BlueCross BlueShield of Illinois

Reimbursement Policy

Policy Number: RP031	**Policy Title:** Trauma Activation – Facility Services
Approval Date: Aug. 6, 2026	**Effective Date:** Aug. 14, 2026

Policy Disclaimer

If a conflict arises between a Reimbursement 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 reimbursement 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's 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 Illinois 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 submitting 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 ICD-10-PCS, National Drug Codes, Diagnosis Related Group guidelines, Centers for Medicare & 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 and procedures billed. Claim submissions are subject to claim review, including but not limited to, any terms of benefit coverage, provider contract language, medical policies and reimbursement policies, as well as coding software logic. Upon request, the provider is urged to submit any additional documentation.

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 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 describes a comprehensive trauma system as one designed to deliver coordinated care across the full continuum of injury management. This includes injury prevention, access to care, pre-hospital response and transportation, hospital-based treatment, rehabilitation, and research activities. According to ACS guidance, trauma activation decisions are generally informed by three core domains: physiologic findings, anatomic injuries, and the mechanism of injury. Additional factors may be considered as appropriate based on clinical judgment, including patient age, anticoagulation status or bleeding disorders, burn injuries, end-stage renal disease requiring dialysis, pregnancy greater than 20 weeks, time-sensitive extremity injuries, cardiopulmonary resuscitation events, blunt or penetrating trauma, trauma registry data, and relevant 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 healthcare professionals 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. Documented circulatory instability, including hypotension in adult patients or age-adjusted hypotension in pediatric patients.
2. Actual or impending compromise of airway or ventilatory status.
3. Administration of blood products to support hemodynamic stability during interfacility transfer.
4. Determination by the treating emergency physician that the member's condition warrants a trauma response.
5. Gunshot wounds involving critical anatomical regions or major vascular or organ

systems.

6. Evidence of significantly altered level of consciousness attributed to traumatic injury - Glasgow Coma Score of <9.

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, Current Procedural Terminology (CPT) code 99291 (critical care doctor services) and Healthcare Common Procedure Coding System (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

The following table provides examples of correct billing submissions

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)

Additional Resources

Reimbursement Policy (formerly known as Clinical Payment and Coding Policy)

CPCP003 Emergency Department Evaluation and Management - E/M Coding - Facility Services

References

CMS Manual System, Pub 100-04 Medicare Claims Processing, Coding and Payment for Critical Care. Accessed April 24, 2026:

Medicare Claims Processing Manual, Chapter 25 Completing and Processing the Form. Accessed April 24, 2026

CMS OPPS Visit Codes Frequently Asked Questions. Accessed April 24, 2026

American College of Surgeons Trauma Programs 2022 Resources Repository. Accessed April 24, 2026.

Optum. Copyright 2026. Uniform Billing Editor. Optuminsight. Revenue Code 0681, 0682, 0683, 0684, and 0689

Centers for Medicare & Medicaid Services (2026). Healthcare Common Procedure Coding System (HCPCS). Accessed April 24, 2026.

American College of Surgeons, Trauma Programs 2023 Data Dictionary Download. Accessed April 24, 2026.

American College of Surgeons, 2022 ACS Standards Manual, Optimal Care of the Injured Patient. Accessed and downloaded April 24, 2026.

Policy 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
07/22/2024	Annual Review
09/26/2025	Annual Review; Grammatical and formatting updates; References updated.
08/06/2026	Annual Review; CPT, HCPCS and ACS References were added