CMS Manual System

Pub. 100-07 State Operations Provider Certification

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

Transmittal 201 **Date: June 19, 2020**

SUBJECT: State Operations Manual (SOM) Chapter 2, The Certification Process

I. SUMMARY OF CHANGES: The SOM Chapter 2 sections that provide instructions on Vvoluntary termination work is revised. The revisions are part of an effort to streamline the enrollment process for certified providers/suppliers. Certain certification functions performed by the CMS regional locations are transitioning to CMS' Center for Program Integrity (CPI) Provider Enrollment Oversight Group (PEOG) and the Medicare Administrative Contractors (MACs). The voluntary termination work is the first phase of the certification work to transition. The MAC will process and finalize voluntary termination actions and will coordinate with the State Survey Agency directly as needed. The approval recommendation made to the CMS regional locations by the MAC has been removed. The MAC will notify the provider or supplier of approval of voluntary termination and send copies of the letter to the State Survey Agency, CMS regional locations and Accrediting Organizations. Additionally, Community Mental Health Center (CMHC) sections 2252A through 2252F are being deleted sine they were mistakenly omitted from Transmittal 197.

NEW/REVISED MATERIAL - EFFECTIVE DATE: June 19 2020
IMPLEMENTATION DATE: July 27, 2020

Or

MANUALIZATION/CLARIFICATION – EFFECTIVE/IMPLEMENTATION DATES:.

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
R	2/Table of Contents
R	2/2005F/Voluntary Terminations
D	2/2252/Certification Process
D	2/2252A/General
D	2/2252B/Request to Participate
D	2/2252C/Information to be Sent to CMHC Applicant

D	2/2252D/Processing CMHC Requests, FI Role
D	2/2252E/Processing CMHC Requests, SA Role
D	2/2252F/Processing CMHC Requests, RO Role
R	2/2760/Forwarding SA Certification
R	2/2762A/Purpose of Form CMS-1539
R	2/2762D/Amended Certifications
R	2/2764/SA Completion Instructions for Certifications and Transmittals, Form CMS-1539, Items 1-32
D	2/2764.1/RO Completion Instructions for Certification and Transmittal, Form CMS-1539, Items 19-32
R	2/2765/MAC Tie-In Activities
R	2/2783A/Purpose
R	2/2783B/CMS Responsibility for Form CMS-2007 Completion
R	2/2783C/CMS Completion of Form CMS-2007
R	2/2783D/Distribution

III. FUNDING: No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.
Or
Funding for implementation activities will be provided to contractors through the regular budget process.

IV. ATTACHMENTS:

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

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

State Operations Manual
Chapter 2 - The Certification Process

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(Rev. 201, 06-19-20)

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2005F - Voluntary Terminations

(Rev. 201, Issued: 06-19-20, Effective: 06-19-20, Implementatiom: 07-27-20)

A provider *agreement may be voluntarily terminated in accordance with the regulations at 42 CFR §489.52. The provider must send written notice of its intention, a letter on letterhead with an authorized signature, to its RO or SA within the timeframes addressed in §489.52. Suppliers must provide notice in accordance with the regulatory requirements specific for the* supplier *type.*

Additionally, a provider/supplier *must properly complete and submit the applicable Form CMS-855A or CMS-855B* to the MAC. If the provider/supplier sends the Form CMS-855A or CMS-855B for voluntary termination directly to the *MAC*, then the *MAC* will notify the RO and *SA via email within three days from the receipt of the completed form.*

NOTE: *In a change of ownership situation, the rejection of automatic assignment of the existing provider/supplier agreement (by the new owner) is a voluntary termination of the agreement/approval, including its associated CCNs, in accordance with 42 CFR 489.52.*

Further, if the new owner rejects automatic assignment of the acquired facility's existing provider/supplier agreement, and that facility previously was deemed to meet the applicable conditions based on its accreditation under a CMS-approved Medicare accreditation program, the accrediting organization (AO) may not "extend" the facility's prior deemed status to the new owner. Instead, the AO must conduct a full initial accreditation survey of the facility under its new ownership after the acquisition date. The effective date of the new owner's Medicare provider agreement or supplier approval is established in accordance with the provisions of 42 CFR 489.13. For complete information on CHOWs, see SOM 3210.

NOTE: *A cessation of business is a voluntary termination under 42 CFR 489.52(b)(3).*

2760 - Forwarding *SA* Certification

(Rev. 201, Issued: 06-19-20, Effective: 06-19-20, Implementatiom: 07-27-20)

Only CMS makes the determination to approve or deny a provider or *supplier (except for FQHCs) for participation in* the *Medicare program. The SA transmittal of its findings* is *a recommendation to the RO or MAC for the certification action.* The SA certification *is used* as the primary item of evidence to support decisions to approve or *deny* Medicare provider participation or coverage of *provider or* supplier services. The SA sends the entire certification packet to the RO *or MAC for* any action other than a routine periodic recertification. In routine recertifications, the SA inputs the data into the *national data* system and, as appropriate, forwards an abbreviated packet of documents to the RO *and MAC*.

The SA completes the appropriate *provider worksheet* to distill essential information from the survey report for input into the *national data* system. Each *provider worksheet* is identified by the same form number as the corresponding survey report. The alpha

prefix tag number assigned to each survey report data item is listed on the appropriate *provider worksheet*.

The SA completes all pertinent documentation relating to certification actions for each provider/supplier or action category and forwards it to the RO *or MAC* (or *State Medicaid Administrator* (SMA), as appropriate) no later than **45 calendar days** after the exit interview.

2762A - Purpose of Form CMS-1539

(Rev. 201, Issued: 06-19-20, Effective: 06-19-20, Implementatiom: 07-27-20)

The SA uses Form CMS-1539 to certify findings to the RO*, MACs* or *State Medicaid Agency (*SMA*)* with respect to a facility's compliance with *Conditions of Participation, Conditions for Coverage, Conditions for Certification, or Nursing Home R*equirements. Form CMS-1539 is also a transmittal cover sheet for the certification packet. (See Exhibit 9.)

Together with the SA certification file, Form CMS-1539 constitutes the primary record of the determination to approve a provider or supplier. It may be used with supporting documentation in any appellate action. It is essential, therefore, that the SA completes each item fully and accurately. *Each new certification action requires a separate Form CMS-1539.*

The Form CMS-1539 also exists as an electronic form and is more frequently used than the paper version of the form. The Form CMS-1539 is used to process updates to a provider/supplier's information in the national data system.

2762D - Amended Certifications

(Rev. 201, Issued: 06-19-20, Effective: 06-19-20, Implementatiom: 07-27-20)

Should the additional information requested via the Regional Office Request for Additional Information (Form CMS-1666, see §2776) result in any changes in the certification, the SA prepares a new Form CMS-1539 incorporating the additional documentation and any resulting changes in the certification. The SA draws a line through the original Form CMS-1539 and note at the top of this form, "See amended certification dated _____." The SA forwards Form CMS-1539 to the RO *or MAC* indicating in Item 16 that "this certification is amending the certification dated_______."

2764 – SA Completion Instructions for Certification and Transmittal, Form CMS-1539, Items 1-*32*

(Rev. 201, Issued: 06-19-20, Effective: 06-19-20, Implementatiom: 07-27-20)

The main purpose of Form CMS-1539 is to transmit the SA's certification that a facility meets or does not meet the requirements for participation. The SA completes all applicable parts of the form for Medicare/Medicaid providers/suppliers. The SA completes items 1-32 as follows:

Except for the signatures, the SA types *(includes keyboard entry)* all *applicable* entries on Form CMS-1539.

NOTE: Within each item on Form CMS-1539 there are code numbers for data reduction purposes (e.g., (L1), (L2)).

Item 1 - Medicare/Medicaid Provider No
Leave this item blank on all initial certifications. *CMS* assigns the *CCN* for all new providers and suppliers.

CCNs for hospitals and LTC facilities with multiple components and/or distinct parts are assigned by the RO using the following criteria:

A - Long-Term Care Facilities *(SNF or NF)* with Distinct Parts

One CCN is assigned and only one Form CMS-1539 prepared for the following situations (see §2779):

- SNF/NF with a SNF or NF distinct part; and
- SNF with a NF distinct part.

B - Distinct Part *SNF/NF* of Hospitals *or CAHs*

Two *CCNs* are assigned, one for the hospital*/CAH* and one for the SNF/NF. Prepare separate Forms CMS-1539 for certification actions regarding each *provider*.

CCN are assigned in the following fashion:

1 - Hospital *or CAH* with Distinct-Part SNF

Two *CCNs* are assigned, one for the hospital*/CAH* and one for the SNF. Prepare separate Forms CMS-1539 for certification actions regarding each provider.

2 - Hospital or CAH with Distinct-Part NF

Two *CCNs* are assigned, one for the hospital*/CAH* and one for the NF. Prepare separate Forms CMS-1539 for certification actions regarding each provider.

3 - Hospital or CAH with Distinct-Part SNF/NF

C -Hospitals *or CAHs with Swing-Bed Approval*

One CCN is assigned, *however* the *single CCN* for the hospital *or CAH is modified to*

address the hospital's or CAH's swing-bed *approval. A letter `U' or `Z' in the third space of the CCN is used to identify swing-bed approval designation for a short-term hospital or CAH* (See SOM section 2779C). Prepare one Form CMS-1539.

EXAMPLE: *21-0101 – Is ABC Hospital's (Short-Term Hospital) CCN*

- *21U101 – Is ABC Hospital's modified CCN for its swing-bed approval*

EXAMPLE*: 21-1301 –Is XYZ CAH's CCN*

- *21-Z301 is XYZ CAH's modified CCN for its swing-bed approval*

D –*Hospital or CAH I*PPS Excluded *Rehabilitation or Psychiatric Units*

Hospitals *or CAHs* with psychiatric and/or rehabilitation units that are excluded from the *I*PPS are assigned *one CCN but will have their CCN modified by adding an alpha identifier in the third space to identify their IPPS excluded rehabilitation unit and/or psychiatric unit. IPPS excluded units in CAHs are called "distinct part units (DPU)". (See SOM section 2779C and 2779C1)* Prepare one Form CMS-1539.

Item 2 - State Vendor or Medicaid Number
The SA completes this item only for those States that assign separate vendor (or Medicaid ID) numbers for internal controls or for billing purposes. The SA should leave this item blank if a State does not have such a system.

Item 3 - Name and Address of Facility

The *facility properties screen of the national data system automatically generates* the name, *physical* address, city, State, and zip code of the facility. A post office box without a street address is not sufficient.

Item 4 - Type of Action

In the block provided, the SA enters the appropriate code in accordance with the following explanations:

Code 1 (Initial Survey)

In addition to initial certifications, the SA selects this code when recommending an initial denial of participation. The SA indicates in Item 15 that it is recommending denial.

Code 2 (Recertification)

The SA selects this code when conducting a recertification survey.

Code 3 (Termination or retirement of CCN)

The SA selects this code for involuntary termination, voluntary termination/withdrawal, or change in status requiring a new *CCN. Examples of a change in status includes:*

- *When a hospital converts to a CAH,*
- *When a CAH converts to a hospital,*
- *When a short-term hospital reclassifies to become an IPPS-excluded hospital,*
- *When an IPPS-excluded hospital reclassifies to become another classification of hospital (Short-term hospital or IPPS-excluded hospital), or*
- *When a hospital undergoes a CHOW and then is combined with another hospital the new owner already owns.*

Code 4 (CHOW)

The SA selects this code for a CHOW situation.

Code 5 (Sample Validation)

The SA selects this code for a complete survey in an accredited facility for sample validation purposes. The SA completes all appropriate blocks on the form including items 6 (survey date), 8 (accreditation status), and 10 (compliance provision).

Code 6 (Complaints)

The SA selects this code for an onsite complaint investigation.

Code 7 (Onsite Visit)

The SA selects this code for an **onsite** inspection of a facility for some other reason **not** outlined above. Examples include:

1. Onsite revisit to verify that the deficiencies cited on the original survey are corrected and a Form CMS-2567B is completed;
2. Onsite visit to verify that a hospital *or CAH* meets the criteria for hospitals *or CAHs* operating with *swing-beds or IPPS-excluded units*; and
3. Onsite visit to verify that an HHA's satellite meets the branch criteria.

Code 8 (Full Survey After Complaint)

The SA selects this code for when a full survey after a complaint investigation is completed in the complaint system.

Code 9 (Other)

The SA selects this code for any certification action not specified above (e.g., changes in effective date, size, facility name, or address). Whenever action code 9 is selected, the SA shows in Remarks, Item 16, and the reason for completing Form CMS-1539.

Item 5 - CHOW Date

When Item 4 is marked CHOW (code 4), the SA *is unable to* enter the date the change occurred (e.g., 060782) in Item 5. *CMS will enter the date the change occurred.*

Item 6 - Survey Date

For providers who require a *life* safety *code (LSC)* survey, the SA enters the date the health or *LSC* survey is completed, whichever is later. For providers and suppliers who do not need a *LSC* survey, the SA enters the date the health survey is completed (e.g., 060283).

Item 7 - Provider/Supplier Category

In the block provided, the code that is most descriptive of the facility identified on the form is *taken. The SA does not manually* enter *a* code.

Item 8 - Accreditation Status

The SA *does not manually enter accreditation status on this form. It is taken from the information already entered into the deemed tab of the certification kit and populated on the form.*

Item 9 *(L35)* - Fiscal Year Ending Date

The *MAC or CMS PEOG, when applicable,* enters the ending date (month and day) of the provider's/supplier's fiscal year (e.g., 0630).

Item 10 - State Agency Certification

A - In Compliance With Program Requirements

If "A" is entered in the first block and the facility is not in full compliance with the program requirements, all conditional aspects are coded in the blocks following "A." For example, the SA enters A126 when a hospital is in compliance with the program requirements based on an acceptable PoC, recommended waivers for technical personnel, and limited scope of service.

NOTE: A1 applies to all provider/suppliers with an acceptable PoC.
A2 and A6 apply to hospitals only.

A3 applies to hospitals, SNFs, and NFs only.
A4 is no longer applicable.
A8 and A9 apply to all LTC facilities.
A5 applies to all facilities that undergo a fire safety survey.
A7 no longer applies to SNFs.

B - Not in Compliance With Program Requirements (Termination Development)

If "B" is entered in the first block, the documentation supporting the termination action must accompany Form CMS-1539 and be referenced in Item 16 of Remarks. Item "B" is also selected when an accredited hospital is not in compliance with one or more of the CoPs surveyed during the sample validation survey or complaint investigation.

C - Not in Compliance With Program Requirements (Denial of Payments for New Admissions for SNF, NF, and ICF/IID)

1 - Denial of Payments Recommended

The SA marks "B" in the first block when a recertified SNF, NF, or ICF/IID is not in compliance with the program requirements and is a likely candidate for denial of payments for new admissions. The SA annotates Item 16, "Remarks" to indicate that a denial of payments may be applied.

2 - Resurvey Finds Substantial Compliance

Following a revisit, the SA marks "A" in the first block when the facility is found to be in substantial compliance with the program requirements. The SA annotates Item 16, "Remarks" to show that the denial of payments for new admissions should be ended.

D - Resurvey Does Not Find Significant Progress
Following the revisit, the SA marks "B" in the first block when a facility is still not in compliance with program requirements and significant progress in correcting the deficiencies cannot be documented. The SA annotates Item 16 "Remarks" to show that the denial of payments for new admissions should remain in effect or that a termination action is being initiated.

NOTE: In all cases, the appropriate SA documentation must accompany Form CMS-1539.

Item 11 - LTC Period of Certification

TLAs are *no longer* required for ICFs/IID. The SA *does not need to* insert the recommended beginning (FROM) and ending (TO) dates of the TLA.

Item 12 - Total Facility Beds (Complete for Hospitals, SNFs, NFs, and ICF/IIDs)

The SA enters the total number of beds in the facility, including those in non-participating and non-licensed components or areas. **The Number of Beds in the Certified Portion of the Facility Must Not Exceed the Number of Total Beds.**

NOTE: The number of total facility beds and beds in the certified portion of the facility on Form CMS-1539 is restricted to the entire facility or the distinct part identified in Items 1 (*CCN*) and 7 (Provider Category).

Item 13 - Total Certified Beds (Complete for Hospitals, SNFs, NFs, and ICF/IIDs)

The SA enters the number of beds in Medicare and/or Medicaid certified areas.

Item 14 - SNF, NF, and ICF/IID Certified Bed Breakdown

The total number of beds in the certified portion of the facility recorded in Item 13 must be divided in Item 14 according to type of program (i.e., Box A-18 SNF, Box B-18/19, Box C-19 NF, and Box E-ICF/IID). Boxes D and F are no longer applicable.

The SA completes boxes A, B, C, and E, as appropriate. **These blocks must equal Item 13 (total beds in the certified portion of the facility).**

The examples on the following pages illustrate how Items 1 (CMS Certification Number) and 7 (Provider category) must be completed in conjunction with Items 12-14 for all hospital, SNF, NF, and ICF/IID providers.

Item 15 - Nonparticipating Emergency Hospitals and NFs

The SA enters code 1 or 2 in the block provided.

The SA completes this block when a nonparticipating hospital meets the definition of an emergency hospital *(see 42 CFR 424, Subpart G)* in order to claim payment for emergency services rendered to Medicare patients. For participating NFs, the SA enters the appropriate code when the facility meets, or does not meet, the §1861(j) of the Act definition for durable medical equipment (DME) and home health benefit purposes.

Item 16 - State Survey Agency Remarks

The SA uses this space for any required remarks *or recommendations for approval or disapproval. The SA should list the names of the surveyor and the SA approval in this space.*

If the comments exceed the allotted space, the SA continues on a sheet of paper entitled "Item 16 Continuation for CMS-1539." The SA includes the provider number, if known, on the sheet for identification purposes. Whenever Item 4 is completed as "Other," the SA uses "Remarks" to indicate the reason for completing Form CMS-1539. The following is a list of remarks which must be entered whenever appropriate.

Remarks	**SOM Reference**
Exclusion from Certification (Non-PPS)	§§2026, 2048, 2134, and 7016
Loss of Deemed Status Accreditation	§2005B
Certification of Additional Services	§§3220, 3222
RHC Furnishes Home Health Services Determine Whether in HHA Shortage Area	§2246
Waiver(s) Recommended	§§2030, 2140, 2248, 2480, 7014
Multiple Locations	§§2024, 2182, 2184, 2302, 2344
Denial of Payments Is Recommended	§§3006, 7506

EXAMPLE 1

1. *CCN*

| X | X | 0 | 0 | 0 | 0 | (Hospital)

7. CATEGORY	12. TOTAL FACILITY BEDS	13. TOTAL CERTIFIED BEDS
| 0 | 1 | (Hospital)	3 0 0	3 0 0

14.
LTC Certified Bed Breakdown

| SNF | SNF | /NF | NF | ICF/IID |

EXAMPLE 2: ***A total of* 250 bed*s are in the combined* hospital *and DP SNF/NF***

Beds are distributed as follows:
200 beds in hospital portion
50 beds Title 18/19 DP SNF/NF

NOTE: Prepare two Forms CMS-1539 identifying the separate hospital and SNF/NF providers.

1. *CCN*

| X | X | 0 | 0 | 0 | 0 | (Hospital)

7. CATEGORY	12. TOTAL FACILITY BEDS	13. TOTAL CERTIFIED BEDS
| 0|1 |(Hospital)	2 0 0	2 0 0

14.
LTC Certified Bed Breakdown

SNF	SNF/NF	NF	ICF/IID

1. *CCN*

| X | X | 5 | 0 | 0 | 0 | (SNF/NF)

7. CATEGORY	12. TOTAL FACILITY BEDS	13. TOTAL CERTIFIED BEDS
| 0|2|(SNF/NF)	5 0	5 0

14.
LTC Certified Bed Breakdown

SNF	SNF/NF	NF	ICF/IID
	50		

EXAMPLE 3: ***A Total of* 400 bed*s are in the* hospital *and the DP NF***

Beds are distributed as follows:
300 hospital beds
100 beds Title 19 DP NF

NOTE: Prepare two Forms CMS-1539 for hospital and LTC components.

1. *CCN*

| X | X | 0 | 0 | 0 | 0 | (Hospital)

7. CATEGORY	12. TOTAL FACILITY BEDS	13. TOTAL CERTIFIED BEDS
|0 |1 |(Hospital)	3 0 0	3 0 0

14.
LTC Certified Bed Breakdown

| SNF | SNF/NF | NF | ICF/IID |

1. *CCN*

| X | X |A,E, or F | 0 | 0 | 0 | (Title 19 NF)

7. CATEGORY	12. TOTAL FACILITY BEDS	13. TOTAL CERTIFIED BEDS
|1 |0 | (NF Distinct Part)	1 0 0	1 0 0

14.
LTC Certified Bed Breakdown

| SNF | SNF/NF | NF | ICF/IID |
| | | 100 | |

EXAMPLE 4: 44 bed hospital *with* swing-bed *approval*

1. *CCN*

| X | X | 0 | 0 | 0 | 0 | (Hospital)

7. CATEGORY	12. TOTAL FACILITY BEDS	13. TOTAL CERTIFIED BEDS
| 0| 1| (Hospital)	4 4	4 4

14.
LTC Certified Bed Breakdown

| SNF | SNF/NF | NF | ICF/IID |

EXAMPLE 5: 100 bed nursing home (free-standing)

Beds are distributed as follows:
60 beds certified for Medicaid
40 beds not participating in either Medicare or Medicaid

1. *CCN*

(NF6: 75 Medicaid NF CCN| X | X |A, E, or F| 0 | 0 | 0 | (NF)

7.
CATEGORY

12.
TOTAL FACILITY BEDS

13.
TOTAL CERTIFIED BEDS

|_1|_0_|(| (NF) ____7 5____ ____7 51 0 0____

____6 0

14.
LTC Certified Bed Breakdown

| SNF | SNF/NF | NF | ICF/IID |
60

EXAMPLE 6: 75 bed Medicaid NF (free-standing)

1. *CCN*
| SNF | SNF/NF | NF | ICF/IID |
75

EXAMPLE 7: 150 bed SNF/NF and NF

Beds are distributed as follows:
100 beds SNF/NF
50 NF beds

1. *CCN*

|_X_|_X_|_5_|_0_|_0_|_0_| (Title 18 & 19 SNF/NF)

7.
CATEGORY

12.
TOTAL FACILITY BEDS

13.
TOTAL CERTIFIED BEDS

|0_|3_|(SNF/NF) ____1 5 0____ ____1 5 0

14.
LTC Certified Bed Breakdown

| SNF | SNF/NF | NF | ICF/IID |
100 50

EXAMPLE 8: 100 SNF/NF facility

100 beds - SNF/NF dually participating

NOTE: Blocks A-E within item 14 **must not exceed** the total number of certified beds recorded in item 13. Report dually-participating beds in block B (18/19 SNF). Block F is no longer applicable.

1. *CCN*

| X| X | 5 | 0 | 0 | 0 | (18/19 SNF/NF)

7. CATEGORY	12. TOTAL FACILITY BEDS	13. TOTAL CERTIFIED BEDS
|0|2| (SNF/NF Dually-Participating)	1 0 0	1 0 0

14.
LTC Certified Bed Breakdown

SNF	SNF/NF	NF	ICF/IID
	100		

EXAMPLE #9: 125 bed SNF/NF facility

Beds are distributed as follows:
100 beds - Title 19 NF
25 beds - Title 18/19 SNF/NF DP
See Example #8 Note.

1. *CCN*

| X | X | 5 | 0 | 0 | 0 | (18/19 SNF/NF)

7. CATEGORY	12. TOTAL FACILITY BEDS	13. TOTAL CERTIFIED BEDS
|0 | 3|(SNF/NF)	1 2 5	1 2 5

14.
LTC Certified Bed Breakdown

SNF	SNF/NF	NF	ICF/IID
	25	100	

EXAMPLE 10: 150 bed Medicaid-only NF

Beds are distributed as follows:
125 beds - Title 19 NF
25 beds - not participating in Medicare or Medicaid

1. *CCN*

| X | X |A, E, or F | 0 | 0 | 0 | (Title 19 NF)

7. CATEGORY	12. TOTAL FACILITY BEDS	13. TOTAL CERTIFIED BEDS
| 1 | 0| (NF)	1 5 0	1 2 5

14.
LTC Certified Bed Breakdown

SNF	SNF/NF	NF	ICF/IID
		125	

EXAMPLE 11: 140 bed NF (free-standing)

1. *CCN*

| X | X |A, E or F | 0 | 0 | 0 | (NF)

7. CATEGORY	12. TOTAL FACILITY BEDS	13. TOTAL CERTIFIED BEDS
| 1| 0| (NF)	1 4 0	1 4 0

14.
LTC Certified Bed Breakdown

SNF	SNF/NF	NF	ICF/IID
		140	

EXAMPLE #12 - 30 bed ICF/IID (free-standing)

1. *CCN*

| X | X | G | 0 | 0 | 0 | (ICF/IID)

7. CATEGORY	12. TOTAL FACILITY BEDS	13. TOTAL CERTIFIED BEDS
| 1| 1| (IMR)	3 0	3 0

14.
LTC Certified Bed Breakdown

| SNF | SNF/NF | NF | ICF/IID |
30 |

EXAMPLE #13 - 50 bed NF and ICF/IID facility

Beds are distributed as follows:
30 beds - Title 19 NF
20 beds - Title 19 ICF/IID

NOTE: Prepare two Forms CMS-1539 identifying the NF and ICF/IID components.

1. *CCN*

| X | X |A, E, or F | 0 | 0 | 0 | (NF)

7. CATEGORY | 12. TOTAL FACILITY BEDS | 13. TOTAL CERTIFIED BEDS

| 1|0 | (NF) 3 0 3 0

14.
LTC Certified Bed Breakdown

| SNF | SNF/NF | NF | ICF/IID |
30

1. *CCN*

| X | X | G | 0 | 0 | 0 | (ICF/IID) 2 0 2 0

14.
LTC Certified Bed Breakdown

| SNF | SNF/NF | NF | ICF/IID |
20

Item 17 - Surveyor Signature

The surveyor (or survey team leader) signs and dates Form CMS-1539 after ensuring that the certification documents are complete and accurate.

Item 18 - State Agency Approval

The authorized representative of the SA signs and dates Form CMS-1539 and forwards the certification material to the *MAC, when applicable* or *State Medicaid Agency (SMA)*, as appropriate. His/her signature constitutes for Medicare the official "certification" that

the information being reported is correct according to official State files. In Medicaid-only cases, the SA representative's signature on this document represents the adjudicative decision of the SA on the qualifications of the institution to participate in the Medicaid program.

Item 19 - Determination of Eligibility

Enter code 1 or 2 in this block of the SA's findings and certifications. Enter code 1 when the provider/supplier is found eligible to participate in the Medicare and/or Medicaid programs. Also enter code 1 when a denial of payment for new admissions is imposed, continued, or lifted. Enter code 2 when a facility is not eligible to participate.

Item 20 - Compliance with Civil Rights Act (Title VI)

For providers/suppliers needing Office for Civil Rights (OCR) clearance, enter code 1 in the available block if the OCR requirements are met. If not in compliance with Title VI of the Civil Rights Act of 1964, as implemented by 45 CFR part 80, enter code 2 in the box that indicates that the provider is not eligible to participate. For Medicare Part B suppliers not requiring OCR clearance to participate, enter code 3 that indicates "not applicable."

Item 22 - Original Date of Participation

Complete for initial certifications only. Determine when the facility is eligible to begin participation in Medicare and/or Medicaid. Enter the recommended effective date at block L24. The effective date of participation is established pursuant to 42 CFR 489.13 for Medicare and 42 CFR 431.108 for Medicaid.

Items 23-25 - ICF/IID Certification Period ("LTC Agreements")

*When an ICF/IID is found not to be in compliance with program requirements and a denial of payment for new admissions is imposed, enter the beginning (Item 23) and ending (Item 24) dates of the **current** re-certification survey. In Item 25 (extension date), enter a date **not exceeding** the end of the fifteenth month following the month in which the sanction will be imposed.*

Item 26 - Termination Action

If a provider's or supplier's participation in the Medicare/Medicaid program ends, record the reason (see below) in the accompanying block. Also complete Item 28 (termination date).

1 - Voluntary

Code 1 - Enter when a facility closes or merges.

Code 2 - Enter when a provider or supplier is voluntarily withdrawing because of dissatisfaction with reimbursement.

Code 3 - Enter when a facility is leaving the program because it is at risk of being involuntarily terminated.

Code 4 - Enter when a provider or supplier no longer wishes to participate in the program for some other or unknown reason.

2 - Involuntary

Code 5 - Enter when a facility fails to meet health or safety requirements (Conditions of Participation, Conditions for Coverage, Conditions for Certification, or Nursing Home Requirements).

Code 6 - Select this code when a provider fails to meet the terms of their agreement.

***NOTE**: If code 5 or 6 is selected, then the National Practitioner Data Bank (NPDB) appeal status box is generated in the national data system. The options to select are:*
1 – No appeal, termination final
2 – Appeal in progress
3 – All appeals exhausted, termination final

3 - Other

Code 7 - Select this code when you terminate a currently assigned CCN. Examples include:

- *Medicare SNF or dually-participating SNF/NF elects to participate in the Medicaid program only;*
- *Medicaid NF elects to participate in the Medicare or Medicare and Medicaid programs; and*
- *An ASC, ESRD, or RHC elects to participate as free-standing instead of hospital-based and vice versa.*

In any of the above instances, CMS terminates the existing CCN (complete Items 26 and 28) and assigns the new CCN. (See §1060.A.)

Item 27 - Intermediate Sanctions (ICF/IID Only)

When an ICF/IID is found not to meet the requirements of §1905(d) of the Act and the decision is made to impose an intermediate sanction rather than terminate participation, complete the pertinent items on Form CMS-1539 as follows:

1 - Suspension of Admissions

Enter the date in Item 27A that payments for new admissions in the ICF/IID will be denied. In addition, mark Item 10 with "B" (not in compliance with program requirements). Mark Item 19 "1" (facility is eligible to participate). In Item 25 (extension date), enter a date ***not exceeding*** *the end of the eleventh month following the month in which the denial of payments will be imposed. This date may not be extended.*

2 - Rescind Suspension Date

a - Significant Compliance with Program Requirements

Enter the date the denial of payment is rescinded.

The SA will mark Item 10 "A" (in compliance with program requirements) and Item 19 "1" (eligible to participate). In Item 27B, the RO enters the date the denial of payment is rescinded.

NOTE: *Items 23 and 24 can only be completed when Item 10 is marked 'A' (in compliance with program requirements).*

b -Significant Effort or Progress

Item 27b may also be completed when Item 10 is marked "B" (facility is not in compliance with program requirements) and Item 16 (SA Remarks) is documented to show that effort and progress has been made to correct the deficiencies. Item 25 (ICF/IID extension date) remains unchanged. Mark Item 19 with "1" (facility is eligible to participate).

NOTE: *Pursuant to 42 CFR 442.119(a), the denial of payment for new admissions is to be rescinded if the facility has corrected deficiencies or can document it is making good faith efforts to achieve compliance with the conditions of participation. Good faith efforts would not, however, constitute compliance with program requirements. Therefore, it is conceivable that:*

- *The denial of payments could be rescinded;*
- *Effort and progress would be documented;*
- *The SA would certify "not in compliance"; and*
- *The extension would remain in effect.*

If the noncompliance deficiencies are not corrected by the 11th month following the initial month of denial, the ICF/IID's provider agreement must be terminated pursuant to

42 CFR 442.119.

NOTE: *Similar information for SNFs/NFs is extracted from the Form CMS-462L, Adverse Action Extract for SNFs and NFs.*

Item 28 - Termination Date

Enter the effective date of the termination action specified in Item 26.

Item 29 – MAC Number

Enter the five-digit number assigned to the MAC servicing the provider or supplier of health services.

Item 30 – Remarks

Use this block for any remarks that cannot be covered in the structured items above. If comments exceed space allotted in this item, document the additional comments on a sheet of paper entitled: "Item 30, Continuation for Form CMS-1539."

Item 31 – RO or MAC Receipt of Form CMS-1539

Enter the date that a certification package is received.

For Medicaid-only providers, the SMA forwards the certification materials to the RO following review and completion. For Medicare, the SA forwards the package directly to the RO or MAC.

Item 32 - Determination Approval

Following review of the certification documents an authorized CMS or SMA representative must sign and date Form CMS-1539.

2765 – *MAC* Tie-In Activities

(Rev. 201, Issued: 06-19-20, Effective: 06-19-20, Implementatiom: 07-27-20)

The SA maintains a list of the *MACs* available to serve providers in the area. The SA includes this list in the initial mailing kit sent to new provider candidates. This list contains the *MACs*' names, addresses, telephone numbers, and service areas. It also indicates that *MAC* elections are subject to approval by the RO and that questions regarding *MAC* selection should be addressed to the RO. The RO furnishes updated lists to the SA when the availability of *MAC* changes.

2783A – Purpose

(Rev. 201, Issued: 06-19-20, Effective: 06-19-20, Implementatiom: 07-27-20)

Form CMS-2007 (Exhibit 156) is the official notice to the *MAC* of changes in its list of providers *or suppliers* (additions, deletions, corrections, recertifications, and terminations).

2783B – *CMS* Responsibility for Form CMS-2007 Completion

(Rev. 201, Issued: 06-19-20, Effective: 06-19-20, Implementatiom: 07-27-20)

The RO completes a Form CMS-2007 each time a provider *or supplier* is added to or deleted from a *MAC's* list of providers *and suppliers* or when current provider-supplier tie-in records require correction and sends it at the time the provider agreement or supplier approval is countersigned by its office. In *involuntary* termination actions, the RO sends it at the same time it issues official notification to the provider *or supplier*.

2783C - *CMS* Completion of Form CMS-2007

(Rev. 201, Issued: 06-19-20, Effective: 06-19-20, Implementatiom: 07-27-20)

Item I - Identifying Information - This section is self-explanatory. Complete it in all instances.

Item II - New Provider *or Supplier* Certification - *CMS* completes this section when a new provider *or supplier* enters the program or when a participating provider *or supplier* has changed ownership. Items A, C, and D are completed in all cases, and Items E through H for changes in ownership. In item B, *CMS* shows the month and day of the provider's *or supplier's* fiscal year ending date for Medicare cost report purposes *(if it summits cost reports)* if the information is available or is readily obtainable. *CMS* contacts the provider *or supplier* directly or solicits the aid of the *MAC* to determine the provider's *or supplier's Medicare* fiscal year ending date. There should be no delay issuing this notice even if the fiscal year information is not obtainable or is not known at the time of certification.

This procedure assures that *CMS* contacts a responsible official or officer of the provider *or supplier* for this information and allows several days for the provider *or supplier* to respond when it appears the information is currently available. The information is not considered readily available if the provider does not know or will decide at a later date.

Item III - Change of *MAC* – *This* section *is not applicable to t*he RO.

Item IV – Termination -This section is completed when a provider *or supplier* involuntarily ends its participation in the program. *When* the new owner *rejects assignment of the existing Medicare agreement following a change in ownership* it *is treated* as a voluntary termination.

Item V – Remarks –*CMS* uses this section for pertinent information. If the provider is part of a chain, insert the name and address of a parent or controlling organization in this section. If Form CMS-2007 corrects previously furnished information, include an explanation of the change.

If a SNF's participation will end, include an explanation relating to services after termination (see §§3008.1 and 3008.2) in the remarks.

EXAMPLE: An agreement with a participating SNF is involuntarily terminated for cause (e.g., failure to file cost reports), and the effective date of termination is established as October 15, *2015*. As with all providers, this termination takes effect on *(0001 hours on a 24 hour clock)* October 15, *2015*, and not at the close of *(2400 hours on a 24 hour clock)* October 15, *2015*. Therefore, the remarks should indicate "Termination for cause--payment can continue for up to 30 calendar days of post-hospital skilled nursing care services furnished **on or after** October 15, *2015*, to beneficiaries admitted to the facility **before** October 15, *2015*. Do not make payment for new admissions which occur **on or after** October 15, *2015*."

2783D – Distribution

(Rev. 201, Issued: 06-19-20, Effective: 06-19-20, Implementatiom: 07-27-20)

Whenever there is a change to Form CMS-2007 (new provider *or supplier*, change in *MAC*, or *involuntary* termination) *CMS* forwards *a* copy to the provider's *or supplier's MAC*.