Administrative Days

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‹‹This section contains information to help providers bill for level 1 and level 2 administrative days. For those providers that require a *Treatment Authorization Request* (TAR) for Acute Administrative Days (AAD) services, refer to the TAR Criteria for Acute Administrative Days (AAD) section in the Inpatient Services provider manual for specific AAD criteria. For instructions on how to complete a TAR for AAD services refer to the TAR Request for Extension of Stay in Hospital (Form 18-1) section in the appropriate Part 2 manual.

Administrative Days

California Code of Regulations, Title 22, Section 51173 describes acute administrative days (AAD) as those days approved in an acute inpatient facility which provides a higher level of medical care than that currently needed by the patient.

Level 1 and Level 2 Administrative Days

Providers bill administrative days at two levels. Level 1 is a lower level of service rendered to a patient in an acute care hospital awaiting placement in a Nursing Facility Level A (NF-A) a Nursing Facility Level B (NF-B), requiring non-acute obstetric care, or requiring non-acute tuberculosis care. Level 1 is billed with revenue code 169 (room and board, other). Level 1 days are payable to hospitals reimbursed according to both diagnosis related groups (DRG) and non-DRG methodologies.

Level 2 administrative days are reimbursed at a higher rate than level 1 days. Level 2 is only for services rendered to patients awaiting placement in a Subacute Nursing Facility. Level 2 days are reimbursable only to DRG-reimbursed hospitals. (Refer to the *Diagnosis-Related Groups (DRG): Inpatient Services* section in this manual).

Level 2 care for children is billed with revenue code 190 (room and board, subacute pediatric). Level 2 care for adults is billed with revenue code 199 (room and board, subacute, adult).››

Interim Claims

Both level 1 and level 2 administrative days claims can be billed on an interim claim basis, for any length of stay, with the appropriate patient status code.

Type of Bill

Type of Bill for Acute Inpatient Intensive Rehabilitation (AIIR), Administrative Days and Medicare Crossover Claims

Type of Bill Code	Description
111	Inpatient claim with Medicare Part B: admit through discharge
112	Inpatient claim with Medicare Part B: interim, first claim
113	Inpatient claim with Medicare Part B: interim, continuous claim
114	Inpatient claim with Medicare Part B: final claim

Type of Bill for Inpatient Claims with Medicare Part B

Type of Bill Code	Description
121	Inpatient claim with Medicare Part B: admit through discharge
122	Inpatient claim with Medicare Part B: interim, first claim
123	Inpatient claim with Medicare Part B: interim, continuous claim
124	Inpatient claim with Medicare Part B: final claim

‹‹Coverage

Administrative Days are reimbursable for Medi-Cal recipients within the following types of aid codes:

- Full scope aid codes and certain restricted aid codes with coverage for Long-Term Care (LTC) Services
- Full scope aid codes and certain restricted aid codes with coverage for pregnancy-related services
- Full scope aid codes and certain restricted aid codes with coverage for emergency services

Providers are reminded to verify eligibility prior to submitting TAR.

Authorization

For DRG paid hospitals, both level 1 and level 2 administrative days are subject to authorization by Medi-Cal consultants. For non-DRG paid hospitals, only level 1 administrative days are subject to authorization by Medi-Cal consultants.

For those providers that require a TAR for AAD services, an approved daily TAR is required for administrative days to be reimbursed. Documentation submitted with the TAR must meet AAD criteria for each requested day.››

In authorizing administrative days, the Medi-Cal consultant will check the “Admin” related boxes in the For State Use Only area in the lower right-hand corner of the *Request for Extension of Stay in Hospital* (18-1 TAR) form. The date span and number of days submitted and approved with the *Treatment Authorization Request* (TAR) must match the date span and number of days submitted on the claim.

Only one TAR or Service Authorization Request (SAR) for California Children’s Services/Genetically Handicapped Persons Program (CCS/GHPP) clients may be submitted per claim; if multiple TARs or SARs are issued, the claim must be split billed to match the TARs/SARs.

CCS/GHPP clients who are transferred to a different county will receive more than one SAR for the stay. Claims must be split billed to match the SARs. If a recipient loses CCS/GHPP eligibility a TAR must be obtained for any days the patient remains confined after CCS/GHPP eligibility ends. The claim must be split billed to match the SAR and TAR approved days.

Any stay for which days are denied must be split billed so the denied days are billed with that portion of the claim matching the TAR that denies the specific days. Providers complete an additional claim that begins with the date the stay is reauthorized.

Ancillary Services Reimbursable With Administrative Days

The Department of Health Care Services (DHCS) has established limits on reimbursement of ancillary services provided during administrative days. Only codes listed with a yen sign (¥) in the *Ancillary Codes* section of this manual are reimbursable when billed with administrative days. If ancillary codes that are not marked with a yen are billed with administrative days, the ancillary services will be denied.

Ancillary Services Not Reimbursable With Administrative Days

All services in the chart at the back of this section are not reimbursable when billed with administrative days; however, some may be billed on an outpatient basis.

The services listed in the chart at the back of this section without an asterisk are not reimbursable as separate charges. The services are either already accounted for in the basic administrative days accommodation rate (that is, central services and supplies, inhalation therapy) or not required for an NF-B or subacute patient in an administrative day bed.

Level 1 Administrative Days

Level 1 Administrative Days Revenue Code 169

The following information pertains to level 1 administrative days. Level 1 administrative days (revenue code 169, room and board, other) are billed for services rendered to a Medi-Cal recipient who meets criteria for awaiting placement in a NF-A or NF-B or who meets criteria for obstetric or tuberculosis administrative days.

Billing and Reimbursement

Revenue code 169 must be used when billing for accommodation charges for administrative days. Claims containing a mixture of administrative days and any other revenue code will be denied.

The following dates of service and rates are used for billing administrative days (billed with revenue code 169).

Dates of service on or after:	Reimbursement
‹‹January 1, 2024	$704.86∞››
May 12, 2023	$704.86+
August 1, 2022	$761.82 ¥
August 1, 2021	$693.00 ¥∞
August 1, 2020	$626.60 ¥ ∞
August 1, 2019	$569.54 ∞
August 1, 2018	514.95 ∞
August 1, 2017	487.57 ∞

Level 2 Administrative Days

Level 2 Administrative Days

The following information pertains to level 2 administrative days. Level 2 administrative days are billed for services rendered to a patient awaiting placement in a Subacute Nursing Facility.

Pediatric Patient: Revenue Code 190

Level 2 administrative days for pediatric patients are billed with Revenue Code 190 revenue code 190 (room and board, pediatric subacute). The pediatric patient is younger than 21 years of age with a fragile medical condition. The patient's medical and nursing care needs must meet the requirements outlined in the *Subacute Care Programs: Pediatric* section in the appropriate Part 2 provider manual and the *Manual of Criteria for Medi-Cal Authorization*, Chapter 7.

Adult Patient: Revenue Code 199

Level 2 administrative days for adult patients are billed with revenue code 199 (room and board, adult subacute). The adult patient is 21 years of age or older and has a fragile medical condition. The patient's medical and nursing care needs must meet the requirements outlined in the *Subacute Care Programs: Adult section* in the appropriate Part 2 provider manual and the *Manual of Criteria for Medi-Cal Authorization*, Chapter 7.

Billing and Reimbursement

Revenue codes 190 and 199 must be used when billing for accommodation charges for administrative days. Claims containing a mixture of administrative days and any other revenue code will be denied.

Current rates (updated each July 1), used for billing level 2 administrative days (revenue codes 190 and 199), are available on the DHCS website. Providers may view the rates by the following sequence of links:

- Diagnosis Related Group Hospital Inpatient Payment Methodology page (http://www.dhcs.ca.gov/provgovpart/pages/DRG.aspx)
- Pricing Resources SFY (appropriate year)
- Hospital Characteristics File

The following ancillary codes are not payable and will be denied when billed with administrative days.

Ancillary Code	Description
* 270	Medical/Surgical Supplies and Devices, General
* 271	Medical/Surgical Supplies and Devices, Non-Sterile Supply
* 272	Medical/Surgical Supplies and Devices, Sterile Supply
* 274	Medical/Surgical Supplies and Devices, Prosthetic/Orthotic
275	Medical/Surgical Supplies and Devices, Pacemaker
* 276	Medical/Surgical Supplies and Devices, Intraocular Lens
278	Medical/Surgical Supplies and Devices, Other Implants
* 279	Medical/Surgical Supplies and Devices, Other Supplies/Devices
* 290	DME (Other than Renal Equipment), General
* 291	DME (Other than Renal Equipment), Rental
* 292	DME (Other than Renal Equipment), Purchase of New DME
* 293	DME (Other than Renal Equipment), Purchase of Used DME)
* 299	DME (Other than Renal Equipment), Other Equipment
* 310	Laboratory, Pathology, General
* 311	Laboratory, Pathology, Cytology
* 314	Laboratory, Pathology, Biopsy
* 350	Computed Tomographic Scan, General
* 351	Computed Tomographic Scan, Head
* 352	Computed Tomographic Scan, Body
* 359	Computed Tomographic Scan, Other
* 360	Operating Room Services, General
* 361	Operating Room Services, Minor Surgery
362	Operating Room Services, Organ Transplant Other than Kidney
367	Operating Room Services, Kidney Transplant
* 369	Operating Room Services, Other Operating Room Services

Ancillary Code	Description
* 370	Anesthesia, General
* 371	Anesthesia, Incident to Radiology
* 372	Anesthesia, Incident to Other Diagnostic Services
* 374	Anesthesia, Minor Surgery
* 379	Anesthesia, Other
380	Blood, General
381	Blood, Packed Red Cells
382	Blood, Whole Blood
383	Blood, Plasma
384	Blood, Platelets
385	Blood, Leukocytes
386	Blood, Other Components
387	Blood, Other Derivatives (Cryoprecipitates)
389	Blood, Other
390	Blood Storage and Processing, General
391	Blood Storage and Processing, Blood Administration
410	Respiratory Services, General
412	Respiratory Services, Inhalation Services
413	Respiratory Services, Hyperbaric Oxygen Therapy
419	Respiratory Services, Other
450	Emergency Room, General
459	Emergency Room, Other Emergency Room
* 460	Pulmonary Function, General
481	Cardiology, Cardiac Catheterization
489	Cardiology, Other
* 621	Medical/Surgical Supplies, Incident to Radiology
* 622	Medical/Surgical Supplies, Incident to Other Diagnostic Services
* 710	Recovery Room, General

Ancillary Code	Description
720	Labor Room/Delivery, General
721	Labor Room/Delivery, Labor
724	Labor Room/Delivery, Birthing Center (Unlicensed Beds)
729	Labor Room/Delivery, Other
* 730	Electrocardiogram (EKG/ECG), General
* 731	Electrocardiogram (EKG/ECG), Holter Monitor
* 740	Electroencephalogram (EEG), General
750	Gastro-Intestinal Services, General
800	Inpatient Renal Dialysis, General
801	Inpatient Renal Dialysis, Hemodialysis
802	Inpatient Renal Dialysis, Peritoneal (Non-CAPD)
803	Inpatient Renal Dialysis, Continuous Ambulatory Peritoneal (CAPD)
804	Inpatient Renal Dialysis, Continuous Cycling Peritoneal (CCPD)
809	Inpatient Renal Dialysis, Other
* 922	Other Diagnostic Services, Electromyogram
949	Other Therapeutic Services

Legend

Symbols used in the document above are explained in the following table.

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.
*	Services marked with an asterisk are reimbursable only on an outpatient basis when required for the care of an administrative days patient. These services must be billed on a *UB-04* claim using appropriate CPT® or HCPCS codes. (These are services that patients in an NF-B or subacute care facility usually receive through clinics or hospital outpatient departments.)
‹‹+	Rate year 2022-2023, effective May 12, 2023.››
¥	‹‹Temporary COVID-19 increased rate. Temporary COVID-19 increase expired on May 11, 2023.››
∞	Services marked with an infinity are maximum rate payable. In accordance with *California Code of Regulations* (CCR), Title 22, Section 51542 and 51511, a Distinct-Part Nursing Facility Level B (DP/NF-B) of an acute care hospital will receive the lesser of its projected costs or the DP/NF-B median rate. Acute care hospitals without a DP/NF will receive the DP/NF-B median rate.