If a conflict arises between a Clinical Payment and Coding Policy and any plan document under which a member is entitled to Covered Services, the plan document will govern. If a conflict arises between a Clinical Payment and Coding Policy and any provider contract pursuant to which a provider participates in and/or provides Covered Services to eligible member(s) and/or plans, the provider contract will govern. "Plan documents" include, but are not limited to, Certificates of Health Care Benefits, benefit booklets, Summary Plan Descriptions, and other coverage documents. Blue Cross and Blue Shield of Oklahoma may use reasonable discretion interpreting and applying this policy to services being delivered in a particular case. BCBSOK has full and final discretionary authority for their interpretation and application to the extent provided under any applicable plan documents.

Providers are responsible for submission of accurate documentation of services performed. Providers are expected to submit claims for services rendered using valid code combinations from Health Insurance Portability and Accountability Act approved code sets. Claims should be coded appropriately according to industry standard coding guidelines including, but not limited to: Uniform Billing Editor, American Medical Association, Current Procedural Terminology, CPT® Assistant, Healthcare Common Procedure Coding System, ICD-10 CM and PCS, National Drug Codes, Diagnosis Related Group guidelines, Centers for Medicare and Medicaid Services National Correct Coding Initiative Policy Manual, CCI table edits and other CMS guidelines.

Claims are subject to the code edit protocols for services/procedures billed. Claim submissions are subject to claim review including but not limited to, any terms of benefit coverage, provider contract language, medical policies, clinical payment and coding policies as well as coding software logic. Upon request, the provider is urged to submit any additional documentation.

Trauma Activation- Facility Services

Policy Number: CPCP031

Version 1.0

Clinical Payment and Coding Policy Committee Approval Date:
Sept. 26, 2025

Plan Effective Date: Jan. 6, 2026

Description

This policy provides information for when trauma activation occurs and how the Plan reimburses for trauma care, critical care, and emergency department services. Providers (i.e., facilities, hospitals, physicians, and other qualified healthcare professionals) are expected to exercise independent medical judgement in providing care to members. This policy is not intended to impact care decisions or medical practice.

The American College of Surgeons defines an "ideal trauma system" as one that provides "optimal trauma care such as prevention, access, prehospital care and transportation, acute hospital care, rehabilitation and research activities." The ACS has established domain criteria for facilities when creating a hospital activation policy that is published in the *Optimal Resources* guide. Three domains are used to help determine the levels of response for trauma activation. They are **Physiologic**, **Anatomic** and the **Mechanism of the injury**. Other factors may be taken into consideration such as age, anticoagulation, or bleeding disorders, burns, end-stage renal disease requiring dialysis, pregnancy greater than twenty (20) weeks, time-sensitive extremity injury, CPR and blunt force or penetrating trauma, trauma registry data, and regional considerations.

Reimbursement Information

The Plan reserves the right to request supporting documentation. Failure to adhere to coding and billing policies may impact claims processing and reimbursement. Providers should contact the Plan for additional information on trauma activation or trauma related procedure billing.

A trauma activation team is made up of key staff members who receive the members information from a pre-hospital caregiver prior to the member's arrival at the facility for triage. Trauma Centers and hospitals must be licensed, designated, or authorized by the state, and are assigned a trauma level. Trauma activation teams may be defined as a single or multi-tiered response team.

Minimal Criteria for Highest Level of Trauma Activation Must Include One (1) of the Below:

1. Confirmed systolic blood pressure of <90 mm Hg in adults and age-specific hypotension in children
2. Respiratory compromise, obstruction, or intubation
3. Use of blood products to maintain vital signs in patients transferred from other hospitals
4. Discretion of the emergency physician
5. Gunshot wounds to abdomen, neck, chest, or extremities proximal to the elbow or knee
6. Glasgow Coma Score less than 9 with mechanism attributed to trauma

Billing Guidelines for Designated Trauma Centers

- Only designated trauma centers or hospitals may submit revenue code 068X.
- The revenue code a facility can bill is determined by the ACS designation.
- The revenue code submitted is determined by the activation level.
- Revenue code 068X is only permitted for reporting trauma activation charges.

Revenue Code(s) 068X are defined as:

Revenue Code	Description
0681	**Trauma Response Level I**
0682	**Trauma Response Level II**
0683	**Trauma Response Level III**
0684	**Trauma Response Level IV**
0689 **Assigned by state or local authorities with levels that extend beyond trauma center level IV.**	**Other Trauma Response**

Designated Trauma centers should not bill a trauma response activation level higher than their designated trauma center level. **For example**, a designated trauma level II center cannot bill a level I trauma response regardless if a trauma response level I was activated. Additional examples are provided later in the policy.

Revenue Code(s) 068X and Form Locator (FL) 14, Visit Code 05

The National Uniform Billing Committee has provided guidelines on how to determine if trauma activation has occurred. Revenue code(s) 068X should be used when billing for trauma activation in conjunction with FL 14, Type of Admission/Visit code 05. In the event this occurred, the facility must have received a pre-arrival notification from a pre- hospital caregiver such as an Emergency Medical System provider. However, if a member is driven to the hospital or the member has walked into the hospital without notification, revenue code(s) 068X should not be billed, but the member may be classified as trauma using FL 14, Type of Admission/Visit code 05 when identifying the member for follow-up purposes. **Non-designated trauma centers should not use FL 14, type 5 or 068X when billing for trauma services.**

Critical Care Services

If a trauma activation occurs under one of the levels of response for revenue code(s) 068X, and a designated hospital or facility administers at least thirty (30) minutes of critical care for the same date of service, CPT code 99291 (critical care doctor services) and HCPCS G0390 (trauma response team) may each be reported with one unit. Trauma activation is considered a one-time occurrence in

association with critical care services and therefore may only be billed with one unit per day. Critical care services administered by a hospital for less than thirty (30) minutes when a trauma activation occurs may report a charge under revenue code(s) 068X, but HCPCS code G0390 should **not** be reported.

Emergency Department Services with Trauma Team Activation

Emergency department level of care should be billed in addition to trauma activation services on a single claim submission. Revenue codes 045X and 068X **cannot** be bundled. However, the appropriate level of emergency department care and trauma activation services may be billed for a member on the same date of service on the same claim.

Level I or Level II Designated Trauma Center Appropriate Line Level Billing Examples:

Level I Designated Trauma Center	Level II Designated Trauma Center
Level I Trauma Activation: REV 0681 + HCPCS G0390 and REV 0450 + CPT 99291	**Level I Trauma Activation:** REV 0682 + HCPCS G0390 and REV 0450 + CPT 99291
Level II Trauma Activation: REV 0682 + HCPCS G0390 and REV 0450 + CPT 99291	**Level II Trauma Activation:** REV 0682 + HCPCS G0390 and REV 0450 + CPT 99291
Level III Trauma Activation: REV 0683 + HCPCS G0390 and REV 0450 + CPT 99291	**Level III Trauma Activation:** REV 0683 + HCPCS G0390 and REV 0450 + CPT 99291
Level IV Trauma Activation: REV 0684 + HCPCS G0390 and REV 0450 + CPT 99291	**Level IV Trauma Activation:** REV 0684 + HCPCS G0390 and REV 0450 + CPT 99291
Level I Activation and member expires 15 minutes after arrival: REV 0681 and REV 0450 + CPT 99285 (or other appropriate level of care code that is not time-based)	**Level II Activation and member expires 15 minutes after arrival:** REV 0682 and REV 0450 + CPT 99285 (or other appropriate level of care code that is not time-based)

References

CMS Manual System, Pub 100-04 Medicare Claims Processing, Coding and Payment for Critical Care. Accessed 5/9/2025:

Medicare Claims Processing Manual, Chapter 25 Completing and Processing the Form. Accessed 5/9/2025

CMS OPPS Visit Codes Frequently Asked Questions. Accessed 5/9/2025

American College of Surgeons (ACS) Trauma Programs 2022 Resources Repository

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American College of Surgeons, Trauma Programs 2023 Data Dictionary Download

Policy Update History

Approval Date	Description
05/11/2021	New Policy
02/24/2022	Annual Review
07/11/2023	Annual Review
07/22/2024	Annual Review
09/26/2025	Annual Review; Grammatical and formatting updates; References updated; Policy Update History updated.