CareSource

ADMINISTRATIVE POLICY STATEMENT
Ohio Medicaid

Policy Name & Number	Date Effective
Readmission–Behavioral Health–OH MCD-AD-1018	10/1/2025
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.

Table of Contents

A. Subject 2
B. Background 2
C. Definitions 2
D. Policy 3
E. Conditions of Coverage 4
F. Related Policies/Rules 4
G. Review/Revision History 5
H. References 5

A. Subject

Readmission – Behavioral Health

B. Background

Following a hospitalization, readmission within 30 days is often costly and preventable. Readmissions result from many factors but, most often, are due to lack of transitional care or discharge planning. Members with schizophrenia, depression, medical comorbidities, and substance use disorder are more likely to be readmitted after hospitalization. For individuals hospitalized for behavioral health (BH) conditions, including SUD, recommended post-discharge treatment includes a visit with a mental health provider within 30 days of discharge, and ideally, within 7 days of discharge. However, use of follow-up care within members with BH diagnoses, including SUD, often falls short of these recommendations.

CareSource strives to improve the quality of inpatient and transitional care, including communication between the member, caregivers, providers, providing the patient with education to maintain care at home to prevent readmission, performing predischarge assessment to ensure readiness for discharge, 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.

C. Definitions

- **Clinical Review** – Review of records by a health care professional with appropriate clinical expertise in the treatment of BH conditions, including member diagnoses, living situation, supports, and severity of the condition.
- **Diagnosis Related Groups (DRGs)** – A patient classification system that reflects clinically cohesive groupings of services that consume similar amounts of hospital resources in an inpatient setting used to assign cases for claims payment.
- **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 and admitted to a bed in an inpatient psychiatric facility or is discharged within the same hospital from a bed in an inpatient psychiatric facility to an acute care bed, or 4) signs self out against medical advice.
- **Hospital** – Defined by OAC 5160-2-01 and includes both general acute care facilities and Institutions of Mental Disease (IMD).
- **Inpatient** – 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.
- **Planned Readmission** – A non-acute admission for a scheduled procedure for limited types of care when further treatment is indicated following diagnostic tests but cannot begin at the time of initial admission.
- **Potentially Preventable Readmission** – An inpatient readmission following a prior discharge from a hospital within 30 days that is clinically related and clinically preventable to the initial admission.

- **Readmission** – An admission to the same institution within 30 days of discharge for hospitals paid under ODM's prospective payment system.
- **Same Day** – Midnight to midnight of a single day.

D. Policy

I. Review of medical necessity for the initial or subsequent inpatient stay is conducted pre-service delivery using the related medical necessity criteria. The review process and determination are separate from any readmission review process and determination, Members under the age of 21 years will be reviewed for medical necessity as required by the Early Periodic Screening, Diagnosis and Treatment (EPSDT) program. Sentinel events are not reimbursable.

II. Readmission Reviews and Payment Processes
ODM publishes a list of psychiatric and substance use DRGs. Providers are responsible for use of appropriate DRGs.

A. Readmission Review Process
CareSource conducts post-service clinical readmission reviews pre- or post-payment by examining medical records to determine if a readmission was a preventable, clinically related readmission. Pertinent and complete medical records for **both** admissions must be included with claim submission to determine the appropriateness of the admissions. The following will result in an automatic denial of the claim for the readmission:

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 as a result of complications or other circumstances due to early discharge or treatment errors
   Note: Providers are expected to follow discharge planning requirements for inpatient psychiatric facilities and units in OAC 5122-14-12.
3. treatment or care provided during the readmission that should have been provided during the first hospitalization

B. Payment Process
CareSource manages the provider payment process for readmissions according to guidelines found in OAC 5160-2-65. 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 unavoidable or unrelated to the first admission, related claims will be treated as, and adjudicated as, 2 separate admissions.
   b. If a clinical readmission review determines that the readmission is related to the first admission and is a preventable, clinically related readmission, the readmission claim will be rejected. The provider must collapse the 2 admissions 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, clinically related.
2. 1-calendar day readmissions (same day or next day readmissions) will be reimbursed as 1 DRG payment. If an institution submits claims for both admissions, the second claim processed will be denied. The 2 admissions must be collapsed into 1 claim and resubmitted for payment.
3. Sentinel events are not reimbursable.

III. Exclusions to readmission review (2-30 days) include
A. readmission as part of a planned readmission evident from initial admission medical records that additional work-up, treatment or procedures are planned or expected for the same episode of illness or care
B. chronic or similar repetitive treatments for members (eg, cancer chemotherapy, transfusions for chronic anemia, dialysis, pregnancy)
C. transfers from out of network to in-network facilities
D. transfers of members to receive care not available at the first facility
E. original discharges that were member initiated (ie, left against medical advice), which is documented in the original medical record
F. transfers to distinct psychiatric units within the same facility with documentation that shows that the diagnosis necessitating the transfer was psychiatric in nature and that the member received active psychiatric treatment
G. admissions to Skilled Nursing Facilities, Long-Term Acute Care facilities and Inpatient Rehabilitative Facilities
H. transfers received by or discharging from a freestanding psychiatric hospital

E. Conditions of Coverage
Prior authorization of the initial or subsequent stay or admission is not a guarantee of payment and is subject to administrative review at CareSource's discretion.

F. Related Policies/Rules
Sentinel Events and Provider Preventable Conditions

G. Review/Revision History

	DATES	ACTION
Date Issued	12/01/2021	Approved at PGC.
Date Revised	05/24/2023 01/17/2024 04/23/2025	Annual review. Updated background, definitions, reference list. Added related policies. Approved at Committee. Updated definitions, added DRG. Added OAC references to policy body. Updated References. Approved at Committee. Deleted I. Readmission Criteria from OAC 5160-2-14 (rescinded 2/2025). Added II.A.1-3 from 5160-2-13 & III. Updated references. Approved at Committee.
Date Effective	10/01/2025	
Date Archived		

H. References

1. Eligible Providers, OHIO ADMIN. CODE 5160-2-01 (2023).
2. General Provisions: Hospital Services, OHIO ADMIN. CODE 5160-2-02 (2024).
3. Hospital Inpatient Readmission Policy. Ohio Dept of Medicaid; Deputy Director; 2020. Accessed April 16, 2025. www.ohio.gov
4. Hospital readmission reduction program. Centers for Medicare and Medicaid Services. Updated September 10, 2024. Accessed April 15, 2025. www.cms.gov
5. Inpatient Hospital Reimbursement, OHIO ADMIN. CODE 5160-2-65 (2024).
6. Medical Records, Documentation and Confidentiality. Ohio Admin. Code 5122-14-13 (2024).
7. *Potentially Preventable Readmissions.* Ohio Dept of Medicaid. HHTL 3352-25-03; 2025. Accessed June 5, 2025. www.ohio.gov
8. Program, Specialty Services, and Discharge Planning Requirements, OHIO ADMIN. CODE 5122-14-12 (2024).
9. Richardson R. *Hospital Inpatient Readmission Policy*. Ohio Dept of Medicaid; 2020. Accessed April 15, 2025. www.medicaid.ohio.gov
10. *Office of Policy Hospital Billing Guidelines*. Ohio Dept of Medicaid. Revised July 26, 2021. Accessed April 15, 2025. www.medicaid.ohio.gov
11. Tassie J. *Potentially Preventable Readmissions Program Changes*. Ohio Dept of Medicaid; 2018. Hospital Handbook Transmittal Letter 3352-19-02. Accessed April 15, 2025. www.medicaid.ohio.gov
12. Utilization Review, OHIO ADMIN. CODE 5160-2-13 (2022).

Approved by Ohio Dept. of Medicaid 06/27/2025..

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