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14. ABSTRACT The purpose of this grant was to demonstrate the feasibility of a Trauma Institute and Burn Center with missions in patient care, research, and education. Goals met: a burn surgeon/director was recruited to improve sustainability of BAMC Burn Center; TRISAT members have studied how combining resources will generate greater financial sustainability; a national trauma consultant reviewed the financial/economic status of each program and presented recommendations; an independent legal firm reviewed issues related to military and civilian doctors providing services across hospital lines and submitted recommendations; Surgical/Anesthesia Critical care fellowship program curriculum and rotation schedules have been integrated; patient databases and a regional trauma registry have been developed allowing use of regional data for research, both military and civilian; trauma and burn surgeons have submitted protocols for joint research and have conducted multi-site clinical research; the TRISAT Foundation has been incorporated in Texas. Goals include: improved survival rates of military and civilian casualties, increased innovation in combat casualty care, improved educational experience for surgical/critical care trainees, improved pre-hospital evaluation and resuscitation, and improved mass casualty/disaster response capabilities.					
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INTRODUCTION

The University of Texas Health Science Center at San Antonio (UTHSC) proposed to utilize \$1.814M in congressional funding to work collaboratively with Brooke Army Medical Center (BAMC) and the US Army Institute of Surgical Research, Wilford Hall Medical Center (WHMC) and University Hospital (UH). The awarded grant enabled these partners to create the Trauma Institute of San Antonio, Texas (TRISAT), to conduct a financial and legal feasibility study and to demonstrate the capabilities of this joint military/civilian Trauma Institute with a Burn Center. Level I trauma and burn care by TRISAT members cover Bexar County and State Trauma Service Area "P" (a 22 county region covering over 26,000 square miles) and beyond. The original Statement of Work described goals in the areas of patient care, research, and education, and specifically cited the need to secure and sustain the BAMC Burn Center. Before OIF/OEF TRISAT hospitals cared for 8,000 trauma admissions a year, military and civilian, making this the largest trauma program in the US. When the grant was awarded, the resulting numbers of casualties from the global war on terrorism were not yet known. The combat casualty care training that military physicians, nurses, and others receive by caring for civilian trauma patients is critical to their training and ability to care for soldiers, sailors, airmen and marines wounded in the battlefield. Our proposal centered upon the historical strength of the burn center (US Army Institute of Surgical Research) at BAMC which is considered to be an important foundation for the TRISAT's future. Funding from the Department of the Army was not considered to be sufficient to keep the burn center operational in its pre-war capacity; without this funding, the future of burn care for the military and civilian population in Bexar County and South Texas was threatened. Without a strong burn center, the army's commitment to burn care and research related to combat casualty care was also threatened. The collaborative nature of TRISAT permits all partners to take advantage of their individual strengths in the areas of patient care, research and teaching and creates a joint operation that is thought to have stronger sustainability to ensure that Bexar County, South Texas and our nation's armed forces have access to much needed trauma and burn care services. TRISAT is also improving the ability of UTHSC, BAMC and WHMC to provide stronger educational programs, thus enhancing mission readiness. Information gained and practices established from this review and feasibility study have benefited the larger endeavor of securing permanent comprehensive trauma services for Bexar County and South Texas through the collaborative efforts of UHS, UT, BAMC and WHMC.

Body:

The Statement of Work includes these tasks which are addressed in detail in this section:

1. Financial/economic review of current Level 1 trauma centers, the BAMC Burn Center, and trauma surgeon groups, military and civilian.
2. Legal review of issues, obstacles, and implications for military and civilian business with Medicare, Medicaid, and third party insurance companies
3. Market analysis of San Antonio and South Texas to assess impact of population/demographic projections, based on both civilian and military populations
4. Business Plan to move forward with approved recommendations based on the above
5. Management of trauma surgeon resources
6. Other opportunities for collaboration

In order to address these tasks, members formed a Board of Directors and Command Council, with a set of written Organizational Principles for management and governance of TRISAT. Support staff includes the Project Coordinator, Academic Coordinator and Research Assistant.

Financial/Economic Review

The TRISAT Board of Directors contracted with Bishop + Associates, a nationally recognized consultant specializing in trauma programs, to complete a financial and legal review of the current status of each trauma program, burn center, and trauma surgeon group or practice. The TRISAT Board accepted the report and recommendations of the consultants. The scope of the project included estimating incremental reimbursement and recommended operational enhancements to billing activities by civilian and military physicians and hospitals. The Executive Summary is appended to this report and states that hospital and physician trauma and burn charges are sub-optimal, as shown in the table below.

Recommendations pertaining to military physician billing for care provided to civilian trauma patients cannot yet be implemented due to regulatory constraints placed on military Medical Treatment Facilities. These regulations currently prohibit BAMC and WHMC ability to bill insurance programs and patients for specific physician services. Until such time as these constraints are removed, BAMC and WHMC cannot attain physician billing and revenue targets.

TRISAT staff has completed a project describing the necessary processes for physician billing by military treatment facilities that may be implemented following changes in regulations currently preventing this activity. When these changes occur, TRISAT members will be able to fully pursue financial goals, which would result in incremental clinical income from physician services of over \$6 million a year.

CURRENT & OPTIMAL TRAUMA AND BURN REIMBURSEMENT

	Current \$	Optimal \$	Change \$
Hospital			
UHS	22,229,214	28,925,788	6,696,574
BAMC	6,347,148	13,279,655	6,932,507
BAMC Burn	4,450,293	7,112,023	2,661,730
WHMC	6,962,489	11,286,075	4,323,586
Total	39,989,144	60,603,541	20,614,397
Physician			
UPG	1,962,893	3,881,469	1,918,576
BAMC	-	1,746,990	1,746,990
BAMC Burn	-	576,000	576,000
WHMC	-	2,270,979	2,270,979
Total	1,962,893	8,475,438	6,512,545
Trauma/ Burn Totals	41,952,037	69,078,979	27,126,942

Legal Review

TRISAT contracted with the Washington, D. C.-based legal firm of McDermott, Will & Emery to conduct a review of current federal and state laws and regulations specific to military and civilian billing/collection relationships with Medicare, Texas Medicaid, and third party commercial insurers. The review was completed and is specific to allowable practices and obstacles to be addressed. The Executive Summary of this report is appended. Key recommendations (Possible Action Items) address these questions:

- A. Can a civilian physician bill for trauma care provided at a military treatment facility?
- B. Can the military bill for trauma care provided to civilians?
- C. Can a military physician bill for trauma care at a trauma facility?

The review also explored physician licensure and malpractice issues related to the same questions.

Resident/Fellow Education

TRISAT members integrated the curriculum and clinical rotation schedules of Surgical and Anesthesia Critical Care Fellows under the guidance of the Program Directors and the TRISAT Critical Care Education Consortium. Currently the program includes four (4) Surgical Critical Care fellows.

TRISAT members share responsibility for two (2) lectures per week, over 90 per year, delivered by video teleconference at all three sites to faculty, fellows, residents and students. Lectures are prepared and given by faculty and fellows. Those identified as core curriculum are recorded and stored on the TRISAT website.

A reading compendium covering the required curriculum for surgical and anesthesia critical care fellows has been compiled and made available to fellows on-line. Program directors share responsibility for adding current relevant literature to the compendium and creating self-assessment questions that must be answered by the fellow for each article read.

A clinical rotation schedule was developed for all critical care fellows so that ACGME guidelines and clinical needs are met at each facility.

The 2006-2007 lecture schedule and clinical rotation schedule are appended to this report.

Clinical Research

The TRISAT Research Group includes surgeons, research nurses and staff from all facilities. The group meets on a biweekly basis to consider ideas for research as well as protocols under development at any one facility.

During the three years of this grant TRISAT has twice met the federal "exception from informed consent" requirements to obtain community consent in lieu of individual informed consent for clinical research. The first was for study of an artificial hemoglobin product developed by Northfield Laboratories and the second was for a study of low-dose Vasopressin, funded by the Office of Naval Research.

TRISAT has applied for NIH grants, sponsored studies, and grants from other agencies. Presently, one TRISAT member/physician serves as Principal Investigator on each grant/study and receives and disburses funds accordingly.

In 2006, the TRISAT Board, which had been an unincorporated association, established the TRISAT Research Foundation as a Texas nonprofit corporation (501 c 3) in order to seek, accept and distribute research funds to TRISAT members. The Foundation will develop private sources for research funds as well.

Trauma Surgeon Resources

The TRISAT Board recruited Dr. Steven Wolf to become the first civilian director of the Burn Center at BAMC. Dr. Wolf joined the Burn Center on 6 April 2004 and directs burn research at the USAISR. Dr. Wolf is an employee of UTHSC on full-time assignment to the USAISR/Burn Center. The NIH transferred Dr. Wolf's RO1 grant to UTHSC; this project is titled "Effects of Insulin on Post-Burn Hypermetabolism." Under Dr. Wolf's direction, University Hospital has developed a pediatric burn unit for children 12 years of age and under. Prior to his arrival, all children with significant burns were transferred to Dallas or Houston for care.

Other Opportunities for Collaboration

TRISAT coordinated the development of the Regional Trauma Registry and Database project with the state's Regional Advisory Council for Trauma. All of the hospitals providing trauma services in 22 counties, and 35 EMS companies participate by utilizing

the same trauma registry software. This is resulting in available, accessible and standardized patient data for clinical research conducted by TRISAT and other qualified state and national health agencies.

TRISAT Foundation

Having proven the value of TRISAT, the board determined to incorporate as a non-profit corporation in Texas, which was accomplished in January of 2006. The TRISAT Foundation will seek 501 c 3 status with the IRS so that it can pursue private donor funds, reducing its reliance on federal funds. Private funds will supplement donor funds and will help to make stated TRISAT goals achievable.

Key Research Accomplishments

The purpose of this grant is not research. Key accomplishments other than research are addressed in the Body section of this report.

Reportable Outcomes

Not applicable to the purpose of this grant

Conclusion

TRISAT is a unique combination of military and civilian trauma and burn centers and will serve as a model of coordinated care, research and education across multiple locations within a city. Preliminary reports illustrate that there are significant opportunities for improved operations and financial outcomes through this collaboration. Given the increasing restrictions on reimbursement for civilian trauma services, whether delivered at civilian or military facilities, it is clear that any opportunity for increased revenue outside of government subsidization is advantageous. Generating increased revenue in these programs enhances our ability to conduct independent investigator-initiated research, extend training inside our institutions and beyond, and solidify the presence of much-needed Level 1 trauma services to civilians and military services. Most of these improvements will not be possible under current regulations that prevent military treatment facilities from billing private insurance companies for care delivered to civilians.

The vision for TRISAT includes becoming the primary site for trauma and burn research in the U.S. and preserving and building the strength and reputation of the internationally recognized BAMC Burn Center. Measurable improvements due to our work will include: improved survival rates of civilian and military casualties; increased innovation in combat casualty care; improved educational experience for UTHSC and DoD surgical/critical care trainees; improved pre-hospital evaluation and resuscitation; and improved mass casualty/disaster response in South Texas and at the U.S./Mexico border.

We will implement initiatives that include a surgical research center of excellence, burn center research and program development, video teleconference technology to connect all centers to each other for purposes of disaster/bioterrorism response coordination and shared professional education, a regional ICU registry that will provide the data needed to further research, and the support infrastructure needed to develop these initiatives.

The global war on terrorism presents a critical and increasing need for combat casualty care; since our military partners (BAMC and WHMC) are the only two Level 1 Trauma Centers and the BAMC Burn Center is the only ABA-verified burn program in the DoD, trauma training at these sites is critical. US military trauma program directors in Iraq praise the accomplishment of deployed San Antonio trained staff. Physicians, nurses and enlisted members from the Army and Air Force utilize their skills obtained from daily trauma training in their respective Level 1 Trauma Centers. The intangible aspects of experience and confidence, derived from direct clinical practice in the military's only level I trauma centers, continues to save lives on the battlefield. Continued TRISAT research and clinical studies enable us to develop new protocols for trauma management that will save soldiers in future conflicts and victims of trauma at home.

TRISAT PHYSICIAN BILLING REPORT

July 26, 2004

I. EXECUTIVE SUMMARY

Purpose

TRISAT contracted with Bishop + Associates to conduct a financial assessment of the University of Texas and military medical staff located at Brook Army Medical Center (BAMC) and Wilford Hall Medical Center (WHMC). The scope of the project also includes estimating incremental reimbursement and operational enhancements to billing activities to support the continued provision of high quality, cost effective trauma care for the San Antonio region.

Findings

Documentation and accurate coding of physician care is a significant issue for UPG. On the military side, charge capture is a major issue.

Overall reimbursement of 18% of billed charges for UPG reflects a large opportunity for improvement. Reimbursement on the military side for civilian trauma care is negligible, in spite of 20-30% of the military volumes being provided to civilians.

There is a lack of knowledge of effective billing and collection strategies for trauma cases on the part of the billing staff.

Potential Reimbursement Enhancements

Taking into account all trauma related specialties (trauma surgery, ortho, neuro, plastics, etc.) the impact of implementing a consolidated approach to trauma billing has the potential to:

- Increase billed charges between \$7-\$10 Million
- Increase reimbursement between \$4-\$5 Million
- Increase reimbursement rate from 18% to 40%

Consolidated Trauma Billing Program Organizational Structure

The recommended structure at the present time is to have TRISAT contract with UPG to conduct billing services for all trauma physician specialists. This structure will require creation of a separate workgroup within UPG that will focus on the entire billing operation for trauma cases. This workgroup will consist of approximately 6-8 full-time equivalents.

CTBP Operations

Specific roles are outlined for the key parties involved in the implementation of the new billing process; physicians, billing staff, and the hospital. The specific components of the billing system are outlined. In addition, the billing program process is outlined in significant detail. This outline encompasses four phases; from patient identification through monthly reporting of billing activities.

Implementation tasks are identified. Those tasks include preparation and execution of contracts, credentialing of military physicians, updating fee schedules and development of forms, and development of systems.

Key Performance Indicators & Accountabilities

Development and implementation of a new approach to trauma billing is outlined in detail in the report.

Specific and objective performance indicators have been developed so that the program can be monitored and managed effectively. Significant improvement in UPG's current reimbursement performance on trauma is critical to the future of trauma care for the San Antonio region.

II. FINDINGS OF UPG TRAUMA SURGEON BILLING ASSESSMENT

TRISAT contracted with Bishop + Associates to conduct a financial assessment of the University of Texas and military medical staff. Thirty (30) operative reports from UPG Trauma Surgeons were provided. In addition, discussions were held with staff from the two military hospitals. The assessment included a review of the following key components of trauma surgeon physician billing:

- Evaluation & Management Documentation & Coding
- Procedural & Diagnosis Documentation & Coding
- Pricing, Fee Schedules, & Managed Care Contracting
- Billing Processes including Compliance Issues
- Funding Source Assessment
- Financial Performance Enhancement Strategies

EVALUATION & MANAGEMENT DOCUMENTATION & CODING

The purpose of this evaluation is to provide a comprehensive review of trauma surgeon evaluation and management coding.

- a) Physicians are not documenting their time for critical care services and are not including total time in their dictated notes.
- b) Standardized and accurate documentation of Evaluation and Management services rendered is required to assure complete and compliant billings. The use of preprinted rounds cards filled out by the physicians in a timely manner will accomplish this.
- c) Physicians' dictation was not clear, concise and comprehensive. Physicians are leaving out essential information in their operative reports. Physicians are not documenting evaluation and management services or minor procedures.

PROCEDURAL & DIAGNOSIS DOCUMENTATION & CODING

Our highly credentialed and expert coding staff reviewed 30 general surgery operative reports and codes and noted the following findings regarding procedural and diagnosis coding, and the use of modifiers.

Surgery codes should identify all procedures and services provided with maximum and appropriate diagnosis coding including payer specific modifiers. These processes assure that maximal payment for the higher levels of care rendered for trauma cases are achieved.

- a) Dictated reports are required in order to correctly assign procedural and diagnosis codes.

- b) Diagnosis codes were not linked appropriately with the procedure or service to receive correct reimbursement.
- c) The physicians' dictation does not clearly state indications or findings. E codes (Cause of Injury Codes) were not able to be determined due to the limited documentation in the operative reports. The use of E codes is vital when billing insurance carriers for trauma services.
- d) In teaching hospitals, use of GC modifiers when billing Medicare is a common billing practice in order to receive reimbursement for attending physician services. Medicare will not reimburse claims for physician services in a teaching hospital if the modifier is not used.
- e) Due to a lack of prior indication and notation that the patient was in post operative, determination of correct modifiers is not possible.
- f) All operative reports provided were for general surgery cases. Modifier –22 for trauma exploration should be used to document this service. When billing with this modifier a letter of explanation is required. (Sample letter provided as attachment)
- g) When billing for Central line insertions, fluoroscopy is not being indicated. Code 75998-26 per AMA is a separately billable service.

PRICING, FEE SCHEDULE, & CONTRACTING

This component of the medical staff assessment included review of existing fees by CPT code compared to 275% of the Medicare Allowable fees. In addition, reimbursement by payer class was also reviewed and compared to benchmark data.

- a) An analysis of UPG's professional fees reflects a range of 129%-1,253% of current Medicare Allowable fees being charged for trauma services, with an average rate of 390%. National norms for trauma reflect a range of 275%-300% of Medicare Allowable in order to assure maximum levels of reimbursement across all payer categories.
- b) In addition, the current fee schedule reflects a range of \$48-\$468 per relative value unit being charged, with an average of \$146 per unit.
- c) The overall reimbursement rate for UPG trauma surgeons is 18.2%. This represents less than one-half the physician reimbursement rates compared to regional, State of Texas, and national norms for trauma physician reimbursement.

- d) With a reimbursement rate of 33% on commercially insured patients, it is apparent that trauma has not been carved out of MCO contracts, and that there are large discounts being taken on trauma.

BILLING PROCESSES

Trauma billing and collections practices are very unique and most trauma centers experience a significant improvement in payments by focusing collections with only certain individuals designated to the trauma service. At the present time, there is no coordinated billing system in place. Trauma surgeon billing is conducted within the UPG billing department with other physician specialty billing.

There is a general lack of awareness of the unique nature of trauma patient coding, charge, and reimbursement issues by billing personnel.

Patient Registration/Demographic Information

Successful billing is based on strong patient demographic information links between the hospitals, trauma physicians and trauma billing staff.

- a) At UPG, Bishop+Associates found fragmented information flows between these groups.
- b) There is a lack of, and poor quality demographic information being collected on trauma patients. This information is the foundation for maximum reimbursement and is not being pursued aggressively.

Charge Capture

Charge capture is another critical component of the billing system. Follow-up can only be done on those charges that have been billed.

- a) Our findings reflect a significant issue with charge capture in the military hospital setting.
- b) Billing staff are holding charges until after discharge which causes unnecessary delays in receipt of reimbursement. In some cases, there may be a 40 day delay in getting charge documents to the billing department.
- c) Physicians should be accountable for submitting charges within 5 days of trauma services being rendered.

Collections and Appeals

Fragmented and disjointed coding, documentation, billing, and collection processes prevent problematic trauma accounts from being pursued aggressively.

- a) The current collection process is operationally ineffective, with very little aggressive follow-up with respect to low reimbursement or outright denials for payment.
- b) Lack of accurate documentation affects reimbursement and limits any appeal process effectiveness.

There is generally a lack of incentive to pursue reimbursement from payers to improve reimbursement of physician professional fees from trauma care. This significantly contributes to the large financial losses for UT in the provision of trauma care.

MILITARY HOSPITAL FINDINGS

A cursory review of billing systems and processes was done at BAMC and WHMC. The following findings are relevant to the project's objectives:

- a) Military physicians are effectively documenting the care provided.
- b) Existing military professional fees will need to be reviewed and enhanced for billing of non-military trauma cases.
- c) Charge capture is a major concern in the military setting.

III. ESTIMATED TRISAT TRAUMA SERVICE REVENUE & REIMBURSEMENT

UPG trauma surgeon charge and reimbursement data was provided for the fiscal year 9/02 to 8/03. Based upon anecdotal information, sixty-five (65) percent of the total was estimated to represent trauma. The balance of thirty-five (35) percent was estimated to represent emergency care provided by the trauma surgeons.

This consolidated analysis also considered charges and reimbursement for the military hospitals for civilian patients. However, since the military hospitals include billing for physician services with hospital charges, the physician charges and reimbursement for purposes of this analysis are assumed to be zero.

It is assumed that trauma care provided to military beneficiaries is based upon cost formulas, and not within the scope of the TRISAT project.

Therefore, current consolidated trauma surgeon physician fees for civilian care for the three hospitals are estimated at \$3,084,897. Current collections are estimated at \$560,827, or 18.2%. This is an exceptionally low reimbursement rate for trauma care compared to national benchmark data from the National Foundation for Trauma Care.

Assuming similar volume from the 2002-2003 fiscal year of 3,767 non-beneficiary cases meeting ACS trauma patient criteria, anticipated annual projected charges and collections for all trauma service specialists (trauma surgeons, ortho, neuro, plastics, etc) and attainable with improved billing processes using a financial model developed by Bishop + Associates are as follows:

Facility	*****CURRENT*****		*****OPTIMIZED*****		*****IMPROVEMENT*****		
	Charges	Reim.	Charges	Reim.	Charges	Reim.	Reim. %
UPG	10,797,141	1,962,893	12,581,744	3,881,469	1,784,603	1,918,576	107.5%
BAMC	0	0	5,259,751	1,746,990	5,259,751	1,746,990	33.2%
WHMC	0	0	6,153,623	2,270,979	6,153,623	2,270,979	36.9%
Total	10,797,141	1,962,893	23,995,118	7,899,437	13,197,977	5,936,544	45.0%

Achievement of 75-90% of the optimized reimbursement would bring an additional \$4-\$6 million dollars in incremental reimbursement for trauma care for the three facilities.

Implementation of a separately managed and staffed, discreet consolidated trauma billing program (CTBP) for all trauma specialists providing care to trauma patients has the following opportunities:

- Increase in billed charges of approximately \$7-\$10 Million
- Increase in collections of approximately \$4-\$5 Million
- Estimated improvement in collection rate from 18% to 40%

IV. CONSOLIDATED TRAUMA BILLING PROGRAM (CTBP) ORGANIZATIONAL STRUCTURE

Definition and Purpose

Unlike a typical trauma center where up to 150 physicians in 15 specialties will be on a call panel, UHS has a faculty practice employee-model where trauma surgeons and other surgical specialists handle virtually all trauma cases. BAMC and WHMC are military hospitals staffed and operated by military personnel. For UHS, the faculty practice requires the surgical specialists to sign Managed Care Organization (MCO) contracts discounting their fees, so when they treat a trauma victim, at best they get paid low MCO rates. Billing for auto insurance, victims of crime and other unique sources is also problematic. The solution is a consolidated trauma physician billing program (CTBP) that functions like a trauma multi-specialty medical group which can shun MCO contracts and help streamline the billing process.

The purpose for forming a consolidated trauma billing program is to optimize physician professional fees which will strengthen the San Antonio region Level I trauma care being provided at UHS, BAMC, and WHMC. Doing so will significantly reduce the large financial losses being incurred at the present time.

Participation

This plan outlines the specific components of the program along with the steps needed for its successful implementation and operation.

Initially, participation in the CTBP from the three hospitals will be limited to the trauma surgeons. Over time, orthopedic, neurosurgery, plastic and other low volume specialty surgeons will participate as well, in order to optimize physician revenue for all surgical specialists providing trauma care.

Other specialties should achieve the same kind of financial improvement based on an increase in trauma charges of roughly 20%. This amount was determined by using the B+A proprietary physician billing model and TRISAT payer mix.

Benefits of Using a Consolidated Approach

The benefits of using a consolidated approach to billing for trauma include:

- Enables higher fees that reflect challenging nature of trauma care
- Improves the trauma physician's documentation of services
- Assures expert coding, systems and training
- Circumvents MCO/PPO discounts on professional fees
- Aggressively appeals down coding and denials
- Effectively collects from trauma care's unique payer sources

Two Organizational Alternatives; Build versus Buy

TRISAT understands the functions the CTBP will undertake once developed. A CTBP is challenging to establish and operate. Two organizational alternatives for TRISAT have been carefully considered by B+A.

1. Organize a new TRISAT sponsored physician group of civilian and military trauma surgeons. TRISAT then establishes an organization to bill and collect physician fees. (Build decision)
2. Have UPG provide the staff and conduct distinct billing and collection services for the existing UPG trauma surgeons. Within a predetermined timeframe, bring the military trauma surgeon billing activities into the same separate and distinct work group. Additionally, billing activities for civilian and military trauma specialists (ortho, neuro, plastics, etc) will be incorporated into the work group. (Buy decision)

At this time, the preferable alternative is the buy decision. This alternative has many advantages over the build decision.

A CTBP managed by UPG will be developed to support improvements to existing physician reimbursement and to efficiently contract with payers that require a relationship with the Trauma program.

Advantages/Disadvantages of Each Alternative

Building a new organization to bill for TRISAT physician services will

- Require significant upfront capitalization
- Encompass a lengthy start up period
- Likely not meet the approval of UT-Austin
- Create conflicting objectives for the new Chairman of Surgery at UHS
- Provide an opportunity to design a system for maximum potential
- Establish performance accountabilities up front
- Allow coordinated recruitment efforts based upon performance criteria

Utilizing UPG to bill for TRISAT physician services will

- Require creation of a department within an already established workgroup
- Reinforce physician concerns regarding accountabilities and performance of UPG
- Run the risk of experiencing the same low level of reimbursement
- Capitalize on existing UPG capabilities, resources, and knowledge
- Require minimal upfront capitalization
- Allow for much quicker implementation

- Allow TRISAT to focus on other goals (funding, research, etc.)
- Provide an opportunity for UPG to leverage performance improvements from this initiative

Staffing: Structure, Levels, and FTE's

An estimate of required staffing for billing of 3,500 to 4,000 trauma cases per year on behalf of TRISAT would include:

- Billing Manager-1.0 FTE
- Coding/Billing Representatives-1.5-2.0 FTE's
- Collections Representatives-2.0-2.5 FTE's
- Data Entry Coordinators-1.5-2.0 FTE's

Staffing levels will be highly dependent upon:

- Electronic capabilities of the billing processes
- Level of experience of staff in ED/Surgical billing and collections
- Managerial effectiveness
- Alignment of Performance Goals with Achievement

Steering Committee

A Steering Committee should be established to oversee the organization and performance of the consolidated trauma billing program (CTBP). The Steering Committee can provide a forum for physician input on billing issues as well as create policy to fine-tune the billing process. In most instances, the Steering Committee handles issues which can impact hospitals overall; (resident coverage, etc.). B+A suggests the following participants for a 3 – 6 month period:

- Sharon Smith, TRISAT, Project Coordinator
- Dr. Ronny Stewart, UHS, Trauma Director
- Col. Toney Baskin, BAMC, Director Trauma Surgery
- Col. Donald Jenkins, WHMC, Director Trauma Surgery
- Ed Grab, UPG, CEO
- 1 Representative from each Hospital

Agreements/Contracts

Legal counsel may need to draft a services agreement between UPG and TRISAT. The characteristics of the billing and service agreement are as follows:

- Seeing all patients that meet Texas state trauma center criteria and ACS requirements

- Agreeing to allow UPG to bill and collect on their behalf, with the actual services provided by contract with UPG
- Providing timely, complete and accurate documentation for coding and billing purposes
- Maintaining trauma service coverage and other hospital requirements
- Completion of Payer Credentialing Requirements
- Appropriate billing fee

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V. CONSOLIDATED TRAUMA BILLING PROGRAM OPERATIONS

ROLES AND RESPONSIBILITIES

The key to an effective billing system is to connect the necessary resources and staff, thus creating a collaborative system. The main roles and responsibilities are as follows:

Role of TRISAT Trauma Physicians

- Assign billing on all trauma patients to the UPG Trauma Billing Department
- Provide timely, complete and accurate documentation
- Provide input on development of the program
- Over time, increase scope to assure all trauma surgical specialists are participating

Role of UPG Trauma Physician Billing Department

- Contract with TRISAT
- Establish a separate and discreet Trauma Service Billing Department
- Send out HCFA 1500 claims with appropriate documentation in a timely manner
- Provide monthly statements to patients
- Carry out aggressive follow up of outstanding claims
- Follow established appeal protocols
- Post payments to the billing system in a timely manner
- Prepare month end reports for TRISAT, multi-hospital administration, and key physicians
- Assure creation of a multi-disciplinary work team for trauma billing
- Build effective communications among all patient financial services departments

Role of Hospitals

- Provide view only access to registry for billing
- Provide view only patient demographic information (this will also help improve hospital collections)
- Assure Medical Records availability for billing

BILLING SYSTEM COMPONENTS

Patient Identification/Information System

The trauma program should identify all trauma patients coming into the hospitals by state or ACS trauma triage criteria. The trauma program should issue a daily trauma

log from the trauma program by patient name, medical record number and physician highlighting demographic information that may be missing. Capturing current trauma patient demographics is important to a successful billing program.

Fee Schedule

To assure adequate levels of reimbursement, national norms for trauma surgeon fees are set between 2.75 to 3 times Medicare's RBRVS (cognitive or procedural) participating provider reimbursement.

The current UPG fee schedule should be revised to insure consistency of the conversion rates across all CPT codes. For example, CPT code 99291 has 5.44 RVU's attached to it times \$35.47 current Regional Medicare conversion rate = \$193. UPG's current charge for 99291 is \$822 but should be decreased to a range from \$481 – \$578.

The fee schedule should also be revisited each year when Medicare updates the conversion rate. Medicare geographic price indexes should also be reviewed each year (see the attached Excel spreadsheet).

Contracting

A program billing exclusively for trauma services and procedures for all trauma specialties enables the physicians to charge a higher rate for trauma keeping it separate from other physician contractual rates. The fact that trauma is unique needs to be conveyed to the third party payers. Trauma physician services should be removed /carved out of existing managed care contracts so that payers begin paying for the increased costs incurred in the treatment of trauma patients.

Charge Documents

The physicians must use a standard charge ticket/document to indicate the level of E/M service, diagnosis and if a procedure was done. This must be completed for both admitted trauma patients and trauma ER patients. Current anecdotal information suggests that UPG may not be capturing all trauma critical care and resuscitation charges due to resident coverage, high level of activity, and patients leaving AMA.

Professional Fee Coding

The trauma service should bill for all procedures and services by CPT code at the maximum appropriate unit value, including relevant modifiers, coupled with appropriate diagnosis codes. All of these processes enhance revenue and assure maximum payment for the higher level of trauma services provided. In an optimized billing process, CPT and ICD-9 codes are selected based on the physician's dictation in the form of clear and comprehensive operative notes. These documents must contain specific information critical to higher reimbursement.

The physicians should code all their E/M services and indicate the patient's diagnosis in written form. Insurance type will not impact the physician process, but does affect the coder and their use of modifiers.

Software and Hardware

An assessment of UPG's existing software and hardware will need to be made to determine its capabilities relative to operation and management of a separate and distinct trauma workgroup. UPG should be linked to UHS', and eventually BAMC and WHMC's financial systems to allow retrieval of patient demographic information.

Payment Posting System

UPG will modify existing systems or establish effective systems for follow up and appeal processes. Use of a lockbox for receipt of payment notifications for trauma physicians is recommended. Payments should be posted to the patient's accounts from the copies of checks and EOB's received from the lockbox. Use of a managed care contract reporting system can efficiently identify underpayments.

Reporting Systems

Development of a reporting system specific to trauma physician services rendered to patients meeting ACS or Texas state trauma criteria is required. This system would reflect charges and collection amounts for individual patients, as well as monthly and yearly totals. This system will provide information to measure efficiency, effectiveness, and accountability of the billing service.

Monthly or quarterly meetings between the trauma physicians, the trauma billing management and staff are an important part of the collaborative process. These meetings will address paper flow problems, review month-end reports on the productivity of the trauma physicians, and review current collections and charges. This is also an opportunity to review difficult cases with the physician(s) for assistance with the appeal process.

An information vacuum can occur that favors the payer and the patient and reduces physician income without detailed reporting systems. This can be corrected by developing a comprehensive trauma physician management report package that accurately tracks the accounts receivable status of each case.

BILLING PROGRAM PROCESS

Phase One: Information Gathering

1. Identification Process of all Trauma Patients

The trauma programs will identify trauma patients by ACS/state trauma guidelines when each hospital receives them. A unique number will be assigned to each trauma patient. UPG will rely on the primary demographic findings of the hospitals, thus requiring a close working relationship on registration information.

The trauma registries will create trauma logs listing trauma patients by name, medical record number, and physician. These lists will be sent directly to UPG Trauma Billing Program to distinctly identify trauma patients from the other non-trauma hospital patients.

2. Collection of Demographic Information

UPG's Trauma Billing Department data entry personnel, with view only access to the three hospital's patient registration systems, will access the systems and collect the trauma patients' registration information.

UPG will need access to the hospitals' registration systems with notification of changes to patient accounts for up to 60 to 90 days.

3. Physician Documentation of Care

Physicians should use preprinted rounds card to document their evaluation and management services. History & Physicals, consultations, and critical care notes will be dictated. All minor procedures and operative procedures will be dictated and copies of all dictated reports and rounds cards will be sent to the UPG Trauma Billing Department.

Phase Two: Professional Coding for Surgical Procedures

1. Professional Coding

Surgical and minor procedures will be forwarded to UPG for professional coding. UPG will code using appropriate modifiers and ICD9-CM codes. In addition, the surgical coding worksheet will be used to document the coding process.

Phase Three: Billing Process

Enhancement of the existing billing and collections systems will significantly increase physician professional fee revenues.

1. Information Review and Data Entry

Registration received from the hospital will be reviewed by UPG Trauma Program billing staff for accurate and complete information. Appropriate staff should check the hospital systems for updated information on a periodic basis (daily, weekly). Self-pay patients will receive a statement of charges immediately; this will also serve as a request for insurance information.

Data entry will enter the charges from the preprinted physician's rounds cards or the surgical coding worksheet.

2. Generation of HCFA 1500 Claim Forms

The system will generate for UPG the HCFA 1500 claim forms. Claims should be reviewed by experienced staff for accuracy and checked that all necessary reports for trauma consults, History & Physicals, minor procedures, and surgical cases are included. Reports do not need to be attached for hospital visits.

3. Account Follow-up

A protocol should be developed that concentrates the collection efforts for this unique patient population. This includes knowledgeable staff that can deal with and focus their efforts on the complexities of trauma care only.

Insurance claims should be aggressively followed up when they have been out to the carrier over 60 days. All follow-up activity should be noted utilizing the electronic note feature of the billing system. At a minimum, the following information should be tracked within the note feature: date, time, activity (call, letter, email, etc), contact name and other pertinent information for future reference.

Carriers should be educated on the unique nature of trauma services and its billing intricacies in a proactive manner.

Carelink and other Bexar County aid programs should be aggressively considered for possible sources of reimbursement on all uninsured patients.

The collectors will track payments by payer closely and monitor trends in underpayment that would otherwise go unnoticed.

Only when knowledgeable and skilled individuals who understand the nuances of trauma are conducting the billing functions, will collections increase.

4. Appeals Process

An aggressive appeals protocol should be established for denied or low reimbursed charges. In a typical trauma surgeon practice, an aggressive follow-through process to deal with low reimbursement or denials for difficult cases can increase income significantly. An organized approach to appeals should be taken and be the responsibility of the trauma collectors.

Appeal protocols will include an appeal letter, copy of the original claim, and all required reports (copy of an appeal letter is attached). Appeal letters should be sent to the carrier, with follow-up beginning 60 days from the date the appeal letter was sent until resolved.

On all difficult cases the trauma surgeon should be involved in the appeal process to help in clarifying the complexities of the case.

5. Payment Posting

Payments are posted to the accounts on a daily basis from copies of checks or EOB's received from the lockbox. The payment posting staff should forward all EOB's to the auditor/collectors in order for the appeal process to be initiated.

6. **Statement Processing**

Once a month, statements should go out to all patients with an open balance; dunning notices should be included on the statements.

When a balance is the responsibility of the patient, a letter should be sent indicating the amount due and why the patient is responsible (i.e. after insurance payment, non-coverage issues, etc.). The name of the patient account representative assigned to each account will be referenced with their direct phone number on the statement.

7. **Collection Activities**

There should be automatic letter generation capability in the billing system utilized by UPG in order to efficiently generate pre-collection letters to patients. Accounts that have had no response from the patient and have aged over 45 days should be reviewed for possible transfer to a collection agency. A final collection letter is sent certified with a return receipt showing that the patient or agent has signed for the notice.

When asking the patient to sign a lien, focus on the patient being responsible for payment. This is critical whether or not litigation is pending or other parties may be ultimately found responsible. A lien program that runs in conjunction with the hospital clearly benefits the trauma surgeons. Where legally possible, the patient must be held responsible for payment of services despite any pending liability, lawsuit or third party involvement, none of which erases the patient responsibility.

8. **Small Balance Write Offs**

UPG Trauma Billing Department needs to propose to TRISAT a dollar limit for small balance account write-offs. This amount is usually set at \$10.00 to \$20.00. An effort should still be made to collect on all amounts due; however, it is not cost effective to spend more in staff time to collect on a balance that is under a certain established dollar limit.

Phase Four:

1. **Accounts Receivable Monthly Reporting System**

At the end of each month, reports will be run and then reviewed by the trauma staff. Reports will be broken down by hospital, specialty group, individual physician within the group, or other means as determined by the department.

The reports will include:

- Patient Detail Accounts Receivable Aging report up to 180 days
- Cash basis report for the year (copy of cash basis report)
- CPT Code Frequency report, month-to-date and year-to-date, by surgeon and by group
- Charges, payments and adjustments month-to-date and year-to-date, by surgeon and by group
- Summary charges, payments and adjustments by payer class
- Report of items of special concern to review with Trauma Medical Director
- Quarterly report that indicates each patient's ISS score

IMPLEMENTATION

Once the organizational structure is agreed to, and the initial contracts are signed, the consolidated trauma billing program should be implemented. The Steering Committee should supervise the implementation, and the following steps:

Preparation and Execution of Contracts

Develop contracts with UPG, and the physicians for inclusion in the Trauma Physician Billing Program. Begin the contract process for any vendor arrangements needed for the success of this program.

Credentialing of Military Physicians

Facilitate the documentation of physician licenses and other credentials required by Medicare and Medicaid to allow military physician billing of these carriers, if permitted. This should be started as soon as possible since Medicare/Medicaid credentialing can take at least 8-10 weeks for processing.

Update of Fee Schedule and Development of Forms

Review all existing charges to ensure fees are standardized, appropriate and within industry norms.

Samples of the following reports and forms are included in the Appendix:

- A/R Practice Report
- Draft of Appeal Letter
- Tips for Using Modifier -22
- Preprinted Rounds Card
- Surgical Coding Worksheet
- Comparison of UPG Fee Schedule with Medicare Allowable Fees
- Consolidated Billing Program Schematic

Development of Systems

- Identify trauma patient by ACS/Texas State criteria and the trauma registry
- Provide Physician Training in Documentation Requirements

- Professional coding
- Billing process and reporting system

COMPLIANCE

A consolidated trauma physician billing program, like all aspects in trauma care for TRISAT in San Antonio, should be conducted with a high quality approach. When implementing such a program which benefits everyone involved, including the hospitals, physicians, and TRISAT, all key participants must mutually agree to put in a concerted effort to ensure the success of the program.

It is imperative that all participants in the program take a rigorous approach when adhering to compliance issues regarding all facets of healthcare. This will improve the overall quality of care of the program, which is the ultimate goal of everyone involved at TRISAT and UPG.

Physician and employees must be cognizant of all applicable federal and state laws and regulations that apply to and affect the physician's documentation, coding, billing, and competitive practices, as well as the day to day activities of the physician and its employees and agents. Each employee who is materially involved in any of the physician's documentation, coding, billing, or competitive practices has an obligation to familiarize him/herself with all applicable laws and regulations and to adhere at all times to the requirements.

VI. TRAUMA PHYSICIAN BILLING PERFORMANCE & ACCOUNTABILITY

The following key performance indicators should be monitored to assure optimal financial outcomes for trauma patient physician services.

- Completion of training by physicians in documentation and coding requirements
- Annual coding training for physicians and staff
- Supervision by attending physicians of care provided by residents is documented to support billing for the attending physician
- Physicians utilize preprinted rounds cards and complete dictation in a timely manner to document all care being provided (Evaluation/Management and Procedural services)
- Surgical, diagnosis, and E coding is completed within 5 days of service
- Comparison daily of the trauma registry patient listing with billing records (average work day will include 15 new trauma cases)
- Periodic audit of physician demographic data compared to hospital demographic data to assure follow-up on physician side
- For trauma surgeons, weighted average RVU's per case between 17.25 and 18.00

RVU's per ISS Category

ISS 0-8	9.07
ISS 9-14	14.23
ISS 15-24	27.40
ISS >24	52.81

- \$96.68 Charge per RVU (275% of Medicare Allowable per RVU)
- Weighted average collection rate 32.9% (currently at 18.2%)

Collection Rates per Payer Category

Commercial	70%
MCO/Contracts	45%
Work Comp	50%
Medicare	30%
Medicaid	25%
Self Pay	5%

- The same approach would be used for other surgical specialties providing care to trauma patients; the estimated factor in additional services being 3.5 times the trauma surgeon RVU's, charges, etc.

VII. APPENDIX

- A/R Practice Report
- Draft of Appeal Letter
- Tips for Use of Modifier -22
- Preprinted Rounds Card
- Surgical Coding Worksheet
- Comparison of UPG Fee Schedule with Medicare Allowable Fees
- Consolidated Billing Program Schematic

DRAFT

Date: June 2, 2004

cc: Tim O'Leary

To: Greg Bishop **From:** McDermott Will & Emery

Re: Executive Summary Regarding Core TRISAT Legal Issues With Respect to Military/Civilian Trauma Services

In response to the issues raised in your memorandum to Sharon Smith, dated January 6, 2004, and entitled "Core TRISAT Legal Issues," as modified by the subsequent meeting at our offices, this Executive Summary provides a brief description of our analysis regarding several issues related to a joint program between military and civilian facilities and physicians for the provision of trauma care. A more detailed legal memorandum as well as backup documents from our legal research are attached.

MILITARY/CIVILIAN BILLING ISSUES

A. Can a Civilian Physician Bill for Trauma Care Provided at a Military Treatment Facility ("MTF")?

1. Civilian physician at MTF caring for civilian patients

The Department of Defense ("DOD") is required to implement procedures under which an MTF may bill for providing trauma and other medical care to civilians. The MTF may retain and use the amounts collected. The only DOD guidance on this issue allows the MTF to generate bills for hospital and professional services provided to civilian emergency patients. There are no provisions addressing whether a military or civilian physician could bill separately for services provided to civilians at an MTF. It is likely that if a civilian provider is rendering medical services at an MTF, such services are presumably being provided pursuant to an internal resource sharing agreement, with the parties specifying whether the military would pay the non-military provider for services or whether the non-military provider would bill third party payors.

According to Texas Medicaid program requirements, "Although Medicare reimburses for emergency outpatient and inpatient services, Medicaid does not reimburse for either outpatient or physician services." [Texas Medicaid Manual, Part I, §32.3.2]. Thus, civilian physicians may not bill the Medicaid program for services provided in MTFs.

We found no Medicare program prohibitions regarding a civilian physician enrolled in the Medicare program billing for services provided in an MTF.

Possible Action Items: Develop internal resource sharing agreement that allows the civilian physician to bill third party payers for services provided at the MTF. Change

Texas Medicaid reimbursement limitations regarding physician services in MTFs, as currently set forth in Texas Medicaid Manual, Part I, §32.3.2.

2. Civilian physician caring for active military patients

According to DOD requirements, a civilian doctor providing care to an active military patient in a military facility may be covered by an internal resource sharing arrangement. Alternatively, a civilian doctor may be able to bill the military directly for his or her services absent a resource sharing agreement.

Possible Action Item: Determine whether an internal resource sharing agreement is necessary or whether such civilian physician services in MTFs can be billed directly to the military.

3. Civilian physician caring for military retirees and dependents

According to DOD requirements, this arrangement would likely arise pursuant to a resource sharing arrangement. Under a resource sharing agreement, the civilian physician would bill the military for the services rendered. Alternatively, a civilian doctor may be able to bill the military directly for his or her services absent a resource sharing agreement.

Possible Action Item: Determine whether an internal resource sharing agreement is necessary or whether such civilian physician services in MTFs can be billed directly to the military.

B. Can the Military Bill for Trauma Care Provided to Civilians?

The DOD is required to implement procedures under which an MTF may charge fees to civilians or their insurers to cover the costs of trauma and other medical care provided to such civilians. The MTF may retain and use the amounts collected for (1) trauma consortium activities; (2) administrative, operating, and equipment costs; and (3) readiness training. According to statutory authority, MTFs have the right to bill and retain third party payments for services rendered to civilians. Regulations require that third party payers receive and pay a claim for services in the same manner and for the same charges as any similar services provided by a facility of the Uniformed Services.

An MTF can participate and be reimbursed for emergency inpatient and outpatient services provided to civilian Medicare beneficiaries. Under Medicare program requirements, the MTF need not be licensed in the state where it provides services. There is also a mechanism in place for MTFs to submit bills to the Medicare program, although it is not known whether the mechanism is effective.

MTFs may provide and be reimbursed for limited inpatient emergency services provided to Medicaid civilian beneficiaries. In order to bill for services, the Texas Medicaid Program requires that the MTF be certified by Medicare and have a valid provider agreement by

completing the Medicaid enrollment process. The Medicaid program does not require that a MTF meet Texas state licensure requirements.

A military physician may obtain provider numbers and enroll in the Medicare program in order to bill for services provided to Medicare civilian beneficiaries at MTFs. According to Texas Medicaid program requirements, military physicians may not bill the Medicaid program for services provided in MTFs.

Possible Action Items: MTFs would need to develop a fee schedule in order to bill non-governmental third party payers for physician and facility services. With respect to Medicare reimbursement, the military physicians would need to obtain Medicare provider numbers. With respect to Medicaid reimbursement, amend the current Texas Medicaid rules prohibiting reimbursement for physician services in MTFs as set forth in Texas Medicaid Manual, Part I, §32.3.2.

C. Can a Military Physician Bill for Trauma Care at a Civilian Facility?

There are no DOD manual provisions or regulations that address this situation. Staff at TRICARE Management Activity (“TMA”) stated that, historically, a military physician would be at the civilian facility to treat non-civilian patients only. However, where there was, for example, a shortage of physicians, the provision of trauma care at a civilian facility by a military provider could occur where the military physician was on-site pursuant to an external resource sharing agreement and was needed to treat a civilian patient because a civilian physician was not available. TMA staff was not aware of circumstances where the military physician would bill for services rendered to the civilian. However, it is possible that a resource sharing agreement could provide that the civilian facility or faculty practice plan could bill for the military physician services to civilians as there are no specific prohibitions on a military physician who is properly licensed billing for services provided at a civilian facility.

A military physician may obtain provider numbers and enroll in the Medicare program in order to bill for services provided to Medicare civilian beneficiaries at non-MTF facilities. The Medicare program does not require that physicians working in the scope of their federal employment be licensed in the state where they are providing services.

The Texas Medicaid Program manual does not allow physicians to enroll in the Medicaid program unless they are “authorized by the licensing authority of their profession to practice in the state where the service is performed at the time services are provided.” [Texas Medicaid Manual, Part I, §34.1.1] We contacted the enrollment unit of the Medicaid program and asked whether this requirement would apply to active military physicians who hold part-time appointments at Texas medical schools, allowing them to be eligible for “faculty temporary permits” issued by the Texas Medical Board. We were told that faculty temporary permits would not be a substitute for licensure and that all physicians can only participate and bill Medicaid for their services only if they are licensed in Texas.

Possible Action Items: Seek clarification from DOD regarding developing an external resource sharing agreement that allows the civilian facility or faculty practice plan to bill

for the military physician services to civilians. With respect to Medicare reimbursement, the military physicians would need to obtain Medicare provider numbers. With respect to Medicaid reimbursement, “faculty temporary permits” issued by the Texas Medical Board will not assist the physicians in billing the Medicaid program absent a change in the licensing requirements in Texas Medicaid Manual, Part I, §34.1.1 or the interpretation of those requirements by the Texas Medical Assistance Program.

PHYSICIAN FACILITY LICENSURE AND MALPRACTICE ISSUES

A. Military Physician Licensure in Texas.

Federal law requires that all military health care providers must have a current appropriate health care license, but such license may be from a state other than the state in which such provider practices so long as the provider is performing duties authorized by the Department of Defense (“DoD”). Services authorized by the DoD are interpreted to include health care services rendered at a civilian health care facility pursuant to a Resource Sharing Agreement, as well as such services rendered at an MTF. Nevertheless, the Texas Medical Board of Examiners (the “Texas MBE”) generally takes the position that a military health care provider must have a Texas license unless that provider is practicing in a federal facility. While it appears that the position of the Texas MBE may be subject to federal preemption, we are aware of no case law in Texas or elsewhere regarding this specific issue.

However, the Texas MBE created an exception to its rules, effective September 14, 2003, for active military physicians who hold part-time appointments at Texas medical schools, allowing them to be eligible for “faculty temporary permits” if the physician holds a faculty position of assistant professor or higher and works at least on a part-time basis at, inter alia, the University of Health Science Center at San Antonio. Under this new rule, the Texas MBE must also determine that the physician’s practice under the faculty temporary permit will fulfill a critical need of the citizens of Texas and that the physician meets certain other requirements of the rule. This “loophole” would appear to permit non-Texas-licensed military physicians to care for patients at that facility if they qualify for such “faculty temporary permits.”

On the other hand, it is clear that a civilian health care professional providing services in an MTF must have an appropriate Texas health care professional license. Note that if a provider does not hold a valid and appropriate license or certification, TRICARE will make no payment for otherwise covered services.

Possible Action Items: Those military physicians who are not licensed in Texas should apply for a “faculty temporary permit” from the Texas MBE. However, the “faculty temporary permit” will not allow such physicians to bill the Medicaid program absent a change in the licensing requirements in Texas Medicaid Manual, Part I, §34.1.1’ and/or the interpretation of those requirements by the Texas Medical Assistance Program. Thus, that provision would need to be amended or the Program’s interpretation changed in order to permit such physicians to bill and collect from the Texas Medicaid program.

B. Military Physician Malpractice in Texas.

All claims by military personnel and their dependents for negligent health care provided by military physicians must be brought under the Federal Tort Claims Act. (Note that active duty military personnel are not entitled to bring such a claim, based on the 1950 United States Supreme Court case, Feres v. United States.) Thus, the civilian institutions participating in TRISAT would need to consider accepting such Federal Tort Claims Act coverage for military physicians, in lieu of traditional malpractice coverage. In the highly unlikely event that the military health care provider also treats civilian patients and has a medical malpractice coverage for his private practice, a patient alleging malpractice could pursue a claim under such insurance. In addition, if the services are provided in a civilian health care facility, that facility may be sued for malpractice or corporate negligence based upon, for example, negligently approving or supervising such physician's provision of services in the facility.

It is recommended that military residents/physicians have civilian medical malpractice coverage in addition to federal coverage to practice at civilian facilities.

Possible Action Items: Amend Federal Tort Claims Act to cover services provided by military physicians in non-military facilities within the scope of a resource sharing agreement and/or in case of shortage of trauma services. However, obtaining an amendment of the Federal Tort Claims Act is unlikely. An alternative would be for either TRISAT or the non-military facilities or the Faculty practice plan at the University Health Science Center to cover such military physician services under an umbrella malpractice policy or, or cover additional insureds under their existing policy, if such coverage is available at a reasonable cost.

C. Malpractice Cap in Texas.

The malpractice cap provisions governing state licensed acute hospitals in Texas would apply if such facilities are sued for malpractice on the basis of a military physician's provision of care at such a facility, e.g., under a Resource Sharing Agreement since there is no express exclusion. It would not apply to military facilities, where such liability is covered under the Federal Tort Claims Act.

Possible Action Items: None identified.

**TRAUMA INSTITUTE/CONSOLIDATED TRAUMA PHYSICIAN/FACILITY
BILLING ISSUES**

A. Consolidated Billing.

1. Facility Services.

Under Medicare rules, facility may bill Medicare for inpatient and outpatient hospital services. [42 U.S.C. §1395y(a)] Nevertheless, a facility may enter into a contractual arrangement with another entity that serves as a billing agent for the facility and/or provides other management of

services such as trauma. The management or billing compensation need to be consistent with the fair market value of the services so as not to run afoul with the Anti-Kickback Law that covers participation in federal health care programs including Medicare and Medicaid. [42 U.S.C. §1320a-7b(b).]

Possible Action Items: Change the Medicare rules regarding billing for facility services in 42 U.S.C. §1395y(a), which is unlikely, or have TRISAT enter into management/billing agreements with the facilities.

2. Physician Services.

Under the Medicare and Medicaid programs participating facilities may not have another entity bill and collect for services. However, there are exceptions to what is called the “reassignment rule” which are applicable to physician services. Under an exception to the Medicare and Medicaid reassignment rules, the employer of the military physicians or the facility (i.e., either the MTF or civilian facility) where the services are performed may bill for their services. [Medicare Claims Processing Manual, CMS Pub. 100-04 §30.2; *see also* 42 U.S.C. §1395u(b)(6) and 42 C.F.R. §424.80] Under new amendments to the Medicare reassignment rule, any entity may bill and collect on behalf of physicians if the entity is enrolled in the Medicare program. However, this exception would have limited applicability to TRISAT because Medicare has specific categories of providers/suppliers, and the only type under which TRISAT might be able to qualify would be as a physician group or clinic. If TRISAT were to form a physician group or clinic (e.g., operating as a Texas 501(a) foundation) it could obtain Medicare and Medicaid numbers and then bill and collect for the services of its individual physician members.

Alternatively, TRISAT could function as the billing agent for the physicians. However, the Medicare and Medicaid rules require that the agent’s compensation be (1) related to the cost of billing, (2) not be dependent on the payment collection, and (3) not be related on a percentage basis or other basis to the amount that is billed and collected. Entities have established what is called a “lockbox arrangement” in order to have different agent compensation (e.g., based on a percentage of revenue.) Under such a lockbox arrangement, the physician group would open a bank account that the group ultimately controls, with instructions to the bank to sweep the account daily into the agent’s account. Note that such lockbox arrangements have been questioned by the government and it is possible that they may be prohibited in the near future.

Possible Action Items: Have TRISAT form and manage a Texas 501(a) foundation that includes the military physicians as employees or independent contractors. Alternatively, either change Medicare and Medicaid rules that would prohibit TRISAT from billing and collecting directly from the Medicare and Medicaid programs in 42 U.S.C. §1395u(b)(6), 42 C.F.R. §§424.80 and 447.10 and Medicare Claims Processing Manual §30.2, which is unlikely, or have TRISAT enter into a billing agent/lockbox arrangement with the physicians.

B. Texas Legal Entities Flow of Funds to DOD Facilities.

As agreed at the meeting at our offices, these issues are beyond the scope of this report. However, in light of the distinct and separate physician licensure and medical malpractice rules for military physicians, as summarized above, and in particular the Texas MBE position on non-Texas-licensed military physician practice, it does not appear that military physicians and facilities could become owners of a Texas 501(a) Foundation entity without an express statutory authorization to do so under both federal and Texas law.

Possible Action Items:

Additional legal research and analysis beyond the scope of this memorandum is required to determine definitively if military physicians participate in a form a Texas 501(a) foundation entity with non-military physicians. The military physicians only may be allowed to subcontract with the 501(a) entity for the provision of their services. Military physician ownership in the 501(a) entity may be viewed by the military as unduly exposing the federal government to vicarious liability for the actions of all physician owners of the 501(a) entity.

2006-2007 SURGERY CRITICAL CARE ROTATION - BAMC, UTHSCSA, WILFORD HALL - Revised 7/6/06

Block	1	2	3	4	5	6	7	8	9	10	11	12	13
Dates	7/1-7/27	7/28-8/24	8/25-9/21	9/22-10/19	10/20-11/16	11/17-12/14	12/15-1/11	1/12-2/8	2/9-3/8	3/9-4/5	4/6-5/3	5/4-5/31	6/1-6/30
Claudio Nunes UTHSC	Research	UT SICU	UT SICU	BAMC Burn Unit	UT SICU	WHMC SICU	WHMC SICU	Elective	BAMC SICU and ICI	BAMC SICU	BAMC Burn Unit	UT SICU	UT SICU
Evan Renz BAMC	WHMC SICU	BAMC Burn Unit	WHMC SICU	UTSICU	Elective	UT SICU	BAMC Burn Unit	WHMC SICU	Elective and ICI	UT SICU	UT SICU	BAMC SICU	BAMC SICU
Cancio BAMC	UT SICU	WHMC SICU	BAMC SICU	ELECTIVE	WHMC SICU	ELECTIVE	BAMC SICU	BAMC Burn Unit					
Harry Stinger BAMC	BAMC Burn Unit	BAMC SICU	ELECTIVE	ELECTIVE	BAMC Burn Unit	BAMC Burn Unit	UT SICU	UT SICU	**UT SICU and ICI Course	BAMC Burn Unit	BAMC SICU	WHMC SICU	WHMC SICU
VTC	3	3	3	2	3	2	3	3	3	2	3	2	2
Burn Fellow													
WH has fellow				WH Pulm					WH Pulm		WH Pulm		
B has fellow	BAMC PULM			BAMC PULM	BAMC PULM	BAMC PULM		BAMC PULM					
UT Has Fellow													
ICI Course									Feb 5-16				
Meeting			Trauma Symposium 9/19-21 AAST 9/28-30 ACS 10/8-10/12				SCCM Feb18-21						

One lecture per month/fellow

One Journal club/month

12 Articles per month from compendium with self assessment questions

REVISION 7/5/06 - Switched Evans/Cancio Blocks 1, 4, and 5

TRISAT CRITICAL CARE EDUCATION CONSORTIUM

VIDEO TELECONFERENCE LECTURE SERIES

11 A.M., Tuesdays and Thursdays

Tuesday

Feb. 15, WHMC (Sepsis)

Feb. 22, UTHSC (ARDS)

Mar. 1, BAMC

Thursday

Feb. 17, BAMC

Feb. 24, WHMC

Mar.3, UTHSC