

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 13725	Date: April 10, 2026
	Change Request 14416

SUBJECT: New Monthly Adjustment Process for Prospective Payment System (PPS) Hospital Interim Bills Verifying Patient Status and Service Dates

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to implement a new monthly adjustment process for PPS Hospital inpatient claims in order to enforce correct interim billing procedures by requiring PPS hospitals to verify the patient status and correct application of benefit days, for interim bills that have not been adjusted, canceled, or continued within 90 days after finalization for payment.

EFFECTIVE DATE: October 1, 2024 - Effective for discharges on or after 10/01/2024

**Unless otherwise specified, the effective date is the date of service.*

IMPLEMENTATION DATE: October 5, 2026

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R=REVISED, N=NEW, D=DELETED-Only One Per Row.

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	1/50/50.2.1 – Inpatient Billing From Hospitals and SNFs

III. FUNDING:

For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

**Business Requirements
Manual Instruction**

Attachment - Business Requirements

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II. GENERAL INFORMATION

A. Background: Frequency of Billing for Inpatient Hospitals

Different types of providers are paid based on different payment policies depending upon the circumstances of the provider. Medicare billing requirements strike a balance between program administration efficiency and maintaining cash flow for providers. Shared System Maintainers (SSMs) ensure that providers adhere to these requirements.

PPS Hospitals

Inpatient acute-care PPS hospitals, Inpatient Rehabilitation Facilities (IRFs), Long-Term Care Hospitals (LTCHs) and Inpatient Psychiatric Facilities (IPFs) may interim bill in at least 60-day intervals. Subsequent bills must be in the adjustment bill format. Each bill must include all applicable diagnoses and procedures.

All inpatient providers are required to submit a bill when the beneficiary's benefits exhaust. This permits them to bill a secondary insurer when Medicare ceases to make payment. Initial inpatient acute care PPS hospital, IRF, IPF and LTCH interim claims must have a patient status code of 30 (still patient). When processing interim PPS hospital bills, providers use the bill designation of 112 (interim bill - first claim). Upon receipt of a subsequent bill, the A/B MAC (Part A) must cancel the prior bill and replace it with one of the following bill designations:

- For subsequent interim bills, bill type 117 with a patient status of 30 (still patient); or
- For subsequent discharge bills, bill type 117 with a patient status other than 30. (See Chapter 25 for a list of valid patient discharge status codes)

All inpatient providers **must** submit bills when any of the following occur, regardless of the date of the prior bill (if any):

- Benefits are exhausted;
- The beneficiary ceases to need a hospital level of care (all hospitals);
- The beneficiary falls below a skilled level of care (Skilled Nursing Facilities (SNFs) and hospital swing beds); or
- The beneficiary is discharged.

When a beneficiary’s Medicare benefits exhaust in an IPF or an LTCH, the hospital is allowed to submit a no-pay bill (TOB 110) with a patient status code 30 in 60-day increments until discharge. These providers do not have to continually adjust bills until physical discharge or death. The last bill shall contain a discharge patient status code.

This CR implements a new monthly adjustment process to enforce correct billing procedures for PPS interim claims.

B. Policy: No new policy. These changes enforce payment determinations to providers of services with respect to the existing policy in Sec. 1815. [42 U.S.C. 1395g] (a) The Secretary shall periodically determine the amount, which should be paid under this part to each provider of services with respect to the services furnished by it, and the provider of services shall be paid, at such time or times as the Secretary believes appropriate (but not less often than monthly) and prior to audit or settlement by the Government Accountability Office, from the Federal Hospital Insurance Trust Fund, the amounts so determined, with necessary adjustments on account of previously made overpayments or underpayments; except that no such payments shall be made to any provider unless it has furnished such information as the Secretary may request in order to determine the amounts due such provider under this part for the period with respect to which the amounts are being paid or any prior period.

III. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DM E MA C	Shared-System Maintainers				Other
		A	B	HH H		FIS S	MC S	VM S	CW F	
14416.1	<p>The Shared System Maintainer (SSM) shall create a new monthly process to adjust and reject paid history inpatient PPS hospital interim claims for failure to submit an adjustment to update the patient status and service dates as follows:</p> <ul style="list-style-type: none"> • Type of bill= 11X (excluding 110), • Statement Through Date= On or after 10/01/2024, • Patient Discharge Status Code= 30, • Occurrence Codes A3, B3, or C3 are not present, • Billing Provider CCN= PPS Hospital (Inpatient acute-care PPS hospitals, inpatient rehabilitation facilities (IRFs), long term care hospitals (LTCHs) or inpatient psychiatric facilities (IPFs)), and 					X				

Number	Requirement	Responsibility								
		A/B MAC			DM E MA C	Shared-System Maintainers				Other
		A	B	HH H		FIS S	MC S	VM S	CW F	
	<ul style="list-style-type: none"> invalid beginning and ending dates of the period billed. <ul style="list-style-type: none"> ○ MA43: Missing/incomplete/invalid patient status. • MSN Messages: <ul style="list-style-type: none"> ○ 16.71: Your provider must complete and submit your claim. ○ 31.9: This claim was adjusted because there was an error in billing. • Medicare contractors shall set the new claim level reason code to reject. 									

IV. PROVIDER EDUCATION

Medicare Learning Network® (MLN): CMS will develop and release national provider education content and market it through the MLN Connects® newsletter shortly after we issue the CR. MACs shall link to relevant information on your website and follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 for distributing the newsletter to providers. When you follow this manual section, you don't need to separately track and report MLN content releases. You may supplement with your local educational content after we release the newsletter.

Impacted Contractors: A/B MAC Part A

V. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

VI. CONTACTS

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VII. FUNDING

Section A: For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

Medicare Claims Processing Manual

Chapter 1 - General Billing Requirements

(Rev. 13725; Issued: 04-10-26)

50.2.1 – Inpatient Billing From Hospitals and SNFs

(Rev. 13725; Issued: 04-10-26; Effective: 10-01-26; Implementation: 10-05-26)

Non PPS Hospitals and SNFs

Inpatient services in TEFRA hospitals (i.e., hospitals excluded from inpatient prospective payment system (PPS), cancer and children's hospitals) and SNFs are billed:

- Upon discharge of the beneficiary;
- When the beneficiary's benefits are exhausted;
- When the beneficiary's need for care changes; or
- On a monthly basis.

Hospitals in Maryland that are under the jurisdiction of the Health Services Cost Review Commission are subject to monthly billing cycles.

Providers shall submit a bill to the FI when a beneficiary in one of these hospitals ceases to need a hospital level of care (occurrence code 22). FIs shall not separate the occurrence code 31 and occurrence span code 76 on two different bills. Each bill must include all applicable diagnoses and procedures. However, interim bills are not to include charges billed on an earlier claim since the "From" date on the bill must be the day after the "Thru" date on the earlier bill.

SNF providers shall follow the billing instructions provided in Chapter 6 (SNF Inpatient Part A Billing), Section 40.8 (Billing in Benefits Exhaust and No-Payment Situations) for proper billing in benefits exhaust and no-payment situations.

PPS Hospitals

Inpatient acute-care PPS hospitals, inpatient rehabilitation facilities (IRFs), long term care hospitals (LTCHs) and inpatient psychiatric facilities (IPFs) may interim bill in at least 60-day intervals. Subsequent bills must be in the adjustment bill format. Each bill must include all applicable diagnoses and procedures.

All inpatient providers will also submit a bill when the beneficiary's benefits exhaust. This permits them to bill a secondary insurer when Medicare ceases to make payment. Initial inpatient acute care PPS hospital, IRF, IPF and a LTCH interim claims must have a patient status code of 30 (still patient). When processing interim PPS hospital bills, providers use the bill designation of 112 (interim bill - first claim). Upon receipt of a subsequent bill, the FI must cancel the prior bill and replace it with one of the following bill designations:

- For subsequent interim bills, bill type 117 with a patient status of 30 (still patient); or
- For subsequent discharge bills, bill type 117 with a patient status other than 30. (See Chapter 25 for a list of valid patient discharge status codes)

All inpatient providers must submit bills when any of the following occur, regardless of the date of the prior bill (if any):

- Benefits are exhausted;
- The beneficiary ceases to need a hospital level of care (all hospitals);
- The beneficiary falls below a skilled level of care (SNFs and hospital swing beds); or
- The beneficiary is discharged.

Effective December 3, 2007, when a beneficiary's Medicare benefits exhaust in an IPF or an LTCH, the hospital is allowed to submit a no pay bill (TOB 110) with a patient status code 30 in 60 day increments

until discharge. They no longer have to continually adjust bills until physical discharge or death. The last bill shall contain a discharge patient status code.

Examples:

- *Submit a claim for admission through day 60: TOB 112 (interim bill – first claim); patient status code 30 (still patient).*
- *Submit subsequent claims every 60 days until benefits exhaust: TOB 117 (adjustment); patient status code 30 (still patient).*
- *Submit no pay claims every 60 days after benefits exhaust: TOB 110 (no pay); patient status code 30 (still patient).*
- *Submit a final claim upon physical discharge or death: TOB 110 (no pay); appropriate patient status code (other than 30).*

These instructions for hospitals and SNFs apply to all providers, including those receiving Periodic Interim Payments (PIP). Providers should continue to submit no-pay bills until discharge.

Effective for discharges on or after 10/01/2024, a new system-generated adjustment shall enforce correct PPS hospital interim billing procedures by rejecting finalized interim claims (excluding TOB 110) reporting patient status 30 (still patient), no benefits exhaust coding is reported, and the claim has been finalized for payment without adjustment or cancel for 90 days or greater. Providers should rebill the stay from admit through discharge, or current service dates if the patient is still confined, and must include current utilization of benefit days, and the appropriate patient status code at the time of claim re-submission.

MACs (A) shall use the following remittance advice and MSN messaging when rejecting claims for failure to update patient status and service dates:

Group Code: CO

CARC: 16

RARC: MA31, MA43

MSN: 16.71, 31.9

NOTE: For stays that necessitate the reporting of more than ten OSCs (i.e., more OSCs than the claim formats allow), Long Term Care Hospitals, Inpatient Psychiatric Facilities, and Inpatient Rehabilitation Facilities shall refer to instructions provided in Chapter 32, section 74.3 of this manual.