HUSKY HEALTH
CONNECTICUT

HUSKY Health Benefits and Prior Authorization Grid

Hosptial Outpatient

Covered Services for HUSKY Health A, B, C, and D Members

HUSKY Health Benefits and Prior Authorization Requirements Grid*
Hospital Outpatient
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	HUSKY B	HUSKY D
Cardiac Rehab	100% covered	100% covered	100% covered
Dialysis	100% covered	100% covered	100% covered
Emergency Care	Covered – no co-pays for emergency room visits Emergent admissions must be called in or faxed by the admitting facility to CHNCT within 2 business days. Notifications greater than 2 days from the admission date are subject to denial of services. Out of state emergency care in an ER facility is reviewed retrospectively for medical necessity. Out of state providers MUST enroll with CMAP in order to receive payment. If out of state emergency room care is required, the member should call their PCP within 24 hours of the emergency room visit. Out of state emergency care at a provider's office is non-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).	Covered – no co-pays for emergency room visits Urgent care $10 co-pay Emergent admissions must be called in or faxed by the admitting facility to CHNCT within 2 business days. Notifications greater than 2 days from the admission date are subject to denial of services. Out of state emergency care in an ER facility is reviewed retrospectively for medical necessity. Out of state providers MUST enroll with CMAP in order to receive payment. If out of state emergency room care is required, the member should call their PCP within 24 hours of the emergency room visit. Out of state emergency care at a provider's office is non-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).	Covered – no co-pays for emergency room visits Emergent admissions must be called in or faxed by the admitting facility to CHNCT within 2 business days. Notifications greater than 2 days from the admission date are subject to denial of services. Out of state emergency care in an ER facility is reviewed retrospectively for medical necessity. Out of state providers MUST enroll with CMAP in order to receive payment. If out of state emergency room care is required, the member should call their PCP within 24 hours of the emergency room visit. Out of state emergency care at a provider's office is non-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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Labs	100% covered	100% covered	100% covered
Miscellaneous Drugs and Skin Substitutes Including: • Supprelin LA • Spinraza • Exondys • Puraply	Refer to the Outpatient Hospital Prior Authorization Grid available on the Hospital Modernization page of the DSS CT Medical Assistance Program (CMAP) website at: www.ctdssmap.com	Refer to the Outpatient Hospital Prior Authorization Grid available on the Hospital Modernization page of the DSS CT Medical Assistance Program (CMAP) website at: www.ctdssmap.com	Refer to the Outpatient Hospital Prior Authorization Grid available on the Hospital Modernization page of the DSS CT Medical Assistance Program (CMAP) website at: www.ctdssmap.com
Nutritional Counseling	100% covered. Nutritional counseling services may be performed by: • Independently enrolled physicians, advanced practice registered nurses and physician assistants (as part of an evaluation and management service); and • CMAP enrolled clinics (including FQHCs and hospital outpatient clinics). Currently registered dieticians are not eligible for CMAP enrollment and therefore are not able to receive reimbursement for services. When nutritional counseling is performed in a hospital outpatient clinic, reimbursement is limited to the clinic under HCPCS G0463 (clinic visit) and no separate payment will be made to the individual provider.	100% covered. Nutritional counseling services may be performed by: • Independently enrolled physicians, advanced practice registered nurses and physician assistants (as part of an evaluation and management service); and • CMAP enrolled clinics (including FQHCs and hospital outpatient clinics). Currently registered dieticians are not eligible for CMAP enrollment and therefore are not able to receive reimbursement for services. When nutritional counseling is performed in a hospital outpatient clinic, reimbursement is limited to the clinic under HCPCS Code G0463 (clinic visit) and no separate payment will be made to the individual provider.	100% covered. Nutritional counseling services may be performed by: • Independently enrolled physicians, advanced practice registered nurses and physician assistants (as part of an evaluation and management service); and • CMAP enrolled clinics (including FQHCs and hospital outpatient clinics). Currently registered dieticians are not eligible for CMAP enrollment and therefore are not able to receive reimbursement for services. When nutritional counseling is performed in a hospital outpatient clinic, reimbursement is limited to the clinic under HCPCS Code G0463 (clinic visit) and no separate payment will be made to the individual provider.

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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.
Outpatient Surgical Facility (Hospital or Ambulatory Surgical Center)	100% covered 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 and request authorization within 2 business days.	100% covered 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 and request authorization within 2 business days.	100% covered 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 and request authorization within 2 business days.
Procedures requiring Prior Authorization (for a full listing of procedures requiring prior authorization please refer to the DSS Physician - Surgical Fee Schedule)	• Tattooing • Collagen injections • Insertion and removal of tissue expanders • Dermabrasion • Abrasion • Chemical Peel • Cervicoplasty • Blepharoplasty • Lipectomy/Liposuction • Destruction of cutaneous vascular lesions	• Tattooing • Collagen injections • Insertion and removal of tissue expanders • Dermabrasion • Abrasion • Chemical Peel • Cervicoplasty • Blepharoplasty • Lipectomy/Liposuction • Destruction of cutaneous vascular lesions	• Tatooing • Collagen injections • Insertion and removal of tissue expanders • Dermabrasion • Abrasion • Chemical Peel • Cervicoplasty • Blepharoplasty • Lipectomy/Liposuction • Destruction of cutaneous vascular lesions

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Procedures requiring prior authorization (cont.)	• Cryotherapy for acne • Electrolysis • Mastectomy for gynecomastia • Mastopexy • Breast reduction • Breast augmentation • Removal/insertion of breast implants • Breast reconstruction • TMJ related procedures • Oral splints • Interdental fixation devices • Interdental wiring non-fracture • Canthopexy • Otoplasty • Rhinoplasty • Septoplasty • Varicose vein injection treatment or stab phlebotomy, ligation and division of veins • TMJ related procedures/treatments • Surgical treatment of obesity • Insertion/removal of penile implants • Female genital repair • Vaginoplasty for inter-sex state • Chemodenervation • Blepharoptosis repair • Brow ptosis repair • Correction lid retraction	• Cryotherapy for acne • Electrolysis • Mastectomy for gynecomastia • Mastopexy • Breast reduction • Breast augmentation • Removal/insertion of breast implants • Breast reconstruction • TMJ related procedures • Oral splints • Interdental fixation devices • Interdental wiring non-fracture • Canthopexy • Otoplasty • Rhinoplasty • Septoplasty • Varicose vein injection treatment or stab phlebotomy, ligation and division of veins • TMJ related procedures/treatments • Surgical treatment of obesity • Insertion/removal of penile implants • Female genital repair • Vaginoplasty for inter-sex state • Chemodenervation • Blepharoptosis repair • Brow ptosis repair • Correction lid retraction	• Cryotherapy for acne • Electrolysis • Mastectomy for gynecomastia • Mastopexy • Breast reduction • Breast augmentation • Removal/insertion of breast implants • Breast reconstruction • TMJ related procedures • Oral splints • Interdental fixation devices- • Interdental wiring non-fracture • Canthopexy • Otoplasty • Rhinoplasty • Septoplasty • Varicose vein injection treatment or stab phlebotomy, ligation and division of veins • TMJ related procedures/treatments • Surgical treatment of obesity • Insertion/removal of penile implants • Female genital repair • Vaginoplasty for inter-sex state • Chemodenervation • Blepharoptosis repair • Brow ptosis repair • Correction lid retraction

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Procedures requiring prior authorization (cont.)	• Procedures to correct myopia, refractive errors, and surgically induced astigmatism • Procedures related to corneal prosthetics Genetic testing (see code list under genetic testing)	• Procedures to correct myopia, refractive errors, and surgically induced astigmatism • Procedures related to corneal prosthetics Genetic testing (see code list under genetic testing)	• Procedures to correct myopia, refractive errors, and surgically induced astigmatism • Procedures related to corneal prosthetics Genetic testing (see code list under genetic testing)
Radiology Services	Refer to the Outpatient Hospital Prior Authorization Grid available on the Hospital Modernization page of the DSS CT Medical Assistance Program (CMAP) website at: www.ctdssmap.com	Refer to the Outpatient Hospital Prior Authorization Grid available on the Hospital Modernization page of the DSS CT Medical Assistance Program (CMAP) website at: www.ctdssmap.com	Refer to the Outpatient Hospital Prior Authorization Grid available on the Hospital Modernization page of the DSS CT Medical Assistance Program (CMAP) website at: www.ctdssmap.com
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.
Screening, Brief Intervention, and Referral to Treatment (SBIRT) Covered for Primary Care Providers (PCPs) Only	When rendering SBIRT Services, providers must: • Use a validated screening tool • Utilize evidenced based brief intervention guidelines • Make referrals to treatment as appropriate For a list of validated screening tools please access the following link: https://www.samhsa.gov/sbirt/resources	When rendering SBIRT Services, providers must: • Use a validated screening tool • Utilize evidenced based brief intervention guidelines • Make referrals to treatment as appropriate For a list of validated screening tools please access the following link: https://www.samhsa.gov/sbirt/resources	When rendering SBIRT Services, providers must: • Use a validated screening tool • Utilize evidenced based brief intervention guidelines • Make referrals to treatment as appropriate For a list of validated screening tools please access the following link: https://www.samhsa.gov/sbirt/resources

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Screening, Brief Intervention and Referral to Treatment (SBIRT) Covered for Primary Care Providers (PCPs) Only (cont.)	**Documentation Requirements:** Provider must document: • The screening tool used • The score obtained • The time spent performing the service • Any action taken as a result of the screening (including referrals) • Name and credentials of practitioner who provided the service • A dated note **Billing:** SBIRT services should be performed in conjunction with a medical clinic or emergency department visit and therefore separate reimbursement will not be made to the facility. SBIRT services should be billed under HCPCS Code G0463. CPT codes 99408 and 99409 are reimbursed professional service only. • Reference: DSS PB 2015-79 “Screening, Brief Intervention and Referral to Treatment (SBIRT) in Primary Care”.	**Documentation Requirements:** Provider must document: • The screening tool used • The score obtained • The time spent performing the service • Any action taken as a result of the screening (including referrals) • Name and credentials of practitioner who provided the service • A dated note **Billing:** SBIRT services should be performed in conjunction with a medical clinic or emergency department visit and therefore separate reimbursement will not be made to the facility. SBIRT services should be billed under HCPCS Code G0463. CPT codes 99408 and 99409 are reimbursed professional service only. • Reference: DSS PB 2015-79 “Screening, Brief Intervention and Referral to Treatment (SBIRT) in Primary Care”.	**Documentation Requirements:** Provider must document: • The screening tool used • The score obtained • The time spent performing the service • Any action taken as a result of the screening (including referrals) • Name and credentials of practitioner who provided the service • A dated note **Billing:** SBIRT services should be performed in conjunction with a medical clinic or emergency department visit and therefore separate reimbursement will not be made to the facility. SBIRT services should be billed under HCPCS Code G0463. CPT codes 99408 and 99409 are reimbursed professional service only. • Reference: DSS PB 2015-79 “Screening, Brief Intervention and Referral to Treatment (SBIRT) in Primary Care”.

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Short Term Rehab (ST/PT/OT/ Audiology) Benefit	**Prior Authorization Required For:** • PT/ST - 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/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: 1. A mental disorder including mental retardation or a specific delay in development; 2. A musculoskeletal system disorder involving the spine; or 3. A symptom related to nutrition, metabolism or development. *For the list of ICD-10 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) Independent PT/ST/Audiology covered 100%	**Prior Authorization Required For:** • PT/ST - 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/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: 4. A mental disorder including mental retardation or a specific delay in development; 5. A musculoskeletal system disorder involving the spine; or 6. A symptom related to nutrition, metabolism or development. *For the list of ICD-10 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) Independent PT/ST/Audiology covered 100%	**Prior Authorization Required For:** • PT/ST - 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/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: 7. A mental disorder including mental retardation or a specific delay in development; 8. A musculoskeletal system disorder involving the spine; or 9. A symptom related to nutrition, metabolism or development. *For the list of ICD-10 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) Independent PT/ST/Audiology covered 100%

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Smoking and Tobacco Cessation Counseling	Covered when performed in hospital outpatient clinics. Primary ICD 10 diagnosis must be: • Nicotine Dependence (use F17.200 - F17.299) For group sessions, bill with RCC 953 with CPT 99412 Group session must last longer than 45 minutes. Member must attend entire session to bill for service Group size is limited to 3-12 members Individual counseling performed by licensed BH clinician – bill with RCC 914 and CPT codes 99406-99407	Covered when performed in hospital outpatient clinics. Primary ICD 10 diagnosis must be: • Nicotine Dependence (use F17.200 - F17.299) For group sessions, bill with RCC 953 with CPT 99412 Group session must last longer than 45 minutes Member must attend entire session to bill for service. Group size is limited to 3-12 members Individual counseling performed by licensed BH clinician – bill with RCC 914 and CPT codes 99406-99407	Covered when performed in hospital outpatient clinics. Primary ICD 10 diagnosis must be: • Nicotine Dependence (use F17.200 - F17.299) For group sessions, bill with RCC 953 with CPT 99412 Group session must last longer than 45 minutes Member must attend entire session to bill for service. Group size is limited to 3-12 members Individual counseling performed by licensed BH clinician – bill with RCC 914 and CPT codes 99406-99407
Synagis®	Prior Authorization required The Synagis Prior Authorization Form is located on the HUSKY Health website at: www.ct.gov/husky. Click Information For Providers → Prior Authorization → Prior Authorization Forms and Manuals.	Prior Authorization required The Synagis Prior Authorization Form is located on the HUSKY Health website at: www.ct.gov/husky. Click Information For Providers → Prior Authorization → Prior Authorization Forms and Manuals.	Medication not applicable for membership

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Synagis® (cont.)	Providers may contact the HUSKY Health Synagis Program by calling 1-800-440-5071 and selecting the prompts for medical authorizations.	Providers may contact the HUSKY Health Synagis Program by calling 1-800-440-5071 and selecting the prompts for medical authorizations.	
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	Refer to Emergency Care section for emergency care specifics Non-emergent care requires prior authorization	Refer to Emergency Care section for emergency care specifics Non-emergent care requires prior authorization	Refer to Emergency Care section for emergency care specifics 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 Islands, US Virgin Islands)	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).
Translation Services	1.800.440.5071	1.800.440.5071	1.800.440.5071
Benefit Exclusions	• Infertility treatment (i.e. reversal sterilization; artificial insemination; in vitro fertilization; fertility drugs)	• Infertility treatment (i.e. reversal sterilization; artificial insemination; in vitro fertilization; fertility drugs)	• Infertility treatment (i.e. reversal sterilization; artificial insemination; in vitro fertilization; fertility drugs)

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This is a general listing and includes but is not limited to the following:	• Drugs used to treat sexual or erectile dysfunction • Weight reduction programs • All services of a plastic or cosmetic nature e.g. hair transplants, electrolysis • Ambulatory BP monitoring • 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 • Implantation of nuclear powered pacemakers • Inpatient charges related to autopsy • 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.	• Weight reduction programs • Surgical treatment or hospitalization for the treatment of morbid obesity except where prior authorized • 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, 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 • Acupuncture, biofeedback, hypnosis • Nuclear powered pacemakers • Implantation of nuclear powered pacemakers • Inpatient charges related to autopsy • Routine foot care	• Drugs used to treat sexual or erectile dysfunction • Weight reduction programs • All services of a plastic or cosmetic nature e.g. hair transplants, electrolysis • Ambulatory BP monitoring • 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 • Implantation of nuclear powered pacemakers • Inpatient charges related to autopsy • 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.

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Benefit Exclusions (cont.)	• 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	• 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 • Power wheelchairs Non-emergency transport	• 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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