Utah Department of
Health & Human
Services

UTAH DEPARTMENT OF HEALTH & HUMAN SERVICES
DIVISION OF LICENSING & BACKGROUND CHECKS
OFFICE OF LICENSING

PO BOX 144103
SALT LAKE CITY, UT 84114-4103
(801) 273-2994
(800) 662-4157 toll free

INITIAL REQUIREMENTS FOR RURAL HEALTH CLINIC

LICENSING REQUIREMENTS

If the proposed health clinic is a free-standing entity, it is not required to be licensed, other than the business license required by the municipal authority.

If the proposed clinic is affiliated with a hospital, the initial step in the Medicare/Medicaid certification process is to obtain a license as a satellite of the hospital.

LICENSING DOCUMENTATION

Notice of Intent

Application

All information that is submitted on the application is official and can not be amended by Office of Licensing staff. If a change occurs, a new application must be submitted with the corrected information.

Fees

Please see "Fee Schedule" for a current listing of all applicable fees.

Business License

Please provide a copy of the facility's business license from the local municipality. If the local municipality will not issue a business license until the state has issued the license, please provide us with a copy of the business license application and a receipt showing the licensing application fees have been paid.

Construction

Your facility must be in compliance with the program requirements as defined in UAC R432-004 and R432-006.

Per UAC R432-004-14, prior to submitting documents for plan review, the facility licensee or designee shall schedule a conference with department representatives, the licensee's architect, and the licensee or his designee to outline the required plan review process. Please call Andrew Baxter at 801-273-2994 or toll free 1-800-662-4157 to schedule a meeting.

FEDERAL MEDICARE REQUIREMENTS

On December 13, 1977, President Carter signed into law Public Law 95-210 which provides for Medicare and Medicaid reimbursement to rural health clinics. To participate as a supplier of rural health clinic services, a clinic must be located in an area designated by the office of licensing of the Census as non-urbanized and by the Secretary of Health and Human Services as a shortage area, where a shortage of personal health services or a shortage of primary medical care manpower exists. If you have any questions about Public Law 95-210, you can access the website at http://www.consult-rha.com/.

Under the law, the clinic also must employ either a physician's assistant, a nurse practitioner or nurse midwife; must make arrangements with a physician for medical direction, guidance, and supervision; and must make arrangements with a Medicare certified hospital for referral and admission of patients by the clinic.

The Department of Health and Human Services has prepared regulations specifying the minimal health and safety standards rural health clinics must meet to qualify for reimbursement under this law. Your facility must be in compliance with the program requirements as defined in the Code of Federal Regulations. To assist you in determining that you are in compliance with the Federal Medicare conditions of participation, we have included the following copies on the enclosed CD. The State Operations Manual is periodically updated; these updates can be found at http://www.cms.hhs.gov/manuals/iom/list.asp:

1. Title 42 of the Code of Federal Regulation, Part 491, Certification of Certain Health Facilities;
2. State Operations Manual, Appendix G: Rural Health Clinics - Interpretative Guidelines;
3. State Operations Manual, Chapter 2, §2240-2249 - The Certification Process - Rural Health Clinics.
4. CMS-30 - Rural Health Clinic Survey Report

MEDICARE/MEDICAID DOCUMENTATION REQUIREMENTS

In order to process your Medicare certification request, documents 2 through 7 need to be returned to the Office of Licensing and Certification.

1. Medicare Health Care Provider/Supplier Enrollment Application - (CMS-855)

The Medicare Health Care Provider/Supplier Enrollment Application is processed directly through your Medicare Administrative Contractor (MAC). If you have any questions or would like to select a different MAC, you can access information regarding the enrollment process through the CMS's website at http://www.cms.hhs.gov/CMSForms.

The Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated the adoption of standard unique identifiers for health care providers. The purpose of these provisions is to improve the efficiency and effectiveness of the electronic transmission of health information. The Centers for Medicare & Medicaid Services (CMS) has developed the National Plan and Provider Enumeration System (NPPES) to assign these unique National Provider Identifiers (NPI). It is recommended that you apply for and receive an NPI before submitting your CMS-855 application. An application for an NPI may be submitted online or obtained at https://nppes.cms.hhs.gov or by calling 1-800-465-3203. For further information about the NPI, please access the website or call the customer service number listed above.

2. Request to Establish Eligibility (CMS-29)

In those instances where a central organization provides rural health services at more than one clinic site, each site will be considered a clinic and the location of the clinic site will determine its location eligibility (i.e., rural, shortage area) rather than the location of the central organization. A separate Request to Establish Eligibility CMS-29 to participate is required for each clinic site. Please contact this office if you require more than one CMS-29.

3. Health Insurance Benefits Agreement (CMS 1561):

On the second line of this form, after the term "Social Security Act", enter the entrepreneurial name of the enterprise, followed by the trade name (if different from the entrepreneurial name). The person signing the Health Insurance Benefits Agreement must be someone who has the authorization of the owners of the facility to enter into this agreement.

4. Operating Hours and Alternate Contact Number:

Many health care entities in the state do not operate 24 hours per day, or have business hours in which they are open each day of the week, or all hours of the day. Due to this fact, we are requesting that you please complete the enclosed form designating an alternate phone number where the administrator or owner can be reached, such as a cell or home phone number; and the operating hours of your facility by day of the week and hours of the day. This will assist us in contacting a responsible party in the event that we must make contact at times other than your normal business hours.

5. Policy and Procedure Manual:

The manual shall address the standards and requirements set forth in the Utah Administrative Code for the proposed health facility/ agency license requested and Title 42 Code of Federal Regulations. The licensing sections of your policy and procedure manual shall be reviewed at the time of your state licensing surveys. The deeming organization will review the federal regulation sections of your policy and procedure manual for completeness. Please provide a copy of your visitation policy and procedure to the office of licensing.

6. Assurance of Compliance (HHS 690) and Civil Rights Compliance and Checklist

Title VI of the Civil Rights Act of 1964 prohibits discrimination on grounds of race, color, or national origin in any program receiving federal financing assistance. Although your facility may already have been given assurance of compliance with civil rights requirements in connection with other Federal programs, you will need to complete the online Civil Rights clearance to remove any chance that your participation would be delayed on that account.

The Civil Rights clearance is completed online at https://ocrportal.hhs.gov/ocr/pgportal/. When you submit the packet online the packet will go directly into the OCR intake que and you will receive an e-mail from OCR stating you have completed the civil rights submission. You will need to submit a copy of the e-mail with confirmation number to the Office of Licensing. The Office of Licensing will submit the e-mail with your certification packet to CMS to complete the Civil Rights requirement.

7. Provider Based Designation Questionnaire

Effective October 1, 2002, the mandatory requirement for provider-based determinations under Section 413.65(b) has been replaced with voluntary attestation process. Providers are no longer required to apply for and receive a provider-based determination for their facilities prior to billing for services in those facilities that are provider-based. However, under Section 413.65(b)(3), a provider may choose to obtain a determination of provider-based status by submitting an attestation stating that the facility meets the relevant provider-based requirements. Providers who wish to obtain such a determination of provider-based status for their facilities after October 1, 2002 should do so through the self-attestation process.

Attached are:

42 CFR §413.65 - Requirements for a Determination that a Facility or an Organization Has Provider-Based Status.

Interim Provider-Based Status Attestation Statement.

While the attestation process is voluntary, we want to strongly encourage providers to complete the attestation statement.

GENERAL MEDICARE INFORMATION:

The appropriate official should sign the forms at this time to be assured the earliest possible effective date of participation.

When you have received an approval of the CMS-855, submitted all required documentation and are ready for survey, please call Mr. Kelly J. Criddle, CMS Certification Director, Office of Licensing at (801) 273-2994 or toll free 1-800-662-4157 to schedule an initial survey.

After the Office of Licensing has completed the initial survey and reviewed all documentation pertaining to your request for certification, the packet will be forwarded to the Centers for Medicare and Medicaid Services, Division of Health Standards and Quality, Denver Region VIII Office. They will review the documents, determine the effective date, and send you official notification that the certification has been approved. One copy of the Health Insurance Benefits Agreements will be returned to you along with the notification that your facility has been approved. **Until you have received such notification, Medicare certification is not official.**

MEDICAID REQUIREMENTS

The State Medicaid Agency accepts the Medicare certification as evidence that a provider meets the requirements to receive Medicaid funding. If you desire to participate as a Medicaid provider, you will need to complete the Medicaid Enrollment Application after you have completed the Medicare certification process. For information regarding the Medicaid enrollment process, please contact Medicaid Provider Enrollment, at (801) 538-6155 (press option 3 then option 4) or toll free at 1-800-662-9651. Email providerenroll@utah.gov

OTHER PROGRAM REQUIREMENTS -UTAH CLIA STATE AGENCY

In addition to the certification requirements enclosed with this letter, we also need to inform you of a Federal program established by the Congress to improve the quality and reliability of laboratory testing and to notify you of legal requirements that fall under the law. The Clinical Laboratory Improvement Amendments of 1988 (CLIA-88) requires all clinical laboratories to meet quality standards and to be certified by the U.S. Department of Health and Human Services. The law also requires that laboratories finance the administration and enforcement of this law for this purpose. Therefore it will be necessary for you to contact the Utah CLIA State Agency, 195 North 1950 West, Salt Lake City, UT 84116, telephone number 385-499-3872. Email: labimprovement@utah.gov Website: https://uphl.utah.gov/certifications/clinical-laboratory-certification/and request the CMS Form 116 in order for your laboratory to become registered in accordance with CLIA-88 requirements.