



**HUSKY
HEALTH**

CONNECTICUT



HUSKY Health Benefits and Prior Authorization Grid

Physician

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



HUSKY Health Benefits and Prior Authorization Requirements Grid*
Physician
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
Allergy	100% covered.	100% covered.	100% covered.
Cardiac Rehab	100% covered.	100% covered.	100% covered.
Contraceptives	100% covered.	Covered. Oral Contraceptives: <ul style="list-style-type: none"> • Pharmacy co-pays apply. • No co-pay if provided in physician office or clinic setting. 	100% covered.
Family Planning	100% covered. Services can be performed by a Primary Care Provider (PCP) or specialist. Sterilization requires submission of a completed W612 Consent to Sterilization form. Sterilization is covered only for members age 21 or older. Exclusions – not covered: <ul style="list-style-type: none"> • Sterilizations for patients who are under age 21, mentally incompetent, or institutionalized. • Hysterectomies performed solely for the purpose of rendering an individual permanently incapable of reproducing. • Services for infertility treatment including-reversal sterilization, tuboplasty, artificial insemination, in vitro fertilization, fertility drugs. 	100% covered for office visit. Services can be performed by a PCP or specialist. Exclusions – not covered: <ul style="list-style-type: none"> • Fertility drugs are not covered. • Sterilization is not a covered benefit. 	100% covered. Services can be performed by a PCP or specialist. Sterilization requires submission of a completed W612 Consent to Sterilization form. Sterilization is covered only for members age 21 or older. Exclusions – not covered: <ul style="list-style-type: none"> • Sterilizations for patients who are under age 21, mentally incompetent, or institutionalized. • Hysterectomies performed solely for the purpose of rendering an individual permanently incapable of reproducing. • Services for infertility treatment including-reversal sterilization, tuboplasty, artificial insemination, in vitro fertilization, fertility drugs.



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Genetic Testing	<p>Prior authorization (PA) required.</p> <p>Refer to DSS Laboratory Fee Schedule for specific codes requiring PA.</p> <p>PA will not be required for cystic fibrosis testing (CPT codes 81220-81224) if billed with one of the diagnosis codes listed in Table 11 of the DSS Fee Schedule Instructions located at www.ctdssmap.com → Provider → Provider Fee Schedule Download.</p> <p>PA will not be required for spinal muscular atrophy (SMA) testing (CPT code 81329) if billed with one of the diagnosis codes listed in Table 11A of the DSS Fee Schedule Instructions located at www.ctdssmap.com → Provider → Provider Fee Schedule Download.</p>	<p>PA required.</p> <p>Refer to DSS Laboratory Fee Schedule for specific codes requiring PA.</p> <p>PA will not be required for cystic fibrosis testing (CPT codes 81220-81224) if billed with one of the diagnosis codes listed in Table 11 of the DSS Fee Schedule Instructions located at www.ctdssmap.com → Provider → Provider Fee Schedule Download.</p> <p>PA will not be required for SMA testing (CPT code 81329) if billed with one of the diagnosis codes listed in Table 11A of the DSS Fee Schedule Instructions located at www.ctdssmap.com → Provider → Provider Fee Schedule Download.</p>	<p>PA required.</p> <p>Refer to DSS Laboratory Fee Schedule for specific codes requiring PA.</p> <p>PA will not be required for cystic fibrosis testing (CPT codes 81220-81224) if billed with one of the diagnosis codes listed in Table 11 of the DSS Fee Schedule Instructions located at www.ctdssmap.com → Provider → Provider Fee Schedule Download.</p> <p>PA will not be required for SMA testing (CPT code 81329) if billed with one of the diagnosis codes listed in Table 11A of the DSS Fee Schedule Instructions located at www.ctdssmap.com → Provider → Provider Fee Schedule Download.</p>
Inpatient MD (professional)	100% covered.	100% covered, no co-pays.	100% covered.
Labs	100% covered.	100% covered.	100% covered.
Maternity	100% covered for prenatal and postpartum visits.	100% covered for prenatal and postpartum visits.	100% covered for prenatal and postpartum visits.



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<p>Maternal Depression Screenings</p>	<p>Covered up to one year after delivery. Multiple screenings can be performed when there is a documented risk of depression. Requires validated screening tool. May be performed by pediatric providers on mother to assess risk to infant. Based on risk, a pediatric provider can perform multiple screenings on the mother until the infant turns one.</p> <p>For positive screens, mothers should be referred to CT BHP for follow-up care. Providers may contact: 1.877.552.8247. Uninsured or undocumented mothers who need a depression screen should be directed to call 211 for alternative resources.</p> <p>Billing requirements:</p> <ul style="list-style-type: none"> Providers should bill using code 96160 "Administration of patient-focused health risk assessment instrument (e.g., health hazard appraisal) with scoring and documentation, per standardized instrument" or 96161 "Administration of caregiver-focused health risk assessment instrument (e.g., depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument." Modifier use is not required to identify a positive or negative screen. 	<p>Covered up to one year after delivery. Multiple screenings can be performed when there is a documented risk of depression. Requires validated screening tool. May be performed by pediatric providers on mother to assess risk to infant. Based on risk, a pediatric provider can perform multiple screenings on the mother until the infant turns one.</p> <p>For positive screens, mothers should be referred to CT BHP for follow-up care. Providers may contact: 1.877.552.8247. Uninsured or undocumented mothers who need a depression screen should be directed to call 211 for alternative resources.</p> <p>Billing requirements:</p> <ul style="list-style-type: none"> Providers should bill using code 96160 "Administration of patient-focused health risk assessment instrument (e.g., health hazard appraisal) with scoring and documentation, per standardized instrument" or 96161 "Administration of caregiver-focused health risk assessment instrument (e.g., depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument." Modifier use is not required to identify a positive or negative screen. 	<p>N/A</p>



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Maternal Depression Screenings (Continued)	<ul style="list-style-type: none"> Pediatric providers should bill using code 96161 and the infant's ID number. <p>Documentation requirements:</p> <ul style="list-style-type: none"> Screening tool used Score Time spent Actions taken including referrals Name and credentials of practitioner who performed screening Date of service <p>Pediatric medical providers should document in the pediatric patient's record.</p> <p>Reference: DSS PB 2016-63 "Maternal Depression Screenings."</p>	<ul style="list-style-type: none"> Pediatric providers should bill using code 96161 and the infant's ID number. <p>Documentation requirements:</p> <ul style="list-style-type: none"> Screening tool used Score Time spent Actions taken including referrals Name and credentials of practitioner who performed screening Date of service <p>Pediatric medical providers should document in the pediatric patient's record.</p> <p>Reference: DSS PB 2016-63 "Maternal Depression Screenings."</p>	
Nurse Midwife	Covered 100%.	Covered. Preventive - No co-pay. Non-Preventive - \$10 co-pay.	Covered 100%.
Nurse Practitioners	Covered 100%.	Covered. Preventive - No co-pay. Non-Preventive - \$10 co-pay.	Covered 100%.



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<p>Nutritional Counseling</p>	<p>100% covered.</p> <p>Nutritional counseling services may be performed by independently enrolled physicians, Advanced Practice Registered Nurses (APRNs), and Physician Assistants (PAs) (as part of an evaluation and management service).</p> <p>Effective July 1, 2025 (Reference DSS PB 2025-18: New Coverage of Medical Nutrition Therapy): Medical Nutrition Therapy (MNT) services may be performed by independently enrolled certified dietitian-nutritionists. These services must be recommended/referred/ordered by a licensed and CMAP-enrolled physician, APRN, PA, or Certified Nurse-Midwife (CNM). Medical nutritional therapy will be limited to three hours per calendar year per HUSKY Health member. Reimbursement is limited to CPT codes 97802-97804 and must be submitted with an ICD-10 diagnosis code from Table 26 "Diagnosis Codes for MNT Services" of the DSS Fee Schedule Instructions.</p> <p>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</p>	<p>100% covered.</p> <p>Nutritional counseling services may be performed by independently enrolled physicians, APRNs, and PAs (as part of an evaluation and management service).</p> <p>Effective July 1, 2025 (Reference DSS PB 2025-18: New Coverage of Medical Nutrition Therapy): MNT services may be performed by independently enrolled certified dietitian-nutritionists. These services must be recommended/referred/ordered by a licensed and CMAP-enrolled physician, APRN, PA, or CNM. Medical nutritional therapy will be limited to three hours per calendar year per HUSKY Health member. Reimbursement is limited to CPT codes 97802-97804 and must be submitted with an ICD-10 diagnosis code from Table 26 "Diagnosis Codes for MNT Services" of the DSS Fee Schedule Instructions.</p> <p>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 Codes for MNT Services" of the DSS Fee Schedule Instructions. Additionally, claims must include</p>	<p>100% covered.</p> <p>Nutritional counseling services may be performed by independently enrolled physicians, APRNs, and PAs (as part of an evaluation and management service).</p> <p>Effective July 1, 2025 (Reference DSS PB 2025-18: New Coverage of Medical Nutrition Therapy): MNT services may be performed by independently enrolled certified dietitian-nutritionists. These services must be recommended/referred/ordered by a licensed and CMAP-enrolled physician, APRN, PA, or CNM. Medical nutritional therapy will be limited to three hours per calendar year per HUSKY Health member. Reimbursement is limited to CPT codes 97802-97804 and must be submitted with an ICD-10 diagnosis code from Table 26 "Diagnosis Codes for MNT Services" of the DSS Fee Schedule Instructions.</p> <p>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 Codes for MNT Services" of the DSS Fee Schedule Instructions. Additionally, claims must include</p>



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Nutritional Counseling (Continued)	<p>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. There is no separate professional reimbursement for MNT services provided in the outpatient hospital setting.</p> <p>MNT services rendered by a certified dietitian-nutritionist performed in a FQHC will continue to be reimbursed by their encounter rate. Reimbursement is limited to CPT codes 97802-97804 and must be submitted with an ICD-10 diagnosis code from Table 26 “Diagnosis Codes for MNT Services” of the DSS Fee Schedule Instructions. Claims submitted with MNT services must include the certified dietitian-nutritionist as the rendering provider.</p>	<p>the certified dietitian-nutritionist as the rendering provider. There is no separate professional reimbursement for MNT services provided in the outpatient hospital setting.</p> <p>MNT services rendered by a certified dietitian-nutritionist performed in a FQHC will continue to be reimbursed by their encounter rate. Reimbursement is limited to CPT codes 97802-97804 and must be submitted with an ICD-10 diagnosis code from Table 26 “Diagnosis Codes for MNT Services” of the DSS Fee Schedule Instructions. Claims submitted with MNT services must include the certified dietitian-nutritionist as the rendering provider.</p>	<p>the certified dietitian-nutritionist as the rendering provider. There is no separate professional reimbursement for MNT services provided in the outpatient hospital setting.</p> <p>MNT services rendered by a certified dietitian-nutritionist performed in a FQHC will continue to be reimbursed by their encounter rate. Reimbursement is limited to CPT codes 97802-97804 and must be submitted with an ICD-10 diagnosis code from Table 26 “Diagnosis Codes for MNT Services” of the DSS Fee Schedule Instructions. Claims submitted with MNT services must include the certified dietitian-nutritionist as the rendering provider.</p>
Obesity	<p>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 it requires PA for medical necessity.</p>	<p>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 it requires PA for medical necessity.</p>	<p>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 it requires PA for medical necessity.</p>
Organ Transplants	PA required.	PA required.	PA required.
Physician Office Visits	100% covered.	<p>Covered.</p> <p>Preventive office visits - No co-pay. Non-preventive office visits - \$10 co-pay.</p>	100% covered.



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Prescription Drug Coverage (retail pharmacy)	Covered through DSS (Gainwell Technologies). Providers may call: CT Medical Assistance Pharmacy Prior Authorization Center: 1.866.409.8386 (phone) 1.866.759.4110 (fax) 1.866.604.3470 (TTY/TDD line) Members may call: 1.866.409.8430 or 1.860.269.2031 www.ctdssmap.com No co-pays. Members must use their ConneCT card at the pharmacy to acquire prescriptions.	Covered through DSS (Gainwell Technologies). Providers may call: CT Medical Assistance Pharmacy Prior Authorization Center: 1.866.409.8386 (phone) 1.866.759.4110 (fax) 1.866.604.3470 (TTY/TDD line) Members may call: 1.866.409.8430 or 1.860.269.2031 www.ctdssmap.com Prescription Medication: Generic - \$5 co-pay Brand - \$10 co-pay Members must use their ConneCT card at the pharmacy to acquire prescriptions.	Covered through DSS (Gainwell Technologies). Providers may call: CT Medical Assistance Pharmacy Prior Authorization Center: 1.866.409.8386 (phone) 1.866.759.4110 (fax) 1.866.604.3470 (TTY/TDD line) Members may call: 1.866.409.8430 or 1.860.269.2031 www.ctdssmap.com No co-pays. Members must use their ConneCT card at the pharmacy to acquire prescriptions.
Preventive Care	100% covered including well-child care or EPSDT visits and immunizations.	The following preventive services require no co-pay: <ul style="list-style-type: none"> • Immunizations and the office visit for the immunization. • WIC evaluations. • Prenatal and postpartum care for women under age 19. • Regular newborn screening exam in the hospital or office. • Annual physical exams and lab tests related to those exams. 	100% covered including well-child care or EPSDT visits and immunizations.

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Procedures requiring PA regardless of where the procedure is performed	<ul style="list-style-type: none"> • 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 splint services • Interdental fixation device services • Interdental wiring non-fracture • Canthopexy • Otoplasty • Rhinoplasty • Septoplasty 	<ul style="list-style-type: none"> • 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 splint services • Interdental fixation device services • Interdental wiring non-fracture • Canthopexy • Otoplasty • Rhinoplasty • Septoplasty 	<ul style="list-style-type: none"> • 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 splint services • Interdental fixation device services • Interdental wiring non-fracture • Canthopexy • Otoplasty • Rhinoplasty • Septoplasty



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Benefit	HUSKY A, HUSKY C	HUSKY B	HUSKY D
Procedures requiring PA regardless of where the procedure is performed (Continued)	<ul style="list-style-type: none"> • 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 • Procedures related to sterilization reversal • 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 category.) 	<ul style="list-style-type: none"> • 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 • Procedures related to sterilization reversal • 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 category.) 	<ul style="list-style-type: none"> • 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 • Procedures related to sterilization reversal • 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 category.)
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.



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<p>Screening, Brief Intervention and Referral to Treatment (SBIRT) Covered for PCPs Only</p>	<p>Covered codes: 99408 and 99409</p> <p>When rendering SBIRT services, providers must:</p> <ul style="list-style-type: none"> • Use a validated screening tool. • Utilize evidenced-based brief intervention guidelines. • Make referrals to treatment as appropriate. <p>For a list of validated screening tools, please access the following link: https://www.samhsa.gov/substance-use/treatment/resources</p> <p>Documentation Requirements Provider must document:</p> <ul style="list-style-type: none"> • 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. <p>Billing: SBIRT codes may be billed on the same date of service as an Evaluation and Management (E&M) code. Modifier 25 should be used to indicate that the SBIRT services were distinct</p>	<p>Covered codes: 99408 and 99409</p> <p>When rendering SBIRT services, providers must:</p> <ul style="list-style-type: none"> • Use a validated screening tool. • Utilize evidenced-based brief intervention guidelines. • Make referrals to treatment as appropriate. <p>For a list of validated screening tools, please access the following link: https://www.samhsa.gov/substance-use/treatment/resources</p> <p>Documentation Requirements Provider must document:</p> <ul style="list-style-type: none"> • 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. <p>Billing: SBIRT codes may be billed on the same date of service as an E&M code. Modifier 25 should be used to indicate that the SBIRT services were distinct and separate from the</p>	<p>Covered codes: 99408 and 99409</p> <p>When rendering SBIRT services, providers must:</p> <ul style="list-style-type: none"> • Use a validated screening tool. • Utilize evidenced-based brief intervention guidelines. • Make referrals to treatment as appropriate. <p>For a list of validated screening tools, please access the following link: https://www.samhsa.gov/substance-use/treatment/resources</p> <p>Documentation Requirements Provider must document:</p> <ul style="list-style-type: none"> • 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. <p>Billing: SBIRT codes may be billed on the same date of service as an E&M code. Modifier 25 should be used to indicate that the SBIRT services were distinct and separate from the</p>



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SBIRT Covered for PCPs Only (Continued)	and separate from the E&M service with medical record documentation to support. Reference: DSS PB 2015-79 "Screening, Brief Intervention and Referral to Treatment (SBIRT) in Primary Care."	E&M service with medical record documentation to support. Reference: DSS PB 2015-79 "Screening, Brief Intervention and Referral to Treatment (SBIRT) in Primary Care."	E&M service with medical record documentation to support. Reference: DSS PB 2015-79 "Screening, Brief Intervention and Referral to Treatment (SBIRT) in Primary Care."
Smoking and Tobacco Cessation Counseling (Individual and Group Counseling)	Covered 100% when done in physician office. Individual Counseling: Covered codes: 99406, 99407 will require a tobacco-related diagnosis code. Group Counseling: <ul style="list-style-type: none"> • Covered code 99412 requires a primary diagnosis code on the claim to be in the following range: Nicotine Dependence (ICD-10 F17.200 - F17.299). • PA not required. • Group size limited to three to 12 members. • Limited to 12 sessions per member per episode of care and 24 sessions per member per 365 days. 	Individual Counseling: Covered codes: 99406, 99407 will require a primary tobacco-related diagnosis code. Group Counseling: <ul style="list-style-type: none"> • Covered code 99412 requires a primary diagnosis code on the claim to be in the following range: Nicotine Dependence (ICD-10 F17.200 - F17.299). • PA not required. • Group size limited to three to 12 members. • Limited to 12 sessions per member per episode of care and 24 sessions per member per 365 days. 	Covered 100% when done in physician office. Individual Counseling: Covered codes: 99406, 99407 will require a tobacco-related diagnosis code. Group Counseling: <ul style="list-style-type: none"> • Covered code 99412 requires a primary diagnosis code on the claim to be in the following range: Nicotine Dependence (ICD-10 F17.200 - F17.299). • PA not required. • Group size limited to three to 12 members. • Limited to 12 sessions per member per episode of care and sessions per member per 365 days.
Specialist	100% Coverage.	Covered. \$10 co-pay applies. No co-pay for allergy injections.	100% Coverage.



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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	Non-emergent care requires PA.	Non-emergent care requires PA.	Non-emergent care requires PA.
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:	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • 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 medically necessary 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. 	<ul style="list-style-type: none"> • 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.

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Benefit Exclusions (Continued)	<ul style="list-style-type: none"> • Services for which PA is required and is not obtained. • 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. • Nuclear-powered pacemakers. • Implantation of nuclear-powered pacemakers. • Inpatient charges related to autopsy. • Services beyond what is necessary to treat 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. 	<ul style="list-style-type: none"> • 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. • 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. 	<ul style="list-style-type: none"> • Services for which PA is required and is not obtained. • 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. • Nuclear-powered pacemakers. • Implantation of nuclear-powered pacemakers. • Inpatient charges related to autopsy. • Services beyond what is necessary to treat 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.



HUSKY Health Benefits and Prior Authorization Requirements Grid*
Physician
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
Benefit Exclusions (Continued)	<ul style="list-style-type: none"> • Sterilizations for patients who are under age 21, mentally incompetent, or institutionalized. • Hysterectomies performed solely for the purpose of rendering an individual permanently incapable of reproducing. 	<ul style="list-style-type: none"> • Services not related to illness or problems at the time of treatment. 	<ul style="list-style-type: none"> • Sterilizations for patients who are under age 21, mentally incompetent, or institutionalized. • Hysterectomies performed solely for the purpose of rendering an individual permanently incapable of reproducing.