

HUSKY Health Program and Charter Oak Health Plan Prior Authorization

Objectives

- Gain knowledge about what types of prior authorizations are processed
- Have a better understanding of how to submit a prior authorization request
- Learn more in-depth detail about the PA process at CHNCT

Introductions

- Community Health Network of Connecticut, Inc. is the administrative services organization (ASO) for the HUSKY Health Program and Charter Oak Health Plan.
- The ASO model of care covers all of the Department of Social Services (DSS) medical assistance clients.
- All HUSKY Health and Charter Oak members receive all health services only from CMAP-enrolled providers.

Overview

- Prior Authorization (PA) is approval from the Department of Social Services (DSS) or its contracted administrative services organization (ASO), for the provision of a service or the delivery of goods before the provider actually performs the service or delivers the goods.
- To receive reimbursement from DSS, a provider must comply with all PA requirements. DSS has sole discretion to determine what information is necessary to approve a PA request. Obtaining PA does not guarantee payment or ensure client eligibility. It is the responsibility of the provider to verify client eligibility for the appropriate date(s) of service.

Services Requiring Prior Authorization

- Durable Medical Equipment (including Customized Wheelchairs)
- Hearing Aids
- Laboratory (Genetic Testing)
- Medical/Surgical Supplies
- Occupational Therapy
- Orthotics & Prosthetic Devices
- Oxygen
- Physical Therapy
- Professional/Surgical Services
- Radiology Services
- Speech/Audiology Therapy
- Vision Care Services

Services Requiring Prior Authorization

- Benefit and authorization grids providing a general summary of benefits and authorization requirements for the HUSKY Health Program and Charter Oak Health Plan are located on the plan's websites. Please refer to either of the following websites for information on benefit or authorization requirements:

www.huskyheath.com

www.charteroakhealthplan.com

- From either of these websites, click *For Providers* followed by *Benefits and Authorizations*.

Services Requiring Prior Authorization

- For a definitive list of benefits and limitations, please review the CMAP Fee schedules and regulations at:

www.ctdssmap.com

- For fee schedule information, click on *Provider*, followed by *Provider Fee Schedule Download*.
- For regulations, click on *Information*, then *Publications* and view Chapter 7.

Retrospective Authorization Requests

- All authorization requests must be received prior to administration of services.
- HUSKY Health does not permit retro-authorization requests unless it is a member or provider retro-enrollment situation.

Prior Authorization of Specialized Services

- Behavioral Health - Contact CTBHP at 1.877.552.8247
- Dental Health - Contact CTDHP at 1.855.283.3682
- Non-Emergent Transportation - Contact Logisticare at 1.888.248.9895
- Radiology Services - Contact Care to Care at 1.800.440.5071; follow the prompts for radiology.
- Waiver Programs - PA requests for home care services for members in the following programs must continue to be submitted to Hewlett Packard (HP) at fax 1.860.269.2138 or phone 1.860.842.8440:

Home Care Program for the Elders
Money Follows the Person

How to Obtain Prior Authorization

Providers have three options for submitting a request for PA:

1. Clear Coverage, the secure online web portal
2. Phone: 1.800.440.5071 - Follow the prompts for authorization
3. Fax: 203.265.3994 - Must submit with a completely filled out Prior Authorization Form and all pertinent clinical documentation

The Prior Authorization request forms and instructions can be downloaded from the web portal at www.huskyhealthct.org; click *For Providers*, then *Provider Bulletins, Updates and Forms*.

Timeliness Standards for Review Determinations

CHNCT will render decisions regarding requests for goods and services based on the following timeframes:

- Initial authorization for radiology, Synagis, outpatient surgery and home care: 2 business days
- Re-authorization for outpatient therapy and home care: 14 calendar days
- Durable medical equipment (DME): 14 calendar days
- New requests for therapies (speech, physical, occupational): 2 business days
- Urgent and expedited requests: 1 business day
- All other non-emergent services subject to prior authorization: 14 calendar days

Written notices regarding all decisions will be sent within 3 business days of the decision.

Rehabilitation Clinic, Independent Therapy, Physician Therapy

Prior Authorization Instructions

Therapy Prior Authorization Requirements

Initial Authorization Requests:

- Subject to 2 business day turnaround time
- Completed Outpatient Prior Authorization Request Form
- Initial evaluation
- Treatment plan including assessment, established short and long term goals, treatment modalities, and rehab potential/prognosis

Therapy Prior Authorization Requirements

Re-authorization Requests

- Subject to 14 calendar day turnaround time
- Completed Outpatient Prior Authorization Request Form
- Signed MD script **or** MD signed therapy treatment plan
- Daily notes (approx. 4 previous notes to determine the medical necessity of treatments being provided)
- Documentation of home program or home strategies
- Most recent progress note that indicates progress to goals
- Documentation of rehab potential/prognosis for member to meet updated goals

Chiropractic Services

Prior Authorization Instructions

Chiropractic Services

- Medically necessary independent chiropractic services are available for HUSKY Health members under the age of 21 only as EPSDT special services, as well as for HUSKY B members with prior authorization.
- Prior authorization must be requested and approved before providing services under EPSDT special services or HUSKY B, otherwise the claim will be denied.

Chiropractic Services Prior Authorization Requirements

When requesting prior authorization under EPSDT special services or HUSKY B the following must be submitted:

- An order provided by a physician licensed pursuant to Sec. 20-13 of the Connecticut General Statutes, APRN, or PA who is enrolled with the CT Medical Assistance Program
- A description of the outcomes of any alternative measure tried
- Any other documentation reasonably requested by the department or any designated agent of the department which may be required to make a decision

Chiropractic Services Prior Authorization Requirements

- Fax all requests, **including the order from the licensed physician, APRN or physician assistant** to CHNCT at 203.265.3994.
- As outlined in Policy Bulletin 2003-24, for dually eligible HUSKY Health members, independently enrolled chiropractors may submit claims for deductibles or co-insurance.
- **Please note: If Medicare denies a chiropractic claim for a dually eligible member, these services will not be covered under the HUSKY Health program.**

Home Health Services

Prior Authorization Instructions

Home Health Services Prior Authorization Requirements

Initial Authorization Requests:

- Subject to 2 business day turnaround time
- Completed Outpatient Prior Authorization Request Form
- Orders signed by the licensed physician responsible for the plan of care
- OASIS Assessment
- Comprehensive plan of care including skills being provided and measurable short and long term goals. Goals should include plan for member/primary caregiver teaching

Chiropractic Services Prior Authorization Requirements

Re-authorization Requests:

- Subject to 14 calendar day turnaround time
- Completed Outpatient Prior Authorization Request Form
- Recent orders signed by the licensed physician
- Comprehensive nursing assessment
- Nursing narrative notes from previous certification period
- Updated comprehensive plan of care documenting progress to established goals and/or the need to update the treatment plan
- Member and/or primary caregiver response to teaching

Durable Medical Equipment

Prior Authorization Instructions

Definition of Durable Medical Equipment

Reference: Regulations Connecticut State Agencies
17b-262 673(5)

- Can withstand repeated use;
- Is primarily and customarily used to serve a medical purpose;
- Generally is not useful to a person in the absence of an illness or injury; and
- Is non disposable

Durable Medical Equipment

For all Durable Medical Equipment (DME) that requires prior authorization, the following must be submitted with the request:

- Completed Outpatient Prior Authorization Request Form
- Physician's prescription
- Detailed product description and quotation including manufacturer, model/part number, product description, HCPC code, unit(s), quantity, Medicaid allowable price, and retail price
- Clinical documentation explaining why the requested DME is medically necessary for the member's specific clinical situation

Durable Medical Equipment Specific Clinical Guidelines

Foot Orthotics

- Prior authorization is required for foot orthotics including inserts, arch supports, and modifications to orthopedic shoes.
- The *“Foot Orthotics Clinical Guideline”* is located on the HUSKY Health Program and Charter Oak Health Plan website at www.huskyhealthct.org.

FES Walkaide

- Prior authorization is required for FES Walkaide requests.
- The *“FES Walkaide Clinical Guideline”* is located on the HUSKY Health Program and Charter Oak Health Plan website at www.huskyhealthct.org.

Customized Wheelchairs

The Regulations of CT State Agencies, Section 17-134d-46(b), defines a customized wheelchair as one that is specifically manufactured to meet the needs of a recipient who cannot independently maintain proper body alignment. Medical needs take priority over functional needs.

Customized Wheelchairs

Prior Authorization Requirements:

- Completed Outpatient Prior Authorization Request Form
- Supporting pricing for all components of the custom wheelchair
- Prescription (dated before dates for supporting pricing from the vendor)
- Interdisciplinary team (IDT) assessment
- Orthopedic or physiatrist consult
- PT or OT consult
- Completed customized wheelchair prescription (W 628)

Medical/Surgical and Miscellaneous Supplies

Prior Authorization Services

Medical/Surgical and Miscellaneous Supplies

- Medical /Surgical and miscellaneous supplies in excess of the monthly quantity limits on the DSS fee schedule require Prior Authorization
- A Completed Outpatient PA Request Form with a detailed prescription signed by a physician who specifies the need for that product or service must be obtained by the provider *before the product or service is provided.*
- Supplies that are authorized by CHNCT must be purchased within six months of the date of authorization.

Diapers and Incontinence Supplies

- Prior authorization of diapers and incontinence supplies is required for HUSKY A, C and D members between the ages of 3 and 12 years. Prior authorization is required for clients 13 years of age and older for supplies which exceed the monthly quantity limit of 250 diapers or absorbent undergarments per month.
- Diapers and incontinence supplies are not a covered benefit for children ages 0-2. Diapers and incontinence supplies are not covered for clients enrolled in the HUSKY B Program and Charter Oak Health Plan, regardless of age.
- All requests will be reviewed based on the DSS definition of medical necessity and must be in direct accordance with a signed prescription from the member's ordering physician.

Diapers and Incontinence Supplies: Prior Authorization Requirements

- Completed Outpatient PA Request Form must be submitted by the billing provider.
- The billing provider must be an enrolled DME/Medical Surgical provider with the Connecticut Medical Assistance Program (CMAP).
- Requests must be in accordance with a signed prescription from the member's ordering physician.

Diapers and Incontinence Supplies: Prescription Requirements

All prescriptions must contain the following:

1. Member's name, address and date of birth
2. Diagnosis for which the medical and surgical supplies are required
3. Detailed description of the medical and surgical supplies, including the quantities and directions for usage, when appropriate
4. Length of need for the prescribed medical and surgical supplies
5. Name and address of prescribing practitioner
6. Prescribing practitioner's signature and date signed

Professional/Surgical Services

Prior Authorization Instructions

Prior Authorization Requirements for Surgical Services

- All elective inpatient hospital admissions require prior authorization.
- All outpatient surgical procedures, as determined by the Physician Surgical Fee Schedule, require prior authorization.
- The updated fee schedule can be accessed and downloaded by going to the Connecticut Medical Assistance website at www.ctdssmap.com. From this web page, go to “Provider Fee Schedule Download,” then to “Physician Surgical” in order to locate the surgical procedure fee schedules.
- A ‘Y’ in the column titled ‘PA’ indicates a prior authorization requirement.

Prior Authorization Requirements for Surgical Services

- All requests for elective inpatient services and any requests for outpatient surgery (as determined by the Physician Fee Schedule) should be submitted by sending a completed request form to CHNCT by either fax 1.203.265.3994 or phone 1.800.440.5071.
- Appropriate forms can be downloaded from the web portal at www.huskyhealthct.org. Click on For Providers, Provider Bulletins, Updates and Forms and then accessing the *Inpatient Surgery PA Form* or the *Outpatient PA Request Form*.
- Requests must include all pertinent clinical documentation to support medical necessity of the procedure.

Prior Authorization Requirements for Laboratory Services

- Prior authorization of genetic testing is required with the exception of those tests used for cystic fibrosis screening during pregnancy. Coverage determinations will be based upon a review of requested and/or submitted case-specific information.
- Requests for the prior authorization of genetic testing must be made using one of the “new” 2012 CPT codes (81200 – 81408) specific to the test being requested. The new code must be supported by the codes billed prior to January 2012 (83890 – 83914) as “stacked” codes with the number of units for each.

Prior Authorization Requirements for Laboratory Services

- If there is not a “new” 2012 code specific to the test being ordered, prior authorization should be requested using the codes billed prior to January 2012 (83890-83914)
- A complete listing of molecular pathology and molecular diagnostic procedures requiring prior authorization may be found on the “Lab Fee Schedule” located on the DSS Connecticut Medical Assistance (CMA) website www.ctdssmap.com under “Provider Fee Schedule Download.”
- The Genetic Testing clinical policy can be found on www.huskyhealthct.org. Click For Providers, then Policies and Procedures.

Radiology Services

Prior Authorization Instructions

Prior Authorization Requirements for Radiology Services

- Prior Authorization is required for non-emergent, advanced imaging and nuclear cardiology services.
- CHNCT manages radiology services with assistance from Care to Care (CtC), a radiology benefit management company
- The specific prior authorization instructions can be found at www.huskyhealthct.org. Click *For Providers, Provider Bulletins, Updates and Forms* and then *PB 2012 18 Important Changes to Radiology Services*.
- Care to Care can be reached by calling the CHNCT Provider Line at 1.800.440.5071. Follow the prompts for radiology authorizations.

(Palivizumab) Synagis

Prior Authorization Instructions

Palivizumab (Synagis)

- Certain infants and young children should be strongly considered as candidates for Palivizumab (Synagis®) for respiratory syncytial virus (RSV) infection prophylaxis. Recommendations for the use of Palivizumab during the annual “RSV Season” for those considered at particular risk of RSV infection-related hospitalization are periodically published by the American Academy of Pediatrics.
- Coverage guidelines for the use of Palivizumab will be made in accordance with the DSS definition of medical necessity and in line with published recommendations of the American Academy of Pediatrics.

Palivizumab (Synagis) Prior Authorization Requirements

- Requests for the prior authorization of Palivizumab must be submitted by the physician via fax to 860.632.3696. Questions regarding the form should be directed to 1.866.615.9475.
- There is a specific request form for Palivizumab. It is available on the DSS website at www.ctdssmap.com. Click *Information, Publications, Forms, Authorization/Certification Forms* and then select the Synagis® **Prior Authorization Request Form link.**

Palivizumab (Synagis) Prior Authorization Requirements

Information Required for Review:

- Fully completed State of Connecticut, Department of Social Services HUSKY Health Program Palivizumab (Synagis) Request form (to include physician's order and signature)
- Clinical information supporting the medical necessity of the treatment
- Other information as requested

Important Phone Numbers

Member and Provider Call Centers

Member phone number: **1.800.859.9889**

Provider phone number: **1.800.440.5071**

Open Monday through Friday from 9 a.m. to 7 p.m.

HP Provider Assistance Center 1.800.842.8440

Open Monday through Friday from 8 a.m. to 5 p.m.

Behavioral Health

CT Behavioral Health Partnership **1.877.552.8247**

The TTY/TDD telephone number is 1.866.218.0525

Open Monday through Friday from 9 a.m. to 7 p.m.

Website: www.ctbhp.com

Important Phone Numbers

Dental

CT Dental Health Partnership **1.866.420.2924** or
1.855 CT DENTAL(1.855.283.3682)

The TTY/TDD telephone number is 1.866.218.0525

Open Monday through Friday 8 a.m. to 5 p.m.

Website: www.ctdhp.com

Prescriptions

Pharmaceutical Benefits or Authorization Requirements

1.866.409.8386

Website: www.ctdssmap.com/CTPORTAL/Pharmacy