State: Nevada

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

The following ambulatory services are provided.

N/A

State: Nevada

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): N/A

1. Inpatient hospital services other than those provided in an institution for mental diseases.

___ Provided: ____ No limitations ___With limitations*

2.a. Outpatient hospital services.

___ Provided: ____ No limitations ___With limitations*

b. Rural health clinic services and other ambulatory services furnished by a rural health clinic.

___ Provided: ____ No limitations ___With limitations*

3. Other laboratory and X-ray services

___ Provided: ____ No limitations ___With limitations*

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

___ Provided: ____ No limitations ___With limitations*

b. Early and periodic screening and diagnosis of individuals under 21 years of age, and treatment of conditions found.

___ Provided: ____ Limited to Federal requirements ___ In excess of Federal requirements

c. Family planning services and supplies for individuals of childbearing age.

___ Provided: ____ No limitations ___With limitations*

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

___ Provided: ____ No limitations ___With limitations*

Description provided on attachment.

State: Nevada

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): N/A

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

   a. Podiatrists' Services

      ___ Provided: ____ No limitations ___With limitations*

   b. Optometrists' Services

      ___ Provided: ____ No limitations ___With limitations*

   c. Chiropractors' Services

      ___ Provided: ____ No limitations ___With limitations*

   d. Other Practitioners' Services

      ___ Provided: ____ No limitations ___With limitations*

7. Home Health Services

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

      ___ Provided: ____ No limitations ___With limitations*

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

      ___ Provided: ____ No limitations ___With limitations*

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

      ___ Provided: ____ No limitations ___With limitations*

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

      ___ Provided: ____ No limitations ___With limitations*

* Description provided on attachment.

State: Nevada

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): N/A

8. Private duty nursing services.

___ Provided: ____ No limitations ___With limitations*

9. Clinic services.

___ Provided: ____ No limitations ___With limitations*

10. Dental services.

___ Provided: ____ No limitations ___With limitations*

11. Physical therapy and related services.

a. Physical therapy

___ Provided: ____ No limitations ___With limitations*

b. Occupational therapy.

___ Provided: ____ No limitations ___With limitations*

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

___ Provided: ____ No limitations ___With limitations*

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

a. Prescribed drugs.

___ Provided: ____ No limitations ___With limitations*

b. Dentures.

___ Provided: ____ No limitations ___With limitations*

* Description provided on attachment

State: Nevada

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): N/A

c. Prosthetic devices.

___ Provided: ____ No limitations ___With limitations*

d. Eyeglasses.

___ Provided: ____ No limitations ___With limitations*

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

a. Diagnostic services.

___ Provided: ____ No limitations ___With limitations*

b. Screening services.

___ Provided: ____ No limitations ___With limitations*

c. Preventive services.

___ Provided: ____ No limitations ___With limitations*

d. Rehabilitative services.

___ Provided: ____ No limitations ___With limitations*

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

a. Inpatient hospital services.

___ Provided: ____ No limitations ___With limitations*

b. Skilled nursing facility services.

___ Provided: ____ No limitations ___With limitations*

* Description provided on attachment

State: Nevada

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): N/A

c. Intermediate care facility services.

___ Provided: ____ No limitations ___With limitations*

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

___ Provided: ____ No limitations ___With limitations*

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

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

___ Provided: ____ No limitations ___With limitations*

17. Nurse-midwife services.

___ Provided: ____ No limitations ___With limitations*

18. Hospice care (in accordance with Section 2302 of the Affordable Care Act).

___ Provided: ____ No limitations ___With limitations*

* Description provided on attachment.

State: Nevada

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): N/A

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

___ Provided: ___With limitations ___Not provided

20. Extended services for pregnant women.

a. Pregnancy-related and postpartum services for 60 days after the pregnancy ends.

\+ ++

___ Provided: ____ Additional coverage

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

\+ ++

___ Provided: ____ Additional coverage ___Not provided

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

___ Provided: ____ No limitations ___With limitations*

___Not provided

\+ Attached is a list of major categories of services (e.g., inpatient hospital, physician, etc) and limitations on them, if any, that are available as pregnancy-related services or services for any other medical condition that may complicate pregnancy.

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

*Description provided on attachment

State: Nevada

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

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

___ Provided: ____ No limitations ___With limitations*

___Not provided

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

a. Transportation

___ Provided: ____ No limitations ___With limitations*

b. Services provided in religious Non-Medical Health Care Institutions.

___ Provided: ____ No limitations ___With limitations*

c. Reserved

d. Skilled nursing facility services for patients under 21 years of age.

___ Provided: ____ No limitations ___With limitations*

e. Emergency hospital services.

___ Provided: ____ No limitations ___With limitations*

f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse.

___ Provided: ____ No limitations ___With limitations*

* Description provided on attachment