RON DESANTIS
GOVERNOR

SHEVAUN L. HARRIS
ACTING SECRETARY

November 4, 2020

Statewide Medicaid Managed Care (SMMC) Policy Transmittal: 2020-56

Applicable to the **2018-2023 SMMC contract benefits** for:
- ☒ Managed Medical Assistance (MMA) and MMA Specialty
- ☐ Long-Term Care (LTC)
- ☐ Dental

Re: Interim Billing for Inpatient Hospital Services

Pursuant to section 409.975(6), F.S., and the managed care plan and hospital(s) shall negotiate mutually acceptable rates, methods, and terms of payment. (Attachment II, Exhibit II-A, Section VIII.E.4.) The purpose of this policy transmittal is to direct the managed care plan on a new requirement for interim billing of inpatient hospital services.

The managed care plan must establish a process for submission of interim billing for inpatient hospital stays that exceed one hundred (100) consecutive days in those instances where a hospital provider requests assistance due an enrollee's protracted length of stay (greater than one hundred (100) days) and due to the financial strain it imposes on the provider's resources in having to wait for the enrollee to be discharged to seek reimbursement. Managed care plans utilizing the All Patient Refined Diagnosis Related Group (APR-DRG) or Diagnosis Related Group (DRG) payment methodology, must reconcile interim billing for the inpatient hospital stay within ninety (90) days of the enrollee's discharge to ensure that all interim payments made to the hospital provider do not exceed the amount that would have been paid through the APR-DRG or DRG reimbursement methodology.

For billing interim inpatient hospital stays that exceed one hundred (100) consecutive days, the managed care plan must require hospital provider claims to be billed with the 0112 Interim (First Claim) Inpatient Type of Bill Code. The managed care plan must require that, with each subsequent inpatient hospital billing, the previous interim claim is voided and replaced with a new claim. The managed care plan must require the new inpatient hospital claim to include initial date of admission, the dates of service and amounts from previous claim(s) through the current billing. The managed care plan must require that the final replacement claim be billed for the complete stay, from the first date of admission through the date of final discharge.

No later than the close of business on February 1, 2021, the managed care plan must submit a policy and procedure for interim billing for inpatient hospital services and include in the submission the managed care plan's direct link to its webpage. The documentation must be submitted to the Agency's SMMC_CY18-23 secure file transfer protocol site, Port 4443, within the managed care plan's designated folder path, in the AdHoc/2020 folder. The managed care plan must use the file naming convention "ABC_INTERIM_BILLING" where ABC is the plan's three-digit identifier.

If you have questions or concerns, please contact your contract manager.

Sincerely,

Beth Kidder
Deputy Secretary for Medicaid

BK/sar