Clinical Policy: Administrative Days

Reference Number: WA.CP.MP.519
Last Review Date: 07/24
Effective Date: 07/01/24

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

This policy describes medical necessity criteria for administrative days as defined by the Washington State Health Care Authority. Administrative days may be paid when a member has met criteria for a social admission, is on hold pending state investigation, or previously met, but no longer meets, medical necessity criteria for observation or inpatient stay. See Policy/Criteria for specific guidelines.

Social admission is defined as a hospital admission with no acute medical issues, rather the member's social circumstances are the sole cause for admission. This circumstance may be a breakdown of home supports or inability of the caregivers to cope with the demands of the member's Activities of Daily Living (ADL). The administrative day rate will be paid starting with the date of hospital admission if the admission is solely for a no placement administrative day stay (social admission).

A postpartum parent may meet criteria for Newborn Administrative Days as defined in the Policy/Criteria.

Policy/Criteria

Note: For all indications below (sections I.- IV.), medical records are required to assess the appropriateness of administrative days. Administrative days will not be authorized if no medical records have been received.

I. Physical Health-No-Placement: It is the policy of Coordinated Care of Washington, Inc., in accordance with the Health Care Authority, that *No-Placement Administrative Days* for physical health related services may be *approved* when A. is met *and* B. *or* C. are met:

- A. None of the following levels of care is medically necessary:
  - i) Acute inpatient, or
  - ii) Observation, or
  - iii) Long Term Acute Care (LTAC), or
  - iv) Inpatient Rehabilitation (IPR) AND
- B. Appropriate non-hospital placement is not readily available OR
- C. Outpatient level of care is not applicable.

II. Physical Health-Newborn, Initial Five Days: It is the policy of Coordinated Care of Washington, Inc., in accordance with the Health Care Authority, that when the postpartum parent does not meet criteria for acute inpatient level of care, but their infant is still an inpatient being observed for potential post-in utero exposure to substances that may lead to

physiologic dependence (Neonatal Abstinence Syndrome {NAS}), an initial five *Newborn Administrative Days* for physical health related services may be *approved* for the postpartum parent when ALL of the following (A-E) are met:

A. Newborn remains in an inpatient status to monitor in-utero exposure to substances that may lead to physiologic dependence AND
B. Continuous care by the member who delivered the baby(ies) is the appropriate first-line treatment (e.g., "Eat, Sleep, Console" or other non-pharmacologic similar model defined by continuous care by the birth parent) AND
C. The member who delivered the baby(ies) rooms in with their newborn and provides parental support/care AND
D. The hospital provides all prescribed medications to the postpartum parent for the duration of the stay, including medications prescribed to treat substance use disorder.
E. The hospital provides additional services to the postpartum parent: hospital bed/rooming in with newborn, nutritional support for the parent, other support services depending on the newborn's needs (e.g., lactation support, nursing assessment and intervention, rounding, and discharge planning).

III. Physical Health-Newborn, Subsequent Days: It is the policy of Coordinated Care of Washington, Inc., in accordance with the Health Care Authority, that additional Admin days for the postpartum parent, beyond the initial five days, may be *approved* for the postpartum parent when the criteria in section II. have been met and the following additional criteria are also met:

A. Newborn requires ongoing monitoring and does not meet criteria for discharge because the newborn is having difficulty with one or more of the following:
    a. Feeding or sucking or poor weight gain
    b. Gastrointestinal disturbance (e.g., vomiting, diarrhea, cramping)
    c. Sleep (i.e., falling asleep or maintaining sleep)
    d. Being consoled (e.g., excessive crying or irritability, tremors, hypertonia)
B. The newborn can receive continuous care from the postpartum parent:
    a. The newborn has not transferred into the neonatal intensive care unit (NICU) or the pediatric specialty unit for closer monitoring,
    b. The postpartum parent is staying at the hospital to provide continuous care.

IV. Behavioral Health: It is the policy of Coordinated Care of Washington, Inc., in accordance with the Health Care Authority, that administrative days for behavioral health related services may be *approved* when an inpatient psychiatric level of care is not medically necessary, and ALL of the following (A-C) are met:

A. Member/Enrollee is already in a psychiatric facility, AND
B. Member/Enrollee has a legal status of "voluntary", AND
C. No less restrictive alternative placement is available.

Billing

Facilities that have approval to bill for administrative days must bill approved inpatient and administrative days on separate claims. Status code on the inpatient acute bill must be "30" to indicate continuation of stay at the administrative day level. Facilities may bill for pharmacy

services and pharmaceuticals, laboratory services, radiology and imaging services, physical therapy, occupational therapy, speech therapy, and dialysis provided during administrative days. This list includes general service categories, please refer to the current Health Care Authority billing guidelines for a complete list of allowable revenue codes.

Payment for administrative days is based on the Health Care Authority Administrative Day payment methodology. When inpatient stay precedes administrative days, the administrative days are reimbursed only if the inpatient portion of the stay qualifies for outlier payment and only after the DRG average length of stay has elapsed. Retrospective audit of administrative day reimbursement may be conducted.

Coding Implications
The following codes are for informational purposes only. They are current at time of review of this policy. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

Revenue Codes	Description
0191	Subacute Care – Level 1 (used by inpatient hospitals)
0169	Room & Board, Other (used by inpatient rehab and psych facilities and LTACs)

Reviews, Revisions, and Approvals	Date	Approval Date
Policy adopted. Previously WA.UM.03.01	09/19	09/19
Clarified that Admin Days only apply if inpatient stay is an outlier. Updated references.	02/20	03/20
Removed exclusion for custodial care days.	05/20	06/20
Annual review. References updated. Replaced all occurrences of "member" with "member/enrollee".	04/21	04/21
Criteria for Physical Health (Section I.) re-ordered, and discharge planning criteria restated. Section II on non-approval removed. Criteria for Behavioral Health, previously Section III, renumbered and re-ordered. References reviewed and updated. All occurrences of "member" replaced with "member/enrollee"	04/22	05/22
Clarified that Administrative Day rate applies to social admissions. Added Newborn Administrative Days section. Added Note regarding request timeliness.	08/22	09/22
Added section III for Newborn Subsequent Days. References updated. Removed redundant revision note for 04/21.	02/23	02/23
Changed "denial" to "discharge" in Note.	09/23	10/23
References reviewed and updated. Removed note requiring providers to request administrative days. Section I. subsections D. and E. and section IV. subsections E. and F. facility requirements for discharge planning removed to align with WAC. Billing section updated to include other service categories that may be billed per revenue codes in the billing guidelines. Section II. E. added to reflect additional newborn administrative day services per the billing guidelines.	05/24	05/24
References reviewed and updated. Added references for acute PM&R. Description updated to clarify the process for social admissions per WAC 182-550-4550. WAC reference removed from description and replaced with Washington State Health Care Authority. Section I. approval requirements changed from "all" to "A. and B. or C." per the HCA billing guidelines. Section IV. D. removed.	07/24	07/24

References

1. Washington State Health Care Authority. Inpatient Hospital Services Billing Guide. https://www.hca.wa.gov/assets/billers-and-providers/Inpatient-hospital-bg-20240701.pdf. Revision effective July 1, 2024.
2. Washington State Health Care Authority. Mental Health Services Billing Guide. https://www.hca.wa.gov/assets/billers-and-providers/mental-health-svcs-20240701.pdf. Revision effective July 1, 2024.
3. Washington State Health Care Authority. Acute Physical Medicine and Rehabilitation (PM&R) Billing Guide. https://www.hca.wa.gov/assets/billers-and-providers/acute-pmr-bg-20240701.pdf. Revision effective July 1, 2024.
4. Washington Administrative code 182-550-2561 (Acute PM&R Services), https://app.leg.wa.gov/WAC/default.aspx?cite=182-550-2561. Accessed July 5, 2024.

5. Washington Administrative Code 182-550-2590 (LTAC Services), https://app.leg.wa.gov/wac/default.aspx?cite=182-550-2590. Accessed July 5, 2024.
6. Washington Administrative Code 182-550-2600 (Inpatient Psychiatric Services), https://apps.leg.wa.gov/wac/default.aspx?cite=182-550-2600. Accessed July 5, 2024.
7. Washington Administrative code 182-550-2900 (Inpatient Hospital Services) https://apps.leg.wa.gov/wac/default.aspx?cite=182-550-2900. Accessed July 5, 2024.
8. Washington Administrative Code 182-550-4550 (Administrative Day Rate), https://app.leg.wa.gov/wac/default.aspx?cite=182-550-4550. Accessed July 5, 2024.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/Enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.

Note: For Medicaid members/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.