NATIONAL FOUNDATION FOR TRAUMA CARE

FREQUENTLY ASKED QUESTIONS (FAQs)
Trauma Codes
Form Locator (FL) 19, Type 5 and Revenue Code, 68x
"G" 0390 and APC 0618

1. **Why should we use a trauma activation fee?**
   A. Trauma patients receive an intensive level of evaluation which requires hospitals to expend higher level of resources. ED level of services do not cover this additional cost burden. With the UB-04 revenue code 68x, hospitals have the opportunity to bill for these costs.

2. **What is the difference between the Form Locator (FL) 19, Type 5 and the 68x code?**
   A. FL 19, Type 5 is the new admission type for trauma patients treated at a trauma center/hospital that is verified by the American College of Surgeons (ACS) or designated by State/local authority. 68x is the assigned UB-04 code for finance/billing departments to bill for trauma activation fees.

3. **Can non-verified trauma centers use the new codes?**
   A. No. However, this is an incentive to get ACS verification or State/local designation.

4. **Can we use the 68x code if a patient is driven to the hospital by family member or walked into the trauma center?**
   A. You will **not** be able to charge the patient using the 68x code, but you will be able to use the FL 19, type 5 to ID the patient as a trauma patient. If there are significant numbers of these patients, we petition the National Uniform Billing Committee (NUBC) to alter this definition.

5. **Can we use the 68x code for hospital transfers?**
   A. Yes. You will be able to use the 68x code as long as there was some type of organized response rendered and the patient met criteria for trauma triage or interhospital transfer.

6. **Do HCPCS (CPT) and APC codes need to be used with the trauma activation charges (68x)?**
   A. Yes, in December 2006, CMS (Medicare) assigned a new "G" code 0390 as well as APC 0618 to Trauma Response 68x. In a somewhat confusing manner, they have limited payments of nearly $500 per activation, to only those trauma responses associated with a HOSPITAL HCPCS critical care code, 99291, on the same day of service..

7. **Do we still bill for ED services?**
   A. Yes. Revenue code 45x will still be used to charge for the appropriate level of ED service.

8. **How do we incorporate revenue code 68x if we already bill for trauma activation under revenue code 45x?**
   A. You will need to "unbundle" your ED level of services and trauma activation fee. The ED level of services will be billed as before and the trauma activation component will be billed under the new revenue code 68x.

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9. **Can we bill trauma and ED charges on the same bill?**
   A. Yes. The trauma activation charge should be placed on the patient hospital bill in addition to the ED charge under revenue code 45x.

10. **Should the trauma activation fee levels differ based on whether the patient was admitted or not?**
    A. No. The trauma activation charge is for the level of response a patient **received** regardless of admission or discharge.

11. **Should we chart the reasons for trauma team activation?**
    A. You should always chart the fact that there was prearrival notice from a medical third party, the reason for activation, and keep documentation of the activation and response in the patient's medical record. Trauma centers need this documentation to dispute charges with payers and to track utilization.

12. **Should trauma centers contact payer groups before implementation of the trauma activation charge?**
    A. Possibly. Trauma centers may want to contact payer groups directly and have open discussions about the new charge. Trauma centers can provide an executive summary introducing and explaining the trauma activation fees. Additional suggestions include: providing educational materials on the differences between ED charges and trauma charges, offering trauma center site visits to payer groups, and/or using the "Community Standard" approach, etc. See the NFTC document about Managed Care Contracting.

13. **Why will Medicare not pay UB-04 68x unless it is associated with 99291, critical care?**
    A. UB-04 68x is still being studied by CMS. However, they have already determined that costs are higher for trauma critical care than for adult critical care and are paying more based on their data. This should result in increased inpatient payment for 68x under the DRG for trauma patient care if the patient receives critical care 99291 on the same day of service. More importantly, correct billing by hospitals will allow CMS to collect more cost data which can result in increased payments to trauma centers overall for trauma care or push the bill into higher outlier payments.

14. **What should we do if insurers refuse to pay the trauma surcharge?**
    A. Hospitals should follow their standard procedures for collection/billing. In addition, standard appeal letters should be developed to be accompanied by copies of ACS and local/state field triage or transfer criteria.

15. **Where can I find additional information on the new codes?**
    A. NFTC offers advice and guidance on implementation of the new codes to Members ONLY. For more information on membership, please contact Connie Potter, RN, MBA, Executive Director at connie@traumafoundation.org.