

111-2-2-.11 Service-Specific Review Considerations Generally.

(1) The Department has adopted the following service-specific requirements and review considerations:

(a) Acute Care and Acute Care-Related Rules:

1. Short-Stay General Hospital Services, 111-2-2-.20;
2. Adult Cardiac Catheterization Services, 111-2-2-.21;
3. Open Heart Surgical Services, 111-2-2-.22;
4. Pediatric Cardiac Catheterization and Open Heart Services, 111-2-2-.23;
5. Perinatal Services, 111-2-2-.24;
6. Freestanding Birthing Center Services, 111-2-2-.25; and
7. Psychiatric and Substance Abuse Inpatient Services, 111-2-2-.26;

(b) Long-Term Care Rules:

1. Skilled Nursing and Intermediate Care Facility Services, 111-2-2-.30;
2. Personal Care Home Services, 111-2-2-.31;
3. Home Health Services, 111-2-2-.32;
4. Continuing Care Retirement Communities (“CCRC”), 111-2-2-.33;
5. Traumatic Brain Injury Services, 111-2-2-.34; and
6. Comprehensive Inpatient Physical Rehabilitation Services, 111-2-2-.35;

(c) Special and Other Health Services:

1. Ambulatory Surgical Services, 111-2-2-.40;
2. Positron Emission Tomography, 111-2-2-.41; and
3. Radiation Therapy Services, 111-2-2-.42.

(2) The review considerations and standards that are promulgated in service-specific rules are considerations and standards that apply to specific services in addition to the general considerations in 111-2-2-.09. Any conflict between the meaning or application of a service-specific requirement and the general considerations shall be interpreted in favor of the service-specific consideration, unless a general consideration specifically indicates that it supersedes any and all service-specific considerations.

(3) The meaning of words as they are defined in a particular service-specific rule only applies to that service-specific rule, unless a specific citation is made to another service-specific rule.

(4) Numerical Need Calculations.

(a) The numerical need calculations, which shall apply to an application for a clinical health service for which service-specific rules exist, shall be the calculated need in effect on the date the application is deemed complete for review less any subsequently approved units and services during the review period. This provision does not apply to batching reviews as the need applicable to batching decisions is the need stated in the batching notice.

(b) In the instance of joined projects where one project is reviewed as an exception based on utilization and the other is reviewed as need-based, the approval of the utilization exception shall not preclude an approval based on a numerical need projection should, prior to the approval of any of the joined projects, the numerical need projection indicates a need for the clinical health service.

(c) Approved projects that affect service-specific numerical need calculations shall be added to the Department's service-specific inventories and the numerical need projections shall be adjusted as of the approved date of the project.

(d) Approved projects that are reversed through administrative and/or judicial appeal final resolution shall be subtracted from the Department's service-specific inventories and the numerical need projections shall be adjusted as of the date of such final resolution.

(5) Service-specific component plans provide general background on specific considerations that were undertaken in developing service-specific rules. The service-specific rules shall supersede a component plan.

(6) If any provision of these service-specific rules, or the application thereof to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the particular service-specific rule in question or of the service-specific rules in general which can be given effect without the invalid provision or application, and to this end the provisions of these service-specific rules are severable.

(7) The commissioner shall be authorized, with the approval of the board, to place a temporary moratorium of up to six (6) months on the issuance of certificates of need for new and emerging health care services. Any such moratorium placed shall be for the purpose of promulgating service-specific rules and regulations regarding such new and emerging health care services. A moratorium may be extended one time for an additional three (3) months if circumstances warrant, as approved by the board. In the event that final service-specific rules and regulations are not promulgated within the time period allowed by the moratorium, any applications received by the department for a new and emerging health care service shall be reviewed under existing general statutes and regulations relating to certificates of need. Upon the identification by the Department of a new and emerging health care service as defined by 111-2-2-.01(38), and the request for and receipt of approval by the board of a moratorium as provided in this subsection, the Department shall publish notice of the moratorium and the identified service in a manner used in the normal course for other certificate of need information and announcements.

Authority O.C.G.A. Secs. 31-5A et seq., 31-6 et seq. **History.** Original Rule entitled “Service-Specific Review Considerations Generally” adopted. F. Dec. 16, 2004; eff. Jan. 5, 2005. **Amended:** F. Dec. 14, 2007; eff. Jan. 3, 2008. **Amended:** F. Sept. 11, 2008; eff. Oct. 1, 2008.