HUSKY HEALTH
CONNECTICUT

HUSKY Health Benefits and Prior Authorization Grid

Limited Eligibilty Group Coverage Grid

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

Connecticut Medical Assistance Program
Limited Eligibilty Group Coverage Grid
Effective: January 1, 2012

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

Eligibility Group	Coverage, Limitations, and Exclusions

Tuberculosis (TB) Eligibility Group	Coverage limited to TB related services
	• Covered services include those provided by physicians, APRNs, CNMs, and PAs; medical, rehab and dialysis clinics; independent labs; independent radiology facilities; local health departments; and outpatient hospitals related to a TB diagnosis. **
	• Respiratory therapy in a rehab clinic is covered. Prior authorization is required for CPT code 94664 (demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered dose inhaler or IPPB device) when performed in a rehab clinic setting. **
	• Limited pharmacy coverage is available. A select group of drugs relevant to the treatment of TB will be covered. A TB diagnosis must be present on both the prescription and the pharmacy claim. Drugs covered include select antibacterials, antimycobacterials, antimicrobials, and steroids/ anti-inflammatory agents. A comprehensive list of covered drugs is available at: www.ctdssmap.com. From the home page, navigate to Pharmacy Information, Pharmacy Program Publications, TB drug list.
	• Local Health Departments will be limited to bill a select group of diagnosis codes essential for the diagnosis, treatment and management of individuals diagnosed with TB. For TB-related services, select procedure codes are listed on the Special Services fee schedule with the rate type "TB" and there are billing instruction posted to the DSS Web site, www.ctdssmap.com.
	• Home Health is limited to Direct Observed Therapy – HCPCS codes:
	  ○ G0493. "Skilled Nursing services of a licensed nurse (LPN) for the observation and assessment of the patient's condition, each 15 minutes"; or
	  ○ G0494. "Skilled Nursing services of a registered nurse (RN) for the observation and assessment of the patient's condition, each 15 minutes".
	  ○ Prior authorization is NOT required. These codes are for nurse observation of individuals diagnosed with TB self-administering oral TB medication.
	• Non-emergency medical transportation is covered.
	• Services unrelated to TB are non-covered.
	• Providers must be an enrolled CMAP provider in order to be reimbursed for services.
	
	****Primary diagnosis must be TB (For a full list of ICD-10 CM diagnosis codes please visit the DSS fee schedule instructions – Table 12 located at www.ctdssmap.com →Provider → Provider)**

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HUSKY Health Benefits and Prior Authorization Requirements Grid*
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Eligibility Group	Coverage, Limitations, and Exclusions
Inmate Eligibility Group	Coverage limited to inpatient hospital care • Hospital staff must check for current eligibility using the AEVS. • If currently eligible, the hospital staff should send an email to the Department's Pre-Release Entitlement Unit at PRE-DSS@ct.gov and include the member name, date of admission, date of discharge, billing address, and Medicaid provider ID. • If the inmate is not currently eligible, hospital staff should assist the inmate with completing and signing the Application for Individual health Coverage and Cost Savings Program (AH2). Hospital staff must eFax the completed application to the Department's Pre-Release Entitlements Unit at: PRE.CSS@ct.gov. If eFax is not available, should fax to 860-424-4939. For extended inpatient hospital admissions, the application must be faxed no later than the end of the fourth month following the date of admission as this may impact Medicaid coverage. • In addition to the application, the hospital staff should email the Department's Pre-Release Entitlement Unit at PRE.DSS@ct.gov and include the member name, date of admission, date of discharge, billing address and Medicaid provider ID. • Pre-Release Entitlement staff will determine eligibility for the period spanning the inpatient admission. • Once eligibility has been granted, the hospital will request a retroactive authorization from CHNCT. • Decisions regarding approval or denial of inpatient admissions must be rendered within 30 calendar days. • Coverage is limited to care received while in the hospital. Reimbursement will be made to providers • who provided care while in the hospital. • Hospitals must be an enrolled with CMAP to be eligible for reimbursement.
Family Planning Eligibility Group	**Coverage limited to family planning and family planning related services for individuals of childbearing age (including minors)** • Covered services include those provided by Physicians, APRNs, CNMs, ambulatory surgical centers, clinics, independent labs and outpatient hospital services as part of or as a follow-up to a family planning visit. ** • Coverage includes comprehensive physical exams, screening and treatment services for sexually transmitted disease/illness, voluntary sterilizations (in accordance with federal guidelines), contraceptive services and supplies, HPV vaccinations (male and female), family planning related surgical treatments (e.g. treatment for a perforated uterus secondary to an IUD) and pregnancy tests. • Coverage does NOT include infertility services and related treatment, hysterectomies,

**Not a Legal Document. Contents provide a general description of HUSKY Health benefits. Coverage subject to change per the CT Department of Social Services (DSS).*

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Eligibility Group	Coverage, Limitations, and Exclusions
Family Planning Eligibility Group (cont.)	• termination of pregnancy, pregnancy care, treatment for HIV/AIDS or hepatitis, treatment for cancer, and any other service that is not provided as part of or as follow- up to a family planning visit. • Limited pharmacy coverage is available. A select group of drugs relevant to the treatment of family planning and family planning-related services will be covered. A family planning diagnosis ** must be on both the prescription and the pharmacy claim. Drugs covered include antibiotics, antibacterials, antimyotics, antiparasitics, analgesics, drugs acting principally on joints, and contraceptives (oral, topical and systemic – non-oral). • Transportation to and from scheduled medical appointments will be available for clients eligible under the family planning coverage group through LogistiCare (1.888.248.9895). • Condoms and spermicide - condoms and spermicide are covered when dispensed by MEDS providers (prescription required) and FP clinics (documentation in the medical record required; documentation must include a statement that items were recommended and dispensed, along with quantity dispensed). ** • For members under the age of 21: condoms and spermicide are also covered when dispensed by pharmacies (prescription required). ** Quantity limits apply (male condoms – 36/month, female condoms – 30/month, spermicide 1/month. Truvada-Pre-Exposure Prophylaxis Medication (PrEP) Truvada is covered at 100% for Family Limited Benefit members. The covered codes include the following: • S5001 • S5000 Code S5001 must be used for a 30 day supply, while code S5000 must be used for a 90 day supply. Please note, procedure code S5001 and the corresponding NDC must be billed when a 30 days' supply of Truvada is dispensed. Procedure code S5000 and the corresponding NDC must be billed when a 90 days' supply of Truvada is dispensed. The quantity and NDC units for both the 30 days' supply and 90 days' supply must be billed as 1 in order to receive the correct reimbursement, otherwise the detail will deny. **<u>** Primary Diagnosis code must be identified as family planning and related services (For a list of ICD-10 CM diagnosis codes please visit the DSS fee schedule instructions located at www.ctdssmap.com →Provider → Provider Fee Schedule Download).</u>**