Source:	**Original Effective Date:** 01/01/2021
☐ **CORPORATE**	**Subject:** Interim Billing
☐ **ASO** ☐ **FHK** ☒ **MMA**	**Policy Number:** CLO59
☐ **UNINSURED**	**Supersedes:**
☐ **OTHER**	**Date last reviewed/revised:** 01/07/2021

POLICY TITLE: Interim Billing for Inpatient Hospital Services

PURPOSE: The purpose of this policy is to direct the managed care plan on the requirement for interim billing of inpatient Hospital services

DEFINITION:

Interim Billing - When a patient receives a continuous course of treatment in an inpatient department of a hospital which is expected to cover multiple months of care**.** These interim claims need to be coded correctly to identify the claim is part of ongoing care and the patient will continue to receive additional care.

Bill Type- Medical billing uses three-digit codes on a claim form to describe the type of bill a provider is submitting to a payor. Each digit has a specific purpose and is required on all UB-04 claims

POLICY: For billing interim inpatient hospital stays that exceed one hundred (100) consecutive days, the managed care plan must require hospital provider claims to be billed with the 0112 Interim (First Claim) Inpatient Type of Bill Code. The managed care plan must require that, with each subsequent inpatient hospital billing, the previous interim claim is voided and replaced with a new claim. The managed care plan must require the new inpatient hospital claim to include initial date of admission, the dates of service and amounts from previous claim(s) through the current billing. The managed care plan must require that the final replacement claim be billed for the complete stay, from the first date of admission through the date of final discharge.

PROCEDURE:

1. The Facility sends inpatient claim to CCP with the interim billing type of bill (0112) (First Claim) and a service date span that has exceeded 100 days.
2. CCP will pay the claim at the appropriate APR-DRG rate;

Ivelisse Torres
Claims Director

Kenneth Walters
SVP and Chief Operating Officer

Department Committee Approval _____ **QIC Approval** _____

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3. CCP will send the encounter claim to the fiscal agent as an original claim;
4. Upon patient discharge, facility sends a replacement claim with the updated date span, charges, and any additional diagnoses or services provided, using type of bill (0117) (Replacement Claim).
5. When the facility submits a subsequent interim bill, they must include the original CCP claim ID (ICN) located on the original remittance advice;
6. CCP will reprice the APR-DRG using the new replacement claim and if there is an additional
7. Reimbursement amount pay the provider the additional reimbursement.
8. CCP will send the encounter claim to the fiscal agent as a replacement claim with reference to the original ICN.

REFERENCES:

ATTACHMENTS:	
REVISION LOG:	DATE:

Ivelisse Torres
Claims Director

Kenneth Walters
SVP and Chief Operating Officer

Department Committee Approval _____ **QIC Approval** _____