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State/Territory Name: Georgia

State Plan Amendment (SPA) #: 09-004

This file contains the following documents in the order listed:

1) RO Follow-Up Approval Letter
2) Pharmacy Approval Letter
3) CMS 179 Form
4) Approved SPA Pages

Department of Health & Human Services
Centers for Medicare & Medicaid Services
61 Forsyth St., Suite 4T20
Atlanta, Georgia 30303-8909

November 20, 2009

Dr. Jerry Dubberly, MBA Chief
Department of Community Health
Medical Assistance Plans
Two Peachtree Street NW
Atlanta, GA 30303-3159

Re: Georgia Title XIX State Plan Amendment, Transmittal #09-004

Dear Dr. Dubberly:

This is a follow up to the approval letter that you should have received from Mr. Larry Reed, Director, Division of Pharmacy, Centers tor Medicare & Medicaid Services dated November 16, 2009.

Enclosed is a copy of the approval letter the signed 11CFA-179 and the approved plan pages.
The effective date of this amendment is September 1. 2009.

Sincerely,

//s//
Mary Kaye Justis, RN, MBA
Acting Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosures

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-14-26
Baltimore, Maryland 21244-1850

Disabled & Elderly Health Programs Group
Center for Medicaid and State Operations

November 16, 2009

Mr. Jerry Dubberly
Chief
Medical Assistance Plans
Department of Community Health
2 Peachtree Street, N.W.
Atlanta, Georgia 30303-3159

Dear Mr. Dubberly:

We have reviewed Georgia's State Plan Amendment (SPA) 09-004 received in the Atlanta Regional Office on August 26, 2009. Under this amendment, the State of Georgia proposes a maximum allowance reimbursement methodology for the administration of physician injectible drugs. We are pleased to inform you that Georgia SPA 09-004 is approved, effective September 1, 2009.

Based upon the information provided, we believe this amendment is consistent with the objectives of the Medicaid program, is designed to increase the efficiency and economy of the Medicaid program and benefits Medicaid beneficiaries. The Atlanta Regional Office will forward to you a copy of the CMS-179 form, as well as the pages approved for incorporation into the Georgia Medicaid State Plan. If you have any questions regarding this amendment, please contact Bernadette Leeds at (410) 786-9463.

Sincerely,

/s/

Larry Reed
Director
Division of Pharmacy

cc: Mary K. Justis, Acting ARA-Atlanta Regional Office
Shantrina Roberts, Atlanta Regional Office
Darlene Noonan, Atlanta Regional Office
Mary Holly, Atlanta Regional Office

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 09-004

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: September 1, 2009

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

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

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

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.300

7. FEDERAL BUDGET IMPACT:

FFY	2010	$(986,064)
FFY	2011	$(11,927,139)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B, pp. 4-4.001

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-B, pp. 4-4(continued)

10. SUBJECT OF AMENDMENT:
PHYSICIAN INJECTIBLE DRUGS REIMBURSEMENT METHODOLOGY

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:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
//s//

13. TYPED NAME: Jerry Dubberly

14. TITLE: Chief, Division of Medicaid

15. DATE SUBMITTED: 08-26-09

16. RETURN TO:
Department of Community Health
Division of Medicaid
2 Peachtree Street, NW, 36th Floor
Atlanta, Georgia 30303-3159

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 08-26-09

18. DATE APPROVED: 11-12-09

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 09-01-09

20. SIGNATURE OF REGIONAL OFFICIAL:
//s//

21. TYPED NAME:
Mary Kaye Justis

22. TITLE: Acting Associate Regional Administrator
Division of Medicaid & Children Health Opns

23. REMARKS: Approved with the following changes as authorized by state agency email s dated 11-02-09.

Block#7a changed to read: FFY 2009, **Block 7b changed to read:** FFY 2010.

Block #8 changed to read: Attachment 4.19-B pages 4-4.001 and Attachment 3.1-A pages 2b, 2c and 3a.

Block #9 changed to read: Attachment 4.19-B pages 4-4.001 and Attachment 3.1-A pages 2b, 2c and 3a

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYPES OF CARE OR SERVICES

J. PHYSICIAN SERVICES (Includes Physicians, Podiatrists, Optometrists and Psychologists)

Professional Services:

Payments for certain professional services rendered in a hospital, outpatient, or Ambulatory Surgical Center setting which are normally performed in a physician's private office or clinic, are made on a statewide basis and are limited to the lower of:

(a) The actual charge for the service; or

(b) The statewide rate in effect with the appropriate site of service differential on the date of service.

Services that are primarily performed in office settings will be subject to a reimbursement reduction when performed in an inpatient, outpatient, emergency, or ambulatory surgical setting. The reduced reimbursement is calculated at 90% of the Resource Based Relative Value Scale (RBRVS) facility-setting rate as specified by the current Medicare Fee Schedule.

Injectable Drugs:

Effective for dates of services on or after September 1, 2009, the maximum allowable reimbursement for physician's injectable drugs administered by a provider or appropriate designee, in an office or outpatient setting, to the lower of:

a) Usual and customary charge, or
b) Average Sales Price (ASP) plus 6% as defined January 1st of each year or upon the drug's initial availability in the marketplace which ever is later; or
c) Average Wholesale Price (AWP) minus 11%, for drugs that do not have a published ASP price until such time ASP pricing becomes available and ASP plus 6% pricing can be utilized.

All agency rates for injectable drugs are published on the Physician's Injectable Drug List (PIDL), which is published on the agency's website. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYPES OF CARE OR SERVICES

J. PHYSICIAN SERVICES cont'd (Includes Physicians, Podiatrists, Optometrists and Psychologists)

Providers subject to this change include but may not be limited to: Physicians, Physician assistants, Nurse Midwives, Advanced Nurse Practitioners, Podiatrists, Oral Maxillofacial Surgeons, and related providers eligible to administer injectable drugs.

Anesthesia Services:

Payments to physicians for anesthesia services performed by the physician or the mid level providers supervised by the physician are paid based on the calculated anesthesia formula in effect on the date of service.

The sum of Base Units plus Time Units plus Special Condition Units, if applicable, is multiplied times the conversion factor for anesthesia services.

The conversion factor service dates beginning on or after January 1, 1992, is 16.00 for all geographic areas when filing modifier* AA or 78.

For modifiers* QK and QY, the conversion factor is 5.58 and modifiers* QX and QZ conversion factors are 10.42 and 15.84, respectively.

If a CPT procedure is non-covered, anesthesia for that service is also non-covered.

*Descriptions:

AA Anesthesia services personally rendered by an Anesthesiologist

QK Medical direction of 2, 3, or 4 concurrent anesthesia procedures involving qualified individual(s) [CRNA's] or [PAAA's] by an anesthesiologist.

QX Medically Directed—salaried employee of Anesthesiology

QY Medical direction of on anesthesia procedure involving a qualified individual [CRNA's] or [PAAA's] by anesthesiologist

QZ Non medically Directed—self employed

78 Return to the operating room

5a PHYSICIAN SERVICES

All medically necessary, non-experimental physicians' services are covered when provided for EPSDT recipients under age 21.

Limitations

1. For recipients 21 years of age and over, Medicaid will not provide reimbursement to any physician for office visits that exceed 12 per recipient per calendar year unless medically justified through prior authorization.

2. The Medicaid Program will not provide reimbursement to any physician for visits to a nursing home which exceed 12 per recipient per calendar year, unless medically justified through prior authorization.

3. The Medicaid Program will not provide reimbursement to a physician for any pre-operative hospital visits to a recipient hospitalized for elective surgery, unless sufficient medical documentation is provided to substantiate such visits. Only one pre-operative hospital visit to a recipient hospitalized for non-elective surgery is reimbursable unless sufficient medical documentation is provided to substantiate additional pre-operative visits.

4. The Medicaid Program will not provide reimbursement to a physician for more than one hospital visit per patient per day of hospitalization.

5. The Medicaid Program will not provide reimbursement to non-enrolled, out-of-state physicians for "term" obstetrical deliveries on recipients who travel to other states to bear their children for reasons other than medical.

6. Reimbursement for injectable drugs is restricted to those listed in the Physicians Injectable Drug List.

7. Routine refractive services and optical/prosthetic devices are reimbursable according to policies governing the Vision Care Services Program.

8. The Department has no provision for direct enrollment of or payment to auxiliary personnel employed by the physician, such as nurses, non-physician anesthetists, unlicensed surgical assistants or other aides. Physician's Assistant services, provided under the supervision of a physician, are reimbursable only under criteria set forth in subsection 601.9 of the Policies & Procedures for Physician Services manual. Certified Pediatric, OB/GYN, Family Nurse Practitioners, and CRNAs are eligible for enrollment. Licensed physical, occupational, and speech pathology therapists are eligible for enrollment to provide services to recipients less than twenty-one years of age.

When the physician employs auxiliary personnel to assist in rendering services to patients and bills the charges as pat of the physician's charge for the service, the Department may reimburse the physician for such services if the following criteria are met:

a) the services are rendered in a manner consistent with the requirement of Section 901.1 of the Policies & Procedures for Physician Services manual;

PHYSICIAN SERVICES (continued)

b) the services furnished are "incident to" services performed under the direct supervision of the physician as an adjunct to the physician's personal service;

c) the services are of kinds that are "commonly furnished" in the particular medical setting; and

d) the services are not traditionally reserved to physicians.

9. Kidney transplants are covered for recipients with documented end stage renal disease. Prior approval is not required unless the procedure is performed out-of-state.

Prior Approval

The Department requires that the following services be approved prior to the delivery of such services, except in documented emergency, life threatening situations:

1. Tonsillectomies and/or adenoidectomies;

2. Removal of keloids;

3. Any surgery to correct morbid obesity and adjunctive surgery, i.e., lipectomies;

4. Plastic surgeries that are associated with functional disorders; (cosmetic surgeries for aesthetic purposes are not covered.)

5. Hyperbaric oxygen pressurization;

6. Ligation and stripping of varicose veins of the lower limb(s);

7. Mammoplasties that are associated with functional disorders or post cancer surgery. Mammoplasties for aesthetic purposes are not covered;

8. More than six prescriptions per month for life-sustaining drugs for any one recipient;

9. More than twelve medically necessary office or nursing home visits per year (July 1 through June 30) for any one recipient.

10. Prior approval for liver transplantation may be requested for eligible recipients with the following disorders. Records for all candidates for coverage will be reviewed for determination of disorders, prognosis and factors of contraindication. In applying standards to provide liver transplants, similarly situated individuals will be treated alike.

6. d. **OTHER PRACTITIONER'S SERVICES**

A. PSYCHOLOGICAL SERVICES

Limitations:

1. Medically necessary psychological services are provided only to EPSDT eligible individuals.

2. Psychological services are limited to 24 hours (48 units) per calendar year per recipient. Exceptions to the limitation can be exceeded based on medical necessity—in accordance with the State's guidelines.

Coverage of psychological services is limited to those providers fully and permanently licensed by the State Board of Examiners of Psychologists as required by Title 43, Chapter 39, of the Official Code of Georgia Annotated and Chapter 510 of the Rules and Regulations of the State of Georgia.