If a conflict arises between a Clinical Payment and Coding Policy ("CPCP") and any plan document under which a member is entitled to Covered Services, the plan document will govern. If a conflict arises between a CPCP 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. BCBSIL may use reasonable discretion interpreting and applying this policy to services being delivered in a particular case. BCBSIL 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 ("HIPAA") approved code sets. Claims should be coded appropriately according to industry standard coding guidelines including, but not limited to: Uniform Billing ("UB") Editor, American Medical Association ("AMA"), Current Procedural Terminology ("CPT®"), CPT® Assistant, Healthcare Common Procedure Coding System ("HCPCS"), ICD-10 CM and PCS, National Drug Codes ("NDC"), Diagnosis Related Group ("DRG") guidelines, Centers for Medicare and Medicaid Services ("CMS") National Correct Coding Initiative ("NCCI") 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: July 11, 2023

Plan Effective Date: July 11, 2023

Description

The purpose of this policy is to provide information for trauma activation criteria and reimbursement when trauma services are rendered. 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. Healthcare providers (i.e., facilities, hospitals, physicians, and other qualified healthcare professionals (QHP)) 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 (ACS) 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 (ESRD) 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:

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 <90mmHg 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 may 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 068x are defined as the following:

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 in the chart below.

Billing with Revenue Code 068x and Form Locator (FL) 14, Visit Code 05

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. For examples of possible emergency department services rendered per the level of care, refer to ***CPCP003 Emergency Department E/M Services Coding-Facility Services*** on the plan's website.

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)

The plan reserves the right to request supporting documentation. Failure to adhere to coding and billing policies may impact claims processing and reimbursement. Claims may be reviewed on a case-by-case basis. For additional information on trauma activation or trauma related procedures please contact your Network Management Office.

References:

Texas EMS Trauma & Acute Care Foundation, Trauma Activation Guideline© https://pdf4pro.com/amp/view/tetaf-trauma-activation-guidelines-438046.html

EMS/Trauma Systems Interactive Map. Accessed 5.19.2023 https://dshs.texas.gov/emstraumasystems/etrahosp.shtm

CMS Manual System, Pub 100-04 Medicare Claims Processing, Coding and Payment for Critical Care. Accessed 5/19/2023: https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1139CP.pdf

Medicare Claims Processing Manual, Chapter 25 Completing and Processing the Form. Accessed 5/19/2023 https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c25.pdf

CMS OPPS Visit Codes Frequently Asked Questions. Accessed 5.19.2023 https://www.cms.gov/medicare/medicare-fee-for-service-payment/hospitaloutpatientpps/downloads/opps_qanda.pdf

American College of Surgeons (ACS) Trauma Programs 2022 Resources Repository https://www.facs.org/quality-programs/trauma/quality/verification-review-and-consultation-program/standards/2022-resources-repository/

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American College of Surgeons, Trauma Programs 2023 Data Dictionary Download https://www.facs.org/quality-programs/trauma/quality/national-trauma-data-bank/national-trauma-data-standard/data-dictionary/access/

Policy Update History:

Approval Date	Description
05/08/2020	New policy
05/11/2021	Annual Review, Update verbiage; Update examples
02/24/2022	Annual Review
07/11/2023	Annual Review