SEPTEMBER 2025

Spotlight: Series Billing Could be Losing Your Hospital Millions of Dollars

A billing practice required by Medicare decades ago is still in use today at some hospitals, likely to their detriment, despite the fact that it is largely no longer necessary.

"Series billing" refers to the practice of combining hospital outpatient visits that occur across multiple dates of service into a single claim, rather than submitting a separate bill for each date of service. In many cases, series billing leads to lower overall payment because of the way Medicare packages items and services on outpatient claims.

When is Series Billing Required?

Series billing was historically required for certain recurring services, including chemotherapy and radiation oncology visits, but the Centers for Medicaid & Medicare Services (CMS) significantly narrowed that requirement decades ago. Nowadays, series billing is *not* required for the vast majority of outpatient services. It is only mandated for recurring physical, occupational, speech, pulmonary, cardiac rehabilitation, and intensive cardiac rehabilitation therapy visits.[1]

CMS left series billing as an *option* for oncology and similar services, and many hospitals continued to use series billing more broadly than they are actually required to, with little to no impact on their payment. In 2016, however, CMS began applying the agency's Outpatient Prospective Payment System (OPPS) packaging logic at the claim level rather than by date of service.[2] Specifically, CMS now packages low-cost drugs and biologicals, minor procedures, labs, and more, based on the claim's *date span, i.e., all of the individual dates that are included in a series claim*.

Under this claim-based packaging logic, CMS evaluates all codes and charges on a single claim, even when the claim includes multiple visits and different dates of service. When multiple dates are billed on a single series claim, the net result is reduced overall payment because more services are subject to packaging.

Hospitals that submit series claims for services when they are not required to are almost certainly leaving dollars on the table. This is particularly true for oncology, where chemotherapy and radiation therapy services are provided as part of a treatment plan spanning multiple dates within a single month. The bottom line: hospitals that maintain series billing are suffering unnecessary and self-imposed payment reductions.

Is it Worth It? Real-World Lessons from Switching to Per-Day Billing

Hospitals that continue to use series billing primarily do so because of legacy system design and the desire to avoid the workflow challenges that come with changing their processes. But, modern patient accounting systems have largely eliminated these barries. Today, the most widely used hospital patient accounting systems can maintain monthly registrations while simultaneously generating claims by date of service. In other words, hospitals can keep their existing registration workflows and still submit individual date-of-service claims with no major front-end system overhaul required.

In today's resource-scarce health care environment, Nimitt encourages hospitals to evaluate the benefit of making the switch to per-day billing. In our work with hospitals across the country, we have seen, firsthand, the financial and operational benefits they have gained by transitioning to per-day billing, and note that these benefits were achieved without major changes to their front-end processes.

Switching to per-day billing increases efficiency and improves payments from payers that follow OPPS processes. Hospitals have reported significant improvements, including:

- **Higher reimbursement.** Clients are reporting anywhere from 25–90% higher reimbursement by billing per-day claims instead of series claims to Medicare. On average this translates into significant financial improvements, often reaching the high six-figures—or more.
- **Fewer payment delays from commercial payers**. High-dollar outpatient claims are often flagged for medical record review, which slows cash flow. Shifting from series to per-day claims reduces the value of each claim and results in fewer medical record requests, which accelerates payment and reduces administrative burden.
- **Minimal operational disruption**. When series registration remains in place and the system is programmed for per-day claims, there are fewer claims with overlapping dates—further reducing administrative burden on billing teams and improving cash flow.

Old Habits Die Hard:
Why Series Billing Has Stuck Around

- **Operational simplicity:** Existing systems and workflows are already built for it
- **Perceived patient benefit:** One consolidated bill may feel easier for patients
- **Ease across departments:** Registration, ordering, and billing may seem smoother
- **Minimal initial impact:** Early on, there was little financial downside, so few facilities questioned it

Don't Let Millions Keep Slipping Through the Cracks

Series billing may seem like a small issue, given the myriad pressures that hospitals face. But, if you want to see improved reimbursement and cash flow, re-evaluating existing practices is a no-brainer. Join the hospitals that have successfully phased out series billing and experienced meaningful improvements in revenue and workflow—with little operational disruption or expense.

References

[1] The list of services still subject to the series billing requirement is available at CMS guidance.
[2] The OPPS Final Rule for CY 2006 is available here.

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