Provider Notice

July 21, 2023

HOSPITAL ADMINISTRATIVE DAY PROCESS- REMINDER

Administrative Day Coverage Criteria: For full IAMHP Policy click **here**

- 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 the MCO of an initial member admission within 24 hours.
- The initial admission was authorized by the MCO.
- The member:
  - no longer meets medical necessity criteria for inpatient acute care.
  - there is a specific and documented discharge plan in place to a lower level of care.
  - has documented barriers to implementation of the discharge plan exist that are beyond the control of the provider, facility and the MCO.
- The facility notifies the MCO as soon as they believe post-discharge placement will be difficult so the MCO can collaborate on discharge placement and the hospital can obtain authorization number to ensure proper payment.
- If MCO is notified of admission and has information that indicates member could be difficult to place, the MCO will communicate and work with facility to find placement.
- The provider or facility has made reasonable and documented efforts to engage the MCO in discharge planning and has identified substantial barriers to discharge in advance of the discharge date.

Administrative Day Exclusions:

Administrative days are not covered due to:

- Convenience of the recipient (member), recipient's family or physician; OR
- The facility, physician or member refuse to cooperate with Health Plan discharge planning efforts or refuse placement at lower level of care or other available alternative setting; OR
- A facility has not provided documented evidence of a comprehensive discharge plan; OR
- Submitted request is illegible.
- There is not an acceptable reason and timeframe for unavoidable delay of discharge, such as awaiting a court date for appointment of medical guardianship, to allow an out-of-state NF placement, or surgical date
- Long Term Acute Care facilities, Skilled Nursing Home facilities, Rehab, and Residential treatment facilities are not eligible for Administrative days.

Provider Request: For details click here on Page 314

1. Administrative days may be requested by an acute care facility within 2 business days from date of adverse determination for administrative days to be considered.
2. Retro requests will be considered but must contain clear documentation of substantial discharge barriers to be considered.
3. Provider should fully complete and submit Request for Administrative Days form.
4. Requests form should be submitted via the portal or faxed to the following numbers:
   - Physical Health Fax Number: 1-800-856-9434
   - Behavioral Health/Substance Use Fax Number: 1-800-498-8217
   - 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.

5. HFS /CountyCare will allow $289.48 per day payment for correctly documented and authorized Administrative Days.
6. Add-on payments (MHVA, MPA or any others) do not apply to Administrative Days per legislative mandate.

Provider Claims / Billing Submission Requirements:

- Administrative days will be paid when there is a valid authorization
- Administrative Days will need to be billed on an UB04/837I Institutional Claim format.

Claims Submission: The facility will submit two claims to the MCO: For details and example click here. Page 316

- **Claim 1:**
  - Regular inpatient claim with room and board, services, and ancillaries
  - Follow billing guidelines per the inpatient section of the IAMHP Comprehensive Billing Guide
  - The regular inpatient claim must have discharge date preceding admission date of Claim 2
  - Must use discharge code 95
- **Claim 2:** Inpatient claim for Administrative Days only
  - Submit using revenue code 0169 for room and board charges only
  - Ancillary codes/services should not be billed on this second claim and will not be payable by an MCO while the member is awaiting placement
  - Value code 80 should be utilized for all Administrative Days on Claim 2.
  - The inpatient claim for Administrative Days must have admission date subsequent of discharge date for Claim 1
  - Use Type of Bill 011X
  - since the second claim is reimbursable at a per diem rate, the standard HFS rules for Interim Claims apply. Per IAMHP Billing Guide, interim claims for inpatient services rendered and paid by the per diem reimbursement methodology cannot be split unless the stay exceeds 30 days or the patient is transferred to another facility or category of service

Contact us

Thank you for working with us to ensure that CountyCare members receive quality care at the right time and in the right setting. If you have any questions or would like additional information, please contact CountyCare Provider Services at **312-864-8200, Option 6**.

- You can also use our Interactive Voice Response (IVR) system to verify eligibility.
- The Provider Services Representatives can assist you with eligibility and claim status.
- They can connect you with your assigned PR Representative.

You can also contact your assigned Provider Relations Representative directly. If you do not have their contact information or do not know your assigned Representative, please contact CountyCareProviderServices@cookcountyhhs.org or you can click here to review the CountyCare Provider Relations team assignments.