



ADMINISTRATIVE POLICY STATEMENT

Ohio Medicaid

Policy Name & Number	Date Effective
Provider Home Visits-OH MCD-AD-1165	08/01/2026
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

Provider Home Visits

B. Background

Provider home visits are medical care visits rendered in the home setting to a member for the examination, diagnosis, and/or treatment of an injury or illness. For the purposes of this policy, home is defined as the member's place of residence, including private residence/domicile, assisted living facility, group home, custodial care facility, long-term care facility, or skilled nursing facility.

C. Definitions

- **Home** – A member's place of residence, including private residence/domicile, assisted living facility, group homes, custodial care facility, long-term care facility, or skilled nursing facility.
- **Network (Participating) Provider** – Any provider, group of providers, or entity that has a network provider contract with CareSource to provide services to members.
- **Place of Service (POS)** – A 2-digit code that indicates the setting in which a service was provided.
- **Provider** – A hospital, health care facility, physician, dentist, pharmacy, or otherwise licensed or certified appropriate individual or entity that is authorized to or may be entitled to reimbursement for health care-related services rendered to a CareSource member.
- **Out of Network (Non-Participating) Provider** – Any provider, group of providers, or entity who is not contracted with CareSource to provide services to its members.
- **Services** – Services that occur in the member's place of residence that typically would be performed in an office/outpatient setting, such as evaluation and management (E&M) visits, wound care, podiatry care, eye care, etc.

D. Policy

- I. CareSource reimburses participating or non-participating providers for services performed in a member's place of residence that usually can be performed at an office visit.
 - A. CareSource will reimburse providers according to the Medicaid fee schedule.
 - B. Durable medical equipment (DME) services in the place of residence are subject to medical necessity review and should be provided by an in-network (participating) provider.
 - C. Ancillary services, such as labs and x-ray services, in the place of residence are subject to medical necessity review and should be provided by an in-network (participating) provider.
- II. Claim submission must include the appropriate Current Procedural Terminology (CPT) codes along with any applicable modifier with the appropriate place of service (POS) code. POS for provider services in the member's place of residence should include one of the following:

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

- A. POS 12 – Home
 - B. POS 13 – Assisted Living Facility
 - C. POS 14 – Group Home
 - D. POS 31 – Skilled Nursing Facility (SNF)
 - E. POS 32 – Nursing Facility
 - F. POS 33 – Custodial Care Facility
- III. CareSource reimburses for services that occur in the member's place of residence that typically would be performed in an office/outpatient setting, such as E&M visits, wound care, podiatry care, eye care, etc.
- A. CareSource members do not need to be confined to a place of residence to receive services rendered by a provider.
 - B. The CareSource member's medical record must document the medical necessity of the visit made in place of residence.
 - C. A visit cannot be billed by a provider unless the provider was actually present in the member's place of residence.
- IV. Services performed in the member's place of residence may be subject to review. CareSource may request documentation of services performed. Appropriate and complete documentation must be presented at the time of review to validate medical necessity. If medical necessity is not confirmed based on the documentation submitted, recoupment may occur.
- E. Conditions of Coverage
NA
- F. Related Policies/Rules
Medical Necessity Determinations

G. Review/Revision History

DATE		ACTION
Date Issued	01/01/2019	New policy
Date Revised	02/16/2022	Converted from PY-0444 to AD-1165. Changed physician to provider to more inclusive. Approved at PGC.
	05/10/2023	Annual review. Update reference. Approved at Committee.
	01/17/2024	Annual review. Updated references. Added related policy. Approved at Committee.
	04/09/2025	Periodic review. Updated references. Approved at Committee
	05/06/2026	Review: revised POS names and updated references. Approved at Committee.
Date Effective	08/01/2026	
Date Archived		

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H. References

1. Managed Care: Definitions, OHIO ADMIN. CODE 5160-26-01 (2022).
2. *Ohio Medicaid Provider Agreement for Managed Care Organization*. Ohio Dept of Medicaid. 2026. Accessed April 21, 2026. www.medicaid.ohio.gov
3. *Ohio Medicaid Provider Manual*. CareSource; 2025. Accessed April 21, 2026. www.caresource.com
4. Place of service codes for professional claims. Centers for Medicare & Medicaid Services. Updated May 2, 2024. Accessed April 21, 2026. www.cms.gov

Approved ODM 05/19/2026

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