Evolent Clinical Guideline 2741.CC for Administrative Days Requests

Guideline Number:	Applicable Codes	
EVH_CG_2741.CC		
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Original Date:	**Last Revised Date:**	**Implementation Date:**
November 1, 2025	November 20, 2025	December 1, 2025

TABLE OF CONTENTS

STATEMENT

General Information

- *It is an expectation that all patients receive care/services from a licensed clinician. All appropriate supporting documentation, including recent pertinent office visit notes, laboratory data, and results of any special testing must be provided. If applicable: All prior relevant imaging results and the reason that alternative imaging cannot be performed must be included in the documentation submitted.*
- *Where a specific clinical indication is not directly addressed in this guideline, medical necessity determination will be made based on widely accepted standard of care criteria. These criteria are supported by evidence-based or peer-reviewed sources such as medical literature, societal guidelines, and state/national recommendations.*
- *The guideline criteria in the following sections were developed utilizing evidence-based and peer-reviewed resources from medical publications and societal organization guidelines as well as from widely accepted standard of care, best practice recommendations.*

Purpose

The purpose of this policy is to define the process for requesting administrative days.

Special Note

- It is the policy of CountyCare Health Plan to offer approval of administrative days when specific criteria are met per this policy in the **IAMHP Biling Manual**.
- Administrative Days (ADs) are inpatient stay days for members who no longer require acute hospital care but could discharge to a lower level of care (home, sub-acute or other post-acute settings) but transfer has proven problematic due to the unique circumstances of these members. It is expected that the facility will know the impediments to placement early in the patient's stay and begin working collaboratively with CountyCare on discharge planning as soon as possible

INDICATIONS

Coverage Criteria

- The member is covered by Medicaid and was initially admitted with a diagnosed condition that required an acute inpatient level of care, either medical or psychiatric care.
- The provider notifies CountyCare of an initial member admission within 24 hours.
- The initial admission was authorized by CountyCare.
- The member no longer meets medical necessity criteria for inpatient acute care; or there is a specific and documented discharge plan in place to a lower level of care; however, documented barriers to implementation of the discharge plan exist that are beyond the

control of the provider, facility and CountyCare.

- The facility notifies CountyCare as soon as they believe post-discharge placement will be difficult so CountyCare can collaborate on discharge placement, and the hospital can obtain authorization numbers to ensure proper payment.
- If CountyCare is notified of the admission and has information that indicates member could be difficult to place, they will communicate and work with facility to find placement.
- The provider/facility has made reasonable and documented efforts to engage CountyCare in discharge planning and has identified substantial barriers to discharge in advance of the discharge date.

Exclusionary Criteria

The member has met his/her individualized discharge criteria and substantial barriers to discharge no longer exist. ADs do not replace any or all non-covered days past medical necessity unless coverage criteria above are met.

The inpatient facility is pursuing a discharge to a level of care or service that CountyCare has explicitly stated is not a Medicaid covered benefit, and/or the member does not meet clinical criteria for the intended placement, and the facility has not worked with CountyCare to identify alternative and appropriate placement.

CountyCare is not responsible for administrative days that are the responsibility of the Department of Children and Family Services (DCFS).

For Billing see **I-2 IAMHP Comprehensive Billing Manual**.

PROVIDER REQUEST

- ADs should be requested by an acute care facility within at least two (2) business days of the date of adverse determination by submitting the “Request for Administrative Days Form” with clinical information to support all discharge planning efforts.
- Request forms should be submitted via the CountyCare Provider Authorization Portal or faxed to the following numbers to the Utilization Management Department
    - Physical Health Fax Number: 1-800-856-9434
    - Behavioral Health/Substance Use Fax Number: 1-800-498-8217

  NOTE: The preferred method for providers to submit the form is electronic via the provider portal, however, forms may also be completed by hand and submitted via fax. Handwritten forms must be legible. Illegible and/or incomplete forms will be rejected, and administrative days will not be approved.
- UM will review the “Administrative Day Request Form" for documentation of substantial discharge barriers and efforts to transition the member to an alternative level of care based on the criteria as noted above.
- Administrative decisions on requests for administrative day requests are NOT eligible for appeals or peer-peer discussions.

- Failure of a hospital to provide timely responses to these outreach efforts or follow any of these guidelines can result in a rejection of the request.
- UM will accept retrospective requests only when there are extenuating circumstances.

CODING AND STANDARDS

Codes

N/A

Applicable Lines of Business

☐	CHIP (Children's Health Insurance Program)
☐	Commercial
☐	Exchange/Marketplace
☒	Medicaid
☐	Medicare Advantage

POLICY HISTORY

Date	Summary
November 20, 2025	• This guideline replaces PA.263.CC Administrative Days Requests • Editorial changes to match the formatting and layout of the new template, no changes to clinical content

LEGAL AND COMPLIANCE

Guideline Approval

Committee

Reviewed / Approved by Evolent Administrative Services Medical Policy Committee

Disclaimer

Evolent Clinical Guidelines do not constitute medical advice. Treating health care professionals are solely responsible for diagnosis, treatment, and medical advice. Evolent uses Clinical Guidelines in accordance with its contractual obligations to provide utilization management. Coverage for services varies for individual members according to the terms of their health care coverage or government program. Individual members' health care coverage may not utilize some Evolent Clinical Guidelines. Evolent clinical guidelines contain guidance that requires prior authorization and service limitations. A list of procedure codes, services or drugs may not be all inclusive and does not imply that a service or drug is a covered or non-covered service or drug. Evolent reserves the right to review and update this Clinical Guideline in its sole discretion. Notice of any changes shall be provided as required by applicable provider agreements and laws or regulations. Members should contact their Plan customer service representative for specific coverage information.

REFERENCES

1. Illinois Association of Medicaid Plans. Comprehensive Billing Manual. Version 35.0. **https://irp.cdn-website.com/9e648e12/files/uploaded/IAMHP_billing-manual_v35.0-b0b57cc8.pdf**