



HEALTH PLAN & PROVIDER



REPORT

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'Trauma' Contract Ambiguities Can Potentially Cost Health Plans Big Money

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A recurring issue in arbitrations between health plans and hospitals is whether claims involving "trauma" injuries should be reimbursed at contractually agreed upon trauma rates, which are significantly higher than the rate for normal acute care admissions.

Typically, the hospital will contend that it either activated or used its trauma team to treat a "trauma" victim, thereby entitling it to reimbursement at the high trauma rates. The health plan will counter that the patient's injury was not severe enough to warrant designation as a "trauma" condition, and/or that the hospital's trauma team was not used to treat the patient. What the claims boil down to is:

- The contract definition of "trauma condition"¹
- The contract definition of "trauma team"²
- Application of those definitions to the facts of the claim(s) at issue.

¹ Referred to in some contracts as "trauma medical condition" or "trauma injury."

² Referred to in some contracts as "trauma response team."

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The clearer the language in the contract, the fewer disputes regarding trauma claims. The real problem lies when the contract language is unclear and creates ambiguities in the key terminology. This article will discuss those ambiguities and how they can be avoided in the future.

Why the Huge Difference Between Trauma and Normal Inpatient Acute-Care Rates? Disputes between hospitals and health plans regarding trauma cases are not uncommon, as trauma claims involve unusually high reimbursement rates.

Many hospitals, particularly those that are designated as trauma centers, negotiate very high rates for admissions involving "trauma conditions" that require activation or use of the hospital's trauma team. The difference between trauma rates and normal acute-care hospital rates is considerable. Whereas a hospital might be reimbursed \$2,000 per day for an acute-care admission, that same hospital might receive \$10,000 or more per day for trauma claims³.

The reason why trauma rate per diems are so much greater than normal hospital acute-care per diems (and even the Intensive Care Unit per diems) is because one emergency trauma claim involving a critically injured patient can require the immediate assembly of multiple emergency and specialist physicians (sometimes including such specialists as neurosurgeons, orthopedic surgeons, radiologists, etc.) as well as multiple nurses and technicians.

To illustrate, consider a severely injured patient who was involved in an automobile collision. Upon that patient's arrival to a trauma center, physicians, nurses and technicians (i.e., the trauma team) must drop whatever

³ In some cases, the hospital might negotiate payment of most or all of its covered billed charges for a trauma admission.

they were doing and head to the emergency department so that they are present upon the patient's arrival to immediately evaluate, and possibly resuscitate, the patient.

In these cases, a heightened trauma rate per diem is warranted not only because the hospital was required to expend its resources on this patient upon his or her arrival to the hospital, but also because the hospital was required to adequately staff itself in order to have been prepared for this and other similarly situated patients.

Drafting Contract Provisions Defining "Trauma Condition" and Activation/Use of "Trauma Team." In the typical trauma claim dispute between a health plan and a hospital, the parties more or less agree that certain injuries trigger activation of the hospital's trauma team, but the dispute is 1) whether the patient had a trauma condition, and 2) whether the hospital's trauma team was in fact activated. The clearer the contract definition of "trauma condition," the easier it is to define the universe of claims that qualify for reimbursement at heightened trauma rates.

The following are examples of three definitions of "trauma condition":

Contract #1: In Contract #1, "trauma" is defined by the local county's Trauma Guidelines⁴, and "Trauma Care" is defined as those designated trauma services rendered in a Certified Trauma Center in accordance with the local county Trauma Guidelines. Hospital #1 is entitled to reimbursement at trauma rates when it provides trauma care.

The provision requires reference to the local county's Trauma Guidelines, which provide objective criteria (type of injuries, baseline vital signs, etc.) upon which a medical professional can objectively determine whether a patient has a trauma condition. The contract does not describe a "Trauma Team" rather it describes the care provided by reference to the local county Trauma Guidelines. Although the provision is sparse, it is extremely effective in providing both the hospital and the health plan with notice as to what condition and care qualifies for the heightened trauma rates.

Contract #2: In Contract #2, the trauma reimbursement rate applies to all services provided to a member who is designated a "Trauma patient" either in the emergency department by a qualified specialist⁵ or in the field by the mobile intensive care nurse ("MICN"), and resulting in the activation of the hospital-based trauma team.

Here, a patient can be designated a trauma patient in the field by non-hospital personnel, or in the hospital by a qualified specialist. The acceptance of an MICN's designation of the patient as being a Trauma patient makes sense because the hospital must rely upon the MICN's judgment while the patient is in the field and respond accordingly. Even if it turns out that the MICN over-estimated the severity of the patient's condition, if

⁴ Note that the trauma guidelines for most, if not all, California counties are readily available by contacting the counties or by checking their websites.

⁵ "Qualified Specialist" is generally defined in California Administrative Code § 100242 as a physician that is board certified in a specialty by the American Board of Medical Specialties, the Advisory Board for Osteopathic Specialties, or an approved foreign specialty board.

the hospital responded by activating its trauma team, then it will have expended the resources justifying application of the trauma rates for that patient.

The fact that a "qualified specialist" at the hospital can designate a trauma patient adds subjectivity to the definition, as the contract does not specify which criteria the specialist is to use in making a trauma designation. The built-in checks against abuse of this particular provision are that 1) *only* a qualified specialist can make the designation, which would imply that the patient must at least be seen by a specialist before the designation is made, and 2) *activation* of the hospital's trauma response team is still required in order for the trauma rates to apply.

Contract #3: In Contract #3, a patient can be designated as having a "Trauma Medical Condition" by (1) the medical judgment of pre-hospital field personnel, transferring hospital personnel, *or provider hospital personnel upon presentation or ongoing assessment of the patient for care*, or (2) based upon criteria set forth in local county Trauma Guidelines. The contract also provides that trauma rates will apply when (1) a patient has a Trauma Medical Condition, (2) the patient is admitted to the hospital, and (3) the hospital's trauma response team is used.

The trauma provisions of this particular contract was described by one arbitrator as a "morass which led to having to interpret vague, ambiguous, and inconsistent terms and provisions, none the least of which is the term trauma."

Obviously, the terms are extremely favorable to the hospital, essentially allowing any hospital personnel at any time to designate the patient as having a "Trauma Medical Condition" without requiring any objective criteria for that personnel—whether physician, nurse, or technician—to consider in exercising his or her judgment. This led to the hospital at one point arguing that essentially *any* physical injury can qualify as a "Trauma Medical Condition."

Problems With Ambiguous Provisions. Consider Contract #3, the most ambiguous of the three contracts. This contract contains two major ambiguities that have become the subject of litigation. First, as mentioned above, the "Trauma Medical Condition" provision, on its face, gives the *personnel* absolute discretion to declare that a patient has a "Trauma Medical Condition" – there is no requirement that the personnel refer to established local county Trauma Guidelines or even be aware of such guidelines when making the designation. Given the lack of any objective criteria, the only boundaries in designating a "Trauma Medical Condition" is the definition of trauma itself, which as this particular hospital's Chief of Trauma testified could be as narrow as the conditions set forth in the local county Trauma Guidelines, and as broadly as *any* physical injury.

The definition that eventually emerges is, invoking the late Supreme Court Justice Potter Stewart, "I'll know it when I see it."⁶ Given the deference which arbitrators routinely give to physician and nurse judgment, it is virtually impossible for a health plan to overcome the "Trauma Medical Condition" provision, no matter how liberally applied.

⁶ *Jacobellis v. Ohio*, 378 U.S. 184, 197 (1964) (Stewart, concurring).

The other main ambiguity is the phrase “*use of the trauma response team*,” which is never defined in the contract. Again, this particular hospital’s Chief of Trauma testified from his perspective that the term can be defined as narrowly as the “trauma team” personnel identified in the hospital’s trauma protocols who specifically deal with critical trauma emergencies upon the trauma patient’s presentation to the hospital, or it can be defined as broadly as any treatment provided by a physician or nurse to a patient with a “Trauma Medical Condition”. If the broad interpretations of “Trauma Medical Condition” and “use of the trauma response team” are used, then essentially any physical injury treated at the hospital that requires admission should be reimbursed at the trauma rate. Following that reasoning a claim involving a finger cut could require reimbursement in excess of \$10,000 per day!

Avoiding Ambiguities: Controlling the Conditions. Sometimes a trauma provision that is extremely favorable to one party is the result of superior bargaining power. For example, Level 1 trauma centers are few and far between, and a hospital with a Level 1 trauma center in a relatively remote region will have superior bargaining power in negotiating trauma terms with a health plan compared to a hospital with a Level 2 trauma center in a major metropolitan region with multiple neighboring trauma centers.

However, strength in bargaining power aside, there are several points both parties should consider when negotiating trauma provisions (or most any provisions for that matter) in order to minimize ambiguities and not unnecessarily weaken either side’s position.

- Rather than amending by simply adding and modifying provisions, sometimes it is better to start with a clean slate and completely replace superseded provisions.

Part of the reason for the ambiguities in Contract #3 above was that the hospital, in drafting the amendment, tried to keep some of the old trauma language, even though the new provisions that it added completely revamped the conditions upon which it was to receive trauma rate reimbursement. However, the hospital did not draft the new provisions in a manner consistent with the old language, introducing new terminology without squaring it with the existing terminology. It is as if the hospital sought to add language verbatim from a contract it had with another health plan, without seriously considering how well it would fit with the old language. This led to a dispute about whether the new provisions superseded the old ones, or whether enough of the old provisions were still in the amendment thus requiring the parties to pay more than lip service to the old provisions. As a practical matter, if the new provisions cannot be made to seamlessly supplement the existing provisions, the old provisions should simply be scrapped and replaced by entirely new provisions.

- The drafters of the provisions would have done well by consulting the persons that would be applying and enforcing the provisions and carefully defining them in the contract.

Another potential reason for ambiguities is the disconnect between the different people involved in the drafting, interpretation, and application of contract provisions. The contract provisions are drafted by attor-

neys anticipating certain actions by the hospital’s nurses, doctors, billing administrator, and claims processors. However, unless everyone is speaking the same language, different terms can mean different things to different people. For instance, in Contract #3, the hospital’s Chief of Trauma testified that the terms “Trauma Medical Condition” and “Trauma Response Team” are not used in the Trauma Department, and while he can (and did) provide his opinion as to what they meant to him, he had no idea what those terms meant as used in the contract.

Thus, if possible, the provisions should be prepared using terminology both parties are familiar with, **and those terms should be clearly defined somewhere in the contract**. Even if other personnel cannot be consulted, basically any terminology **can** be used as long as that terminology is clearly defined.

- Reliance upon custom and practice to fill gaps in the contract language should be avoided.

What is almost as interesting as the ambiguities in Contract #3 is how long it took for the parties’ dispute over the meaning of the terms to result in litigation. It is possible that despite the ambiguous language, the parties understood how trauma claims should be handled *at the time the amendment went into effect*.

Sometimes over-familiarity with custom and practice leads to complacency with respect to contract drafting. Thus, contracts between health plans and hospitals are constantly amended and superseded, and it is not uncommon (although certainly not recommended) for the parties to either “shorthand” or not even mention certain terms or details that have become second nature to the parties. In those instances, the current personnel may have no problem implementing an otherwise ambiguous contract provision based upon custom and practice, although the provision may make less and less sense as time passes and personnel dealing with the contract provision turn over.

With respect to the “Trauma Medical Condition” provision in Contract #3, it is likely that, although on paper the hospital appears to have absolute discretion to designate a “Trauma Medical Condition,” in practice the hospital’s personnel initially made such designations (relatively) consistent with objective criteria contained in local county Trauma Guidelines, so there were few objections to the hospital’s trauma claims. However, as personnel turn over, new eyes interpret the provisions as they appear, with less and less reliance upon custom and practice. That could explain the hospital’s sudden attempt to broadly interpret the terms “Trauma Medical Condition” and “Trauma Response Team”. Such a shift from self-policing to broad interpretation is, in most cases, inevitable, and should be avoided by not taking custom and practice for granted in drafting these contract provisions.

In summary, the keys to creating unambiguous trauma provisions are to take care in defining key trauma terms such as “trauma condition” and “trauma team,” and to avoid shortcuts in drafting trauma provisions or amendments to trauma provisions. Clean trauma provisions will ultimately lead to fewer trauma reimbursement disputes.