CMS Manual System

Pub. 100-07 State Operations Provider Certification

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

Transmittal 61 **Date: July 23, 2010**

SUBJECT: Corrections to the Exhibits Table of Contents

I. SUMMARY OF CHANGES: The Exhibits Table of Contents has been revised to ensure that the listings here correctly match the title of the applicable exhibits, and to ensure that correct hyperlinks are provided to exhibits residing on other Department websites. In addition, a hyperlink has been provided for Exhibit 2, and Exhibit 35 has been deleted because it is obsolete.

NEW/REVISED MATERIAL - EFFECTIVE DATE*: July 23, 2010
IMPLEMENTATION DATE: July 23, 2010

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	Exhibits/Table of Contents
R	Exhibits/2/Civil Rights Clearance for Medicare Provider Certification
R	Exhibits/14I/ESRD Facility Survey Report-Critical Data Extract, Form CMS-3427E to be Used With Part II of Form CMS-3427
D	Exhibits/35/Survey Materials
R	Exhibits/127/Attestation Statement for Exclusion From PPS For Fiscal Year Beginning (Date)

III. FUNDING: No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

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.**

Medicare State Operations Manual
Chapter 9 - Exhibits

EXHIBITS

(Rev.61, 07-23-10)

Exhibit	Description	Download
2	*Civil Rights Clearance for Medicare Provider Certification*	http://www.hhs.gov/ocr/civilrights/resources/providers/medicare_providers/index.html
14I	ESRD Facility Survey Report- Crucial Data Extract, *Form CMS-3427E* (To be used with Part II of Form CMS-3427)	42 KB
27	Model Letter to Previously Approved Facility Requesting Approval to Expand or Add a New End Stage Renal Disease (ESRD) Service	23 KB
30	Model Letter to Facility Returning Application not Accompanied by Required Certificate of Need (Where Applicable)	21 KB*
35	Survey Material	*Deleted*
81	Model Letter Requirements *for* Swing-Bed Approval *in Hospitals*	28 KB`
103	Instructions for the Home Health Functional Assessment	242 KB

	Instrument *(FAI)*	
127	Attestation Statement for Exclusion from PPS *for Fiscal Year Beginning: (Date)*	78 KB
135	Model Letter *Transmitting Swing-Bed Approval Notification in a Critical Access Hospital (CAH)*	93 KB
143	Model Letter to Provider *(Imposition of Remedies) (Immediate Jeopardy Exists)*	51 KB
149	*Model Letter* Critical Access Hospital (CAH) Denial for Medicare Participation	16 KB
150	*Model Letter* Critical Access Hospital (CAH) Approval Notification	22 KB
151	*Model Letter* Request For A Plan of Correction Following an Initial Critical Access Hospital (CAH) Survey	19 KB
152	*Model Letter* Critical Access Hospital (CAH) Termination Letter	23 KB
158	Notice - Recertification of ESRD Facility *(Not Used for Special Purpose Renal Dialysis Facilities)*	25 KB
170	Model Letter: Organ Procurement Organization Denial - Failure to Meet Requirements	76 KB
171	Model Letter: Organ Procurement Organization Denial - Competing Applications	28 KB
195	Model *Letter* Announcing to an Accredited Hospital That the Hospital Does	80 KB

	Not Comply with all the Conditions of Participation and That There is Immediate *and* Serious Threat to Patient Health and Safety	
196	Model Letter Announcing to *Deemed,* Accredited *Provider/Supplier* After a Sample Validation Survey That *It* Does Not Comply with all Conditions of Participation*/Conditions for Coverage*	27 KB
223	*Model Letter Announcing to* Accredited Laboratory that it is in Compliance with all CLIA Conditions after the Correction of Deficiencies	15 KB
224	*Notice to Accredited Laboratory Announcing Approval of Plan of Correction and Completion Schedule for Correcting Deficiencies*	15 KB
255A	Model Letter Notification of Pending Involuntary Termination Based on CHOW Review of the Medicare General Enrollment Health Care Provider/Supplier Application *(Form CMS 855)*	30 KB
255B	Model Letter Notification of Involuntary Termination Based on CHOW Review of the Medicare General Enrollment Health Care Provider/Supplier Application *(Form CMS 855)*	34 KB

263	*Submission Timeframe for MDS Records*	50 KB
269	Facility Quality *Measure*/Indicator Report	44 KB
270	Resident Level *Quality Measure/Indicator Report: Chronic Care Sample*	39 KB
271	*QM/QI Reports Technical Specifications: Version 1.0*	233 KB
274	Definition of *Important* Dates in the RAI Process	24 KB
277	Fiscal Intermediary (FI) *Medicare* Provider Billing Number Deactivation Letter Used by FI	17 KB
285	Worksheet for OBQM & OBQI Reports *– Pre-Survey Process and Sample Selection*	164 KB
289	Model Reciprocal Agreement *Between States for* Survey and Certification of Home Health Agencies and/or Hospices	25 KB

EXHIBIT 2

(Rev.61, Issued: 07-23-10, Effective: 07-23-10 Implementation: 07-23-1007-23-10)

Civil Rights Clearance for Medicare Provider Certification

http://www.hhs.gov/ocr/civilrights/resources/providers/medicare_providers/index.html

EXHIBIT 14 I

(Rev. 61, Issued: 07-23-10, Effective: 07-23-10 Implementation: 07-23-10)

ESRD FACILITY SURVEY REPORT -
CRUCIAL DATA EXTRACT, FORM CMS-3427E
(TO BE USED WITH PART II OF FORM 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 127

(Rev. 61, Issued: 07-23-10, Effective: 07-23-10 Implementation: 07-23-10)

ATTESTATION STATEMENT FOR EXCLUSION FROM PPS
FOR FISCAL YEAR BEGINNING: (DATE)

(**Date**)

State Agency Director Name
State Agency Name
Address
City, State, ZIP Code

Dear (**State Agency Director**):

This attestation must be signed by the Administrator/Chief Executive Officer of the hospital (including hospitals with excluded units).

ATTENTION: Read the following carefully before signing.

STATEMENTS OR ENTRIES GENERALLY: Whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or makes any false, fictitious or fraudulent statement or representations, or makes or uses any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry, shall be fined not more than $10,000 or imprisoned not more than five years, or both. (18 U.S.C., Sec.1001)

Based upon my personal knowledge and belief, I attest that the responses on the attached prospective payment system (PPS) exclusion work sheet are true and correct, and that (**name of PPS-Excluded Hospital or Unit**) currently meets and will continue to meet the applicable requirements for exclusion from PPS for the period beginning (**first day of hospital's fiscal year**), as set out in Subpart B of 42 CFR Part 412. I agree that if the (**hospital or unit**) fails to meet any of these requirements between the date of attestation and the first day of the hospital's fiscal year, I will notify the Regional Office (**name and address of RO**) of the change immediately in order to permit a valid determination of distinct part status prior to the beginning of the fiscal year. (**Include the next sentence for units only**): The unit is located in (**enter building name, room numbers and address**), and consists of square feet.

I understand that the Centers for Medicare & Medicaid Services (CMS) or its representative has the right to conduct an on-site survey at any time to validate whether the statements made on the attached work sheet are true.

Signature_____
(Administrator/Chief Executive Officer of the hospital)

Title_____

Date_____

Fill in blanks before sending the form to the facility.