TITLE 310. OKLAHOMA STATE DEPARTMENT OF HEALTH
CHAPTER 669. TRAUMA CARE ASSISTANCE REVOLVING FUND

Unofficial Version

[Authority: Oklahoma State Board of Health; 63 O.S. §§ 1-104 et seq.; and Title 63 O.S. § 1-2530.9]
[Source: Codified June 11, 2001]

SUBCHAPTER 1. GENERAL PROVISIONS

310:669-1-1. Purpose

This Chapter implements a Trauma Care Assistance Revolving Fund under authority of the following laws: 63 O.S. Supp. 2000, Section 330.97; and 75 O.S. Supp. 2000, Section 250.1 through 323, (Administrative Procedures Act).
[Source: Added at 17 Ok Reg 3465, eff 8-29-2000(emergency); Added at 18 Ok Reg 2047, eff 6-11-2001]

310:669-1-2. Definitions

The following words or terms, when used in this Chapter, shall have the following meaning unless the context clearly indicates otherwise:

"Ambulance service" means an entity licensed in accordance with 63 O.S. Supp. 2000, 1-2501, et seq.

"Bad debt" means the actual amount of uncollectible charges written off by a distribution entity, and arising from providing trauma care at an inpatient or outpatient facility, or transportation service, and that is calculated as the net of bad debt recoveries applied against bad debt expenses.

"Charity care" means trauma care at an inpatient or outpatient facility, or transportation services for which a distribution entity never expected to be reimbursed based on the distribution entity's determination of the patient’s ability to pay based on the distribution entity's established standards.

"Commissioner" means the State Commissioner of Health.

"Cost report" means the latest annual reporting statement filed by a facility with its fiscal intermediary in compliance with requirements enforced by the Centers for Medicare and Medicaid Services.

"Cost to charge ratio" means the factor(s) calculated annually using information reported as part of a facility's cost report.

"Department" means the State Department of Health.

"Distribution entity" means an ambulance service or trauma facility that provided uncompensated care and reported the care respectively to the pre-hospital emergency medical service database in accordance with OAC 310:631-3-160(b), and the state trauma registry in accordance with OAC 310:669-3-1. This will also include physicians licensed in Oklahoma during the time the trauma care is provided.

"Fund" means the Trauma Care Assistance Revolving Fund.

"Gross revenues" means the charges for inpatient and outpatient services uniformly applied at the regular rates established to all patients by the distribution entity prior to the application of any adjustments, allowances, discounts, or revenue deductions.

"Medicare Allowed Reimbursement" means the allowed reimbursement established by the Centers for Medicare and Medicaid Services for the geographic location where inpatient or outpatient care is provided by a physician or transportation services are provided by a freestanding ambulance service.

"Run report" means the standard report form developed by the Commissioner to facilitate the collection of a standardized data set related to the provision of emergency medical and trauma care in accordance with 63 O.S. Section 1-2511.

"Tier A Physician" means a physician credentialed by the medical staff to provide emergency care to trauma patients in the specialties of emergency medicine, neurosurgery, general surgery, maxillo-facial surgery, orthopedic surgery, surgery specialties, anesthesiology, and trauma intensivists.

"Tier B Physician" means a physician credentialed by medical staff to provide care to trauma patients in a specialty area not defined in Tier A.

"Trauma" means bodily injury that produces injuries severe enough to cause disability or death.

"Trauma care" means treatment or transportation for treatment of a bodily injury that produces injures severe enough to cause disability or death.

"Trauma facility" means a hospital classified by the Department as providing a Level I, II, III, or IV Trauma and Emergency Operative Service.

"Trauma registry" means *the statewide emergency medical services and trauma analysis system developed pursuant to the*

provisions of Section 1-2511 of Title 63 of the Oklahoma Statutes. [63:330.97]

"Trauma team" means a specific team identified in policy and required to respond to the hospital to care for the traumatically injured within a specified period of time, monitored by a quality assurance process.

"Uncompensated care" means care provided for which expected payment was not received from the patient or insurer or any other identified payor source. Uncompensated care is the sum of a distribution entity's bad debt and charity care.

[Source: Added at 17 Ok Reg 3465, eff 8-29-2000(emergency); Added at 18 Ok Reg 2047, eff 6-11-2001; Amended at 19 Ok Reg 393, eff 11-19-2001(emergency); Amended at 19 Ok Reg 1064, eff 5-13-2002; Amended at 22 Ok Reg 2440, eff 7-11-2005; Amended at 24 Ok Reg 2025, eff 6-25-2007]

310:669-1-3. Rounding of numbers

The Department shall:

(1) Take the pro rata distributions to the second decimal point or hundredths place (.00) by rounding back from the third or thousandths place (.000); and

(2) Take the fraction for distribution calculations to the third decimal point or thousandths place (.000) by rounding back from the fourth or ten-thousandths place (.0000).

[Source: Added at 17 Ok Reg 3465, eff 8-29-2000(emergency); Added at 18 Ok Reg 2047, eff 6-11-2001]

SUBCHAPTER 3. DATA ACCUMULATIONS

Section

310:669-3-1. Data accumulation

(a) A trauma facility shall accumulate data in accordance with the following procedures:

(1) Within thirty (30) calendar days of receiving a run report from an ambulance service, enter transportation-related data to the trauma registry;

(2) Immediately after entering data received from an ambulance service into the trauma registry, indicate the date entered and initials of the person making the entry on the ambulance service's filing; and

(3) Periodically throughout the year make entries to the trauma registry for the facility's own total charges, total costs, or total collections.

(b) An ambulance service shall submit run reports to the Department in accordance with the requirements of OAC 310:641-3-160(b).
(c) A physician submitting claim for payment to the Trauma Care Assistance Revolving Fund shall maintain records on all trauma cases showing all charges, the Centers for Medicare and Medicaid Services reimbursement methodology based on the appropriate procedure code, and subsequent collections.
[Source: Added at 17 Ok Reg 3465, eff 8-29-2000(emergency); Added at 18 Ok Reg 2047, eff 6-11-2001; Amended at 22 Ok Reg 2440, eff 7-11-2005]

SUBCHAPTER 5. REPORTS AND FINANCIAL STATEMENTS

Section

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 8-29-2000(emergency); Added at 18 Ok Reg 2047, eff 6-11-2001; Amended at 19 Ok Reg 393, eff 11-19-2001(emergency); Amended at 19 Ok Reg 1064, eff

5-13-2002; Amended at 20 Ok Reg 1665, eff 6-12-20031; Amended at 22 Ok Reg 2440, eff 7-11-2005; Amended at 24 Ok Reg 2025, eff 6-25-2007]

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 8-29-2000(emergency); Added at 18 Ok Reg 2047, eff 6-11-20011; Amended at 22 Ok Reg 2440, eff 7-11-2005; Amended at 24 Ok Reg 2025, eff 6-25-2007]

310:669-5-3. Verification and documentation

Upon written request from the Department, a distribution entity shall submit to the Department a copy of the following:

(1) Cost report; or

(2) Other financial, licensure, statistical, contractual, or payment information to verify the distribution entity's data.

[Source: Added at 17 Ok Reg 3465, eff 8-29-2000(emergency); Added at 18 Ok Reg 2047, eff 6-11-2001]

310:669-5-4. Amendments

(a) A distribution entity's data originally reported to the trauma registry may be subject to audit 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 auditor may perform an audit. The audit 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 audit 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.
[Source: Added at 17 Ok Reg 3465, eff 8-29-2000(emergency); Added at 18 Ok Reg 2047, eff 6-11-20011; Amended at 22 Ok Reg 2440, eff 7-11-2005; Amended at 24 Ok Reg 2025, eff 6-25-2007]

SUBCHAPTER 7. FUND DISTRIBUTION

Section

310:669-7-1. Calculation of pro rata share

(a) Available monies in the Trauma Care Assistance Revolving Fund shall be disbursed as follows:

(1) A minimum of seventy-percent of the total available monies shall be allotted for distribution to ambulance services and hospitals in accordance with the Department's calculated pro rata share.

(2) Up to thirty (30) percent of the total available monies shall be allotted for distribution to Tier A physicians in accordance with the Department’s calculated pro rata share. If the total available monies distributed to Tier A physicians is less than thirty (30) percent of the total available monies, the remainder of this thirty (30) percent shall be allotted for distribution to Tier B physicians. If the total available monies distributed to Tier A and Tier B physicians is less than thirty (30) percent of the total available monies, the remainder of the monies shall be allotted for distribution to ambulance services and hospitals.

(b) For each distribution entity that filed a report in accordance with OAC 310:669-5-1 and 5-2, the Department shall calculate the distribution entity's pro rata share of the available monies in the Trauma Care Assistance Revolving Fund developed in accordance with 47 O.S. Supp. 2000 Section 6-101 using the following fraction:

(1) The numerator of the fraction shall equal the sum of the distribution entity's own uncompensated trauma care dollars multiplied by the cost to charge ratio of the facility; and

(2) The denominator of the fraction shall equal the sum of the uncompensated trauma care dollars for all distribution entities after each facility's cost to charge ratio is applied.

[Source: Added at 17 Ok Reg 3465, eff 8-29-2000(emergency); Added at 18 Ok Reg 2047, eff 6-11-20011; Amended at 22 Ok Reg 2440, eff 7-11-2005; Amended at 24 Ok Reg 2025, eff 6-25-2007]

310:669-7-2. Distribution procedure

(a) The Department shall distribute a pro rata share of the Trauma Care Assistance Revolving Fund to each distribution entity that filed a report as required by OAC 310:669-5-1 and 5-2, in accordance with the designated filing periods as described in 310:669-5-1, as follows:

(1) Calculated in accordance with OAC 310:669-7-1; and

(2) Adjusted for amendments of data filed in accordance with OAC 310:669-5-4.

(b) The Department shall notify each distribution entity in writing of the pro rata distribution share the Department calculated in accordance with OAC 310:669-7-1. The distribution notice shall include the following:

(1) The total Trauma Care Assistance Revolving Fund monies available to be distributed, and to be retained by the Department;

(2) The numerator and the denominator of the distribution entity's pro rata distribution fraction calculated in accordance with OAC 310:669-7-1; and

(3) The contact person and the address at the Department to submit questions.

(c) The Department shall make a pro rata distribution of the Trauma Care Assistance Revolving Fund.

[Source: Added at 17 Ok Reg 3465, eff 8-29-2000(emergency); Added at 18 Ok Reg 2047, eff 6-11-2001; Amended at 19 Ok Reg 393, eff 11-19-2001(emergency); Amended at 19 Ok Reg 1064, eff 5-13-20021; Amended at 22 Ok Reg 2440, eff 7-11-2005]