DEVELOPING A TRAUMA ACTIVATION FEE (068x)

You can utilize Trauma Activation fees to pay for your Trauma Programs costs. In this day and age, all programs MUST be self-sustaining. In calculating your fees, include EVERYTHING: Administrative costs, Trauma Medical Director, Trauma Coordinator, Team Activation salaries, Physician Trauma Coverage agreements, committee work, case reviews, education, policy/procedure/protocol development; EVERYTHING.

- **Must be an ACS verified or State designated trauma center to charge an activation fee**

- **May utilize for patients for whom a trauma activation occurred; "Notification of key hospital personnel in response to triage information from pre-hospital care-givers in advance of the patient's arrival".**

<u>Only</u> for patients who meet field triage trauma criteria for whom there has been <u>pre-hospital</u> notification (including trauma patient transfers by some form of EMS ED to ED).
May NOT use for trauma patients meeting criteria who arrive by private vehicle, drive-by, walk-up or by EMS WITHOUT advance notification.

068X level codes were developed by the Trauma Center Association of America (traumafoundation.org)

The facility must document there was pre-arrival notice from a "medical third party" (EMS), the reason for activation and keep documentation of the activation and response in the patient's medical record.

Unfortunately, no "ballpark" activation "dollar" fee amounts are available for reference. Each facility must calculate its own Trauma Activation fee internally, which takes time and "legwork". CMS/Medicare will pay up to $500 and private insurers may pay substantially more if correct billing procedures are followed.

Involve your facility fiscal/billing staff from the beginning to ensure accuracy and standardization of the process in accordance with the latest rules, billing codes, charge forms and regulations that are available. When (not if) audited, your facility must be able to demonstrate how the fee was developed.

Trauma activation fees are charged whether the patient is admitted, is discharged, is transferred or died. Transfers should be ED to ED.

Critical Care charges may be incorporated, especially for payment from CMS/Medicare.
You must add "G0390´and APC 0618 for Medicare patients to get the Trauma Activation category paid. (Your billing folks can help with these kinds of details!!!)

Fiscal staff will be able to assist you in addressing supplies and equipment. As you know, some are already incorporated into the ED level charges and cannot be separately charged for. Procedures and some equipment can be additionally charged for separately, not in the Activation charge.

Trauma activation fees are IN ADDITION TO ED level charges, NOT INSTEAD OF ED level charges.

Patients are registered as "Emergent, Urgent, Elective or Newborn" (FL 14, patient Types 1-4). Once a facility is designated/verified, Registration/Admitting/HUC staff must be able to add/change to "Trauma Center" patient type for those patients who receive a Trauma Activation. This provides ease/continuity for billing and the ability to track these patients in MANY ways.
These can be found on Form Locator # 14, (FL 14) and would be "Type 5" patients (Type 1 patients are "Emergent")

If you send patients to the OR, you may be able to generate a charge for an "OR Case Cart" that contains instruments/equipment above and beyond the "usual" for OR charges for those trauma patients meeting criteria who go directly to OR from ED (not to ICU or the floor prior to surgery).

SOME SUGGESTIONS FOR CALCULATING FEE COMPONENTS;

Determine the level(s) of trauma alert your facility will use for the activation fee structure and calculate a level for each of the levels. (Some facilities have 2 levels, smaller facilities may have only one level). If more than one level is used, you will need to calculate different charges for each level based on resources utilized.

A FACILITY may bill patients for a "Trauma Evaluation" level (often called a "Consult" currently) as long as: it's called an "evaluation" not a "consult" for patients that meet some of the activation criteria.
Such a "Trauma Evaluation" charge may be utilized when any credentialed MD evaluates the patient anywhere in the hospital (including the ED) within 2-3 hours of patient arrival AND MUST have an RN accompanying them who MUST document it in the medical record. Otherwise, the FACILITY cannot utilize this third level of activation charge.

Ideas for calculating costs (these are examples you could use);
1.Trauma Team
Take the number of average trauma team staff called in for a Trauma Alert (include everyone: Nursing, Lab, Xray, RT, House Supervisor, etc.)
multiplied by; their average salaries (use OT avg. for those called in and regular time avg. for those in-house)
multiplied by; an average number of hours a trauma response takes:
Team staff: 7 X $ 18.53 = $ 129.71 X 4.5hr
= $583.95/per Trauma Activation for Trauma Team

If your facility provides call pay to surgeons or any other physicians who are expected to respond, factor that in as well
If your facility uses 2 levels and one level includes calling in an Operating Room team, calculate and factor those salaries in as well.
Plus

2. Trauma Coordinator Time
Factor in the Trauma Coordinator FTE time and/or total salary divided by the number of annual Trauma patient cases. (1 FTE = 2080 annual hours) multiplied by an average number of hours devoted to reviewing/evaluating a case, attending RTAC, STCC plus the meetings and activities conducted annually.

.4FTE = 832 hr
44 avg. TR cases/year = 18.9hr/case (TOTAL)

= AVG review of each case, including review of chart documentation, consultation w/team, identification of issues, tracking processes
= 5.2hr X hourly salary (27.00)
= $140.40 /per Trauma Activation

+ meeting days (1 day per meeting attended, preparation, etc.), etc. annually
4 RTAC meeting days, + 2 STCC meeting days, + 6 trauma committee meeting days = 12 days X 10 hr = 120hr @ 27.00/hr = 3240 divided by 44 cases/yr
= $73.63/per Trauma Activation

+ Education/Instruction/Policy/Procedure development time (days per year average)
= 7 days X 10hr = 70hr @ 27.00/hr = 1890 divided by 44 cases/yr
= $42.95/per Trauma Activation

= $256.98/ per Trauma Activation for Trauma Coordinator time

Plus
3.Trauma Registrar/Data Entry time;
44 avg. cases/year X 1.5 hr data entry = 66 hr X 17.50/hr = $1155
Divided by 44 cases/year
= $26.25/per Trauma Activation for TR/Data Entry time

Plus
4. Trauma Medical Director time
$500/month (T $6000/yr) divide by 44 avg. TR cases/year
= $136.36/per Trauma Activation for Trauma Medical Director time

$583.95 + $256.98 + $26.25 + $136.36
=
Total so far *just to recoup these costs* = <u>$1003.36/per Trauma Activation</u>

If ACS conducts a Trauma Verification visit for your facility, you may want to calculate that fee into the activation charges as well (divide amount by annual activations the same way as above and add it in). MT does not charge for its Designation Site Reviews, so that's not an issue.

As stated above, if you pay surgeons to take trauma call/provide coverage, calculate those amounts and add them in, too.

If you contract with physicians to provide trauma call, include ALL expectations into that agreement up front; call coverage, response expectations/times, requirements for meeting attendance, CME they must obtain, agreement to adhere to trauma programs policies/procedures, etc.

If you contemplate paying trauma surgeons for trauma call/coverage consider;

- **Utilize a more modest charge (say $250/night/date or whatever) for the inconvenience of carrying the beeper/being available.**
- **Reserve a larger amount (say, $1000 or whatever) for actually responding IN to direct resuscitation of a patient. If a provider responds in and it's a multi-patient wreck, that's ONE response charge. If the provider responds in, leaves and is called back for another patient resuscitation (even if 10 minutes later) that's TWO response charges.**