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

March 16, 2010

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 #09-010

Dear Dr. Dubberly:

We have reviewed the proposed amendment to the Georgia State Plan that was submitted under transmittal number 09-010. This amendment establishes the reimbursement rate paid to providers for administering the H1N1 influenza vaccine, and other vaccines provided at no cost to the provider, for adults over twenty –one (21) years of age.

Based on the information provided, we are pleased to inform you that Medicaid State Plan Amendment 09-010 was approved on March 15, 2010. The effective date for this amendment is October 9, 2009. We are enclosing the approved CMS Form 179 and approved Plan Pages.

If you have any questions or need any further assistance, please contact Trina Roberts at (404) 562-7418 or Kia Carter-Anderson at (404) 562-7431.

Sincerely,

/s/

Jackie Glaze
Acting Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosure

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: 09-010

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
October 6, 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:
a. FFY 2010 $3,853,819

"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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: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 (cont'd)

10. SUBJECT OF AMENDMENT:
PHYSICIAN REIMBURSEMENT/ VACCINE ADMINISTRATION FOR ADULTS

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. [redacted]FFICIAL:

13. TYPED NAME: JERRY DUBBERLY

14. TITLE: CHIEF, Medicaid Division

15. DATE SUBMITTED:

16. RETURN TO:

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

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
11/16/09

18. DATE APPROVED:
03/15/10

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
10/09/09

20. [redacted] OFFICIAL:

21. TYPED NAME:
Jackie Glaze

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

23. REMARKS:

Approved with the following changes as authorized by State Agency on email dated 03-16-10:

Block # 8: Attachment 4.19-B, pages 4-4.001 **changed to read**; Attachment 4.19-B, pages 4-4.001 and Attachment 3.1-A pages 2b-2c, 2e, 3a-1 and 8a-1 **Block # 9**: Attachment 4.19-B, pages 4-4.001 (cont'd) **changed to read**; Attachment 4.19-B, pages 4-4.001 (cont'd) and Attachment 3.1-A pages 2b-2c, 2e, 3a-1 and 8a- 1 (new).

FORM HCFA-179 (07-92)

GA SPA 09-010 – H1N1
Request for Additional Information Addendum
February 924, 2010

Program Issues:

1.Attachment 3.1-A, Page 2, 5(b)

Medical and surgical services furnished by a dentist are a mandatory physician benefit found at CFR 440.50(b). The DCH should add 5(b) back on the pre-print page and indicate the service is provided. If there are limitations to 5(b), the State must add the limitations to the 3.1A pages under item 5(b).

DCH: Reference to Section 5b, which provides for Medical and surgical services furnished by a dentist (in accordance with Section 1905(a) (5) (B) of the Act), was re-added to the pre-printed page with limitations outlined on Attachment 3.1-A, page 2e, Section 5b (attached).

2.Attachment 3.1-A, Page 2e

The State submitted Attachment 3.1_A, page 2e, with the new transmittal of GA SPA 09-010. This page was revised and approved in GA 09-004 on November 12, 2009 with a September 1, 2009 effective date. The State submitted an old SPA page which Mr. Jerry Dubberly Page 2 of 3 contained old language that was removed in the approval of GA 09-004.

Please resubmit the current 3.1-A, 2e page with revised language for GA SPA 09-0] O010.

DCH: The oversight was corrected and the previously approved page for 3.1-A, page 2e, under GA SPA 0309 004 was added andis included in this GA SPA 09-010 transmittal (attached).

The State needs to add a 3.lA/B page for 5(b) services. If there are limitations, please submit on a page as item 5(b).

DCH: Reference to Section 5b, which provides for Medical and surgical services furnished by a dentist (in accordance with Section 1905(a) (5) (B) of the Act), was re-added to the pre-printed page with limitations outlined on Attachment 3.1-A, page 2e, Section 5b (attached).

3.Attachment 3.l-A.l, Page 8a-l

Item 23 contains language which is not acceptable. Please remove language in paragraphs 2 3, and 4 that refers to Practitioner's other than Family and Pediatric Nurse Practitioner's.

On the same page, in paragraph 5, please remove the words "OB/GYN Nurse Practitioners, Adult Nurse Practitioners, Gerontological Nurse Practitioners, and Certified Registered Nurse Anesthetists" from that sentence.

Under "Non-Covered Services" #4, please remove the reference of "Adult, Gerontological, OB/GYN or CRNA" from item #4.

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~~DCH: The scope of service and limitation for Attachment 3.1-A, Page 8a-1, Section 23—CERTIFIED PEDIATRIC OR FAMILY PRACTITIOINERS' SERVICES, was newly added to correspond to the established pre-print page.~~

~~Paragraphs 2, 3, 4, and 5; and #4 (Non-Covered Services), in Section 23, were revised with all references to "Other Nurse Practitioners" (OB/GYN, Adult, Gerontology, and Certified Nurse Anesthetists) removed. Refer to Section 6b for scope of services and limitation for "Other Nurse Practitioner Services".~~

~~The State needs to remove all references of Family and Pediatric Nurse Practitioner's under item 6d since that is not the correct benefit category.~~

~~DCH: Attachment 3.1-A, Page 8a-1, Section 6d—OTHER NURSE PRACTITIONER SERVICES, was revised with all references to "Certified Pediatric Nurse Practitioner and Family Nurse Practitioners' Services" removed. Refer to Section 23 for scope of service and limitation for "Certified Pediatric Nurse Practitioner and Family Nurse Practitioners' Services"~~

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;

5a 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.

5a PHYSICIAN SERVICES (continued)

Non-Covered Services

1. Cosmetic surgery
2. Services provided by a portable x-ray service.
3. Laboratory services furnished by the state or a public laboratory
4. 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.
5. 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~~A d~~ 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. 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 any podiatrist for office visits that exceed 12 per recipient per calendar year except in the case of EPSDT recipients for whom additional medical necessity services must be documented and provided to the Department.
2. 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.
3. The Medicaid program will not provide reimbursement to a podiatrist for more than one inpatient hospital visit per recipient per day of hospitalization.
4. 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.
5. Reimbursement for injectable drugs is restricted to those listed in the Physicians' Injectable Drug List.

Prior Approval

Ail 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.

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

Prior Approval

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

Non-Covered Services

1. Services provided by a portable x-ray service.
2. Laboratory services furnished by the State or a public laboratory.
3. 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.
4. Any procedure outside the legal scope of Pediatric and Family Health Nurse practitioner services
5. Services not covered under the physicians' program.

6d OTIIER PRACTITIONER'S SERVICES

B. 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.

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5a PHYSICIAN SERVICES (continued)

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4. Any procedure outside the legal scope of OB/GYN, CRNA, Adult, or Gerontological Nurse practitioner services
5. Services not covered under the physicians' program.

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 provider'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 lesser 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 fiscal agent's website[1]. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.

[1]The fiscal agent's website is assessable via Georgia Medicaid's website at www.dch.georgia.gov; *click on the "Georgia Medicaid" link, then click on the fiscal agent, Georgia Health Partnership's link (Hewlett Packard (HP) after July 1, 2010).*

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.

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

Vaccine Administration:

Effective for dates of services on and after October 9, 2009, the maximum allowable reimbursement to providers administering the H1N1 influenza vaccine to adults over 19 years of age, where the vaccine is supplied at no cost to the provider, shall be paid at the lesser of (a) the usual and customary charge or b) the statewide maximum allowable reimbursement amount allowed for the procedure code reflecting the service rendered.

The agency's rates were set as of October 9, 2009, and are effective for services on or after that date. All rates are published on the agency's fiscal agent's website. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.

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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