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State/Territory Name: Georgia

State Plan Amendment (SPA) #:17-0005

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Atlanta Regional Office
61 Forsyth Street, Suite 4T20
Atlanta, Georgia 30303

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

August 18, 2017

Ms. Lynette Rhodes
Medicaid Lead
Georgia Department of Community Health
Medicaid Division
2 Peachtree Street, NW, 36th floor
Atlanta, GA 30303-315

RE: Title XIX State Plan Amendment, GA 17-0005

Dear Ms. Rhodes:

We have reviewed the proposed State Plan Amendment, GA 17-0005, which was submitted to the Atlanta Regional Office originally on June 25, 2017. This state plan amendment adds coverage for Portable X-Rays and CT Scans.

Based on the information provided, the Medicaid State Plan Amendment GA 17-0005 was approved on August 18, 2017. The effective date of this amendment is July 1, 2017. We are enclosing the approved HCFA-179 and the plan pages.

If you have any additional questions or need further assistance, please contact Etta Hawkins at (404) 562-7429 or Etta.Hawkins@cms.hhs.gov.

Sincerely,

//s//

Shantrina Roberts, RN, MSN
Acting Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosures

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL	1. TRANSMITTAL NUMBER: 17-005	2. STATE GEORGIA
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE AND MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE July 1, 2017	

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN AMENDMENT TO BE CONSIDERED AS NEW PLAN X AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: 42 C.F.R. §447.205	7. FEDERAL BUDGET IMPACT: FFY 2017 $197,177.78 FFY 2018 $788,711.00
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 3.1-A, Page 2e through 2f.	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Attachment 3.1-A, Page 2e through 2f.

10. SUBJECT OF AMENDMENT:

Reimbursement for Portable X-Ray and CT Scan Services.

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Single State Agency Comments Attached

12. SIGNATURE OF STATE AGENCY OFFICIAL: /s/	16. RETURN TO: Department of Community Health Division of Medicaid 2 Peachtree Street, NW, 36th Floor Atlanta, Georgia 30303-3159
13. TYPED NAME: LINDA WIANT	
14. TITLE: CHIEF, DIVISION OF MEDICAID	
15. DATE SUBMITTED:	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:06/25/17	18. DATE APPROVED: 08/18/17
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: 07/01/17	20. SIGNATURE OF REGIONAL OFFICIAL: /s/
21. TYPED NAME: Shantrina Roberts	2Division of Medicaid & Children Health Opns2. TITLE: Acting Associate Regional Administrator

23. REMARKS: Approved with the following changes to block # 8 and 9 authorized by state agency on email dated 07/17/17.

Block # 8 changed to read: Attachment 3.1-A pages 2e, 2f, 3a1, 6a1 and 8a1.

Block # 9 changed to read: Attachment 3.1-A pages 2e, 2f, 3a1, 6a1 and 8a1.

5a. PHYSICIAN SERVICES (continued).

Non-Covered Services.

1. Cosmetic surgery.

2. Laboratory services furnished by the state or a public laboratory.

3. Experimental services drugs, or those procedures that are not generally recognized by the medical profession or the U. S. Public Health Service as acceptable treatment.

4. Non-essential foot care for recipients twenty-one years of age or older, including, but not limited to, elective.

5b. MEDICAL AND SURGICAL SERVICES furnished by a Dentist (in accordance with Section 1905(a) (5) (B) of the Act) are covered when:

1. A doctor of dental medicine or dental surgery who is authorized to furnish those services in the State in which he or she furnishes the services;

2. The services are within the scope of practice of medicine or osteopathy as defined by State law; and,

3. The services are furnished by or under the personal supervision of an individual licensed under State law to practice medicine or osteopathy.

6a. PODIATRY SERVICES.

Limitations.

1. The Medicaid program will not provide reimbursement to a podiatrist for nail debridement on patients who are not diabetic or do not have peripheral vascular disease.

2. The Medicaid program will not provide reimbursement to a podiatrist for more than one inpatient hospital visit per recipient per day of hospitalization.

3. The Medicaid program will not provide reimbursement to a podiatrist for services rendered in a nursing home unless referral is made by the patient's attending physician.

4. Reimbursement for injectable drugs is restricted to those listed in the Physician Administered Drug List.

Prior Approval. All surgery performed in a nursing home by a podiatrist must be approved by the Department prior to the surgery except the following:

1. Routine debridement of mycotic nails

2. Incision and drainage of abscess with documented cellulites.

Podiatry Services (Continued).

Prior Approval (Continued).

3. Surgical debridement of statis, performing, or decubitis ulcer.

4. Emergency relief of pain and infection except that all procedures involving soft tissue or bone surgery must be prior approved by the Department.

Prior approval is required for the surgical correction of flat feet.

Non-Covered Services.

1. Ancillary services unrelated to the diagnosis or treatment of the patient.

2. Services performed outside the scope of the practice of Podiatry as outlined in the applicable State law.

3. Experimental services or procedures or those which are not recognized by the profession or the U.S. Public Health Service as universally accepted treatment.

4. Charges for the following services:

   a. Flatfoot: The evaluation or non-surgical treatment of a flatfoot condition regardless of the underlying pathology.

   b. Subluxation: The evaluation of subluxation of the foot and non-surgical measures to correct the condition or to alleviate symptoms.

   c. Routine Foot Care: Routine foot care for ambulatory or bedridden patients; includes cutting or removal of corns, warts, or callouses; the trimming of nails and other hygienic and preventive maintenance care in the realm of self-care such as cleansing, soaking, and the use of skin creams.

   d. Supportive Devices - Orthopedic shoes rather than shoes that are an integral part of a brace and arch support. An orthopedic shoe that is built into a leg brace is reimbursable. Biomechanical orthotics are not reimbursable.

   e. Vitamin B-12 Injection- To strengthen tendons, ligaments, etc., of the foot.

5. Non-essential foot care for recipients twenty-one years of age or older including elective procedures such as, but not limited to, hammertoe repair, bunionectomies and related services, and treatment of ingrown nails.

6d. OTHER PRACTITIONER'S SERVICES.

8. NURSE PRACTITIONER SERVICES .

Limitations.

1. The scope of service for certified Ob/ Gyn Nurse Practitioners is the care of children and adults for Ob/ Gyn services.

The scope of service for Certified Registered Nurse Anesthetists (CRNA) is the management and care of children and adults for anesthesia services.

The scope of service for certified Adult Nurse Practitioners is the management and care of adults for primary and preventive health care.

The scope of service for Certified Gerontological Nurse Practitioners is the management and care for geriatric adults for primary and preventive health care.

Providers must be currently licensed as registered professional nurses, be currently certified as Ob/ Gyn Nurse Practitioners, Adult Nurse Practitioners, Gerontological Nurse Practitioners or Certified Registered Nurse Anesthetists, by the appropriate certifying body and be registered with the Georgia Board of Nursing for the specialty.

1. The Medicaid program will not provide reimbursement to a nurse practitioner for the following:

   a. Office visits which exceed 12 per recipient per calendar year unless medically justified.
   b. Nursing home visits that exceed 12 per recipient per calendar year unless medically justified.
   c. More than one hospital visit per patient per day of hospitalization, except when additional visits can be medically justified and approved.

2. Reimbursement for injectable drugs is restricted to those listed in the Physician's Administered Drug List.

Prior Approval.
More than twelve medically necessary offices or nursing home visits per year (January I through December 31) for any one recipient.

Non-Covered Services (continued).

1. Laboratory services furnished by the State or a Public Laboratory.

2. Experimental services, drugs or procedures which are not generally recognized by the advanced nursing profession, the medical profession or the U.S, Public Health Service as acceptable treatment.

3. Any procedure outside the legal scope of Ob/ Gyn CRNA, Adult, or Gerontological Nurse Practitioner services.

4. Services not covered under the Physicians' Program.

13. a) DIAGNOSTIC, b) SCREENING, c) PREVENTIVE SERVICES (continued).

Non-Covered Services (continued).

Family Planning Services.

Drugs used or dispensed in the clinic except those injectables authorized by the Department.

Health Check screening services.

Laboratory services.

Experimental Services.

Educational supplies, medical testimony, special response, travel by the nurse, no-show or canceled appointments, additional allowances for services provided after clinic hours or between 10:00 p.m. and 8:00 a.m. or on weekends or holidays.

Services or procedures performed without regard to the policies contained in the manual.

Services performed outside protocol or licensure of the specific practitioner.

The first two nutrition education contracts for WIC-eligible recipients.

Speech, language and hearing services for recipients 21 years of age and older.

The initial basic audiometer screening (Initial screening must be done under Health Check).

Investigation items and experimental services; drugs or procedures or those not Recognized by the Federal Drug Administration, the United States Public Health Service; Medicare and the Department's contracted peer review organization as universally accepted treatment, including but not limited to, position emission topography, dual photon, absorptiometry, etc.

Lead investigations done at sites other than a child's primary place of residence.

Services not covered in the physician program except where determined medically necessary for EPSDT eligible children.

23. CERTIFIED PEDIATRIC OR FAMILY NURSE PRATITIONERS' SERVICES.

NURSE PRACTITIONER SERVICES.

Limitations.

1. The scope of service for certified Pediatric Nurse Practitioners is the management and care of children up to 18 years of age for primary and preventive health care.

The scope of service for certified Family Nurse Practitioners is the management and care of children and adults for primary and preventive health care.

Providers must be currently licensed as registered professional nurses, be currently certified as Pediatric Nurse Practitioners or Family Nurse Practitioners by the appropriate certifying body and be registered with the Georgia Board of Nursing for the specialty.

2. The Medicaid program will not provide reimbursement to a nurse practitioner for the following:

   a. Office visits which exceed 12 per recipient per calendar year unless medically justified.

   b. Nursing home visits that exceed 12 per recipient per calendar year unless medically justified.

   c. More than one hospital visit per patient per day of hospitalization, except when additional visits can be medically justified and approved.

1. Reimbursement for injectable drugs is restricted to those listed in the Physician Administered Drug List.

Prior Approval.

More than twelve medically necessary office or nursing home visits per year (January I through December 31) for any one recipient.

Non-Covered Services.

1. Laboratory services furnished by the State or a Public Laboratory.

2. Experimental services, drugs or procedures which are not generally recognized by the Advanced Nursing Profession, the Medical Profession, or the U. S. Public Health Service as acceptable treatment.

3. Any procedure outside the legal scope of Pediatric and Family Health Nurse Practitioner services.

4. Services not covered under the Physicians' Program.