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Hospitals Charged CMS for Trauma Team Activations That Did Not Comply With Federal Requirements

REPORT HIGHLIGHTS

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Hospitals Charged CMS for Trauma Team Activations That Did Not Comply With Federal Requirements

Why OIG Did This Audit

- There has been significant press about trauma care over the past decade including allegations that hospitals are deliberately overusing trauma team activation codes and patients are being forced to pay exorbitant medical costs when the care does not seem to rise to trauma level care.
- There has also been media attention on the variability of trauma fees among hospitals and how much patients are forced to pay.
- This audit assessed whether CMS made Medicare payments to providers for trauma team activations that complied with Federal requirements.

What OIG Found

- CMS made Medicare payments to trauma centers for trauma team activations that did not comply with Federal requirements. Specifically, 107 of 125 sampled claims with trauma team activations did not meet Medicare requirements—100 sampled claims had unallowable trauma team activation charges that totaled $728,468, and 7 sampled claims had coding errors that did not have any impact on payment or charges associated with the trauma team activation.
- We estimated that approximately 77 percent of all claims submitted to Medicare with trauma team activations did not comply with Federal requirements. Additionally, we estimated that hospitals also billed approximately $2.4 billion in unallowable charges for trauma team activations that did not meet Medicare requirements from January 1, 2020, through June 30, 2022.

What OIG Recommends

We made four recommendations, including that CMS take the necessary steps to address the estimated $2.4 billion in unallowable trauma team activation charges reported on hospitals' cost reports and the resulting incorrect outlier payments to improve the accuracy of data used to establish future prospective payment system payment rates. In addition, we made procedural recommendations. The full recommendations are in the report.

CMS did not concur with our first and second recommendations. CMS did not indicate concurrence or nonconcurrence with our third and fourth recommendations but stated that it will review existing guidance and assess the need for additional education.

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INTRODUCTION

WHY WE DID THIS AUDIT

There has been significant press about trauma care over the past decade including allegations that hospitals are deliberately overusing trauma team activation codes and patients are charged exorbitant medical costs when the care does not seem to rise to trauma level care.[1] There has also been media attention on the variability of trauma fees among hospitals and how much patients are charged.[2] These media sources point to a lack of guidance that would tell hospitals when they should activate trauma teams. The Centers for Medicare & Medicaid Services (CMS) established a billing code for trauma team activation in 2002 and added a payment for trauma team activation in 2007. We performed this audit to determine how hospitals are using and billing for trauma team activations.

OBJECTIVE

Our objective was to determine whether CMS made Medicare payments to providers for trauma team activations that complied with Federal requirements.

BACKGROUND

The Medicare Program

The Medicare program provides health insurance coverage to people aged 65 and over, people with disabilities, and people with end-stage renal disease. CMS administers the Medicare program. All health care providers who participate in the Medicare program are required to use a National Provider Indicator (NPI) when submitting transactions to Medicare.[3] Medicare Part A provides inpatient hospital insurance benefits and coverage of extended care services for patients after hospital discharge. Medicare Part B provides supplementary insurance for medical and other health services, including coverage of hospital outpatient services, physician services, laboratory services, and ambulance services. Medicare enrollees are responsible for certain out-of-pocket costs, such as deductibles and coinsurance, for both Medicare Part A and Part B services. Medicare only pays for services that are reasonable and necessary for the

[1] *Kaiser Health News*, "Hospital 'Trauma Centers' Charge Enormous Fees to Treat Minor Injuries and Send People Home." Accessed on Feb. 26, 2025. Vox.com, "A Baby Was Treated With a Nap and a Bottle of Formula. His Parents Received an $18,000 Bill." Accessed on Feb. 26, 2025. *Tampa Bay Times*, "Florida Trauma Centers Charge Outrageous Fees the Moment You Come Through the Door." Accessed on Feb. 26, 2025.

[2] *Cureus*, "Variation in Trauma Team Response Fees in United States Trauma Centers: An Additional Undisclosed Variable Cost in Trauma Care." Accessed on Feb. 26, 2025. *Tampa Bay Times*, "Trauma Fees Growing Across the Nation at 'Absurd' Rate." Accessed on Feb. 26, 2025.

[3] 42 CFR § 424.506(c)(1).

diagnosis or treatment of a patient's illness or injury or to improve the functioning of a malformed body member.[4]

CMS uses a prospective payment system (PPS) to pay for Medicare items and services based upon a predetermined, fixed amount. Under the hospital outpatient PPS (OPPS), CMS classifies groups of service codes into ambulatory payment classifications (APCs) based upon clinical and cost similarity and makes a single payment for all services within an APC. Under the hospital inpatient PPS (IPPS), Medicare makes a single payment for each hospital discharge identified by the Medicare severity diagnosis-related group (MS-DRG) into which the discharge is classified.

Hospitals participating in Medicare are required to submit to Medicare an annual cost report containing provider information, including costs and charges by cost center.[5] CMS contracts with Medicare administrative contractors (MACs) to process Medicare claims, settle cost reports, and serve as the primary operational contact between the Medicare program and health care providers enrolled in the program.

Hospitals and Trauma Team Activation

Hospitals recognized as trauma centers can be either licensed or designated by a cognizant State or local agency, or verified by the American College of Surgeons (ACS). There are different levels of trauma centers that are equipped to care for patients with physical injuries based on severity of their injuries. Physical injuries include severe blunt, blast, or penetrating wounds primarily caused by automobile crashes, gunshots, knife wounds, falls, battery, or burns. When a patient suffers from a physical injury, the trauma center uses triage information from prehospital caregivers in advance of the patient's arrival to determine whether trauma team activation is reasonable and necessary and, if it is, notifies key hospital personnel also known as the trauma team.[6]

A trauma team is a multidisciplinary group of health care professionals. Specifically, a trauma team includes surgeons, emergency physicians, nurses, an anesthesiologist, and radiology technicians. Other important members of the trauma team include communication coordinators, laboratory medicine couriers, and security.

Once the patient arrives at a hospital, the trauma team performs assessments and provides care for life threatening physical injuries until the patient is transferred to the operating room or intensive care unit.

[4] Social Security Act § 1862(a)(1)(A).

[5] 42 CFR § 413.20(b).

[6] 71 Fed. Reg. 67960, 68134, Nov. 24, 2006; *Medicare Claims Processing Manual*, chapter 4, § 160.1; and the NUBC, *Official UB-04 Data Specifications Manual* (NUBC Manual), form locator 42, revenue category 068X.

Billing Requirements for Trauma Team Activation

Medicare billing requirements for trauma team activation refer to the National Uniform Billing Committee's *Official UB-04 Data Specifications Manual* (NUBC Manual) that contains guidelines related to the reporting of revenue codes. Charges representing trauma team activation are identified by using codes under the revenue category 068X.[7] Additionally, the NUBC Manual states that revenue category 068X must be used in conjunction with type of admission code 05 when a trauma team activation occurred. The 068X category includes revenue codes 0681, 0682, 0683, 0684, and 0689. The number that replaces the X generally represents the designation or verification level of the trauma center, except for 0689 that represents other trauma centers designated by State or local authorities with levels greater than IV.

To bill Medicare for trauma team activation, the hospital must be a recognized trauma center. In addition, the hospital must meet the following six Federal requirements when billing for trauma team activations: (1) the hospital received notification prior to the arrival of the patient; (2) the hospital activated the trauma team; (3) the trauma team was activated prior to patient arrival; (4) the trauma team treated the patient; (5) the care provided by the trauma team was reasonable and necessary; and (6) the Medicare claim was correctly coded.

If the hospital activates the trauma team and the patient is admitted to the hospital as inpatient, no additional payment is made for trauma team activation. Instead, the hospital receives a payment under IPPS based upon the assigned MS-DRG, and that payment includes reimbursement for both the hospital stay and all related outpatient services provided during the 3 days before the inpatient hospital admission date.[8] However, the hospital charges for trauma team activation are still submitted under revenue category 068X.

If a hospital activates the trauma team and the patient is not admitted as an inpatient, the hospital may receive an additional payment for trauma team activation if certain conditions are met. Critical care services can be provided with or without trauma team activation. However, a hospital is only allowed to bill one unit of Healthcare Common Procedure Coding System (HCPCS) code G0390 (trauma team activation with hospital critical care service), which results in an additional payment under APC 0618, if the hospital bills CPT® code 99291 for critical care

[7] NUBC Manual, form locator 42, revenue category 068X. Trauma team activation charges are not a replacement or substitute for other charges, such as emergency room visit charges.

[8] Social Security Act § 1886(a)(4); and 42 CFR § 412.2(c)(5).

provided to a patient who is not admitted as an inpatient.[9, 10, 11] The charges related to the trauma team activation are reported under revenue category 068X regardless of whether critical care services are provided.

Under IPPS and OPPS, Medicare makes an additional outlier payment for high-cost patients. Generally, Medicare uses charges and costs submitted by hospitals, including trauma team activation charges, to determine whether an outlier payment is warranted and to calculate future PPS payment rates.[12]

HOW WE CONDUCTED THIS AUDIT

Our audit covered 303,903 claims for trauma team activation (e.g., claims that were billed with revenue category 068X or submitted with HCPCS code G0390) with approximately $29 billion in charges, $4.3 billion in Medicare Part A and B payments, and approximately $27 million inpatient copayments.[13] These claims had dates of service from January 1, 2020, through June 30, 2022 (audit period).

We selected a stratified random sample consisting of 125 claims across 5 strata.[14] For each claim, we requested supporting documentation for the claim submitted from the billing

[9] Hospitals may bill CPT code 99291 for the first 30-74 minutes of critical care services.

[10] *CPT copyright 2022 American Medical Association. All rights reserved.*

Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.

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[12] 42 CFR § 412.80(a)(3) for IPPS; and 42 CFR § 419.43(d) for OPPS.

[13] At the time we started our audit, this represented the most recent data available.

[14] We did not contact one of the selected trauma centers because of ongoing OIG work related to that trauma center. As a result, we did not determine whether this trauma center complied with Federal requirements. To be conservative, we considered this sample item a non-error.

hospital.[15] We used an independent medical reviewer to determine, based on the supporting documentation, whether trauma centers met Medicare requirements when billing for trauma team activation.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A contains details of our audit scope and methodology, Appendix B contains details of our statistical sampling methodology, Appendix C contains our sample results and estimates, and Appendix D contains the results of review of each of our sample items.

FINDINGS

CMS made Medicare payments to hospitals for trauma team activations that did not comply with Federal requirements. Specifically, 18 of 125 sampled claims with trauma team activations met Medicare requirements. However, 107 sampled claims with trauma team activations did not meet Medicare requirements. For 100 of the 107 sampled claims, we found $728,468 in unallowable trauma team activation charges submitted by hospitals. The remaining seven sampled claims that did not meet Medicare requirements had coding errors that did not have any impact on payment or charges associated with the trauma team activation.

Based on our sample results, we estimated that 234,248 claims were submitted to Medicare by hospitals for trauma team activations that did not comply with Federal requirements. This represents approximately 77 percent of all claims submitted to Medicare with trauma team activation during our audit period. Additionally, we estimated that hospitals also billed approximately $2.4 billion in unallowable charges for trauma team activations that did not meet Medicare requirements.[16] These unallowable charges may have caused CMS to make incorrect outlier payments and affected the rate-setting factors CMS used for future payments.

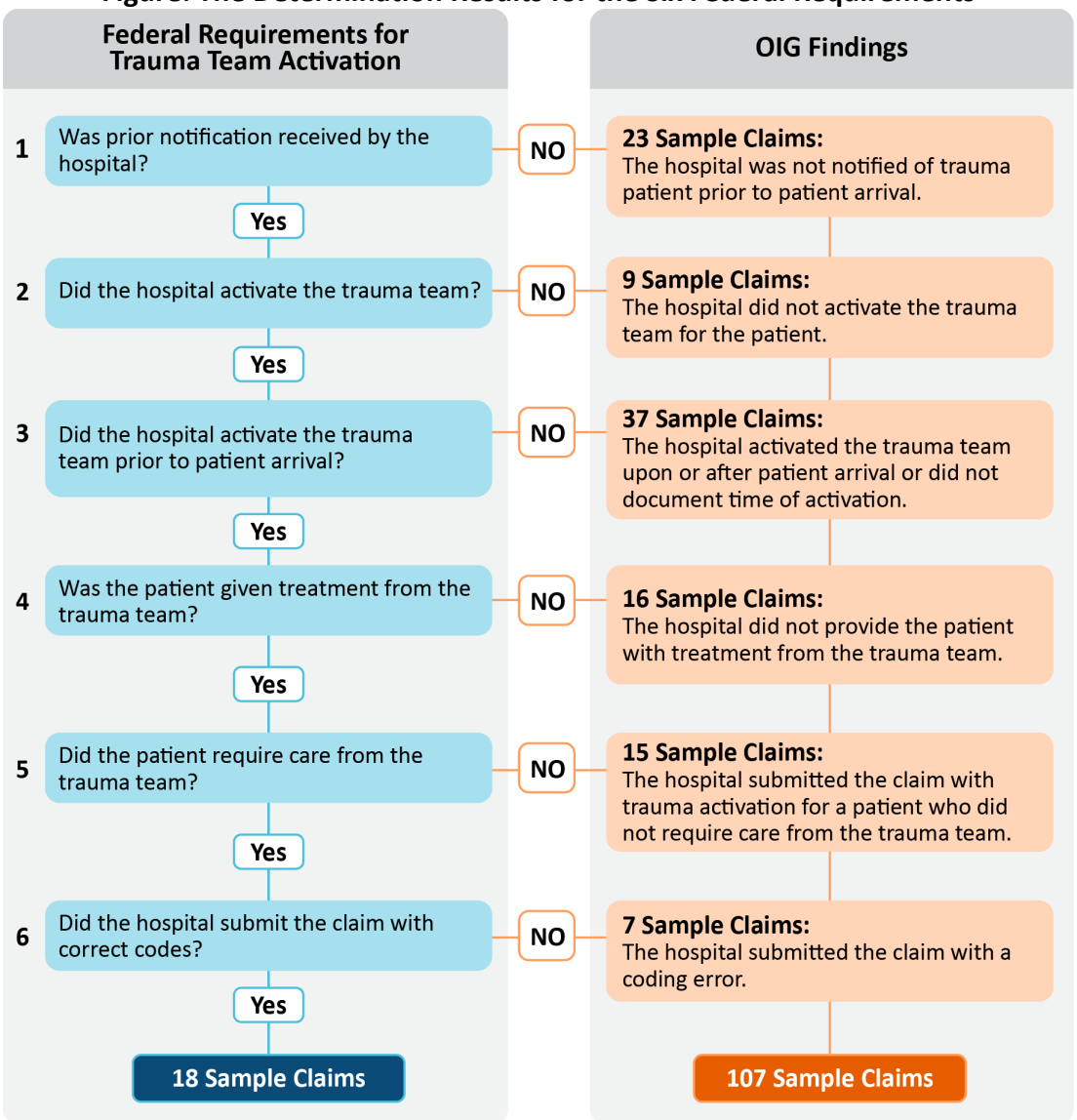
[15] We confirmed the designation or verification level of each provider selected in our sample by asking the provider for proof, contacting the State, county, or other agency responsible for designation, and checking the ACS website. We found that all the providers whose claims were selected as part of our sample were trauma centers, and we use the term “hospitals” to describe providers confirmed to be trauma centers in this report.

[16] We did not include any Medicare payments related to our findings because: (1) there is no separate trauma team activation payment made to the hospitals for inpatient claims, and (2) CMS does not have an outpatient pricing tool, and, because of the complexity of the payment system, we could not calculate the overpayment manually. The inpatient payments for trauma team activations are based on the MS-DRG. Therefore, even if a trauma team activation is not necessary, there is no payment impact to the inpatient claim since the MS-DRG did not change. However, the approximately $2.4 billion in unallowable charges for trauma team activations would affect payments.

Trauma team activations did not comply with Federal requirements primarily because CMS did not provide specific guidelines that explained when a trauma team activation should occur. Although hospitals are responsible for maintaining their own policies for trauma team activations, often the terms in these policies are too broad, and CMS does not verify that these policies meet the requirements that trauma team activations are reasonable and necessary. In addition, CMS provided infrequent training to hospitals on the existing coding and trauma team activation requirements. Lastly, hospitals did not include sufficient documentation in the medical records to support that they met the Medicare coverage requirements for trauma team activations.

We identified six Federal requirements that hospitals did not meet when they billed for trauma team activations. We reviewed each sampled claim against all six Federal requirements. These six requirements are presented in the figure below.

Figure: The Determination Results for the Six Federal Requirements



CMS MADE PAYMENTS TO HOSPITALS FOR CLAIMS WITH TRAUMA TEAM ACTIVATIONS THAT DID NOT COMPLY WITH FEDERAL REQUIREMENTS

Hospitals Were Not Notified of Trauma Patients Prior to Patients' Arrival (Requirement 1)

The CMS *Medicare Claims Processing Manual* and the NUBC Manual state that "only patients for whom there has been pre-hospital notification, who meet either local, state or ACS field triage criteria, or are delivered by inter-hospital transfers . . . can be billed the trauma activation fee charge. Patients who are 'drive-by' or arrive without notification cannot be charged for activations."[17]

We found that 23 sampled claims did not show evidence of prehospital notification.[18]

Examples of Claims Without Prehospital Notification

For one sampled claim, the medical records indicated that the patient tripped and fell. The patient was brought in by private automobile to the emergency department. This was a "drive-by" patient without any prior hospital notification. Therefore, the hospital should not have billed for the trauma team activation. The patient was discharged home after being treated by emergency department staff.

For one sampled claim, the medical records indicated that the patient fell out of bed and had a possible seizure. The patient arrived via ambulance; however, the ambulance staff did not notify the hospital to activate the trauma team because the patient's condition was not life threatening. Therefore, the hospital should not have billed Medicare for the trauma team activation. The patient was discharged home after being treated by emergency department staff.

Hospitals Did Not Activate Trauma Teams for Patients (Requirement 2)

The CMS *Medicare Claims Processing Manual* and the NUBC Manual state that revenue category 068X is "for use by trauma center/hospitals, licensed, designated or authorized by the state or local government authority as a trauma center, or verified by the ACS and as a facility with a trauma activation team." The *Medicare Claims Processing Manual* also states that the revenue category may only be used for patients for whom a trauma activation occurred and that a trauma team activation is a "notification of key hospital personnel in response to triage information from pre-hospital caregivers."[19]

We found nine sampled claims for which there was no indication in the medical records that the hospital activated the trauma team.

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[17] *Medicare Claims Processing Manual*, chapter 4, § 160.1, chapter 25, § 75.4; and the NUBC Manual, form locator 42, revenue category 068X, usage note 5.

[18] Since patients who are interhospital transfers do not require prehospital notification, per Medicare requirements, we did not include patients who arrived from another hospital as findings.

[19] *Medicare Claims Processing Manual*, chapter 4, § 160.1, chapter 25, § 75.4; and the NUBC Manual, form locator 42, revenue category 068X, usage notes 1 and 2.

An Example of a Claim for Trauma Team Activation That Did Not Occur

For one sampled claim, the medical records indicated that the patient with a past medical history of lung cancer was brought to the hospital by ambulance after the patient was determined to have low blood pressure and low potassium at the extended care facility where the patient lived. The patient did not suffer an external injury. There was no indication in the medical records that the trauma team was activated. Therefore, the hospital should not have billed Medicare for the trauma team activation. The patient was treated by emergency department staff and admitted to the hospital for further care.

Hospitals Activated Trauma Teams Upon or After Patients' Arrival or Did Not Indicate Times of Activation (Requirement 3)

An Example of a Claim With Trauma Team Activation Upon or After Patient Arrival or No Time Was Indicated

For one sampled claim, the medical records indicated that the patient had fallen while walking the day prior. The patient was unable to walk due to hip pain and called for an ambulance for transport to the hospital. The medical record indicated that the patient arrival time and trauma team activation time were the same. Therefore, the hospital should not have billed Medicare for the trauma team activation. The patient suffered a broken leg and was admitted for further care.

The CMS *Medicare Claims Processing Manual* and the NUBC Manual state that revenue category 068X is "for use by trauma center/hospitals, licensed, designated or authorized by the state or local government authority as a trauma center, or verified by the ACS and as a facility with a trauma activation team." The NUBC Manual also states that a trauma team activation is a "notification of key hospital personnel . . . in advance of the patient's arrival."[20]

We found 37 sampled claims in which the trauma team was activated upon or after patient arrival, or no time was indicated in the medical record documentation. Specifically, for 35 sampled claims, the medical records indicated that activation occurred at or after the patient's arrival. For two sampled claims, we could not confirm that the trauma team was activated prior to patient arrival because the medical records did not indicate when the trauma team was activated.

[20] *Medicare Claims Processing Manual*, chapter 4, § 160.1, and chapter 25, § 75.4; and the NUBC Manual, form locator 42, revenue category 068X, usage notes 1 and 2.

Hospitals Did Not Provide Patients With Treatment From the Trauma Team (Requirement 4)

The CMS *Medicare Claims Processing Manual* and the NUBC Manual state that "only patients . . . [who] are given the appropriate team response can be billed the trauma activation fee charge."[21]

We found 16 sampled claims in which the patient was not treated by a trauma team. These patients were generally treated by emergency room physicians, but there was no indication these physicians were part of the trauma team.

Examples of Claims With No Treatment From the Trauma Team

For one sampled claim, the medical records indicated the patient fell to the ground from standing and was not treated by the trauma team. Instead, the patient was treated by an emergency department physician. Therefore, the hospital should not have billed Medicare for the trauma team activation. Hospital testing was negative for traumatic injuries but showed the patient had a urinary tract infection. The patient was admitted for observation for the infection.

For one sampled claim, the medical records indicated the patient fell to the ground from standing and was not treated by the trauma team. Instead, the patient was treated by an emergency department physician. Therefore, the hospital should not have billed Medicare for the trauma team activation. The patient showed a change in their mental status and was experiencing an increased heart rate. Imaging demonstrated a subdural hemorrhage, and the patient was admitted to the intensive care unit for treatment.

Hospitals Submitted Claims With Trauma Activation for Patients Who Did Not Require Care From a Trauma Team (Requirement 5)

The Social Security Act, section 1862(a)(1)(A), states that no payment may be made for any expenses incurred for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.[22]

[21] *Medicare Claims Processing Manual*, chapter 4, § 160.1, and chapter 25, § 75.4; and the NUBC Manual, form locator 42, revenue category 068X, usage note 5.

[22] 42 U.S.C. 1395y(a)(1)(A).

Examples of Claims in Which the Patient Did Not Require Care From a Trauma Team

For one sampled claim, the patient passed out while driving and was in a motor vehicle accident. The patient was found restrained with the vehicle on its side and the airbag deployed. The ambulance staff noted that the patient had nontraumatic injuries; however, the hospital activated the trauma team. The patient did not have a life-threatening physical injury. Therefore, the hospital should not have billed Medicare for the trauma team activation. The patient suffered a mild sternal fracture and was admitted for observation because of fainting that was caused by the accident.

For one sampled claim, the patient fell at ground level and was stable. Imaging demonstrated a right wrist fracture that was splinted and a left orbital floor fracture. The patient did not have a life-threatening physical injury. Therefore, the hospital should not have billed Medicare for the trauma team activation. The patient was admitted for pain control and orthopedic consult.

We found 15 sampled claims in which the medical records did not indicate that the patient required care from a trauma team. These patients only required care from physicians in the emergency department; therefore, the charges related to trauma team activation were not reasonable and necessary.

Hospitals Submitted Claims With Coding Errors (Requirement 6)

A hospital must submit a Medicare claim with Type of Admission/Visit Code for trauma ("05") when a trauma team activation has occurred. The code value for the type of admission code "05" is defined as a visit to a trauma center or hospital as licensed or designated by the State or local government authority authorized to do so, or as verified by ACS and involving trauma activation.[23] A hospital must submit its trauma team activation charges on a claim line using only revenue category 068X. Table 1 represents the subcategory codes in revenue category 068X.

Table 1: NUBC Identified Subcategories for Revenue Category 068X

Subcategory	Subcategory Definition	Standard Abbreviation
0	Not Used	
1	Level I Trauma	TRAUMA LEVEL I
2	Level II Trauma	TRAUMA LEVEL II
3	Level III Trauma	TRAUMA LEVEL III
4	Level IV Trauma	TRAUMA LEVEL IV
5–8	RESERVED	
9	Other Trauma Response	TRAUMA OTHER

[23] NUBC Manual, form locator 14.

Levels I, II, III, and IV refer to the designations given to the hospital by the State or local government authority or as verified by ACS. Subcategory 9 is for States or local authorities with levels beyond IV.

All health care providers who participate in the Medicare program are required to use an NPI when submitting transactions to Medicare.[24] Health care providers, including hospitals, must communicate to the National Provider System any changes in the required data elements, including provider name and practice address, within 30 days of the change.[25] In order to be processed correctly and promptly, Medicare claims must be completed accurately.[26]

CMS uses claim information to provide data to its contractors and the public. CMS also uses these data in its own research. Incorrect claim information may result in poor data quality that negatively affects the continuity of care, patient safety, clinician productivity, and research results. For example, if a claim contains the wrong admission type code, the severity of the patient's injuries could be misrepresented.

Examples of Claims Submitted With Incorrect Coding

One sampled claim was submitted with type of admission code 02, which means "Urgent." However, the trauma center should have submitted the claim with type of admission code 05, "Trauma."

One sampled claim was submitted with revenue code 0689 that denotes a trauma level beyond IV. The trauma center was designated by the State as level II trauma center.

One sampled claim was submitted with an NPI for the wrong hospital. The hospital is owned by a parent company that owns hospitals in different locations. The hospital indicated by the NPI number on the claim was not a designated or verified trauma center. However, the medical record indicated that the patient was treated at a different hospital than indicated by the NPI number on the claim. The hospital where the patient was treated was a trauma center as designated by the State.

We found seven sampled claims in which the coding was inconsistent with Federal requirements. Of the seven sampled claims with coding errors, four claims were submitted with a Type of Admission/Visit Code that was not trauma ("05"), two claims were submitted with a 068X category that did not match their trauma designation level,[27] and one claim was submitted with incorrect NPI information. These errors did not affect claim payment amounts. As a result, we did not include the sampled claims with coding errors in our unallowable charge calculations.

[24] 42 CFR § 424.506(c)(1).

[25] 45 CFR § 162.410(a)(4).

[26] *Medicare Claims Processing Manual*, chapter 1, § 80.3.2.2.

[27] The trauma designation level errors did not affect claim payment amounts. However, such errors could negatively affect continuity of care, patient safety, clinician productivity, and research results.

Why Hospitals Did Not Comply With Federal Requirements

Hospitals submitted sampled claims that did not comply with CMS and NUBC Manual requirements because CMS did not provide updated guidance related to trauma team activation billing requirements. The latest guidance on trauma team activation billing was issued by CMS in 2008. Additionally, the *Medicare Claims Processing Manual* no longer lists the details of each revenue code with instructions for the claim form; instead, it directs readers to contact Medicare contractors or to read the NUBC Manual, a publication that is only available to paid subscribers.[28]

Hospitals submitted sampled claims that did not meet the requirement for reasonable and necessary treatment. Specifically, hospitals followed internal policies that were too broad to determine when to appropriately activate trauma teams. As a result, hospitals followed internal policies that resulted in trauma team activation in circumstances when activation was not reasonable and necessary. For example, some hospitals had a policy to activate trauma teams any time they received a patient over the age of 65 who suffered from a fall from any height. After reviewing the supporting documentation, some hospitals stated that some of the claims in our sample should not have been submitted with trauma team activations.

Hospitals also submitted sampled claims with coding inconsistencies because CMS has infrequently provided training on the details of these specific coding requirements. Additionally, the claims with incorrect NPI information occurred because of provider data entry errors. These coding errors have not historically been emphasized by CMS because they do not affect hospital payment, despite contributing to the inaccuracies of Medicare data.

The Effect and Estimates of Unallowable Charges Resulting From Incorrectly Billed Claims

Charges submitted by hospitals are used to determine outlier payments and future payment rates.[29] CMS ensures that hospitals are protected from extraordinarily high costs by providing an outlier payment when costs exceed a fixed threshold. Additionally, CMS uses charges submitted by hospitals on

An Example of a Claim With Reduction of Outlier Payment Due to Unallowable Trauma Team Activation Charges

A hospital submitted $345,264 in total charges on a sampled claim, including $22,385 for trauma team activation. Due to the extraordinarily high charges on the claim, Medicare paid the hospital an outlier payment of $10,038 in addition to the regular claim payment of $58,329. The trauma team activation was determined to be unallowable. As a result, removal of the unallowable charges associated with the unallowable trauma team activation reduced the outlier payment by $4,764.

[28] *Medicare Claims Processing Manual*, chapter 25, § 75.4.

[29] Generally, Medicare uses charges and costs submitted by hospitals, including trauma team activation charges, to determine whether an outlier payment is warranted and to calculate future PPS payment rates.

hospital cost reports, including trauma team activation charges, to determine future hospital payment rates. If claims are submitted with unallowable charges, this affects both the calculation of an outlier payment for claims with extraordinarily high costs as well as rate-setting factors CMS uses for future payments.

For 100 sampled claims, the hospitals submitted a total of $728,468 in unallowable trauma team activation charges. These unallowable trauma team activation charges may have caused CMS to make incorrect outlier payments and affect future years' payments because CMS uses charges from prior years to calculate payment rates. If these charges are not removed, they would be included in the calculation, potentially resulting in higher future payments.

Based on our sample results, we estimated that 234,248 claims were submitted to Medicare by hospitals for trauma team activations that did not comply with Federal requirements. This represents approximately 77 percent of all claims submitted to Medicare with trauma team activation during our audit period. Additionally, we estimated that hospitals also billed approximately $2.4 billion in unallowable charges for trauma team activations that did not meet Medicare requirements.

CONCLUSION

Some hospitals did not properly document the need for trauma team activation as required because CMS did not provide updated guidance related to trauma team activation billing requirements. In addition, hospitals followed internal policies that were too broad to determine when to appropriately activate trauma teams. This may have resulted in trauma team activations in circumstances when activations were not reasonable and necessary. Further, incorrect claim information from hospitals may continue to result in poor data quality that negatively affects the continuity of care, patient safety, clinician productivity, and research results.

RECOMMENDATIONS

We recommend that the Centers for Medicare & Medicaid Services:

- take the necessary steps to address the estimated $2.4 billion in unallowable trauma team activation charges reported on hospitals' cost reports and the resulting incorrect outlier payments to improve the accuracy of data used to establish future PPS payment rates;

- work with the MACs to identify similar instances of noncompliance that occurred after our audit period to determine and address the impact to the Federal Government related to claims for trauma team activation that did not comply with Federal requirements;

- revise CMS guidance to explain when trauma team activation is reasonable and necessary (e.g., by incorporating ACS trauma center requirements and, if necessary, providing specific examples); and

- provide more frequent education to hospitals on CMS requirements for submitting claims with trauma team activation.

CMS COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, CMS did not concur with our first and second recommendations. CMS did not state whether it concurred with our third and fourth recommendations but stated that it will review existing guidance and assess the need for additional education. After reviewing CMS's comments, we maintain that all our recommendations are valid.

The following sections summarize CMS's comments and our response.

CMS's comments are included in their entirety as Appendix E.

CMS COMMENTS

In response to our first two recommendations, CMS stated that we based our findings on six criteria that go beyond CMS requirements. In addition, in its general comments on the report, CMS stated that trauma team activation is a complex process for which different billing codes exist based on whether the trauma response was activated and fully performed or activated and called off upon examination of the patient on arrival, and that medical review is necessary to determine whether a case was billed appropriately.

In response to our third and fourth recommendations, CMS did not indicate that it would take the recommended actions but stated that it will review existing guidance and assess the need for additional education.

OIG RESPONSE

With respect to CMS's comment on our first two recommendations, the six requirements upon which we based our findings are found in CMS's *Medicare Claims Processing Manual* (chapter 4, § 160.1, and chapter 25, § 75.4), the NUBC Manual (form locator 42), and the Social Security Act, section 1862(a)(1)(A). In its response, CMS indicated that these are the guidelines that providers should follow to determine whether they may bill for trauma activation. Additionally, our audit used an independent medical review contractor to determine whether trauma team activations met Medicare requirements. We, therefore, maintain these recommendations are valid.

With respect to our third and fourth recommendations, our report shows that CMS guidance is outdated and that CMS has not provided education on trauma team activation billing requirements in more than a decade. Specifically, with respect to our third recommendation, we note that CMS's latest guidance on trauma team activation billing was issued in 2008 and does not explain when trauma team activation is reasonable and necessary (e.g., it does not incorporate ACS trauma center requirements or provide specific examples). In addition, the current *Medicare Claims Processing Manual* no longer lists the details of each revenue code with instructions. With respect to our fourth recommendation, we note that CMS's most recent education to hospitals on trauma team activation billing was provided in 2007. The findings in our report show that there are issues with hospitals correctly billing for trauma team activation and thus, more education for hospitals would be beneficial. We maintain that these recommendations are valid, and we do not believe that CMS conducting a review of guidance or assessing the need for additional education will sufficiently address them.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our nationwide audit covered 303,903 in Medicare Part A and B claims with dates of service from January 1, 2020, through June 30, 2020, that were billed with either revenue category 068X or with HCPCS code G0390 that indicated trauma team activation. We selected a stratified random sample of 125 claims for review that included trauma team activation during our audit period.

We requested supporting documentation from the hospitals that submitted the claims included in our sample. To determine whether hospitals documented trauma team activations in compliance with Medicare requirements, we provided the medical records to an independent medical review contractor to determine if all of the requirements of trauma team activation were met and to determine the medical necessity of the trauma team activations.

We did not perform an overall assessment of the internal control structures of CMS, MACs, or hospitals. Rather, we limited our review to those internal controls (i.e., program safeguards) related to Medicare billing and payment requirements for trauma team activation. To assess internal controls, we interviewed CMS officials to obtain an understanding of trauma team activation requirements on inpatient and outpatient claims. Additionally, we obtained written responses to a questionnaire sent to sampled hospitals to understand their processes for billing trauma team activation.

Our audit procedures enabled us to establish reasonable assurance of the authenticity and accuracy of the data obtained from CMS's Integrated Data Repository, but we did not assess the completeness of the data.

We conducted our audit from November 2022 through May 2025.

METHODOLOGY

To accomplish our audit objective, we:

- reviewed applicable Federal laws, regulations, and guidance;

- communicated with CMS officials to gain a better understanding of the Federal regulations on trauma team activation and coding of claims that indicate trauma team activation;

- reviewed industry guidance from ACS, as this guidance was referenced within CMS manuals;

- extracted from CMS's Integrated Data Repository the Medicare paid claims data for claims with dates of service from January 1, 2020, through June 30, 2022, that were billed with either a revenue code or HCPCS code indicating trauma team activation;

- created a sampling frame of 303,903 claims resulting in $29,077,224,071 in charges submitted by hospitals for trauma team activation, $4,342,768,413 in Medicare payments, and $27,243,897 in patient copayments;

- selected a stratified random sample of 125 claims that included trauma team activation (Appendix C);

- reviewed data from CMS's Common Working File and other available data for the services for the sample items to determine whether the claims had been canceled or adjusted;

- requested supporting medical record documentation, trauma policies and procedures, and cost reports from the submitting hospitals;

- asked hospitals to review the sampled claims they submitted to determine whether they met Medicare requirements for trauma team activation;

- verified trauma center designation with applicable States based on the sample items chosen and trauma center verification with the ACS website;

- used an independent medical review contractor to determine whether hospitals complied with Medicare billing requirements for trauma team activation and if trauma team activation was reasonable and necessary;

- calculated the amount of unallowable charges submitted by hospitals in our sample;[30]

- estimated the number and percentage of claims incorrectly billed with trauma activation charges and the total amount of unallowable charges submitted by hospitals in our sampling frame (Appendix D); and

- discussed the results of our audit with CMS officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based upon our audit objectives.

[30] To calculate the amount of unallowable charges submitted by hospitals, we determined the reduction to the total amount charged by the amount charged on the 068X revenue line.

APPENDIX B: STATISTICAL SAMPLING METHODOLOGY

SAMPLING FRAME

The sampling frame consisted of 303,903 inpatient and outpatient Medicare claims totaling $4,342,768,413 in Medicare payments, $27,243,897 in patient copayments, and $29,077,224,071 in charges submitted by hospitals. These claims were submitted with a revenue category 068X or submitted with HCPCS code G03902 (claims with trauma team activation) with dates of service from January 1, 2020, to June 30, 2022 (audit period) where payment was made from the Medicare Trust Fund to trauma centers that participate in OPPS and IPPS.

SAMPLE UNIT

The sample unit was a claim with trauma team activation.

SAMPLE DESIGN AND SAMPLE SIZE

We used a stratified random sample containing five strata on the basis of the hospital's designation or verification level.[31] Table 2 defines the strata used in the sample.

Table 2: Frame Strata Definitions

Stratum	Description
1	Claims Submitted by Level 1 Trauma Centers
2	Claims Submitted by Level 2 Trauma Centers
3	Claims Submitted by Level 3 Trauma Centers
4	Claims Submitted by Level 4 or 5 Trauma Centers
5	Claims Submitted by Facilities Potentially Not Designated as Trauma Centers

[31] The trauma center designation level used for stratification was determined through survey research prior to field work. During field work, we confirmed each sampled provider's designation or verification level by asking the provider for proof, contacting the State, county, or other agency responsible for designation, and checking the ACS website. In the end, all of the providers whose claims were selected as part of our sample were trauma centers.

We selected 125 claims in total for review, as shown in Table 3.

Table 3: Frame Sample Size

Stratum	Number of Frame Units	Frame Medicare Paid Amounts	Frame Patient Copayment Amounts	Frame Charges Submitted	Sample Size
1	134,604	$2,592,895,841	$9,659,422	$15,280,918,081	25
2	110,974	1,338,255,440	9,744,768	10,579,839,286	25
3	41,971	302,694,189	5,615,562	2,383,816,666	25
4	13,029	69,148,099	1,915,422	567,392,561	25
5	3,325	39,774,844	308,723	265,257,477	25
Total	**303,903**	**$4,342,768,413**	**$27,243,897**	**$29,077,224,071**	**125**

SOURCE OF RANDOM NUMBERS

The source of the random numbers for our sample was the OIG, Office of Audit Services (OAS), statistical software.

METHOD OF SELECTING SAMPLE ITEMS

We sorted the items in each stratum by the Record Link Number in ascending order and then consecutively number the items in each stratum in the sampling frame. After generating the random numbers for our sample in accordance with our sample design we selected the corresponding frame items for review.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate the number and percentage of claims incorrectly billed with trauma activation charges and the total amount of unallowable charges submitted by trauma centers in our sampling frame. We used this software to calculate the point estimate and the corresponding two-sided 90-percent confidence interval for each of these estimates.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

Table 4: Statistical Sample Item Results – Claim Counts

Stratum	Number of Frame Units	Sample Size	Number of Incorrectly Billed Claims in Sample	Number of Incorrectly Billed Claims with a Monetary Effect	Number of Incorrectly Billed Claims with Only Coding Errors	Number of Correctly Billed Claims
1	134,604	25	21	21	0	4
2	110,974	25	18	16	2	7
3	41,971	25	22	21	1	3
4	13,029	25	24	24	0	1
5	3,325	25	22	18	4	3
Total	**303,903**	**125**	**107**	**100**	**7**	**18**

Table 5: Statistical Sample Item Results – Value of Unallowable Charges

Stratum	Value of Charges Submitted by Hospitals in Sample	Value of Unallowable Charges Submitted by Hospitals in Sample
1	$3,720,480	$272,857
2	2,565,684	161,630
3	1,311,015	123,885
4	678,768	76,011
5	2,096,191	94,085
Total	**$10,372,138**	**$728,468**

ESTIMATES

Table 6: Estimated Value of Unallowable Charges in the Sampling Frame (Limits Calculated at the 90-Percent Confidence Level)

Estimate	Number of Incorrectly Billed Claims	Percent of Incorrectly Billed Claims	Unallowable Charges Submitted by Hospitals
Point Estimate	234,248	77.08%	$2,446,687,316
Lower Limit	209,310	68.87%	1,869,764,814
Upper Limit	259,186	85.29%	3,023,609,817

APPENDIX D: DETAILED SAMPLE RESULTS

Sample Item Number	Principal Finding Category	Finding 1 No Pre Hospital Notification	Finding 2 No Trauma Team Activation	Finding 3 Activation Occurred at Arrival or No Time Indicated	Finding 4 Not Treated by Trauma Team	Finding 5 Care Not Required	Finding 6 Incorrect Coding
1-1	3			X		X	X
1-2	3			X	X	X	
1-3	5					X	
1-4	3			X			
1-5	5					X	
1-6	5					X	
1-7	3			X		X	
1-8	1	X		X		X	
1-9	4				X	X	
1-10	5					X	
1-11	3			X			
1-12	4				X	X	
1-13	5					X	
1-14	3			X			
1-15	5					X	
1-16	1	X		X	X	X	X
1-17	5					X	
1-18	None						
1-19	None						
1-20	3			X			X
1-21	5					X	
1-22	2		X			X	
1-23	None						
1-24	None						
1-25	2		X		X	X	
2-1	5					X	
2-2	2		X		X	X	
2-3	None						
2-4	5					X	
2-5	1	X		X		X	
2-6	None						
2-7	None						
2-8	3			X			
2-9	4				X	X	
2-10	4				X	X	
2-11	None						
2-12	3			X	X	X	X
2-13	2		X		X	X	
2-14	None						

Sample Item Number	Principal Finding Category	Finding 1 No Pre Hospital Notification	Finding 2 No Trauma Team Activation	Finding 3 Activation Occurred at Arrival or No Time Indicated	Finding 4 Not Treated by Trauma Team	Finding 5 Care Not Required	Finding 6 Incorrect Coding
2-15	1	X	X		X	X	
2-16	6						X
2-17	5					X	
2-18	2		X		X	X	
2-19	None						
2-20	5					X	
2-21	2		X		X	X	
2-22	6						X
2-23	1	X		X		X	X
2-24	1	X		X			X
2-25	None						
3-1	3			X		X	
3-2	None						
3-3	4				X	X	X
3-4	3			X		X	
3-5	6						X
3-6	3			X	X	X	
3-7	4				X	X	
3-8	3			X	X		
3-9	None						
3-10	3			X	X	X	X
3-11	1	X		X	X	X	X
3-12	1	X		X	X	X	X
3-13	None						
3-14	3			X		X	
3-15	3			X	X	X	
3-16	3			X	X	X	
3-17	1	X	X		X	X	
3-18	4				X	X	
3-19	1	X		X	X	X	
3-20	4				X	X	
3-21	3			X	X	X	
3-22	3			X	X	X	
3-23	1	X		X		X	
3-24	2		X		X		
3-25	5					X	
4-1	4				X	X	
4-2	3			X	X	X	X

Sample Item Number	Principal Finding Category	Finding 1 No Pre Hospital Notification	Finding 2 No Trauma Team Activation	Finding 3 Activation Occurred at Arrival or No Time Indicated	Finding 4 Not Treated by Trauma Team	Finding 5 Care Not Required	Finding 6 Incorrect Coding
4-3	3			X	X	X	
4-4	3			X	X	X	X
4-5	3			X	X	X	
4-6	1	X	X		X	X	X
4-7	3			X	X	X	
4-8	3			X	X	X	
4-9	1	X		X	X	X	
4-10	4				X	X	
4-11	3			X	X	X	
4-12	3			X			X
4-13	4				X	X	X
4-14	3			X			X
4-15	3			X	X		
4-16	4				X	X	
4-17	1	X		X	X		
4-18	4				X	X	
4-19	1	X	X		X	X	X
4-20	4				X		X
4-21	4				X	X	X
4-22	3			X	X		
4-23	1	X	X		X	X	
4-24	None						
4-25	3			X	X		
5-1	6						X
5-2	5					X	
5-3	3			X	X	X	
5-4	3			X			
5-5	2		X				
5-6	1	X		X	X	X	X
5-7	3			X	X	X	
5-8	3			X		X	
5-9	3			X			X
5-10	2		X		X	X	X
5-11	1	X		X	X	X	
5-12	None						
5-13	6						X
5-14	1	X		X	X	X	
5-15	1	X		X	X	X	X
5-16	5					X	X

Sample Item Number	Principal Finding Category	Finding 1 No Pre Hospital Notification	Finding 2 No Trauma Team Activation	Finding 3 Activation Occurred at Arrival or No Time Indicated	Finding 4 Not Treated by Trauma Team	Finding 5 Care Not Required	Finding 6 Incorrect Coding
5-17	1	X	X		X	X	
5-18	1	X		X	X	X	
5-19	1	X		X		X	
5-20	None						
5-21	None						
5-22	6						X
5-23	4				X	X	X
5-24	3			X	X	X	
5-25	6						X
Finding Category Total*		**23**	**15**	**54**	**62**	**82**	**32**
Principal Finding Category Total†		**23**	**9**	**37**	**16**	**15**	**7**

* The total is the sum of each Finding Category column.

† The total is the sum from Principal Finding Category column for each category.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: August 1, 2025

TO: Carla J. Lewis
Acting Deputy Inspector General for Audit Services
Office of Inspector General

FROM: Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services

SUBJECT: Office of Inspector General (OIG) Draft Report: *CMS Paid for Trauma Team Activations That Did Not Comply With Federal Requirements*, A-01-23-00500

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report on whether Medicare payments to trauma centers complied with federal requirements.

When a patient experiences severe physical injury, such as wounds caused by events such as automobile crashes, gunshots, knife wounds, etc., it may be necessary for a hospital to activate a trauma team to assess and care for the patient upon arrival at the hospital. A trauma team is a group of health care professionals from multiple disciplines ranging from surgeons and emergency physicians to nurses, anesthesiologists and radiologists. In general, for an item or service to be considered for Medicare coverage it must be "reasonable and necessary" for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.[1]

To determine whether they may bill for trauma activation, providers are to follow the National Uniform Billing Committee (NUBC) guidelines related to the reporting of the trauma revenue codes in the 68x series. The guidelines are listed in the Medicare Claims Processing Manual.[2] In summary, revenue code series 68x can be used only by licensed or verified trauma centers/hospitals. Only patients for whom there has been prehospital notification based on triage information from prehospital caregivers, who meet either local, state or American College of Surgeons field triage criteria, or are delivered by inter-hospital transfers, and are given the appropriate team response, can be billed a trauma activation charge.

[1] Please see §1862(a)(1)(A) of the Act

[2] Please see Medicare Claims Processing Manual, Chapter 4 - Chapter 4 - Part B Hospital (Including Inpatient Hospital Part B and OPPS), § 160.1, available at: https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c04.pdf
Medicare Claims Processing Manual, Chapter 25 - Completing and Processing the Form CMS-1450 Data Set, § 75.4, available at: https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c04.pdf
National Uniform Billing Committee Manual, form locator 42, revenue category 068X, usage notes 1 and 2 at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c25.pdf

OIG based its findings on six criteria, which go beyond the above CMS requirements. Trauma activation is a complex process for which different billing codes exist based on whether the trauma response was activated and fully performed or activated and called off upon examination of the patient on arrival. Medical review is necessary to determine whether a case was billed appropriately.

CMS takes claims oversight very seriously and appreciates OIG's work and findings. OIG's recommendations and CMS's responses are below.

OIG Recommendation

CMS should take the necessary steps to address the estimated $2.4 billion in unallowable trauma team activation charges reported on hospitals' cost reports and the resulting incorrect outlier payments to improve the accuracy of data used to establish future PPS payment rates.

CMS Response

CMS does not concur with this recommendation. CMS appreciates the intent of this recommendation; however, the six criteria OIG used to conduct the analysis for this report exceed CMS requirements.

OIG Recommendation

CMS should work with the MACs to identify similar instances of noncompliance that occurred after our audit period to determine and address the impact to the Federal Government related to claims for trauma team activation that did not comply with federal requirements.

CMS Response

CMS does not concur with this recommendation. The six criteria OIG used to conduct the analysis for this report exceed CMS requirements.

OIG Recommendation

CMS should revise CMS guidance to explain when trauma team activation is reasonable and necessary (e.g., by incorporating ACS trauma center requirements and, if necessary, providing specific examples).

CMS Response

CMS appreciates the intent of this recommendation and will review existing guidance.

OIG Recommendation

CMS should provide more frequent education to hospitals on CMS requirements for submitting claims with trauma team activation.

CMS Response

CMS appreciates the intent of this recommendation and will assess the need for additional education.

CMS thanks OIG for their efforts on this issue and looks forward to working with OIG on this and other issues in the future.

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