ADMINISTRATIVE POLICY STATEMENT
TrueCare

Policy Name & Number	Date Effective
Three-Day Window Payment-TrueCare-AD-1324	07/01/2025
Policy Type	
ADMINISTRATIVE	

Administrative Policy Statements are derived from literature based on and supported by clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased, or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any Evidence of Coverage or Certificate of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other plan policies and procedures.

Administrative Policy Statements do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage or Certificate of Coverage) for the service(s) referenced in the Administrative Policy Statement. Except as otherwise required by law, if there is a conflict between the Administrative Policy Statement and the plan contract, then the plan contract will be the controlling document used to make the determination.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

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A. Subject

Three-Day Window Payment

B. Background

TrueCare follows the 3-day window payment policy as established by the Centers for Medicare & Medicaid Services (CMS). According to the 3-day rule, if an admitting hospital (or wholly owned or wholly operated physician practice) provides diagnostic or nondiagnostic services 3 days prior to and including the date of the member's inpatient admission, the services are considered inpatient services and are included in the inpatient payment (eg, bundled service). This includes services performed as pre-admission or preoperative procedures when occurring within 3 days of the inpatient admission. The 3-day window payment will apply to diagnostic and nondiagnostic services clinically related to the reason for the member's inpatient admission regardless of whether the inpatient and outpatient diagnoses are identical. Hospitals (or wholly owned or wholly operated physician practices) are allowed to bill services separately from the inpatient admission if the outpatient services are unrelated to the inpatient admission.

C. Definitions

- **Inpatient** – The Division of Medicaid considers a patient an inpatient if formally admitted as an inpatient with the expectation that they will remain at least overnight and occupy a bed even though it later develops that they can be discharged or is transferred to another hospital and does not actually use a hospital bed overnight.
- **Outpatient** – A patient of an organized medical facility, or distinct part of that facility, who is expected to receive, and does receive, professional services for less than a 24-hour period regardless of the hour of admission, whether or not a bed is used, or whether or not the patient remains in the facility past midnight.
- **Inpatient Services** – Services that are ordinarily furnished by the hospital for the care and treatments of the patient, solely during a stay in the hospital.

D. Policy

I. Three-Day Payment Rule

A. Outpatient services provided to a member by the admitting hospital, or by an entity wholly owned or operated by the admitting hospital, within the 3 days prior to an inpatient hospital admission that are related to the reason for the inpatient hospital stay must be included in the APR-DRG payment for the inpatient hospital stay. The inpatient hospital claim must include the following:

1. diagnostic services provided to a member within 3 days prior to and including the date of an inpatient hospital admission
2. therapeutic (non-diagnostic) services related to an inpatient hospital admission and provided to a member within 3 days prior to and including the date of the inpatient admission

B. If outpatient services are provided more than 3 days prior to admission to a member by the admitting hospital, or an entity wholly owned or operated by the admitting hospital, and the outpatient service dates span to days outside of the 3-day window, the hospital must

1. split bill for the outpatient services provided outside of the 3-day window on a claim separate from the inpatient claim, and
2. include the outpatient services that are related to the reason for the inpatient hospital stay within the 3-day window on the inpatient hospital claim

II. Maintenance renal dialysis services are excluded from the 3-day window payment rule.

III. Although the Division of Medicaid's policy is based on Medicare policy, the Division of Medicaid's policy applies if there is a difference.

E. Conditions of Coverage
NA

F. Related Policies/Rules
NA

G. Review/Revision History

	DATE	ACTION
Date Issued	02/26/2025	New market, approved at Committee.
Date Revised		
Date Effective	07/01/2025	
Date Archived		

H. References
1. Definitions, 23-202 MISS. CODE R. § 1.1 (2024).
2. Inpatient Hospital Payment, 23-202 MISS. CODE R. § 1.14 (2024).
3. Split Billing, 23-202 MISS. CODE R. § 1.16 (2024).