Clinical Policy: Administrative Days
Reference Number: WA.CP_MP.519
Last Review Date: 09/19

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

Description
Medical necessity criteria for administrative days.

Policy/Criteria
I. It is the policy of Coordinated Care of Washington, Inc., in accordance with the Health Care Authority, that administrative days may be approved when all the following conditions are met:
   A. An inpatient hospital, long term acute care (LTAC), inpatient rehabilitation (IPR), or inpatient psychiatric level of care is not medically necessary, and
   B. Appropriate non-hospital placement is not readily available and
   C. There is documentation of ongoing discharge planning by the inpatient facility and Coordinated Care of Washington, Inc., discharge planning team.

II. It is the policy of Coordinated Care of Washington, Inc., in accordance with the Health Care Authority, that administrative days are not approved for the following:
   A. Member was not approved for at least one acute inpatient or observation hospital day immediately preceding the initial request for administrative days, unless admission is solely for the purpose of placement,
   B. Member requires custodial care, only,
   C. Administrative days are only for the convenience of the recipient, recipient’s family or physician,
   D. Facility or physician refuse to cooperate with Coordinated Care of Washington, Inc. discharge planning efforts or refuse placement at lower level of care or other available alternative setting,
   E. Facility has not provided documented evidence of a comprehensive discharge plan,
   F. There is not an acceptable reason and timeframe for unavoidable delay of discharge, examples include:
      1. awaiting a court date for appointment of medical guardianship,
      2. awaiting out-of-state nursing facility placement or surgery date
   G. The member’s stay becomes primarily behavioral health related.

III. It is the policy of Coordinated Care of Washington, Inc., in accordance with the Health Care Authority, that behavioral health related administrative days may be approved when all the following conditions are met:
   A. Member is already in a psychiatric facility,
   B. Member has a legal status of “voluntary,
   C. Member no longer meets medical necessity criteria,
   D. No less restrictive alternative placement is available,
E. Psychiatric facility and Coordinated Care of Washington, Inc., agree to the appropriateness of the administrative day,
F. Psychiatric facility or provider actively work with Coordinated Care of Washington, Inc., on discharge planning efforts,
G. Psychiatric facility provides documented evidence of a comprehensive discharge plan.

Billing
Facilities that have approval to bill for administrative days must billed 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 provided during administrative days.

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 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.

<table>
<thead>
<tr>
<th>Revenue Codes</th>
<th>Description</th>
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<tr>
<td>0191</td>
<td>Subacute Care – Level 1 (used by inpatient hospitals)</td>
</tr>
<tr>
<td>0169</td>
<td>Room &amp; Board, Other (used by inpatient rehab and psych facilities and LTACs)</td>
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Reviews, Revisions, and Approvals

<table>
<thead>
<tr>
<th>Reviews, Revisions, and Approvals</th>
<th>Date</th>
<th>Approval Date</th>
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<tbody>
<tr>
<td>Policy adopted. Previously WA.UM.03.01</td>
<td>09/19</td>
<td>09/19</td>
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References
   Revision effective July 1, 2019.
   Revision effective July 1, 2019.

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. This clinical policy is not intended to recommend treatment for members. Members 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.

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**Note:** For Medicaid members, 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.

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