



**DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
REGION IX**

75 Hawthorne Street
Suite 408
San Francisco, CA 94105

Refer to: MCD-SCG-SMC

JAN 24 2002

Dennis G. Rodriguez
Director
Department of Public Health and Social Services
P.O. Box 2816
Hagatña, Guam 96932

Dear Mr. Rodriguez:

Enclosed is an approved copy of State Plan Amendment (SPA) 02-002, effective October 1, 2001. This SPA revises Attachment 3.1A to add outpatient mental health services, mammography, and pelvic exams, and to make a technical correction adjust the EPSDT age limit to 21 years. This approval includes the material received by this office on January 14, 2002 and the pen-and-ink changes to the HCFA 179 agreed to by John Castro on January 15, 2002.

If you have any questions please call Sue Castleberry at (415) 744-3599.

Sincerely,

Linda Minamoto
Associate Regional Administrator
Division of Medicaid

Enclosures

cc: John Castro, Department of Public Health and Social Services
Mary Rydell, Pacific Area Representative, CMS Region IX
Elliot Weisman, CMS, CMSO, PCPG

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER:
0 2 - 0 0 2

2. STATE:
Guam

3. PROGRAM IDENTIFICATION - TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID): TITLE XIX Medicaid Assistance Program

4. PROPOSED EFFECTIVE DATE
October 01, 2001

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

5. TYPE OF PLAN MATERIAL (Check One):

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

COMPLETE BLOCKS 6 THRU 9 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

7. FEDERAL BUDGET IMPACT:
a. FFY 2002 \$ 5,880,000.00
b. FFY _____ \$ _____

8. NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Att.3.1A pp.5,6,13,15,25,25a,38,38a,38b,38c

9. NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):
Att.3.1A pp.5,6,13,15,25,38

10. SUBJECT OF AMENDMENT: To include Psychiatric services on an outpatient basis for individuals of any age; Screening Mammography; and Pelvic Examination as covered services under the program.

11. GOVERNOR'S REVIEW (Check One):

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

12. SIGNATURE OF STATE AGENCY OFFICIAL:


13. TYPED NAME:
CARL T.C. GUTIERREZ

14. TITLE:
GOVERNOR OF GUAM

15. DATE SUBMITTED:
11.21.01

16. RETURN TO: Bureau of Health Care Financing, Division of Public Welfare
Department of Public Health and Social Services
P.O. Box 2816, Hagatna, Guam 96932

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
November 30, 2001

18. DATE APPROVED:
January 24, 2002

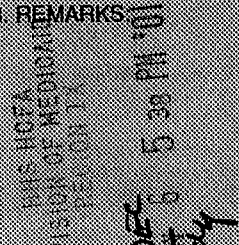
PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
October 1, 2001

20. SIGNATURE OF REGIONAL OFFICIAL:


21. TYPED NAME:
Linda Minamoto

22. TITLE:
Associate Regional Administrator

23. REMARKS:


AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed drugs.

Provided: No limitations With limitations*
 Not provided.

b. Dentures.

Provided: No limitations With limitations*
 Not provided.

c. Prosthetic devices.

Provided: No limitations With limitations*
 Not provided.

d. Eyeglasses.

Provided: No limitations With limitations*
 Not provided.

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

a. Diagnostic services.

Provided: No limitations With limitations*
 Not provided.

*Description provided on attachment.

TN No. _____
Supersedes _____
TN No. _____

Approval Date JAN 24 2002

Effective Date OCT 1 2001

HCFA ID: 0069P/0002P

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

b. Screening services.

Provided: No limitations With limitations*
 Not provided.

c. Preventive services.

Provided: No limitations With limitations*
 Not provided.

d. Rehabilitative services.

Provided: No limitations With limitations*
 Not provided.

14. Services for individuals age 65 or older in institutions for mental diseases.

a. Inpatient hospital services.

Provided: No limitations With limitations*
 Not provided.

b. Skilled nursing facility services.

Provided: No limitations With limitations*
 Not provided.

c. Intermediate care facility services.

Provided: No limitations With limitations*
 Not provided.

*Description provided on attachment.

TN No. _____
Supersedes
TN No. _____

Approval Date JAN 24 2002

Effective Date OCT 1 2001

4.b. Early Periodic Screening, Diagnosis and Treatment Services (EPSDT)

Early Periodic Screening, Diagnosis and Treatment services are screening and diagnostic services to determine physical or mental defects in recipients under age 21, and health care, treatment, and other measures to correct or ameliorate any defects and chronic conditions discovered.

A. Provider Eligibility Requirements

The following providers are authorized to provide Early Periodic Screening, Diagnosis and Treatment services:

1. All Medicaid approved practitioners, physicians, dentists, audiologists and optometrists.
2. Independent clinics and hospitals that have executed a signed agreement with the Medicaid Program.

B. Benefits Limitations

1. Covered Services
 - a. Early Periodic Screening, Diagnosis and

- g. Medical care as covered under the State Plan.
- h. Assistance with transportation to and from screening, diagnostic services and treatment.
- i. Assistance with making medical appointments.

2. Not Covered Services

Screening of persons twenty-one (21) years old and over.

4.c. Family Planning Services and Supplies for Individuals of Child-Bearing Age

Provided with no limitations.

5. Physician's Services

Physician's services includes those reasonable and medically necessary diagnostic or treatment services provided by or under the personal supervision of a physician and which are within the scope of practice of the physician's profession as defined by State Law. The services may be furnished in the office, the patient's home, a hospital, skilled nursing facility or elsewhere.

A. Provider Eligibility Requirements

A participating public or private practitioner meeting the following requirements:

1. Psychiatrist, Clinical Psychologist, or Individual, Marriage and Family Therapist certified and licensed by state or local Medical Licensure Law.
2. Approval for participation by the Guam Medicaid Program as a practitioner on psychiatric care services.

B. Benefit Limitations

1. Covered Services
 - a. Mental disorders and psychiatric services for individuals of any age on an outpatient basis for up to 20 sessions.

7. Home Health Services

A. Provider Eligibility Requirements

A participating Home Health Agency is a public or private agency or organization which meets the following requirements:

-25-

Approval Date: JAN 24 2002 Effective Date: OCT 1 2001

1. Certification as a Home Health Agency under Title XVIII Medicare Program.
2. Approval for participation as a Home Health services provider by the Guam Medicaid Program.

B. Benefit Limitations

1. Covered Services

- a. Nursing Care when ordered by and included in the attending physician's plan of treatment and provided by or under the direct supervision of a licensed nurse (Registered Nurse, Licensed Practical Nurse) on an intermittent or part-time basis.

-25a-
Approval Date: JAN 24 2002 Effective Date: OCT 1 2001

2. Not Covered Services

- a. Eyeglasses with correction of below plus or minus (+ or -) .50 diopters or 10 cylinder axis.
- b. Contact lenses.
- c. Sunglasses

13.a. Diagnostic Services

A. Benefit Limitations

1. Covered Services:

- a. Any "Diagnostic" medical procedures or supplies recommended by a licensed professional practitioner (physician, dentist, optometrist) within the scope of his practice under State Law to enable him to identify the existence, nature, or extent of illness, injury, or other health deviation in a recipient.

Performed only when deemed medically necessary. Documentation of diagnosis must be attached to the claims when billing Medicaid.

13.b. Screening Services

Not provided.

13.c. Preventive Services

A. Benefit Limitations

1. Covered Services

a. Pelvic Examination

Pelvic Examination means a preventive/screening examination, performed by a physician and associated laboratory test, furnished to a woman of childbearing age without signs or symptoms for the purpose of early detection of cervical cancer or other abnormalities and includes the physician's interpretation of the results of the procedure

The following limitations apply to coverage:

- 1) For female 16 years of age and above, one pelvic exam every 36 months;

-38 a-
Approval Date:

JAN 24 2002

Effective Date: OCT 1 2001

- 2) For female age 16 and over with a history and/or family history of cervical cancer, transmitted diseases and/or other high risk factors, pelvic examination may be provided more frequent than 36 months subject to justification from a physician.

Prior authorization is required. When billing Medicaid, a copy of the prior authorization must be attached to the claim.

b. Screening Mammography

Screening mammography means a radiologic procedure furnished to a woman without signs or symptoms of breast disease, for the purpose of early detection of breast cancer, and includes a physician's interpretation of the results of the procedure.

The following limitations apply to coverage:

- 1) The service must be, at a minimum, a two-view exposure (that is, a cranio-caudal and a medial lateral oblique view) of each breast.
- 2) For women 35-39 years of age, one baseline mammogram;
- 3) For women 40-49 years of age, one mammogram every two years;

-38b-

Approval Date:

JAN 24 2002

Effective Date: OCT 1 2001

- 4) For women 50 years of age or older, one mammogram every twelve months;
- 5) For women age 40 and over with a history and/or family history of breast cancer, one mammogram every twelve months.

Provider Eligibility Requirements: Supplier of screening mammography means a facility that is certified or holds a provisional certification by Medicare and/or Food and Drug Administration as described in 21 CFR sec. 900.11 and 12.

13.d. Rehabilitative Services

Not provided.

14. Services for Ages 65 or older for Mental Diseases

Not provided.

15. Intermediate Care Facility

Not provided.

16. Inpatient Psychiatric Facility Services

Not provided.

-38c-

Approval Date: JAN 24 2002

Effective Date: OCT 1 2001