

## MEMORANDUM

### Texas Department of Human Services \* Long Term Care/Policy

**TO:** Long Term Care -Regulatory  
Regional Directors and State Office Managers

**FROM:** Marc Gold, Director  
Long Term Care Policy  
State Office MC: W-519

**SUBJECT:** Regional Survey & Certification Letter #02-05

**DATE:** July 10, 2002

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The attached RS&C Letter is being provided to you for information purposes and should be shared with all professional staff.

- **RS&C Letter No. 02-05** - Subject: Procedural Changes for ASCs, CMHCs, CORFs, ESRDs, Hospitals, and OPT/SP (This RS & C letter revises HSQ letter 88-01)

If you have any questions, please direct inquiries to the Texas Department of Health, Health Facility Licensing and Compliance Division at (512) 834-6648.

~Original Signature on File~

Marc Gold

[Attachment](#)

1301 Young Street, Room 827  
Dallas, Texas 75202  
Phone (214) 767-6301  
Fax (214) 767-0270

May 2 , 2002

REGIONAL SURVEY AND CERTIFICATION LETTER NO: 02-05

To: All State Survey Agencies (Action)  
All Title XIX Single State (Information)  
Agencies

Subject: Procedural Changes for ASCs, CMHCs, CORFs, ESRDs, Hospitals, and  
OPT/SP

***This Regional Survey and Certification (RS & C) letter revises HSQ letter 88-01.***

There are some inconsistencies in the way our State survey agencies are submitting provider/supplier certification packets for the above providers to the regional office (RO) for approval/denial actions.

The State agency (SA) should ensure that the following sections on the C & T are completed for all provider types:

1. (L24) Original Date of Participation (On CHOWs Only)
2. (L31) Intermediary/Carrier number
3. Number 16 - State Survey Remarks. In this section annotate appropriate detailed information, such as change of name and/or address, change in bed sizes, changes in services, addition or deletion of stations (ESRD), branches (HHA), extensions (OPT/SP) and effective date of changes. On initial certification activities, list the approved services, SA recommendation for approval or denial of certification and effective date.

**Effective Immediately:** The following notification and certification activities for ESRDs, OPT/SP, CORFs, CMHCs, Hospitals & ASCs will be transferred from the SA to the Regional Office (RO).

The HCFA-1539 will be sent by the SA to the RO for (a) name changes, (b) address changes, (c) change in bed sizes, (d) changes in services, (e) addition or deletion of stations (ESRD), extension approvals (OPT/SP). The RO will return copies of the approved /denied HCFA-1539 to the SA and intermediaries to update the computer database (Oscar/Odie, Aspen, etc.).

\*Please remember the HCFA-1540 is obsolete and should not be used. ESRD suppliers

do not need to complete Health Insurance Benefit Agreements (HCFA-1561).

Enclosed is a list of instructions for completing SA packets that are sent to the RO by provider type.

If you have any questions regarding OPT/SP, CORFs, or CMHCs contact Connie Jones at (214) 767-6213; ESRDs, Rachel McCarty at (214) 767-2082; and Hospitals or ASCs, Colleen Sanders at (214) 767-4412.

Sincerely,

~Signature on File~

Molly Crawshaw  
Survey and Certification Operations  
Branch  
Division of Medicaid and State Operations

Enclosures-ASC Workflow ( [Attachment 1](#) ) (in .pdf format)  
CMHC Workflow ( [Attachment 2](#) ) (in .pdf format)  
CORF Workflow ( [Attachment 3](#) ) (in .pdf format)  
ESRD Workflow ( [Attachment 4](#) ) (in .pdf format)  
HOSPITAL Workflow ( [Attachment 5](#) ) (in .pdf format)  
OPT Workflow ( [Attachment 6](#) ) (in .pdf format)

\*ESRD Suppliers only

Return to [Cover Memo](#)

## **Ambulatory Surgical Center (Attachment 1)**

### **Initials Unaccredited (State)**

	Certification and Transmittal <b>Complete</b>	HCFA-1539
	Ambulatory Surgical Center Survey Report	HCFA-378
	Ambulatory Surgical Center Request to Certification	HCFA-377
	Ownership and Control Interest Disclosure Statement	HCFA-513
*	Statement of Deficiencies and Plan of Correction – Health	HCFA-567
	Statement of Deficiencies and Plan of Correction –LSC	HCFA-567
	Survey Team Composition and Workload Report	HCFA-670
	Provider Enrollment Application/with approval letter	HCFA-855
**	Health Insurance Benefit Agreement (3 signed copies)	HCFA-370

### **Initial AAAHC\JCAHO\AAAASF Accreditation**

	Certification and Transmittal <b>Complete</b>	HCFA-1539
	Ambulatory Surgical Center Survey Report	HCFA-378
	Ambulatory Surgical Center Request to Certification	HCFA-377
	Ownership and Control Interest Disclosure Statement	HCFA-513
	Provider Enrollment Application/with approval letter	HCFA-855
**	Health Insurance Benefit Agreement (3 signed copies)	HCFA-370
	Official Accreditation Decision Report	

### **Change of Ownership (CHOW's)**

	Certification and Transmittal <b>Complete</b>	HCFA-1539
	Ownership and Control Interest Disclosure Statement	HCFA-1513
	Ambulatory Surgical Center Request to Certification	HCFA-377
	Provider Enrollment Application/with approval letter	HCFA-855
	Health Insurance Benefit Agreement (3 signed copies)	HCFA-370
	Legal Documentation of Sales/Purchase/Lease	

### **Denial**

Same forms as an initial.

### **Validation (NEW)**

	Certification and Transmittal <b>Complete</b>	HCFA-1539
	Ambulatory Surgical Center Survey Report	HCFA-378
	Ambulatory Surgical Center Request to Certification	HCFA-377
	Ownership and Control Interest Disclosure Statement	HCFA-513
*	Statement of Deficiencies and Plan of Correction – Health	HCFA-567
	Statement of Deficiencies and Plan of Correction –LSC	HCFA-567
	Survey Team Composition and Workload Report	HCFA-670
	All correspondence to facility (Validation)	

**Community Mental Health Centers (Attachment 2)**  
**REGIONAL OFFICE DOCUMENTS**

Send the following forms to the CMS Regional Office:

**Initial Certification**

Medicare General Enrollment & FI Approval letter	HCFA-855
Medicare/Medicaid Certification and Transmittal (C&T)	HCFA-1539
Statement of Financial Solvency (Exhibit 5 in SOM)	HCFA-2572
CMHC Crucial Data Extract (CDE) (Exhibit 131 in SOM)	
CMHC Provider Agreement (Exhibit 276 in SOM) 3 signed originals	
Attestation Statement (Exhibit 275 in SOM)	

**Change of Ownerships (CHOWs)**

Medicare General Enrollment	HCFA-855
CMHC Crucial Data Extract (CDE) (Exhibit 131 in SOM)	
CMHC Provider Agreement (Exhibit 276 in SOM) 3 copies	
Medicare/Medicaid Certification and Transmittal (C&T)	HCFA-1539
Legal Documentation of Sale	

**Involuntary Terminations**

Medicare/Medicaid Certification and Transmittal (C&T)	HCFA-1539
Any other supporting documentation	

**Voluntary Terminations/Cessation of Business**

Medicare General Enrollment	HCFA-855
Medicare/Medicaid Certification and Transmittal (C&T)	HCFA-1539
Proof of the reason for voluntary termination or withdrawal	
Copy of newspaper notice (if applicable)	

**Complaints**

Medicare/Medicaid Certification and Transmittal (C&T)	HCFA-1539
Medicare/Medicaid/CLIA Complaint Form	HCFA-562
Narrative Report	

**Name Change/Address Change/Addition or Deletion of Stations or Services**

Medicare General Enrollment	HCFA-855
Medicare/Medicaid Certification and Transmittal (C&T)	HCFA-1539
Any supporting documentation that shows changes	

**Comprehensive Outpatient Rehabilitation Facilities (Attachment 3)**  
**REGIONAL OFFICE DOCUMENTS**

Send the following forms to the CMS Regional Office:

**Initial Certification**

Medicare General Enrollment & FI Approval	HCFA-855
Medicare/Medicaid Certification and Transmittal (C&T)	HCFA-1539
Request to Establish Eligibility	HCFA - 359
Ownership and Control Interest Disclosure Statement	HCFA - 1513
Statement of Deficiencies and Plan of Correction	HCFA-2567
Health Insurance Benefit Agreement ( 3 signed originals)	HCFA - 1561

**Change of Ownerships (CHOWs)**

Medicare General Enrollment & FI Approval	HCFA-855
Medicare/Medicaid Certification and Transmittal (C&T)	HCFA-1539
Ownership and Control Interest Disclosure Statement	HCFA - 1513
Statement of Deficiencies and Plan of Correction	HCFA-2567
Health Insurance Benefit Agreement	HCFA - 1561
Legal Documentation of Sale	

**Initial Denials**

Medicare General Enrollment	HCFA-855
Medicare/Medicaid Certification and Transmittal (C&T)	HCFA-1539
Statement of Deficiencies and Plan of Correction	HCFA-2567

**Involuntary Terminations**

Medicare/Medicaid Certification and Transmittal (C&T)	HCFA-1539
Statement of Deficiencies and Plan of Correction	HCFA-2567
Any other supporting documentation	

**Voluntary Terminations/Cessation of Business**

Medicare General Enrollment	HCFA-855
Medicare/Medicaid Certification and Transmittal (C&T)	HCFA-1539
Proof of the reason for voluntary termination or withdrawal	
Copy of newspaper notice (if applicable)	

**Complaints**

Medicare/Medicaid Certification and Transmittal (C&T)	HCFA-1539
Medicare/Medicaid/CLIA Complaint Form	HCFA-562
Narrative Report	

**Name Change/Address Change/Addition or Deletion of Stations or Services**

Medicare General Enrollment & FI Approval  
Medicare/Medicaid Certification and Transmittal (C&T)  
Any supporting documentation that shows changes

HCFA-855  
HCFA-1539

**END STAGE RENAL DISEASE (Attachment 4)**  
**REGIONAL OFFICE DOCUMENTS**

Send the following forms to the CMS Regional Office:

**Initial Certification**

Medicare General Enrollment (include intermediary approval letter)	HCFA-855
Medicare/Medicaid Certification and Transmittal (C&T)	HCFA-1539
ESRD Application/Notification and Survey and Certification Report	HCFA-3427
Statement of Deficiencies and Plan of Correction	HCFA-2567
Expression of Intermediary Preference	

**Change of Ownerships (CHOWs)**

Medicare General Enrollment (include intermediary approval letter)	HCFA-855
Medicare/Medicaid Certification and Transmittal (C&T)	HCFA-1539
ESRD Application/Notification and Survey and Certification Report	HCFA-3427
Legal Documentation of Sale	
Statement of Financial Solvency	
Expression of Intermediary Preference	

**Initial Denials**

Medicare General Enrollment (include intermediary approval letter)	HCFA-855
Medicare/Medicaid Certification and Transmittal (C&T)	HCFA-1539
Statement of Deficiencies and Plan of Correction	HCFA-2567

**Involuntary Terminations**

Medicare/Medicaid Certification and Transmittal (C&T)	HCFA-1539
Statement of Deficiencies and Plan of Correction	HCFA-2567
Any other supporting documentation	

**Voluntary Terminations/Cessation of Business**

Medicare General Enrollment	HCFA-855
Medicare/Medicaid Certification and Transmittal (C&T)	HCFA-1539
Proof of the reason for voluntary termination or withdrawal	
Copy of newspaper notice (if applicable)	

**Complaints**

Medicare/Medicaid Certification and Transmittal (C&T)	HCFA-1539
Medicare/Medicaid/CLIA Complaint Form	HCFA-562
Narrative Report	

**Name Change/Address Change/Addition or Deletion of Stations or Services**

Medicare General Enrollment	HCFA-855
Medicare/Medicaid Certification and Transmittal (C&T)	HCFA-1539
Any supporting documentation that shows changes	

## **Hospitals** (Attachment 5)

Please contact the following RO staff regarding PPS Units, Long Term Care (LTC), Critical Access Hospital (CAH), Complaints, JCAHO, Termination & EMTALA:

Charlene Belfrey	214-767-4427	PPS Units, LTC & CAH
Juanita Cortez	214-767-4403	Complaints, JCAHO, Termination
Dodjie Guioa	214 7676179	EMTALA in Texas
Dorsey Sadongei	214-767-3570	EMTALA in Oklahoma and New Mexico
David Wright	214 767-6346	EMTALA in Louisiana and Arkansas

Please forward the following hospital forms according to the action:

### **Initial Certifications** **Short-Term Acute**

#### **JCAHO/AOA Accredited Hospitals -**

Certification and Transmittal	<b>Complete</b>	HCFA-1539
Ownership and Control Interest Disclosure Statement		HCFA-1513
Request to Establish Eligibility (By Surveyor)		HCFA-1514
Statement of Intermediary Preference		
Statement of Financial Solvency		
Provider Enrollment Application/with approval letter		HCFA-855
Health Insurance Benefit Agreement (3 signed copies)		HCFA-1561
Official Accreditation Decision Report		

#### **Unaccredited Hospital (State)**

Certification and Transmittal	<b>Complete</b>	HCFA-1539
Request to Establish Eligibility (By Surveyor)		HCFA-1514
Ownership and Control Interest Disclosure Statement		HCFA-1513
* Statement of Deficiencies and Plan of Correction – Health		HCFA-2567
Statement of Deficiencies and Plan of Correction –LSC		HCFA-2567
Survey Team Composition and Workload Report		HCFA-670
Statement of Intermediary Preference		
Statement of Financial Solvency		
Provider Enrollment Application/with approval letter		HCFA-855
** Health Insurance Benefit Agreement (3 signed copies)		HCFA-1561

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### **PPS HOSPITALS**

#### **Psychiatric - Accredited JCAHO/AOA Hospitals**

Certification and Transmittal	<b>Complete</b>	HCFA-1539
Request to Establish Eligibility		HCFA-1514
* Statement of Deficiencies and Plan of Correction - Health		HCFA-2567
** Psychiatric Hospital Survey Report		HCFA-1537A

Health Insurance Benefit Agreement (3 signed originals)	HCFA-1561
Statement of Financial Solvency	HCFA-2572
Statement of Intermediary Preference	
Survey Team Composition and Workload Report	HCFA-670
Official Accreditation Decision Report	
Provider Enrollment Application/with approval letter	HCFA-855

### **Psychiatric - Unaccredited (State) Hospitals**

Certification and Transmittal	<b>Complete</b>	HCFA-1539
Request to Establish Eligibility		HCFA-1514
Ownership and Control Interest Disclosure Statement		HCFA-1513
* Statement of Deficiencies and Plan of Correction - Health		HCFA-2567
** Statement of Deficiencies and Plan of Correction –LSC		HCFA-2567
Psychiatric Hospital Survey Report		HCFA-1537A
Health Insurance Benefit Agreement (3signed originals)		HCFA-1561
Statement of Financial Solvency		HCFA-2572
Statement of Intermediary Preference		
Survey Team Composition and Workload Report		HCFA-670
Provider Enrollment Application/with approval letter		HCFA-855

The initial packet for a psychiatric hospital must include the two Special Conditions. If the hospital is certified by a national accrediting organization or by the State, the two Special Conditions must be surveyed by qualified psychiatric personnel. If the state does not have a qualified individual to conduct this survey arrangements should be made **prior** to scheduling the initial survey so that the State and Central Office can coordinate the survey with the psychiatric consultants.

### **Rehabilitation Accredited JCAHO/AOA Hospitals**

Certification and Transmittal	<b>Complete</b>	HCFA-1539
Request to Establish Eligibility		HCFA-1514
Ownership and Control Interest Disclosure Statement		HCFA-1513
* Health Insurance Benefit Agreement (signed originals)		HCFA-1561
Statement of Financial Solvency		HCFA-2572
Statement of Intermediary Preference		
Provider Enrollment Application/with approval letter		HCFA-855

Hospital would have to provide to the State a written certification that inpatient population it intends to serve meets the requirements of 412.23(b)(2).

The State has the option of reviewing the Medical Director documents onsite or in house, if the hospital is JCAHO accredited as a hospital (ref 412.23(b)(1)). The State must have the letter from JCAHO to the hospital accrediting the hospital, based on the results of an onsite survey.

### **Rehabilitation Unaccredited (State) Hospitals**

Certification and Transmittal	<b>Complete</b>	HCFA-1539
Request to Establish Eligibility		HCFA-1514
Ownership and Control Interest Disclosure Statement		HCFA-1513
* Statement of Deficiencies and Plan of Correction - Health		HCFA-2567
Health Insurance Benefit Agreement (signed originals)		HCFA-1561
Statement of Financial Solvency		HCFA-2572
Statement of Intermediary Preference		
Survey Team Composition and Workload Report		HCFA-670
Rehabilitation Hospital Criteria Worksheet	HCFA-437A or	HCFA-437B
Provider Enrollment Application/with approval letter		HCFA-855

### **Children's Hospital Accredited/Unaccredited**

**Paperwork is the same as an acute hospital Accredited/Unaccredited.**

**The State forward the paperwork from the intermediary verifying that the hospital has an agreement to participate as a hospital and that a majority of the hospital inpatients are individuals under the age of 18.**

### **Swing-Beds**

Certification and Transmittal	<b>Complete</b>	HCFA-1539
Request for Approval as a Hospital Provider of Extended Care Services		HCFA-605
Hospital Survey Report Crucial Data Extract		HCFA-1537E
Statement of Deficiencies and Plan of Correction		HCFA-2567
Medicare/Medicaid Hospital Swing-Bed Survey Report		HCFA-1537C
Survey Team Composition and Workload Report		HCFA-670

### **(Validations/Complaints)**

Certification and Transmittal	<b>Complete</b>	HCFA-1539
Authorization by Accredited Hospital to Disclose JCAHO/AOA Accreditation Survey		HCFA-2674
Crucial Data Extract - Health (if applicable)		HCFA-1537E
Crucial Data Extract - Life Safety Code (if applicable)		HCFA-2786E
Statement of Deficiencies and Plan of Correction - Health (if applicable)		HCFA-2567
Statement of Deficiencies and Plan of Correction - LSC (if applicable)		HCFA-2567
Survey Team Composition and Workload Report		HCFA-670
All correspondence to facility (Validation)		
Narrative Report (Complaints)		

Follow-up reports on hospitals under SA monitoring should contain the following:

Certification and Transmittal (Item 11 completed with either box 2 or box 4 checked)	HCFA-1539
Post-Certification Revisit Report	HCFA-2567B

### **Recertification-Accredited JCAHO/AOA Hospital- Short Term**

Certification and Transmittal	<b>Complete</b>	HCFA-1539
Request to Establish Eligibility		HCFA-1514
Ownership and Control Interest Disclosure Statement		HCFA-1513
Statement of Deficiencies and Plan of Correction		HCFA-2567
Survey Team Composition and Workload Report		HCFA-670

### **Change of Ownership (CHOW's)**

Certification and Transmittal	<b>Complete</b>	HCFA-1539
Ownership and Control Interest Disclosure Statement		HCFA-1513
Request to Establish Eligibility (By Surveyor)		HCFA-1514
Statement of Intermediary Preference		
Provider Enrollment Application/with approval letter		HCFA-855
Health Insurance Benefit Agreement (3 signed copies)		HCFA-1561
Legal Documentation of Sales/Purchase/Lease		
Statement of Financial Solvency		

### **Voluntary Termination/Cessation of Business**

Certification and Transmittal	<b>Complete</b>	HCFA-1539
Proof of the reason for voluntary termination or withdrawal		
Copy of newspaper notice (if applicable)		

### **Involuntary Termination**

**Refer to RSC-Letter No. 02-04 on required forms.**

### **Denial**

Same forms as an initial.

### **Name Change/Address Change/Addition or Deletion of Stations or Services**

Medicare General Enrollment	HCFA-855
Medicare/Medicaid Certification and Transmittal (C&T)	HCFA-1539
Any supporting documentation about changes	

### **Emergency Services for a non-participating hospital**

Medicare/Medicaid Certification and Transmittal (C&T)	HCFA-1539
Any supporting documentation of service	
Request to Establish Eligibility (By Facility)	HCFA-1514

**The SA annotates at the top of form, "Emergency Hospital Services Only"**

**Outpatient Physical Therapy (OPT) (Attachment 6)**  
**REGIONAL OFFICE DOCUMENTS**

Send the following forms to the CMS Regional Office:

**Initial Certification**

Medicare General Enrollment & FI Approval	HCFA-855
Medicare/Medicaid Certification and Transmittal (C&T)	HCFA-1539
Request to Establish Eligibility	HCFA -1856
Ownership and Control Interest Disclosure Statement	HCFA - 1513
Statement of Deficiencies and Plan of Correction	HCFA-2567
Health Insurance Benefit Agreement (3 signed originals)	HCFA - 1561
List of Personnel and Job Titles	
Copy of Provider's Social/Vocational Adjustment Services Screening Form (If applicable)	

**Change of Ownerships (CHOWs)**

Medicare General Enrollment & FI Approval	HCFA-855
Medicare/Medicaid Certification and Transmittal (C&T)	HCFA-1539
Ownership and Control Interest Disclosure Statement	HCFA - 1513
Statement of Deficiencies and Plan of Correction	HCFA-2567
Health Insurance Benefit Agreement	HCFA - 1561
Legal Documentation of Sale	

**Extension Unit Request**

Medicare General Enrollment & FI Approval	HCFA-855
Medicare/Medicaid Certification and Transmittal (C&T)	HCFA-1539
Requesting Identification of Extension Units	HCFA - 381

**Initial Denials**

Medicare General Enrollment	HCFA-855
Medicare/Medicaid Certification and Transmittal (C&T)	HCFA-1539
Statement of Deficiencies and Plan of Correction	HCFA-2567

**Involuntary Terminations**

Medicare/Medicaid Certification and Transmittal (C&T)	HCFA-1539
Statement of Deficiencies and Plan of Correction	HCFA-2567
Any other supporting documentation	

**Voluntary Terminations/Cessation of Business**

Medicare General Enrollment	HCFA-855
Medicare/Medicaid Certification and Transmittal (C&T)	HCFA-1539
Proof of the reason for voluntary termination or withdrawal	
Copy of newspaper notice (if applicable)	

**Complaints**

Medicare/Medicaid Certification and Transmittal (C&amp;T)

HCFA-1539

Medicare/Medicaid/CLIA Complaint Form

HCFA-562

Narrative Report

**Name Change/Address Change/Addition or Deletion of Stations or Services**

Medicare General Enrollment &amp; FI Approval

HCFA-855

Medicare/Medicaid Certification and Transmittal (C&amp;T)

HCFA-1539

Any supporting documentation that shows changes

Note: HCFA Form 381 must be updated annually by OPT providers and a SA report must be submitted to the RO.