

*Montana Trauma Systems with the Rural Hospital
Flexibility Grant:*

*Trauma Team Activation Reimbursement:
Performance Improvement Project 2016-2017*

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Project Goal

To assist 3 trauma facilities in developing a Trauma Activation Fee (if not already developed) and ensure proper billing/coding is being met in order to maximize reimbursement from payer sources for trauma activations and/or critical care codes.

Project Outline

- Complete baseline data collection on all trauma cases for 2015
- Face to face meeting to go over data collection findings
- Identify project scope and processes that need improvement
- Regional Meeting in Great Falls- work with trauma coding and billing experts to discuss possible improvement ideas and to gather some tools and resources
- Implement changes that each facility developed
- Report out- using A3 problem solving format
- Re-measure through end of 2016

CASE #: _____

Facility Name: _____ Facility Contact: _____

Is there a Trauma Activation Fee developed for your facility?	YES	NO
Case Abstraction		
1) Method of arrival (ambulance, helicopter/plane, private vehicle, law enforcement, walk-in, or other)		
2) Date/Time of arrival		
3) Was there documented pre-arrival notice from EMS that met local, state or ACS field triage criteria?	YES	NO
4) Was the trauma team activated?	YES	NO
4a) What was the reason for activation or not activating the trauma team?		
5) Was it documented which provider(s) were notified?	YES	NO
6) What was the time that the provider(s) were notified?		not documented
7) If patient arrived by POV/ walk-in OR there was no TTA (Trauma Team Activation), were there documented periods of time that would qualify for a minimum of 30 minutes of critical care?	YES	NO
7a) If yes, was a critical care code appropriately billed for this case?	YES	NO
8) If your facility has an activation fee developed, was it billed out for this case using appropriate codes (068x and G0390)? <i>Note: 068x is the code that must be submitted for activation fee. If TTA occurs allowing a charge under 068x and the hospital provides at least 30 min of critical care so that CPT code 99291 is reported, the hospital may also bill one unit of HCPCS code G0390. Hospitals that provide less than 30 min. of critical care when TTA occurs can report a charge of 068x but they may NOT report HCPCS code G0390.</i>	YES	NO
9) Who is the payor source for the case?		
10) Was your facility paid/reimbursed for all trauma related charges?	YES	NO

Complete one extraction form per chart reviewed.

CURRENT STATE

	Trauma Center #1	Trauma Center #2	Trauma Center #3
Number of Trauma Cases	19	6	12
Number that Arrived by Ambulance with Pre-Arrival Notification	17	2	5
Trauma Activation Fee:	\$525	\$2,070	Not Established
	Total Amount	Total Amount	Total Amount
Facility Actually Billed for TTA	\$4,200	\$4,034	\$0
Facility Should Have Billed for TTA	\$31,050	\$4,034	\$7,050
Potential Lost Revenue for TTA	-\$26,850	\$0	\$7,050
Facility Actually Reimbursed for TTA	\$2,625	\$2,720	\$0
Insurer/Payer Would Have Reimbursed for TTA	\$18,775	\$2,720	\$5,050
Lost Revenue for TTA	(\$16,150)	\$0	(\$5,050)
Critical Care Charges Billed @ \$240/ occurrence	\$0	\$240	\$720
Potential Critical Care Charges @ \$240/occurrence	up to 17	up to 5	up to 10
Potential Critical Care Charges @ \$240/occurrence	\$0 to \$4080	\$240 to \$960	\$1200 to \$1920
Total Potential Lost Revenue	between \$16,150 and \$20,230	between \$240 and \$960	between \$5530 and \$6250
	Summary of Lost Revenue	Summary of Lost Revenue	Summary of Lost Revenue
Provider Notification Time AFTER Arrival Time OR not documented	\$4,525	\$0	\$0
Provider Name Not Documented	\$2,000	\$0	\$2,000
Billing only \$525 when Actual Fee could be reimbursed at \$2000	\$5,500	NA	NA
Not Billing any Trauma Charges	\$4,125	\$0	\$5,050
Critical Care Charges	up to \$4080	between \$240 and \$960	between \$480 and \$1200
Number of cases with no reimbursement/charity (not included in lost revenue)	5	0	3

Project Root Cause Analysis

- **Trauma Center #1:**
 - Disconnect between MMC and the outsourced coding and billing departments!!
 - No communication between coding/billing and trauma team to identify potentially missed elements
 - TTA fee only set at Medicare's allowable rate- not covering the full expense that may be reimbursed by private payers
 - No identifier for Trauma Activation Cases @ registration
 - Software update is not allowing for documentation changes to happen until October in EHR
 - Inadequate process for documenting all elements for TTA or Critical Charge reimbursement
 - Lack of education on where times need to be documented for Critical Care
- **Trauma Center #2**
 - Documentation is incomplete for reimbursement on trauma fees
- **Trauma Center #3**
 - No Trauma Team Activation Fee established!!
 - No criteria established for making certain the TTA fees are charged once the new fee is established
 - Identifier for Trauma Team Activated cases not being used in EHR

Workshop Countermeasures

Trauma Center #1

- Review policies w/outourced coding/billing and develop a communication process for a feedback loop on trauma cases
- Develop a report of the monetary losses due to charges being missed because of documentation errors to be shared w/physicians
- Develop a method of direct communication between coders and medical staff for resolving questions
- Develop or better use existing ways to ID trauma activation cases in registration
- Case review of trauma cases by business office prior to sending to outside coder
- Education for medical staff about documentation for Critical Care Charge Capture
- Education for Coding/Billing of where and what to look for within a trauma chart for billing
- Revise EMS Flowsheet and educate staff
- Use check box option Meditech for indicating Critical Care Charges
- FEE REVIEW!! Determine what the reimbursement amount should be for TTA (do not bill a standard fee of \$525)

Workshop Countermeasures

Trauma Center #2

- Chart reviews of trauma cases by nursing/medical staff
- Education for medical staff about documentation for Critical Care Charge Capture on:
 - flow sheet
 - cost impact
 - communication between coding and medical staff
- Check list for Coding/Billing of where and what to look for within a trauma chart for billing
- Check list for medical staff of where and what to document within a trauma chart for charge capture

Workshop Countermeasures

Trauma Center #3

- Develop a way to ID Trauma Activation Cases in the EHR
 - Educate registration on new method
- Talk to EMS about drop sheets (trip reports) to make sure they indicate Trauma Activation
- Education for medical staff about documentation for Critical Care Charge Capture on:
 - flow sheet
 - cost impact
 - communication between coding and medical staff
- Educate Coding/Billing of where and what to look for within a trauma chart for billing
- Educate medical staff of where and what to document within a trauma chart for charge capture

TITLE: What is the specific issue/problem you are addressing?

Date: Latest Draft	Owner: Preparer of the A3
Approval Date:	Manager Approval:

BACKGROUND

- Why are you talking about it?
- What is the business case? What problem are you trying to solve or analyze? Be concise, use data & facts- communicate WHY you are addressing this issue.

CURRENT CONDITIONS

- What is going on? **USE YOUR DATA!**
- Use facts, date, times, counts, etc.
- Be visual- use Pareto charts, pie charts, workflow maps, value stream maps, etc.
- Make the problem clear- Highlight the issues!!

Goal

- State the specific target (s). State in measurable or identifiable terms.

ANALYSIS

- Use the simplest problem-analysis tool that will suffice to find the root cause of the problem.
- Five whys; fishbone diagram, problem or process analysis tree, 7 QC tools (old or new), tools from the Six Sigma, Kepner-Tragoe, Shainin, Taguchi, TRIZ or other toolbox of your choice

PROPOSAL/TARGET CONDITION/ COUNTERMEASURES

- Draw out or state your target state: the ideal outcome if the root causes of the problem are addressed
- State the countermeasures that need to be in place to reach this target state (use a table or bulleted list- keep this clean and simple)

IMPLEMENTATION PLAN

- Timeline with who, what, when, where and how you will achieve your target state- details of how to implement your countermeasures

TEST OUTCOMES

- What are the measurable results of the test or pilot?
- Did you meet your goals?
- Did you achieve your target state?
- What was the cost of implementation and/or savings from changing the process?

FOLLOW UP

- What issues or remaining problems can you anticipate?
- Who is responsible for the follow up task?
- What is the time frame for completing the follow up tasks?
- What are the next steps or proposed projects to work towards continuous improvement?

BACKGROUND

- This performance improvement project is focused on trauma reimbursement. The project goal is to develop a trauma activation fee (if not already in place) and ensure proper billing/coding is being performed in order to maximize reimbursement from payer sources for trauma activation and/or critical care codes.
- Departments involved: Nursing, billing, coding and medical records.
- Trauma Activation Fee already in place. Fee is \$2017 and has not been reviewed in the past year.

CURRENT CONDITION

Case #1: Trauma team activated but did not meet criteria for trauma activation (trauma must be called in field and must meet level 5 critical care). Patient arrived via law enforcement and trauma called in ER. Met level 3 critical care. Facility charged insurance \$5336.50 and facility reimbursed for all except \$350.

Case #2: Trauma team activation. Trauma called in field. Blue Cross Blue Shield. Trauma activation fee and critical care charges level 5. \$11,079.00, paid all but 1,107.90

Case #3: Trauma team activation. Met all criteria. Facility fully reimbursed for trauma activation fee and level 5 critical care charges. \$8,647 (auto insurance)

Case #4: Trauma team activated but patient arrived via private vehicle. Level 5 Critical care fee charged as well as critical care physician fees. Total charge \$5,311.17. Medicare paid \$2,577.29

Case #5: No trauma team activation. Critical care charges level 4. Total charged: 4,188.83. Medicare paid 1385.02. Other insurance paid 2800.83

Case #6: Trauma Team Activated, but did not meet criteria for charge. Critical care Level 4. BC/BS paid 2140.94 of 8287.54, rest was paid by patient

GOAL

To be fully reimbursed for critical care provided to trauma activations that arrived by private vehicle or walk-in and/or any trauma patient that meets appropriate critical care billing requirements.

ANALYSIS

FINDINGS AFTER ANALYZING ALL CASES:

- Documentation is incomplete for reimbursement on CRITICAL CARE charges

PROPOSAL/TARGET CONDITION/ COUNTERMEASURES

- Chart reviews of trauma cases by nursing staff with specific measures to identify.
- Education to medical staff about documentation for critical care charge capture on:
 - Flow sheet
 - Cost impact
 - Communication between coding and medical staff.
- Checklist for coding/billing of where and what to look for within a trauma chart for billing.
- Checklist for medical staff of where and what to document within a trauma chart for charge capture.

Vision: Proper documentation performed by medical staff without prompting by billing/coding/nursing. This will ensue proper reimbursement and make billing/coding staff job duties easier to achieve.

IMPLEMENTATION PLAN

What – Specific Task	Who – person(s) doing it	When – Due Date	Task Complete? Notes
Acuity Form-Utilize in ER	Nursing Staff	Immediate	Yes...form already exists just was not being used properly.
Provider EHR Utilization	Provider/superuser/nursing	Full utilization October 25 th , 2016. This is the go live date for full EHR integration (one system)	In progress. Hospital EHR optimization plan in place and occurring right now.
New PI forms for Trauma	Trauma coordinator	By end of August 2016	Done but is also a work in progress.
Education to Nurse's on proper utilization of trauma flow sheet.	Trauma coordinator	Mid-September	Have completed sample trauma flowsheet for nurses to examine/use.
Provider Education on documentation and improve communication between medstaff and coding.	CNO/Trauma Coordinator	Continual	Discuss any issues in daily provider meetings and provide education as to why documentation is important.
Chart Reviews	Nursing	October 1 st 2016	Have completed PI chart review but working on a more specific one for nurses and what is required of them for billing

TEST OUTCOMES

- Trauma activation fee and criteria already in place. Reimbursement for critical charges not a huge issue at start of study.
- Nursing staff and providers have increased awareness of need for excellent documentation as it affects our revenues. Need to work as a team and not in silos.
- No trauma activations since start of study.
- Increased awareness for trauma coordinator/cno in regards to billing/coding and criteria.

FOLLOW UP

What – Specific Task	Who – person(s) doing it	When – Due Date	Task Complete? Notes
Review trauma when one occurs.	Trauma Coordinator/nurses	As they occur	Use review checklist to ensure that proper documentation is present for reimbursement.
Education	Trauma Coordinator/CNO	Continual	Continual
Review billing records to determine reimbursement	Trauma Coordinator/Billing	As critical care/ traumas occur.	Continual

BACKGROUND
 Importance: reimbursement for resources to maintain the trauma program, availability 24/7 of clinical support.

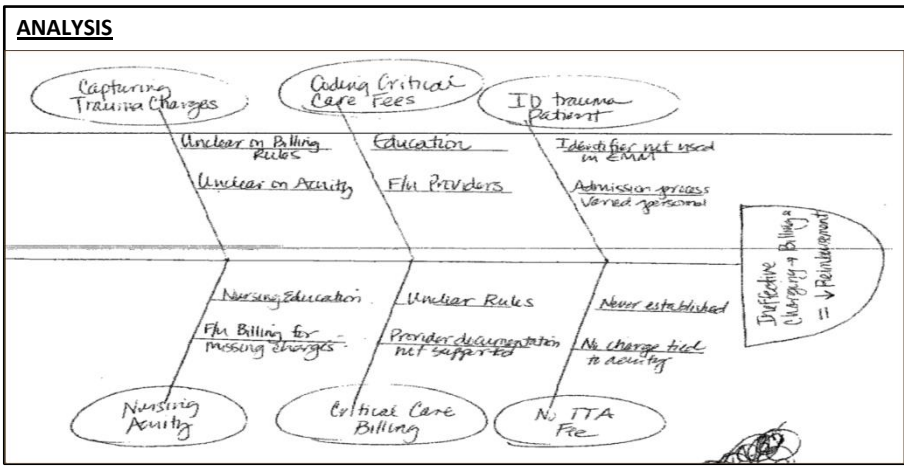
- Departments: DON/Trauma Coordinator, Billing, Coding
- Issue: DON "thought" we had a TTA fee as it was built onto ER acuity, but it had no charge associated. Additionally, Billing was unclear about rules. It was realized when we started this project and examined the billing and reimbursement.

CURRENT CONDITION

- 2015 Trauma Cases = 12, 5 activated by EMS
- We billed \$0 with an available \$7,000 and a potential reimbursement of \$5,000
- We had 10 critical care charges available with \$720 billed out of a possible \$1900
- Total Lost Revenue= \$5,500-6,200
- Problems: 1) No TTA fee established 2)Trauma patient not triggered for billing and coding 3)Billing and coding not following up on lost charges 4)Critical care documentation not established 5)Unclear on billing rules 6)Nursing Acuity needs updated and clarified

Goal

1. Establish a Trauma Team Activation (TTA) fee that fully reimburses for the allowable expenses incurred during a trauma team activation for 100% of the cases meeting the appropriate criteria
2. Establish critical care documentation to be fully reimbursed for critical care provided to trauma activations that arrived by private vehicle or walk-in and/or any trauma patient that meets appropriate critical care billing requirements.



PROPOSAL/TARGET CONDITION/ COUNTERMEASURES

- 1) Educate all who register in ER on "trauma" visit type in EMM
- 2) Develop TTA fee and have charge built in EMM
- 3) Revise nursing acuity- make options clear, remove point values
- 4) Education nursing staff on proper acuity completion
- 5) Establish routine for Coding to look for proper documentation and F/U with providers
- 6) Educate Providers & Nurses on proper critical care documentation
- 7) Billing to establish routine for screening trauma, acuities, documentation for charge capture
- 8) Monitor results

IMPLEMENTATION PLAN

What – Specific Task	Who – person(s) doing it	When – Due Date	Task Complete? Notes
Build TTA Fee	KJ	Sept 9 th	Yes
Attach Fee to acuity	KJ- Reece	Sept 9 th	Yes
Revise Acuity	KJ- Reece- Katie	Sept 9 th	Yes
Education Nrsng Staff	KJ- email		Yes
-Trauma identifier	Medworx Class- Reece, KJ	Sept 28 th	NO
Educate Providers	Katie/Holly/Reece: Class	Sept 28 th	NO
Coding F/U policy	Holly	Oct 1	NO
Billing F/U policy	Katie	Oct 1	NO
Monitor reimbursement	Katie	Sept- then Q month	

TEST OUTCOMES

- TTA Fee established- Early August
- Patients Billed/Reimbursement since launch- August 1
 - # Trauma cases 4
 - # TTA billed 4
 - \$ TTA billed 28,620 \$Reimbursed _____
 - # CC eligible 4
 - # CC Billed 4
 - \$ CC billed \$3,283 \$Reimbursed _____

FOLLOW UP

What – Specific Task	Who – person(s) doing it	When – Due Date	Task Complete? Notes
Nursing Documentation	KJ	Each trauma chart review	
Nursing Acuity	KJ, Katie	All ER visits	
Trauma Identifier	Katie	All trauma visits	
Provider documentation			
-Level of care charges	Katie	All ER visits	
-Critical care evidence	Holly	All ER visits	

Trauma Activation Fee

- Must be ACS verified or State designated trauma center to charge an activation fee
- May be utilized for patients for whom a trauma activation occurred, who meet field triage trauma criteria
- There must be pre-hospital notification (including trauma patient transfers by some form of EMS, ED to ED) prior to patient's arrival
- May NOT be used for trauma patients meeting criteria who arrive by private vehicle, walk-in or by EMS without advance notification
- The facility must document and keep documentation of the activation in the patient's medical record:
 - the pre-arrival notification time
 - the reason for the activation
 - the provider's name & time he/she was notified

Trauma Team Activation Fee

- 68x Trauma Revenue Code
 - “x” relates to level of Trauma Center designation/verification:
 - 681=Level I
 - 682=Level II
 - 683=Level III
 - 684=Level IV
 - 689=Other Trauma (state or local authorities with levels beyond IV)
 - HCPCS G0390: Trauma response team associated with hospital care service
 - Trauma activation fees are charged whether the patient is admitted, discharged, transferred or dies.
 - Fees are in addition to ED level charges, not in place of ED level charges.

Fee Example

- **G0390 – Trauma response team associated with hospital critical care services**

Example of how RTC has Trauma Activation charges set up.

- Trauma Activation Level I, Rev 682, HCPCS G0390, \$7,981
- Trauma Activation Level II, Rev 682, HCPCS G0390, \$6,854
- Trauma Activation Level III, Rev 682, HCPCS G0390, \$2,757

Developing a Trauma Activation Fee

- No set activation dollar amount exists. Each facility must calculate its own Trauma Activation fee internally, based on resource availability.
- CMS/Medicare will pay a set flat fee, but private insurers may pay substantially more if correct billing procedures are followed.
- When calculating costs ensure inclusion of:
 - Trauma Team (nursing, lab, xray, RT, house supervisor, provider, surgeon, OR staff etc...)
 - Trauma Coordinator time
 - Trauma Registrar time
 - Trauma Medical Director time
 - If ACS conducts a trauma verification review, may consider calculating that fee into activation charges as well (Montana does not charge for designation reviews)

Critical Care 99291-99292

- CPT Code: 99291 (critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes)
- CPT Code 99292 (each additional 30 min.)
- Services that are separately payable and not bundled into critical care may not be included and counted toward critical care time
- Critical care can not be billed if less than 30 minutes was spent in a day by a single provider/or group (use the appropriate level of E/M.)

Critical Care Charges

- The following services are included in "critical care" time:
 - Interpretation of cardiac output measurements
 - Pulse oximetry
 - Chest x-rays, professional component
 - Blood gases, and information data stored in computers (e.g., ECGs, blood pressures, hematologic data)
 - Gastric intubation
 - Transcutaneous pacing
 - Ventilator management
 - Peripheral vascular access procedures
- Any services performed that are not listed above may be reported separately.

Documentation Requirements

- The critical and unstable nature of the patient's condition should be accurately documented to support the medical necessity of the extended 1 to1 services
- Complexity of medical decision making
- Aggregation of time spent by the billing provider if applicable
- Patient assessment
- Family discussions- substance of discussion
- Total time spent– **Key Component**

Critical Care Codes

- Critical Care 99291-99292
- Time-based service codes provided on an hourly or fraction of an hour basis.
- Time counted towards critical care service may be continuous clock time or intermittent and aggregated in time increment
- Documentation for each date and encounter must accurately state the appropriateness and include the total time spent providing critical care

2017 PIN/Trauma PI Project

ERTAC Facility List:

1. Columbus
2. Hardin
3. Lewistown
4. Red Lodge
5. Wolf Point/Poplar
6. Harlowton
7. Culbertson
8. Plentywood
9. Terry
10. Forsyth
11. Big Timber

WRTAC Facility List:

1. Plains
2. Superior
3. Sheridan
4. Ennis