

# Amida Care Benefit Guide

<b>Topic</b>	<b>Page</b>
I. Amida Care Services	1
II. HIV SNP Enhanced Services	16

I. Amida Care (AC) Services:

Service	AC Benefit	Prior Auth Required	Guidelines
<b>Abortions</b>	Yes	No	Members can “self- refer” to any Amida Care provider.  Members can use their Medicaid Card to access non-participating providers who accept Medicaid.
<b>Acupuncture</b>	Yes	No	Provider must be a NYS Education Department licensed provider for acupuncture.  One initial session and 11 additional sessions for a <b>maximum</b> of 12 appointments each year.  After 12 sessions, a prior authorization is required.
<b>AIDS Adult Day Health Care (AADHC)</b>	Yes	Yes	<b>New:Request</b> <ul style="list-style-type: none"> <li>▪ An MD order is required for initial assessment</li> <li>▪ Care Plans, Registrant Assessment Instruments (RAIs), and assessments are required for continued authorizations thereafter.</li> </ul> <b>Concurrent:</b> Care Plans and assessments are required every two (2), three (3), or six (6) months dependent upon the frequency of services received.
<b>Allergen Desensitization Treatments</b>	Yes	No	N/A
<b>Ambulatory Surgery - Diagnostic</b>	Yes	No	Diagnostic and preventative non-operative procedures with or without biopsy i.e. colonoscopy/EGD, bronchoscopy, cystoscopy do not require pre-authorization. Unless non-par provider is performing, or procedure is being performed in a non-par facility.
<b>Ambulatory Surgery - Outpatient</b>	Yes	Yes	
<b>Amniocentesis</b>	Yes	Yes	N/A
<b>Anesthesia Services – Pain Management</b>	Yes	Yes	N/A
<b>Artificial Insemination</b>	No	N/A	N/A

Service	AC Benefit	Prior Auth Required	Guidelines
<b>Asthma Self-Management Training (ASMT)</b>	Yes	No	<p>This benefit covers a maximum of ten (10) hours of patient education during the initial year and two (2) hours of patient education for the following year and there-after.</p> <p>ASMT services can only be performed by one of the following New York State (NYS) licensed, registered, or certified professionals affiliated with an ASMT program and who practices in one of the following professional disciplines:</p> <ul style="list-style-type: none"> <li>• Registered Nurse</li> <li>• Registered Nurse Practitioner</li> <li>• Physician [Medical Doctor (MD), Doctor of Osteopathy (DO)]</li> <li>• Pharmacist</li> <li>• Physician Assistant</li> <li>• Respiratory Therapist</li> <li>• Licensed Clinical Social Worker</li> <li>• Licensed Master Social Worker</li> <li>• Physical Therapist;</li> <li>• Occupational Therapist</li> </ul>
<b>Bariatric Surgery</b>	Yes	Yes	N/A
<b>Behavioral Health Services:</b> Inpatient Mental Health	Yes	No	<p>Members can self- refer.</p> <p>Notification by site/institution to Amida Care is required within 48 hours. <i>Call: 1-866-664-7142</i></p> <p><b>NOTE: Non HIV/AIDS SSI SNP Coverage is covered by FFS Medicaid.</b></p>
<b>Behavioral Health Services:</b> Inpatient Detoxification	Yes	No	<p>Members can self- refer.</p> <p>Notification by site/institution to Amida Care is required within 48 hours. <i>Call: 1-866-664-7142</i></p>
<b>Behavioral Health Services:</b> Inpatient Chemical Dependence (Rehabilitation)	Yes	No	<p>Members can self-refer</p> <p>Notification by site / institution to Amida Care is required within 48 hours. <i>Call: 1-866-664-7142</i></p> <p><b>NOTE: Non HIV/AIDS SSI SNP Coverage is covered by FFS Medicaid.</b></p>
<b>Behavioral Health Services:</b> Outpatient Detoxification (ETOH)	Yes	No	<p>Members can self-refer.</p> <p>Notification to Amida Care recommended.</p> <p><i>Call: 1-866-664-7142</i></p>
<b>Behavioral Health Services:</b> Outpatient Mental Health	Yes	No	<p>Members can self-refer.</p> <p>Notification to Amida Care recommended.</p> <p><i>Call: 1-866-664-7142</i></p> <p><b>NOTE: Non HIV/AIDS SSI SNP Coverage is covered by FFS Medicaid.</b></p>

Service	AC Benefit	Prior Auth Required	Guidelines
<b>Behavioral Health Services:</b> Outpatient Substance Abuse	No	N/A	Services carved out to FFS Medicaid.
<b>Birth Centers – Free Standing</b>	Yes	Yes	Requires UM notification within 48 hours of admission.
<b>Breastfeeding Education/Lactation Services</b>	Yes	No	Breastfeeding education and lactation counseling services must be ordered by a physician, NP, MW, or PA.
<b>Buprenorphine Management</b>	Yes	No	Management of Buprenorphine by registered and / or certified provider for maintenance or detoxification when furnished and administered as part of a clinical office visit.
<b>Cardiac Catheterization</b>	Yes	Yes	Based upon medical necessity.
<b>Cardiac Rehab – Outpatient</b>	Yes	Yes	Based upon medical necessity.
<b>Cardiac Stress Test</b>	Yes	Yes	Based upon medical necessity.
<b>Case Management (CM)</b>	Yes	No	Initial Comprehensive Case Management Assessment within 60 days from effective date of enrollment.  Case Management re-assessment every 180 days.  Fax assessments to 646-786-1802 attention Case Management Department at Amida Care.  <b>NOTE: Home Health CM is covered by FFS Medicaid.</b>
<b>Chemotherapy - Inpatient</b>	Yes	Yes	
<b>Chemotherapy – Outpatient</b>	Yes	No	UM Notification Required.
<b>Chiropractic Services</b>	No	N/A	N/A
<b>Cologuard (FIT – DNA)</b>	Yes	No	Type of Colorectal Cancer Screening Method for patients considered to be of average risk.  Allow for one screening per year, prior to requiring a prior auth.
<b>Comfort Items</b>	No	N/A	N/A
<b>Compression and support stockings</b>	Yes	No	N/A
<b>Consultation for Gender Affirming Surgery</b>	Yes	No	Contact Amida Care for more information.
<b>Contact Lenses: for vision</b>	No	N/A	Refer to Vision Section.

Service	AC Benefit	Prior Auth Required	Guidelines
<b>Contact Lenses: for medical necessity</b>	Yes	Yes	Refer to Vision Section.
<b>Continued Glucose Monitors (DME)</b>	Yes	Yes	Continued Glucose Monitors are a glucose monitoring technology that continuously measures and displays interstitial glucose levels. Alarms and alerts are used to notify members when their blood glucose level is exceeding or falling below specified thresholds. This information is used by members to self-manage their diabetes.  NYS Medicaid coverage of a RT-CGM may be available for members who meet each of the following criteria. The member must: <ul style="list-style-type: none"> <li>• Have a diagnosis of type 1 diabetes</li> <li>• Be under the care of an endocrinologist, or an enrolled Medicaid provider with experience in diabetes treatment, who orders the device</li> <li>• Currently be performing multiple finger-stick glucose tests daily</li> <li>• Be on an insulin treatment plan that requires frequent adjustment of insulin dosing</li> <li>• Be able, or have a caregiver who is able, to hear and view RT-CGM alerts and respond appropriately.</li> </ul>
<b>Continuity of Care - New Member</b>	Yes	Yes	Transition period of up to 60 days of care with non-par provider if the member has a “life threatening” or “degenerative and disabling” condition or disease. Applies also to new member’s receiving Personal Care Services and/or ongoing course of treatment.
<b>Continuity of Care Provider Left Network</b>	Yes	Yes	Transition period of up to 90 days if member needs to continue ongoing treatment with current provider. Applies to member receiving Personal Care Services and/or ongoing course of treatment.
<b>Cosmetic Surgery</b>	No	N/A	<i>See Plastic/Reconstructive Surgery.</i>
<b>Court Ordered Services</b>	Yes	Yes	A copy of the Court order will be requested.
<b>CT Scan</b>	Yes	No	N/A
<b>Custodial Care</b>	N/A	N/A	Refer to the Personal Care Services (PCS) benefit
<b>Dermal Filler</b>	Yes	Yes	Primary Care Provider must refer the member to a mental health professional (psychiatrist, psychotherapist, LCSW / LMSW) for an evaluation to determine if the member suffers from an emotional or psychiatric condition caused by their lipoatrophy. Evaluations must be updated annually.  Written Treatment plan from the PCP completed upon initial request that provides medical necessity, goals and duration for the treatment
<b>Detoxification</b>	<i>See Behavioral Health Services</i>		N/A

Service	AC Benefit	Prior Auth Required	Guidelines
<b>Diabetes Self Training (DSMT)</b>	Yes	No	Members newly diagnosed with Diabetes can self-refer.  Benefit covers up to 10 hours for 12 continuous month period and 2 hours for subsequent year for follow up training. DSMT must be performed by a New York State licensed, registered, or certified professional in one of the following professional disciplines: <ul style="list-style-type: none"> <li>▪ Registered Nurse</li> <li>▪ Registered Nurse Practitioner</li> <li>▪ Registered Dietician</li> <li>▪ Physician (MD, DO)</li> <li>▪ Pharmacist</li> <li>▪ Physician Assistant</li> <li>▪ Physical Therapist</li> <li>▪ Respiratory Therapist</li> <li>▪ Licensed Clinical Social Worker</li> <li>▪ Licensed Master Social Worker</li> <li>▪ Physical Therapist</li> <li>▪ Occupational Therapist</li> </ul> AND accredited by the American Diabetes Association (ADA), American Association of Diabetes Educators (AADE) as a DMST trainer.
<b>Diabetic Supplies – Preferred</b>	Yes	No	Refer to <a href="http://www.amidacareny.org">www.amidacareny.org</a> for list of preferred supplies.
<b>Diabetic Supplies – Non Preferred</b>	Yes	Yes	Refer to <a href="http://www.amidacareny.org">www.amidacareny.org</a> for list of preferred supplies.
<b>Dialysis - Outpatient</b>	Yes	No	Prior authorization can be given for up to 6 month intervals.
<b>Directly Observed Therapy (DOT)</b>	Yes	Yes	Includes Tuberculosis and Antiretroviral (ARV) Therapy.
<b>Doula Services</b>	Yes	No	Effective April 1 <sup>st</sup> , 2025 for MMC and 3/1/2024 for FFS, doula services are covered for pregnant, birthing, and postpartum individuals, through 12 months after the end of the pregnancy regardless of how the pregnancy ends.
<b>Durable Medical Equipment (DME) – Below \$500</b>	Yes	No	Non-par Providers need a Prior Authorization.
<b>Durable Medical Equipment (DME) – Above \$500</b>	Yes	Yes	N/A
<b>Dual Energy X-Ray Scan</b>	Yes	No	A maximum of one (1) screening every two (2) years for men and women over 50 years of age with risk factors in developing osteoporosis.

Service	AC Benefit	Prior Auth Required	Guidelines
<b>Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services/Child Teen Health Programs (C/THP)</b>	Yes	No	A package of early and periodic screening including inter-periodic screens and diagnostic and treatment services that NYS offers all Medicaid eligible children under twenty-one (21) years of age to include corrective, preventive, maintenance of medical, dental, vision and hearing screens.
<b>Echocardiogram</b>	Yes	Yes	Based upon medical necessity
<b>Emergency Room (ER) Visits</b>	Yes	No	UM notification and clinical summary by participating hospitals recommended within 48 hours.  <b>NOTE: Emergency Services also include Screening, Brief Intervention, and Referral to Treatment (SBIRT) for chemical dependency.</b>
<b>End of Life/Curative/Palliative Care</b>	Yes	Yes	See Hospice Care
<b>Experimental/Investigational Procedures/Services</b>	Yes	Yes	Covered on a case by case basis
<b>Family Planning and Reproductive Health Services</b>	Yes	No	Member can "self -refer" to any Amida Care Provider or the Member can use their Medicaid Card to access non-participating providers who accept Medicaid.
<b>Flexible Sigmoidoscopy (SIG)</b>	Yes	No	No prior authorization for in-network providers  Type of Colorectal Cancer Screening Method for patients considered to be of average risk.
<b>Gender Affirming Surgery</b>	Yes	Yes	Contact Amida Care for more information.
<b>Genetic Counseling</b>	Yes	Yes	A written order is required  Maximum allowable session length is two (2) hours  Maximum of two (2) hours of pre-genetic test counseling and maximum of two (2) hours of post-genetic test counseling  Provided in a practitioner's office, hospital outpatient department, or free standing diagnostic and treatment center.
<b>Growth Hormone – administered in the providers office</b>	Yes	Yes	N/A
<b>Harm Reduction Services</b>	Yes	No	Harm reduction services represent a fully integrated member-focused approach to health and wellness, which includes, but is not limited to, overdose prevention and response and preventing transmission of HIV, Hepatitis B and C, and other illnesses in substance users.  Must be recommended in writing by a physician or other licensed practitioner.

Service	AC Benefit	Prior Auth Required	Guidelines
Hearing Aids	Yes	Yes	N/A
Hearing Aid Battery	Yes	No	N/A
Hearing Implants	Yes	Yes	N/A
Hearing Testing	Yes	No	N/A
Home Delivered Meals	Yes	Yes	Home Delivered Meals in Medicaid/HIV SNP covered only for those enrollees transitioning from Long Term Home Health Care Program (LTHHCP) and who received Home Delivered Meals while in the LTHHCP. The Home Delivered Meals benefit includes up to two meals per day on week days and/or weekends when enrollee's needs cannot be met by existing support services, including family and approved PCA's.
Home Health Care Skilled Nursing, Physical Therapy, Occupational Therapy, Speech Therapy, Social Worker, Home Health Aide	Yes	No	<p>An evaluation will be done by a nurse prior to the start of services.</p> <p>No prior authorization is needed for the first 20 visits. Prior authorization is needed starting at the 21<sup>st</sup> visit.</p> <p>Home care can be requested as part of discharge planning post hospitalization, after a short-term rehab admission or based on the member's condition as evaluated by the member's PCP, CM or Amida Care Care Coordination staff.</p> <p>Authorization is provided without applying Clinical Criteria for the following:</p> <ul style="list-style-type: none"> <li>▪ Delivery of high-risk infants (newborns)</li> <li>▪ Women discharged from the hospital less than 48 hours after vaginal delivery</li> <li>▪ Women discharged from the hospital less than 96 hours after Cesarean birth</li> <li>▪ Post discharge from hospital or SNF.</li> </ul> <p><b>Note: Clinical information and plan of care should be submitted with request for additional services.</b></p>
Hospital at Home	Yes	Yes	As of 4/15/2024, Mt. Sinai (NY), Mt. Sinai Beth Israel (NY), Mt. Sinai Morningside (NY), Northwell (North Shore University Hospital), St. Francis Hospital, The Heart Center (NY), St. Joseph Hospital (NY), Mercy Medical Center (NY), St. Charles Hospital (NY), St. Catherine of Siena Medical Center (NY), Good Samaritan Hospital Medical Center (NY), UHS Binghamton General Hospital and Wilson Regional Medical Center (NY)
Tele-Health	Yes	Yes	Only members whose risks are assessed in-person prior to the receipt of tele-health services will be eligible for reimbursement.



Service	AC Benefit	Prior Auth Required	Guidelines
<b>Home Health Interim Care with NO Skilled Nursing Need</b>	Yes	Yes	<p>Interim is defined as a set timeframe (usually 30 days) to allow the transition of home care services from skilled nursing services to personal care services.</p> <p>The interim benefit provides time for the primary care provider to initiate and submit the required form (M11Q) to the Plan for review and approval for personal care services and a Universal Assessment be completed by an RN</p> <p>The benefit covers a maximum of 45 days for interim homecare.</p> <p>Personal Care Services are services rendered by a home attendant or home maker (i.e. cooking, shopping, cleaning etc.).</p> <p><b>NOTE: Interim services are also provided for members post hospital discharge and new enrollees receiving personal care services prior to enrollment from a CHHA utilizing skilled nursing staff to render personal care.</b></p>
<b>Home Health Post Labor and Delivery</b>	Yes	No	<p>Amida Care must provide up to 2 post-partum home visits for:</p> <ul style="list-style-type: none"> <li>▪ High risk mothers</li> <li>▪ Women with less than a 48 hour hospital stay after a vaginal deliver</li> <li>▪ Women with less than a 96 hour hospital stay after a cesarean delivery</li> </ul> <p>Post-partum home visits must be made by a qualified health professional (minimum qualifications being a registered nurse with maternal/child health background), and the first visit must occur within 48 hours of discharge.</p>
<b>Home IV Infusion Therapy</b>	Yes	Yes	N/A
<b>Hospice Care</b>	Yes	Yes	Need to obtain documentation from Physician stating that the member has less than a year to live.
<b>Hospital Admissions - Elective</b>	Yes	Yes	N/A
<b>Hospital Admissions – Emergency, Labor &amp; Delivery</b>	Yes	No	N/A
<b>Hospital Alternate Level of Care (ALC)</b>	Yes	Yes	N/A
<b>Hyperbaric Oxygen Therapy</b>	Yes	Yes	N/A
<b>Hysterectomy (elective)</b>	Yes	Yes	N/A
<b>Immunizations</b>	Yes	No	Childhood immunizations (below the age 19) are paid for via the VFC (Vaccine for Children) Program. Meningococcal included.
<b>Implantable Contraceptives</b>	Yes	No	NA

Service	AC Benefit	Prior Auth Required	Guidelines
<b>Infertility treatment</b>	Yes	Yes	<p>Amida Care will cover some drugs for infertility. This benefit will be limited to coverage for 3 cycles of treatment per lifetime.</p> <p>Amida Care will also cover services related to prescribing and monitoring the use of such drugs. The infertility benefit includes:</p> <ul style="list-style-type: none"> <li>• Office visits</li> <li>• X-ray of the uterus and fallopian tubes</li> <li>• Pelvic ultrasound</li> <li>• Blood testing</li> </ul> <p>You may be eligible for infertility services if you meet the following criteria:</p> <ul style="list-style-type: none"> <li>• You are 21-34 years old and are unable to get pregnant after 12 months of regular, unprotected sex.</li> <li>• You are 35-44 years old and are unable to get pregnant after 6 months of regular, unprotected sex.</li> </ul>
<b>Injectable Medications</b>	Yes	No	N/A
<b>Inpatient Admission</b>	Yes	Yes	N/A
<b>Insulin Pump</b>	Yes	Yes	Covered as DME and requires Prior Authorization if $\geq$ \$500.
<b>In-vitro Fertilization</b>	No	N/A	N/A
<b>Laboratory Tests – Routine</b>	Yes	No	N/A
<b>Laboratory Tests – Resistance and Tropism Testing</b>	Yes	No	N/A
<b>Mammography – Diagnostic and Routine Screening</b>	Yes	No	N/A
<b>Medical Supplies - Disposable</b>	Yes	No	Refer to <a href="http://www.amidacareny.org">www.amidacareny.org</a> for a list of medical supplies.
<b>Medically Tailored Meals (MTM)</b>	Yes	Yes	<p><u>Eligibility</u></p> <p>To be eligible to receive Medically Tailored Meals your provider must provide a referral and you must:</p> <ul style="list-style-type: none"> <li>• Be diagnosed with one or more serious or long-lasting illness</li> <li>• Be unable to complete day-to-day tasks</li> <li>• Receive 20 hours/week or more of Personal Care Assistant (PCA) care with time assigned for meal preparation*</li> </ul> <p>*This service will be in the place of PCA meal preparation, which will result in a reduction in the amount of PCA hours received each week, for a 6-month period.</p>
<b>Midwife Services</b>	Yes	No	N/A
<b>MRI</b>	Yes	No	N/A
<b>Multiple Surgical Procedures</b>	Yes	Yes	When multiple surgical procedures are performed during the same operative session, provider is reimbursed 100% for the major procedure, 50% for the second procedure and each additional procedure.

Service	AC Benefit	Prior Auth Required	Guidelines
National Diabetes Prevention Program	Yes	Yes	<u>Eligibility:</u> <ul style="list-style-type: none"> <li>• Be at least 18 years old</li> <li>• Must have body mass index (BMI) of greater than or equal to 25; greater than or equal to 23 if Asian American</li> <li>• Have no previous diagnosis of type 1 or type 2 diabetes (with the exception of gestational diabetes (GDM))</li> <li>• Have a blood test result in the prediabetes range within the past year: <ul style="list-style-type: none"> <li>○ Hemoglobin A1C: 5.7% - 6.4% or</li> <li>○ Fasting plasma glucose: 100-125 mg/dL or</li> <li>○ Two-hour plasma glucose (after a 75 gm glucoseload): 140 – 199mg/dL</li> </ul> </li> <li>• Score 5 or higher on CDC/ADA Prediabetes Risk Test</li> <li>• Not currently pregnant</li> </ul>
Newborn Eligibility	Yes	No	UM Notification recommended.
Non-Par Providers	N/A	Yes	Coverage only applies to Continuity of Care instances.
Nerve Stimulation (Hypoglossal)	Yes	Yes	<b>Effective March 1, 2025</b> , Hypoglossal Nerve Stimulation will be covered for individuals 13years of age through 17 years of age with Down Syndrome and a diagnosis of moderate to severe OSA with inability to tolerate PAP therapy or has failed PAP therapy. Individuals 18years of age and over with a diagnosis of moderate to severe OSA and inability to tolerate PAP therapy or has a failed PAP therapy
Nuclear Medicine	Yes	No	N/A
Nursing Home (Long Term –Custodial Care)	Yes	Yes	N/A
Nutritional Counseling – Outpatient	Yes	No	Must be part of a demonstrable medical need under guidance of a physician such as prenatal care, diabetes care, obesity, and malnutrition.
Nutritional Therapy- Medical	Yes	Yes	Initial assessment and intervention, individual, face to face with the patient 15 minutes session
Nutritional Therapy- Medical	Yes	Yes	Medical Nutrition Therapy follow up, re-assessment, and intervention, individual, face to face with the patient 15 minutes session.
OB / GYN and Prenatal Care	Yes	No	Members can “self refer” to any Amida Care provider.  Members can use their Medicaid Card to access non-participating providers who accept Medicaid.  In addition to OB/GYN services, benefits also include services such as: childbirth classes, smoking cessation counseling (up to six (6) sessions annually), nutritional care, HIV testing and counseling, extended care, and parenting classes.
Observation	Yes	Yes	*As of 4/15/2024, only facilities eligible are Mt. Sinai (Hospitals) and SUNY Downstate

<b>Prognostic Tests for Breast Cancer Treatment</b>	Yes	Yes	Oncotype DX, EndoPredict, and Prosigna prognostic gene expression tests assist practitioners in making determinations regarding the effective and appropriate use of chemotherapy in female and male patients with malignant neoplasms of the breast
<b>Oral surgery</b>	Yes	Yes	N/A

<b>Service</b>	<b>AC Benefit</b>	<b>Prior Auth Required</b>	<b>Guidelines</b>
<b>Orthopedic Shoes/ Prescription Footwear and Custom Orthotics</b>	Yes	Yes	Orthopedic shoes limited to two (2) pairs of shoes per year.
<b>Out of State – Elective Care</b>	No	N/A	N/A
<b>Out of State Emergency-ER visits / Admissions</b>	Yes	No	N/A
<b>Office Visit – New Consultation</b>	Yes	No	N/A
<b>Out Patient Procedures</b>	Yes	Yes	N/A
<b>Pasteurized Donor Human Milk (PDHM)</b>	Yes	Yes	Medicaid managed care (MMC) plans are required to cover inpatient use of PDHM when medically necessary.
<b>Palliative - Bereavement Service</b>	Yes	Yes	N/A
<b>Palliative - Expressive Therapy</b>	Yes	Yes	N/A
<b>Palliative - Massage Therapy</b>	Yes	Yes	N/A
<b>Palliative – Pain and Symptom Management</b>	Yes	Yes	N/A
<b>Personal Care Services (PCS)</b>	Yes	Yes	<p>For new requests, members can call the New York Independent Assessor (NYIA) Helpline and speak to a NYIA call center representative at 855-222-8350.</p> <p>New requests require an assessment and clinical appointment to be completed by NYIA.</p> <p>Level 1 services are limited to a max of 8hrs/week. Level 2 services are for Personal Care, based upon the member's needs.</p> <p>Consumer Directed Personal Care Services (CDPAS) is covered.</p>
<b>Personal Emergency Response System (PERS)</b>	Yes	Yes	<p>PERS must be in conjunction with Personal Care Services or Home Care Services.</p> <p>Authorization for PERS services is based upon approval of PCA services.</p> <p>Amida Care evaluates PERS for medical necessity and authorizes services for periods of up to 6 months. Authorization of PERS is not a substitute for, or in lieu of, assistance with PCS tasks.</p>
<b>PET scans</b>	Yes	No	N/A

Service	AC Benefit	Prior Auth Required	Guidelines
Plastic Surgery /Reconstructive Surgery- Not Cosmetic	Yes	Yes	N/A
Podiatry	Yes	No	Covered when physical condition poses a hazard due to the presence of localized illness, injury or symptoms of the foot, or for the diagnosis and treatment of diabetes, ulcers and infections.  Routine foot care such as treatment of corns, calluses, nail trimming, soaking or cleaning is <b>NOT</b> covered in the absence of a disease.
Postpartum Maternal Depression Screening	Yes	Yes	First screening does not require a prior authorization, as long as the screening takes place within the first year of the infant's life. Additional screenings require a prior authorization. Maximum of three (3) screenings within the first year of the infant's life.
Pre-natal Care	Yes	No	In addition to OB/GYN services benefits also include services such as: childbirth classes, smoking cessation counseling (up to 6 sessions annually), nutritional care, HIV testing and counseling, extended care, and parenting classes.(Manager of Long Term Care Services)
Prenatal Carrier Testing (Fragile X Syndrome)	Yes	Yes	Covered when one or more of the following criteria is met: <ul style="list-style-type: none"> <li>▪ There is a personal or family history of Fragile X Tremor / Ataxia Syndrome, Autism Spectrum Disorder or unexplained mental retardation in a 1<sup>st</sup>, 2<sup>nd</sup> or 3<sup>rd</sup> degree relative of either parent</li> <li>▪ The mother has elevated Follicle Stimulating Hormone (FSH) level before the age of 40 or premature ovarian failure with no known cause; or</li> <li>▪ The mother of a 1<sup>st</sup> or 2<sup>nd</sup> degree female relative of either parent in a confirmed carrier.</li> </ul>
Prenatal Carrier Testing (Spinal Muscular Atrophy)	Yes	Yes	Covered when one or more of the following criteria is met: <ul style="list-style-type: none"> <li>▪ There is a personal or family history of Spinal Muscular Atrophy (SMA) or other muscular dystrophy of unknown type in a 1<sup>st</sup> degree or 2<sup>nd</sup> degree relative of either parent</li> <li>▪ The father is a known carrier</li> </ul> <p>Carrier screening for SMA of the male partner of a pregnancy will be covered if the pregnant female is found to be a carrier.</p>
Prenatal Testing for Trisomy 21, 18, and 13	Yes	Yes	Covered when one or more of the following criteria is met: <ul style="list-style-type: none"> <li>▪ Either parent has a family history of an aneuploidy in a 1<sup>st</sup> or 2<sup>nd</sup> degree relative</li> <li>▪ The pregnant woman is of advanced maternal age (30 years and older at the time of delivery)</li> <li>▪ Standard serum screening or fetal ultra-sonographic findings indicate an increased risk of an aneuploidy</li> <li>▪ Parent(s) have a history of a previous pregnancy with a trisomy</li> <li>▪ Either parent is known to have a Robertsonian translocation</li> <li>▪ Twin pregnancy, but not higher multi-gestational pregnancies</li> </ul>

Service	AC Benefit	Prior Auth Required	Guidelines
<b>Prenatal- Non-stress Tests</b>	Yes	No	Prior authorization applies if more than two instances during the course of the pregnancy.
<b>Prescription and Non-Prescription (OTC) Drugs, Medical Supplies, and Enteral Formula</b>	Yes	Yes	<p><b>Includes pharmaceuticals and medical supplies</b></p> <p><b>Cross Gender Hormone Therapy (CGHT) previously known as Hormone Replacement Therapy (HRT) requires prior authorization.</b></p> <p><b>Call Express Scripts (ESI) 1-800-417-8164.</b></p> <p><i>Refer to Plan's pharmacy formulary at <a href="http://www.amidacareny.org">www.amidacareny.org</a> for preferred medications, medications requiring prior-authorization or step therapy.</i></p>
<b>Preventive Health Services</b>	Yes	No	N/A
<b>Private Duty Nursing</b>	Yes	Yes	N/A
<b>Procedure (Testopel)</b>	Yes	Yes	N/A
<b>Prosthetics</b>	Yes	Yes	N/A
<b>Radiation Therapy</b>	Yes	No	N/A
<b>Radiology Diagnostic exams (Excluding Pet Scans)</b>	Yes	No	N/A
<b>Rehabilitation – Inpatient</b>	Yes	Yes	Services must be medically necessary, reasonable necessary to furnish on an in-patient hospital basis rather than in a less intensive facility such as SNF or on an outpatient basis.
<b>Rehabilitation – Outpatient (Physical Therapy)</b> <b>GAS/Home Health/Outpatient</b>	Yes	No	No Prior Authorization needed for initial 20 visits; Prior Authorization needed starting at 21st visit
<b>Rehabilitation – Outpatient (Occupational Therapy)</b> <b>GAS/Home Health/Outpatient</b>	Yes	No	No Prior Authorization needed for initial 20 visits; Prior Authorization needed starting at 21st visit
<b>Rehabilitation – Outpatient (Speech Therapy)</b> <b>GAS/Home Health/Outpatient</b>	Yes	No	No Prior Authorization needed for initial 20 visits; Prior Authorization needed starting at 21st visit.

Service	AC Benefit	Prior Auth Required	Guidelines
Residential Health Care – Short Term Skilled Nursing Facility	Yes	Yes	N/A
Residential Health Care Long Term Skilled Nursing Facility	Yes	Yes	N/A
Screening, Brief Intervention and Referral to Treatment (SBIRT)	Yes	No	SBIRT services are available to members aged ten (10) years and older in emergency rooms, hospital outpatient departments, diagnostic and treatment centers and physician offices.
Second Opinions-Medical or Surgical	Yes	No	Prior-authorization is <b>only</b> required for out-of-network providers.
Sleep Apnea Study	Yes	Yes	Can be outpatient overnight or inpatient with presenting symptoms. Effective October 1, 2024, the New York State (NYS) Medicaid fee-for-service (FFS) program will reimburse for an at Home Sleep Test (HST)
Smoking Cessation Counseling (SCC)	Yes	No	No limit to the number of counseling session per calendar year  SCC must be provided face-to-face by a Physician, Registered Physician Assistant, Registered Nurse Practitioner, or Licensed Midwife, Registered Nurse, Clinical Psychologist, Licensed Clinical Social Worker, Licensed Master Social Worker, or Licensed Practical Nurse during a medical visit. (No group sessions).
Smoking Cessation Products	Yes	No	Two (2) courses of smoking cessation therapy per recipient, per calendar year are allowed.  A course of therapy is defined as no more than a 90-day supply (an original order and two (2) refills, even if less than a 30 day supply is dispensed in any fill).
Sonograms	Yes	No	Prior authorization is only required for more than one (1) sonogram per trimester.
Specialist as PCP	Yes	Yes	
Sterilization	Yes	No	N/A
Sterilization Reversal	No	N/A	N/A
Transplants	Yes	Yes	N/A
Vaginal Dilators	Yes	Yes	N/A
Urgent Care and Walk-ins	Yes	No	N/A
Wound Vac. – Inpatient	Yes	Yes	Members must be residing in a Short Term or Long-Term Nursing Homes to receive service.
Wound Vac. – Outpatient	Yes	Yes	N/A



Service	AC Benefit	Prior Auth Required	Guidelines
<b>Vision: Eye Care and Low Vision Services- Well Vision</b> (Refractive Exams)	Yes	No	Benefit managed by Davis Vision. Member(s) can contact Davis Vision directly at 1-800-999-5431. Eye exam every two (2) years New pair of glasses every two (2) years Low vision exam and specialist needs referral
<b>All other services</b> (Not listed above)	<b>For any services or situations other than those listed above, contact the Plan for directions.</b>		

## II. HIV SNP Enhanced Services:

Service	Description
<b>Case Management Assessments/Service Plans</b>	Member may be assessed for psycho-social or non-medical needs, which result in the development of a "service plan" by a case manager.  The initial assessment/service plan will be completed within the first 60 days of intake, and then re-assessed at least every 180 days thereafter.  For more information, see <i>Case Management</i> .
<b>Directly Observed Therapy (DOT) or Directly Observed Antiretroviral Therapy (DART)</b>	Members have to see a licensed medical provider for the purposes of taking medications as prescribed.  This must be a documented face to face encounter coinciding with a medical treatment schedule and incorporated into a goal-oriented service plan.
<b>Escorts</b>	Members may be escorted roundtrip (to/from) a medical/specialty care appointment or other appointment, such as Medicaid recertification or other benefits, legal or supportive services.  This service can be secured through Amida Care Retention in Care Unit (RICU).
<b>Treatment Adherence Services/Treatment Education</b>	Members may see a trained counselor, pharmacist or medical team member for the purpose of increasing adherence to a treatment regime or treatment education.