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SCOPE: All HCA Healthcare-affiliated entities performing and/or billing outpatient and/or inpatient services. Specifically, the following departments:

Administration
Ethics & Compliance Officers
Shared Service Centers
Hospital Wholly Owned/Operated Physician Entities
Legal Operations

PURPOSE: To establish guidelines for processing, coding, and billing Medicare outpatient services provided in accordance with the CMS regulations.

Background:
Medicare's "Three-Day Window" rule ("Rule") requires that certain hospital outpatient services and services furnished by a Part B entity (e.g., physician, Ambulatory Surgery Center (ASC)) that is "wholly owned or operated" by the hospital be included on the hospital's inpatient claim. Inclusion of these services must occur for any Medicare beneficiary who is admitted as an inpatient within the payment window (three days for acute care Inpatient Prospective Payment System (IPPS) hospitals or one day for non-IPPS hospitals). Outpatient services furnished by the admitting hospital and other outpatient services furnished by another hospital or Part B entity wholly owned or operated by the admitting hospital that must be bundled on the inpatient claim include (1) all diagnostic services, and (2) non-diagnostic (therapeutic) services that are "related to" the subsequent inpatient admission as follows:

- All outpatient diagnostic and non-diagnostic services furnished on the day of a hospital admission must be combined with the inpatient claim.
- All outpatient diagnostic services furnished within the payment window must be combined with the inpatient claim.
- All outpatient non-diagnostic services furnished within the payment window are deemed related to the admission, and must be combined with the inpatient claim, unless the hospital attests to specific non-diagnostic services as being unrelated to the hospital claim.

POLICY:

The following services provided by the admitting facility or another hospital/Part B entity wholly owned or operated by the admitting facility must be combined with the hospital admission as described in 1-6 below:

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- Outpatient services provided on the day of admission; and
- Outpatient diagnostic and related outpatient non-diagnostic services provided within the payment window.

1. **Hospitals paid under the Prospective Payment System (PPS) for acute care services:** All outpatient services provided within three days prior to the inpatient admission, including the date of admission, must be combined with the inpatient admission. Outpatient services provided prior to the three-day payment window must not be included on the inpatient claim and may be billed separately.

2. **Hospitals or Distinct Part Units excluded from the PPS for acute care services:** All outpatient services provided within one day prior to the inpatient admission must be combined with the inpatient admission. Outpatient services provided prior to the one-day payment window must be billed separately.

3. **The following exceptions apply to this policy:**

   a. **Home Health Agency (HHA), Skilled Nursing Facility (SNF) or Hospice:** Services provided within the applicable window by an HHA, SNF, or Hospice wholly owned or operated by the admitting facility do not need to be combined with the inpatient admission unless such services are diagnostic and payable under Medicare Part B. Diagnostic services payable under Medicare Part B that are rendered by an HHA, SNF, or Hospice wholly owned or operated by the admitting facility must be combined with the inpatient admission.
   b. **Ambulance transportation services:** Ambulance transportation services provided within the applicable window by an entity wholly owned or operated by the admitting facility do not need to be combined with the inpatient admission unless such services are rendered during an inpatient admission for the purpose of the patient receiving specialized services not available where the patient is an inpatient. When rendered during an inpatient admission, the cost of ambulance transportation services should be included in the ancillary cost center representing the specialized service provided.
   c. **Maintenance renal dialysis:** Maintenance renal dialysis provided within the applicable window by an entity wholly owned or operated by the admitting facility does not need to be combined with the inpatient admission.
   d. **Physician professional services:** The professional component of services personally furnished by physicians do not need to be combined with the inpatient admission.
   e. **Screening Mammograms:** Screening mammograms are exempt from the applicable payment window and should not be combined with the inpatient claim.
   f. **Critical Access Hospitals (CAH**): Services provided by CAHs are not subject to the three-

day or one-day payment window.

g. **Outpatient non-diagnostic services that are not payable under Part B:** Medicare states that hospitals must not include any outpatient non-diagnostic services, such as self-administered drugs, on a claim for inpatient services that are not payable under Part B.
h. **Rural Health Clinic (RHC):** Medicare pays for RHC services through an all-inclusive rate that incorporates payment for all covered items and services and related services and supplies that are provided to a beneficiary on a single day. RHC services paid under the all-inclusive rate that are provided within the payment window are exempt and do not need to be combined to the inpatient claim. Services provided in an RHC which are reimbursed outside of the all-inclusive rate are subject to the payment window.
i. **Rural Emergency Hospital (REH):** Services provided by REHs are not subject to the three-day or one-day payment window.

4. This policy applies whether Medicare Part A is the primary or secondary payer.

5. "Inpatient Only" procedures provided to a patient in the outpatient setting on the date of the inpatient admission or during the three calendar days (or one calendar day for hospitals or units excluded from the IPPS) preceding the date of the inpatient admission that are deemed related to the admission, will be covered by CMS and should be combined on the inpatient claim.

6. Under no circumstances may outpatient services be scheduled at another facility or in a manner to purposefully avoid combining outpatient services with anticipated inpatient admissions.

PROCEDURE:

Identification of Wholly Owned and Wholly Operated Facilities
The hospital CFO or designee must work in conjunction with its Operations Counsel to keep an accurate list of all wholly owned or wholly operated entities. On an annual basis, Parallon and Internal Audit will survey the hospital CFO to confirm the wholly owned and wholly operated entities.

Every three years, the tax and legal departments will perform an analysis of all wholly owned or operated entities. Results of this review will be communicated to the relevant facilities, corporate departments, and Parallon.

Billing – Shared Service Centers
Shared Service Centers (SSC), including the Medicare Service Center (MSC), must implement any and all processes required to appropriately combine related claims. SSC/MSC colleagues must identify Medicare Administrative Contractor (MAC) interpretations which may vary from the interpretations in this policy. Specific documentation from the MAC related to the variance(s) must be

obtained and provided to Regulatory Compliance Support (Regs). Documentation may be sent to the Regs Helpline at https://regshelpline.app.medcity.net.

The Shared Service Centers must develop a process that will accomplish the requirements below to identify services subject to policy:

1. Shared Services Center colleagues must identify on a daily basis patients who have received outpatient services within the applicable window of an inpatient admission and communicate impacted accounts with HSC (HIM Service Center) colleagues. This can be accomplished by utilizing reports such as the Payment Window Report (CENS:CENS10) or the Final Bill Alert Exception Report by Patient Type (BILL:BILL49).
2. HSC colleagues must review both the appropriate inpatient and outpatient accounts to provide the accurate code assignment, sequencing of codes, Present on Admission (POA) Indicator, and MS-DRG recalculation. Reference PARA.HSC.COD.02 “Payment Window and Multi Visit Account Merge Manual Coding Process.”
3. The Monthly Payment Window Report, COMP 3DAY01 report must be reviewed monthly by Shared Services Center colleagues to validate that the appropriate combination of accounts, from such as the Payment Window Report or Final Bill Alert Exception Report by Patient Type, has occurred for billing. These reviews must be documented on the Three-Day Window reports or other electronic tools and maintained in accordance with the Records Management policies.
4. Shared Service Center colleagues must establish a mechanism to identify services rendered by wholly owned or operated entities that do not utilize the hospital main A/R system for billing (e.g.., physician practices/clinics).
5. If such services are noted that were provided by a wholly owned or operated physician practice/clinic, the provider of service must bill the professional components of the services that meet the criteria and write the technical components of such services off their accounts receivable.
6. HSC colleagues must provide the accurate sequencing of codes and MS-DRG recalculation. A copy of the combined code changes (e.g., mock abstract) must be maintained in the inpatient medical record.

Shared Service Center Colleagues should follow Parallon Policy, PARA.PP.BILL.201, for instructions on how to combine claims for patients who have Medicare Part A only.

Education
All billing/coding staff, clerical employees, managers, supervisors, wholly owned physician entities, and colleagues involved in working daily or monthly payment window reports or preparing and/or submitting Medicare bills relating to outpatient services rendered in connection with inpatient admissions must be educated on this policy within 90 days of hire. This includes any existing staff

that transfers into a position impacted by this policy.

DEFINITIONS:

The following definitions are meant to be illustrative. Questions regarding these definitions should be discussed with a facility's operations counsel.

Diagnostic Services: Diagnostic services are those services or tests which are provided to a patient in order to obtain information to aid in the assessment of a medical condition, the identification of a disease, or to determine the nature and severity of an injury. Examples of these include laboratory tests, imaging services and EKGs.

Non-diagnostic/therapeutic Services: Services that aid the physician or practitioner in the treatment of the patient. Such therapeutic services include emergency room (E/M) services, observation services, and procedures which are performed to remedy a patient's illness or injury.

Part B Entity: Entity which provides Part B services (e.g., physician office/clinic, Independent Diagnostic Testing Facility (IDTF), free-standing radiation oncology center, ASC).

Payment (or Three-Day) Window: Three calendar days prior to an inpatient admission for acute care IPPS hospitals and one day prior to inpatient admission for hospitals or units exempt from acute care IPPS.

Wholly Owned: A hospital other than the admitting hospital or a Part B entity for which the admitting hospital itself is the sole owner.

Wholly Operated: A hospital other than the admitting hospital or a Part B entity that is wholly (solely) operated by the admitting hospital. An entity is considered wholly operated by an admitting hospital if the admitting hospital has exclusive responsibility for conducting and overseeing the entity's routine day-to-day operations. A hospital need not have policymaking authority over the entity to be the sole operator. Collectively, the following factors are helpful when applying the Rule and determining whether another hospital or a Part B entity is wholly operated by a hospital. These factors are not an exhaustive list. However, they are the most common ones to consider when assessing whether another hospital or a Part B entity is wholly operated by the admitting hospital:

- There is an exclusive management agreement between the admitting hospital and another hospital or Part B entity whereby the admitting hospital provides management services at the other hospital/entity;
- The admitting hospital has ultimate control over substantive areas that are central to running the day-to-day operations of the other hospital or Part B entity, such as decisions regarding executive

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staff, medical staff appointment, admissions policies and the like;
- The admitting hospital's name is included in the Part B entity's name such that the Part B entity is being held out as a part of the hospital;
- Leadership at the Part B entity reports directly to management or senior administrators of the admitting hospital;
- Any costs of the Part B entity are included anywhere in the admitting hospital's Medicare cost report as either an allowable or non-allowable cost; and/or

The admitting hospital and Part B entity have overlapping Boards.

REFERENCES:

1. Federal Register, Volume 76, Number 228, November 28, 2011, Bundling of Services 42 CFR 412.2; 413.40
2. Office of Inspector General (OIG) - "Follow-up Audit of Improper Medicare Payments to Hospitals for Non-physician Outpatient Services Under the Inpatient Prospective Payment System," (A-01-00-00506) July 31, 2001
3. Program Memorandum A-03-008
4. CMS Claims Processing Manual (Pub 100-4) Chapter 3, Section 40.3
5. CMS Claims Processing Manual (Pub 100-4) Chapter 4, Section 10.12,180.7
6. CMS Benefit Policy Manual (Pub 100-2) Chapter 6, Sections 20.3 and 20.4
7. CMS Benefit Policy Manual (Pub 100-2) Chapter 11, Section 10
8. Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010
9. CMS Transmittal 2234, May 27, 2011