3-Day Payment Window Hospital Outpatient Department (HOPD) Billing Information

cytalux® (pafolacianine) injection

Medicare's 3-day (or 1-day) payment window applies to outpatient services furnished by hospitals and hospitals' wholly owned or wholly operated Part B entities.

The statute requires that hospitals bundle the technical component of all outpatient diagnostic services and related non-diagnostic services (e.g. therapeutic) with the claim for an inpatient stay when services are furnished to a Medicare beneficiary in the 3 days (or, in the case of a hospital that is not a subsection (d) hospital, during the 1-day) preceding an inpatient admission in compliance with §1886 of the Social Security Act.

Policy

Under the 3-day payment window, a hospital (or an entity that is wholly owned or wholly operated by the hospital) must include on the claim for a beneficiary's inpatient stay, the diagnoses, procedures, and charges for all outpatient diagnostic services and admission-related outpatient nondiagnostic services provided during the payment window. The law makes the policy pertaining to admission-related outpatient nondiagnostic services more consistent with common hospital billing practices.

All services other than ambulance and maintenance renal dialysis services, provided by the hospital (or an entity wholly owned or wholly operated by the hospital) on the same date of the inpatient admission are deemed related to the admission and are not separately billable. Additionally, outpatient nondiagnostic services, other than ambulance and maintenance renal dialysis services, provided by the hospital (or an entity wholly owned or wholly operated by the hospital) on the first, second, and third calendar days (first calendar day for non-subsection (d) hospitals) preceding the date of a beneficiary's admission are deemed related to the admission, and thus, must be billed with the inpatient stay, unless the hospital attests to specific nondiagnostic services as being unrelated to the hospital claim (that is, the preadmission nondiagnostic services are clinically distinct or independent from the reason for the beneficiary's admission) by adding a condition code 51 (definition "51 - Attestation of Unrelated Outpatient Non-diagnostic Services") to the separately billed outpatient non-diagnostic services claim.

Therefore, for HOPD billing on the same day as an inpatient admission and under Medicare, it will be bundled under the inpatient admission DRG.

Scan QR code or visit https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Three_Day_Payment_Window for more information.

Frequently Asked Questions

For the most up-to-date answers to frequently asked questions, visit the Centers for Medicare & Medicaid Services FAQ at https://www.cms.gov/medicare/medicare-fee-for-service-payment/acuteinpatientpps/downloads/cr7502-faq.pdf.

CYTALUX Reimbursement Support

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