

Question and Answer for the FY17 Uncompensated Trauma Care Funding Application

1. If we admit a patient within the applicable ICD-9 codes and the patient leaves the hospital against medical advice prior to 24 hours, can we include this patient in the application?

Answer: Yes, if the patient meets criteria outlined in the definition of trauma care but leaves against medical advice, this patient can be included in the application.

2. The operative intervention definition says that we can include outpatients that go directly from the emergency department (ED) to the operating room (OR) and do not get admitted with the applicable ICD-9 codes. We can then include any patient that meets this criterion? The patient can go home directly from the OR and doesn't necessarily have to expire in the OR to be included on the application?

Answer: To be included on the application, the patient encounter must meet the definition of trauma care as described in Rule. If an eligible trauma patient is taken directly from the emergency department to an operating suite and receives an operative intervention and who underwent treatment specified in at least one of the ICD-9 outlined in the definition of trauma care, can be included in the application regardless of clinical outcome.

3. Can we count insured patient co-pays and deductibles that the hospital writes-off to bad debt in accordance with our bad debt policy if the patient falls into the applicable ICD-9 codes? For example, the gross charges on the patient account are \$5,000. Our contract with Aetna says they will pay us \$1,000 but the patient has a deductible of \$500. Aetna pays us \$500 and we try to collect the remaining \$500 from the patient but after numerous collection efforts, we cannot collect the patient portion so we write it off to bad debt. Can we include the \$500 deductible that the hospital was unable to collect? Would it make a difference on who the third-party payor is? If we cannot include Aetna, Humana, etc., could we include bad debts from Medicaid HMO and Medicare HMO patients?

Answer: The charges for the co-pay\deductible mentioned above can be included as Bad Debt or Charity write-offs as long as there is not a prospectively agreed upon "write-off" by the hospital of the uncollected co-pay associated with the contract agreement between the hospital and the third party payor. Additionally, the charges must have been written off as bad debt per hospital policy after due diligence to collect (please see bad debt definition). Contractual adjustments in reimbursement for trauma services based upon an agreement with a payor (to include but not limited to Medicaid, Medicare, Children's Health Insurance Program (CHIP), etc.) is not uncompensated trauma care and cannot be included.

4. Bad Debt - Are you looking for what we actually wrote off on discharges from January 2015 thru December 2015 or what we expect to write off?

Answer: An eligible patient must have received trauma care and have been discharged from the hospital sometime between January 1, 2015 through December 31, 2015, and the account must receive a classification of bad debt or charity care based upon hospital policy to be included on the application. A hospital's bad debt policy should be in accordance with generally accepted accounting principles. (i.e.: The amount/charge in-question must be recorded in the hospital's General Ledger account for Bad Debt or Charity.)

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5. Can we include the patients' deductible or co-pay which we have written off to bad debt? This would include Medicare patients as well.

Answer: The charges for the co-pay\deductible mentioned above can be included as Bad Debt or Charity write-offs as long as there is not a prospectively agreed upon "write-off" by the hospital of the uncollected co-pay associated with the contract agreement between the hospital and the third party payer. Additionally, the charges must have been written off as bad debt per hospital policy after due diligence to collect (please see bad debt definition). Contractual adjustments in reimbursement for trauma services based upon an agreement with a payor (to include but not limited to Medicaid, Medicare, Children's Health Insurance Program (CHIP), Crime Victim's fund, etc.) is not uncompensated trauma care and cannot be included.

6. If a patient has exhausted their Medicaid benefits and Medicaid pays only a portion of the contractual, and we have written the balance off to our Charity-Medicaid exhausted account, can we include that amount? For example, consider if we have a patient with DRG 94 and total charges of \$14,000. Medicaid should pay \$5,174, but the patient has exhausted their benefits and Medicaid paid only \$1000. Can we include the \$4,174 balance?

Answer: Yes, the portion not covered due to exhaustion of benefits can be included if the charges have been written off as bad debt or charity care as defined in Rule and according to the hospital's policy after due diligence to collect.

7. We have a hospital-based ambulance service. Can we include those costs on this report?

Answer: No. Ambulance cost associated with the hospital based EMS cannot be included as uncompensated trauma care in the application.

8. We are wondering about the reporting of uncompensated trauma care provided to patients who have a bad debt self-pay balance after insurance. For example, we have a patient with \$100,000 in charges where insurance pays \$60,000 with the patient owing \$20,000. The patient portion rolls to bad debt and is never paid. For reporting, you have asked for gross charges rather than the methodology used in year's past. My concern is that the \$20,000 represents a portion of the \$100,000 in gross charges and to further reduce the \$20,000 that amount by the cost-charge ratio would be inconsistent compared to true charity care where we are reporting the true gross charge number. How do we need to handle these amounts for reporting? It is very difficult if not impossible to tie a co-pay or deductible back to specific charges on an account. I am asserting that these amounts are reportable due to the inclusion of medically indigent patients in the definition. Please let me know how to handle these accounts for reporting purposes.

Answer: From the description presented above, if the hospital has agreed to accept \$60,000 from the insurance company as "payment in full" of the insurance company's portion of the \$100,000 bill, and the hospital has agreed to accept \$20,000 from the patient as "payment in full" of the patient's portion of the \$100,000 bill, then this leaves a \$20,000 contractual adjustment that may not be subsequently included in Bad Debt or Charity charges.

If the patient's failure to pay the agreed upon "payment in full" amount of \$20,000 meets the rule definition of "bad debt", then the hospital can utilize that amount (the patient's unpaid \$20,000) in seeking reimbursement for uncompensated trauma care.

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9. Item #1: This example is for a Veterans Administration (VA) patient. The VA requires claims be filed within 90 days. This is an issue because all correspondence goes to a centralized lock box and does not get to the hospital on a timely manner and a filing deadlines are missed. The majority of the VA patients do not have any insurance other than the VA and therefore will qualify for a hospital write-off, whether charity or bad debt.

Answer: Inclusion of this case is not allowable since the facility or agency failed to file in a timely manner.

10. Item #2: Medicaid-TMHP pays PCCM claims and Texas Medicaid does not allow the hospital to bill the Medicaid eligible client for hospital failure to bill timely. Medicaid clients generally qualify for charity/indigent write-offs.

Answer: Inclusion of this case is not allowable since the facility or agency failed to file or receive authorization from the insurer in a timely manner.

11. Item #3: If the county indigent program does not pay the hospital for the services rendered, then the patient is not billed because the hospital has already determined that he/she qualifies as indigent.

Answer: Inclusion of this case is allowable since the person meets the indigent care criteria. The only way it should not is if there is some contractual obligation that would prohibit the facility from writing the portions off as bad debt.

12. In order to make sure that we include the appropriate patients, can you please define the 23 hours? Is this from patient first clinical contact or from the date the admission is ordered by the physician? I ask this because the Medicaid definition is from first clinical contact. If you are using the State definition then I want to make sure we count the same way.

Answer: For the purposes of this application the date and time of admission must be consistent with the hospital's policies and procedures. If the facility does not have a hospital policy addressing in-patient admission for patients written off as bad debt or charity care, for the purposes of this application, the facility must use the admission guidelines outlined in the Texas Medicaid rules.