Hospitals

Medicare Certification Application Process

1. The State of Alaska, Department of Health & Social Services (DHSS) has an agreement to assist the U.S Department of Health & Human Services (DHHS) in determining whether health care facilities meet, and continue to meet, the Conditions of Participation.
2. Refer to the Conditions for Participation for all Title XVIII Medicare program requirements.
3. In order to qualify for Medicare reimbursement, your hospital must be in compliance with the Medicare Conditions of Participation, reimbursement requirements, including financial solvency and the requirements of Title VI of the Civil Rights Act of 1964.
4. CMS-855(A) or CMS-855(B) Form:

- Beginning November 1, 2001, only the fiscal intermediary (FI) or carrier will distribute enrollment applications for providers/suppliers that they enroll.
- The provider/supplier should complete the application and submit it directly to the intermediary or carrier.
- Within 10 calendar days of receipt of the CMS-855A or CMS-855B, the FI/carrier will send a copy of the application to the state agency or the regional office, as applicable.
- The Centers for Medicare and Medicaid Services (CMS) website located at http://cms.gov/MedicareProviderSupEnroll\ is designed to provide Medicare enrollment information for providers, physicians, non-physician practitioners, and other suppliers.
- You will also find list of FIs and carriers by state and specialty. If the provider/supplier needs to select an FI or carrier, it may access this website.
- New free-standing providers are no longer permitted to express a preference for a particular fiscal intermediary (FI). New providers must be assigned to the designated local FI. The FI/carrier will answer any applicant inquiries concerning completion of the enrollment application.
- The provider/supplier must still contact the state agency for the other required Medicare and/or Medicaid certification forms for their provider/supplier type.
- If the FI recommends approval of the enrollment application, it will provide the state agency and relevant Regional Office with a written recommendation for approval.
- Please be reminded that the issuance of a license to a new operator cannot guarantee the new applicant automatic federal Medicare certification until the CMS-855 approval process has been completed and confirmed by the fiscal intermediary.

Fiscal Intermediaries List
CMS 855 Enrollment Application Information
CMS 855 Application Fee Information

Provider/Supplier Enrollment Forms and List (855 Application, etc.)
Health Insurance Benefit Agreement Form (CMS-1561) – 2 originals required

Publication 10, Hospital Manual
Interpretive Guidelines (Regulations) - Appendix A
Conditions of Participation for Hospitals

Federal Certification Information

Federal Information:

Federal Links - Centers for Medicare and Medicaid Services (including S&C letters), HIPAA, Civil Rights, US Department of Labor, etc.

- **IMPORTANT, PLEASE READ:** Centers for Medicare & Medicaid Services (CMS) Requirements for Hospital Medical Staff Privileging (PDF), S&C Letter 05-04, November 12, 2004
    - The hospital's Governing Body must ensure that all practitioners who provide a medical level of care and/or conduct surgical procedures in the hospital are individually evaluated by its Medical Staff and that those practitioners possess current qualifications and demonstrated competencies for the privileges granted.

  Final Rule: Hospital Conditions of Participation - Quality Assessment and Performance Improvement (PDF, 128 KB)
    - The rule can also be retrieved from the Federal Register:
        - Select 2003
        - Select January 24, 2003
        - Scroll down to "Centers for Medicare and Medicaid Services" or do Find (Control+F) for "Hospital"
        - Select either Text or PDF for the version you prefer
- Interim Guidance for the Hospital Quality Assessment and Performance Improvement Condition of Participation (PDF), S&C 03-16

CMS Survey & Certification Letter S&C 03-15 (exit DHS; PDF):

- "Review of Protected Health Information and Applicability of Business Associate Agreements under the Health Insurance Portability and Accountability Act (HIPAA) for the Purposes of Survey and Certification"
- Concerns sharing private health care information with state agencies

Recalled Sprinkler Heads,(exit DHS) Centers for Medicare and Medicaid Services Program Letter

- **EMTALA Final Rule** November 10, 2003 - EMTALA Interim Guidance (PDF) S&C 04-10
- CMS Hospital Center
- Information for Providers
- **IMPORTANT, please read** - Adoption of New Fire Safety Requirements CMS S&C Letter 03-21 (PDF)
- Question and Answer (exit DHS) Relating to Bioterrorism and the Emergency Medical Treatment and Labor Act (EMTALA)

- **EMTALA Final Rule** November 10, 2003 - EMTALA Interim Guidance (exit DHS; PDF) S&C 04-10
- CMS Hospital Center (exit DHS)
- Information for Providers (exit DHS)

Federal Links

Centers for Medicare & Medicaid Services (exit DHS), CMS

Federal Certification Information

- Certification and Compliance (all providers) (exit DHS)
- Survey & Certification - Guidance to Laws & Regulations (all providers) (exit DHS)
- Transmittals (exit DHS)
- Medicare & Medicaid Program Manuals (exit DHS) - includes links to the **State Operations Manual** (Pub 07) via Internet Manuals. Select Appendices from the Table of Contents, then select the appropriate one for your provider type(s)
- Conditions for Coverage and Conditions of Participation (exit DHS)
- Medicare Learning Network (exit DHS) for healthcare professionals

CMS Survey & Certification Letters main site (exit DHS)
U.S. Department of Health and Human Services, Office for Civil Rights: How to File A Health Information Privacy Complaint (exit DHS) (HIPAA)
U.S. Department of Labor - www.dol.gov (exit DHS)
Information regarding Federal Wage and Hour Laws

- Employment Laws assistance (exit DHS) for workers and small businesses
- Employment Standards Administration, Wage and Hour Division (exit DHS) (including Fair Labor Standards Act)

Centers for Disease Control, Health Alert Network (exit DHS

Critical Access Hospital

Fiscal Intermediaries List
CMS 855 Enrollment Application Information
CMS 855 Application Fee Information
Provider/Supplier Enrollment Forms and List (855 Application, etc.)
Interpretive Guidelines (Regulations) - Appendix W
CMS Fact Sheet on Critical Access Hospitals
Link to CMS website regarding Critical Access Hospitals
Federal Authorization: 42 CFR Part 485, Subpart F (Code of Federal Regulations

Psychiatric Hospitals

Fiscal Intermediaries List
CMS 855 Enrollment Application Information
CMS 855 Application Fee Information
Provider/Supplier Enrollment Forms and List (855 Application, etc.)
Health Insurance Benefit Agreement Form (CMS-1561) – 3 originals required
Interpretive Guidelines (Regulations) - Appendix A
Interpretive Guidelines (Regulations) – Appendix AA

Swing Beds

Interpretive Guidelines (Regulations) - Appendix T

End Stage Renal Disease Centers

Federal Certification Forms and Regulations:

On April 15, 2008, a Final Rule, which establishes new conditions for coverage that dialysis facilities must satisfy to be certified under the Medicare program was published in the **Federal Register**. According to CMS, the Final Rule reflects advances in dialysis technology and standard care practices since the existing conditions for coverage were issued in 1976. CMS has posted a **Fact Sheet** on the CMS website.
CMS also recently released a "**Frequently Asked Questions**" document as well as a **crosswalk** that compares the former conditions to the final revised conditions that were issued in the Final Rule.

Implementation of the Life Safety Code (LSC) Component Conditions for Coverage: S&C Letter 09-24

ESRD Program Interpretive Guidance is contained in the S&C Letter 09-01 issued on October 3, 2008.

Medicare ESRD Network Organization Manual

Fiscal Intermediaries List
CMS 855 Enrollment Application Information
CMS 855 Application Fee Information
Provider/Supplier Enrollment Forms and List (855 Application, etc.)
Link to CMS website regarding End Stage Renal Dialysis Centers
Interpretive Guidelines (Regulations) – Appendix H
42 CFR 405, Subpart U -- Conditions for Coverage of Suppliers of End-Stage Renal Disease (ESRD), Code of Federal Regulations provides information on:

§ 405.2102 Definitions
§405.2110 Designation of ESRD networks
§405.2112 ESRD network organizations
§405.2113 Medical review board

CMS ESRD Information Resource

Home Health Agencies

- **NEW** - Home Health Agency Medicare Certification Information

Centers for Medicare & Medicaid Services (CMS) Survey & Certification Letter S&C 03-15 (PDF)

Federal Certification Information

- "Review of Protected Health Information and Applicability of Business Associate Agreements under the Health Insurance Portability and Accountability Act (HIPAA) for the Purposes of Survey and Certification"
- Concerns sharing private health care information with state agencies

CMS OASIS C anticipated implementation January, 2010

- Home Health Agency Manual Publication 11

Fiscal Intermediaries List
CMS 855 Enrollment Application Information
CMS 855 Application Fee Information
Provider/Supplier Enrollment Forms and List (855 Application, etc.)
Interpretive Guidelines (Regulations) - Appendix B
Health Insurance Benefit Agreement - CMS-1561
Oasis Requirements-Medicare Certification

NOTE TO APPLICANTS: INITIAL SURVEYS FOR MEDICARE PARTICIPATION: S&C Memo 08-03: Initial Surveys for New Medicare Providers (PDF, 103 KB)

NOTE: Do not complete a Home Health Agency application if the intent is to provide **only personal care services** that include assistance with activities of daily living, housekeeping activities, and/or accompanying client to medical appointments.

- Federal Conditions of Participation for Home Health Agencies, 42 CFR 484, via Code of Federal Regulations
- The Home Health Prospective Payment System (PPS)
- Federal OASIS Site
- Home Health Information Resource for Medicare
- Fiscal Intermediaries List
  CMS 855 Enrollment Application Information
  CMS 855 Application Fee Information
  Provider/Supplier Enrollment Forms and List (855 Application, etc.)
- Necessary Office of Civil Rights documents
  -HHS 690 and Related Documents for Title VI of the Civil Rights Act of 1964
-
- Submit the following federal Home Health Agency Survey and Deficiencies Report (CMS-1572); (PDF, 50 KB)
- CMS State Operations Manual
  - Chapter 2 (PDF) - Go to section 2202, page 157 OASIS Requirements
    - OASIS - HHAs seeking Initial Certification should review 2202.10 A thru F
  - Appendix B - Guidance to Surveyors: Home Health Agencies
- Health Insurance Benefit Agreement (CMS-1561); (PDF) (2 copies)
- Expression of Intermediary Preference
- Medicare Certification Civil Rights Information Request Form (Word) - Please review carefully and fill out and submit all requested items

Federal Certification Information

- Licensed Home Health Agencies seeking Medicare and Medicaid certification should in particular review the **OASIS Regulations,** the **OASIS User's Manual , and CMS Memorandum S&C- 01-02 Application of OASIS to Medicare Beneficiaries**
- **CMS Survey & Certification Letters** - ongoing federal updates for Home Health Agencies including OASIS information
- OASIS Transmission Guidance for Newly Licensed Home Health Agencies Applying for Medicare Certification (PDF, 21 KB)
- AT&T Global Network Client Software and Installation Instructions available on the QIES Tech Support Office Website
-

Resources

- CMS OASIS Home Page
- CMS OASIS-C Home Page
- New OASIS-C Guidance Manual CY2011 Revisions are available as of 1/6/2012
- OASIS-C Guidance Manual Chapter 5-Resources/Links (PDF, 118 KB)
- OASIS-C Timepoints (Data Set)
- OASIS Assessment Completion Resource Sheet
- CMS/OCCB Quarterly Q&As: August 2004 to present
- QIES Technical Support Office for OASIS (QTSO): OASIS Questions and Answers- some categories updated 01/11 (posted on the bottom of the OASIS Download web page)
- Medicare Learning Network (MLN) "OASIS-C Train-the-Trainer conference calls (held in October, November, and December 2009)
  - Transcripts
  - Slides/Handouts
- CMS OASIS-C presentation at the 10/09 National Association of Home Care and Hospice's (NAHC) convention (four presentations and slides)
- CMS OASIS Considerations for Medicare PPS Patients
- CMS announced 10/19/2010, the "OASIS Management of a Single Visit" guidance is no longer applicable due to PPS changes for HHAs

Technical Resources

- QIES Technical Support Office for OASIS (QTSO) includes the following manuals posted on OASIS Download web page:
  - System User's Guide
  - HHA Error and Message Description Guide
  - Correction Policy
- CMSNet (Verizon) Access Request Forms
- OASIS Personal Login ID Account Request Forms
- HAVEN
- OASIS Transmission Guidance for Newly Licensed Home Health Agencies Applying for Medicare Certification (PDF, 21 KB) NEED TO REVISE
-

OASIS Personal Login ID Requirement

An OASIS Personal Login ID is required in order to access the OASIS Submission System and CASPER Reports. Effective April 1, 2011, the HHA Individual User Registration link with be removed from the OASIS Welcome Page. In order to acquire an OASIS Individual Login ID, a

request must be submitted to the QIES Technical Support Office using the OASIS Individual Request form available on the QTSO website located at https://www.qtso.com/accesshha.html. This same form is used to revoke access for a user.
Each HHA and each branch location are allowed two individuals with personal user IDs to submit OASIS assessment information and view CASPER reports. It is the agency's responsibility to revoke access for any users who no longer require access to this data. Revoking the account of a user who no longer requires access permits the agency to request a personal login ID for an additional user.

Personal Login Passwords

A user selects their own personal login password when they register for an OASIS personal login account. The password must meet stringent password rules that are available to view on the password web page. Passwords are set to expire in 60 days. Users must enter a new password when they are prompted to change their password or they may use the QIES User Maintenance application that is available on the OASIS Welcome Page to change their password at any time prior to the 60 day expiration date.

Forgot Personal Login Password and Inactivated Accounts

If the incorrect personal login password is entered too many times, a personal login account will be made inactive. If the user does not log into CASPER reports within 60 days, their account will also be made inactive. Inactive accounts will not be able to submit OASIS assessments.
One indication of an inactive account or an expired password: after attempting to login the following message appears, "Authorization Required", indicating the server can't verify the appropriate access credentials.
To reactivate an OASIS personal account, follow these steps:

1. On the State OASIS Welcome page select the QIES User Maintenance link.
2. Select "Forgot your password or Inactive Account?".
3. Enter your Personal Login ID and answer the three security questions and follow the directions provided.

Providing answers to the security questions were part of the process for registering for an individual OASIS account. Users will have three attempts to correctly answer the security questions, after that, they are locked out and must contact the QIES Help Desk to reset their account, 800-339-9313.
To avoid getting locked out be sure to log into CASPER or the QIES User Maintenance application at least once every 60 days.

Outcome Based Quality Monitoring (OBQM)

- OBQM Manual and related reports (for OASIS-C)
- Archived OBQM Manual for OASIS-B

Outcome Based Quality Improvement (OBQI)

- OBQI Manual and related reports (for OASIS-C)
- Archived OBQI Manual for OASIS-B
- Home Health Quality Measure Reporting Static Period during the transition to OASIS-C measures (PDF, 11 KB)
- Two Year Transition from OASIS-B1 to OASIS-C: Reportable data on CASPER and Home Health Compare (PDF, 31 KB)
- 2nd Home Health Quality Improvement National Campaign - Voluntary participation; learn more or sign up

Process-Based Quality Improvement (PBQI)

Federal Certification Information

- Processed-Based Quality Improvement Manual
- CMS PBQI training video

Additional CMS Resources

- Home Health Agency Center
- Home Health Quality Initiatives
- Medicare Home Health Benefit Policy Manual (PDF, 445 KB)
- Medicare Learning Network
- Home Health Advanced Beneficiary Notice (HHABN)
- Home Heath Prospective Payment System (PPS)
- CMS Transmittal 1505: Determination of early vs. late episodes under HH PPS
- Home Health Agency Interpretive Guidelines: federal home health regulations including those related to OASIS
- S&C-01-02, dated 2/2/01, CMS Memorandum - OASIS Considerations for HHAs Seeking Initial Certification

Related Resources

- Home Health Care CAHPS Survey website
- Medicare Home Health Compare
- Medicare Home Health Compare Refresh Schedule
- AHRQ's State Snapshots: Alaska Home Health scores. (Data taken from Home Health Compare)
- MedQIC: General Quality Improvement (QI) tools and HH-specific QI tools developed by the Quality Improvement Organizations (QIOs) with many related QI links and resources
- QIES Technical Support Office for OASIS
- OASIS Certification and Competency Board (OCCB)
- National Government Services - Medicare claims
- ICD-9-CM Coding Information
- ICD-9-CM Official Guidelines for Coding and Reporting, effective October 1, 2010 (PDF, 425 KB)
- ICD-10 and Version 5010 for HIPAA electronic health care transactions (CMS)
- ICD-10 (AHIMA)

Home Health Agency – Branch Location

If you are interested in opening a branch location please see the list of items to be submitted (link below) to the Office of Health Facilities Licensing and Certification (HFL&C), along with a written request to add a branch location. You will also need to complete a new license application to add the branch. We will review the information and submit a request to the Centers for Medicare & Medicaid Services Regional Office (CMS-RO) for approval or denial.

You are also subject to complete an updated and appropriate CMS-855 form. It is your responsibility to contact the appropriate fiscal intermediary (FI) or carrier for the appropriate application.

The CMS website:
http://www.cms.hhs.gov/MedicareProviderSupEnroll/03_EnrollmentApplications.asp, co

ntains a list of the FIs and carriers as well. Questions regarding this application must be directed to the FI or carrier. Once you have received and completed the application form, you must submit it directly to the FI or carrier. Our office will be notified by the FI or carrier of their review and recommendations to CMS with regard to your application. **Until such time HFL&C cannot make a recommendation to the CMS-Regional Office.**

If you have questions or need further information, please feel free to contact the Office of Healthcare Licensing and Surveys at (907) 334-2482.

Hospice Agencies

Hospices must be licensed in Alaska prior to obtaining Medicare or Medicaid certification.

NOTE TO APPLICANTS: INITIAL SURVEYS FOR MEDICARE PARTICIPATION: S&C Memo 08-03: Initial Surveys for New Medicare Providers (PDF, 103 KB)

The issuance of a state license to operate a hospice in Alaska is separate from the Medicare provider enrollment and certification process.

THE FEDERAL MEDICARE CERTIFICATION PROCESS MAY A YEAR TO COMPLETE

Hospice Information Resource for Medicare

Fiscal Intermediaries List
CMS 855 Enrollment Application Information
CMS 855 Application Fee Information
Provider/Supplier Enrollment Forms and List (855 Application, etc.)
Hospice Interpretive Guidance Update (CMS S&C-09-19; 01/02/09)
Health Insurance Benefit Agreement Form (CMS-1561) – 3 originals required
Interpretive Guidelines (Regulations) – Hospice
Federal Conditions of Participation for Home Health Agencies, 42 CFR 418 (Code of Federal Regulations

- Medicaid and Medicare Program Manuals:
  - **Federal Interpretive Guidelines:** select State Operations Manual, Pub 07, then search for Appendix M (Hospice).
  - **CMS (HCFA) Publication 21,** Hospice Manual

42 CFR 418, Hospice Conditions of Participation, Code of Federal Regulations

Medicare Definition of Hospice:

- Hospices limiting their scope of services to treating only patients in residential facilities do not meet the definition of hospice as defined by Medicare.

Federal Certification Information

- Section 1861(dd)(2)(A)(ii) of the Social Security Act defines a hospice program as a public agency or private organization which provides for such care and services in individuals' homes, on an outpatient basis, and on a short-term inpatient basis.
- Entities that only provide hospice services to their residents and exclude outpatients do not meet this definition and may not participate in the Medicare program as a hospice.
- This determination may also apply to hospices serving patients only in residential facilities which are not owned directly by the hospice.

Hospice care is an essential Medicare benefit that focuses on the patient and family, and special support to the dying.

Medicare is committed to ensuring that all beneficiaries receive appropriate care tailored to their own needs at the end of life and that they understand their rights and options.

It was not intended to limit services to a select group of people or to place any barriers to the provision of care.

Core Services Requirements:

A. A Hospice must **directly furnish** all of the following:

1. Nursing care by or under the supervision of a registered nurse
2. Medical Social Services by a qualified social worker under the direction of a physician
3. Physician Services
4. Counseling, including, but not limited to bereavement, spiritual and dietary counseling

B. The **following services may be provided** either directly or under arrangement by the hospice:

1. Physical therapy, occupational therapy, speech-language pathology and dietary services
2. Services of a home-health aide who successfully completed a training program approved by the Secretary
3. Medical supplies and the use of medical appliances
4. Short term inpatient care
5. Homemaker/Companion services

Federal Forms - Complete and submit:

- CMS 417 - Hospice Request For Certification in the Medicare Program (PDF 445 KB)
- Submit **two copies** of Health Insurance Benefit Agreement (CMS-1561) (PDF 426 KB)
    - The person signing the Health Insurance Benefits Agreement (CMS 1561) must be someone who has the authorization of the owners of the agency to enter into this agreement.
- Office for Civil Rights forms:
    - Data Request Checklist-Civil Rights Information Request
    - HHS 690- Assurance of Compliance form
- Contact your Fiscal Intermediary to have a **Medicare General Enrollment Health Care Provider/Supplier Application** (CMS- 855A) completed and submitted.
- This separate enrollment requirement **must precede** survey and certification.

Medicare Certification:

An initial Medicare on-site survey will be performed by a surveyor, who will inspect the facility, interview you and members of your staff, review documents, and perform other procedures necessary to evaluate your agency's compliance with the Conditions of Participation.

Full Operation Letter - Prepare and submit a written notification once the hospice is in "full operation," i.e., the agency has provided services to patients and has records to review. Do this:

- once the agency is operational
- has served at least five (5) patients
- at least three (3) patients remain active
- the CMS 855 enrollment application has been completed

- agency has been approved by the fiscal intermediary

Notice of anticipated date of full operation is **not sufficient**.
This notification is required in order to signal that your agency is ready for a state and federal onsite survey to determine if all conditions of participation and compliance with HFS 131 rules are met.
It is important to remember that a survey will not be scheduled until the notification is received. The notification should be sent to Department of Health and Social Services, Health Facilities Licensing & Certification (HFL&C). Following the survey, HFL&C will recommend to the U.S. Department of Health and Human Services (DHHS) whether the agency is to be certified in the Medicare program. If denied Medicare approval, notification will be sent identifying the reasons for denial, with information about rights to appeal the decision.

Federal Links - Centers for Medicare and Medicaid Services (including S&C letters), HIPAA, Civil Rights, US Department of Labor, etc.

- S&C Letter 02-44 (PDF): "Impact of Nursing Shortage on Hospice Care", 9/12/02 - Temporary measure allowing hospices to contract for nursing care
- S&C Letter 02-29 (PDF): "Promising Practices in the Implementation of the Medicare Hospice Benefit in Nursing Homes", 5/10/02
- CMS Provider Center - Hospice Resource
- Hospice Conditions of Participation
- MDS (Minimum Data Set) What's New

Ambulatory Surgical Centers

- Fiscal Intermediaries List
  CMS 855 Enrollment Application Information
  CMS 855 Application Fee Information
  Provider/Supplier Enrollment Forms and List (855 Application, etc.)
- Health Insurance Benefit Agreement Form (CMS-370) – 3 originals required.
- Request for Certification in the Medicare Program (CMS-377)
- Interpretive Guidelines (Regulations) - Appendix L (updated 12/22/11)
  Life Safety Code Requirements
- National Fire Protection Association (NFPA)
- Part 416 of the Code of Federal Regulations 42 CFR Part 416
- ASC's-Citations and Descriptions - State Operations Manual Chapter 2; PDF, 2.36 MB) - on the left side select Bookmarks, then scroll down to 2210- ASCs
- Office of Civil Rights (OCR) Assurance of Compliance Form HHS-690; PDF, 292 KB)
- Office for Civil Rights (OCR) Civil Rights Information Request for Medicare Certification (PDF, 81 KB)

All licensed ASC facilities seeking initial Medicare certification must apply to one of the following accreditation organizations for an "initial deemed status Medicare survey":
a. TJC - The Joint Commission

b. AAAHC - Accreditation Association of Ambulatory Care
c. AAAASF - American Association for the Accreditation of Ambulatory Surgery Facilities, Inc.
d. AOA - American Osteopathic Association

After the initial deemed status Medicare survey has been completed, HFL&C must receive a copy of the "deemed status" award letter.

Intermediate Care Facility for Persons With Mental Retardation (ICF/MR)

Interpretive Guidelines (Regulations) - Appendix J
42 CFR 440.150; 42 CFR 483.410 through 483.480 (Code of Federal Regulations Information for Health Care Professionals
CMS Intermediate Care Facility for People with Mental Retardation Program

Nursing Homes

Attention Nursing Homes
SC11-22 QAPI Initiatives related to Section 6102 (c) of the Affordable Care Act for Nursing (requirement for increased emphasis on Quality Assurance and Performance Improvement programming in nursing homes and the requirement for CMS to provide technical assistance to nursing homes in developing a program).

Note re MDS 3.0 (10/01/10):
jRAVEN is the new data entry software, which Nursing Homes and Swing Bed providers may use to collect and maintain the MDS 3.0 assessment, resident and facility data and create the MDS 3.0 submission files. Information is available at: https://www.qtso.com/mds30.html

Important notes:

1. Effective September 1, 2008: Revisions to Appendix PP - "Interpretive Guidelines for Long-Term Care Facilities," become effective. Summary of changes: This instruction deletes Tag F326 and incorporates the guidance into Tag F325. It also deletes Tag F370 and incorporates that guidance into F371. **Link to S&C Letter 08-28.**

2. Effective March 31, 2009: Issuance of Revised Quality of Care Guidance at F309, including Pain Management as Part of Appendix PP, State Operations Manual, Additional Minor Changes Made to Appendices P and PP. **Link to S&C Letter 09-22.**

3. Effective September 30, 2009: **Revisions to Appendix PP–Tag F441.**

Federal Certification Information

I Fiscal Intermediaries List
CMS 855 Enrollment Application Information
CMS 855 Application Fee Information
Provider/Supplier Enrollment Forms and List (855 Application, etc.)
nterpretive Guidelines (Regulations) - Appendix PP
Health Insurance Benefit Agreement Form (CMS-1561) – 3 originals required
Long Term Care Facility Application for Medicare and Medicaid (CMS-671)
Resident Census and Conditions of Residents (CMS-672)

Federal Regulations: 42 CFR 483.5, 42 CFR 483.10 through 483.75 (Code of Federal Regulations)

- Also review Federal Information for Survey & Certification Letters and other federal updates

Related Links

- American Health Care Associations (exit DHS) - Congress and Long Term Care

- **RAI User's Manual**.
  - See MDS 3.0 CMS web site (exit DHS)
  - QTSO MDS Download website (exit DHS)
- Medicaid and Medicare Program Manuals (exit DHS)
  - **Federal Interpretive Guidelines:** State Operations Manual (exit DHS) - Long Term Care (Appendix P and PP) and Resident Assessment (Appendix R) - select from the Appendices Table of Contents.
  - **CMS Publication 12,** Skilled Nursing Facility Manual

Federal Information

Federal Links - Centers for Medicare and Medicaid Services, HIPAA, Civil Rights, US Department of Labor, etc.
CMS Nursing Home Compare: (exit DHS) Compare nursing homes throughout the United States
FDA Alert on Bedrails (exit DHS)

National Associations

American Association of Homes and Services for the Aging (exit DHS)
American Health Care Associations (exit DHS) - Congress and Long Term Care

Outpatient Physical Therapy/Speech Pathology

Fiscal Intermediaries List
CMS 855 Enrollment Application Information

Federal Certification Information

CMS 855 Application Fee Information
Provider/Supplier Enrollment Forms and List (855 Application, etc.)
Interpretive Guidelines (Regulations) - Appendix E
Health Insurance Benefit Agreement Form (CMS-1561 – 3 originals required)
Request for Certification in the Medicare and/or Medicaid Program to Provide Outpatient Physical Therapy and/or Speech Pathology Services (CMS-1856)

Portable X-Ray

Fiscal Intermediaries List
CMS 855 Enrollment Application Information
CMS 855 Application Fee Information
Provider/Supplier Enrollment Forms and List (855 Application, etc.)
Interpretive Guidelines (Regulations) - Appendix D
Request for Certification as Supplier of Portable X-Ray Services under the Medicare and/or Medicaid Program (CMS-1880)

Rural Health Clinics

NOTE TO APPLICANTS: INITIAL SURVEYS FOR MEDICARE PARTICIPATION: S&C Memo 08-03: Initial Surveys for New Medicare Providers (PDF, 103 KB)

Fiscal Intermediaries List
CMS 855 Enrollment Application Information
CMS 855 Application Fee Information
Provider/Supplier Enrollment Forms and List (855 Application, etc.)
Interpretive Guidelines (Regulations) - Appendix G

Occupancy approval - To insure the safety of patients, personnel, and the public, the physical plant should be maintained consistent with appropriate State and local building, fire, and safety codes. Please submit a copy of reports prepared by State and local personnel responsible for insuring that the appropriate codes are met (occupancy approval).

Chapter 2 The Certification Process - See Sections 2240-2249
CMS Publication 27, Medicare Rural Health Clinic Manual

- Title 42: Public Health, PART 491—CERTIFICATION OF CERTAIN HEALTH FACILITIES, Subpart A—Rural Health Clinics: Conditions for Certification; and FQHCs Conditions for Coverage
- 42 CFR Chapter IV, Part 491, Subpart A RHC: Conditions for Certification (Exit DHS)
- CMS S&C Letters
- S&C-07-06, December 7, 2006
  Hours of Operation for Rural Health Clinics (RHC)

Federal Certification Information

- S&C-04-42, August 12, 2004
  Status of the December 24, 2003 Final Rule: Rural Health Clinics