HUSKY HEALTH
CONNECTICUT

HUSKY Health Benefits and Prior Authorization Grid

Rehabilitation Clinic

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

HUSKY Health Provider Benefits and Prior Authorization Requirements Grid*

Rehabilitation Clinic

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
Rehabilitation Services: 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* 2. A musculoskeletal system disorder involving the spine* 3. A symptom related to nutrition, metabolism or development* *For a list of ICDD-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)	**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* 2. A musculoskeletal system disorder involving the spine* 3. A symptom related to nutrition, metabolism or development* *For a list of ICDD-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)	**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* 2. A musculoskeletal system disorder involving the spine* 3. A symptom related to nutrition, metabolism or development* *For a list of ICDD-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)
Rehabilitation Services: Outpatient Rehab Clinic - PT/ST/OT/ Audiology	Covered **Prior Authorization Required For:** • PT/ST/Audiology - greater than one evaluation per calendar year, per provider and two visits per consecutive 7 day period, per provider	Covered **Prior Authorization Required For:** • PT/ST/Audiology - greater than one evaluation per calendar year, per provider and two visits per consecutive 7 day period, per provider	Covered **Prior Authorization Required For:** • PT/ST/Audiology - greater than one evaluation per calendar year, per provider and two visits per consecutive 7 day period, per provider

Last Update: 03/15/2022 / MMTPE0001-0312

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Rehabilitation Services: Outpatient Rehab Clinic - PT/ST/OT/ Audiology (Continued)	• OT – greater than one evaluation per calendar year, per provider and one visit per consecutive 7 day period, per provider • PT/ST/Audiology/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* 2. A musculoskeletal system disorder involving the spine* 3. A symptom related to nutrition, metabolism or development* *For a list of ICDD-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)	• OT – greater than one evaluation per calendar year, per provider and one visit per consecutive 7 day period, per provider • PT/ST/Audiology/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* 2. A musculoskeletal system disorder involving the spine* 3. A symptom related to nutrition, metabolism or development* *For a list of ICDD-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)	• OT – greater than one evaluation per calendar year, per provider and one visit per consecutive 7 day period, per provider • PT/ST/Audiology/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* 2. A musculoskeletal system disorder involving the spine* 3. A symptom related to nutrition, metabolism or development* *For a list of ICDD-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)
Rehabilitation Services: 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	Non-Covered	Non-Covered

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Out of Network Services (Continued)	Providers must be an enrolled CMAP provider to be reimbursed for services.	Providers must be an enrolled CMAP provider to be reimbursed for services.	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 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 This is a general listing of those exclusions to most applicable therapy services and includes but is not limited to the following:	• Care out of the country • Services which prior authorization is required and not obtained • Services that are considered to be an unproven, experimental or research nature or cosmetic, social, habilitative, vocational, recreational or educational • Services that are not medically necessary • Services not within practitioners scope of practice pursuant to state law • Services beyond what is necessary to treat the medical problems	• 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	• 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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Benefit Exclusions (Continued)	• 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 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	• 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