GEORGIA TRAUMA CARE NETWORK COMMISSION

VALIDATION OF UNCOMPENSATED CARE CLAIM DATA

AGREED UPON PROCEDURES

For the Year Ending December 31, 2012
# GEORGIA TRAUMA CARE NETWORK COMMISSION

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**For the Year Ending December 31, 2012**

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INDEPENDENT ACCOUNTANTS’ REPORT

To the Georgia Trauma
Care Network Commission

We have performed the procedures enumerated on Attachments A and A-1, which were agreed to by you, solely to assist you with respect to the validation of uncompensated care claim data for the year ending December 31, 2012. The Georgia Trauma Care Network Commission and the Georgia-designated Trauma Centers’ (as listed on Attachment A) management are responsible for the uncompensated care claim data submitted for these procedures. This agreed-upon procedures engagement was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants. The sufficiency of the procedures is solely the responsibility of the Georgia Trauma Care Network Commission. Consequently, we make no representation regarding the sufficiency of the procedures described on Attachments A and A-1, either for the purpose for which this report has been requested, or for any other purpose.

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

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

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

WARREN AVERETT, LLC

WARREN AVERETT, LLC

May 8, 2014
Atlanta, Georgia
Georgia-designated Level I and II Trauma Centers and Burn Centers:
- Atlanta Medical Center (AMC) – Atlanta
- Grady Memorial Hospital (Grady) – Atlanta
- Medical Center of Central Georgia, Inc. (MCCG) – Macon
- GA Health Sciences Medical Center (GHS) – Augusta
- Memorial Health University Medical Center (Memorial) – Savannah
- Athens Regional Medical Center (Athens) – Athens
- Floyd Medical Center (Floyd) – Rome
- Gwinnett Medical Center (Gwinnett) – Lawrenceville
- Hamilton Medical Center (Hamilton) – Dalton
- John D. Archbold Memorial Hospital (Archbold) – Thomasville
- Medical Center-Columbus (Columbus) – Columbus
- North Fulton Regional Hospital (North Fulton) – Roswell
- Childrens Healthcare of Atlanta at Egleston (Egleston) – Atlanta
- Childrens Healthcare of Atlanta at Scottish Rite (Scottish Rite) – Atlanta
- Doctors Hospital (Doctors) – Augusta
- Wellstar Kennestone Hospital (Wellstar) – Marietta
- Grady Burn Center (GBC) – Crestview

Procedures:
The following are the agreed-upon procedures that Warren Averett, LLC (WA) was engaged to perform related to the Georgia-designated Trauma Centers (Trauma Centers) listed above.

1. WA will assist the Georgia Trauma Care Network Commission (GTCNC) in the development of the uncompensated care claims survey instrument for the year ending December 31, 2012 (CY2012).

2. WA will deliver the survey instrument and collect the listing of uncompensated care claims submitted by each Level I Trauma, Level II Trauma and Burn Centers. The listing will contain the claim identification number, trauma registry or equivalent number, date of admission and the patient’s severity scoring.

3. For each Trauma (Burn) Center, WA will select a sample of the uncompensated care claims for testing as follows:
   a. For Trauma Centers with less than 25 claims, WA will test 5 claims;
   b. For Trauma Centers with between 25 and 50 claims, WA will test 10 claims;
   c. For Trauma Centers with between 50 and 150 claims, WA will test 20 claims; and,
   d. For Trauma Centers with greater than 150 claims, WA will test 40 claims.
ATTACHMENT A

VALIDATION OF UNCOMPENSATED CARE CLAIM DATA: PROCEDURES

4. For each claim selected in procedure #3 above, WA will view (on site at the Trauma (Burn) Center location) the electronic billing record (EBR) or documents comparable to the EBR to determine that as of February 14, 2014 each claim selected in our sample met the criteria for consideration as an uncompensated care claim. The criteria for consideration as an uncompensated care claim are as follows:

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

5. For each claim selected in our sample (as defined above), WA will determine that the Trauma (Burn) Center has documented attempts at collection using the documentation that is available at each Trauma (Burn) Center.

6. WA will verify that the Severity Score Category (SSC) assigned to each claim selected in our sample (as defined above) matches the SSC for that patient in NTRACS (trauma registry software) used by all Trauma Centers or the burn registry used by Burn Centers.

7. WA will consider the additional clarifications approved by the GTCNC listed below:

   A. Claims deemed qualified under the GTCNC uncompensated care definition:
      a. Cases where financial counselors at the Trauma Center determined that the patients qualified for a charity program offered by the hospital whereby the account was written off and further attempts to collect were not made.
      b. Cases where patients were victims of a crime and the Trauma Center received a small payment up to 10% of hospital charges from a third party charity.
      c. Cases where patients were undocumented aliens and the Trauma Center received a small payment up to 10% of hospital charges from a third party charity.
      d. Cases where insurance could not be verified.
B. Claims deemed NOT qualified under the GTCNC uncompensated care definition:
   a. Cases where the patient expired and the Trauma Center did not attempt to collect.
   b. Cases where patients received settlements directly but did not pay the Trauma Center after repeated collection attempts.
   c. Cases where there was a reciprocal agreement with another party for exchange of services and the Trauma Center did not attempt further collection procedures.
   d. Cases where claims are sold to collections agency.
ATTACHMENT A-1

ADDITIONAL PROCEDURES PERFORMED

WA discussed the findings summarized in Attachment B and presented in detail in Attachment B-1 from the execution of our agreed-upon procedures as described in Attachment A with the Executive Director for the Georgia Trauma Care Network Commission. Various criteria were used by the Commission staff to determine the appropriate additional procedures to be performed as outlined below. Examples of the criteria used were: the number of exceptions noted, the pervasiveness of the exceptions noted, and the type of exceptions noted from the execution of our agreed-upon procedures as described in Attachment A. As a result of the Commission staff’s review of the findings summarized in Attachment B and presented in detail in Attachment B-1, WA was engaged to perform the following additional procedures:

1. Provide each Trauma (Burn) Center with the findings from our agreed-upon procedures as described in Attachment A. See the information that was provided to each Trauma (Burn) Center in Attachment B-1.

2. Request revised lists of uncompensated care claims from the following Trauma (Burn) Centers:
   - AMC
   - Grady
   - MCCG
   - Columbus

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

3. Compare the revised lists received above against the original lists received to ensure that errors WA noted in the AUP were eliminated (along with any other claims that the hospitals identified as erroneous) and that there are no new claims added to the list.

4. Revise WA AUP report to report the updated uncompensated care claims for each Trauma (Burn) Center. Results are presented in Attachment B-2.

5. Present our final report to the Executive Director of the Georgia Trauma Care Network Commission.

WA performed only the procedures outlined in Attachments A and A-1 and did not perform any additional procedures. We did not perform any procedures to evaluate if there were trauma patient claims that should have been reported by the Trauma (Burn) Centers as uncompensated care claims and were not.
ATTACHMENT B
VALIDATION OF UNCOMPENSATED CARE CLAIM DATA

FINDINGS SUMMARY:
We have accumulated our findings from our agreed-upon procedures that are outlined in Attachment A. They are outlined below along with our recommendations which have been considered and acted upon as deemed appropriate (See Attachment A-1). Additional information for each finding can be found in the detailed reports by location. (See Attachment B-1)

1. Finding: We noted claims at the following Trauma (Burn) Centers where we concluded that the documentation did not meet the criteria for an uncompensated care claim due to:

A. Patient had insurance including Medicare Part B coverage
   • MCCG
   • Memorial
   • Columbus

Recommendation: We recommend the GTCNC consider requesting that these Trauma (Burn) Centers revise their CY2012 uncompensated care claim list to exclude all claims where patients had insurance including Medicare Part B coverage.

B. Patient was eligible for medical assistance coverage
   • Athens
   • Doctors

Recommendation: We recommend the GTCNC consider requesting that these Trauma (Burn) Centers revise their CY2012 uncompensated care claim list to exclude all claims where patients were eligible for medical assistance coverage.

C. Patient had medical coverage for trauma care through workers’ compensation, automobile insurance, or any other third party, including any settlement or judgment resulting from such coverage.
   • AMC
   • Grady
   • MCCG
   • GBC
   • Columbus
Recommendation: We recommend the GTCNC consider requesting that these Trauma (Burn) Centers revise their CY2012 uncompensated care claim list to exclude all claims where patients had medical coverage for trauma care through workers’ compensation, automobile insurance, or any other third party, including any settlement or judgment resulting from such coverage.

D. Payment by patient greater than 10%
   • Floyd

Recommendation: We recommend that the CTGNC consider requesting these Trauma (Burn) Centers revise their CY2012 uncompensated care claim list to exclude all claims where patient payments greater than 10% were received.

E. Receipt of a third party payment
   • AMC
   • MCCG
   • Memorial
   • Athens
   • Columbus

Recommendation: We recommend that the GTCNC consider requesting these Trauma (Burn) Centers revise their CY2012 uncompensated care claim list to exclude all claims where third party payments were received.

F. No collection attempts were made by the Trauma Center.
   • Grady
   • Egleston
   • Doctors

Recommendation: We recommend the GTCNC consider requesting that these Trauma (Burn) Centers revise their CY2012 uncompensated care claim list to exclude all claims where there were no collection attempts made.
HOSPITAL: AMC

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

Procedures: For hospitals with greater than 150 claims, we will test 40.

AMC reported 291 claims, therefore we selected a sample of 40.

For each claim selected, we viewed the electronic billing record (EBR) or documents comparable to the EBR.

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

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

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

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

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

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

Additionally, for each claim selected we determined the following:

1. We verified that the ISS reported is the same as that listed in the hospital’s trauma registry software.

<table>
<thead>
<tr>
<th>Medical Record No</th>
<th>Trauma Number</th>
<th>Admit Date</th>
<th>ISS</th>
<th>a</th>
<th>b</th>
<th>c</th>
<th>d</th>
<th>e</th>
<th>f</th>
<th>g</th>
<th>h</th>
<th>i</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>5244195</td>
<td>13616</td>
<td>4/11/12</td>
<td>4</td>
<td>P</td>
<td>P</td>
<td>X</td>
<td>X</td>
<td>P</td>
<td>P</td>
<td>Settlement reached and payment of settlement was received on 5/24/13.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5245483</td>
<td>13199</td>
<td>4/10/12</td>
<td>10</td>
<td>P</td>
<td>P</td>
<td>X</td>
<td>X</td>
<td>P</td>
<td>P</td>
<td>Settlement reached and payment of settlement was received on 2/26/13.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Tickmark Explanations:

P  Step performed without exception

X  Issue noted, see explanation to the right of claim.
ATTACHMENT B-1

DETAIL FINDINGS BY LOCATION

HOSPITAL: GRADY

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

Procedures: For hospitals with greater than 150 claims, we will test 40.

Grady reported 914 claims, therefore we selected a sample of 40 for testing.

For each claim selected, we viewed the electronic billing record (EBR) or documents comparable to the EBR.

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

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

Additionally, for each claim selected we determined the following:

1. We verified that the ISS reported is the same as that listed in the hospital’s trauma registry software.

<table>
<thead>
<tr>
<th>Acct No</th>
<th>Medical Record No</th>
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<th>a</th>
<th>b</th>
<th>c</th>
<th>d</th>
<th>e</th>
<th>f</th>
<th>I</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>5000626012</td>
<td>637998</td>
<td>6/2/2012</td>
<td>P</td>
<td>P</td>
<td>X</td>
<td>P</td>
<td>P</td>
<td>X</td>
<td>P</td>
<td>Victim of Crime adjustments and no documented attempts at collection</td>
</tr>
<tr>
<td>2</td>
<td>5001022551</td>
<td>100099454</td>
<td>12/27/2012</td>
<td>P</td>
<td>P</td>
<td>X</td>
<td>X</td>
<td>P</td>
<td>X</td>
<td>P</td>
<td>Victim of Crime adjustments and no documented attempts at collection</td>
</tr>
<tr>
<td>3</td>
<td>5000801669</td>
<td>20235376</td>
<td>9/8/2012</td>
<td>P</td>
<td>P</td>
<td>X</td>
<td>P</td>
<td>P</td>
<td>X</td>
<td>P</td>
<td>Victim of Crime adjustments and no documented attempts at collection</td>
</tr>
<tr>
<td>4</td>
<td>5000890146</td>
<td>100090540</td>
<td>10/17/2012</td>
<td>P</td>
<td>P</td>
<td>X</td>
<td>P</td>
<td>P</td>
<td>X</td>
<td>P</td>
<td>Victim of Crime adjustments and no documented attempts at collection</td>
</tr>
<tr>
<td>5</td>
<td>5000989277</td>
<td>5845338</td>
<td>12/6/2012</td>
<td>P</td>
<td>P</td>
<td>X</td>
<td>P</td>
<td>P</td>
<td>X</td>
<td>P</td>
<td>Victim of Crime adjustments and no documented attempts at collection</td>
</tr>
<tr>
<td>6</td>
<td>5000560444</td>
<td>9573341</td>
<td>4/30/2012</td>
<td>P</td>
<td>P</td>
<td>X</td>
<td>P</td>
<td>P</td>
<td>X</td>
<td>P</td>
<td>Victim of Crime adjustments and no documented attempts at collection</td>
</tr>
</tbody>
</table>

Tickmark Explanations:

P  Step performed without exception
X  Issue noted, see explanation to the right of claim.
HOSPITAL: MCCG – MACON

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

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

MCCG reported 381 claims, therefore we selected a sample of 40 for testing.

For each claim selected, we viewed the electronic billing record (EBR) or documents comparable to the EBR.

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

- The EBR shows the patient had no medical insurance, including Medicare Part B coverage.
- The EBR shows the patient was not eligible for medical assistance coverage.
- The EBR shows the patient has not paid more than 10% of total charges after documented attempts by the trauma care services provider to collect payments.
- The EBR shows that there were no third party payments received.
- The hospital has documented attempts at collection via documentation available at the hospital.

Additionally, for each claim selected we determined the following:

1. We verified that the ISS reported is the same as that listed in the hospital’s trauma registry software.

### Medical Record No. Admit Date ISS a b c d e f i Comments

<table>
<thead>
<tr>
<th>Medical Record No</th>
<th>Admit Date</th>
<th>ISS</th>
<th>a</th>
<th>b</th>
<th>c</th>
<th>d</th>
<th>e</th>
<th>f</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>986923752273</td>
<td>9/29/2012</td>
<td>Basic: 0-8</td>
<td>P</td>
<td>P</td>
<td>X</td>
<td>P</td>
<td>X</td>
<td>P</td>
<td>Victim of Crime payments received over the 10% threshold</td>
</tr>
<tr>
<td>986783252138</td>
<td>5/17/2012</td>
<td>Major: 16-24</td>
<td>P</td>
<td>P</td>
<td>X</td>
<td>P</td>
<td>X</td>
<td>P</td>
<td>Victim of Crime payment received over the 10% threshold</td>
</tr>
<tr>
<td>986841972197</td>
<td>7/15/2012</td>
<td>Major: 16-24</td>
<td>P</td>
<td>P</td>
<td>X</td>
<td>P</td>
<td>X</td>
<td>P</td>
<td>Victim of Crime payment received over the 10% threshold</td>
</tr>
<tr>
<td>986968112315</td>
<td>11/10/2012</td>
<td>Major: 16-24</td>
<td>X</td>
<td>P</td>
<td>P</td>
<td>X</td>
<td>P</td>
<td>P</td>
<td>Insurance payment received</td>
</tr>
<tr>
<td>9866529092016</td>
<td>1/16/2012</td>
<td>Moderate: 9-15</td>
<td>P</td>
<td>P</td>
<td>X</td>
<td>P</td>
<td>X</td>
<td>P</td>
<td>Victim of Crime payment received over the 10% threshold</td>
</tr>
<tr>
<td>9867108582070</td>
<td>3/10/2012</td>
<td>Moderate: 9-15</td>
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<td>X</td>
<td>P</td>
<td>Auto insurance payment received</td>
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<tr>
<td>986836132192</td>
<td>7/10/2012</td>
<td>Moderate: 9-15</td>
<td>P</td>
<td>P</td>
<td>X</td>
<td>P</td>
<td>X</td>
<td>P</td>
<td>Victim of Crime payment received over the 10% threshold</td>
</tr>
<tr>
<td>986815342170</td>
<td>6/18/2012</td>
<td>Severe: &gt;24</td>
<td>P</td>
<td>P</td>
<td>X</td>
<td>P</td>
<td>X</td>
<td>P</td>
<td>Victim of Crime payment received over the 10% threshold</td>
</tr>
<tr>
<td>986905722257</td>
<td>9/11/2012</td>
<td>Severe: &gt;24</td>
<td>P</td>
<td>P</td>
<td>X</td>
<td>P</td>
<td>X</td>
<td>P</td>
<td>Medicaid payment received</td>
</tr>
</tbody>
</table>

**Tickmark Explanations:**
- P Step performed without exception
- X Issue noted, see explanation to the right of claim.
HOSPITAL: MEMORIAL

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

Procedures: For hospitals with greater than 150 claims, we will test 40.
Memorial Health reported 318 claims, therefore we selected a sample of 40 for testing.
For each claim selected, we viewed the electronic billing record (EBR) or documents comparable to the EBR.
We determined whether the claims selected met the criteria for consideration as an uncompensated care claim. The criteria are as follows:
a The EBR shows the patient had no medical insurance, including Medicare Part B coverage.
b The EBR shows the patient was not eligible for medical assistance coverage.
c The EBR shows that the patient had no medical coverage for trauma care through workers’ compensation, automobile insurance, or any other third party, including any settlement or judgment resulting from such coverage.
d The EBR shows that the patient has not paid more than 10% of total charges after documented attempts by the trauma care services provider to collect payments.
e The EBR shows that there were no third party payments received.
f The hospital has documented attempts at collection via documentation available at the hospital.
Additionally, For each claim selected we determined the following:
1 We verified that the ISS reported is the same as that listed in the hospital’s trauma registry software.

<table>
<thead>
<tr>
<th>Trauma Registry No.</th>
<th>Patient ID</th>
<th>Admit Date</th>
<th>ISS</th>
<th>a</th>
<th>b</th>
<th>c</th>
<th>d</th>
<th>e</th>
<th>f</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>40438</td>
<td>1224501760</td>
<td>9/2/2012</td>
<td>4</td>
<td>X</td>
<td>P</td>
<td>P</td>
<td>N</td>
<td>P</td>
<td>P</td>
<td>Medicaid payment received</td>
</tr>
</tbody>
</table>

Tickmark Explanations:
P  Step performed without exception
X  Issue noted, see explanation to the right of claim.
HOSPITAL: ATHENS

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

**Procedures:** For hospitals with 50-150 claims, we will select 20.

- Athens reported 88 claims, therefore we selected a sample of 20 for testing.
- For each claim selected, we viewed the electronic billing record (EBR) or documents comparable to the EBR.
- We determined whether the claims selected met the criteria for consideration as an uncompensated care claim. The criteria are as follows:
  a. The EBR shows the patient had no medical insurance, including Medicare Part B coverage.
  b. The EBR shows the patient was not eligible for medical assistance coverage.
  c. The EBR shows that the patient had no medical coverage for trauma care through workers’ compensation, automobile insurance, or any other third party, including any settlement or judgment resulting from such coverage.
  d. The EBR shows that the patient has not paid more than 10% of total charges after documented attempts by the trauma care services provider to collect payments.
  e. The EBR shows that there were no third party payments received.
  f. The hospital has documented attempts at collection via documentation available at the hospital.

- Additionally, for each claim selected we determined the following:
  1. We verified that the ISS reported is the same as that listed in the hospital’s trauma registry software.

<table>
<thead>
<tr>
<th>Trauma No</th>
<th>Account No</th>
<th>Admit Date</th>
<th>ISS</th>
<th>a</th>
<th>b</th>
<th>c</th>
<th>d</th>
<th>e</th>
<th>f</th>
<th>i</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>3636</td>
<td>50452344</td>
<td>11/6/2012</td>
<td>4</td>
<td>P</td>
<td>X</td>
<td>P</td>
<td>X</td>
<td>P</td>
<td>P</td>
<td>This account was mistakenly added to the list, medicaid patient</td>
</tr>
</tbody>
</table>

**Tickmark Explanations:**
- **P** Step performed without exception
- **X** Step performed with exception, see comments to the right for more information.
ATTACHMENT B-I

DETAIL FINDINGS BY LOCATION

HOSPITAL: FLOYD

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

Procedures: For hospitals with 25-50 cases, we will select 10.

Floyd Medical Center reported 50 claims, therefore we selected a sample of 10 for testing.

For each claim selected, we viewed the electronic billing record (EBR) or documents comparable to the EBR.

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

- The EBR shows the patient had no medical insurance, including Medicare Part B coverage.
- The EBR shows the patient was not eligible for medical assistance coverage.
- The EBR shows that the patient had no medical coverage for trauma care through workers’ compensation, automobile insurance, or any other third party, including any settlement or judgment resulting from such coverage.
- The EBR shows that the patient has not paid more than 10% of total charges after documented attempts by the trauma care services provider to collect payments.
- The EBR shows that there were no third party payments received.
- Additionally, for each claim selected we determined the following:
  - We verified that the ISS reported is the same as that listed in the hospital’s trauma registry software.

<table>
<thead>
<tr>
<th>Trauma No</th>
<th>Account No</th>
<th>Admit Date</th>
<th>ISS</th>
<th>a</th>
<th>b</th>
<th>c</th>
<th>d</th>
<th>e</th>
<th>f</th>
<th>l</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>3400</td>
<td>F0000926945</td>
<td>8/8/2012</td>
<td>2</td>
<td>P</td>
<td>P</td>
<td>X</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>Patient paid entire balance</td>
</tr>
</tbody>
</table>

Tickmark Explanations:
- P: Step performed without exception
- X: Issue noted, see explanation to the right of claim.
ATTACHMENT B-1

DETAIL FINDINGS BY LOCATION

HOSPITAL: EGLESTON

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

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

- Children's Healthcare of Atlanta at Egleston reported 48 claims, therefore we selected a sample of 10 for testing.

- For each claim selected, we viewed the electronic billing record (EBR) or documents comparable to the EBR.

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

- Additionally, for each claim selected we determined the following:
  1. We verified that the ISS reported is the same as that listed in the hospital’s trauma registry software.

### Table

<table>
<thead>
<tr>
<th>Medical Record #</th>
<th>Account #</th>
<th>Admit Date</th>
<th>ISS</th>
<th>a</th>
<th>b</th>
<th>c</th>
<th>d</th>
<th>e</th>
<th>f</th>
<th>1</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>2323771</td>
<td>601541407</td>
<td>11/19/2012</td>
<td>9</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>X</td>
<td>P</td>
<td>No documented attempts at collection</td>
</tr>
</tbody>
</table>

**Tickmark Explanations:**

- **P** Step performed without exception
- **X** Issue noted, see explanation to the right of claim.
**HOSPITAL: COLUMBUS**

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

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

Columbus reported 117 claims, therefore we selected a sample of 20.

For each claim selected, we viewed the electronic billing record (EBR) or documents comparable to the EBR.

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

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

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

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

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

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

Additionally, for each claim selected we determined the following:

1. We verified that the ISS reported is the same as that listed in the hospital’s trauma registry software.

<table>
<thead>
<tr>
<th>Medical Record #</th>
<th>Registry #</th>
<th>ISS</th>
<th>Admit Date</th>
<th>a</th>
<th>b</th>
<th>c</th>
<th>d</th>
<th>e</th>
<th>f</th>
<th>l</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 1000275447</td>
<td>9496</td>
<td>4</td>
<td>5/25/2012</td>
<td>X</td>
<td>P</td>
<td>P</td>
<td>X</td>
<td>P</td>
<td>P</td>
<td>Medicare A payment received</td>
<td></td>
</tr>
<tr>
<td>2 1000275927</td>
<td>9504</td>
<td>5</td>
<td>5/26/2012</td>
<td>X</td>
<td>P</td>
<td>P</td>
<td>X</td>
<td>P</td>
<td>P</td>
<td>GA Medicaid payment received</td>
<td></td>
</tr>
<tr>
<td>3 1000315638</td>
<td>9648</td>
<td>8</td>
<td>7/17/2012</td>
<td>P</td>
<td>P</td>
<td>X</td>
<td>P</td>
<td>X</td>
<td>P</td>
<td>Victim of Crime payment over the 10% threshold</td>
<td></td>
</tr>
<tr>
<td>4 1000278956</td>
<td>9512</td>
<td>11</td>
<td>5/31/2012</td>
<td>X</td>
<td>P</td>
<td>P</td>
<td>X</td>
<td>P</td>
<td>P</td>
<td>Insurance payment received</td>
<td></td>
</tr>
<tr>
<td>5 1000290126</td>
<td>9558</td>
<td>11</td>
<td>6/14/2012</td>
<td>X</td>
<td>P</td>
<td>X</td>
<td>X</td>
<td>P</td>
<td>P</td>
<td>Insurance and auto insurance payments received; Victim of Crime payment over the 10% threshold</td>
<td></td>
</tr>
<tr>
<td>6 1000432913</td>
<td>10025</td>
<td>14</td>
<td>12/6/2012</td>
<td>P</td>
<td>P</td>
<td>X</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>Prison payment received</td>
<td></td>
</tr>
<tr>
<td>7 1000262093</td>
<td>9454</td>
<td>17</td>
<td>5/8/2012</td>
<td>X</td>
<td>P</td>
<td>X</td>
<td>X</td>
<td>P</td>
<td>P</td>
<td>Insurance and auto insurance payments received</td>
<td></td>
</tr>
</tbody>
</table>

**Tickmark Explanations:**

- **P** Step performed without exception
- **X** Step performed with exception, see explanation to right
ATTACHMENT B-1

DETAIL FINDINGS BY LOCATION

HOSPITAL: DOCTORS

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

Procedures: For hospitals with greater than 150 claims, we will test 40.

Doctors Hospital reported 206 claims, therefore we selected a sample of 40 for testing.

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

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

Additionally, for each claim selected we determined the following:

1 We verified that the severity category listed on the listing provided on the next tab is the same as that listed in the hospital’s burn registry software.

<table>
<thead>
<tr>
<th>Burn Registry No</th>
<th>Medical Record No</th>
<th>Admit Date</th>
<th>Injury Severity Code</th>
<th>a</th>
<th>b</th>
<th>c</th>
<th>d</th>
<th>e</th>
<th>f</th>
<th>i</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>34109</td>
<td>G000749266</td>
<td>4/12/47</td>
<td></td>
<td></td>
<td>X</td>
<td>P</td>
<td>P</td>
<td></td>
<td></td>
<td>Patient had medical insurance and a claim was filed, insurance company has not denied or paid</td>
</tr>
<tr>
<td>2</td>
<td>34164</td>
<td>G000750112</td>
<td>4/12/57</td>
<td></td>
<td></td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>X</td>
<td></td>
<td>No documented attempts at collection</td>
</tr>
</tbody>
</table>

Tickmark Explanations:

P Step performed without exception
X Issue noted, see explanation to the right of claim.
HOSPITAL: GBC

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

**Procedures:** For hospitals with greater than 150 claims, we will test 40.
- Grady Burn Center reported 185 claims, therefore we selected a sample of 40 for testing.
- For each claim selected, we viewed the electronic billing record (EBR) or documents comparable to the EBR.
- We determined whether the claims selected met the criteria for consideration as an uncompensated care claim. The criteria are as follows:
  a. The EBR shows the patient had no medical insurance, including Medicare Part B coverage.
  b. The EBR shows the patient was not eligible for medical assistance coverage.
  c. The EBR shows that the patient had no medical coverage for trauma care through workers’ compensation, automobile insurance, or any other third party, including any settlement or judgment resulting from such coverage.
  d. The EBR shows that the patient has not paid more than 10% of total charges after documented attempts by the trauma care services provider to collect payments.
  e. The EBR shows that there were no third party payments received.
  f. The hospital has documented attempts at collection via documentation available at the hospital.
- Additionally, for each claim selected we determined the following:
  1. We verified that the ISS reported is the same as that listed in the hospital’s burn registry software.

<table>
<thead>
<tr>
<th>Trauma Registry No</th>
<th>Account No</th>
<th>Date of Admission</th>
<th>ISS</th>
<th>a</th>
<th>b</th>
<th>c</th>
<th>d</th>
<th>e</th>
<th>f</th>
<th>l</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>10872509</td>
<td>5000873416</td>
<td>10/8/2012</td>
<td>Smoke Inhalation, TBSA 11-20%</td>
<td>P</td>
<td>P</td>
<td>X</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>Medicaid was approved but no payments were received</td>
<td></td>
</tr>
</tbody>
</table>

**Tickmark Explanations:**
- **P** Step performed without exception
- **X** Exception noted see comment for explanation
## ATTACHMENT B-2

### SUMMARY FINDINGS BY LOCATION

<table>
<thead>
<tr>
<th>Locations Tested With Claims Resubmitted</th>
<th>Basic</th>
<th>Moderate</th>
<th>Major</th>
<th>Severe</th>
<th>Total</th>
<th>Severity Score Category</th>
<th>Basic</th>
<th>Moderate</th>
<th>Major</th>
<th>Severe</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMC</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>Grady</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per Original Survey</td>
<td>127</td>
<td>97</td>
<td>48</td>
<td>19</td>
<td>291</td>
<td>Per Original Survey</td>
<td>489</td>
<td>307</td>
<td>88</td>
<td>30</td>
<td>914</td>
</tr>
<tr>
<td>Per AUP</td>
<td>126</td>
<td>96</td>
<td>48</td>
<td>19</td>
<td>289</td>
<td>Per AUP</td>
<td>487</td>
<td>305</td>
<td>87</td>
<td>29</td>
<td>908</td>
</tr>
<tr>
<td>Difference 1</td>
<td>(1)</td>
<td>(1)</td>
<td>-</td>
<td>-</td>
<td>(2)</td>
<td>Difference 1</td>
<td>(2)</td>
<td>(2)</td>
<td>(1)</td>
<td>(1)</td>
<td>(6)</td>
</tr>
<tr>
<td>Per Revised List</td>
<td>125</td>
<td>96</td>
<td>48</td>
<td>19</td>
<td>288</td>
<td>Per Revised List</td>
<td>406</td>
<td>228</td>
<td>65</td>
<td>19</td>
<td>718</td>
</tr>
<tr>
<td>Difference 2</td>
<td>(2)</td>
<td>(1)</td>
<td>-</td>
<td>-</td>
<td>(3)</td>
<td>Difference 2</td>
<td>(83)</td>
<td>(79)</td>
<td>(23)</td>
<td>(11)</td>
<td>(196)</td>
</tr>
<tr>
<td>Columbus</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>MCCG</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per Original Survey</td>
<td>37</td>
<td>42</td>
<td>21</td>
<td>17</td>
<td>117</td>
<td>Per Original Survey</td>
<td>202</td>
<td>111</td>
<td>39</td>
<td>29</td>
<td>381</td>
</tr>
<tr>
<td>Per AUP</td>
<td>34</td>
<td>39</td>
<td>20</td>
<td>17</td>
<td>110</td>
<td>Per AUP</td>
<td>201</td>
<td>108</td>
<td>36</td>
<td>27</td>
<td>372</td>
</tr>
<tr>
<td>Difference 1</td>
<td>(3)</td>
<td>(3)</td>
<td>(1)</td>
<td>-</td>
<td>(7)</td>
<td>Difference 1</td>
<td>(1)</td>
<td>(3)</td>
<td>(3)</td>
<td>(2)</td>
<td>(9)</td>
</tr>
<tr>
<td>Per Revised List</td>
<td>18</td>
<td>31</td>
<td>14</td>
<td>10</td>
<td>73</td>
<td>Per Revised List</td>
<td>181</td>
<td>88</td>
<td>35</td>
<td>23</td>
<td>327</td>
</tr>
</tbody>
</table>

*Difference 1: ineligible claims determined by WA*

*Difference 2: ineligible claims determined by WA plus ineligible claims determined by center during resubmission process*
## ATTACHMENT B-2

### SUMMARY FINDINGS BY LOCATION—Continued

<table>
<thead>
<tr>
<th>Severity Score Category</th>
<th>Basic</th>
<th>Moderate</th>
<th>Major</th>
<th>Severe</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Locations Tested With Claims Resubmitted</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>855</td>
<td>557</td>
<td>196</td>
<td>95</td>
<td>1,703</td>
</tr>
<tr>
<td>Per AUP</td>
<td>848</td>
<td>548</td>
<td>191</td>
<td>92</td>
<td>1,679</td>
</tr>
<tr>
<td>Difference 1</td>
<td>(7)</td>
<td>(9)</td>
<td>(5)</td>
<td>(3)</td>
<td>(24)</td>
</tr>
<tr>
<td>Per Revised List</td>
<td>730</td>
<td>443</td>
<td>162</td>
<td>71</td>
<td>1,406</td>
</tr>
<tr>
<td>Difference 2</td>
<td>(125)</td>
<td>(114)</td>
<td>(34)</td>
<td>(24)</td>
<td>(297)</td>
</tr>
</tbody>
</table>

*Difference 1: ineligible claims determined by WA
Difference 2: ineligible claims determined by WA plus ineligible claims determined by center during resubmission process*
### ATTACHMENT B-2

**SUMMARY FINDINGS BY LOCATION—Continued**

<table>
<thead>
<tr>
<th>Locations Tested Without Resubmission</th>
<th>Severity Score Category</th>
<th>Severity Score Category</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Basic</td>
<td>Moderate</td>
</tr>
<tr>
<td><strong>Archbold</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per Original Survey</td>
<td>23</td>
<td>16</td>
</tr>
<tr>
<td>Per AUP</td>
<td>23</td>
<td>16</td>
</tr>
<tr>
<td>Difference 1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total claims per AUP</td>
<td>23</td>
<td>16</td>
</tr>
<tr>
<td><strong>Athens</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per Original Survey</td>
<td>32</td>
<td>33</td>
</tr>
<tr>
<td>Per AUP</td>
<td>31</td>
<td>33</td>
</tr>
<tr>
<td>Difference 1</td>
<td>(1)</td>
<td>-</td>
</tr>
<tr>
<td>Total claims per AUP</td>
<td>31</td>
<td>33</td>
</tr>
<tr>
<td><strong>Doctors</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per Original Survey</td>
<td>162</td>
<td>33</td>
</tr>
<tr>
<td>Per AUP</td>
<td>161</td>
<td>32</td>
</tr>
<tr>
<td>Difference 1</td>
<td>(1)</td>
<td>(1)</td>
</tr>
<tr>
<td>Total claims per AUP</td>
<td>161</td>
<td>32</td>
</tr>
<tr>
<td><strong>Egleston</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per Original Survey</td>
<td>33</td>
<td>10</td>
</tr>
<tr>
<td>Per AUP</td>
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<td>9</td>
</tr>
<tr>
<td>Difference 1</td>
<td>-</td>
<td>(1)</td>
</tr>
<tr>
<td>Total claims per AUP</td>
<td>33</td>
<td>9</td>
</tr>
</tbody>
</table>

*Difference 1: ineligible claims determined by WA*
## ATTACHMENT B-2

### SUMMARY FINDINGS BY LOCATION—Continued

<table>
<thead>
<tr>
<th>Locations Tested Without Resubmission</th>
<th>Severity Score Category</th>
<th>Locations Tested Without Resubmission</th>
<th>Severity Score Category</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Basic</td>
<td>Moderate</td>
<td>Major</td>
</tr>
<tr>
<td>bakery</td>
<td>15</td>
<td>25</td>
<td>9</td>
</tr>
<tr>
<td>per AUP</td>
<td>15</td>
<td>25</td>
<td>9</td>
</tr>
<tr>
<td>Difference 1</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total claims per AUP</td>
<td>15</td>
<td>25</td>
<td>9</td>
</tr>
<tr>
<td>Scottish Rite</td>
<td>107</td>
<td>130</td>
<td>51</td>
</tr>
<tr>
<td>per AUP</td>
<td>107</td>
<td>130</td>
<td>51</td>
</tr>
<tr>
<td>Difference 1</td>
<td>(1)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total claims per AUP</td>
<td>107</td>
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<td>51</td>
</tr>
<tr>
<td>Total</td>
<td>822</td>
<td>505</td>
<td>161</td>
</tr>
</tbody>
</table>

*Difference 1: ineligible claims determined by WA*
### Summary

**Severity Score Category**

<table>
<thead>
<tr>
<th></th>
<th>Basic</th>
<th>Moderate</th>
<th>Major</th>
<th>Severe</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Claims Per Original Survey</td>
<td>1,677</td>
<td>1,062</td>
<td>357</td>
<td>216</td>
<td>3,312</td>
</tr>
<tr>
<td>Totals Per AUP</td>
<td>1,666</td>
<td>1,050</td>
<td>352</td>
<td>213</td>
<td>3,281</td>
</tr>
<tr>
<td>Difference 1</td>
<td>(11)</td>
<td>(12)</td>
<td>(5)</td>
<td>(3)</td>
<td>(31)</td>
</tr>
<tr>
<td>Per Revised List</td>
<td>730</td>
<td>443</td>
<td>162</td>
<td>71</td>
<td>1,406</td>
</tr>
<tr>
<td>Per AUP Without Resubmission</td>
<td>818</td>
<td>502</td>
<td>161</td>
<td>121</td>
<td>1,602</td>
</tr>
<tr>
<td>Total After Revised List and AUP</td>
<td>1,548</td>
<td>945</td>
<td>323</td>
<td>192</td>
<td>3,008</td>
</tr>
<tr>
<td>Difference 2</td>
<td>(129)</td>
<td>(117)</td>
<td>(34)</td>
<td>(24)</td>
<td>(304)</td>
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<td>Total Claims</td>
<td>1,548</td>
<td>945</td>
<td>323</td>
<td>192</td>
<td>3,008</td>
</tr>
</tbody>
</table>

*Difference 1: ineligible claims determined by WA*

*Difference 2: ineligible claims determined by WA plus ineligible claims determined by center during resubmission process*
CONCLUSION:

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

Very truly yours,

Warren Averett, LLC

WARREN AVERETT, LLC