



| PAYMENT POLICY                                                                                                             |                |               |
|----------------------------------------------------------------------------------------------------------------------------|----------------|---------------|
| Interim Billing                                                                                                            |                |               |
| Original Date Approved                                                                                                     | Effective Date | Revision Date |
| 07/01/2026                                                                                                                 | 09/01/2026     | 07/01/2026    |
| Applies to Products:                                                                                                       |                |               |
| <input checked="" type="checkbox"/> Senior Care Options (FIDE-SNP) <input checked="" type="checkbox"/> One Care (FIDE-SNP) |                |               |

#### **PAYMENT POLICY STATEMENT:**

This payment policy outlines CCA's policy for interim billing in accordance with state and federal guidelines.

#### **DEFINITIONS:**

**Interim Billing:** A series of claims for a patient's ongoing treatment over an extended time period.

**Inpatient Prospective Payment System (IPPS):** A payment system used to reimburse hospitals for inpatient stays using a fixed rate determined by the patient's diagnosis and treatment by Diagnosis-Related Groups (DRG) classification.

**Diagnosis-Related Group (DRG):** A case-mix complexity system implemented to categorize patients with similar clinical diagnoses in order to standardize hospital reimbursement and improve efficiency.

**Centers for Medicare & Medicaid Services (CMS):** A federal agency that is part of the U.S. Department of Health and Human Services responsible for administering and managing the Medicare, Medicaid, State Children's Health Insurance Program (SCHIP), HIPAA, and the Clinical Laboratory Improvement Amendments (CLIA) programs.

**Type of Bill (TOB):** A 3-digit numeric code located on an institutional/facility claim that describes the type of facility, type of care, and episode of care (frequency) for the services rendered.

**CMS-1450:** (also known as UB-04) Claim form used for institutional (facility) services.

#### **AUTHORIZATION REQUIREMENTS (If applicable):**

Prior authorization requirements are based on the services rendered to the member. Please review the CCA Provider Manual for the list of services that require prior authorization.



## REIMBURSEMENT GUIDELINES:

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CCA allows interim billing for payment of services rendered by a hospital, skilled nursing facility, home health agency, and hospice agency. Interim billing is also known as split billing and is used when a member is expected to remain in a facility for an extended period of time. An interim bill is required:

- On a monthly basis for non-IPPS facilities (**NOTE:** IPPS facilities may bill 60-day intervals for inpatient services.);
- Upon discharge of the member;
- When a member's benefits are exhausted; or
- When a member's need for care changes.

To receive reimbursement, each interim bill must include:

- The correct TOB for the provider type with the appropriate frequency digit:
  - 1 – Admit through discharge claim
  - 2 – Interim-First Claim
  - 3 – Interim-Continuing Claim
  - 4 – Interim-Last Claim(Final bill)
- The correct “from date” and “through date” (**NOTE:** The “from date” must be after the “through date” on the earlier bill.);
- The admission or start date of care;
- Patient status of 30 (Still a Patient) unless member has been discharged (**NOTE:** When discharged, please use the appropriate discharge status code. If patient status 30 is billed with frequency digit 1 or 4, the claim will be denied.); and
- Submission of a final bill required within timely filing requirements or payment for the interim claims will be recouped.
- All applicable diagnoses and procedures.

The interim bill must be submitted in sequential order and should include all diagnosis and procedure codes related to the claim date span. It should not include charges from the previous claims because the “from date” must be the day after the “through date” on the earlier claim. For DRG claims, payment is made only on claims that show a discharge date and status; no payment is made on IPPS claims that contain patient status 30 (Still a Patient). Once the member is discharged, the facility must submit an adjustment claim for the entire stay from admission to discharge.

Please refer to the CMS Inpatient Hospital Billing and the General Billing Requirements Medicare Claims Processing Manuals for additional guidelines on interim billing.



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**AUDIT and DISCLAIMER:**

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, state and federal cost sharing rules, referral/authorization, utilization management guidelines when applicable, adherence to plan policies and procedures, and claims editing logic. CCA has the right to conduct audits on any provider and/or facility to ensure accuracy and compliance with the guidelines stated in this payment policy. If such an audit determines that a provider/facility did not comply with this payment policy, CCA has the right to recover refunds from provider/facility for all payments related to non-compliance. CCA reserves the right to amend a payment policy at its discretion. CPT and HCPCS codes are updated as applicable; provider/facility to the most recent CPT and HCPCS coding guidelines.

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**REFERENCES:**

CMS Medicare Claims Processing Manual, Chapter 3 - Inpatient Hospital Billing  
<https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c03.pdf>

CMS Medicare Claims Processing Manual Chapter, 1 - General Billing Requirements  
<https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c01.pdf>

MassHealth Billing Guide for the UB-04  
<https://www.mass.gov/doc/ub-04-billing-guide-0/download>

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**POLICY TIMELINE DETAILS:**

1. Approved: