Alternative Benefit Plan

State Name: Nebraska

Attachment 3.1-L-

OMB Control Number: 0938-1148

Transmittal Number: NE - 24 - 0002

Benefits Description ABP5

The state/territory proposes a "Benchmark-Equivalent" benefit package. No

Benefits Included in Alternative Benefit Plan

Enter the specific name of the base benchmark plan selected:

Blue Cross Blue Shield of Nebraska: BluePride Plus Option 102 Gold
Aligned Medicaid ABP

Enter the specific name of the section 1937 coverage option selected, if other than Secretary-Approved. Otherwise, enter "Secretary-Approved."

Secretary- Approved

Alternative Benefit Plan

☑ 1. Essential Health Benefit: Ambulatory patient services Collapse All ☐

Remove

Benefit Provided: Outpatient Hospital Services

Source: State Plan 1905(a)

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Other

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

All psychiatric testing and evaluations must be performed by a licensed psychologist or under the supervision of a licensed psychologist.

Remove

Benefit Provided: Physician's Services

Source: State Plan 1905(a)

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Prior authorization required for cosmetic and reconstruction surgical procedures, except for the following, cleft lip and cleft palate, post-mastectomy breast reconstruction, congenital hemangioma's of the face, and nevus (mole) removals.

Remove

Benefit Provided: Clinic Services

Source: State Plan 1905(a)

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Other

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Services provided by community mental health centers are limited to medically necessary acute psychiatric services. Day treatment services are limited to a half-day or full-day rate, established on the basis of each facility's cost report which is reviewed annually.

The "facility fee" includes payment for services and items provided by an ASC in connection with a covered surgical procedure.

Prior authorization is required for the evaluation and treatment of infants and children who fail to eat and/or drink a sufficient quantity or variety of foods or liquids to meet their nutritional and/or hydration needs by hospital affiliated clinics or free-standing clinics.

Remove

Benefit Provided: Hospice Care

Source: State Plan 1905(a)

Authorization: Authorization required in excess of limitation

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: Other

Scope Limit:

The client must be certified as terminally ill with a six-month life expectancy by the Hospice medical director and the attending physician at the beginning of the first benefit period and by the Hospice medical director for all subsequent periods.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

A client may elect to receive hospice care during one or more of the following election periods: an initial 90-day period, a subsequent 90-day period, an initial 60-day period, a subsequent 60-day period, and a third 60-day period.

Additional 60-day benefit periods must be approved as an exception under the prior authorization provision.

Remove

Benefit Provided: Home Health Services

Source: State Plan 1905(a)

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: Other

Scope Limit: Other

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Coverage for all home health agency services is based on medical necessity, and must be necessary to continuing a medical treatment plan, prescribed by a licensed physician, nurse practitioner, physician

assistant, or clinical nurse specialist, and re-certified at least every 60 days.

Remove

Benefit Provided: Other Practitioner Services

Source: State Plan 1905(a)

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Remove

Benefit Provided: Chiropractic Services

Source: State Plan 1905(a)

Authorization: Authorization required in excess of limitation

Provider Qualifications: Medicaid State Plan

Amount Limit: Other

Duration Limit: Other

Scope Limit: Other

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

No limits, all treatments based on medical necessity.

Remove

Benefit Provided:

Source:

Authorization: Yes

Provider Qualifications:

Amount Limit:

Duration Limit:

Scope Limit:

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

Alternative Benefit Plan

☑ 2. Essential Health Benefit: Emergency services — Collapse All ☐

Benefit Provided: Emergency Hospital Services
Source: State Plan 1905(a)
Remove

Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Transportation Services: Emergency
Source: State Plan 1905(a)
Remove

Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: Covers medically necessary ambulance services required to transport a client during an emergency or required to obtain medical care.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

Alternative Benefit Plan

☑ 3. Essential Health Benefit: Hospitalization Collapse All ☐

Remove

Benefit Provided:
Inpatient Hospital Services

Source:
State Plan 1905(a)

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Other

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Covers medical transplants including donor services that are medically necessary and defined as non-experimental by Medicare. If no Medicare policy exists for a specific type of transplant, it is covered if the transplant is medically necessary and non-experimental. Prior Authorization is required.

Prior authorization is required for cosmetic and reconstructive surgical procedures except for the following conditions: cleft lip and cleft palate, post-mastectomy breast reconstruction, congenital hemangioma's of the face, and nevus (mole) removals.

Add

Alternative Benefit Plan

☑ 4. Essential Health Benefit: Maternity and newborn care — Collapse All ☐

Benefit Provided: Nurse-Midwife Services
Source: State Plan 1905(a)
Remove

Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: Other
Scope Limit: Other

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Nurse-Midwife services are covered that are medically necessary and are concerned with the management of the care of mothers and newborns throughout the maternity cycle. The maternity cycle includes pregnancy, labor, birth, and the immediate postpartum period (up to six weeks), including care of the newborn. To be covered, the services must be provided by a certified nurse-midwife according to the terms of the practice agreement between the nurse-midwife and the physician.

Benefit Provided: Inpatient Hospital Services-Maternity
Source: State Plan 1905(a)
Remove

Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Outpatient Hospital Services-Maternity
Source: State Plan 1905(a)
Remove

Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Freestanding Birth Center Services

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Other

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Services are limited to facility services provided during the labor, delivery and postpartum periods.

Cesarean section procedures are prohibited. Each mother and newborn must be discharged within 24 hours after admission, in a condition which will not endanger the well-being of either. If the condition of mother or newborn does not allow discharge within 24 hours, then transfer to a hospital must occur.

Benefit Provided: Other Practitioners Services-Maternity

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Physician's services-Maternity

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Does not cover routine office visits to a physician when a nurse-midwife is providing complete obstetrical care, unless documentation of medical necessity for the physician's office visit is submitted.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Extended Services for Pregnant Women

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: Other

Scope Limit: Other

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Covers pregnancy-related and postpartum services for 60 days after the pregnancy ends or at the end of the month in which the 60th day falls.

Benefit Provided: Tobacco Cessation-Maternity

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Home Health Services-Maternity

Source: State Plan 1905(a)

Remove

Alternative Benefit Plan

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
Other

Scope Limit:
Other

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Coverage for all home health agency services is based on medical necessity, and must be necessary to continuing a medical treatment plan, prescribed by a licensed physician, nurse practitioner, physician assistant, or clinical nurse specialist, and re-certified at least every 60 days.

Add

Alternative Benefit Plan

Collapse All ☐

☑ 5. Essential Health Benefit: Mental health and substance use disorder services including behavioral health treatment

☑ The state/territory assures that it does not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification.

Remove

Benefit Provided: Outpatient Hospital Services: MH/SUD

Source: State Plan 1905(a)

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: Other

Duration Limit: Other

Scope Limit: Other

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Intensive outpatient mental health services include psychotherapy by professionals 2-4 times a week 3-6 hours per day.

Partial hospitalization includes up to 7 days a week 3-6 hours per day. Recipients must be seen by a physician 3 times a week. The provider must have access to pharmacy, dietary, nursing, psychology and psychotherapy.

Remove

Benefit Provided: Inpatient Hospital Services: MH/SUD

Source: State Plan 1905(a)

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Remove

Benefit Provided: Physician's Services: MH/SUD

Source: State Plan 1905(a)

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: Other

Scope Limit: Other

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Treatment crisis intervention must be clinically necessary to relieve a crisis prior to comprehensive psychiatric assessment.

Adult crisis stabilization provides continuous 24-hour observation and supervision up to 72 hours for individuals who do not require assessment and treatment in an acute inpatient hospital setting.

Benefit Provided: Rehabilitative Services: MH/SUD

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Clinic Services: MH/SUD

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Alternative Benefit Plan

Benefit Provided:
Other Practitioner's Services: MH/SUD

Source:
State Plan 1905(a)

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
Other

Scope Limit:
Other

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Treatment crisis intervention must be clinically necessary to relieve a crisis prior to comprehensive psychiatric assessment.

Adult crisis stabilization provides continuous 24-hour observation and supervision up to 72 hours for individuals who do not require assessment and treatment in an acute inpatient hospital setting.

Benefit Provided:
Home Health Services: MH/SUD

Source:
State Plan 1905(a)

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:

Psychiatric Nursing Services are mental health home health services that are provided to eligible clients who are unable to access office based services.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Coverage for all home health agency services is based on medical necessity, and must be necessary to continuing a medical treatment plan, prescribed by a licensed physician, nurse practitioner, physician assistant, or clinical nurse specialist, and re-certified at least every 60 days.

Add

■ 6. Essential Health Benefit: Prescription drugs

☑ The state/territory assures that the ABP prescription drug benefit plan is the same as under the approved Medicaid State Plan for prescribed drugs.

Benefit Provided:

Coverage is at least the greater of one drug in each U.S. Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.

Prescription Drug Limits (Check all that apply.):

- ☒ Limit on days supply
- ☐ Limit on number of prescriptions
- ☐ Limit on brand drugs
- ☒ Other coverage limits
- ☒ Preferred drug list

Authorization:	Provider Qualifications:
Yes	State licensed

Coverage that exceeds the minimum requirements or other:

☑ 7. Essential Health Benefit: Rehabilitative and habilitative services and devices — Collapse All ☐

☑ The state/territory assures that it is not imposing limits on habilitative services and devices that are more stringent than limits on rehabilitative services (45 CFR 156.115(a)(5)(ii)). Further, the state/territory understands that separate coverage limits must also be established for rehabilitative and habilitative services and devices. Combined rehabilitative and habilitative limits are allowed, if these limits can be exceeded based on medical necessity.

Remove

Benefit Provided: Home Health Services: PT, OT, ST, & Audiology

Source: State Plan 1905(a)

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

These therapies for adults (age 21 and older) are a Home Health Agency Service only when there is no other method for the client to receive the service.

Coverage for all home health agency services is based on medical necessity, and must be necessary to continuing a medical treatment plan, prescribed by a licensed physician, nurse practitioner, physician assistant, or clinical nurse specialist, and re-certified at least every 60 days.

Remove

Benefit Provided: Physical Therapy and related services: PT

Source: State Plan 1905(a)

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: Other

Duration Limit: Per fiscal year

Scope Limit: Other

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

A combined total of 60 therapy sessions which include rehabilitative and habilitative services (physical therapy, occupational therapy, and speech therapy) are covered for individuals age 21 and older. May be exceeded based on medical necessity.

Remove

Benefit Provided: Physical Therapy and related services: OT

Source: State Plan 1905(a)

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: Other

Duration Limit: Per fiscal year

Scope Limit: Other

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

A combined total of 60 therapy sessions which include rehabilitative and habilitative services (physical therapy, occupational therapy, and speech therapy) are covered for individuals age 21 and older. May be exceeded based on medical necessity.

Remove

Benefit Provided: Short-Term Nursing Facility Services

Source: State Plan 1905(a)

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Other

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

As approved in section 3.1-A of the Medicaid state plan.

Remove

Benefit Provided: Home Health Services: Medical Supplies, Equipment,

Source: State Plan 1905(a)

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: Other

Duration Limit: Other

Scope Limit:

Does not cover items which primarily serve personal comfort, convenience, education, hygiene, safety, cosmetic, and new equipment of unproven value, external powered prosthetics and equipment of questionable current usefulness or therapeutic value.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Orthotic devices when medically necessary and prescribed. One pair of orthopedic shoes at the time of purchase. One pair of shoes in a one-year period.

Prior authorization is required for some rental and purchase of items.

Coverage for all home health agency services is based on medical necessity, and must be necessary to

continuing a medical treatment plan, prescribed by a licensed physician, nurse practitioner, physician assistant, or clinical nurse specialist, and re-certified at least every 60 days.

Benefit Provided: Svs. for ind. with speech, hearing, & language

Source: State Plan 1905(a)

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: Other

Duration Limit: Other

Scope Limit: Other

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Complete title: Services for individuals with speech, hearing, & language disorders

A combined total of 60 therapy sessions which include rehabilitative and habilitative services (physical therapy, occupational therapy, and speech therapy) are covered for individuals age 21 and older. May be exceeded based on medical necessity.

For clients age 21 and older, covers hearing aids limited to not more than one aid per ear every four years and then only when required by medical necessity.

Does not cover hearing aid batteries for residents of a nursing facility except with the initial fitting. Does not cover accessories which are for convenience and not medically necessary.

Benefit Provided: Physical therapy and related services: ST

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: Other

Duration Limit: Per fiscal year

Scope Limit: Other

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

A combined total of 60 therapy sessions which include rehabilitative and habilitative services (physical therapy, occupational therapy, and speech therapy) are covered for individuals age 21 and older. May be exceeded based on medical necessity.

Benefit Provided: Prosthetic Devices

Source: State Plan 1905(a)

Remove

Alternative Benefit Plan

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

Other

Duration Limit:

Other

Scope Limit:

Does not cover items which primarily serve personal comfort, convenience, education, hygiene, safety, cosmetic, and new equipment of unproven value, external powered prosthetics and equipment of questionable current usefulness or therapeutic value.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Orthotic devices when medically necessary and prescribed. One pair of orthopedic shoes at the time of purchase. One pair of shoes in a one-year period.

Prior authorization is required for some rental and purchase of the items.

Add

Alternative Benefit Plan

☑ 8. Essential Health Benefit: Laboratory services Collapse All ☐

Benefit Provided:
Other Laboratory and X-ray Services

Source:
State Plan 1905(a)

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

Alternative Benefit Plan

■ 9. Essential Health Benefit: Preventive and wellness services and chronic disease management Collapse All ☐

The state/territory must provide, at a minimum, a broad range of preventive services including: "A" and "B" services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

Remove

Benefit Provided: Family Planning Services & Supplies

Source: State Plan 1905(a)

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

No authorization required.

Remove

Benefit Provided: Other Diagnostic, Screening, Preventative,

Source: State Plan 1905(a)

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Covers diagnostic and screening mammograms. Covers immunizations for adults (age 21 & older) when medically necessary.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

*Complete title: Other Diagnostic, Screening, Preventative, and Rehabilitative Services

Remove

Benefit Provided: Nutrition Services

Source: State Plan 1905(a)

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Alternative Benefit Plan

Scope Limit:

Other

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Medical Nutritional Therapy is only available to select individuals with medical needs that require nutritional assessment, intervention, and continued monitoring.

Available only by physician or nurse practitioner referral.

Add

Alternative Benefit Plan

☑ 10. Essential Health Benefit: Pediatric services including oral and vision care

Collapse All ☐

Remove

Benefit Provided:
Medicaid State Plan EPSDT Benefits

Source:
State Plan 1905(a)

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
Up to age 21

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Services described in section 1905(a) of the Social Security Act that are not covered under the Nebraska State Plan for Medical Assistance are covered for treatment when the condition is disclosed in an EPSDT exam, health screen, dental screen, vision screen, or hearing screen. These services require prior authorization.

Add

☐ 11. Other Covered Benefits from Base Benchmark Collapse All ☐

☒ 12. Base Benchmark Benefits Not Covered due to Substitution or Duplication Collapse All ☐

Base Benchmark Benefit that was Substituted: Primary Care Visit to Treat an Injury or Illness
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under Nebraska Medicaid State Plan as Physician's Services and Other Practitioner Services in EHB 1: Ambulatory Patient Services.

Base Benchmark Benefit that was Substituted: Specialist Visit
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under Nebraska Medicaid State Plan as Physician's Services and Other Practitioner Services in EHB 1: Ambulatory Patient Services.

Base Benchmark Benefit that was Substituted: Outpatient Surgery Physician/Surgical Services
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under Nebraska Medicaid State Plan as Physician's Services and Other Practitioner Services in EHB 1: Ambulatory Patient Services.

Base Benchmark Benefit that was Substituted: Hospice Services
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under Nebraska Medicaid State Plan as Hospice Care in EHB 1: Ambulatory Patient Services.

Base Benchmark Plan: The covered person must have a life expectancy of six months or less as documented in writing by the attending physician. The hospice services must be ordered by a physician. Services provided must be appropriate for palliative support or management of a covered persons with terminal medical illness.

Base Benchmark Benefit that was Substituted: Urgent Care Center or Facilities
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under Nebraska Medicaid State Plan as Outpatient Hospital Services and Clinic Services in EHB 1: Ambulatory Patient Services.

Base Benchmark Benefit that was Substituted: Emergency Room Services
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
Duplication: Covered under Nebraska Medicaid State Plan as Emergency Hospital Services in EHB 2: Emergency Services.

Base Benchmark Benefit that was Substituted: Emergency Transportation/Ambulance
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
Duplication: Covered under Nebraska Medicaid State Plan as Transportation Services: Emergency in EHB 2: Emergency Services.

Base Benchmark Benefit that was Substituted: Home Health Care Services
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
Duplication: Covered under Nebraska Medicaid State Plan as Home Health Services EHB 1: Ambulatory Patient Services.

Base Benchmark Plan: Limited to 60 days.

Base Benchmark Benefit that was Substituted: Inpatient Hospital Services
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
Duplication: Covered under Nebraska Medicaid State Plan as Inpatient Hospital Services EHB 3: Hospitalization.

Base Benchmark Benefit that was Substituted: Inpatient Physician and Surgical Services
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
Duplication: Covered under Nebraska Medicaid State Plan as Inpatient Hospital Services: EHB3: Hospitalization.

Base Benchmark Benefit that was Substituted: Skilled Nursing Facility
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under Nebraska Medicaid State Plan as Short-Term Nursing Facility Services in EHB 7: Rehabilitative and Rehabilitative Services and Devices.

Base Benchmark Plan: 60 day(s) per year
Exclusions: Skilled nursing facility care does not include:
a) supportive services for a stabilized condition;
b) care which can be learned and given by unlicensed or uncertified medical personnel;
c) routine health care services;
d) general maintenance or supervision of routine daily activities; or
e) routine administration of oral or nonprescription drugs.

Base Benchmark Benefit that was Substituted: Prenatal and Postnatal Care

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under Nebraska Medicaid State Plan as Outpatient Hospital Services-Maternity, Physician Services-Maternity, Other Practitioner's Services-Maternity, Nurse-midwife Services, Free Standing Birth Center Services, Inpatient Hospital Services-Maternity, Tobacco Cessation-Maternity, Home Health Services-Maternity, Extended Services for Pregnant Women in EHB 4: Maternity and Newborn Care.

Base Benchmark Benefit that was Substituted: Delivery and All Inpatient Services for Maternity

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under Nebraska Medicaid State Plan as Inpatient Hospital Services-Maternity, Nurse-midwife Services, Free Standing Birth Center Services in EHB 4: Maternity and Newborn Care.

Base Benchmark Benefit that was Substituted: Basic Dental Care - Child

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under Nebraska Medicaid State Plan as Medicaid State Plan EPSDT Benefits in EHB 10: Pediatric Services - including oral and vision. Base Benchmark Plan: Limit: 2 exam(s) per year.

Base Benchmark Benefit that was Substituted: Well Baby Visits and Care

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under Nebraska Medicaid State Plan as Medicaid State Plan EPSDT Benefits in EHB 10: Pediatric Services - including oral and vision.

Base Benchmark Benefit that was Substituted: Dental Check-up for Children
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
Duplication: Covered under Nebraska Medicaid State Plan as Medicaid State Plan EPSDT Benefits in EHB 10: Pediatric Services - including oral and vision.

Base Benchmark Benefit that was Substituted: Eye Glasses for Children
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
Duplication: Covered under Nebraska Medicaid State Plan as Medicaid State Plan EPSDT Benefits in EHB 10: Pediatric Services - including oral and vision.

Base Benchmark Benefit that was Substituted: Routine Eye Exam for Children
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
Duplication: Covered under Nebraska Medicaid State Plan as Medicaid State Plan EPSDT Benefits in EHB 10: Pediatric Services - including oral and vision.

Base Benchmark Benefit that was Substituted: Laboratory Outpatient and Professional Services
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
Duplication: Covered under Nebraska Medicaid State Plan as Other Laboratory and X-ray Services in EHB 8: Laboratory Services.

Base Benchmark Benefit that was Substituted: X-rays and Diagnostic Imaging
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
Duplication: Covered under Nebraska Medicaid State Plan as Other Laboratory and X-ray Services in EHB 8: Laboratory Services.

Base Benchmark Benefit that was Substituted: Imaging (CT/PET Scans, MRIs)
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under Nebraska Medicaid State Plan as Other Laboratory and X-ray Services in EHB 8: Laboratory Services.

Base Benchmark Benefit that was Substituted: Mental/Behavioral Health Outpatient Services

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under Nebraska Medicaid State Plan as Outpatient Hospital Services: MH/SUD, Physician's Services: MH/SUD, Clinic Services: MH/SUD, Other Practitioner's Services: MH/SUD, Rehabilitative Services: MH/SUD and Home Health Services: MH/SUD in EHB 5: Mental Health and Substance Use Disorder Services.

Base Benchmark Benefit that was Substituted: Mental/Behavioral Health Inpatient Services

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under Nebraska Medicaid State Plan as Inpatient Hospital Services: MH/SUD, Physician's Services: MH/SUD, Clinic Services: MH/SUD, Other Practitioner's Services: MH/SUD, Rehabilitative Services: MH/SUD in EHB 5: Mental Health and Substance Use Disorder Services.

Base Benchmark Plan: Excludes programs that treat obesity or gambling addiction and residential treatment programs.

Exclusions include: programs for co-dependency; employee assistance; probation; prevention; educational or self-help; programs which treat obesity, gambling, or nicotine addiction; Custodial Care for Mental Illness and/or Substance Dependence and Abuse; halfway house or Substance Dependence and Abuse maintenance programs; programs ordered by the Court determined to be not Medically Necessary.

Base Benchmark Benefit that was Substituted: Substance Abuse Disorder Outpatient Services

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under Nebraska's 1915(b)(3) waiver services as Outpatient Hospital Services: MH/SUD, Physician's Services: MH/SUD, Clinic Services: MH/SUD, Other Practitioner's Services: MH/SUD, Home Health Services: MH/SUD in EHB 5: Mental Health and Substance Use Disorder Services.

Base Benchmark Benefit that was Substituted: Substance Abuse Disorder Inpatient Services

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under Nebraska's 1915(b)(3) waiver services as Inpatient Hospital Services: MH/SUD, Physician's Services: MH/SUD, Clinic Services: MH/SUD, Other Practitioner's Services:

MH/SUD in EHB 5: Mental Health and Substance Use Disorder Services.

Base Benchmark Benefit that was Substituted: Durable Medical Equipment
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under Nebraska Medicaid State Plan as Home Health Services: Medical Supplies, Equipment, and Appliances in EHB 7: Rehabilitative and Habilitative Services.

Base Benchmark Benefit that was Substituted: Chemotherapy
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under Nebraska Medicaid State Plan as Physician's Services in EHB 1: Ambulatory Patient Services.

Base Benchmark Benefit that was Substituted: Prosthetic Devices
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under Nebraska Medicaid State Plan as Home Health Services: Prosthetic Devices and Home Health Services:Medical Supplies, Equipment, and Appliances in EHB 7: Rehabilitative and Habilitative Services.

Base Benchmark Benefit that was Substituted: Transplant
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under Nebraska Medicaid State Plan as Inpatient Hospital Services in EHB 3: Hospitalization.

Base Benchmark Benefit that was Substituted: Other Practitioner Office Visit (RN, PA)
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under Nebraska Medicaid State Plan as Physician's Services and Other Practitioner Services in EHB 1: Ambulatory Patient Services.

Base Benchmark Benefit that was Substituted: Nutritional Counseling
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under Nebraska Medicaid State Plan as Nutrition Services in EHB 9: Preventative and Wellness Services and Chronic Disease Management.

Base Benchmark Plan: Only for diabetes management.

Base Benchmark Benefit that was Substituted: Rehabilitative OT and Rehabilitative PT

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under Nebraska Medicaid State Plan as Home Health Services: PT, OT, ST, & Audiology, Physical Therapy and related services: PT, and Physical Therapy and related services: OT, and Services for Individuals with speech, hearing, and language disorders in EHB 7: Rehabilitative and Habilitative Services.

Base Benchmark Plan: Limit: 45 visit(s) per year

Explanation: Limits to rehab and hab combined: Physical, occupational or speech therapy services, chiropractic or osteopathic physiotherapy (combined limit to 45 sessions per calendar year).

Base Benchmark Benefit that was Substituted: Rehabilitative Speech Therapy

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under Nebraska Medicaid State Plan as Home Health Services: PT, OT, ST, & Audiology, Physical Therapy and related services: ST, services for individuals with speech, hearing, and language disorders in EHB 7: Rehabilitative and Habilitative Services.

Base Benchmark Plan: Limit: 45 visit(s) per year

Explanation: Limits to rehab and hab combined: Physical, occupational or speech therapy services, chiropractic or osteopathic physiotherapy (combined limit to 45 sessions per calendar year).

Base Benchmark Benefit that was Substituted: Outpatient Rehabilitation Services

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under Nebraska Medicaid State Plan as Home Health Services: PT, OT, ST, & Audiology, Physical Therapy and related services: PT, Physical Therapy and related services: OT, Physical Therapy and related services: ST, and in EHB 7: Rehabilitative and Habilitative Services.

Base Benchmark Plan: 45 treatment(s) per year
Limits apply to rehab and hab combined: physical, occupational or speech therapy services, chiropractic or osteopathic physiotherapy (combined limit to 45 sessions per calendar year).

Base Benchmark Benefit that was Substituted: Habilitation Services

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under Nebraska Medicaid State Plan as Home Health Services: PT, OT, ST, & Audiology, Physical Therapy and related services: PT, Physical Therapy and related services: ST, Physical Therapy and related services:OT in EHB 7: Rehabilitative and Habilitative Services.

Base Benchmark Plan: Limit: 45 treatment(s) per year

Autism exclusions: Services for treatment of austism spectrum disorders, including, but not limited to applied behavioral anaylsis and early intensive behavioral intervention.

Services for autism spectrm disorders or pervasive developmental conditions, developmental delays or sensory integration disorders...unless otherwise required by law or specifically covered elsewhere in this contract.

Explanations: Nebraska supplemented this EHB category for Habilitative Services: "Health care services that help a person keep, learn, or improve skills and functioning for daily living. These services may include physical and occupational therapy, speech language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings." Quantitative limits on services apply to outpatient, only.

Base Benchmark Benefit that was Substituted: Chiropractic Care

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under Nebraska Medicaid State Plan as Chiropractic Services in EHB1: Ambulatory Patient Services.

Base Benchmark Plan: Limit: 20 visit(s) per year. Chiropractic physiotherapy has a combined limit with PT, OT and speech therapies of 45 sessions per calendar year. Chiropractic manipulative adjustments have a combined limit with osteopathic physiotherapy of 20 sessions per calendar year.

Base Benchmark Benefit that was Substituted: Dialysis

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under Nebraska Medicaid State Plan as Clinic Services, Outpatient Hospital Services, and Physician Services in EHB1: Ambulatory Patient Services and Inpatient Hospital Services in EHB3: Hospitalization.

Base Benchmark Benefit that was Substituted: Accidental Dental

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under Nebraska Medicaid State Plan as Clinic Services, Outpatient Hospital Services, and Physician Services in EHB1: Ambulatory Patient Services and Inpatient Hospital Services in EHB3: Hospitalization.

Base Benchmark Plan: Benefits are limited to treatment provided within 12 months of the injury. Benefits are not available for orthodontics or dental implants. Benefits shall not be provided for such services when the injury occurs as the result of eating, biting, or chewing.

Base Benchmark Benefit that was Substituted: Radiation

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under Nebraska Medicaid State Plan as Physician Services in EHB1: Ambulatory Patient Services and Inpatient Hospital Services in EHB3: Hospitalization.

Base Benchmark Benefit that was Substituted: Infusion Therapy

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under Nebraska Medicaid State Plan as Physician Services in EHB1: Ambulatory Patient Services and Inpatient Hospital Services in EHB3: Hospitalization.

Base Benchmark Benefit that was Substituted: Reconstructive Surgery

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under Nebraska Medicaid State Plan as Physician Services in EHB1: Ambulatory Patient Services and Inpatient Hospital Services in EHB3: Hospitalization.

Base Benchmark Plan: Available only post-mastectomy or when required to restore, reconstruct or correct any bodily function that was lost, impaired or damaged as a result of injury or illness.

Base Benchmark Benefit that was Substituted: Diabetes Education

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Substitution: Diabetes Education was removed and replaced in EHB9: Preventative and Wellness Services and Chronic Disease Management by substitution with the actuarial value of Family Planning Services & Supplies, which are not covered in the base benchmark plan. Coverage for Family Planning Services & Supplies comes from the preventative coverage provided in the State Plan.

Alternative Benefit Plan

Base Benchmark Benefit that was Substituted:
Preventative Care/Screening/Immunization

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under Nebraska Medicaid State Plan as Other Diagnostic, Screening, Preventative, and Rehabilitative Services in EHB 9: Preventative and Wellness Services and Chronic Disease Management.

Base Benchmark Benefit that was Substituted:
Outpatient Facility Fee (e.g. ambulatory surgery)

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under Nebraska Medicaid State Plan as Clinic Services in EHB 1: Ambulatory Patient Services and Freestanding Birth Center Services in EHB 4: Maternity and Newborn Care.

Add

☐ 13. Other Base Benchmark Benefits Not Covered Collapse All ☐

Alternative Benefit Plan

☒ 14. Other 1937 Covered Benefits that are not Essential Health Benefits Collapse All ☐

Other 1937 Benefit Provided: Personal Assistance Services

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Authorization required in excess of limitation

Provider Qualifications: Medicaid State Plan

Amount Limit: 40 hours per week

Duration Limit: 7 day period

Scope Limit: Other

Other: Personal assistance services are authorized by the state or designee, provided by qualified providers who are not legally responsible relatives, and are furnished inside the home, and outside the home with limitations. Provided at a client's worksite to the extent the authorized task might otherwise be needed in the home and community. Not provided to individuals residing in residential facilities where personal assistance services are required under the licensing requirements.

Other 1937 Benefit Provided: Rural Health Clinic Services

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Yes

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other: No prior authorization.

Other 1937 Benefit Provided: FQHC

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other:
No prior authorization.

Other 1937 Benefit Provided:
Certified Pediatric & Family Nurse Practitioner

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
No prior authorization.

Other 1937 Benefit Provided:
Podiatrists' Services

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
Other

Duration Limit:
Other

Scope Limit:
Covers medically necessary podiatry services within the scope of the podiatrists' licensure and within program guidelines.

Other:
Orthotic devices and orthotic footwear: Covers orthotic devices, orthopedic footwear, shoe corrections, and other items for the feet if medically necessary for the client's condition.

Pallatative foot care: Palliative foot care includes the cutting or removal of corns or callouses; the trimming of nails; other hygienic and preventive maintenance care or debridement, such as cleaning and soaking the feet and the use of skin creams to maintain the skin tone of both ambulatory and non-ambulatory clients; and any services performed in the absence of localized illness, injury, or symptoms involving the foot. Coverage of palliative footcare is limited to one treatment every 90 days for non-ambulatory clients and one treatment every 30 days for ambulatory clients.

Other 1937 Benefit Provided:
Dental Services

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
Other

Duration Limit:
Other

Scope Limit:
Other

Other:
Diagnostic services and preventive dental care, do not require prior authorization.

Periodic oral evaluation is covered once every 180 days or more often if medically necessary.

Oral Surgery: Oral surgery, as defined by HCPCS, is covered as a physician service.

Cosmetic Services: Cosmetic dental services are not covered.

Radiology: Nebraska covers the following radiographs: Intraoral complete series, intraoral periapical films, extraoral films, bitewings, panoramic films, and cephalometric film. Coverage of these procedures is specified in state regulations.

Endodontics: Nebraska Medicaid covers endodontics for anterior and posterior teeth when the prior authorization request, which includes submitted x-rays with clinical documentation, substantiates medical necessity.

Periodontics: Nebraska Medicaid covers periodontics for anterior and posterior teeth when prior authorized.

Other 1937 Benefit Provided:
Dentures

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
Other

Duration Limit:
Other

Scope Limit:
Other

Other:
The following prosthetic appliances are covered when coverage criteria is met:
1. Dentures (immediate, replacement/complete, or interim/complete);
2. Resin base partial dentures;
3. Flipper partials; and
4. Cast metal framework with resin denture base partials for clients age 20 and younger.

Replacement prosthetic appliances are covered when:
1. The client's dental history does not show that previous prosthetic appliances have been unsatisfactory to the client;
2. The client does not have a history of lost prosthetic appliances;
3. A repair will not make the existing denture or partial functional;

4. A reline will not make the existing denture or partial functional; or
5. A rebase will not make the existing denture or partial functional.

Partial dentures for clients are covered that do not have adequate occlusion.

Prior authorization is required for replacement/complete dentures, maxillary resin base partials, and flipper partials.

Other 1937 Benefit Provided:
Eyeglasses

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
1

Duration Limit:
Every 24 months

Scope Limit:

Other:

Exams: Eye examinations are covered for clients age 21 and older once every 24 months. More frequent eye examinations will also be covered when reasonable and appropriate.

Eyeglass frames: Eyeglass frames are covered under the following conditions:
1. The client's first pair of prescription eyeglasses; or
2. Size change due to growth; or
3. A prescribed lens change only if new lenses cannot be accommodated by the current frame; or
4. The client's current frame is no longer usable due to irreparable wear/damage; breakage or loss. Replacement of frames is limited to one per year for clients 21 years and older.

A pair of eyeglasses is covered for adults (21 and older) when one of the above conditions is met within a 24-month period.

Eyeglass lenses: Eyeglass lenses under the following conditions:
1. The client's first pair of prescription eyeglasses; or
2. Change in size due to growth; or
3. When new lenses are required due to a new prescription when the refraction correction meets one of the following criteria:
a. A change of 0.50 diopters in the meridian of greatest change when placed on an optical cross;
b. A change in axis in excess of 10 degrees for 0.50 cylinder, five degrees for 0.75 cylinder; or
c. A change of prism correction of 1/2 prism diopter vertically or two prism diopters horizontally or more.

For persons 21 and older, a pair of lenses is covered within a 24 month period when anyone of the above medical reasons exist. Lenses must meet the specifications for eyeglass lenses and coverage criteria.

Contact lens services are covered only when prescribed for correction of keratoconus, monocular aphakia, or other pathological conditions of the eye when useful vision cannot be obtained with eyeglasses. Contact lenses are not covered when prescribed for routine correction of vision.

Services not covered: Sunglasses, multiple pairs of eyeglasses for the same individual, non-spectacle

mounted aids, hand-held or single lens spectacle mounted low vision aids, and telescopic and other compound lens systems, and replacement insurance.

Remove

Other 1937 Benefit Provided:
Private Duty Nursing Services

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
Other

Duration Limit:
Other

Scope Limit:
None

Other:
The following limitations are applied to nursing services (RN and LPN) for adults age 21 and older:
1. Per diem reimbursement for nursing services for the care of ventilator-dependent clients shall not exceed the average ventilator per diem of all Nebraska nursing facilities which are providing that service. This average shall be computed using nursing facility's ventilator interim rates which are effective January 1 of each year, and are applicable for that calendar year period.
2. Per diem reimbursement for all other in-home nursing services shall not exceed the average case-mix per diem for the Extensive Special Care 2 case-mix reimbursement level. This average shall be computed using the Extensive Special Care 2 case-mix nursing facility interim rates which are effective January 1 of each year and applicable for that calendar year period.

Under special circumstances, the per diem reimbursement may exceed this maximum for a short period of time - for example, a recent return from a hospital stay. However, in these cases, the 30-day average of the in-home nursing per diems shall not exceed the maximum above. (The 30 days are defined to include the days which are paid in excess of the maximum plus those days immediately following, totaling 30.)

Remove

Other 1937 Benefit Provided:
Case Management

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
For aged, blind, and disabled individuals, AFDC-related individuals, and individuals with developmental disabilities.

Other:
No prior authorization.

Other 1937 Benefit Provided: Intermediate Care Facility Services

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Other

Other: No prior authorization required. For individuals with intellectual disabilities. The individual must have a diagnosis of an intellectual disability as the primary diagnosis and can benefit from active treatment.

Other 1937 Benefit Provided: Inpatient Psychiatric Services Under Age 21

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other: Prior authorization and certification of need required.

Other 1937 Benefit Provided: Telehealth

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other: Services are covered when provided via telehealth technologies subject to the limitations as set forth in 3.1-A and 3.1-B of the approved Medicaid state plan. Services requiring “hands on" professional care are excluded.

Alternative Benefit Plan

Remove

Other 1937 Benefit Provided:
Non-Emergency Medical Transportation

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:

Other:
Authorization for NEMT services shall be requested for a scheduled trip at least three business days in advance, with the exception of an unscheduled trip for urgent medical care. The authorization shall be requested and the trip(s) shall be arranged according to the most appropriate mode of transportation for the service provided to the client.

Remove

Other 1937 Benefit Provided:
Respiratory Care Services

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Must be reasonable and necessary for the diagnosis or treatment of an illness or injury.

Other:
No prior authorization required.

Remove

Other 1937 Benefit Provided:
Abortion Services

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Only as required under 42 CFR 457.475.

Alternative Benefit Plan

Other:

Other 1937 Benefit Provided: Critical Care Hospital

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: As defined in 42 CFR 440.170(g).

Other: No prior authorization is required.

Other 1937 Benefit Provided: 1915(c) HCBS Waivers

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: Other

Duration Limit: Other

Scope Limit: Other

Other: Services as outlined in Nebraska's approved 1915(c) HCBS Waivers.

Other 1937 Benefit Provided: Long-Term Nursing Facility Services

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:
Other

Other:
As approved in section 3.1-A of the Medicaid state plan.

Other 1937 Benefit Provided:
PACE

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
Other

Duration Limit:
Other

Scope Limit:
Other

Other:
As approved in section 3.1-A in Nebraska's Medicaid State Plan.

Other 1937 Benefit Provided:
Optometrists' Services

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
All surgical procedures provided by an optometrist or ophthalmologist require approval from the Primary Care Case Management plan.

Other 1937 Benefit Provided:
Medically-monitored Inpatient Withdrawal Managemen

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
Other

Duration Limit:
Other

Scope Limit:
Other

Other:
Medically-monitored Inpatient Withdrawal Management (ASAM Level 3.7-WM) is an organized service delivered by medical and nursing professionals, which provide for 24-hour medically supervised evaluation under a defined set of physician-approved policies and physician-monitored procedures or clinical protocols. This level provides care to patients whose withdrawal signs and symptoms are sufficiently severe to require 24-hour residential care.

Other 1937 Benefit Provided:
Opioid Treatment Program (OTP)

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
Other

Duration Limit:
Other

Scope Limit:
Other

Other:
The OTP service offers community-based, non-residential rehabilitative services for individuals diagnosed with an opioid use disorder, as defined in the Diagnostic Statistical Manual. OTP services include rehabilitative services to administer opioid treatment medication and to alleviate the adverse medical, psychological, or physical effects to opioid addiction.

Other 1937 Benefit Provided:
Medication-Assisted Treatment (MAT)

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
Other

Duration Limit:
Other

Scope Limit:
Other

Other:
MAT is provided as defined in the approved state plan 3.1A and if applicable, 3.1B pages.

MAT is provided in accordance with 1905(a)(29) for the period beginning October 1, 2020, and ending September 30, 2025.

Alternative Benefit Plan

Other 1937 Benefit Provided:
Routine Patient Cost in Qualifying Clinical Trials

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
Varies

Duration Limit:
Varies

Scope Limit:
Varies

Other:
See Supplement to Attachment 3.1-A, Item 30 and 3.1-B, Item 30. Coverage of Routine Patient Cost in Qualifying Clinical Trials.

Other 1937 Benefit Provided:

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:

Amount Limit:

Duration Limit:

Scope Limit:

Other:

Add

☐ 15. Additional Covered Benefits (This category of benefits is not applicable to the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act.)

Collapse All ☐

PRA Disclosure Statement

Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) for the purpose of standardizing data. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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