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# CMS Manual System

## Pub. 100-07 State Operations

### Provider Certification

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

Transmittal 44

Date: MAY 8, 2009

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**SUBJECT: Revisions to Exhibit 286, "Hospital/CAH Medicare Database Worksheet"**

**I. SUMMARY OF CHANGES:** The Medicare Database Worksheet has been updated to reflect changes in accreditation organizations for hospitals, to increase internal consistency among data categories, and to eliminate outdated categories.

**NEW/REVISED MATERIAL - EFFECTIVE DATE\*: May 8, 2009**

**IMPLEMENTATION DATE: May 8, 2009**

*Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.*

**II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual not updated.)**

**(R = REVISED, N = NEW, D = DELETED) – (Only One Per Row.)**

| R/N/D | CHAPTER/SECTION/SUBSECTION/TITLE                     |
|-------|--|
| R     | Exhibit 286/Hospital/CAH Medicare Database Worksheet |

**III. FUNDING:** No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2009 operating budgets.

**IV. ATTACHMENTS:**

|   |                                      |
|---|--------------------------------------|
|   | <b>Business Requirements</b>         |
| x | <b>Manual Instruction</b>            |
|   | <b>Confidential Requirements</b>     |
|   | <b>One-Time Notification</b>         |
|   | <b>Recurring Update Notification</b> |

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

EXHIBIT 286

(Rev. 44, 05-08-09)

HOSPITAL/CAH MEDICARE DATABASE WORKSHEET

Worksheet completed by the SA surveyor to gather data of worksheet, not to be given to provider to fill out.

CMS Certification Number (CCN): \_\_\_\_\_ Date of Worksheet Update: \_\_\_\_\_

Medicaid Provider Number: \_\_\_\_\_ (MMDDYYYY) (M1)

National Provider Identification Number(s) (NPI): \_\_\_\_\_

Fiscal Year Ending Date (MMDD): \_\_\_\_\_

Name and Address of Facility (Include City, State):

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone Number (M2): \_\_\_\_\_ Fax Number (M3): \_\_\_\_\_

CEO Telephone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Website Address: \_\_\_\_\_

Accreditation Status: \_\_\_\_\_

Effective Date of Accreditation: \_\_\_\_\_

Select one

(MMDDYYYY) (M4)

0 Not Accredited

1 JC

Renewal Date of Accreditation: \_\_\_\_\_

2 AOA

(MMDDYYYY) (M5)

3 DNV

Multiple Accreditation Status: Yes \_\_\_\_\_ No \_\_\_\_\_

(Select all others that apply; do not include the primary accreditation organization):

JC \_\_\_\_\_

AOA \_\_\_\_\_

DNV \_\_\_\_\_

State/County Code (M6): \_\_\_\_\_

State Region Code (M7): \_\_\_\_\_

Type of Program Participation (M8):\_\_\_\_\_

CLIA ID Numbers (M9):

Select one

1 Medicare

2 Medicaid

3 *Medicare & Medicaid*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*Medicare CAH Status or Type of Medicare Hospital* (select 1) (M10):\_\_\_\_\_

01 Short-term \_\_\_\_

06 Childrens\_\_\_\_

02 Long-term \_\_\_\_

07 Distinct Part Psychiatric  
Hospital\_\_

03 Religious Nonmedical Health Care Institution\_\_\_\_

08 Cancer Hospital\_\_\_\_

04 Psychiatric \_\_\_\_

11 Critical Access Hospital (CAH)\_\_\_\_

05 Rehabilitation \_\_\_\_

Affiliation with a Medical School (M11):\_\_\_\_\_

01 Major

02 Limited

03 Graduate School

04 No Affiliation

Resident Programs (M12) (select all that apply):\_\_\_\_\_

01 *Allopathic*

02 *Dental*

03 *Osteopathic*

04 Other

06 Podiatric

Ownership Type (select 1) (M13):\_\_\_\_\_

01 Church

06 State

02 Private (Not for Profit)

07 Local

03 Other (specify:\_\_\_\_\_)

08 Hospital District or Authority

04 *Private* (For Profit)

09 Physician Ownership

05 Federal\_

10 Tribal

Average Daily Census (M14):\_\_\_\_\_

Number of Staffed Beds (M15):\_\_\_\_\_

Type of Chain/Health System Involvement (M16): \_\_\_\_\_

01 None

02 System Ownership

03 System Management

Name of System (M17): \_\_\_\_\_

Corporate Headquarters City (M18): \_\_\_\_\_ State (M19): \_\_\_\_\_

| Number of Employees Salaried by Hospital/CAH<br>(Use Full Time Equivalents FTE) |                                   |  |     |                                       |  |
|---|-----------------------------------|--|-----|---------------------------------------|--|
| M20   | Physicians (Salaried only)        |  | M30 | Medical Technologists (Lab)           |  |
| M21   | Physicians - Residents            |  | M31 | Nuclear Medicine Technicians          |  |
| M22   | Physician Assistants (PA)         |  | M32 | Occupational Therapists               |  |
| M23   | Nurses - CRNA                     |  | M33 | Pharmacists (Registered)              |  |
| M24   | Nurses - Practitioners            |  | M34 | Physical Therapists                   |  |
| M25   | Nurses - Registered               |  | M35 | Psychologists                         |  |
| M26   | Nurses – LPN                      |  | M36 | Radiology Technicians<br>(Diagnostic) |  |
| M27   | Dieticians                        |  | M37 | Respiratory Therapists                |  |
| M28   | Medical Social Workers            |  | M38 | Speech Therapists                     |  |
| M29   | Medical Laboratory<br>Technicians |  | M39 | All Others                            |  |

**Medicare Payment-Related Categories for a Hospital or a CAH (select all that apply) (M40):** \_\_\_\_\_

|    | CAH Categories         |  |    | Hospital Categories              |  |
|----|------------------------|--|----|----------------------------------|--|
| 01 | CAH Psychiatric DPU    |  | 07 | Hospital PPS Excluded Psych Unit |  |
| 02 | CAH Rehabilitation DPU |  | 08 | Hospital PPS Excluded Rehab Unit |  |
| 03 | CAH Swing Beds         |  | 09 | Hospital Swing Beds              |  |
|    |                        |  | 10 | Medicare Dependent Hospital      |  |
|    |                        |  | 11 | Regional Referral Center         |  |

|  |  |  |    |                         |  |
|--|--|--|----|-------------------------|--|
|  |  |  | 12 | Sole Community Hospital |  |
|--|--|--|----|-------------------------|--|

Services Provided by the Facility (M41): \_\_\_\_\_

- 0 Service not provided
- 1 Services provided by facility staff only
- 2 Services provided by arrangement or agreement
- 3 Services provided through a combination of facility staff and through agreement

|    |  |  |    |   |  |
|----|--|--|----|---|--|
|    |  |  | 34 | Operating Rooms   |  |
| 02 | Alcohol and/or Drug Services           |  | 35 | Ophthalmic Surgery  |  |
| 03 | Anesthesia Service                     |  | 36 | Optometric Services   |  |
| 04 | Audiology                              |  |    |   |  |
|    |  |  | 38 | Organ Transplant Services ( <i>Not Medicare-certified</i> ) |  |
| 06 | Burn Care Unit                         |  | 39 | Orthopedic Surgery  |  |
| 07 | Cardiac Catheterization Laboratory     |  | 40 | Outpatient Services   |  |
| 08 | Cardiac-Thoracic Surgery               |  | 41 | Pediatric Services  |  |
| 09 | Chemotherapy Service                   |  | 42 | Pharmacy  |  |
| 10 | Chiropractic Service                   |  | 43 | Physical Therapy Services                                   |  |
| 11 | CT Scanner                             |  | 44 | Positron Emission Tomography Scan                           |  |
| 12 | Dental Service                         |  | 45 | Post-Operative Recovery Rooms                               |  |
| 13 | Dietetic Service                       |  | 46 | Psychiatric Services - Emergency                            |  |
| 14 | Emergency Department (Dedicated)       |  | 47 | Psychiatric - Child/Adolescent                              |  |
|    |  |  | 48 | Psychiatric - Forensic                                      |  |
| 16 | Extracorporeal Shock Wave Lithotripter |  | 49 | Psychiatric - Geriatric                                     |  |
| 17 | Gerontological Specialty Services      |  | 50 | Psychiatric – Adult Inpatient                               |  |
|    |  |  | 51 | Psychiatric - Outpatient                                    |  |
|    |  |  | 52 | Radiology Services - Diagnostic                             |  |
| 20 | ICU - Cardiac (non-surgical)           |  | 53 | Radiology Services - Therapeutic                            |  |
| 21 | ICU - Medical/Surgical                 |  | 54 | Reconstructive Surgery                                      |  |
| 22 | ICU - Neonatal                         |  | 55 | Respiratory Care Services                                   |  |
| 23 | ICU - Pediatric                        |  | 56 | Rehab Services - Inpatient                                  |  |
| 24 | ICU - Surgical                         |  |    |   |  |
|    |  |  | 58 | Rehab -Outpatient   |  |
| 26 | Laboratory - Clinical                  |  | 59 | Renal Dialysis (Acute Inpatient)                            |  |
|    |  |  | 60 | Social Services   |  |
| 28 | Magnetic Resonance Imaging (MRI)       |  | 61 | Speech Pathology Services                                   |  |
| 29 | Neonatal Nursery                       |  | 62 | Surgical Services - Inpatient                               |  |
| 30 | Neurosurgical Services                 |  | 63 | Surgical Services - Outpatient                              |  |
| 31 | Nuclear Medicine Services              |  | 64 | Trauma Center ( <i>Designated</i> )                         |  |
| 32 | Obstetric Service                      |  | 65 | <i>Transplant Center (Medicare Certified)</i>               |  |
| 33 | Occupational Therapy Services          |  | 66 | Urgent Care Center Services                                 |  |

Sprinkler Status, *Main Campus* (select 1) (M42): \_\_\_\_\_

- 01 Totally sprinklered: All required areas are sprinklered
- 02 Partially sprinklered: Some but not all required areas are sprinklered

03 Sprinklers: *No required areas are sprinklered*

Total number of *provider-based* off-site locations under the same CCN (M43): \_\_\_\_\_

| TYPES OF OFF-SITE LOCATIONS |   |  |    |  |  |
|-----------------------------|---|--|----|--|--|
| 01                          | Inpatient Remote Location                       |  | 07 | Satellite of an <i>IPPS-Excluded</i> Psych Unit          |  |
| 02                          | Offsite Outpatient Surgery                      |  | 08 | Satellite of a Long Term Care Hospital                   |  |
| 03                          | <i>Offsite</i> Urgent Care Center               |  | 09 | Satellite of a Cancer Hospital                           |  |
| 04                          | Satellite of a Rehabilitation Hospital          |  | 10 | Satellite of a Childrens' Hospital                       |  |
| 05                          | Satellite of a Psychiatric Hospital             |  | 11 | <i>Offsite</i> Emergency Department                      |  |
| 06                          | Satellite of an <i>IPPS-Excluded</i> Rehab Unit |  | 12 | Other Provider-Based Offsite Facility/ <i>Department</i> |  |

*For each* off-site location, complete and attach the Provider-Based Off-Site Locations Continuation Worksheet.

Number of related or affiliated providers or suppliers (M44): \_\_\_\_\_

| TYPES OF AFFILIATED PROVIDERS/ <i>SUPPLIERS</i> |                                   |  |    |  |  |
|---|-----------------------------------|--|----|--|--|
| 01  | <i>Ambulance Service</i>          |  | 06 | Hospice                                    |  |
| 02  | Ambulatory Surgery Center         |  | 07 | <i>Organ Procurement Organization</i>      |  |
| 03  | End Stage Renal Disease           |  | 08 | Psychiatric Residential Treatment Facility |  |
| 04  | Federally Qualified Health Center |  | 09 | Rural Health Clinic                        |  |
| 05  | Home Health Agency                |  | 10 | Skilled Nursing Facility (SNF)             |  |

*For each affiliated provider/supplier, complete and attach the Affiliated Provider/Supplier Continuation Worksheet, indicating the provider/supplier name, CCN, and type.*

(M45) *Co-location Status: Is there another hospital, or a satellite location of another hospital, that occupies space in a building used by the hospital described in this worksheet?*

- 01 Yes
- 02 No

*If yes, provide the name and CCN number of the co-located hospital:*

*Name* \_\_\_\_\_ *CCN* \_\_\_\_\_

PROVIDER-BASED OFF-SITE LOCATION CONTINUATION WORKSHEET

PAGE 1 OF \_\_\_\_\_

ENTRY# \_\_\_\_\_

**Type of Off-site Location (from table M43):** \_\_\_\_\_

Name of Off-Site Location: \_\_\_\_\_

Off-Site Street Address: \_\_\_\_\_

County: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Sprinklered Status of Off-site Location (select 1): \_\_\_\_\_

- 01 Totally sprinklered: All required areas are sprinklered;
- 02 Partially sprinklered: Some but not all required areas sprinklered;
- 03 Sprinklers: *No required areas are sprinklered*
- 04 Sprinklers are not required

ENTRY# \_\_\_\_\_

**Type of Off-site Location (from table M43):** \_\_\_\_\_

Name of Off-Site Location: \_\_\_\_\_

Off-Site Street Address: \_\_\_\_\_

County: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Sprinklered Status of Off-site Location (select 1): \_\_\_\_\_

- 01 Totally sprinklered: All required areas are sprinklered;
- 02 Partially sprinklered: Some but not all required areas sprinklered;
- 03 Sprinklers: *No required areas are sprinklered*
- 04 Sprinklers are not required

ENTRY# \_\_\_\_\_

**Type of Off-site Location (from table M43):** \_\_\_\_\_

Name of Off-Site Location: \_\_\_\_\_

Off-Site Street Address: \_\_\_\_\_

County: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Sprinklered Status of Off-site Location (select 1): \_\_\_\_\_

- 01 Totally sprinklered: All required areas are sprinklered;
- 02 Partially sprinklered: Some but not all required areas sprinklered;
- 03 Sprinklers: *No required areas are sprinklered*
- 04 Sprinklers are not required

Make additional copies as needed for additional off-site locations.

**AFFILIATED *PROVIDER/SUPPLIER* CONTINUATION WORKSHEET PAGE 1 OF \_\_\_\_\_**

**Identify all affiliated Medicare-*certified* providers/suppliers, indicating for each the name, CCN, and type of provider/supplier, using the codes from M44.**

*Entry #* \_\_\_\_\_

*Name* \_\_\_\_\_ *CCN* \_\_\_\_\_

*Type of Provider/Supplier* \_\_\_\_\_

*Entry #* \_\_\_\_\_

*Name* \_\_\_\_\_ *CCN* \_\_\_\_\_

*Type of Provider/Supplier* \_\_\_\_\_

*Entry #* \_\_\_\_\_

*Name* \_\_\_\_\_ *CCN* \_\_\_\_\_

*Type of Provider/Supplier* \_\_\_\_\_

*Entry #* \_\_\_\_\_

*Name* \_\_\_\_\_ *CCN* \_\_\_\_\_

*Type of Provider/Supplier* \_\_\_\_\_

*Entry #* \_\_\_\_\_

*Name* \_\_\_\_\_ *CCN* \_\_\_\_\_

*Type of Provider/Supplier* \_\_\_\_\_

**Make additional copies as needed for additional affiliated providers/*suppliers*.**