



ADMINISTRATIVE POLICY STATEMENT

Ohio MyCare

Policy Name & Number	Date Effective
Provider Home Visits-MyCare OH FIDE-AD-1589	08/01/2026
Policy Type	
ADMINISTRATIVE	

Administrative Policy Statements 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 or Certificate of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other plan policies and procedures.

Administrative Policy Statements do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage or Certificate of Coverage) for the service(s) referenced in the Administrative Policy Statement. Except as otherwise required by law, if there is a conflict between the Administrative Policy Statement and the plan contract, then the plan contract 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.
- **Participating Provider** – A provider contracted with CareSource to provide service(s) to members.
- **Place of Service (POS)** – A 2-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 who is not contracted with CareSource to provide service(s) to 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.
 - D. CareSource members do not need to be confined to a place of residence to receive services.
 - E. The member's medical record must document the medical necessity of the visit made in place of residence.
 - F. A visit cannot be billed by a provider unless the provider was actually present in the member's place of residence.

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

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, including 1 of the following:

- 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

E. Conditions of Coverage

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.

F. Related Policies/Rules

Medical Necessity Determinations

G. Review/Revision History

DATES		ACTION
Date Issued	07/16/2025	New policy. Approved at Committee.
Date Revised	05/06/2026	Review: revised POS names and added Med Nec policy. Approved at Committee.
Date Effective	08/01/2026	
Date Archived		

H. References

1. Place of service codes for professional claims. Centers for Medicare & Medicaid Services. Updated May 2, 2024. Accessed April 21, 2026. www.cms.gov

ODM Approved 05/19/2026

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