



<b>Policy</b>	<b>REIMB_0033</b>
<b>Effective Date</b>	<b>01/01/2026</b>
Reviewed/Revised Date	10/29/2025
Next Review Date	10/26/2026
Origination Date	09/01/2024
Originated Department	Clinical Operations

### Interim Billing

<b>Audience</b>
Claims

<b>Purpose</b>
<p>Payment policies provide general support for applying Mountain Health CO-OP member policy document coverage decisions, and the member-specific benefit plan document must be referenced. The terms of the member-specific policy document may differ from the standard benefit plan based on this payment policy. If there is a conflict between a member-specific policy document and the Mountain Health CO-OP payment policy, the document supersedes this policy. Any person(s) applying this payment policy must identify member eligibility, the member-specific policy document, and related policies or guidelines before applying this payment policy, including the existence of any state or federal guidance. Mountain Health CO-OP payment policies are designed for informational purposes only and are not an authorization, explanation of benefits, or contract. Receipt of benefits is subject to the satisfaction of all terms and conditions of the member-specific policy document coverage. Mountain Health CO-OP reserves the sole discretionary right to modify all policies and guidelines at any time.</p>

<b>Definition</b>
<p>Interim bills are a series of claims filed by a facility or practitioner to the same payer for the same confinement or course of treatment for a patient who is expected to remain in a facility or receive repetitive services for an extended period of time.</p> <p>This policy outlines Mountain Health Coop’s reimbursement criteria for facility and outpatient interim hospital claims. 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.</p>

<b>Policy/Procedure</b>
-------------------------

Mountain Health Coop considers interim billing for payment of services provided by an acute rehabilitation hospital, a skilled nursing facility, and hospice, as well as the following outpatient repetitive services are applicable for interim billing per CMS guidelines.

Type of Service	Revenue Code(s)
DME Rental	0290 – 0299
Radiation Therapy	0333
Respiratory Therapy	0410 – 0419
Physical Therapy	0420 – 0429
Occupational Therapy	0430 – 0439
Speech Pathology	0440 – 0449
Home Health Visits	0550 – 0590
Hospice	0650 – 0659
Kidney Dialysis Treatments	0820 – 0859
Cardiac Rehabilitation Services	0482, 0943
Psychological Services	0900-0907, 0911 - 0919 (in a psychiatric facility), 0944, 0945, 0953, 1000-1002

Interim billing is considered for those acute care hospitals that are **NOT** being reimbursed using DRG grouper/price methodology. Interim bills received on a DRG grouper/pricing methodology will be rejected.

Chemotherapy administration is not a repetitive service. However, it is common to administer it across multiple encounters in a month. Where there are multiple encounters for chemotherapy or other non-repetitive services in a month, they may all be reported on the same claim or may be billed separately.

### 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 indicate that the patient is still under care, a valid patient discharge status code must be included 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."

Mountain Health Coop may implement a facility edit to examine interim hospital claims with bill types ending in frequency codes 2 or 3 against the discharge status code. Absence of discharge status code 30 will result in claim denial for inappropriate billing per UB-04 billing guidelines.

1. Interim bills must include the following:
  - a. Initial interim bill:
    - i. Admission or start of care date
    - ii. Statement Covered "from" date must equal the admission date
    - iii. Patient discharge status of "30"; is still a patient
    - iv. All diagnosis and procedure codes relating to that period
  - b. Continuing interim bill:
    - i. Admission of start of care date
    - ii. Statement Covered "from" date must NOT equal the admission date
    - iii. Patient discharge status of "30"; still a patient
    - iv. All diagnosis and procedure codes relating to that time period
  - c. Final interim bill:
    - i. Admission or start of care date
    - ii. Statement Covered "from" date must NOT equal the admission date
    - iii. The Statement Covered "through" date must reflect the date of discharge for the admission
    - iv. Patient discharge status is NOT "30"; still a patient
    - v. All diagnosis and procedure codes relating to the entire admission
2. Interim billing once per month (every 30 calendar days) except for the final interim bill, which would be upon discharge.
3. Interim billing for a single stay and repetitive outpatient services must be submitted in sequence to the time at which they occur. If an interim claim is presented out of order, succeeding the prior interim claim, it will not qualify for reimbursement.

### **Medical Criteria**

Not Applicable

### **Coverage**

Mountain Health CO-OP Commercial products  
Interim Billing may vary between hospital contracts.

## References

1. Centers for Medicare and Medicaid Services, 50.2 Frequency of Billing Fis for outpatient services. [www.cms.gov/regulations](http://www.cms.gov/regulations)
2. <https://med.noridianmedicare.com/web/jfa/topics/claim-submission/revenue-codes>
3. Medicare Claims Processing Manual Chapter 1, Frequency for Providers submitting Institutional claims with Outpatient Services. [www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdf](http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdf)
4. CMS Manual Pub 100-004 Hospital Billing Repetitive Services <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R407CP.pdf>

## Vendors

- HPS

## Review/Revision/Approval History

Date	Description
9/1/2024	Reviewed and adopted during transition to Health Plan Services
10/29/2025	Revised and adopted

## Disclaimer

This document is for informational purposes only and should not be relied on in the diagnosis and care of individual patients. Medical and Coding/Reimbursement policies do not constitute medical advice, plan preauthorization, certification, an explanation of benefits, or a contract. Members should consult appropriate healthcare providers for medical advice, care, and treatment. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Benefits are determined by the member's benefit plan, effective when services are rendered.

The codes for treatments and procedures applicable to this policy are included for informational purposes. Including or excluding a procedure, diagnosis, or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as they apply to an individual member.

Mountain Health CO-OP makes no representations and accepts no liability regarding the content of any external information cited or relied upon in this policy. Mountain Health CO-OP updates its Coverage Policies regularly and reserves the right to amend these policies and give notice per State and Federal requirements.

No part of this publication may be reproduced, stored in a retrieval system, or transmitted in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from Mountain Health CO-OP.

"Mountain Health CO-OP" and its accompanying logo and marks are protected and registered trademarks of Mountain Health CO-OP. The content of this Service is proprietary and protected by copyright. You may access the copyrighted content of this Service only for purposes outlined in these Conditions of Use.

© CPT Only – American Medical Association