



Alternative Benefit Plan

State Name:

Attachment 3.1-L-

OMB Control Number: 0938-1148

Transmittal Number: ____ - ____ - ____

Benefits Description	ABP5
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The state/territory proposes a "Benchmark-Equivalent" benefit package.

Benefits Included in Alternative Benefit Plan

Enter the specific name of the base benchmark plan selected:

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



Alternative Benefit Plan

1. Essential Health Benefit: Ambulatory patient services

Collapse All

Benefit Provided:	Source:	Remove
Physician Services	State Plan 1905(a)	
Authorization:	Provider Qualifications:	
None	Medicaid State Plan	
Amount Limit:	Duration Limit:	
none	n/a	
Scope Limit:		
within state licensing requirements		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		
n/a		

Benefit Provided:	Source:	Remove
Hospice care	State Plan 1905(a)	
Authorization:	Provider Qualifications:	
Prior Authorization	Medicaid State Plan	
Amount Limit:	Duration Limit:	
none	none	
Scope Limit:		
Initial increment six months. Re-evaluate every 3 months		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		
n/a		

Benefit Provided:	Source:	Remove
Home Health Care	State Plan 1905(a)	
Authorization:	Provider Qualifications:	
Prior Authorization	Medicaid State Plan	
Amount Limit:	Duration Limit:	
none	n/a	
Scope Limit:		
Skill nursing, PT, OT, PT, ST, RT, dietitians, HH Aids, Must be intermittent services.		



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

physician order and plan of care determine tx hours

Benefit Provided:

Family Planning Services

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

none

Duration Limit:

none

Scope Limit:

Must be FDA approved

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

n/a

Benefit Provided:

Personal Care Services

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

none

Duration Limit:

reassessment process

Scope Limit:

PCS include a range of human assistance provided to a person with disabilities and chronic conditions of all ages. Assistance with IADLs and ADLs.

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

The assessment is conducted by licensed physical and/or occupational therapist. Authorizations are dependent upon assessment process and will not exceed one year. Reassessments are required 30 days prior to expiration of authorization.

Benefit Provided:

Private Duty Nursing

Source:

State Plan 1905(a)

Remove

Authorization:

Authorization required in excess of limitation

Provider Qualifications:

Medicaid State Plan

Amount Limit:

see below

Duration Limit:

none



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Scope Limit:

The intent of private duty nursing is to assist the non-institutionalized recipient with complex direct skilled nursing care, to develop caregiver competencies through training and education, and to optimize recipient health status and outcomes.

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

Hourly service limitations are dependent upon diagnosis, caregiver availability, age and medical necessity. Hourly services may be exceeded with authorization.

Benefit Provided:

Outpatient Hospital Services

Source:

State Plan 1905(a)

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

none

Duration Limit:

n/a

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 require authorization dependent upon service being provided. Services provided include emergency room, radiology, laboratory, diagnostic, therapy, ambulatory surgery and observation.

Benefit Provided:

Clinics (1905 Clinics Under the Direction of Phys)

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

none

Duration Limit:

none

Scope Limit:

Within licensure requirements

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

Services provided under the direction of a physician.

Benefit Provided:

Podiatry

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan



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Amount Limit:

none

Duration Limit:

n/a

Scope Limit:

Within state licensing requirements

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

n/a

Add



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2. Essential Health Benefit: Emergency services

Collapse All

Benefit Provided:	Source:	Remove
Clinic: Urgent Care Clinics	State Plan 1905(a)	
Authorization:	Provider Qualifications:	
None	Medicaid State Plan	
Amount Limit:	Duration Limit:	
none	n/a	
Scope Limit:		
Within state licensing requirements		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		
n/a		

Benefit Provided:	Source:	Remove
Outpatient Hospital: Emergency Room Coverage	State Plan 1905(a)	
Authorization:	Provider Qualifications:	
None	Medicaid State Plan	
Amount Limit:	Duration Limit:	
none	n/a	
Scope Limit:		
Within state licensing requirements		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		
n/a		

Benefit Provided:	Source:	Remove
Transportation: Emergency	State Plan 1905(a)	
Authorization:	Provider Qualifications:	
None	Medicaid State Plan	
Amount Limit:	Duration Limit:	
none	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:		
Emergent transports requiring "911" to acute facility and scheduled specialty care transports for hospital-to-		



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hospital transports of a critically ill or ill recipient by a ground or air ambulance vehicle needing medically necessary supplies and services at a level beyond scope of EMT-intermediate or paramedic

Add



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3. Essential Health Benefit: Hospitalization

Collapse All

Benefit Provided:

Inpatient hospital

Source:

State Plan 1905(a)

Remove

Authorization:

Concurrent Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

none

Duration Limit:

none

Scope Limit:

med/surg tx; diagnostic testing; psychiatric/substance abuse/detox in a general acute care hospital; trauma; ICU medical rehab.

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

Admission, concurrent, and retrospective authorization requirements. Medicare certified.

Benefit Provided:

Inpatient Hospital: psychiatric

Source:

State Plan 1905(a)

Remove

Authorization:

Concurrent Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

Dependent upon concurrent authorization

Duration Limit:

Dependent upon authorization and recipient age

Scope Limit:

Free-standing psychiatric hospital, or general med/surg hospital with a dedicated psychiatric unit. Services not covered for recipient ages 22-64 in a free-standing psychiatric hospital due to Institute of Mental Disease (IMD) exclusion regulation.

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

n/a

Benefit Provided:

Inpatient Hospital: Substance Abuse (detox/tx)

Source:

State Plan 1905(a)

Remove

Authorization:

Concurrent Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

Detox 5 days Treatment 21 hospital days

Duration Limit:

Unlimited lifetime admissions

Scope Limit:

Free-standing substance abuse tx hospitals or general hospital with a specialized substance abuse tx unit



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which includes a secure, structured environment, 24 hr observation and supervision by mental health substance abuse professionals

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

All ages require results of urine drug screen or blood alcohol test at the time of the request for authorization. May exceed limits with authorization. Services not covered for recipients ages 22-64 in a free-standing psychiatric hospital due to Institute for Mental Disease (IMD) exclusion regulations.

Benefit Provided:

Inpatient hospital: Transplants

Source:

State Plan 1905(a)

Remove

Authorization:

Concurrent Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

none

Duration Limit:

none

Scope Limit:

Covered adult transplants: bone marrow/stem cell, corneal, kidney, and liver

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

Admission, concurrent, and retrospective authorization requirements. Medicare certified.

Benefit Provided:

Inpatient hospital: Skill/Admin Days

Source:

State Plan 1905(a)

Remove

Authorization:

Concurrent Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

none

Duration Limit:

none

Scope Limit:

Provides for ongoing hospital svcs for those who don't require acute care but can't be discharged due to waiting for alternate placement. Not for convenience of caregiver. Must be due to medical intervention.

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

Admission, concurrent, and retrospective authorization requirements. Medicare certified.

Benefit Provided:

RTC: Psychiatric Residential Treatment Facility

Source:

State Plan 1905(a)

Remove

Authorization:

Concurrent Authorization

Provider Qualifications:

Medicaid State Plan



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Amount Limit:

none

Duration Limit:

none

Scope Limit:

Psychiatric, medical-model facility accredited by Joint Commission, CARF, COA for recipients under age 21. providing active treatment, psychiatric services, psychological services therapeutic and behavioral modification, therapy, & nursing services.

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

Dependent upon concurrent authorization.

Add



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4. Essential Health Benefit: Maternity and newborn care

Collapse All

Benefit Provided:	Source:	Remove
Free Standing Birthing Centers	State Plan 1905(a)	
Authorization:	Provider Qualifications:	
None	Medicaid State Plan	
Amount Limit:	Duration Limit:	
Labor, delivery, postpartum care	Labor, delivery, postpartum care only	
Scope Limit:		
Natural childbirth procedures for labor, delivery, postpartum care and immediate newborn care.		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		
Uncomplicated low-risk prenatal course is reasonably expected to result in a normal uncomplicated vaginal birth.		

Benefit Provided:	Source:	Remove
Physician: Maternity Services	State Plan 1905(a)	
Authorization:	Provider Qualifications:	
Other	Medicaid State Plan	
Amount Limit:	Duration Limit:	
none	none	
Scope Limit:		
Obstetric/maternity/family planning procedures at time of delivery; newborn/neonatal/pediatric/postpartum		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		
No authorization required for less than 48 hour normal vaginal delivery and/or 96 hour cesarean section delivery. C-section less than 39 weeks gestation and elective c-sections require prior authorization.		

Benefit Provided:	Source:	Remove
Inpatient hospital-maternity	State Plan 1905(a)	
Authorization:	Provider Qualifications:	
Concurrent Authorization	Medicaid State Plan	
Amount Limit:	Duration Limit:	
none	none	
Scope Limit:		
Obstetric/maternity/family planning procedures at time of delivery, newborn/neonatal pediatric		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		
Admission, concurrent, and retrospective authorization requirements. Medicare certified. No authorization		



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required for less than 48 hour vaginal delivery and/or 96 hour cesarean section delivery. C-section less than 39 weeks gestation and elective c-section requires prior authorization. Inpatient and physician maternity services.

Add



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

Collapse All

Benefit Provided:	Source:	Remove
Partial Hospitalization (BH/SA): PHP (1915)	State Plan 1915(i)	
Authorization:	Provider Qualifications:	
Prior Authorization	Medicaid State Plan	
Amount Limit:	Duration Limit:	
Dependent upon authorization and intensity of need	none	
Scope Limit:		
Medical model by a hospital, in an outpatient setting which encompasses a variety of psychiatric modalities to coordinate intensive, comprehensive and multidisciplinary tx not generally provided in an outpatient setting.		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		
Mental health rehab service based upon the assessed needs of the recipient based upon standardized assessments. The service has been standardized to a utilization system based upon a level of care placement system specific to children and adults.		

Benefit Provided:	Source:	Remove
Intensive Outpatient Program (BH/SA): IOP(1915)	State Plan 1915(i)	
Authorization:	Provider Qualifications:	
Prior Authorization	Medicaid State Plan	
Amount Limit:	Duration Limit:	
Dependent upon authorization and intensity of need	none	
Scope Limit:		
Comprehensive interdisciplinary program of array of direct mental health/substance abuse & rehabilitative services which are expected to improve or maintain an individual's condition and functioning level for prevention of relapse or hospitalization.		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		
Mental health rehab services based upon the assessed need of the recipient based upon standardized assessments. The service has been standardized to a utilization system based upon a level of care placement system specific to children and adults.		

Benefit Provided:	Source:	Remove
BH/SA Outpatient Services: Rehab(1905)	State Plan 1905(a)	
Authorization:	Provider Qualifications:	
Authorization required in excess of limitation	Medicaid State Plan	



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Amount Limit:

none

Duration Limit:

none

Scope Limit:

Services recommended by physician/licensed practitioner of the healing arts, within their scope of practice under State law for the maximum reduction of a physical or mental disability and to restore the individual to the best function level.

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

n/a

Add



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■ 6. Essential Health Benefit: Prescription 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:

Yes

Provider Qualifications:

State licensed

Coverage that exceeds the minimum requirements or other:

Follows all requirements under Section 1927 of the Social Security Act. Implementing the Nevada Medicaid State Plan pharmacy coverage 3.1a in its entirety. Nevada ABP prescription drug benefit plan is the same as under the approved Medicaid state plan for prescribed drugs.



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7. Essential Health Benefit: Rehabilitative and habilitative services and devices

Collapse All

Benefit Provided:

Physical Therapy and Related Services

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

none

Duration Limit:

none

Scope Limit:

Medically necessary therapy services for an illness or injury resulting in functional limitations which can respond or improve as a result of the prescribed therapy treatment plan in a reasonable, predictable period of time.

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

n/a

Benefit Provided:

Maintenance Therapy:Physical Therapy & Related Svs

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

none

Duration Limit:

10 visits every three years

Scope Limit:

Design or establish a maintenance plan, assure patient safety, train the patient, family members and/or unskilled personnel and make infrequent but periodic reevaluations of the plan.

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

Service cannot be exceeded through prior authorization. The goals of a maintenance program are to maintain functional status at a level consistent with the patient's physical or mental limitations or to prevent decline in function.

Benefit Provided:

Durable Medical Equipment : Home Health Care

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

Authorization dependent upon the service

Duration Limit:

Dependent upon the service

Scope Limit:

Items must have received approval by FDA and be consistent with approved use. Products for



Alternative Benefit Plan

experimental or investigational purposes are non-covered. Consideration may be given to items classified by FDA as Humanitarian Device Exemptions (HDE).

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

n/a

Benefit Provided:

Medical Supplies: Home Health Care

Source:

State Plan 1905(a)

Remove

Authorization:

Authorization required in excess of limitation

Provider Qualifications:

Medicaid State Plan

Amount Limit:

Quantity limitation dependent upon service

Duration Limit:

Lifetime limit dependent upon service

Scope Limit:

Items must have received approval by FDA and be consistent with approved use. Product for experimental or investigational purposes are non-covered. Consideration may be given to items classified by FDA as Humanitarian Device Exemptions (HDE).

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

n/a

Benefit Provided:

Orthotics and Prosthetics: Prosthetic Devices

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

Authorization dependent upon the service

Duration Limit:

Lifetime limit dependent on service

Scope Limit:

Items must have received approval by FDA and be consistent with approved use. Product for experimental or investigational purposes are non-covered. Consideration may be given to items classified by FDA as Humanitarian Device Exemptions (HDE).

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

n/a

Benefit Provided:

Ocular - hardware : eyeglasses

Source:

State Plan 1905(a)

Remove



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Authorization:

Authorization required in excess of limitation

Provider Qualifications:

Medicaid State Plan

Amount Limit:

1/12 months

Duration Limit:

n/a

Scope Limit:

Change in refractive error must exceed plus or minus 0.5 diopter or 10 degrees in axis deviation in order to qualify within 12 mo limitation or EPSDT.

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

n/a

Benefit Provided:

Occupational Therapy-Physical Therapy & Related Svs

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

n/a

Scope Limit:

Medically necessary therapy services for an illness or injury resulting in functional limitations which can respond or improve as a result of the prescribed therapy treatment plan in a reasonable, predictable period of time.

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

n/a

Benefit Provided:

Speech, hearing and language -Physical Therapy & R

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

none

Duration Limit:

n/a

Scope Limit:

Medically necessary therapy services for an illness or injury resulting in functional limitations which can respond or improve as a result of the prescribed therapy treatment plan in a reasonable, predictable period of time.

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

n/a



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<input type="text"/>		
Benefit Provided: Adult Day Health Care	Source: State Plan 1915(i)	<input type="button" value="Remove"/>
Authorization: Prior Authorization	Provider Qualifications: Medicaid State Plan	
Amount Limit: Universal Needs Assessment & Physician Eval	Duration Limit: none	
Scope Limit: Services include health and social services needed to ensure the optimal functioning of the participant. Services are generally furnished within four or more hours per day on a regularly scheduled basis. Recipient must be at least 18 years of age.		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: n/a		
Benefit Provided: Home Based Habilitation Services	Source: State Plan 1915(i)	<input type="button" value="Remove"/>
Authorization: Other	Provider Qualifications: Medicaid State Plan	
Amount Limit: Universal Needs Assessment Tool	Duration Limit: None	
Scope Limit: Pt. must have endurance for 3 hours of habilitative services per day, 5 days a week.		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Day tx program for individuals to assist in acquiring, retaining, and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community setting. Habilitation services are prescribed by a physician, and provided by the appropriate qualified staff.		
		<input type="button" value="Add"/>



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8. Essential Health Benefit: Laboratory services

Collapse All

Benefit Provided:	Source:	Remove
Laboratory and x-ray services	State Plan 1905(a)	
Authorization:	Provider Qualifications:	
Prior Authorization	Medicaid State Plan	
Amount Limit:	Duration Limit:	
none	none	
Scope Limit:		
These services include, but not limited to microbiology, serology, immunohematology, cytology, histology, chemical, hematology, toxicology, or other methods of "in-vitro" exam of tissues, secretions, excretions or other human body parts.		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		
Gentotype and phenotype are covered and require PA. Clinic and facility based services.		

Benefit Provided:	Source:	Remove
Laboratory and X-ray services: diagnostics	State Plan 1905(a)	
Authorization:	Provider Qualifications:	
None	Medicaid State Plan	
Amount Limit:	Duration Limit:	
none	none	
Scope Limit:		
X-ray and diagnostic testing		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		
Medically necessary services for diagnosis and treatment of a specific illness, symptom, complaint or injury or to improve the function of a malformed body part. The investigational use for any radiological test is not covered. Clinic and facility based services.		

Add



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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).

Benefit Provided:	Source:	Remove
Preventive Services	State Plan 1905(a)	
Authorization:	Provider Qualifications:	
None	Medicaid State Plan	
Amount Limit:	Duration Limit:	
none	none	
Scope Limit:	U.S. Preventive Services Task Force A & B recommendations, ACIP and Bright Future, and IOM Women's Health	
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		
Nevada State Plan Preventive services are exclusive to the USPSTF/ACIP/Bright Futures/IOM EHB requirements.		

Benefit Provided:	Source:	Remove
Medical Nutrition Therapy	State Plan 1905(a)	
Authorization:	Provider Qualifications:	
Authorization required in excess of limitation	Medicaid State Plan	
Amount Limit:	Duration Limit:	
4 hours - 1st year; 2 hours - subsequent years	none	
Scope Limit:	Medical nutrition therapy (MNT) is provided for recipients with nutritionally related chronic disease states. MNT can only be provided by registered dietitians working under state licensing requirements.	
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		

Add



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

Collapse All

Benefit Provided:

Medicaid State Plan EPSDT Benefits

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

none

Duration Limit:

none

Scope Limit:

Medically Necessary services for children under the age of 21

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

n/a

Add



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11. Other Covered Benefits from Base Benchmark

Collapse All



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

Base Benchmark Benefit that was Substituted:

Heart, heart/lung transplant adults

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:

Substituted for (hospital) Residential Treatment Center benefit for adolescents 19-20, up to 22 if in facility on birthday and Skilled Inpatient Administrative Days are mapped to EBH3

Base Benchmark Benefit that was Substituted:

pancreas, pancreas/liver transplant adults

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:

Substituted for (hospital) Residential Treatment Center benefit for adolescents 19-20, up to 22 if in facility on birthday and Skilled Inpatient Administrative Days are mapped to EHB3

Base Benchmark Benefit that was Substituted:

Fertility, Accupuncture, Chiropractic

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:

Substituted for personal care services and Private Duty Nursing Services are mapped to EHB1.

Base Benchmark Benefit that was Substituted:

Physicians and other healthcare professionals

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 the Nevada Medicaid State Plan as EHB 1 (physician, family planning, clinic benefit). Base benchmark: covers services by physicians and other health care professionals determined to be medically necessary. Services include consultations, second surgical opinions, clinic visits, office visits, home visits, initial exam of newborns, and nutritional counseling. No service limitation.

Base Benchmark Benefit that was Substituted:

Lab, X-ray, and other diagnostic 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 the Nevada Medicaid State Plan as EHB 8 (lab and x-ray benefit). Services ordered by a physician. Billed, by physician, independent laboratory, and/or outpatient hospital department. Base benchmark does not cover genetic screening, requires cancer diagnosis for BRCA testing. No service limitations.



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Base Benchmark Benefit that was Substituted:

Preventive care, adult

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 the Nevada Medicaid State Plan as EHB9. Base benchmark: Services recommended under PPACA. Services have quantity limitations, 1 per year. FDA approved immunizations. Group counseling not covered.

Base Benchmark Benefit that was Substituted:

Preventive care, 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 the Nevada Medicaid State Plan as EHB9 (preventive benefit). Nevada Medicaid does not limit STI. Base benchmark: Services recommended under the PPACA and AAP. Newborn visits and screens, lab tests, hearing and vision screenings, FDA approved immunizations, screenings for STI, HPV, HIV, STI limited to 1 per year.

Base Benchmark Benefit that was Substituted:

Maternity 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 the Nevada Medicaid State Plan as EHB4 (free-standing birth centers, physician-maternity, inpatient-maternity benefit), and EHB5 (BH/SA Outpatient Services benefit). Base benchmark : Prenatal care, tocolytic therapy, delivery postpartum care, surgery, anesthesia, and mental health tx for postpartum depression. No service limitations.

Base Benchmark Benefit that was Substituted:

Family Planning

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 the Nevada Medicaid State Plan as EHB6 (prescription benefit), EHB1 (physician, family planning, clinic, urgent care, outpatient hospital, emergency room benefit), EHB7 (HH: medical supplies). Base benchmark: Contraceptive counseling, contraceptive supplies (oral, injectable, implants, transdermal, condoms), fitting, insertion, implantation, or removal of the contraception, voluntary sterilization. Non-covered reversal of voluntary sterilization. No service limitations

Base Benchmark Benefit that was Substituted:

Allergy 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 the Nevada Medicaid State Plan as EHB1 (physician services, clinics benefit). Base benchmark: no service limitations.



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Base Benchmark Benefit that was Substituted:

Treatment Therapies

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 the Nevada Medicaid State Plan as EHB1 (physicians, clinics, outpatient hospital benefit) and EHB8 (laboratory/x-ray benefits). Base benchmark : no service limitations.

Base Benchmark Benefit that was Substituted:

PT, ST, OT, Cognitive 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 the Nevada Medicaid State Plan as EHB7 (physical therapy & related services; PT/ST/OT/Cognitive therapy benefit) EHB1 (Outpatient Hospital benefit), EHB5 (BH/SA Outpatient Services benefit). Nevada Medicaid State Plan provides a greater benefit for therapy services due to a lesser service limitations. Cognitive therapy covered under both medical and behavioral therapy. Base benchmark: covers licensed therapist or physician. Non-covers; Maintenance, recreation, education, exercise, and hippotherapy non-covered. Limited to 50 visits per calendar year for, combination of PT, OT, ST.

Base Benchmark Benefit that was Substituted:

Hearing svcs (testing, tx, supplies)

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 the Nevada Medicaid State Plan as EHB1 (physicians, clinics benefit), EHB7 (physical therapy & related services benefit, orthotics and prosthetics: prosthetic devices), EHB8 (laboratory, x-ray benefit). Nevada Medicaid State Plan provides a greater benefit for Hearing Aid services due to no annual expenditure limit. Base benchmark: Annual expenditure amount on hearing aids.

Base Benchmark Benefit that was Substituted:

Vision 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 the Nevada Medicaid State Plan as EHB1 (physician services and clinic benefits) EHB 7 (ocular-hardware: eyeglasses benefit). Nevada Medicaid State Plan provides for all medically necessary conditions. Service limitation exceeded through EPSDT. Base benchmark: covers exam related to amblyopia and strabismus for children under age 18. non-covered-routine eye exam and hardware.

Base Benchmark Benefit that was Substituted:

Orthopedic and 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 the Nevada Medicaid State Plan as EHB7 (orthotics and prosthetic: prosthetic



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device benefit). Nevada Medicaid State Plan provides coverage of orthotics and prosthetics by licensed and Medicare certified/bonded providers. Base benchmark: lifetime limit on wigs as a result of cancer. non-cover over-the-counter orthotics, shoes, arch supports, heal pads/supports.

Base Benchmark Benefit that was Substituted:

Durable medical equipment (DME)

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 the Nevada Medicaid State Plan as EHB7 (Durable medical equipment: home health care benefit). Nevada Medicaid State Plan provides a greater benefit for DME services due to coverage of bathroom equipment. Providers must be licensed, bonded and Medicare Certified. base benchmark: Annual expenditure amounts on SGD, non-cover bathroom equipment.

Base Benchmark Benefit that was Substituted:

Medical Supplies

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 the Nevada Medicaid State Plan as EHB7 (medical supplies: home health care benefit). Base benchmark: no limitation.

Base Benchmark Benefit that was Substituted:

Home health 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 the Nevada Medicaid State Plan as EHB1 (home health care benefit). Nevada Medicaid State Plan provides a greater benefit for Home health services due to coverage of PT, OT, ST, RT services under home health benefits and lesser service limitations. Base benchmark: service limitations up to 25 visits per calendar year, provider qualifications of RN/LPN, and skilled visit coverage only.

Base Benchmark Benefit that was Substituted:

Educational classes and programs

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 the Nevada Medicaid State Plan as EHB1 (physician and clinic benefits) and EHB9 (Preventive benefit) as physician services and other practitioners as preventive services, smoking and tobacco cessation, diabetic education, medical nutritional therapy. Base benchmark: non-cover educational classes not listed above.

Base Benchmark Benefit that was Substituted:

Surgical Procedures

Source:

Base Benchmark

Remove

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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 the Nevada Medicaid State Plan as EHB3 (inpatient hospital, inpatient hospital: transplant benefit), EHB 1 (physician services, outpatient hospital services, 1905 clinics: under the direction of benefit) and EHB2 (outpatient hospital emergency room services and urgent care clinics benefit). Base benchmark: non covers reversal of voluntary sterilization, standby physician, routine tx of conditions of foot, cosmetic surgery and refractive surgery.

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 the Nevada Medicaid State Plan as EHB3 (inpatient hospital, inpatient hospital: transplant benefit), EHB1 (physician services, outpatient hospital services, 1905 clinics: under the direction of benefit) and EHB2 (outpatient hospital emergency room services and urgent care clinics benefit). Base benchmark: non-covers cosmetic surgery, sexual dysfunction, and/or inadequacy. Unless in the case of post mastectomy due to cancer.



Base Benchmark Benefit that was Substituted:

Oral and maxillofacial 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 the Nevada Medicaid State Plan as EHB3 (inpatient hospital), EHB1 (physician services, outpatient hospital services, 1905 clinics: under the direction of benefit) and EHB2 (outpatient hospital emergency room services and urgent care clinics benefit). Covered in physician office, hospital, hospital outpatient, SNF, ASC center. Base benchmark: dental/orthodontic care only covered for accidental injuries.

Base Benchmark Benefit that was Substituted:

Anesthesia

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 the Nevada Medicaid State Plan as EHB3 (inpatient hospital, inpatient hospital: transplant benefit) EHB1 (physician services, outpatient hospital services, 1905 clinics: under the direction of benefit) and EHB2 (outpatient hospital emergency room services benefit). Base benchmark: Covered by qualified healthcare professionals in hospital (inpatient, outpatient), skilled nursing facility, ambulatory surgical center and office. No service limitations.

Base Benchmark Benefit that was Substituted:

Inpatient hospital

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 the Nevada Medicaid State Plan as EHB3 (inpatient hospital, inpatient hospital: transplant, inpatient hospital: skilled/admin days benefit) and EHB4 (inpatient hospital: maternity



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and free-standing birthing center benefit) as inpatient hospital services. Base benchmark services covers operating, recover, maternity, and other treatment rooms. Prescribed drugs, Diagnostic studies, radiology, lab, pathology and supplies. : non-covered - nursing homes, extended care facilities, schools, residential treatment centers, private duty nursing.

Base Benchmark Benefit that was Substituted:

Outpatient hospital and ambulatory surgical center

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 the Nevada Medicaid State Plan as EHB1 (Outpatient hospital services benefit) ambulatory services and EHB4 (free-standing birthing center benefit) maternity/newborn care. Base benchmark services covers operating, recovery, and other treatment rooms, free-standing birthing centers, pre-surgical testing performed within one day of surgery. Observation, radiology, diagnostic, supplies, therapies, treatment therapies, and free-standing ASC services. No service limitations.

Base Benchmark Benefit that was Substituted:

Hospice 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 the Nevada Medicaid State Plan as EHB1 (hospice benefit) ambulatory and EHB3 (inpatient hospital benefit) hospitalization. Base benchmark covers home and facility services. Service limited to 7 consecutive days for home and 30 consecutive days in facility. Episodes may be reauthorized. Non-covered- homemaker, home health aide.

Base Benchmark Benefit that was Substituted:

Ambulance-Emergency

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 the Nevada Medicaid State Plan as EHB2 (transportation: emergency benefit) emergency services. Base benchmark covers emergency transport/ambulance with covered hospital inpatient care related to medical emergency and/or covered hospice care. Non-covered: non-emergency transport.

Base Benchmark Benefit that was Substituted:

Accidental injury (ER) Medical emergency

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 the Nevada Medicaid State Plan as EHB2 (outpatient hospital: emergency room benefit) emergency services. Base benchmark covers inpatient and physician benefits under emergency services. No limitations.

Base Benchmark Benefit that was Substituted:

MH/SA professional services

Source:

Base Benchmark

Remove



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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 the Nevada Medicaid State Plan as EHB1 (physician services benefit) EHB5 (MH/SA: partial hospitalization; Intensive outpatient program; outpatient services benefit). Nevada Medicaid State Plan provides a greater benefit for MH/SA rehab services including, day treatment (medical model), BST, PSR and peer support. Base benchmark covers professional services for individual, group therapy, office visits, pharmacotherapy, and psychological testing. Covered in outpatient hospital dept. and inpatient visit. Must be licensed professional. Non-covered: non-licensed professional, marital, family, educational or other counseling services, testing and tx for learning disabilities and mental retardation, applied behavior analysis (ABA) or ABA therapy, services performed or billed by residential treatment centers, schools, halfway houses, residential camps, and light boxes.

Base Benchmark Benefit that was Substituted:

MH/SA inpatient hospital or other covered 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 the Nevada Medicaid State Plan as EHB3 (MH/SA inpatient hospital: substance abuse, inpatient hospital: psychiatric, inpatient hospital: Skilled/Admin days, RTC/Psychiatric Residential Treatment Facilities benefit). Services for individuals age 22-64 are non-covered by Nevada Medicaid in an IMD. Base benchmark covers MH/SA inpatient services. Non-covered: non-licensed professionals, marital, family, educational or other counseling/training services, testing and tx for learning disabilities and mental retardation, applied behavior analysis (ABA) or ABA therapy, services performed or billed by residential treatment centers, schools, halfway houses, residential camps, and light boxes.

Base Benchmark Benefit that was Substituted:

MH/SA outpatient hospital or covered 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 the Nevada Medicaid State Plan as EHB5 (MH/SA: partial hospitalization; intensive outpatient program; outpatient services benefit). Services for individuals age 22-64 are non-covered by Nevada Medicaid in an IMD. Base benchmark covers outpatient hospital, partial hospitalization, facility-based intensive outpatient treatment, diagnostic testing, and psychological testing. Non-covered: non-licensed professionals, marital, family, educational or other counseling/training services, testing and tx for learning disabilities and mental retardation, applied behavior analysis (ABA) or ABA therapy, services performed or billed by residential treatment centers, schools, halfway houses, residential camps, and light boxes.

Base Benchmark Benefit that was Substituted:

Prescribed drug benefits

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 the Nevada Medicaid State Plan as EHB6 (prescription drug benefit) Pharmacy services. Nevada Medicaid is required to comply with all regulatory requirements of Section 1927 of the Social Security Act. Base benchmark covers a four-tier system to categorize their payment levels for drugs; Tier 1: generic drugs, Tier 2: Preferred brand-name drugs, Tier 3: non-preferred brand-name drugs, and Tier 4: specialty drugs.



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Base Benchmark Benefit that was Substituted:

Dental benefits

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 the Nevada Medicaid State Plan as EHB10 (EPSDT benefit) Pediatric oral services. Nevada Medicaid covers under EPSDT and Dental services. Base benchmark: covers eval, xray, preventive, palliative and extractions. Service limitations- preventive (1/yr), xray (1/3yr)

Base Benchmark Benefit that was Substituted:

Transplant benefits

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 the Nevada Medicaid State Plan as EHB2 (hospitalization benefits) and EHB1 (ambulatory benefit). Base benchmark covers bone marrow, stem cell, liver, cornea transplants. Reference Substitution section for additional transplants.

Add



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13. Other Base Benchmark Benefits Not Covered Collapse All

Base Benchmark Benefit not Included in the Alternative Benefit Plan: <input type="text" value="Adult Dental"/>	Source: <input type="text" value="Base Benchmark"/>	<input type="button" value="Remove"/>
Explain why the state/territory chose not to include this benefit: <input type="text" value="Adult dental benifit from the base benchmark plan (FEHBP) will not be covered in the ABP."/>		
<input type="button" value="Add"/>		



Alternative Benefit Plan

14. Other 1937 Covered Benefits that are not Essential Health Benefits

Collapse All

Other 1937 Benefit Provided:

Targeted Case Mangement

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Authorization required in excess of limitation

Provider Qualifications:

Medicaid State Plan

Amount Limit:

30 hours per month

Duration Limit:

n/a

Scope Limit:

7 covered target groups. Seriously Mentally Ill, Emotional Disturbance, Axis I (non SED non SMI), Juvenile Protective Services, Child Welfare, Developmentally Delayed ages 0-3, Mental Retardation and Related Conditions.

Other:

n/a

Other 1937 Benefit Provided:

Inst. Facility for Individuals w/Intellectual w/D

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

Based upon authorization determination

Duration Limit:

none

Scope Limit:

Must be certified and comply with all Federal Cond of Participation in 8 areas, including mngt, client protections, facility staffing, active tx services, client behavior and facility practices, healthcare services, physical enviro, & dietetic svcs.

Other:

Institutional Facility for Individuals with Intellectual with Disabilities
Formally ICF/MR

Other 1937 Benefit Provided:

Transportation (non-emergency)

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

Dependent upon services

Duration Limit:

none



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Scope Limit:

NET includes: charter air flight, commercial air, rotary wing, fixed wing, ground ambulance, bus (local and out-of-town), paratransit (private and public), private vehicle, and taxi.

Other:

Non-emergency Transportation (NET) services are provided to all Medicaid recipients through the contracted NET broker and must be authorized by the broker.

Other 1937 Benefit Provided:

Dental

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

see below

Duration Limit:

none

Scope Limit:

Individuals under the age of 21 Medicaid-eligible for EPSDT benefits receive comprehensive dental care such as periodic and routine dental services needed for restoration of teeth, prevention, and maintenance of dental health.

Other:

Individuals over age 21, Dental services for Medicaid-eligible adults who qualify for full benefits receive emergency extractions, palliative care, and may also be eligible to receive prosthetic care (dentures/partials) under certain guidelines and limitations.

Other 1937 Benefit Provided:

Nursing Facility

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

based upon level of care screens

Duration Limit:

n/a

Scope Limit:

Level of Care assessment to determine appropriateness of NF placement. Options include; NF standard, NF ventilator dependent, Pediatric specialty I/II, and Behaviorally Complex, PASRR I/II screens completed for behavioral health rule out procedures.

Other:

Provide health related care and services on a 24-hour basis to individuals, due to medical disorders, injuries, developmental disabilities, and/or related cognitive and behavioral impairments, exhibit the need for medical, nursing, rehab, psychosocial, management.

Other 1937 Benefit Provided:

Optometrist



Alternative Benefit Plan

Source:

Remove

Section 1937 Coverage Option Benchmark Benefit Package

Authorization:

Authorization required in excess of limitation

Provider Qualifications:

Medicaid State Plan

Amount Limit:

1 exam per 12 months

Duration Limit:

n/a

Scope Limit:

n/a

Other:

Ophthalmologist no limit for medical condition, no PA under physician visit. Ocular exam for medical exam by optometrist do not require PA, ICD9 required. (glaucoma, diabetes, follow up from cataract surgery, EPSDT referral)

Other 1937 Benefit Provided:

Peer Support Services: Rehab (1905)

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Authorization required in excess of limitation

Provider Qualifications:

Medicaid State Plan

Amount Limit:

none

Duration Limit:

none

Scope Limit:

Rehab interventions to restore recipient to highest level of functioning through peer supporters.

Other:

Mental health rehab service based upon an the assessed needs of the recipient based upon standardized assessments. The service has been standardized to a utilization system based upon a level of care placement system specific to children and adults.

Other 1937 Benefit Provided:

Basic Skills/Psychosocial Rehab: Rehab (1905)

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Authorization required in excess of limitation

Provider Qualifications:

Medicaid State Plan

Amount Limit:

none

Duration Limit:

none

Scope Limit:

BST services help recipients acquire (learn) constructive cognitive and behavioral skills through positive reinforcement modeling, operant condition and other techniques. PSR target psychological functioning within a variety of social settings.



Alternative Benefit Plan

Other:

Mental health rehab services based upon an the assessed needs of the recipient based upon standardized assessments. The service has been standardized to a utilization system based upon a level of care placement system specific to children and adults.

Other 1937 Benefit Provided:

Respiratory Therapy

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:

Medically necessary therapy services for an illness or injury resulting in functional limitations which can respond or improve as a result of the prescribed therapy treatment plan in a reasonable, predictable period of time.

Other:

n/a

Other 1937 Benefit Provided:

Tobacco-cessation for Pregnant Women

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

none

Duration Limit:

none

Scope Limit:

Services provided according to the USPSTF.

Other:

No prior authorization required.

Other 1937 Benefit Provided:

OLP - Community Paramedicine

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan



Alternative Benefit Plan

Amount Limit:

none

Duration Limit:

none

Scope Limit:

Community paramedicine services are delivered according to a recipient-specific plan of care under the supervision of a Nevada-licensed primary care provider's care plan.

Other:

No prior authorization required.

Add



Alternative Benefit Plan

<input type="checkbox"/> 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 <input type="checkbox"/>
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PRA Disclosure Statement

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 0938-1148. 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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