PROVIDER TYPE SPECIFIC PACKET/CHECKLIST

(Louisiana Medicaid Program)

Family Planning Clinic

(Enrollment packet is subject to change without notice.)

Family Planning Clinic

REQUIRED DOCUMENTS FOR ENROLLMENT

The following checklist shows all required documents that MUST be submitted to enroll with Fee For Service (FFS) Louisiana Medicaid. Please make certain to complete each required form in its entirety to avoid processing delays.

*Form is included in the **Basic Enrollment Packet for Entities/Businesses**.

**Forms are included here.

Completed		Document Name
☐	*	1. Entity/Business Louisiana Medicaid PE-50 Provider Enrollment Form.
☐	*	2. PE-50 Addendum – Provider Agreement Forms (three pages).
☐	*	3. Medicaid Direct Deposit (EFT) Authorization Agreement Form.
☐	*	4. Louisiana Medicaid Ownership Disclosure Information Forms.
☐	*	5. **(If submitting claims electronically)** Provider's Election to Employ Electronic Data Interchange of Claims for Processing in the Louisiana Medical Assistance Program (EDI Contract) Form **and** Power of Attorney Form (if applicable).
☐		6. Copy of voided check or letter from the bank on bank letterhead verifying the account and routing number for the account to which you wish to have your funds electronically deposited **(deposit slips are not accepted**).
☐		7. Copy of a pre-printed document received from the IRS showing both the employer identification number (EIN) and the official name as recorded on IRS records (**W-9 forms are not accepted**).
☐		8. Copy of Clinical Laboratory Improvements Amendment (CLIA) Certificate, if applicable.
☐	**	9. Clinic Certification / Professional Staff Listing Form.
☐		10. On **Section A** of the PE-50 Form, in the **Specialty Code** space write in **'97'** (Family Planning Clinic) and leave the **Subspecialty Code** space **'blank'**.
☐		11. On **Section D** of the PE-50 Form, in the **Provider Type Description** space write in '**Family Planning Clinic'** and in the **Provider Type Code** space write in '**71'.**

Original Signatures Required – Please Do NOT Use Black Ink

Please submit all required documentation to:

Gainwell Provider Enrollment Unit

PO Box 80159

Baton Rouge, LA 70898-0159

225-216-6370

Clinic Certification / Professional Staff Listing Form

I have read **the attached** Section 4320 of Chapter 4 from Publication #45, The State Medicaid Manual, published by the Centers for Medicare & Medicaid Services (CMS), and I can state that this agency meets the definition of "clinic" based on these guidelines.

List all Physicians, Physicians Assistants, and Nurse Practitioners that are affiliated with this clinic:

Provider Name	Professional Title (MD, PA, NP)	Provider Number

_____ _____

Clinic Name | Clinic Street Address, City, State, Zip

_____ _____

Print Name of Authorized Representative | Title

_____ _____

Signature of Authorized Representative | Date of Signature

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Publication #45, The State Medicaid Manual, Chapter 4, Section 4320:

4320. CLINIC SERVICES.

A. Background.--Section 1905(a) (9) of the Social Security Act authorizes under the term "medical assistance," payment for clinic services. As amended by the Deficit Reduction Act of 1984, section 1905(a)(9) describes clinic services as "services furnished by or under the direction of a physician without regard to whether the clinic itself is administered by a physician." The purpose of the 1984 amendment was to clarify that while clinic services have to be provided under the direction of a physician, the clinic does not have to be administered by a physician. This clarification was needed because the physician direction requirement, which has been a requirement for clinic services since the beginning of the Medicaid program, has been in certain cases interpreted erroneously to mean that clinic administrators had to be physicians.

Regulations at 42 CFR 440.90 define clinic services as preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services that--

1. are provided to outpatients;
2. are provided by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients; and
3. except in the case of nurse-midwife services, as specified in 440.165, are furnished by or under the direction of a physician or dentist.

B. Physician Direction Requirement.--Regulations at 42 CFR 440.90 limit coverage of clinic services to situations in which services are furnished under the direction of a physician. As stipulated by section 1905(a)(9) of title XIX of the Social Security Act, this requirement does not mean that the physician must necessarily be an employee of the clinic, or be utilized on a full time basis or be present in the facility during all the hours that services are provided. However, each patient's care must be under the supervision of a physician directly affiliated with the clinic. To meet this requirement, a physician must see the patient at least once, prescribe the type of care provided, and, if the services are not limited by the prescription, periodically review the need for continued care. Although the physician does not have to be on the premises when his/her patient is receiving covered services, the physician must assume professional responsibility for the services provided and assure that the services are medically appropriate. Thus, physicians, who are affiliated with the clinic, must spend as much time in the facility as is necessary to assure that patients are getting services in a safe and efficient manner in accordance with accepted standards of medical and dental practice. For a physician to be affiliated with a clinic, there must be a contractual agreement or some other type of formal arrangement between the physician and the facility by which the physician is obligated to supervise the care provided to the clinic's patients. Some clinics will require more physician involvement than one person can provide. The size of the clinic and the type of services it provides should be used to determine the number of physicians that must be affiliated with a clinic to meet the physician direction requirement. Also, each clinic must have a medical staff which is licensed by State law to provide the medical care delivered to its patients.

C. Coverage Options.--Clinic services, as defined by 42 CFR 440.90, do not include services provided by hospitals to outpatients. Outpatient hospital services, which are authorized by the regulations at 42 CFR 440.20, are separate and distinct from clinic services. As defined by the regulations, clinic services must be provided by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients. Thus, clinic services, in accordance with 42 CFR 440.90, must be provided by a freestanding facility, which means that the clinic may not be part of a hospital. However, a clinic may be located in the same building as a hospital, as long as there is no administrative, organizational, financial or other connection between the clinic and the hospital.

Clinic services are optional; States may or may not elect to cover these services under their Medicaid programs. There are different types of freestanding clinics that are organized and operated to provide medical care to outpatients, and different types of clinic services that are available. If a State elects to cover clinic services, it may choose the type of clinics or clinic services that are covered, provided that the services constitute medical or remedial care. Thus, a State may provide coverage for some but not all kinds of clinic services.

D. Provision of Clinic Services to Residents of SNFs, ICFs, AND ICFs/IID.--Clinic services are defined in part, at 42 CFR 440.90, as services that are provided to outpatients. At 42 CFR 440.2, an outpatient is defined as a patient who is receiving professional services at an organized medical facility, or distinct part of such a facility, neither of which is providing the patient with room and board and professional services on a continuous 24-hour-a-day basis.

The definition of outpatient does not exclude residents of title XIX long term care facilities from receiving clinic services either through an arrangement between the facility and the clinic or from a clinic which is chosen by the resident. However, because of the regulatory requirement that clinic services may be provided to outpatients only, the clinic from which they receive services may not provide them with room and board and professional services on a continuous 24-hour-a-day basis. Furthermore, because of the outpatient requirement, eligibility for clinic services is limited to those patients:

1. who for the purpose of receiving necessary health care go or are brought to a clinic, or other site at which the clinic staff is available; and

2. who the same day leave the site at which the services are provided.

Thus, this requirement precludes residents of skilled nursing facilities, intermediate care facilities and intermediate care facilities for the mentally retarded from receiving clinic services that are provided in the long-term care facility itself. Therefore, these services must be provided at a location which is not a part of the long-term care facility. While such services, if provided at the location of the facility, may not be covered as clinic services, they could be covered as long-term care services if included in the package of institutional services provided to the residents of the facility.

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