

Administrative Days Reimbursement Implementation

Effective with dates of service on or after July 1, 2019, MCOs will provide reimbursement for inpatient stays extended beyond medical necessity ("Administrative Days") for HealthChoice Illinois and MMAI members due to the inability of the member's MCO or the hospital discharge planner to find an appropriate post-discharge placement

Administrative Days (ADs) are inpatient stay days for members who no longer require acute hospital care, but discharge to a sub-acute or post-acute setting 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 the member's MCO on discharge planning as soon as possible.

Criteria for ADs

Discharge planning is a partnership between hospitals and MCOs, and both parties should work collaboratively to identify any barriers to post-discharge placement as soon as possible upon admission.

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 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;
 - however, 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.

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 a MCO 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 the MCO to identify alternative and appropriate placements.

- Long Term Acute Care Hospitals (LTACHs) are not eligible for Administrative Day reimbursement.
- Health Plans are not responsible for administrative days that are the responsibility of DCFS.

Billing requirements for ADs

For dates of service on or after 7/1/2019, ADs will need to be billed on an UB04/837I Institutional Claim format. NOTE: When the initial hospital stay is reimbursed under the DRG system, only days that exceed the DRG average length of stay can qualify as Administrative Days.

The facility will submit two claims to the MCO:

- **Claim 1:** Regular inpatient claim following billing guidelines per the inpatient section of the IAMHP Comprehensive Billing Guide. Facility is to use Discharge Code 95.
- **Claim 2:** Inpatient claim for ADs only, 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. Claims containing a mixture of administrative days and any other revenue code will be denied.
- Since the second claim is reimbursable at a per diem rate, the standard HFS rules for Interim Claims apply. As noted in the IAMHP Comprehensive 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.

Reimbursement rate for ADs.

Effective 7/1/2019, HFS will require the MCOs to reimburse for ADs when correctly authorized and documented. MHVA, MPA or any other add-on payments do not apply to ADs per legislative mandate.

MCO/FFS Coverage Changes

This guidance applies when coverage changes during an Administrative Day, from FFS to/from an MCO or from MCO to MCO.

HFS-MCO Contracts (MCO to MCO Changes)

Effective Enrollment Date for Hospital ADs:

If an Enrollee is receiving hospital long term care services (ADs), as defined at 89 Ill. Adm. Code 148.50(c), on the Effective Enrollment Date, Contractor shall assume responsibility for the management of such care and shall be liable for all claims for Covered Services from that date. Hospital notification to a Contractor of an admission within 24 hours is not required for reimbursement when the Effective Enrollment Date occurs after that initial 24-hour period described in 305 ILCS 5/14-13.

Charges for MCO Patients Whose Coverage Begins or Ends during a Hospital Long Term Care Day

- MCO Coverage Beginning During Hospital Long Term Care Stay

If an individual is receiving hospital long term care services (ADs), as defined at 89 Ill. Adm. Code 148.50(c), the MCO's liability for the management of such care and payment of claims for covered services begins on the effective date of enrollment.

- MCO Coverage Ending During Hospital Long Term Care Stay

If an individual is receiving hospital long term care services (ADs), as defined at 89 Ill. Adm. Code 148.50(c), the MCO will be liable for the management of such care and payment of claims for covered services until the effective date of disenrollment.

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