

**GEORGIA TRAUMA CARE  
NETWORK COMMISSION**

**AGREED UPON PROCEDURES**

# GEORGIA TRAUMA CARE NETWORK COMMISSION

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For the Year Ended December 31, 2009

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## INDEPENDENT ACCOUNTANTS' REPORT

To the Georgia Trauma  
Care Network Commission

We have performed the procedures enumerated on Attachments A and A-1, which were agreed to by you, solely to assist you with respect to the validation of uncompensated care case data for the year ended December 31, 2009 and the documentation of preparation processes for Emergency Medical Services for the year ended December 31, 2008. The Georgia Trauma Care Network Commission and the Georgia-designated Trauma Centers' (as listed on Attachment A) management are responsible for the uncompensated care case data submitted for these procedures. This agreed-upon procedures engagement was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants. The sufficiency of the procedures is solely the responsibility of the Georgia Trauma Care Network Commission. Consequently, we make no representation regarding the sufficiency of the procedures described on Attachments A and A-1, either for the purpose for which this report has been requested, or for any other purpose.

Our findings, documentation and recommendations for the procedures outlined in Attachments A and A-1 are outlined in Attachments B, B-1, B-2, C and D to this report.

We were not engaged to, and did not, conduct an audit or examination, the objective of which would be the expression of an opinion on the uncompensated care case data. Accordingly, we do not express such an opinion. Had we performed additional procedures, other matters might have come to our attention that would have been reported to you.

This report is intended solely for the information and use of the Georgia Trauma Care Network Commission and the Georgia-designated Trauma Centers and is not intended to be and should not be used by anyone other than these specified parties.



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## ATTACHMENT A

VALIDATION OF UNCOMPENSATED CARE CASE DATA: PROCEDURES

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**Georgia-designated Trauma Centers:**

- John D. Archbold Memorial Hospital (Archbold) – Thomasville
- Atlanta Medical Center (AMC) – Atlanta
- CHOA Egleston (Egleston) – Atlanta
- CHOA Scottish Rite (Scottish Rite) – Atlanta
- Medical Center – (Columbus)
- Floyd Medical Center (Floyd) – Rome
- Grady Memorial Hospital (Grady) – Atlanta
- Gwinnett Medical Center (Gwinnett) – Lawrenceville
- Hamilton Medical Center (Hamilton) – Dalton
- Medical Center of Central Georgia (MCCG) – Macon
- Medical College of Georgia (MCG) – Augusta
- Memorial Health University Medical Center (Memorial) – Savannah
- North Fulton Regional Hospital (North Fulton) – Roswell
- Walton Regional Medical Center (Walton) – Monroe

**Procedures:**

The following are the agreed-upon procedures that Gifford, Hillegass & Ingwersen, LLP (GH&I) was engaged to perform at each Georgia-designated Trauma Center listed above.

1. GH&I will obtain the listing of uncompensated care claims submitted by each trauma center to Bishop + Associates (the consulting firm that gathered the case data) for the year ended December 31, 2009 (CY2009).
2. GH&I will select a sample of the uncompensated care cases from the list obtained in #1 above as follows:
  - a. For Trauma Centers with less than 25 cases, GH&I will test 5 cases;
  - b. For Trauma Centers with between 25 and 50 cases, GH&I will test 10 cases;
  - c. For Trauma Centers with between 50 and 150 cases, GH&I will test 20 cases; and,
  - d. For Trauma Centers with greater than 150 cases, GH&I will test 40 cases.
3. For each case selected above, GH&I will view (on site at the Trauma Center location) the electronic billing record (EBR) or systems comparable to the EBR to determine that as of March 31, 2011 each case selected in our sample met the criteria for consideration as an uncompensated care case. The criteria (from Georgia Senate Bill 60) for consideration as an uncompensated care case are as follows:
  - a. The EBR documents that the patient had no medical insurance, including Medicare Part B coverage;

**ATTACHMENT A****VALIDATION OF UNCOMPENSATED CARE CASE DATA: PROCEDURES**

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- b. The EBR documents the patient was not eligible for medical assistance coverage;
  - c. The EBR documents that the patient had no medical coverage for trauma care through workers' compensation insurance, automobile insurance, or any other third party, including any settlement or judgment resulting from such coverage;
  - d. The EBR documents that the patient has not paid more than 10% of total charges after documented attempts by the trauma care services provider to collect payments;
  - e. The EBR documents that there were no third party payments received.
4. For each case selected in our sample (as defined above), GH&I will determine that the Trauma Center has documented attempts at collection using the documentation that is available at each Trauma Center.
  5. GH&I will verify that the ISS (Injury Severity Score) assigned to each case selected in our sample (as defined above) matches the ISS for that patient in NTRACS (trauma registry software) used by all Trauma Centers.
  6. GH&I will document the process by which each trauma center funds their physicians with their portion of the readiness and uncompensated care funding and will recommend suggestions for improvement and consistency across all trauma centers. (See Attachment C)
  7. GH&I will select 20 out of the 44 Emergency Medical Services service companies receiving funding from the FY 2010 EMS Uncompensated Care Program (CY 2008 claims) and document the preparation processes for each EMS service company selected. (See Attachment D)

**ATTACHMENT A-1****ADDITIONAL PROCEDURES PERFORMED**

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GH&I met with the Executive Director and Business Operations Officer for the Georgia Trauma Care Network Commission to discuss the findings summarized in Attachment B and presented in detail in Attachment B-1 from the execution of our agreed-upon procedures as described in Attachment A. As a result of this meeting, GH&I was engaged to perform the following additional procedures:

1. Provide each Trauma Center with the findings from our agreed-upon procedures as described in Attachment A. See the information that was provided to each Trauma Center in Attachment B-2.
2. Request revised lists of uncompensated care cases from the following Trauma Centers:
  - Archbold
  - AMC
  - Floyd
  - Grady
  - Gwinnett
  - MCCG
  - MCG
  - Memorial
  - North Fulton
  - Walton

These revised lists should be duplicates of the original list provided to GH&I minus any cases that were identified in our agreed-upon procedures (AUP) to be in error (re: Attachment B Findings A through G in our report).

3. Compare the revised lists received above against the original lists received to ensure that errors GHI noted in their AUP are eliminated (along with any other cases that the hospitals identified) and that there are no cases added to the list.
4. Revise GHI AUP report to report new uncompensated care cases for each Trauma Center. Results are presented in Attachment B-2.
5. Present report at Georgia Trauma Care Network Commission meeting on 27 January 2012 in Rome, Georgia.
6. Make any additional revisions to the report as requested by the Commission.
7. GH&I performed only the procedures outlined in Attachments A and A-1 and did not perform any additional procedures. We did not perform any procedures to evaluate if there were trauma cases that should have been reported by the Trauma Centers as uncompensated care cases and were not.



## ATTACHMENT B

### VALIDATION OF UNCOMPENSATED CARE CASE DATA

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#### **FINDINGS SUMMARY:**

We have accumulated our findings from our agreed-upon procedures that are outlined in Attachment A. They are outlined below along with our recommendations. Additional information for each finding can be found in the detail reports by location. (See Attachment B-1)

1. Finding: We noted cases at the following Trauma Centers where we concluded that the documentation did not meet the criteria for an uncompensated care case due to:

A. Patient had insurance including Medicare Part B coverage

- Grady
- Gwinnett
- MCG
- Memorial

Recommendation: We recommend the Trauma Commission consider requesting that these Trauma Centers revise their CY2009 uncompensated care case list to exclude all cases where patients had insurance including Medicare Part B coverage

B. Patient was eligible for medical assistance coverage

- Grady
- Walton

Recommendation: We recommend the Trauma Commission consider requesting that these Trauma Centers revise their CY2009 uncompensated care case list to exclude all cases where patients were eligible for medical assistance coverage.

C. Patient had medical coverage for trauma care through workers' compensation, automobile insurance, or any other third party, including any settlement or judgment resulting from such coverage.

- Archbold
- AMC
- Floyd
- Grady
- MCCG
- MCG
- Memorial
- North Fulton
- Walton

## ATTACHMENT B

VALIDATION OF UNCOMPENSATED CARE CASE DATA

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Recommendation: We recommend the Trauma Commission consider requesting that these Trauma Centers revise their CY2009 uncompensated care case list to exclude all cases where patients had medical coverage for trauma care through workers' compensation, automobile insurance, or any other third party, including any settlement or judgment resulting from such coverage.

D. Payment by patient greater than 10%

- Archbold

Recommendation: We recommend the Trauma Commission consider requesting that this Trauma Center revise its CY2009 uncompensated care case list to exclude all cases where patients paid greater than 10% of the total charges.

E. Receipt of a third party payment

- Floyd
- Grady
- Gwinnett
- MCCG
- MCG
- North Fulton
- Walton

Recommendation: We recommend that the Trauma Commission consider requesting these Trauma Centers revise their CY2009 uncompensated care case list to exclude all cases where third party payments were received.

F. No collection attempts were made by the Trauma Center.

- Grady
- MCG

Recommendation: We recommend the Trauma Commission consider requesting that these Trauma Centers revise their CY2009 uncompensated care case list to exclude all cases where there were no collection attempts made.

**ATTACHMENT B****VALIDATION OF UNCOMPENSATED CARE CASE DATA**

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G. The ISS provided in the detail list of uncompensated care cases submitted to Bishop + Associates and used for testing did not match the ISS listed in NTRACS, the trauma registry.

- Archbold
- MCG

Recommendation: We recommend the Trauma Commission consider requesting that these Trauma Centers revise their CY2009 uncompensated care case list to reflect the ISS listed in NTRACS.

ATTACHMENT B-1

DETAIL FINDINGS BY LOCATION

HOSPITAL: ARCHBOLD

**Purpose:** To test that uncompensated care cases are properly recognized according to the criteria identified below.

**Procedures:** For hospitals with between 50 and 150 cases we will test 20.

Archbold reported 58 cases, therefore we selected a sample of 20 uncompensated care cases from the list provided by Bishop + Associates.

For each case selected we viewed the electronic billing record (EBR) or systems comparable to the EBR.

We determined whether the cases selected met the criteria for consideration as an uncompensated care claim case. The criteria are as follows:

- a The EBR shows the patient had no medical insurance, including Medicare Part B coverage.
  - b The EBR shows the patient was not eligible for medical assistance coverage.
  - c The EBR shows that the patient had no medical coverage for trauma care through workers' compensation, automobile insurance, or any other third party, including any settlement or judgment resulting from such coverage.
  - d The EBR shows that the patient has not paid more than 10% of total charges after documented attempts by the trauma care services provider to collect payments.
  - e The EBR shows that there were no third party payments received.
  - f The hospital has documented attempts at collection via documentation available at the hospital.
- Additionally, for each case selected we determined the following:
- 1 We determined whether the ISS listed on the listing provided is the same as that listed in the hospital's trauma registry software.

**Procedures performed with:** Kelli Vaughn for ISS, Lana Allen for EBR testing

**Findings:** Our findings that we believe to be inconsistent with the uncompensated care criteria outlined above are as follows:

Hosp #	ED Arr Date	ISS	a	b	c	d	e	f	1	Comments	Additional Notes
10241383	5-Mar-09	3	P	P	P	P	P	P	X	NISS of 3, regular ISS 1 (national ISS)	
10550361	15-Nov-09	8	P	P	P	P	P	P	X	NISS of 8, regular ISS of 4	
10506544	10-Oct-09	9	P	P	P	P	P	P	X	NISS 9, regular ISS 6	
10405780	25-Jul-09	12	P	P	P	P	P	P	X	NISS 12, regular ISS 9	
10445498	23-Aug-09	13	P	P	P	P	P	P	X	NISS 13, regular ISS 9	
10276262	3-Apr-09	14	P	P	P	P	P	P	X	NISS 14, regular ISS 10	
10595062	21-Dec-09	17	P	P	X	P	X	P	P		Progressive auto insurance was listed in the electronic billing record. Med-pay was exhausted prior to the claim. Payment in full of \$14,648 was made in a settlement check from the attorney to the patient on 7/15/10. Payment was received by the hospital on 8/6/10. The account was closed. Patient owes nothing now.

**Tickmark Explanations:**

- P Step performed without exception
- X Issue noted, see explanation to the right of case.

**Recommendations to the**

**Trauma Commission:** We will recommend to the Trauma Commission that the hospital revise their list of uncompensated care cases (CY 2009) to include only those cases with no third party payments received (through March 31, 2011). We will recommend to the Trauma Commission that the hospital revise their list of uncompensated care cases (CY 2009) to include ISS rather than NISS which was submitted in the original data tested.

	0-4	5-8	9	10-15	16-24	>24	Total
Per Bishop Survey	15	8	10	12	7	6	58
Per AUP	16	8	11	10	6	6	57
Difference 1	1	-	1	(2)	(1)	-	(1)
Per Revised List	20	8	11	9	4	5	57
Difference 2	5	-	1	(3)	(3)	(1)	(1)

**Trauma Center Response:** Each Trauma Center received the above findings detail and was given the opportunity to respond. Kelli Vaughn indicated agreement with our findings.

ATTACHMENT B-1

DETAIL FINDINGS BY LOCATION

HOSPITAL: AMC

**Purpose:** To test that uncompensated care cases are properly recognized according to the criteria identified below.

**Procedures:** For hospitals with greater than 150 cases we will test 40.

AMC reported 328 cases, therefore we selected a sample of 40 uncompensated care cases from the list provided by Bishop + Associates.

For each case selected we viewed the electronic billing record (EBR) or systems comparable to the EBR.

We determined whether the cases selected met the criteria for consideration as an uncompensated care claim case. The criteria are as follows:

- a The EBR shows the patient had no medical insurance, including Medicare Part B coverage.
- b The EBR shows the patient was not eligible for medical assistance coverage.
- c The EBR shows that the patient had no medical coverage for trauma care through workers' compensation, automobile insurance, or any other third party, including any settlement or judgment resulting from such coverage.
- d The EBR shows that the patient has not paid more than 10% of total charges after documented attempts by the trauma care services provider to collect payments.
- e The EBR shows that there were no third party payments received.
- f The hospital has documented attempts at collection via documentation available at the hospital.

Additionally, for each case selected we determined the following:

- 1 We determined whether the ISS listed on the listing provided is the same as that listed in the hospital's trauma registry software.

**Procedures performed with:** Mayuri Patel for EBR portion, Rochella Mood - ISS

**Findings:** Our findings that we believe to be inconsistent with the uncompensated care criteria outlined above are as follows:

Patient Account Number	Patient Classification	Admit Date	ISS Rating	a	b	c	d	e	f	1	Comments
14939441	I	20090327	1	P	P	X	P	P	P	P	The patient had State Farm auto insurance. The insurance company paid the patient directly. The hospital never received any payments from the patient or the insurance company.

**Tickmark Explanations:**

- P Step performed without exception
- X Issue noted, see explanation to the right

**Recommendations to the**

**Trauma Commission:** We will recommend to the Trauma Commission that the hospital revise their list of uncompensated care cases (CY 2009) to include only those cases with no third party payments received (through March 31, 2011) by the patient

	0-4	5-8	9	10-15	16-24	>24	Total
Per Bishop Survey	108	51	57	54	40	18	328
Per AUP	107	51	57	54	40	18	327
Difference 1	(1)	-	-	-	-	-	(1)
Per Revised List	106	47	56	53	36	17	315
Difference 2	(2)	(4)	(1)	(1)	(4)	(1)	(13)

**Trauma Center Response:** Each Trauma Center received the above findings detail and was given the opportunity to respond. Mike Miller response below:

- We have no proof of med pay coverage from the patient's auto insurance; we just have word from the adjuster stating they settled claim with the patient.
- Numerous attempts have been made to collect from the patient (statements, phone calls) and the patient has not responded or paid on this account yet. The account is now with collections and is also reported on the patient's credit report.

**ATTACHMENT B-1**

**DETAIL FINDINGS BY LOCATION**

**HOSPITAL: EGLESTON**

**Purpose:** To test that uncompensated care cases are properly recognized according to the criteria identified below.

**Procedures:** For hospitals with less than 25 cases we will test 5.

Egleston reported 24 cases, therefore we selected a sample of 5 uncompensated care cases from the list provided by Bishop + Associates.

For each case selected we viewed the electronic billing record (EBR) or systems comparable to the EBR.

We determined whether the cases selected met the criteria for consideration as an uncompensated care claim case. The criteria are as follows:

- a** The EBR shows the patient had no medical insurance, including Medicare Part B coverage.
  - b** The EBR shows the patient was not eligible for medical assistance coverage.
  - c** The EBR shows that the patient had no medical coverage for trauma care through workers' compensation, automobile insurance, or any other third party, including any settlement or judgment resulting from such coverage.
  - d** The EBR shows that the patient has not paid more than 10% of total charges after documented attempts by the trauma care services provider to collect payments.
  - e** The EBR shows that there were no third party payments received.
  - f** The hospital has documented attempts at collection via documentation available at the hospital.
- Additionally, for each case selected we determined the following:
- 1** We determined whether the ISS listed on the listing provided is the same as that listed in the hospital's trauma registry software.

**Procedures performed with:** Teri Skipper for EBR, Greg Pereira for ISS

Findings:	HOSP ACCT ID	ADM DATE	ISS	a	b	c	d	e	f	1	Comments
NO FINDINGS											
				<b>0-4</b>	<b>5-8</b>	<b>9</b>	<b>10-15</b>	<b>16-24</b>	<b>&gt;24</b>	<b>Total</b>	
			<b>Per Bishop Survey</b>	15	2	4	-	3	-	24	
			<b>Per AUP</b>	15	2	4	-	3	-	24	
			<b>Difference 1</b>	-	-	-	-	-	-	-	

**Trauma Center Response:** Each Trauma Center received the above findings detail and was given the opportunity to respond. There were no findings to comment on.

ATTACHMENT B-1

DETAIL FINDINGS BY LOCATION

HOSPITAL: SCOTTISH RITE

**Purpose:** To test that uncompensated care cases are properly recognized according to the criteria identified below.

**Procedures:** For hospitals with between 25 and 50 cases we will test 10.

Scottish Rite reported 28 cases, therefore we selected a sample of 10 uncompensated care cases from the list provided by Bishop + Associates.

For each case selected we viewed the electronic billing record (EBR) or systems comparable to the EBR.

We determined whether the cases selected met the criteria for consideration as an uncompensated care claim case. The criteria are as follows:

- a** The EBR shows the patient had no medical insurance, including Medicare Part B coverage.
  - b** The EBR shows the patient was not eligible for medical assistance coverage.
  - c** The EBR shows that the patient had no medical coverage for trauma care through workers' compensation, automobile insurance, or any other third party, including any settlement or judgment resulting from such coverage.
  - d** The EBR shows that the patient has not paid more than 10% of total charges after documented attempts by the trauma care services provider to collect payments.
  - e** The EBR shows that there were no third party payments received.
  - f** The hospital has documented attempts at collection via documentation available at the hospital.
- Additionally, for each case selected we determined the following:
- 1** We determined whether the ISS listed on the listing provided is the same as that listed in the hospital's trauma registry software.

**Procedures performed with:** Teri Skipper for EBR; Greg Pereira for ISS and physician compensation

Findings:	HOSP ACCT ID	ADM DATE	ISS	a	b	c	d	e	f	1	Comments
NO FINDINGS											
				<b>0-4</b>	<b>5-8</b>	<b>9</b>	<b>10-15</b>	<b>16-24</b>	<b>&gt;24</b>	<b>Total</b>	
			<b>Per Bishop Survey</b>	18	-	8	-	2	-	28	
			<b>Per AUP</b>	18	-	8	-	2	-	28	
			<b>Difference 1</b>	-	-	-	-	-	-	-	

**Trauma Center Response:** Each Trauma Center received the above findings detail and was given the opportunity to respond. There were no findings to comment on.

ATTACHMENT B-1

DETAIL FINDINGS BY LOCATION

HOSPITAL: COLUMBUS

**Purpose:** To test that uncompensated care cases are properly recognized according to the criteria identified below.

**Procedures:** For hospitals with between 50 and 150 cases we will test 20.

Columbus Regional reported 61 cases therefore we selected a sample of 20 uncompensated care cases from the list provided by Bishop + Associates.

For each case selected we viewed the electronic billing record (EBR) or systems comparable to the EBR.

We determined whether the cases selected met the criteria for consideration as an uncompensated care claim case. The criteria are as follows:

- a** The EBR shows the patient had no medical insurance, including Medicare Part B coverage.
- b** The EBR shows the patient was not eligible for medical assistance coverage.
- c** The EBR shows that the patient had no medical coverage for trauma care through workers' compensation, automobile insurance, or any other third party, including any settlement or judgment resulting from such coverage.
- d** The EBR shows that the patient has not paid more than 10% of total charges after documented attempts by the trauma care services provider to collect payments.
- e** The EBR shows that there were no third party payments received.
- f** The hospital has documented attempts at collection via documentation available at the hospital.

Additionally, for each case selected we determined the following:

- 1** We determined whether the ISS listed on the listing provided is the same as that listed in the hospital's trauma registry software.

**Procedures performed with:** Imogene Willis for ISS portion, Bill Wilson and Susan Norton for EBR

Findings:	EDP	ISS Score	a	b	c	d	e	f	1	Comments
NO FINDINGS										
			<b>0-4</b>	<b>5-8</b>	<b>9</b>	<b>10-15</b>	<b>16-24</b>	<b>&gt;24</b>	<b>Total</b>	
	<b>Per Bishop Survey</b>		6	13	11	16	12	3	61	
	<b>Per AUP</b>		6	13	11	16	12	3	61	
	<b>Difference 1</b>		-	-	-	-	-	-	-	

**Trauma Center Response:** Each Trauma Center received the above findings detail and was given the opportunity to respond. There were no findings to comment on.

ATTACHMENT B-1

DETAIL FINDINGS BY LOCATION

HOSPITAL: FLOYD

**Purpose:** To test that uncompensated care cases are properly recognized according to the criteria identified below.

**Procedures:** For hospitals with between 25 and 50 cases we will test 10

Floyd Medical Center reported 44 cases, therefore we selected a sample of 10 uncompensated care cases from the list provided by Bishop + Associates.

For each case selected we viewed the electronic billing record (EBR) or systems comparable to the EBR.

We determined whether the cases selected met the criteria for consideration as an uncompensated care claim case. The criteria are as follows:

- a** The EBR shows the patient had no medical insurance, including Medicare Part B coverage.
  - b** The EBR shows the patient was not eligible for medical assistance coverage.
  - c** The EBR shows that the patient had no medical coverage for trauma care through workers' compensation, automobile insurance, or any other third party, including any settlement or judgment resulting from such coverage.
  - d** The EBR shows that the patient has not paid more than 10% of total charges after documented attempts by the trauma care services provider to collect payments.
  - e** The EBR shows that there were no third party payments received.
  - f** The hospital has documented attempts at collection via documentation available at the hospital.
- Additionally, for each case selected we determined the following:
- 1** We determined whether the ISS listed on the listing provided is the same as that listed in the hospital's trauma registry software.

**Procedures performed with:** Donna Casey to perform the ERB procedures, discussed uncompensated care funding; Chad Taylor to perform the ISS procedures, discussed readiness funding

**FINDINGS:** Our findings that we believe to be inconsistent with the uncompensated care criteria outlined above are as follows:

Acct #	ISS	ISS	Financial#	Medical Record	a	b	c	d	e	f	1	Comments
F0917200077	ISS 5-8	5	0917200077	944732	P	P	X	P	X	P	P	Floyd received \$5,341.86 in September 2010 on a total bill of \$22,639.25. This payment was a "10-11" payment (money available for a period of time for illegal immigrant). One statement was sent to patient.

**Tickmark Explanations:**

- P** Step performed without exception
- X** Issue noted, see explanation to the right of case.

**Recommendations to the**

**Trauma Commission:** We will recommend to the Trauma Commission that the hospital revise their list of uncompensated care cases (CY 2009) to include only those cases with no third party payments received (through March 31, 2011).

	0-4	5-8	9	10-15	16-24	>24	Total
Per Bishop Survey	6	10	7	12	7	2	44
Per AUP	6	9	7	12	7	2	43
Difference 1	-	(1)	-	-	-	-	(1)
Per Revised List	5	6	7	10	7	2	37
Difference 2	(1)	(4)	-	(2)	-	-	(7)

**Trauma Center Response:** Each Trauma Center received the above findings detail and was given the opportunity to respond. Donna Casey indicated agreement with our findings. See her comment below:

On the one account where the 10-11 payment was received, that is a lengthy process and was not completed until 15 months after the date of service on this patient.

It is not something we would have known at the time of service to flag the patient as anything other than uncompensated. This will not be an issue in the future since this funding is depleted.

ATTACHMENT B-1

DETAIL FINDINGS BY LOCATION

HOSPITAL: GRADY

**Purpose:** To test that uncompensated care cases are properly recognized according to the criteria identified below.

**Procedures:** For hospitals with greater than 150 cases we will test 40.

Grady reported 1057 cases, therefore we selected a sample of 40 uncompensated care cases from the list provided by Bishop + Associates.

For each case selected we viewed the electronic billing record (EBR) or systems comparable to the EBR.

We determined whether the cases selected met the criteria for consideration as an uncompensated care claim case. The criteria are as follows:

- a** The EBR shows the patient had no medical insurance, including Medicare Part B coverage.
- b** The EBR shows the patient was not eligible for medical assistance coverage.
- c** The EBR shows that the patient had no medical coverage for trauma care through workers' compensation, automobile insurance, or any other third party, including any settlement or judgment resulting from
- d** The EBR shows that the patient has not paid more than 10% of total charges after documented attempts by the trauma care services provider to collect payments.
- e** The EBR shows that there were no third party payments received.
- f** The hospital has documented attempts at collection via documentation available at the hospital.

Additionally, for each case selected we determined the following:

- 1** We determined whether the ISS listed on the listing provided is the same as that listed in the hospital's trauma registry software.

**Procedures performed with:** Maria Kemp- patient finance and Anita Wright- reimbursement analyst for EBR, Met with Fran Lewis for ISS

**FINDINGS:** Our findings that we believe to be inconsistent with the uncompensated care criteria outlined above are as follows:

ACCT NO	ISS	a	b	c	d	e	f	1	Comments
454853144	9	P	P	X	P	P	P	P	No insurance information was listed in the system. Victim of Crime (VOC) was billed. Some sort of insurance was billed but was not clearly identified in the billing system. A settlement was reached. The patient collected on the settlement but the patient refused to pay the hospital.
454875501	9	P	P	P	P	P	X	P	This patient expired. The hospital did not attempt to collect from the patient's family. However, the hospital did attempt to get the patient's family to apply for several assistance programs specifically Title 16 (grants to states for medical assistance programs). The hospital tried to bill to title 16 and to Medicaid without success. The account was eventually written off.
451731913	14	P	P	X	P	X	P	P	A possible liability was recorded and billed on 8/12/09. A commercial payment was posted on 8/31/11 from an insurance company/settlement payment. The total account balance was \$11,459.40. The settlement payment was \$8,873.
449328012	19	P	X	P	P	X	P	P	Medicaid was approved on 9/14/10 and billed. The hospital received \$42,543 on 7/11/11 from Medicaid.
448342014	22	P	P	X	P	P	P	P	This patient was a prisoner of Atlanta and the charges of \$45k were recorded as prisoner of Atlanta charges and the patient was not billed.
450995204	25	P	P	P	P	P	X	P	The patient expired. The hospital attempted to get the patient's family to apply for Title 16 but the family did not cooperate.
449015973	75	X	P	X	P	P	P	P	Some sort of insurance information was listed in the billing record. The patient expired via a motor vehicle accident. Insurance was billed but coverage was initially denied. A \$3,000 personal injury protection payment from med-pay was issued to the patient's estate but not to Grady.

**Tickmark Explanations:**

- P** Step performed without exception
- X** Issue noted, see explanation to the right of case.



ATTACHMENT B-1

DETAIL FINDINGS BY LOCATION

HOSPITAL: GRADY—Continued

Recommendation to the

- Trauma Commission:** (1) We will recommend to the Trauma Commission that the hospital revise their list of uncompensated care cases (CY 2009) to include only those cases with no third party payments received (through March 31, 2011) by the patient or the hospital.  
 (2) We will recommend to the Trauma Commission that the hospital revise their list of uncompensated care cases (CY 2009) to exclude cases where there was no collection attempt due to an agreement with another party for exchange of services.  
 (3) We will recommend to the Trauma Commission that the hospital revise their list of uncompensated care cases (CY 2009) to exclude cases where there was no collection attempt due to the patient expiring.  
 (4) We will recommend to the Trauma Commission that the hospital revise their list of uncompensated care cases (CY 2009) to exclude cases where the patient had medical coverage from a third party (auto insurance).

	0-4	5-8	9	10-15	16-24	>24	Total
Cases Prior to Agreed Upon Procedures	374	120	179	161	128	90	1,052
Exceptions from above Differences	374	120	177	160	126	88	1,045
Cases After Results of Agreed Upon Procedures	-	-	(2)	(1)	(2)	(2)	(7)
	247	71	113	115	69	63	678
Cases After Results of Agreed Upon Procedures and Center Self Scrub	(127)	(49)	(66)	(46)	(59)	(27)	(374)

**Trauma Center Response:** Each Trauma Center received the above findings detail and was given the opportunity to respond. William Bodley indicated agreement with our findings.

For each of the above mentioned recommendations William's response is as follows:

- (1) Grady agrees to comply with this recommendation.
- (2) Grady agrees to comply, this applies to City, County and State Prisoners
- (3) Grady agrees to comply with this criteria
- (4) Grady agrees to comply with this recommendation

ATTACHMENT B-1

DETAIL FINDINGS BY LOCATION

HOSPITAL: GWINNETT

**Purpose:** To test that uncompensated care cases are properly recognized according to the criteria identified below.

**Procedures:** For hospitals with between 50 and 150 cases we will test 20

Gwinnett reported 107 cases, therefore we selected a sample of 20 uncompensated care cases from the list provided by Bishop + Associates.

For each case selected we viewed the electronic billing record (EBR) or systems comparable to the EBR.

We determined whether the cases selected met the criteria for consideration as an uncompensated care claim case. The criteria are as follows:

- a** The EBR shows the patient had no medical insurance, including Medicare Part B coverage.
  - b** The EBR shows the patient was not eligible for medical assistance coverage.
  - c** The EBR shows that the patient had no medical coverage for trauma care through workers' compensation, automobile insurance, or any other third party, including any settlement or judgment resulting from such coverage.
  - d** The EBR shows that the patient has not paid more than 10% of total charges after documented attempts by the trauma care services provider to collect payments.
  - e** The EBR shows that there were no third party payments received.
  - f** The hospital has documented attempts at collection via documentation available at the hospital.
- Additionally, for each case selected we determined the following:
- 1** We determined whether the ISS listed on the listing provided is the same as that listed in the hospital's trauma registry software.

**Procedures performed with:** Gina Solomon for ISS portion, Cynamin Kinnard for EBR portion

**FINDINGS:** Our findings that we believe to be inconsistent with the uncompensated care criteria outlined above are as follows:

Registry No.	Hospital Account #	Admission Date	ISS Score	a	b	c	d	e	f	1	Comments
5740	3100555864	09-Dec-09	9	X	P	P	P	X	P	P	The patient does have an insurance plan on file with a \$1,000 maximum limit coverage. The total account balance was \$38,986. \$1,000 was collected prior to 3/31/11 and the remaining \$37,000 was sent to debt. There was a lien on this account which was satisfied after the \$1k payment.

**Tickmark Explanations:**

- P** Step performed without exception
- X** Issue noted, see explanation to the right of case.

**Recommendation to the**

**Trauma Commission:** We will recommend to the Trauma Commission that the hospital revise their list of uncompensated care cases (CY2009) to include only those cases with no third party payments received (through March 31, 2011).

	0-4	5-8	9	10-15	16-24	>24	Total
<b>Per Bishop Survey</b>	17	14	27	30	10	9	107
<b>Per AUP</b>	17	14	26	30	10	9	106
<b>Difference 1</b>	-	-	(1)	-	-	-	(1)
<b>Per Revised List</b>	17	14	26	30	10	9	106
<b>Difference 2</b>	-	-	(1)	-	-	-	(1)

**Trauma Center Response:** Each Trauma Center received the above findings detail and was given the opportunity to respond. Glenda Puckett indicated agreement with our findings. See her response below:  
*The payment on this account is correct. Glenda Puckett, GHS Corporate Finance, 678-312-5623*

ATTACHMENT B-1

DETAIL FINDINGS BY LOCATION

HOSPITAL: HAMILTON

**Purpose:** To test that uncompensated care cases are properly recognized according to the criteria identified below.

**Procedures:** For hospitals with less than 25 cases we will test 5.

Hamilton reported 21 cases, therefore we selected a sample of 5 uncompensated care cases from the list provided by Bishop + Associates.

For each case selected we viewed the electronic billing record (EBR) or systems comparable to the EBR.

We determined whether the cases selected met the criteria for consideration as an uncompensated care claim case. The criteria are as follows:

- a** The EBR shows the patient had no medical insurance, including Medicare Part B coverage.
  - b** The EBR shows the patient was not eligible for medical assistance coverage.
  - c** The EBR shows that the patient had no medical coverage for trauma care through workers' compensation, automobile insurance, or any other third party, including any settlement or judgment resulting from such coverage.
  - d** The EBR shows that the patient has not paid more than 10% of total charges after documented attempts by the trauma care services provider to collect payments.
  - e** The EBR shows that there were no third party payments received.
  - f** The hospital has documented attempts at collection via documentation available at the hospital.
- Additionally, for each case selected we determined the following:
- 1** We determined whether the ISS listed on the listing provided is the same as that listed in the hospital's trauma registry software.

**Procedures performed with:** Patti Ferko for EBR portion, and Kim Brown for ISS portion

FINDINGS:	Patient	Admission	ISS	a	b	c	d	e	f	1	Comments
	Account	Date									
	Number										
NO FINDINGS											
				<b>0-4</b>	<b>5-8</b>	<b>9</b>	<b>10-15</b>	<b>16-24</b>	<b>&gt;24</b>	<b>Total</b>	
			<b>Per Bishop Survey</b>	10	-	8	1	1	1	21	
			<b>Per AUP</b>	10	-	8	1	1	1	21	
			<b>Difference 1</b>	-	-	-	-	-	-	-	

**Trauma Center Response:** Each Trauma Center received the above findings detail and was given the opportunity to respond. There were no findings to comment on.

ATTACHMENT B-1

DETAIL FINDINGS BY LOCATION

HOSPITAL: MCGG

**Purpose:** To test that uncompensated care cases are properly recognized according to the criteria identified below.

**Procedures:** For hospitals with greater than 150 cases we will test 40

MCCG reported 160 cases, therefore we selected a sample of 40 uncompensated care cases from the list provided by Bishop + Associates.

For each case selected we viewed the electronic billing record (EBR) or systems comparable to the EBR.

We determined whether the cases selected met the criteria for consideration as an uncompensated care claim case. The criteria are as follows:

**a** The EBR shows the patient had no medical insurance, including Medicare Part B coverage.

**b** The EBR shows the patient was not eligible for medical assistance coverage.

**c**

The EBR shows that the patient had no medical coverage for trauma care through workers' compensation, automobile insurance, or any other third party, including any settlement or judgment resulting from such coverage.

**d** The EBR shows that the patient has not paid more than 10% of total charges after documented attempts by the trauma care services provider to collect payments.

**e** The EBR shows that there were no third party payments received.

**f** The hospital has documented attempts at collection via documentation available at the hospital.

Additionally, for each case selected we determined the following:

**1** We determined whether the ISS listed on the listing provided is the same as that listed in the hospital's trauma registry software.

**Procedures performed with:** Robin May to perform steps a-f and Brian Forlines to perform step 1

**FINDINGS:** Our findings that we believe to be inconsistent with the uncompensated care criteria outlined above are as follows:

I.D.	ISS SCORE	AMIT		a	b	c	d	e	f	1	Comments
		DATE									
985795079206	5	7/25/2009		P	P	X	P	X	P	P	Victim of Crime (VOC) paid \$7,500 on 9/4/09 on a total bill of \$12,447.60.
982004279009	9	1/9/2009		P	P	X	P	X	P	P	VOC paid a total of \$15,000. The hospital received a \$7,500 payment on 3/12/09 and 6/10/10. The total bill was \$32,606.35.
985828879237	10	8/25/2009		P	P	X	P	X	P	P	VOC paid a total of \$15,000. The hospital received a \$7,500 payment on 1/13/10 and 3/26/10. The total bill was \$15,016.90.
985810049220	13	8/8/2009		P	P	X	P	P	P	P	VOC was awarded totaling \$15,000 but the patient denied the application of the approved \$15,000 payment. The patient said that Medicaid would pay it. However, Medicaid was not approved.
985644209054	21	2/24/2009		P	P	X	P	X	P	P	VOC paid a total of \$15,000. The hospital received a payment of \$7,500 on 6/8/09 and on 10/23/09. The total bill was \$76,766.27.

**Tickmark Explanations:**

**P** Step performed without exception

**X** Issue noted, see explanation to the right of case.

**Recommendation to the**

**Trauma Commission:** We will recommend to the Trauma Commission that the hospital revise their list of uncompensated care cases (CY2009) to include only those cases with no third party payments received (through March 31, 2011).

We will recommend to the Trauma Commission that the hospital revise their list of uncompensated care cases (CY2009) to include only those cases not eligible for medical coverage through a third party.

	0-4	5-8	9	10-15	16-24	>24	Total
Per Bishop Survey	14	33	21	49	34	9	160
Per AUP	14	32	20	47	33	9	155
Difference 1	-	(1)	(1)	(2)	(1)	-	(5)
Per Revised List	13	29	20	44	31	8	145
Difference 2	(1)	(4)	(1)	(5)	(3)	(1)	(15)

**Trauma Center Response:** Each Trauma Center received the above findings detail and was given the opportunity to respond. Bryan Forlines responded via phone on 10/27/11. He is in agreement with our findings.

ATTACHMENT B-1

DETAIL FINDINGS BY LOCATION

HOSPITAL: MCG

**Purpose:** To test that uncompensated care cases are properly recognized according to the criteria identified below.

**Procedures:** For hospitals with greater than 150 cases we will test 40.

MCG reported 229 cases, therefore we selected a sample of 40 uncompensated care cases from the list provided by Bishop + Associates.

For each case selected we viewed the electronic billing record (EBR) or systems comparable to the EBR.

We determined whether the cases selected met the criteria for consideration as an uncompensated care claim case. The criteria are as follows:

- a** The EBR shows the patient had no medical insurance, including Medicare Part B coverage.
  - b** The EBR shows the patient was not eligible for medical assistance coverage.
  - c** The EBR shows that the patient had no medical coverage for trauma care through workers' compensation, automobile insurance, or any other third party, including any settlement or judgment resulting from such coverage.
  - d** The EBR shows that the patient has not paid more than 10% of total charges after documented attempts by the trauma care services provider to collect payments.
  - e** The EBR shows that there were no third party payments received.
  - f** The hospital has documented attempts at collection via documentation available at the hospital.
- Additionally, for each case selected we determined the following:
- 1** We determined whether the ISS listed on the listing provided is the same as that listed in the hospital's trauma registry software.

**Procedures performed with:** Sheryl Jackson for steps 1-f, Regina Medeiros for ISS

**FINDINGS:** Our findings that we believe to be inconsistent with the uncompensated care criteria outlined above are as follows:

MRN	ISS	Admit Date	a	b	c	d	e	f	1	Comments
009033057	6	1/18/2009	X	P	X	P	X	P	P	The patient had commercial insurance. The hospital received an attorney payment of \$8,273.90 on 6/14/10. The total original balance of the account was \$13,676.
001366580	9	6/4/2009	X	P	X	P	P	X	P	The memo on file in the billing record gave instruction to not bill the patient. The patient did have insurance. The account was written off to risk management. The patient was a victim of crime on the campus.
009033796	22	5/30/2009	P	P	P	P	P	P	X	ISS in registry is 26

**Tickmark Explanations:**

- P** Step performed without exception
- X** Issue noted, see explanation to the right of case.

**Recommendation to the**

**Trauma Commission:** We will recommend to the Trauma Commission that the hospital revise their list of uncompensated care cases (CY2009) to include only those cases with no third party payments received (through March 31, 2011).

We will recommend to the Trauma Commission that the list of uncompensated care cases (CY2009) for MCG Health, Inc. be revised to reflect the ISS numbers listed in the registry database.

We will recommend to the Trauma Commission that the hospital revise their list of uncompensated care cases (CY2009) to include only those cases where there were collection attempts.

	0-4	5-8	9	10-15	16-24	>24	Total
<b>Per Bishop Survey</b>	39	39	43	53	41	14	229
<b>Per AUP</b>	39	38	42	53	40	15	227
<b>Difference 1</b>	-	(1)	(1)	-	(1)	1	(2)
<b>Per Revised List</b>	39	38	42	53	40	15	227
<b>Difference 2</b>	-	(1)	(1)	-	(1)	1	(2)

**Trauma Center Response:** Each Trauma Center received the above findings detail and was given the opportunity to respond. Regina Medeiros and Ben Fuller indicated agreement with our findings.

We agree with your findings – Regina

ATTACHMENT B-1

DETAIL FINDINGS BY LOCATION

HOSPITAL: MEMORIAL

**Purpose:** To test that uncompensated care cases are properly recognized according to the criteria identified below.

**Procedures:** For hospitals with greater than 150 cases we will test 40.

Memorial Health reported 276 cases, therefore we selected a sample of 40 uncompensated care cases from the list provided by Bishop + Associates.

For each case selected we viewed the electronic billing record (EBR) or systems comparable to the EBR.

We determined whether the cases selected met the criteria for consideration as an uncompensated care claim case. The criteria are as follows:

- a** The EBR shows the patient had no medical insurance, including Medicare Part B coverage.
  - b** The EBR shows the patient was not eligible for medical assistance coverage.
  - c** The EBR shows that the patient had no medical coverage for trauma care through workers' compensation, automobile insurance, or any other third party, including any settlement or judgment resulting from such coverage.
  - d** The EBR shows that the patient has not paid more than 10% of total charges after documented attempts by the trauma care services provider to collect payments.
  - e** The EBR shows that there were no third party payments received.
  - f** The hospital has documented attempts at collection via documentation available at the hospital.
- Additionally, for each case selected we determined the following:
- 1** We determined whether the ISS listed on the listing provided is the same as that listed in the hospital's trauma registry software.

**Procedures performed with:** Jamie Watson for EBR and Gretchen Goodman ISS

**FINDINGS:** Our findings that we believe to be inconsistent with the uncompensated care criteria outlined above are as follows:

PATIENT ID	ISS	ADMIT DATE	a	b	c	d	e	f	1	Comments
925500042	9	9/12/2009	X	P	X	P	P	P	P	Coventry is the health insurance the patient had. Memorial could not get the auto insurance information so they sent claim to Coventry. They got the police report and the auto insurance carrier but could not find the policy number. Health insurance will not pay until auto insurance pays. The state of Kansas does not subrogate therefore the health insurance company would not pay until the auto insurance company paid.
917500889	14	6/24/2009	P	P	X	P	P	P	P	The patient was involved in a motor vehicle accident. The hospital corresponded with the patients attorney and noted per discussion with the attorney that there was a \$50,000 total settlement. However there were seven people involved in the accident. The attorney told the hospital that he could offer them \$7,500. The Hospital agreed to accept the \$7,500 and the patient could file for financial assistance for the remainder. The attorney never sent payment. The Hospital attempted several times to collect settlement from the attorney. (Total bill \$20,378)

**Tickmark Explanations:**

- P** Step performed without exception
- X** Issue noted, see explanation to the right of case.



ATTACHMENT B-1

DETAIL FINDINGS BY LOCATION

HOSPITAL: MEMORIAL—Continued

Recommendation to the

**Trauma Commission:** We will recommend to the Trauma Commission that the hospital revise their list of uncompensated care cases (CY 2009) to include only those cases with no third party payments received (through March 31, 2011) by the patient or the hospital.

We will recommend to the Trauma Commission that the hospital revise their list of uncompensated care cases (CY 2009) to include only those cases where the patient had no medical insurance or medical coverage through an automobile insurance.

	0-4	5-8	9	10-15	16-24	>24	Total
<b>Per Bishop Survey</b>	51	40	50	67	52	16	276
<b>Per AUP</b>	51	40	49	66	52	16	274
<b>Difference 1</b>	-	-	(1)	(1)	-	-	(2)
<b>Per Revised List</b>	51	40	49	66	52	16	274
<b>Difference 2</b>	-	-	(1)	(1)	-	-	(2)

**Trauma Center Response:** Each Trauma Center received the above findings detail and was given the opportunity to respond. Elaine Frantz indicated agreement with our findings and comments as follows:

With regard to the 2 patients identified who did not meet specific Uncompensated Care criteria, I appreciate and support your recommendations to forward to the Trauma Commission.

Your analysis regarding inability to determine and/or confirm the presence or absence of medical assistance in conjunction with the patient's non-compliance clearly indicates due diligence on the part of our revenue cycle team. Reconsideration would be highly welcomed!

ATTACHMENT B-1

DETAIL FINDINGS BY LOCATION

HOSPITAL: NORTH FULTON

**Purpose:** To test that uncompensated care cases are properly recognized according to the criteria identified below.

**Procedures:** For hospitals with between 50 and 150 cases we will test 20.

North Fulton reported 63 cases, therefore we selected a sample of 20 uncompensated care cases from the list provided by Bishop + Associates.

For each case selected we viewed the electronic billing record (EBR) or systems comparable to the EBR.

We determined whether the cases selected met the criteria for consideration as an uncompensated care claim case. The criteria are as follows:

- a** The EBR shows the patient had no medical insurance, including Medicare Part B coverage.
  - b** The EBR shows the patient was not eligible for medical assistance coverage.
  - c** The EBR shows that the patient had no medical coverage for trauma care through workers' compensation, automobile insurance, or any other third party, including any settlement or judgment resulting from such coverage.
  - d** The EBR shows that the patient has not paid more than 10% of total charges after documented attempts by the trauma care services provider to collect payments.
  - e** The EBR shows that there were no third party payments received.
  - f** The hospital has documented attempts at collection via documentation available at the hospital.
- Additionally, for each case selected we determined the following:
- 1** We determined whether the ISS listed on the listing provided is the same as that listed in the hospital's trauma registry software.

**Procedures performed with:** Jim Sargent for ISS, Patty Barton for EBR, but it was hard copied onto paper

**FINDINGS:** Our findings that we believe to be inconsistent with the uncompensated care criteria outlined above are as follows:

Patient Account Number	Admit Date	Injury Severity Code	a	b	c	d	e	f	1	Comments
17835299	2009/07/08	13	P	P	X	P	X	P	P	The account was listed as private pay/uninsured. The hospital gave an uninsured discount of \$62,886 on the \$86,345 bill. The hospital received a \$5,000 payment from Georgia BA auto insurance on 1/4/10. The remaining balance went to bad debt. The case was taken to court but could not settle.
17882788	2009/07/13	20	P	P	X	P	X	P	P	The account was listed as private pay/uninsured. The hospital gave an uninsured discount of \$48,407.50 on the \$96,815 bill. Insurance paid \$6,033.54 on 1/21/10. The remaining balance went to bad debt. The cap on insurance benefit was \$15,000, but the hospital only received \$6,033.

**Tickmark Explanations:**

- P** Step performed without exception
- X** Issue noted, see explanation to the right of case.

**Recommendation to the**

**Trauma Commission:** We will recommend to the Trauma Commission that the hospital revise their list of uncompensated care cases (CY2009) to include only those cases with no third party payments received (through March 31, 2011).

	0-4	5-8	9	10-15	16-24	>24	Total
Per Bishop Survey	14	9	8	11	14	7	63
Per AUP	14	9	8	10	13	7	61
Difference 1	-	-	-	(1)	(1)	-	(2)
Per Revised List	14	9	8	10	12	6	59
Difference 2	-	-	-	(1)	(2)	(1)	(4)

**Trauma Center Response:** Each Trauma Center received the above findings detail and was given the opportunity to respond. Joy Scott indicated agreement with our findings. See her response below.  
I have reviewed your report and I will change and re-submit the report as recommended in your analysis.

ATTACHMENT B-1

DETAIL FINDINGS BY LOCATION

HOSPITAL: WALTON

**Purpose:** To test that uncompensated care cases are properly recognized according to the criteria identified below.

**Procedures:** For hospitals with less than 25 cases we will test 5.

Monroe(Walton) reported 6 cases, therefore we selected a sample of 5 uncompensated care cases from the list provided by Bishop + Associates.

For each case selected we viewed the electronic billing record (EBR) or systems comparable to the EBR.

We determined whether the cases selected met the criteria for consideration as an uncompensated care claim case. The criteria are as follows:

- a** The EBR shows the patient had no medical insurance, including Medicare Part B coverage.
  - b** The EBR shows the patient was not eligible for medical assistance coverage.
  - c** The EBR shows that the patient had no medical coverage for trauma care through workers' compensation, automobile insurance, or any other third party, including any settlement or judgment resulting from such
  - d** The EBR shows that the patient has not paid more than 10% of total charges after documented attempts by the trauma care services provider to collect payments.
  - e** The EBR shows that there were no third party payments received.
  - f** The hospital has documented attempts at collection via documentation available at the hospital.
- Additionally, for each case selected we determined the following:
- 1** We determined whether the ISS listed on the listing provided is the same as that listed in the hospital's trauma registry software.

**Procedures performed with:** Nick Atwell for steps a-f, Met with Bambi Bruce for ISS piece

**FINDINGS:** Our findings that we believe to be inconsistent with the uncompensated care criteria outlined above are as follows:

Acct #	DOS	ISS	a	b	c	d	e	f	1	Comments
2256713	12-Nov-09	1	P	P	P	P	X	P	P	The patient was listed as self pay/uninsured. No payments were received and the debt was sold to an outside collection agency.
2257906	22-Nov-09	4	P	X	X	P	X	P	P	The hospital received a Medicaid payment of \$11,285 on 10/5/10. The total account balance was \$30,823.59.
2232685	14-May-09	4	P	P	P	P	X	P	P	No payments were received and the debt was sold to an outside collection agency.
2255195	1-Nov-09	9	P	P	P	P	X	P	P	No payments were received and the debt was sold to an outside collection agency.

**Tickmark Explanations:**

- P** Step performed without exception
- X** Issue noted, see explanation to the right of case.

**Recommendations to the**

**Trauma Commission:** We will recommend to the Trauma Commission that the hospital revise their list of uncompensated care cases (CY2009) to include only those cases with no third party payments received (through February 2010), including accounts sold to a collection agency.

	0-4	5-8	9	10-15	16-24	>24	Total
<b>Per Bishop Survey</b>	4	-	1	-	-	1	6
<b>Per AUP</b>	3	(2)	-	-	-	1	2
<b>Difference 1</b>	(1)	(2)	(1)	-	-	-	(4)
<b>Per Revised List</b>	1	-	-	-	-	1	2
<b>Difference 2</b>	(3)	-	(1)	-	-	-	(4)

**Trauma Center Response:** Each Trauma Center received the above findings detail and was given the opportunity to respond. Bill Dohn indicated agreement with our findings. See his response below.

- 2256713 Reimbursement received when account was sold is less than 10% of billed charges
- 2257906 In agreement
- 2232685 Reimbursement received when account was sold is less than 10% of billed charges
- 2255195 Reimbursement received when account was sold is less than 10% of billed charges

## ATTACHMENT B-2

## SUMMARY FINDINGS BY LOCATION

Location		ISS Category						Total	Location		ISS Category						Total
		0-4	5-8	9	10-15	16-24	>24				0-4	5-8	9	10-15	16-24	>24	
<b>MCCG</b>	Per Bishop Survey	14	33	21	49	34	9	160	<b>AMC</b>	Per Bishop Survey	108	51	57	54	40	18	328
	Per AUP	14	32	20	47	33	9	155		Per AUP	107	51	57	54	40	18	327
	Difference 1	-	(1)	(1)	(2)	(1)	-	(5)		Difference 1	(1)	-	-	-	-	-	(1)
	Per Revised List	13	29	20	44	31	8	145		Per Revised List	106	47	56	53	36	17	315
	Difference 2	(1)	(4)	(1)	(5)	(3)	(1)	(15)		Difference 2	(2)	(4)	(1)	(1)	(4)	(1)	(13)
<b>MCG</b>	Per Bishop Survey	39	39	43	53	41	14	229	<b>Gwinnett</b>	Per Bishop Survey	17	14	27	30	10	9	107
	Per AUP	39	38	42	53	40	15	227		Per AUP	17	14	26	30	10	9	106
	Difference 1	-	(1)	(1)	-	(1)	1	(2)		Difference 1	-	-	(1)	-	-	-	(1)
	Per Revised List	39	38	42	53	40	15	227		Per Revised List	17	14	26	30	10	9	106
	Difference 2	-	(1)	(1)	-	(1)	1	(2)		Difference 2	-	-	(1)	-	-	-	(1)
<b>Grady</b>	Per Bishop Survey	374	120	179	161	128	90	1,052	<b>Columbus</b>	Per Bishop Survey	6	13	11	16	12	3	61
	Per AUP	374	120	177	160	126	88	1,045		Per AUP	6	13	11	16	12	3	61
	Difference 1	-	-	(2)	(1)	(2)	(2)	(7)		Difference 1	-	-	-	-	-	-	-
	Per Revised List	247	71	113	115	69	63	678		Per Revised List-NA							
	Difference 2	(127)	(49)	(66)	(46)	(59)	(27)	(374)									
<b>Memorial</b>	Per Bishop Survey	51	40	50	67	52	16	276	<b>North Fulton</b>	Per Bishop Survey	14	9	8	11	14	7	63
	Per AUP	51	40	49	66	52	16	274		Per AUP	14	9	8	10	13	7	61
	Difference 1	-	-	(1)	(1)	-	-	(2)		Difference 1	-	-	-	(1)	(1)	-	(2)
	Per Revised List	51	40	49	66	52	16	274		Per Revised List	14	9	8	10	12	6	59
	Difference 2	-	-	(1)	(1)	-	-	(2)		Difference 2	-	-	-	(1)	(2)	(1)	(4)

## ATTACHMENT B-2

## SUMMARY FINDINGS BY LOCATION—Continued

Location		ISS Category						Total	Location		ISS Category						Total
		0-4	5-8	9	10-15	16-24	>24				0-4	5-8	9	10-15	16-24	>24	
<b>Archbold</b>	Per Bishop Survey	15	8	10	12	7	6	58	<b>Floyd</b>	Per Bishop Survey	6	10	7	12	7	2	44
	Per AUP	16	8	11	10	6	6	57		Per AUP	6	9	7	12	7	2	43
	Difference 1	1	-	1	(2)	(1)	-	(1)		Difference 1	-	(1)	-	-	-	-	(1)
	Per Revised List	20	8	11	9	4	5	57		Per Revised List	5	6	7	10	7	2	37
	Difference 2	5	-	1	(3)	(3)	(1)	(1)	Difference 2	(1)	(4)	-	(2)	-	-	(7)	
<b>Egleston</b>	Per Bishop Survey	15	2	4	-	3	-	24	<b>Hamilton</b>	Per Bishop Survey	10	-	8	1	1	1	21
	Per AUP	15	2	4	-	3	-	24		Per AUP	10	-	8	1	1	1	21
	Difference 1	-	-	-	-	-	-	-		Difference 1	-	-	-	-	-	-	-
	Per Revised List-NA								Per Revised List-NA								
<b>Scottish Rite</b>	Per Bishop Survey	18	-	8	-	2	-	28	<b>Walton</b>	Per Bishop Survey	4	-	1	-	-	1	6
	Per AUP	18	-	8	-	2	-	28		Per AUP	3	(2)	-	-	-	1	2
	Difference 1	-	-	-	-	-	-	-		Difference 1	(1)	(2)	(1)	-	-	-	(4)
	Per Revised List-NA								Per Revised List	1	-	-	-	-	1	2	
									Difference 2	(3)	-	(1)	-	-	-	(4)	
								<b>Totals</b>									
										Per Bishop Survey	691	339	434	466	351	176	2,457
										Per AUP	690	334	428	459	345	175	2,431
										Difference 1	(1)	(5)	(6)	(7)	(6)	(1)	(26)
										Per Revised List	513	262	332	390	261	142	1,900
										Difference 2	(129)	(62)	(71)	(59)	(72)	(30)	(423)

## ATTACHMENT C

**DOCUMENTATION OF PROCESSES FOR FUNDING  
PHYSICIANS PORTION OF READINESS AND UNCOMPENSATED CARE**

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**SUMMARY:**

We have summarized the processes of physician funding for readiness and uncompensated care as described to us by a knowledgeable person from each Trauma Center. We have also listed our recommendations below the summarized processes.

**1. Archbold**

- A. Readiness:** The Trauma Center has a Trauma committee made up of physician representatives that qualify for the readiness portion. (Physicians who qualify are defined in the State contract). The committee physicians meet to determine a recommendation for how the total readiness funds will be allocated to each eligible physician. Factors such as number of admissions and time spent at the Trauma Center are considered in determining a recommendation. The recommendation is presented to the CEO. Once the CEO reviews and approves the allocation recommendation, the hospital's accounting department pays each physician.
- B. Uncompensated Care:** The Trauma Commission's contract specifies that 75% of the total available uncompensated care funding should go to the Trauma Center and the remaining 25% should be allocated among the physicians. The hospital sends a letter to each physician along with a list of all trauma patients. (The list has not been analyzed for any uncompensated care criteria.) The letter outlines the criteria for uncompensated care, documentation required to be submitted, funding received from the State of Georgia, and the timeline for submitting the requests. Note that the physicians are given the exact definition of uncompensated care from the Commission contract, which was taken from Senate Bill 60, in their initial letter defining uncompensated care. The physicians' offices are responsible for providing support for the uncompensated care claims. Once the physicians have returned the supporting documentation, the total of each submission is tallied for each individual physician. Then a total is accumulated for all physician submissions. The total amount submitted from the physicians is typically greater than the funding received. The physicians' payments are allocated based on the percentage of the total submitted. Once the amount has been determined, the hospital will prorate payment to the physicians and/or physician groups based on this methodology. Payments are prepared by the hospital's accounting department.

**2. AMC**

- A. Readiness:** The trauma director oversees the day to day functions in this area. There are physicians on call providing services in the following areas: cardiology, internal medicine, nephrology, neurology, OB/Gyn, pediatrics, plastic surgery, and trauma as well

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as other areas. These physicians submit logs on a monthly basis that detail their work schedule for that month. Check requests are then prepared and approved by the appropriate individuals and submitted to the accounts payable department for check processing. The actual amount paid to the physicians in the form of their salary far exceeds the total amount provided by the Commission, therefore, the physicians do not receive a separate check for readiness funding.

- B. Uncompensated Care:** The Trauma Commission's contract specifies that 75% of the total available uncompensated care funding should go to the hospital and the remaining 25% should be allocated among the physicians. The hospital sends a letter and a list of eligible trauma patients to the physicians and diagnostic professionals. This list has not been analyzed for uncompensated care criteria. The letter outlines the criteria for uncompensated care, documentation required, funding received from the State of Georgia and the timeline for submitting requests. The physicians are given the exact definition of uncompensated care from the Commission contract, taken from Senate Bill 60, in their initial letter defining uncompensated care. The physician and/or physician group will submit the appropriate documentation for the patients identified as qualifying uncompensated care cases. The physician submitted data is compared against the hospital data to make sure that the cases are eligible. The hospital looks at the state schedule for reimbursement by CPT codes and then assigns state rates and looks at how much physicians would receive based on their claims. The total of each submission is tallied for each individual physician and then a total is reached for all physician submissions. The total amount submitted from the physicians is typically greater than the funding received. The physicians' payments are allocated based on the percentage of the total submitted. The hospital's accounts payable function then prepares the payments to the physicians and/or physician groups.

**3. Egleston**

- A. Readiness:** The readiness portion is funded on the front end in the form of call pay fees paid to eligible physicians, therefore, no money is actually sent to the physicians when the readiness portion is received by the Hospital (The total call pay fees exceed the amount received for Readiness Compensation.)
- B. Uncompensated Care:** The physicians sign a waiver stating that they want the uncompensated care funds to go to CME (Continuing Medical Education). The physicians believe that the cost of paying an assistant to go through all the paperwork is not worth the compensation that they get in return so it all goes into CME. All CME receipts are documented. The chief of each of the groups/specialties also signs a letter waiving the right to compensation. The Trauma Guiding Team decides on education

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classes that will be held. The money goes into a restricted account and the Trauma Program Manager fills out payment vouchers to use the restricted account funds.

**4. Scottish Rite**

- A. Readiness:** The Readiness portion is funded on the front end in the form of call pay fees paid to eligible physicians, therefore, no money is actually sent to the physicians when the readiness portion is received by the Hospital (The total call pay fees exceed the amount received for Readiness Compensation.)
- B. Uncompensated Care:** The physicians sign a waiver stating that they want the uncompensated care funds to go to CME (Continuing Medical Education). The physicians believe that the cost of paying an assistant to go through all the paperwork is not worth the compensation that they get in return so it all goes into CME. All CME receipts are documented. The chief of each of the groups/specialties also signs a letter waiving the right to compensation. The Trauma Guiding Team decides on education classes that will be held. The money goes into a restricted account and the Trauma Program Manager fills out payment vouchers to use the restricted account funds.

**5. Columbus**

- A. Readiness:** Readiness is funded to the physicians on the front end in the form of their on call pay. The amount that is paid to the physicians far exceeds the amount that is funded by the Commission, therefore, no money is actually sent to the physicians when the readiness portion is received. The funds are recorded in a revenue account and costs are offset against the funding.
- B. Uncompensated Care:** The physician groups have contracts with the trauma center. The contracts state the responsibilities of the physicians for submitting claims to the hospital to be reimbursed for uncompensated care patients. The physicians submit their own information to the Manager of Group Practices at the trauma center. The Manager then compares the information submitted by the physicians to the trauma center records to determine if the cases meet the definition of uncompensated care. The trauma center defines uncompensated care using the definition set forth in the Commission contract. The physician's cases are then given a total value based on the Medicaid allowable rate. Each physician/physician group is paid the full amount of their claims regardless of the amount that the Commission funds the trauma center. The total amount funded to the physicians far exceeds the amount awarded by the Commission. Therefore, when the

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Commission funding is received, the funding is recorded in a revenue account and costs are offset against the funding.

**6. Floyd**

- A. Readiness:** Readiness is based on actual on-call time for physicians who have been designated as eligible. The physicians are compensated for readiness based on a set dollar amount per on-call day. This is verified through the on-call system. The actual amount paid to the physicians far exceeds the total amount provided by the Commission, therefore, the physicians do not receive a separate check for readiness funding.
- B. Uncompensated Care:** The Commission's contract specifies that 75% of the total available uncompensated care funding should go to the hospital and the remaining 25% should be allocated among the physicians. The hospital sends a letter to each physician along with a list of eligible trauma patients. The list has not been analyzed for uncompensated care criteria. The letter outlines the criteria for uncompensated care (as defined in the Commission contract), documentation required to be submitted, funding received from the State of Georgia and the timeline for submitting the requests. The physicians are instructed to review the list and if the physician wishes to apply for trauma funding, to provide documentation for their uncompensated care cases. Once the physicians have returned the supporting documentation, the Director of Patient Financial Services reviews all of the documentation and makes sure that all the patients are eligible. The Director then sends all of the eligible cases to the accounting manager. The accounting manager totals each physician's submission. Then a total is reached for all physician submissions. The total amount submitted from the physicians is typically greater than the funding received. The physicians' payments are allocated based on the percentage of the total submitted. Once the amount has been determined, the medical center will prorate payment to the physicians based on this methodology. Checks are then prepared and sent to the physicians.

**7. Grady**

- A. Readiness:** Each year the finance department summarizes on-call fees paid to the physician groups. The on-call fees paid to both Emory and Morehouse exceed the amount of Readiness funding provided under the grant; therefore, the physicians do not receive a separate check for readiness funding.
- B. Uncompensated Care:** Each year the trauma coordinator determines the patients that were entered in the trauma registry that were identified as uncompensated care based on the definition set forth in the Commission contract. The patients are further stratified by

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the physician that provided care. Each physician and /or physician group receives a patient listing and an email from the medical center explaining the process. The email outlines the criteria for uncompensated care, documentation required, funding received from the State of Georgia and the timeline for submitting requests. The physician and/or physician group submits the appropriate documentation for the patients identified. The total of each submission is tallied for each individual physician. Then a total is reached for all physician submissions. The total amount submitted from the physicians is typically greater than the funding received. The physician payments are allocated based on the percentage of the total submitted. The medical center provides payment to the physician groups based on this methodology.

**8. Gwinnett**

- A. Readiness:** Readiness is based on eligible physician's salaries. It is funded on the front end through the eligible physicians' salaries. Examples of eligible physicians include the trauma surgeons and the trauma coordinators, etc. The actual amount paid to the physicians in the form of their salary far exceeds the total amount provided by the Commission, therefore, the physicians do not receive a separate check for readiness funding.
- B. Uncompensated Care:** The Commission's contract specifies that 75% of the total available uncompensated care funding should go to the hospital and the remaining 25% should be allocated among the eligible physicians. A list is prepared from the registry of all trauma patients that were seen by each eligible physician. A letter along with the physician's list of trauma patients is sent to each physician. (This list contains all trauma patients and has not been analyzed for uncompensated care criteria.) The physicians are asked to provide certain documentation to show that the case meets the qualifications for uncompensated care as defined by Senate Bill 60. Documentation may include billing records, Health Insurance Claim Form (HICF), CPT code showing how the patient is charged, and a statement showing that the physician did not receive payment. The trauma department receives the documents from each physician and reviews the support to make sure that the information matches the hospital's information and that the qualifications for uncompensated care are met. Once all documents have been received and reviewed, the trauma department creates a new spreadsheet by specialty with all of the information obtained from the supporting documents. The physicians have two months to gather and return the information and if the information is not complete or timely, it will not be included in the submission. (Per Gina Solomon, this is a very time consuming process – radiology and anesthesia opted not to participate due to the cost/benefit analysis of the process.) The trauma department sends the final spreadsheet to the finance department and the finance department determines the amounts to distribute to each physician based

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on a percentage of the total physician charges and the total amount funded by the Commission. The hospital's finance department prepares the checks and distributes to the physicians.

**9. Hamilton**

- A. Readiness:** The Readiness portion is funded on the front end in the form of call pay fees paid to eligible physicians, therefore, no money is actually sent to the physicians when the Readiness portion is received by the Hospital (The total call pay fees exceed the amount received for Readiness Compensation.)
- B. Uncompensated Care:** Each year the trauma coordinator accumulates the patients that were entered in the trauma registry and identified as uncompensated care. The patients are stratified by the physician that provided care. Each physician and/or physician group will receive a patient listing and a letter from the medical center explaining the process. The letter outlines the criteria for uncompensated care (as defined in the Commission contract), documentation required, funding received from the State of Georgia and the timeline for submitting requests. The physician and/or physician group will submit the appropriate documentation for the patients identified. The total of each submission is tallied for each individual physician. Then a total is reached for all physician submissions. The total amount submitted from the physicians is typically greater than the funding received. The physicians' payments are allocated based on the percentage of the total submitted. Once the amount has been determined, the medical center will provide payment to the physician and/or physician group based on this methodology.

**10. MCCG**

- A. Readiness:** Readiness payments are based on "on-call" time and funded on the front end. The readiness costs are well above the allotted Readiness compensation that the hospital receives from the Commission so there is not a separate payment to the physician. It is funded on the front end to the physician in the form of on-call pay.
- B. Uncompensated Care:** The reimbursement director sends a letter to all the physicians informing them of the process to submit their claims as well as a list of their patients. The list includes patients with a trauma charge, who also appear on the trauma registry, who have at least a two day stay, no third-party insurance and have made payments of less than 10% of their charges. The physicians submit their information to the finance department with support for each uncompensated trauma case. The physicians are asked to send in the HICF with each case submitted. The reimbursement analyst then uses a United Fee schedule to assign a value to each case. Then the reimbursement director

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calculates a percentage for each physician based on the total uncompensated claims. The director assigns a value based on the percentage determined and the total allocated funding from the Commission. Once the amount has been determined the hospital will provide payment to the physician and/or physician group based on this methodology.

**11. MCG**

- A. Readiness:** MCG does not pay a stipend for on-call. The Readiness funding is distributed based on the following formula and criteria. Of the total amount received for Readiness funding, 75% goes to the adult and pediatric trauma services. This amount is then split 85% adult and 15% pediatric. The remaining 25% is split amongst the remaining qualifying physicians: emergency medicine, neurosurgery, orthopedics, plastics, OMFS, anesthesia and radiology. To determine how much of the 25% each service receives, the total number of “consults or encounters” is divided into the amount of funds available. The resulting amount then becomes the factor by which the consults are multiplied to determine the amount of funds received. To determine the number of consults, the registrar provides the Trauma Program Manager a list of all trauma activations and any consultations for trauma patients. The Trauma Program Manager reviews the list of trauma patients. A calculation is made and sent to Physicians Practice Group (PPG) as a recommendation and then funding is distributed to the physicians.
- B. Uncompensated Care:** The registrar prepares a report of all registry patients within the date range per the contract. (This list contains all trauma patients and has not been analyzed for uncompensated care criteria.) The report is sent to the Physician Practice Groups along with a listing of uncompensated care requirements. The PPG representative reviews all patients to determine which ones meet the uncompensated care criteria. (The representative has access to the billing system to verify any payments). The representative then sends the spreadsheet back to the Trauma Program Manager (the spreadsheet is organized by department and physician). The Trauma Program Manager prorates the total amount funded by the Commission for uncompensated care among the physicians. The Trauma Program Manager sends the spreadsheet (now including recommended allocations of payments for each physician) to the PPG representative. Included with the updated spreadsheet is the check for total payment. The money is deposited and the accounting department allocates the funds to the physician departments.

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**12. Memorial**

- A. Readiness:** The hospital is awarded a designated amount for “Readiness Services Program.” This amount is received through a grant and recorded in a separate fund. The total award is allocated to a system wide cost center revenue account to offset “readiness” related costs incurred by eligible departments. This includes “on call pay” for eligible physicians. Eligible departments are defined in the Commission contract.
- B. Uncompensated Care:** The finance department obtains a list of all patients in the trauma registry and compares the registry list to the billing system to determine that the patient meets the qualifications for uncompensated care as defined in the Commission contract. (The hospital scrubs the trauma registry list for all uncompensated care criteria prior to sending the list to the physicians). The hospital sends a letter to each physician along with the list of eligible patients. The letter outlines the criteria for uncompensated care, documentation required to be submitted, funding received from the State of Georgia and the timeline for submitting the requests. The physicians are responsible for providing statements for each of their registry patients showing that no compensation was received. The physicians submit their information to the Grant and Contract Account Manager. The Grant and Contract Account Manager’s team reviews the information to make sure each case qualifies. This includes verification that collection attempts have been made. The total amount funded by the Commission is allocated proportionately among the physicians. If a physician declines the money, then that portion is reallocated to the other physicians. Any excess is applied to the trauma fund.

**13. North Fulton**

- A. Readiness:** Readiness is paid to physicians who are on call. The hospital pays them per diem for any days on call—there are no minimum requirements. This per diem is a flat rate per day paid to whoever is on the contract (for example the physician group instead of the individual physician). The rate varies depending on specialty. Readiness is funded on the front-end, in the form of the per diem payments. Since the total amount paid for readiness far exceeds the amount funded by the Commission, no additional payments are made when the readiness portion is received by the hospital.
- B. Uncompensated Care:** At the end of each year, the hospital makes a list of trauma patients that did not pay for services. The Contract Specialist sends out the list of uncompensated care cases to the physician groups. The physician groups are asked to review their records and pull all of the paperwork showing that they treated the patient did not receive compensation and did attempt to collect. The doctors return the

## ATTACHMENT C

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documentation to the Contract Specialist who then reviews all of the support. (The physicians typically turn in numerous cases that do not qualify, so the Contract Specialist removes all of the unqualified cases.) The Contract Specialist then submits the list including supporting documentation for all of the qualified cases to Joy Scott. Joy calculates payments based on a Medicare fee schedule (if the uncompensated fund is adequate). If the total submitted exceeds the funds, the funds are allocated based on a percentage of physician claims to total claims submitted and approved. Once the calculations are complete, check requests are made and approved by the CFO. Once approved, the hospital's accounts payable function prepares the checks.

**14. Walton**

- A. Readiness:** Physicians are compensated for readiness based on “call pay.” An on call schedule is maintained for each month. Surgeons are required to be on call for 10 days. Anything over 10 days is compensated on a per day basis with a weekday rate (\$400) or a weekend/holiday rate (\$600). The controller prepares a spreadsheet and calculates the total “call pay” per physician. This is funded on the front end, in the form of the “call pay” payments the physicians receive. The total amount paid for “call pay” far exceeds the amount funded by the Commission.
- B. Uncompensated Care:** Physicians are compensated for uncompensated care based on “call pay”. An on call schedule is maintained for each month. Surgeons are required to be on call for 10 days. Anything over 10 days then becomes compensated for per day with a weekday rate (\$400) and a weekend/holiday rate (\$600). The controller prepares a spreadsheet and calculates the total “call pay” per physician. This is funded on the front end, in the form of the “call pay” payments the physicians receive, since the total amount paid for “call pay” far exceeds the amount funded by the Commission.

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**DOCUMENTATION OF PROCESSES FOR FUNDING  
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**OBSERVATIONS:**

We noted common themes as well as inconsistencies in our review of the processes documented above. The most common theme that we noted is the process of pre-funding physicians for the Readiness portion of the Commission's grant. We noted that twelve of the fourteen trauma centers use a similar process for pre-funding the physicians for the Readiness portion. This process consists of tracking "call pay" for all eligible physicians. The physicians are funded on the front end for Readiness in the form of their "call pay" and/or salary. The actual amount paid to the physicians in the form of their "call pay" and/or salary far exceeds the total amount awarded by the Commission. Therefore, the physicians do not receive a separate check for Readiness funding. Instead the trauma centers retain the funds awarded by the Commission and use these funds to offset the costs of the "call pay" previously paid. The remaining two trauma centers (Archbold and MCG) do not pay their physicians a separate stipend or call pay; therefore, those locations do not follow the common practice noted above.

We also noted in our review that there is a common process of funding physicians with uncompensated care funding. We noted that five out of fourteen trauma centers follow the process described below:

A list of all trauma patients is prepared. This list includes all trauma patients for the period of the Commission contract. The list has not been analyzed for uncompensated care criteria. The trauma patient list is stratified by physician and sent to the physician/physician office with a letter describing the process for submitting claims. The letter includes the definition/criteria for uncompensated care as described in the Commission contract. The trauma centers use the criteria set forth in the Commission contract, which they understand to be derived from Senate Bill 60. The physicians are required to submit documentation to support the definition of uncompensated care for each case to be submitted for funding. The trauma centers receive the documentation and review the support to make sure that the case meets the definition of uncompensated care. Once all claims are submitted the trauma center (typically the finance/accounting department) determines the amounts to distribute to each physician based on a percentage of the total physician charges and the total amount funded by the Commission.

One variation that we noted from the above process was identified in five of the other trauma centers. This variation is that the list of patients sent to each physician was analyzed for uncompensated care criteria by the trauma center before the list was sent to the physicians.

Of the remaining four trauma centers that we reviewed, the physicians at two of the trauma center locations opted out of receiving the uncompensated care funding. Instead the physicians sign a waiver stating that they wanted the uncompensated care funds to go to CME (Continuing Medical Education). The physicians believe that the cost of paying an assistant to go through all

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the paperwork is not worth the compensation that they received, so all of the funds are directed to offset the costs of CME.

The remaining two locations, Columbus and Walton, each use a different process than any of the processes described above. Columbus compensates physician/physician groups for the entire amount of the physician submitted uncompensated care claims using the Medicaid allowable rate regardless of the amount funded by the Commission. Columbus records the funding that is received from the Commission in a revenue account and costs are offset against the funding. Walton compensates physicians based on a call pay schedule. Physicians are funded on the front end in the form of the call pay payments the physicians receive, since the total amount paid for call pay far exceeds the amount funded by the Commission.

**RECOMMENDATIONS:**

We recommend that the trauma centers continue the processes in place to fund the physicians with the Readiness portion of funding. Twelve of the fourteen trauma centers use a similar process. The two trauma centers that do not follow the common process have developed another process that is appropriate for their location.

We recommend that the trauma centers standardize the process of funding the physicians with their portion of uncompensated care funding. Although we noted a common theme in this process, we also noted that about half of the trauma centers analyze the list of trauma patients for uncompensated care criteria using the criteria outlined in the Commission contract. This process seems to be the best practice currently followed by any of the trauma centers. The other half of the trauma centers, who also prepare a list, do not analyze the list using the criteria outlined in the Commission contract, which is taken from Senate Bill 60. These trauma centers send the entire list of that physician's trauma patients to the physician. Based on our understanding gained during our inquiry, we recommend the following:

Therefore, we recommend that the trauma centers analyze the list of trauma patients before sending the list to the individual physicians using the following criteria (as outlined in the Commission contract, which is taken from Senate Bill 60):

- The EBR shows the patient had no medical insurance, including Medicare Part B coverage
- The EBR shows the patient was not eligible for medical assistance coverage
- The EBR shows that the patient had no medical coverage for trauma care through workers' compensation, automobile insurance, or any other third party, including any settlement or judgment resulting from such coverage
- The EBR shows that there were no third party payments received

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These criteria are the specific criteria that, if noted in the hospital records, would disqualify the patient from being eligible for funding as an uncompensated care claim.

The additional test that must be satisfied to meet the criteria for consideration as an uncompensated care claim is:

- The EBR shows that the patient has not paid more than 10% of total charges after documented attempts by the trauma care services provider to collect payments.

Since the result of this test could be different for the trauma center versus the physician's office, it should be reviewed and verified by the physicians/physician offices for each claim included in the list that the trauma center provides.

**ATTACHMENT D****DOCUMENTATION OF PROCESSES FOR EMS SERVICE CLAIMS  
FOR UNCOMPENSATED CARE**

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**SUMMARY:**

Of the 44 EMS services receiving funding from the FY 2010 EMS Uncompensated Care Program (CY 2008 claims), we selected 20 EMS service companies to contact, interview and document the process for uncompensated care claim data preparation. (See Attachment D-1 for locations selected for interview.) Below is a summary of the information we obtained from each service center selected. We have also listed our recommendations below the summarized data.

1. We asked each EMS service company what billing and collection system does their company use. We identified that 7 of the 20 EMS companies that we contacted use EMS Consultants. The remaining 13 EMS companies use various other billing and collection systems/software. We noted that all of the EMS locations that we contacted perform their own billing and collection services in house. We noted one service provider that handles all billing and collections efforts through their corporate office located out of state.
2. All 20 of the EMS services that we contacted indicated a similar process was followed for determining an uncompensated care case. The EMS contacts that we interviewed indicated that someone from their staff reviews the criteria required by the Commission and compares the criteria to each trauma case. The following criteria were stated as meeting the uncompensated care definition: patients with no insurance, no Medicare, no Medicaid, and no auto insurance, have been billed repeatedly and have not received any payments or, payments received are less than 10% of total charges. The persons that we contacted did not give specific reference to using Senate Bill 60 but did say that they follow the criteria set forth by the Commission.
3. Nineteen of the 20 EMS services indicated that they do not determine trauma eligibility. This information is provided by the hospitals that the EMS locations serve.

One EMS location stated that the billing director compares the transportation log to the local trauma center records and checks each transport to that trauma center to determine if the transport was trauma related. If so, the billing director reviews the case to determine if it fits the requirements for an eligible trauma case.

4. All 20 of the EMS services that we contacted indicated a similar process of gathering and submitting claims to the Commission. The list of trauma cases is reviewed and compared to the billing system to verify no insurance, no payments on accounts or less than 10% of total charges were received, re-verified that there was a check for insurance including Medicaid, and verified that statements were sent to the patient. Then all eligible uncompensated care cases were included in a spreadsheet template that the Commission provided and were submitted electronically.



**ATTACHMENT D**

**DOCUMENTATION OF PROCESSES FOR EMS SERVICE CLAIMS  
FOR UNCOMPENSATED CARE**

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5. We noted the following information regarding the preparer and the reviewer of the list prior to its submission to the Commission:

	<b>Preparer – Title</b>	<b>Reviewer – Title</b>
1	Office Manager	The preparer
2	Billing EMT	The preparer
3	Billing Director	The preparer
4	3 <sup>rd</sup> Party Billing Company	EMS Director
5	Business Operations Coordinator	Financial Operations Manager
6	EMS Director	The preparer
7	Billing Clerk	EMS Director
8	Billing Manager and Assistant	Billing Manager
9	Assistant of the Assistant Director of the Central Billing Office	Assistant Director of the Central Billing Office
10	Executive Assistant for Billing Service	CEO, COO and President
11	Program Analyst	The preparer
12	Administrator	The preparer
13	COO and Vice President of Billing	COO
14	Coding Specialist	The preparer
15	EMS Director	Administrative Supervisor
16	Billing Clerk	The preparer
17	Director of Clinic Services	Market General Manager
18	Projects Coordinator	Billing Supervisor
19	Billing Clerk	EMS Director
20	COO and Vice President of Billing	COO

6. We noted that the majority of the EMS locations that we contacted have similar collections policies. Patients are billed three to four times over a time period that is set by the individual EMS companies. This time period ranged from 90-120 days. After this process is completed and no payments are received, the account is either written off or sent to a collection agency. There were two EMS locations that did not have specific collection policies.
7. Eight of the 20 EMS locations that we contacted indicated that there have been no additional collections on the FY 2010 submitted claims. Nine of the 20 EMS locations were unable to give an exact number due to various computer issues including password protected files, no access to database with that information, or unable to find the information. Two locations indicated that they received a payment for one of the submitted claims after the claim was

**ATTACHMENT D****DOCUMENTATION OF PROCESSES FOR EMS SERVICE CLAIMS  
FOR UNCOMPENSATED CARE**

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submitted. One location indicated that 17 claims received payments after the uncompensated care claims were submitted.

**OBSERVATIONS:**

Through our interviews with the noted EMS service companies we were able to gain an understanding of the general process that the EMS service companies go through in accumulating and submitting their claims for uncompensated care funding. We noted the following general process.

The EMS service companies receive a listing of trauma patients from the trauma centers that they service. This list of trauma patients is used as a starting point to further determine which cases qualify for uncompensated care claims. Someone at the EMS company, usually a billing clerk, reviews the trauma listing and identifies the cases on that list that meet the criteria set forth by the Commission for uncompensated care claim. We noted that some locations required a second person to review the list to make sure that the list was accurate, but not all locations required a second review. All eligible uncompensated care claims are included on a spreadsheet template that the Commission provides and are submitted electronically to the Commission representative. We also noted in our inquiry, that the locations follow the guidelines set forth by the Commission in their contract but the contacts were not specifically familiar with Senate Bill 60.

Although we noted a general process as outlined above, we also noted that one location followed a slightly different approach. This location did not obtain the trauma listing from the trauma center. Instead, this location stated that the billing director reviews the transportation log comparing it to the local trauma center records and checks each transport to that trauma center to determine if the transport was trauma related. If so, the billing director reviews the case to determine if it fits the requirements for an eligible trauma case.

**RECOMMENDATIONS:**

We recommend that the EMS service companies standardize the process of submitting claims for uncompensated care funding. The general process that we noted above is an appropriate standardized process. However, since we did identify a location that varied from this process there may be other locations that vary from this process that were not in our sample. We suggest that all EMS service companies follow the same process of receiving their initial registry list from the trauma centers that they serve. This will create efficiencies for the EMS service companies. By starting with an eligible trauma patient list (identified by the trauma center using

**ATTACHMENT D****DOCUMENTATION OF PROCESSES FOR EMS SERVICE CLAIMS  
FOR UNCOMPENSATED CARE**

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the guidelines set forth by the Commission in their contract, which is taken from Senate Bill 60), the EMS service companies can eliminate time spent trying to determine trauma eligibility.

We also noted that some EMS service companies do not have a written or standard collections policy. We recommend that all EMS service companies have a written policy and follow that policy so that each case is handled in a consistent manner.

We also noted that 8 of the 20 EMS service companies that we contacted do not have a second review of the uncompensated care claims list. It is a best practice to have a second review of the list prior to its submission to the Commission to ensure the list is correct and free of errors. We recommend that all locations consider implementing a second review before the list is submitted to the Commission.

## ATTACHMENT D-1

## EMS SERVICE CLAIMS BY LOCATION AND SAMPLE

<u>Service Name</u>	<u>Total Charges</u>	<u>Total Amount Received</u>	<u>No of Claims</u>
Green Co EMS	\$457.53	\$233.79	1
Toombs Co EMS	\$1,176.00	\$600.91	1
Vital Care	\$1,576.00	\$805.31	3
North East GA medical transport	\$1,895.00	\$968.31	3
* Pickens Co EMS	\$1,897.50	\$969.59	3
Brantley County EMS	\$2,267.00	\$1,158.39	4
Regional EMS	\$2,935.00	\$1,499.73	3
Gordon EMS	\$3,996.00	\$2,041.88	5
* Warren County EMS	\$4,049.71	\$2,069.32	5
Jasper Co EMS	\$4,559.00	\$2,329.56	6
Ben Hill EMS	\$4,624.00	\$2,362.77	4
* Forrest Park Fire and EMS	\$6,066.29	\$3,099.76	13
Upson EMS	\$6,851.00	\$3,500.73	6
* Grady Co EMS	\$6,876.24	\$3,513.62	14
Metro Atlanta EMS	\$7,237.00	\$3,697.97	10
* Ambucare	\$8,135.75	\$4,157.21	7
Murray Medical Center	\$8,321.60	\$4,252.17	10
* Jeff Davis EMS	\$8,541.75	\$4,364.67	7
Coweta EMS	\$8,677.97	\$4,434.27	13
* Thomas County EMS	\$9,020.00	\$4,609.04	20
Mitchell County EMS	\$9,086.50	\$4,643.02	13
National EMS	\$9,381.25	\$4,793.63	14
* Monroe Co EMS	\$10,120.00	\$5,171.12	19
Effingham Co EMS	\$10,786.50	\$5,511.69	17
* Mercy/Southside	\$11,294.46	\$5,771.25	19
Laurens Co EMS	\$11,349.50	\$5,799.37	12
* Douglas Co EMS	\$11,734.00	\$5,995.84	27
Emanuel Medical Center EMS	\$12,645.50	\$6,461.60	14
Henry Fire Dpt	\$16,554.00	\$8,458.77	29
Crisp County EMS	\$18,462.00	\$9,433.72	12
Floyd EMS	\$21,136.00	\$10,800.08	27
Puckett EMS	\$27,054.00	\$13,824.06	34
Wilkes Co EMS	\$27,246.00	\$13,922.17	25
* Burke County EMS	\$28,556.78	\$14,591.96	53
Houston County EMS	\$37,420.00	\$19,120.89	49
* Heartland EMS	\$41,276.47	\$21,091.47	28
* Med Star EMS	\$41,306.00	\$21,106.56	66
* Mid GA Ambulance	\$113,881.00	\$58,190.96	110
* Rural Metro Ambulance	\$117,971.00	\$60,280.87	143
* MCCG EMS	\$134,337.00	\$68,643.58	139
* Gwinette Co Fire and EMS	\$136,951.45	\$69,979.51	223
* Gold Cross EMS	\$148,547.08	\$75,904.65	500
* Children's Transport	\$239,388.50	\$122,322.83	66
* Grady Health System	\$621,376.85	\$317,511.40	520

\* Indicates EMS center selected for interview

**CONCLUSION:**

We appreciate the opportunity to be of service to you. This report summarizes the results of our engagement. If you have any questions, please let us know.

Very truly yours,

A handwritten signature in black ink, written in a cursive style, that reads "Gifford, Hillegass & Ingwersen, LLP".

GIFFORD, HILLEGASS & INGWERSEN, LLP