

## Interim Billing

### Policy<sup>1</sup>

Harvard Pilgrim allows interim billing for payment of inpatient services provided by rehabilitation facility, long term acute hospital or skilled nursing facility, and for outpatient services when provided by a hospice or home health care agency. Interim bills will not be reimbursed when associated with any other services.

### Provider Billing Guidelines and Documentation

Use the following chart to determine billing requirements by facility:

| Type of Facility                                | Interim Bill   |
|---|--|
| Skilled Nursing Facility & Acute Rehabilitation | <ul style="list-style-type: none"> <li>• Interim bill for acute rehabilitation and skilled care admissions only</li> <li>• Bill upon discharge or after seven days as an inpatient and every seven days thereafter</li> <li>• Each bill must include all diagnoses and procedures applicable to the admission</li> <li>• When billing, the “from date” must be after the “through date” on the earlier bill</li> </ul> |
| Hospice Service                                 | <ul style="list-style-type: none"> <li>• Bill outpatient services monthly or at the conclusion of the treatment</li> <li>• Bill using the “from date” to the “through date”</li> <li>• Bill subsequent interim bills from the date after the “through date” on the earlier bill</li> </ul>   |
| Home Health Care <sup>2</sup>                   | <ul style="list-style-type: none"> <li>• Bill outpatient services monthly or at the conclusion of the treatment</li> <li>• When billing monthly, an itemization of daily services must be included</li> <li>• Bill using the “from date” to the “through date”</li> <li>• Bill subsequent interim bills from the date after the “through date” on the earlier bill</li> </ul>  |

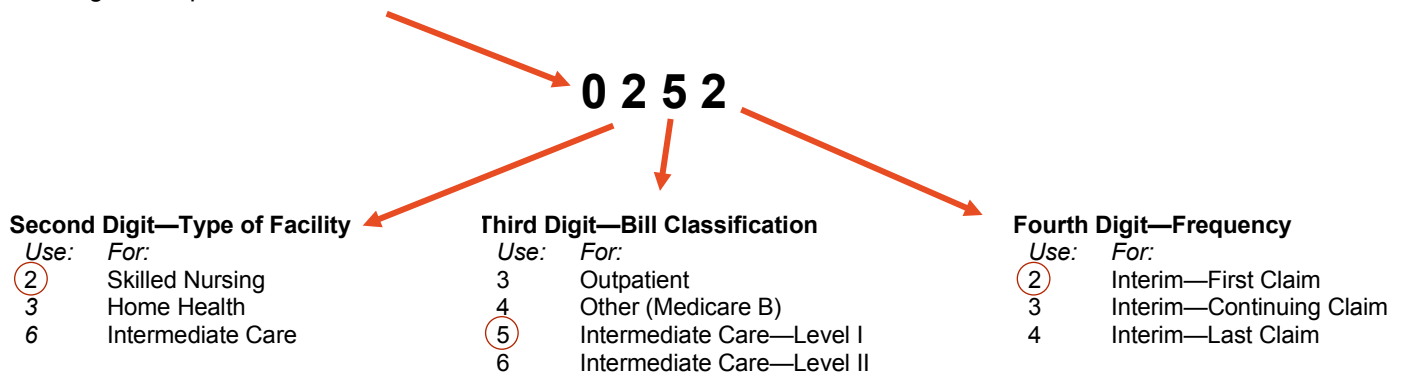
### How to Bill

Previously billed charges should *not* be included on subsequent claims.

### Type of Bill Coding

Designate the type of bill in Form Locator 4 on the paper UB-04 claim form, using a three-digit number or loop 2300, CLM segment with appropriate codes in data element CLM05-1, CLM05-2, CLM05-3 of the electronic 837I.

*Example:* Type of bill code for the first claim for intermediate level II services at a skilled nursing facility. First digit is “0” place holder—not used on electronic 837I



## Related Policies

### Payment Policies

- Home Health Care
- Home Infusion Therapy
- Hospice Care
- Rehabilitation Facilities/Long-Term Acute Care Hospitals
- Skilled Nursing Facility

### PUBLICATION HISTORY

|          |   |
|----------|---|
| 09/15/00 | original documentation  |
| 04/01/01 | interim billing no longer a hospital inpatient billing option   |
| 07/01/02 | added billing examples  |
| 04/01/03 | annual review; billing example clarification  |
| 10/31/04 | annual review   |
| 10/31/08 | annual review; minor edits for clarity  |
| 08/15/09 | annual review; no changes   |
| 09/15/10 | annual review; changed long-term rehab to acute; added Rehab/Long-Term Acute Care to related policies |
| 09/15/11 | annual review; billing example clarification  |
| 01/01/12 | removed First Seniority Freedom information from header   |
| 09/15/12 | annual review; minor edits for clarity  |
| 08/15/13 | annual review; no changes   |
| 06/15/14 | added <i>Connecticut Open Access HMO</i> referral information to Prerequisites                        |
| 08/15/14 | annual review; administrative edits   |
| 08/15/15 | annual review; updated electronic billing guidelines  |
| 08/15/16 | annual review; no changes   |
| 08/15/17 | annual review; no changes   |
| 09/04/18 | annual review; no changes   |
| 09/03/19 | annual review; EDI updates  |
| 09/01/20 | annual review; no changes   |
| 09/01/21 | annual review; no changes   |

<sup>1</sup>This policy applies to the products of Harvard Pilgrim Health Care and its affiliates—Harvard Pilgrim Health Care of Connecticut, Harvard Pilgrim Health Care of New England, and HPHC Insurance Company—for services performed by contracted providers. Payment is based on member benefits and eligibility, medical necessity review, where applicable, and provider contractual agreement. Payment for covered services rendered by contracted providers will be reimbursed at the lesser of charges or the contracted rate. (Does not apply to inpatient per diem, DRG, or case rates.) HPHC reserves the right to amend a payment policy at its discretion. CPT and HCPCS codes are updated annually. Always use the most recent CPT and HCPCS coding guidelines.

<sup>2</sup>Billing for home health services can be submitted on a CMS-1500 form.