


# PROVIDER BULLETIN

 <b>AETNA BETTER HEALTH® OF FLORIDA</b>  261 N. University Drive Plantation, FL 33324 <a href="http://www.AetnaBetterHealth.com/Florida">www.AetnaBetterHealth.com/Florida</a>	<b>Date:</b>	<b>January 21<sup>st</sup>, 2021</b>
	<b>Purpose:</b>	<b>Provider Bulletin: Educate providers in regard to Policy Transmittal: 2020-56</b>
	<b>Subject:</b>	<b>Interim Billing for Inpatient Hospital Services</b>
	<b>Products:</b>	<b>Managed Medical Assistance (MMA) and MMA Specialty</b>
	<b>From:</b>	<b><u>Provider Relations</u></b>

Dear Provider,

This communication is to inform you that Aetna Better Health of Florida (ABHFL) will be establishing a NEW process and policy for submission of interim billing for inpatient hospital services.

An interim claim is billed when a patient receives a continuous course of treatment in an inpatient department of a hospital which is expected to cover multiple months of care. These interim claims need to be coded correctly to identify the claim is part of ongoing care and the patient will continue to receive additional care.

Bills for a continuous course of treatment must be submitted in the same sequence in which the services were rendered. This results in interim claims being submitted for **each month's worth of services**. This only applies when a member is inpatient for 100 or more days. The first interim should be billed after the 100<sup>th</sup> day is passed. If the interim claim is submitted out of sequence from the prior interim claim, it will be denied reimbursement.

#### **ABHFL requires:**

- Each subsequent inpatient hospital billing, the previous interim claim is voided and replaced with a new claim
- New Inpatient Hospital claim to include initial date of admission, the dates of service and amounts from previous claim(s) through the current billing
- Final replacement claims to be billed for the complete stay, from the first date of admission through the date of final discharge

#### **UB Form:**

Interim claims are identified by the bill type code billed in field 4 on a UB-04 claim form (see field). The third digit in the Bill Type code identifies the frequency as follows:

- 112 – Interim - First Claim
- 113 – Interim – Continuing Claim
- 114 – Final Claim – Last Claim (admit through discharge to replace interim claims)

The *from* and *through* dates on the claim (Field 6) indicate the date span covered by each Interim claim.

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In addition, to indicate that the patient is still receiving care, a correct patient discharge status code is required on the claim as well. For any Interim claim with a bill type code that ends in frequency code 2 or 3, the required discharge code needed in field 17 is **30 – Still a Patient**.

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Once the final claim is submitted with bill type frequency code 4, the discharge code in field 17 should represent the final status of the patient such as discharged to home.

For additional information please refer to **Policy Transmittal: 2020-56:**

- [Policy Transmittal: 2020-56 – Interim Billing for Inpatient Hospital Services](#)

We appreciate the excellent care you provide to our members. If you have any questions, please feel free to contact us via e-mail: [FLMedicaidProviderRelations@Aetna.com](mailto:FLMedicaidProviderRelations@Aetna.com). You can also fax us at 1-844-235-1340 or call us through our Provider Relations telephone line: 1-844-528-5815.

Thank you

Aetna Better Health of Florida  
**Provider Relations Department**

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