

State: Nebraska

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE
AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

1. Inpatient hospital services other than those provided in an institution for mental diseases.
- Provided: No limitations With limitations*
2. a. Outpatient hospital services.
- Provided: No limitations With limitations*
- b. Rural health clinic services and other ambulatory services furnished by a rural health clinic (which are otherwise included in the State Plan)
- Provided: No limitations With limitations*
- Not provided.
- c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with sec. 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).
- Provided: No limitations With limitations*
3. Other laboratory and x-ray services.
- Provided: No limitations With limitations*

* Description provided on attachment

TN No. MS-00-06

Supersedes

TN No. MS-92-1

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State: Nebraska

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE
AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

4. a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

Provided: No limitations With limitations*

- b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.*

Provided: No limitations With limitations*

- c. Family planning services and supplies for individuals of child-bearing age.

Provided: No limitations With limitations*

- d. 1) Face-to-Face Tobacco Cessation Counseling Services provided (by):

(i) By or under supervision of a physician;

(ii) By any other health care professional who is legally authorized to furnish such services under State law and who is authorized to provide Medicaid coverable services *other* than tobacco cessation services; or

(iii) Any other health care professional legally authorized to provide tobacco cessation services under State law *and* who is specifically *designated* by the Secretary in regulations. (None are designated at this time; this item is reserved for future use.)
*describe if there are any limits on who can provide these counseling services.

- 2) Face-to-Face Tobacco Cessation counseling Services Benefit Package for Pregnant Women

Provided: No limitations With limitations*

*Any benefit package that consists of *less* than four (4) counseling sessions per quit attempt, with a minimum of two (2) quit attempts per 12 month period (eight (8) per year) should be explained below.

Please describe any limitations:

State: Nebraska

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE
AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

5. a. Physicians' services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere.

Provided: No limitations With limitations*

b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the act).

Provided: No limitations With limitations*

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by state law.

a. Podiatrists' services.

Provided: No limitations With limitations*

* Description provided on attachment

State/Territory: Nebraska

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE
AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

b. Optometrists' services.

Provided: No limitations With limitations*
 Not Provided

c. Chiropractors' services.

Provided: No limitations With limitations*
 Not Provided

d. Other practitioners' services.

Provided: Identified on attached sheet with description of
 Not Provided limitations.

7. Home health services.

a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.

Provided: No limitations With limitations*

b. Home health aide services provided by a home health agency.

Provided: No limitations With limitations*

c. Medical supplies, equipment, and appliances suitable for use in the home.

Provided: No limitations With limitations*

* Description provided on attachment.

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State/Territory: Nebraska

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE
AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

- d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

Provided: No limitations With limitations*
 Not Provided

8. Private duty nursing services.

Provided: No limitations With limitations*
 Not Provided

* Description provided on attachment.

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State/Territory: Nebraska

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE
AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

9. Clinic services.

Provided: No limitations With limitations*
 Not Provided

10. Dental Services.

Provided: No limitations With limitations*
 Not Provided

11. Physical therapy and related services.

a. Physical therapy

Provided: No limitations With limitations*
 Not Provided

b. Occupational therapy.

Provided: No limitations With limitations*
 Not Provided

c. Services for individuals with speech, hearing, and language disorders (provided by or under the supervision of a speech pathologist or audiologist).

Provided: No limitations With limitations*
 Not Provided

*Description provided on attachment

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State/Territory: Nebraska

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE
AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

12. Proscribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed drugs.

Provided: No limitations With limitations*
 Not Provided

b. Dentures.

Provided: No limitations With limitations*
 Not Provided

c. Prosthetic devices

Provided: No limitations With limitations*
 Not Provided

d. Eyeglasses

Provided: No limitations With limitations*
 Not Provided

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

Provided: No limitations With limitations*
 Not Provided

*Description provided on attachment

TN No. MS-00-06

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State/Territory: Nebraska

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE
AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

b. Screening services

Provided: No limitations With limitations*
 Not Provided

c. Preventive services

Provided: No limitations With limitations*
 Not Provided

d. Rehabilitative services

Provided: No limitations With limitations*
 Not Provided

14. Services for individual age 65 or older in institutions for mental diseases.

a. Inpatient hospital services.

Provided: No limitations With limitations*
 Not Provided

b. Skilled nursing facility services

Provided: No limitations With limitations*
 Not Provided

c. Intermediate care facility services

Provided: No limitations With limitations*
 Not Provided

*Description provided on attachment

TN No. MS-00-06

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State/Territory: Nebraska

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE
AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

15. a. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined in accordance with section 1902(a)(31)(A) of the Act, to be in need of such care.

Provided No limitations

With limitations* Not Provided:

- b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

Provided No limitations

With limitations* Not Provided:

16. Inpatient psychiatric facility services for individuals under 22 years of age.

Provided No limitations With limitations*

Not Provided:

17. Nurse-midwife services

Provided No limitations With limitations*

Not Provided:

18. Hospice care (in accordance with section 1905(o) of the Act).

Provided No limitations Provided in accordance with section 2302 of the Affordable Care Act

With limitations* Not Provided:

*Description provided on attachment

TN No. NE 11-14

Supersedes
TN No. 11-10

Approval Date DEC 21 2011 Effective Date JUL 01 2011

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Nebraska

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE
AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

19. Case management services and Tuberculosis related services

- a. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act.)

Provided: With limitations*
 Not Provided

- b. Special tuberculosis (TB) related services under section 1902(z)(2)(F) of the Act.

Provided: With limitations*
 Not Provided

20. Extended services for pregnant women

- a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.

Additional coverage ++

- b. Services for any other medical conditions that may complicate pregnancy.

Additional coverage ++

Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

*Description provided on attachment

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State/Territory: Nebraska

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE
AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by an eligible provider (in accordance with section 1920 of the Act).

Provided: No limitations With limitations*
 Not Provided

22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act).

Provided: No limitations With limitations*
 Not Provided

23. Certified pediatric or family nurse practitioners' services.

Provided: No limitations With limitations*

*Description provided on attachment

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24. Any other medical care and any other type of remedial care recognized under State law specified by the Secretary.

a. Transportation.

Provided: No limitations With limitations*
 Not Provided

b. Services of Christian Science nurses.

Provided: No limitations With limitations*
 Not Provided

c. Care and services provide in Christian Science sanatoria

Provided: No limitations With limitations*
 Not Provided

d. Nursing facility services for patients under 21 years of age

Provided: No limitations With limitations*
 Not Provided

e. Emergency hospital services.

Provided: No limitations With limitations*
 Not Provided

*Description provided on attachment

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State/Territory: Nebraska

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE
AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

25. Home and Community Care for Functionally Disabled Elderly Individuals, as defined described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

Provided: Not provided

26. Personal assistance services are those services provided to a Medicaid client who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, institution for mental disease, or prison, which are authorized on a written service plan according to individual needs identified in a written assessment.

Personal assistance services are A) authorized by a Social Services Worker or designee, B) provided by qualified providers who are not legally responsible relatives, and C) are furnished inside the home, and outside the home with limitations.

Provided: State Approved (Not Physician) Service Plan Allowed
 Services Outside the Home Also Allowed
 Limitations Described on Attachment
 Not Provided

27. Program of All-Inclusive Care for the Elderly (PACE) services, as described in Supplement 4 to Attachment 3.1-A.

X Election of PACE: By virtue of this submittal, the State elects PACE as an optional State Plan service.

___ No election of PACE: By virtue of this submittal, the State elects to not add PACE as an optional State Plan service

28. (i) Licensed or Otherwise State-Approved Freestanding Birth Center

Provided: No limitations With limitations None licensed or approved

Please describe any limitations:

Facilities must:

- (a) Be specifically approved by Department of Health and Human Services, Division of Public Health to provide birthing center Services.
(b) Maintain standards of care required by Department of Health and Human Services, Division of Public Health for licensure.

State/Territory: Nebraska

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE
AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

28. (ii) Licensed or Otherwise State-Recognized covered professionals providing services in the Freestanding Birth Center

Provided: No limitations With limitations (please describe below)
 Not Applicable (there are no licensed or State approved Freestanding Birth Centers)

Please check all that apply:

- (a) Practitioners furnishing mandatory services described in another benefit category and otherwise covered under the State plan (i.e. physicians and certified nurse midwives).
- (b) Other licensed practitioners furnishing prenatal, labor and delivery, or postpartum care in a freestanding birth center within the scope of practice under State law whose services are otherwise covered under 42 CFR 440.60 (e.g., lay midwives, certified professional midwives (CPMs), and any other type of licensed midwife).*
- (c) Other health care professionals licensed or otherwise recognized by the State to provide these birth attendant services (e.g., doulas, lactation consultant, etc.).*

Telehealth means the use of medical information electronically exchanged from one site to another, whether synchronously or asynchronously, to aid a health care practitioner in the diagnosis or treatment of a patient. Telehealth includes services originating from a patient's home or any other location where such patient is located. Asynchronous services involving the acquisition and storage of medical information at one site that is then forwarded to and retrieved by a health care practitioner at another site for medical evaluation and telemonitoring.

Telehealth consultation means any contact between a patient and a health care practitioner relating to the health care diagnosis or treatment of such patient through telehealth, but does not include a telephone conversation, electronic mail message, or facsimile transmission between a health care practitioner and a patient or a consultation between two health care practitioners.

Telemonitoring means the remote monitoring of a patient's vital signs, biometric data, or subjective data by a monitoring device which transmits such data electronically to a health care practitioner for analysis and storage.

Health care practitioners must:

1. act within their scope of practice;
2. be enrolled with Nebraska Medicaid; and
3. be appropriately licensed, certified, or registered by Nebraska HHS Regulation and Licensure for the service for which they bill Medicaid.

All state plan prior authorization requirements must be met to be covered as a telehealth service. Prior authorization requests must state the intent to provide the service as a telehealth service.

A telehealth service is not covered when the service delivered via telecommunication technology is deemed to be investigational or experimental.

Transmission costs are not covered when the telehealth service provided by the health care practitioner is not a covered state plan service.

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