HUSKY HEALTH
CONNECTICUT

HUSKY Health Benefits and Prior Authorization Grid

Hospital 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 Engagement Services: 1.800.859.9889
Authorizations: 1.800.440.5071, 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 two business days. Notifications greater than two 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 Primary Care Provider (PCP) within 24 hours of the emergency room visit. Out-of-state emergency care at a provider's office is not 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 two business days. Notifications greater than two 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 not covered.	Covered – no co-pays for emergency room visits. Emergent admissions must be called in or faxed by the admitting facility to CHNCT within two business days. Notifications greater than two 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 not covered. Out of the country care (including emergency care) is not a covered benefit (with the exception of Puerto Rico and other U.S. territories – where emergency care is covered).

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Emergency Care (Continued)	Out of the country care (including emergency care) is not a covered benefit (with the exception of Puerto Rico and other U.S. 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 U.S. territories – where emergency care is covered).	
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 Connecticut Medical Assistance Program (CMAP) website: www.ctdssmap.com	Refer to the Outpatient Hospital Prior Authorization Grid available on the Hospital Modernization page of the DSS CMAP website: www.ctdssmap.com	Refer to the Outpatient Hospital Prior Authorization Grid available on the Hospital Modernization page of the DSS CMAP website: www.ctdssmap.com
Nutritional Counseling	100% covered. Effective July 1, 2025 (Reference DSS PB 2025-18: New Coverage of Medical Nutrition Therapy): Medical Nutrition Therapy (MNT) services rendered by a certified dietitian-nutritionist performed in an **outpatient hospital** clinic will be reimbursed via CMAP Addendum B. Outpatient hospital claims submitted with MNT services must be billed with CPT codes 97802-97804 with an ICD-10 diagnosis code	100% covered. Effective July 1, 2025 (Reference DSS PB 2025-18: New Coverage of Medical Nutrition Therapy): MNT services rendered by a certified dietitian-nutritionist performed in an **outpatient hospital** clinic will be reimbursed via CMAP Addendum B. Outpatient hospital claims submitted with MNT services must be billed with CPT codes 97802-97804 with an ICD-10 diagnosis code from Table 26 “Diagnosis	100% covered. Effective July 1, 2025 (Reference DSS PB 2025-18: New Coverage of Medical Nutrition Therapy): MNT services rendered by a certified dietitian-nutritionist performed in an **outpatient hospital** clinic will be reimbursed via CMAP Addendum B. Outpatient hospital claims submitted with MNT services must be billed with CPT codes 97802-97804 with an ICD-10 diagnosis code from Table 26 “Diagnosis

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Nutritional Counseling (Continued)	from Table 26 "Diagnosis Codes for MNT Services" of the DSS Fee Schedule Instructions. Additionally, claims must include the certified dietitian-nutritionist as the rendering provider. MNT services rendered by a certified dietitian-nutritionist performed in an outpatient hospital clinic will be reimbursed via CMAP Addendum B. There is no separate professional reimbursement for MNT services provided in the outpatient hospital setting.	Codes for MNT Services" of the DSS Fee Schedule Instructions. Additionally, claims must include the certified dietitian-nutritionist as the rendering provider. MNT services rendered by a certified dietitian-nutritionist performed in an outpatient hospital clinic will be reimbursed via CMAP Addendum B. There is no separate professional reimbursement for MNT services provided in the outpatient hospital setting.	Codes for MNT Services" of the DSS Fee Schedule Instructions. Additionally, claims must include the certified dietitian-nutritionist as the rendering provider. MNT services rendered by a certified dietitian-nutritionist performed in an outpatient hospital clinic will be reimbursed via CMAP Addendum B. There is no separate professional reimbursement for MNT services provided in the outpatient hospital setting.
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 it then requires Prior Authorization (PA) 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 it then requires PA 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 it then requires PA for medical necessity.
Outpatient Surgical Facility (Hospital or Ambulatory Surgical Center)	100% covered. Not all procedures require PA. Refer to the list under *Procedures Requiring PA* regardless of where procedure is performed. Authorization required for: Outpatient procedure turned inpatient. Hospital must notify CHNCT and request authorization within two business days.	100% covered. Not all procedures require PA. Refer to the list under *Procedures Requiring PA* regardless of where procedure is performed. Authorization required for: Outpatient procedure turned inpatient. Hospital must notify CHNCT and request authorization within two business days.	100% covered. Not all procedures require PA. Refer to the list under *Procedures Requiring PA* regardless of where procedure is performed. Authorization required for: Outpatient procedure turned inpatient. Hospital must notify CHNCT and request authorization within two business days.

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Procedures Requiring PA (For a full listing of procedures requiring PA, 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 • Cryotherapy for acne • Electrolysis • Mastectomy for gynecomastia • Mastopexy • Breast reduction • Breast augmentation • Removal/insertion of breast implants • Breast reconstruction • 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	• Tattooing • Collagen injections • Insertion and removal of tissue expanders • Dermabrasion • Abrasion • Chemical peel • Cervicoplasty • Blepharoplasty • Lipectomy/Liposuction • Destruction of cutaneous vascular lesions • Cryotherapy for acne • Electrolysis • Mastectomy for gynecomastia • Mastopexy • Breast reduction • Breast augmentation • Removal/insertion of breast implants • Breast reconstruction • 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	• Tattooing • Collagen injections • Insertion and removal of tissue expanders • Dermabrasion • Abrasion • Chemical peel • Cervicoplasty • Blepharoplasty • Lipectomy/Liposuction • Destruction of cutaneous vascular lesions • Cryotherapy for acne • Electrolysis • Mastectomy for gynecomastia • Mastopexy • Breast reduction • Breast augmentation • Removal/insertion of breast implants • Breast reconstruction • 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

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Procedures Requiring PA (Continued)	• Insertion/removal of penile implants • Female genital repair • Vaginoplasty for inter-sex state • Chemodenervation • Blepharoptosis repair • Brow ptosis repair • Correction lid retraction • Procedures to correct myopia, refractive errors, and surgically induced astigmatism • Procedures related to corneal prosthetics • Genetic testing (See code list under genetic testing.)	• Insertion/removal of penile implants • Female genital repair • Vaginoplasty for inter-sex state • Chemodenervation • Blepharoptosis repair • Brow ptosis repair • Correction lid retraction • Procedures to correct myopia, refractive errors, and surgically induced astigmatism • Procedures related to corneal prosthetics • Genetic testing (See code list under genetic testing.)	• Insertion/removal of penile implants • Female genital repair • Vaginoplasty for inter-sex state • Chemodenervation • Blepharoptosis repair • Brow ptosis repair • Correction lid retraction • 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 CMAP website: www.ctdssmap.com.	Refer to the Outpatient Hospital Prior Authorization Grid available on the Hospital Modernization page of the DSS CMAP website: www.ctdssmap.com.	Refer to the Outpatient Hospital Prior Authorization Grid available on the Hospital Modernization page of the DSS CMAP website: www.ctdssmap.com.
Reconstructive Surgery	PA required. Not a covered benefit except for surgery related to a malignant tumor or some other cases of surgeries needed to restore normal function.	PA required. Not a covered benefit except for surgery related to a malignant tumor or some other cases of surgeries needed to restore normal function.	PA 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 PCPs Only	When rendering SBIRT services, providers must: • Use a validated screening tool. • Utilize evidenced-based brief intervention guidelines.	When rendering SBIRT services, providers must: • Use a validated screening tool. • Utilize evidenced-based brief intervention guidelines.	When rendering SBIRT services, providers must: • Use a validated screening tool. • Utilize evidenced-based brief intervention guidelines.

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Screening, Brief Intervention and Referral to Treatment (SBIRT) Covered for PCPs Only (Continued)	• Make referrals to treatment as appropriate. For a list of validated screening tools please access the following link: https://www.samhsa.gov/substance-use/treatment/resources **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."	• Make referrals to treatment as appropriate. For a list of validated screening tools please access the following link: https://www.samhsa.gov/substance-use/treatment/resources **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."	• Make referrals to treatment as appropriate. For a list of validated screening tools please access the following link: https://www.samhsa.gov/substance-use/treatment/resources **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	**PA 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%.	**PA 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%.	**PA 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%.

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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 three to 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 three to 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 three to 12 members. Individual counseling performed by licensed BH clinician — bill with RCC 914 and CPT codes 99406-99407.
Out of Network Services	Not covered. Providers must be an enrolled CMAP provider to be reimbursed for services.	Not covered. Providers must be an enrolled CMAP provider to be reimbursed for services.	Not 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 PA.	Refer to Emergency Care section for emergency care specifics. Non-emergent care requires PA.	Refer to Emergency Care section for emergency care specifics. Non-emergent care requires PA.

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Out of the Country Care (with the exception of Puerto Rico and U.S. territories of American Samoa, Federated States of Micronesia, Guam, Midway Islands, Northern Marina Islands, U.S. Virgin Islands)	Out of the country care (including emergency care) is not a covered benefit (with the exception of Puerto Rico and other U.S. 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 U.S. 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 U.S. territories – where emergency care is covered).
Translation Services	Provider Engagement Services: 1.800.440.5071	Provider Engagement Services: 1.800.440.5071	Provider Engagement Services: 1.800.440.5071
Benefit Exclusions - This is a general listing and includes, but is not limited to, the following:	• Infertility treatment (i.e., reversal sterilization; artificial insemination; in vitro fertilization; fertility drugs). • 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 PA is required and is not obtained. • Services that are considered unproven, experimental, or performed for research purposes.	• Infertility treatment (i.e., reversal sterilization; artificial insemination; in vitro fertilization; fertility drugs). • 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 PA is required and is not obtained.	• Infertility treatment (i.e., reversal sterilization; artificial insemination; in vitro fertilization; fertility drugs). • 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 PA is required and is not obtained. • Services that are considered unproven, experimental, or performed for research purposes.

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Benefit Exclusions (Continued)	• Services that are cosmetic, social, habilitative, vocational, recreational, or educational in nature. • Services that are not medically necessary. • Services required by third parties, such as school or employers, court ordered testing, diagnostics, etc. • Services not within the 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. • 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.	• Services that are considered unproven, experimental, or performed for research purposes. • Services that are cosmetic, social, habilitative, vocational, recreational, or educational in nature. • Services that are not medically necessary. • Services required by third parties, such as school or employers, court ordered testing, diagnostics, etc. • Services not within the 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. • 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 that are cosmetic, social, habilitative, vocational, recreational, or educational in nature. • Services that are not medically necessary. • Services required by third parties, such as school or employers, court ordered testing, diagnostics, etc. • Services not within the 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. • 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.