BOSTON MEDICAL CENTER HEALTHNet PLAN

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WELL SENSE HEALTH PLAN

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Administrative Policy

Administratively Necessary Days

Policy Number: OCA 3.102
Version Number: 13
Version Effective Date: 11/01/21

Product Applicability	☐ **All Plan+ Products**
WellSense Health Plan	**Boston Medical Center HealthNet Plan**
☐ NH Medicaid	☒ MassHealth ACO
☐ NH Medicare Advantage	☒ MassHealth MCO
	☐ Qualified Health Plans/ConnectorCare/Employer Choice Direct
	☐ Senior Care Options

+ Note: Disclaimer and audit information is located at the end of this document.

Policy Summary

The Plan provides coverage for administratively necessary days (AND) for MassHealth members when Plan criteria are met. Prior authorization is required. Administratively necessary days are not a covered benefit for members enrolled in other Plan products.

The MassHealth contract definition of AND is a day of acute inpatient hospitalization on which an enrollee's care needs can be provided in a setting other than an acute inpatient hospital and on which an enrollee is clinically ready for discharge, but for whom an appropriate setting is not available. Examples of situations that may require an AND in the acute inpatient hospital setting, where a lower level of care is required by the member (but the lower level of care setting is not currently available), include but are not limited to ANY of the following, as specified below in items 1 through 7.

1. A member is awaiting transfer to a chronic disease hospital, rehabilitation hospital, nursing facility, or any other institutional placement; the transfer process was initiated in a timely manner and there is a delay due to availability of network providers.

2. A member is awaiting arrangement of home services (i.e., nursing, home health aide, durable medical equipment, personal care attendant, therapies, or other community-based services); the services request was initiated in a timely manner but there is a delay due to availability of network providers.

3. A member is awaiting arrangement of residential, social, or medical services by a public or private agency. (Refer to Beacon Health Options policies regarding AND for behavioral health services or placement available at www.beaconhealthstrategies.com.)

4. A member with lead poisoning is waiting for de-leading of his or her residence.

5. A member is awaiting results of a report of abuse or neglect made to any public agency charged with the investigation of such reports.

6. A member in the custody of the Department of Children and Families is awaiting foster care when other temporary living arrangements are unavailable or inappropriate.

7. A member cannot be treated or maintained at home because the primary caregiver is absent due to a medical or psychiatric crisis, and a substitute caregiver is not available.

Policy Statement

An administratively necessary day (AND) is reimbursable by the Plan if it is a covered service for the Plan member, as specified in the member's applicable benefit document available at www.bmchp.org, and BOTH of the following criteria are met, as specified below in item 1 and item 2:

1. The member requires a continued stay in a hospital for a medical condition that is no longer acute; AND

2. The provider has determined that the member's condition is stable and can be treated in a lower level of care setting, but that setting is not available.

Procedure

This policy outlines the guidelines that must be met for the approval of an administratively necessary day (AND) when requested by a provider for a Plan member and an AND is a covered service for the Plan member. In addition, the Plan's Acute Care Coordination (ACC) Clinicians identify potential administratively necessary days when conducting concurrent review for acute level of care, as outlined below in items 1 through 5:

1. Upon continued stay review (using InterQual® criteria or medical criteria included in a Plan medical policy), the ACC Clinician determines that the acute inpatient stay does not meet hospital level of care (LOC) and meets the criteria listed in this AND administrative policy.

2. The ACC Clinician discusses AND LOC appropriateness with the provider.

3. If the provider agrees that AND LOC is appropriate, the ACC Clinician updates the authorization.

4. If the provider states that the member is at an acute LOC and disagrees that the member is at an AND LOC, the event is referred to the Medical Director by the ACC Clinician for a medical necessity determination for acute LOC. See the Plan's *Medically Necessary* medical policy, policy number OCA 3.14, for the product-specific definitions of medically necessary treatment.

5. The ACC Clinician continues to monitor the discharge plan until discharge and documents the discharge status in the Plan's medical management system.

Limitations and Exclusions

Inpatient days are NOT reimbursable as administratively necessary under ANY of the following circumstances, as specified below in items 1 through 6:

1. A hospitalized member is awaiting an appropriate placement or services that are currently available, but the hospital has not transferred or discharged the member because of the hospital's administrative or operational delays; OR

2. The Plan determines that appropriate non-institutional or institutional placement or services are available within a reasonable distance∞ of the member's non-institutional (customary) residence and the member, the member's family, and/or any person legally responsible for the member refuses the placement or services; OR

3. The Plan determines that appropriate non-institutional or institutional placement or services are available within a reasonable distance∞ of the member's non-institutional (customary) residence, the Plan advises the hospital of the determination, and the hospital or the physician refuses or neglects to discharge the member; OR

4. An inpatient procedure has been delayed due to cancellations, scheduling conflicts, oversights, malfunctioning equipment, delayed test results, or consultations; OR

5. Pre-operative/procedure admission days or discharge delays occur that are solely for the convenience of the member and/or family; OR

6. The hospital care management staff and/or the treating physician do not provide timely clinical information in which to make an admission or continued stay decision, which will result in administrative denial of payment.

∞ Note: Reasonable distance for a MassHealth member is up to 30 miles or 60 minutes from the member's customary, non-institutional residence. Greater distances may be considered reasonable under certain circumstances including but not limited to those where the member's residence is in a rural area, member has no family or regular visitors, and/or member requires specialized services only available in a facility located at a greater distance.

Applicable Coding

Refer to the Plan's applicable reimbursement policies, including *Inpatient Hospital* reimbursement policy, policy number 4.110, for billing and reimbursement guidelines related to administratively necessary days.

Definitions

Administratively Necessary Day (MassHealth Contract Definition): A day of acute inpatient hospitalization on which an enrollee's care needs can be provided in a setting other than an acute inpatient hospital and on which an enrollee is clinically ready for discharge, but for whom an appropriate setting is not available.

Attending Physician: Admitting physician or his/her covering physician.

Reasonable Distance for MassHealth Member: Up to 30 miles or 60 minutes from the member's customary, non-institutional residence. Greater distances may be considered reasonable under certain circumstances including but not limited to those where:

1. Member's residence is in a rural area; OR

2. Member has no family or regular visitors; OR

3. Member requires specialized services only available in a facility located at a greater distance.

References

Contract between the Massachusetts Office of Health and Human Services (EOHHS) and Boston Medical Center Health Plan, Inc.

Commonwealth of Massachusetts. MassHealth Provider Bulletins. Accessed at: https://www.mass.gov/masshealth-provider-bulletins

Commonwealth of Massachusetts. MassHealth Provider Manuals. Accessed at: https://www.mass.gov/lists/masshealth-provider-manuals

Commonwealth of Massachusetts. MassHealth Transmittal Letters. Accessed at: https://www.mass.gov/masshealth-transmittal-letters

Revision History

Original Approval Date	Original Effective Date and Version Number	Policy Owner	Original Policy Approved by
Regulatory Approval: N/A Internal Approval: 06/07/06	06/07/06 Version 1	Director of Medical Policy as Chair of the Medical Policy, Criteria, and Technology Assessment Committee (MPCTAC)	MPCTAC and Quality Improvement Committee (QIC)

Policy Revisions History			
Review Date	**Summary of Revisions**	**Revision Effective Date and Version Number**	**Approved by**
12/01/10	Policy was reviewed, updated template into clinical criteria, added coding and references.	Version 2	01/04/11: MPCTAC 01/26/11: QIC
12/21/11	Annual review; reference note added to refer to Beacon Health Strategy policies regarding AND, eliminated reference to CM Select Clinicians, updated reasonable distance to 30 miles or 60 minutes travel time for MassHealth, added reference for coding to refer to the reimbursement policy "Reimbursement for Administratively Necessary Days (AND) policy."	Version 3	01/19/12: MPCTAC 01/25/12: QIC
01/01/13	Annual review, updated references, changed reimbursement policy reference to *Reimbursement Guidelines: Inpatient Hospital* (policy number 4.110), referenced *Medically Necessary* policy, reference members for which AND is a covered service in the Procedure and Clinical Guideline	Version 4	01/16/13: MPCTAC 02/21/13: QIC

Policy Revisions History			
	Statement sections. Removed "psychiatric services" from example 3 in the Description of Item or Service section. Made the following revisions to comply with the format of an administrative policy: changed policy category from "Clinical Coverage Guidelines" to "Policy Title," current effective date and last review date listed as the QIC policy approval date, added policy type to the beginning of document, removed footer text, and removed disclaimer note at the end of policy stating that not all services are covered for all products or employer groups.		
01/01/14	Annual review for effective date 02/18/14. Revised language in Summary, Description of Item or Service, Procedure, Definitions, and Limitations sections without changing criteria.	02/18/14 Version 5	01/15/14: MPCTAC 02/18/14: QIC
01/01/15	Annual review for effective date 05/01/15. Updated Procedure section. Added limitations.	05/11/15 Version 6	01/21/15: MPCTAC 02/11/15: QIC
11/01/15	Annual review for effective date 12/09/15. Updated template for applicable products.	12/09/15 Version 7	11/18/15: MPCTAC 12/09/15: QIC
11/01/16	Review for effective date 12/14/16. Administrative change made to the Summary section.	12/14/16 Version 8	11/16/16: MPCTAC 12/14/16: QIC
11/01/17	Review for effective date 11/15/17. Updated list of Other Applicable Policies section.	11/15/17 Version 9	11/15/17: MPCTAC
10/01/18	Review for effective date 11/01/18. Administrative changes made to the Applicable Coding and Other Applicable Policies sections.	11/01/18 Version 10	10/17/18: MPCTAC
09/01/19	Review for effective date 10/01/19. Administrative changes made to the References and Reference to Applicable Laws and Regulations sections.	10/01/19 Version 11	09/18/19: MPCTAC
09/01/20	Review for effective date 10/01/20. No revisions.	10/01/20 Version 12	09/16/20: MPCTAC

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[+] *Plan* refers to Boston Medical Center Health Plan, Inc. and its affiliates and subsidiaries offering health coverage plans to enrolled members. The Plan operates in Massachusetts under the trade name Boston Medical Center HealthNet Plan and in other states under the trade name WellSense Health Plan.

Policy Revisions History			
10/01/21	Review for effective date 11/01/21. Administrative changes made to the Policy Summary and Limitations and Exclusions sections.	11/01/21 Version 13	10/20/21: MPCTAC

Next Review Date

09/01/22

Authorizing Entity

MPCTAC

Other Applicable Policies

Medical Policy - *Medically Necessary*, policy number OCA 3.14
Reimbursement Policy - *General Billing and Coding Guidelines*, policy number 4.31
Reimbursement Policy - *General Clinical Editing and Payment Accuracy Review Guidelines*, policy number 4.108
Reimbursement Policy - *Inpatient Hospital*, policy number 4.110
Reimbursement Policy - *Non-Reimbursed Codes*, policy number 4.38
Reimbursement Policy - *Physician and Non-Physician Practitioner Services*, policy number 4.608
Reimbursement Policy - *Provider Preventable Conditions and Serious Reportable Events*, policy number 4.610

Reference to Applicable Laws and Regulations

130 CMR. Code of Massachusetts Regulations. Division of Medical Assistance.

Disclaimer Information: +

Medical Policies are the Plan's guidelines for determining the medical necessity of certain services or supplies for purposes of determining coverage. These Policies may also describe when a service or supply is considered experimental or investigational, or cosmetic. In making coverage decisions, the Plan uses these guidelines and other Plan Policies, as well as the Member's benefit document, and when appropriate, coordinates with the Member's health care Providers to consider the individual Member's health care needs.

Plan Policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization standards (including NCQA). Medical Policies are also developed, as appropriate, with consideration of the medical necessity definitions in various Plan products, review of current literature, consultation with practicing Providers in the Plan's service area who are medical experts in the particular field, and adherence to FDA and other government agency policies. Applicable state or federal mandates, as well as the Member's benefit document, take precedence over these guidelines. Policies are reviewed and updated on an annual basis, or more frequently as needed. Treating providers are solely responsible for the medical advice and treatment of Members.

The use of this Policy is neither a guarantee of payment nor a final prediction of how a specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement.

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