Fiscal Year 2017
Designated Trauma Facility & Emergency Medical Services Account, Hospital Allocation

Uncompensated Trauma Care Application
DUE FEBRUARY 28, 2017

Eligibility Provisions

- **A DSHS-designated trauma facility** in receipt of funding from the Designated Trauma Facility and Emergency Medical Services Account, Hospital Allocation that fails to maintain its designation must return an amount as follows to the account by no later than **90 days** after noncompliance is determined:

  (i). 1 to 60 days expired/suspended designation: 0% of the facility's Hospital Allocation for the state biennium when the expiration/suspension occurred
  (ii). 61 to 180 days expired/suspended designation: 25% of the facility's Hospital Allocation for the state biennium when the expiration/suspension occurred plus a penalty of 10%;
  (iii). greater than 180 days expired/suspended designation: 100% of the facility's Hospital Allocation for the state biennium when the expiration/suspension occurred plus a penalty of 10%

- **An undesignated facility who met "in active pursuit of designation"** requirements and does not achieve DSHS -trauma designation on or before the second anniversary of the date the facility came into compliance with these requirements, must return to DSHS any funds received from the account, plus a penalty of 10% by no later than 90 days after noncompliance is determined.

- Prior to receiving any future disbursements from the Designated Trauma Facility and Emergency Medical Services Account, Hospital Allocation a facility must have paid in full all outstanding balances owed to the Department.

APPLICATION INFORMATION
PARTS A, B, & C
Application must be received by email on or before February 28, 2017 to:
FundingApp@dshs.state.tx.us

PART A – APPLICATION (Page 4)
Detailed completion instructions are on Pages 2 – 3.

PART B – AFFIDAVIT (Page 5)
This form must be completed by all individuals listed to be eligible for funding. Completed form must be scanned and attached as a PDF file along with the application upon completion.

PART C – SUPPORTING DATA SUBMISSION
Submit via email detailed data for patient accounts and claims on items 14 and 15 from Part A – Application (see Inclusion Criteria and Guidance to complete the form on Page 6). *The facility charges (item 14) and patient accounts (item 15) on Part A – Application **must** match the information submitted in Part C – Supporting Data Submission.*

All parts (Parts A, B, and C) of the application must be emailed as a single submission to: FundingApp@dshs.state.tx.us.
The file name(s) submitted must include the name of the facility for identification purposes (Example: Subject line – Happy Days Hospital).

Confirmation of receipt will be sent within 24 – 48 hours. Please note confirmation receipt does not imply the submission has been reviewed. If you have not received a confirmation email within 24-48 hours, you may contact Indra Hernandez at the Office of EMS/Trauma Systems Coordination for further instructions by phone: (512) 834-6669 or by email: indra.hernandez@dshs.state.tx.us.

Fiscal Year 2017
Designated Trauma Facility & Emergency Medical Services Account, Hospital Allocation
Uncompensated Trauma Care Application
DUE FEBRUARY 28, 2017

INSTRUCTIONS FOR COMPLETING THE APPLICATION

Hospitals under common ownership must apply individually. Questions 1-16 and the affidavit must be completed fully and submitted.

Item 1: Enter the business name of the hospital—not the name of the organization that owns the hospital.

Item 2: A unique number assigned by the Texas Department of State Health Services to identify licensed hospitals in the state of Texas. Please refer to the following link if you are unable to locate your hospital's license number. **http://www.dshs.state.tx.us/HFP/apps.shtm#directoryhosp**

Items 3-4: Enter the hospital's mailing address, city, state, and zip code.

Item 5-6: Enter the name, title and phone number for the contact person who can verify questions #14-16 on this application.

Item 7: The TPI number is a nine-digit number that uniquely identifies a Texas Medicaid billing provider.

Item 8: A federal tax identification number is a nine-digit number also know as an Employer Identification Number (EIN), and is used to identify a business entity or nonprofit organization. The EIN is issued by the Internal Revenue Service.

Item 9: Eligibility to apply for this funding requires the hospital to be a state designated trauma facility or meet #10.

Item 10: If not a currently designated trauma facility, to be eligible the facility has received a letter from the department indicating that it is "in active pursuit of trauma designation" and has met the following requirements prior to the application due date: Submitted to the department a "letter of intent" to trauma designate and a timely and sufficient complete application (with fee) to the department's trauma facility designation program or appropriate agency for trauma verification; evidence of participation in your Trauma Services Area (TSA) Regional Advisory Council (RAC) initiatives; evidence of a hospital trauma performance improvement committee; and submitted data to the department's EMS/Trauma Registry.

Item 11: Total number of patients entered in to the facility's Trauma Registry by your facility for calendar year 2015. Please consult your Trauma Nurse Coordinator/Trauma Program Manager for this information.

Item 12: Total number of times the trauma team was activated in the facility for calendar year 2015. Please consult your Trauma Nurse Coordinator/Trauma Program Manager for this information.

Item 13: Total number of all patients evaluated in and discharged from your emergency department for calendar year 2015.

Item 14: Uncompensated Trauma Care Charges (for **discharges** occurring in **calendar year 2015**),

Trauma care – Care provided to patients who (each checkbox below must be checked to include as eligible patient):

- ☐ met the facility's trauma team activation criteria and/or were entered into the facility's Trauma Registry,
  AND
- ☐ underwent treatment specified in at least one of the following ICD-9 (International Classification of Diseases, 9th Revision, of the National Center of Health Statistics) codes:
  - between 800.00 and 959.9;
  - including 940-949 (burns),
  - **excluding** 905-909 (late effects of injuries), 910-924 (blisters, contusions, abrasions, and insect bites), 930 – 939 (foreign bodies),

  AND
- ☐ MEETS at least one of the following criteria:
  - were transferred into or out of the hospital.
  - underwent an operative intervention (See definition below);
  - were admitted as an inpatient for greater than 23-hours;
  - died after receiving any emergency department evaluation or treatment; or
  - were dead on arrival to the facility
  - leaves hospital against the advice of the doctor (AMA)

Operative intervention-- Any surgical procedure resulting from a patient being taken **directly from the emergency department** to an operating suite regardless of whether the patient was admitted to the hospital.

Fiscal Year 2017
Designated Trauma Facility & Emergency Medical Services Account, Hospital Allocation
Uncompensated Trauma Care Application
DUE FEBRUARY 28, 2017

Uncompensated trauma care-- The sum of "bad debt" and "charity care" resulting from **trauma care** after due diligence to collect. Contractual adjustments in reimbursement for trauma services based upon an agreement with a payor (to include but not limited to Medicaid, Medicare, Children's Health Insurance Program (CHIP), Crime Victims Account, etc.) are not uncompensated trauma care.

1. **Bad debt**-- The unreimbursed cost to a hospital of providing health care services on an inpatient or emergency department basis to a person who is financially unable to pay, in whole or in part, for the services rendered and whose account has been classified as bad debt based upon the hospital's bad debt policy. A hospital's bad debt policy should be in accordance with generally accepted accounting principles.

2. **Charity care**-- The unreimbursed cost to a hospital of providing health care services on an inpatient or emergency department basis to a person classified by the hospital as "financially indigent" or "medically indigent".

    - **Financially indigent**-- An uninsured or underinsured person who is accepted for care with no obligation or a discounted obligation to pay for the services rendered based on the hospital's eligibility system.

    - **Medically indigent**-- A person whose medical or hospital bills after payment by third-party payors (to include but not limited to Medicaid, Medicare, CHIP, etc.) exceed a specified percentage of the patient's annual gross income, determined in accordance with the hospital's eligibility system, and the person is financially unable to pay the remaining bill.

Item 15: The total number of accounts that were defined as uncompensated trauma care and used to calculate the facility's total uncompensated trauma care charges listed in Item 14 (note, there has been a lot of confusion on this question so for clarification here's an example – 200 patient accounts are in the facility's trauma registry, 52 of them are uncompensated trauma care accounts and it is those 52 accounts that were totaled to answer #14 – we want the answer of "52" in item 15).

Item 16: Total collections received on uncompensated patient accounts submitted in previous Uncompensated Trauma Care Applications from 2005 to 2016 AND not previously reported as collected.

NOTE:

DSHS will determine the facility's uncompensated trauma care costs by utilizing the cost-to-charge ratio provided by the Texas Health and Human Services Commission's Medicaid Office.

Cost-to-charge ratio – A Hospital's overall cost-to-charge ratio determined by the Texas Health and Human Services Commission from the hospital's Medicaid cost report. The hospital's latest available cost-to-charge ratio shall be used to calculate its uncompensated trauma care costs.

If a facility does not have a Medicaid cost-to-charge ratio determined by the Texas Health and Human Services Commission from the hospital's Medicaid cost report, the facility's cost-to-charge ratio will be derived from an average of the cost-to-charge ratios provided by qualified hospitals that year.

Please refer to Chapter 780 of the Texas Health and Safety Code for the statute that authorizes the Designated Trauma Facility & Emergency Medical Services Account.

Please refer to the Texas Administrative Code Title 25, Part 1, Chapter 157. Section 157.131 for the rule that outlines the Designated Trauma Facility & Emergency Medical Services Account, Hospital Allocation. Rule 157.131 can be accessed at http://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=25&pt=1&ch=157&rl=131

Fiscal Year 2017
Designated Trauma Facility & Emergency Medical Services Account, Hospital Allocation

Uncompensated Trauma Care Application
DUE FEBRUARY 28, 2017

PART A – APPLICATION

For assistance with any part of this application, please contact Indra Hernandez (512)834-6669 or indra.hernandez@dshs.state.tx.us)

Facility and Trauma Patient Information: ……..……..

(1) Hospital Name _____ (2) Hospital License Number _____

(3) Mailing Address _____ (4) City/State/Zip: _____

(5) Contact Name/Title_____ (6) Phone # _____

(7) Texas Provider Identifier # (TPI) _____ (8) Federal Tax ID# _____

(9) Hospital is currently a Designated Trauma Facility?	Yes ____No ____ Level ____
(10) If not currently designated, hospital has met "in active pursuit of designation" requirements before this application's due date?	Yes ____No ____ N/A ____

(11) Number of patients entered into the facility's Trauma Registry from January 1, 2015 thru December 31, 2015: _____

(12) Number of trauma team activations at your facility from January 1, 2015 thru December 31, 2015: _____

(13) Total number of all patients evaluated in your emergency department from January 1, 2015 thru December 31, 2015: _____

Financial Information:…… …

*__Please read carefully the instructions on pages 2 and 3 before completing Items 14, 15 & 16.__

Use patient discharges from January 1, 2015 thru December 31, 2015 to complete this section*

(14) **Facility's Charges*** for uncompensated trauma care: $ _____
(sum of uncompensated trauma care classified as charity care or bad debt according to the Hospital's policy)

(15) Number of patient accounts* used to calculate the facility's uncompensated trauma care charges in Item 14: _____

(16) Collections* received on uncompensated patient accounts submitted in previous Uncompensated Trauma Care Applications AND not previously reported as collected: $ _____

Fiscal Year 2017
Designated Trauma Facility & Emergency Medical Services Account, Hospital Allocation

Uncompensated Trauma Care Application
DUE FEBRUARY 28, 2017

PART B – AFFIDAVIT

(NOTE: This form must be completed with required signatures individually notarized to be eligible for funding)

I, _____, **Chief Executive Officer** for the hospital named above, swear or affirm that the information contained in this application is true and correct. I also swear or affirm that I have fully read and understand the stipulations listed on page 2 of this application.

REQUIRED: Subscribed and sworn before me, a Notary Public, on the _____ day of _____, 201___.

_____, Notary Public, County _____

State of _____ My Commission expires _____

Chief Executive Officer: _____ _____
Name (printed or typed) Signature

.....

I, _____, **Chairman of the Board of Directors** for the hospital named above, swear or affirm that the information contained in this application is true and correct. I also swear or affirm that I have fully read and understand the stipulations listed on page 2 of this application.

REQUIRED: Subscribed and sworn before me, a Notary Public, on the _____ day of _____, 201___.

_____, Notary Public, County _____

State of _____ My Commission expires _____

Chairman of the Board of Directors: _____ _____
Name (printed or typed) Signature

.....

I, _____, **Chief Financial Officer** for the hospital named above, swear or affirm that the information contained in this application is true and correct. I also swear or affirm that I have fully read and understand the stipulations listed on page 2 of this application.

REQUIRED: Subscribed and sworn before me, a Notary Public, on the _____ day of _____, 201___.

_____, Notary Public, County _____

State of _____ My Commission expires _____

Chief Financial Officer: _____ _____
Name (printed or typed) Signature

.....

I, _____, **Trauma Medical Director** for the hospital named above, acknowledge that a copy of this application was made available for my review.

Trauma Medical Director: _____ _____
Name (printed or typed) Signature

.....

I, _____, **Trauma Nurse Coordinator/Trauma Program Manager** for the hospital named above, acknowledge that a copy of this application was made available for my review prior to submission.

Trauma Nurse Coordinator/Trauma Program Manager:_____ _____
Name (printed or typed) Signature

Source: Office of EMS/Trauma Systems Coordination
UPDATED-November 2016

Fiscal Year 2017
Designated Trauma Facility & Emergency Medical Services Account, Hospital Allocation

Uncompensated Trauma Care Application
DUE FEBRUARY 28, 2017

PART C – SUPPORTING DATA SUBMISSION

Uncompensated Trauma Care Charges (for **discharges** occurring in **calendar year 2015**),

INCLUSION CRITERIA:

Trauma care – Care provided to patients who (each checkbox below must be checked to include as eligible patient):

- ☐ met the facility's trauma team activation criteria and/or were entered into the facility's Trauma Registry,

AND

- ☐ underwent treatment specified in at least one of the following ICD-9 (International Classification of Diseases, 9th Revision, of the National Center of Health Statistics) codes:
  - between 800.00 and 959.9;
  - including 940-949 (burns),
  - **excluding** 905-909 (late effects of injuries), 910-924 (blisters, contusions, abrasions, and insect bites), 930 – 939 (foreign bodies),

AND

- ☐ MEETS at least one of the following criteria:
  - were transferred into or out of the hospital.
  - underwent an operative intervention (See definition below);
  - were admitted as an inpatient for greater than 23-hours;
  - died after receiving any emergency department evaluation or treatment; or
  - were dead on arrival to the facility
  - leaves hospital against the advice of the doctor (AMA)

Operative intervention-- Any surgical procedure resulting from a patient being taken **directly from the emergency department** to an operating suite regardless of whether the patient was admitted to the hospital.

Guidance for completing form:
(Do not use medical records or Social Security Numbers in submission)

For Trauma Services (columns in blue)

- **Unique Patient Identifier: (determined by facility)**
- **Pt in Trauma Registry: (Yes or No)**
- **Meets Facility Trauma Team Activation Criteria: (Yes or No, E.g. Alert, Consult, Activation, Met but not activated)**
- **TRAUMA ICD-9 codes (Provide only codes that meet inclusion criteria)**
- **Transferred in or out: (Yes or No)**
- **Disposition from Emergency Department: (E.g. Admitted, ED to OR, Death, AMA, Transfer)**
- **Admitted: (Yes or No)**
- **Admit Date: (Month / Date / Year)**
- **Admit Time: (Military Time preferred)**
- **Discharge Date: (Month / Date / Year)**
- **Discharge Time: (Military Time preferred)**

For Finance (columns in green)

- **Uncomp charges (amount claimed in line 14 of the Application): (the sum total of the spreadsheet must be consistent with Item 14 of the application above).**
- **Original Amount Billed to Patient: (the total amount before payment made by third-party payors (Medicaid, Medicare, CHIP, etc.) OR total amount before applying calculated charitable dollar amounts)**

Fiscal Year 2017
Designated Trauma Facility & Emergency Medical Services Account, Hospital Allocation

Uncompensated Trauma Care Application
DUE FEBRUARY 28, 2017

***This form is available to download on the DSHS OEMS/TS website: FY17 Addendum Data Template (Excel, 51KB)**

PART C – SUPPORTING DATA SUBMISSION
UNCOMPENSATED TRAUMA CARE APPLICATION

HOSPITAL NAME

(LEVEL), CITY, TEXAS

ICD-9 800-959.9 excluding 905-909 and 910-924 and 930-939 are BOLDED

TRAUMA SERVICES											*FINANCE*	
Unique Patient Identifier	Pt in Trauma Registry? (Y or N)	Meets Facility Trauma Team Activation Criteria (Y or N)	TRAUMA ICD-9 codes	Transferred in or out? (Y or N)	Disposition from Emergency Department	Admitted? (Y or N)	Admit Date (MM/DD/YYYY)	Admit Time	Discharge Date (MM/DD/YYYY)	Discharge Time	Uncomp charges (amount claimed in line 14 of the Application)	Original Amount Billed to Patient
2	Y	Y	**886.0, 816.11**	Y							$10,000.00	$10000
3	Y	Y	**812.40**	Y							$10,000.00	$150,000
4	Y	Y	**881.00, 946.3**	N	Admitted	Y	6/20/2015	17:20	6/21/2015	17:55	$5,000.00	$5000
5	Y	Y	**854.06**	N	DOA	N	N/A	N/A	2/17/2015	15:42	$5,000.00	$15,000

Source: Office of EMS/Trauma Systems Coordination
UPDATED-November 2016