### HUSKY Health Program Benefits and Prior Authorization Requirements Grid*

**Therapy Services**

**Effective: January 1, 2012**

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

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<table>
<thead>
<tr>
<th>Benefit</th>
<th>HUSKY A, HUSKY C (ABD)</th>
<th>HUSKY B</th>
<th>HUSKY D (LIA)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Short Term Rehab Home</strong></td>
<td><strong>Prior Authorization Required For:</strong></td>
<td><strong>Prior Authorization Required For:</strong></td>
<td><strong>Prior Authorization Required For:</strong></td>
</tr>
</tbody>
</table>
| | • PT/ST – greater than initial evaluation and two visits per week  
  • OT – greater than initial evaluation and one visit per week  
  • PT/ST/OT – 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:  
  1. A mental disorder including mental retardation or a specific delay in development (ICD 9 CM diagnosis range 291-319)  
  2. A musculoskeletal system disorder involving the spine (ICD 9 CM diagnosis code range 722.XX – 724.XX) or  
  3. A symptom related to nutrition, metabolism or development (ICD 9 CM diagnosis code 783.X).  
  **For a list of equivalent ICD 10 CM Diagnosis codes, please visit The DSS Fee** | • All PT, ST, OT services after initial evaluation  
  PT, ST, OT: For conditions where significant improvement is expected within 60 days  
  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. | • PT/ST – greater than initial evaluation and two visits per week  
  • OT – greater than initial evaluation and one visit per week  
  • PT/ST/OT – 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:  
  1. A mental disorder including mental retardation or a specific delay in development (ICD 9 CM diagnosis range 291-319)  
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<tr>
<td>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)</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

**Short Term Rehab Outpatient Independent Therapist (PT/ST/OT Audiology)**

**Member 21 years of age and older:**  
Independent PT/ST/OT/Audiology **Not** covered. Member must receive services in a hospital outpatient clinic setting. Reimbursement is limited to the clinic.

**Members under 21 years of age:**  
Independent PT/ST/OT/Audiology **is** covered for members under 21 years of age. Prior Authorization Required For:

- **PT/ST/Audiology-Greater than one evaluation per calendar year per provider and two visits per calendar week per provider**
- **OT Greater than one evaluation per calendar year per provider and two visits per calendar week per provider**
- **PT/ST/OT/Audiology – 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:**

<table>
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<tr>
<th>Prior Authorization Required For:</th>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td><strong>ALL PT/ST/OT/Audiology services after initial evaluation</strong></td>
<td>Independent PT/ST/OT/Audiology covered 100%</td>
<td>Independent PT/ST/OT/Audiology not covered. Member must receive services in a hospital outpatient clinic setting. Reimbursement is limited to the clinic.</td>
</tr>
</tbody>
</table>
| **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.** | **PT/ST/OT/Greater than 60 days eligible for Husky Plus referral for supplemental coverage. Call 1-800-440-5071 for more information.** | **Members under 21 years of age:**  
Independent PT/ST/OT/Audiology **is** covered for members under 21 years of age. Prior Authorization Required For:

- **PT/ST/Audiology-Greater than one evaluation per calendar year per provider and two visits per calendar week per provider**
- **OT Greater than one evaluation per calendar year per provider and two visits per calendar week per provider**
- **PT/ST/OT/Audiology – 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:**

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<tr>
<td><strong>1.</strong></td>
<td>A mental disorder including mental retardation or a specific delay in development (ICD 9 CM diagnosis range 291-319)</td>
<td><strong>1.</strong></td>
<td>A mental disorder including mental retardation or a specific delay in development (ICD 9 CM diagnosis range 291-319)</td>
</tr>
<tr>
<td><strong>2.</strong></td>
<td>A musculoskeletal system disorder involving the spine (ICD 9 CM diagnosis code range 722.XX – 724.XX ) or</td>
<td><strong>2.</strong></td>
<td>A musculoskeletal system disorder involving the spine (ICD 9 CM diagnosis code range 722.XX – 724.XX ) or</td>
</tr>
<tr>
<td><strong>3.</strong></td>
<td>A symptom related to nutrition, metabolism or development (ICD 9 CM diagnosis code 783.X).</td>
<td><strong>3.</strong></td>
<td>A symptom related to nutrition, metabolism or development (ICD 9 CM diagnosis code 783.X).</td>
</tr>
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</table>

***For a list of equivalent ICD 10 CM Diagnosis codes, please visit The DSS Fee Schedule Instructions located at www.ctdssmap.com → Provider → Provider Fee Schedule Download → Provider Fee Schedule Instructions (table 15)***

### Short Term Rehab

**Outpatient Rehab Clinic (PT/ST/OT/)**
- Prior Authorization Required For:
  - PT/ST/Audiology-Greater than one evaluation per calendar year, per provider and two visits per

**Prior Authorization Required For:**
- All PT/ST/OT/Audiology services after initial evaluation

**Prior Authorization Required For:**
- PT/ST/Audiology-Greater than one evaluation per calendar year, per provider and two visits per

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<tr>
<td><strong>Audiology</strong></td>
<td>consecutive 7 day period, per provider</td>
<td>PT/ST/OT/Audiology covered 100%</td>
<td>consecutive 7 day period, per provider</td>
</tr>
<tr>
<td></td>
<td>• OT – Greater than one evaluation per calendar year, per provider and one visit per</td>
<td>PT/ST/OT/Audiology requires that significant improvement is expected</td>
<td>• OT – Greater than one evaluation per calendar year, per provider</td>
</tr>
<tr>
<td></td>
<td>consecutive 7 day period, per provider</td>
<td>within 60 days</td>
<td>and one visit per consecutive 7 day period, per provider</td>
</tr>
<tr>
<td></td>
<td>• PT/ST/Audiol/OT – greater than nine visits per therapy, per calendar year, per</td>
<td>PT, ST, OT and audiology services are limited to 60 days of combined</td>
<td>• PT/ST/Audiol/OT – greater than nine visits per therapy, per calendar year,</td>
</tr>
<tr>
<td></td>
<td>provider if the primary diagnosis associated with the requested service is one of the</td>
<td>services per injury or condition. This includes short term</td>
<td>per provider if the primary diagnosis associated with the requested service is</td>
</tr>
<tr>
<td></td>
<td>following:</td>
<td>short term rehab services performed in a home, clinic outpatients</td>
<td>one of the following:</td>
</tr>
<tr>
<td></td>
<td>1. A mental disorder including mental retardation or a specific delay in development</td>
<td>hospital or independent setting.</td>
<td>1. A mental disorder including mental retardation or a specific delay in</td>
</tr>
<tr>
<td></td>
<td>(ICD 9 CM diagnosis range 291-319)</td>
<td></td>
<td>development (ICD 9 CM diagnosis range 291-319)</td>
</tr>
<tr>
<td></td>
<td>2. A musculoskeletal system disorder involving the spine (ICD 9 CM diagnosis code</td>
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<td></td>
<td>code range 722.XX – 724.XX ) or</td>
<td></td>
<td>diagnosis code range 722.XX – 724.XX ) or</td>
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<td></td>
<td>3. A symptom related to nutrition, metabolism or development (ICD 9 CM diagnosis code</td>
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<td>783.X)</td>
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<td>diagnosis code 783.X).</td>
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***For a list of equivalent ICD 10 CM

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<tr>
<td>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)</td>
<td>PT/ST/Audiology/OT covered 100%</td>
<td>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)</td>
<td>PT/ST/Audiology/OT covered 100%</td>
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### Short Term Rehab

**Outpatient Rehab Clinic (Respiratory Therapy)**

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<tbody>
<tr>
<td>Prior Authorization Required For: CPT code 94664 (Demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered dose inhaler or IPPB device)</td>
<td>Non-Covered Providers must be an enrolled CMAP provider to be reimbursed for services.</td>
<td>Non-Covered Providers must be an enrolled CMAP provider to be reimbursed for services.</td>
<td>Non-Covered Providers must be an enrolled CMAP provider to be reimbursed for services.</td>
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### Out of Network Services

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### Out of State Care

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<tr>
<td>Out of the country care (including emergency care) is not a covered benefit (with the exception of Puerto Rico and other USA territories – where emergency care is covered).</td>
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MMTPE0001-0312
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<td>Islands, US Virgin Islands</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Translation services</td>
<td>1-800-440-5071</td>
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**Benefit EXCLUSIONS**

This is a general listing of those exclusions most applicable to Therapy Services and includes but is not limited to the following:

- 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 not within scope of practitioners scope of practice pursuant to state law
- 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
- Services not usually performed by the provider

- 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 not within scope of practitioners scope of practice pursuant to state law
- Acupuncture, biofeedback, hypnosis
- Routine foot care
- 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

- 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 not within scope of practitioners scope of practice pursuant to state law
- Services beyond what is necessary to treat the medical problems,
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- Services or items for which the provider does not usually charge
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**HUSKY Plus** provides supplemental

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<tr>
<td></td>
<td></td>
<td></td>
<td>coverage of services not covered under the HUSKY B plan for children with intensive physical health needs. Call 1-800-440-5071 for more information.</td>
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