








**Prior-Authorization Requirements
HMO, EPO, PPO and Senior Care Plus Plans**

| Services |  Renown[®] HEALTH PLAN <small>Brought to you by Hometown Health</small> HMO Plans |  Hometown Health <small>Plan</small> EPO Plans |  Hometown Health <small>Providers</small> PPO Plans |  Senior Care Plus Renown[®] PREFERRED PLAN <small>Brought to you by Senior Care Plus</small> SCP HMO Plans |
|--|---|--|---|---|
| Acupuncture | No | No | No | Yes |
| Autism Services | Yes | Yes | Yes | N/A |
| Cardiac Rehabilitation | No | No | No | No |
| Chemotherapy | Yes- see Medical Benefit Drug Matrix | Yes- see Medical Benefit Drug Matrix | Yes- see Medical Benefit Drug Matrix | Yes- see Medical Benefit Drug Matrix |
| Dialysis Treatment | No | No | No | No |
| Drugs - Medical Specialty Drugs | Yes- see Medical Benefit Drug Matrix | Yes- see Medical Benefit Drug Matrix | Yes- see Medical Benefit Drug Matrix | Yes- see Medical Benefit Drug Matrix |
| Durable Medical Equipment | Yes - Cost greater than \$500 per item | Yes - Cost greater than \$500 per item | Yes - Cost greater than \$500 per item | Yes - Cost greater than \$500 per item |
| Gastric Restrictive | Yes - All Services | Yes - All Services | Yes - All Services | Yes - All Services |
| Genetic Counseling & Testing | Yes - All Services | Yes - All Services | Yes - All Services | Yes - All Services |
| Hearing Aids | No - See Plan Document for Coverage | No - See Plan Document for Coverage | No - See Plan Document for Coverage | No - See Plan Document for Coverage |
| Home Health Care | No | No | No | No |
| Hospice | No | No | No | No |
| Infertility Diagnostic X-Ray Screening | Yes | Yes | Yes | N/A |
| Infertility Laboratory Screening | Yes | Yes | Yes | N/A |
| Infusion Therapy | Yes- see Medical Benefit Drug Matrix | Yes- see Medical Benefit Drug Matrix | Yes- see Medical Benefit Drug Matrix | Yes- see Medical Benefit Drug Matrix |
| Hospital - Inpatient | Yes - except for Newborn and Maternity Care up to 48 hours for a vaginal delivery and 96 hours for a cesarean section | Yes - except for Newborn and Maternity Care up to 48 hours for a vaginal delivery and 96 hours for a cesarean section | Yes - except for Newborn and Maternity Care up to 48 hours for a vaginal delivery and 96 hours for a cesarean section | Yes |
| Hospital - Observation | Yes | Yes | Yes | Yes |
| Mental Health - Inpatient | Yes | Yes | Yes | Yes |
| Mental Health - Outpatient | Yes - CPT 90867-90869 | Yes - CPT 90867-90869 | Yes - CPT 90867-90869 | Yes - CPT 90867-90869 |
| Nutrition - Medical Therapy/ Special Food Products | Yes - CPT B4161, S9434, S9435 | Yes - CPT B4161, S9434, S9435 | Yes - CPT B4161, S9434, S9435 | No |

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| <p align="center">Services</p> |  <p align="center">HMO Plans</p> |  <p align="center">EPO Plans</p> |  <p align="center">PPO Plans</p> |  <p align="center">SCP HMO Plans</p> |
|---|--|---|---|---|
| Occupational Therapy - Outpatient | Yes - Greater than 20 visits/cal yr | Yes - Greater than 20 visits/cal yr | Yes - Greater than 20 visits/cal yr | Yes - Greater than 20 visits/cal yr |
| Organ Transplants - All Services | Yes | Yes | Yes | Yes |
| Ostomy Supplies | No | No | No | No |
| Out of Network Services | Yes | Yes | Yes | Yes |
| Pain Management | Yes - see Pain Management Codes | Yes - see Pain Management Codes | Yes - see Pain Management Codes | Yes - see Pain Management Codes |
| Physiatry - Outpatient Treatment | Yes - see Pain Management Codes | Yes - see Pain Management Codes | Yes - see Pain Management Codes | Yes - see Pain Management Codes |
| Physical Therapy - Outpatient | Yes - Greater than 20 visits/cal yr | Yes - Greater than 20 visits/cal yr | Yes - Greater than 20 visits/cal yr | Yes - Greater than 20 visits/cal yr |
| Prosthetic & Orthopedic Devices | Yes - Cost greater than \$800 | Yes - Cost greater than \$800 | Yes - Cost greater than \$800 | Yes - Cost greater than \$800 |
| Pulmonary Rehabilitation - Outpatient | No | No | No | No |
| Radiation Therapy | Yes - see Radiation Therapy Codes | Yes - see Radiation Therapy Codes | Yes - see Radiation Therapy Codes | Yes - see Radiation Therapy Codes |
| Second Opinion Services | Yes | Yes | Yes | Yes |
| Skilled Nursing Facilities | Yes | Yes | Yes | Yes |
| Specialist Office Visits | Yes - For IFP HMO only except for OB/GYN, Pediatrician, & contracted Walk-in Clinics. Must have office visit auth on file for ALL SERVICES provided in the office | No | No | No |
| Speech Therapy - Outpatient | Yes - Greater than 20 visits/cal yr | Yes - Greater than 20 visits/cal yr | Yes - Greater than 20 visits/cal yr | Yes - Greater than 20 visits/cal yr |
| Substance Abuse Detoxification - Inpatient | Yes | Yes | Yes | Yes |
| Substance Abuse - Partial Stay/Day Hospitalization | No | No | No | No |
| Substance Abuse Treatment - Outpatient | No | No | No | No |
| Supervised Exercise Therapy *See definition below | No | No | No | No |
| Surgical Services - Ambulatory Surgery Center | Yes - Except Breast Biopsies & Colonoscopies | Yes - Except Breast Biopsies & Colonoscopies | Yes - Except Breast Biopsies & Colonoscopies | Yes - Except Breast Biopsies & Diagnostic/Screening Colonoscopies |
| Surgical Services - In Office | Yes - Cost greater than \$750 | Yes - Cost greater than \$750 | Yes - Cost greater than \$750 | No |

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|---|---|--|---|--|
| Surgical Services - Outpatient Hospital Facility | Yes - Except Breast Biopsies & Colonoscopies | Yes - Except Breast Biopsies & Colonoscopies | Yes - Except Breast Biopsies & Colonoscopies | Yes - Except Breast Biopsies & Diagnostic/Screening Colonoscopies |
| Transportation - Air Ambulance (Emergent) | No | No | No | No |
| Transportation - Non Emergent | Yes | Yes | Yes | Yes |
| Wound Therapy - Outpatient clinic visits | Yes- Greater than 12 visits/ cal yr | Yes- Greater than 12 visits/ cal yr | Yes- Greater than 12 visits/ cal yr | Yes- Greater than 12 visits/ cal yr |
| Wound Therapy - Hyperbaric Treatment | Yes | Yes | Yes | Yes |
| Wound Therapy - Biological skin therapies | Yes | Yes | Yes | Yes |

Hometown Health performs Utilization Review only to precertify the medical necessity of the requested services for the care and treatment of an illness or injury. Hometown Health will also review for alternative methods of medical care or treatment. Precertification by Hometown Health does not guarantee that all charges are covered under the policy. Charges submitted for payment are subject to all terms of the policy.

***Supervised Exercise Therapy:** Consists of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for Peripheral artery disease (PAD) in patients with claudication. Delivered by qualified auxiliary personnel who are trained in exercise therapy for PAD, and under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist.