Interim Billing

Updated 12/01/2021

Interim claims are no longer accepted, with one exception as described below. (Note that this change became effective with inpatient hospital admissions on or after January 1, 2015, when the new Diagnosis Related Group (DRG) pricing was implemented.)

One interim claim is allowed when the actual length of stay reaches 29 days. In lieu of a second interim claim, the first interim claim must be adjusted, or recouped and resubmitted, if the hospital wishes to submit for payment any additional days of the stay. If the actual length of an inpatient admission is less than 29 days, the hospital must bill for the entire admission on one claim. If an inpatient claim is submitted with a patient discharge status of 30, indicating the patient is still in the hospital, it will be denied if the number of days submitted is less than 29 days. The inpatient claim will deny with Explanation of Benefit (EOB) code 0674 - DRG interim claims not allowed.

If an inpatient claim is submitted where there is a paid interim claim in history for the same admit date, the inpatient claim will deny with Explanation of Benefit (EOB) code 5075 – Only one interim claim allowed per stay or 5076 – Paid interim and final claim for same admission not allowed. To obtain payment for additional days, the hospital must either adjust, or recoup and resubmit, the first interim claim.

For example, if the hospital stay spanned 6/1/2021 – 7/15/2021:

> One interim claim will be allowed with a date span no less than 6/1/2021 – 6/29/2021.
>
> A second interim claim with a date span of 6/30/2021 – 7/10/2021 **will be rejected** because only one claim can be paid during the length of the stay. To receive payment for 6/30/2021 – 7/10/2021, the first interim claim listed above must either be adjusted, or recouped and resubmitted, with the date span of 6/1/2021 – 7/10/2021.
>
> Once the client is discharged, the interim claim must be either adjusted, or recouped and resubmitted, for the entire stay with the date span of 6/1/2021 – 7/15/2021.

Some hospitals have historically submitted interim claims when the stay spans their fiscal period, or when it overlaps a calendar year. Hospitals are no longer allowed to submit interim claims under these circumstances. Hospitals also no longer need to submit interim claims due to hospital rate changes or partial client eligibility.

This interim billing rules applies to all inpatient claims, including child psychiatric and rehabilitation claims not employing DRG pricing.

Interim Billing FAQs

1. How does the payment calculate for an interim claim when the actual stay is greater than 29 days?

A. Interim claims are calculated based on the formula:
Length of Stay (LOS) (admission date to through date) * (Base DRG payment/ALOS)

2. How does the hospital bill the final claim when the actual length of stay is greater than 29 days and the hospital has already billed an interim claim?

   A. The original interim claim can either be recouped and a new claim submitted for the full admission submitted, or the interim claim can be adjusted by changing all relevant claim data to include all services for the entire stay.

3. How does a claim pay if an inpatient admission overlaps a DRG rate change?

   A. Payment will be made based on the DRG rate on file on the discharge date.

4. How is the inpatient claim submitted when the client has partial eligibility? For example: A Medicaid client is admitted to the hospital on January 1, 2021 and is not eligible for Medicaid until January 3, 2021.

   A. The hospital can bill the entire inpatient claim even when the client is only partially eligible for Medicaid. The payment of this claim will be prorated based on the number of days eligible.

   The formula used to determine payment is:
   Base DRG Payment * [number of days eligible/LOS of claim (through date – admit date)]

5. If the client's benefit plan changes during an inpatient admission will hospitals be required to split their inpatient claims?

   A. No. Hospitals do not need to submit interim claims when the client's benefit plan changes. The system will process the claim according to the client's benefit plan in place on the discharge date.

6. Can hospitals bill with Type of Bill (TOB) 117 or 118 for their electronic adjustments?

   A. Yes. Hospitals can use TOB 117 (Adjustments) and TOB 118 (Void) to adjust or void a paid claim electronically through their 837I Health Care Format.