ADMINISTRATIVE POLICY STATEMENT Ohio Medicaid	
Policy Name & Number	**Date Effective**
Readmission-OH MCD-AD-0972	07/01/2026
Policy Type	
ADMINISTRATIVE	

Administrative Policy Statement prepared by CareSource and its affiliates 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 documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

Administrative Policy Statements prepared by CareSource and its affiliates do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced in the Administrative Policy Statement. If there is a conflict between the Administrative Policy Statement and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) 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
Readmission

B. Background
Following a hospitalization, readmission within 30 days is often a costly preventable event and a quality-of-care issue. It has been estimated that readmissions within 30 days of discharge can cost health plans more than $1 billion on an annual basis. Readmissions can result from many situations but most often are due to lack of transitional care or discharge planning and can be a major source of stress to the patient, family and caregivers. However, there are some readmissions that are unavoidable due to the inevitable progression of a disease state or due to chronic conditions.

The purpose of this policy is to improve the quality of acute care and transitional care rendered to CareSource members on initial admission that are paid using the DRG methodology, including, but not limited to, improving communication between the patient, caregivers and clinicians, providing patient education needed to maintain care at home to prevent a readmission, performing pre-discharge assessment to ensure the patient is ready to be discharged, and providing effective post-discharge coordination of care. CareSource follows guidance from the Ohio Department of Medicaid (ODM) and Ohio Administrative Code (OAC) for readmissions, particularly OAC 5160-2-02 and 65.

C. Definitions
- **Clinical Review** – Review of records by a health care professional with appropriate clinical expertise in the treatment of medical conditions, including member diagnoses, living situation, supports, and severity of the condition.
- **Diagnosis Related Groups (DRGs)** – A patient classification scheme, which provides a means of relating the type of patients a hospital treats (ie, its case mix) to the costs incurred by the hospital. DRGs have been established as the basis of Medicare's hospital reimbursement system.
- **Discharged** – A patient who 1) is formally released from a hospital, 2) dies while hospitalized, 3) is discharged within the same hospital from an acute care bed to a bed in an inpatient psychiatric facility or vice versa, or 4) signs self out against medical advice.
- **External Medical Review (EMR)** –The review process conducted by an ODM-identified, independent, external medical review entity initiated by a provider disagreeing with the CareSource's decision to deny, limit, reduce, suspend or terminate a covered service for lack of medical necessity.
- **Hospital** – Defined by OAC 5160-2-01 and includes general acute care facilities.
- **Inpatient Services** – A patient admitted to a hospital based upon written orders of a practitioner of physician services and whose inpatient stay continues beyond midnight of the day of admission.
- **Observation Services** – Services furnished in an outpatient hospital setting, including use of a bed and periodic monitoring by a hospital's nursing or other staff

which are reasonable and necessary to evaluate a patient's condition or determine the need for possible admission as an inpatient.

- **Planned Readmission** – A non-acute admission for a scheduled procedure for limited types of care to include obstetrical delivery, transplant surgery, and maintenance chemotherapy/radiotherapy/immunotherapy.
- **Potentially Preventable Obstetrical Readmissions** – A readmission due to a preterm or post-partum complication, including but not limited to:
  - retained placenta
  - retained products of conception
  - post-partum sepsis
  - other acquired hospital-acquired condition
- **Potentially Preventable Readmission (PPR)** – An inpatient readmission following a prior discharge from a hospital within 30 days that is clinically related and clinically preventable to the initial admission.
- **Pre-Existing Condition** – A chronic health condition the patient had before the date of the admission.
- **Readmission** – An admission to the same institution within 30 days of discharge for hospitals paid under ODM's prospective payment system as described in OAC 5160-2-65.
- **Related Medical Condition** – Medical condition or diagnosis that is related or associated to the original admission.
- **Same or Similar Condition –** A condition or diagnosis that is the same or a similar condition as the diagnosis or condition that is documented on the initial admission.

D. Policy

I. Although a review of medical necessity for initial or subsequent inpatient stays are conducted pre-service delivery using the related medical necessity criteria, including review for members under 21 according to Early Periodic Screening, Diagnosis and Treatment (EPSDT) program requirements, prior authorization and medical necessity review processes are separate and not related to readmission review processes.

II. Payment rules for hospitals and acute care facilities reimbursed for inpatient or observational services are as follows:

A. Caresource reviews both the initial and second admission for medical necessity at the time of the initial authorization.

B. Readmission reviews are clinical, post-service audits of the initial and second admission conducted by registered nurses (RNs) qualified to complete the review. If a decision is made to deny a claim or combine 2 claims due to medically preventable issues, a physician will assist in the clinical determination using review guidelines that were developed by physicians.

C. The readmission review audits will determine whether a second admission (readmission) was related and preventable to or otherwise linked with the initial admission. If the audit finds the 2 admissions are related and preventable, the provider must combine the 2 inpatient stays into a single adjusted claim that

includes services and charges for the entire hospitalization and resubmit that combined claim for payment. If the admissions are not related or preventable, the claims will be adjudicated as separate admissions.

D. Readmissions that are potentially preventable as determined by the provision of appropriate care consistent with the criteria are outlined below (not all-inclusive):
   1. a continuation or recurrence of the reason for the initial admission due to lack of care or for a closely related condition
   2. an acute decompensation of a chronic problem that was not the reason for the initial admission but was potentially related to a lack of care rendered either during or immediately after the initial admission
   3. an acute medical complication potentially related to a lack of care rendered during an initial admission
   4. a surgical procedure to address
      a. a continuation or recurrence of a problem causing an initial admission
      b. a complication resulting from a lack of care rendered during an initial admission
   5. a condition or procedure clinically related to care provided during the prior discharge or resulting from inadequate discharge planning

E. When the PPR chain contains 1 or more readmissions clinically related to an initial admission and preventable, the 30-day timeframe may begin again at discharge of either the initial admission or the most recent readmission clinically related and preventable to the initial admission.

III. Readmission Review Process

A. CareSource conducts clinical readmission reviews pre- or post-payment by examining medical records to determine if a readmission was a preventable, clinically related readmission linked to complications or errors from an initial admission. Pertinent and complete medical records for **both** admissions must be included with claim submission to determine appropriateness and preventability of the admissions. The following will result in an automatic denial of the claim (not all inclusive):
   1. failure to provide complete medical or clinical records, as requested, including major documentation components below (not an all-inclusive list):
      a. face sheets
      b. admission history and/or physical
      c. physician orders
      d. emergency department records, physician and nursing notes
      e. other progress notes
      f. diagnostic and/or laboratory testing
      g. discharge summaries and medication lists
      h. appropriate, complete, signed and dated consents for treatment and releases of confidential information
      i. any treatment plans or plans of care
      j. any additional therapy notes (eg, speech, physical or occupational therapy)

k. discharge planning notes
l. any medication adjudication records
2. readmission related to the first hospitalization resulting from preventable complications or other circumstances due to early discharge or treatment errors
3. treatment or care provided during the readmission that should have been provided during the first hospitalization

B. Payment Process
CareSource enforces 3 calendar day roll-in requirements pursuant to OAC 5160-2-02 and follows the readmission policies as outlined in OAC 5160-2 for inpatient hospital stays. CareSource accepts corrected claims from providers that encompass all dates of service.
1. 30-Day Readmissions
   a. If a clinical readmission review determines that the readmission was not preventable, unavoidable or unrelated to the first admission, related claims will be treated and adjudicated as 2 separate admissions.
   b. If a clinical readmission review determines that the readmission is related to the first admission and was preventable, the provider must collapse the 2 inpatient stays into 1 claim and resubmit for payment, which will be reimbursed as 1 DRG payment. Any days between admissions should be billed as non-covered days. CareSource may recoup any payments made for readmission(s) that are deemed preventable and clinically related.
2. A readmission within 1-calendar day of discharge to the same institution is considered to be 1 discharge for payment purposes so that 1 DRG payment is made. If 2 claims are submitted, the second claim processed will be denied. In order to receive payment for the entire period of hospitalization, the hospital will need to submit an adjustment claim reflecting services and charges for the entire hospitalization (ie, the 2 admissions must be collapsed into 1 claim and resubmitted for payment).
3. Sentinel events are not reimbursable.

IV. A clinically related and preventable readmission that occurs within 1 calendar day (ie, same day or next day) to the same institution is considered 1 discharge for payment purposes and will be reimbursed as 1 DRG payment per OAC 5160-2-65.
   A. If 2 claims are submitted, the second claim processed will be rejected.
   B. The hospital will need to submit an adjusted claim for the entire hospitalization.

V. If the readmission is within 2-30 days, CareSource will determine through clinical review if the readmission was preventable and related to the first admission.
   A. If not preventable and/or unrelated to the first admission, both claims will be treated as 2 separate admissions.
   B. If preventable and/or related to the first admission, that claim will be denied, and the provider may resubmit a corrected claim for the entire length of stay.

VI. Exclusions to readmission administrative review (2-30 days) include:

A. scheduled, staged surgical procedures
B. readmissions for/associated with
    1. unpreventable, routine obstetrical or neonatal readmissions
    2. burns or cystic fibrosis
C. transfers
    1. of a member from an out-of-network to an in-network facility or to a facility that provides care that is unavailable at the initial facility
    2. acute rehabilitation transfers
    3. to distinct psychiatric units within the same facility with documentation that shows the diagnosis necessitating the transfer was psychiatric in nature and the patient received active psychiatric treatment
D. original discharges that are
    1. patient-initiated or against medical advice (AMA) with circumstances documented in the medical record
    2. for securing treatment of a major or metastatic malignancy, major trauma, transplant, or HIV

VII. Post Service Review Process:
Prior authorization and/or approval of the initial or subsequent medical necessity review of admission or stay is not a guarantee of payment and is subject to clinical readmission review at CareSource's discretion.
A. CareSource will ensure that staff conducting peer-to-peer consultations and provider appeals for medical necessity determinations are health care professionals with clinical expertise in treating member conditions with the equivalent or higher credentials as the requesting or ordering provider.
B. Medical necessity review and clinical readmission review processes are separate and distinct processes.

E. Conditions of Coverage

I. Prior authorization and/or approval of the initial or subsequent medical necessity review for admission or stay is not a guarantee of payment and is subject to clinical readmission review at CareSource's discretion.
A. CareSource will ensure that staff conducting peer-to-peer consultations and provider appeals for medical necessity determinations are health care professionals with clinical expertise in treating the member's condition with the equivalent or higher credentials as the requesting or ordering provider.
B. Medical necessity review and clinical readmission review processes are separate and distinct processes.

II. CareSource provides provider appeal processes and claims dispute resolution processes prior to EMR. EMR process instructions are provided in provider appeal letters.

F. Related Policies/Rules

Readmission-Behavioral Health

Non-Emergent-Facility to Facility Transfers
Sentinel Events and Provider Preventable Conditions

G. Review/Revision History

	DATES	ACTION
Date Issued	04/01/2019	
Date Revised	11/11/2020	Changed from PY-0724. Removed reference to Medicare Advantage, updated definitions, and per ODM guidance.
	12/18/2020	Updated exclusions and revised V. 2. Changed post payment to post service in D. IV. and D.IV A. Removed appeals and peer to peer language in D. V. and D. IV. B. Updated references. Approved at Committee.
	08/04/2021	No change to content. Updated references. Approved at Committee.
	08/31/2022	No change to content. Updated references. Approved at Committee.
	11/08/2023	Updated definitions. Added D. IV. Updated D. VII. and F. Updated references. Approved at Committee.
	11/06/2024	Annual review. Updated background, definitions, D. V. and VI. Updated references. Approved at Committee.
	11/19/2025	Annual review. Updated background, Section D.IV, V, VII and references. Approved at Committee.
	02/11/2026	Periodic review. Updated background and definitions. Added D. I and II. Updated D. III, VI, VII, VIII IX B. and references. Added “preventable” to every “related” per ODM. Matched language to the Readmission-Behavioral Health policy where applicable. Approved at Committee.
Date Effective	07/01/2026	
Date Archived		

H. References

1. Case Review. *Quality Improvement Organization Manual Chapter 4*. US Centers for Medicare and Medicaid Services; 2014. Accessed January 20, 2026. www.cms.gov
2. *Eliminating Serious, Preventable, and Costly Medical Errors – Never Events* Center for Medicare & Medicaid Services; 2006. Accessed January 20, 2026. www.cms.gov
3. General Provisions: Hospital Services, OHIO ADMIN. CODE 5160-2-02 (2026).
4. Goldfield NI, McCullough EC, Hughes JS, et al. Identifying potentially preventable readmissions. *Health Care Financing Rev*. 2008;30(1):75-91. Accessed January 20, 2026. www.ncbi.nlm.nih.gov
5. Hospital-acquired conditions. Centers for Medicare & Medicaid Services. Updated September 10, 2024. Accessed January 20, 2026. www.cms.gov
6. *Hospital Readmission Reduction Program (HRRP)*. US Centers for Medicare and Medicaid Services; Updated August 11, 2025. Accessed January 20, 2026. www.cms.gov

The ADMINISTRATIVE Policy Statement detailed above has received due consideration as defined in the ADMINISTRATIVE Policy Statement Policy and is approved.

7. Inpatient Hospital Reimbursement, OHIO ADMIN. CODE 5160-2-65 (2026).
8. List of SREs. National Quality Forum. Accessed January 20, 2026. www.qualityforum.org
9. McIlvennan CK, Eapen ZJ, Allen LA. Hospital readmissions reduction program. *Circulation*. 2015;131(20):1796-1803. doi:0.1161/CIRCULATIONAHA.114.010270
10. Utilization review: Hospital Services, OHIO ADMIN. CODE 5160-2-13 (2022).

Approved by ODM 04/02/2026

The ADMINISTRATIVE Policy Statement detailed above has received due consideration as defined in the ADMINISTRATIVE Policy Statement Policy and is approved.