HUSKY HEALTH
CONNECTICUT

HUSKY Health Benefits and Prior Authorization Grid

Clinic Medical

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

HUSKY Health Benefits and Prior Authorization Requirements Grid*
Clinic Medical
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
Health and Behavior Assessments (CPT 96150-96155)	100% covered under medical benefit for non-behavioral health diagnoses (those ICD-10 diagnosis codes not listed in Table 11 of the DSS fee schedule instructions located at www.ctdssmap.com →Provider → Provider Fee Schedule Download.) • Service must be requested via physician order • Prior Authorization NOT needed For benefit coverage and authorization requirements for behavioral health diagnoses* contact the Connecticut Behavioral Health Partnership: 1-877-552-8247. *For a list of ICD-10 diagnosis codes please visit the DSS fee schedule instructions located at www.ctdssmap.com → Provider → Provider Fee Schedule Download.	Contact the Connecticut Behavioral Health Partnership: 1-877-552-8247 for benefit coverage, authorization requirements and co-pays that apply.	100% covered under medical benefit for non-behavioral health diagnoses (those ICD- 10 diagnosis codes not listed in Table 11 of the DSS fee schedule instructions located at www.ctdssmap.com →Provider → Provider Fee Schedule Download.) • Service must be requested via physician order • Prior Authorization NOT needed For benefit coverage and authorization requirements for behavioral health diagnoses* contact the Connecticut Behavioral Health Partnership: 1-877-552-8247 *For a list of ICD-10CM diagnosis codes please visit the DSS fee schedule instructions located at www.ctdssmap.com → Provider → Provider Fee Schedule Download.
Nurse Midwives	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%

Last Update: 03/28/2023 / MMTPE0001-0312

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Nutritional Counseling	Covered 100%. 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 RCC 510 (clinic visit) and no separate payment will be made to the individual provider.	Covered 100%. 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 RCC 510 (clinic visit) and no separate payment will be made to the individual provider.	Covered 100%. 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 RCC 510 (clinic visit) and no separate payment will be made to the individual provider.
Prescription Drug Coverage (retail pharmacy)	Covered through DSS (EDS) 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)	Covered through DSS (EDS) 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)	Covered through DSS (EDS) 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)

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Preventive Care	100% covered including well child care or EPSDT visits and Immunizations.	The following Preventive Services require no co-pay: • 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.
Smoking and Tobacco Cessation Counseling - Individual	Covered Codes: 99406 and 99407. Will require a nicotine dependency primary diagnosis code (F17.20-F17.299). Covered 100% when done in physician office and other outpatient settings. Smoking cessation counseling performed by behavioral health clinicians or in a mental health clinic is covered under and billed to the behavioral health benefit	Covered Codes: 99406 and 99407. Will require a tobacco-related primary diagnosis code (F17.20-F17.299). Covered 100% when done in physician office and other outpatient settings. Smoking cessation counseling performed by behavioral health clinicians or in a mental health clinic is covered under and billed to the behavioral health benefit	Covered Codes: 99406 and 99407. Will require a nicotine dependency primary diagnosis code (F17.20-F17.299). Covered 100% when done in physician office and other outpatient settings. Smoking cessation counseling performed by behavioral health clinicians or in a mental health clinic is covered under and billed to the behavioral health benefit
Screening, Brief Intervention, and Referral to Treatment (SBIRT) Covered for Primary Care Providers (PCPs) in Medical FQHCs	Covered Codes: 99408 and 99409 When rendering SBIRT Services, providers must: • Use a validated screening tool • Utilize evidenced based brief intervention guidelines	Covered Codes: 99408 and 99409 When rendering SBIRT Services, providers must: • Use a validated screening tool • Utilize evidenced based brief intervention guidelines	Covered Codes: 99408 and 99409 When rendering SBIRT Services, providers must: • Use a validated screening tool • Utilize evidenced based brief intervention guidelines

Benefit	HUSKY A, HUSKY C	HUSKY B	HUSKY D
Screening, Brief Intervention, and Referral to Treatment (SBIRT) Covered for Primary Care Providers (PCPs) in Medical FQHCs (cont.)	• Make referrals to treatment as appropriate For a list of validated screening tools please access the following link: https://www.samhsa.gov/sbirt/resources **Documentation Requirements:** Provider must document: • The screening tool used • The score obtained • The time spent • Any action taken as a result of the screening (including referrals) • Name and credentials of practitioner who provided service • A dated note **Billing:** Bill SBIRT codes on the claim along with code T1015 and any other appropriate codes(s) for other services rendered during that encounter. 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/sbirt/resources **Documentation Requirements:** Provider must document: • The screening tool used • The score obtained • The time spent • Any action taken as a result of the screening (including referrals) • Name and credentials of practitioner who provided service • A dated note **Billing:** Bill SBIRT codes on the claim along with code T1015 and any other appropriate codes(s) for other services rendered during that encounter. 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/sbirt/resources **Documentation Requirements:** Provider must document: • The screening tool used • The score obtained • The time spent • Any action taken as a result of the screening (including referrals) • Name and credentials of practitioner who provided service • A dated note **Billing:** Bill SBIRT codes on the claim along with code T1015 and any other appropriate codes(s) for other services rendered during that encounter. Reference: DSS PB 2015-79 “Screening, Brief Intervention and Referral to Treatment (SBIRT) in Primary Care”.
Smoking and Tobacco Cessation Counseling – Group	Primary diagnosis must be Nicotine Dependence (ICD-10 diagnosis codes F17.200 -F17.299).	Primary diagnosis must be Nicotine Dependence (ICD-10 diagnosis codes F17.200 -F17.299).	Primary diagnosis must be Nicotine Dependence (ICD-10 diagnosis codes F17.200 -F17.299).

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Smoking and Tobacco Cessation Counseling – Group (cont.)	FQHCs: Bill with HCPCS T1015 with CPT 99412 All other medical clinics: Bill with 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. Limited to 12 sessions per member per episode of care and 24 sessions per member per 365 days.	FQHCs: Bill with HCPCS T1015 with CPT 99412 All other medical clinics: Bill with 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. Limited to 12 sessions per member per episode of care and 24 sessions per member per 365 days.	FQHCs: Bill with HCPCS T1015 with CPT 99412 All other medical clinics: Bill with 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. Limited to 12 sessions per member per episode of care and 24 sessions per member per 365 days.
Specialist	100% coverage	Covered $10 co-pay applies	100% coverage
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	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	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).

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States of Micronesia, Guam, Midway Islands, Northern Marina Islands, US Virgin Islands)			
Translation Services	1.800.440.5071	1.800.440.5071	1.800.440.5071
Benefit Exclusions This is a general listing of those exclusions most applicable to Naturopathic Services and includes but is not limited to the following:	• Infertility treatment (i.e. reversal sterilization; artificial insemination; invitro fertilization; fertility drugs) • Drugs used to treat sexual or erectile dysfunction • Weight reduction programs • 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 • Services beyond what is necessary to treat the medical problems	• Infertility treatment (i.e. reversal sterilization; artificial insemination; invitro fertilization; fertility drugs) • Weight reduction programs • 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 • Inpatient charges related to autopsy • Routine foot care • Sterilization • Services beyond what is necessary for treatment	• Infertility treatment (i.e. reversal sterilization; artificial insemination; invitro fertilization; fertility drugs) • Drugs used to treat sexual or erectile dysfunction • Weight reduction programs • 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 • Services beyond what is necessary to treat the medical problems

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Benefit Exclusions (cont.)	• 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	• 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 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