HUSKY Health Program Benefits and Prior Authorization Requirements Grid*
Clinic - Ambulatory Surgical Center
Effective: January 1, 2012

Member Services: 800-859-9889
Authorizations: 800-440-5071 Option #2
Authorization Fax: 203-265-3994

Benefit	HUSKY A, HUSKY C (ABD)	HUSKY B	HUSKY D (LIA)
Ambulatory Surgical Center	100% covered – Limited to procedures listed on the DSS Clinic – Ambulatory Surgical Center Fee Schedule **Not all procedures require Prior Authorization. Refer to the list under Procedures requiring Prior Authorization regardless of where procedure is performed** **Authorization Required for:** **Outpatient procedure turned inpatient. Hospital must notify CHNCT Auth unit and request authorization within 2 business days**	100% covered, no copay - Limited to procedures listed on the DSS Clinic – Ambulatory Surgical Center Fee Schedule **Not all procedures require Prior Authorization. Refer to the list under Procedures requiring Prior Authorization regardless of where procedure is performed** **Authorization Required for:** **Outpatient procedure turned inpatient. Hospital must notify CHNCT Auth unit and request authorization within 2 business days**	100% covered - Limited to procedures listed on the DSS Clinic – Ambulatory Surgical Center Fee Schedule **Not all procedures require Prior Authorization. Refer to the list under Procedures requiring Prior Authorization regardless of where procedure is performed** **Authorization Required for:** **Outpatient procedure turned inpatient. Hospital must notify CHNCT Auth unit and request authorization within 2 business days**
Obesity	Treatment for obesity is not a covered benefit unless caused by an illness or is aggravating an illness, (including but not limited to cardiac and respiratory conditions, diabetes and hypertension) and then requires prior authorization for Medical Necessity	Treatment for obesity is not a covered benefit unless caused by an illness or is aggravating an illness, (including but not limited to cardiac and respiratory conditions, diabetes and hypertension) and then requires prior authorization for Medical Necessity	Treatment for obesity is not a covered benefit unless caused by an illness or is aggravating an illness, (including but not limited to cardiac and respiratory conditions, diabetes and hypertension) and then requires prior authorization for Medical Necessity
Procedures requiring Prior Authorization	Tattooing Collagen injections Insertion and removal of tissue expanders	Tattooing Collagen injections Insertion and removal of tissue expanders	Tattooing Collagen injections Insertion and removal of tissue expanders

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MMTPE0001-0312

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Benefit	HUSKY A, HUSKY C (ABD)	HUSKY B	HUSKY D (LIA)
(For a full listing of procedures requiring prior authorization please refer to the DSS Fee Schedule).	Dermabrasion Abrasion Chemical Peel Cervicoplasty Blepharoplasty Lipectomy/Liposuction Destruction of cutaneous vascular lesions Cryotherapy for acne Electrolysis Mastectomy for gynecomastia Mastopexy Breast reduction Breast augmentation Removal/insertion of breast implants Breast reconstruction TMJ related procedures **Oral splints – Pa required starting 2/1/12** **Interdental fixation devices – PA required starting 2/1/12** **Interdental wiring non-fracture – PA required starting 2/1/12** Canthopexy Otoplasty Rhinoplasty Septoplasty Varicose vein injection treatment or stab	Dermabrasion Abrasion Chemical Peel Cervicoplasty Blepharoplasty Lipectomy/Liposuction Destruction of cutaneous vascular lesions Cryotherapy for acne Electrolysis Mastectomy for gynecomastia Mastopexy Breast reduction Breast augmentation Removal/insertion of breast implants Breast reconstruction TMJ related procedures **Oral splint services – PA required starting 2/1/12** **Interdental fixation device services- PA required starting 2/1/12** **Interdental wiring non-fracture – PA required starting 2/1/12** Canthopexy Otoplasty Rhinoplasty Septoplasty	Dermabrasion Abrasion Chemical Peel Cervicoplasty Blepharoplasty Lipectomy/Liposuction Destruction of cutaneous vascular lesions Cryotherapy for acne Electrolysis Mastectomy for gynecomastia Mastopexy Breast reduction Breast augmentation Removal/insertion of breast implants Breast reconstruction TMJ related procedures **Oral splint services – PA required starting 2/1/12** **Interdental fixation device services-PA required starting 2/1/12** **Interdental wiring non-fracture-PA required starting 2/1/12** Canthopexy Otoplasty Rhinoplasty Septoplasty

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Benefit	HUSKY A, HUSKY C (ABD)	HUSKY B	HUSKY D (LIA)
	phlebotomy, **ligation and division of veins – PA required starting 2/1/12** TMJ related procedures/treatments Surgical treatment of Obesity Insertion/removal of penile implants **Female genital repair – PA required starting 2/1/12** Vaginoplasty for inter-sex state Procedures related to sterilization reversal Chemodenervation Blepharoptosis repair Brow ptosis repair Correction lid retraction Procedures to correct myopia, refractive errors and surgically induced astigmatism Procedures related to corneal prosthetics Genetic testing (see code list under genetic testing)	Varicose vein injection treatment or stab phlebotomy **ligation and division of veins – PA required starting 2/1/12** TMJ related procedures/treatments Surgical treatment of Obesity Insertion/removal of penile implants **Female genital repair – PA required starting 2/1/12** Vaginoplasty for inter-sex state Procedures related to sterilization reversal Chemodenervation Blepharoptosis repair Brow ptosis repair Correction lid retraction Procedures to correct myopia, refractive errors and surgically induced astigmatism Procedures related to corneal prosthetics Genetic testing (see code list under genetic testing category)	Varicose vein injection treatment or stab phlebotomy **ligation and division of veins – PA required starting 2/1/12** TMJ related procedures/treatments Surgical treatment of Obesity Insertion/removal of penile implants **Female genital repair – PA required starting 2/1/12** Vaginoplasty for inter-sex state Procedures related to sterilization reversal Chemodenervation Blepharoptosis repair Brow ptosis repair Correction lid retraction Procedures to correct myopia, refractive errors and surgically induced astigmatism Procedures related to corneal prosthetics Genetic testing (see code list under genetic testing)
Reconstructive surgery	**Prior Authorization Required**: Not a covered benefit except for surgery related to a malignant tumor or some other cases of surgeries needed to restore normal function.	**Prior Authorization Required**: Not a covered benefit except for surgery related to a malignant tumor or some other cases of surgeries needed to restore normal function.	**Prior Authorization Required**: Not a covered benefit except for surgery related to a malignant tumor or some other cases of surgeries needed to restore normal function.
Translation Services	1-800-440-5071	1-800-440-5071	1-800-440-5071

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Benefit EXCLUSIONS **This is a general listing of those exclusions most applicable to Ambulatory Surgical Centers and includes but is not limited to the following:**	• Infertility treatment (i.e. reversal sterilization; artificial insemination; invitro fertilization; fertility drugs) • All services of a plastic or cosmetic nature e.g. hair transplants, electrolysis • Care out of the country • Services for which prior authorization is required and is not obtained • Services that are considered to be of an unproven, experimental or research nature or cosmetic, social, habilitative, vocational, recreational or educational • Services that are not medically necessary • Services required by third parties, such as school or employers, court ordered testing, diagnostics, etc. • Services not within scope of practitioners scope of practice pursuant to state law • Nuclear powered pacemakers	• Infertility treatment (i.e. reversal sterilization; artificial insemination; invitro fertilization; fertility drugs) • Surgical treatment or hospitalization for the treatment of morbid obesity except where prior authorized medically necessary care, treatment, procedures, services or supplies that are primarily for dietary control including, but not limited to, any exercise weight reduction programs, whether formal or informal • All services of a plastic or cosmetic nature e.g. hair transplants, electrolysis. • Ambulatory BP monitoring • Services for which prior authorization is required and is not obtained • Services that are considered to be of an unproven, experimental or research nature or cosmetic, social, habilitative, vocational,	• Infertility treatment (i.e. reversal sterilization; artificial insemination; invitro fertilization; fertility drugs) • All services of a plastic or cosmetic nature e.g. hair transplants, electrolysis • Care out of the country • Services for which prior authorization is required and is not obtained • Services that are considered to be of an unproven, experimental or research nature or cosmetic, social, habilitative, vocational, recreational or educational • Services that are not medically necessary • Services required by third parties, such as school or employers, court ordered testing, diagnostics, etc. • Services not within scope of practitioners scope of practice pursuant to state law • Nuclear powered pacemakers

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	• Implantation of nuclear powered pacemakers • Services beyond what is necessary to treat the medical problems, • Services that have nothing to do with the illness or problem of the visit. • Services or items for which the provider does not usually charge • Drugs that are not approved by the FDA. • Services not usually performed by the provider • Sterilizations for patients who are under age twenty-one (21), mentally incompetent, or institutionalized • Hysterectomies performed solely for the purpose of rendering an individual permanently incapable of reproducing.	recreational or educational • Services that are not medically necessary • Services required by third parties, such as school or employers, court ordered testing, diagnostics, etc. • Services not within scope of practitioners scope of practice pursuant to state law • Nuclear powered pacemakers • Implantation of nuclear powered pacemakers • Sterilization • Services beyond what is necessary for treatment • Services not related to illness or problems at the time of treatment • Services or items for which the provider does not usually charge • Drugs not approved by the FDA.	• Implantation of nuclear powered pacemakers • Services beyond what is necessary to treat the medical problems, • Services that have nothing to do with the illness or problem of the visit. • Services or items for which the provider does not usually charge • Drugs that are not approved by the FDA. • Services not usually performed by the provider • Sterilizations for patients who are under age twenty-one (21), mentally incompetent, or institutionalized • Hysterectomies performed solely for the purpose of rendering an individual permanently incapable of reproducing.

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