curative

TITLE:	TRAUMA ACTIVATION
DEPARTMENT:	PAYMENT POLICY
ORIGINAL EFF. DATE:	08/05/26
REVISION DATE:	N/A

1. PURPOSE

This Payment Policy outlines clear and consistent reimbursement guidelines to ensure compliant, transparent, and timely payment for medically necessary, cost-effective care.

2. SCOPE

This policy applies to the reimbursement of covered services for all members and providers. Curative will allow reimbursement for services according to the criteria outlined in this policy, unless modified or superseded by contractual language.

3. DEFINITIONS

The following terms are defined as follows regarding this policy.

3.1. **Revenue Codes** Categorization institutional services (e.g. room, lab, pharmacy).

4. POLICY

Disclaimer: These Payment Policies serve as a comprehensive guide for all providers, assisting in submitting accurate claims and outlining the essential framework for reimbursement. The determination that a service, procedure, or item is covered under a Curative member's benefit plan does not constitute a guarantee of payment. Services must meet medical necessity and authorization guidelines appropriate to the procedure and diagnosis and, where mandated, the members state of residence. Services rendered must be within the legal scope of practice for the specific type of provider and align with the professional credentials and training in the state where the care is furnished.

To ensure proper processing, providers are required to adhere to industry-standard, compliant codes and follow proper coding, billing, and submission guidelines. To ensure accurate reimbursement and proper claims adjudication, all services provided to the same member, by the same provider, and on the same date of service must be reported on a single claim. Current Procedure Terminology (CPT®*) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or relevant revenue codes must be used for billing. Codes submitted must be fully supported by corresponding documentation in the medical record. Unless noted otherwise within a policy, these payment policies apply to both participating and non-participating providers and facilities.

Curative reserves the right to take corrective action, which may include the rejection or denial of the claim, or the recovery and/or recoupment of any previous claim payment if proper coding, billing guidelines, or these established payment policies are not followed. Providers may refer to the Provider Manual for guidance on addressing such actions, including the formal claim reconsideration, appeals, and dispute resolution processes.

These policies may be superseded by mandates within provider contracts, state or federal laws, or requirements issued by the Centers for Medicare & Medicaid Services (CMS). Curative retains the right to revise these policies as deemed necessary and will publish the most current version on the Curative website.

Curative reserves the right to request and review comprehensive medical records to support claims submitted under this policy. Discrepancies, incomplete documentation, or coding misalignments may result in claim adjustments, denials, or post-payment recoveries.

Reimbursement is contingent upon provider, state, and federal contracts, and is subject to review on an individual claim basis.

Reimbursement Guidelines

This policy outlines how Curative reimburses health care providers for trauma activation at trauma centers. This policy serves as a billing guide. It is not intended to influence, restrict, or dictate clinical decisions or medical practice. All participating providers should exercise independent medical judgment when delivering care to our members.

A trauma team consists of a coordinated, multidisciplinary group of healthcare professionals. To constitute a valid activation, the team must be mobilized based on pre-arrival information received from pre-hospital EMS (Emergency Medical Services) personnel prior to the patient's arrival. Facilities may utilize either single-tier or multi-tiered team response protocols.

In alignment with the American College of Surgeons (ACS) *National Guidelines for the Field Triage of Injured Patients*, trauma activation levels are determined by evaluating three primary clinical domains:

- Physiologic Indicators: Vital signs and systemic stability.
- Anatomic Indicators: Specific physical injuries and anatomical damage.
- Mechanism of Injury: The physics and nature of the traumatic event.

Providers should also consider aggravating variables such as advanced or pediatric age, active anticoagulation therapy, bleeding disorders, severe burns, end-stage renal disease (ESRD) requiring dialysis, pregnancy beyond 20 weeks, time-critical extremity injuries, active CPR, blunt or penetrating force trauma, registry analytics, and regional systemic protocols.

Revenue Code 068x, Trauma Response, should be used to identify the appropriate level of activation provided. Only licensed or state-designated trauma centers verified by the ACS may submit claims under Revenue Code 068x.

- The specific revenue code billed must align directly with the facility's ACS-designated tier and the corresponding level of team activation.
- Designation Cap Rule**:** A facility may never bill a trauma response tier that exceeds its authorized designation level. For example, a designated Level II trauma center cannot bill a Level I trauma activation, even if a Level I-equivalent team was mobilized.

To qualify for the highest level of trauma team mobilization, the patient must meet **at least one** of the following clinical indicators upon arrival or via pre-hospital report:

- Hypotension: A confirmed systolic blood pressure of less than 90 mm Hg in adults, or age-specific hypotension in pediatric patients.
- Airway Compromise: Active respiratory distress, airway obstruction, or emergency intubation.

- Transfusion Support: The administration of blood products to sustain vital signs in patients transferring from an outside facility.
- Physician Discretion: Explicit clinical judgment exercised by the attending emergency physician.
- Penetrating Trauma: Gunshot wounds to the torso (chest, abdomen), neck, or proximal extremities (above the elbow or knee).
- Neurological Deficit: A Glasgow Coma Scale (GCS) score of less than 9 due to a traumatic mechanism.

To ensure billing compliance under National Uniform Billing Committee (NUBC) guidelines, use the following logic when pairing Revenue Code 068x and Form Locator (FL) 14, Type of Admission/Visit Code 05 Trauma Center:

Patient Arrival Type	**Revenue Code 068x**	**FL 14, Code 05 (Type of Admission)**	**Billing Rule**
Pre-Hospital Notification Received (EMS / Inter-hospital Transfer)	**Permitted**	**Required**	Billable if the team is activated.
Walk-in / Drive-up Patient (No Pre-Arrival Notification)	**Prohibited**	**Permitted (For Tracking Only)**	Do not bill 068x. FL 14 Code 05 may be used solely for internal trauma registry tracking.
Non-Designated Trauma Facility	**Prohibited**	**Prohibited**	Non-designated facilities may not use 068x or FL 14, Type 5.

When a qualified trauma activation occurs, reimbursement is determined by the duration of critical care provided on the same date of service:

- Critical Care of 30 Minutes or More:
    - The facility may bill one (1) unit of HCPCS G0390 (Trauma Response Team) and one (1) unit of CPT 99291 (Critical Care, first 30–74 minutes).
    - HCPCS G0390 is limited to a maximum of one unit per date of service, as trauma activation is considered a single, non-recurring event per episode.
- Critical Care of Less Than 30 Minutes:
    - The facility may report charges under Revenue Code 068x to cover mobilization costs.

- HCPCS G0390 must not be billed on the claim.

Standard Emergency Department Evaluation and Management (E/M) facility services may be billed alongside trauma activation services on a single claim. Revenue Codes 045x (Emergency Department) and 068x are distinct and both may be reimbursed on the same date of service when supported by documentation.

5. REFERENCE DOCUMENTS AND MATERIALS

5.1 CMS Manual System, Pub 100-04 Medicare Claims Processing, Chapter 4 Part B Hospital, 160.1 Critical Care Services

5.2 American College of Surgeons (ACS). *National Guidelines for the Field Triage of Injured Patients: Recommendations of the National Expert Panel on Field Triage, 2021*. Published in *J Trauma Acute Care Surg.* 2022;93(2):e49-e60. PMCID: PMC9323557 https://www.facs.org/quality-programs/trauma/systems/field-triage-guidelines/

5.3 Drendel AL, Gray MP, Lerner EB. A Systematic Review of Hospital Trauma Team Activation Criteria for Children. *Pediatr Emerg Care*. 2019;35(1):8-15. doi:10.1097/PEC.0000000000001256. PMCID: PMC6913171.

6. COLLABORATING DEPARTMENTS

6.1. Claims

6.2. Compliance

6.3. Medical Management

6.4. Network

6.5. System Configuration

7. POLICY & PROCEDURE CONTROL

This Policy will be reviewed at least annually and as necessary.

REVISION HISTORY			
Date	**Author**	**Version**	**Comments**
08-05-2026	CJ Wisecarver	001	Initial Version