3-Day (or 1-Day) Payment Window

Last revised: 03/16/2026

Purpose

The purpose of this policy is to ensure that payment for the technical component of all outpatient diagnostic services and related non-diagnostic services are bundled with the claim for an inpatient stay when services are furnished within 3 calendar days (or, with respect to a non-IPPS hospital, within 1 day) prior to and including the date of the inpatient admission.

Scope

This policy applies to payment and billing of outpatient diagnostic and admission-related nondiagnostic services provided prior to an inpatient hospital admission by the admitting hospital and its wholly owned/wholly operated or under-arrangement entities, as well as to non-IPPS hospitals, consistent with CMS guidance.
This policy applies to Columbia Pacific CCO, Jackson Care Connect, Health Share of Oregon, and CareOregon Advantage plans. This policy also applies to claims and payment integrity teams.

Policy

IPPS hospitals: Outpatient diagnostic services and admission-related nondiagnostic services furnished on the date of admission, or within the 3 calendar days immediately preceding it, are deemed inpatient and must be bundled on the admitting hospital's claim for the member's inpatient stay at the admitting hospital.
Non-IPPS hospitals (psychiatric, IRF, LTCH, children's, cancer): The 1-day window applies; such services on the date of admission or within 1 day prior must be bundled on the admitting hospital's claim for the member's inpatient stay at the admitting hospital.
Critical Access Hospitals (CAHs): Preadmission services are not subject to the 3-day/1-day window and are separately reimbursable.
RHCs and FQHCs: Payment window does not apply to services included in their all-inclusive rate.

Diagnostic services billed on outpatient bill types will be denied when the line-item date of service (LIDOS) falls on the day of admission or any of the 3 days (or with respect to a non-IPPS hospital, the 1 day) immediately prior to the date of the admission.

Exclusions
The bundling requirement does not apply to those services excluded, such as, ambulance and outpatient maintenance renal dialysis services.

Hospital Reimbursement
Outpatient diagnostic services (including clinical diagnostic laboratory tests) provided to a member by a

hospital on the date of an inpatient admission or within 3 days (or with respect a non-IPPS hospital, 1 day) prior to the date of the inpatient admission are deemed to be inpatient services and included in the inpatient payment (e.g., per diem, DRG, or per-case payment). This provision does not apply to services excluded from time to time by The Health Plan from this policy. As of the effective date, the following services are excluded from being subject to this bundling requirement: ambulance services, maintenance renal dialysis services, and services furnished by skilled nursing facilities, home health agencies, and hospices.

Outpatient diagnostic services provided to a member by a hospital on the date of an inpatient admission or within 3 days (or with respect a non-IPPS hospital, 1 day) prior to the date of the inpatient admission are deemed to be inpatient services and must be bundled on the admitting hospital's claim for the member's inpatient stay at the admitting hospital.

Outpatient diagnostic services include, but are not limited to, the following revenue and/or CPT codes:

CPT/HCPCS	Descriptor
0254	Drugs Incident to other diagnostic services
0255	Drugs incident to radiology
030X	Laboratory
031X	Laboratory pathological
032X	Radiology diagnostic
0341	Nuclear medicine, diagnostic
0343	Nuclear medicine, diagnostic radiopharmaceuticals
035X	CTR Scan
0371	Anesthesia incident to Radiology
0372	Anesthesia incident to other diagnostic services
040X	Other imaging services
046X	Pulmonary function
0471	Audiology diagnostic
0481, 0489	Cardiology, Cardiac Catheter Lab/Other Cardiology with CPT codes 94351-94364, 93503, 93505, 93530-93533, 93561-93568, 93571-93572, G2057, and G0278 diagnostic
0482	Cardiology, Stress Test
0483	Cardiology, Echocardiology
053X	Osteopathic services
061X	MRT
062X	Medical/surgical supplies, incident to radiology or other diagnostic services
073X	EKG/ECG
074X	EEG
0918, 0919	Testing-Behavioral Health
092X	Other diagnostic service

3-Day (or 1-Day) Payment Window

Last revised: 03/16/2026

Diagnostic services billed on outpatient bill types will be denied when the line-item date of service (LIDOS) falls on the day of admission or any of the 3 days (or with respect to a non-IPPS hospital, the 1 day) immediately prior to the date of the admission.

Non-diagnostic services, other than ambulance and maintenance renal dialysis services, provided by a hospital on the day of the inpatient admission or on any of the 3 days (or with respect to a non-IPPS hospital, the 1 day) immediately prior to the date of the admission and that are deemed related to the admission, are considered inpatient services, and must be bundled on the claim for the member's inpatient stay at the admitting hospital, unless the hospital attests (as provided below) to specific nondiagnostic services as being unrelated to the hospital inpatient stay (i.e., the preadmission nondiagnostic services must be clinically distinct or independent from the reason for the member's admission).

Unrelated Services

Outpatient non-diagnostic services provided during the payment window that are **unrelated** to the admission may be separately billed to CareOregon. A hospital must maintain documentation in the member's medical record to support its claim that the preadmission outpatient non-diagnostic services are unrelated to the inpatient admission. For such **unrelated** outpatient non-diagnostic services, the hospital must bill the unrelated outpatient non-diagnostic services separately from the admitting hospital's claim for the inpatient admission and must include on the claim a condition code 51 (Attestation of Unrelated Outpatient Non-diagnostic Services) for the separately billed outpatient non-diagnostic services.

Outpatient facility claims for non-diagnostic services will be denied when the following occurs:

(1) condition code 51 (Attestation of Unrelated Outpatient Non-diagnostic Services) is not included on the outpatient claim for non-diagnostic services provided during the payment window that are unrelated to the admission; and
(2) the line-item date of service (LIDOS) falls on the day of admission or any of the 3 days (or with respect to a non-IPPS hospital, the 1 day) immediately prior to the date of the admission.

Professional Services

When a related facility furnishes a service subject to the provisions of this policy and submits a claim in accordance with this policy (e.g., the PD modifier described below is appropriately included), CareOregon will pay:

(1) the professional component for such a service with a technical and professional component split, or
(2) the facility rate for such a service that does not have a technical and professional component split.

3-Day (or 1-Day) Payment Window

Last revised: 03/16/2026

Once the related entity has received confirmation of a member's inpatient admission from the admitting hospital, the related entity must append a CMS payment modifier to all claim lines for diagnostic services and for non-diagnostic services that have been identified as related to the inpatient stay that are furnished on the date of admission or within any of the 3 days (or with respect to a non-IPPS hospital, the 1 day) immediately prior to the date of the admission.
Physician non-diagnostic services that are unrelated to the hospital admission are not subject to the payment window and should be billed without the payment modifier.

The payment modifier "**PD**" (Diagnostic or related nondiagnostic item or service provided in a wholly owned or operated entity to a patient who is admitted as an inpatient within 3 days), must be appended to the claim submitted by a related entity that is a physician practice/office for preadmission diagnostic and admission-related non-diagnostic services that are billed with HCPCS/CPT codes and that are subject to the provisions of this policy. The related entity must manage its billing processes to ensure that the claims for physician services are appropriately submitted when a related inpatient admission has occurred. The admitting hospital is responsible for notifying the related entity of an inpatient admission for a member who received services from a related entity within any of the 3 days (or with respect to a non-IPPS hospital, the 1 day) immediately prior to the date of the inpatient admission.

Only unrelated nondiagnostic preadmission services are not subject to the above bundling and billing requirements. To be "unrelated," the preadmission nondiagnostic services must be clinically distinct or independent from the reason for the member's inpatient admission and must be furnished within any of the 3 days (or with respect to a non-IPPS hospital, the 1 day) immediately prior to the date of the admission. Note: non-diagnostic services furnished by a related entity that is a physician practice/office on the date of a member's inpatient admission to the admitting hospital are always deemed to be related to the admission and the technical portion for such services must be included on the bill for the inpatient admission.

Definitions

3-Day (or 1-Day) Payment Window: The time period prior to and including the date of inpatient admission during which outpatient diagnostic services and clinically related nondiagnostic services are bundled into the inpatient claim—3 days for IPPS hospitals; 1 day for non-IPPS hospitals (psychiatric, IRF, LTCH, children's, cancer).

Admitting Hospital: The hospital at which inpatient admission occurs.

Wholly Owned / Wholly Operated: Entities meeting 42 CFR §412.2 definitions; sole ownership or exclusive responsibility for routine operations.

Condition Code 51: Attestation of unrelated outpatient nondiagnostic services on outpatient facility claims.

Modifier PD: Indicates diagnostic or related nondiagnostic services furnished in a wholly owned/operated Part B entity within the payment window to a patient admitted as inpatient within 3 (or 1) days.

References

Current Procedural Terminology (CPT®), 2025

HCPCS Level II, 2025

International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM), 2022

ICD-10-CM Official Draft Code Set, 2023

CMS Publication 100-04, Medicare Claims Processing Manual, Chapter 3, Section 40.3 (Outpatient Services Treated as Inpatient Services)

CMS Publication 100-04, Medicare Claims Processing Manual, Chapter 12, Section 90.7 (Bundling of Payments for Services Provided in Wholly Owned and Wholly Operated Entities (including Physician Practices and Clinics): 3-Day Payment Window)

CMS Publication 100-04, Medicare Claims Processing Manual, Chapter 12, Section 90.7.1 (Payment Methodology: 3-Day Payment Window in Wholly Owned or Wholly Operated Entities [including Physician Practices and Clinics])

MLN Matters, MM7502 (Bundling of Payments for Services Provided to Outpatients Who Later Are Admitted as Inpatients: 3-Day Payment Window Policy and the Impact on Wholly Owned or Wholly Operated Physician Offices).

MLN Matters, SE1232 (Frequently Asked Questions (FAQs) on the 3-Day Payment Window for Services Provided to Outpatients Who Later Are Admitted as Inpatients).

affiliates make no claim, promise, or guarantee of any kind about the accuracy, completeness, or adequacy of the content for a specific claim, situation, or provider office application, and expressly disclaim liability for errors and omissions in such content. As CPT® codes change annually, you should reference the current version of published coding guidelines and/or recommendations from nationally recognized coding organizations for the most detailed and up-to-date information.