

State/Territory: Nebraska

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): _____

The following ambulatory services are provided.

Rural health clinic services
Other laboratory and x-ray services
Early and Periodic Screening, Diagnosis, and Treatment
Family planning services
Physicians' services
Podiatrists' services
Optometrists' services
Chiropractors' services
Other practitioners' services
Home health services
Private duty nursing services
Clinic services
Dental services
Physical therapy and related services
Prescribed drugs, dentures, and prosthetic devices
Eyeglasses
Transportation
Personal care services
Nurse Practitioner Services
Freestanding Birth Center Services

*Description provided on attachment.

TN No. NE 11-21

Supersedes

TN No. MS-86-25

Approval Date APR 02 2012

Effective Date FEB 14 2012

HCFA ID: 0140P/0102A

State/Territory: Nebraska

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): All Groups

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*

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*

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*

*Description provided on attachment

TN No. NE-11-32

Supersedes

TN No. MS-00-06

Approval Date MAR 19 2012

Effective Date OCT 01 2011

HCFA ID: 7986E

State/Territory: Nebraska

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): All Groups

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:

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*

* Description provided on attachment.

TN No. NE-11-32

Supersedes

Approval Date MAR 19 2012

Effective Date OCT 01 2011

TN No. MS-00-06

State/Territory: Nebraska

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): All covered groups

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*

b. Optometrists' services.

Provided No limitations With Limitations*

c. Chiropractors' services:

Provided No limitations With Limitations*

d. Other practitioners' services.

Provided No limitations With 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*

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*

"Description provided on attachment.

TN No. MS-00-06

Supersedes

Approval Date Mar 16 2001

Effective Date Jul 1 2000

TN No. MS-86-25

State/Territory: Nebraska

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): All covered groups

8. Private duty nursing services
 Provided No limitations With Limitations*
9. Clinic services
 Provided No limitations With Limitations*
10. Dental services
 Provided No limitations With Limitations*
11. Physical therapy and related services.
- a. Physical therapy
 Provided No limitations With Limitations*
- b. Occupational therapy
 Provided No limitations With Limitations*
- 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*
12. Prescribed 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*
- b. Dentures
 Provided No limitations With Limitations*

*Description provided on attachment.

TN No. MS-00-06

Supersedes

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TN No. MS-93-15

State/Territory: Nebraska

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): All covered groups

- c. Prosthetic devices
 Provided No limitations With Limitations*
- d. Eyeglasses
 Provided No limitations With Limitations*
13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.
- a. Diagnostic services.
 Provided No limitations With Limitations*
 Not Provided
- b. Screening services.
 Provided No limitations With Limitations*
- c. Preventive services.
 Provided No limitations With Limitations*
 Not Provided
- d. Rehabilitative services.
 Provided No limitations With Limitations*
14. Services for individuals age 65 or older in institutions for mental diseases.
- a. Inpatient hospital services.
 Provided No limitations With Limitations*
- b. Skilled nursing facility services.
 Provided No limitations With Limitations*

*Description provided on attachment.

TN No. MS-00-06

Supersedes

Approval Date Mar 16 2001

Effective Date Jul 1 2000

TN No. MS-95-9

State/Territory: Nebraska

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

- c. Intermediate care facility services.
 Provided No limitations With limitations*
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*
- b. Including such services in a public institution (or district part thereof) for the mentally retarded or persons with related conditions.
 Provided No limitations With limitations*
16. Inpatient psychiatric facility services for individuals under 22 years of age.
 Provided No limitations With limitations*
17. Nurse-midwife services.
 Provided No limitations With limitations*
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*

*Description provided on attachment -

TN No. NE 11-14

Supersedes

Approval Date DEC 21 2011 Effective Date JUL 01 2011

TN No. 11-10

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Nebraska

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): All covered groups

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.

Provided Additional coverage ++

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

Provided Additional coverage ++ Not provided

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.

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

*Description provided on attachment.

State/Territory: Nebraska

Major Categories of Services That Are Available As
Pregnancy-Related services or Services For Any
Other Condition That May Complicate Pregnancy

The Nebraska Medical Assistance Program covers the following major categories of services as pregnancy-related services or services for a condition that may complicate pregnancy:

1. All services covered under the Title XIX Plan are available when pregnancy-related or for a condition that may complicate pregnancy; and
2. The same limitations listed in Attachment 3.1-A are applied to pregnancy-related services or services for a condition that may complicate pregnancy.

TN No. MS-00-06

Supersedes

TN No. MS-91-24

Approval Date Mar 16 2001

Effective Date Jul 1 2000

State/Territory: Nebraska

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): All covered groups

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*

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*

b. Services of Christian Science nurses.

Provided No limitations With Limitations*
 Not Provided

c. Care and services provided in Christian Science sanatoria.

Provided No limitations With Limitations*
 Not Provided

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

Provided No limitations With Limitations*

e. Emergency hospital services.

Provided No limitations With Limitations*

*Description provided on attachment.

TN No. MS-00-06

Supersedes

Approval Date Mar 16 2001

Effective Date Jul 1 2000

TN No. MS-87-11

State/Territory: Nebraska

24. Pediatric or family nurse practitioners' services as defined in Section 1905(a)(21) of the Act (added by Section 6405 of OBRA'89):

Provided No limitations With Limitations*

* Description provided on attachment.

TN No. MS-91-2

Supersedes

TN No. new page

Approval Date Feb 26 1991

Effective Date Jan 1 1991

State/Territory: Nebraska

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): All groups

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 mental 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. Reserved

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

Provided: No Limitations With Limitations None licensed or approved
 Not Applicable (there are no licensed or State approved Freestanding Birth Centers)

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, and
- (b) Maintain standards of care required by Department of Health and Human Services, Division of Public Health for licensure.

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

Provided: No Limitations With Limitations (please describe below)

* Exception described on attachment

TN No. NE 11-21

Supersedes

Approval Date APR 02 2012

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TN No. MS 04-03

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.).*

TN No. NE 11-21

Supersedes

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TN No. New page

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.

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.

TN No. NE 14-006

Supersedes

TN No. MS-00-06

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Effective Date 07/01/2014

State/Territory: Nebraska

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): All covered groups

The limitations to services listed in Attachment 3.1-B are the same as the limitations for services listed in Attachment 3.1-A.

TN No. MS-86-25

Supersedes

TN No. MS-81-11

Approval Date Jan 7 1987

Effective Date Oct 1 1986