Reimbursement Policy for 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 plan document 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 interim hospital claims by providers. This policy pertains to the examination of bill types 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. It's imperative that these 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:

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:

- NNN2 – Interim - First Claim
- NNN3 – Interim – Continuing Claim
- NNN4 – 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-sequence 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

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