Medicare
State Operations Manual
Provider Certification

Department of Health and Human Services (DHHS)

HEALTH CARE FINANCING ADMINISTRATION (HCFA)

Transmittal 16 **Date: MAY 2000**

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
2762 - 2762 (Cont.)	2-143 - 2-144 (2 pp.)	2-143 - 2-144 (2 pp.)
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3112.3 - 3206	3-59 - 3-62 (11 pp.)	3-59 - 3-62 (4 pp.)

CLARIFICATION/MANUALIZATION--EFFECTIVE DATE: Not Applicable

Section 2762, Medicare/Medicaid Certification and Transmittal, Form HCFA-1539, clarifies the definition in subsection B of a distinct part and clarifies and incorporates material already published in §2779.

Section 3202, Change in Size or Location of Participating SNF and/or NF, is retitled. Manualized in this section are policies articulated in the January 1999 regional office memorandum on bed size changes in SNFs and NFs.

NEW/REVISED MATERIAL--EFFECTIVE DATE: ***June 1, 2000***

Section 2762, Medicare/Medicaid Certification and Transmittal, Form HCFA-1539, adds a new definition for fully participating and **deletes** the definition of dually certified.

Section 3112.2, RO Verifying Continued Compliance With Exclusion Criteria by Currently Excluded Hospitals or Units, subsection B4 is revised.

Section 3202, Change in Size or Location of Participating SNF and/or NF, revises manualized policies articulated in the January 1999 regional office memorandum regarding HCFA's policies on bed size changes in SNFs and NFs.

Section 3204, Change in Provider Location and/or Bed Complement - Other Than Distinct Part, is **deleted**.

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.

Processing Certifications

2760. FORWARDING CERTIFICATIONS TO RO

The RO uses the SA certification as the primary item of evidence to support its decisions to approve or disapprove Medicare provider participation or coverage of supplier services. The SA sends the entire certification packet to the RO in an initial certification, a termination, or any action other than a routine periodic recertification. (See Exhibit 63.) In routine recertifications, the SA inputs the data into the OSCAR system and, as appropriate, forwards an abbreviated packet of documents to the RO.

The SA completes the appropriate crucial data extract (CDE) to distill essential information from the survey report for input into the OSCAR system. (See Exhibits 14A-140.) Each CDE 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 CDE.

The SA completes all pertinent documentation relating to certification actions for each provider/supplier or action category and forwards it to the RO (or SMA, as appropriate) no later than 45 days after the exit interview. The SA is not to delay the certification process beyond the certification due date when having to follow-up on Form HCFA-1513. Instead, the SA writes the reason why the Form HCFA-1513 is missing on Form HCFA-1539 when the certification file is sent to the RO, and forwards Form HCFA-1513 as soon as possible.

2762. MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL, FORM HCFA-1539

A. Purpose of Form HCFA-1539.--The SA uses Form HCFA-1539 to certify findings to the RO or SMA with respect to a facility's compliance with health and safety requirements. Form HCFA-1539 is also a transmittal cover sheet for the certification packet. Part I of the form is completed by the SA and Part II by the RO or SMA. Form HCFA-1539 may be computer generated (ASPEN), but it must be an exact replica of the actual form. (See Exhibit 9.)

Together with the SA certification file, Form HCFA-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.

B. Definitions of Terms Used on Form HCFA-1539.--

1. Facility.--For Form HCFA-1539 purposes, facility means the provider entity or the business establishment of a provider or supplier which is subject to certification and approval in order for the provider or supplier's services to be approved for payment. If a provider operates separate provider institutions or a supplier operates separate businesses, they are regarded as separate facilities for Form HCFA-1539 purposes. A LTC facility with a SNF and a NF distinct part is one facility, even though the distinct parts are separately certified for Medicare and Medicaid. Although an agency, such as an HHA with subunits, is one facility, the subunits must be separately certified. "One enterprise; one facility; one certification" is NOT always the rule. Rather, the way HCFA assigns provider identification numbers determines how many certifications the SA prepares for any given institution. (See §2764.)

2. Certified Beds.--The Medicare/Medicaid program does not actually "certify" beds. This term means counted beds in the certified provider or supplier facility or in the certified component. A count of facility beds may differ depending on whether the count is used for licensure, eligibility for Medicare payment formulas, eligibility for waivers, or other purposes. For Form HCFA-1539, all the following are excluded from "certified beds:" pediatric visitors, newborn nursery cribs, maternity labor and delivery beds, intensive therapy beds which a patient occupies for only a short time (such as in radiation therapy units), and temporary extra beds. The following are included: designated bed locations (even though an actual bed is not in evidence) and beds which a patient occupies for an extensive period of time in special care units such as cancer treatment units,

as well as all routine inpatient beds.

3. Dually-Participating.--Simultaneous participation of an institution, in the Medicare and Medicaid programs.

4. Distinct Part.-The term "distinct part" refers to a portion of an institution or institutional complex (e.g., a nursing home or a hospital) that is certified to provide SNF and/or NF services. A distinct part must be physically distinguishable from the larger institution and fiscally separate for cost reporting purposes. An institution or institutional complex can only be certified with one distinct part SNF and/or one distinct part NF. A hospital-based SNF is by definition a distinct part. Multiple certifications within the same institution or institutional complex are strictly prohibited. The distinct part must consist of all beds within the designated area. The distinct part can be a wing, separate building, a floor, a hallway, or one side of a corridor. The beds in the certified distinct part area must be physically separate from (that is, not commingled with) the beds of the institution or institutional complex in which it is located. However, the distinct part need not be confined to a single location within the institution or institutional complex's physical plant. It may, for example, consist of several floors or wards in a single building or floors or wards that are located throughout several different buildings within the institutional complex. In each case, however, all residents of the distinct part would have to be located in units which are physically separate from those units housing other patients of the institution or institutional complex. Where an institution or institutional complex owns and operates a distinct part SNF and/or NF, that distinct part SNF and/or NF is a single distinct part even if it is operated at various locations throughout the institution or institutional complex. The aggregate of the SNF and/or NF locations represents a single distinct part subprovider, not multiple subproviders, and must be assigned a single provider number.

5. Fully Participating.-Participation of an institution in its entirety either in the Medicare or Medicaid program, or both.

C. Distributing Form HCFA-1539.--The SA completes the five copies of Form HCFA-1539. Copies are transmitted as follows:

1. First copy (white) - to the RO.

2. Second copy (yellow) - to the RO for a Medicare-only or a dually-participating facility, or the SMA for a Medicaid-only facility or any facility with a Medicaid-only distinct part.

3. Third copy (pink) - retain for SA files.

4. Fourth copy (green) - a convenience copy that the SA may use for cross filing.

5. Fifth copy (blue) - to the SMA. In the case of a Medicaid-only facility or Medicaid-only distinct part, this copy is intended to be transmitted to the RO by the SMA to indicate the issuance of a provider agreement.

If Form HCFA-1539 is computer generated, copies are distributed the same as above.

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

CHAPTER 3

ADDITIONAL PROGRAM ACTIVITIES

Adverse Actions

Adverse Actions

Reconsideration, Hearings and Appeals

Prospective Payment System (PPS)

Changes in Provider Status or Services

Expansion of Services

B. RO Verifying Exclusion Eligibility of Other Facilities.--

1. Currently Certified Psychiatric Hospital.--A hospital currently participating in Medicare and identified by its provider number as a psychiatric hospital is excluded from PPS and is not required to make any special requests for exclusion.

2. Children's Hospital.--A hospital is an excluded children's hospital if it has in effect an agreement to participate as a hospital, and if the majority of its inpatients are individuals under the age of 18. The determination is based on the hospital's most recently filed cost report. If there is an indication that the age of the patient population has changed since the close of the period covered by the report, the RO uses data for the prior 6-month period, asking the servicing intermediary to verify whether the age criterion has been met (i.e., whether the majority of the hospital's inpatients are individuals under the age of 18). This may be based on the intermediary's knowledge of the provider, or based on a separate contact.

3. Long-Term Hospitals.--A hospital is an excluded long-term hospital if it has in effect an agreement to participate as a hospital and if the average inpatient length of stay is greater than 25 days. The RO bases its determination on the hospital's most recently filed cost report. If there is an indication that the length of stay has changed since the close of the period covered by the report, use data for the prior 6-month period, asking the servicing intermediary to verify whether the length of stay criterion has been met (i.e., whether the average length of stay is in excess of 25 days). Rehabilitation hospitals meeting the length of stay criterion as a long-term hospital are eligible for a long-term hospital exclusion from PPS and do not have to meet the special criteria established for these categories of facilities.

The "hospital-within-hospital" criteria described in §3112.1 apply to all long-term hospitals with cost reporting periods beginning on or after October 1, 1995. If the RO becomes aware of any long-term hospital operated in a building or campus occupied by another hospital, the hospital must be in compliance with the criteria described in §3112.1.

4. Cancer Hospitals.--The RO verifies through contact with the Center for Health Plans and Providers, that the hospital continues to be designated as a cancer hospital.

3112.3 Role of FIs In Reverification of PPS Excluded Hospitals and Units

The FIs are to verify the following:

- Rehabilitation Hospitals and Units.--75 percent rule applied to diagnoses.
- Children's Hospitals.--Age criterion.
- Long-Term Hospitals.--Length of stay criterion.
- All Distinct Part Units.--Unit is a separate cost center for cost finding and apportionment, meeting requirements of Provider Reimbursement Manual §2803.

The next page is 3-61

Changes in Provider Status or Services

3200. ACTION BASED ON CHANGES IN PROVIDER ORGANIZATION, SERVICES, OR ACTION OF OTHER APPROVING AGENCIES

Notification that an entity has undergone organizational changes, added or relocated units, or received an accreditation may require a change in SA scheduling.

3202. CHANGE IN SIZE OR LOCATION OF PARTICIPATING SNF AND/OR NF

Under §1866 of the Social Security Act (the Act), the Secretary has the authority to enter into an agreement with an institution or an institutional complex to provide covered services to our beneficiaries. The provider agreement requires compliance with the requirements the Secretary deems necessary for participation in the Medicare or Medicaid program. See §1866(b)(2) and §1902 (a)(27) of the Act. On the effective date of the provider agreement, the institution or institutional complex is deemed to have met the requirements for participation based upon a survey of the institution or institutional complex as it was configured (i.e., bed size/bed location configuration) on the date(s) of the survey. HCFA's authority to regulate bed size changes in a SNF or a NF is based on the authority to ensure compliance with the provider agreement under §1866 of the Act and to further ensure that the configuration that has been approved for the institution or institutional complex does not so drastically change from that of the original certified configuration so as to endanger resident health and safety or otherwise change in a material fashion the identity of the entity that HCFA originally certified for program participation.

An institution or institutional complex may choose to participate in the Medicare and/or Medicaid programs either in its entirety (i.e., fully participating), or a portion thereof (i.e., a distinct part), but not both. If only a portion of an institution or institutional complex actually participates in either program it is classified as a distinct part and must meet the criteria found in §2762. For example, an institution has 4 wings that consist of 25 beds each. Three contiguous wings that contain 75 beds are dually participating (i.e., participating in Medicare and Medicaid). The fourth wing is only certified to participate in Medicare. It consists of 25 beds. Therefore, in this instance the institution is fully participating for purposes of Medicare (i.e., 100 beds) and a distinct part for purposes of Medicaid (i.e., 75 beds). The policies on bed size changes and changes in designated bed locations that are included in this section apply, regardless of whether an institution is fully participating (i.e., all beds within the institution or institutional complex are certified to participate in the Medicare and/or Medicaid program) or participating as or with a distinct part.

A SNF or NF may be:

- An entire institution for skilled nursing or rehabilitative care, such as a nursing home; or,
- A distinct part of an institution such as, a hospital, personal care home, assisted living facility, board and care home, domiciliary care facility, rest home, continuing care retirement community or nursing home.

An institution that is primarily for the care and treatment of mental diseases cannot be a SNF or NF.

A. Requirements for Distinct Part Certification.-- If the institution or institutional complex is participating as a distinct part SNF and/or NF, for a change to be approved the requested change in bed size must conform with the requirements to be classified as a distinct part. The term "distinct part" refers to a portion of an institution or institutional complex (e.g., a nursing home or a hospital) that is certified to provide SNF and/or NF services. A distinct part must be physically distinguishable from the larger institution and fiscally separate for cost reporting purposes. An institution or institutional complex can only be certified with one distinct part SNF and/or one

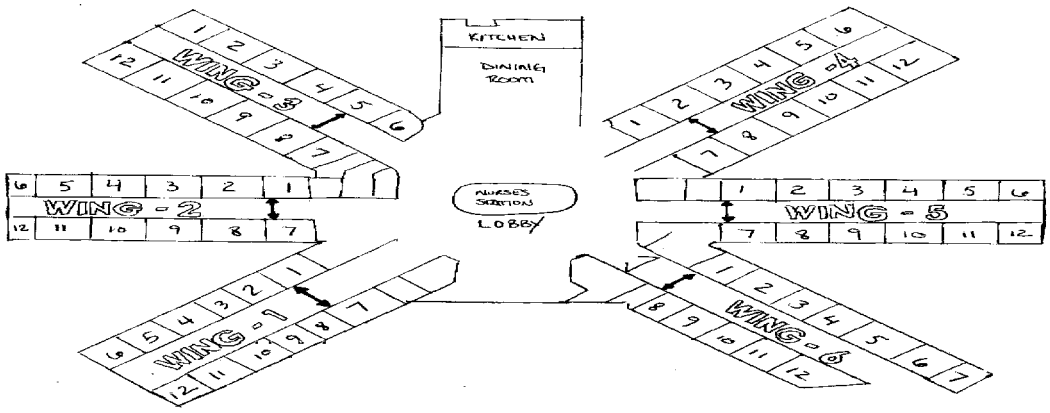

EXHIBIT I

FLOOR PLAN OF NURSING FACILITY

distinct part NF. A hospital based SNF is by definition a distinct part. Multiple certifications within the same institution or institutional complex are strictly prohibited. The distinct part must consist of all beds within the designated area. The distinct part can be a wing, separate building, a floor, a hallway, or one side of a corridor. The beds in the certified distinct part area must be physically separate from (that is, not commingled with) the beds of the institution or institutional complex in which it is located. However, the distinct part need not be confined to a single location within the institution or institutional complex's physical plant. It may, for example, consist of several floors or wards in a single building or floors or wards that are located throughout several different buildings within the institutional complex. In each case, however, all residents of the distinct part would have to be located in units which are physically separate from those units housing other patients of the institution or institutional complex. Where an institution or institutional complex owns and operates a distinct part SNF and/or NF, that distinct part SNF and/or NF is a single distinct part even if it is operated at various locations throughout the institution or institutional complex. The aggregate of the SNF and/or NF locations represents a single distinct part subprovider, not multiple subproviders, and must be assigned a single provider number. Exhibit I, above, is an illustration of a floor plan of a nursing facility followed below by examples which meet the requirements for a distinct part, as well as examples that do not meet the requirements for a distinct part. The purpose of the Exhibit is to assist the State and the RO in ensuring proper distinct part certification.

1. Meet Distinct Part Certification.--An institution or institutional complex can select any **one** of the following examples discussed in the context of Exhibit I above, that meets the requirements for distinct part certification.

o All rooms numbered 1 through 12 in wing 1 and all rooms numbered 1 through 12 in wing 2 constitute a distinct part. This option is approvable because it constitutes all beds in each wing.

o All rooms numbered 1 through 12 in wing 5. This option is approvable because it includes all beds in the wing.

o Room numbers 1 through 6 in wing 4 constitute a distinct part. This option is approvable because it includes all beds that constitute a single side of the corridor.

o Room numbers 7 through 12 in wing 2 and all rooms 1 through 12 in wing 1 constitute a distinct part. This option is approvable because it includes all beds in wing 1 and all beds that constitute a single side of the corridor in wing 2.

2. Do Not Meet Distinct Part Certification.--Neither of the examples discussed below, in the context of Exhibit I above, meet the requirements for distinct part certification.

o Room numbers 1 through 12 in wing 1 and rooms 3,4, and 5 in wing 6 do not constitute a distinct part. This option is not approvable because of the inclusion of the three rooms in wing six.

o Room number 2 in wing 1, room numbers 5 and 7 in wing 6, and room numbers 4,5,6, 10, 11, and 12 in wing 4. This option is not approvable because the distinct part area must be physically separate from (that is, not commingled with) the beds of the institution or institutional complex in which it is located.

B. Changes in Bed Size of Participating SNF and/or NF.--When an institution or institutional complex not previously certified as or with a SNF and/or NF establishes a SNF and/or NF, it must be initially certified and periodically recertified. If an institution or institutional complex has an existing SNF and/or NF agreement, it may elect to change the number of beds that are certified to participate in the Medicare or Medicaid program up to two times per cost reporting year in accordance with the requirements set out below. Where a change in the size of an SNF also impacts the size of a NF, or vice versa, this represents one change for the SNF and one change for the NF. An institution or institutional complex that is participating in the Medicare program can find these same requirements in §2337 of the Provider Reimbursement Manual, Part I. An institution or institutional complex may only change the bed size of its SNF and/or its NF once on the first day of the beginning of its cost reporting year and again on the first day of a single cost reporting quarter within that same cost reporting year in order to effect one of the following combinations:

o An increase in its bed size on the first day of the beginning of its cost reporting year and an increase in its bed size on the on the first day of a single cost reporting quarter that falls within the same cost reporting year, or;

o An increase in its bed size on the first day of the beginning of its cost reporting year and a decrease in its bed size on the first day of a single cost reporting quarter that falls within the same cost reporting year, or;

o A decrease in its bed size on the first day of the beginning of its cost reporting year and an increase in its bed size on the first day of a single cost reporting quarter that falls within the same cost reporting year.

At no time can the RO or the SA approve two decreases in the bed size of an institution within the same cost reporting year.

The institution or institutional complex may submit only ONE change in bed size at a time. Furthermore, an institution cannot request a change in its bed size just because it undergoes a change

of ownership (CHOW) or because it has been approved to change its cost reporting year. In either of these circumstances, it is still bound by the filing requirements found in subsection C.

A request for a change in the number of certified beds cannot be approved on a retroactive basis. All changes are made on a prospective basis only in accordance with the effective date indicated above. The institution requesting a change in bed size must submit a written request to the RO or SA (as appropriate) in conformance with the requirements found in subsection C. An institution or institutional complex can not self-designate the effective date of a change in bed size.

C. General Request Filing Requirements.--An institution or institutional complex seeking a change in the number of Medicare and/or Medicaid certified beds must:

o Submit a written request to the RO or SA (as appropriate) for the change 45 days before

- the first day of its cost reporting year to effect a change on the first day of its cost reporting year or;

- the first day of a single cost reporting quarter within the same cost reporting year at which time it seeks to change its bed size to effect a change on the first day of the designated cost reporting quarter.

o Submit floor plans identifying all areas of the institution or institutional complex with the current certified bed configuration and the proposed certified bed configuration in order for the RO or SA to determine that the proposed change is in fact, in conformance with the rules for full participation or distinct part certification, whichever applies.

o Include a reference to the cost reporting year of the institution or institutional complex. If there has been a change in the cost reporting year originally selected by the institution or institutional complex at the time of its initial certification, submit a copy of the letter submitted to the fiscal intermediary and the fiscal intermediary's response to the request.

D. Exceptions-- There are certain situations (described below) which we believe warrant an exception to the above policy. Therefore, even if the institution or institutional complex has been approved for a change in bed size in accordance with the policies articulated above, the institution or institutional complex may be granted a change in bed size on the basis of one of these situations. To request a change in bed size based on one of these situations, the institution or institutional complex must file a written request with the RO or SA (as appropriate) 45 days before the first day of its next cost reporting quarter, at which time the request will be effective if approved, along with floor plans identifying all areas of the institution or institutional complex with the current certified bed configuration and the proposed certified bed configuration. An exception may be granted based only on one of the following situations:

1. Life Safety Code (LSC) Requirements.--An exception may be granted if the request is to reduce the size of the SNF or NF to avoid being out of compliance with LSC requirements (e.g., sprinkler installation). The proposed bed configuration must be separated from the rest of the institution or institutional complex by a 2-hour fire wall, so that there is no danger of the fire spreading there from other parts not meeting safety requirements. In this case, the proposed reduction in the size of the SNF or NF may be established with an effective date that is requested by the institution or institutional complex, but not earlier than the date that the separation can be documented. A full survey by the fire authority must be performed if the reason for the request is to limit noncompliance with LSC requirements.

2. Elimination of Distinct Part.--An exception may be granted if an institution or institutional complex concludes that it wants to become fully participating (i.e., all beds within the institution or institutional complex are certified to participate in the Medicare and/or Medicaid program). If the institution or institutional complex decides to become fully certified to participate in the Medicare and/or Medicaid program, **it cannot return** to distinct part certification until, at the earliest, the beginning of its next cost reporting year.

3. Enlargement Through Construction, Purchase or Lease of Additional Space, An exception may be granted if the institution or institutional complex requests to increase the size of its SNF or NF to include space acquired through new construction, purchase or lease (e.g., constructing a new wing, purchasing an adjacent building or leasing a floor in a hospital).

E. Change in Designated Bed Location(s).--An institution or institutional complex may request to change its designated bed locations, as long as there is no change in the number of beds certified to participate in the Medicare and/or Medicaid program, by submitting a written request to the SA or the RO 30 days in advance of such a change. In addition, the institution or institutional complex must submit floor plans identifying all areas of the institution or institutional complex with the current certified bed configuration and the proposed certified bed configuration in order for the RO or SA to determine that the proposed change is in fact, in conformance with the rules for full certification or distinct part certification, whichever applies. The institution or institutional complex must adhere to the notification requirements found in 42 CFR 483.10(b)(11)(ii)(A) and the residents rights requirements found in 42 CFR 483.10(o). The request must be approved by the RO or SA before the institution or institutional complex makes the change. No changes are made on a retroactive basis.

F. RO or SA (as appropriate) Actions Upon Receipt of Written Request for Change in Bed Size/Location.--The RO or the SA must take the following actions when reviewing a request for a change in bed size:

- Date stamp the letter from the institution requesting a change in bed size with the date it was received by the RO or SA;

- Verify the cost reporting year selected by the institution or institutional complex using the OSCAR system. The cost reporting year of the provider must match what is contained in OSCAR. If the reported cost reporting year is different than that found in OSCAR it would be as a consequence of a change in cost reporting year (for Medicare) which must be approved by the fiscal intermediary in accordance with the requirements found in 42 C.F.R. 413.34(f). Absent such a change, the institution or institutional complex must adhere to the cost reporting year selected at its initial certification;

- Document information as required under §2764;

- Complete the Form HCFA-1539 reflecting the change in bed size/designated bed location(s) if the request is approved;

- Notify the institution or institutional complex in writing of the RO or SA decision to either approve or disapprove the request prior to the effective date of the change. If approved the letter must include the effective date of the change in bed size and/or designated bed locations, the total number of beds certified and the designated bed locations. If disapproved the letter must explain the requirement(s) not met;

- Send a copy of the letter notifying the institution or institutional complex of the RO or SA decision to approve or disapprove the request to the appropriate fiscal intermediary;

- Update the OSCAR system.

Usually, advancing the scheduled SA standard survey to recertify the changed configuration is unnecessary. A telephone contact often resolves most questions, such as changing bylaws, staffing, or other issues regarding the capacity of the institution or institutional complex to furnish the level of care contemplated in the long term care requirements. The SA must advance the survey schedule and perform a survey if;

o There is reason to question whether the institution remains in compliance with the long term care requirements (e.g., the proposed relocation site is unsuitable);

o Information suggests that as a part of the change, a different governing body or managing personnel directs the distinct part. (See §3210.); or

o The area within the physical plant to be certified has not been subjected to a life safety code survey.

G. Evaluation.--The SA bases its evaluation of the proposed certified area upon the following guidelines.

1. Shared Facilities and Services.--Rarely is a distinct part SNF or NF so completely self-contained that it independently meets all of the long term care requirements. Therefore, to the extent necessary, the SA evaluates services, facilities, and activities located outside the distinct part that are used by the distinct part's residents. This evaluation is not an assessment of whether the distinct part meets the requirements to be considered provider-based for purposes of Medicare reimbursement.

Often, the distinct part will share central supporting services such as dietary, housekeeping, and plant maintenance with the rest of the institution or institutional complex. Depending on the size and type of the institution or institutional complex, the distinct part may also have shared administration and supervisory, medical, and therapeutic services.

The primary consideration in the evaluation of shared services is whether the sharing can be done without sacrificing the quality of care rendered to distinct part residents or endangering their health and safety. The distinct part must demonstrate a capacity to provide all of the services, facilities, and supervision required by the long term care requirements. For this reason, the SA may need to consider the total staff of an institution or institutional complex, particularly with respect to the amount of shared responsibilities.

2. Effect of Hospital Accreditation or Certification on SNF or NF.--Make no assumption regarding a distinct part SNF or NF's compliance with long term care requirements on the basis of the institutional or institutional complex's accreditation by the Joint Commission on Accreditation of Healthcare Organizations or AOA or the institution or institutional complex's Medicare participation. Survey and evaluate the institution or institutional complex to determine its compliance with all of the long term care requirements.

3. SNF or NF as Distinct Part of a Psychiatric Hospital.--The guidelines for the identification of a distinct part SNF or NF, regardless of the type of institution or institutional complex in which it is located, are generally applicable. However, there are special factors to consider when an institutional complex is certified to participate as a psychiatric hospital.

A SNF or NF cannot be certified if it is primarily for the care and treatment of mental diseases. In the context of a psychiatric hospital, for example, the presumption is that in most cases a SNF or NF distinct part of such a hospital is designed primarily for the care and treatment of patients with mental diseases. A distinct part SNF or NF cannot be established unless the psychiatric hospital either has a separate medical-surgical unit which is participating as a distinct part general hospital

or has an arrangement with a community hospital for transfer to the hospital and back to the distinct part for post-hospital convalescence when a beneficiary requires medical-surgical services. In determining whether a distinct part SNF or NF is primarily for the care and treatment of mental diseases, the SA must look at the primary purposes for the unit's existence, in combination with the requirements discussed above. A psychiatric hospital can have such a unit or section certified as a distinct part SNF or NF, only if the primary purpose of the unit is to provide medical services and the hospital meets one of the requirements discussed in the last sentence of the preceding paragraph.

In addition, a distinct part SNF or NF of a psychiatric hospital would also have to be licensed pursuant to the State or local law which provides for licensing of institutions of a type which qualify as SNFs, i.e., the distinct part would have to be licensed as a nursing home.

H. Survey Considerations.--Although an immediate survey is not mandatory, the SA must complete Form HCFA-1539 promptly to report the change in size and location of the SNF or NF. Furthermore, the SA completes a spell of illness certification for any components of the institution or institutional complex that are being removed from inclusion in the SNF or NF. (See §2164.) If, in order to process this certification, the SA finds that survey is necessary, it may perform a full standard survey.

3206. EXISTING ESRD FACILITY RELOCATION, EXPANSION, OR ADDITION OF NEW SERVICE

A new application is required when an ESRD facility relocates, expands, or adds a new service. An ESRD facility may relocate in order to expand because public transportation will make it more accessible to its patient population or because it wishes to add new services (see §2274).

3210. CHOW OF PROVIDERS AND SUPPLIERS

Regulations covering CHOWs are in 42 CFR 489.18.

The initial development of facts concerning a CHOW is made by the SA. After the SA concludes its fact-finding, it forwards the findings, with supporting documentation, to the RO with its recommendations for determination.

When a provider undergoes a CHOW, the provider agreement is automatically assigned to the new owner unless the new owner rejects assignment of the provider agreement. If the new owner rejects this assignment, the provider organization will not be able to participate in the Medicare program without going through the same process as any new provider, i.e., applying for participation, undergoing Office of Civil Rights (OCR) clearance and an initial survey, having an effective date of participation assigned based upon regulation, etc. Automatic assignment of the existing provider agreement to the new owner means the new owner is subject to all the terms and conditions under which the existing agreement was issued. Terms and conditions include, but are not limited to:

A. Existing PoC.--The new owner must meet the time frames for correcting deficiencies cited in the existing PoC. A CHOW is not a basis for extending the time given for correction. Documented evidence of effort and progress and the absence of jeopardy to patient health and safety remain the only acceptable reasons for giving additional time for correction of deficiencies.

B. Compliance With Health and Safety Standards.--Assignment of an existing provider agreement assumes that a CHOW will have no adverse effect on patient health and safety. Consequently, a survey may not be required. If, however, there is any indication that patient care has deteriorated following a CHOW, the State must conduct a survey. If such a survey indicates noncompliance, the RO applies the enforcement action that is applicable to the provider/supplier type and appropriate to the level of noncompliance.

C. Compliance With Ownership and Financial Interest Disclosure Requirement.--Disclosure of ownership information is not a prerequisite to assignment of the agreement. However, ownership disclosure is a statutory requirement for all participating providers and suppliers. Upon learning of an ownership change, the SA will forward Form HCFA-1513 to the new owner for completion. Refusal to submit the requested information is a basis for termination. In no instance may the new owner be certified and issued a new provider agreement until a completed Form HCFA-1513 is received. The new owner must complete and return the form within 30 days of receipt.

D. Compliance With Civil Rights Requirements.--The RO notifies the OCR-RO of CHOWs of providers. Assignment of the existing provider agreement is not withheld pending civil rights clearance, and a new agreement can be issued before clearance by the OCR-RO is obtained. However, under these circumstances, a restricted provider agreement is issued with a contingency clause which states that if OCR clearance is not obtained, any payments made during the period will be recouped from the facility as of the effective date of the CHOW.

E. All Medicare Sanctions and Penalties.--Medicare sanctions and penalties are assigned to the new owner with the following exceptions: