Interim & Split Billing

Reimbursement Policy

Purpose

Interim and split bills are a series of claims for a course of treatment when a member is expected to remain in the facility for an extended period of time or when a member's benefit crosses calendar or benefit years.

Policy

Interim and split (hospital, skilled nursing facility, hospice and home health agency) billing is required:

- On a monthly basis
- Upon discharge of the member
- Annual billing that crosses a new benefit year

Interim and split bills must include the following:

1. Type of Bill (*form locator 4)* – use reference table within this policy for constructing the appropriate type of bill for the billing period.
   Example:
   112 Hospital initial interim bill
   113 Hospital continuing interim bill
   114 Hospital final interim bill
2. Statement Covers Period – From/Through (*form locator 6*)
   a. Initial bill "from date" is the first start date of care/admission and the subsequent billing(s) will use this field as the first date of the following month
   b. "Through date" represents the last day of the month for the episode of care or in the instance of the final bill will represent the date of discharge
3. Admission or Start date of care (*form locator 12*)
4. Patient Discharge Status (*form locator 17*)
   a. Initial and subsequent bill(s) should use the value 30 – Still patient. The final billing assignment is required to use the appropriate discharge status code based on the national standard code set.
5. Interim and split billing for the continuous episode of care must be submitted in the order in which it occurs along with all diagnosis and procedure codes related to that billing time-period. Final interim/split billing should include diagnosis and procedure codes for the entire admission.

Interim and split bills are not to include charges billed on an earlier claim since the subsequent billing date range begins on the first day of the following month and dates billed should be in-line with the charge dates. Billing needs to be received in the order of the services performed.

Hospital DRG billing has its own distinct guidelines for interim billing, under separate cover.

Form Locator Table (Form locator 4)

1st digit is leading zero (this field is ignored)

2nd digit identifies the facility

1	Hospital
2	Skilled Nursing Facility (SNF)
3	Home Health
6	Intermediate Care
7	**Clinic** or Hospital based End Stage Renal Disease (ESRD) facility
8	**Special facility** or hospital (Critical Access Hospital (CAH)) (Ambulatory Surgical Center (ASC)) surgery

3rd digit identifies the location or type of care at the facility

All Others (2nd digit not 7 or 8)		Clinics (7 as 2nd digit)		Special Facility (8 as 2nd digit)	
1	Inpatient (Including Medicare Part A)	1	Rural Health Center (RHC)	1	Hospice (non-hospital based)
2	Inpatient (Medicare Part B Only)	2	Hospital Based or Independent Renal Dialysis Center	2	Hospice (Hospital Based)
3	Outpatient	3	Free Standing Provider-Based Federally Qualified Health Center (FQHC)	3	Ambulatory Surgery Center (ASC) to Hospital Outpatients
4	Other	4	Other Rehabilitation Facility (ORF)	4	Free Standing Birthing Center
5	Intermediate Care - Level I	5	Comprehensive Outpatient Rehabilitation Facility (CORF)	5	Critical Access Hospital (CAH)
6	Intermediate Care - Level II	6	Community Mental Health Center (CMHC)	6	Reserved for National Assignment
7	Reserved for National Assignment	7	Reserved for National Assignment	7	Reserved for National Assignment
8	Swing Beds	8	Reserved for National Assignment	8	Reserved for National Assignment
		9	Other	9	Other

4th digit identifies the "frequency" of the bill in the episode of care

0	Non-payment/Zero Claim
1	**Admit Through Discharge** - Use for a bill encompassing an entire inpatient confinement or course of outpatient treatment
2	**Interim - First Claim**
3	**Interim-Continuing Claims**
4	**Interim - Last Claim;** last of a series for this confinement or course of treatment
5	**Late Charge Only** - These bills contain only additional charges
7	**Replacement of Prior Claim**
8	**Void/Cancel of Prior Claim**

Resources/References

Medicare Claims Processing Manual 100-04, *Chapter 25 – Completing and Processing the Form CMS-1450 Data Set*: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS018912

National Uniform Billing Committee (NUBC), *Official UB-04 Data Specifications Manual*: www.nubc.org

Document Publication History

6/20/2023 Annual review; no changes
6/21/2022 Annual review; revised language on DRG billing
6/03/2021 Annual review; no changes
4/27/2020 Complete revision
2/20/2017 Initial approval and publication

This policy provides information on Community Health Options' claims adjudication processing guidelines. As every claim is unique, the use of this policy is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable, adherence to plan policies and procedures, and claims editing logic. Community Health Options reserves the right to amend a payment policy at its discretion. Policies are enforced unless underpinning direction stated otherwise.