PROVIDER REQUIREMENTS

Location

A Rural Health Clinic (RHC) must be located in an area defined by the United States Department of Commerce, Census Bureau as non-urbanized. The Census Bureau defines a non-urbanized area as an area outside an urbanized area with a densely settled territory that contains 50,000 or more people.

Shortage Area Designation

A practice is eligible for initial RHC certification if it is located in an area "currently" designated as a Medically Underserved Area (MUA) or Health Professional Shortage Area (HPSA). The shortage area designation cannot be more than three (3) years old to be considered current.

In order for RHCs to be eligible for HPSA facility designation, the clinic shall:

1. Not deny requested health care services, and shall not discriminate in the provision of services to an individual who is unable to pay for services or whose services are paid by the Medicare, Medicaid, or Children's Health Insurance Program;

2. Prepare a schedule of fees consistent with locally prevailing rates or charges;

3. Prepare a corresponding schedule of discounts (including waivers) to be applied to such fees or payments, with adjustments made on the basis of the patient's ability to pay;

4. Make every reasonable effort to secure from patients the fees and payments for services, and fees should be sufficiently discounted in accordance with the established schedule of discounts;

5. Enter into agreements with the state Medicaid agency to ensure coverage of beneficiaries; and

6. Take reasonable and appropriate steps to collect all payments due for services.

Staffing

An RHC is required to employ a mid-level provider such as a nurse practitioner or physician assistant at least 50 percent of the time the practice is open to see patients. RHC primary care services are to be provided by licensed physicians, licensed physician assistants, nurse

practitioners, or nurse-midwives operating under the direct supervision of the RHC physician and within the scope of the physician extender's licensure or certification.

Direct supervision does not mean that the physician must be in the same room when services are rendered; however, the physician must be immediately available (at least by telephone) to provide direction or assistance when necessary.

Services of licensed clinical psychologists and clinical social workers are not required, but can be considered an RHC service when these personnel provide diagnosis and treatment of mental illness. These services must be included in the HPSA scope of service in order to receive reimbursement.

Commingling

Commingling refers to the sharing of RHC space, staff (employed or contracted), supplies, equipment, and/or other resources with an onsite Medicare Part B or Medicaid fee-for-service practice operated by the same RHC physician(s) and/or non-physician(s) practitioners. Commingling is prohibited in order to prevent the following:

1. Duplicate Medicare or Medicaid reimbursement (including situations where the RHC is unable to distinguish its actual costs from those that are reimbursed on a fee-for-service basis); or

2. Selectively choosing a higher or lower reimbursement rate for the services.

RHC practitioners may not furnish RHC-covered professional services as a Part B provider while in the RHC or in an area outside of the certified RHC space, such as a treatment room adjacent to the RHC, during RHC hours of operation.

If an RHC is located in the same building with another entity such as an unaffiliated medical practice, x-ray and lab facility, dental clinic, emergency room, etc., the RHC space must be clearly defined. If the RHC leases space to another entity, all costs associated with the leased space must be carved out of the cost report.

RHCs that share resources (e.g., waiting room, telephones, receptionist, etc.) with another entity must maintain accurate records to assure that all costs claimed for Medicare reimbursement are only for the RHC staff, space, or other resources. Any shared staff, space, or other resources must be allocated appropriately between RHC and non-RHC usage to avoid duplicate reimbursement.

This commingling policy does not prohibit a provider-based RHC from sharing its health care practitioners with the hospital emergency department in an emergency, or prohibit an RHC physician from providing on-call services for an emergency room, as long as the RHC would

continue to meet the RHC conditions for coverage even if the practitioner were absent from the facility. The RHC must be able to allocate appropriately the practitioner's salary between RHC and non-RHC time. It is expected that the sharing of the physician with the hospital emergency department would not be a common occurrence.

The fiscal intermediary has the authority to determine acceptable accounting methods for allocation of costs between the RHC and another entity. In some situations, the practitioner's employment agreement will provide a useful tool to help determine appropriate accounting.

Medicaid Enrollment Criteria

To be eligible for enrollment in the Louisiana Medicaid program, the RHC must be an entity:

1. Receiving certification for participation in the Medicare program;

2. Receiving licensure/certification from the Louisiana Department of Health, Health Standards Section; and

3. Complying with the Clinical Laboratory Improvement Amendment (CLIA) for all laboratory sites, if applicable.

The fiscal intermediary (FI) will verify CMS enrollment via the Provider Enrollment, Chain, and Ownership System (PECOS).

The RHC must provide to the fiscal intermediary's (FI's) provider enrollment unit a list of the names of all physicians and other practitioners who will be providing medical services at the center and include the practitioners':

1. National Provider Identifier (NPI); and

2. Assigned Medicaid provider number, if they are enrolled in Medicaid.

All enrollments of any practitioner in any Medicaid category of service, other than the RHC program, must be submitted to the FI's provider enrollment unit.

NOTE: The FI's provider enrollment unit must be notified immediately of any change in the above. Failure to maintain current information with the provider enrollment unit may result in a loss of reimbursement for services provided by those practitioners not identified as RHC staff.

All practitioners providing patient services must be enrolled with the fiscal intermediary's (FI) provider enrollment unit and be linked to the RHC at the time of enrollment in order for the facility to receive reimbursement.

NOTE: The effective date of enrollment shall not be prior to the date of receipt of a completed enrollment packet and the PECOS enrollment effective date.

Services

The RHC agrees to provide those primary care services typically included as part of a physician's medical practice. The RHC must provide, either directly or by referral, a full range of primary diagnostic and therapeutic services and supplies which include the following:

1. Medical history;

2. Physical examination;

3. Assessment of health status and treatment of a variety of conditions amendable to medical management on an ambulatory basis by a physician or a physician extender;

4. Evaluation and diagnostic services to include the following:

    a. Radiological services; and

    b. Laboratory and pathology services.

5. Services and supplies incident to a physician's or a physician extender's services such as:

    a. Pharmaceuticals; and

    b. Supplies.

In addition, an RHC can provide services related to the diagnosis and treatment of mental illness, and in certain instances, visiting nurse services.

Billing

The RHC agrees to bill its usual and customary charge for each RHC-related service using applicable diagnoses and procedure codes. RHC services must be billed using the RHC's NPI and

Medicaid provider number assigned to the specific RHC location and Tax Identification Number (TIN) of the specific RHC location where the services were provided and/or the rendering provider is based, as required by each health plan and/or the fiscal intermediary.

"Usual and customary" is defined as the fee charged to private paying patients for the same procedure during the same period of time. Records on both Medicaid eligible and private pay patients must be maintained for a minimum of five years in order to verify compliance with this policy. The RHC shall also furnish its authorized representative or contractual agents, with all information that may be requested regarding "usual and customary" fees.

The RHC must ensure that no staff or contract provider will seek separate reimbursement from Medicaid for specific services that are ordered and/or performed in the RHC and are billable under the RHC program. Laboratory, pathology, radiological and other services ordered by the RHC staff, but provided by an organization independent of the RHC, must be billed by the provider of the service and not the RHC.

Diabetes Self-Management Training

In order to receive Medicaid reimbursement for diabetes self-management training (DSMT) services, the RHC must have a DSMT program that meets the quality standards of one of the following accreditation organizations:

1. The American Diabetes Association;

2. The American Association of Diabetes Educators; or

3. The Indian Health Service.

All DSMT programs must adhere to the national standards for diabetes self-management education. Each member of the instructional team must:

1. Be a certified diabetes educator (CDE) certified by the National Certification Board for Diabetes Educators; or

2. Have recent didactic and experiential preparation in education and diabetes management.

At a minimum, the instructional team must consist of one of the following professionals who is a CDE:

1. A registered dietician;

2. A registered nurse; or

3. A pharmacist.

All members of the instructional team must obtain the nationally recommended annual continuing education hours for diabetes management.

Satellite Clinics

Satellite clinics must enter into a separate provider agreement from the parent center and obtain its own provider number for billing and reimbursement purposes.

Mobile Clinics

An RHC is prohibited from enrolling a mobile clinic in the Louisiana Medicaid program. Services rendered at the mobile clinic must be billed using the stationary clinic's provider number.

NOTE: All mobile clinics must be HRSA approved facilities.

Out of State RHCs in Trade Areas

An RHC located in the trade areas designated by the Department that wishes to enroll in the Louisiana Medicaid program, must meet the provider enrollment requirements of an RHC located in Louisiana and include a letter from the RHCs home state verifying its reimbursement rate.

Change in Ownership

When there is a change in ownership, Medicaid must be notified within 30 calendar days of the date of the RHC ownership change. The new owner is required to enter into a new provider agreement with the Louisiana Medicaid program. Failure to enter into a new provider agreement following a change in ownership will result in the clinic's termination as a Louisiana Medicaid provider.

Change of Address

RHCs are required to report address changes. Providers must complete a file update form to submit to Provider Enrollment along with documentation from HRSA of the address change.

Cost Reports

RHCs are required to file an annual cost report with appropriate addenda within five months of the clinic's fiscal year end. Failure to submit cost reports by the due date may result in Medicaid payments being suspended. (See Appendix A for contact information).

Medicare Certification

RHCs are required to submit proof on an annual basis of Medicare certification as a RHC. Failure to submit the annual certification may result in disenrollment or payments being suspended.