Interim Billing

***all red text is new for 11/04/2014**

For claims containing an admission date prior to January 1, 2015, interim billing, sometimes referred to as split-bills or interim claims, allows a hospital to submit a claim for a portion of the client's hospital stay. Multiple interim claims may be billed throughout the hospital stay followed by the final claim with the appropriate discharge status. Inpatient interim claims contain a Type of Bill (TOB) of 112 "Inpatient – 1st Claim", 113 "Inpatient – Cont. Claim", and 114 "Inpatient – Last Claim". Claims with TOB 112 and 113 contain a Patient Status of 30 "Still Patient".

Effective with inpatient hospital admissions on or after January 1, 2015, when the new DRG pricing is implemented, interim claims will no longer be accepted, with one exception. **One** interim claim will be 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 a newly created Explanation of Benefit (EOB) code.

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 a newly created Explanation of Benefit (EOB) code. In order to obtain payment for addition days, the provider must either adjust, or recoup and resubmit the first interim claim.

For example, if the hospital stay spanned 6/1/2015 – 7/15/2015:

> One interim claim will be allowed with a date span no less than 6/1/2015 – 6/29/2015.
>
> A second interim claim with a date span of 6/30/2015 – 7/10/2015 **will be rejected** because only one claim can be paid during the length of the stay. In order to receive payment for 6/30/2015 – 7/10/2015, the first interim claim listed above must either be adjusted, or recouped and resubmitted with the date span of 6/1/2015 – 7/10/2015.
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> 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 6/1/2015 – 7/15/2015.

Some hospitals have historically submitted interim claims when the stay spans their fiscal period, or when it overlaps a calendar year. Hospitals will no longer be allowed to submit interim claims under these circumstances. Hospitals will 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 will the payment calculate for an interim claim when the actual stay is greater than 29 days for admissions on or after January 1, 2015?

    A. Interim claims are calculated based on the formula:
    Length of Stay (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 will claims 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. If the hospital has a client who was admitted prior to 1/1/2015 and the client discharges in 2015, would the hospital need to split their inpatient claim?

    A. No. DRG pricing is based on the date of admission present on the claim. If a patient is admitted to a hospital on 01/01/2015 or after, DRG pricing will be used. If a patient is admitted to a hospital on 12/31/2014 or prior, per diem pricing will be used.

5. 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, 2015 and is not eligible for Medicaid until January 3, 2015.

    A. The system will be modified to allow the hospital to 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 for determine payment is:
    Base DRG Payment * [number of days eligible/LOS of claim (through date – admit date)]

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

    A. No. Hospitals will no longer 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.

7. For admissions on January 1, 2015 and forward, can hospital still bill with Type of Bill (TOB) 117 or 118 for their electronic adjustments?

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