered to facility; and

(H) The Glascow Coma Score and trauma criteria as reported on the run report, or information using such other

uniform trauma reporting standards as the Department determines are reasonable and necessary to accurately classify each trauma case.

(2) Financial information from the hospital-based ambulance financial records of the ambulance service including:

(A) Total reimbursement using the lesser of the Medicare per trip limit or the services' charges multiplied by the hospital's ambulance department specific cost to charge ratio;

(B) Actual total collections for the transported person's services as of the date the is prepared by the emergency medical service provider;

(C) Contractual adjustments pertinent to the transportation services received by the transported person;

(D) The hospital-based ambulance services uncompensated care for the transported person is calculated by subtracting the figures in items (B) of this paragraph and (C) of this paragraph from the amount in (A) of this paragraph.

(3) As an alternative to the report described in (1) of this subsection, a hospital-based ambulance service may report using a format approved by the Department by extracting from the trauma registry all information the trauma facility reports and adding to that information the ambulance-specific information from (1) of this subsection and (2) of this subsection.

(d) It is the responsibility of a physician submitting a claim for Trauma Fund disbursement to validate the submission of trauma cases meeting the requirements of 310:669-5-1 with the trauma registrar in the hospital in which the trauma care was provided, and to submit eligible trauma cases and summarize uncompensated care in a format approved by the Department which includes the following:

(1) Demographic data extracted from the trauma registry including:

(A) Creation number of the trauma registry entry;

(B) Patient's Social Security Number, if available;

(C) Patient's date of arrival at the trauma facility in the format mm/dd/yyyy;

(D) Patient date of birth in the format mm/dd/yyyy, if available; and

(E) Physical findings and treatment as specified in the Centers for Medicare and Medicaid Services reimbursement methodology based on the appropriate procedure code.

(2) Financial information from the physician records including:

(A) Total allowable reimbursement using the Medicare methodology in place on the date of care;

(B) Actual total collections for patient services as of the date the request for revolving fund distribution is prepared in a format approved by the Department;

(C) Contractual adjustments pertinent to the services received by the patient;

(D) The physician's uncompensated care cost calculated by subtracting the figures in items (B) of this paragraph; and (C) of this paragraph from the amount in (A) of this paragraph.

(e) Each distribution entity shall file with the appropriate request form a properly signed and notarized contract in accordance with the Central Purchasing Act (74 O.S. Supp. 2000 Section 85.1 et seq.) to permit encumbrance by the State of the funds for the distribution.

[**Source:** Added at 17 Ok Reg 3465, eff 8-29-00 (emergency); Added at 18 Ok Reg 2047, eff 6-11-01; Amended at 21 Ok Reg 2440, eff 7-11-05; Amended at 24 Ok Reg 2025, eff 6-25-07]