Newborn Administrative Day Rate (NADR) FAQs

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What

What is an administrative day rate?

Medicaid defines Administrative Days as one or more days of a hospital stay in which an acute inpatient or observation level of care is not medically necessary, and a lower level of care is appropriate. (Washington State Administrative Code 182-550-4550)

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What is the newborn administrative day rate (NADR)?

The NADR was created to reduce barriers for the postpartum parent who is willing and able to stay with their newborn while that newborn is admitted to the hospital for substance exposure monitoring and care. With the NADR, stable postpartum patients are an inpatient for the purposes of medication

administration, as well as billing, as long as they are the primary care giver for their hospitalized newborn.

Is the NADR the same as the Swedish Compassion Stay?

No. The NADR should not to be confused with the Compassion Stay program, which is a separate inpatient SUD program with robust wrap around services specific to Swedish Hospital Systems.
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Why

Why is the NADR important?

Following substance exposure, the standard of care is for newborns to receive inpatient monitoring and care for at least five days. Simultaneously, parents should be with the newborn providing care and comfort. Having the postpartum parent as the best "medicine" for the newborn's care is best practice and the right thing to do for the newborn and the postpartum parent. NADR allows the parent to receive their medication from the hospital, negating the need to leave their newborn to receive medication from an outpatient clinic.
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Who

Who is eligible for the NADR?

Postpartum patients who are medically and obstetrically cleared for discharge and who have a newborn admitted to the hospital for intrauterine substance exposure monitoring. These patients would otherwise be discharged and stable enough to receive care from medical, obstetric, or substance use outpatient providers. The patient remains admitted to the hospital to have close contact with and provide continuous care for the newborn as first-line treatment (i.e., "Eat, Sleep, Console") and receive their medications for OUD directly from the hospital.
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What does continuous care mean?

The birth parent should be participating in most of the care for the newborn. The patient is allowed to leave the bedside for short periods of time (i.e. sleep between feedings, self-care, etc.) but documentation should reflect that the parent was present for most of the day and involved with care of the newborn.
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What if the patient did not deliver at the hospital?

Examples: The patient had a precipitous delivery prior to arrival, the patient had a planned community birth, the patient was transferred to your hospital after delivery at another hospital.

The birth parent would be admitted to the postpartum patient on the Newborn Admin Day Rate for the sake of being the primary care provider for the newborn.
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Who is NOT eligible for the NADR?

Patients who are not medically cleared for discharge; Patients who are unable to be the primary care provider for the infant as first-line treatment (i.e., “Eat, Sleep, Console”).
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Where

Where can the birthing person receive care while on the NADR?

This may look different for each hospital or organization depending on factors such as room availability, provider rounding, and nursing availability.

Example, postpartum unit: An appropriate place for the postpartum person to receive care is where other postpartum patients receive care. Postpartum nurses and providers may be the best treatment team to provide support for the dyad and identify abnormal postpartum complications, if they arise.

Outside of the postpartum unit: The patient could be transferred to another unit for the purposes of room, in-house provider, and nursing availability. Consider the distance from the neonate.
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Where is the birthing parent throughout the day?

Room availability for patients on NADR will vary by facility. Family-centered and trauma-informed care does not mean 100% continuous care or require the birthing person and neonate to be admitted in the same room. Everyone needs to eat, shower, use the bathroom, rest, walk, and take breaks. The intent is that they are at the bedside enough to be the primary care giver for the baby.
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Where does the patient go if they require a higher level of hospital care while on the NADR?

If a patient becomes unstable while on the NADR and requires hospital care, the care team can return the patient to an inpatient postpartum status and/or transfer the patient to the appropriate unit for inpatient care. The patient does not need to be discharged and readmitted, or sent to the Emergency Department for evaluation, because the patient is still an inpatient. Hospital teams will follow current practice for consultation, transfer within the hospital, and documentation of the change in status. *Please consult with utilization management for workflows that may already be in place.* Examples may include: Severe range blood pressures, signs of severe infection, signs of excessive bleeding, or patient status requiring hospital treatment.
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When

When does the NADR start?

The NADR begins on the day that the patient would have otherwise been discharged.
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What is the duration of the NADR?

The NADR allows for 5 billable days in the hospital. An expedited prior authorization can be submitted if 6+ days are needed. Refer to the current HCA Inpatient Hospital Services Billing Guide for criteria and

additional details.
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How (implementation):

Champion group:

A multi-disciplinary team will be necessary to implement the NADR. Group expertise should include: Utilization management, billing, nursing management, social work, postpartum nursing, neonatal nursing, providers for the postpartum patients, providers for the newborn, substance use experts, and people with lived experiences.

Questions for this group to answer may include:

- Where will the postpartum parent stay while on the NADR and will this be situationally dependent?
- Where will the newborn be admitted and will this be situationally or clinically dependent?
- Who will be the attending provider for this patient?
- What do bylaws dictate about care for these patients (e.g., provider rounding)?
- Nursing and provider assessments or rounding?
- What orders should be placed?
- What documentation is required?
- Are billing staff familiar with billing the admin day rate and the HCA Inpatient Hospital Services Billing Guide?

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Phase of care:

One way to document that a patient is admitted under the NADR is to create a NADR phase of care. For instance, providers can discontinue the patient's postpartum orders and start a new order set, admitting the patient to an NADR phase of care. This phase will have a separate standard of care with its own frequency of assessments and vital signs that are appropriate for an inpatient who is stable for outpatient treatment but waiting for discharge.

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Education:

Education should be provided to all organizational personnel who will be affected by the use of the NADR (see champion group). Hospitals should create patient-facing materials to ensure postpartum patients understand how they can best care for their newborn and what they can expect from hospital staff.
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Billing:

How do I find the Billing Guide and Fee Schedule?

The links to these billing guides are updated regularly. Do not keep this guide as a favorite for reference. It is best to follow the search directions below, or favorite the billing and fee schedule website.

Search online for “DOH WA Provider Billing Guide and Fee Schedules” and it should be the first link. Scroll down to “Billing Guide and Fee Schedules.” Narrow your search by selecting “I” in the alphabet for “Inpatient Hospital.” Choose the most recent version of the Inpatient Hospital Services Billing Guide which will be the top option after they cascade. To find information on the NADR, you can search the document (Ctrl+F) for “newborn administrative.” |
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How much does the NADR pay?

To access the most recent fee schedule, follow the directions above to find the billing and fee schedule guides.

The reimbursement rate will not cover all, or even most, of the care provided while the patient is admitted under the NADR. The NADR is an option for hospitals to receive some payment for providing exceptional care to an at-risk dyad by helping reduce barriers for postpartum parents to care for their hospitalized newborn.
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How do I charge for the NADR?

The best answer is to access the most updated Billing Guide (directions above).

Copied from HCA Inpatient Billing Guide, version from 11/2023:

> The hospital must bill newborn administrative days using revenue code 0191 with the appropriate diagnosis code, ICD 10 diagnosis code O99.320 (drug use complicating pregnancy), on the postpartum parent’s ProviderOne ID. The hospital must bill pharmaceuticals prescribed for the postpartum parent during the administrative portion of their stay on a claim separate from that of the acute care stay. HCA does not require prior authorization for fee-for-service clients. For the acute care stay claim, the provider must bill with inpatient status code 30 to indicate the provider will be submitting a separate claim for newborn administrative days, and include a claim note stating, “Admin. Days claim to follow.”

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Are Critical Access Hospitals eligible to use the newborn administrative day rate?

Yes, there are no restrictions specific to Critical Access Hospitals.
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Nursing:

What about patient acuity and nursing productivity?

Although patients on the NADR are otherwise able to receive outpatient treatment for their conditions, patients will require varying degrees of hospital resources and nursing care. Hospitals will have to consider how they capture acuity and productivity for individual patients on the NADR.
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Assessments, orders, rounding, and hospital bylaws:

Assessment frequency depends on the hospital-based standard of care for patients on the NADR, individualized nursing judgement, provider order, and/or hospital bylaws.

Example, stable on MOUD: For a patient who is admitted on the NADR who has been stable on their MOUD for three years and is receiving medications once daily, they clinically may only need daily nursing focused assessments and vital signs. If the healthcare team decides that daily nursing assessments and vital signs, and every other day provider rounding is acceptable, this must align with the written nursing standard, provider orders, and hospital bylaws.

Example, up-titrating MOUD: A postpartum patient who is requiring up-titration of MOUD, may be clinically stable for hospital discharge and outpatient management of MOUD. For medication safety, they may clinically need nursing COWS assessments every 4 hours, vital signs before and after MOUD administration, and daily provider rounding and order placement. This treatment plan should also align with the written nursing standard, provider orders, and hospital bylaws.

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Other examples:

Example 1: A patient has an uncomplicated vaginal delivery at 1000. The patient is medically and obstetrically clear for discharge the following morning. The patient needs to have access to methadone for MOUD maintenance while the newborn is admitted for substance exposure monitoring. Instead of discharging the patient, the first of the 5 NADR days start on that first postpartum day. This hospital unit is small, and the family practice doctor managing their care does not round on patients daily. The hospital teams have approved a plan where a patient on the NADR can be transferred to the in-house inpatient provider group while remaining on the postpartum unit to care for their baby. This provider group rounds daily on the patient to assess stability and consider alterations in the medication regimen, as needed.

Example 2: A patient has initiated MOUD during their delivery admission. They have an otherwise uncomplicated vaginal delivery at 1000, and are obstetrically clear for discharge the following morning. The patient is on their second day of initiating MOUD and it has been difficult to titrate MOUD to relieve withdrawal symptoms and cravings. The patient is requiring opioids to treat postpartum pain. Three days postpartum, the patient's withdrawal symptoms, cravings, and pain are well controlled and they are actively caring for their baby. The team has a plan to further up-titrate the patient's MOUD, but the patient would otherwise be managing their care and MOUD outpatient. The first of the 5 NADR days start on the day the patient is stable enough for discharge.

Example 3: A patient arrives to the hospital and requires and emergent cesarean delivery of a preterm newborn. The newborn is transferred to the neonatal intensive care unit for preterm care and monitoring for substance use exposure. The postpartum patient is started on MOUD on the first day postpartum. During the first days of MOUD treatment, the team works with the patient to relieve the patient's surgical pain and withdrawal symptoms. On postpartum day 3, the patient is relatively stable up-titrating their MOUD and taking hydrocodone prn for breakthrough opioid cravings. The first of the 5 NADR days start on the day the patient is stable enough for discharge. This hospital has a NICU where postpartum patients can spend nearly 24 hours in the newborn's room. Although the patient has an official room on the postpartum unit, the postpartum nurse in this hospital typically rounds on the patient in the NICU.

Example 4: While a patient is on day 4 of 5 for their NADR, their cesarean section surgical site dehisces. The NICU calls the postpartum nurse assigned to the patient, and the postpartum nurse calls the OB provider to come to the bedside. The patient's status is changed from the NADR to postpartum. The provider documents the need for level of care, places postpartum orders. The nurse follows postpartum nursing standards of care. The nurse, charge nurse or unit leader consults with utilization management to review the case and provide guidance on documentation and ensure pre-approvals are processed. Once stable enough, the patient returns to the newborn's bedside to be the primary care provider. If the newborn is not yet ready for discharge, the birth parent can utilize the 5th day of the NADR and additional days (starting with day 6) can be billed for as outlined in the billing guide. The patient is discharged from their postpartum status in stable condition with their baby.

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FAQ on Washington State Administrative Code (WAC) 182-550-4550

Administrative day rate and swing bed day rate.	Question	Answer
(1) Administrative day rate. (a) The medicaid agency allows hospitals an administrative day rate for those days of hospital stay in which a client does not meet criteria for acute inpatient level of care, but is not discharged because: (i) An appropriate placement outside the hospital is not available (no placement administrative day); or (ii) The postpartum parent's newborn remains on an inpatient claim for monitoring post-in utero exposure to substances that may lead to physiologic dependence and continuous care by the postpartum parent is the appropriate first-line treatment (newborn administrative day). "Postpartum parent" means the client who delivered the baby(ies). (b) The agency uses the annual statewide weighted average nursing facility medicaid payment rate to update the all-inclusive administrative day rate on November 1st of each year. (c) The agency does not pay for ancillary services, except for pharmacy services and pharmaceuticals, provided during administrative days.	What does ancillary services mean?	Anything outside of pharmacy services and pharmaceuticals.
(d) The agency identifies administrative days during the length of stay review process after the client's discharge from the hospital. (e) The agency pays for up to five newborn administrative days. The agency pays for additional days with expedited prior authorization (EPA). For EPA, a hospital must establish that the clinically appropriate EPA criteria outlined in the agency's published billing guides have been met. The hospital must use the appropriate EPA number when billing the agency. (f) The agency pays the hospital the administrative day rate starting with the date of hospital admission if the admission	What if the patient did not deliver at this hospital (i.e., delivered at home or was transferred from a different hospital)?	The hospital should be able to admit the postpartum patient on the Newborn Admin Day Rate for the sake of being the primary care provider for the newborn.

is solely for a no placement administrative day stay.		
(g) The agency pays the hospital the newborn administrative day rate only if: (i) The postpartum parent rooms in with their newborn and provides parental support/care; and (ii) The hospital provides all prescribed medications to the postpartum parent for the duration of the stay, including medications prescribed to treat substance use disorder.	Does this require "rooming in"? What if the baby is admitted to a nursery?	Family-centered and trauma-informed care does not mean 100% continuous care or require the birthing person and neonate to be admitted in the same room. The intent is that they are at the bedside enough to be the primary care giver for the baby. Staff should ensure that documentation in the medical record reflects the support to the infant by the parent.

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