



**HUSKY Health Benefits and Prior Authorization Requirements Grid\***

**Home Health  
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)
<b>Home Health Care Skilled Nursing</b>	<p><b><u>Prior Authorization Required For</u></b></p> <ul style="list-style-type: none"> <li>• Greater than 2 visits/week</li> <li>• Extended Nursing (Greater than 2 hours/day)</li> </ul> <p>Home infusion services are covered for members under the age of 21.</p> <p><u>Home infusions services are NOT covered for members 21 and over.</u></p>	<p><b><u>Prior Authorization Required For:</u></b></p> <ul style="list-style-type: none"> <li>• Greater than 2 visits/week</li> </ul> <p><b><u>Extended nursing is not a covered benefit under HUSKY B.</u></b> Home infusion services are covered for HUSKY B members.</p>	<p><b><u>Prior Authorization Required For:</u></b></p> <ul style="list-style-type: none"> <li>• Greater than 2 visits/week</li> <li>• Extended Nursing (Greater than 2 hours/day)</li> </ul> <p>Home infusion services are covered for members under the age of 21.</p> <p><u>Home infusions services are NOT covered for members 21 and over.</u></p>

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<b>Medication Administration</b>	<p><b><u>Med Admin RN or LPN -</u></b></p> <ul style="list-style-type: none"> <li>• <b><u>Prior Authorization required for:</u></b> greater than 2 visits/week.</li> </ul> <p><b><u>Med Admin RN or LPN -</u></b></p> <p><b><u>Pre-Pour for 1 week or more:</u></b></p> <ul style="list-style-type: none"> <li>• No PA required. Bill with skilled nursing code. If medication is not available for pre-pour, or if there is an adjustment in the dosage of a medication and the nurse must return to the home, the agency may bill a <u>medication administration code</u> for the second visit.</li> <li>• If a second skilled visit is required to complete a medication pre-pour for any other reason (newly prescribed medication, significant change in member's condition etc.), agency may bill a <b><u>skilled nursing visit code</u></b> for the second visit.</li> <li>• Ref: DSS PB 2009-34</li> </ul>	<p><b><u>Med Admin RN or LPN -</u></b></p> <ul style="list-style-type: none"> <li>• <b><u>Prior Authorization required for:</u></b> greater than 2 visits/week.</li> </ul> <p><b><u>Med Admin RN or LPN -</u></b></p> <p><b><u>Pre-Pour for 1 week or more:</u></b></p> <ul style="list-style-type: none"> <li>• No PA required. Bill with skilled nursing code. If medication is not available for pre-pour, or if there is an adjustment in the dosage of a medication and the nurse must return to the home, the agency may bill a <u>medication administration code</u> for the second visit.</li> <li>• If a second skilled visit is required to complete a medication pre-pour for any other reason (newly prescribed medication, significant change in member's condition etc.), agency may bill a <b><u>skilled nursing visit code</u></b> for the second visit.</li> <li>• Ref: DSS PB 2009-34</li> </ul>	<p><b><u>Med Admin RN or LPN -</u></b></p> <ul style="list-style-type: none"> <li>• <b><u>Prior Authorization required for:</u></b> greater than 2 visits/week.</li> </ul> <p><b><u>Med Admin RN or LPN -</u></b></p> <p><b><u>Pre-Pour for 1 week or more:</u></b></p> <ul style="list-style-type: none"> <li>• No PA required. Bill with skilled nursing code. If medication is not available for pre-pour, or if there is an adjustment in the dosage of a medication and the nurse must return to the home, the agency may bill a <u>medication administration code</u> for the second visit.</li> <li>• If a second skilled visit is required to complete a medication pre-pour for any other reason (newly prescribed medication, significant change in member's condition etc.) agency may bill a <b><u>skilled nursing visit code</u></b> for the second visit.</li> <li>• Ref: DSS PB 2009-34</li> </ul>

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Benefit	HUSKY A, HUSKY C (ABD)	HUSKY B	HUSKY D (LIA)
	<p><b>Med Admin HHA:</b>  <b><u>Nurse Delegated Medication Administration to Medication-certified HHA:</u></b></p> <ul style="list-style-type: none"> <li>Request PA using code T1021</li> <li>Prior Authorization required beginning with the first visit</li> <li>Ref: DSS Provider Bulletin 2014-44</li> </ul> <p><b><u>Personal Automated Medication Dispensers</u></b></p> <ul style="list-style-type: none"> <li>Request PA using code S5185</li> <li>Separate payment for automated medication dispensers for members covered by home and community based waiver programs or CHC is not allowed. Therefore code S5185 may NOT be authorized for these members.</li> <li>The initial authorization period may not exceed 30 days and must be accompanied by a minimum of one skilled nursing visit.</li> </ul>	<p><b>Med Admin HHA:</b>  <b><u>Nurse Delegated Medication Administration to Medication-certified HHA:</u></b></p> <ul style="list-style-type: none"> <li>Request PA using code T1021</li> <li>Prior Authorization required beginning with the first visit</li> <li>Ref: DSS Provider Bulletin 2014-44</li> </ul> <p><b><u>Personal Automated Medication Dispensers</u></b></p> <ul style="list-style-type: none"> <li>Request PA using code S5185</li> <li>Separate payment for automated medication dispensers for members covered by home and community based waiver programs or CHC is not allowed. Therefore code S5185 may NOT be authorized for these members.</li> <li>The initial authorization period may not exceed 30 days and must be accompanied by a minimum of one skilled nursing visit.</li> </ul>	<p><b>Med Admin HHA:</b>  <b><u>Nurse Delegated Medication Administration to Medication-certified HHA:</u></b></p> <ul style="list-style-type: none"> <li>Request PA using code T1021</li> <li>Prior Authorization required beginning with the first visit</li> <li>Ref: DSS Provider Bulletin 2014-44</li> </ul> <p><b><u>Personal Automated Medication Dispensers</u></b></p> <ul style="list-style-type: none"> <li>Request PA using code S5185</li> <li>Separate payment for automated medication dispensers for members covered by home and community based waiver programs or CHC is not allowed. Therefore code S5185 may NOT be authorized for these members.</li> <li>The initial authorization period may not exceed 30 days and must be accompanied by a minimum of one skilled nursing visit.</li> </ul>

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	<ul style="list-style-type: none"> <li>Ref: DSS Provider Bulletin 2013-76</li> </ul> <p><b>Medication Prompting by a HHA</b></p> <ul style="list-style-type: none"> <li>Request PA using code H0033</li> <li>H0033 is to be used ONLY for members who are currently receiving daily or more frequent medication administration.</li> <li>Ref: DSS Provider Bulletin 2015-75</li> </ul>	<ul style="list-style-type: none"> <li>Ref: DSS Provider Bulletin 2013-76</li> </ul> <p><b>Medication Prompting by a HHA</b></p> <ul style="list-style-type: none"> <li>Request PA using code H0033</li> <li>H0033 is to be used ONLY for members who are currently receiving daily or more frequent medication administration.</li> <li>Ref: DSS Provider Bulletin 2015-75</li> </ul>	<ul style="list-style-type: none"> <li>Ref: DSS Provider Bulletin 2013-76</li> </ul> <p><b>Medication Prompting by a HHA</b></p> <ul style="list-style-type: none"> <li>Request PA using code H0033</li> <li>H0033 is to be used ONLY for members who are currently receiving daily or more frequent medication administration.</li> <li>Ref: DSS Provider Bulletin 2015-75</li> </ul>
<b>Home Health Care Home Health Aide</b>	<p><b>Prior Authorization Required For:</b></p> <ul style="list-style-type: none"> <li>Greater than 14 hours/week</li> </ul> <p><u>Custodial or homemaker services are not a covered benefit.</u></p>	<p><b>Prior Authorization Required For:</b></p> <ul style="list-style-type: none"> <li>Greater than 14 hours/week</li> </ul> <p><u>Custodial or homemaker services are not a covered benefit.</u></p>	<p><b>Prior Authorization Required For:</b></p> <ul style="list-style-type: none"> <li>Greater than 14 hours/week</li> </ul> <p><u>Custodial or homemaker services are not a covered benefit.</u></p>

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<b>Home Health Care Maternity</b>	<p><b>Prior Authorization Required For:</b></p> <ul style="list-style-type: none"> <li>Greater than two prenatal visits</li> <li>Greater than two postpartum visits</li> </ul> <p><b>Coverage limited to services for women at high risk of a negative pregnancy outcome. For a listing of high risk indicators please refer to: Sec. 17b-262-731 "Requirements for Payment of Home Health Services of the Regulations of Connecticut State Agencies"</b> Regulation specifics may be found in Chapter 7 – Home Health of the DSS Provider Manual</p>	<p><b>Prior Authorization Required For:</b></p> <ul style="list-style-type: none"> <li>Greater than two prenatal visits</li> <li>Greater than two postpartum visits</li> </ul> <p><b>Coverage limited to services for women at high risk of a negative pregnancy outcome. For a listing of high risk indicators please refer to: Sec. 17b-262-731 "Requirements for Payment of Home Health Services of the Regulations of Connecticut State Agencies"</b> Regulation specifics may be found in Chapter 7 – Home Health of the DSS Provider Manual</p>	<p><b>Prior Authorization Required For:</b></p> <ul style="list-style-type: none"> <li>Greater than two prenatal visits</li> <li>Greater than two postpartum visits</li> </ul> <p><b>Coverage limited to services for women at high risk of a negative pregnancy outcome. For a listing of high risk indicators please refer to: Sec. 17b-262-731 "Requirements for Payment of Home Health Services of the Regulations of Connecticut State Agencies"</b> Regulation specifics may be found in Chapter 7 – Home Health of the DSS Provider Manual</p>
<b>Out of Network Services</b>	Non-Covered Providers must be an enrolled CMAP provider to be reimbursed for services.	Non-Covered Providers must be an enrolled CMAP provider to be reimbursed for services.	Non-Covered Providers must be an enrolled CMAP provider to be reimbursed for services.
<b>Short Term Rehab</b>	<b>Prior Authorization Required For:</b>	<b>Prior Authorization Required For:</b>	<b>Prior Authorization Required For:</b>

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<b>Home</b>	<ul style="list-style-type: none"> <li>• PT/ST – greater than initial evaluation and <u>two</u> visits per week</li> <li>• OT – greater than initial evaluation and <u>one</u> visit per week</li> <li>• PT/OT/ST greater than nine visits per therapy, per calendar year, per provider if the primary diagnosis associated with the requested service is one of the following::               <ol style="list-style-type: none"> <li>1. A mental disorder including mental retardation or a specific delay in development (ICD-9 CM diagnosis range 291-319)</li> <li>2. A musculoskeletal system disorder involving the spine (ICD-9 CM diagnosis code range 722.XX – 724.XX ) or</li> <li>3. A symptom related to</li> </ol> </li> </ul>	<ul style="list-style-type: none"> <li>• All PT, ST, OT services after initial evaluation</li> </ul> <p><u>PT, ST, OT:</u> For conditions where significant improvement is expected within 60 days</p> <p><u>PT, ST, OT and audiology services are limited to 60 days of combined services per injury or condition. This includes short term rehab services performed in a home, clinic outpatient hospital or independent setting.</u></p>	<ul style="list-style-type: none"> <li>• PT/ST – greater than initial evaluation and <u>two</u> visits per week</li> <li>• OT – greater than initial evaluation and <u>one</u> visit per week</li> <li>• PT/OT/ST greater than nine visits per therapy, per calendar year, per provider if the primary diagnosis associated with the requested service is one of the following:               <ol style="list-style-type: none"> <li>1. A mental disorder including mental retardation or a specific delay in development (ICD-9 CM diagnosis range 291-319)</li> <li>2. A musculoskeletal system disorder involving the spine (ICD-9 CM diagnosis code range 722.XX – 724.XX ) or</li> <li>3. A symptom related to</li> </ol> </li> </ul>

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	<p align="center">nutrition, metabolism or development (ICD-9 CM diagnosis code 783.X).</p> <p>***For a list of equivalent ICD-10 CM Diagnosis codes, please visit The DSS Fee Schedule Instructions located at <a href="http://www.ctdssmap.com">www.ctdssmap.com</a> → Provider → Provider Fee Schedule Download → Provider Fee Schedule Instructions (table 15)</p>		<p align="center">nutrition, metabolism or development (ICD-9 CM diagnosis code 783.X).</p> <p>***For a list of equivalent ICD-10 CM Diagnosis codes, please visit The DSS Fee Schedule Instructions located at <a href="http://www.ctdssmap.com">www.ctdssmap.com</a> → Provider → Provider Fee Schedule Download → Provider Fee Schedule Instructions (table 15)</p>
<b>Translation services</b>	1-800-440-5071	1-800-440-5071	1-800-440-5071

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