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

Benefit	HUSKY A, HUSKY C (ABD)	HUSKY B	HUSKY D (LIA)
Short Term Rehab Home	**Prior Authorization Required For:** • 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	**Prior Authorization Required For:** • 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.	**Prior Authorization Required For:** • 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

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	Schedule Instructions located at www.ctdssmap.com→ Provider → Provider Fee Schedule Download → Provider Fee Schedule Instructions (table 15)		Schedule Instructions located at www.ctdssmap.com→ Provider → Provider Fee Schedule Download → Provider Fee Schedule Instructions (table 15)
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:	**Prior Authorization Required For:** • **ALL** PT/ST/OT/Audiology services after initial evaluation Independent PT/ST/OT/Audiology covered 100% PT/ST/OT/Audiology requires that 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/OT greater than 60 days eligible for Husky Plus referral for supplemental coverage. Call 1-800-440-5071 for more information.	**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:

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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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Audiology)	consecutive 7 day period, per provider • OT – Greater than one evaluation per calendar year, per provider and one visit per consecutive 7 day period, per provider • PT/ST/Audiol/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	PT/ST/OT/Audiology covered 100% PT/ST/OT/Audiology requires that 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/OT greater than 60 days eligible for Husky Plus referral for supplemental coverage. Call 1-800-440-5071 for more information.	consecutive 7 day period, per provider • OT – Greater than one evaluation per calendar year, per provider and one visit per consecutive 7 day period, per provider • PT/ST/Audiol/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

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	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) PT/ST/Audiology/OT covered 100%		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) PT/ST/Audiology/OT covered 100%
Short Term Rehab Outpatient Rehab Clinic (Respiratory Therapy)	**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)	**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)	**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)
Out of Network 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.	Non-Covered Providers must be an enrolled CMAP provider to be reimbursed for services.
Out of State Care	**Non Emergent Care Requires Prior Authorization**	**Non Emergent Care Requires Prior Authorization**	**Non Emergent Care Requires Prior Authorization**
Out of Country Care (with the exception of Puerto Rico and USA territories of American Samoa, Federated States of Micronesia, Guam, Midway Islands, Northern Marina	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).**	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).**	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).**

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Islands, US Virgin Islands)			
Translation services	1-800-440-5071	1-800-440-5071	1-800-440-5071
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 HUSKY Plus provides supplemental	• 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

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		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.	