Reimbursement/Billing Policy

Critical Care Services and Trauma Activation
Policy Number: RM047
Last Review: 12/15/2025

GUIDELINES:

- Paramount Reimbursement Policies have been developed to assist in administering proper payment under benefit contracts.
- Reimbursement policies may be superseded by mandates in provider, state, federal, or CMS contracts and/or requirements.
- Paramount utilizes industry standard coding methodology and claims editing in the development of reimbursement policies. Industry standard resources include, but are not limited to, CMS National Correct Coding Initiative (NCCI), Medically Unlikely Edits (MUEs), Integrated Outpatient Code Editor (I/OCE) Clinical edits, Medical Policies, Reimbursement Policies, and Administrative/Provider Manuals. Paramount will not reimburse services determined to be Incidental, Mutually Exclusive, or Unbundled.
- All health care services, devices, and pharmaceuticals must be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes and modifiers, which most accurately represent the services rendered, unless otherwise directed by the Paramount. All billed codes must be fully supported in the member's legal medical record.
- Paramount utilizes CMS pricing algorithms where appropriate based on, National Physician Fee Schedule Relative Value File (NPFSRVF) pricing rules, Inpatient Prospective Payment Systems (MS-DRG, LTC, IPF, IRF & IPSNF) and Outpatient Prospective Payment Systems (OPPS, HHA, ASC, ESRD & OPSNF).
- Paramount liability will be determined after coordination of benefits (COB) and third-party liability (TPL) is applied to the claim. Member liability may include, but is not limited to, co-payments, deductibles, and coinsurance. Members' costs depend on member benefits.
- Paramount routinely reviews reimbursement policies. Updates are published on Paramount's website https://www.paramounthealthcare.com. The information presented in this reimbursement policy is accurate and current as of the date of publication. Paramount communicates policy updates to providers via Paramount's monthly bulletin.

SCOPE:

☐ Professional
☒ Facility

Applicability:

☒ Commercial and Marketplace (Fully Insured and Self-Funded)
☒ Medicare Advantage

Definition:

Critical Care is defined by CMS as the direct delivery by a physician(s) medical care for a critically ill or critically injured patient. A critical illness or injury acutely impairs one or more vital organ systems such that there is a high probability of imminent or life-threatening deterioration in the patient's condition.

Trauma Activation is the deployment of medical professionals, or a trauma team, to coordinate care for a patient with traumatic injury based on predefined criteria, for instance vital sign abnormalities, neurological dysfunction, or mechanism of injury.

This policy outlines reimbursement and coding guidelines for Critical Care (99291-99292) and Trauma Activation (G0390) services submitted on a UB04 claim form or the electronic equivalent.

Reimbursement Policy:

Critical Care
Critical Care services are considered for reimbursement when at least 30 minutes of face-to-face critical care is performed by a physician. CPT code 99291 (critical care, first hour) and revenue code 045x are used to report the services of a physician providing full attention to a critically ill or critically injured patient from 30-74 minutes.

CPT code 99292 is used to report additional block(s) of time, of up to 30 minutes each beyond the first 74 minutes of critical care.

Critical care CPT codes must not be reported for critical care of less than 30 minutes. An appropriate E/M code such as subsequent hospital care should be used.

Critical care is not reimbursable if the member is discharged the same or next day with a discharge status code of 01 (discharged to home or self-care).

Trauma Activation
If trauma activation occurs under one of the levels of response, and a hospital or facility administers at least thirty (30) minutes of critical care for the same date of service, designated trauma centers/hospitals may bill for trauma activation using HCPCS code G0390 (trauma response team) and revenue code 068X.

If trauma activation occurs under one of the levels of response, and a hospital or facility administers less than thirty (30) minutes of critical care services, trauma activation may be reported under revenue code 068x but HCPCS code G0390 must not be reported, and trauma activation is not eligible for separate reimbursement.

When billing for trauma activation, revenue code 068x must be used in conjunction with Field Locator (FL) 14 and Type of Admission/Visit code 05.

Trauma activation is only eligible for reimbursement when provided on the same date of service and billed on the same claim as critical care service, CPT code 99291, billed under revenue code 0450. Trauma activation will not be considered for reimbursement when submitted without the critical care CPT code billed on the same claim.

Trauma activation is considered a one-time occurrence in association with critical care service. Therefore, only one unit of G0390 is reimbursable per date of service.

Revenue code 068X may only be used by trauma centers/hospitals as licensed or designated by the state or local government authority authorized to do so, or as verified by the American College of Surgeons. Paramount may deny or adjust reimbursement if there is a discrepancy between the trauma response level billed and designated trauma center level.

To bill for trauma activation there must have been prehospital notification based on triage information from prehospital caregivers, who meet either local, state or American College of Surgeons field triage criteria, or are delivered by inter-hospital transfers, and are given the appropriate team response. In order to bill for trauma response there must be clear documentation that the trauma team was notified prior to the patient's arrival along with the trauma care provided.

Sources of Information:

Centers for Medicare & Medicaid Services (CMS), Medicare Claims Processing Manual

Additional Publications by the Centers for Medicare & Medicaid Services (CMS)

American Medical Association Publications

Optum. HCPCS Level II. Expert ed., 2025

REVISION HISTORY EXPLANATION: ORIGINAL EFFECTIVE DATE:

Date	Explanation & Changes
12/15/2025	• Policy Created
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