SAVING LIVES MEDICAL CENTER

Level I Trauma Center
CCN: 123456

2025

REPORT ON TRAUMA CENTER MEDICARE CLAIMS DATA

This report provides information to help your center understand its claims reporting for trauma cases. This report is based on inpatient and outpatient claims your center billed to original (Fee-for-service) Medicare (i.e., this does not include Medicare Advantage) during calendar 2023. If there are opportunities to improve claim reporting on Medicare cases, the concept is you will have similar opportunities to improve claim reporting to other payers. Trauma cases are identified by diagnosis codes using the National Trauma Data Standard codes. Find a listing of these codes at: www.facs.org/media/hkejeat2/2023-data-dictionary.pdf

Trauma Team Response

The National Uniform Billing Committee (NUBC) defines values and fields on claims submitted by hospitals to payers. A value of 5 in Form locator 14 (FL14) means the hospital patient received a trauma team response and includes patients with and without pre-arrival notification. A charge on the claim with a revenue code in the 068x series means the trauma team response occurred with pre-arrival notification. The last digit in the 068x represents your trauma program certification level. Remember, there will be cases having traumatic injuries treated by your program and included in your trauma registry, but which did not benefit from a trauma team response. The goal is to report a FL14=5 for every trauma team response which should include most trauma cases.

For all trauma centers, 15.8 % of inpatient trauma claims report FL14 = 5 compared to 12.1% reporting a 068x charge. Because a 068x charge requires pre-arrival notification, it is expected that more trauma claims will have FL14 = 5 because trauma team activations occur immediately post-ED arrival in addition to those with pre-arrival notification.

Outpatient Trauma Responses

When the treated injury allows discharge for follow-up care or if the patient is transferred or expires prior to inpatient admission, the claim is reported as an outpatient claim.

When the outpatient meets the AMA CPT® definition for critical care and the elapsed time receiving critical care services is greater than 30 minutes, then the critical care CPT code 99291 should be reported on the claim (American Medical Association, 2023, P. 21-23). When a trauma team response based on pre-arrival notification occurs (i.e., a 068x charge) and the patient receives critical care services (i.e., a 99291 is reported), then HCPCS code G0390 should also be reported. CPT codes are not reported on inpatient claims, so it is not possible to determine whether critical care services occurred or not.

The goal is that the number of cases having both critical care and pre-arrival activations is equal to the number of cases with HCPCS G0390 for your center.

Overall, claims data show 6.57% of total trauma cases are billed as outpatients; of the outpatient cases, 98.24% were discharged alive, 17.8% had critical care, and 15.6% had pre-arrival notification, critical care and trauma response HPCS G0390.

Trauma ICU

Inpatients having a trauma response and are admitted to the ICU have their ICU care coordinated by the trauma program. This care coordination should be documented in the medical record and reflected on claims with the presence of revenue code 0208 for trauma ICU accommodation.

Overall, 36.3% of trauma ICU claims reported ICU days, but only 3.1% used revenue code 0208. The average length of stay (LOS) for ICU patients coded with 0208 is 3.7 compared to those without 0208 which is 4.5. Ideally, all trauma centers would report ICU days using revenue code 0208.

National Data

CMS requires hospital charges for a service be related to the cost of furnishing the service; therefore, because each hospital's trauma program is unique, benchmarking trauma response fees from one hospital to another provides general information and should not be relied upon as the basis for a trauma program's charges.

MEDICARE CLAIMS DATA ONLY

2025

Medicare Trauma Cases	Inpatients		Outpatients	
	Your Center	National	Your Center	National
Number	165	597,103		
Revenue Code 068x Charge Present	29	72,223	*	41,983
No. with FL14 = 5	28	94,459	Not included in CMS data	

** Data use agreement with CMS means values less than 11 cannot be displayed.*

[X will be the value reported on the TC's claims]

Medicare Trauma Outpatients	068x Charge Present		HCPCS G0390 Present	
	Your Center	National	Your Center	National
Proportion with Critical Care Code Present	6	17.8%	4	15.6%
Proportion without Critical Care Code Present	20	80.9%	25	3.4%

Trauma Inpatients	Your Trauma Cases	Average ICU Days		Overall Average Length of Stay	
		Your Center	National	Your Center	National
With ICU 0208	55	3.7	3.7	6.1	5.5
Without ICU 0208	16	3.2	4.5		
Without ICU	166	4.7	3.8		

Trauma Program Level	Mean Charge	Median Charge	5th Percentile	95th Percentile
0681	$13,281	$9,995	$2,969	$41,408
0682	$13,078	$9,285	$1,669	$37,914
0683	$7,350	$5,276	$1,659	$26,204
0684	$4,529	$3,697	$986	$11,132
Your Center	$35,615	$33,657		

Medicare Payment for Trauma

On average your hospital received payment for trauma cases as follows compared to national payment rates.

	Your Average Payment	National Average Payment	Your Proportion with Outliers	Your Average Outlier Payment
Total Trauma Inpatients	$31,922	$17,920	*	$1,077.96
Total Trauma Outpatients	$2,098	$2,007	NA	NA
Total Inpatients	$28,205	$18,012	2.2%	$684.51
Total Outpatients	$412	$734	NA	NA

MEDICARE CLAIMS DATA ONLY

2025

MS-DRGs are not well designed to reflect trauma care, but the case mix index (CMI) is often used as an indicator of patient acuity. CMI may be improved by clinical documentation improvement.

	Case Mix Index
Your Hospital CMI for 0681	4.5
National Trauma CMI for 0681	2.5
Overall National Trauma CMI	1.8779
Overall National CMI	1.7609

CC/MCC Capture Rate

Inpatient payment based on Medicare Severity-Diagnosis Related Groups (MS-DRGs) and other DRG-based case rates increases when the patient has ICD-10 codes for complications and co-morbidities (CCs) and major complications and co-morbidities (MCCs). Additionally, for quality measures, risk of morbidity and mortality scores increase with CCs and MCCs. Below is a graph comparing your hospitals coding of CCs/MCCs on inpatient trauma cases. Clinical documentation improvement specialists can assist clinicians with medical record documentation practices that better capture patients' CCs and MCCs in medical terminology that helps improve coding of these conditions.

	All Inpatients Nationally
No CC/MCC	12%
CC Only	38%
MCC Only	3%
Both CC/MCC	47%

	Your Trauma Inpatients
No CC/MCC	*
CC Only	41%
MCC Only	*
Both CC/MCC	51%

	All Trauma Inpatients Nationally
No CC/MCC	11%
CC Only	47%
MCC Only	3%
Both CC/MCC	39%