Priority Health	BILLING POLICY No. 202
Trauma Team Activation	
Date of origin: 06/2026	**Review dates: None yet recorded**

DEFINITION

This policy provides guidance for trauma activation billing and reimbursement when trauma services are rendered.

Critical care

Critical care is a physician's direct delivery of medical care for a critically ill or critically injured patient. It involves decision making of high complexity to assess, manipulate and support vital organ system failure and/or to prevent further life-threatening deterioration of the patient's condition. Examples of vital organ system failure include, but aren't limited to central nervous system failure, circulatory failure, shock, renal, hepatic, metabolic and/or respiratory failure.

Trauma activation team

A trauma activation team is made up of key staff members who receive the member's information for triage. Healthcare providers (i.e., facilities, hospitals, physicians and other qualified healthcare professionals) are expected to exercise independent medical judgement in providing care to members.

FOR MEDICARE

For indications that don't meet criteria of NCD, local LCD or specific medical policy, a Pre-Service Organization Determination (PSOD) will need to be completed. Get more information on PSOD in our Provider Manual.

POLICY SPECIFIC INFORMATION

- Critical care services can be considered for reimbursement when at least 30 minutes of face-to-face critical care are performed by a physician and/or qualified healthcare professional, billed with CPT 99291 and revenue code 045X, and/or documented in the medical records for the same date of service.
- CPT 99292 can be billed for each additional 30 minutes of critical care provided.

- Critical care services less than 30 minutes should be billed as a visit, such as an Emergency Department visit, at the appropriate level. Critical care isn't reimbursable if the member is discharged the same or next day with a discharge status code of 01 (discharged to home or self-care).
- Use revenue code 068x in conjunction with FL 14, Type of Admission/Visit code 05. In the event of trauma activation, the facility must have received a prearrival notification from a prehospital caregiver, such as a paramedic or other emergency medical services provider.
- If the member wasn't assigned a prehospital notification revenue code, 068X shouldn't be billed. However, the member may be classified as experiencing trauma on the UB-04, using FL 14, Type of Admission/Visit code 05 when identifying the member for follow-up purposes.
- Non-designated trauma centers shouldn't use FL 14, type 5 or 068X when billing for trauma services

Place of service
Coverage will be considered for services furnished in the appropriate setting to the patient's medical needs and condition. Authorization may be required. Get more information in our Provider Manual.

Documentation requirements
Complete and thorough documentation to substantiate the procedure performed is the responsibility of the Provider. In addition, the Provider should consult any specific documentation requirements that are necessary for any applicable defined guidelines.

Trauma activation is eligible for reimbursement when the following is met:

- Billed on a UB04.
- At least thirty (30) minutes of critical care is provided for the same date of service and documented in medical records.
- Trauma team activation is documented in medical records and billed with HCPCS code G0390 and the appropriate 068X revenue code. CMS believes that trauma activation is a one-time occurrence in association with critical care services, and therefore, the health plan will only reimburse for one unit of G0390 per day.
- Trauma center/hospital is licensed or designated by the state or local government authority or verified by the American College of Surgeons as a trauma facility and the facility is billing a trauma response activation level (revenue code) appropriate to their facility's trauma level designation.

Revenue codes for trauma team activation

- **0681**: Trauma Response Level I
- **0682**: Trauma Response Level II
- **0683**: Trauma Response Level III
- **0684**: Trauma Response Level IV
- **0689**: Trauma Response Level Other Trauma Response

American College of Surgeons (ACS) criteria

In addition to appropriately billing trauma activation, there's also trauma activation criteria set forth by the ACS. Apply the ACS criteria in the prehospital setting to identify trauma patients who would benefit most from the highest level of trauma activation.
The minimum criteria to activate the highest level of trauma activation is based on ACS 2022 updates to *Resources for Optimal Care of the Injured Patient*. It includes one or more of the following:

- Confirmed blood pressure less than 90 mm hg at any time in adults, and age-specific hypotension in children
- Gunshot wounds to the neck, chest or abdomen
- Glasgow Coma Scale less than 9, with mechanism attributed to trauma
- Transfer patients from another hospital who require ongoing blood transfusion
- Patients intubated in the field and directly transported to a trauma center
- Patients who have respiratory compromise or need an emergent airway
- Transfer patients from another hospital with ongoing respiratory compromise (excludes patients intubated at another facility who are now stable from a respiratory standpoint)
- Patients experiencing an emergency as determined by a physician

Coding specifics

CPT 99291 revenue code 045X-Critical care services can be considered for reimbursement when at least 30 minutes of face-to-face critical care are performed by a physician and/or qualified healthcare professional, and/or documented in the medical records for the same date of service.

CPT 99292- can be billed for each additional 30 minutes of critical care provided.

HCPCS code G0390-Trauma team activation is documented in medical records and billed with the appropriate 068X revenue code. Trauma activation is a one-time occurrence in association with critical care services, and therefore, the health plan will only reimburse for one unit of G0390 per day.

Modifiers

Priority Health follows standard billing and coding guidelines which include CMS NCCI. Modifiers should be applied when applicable based on this guidance and only when supported by documentation.

Resources

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/mm5438.pdf page 12

DISCLAIMER

CMS and/or MDHHS guidelines apply unless otherwise specified in this policy or provider manual. Where such guidance is absent, this policy applies. Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
06/2026	Provider manual page formatted into billing policy