DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 2 0 0 2

2. STATE: GEORGIA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2002

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

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

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

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.200,201; 440.230

7. FEDERAL BUDGET IMPACT:
a. FFY _____ $ No Budget Impact
b. FFY _____ $ _____

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B, p. 11
Attachment 3.1-A, pp. 6a, 6a1

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-B, p. 11
Attachment 3.1-A, pp. 6a, 6a1

10. SUBJECT OF AMENDMENT:
AMENDING REIMBURSEMENT METHODOLOGY AND COVERAGE FOR DIAGNOSTIC, SCREENING AND PREVENTIVE SERVICES

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

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

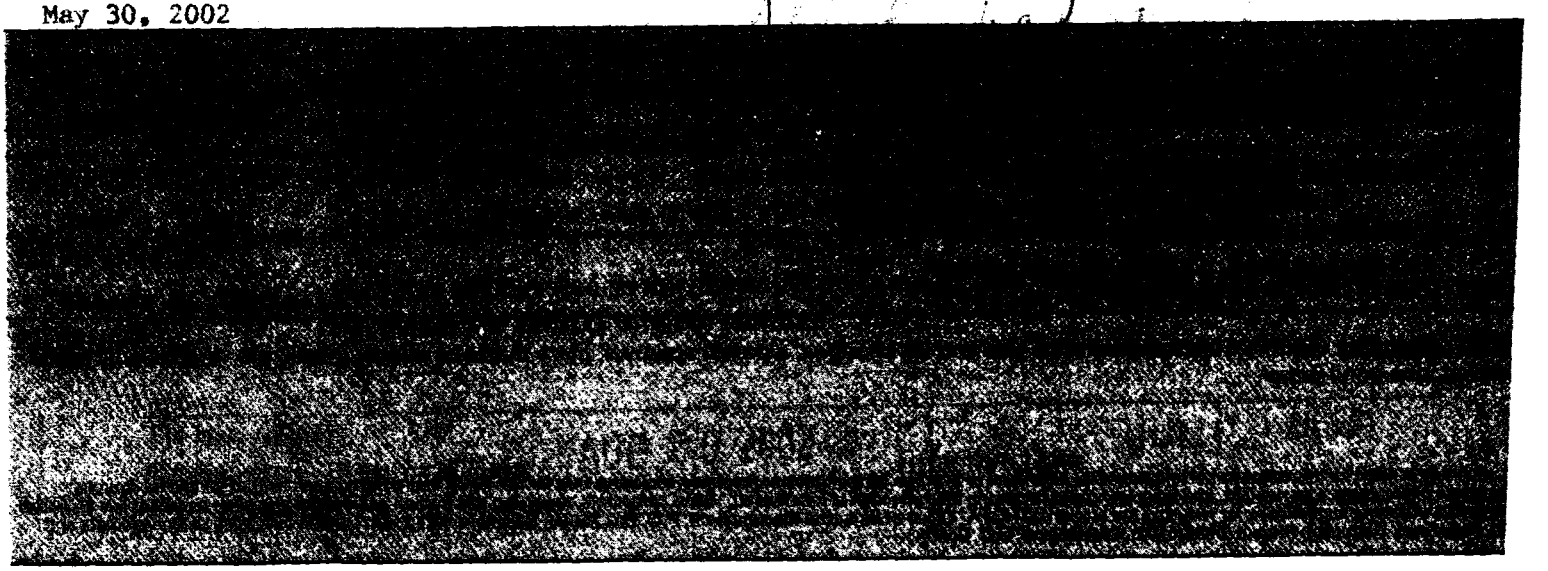
12. SIGNATURE OF STATE AGENCY OFFICIAL: Mark Trail

13. TYPED NAME: Mark Trail

14. TITLE: Director, Division of Medical Assistance

15. DATE SUBMITTED: May 30, 2002

16. RETURN TO:
Department of Community Health
Division of Medical Assistance
2 Peachtree Street, N.W.
Atlanta, GA 30303-3159



FORM HCFA-179 (07-92)

Instructions on Back

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

Non-Covered Services (continued)

Family Planning services

Radiological procedures performed by a portable x-ray service

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

Health Check screening services

Laboratory services

Experimental services

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

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

Services performed outside protocol or licensure of the specific practitioner

The first two nutrition education contracts for WIC-eligible recipients

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

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

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

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

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

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.