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

A. Ambulance Services

Payment for covered services shall not exceed the lower of:

(a) The provider's submitted charge; or

(b) The statewide maximum allowable rate in effect on the date of service.

The maximum allowable amount is derived from Medicare's maximum allowable reimbursement rates for non-hospital based ambulance services. The maximum rates are 90% of the CY2002 Medicare fee schedule for Locality 01 for Medicaid-covered procedure codes in the Emergency Ambulance Services (EAS) program. Fee schedule rates for public and private providers of ambulance services are the same and the state does not subdivide or sub classify its payment rates based on whether the provider is a public or private entity/provider. Annual or periodic adjustments will be made and such adjustments will be reflected in the fee schedule that is made available to the providers and public.

B. Emergency Air Ambulance

Emergency air ambulance covered services consist of fixed wing air ambulance and rotary wing air ambulance. The reimbursement rate for fixed wing is determined by obtaining three estimates from Air Ambulance providers who provide fixed wing transports. These estimates include the base rate plus loaded mileage which will equal the cost to provide the transport. The three estimates are compared to the transportation provider's submitted charge. Payment for covered services will be the lower of the three estimates or the provider's submitted charge.

The reimbursement rate for rotary wing is determined by obtaining three estimates from Air Ambulance providers who provide rotary wing transport. These estimates include the base rate plus loaded mileage plus $750 which equals the cost to provide the transport. (The $750 payment is included as the cost for all medical personnel when a critical care flight is approved). The three estimates are compared to the transportation provider's submitted charge. Payment for covered services will be the lower of the three estimates or the provider's submitted charge.

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

B. Clinic Services

1. Family Planning Services

Pre-established rates are based on actual costs information submitted from the Division of Physical Health, Department of Human Resources, to the Department of Community Health. Reimbursement is provided at a flat rate for initial, annual, and follow-up visits. There is no retroactive settlement. Reimbursement rates are based on the lesser of actual reasonable costs of the limitations set forth in 42 CFR 447.325.

C. Community Mental Health Services

Effective July 1, 1999, the Department adopted statewide, fee-for-service, reimbursement rates for each procedure code in the Community Mental Health Program. Rates are calculated from statewide median base year cost documented in provider cost reports. The Department may in subsequent years and subject to legislative appropriation, re-calculate the base year using updated cost report data, or adjust the base year using a HCFA accepted inflation factor.

Rates for new procedure codes will be established based on estimated cost and expected utilization data. New procedure rates are also compared to other public sector fee-for-service rates and utilization from other southeastern states. Reimbursement rates will be lower than the limitations set forth in 42 CFR 447.325.

Community Mental Health Procedures Effective July 1, 2001	Unit	Initial Authorization Units
Diagnostic Assessment	15 minutes	16
Intensive Day Treatment	1 hour	50
Ambulatory Detoxification	15 minutes	60
Nursing Assessments and Care	15 minutes	16
Physician Assessment and Care	15 minutes	12
Physical Therapy	15 minutes	12
Speech and Hearing Therapy	15 minutes	12
Occupational Therapy	15 minutes	12
Activity Therapy	15 minutes	360
Medication Administration	15 minutes	12/30 (for children)
Clinic-Based Crisis Management	15 minutes	16
Out of Clinic Crisis Management	15 minutes	16
Family Outpatient Services	15 minutes	24
Group Outpatient Services	15 minutes	32
Individual Outpatient Services	15 minutes	24
Day Treatment for Children and Adolescents with SED	1 Hour	450
Intensive Family Intervention	1 Hour	
Substance Abuse Adolescent Day Treatment	1 hour	450
Peer Supports	1 Hour	Unlimited
Day Supports	1 Hour	600
Assertive Community Treatment	1 Hour	90
Psychosocial Rehabilitation	1 Hour	450
Substance Abuse Intensive Outpatient Services	1 Hour	450
Community Support-Individual	15 minutes	200
Community Support-Team	1 hour	450
Crisis Residential Services	4 hours	18
Residential Rehabilitate Supports	1 Day	90

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

B. Clinic Services (continued)

3. Federally Qualified Health Centers (FQHC) (COMMUNITY HEALTH CENTERS SERVICES (CHCS)

In accordance with Section 702 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000, effective January 1,2001, reimbursement is provided for "core" services and other ambulatory services (excluding in- house pharmacy services) at a prospective payment rate (PPS) per encounter. The rates will be calculated on a per visit basis and will reflect 100 percent of the average FQHC's reasonable cost of providing Medicaid-covered services including other ambulatory services cost during FY 1999 and FY 2000. Those costs will be adjusted to take into account any increase (or decrease) in the scope of services furnished by the FQHC during FY 2001 for services that only occurred in calendar year 2000. Cost reports for the FQHC's FY 1999 and FY 2000 periods will be used to establish the baseline rate for each FQHC effective January 1, 2001. The baseline rate will be calculated by dividing the sum of the total reasonable cost of providing Medicaid covered services during FY 1999 and FY 2000 by the total Medicaid visits during the two fiscal years. Until the baseline rates are established, FQHCs will be paid their interim rate effective December 31, 2000. When the baseline rates and are established, they will be paid retroactive to January 1, 2001.

The baseline rates effective January 1, 2001 will be adjusted by the Medicare Economic Index (MEI) effective for dates of service on and after October 1,2001 based on the MEI and for changes in the FQHC's scope of services during January 1, 2001 through September 30, 2001. For Federal Fiscal Year (FFY) 2002 and FFYS thereafter, per visit rate will be calculated by adjusting the previous year's rate by the MEI for primary care, and for changes in the FQHC's scope of services during the prior FFY.

For newly qualified FQHCs that participate in FY 2000 only, the Department will use the FY 2000 cost for calculating the baseline PPS rate effective January 1,2001. Centers that qualify after fiscal year 2000 will have their initial rates established by a statewide average of similar centers. After the initial year, payment will be set using the MEI and change of scope methods used for other clinics.

For purposes of this plan, a change in scope of services is defined as a change in the type, intensity, duration and/or amount of services. It is the center's responsibility to recognize any changes in their scope of services and to notify the Department of these changes and to provide the Department with documentation and projections of the cost and volume impact of the change.

If an FQHC provides core services pursuant to a contract between the center and a managed care entity (as defined in section 1932(a)(1)(B)), the State shall provide payment of a supplemental payment equal to the amount (if any) by which the PPS rate calculated above exceeds the amount of the payments provided under the contract. These supplemental payments shall be made pursuant to a payment schedule of four months or less agreed to by the State and the Federally Qualified Health Center.

Effective for dates of service July 1, 1994, and after, a $2.00 recipient co-payment is required on all Federally Qualified Health Center Services (FQHC) Community Health Center Services (CHC). Pregnant women, recipients under twenty-one years of age, nursing home residents, and hospice care participants are not subject to the co-payment. Emergency services and family planning services are also exempt from a co-payment.

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

B. Clinical Services (continued)

4. Dialysis Services

a. Physician Services

The Department will pay physicians the lower of the submitted charge or the statewide monthly capitation payment (MCP) as determined by Medicare. Reimbursement for the monthly capitation (MCP) is not to exceed the Medicare reimbursement for those services. Physicians will receive the MCP each month for each enrolled patient (member) under their care. Physicians enrolled in this program will receive a monthly capitation payment (MCP) for professional services. Professional services include the monthly supervision of medical care, dietetic services, social services and procedures directly related to ESRD.

b. Facility Services

Facilities enrolled in this program will receive a monthly composite rate (MCR) for technical services including routine laboratory work, and cost of supplies and equipment as described in the policy manual. Facilities will be reimbursed the lower of the submitted charge or the statewide monthly composite rate as determined by Medicare. Reimbursement for the monthly composite rate (MCR) is not to exceed the Medicare reimbursement for those services. Facilities will receive the MCR each month for each enrolled patient (member) under their care.

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

c. Dental Services

Payments are ,made for specific authorized procedures on a statewide basis and are limited to the lower of:

(1)` The dentist's actual charge for the service; or

(2) The statewide reimbursement rate in effect on the date of services.

Reimbursement will be made on a per procedure basis.

Reimbursement to providers of dental services is made on an established fee schedule not to exceed prevailing charges in the state.

Reimbursement will be provided on a per procedure basis. The current reimbursement rates will be based on a percentage of usual and customary reimbursement, not to exceed 100 percent. The usual and customary reimbursement will be determined using regional data on a periodic basis.

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

d. Prescribed Drugs

1. Medicaid pays for prescribed legend and non-legend drugs authorized under the program. Reimbursement for covered multiple source drugs shall not exceed the lowest of:

   (a) The federal mandated upper limit for certain multiple source drugs as established and published by CMS plus a reasonable dispensing fee as established in item 2; or
   (b) The Georgia Maximum Allowable Cost (GMAC) as established by the Department for additional multiple source drugs plus a reasonable dispensing fee as established in item 2 below; or
   (c) The Georgia Estimated Acquisition Cost (GEAC) for multiple source drugs plus a reasonable dispensing fee as established in item 2 below; or
   (d) The usual and customary charge as defined below by the Department for the prescription.

   Reimbursement for covered drugs other than multiple source drugs shall not exceed the lower of:

   (a) The GEAC for all other drugs plus a reasonable dispensing fee as established in item 2 below.

   (b) The usual and customary charge as defined by the Department for the prescription.

   GEAC is defined as the average wholesale price (AWP) of the drug less an 11% discount for all drugs.

   The Department defines usual and customary as the lower of the lowest price reimbursed to the pharmacy by other third party payers (including HMOs); or the lowest price routinely offered to any segment of the general public. Donations or discounts provided to charitable organizations, or fees charged to or paid by federal or state funded programs are not considered usual and customary charges.

2. The dispensing fee for profit and non-profit community pharmacies is based on periodic surveys of pharmacy operating costs including professional salaries and fees, overhead costs and reasonable profit. Between these periodic surveys, the Department, in consultation with the Pharmacy Advisory Committee and the Governor's Office of Planning and Budget, reviews the fee. When appropriate, the fee is adjusted based on an inflation factor. The Medicaid dispensing fee shall be $4.63 for profit pharmacies and $4.33 for non-profit pharmacies. The dispensing fee paid by the Department shall be subject to the usual and customary charge as defined by the Department above.

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

d. Prescribed Drugs (continued)

A. Exception: Effective July 1, 1996, the Department will encourage the use of multiple source drugs. The innovator brand or a multiple source drug may be dispensed for a medically accepted indication.

3. No dispensing fee is allowed to the physician dispensing drugs.

4. Payment for special approved drugs as requested by the prescribing physician is determined as in 1. above.

5. Prescriptions supporting Medicaid claims must be initiated and recorded in accordance with State and Federal laws. The maximum quantity payable for a prescription or its refill will be one (1)-month supply.

6. Effective with the date of service on or after June 1, 2001, the Department will impose a co-payment for each non-preferred or non-generic prescription drug dispensed to a Medicaid recipient based on the typical payment by the Department for the prescription as follows:

Cost to State	Co-Payment
$10.00 or less	$0.50 co-payment
$10.01 to $25.00	$1.00 co-payment
$25.01 to $50.00	$2.00 co-payment
$50.01 or more	$3.00 co-payment

Recipients under age twenty-one (21), pregnant women, institutionalized individuals, and hospice care recipients are not required to pay this co-payment. Emergency services and family planning services are also exempt from this co-payment. The Department will impose a nominal co-payment of $.50 for each generic or preferred prescribed drug dispensed by the pharmacy.

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

E. Durable Medical Equipment Services

The maximum reimbursement for providers of medical equipment is limited to the lower of:

(a) the actual charges for the item; or

(b) the statewide rate in effect on the dates of service.

Reimbursement for delivery mileage is limited to 100 miles, one way.

Effective for dates of service July 1, 1994 and after, a $3.00 recipient co-payment is required on all Durable Medical Equipment and a $1.00 co-payment for all Durable Medical Equipment Supplies and Rentals.

Pregnant women, recipients under twenty-one years of age, nursing home residents, and hospice care recipients are not required to pay the co-payment. Emergency services and family planning services are also exempt from a co-payment.

TRANSMITTAL 94-020
APPROVED 2-3-95
EFFECTIVE 7-1-94
SUPERSEDES 92-029

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYES OF CARE OR SERVICE

F. HEALTH CHECK (EPSDT) SERVICES

Reimbursement to Health Check (EPSDT) screening providers is based on the lower of submitted charges or the state's maximum allowable rate. Immunizations are reimbursed separately at established rates. Medically necessary noninstitutional and institutional services which are not otherwise covered under the State Plan require prior approval and will be reimbursed under the respective program using that program's established reimbursement methodology as described on Supplement 1 to Attachment 4.19-B, Page 1.

For complete screen visits, the following are the state's maximum allowable rates:

Patient age	Provider type	Maximum rate
0 to 8	All providers	$67.38
8 or older	Public Health providers	$55.38
8 or older	All other providers	$75.38

For interperiodic hearing only and vision only procedure codes, the state's maximum allowable rate is $5.62.

For immunizations, tuberculin skin tests and blood lead level screenings, the following are the state's maximum allowable rates:

Procedure	Maximum rate
Hep A (For Members who reside in Fulton County Only; All other members covered under other Medicaid Programs)	$8.00
HIB	$8.00
Influenza (preservative free)	$8.00
Influenza ages 6 – 35 months (split virus)	$8.00
Influenza ≥ ages three (3) years (split virus)	$8.00
(Prevnar) Pneumococcal Conjugate	$8.00
DTAP	$10.00
DT	$18.55
MMR	$10.00
IPV	$8.00
Decavac® (preservative free TD)	$10.00

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYES OF CARE OR SERVICE

Varicella	$8.00
TD	$10.00
(DTAP, Hep B, and IPV)	$10.00
(Pneumovax 23) Pneumococcal Polysaccharide	$8.00
Menactra ® (Meningococcal Conjugate for members 11 yrs – 18 yrs, 11 mths)	$8.00
Hepatitis B	$8.00
Combination HEP B and HIB	$10.00
TB Skin Test	$3.00 (public) $8.13 (private)
Blood Lead Test	$0.00

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

G. HOME HEALTH SERVICES

The Department will reimburse each Home Health Agency a specific rate per visit for covered services. The specific rate per visit is the total of the agency's inflated base rate, any efficiency incentive applicable to the agency, and a supply rate. Base rates, efficiency incentives, and supply rates are subject to ceilings. Rates, incentives, and ceilings are determined as follows:

(a) Each agency's base rate is calculated using data contained in the as-filed or audited Medicaid cost report for that agency's base period. An inflation percentage is applied to base period date and the resulting inflated base period cost per visit is the agency's base rate. The inflation percentage and base period are set by the Department.

(b) Each agency is classified into one of the following categories; hospital-based, freestanding urban, and freestanding rural. For each category the 75th percentile of inflated base period cost per visit is determined. This amount is the base rate ceiling for agencies in the category.

(c) An efficiency incentive may be added to the base rate for an agency as follows:

If an agency's base rate is less than or equal to the base rate ceiling in the agency's category, the difference between the base rate and the ceiling is multiplied by 20%, and the product (not to exceed $1.76) is added to the base rate. The total of base rate plus incentive shall not exceed the base rate ceiling for the agency's category.

(d) The supply cost per visit for each agency is based on data contained in the as-filed or audited Medicaid cost report for the agency's base period. An inflation percentage is applied to base-period data to determine each agency's inflated supply cost per visit. The inflation percentage and base period for supply costs are set by the Department. Inflated base period supply costs per visit for each agency are arrayed on a statewide basis and the 75th percentile cost from that array is the supply rate. The supply rate is added to each agency's base rate plus any applicable efficiency incentive.

(e) The reimbursement rate for each freestanding agency shall not exceed the base rate ceiling for that agency's category plus the supply rate. The reimbursement rate for each hospital-based agency will be calculated as noted in paragraphs (a) through (d), and shall not exceed the maximum rate noted in paragraph (f) below.

TRANSMITTAL 94-22
APPROVED 2/7/95
EFFECTIVE 7/1/94
SUPERSEDES 91-46

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

(f) For purposes of setting the maximum rate per visit for hospital-based agencies, the Department has established two subcategories: Urban hospital-based and rural hospital-based. The maximum rate per visit for each agency in these subcategories is determined by adding a hospital-based adjustment amount to the freestanding urban and freestanding rural based rate ceilings. The adjustment is calculated as follows:

The mean of the agencies' inflated base period cost per visit will be calculated for each of the subcategories. A percentage of the mean for each subcategory will be calculated and added to the base rate ceiling for the corresponding freestanding urban or rural category, plus the supply rate to establish the maximum rate for hospital-based agencies in that subcategory.

Each hospital-based agency will be reimbursed the lesser of its rate calculated as noted in paragraphs (a) through (d), or the maximum rate per visit for its subcategory.

Assignment to a subcategory is determined according to the criteria outlined in the section labeled classification of agencies.

(g) Reimbursement rates will be adjusted for home health agencies which provide certain home-delivered services to community-care recipients. The rate adjustment will be calculated using the home health reimbursement methodology in paragraphs (a) through (f) above, and the calculation will include both home health and home delivered services utilization data for the base period.

Reimbursement rates will be adjusted only for those agencies currently enrolled and providing services in the community care home-delivered services program and for which at least nine months of cost and utilization data exists for the base period. Home health agencies which discontinue

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

the provision of home-delivered services will be subject to a reduction in their reimbursement rate.

(h) Effective for dates of service July 1, 1994 and after, a $3.00 recipient co-payment is required on all home health visits. Pregnant women, recipients under twenty-one years of age, nursing home residents, and hospice care recipients are not required to pay the co-payment. Emergency services and family planning services are also exempt from a co-payment.

Cost Reports

Each agency must submit a copy of its as-filed Medicare cost report and a completed Medicaid Cost Data Form (supplied by the Department) to the Department. These documents must be received by the Department within one hundred fifty (150) days after each agency's fiscal year end. If the Medicare and Medicaid reports have not been received after this one hundred fifty (150) day period, a rate reduction of 10% on the current rate will be imposed. This rate reduction will remain in effect through the final day of the month in which the cost information is received. If the information is received after any fraction of a month beyond the one hundred fifty (150) day period, the rate reduction of 10% will be applied for the entire month. If an agency's cost information is not received by the time the Department establishes individual provider rates and determines the percentiles and rate ceilings, that agency will be assigned the lesser of its current rate or the lowest rate in the State for the appropriate category, less applicable incentive, as established by the rate-setting process. If the agency's cost information is received after rates are established, the Department will calculate a rate based on the

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

information received and retroactively and prospectively adjust the agency's previously assigned rate only if it is greater than the calculated rate. The agency's rate will remain in effect until the next rate adjustment period, as determined by the Department. Failure to submit cost information may result in suspension or termination of the agency from the Medicaid Home Health program.

An agency's Medicaid cost report is subject to review or audit by the Department or its agent(s) in accordance with HCFA-15 principles of reimbursement and Medicaid policies and procedures. The agency's reimbursement rate will be adjusted (if necessary) for the period for which the rate was effective as a result of the review or audit performed. Percentile and rate ceilings as initially established will not be adjusted based upon subsequent audits. An agency may appeal any audit adjustments and rates resulting therefrom using the administrative review procedures outlined in the home health policy manual.

Nonallowable Costs

Effective for the determination of reasonable costs used in the calculation of rates initially established on and after April 1, 1991, the costs outlined below are nonallowable for Medicaid purposes:

(a) Costs related to lobbying and government relations, including costs for employees with duties related to lobbying and government relations, honorariums and reimbursement of travel or other expenses of elected officials;

(b) Memberships in civic organizations;

(c) Out-of-state travel paid by the provider for persons other than board members or those employed or contracted by the provider. Out-of-state travel for provider personnel must be related to patient care;

(d) Vehicle depreciation or vehicle lease expense in excess of the lesser of IRS limits per vehicle or the amount allowed under Medicare reimbursement principles; provided, however, such limits shall not apply to specialized patient transport vehicles (e.g., ambulances);

(e) Air transport vehicles that are not used to transport patient care staff or patients. If these vehicles are sometimes used for patient care staff or patient transport, the portion of cost that is unrelated to patient transport is nonallowable;

(f) Fifty percent (50%) of professional dues for national, state, and local associations.

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

(g) Legal services for an administrative appeal or hearing, or court proceeding involving the provider and the Department or any other state agency when judgment or relief is not granted to the provider. Legal services associated with certificate of need issuance reviews, appeals, disputes or court proceedings are not allowable regardless of outcome. Legal services associated with a provider's initial certificate of need request shall be allowable.

(h) Advertising costs that are (a) for fund-raising purposes, (b) incurred in the sale or lease of a facility or agency or in connection with issuance of the provider's own stock, or the sale of stock held by the provider in another corporation, (c) for the purpose of increasing patient utilization of the provider's facilities; (d) for public image improvement; or (e) related to government relations or lobbying.

Information on these nonallowable costs will be obtained by the Department or its agent at the time of review or audit of the agency.

The agency's reimbursement rate will be adjusted (if necessary) for the period for which the rate was effective as a result of the review or audit performed. Percentile and rate ceilings as initially established will <u>not</u> be adjusted based upon subsequent audits. An agency may appeal any audit adjustments and rates resulting therefrom using the Department's Administrative Review Procedures.

<u>New Agencies</u>

a) A new agency will be reimbursed a rate equal to the statewide average reimbursement rate for the appropriate category, as of the effective date of enrollment of the new agency. This new agency rate will be reimbursed until a cost report for a base period (minimum nine months) on which an agency-specific rate per visit can be based, is received by the Department. There will <u>not</u> be a cash settlement determination for new agencies.

b) A new agency is defined as an agency established by the initial issuance of a Certificate of Need (CON), Medicare certification and state license; it is reimbursed as described in paragraph a) above. An agency formed as a result of a merger, acquisition, other change of ownership, business combination, etc. is not a new agency. Each agency of this type will maintain the reimbursement rate it was assigned prior to the transaction. When rates are subsequently adjusted, the appropriate cost report for the base period (as determined by the Department) will be used as a basis for determining the agency's rate.

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

Agencies With Insufficient or Unauditable Cost Data

If an existing agency submits costs data for its fiscal year that corresponds to the base period and the fiscal year is for an insufficient period of time (as determined by the Department but usually a period of less than nine (9) months), that cost data will not be used in establishing the percentile and rate ceilings for the appropriate category and in calculating the statewide supply rate per visit. However, the data will be used to calculate a rate per visit using the methodology previously described. A freestanding agency's actual reimbursement rate in this instance will be the lesser of the calculated rate per visit (including applicable incentive) or the 75th percentile for the appropriate category, calculated exclusive of the agency's insufficient cost data, plus the statewide supply rate per visit, also calculated exclusive of the agency's insufficient cost data. A hospital-based agency's actual reimbursement rate in this instance will be the lesser of the calculated rate per visit (including applicable incentive) or the maximum rate per visit for the appropriate hospital-based subcategory, calculated exclusive of the agency's insufficient cost data, plus the supply rate per visit, also calculated exclusive of the agency's insufficient cost data. There will be no cash settlement for existing agencies with insufficient cost data for the base year.

Existing agencies with cost data which cannot be audited for the fiscal year that corresponds to the base period will be omitted from the rate setting process and assigned the lowest rate in the state for the applicable category until the appropriate records are made available to verify (audit) the cost information.

Amended Medicare and Medicaid Cost Data

An agency may submit an amended Medicare cost report and Medicaid Cost Data Form after the initial submission for the most recent fiscal year. An amended report and cost data form must be received by the Department no later than ninety (90) days after the due date of the initial report and form, or ninety (90) days after any due date extension granted by the Department. The amended Medicare report must support the amended Medicaid cost data form. The due date of the initial report and cost data form is contained in the cost report section.

Classification of Agencies

For reimbursement purposes Home Health agencies will be classified as follows:

(a) Urban - Agency located in a Metropolitan Statistical Area, as evidenced by documentation on file with the Department, including, but not limited to, the address on the Medicare cost report received by the Department or fiscal intermediary.

TRANSMITTAL 91-48
APPROVED 1-28-92
EFFECTIVE 11-1-91
SUPERSEDES NEW

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

b) Rural - An agency located in a non-Metropolitan Statistical Area, as evidenced by documentation on file with the Department, including, but not limited to, the address on the Medicare cost report received by the Department or fiscal intermediary.

c) Hospital-based - An agency classified as hospital-based for Medicare purposes will be considered hospital-based for Medicaid purposes. Hospital-based agencies will be further categorized as urban or rural using the criteria in (a) and (b) above. Agencies retrospectively classified as hospital-based by Medicare will not be classified retrospectively as hospital-based by the Department. The agency will be notified of the prospective effective date.

Agencies which submit Medicare cost reports with addresses different from the address on the Statement of Participation on file with the Department will have their cost reports returned for verification. If the agency uses the address on the Medicare cost report for Medicare purposes, this same address will be utilized in designation of a location for rate setting purposes for the Department.

H. **EPSDT Private Duty (Continuous) Nursing Services**

The maximum reimbursement for public and private providers of private duty nursing services is limited to the lower of:

a) The actual charges for the service; or

b) The statewide rate in effect on the dates of services is based on a survey of seven (7) states conducted in 1999. Another state survey will be conducted when legislatively mandated.

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

H. INDEPENDENT LABORATORY AND X-RAY SERVICES

Payments are made for specific authorized procedures on a statewide basis and are limited to the lower of:

(a) the actual charge for the procedure, or

(b) the statewide rate in effect on the date of service.
Reimbursement for laboratory services performed by an independent laboratory will not exceed the upper limit of payment established by Medicare for the same clinical laboratory test.

I. ORTHOTICS AND PROSTHETICS SERVICES

The maximum reimbursement amount for it5ems and services will not exceed rates established by the State Agency based upon the usual and customary charge for the items and services.

Effective for dates of service July 1, 1994 and after, a $3.00 recipient co-payment is required on Orthotics and Prosthetics services.

Pregnant women, recipients under twenty-one years of age, , nursing home residents, and hospice services are not required to pay a co-payment. Emergency services and family planning are also exempt from a co-payment.

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

Payments are made for specific authorized procedures on a statewide basis and are limited to the lower of:

(a) The actual charge for the services; or

(b) The statewide rate in effect on the date of services.

(c) If the recipient is referred in writing by the surgeon to an optometrist for post-cataract surgery follow-up care, the surgeon's fee will be reduced by an amount equal to the maximum allowable reimbursement for the post-cataract surgery follow-up care.

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

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

Payments for certain 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.

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. Modifiers* QX and QZ conversion factors are 10.42 and 15.84, respectively.

If a CPT-4 procedure is non-covered, anesthesia for that service is also non-covered.

POLICY AMD NETJPDS FPR ESTABLISHING
PAMENT RATES FOR OTHER TYPES OF CARE OR SERVICES

J. **PHYSICIAN SERVICE** (Includes Physicians, Podiatrists, Optometrists and Psychologists)(continued)

*Descriptions:

AA Anesthesia services personally performed by an Anesthesiologist

QK Medical direction of 2, 3 or 4 concurrent anesthesia procedures involving qualified individual(s) [i.e., Certified Registered Nurse Anesthetists (CRNAs) or Physician Assistant Anesthesiology Assistants (PAAAs)] by an Anesthesiologist

QX CRNA and PAAA performing anesthesia services under the direct supervision of an anesthesiologist

QY Single (one) medically directed anesthesia service performed by an Anesthesiologist

QZ Non-medically directed CRNAs

78 Return trip to the operating room

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYES OF CARE OR SERVICE

M(2) Specialized Transportation for Medicaid eligible Children under age 21, an with Individual Education Programs (IEP)

1. Reimbursement for specialized transportation will be based on a flat rate.
2. The statewide rate will be established using the average historic cost of providing specialized transportation services in the school districts.
3. The cost of non-school provided transportation will be excluded form the calculation and will not be paid by Medicaid.
4. The Department will consider periodic inflationary adjustments to the rate.
5. The reimbursement authority to pay for specialized transportation services provided in schools will end effective June 30, 2007.

A trip, for Medicaid billing purposes is defined as a trip for a Medicaid eligible student requiring special transportation services, picked up at home or school, delivered to a location where an approved Medicaid service is provided, or delivered back to home or school from the Medicaid service. This definition is consistent with Section 3.1 a/b of the State Plan.

The school districts will maintain daily transportation logs and provide data related to the number of specialized transportation trips per student. These data will include the number of special transportation students transported and the number of days transported.

Medicaid will be billed only for children who have been determined eligible for Medicaid. In this way the total costs of specialized transportation will be allocated between Medicaid and Non-Medicaid. A specialized transportation claim will only be accepted if the school district can document that the child received specialized transportation service on the same day that a Medicaid covered IEP service was provided.

TN No.: 06-018
Supersedes
TN No.: 01-027

APPROVAL DATE: 02/26/07
EFFECTIVE DATE: 01/01/07

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

N. CASE MANAGEMENT SERVICES

(a) Case Management services will be reimbursed on a negotiated rate basis not to exceed actual costs, which meets all requirements of the Office of Management and Budget Circular A-97 dated January 15, 1981.

(b) Perinatal Case Management Services will be reimbursed on a fee-for-service basis billed monthly on the HCFA 1500 form.

For private providers, payments are limited to the lesser of the submitted charges or the established fees as determined for public providers below.

Fees-for-service will be prospective, based on the actual cost of public providers and will be evaluated annually to reflect actual cost.

POLICY AND METHODS FOR ESTABLISHING RATES FOR OTHER TYPES OR CARE OR SERVICE

PERINATAL CASE MANAGKMENT (PCM) NEW PATIENT, COMPREHENSIVE: Service to a new patient whose case management and administrative records need to be established. This service will be completed within 30 days of enrollment into case management services. A comprehensive level of service will be provided including an assessment and individualized plans for 1) medical, 2) nutritional, 3) psychosocial and 4) health educational needs of the client. A problem list will be developed based on this comprehensive assessment and priorities set. Initial linkages will be made with required services for no less than the top three priorities. For example:

* A prenatal care provider who accepts Medicaid clients will be located and an appointment made.
* A nutritional assessment will be done and/or an appointment made for WIC enrollment and nutritional counseling.
* Arrangements for any necessary transportation will be made.

This unit of service will be billed once per pregnancy.

PERINATAL CASE MANAGEMENT FOLLOW-UP: Services to an established patient. All contacts with the client, by professional or paraprofessional staff, must be documented by level of service to receive reimbursement. Reimbursement is limited to a maximum of (8) eight follow-up services per pregnancy in any combination (e.g., one brief or one extended follow-up unit per month.) Dates of service must be after the date of the comprehensive assessment and before the date of delivery.

The level of service billed will be based on the patient's individualized assessment and need for Case Management assistance as defined below:

Brief follow-up: Consists of at least one (1) minimal contact (direct or indirect) to ensure the recipient is complying with the established plan for care. A tracking system will be maintained for monitoring monthly follow-up of the recipient's established plan.

Extended follow-up: Consists of a minimum of one direct contact to reevaluate or reassess the individualized plan for medical, nutritional, psychosocial and health education needs due to complications of pregnancy or change in environmental factors.

TRANSMITTAL 89-14
APPROVED 8-21-90
EFFECTIVE 4-1-89
SUPERSEDES (NEW)

POLICY AND METHODS FOR ESTABLISHING RATES FOR OTHER TYPES OR CARE OR SERVICE

PERINATAL CASE MANAGEMENT, POSTPARTUM FOLLOW-UP: Services provided to an established patient after the delivery. Assessments, plans and initial linkages will be made based on the mother's needs for postpartum, family planning and other services, and to assist her with obtaining Medicaid enrollment, WIC, EPSDT and other services needed by her infant. Service will be provided by professional staff and may be supported by paraprofessional staff. Final case management services will be completed within 60 days after delivery and can not be later than the last day of Medicaid eligibility. This unit of service will be billed once per pregnancy.

TRANSMITTAL 89-14
APPROVED 8-21-90
EFFECTIVE 4-1-89
SUPERSEDES (New)

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

N. (c) Early Intervention Case Management services will be reimbursed directly to the providers of case management services on a negotiated rate basis not to exceed actual costs, which meets all requirements of the Office of Management and Budget Circular A-87 dated January 15, 1981.

TRANSMITTAL 91-20
APPROVED 12-5-91
EFFECTIVE 5-21-91
SUPERSEDES NEW

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

N. (d.) Children At-Risk Case Management Services will be billed monthly on the HCFA 1500 form and be reimbursed on a prospective fee-for service basis. Payments to providers are limited to the lesser of the submitted charge or the established rate. The established statewide rates are based on the median cost per visit of providers currently enrolled in the program. Cost will be evaluated periodically and reimbursement rates will be adjusted to reflect cost.

NEW CHILD, COMPREHENSIVE ASSESSMENT: Service to a new child whose care management records must be established. This service will be completed within 30 days of enrollment into case management services. A comprehensive level of service will be provided including an assessment and individualized service plan for the health, educational, social, psychological, and other needs of each youth. A problem list will be developed based upon the comprehensive assessment and service priorities established, initial linkages will be made with providers of the needed identified services for at least the top three priorities. For example:

1. Those children assessed as being in need of health care will be referred to an EPSDT provider for EPSDT services.
2. A referral will be made to the County Department of Family and Children Services to assist children living in abusive family situations.
3. Arrangements will be made for any necessary transportation.

This unit of service will be billed only once for each eligible child served.

CASE MANAGEMENT FOLLOW-UP: Services to an established service recipient. All contacts with the recipient and/or his/her family by Family Connection Case Management personnel must be documented by level of service to receive reimbursement. Reimbursement is ~~limited to a maximum of 12 visits annually~~. ~~Dates of service must occur after the comprehensive assessment~~.

SGE 7/1/97

TN No. 97-003 Supersedes TN No. 95-022	Approval 7/3/97	Effective 3/1/97

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

limited to a maximum of <u>12 visits annually</u>. Dates of service must occur after the comprehensive assessment.

The level of service billed will be based on the service recipient's individual service plan and the need for case management assistance as defined below.

<u>Brief follow-up:</u> Consist of at least one (1) minimal contact with the recipient, the family or the service provider to ensure that the recipient is complying with the established service delivery plan.

<u>Extended follow-up:</u> Consist of a minimum of one direct contact with the recipient and the family to reevaluate or reassess the individual service delivery plans due to changes in recipient's personal or family factors.

TRANSMITTAL 92-01
APPROVED 5-12-92
EFFECTIVE 2-1-92
SUPERSEDES (NEW)

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

N. (e.) Dropout Recovery Case Management Services will be billed monthly on the HCFA 1500 form and be reimbursed on a prospective fee-for-service basis. Payments to public <u>and</u> private providers are limited to the lesser of the submitted charge or the established fees based on the actual cost of public providers as determined by time studies conducted pursuant to methodology approved by HCFA, Region IV. Costs will be evaluated annually and fees adjusted to reflect actual cost.

<u>NEW CLIENT, COMPREHENSIVE ASSESSMENT:</u> Service to a newly recovered dropout whose case management records must be established. This service will be completed within 30 days of enrollment into case management services. A comprehensive level of service will be provided including an assessment and individualized service plan for the health, educational, social, psychological, and other needs of each youth. A problem list will be developed based upon the comprehensive assessment and service priorities established. Initial linkages will be made with providers of the needed identified services for at least the top three priorities. For example:

1. Those recovered dropouts assessed as being in need of health care will be referred to an EPSDT provider for EPSDT services.

2. A referral will be made to the County Department of Family and Children Services to assist recovered dropouts living in abusive family situations.

3. A referral will be made to the Public School System or GED providers to assist recovered dropouts to complete a planned secondary educational program.

This unit of service will be billed only once for each eligible child served.

TRANSMITTAL 92-31
APPROVED 10-27-92
EFFECTIVE 10-15-92
SUPERSEDES (NEW)

CASE MANAGEMENT FOLLOW-UP: Services to an established service recipient. All contacts with the recipient and/or his/her family by Dropout Recovery Case Management personnel must be documented by level of service to receive reimbursement. Reimbursement is limited to a maximum of 12 visits annually. Dates of service must occur after the comprehensive assessment.

The level of service billed will be based on the service recipient's individual service plan and the need for case management assistance as defined below.

Brief follow-up: Consist of at least one (1) minimal contact with the recipient, the family or the service provider to ensure that the recipient is complying with the established service delivery plan.

Extended follow-up: Consist of a minimum of one direct contact with the recipient and the family to reevaluate or reassess the individual service delivery plans due to changes in recipient's personal or family factors.

Policy and Methods for Establishing Payment Rates for other Types of Care or Services

N.(f) Case Management Services for Adults with AIDS will be billed monthly on the DMA-1500C (4/92) form and will be reimbursed on a prospective fee-for-service basis.

Payments to private providers are limited to the lesser of the submitted charge or the established fee(s) based on actual cost as determined by time studies conducted pursuant to methodology approved by the Health Care Financing Administration.

Public providers of case management services will be reimbursed directly on a negotiated rate basis not to exceed actual cost.

Costs will be evaluated annually and fees adjusted to reflect actual cost.

New Client Comprehensive Assessment:

Service to a new client whose case management records must be established. This service must be initiated within 48 hours of the request for services and must be completed within 30 days of enrollment into case management.

A comprehensive level of service shall be provided including obtaining a medical assessment from the client's primary physician, conducting a psychosocial assessment, developing an individualized service plan for the client's medical, nutritional, social, educational, psychological transportation, housing, legal, financial, and other needs. A problem list shall be generated based on the comprehensive assessment and service priorities shall be established. Initial linkages shall be made with providers of the needed identified services. This unit of service may be billed only once for each client served.

TRANSMITTAL 92-40
APPROVED 1-28-93
EFFECTIVE 10-1-92
SUPERSEDES (New)

Case Management Follow-Up:

Services to an established service recipient. All contacts with the recipient, his or her family members, significant others, and service providers must be documented to receive reimbursement. Reimbursement is limited to a maximum of 12 follow-up services annually. Providers may not bill for an extended and a brief follow-up performed in the same month. Providers may bill for no more than three (3) extended follow-up services annually. Dates of follow-up services must occur after the comprehensive assessment.

The level of service (brief or extended) billed shall be based on the recipient's individual service plan and the descriptions of case management follow-up found below.

Brief Follow-Up:

Consists of at least one (1) contact with the recipient AND, if appropriate, his or her significant other, family member, or service provider to ensure that the recipient is complying with the established service delivery plan.

Extended Follow-Up:

Consists of at least one (1) direct contact with the recipient to re-evaluate or reassess the individual service delivery plan due to crisis resulting from changes in recipient's medical condition, loss of social support, employment, or housing, legal problems, or other significant events.

TRANSMITTAL 92-40
APPROVED 1-28-93
EFFECTIVE 10-1-92
SUPERSEDES (NEW)

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

5.(g) The results of a time study were applied to projected costs for each of the prospective providers and statewide rates for the first year were established based on an arraying of the costs of the 50th percentile. Cost reports from all providers will be evaluated annually after the first year of implementation to determine subsequent statewide rates. Payments to public and private providers will be limited to the lesser of the submitted charge or established fee based on cost reports from providers. Payment to providers may not exceed actual cost of providing services.

At-Risk of Incarceration Case management Services will be reimbursed on a fee- for-service basis billed monthly on the HCFA 1500 form.

The Department will reimburse one unit of case management service per month per beneficiary. The specific service component (billing unit) covered under the At-Risk of Incarceration program is *Basic Case Management.*

Basic Case Management

"Basic Case Management" must be provided by a qualified provider to a child in the care of the Department of Juvenile justice. It must include at least one (1) contact with the recipient, family or service provider to ensure that services are being delivered in accordance with the established service delivery plan. It includes one or more of the following activities:

A. *Establishing the comprehensive case file for development and implementation of an individualized service plan to meet the assessed service needs of the child.*

B. *Assisting the child in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan.*

C. *Monitoring the child and service providers to determine that the services received are adequate in meeting the child's needs.*

D. *Reassessment of the child to determine services needed to resolve any crisis situation resulting from divorce, death, separation, changes in family structure or living conditions, or other events.*

Extended Follow-up

The extended follow-up consists of at least one (1) direct contact with the beneficiary and a family member or provider to re-evaluate the individual service plan due to changes in the beneficiary's personal or family factors.

The extended follow-up will require additional documentation if billed more than three (3) times during a calendar year. If subsequent visits are billed, documentation of necessity of the service must be attached to each claim. The Department will either approve or deny the claim.

Only one (1) brief or one (1) extended follow-up may be billed each month with a maximum of twelve (12) follow-up services per year.

Dates of service for case management follow-up must occur after the initial assessment.

In the event of multiple types of targeted case management, only one type will be reimbursed during the calendar month for each beneficiary.

STATE: Georgia

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

N. (h) Perinatal Case Management Services/Area C will be billed monthly on the HCFA 1500 form and be reimbursed on a prospective fee-for-service basis. Payments to public and private providers are limited to the lesser of the submitted charge or the established fees based on the actual cost of public providers as determined by time studies conducted pursuant to methodology approved by HCFA, Region IV. Costs will be evaluated annually and fees adjusted to reflect actual cost.

PREGNANT WOMAN, COMPREHENSIVE ASSESSMENT: Service to a newly pregnant woman whose case management records must be established. This service will be completed within 30 days of enrollment into case management services. A comprehensive level of service will be provided including an assessment and individualized service plan for the health, educational, social, psychological, and other needs of each pregnant woman. A problem list will be developed based upon the comprehensive assessment and service priorities established. Initial linkages will be made with providers of the needed identified services for at least the top three priorities. For example:

1. Pregnant women will be referred to a prenatal care provider.
2. Pregnant women will be referred to the County Department of Health for nutritional assessment and for WIC benefits.
3. Arrangements will be made for any necessary transportation to prenatal care appointments.

This unit of service will be billed once for each eligible pregnant woman.

NEWBORN, COMPREHENSIVE ASSESSMENT: Service to a newborn whose case management records must be established. This service will be completed within 30 days of birth. A comprehensive level of service will be provided including an assessment and individualized service plan for the health, social, psychological, and other needs of each newborn. A problem list will be developed based upon the comprehensive assessment and service priorities established. Initial linkages will be made with providers of the needed identified services for at least the top three priorities. For example:

1. Newborns will be referred to an EPSDT provider for EPSDT services.
2. Newborns will be referred to the County Department of Health for nutritional assessment and for WIC benefits.
3. A referral will be made to the County Department of Family and Children Services to assist newborns living in abusive family situations.

This unit of service will be billed one for each eligible newborn.

TRANSMITTAL 93-026
APPROVED 5-4-94
EFFECTIVE 4-1-93
SUPERSEDES NEW

STATE: Georgia

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

CASE MANAGEMENT FOLLOW-UP: Services to an established service recipient. All contacts with the recipient and/or recipient's family by Case Management personnel must be documented by level of services to receive reimbursement. Reimbursement is limited to a maximum of 12 visits annually. Dates of service must occur after the comprehensive assessment.

The level of service billed will be based on the service recipient's individual service plan and the need for case management assistance as defined below.

Brief Follow-up: Consist of at least one (1) minimal contact with the recipient, the family or the service provider to ensure that the recipient is complying the established service delivery plan.

Extended Follow-up: Consist of a minimum of one direct contact with the recipient and the family to reevaluate or reassess the individual service delivery plans due to changes in recipient's personal or family factors.

TRANSMITTAL 93-020
APPROVED 5-4-94
EFFECTIVE 4-1-93
SUPERSEDES NEW

**Policy and Methods for Establishing Payment Rates
For Other Types of Care or Services**

N.(i) Reimbursement rates will be established based on cost as determined by the quarterly Social Services Random Moment Sample Study. Rates will be adjusted annually based on the results of the previous four quarters. The Random Moment Sample Study must provide an audit trail that identifies each client whose case is included in the data used for rate formulation.

A maximum of one unit of case management services will be reimbursed per month for each eligible recipient. However, if a family has more than one child in the home with the parent and no children have been placed outside of the home, the Department will only reimburse for one child within the family unit. Services will be reimbursed only for eligible recipients.

A unit of case management service is defined as at least one telephone or face-to-face contact with the recipient, a family member, significant other, or agency from which the client receives or may receive services. All contacts must be for the coordination or linkage of services.

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

N.(j) Reimbursement rates will be established based on cost as determined by the quarterly Social Services Random Moment Sample Study. Rates will be adjusted annually based on the results of the previous four quarters. The Random Moment Sample Study must provide an audit trail that identifies each client whose case is included in the data used for rate formulation.

A maximum of one unit of case management services will be reimbursed per month for each eligible recipient. A unit of case management service is defined as at least one telephone or face-to-face contact with the recipient, a family member, significant other, or agency from which the client receives or may receive services. All contacts must be for the coordination or linkage of services for a specific recipient.

TRANSMITTAL 93-091
APPROVED 8/24/94
EFFECTIVE 7/01/93
SUPERSEDES New

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

Rural Health Clinic Services (RHC)

In accordance with Section 702 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000, effective January 1, 2001, reimbursement is provided for "core" services and other ambulatory services (excluding in-house pharmacy services) at a prospective payment rate (PPS) per encounter. The rates will be calculated on a per visit basis and will reflect 100 percent of the average of the RHC's reasonable cost of providing Medicaid-covered services including other ambulatory services cost during FY 1999 and FY2000., Those costs will be adjusted to take into account any increase (or decrease) in the scope of services furnished by the RHC during FY2001for services that only occurred in calendar year 2000. Cost reports for the RHC's FY 1999 and FY 2000 periods will be used to establish the baseline rate for each RHC effective January 1, 2001. The baseline rate will be calculated by dividing the sum of the total reasonable cost of providing Medicaid covered services during FY 1999 and FY 2000 by the total Medicaid visits during the two fiscal years. Until the baseline rates are established, RHCs will be paid their interim rate effective December 31,2000. When the baseline rates are established, they will be paid retroactive to January 1,2001.

The baseline rates effective January 1,2001 will be adjusted by the Medicare Economic Index (MEI) effective for dates of service on and after October 1, 2001 based on the MEI and for changes in the RHC's scope of services during January 1, 2001 through September 30, 2001. For Federal Fiscal Year (FFY) 2002 and FFYs thereafter, the per visit rate will be calculated by adjusting the previous year's rate by the MEI for primary care, and for changes in the RHC's scope of services during the prior FFY.

For newly qualified RHCs that participate in FY 2000 only, the Department will use the FY 2000 cost for calculating the baseline PPS rate effective January 1,2001. Clinics that qualify after fiscal year 2000 will have their initial rates established by a statewide average of similar centers. After the initial year, payment will be set using the MEI and change of scope methods used for other clinics.

For purposes of this plan, a change in scope of services is defined as a change in the type, intensity, duration and/or amount of services. It is the clinic's responsibility to recognize any changes in their scope of services and to notify the Department of those changes and to provide the Department with documentation of and projections for the cost and volume of the change.

If a RHC provides core services pursuant to a contract between the center and a managed care entity (as defined in section 1932(a)(1)(B)), the State shall provide payment of a supplemental payment equal to the amount (if any) by which the PPS rate calculated above exceeds the amount of the payments provided under the contract. These supplemental payments shall be made pursuant to a payment schedule of four months or less agreed to by the State and the Rural Health Clinic.

An alternative payment methodology is established for services furnished in Rural Health Clinics located at Critical Access Hospitals. The reimbursement methodology will follow the provisions established in Attachment 4.19-B, Page 8a.1 (Outpatient Hospital). All clinics affected by this methodology have agreed and their payments will at least equal the amount they would have received under the PPS methodology. .

Effective for dates of service July 1, 1994, and after, a $2.00 recipient co-payment is required on all Rural Health Clinic Services (RHC). Pregnant women, recipients under twenty-one years of age, nursing home residents, and hospice care participants are not subject to the co-payment. Emergency services and family planning services are also exempt from a co-payment

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

Non-Emergency Transportation Services

Non-Emergency Transportation is reimbursed according to the following methods, depending on type of vehicle and number of passengers for exceptional travel or the number of Medicaid eligibles in a region. Upper reimbursement limits shall not exceed charge determined to be reasonable by the State.

(a) The Broker is reimbursed a monthly capitated rate for each Medicaid member residing in the region.

(b) For exceptional travel, the Department of Family and Children Services is reimbursed a mileage rate per passenger for automobile services; commercial and public transportation are reimbursed at the usual and customary rate; escorts, meals and lodging are also reimbursed at the usual and customary rate.

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

N (k) Services Coordination for Children with Individualized Education Programs (IEPs)

- Reimbursement for service coordination will be on a fee-for-service basis billable monthly on a HCFA 1500.
- The initial statewide maximum allowable rates will be established using comparable service coordination activities and rates paid in other existing targeted case management programs (i.e. Children at Risk).
- The Division will collect and evaluate cost data after the first year of service and periodically thereafter from participating local education agencies (LEA) to determine the actual cost of providing this service and establish a statewide fee structure.
- If the initial statewide maximum allowable rates exceed the actual cost of providing this service, the cost data will be utilized to set the maximum allowable rates. If the statewide maximum allowable rates are lower than the actual cost, the Division will periodically consider an increase subject to the availability of funds.

Service Categories

Ongoing monthly special education service coordination activities will be billed based on the child's IEP and the need for service coordination case management services as defined below:

1) Initial IEP
The initial IEP requires that the service coordinator integrate all evaluation data into a description of status that highlights the overall pattern of strengths and weaknesses of the student. Goals and objectives must be developed to address specific weaknesses. Supplementary aids and services to address those goals, in the least restrictive environment, must be considered. Input from the IEP Multidisciplinary Team, a schedule of required services, along with goals and objectives for each, must be determined and documented.

   - This service can be billed as one (1) per lifetime for each Medicaid eligible child with an IEP.

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

N (k) Services Coordination for Children with Individualized Education Programs (IEPs) (continued)

2) IEP Review
The compilation of progress reports and updated testing information by the service coordinator supports the required annual review of the IEP goals, objectives and services. The service coordinator must integrate this data so that a service schedule can be developed. This review must be done more often if the parent or a professional serving the student request a consideration of a change in services by the IEP Multi-disciplinary Team.

- This service can be billed as one (1) minimal contact or a maximum of three (3) per year.

3) Triennial IEP
Every three years the service coordinator must undertake a comprehensive analysis of available and relevant assessment information on the student. Necessary evaluations must be scheduled and a new IEP per child developed and adopted by the IEP Multi-disciplinary Team.

- This service can be billed as one (1) review every 3 years.

4) On-going Service Coordination
The ongoing contact (billable intervals) of the service coordinator in coordinating and monitoring follow-up with the child, the family, or the service providers (private and public agencies), to ensure access and compliance, as developed and adopted by the IEP Multi-disciplinary Team.

- This service can be billed at intervals of one (1) unit, which equals 15 minutes.

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

o. Ambulatory Surgical Center Services and Birthing Center Services

1. Reimbursement for surgical procedures performed in the center is limited to the ASC facility fee as determined by Medicare with the exception of dental procedures that are reimbursed at Medicaid designated rates.

2. Reimbursement for the facility vaginal delivery fee will not exceed the amount that Medicare would reimburse. The facility fee payment for delivery services is made at the Group Four (4) ASC surgical reimbursement rate for the geographical area in which the billing facility is located. Rate adjustments are based on changes made in the ASC facility fee assigned for the group. The payments for related services provided by dentists, physicians or physician extenders are made under other Medicaid service programs.

3. Effective for dates of service July 1, 1994 and after, a $3.00 recipient co-payment is required on all ASC facility services. Pregnant women, recipients under twenty-one (21) years of age, nursing home residents, and hospice care recipients, are not required to pay the co-payment. Emergency services and family planning services are exempt from a co-payment.

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

ø. Hospice Services

s|b p. The Department reimburses hospices for hospice services in accordance with hospice payment rates defined at Section 4306.3 of the State Medicaid Manual. The Department will continue the payment rates which were in effect on October 1, 1990, through the end of the calendar year. There will be no reduction as required by Section 4007 of the Omnibus Budget Reconciliation Act of 1990 applicable to the Medicare program. Payment for physicians' professional services is in accordance with the usual Georgia Medicaid reimbursement policy for physicians' services.

The Department pays an additional per diem amount for routine home care and continuous home care days for hospice care that is furnished to an individual living in a nursing facility. This additional amount is for "room and board" which includes performance of personal care services, including assistance in the activities of daily living, socializing activities, administration of medications, maintaining the cleanliness of a resident's room, and supervision therapies. This amount is 95% of the per diem that would have been paid to the nursing facility for that individual in that facility under the State Plan. This rate is in addition to the routine home rate or the continous home care rate. The hospice retains full responsibility of the professional management of the individual's hospice care and the nursing facility agrees to provide "room and board" to the individual.

TRANSMITTAL 90-46
APPROVED 8-15-91
EFFECTIVE 10-1-90
SUPERSEDES (NEW)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SE URITY ACT
MEDICAL ASSISTANCE PROGRAM
STATE: GEORGIA

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

Item: Q . Payment of Title XVIII Part A and Paart B Deductible/Coinsurance

Except for a nominal recipient copayment, if applicable, the Medicaid agency may use the following method:

	Medicare-Medicaid Individual	Medicare-Medicaid/QMB Individual	Medicare-QMB Individual
Part A Deductible	X Limited to State Plan Rate*	x Limited to State Plan Rate*	X Limited to State Plan Rate*
	___ Full Amount	___ Full Amount	___ Full Amount
Part A Coinsurance	X Limited to State Plan Rate*	X Limited to State Plan Rate*	X Limited to State Plan Rate*
	___ Full Amount	___ Full Amount	___ Full Amount
Part B Deductible	X Limited to State Plan Rate*	X Limited to State Plan Rate*	X Limited to State Plan Rate*
	___ Full Amount	___ Full Amount	___ Full Amount
Part B Coinsurance	X Limited to State Plan Rate*	X Limited to State Plan Rate*	X Limited to State Plan Rate*
	___ Full Amount	___ Full Amount	___ Full Amount

* For those Title XVIII services not otherwise covered by the Title XIX State Plan, the Medicaid agency has established reimbursement methodologies as described in Items 2 and 3, specified on page 1 of Attachment 4.19-B.

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

R. OUTPATIENT HOSPITAL SERVICES

1. Outpatient services by Georgia hospitals are reimbursed on a determination of allowable costs. The Department will apply the principles and standards described in 42 CFR 413.1 -413.178, with exceptions as outlined in this plan. The determination of allowable costs is made retrospectively and is based on a cost report submitted by the hospital and audited by the Department or its agents. Only costs incurred in providing patient care are eligible for reimbursement.

   The amount of interim payment is calculated as a percentage of covered charges. This payment rate is defined by covered as allowable outpatient costs divided outpatient charges. An interim payment rate cannot exceed one hundred percent of covered charges and is subject to cash settlement determination after an audited cost report is received, reviewed and accepted.

   Clinical diagnostic laboratory services performed for outpatients and nonhospital patients on or after October1, 1984, are reimbursed at the lesser of the submitted charges or 60% of the prevailing Medicare charge level.

2. The Department will provide for appropriate audit to assure that payments made to providers for outpatient hospital services meet the requirements of reasonable cost.

3. Outpatient services provided by non-Georgia hospitals are reimbursed at 65% of covered charges.

4. The maximum allowable payment for outpatient services will be 85.6% of the hospital specific inpatient per case rate for enrolled Georgia hospitals and enrolled non-Georgia hospitals.

5. Emergency room visits for minor and nonacute illnesses which are not considered as true or potential medical emergencies will be reimbursed at an all-inclusive rate of $50.00.

6. The maximum allowable payment to enrolled Georgia and non-Georgia hospitals for Medicare outpatient coinsurance (crossover claims) will be the hospital specific Medicaid per case rate. The maximum allowable payment to non-Georgia hospitals not enrolled the Georgia Medicaid program for Medicare outpatient

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

crossover claims will be the average hospital-specific inpatient per case rate for enrolled non-Georgia hospitals.

7. Effective for the determination of reasonable and reimbursable costs using cost reports for fiscal year1988 and after, the costs listed below are nonallowable:

   a) Costs related to lobbying and government relations, including costs for employees with duties related to lobbying and government relations, honorariums and reimbursement of travel or other expenses of elected officials;

   b) Memberships in civic organizations;

   c) Out-of-state travel paid by the provider for persons other than board members or those employed or contracted by the provider. Out-of-state travel for provider personnel must be related to patient care;

   d) Vehicle depreciation or vehicle lease expense in excess the lesser of IRS limits per vehicle or the amount allowed under Medicare reimbursement principles; provided, however, such limit shall not apply to specialized patient transport vehicles(e.g., ambulances);

   e) Air transport vehicles that are not used to transport patient care staff or patients. If these vehicles are sometimes used for patient care staff or patient transport, the portion of cost that is unrelated to patient care staff or patient transport is nonallowable;

   f) Ten percent (10%) of membership dues for national, state, and local associations;

   g) Legal services for an administrative appeal or hearing, or court proceeding involving the provider and the Department or any other state agency when judgment or relief is not granted to the provider. Legal services associated with certificate of need issuance reviews, appeals, disputes or court proceedings are not allowable regardless of outcome. Legal services associated with a provider's initial certificate of need request shall be allowable; and

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

h) Advertising costs that are (a) for fund-raising purposes, (b) incurred in the sale or lease of a facility or agency or in connection with issuance of the provider's own stock, or the sale of stock held by the provider in another corporation, (c) for the purpose of increasing patient utilization of the provider's facilities, (d) for public image improvement, or (e) related to government relations or lobbying.

8a. Effective with dates of payment of February 1, 1991, and after, the maximum allowable payment for any outpatient hospital services claim will be the hospital's Medicaid-specific inpatient per case rate. When the outpatient cost-based settlements are made, claims for outpatient services which were paid at the per case rate will be excluded from the settlement calculations.

8b. Effective for outpatient services provided for dates of service on and after July 1, 1991, hospital-based physicians services will no longer be reimbursed if billed to the Hospital program on the UB-92 claim form. These services must be billed to the Physician program in order to be reimbursed by the Department.

8c. Effective with dates of payment on and after July 1, 1997, the Department will reimburse for cost-based outpatient services at 90 percent of allowable operating costs plus 90 percent of allowable capital costs. The final determination of reimbursable costs will be made at the time outpatient settlements are made using audited cost reports.

8d. Effective with dates of payment on and after November 1, 1991, the Department will limit payment on outpatient Medicare crossover claims as follows: (a) multiply the allowable deductible and coinsurance amount by the hospital-specific percent of charges rate in effect on the date of payment; (b) compare the product from (a) to the hospital's inpatient per case rate in effect on the date of payment; (c) reimburse the lower of the two amounts in (b).

8e. Effective for dates of service July 1, 1994 and after, a $3.00 recipient co-payment is required on all non-emergency outpatient hospital visits. Pregnant women, recipients under twenty-one years of age, nursing home residents, and hospital care recipients are not subject to the co-payment. Emergency services and family planning services are exempt from co-payment. When the outpatient cost-based settlements are made for hospital services, the co-payments plus Medicaid and certain third party payments will be compared to the allowable cost to determine the amount of final settlement.

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

8f. Effective with outpatient settlements made on and after July 15,1993, the Department shall exclnde from paid claims data used to calculate settlement claims for which a third party paid at or in excess of the amount Medicaid would pay. Third party payments which were below the Medicaid payment amount will be included in the interim payment amounts that are compared to reimbnrsable costs. The paid claims data used in the initial determination of outpatient settlements will be used when such settlements are adjusted.

8g. Effective July 1, 2000 or when a hospital has been designated by the Department of Community Health as meeting conditions to be critical access eligible, whichever occurs later, and subject to the availability of funds, payments will be increased by rate adjustments, as described below.

- For non-governmental hospitals, rate adjustments will be based on the difference between 100% of costs and initial payments for outpatient services provided to Medicaid patients.

For governmental hospitals, subject to the upper payment limit for outpatient services, rate adjustments will be based on the difference between the greater of each hospital's charges or costs, and initial payments for outpatient services provided to Medicaid patients.

8h. Effective July 1, 2000 or when a hospital has been designated by the Department of Community Health as State owned or operated, whichever occurs later, and subject to the availability of funds, payments will be increased by rate adjustments. Subject to the upper payment limit for outpatient services, rate adjustment payments will be based on the difference between the greater of each hospital's charges or costs, and initial payments for outpatient services provided to Medicaid patients.

8i. Effective for services on and after July 1, 2001, payment rates will be increased to 100% of costs for historically minority-owned hospitals.

8j. Effective for dates of service on and after July 1, 2004, the payment method is modified as follows:

- For those hospitals that were previously reimbursed at 90% of the cost of services provided, the reimbursement rate is reduced to 85.6% of costs.
- For out-of-state enrolled hospitals, payments are made at the statewide average percentage of charges paid to Georgia hospitals that are reimbursed at

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

85.6% of costs. The payment rate for out-of-state enrolled hospitals will not exceed 65% of covered charges.

- For hospitals that are designated as a Critical Access Hospital, a historically minority-owned hospital, or as a state-owned hospital, the reimbursement rate continues at 100% of costs.

Example settlement calculation for critical access, historically minority owned hospital, or state-owned hospitals:

Percentage of charges paid on interim basis	60%
Charges for services provided during cost report period	$1,000,000
Interim payments	$600,000
Retrospective determination of allowable costs*	$585,000
% of allowable costs reimbursed	100%
Retrospective determination of reimbursable costs	$585,000
Settlement amount due from hospital	$15,000

Example settlement calculation for all other enrolled Georgia hospitals:

Percentage of charges paid on interim basis	52%
Charges for services provided during cost report period	$1,000,000
Interim payments	$520,000
Retrospective determination of allowable costs*	$585,000
% of allowable costs reimbursed	85.6%
Retrospective determination of reimbursable costs	$500,760
Settlement amount due from hospital	$19,240

* amount would not exceed charges for services

For payments made for services provided on or after July 1, 2005, governmental facilities and Critical Access eligible hospitals which meet departmental requirements will be eligible for rate payment adjustments. The rate adjustment payments are intended to provide supplemental funding for Medicaid services to these facilities that, based on their governmental status, need sufficient funds for their commitments to meet the healthcare needs of all members of their communities.

The rate payment adjustments will be subject to federal upper payment limits. For the appropriate groupings of State governmental facilities, non-State governmental facilities and non-governmental facilities, aggregate rate adjustment payments available without exceeding upper payment limits will be determined by measuring the difference between:

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

- All amounts paid for services provided to Medicaid patients including interim Medicaid claim payments and estimated Medicaid cost report settlement amounts and
- Estimated payment amounts for such services if payments were based on Medicare payment principles. Either cost based or rate payment measures may be used as Medicare payment principles.

Comparisons of amounts paid for services provided to Medicaid patients and estimated payment amounts for such services if payments were based on Medicare payment principles will also be made for each facility to determine facility-specific rate adjustment payments. If an individual facility cannot be paid a portion of its full rate adjustment payment due to a facility-specific charge limit, this rate adjustment amount can be allocated to other facilities that are eligible to receive additional rate adjustment payments without exceeding facility-specific charge limits. These rate payment adjustments will be made on a monthly, quarterly or annual basis and will be determined in a manner that will not duplicate compensation provided from payments for individual patient claims. A sample of how a rate adjustment payment is calculated is presented on the following page.

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

Facility Name	XYZ Hospital
base period report period beginning date	9/1/2003
base period report period ending date	8/31/2004
HS&R processing date for Medicaid data	9/6/2005
adjustment factor (if period not equal to 1 year)	1.00000
CAH status (1 =yes)	0
subject to cost settlement	
cost of Medicaid covered services	755,769
covered charges	2,511,680
annual cost of Medicaid covered services	755,769
cost settlement rate	85.6%
annual Medicaid payments after cost settlement	646,938
fee schedule lab only	
covered charges	813,178
payments	102,275
annual covered charges	813,178
annual interim payments	102,275
annual cost of services if CAH	0
annual Medicare payments if not CAH	116,594
subject to fixed fee payment	
covered charges	223,627
payments	26,427
annual covered charges	223,627
annual interim payments	26,427
annual cost of services	67,290
subject to limit of inpatient rate	
covered charges	137,463
payments	48,481
annual covered charges	137,463
annual interim payments	48,481

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

Facility Name	XYZ Hospital
annual cost of services	41,363
Total Medicaid annual payments	824,121
Total annual cost of services	981,016
adjustment factors	
inflation	1.073852
volume allowance	1.027698
combined factors	1.103596
adjusted Medicaid annual payments	909,497
adjusted annual cost of services	1,082,645
UPL estimate	173,148

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

9. Effective for dates of service April 1, 1991, and after, the Department will provide payment to enrolled hospitals which offer, either directly or through contract, birthing and parenting classes to Medicaid-eligible pregnant women. Reimbursement will be the lesser of the amount billed for revenue code 942 or the maximum allowable payment amount established by the Department. When the outpatient cost-based settlements are made, claims for outpatient services for birthing and parenting classes will be excluded from the settlement calculations as reimbursement is at a fixed payment rate.

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

S. Nurse Practitioner Services

Payments are limited to the lower of:

(a) The submitted charge; or

(b) Ninety percent (90%) of the statewide rate for physician services in effect on the date of service.

(c) Effective with date of service July 1, 1994, a $2.00 recipient co-payment is required on all non-emergency office visit services for nurse practitioner providers. Pregnant women, recipients under twenty-one years of age, nursing home residents, and hospice care recipients are not required to pay the co-payment. Emergency services and family planning services are also exempt from the co-payment.

EPSDT Nursing Services

Nursing services which includes medication administration and nursing treatment will be reimbursed based on a statewide rates established by the Division. Statewide rates will be based on reasonable cost for the services provided.

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

T. Extended Services to Pregnant Women

Postpartum Services

Payment for services shall not exceed the lower of the provider's submitted charge or the statewide maximum allowable rate in effect on the date of service. The statewide maximum allowable rate for postpartum home visits is based on the home health reimbursement composite rate which is calculated by dividing the sum of the home health reimbursement rates for all enrolled agencies by the total number of enrolled agencies.

CHILDBIRTH EDUCATION PROGRAM

Reimbursement for childbirth education classes is based on an average of the fee charged for childbirth education classes provided by local area hospitals.

Instructors will be reimbursed the instructor's usual and customary charge or the maximum allowable, whichever is lower.

TRANSMITTAL 94-03
APPROVED 2-15-95
EFFECTIVE 1-1-94
SUPERSEDES 91-19

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

U. DIAGNOSTIC, SCREENING, AND PREVENTIVE SERVICES

Payments are limited to the lower of:

a) The submitted charge for the procedure; or

b) the statewide rate based on a percentage of Medicare's RBRVS (Resource Based Relative Value Scale) not to exceed the current applicable year.

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

u. 1. **Rehabilitative Services**

Payments are made to all providers for specific authorized procedures on a statewide basis and are limited to the lower of:

a. The actual charge for the services; or

b. The statewide rate in effect on the date of service based on the Resource Based Relative Value Scale (RBRVS) for Region I (Atlanta) except for nursing, and counseling services. The rates for Nursing Services and Counseling Services are based on established statewide rates.

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

V. Therapy Services: (Includes Physical, Occupational, and Speech Pathology Therapists)

Payments are made for specific authorized procedures 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 on the date of service based on the Resource Based Relative Value Scale (RBRVS) for Region 1 (Atlanta).

TRANSMITTAL 93-050
APPROVED 3-25-94
EFFECTIVE 10-15-93
SUPERSEDES 93-044

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYES OF CARE OR SERVICE

V. Therapy Services (Includes Physical, Occupational and Speech Pathology Therapists), Nursing Services, Counseling Services, Nutrition Services and Audiology Services

Reimbursement to Therapy Services providers is based on the lower of submitted charges or the state's maximum allowable rate, as listed in the table below. For services not listed in the table, the state's maximum allowable rate will be based on 84.645% of Medicare's Resource Based Relative Value Scale (RBRVS) for 2000 for Region 1 (Atlanta). The reimbursement authority to pay for services provided in schools will end effective June 30, 2007.

procedure code	maximum allowable
92506	54.93
92507	47.82
92508	26.35
92526	44.66
92551	14.49
92552	15.63
92555	13.38
92557	42.04
92567	18.46
92568	13.38
92579	25.19
92582	25.19
92585	109.76
92586	65.99
92587	52.51
92588	70.52
92597	85.57
92609	54.75
92610	117.54
96105	62.10
96110	11.77
96111	62.10

TN No.: 06-018
Supersedes
TN No.: NEW

APPROVAL DATE: 02/26/07
EFFECTIVE DATE: 01/01/07

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYES OF CARE OR SERVICE

procedure code	maximum allowable
97001	52.99
97002	25.06
97003	52.99
97004	24.74
97022	12.97
97024	9.22
97032	14.50
97035	10.69
97110	20.07
97112	21.03
97113	22.32
97116	18.85
97124	17.29
97140	22.97
97530	19.76
97532	22.43
97533	24.46
97535	21.67
97537	21.37
97542	14.82
97750	22.31
T1002	5.78
T1502	5.78
96150	22.80
96151	22.19
97802	14.89
97803	14.89
99212	25.12
92601	116.23
92602	81.09
92603	76.74
92604	51.30

TN No.: 06-018
Supersedes
TN No.: NEW

APPROVAL DATE: 02/26/07
EFFECTIVE DATE: 01/01/07

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYES OF CARE OR SERVICE

procedure code	maximum allowable
92510	97.27
92592	22.50
92593	21.16

TN No.: 06-018
Supersedes
TN No.: NEW

APPROVAL DATE: 02/26/07
EFFECTIVE DATE: 01/01/07

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

W. Psychological Services:

Payments are limited to the lower of:

(a) The submitted charge, or

(b) The statewide rate as based on a percentage of Medicare's RBRVS (Resource Based Relative Value Scale) not to exceed the current applicable year.

X Counseling Services:

Counseling services are reimbursed based on statewide rates established by the Division. These rates were established by surveying states in the region and private insurance companies. Currently, the reimbursement is based on Georgia specific codes (based on reasonable cost for the services provided) that will be cross-walked to national codes. Once these codes are nationally approved, the counseling services will be reimbursed on the Resource Based Relative Value Scale (RBRVS).

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

X. Case Management for Mental Retardation Services under the Home and Community Based Waiver.

1. The reimbursement rate for case management is established based on historical cost data. That historical cost data represents information from an audited cost report for this same type of service. This data will be used to establish a monthly case management rate.
    - i. The monthly case management reimbursement rate is established as follows;
        1. The total allowable cost from the historical data is divided by the number of recipients served per caseload during that cost report period.
        2. The result from the above step (1) is divided by twelve (12) to develop a monthly rate to which an inflation factor was added.
2. The Department may in subsequent years adjust the rate based on a CMS accepted inflation factor, if legislative appropriation is received.