

# **Maryland Health Care Commission Health Services Cost Review Commission**

## **Maryland Trauma Fund Annual Stand-by Trauma Services Application**

### **Trauma Center's Request for Reimbursement**

***Andrew N. Pollak  
Chairman  
Maryland Health  
Care Commission***

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Health Services Cost  
Review Commission***

**Maryland Trauma Fund  
Annual Stand-by Trauma Services Application**

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# Maryland Trauma Fund Annual Stand-by Trauma Services Application

## OVERVIEW

The Maryland Health Care Commission requires specific information on Trauma Center operations. Please **READ** and **CAREFULLY RECORD** your responses legibly.

***When to File an Application? – The Trauma Center must submit a complete and accurate application within thirty days of its fiscal year semi-annual and annual end date.***

***Over What Period Can I Request Payment? – The Trauma Center can submit a claim for reimbursement of Stand-by costs incurred within the Trauma Center's current fiscal year.***

# **Maryland Trauma Fund Annual Stand-by Trauma Services Application**

## **BEFORE YOU MAIL CHECK LIST**

- ☒ (1) Did you review this report to verify that the information provided is accurate?
  
- ☒ (2) Did you complete the responses on every page?
  
- ☒ (3) Did you report each of the trauma physicians that were Stand-by during this twelve-month reporting period on p. 6? (N/A)
  
- ☒ (4) Did the trauma center's administrator sign the statement of verification on page 8?

## **Application Questions**

PLEASE BEGIN REPORT

1. The information reported in this application is for experience in a 6-month period representing either the first or second half of the applicant's fiscal year. Please identify the time period represented in this report.

Beginning     
Mo. Day Yr.

Ending     
Mo. Day Yr.

2. Trauma Center Name \_\_\_\_\_  
Street \_\_\_\_\_  
City/State \_\_\_\_\_  
Zip Code \_\_\_\_\_ Area Code/Telephone \_\_\_\_\_  
E-mail Address \_\_\_\_\_

3. Please list the person to contact for information concerning this report:
- Name \_\_\_\_\_  
Title \_\_\_\_\_  
Area Code/Telephone \_\_\_\_\_  
E-mail Address \_\_\_\_\_



5. Please provide the trauma center’s actual net Stand-by costs, the number of trauma physicians, and total hours for maintaining trauma physicians’ Stand-by during this six-month reporting period.

**Table 2: Summary Physician Stand-by Information**

<b>Specialty</b>	<b>\$ Net Stand-by Costs</b>	<b>Number of Stand-by Physicians</b>	<b>Total Stand-by Hours</b>
Anesthesiologist			
Neurosurgeon			
Orthopedist			
Trauma Surgeon			

6. Please give the name and address where the remittance for the trauma center’s Stand-by costs should be sent.

Name \_\_\_\_\_

Street \_\_\_\_\_

City/State \_\_\_\_\_ Zip Code \_\_\_\_\_

Tax ID Number \_\_\_\_\_

**Maryland Trauma Fund  
Annual Stand-by Trauma Services Application**

**VERIFICATION OF INFORMATION**

I hereby authorize that the facts stated in the Maryland Trauma Fund Annual Stand-by Trauma Services Application are correct to the best of my knowledge, information, and belief. I am an Administrator of the Trauma Center/Hospital, and can verify that all information submitted in this form is accurate and true.

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(Name of Trauma Center/Hospital - please print or type)

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(Trauma Center Administrator's name & title – please print or type)

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(Trauma Center Administrator's Signature)

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(Date)



## **Glossary of Terms**

**Application** – The Maryland Trauma Physician Payment Application.

**Commission** – Maryland Health Care Commission.

**Fraud** – The act of (1) knowingly and willfully making or causing any false statement or representation of a material fact in any application for payment and (2) knowingly and willfully making or causing any false statement or representation of a material fact for use in determining rights to payments.

**Fiscal Year** – A 12-month accounting period that may or may not end on December 31<sup>st</sup>.

**Fund** – Maryland Trauma Physician Services Fund.

**HSCRC** – Health Services Cost Review Commission.

**Maryland Trauma Registry** – A clinical trauma registry that monitors and provides information necessary to evaluate major trauma or specialty patient care, outcome, and cost, as well as assess how designated Trauma Centers and other hospitals comply with the trauma standards, regulations, and protocols.

**MIEMSS** – Maryland Institute for Emergency Medical Services Systems.

**Remittance** – Payment for Stand-by costs.

**Report** – Information required by the Maryland Health Care Commission for the purpose of distributing funds.

**Reporting Cycle** – A six-month period that corresponds to the semi-annual or annual half of an organization's own fiscal year.

**Service Period** – The time from entrance to the Trauma Center or Emergency Room until the dismissal from the Trauma Center or discharge from the acute care hospital.

**Stand-by Costs** – The costs to a trauma center or its affiliated hospital for paying physicians to be available on site at the trauma center or its affiliated hospital to treat trauma patients.

**Stipend** – The amount of payment made by the Trauma Center to have a Trauma Physician available on Stand-by for a specific time period.

**Trauma Patient** – A patient must have a record in the Maryland Trauma Registry.

**Trauma Physician** – A Trauma Surgeon, an Orthopedic Surgeon, a Neurosurgeon, a Critical Care Physician, an Anesthesiologist, or an Emergency Room Physician who provides care in a Trauma Center to Trauma Patients on the State Trauma Registry.

**Trauma Physician Tax Identification Number** – An employer identification number used by a trauma physician for tax filing purposes and health care reimbursement for services provided at the Trauma Center.

**THANK YOU FOR COMPLETING**

**MARYLAND TRAUMA FUND  
ANNUAL STAND-BY COST APPLICATION**

**PLEASE REVIEW THE CHECK LIST  
AT THE BEGINNING OF THE APPLICATION.**

**PLEASE RETURN APPLICATION TO:**

**Ms. Denise Ridgely  
Maryland Health Care Commission  
4160 Patterson Avenue  
Baltimore MD 21215**

**mhcc.trauma@maryland.gov  
410-764-3780  
410-358-1236 (FAX)**