DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-12-25
Baltimore, Maryland 21244-1850

Center for Medicaid and State Operations/Survey and Certification Group

Ref: S&C-08-06

DATE: **December 7, 2007**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Revisions to State Operations Manual (SOM) Exhibits

Memorandum Summary

- The Centers for Medicare & Medicaid Services (CMS) has conducted a comprehensive review of the Exhibits to the State Operations Manual (SOM).
- As a result, a number of Exhibits have been added, deleted, or revised.

CMS continues to improve its support for Survey and Certification activities conducted by Regional Offices and State Survey Agencies through provision of Exhibits to the SOM. Exhibits include model language for official CMS correspondence and notices, official CMS forms; reporting formats and worksheets, and supplemental guides for instructions in the SOM Chapters and the Appendices. Some of the exhibits are also incorporated into the ASPEN systems that support survey and certification activities. As a result of comprehensive review by CMS of the Exhibits, the on-line SOM (i.e., Internet-only Manual, Pub. 100-07) is being revised as follows:

- Obsolete exhibits were deleted;
- Model language was updated and standardized;
- New Exhibits were added; and
- For all Exhibits which are forms, hyperlinks to the form on the CMS Web site were added.

We are also reviewing the ASPEN system to identify whether there are Exhibits captured in that system that need parallel updating.

Included in this memorandum is a list of all Exhibits indicating additions, deletions, and revisions for your advance notification, as well as advance copies of the new or revised exhibits. We expect the transmittal communicating the list of changes and the updated Exhibits section of the SOM to be published in the on-line manual in the near future. The on-line version of the SOM Exhibits may be accessed at:
http://www.cms.hhs.gov/manuals/downloads/som107c09_exhibitstoc.pdf

If you have further questions regarding SOM Exhibits, please contact JoAnn Perry at 410-786-3336 or at JoAnn.Perry@cms.hhs.gov

/s/
Thomas E. Hamilton

cc: Regional Office Survey and Certification Management

Attachments

CMS Manual System

Pub. 100-07 State Operations Provider Certification

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal **Date:**

SUBJECT: Revisions, deletions, and changes to the SOM Exhibits.

I. SUMMARY OF CHANGES: The current exhibits are being deleted or revised with updated information which affects the following providers: Psychiatric Hospitals, Rehabilitation/Outpatient (OT/PT), End Stage Renal Disease (ESRD), Home Health Agencies (HHA), Organ Procurement Organization (OPO), Critical Access Hospital (CAH), Swing-Bed Hospitals, Emergency Medical Treatment and Labor Act (EMTALA), Physical Therapist (PT), Out-Patient Occupational Therapist (OOT), Out-Patient Physical Therapy/Out-Patient Speech Pathology (OPT/OSP), Life Safety Code (LSC), Skilled Nursing Facilities, and Budget.

NEW/REVISED MATERIAL - EFFECTIVE DATE*:
IMPLEMENTATION DATE:

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (*N/A if manual not updated.*)
(R = REVISED, N = NEW, D = DELETED) – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
D	Exhibit 1B-2/ Model Letter Transmitting CLIA Application and CMS-1513 to Laboratories
D	Exhibit 1B-3/ Initial Forms Required by Laboratories for CLIA Registration
D	Exhibit 1F/ Model Letter Transmitting Title XVIII Materials to Individual Requesting to Participate as a Physical Therapist in Independent Practice
D	Exhibit 3/ Expression of Intermediary Preference
D	Exhibit 10/ Certification and Transmittal Spell of Illness Supplement, CMS-1539A
D	Exhibit 14A/ Hospital Survey Report Crucial Data Extract
D	Exhibit 14B/ Fire Safety Survey Report – Crucial Data Extract, CMS-2786E
R	Exhibit 14C/ Skilled Nursing Facility and Intermediate Care Facility Crucial Data Extract, CMS-519E
R	Exhibit 14H/ Outpatient Physical Therapy Survey Report – Crucial Data

	Extract, CMS-1893E
R	Exhibit 14I/ ESRD Facility Survey Report Crucial Data Extract CMS-3427E
R	Exhibit 14J/ Rural Health Clinic Survey Report – Crucial Data Extract, CMS-30E
R	Exhibit 14K/ Intermediate Care Facility – Mentally Retarded Survey Report – Crucial Data Extract, CMS 3070B(E)
R	Exhibit 14L/ Ambulatory Surgical Center Report
R	Exhibit 14M/ Therapist in Independent Practice – Crucial Data Extract, CMS-3042E
R	Exhibit 14O/ Hospice Survey Report – Crucial Data Extract, CMS-449E
N	Exhibit 16/ An Important Message from Medicare About your Rights
D	Exhibit 24/ Model Letter To Ineligible Physical Therapist Requesting to Participate as a Physical Therapist in Independent Practice
D	Exhibit 32/ Model Letter Explaining to Provider that One-Story Protected Wood Frame Facility Does Not Meet Sprinkler Equivalency Standard
D	Exhibit 36/ Instruction for Completing Hospital Request for Certification in the Medicare/Medicaid Program, CMS-1514 (Contains Authorization Statement for AOA and Joint Commission Hospitals)
R	Exhibit 37/ Model Letter Announcing Validation Survey of Accredited Hospital
D	Exhibit 38/ Model Form for Certification of Chiropractors Where Requirements Prior to July 1, 1974 Apply
D	Exhibit 39/ Model Form for Certification of Chiropractors Where Requirements after June 30, 1974 Apply
R	Exhibit 42/ Orientation & Basic Training Program for the Newly Employed Health Facility Surveyor
R	Exhibit 45/ State Agency Budget Expenditure Report, CMS 435
R	Exhibit 47/ State Agency Budget List of Positions, CMS-1465A
R	Exhibit 52/ State Survey Agency Certification Workload Report, CMS-434
R	Exhibit 54/ State Agency Schedule for Equipment Purchases, CMS-1466
R	Exhibit 58/ Example of Regular Disallowance Letter
R	Exhibit 59/ Example of Deferral Letter
R	Exhibit 60/ Example of Disallowance Letter For Amounts Previously Deferred
R	Exhibit 63/ List of Documents in Certification Packets (Initial Certifications Include Initial Denials)
D	Exhibit 69/ Certification Recommendation – CLIA Laboratory, CMS-197
D	Exhibit 71/ Fire Safety Survey Report – Short Form, CMS 2786C
R	Exhibit 74/ Survey Team Composition and Workload Report, CMS-670
D	Exhibit 79/ Model Letter to Individuals Requesting Participation in Medicare as Occupational Therapists in Independent Practices
R	Exhibit 81/ Model Letter Requirement For Swing-Bed Approval in Hospitals
R	Exhibit 82/ Model Letter Approval Notification for Swing-Beds in a Hospital
R	Exhibit 83/ Model Letter Denial for Swing-Bed Approval in a Hospital
D	Exhibit 83B/ Model Letter – Denial For Swing-Bed Approval in a Hospital
D	Exhibit 84/ESRD Facility Survey Report Form – Addendum CMS-3427A

D	Exhibit 96/ OSCAR Report 3 (History Facility Profile) and OSCAR Report 4 (Full Facility Profile)
D	Exhibit 105/ State Test Administration Plan
D	Exhibit 107/ Request for Validation Survey of Laboratory, CMS-2802A
D	Exhibit 108/ Laboratory Authorization Form
D	Exhibit 110/ Compliance Warning Letter – Failure to Apply for Certificate
D	Exhibit 111/ Model Letter Notifying Laboratory of Cited Deficiencies and Requesting a Plan of Correction
D	Exhibit 112/ Model Letter – CLIA Requirements Not Met – Laboratory Out of Compliance
D	Exhibit 113/ Model Letter – CLIA Requirements Not Met – Immediate Jeopardy
D	Exhibit 114/ Model Letter Warning CLIA Laboratory of Possible Sanction – Failure to Disclose Financial Interest and Ownership Information
D	Exhibit 115/ Model Letter – Change of Ownership – Laboratories
R	Exhibit 116/ Budget Request, Clinical Laboratory Improvement Amendments Program – CMS-102
R	Exhibit 117/ 1465A – State Agency Budget List of Positions for CLIA Program
R	Exhibit 118/ 1466 – CLIA Program State Agency Schedule for Equipment Purchases
R	Exhibit 119/ Planned Workload Report, Clinical Laboratory Improvement Amendments Program, CMS-105
D	Exhibit 120/ Standard Form 1199A, Direct Deposit Sign-Up Form
D	Exhibit 121/ Payment Management System, SMARTLINK II, User's Manual
R	Exhibit 122/ OMB Circular No. A-102, Subject: Uniform Administrative Requirements for Grant-In-Aid to State and Local Governments
D	Exhibit 123/ Blood Bank Inspection Checklist and Report, CMS 282 (Form FDA 2609)
D	Exhibit 124/ Laboratory Personnel Report, CMS-114
R	Exhibit 126/ Model Letter Accompanying Self-Attestation Work Sheets
R	Exhibit 134/ Model Letter Transmitting Requirements to a Hospital Requesting a Change in Status to a Critical Access Hospital (CAH)
R	Exhibit 135/ Model Letter Transmitting Swing-Bed Approval Notification in a Critical Access Hospital (CAH)
R	Exhibit 138/ EMTALA Physician Review Worksheet
R	Exhibit 149/ Model Letter Critical Access Hospital (CAH) Denial for Medicare Participation
R	Exhibit 150/ Model Letter Critical Access Hospital (CAH) Approval Notification
R	Exhibit 151/ Model Letter Request for a Plan of Correction Following an Initial Critical Access Hospital (CAH) Survey
R	Exhibit 152/ Model Letter Critical Access Hospital (CAH) Termination Letter
D	Exhibit 159/ List of VA Hospitals having Sharing Arrangements with Participating ESRD Hospitals
R	Exhibit 161/ Notice of Interim Approval of CAPD Services

R	Exhibit 162/ Model Letter Request for a Plan of Correction Following an Initial Survey for Swing-Bed Approval in a Hospital
R	Exhibit 163/ Model Letter Termination Letter for Hospital Swing-Bed Services
D	Exhibit 164/ RO Adjudication of Sa Certification Actions
R	Exhibit 167/ CMS-576, 576A Organ Procurement Organization Application and Agreement
R	Exhibit 169/ United Network for Organ Sharing Members
R	Exhibit 172/ Model Letter: Organ Procurement Organization Approval
D	Exhibit 178/ Federally Qualified Health Center Crucial Data Extract
R	Exhibit 180/ Notice to Accredited Psychiatric Hospital of Involuntary Termination
R	Exhibit 181/ Notice to Hospital Provider of Involuntary Termination
R	Exhibit 183/ Model Public Notice of Medicare Termination of Hospital Provider Agreement
D	Exhibit 184/ Advertising Order, SF-1143, and Public Voucher for Advertising, SF-1144
D	Exhibit 186/ Sample Memorandum Disallow Claims for Federal Payments (Used In Look-Behind Disapprovals)
D	Exhibit 193/ Model Letter Informing PPS-Excluded Hospital/Units That Re-verification Has Been Approved
R	Exhibit 195/ Model Notice Announcing to an Accredited Hospital that the Hospital does not comply with all the Conditions of Participation and that there is Immediate or Serious Threat to Patient Health and Safety
R	Exhibit 196/ Model Letter Announcing to Accredited Hospital after a Sample Validation Survey that the Hospital Does not comply with All Conditions of Participation
R	Exhibit 199/ Model Letter Announcing to Accredited Hospital After a Substantial Allegation Survey that the Hospital Does Not Comply With all Conditions of Participation
R	Exhibit 200/ Model Letter Acknowledging Complaint Alleging Noncompliance with 42 CFR 489.24 and/or the Related Requirements of 42 CFR 489.20 Investigation not warranted
R	Exhibit 201/ Model Letter Acknowledging Complaint Alleging Noncompliance with 42 CFR 489.24 and/or the Related Requirements of 42 CFR 489.20 Investigation warranted
R	Exhibit 202/ Model Letter Requesting QIO Review of a Possible Violation of 42 CFR 489.24
R	Exhibit 203/ Model Letter Following Investigation Into Alleged Violation of 42 CFR 489.24 And/Or the Related Requirements of 42 CFR 489.20 Facility In Compliance
R	Exhibit 204/ Model Letter for Violation of 42 CFR 489.24: Preliminary Determination Letter (Immediate and Serious Threat)
R	Exhibit 205/ Model Letter for Violation of 42 CFR 489.24 And/Or The Related Requirements of 42 CFR 489.20; Preliminary Determination Letter (90 Day Termination Track)
R	Exhibit 206/ Model Letter to Complaint Following Investigation of Alleged

	Violation of 42 CFR 489.24 And/Or The Related Requirement of 42 CFR 489.20 Complaint Not Substantiated.
R	Exhibit 207/ Model Letter To Complainant Following Investigation of Alleged Violation of 42 CFR 489.24 And/Or The Related Requirements of 42 CFR 489.20 Complaint Substantiated.
R	Exhibit 208/ Model Letter for Referring a Violation of 42 CFR 489.24 to The Office of Inspector General
R	Exhibit 209/ Model Letter for Referring Violation of 42 CFR 489.24 to the Regional Office for Civil Rights
R	Exhibit 210/ Model Letter for Past Violation of 42 CFR 489.24 And/Or the Related Requirements of 42 CFR 489.20: No Termination
R	Exhibit 211/ Model Letter for Violation of 42 CFR 489.24 And/Or The Related Provisions of 42 CFR 489.20 Notice of Termination
R	Exhibit 212/ Model Letter Requesting QIO Review of A Confirmed Violation of 42 CFR 489.24 For Purpose of Assessing Civil Monetary Penalties (CMPs) Or Excluding Physicians
D	Exhibit 213/ State Test Administration Plan
D	Exhibit 215/ Notification to Provider/Supplier Warning of Possible Termination –Failure to Disclose Financial Interest and Ownership Information
R	Exhibit 216/ Report on Initial Survey Activity
R	Exhibit 217/ Aging Report on Pending Initial Survey Activity
D	Exhibit 218/ Prerelease Notification Document
R	Exhibit 222/Audit Clearance Document
D	Exhibit 226/ Accredited Laboratory Allegation(s) Report, CMS-2878A
D	Exhibit 233 Fraud and Abuse – Office of Inspector General, Office of Investigations Field Officer
D	Exhibit 234/ CLIA Notice of Noncompliance and Proposed Alternative Sanction(s) – No Immediate Jeopardy
D	Exhibit 235/ Notice of Suspension or Limitation of the CLIA Certification – Immediate Jeopardy
D	Exhibit 236 Notice of Imposition of Sanction(s): Acknowledgement of Information Received
D	Exhibit 239/ Clinical Laboratory Improvement Amendments (CLIA) Alternate Quality Assessment Survey, CMS-667
D	Exhibit 240/ Notice of Proposed Limitation of the CLIA Certification and Suspension of Medicare Payments When a Laboratory Has Failed to Participate Successfully in a Proficiency Testing Program
D	Exhibit 245/ CLIA Adverse Action Extract, CMS-462A/B
D	Exhibit 246/ Model Letter: Regional Office Notifying a State Operated Laboratory of Cited Deficiencies and Requesting a Plan of Correction
D	Exhibit 247/ Notice of (Limitation or) Revocation of a Laboratory's CLIA Certificate – No Immediate Jeopardy
D	Exhibit 248/ Notice of Proposed Limitation, Suspension, or Revocation of the CLIA Certificate; Opportunity for a Hearing – No Immediate Jeopardy
R	Exhibit 249/ Model Application Letter Notifying Transplant Hospital That a Complete Medicare General Enrollment Health Care Form CMS 855-A Needs

	to be Completed
R	Exhibit 250/ Model Application Letter to Transplant Hospital Requiring Partial Medicare General Enrollment Health Care Form CMS-855A
R	Exhibit 251/Model Letter for First Rejection of a Request for Medicare Approval of One or More Organ Transplant Programs
R	Exhibit 252/ Model Reminder Letter for First Rejection of a Request for Medicare Approval of One or More Organ Transplant Programs
N	Exhibit 253/ Organ Transplant Hospital Worksheet
R	Exhibit 286/ Hospital/CAH Medicare Data Base Worksheet
R	Exhibit 287/ Authorization by Deemed Provider/Supplier Selected for Accreditation Organization Validation Survey
R	Exhibit 289/ Model Reciprocal Agreement Between States for Survey and Certification of HHA and/or Hospice Surveys
N	Exhibit 290/ Model letter to HHAs Assigning Branch Identification Numbers
N	Exhibit 291/ Model Notice to Hospital/CAH of Collection of Data by the State Agency

III. FUNDING: Medicare contractors shall implement these instruction within their current operating budgets.

IV. ATTACHMENTS:

	Business Requirements
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

***Unless otherwise specified, the effective date is the date of service.**

Medicare State Operations Manual
Chapter 9 – Exhibits

Refer to the CMS Manuals Website for the updated version of this table of contents

Exhibits

Exhibit	Description
1A	Model Letter Transmitting Materials to Providers
1B-1	Model Letter Transmitting CLIA Application and CMS-855 to Laboratories
1B-2 delete	*Model Letter Transmitting CLIA Application and CMS-1513 to Laboratories*
1B-3 delete	*Initial Forms Required by Laboratories for CLIA Registration*
1C	Model Letter Transmitting Forms to Persons Furnishing Portable X-Ray Services
1D	Model Letter Transmitting Materials to Rural Health Clinics
1E	Model Letter to Operational ESRD Facility Requesting Initial Approval
1F delete	*Model Letter Transmitting Title XVIII Materials to Individual Requesting to Participate as a Physical Therapist in Independent Practice*
2	Assurance of Compliance with the Department of Health and Human Services Regulations Under Title VI of the Civil Rights Act of 1964, HHS-441
3 delete	*Expression of Intermediary Preference*
4	Health Insurance Benefits Agreement, CMS-1561
4B	Health Insurance Benefits Agreement, CMS-1561A (Rural Health Clinics)
5 Deleted	Statement of Financial Solvency, CMS-2572
6 Deleted	Ownership and Control Interest Disclosure Statement, CMS-1513
6 Deleted	Errata Sheet to Ownership and Control Interest Disclosure Statement, CMS-1513
7	Statement of Deficiencies and Plan of Correction, CMS-2567
7A	Principles of Documentation
8	Post-Certification Revisit Report, CMS-2567B
9	Medicare/Medicaid Certification and Transmittal, CMS-1539

10 delete	*Certification and Transmittal Spell of Illness Supplement, CMS-1539A*
12	Survey Report Form (CLIA), CMS-1557
14A delete	*Hospital Survey Report - Crucial Data Extract, CMS-1537E*
*14B d*elete	*Fire Safety Survey Report - Crucial Data Extract, CMS-2786E*
14C Located in Aspen	*Skilled Nursing Facility and Intermediate Care Facility Crucial Data Extract, CMS-519E*
14D Deleted	Home Health Agency Survey and Deficiencies Report, CMS-1572
14H Located in Aspen	*Outpatient Physical Therapy Survey Report - Crucial Data Extract, CMS-1893E*
14I	*ESRD Facility Survey Report- Crucial Data Extract, CMS-3427E*
14J Located in Aspen	*Rural Health Clinic Survey Report - Crucial Data Extract, CMS-30E*
14K Located in Aspen	*Intermediate Care Facility - Mentally Retarded Survey Report-Crucial Data Extract, CMS-3070B(E)*
14 Located in Aspen	*Ambulatory Surgical Center Report - Crucial Data Extract, CMS-378E*
14M Located in Aspen	*Therapist in Independent Practice - Crucial Data Extract, CMS-3042E*
14O Located in Aspen	*Hospice Survey Report - Crucial Data Extract, CMS-449E*
15	Regional Office Request for Additional Information, CMS-1666
16	An Important Message from Medicare About Your Rights
21	Request For Certification in the Medicare and/or Medicaid Program to Provide Outpatient Physical Therapy and/or Speech Pathology Services, CMS-1856
22	Guidance to Distinquish Between the Priorities of Immediate Jeopardy and Non-Immediate Jeopardy-High in Nursing Home Allegations
23	ACTS Required Fields
24 delete	*Model Letter to Ineligible Physical Therapists Requesting to Participate as a Physical Therapist in Independent Practice*
25	Model Letter to Rural Health Clinic Regarding Scheduling a Survey
26	Model Letter to Rural Health Clinic Ineligible to Participate
27	Model Letter to Previously Approved Facility Requesting Approval to Expand or Add a New ESRD Service
30	Model Letter to Facility Returning Application not Accompanied by Required Certificate of Need

31	End Stage Renal Disease Survey Report and Deficiencies Report, CMS-3427
32 delete	*Model Letter Explaining to Provider That One-Story Protected Wood Frame Facility Does Not Meet Sprinkler Equivalency Standard*
33	Request for Validation of Accreditation Survey, CMS-2802
35	Survey Material (Attachment for Model Letters, Exhibits 37, Listing Documents Requested for Validation Surveyor's Inspection)
36 delete	*Instructions for Completing Hospital Request for Certification in the Medicare/Medicaid Program, CMS-1514 (Contains Authorization Statement for AOA and Joint Commission Hospitals)*
37	*Model Letter Announcing Validation Survey of Accredited Hospital*
38 delete	*Model Form for Certification of Chiropractors Where Requirements Prior to July 1, 1974 Apply*
39 delete	*Model Form for Certification of Chiropractors Where Requirements After June 30, 1974 Apply*
41	State Agency's Letter to Medicare SNF Seeking Readmission After Involuntary Termination
42	*Orientation & Basic Training Program for the Newly Employed Health Facility Surveyor*
45	*State Agency Budget Expenditure Report, CMS-435*
47	*State Agency Budget List of Positions, CMS-1465A*
52	*State Survey Agency Certification Workload Report, CMS-434*
54	*State Agency Schedule for Equipment Purchases, CMS-1466*
56	Identification of Extension Units of OPT/OSP Providers, CMS-381
57	Model Letter Requesting Identification of Extension Units
58	*Example of a Regular Disallowance Letter*
59	*Example of a Deferral Letter*
60	*Example of a Disallowance Letter for Amounts Previously Deferred*
61	Example of an Audit Disallowance Letter

62 Deleted	Model Letter - State Agency Advising a Provider or Supplier of an Impending Federal
63	*List of Documents in Certification Packets (Initial Certifications Include Initial Denials)*
64	Ambulatory Surgical Center Request for Certification in the Medicare Program, CMS-377
65	Health Insurance Benefits Agreement, CMS-370
69 delete	*Certification Recommendation - CLIA Laboratory, CMS-197*
71 d*elete*	*Fire Safety Survey Report - Short Form, CMS-2786C*
72	Hospice Request for Certification in the Medicare Program, CMS-417
73	State Agency Worksheets for Verifying Exclusions from the Prospective Payment System, CMS-437
74	*Survey Team Composition and Workload Report, CMS-670*
75	Medicare/Medicaid Complaint Form, CMS-562
76	Model Letter to Clinics, Rehabilitation Agencies and Public Health Agencies Initially Applying to Serve as Providers of Outpatient Occupational Therapy Services
77	Model Letter to Approved Medicare Clinics, Rehabilitation Agencies and Public Health Agencies that Request to Add Outpatient Occupational Therapy Services
79 delete	*Model Letter to Individuals Requesting Participation in Medicare as Occupational Therapists in Independent Practices*
80	Intermediate Care Facility for the Mentally Retarded Survey Report, Form CMS-3070G
81	*Model Letter Transmitting Requirements to a Hospital Requesting Swing-Bed Approval*
82	*Model Letter Approval Notification for Swing-Beds in a Hospital*
83	*Model Letter Denial for Swing-Bed Approval In A Hospital*
83B delete	*Model Letter - Denial For Swing-Bed Approval In A Hospital*
84 d*elete*	*ESRD Facility Survey Report Form - Addendum, CMS-3427A*
85	Long Term Care Facility Application for Medicare and Medicaid, CMS-671
87	Extended/Partial Extended Survey Worksheet, CMS-673
88	Medication Pass Worksheet, CMS-677
89	Offsite Survey Preparation Worksheet, CMS-801
91	General Observations of the Facility, CMS-803
92	Kitchen/Food Service Observation, CMS-804

93	Resident Review Worksheet, CMS-805
94	Quality of Life Assessment, CMS-806 A, B, and C
95	Surveyor Notes Worksheet, CMS-807
96 delete	*OSCAR Report 3 (History Facility Profile) and OSCAR Report 4 (Full Facility Profile)*
103	Instructions for the Home Health Functional Assessment Instrument
104	Consent For Home Visit, CMS-36
105 delete	*State Test Administration Plan*
106	Laboratory Personnel Report (CLIA), CMS-209
107 delete	*Request for Validation Survey of Laboratory, CMS-2802A*
108 delete	*Laboratory Authorization Form*
110 delete	*Compliance Warning Letter - Failure to Apply for Certificate*
111 delete	*Model Letter Notifying Laboratory of Cited Deficiencies and Requesting a Plan of Correction*
112 delete	*Model Letter - CLIA Requirements Not Met - Laboratory Out of Compliance*
113 delete	*Model Letter - CLIA Requirements Not Met - Immediate Jeopardy*
114 delete	*Model Letter Warning CLIA Laboratory of Possible Sanction - Failure to Disclose Financial Interest and Ownership Information*
115 delete	*Model Letter - Change of Ownership - Laboratories*
116	Budget Requests, Clinical Laboratory Improvement Amendments Program - CMS-102
117	*1465A - State Agency Budget List of Position for CLIA Program*
118	*1466 – CLIA Program State Agency Schedule for Equipment Purchases*
119	*Planned Workload Report, Clinical Laboratory Improvement Amendments Program, CMS-105*
120 delete	*Standard Form 1199A, Direct Deposit Sign-Up Form*
121 delete	*Payment Management System, SMARTLINK II, User's Manual*
122	*OMB Circular No. A-102, Subject: Uniform Administrative Requirements for Grant-In-Aid to State and Local Governments*
123 delete	*Blood Bank Inspection Checklist and Report, CMS-282 (Form FDA 2609)*
124 delete	*Laboratory Personnel Report, CMS-114*
125	Clinical Laboratory Application, CMS-116

126	*Model Letter Accompanying Self-Attestation Worksheets*
127	Attestation Statement for Exclusion from PPS
128	Model Consent for Hospice Home Visit
129	Hospice Survey and Deficiencies Report, CMS-643
130	Model Letter to Entity Seeking Participation in Medicare as a Community Mental Health Center (CMHC) Providing Partial Hospitalization Services
131	Community Mental Health Center Crucial Data Extract
132	Public Health Service Act-Section 1916(c)(4)
133	Health Insurance Benefit Agreement
134	*Model Letter Transmitting Requirements to a Hospital Requesting a Change in Status to a Critical Access Hospital (CAH)*
135	*Model Letter Critical Access Hospital Swing-Bed Approval Notification*
136	Request for Survey of 42 CFR §489.20 and 42 CFR §489.24, Essentials of Provider Agreements: Responsibilities of Medicare Participating Hospitals in Emergency Cases, CMS-1541A
137	Responsibilities of Medicare Participating Hospitals in Emergency Cases Investigation Report, CMS-1541B
138	*EMTALA Physician Review Worksheet*
139	Model Letter to Provider (Send with Form CMS-2567)(Immediate Jeopardy Does Not Exit)
140	Model Letter Notifying Provider of Acceptance of Allegation of Compliance
141	Model Letter Notifying Provider of Results of Revisit
142	Model Letter to Provider (Imposition of Remedies) (Immediate Jeopardy Does Not Exist)
143	Model Letter to Provider (Imposition of Remedies)
144	Notice of Imposition of a Civil Money Penalty (Insert to formal notice)
145	Notification of Change in the Amount of the Civil Money Penalty
146	Notice of Receipt of the Written Request of Waiver of Right to a Hearing
147	Notice of Payment Amount Due and Payable
148	Notification of Deduction of Civil Money Penalty from Money Owing to the Provider
149	*Critical Access Hospital (CAH) Denial for Medicare Participation*
150	*Critical Access Hospital (CAH) Approval Notification*

151	Request *For A Plan of Correction Following an Initial Critical Access Hospital (CAH) Survey*
152	*Critical Access Hospital (CAH) Termination Letter*
153 Deleted	Notice of Technical Denial - Certificate of Need Denied
154	Notice of Initial Approval of End - State Renal Disease (ESRD) Facility
155	End-Stage Renal Disease (ESRD) Denial Notice
156	Provider Tie-In Notice, CMS-2007
157	Notice - Expansion and/or Additional Service (Approval, Partial Approval or Denial) of ESRD Facility
158	Notice - Recertification of ESRD Facility
159 Delete	*List of VA Hospitals Having Sharing Arrangements with Participating ESRD Hospitals*
160	Notice to ESRD Facility - Alternative Sanction for failure to participate with Network Goals and Objectives
161	*Notice of Interim Approval of CAPD Services*
162	*Model Letter Request for a Plan of Correction Following an Initial Survey for Swing-Bed Approval in a Hospital*
163	*Model Letter Termination Letter for Hospital Swing-Bed Services*
164 Delete	*RO Adjudication of SA Certification Actions*
165	Notice to a Provider that Agreement Was Accepted
166	Notice of Approval of Supplier of Services
167	*CMS-576, CMS-576A, Organ Procurement Organization Application and Agreement*
168	Organ Procurement Organization Report Form
169	United Network for Organ Sharing Members
170	Model Letter A: Organ Procurement Organization Denial - Failure to Meet Requirements
171	Model Letter B: Organ Procurement Organization Denial - Competing Applications
172	*Model Letter: Organ Procurement Organization Approval*
173	Model Letter: Organ Procurement Organization Notice of Termination
174	Model Letter: Organ Procurement Organization Notice to Public and State Medicaid/Medicare Agencies
175	Model Letter: Organ Procurement Organization Notice to

	Bordering OPOs
176	Model Letter: Organ Procurement Organization Corrective Action Notice
177	Attestation Statement for Federally Qualified Health Centers
178 delete	*Federally Qualified Health Center Crucial Data Extract*
179 Deleted	Model Letter to Applicants for Participation in Medicare as a Federally Qualified Health Center
180	*Notice to Accredited Psychiatric Hospital of Involuntary Termination*
181	*Notice to Hospital Provider of Involuntary Termination*
182	Notice of Termination to Supplier
183	*Model Public Notice of Medicare Termination of Hospital Provider Agreement*
184 delete	*Advertising Order, SF-1143, and Public Voucher for Advertising, SF-1144*
185	Model Telegram-Notice of Termination to a Medicaid ICF/MR Following "Look Behind" Survey: Immediate and Serious Threat to Patient Health and Safety
186 delete	*Sample Memorandum Disallowance Claims for Federal Payments, (Used in Look-Behind Disapprovals)*
187	Notification to Previously Approved Supplier of a Pending Termination
188	Notification: Voluntary Termination of Provider Agreement Approved
189	Notification: Approval of Voluntary Termination of a Supplier
190	Notification to Provider That Has Ceased or Is Ceasing Operations
191	Notification to Supplier That Has Ceased or is Ceasing Operations
192	Acknowledgment of Request for Hearing
193 Deleted	*Model Letter* Informing PPS-Excluded Hospital/Units that Reverification has Been Approved
194	Model Letter Announcing Compliance with all Surveyed Medicare Conditions of Participation After a Sample Validation or Substantial Allegation Survey
195	*Model Notice Announcing to an Accredited Hospital That the Hospital Does Not Comply with all the Conditions of Participation and That There is Immediate or Serious Threat to Patient Health and Safety*
196	*Model Letter Announcing to Accredited Hospital After a Sample Validation Survey That the Hospital Does Not Comply with all Conditions of Participation*

214	Model Letter Announcing to State Survey Agency the Requirements for Administering the Long Term Care Surveyor Minimum Qualifications Test (SMQT)
215 delete	*Notification to Provider/Supplier Warning of Possible Termination--Failure to Disclose Financial Interest and Ownership Information*
216	*Report on Initial Survey Activity*
217	*Aging Report on Pending Initial Survey Activity*
218 delete	*Prerelease Notification Document*
219	Model Audit Disallowance Letter - Title XVIII
220	Model Audit Disallowance Letter - Title XIX
221	Example of Regular Disallowance Letter
222	*Audit Clearance Document*
223	Notice to Accredited Laboratory Announcing Approval of Plan of Correction and Completion Schedule for Correcting Deficiencies
224	Model Letter: Announcing to Accredited Laboratory That It Is In Compliance With All Conditions After The Correction of Deficiencies
225	Model Letter: Announcing Compliance With Applicable CLIA Conditions After A Sample Validation or Substantial Allegation of Noncompliance Survey
226 delete	*Accredited Laboratory Allegation(s) Report, CMS-2878A*
227	Model Letter: Announcing to the CLIA-Exempt Laboratory After a Sample Validation or Substantial Allegation of Noncompliance Survey That It Does Not Comply With Application Program Requirements
228	Model Letter: Announcing to the State Laboratory Program, After A Sample Validation or Substantial Allegation of Noncompliance Survey That a CLIA-Exempt Laboratory Does Not Comply With Applicable Program Requirements
229	Model Letter: Announcing to the CLIA-Exempt Laboratory, That CMS Will Seek a Temporary Injunction or Restraining Order
230	Model Letter: Announcing to the State Laboratory Licensure Program That CMS Will Seek a Temporary Injunction or Restraining Order to Enjoin Continued Operation
231	Model Letter: Announcing to the CLIA-Exempt Laboratory, After a Sample Validation or Substantial Allegation of Noncompliance Survey That It Does Not Comply With Applicable Program Requirements (No Immediate Jeopardy)
232	Model Letter: Announcing to the State Laboratory Program, After a Sample Validation or Substantial Allegation of Noncompliance Survey, That a CLIA-Exempt Laboratory Does Not Comply With Applicable Program Requirements (No Immediate Jeopardy)

233 delete	*Fraud and Abuse - Office of Inspector General, Office of Investigations Field Officer*
234 delete	*CLIA Notice of Noncompliance and Proposed Alternative Sanction(s) - No Immediate Jeopardy*
235 delete	*Notice of Suspension or Limitation of the CLIA Certification - Immediate Jeopardy.*
236 delete	*Notice of Imposition of Sanction(s): Acknowledgment of Information Received*
237	Model Letter: Announcing to an Accredited Laboratory After a Sample Validation Survey or a Substantial Allegation of Noncompliance Survey That It Does Not Comply with all CLIA Conditions and That There Exists, Immediate Jeopardy to the Health and Safety of Individuals or That of the General Public
238	Model Letter: Announcing to an Accredited Laboratory After a Sample Validation Survey That the Laboratory Does Not Comply With All the CLIA Conditions- No Immediate Jeopardy
239 delete	*Clinical Laboratory Improvement Amendments (CLIA) Alternate Quality Assessment Survey, CMS-667*
240 delete	*Notice of Proposed Limitation of the CLIA Certification and Suspension of Medicare Payments When a Laboratory Has Failed to Participate Successfully in a Proficiency Testing Program*
241	Model Letter: Announcing to Accredited Laboratory After a Substantial Allegation of Noncompliance Survey That the Laboratory Does Not Comply With All CLIA Conditions (Complaint)
242	Request for Validation of Accreditation Survey for Laboratories, CMS-2802A
243	Model Letter: Announcing to a CLIA Exempt Laboratory That It Is In Compliance With the CLIA Conditions After a Sample Validation or Substantial Allegation of Noncompliance Survey
244	Model Letter: Announcing to the State Laboratory Program, That A CLIA-Exempt Laboratory is in Compliance with the CLIA Conditions After a Sample Validation or Substantial Allegation of Noncompliance Survey
245 delete	*CLIA Adverse Action Extract, CMS-462A/B*
246 delete	*Model Letter: Regional Office Notifying a State-Operated Laboratory of Cited Deficiencies and Requesting a Plan of Correction*
247 delete	*Notice of (Limitation or) Revocation of a Laboratory's CLIA Certificate - No Immediate Jeopardy*
248 delete	*Notice of Proposed Limitation, Suspension, or Revocation of the CLIA Certificate; Opportunity for a Hearing - No Immediate Jeopardy*
249	*Model Application Letter Notifying Transplant Hospital that a complete Medicare General Enrollment Health Care CMS-855A*

	need to be completed
250	*Model Application Lettter to Transplant Hospital Requiring Partial Medicare General Enrollment Health Care CMS-855A*
251	*Model Letter for First Rejection of a Request for Medicare approval of one or more Organ Transplant Programs*
252	*Model Reminder Letter for First Rejection of a Request for Medicare approval of one or more Organ Transplant Programs*
253 NEW	*Organ Transplant Hospital Worksheet*
254	Model Letter: Notification to Applicant that Medicare General Enrollment Health Care Provider/Supplier Application Has Been Denied
255A	Model Letter: Notification of Pending Involuntary Termination Based on CHOW Review of the Medicare General Enrollment Health Care Provider/Supplier Application
255B	Model Letter: Notification of Involuntary Termination Based on CHOW Review of the Medicare General Enrollment Health Care Provider/Supplier Application
256	Form CMS-855 - Medicare and Other Federal Health Care Program General Enrollment Health Care Provider/Supplier Application
257	Form CMS-855C - Medicare and Other Federal Health Care Program Change of Information Health Care Provider/Supplier Application
258	Form CMS-855R - Medicare and Other Federal Health Care Program Individual Reassignment of Benefits Health Care Provider/Supplier Application
259	Minimum Data Set Automation Contract/Agreement Approval RO Checklist
260	MDS Key Field Correction Form
261	Privacy Act Statement - Health Care Records
262	Overview of MDS Version 2.0 Correction Policy for Locked Records
263	Maximum Time Frames for MDS Completion, Data Entry, Editing, Locking and Transmission
264	Resident Census and Conditions of Residents - CMS-672
265	Roster/Sample Matrix - CMS-802
266	Roster/Sample Matrix Provider Instructions (Use with Form CMS-802) - CMS-802P
267	Roster/Sample Matrix Instructions for Surveyors (Use with Form CMS-802) - CMS-802S
268	Facility Characteristics

269	Facility Quality Indicator Profile
270	Resident Level Summary
271	Quality Indicator Matrix
272	Overview of MDS Submission Record
273	Correction Policy Summary Matrix
274	Definition of Selected Dates in the RAI Process
275	Attestation Statement for CMHCs
276 Deleted	Health Insurance Benefit Agreement for CMHCs
277	Fiscal Intermediary (FI) Provider Billing Number Deactivation Letter Used by FI
278	Model Denial Letter for CMHC Applicants - State Restrictions on Screening
279	Model Letter - Notice of Findings for Noncompliance for CMHCs
280	Model Letter - Notice of Termination of Provider Agreement for CMHCs
281	Model Letter - CMHC That Has Ceased Operation
282	Model Letter - Participation in Medicare as a CMHC Providing Partial Hospitalization Services (Including Threshold and Service Requirements)
283	Model Letter - Notice of Failure to Meet Threshold and Service Requirements, CMHCs
284	Model Denial Letter - To a Home Health Agency (HHA) That Requested a Branch Office
285	Worksheet for OBQM & OBQI Reports
286	*Hospital/CAH Medicare Database Worksheet*
287	*Authorization by Deemed Provider/Supplier Selected for Accreditation Organization Validation Survey*
288	Surveyor Worksheet For Swing-Beds
289	*Model Reciprocal Agreement Survey and Certification of Home Health Agencies and/or Hospices*
290 NEW	*Model letter to HHAs Assigning Branch Identification Numbers*
291 NEW	*Model Notice to Hospital/CAH of Collection of Data by the State Agency*

EXHIBIT 14 I

ESRD FACILITY SURVEY REPORT -
CRUCIAL DATA EXTRACT
(TO BE USED WITH PART II OF CMS-3427)

***CMS Certification* Number**	Facility Name	Survey Date

Survey Team Composition (V34)

SF 42: Indicate the number of surveyors according to discipline.

A.	_____	Administrator	H.	_____	Life Safety Code Spec.
B.	_____	Nurse	I.	_____	Laboratorian
C.	_____	Dietitian	J.	_____	Sanitarian
D.	_____	Pharmacist	K.	_____	Therapist
E.	_____	Records Administrator	L.	_____	Physician
F.	_____	Social Worker	M.	_____	Psychologist
G.	_____	Qualified Mental Retardation Professional	N.	_____	Other _____

NOTE: More than one discipline may be marked for surveyors qualified in multiple disciplines.

SF7: Indicate the total number of surveyors onsite: _____

*Mandatory Field

EXHIBIT 37

MODEL LETTER ANNOUNCING VALIDATION SURVEY OF ACCREDITED HOSPITAL

PLEASE NOTE: Per Section 2700A, all surveys are unannounced.

(**Date**)

Hospital Administrator Name
Hospital Name
Address
City, State, ZIP Code

Re: *CMS Certification* Number *(CCN)*

Dear (**Hospital Administrator Name**):

Section 1865 of the Social Security Act *(the Act)* provides hospitals accredited by The Joint Commission *(JC) are* deemed to meet the Medicare Conditions of Participation *(CoPs),* with the exception of those relating to utilization review and special psychiatric hospital medical staffing and medical records requirements. *The law extends* deemed status to hospitals accredited by the American Osteopathic Association *(AOA) with periodic review by the Secretary of the Department of Health and Human Services (the Secretary).*

Section 1864 of the Act authorizes the Secretary to conduct, on a selective *sampling* basis, *surveys* of accredited hospitals as a means of validating *the accrediting organization's survey requirements.* In (**Name of State**), Medicare validation surveys of accredited hospitals are conducted by the (**State agency**). This agency, under agreement with the Centers for Medicare and Medicaid Services *(CMS), surveys hospitals and other providers of Medicare services* to *determine compliance with* the Medicare CoPs.

*The last accreditation survey of **[Hospital Name]**, conducted by **[AO],** was completed on [date].*

Your facility has been selected for a sample validation survey. This is an unannounced survey following procedures established by CMS.

Section 1865 of the Act requires *hospitals deemed to meet the COPs to* authorize the accrediting body to release to the Secretary (or to a State agency designated by him), upon his request, a copy of the accreditation survey *information* of such institution.

You may also be requested to provide or verify information on the Hospital/CAH Medicare Database Worksheet by a member of the survey team.

A copy of the Medicare sample validation survey findings will be subject to public disclosure after *hospital staff have* been given an opportunity to review the findings, present comments to us, and submit a plan for correction *for the* deficiencies *cited*.

During this survey, the State agency will conduct a survey of all the CoPs to determine compliance with all the requirements for Medicare-participating hospitals. The survey team will request facility documents to review, require access to all areas of the hospital, and observe patient services or procedures to assist them in their compliance determination.

If you have any questions *regarding this letter, please telephone* ***[Name]*** *at* ***[Telephone number].***

Sincerely yours,

Director

Enclosures:
Hospital /CAH Medicare Database Worksheet
Survey Material List

cc:
CMS, DSC, Regional Office
CMS, CMSO, Division of Acute Care Services

EXHIBIT 42

ORIENTATION *& BASIC TRAINING* PROGRAM FOR THE NEWLY EMPLOYED HEALTH FACILITY SURVEYOR

A. Primary Objective

The primary objective of the orientation and training program for the newly employed health facility surveyor is to prepare the new employee to assume the responsibilities of a health facility surveyor.

Authority: Section 1819G of the Social Security Act mandates that the "Secretary of HHS, through the CMS Administrator, assure that surveyors are trained to make determinations about the Conditions of Participation (CoP) of providers." Related authority: US Code, Section 1396 – 1396v, Subchapter XIX, Chapter 7 and Title 42. Also: Chapter IV, Title 42, and Title 45, Code of Federal Regulations, and Section 1919(g), "Survey and Certification Process," subparagraph (iii), "The Secretary shall provide for the comprehensive training of State and Federal Surveyors in the conduct of standard and extended surveys…." "No individual shall serve as a member of a survey team unless the individual has successfully completed a training and testing program in survey and certification techniques that has been approved by the Secretary."

While the authority above is primarily aimed at the needs of Skilled Nursing Facilities (SNFs) and Nursing Homes (NHs), every surveyor must be equipped to determine whether providers are in compliance with CMS Conditions of Participation. Trainers and surveyors in each survey discipline (provider type) are expected to comply with the training objectives and organizational structure outlined below.

B. Broad Objective

At the completion of this program the newly employed surveyor will be able to demonstrate acquired knowledge and skills by:

1. *Performing effectively, efficiently, and independently in areas of observation, decision making, documentation and evaluation of the performance of providers and suppliers.*

2. *Uniformly imparting the HHS philosophy and intent of Federal regulations in face-to-face contact with providers and suppliers.*

This orientation and training program is designed to provide meaningful learning opportunities for health care professionals to gain additional technical knowledge, knowledge of Medicare/Medicaid health and safety regulations, and skills required to perform their duties more effectively. Participants study the

survey and certification processes, read Federal regulations, review slides, view videos, participate in on-line training and web-based training (WBT), and practice survey skills under supervision and through the Virtual Classroom (VC).

Some new employees will be hired to function in a "certification" role. These individuals need much of the same orientation and training as field surveyors receive. Certification staffs are the persons who receive the results of surveyor reports and administratively process them to determine and document compliance with CMS certification procedures. The orientation and training requirements here apply equally to new surveyors and certification specialists in SAs and ROs.

C. Introduction

The orientation and training program is divided into 5 parts and should be customized to fit the individual strengths and weaknesses of each new surveyor. The orientation is usually completed in a 6 to 9 month period and is followed by formal completion of the CMS-provided VC or traditional-classroom trainings. Basic trainings include classroom experience for Basic Long Term Care, Basic Hospital, Basic HHA, Basic ESRD, etc.

At the conclusion of State Agency (SA) and CMS-provided Orientation and Basic training, the surveyor is presented with a certificate of program completion. Special Note: While the Basic LTC training course provides fundamentals of survey practice, it does not provide all of the information that a surveyor needs to successfully complete the Surveyor Minimum Qualification Test (SMQT). It is the combination of pre-Basic (Preceptoring, Mentoring and WBT), Basic (VC and on-site classroom), and post-Basic training and mentoring (such as specialized and tailored learning experiences) that assures that surveyors are prepared to successfully complete the SMQT and to conduct CMS-required surveys of providers seeking or maintaining participation status. Certificates of Completion for all CMS trainings are provided by the CMSO/Survey and Certification Group/Training Staff in Baltimore.

D. Program Content

Part I - General Principles

Outlines the surveyor's role and responsibilities, indoctrination to standards and the survey/certification process, confidentiality, patient rights, technique of oral communication, basic data-collecting skills, and documentation of findings.

These materials are available via the Preceptor Manual (CMS-provided and enhanced with SA-related materials), as well as by WBT, VC and other pre-Basic on-site classroom training. The Preceptor Manual was created by a national workgroup of SA and RO trainers and surveyors, and is a non-

mandatory guide to trainers seeking to thoroughly prepare students for Basic trainings. While much of the content of the Preceptor Manual addresses LTC issues and survey methods, the Manual provides a useful training structure to guide all surveyors and their trainers in non-LTC survey. There are also a number of Web Based Training (WBT) tools that are available online and may be prerequisites for classroom training or post-basic training opportunities. WBT tools are provided at the CMS training website.

Part II - Survey Methods

Outlines investigative techniques and approaches to surveying standards for administration, medical direction, nursing, patient management, patient care planning, dietary service, pharmacy, medical records, restorative service, patient activities, physical therapy, occupational therapy, fire safety and disaster planning.

Other selected conditions of participation and standards for specific suppliers of service, e.g., HHA, ESRD, are outlined. *These materials are provided via WBT, VC and on-site classroom and tailored to the needs of the surveyor having completed initial chapters of the Preceptor Manual and SA-provided mentoring.*

These materials are designed to help surveyors determine compliance with provider or supplier requirements for which the surveyor is being trained. This includes following CMS written survey procedures. Emphasis should be placed on the determination of potential and actual outcomes of the care and services provided and the systems to ensure positive beneficiary outcomes. Training resources include WBT, the Preceptor Manual, and satellite broadcasts (or videos from those broadcasts). Again, training methods should be tailored to the needs of the individual surveyor.

Part III - Field Experience

Emphasizes the process of surveying and the practice application of Part I and Part II.

The surveyor participates as a supervised team member while the student surveyor assesses the certified entity's compliance with requirements. They do so by following CMS survey procedures. Training resources include the Preceptor Manual and emphasize topics such as patient rights, nursing, medical records, etc., until all areas have been covered.

Part IV - Regional Office *(RO), Central Office (CO), State Agency (SA) structure*

Provides an overview of the Federal-State relationship in Title XVIII and XIX programs, requirements for common Medicare/Medicaid standards and procedures, organization and role of DHHS in survey and certification programs, the role and relation of the RO to the SA, and other selected topics identified by

the RO. *This information is available by WBT at the internet streaming Web site and may be supplemented by SA Training Coordinators.*

Part V – Basic training in the VC and traditional classroom

The objectives of classroom training include opportunities to practice skills and knowledge acquired during SA-led training, acquire new information, ask national CMS Subject Matter Experts (SMEs) questions to clarify policy and procedure, and to form and share the surveyor culture.

Recommended time spans for the 5 parts are:

Part I	2 weeks
Part II	9 weeks
Part III	3 weeks
Part IV	1 week
Part V	*2 to 6 weeks*

E. Administration

The orientation *and training* program is designed to be a cooperative responsibility of the SA and RO. Most of the orientation is conducted at the SA. As necessary, the surveyor may travel to the RO and make site visits to implement certain aspects of the program.

F. State Agency *and State Regional/District Office (where applicable)*

The office in which the surveyor is employed has the overall responsibility for planning, coordinating, and supervising the orientation program for each new surveyor. *In the assessment of the new surveyor's performance,* the SA should have input from the State RO when appropriate. *The responsible office (SA or* State RO) is also responsible for appointing a preceptor and/or coordinator for the orientation program*. The CMS Central Office provides content, access to WBT and the VC. CMS offers instructor training, and provides overall training-policy supervision.*

1. Preceptor

   The preceptor should be a person who has successfully completed an orientation and a basic surveyor training program and has been responsible for successfully completing a number of surveys. This person must work closely with the new surveyors to set up time-tables for completion of the *orientation* program, hold conferences, and *assess* each new surveyor's progress throughout the orientation period. In States that have *State* ROs, *and if* new surveyors need to receive their training out in the *State* region,

each State RO or district office will need to appoint a preceptor to assure that training objectives are met.

2. *The State Training Coordinator (STC) and Backup*

It is mandatory that each SA identify a training coordinator and a backup person who will be available when needed for training purposes. The coordinator is the person responsible for communicating with the CMS regional training administration and for making the arrangement for the Regional Training Administrator (RTA) to meet individually or with a group of persons enrolled at any one time in the orientation training program. The SA training coordinator is also responsible for the design and expediting of training programs for surveyors who have completed the orientation program. *Overall, the STC or their backup is responsible for supervision of the precepting, mentoring, training and assessment of their SA surveyors.*

G. *CMS* Regional Office

The CMS RO and the SA *collaborate on* the orientation of the new surveyor. The RO is responsible for assisting States in developing an orientation program utilizing the *CMS* curriculum *expressed in the CMS Preceptor Manual and other CO-supplied training resources,* and in reviewing and approving plans *for SA-led instructional,* technical and field experiences, and monitoring the implementation of the program.

Each RO is required to have an RTA and backup person. The RTA has the responsibility for assuring that an effective and meaningful orientation is defined for each new surveyor. The RTA is also responsible for assuring that they and their backup, as well as STC and backup receive required CMS CO training on use of the Learning Management System (LMS) and Virtual Classroom, as well as other training-system orientation, as required by the CMS CO.

H. *Training Resources*

Training resources are made available by the budget process, which includes as its first step the completion of the CO Surveyor Employment and Training (SET) report. The CMS RO provides guidance to STCs for assembling SA inputs to the SET.

SAs are expected to carefully and accurately assess training needs and report those needs to the RTA. In turn, RTAs submit these needs to CO, where CO determines the placement and frequency of classroom offerings (the Training Schedule), the priority for new class design and development, and the types of technology that STCs and RTAs will need to have to be able to access WBT and other forms of distance learning.

EXHIBIT 58

EXAMPLE OF REGULAR DISALLOWANCE LETTER

Certified Mail - Return Receipt Requested

FILE ID: RE: File No._____

ADDRESSEE: Dear (**Medicaid State Agency Director**):

INTRODUCTION: The Quarterly Statement of Expenditures, CMS-*435*, for the State provider certification program submitted by your Department for the quarter ending _____has been reviewed by this office. The statement contains a claim totaling $_____ in Federal financial participation (FFP) of which $_____ is being disallowed.

BACKGROUND FACTS: (**Description of the issues involved and the findings of fact**.)

DISALLOWANCE DETERMINATION: (**Citation of statute and/or regulations, an explanation of how the statute or regulation has been violated, and the decision**.)

CMS regulation _____ CFR §_____ provides that:

(**Provide explanation here.**)

Therefore, in accordance with the regulation(s) cited above, this letter constitutes your notice of disallowance in the amount of $ _____ FFP. Please resubmit the Quarterly Statement of Expenditures for which this disallowance action was taken, making the applicable decreasing adjustment and referencing disallowance number.

NOTICE OF ADJUSTMENT: As this disallowance includes FFP previously paid the State for expenditures for services furnished on or after October 1, 1980, it is subject to the provisions of section 961(a) of the Omnibus Reconciliation Act of 1980 (Public Law 96-499) as amended by section 2163 of the Omnibus Reconciliation Act of 1981 (Public Law 97-35). If you appeal this disallowance as provided below, Public Law 96-499 provides you the option of retaining the funds disallowed by this notice pending a final administrative decision. If the final decision upholds the disallowance and you elected to retain the funds during the appeal process, the proper amount of the disallowance, plus interest computed pursuant to Public Laws 96-499 and 97-35, will be offset in a subsequent grant award. You may exercise your option to retain the disputed funds by notifying the Regional Administrator in writing no later than 30 days after the postmarked date of this letter. In the absence of your notification that you elect to retain the funds, the Secretary will recover the disputed funds pending the final decision of the Grant Appeals Board.

APPEAL RIGHTS: Under section 1116(d) of the Social Security Act, you have the right to request reconsideration of this disallowance. Your reconsideration request must be submitted to the Executive Secretary, Departmental Grant Appeals Board, U.S. Department of Health and Human Services, Washington, DC 20201, no later than 30 days after your receipt of this letter. Your request must include a copy of this decision, a brief statement of the amount in dispute in your appeal, and a brief statement as to why you believe this decision is incorrect. Please send one copy of your request to me and one copy to the Associate Regional Administrator, *Survey and Certification Group.* Your request will be processed pursuant to the rules and regulations of the Departmental Grant Appeals Board which are currently found at 45 CFR Part 16. (See "Federal Register", Vol. 46, No. 168, published August 31, 1981.)

RO/DHSQ PROGRAM CONTACT: Should you require further details regarding this matter, please contact the Associate Regional Administrator, *Survey and Certification Group* at (**area code and telephone number**).

Sincerely,

(Regional Administrator)

Enclosures: (if any)

cc: Central Office

EXHIBIT 59

EXAMPLE OF DEFERRAL LETTER

(**NOTE:** This letter is to be sent prior to the disallowance letter with regard to amounts deferred.)

(**Date**)

Facility or Provider Name
Address
City, State, ZIP Code

Dear _____:

We have reviewed your Quarterly Statement of Expenditures, Form CMS-*435*, for title XIX survey and certification activities for the quarter ending _____. Our review disclosed that consultant claims on section I of the Statement of Expenditures were claimed by the State at 75 percent Federal financial participation (FFP).

In accordance with section 1903(a)(2) of the Social Security Act and 42 CFR 432.50, Code of Federal Regulations, 75 percent FFP is available in expenditures for salaries or other compensation, fringe benefits, travel, per diem, and training for personnel of the State agency responsible for inspection of providers which participate in the Medicaid program.

No evidence was found during our review to indicate that the services provided by consultants are allowable at 75 percent FFP. Therefore, I am deferring your claim for FFP by $_____ in accordance with the requirement of 45 CFR 201.15.

Please make available for review, within 60 days from the date of this letter, documentation that shows the type of work performed by consultants. If you find that you require additional time to make the requested documentation available for review, you may request in writing (in accordance with 45 CFR 201.15) an extension of up to an additional 60 days. If documentation reflects that services provided were directly related to the inspection of facilities, the deferred amount of $_____will be reinstated on your next grant award.

Inquiries regarding this matter may be directed to my office, or you may contact me at (**phone number**).

Sincerely,

Regional Administrator

Enclosures: (if any)

cc: Central Office

EXHIBIT 60

EXAMPLE OF DISALLOWANCE LETTER FOR AMOUNTS PREVIOUSLY DEFERRED

Certified Mail - Return Receipt Requested

FILE ID: RE: File No._____

ADDRESSEE: Dear (**Medicaid State Agency Director**):

INTRODUCTION: Your department was notified by our letter dated _____ (copy enclosed) of our decision to defer, in accordance with 45 CFR §201.15, a claim totaling $____ in Federal financial participation (FFP) for_____. This claim was made on line(s) _____ of the Quarterly Statement of Expenditures, CMS-*435,* for the State provider certification program submitted by your Department for the quarter ending.

This deferral action was taken because we questioned whether _____. In accordance with 45 CFR §201.15, you were requested to make available all related documents and materials necessary to determine the allowability of the claim.* This letter is to inform you of our decision after review of the documentation, regarding your claim for FFP.

BACKGROUND FACT: (**Description of the issues involved and the findings of fact**.)

DISALLOWANCE DETERMINATION: (**Citation of statute and/or regulations, an explanation of how the statute or regulation has been violated, and the decision**)

* If the deferral time requirements are not met you should also add the following:

Since we were unable to meet the time requirements of 45 CFR §201.15, your claim was paid on your grant award for the _____ quarter of fiscal year_____ dated_____.

CMS regulation_____ CFR _____ provides that:

(Provide explanation here.)

Therefore, in accordance with the regulation(s) cited above, this letter constitutes your notice of disallowance in the amount of $_____FFP. Please resubmit the Quarterly Statement of Expenditures for which this disallowance action was taken, making the applicable decreasing adjustment and referencing disallowance number.

NOTICE/ ADJUSTMENT:	As this disallowance includes FFP previously paid the State for expenditures for services furnished on or after October 1, 1980, it is subject to the provisions of Section 961(a) of the Omnibus Reconciliation Act of 1980 (Public Law 96-499) as amended by Section 2163 of the Omnibus Reconciliation Act of 1981 (Public Law 97-35). If you appeal this disallowance as provided below, Public Law 96-499 provides you the option of retaining the funds disallowed by this notice pending a final administrative decision. If the final decision upholds the disallowance and you elected to retain the funds during the appeal process, the proper amount of the disallowance, plus interest computed pursuant to Public Laws 96-499 and 97-35, will be offset in a subsequent grant award. You may exercise your option to retain the disputed funds by notifying the Regional Administrator in writing no later than 30 days after the postmarked date of this letter. In the absence of your notification that you elect to retain the funds, the Secretary will recover the disputed funds pending the final decision of the Grant Appeals Board.
APPEAL RIGHTS:	Under Section 1116(d) of the Social Security Act, you have the right to request reconsideration of this disallowance. Your reconsideration request must be submitted to the Executive Secretary, Departmental Grant Appeals Board, U.S. Department of Health and Human Services, Washington, DC 20201, no later than 30 days after your receipt of this letter. Your request must include a copy of this decision, a brief statement of the amount in dispute in your appeal, and a brief statement as to why you believe this decision is incorrect. Please send one copy of your request to me and one copy to the Associate Regional Administrator, *Survey and Certification Group*. Your request will be processed pursuant to the rules and regulations of the Departmental Grant Appeals Board which are currently found at 45 CFR part 16. (See "Federal Register," Vol. 46, No. 168, published August 31, 1981.)
RO PROGRAM CONTACT:	Should you require further details regarding this matter, please contact the Associate Regional Administrator, *Survey and Certification Group* at (area code and telephone).

Sincerely

(Regional Administrator)

Enclosures: (if any)
cc: Central Office

EXHIBIT 63

LIST OF DOCUMENTS IN CERTIFICATION PACKET	
Title	**Form Number**
Initial Certification – Accredited (Deemed)* Hospital – Short-Term Acute	
Medicare General Enrollment Healthcare Provider/Supplier Application	*CMS-855A*
Certification and Transmittal	*CMS-1539*
Health Insurance Benefit Agreement (two signed originals	*CMS-1561*
Office of Civil Rights (OCR) Clearance *•Assurance of Compliance form* *•Medicare Certification Civil Rights Information Request form (and applicable attachments)*	*www.hhs.gov/ocr/crclearance.html/HHS-690 and HHS441*
FI/Carrier's Letter Recommending Enrollment	*Letter*
AO Decision Letter	*Letter*
Recertification – Accredited (Deemed) Hospital - Short-Term Acute	
Certification and Transmittal	*CMS-1539*
Health Insurance Benefit Agreement (two signed originals)	*CMS-1561*
Office of Civil Rights (OCR) Clearance *•Assurance of Compliance form* *• Medicare Certification Civil Rights Information Request form (and applicable attachments)*	*www.hhs.gov/ocr/crclearance.html/HHS-690 and HHS441*
AO Decision Letter	*Letter*

* Some accreditation organizations (AOs) recognized by CMS offer several levels of accreditation to health care facilities. For CMS survey and certification purposes, the only relevant accreditation is one where the AO has deemed the facility to be in substantial compliance with Medicare health and safety requirements found in the Conditions of Participation/Conditions for Coverage. While AOs may refer to some facilities as "accredited" and others as "deemed," CMS regulations do not recognize such a distinction. The regulations define an "accredited provider or supplier" to mean only one that is accredited under an approved AO program that has been deemed as satisfying CMS certification standards. We use "Accredited (Deemed)" to make this clear.

LIST OF DOCUMENTS IN CERTIFICATION PACKET	
Title	**Form Number**
Initial Certification – Psychiatric Unit within Accredited/ (Deemed) Hospital and, when the Unit is Certified after the Hospital, Non-accredited Hospital	
Certification and Transmittal	*CMS-1539*
Medicare General Enrollment Health Care Provider/Supplier Application	*CMS-855A*
Medicare General Enrollment Health Care Provider/Supplier Application	*CMS-855A*
Statement of Deficiencies and Plan of Correction – Health (for the psychiatric special conditions)	*CMS-2567*
Hospital/CAH Medicare Database Worksheet (when onsite survey is conducted)	*Exhibit 286*
Psychiatric Unit Criteria Worksheet Report	*CMS-437*
Survey Team Composition and Workload Report	*CMS-670 (electronically in ASPEN)*
Health Insurance Benefit Agreement (two signed originals)	*CMS-1561*
FI Letter Recommending/Denying Enrollment	*Letter*
Office of Civil Rights (OCR) Clearance *• Assurance of Compliance Form* *• Medicare Certification Civil Rights Information Request Form (and applicable attachments)*	*www.hhs.gov/ocr/crclearance.html/* *HHS-690 and HHS 441*
Initial Certification of the Rehabilitation Criteria in an Accredited/Deemed Rehabilitation Hospital or a Rehabilitation Unit within an Acute Care Hospital (Accredited (Deemed) and, when the Unit is Certified after the Hospital, Non-accredited)	
Certification and Transmittal	*CMS-1539*
Medicare General Enrollment Health Care Provider/Supplier Application	*CMS-855A*
Statement of Deficiencies and Plan of Correction – Health (for the psychiatric special conditions)	*CMS-2567*
Hospital/CAH Medicare Database Worksheet	*Exhibit 286*

LIST OF DOCUMENTS IN CERTIFICATION PACKET	
Title	**Form Number**
(when onsite survey is conducted)	
Rehabilitation Criteria for Rehabilitation Hospital or Unit Criteria Worksheet Report	*Applicable CMS-437A (unit criteria) or CMS-437-B(hospital criteria)*
Survey Team Composition and Workload Report	*CMS-670 (electronically in ASPEN)*
Health Insurance Benefit Agreement (two signed originals)	*CMS-1561*
AO Decision Letter	*Letter*
FI Letter Recommending/Denying Enrollment	*Letter*
Office of Civil Rights (OCR) Clearance *• Assurance of Compliance Form* *• Medicare Certification Civil Rights Information Request Form (and applicable attachments)*	*www.hhs.gov/ocr/crclearance.html/* *HHS-690 and HHS 441*
Recertification – Psychiatric Unit within Accredited (Deemed) Hospital	
Certification and Transmittal	*CMS-1539*
Hospital/CAH Medicare Database Worksheet (when onsite survey is conducted)	*Exhibit 286*
X Statement of Deficiencies and Plan of Correction – Health (for the psychiatric special conditions)	*CMS-2567*
2 Psychiatric Unit Criteria Worksheet Report	*CMS-437*
Survey Team Composition and Workload Report	*CMS 670(electronically in ASPEN)*
Recertification of the Rehabilitation Criteria for an Accredited(Deemed) Rehabilitation Hospital or a Rehabilitation Unit within an Accredited(Deemed) Acute Care Hospital	
Certification and Transmittal	*CMS-1539*
Hospital/CAH Medicare Database Worksheet (when onsite survey conducted)	*Exhibit 286*
X Statement of Deficiencies and Plan of Correction – Health (for the psychiatric special conditions)	*CMS-2567*

LIST OF DOCUMENTS IN CERTIFICATION PACKET	
Title	**Form Number**
[2] *Rehabilitation Hospital or Rehabilitation Unit Criteria Worksheet Report*	*CMS-437B (hospital criteria) or CMS-437A (unit criteria)*
Survey Team Composition and Workload Report	*CMS 670(electronically in ASPEN)*
Initial Certification – Non-accredited (Non-deemed) Hospital - Short-Term Acute	
Certification and Transmittal	*CMS-1539*
Hospital/CAH Medicare Database Worksheet	*Exhibit 286*
Medicare General Enrollment Health Care Provider/Supplier Application	*CMS-855A*
Crucial Data Extract - Life Safety Code	*CMS-2786E (electronically in ASPEN)*
Crucial Data Extract - Health	*CMS-1537A (electronically in ASPEN)*
Statement of Deficiencies and Plan of Correction - Health	*CMS-2567*
Statement of Deficiencies and Plan of Correction - LSC	*CMS-2567*
[2] *FI Letter Recommending/Denying Enrollment*	*Letter*
[1/2] *Fire Safety Survey Report (if waiver recommended)*	*CMS-2786R*
[2] *Survey Team Composition and Workload*	*CMS-670*
Office of Civil Rights (OCR) Clearance *•Assurance of Compliance* *•Medicare Certification Civil Rights Information Request form (and applicable attachments)*	*HHS-690 and HHS 441* *www.hhs.gov/ocr/crclearance.html*
Health Insurance Benefit Agreement (two signed originals)	*CMS-1561*
As Applicable for Rehab Hospitals, Rehab Units, or Psychiatric units	*CMS-437B, CMS-437A, or CMS-437*

LIST OF DOCUMENTS IN CERTIFICATION PACKET	
Title	**Form Number**
[3] ***Recertification – Non-accredited (Non-deemed) Hospital - Short-Term Acute***	
Certification and Transmittal	*CMS-1539*
Hospital/CAH Medicare Database Worksheet	*Exhibit 286*
Crucial Data Extract - LSC	*CMS-2786E (electronically in ASPEN)*
Crucial Data Extract-Health	*CMS-1537E (electronically in ASPEN)*
Statement of Deficiencies and Plan of Correction - Health	*CMS-2567*
Statement of Deficiencies and Plan of Correction - LSC	*CMS-2567*
[1/2] *Fire Safety Survey Report (if waiver recommended)*	*CMS-2786R*
Survey Team Composition and Workload Report	*CMS-670 (electronically in ASPEN)*
As applicable for rehab hospitals, rehab units, or psychiatric units	*CMS-437B, CMS-437A, or CMS-437*
Initial Certification – Non-accredited (Non-deemed) Psychiatric Hospital and Psychiatric Distinct Part Hospital	
Certification and Transmittal	*CMS-1539*
Hospital/CAH Medicare Database Worksheet	*Exhibit 286*
Medicare General Enrollment Health Care Provider/Supplier Application	*CMS-855A*
Crucial Data Extract –Life Safety Code	*CMS-2786E (electronically in ASPEN)*
Crucial Data Extract-Health	*CMS 1537E (electronically in ASPEN)*
Statement of Deficiencies and Plan of Correction - Health (for the psychiatric special conditions)	*CMS-2567*
Statement of Deficiencies and Plan of Correction - LSC	*CMS-2567*
[2] *Psychiatric Hospital Survey Report*	*CMS-724*

LIST OF DOCUMENTS IN CERTIFICATION PACKET	
Title	**Form Number**
[1/2] *Fire Safety Survey Report*	*CMS-2786R*
[2] *Survey Report Form (CLIA)*	*CMS-1557*
Laboratory Personnel Report (CLIA)	*CMS-209*
Health Insurance Benefit Agreement (two signed originals)	*CMS-1561*
Office of Civil Rights (OCR) Clearance *•Assurance of Compliance Form* *•Medicare Certification Civil Rights Information Request Form (and applicable attachments)*	*HHS-690 and/or HHS 441* *www.hhs.gov/ocr/crclearance.html*
FI Letter Recommending/Denying Enrollment	*Letter*
Survey Team Composition and Workload Reports (use one CMS-670 for each that applies) • *LSC* • *Health* • *If appropriate-Special Conditions for psychiatric hospitals*	*CMS-670 (electronically in ASPEN)*
[2] ***Recertification – Non-accredited (Non-deemed) Psychiatric Hospital and Psychiatric Distinct Part Hospital***	
Certification and Transmittal	*CMS-1539*
Crucial Data Extract -LSC	*CMS-2786E (electronically in ASPEN)*
Crucial Data Extract-Health	*CMS-1537E (electronically in ASPEN)*
Hospital/CAH Medicare Database Worksheet	*Exhibit 286*
[1/2] *Fire Safety Survey Report (if waiver recommended)*	*CMS-2786R*
Statement of Deficiencies and Plan of Correction - Health	*CMS-2567*
Statement of Deficiencies and Plan of Correction – Health (for the psychiatric special conditions)	*CMS-2567*

LIST OF DOCUMENTS IN CERTIFICATION PACKET	
Title	**Form Number**
Statement of Deficiencies and Plan of Correction - LSC	*CMS-2567*
Survey Team Composition and Workload Report	*CMS-670 (electronically in ASPEN)*
Accredited (Deemed) Hospital Complaint/Validation	
Certification and Transmittal	*CMS-1539*
Medicare/Medicaid/CLIA Complaint Form	*CMS-562*
Authorization by Deemed Provider/Supplier Selected for Accreditation Organization Validation Survey	*Exhibit-287*
Crucial Data Extract - Health (if applicable)	*CMS-1537E (electronically in ASPEN)*
Statement of Deficiencies and Plan of Correction - Health (if applicable)	*CMS-2567*
Statement of Deficiencies and Plan of Correction - LSC (if applicable)	*CMS-2567*
Narrative Report (Complaints)	--
Fire Safety Survey Report (if applicable)	*CMS-2786R*
Survey Team Composition and Workload Report	*CMS-670 (electronically in ASPEN)*
Follow-up reports on hospitals under SA monitoring should contain the following:	
Certification and Transmittal (Item 11 completed with either box 2 or box 4 checked)	*CMS-1539*
Post-Certification Revisit Report	*CMS-2567B*
Hospital/CAH Medicare Database Worksheet	*Exhibit 286*
Initial Certification –Non-accredited (Non-deemed) Critical Access Hospital	
Survey Team Composition and Workload Report	*CMS-670 (electronically in ASPEN)*
Medicare General Enrollment Healthcare Provider/Supplier Application	*CMS-855A*

LIST OF DOCUMENTS IN CERTIFICATION PACKET	
Title	**Form Number**
Statement of Deficiencies – Health/LSC	*CMS-2567*
Fire Safety Report (if waiver recommended)	*CMS-2786R*
Certification and Transmittal	*CMS-1539*
Crucial Data Extract-Health	*CMS-1537E (electronically in ASPEN)*
Crucial Data Extract-LSC	*CMS-2786E (electronically in ASPEN)*
Hospital/CAH Database Worksheet	*Exhibit 286*
Health Insurance Benefit Agreement (two signed originals)	*CMS-1561*
Health Insurance Benefit Agreement (two signed originals)	*CMS-1561*
Health Insurance Benefit Agreement (two signed originals)	*CMS-1561*
Office of Civil Rights (OCR) Clearance *•Assurance of Compliance Form* *•Medicare Certification Civil Rights Information Request Form (and applicable attachments)*	*www.hhs.gov/ocr/crclearance.html/* *HHS-690 and HHS 441*
FI/Carrier's Letter Recommending approval or disapproval of CMS 855A	*Letter*
Determination that the CAH is rural	*www.census.gov*
Recertification –Non-accredited (Non-deemed) Critical Access Hospital	
Certification and Transmittal	*CMS-1539*
Statement of Deficiencies-Health/LSC	*CMS-2567*
Survey Team Composition and Workload Report	*CMS-670 (electronically in ASPEN)*
Fire Safety Report (if waiver recommended)	*CMS-2786R*
Hospital/CAH Database Worksheet	*Exhibit 286*
Crucial Data Extract-LSC	*CMS-2786E (electronically in ASPEN)*

LIST OF DOCUMENTS IN CERTIFICATION PACKET	
Title	**Form Number**
As applicable for Distinct Part Units of CAHs	*CMS-437-psychiatric* *CMS-437A-rehabilitation*
Initial Certification – Accredited (Deemed) Critical Access Hospital	
Certification and Transmittal	*CMS-1539*
Medicare General Enrollment Healthcare Provider/Supplier Application	*CMS- 855A*
Health Insurance Benefit Agreement (two signed originals)	*CMS-1561*
FI Letter Recommending/Denying Enrollment	*Letter*
AO Decision Letter	*Letter*
Office of Civil Rights (OCR) Clearance *•Assurance of Compliance Form* *• Medicare Certification Civil Rights Information Request Form (and applicable attachments)*	*www.hhs.gov/ocr/crclearance.html/* *HHS-690 and HHS 441*
Recertification – Accredited (Deemed) Critical Access Hospital	
Certification and Transmittal	*CMS-1539*
Hospital/CAH Medicare Database Worksheet	*Exhibit 286*
Critical Access Hospital Distinct Part Unit	
Certification and Transmittal	*CMS-1539*
Medicare General Enrollment Healthcare Provider/Supplier Application	*CMS-855A*
Crucial Data Extract-LSC	*CMS-2786E (electronically in ASPEN)*
Statement of Deficiencies-Health/LSC	*CMS-2567*
As applicable: Psychiatric or Rehab Hospital Survey Report	*CMS-437 or CMS-437A*
Health Insurance Benefit Agreement (two signed	*CMS-1561*

LIST OF DOCUMENTS IN CERTIFICATION PACKET	
Title	**Form Number**
originals)	
Survey Team Composition and Workload Report	*CMS 670 (electronically in ASPEN)*
Initial Certification – Swing Beds	
Statement of Deficiencies – Health/LSC	*CMS-2567*
Survey Team Composition and Workload Report	*CMS-670 (electronically in ASPEN)*
Certification and Transmittal	*CMS-1539*
Crucial Data Extract-Health	*CMS-1537E (electronically in ASPEN)*
Swing Bed Survey Report	*CMS-1537C*
FI/Carrier's letter recommending approval or disapproval of CMS 855A	
Determination that the Hospital/CAH is rural	*www.census.gov*
Recertification of Swing Beds	
Statement of Deficiencies-Health/LSC	*CMS-2567*
Survey Team Composition and Workload Report	*CMS-670 (electronically in ASPEN)*
Certification and Transmittal	*CMS-1539*
Crucial Data Extract-Health	*CMS-1537E (electronically in ASPEN)*
Swing Bed Survey Report	*CMS-1537C*
Initial Certification – Religious Nonmedical Health Care Institution	
Survey Team Composition and Workload Report	*CMS-670 (electronically in ASPEN)*
Statement of Deficiencies –Health/LSC	*CMS-2567*
Fire Safety Survey Report Form	*CMS-2786R*
Medicare Enrollment Health Care Provider/Supplier Agreement	*CMS-855A*

LIST OF DOCUMENTS IN CERTIFICATION PACKET	
Title	**Form Number**
Health Insurance Benefit Agreement	*CMS-1561*
Office of Civil Rights (OCR) Clearance *•Assurance of Compliance Form* *•Medicare Certification Civil Rights Information Request Form (and applicable attachments)*	*HHS-690* *www.hhs.gov/ocr/crclearance.html*
Recertification – Religious Nonmedical Health Care Institution	
Survey Team Composition and Workload Report	*CMS-670 (electronically in ASPEN)*
Statement of Deficiencies –Health/LSC	*CMS-2567*
Fire Safety Survey Report Form	*CMS-2786R*
Medicare Enrollment Health Care Provider/Supplier Agreement	*CMS-855A*
Health Insurance Benefit Agreement	*CMS-1561*
Office of Civil Rights (OCR) Clearance *•Assurance of Compliance Form* *•Medicare Certification Civil Rights Information Request Form (and applicable attachments)*	*HHS-690* *www.hhs.gov/ocr/crclearance.html*
Initial Certification - CLIA Laboratory	
Certification and Transmittal	*CMS-1539*
Clinical Laboratory Application	*CMS-116*
[5] Medicare General Enrollment Health Care Provider/Supplier Application	*CMS-855B*
Medicare/Medicaid/CLIA Complaint form	*CMS-562*
[2] Survey Report Form (CLIA)	*CMS-1557*
Laboratory Personnel Report (CLIA)	*CMS-209*
Statement of Deficiencies and Plan of Correction	*CMS-2567*
Post Certification Revisit Report	*CMS-2567B*

LIST OF DOCUMENTS IN CERTIFICATION PACKET	
Title	**Form Number**
Survey Team Composition and Workload Report	*CMS-670 (electronically in ASPEN)*
Recertification - CLIA Laboratory	
Certification and Transmittal	*CMS-1539*
Medicare/Medicaid/CLIA Complaint for	*CMS-562*
[4] *Survey Report Form (CLIA) (cover page)*	*CMS-1557*
Laboratory Personnel Report (CLIA)	*CMS-209*
Statement of Deficiencies and Plan of Correction	*CMS-2567*
Post Certification Revisit Report	*CMS-2567B*
Survey Team Composition and Workload Report	*CMS-670 (electronically in ASPEN)*
Advance Approval/Expansion - End-Stage Renal Disease Facility	
Certification and Transmittal	*CMS-1539*
ESRD Facility Survey Report	*CMS-3427*
Narrative Report Describing Services to be Provided	--
Certificate of Need in the States Where it is Required	--
Survey Team Composition and Workload Report	*CMS-670 (electronically in ASPEN)*
Initial Certification - End-Stage Renal Disease Facility	
Certification and Transmittal	*CMS-1539*
Medicare General Enrollment Health Care Provider/Supplier Application	*CMS-855A*
Statement of Deficiencies and Plan of Correction	*CMS-2567*
[2] *ESRD Facility Survey Report*	*CMS-3427*
[6] *Narrative Report Describing Services to be Provided*	--

LIST OF DOCUMENTS IN CERTIFICATION PACKET	
Title	**Form Number**
[6] *Certificate of Need in the States Where it is Required*	--
Survey Team Composition and Workload Report	*CMS-670 (electronically in ASPEN)*
Expansion With No Survey - End-Stage Renal Disease Facility	
Certification and Transmittal	*CMS-1539*
Narrative Report Describing Services to be Provided	---
Certificate of Need in the States Where it is Required	---
Recertification - End-Stage Renal Disease Facility	
Certification and Transmittal	*CMS-1539*
Statement of Deficiencies and Plan of Correction	*CMS-2567*
[6] *ESRD Facility Survey Report (page 2)*	*CMS-3427*
Survey Team Composition and Workload Report	*CMS-670(electronically in ASPEN)*
Initial Certification – Non-accredited (Non-deemed) Home Health Agency	
Certification and Transmittal	*CMS-1539*
Request to Establish Eligibility	*CMS-1515 a.b.c.d.e.f*
Medicare General Enrollment Health Care Provider/Supplier Application	*CMS-855A*
Crucial Data Extract - HHA	*CMS-1572E (electronically in ASPEN)*
Statement of Deficiencies and Plan of Correction	*CMS-2567*
[6] *Home Health Agency Survey and Deficiencies Report*	*CMS-1572a*
Survey Team Composition and Workload Report	*CMS-670 (electronically in ASPEN)*

LIST OF DOCUMENTS IN CERTIFICATION PACKET	
Title	**Form Number**
Send the following to the RO as soon as received and prior to the survey:	
Health Insurance Benefit Agreement (signed originals)	*CMS-1561*
Office of Civil Rights (OCR) Clearance *•Assurance of Compliance Form* *•Medicare Certification Civil Rights Information Request Form (and applicable attachments)*	*HHS-690* *www.hhs.gov/ocr/crclearance.html*
Recertification – Non-accredited (Non-deemed) Home Health Agency	
Certification and Transmittal	*CMS-1539*
Request to Establish Eligibility (By Surveyor)	*CMS-1515 a,b,c,d,e,,f*
[6] Home Health Agency Survey and Deficiencies Report	*CMS-1572a*
Statement of Deficiencies and Plan of Correction	*CMS-2567*
Survey Team Composition and Workload Report	*CMS-670 (electronically in ASPEN)*
Initial Certification Accredited (Deemed) Home Health Agency	
Certification and Transmittal	*CMS-1539*
Request to Establish Eligibility	*CMS-1515 a.b.c.d.e.f*
Medicare General Enrollment Health Care Provider/Supplier Application	*CMS-855A*
[6] Home Health Agency Survey and Deficiencies Report	*CMS-1572a*
Office of Civil Rights (OCR) Clearance *•Assurance of Compliance Form* *•Medicare Certification Civil Rights Information Request Form (and applicable attachments)*	*HHS-690* *www.hhs.gov/ocr/crclearance.html*
Send the following to the RO as soon as received and prior to the survey:	
Health Insurance Benefit Agreement (signed originals)	

LIST OF DOCUMENTS IN CERTIFICATION PACKET	
Title	**Form Number**
Recertification Accredited (Deemed) Home Health Agency	
Certification and Transmittal	*CMS-1539*
Request to Establish Eligibility (By Surveyor)	*CMS-1515 a,b,c,d,e,f*
[6] Home Health Agency Survey and Deficiencies Report	*CMS-1572a*
Statement of Deficiencies and Plan of Correction	*CMS-2567*
Community Mental Health Clinic	
Certification and Transmittal	*CMS-1539*
Medicare General Enrollment Health Care Providers/Supplier Application	*CMS-855A*
Program Memorandum Intermediaries Transmittal A-02-002 1/11/2002	*Attachment A* *Attachment B*
Model Letter to Entity Seeking Participation in Medicare as a Community Mental Health Center (CMHC) Providing Partial Hospitalization Services	*Exhibit 130*
CMHC Crucial Data Extract (CDE)	*Exhibit 131*
CMHC Attestation Statement	*Exhibit 275*
Health Benefits Agreement for CMHCs	*CMS-1561 or Exhibit 133*
Model Denial Letter for CMHC Applicants – State Restrictions on Screening	*CMS 278*
Model Letter explaining participation in Medicare as A CMHC	*Exhibit 282*
Survey Team Composition and Workload Report	*CMS-670 (electronically in ASPEN)*
Psychiatric Resident Treatment Facility	
Medicare/Medicaid Certification and	*CMS-1539*

LIST OF DOCUMENTS IN CERTIFICATION PACKET	
Title	**Form Number**
Transmittal	
Survey Team Composition and Workload Report	*CMS-670 (electronically in ASPEN)*
Offsite Survey Preparation Worksheet	*CMS-801*
Surveyor Notes Worksheet	*CMS-807*
Individual Observation Worksheet	*CMS-3070I*
Death Record Review Data Sheet	*CMS-726*
Statement of Deficiencies and Plan of Correction	*CMS-2567*
Post Certification Revisit Report	*CMS-2567B*
Initial Certification - Outpatient Physical Therapy - Speech Pathology	
Certification and Transmittal	*CMS-1539*
Request to Establish Eligibility	*CMS-1856*
Medicare General Enrollment Health Care Provider/Supplier Application	*CMS-855A*
Crucial Data Extract - OPT-SP	*CMS-1893E (electronically in ASPEN)*
Statement of Deficiencies and Plan of Correction	*CMS-2567*
[2] OPT-SP Survey Report	*CMS-1893*
Survey Team Composition and Workload Report	*CMS-670 (electronically in ASPEN)*
Send the following to the RO as soon as received and prior to the survey:	
Health Insurance Benefit Agreement (signed originals)	*CMS-1561*
Office of Civil Rights (OCR) Clearance *•Assurance of Compliance Form* *•Medicare Certification Civil Rights Information Request Form (and applicable attachments)*	*HHS-690* *www.hhs.gov/ocr/crclearance.html*

LIST OF DOCUMENTS IN CERTIFICATION PACKET	
Title	**Form Number**
Recertification - Outpatient Physical Therapy - Speech Pathology	
Certification and Transmittal	*CMS-1539*
Request to Establish Eligibility	*CMS-1856*
Crucial Data Extract - OPT-SP	*CMS-1893E (electronically in ASPEN)*
Statement of Deficiencies and Plan of Correction	*CMS-2567*
Survey Team Composition and Workload Report	*CMS-670 (electronically in ASPEN)*
Initial Certification - Portable X-Ray	
Certification and Transmittal	*CMS-1539*
Request to Establish Eligibility	*CMS-1880*
Medicare General Enrollment Health Care Provider/Supplier Application	*CMS-855B*
Crucial Data Extract - PX-R	*CMS-1882E (electronically in ASPEN)*
Statement of Deficiencies and Plan of Correction	*CMS-2567*
[2] *Portable X-Ray Survey Report*	*CMS-1882*
Survey Team Composition and Workload Report	*CMS-670 (electronically in ASPEN)*
Recertification - Portable X-Ray	
Certification and Transmittal	*CMS-1539*
Request to Establish Eligibility (By Surveyor)	*CMS-1880*
Crucial Data Extract - PX-R	*CMS-1882E (electronically in ASPEN)*
Statement of Deficiencies and Plan of Correction	*CMS-2567*
Survey Team Composition and Workload Report	*CMS-670 (electronically in ASPEN)*
Initial Certification - Rural Health Clinic	
Certification and Transmittal	*CMS-1539*

LIST OF DOCUMENTS IN CERTIFICATION PACKET	
Title	**Form Number**
Request to Establish Eligibility	*CMS-29*
Medicare General Enrollment Health Care Provider/Supplier Application	*CMS-855A*
Crucial Data Extract - RHC	*CMS-30E (electronically in ASPEN)*
Statement of Deficiencies and Plan of Correction	*CMS-2567*
[2] Rural Health Clinic Survey Report	*CMS-30*
Survey Team Composition and Workload Report	*CMS-670*
Send the following to the RO as soon as received and prior to the survey:	
Health Insurance Benefit Agreement (signed originals)	*CMS-1561a*
Office of Civil Rights (OCR) Clearance *•Assurance of Compliance Form* *•Medicare Certification Civil Rights Information Request Form (and applicable attachments)*	*HHS-690* *www.hhs.gov/ocr/crclearance.html*
Request to Establish Eligibility	*CMS-29*
Recertification - Rural Health Clinic	
Certification and Transmittal	*CMS-1539*
Request to Establish Eligibility (By Surveyor)	*CMS-29*
Crucial Data Extract - RHC	*CMS-30E(electronically in ASPEN)*
Statement of Deficiencies and Plan of Correction	*CMS-2567*
Survey Team Composition and Workload Report	*CMS-670(electronically in ASPEN)*
Federally Qualified Health Center Complaint Investigation	
Statement of Deficiencies and POC	*CMS-2567*
Certification and Transmittals	*CMS-1539*

LIST OF DOCUMENTS IN CERTIFICATION PACKET	
Title	**Form Number**
Survey Team Composition and Workload Report	*CMS-670 (electronically in ASPEN)*
Initial Certification - Comprehensive Outpatient Rehabilitation Facility	
Certification and Transmittal	*CMS-1539*
Request to Establish Eligibility	*CMS-359*
Medicare General Enrollment Health Care Provider/Supplier Application	*CMS-855A*
Crucial Data Extract - CORF	*CMS-360E (electronically in ASPEN)*
Statement of Deficiencies and Plan of Correction	*CMS-2567*
[2] CORF Survey Report	*CMS-360*
Survey Team Composition and Workload Report	*CMS-670 (electronically in ASPEN)*
Send the following the RO as soon as received and prior to the survey:	
Health Insurance Benefit Agreement (signed originals)	*CMS-1561*
Office of Civil Rights (OCR) Clearance *•Assurance of Compliance Form* *•Medicare Certification Civil Rights Information Request Form (and applicable attachments)*	*HHS-690* *www.hhs.gov/ocr/crclearance.html*
Recertification - Comprehensive Outpatient Rehabilitation Facility	
Certification and Transmittal	*CMS-1539*
Request to Establish Eligibility (By Surveyor)	*CMS-359*
Crucial Data Extract - CORF	*CMS-360E (electronically in ASPEN)*
Statement of Deficiencies and Plan of Correction	*CMS-2567*
Survey Team Composition and Workload Report	*CMS-670 (electronically in ASPEN)*
Independent Physical Therapists	
Certification and Transmittal	*CMS-1539*

LIST OF DOCUMENTS IN CERTIFICATION PACKET	
Title	**Form Number**
Statement of Deficiencies and Plan of Correction	*CMS-2567*
[2] *Physical Therapists in Independent Practice Survey Report*	*CMS-3042*
Request for Certification	*CMS-262*
Survey Team Composition and Workload Report	*CMS-670 (electronically in ASPEN)*
Above documents listed are required for initial and recertification packets. Omit request for certification on relocation survey packets.	
Medicare General Enrollment Health Care Provider/Supplier Application (only required for initial certifications)	*CMS-855I*
Initial Certification – Non-accredited (Non-deemed) Ambulatory Surgical Center	
Certification and Transmittal	*CMS-1539*
Request to Establish Eligibility	*CMS-377*
Medicare General Enrollment Health Care Provider/Supplier Application	*CMS-855B*
Crucial Data Extract - ASC	*CMS-378E (electronically in ASPEN)*
Statement of Deficiencies and Plan of Correction --Health	*CMS-2567*
Statement of Deficiencies and Plan of Correction - LSC	*CMS-2567*
[2] *Ambulatory Surgical Center Survey Report*	*CMS-378*
[2] [8] *Fire Safety Survey Report*	*CMS-2786U*
Survey Team Composition and Workload Report	*CMS-670 (electronically in ASPEN)*
Health Insurance Benefit Agreement (two signed copies)	*CMS-1561*
Office of Civil Rights (OCR) Clearance *•Assurance of Compliance Form* *•Medicare Certification Civil Rights Information*	*HHS-690* *www.hhs.gov/ocr/crclearance.html*

LIST OF DOCUMENTS IN CERTIFICATION PACKET	
Title	**Form Number**
Request Form (and applicable attachments)	
Recertification – Non-accredited (Non-deemed) Ambulatory Surgical Center	
Certification and Transmittal	*CMS-1539*
Request to Establish Eligibility (By Surveyor)	*CMS-377*
Crucial Data Extract - ASC	*CMS-378E (electronically in ASPEN)*
Statement of Deficiencies and Plan of Correction - Health	*CMS-2567*
Statement of Deficiencies and Plan of Correction - LSC	*CMS-2567*
[2] [8] Fire Safety Survey Report	*CMS-2786U*
Survey Team Composition and Workload Report	*CMS-670 (electronically in ASPEN)*
Initial Certification Accredited (Deemed) Ambulatory Surgical Centers	
Certification and Transmittal	*CMS-1539*
Medicare General Enrollment Healthcare Provider/Supplier Application	*CMS-855B*
Health Insurance Benefit Agreement (two signed originals)	*CMS-1561*
FI Letter Recommending/Denying Enrollment	*Letter*
AO Decision Letter	*Letter*
Office of Civil Rights (OCR) Clearance *•Assurance of Compliance Form* *•Medicare Certification Civil Rights Information Request Form (and applicable attachments)*	*HHS-690* *www.hhs.gov/ocr/crclearance.html*

LIST OF DOCUMENTS IN CERTIFICATION PACKET	
Title	**Form Number**
Recertification Accredited (Deemed) Ambulatory Surgical Centers	
Certification and Transmittal	*CMS-1539*
Initial Certification – Non-accredited (Non-deemed) Hospice	
Hospice Request for Certification in the Medicare Program	*CMS-417*
Certification and Transmittal	*CMS-1539*
Medicare General Enrollment Health Care Provider/Supplier Application	*CMS-855A*
Statement of Deficiencies and Plan of Correction - Health	*CMS-2567*
[2] Hospice Survey Report	*CMS-449*
Survey Team Composition and Workload Report	*CMS-670 (electronically in ASPEN)*
Send the following to the RO as soon as received and prior to the survey:	
Health Insurance Benefit Agreement (signed originals)	*CMS-1561*
Office of Civil Rights (OCR) Clearance *•Assurance of Compliance Form* *•Medicare Certification Civil Rights Information Request Form (and applicable attachments)*	*HHS-690* *www.hhs.gov/ocr/crclearance.html*
***Freestanding Hospice**- in addition to the forms noted above, freestanding hospices require:*	
[2] Freestanding Hospice Survey Report	
[1/2] Fire Safety Survey Report	*CMS-2786R*
Statement of Deficiencies and Plan of Correction - LSC	*CMS-2567*
Recertification – Non-accredited (Non-deemed) Hospice	
Certification and Transmittal	*CMS-1539*

LIST OF DOCUMENTS IN CERTIFICATION PACKET	
Title	**Form Number**
Hospice Request for Certification (By Surveyor)	*CMS-417*
Statement of Deficiencies and Plan of Correction - Health	*CMS-2567*
Survey Team Composition and Workload Report	*CMS-670 (electronically in ASPEN)*
***Freestanding Hospice** - in addition to the forms noted above, freestanding hospices with inpatient units require:*	
[1/2] Fire Safety Survey Report	*CMS-2786R*
Statement of Deficiencies and Plan of Correction - LSC	*CMS-2567*
Initial Certification Accredited (Deemed) Hospice	
Hospice Request for Certification in the Medicare Program	*CMS-417*
Certification and Transmittal	*CMS-1539*
Medicare General Enrollment Health Care Provider/Supplier Application	*CMS-855A*
[2] Hospice Survey Report	*CMS-449*
Health Insurance Benefit Agreement (signed originals)	*CMS-1561*
Office of Civil Rights (OCR) Clearance *•Assurance of Compliance Form* *•Medicare Certification Civil Rights Information Request Form (and applicable attachments)*	*HHS-690* *www.hhs.gov/ocr/crclearance.html*
Recertification Accredited (Deemed) Hospice	
Certification and Transmittal	*CMS-1539*
Hospice Request for Certification in the Medicare Program	*CMS-417*
[2] Hospice Survey Report	*CMS-449*

LIST OF DOCUMENTS IN CERTIFICATION PACKET	
Title	**Form Number**
Health Insurance Benefit Agreement (signed originals)	*CMS-1561*
Office of Civil Rights (OCR) Clearance *•Assurance of Compliance Form* *•Medicare Certification Civil Rights Information Request Form (and applicable attachments)*	*HHS-690* *www.hhs.gov/ocr/crclearance.html*
Initial Certification - Title XVIII Skilled Nursing Facility	
Certification and Transmittal	*CMS-1539*
Medicare General Enrollment Health Care Provider/Supplier Application	*CMS-855A*
Statement of Deficiencies and Plan of Correction - Health	*CMS-2567*
Statement of Deficiencies and Plan of Correction - LSC	*CMS-2567*
Post Certification Revisit Report - Health (if applicable)	*CMS-2567B*
Post Certification Revisit Report - LSC (if applicable)	*CMS-2567B*
Skilled Nursing Facility and Nursing Facility	
Long-Term Care Facility Application for Medicare and Medicaid	*CMS-671*
Resident Census and Conditions of Residents	*CMS-672*
Extended/Partial Extended Survey Worksheet	*CMS-673*
Resident Rights and Quality of Life:	*CMS-674*
Individual Interview Guide Resident Rights and Quality of Life: Family	*CMS-674A*
Interview Guide Resident Rights and Quality of Life: Group Interview Guide	*CMS-675*
Quality of Care Assessment Worksheet	*CMS-676*

LIST OF DOCUMENTS IN CERTIFICATION PACKET	
Title	**Form Number**
Quality of Care Assessment Worksheet, MDS+	*CMS-676A*
Medication Pass Worksheet	*CMS-677*
Environmental Quality Assessment Worksheet	*CMS-678*
Dietary Services System Worksheets	*CMS-679A,B,C*
Closed Records Discharge Review Worksheet	*CMS-680*
Surveyor Notes Worksheet	*CMS-681*
Resident Roster	*CMS-682*
1/2 Fire Safety Survey Report	*CMS-2786R*
Waiver (if applicable)	--
Utilization Review Plan	
Survey Team Composition and Workload Report	*CMS-670 (electronically in ASPEN)*
Send the following to the RO as soon as received and prior to the survey:	
Health Insurance Benefit Agreement (signed originals)	*CMS-1561*
Office of Civil Rights (OCR) Clearance *•Assurance of Compliance Form* *•Medicare Certification Civil Rights Information Request Form (and applicable attachments)*	*HHS-690* *www.hhs.gov/ocr/crclearance.html*
Recertification - Title XVIII Skilled Nursing Facility	
Certification and Transmittal	*CMS-1539*
Statement of Deficiencies and Plan of Correction - Health	*CMS-2567*
Statement of Deficiencies and Plan of Correction - LSC	*CMS-2567*
Post Certification Revisit Report - Health (if applicable)	*CMS-2567B*

LIST OF DOCUMENTS IN CERTIFICATION PACKET	
Title	**Form Number**
Post Certification Revisit Report - LSC (if applicable)	*CMS-2567B*
[1/2] Fire Safety Survey Report	*CMS-2786R*
Survey Team Composition and Workload Report	*CMS-670 (electronically in ASPEN*
Initial Certification - Title XIX Nursing Facility	
Certification and Transmittal	*CMS-1539*
Statement of Deficiencies and Plan of Correction - Health	*CMS-2567*
Statement of Deficiencies and Plan of Correction - LSC	*CMS-2567*
Post Certification Revisit Report - Health (if applicable)	*CMS-2567B*
Post Certification Revisit Report - LSC (if applicable)	*CMS-2567B*
Skilled Nursing Facility and Nursing Facility Long-Term Care Facility Application for Medicare and Medicaid	*CMS-671*
Resident Census and Conditions of Residents	*CMS-672*
Extended/Partial Extended Survey Worksheet	*CMS-673*
Resident Rights and Quality of Life: Individual Interview Guide	*CMS-674*
Resident Rights and Quality of Life: Family Interview Guide	*CMS-674A*
Resident Rights and Quality of Life: Group Interview Guide	*CMS-675*
Quality of Care Assessment Worksheet	*CMS-676*
Quality of Care Assessment Worksheet, MDS+	*CMS-676A*
Medication Pass Worksheet	*CMS-677*

LIST OF DOCUMENTS IN CERTIFICATION PACKET	
Title	**Form Number**
Environmental Quality Assessment Worksheet	*CMS-678*
Dietary Services System Worksheets	*CMS-679A,B,C*
Closed Records Discharge Review Worksheet	*CMS-680*
Surveyor Notes Worksheet	*CMS-681*
Resident Roster	*CMS-682*
1/2 Fire Safety Survey Report	*CMS-2786R*
Survey Team Composition and Workload Report	*CMS-670 (electronically in ASPEN)*
SNF XIX-only: If waivers are requested (Health or LSC), forward two copies of the waiver recommendation and the applicable survey report prior to sending the survey packet.	
Recertification - Title XIX Nursing Facility	
Certification and Transmittal	*CMS-1539*
Statement of Deficiencies and Plan of Correction - Health	*CMS-2567*
Statement of Deficiencies and Plan of Correction - LSC	*CMS-2567*
Post Certification Revisit Report - Health (if applicable)	*CMS-2567B*
Post Certification Revisit Report - LSC (if applicable)	*CMS-2567B*
The same waiver as in initial certification requires submittal of only page 1 of Fire Safety Report	
1/2 Fire Safety Survey Report	*CMS-2786R*
Survey Team Composition and Workload Report	*CMS-670 (electronically in ASPEN)*
SNF XIX-only: Waiver requests (Health or LSC) must come in prior to the survey packet.	

LIST OF DOCUMENTS IN CERTIFICATION PACKET	
Title	**Form Number**
Recertification - Medicare Skilled Nursing Facility While Subject to Denial of Payments for New Admissions	
Certification and Transmittal	*CMS-1539*
Statement of Deficiencies and Plan of Correction - Health	*CMS-2567*
NOTE: Plan of correction may or may not be submitted by the provider.	
Statement of Deficiencies and Plan of Correction - Life Safety Code	*CMS-2567*
[1] Fire Safety Survey Report	*CMS-2786R*
Survey Team Composition and Workload Report	*CMS-670 (electronically in ASPEN)*
Revisit After Credible Allegation - Medicare Skilled Nursing Facility While Subject to Denial of Payments for New Admissions	
Certification and Transmittal	*CMS-1539*
Statement of Deficiencies and Plan of Correction (for deficiencies found not corrected)	*CMS-2567*
Post-Certification Revisit Report (for deficiencies found to have been corrected)	*CMS-2567B*
Survey Team Composition and Workload Report	*CMS-670 (electronically in ASPEN)*
Recertification - Medicaid-Only Nursing Facility While Subject to Denial of Payments for New Admissions	
Certification and Transmittal	*CMS-1539*
Statement of Deficiencies and Plan of Correction - Health	*CMS-2567*
NOTE: Plan of Correction may or may not be submitted by the provider.	
Statement of Deficiencies and Plan of Correction - Life Safety Code	*CMS-2567*
[1]Fire Safety Survey Report	*CMS-2786R*

LIST OF DOCUMENTS IN CERTIFICATION PACKET	
Title	**Form Number**
(The same waiver as in initial certification requires submittal of only page 1 of Fire Safety Report)	
Survey Team Composition and Workload Report	*CMS-670 (electronically in ASPEN)*
Revisit After Credible Allegation - Medicaid-Only Nursing Facility While Subject to Denial of Payments for New Admissions	
Certification and Transmittal	*CMS-1539*
Statement of Deficiencies and Plan of Correction (for deficiencies found not corrected)	*CMS-2567*
Post-Certification Revisit Report (for deficiencies found to have been corrected)	*CMS-2567B*
Survey Team Composition and Workload Report	*CMS-670 (electronically in ASPEN)*
Initial Certification - Intermediate Care Facility for the Mentally Retarded	
Certification and Transmittal	*CMS-1539*
Request to Establish Eligibility	*CMS-1516*
Crucial Data Extract - Health	*CMS-3070BE (electronically in ASPEN)*
Statement of Deficiencies and Plan of Correction - Health	*CMS-2567*
Statement of Deficiencies and Plan of Correction - LSC	*CMS-2567*
[2] Institutions of Mentally Retarded or Persons with Retarded Conditions Survey Report	*CMS-3070 G,H, I*
[1/2] Fire Safety Survey Report for each building involved, or for each construction type for any building having more than one construction type	*CMS-2786 V,M,Y*
[9] Life Safety Code Waivers	--
Listing of QMRPs with Qualifications	--
Direct Care Staffing Information - Individual Units	--

LIST OF DOCUMENTS IN CERTIFICATION PACKET	
Title	**Form Number**
Description of Living Units	--
Survey Team Composition and Workload Report	*CMS-670 (electronically in ASPEN)*
[9] ***Recertification - Intermediate Care Facility for the Mentally Retarded***	
Certification and Transmittal	*CMS-1539*
Request to Establish Eligibility (By Surveyor)	*CMS-1516*
Crucial Data Extract - Health	*CMS-3070E (electronically in ASPEN)*
Statement of Deficiencies and Plan of Correction - Health	*CMS-2567*
Statement of Deficiencies and Plan of Correction - LSC	*CMS-2567*
Listing of QMRPs with Qualifications	--
Direct Care Staffing Information - Individual Units	--
Description of Living Units	--
Survey Team Composition and Workload Report	*CMS-670 (electronically in ASPEN)*
1861(j)(l) Certifications	
Certification and Transmittal - Spell of Illness, 1861(j)(1) Supplement	*CMS-1539A*
1861(j)(1) Determinations - Computation of Nurse to Resident Ratio Form	--
[2] *Intermediate Care Facility Survey Report (page 24)*	*CMS-3070*
Survey Team Composition and Workload Report	*CMS-670 (electronically in ASPEN)*
Post-Certification Revisit Report - All Facilities Except Long-Term Care	
Post-Certification Revisit Report - Health (if applicable)	*CMS-2567B*

LIST OF DOCUMENTS IN CERTIFICATION PACKET	
Title	**Form Number**
Post-Certification Revisit Report - LSC (if applicable)	*CMS-2567B*
Survey Team Composition and Workload Report	*CMS-670 (electronically in ASPEN)*
Post Certification Revisit Report with Amended CMS-1539	
Certification and Transmittal	*CMS-1539*
Post-Certification Revisit Report - Health (if applicable)	*CMS-2567B*
Post-Certification Revisit Report - LSC (if applicable)	*CMS-2567B*
Survey Team Composition and Workload Report	*CMS-670 (electronically in ASPEN)*
Addition and/or Deletion of Services	
Certification and Transmittal	*CMS-1539*
Medicare General Enrollment Health Care Provider/Supplier Application	*CMS-855*
Appropriate Request to Establish Eligibility (By Surveyor)	--
Statement of Deficiencies and Plan of Correction (if applicable);	*CMS-2567*
Survey Team Composition and Workload Report	*CMS-670(electronically in ASPEN)*
Address and/or Name Change	
Medicare Change of Information Health Care	*CMS-855*
Provider/Supplier Application Certification and Transmittal	*CMS-1539*
Change of Ownership - Title XVIII or XVIII-XIX Providers	
Certification and Transmittal	*CMS-1539*
[10] Health Insurance Benefit Agreement (signed originals)	*CMS-1561*

LIST OF DOCUMENTS IN CERTIFICATION PACKET	
Title	**Form Number**
Office of Civil Rights (OCR) Clearance *•Assurance of Compliance Form* *•Medicare Certification Civil Rights Information Request Form (and applicable attachments)*	*HHS-690* *www.hhs.gov/ocr/crclearance.html*
Request to Establish Eligibility (for applicable provider)	--
Medicare General Enrollment Health Care Provider/Supplier Application	*CMS-855*
[11] Long Term Care Facility Application for Medicare and Medicaid	*CMS-671*
Change of Ownership - Providers - Title XIX Nursing Facilities	
Certification and Transmittal	*CMS-1539*
Request to Establish Eligibility	*CMS-1516*
Long Term Care Facility Application for Medicare and Medicaid	*CMS-671*
Survey Team Composition and Workload Report	*CMS-670 (electronically in ASPEN)*
Change of Ownership - Suppliers	
Certification and Transmittal	*CMS-1539*
Request to Establish Eligibility (for applicable supplier)	--
Medicare General Enrollment Health Care Provider/Supplier Application	*CMS-855*
Survey Team Composition and Workload Report	*CMS-670*
General Complaint	
Medicare/Medicaid/CLIA Complaint Form	*CMS-562*
Narrative Report	
Statement of Deficiencies and Plan of Correction (if applicable)	*CMS-2567*

LIST OF DOCUMENTS IN CERTIFICATION PACKET	
Title	**Form Number**
Portions of: Health or Fire Safety Code Survey Report (as applicable)	*CMS-2786*
Survey Team Composition and Workload Report	*CMS-670 (electronically in ASPEN)*

Notes

[1] *If FSES is applied, the following are needed: Form CMS-2786T for all zones, table 8 for entire facility.* ***Do not*** *send LSC survey report to RO if it is a Form CMS-2786R,* ***and*** *no use of FSES or waivers.*

[2] *As required by §2720 of the "State Operations Manual."*

[3] *Hospitals not in compliance, RN waiver requests, and hospitals no longer accredited--Send complete survey reports.*

[4] *If there is a change in name, address, ownership, or services at the time of recertification, send in the same information as for an initial certification.*

[5] *The Form CMS-855 is for participation in Medicare*

[6] *Only if these documents have not been sent in with the request for advance approval.*

[7] *Needed only if expansion of services or stations done at time of recertification.*

[8] *If a waiver of a LSC item is requested, send Form CMS-2786Y and all necessary documentation.*

[9] *When a waiver is granted for the first time, send in the complete Fire Safety Report. Subsequent requests for approval of the same waiver require submittal of only page 1 of Fire Safety Report.*

[10] *Send in as soon as available.*

[11] *Required for skilled nursing facilities and nursing facilities only.*

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Exhibit 74
SURVEY TEAM COMPOSITION AND WORKLOAD REPORT
CMS 670

CMS Certification Number (CCN)	*Provider/Supplier Name*

Type of Survey (select all that apply)

A	*Complaint Investigation*	*E*	*Initial Certification*	*I*	*Recertification*
B	*Dumping Investigation*	*F*	*Inspection of Care*	*J*	*Sanctions/Hearing*
C	*Federal Monitoring*	*G*	*Validation*	*K*	*State License*
D	*Follow-up Visit*	*H*	*Life Safety Code*	*L*	*CHOW*
M	*Other*				

Extent of Survey (select all that apply)

A Routine/Standard Survey (all providers/suppliers)
B Extended Survey (HHA or Long Term Care Facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's identification number.

Surveyor ID Number (A)	*First Date Arrived (B)*	*Last Date Departed (C)*	*Pre-Survey Preparation Hours (D)*	*On-Site Hours 12am-8am (E)*	*On-Site Hours 8am-6pm (F)*	*On-Site Hours 6pm-12am (G)*	*Travel Hours (H)*	*Off-Site Report Preparation Hours (I)*
1. 0								
2. A								
3. A								
4. A								
5. A								
6. A								
7. A								
8. A								
9. A								
10. A								
11. A								
12. A								
13. A								
14. A								

Total SA Supervisory Review Hours.....

Total RO Supervisory Review Hours.... *0.00*

Total SA Clerical/Data Entry Hours....

Total RO Clerical/Data Entry Hours..... *0.00*

Was Statement of Deficiencies given to the provider on-site at completion of the survey?....

Exhibit 81

Model Letter Requirements For
Swing-Bed Approval in Hospitals

Name/Title of Hospital Administrator, CEO, or Responsible Individual
Name of Hospital
Street Address
City, State, Zip Code

Dear _____:

This letter concerns the requirements and procedures through which (name of facility) may be approved under Medicare as a hospital with swing-bed approval. This State survey agency (SA) certifies and periodically re-certifies hospitals to assist the Centers for Medicare and Medicaid Services (CMS) in determining whether they meet the Medicare Conditions of Participation for hospitals at 42 CFR 482. Such approval is a prerequisite to qualify for participation in the Medicaid program also.

To be eligible for certification under Medicare as a hospital with swing-beds, (name of facility) must first be designated as a hospital by the State. In addition, it must also:

- Have fewer than 100 beds excluding beds for newborns and beds in intensive care type inpatient units;
- Be located in a rural area. This includes all areas not delineated as ”urbanized” areas by the Census Bureau, based on the most recent census;
- Have a current Medicare participation agreement;
- Be in compliance with the Medicare hospital Conditions of Participation (CoPs) at 42 CFR 482;
- Not have in effect a 24-hour nursing waiver granted under 42 CFR 488.54(c)*;*
- Not have *had* a swing-bed approval *that was* terminated with*in 2* years previous to application;
- Meet the swing-bed requirements at 42 CFR 482.66; and
- *Complete and submit to the SA the forms included with this letter.*

If your facility has been *found to be eligible, you will be subject to an unannounced survey* to determine compliance with the hospital swing-bed CoPs. The surveyors will inspect the facility, interview you and members of your staff, review documents, and *employ* other *processes* necessary to evaluate the extent to which the facility meets the hospital swing-bed CoPs. If *your* facility has significant deficiencies in any of the hospital swing-bed CoPs, you will be informed and given an opportunity to correct them.

Please be advised that your facility may not be paid for any swing-bed services provided prior to the effective date for swing-bed approval.

Please to not hesitate to contact this office at (telephone number of SA) if you have any questions.

Sincerely,

(State agency)

Enclosures: (list as appropriate)

cc: CMS Regional Office

Exhibit 82

Model Letter
Approval Notification for Swing-beds in a Hospital

Name/Title of Hospital Administrator, CEO, or Responsible Individual
Name of Hospital
Street Address
City, State, Zip Code

Dear_____:

We are pleased to notify you that (name of Hospital) meets the requirements at 42 CFR Part 482.66 for participation in the Medicare program as a hospital with swing-bed approval. The effective date of this approval is (effective date).

Effective with this approval (name of Hospital's) participation as an acute care hospital will use the current CMS Certification Number(CCN) (insert hospital CCN) for acute care patients. Your new CCN for swing-beds services is like your general Medicare CCN, except that the "third digit" is changed to the alpha-character "u". It is important that this sub-provider CCN (swing-bed CCN) be entered on all forms, claims, and correspondence relating to skilled nursing care services. You will continue to the use the general Medicare CCN (hospital CCN) on all forms, claims, and correspondence relating to hospital acute care services.

The swing-bed CCN should be used on all correspondence and billing for the Medicare program starting (effective date).

If deficiencies were found during the survey of your facility, it is expected that you will correct these citations as stated in your plan of correction. The State Agency will monitor progress made in correcting the identified deficiencies.

Your fiscal intermediary is (name of fiscal intermediary). Questions concerning billing and other fiscal matters should be directed to them at (contact number). Questions related to the Conditions of Participation for hospitals should be referred to your SA (SA contact information).

Sincerely,

(Associate Regional Administrator or Equivalent)

cc:
Fiscal Intermediary/Medicare Administrative Contractor
Regional Administrator
State Department of Health

Exhibit 83

Model Letter
Denial for Swing-bed Approval in a Hospital

Name/Title of Hospital Administrator, CEO, or Responsible Individual
Name of Hospital
Street Address
City, State, Zip Code

Dear_____:

This letter is to inform you that your request for approval as a provider of swing-bed services is being denied. In order to participate in the Medicare swing-bed program, a hospital must comply with all regulatory requirements at 42 CFR Part 482 .66. Based on the deficiencies identified on the CMS Form-2567, your hospital does not qualify for participation.

Although your facility does not qualify as a provider of swing-bed services at this time, you may take steps to correct these deficiencies and reapply to establish Medicare eligibility.

If you believe this determination is incorrect, you may ask that it be reconsidered. Your request must be submitted in writing to this office within 60 days from the date of receipt of this letter. You may submit with your request for reconsideration any additional information you believe to be pertinent to this decision.

Sincerely,

(Associate Regional Administrator or Equivalent)

Enclosures: (list as appropriate)

EXHIBIT 126

MODEL LETTER ACCOMPANYING SELF-ATTESTATION WORK SHEETS

(**Date**)

Name of *IPPS*-Excluded Hospital or Hospital *Unit*
Street Address
City, State, ZIP Code

Dear (**Name of Hospital/Unit**):

For this facility or unit *to* continue to be eligible for exemption from the Medicare *Inpatient* Prospective Payment System (*I*PPS) for the fiscal year beginning (**date**) the Administrator or Chief Executive Officer of the hospital (i.e., the individual principally responsible for the operation of the hospital) must complete and return the attached attestation statement and work sheet. Hospitals and units may be excluded from *I*PPS if they meet certain requirements of 42 CFR Parts 412.23 through 412.30 and §*3100 of the State Operations Manual*. If a hospital/unit does not in fact, meet the exclusion criteria, Medicare payment will be made under the *I*PPS.

According to our records the (**name of *I*PPS-excluded hospital or unit**) will need to be reverified by (**date**). In order to continue to receive payment under Medicare and Medicaid as a (**type of *I*PPS-excluded hospital or unit**), an officer of the hospital/unit must certify, at least 90 days prior to the beginning of the next cost reporting period, that the hospital or unit currently meets and will continue to meet all of the *I*PPS-exclusion criteria.

In order to receive the certification in a timely manner, the Administrator or Chief Executive Officer, as appropriate, of the hospital must:

- Respond to every item on the attached worksheet;
- Sign and date the front page of the attached worksheet (Forms CMS-437, CMS-437A or CMS-437B, as appropriate) in the space marked, “Verified By:”; and
- Return both the signed attestation statement and the signed completed work sheet to (**State agency address**) by (**date that is 90 days prior to the beginning of the cost reporting period**).

Please note that the hospital/unit should notify the Regional Office (**RO address**) immediately if it does not wish to continue as a *I*PPS-excluded hospital/unit. In addition, if hospitals/units are not interested or otherwise unable to use the self-attestation process to apply for continued exclusion from *IPPS*, a survey process may be used to determine if the hospital/unit should continue to be excluded from *I*PPS.

Please note that hospitals/units are under a continuing obligation to notify the State agency if the hospital or unit fails to meet one of the applicable requirements in the period between the attestation and the start of the fiscal year. CMS will continue to verify separately, through the appropriate fiscal intermediary, compliance with certain criteria (e.g., the 75% requirement for rehabilitation units) currently verified by the fiscal intermediary. Please be advised that CMS may validate the compliance of any requirement without prior notice.

If there are any questions about the requirements or completion of the worksheet or the attestation, please contact (**name, address, and phone number of contact person**).

Sincerely yours,

State Agency Director

Exhibit 134

Model Letter
Letter Transmitting Requirements to a Hospital Requesting a Change in Status to a Critical Access Hospital (CAH)

Name/Title of Responsible Individual
Name of Hospital
Street Address
City, State, Zip Code

Dear_____:

The Regional Office of the Centers for Medicare and Medicaid Services (CMS-RO) and the State Agency have received information that your hospital is requesting a change in Medicare provider status to critical access hospital (CAH). The purpose of this letter is to inform you of the requirements and procedures that are required to become certified as a Medicare CAH.

To be eligible for certification as a CAH, the hospital must first be designated as eligible in writing by the State. In addition the following criteria must be met.

- *Location in a rural area. If the hospital is located within a metropolitan statistical area (MSA) the hospital must apply to CMS for reclassification under a State statute or regulation that has been codified in law that would define your location to be rural for your State rural health programs. If located within an MSA, you must provide the CMS RO with a letter requesting reclassification, along with a copy of the State law that would qualify the hospital to be reclassified as rural under 42 CFR 412.103.*

- *The provider must be a current Medicare-participating hospital, an otherwise qualified closed hospital, or a hospital that was previously down-sized to a rural health clinic, as defined at 42 CFR 485.610(a).*

- *The hospital must be located in a State that has established a Medicare Rural Hospital Flexibility Plan.*

- *The hospital must currently be in compliance with the Medicare hospital Conditions of Participation (CoPs).*

- *As specified at 42 CFR 485.610(c), the hospital must be located more than a 35 mile drive from any other hospital or CAH, or 15 miles in mountainous terrain or in areas with only secondary roads available.*

- *The hospital must operate not more than 25 beds for inpatient care.*

- *The hospital must provide acute inpatient care for a period that does not exceed, on an annual average basis, 96 hours per patient, as required by 42 CFR 485.620(b)*

.

- *The facility may choose to offer skilled nursing facility (SNF) - level care in swing beds under a specific swing-bed approval, upon demonstration of compliance with the swing-bed requirements, found at 42 CFR 485.645. Swing beds do count toward the 25-bed limit but do not have a length of stay restriction and are not used to compute the facility length of stay average.*

- *The hospital may also provide services in a maximum 10-bed psychiatric distinct part unit (DPU) and/or a maximum 10-bed rehabilitation DPU after demonstrating compliance with 42 CFR 485.647. These units are exempt from the 25 bed limit and are not used to compute the facility annual average inpatient length of stay.*

- *The hospital must comply with all other CAH CoPs found at 42 CFR 483 Subpart F, including provision of emergency services 24 hours a day and 7 days a week.*

- *The hospital must complete the forms that are included with this letter and return the package to the SA.*

- *The hospital must successfully complete an initial survey demonstrating compliance with the CAH CoPs at 42 CFR 485 Subpart F.*

Your facility may not receive reimbursement for services as a CAH prior to the Medicare effective date for certification in the Medicare program issued by the CMS RO.

Please do not hesitate to contact this office at (telephone number of SA) if you have any questions regarding the CAH survey process or any of the documentation requested.

Sincerely,

State agency representative

Enclosures: (list as appropriate)

cc:

Fiscal Intermediary/Medicare Administrative Contractor
Regional Administrator
State Department of Health

Exhibit 135

Model Letter Transmitting
Swing-Bed Approval Notification in a Critical Access Hospital (CAH)

Name/Title of Responsible Individual
Name of Hospital
Street Address
City, State, Zip Code

Dear_____:

We are pleased to notify you that (insert name of hospital) meets the requirements at 42 CFR Part 485 Subpart F for participation in the Medicare program as a CAH with swing-bed approval as of (effective date). This approval allows your facility to provide skilled nursing care to post-hospital patients.

Your new CMS Certification number (CCN) for your CAH swing-bed approval is (insert CAH CCN). This CCN should be used on all correspondence and billing for the Medicare program starting on (effective date).

Your fiscal intermediary is (name of fiscal intermediary/Medicare Administrative Contractor). Questions concerning billing and other fiscal matters should be directed to the FI/MAC. Questions related to the Conditions of Participation for CAHs should be referred to your SA (insert contact information).

Sincerely,

Associate Regional Administrator/Equivalent

cc:

Fiscal Intermediary/Medicare Administrative Contractor
Regional Administrator
State Department of Health

EXHIBIT 138

EMTALA Physician Review Worksheet

☐ ***5 - Day Review*** ☐ ***60 - Day Review***

SECTION I

Regional Office staff or QIO may complete.

*Complaint Control Number:*_____ *Patient ID:*_____

Name of Patient: _____ *DOB:* _____

Name of Alleged Violating Hospital and/or Physician: _____

NPI Number: _____

City: _____ *State:* _____ *CMS Certification Number:* _____
(formerly the Medicare Provider Number)

Date and Time of Admission to Emergency Services: _____

Date and Time of Discharge from Emergency Services: _____

Name of Receiving Hospital (if applicable): _____

NPI Number: _____

City: _____ *State:* _____ *CMS Certification Number:* _____
(formerly the Medicare Provider Number)

*Date and Time of Admission to Receiving Hospital (if applicable):*_____

Manner of Transport: _____

Location and Distance from Sending Hospital (if known): _____

SECTION II

Note to Physician Reviewer: Please complete the following questions to address issues related to EMTALA. Please be sure to include your clinical rationale for your determinations, and make any summary comments and comments on other aspects of the case in the summary section on the last page of this document. Please keep in mind that the purpose of your comments is to provide your clinical perspective on the care rendered, for the CMS 5-day review or for the OIG 60-day review. ***Therefore, please refrain from making ANY statements about whether or not a violation of EMTALA has occurred, as that decision is the responsibility of CMS and the OIG only.*** *(Violations of EMTALA may also constitute negligence under state malpractice law.)*

MEDICAL SCREENING EXAMINATION

Note to Physician Reviewer: *Depending upon an individual's presenting symptoms, an appropriate medical screening examination can range from a simple process involving only a brief history and physical examination to a complex process that also involves performing ancillary studies and procedures such as (but not limited to) lumbar puncture, clinical laboratory tests, CT scans and other diagnostic tests and procedures.*

EXHIBIT 138
EMTALA Physician Review Worksheet

A hospital must provide appropriate screening and treatment services within the full capabilities of its staff and facilities, including access to specialists who are on call.

1 a. Did the hospital provide a medical screening examination that was appropriate to the individual's medical complaint(s) and symptoms?

☐ ***YES*** ☐ ***NO***

Please explain your clinical rationale: _____

_____

_____

1 b. Did the hospital provide (within its capability - including ancillary services routinely available and consultations by on–call specialist physicians) a medical screening examination that was, within reasonable clinical confidence, sufficient to determine whether or not an EMERGENCY MEDICAL CONDITION (as defined below) existed?

☐ ***YES*** ☐ ***NO***

Please explain your clinical rationale: _____

_____

_____

Note: *An* ***Emergency Medical Condition*** *is defined by statute as* ***EITHER****: (1) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in: placing the individual's health (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part;* ***OR*** *(2) with respect to a pregnant woman who is having contractions, that there is inadequate time to effect a safe transfer to another hospital before delivery, or that the transfer may pose a threat to the health or safety of the woman or the unborn child.*

EMERGENCY MEDICAL CONDITION

2. Did this individual have an EMERGENCY MEDICAL CONDITION as defined by Part (1) of the statutory definition noted above? *(Individual conditions meeting the definition in Part 2 above are addressed in subsequent questions.)*

☐ ***YES*** ☐ ***NO***

Please explain your clinical rationale: _____

_____

_____

3. Was this individual a pregnant woman who was having contractions?

☐ ***YES*** ☐ ***NO***

Please explain your clinical rationale: _____

_____

_____

_____

a) If "Yes" and the pregnant woman was transferred/discharged, at the time of transfer/discharge, could it be determined with reasonable medical certainty that there would be adequate time to effect a safe transfer to another hospital before delivery?

☐ ***YES*** ☐ ***NO*** ☐ ***N/A***

Please explain your clinical rationale: _____

_____

_____

_____

b) If the pregnant woman with contractions was transferred/discharged, at the time of transfer/discharge could it be determined, with reasonable medical certainty, that the transfer/discharge would not pose a threat to the health or safety of the individual or the unborn child?

☐ ***YES*** ☐ ***NO*** ☐ ***N/A***

Please explain your clinical rationale: _____

_____

_____

_____

EXHIBIT 138
EMTALA Physician Review Worksheet

STABILIZING TREATMENT

Note to Physician Reviewer: *Terms relating to "stabilization" are specifically defined under EMTALA. These terms DO NOT REFLECT the common usage in the medical profession, but instead focus on the medical risks associated with a particular transfer/discharge. Thus, when answering questions related to "stability" for EMTALA, please be very careful to refer to the definition provided in parentheses in question 4 below. In addition, the clinical outcome of an individual's condition is not a proper basis for determining whether a person transferred was stabilized. However, the individual's outcome may be a "red flag" indicating that a more thorough evaluation of the individual's condition at the time of transfer was needed.*

4. If an emergency medical condition (EMC) existed at the time of transfer/discharge, was the individual's EMC "stabilized" (meaning that no material deterioration of the condition was likely, within reasonable medical probability, to result from or occur during the transfer/discharge of the individual from the hospital, or in the case of a pregnant woman in labor, that the pregnant woman had delivered the child and placenta)?

☐ ***YES*** ☐ ***NO*** ☐ ***N/A***

Please explain your clinical rationale: _____

_____

_____

5 a. Is there any evidence that the hospital was equipped with such staff, services, or equipment necessary to "stabilize" (assure within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a hospital, or a pregnant woman has delivered both the child and the placenta) the emergency medical condition?

☐ ***YES*** ☐ ***NO*** ☐ ***N/A***

Please explain your clinical rationale: _____

_____

_____

5 b. If the hospital had the capability to stabilize the individual and the individual was not stabilized prior to transfer/discharge, is there any information available to indicate WHY the emergency medical condition was NOT "stabilized" prior to discharge/transfer?

☐ ***YES*** ☐ ***NO*** ☐ ***N/A***

Please explain your clinical rationale: _____

_____

_____

EXHIBIT 138
EMTALA Physician Review Worksheet

APPROPRIATE TRANSFERS

6 a. If the individual was transferred to another hospital, is there evidence that the sending hospital lacked the capabilities and facilities to provide further medical examination and treatment to stabilize the individual's medical condition?

☐ ***YES*** ☐ ***NO*** ☐ ***N/A***

If yes, what were the specialized capabilities that were required for the individual's emergency medical condition that the sending hospital lacked?

_____

_____

_____

Please explain your clinical rationale: _____

_____

_____

_____

6 b. If the individual was transferred to another hospital, did the transferring hospital provide further examination and stabilizing treatment, within its capabilities (including ancillary services routinely available to it) to minimize the risks of transfer to the individual's health and, where relevant, the health of the unborn child?

☐ ***YES*** ☐ ***NO*** ☐ ***N/A***

Please explain your clinical rationale: _____

_____

_____

7. If the individual was transferred to another hospital, to minimize the risks of transfer, did the transfer of the individual require the use of qualified personnel and transportation equipment, including life support measures if medically appropriate?

☐ ***YES*** ☐ ***NO*** ☐ ***N/A***

Please explain your clinical rationale: _____

_____

_____

8. If the individual was transferred to another hospital, were the transportation equipment and personnel provided appropriate to the transferred individual's needs?

☐ ***YES*** ☐ ***NO*** ☐ ***N/A***

Please explain your clinical rationale: _____

_____

_____

_____

9 a. At the time of transfer, did a physician, or if a physician was not physically present, another qualified medical person (in consultation with a physician, who subsequently countersigned the certification) certify in writing that, based upon the reasonable risks and benefits to the individual, and based upon information available at the time of transfer, the medical benefits reasonably expected from medical treatment at another hospital outweighed the increased risks to the patient from effecting the transfer?

☐ ***YES*** ☐ ***NO*** ☐ ***N/A***

Please explain: _____

_____

_____

_____

9 b. Do you agree that <u>at the time of transfer</u>, based upon the reasonable risks and benefits to the individual and based upon information available at the time of transfer, the medical benefits reasonably expected from medical treatment at another hospital outweighed the increased risk to the individual being transferred?

☐ ***YES*** ☐ ***NO*** ☐ ***N/A***

Please explain your clinical rationale: _____

_____

_____

_____

9 c. If the individual (or a legally responsible person acting on the individual's behalf) requested the transfer in writing, was he/she informed of the hospital's obligations and of the medical risks of transfer?

☐ ***YES*** ☐ ***NO*** ☐ ***N/A***

Please explain: _____

_____

_____

_____

10. Did the transferring hospital obtain the agreement of the receiving hospital to accept the transfer and to provide appropriate medical treatment?

☐ ***YES*** ☐ ***NO*** ☐ ***N/A***

Please explain, including, if "yes," how this was documented: _____

_____

_____

_____

11. Does the documentation suggest that the transferring hospital sent to the receiving hospital all available and pertinent medical documentation related to the emergency medical condition?

☐ ***YES*** ☐ ***NO*** ☐ ***N/A***

Please explain: _____

_____

_____

_____

12. If the individual refused to consent to necessary stabilizing treatment or to an appropriate transfer, is there evidence that the hospital first offered the individual the further medical examination and treatment or appropriate transfer, informing him/her of the risks and benefits, and obtained the individual's informed written refusal?

☐ ***YES*** ☐ ***NO*** ☐ ***N/A***

Please explain: _____

_____

_____

_____

_

EXHIBIT 138
EMTALA Physician Review Worksheet

RESPONSIBILITY OF HOSPITALS WITH SPECIALIZED DIAGNOSTIC OR TREATMENT CAPABILITIES OR FACILITIES

Note to physician reviewer: *While "specialized capabilities or facilities" include such facilities as burn units, shock-trauma units, neonatal intensive care units or regional referral centers, it also includes much more. Most simply, if an individual with an emergency medical condition needs services to stabilize that condition that cannot be made available in a clinically appropriate timeframe at the hospital where the individual presented, but are available at another hospital, the hospital with these capabilities/services must accept a request for transfer if it has the capacity to provide the needed capabilities/services.*

13. Is there any evidence that a Medicare-participating hospital that refused a transfer request has specialized capabilities or services (not available at the transferring hospital) that an individual required?

☐ ***YES*** ☐ ***NO*** ☐ ***N/A***

Please explain: _____

_____

_____

DELAY IN TREATMENT

14. Is there any evidence that the hospital under review delayed for an inappropriate length of time the provision of an appropriate medical screening examination or further medical examination and treatment?

☐ ***YES*** ☐ ***NO***

Please explain:

_____

_____

_____

QUALITY

15. Do you have any specific concerns about the quality of care rendered to the individual that have not already been addressed fully above?

☐ ***YES*** ☐ ***NO***

Please explain your clinical rationale:

_____

_____

_____

EXHIBIT 138

EMTALA Physician Review Worksheet

SUMMARY OF FINDINGS:

16. Please summarize the key facts of the case below and any concerns or clarifications to your answers above with regard to this case. Remember, do not state an opinion regarding whether EMTALA was violated.

I agree to provide medical advice to the Centers for Medicare & Medicaid Services and/or the Office of Inspector General, as necessary, to properly adjudicate any issues and to testify as an expert witness on behalf of the Office of Inspector General, if necessary.

Physician Reviewer Name (printed): _____

Physician Reviewer Signature: _____

Specialty: _____ ***Date:*** _____

Exhibit 149

Model Letter
Critical Access Hospital (CAH) Denial for Medicare Participation

Name/Title of Responsible Individual
Name of Hospital
Street Address
City, State, Zip Code

Dear _____:

This letter is to inform you that your request for certification as a provider of Medicare services as a critical access hospital (CAH) has been denied. In order to participate in the Medicare program, a critical access hospital must comply with all regulatory requirements at 42 CFR Part 485 Subpart F and any additional State requirements. Based on the deficiencies identified, your hospital does not qualify for participation as a CAH.

Although your facility does not qualify as a provider of CAH services at this time, you may take steps to correct these deficiencies and reapply to establish Medicare eligibility.

If you believe this determination is incorrect, you may ask that it be reconsidered. Your request must be submitted in writing to this office within 60 days from the date of receipt of this letter. You may submit with your request for reconsideration any additional information you believe to be pertinent to this decision.

Sincerely,

Associate Regional Administrator/Equivalent

cc:

Fiscal Intermediary/Medicare Administrative Contractor
Regional Administrator
State Department of Health

Exhibit 150

Model Letter
Critical Access Hospital (CAH) Approval Notification

Name/Title of *Responsible Individual*
Name of *Hospital*
Street Address
City, State, Zip Code

Dear_____:

We are pleased to notify you that (name of hospital) meets the requirements at *42 CFR Part 485 Subpart F* for participation in the Medicare program as a critical access hospital (CAH). The effective date of this approval is (effective date).

Effective with *this* approval (name of hospital's) participation as an acute care hospital under *CMS certification number (CCN)* has been canceled effective (*CAH* effective date). *Your new CCN for your CAH is (CAH CCN). This CCN* should be used on all correspondence and billing for the Medicare program *starting (effective date).*

Your fiscal intermediary is (name of fiscal intermediary/Medicare Administrative Contractor). Questions concerning billing and other fiscal matters should be directed to the FI/MAC. Questions related to the Conditions of Participation for CAHs should be referred to your SA (insert contact information).

Welcome to the CAH program.

Sincerely,

Associate Regional Administrator/Equivalent

cc:

Fiscal Intermediary/Medicare Administrative Contractor
Regional Administrator
State Department of Health

Exhibit 151

Model Letter
Request for a Plan of Correction Following an Initial Critical Access Hospital (CAH) Survey

Name/Title of Responsible Individual
Name of Hospital
Street Address
City, State, Zip Code

Dear _____:

Enclosed you will find the Form CMS-2567 "Statement of Deficiencies and Plan of Correction." This form enumerates deficiencies found during the initial Medicare certification survey completed at your facility on (date).

Your plan of correction must be returned to this office signed and dated, with an anticipated completion date for each corrective action, within ten (10) days of receipt of this letter.

The Plan of Correction must contain the following:

- *What measures will be put into place or what systematic changes will be made to ensure the deficient practice does not recur, including the anticipated implementation date (a reasonable time frame is allowed); and*

- *How the corrective action will be monitored to ensure compliance: what quality assurance indicators will be put into place and who will be responsible to oversee their monitoring.*

The State agency will review the plan to determine if it is acceptable. If acceptable and the State determines that a revisit is not necessary, the State will recommend certification as a CAH to the CMS regional office (CMS- RO). If a revisit is deemed necessary, and the State determines by the revisit survey that the facility is in compliance, the State will recommend certification as a CAH. The CMS-RO will determine the effective date of CAH certification.

A complete copy of the Form CMS-2567 is subject to public disclosure. All responses must be shown on this form. Attachments may be submitted as supporting documentation. Please be specific as to how the deficient practice will be corrected. Failure to do so will result in the plan being returned for revision, creating a delay in the approval of your plan of correction.

Sincerely,

State Agency Representative

Enclosure: Form CMS-2567

cc:

Fiscal Intermediary/Medicare Administrative Contractor
Regional Administrator
State Department of Health

Exhibit 152

Model Letter
Critical Access Hospital (CAH) Termination Letter

Name/Title of Responsible Individual
Name of *Hospital*
Street Address
City, State, Zip Code

Re: CMS Certification Number (CCN)

Dear _____:

After a careful review of the facts, the Centers for Medicare and Medicaid Services (CMS) has determined that (insert name of CAH) no longer meets the requirements for participation as a *CAH* provider of services in the Medicare program under Title XVIII of the Social Security Act.

To participate in the Medicare program as a *CAH, a provider* must meet the *applicable* provisions of §1820 of the Act and be in compliance with the Conditions of Participation (CoPs) at 42 CFR Part 485 *Subpart F. If the CAH has* swing-bed approval*, the provider* must also comply with the skilled nursing facility requirements for *CAHs* at 42 CFR §485.645. If the CAH has distinct part units, the provider must also comply with the requirements for CAHs at 42 CFR §485.647.

The (name of State agency) certifies to the CMS-*Regional Office* (CMS-*RO)* whether *a CAH* meets the CoPs. Based on the record of the State agency's visits, findings, and recommendations, we *find that (name of CAH) does not meet* the requirement(s) contained in (insert specific requirements that have not been met and a brief explanation of the circumstances of noncompliance).

The date on which *your Medicare provider* agreement terminates is (termination date). The Medicare program will *no longer* make payment for *CAH* services to patients admitted after the termination date. For patients admitted prior to the termination date, payment may continue to be made for a maximum of *96* hours for inpatient services furnished on or after the termination date.

For swing-bed patients receiving a SNF level of care *that* are admitted prior to the termination date, payment may continue to be made for a maximum of 30 days after the termination date. You should submit a list of names and Medicare claim numbers of beneficiaries in your *CAH* on the termination date to the (CMS-RO name and address) *as soon as possible*.

We will publish a public notice of termination in the (name of local newspaper). You will be advised of the publication date for the notice.

You may take steps to meet the participation requirements. The (name of State agency) is available to provide assistance in order to accomplish this.

If you wish to be readmitted to the program *following termination,* you must demonstrate that you are able to maintain compliance. Readmission to the program will not be approved until you are able to demonstrate compliance for a period of not less than (insert number of days) consecutive days.

If you do not believe this determination is correct, you may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in the regulations at 42 CFR §498.40 et. Seq. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. *To* expedite handling, the request may be made to:

Associate Regional Administrator or Equivalent
Street Address
City, State, Zip Code

At your option, you may instead submit a hearing request directly, accompanied by a copy of this letter to:

Departmental Appeals Board, Civil Remedies Division
Room *G-644-Cohen Building*
330 Independence Avenue, S.W.
Washington, D.C. 20201

Attn: Director, Departmental Appeals Board

A copy of your request *should be provided to the State agency.*

A request for a hearing should identify the specific issues and the findings of fact and conclusions that *you consider to* be incorrect. You may be represented by counsel at a hearing at your own expense. We will forward your request to the Chief Administrative Law Judge in the Office of Hearings and Appeals.

If you have any questions concerning this *letter,* please contact (insert contact information).

Sincerely,

Associate Regional Administrator/Equivalent

Enclosure: Form CMS-2567 Statement of Deficiencies

cc:

Fiscal Intermediary*/Medicare Administrative Contractor*
State Department of Health
CMS *Regional Office*

EXHIBIT 161

NOTICE OF INTERIM APPROVAL OF CAPD SERVICES

(**Date**)

Provider Name
Address
City, State, ZIP Code

Re: ***CMS Certification Number (CCN)***

Dear (**Provider Name**):

We have considered your request to furnish directly continuous ambulatory peritoneal dialysis (CAPD) patient training and support services (which may be provided via an agreement or arrangement with another approved ESRD facility).

Your facility has been approved on a temporary basis to furnish CAPD training and support services, effective (**date**). This approval is subject to later review and reevaluation upon publication of specific regulations reciting program requirements, and Certificate of Need approval where required by State Law.

Your intermediary will contact you shortly to explain any special reimbursement procedures to be followed for CAPD. Use your *CCN*, shown above, on all billings and correspondence concerning CAPD services.

Should you have any questions regarding your furnishing of CAPD services, please contact this office.

Sincerely yours,

Associate Regional Administrator
(or its equivalent)

cc:
Fiscal Intermediary*/Medicare Administrative Contractor*
State Agency
Central Office

Exhibit 162

Model Letter
Request for a Plan of Correction Following an Initial Survey *for Swing-bed Approval in a Hospital*

Name/Title of *Hospital* Administrator, CEO, or Responsible Individual
Name of Hospital
Street Address
City, State, Zip Code

Re: CMS Certification Number (CCN)

Dear _____:

You will find enclosed the Form CMS-2567 "Statement of Deficiencies and Plan of Correction," which enumerates deficiencies found as a result of the initial Medicare certification survey completed at your facility on (date).

Your plan of correction must be returned to this office, signed and dated, with an anticipated completion date for each corrective action, within ten (10) days of receipt of this letter.

Your plan of correction must contain the following:

- What measures will be put into place or what systematic changes will be made to ensure the deficient practice does not recur including the anticipated implementation date (a reasonable time-frame is allowed); and

- How the corrective action will be monitored to ensure compliance; what quality assurance indicators will be put into place and who will be responsible to oversee their monitoring.

The State agency will review the plan to determine if it is acceptable. If acceptable and the State determines that a revisit is not necessary, the State will recommend certification as a hospital with swing-bed approval to the CMS regional office. If a revisit is *deemed* necessary, and the State determines by the *revisit* survey that the facility is in compliance, *the State will recommend certification as a hospital with swing-bed approval. The CMS-RO will determine the effective date of the swing bed certification.*

A complete copy of the Form CMS-2567 is subject to public disclosure. All responses must be shown on this form. Attachments may be submitted as supporting documentation. Please be specific as to how the deficient practice will be corrected. Failure to do so will result in the plan being returned for revision, creating a delay in the approval of your plan of correction.

Sincerely,

(State Agency)

Enclosure: Form CMS-256

Exhibit 163

Model Letter
Termination *Letter* for Hospital Swing-bed Services

Name/Title of Hospital Administrator, CEO, or Responsible Individual
Name of Hospital
Street Address
City, State, Zip Code

Re: CMS Certification Number (CCN)

Dear_____:

After a careful review of the facts, the Centers for Medicare and Medicaid Services (CMS) has determined that the (name of Hospital) no longer meets the requirements for participation as a provider of hospital swing-bed services in the Medicare program under "Title XVIII of the Social Security Act.

To continue to participate in the Medicare swing-bed program, a hospital must meet the appropriate statutory provisions of §1820 of the Act and be in compliance with the Conditions of Participation (CoPs) at 42 CFR *Part 482*. *Hospitals with swing-bed approvals must also comply with the skilled nursing facility requirements at 42 CFR §482.66.*

The (name of State agency) certifies to CMS whether hospitals meet the CoPs at 42 CFR Part 482.66. Based on the record of the State agency's visits, findings, and recommendations, we find that (name of Hospital) does not meet the requirement(s) contained in (insert the specific requirement(s) that have not been met and a brief explanation of the circumstances of noncompliance).

The date on which the swing-bed agreement terminates is (date of termination). The Medicare program will not make payment for inpatient swing-bed services furnished for patients admitted *on or* after the (date of termination). For swing-bed patients receiving a SNF level of care that are admitted prior to (date of termination), payment may continue to be made for a maximum of 30 days after (date of termination). You should submit, as soon as possible, a list of names and Medicare claim numbers of beneficiaries in your hospital on (date of termination) to the (name and address of CMS regional office involved) to facilitate payment for these individuals.

We will publish a public notice of swing-bed termination in the (name of local newspaper). You will be advised of the publication date *for the* notice.

You may, of course, take steps to meet the participation requirements and establish the hospital's eligibility to participate as a provider of swing-bed services. The (State agency) is available to provide assistance you may need in order to accomplish this.

If you wish to be readmitted to the program, you must demonstrate to the (State agency) and CMS that you are able to maintain compliance. Readmission to the program will not be approved until you are able to demonstrate compliance for a period of not less than (insert number of days) consecutive days.

If you do not believe this determination is correct, you may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board. Procedures governing this process are set out in the regulations at 42 CFR *498.40. et. seq.* A written request for a hearing must be *filed no later than 60 days from the* date of receipt of this letter. For expedited handling, such a request may be made to the following:

(Associate Regional Administrator or Equivalent)
(Street Address)
(City, State, Zip Code)

We will forward your request to the Chief Administrative Law Judge in the Office of Hearings and Appeals.

At your option, you may instead submit a hearing request directly (accompanied by a copy of this letter) to the following address. Send a copy of your request to this office also.

Departmental Appeals Board, Civil Remedies Division
Room G-644-Cohen Building
330 Independence Avenue, S.W.
Washington, D.C. 20201

ATTN: Director, Departmental Appeals Board

A request for a hearing should identify the specific issues, and the findings of fact and conclusions that you consider to be incorrect. You may be represented by counsel at a hearing at your own expense.
If you have any questions concerning this letter, please contact (name of contact) at (phone number).

Sincerely,

(Associate Regional Administrator or Equivalent)

Enclosure: Form CMS-2567, *Statement of Deficiencies*

cc:
Fiscal Intermediary*/Medicare Administrative Contractor*
State Department of Health
CMS Central Office

Exhibit 172
Model Letter: Organ Procurement Organization Approval

(Date)

(First Name) (Last Name) (Title)
(Company Name)
(Address)
(City), (State) (Postal Code)

Re: CMS Certification Number (CCN):

Dear: *(Name):*

Your application for redesignation as an Organ Procurement Organization (OPO) for the Medicare and Medicaid program under §1138 of the Social Security Act has been approved by the Center for Medicare and Medicaid Services. Effective _____, you are designated as the OPO for the *following* service area: *(counties)*

Enclosed is one *signed* copy of the *provider* agreements for your records. Enter the *CCN* shown above on all forms and correspondence relating to this program. The *(fiscal intermediary)* has been authorized as your Fiscal Intermediary, and it can provide you with information concerning payment procedures.

If you believe the above information is not correct (i.e., service area, effective date) please submit *it,* in writing, to this office within 60 working days of receipt of this notice. We welcome your *continued* participation and look forward to working with you. *If you have any questions, please contact (name), at phone number.*

Sincerely

Associate Regional Administrator/ Equivalent

Enclosure

EXHIBIT 180

NOTICE TO ACCREDITED PSYCHIATRIC HOSPITAL OF INVOLUNTARY TERMINATION

(**Date**)

Psychiatric Hospital Name
Address
City, State, ZIP Code

Re: CMS Certification Number (CCN)

Dear _____:

Section 1865 of the Social Security Act (the Act) and pursuant regulations provide that a hospital accredited by The Joint Commission (***JC)*** *or the American Osteopathic Association (**AOA***) is "deemed" to meet all of the Medicare Conditions of Participation for hospitals, with the exception of *those relating to* utilization review and the special staffing and medical record requirements for psychiatric hospitals. Section 1864 of the Social Security Act authorizes the Secretary of *the Department of* Health and Human Services ***(the Secretary)*** to conduct surveys of accredited hospitals participating in the Medicare program.

When a hospital, regardless of its accreditation status, is found to be out of compliance with the special staffing or medical record requirements for psychiatric hospitals, a determination must be made that the facility no longer meets the requirements for participation as a provider of services in the Medicare program. Such a determination has been made in the case of (**hospital name**) and accordingly, the Medicare provider agreement between (**hospital name**) and the Secretary is being terminated.

A survey conducted at (**name of hospital**) on (**date**) found that the hospital was not in compliance with the Medicare health and safety requirements *(indicate* **Special Medical Record Requirement (42 CFR 482.61) and/*or* Special Staff requirement (42 CFR 482.62**)) for psychiatric hospitals.

A listing of all deficiencies found *is* enclosed. These deficiencies have been determined to be of such a serious nature as to substantially limit the hospital's capacity to provide adequate care.

The date on which the agreement terminates is (**date**). The Medicare program will not make payment for inpatient hospital services furnished to patients who are admitted on or after (**date of termination**). For patients admitted prior to (**date of termination**), payment may continue to be made for a maximum of 30 days of inpatient hospital

services furnished on or after (**date of termination**). You should submit as soon as possible, a list of names and Medicare claim numbers of beneficiaries in your hospital on (**date of termination**) to the (**name and address of the RO involved**) to facilitate payment for these individuals.

We will publish a public notice in the (**local newspaper**). You will be advised of the publication date for the notice. If you feel that these findings are incorrect, you have 15 days from the date of this notice to request an informal review of the findings by this office as provided by 42 CFR 488.456(c)(2). Include in the request any evidence and arguments which you may wish to bring to the attention of the Centers for Medicare & Medicaid Services (CMS). *[Public notice language is optional]*

Termination can only be averted by correction of the deficiencies within 45 days of your receipt of this letter. Your plan of correction (written on the enclosed statement of Deficiency and Plan of Correction forms) should be returned to us as soon as possible.

An acceptable plan of correction must contain the following elements:

1) *The plan for correcting each specific deficiency cited;*
2) *The plan should address improving the processes that led to the deficiency cited;*
3) *The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;*
4) *A completion date for correction of each deficiency cited must be included;*
5) *All plans of correction must demonstrate how the hospital has incorporated its improvement actions into its Quality Assessment and Performance Improvement (**QAPI**) program, addressing improvements in its systems in order to prevent the likelihood of the deficient practice reoccurring. The plan must include the monitoring and tracking procedures to ensure the plan of correction is effective and that specific deficiencies cited remain corrected and/or in compliance with the regulatory requirements; and*
6) *The plan must include the title of the person responsible for implementing the acceptable plan of correction.*

After termination if you wish to be readmitted to the program, you must demonstrate to the (**State agency**) and CMS that you are able to maintain compliance. Readmission to the program will not be approved until you are able to demonstrate compliance for a period of not less than (**number of days**) consecutive days.

If you do not believe this termination decision is correct, you may request a hearing before an Administrative Law Judge (**ALJ**) as outlined in Title 42 of the Code of Federal Regulations, Section *498.5(b)* et. seq. To be effective, a written request for a hearing must be filed not later than 60 days after the date you receive this letter. Such a request may be made to the *Consortium Survey and Certification Officer*, (**address**) who will forward your request to the *Civil Remedies Division* ALJ in the *Departmental Appeals Board*. The request for a hearing should state why the decision is considered incorrect, and should be accompanied by any evidence and arguments you may wish to bring to the attention of the Department of Health and Human Services. Evidence and arguments may be presented at the hearing, and you may be represented by counsel *at your own expense.*

Sincerely yours,

Consortium Survey and Certification Officer
(or its equivalent)

Enclosures

EXHIBIT 181

NOTICE TO HOSPITAL PROVIDER OF INVOLUNTARY TERMINATION

(**Date**)

Provider Name
Address
City, State, ZIP Code

Re: CMS Certification Number (CCN)

Dear (**Provider Name**):

After a careful review of the facts, the Centers for Medicare & Medicaid Services *(CMS)* has determined that the (**name of facility**) no longer meets the requirements for participation as a *Medicare* provider established under Title/XVIII of the Social Security Act *(the Act)*.

To continue to participate in the Medicare program, a hospital must meet all of the statutory provisions of section 1861(e) of the Act and be in compliance with the Conditions of Participation *(CoPs) found at 42 CFR Part 482.*
Example:

> We find that (**name of facility**) does not meet the requirements contained in 42 CFR *482.23(b) implementing* section 1861(e) (5) of the Act. This requirement states in part that a hospital "provides 24-hour nursing service rendered or supervised by a registered professional nurse." For a protracted period the records show that your hospital has an RN on the day shift 7 days a week and that evening and night shifts are covered by LPN's who perform nursing duties without RN supervision.
>
> The (**State agency**) which certifies to CMS whether hospitals meet the *CoPs*, has discussed the 24-hour nursing requirement with you on numerous occasions. Based on the record of the State agency's visits, findings, and recommendations, we have determined that the requirement is not now and is not likely to be met within an acceptable time.

The date on which the agreement terminates is (**date of termination**). The Medicare program will not make payment for inpatient hospital services furnished to patients who are admitted on or after (**date of termination**). For patients admitted prior to (**date of termination**), payment may continue to be made for a maximum of 30 days of inpatient hospital services furnished on or after (**date of termination**). You should submit as soon

as possible, a list of names and Medicare claim numbers of beneficiaries in your hospital on (**date of termination**) to the (**name and address of the RO involved**) to facilitate payment for these individuals.

We will publish a public notice in the (**local newspaper**). You will be advised of the publication date for the notice.

You may, of course, take steps to meet the participation requirements and establish the hospital's eligibility to participate as a provider of services. The (**State agency**) is available to provide consultation or assistance you may need in order to accomplish this.

If you wish to be readmitted to the program, you must demonstrate to the (**State agency**) and CMS that you are able to maintain compliance. Readmission to the program will not be approved until you are able to demonstrate compliance for a period of not less than (**number of days**) consecutive days.

If you do not believe this termination decision is correct, you may request a hearing before an *A*dministrative *L*aw *J*udge *(ALJ) of the Department of Health and Human Services, Departmental Appeals Board. Procedures governing this process are set out in regulations at 42 CFR 498.40 et. seq. A* written request for a hearing must be filed *no* later than 60 days *from* the date *of receipt* of this letter. Such a request may be made to the *Consortium Survey and Certification Officer*, (**address**). *We* will forward your request *to the Chief Administrative Law Judge in the* Office of Hearing and Appeals.

At your option you may instead submit a hearing request directly (accompanied by a copy of this letter) to the following address. Send a copy of your request to this office also.

Departmental Appeals Board, Civil Remedies Division
Room G-644-Cohen Building
330 Independence Avenue, S.W.
Washington, D.C. 20201
Attn: Director, Departmental Appeals Board

*A request for a hearing should identify the specific issues, and the findings of fact, and conclusions that you consider to be incorrect. Y*ou may be represented by counsel *at a hearing at your own expense*.

Sincerely yours,

Associate Regional Administrator/Equivalent

EXHIBIT 183

MODEL PUBLIC NOTICE OF MEDICARE TERMINATION OF *HOSPITAL* PROVIDER AGREEMENT

FOR PUBLICATION: (**Date**)

(Provider Name)
(Address)
(City, State and Zip code)

LEGAL NOTICE

*Effective **(termination date)**, the Secretary of the Department of Health and Human Services will terminate its Medicare provider agreement with (**Provider Name)** in **(City, State.)** This action is being taken because this hospital was found to not be in compliance with Section 1861 of the Social Security Act, which requires a hospital to provide services which are sufficient to meet the needs of its patients. Non-compliance was established during a survey completed on **(date of survey)** by the **(name of State Survey Agency.)***

*The Medicare and Medicaid programs will not make payments for inpatient hospital services furnished to patients who are admitted on or after (termination date.) For patients admitted prior to (termination date), payment may continue to be made for covered services provided through **(30 days after termination date).***

Sincerely yours,

Consortium Survey and Certification Officer
(or its equivalent)

EXHIBIT 195

MODEL NOTICE ANNOUNCING TO AN ACCREDITED HOSPITAL THAT THE HOSPITAL DOES NOT COMPLY WITH ALL THE CONDITIONS OF PARTICIPATION AND THAT THERE IS IMMEDIATE *AND* SERIOUS THREAT TO PATIENT HEALTH AND SAFETY

(**Date**)

Hospital Name
Address
City, State, ZIP Code

Re: CMS Certification Number (CCN)

Dear (**Administrator**):

Section 1865 of the Social Security Act (the Act) and pursuant regulations provide that a hospital accredited by The Joint Commission (JC) *or the American Osteopathic Association (AOA) is* "deemed" to meet all of the Medicare Conditions of Participation *(CoPs)* for hospitals, with the exception of *those relating to* utilization review, the special staffing and medical record requirements for psychiatric hospitals, *and the special requirements for hospital providers of long-term care services*. Section 1864 of the Act authorizes the Secretary of *the Department of* Health and Human Services *(the Secretary)* to conduct surveys of accredited hospitals participating in the Medicare program.

A survey was conducted at (**name of hospital**) on (**date**). At the conclusion of this survey, the findings were discussed with (**you or your representative's name**) and (**you, he, she**) (**was, were**) informed that conditions within (**name of facility**) posed an immediate and serious threat to the health and safety of patients. Specifically, the facility does not meet:

(**Cite Conditions of Participation**).

When a hospital, regardless of its *JC or AOA* accreditation status, is found to be out of compliance with one or more *CoPs* and immediate *and* serious threat to patient health and safety exists, a determination must be made that the facility no longer meets the requirements for participation as a provider of services in the Medicare program. Such a determination has been made in the case of (**name of hospital**) and, accordingly, the Medicare provider agreement between (**name of hospital**) and the Secretary is being terminated. This termination will be effective (**date**).

The Medicare program will not make payment for services furnished to patients who are admitted on or after (**date of termination**). For patients admitted prior

to (**date of termination**), payment may continue to be made for a maximum of 30 days for inpatient hospital services furnished on or after (**date of termination**). You should submit as soon as possible, a list of names and Medicare claim numbers of beneficiaries in your hospital on (**date of termination**) to the (**name and address of the RO involved**) to facilitate payment for these individuals.

We will publish a public notice in the (**local newspaper**). You will be advised of the publication date for the notice. Termination can only be averted by correction of these deficiencies by (**insert date 5 days after date of *letter***). Should we not hear from you, we will assume that the situation has not been corrected. If you have corrected this situation, please advise us immediately. If you notify us by (**date**) that corrections have been made, representatives of the Centers for Medicare & Medicaid Services *(CMS)* will revisit the facility within 2 working days to verify necessary corrections. If *CMS* determines that the reasons for termination remain, the effective date of the termination remains (**date**), and you will be so informed in writing. If corrections have been made, the termination procedures will be halted, and you will be notified in writing.

If you do not believe this termination decision is correct, you may request a hearing before an Administrative Law Judge (ALJ) *of the Department of Health and Human Services, Departmental Appeals Board. Procedures governing this process are set out in regulations at 42 CFR 498.40 et. seq. A* written request for a hearing must be filed no later than 60 days *from* the date *of receipt of* this letter. Such a request may be made to the *Consortium Survey and Certification Officer*, (**address**). *We will forward your request to the Chief Administrative Law Judge in the Office of Hearing and Appeals.*

At your option you may instead submit a hearing request directly accompanied by a copy of this letter to the following address. Send a copy of your request to this office also:

Departmental Appeals Board, Civil Remedies Division
Room G-644-Cohen Building
330 Independence Avenue, S.W.
Washington, D.C. 20201
Attn: Director, Departmental Appeals Board

You may be represented by counsel *at a hearing at your own expense*.

Sincerely yours,

Consortium Survey and Certification Officer
(or its equivalent)

EXHIBIT 196

MODEL LETTER ANNOUNCING TO ACCREDITED HOSPITAL AFTER A SAMPLE VALIDATION SURVEY THAT THE HOSPITAL DOES NOT COMPLY WITH ALL CONDITIONS OF PARTICIPATION

(Do Not Use When Immediate and Serious Threat to Patient Health or Safety Deficiencies Exist)

(**Date**)

Administrator Name
Hospital Name
Address
City, State, ZIP Code

Re: CMS Certification Number (CCN)

Dear (**Administrator**)

Section 1865 of the Social Security Act *(the Act)* and pursuant regulations provide that a hospital accredited by *The* **Joint Commission (JC**) *or* **American Osteopathic Association (AOA)**) will be "deemed" to meet all of the Medicare *Conditions of Participation (CoPs) for hospitals,* with the exception of those relating to utilization review*, the* special medical record and staffing requirements for psychiatric hospitals*, and* special requirements for hospital providers of long-term care services ("swing beds"). Section 1864 of the Act authorizes the Secretary of *the Department of* Health and Human Services *(the Secretary)* to conduct, on a selective sampling basis, surveys of accredited hospitals participating in Medicare as a means of validating reliance on the Accreditation process**.** If in the course of such a survey a hospital is found to have deficiencies with respect to compliance with *one or more CoPs*, we are required, following timely notification of the accrediting body, to keep the hospital under Medicare State agency survey jurisdiction until its significant Medicare deficiencies have been corrected and it is *determined to be* in compliance with all Medicare *CoPs*.

We have received a report of deficiencies found by the (**State agency**) during the recent validation survey of your hospital. *Based on this report, we find that (name of hospital) is not in compliance with all the CoPs for hospitals.* A complete listing of all deficiencies found by the (**State agency**) is enclosed (Form CMS-2567, Statement of Deficiencies and Plan of Correction). These deficiencies have been *determined to* be of such serious nature as to substantially limit your hospital's capacity to render adequate care and prevent it from being in compliance with all the CoPs for hospitals.

Sample language: (Name of Hospital) was found not in compliance with:

- *The provisions of the National Fire Protection Association's Life Safety Code (2000 edition), which are included in the Medicare health and safety regulatory requirements for hospitals (42 CFR 482.41(b);*
- *Medicare health and safety requirements for Nursing Services (42 CFR 482.23); and*
- *Medicare health and safety requirements for Pharmaceutical Services (42 CFR 482.25).*

In addition, a number of deficiencies related to other Medicare requirements were found.

You are therefore requested to submit to the (***Regional office***) a plan of correction, with acceptable time schedules, *that* will lead to the correction of the cited deficiencies. Enter on the right side of the Form CMS-2567, opposite the deficiencies, your planned action to correct the deficiencies and the expected completion date. *Your acceptable plan of correction should be received by the Regional Office within 10 calendar days from the receipt of this letter.* (**Use if applicable**--You may also submit a request for waiver of National Fire Protection Association's Life Safety Code deficiencies, including rationale justifying the request.)

An acceptable plan of correction must contain the following elements:

1) *The plan for correcting each specific deficiency cited;*
2) *The plan should address improving the processes that led to the deficiency cited;*
3) *The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;*
4) *A completion date for correction of each deficiency cited must be included;*
5) *All plans of correction must demonstrate how the hospital has incorporated its improvement actions into its Quality Assessment and Performance Improvement (QAPI) program, addressing improvements in its systems in order to prevent the likelihood of the deficient practice reoccurring. The plan must include the monitoring and tracking procedures to ensure the plan of correction is effective and that specific deficiencies cited remain corrected and/or in compliance with the regulatory requirements; and*
6) *The plan must include the title of the person responsible for implementing the acceptable plan of correction.*

The requirement that the (**name of hospital**) must submit a plan to correct its Medicare deficiencies does not affect its Medicare payments or its current status as a participating provider of hospital services in the Medicare program. When the plan of correction has been implemented, *and the hospital* has been found to meet all the CoPs, *the State agency will discontinue its survey jurisdiction.*

Under CMS regulations at 42 CFR *498.3(d*), this notice of findings is an administrative action, not an initial determination by the Secretary, and, therefore, formal reconsideration and hearing procedures do not apply.

Copies of this letter are being forwarded to the (**State agency**) and to (JC) (AOA).

Sincerely yours,

Consortium Survey and Certification Officer
(or its equivalent)

Enclosure: Form CMS-2567

cc:
Central Office
JC/AOA
State Agency

EXHIBIT 199

MODEL LETTER ANNOUNCING TO ACCREDITED HOSPITAL AFTER A SUBSTANTIAL ALLEGATION SURVEY THAT THE HOSPITAL DOES NOT COMPLY WITH ALL CONDITIONS OF PARTICIPATION

(Do Not Use When Immediate and Serious Threat To Patient or Safety Deficiencies Exist)

(**Date**)

Hospital Administrator
Hospital Name
Address
City, State, ZIP Code

Re: CMS Certification Number (CCN)

Dear (**Hospital Administrator**)

Section 1865 of the Social Security Act *(the Act)* and implementing regulations (42 CFR *488.5*, provide that a hospital accredited by *T*he Joint Commission *(JC)* or the American Osteopathic Association *(AOA)* will be "deemed" to meet all the Medicare Conditions of Participation *(CoPs)*, with the exception of *those relating to* utilization review, special medical staffing and medical record requirements for psychiatric hospitals and special requirements for hospital providers of long-term care services ("swing-bed"). Section 1864 of the Act *authorizes* the Secretary of *the Department of* Health and Human Services *(the Secretary)* to conduct a survey of an accredited hospital participating in Medicare if there is a substantial allegation of a serious deficiency or deficiencies which would, if found to be present, adversely affect the health and safety of patients. If in the course of such a survey a hospital is found to have *deficiencies with respect to compliance* with *one or more of the CoPs*, we are required, following timely notification to the accrediting body, to keep the hospital under Medicare State agency survey jurisdiction until *its significant Medicare deficiencies have been corrected and it is determined to be in compliance with all Medicare CoPs.*

We have received a report of the deficiencies found by the (**State agency**) during its recent substantial allegation survey of your hospital. Based on this report, we find that the (**name of hospital**) is not in compliance with all the *CoPs* for hospitals. A complete listing of all deficiencies found by the (**State agency**) is enclosed *(Form CMS 2567, Statement of Deficiencies and Plan of Correction)*. These deficiencies have been determined to be of such serious nature as to substantially limit your hospital's capacity to render adequate care and prevent it from being in compliance with all the *CoPs* for hospitals.

Sample Language:

(Name of hospital) was found not in compliance with the provisions of the National Fire Protection Association's Life Safety Code (*2000 Edition*) which are included in the Medicare health and safety regulatory requirements for hospitals (42 CFR 482.41(b)), Nursing services (42 CFR 482.23) and Pharmaceutical services (42 CFR 482.25). In addition, a number of deficiencies were found in other Medicare requirements.

In accordance with section 1865(b) of the Social Security Act, the (**State agency**) will conduct a *full* survey of your *hospital to* assess compliance with *all the Medicare CoPs*.

After the completion of the *full* Medicare survey, (**name of hospital**) will be asked to submit to the (**State agency**) a plan of correction, *with acceptable time schedules, that will lead to the correction of the cited deficiencies.* (**Use if applicable**--You will also be able to submit a request for waiver of National Fire Protection Association's Life Safety Code deficiencies, including rationale justifying the request.)

An acceptable plan of correction must contain the following elements:

1) *The plan for correcting each specific deficiency cited;*
2) *The plan should address improving the processes that led to the deficiency cited;*
3) *The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;*
4) *A completion date for correction of each deficiency cited must be included;*
5) *All plans of correction must demonstrate how the hospital has incorporated its improvement actions into its Quality Assessment and Performance Improvement (QAPI) program, addressing improvements in its systems in order to prevent the likelihood of the deficient practice reoccurring. The plan must include the monitoring and tracking procedures to ensure the plan of correction is effective and that specific deficiencies cited remain corrected and/or in compliance with the regulatory requirements; and*
6) *The plan must include the title of the person responsible for implementing the acceptable plan of correction.*

The requirement that the (**name of hospital**) must submit a plan to correct its Medicare deficiencies does not affect its Medicare payments or its current status as a participating provider of hospital services in the Medicare program. When *the* plan of correction has been implemented and the hospital has been found to meet all the CoPs, the State agency will discontinue its survey jurisdiction.

Under CMS regulations at 42 CFR *498.3(d)*, this notice of findings is an administrative action, not an initial determination by the Secretary, and, therefore, formal reconsideration and hearing procedures do not apply.

Copies of this letter are being forwarded to the (**State agency**), *and to (JC/AOA).*

Sincerely,

Consortium Survey and Certification Officer
(or its equivalent)

Enclosure: Form CMS-2567

cc:
Central Office
JC/AOA
State Agency

EXHIBIT 200

MODEL LETTER ACKNOWLEDGING COMPLAINT ALLEGING NONCOMPLIANCE WITH 42 CFR 489.24 AND/OR THE RELATED REQUIREMENTS OF 42 CFR 489.20 INVESTIGATION NOT WARRANTED

(**Date**)

Complainant Name
Address
City, State, ZIP Code

Dear (**Complainant Name**):

We have reviewed the information you provided concerning (**hospital, in city, State**), and appreciate the interest you have shown in bringing this matter to our attention. Our responsibility is to assure compliance of Medicare participating hospitals with the health and safety requirements of the *Social Security Act (the Act) and pursuant regulations.* We have not authorized any further investigation of your complaint. Our review did not find that the situation you describe indicates any violation of the law. Based on your individual situation, however, you may wish to consider the civil enforcement provisions of §1867 of the Act on an independent basis.

Thank you for taking the time to bring this matter to our attention. ***[Optional:*** *If you have any additional questions please contact me at (phone number) or by mail (e-mail address*).]

Sincerely yours,

Regional Office Representative
or its equivalent)

Enclosure

EXHIBIT 201

MODEL LETTER ACKNOWLEDGING COMPLAINT ALLEGING NONCOMPLIANCE WITH 42 CFR 489.24 AND/OR THE RELATED REQUIREMENTS OF 42 CFR 489.20: INVESTIGATION WARRANTED

(**Date**)

Complainant Name
Address
City, State, ZIP Code

Dear (**Complainant Name**):

We have reviewed the information you provided concerning (**hospital, in city, State**), and appreciate the interest you have shown in bringing this matter to our attention. Our responsibility is to assure compliance of Medicare-participating hospitals with the health and safety requirements of the *Social Security Act and pursuant regulations*. *Enclosed for your information is a copy of 42 CFR 489.24, Responsibilities of Medicare Participating Hospitals in Emergency Cases and related regulations at 42 CFR 489.20.* We have authorized an investigation of the situation you described. Upon receipt of the investigation report, *we* will contact you again to advise you of the results.

Sincerely yours,

Associate Regional *Administrator*
(or its equivalent)

Enclosure

EXHIBIT 202

MODEL LETTER REQUESTING *QIO* REVIEW OF A POSSIBLE VIOLATION OF 42 CFR 489.24

(**Date**)

Name of QIO Executive Director
Quality Improvement Organization (QIO) Name
Address
City, State, ZIP Code

Dear (**QIO** E**xecutive Director Name**):

Enclosed is a case we have identified as a potential violation of 42 CFR 489.24, Responsibilities of Medicare Participating Hospitals in Emergency Cases. Section 489.24 places special responsibilities on Medicare-participating hospitals that offer emergency services.

Please have this case reviewed by a physician who is a specialist in either the specialty of the physician who attended the patient or the type of service under review. Whenever possible, the physician reviewer should practice in a similar setting as that of the physician who attended the patient.

This review is necessary for the purpose of assisting us in making a compliance determination on an alleged 42 CFR 489.24 violation. We have the onsite investigation findings and require a medical opinion on this case. In order to prevent further situations endangering the community's access to quality emergency care, please sign, date and return this packet to us within 5 working days.

Since the physician reviewer could be needed to serve as an expert witness in the case, secure from the physician a statement of willingness to provide service on the additional development needed to properly adjudicate any issues and to testify as an expert witness.

To assist you in performing your review, we have enclosed:

- A copy of the patient's medical record (at both hospitals, if pertinent),
- A copy of 42 CFR 489.24 and related parts of 42 CFR 489.20; and
- The "EMTALA Physician Review *Worksheet*" upon which the physician should document his/her findings. *The reviewer's* response is not limited to the space provided on the *worksheet;* additional paper *may be used* as needed. It is important that the physician thoroughly document the rationale for each response. *A response should be provided to each worksheet question.*

Thank you for your assistance. If you wish to discuss this case further, please contact ***(EMTALA policy person in RO)*** at (**phone number**).

Sincerely yours,

Associate Regional *Administrato*r
(or its equivalent)

Enclosures

EXHIBIT 203

MODEL LETTER FOLLOWING INVESTIGATION INTO ALLEGED VIOLATION OF 42 CFR 489.24 AND/OR THE RELATED REQUIREMENTS OF 42 CFR 489.20 FACILITY IN COMPLIANCE

(**Date**)

Hospital Administrator Name
Hospital Name
Address
City, State, ZIP Coder

Re: CMS Certification Number (CCN)

Dear (**Hospital Administrator Name**):

This office authorized the (**State**) State agency to conduct a complaint survey of (**hospital**) on (**date**). The complaint concerned an alleged violation of 42 CFR 489.24, Responsibilities of Medicare Participating Hospitals in Emergency Cases and/or the related provisions of 42 CFR 489.20.

I am pleased to inform you that as a result of the survey, your facility was found in compliance with the *above-specified* requirements regarding *its* emergency care obligations.

Thank you for your cooperation during the survey. If you have any questions or concerns about this matter, please contact (**name of contact**) at (**phone number**).

Sincerely yours,

Associate Regional *Administrator*
(or its equivalent)

cc: State Agency
Accrediting Body
Complainant

EXHIBIT 204

MODEL LETTER FOR A VIOLATION OF 42 CFR 489.24: PRELIMINARY DETERMINATION LETTER (IMMEDIATE AND SERIOUS THREAT)

(**Date**)

Hospital Administrator Name
Hospital Name
Address
City, State, ZIP Code

Re: CMS Certification Number (CCN)

Dear (**Hospital Administrator Name**):

To participate in the Medicare program, a hospital must meet the requirements established under title XVIII of the Social Security Act (the Act) and the regulations established by the Secretary of Health and Human Services under the authority contained in §1861(e) of the Act. Further, §1866(b) of the Act authorizes the Secretary to terminate the provider agreement of a hospital that fails to meet these provisions.

Your hospital was surveyed on (**date**) by the (**State survey agency**) based on an allegation of noncompliance with the requirements at 42 CFR 489.24, Responsibilities of Medicare Participating Hospitals in Emergency Cases and/or the related requirements at 42 CFR 489.20. After a careful review of the findings, we have determined that your hospital violated: (**Select as appropriate)**

*The requirements at 42 CFR 489.24 based on: (*failure to screen, failure to treat, failure to appropriately transfer, failure to accept an individual who required the hospital's specialized capabilities, delay in examination or treatment to inquire about an individual's method of payment or insurance status, or adverse action taken against a physician, qualified medical person or hospital employee); and/or

The related anti-dumping provisions found at 42 CFR 489.20 based on the hospital's failure to enforce policies to ensure compliance with the requirements of 42 CFR 489.24.

The deficiencies identified are listed on the enclosed Form CMS-2567, Statement of Deficiencies *and Plan of Correction*.

We have determined that the deficiencies are so serious that they constitute an immediate and serious threat to the health and safety of any individual who comes to the emergency department and requests examination or treatment for an emergency medical condition. Further, under 42 CFR 489.53, a hospital that violates the provisions of 42 CFR 489.24 is

subject to termination of its provider agreement. Consequently, we plan to terminate (**name of hospital**) participation in the Medicare program.

This preliminary determination letter serves to notify you of the violation. The projected date on which your agreement will terminate is (**date - 23rd day from the date of this letter for immediate and serious threats**).

You will receive a "notice of termination letter" on (**2-4 days prior to the termination date, which is also the 19th-21st day from the date of this preliminary determination letter**). This final notice will be sent to you concurrently with notice to the public, in accordance with regulations at 42 CFR 489.53.

You may avoid termination action and notice to the public either by providing *prior to the projected public notification date* a credible allegation of correction of the deficiencies, *or credible evidence the* deficiencies did not exist. A credible allegation of correction by the hospital requires a resurvey *prior to the projected termination date, and must be received by this office as soon as possible, to permit timely resurvey to verify the corrections.* If we verify your corrective action, or determine that the findings contained in this letter were in error, your *planned* termination from the Medicare program will be rescinded.

If you have any questions concerning this preliminary determination letter, please contact (**name of contact**) at (**phone number**).

Sincerely yours,

Associate Regional Administrator
(or its equivalent)

Enclosure: Form CMS-2567, Statement of Deficiencies *and Plan of Correction*

cc:

State *Survey* Agency
State *Medicaid* Agency
QIO
Accreditation Organization
Complainant
State Licensing Body
DHHS Congressional Liaison Office
CMS Office of Legislation

EXHIBIT 205

MODEL LETTER FOR A VIOLATION OF 42 CFR 489.24 AND/OR THE RELATED REQUIREMENTS OF 42 CFR 489.20 PRELIMINARY DETERMINATION LETTER (90 DAY TERMINATION TRACK)

(Date)

Hospital Administrator Name
Hospital Name
Address
City, State, ZIP Code

Re: CMS Certification Number (CCN)

Dear (**Hospital Administrator Name**):

To participate in the Medicare program, a hospital must meet the requirements established under title XVIII of the Social Security Act (the Act) and the regulations established by the Secretary of Health and Human Services under the authority contained in §1861(e) of the Act. Further, §1866(b) of the Act authorizes the Secretary to terminate the provider agreement of a hospital that fails to meet these provisions.

Your hospital was surveyed on (**date**) by the (**State survey agency**) based on an allegation of noncompliance with the requirements of 42 CFR 489.24, Responsibilities of Medicare Participating Hospitals in Emergency Cases and/or the related requirements at 42 CFR 489.20. After a careful review of the findings, we have determined that your hospital violated: (**Select as appropriate)**

- The requirements of 42 CFR 489.24 based on (failure to screen, failure to treat, failure to appropriately transfer, failure to accept an individual who required the hospital's specialized capabilities, delay in examination or treatment to inquire about an individual's method of payment or insurance status, or adverse action taken against a physician, qualified medical person or hospital employee).

- The related anti-dumping provisions found at 42 CFR 489.20 based on the hospital's failure to (have and enforce policies to ensure compliance with the requirements of 42 CFR 489.24, maintain transfer records, maintain a list of physicians on call, maintain a central emergency services log, report the reception of a dump, or meet the sign posting requirements).

The deficiencies identified are listed on the enclosed form CMS-2567, Statement of Deficiencies *and Plan of Correction.*

Under 42 CFR 489.53, a hospital that violates the provisions of 42 CFR 489.20 or 42 CFR 489.24 is subject to termination of its provider agreement. Consequently, we plan to terminate name of hospital participation in the Medicare program.

This preliminary determination letter serves to notify you of the violation. The projected date on which your agreement will terminate is (**date - 90th day from the date of this letter**).

You will receive a "notice of termination letter" on (**date - 5th day from the date of this preliminary determination letter**). This final notice will be sent to you concurrently with notice to the public, in accordance with regulations at 42 CFR 489.53.

You may avoid termination action and notice to the public either by providing *prior to the projected public notification* date a credible allegation of correction of the deficiencies, or credible evidence that the deficiencies did not exist. A credible allegation of correction by the hospital requires a resurvey *prior to the projected termination date, and must be received by this office so as to permit timely resurvey to verify the* corrections. If we verify your corrective action, or determine that the findings contained in this letter were in error, your planned termination from the Medicare program will be rescinded.

If you have any questions concerning this preliminary determination letter, please contact (**name of contact**) at (**phone number***), (e-mail address).*

Sincerely yours,

Associate Regional Administrator
(or its equivalent)

Enclosure: Form CMS-2567, Statement of Deficiencies *and Plan of Correction*

cc's:

State *Survey* Agency
State *Medicaid* Agency
OIG
QIO
Accreditation Organization
Complainant
State Licensing Body
DHHS Congressional Liaison Office
CMS Office of Legislation

EXHIBIT 206

MODEL LETTER TO COMPLAINANT FOLLOWING INVESTIGATION OF ALLEGED VIOLATION OF 42 CFR 489.24 AND/OR THE RELATED REQUIREMENTS OF 42 CFR 489.20 COMPLAINT NOT SUBSTANTIATED

(**Date**)

Complainant Name
Address
City, State, ZIP Code

Dear (**Complainant Name**):

We have received the report from the investigation that we authorized in response to your allegation that (**name and location of hospital**) violated the emergency care obligations of 42 CFR 489.24, Responsibilities of Medicare Participating Hospitals in Emergency Cases and/or the related requirements of 42 CFR 489.20. *We did not confirm* a violation of 42 CFR 489.24 or 42 CFR 489.20. Based on your individual situation, however, you may wish to consider the civil enforcement provisions of §1867 of the Social Security Act on an independent basis.

Thank you for bringing this matter to our attention. (***Optional:*** *If you have any questions please contact (name), at (phone number, (email address)).*

Sincerely yours,

Associate Regional Administrator
(or its equivalent)

EXHIBIT 207

MODEL LETTER TO COMPLAINANT FOLLOWING INVESTIGATION OF ALLEGED VIOLATION OF 42 CFR 489.24 AND/OR THE RELATED REQUIREMENTS OF 42 CFR 489.20 COMPLAINTS SUBSTANTIATED

(**Date**)

Complainant Name
Address
City, State, ZIP Code

Dear (**Complainant Name**):

We have received the report from the investigation that we authorized in response to your allegation that (name and location of hospital) violated the emergency care obligations of 42 CFR 489.24, Responsibilities of Medicare Participating Hospitals in Emergency Cases and/or the related provisions at 42 CFR 489.20. *We confirmed* a violation of (**select as appropriate**: 42 CFR 489.20, 42 CFR 489.24)

Enclosed is a copy of the letter we sent to the hospital. If the hospital violated 42 CFR 489.24, we are notifying the Office of Inspector General, *which* has responsibility for the enforcement of the civil monetary penalties *authorized* by §1867 of the Social Security Act (the Act). In addition, we *may* notify the Office for Civil Rights, *which* may take action under the Hill-Burton Subpart G Community Service regulations. Based on your individual situation, you may wish to consider the civil enforcement provisions of §1867 of the Act on an independent basis.

It is our goal to help health care facilities provide the best possible care to patients. Thank you for bringing this matter to our attention.

Sincerely yours,

Associate Regional Administrator
(or its equivalent)

Enclosure

EXHIBIT 208

MODEL LETTER FOR REFERRING A VIOLATION OF 42 CFR 489.24 TO THE OFFICE OF INSPECTOR GENERAL

(**Date**)

OIG Director Name
Office of Inspector General Director
Address
City, State, ZIP Code

Re: CMS Certification Number (CCN)
Hospital (Hospital Name)

Dear (**OIG Director Name**):

In order to participate in the Medicare program, a hospital must meet the requirements established under title XVIII of the Social Security Act (the Act) and must also meet the additional requirements established by the Secretary of Health and Human Services under the authority contained in §1861(e) of the Act. Further, §1866(b) of the Act authorizes the Secretary to terminate the provider agreement of a hospital that fails to meet these provisions.

This office authorized the (**State,**) State agency to conduct a survey of (**hospital**) on (**date**). As a result of that survey, it was determined that the facility violated 42 CFR 489.24, Responsibilities of Medicare Participating Hospitals in Emergency Cases. The deficiencies cited in the enclosed Statement of Deficiencies posed: (**select as appropriate**):

- An immediate and serious threat to the health and safety of *patients* in need of emergency medical care, (**23 day termination track**); or

- A threat to the health and safety of patients in need of emergency care, (**90 day termination track**); and we initiated termination action on (**date**).

***(Add, if applicable:** The hospital completed sustainable corrective actions, and remains a participant in the Medicare program.)*

We are referring this case to the Office of Inspector General for *determination of the* enforcement of the civil monetary penalties *authorized by* §1867 of the Act.

If you have any questions or concerns about this matter, please let us know.

Sincerely yours,

Associate Regional Administrator
(or its equivalent)

Enclosures

EXHIBIT 209

MODEL LETTER FOR REFERRING A VIOLATION OF 42 CFR 489.24 TO THE REGIONAL OFFICE FOR CIVIL RIGHTS

(**Date**)

Regional Director Name
Office of Civil Rights
Address
City, State, ZIP Code

Re: CMS Certification Number (CCN)
Hospital (Hospital Name)

Dear (**Office of Civil Rights Director Name**):

In order to participate in the Medicare program, a hospital must meet the requirements established under title XVIII of the Social Security Act (the Act), and must also meet the additional requirements established by the Secretary of Health and Human Services under the authority contained in §1861(e) of the Act. Further, §1866(b) of the Act authorizes the Secretary to terminate the provider agreement of a hospital that fails to meet these provisions.

This office authorized the (**State**) State agency to conduct a survey of (**hospital**) on (**date**). As a result of that survey, it was determined that the facility violated 42 CFR 489.24, Responsibilities of Medicare Participating Hospitals in Emergency Cases. The deficiencies cited in the enclosed Statement of Deficiencies posed an immediate and serious threat to the health and safety of patients in need of emergency medical care, and we initiated termination action on (**date**).

We are referring this case to the regional Office for Civil Rights *in connection with your authority* under the Hill-Burton Subpart G Community Service regulations at 42 CFR 124.603(b)(1).

If you have any questions or concerns about this matter, please let us know.

Sincerely yours,

Associate Regional Administrator
(or its equivalent)

Enclosure

EXHIBIT 210

MODEL LETTER FOR A PAST VIOLATION OF 42 CFR 489.24 AND/OR THE RELATED REQUIREMENTS OF 42 CFR 489.20: NO TERMINATION

(**Date**)

Hospital Administrator Name
Hospital Name
Address
City, State, ZIP Code

Re: CMS Certification Number (CCN)

Dear (**Hospital Administrator Name**):

In order to participate in the Medicare program, a hospital must meet the requirements established under title XVIII of the Social Security Act (the Act), and must also meet the additional requirements established by the Secretary of Health and Human Services under the authority contained in §1861(e) of the Act. Further, §1866(b) of the Act authorizes the Secretary to terminate the provider agreement of a hospital that fails to meet these provisions.

This office authorized the (**State**) State agency to conduct a survey of (**hospital**) on (**date**). As a result of that survey, it was determined that your facility violated 42 CFR 489.24, "Responsibilities of Medicare Participating Hospitals in Emergency Cases," and/or the related provisions of 42 CFR 489.20. The deficiencies identified are cited in the enclosed Statement of Deficiencies *and Plan of Correction.*

The State agency found that*, prior to the survey,* you discovered the violation and implemented corrective action that has been effective *over* the long*er* term. Therefore*,* we are not *proceeding with a* termina*tion of* your Medicare provider agreement with the Secretary of Health and Human Services.

(NOTE: Only include the following paragraph if the requirements of 42 CFR 489.24 were violated.)

As the requirements for participation in the Medicaid program under 42 CFR 440.10(a)(3)(iii) include meeting Medicare requirements, we are notifying the appropriate State officials concerning your hospital's past violation of the requirements of 42 CFR 489.24. 9. ***(Add as appropriate:*** We are also notifying the Office of Inspector General *which* has responsibility for the enforcement of the civil monetary penalties prescribed by §1867 of the Act.***)*** (***Add as appropriate:*** In addition, we are notifying the regional Office for Civil Rights, which may take action under the Hill-Burton Subpart G Community Service regulations at 42 CFR 124.603(b)(1). ***)***

If you have any questions or concerns about this matter, please contact (**name of contact**) at (**phone number**).

Sincerely yours,

Associate Regional Administrator
(or its equivalent)

Enclosure: Form CMS-2567, Statement of Deficiencies

cc:

State Survey Agency
State Medicaid Agency
OIG ***(if appropriate)***
OCR/FO ***(if appropriate)***
QIO
Accreditation Organization
Complainant
State Licensing Body
DHHS Congressional Liaison Office
CMS Office of Legislation

EXHIBIT 211

MODEL LETTER FOR A VIOLATION OF 42 CFR 489.24 AND/OR THE RELATED PROVISIONS OF 42 CFR 489.20 NOTICE OF TERMINATION

(**Date**)

Hospital Name
Address
City, State, ZIP Code

Re: CMS Certification Number (CCN)

Dear (**Hospital Administrator Name**):

In order to participate in the Medicare program, a hospital must meet the requirements established under title XVIII of the Social Security Act (the Act) and must also meet the additional requirements established by the Secretary of Health and Human Services under the authority contained in §1861(e) of the Act. Further, §1866(b) authorizes the Secretary to terminate the provider agreement of a hospital that fails to meet these provisions.

After a careful review of the facts, we have determined that (**hospital**) no longer meets the requirements for participation as a provider of services in Medicare. Our review of the (**date**) survey conducted by the (**State survey agency**) indicates that your hospital violated:

(**Select as appropriate**)

- The requirements of 42 CFR 489.24, "Responsibilities of Medicare Participating Hospitals in Emergency Cases," based on: (failure to screen, treat, appropriately transfer, or accept an individual who required the hospitals specialized capabilities: or delay in examination or treatment, a penalty or adverse action taken against a physician, qualified medical person or hospital employee).

- The related anti-dumping provisions of 42 CFR 489.20 based on the hospital's failure to: (have and enforce policies to ensure compliance with the requirements of §1867 of the Act, maintain transfer records, maintain an on-call list of physicians, maintain a central emergency services log, report the reception of a dump, or meet the sign posting requirements).

The deficiencies cited by the (**State survey agency**) are listed on the enclosed *CMS Form 2567,* Statement of Deficiencies *and Plan of Correction*.

Under 42 CFR 489.53, a hospital that violates the provisions of 42 CFR 489.24 and/or the related provisions of 489.20 is subject to termination of its provider agreement in accordance with §1866(b) of the Act. Consequently, we are terminating your participation in the Medicare program.

The date on which your agreement terminates is (**date**). The *Medicare* program will not make payment for hospital services furnished to patients admitted on or after (**termination date**). For patients admitted prior to (**termination date**), payment may continue to be made for up to 30 days *for covered inpatient hospital* services furnished on or after (**termination date**). A list showing the names and health insurance claim numbers of *the Medicare patients remaining in* your facility on (**day before termination date**) should be forwarded to (*RO contact* **and address**).

As the requirements for participation in the Medicaid program under 42 CFR 440.10(a)(3)(iii) include meeting Medicare requirements, we are notifying the appropriate State officials concerning your hospital's violation of 42 CFR 489.20 and/or 42 CFR 489.24.

(**Insert for 42 CFR 489.24 violation:** We are also notifying the Office of Inspector General which has responsibility for the enforcement of the civil monetary penalties prescribed by §1867 of the Act). ***(Insert for referral to OCR:*** In addition, we are notifying the regional Office of Civil Rights, *which* may take action under the Hill-Burton Subpart G Community Service regulations at 42 CFR 124.603(b)(1).)

If you believe this determination is not correct, you may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board. Procedures governing this process are set out in regulations at 42 CFR 498.40 et seq. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. For expedited handling, such a request may be made to the following:

(**Name**)
(**Associate Regional Administrator (or its equivalent**))
(**Address**)
(**City, State, ZIP**)

We will forward your request to the regional Chief Administrative Law Judge in the Office of Hearings and Appeals.

At your option, you may instead submit a hearing request directly (accompanied by a copy of this letter) to:

Departmental Appeals Board, Civil Remedies Division
Room G-644-Cohen Building
330 Independence Avenue, S.W.
Washington, D.C. 20201

Additionally, send a copy of your request to this office.

A request for a hearing should identify the specific issues, the findings of fact and the conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You may be represented by counsel at a hearing at your own expense.

If you have any questions concerning this, please contact (**name of contact**) at (**phone number**).

Sincerely yours,

Associate Regional Administrator
(or its equivalent)

Enclosure: Form CMS-2567, Statement of Deficiencies
cc:
State *Survey* Agency
State *Medicaid* Agency
OIG*(if appropriate)*
OCR/FO *(if appropriate)*
QIO
Accreditation Organization
Complainant

State Licensing Body
DHHS Congressional Liaison Office
CMS Office of Legislation

EXHIBIT 212

MODEL LETTER REQUESTING QIO REVIEW OF A CONFIRMED VIOLATION OF 42 CFR 489.24 FOR PURPOSES OF ASSESSING CIVIL MONETARY PENALTIES (CMPS) OR EXCLUDING PHYSICIANS

(**Date**)

QIO Executive Director
Quality Improvement Organization (QIO) Name
Address
City, State, ZIP Code

*Dear (**QIO Executive Director Name**):*

Enclosed is a case that we determined was a violation of 42 CFR §489.24, which places special responsibilities on Medicare-participating hospitals that offer emergency services. Because the Office of the Inspector General (OIG) has the authority to assess *civil monetary penalties (*CMPs*)* and exclude physicians from the Medicare program for violations of §1867 *of the Social Security Act*, we referred our confirmed violation decision to the OIG for *its* review.

In accordance with 42 CFR §489.24(g), before CMPs may be assessed or physicians may be excluded from the Medicare program for a violation of 42 CFR §489.24, the appropriate Quality Improvement Organization (QIO) must review the case to assess whether the individual had an emergency medical condition which had not been stabilized, and provide a report on its findings. Except in the case in which a delay would jeopardize the health or safety of individuals, the Secretary shall request such a review before effecting a sanction, and shall provide a period of at least 60 days for such review. During the 60 days, you are to provide the hospital and/or affected physician with an opportunity to discuss the case and submit additional information.

Please have this case reviewed by a physician who is a specialist in either the specialty of the physician who attended the patient or the type of service under review. Whenever possible, the physician reviewer should practice in a similar setting as that of the physician who attended the patient. Since the physician reviewer could be needed to serve as an expert witness in the case, secure from the physician a statement of willingness to provide service on the additional development needed to properly adjudicate any issues and to testify as an expert witness.

To assist you in performing your review, we have enclosed:

- A copy of the patient's medical record (at both hospitals, if pertinent);
- A copy of 42 CFR §489.24 and related provisions of 42 CFR §489.20; and

- The *EMTALA Physician Review Worksheet* upon which the physician will document his/her findings. Your response is not limited to the space provided on the form. It is important that the physician thoroughly document the *clinical* rationale for each response.

Thank you for your assistance. If you wish to discuss this case further, please contact (**policy person in RO**) at (**phone number**).

Sincerely yours,

Associate Regional Administrator
(or its equivalent)

Enclosures:

Exhibit 216
Medicare Survey and Certification Program
Report on Initial Survey Activity

State: *for the Quarter Ending (Date)*

	Column A	*Column B*	*Column C*	*Column D*	*Column E*	*Column F **
Type of Initial Survey Activity	*# of Initial Pending Surveys at Start of ____ QTR.*	*# of Initials Requested for the QTR.*	*# of Initials Completed for the QTR.*	*# of Initials Completed Year to Date*	*# of Applications Withdrawn for the QTR.*	*# of Initials Pending End of the QTR.*
SNF XVIII						
SNF XVIII/XIX						
Hospital						
HHA						
ESRD						
Hospice						
RHC						
ASC						
Other - OPPT						
CORF						
PXR						
CAH						
Total	*Sum A*	*Sum B*	*Sum C*	*Sum D*	*Sum E*	*Sum F*

**FORMULA: COLUMN A + COLUMN B - COLUMN C - COLUMN E = COLUMN F*

INSTRUCTIONS FOR THE
PREPARATION OF REPORT ON STATE INITIAL SURVEY ACTIVITY

Usage *-- The "Report on Initial Survey Activity " is used to record initial surveys requested by prospective Medicare providers in each State.*

Heading *-- Insert the State for which the information is being reported. Enter the quarter and year for which the activity is being reported.*

Definition of a Pending Initial *-- A pending initial is one in which a prospective provider of care has requested and is ready for a survey. The prospective provider must also have in place the tangible assets necessary to do business, such as a facility, equipment, etc., and have submitted an application to become a Medicare provider.*

Column A, # of Initial Pending Surveys at Start of the Quarter -- *Enter for each facility type the number of pending initial surveys that were not completed at the beginning of the report period.*

Column B, # of Initials Requested for the Quarter *-- Enter for each facility type the number of initial surveys that have been requested by a prospective provider for the current quarter.*

Column C, # of Initials Completed for the Quarter -- *Enter for each facility type the number of initial surveys that were completed (i.e., a survey was performed) for the current quarter being reported.*

Column D, # of Initials Completed Year to Date -- *Enter for each facility type the number of initial surveys that were completed (i.e., a survey was performed) beginning with the current fiscal year through the current reporting period.*

Column E, # of Applications Withdrawn for the Quarter *-- Enter for each facility type the number of initial applications that were withdrawn (i.e., prospective providers that requested an initial survey but withdrew their request before being surveyed) for the current quarter being reported.*

Column F, # of Initials Pending End of Quarter -- *Enter for each facility type the number of initial surveys remaining at the end of the current quarter. This number must be obtained by adding Column A and Column B and subtracting Column D and Column E.*

Exhibit 217
Medicare Survey and Certification Program
Aging Report on Pending Initial Survey Activity

State: *for the _____ QUARTER*

Type of Initial Survey Activity Pending	*Column A* *0 - 30 days*	*Column B* *31 - 60 days*	*Column C* *61 - 90 days*	*Column D* *91 - 120 days*	*Column E* *Over 120 days*
SNF XVIII					
SNF XVIII/XIX					
Hospital					
HHA					
ESRD					
Hospice					
RHC					
ASC					
Other -OPPT					
CORF					
PXR					
CAH					
Total Pending	*SUM A*	*SUM B*	*SUM C*	*SUM D*	*SUM E*

Note: Column 'F" on the Report on Pending Initial Survey Activity must agree to the aggregate number on pending initials that are aged on the Aging Report on Pending Initial Survey Activity.

PREPARATION OF AGING REPORT ON PENDING INITIAL SURVEY ACTIVITY

Usage *-- The "Aging Report on Pending Initial Survey Activity " is used to record the number of days an initial survey is pending for each State by facility type.*

Heading *-- Insert the State for which the information is being reported. Enter the quarter and year for which the activity is being reported.*

Reconciliation *-- The number of pending initials as reported in column "H" on the "Report on Initial Survey Activity" must reconcile to the aggregate number of pending initials that are aged on the "Aging Report on Pending Initial Survey Activity."*

Column A, 0 - 30 days *-- Enter for each facility type the number of pending initials that are outstanding 0 to 30 days.*

Column B, 31 - 60 days *-- Enter for each facility type the number of pending initials that are outstanding 31 to 60 days.*

Column C, 61 - 90 days *-- Enter for each facility type the number of pending initials that are outstanding 61 to 90 days.*

Column D, 91 - 120 days *-- Enter for each facility type the number of pending initials that are outstanding 91 to 120 days.*

Column E, Over 120 days *-- Enter for each facility type the number of pending initials that are outstanding over 120 days.*

Exhibit 222

AUDIT CLEARANCE DOCUMENT
PART I

Audit Control No. _____ *Report Date* _____
Cognizant Division or Unit _____ *Program* _____
Other Division or Unit _____

Grantee/Contractor

Name _____
Address _____
City _____ *State* _____ *Zip Code* _____

Grant/Contract No. _____

*Common Accounting No.*_____ *Appropriation No.*_____

Audit Recommendation: _____
_____
_____
_____
_____

Amounts Recommended for Financial Adjustment:

Finding Code-Cost Element	*Amount Recommended*	*Amount Sustained*
*1.*_____	*$*_____	*$*_____
*2.*_____	_____	_____
*3.*_____	_____	_____
*4.*_____	_____	_____
Totals	*$*_____	*$*_____

Action Taken on Recommendation: _____
_____
_____
_____
_____
_____

_____ _____
Signature, Originating Official *Date* *Signature, Approving Official* *Date*

_____
Signature, Office of the General Counsel *Date*

AUDIT CLEARANCE DOCUMENT
PART I (Continuation Sheet)

*Date*_____

Audit Control No. _____ *Report Date* _____

Audit Recommendation: _____

Amounts Recommended for Financial Adjustment:

Finding Code-Cost Element	*Amount Recommended*	*Amount Sustained*
1.	*$*	*$*
2.		
3.		
4.		
Totals	*$*	*$*

Action Taken on Recommendation: _____

AUDIT CLEARANCE DOCUMENT
PART II Recommendation Remaining Open

*Date*_____ *Audit Control No.* _____

Finding Code	*Recommendation*	*Amount Recommended for Financial Adjustment*

CENTERS FOR MEDICARE AND MEDICAID SERVICES

AUDIT STATUS FOLLOW-UP REPORT

AS OF_____

PROGRAM_____ Audit Control Number _____

Auditee_____

Number of Recommendations in Report _____

Recommendations Closed to Date: No. _____

Recommendations Cleared Only:

Status of Actions Taken:

_____
Regional Program Director

EXHIBIT 249

MODEL APPLICATION LETTER NOTIFYING TRANSPLANT HOSPITAL THAT A COMPLETE MEDICARE GENERAL ENROLLMENT HEALTH CARE FORM CMS-855A NEEDS TO BE COMPLETED

(Date)

Transplant Hospital Name
Address
City, State, Zip Code
Attn:

Dear ***(Name)****:*

On ***(date)*** *the Centers for Medicare & Medicare Services (CMS) received your request for Medicare approval of one or more organ transplant programs.*

Medicare-approval was requested for the following program:

(List of Programs)

The information that you submitted is in the review process which will include an on-site evaluation and you will be notified in writing of your approval or disapproval upon completion of the review.

Please refer to our Web site below for frequently asked questions and answers, periodic program updates, and the requirements for notifying CMS (under 42 CFR 482.74) of any significant changes to a transplant program:

http://www.cms.hhs.gov/CertificationandComplianc/20_Transplant.asp

While your hospital is an established Medicare provider, it has never completed a CMS-855A enrollment form in its entirety. In order to process this transaction, your hospital must complete a CMS-855A application in full. Please notify your hospital administrative office that it must submit the complete CMS-855A to your assigned Medicare contractor. To designate that the hospital has an organ transplant program, please check the "Other" box in Section 2A2 and write "Organ Transplant Program" next to the checkbox.

Any additional questions concerning your approval request may be directed to Survey and Certification Group at telephone number 410-786-8476 or email; Sherry.Clark@cms.hhs.gov.

Additional information about the Medicare enrollment process and a copy of the form CMS-855A can be found at:

www.cms.hhs.gov/MedicareProviderSupEnroll/03_EnrollmentApplications.asp#TopOfPage

Sincerely,

Administrative Officer
Survey and Certification Group

EXHIBIT 250

MODEL APPLICATION LETTER TO TRANSPLANT HOSPITAL REQUIRING PARTIAL MEDICARE GENERAL ENROLLMENT HEALTH CARE FORM CMS-855A

(Date)

Transplant Hospital Name
Address
City, State, Zip Code
Attn:

*Dear **(Name)**:*

*On **(date)** the Centers for Medicare & Medicare Services (CMS) received your request for Medicare approval of one or more organ transplant programs.*

Medicare approval was requested for the following programs:

Adult Heart
Adult Kidney
Adult Pancreas
Adult Kidney/Pancreas
Pediatric Heart
Pediatric Kidney

The information that you submitted is in the review process which will include an on-site evaluation and you will be notified in writing of your approval or disapproval upon completion of the review.

Please refer to our Web site below for frequently asked questions and answers, periodic program updates, and the requirements for notifying CMS (under 42 CFR 482.74) of any significant changes to a transplant program:

http://www.cms.hhs.gov/CertificationandComplianc/20_Transplant.asp

For Hospitals Needing a Partial Form CMS-855 – Use this paragraph.

Your hospital's Medicare provider enrollment information must be updated to include the organ transplant program(s). Please notify your hospital administrative office that it must submit a CMS-855A change of information request to its assigned Medicare contractor. To designate that the hospital has an organ transplant program, please check the "Other" box in Section 2A2 and write "Organ Transplant Program" next to the checkbox. The hospital must also complete those sections of the form identified in the box next to the "Identifying Information" checkbox in Section 1B (i.e., Sections 1, 2, 3, 13, and either 15 or 16).

Any additional questions concerning your approval request may be directed to Survey and Certification Group at telephone number 410-786-8476 or email; Sherry.Clark@cms.hhs.gov.

Additional information about the Medicare enrollment process and a copy of the CMS-855A form can be found at:

www.cms.hhs.gov/MedicareProviderSupEnroll/03_EnrollmentApplications.asp#TopOfPage

Sincerely,

Administrative Officer
Survey and Certification Group

cc: James Bossenmeyer
Director, Division of Provider/
Supplier Enrollment, CMS

EXHIBIT 251

MODEL LETTER FOR FIRST REJECTION OF A REQUEST FOR MEDICARE APPROVAL OF ONE OR MORE ORGAN TRANSPLANT PROGRAMS

(Date)

Transplant Hospital Name
Address
City, State, Zip Code
Attn:

Dear ***(Name):***

Your request for Medicare approval of your organ transplant program(s)

(fill in)

was received by the Centers for Medicare & Medicaid Services (CMS) on (Date), however the following required information is needed to continue processing your application:

_____ *Signature of hospital representative;*

_____ *Hospital name, address, phone and fax numbers, and e-mail;*

_____ *Hospital's National Provider Identification Number or*
_____ *CMS Certification Number (Medicare I.D.);*

_____ *The type of transplant program for Medicare approval;*

_____ *Name of the designated primary transplant surgeon (fill-in program)_____;*

_____ *Name of the primary transplant physician (fill-in program)_____;*

_____ *Name of the OPO(s) with which the hospital has an agreement; and*

_____ *Other: _____;*

Your request cannot be processed until all the above information has been received by CMS. Please submit the information within 30 days to:

Center for Medicare and Medicaid Services
Survey and Certification Group
7500 Security Blvd
Mailstop: S2-12-25
Baltimore, Maryland 21244

Any questions concerning missing information should be directed to Survey and Certification Group at telephone number 410-786-8476 or email to ***Sherry.Clark@cms.hhs.gov****.*

Sincerely,

Administrative Officer
Survey and Certification Group

EXHIBIT 252

MODEL REMINDER LETTER FOR FIRST REJECTION OF A REQUEST FOR MEDICARE APPROVAL OF ONE OR MORE ORGAN TRANSPLANT PROGRAMS

(Date)

Transplant Hospital Name
Address
City, State, Zip Code
Attn:

*Dear **(Name)**:*

On (date) we sent you a letter requesting additional information regarding your application, for Medicare approval of your organ transplant program(s).
(fill in)

We have not received the information and want to remind you that the approval process cannot proceed without the missing information. The information requested with your application is:

_____ *Signature of hospital representative;*

_____ *Hospital name, address, phone and fax numbers, and e-mail;*

_____ *Hospital's National Provider Identification Number or*
_____ *CMS Certification Number (Medicare I.D.);*

_____ *The type of transplant program for Medicare approval;*

_____ *Name of the designated primary transplant surgeon (fill-in program)_____;*

_____ *Name of the primary transplant physician (fill-in program)_____;*

_____ *Name of the OPO(s) with which the hospital has an agreement; and*

_____ *Other: _____;*

Your request cannot be processed until all the above information has been received by CMS. Please submit the information within 30 days to:

Center for Medicare and Medicaid Services
Survey and Certification Group
7500 Security Blvd
Mailstop: S2-12-25
Baltimore, Maryland 21244

If you wish to withdraw your application or you have questions concerning missing information please contact Survey and Certification Group at 410-786-8476 or email to Sherry.Clark@cms.hhs.gov.

Sincerely,

Sherry Clark
Administrative Officer

EXHIBIT 253

Organ Transplant Hospital Worksheet

1. Date of Survey: *____/____/_____ (mm/dd/yyyy)*

2. Type of Survey *(Check all that apply)*

__Initial Certification
__Re-certification
__Follow-Up/ Re-Visit
__Validation
__Complaint
__Accreditation (Organization) _____
__Other (Specify)_____

3. Surveyor Number: *_____*

4. National Provider Identification Number (NPI): *_____*

5. CMS Certification Number (CCN): *_____*

6. Name of Facility *_____*
City_____ State_____

7. Host Hospital Accreditation Status: *_____*

0 Not Accredited
1 JC Accredited
2 AOA Accredited
4 Both

Effective Date of Accreditation: _____
(mm/dd/yyyy)
Expiration Date of Accreditation: _____
(mm/dd/yyyy)

Which Programs Were Surveyed During This Review?

	Surveyed During This Review (Check All that Apply)	*Any tags cited during the survey? (Check if Yes)*
Adult Kidney-Only		
Adult Kidney/Pancreas		
Adult Pancreas-Only		
Adult Heart-Only		
Adult Heart/Lung		
Adult/Lung-Only		
Adult Liver		
Adult Intestine and/or Multi-visceral		
Pediatric Kidney-Only		
Pediatric Kidney/Pancreas		
Pediatric Pancreas-Only		
Pediatric Heart-Only		
Pediatric Heart/Lung		
Pediatric/Lung-Only		
Pediatric Liver		
Pediatric Intestine and/or Multi-visceral		

Send this Worksheet to the Contact Below:

Mail to:
Centers for Medicare and Medicaid Services
Survey and Certification Group
7500 Security Blvd.
Mailstop: S2-12-25
Baltimore, MD 21244

E-Mail to:
Sherry.Clark@cms.hhs.gov

Fax to:
(410) 786-0194

EXHIBIT 286

HOSPITAL/CAH MEDICARE DATABASE WORKSHEET

Worksheet completed by the SA surveyor to gather data *of worksheet*, not to be given to provider to fill out

***CMS Certification* Number (*CCN*):_____ Date *of Worksheet* Update: _____**

Medicaid Provider Number:_____ (MMDDYYYY) (M1)

National Provider Identification Number (NPI):_____

Fiscal Year Ending Date (MMDD): _____

Name and Address of Facility (Include City, State):

_____

_____

_____**Zip Code:**_____

Telephone Number (M2): _____ *Fax Number (M3):*_____

***Email Address:*_____**

Accreditation Status:_____ Effective Date of Accreditation: _____

0 Not Accredited (MMDDYYYY) (M4)

1 JC Accredited *Renewal* Date of Accreditation:_____

2 AOA Accredited (MMDDYYYY) (M5)

4 Both

State/County Code (M6):_____ CLIA ID Numbers (M9):

State Region Code (M7):_____ _____

Type of Program Participation **(M8):_____** _____

1 Medicare _____

2 Medicaid _____

3 Both _____

Type of Hospital or a Critical Access Hospital (CAH) (select 1) (M10):_____

01 Short-term
02 Long-term
03 Religious Non-medical Health Care Institution
04 Psychiatric
05 Rehabilitation
06 Childrens
07 Distinct Part Psychiatric Hospital
08 *Cancer Hospital*
11 Critical Access Hospital (CAH)

Affiliation with a Medical School (M11):_____

01 Major **03 Graduate School**
02 Limited **04 No Affiliation**

Resident Programs (M12):_____
(select all that apply)

01 AMA **02 ADA** **03 AOA**
04 Other **05 No Program** ***06 Podiatric***

Ownership Type **(select 1) (M13):_____**

01 Church
02 ***Private(Not for Profit)***
03 ***Other (specify*****:_____**
04 ***Proprietary(For Profit)***
05 *Federal_*
06 ***State***
07 ***Local***
08 *Hospital District or Authority*
09 Physician Ownership
10 Tribal

Average Daily Census (M14):_____ **Number of Staffed Beds (M15):_____**

Type of ***Chain/Health*** **System Involvement (M16):_____**

01 None
02 System Ownership
03 System Management
04 Both System Owned and Managed

Name of System (M17):_____

Corporate Headquarters City (M18):_____ State (M19):_____

Number of Employees Salaried by Hospital/CAH (Use Full Time Equivalents FTE)					
M20	**Physicians (Salaried only)**		**M30**	**Medical Technologists (Lab)**	
M21	**Physicians - Residents**		**M31**	**Nuclear Medicine Technicians**	
M22	**Physician Assistants (PA)**		**M32**	**Occupational Therapists**	
M23	**Nurses - CRNA**		**M33**	**Pharmacists (Registered)**	
M24	**Nurses - Practitioners**		**M34**	**Physical Therapists**	
M25	**Nurses - Registered**		**M35**	**Psychologists**	
M26	**Nurses – LPN**		**M36**	**Radiology Technicians (Diagnostic)**	
M27	**Dieticians**		**M37**	**Respiratory Therapists**	
M28	**Medical Social Workers**		**M38**	**Speech Therapists**	
M29	**Medical Laboratory Technicians**		**M39**	**All Others**	

Type of Reimbursement *or Status Categories of a Hospital or a CAH* (select all that apply) (M40):_____

01	CAH Psychiatric DPU		07	Hospital PPS Excluded Psych Unit	
02	CAH Rehabilitation DPU		08	Hospital PPS Excluded Rehab Unit	
03	CAH Swing Beds		09	Hospital Swing Beds	
04	Specialty Hospital		10	Medicare Dependent Hospital	
05	Hospital in a Hospital - Host		11	Regional Referral Center	
06	Hospital in a Hospital - Tenant		12	Sole Community Hospital	

Services Provided by the Facility (M41):_____

0 Service not provided

1 Services provided by facility staff *only*

2 Services provided by arrangement or agreement

3 Services provided through a combination of facility staff and through agreement

01	Ambulance Services (Owned)		34	Operating Rooms	
02	Alcohol and/or Drug Services		35	Opthalmic Surgery	
03	Anesthesia		36	Optometric Services	
04	Audiology		37	Organ Bank	
05	Blood Bank *- FDA Approved*		38	Organ Transplant Services	
06	Burn Care Unit		39	Orthopedic Surgery	
07	Cardiac Catheterization Laboratory		40	Outpatient Services	
08	Cardiac-Thoracic Surgery		41	Pediatric Services	
09	Chemotherapy Service		42	Pharmacy	
10	Chiropractice Service		43	Physical Therapy Services	
11	CT Scanner		44	Positron Emission Tomography Scan	
12	Dental Service		45	Post-Operative Recovery Rooms	
13	Dietetic Service		46	Psychiatric Services - Emergency	
14	Emergency Department (Dedicated)		47	Psychiatric - Child/Adolescent	
15	Emergency Services		48	Psychiatric - Forensic	
16	Extracorporeal Shock Wave Lithotripter		49	Psychiatric - Geriatric	
17	Gerontological Specialty Services		50	Psychiatric - Inpatient	
18	Home Health Services		51	Psychiatric - Outpatient	
19	Hospice		52	Radiology Services - Diagnostic	
20	ICU - Cardiac (non-surgical)		53	Radiology Services - Therapeutic	
21	ICU - Medical/Surgical		54	Reconstructive Surgery	
22	ICU - Neonatal		55	Respiratory Care Services	
23	ICU - Pediatric		56	Rehab -Inpatient (CARF Acc)	
24	ICU - Surgical		57	Rehab -Inpatient (Not CARF Acc)	
25	Laboratory - Anatomical		58	Rehab -Outpatient	
26	Laboratory - Clinical		59	Renal Dialysis (Acute Inpatient)	
27	Long Term Care (swing-beds)		60	Social Services	
28	Magnetic Resonance Imagining (MRI)		61	Speech Pathology Services	
29	Neonatal Nursery		62	Surgical Services - Inpatient	
30	Neurosurgical Services		63	Surgical Services - Outpatient	
31	Nuclear Medicine Services		64	*Tissue Bank Services*	
32	Obstetric Service		65	*Trauma Center (Certified)*	
33	Occupational Therapy Services		*66*	Urgent Care Center Services	

Sprinkler Status, Primary Location (select 1) (M42): _____

01 Totally sprinklered: All required areas are sprinklered

02 Partially sprinklered: Some but not all required areas are sprinklered

03 Sprinklers: None

***Total n*umber of off-site locations *under* the same *CCN* (M43):_____**

TYPES OF OFF-SITE LOCATIONS					
01	**Inpatient Remote Locations**		**07**	**Satellites of a PPS-Excluded Psych Unit**	
02	**Offsite Freestanding Outpatient Surgery**		***08***	**Satellites of a Long Term Care Hospital**	
03	**Urgent Care Center (Freestanding)**		***09***	**Satellites of a Cancer Hospital**	
04	**Satellites of a Rehabilitation Hospital**		***10***	**Satellites of a Childrens' Hospital**	
05	**Satellites of a Psychiatric Hospital**		**11**	**Other Provider-Based Location**	
06	**Satellites of a PPS-Excluded Rehab Unit**		**12**	Offcampus Emergency Department	

Identification Number Assigned to the Specific* Off-site Location *(from table)

***(M44)*_____**

Name of Off-site Location (45): _____

Off-site Street Address (M46):_____

***County (47):*_____**

City (M48):_____State (M49):_____ Zip Code (M50):_____

Sprinkler Status of Off-site Location (select 1) (M51):

01 Totally sprinklered: All required areas are sprinklered

02 Partially sprinklered: Some but not all require areas sprinklered

03 Sprinklers: None

04 Sprinklers are not required but the location is sprinklered

If there is more than one off-site location, complete and attach the Provider-Based Off-Site Locations Continuation Worksheet until all locations are accounted for.

Number of related or affiliated *providers or suppliers* (*M52*):_____

TYPES OF AFFILIATED PROVIDERS					
01	**Ambulatory Surgery Center (ASC)**		**06**	**Home Health Agency**	
02	**Collocated Hospitals**		**07**	**Hospice**	
03	**Collocated Satellites of Another Hospital**		**08**	**Psychiatric Residential Treatment Facility**	
04	**End Stage Renal Disease (ESRD) Center**		**09**	**Rural Health Clinic (RHC)**	
05	**Federal Qualified Health Center (FQHC)**		**10**	**Skilled Nursing Facility (SNF)**	

Identification Number of related or affiliated provider numbers (53): _____

Provider Number (54): _____

If there is more than one related or affiliated provider or supplier, attach the Related or Affiliated Provider Numbers Continuation Worksheet until all are accounted for.:

Signature of Authorized Individual:_____

***Print* Name of Authorized Individual:_____ Date:_____**

PROVIDER-BASED OFF-SITE LOCATION CONTINUATION WORKSHEET PAGE 1 OF _____

Type of off-site location and total number of each type of off-site location:

- ***Identify every location (that bills for services using the provider's Medicare CCN) of the provider that is located off the provider's primary campus/location;***
- ***In the block "Number of off-site locations with the same provider number (M43)", write the total number of off campus location; and***
- ***Place the total number of each type of off-site location in the space beside that type of location. Example: If a hospital has two additional campuses, enter the number "2" in the block beside "01 Inpatient Remote Location".***

Total Number of off-site locations with the same CCN (M43):_____

TYPES OF OFF-SITE LOCATIONS					
01	Inpatient Remote Locations		07	Satellites of a PPS Excluded Psych Unit	
02	Off-site Freestanding Oupatient Surgery		08	Satellites of a Long Term Care Hospital	
03	Urgent Care Center (Freestanding)		09	Satellites of a Cancer Hospital	
04	Satellites of a Rehabilitation Hospital		10	Satellites of a Children's Hospital	
05	Satellites of a Psychiatric Hospital		11	Other Provider-Based Locations	
06	Satellites of a PPS Excluded Rehab Unit		12	Off Campus Emergency Department	

- ***Complete an identification entry for each off-site location that bills for services under the provider's CCN. Example: If a hospital has seven off-site locations that bill for services under the hospital's CCN, complete seven separate entries;***
- ***Complete all the blocks for each off-site location;***
- ***From the table above, enter the identification number for the type of off-site location. Example: Enter "02" for an off-site freestanding outpatient surgery location; and***
- ***Using the Code number provided, enter the sprinkler status of each location.***

ENTRY _____
Identification Number Assigned to the Specific Off-site Location (from table) (M44): _____
Name of Off-Site Location (M45):_____
Off-Site Street Address (M46): _____
County (M47): _____
City (M48): _____State (49):_____ Zip Code (M50):_____
Sprinklered Status of Off-site Location (select 1) (M51): _____

01 Totally sprinklered: All required areas are sprinklered;
02 Partially sprinklered: Some but not all required areas sprinklered;
03 Sprinklers: None; or
04 Sprinklers are not required but the location is sprinklered

ENTRY _____
Identification Number Assigned to the Specific Off-site Location (from table) (M44): _____
Name of Off-Site Location (M45):_____
Off-Site Street Address (M46): _____
County (M47): _____
City (M48): _____State (49):_____ Zip Code (M50):_____
Sprinklered Status of Off-site Location (select 1) (M51): _____

05 Totally sprinklered: All required areas are sprinklered;
06 Partially sprinklered: Some but not all required areas sprinklered;
07 Sprinklers: None; or
08 Sprinklers are not required but the location is sprinklered.

Make additional copies as needed for additional off-site locations.

RELATED OR AFFILIATED CCN CONTINUATION WORKSHEET PAGE 1 OF_____

Identify all related or affiliated Medicare or Medicaid providers/suppliers that are:

---Owned and/or operated by the hospital or CAH; or
---Located on a campus or location of the hospital or CAH; and
---Do not bill for services under the hospital or CAH CCN.

- ***In the block "Number of related or affiliated provider/suppliers (M52)", write the total number of all related or affiliated providers/suppliers. Example: If a hospital has 1 collocated hospital, 1 hospice, and 1 SNF to which it is related or affiliated, the number "3" would be entered.***

- ***In the block beside the identified provider/suppliers, write the total number of that particular provider/supplier type that is related or affiliated to the hospital/CAH. Example: If a CAH has one provider-based RHC, enter the number "1" in the block beside "09 RHC"; if a hospital has two affiliated Medicare certified ASC which have their own CCN, enter the number "2" in the block beside "01 ASC"***

TYPES OF AFFILIATED PROVIDERS/SUPPLIERS					
01	***Ambulatory Surgery Center (ASC)***		**06**	**Home Health Agency**	
02	**Collocated Hospitals**		**07**	**Hospice**	
03	**Collocated Satellites of Another Hospital**		**08**	**Psychiatric Residential Treatment Facility**	
04	***End Stage Renal Disease (ESRD) Center***		**09**	***Rural Health Clinic (RHC)***	
05	***Federal Qualified Health Center (FQHC)***		**10**	***Skilled Nursing Facility (SNF)***	

- ***In the block "Type of provider (M53)", enter the number from the above table that identifies the particular type of related or affiliated provide/supplier. Example: Enter the number "10" for a distinct part SNF or a collocated SNF related or affiliated.***

- ***In the block "Provider number (54)", enter the related or affiliated provider's Medicare provider number. In the case of PRTF, write the Medicaid provider number.***

Type of Provider (M53):_____ CCN (M54):_____

Type of Provider (M53):_____ CCN (M54):_____

Type of Provider (M53):_____ CCN (M54):_____

Type of Provider (M53):_____ CCN (M54):_____

Type of Provider (M53):_____ CCN (M54):_____

Type of Provider (M53):_____ CCN (M54):_____

Make additional copies as needed for additional related or affiliated provider numbers.

EXHIBIT 287

AUTHORIZATION *BY DEEMED PROVIDER/SUPPLIER SELECTED FOR ACCREDITATION* ORGANIZATION *VALIDATION SURVEY*

To Whom it May Concern:

*Certain types of providers and suppliers may be deemed in compliance with the appropriate Medicare Conditions of Participation or Conditions for Coverage program **by** submitting evidence of accreditation by a CMS authorized accreditation organization. The Centers for Medicare and Medicaid Services (CMS) may subsequently require a survey of an accredited provider or supplier to validate the accreditation organization's process.*

*In signing this form I acknowledge that I have been advised that **(name of provider/supplier**) has been selected for a validation survey. Furthermore, I acknowledge that, in accordance with the provisions of 42 CFR 488.7(b), I must authorize:*

1) *The validation survey by the State survey agency to take place; and*
2) *The State survey agency to monitor the correction of any deficiencies found through the validation survey.*

_____
Signature of Authorizing Individual

_____
Printed/Typed Name of Individual

_____
Name of *Provider/Supplier*

_____
Date

EXHIBIT 289

MODEL RECIPROCAL AGREEMENT BETWEEN STATES FOR SURVEY AND CERTIFICATION OF HOME HEALTH AGENCIES AND/OR HOSPICES

The State of _____and the State of _____, in order to more effectively administer their survey and certification responsibilities relating ***[home health agencies and/or hospices]*** that provide services across state lines, agree as follows:

GENERAL

The State of _____and _____ will coordinate the administration of the responsibilities under section 1864 of the Social Security Act with respect to ***[home health agencies and/or hospices]*** that are approved to provide services across state lines under a single Medicare agreement and/or number. In general, the States of _____ and _____agree to cooperate and conduct their respective responsibilities related to these providers in a coordinated manner in order to promote streamlined operations and minimize unnecessary burdens on beneficiaries, providers, survey personnel of the states and the Center for Medicare & Medicaid Services (CMS).

PROCEDURES

The State of _____, where the approved provider issued the agreement/number is located, shall be referred to as the Primary State. The Primary State maintains the overall responsibility for coordinating all surveys, including initial surveys, re-surveys, revisits, and complaint surveys of providers providing services across state lines with the State of _____. The Primary State will also report the survey results and the certification recommendations to the CMS regional office responsible for the Primary State.

The Primary State and the State of _____have agreed that the State of _____ will be responsible for conducting any necessary surveys of a practice location in State of _____. The Medicare survey findings of the practice location will be incorporated into the findings of the Medicare survey of the approved provider. The Primary State will notify the approved provider of the survey findings. It will also process any necessary termination or denials or other recommendations resulting from surveys by either state.

Both the State of _____and the State of _____will use CMS forms, guidelines, policies and instructions in processing surveys of providers that *operate* in more than one state.

STATE LICENSURE

1. The States of _____and _____will be responsible to ensuring that their respective state license laws including those related to licensure of personnel, certificate of need and any other applicable requirements relating to ***[home health agencies and/or hospices]*** *are met.*

2. The State of _____and the State of _____ will use survey funds allocated by CMS as compensation for their costs related to a particular survey, re-survey, revisit or complaint survey of a particular provider.

TERMS OF AGREEMENT

This agreement will remain in effect until terminated by mutual consent of the parties.

EXHIBIT 290

MODEL LETTER TO HHAS ASSIGNING BRANCH IDENTIFICATION NUMBERS

(Date)

HHA Administrator Name
HHA Name
Address
City, State, ZIP Code

Dear (HHA Administrator Name):

The Centers for Medicare & Medicaid Services (CMS) is assigning identification numbers to every existing branch of a parent home health agency (HHA) and subunit. The identification system is being implemented nationally and will uniquely identify every branch of every HHA certified to participate in the Medicare home health program. It will also link the parent or subunit to the branch.

This identification number is to be used on Outcome and Assessment Information Set (OASIS) item M0016 (Branch ID) when an assessment is done on a patient by qualified staff of a branch location. *By submitting the branch identification number on OASIS assessments, we will have the capability of developing outcome reports that will help HHAs differentiate and monitor the quality of care delivered by their agencies down to the HHA branch level.*

Each branch will be numbered with the same Federally assigned CMS certification Number (CCN) as the parent or subunit, with two modifications. There will be a "Q" between the state code and four-digit provider designation, plus three more digits for a 10-character branch identifier. Branch identification numbers will be used only once. In the event that an HHA branch closes, its unique branch identification number is terminated and not re-used to identify another branch of that HHA or subunit.

On the next page, please review the information we have on file for your parent or subunit HHA and take not of your assigned branch identification numbers.

If you have any questions or concerns, or wish to submit additional information, please contact (name and address

Sincerely yours

Associate Regional Administrator
(or its equivalent)

THE NAME, ADDRESS AND CMS CERTIFICATION NUMBER (CCN) FOR YOUR PARENT OR SUBUNIT HHA IS:

NAME: _____

ADDRESS: _____

CCN: _____

The following are your branch locations and Federally-assigned branch identification number(s) associated with the above parent or subunit HHA:

Branch Name and Address	*Branch Identification Number*
1. _____	_____
_____	_____
_____	_____
2. _____	_____
_____	_____
_____	_____
3. _____	_____
_____	_____
_____	_____
4. _____	_____
_____	_____
_____	_____
5. _____	_____
_____	_____
_____	_____
6. _____	_____
_____	_____
_____	_____
7. _____	_____
_____	_____
_____	_____
8. _____	_____
_____	_____
_____	_____

EXHIBIT 291

NOTICE TO HOSPITAL/CAH OF COLLECTION OF DATA BY THE STATE AGENCY

To Whom It May Concern:

The Centers for Medicare and Medicaid Services (CMS) maintains a data base with survey and certification information on each hospital and critical access hospital (CAH) that participates in Medicare. To enhance the accuracy and completeness of this data, CMS requires State survey agencies to complete a Hospital/CAH Medicare Data Base Worksheet when they are surveying a hospital or CAH, including accredited hospitals and CAHs. CMS does not expect the hospital or CAH to fill out this worksheet, but we do appreciate your assistance to the surveyors gathering the needed information. The type of information requested is most likely maintained in the hospital or CAH's central administrative/financial office(s). We appreciate your cooperation in responding to the surveyor's request for information.

Sincerely yours,

Associate Regional Administrator
(or its equivalent)