Administrative Day Justification Form

(Instructions on Back of this Form—Please Type or Print in Fields Below)

General Information:

1. Hospital Name:	2. Total Number of Administrative Days:
3. Patient Name:	4. CDCR #:
5. Institution Name:	6. Admission Date:
7. Discharge Date:	8. If more than 1 Form ADJ-01 needed to document an extended stay: **Page _____ of _____**

Physicians Orders:

8. **Physician Name**	9. **Status Change**	10. **Date/Time**	11. **Notes or Comments**
	☐ To Administrative Days ☐ To Acute Care		
	☐ To Administrative Days ☐ To Acute Care		
	☐ To Administrative Days ☐ To Acute Care		
	☐ To Administrative Days ☐ To Acute Care		

Daily Contact Log (see instructions for Field 13):

12. A **Date**	B **Time**	C **Hospital Contact/Title**	D **Authorized CCHCS UM Contact/Title**	E **Method Code**	F **Reason Code**
13. Notes:					
13. Notes:					
13. Notes:					
13. Notes:					
13. Notes:					

Method Codes: P-Phone Call   Reason Codes: (1) No institutional bed available
                     F-FAX (Must notify recipient)   (2) Unsuitable for transfer *(Explain in Notes)*
Adjusted Days: T-Teleconference   (3) Service not available at institution (e.g. isolation, IV ABX) *(Explain in Notes)*
                     E-E-mail   (4) Awaiting hospital service not available at institution *(Explain in Notes)*
                                                       (5) Transportation not available
Internal Use Only: Approved   Denied   (6) Other *(Explain in Notes)*

Reviewed by UM RPA		
_____ Signature	_____ Title	_____ Date

Reason for denial or adjusted days:

Instructions:

This form must be filled out completely and submitted with any medical invoice containing Revenue Code 169. Use the following instructions to complete the Fields on this form:

General Information:

Fill in each Field completely and accurately. Please type or print when filling out form.

Field 1.	Write full hospital name.
Field 2.	Please total the number of Administrative Days being charged to the patient.
Field 3.	Patient's first and last name.
Field 4.	CDCR number as provided by the Institution (e.g. A12345 or AA1234)
Field 5.	Institution Name refers to the prison responsible for the patient. Please write out the institution name or use the common 3 or 4 letter abbreviation.
Field 6.	The date (MM/DD/YYYY) when the patient was first admitted to the hospital.
Field 7.	The date (MM/DD/YYYY) when the patient is discharged from the hospital and returned to the institution.
Field 8.	If more than one Form ADJ-01 is used to document an extended stay, note page number and total pages.

Physicians Orders:

Any time the patient's status changes from Acute Care to Lower Level Care/Administrative Day status, or from Lower Level Care/Administrative Day status back to Acute Care, the change must be noted. Please type or print.

Field 8.	The name of the Physician ordering the change in status.
Field 9.	Check the appropriate Field indicating the change in patient status.
Field 10.	The date (MM/DD/YYYY) **and** time (HH:MM AM/PM) when the status change is ordered. The time of status change is important in determining a chargeable Administrative Day should a patient be readmitted to acute care.
Field 11.	Any notes or comments the attending MD may wish to make as to why InterQual criteria is met or not met, necessitating the change in status.

Contact Log:

Field 12 A.	Date contact was successfully made with an Authorized CCHCS UM Contact (MM/DD/YYYY).
Field 12 B.	Time contact was made (HH:MM AM/PM)
Field 12 C.	Print the name and title of the hospital employee making contact with the Authorized CCHCS UM Contact. The reason for this contact is to obtain permission/acceptance for the inmate to remain at the hospital under Administrative Day status.
Field 12 D.	The name and title of the Authorized CCHCS UM Contact from whom the hospital employee received permission/acceptance for the inmate to stay on Administrative Day status. A list of Authorized CCHCS UM Contacts and their contact information can be found on the Utilization Management Contact List which will be updated as necessary and provided to the hospital.
Field 12 E.	Select an option from the list of *Method Codes* located on the front page of this form (lower left-hand corner). **NOTE:** If using the FAX as an interim method of communication, the transmission must be verified and the recipient must be notified by phone or e-mail to look for a FAX transmission. Include the front of this Form when faxing interim reports to the Authorized Institution Contact. • Attach FAX transmission verifications to this form if using the FAX option
Field 12 F.	Select an option from the list of *Reason Codes* located on the front page of this form (lower right-hand corner).
Field 13.	Use this space to clarify *Reason Codes* 2, 3, 4 and 6, or to note anything out of the ordinary pertaining to communications with the Authorized CCHCS UM Contact. • Note that DAILY communication with the Authorized CCHCS UM Contact must be maintained throughout an inmate's stay under Administrative Day status. Daily communication includes weekends and holidays. Weekend and holiday contact should be through e-mail, if possible, otherwise via FAX. • Patient status **must be documented daily** on this Form even on weekends and holidays, noting why the patient should remain on Administrative Day status, or that the inmate is ready for release back to the institution.

For Authorized CCHCS UM Contact information, see current **Utilization Management Contact List**
If an updated list of UM Contacts is needed, please email UM@cdcr.ca.gov