Utilization Management and Case Management Services

The State of Nevada Public Employees' Benefits Program (PEBP) has contracted with Hometown Health to provide utilization management (UM) services and large case management (CM) services for both their Consumer Driven Health Plan (CDHP) and PEBP Premier Plan (EPO) effective 7/1/2018.

For Utilization Management service requests, providers have several options for submission:

- Approved providers may submit requests directly through our HealthConnect portal. For those providers that need to enroll for access to HealthConnect, please call 775-982-3233.
- Hometown Health will accept precertification requests via fax at 775-982-3744 (form is on the next page).
- Hometown Health will also accept precertification requests and/or supporting clinical information via phone at 775-982-3232 or 1-888-323-1461.

Although this should not be considered an all inclusive list, below are some of the services that require precertification. Failure to precertify will result in a reduction in benefits. Please refer to the corresponding Master Plan Document for more information on precertification requirements.

- All elective inpatient hospital admissions. (Exception: a pregnant mother does not need to notify Hometown Health about the admission for delivery unless the stay will exceed 48 hours for a vaginal delivery or 92 hours for a C-Section)
- All admissions to a skilled nursing facility or sub-acute facility
- All outpatient surgeries performed in a surgery center or outpatient hospital setting
- All organ/tissue pre-transplantation related expenses, including the admission for transplantation services
- Hip surgery
- Knee surgery
- Cardiac pacemakers
- Genetic testing and/or counseling
- Weight loss surgery
- Air ambulance for scheduled inter-facility transport
- Dialysis: inpatient or outpatient
- Illnesses requiring chemotherapy
- Any procedure that might be deemed to be experimental and/or investigational
- Gender Dysphoria – any services related to the diagnosis of or treatment of gender dysphoria
- Durable Medical Equipment over $1,000 (CDHP)
- Prosthetic and orthopedic devices over $100 (EPO)
- Infusion therapy including outpatient and home infusion services

Hometown Health will provide large case management services for participants requiring assistance with complex, costly and/or high technology medical services such as organ and tissue transplants, cancer treatments, and head injuries. Referral requests for case management may be called into 775-982-3232 or 1-888-323-1461.

If you have any questions or concerns, please contact Hometown Health at 775-982-3232/1-888-323-1461 or HealthSCOPE Benefits at 1-888-763-8232. Hometown Health looks forward to assisting you in serving PEBP members.

Medical Prior Authorization

NEVADA PUBLIC EMPLOYEES' BENEFITS PROGRAM

Hometown Health

Date: ____/____/____

Section 1 General Information

Review Type: ☐ **Standard** ☐ **Expedited** Clinical Reason for Expedited: _____

An expedited request is one that by applying the standard time for making a determination could seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Section 2 Member Receiving Services

Name	Phone	DOB / /	☐ Male ☐ Female ☐ Other ☐ Unknown
Street Address City State Zip		Member ID Number	Plan

Section 3 Provider Information

Requesting Provider/Group				Servicing Provider or Facility			
Name		Specialty		Name		Specialty	
Street Address	City	State	Zip	Street Address	City	State	Zip
NPI Number	Tax ID Number			NPI Number	Tax ID Number		
Phone	Fax			Phone	Fax		
Contact Name	Phone						

Section 4 Services Requested (with CPT, CDT, or HCPCS Code) and Supporting Diagnoses (with ICD 10 Code)

Requested Service or Procedure	Code	Start Date	End Date	Diagnosis Description	Code

☐ Inpatient ☐ Outpatient Surgery ☐ Observation ☐ Ambulatory ☐ Specialist Office Visit (Number of Visits) _____ ☐ Other _____

☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy ☐ Cardiac Rehab ☐ Mental Health/Substance Abuse

Number of Sessions _____ Duration _____ Frequency _____ Other _____

☐ Home Health (MD Signed Order Attached? ☐ Yes ☐ No) (Nursing Assessment Attached? ☐ Yes ☐ No)

Number of Visits _____ Duration _____ Frequency _____ Other _____

☐ DME (MD Signed Order Attached? ☐ Yes ☐ No)

Section 5 Additional Information