CareSource

ADMINISTRATIVE POLICY STATEMENT
Ohio Medicaid

Policy Name & Number	Date Effective
Readmission–Behavioral Health–OH MCD-AD-1018	09/01/2026
Policy Type	
ADMINISTRATIVE	

Administrative Policy Statements contain supplemental information regarding standard benefit administration and coverage details. Administrative Policy Statements do not guarantee an authorization or payment of services. The Member's plan contract (e.g., Evidence of Coverage, Member Handbook) contains specific terms and conditions, including limitations, exclusions, benefit maximums, eligibility, and other relevant conditions of coverage. Except as otherwise required by law, if there is a conflict between the Administrative Policy Statement and the plan contract and/or provider agreement, then the plan contract and/or provider agreement will be the controlling document. Reasonable discretion may be used in interpreting and applying this Policy Statement to services provided in a particular case, and the policy may be modified at any time. Policy Statements may be superseded by federal and state laws and regulations, as applicable. In the case of a discrepancy between the Policy Statement's effective date and any applicable legal or regulatory requirement, the law or regulation will govern.

Coverage for mental health and substance use disorder (MH/SUD) benefits are provided at the same level as coverage for medical and surgical (M/S) benefits, as required by the Mental Health Parity and Addiction Equity Act (MHPAEA). MH/SUD benefits are not subject to limits or requirements that are more restrictive than those that apply to M/S benefits.

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A. Subject

Readmission – Behavioral Health

B. Background

Following a hospitalization, readmission within 30 days is often costly and preventable, resulting from many factors but, most often, due to lack of transitional care or discharge planning. Members with schizophrenia, depression, medical comorbidities and substance use disorder (SUD) are more likely to be readmitted after hospitalization. Recommended post-discharge treatment for any member admitted with a behavioral health (BH) condition 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 this population often falls short of these recommendations, and some readmission are unavoidable due to the inevitable progression of the diagnosis or chronic condition(s).

The quality of inpatient and transitional care is important, including communication between the member, caregivers and providers, providing 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, 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 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 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 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. 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 first and second admission for medical necessity at the time of the initial authorization.
   B. Readmission reviews are post-service audits of the initial and second admission conducted by staff with credentials appropriate to complete the reviews.
   C. Readmission review audits will determine whether a second admission (readmission) was related to or otherwise linked with the initial admission. If the audit finds that the 2 admissions are related, 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 claims for payment. If the admissions are not related, the claims will be adjudicated as separate admissions.

III. 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 linked to complications or errors from the initial admission. 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 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 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 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, 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 one 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. 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, electroconvulsive therapy)
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), documented in the original medical record
F. transfers to distinct psychiatric units within the same facility with documentation showing 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

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

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	Annual review. Updated background, definitions, reference list. Added related policies. Approved at Committee.
	01/17/2024	Updated definitions, added DRG. Added OAC references to policy body. Updated References. Approved at Committee.
	04/23/2025	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.
	01/28/2026	Added definition of EMR. Added I.A-C & E.I.A.1-2.B. Updated references. Approved at Committee.
Date Effective	TBD	

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

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 January 21, 2026. www.ohio.gov
4. Hospital readmission reduction program. Centers for Medicare and Medicaid Services. Updated September 10, 2024. Accessed January 21, 2026. 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 January 21, 2026. 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 January 21, 2026. www.medicaid.ohio.gov
10. *Office of Policy Hospital Billing Guidelines*. Ohio Dept of Medicaid. Revised July 26, 2021. Accessed January 21, 2026. 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 January 21, 2026. www.medicaid.ohio.gov
12. Utilization Review, OHIO ADMIN. CODE 5160-2-13 (2022).

Approved by Ohio Dept. of Medicaid 06/05/2026