CORPORATE POLICY

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	Effective Date: 08/13/26
Policy Title: Medicare Overlap and 3-Day Payment Window Bundling Requirements [COMP-RCC 4.07]	**Previous Versions**: 10/12/11,07/03/01,03/15/99
	Approved By: Executive Leadership Team
	Approval Date: 08/11/26

I. Scope

This policy applies to (1) Tenet Healthcare Corporation and its subsidiaries and affiliates (each, an "Affiliate"); (2) any other entity or organization in which Tenet Healthcare Corporation or an Affiliate owns a direct or indirect equity interest greater than 50%; and (3) any hospital or healthcare entity in which Tenet Healthcare Corporation or an Affiliate either manages or controls the day-to-day operations of the entity (each, a "Tenet Entity") (collectively, "Tenet").

II. Purpose

To ensure compliance with the Medicare requirements for the "Bundling" of certain services.

III. Definitions

Bundling: A payment model where healthcare providers receive a single, predetermined payment for a defined episode of care, rather than separate payments for each individual service**.**

IPPS Exempt Hospital: A hospital receiving payment for providing services to Medicare beneficiaries based on the hospital's costs for providing those services.

IPPS Hospital: 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.

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 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 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.

V. Procedure

A. Every Facility, including a Non-Hospital Facility that is wholly owned or wholly operated by the Facility, are subject to Medicare Bundling requirements and shall follow Medicare guidelines for Bundling and do the following:

1. Identify all services subject to Medicare Bundling requirements commonly referred to as the “DRG 3-Day payment window”.
2. Ensure identified Bundled services are not submitted to Medicare for payment until all services have been properly Bundled as required or a determination is made that Bundling is not required.
3. Reference the most current version of the Tenet Overlap Grid to determine which services are required to be Bundled or may be separately billed.

B. Auditing and Monitoring

1. Every Facility shall monitor payment denials based on the Bundling requirements. For those Facilities with wholly owned or wholly operated 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.
2. Under no circumstances will services be scheduled, provided, arranged for, or coded for the purpose of circumventing the Medicare Bundling regulations related to such services. Nor will patients be discharged from a Tenet hospital and subsequently readmitted for the purpose of circumventing the Medicare Bundling regulations related to such services.

VI. 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.

VII. References

Centers for Medicare and Medicaid Services Prospective Payment Systems-General Information

Medicare Claims Processing Manual 100-04, Section 40.3, 14 August 2025

42 CFR 412.2(c)(5)

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42 CFR 413.40(c)(2)

Tenet Overlap Grid - Final - 1-28-2025.xlsx