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|  | Regulatory Compliance Policy | No. COMP-RCC 4.07 | |
| | TITLE: MEDICARE BUNDLING REQUIREMENTS | Page: | 1 of 7 |
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| | | Retires Policy Dated: | 08-01-08 |
| | | Previous Versions Date: | 07-03-01; 03-15-99 |

I. SCOPE:

This policy applies to (1) any Hospital in which Tenet Healthcare Corporation or an affiliate owns a direct or indirect equity interest greater than 50% (each, a “Tenet Hospital”); and (2) any other healthcare facility that a Tenet Hospital either “wholly-owns” or “wholly-operates” (as defined herein) (each, a “Tenet Non-Hospital Facility”) (collectively, “Tenet”).

II. PURPOSE:

The purpose of this policy is to ensure compliance with the Medicare requirements for the “bundling” of certain services.

III. DEFINITIONS:


- A. “IPPS Hospital” means a hospital receiving Medicare payments under the Inpatient Prospective Payment System (IPPS), which is a method of reimbursement in which Medicare payment is made based on a predetermined, fixed amount.¹
- B. “IPPS Exempt Hospital” means a hospital receiving payment for providing services to Medicare beneficiaries on based on the hospital’s costs for providing those services.

IV. POLICY:

Section 1886(a)(4) of the Social Security Act defines the operating costs of inpatient hospital services to include certain outpatient services furnished to a patient by a hospital (or by an entity that is wholly owned or operated by the hospital) if the patient is subsequently admitted as an inpatient within 3 days (for a IPPS hospital) or within 1 day (for a IPPS-exempt hospital) of the date of the outpatient services. This rule also applies to services performed by a hospital “under arrangements” (*i.e.*, by an outside vendor under contract to the hospital), even if the under arrangements vendor is independently owned. These services are deemed to be inpatient services and included in the inpatient payment, unless there is no Part A coverage.

Every Tenet Hospital and Tenet Non-Hospital Facility shall have processes and procedures to identify all services, billings, and claims subject to Medicare bundling requirements. Such processes and procedures must include effective means to prevent claims so identified from being submitted to Medicare for payment until a) the billings have been properly bundled as required, or b) a determination is made that bundling is not required.

¹[Centers for Medicare and Medicaid Services Prospective Payment Systems-General Information](#)

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V. PROCEDURE:

A. Hospital Services

1. Bundling Requirements

The Medicare program requires the bundling of most non-physician services furnished by an IPPS hospital directly or under arrangements within 3 days prior to the date of admission to the hospital or outpatient services rendered at a free-standing outpatient entity that is either wholly-owned or wholly-operated by the hospital (collectively, the “Services”). This rule is commonly referred to as the “DRG 3-Day payment window.” IPPS-exempt hospitals are subject to a similar 1-day bundling requirement. Although the Medicare Administrative Contractors (MACs) may have edits in place to identify claims subject to the bundling requirements and may reject such claims, it is inappropriate for providers to rely on such edits.

2. Entities “Wholly-Owned” or “Wholly-Operated” by the Hospital

For purposes of the Services bundling requirements, an entity is considered to be “wholly owned or operated” by the hospital if either: (1) the hospital is the sole owner of the entity; or (2) the hospital has exclusive responsibility for implementing facility policies (*i.e.*, conducting or overseeing the facility's routine operations), regardless of whether it also has the authority to make the policies.


CMS has clarified that with respect to companies, entities or units that are not wholly owned or operated by *the hospital*, as described above, the admitting hospital would not be required to bundle Services furnished by the entity.

Structuring of transactions or arrangements with entities for the purpose of avoiding the Medicare bundling rule is prohibited. All questions regarding the application of the bundling rule must be referred to the Tenet Ethics and Compliance Department and the Law Department for a final determination.

3. Included Services

If provided at a Tenet Non-Hospital Facility that is wholly-owned or wholly-operated by a Tenet Hospital, services subject to the bundling requirements include:

- a. Diagnostic Services identified on Attachment A.


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- b. Non-diagnostic outpatient services provided on the same date as the inpatient admission (regardless of whether the outpatient services are related to the inpatient admission). This includes direct inpatient admissions from the Emergency Room or other outpatient area.
- c. Non-diagnostic outpatient services that are related to a patient's hospital admission and are provided by the hospital, or by an entity wholly owned or wholly operated by the admitting hospital (or by another entity under arrangements with the admitting hospital), to the patient during the 3 days immediately preceding.

Non-diagnostic Services are related to the admission if they are furnished in connection with the Principal Diagnosis that necessitates the patient's admission as an inpatient (*i.e.*, if the outpatient First Listed Diagnosis is clinically related to the inpatient Principal Diagnosis). Thus, whenever Part A covers an admission, a hospital may bill non-diagnostic Services to Part B as outpatient services only if they are not related to the admission. This determination is to be made by the Hospital Health Information Management Department Director, or designee.

If there are both diagnostic and non-diagnostic Services and the non-diagnostic Services are unrelated to the admission, the hospital may separately bill the non-diagnostic Services to Part B (unless such Services are provided on the day of the inpatient admission, in which case the Services must be bundled with the inpatient admission). This provision applies only when the patient has Part A coverage.

| Included Services Recap | | |
|---|---|---|
| If outpatient service is..... | And outpatient line item date of service is..... | Then ... |
| Diagnostic, related or unrelated to IP | Same Day as IP, <i>and/or</i> 1, 2, or 3 days prior to IP | Move OP diagnosis codes, procedure codes and charges to IP account |
| Non-Diagnostic, related to IP | Same Day as IP, <i>and/or</i> 1, 2, or 3 days prior to IP | Move OP diagnosis codes, procedure codes and charges to IP account |
| Non-Diagnostic, not related to IP | Same Day as IP | Move OP diagnosis codes, procedure codes and charges to IP account |
| Non-Diagnostic, not related to IP | 1, 2, or 3 days prior to IP | Leave OP diagnosis codes, procedure codes and charges on OP account. Medical record must support "not related" decision. Additionally, specific condition code (Condition Code 51) must be reported |

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4. The bundling provision does not apply to the following:
 - a. Ambulance services
 - b. Outpatient maintenance renal dialysis
 - c. Part A services furnished by home health agencies, skilled nursing facilities, and hospices


5. Determining Time Frame for Bundling
 - a. IPPS Hospitals

The 3-Day period includes the three full calendar days immediately preceding the date of admission, as well as the date of admission, not the 72-hour time period that immediately precedes the hour of admission.
 - b. IPPS-Exempt Hospitals

The 1-day period for IPPS-exempt hospitals (*e.g.*, IPPS-exempt psychiatric and rehabilitation hospitals and hospital units and long-term care hospitals) includes the full calendar day immediately preceding the date of admission, as well as the date of admission, not the 24-hour time period that immediately precedes the hour of admission.

6. Additional Tenet Requirements
 - a. Tenet Hospitals

Each Tenet Hospital must identify all Services furnished within the time frames described above to a Medicare patient admitted to the hospital. Such Services include hospital outpatient services and other non-physician services furnished by an entity wholly owned or wholly operated by the admitting hospital or by an entity providing services under arrangement to the hospital. All Services meeting the bundling criteria must be included in the hospital inpatient claim to Medicare. Separate billing of such Services is strictly prohibited.
 - b. Tenet Non-Hospital Facilities

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Tenet Non-Hospital Facilities (*e.g.*, clinics, outpatient imaging sites, laboratories, physician practices, etc.) wholly-owned or wholly-operated by a Tenet Hospital must have procedures to coordinate with the hospital to identify services provided by the entity that require bundling with the inpatient claim. Separate billing of such Services is strictly prohibited. Processes and procedures must be implemented at each Tenet Non-Hospital Facility to prevent the separate billing of Services for which bundling is required.

B. Bundling of Services Furnished During Inpatient Stays and Outpatient Encounters

1. Requirements

The Medicare Program requires the bundling of certain non-physician services furnished to either an inpatient or an outpatient of a hospital by another provider or supplier. Although the MACs may have edits in place to identify claims subject to the bundling requirements and may reject such claims, it is inappropriate for providers to rely on such edits.


2. Included Services

Section 1862(a)(14) of the Social Security Act provides that all non-physician services (with certain exceptions listed below) and items furnished to hospital inpatients and Outpatients (“Hospital Patients”) must be furnished directly by the hospital or billed through the hospital under arrangements. This provision applies to all hospitals, regardless of whether they are subject to the prospective payment system. For the purposes of this rule, the term hospital includes acute, psychiatric, rehabilitation and long-term care hospitals and hospital units.

The non-physician services that are exempt from this provision include: physician assistants working under a physician’s supervision; certified nurse-midwife services; qualified psychologist services; and the services of a certified registered nurse anesthetist.

Where separate reimbursement is available, all non-physician items and services furnished to Hospital Patients must be billed by the hospital where the patient is a registered inpatient. Whenever a Hospital Patient receives non-physician tests, treatment, therapy, prosthetics, etc. from any other hospital or supplier, such services and items must be included in the claim of the hospital where the patient is a registered inpatient.

This provision affects Tenet providers in three ways:

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- a. When a Tenet hospital inpatient is referred for any outside non-physician services and/or items, the Tenet hospital must pay the outside provider/supplier and include the services and/or items on the hospital inpatient claim.
- b. Tenet providers must also furnish either directly or under arrangements all items and non-physician services received by Medicare outpatients when these services are furnished during an encounter with a patient registered by the hospital as an outpatient. Bundling is required not only for diagnostic and therapeutic services furnished during such an encounter, but also for prosthetic devices (*e.g.*, intraocular lenses (IOLs) implanted or fitted during an encounter in the hospital).
- c. When any Tenet provider furnishes non-physician services or items to a Medicare beneficiary who is a hospital inpatient or registered outpatient at another provider, the Tenet provider may only bill the hospital where the patient is a registered inpatient or a registered outpatient.

3. Services for Patients of the Tenet Hospital

All Tenet hospitals must have processes and procedures in place to identify non-physician services and/or items furnished to their patients by outside entities or vendors. The procedures must include properly notifying outside vendors of the bundling requirement and requiring such vendors to submit billings directly to the hospital for non-physician services and/or items furnished to Medicare inpatients and registered outpatients of the hospital. The procedures must also include a mechanism whereby the charges and appropriate codes are entered on the hospital's Medicare claim. Separate billing by the vendor of such services is strictly prohibited. The payment for the services and/or items is between the hospital and the vendor.

4. Services Performed for Patients of Other Hospitals

All Tenet Hospitals and Tenet Non-Hospital Facilities (*e.g.*, clinics, outpatient imaging sites, laboratories, physician practices, etc.) furnishing non-physician services and/or items to Medicare beneficiaries must have processes and procedures in place to identify patients who are registered patients of another hospital. Billings for non-physician services and/or items furnished to such patients must be billed to the hospital where the patient is a registered patient. Separate billing of such services is strictly prohibited. Processes and procedures must be implemented to prevent

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such billings from being submitted to Medicare.

C. Auditing and Monitoring

Tenet Facilities shall monitor payment denials based on the bundling requirements. For those Tenet Hospitals with wholly owned or wholly operated Tenet Non-Hospital Facilities, the hospitals shall develop processes to monitor compliance with this policy. Tenet’s Audit Services Department shall audit adherence to this policy.

D. Responsible Person

The Tenet Facility Chief Financial Officer is responsible for assuring that all individuals adhere to the requirements of this policy, that these procedures are implemented and followed at the Tenet Facility, and that instances of noncompliance with this policy are reported to the Hospital Compliance Officer.

E. Enforcement

All employees whose responsibilities are affected by this policy are expected to be familiar with the basic procedures and responsibilities created by this policy. Failure to comply with this policy will be subject to appropriate performance management pursuant to all applicable policies and procedures, up to and including termination. Such performance management may also include modification of compensation, including any merit or discretionary compensation awards, as allowed by applicable law.

Under no circumstances will services be scheduled, provided, arranged for, or coded for the purpose of circumventing the Medicare bundling regulations relative to such services. Nor will patients be discharged from a Tenet hospital and subsequently readmitted for the purpose of circumventing the Medicare bundling regulations relative to such services.

VI. REFERENCES:

- [Medicare Claims Processing Manual 100-04, Section 40.3, 21October2005](#)
- 42 CFR 412.2(c)(5)
- 42 CFR 413.40(c)(2)

VII. ATTACHMENTS:

- Attachment A: Diagnostic Services Included in Medicare Bundling Requirement

Diagnostic Services Included in Medicare Bundling Requirement

| Revenue Codes | Description | Revenue Codes | Description |
|----------------------|--|----------------------|--|
| 0254 | Drugs incident to other diagnostic services | 0471 | Audiology diagnostic |
| 0255 | Drugs incident to radiology | 0481, 0489 | Cardiology, Cardiac Catheter Lab/Other Cardiology with CPT codes 93501, 93503, 93505, 93508, 93510, 93526, 93541, 93542, 93543, 93544, 93556, 93561, or 93562 diagnostic |
| 030X | Laboratory | 0482 | Cardiology, Stress Test |
| 031X | Laboratory pathological | 0483 | Cardiology, Echocardiology |
| 032X | Radiology diagnostic | 053X | Osteopathic services |
| 0341, 0343 | Nuclear medicine, diagnostic/Diagnostic Radiopharmaceuticals | 061X | MRT |
| 035X | CT scan | 062X | Medical/surgical supplies, incident to radiology or other diagnostic services |
| 0371 | Anesthesia incident to Radiology | 073X | EKG/ECG |
| 0372 | Anesthesia incident to other diagnostic services | 074X | EEG |
| 040X | Other imaging services | 0918 | Testing- Behavioral Health |
| 046X | Pulmonary function | 092X | Other diagnostic services |

Source: Centers for Medicare and Medicaid Services, Medicare Claims Processing Manual, 100-04, Chapter 3, Section 40.3