









<b>Medical Services</b>	 <b>HMO Plans</b>  <i>* PLEASE NOTE: All services done in a specialist office for IFP HMO members require line item authorization for each service requested*</i>	 <b>EPO Plans</b>	 <b>PPO Plans</b>	 <b>SCP HMO Plans</b>
Acupuncture	No <b>*IFP HMO Requires Auth</b>	No	No	Yes Washoe County (EGWP) Does Not Require Authorization
Autism Services	No	No	No	N/A
Cardiac Rehabilitation	No	No	No	No
Cardiac Studies	Yes - Refer to Radiology & Cardiac Studies Authroization Matrix	Yes - Refer to Radiology & Cardiac Studies Authroization Matrix	Yes - Refer to Radiology & Cardiac Studies Authroization Matrix	Yes - Refer to Radiology & Cardiac Studies Authroization Matrix
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
Dry Needling	Yes - CPT 20560-20561	Yes - CPT 20560-20561	Yes - CPT 20560-20561	Yes - CPT 20560-20561
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
Experimental/investigational and benefit related procedures*	Yes	Yes	Yes	Yes
Gastric Restrictive	Yes - All Services	Yes - All Services	Yes - All Services	Yes - All Services
Genetic Counseling & Testing	Yes - All Services (except CPT code 81420)	Yes - All Services (except CPT code 81420)	Yes - All Services (except CPT code 81420)	Yes - All Services (except CPT code 81420)
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	Billed under Medicare Fee For Service
Infertility Diagnostic X-Ray Screening	Yes	Yes	Yes	Not a Covered Benefit
Infertility Laboratory Screening	Yes	Yes	Yes	Not a Covered Benefit
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 or Observation	Yes - Notification Required Within 24 Hours	Yes - Notification Required Within 24 Hours	Yes - Notification Required Within 24 Hours	Yes - Notification Required Within 24 Hours
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
Occupational Therapy - Outpatient	Yes - Greater than 20 Visits per Calendar Year	Yes - Greater than 20 Visits per Calendar Year	Yes - Greater than 20 Visits per Calendar Year	Yes - Greater than 20 Visits per Calendar Year

<b>Medical Services</b>	 <b>HMO Plans</b>  <i>* PLEASE NOTE: All services done in a specialist office for IFP HMO members require line item authorization for each service requested*</i>	 <b>EPO Plans</b>	 <b>PPO Plans</b>	 <b>SCP HMO Plans</b>
Organ Transplants - All Services	Yes	Yes	Yes	Yes
Ostomy Supplies	No	No	No	No
Out of Network Services (OON)	Yes	Yes	No Auth Required to See OON Provider Service Auth Requirements Apply per Authorization Matrix	Yes
Pain Management / Psychiatry - Outpatient	Yes - See Pain Management Auth Matrix <b>IFP HMO - Yes - If done in a specialist office will need line item authorization for ALL pain management codes requested</b>	Yes - See Pain Management Authorization Matrix	Yes - See Pain Management Authorization Matrix	Yes - See Pain Management Authorization Matrix
Physical Therapy - Outpatient	Yes - Greater than 20 Visits per Calendar Year	Yes - Greater than 20 Visits per Calendar Year	Yes - Greater than 20 Visits per Calendar Year	Yes - Greater than 20 Visits per Calendar Year
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 - Refer to Radiation Therapy Authorization Matrix	Yes - Refer to Radiation Therapy Authorization Matrix	Yes - Refer to Radiation Therapy Authorization Matrix	Yes - Refer to Radiation Therapy Authorization Matrix
Radiology Studies	Yes - Refer to Radiology, Cardiac Studies and Radiation Therapy Authorization Matrix	Yes - Refer to Radiology, Cardiac Studies and Radiation Therapy Authorization Matrix	Yes - Refer to Radiology, Cardiac Studies and Radiation Therapy Authorization Matrix	Yes - Refer to Radiology, Cardiac Studies and Radiation Therapy Authorization Matrix
Second Opinion Services	Yes	Yes	Yes	Yes
Skilled Nursing Facilities	Yes	Yes	Yes	Yes
<b>Specialist Office Visits</b> <b>**For IFP HMO - Specialist includes all service providers except primary care, OB/GYN, and pediatrics</b>	<b>Yes for IFP HMO Plans ONLY</b> <b>Referral from an HMO network PCP, OB/GYN or Pediatrician required for all Specialists Visits</b> <b>*PLEASE NOTE: All services done in a specialist office for IFP HMO members require line item authorization for each service requested*</b>	No	No	No
Speech Therapy - Outpatient	Yes - Greater than 20 Visits per Calendar Year	Yes - Greater than 20 Visits per Calendar Year	Yes - Greater than 20 Visits per Calendar Year	Yes - Greater than 20 Visits per Calendar Year
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
Surgical Services - In Office	Yes - Cost Greater than \$1000	Yes - Cost Greater than \$1000	Yes - Cost Greater than \$1000	No

<b>Medical Services</b>	 <b>HMO Plans</b>  <i>* PLEASE NOTE: All services done in a specialist office for IEP HMO members require line item authorization for each service requested*</i>	 <b>EPO Plans</b>	 <b>PPO Plans</b>	 <b>SCP HMO Plans</b>
<b>Surgical Services - Outpatient Hospital Facility or Ambulatory Surgery Center</b>	Yes Except Breast Biopsies (cpt 19081 - 19086; 19100 - 19101) & Diagnostic/Screening Colonoscopies (cpt 44388 - 44408; 45378 - 45398) & Cystourethroscopy (cpt 52353, 52332, 52356)	Yes Except Breast Biopsies (cpt 19081 - 19086; 19100 - 19101) & Diagnostic/Screening Colonoscopies (cpt 44388 - 44408; 45378 - 45398) & Cystourethroscopy (cpt 52353, 52332, 52356)	Yes Except Breast Biopsies (cpt 19081 - 19086; 19100 - 19101) & Diagnostic/Screening Colonoscopies (cpt 44388 - 44408; 45378 - 45398) & Cystourethroscopy (cpt 52353, 52332, 52356)	Yes Except Breast Biopsies (cpt 19081 - 19086; 19100 - 19101) & Diagnostic/Screening Colonoscopies (cpt 44388 - 44408; 45378 - 45398) & Cystourethroscopy (cpt 52353, 52332, 52356)
<b>Transportation - Air Ambulance (Emergent)</b>	No	No	No	No
<b>Transportation - Non Emergent</b>	Yes	Yes	Yes	Yes
<b>Wound Therapy - Outpatient clinic visits</b>	Yes - Greater than 20 Visits per Calendar Year	Yes - Greater than 20 Visits per Calendar Year	Yes - Greater than 20 Visits per Calendar Year	Yes - Greater than 20 Visits per Calendar Year
<b>Wound Therapy - Hyperbaric Treatment</b>	Yes	Yes	Yes	Yes
<b>Wound Therapy - Biological skin therapies</b>	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.				
*Definitions are per the Plan Evidence of Coverage				