In the event of a conflict 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. Plan documents include, but are not limited to, Certificates of Health Care Benefits, benefit booklets, Summary Plan Descriptions and other coverage documents.

In the event of a conflict 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.

Providers are responsible for accurately, completely, and legibly documenting the services performed including any preoperative workup. The billing office is expected to submit claims for services rendered using valid codes from Health Insurance Portability and Accountability Act (HIPPA) 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), National Drug Codes (NDC), Diagnosis Related Group (DRG) guidelines, Centers for Medicare and Medicaid Services (CMS) National Correct Coding Initiative (CCI) Policy Manual, CCI table edits and other CMS guidelines. Claims are subject to the code auditing protocols for services/procedures billed.

Trauma Activation

Policy Number: TXCPCP02

Version 1

Texas Clinical Payment and Coding Policy Committee Approval Date: 3/8/2019

Effective Date: July 1, 2019 (Blue Cross and Blue Shield of Texas)

Description

The purpose of this policy is to provide a reference for trauma activation criteria and a guideline for reimbursement when trauma is billed. A trauma activation team is made up of key staff members who receive patient information from a pre-hospital caregiver prior to the patient's arrival at the facility for triage. Healthcare providers (i.e., facilities, hospitals, physicians and other healthcare professionals) are expected to exercise independent medical judgement in providing care to patients. This policy is not intended to impact care decisions or medical practice.

Reimbursement Information:

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. These 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 (ERSD) 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.

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 single or multi-tiered response teams. Trauma centers and hospital policies, regardless of response team tiering, should contain all six criteria below for the definition of trauma; however, only one of the below six criteria must be met to activate the highest tier response team (major/severe trauma patient):

Reimbursement Information (cont'd):

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 or chest
6. Glasgow Coma Score less than 8 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.
- This code should not be 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 Center Level I
0682	Trauma Center Level II
0683	Trauma Center Level III
0684	Trauma Center Level IV
0689 Assigned by state or local authorities with levels that extend beyond trauma center level IV.	Other Trauma Center Levels

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

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

Trauma activation level charges are the same regardless if the patient was admitted or discharged.

If a trauma activation occurs under one of the levels of response for revenue code 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 and HCPCS G0390 may each be reported with one unit and the hospital may receive an additional payment under Ambulatory Payment Classification (APC) 0618. Critical care services administered for less than thirty (30) minutes when a trauma activation occurs may be billed using revenue code 068x, but HCPCS G0390 should not be billed.

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 patient on the same date of service on the same claim. For examples of level of care possible symptoms and services in the emergency department, refer to ***CPCP003 Facility & Professional Coding of Evaluation and Management of Emergency Department Services*** on the plan's site.

Examples of appropriate line level billing for reimbursement from a Level I Designated Trauma Center are as follows:

Level I Trauma Activation:
REV 0681 + HCPCS G0390 and
REV 0450 + CPT 99291

Level II Trauma Activation:
REV 0681 + HCPCS G0390 and
REV 0450 + CPT 99291

Level III Trauma Activation:
REV 0681 + HCPCS G0390 and
REV 0450 + CPT 99291

Level I Activation and patient expires 15 minutes after arrival:
REV 0681 and
REV 0450 + CPT 99285 or other appropriate level of care code that is not time-based

References:

Texas EMS Trauma & Acute Care Foundation, Trauma Activation Guideline©

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1104CP.pdf

https://www.facs.org/quality-programs/trauma

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c25.pdf

http://tetaf.org/wp-content/uploads/2016/03/trauma-activation-guildelines.pdf

https://www.cms.gov/medicare/medicare-fee-for-service-payment/hospitaloutpatientpps/downloads/opps_qanda.pdf

https://dshs.texas.gov/emstraumasystems/etrahosp.shtm

Policy Update History:

Approval Date	Description
3/8/2019	New policy