

CMS-1539 *User* Guide

Background and Applicability

This document provides an overview and guide on completion of the Form CMS-1539 by the State Survey Agency as it relates to certification actions. The guide provides instructions which apply to those using the national database as well as those SAs which chose to use the manual fillable form. The instructions and guidance for the CMS-1539 does not apply to Organ Procurement Organizations (OPOs) and Religious Nonmedical Health Care Institutions (RNHCIs).

References to Accrediting Organizations use of the fillable Form *CMS-1539* applies only for survey activities surrounding administrative changes (e.g. extension sites, relocations, adding services, etc.) and initial surveys. *The AOs will use the comparable CMS-1539 fillable form developed or a comparable form, in communicating with the MAC.*

Packet of Documentation Attached to Certification and Transmittals

The SA uses Form CMS-1539 form to certify findings to the CMS Location, MACs or State Medicaid Agency (SMA) with respect to a facility's compliance with Conditions of Participation, Conditions for Coverage, Conditions for Certification, or Nursing Home Requirements. The Form CMS-1539 is also a transmittal cover sheet for the certification packet. Note, for deemed facilities, the AOs will use the comparable CMS-1539 form for administrative changes only. If the AO determines any of its deemed facilities are non-compliant and that certification action would result in any enforcement activities, the AO must follow existing processes for notifying CMS.

Together with the SA certification file, Form CMS-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. Each new certification action requires a separate Form CMS-1539.

The Form CMS-1539 also exists as an electronic form and is more frequently used than the paper version of the form. The Form CMS-1539 is used to process updates to a provider/supplier's information in the national data system.

Definitions of Terms Used on Form CMS-1539

1 - Facility

For Form CMS-1539 purposes, facility means the provider entity or the business establishment of a provider or supplier that 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 CMS-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. “One enterprise; one facility; one certification” is NOT always the rule. Rather, the way CMS 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 CMS-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.

Per the Standard Operating Procedures for the Certification Transition, we note that the SA must follow existing processes and the SA communicates with the CMS Location for Medicaid-only facilities.

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. 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 that 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.

Per the Standard Operating Procedures for the Certification Transition, we note that the SA must follow existing processes and the SA communicates with the CMS Location for Medicaid-only facilities.

SA Instructions for Completing the Form CMS-1539

The main purpose of Form CMS-1539 is to transmit the SA's certification that a facility meets or does not meet the requirements for participation. The SA completes all applicable parts of the form for Medicare/Medicaid providers/suppliers. The SA transmits the Form CMS-1539 to the MAC for all certification actions. For SAs using the iQIES national database, manual completion of the form will be required until further notice. Please note, L-Codes on the CMS-1539 form are associated with the ASPEN database. ***AOs will only use the comparable Form CMS 1539 or comparable transmittal for communicating administrative changes to the MAC.***

Item 1 - Medicare/Medicaid Provider No

Leave this item blank on all initial certifications; *for CHOWs where the provider accepts assignment include the current CCN. For administrative changes, include the CCN of the provider/supplier.* CMS assigns the CCN for all new providers and suppliers.

Item 2 - State Vendor or Medicaid Number

The SA completes this item only for those States that assign separate vendor (or Medicaid ID) numbers for internal controls or for billing purposes. The SA should leave this item blank if a State does not have such a system.

Item 3 - Name and Address of Facility

The facility properties screen of the national data system automatically generates the name, physical address, city, State, and zip code of the facility. A post office box without a street address is not sufficient.

Item 4 - Type of Action

For users using the ASPEN database, L8 signifies the Type of Action. For users using the manual form, select the appropriate drop-down selection for the action.

Type of Actions: Initial, Recertification, Termination, CHOW, Validation, Complaint, Onsite Visit, Termination of ICF Beds or Full Survey After Complaint, or Other.

Reminders: For Termination, this includes voluntary and involuntary terminations. Full Survey After Complaint, is only applicable to Hospitals, HHAs, ASCs and Hospice.

In the block provided, the SA *selects* the appropriate code in accordance with the following explanations:

Initial Survey (Code 1 in ASPEN)

In addition to initial certifications, the SA selects this code when recommending an initial denial of participation.

Recertification (Code 2 in ASPEN)

The SA selects this code when conducting a recertification survey.

Termination or retirement of CCN (Code 3 in ASPEN)

The SA selects this code for involuntary termination, voluntary termination/withdrawal, or change in status requiring a new CCN. Examples of a change in status includes:

- When a hospital converts to a CAH,
- When a CAH converts to a hospital,
- When a short-term hospital reclassifies to become an IPPS-excluded hospital,
- When an IPPS-excluded hospital reclassifies to become another classification of hospital (Short-term hospital or IPPS-excluded hospital), or
- When a hospital undergoes a CHOW and then is combined with another hospital the new owner already owns.

If Item #4 annotates “Termination,” the SA must complete Part II, Item 26 (L30) of the CMS-1539. The MAC must carefully review both Items for termination to determine if the termination is voluntary or involuntary. For deemed facilities where involuntary termination is recommended by an AO, the AO will send the information for the recommendation to the SA and CMS Locations for denial/termination as SOG remains responsible for involuntary terminations. For voluntary terminations, the AO will communicate with the SA per [Admin Info 20-08-ALL](#).

CHOW (Code 4 in ASPEN)

The SA selects this code for a CHOW situation. AOs will be copied on CHOWs for deemed providers/suppliers, however the SA (and CMS Locations where applicable) is responsible for review and processing of CHOWs.

When Item 4 is marked CHOW (code 4), the SA will annotate the recommendation of approval effective date of the CHOW in the notes section under Item 16. SAs do not need to complete block L9. CMS issues the final effective date of the CHOW within any approval letters.

Sample Validation (Code 5 in ASPEN)

The SA selects this code for a complete survey in an accredited facility for sample validation purposes. The SA completes all appropriate blocks on the form including items 6 (survey date), 8 (accreditation status), and 10 (compliance provision).

Complaints (Code 6 in ASPEN)

The SA selects this code for an onsite complaint investigation.

Onsite Visit (Code 7 in ASPEN)

The SA selects this code for an **onsite** inspection of a facility for some other reason **not** outlined above. Examples include:

1. Onsite revisit to verify that the deficiencies cited on the original survey are corrected and a Form CMS-2567B is completed;
2. Onsite visit to verify that a hospital or CAH meets the criteria for hospitals or CAHs operating with swing-beds or IPPS-excluded units; and
3. Onsite visit to verify that an HHA's branch location meets the branch criteria.
4. Onsite visit based on any administrative changes not listed above (e.g. relocation, extension site, adding additional services, etc.).

Note: This would include any onsite visits for relocation, adding extensions sites, or any survey activities as needed, if the surveying entity determines an onsite visit prior to recommending approval is needed.

Full Survey After Complaint (Code 8 in ASPEN)

The SA selects this code for when a full survey after a complaint investigation is completed in the complaint system.

Other (Code 9 in ASPEN)

The SA selects this code for any certification action not specified above (e.g., changes in effective date, size, facility name, or address). Whenever this is selected, the SA shows in Remarks, Item 16, and the reason for completing Form CMS-1539.

Item 5 - CHOW Date

When Item 4 is marked CHOW (code 4), the SA will annotate the recommendation of approval effective date of the CHOW in the notes section under Item 16. SAs do not need to complete block L9. CMS issues the final effective date of the CHOW within any approval letters.

Item 6 - Date of Survey

For providers who require a life safety code (LSC) survey, the SA enters the date the health or LSC survey is completed, whichever is later. For providers and suppliers who do not need a LSC survey, the SA enters the date the health survey is completed. *Note: The date of survey differs from the effective date as the effective date is when a provider/supplier is deemed to have met the Medicare conditions.*

Item 7 - Provider/Supplier Category

In the block provided, select the provider/supplier category that is most descriptive of the facility. The Provider/Supplier Category is not shown on the Certification kit in the application except for Nursing Homes, as its value is taken from the Provider's type. It does appear on the printed CMS-1539 from ASPEN.

The SA will enter one of the following:

- Hospital/CAH - Hospitals/Critical Access Hospitals
- SNF/NF/Dual - Skilled Nursing Facilities/Nursing Facilities/Dually Certified
- SNF/NF/Distinct Skilled Nursing Facilities/Nursing Facilities/Distinct Part
- SNF- Skilled Nursing Facility
- HHA – Home Health Agency
- PRTF- Psychiatric Residential Treatment Facility
- X-Ray- Portable X-Ray Supplier
- OPT/SP – Outpatient Physical Therapy/Speech Pathology
- ESRD – End Stage Renal Disease facility
- NF – Nursing Facility
- ICF/IID - Intermediate Care Facility for Individuals with Intellectual Disabilities
- RHC – Rural Health Clinic
- PTIP – Physical Therapy in Independent Practice*
- CORF- Comprehensive Outpatient Rehabilitation Facility
- ASC – Ambulatory Surgical Center
- Hospice
- CMHC- Community Mental Health Center
- CLIA- Clinical Laboratory Improvement Amendments/Labs

*PTIP remain in the ASPEN database however are not a surveyed provider. This is a voided provider type in the ASPEN database.

Item 8 - Accreditation Status

For ASPEN users, the SA does not manually enter accreditation status on this form. It is taken

from the information already entered into the deemed tab of the certification kit and populated on the form. For SAs currently using iQIES, the SA will manually populate the entire CMS Form 1539, therefore must select the AO based on the drop-down menu available.

For ease of reference, the AOs associated programs are also listed within this guidance.

Name of Accrediting Organization	Acronym	Medicare approved programs*
UNACCREDITED	N/A	The provider/supplier is not deemed
American Association for Accreditation of Ambulatory Surgery Facilities	AAAASF	ASC, OPT, RHC
Accreditation Association for Ambulatory Health Care	AAAHC	ASC
Accreditation Commission for Health Care	ACHC	ASC, CAH, ESRD Facilities, HHA, Hospice, Hospital
Community Health Accreditation Partner	CHAP	HHA, Hospice
Center for Improvement and Healthcare Quality	CIHQ	Hospital
DNV Healthcare	DNV	CAH, Hospital, Psychiatric Hospital
National Dialysis Accrediting Commission	NDAC	ESRD
The Compliance Team	TCT	RHC
The Joint Commission	TJC	ASC, CAH, HHA, Hospice, Hospital, Psychiatric Hospital

*Does not include non-certified programs

Item 9 (L35) - Fiscal Year Ending Date

The SA enters the ending date (month and day) of the provider's/supplier's fiscal year, when applicable.

Item 10 - State Agency Certification

A - In Compliance With Program Requirements

If "A" is entered in the first block and the facility is not in full compliance with the program requirements, all conditional aspects are coded in the blocks following "A." If the facility was in compliance without any deficiencies and/or approved waivers, the SA will annotate that the facility was in compliance at "A" and no additional conditional aspects are required.

B - Not in Compliance With Program Requirements (Termination Development)

If "B" is entered in the first block, the documentation supporting the termination action must

accompany Form CMS-1539 and be referenced in Item 16 of Remarks.

Item “B” is also selected when an accredited hospital is not in compliance with one or more of the CoPs surveyed during the sample validation survey or complaint investigation.

Item 11 - LTC Period of Certification

Time Limited Agreements (TLAs) are no longer required for ICFs/IID. The SA does not need to insert the recommended beginning (FROM) and ending (TO) dates of the TLA.

Item 12 - Total Facility Beds (Complete for Hospitals, SNFs, NFs, and ICF/IIDs)

The SA enters the total number of beds in the facility, including those in non-participating and non-licensed components or areas. **The Number of Beds in the Certified Portion of the Facility Must Not Exceed the Number of Total Beds (refer to definition terms above).**

NOTE: The number of total facility beds and beds in the certified portion of the facility on Form CMS-1539 is restricted to the entire facility or the distinct part identified in Items 1 (CCN) and 7 (Provider Category).

Item 13 - Total Certified Beds (Complete for Hospitals, SNFs, NFs, and ICF/IIDs)

The SA enters the number of beds in Medicare and/or Medicaid certified areas.

Item 14 - SNF, NF, and ICF/IID Certified Bed Breakdown

The total number of beds in the certified portion of the facility recorded in Item 13 must be divided in Item 14 according to type of program.

The SA completes boxes A, B, C, and E (in ASPEN) or boxes on the manual form, as appropriate. **These blocks must equal Item 13 (total beds in the certified portion of the facility for SNF, NFs and ICF/IIDs).**

Item 15- Nonparticipating Emergency Hospitals and NFs (VOIDED- no longer needed)

Item 16 - State Survey Agency Remarks- REQUIRED

The SA uses this space for any required remarks or recommendations for approval or disapproval. If the comments exceed the allotted space, the SA continues on a sheet of paper entitled “Item 16 Continuation for CMS-1539.”)

Item 17 - Surveyor Signature

The surveyor (or survey team leader or staff member responsible for the initial review) signs and dates Form CMS-1539 after ensuring that the certification documents are complete and accurate.

Item 18 - State Agency Approval

The authorized representative of the SA (2nd level reviewer) signs and dates Form CMS-1539 and forwards the certification material to the MAC, when applicable or State Medicaid Agency (SMA), as appropriate. His/her signature constitutes for Medicare the official “certification” that the information being reported is correct according to official State files. In Medicaid-only cases, the SA representative’s signature on this document represents the adjudicative decision of the SA on the qualifications of the institution to participate in the Medicaid program.

PART II- TO BE COMPLETED BY THE CMS SURVEY AND OPERATIONS GROUP LOCATION OR STATE AGENCY

Item 19 - Determination of Eligibility

Enter code 1 or 2 in this block of the SA’s findings and certifications. Enter code 1 when the provider/supplier is found eligible to participate in the Medicare and/or Medicaid programs. Also enter code 1 when a denial of payment for new admissions is imposed, continued, or lifted.

Enter code 2 when a facility is not eligible to participate due to non-compliance with the Medicare conditions. *Complete Item #20.*

Item 20 – Initial Survey Results (Manual Form Only)

If Code 2 in Item #19 is selected, Item #20 must annotate whether this is the provider’s 1st, 2nd or final attempt at certification for initial survey and the date of the survey. If the SA (or AO) continues to find the applicant is not in compliance with the conditions of participation/coverage/certification or requirements, the SA will send a CMS-1539 indicating the provider is not eligible to participate and annotate the corresponding reason. Note: Item #20 dates should reflect the same dates as in Item #6 for survey dates.

Following the initial denial, the applicant may submit no more than two reapplications for certification in connection with the one enrollment application (for a total of 3 certification attempts); and no more than six months may have elapsed between the date of the first denial of certification and any subsequent surveys.

Deemed Note: *For prospective providers/suppliers seeking deemed status and failure to comply with the requirements, the SA will receive the recommendation via the AO. The SA will complete the CMS-1539 for deemed providers who are not recommended for initial certification and send to the MAC as indicated above.*

NOTE: *The MAC will only take action to close the CMS-855 when the “Final Attempt” checkbox is selected. The MAC will follow the PIM guidance and only take final action to close the CMS-855 when the “Final Attempt” checkbox is selected on the CMS-1539.*

Examples and additional guidance are provided at the end of this User Guide.

Item 21- VOID (BLANK)

Item 22 – *Effective Date*

Complete for initial certifications only. Determine when the facility is eligible to begin participation in Medicare and/or Medicaid *meaning, the effective date*. The SA will annotate the recommended effective date in the notes section under Item 16. SAs do not need to complete block L24. CMS issues the final effective date of the initial certification within any approval letters. The effective date of participation is established pursuant to [42 CFR 489.13](#) for Medicare and [42 CFR 431.108](#) for Medicaid.

Items 23-25 - ICF/IID Certification Period (“LTC Agreements”)

When an ICF/IID is found not to be in compliance with program requirements and a denial of payment for new admissions is imposed, enter the beginning (Item 23) and ending (Item 24) a 1539 dates of the **current** re-certification survey. In Item 25 (extension date), enter a date **not exceeding** the end of the fifteenth month following the month in which the sanction will be imposed.

Item 26 - Termination Action

If a provider’s or supplier’s participation in the Medicare/Medicaid program ends, record the reason (see below) in the accompanying block. Also, complete Item 28 (termination date).

1 - Voluntary

Code 1 – Merger/Closure-Enter when a facility closes or merges.

Code 2 – Dissatisfaction with Reimbursement-

Enter when a provider or supplier is voluntarily withdrawing because of dissatisfaction with reimbursement.

Code 3 – Risk of Involuntary Termination-Enter when a facility is leaving the program because it is at risk of being involuntarily terminated.

Code 4 – Other Reason for Withdrawal-Enter when a provider or supplier no longer wishes to participate in the program for some other or unknown reason.

2 - Involuntary

Code 5 – Failure to meet health Safety-Enter when a facility fails to meet health or safety requirements (Conditions of Participation, Conditions for Coverage, Conditions for Certification, or Nursing Home Requirements).

Code 6 – Failure to meet agreement-Select this code when a provider fails to meet the terms

of their *provider or supplier* agreement.

NOTE: If code 5 or 6 is selected, then the National Practitioner Data Bank (NPDB) appeal status box is generated in the national data system. The options to select are:

- 1 – No appeal, termination final
- 2 – Appeal in progress
- 3 – All appeals exhausted, termination final

If these codes are selected, please note that the CMS Locations continue to be involved in involuntary terminations.

3 - Other

Code 7 - Select this code when you terminate a currently assigned CCN. Examples include:

- Medicare SNF or dually-participating SNF/NF elects to participate in the Medicaid program only;
- Medicaid NF elects to participate in the Medicare or Medicare and Medicaid programs; and
- An ESRD, or RHC elects to participate as free-standing instead of hospital-based and vice versa.

In any of the above instances, CMS terminates (or SA related to Medicaid providers/suppliers) the existing CCN (complete Items 26 and 28) and assigns the new CCN.

Item 27 - Intermediate Sanctions (ICF/IID Only)

When an ICF/IID is found not to meet the requirements of §1905(d) of the Act and the decision is made to impose an intermediate sanction rather than terminate participation, complete the pertinent items on Form CMS-1539 as follows:

1 - Suspension of Admissions

Enter the date in Item 27A that payments for new admissions in the ICF/IID will be denied. In addition, mark Item 10 with “B” (not in compliance with program requirements). Mark Item 19 “1” (facility is eligible to participate). In Item 25 (extension date), enter a date **not exceeding** the end of the eleventh month following the month in which the denial of payments will be imposed. This date may not be extended.

2 - Rescind Suspension Date

a - Significant Compliance with Program Requirements

Enter the date the denial of payment is rescinded.

The SA will mark Item 10 “A” (in compliance with program requirements) and Item 19 “1” (eligible to participate). In Item 27B, the CMS Location enters the date the denial of payment is rescinded.

NOTE: Items 23 and 24 can only be completed when Item 10 is marked ‘A’ (in compliance with program requirements).

b -Significant Effort or Progress

Item 27b may also be completed when Item 10 is marked “B” (facility is not in compliance with program requirements) and Item 16 (SA Remarks) is documented to show that effort and progress has been made to correct the deficiencies. Item 25 (ICF/IID extension date) remains unchanged. Mark Item 19 with “1” (facility is eligible to participate).

NOTE: Pursuant to 42 CFR 442.119(a), the denial of payment for new admissions is to be rescinded if the facility has corrected deficiencies or can document it is making good faith efforts to achieve compliance with the conditions of participation. Good faith efforts would not, however, constitute compliance with program requirements. Therefore, it is conceivable that:

- The denial of payments could be rescinded;
- Effort and progress would be documented;
- The SA would certify “not in compliance”; and
- The extension would remain in effect.

If the noncompliance deficiencies are not corrected by the 11th month following the initial month of denial, the ICF/IID’s provider agreement must be terminated pursuant to 42 CFR 442.119.

Item 28 - Termination Date

CMS enters the effective date of the termination action specified in Item 26. The SA may annotate the recommended effective date of termination in the notes section under Item 16. CMS issues the final effective date of the termination. Note: The termination date field should reflect the SAs recommendation to the MAC and subsequently CPI/PEOG.

For voluntary terminations, CPI/PEOG is responsible for issuance of the final termination. For involuntary terminations, the CMS Locations remain responsible for issuing the final effective date of termination.

Item 29 – MAC ID Number

Enter the five-digit number assigned to the MAC servicing the provider or supplier of health services. *The SA will receive the MAC ID number within the letters provided by the MAC to the SA upon original request for review of a certification action.*

Item 30 – Remarks

Use this block for any remarks that cannot be covered in the structured items above. If comments exceed space allotted in this item, document the additional comments on a sheet of paper entitled: “Item 30, Continuation for Form CMS-1539.”

Item 31 –Receipt of Form CMS-1539

Enter the date that a certification package is received.

For U.S. Territories (American Samoa; the Commonwealth of the Northern Marianas Islands; Guam and the U.S. Virgin Islands), the CMS Locations will continue to act as the SA, therefore the CMS Location completes Form CMS-1539.

With the exception of the following facilities below which will be completed by the CMS Locations, the MAC will enter applicable information related to the dates into the MACs electronic systems of record.

- Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID),
- Psychiatric Residential Treatment Facilities (PRTFs),
- Nursing Facilities (NFs).
- Critical Access Hospitals (CAHs),
- Religious nonmedical health care institutions (RNHCIs),
- Organ Procurement Organizations (OPOs),
- Rural health clinics (RHCs), or,
- Special Purpose Renal Facilities (SPRDF)

Item 32 - Determination Approval Date

CMS issues the final determination date *which will be given to the provider in the letter of approval from the MAC. This date is completed by the CMS locations for those providers which have not transitioned. The MACs will enter any applicable final information into the MACs electronic systems of record.*

Item 33- Initial Certification Determination Remarks

The SA place any additional comments related to Items 19 or 20 to the remarks section.

Example Guidance for Items 19 & 20

For Initial Certifications of Non Long-Term Care Only

For initial certifications within six months of the initial application to CMS, the following examples apply as outlined within items #19 and 20. If the facility is annotated to not be in compliance per Item #19 Block 2, SAs must complete item 20 on the form. Item 19 may be adjusted three times based on the survey dates of initial certification within the first six months of the application. Item #20 selections on surveys also correlates with Item #6- survey dates.

Item #19.

1- Facility is Eligible to Participate (see Item 6 for survey completion date). Complete Item 20 which will annotate the 1st, 2nd, or 3rd initial survey for certification attempt.

2- Facility is not able to participate at this time

Survey #1					
Check Box if this is the 1 st attempt	See Item #6	Check Box if this is the 2 nd attempt	See #6	Check Box if this is the 3 rd FINAL attempt	See Item #6
SA sends 1539 to MAC; No MAC application status change; CMS-855 pending		SA sends 1539 to MAC; No MAC application status change; CMS-855 pending		Final Determination SA sends 1539 to MAC; MAC Issues Denial Letter and MAC finalizes certification action; will deny provider agreement and provider enrollment *	
MAC Issues Provider Notice		MAC Issues Provider Notice			

OR

Survey #1					
Check Box if this is the 1 st attempt	See Item #6	Check Box if this is the 2 nd attempt	See Item #6	Blank	Blank
SA sends 1539 to MAC; No MAC application status change; CMS-855 pending		Provider has passed the 2 nd attempt at the initial survey and has been found in compliance (Item 19 reflects Code 1)			
MAC Issues Provider Notice		Final Determination SA sends 1539 to MAC; MAC Issues approval Letter to provider, 855 finalized; provider agreement issued and provider enrollment approved.*			

*Provider Agreement: Appeals rights given only. No CAP/recon rights offered.

*Provider Enrollment: Appeals notification will include: CAP/reconsideration/appeals rights specifically related to enrollment.