# ADMINISTRATIVE POLICY STATEMENT
# Ohio MyCare

| Policy Name & Number | Date Effective |
|---|---|
| Provider Home Visits-OH MyCare-AD-1069 | 09/01/2023 |
| **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

**Provider Home Visits**

B. Background

Provider home visits are medical care visits rendered in the home setting to an individual for the examination, diagnosis, and/or treatment of an injury or illness. For the purposes of this policy, home is defined as the individual'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** – An individual's place of residence, including private residence/domicile, assisted living facility, group homes, custodial care facility, long-term care facility, or skilled nursing facility.
- **Participating Provider** – A provider that is contracted with CareSource to service members.
- **Place of Service (POS)** – A two-digit code that indicates the setting in which a service was provided.
- **Provider** – A physician with an MD or DO, a podiatrist, a nurse practitioner, or a physician assistant.
- **Non-Participating Provider** – A provider that is not contracted with CareSource to service members.
- **Services** – Services that occur in the member's place of residence that normally 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 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 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.
   A. Place of service (POS) for provider services in the member's place of residence should include one of the following:
      1. POS 12 – Home
      2. POS 13 – Assisted Living
      3. POS 14 – Group Home

4. POS 31 – Skilled Nursing Facility (SNF)
5. POS 32 – Long-term Facility
6. POS 33 – Custodial Care/Rest Home

III. CareSource reimburses for services that occur in the member's place of residence that normally 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 provided 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
NA

G. Review/Revision History

| | DATES | ACTION |
|---|---|---|
| **Date Issued** | 06/09/2021 | New policy |
| **Date Revised** | 02/16/2022<br><br>05/10/2023 | Change physician to provider to more inclusive. Approved at PGC.<br>No changes. Updated references. Approved at Committee. |
| **Date Effective** | 09/01/2023 | |
| **Date Archived** | | |

H. References
1. Places of service codes for professional claims. Centers for Medicare & Medicaid Services. September 2021. Accessed March 27, 2023. www.cms.gov.