Interim Hospital Claims

Purpose

This policy is intended to ensure correct provider reimbursement and serves only as a general resource regarding Molina Healthcare's reimbursement policy for the services described in this policy. It is not intended to address every aspect of a reimbursement situation, nor is it intended to impact care decisions. This policy was developed using nationally accepted industry standards and coding principles. In a conflict, federal and state guidelines, as applicable, and the member's benefit plans supersede the information in this policy. Also, to the extent of conflicts between this policy and the provider contract language, the Provider contract language will prevail. Coverage may be mandated by applicable legal requirements of a State, the Federal government or the Centers for Medicare and Medicaid Services (CMS). References included were accurate at the time of policy approval. If there is a state exception, please refer to the state exception table listed below.

Policy Overview

Introduction:

This policy outlines Molina Healthcare's reimbursement criteria for outpatient facility interim hospital claims. The primary objective of this policy is to ensure accurate billing and appropriate reimbursement for services rendered in an outpatient department of a hospital.

Policy Statement:

Molina Healthcare is committed to ensuring accurate and appropriate billing for services provided to our members in outpatient facilities. In line with this, Molina Healthcare has established a reimbursement policy regarding the submission of outpatient facility interim hospital claims by providers. This policy pertains to the examination of bill types where the third digit is "3" – indicating outpatient and ending in frequency codes "2" or "3" against the discharge status code as detailed in the UB-04 billing guidelines.

Background:

An interim claim is billed when a patient undergoes a continuous course of treatment in an outpatient department of a hospital, which is anticipated to span multiple months. Examples of outpatient continuous course of treatment could be outpatient dialysis received over a period of months or outpatient chemotherapy treatment over a period of months. It's imperative that these outpatient facility interim claims are accurately coded to signify that they're part of ongoing care, and the patient will continue to benefit from additional care.

Billing Sequence & Criteria:

For a continuous course of treatment, bills must be submitted in the order in which the services were delivered. This means interim claims should be tendered for every month's services. If an interim claim is presented out of order, succeeding the prior interim claim, it will not qualify for reimbursement.

Identification of Interim Claims:

Outpatient interim claims can be recognized by the bill type code billed in field 4 on a UB-04 claim form. The fourth digit of the Bill Type code marks the frequency as follows:

- NN32 – Interim - First Claim
- NN33 – Interim – Continuing Claim
- NN34 – Interim – Last Claim

The "from" and "through" dates on the claim (Field 6) determine the time frame covered by each interim claim.

Patient Discharge Status Code:

To denote that the patient is still under care, a valid patient discharge status code is compulsory on the claim. For any interim claim with a bill type code concluding in frequency code 2 or 3, the mandatory discharge code required in field 17 is 30, which signifies "Still a Patient."

Claim Examination:

Molina Healthcare will implement an outpatient facility edit to scrutinize interim hospital claims with bill types ending in frequency codes 2 or 3 against the discharge status code.

The discharge status code 30 must be present on interim claims with frequency codes 2 or 3 to signify ongoing care. Absence of discharge status code 30 will result in claim denial for inappropriate billing per UB-04 billing guidelines.

Claim Submission:

Bills for continuous treatment must be submitted in the chronological order of service provision, resulting in interim claims being submitted for each month's worth of services.

Out-of-sequent interim claims from the prior interim claim will be denied reimbursement.

Reimbursement Guidelines

Molina Healthcare holds the right to deny reimbursement for claims that do not adhere to the stipulations of this policy. Providers are urged to familiarize themselves with these guidelines to ensure accurate billing and uninterrupted reimbursement. This policy is subject to periodic review to ensure its alignment with industry standards and regulatory requirements. Providers will be duly notified of any updates or amendments.

Supplemental Information

Definitions

Term	Definition
CMS	the Centers for Medicare & Medicaid Services. It is a federal agency within the United States Department of Health and Human Services that administers the Medicare program and works in partnership with state governments to administer Medicaid, the Children's Health Insurance Program (CHIP), and health insurance portability standards.
Interim Claim:	A claim submitted when a member receives a continuous course of treatment in an outpatient department of a hospital, expected to span multiple months.
Bill Type Code	A code specified in field 4 on a UB-04 claim form indicating the nature and sequencing of the claim
Discharge Status Code	A code indicating the discharge status of a patient, specified in field 17 on a UB-04 claim form.

Documentation History

Type	Date	Action
Effective Date	10/23/2024	New Policy

Revised Date	12/16/2024	Updated Template and added references

References

This policy was developed using.

- CMS
- State Medicaid Regulatory Guidance
- State Contracts

Source	Links
CMS	Type of Bill Code Structure - JE Part A - Noridian
CMS	Medicare Claims Processing Manual
AZ	FFS_Chap11.pdf AHCCCS Fee-For-Service Provider Billing Manual
CA	SHORT-DOYLE/MEDI-CAL PROVIDER BILLING MANUAL UB-04 Submission and Timeliness Instructions (ub sub)
FL	INTEROFFICE MEMORANDUM Interim_Billing_Inpatient_100days_030121.pdf
IA	Medicaid Provider Policy Manuals | Health & Human Services All-IV.pdf
ID	General Billing Instructions Information for Medicaid Providers | Idaho Department of Health and Welfare
IL	Provider Handbooks | HFS Chapter100GeneralHandbook.pdf
MA	MassHealth Provider Billing and Claims | Mass.gov
MI	Billing and Reimbursement Institutional-Billing-Tip-Billing-the-Beneficiary.pdf
MS	Provider Billing Handbook - Mississippi Division of Medicaid Paper Claims Billing Manual - Mississippi Division of Medicaid
NE	Provider Handbooks Claims Processing FAQ
NV	NV_Billing_Manual_General Nevada Medicaid
NM	Provider Billing Instructions and Forms - New Mexico Health Care Authority MAD Interim Policies and Procedures (IPPs) - New Mexico Health Care Authority
NY	eMedNY Subsystem User Manual General_Billing_Guidelines_Professional.pdf
OH	Hospital Billing Guidelines
SC	Provider Administrative and Billing Manual | SCDHHS
TX	Texas Medicaid Provider Procedures Manual | TMHP
UT	Manuals - Medicaid: Utah Department of Health and Human Services - Integrated Healthcare Section 1 Genereal Information
VA	Nursing Facility Chapter 5 (updated 7.27.23)_Final.pdf Physician-Practitioner Chapter 5 (updated 7.13.22)_Final.pdf
WA	Inpatient Hospital Services Billing Guide
WI	Medicaid Issues in Wisconsin: Coordination of Benefits: Billing Medicare and Medicaid

CODING DISCLAIMER. *Codes listed in this policy are for reference purposes only and may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement. Listing of a service or device code in this policy does guarantee coverage. Coverage is determined by the benefit document. Molina adheres to Current Procedural Terminology (CPT®), a registered trademark of the American Medical Association (AMA). All CPT codes and descriptions are copyrighted by the AMA; this information is included for informational purposes only. Providers and facilities are expected to utilize industry standard coding practices for all submissions. When improper billing and coding is not followed, Molina has the right to reject/deny the claim and recover claim payment(s). Due to changing industry practices, Molina reserves the right to revise this policy as needed.*