

Self-Funded Auth Matrix

Medical Services	Renown Health PPO, HMO, HDHP	Carson Tahoe Health System	Douglas County School District	Atlantis	Caesars	NDOC
Acupuncture	No	No	Not Covered	Not Covered	No	
ADD/ADHD	No	No	Yes	Not Covered	No	
Anesthesia or Monitored Anesthesia rendered in ASC	No	No	No	No	Yes	
Autism Services	No	No	No	Not Covered	No	
Botox Injections	Yes	N/A	No	No	Yes	
Cardiac Rehabilitation	No	No	No	No	Yes	
Cardiac Studies	No	No	No	No	Yes	
Chemotherapy	Yes	Yes	Yes- if performed in freestanding ASC or Hospital	No	Yes	
Cochlear Implants	Yes	Yes	Not Covered	Not Covered	Yes	
Dialysis Treatment	No	Yes	Yes- if performed in freestanding ASC or Hospital	No	Yes	
Drugs - Medical Specialty Drugs	Yes- see Medical Benefit Drug Matrix	Yes- see Medical Benefit Drug Matrix	Yes- if performed in freestanding ASC or Hospital	No	Yes- see Medical Benefit Drug Matrix	
Durable Medical Equipment	Yes- Greater than \$500	Yes - Greater than \$750	No	No	Yes - Greater than \$500 for Rental Greater than \$1500 for purchase	
Experimental/investigational and benefit related procedures*	Not Covered	Yes	Not Covered	Not Covered	Yes	
Gastric Restrictive	Yes	Yes	Not Covered	Not Covered	Yes	
Gender Assignment/Reassignment	Yes - ALL SERVICES	Yes - Surgery Services	Yes	Not Covered	Yes - ALL SERVICES	
Gene Therapy	No	Yes	Yes	No	Yes	
Genetic Counseling & Testing	Yes	Yes	Yes	Not Covered	Yes	
Hearing Aids	Not Covered	Not Covered	Not Covered	Not Covered	No	
Home Health Care	No	No	No	No	Yes	
Hospice	No	No	No	No	No	
Infertility Diagnostic X-Ray Screening	Yes	No	Not Covered	No	No	
Infertility Laboratory Screening	Yes	No	Not Covered	No	No	
Infusion Therapy	Yes	Yes	Yes- if performed in freestanding ASC or Hospital	No	Yes	
Labs/X-ray Services (NON ROUTINE) To include anything that is billed outside of an annual exam, Urgent Care, or Emergent situation, or for the treatment of Diabetes. This includes but is not limited to diagnostic X-rays, Ultrasounds, labs, and Stress tests.	No	No	No	No	Yes	
Hospital - Inpatient	Yes	Yes	Yes	Yes EXCEPTION: Pre-certification review will not be required for an Inpatient admission for Pregnancy delivery that does not exceed 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery. However, if/when the pregnancy confinement for the mother or newborn is expected to exceed these limits, prior authorization for such extended confinement is required.	Yes	
Hospital - Observation	Yes	Yes	Yes	Yes	Yes	
Mental Health - Inpatient	Yes	Yes	Yes	Not Covered	Yes	
Mental Health - Outpatient	No	No	No	Not Covered	No	
Nuclear Medicine	No	Yes	No	No	No	
Nutrition - Medical Therapy/ Special Food Products	Yes - For special food products	Yes - Feeding Supplies & Food	No	Nutritional Counseling covered under Diabetic Counseling. Special food products- NOT COVERED	Yes - For special food products	

ALL SERVICES REQUIRE PRIOR AUTH
OBTAIN WITH THE BELOW EMAIL
For Medicaid email
medicaidbilling@doc.nv.gov and for
Hometown Health
medicabilling@doc.nv.gov

Self-Funded Auth Matrix

Medical Services	Renown Health	Carson Tahoe Health System	Douglas County School District	Atlantis	Caesars	NDOC
Occupational Therapy - Outpatient	Yes- Greater than 20 visits	Yes- Greater than 30 visits	No	Yes- Greater than 30 visits	No	
Organ Transplants - All Services	Yes	Yes	Yes	Yes - ALL SERVICES	Yes - ALL SERVICES	
Ostomy Supplies	Yes	Yes	No	No	Yes - Greater than \$500 for Rental Greater than \$1500 for purchase	
Out of Network Services	No	No	No	No	No	
Oxylite	No	No	No	No	Yes	
Pain Management / Psychiatry - Outpatient	Yes	No	No	No	Yes	
Physical Therapy - Outpatient	Yes- Greater than 20 Visits	Yes- Greater than 30 visits	No	Yes- Greater than 30 visits	No	
Prosthetic & Orthopedic Devices	Yes- Greater than \$800	Yes - Greater than \$750	No	No	Yes- Greater than \$500	
Pulmonary Rehabilitation - Outpatient	No	No	No	No	No	
Radiation Therapy	Yes	Yes	Yes- if performed in freestanding ASC or Hospital	No	Yes	
Second Opinion Services	Yes	Yes	Yes	No	No	
Skilled Nursing Facilities	Yes	Yes	Yes	No	Yes	
Sleep Studies	No	No	No	No	Yes	
Specialist Office Visits	No - Exception: if the specialty office visit is with a plastic surgery provider, prior authorization (PA) is required.	No	No	No	No	
Speech Therapy - Outpatient	Yes- greater than 20 visits	Yes- Greater than 30 visits	No	Yes- Greater than 30 visits	Yes	
Substance Abuse Detoxification - Inpatient	Yes	Yes	Yes	Not Covered	Yes	
Substance Abuse - Partial Stay/Day Hospitalization	Yes	Yes	Yes	Not Covered	Yes	
Substance Abuse Treatment - Outpatient	No	No	No	Not Covered	Yes	
Surgical Services - In Office	Yes- Greater than \$750 (total billed)	Yes- Greater than \$750 (total billed)	No	No	No	
Surgical Services - Outpatient Hospital Facility or Ambulatory Surgery Center	Yes - Greater than \$750 (total Billed) EXCEPTION: diagnostic and screening colonoscopies and breast biopsies.	Yes EXCEPTION: diagnostic and screening colonoscopies and breast biopsies.	Yes	Yes EXCEPTION: diagnostic and screening colonoscopies and breast biopsies.	Yes - Greater than \$750 (total Billed) EXCEPTION: diagnostic and screening colonoscopies and breast biopsies.	
Spinal Procedures/Conditions/Services, including but not limited to: discograms/ discography; MRIs (cervical to sacrum); CT Scans (cervical to sacrum); trigger point injections (related to back and spine); epidurals; medial branch blocks; facet injections; electromyography/nerve conduction studies; Inpatient admissions related to the spine/spinal procedures; elective hospitalizations and procedures for spinal conditions; Inpatient and Outpatient surgery of the spine; physical/occupational therapy related to the spine beyond 15 visits per diagnosis per body part; chiropractic care beyond 15 visits per diagnosis per body part; passive modalities for spinal conditions where there is a question of the curative nature of the treatment, including, but not limited to: acupuncture, DME modalities, pool therapy, TENS/PENS units, electrical stimulators, hot/cold therapy and traction; and specialist referrals for consultation, including but not limited to referrals to orthopedic specialists and neurosurgeons, for spinal conditions.	No	No	No	No	Yes	
PET Scan, MRI, CT, EEG	No	Yes	No	No	No	
Transportation - Air Ambulance (Emergency)	Yes	Yes	Yes	No	No	
Transportation - Non Emergent	Yes	Yes	Yes	Yes	Yes	
Varicose Veins	Yes	Yes	No	Yes	Yes	
Wound Therapy - Outpatient clinic visits	Yes - greater than 12 visits	Yes	No	No	Yes	
Wound Therapy - Hyperbaric Treatment	Yes	Yes	No	No	Yes	
Wound Therapy - Biological skin therapies	Yes	Yes	No	No	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.						
*Definitions are per the Plan Evidence of Coverage						
Pre-certification does not guarantee that all charges are covered. Benefits are subject to all of the terms of the Plan.						
ALL SERVICES REQUIRE PRIOR AUTH OBTAIN WITH THE BELOW EMAIL For Medicaid email medicaidbilling@doc.nv.gov and for Hometown Health medicaidbilling@doc.nv.gov						