DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–9880–N]

Medicare and Medicaid Programs; Quarterly Listing of Program Issuances—Fourth Quarter, 1999 through First Quarter, 2002

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Notice.

SUMMARY: This notice lists CMS manual instructions, substantive and interpretive regulations, and other **Federal Register** notices that were published from October 1999, through March 2002, relating to the Medicare and Medicaid programs. This notice also identifies certain devices with investigational device exemption numbers approved by the Food and Drug Administration that potentially may be covered under Medicare, and provides information on national coverage determinations affecting specific medical and health care services under Medicare.

Section 1871(c) of the Social Security Act requires that we publish a list of Medicare issuances in the **Federal Register** at least every 3 months. Although we are not mandated to do so by statute, for the sake of completeness of the listing, we are also including all Medicaid issuances and Medicare and Medicaid substantive and interpretive regulations (proposed and final) published during this timeframe.

FOR FURTHER INFORMATION CONTACT: It is possible that an interested party may have a specific information need and not be able to determine from the listed information whether the issuance or regulation would fulfill that need. Consequently, we are providing information contact persons to answer general questions concerning these items. Copies are not available through the contact persons.

Questions concerning Medicare items in Addendum III may be addressed to Karen Bowman, Office of Communications and Operations Support, Division of Regulations and Issuances, Centers for Medicare & Medicaid Services, C5–13–27, 7500 Security Boulevard, Baltimore, MD 21244–1850, (410) 786–5252.

Questions concerning Medicaid items in Addendum III may be addressed to Cindy Potter, Center for Medicaid State Operations, Policy Coordination and Planning Group, Centers for Medicare & Medicaid Services, S2–01–01, 7500 Security Boulevard, Baltimore, MD 21244–1850, (410) 786–6714.

Questions concerning Food and Drug Administration-approved investigational device exemptions may be addressed to Sharon Hippler, Office of Clinical Standards and Quality, Coverage and Analysis Group, Centers for Medicare & Medicaid Services, C4–11–04, 7500 Security Boulevard, Baltimore, MD 21244–1850, (410) 786–4633.

Questions concerning national coverage determinations should be directed to Kimberly Long, Office of Clinical Standards and Quality, Coverage and Analysis Group, Centers for Medicare & Medicaid Services, S3–11–15, 7500 Security Boulevard, Baltimore, MD 21244–1850, (410) 786–5702.

Questions concerning all other information may be addressed to Christopher McClintick, Office of Communications and Operations Support, Division of Regulations and Issuances, Centers for Medicare & Medicaid Services, C5–13–15, 7500 Security Boulevard, Baltimore, MD 21244–1850, (410) 786–4682.

SUPPLEMENTARY INFORMATION:

I. Program Issuances

The Centers for Medicare & Medicaid Services (CMS) is responsible for administering the Medicare and Medicaid programs. These programs pay for health care and related services for 39 million Medicare beneficiaries and 35 million Medicaid recipients. Administration of these programs involves (1) furnishing information to Medicare beneficiaries and Medicaid recipients, health care providers, and the public and (2) maintaining effective communications with regional offices, State governments, State Medicaid agencies, State survey agencies, various providers of health care, fiscal intermediaries and carriers that process claims and pay bills, and others. To implement the various statutes on which the programs are based, we issue regulations under the authority granted to the Secretary of the Department of Health and Human Services under sections 1102, 1871, 1902, and related provisions of the Social Security Act (the Act). We also issue various manuals, memoranda, and statements necessary to administer the programs efficiently.

Section 1871(c)(1) of the Act requires that we publish a list of all Medicare manual instructions, interpretive rules, statements of policy, and guidelines of general applicability not issued as regulations at least every 3 months in the **Federal Register**. We published our first notice June 9, 1988 (53 FR 21730). Although we are not mandated to do so by statute, for the sake of completeness of the listing of operational and policy statements, we are continuing our practice of including Medicare substantive and interpretive regulations (proposed and final) published during the 3-month time frame.

II. How To Use the Addenda

This notice is organized so that a reader may review the subjects of manual issuances, memoranda, substantive and interpretive regulations, and Food and Drug Administration-approved investigational device exemptions, and national coverage determinations published during the timeframe to determine whether any are of particular interest. We expect this notice to be used in concert with previously published notices. Those unfamiliar with a description of our Medicare manuals may wish to review Table I of our first three notices (53 FR 21730, 53 FR 36891, and 53 FR 50577) published in 1988, and the notice published March 31, 1993 (58 FR 16837). Those desiring information on the Medicare Coverage Issues Manual may wish to review the August 21, 1989 publication (54 FR 34555). Those interested in the procedures used in making national coverage determinations may review the April 27, 1999 publication (64 FR 22619). In this publication, the 1989 proposed rule affecting national coverage procedures and decisions (54 FR 4302) was withdrawn, and the procedures for national coverage determinations established.

To aid the reader, we have organized and divided this current listing into six addenda:

- Addendum I lists the publication dates of the most recent quarterly listings of program issuances.
- Addendum II identifies previous **Federal Register** documents that contain a description of all previously published CMS Medicare and Medicaid manuals and memoranda.
- Addendum III lists a unique CMS transmittal number for each instruction in our manuals or Program Memoranda and its subject matter. A transmittal may consist of a single instruction or many. Often, it is necessary to use information in a transmittal in conjunction with information currently in the manuals.
- Addendum IV lists all substantive and interpretive Medicare and Medicaid regulations and general notices published in the **Federal Register** during the quarters covered by this notice. For each item we list the—
- Date published;

- **Federal Register** citation;
- Parts of the Code of Federal Regulations (CFR) that have changed (if applicable);
- Agency file code number;
- Title of the regulation;
- Ending date of the comment period (if applicable); and
- Effective date (if applicable).
- Addendum V includes listings of the Food and Drug Administration-approved investigational device exemption numbers that have been approved or revised during the quarters covered by this notice. On September 19, 1995, we published a final rule (60 FR 48417) establishing in regulations at 42 CFR 405.201 *et seq.* that certain devices with an investigational device exemption approved by the Food and Drug Administration and certain services related to those devices may be covered under Medicare. It is our practice to announce all investigational device exemption categorizations, using the investigational device exemption numbers the Food and Drug Administration assigns. The listings are organized according to the categories to which the device numbers are assigned (that is, Category A or Category B, and identified by the investigational device exemption number).
- Addendum VI includes completed national coverage determinations from June 28, 1999, the effective date of Medicare's new coverage process. Completed decisions are identified by title, a brief description, effective date, and section in the appropriate federal publication.

III. How To Obtain Listed Material

A. Manuals

Those wishing to subscribe to program manuals should contact either the Government Printing Office (GPO) or the National Technical Information Service (NTIS) at the following addresses:

Superintendent of Documents, Government Printing Office, ATTN: New Orders, P.O. Box 371954, Pittsburgh, PA 15250–7954, Telephone (202) 512–1800, Fax number (202) 512–2250 (for credit card orders); or

National Technical Information Service, Department of Commerce, 5825 Port Royal Road, Springfield, VA 22161, Telephone (703) 487–4630.

In addition, individual manual transmittals and Program Memoranda listed in this notice can be purchased from NTIS. Interested parties should identify the transmittal(s) they want. GPO or NTIS can give complete details on how to obtain the publications they sell. Additionally, most manuals are available at the following Internet address: http://www.hcfa.gov/pubforms/progman.htm.

B. Regulations and Notices

Regulations and notices are published in the daily **Federal Register**. Interested individuals may purchase individual copies or subscribe to the **Federal Register** by contacting the GPO at the address given above. When ordering individual copies, it is necessary to cite either the date of publication or the volume number and page number.

The **Federal Register** is also available on 24x microfiche and as an online database through *GPO Access.* The online database is updated by 6 a.m. each day the **Federal Register** is published. The database includes both text and graphics from Volume 59, Number 1 (January 2, 1994) forward. Free public access is available on a Wide Area Information Server (WAIS) through the Internet and via asynchronous dial-in. Internet users can access the database by using the World Wide Web; the Superintendent of Documents home page address is http://www.access.gpo.gov/nara/index.html, by using local WAIS client software, or by telnet to swais.access.gpo.gov, then log in as guest (no password required). Dial-in users should use communications software and modem to call (202) 512–1661; type swais, then log in as guest (no password required).

C. Rulings

We publish rulings on an infrequent basis. Interested individuals can obtain copies from the nearest CMS Regional Office or review them at the nearest regional depository library. We have, on occasion, published rulings in the **Federal Register**. Rulings, beginning with those released in 1995, are available online, through the CMS Home Page. The Internet address is *http://www.hcfa.gov/regs/rulings.htm.*

D. CMS's Compact Disk-Read Only Memory (CD–ROM)

Our laws, regulations, and manuals are also available on CD–ROM and may be purchased from GPO or NTIS on a subscription or single copy basis. The Superintendent of Documents list ID is HCLRM, and the stock number is 717–139–00000–3. The following material is on the CD–ROM disk:

- Titles XI, XVIII, and XIX of the Act.
- CMS-related regulations.
- CMS manuals and monthly revisions.
- CMS program memoranda.

The titles of the Compilation of the Social Security Laws are current as of January 1, 1999. (Updated titles of the Social Security Laws are available on the Internet at *http://www.ssa.gov/OP_Home/ssact/comp-toc.htm.*) The remaining portions of CD–ROM are updated on a monthly basis.

Because of complaints about the unreadability of the Appendices (Interpretive Guidelines) in the State Operations Manual (SOM), as of March 1995, we deleted these appendices from CD–ROM. We intend to re-visit this issue in the near future and, with the aid of newer technology, we may again be able to include the appendices on CD–ROM.

Any cost report forms incorporated in the manuals are included on the CD–ROM disk as LOTUS files. LOTUS software is needed to view the reports once the files have been copied to a personal computer disk.

IV. How To Review Listed Material

Transmittals or Program Memoranda can be reviewed at a local Federal Depository Library (FDL). Under the FDL program, government publications are sent to approximately 1,400 designated libraries throughout the United States. Some FDLs may have arrangements to transfer material to a local library not designated as an FDL. Contact any library to locate the nearest FDL.

In addition, individuals may contact regional depository libraries that receive and retain at least one copy of most Federal Government publications, either in printed or microfilm form, for use by the general public. These libraries provide reference services and interlibrary loans; however, they are not sales outlets. Individuals may obtain information about the location of the nearest regional depository library from any library.

Superintendent of Documents numbers for each CMS publication are shown in Addendum III, along with the CMS publication and transmittal numbers. To help FDLs locate the materials, use the Superintendent of Documents number, plus the transmittal number. For example, to find the Intermediary Manual, Part 3—Claims Process, (HCFA Pub. 13–3) transmittal entitled ''Mammography Screening,'' use the Superintendent of Documents No. HE 22.8/6 and the transmittal number 1782.

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance, Program No. 93.774, Medicare—Supplementary Medical Insurance Program, and Program No. 93.714, Medical Assistance Program)

Dated: June 20, 2002.

Jacquelyn Y. White,

Director, Office of Communications and Operations Support.

Addendum I

This addendum lists the publication dates of the most recent quarterly listings of program issuances.

June 4, 1998 (63 FR 30499)
August 11, 1998 (63 FR 42857)
September 16, 1998 (63 FR 49598)
December 9, 1998 (63 FR 67899)
May 11, 1999 (64 FR 25351)
November 2, 1999 (64 FR 59185)
December 7, 1999 (64 FR 68357)
January 10, 2000 (65 FR 1400)
May 30, 2000 (65 FR 34481)

Addendum II—Description of Manuals, Memoranda, and HCFA Rulings

An extensive descriptive listing of Medicare manuals and memoranda was published on June 9, 1988, at 53 FR 21730 and supplemented on September 22, 1988, at 53 FR 36891 and December 16, 1988, at 53 FR 50577. Also, a complete description of the Medicare Coverage Issues Manual was published on August 21, 1989, at 54 FR 34555. (Please note that in this publication the 1989 proposed rule referred to, concerning the criteria for national coverage determinations, was withdrawn (64 FR 22619)). A brief description of the various Medicaid manuals and memoranda that we maintain was published on October 16, 1992 (57 FR 47468).

Addendum III.—Medicare and Medicaid Manual Instructions

Transmittal No.	Manual/Subject/Publication No.
	October 1999 through December 1999
	Intermediary Manual **Part 3—Claims Process** **(HCFA Pub. 13–3)** **(Superintendent of Documents No. HE 22.8/6)**
1782	• Mammography Screening
1783	• Clarification of Reimbursement for Transfers That Result in Same Day Hospice Discharge and Admission
1784	• Bill Review for Partial Hospitalization Services Provided in Community Mental Health Centers
1785	• Payment Calculation for Outpatient Claims Medicare Secondary Payment Modules
1786	• Pneumococcal Pneumonia, Influenza Virus and Hepatitis B Vaccines
1787	• Review of Form HCFA—1450 for Inpatient and Outpatient Bills Inpatient Part B Services Outpatient Services Calculating the Part B Payment HCFA Common Procedure Coding System Addition, Deletion, and Change of Local Codes Reporting Hospital Outpatient Services Using HCFA Common Procedure Coding System Hospital Outpatient Partial Hospitalization Services
	Carriers Manual **Part 3—Claims Process** **(HCFA Pub. 14–3)** **(Superintendent of Documents No. HE 22.8/7)**
1650	• Services Eligible for HPSA Bonus Payments Post-Payment Review
1651	• Identifying a Screening Mammography Claim
1652	• Medicare Physician Fee Schedule Database 2000 File Layout
1653	• Type of Service
1654	• Cryosurgery of the Prostate Gland
1655	• HCFA Common Procedure Coding System
1656	• Coverage of Chiropractic Services
1657	• Review of the Health Insurance Claim Form—HCFA–1500, Item 24
	Program Memorandum **Intermediaries (HCFA Pub. 60A)** **(Superintendent of Documents No. HE 22.8/6–5)**
A–99–43	• File Descriptions and Instructions for Retrieving the 2000 Physician, Clinical Lab, Durable Medical Equipment, Prosthetics/Orthotics and Supplies Fee Schedule Payment Amounts through HCFA's Mainframe Telecommunications Systems
A–99–44	• Discharges to Swing Bed Units and other Post-Acute Care Providers
A–99–45	• Requirements for Billing and Processing Claims for Services Subject to Line Item Data of Service Reporting
A–99–46	• Implementation and Corrections to the Federal Register Notice Published August 5, 1999 for Home Health Agency Cost Limitation Effective October 1, 1999
A–99–47	• Extended Repayment Schedules for Home Health Agencies Affected by the Interim Payment System
A–99–48	• Renewal of Program Memorandum A–97–8—Instructions to Implement the New Medicare Summary Notice Combined with Program Memorandum AB–98–31
A–99–49	• Proper Reporting and Acceptance of Non-covered Changes and Related Revenue Codes
A–99–50	• Policy Clarification: Coding for Adequacy of Hemodialysis

ADDENDUM III.—MEDICARE AND MEDICAID MANUAL INSTRUCTIONS—Continued

Transmittal No.	Manual/Subject/Publication No.
A–99–51	• FY 2000 Prospective Payment System Tax, Equity, and Fiscal Responsibility Act Hospital, and Other Bill Processing Changes
A–99–52	• Home Health Agency Instructions for the Provision of Advance Beneficiary Notices And for Mandatory Claims Submission (Demand Bills)
A–99–53	• Skilled Nursing Facility Election of Immediate Transition to 100% Federal Rate and Special Rules for Certain Skilled Nursing Facilities
A–99–54	• Advance Beneficiary Notices Must Be Given To Beneficiaries and Demand Bills Must Be Submitted Promptly By Home Health Agencies
A–99–55	• HAS BEEN RESCINDED AND WILL NOT BE RELEASED
A–99–56	• Reopenings for Sole Community Hospital and Medicare Dependent Hospital Cost Reports Due to the Change to the Cost Report Instructions in Calculating the Hospital Specific Amount on Form HCFA–2552–96 and Form HCFA–2552–92
A–99–57	• Hospital Outpatient Procedures: Billing for Contrast Material (Clarification)
A–99–58	• Hospital Outpatient Procedures: Medicare Changes for Radiology and Other Diagnostic Coding Due to the 1999 HCFA Common Procedure Coding System Update; Revised Modifiers
A–99–59	• New Composite Payment Rates Effective January 1, 2000, and Reopening of the Exception Process Under the End Stage Renal Disease Composite Rate System
A–99–60	• Implementation of H.R. 3426, the Medicare, Medicaid, and the State Child Health Insurance Program Balanced Budget Refinement Act of 1999, P.L. 106–113, Section 303 (a) Which Revises the Per-Beneficiary Limitations on Home Health Agency Costs for Certain Home Health Agencies
A–99–61	• Special Adjustment for Federal Skilled Nursing Facility Prospective Payment Rates and Special Payment Rules Applicable to Certain Skilled Nursing Facilities
A–99–62	• Clarification of Allowable Medicaid Days in the Medicare Disproportionate Share Hospital Adjustment Calculation
	Program Memorandum Carriers (HCFA Pub. 60B) (Superintendent of Documents No. HE 22.8/6–5)
B–99–35	• Enrollment of Independent Diagnostic Testing Facilities
B–99–36	• Schedule for Completing the Calendar Year 2000 Update and Enrollment Process for the Medicare Physician Fee Schedule Database
B–99–37	• Calendar Year 2000 Participation Enrollment and Medicare Participating Physicians and Suppliers Directory Procedures
B–99–38	• Addition of Current Procedural Terminology Code 00300 to Use with G8 Monitored Anesthesia Care Modifier
B–99–39	• Corrections to Calendar Year 2000 Medicare Physician Fee Schedule Database and Year 2000 Fact Sheet
B–99–40	• Delay of Change to Form HCFA–1500 Instructions for Processing Physician Claims in Global Payment Systems (Change Request #457)
B–99–41	• Instructions to Implement the New Medicare Summary Notice Program Memorandum B–98–4 and AB–98–31
B–99–42	• Calculation of National Standard Format for Electronic Remittance Advice Amount Fields and Balancing of Data; and Clarification to Claim Field EAO 21 for Coordination of Benefits
B–99–43	• Issues Related to Critical Care Policy
B–99–44	• Medicare Enrollment of Physical Therapists in Private Practice and Occupational Therapists in Private Practice Effective on or after January 1, 1999
B–99–45	• Emergency Changes to the 2000 Medicare Physician Fee Schedule Database
	Program Memorandum Intermediaries/Carriers (HCFA Pub. 60A/B) (Superintendent of Documents No. HE 22.8/6–5)
AB–99–72	• Instructions for Implementing and Updating 2000 Payment Amounts for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies
AB–99–73	• 2000 Payment Limit for Ambulance Services
AB–99–74	• Clarification to Medicare Carrier Manual § 2130 Prosthetic Devices and Coverage Issues Manual § 60–9 Durable Medical Equipment Reference List—Coverage Intermittent Catheterization
AB–99–75	• Interim Instructions for Processing Claims for Factor VIIa (Coagulation Factor, Recombinant)
AB–99–76	• Education of Medicare Providers on the Adoption of Standard Electronic Health Care Transaction Formats in the United States
AB–99–77	• Implementation of Edits for Prostate Cancer Screening
AB–99–78	• Notice of New Interest Rate for Medicare Overpayments and Underpayments
AB–99–79	• Collection of Comprehensive Encounter Data for Long-Term Care Demonstrations (Social Health Maintenance Organization, EverCare), Dual Eligible Demonstrations and Department of Defense Subvention Demonstration
AB–99–80	• Clinical Diagnostic Laboratory Organ or Disease Panel Codes Billing Procedures for January 2000
AB–99–81	• Calculation of Average Allowed Charges for Residual Items and Services Excluding Ambulance Services, Subject to the Reasonable Charge Payment Methodology
AB–99–82	• Procedures for Reporting of Medicare Contractor *NON*-Medicare Secondary Payer Currently Not Collectible Debts
AB–99–83	• Final Rule Revising and Updating Medicare Policies Concerning Ambulance Services
AB–99–84	• Implementation of Calendar Year 2000 Clinical Diagnostic Laboratory Fee Schedule and Laboratory and Ambulance Costs Subject to Reasonable Charge Payment Methodology in 2000
AB–99–85	• Clinical Diagnostic Laboratory Organ or Disease Panel Codes Claims Processing Procedures for April 2000
AB–99–86	• Durable Medical Equipment Regional Carrier Operating Instructions for New National Coverage of the Continuous Subcutaneous Insulin Infusion Pump, Effective for Services Performed on or after April 1, 2000

ADDENDUM III.—MEDICARE AND MEDICAID MANUAL INSTRUCTIONS—Continued

Transmittal No.	Manual/Subject/Publication No.
AB–99–87	• Clarification of Medicare Coverage of Abortion Services Instruction
AB–99–88	• Program Memorandum on Statements of Intent to File Claims for Claims Filing Periods That End on December 31, 1999
AB–99–89	• Start Date Options for Processing Year 2000 Services
AB–99–90	• Clarification of Program Memorandum Transmittal No. AB–98–35 (Consolidated Billing for Skilled Nursing Facilities) and Revision to Transmittal No. AB–98–18 (Consolidated Billing for Skilled Nursing Facilities)
AB–99–91	• Instructions for Implementing and Tracking the Medicare Fraud and Abuse Incentive Reward Program
AB–99–92	• Temporary Conversion from Bundled Payments to Regular Medicare Payments for The Participating Centers of Excellence Demonstration Testing Beginning with Discharges after December 31, 1998
AB–99–93	• Extension of the Limitation on Payment for Services to Individuals Entitled to Benefits On the Basis of End Stage Renal Disease Who Are Covered by Group Health Plans
AB–99–94	• Reimbursement for Ambulance Services to Non-hospital-Based Dialysis Facilities
AB–99–95	• Access to Eligibility Data by Eligibility Verification Vendors
AB–99–96	• Data Collection for Program Integrity Y2K Contingency Planning
AB–99–97	• HCFA Office of the Inspector General Hotline Referrals
AB–99–98	• Extension of Medicare Benefits for Immunosuppressive Drugs
AB–99–99	• Cervical or Vaginal Smear Tests (Pap Smears) Included in Calendar Year 2000 Clinical Diagnostic Laboratory Fee Schedule
AB–99–100	• Model Acknowledgment Letters for Valid and Invalid Written Statements of Intent to Claim Medicare Benefits (As Referenced In PM Transmittal AB–99–88)
AB–99–101	• Section 221 of the Balanced Budget Refinement Act of 1999 ''Revision of Provisions Relating to Therapy Services''
	Program Memorandum State Survey Agencies (HCFA Pub. 65) (Superintendent of Documents No. HE 22.8/6–5)
99–2	• Guideline and Exhibits Regarding Regulatory Requirements for Comprehensive Assessment and Use of the Outcome and Assessment Information Set
	State Operations Manual Provider Certification (HCFA Pub. 7) (Superintendent of Documents No. HE 22.8/12)
11	• State Agency Identification of Potential Provider and Suppliers Provider-Based Designation Hospital Merger/Multiple Campus Criteria Certification of Hospitals with Multiple Components as Single Hospital
12	• Appendix A, Survey Procedures for Hospitals
13	• Introduction Definitions and Acronyms Emphasis, Components and Applicability Informal Dispute Resolution Certification of Compliance and Noncompliance for Skilled Nursing Facility and Nursing Facilities Action When Facility is not in Substantial Compliance Appeal of Certification of Noncompliance Certification—Related Terms Notice Requirements Timing of Civil Money Penalties Enforcement Action When Immediate Jeopardy Exists Key Dates When Immediate Jeopardy Exists Enforcement Action When Immediate Jeopardy Does Not Exist Special Procedures for Recommending and Providing Notice of Category 1 Remedies and Denial of Payment for New Admissions Key Dates When Immediate Jeopardy Does Not Exist Response to the Plan of Correction New Deficiencies Identified Action When There is Substandard Quality of Care Skilled Nursing Facility/Nursing Facility Readmission to Medicare or Medicaid Program After Termination Enforcement Remedies for Skilled Nursing Facilities and Nursing Facilities Life Safety Code Enforcement Guidelines for Skilled Nursing Facilities and Nursing Facilities Denial of Payment for All New Medicare and Medicaid Admissions for Skilled Nursing Facilities and Nursing Facilities Basis for Imposing Civil Money Penalties Determining Amount of Civil Money Penalty Effective Date of Civil Money Penalty Duration of Civil Money Penalty Appeal of Noncompliance Which Led to Imposition of Civil Money Penalty Notice of Amount Due and Collectible Continuation of Payment During Remediation Sanctions for Inadequate State Survey Performance

ADDENDUM III.—MEDICARE AND MEDICAID MANUAL INSTRUCTIONS—Continued

Transmittal No.	Manual/Subject/Publication No.
	Peer Review Organization Manual (HCFA Pub. 19) (Superintendent of Documents No. HE 22.8/8–15)
77	• Introduction
	Assistants at Cataract Surgery
	Hospital and Medicare+Choice Organization Notices of Non-coverage
	Hospital-Requested Higher-Weighted Diagnostic Related Group Assignments
	Potential Concerns Identified During Project Data Collection
	Referrals
78	• Introduction
	Quality Improvement Project Process
	Selecting a Clinical Topic
	Identifying Quality Indicators
	Measuring Baseline Performance on Quality Indicators
	Developing and Conducting Interventions
	Remeasuring Performance on Quality Indicators
	Documenting and Disseminating Results
	National and Regional Projects
	Local Projects
	Medicare+Choice Organization Projects
	Related Activities through Peer Review Organization, Carrier, Intermediary, and End-Stage Renal Disease Network Cooperation
	Information Collection
	Publication Policy
	Project Data Collection
79	• Notice of Discharge and Medicare Appeal Rights Citations and Authority
	Notice of Discharge and Medicare Appeal Rights
	Medicare Enrollee Request for Peer Review Organization Immediate Review
80	• Physician/Provider Meeting Activities Required by Statute
	Physician/Provider Meeting Activities Required by Peer Review Organization Contract
	Peer Review Organization/Intermediary/Carrier Coordination Activities
	Additional Peer Review Organization/Carrier Coordination Activities
	Background
	Confidentiality Requirements
	Report Requirements
	Publication Requirements
	Hospital Manual (HCFA Pub. 10) (Superintendent of Documents No. HE 22.8/2)
745	• Billing for Mammography Screening
746	• Pneumococcal Pneumonia, Influenza Virus, and Hepatitis B Vaccines
747	• HCFA Common Procedure Coding System
	Reporting Outpatient Services Using HCFA Common Procedure Coding System
	Billing for Hospital Outpatient Partial Hospitalization Services
	Completion of Form HCFA—1450 for Inpatient and/or Outpatient Billing
	Home Health Agency Manual (HCFA Pub. 11) Superintendent of Documents No. HE 22.8/5
291	• Billing for Pneumococcal Pneumonia, Influenza Virus, and Hepatitis B Vaccines
	Skilled Nursing Facility Manual (HCFA Pub. 12) Superintendent of Documents No. HE 22.8/3
361	• Special Billing Instructions for Pneumococcal Pneumonia, Influenza Virus, and Hepatitis B Vaccines

ADDENDUM III.—MEDICARE AND MEDICAID MANUAL INSTRUCTIONS—Continued

Transmittal No.	Manual/Subject/Publication No.
	Medicare Rural Health Clinic & Federally Qualified Health Centers Manual (HCFA Pub. 27) Superintendent of Documents No. HE 22.8/19:985
34	• Billing for Mammography Screening by Rural Health Clinics and Federally Qualified Health Centers
	Medicare Renal Dialysis Facility Manual (Non-Hospital Operated) (HCFA Pub. 29) Superintendent of Documents No. HE 22.8/13
87	• Pneumococcal Pneumonia, Influenza Virus and Hepatitis B Vaccines
	Hospice Manual (HCFA Pub. 21) Superintendent of Documents No. HE 22.8/18
56	• Billing for Covered Medicare Services After Hospice Benefits are Exhausted • Clarification of Reimbursement for Transfers That Result in Same Day Hospice Discharge and Admission
57	• Special Billing Instructions for Pneumococcal Pneumonia, Influenza Virus and Hepatitis B Vaccines
	Outpatient Physical Therapy and Comprehensive Outpatient Rehabilitation Facility Manual (HCFA Pub. 9) Superintendent of Documents No. HE 22.8/9
7	• Billing Instructions for Partial Hospitalization Services Provided in Community Mental Health Centers
8	• Pneumococcal Pneumonia, Influenza Virus, and Hepatitis B Vaccines
	Coverage Issues Manual (HCFA Pub. 6) Superintendent of Documents No. HE 22.8/14
120	• Infusion Pumps
121	• Adult Liver Transplantation
	Provider Reimbursement Manual—Part 1 (HCFA Pub. 15–1) (Superintendent of Documents No. HE 22.8/4)
410	• Dismissal for Lack of Board Jurisdiction Provider Reimbursement Review Board Jurisdiction
411	• Development of Skilled Nursing Facility Inpatient Routine Service Cost Limits Provider Requests Regarding Applicability of Cost Limits Requests Regarding New Provider Exemption General Requirements Intermediary Responsibilities Regarding Exceptions Provider-Based Designation Classification of Skilled Nursing Facilities for Cost Limit Application
412	• Regional Medicare Swing-Bed Skilled Nursing Facility Rates
	Provider Reimbursement Manual—Part 2 Provider Cost Reporting Forms and Instructions Chapter 32—Form HCFA–1728–94 (HCFA Pub. 15–2–32) (Superintendent of Documents No. HE 22.8/4)
8	• Home Health Agency Cost Report
	Provider Reimbursement Manual—Part 2 Provider Cost Reporting Forms and Instructions Chapter 35—Form HCFA–2540–96 (HCFA Pub. 15–2–35) (Superintendent of Documents No. HE 22.8/4)
6	• Skilled Nursing Facility and Skilled Nursing Facility Complex Cost Report
7	• Skilled Nursing Facility and Skilled Nursing Facility Complex Cost Report

ADDENDUM III.—MEDICARE AND MEDICAID MANUAL INSTRUCTIONS—Continued

Transmittal No.	Manual/Subject/Publication No.
	Provider Reimbursement Manual—Part 2 **Provider Cost Reporting Forms and Instructions** **Chapter 36—Form HCFA–2552–96** **(HCFA Pub. 15–2–36)** **(Superintendent of Documents No. HE 22.8/4)**
6	• Hospital and Hospital Health Care Complex, Cost Reporting Form
	Provider Reimbursement Manual—Part 2 **Provider Cost Reporting Forms and Instructions** **Chapter 37—Form HCFA–2540S–97** **(HCFA Pub. 15–2–37)** **(Superintendent of Documents No. HE 22.8/4)**
2	• Skilled Nursing Facility Cost Report
	State Medicaid Manual—Part 4 **Services** **(HCFA Pub. 45–5)** **Superintendent of Documents No. HE 22. 8/10**
73	• Personal Care Services
	Medicare/Medicaid **Sanction—Reinstatement Report** **(HCFA Pub. 69)**
99–10	• Report of Physicians/Practitioners, Providers and/or Other Health Care Suppliers Excluded/Reinstated—September 1999
99–11	• Report of Physicians/Practitioners, Providers and/or Other Health Care Suppliers Excluded/Reinstated—October 1999
99–12	• Report of Physicians/Practitioners, Providers and/or Other Health Care Suppliers Excluded/Reinstated—November 1999
	January 2000 through March 2000
	Intermediary Manual **Part 3—Claims Process** **(HCFA Pub. 13–3)** **(Superintendent of Documents No. HE 22.8/6)**
1788	• Provider Electronic Billing File Record Formats
1789	• HCFA Common Procedure Coding System for Hospital Outpatient Radiology Services and Other Diagnostic Procedures
1790	• Oral Cancer Drugs
1791	• Claims Processing Timeliness
	Carriers Manual **Part 2—Program Administration** **(HCFA Pub. 14–2)** **(Superintendent of Documents No. HE 22.8/7–3)**
140	• Function Standards for Claims Processing Claims Operations
	Carriers Manual **Part 3—Program Administration** **(HCFA Pub. 14–3)** **(Superintendent of Documents No. HE 22.8/7)**
1658	• Billing Requirement for Global Surgeries
1659	• External Counterpulsation
1660	• Clinical Psychologists Services
1661	• National Emphysema Treatment Trial Background Coverage Summary Beneficiaries Participating in the Study Sites of Service Format for Submitted Claims Identifying National Emphysema Treatment Trial Bypassing Existing Edits in Your System Common Working File Processing of National Emphysema Treatment Trial Dates of Service Late Claim Submission Termination of the Beneficiary's Participation Coding Payment Managed Care

ADDENDUM III.—MEDICARE AND MEDICAID MANUAL INSTRUCTIONS—Continued

Transmittal No.		Manual/Subject/Publication No.
		Responding to Billing Questions Denied Claims Participating Clinical Center
1662	•	Transmyocardial Revascularization Medicare Coverage of Abortion Services
1663	•	Pancreas Transplants Billing Instructions Pancreas Transplants

Program Memorandum
Intermediaries (HCFA Pub. 60A)
(Superintendent of Documents No. HE 22.8/6–5)

A–00–01	•	Consolidated Billing for Skilled Nursing Facility Patients When Receiving Outpatient Emergency Care in a Medicare-Participating Hospital or Critical Access Hospital
A–00–02	•	Installation of the Medicare Outpatient Code Editor Version 15.1
A–00–03	•	Implementation of H. R. 3426, the Medicare, Medicaid, and the State Child Health Insurance Program Balanced Budget Refinement Act of 1999, P.L 106–113, Section 301 (a) Which Provides an Adjustment to Defray the Cost Incurred by a Home Health Agency Attributable to Data Collection and Reporting Requirements Under the Outcome and Assessment Information Set
A–00–04	•	Provider Statistical and Reimbursement Report Unibill Record
A–00–05	•	Claims Processing Instructions for the National Institutes of Health National Emphysema Treatment Trial
A–00–06	•	Instructions for an End-Stage Renal Disease Facility to Retain Its Previously Approved Exception Payment Rate
A–00–07	•	Addition of Modifiers 25, 58, 78, and 79 to the List of Modifiers Approved for Hospital Outpatient Use and Correction to Program Memorandum A–99–41
A–00–08	•	Payment Safeguard Review of Skilled Nursing Facility Prospective Payment Bills—Updated Instructions
A–00–09	•	Hospital Outpatient Services Prospective Payment System Background
A–00–10	•	Discarding Program Memoranda on Surety Bonds
A–00–11	•	Medicare Home Health Benefit-Section 4615 of the Balanced Budget Act of 1997, Clarification That No Home Health Benefits Are Authorized Based Solely on Drawing Blood
A–00–12	•	Revision of Final Date to Accept Abbreviated Version of the UB–92 for Encounter Data Collection
A–00–13	•	Procedures for Financial Reporting of Medicare Letter of Credit Draws and Collections between the Hospital Insurance and Supplemental Medicare Insurance Trust Funds
A–00–14	•	Hospital Outpatient Radiology Services
A–00–15	•	Hospital Outpatient Procedures: Medicare Changes for Radiology and Other Diagnostic Coding Due to the 1998 HCFA Common Procedure Coding System Update: Changes Miscellaneous
A–00–16	•	The Balanced Budget Refinement Act Revision to PM Trasmittal No. A–99–51: FY 2000 Prospective Payment System and Excluded Hospital Bill Processing Changes—Wage Adjust 75th Percentile Cap of the Target Amounts or Excluded Hospitals and Units

Program Memorandum
Carriers
(HCFA Pub. 60B)
(Superintendent of Documents No. HE 22.8/6–5)

B–00–01	•	Paramedic Intercept Provisions of the Balanced Budget Act of 1997
B–00–02	•	Payment for Teleconsultations in Rural Health Professional Shortage Areas
B–00–03	•	Emergency Change to the 2000 Medicare Physician Fee Schedule Database
B–00–04	•	Fee-for Services Enrollment of Managed Care Organizations for the Indirect Payment Procedure
B–00–05	•	Adjustment to Remittance Advice Explanation of Medicare Benefits and Medicare Summary Notice Messages Generated by Carriers for Services Subject to the Facility/Non-Facility Payment Differential on the Medicare Physician Fee Schedule Database
B–00–06	•	Matrix to Complete Provider/Supplier Enrollment Application (Form HCFA–855)
B–00–07	•	Change to Correct Coding Edits, Version 6.1, Effective April 1, 2000
B–00–08	•	Instruction for Usage of the Revised Oxygen Certificate of Medical Necessity Form 484.2 (11/99)
B–00–09	•	Clarification of Medicare Policies Concerning Ambulance Services
B–00–10	•	First Quarterly Update to the 2000 Medicare Physician Fee Schedule Database
B–00–11	•	Paramedic Intercept—New Definition for Rural
B–00–12	•	Notification Process for Changes to Health Professional Shortage Area Designations
B–00–13	•	Calculation of National Standard Format for Electronic Remittance Advice Amount Fields and Balancing of National Standard Format Data; and Clarification to Claim National Standard Format Field EAO 21 for Coordination of Benefits—Modification of Program Memorandum B–99–42 (CR1016) of December 1999

Program Memorandum
Intermediaries/Carriers
(HCFA Pub. 60A/B)
(Superintendent of Documents No. HE 22.8/6–5)

AB–00–01	•	Prospective Payment System for Outpatient Rehabilitation Services and Application of Financial Limitation
AB–00–02	•	Durable Medical Equipment Regional Carrier—Pre Discharge Delivery of Durable Medical Equipment Prosthetic, Orthotics & Supplies for Fitting and Training
AB–00–03	•	Notice of New Interest Rate for Medicare Overpayments and Underpayments

ADDENDUM III.—MEDICARE AND MEDICAID MANUAL INSTRUCTIONS—Continued

Transmittal No.	Manual/Subject/Publication No.
AB–00–04	• April Quarterly Update for 2000 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Fee Schedule
AB–00–05	• Operating Instructions for Expanded Coverage of the Electrical Osteogenic Stimulator for Fracture Healing. Effective for Services Performed on or after 4/1/2000
AB–00–06	• Do not Forward Initiative
AB–00–07	• Moratorium on Data Center Movements
AB–00–08	• Payment for All Comprehensive Outpatient Rehabilitation Facility Services Under the Medicare Physician Fee Schedule
AB–00–09	• Transmittal number AB–00–09 has been reserved for Y2k contingency planning and will have a limited distribution.
AB–00–10	• Implementing Instructions for Services Provided in Religious Nonmedical Health Care Institutions
AB–00–11	• Medicare Secondary Payer—Identification and Write Off/Adjustment of Medicare Secondary Payer Settlement Related Group Health Plan Based Accounts Receivable, and Write Off of Unsupportable
AB–00–12	• Correction to Coordination of Benefits Contractor Numbers
AB–00–13	• New Waived Tests—Effective Data Receipt
AB–00–14	• Questions and Answers Regarding the Prospective Payment System for Outpatient Rehabilitation Services and Physical Medicine Current Procedural Terminology Coding Guidance
AB–00–15	• Delay of Hyperbaric Oxygen Therapy Coverage Policy
AB–00–16	• Instructions to All Medicare Contractors for Reporting Audited Year 2000 Costs on the Final Administrative Costs Proposals
AB–00–17	• Clarification of Liver Transplant Policy
AB–00–18	• Consolidated Billing for Skilled Nursing Facilities—The Balanced Budget Refinement Act of 1999
AB–00–19	• Access to Eligibility Data by Eligibility Verification Vendors
AB–00–20	• Guidance on April Release Implementation
	State Operations Manual Provider Certification (HCFA Pub. 7) (Superintendent of Documents No. HE 22.8/12)
14	• Nurse Aid Training and Competency Evaluation Programs and Competency Evaluation Programs
	Peer Review Organization Manual (HCFA Pub. 19) (Superintendent of Documents No. HE 22.8/8–15)
81	• Peer Review Organization Responsibilities • Background • Statutory Authority for Memorandum of Agreement • Scope • Provider Memorandum of Agreement Specifications • Introduction • Intermediary/Carrier Memorandum of Agreement Specifications
	Hospital Manual (HCFA Pub. 10) (Superintendent of Documents No. HE 22.8/2)
748	• HCFA Common Procedure Coding System for Hospital Outpatient Radiology Services and Other Diagnostic Procedures
749	• Oral Cancer Drugs Oral Anti-Nausea Drugs as Full Therapeutic Replacements for Intravenous Dosage Forms as Part of a Cancer Chemotherapeutic Regimen
750	• Claims Processing Timelines
	Home Health Agency Manual (HCFA Pub. 11) Superintendent of Documents No. HE 22.8/5
292	• Claims Processing Timeliness **Skilled Nursing Facility Manual (HCFA Pub. 12)Superintendent of Documents No. HE 22.8/3**
362	• Claims Processing Timeliness
	Rural Health Clinic Manual & Federally Qualified Health Centers Manual (HCFA Pub. 27) Superintendent of Documents No. He 22.8/19:985
35	• Claims Processing Timeliness
	Renal Dialysis Facility Manual (Non-Hospital Operated) (HCFA Pub. 29) Superintendent of Documents No. 22. 8/13
88	• Claims Processing Timeliness

ADDENDUM III.—MEDICARE AND MEDICAID MANUAL INSTRUCTIONS—Continued

Transmittal No.	Manual/Subject/Publication No.
	Hospice Manual (HCFA Pub. 21) Superintendent of Documents No. HE 22. 8/18
58	• Claims Processing Timeliness
	Outpatient Physical Therapy and Comprehensive Outpatient Rehabilitation Facility Manual (HCFA Pub. 9) Superintendent of Documents No. HE 22. 8/9
9	• Claims Processing Timeliness
	Coverage Issues Manual (HCFA Pub. 6)Superintendent of Documents No. HE 22. 8/14
122	• External Counterpulsation for Severe Angina
123	• Osteogenic Stimulation
	Provider Reimbursement Manual—Part 1 (HCFA Pub. 15–1) (Superintendent of Documents No. HE 22.8/4)
413	• Travel Expense
	State Medicaid Manual Part 2—State Organization and General Administration (HCFA Pub. 45–2) Superintendent of Documents No. HE 22. 8/10
92	• Compliance with Disclosure of Information on Physician Incentive Plan Regulations
	Medicare/Medicaid Sanction—Reinstatement Report (HCFA Pub. 69)
00–01	Report of Physicians/Practitioners, Providers and/or Other Health Care Suppliers Excluded/Reinstated—December 1999
00–02	Report of Physicians/Practitioners, Providers and/or Other Health Care Suppliers Excluded/Reinstated—January 2000
00–03	Report of Physicians/Practitioners, Providers and/or Other Health Care Suppliers Excluded/Reinstated—February 2000
	[April 2000 through June 2000]
	Intermediary Manual Part 2—Claims Process (HCFA Pub. 13–2) (Superintendent of Documents No. HE 22.8/6)
413	• Assessment of Benefit Savings Attributable to Medical Review Activities
414	• These Manual Changes Reflect Budget Performance Requirements implemented in Fiscal Year 2000 for the Beneficiary Telephone Customer Service
	Intermediary Manual Part 3—Claims Process (HCFA Pub. 13–3) (Superintendent of Documents No. HE 22.8/6)
1792	• Payment for Blood Clotting Factor Administered to Hemophilia Inpatients
1793	• Clarification of Reimbursement for Transfers That Result in Same Day Hospice Discharge and Admission
1794	• Billing for Abortion Services
1795	• Review of Form HCFA–1450 for Inpatient and Outpatient Bills Review of Hospice Bills
1796	• Provider Electronic Billing File and Record Formats
1797	• Routine Services and Appliances Pneumococcal Pneumonia, Influenza Virus and Hepatitis B Vaccines
1798	• Limitation of Liability for Provider Claims Under Parts A and B of Medicare Program Medical Review for Coverage of Skilled Nursing Facility Services
1799	• Medicare Rural Hospital Flexibility Program Requirements for Critical Access Hospital Services and Critical Access Hospital Long-Term Care Services Payment for Services Furnished by a Critical Access Hospital Services
	Carriers Manual Part 2—Claims Process (HCFA Pub. 14–2) (Superintendent of Documents No. HE 22.8/7)
141	These Manual Changes Reflect Budget Performance Requirements Implemented in Fiscal Year 2000 for Beneficiary Telephone Customer Service

ADDENDUM III.—MEDICARE AND MEDICAID MANUAL INSTRUCTIONS—Continued

Transmittal No.	Manual/Subject/Publication No.
	Carriers Manual Part 3—Claims Process (HCFA Pub. 14–3) (Superintendent of Documents No. HE 22.8/7)
1664	• Payment for Oral Anti-Emetic Drugs When Used as Full Replacement for Intravenous Anti-Emetic Drugs as Part of a Cancer Chemotherapeutic Regimen Claims Processing Jurisdiction
1665	• Correction in Section G, to the Type of Service for 78267 and 78268
1666	• Chiropractic Services
1667	• Reasonableness and Necessity Billing for Pneumococcal, Hepatitis B, and Influenza Virus Vaccines Billing Requirements Payment Requirements Simplified Roster Bills
1668	• Durable Medical Equipment, Prosthetic, and Orthotic Supplies: Contents have been moved to the Program Integrity Manual (Pub. 83) Medical Review Program General Information: Contents have been moved to the Program Integrity Manual (Pub. 83) Fraud and Abuse Background, Exhibits and Appendices: Contents have been moved to the Program Integrity Manual (Pub. 83)
1669	• Durable Medical Equipment Regional Carrier Billing Procedures
	Program Memorandum Intermediaries (HCFA Pub. 60A) (Superintendent of Documents No. HE 22.8/6–5)
A–00–17	• Change to FY 2000 Hospital Prospective Payment System Policies as Required by the Medicare, Medicaid, and State Child Health Insurance Program Balanced Budget Refinement Act of 1999, P. L. 106–113
A–00–18	• Fiscal Intermediary Community Mental Health Center Enrollment and Change of Ownership Site Visit Process and Coordination with National Site Visit Contractor
A–00–19	• Implementation of Provider Enrollment, Chain and Ownership System
A–00–20	• The Report of Benefit Savings
A–00–21	• Revised Outpatient Code Editor Specifications for the Outpatient Prospective Payment System
A–00–22	• Instructions For Reporting Additional Detailed Information of Form HCFA–750 Contractor Financial Report (Fiscal Intermediaries Only)
A–00–23	• Hospital Outpatient Prospective Payment System Implementation Instructions
A–00–24	• Upcoming Training on Home Health Prospective Payment System, Outpatient Prospective Payment System and Skilled Nursing Prospective Payment System Refinements and Consolidated Billing
A–00–25	• Provider Statistical and Reimbursement Report
A–00–26	• Payment of Skilled Nursing Facility Claims for Beneficiaries Disenrolling from Terminating Medicare+Choice Plans Who Have Not Met the 3-Day Stay Requirement
A–00–27	• Permitting Reclassification of Certain Urban Hospitals as Rural Application Procedures
A–00–28	• Clarification of Provider Cost Report Filing Requirements
A–00–29	• Electronic Filing of Provider Cost Reports; Home Health Agencies and Skilled Nursing Facilities
A–00–30	• Announcement of Medicare Rural Health Clinics and Federally Qualified Health Centers Payment Rate Increases and Policy Clarifications and Guidance for Services Furnished by Rural Health Clinics and Federally Qualified Health Centers
A–00–31	• Reporting a Patient's Reason for Visit on a Part A Outpatient Claim
A–00–32	• Effectuating Favorable Final Appellate Decisions That a Beneficiary is ''Confined to Home''—Regional Home Health Intermediaries Only
A–00–33	• Education and Outreach to Coordination of Benefits Trading Partners
A–00–34	• Provider Statistical and Reimbursement Report
A–00–35	• Revised Outpatient Code Editor Specifications for the Outpatient Prospective Payment System
A–00–36	• Hospital Outpatient Prospective Payment System Implementation Instructions
A–00–37	• Line Item Denials and the Reporting of Savings Generated by Claim Expansion and Line Item Processing
	Program Memorandum Carriers (HCFA Pub. 60B) (Superintendent of Documents No. HE 22.8/6–5)
B–00–14	• Revisions to Durable Medical Equipment Regional Carrier Information Form (DIF) Immunosuppressive Drugs Durable Medical Equipment Regional Carrier Form (latest revision 7/25/95)
B–00–15	• Change to Health Insurance Claim Form HCFA–1500 Instructions for Processing Physician Claims in Global Payment Systems
B–00–16	• Provider Education Article: Role of Physicians in the Home Health Prospective Payment System
B–00–17	• Emergency Changes to the 2000 Medicare Physician Fee Schedule Database
B–00–18	• Emergency Changes to the 2000 Medicare Physician Fee Schedule Database
B–00–19	• Durable Medical Equipment Regional Carrier Report on Expansion of Immunosuppressive Drugs
B–00–20	• Collection and Submission of Data for the Provider Enrollment and Chain Ownership System
B–00–21	• 2000 Jurisdiction List
B–00–22	• Durable Medical Equipment Regional Carriers and New Oral Anti-Cancer Drugs Approved for Use by Medicare

ADDENDUM III.—MEDICARE AND MEDICAID MANUAL INSTRUCTIONS—Continued

Transmittal No.	Manual/Subject/Publication No.
B–00–23	• Business Requirements For Processing Physician Encounter Data In The HCFA Data Center
B–00–24	• Issues Involving Certificates of Medical Necessity Certified Medical Necessity and Cover Letters for Certified Medical Necessity
B–00–25	• New Temporary K Codes for Hydrogel Impregnated Gauze
B–00–26	• Carrier Adjustments to be Made for Payment for HCFA Common Procedure Coding System Code 90669, Pneumococcal Conjugate Vaccine, Polyvalent, for Intramuscular Use
B–00–27	• Durable Medical Equipment Regional Carriers Common Working File Changes for Codes J8999, E0784, E0781, A4230–4232, E0616, and E0749
B–00–28	• Billing of Influenza (Flu) and Pneumococcal Pneumonia Vaccine Virus Claims for Authorized Centralized Billing Providers to be Processed Through One Designated Carrier
B–00–29	• Correct Effective Date for Adjustment in Payment Amounts for New Technology Intraocular Lenses Furnished by Medicare-Approved Ambulatory Surgical Centers
B–00–30	• Clarification of Billing for G0170 and G0171
B–00–31	• Use of Common Procedural Terminology Code 33999 for Transmyocardial Revascularization
B–00–32	• Common Procedural Terminology Codes 99214 and 99233
B–00–33	• Changes to Correct Coding Edits, Version 6.2, Effective July 1, 2000
	Program Memorandum Intermediaries/Carriers (HCFA Pub. 60A/B) (Superintendent of Documents No. HE 22.8/6–5)
AB–00–21	• Self-Administered Injectable Drugs and Biologicals
AB–00–22	• ''No Fee'' Policy for Medicare Contractors' Provider Education and Training Activities Program Management and Medicare Integrity Program Funded Activities
AB–00–23	• Medigap (Medicare Supplemental Insurance) Insurers Fraud Referrals
AB–00–24	• Development and Dissemination of a Product Classification List for HCFA Common Procedure Coding System Code L0430
AB–00–25	• Contractor Testing Requirements
AB–00–26	• July Quarterly Update for 2000 Durable Medical Equipment, Prosthetics Orthotics, and Supplies
AB–00–27	• Medicare Secondary Payer Government Performance and Results Act Goal for Fiscal Year 2000
AB–00–28	• Update of Rates for Ambulatory Surgical Center Payments
AB–00–29	• Comprehensive Error Rate Testing Program—Medicare Contractor Change Requirements and Medicare Part B/Durable Medical Equipment Regional Carrier Standard System Change Requirements
AB–00–30	• Implementing Instructions for Services Provided in Religious Nonmedical Health Care Institutions
AB–00–31	• Sending Common Working File Referrals for Initial Enrollment Questionnaire and Internal Revenue Services/Social Security Administration/Health Care Financing Administration Data Match Records to the Coordination of Benefits Contractor
AB–00–32	• New Waived Tests
AB–00–33	• Processing of Medicare+Choice Encounter Data at the Health Care Financing Administration Data Center
AB–00–34	• Program Integrity Management Reporting System
AB–00–35	• Further Guidance on April Release Implementation
AB–00–36	• Transfer of Initial Medicare Secondary Payer Development Activities to the Coordination of Benefits Contractor
AB–00–37	• Notice of New Interest Rate for Medicare Overpayments and Underpayments
AB–00–38	• Consolidation of Program Memorandums for Outpatient Rehabilitation Therapy Services
AB–00–39	• Consolidation of Program Memorandums for Outpatient Rehabilitation Therapy Services
AB–00–40	• Written Statements of Intent to Claim Medicare Benefits; 60-Day Grace Period
AB–00–41	• Procedures for the Benefit Integrity and Medical Review Units on Unsolicited Voluntary Refund Checks
AB–00–42	• Claims Processing Instructions for the Medicare Coordinated Care Demonstration
AB–00–43	• Program Memorandum on Written Statements of Intent to Claim Medicare Benefits
AB–00–44	• Medicare Coverage of Non-Invasive Vascular Studies When Used to Monitor the Access Site of End-Stage Renal Disease Patients
AB–00–45	• Award of Medicare+Choice Contract to Sterling Life Insurance Co., Inc. for Medicare+Choice Private Fee-for-Service Plan
AB–00–46	• Health Care Financing Administration Policy for Disclosure of Individually Identifiable Information
AB–00–47	• Release to Be Implemented June 5, 2000
AB–00–48	• Model Acknowledgment Letters for Valid and Invalid Written Statements of Intent to Claim Medicare Benefits (As Referenced in PM Transmittal AB–99–88)
AB–00–49	• Program Memorandum on Statements of Intent to File Claims for Claims Filing Periods that End on December 31, 1999
AB–00–50	• Medicare Fraud Information Specialist Position
AB–00–51	• Claims Processing Instructions for Claims Submitted With a Written Statement of Intent
AB–00–52	• Assisted Suicide Funding Restriction Act of 1997 (P. L. 105–12)
AB–00–53	• Suspension of National Coverage Policy on Electrostimulation for Wound Healing
AB–00–54	• Modified Procedures for Sharing Health Care Financing Administration Data with the Department of Justice
AB–00–55	• Hemodialysis Flow Study
AB–00–56	• Memorandum of Understanding Between the Office of Inspector General and the Department of Justice—Sharing Fraud Referrals
AB–00–57	• Contractor Updating of the International Classification of Diseases, Ninth Revision, Clinical Modification
AB–00–58	• Guidance on Implementation of the Calendar Year 2000 Third Quarter Release
AB–00–59	• Correction to July Quarterly Update for 2000 Durable Medical Equipment Prosthetics, Orthotics, and Supplies Fee Schedule
AB–00–60	• Future Software Releases

ADDENDUM III.—MEDICARE AND MEDICAID MANUAL INSTRUCTIONS—Continued

Transmittal No.	Manual/Subject/Publication No.
AB–00–61	• New Waived Tests
AB–00–62	• Rescinding Change Requests Numbers 1001, 1108, 1116, and 1163
AB–00–63	• Ocular Photodynamic Therapy
AB–00–64	• Medicare Summary Notice Implementation at Seven Contractor Sites
AB–00–65	• Business and System Requirements for the Home Health Prospective Payment System
	State Operations Manual—Provider Certification (HCFA Pub. 7) Superintendent of Documents No. HE 22.8/12
16	• Medicare/Medicaid Certification and Transmittal, Form HCFA–1539 Change in Size or Location of Participating Skilled Nursing Facility and/or Nursing Facility Regional Office Verifying Continued Compliance with Exclusion Criteria by Currently Excluded Hospitals or Units Change in Size or Location of Participating Skilled Nursing Facility and/or Nursing Facility Change in Provider Location and/or Bed Complement—Other Than Distinct Part
17	• Condition of Participation: Patients' Rights
	Hospice Manual (HCFA Pub. 10) (Superintendent of Documents No. HE 22.8/2)
751	• Payment for Blood Clotting Factor Administered to Hemophilia Inpatients
752	• Billing for Mammography Screening
753	• Billing for Abortion Services
754	• Pneumococcal Pneumonia, Influenza Virus, and Hepatitis B Vaccines
755	• Disclosure of Itemized Statement to an Individual for Any Item or Service Provided
756	• Fraud and Abuse—General: Contents have been moved to the Program Integrity Manual (Pub. 83) Focused Medical Review: Contents have been moved to the Program Integrity Manual (Pub. 83) Billing for Part B Intermediary Outpatient Occupational Therapy Services: Contents have been moved to the Program Integrity Manual (Pub. 83) Special Instructions for Billing Dysphagia: Contents have been moved to the Program Integrity Manual (Pub. 83)
757	• Medicare Rural Hospital Flexibility Program Requirements for Critical Access Hospital Services and Critical Access Hospital Long-term Care Services Payment for Services Furnished by a Critical Access Hospital
	Home Health Agency Manual (HCFA Pub. 11) Superintendent of Documents No. HE 22.8/5
293	• Billing for Pneumococcal Pneumonia, Influenza Virus, and Hepatitis B Vaccines
294	• Disclosure of Itemized Statement to an Individual for Any Item or Service Provided
295	• Fraud and Abuse—General: Contents have been moved to the Program Integrity Manual (Pub. 83) Billing for Part B—Outpatient Physical Therapy Services: Contents have been moved to the Program Integrity Manual (Pub. 83) Focused Medical Review: Contents have been moved to the Program Integrity Manual (Pub. 83)
	Skilled Nursing Facility Manual (HCFA Pub. 12) Superintendent of Documents No. HE 22.8/3
363	• Special Billing Instructions for Pneumococcal Pneumonia, Influenza Virus and Hepatitis B Vaccines
364	• Distinct Part of an Institution as a Skilled Nursing Facility
365	• Disclosure of Itemized Statement to an Individual for Any Item or Service Provided
366	• Fraud and Abuse—General: Contents have been moved to the Program Integrity Manual (Pub. 83) Focused Medical Review: Contents have been moved to the Program Integrity Manual (Pub. 83) Billing Part B Intermediary Outpatient Physical Therapy Bills: Contents have been moved to the Program Integrity Manual (Pub. 83)
	Rural Health Clinic Manual & Federally Qualified
	Health Centers Manual (HCFA Pub. 27) Superintendent of Documents No. He 22. 8/19:985
36	• Disclosure of Itemized Statement to an Individual for Any Item or Service Provided
	Renal Dialysis Facility Manual (Non-Hospital Operated) (HCFA Pub. 29) Superintendent of Documents No. 22.8/13
89	• Pneumococcal Pneumonia, Influenza Virus and Hepatitis B Vaccines
90	• Disclosure of Itemized Statement to an Individual for Any Item or Service Provided

ADDENDUM III.—MEDICARE AND MEDICAID MANUAL INSTRUCTIONS—Continued

Transmittal No.	Manual/Subject/Publication No.
	ESRD Network Organizations Manual (HCFA Pub. 81) Superintendent of Documents No. HE 22.9/4
10	• Organizational Structure Medical Review Board Other Committees Network Staff Administrative Reports Health Care Financing Administration Meeting Cooperative Activities with State Survey Agencies and Peer Review Organizations Annual Report Format
	Hospice Manual (HCFA Pub. 21) Superintendent of Documents No. HE 22.8/18
59	• Completion of the Uniform (Institutional Provider) Bill (HCFA–1450) for Hospice Bills
60	• Special Billing Instructions for Pneumococcal Pneumonia, Influenza Virus and Hepatitis B Vaccines
61	• Disclosure of Itemized Statement to an Individual for Any Item or Services Provided
62	• Fraud and Abuse: Contents have been moved to the Program Integrity Manual (Pub. 83) Focused Medical Review: Contents have been moved to the Program Integrity Manual (Pub. 83)
	Outpatient Physical Therapy and Comprehensive Outpatient Rehabilitation Facility Manual (HCFA Pub. 9) Superintendent of Documents No. HE 22.8/9
10	• Pneumococcal Pneumonia, influenza Virus, and Hepatitis B Vaccines
11	• Disclosure of Itemized Statement to an Individual for Any Item or Service Provided
12	• Fraud and Abuse—General: Contents have been moved to the Program Integrity Manual (Pub. 83) Medical Review of Comprehensive Outpatient Rehabilitation Facility Claims: Contents have been moved to the Program Integrity Manual (Pub. 83) Focused Medical Review: Contents have been moved to the Program Integrity Manual (Pub. 83) Intermediary Medical Review of Part B Outpatient Physical Therapy: Contents have been moved to the Program Integrity Manual (Pub. 83)
	Coverage Issues Manual (HCFA Pub. 6) Superintendent of Documents No. HE 22.8/14
124	• Pancreas Transplants
	Provider Reimbursement Manual—Part 1 (HCFA Pub. 15–1) (Superintendent of Documents No. HE 22.8/4)
414	• Effective Date of Change in Bed Size and/or Bed Designation(s) of Participating Skilled Nursing Facility and/or Nursing Facility Requirements for Distinct Part Certification Changes in Bed Size of Participating Skilled Nursing Facility and/or Nursing Facility General Request Filing Requirements Exceptions Change in Designated Bed Location(s) Cost Report Requirement after Change in Bed Size and/or Change in Designated Bed Location(s)
415	• Historical Costs Purchase of Facility as Ongoing Operation Useful Life of Depreciable Assets Salvage Value Disposal of Assets Gains or Loss on Disposal of Depreciable Assets (Excluding Involuntary Conversions) Bona Fide Sale Sale and Leaseback and Lease-Purchase Agreement
416	• Right to Board Hearing Individual Appeals Group Appeals Expedited Judicial Review Request for Board Hearing or for Expedited Judicial Review

ADDENDUM III.—MEDICARE AND MEDICAID MANUAL INSTRUCTIONS—Continued

Transmittal No.		Manual/Subject/Publication No.
		Provider Reimbursement Manual—Part 2 **Provider Cost Reporting Forms and Instructions** **Chapter 18—Form HCFA–2088–92** **(HCFA Pub. 15–2–32)** **(Superintendent of Documents No. HE 22.8/4)**
9	•	Home Health Agency Cost Reporting Form HCFA–1728–94
		State Medicaid Manual—Part 4/Services **(HCFA Pub. 45–6)** **Superintendent of Documents No. HE 22.8/10**
36	•	Updates ingredient prices used by States to establish upper limits for prescription drugs
		Medicare Program Integrity Manual **(HCFA Pub. 83)**
1	•	Medical Review and Benefit Integrity Programs Sources to Identify Aberrancies, and Developing Fraud or Abuse Cases Corrective Actions Examples of Fraudulent Activities Items and Services Having Special Durable Medical Equipment Regional Carrier Review Considerations Intermediary Medical Review Guidelines for Specific Services Medical Review Reports Program Memoranda Medical Review Information Reported Electronically
		Medicare/Medicaid **Sanction—Reinstatement Report** **(HCFA Pub. 69)**
00–04	•	Report of Physicians/Practitioners, Providers and/or Other Health Care Suppliers Excluded Reinstated—March 2000
00–05	•	Report of Physicians/Practitioners, Providers and/or Other Health Care Suppliers Excluded/Reinstated—April 2000
00–06	•	Report of Physicians/Practitioners, Providers and/or Other Health Care Suppliers Excluded/Reinstated—May 2000
		[July through September 2000]
		Intermediary Manual **Part 3—Claims Process** **HCFA Pub. 13–3)** **(Superintendent of Documents No. HE 22.8/6)**
1800	•	Provider Electronic Billing File and Record Formats
1801	•	Prostate Cancer Screening Tests and Procedures
1802	•	Bill Review for Partial Hospitalization Services Provided in Community Mental Health Centers
1803	•	Information Regarding the Release of Medicare Eligibility Data New Policy on Releasing Eligibility Data Advise Your Providers and Network Service Vendors Network Service Agreement
1804	•	Review of Form HCFA–1450 for Inpatient and Outpatient Bills Outpatient Services Hospital Outpatient Partial Hospitalization Services Calculating the Part B Payment Addition, Deletion and Change of Local Codes Reporting Hospital Outpatient Services Using Health Care Financing Administration Common Procedure Coding System
1805	•	Stem Cell Transplantation Allogeneic Stem Cell Transplantation Autologous Stem Cell Transplantation Acquisition Costs
1806	•	Pancreas Transplants
1807	•	Screening Pap Smears and Screening Pelvic Examinations
1808	•	Billing by Home Health Agencies Under Cost/Interim Payment System Reimbursement Billing by Home Health Agencies Under the Home Health Prospective Payment System When Bills Are Submitted Billing for Nonvisit Charges Durable Medical Equipment Furnished as a Home Health Benefit More Than One Agency Furnished Home Health Services Home Health Services Are Suspended or Terminated Then Reinstated Preparation of a Home Health Billing Form in No-Payment Situations Billing for Part B Medical and Other Health Services Reimbursement of Home Health Agency Claims

ADDENDUM III.—MEDICARE AND MEDICAID MANUAL INSTRUCTIONS—Continued

Transmittal No.	Manual/Subject/Publication No.
	Osteoporosis Injections as Home Health Agency Benefit
	Completion of Form HCFA–1450 for Home Health Agency Billing Under Home Health Prospective Payment
	Requests for Anticipated Payment
	Home Health Prospective Payment System Claims
	Home Health Prospective Payment System Claims When No Request for Anticipated Payment Was Submitted
	Background on Home Health Prospective Payment System
	Creation of Home Health Prospective Payment System
	Regulatory Implementation of Home Health Prospective Payment System
	Commonalities of the Cost Reimbursement and Home Health Prospective Payment System Environment
	Effective Date and Scope of Home Health Prospective Payment System for Claims
	Configuration of the Home Health Prospective Payment System Environment
	New Software for the Home Health Prospective Payment System Environment
	The Home Health Prospective Payment System Episodes
	Effect of Election of Health Maintenance Organization and Eligibility Changes on Home Health Prospective Payment System Episodes
	Split Percentage Payment of Episodes and Development of Episode Rates
	Basis of Medicare Prospective Payment System and Case Mix
	Coding of Home Health Prospective Payment System Episode Case-Mix Groups
	On Home Health Prospective Payment System Claims: Research Group and Health Insurance Prospective Payment System Codes
	Composition of Health Insurance Prospective Payment System Codes for Home Health Prospective Payment System
	Significance of Health Insurance Prospective Payment Systems
	Overview of the Provider Billing Process Under Home Health Prospective Payment
	Overview—Grouper Links Assessment and Payment
	Overview—Health Insurance Query Access System Shows Primary Home Health Agency
	Overview—Request for Anticipated Payment: Submission and Processing Establishes Home Health Prospective Payment System Episode and Provides First Percentage Payment
	Overview—Claim Submission and Processing Completes Home Health Prospective Payment System Payment, Closes Episode and Performs A–B Shift
	Overview—Payment, Claim Adjustments and Cancellations
	Definition of the Request for Anticipated Payment
	Definition of Transfer Situation Under Home Health Prospective Payment System
	Payment Effects
	Payment When Death Occurs During a Home Health Prospective Payment System Episode
	Adjustments of Episode Payment—Low Utilization Payment Adjustments
	Adjustments of Episode Payment—Low Utilization Payment Adjustment
	Adjustments of Episode Payment—Special Submission Case: ''No-Request Anticipated Payment'' Low Utilization Payment Adjustments
	Adjustments of Episode Payment—Therapy Threshold
	Adjustments of Episode Payment—Partial Episode Payment
	Adjustments of Episode Payment—Significant Change in Condition
	Adjustments of Episode Payment—Outlier Payments
	Adjustments of Episode Payment—Exclusivity and Multiplicity of Adjustments
	Seven Scenarios for Home Health Prospective Payment Adjustment
	General Guidance on Line Item Billing Under Home Health Prospective Payment System
	Acronym Table
	Home Health Prospective Payment System Consolidated Billing and Primary Home Health Agency
	New Common Working File Requirements for the Home Health Prospective Payment System
	Creation of the Health Insurance Query System for Home Health Agencies And Hospices in the Common Working File—Replacement of Health Insurance Query System for Home Health Agencies
	Health Insurance Query Access System Inquiry and Response
	Timeliness and Limitations of Health Insurance Query System for Home Health Agency Responses
	Inquiries to Regional Home Health Intermediaries Based on Health Insurance Query System for Home Health Agency Responses
	National Home Health Prospective Payment Episode History File
	Opening and Length of Home Health Prospective Payment System Episodes
	Closing, Adjusting and Prioritizing Home Health Prospective Payment System
	Episodes Based on Request for Anticipated Payment and Home Health Prospective Payment System
	Episodes Based on Request for Anticipated Payment and Home Health Agency Claim Activity
	Other Editing and Changes for Home Health Prospective Payment System Episodes
	Priority Among Other Claim Types and Home Health Prospective Payment System
	Consolidated Billing for Episodes
	Medicare Secondary Payment and the Home Health Prospective Payment System Episode File
	Chart Summarizing Effects of Request for Anticipated Payment/Claim Actions on the Home Health Prospective Payment System Episode File
	Home Health Prospective Payment System Episode File Pricer Program
	Outpatient Prospective Payment System Remittance Advice Instructions and 3753, Home Health Prospective Payment System Remittance Advice Instructions
1809	• Under Arrangements
	Outpatient Hospital Psychiatric Services
	Partial Hospitalization Services

ADDENDUM III.—MEDICARE AND MEDICAID MANUAL INSTRUCTIONS—Continued

Transmittal No.		Manual/Subject/Publication No.
1810	•	Definition of Medicare Secondary Payer/Common Working File Medicare Secondary Payer Maintenance Transaction Record Processing
		Carriers Manual Part 3—Claims Process (HCFA Pub. 14–3) (Superintendent of Documents No. HE 22.8/7)
1670	•	Echocardiography Services (Codes 93303—93350)
1671	•	Magnetic Resonance Angiography Magnetic Resonance Angiography Coverage Summary Coding Requirements Payment Requirements and Methodology Format for Submitting Medicare Carrier Claims Claims Editing
1672	•	Claims Processing Jurisdiction
1673	•	Information Regarding the Release of Medicare Eligibility Data New Policy on Releasing Eligibility Data Advise Your Provider and Network Services Vendors Network Service Agreement
1674	•	Stem Cell Transplantation General HCFA Common Procedure Coding System and Diagnosis Code Non-Covered Conditions Edits Suggested Medicare Summary Notice/Explanation of Medicare Benefits and Regional Administrator Messages
1675	•	Screening Pap Smear and Pelvic Examination Screening Pap Smears Billing Requirements Common Working File Edits Medicare Summary Notices and Explanation of Your Medicare Benefits Message Remittance Advice Notices Screening Pelvic Examination
1676	•	HCFA Common Procedure Coding System and Payments Requirements Calculating the Frequency Common Working File Edits Correct Coding Requirements Diagnosis Coding Requirements Denial Messages
1677	•	Definition of Medicare Secondary Payor/Common Working File Terms Medicare Secondary Payor Maintenance Transaction Record Processing
1678	•	Medicare Physician Fee Schedule Database 2001 File Layout
		Carriers Manual Part 4—Professional Relations (HCFA Pub. 14–4) (Superintendent of Documents No. HE 22.8/7–4
22	•	Enrollment Procedures for General Application
		Program Memorandum Intermediaries (HCFA Pub. 60A) (Superintendent of Documents No. HE 22.8/6–5)
A–00–38	•	Change in Hospice Payment Rates, Update to the Hospice Cap, Revised Hospice Wage Index and Hospice Pricer
A–00–39	•	Monitoring Process for Skilled Nursing Facility Exception Determinations
A–00–40	•	Further Information on the Use of Modifier -25 in Reporting Hospital Outpatient Services
A–00–41	•	Transition to the Home Health Prospective Payment System
A–00–42	•	Coding Information for Hospital Outpatient Prospective Payment System
A–00–43	•	Advance Beneficiary Notices for Services for Which Institutional Part B Claims Will be Processed by Fiscal Intermediaries
A–00–44	•	Outpatient Prospective Payment System Contingency Plans and Instructions
A–00–45	•	Interim Process for Certain ''Inpatient Only'' Code Changes
A–00–46	•	Skilled Nursing Facility Adjustment Billing: Adjustments to Health Insurance Prospective Payment System Codes Resulting From Minimum Data Set Corrections
A–00–47	•	Skilled Nursing Facility Annual Update: Prospective Payment System Pricer and Health Insurance Prospective Payment System Coding Changes
A–00–48	•	Drugs, Biologicals, Devices and New Technology HCFA Common Procedure Coding System Codes For Use Under the Hospital Outpatient Prospective Payment System
A–00–49	•	Payment of Skilled Nursing Facility Claims for Beneficiaries Disenrolling From Terminating Medicare+Choice Plans Who Have Not Met the 3-Day Hospital Stay Requirement
A–00–50	•	Department of Veterans Affairs Claims Adjudication Services Project: Systems Changes Needed

ADDENDUM III.—MEDICARE AND MEDICAID MANUAL INSTRUCTIONS—Continued

Transmittal No.	Manual/Subject/Publication No.
A–00–51	• Q Codes For Use Under the Hospital Outpatient Prospective Payment System
A–00–52	• Community Mental Health Centers Payment Instructions For Outpatient Prospective System Contingency Plans
A–00–53	• Proper Billing of Units for Intrathecal Baclofen Under the Outpatient Prospective Payment System
A–00–54	• The Supplemental Security Income Medicare Beneficiary Data for Fiscal Year 1999 for Prospective Payment System Hospitals
A–00–55	• Provider Statistical and Reimbursement Report
A–00–56	• Update of Rates for Ambulatory Surgical Center Payment
A–00–57	• Payment of Skilled Nursing Facility Claims for Beneficiaries Disenrolling from Terminating Medicare+Choice Plans Who Have Not Met the 3-Day Stay Required
A–00–58	• Destroy Outdated Stock of Medicare Summary Notices and Part A Explanation of Medicare Benefits Under the Hospital Outpatient Prospective Payment System
A–00–59	• Home Health Prospective Payment System Phase in Plan, Contingency Plan, and Instructions
A–00–60	• Standard Questions and Answers for Beneficiary Inquiries Related to the Hospital Outpatient Prospective Payment System
A–00–61	• Update 1—Coding Information for Hospital Outpatient Prospective Payment System
A–00–62	• File Descriptions and Instructions for Retrieving the 2001 Physician, Clinical Lab, Durable Medical Equipment, Prosthetics/Orthotics and Supplies Fee Schedule Payment Amounts Through Health Care Financing Administration's Mainframe Telecommunications Systems
A–00–63	• Cost-to-Charge Ratios for Calculating Certain Payments Under the Hospital Outpatient Prospective Payment System
A–00–64	• Terminating State Access to the Common Working File Eligibility Data
A–00–65	• Release of Internal Revenue Service Data Elements on Eligibility Queries
A–00–66	• Fiscal Year 2001 Prospective Payment System Hospital and Other Bill Processing Changes
A–00–67	• Deactivation of Inactive Community Mental Health Center Medicare Numbers
A–00–68	• Provider Statistical and Reimbursement Report
A–00–69	• Background and Documentation for Correct Coding Initiative and Unit of Service Edits
A–00–70	• Provider Statistical and Reimbursement Report
	Program Memorandum Carriers (HCFA Pub. 60B) (Superintendent of Documents No. HE 22.8/6–5)
B–00–34	• This Transmittal Number Was Inadvertently Skipped and Will Not Be Used In the Future
B–00–35	• Addition of Five ''WW'' Codes to Identify a New Source for Methotrexate
B–00–36	• Returned Mail—Unique Physician Identification Number
B–00–37	• Standard System Acceptance of Primary Payer Information at the Line Level
B–00–38	• Addition of ''WW'' Codes to Identify a New Source for an Oral Anti-Cancer Drug in Dosages of 25mg and 100mg
B–00–39	• Department of Veterans Affairs Claims Adjudication Services Project: Systems Changes Needed
B–00–40	• Final Update to the 2000 Medicare Physician Fee Schedule Database
B–00–41	• Changes to Correct Coding Edits, Version 6.3, Effective October 1, 2000
B–00–42	• Analysis of Services Provided in Congregate Settings
B–00–43	• New Temporary ''K'' Codes for Negative Pressure Wound Therapy Pumps
B–00–44	• Site Visits and Enrollment of Independent Diagnostic Testing Facilities
B–00–45	• Reporting of Carrier Pricing Methodology for Influenza and Pneumococcal Vaccinations to Health Care Financing Administration
B–00–46	• Changes to Correct Coding Edits, Version 6.2, Effective September 5, 2000
B–00–47	• Addition of Special Processing Number 39 (Centralized Billing of Flu and Pneumococcal Pneumonia Vaccine Claims) to the Common Working File
B–00–48	• Claims Processing Instructions for the DME Prosthetic, Orthotics & Supplies Competitive Bidding Demonstration
B–00–49	• Implementation of the Health Insurance Portability and Accountability Act Transaction Standards
	Program Memorandum Intermediaries/Carriers (HCFA Pub. 60A/B) (Superintendent of Documents No. HE 22.8/6–5)
AB–00–66	• Coverage of Diabetes Outpatient Self-Management Training Services, Effective: July 1, 1998
AB–00–67	• Implementation of § 4105 of the Balanced Budget Act Regarding Coverage of Diabetes Outpatient Self-Management Training Services
AB–00–68	• Current Status of Medicare Program Memoranda Issued Before Calendar Year 2000
AB–00–69	• Notice of New Interest Rate for Medicare Overpayments and Underpayments
AB–00–70	• Program Safeguard Contractor for Corporate Integrity Agreements
AB–00–71	• Claims Processing Instructions for the Medicare Coordinated Care Demonstration
AB–00–72	• Medical Review Progressive Corrective Action
AB–00–73	• Proper Billing of Outpatient Pathology Services Under the Outpatient Prospective Payment System
AB–00–74	• Transfer of Initial Medicare Secondary Payer Development Activities to the Coordination of Benefits Contractor
AB–00–75	• The Internal Control Certification Statement Required by the Budget and Performance Requirements for the Fiscal Year Ending September 30, 2000
AB–00–76	• Modification of Medicare Policy for Erythropoietin
AB–00–77	• New State Code for Maryland Provider Numbers
AB–00–78	• Reasonable Charge Update for 2001 for Items and Services, Other than Ambulance Services, Still Subject to the Reasonable Change Payment Methodology

ADDENDUM III.—MEDICARE AND MEDICAID MANUAL INSTRUCTIONS—Continued

Transmittal No.	Manual/Subject/Publication No.
AB–00–79	• Establishment of Contractor Numbers for Program Safeguard Contractors
AB–00–80	• Instruction Implementation Reporting
AB–00–81	• Self-Administered Injectable Drugs and Biologicals
AB–00–82	• Update of Rates and Wage Index for Ambulatory Surgical Center Payments Effective October 1, 2000
AB–00–83	• Verteporfin (Visudyne)
AB–00–84	• Provider Toll-Free Telephone Inquiry Service
AB–00–85	• Guidance on Implementation of the Calendar Year 2000 Fourth Quarter Release
AB–00–86	• An Additional Source of Average Wholesale Price Data in Pricing Drugs and Biologicals Covered by the Medicare Program
AB–00–87	• 2001 Payment Limit for Ambulance Services
AB–00–88	• Implementation of the Ambulance Fee Schedule
AB–00–89	• Claims Processing Instructions for Carriers, Durable Medical Equipment Regional Carrier, Intermediaries and Regional Home Health Intermediaries for Claims Submitted for Medicare Beneficiaries Participating in Medicare Qualifying Clinical Trials
AB–00–90	• Year 2001 Health Care Financing Common Procedure Coding System Annual Update Reminder
	Program Memorandum Medicaid State Agencies (HCFA Pub. 17) Superintendent of Documents No. HE 22.8/6–5
00–01	• Current Status of Medicaid Program Memoranda and Action Transmittals Issued Before Calendar Year 2000
	State Operations Manual—Provider Certification (HCFA Pub. 7) Superintendent of Documents No. HE 22.8/12
18	• Religious Nonmedical Healthcare Institutions Certification of Religious Nonmedical Healthcare Institutions Interpretive Guidelines for Responsibilities of Medicare-Participating Religious Nonmedical Healthcare Institutions
19	• Guidelines for Determining Immediate Jeopardy
20	• Guidance to Surveyors—Long-Term Care Facilities
	Peer Review Organization (HCFA Pub. 19) Superintendent of Documents No.HE 22.8/8–15
82	• Disclosure of Quality Review Information to Complainants Scope of Review Complaints That Do Not Meet Statutory Requirements Referrals Review Process Notice of Disclosure Final Response to Complainants Disclosure of Quality Review Information to Complainants Request for Information Model Form Final Response to Inquirer Model Notice (Concern Involved Practitioners) Potential Quality Concern Model Notice
	Hospice Manual (HCFA Pub. 10) (Superintendent of Documents No. HE 22.8/2)
758	• Prostate Cancer Screening Tests and Procedures
759	• Reporting Hospital Outpatient Services Using Health Care Financing Administration Common Procedure Coding System Billing for Hospital Outpatient Partial Hospitalization Services Completion of Form HCFA–1450 for Inpatient and/or Outpatient Billing Addition, Deletion and Change of Local Codes Reporting Hospital Outpatient Services Using Health Care Financing Administration Common Procedures Coding System
760	• Screening Pap Smears and Screening Pelvic Examinations
761	• Outpatient Hospital Psychiatric Services Outpatient Partial Hospitalization Programs
	Skilled Nursing Facility Manual (HCFA Pub. 12) Superintendent of Documents No. HE 22.8/3
367	• Distinct Part of an Institution as a Skilled Nursing Facility

ADDENDUM III.—MEDICARE AND MEDICAID MANUAL INSTRUCTIONS—Continued

Transmittal No.	Manual/Subject/Publication No.
	ESRD Network Organizations Manual **(HCFA Pub. 81)** **Superintendent of Documents No. HE 22.9/4**
11	• End Stage Renal Disease Health Care Quality Improvement Program Responsibilities Quality Improvement Projects Background and Project Topics Quality Improvement Program Frequency, Project Consultant, and Required Reporting Project Idea Quality Improvement Program Narrative Project Plan Final Project Report Identifying Additional Opportunities for Improvement Quarterly Progress and Status Report Clinical Performance Measures Clinical Performance Measures—Network/National Sample Clinical Performance Measures—Sampling Method Clinical Performance Measures—Data Collection Clinical Performance Measures—Data Validation Clinical Performance Measures—Data Validating Reports Health Care Financing Administration—Compiled Data Reports Network Resources to Support the United States Renal Data System End Stage Renal Disease Clinical Performance Measures Annual Estimate of Patient Sample Per Network for United States Renal Data System Special Studies End Stage Renal Disease Network—Project Idea Document Format End Stage Renal Disease Network—Narrative Project Plan Format End Stage Renal Disease Network—Final Project Report Format
	Hospice Manual **(HCFA Pub. 21)** **Superintendent of Documents No. HE 22.8/18**
63	• Reducing Barriers to Pneumococcal Vaccines
	Outpatient Physical Therapy and Comprehensive Outpatient Rehabilitation Facility Manual **(HCFA Pub. 9)** **Superintendent of Documents No. HE 22.8/9**
13	• Billing Instructions for Partial Hospitalization Services Provided in Community Mental Health Centers
14	• General Partial Hospitalization Defined Patient Eligibility Criteria Documentation Requirements and Physician Supervision Community Mental health Center Requirements Outpatient Mental Health Treatment Limitation Documentation Requirements and Physician Supervision
	Coverage Issues Manual **(HCFA Pub. 6)** **Superintendent of Documents No. HE 22.8/14**
125	• Stem Cell Transplantation
126	• Routine Costs of Clinical Trials
	Provider Reimbursement Manual—Part 1 **(HCFA Pub. 15–1)** **(Superintendent of Documents No. HE 22.8/4)**
417	• Special Treatment of Sole Community Hospitals Under Prospective Payment System
	Provider Reimbursement Manual—Part 2 **Provider Cost Reporting Forms and Instructions** **Chapter 1—General—2088–92** **(HCFA Pub. 15–2–1)** **(Superintendent of Documents No. HE 22.8/4)**
20	• Electronic Submission of Hospital Cost Reports Requirement To File Cost Report Initial Cost Reporting Period Cessation of Participation in Program Cost Report Forms

ADDENDUM III.—MEDICARE AND MEDICAID MANUAL INSTRUCTIONS—Continued

Transmittal No.	Manual/Subject/Publication No.
	Use of Substitute Cost Reporting Forms
	Provider Reimbursement Manual—Part 2 **Provider Cost Reporting Forms and Instructions** **Chapter 35—Form HCFA–2540–96** **(HCFA Pub. 15–2–35)** **(Superintendent of Documents No. HE 22.8/4)**
8	• Skilled Nursing Facility & Complex Cost Report
	Provider Reimbursement Manual—Part 2 **Provider Cost Reporting Forms and Instructions** **Chapter 38—Form HCFA–1984–99** **(HCFA Pub. 15–2–38)** **(Superintendent of Documents No. HE 22.8/4)**
2	• Hospice Cost Report
	Medicare Program Integrity Manual **(HCFA Pub. 83)**
2	• Medical Review of Partial Hospitalization Claims
	Medicare/Medicaid **Sanction—Reinstatement Report** **(HCFA Pub. 69)**
00–07	• Report of Physicians/Practitioners, Providers and/or Other Health Care Suppliers Excluded Reinstated—June 2000
00–08	• Report of Physicians/Practitioners, Providers and/or Other Health Care Suppliers Excluded/Reinstated—July 2000
00–09	• Report of Physicians/Practitioners, Providers and/or Other Health Care Suppliers Excluded/Reinstated—August 2000
	October through December 2000
	Intermediary Manual **Part 3—Claims Process**
	(HCFA Pub. 13–3) **(Superintendent of Documents No. HE 22.8/6)**
1811	• Extracorporeal Immunoadsorption Using Protein A Columns Hospital Outpatient Partial Hospitalization Services
1812	• Dialysis for End-Stage Renal Disease—General
1813	• Provider Electronic Billing File and Record Formats
1814	• Claims Processing Timeliness Beneficiary-Driven Demand Billing Under Home Health Prospective Payment System Prospective Payment System Pricer Program Home Health Agency Bills Denials and Conditional Payments in Medicare Secondary Payer Situations Provider Specific Payment Data Provider Specific Payment Data Record Layout and Description Intermediary Responsibilities The Cancel Only Adjustment Code (Action Code 4)
1815	• Payment for Blood Clotting Factor Administered to Hemophilia Inpatients
1816	• Bill Review for Partial Hospitalization Services Provided In Community Mental Health Centers Hospital Outpatient Partial Hospitalization Services
1817	• Heart Transplants
1818	• Oral Anti-Nausea Drugs as Full Therapeutic Replacements for Intravenous Dosage Forms As Part of a Cancer Chemotherapeutic Regimen
1819	• Pneumococcal Pneumonia, Influenza Virus and Hepatitis B Vaccines
1820	• Review of Form HCFA–1450 for Inpatient and Outpatient Bills
1821	• Beneficiary-Driven Demand Billing Under Home Health Prospective Payment System
	Carriers Manual **Part 3—Claims Process** **(HCFA Pub. 14–3)** **(Superintendent of Documents No. HE 22.8/7)**
1679	• Extracorporeal Immunoadsorption Using Protein A Columns Coverage Summary Coding and Payment Denial Messages
1680	• Beneficiaries Previously Enrolled in Managed Care Who Return to Traditional Fee For Service
1681	• Type of Service

ADDENDUM III.—MEDICARE AND MEDICAID MANUAL INSTRUCTIONS—Continued

Transmittal No.		Manual/Subject/Publication No.
1682	•	Furnishing Medicare Physician Fee Schedule Database Pricing Files Furnishing Physician Fee Schedule Data for Local and Carrier Price Codes Furnishing Physician Fee Schedule Data for National Codes Furnishing Fee Schedule (Excluding Physician Fee Schedule), Prevailing Charge and Conversion Factor Data to Palmetto GBA, Fiscal Intermediaries, State Agencies, Indian Health Services and United Mine Workers Health Maintenance Organization Processing Requirements Specialty Code/Place of Service
1683	•	Durable Medical Equipment Regional Carrier Instructions for Denying Claims For Prescription Drugs Billed and/or Paid to Suppliers Not Licensed to Dispense Prescription Drugs
1684	•	Responsibility to Download and Implement Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Fee Schedules
1685	•	Home Use of Durable Medical Equipment Evidence of Medical Necessity Incurred Expenses for Durable Medical Equipment and Orthotic and Prosthetic Devices Evidence of Medical Necessity Oxygen Claims
1686	•	Type of Service
1687	•	End-Stage Renal Disease Bill Processing Procedures Home Dialysis Patients Options for Billing
1688	•	Durable Medical Equipment Regional Carrier Instructions for Denying Claims for Prescription Drugs Billed and/or Paid to Suppliers Not Licensed to Dispense Prescription Drugs
1689	•	Payment and Coding Requirements Processing Claims to Ensure That Payment Conditions Are Met
		Carriers Manual **Part 4—Professional Relations** **(HCFA Pub. 14–4)** **(Superintendent of Documents No. HE 22.8/7–4)**
23	•	Registry Customer Information Control System
		Program Memorandum **Intermediaries (HCFA Pub. 60A)** **(Superintendent of Documents No. HE 22.8/6–5)**
A–00–71	•	Medical Review of Home Health Services—For Regional Home Health Intermediaries
A–00–72	•	Technical Correction to Coding Information for Hospital Outpatient Prospective Payment System
A–00–73	•	Clarification of Modifier Usage in Reporting Outpatient Hospital Services
A–00–74	•	October Outpatient Code Editor
A–00–75	•	Corrections to Calculation of Inpatient Payment Amounts
A–00–76	•	Clarification of the Application of the Regulations at 42 Code of Federal Regulations 413.134(l) to Mergers and Consolidations Involving Non-Profit Providers
A–00–77	•	Change in Hospice Payment Rates, Update to the Hospice Cap, Revised Hospice Wage Index and Hospice Pricer
A–00–78	•	Provider Statistical and Reimbursement Report
A–00–79	•	Settlement Agreement Between the Health Care Financing Administration and National Medical Care, Inc. d/b/a Fresenius Medical Care North America for Payment of Medicare End-Stage Renal Disease Bad Debts
A–00–80	•	Notification to Outpatient Hospital Service Providers Concerning Deductible and Coinsurance Amounts on Electronic Remittance Advice Version 3051.4a
A–00–81	•	Resolution of Outpatient Prospective Payment System Implementation Issues
A–00–82	•	January 2001 Update: Coding Information for Hospital Outpatient Prospective Payment System
A–00–83	•	Business Requirements for Processing Outpatient Encounter Data in the Health Care Financing Administration Data Center
A–00–84	•	Medicare+Choice Inpatient Encounter Data—Migration of Data Processing to the Health Care Financing Administration Data Center
A–00–85	•	The Report of Benefit Savings
A–00–86	•	Changes to Fiscal Year 2000 Nursing and Allied Health Education Payment Policies as Required by the Medicare, Medicaid, and State Child Health Insurance Program Balanced Budget Refinement Act of 1999, P. L. 106–113
A–00–87	•	Off-Label Use of Oral Chemotherapy Drugs Methotrexate and Cyclophosphamide
A–00–88	•	Fee Schedule and Consolidated Billing for Skilled Nursing Facility Services
A–00–89	•	Implementation of Health Insurance Portability and Accountability Act Transaction Standards—Overview and Specific Instruction for Implementing the Inbound Claim
A–00–90	•	Policy Clarification: Coding for Adequacy of Hemodialysis
A–00–91	•	Inpatient Rehabilitation Facility Prospective Payment System
A–00–92	•	Corrections to Calculation of Federal Fiscal Year 2001 Inpatient Payment Amounts
A–00–93	•	Do Not Forward Initiative, Change Request 681, Transmittal No. AB–00–06, Dated February 2000
A–00–94	•	New End Stage Renal Disease Composite Payment Rates Effective January 1, 2001
A–00–95	•	Renewal of Program Memorandum A–97–8—Instructions to Implement the New Medicare Summary Notice Combined with Program Memorandum AB–98–31
A–00–96	•	Clarification of C-Code Reportable Under the Hospital Outpatient Prospective Payment System
A–00–97	•	Partial Implementation of Change Request 1119
A–00–98	•	Reporting of Outpatient Prospective Payment System and Home Health Prospective Payment System Data in Provider Remittance Advice Transactions

ADDENDUM III.—MEDICARE AND MEDICAID MANUAL INSTRUCTIONS—Continued

Transmittal No.	Manual/Subject/Publication No.
A–00–99	• Medicare Contractor Use of the Regional Home Health Intermediary Outcomes and Assessment Information Set Verification Protocol for Review of Home Health Agency Prospective Payment Bills
A–00–100	• Conversion to the UB–92 Version 6.0 and Continued Use of Version 5.0
A–00–101	• Medicare Outpatient Code Editor Version 16.1
A–00–102	• Hospital Outpatient Prospective Payment System Pass-Through Payment Corrections for Two Radiopharmaceuticals
	Program Memorandum Carriers (HCFA Pub. 60B)
B–00–50	• Home Health Prospective Payment System
B–00–51	• Changes to Correct Coding Edits, Version 7.0, Effective January 1, 2001
B–00–52	• Schedule for Completing the Calendar Year 2001 Fee Schedule Updates and the Participating Physician Enrollment Procedures
B–00–53	• Calendar Year 2001 Participation Enrollment and Medicare-Participating Physicians and Suppliers Directory Procedures
B–00–54	• Program Integrity Management Reporting System
B–00–55	• Durable Medical Equipment Regional Carrier Common Working File to Add ICD–9 Diagnosis Code for Oral Anti-Cancer Drugs
B–00–56	• Durable Medical Equipment Regional Carrier Common Working File Edit# 5211 Services after the Date of Death for Durable Medial Equipment Rental Items
B–00–57	• Part B Outbound X12N 837 Coordination of Benefits Mapping
B–00–58	• Durable Medical Equipment Regional Carriers—Change in Common Working File for Code K0009
B–00–59	• Durable Medical Equipment Regional Carrier—Common Working File Revision for Oxygen Certificate of Medical Necessity
B–00–60	• New Temporary ''K'' Codes for Augmentative and Alternative Communication Devices
B–00–61	• Comprehensive Error Rate Testing Program Requirements for Medicare Contractor Operations
B–00–62	• Promoting Influenza and Pneumococcal Vaccinations
B–00–63	• Medicare Payment Allowance for Flu Vaccine
B–00–64	• Program Integrity Sampling Module for Part B and Durable Medical Equipment Carriers
B–00–65	• 2001 Physician Fee Schedule for Payment Policies
B–00–66	• Durable Medical Equipment Regional Carrier Operating Instructions for Coverage of the Ultrasonic Osteogenic Stimulators for Fracture Healing: Effective for Services Performed on or after 1/1/2001
B–00–67	• Consolidated Billing for Skilled Nursing Facility Residents
B–00–68	• X12N Professional Flat File
B–00–69	• Blood Glucose Test Strips—Marketing to Medicare Beneficiaries
B–00–70	• Changes to Correct Coding Edits, Version 7.1, Effective April 1, 2001
B–00–71	• Addition of a Miscellaneous ''WW'' Code and National Drug Code for Oral Anti-Cancer Drugs
B–00–72	• Instructions to Implement the New Medicare Summary Notice—Program Memorandum B–98–4 and PM AB–98–31
B–00–73	• Correct Coding Initiative Edits Correction: Influenza (G0008), Pneumococcal (G0009), and Hepatitis B (G0010) Vaccine Codes
B–00–74	• Claims Processing Instructions for Carriers To Make Available Claims and Medical Records for a Program Safeguard Contractor Task Order Request for Medical Record Review
B–00–75	• Emergency Changes to the 2001 Medicare Physician Fee Schedule Database
B–00–76	• Revised 2001 Anesthesia Conversion Factors
	Program Memorandum Intermediaries/Carriers (HCFA Pub. 60A/B) (Superintendent of Documents No. HE 22.8/6–5)
AB–00–91	• Mammography Screening Payment Limit for Calendar Year 2001
AB–00–92	• Sending Common Working File Referrals for Initial Enrollment Questionnaire and Internal Revenue Services/Social Social Security Administration/Health Care Financing Administration Data Match Records to the Coordination of Benefits Contractor
AB–00–93	• Coordination With the Y2K Program Safeguard Contractor
AB–00–94	• Urokinase (Abbokinas) Shortage
AB–00–95	• Facility Requirements for Transplantation Centers
AB–00–96	• Clarification of Fiscal Intermediary and Durable Medical Equipment Regional Carrier Responsibilities Concerning Home Dialysis Method Election and Claims Processing
AB–00–97	• Notification to Providers and Suppliers of Transaction and Code Set Rule Promulgated In Accordance With the Health Insurance Portability and Accountability Act
AB–00–98	• Medicare Deductible and Premium Rates for Calendar Year 2001
AB–00–99	• Glucose Monitoring Note
AB–00–100	• Mandatory Training on Ambulance Fee Schedule
AB–00–101	• Notice of Interest Rate for Medicare Overpayments and Underpayments
AB–00–102	• Clarification to Medicare Carriers Manual § 2130 Prosthetic Devices and Coverage Issues Manual § 60–9 Durable Medical Equipment Reference List—Coverage of Intermittent Catheterization
AB–00–103	• Final Rule Revising and Updating Medicare Polices Concerning Ambulance Services
AB–00–104	• Autologous Stem Cell Transplantation for Patients with Multiple Myeloma
AB–00–105	• New Waived Test—November 9, 2000
AB–00–106	• Establishment of Provider/Supplier Information and Education Resource Directory

ADDENDUM III.—MEDICARE AND MEDICAID MANUAL INSTRUCTIONS—Continued

Transmittal No.	Manual/Subject/Publication No.
AB–00–107	• Transfer of Initial Medicare Secondary Payer Development Activities to the Coordination of Benefits Contractor
AB–00–108	• Glucose Monitoring
AB–00–109	• 2001 Clinical Laboratory Fee Schedule an Laboratory Costs Subject to Reasonable Charge Payment Methodology
AB–00–110	• Implementation of the New Payment Limit for Drugs and Biologicals
AB–00–111	• Revised Claims Processing Instructions for Medicare Qualifying Clinical Trial Claims for Managed Care Enrollees
AB–00–112	• Home Health Prospective Payment System/Consolidated Billing Edits and Systems Changes—Instructions for Standard Systems, Common Working File, and Contractors Part II
AB–00–113	• Instructions for Implementing and Updating 2001 Payment Amounts for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies
AB–00–114	• Update of Codes and Payments for Ambulatory Surgical Centers
AB–00–115	• Source of Average Wholesale Price Data in Pricing Drugs and Biologicals Covered by the Medicare Program
AB–00–116	• Local Medical Review Policy Development and Format
AB–00–117	• Payment of Drugs, Biologicals and Supplies in a Comprehensive Outpatient Rehabilitation Facility
AB–00–118	• Delay Implementation of the Ambulance Fee Schedule
AB–00–119	• Change in the Collection of Comprehensive Encounter Data for the Medicare Choices Demonstration, Long-Term Care Demonstrations (Social Health Maintenance Organization Evercare, Department of Defense Subvention Demonstration, and Dual Eligible Demonstrations
AB–00–120	• Operating Instructions for Coverage of Non-Implantable Pelvic Floor Electrical Stimulators
AB–00–121	• Medicare Intermediary Claims Processing Standard Systems Delay of Calendar Year 2001 Quarter Release
AB–00–122	• Appeals of Medicare Part A/Part B Coverage Determinations
AB–00–123	• Use of Beneficiary Question & Answers on www.hcfa.gov
AB–00–124	• Payment for Method II Home Dialysis Supplies
AB–00–125	• Accelerated Referral of Non-Medicare Secondary Payor Delinquent Debts (Active and Currently Not Collectible to Debt Collection Center for Cross Servicing and Treasury Offset Program)
AB–00–126	• Use of the American Medical Associations' Physicians' Current Procedural Terminology, Fourth Edition Codes on Contractors' Web Sites
AB–00–127	• Reimbursement for Ambulance Services to Nonhospital-Based Dialysis Facilities
AB–00–128	• Extension of the Limitation on Payment for Services to Individuals Entitled to Benefits on the Basis of End-Stage Renal Disease Who Are Covered by Group Health Plan
AB–00–129	• Coordination of Benefits Contractor Fact Sheet for Providers
AB–00–130	• Intestinal Transplantation
AB–00–131	• Clarification to Implementation of the Ambulance Fee Schedule
AB–00–132	• Clarification Regarding Release of Medicare Eligibility Data
AB–00–133	• Coordination With Provider Education Program Safeguard Contractor
AB–00–134	• Cervical or Vaginal Smear Tests (Pap Smears) in Calendar Year 2001 Clinical Diagnostic Laboratory Fee Schedule
	Program Memorandum State Survey Agencies (HCFA Pub. 65) (Superintendent of Documents No. HE 22.8/6–5)
99–2	• Guidelines and Exhibits Regarding Regulatory Requirements for Comprehensive Assessment and Use of the Outcome and Assessment Information Set
	State Operations Manual Provider Certification (HCFA Pub. 7) (Superintendent of Documents No. HE 22.8/12)
21	• List of Appendices Interpretive Guidelines and Survey Procedures—Hospital—Table of Contents Interpretive Guidelines for Home Health Agencies
22	• Minimum Data Set System System Description Administration Requirements Validation and Editing Process Correction of Errors in Minimum Data Set Records That Have Been Accepted by the Standard Minimum Data Set System at the State
23	• Hospice—Citations and Description Community Mental Health Centers—Citations and Description Attestation Statement Provider Agreement Fiscal Intermediary Medicare Provider Billing Number Deactivation Letter Used by Fiscal Intermediary Model Denial Letter for Community Mental Health Center Applicants—State Restrictions on Screening Model Letter, Notice of Findings of Non-Compliance Model Letter, Notice of Termination of Provider Agreement Model Letter, Community Mental Health Center That Has Ceased Operating Model Letter, Participation in Medicare as a Community Mental Health Center Providing Partial Hospitalization Services (Including Threshold and Service Requirements) Model Letter, Notice of Failure to Meet Threshold and Service Requirements

ADDENDUM III.—MEDICARE AND MEDICAID MANUAL INSTRUCTIONS—Continued

Transmittal No.	Manual/Subject/Publication No.
	Peer Review Organization Manual (HCFA Pub. 19) (Superintendent of Documents No. HE 22.8/8–15)
83	• Introduction Review Responsibilities to Handle Clinical Data Abstraction Center Referrals Developing the Capacity to Estimate Local Payment Error Rates Determining the Types of Errors and Developing the Interventions Necessary to Reduce or Eliminate Errors Developing, Applying, and Assessing the Effect of Interventions Collaborating With Provider and Practitioner Groups Collaborating Efforts with Federal and State Agencies and Other Medicare Contractors
84	• Review Process Notice of Disclosure Final Response to Complainants Disclosure of Quality Review Information to Complainants Request for Information Model Form Final Response to Inquirer Model Notice (Concern Involved Practitioner) Final Response to Inquirer Model Notice (Concern Involved Provider Facility)
	Hospital Manual (HCFA Pub. 10) (Superintendent of Documents No. HE 22.8/2)
762	• Extracorporeal Immunoadsorption Using Protein A Columns
763	• Billing for Sodium Ferric Gluconate Complex in Sucrose Injection
764	• Payment for Blood Clotting Factor Administered to Hemophilia Inpatients
765	• Billing for Hospital Outpatient Partial Hospitalization Services
766	• Heart Transplants
767	• Completion of Form HCFA–1450 for Inpatient and/or Outpatient Billing
	Renal Dialysis Facility Manual (Non-Hospital Operated) (HCFA Pub. 29) (Superintendent of Documents No. 22.8/13)
91	• Billing for Sodium Ferric Gluconate Complex in Sucrose Injection
	ESRD Network Organizations Manual (HCFA Pub. 81) (Superintendent of Documents No. HE 22.9/4)
12	• List of Commonly Used Acronyms, and Glossary Authority Purpose of End-Stage Renal Disease Network Organizations Requirements for End-Stage Renal Disease Network Organization Responsibilities of End-Stage Renal Disease Network Organizations Goals Network Organization's Role in Health Care Quality Improvement Program Annual Report Format Quarterly Progress and Status Report Format
	Outpatient Physical Therapy and Comprehensive Outpatient Rehabilitation Facility Manual (HCFA Pub. 9) (Superintendent of Documents No. HE 22.8/9)
15	• Billing Instructions for Partial Hospitalization Services Provided in Community Mental Health Centers
	Coverage Issues Manual (HCFA Pub. 6) (Superintendent of Documents No. HE 22.8/14)
127	• Extracorporeal Immunoadsorption Using Protein A Columns
128	• Air-Fluidized Beds
129	• Hyperbaric Oxygen Therapy
130	• Intravenous Iron Therapy
131	• Osteogenic Stimulation
132	• Durable Medical Equipment Reference List Speech Generating Devices
133	• Non-Implantable Pelvic Floor Electrical Stimulator
134	• Artificial Hearts and Related Devices

ADDENDUM III.—MEDICARE AND MEDICAID MANUAL INSTRUCTIONS—Continued

Transmittal No.	Manual/Subject/Publication No.
	Provider Reimbursement Manual—Part 1 (HCFA Pub. 15–1) (Superintendent of Documents No. HE 22.8/4)
418	• Requirements for Distinct Part Certification
419	• Regional Medicare Swing-Bed Skilled Nursing Facility Rates
	Provider Reimbursement Manual—Part 2 Provider Cost Reporting Forms and Instructions Chapter 35—Form HCFA–2540–96 (HCFA Pub. 15–2–35) (Superintendent of Documents No. HE 22.8/4)
9	• Skilled Nursing Facility, and Skilled Nursing Facility Health Care Complex Cost Report, Form HCFA–2540–96
	Provider Reimbursement Manual—Part 2 Provider Cost Reporting Forms and Instructions Chapter 36—Form HCFA–2552–96 (HCFA Pub. 15–2–36) (Superintendent of Documents No. HE 22.8/4)
7	• Hospital and Hospital Health Care Complex Cost Report, Form HCFA–2552–96
	Medicare Program Integrity Manual (HCFA Pub. 83) (Superintendent of Documents No. HE 22)
3	• Types of Claims For Which Contractors Are Responsible The Medicare Medical Review Program National Coverage Policy and Local Medical Review Policy and Individual Claim Determinations Individual Claim Determinations Identification of Services for Which A Local Medical Review Policy is Needed Coding Rules in Local Medical Review Policy Local Medical Review Policy Notice Process Manual Review Personnel and Levels of Review The Contractor Advisory Committee Medicare Fraud Information Specialist Medicare Integrity Program—Provider Education and Training Activities Contractor Medical Director Office of Inspector General Referrals and Appropriate Fraud Information Database Entries Introduction Provider Tracking System Evaluating Effectiveness of Corrective Actions Verifying Potential Errors and Setting Priorities Determining Whether the Problem is Widespread or Provider-Specific Provider Education Prepayment Review of Selected Claims Automated and Manual Prepayment Review Prepayment Edits Development of Claims for Additional Documentation Location of Postpay Reviews Advance Determination of Medicare Coverage of Customized Durable Medical Equipment Effectuating Favorable Final Appellate Decisions That A Beneficiary is ''Confined to Home'' Contractor Advisory Committee Structure Contractor Advisory Committee Process The Medicare Fraud Program Staffing of the Fraud Unit and Security Training Durable Medical Equipment Fraud Functions Identifying Potential Errors—Introduction Data Analysis Resources Needed for Data Analysis Determine Indicators to Identify Norms and Deviations Overview of Prepayment and Postpayment Review Automated and Manual Prepayment Review Categories of Medical Review Edits Overpayment Assessment Procedures Consent Settlement Offer Based on Potential Projected Overpayment Certified Medical Necessity as the Written Order Pick-up Slips Incurred Expenses for Durable Medical Equipment and Orthotics and Prosthetic Devices List of Medical Review Codes, Categories, and Conversion Factors for Fiscal Year 2000 Description of Carrier Advisory Committee

ADDENDUM III.—MEDICARE AND MEDICAID MANUAL INSTRUCTIONS—Continued

Transmittal No.	Manual/Subject/Publication No.
	Consent of Settlement Documents HCFA Forms 700 and 701
	Medicare/Medicaid Sanction—Reinstatement Report (HCFA Pub. 69)
00–10	• Report of Physicians/Practitioners, Providers and/or Other Health Care Suppliers Excluded Reinstated—September 2000
00–11	• Report of Physicians/Practitioners, Providers and/or Other Health Care Suppliers Excluded/Reinstated—October 2000
00–12	• Report of Physicians/Practitioners, Providers and/or Other Health Care Suppliers Excluded/Reinstated—November 2000 **January 2001 through March 2001**
	Intermediary Manual Part 1—Claims Process (HCFA Pub. 13–1) (Superintendent of Documents No. HE 22.8/6–3)
130	• Principles of Reimbursement for Administrative Costs
	Intermediary Manual Part 2—Claims Process (HCFA Pub. 13–2) (Superintendent of Documents No. HE 22.8/6–3)
415	• System Security Authority, Exhibits, and Appendices: *www.hcfa.gov/pubforms/pim/pimtoc.htm*
416	• Recovery of Overpayments Due to a Pattern of Furnishing Excessive or Noncovered Services
417	• This Transmittal contains no updated information
	Intermediary Manual Part 3—Claims Process (HCFA Pub. 13–3) (Superintendent of Documents No. HE 22.8/6)
1822	• No Legal Obligation To Pay For Or Provide Services Review of Form HCFA–1450 For Inpatient And Outpatient Bills Medicare Secondary Payor Maintenance Transaction Record Processing Alphabetic Listing Of Data Elements
1823	• Screening Pap Smears and Screening Pelvic Examinations
1824	• Colorectal Screening
1825	• Hospital Outpatient Partial Hospitalization Services
1826	• Review of Form HCFA–1450 For Inpatient and Outpatients Bills
1827	• Beneficiary-Driven Demand Billing Under Home Health Prospective Payment System
	Carriers Manual Part 2—Program Administration (HCFA Pub. 14–1) (Superintendent of Documents No. HE 22.8/7–2)
124	• Principles of Reimbursement for Administrative Costs Budget Preparation Budget Preparation
	Carriers Manual Part 3—Program Administration (HCFA Pub. 14–2) (Superintendent of Documents No. HE 22.8/7)
142	• System Security Authority, Exhibits, and Appendices: *www.hcfa.govpubforms/83__pim/pimtoc.htm*
	Carriers Manual Part 3—Program Administration (HCFA Pub. 14–3) (Superintendent of Documents No. HE 22.8/7)
1690	• Claims for Anesthesia Services Performed on and After January 1, 1992 Entities/Suppliers Whose Physicians' Services Are Paid for Under Fee Schedule Method for Computing Fee Schedule Amounts Payment Conditions for Anesthesiology Services Assisted Suicide Site-of-Service Payment Differential Optometry Services

ADDENDUM III.—MEDICARE AND MEDICAID MANUAL INSTRUCTIONS—Continued

Transmittal No.		Manual/Subject/Publication No.
		Allowable Adjustments
		Evaluation and Management Service Codes—General
		Payment for Office/Outpatient Visits
		Consultations
		Payment For Physician's Visits To Residents of Skilled Nursing Facilities and Nursing Facilities
		Home Care and Domiciliary Care Visits
		Prolonged Services
		Home Services
		Geographic Practice Cost Indices by Medicare Carrier and Locality
		Determining Reasonable Charges for Services of Nurse Practitioners and Clinical Nurse Specialists
1691	•	No Legal Obligation To Pay For Or Provide Services
		Medicare Secondary Payer General Provisions
		Medicare Secondary Payer General Provisions Applicable To Individuals Covered By Group Health Plans and Large Group Health Plans
		Limitation On Payment For Services To Individuals Eligible For Or Entitled To Benefits On Basis Of End Stage Renal Disease Who Are Covered By Group Health Plans
1692	•	Patient and Insured Information
		Physician or Supplier Information
		Place of Service Codes and Definitions Exhibits
1693	•	Physicians Billing for Purchased Diagnostic Tests (Other Than Clinical Diagnostic Laboratory Tests
1694	•	Screening Pap Smear Coverage and Payment Requirements
		Screening Pelvic Examination Coverage and Payment Requirements
		Diagnosis Coding
		Billing Requirements
		Calculating Frequency Limitations
		Common Working File Edits
		Medicare Summary Notices and Explanations of Your Part B Medicare Benefits
		Remittance Advice Notices
1695	•	Coding Changes Became Effective for Hepatitis B Vaccines Through the Health Care Financing Administration Common Procedure Coding System
		Annual Updates
1696	•	Evidence of Medical Necessity Oxygen Claims
1697	•	Covered Services and Health Care Financing Administration Common
		Procedure Coding System Codes
		Coverage Criteria
		Determining Whether or Not the Beneficiary is at High Risk for Developing Colorectal Cancer
		Determining Frequency Standards
		Noncovered Services
		Payment Requirements
		Common Working File Edits
		Medicare Summary Notices and Explanations of Your Part B Medicare Benefits
		Remittance Advice Notices
		Ambulatory Surgical Center Facility Fee
1698	•	Dual Eligibility/Entitlement Situations
		Program Memorandum Intermediaries (HCFA Pub. 60A) (Superintendent of Documents No. HE 22.8/6–5)
A–01–01	•	January Outpatient Code Editor Specifications Version (V2.0)
A–01–02	•	Use of Telehealth In Delivery of Home Health Services
A–01–03	•	Temporary 2-Month Extension of Periodic Interim Payment for Home Health Providers
A–01–04	•	Change in Hospice Payment Rates As Required by the Benefits Improvement and Protection Act
A–01–05	•	Advance Beneficiary Notices Must Be Given To Beneficiaries and Demands Bills Must Be Submitted By Home Health Agencies
A–01–06	•	Restoration of Full Home Health Market Basket Update for Home Health Services for Fiscal Year 2001 and Temporary 10 Percent Payment Increase for Home Health Services Furnished in a Rural Area For 24 Months Under the Home Health Prospective Payment System
A–01–07	•	Application of Wage Index for Wichita, Kansas, Metropolitan Statistical Area Hospice Providers
A–01–08	•	Adjustments to the Federal Skilled Nursing Facility Prospective Payment System Rates for Fiscal Year 2001
A–01–09	•	Exemption of Critical Access Hospital Swing Beds From Skilled Nursing Facility Prospective Payment System
A–01–10	•	Technical Corrections to the January 2001 Update: Coding Information for Hospital Outpatient Prospective Payment System
A–01–11	•	Changes to Federal Fiscal Year 2001 Inpatient Hospital Payment As Required By the Benefits Improvement And Protection Act of 2000 (Public Law 106–554)
A–01–12	•	Provider Statistical and Reimbursement Report
A–01–13	•	Clarification of Allowable Medicaid Days in the Medicare Disproportionate Share Hospital Adjustment Calculation
A–01–14	•	Clarifications to Transmittal A–01–03, Change Request 1437, Temporary 2-Month Extension of Periodic Interim Payment for Home Health Providers
A–01–15	•	Implementation of Sections 111, 401, 403, and 405 of the Medicare, Medicaid, and State Child Health Insurance Program Benefits Improvement and Protection Act of 2000

ADDENDUM III.—MEDICARE AND MEDICAID MANUAL INSTRUCTIONS—Continued

Transmittal No.	Manual/Subject/Publication No.
A–01–16	• Claims Guidance Related to Outpatient Code Editor Edit 27
A–01–17	• Impact of the Benefits Improvement and Protection Act on Devices Eligible for Transitional Pass-Through Payments Under the Hospital Outpatient Prospective Payment System
A–01–18	• Effective Dates for all Medicare Secondary Payer Sub-Modules Found in the Medicare Secondary Payer Pay Module
A–01–19	• New Composite Payment Rates Effective April 1, 2001, through December 31, 2001, and the Application of Exceptions Under the End Stage Renal Disease Composite Rate System
A–01–20	• Health Insurance Portability and Accountability Act Health Care Claim and Coordination of Benefits
A–01–21	• Clarification of the Homebound Definition Under the Medicare Home Health Benefit
A–01–22	• Extension of Due Date for Filing Provider Cost Reports
A–01–23	• Modification to Home Health Prospective Payment System Date Matching Edit in Medicare Standard System Software
A–01–24	• Further Guidance on Handling Outpatient Code Editor Error 13
A–01–25	• New Processing and Reporting Requirements for Resolution of Outpatient Prospective Payment System Implementation Issues
A–01–26	• Clarification of Exclusions to the Temporary 2-Month Extension of Periodic Interim Payments For Home Health Providers
A–01–27	• Problems with Processing of Non-Outpatient Prospective Payment System Claims Through the Outpatient Code Editor
A–01–28	• Addendum to Periodic Interim Payments For Home Health Providers
A–01–29	• Medicare Review of Certification and Re-Certifications of Residents in Skilled Nursing Facilities
A–01–30	• Advance Beneficiary Notices Must Be Given To Beneficiaries and Demand Bills Must Be Submitted By Home Health Agencies
A–01–31	• Clinical Diagnostic Laboratory Tests Furnished by Critical Access Hospitals
A–01–32	• Biweekly Interim Payments for Certain Hospital Outpatient Items and Services That Are Paid On A Cost Basis, and Direct Medical Education Payment, Not Included in the Hospital Outpatient Prospective Payment System
A–01–33	• Fiscal Intermediary Community Mental Health Center Enrollment and Change of Ownership Site Visit Process and Coordination With National Community Mental Health Center Site Visit Contractor
A–01–34	• Salary Equivalency Guidelines Update Factors
A–01–35	• Medicare+Choice Inpatient Encounter Data-Migration of Data Processing to the Health Care Financing Administration Data Center
A–01–36	• April Outpatient Code Editor Specifications Version (V2.1)
A–01–37	• Change in the Standard Paper Remittance Advice for Home Health Agencies
A–01–38	• Changes to Fiscal Year 2001 and Fiscal Year 2002 Graduate Medical Education Policies as Required by the Medicare, Medicaid, and State Child Health Insurance Program Balanced Budget Refinement Act of 1999, P.L. 106–113, and the Medicare, Medicaid, and State Child Health Insurance Program Benefits Improvement and Protection Act of 2000, P.L. 106–554
A–01–39	• Postacute Care Transfer Policy
A–01–40	• Additional Information on Transitional Pass-Through Devices and Drugs
A–01–41	• Categories for Use in Coding Devices Eligible for Transitional Pass-Through Payments Under the Hospital Outpatient Prospective Payment System
A–01–42	• Indian Health Service Hospital Payment Rates for Calendar Years 2000 and 2001
A–01–43	• This Transmittal Has Been Rescinded
A–01–44	• Standard Systems Changes Required to Incorporate Provider-Specific Payment-to-Cost Ratios into the Calculation of Interim Transitional Corridor Payment Outpatient Prospective Payment System
A–01–45	• Clarification and HCFA Common Procedure Coding System Coding Update: Part B Fee Schedule and Consolidated Billing for Skilled Nursing Facility Services
A–01–46	• Further Guidance on Handling the Outpatient Code Editor Edit 43
A–01–47	• Implementation of Updates to the Federal Fiscal Year 2001 Inpatient Hospital Payments and Disproportionate Share Hospital Thresholds and Adjustments as Required by the Benefits Improvement and Protection Act of 2000 (Public Law 106–554)
	Program Memorandum Carriers (HCFA Pub. 60B) (Superintendent of Documents No. HE 22.8/6–5)
B–01–01	• Use of Statistical Sampling for Overpayment Estimation When Performing Administrative Reviews of Part B Claims
B–01–02	• Medicare Requirements for Payment for Medicare-Covered Drugs Administrative Reviews of Part B Claims
B–01–03	• Request for Carriers to Include a Message on Paper Remittance Notices
B–01–04	• New Temporary ''K'' Codes for Insulin Lispro
B–01–05	• Matrix to Complete Provider/Supplier Enrollment Application (HCFA–855)
B–01–06	• Health Insurance Portability and Accountability Act Health Care Claim and Coordination of Benefits
B–01–07	• Apligraf (Graftskin)
B–01–08	• Change in Effective Data For Five ''WW'' Codes For Methotrexate
B–01–09	• Suspension of Recently Implemented Correct Coding Initiative Edits Bundling Evaluation and Management Codes and Ophthalmologic Codes Revision to Version 7.0
B–01–10	• Systems Requirements for the Benefits Improvement and Protection Act of 2000 for Drugs and Biologicals Covered by Medicare, Section 114, Mandatory Submission of Assigned Claims for Drugs and Biologicals
B–01–11	• Supplier Billing for Glucose Test Strips
B–01–12	• Initial Viable Information Processing Systems Virtual Multiple Storage Changes Necessary to Allow for ''Full Program Safeguard Contractor Implementation''
B–01–13	• Explanation of Medicare Benefits, Medicare Summary Notice and Supplier Remittance Message Durable Medical Equipment Regional Carriers Must Use on Claims for Drugs and Related Equipment Supplied by a Supplier Not Licensed to Dispense the Drug

ADDENDUM III.—MEDICARE AND MEDICAID MANUAL INSTRUCTIONS—Continued

Transmittal No.	Manual/Subject/Publication No.
B–01–14	• New Oral Anti-Cancer Drugs Approved for Use by Medicare
B–01–15	• Durable Medical Equipment Regional Carrier System Requirements to Implement § 114 of the Benefits Improvement and Protection Act of 2000
B–01–16	• Clarification of Medicare Policies Concerning Ambulance Services
B–01–17	• Durable Medical Equipment Regional Carrier System Changes to Enforce Medicare Requirements for Payment for Medicare-Covered Drugs
B–01–18	• Changes to Correct Coding Edits, Version 7.2, Effective July 1, 2001
B–01–19	• Additional Information for Trail Blazer Health Enterprise for Centralized Billing of Flu and Pneumococcal Vaccinations
B–01–20	• Two New ''K'' Codes for Heavy Duty Hospital Beds
B–01–21	• Durable Medical Equipment Regional Carrier System Requirements to Implement § 114 of Benefits Improvement and Protection Act of 2000 (Additional Requirements for Change Request (CR) 1562, Transmittal B–01–15)
B–01–22	• Initial Viable Information Processing System Medicare System Virtual Multiple Storage Changes Necessary to Allow for Full Program Safeguard Contractor Implementation
	Program Memorandum Intermediaries/Carriers (HCFA Pub. 60A/B) (Superintendent of Documents No. HE 22.8/6–5)
AB–01–01	• Upcoming Train the Trainer Sessions on Skilled Nursing Facility Prospective Payment System and Consolidated Billing Updates
AB–01–02	• Managing Medicare Appeals Workloads in Fiscal Year 2001
AB–01–03	• April Quarterly Update for 2001 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Fee Schedule
AB–01–04	• Implementation of the National Drug Code to Process Claims for Prescription Drugs and Biologicals and Request for Comments
AB–01–05	• New Waived Tests—Effective Date of Receipt
AB–01–06	• Replacement of Prosthetic Devices and Parts
AB–01–07	• Contractor Testing Requirements
AB–01–08	• Program Safeguard Contractor for Corporate Integrity Agreements
AB–01–09	• Clarification of Physician Certification Requirements for Medicare Hospice
AB–01–10	• Elimination of Time Limit for Coverage of Immunosuppressive Drugs Under Medicare
AB–01–11	• Health Care Financing Administration Business Partner Systems Security Manual
AB–01–12	• Charging Fees to Providers for Medicare Education and Training Activities Program Management
AB–01–13	• Pap Test for Women Aged 65 and Older: Dispelling the Myths
AB–01–14	• Notification to Beneficiaries About Cervical Cancer Month and the Benefit of Pap Tests
AB–01–15	• Instructions to All Medicare Contractors for Reporting Audited Year 2000 Costs on the Final Administrative Costs Proposals
AB–01–16	• Implementation of Benefits Improvement and Protection Act of 2000 Requirements for Drugs and Biologicals Covered by Medicare
AB–01–17	• Medicare Coverage of Epoetin Alfa (Procrit) for Preoperative Use
AB–01–18	• New Automatic Notice of Change to Medicare Secondary Payer Auxiliary File
AB–01–19	• First Update to the 2001 Medicare Physician Fee Schedule Database
AB–01–20	• Payment Revisions For Diagnostic and Screening Mammograms Performed With New Technologies—Effectuated By Benefits Improvement and Protection Act 2000
AB–01–21	• Form HCFA–1522, Monthly Contractor Financial Report, Reconciliation
AB–01–22	• 2001 Payment Limit Update for Ambulance Services
AB–01–23	• Medicare Summary Notices Programming Errors
AB–01–24	• Medicare Secondary Payer: (1) Procedures for ''Write-Off—Closed'' of Medicare Secondary Payer Accounts Receivable; (2) Elimination of Automated/Systems ''Write-Off—Closed'' Actions for Medicare Secondary Payer Accounts Receivable; Zero Backend Tolerance for Medicare Secondary Payer Accounts Receivable (Reminder); and (3) Date for Establishment of Medicare Secondary Payer Accounts Receivable (Reminder)
AB–01–25	• Clarification of Transmittal AB–00–107, Change Request 1163, and Transmittal AB–00–129, Change Request 1460, Regarding the Coordination of Benefits Contract of Benefits Contractor and Medicare Secondary Payer Prepay Work Activities for Customer Service, Medicare Secondary Payer and Standard Systems Contractor Staff
AB–01–26	• Changes to the 2001 Payment Amounts for Durable Medical Equipment Prosthetics, Orthotics, and Supplies
AB–01–27	• Notice of Interest Rate for Medicare Overpayments and Underpayments
AB–01–28	• Current Status of Medicare Program Memoranda Issued Before Calendar Year 2001
AB–01–29	• Free Electronic Billing Software
AB–01–30	• Claims Processing Instructions for the Medicare Coordinated Care Demonstration—Correction and Enhancement
AB–01–31	• Fraud Investigation Database
AB–01–32	• Promoting Colorectal Cancer Screening as a Part of Colorectal Cancer Awareness Month
AB–01–33	• Delay of Carrier and Intermediary Actions Required in Change Requests 1256 and 1323, Consolidated Billing for Skilled Nursing Facility Residents, and Fee Schedule for Part B Residents and Outpatients
AB–01–34	• Health Care Financing Administration Office of the Inspector General Hotline Referrals
AB–01–35	• Delay of Carrier and Intermediary Action Required in Change Request 1412, Transmittal AB–00–112, Dated November 16, 2000, Consolidated Billing for Home Health Agencies
AB–01–36	• Extension of Moratorium on the Application of the Financial Limitation for Outpatient Rehabilitation Services
AB–01–37	• Verteporfin
AB–01–38	• Transmittal number AB–01–38, has been rescinded and will not be released
AB–01–39	• Salary Equivalency Guidelines Update Factors

ADDENDUM III.—MEDICARE AND MEDICAID MANUAL INSTRUCTIONS—Continued

Transmittal No.		Manual/Subject/Publication No.
AB–01–40	•	Correction to Change Request 1500 (Transmittal AB–01–26)—Changes to the 2001 Payment Amounts for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies
AB–01–41	•	Correction to April Quarterly Update for 2001 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Fee Schedule
AB–01–42	•	Changes to 2001 Clinical Laboratory Fee Schedule Required by the Benefits Improvement and Protection Act of 2000
AB–01–43	•	Revision to Carrier/Intermediary Provider Training for Skilled Nursing Facility Prospective Payment System and Consolidated Billing
AB–01–44	•	Binding Contractor Hearing Officers to Local and Regional Medical Review Policies
AB–01–45	•	Retention of HCFA Common Procedure Coding System Level III Codes
AB–01–46	•	New Waived Test—Effective Date of Receipt
AB–01–47	•	Independent Laboratory Billing for the Technical Component of Physician Pathology Services to Hospital Patients
AB–01–48	•	Remittance Advice and Medicare Summary Notice Messages for the Home Health Prospective Payment System
AB–01–49	•	Follow On Instructions to Health Care Financing Administration Business Partners Systems Security Requirements
		Program Memorandum Medicaid State Agencies (HCFA Pub. 17) Superintendent of Documents No. HE 22. 8/6–5
01–01	•	Current Status of Medicaid Program Memoranda and Action Transmittal Issued Before Calendar Year 2001
		Medicare Regional Office Manual—Part 2 (HCFA Pub. 23–3) Superintendent of Documents No. HE 22.8/8
330	•	Security Oversight Manual— *www.hcfa.gov/pubforms/progma.htm.*
		State Operations Manual Provider Certification (HCFA Pub. 7) (Superintendent of Documents No. HE 22.8/12)
24	•	Psychiatric Hospitals Conducting Initial Surveys and Scheduled Resurveys
25	•	Citations and Description Organization of Home Health Agency Characteristics Differentiating Branches From Subunits of Home Health Agency Guidelines for Determining Parent, Branch, or Subunit Processing Change from Branch to Subunit Health Care Financing Administration Approval Necessary for Non-Parent Locations Separate Entities Operation of the Home Health Agencies Consumer Awareness Staff Awareness Operation of Home Health Agencies Across State Lines Surveying Health Maintenance Organization—Operated Home Health Agency Guidelines for Determining Survey Frequency Home Health Agency Survey Process for Determining Quality of Care Definitions Home Health Functional Assessment Instrument Outcome and Assessment Information Set Requirements Clinical Laboratory Improvement Amendments Standard Survey—Structure Survey Tasks Resident Assessment Protocols
26	•	Regional Office Assignment of Provider and Supplier Identification Numbers
		Peer Review Organization Manual (HCFA Pub. 19) (Superintendent of Documents No. HE 22.8/8–15)
85	•	Statutory Background Hospital Requirements Hospital Penalties For Noncompliance Regional Offices Responsibilities State Agency Surveys Peer Review Organization Review Responsibilities Physician Review Outline 60-Day Peer Review Organization Review: Opportunity for Discussion (Sample Letter to Physician/Hospital),
86		Quality Review Admission Review Coverage Review

ADDENDUM III.—MEDICARE AND MEDICAID MANUAL INSTRUCTIONS—Continued

Transmittal No.		Manual/Subject/Publication No.
		Discharge Review Outlier Review Limitation on Liability Determinations Readmission Review Circumvention of Prospective Payment System Introduction Review Setting Using Screening Criteria Providing Opportunity for Discussion Profiling Case Review Results Physician Reviewers Health Care Practitioners Other Than Physicians Conflict of Interest When an Action Plan is Not Need Additional Performance Improvement Activities Denial and Reopening Time Frames
		Hospice Manual (HCFA Pub. 10) (Superintendent of Documents No. HE 22.8/2)
768	•	Screening Pap Smears and Screening Pelvic Examinations
769	•	Billing for Colorectal Screening
770	•	Billing for Hospital Outpatient Partial Hospitalization Services
771	•	Completion of Form HCFA–1450 for Inpatient and /or Outpatient Billing
		Coverage Issues Manual (HCFA Pub. 6) Superintendent of Documents No. HE 22. 8/14
135	•	Photodynamic Therapy
Photosensitive Drugs		**Provider Reimbursement Manual—Part 1 (HCFA Pub. 15–1) (Superintendent of Documents No. HE 22.8/4)**
420	•	Travel Expenses
		Provider Reimbursement Manual—Part 2 Chapter 31, Form HCFA–287–92 (HCFA Pub. 15–2–31) (Superintendent of Documents No. HE 22.8/4)
4	•	Home Office Equity Capital—General Form HCFA–287–92 Worksheets
		Provider Reimbursement Manual—Part 2 Chapter 18, Form HCFA–2088–92 (HCFA Pub. 15–2–18) (Superintendent of Documents No. HE 22.8/4)
4	•	Outpatient Rehabilitation Provider Cost Reporting Form
		Provider Reimbursement Manual—Part 2 Provider Cost Reporting Forms and Instructions Chapter 35/Form HCFA–2540–96 (HCFA Pub. 15–2–35)
10	•	Skilled Nursing Facility and Skilled Nursing Facility Complex Cost Report
		State Medicaid Manual—Part 4/Elegibility (HCFA Pub. 45–3) Superintendent of Documents No. HE 22.8/10
75	•	Medicaid Estate Recoveries
		Medicare Program Integrity Manual (HCFA Pub. 83)
4	•	Physician Assistant Rules Concerning Orders and Certificates of Medical Necessity
5	•	Advance Determination of Medicare Coverage of Customized Durable Medical Equipment Definitions of Customized Durable Medical Equipment Items Eligible for Advance Determination of Medicare Coverage

ADDENDUM III.—MEDICARE AND MEDICAID MANUAL INSTRUCTIONS—Continued

Transmittal No.		Manual/Subject/Publication No.
		Instructions for Processing Advance Determination of Medical Coverage Requests Affirmative Advance Determination of Medical Coverage Decisions Negative Advance Determination of Medical Coverage Decisions Durable Medical Equipment Regional Carrier Tracking
		Business Partners Systems Security Manual (HCFA Pub. 84)
1	•	Introduction Information Technology Systems Security Roles and Responsibilities Information Technology Systems Program Management Health Care Financing Administration Core Security Requirements, and an overview the Contractor Assessment Security Tool An Approach to Risk Assessment An Approach to Business Continuity and Contingency Planning An Approach to Fraud Control Acronyms and Abbreviations Glossary
		Business Partners Security Oversight Manual (HCFA Pub. 85)
1	•	Introduction
2	•	Information Technology Systems Security Roles and Responsibilities Information Technology Systems Security Program Management Audit Protocols and the Contractor Assessment Security Tool
		Medicare/Medicaid Sanction—Reinstatement Report
		(HCFA Pub. 69)
01–01	•	Report of Physicians/Practitioners, Providers and/or Other Health Care Suppliers Excluded/Reinstated—December 2000
02–01	•	Report of Physicians/Practitioners, Providers and/or Other Health Care Suppliers Excluded/Reinstated—January 2001
03–01	•	Report of Physicians/Practitioners, Providers and/or Other Health Care Suppliers Excluded/Reinstated—February 2001
		April 2001 through June 2001
		Intermediary manual
		Part 1—Claims Process (HCFA Pub. 13–1) (Superintendent of Documents No. HE 22.8/6–3)
131	•	General Instructions for Completing the HCFA–750A/B Contractor Financial Reports Instructions for Completing the HCFA–751A/B Status of Accounts Receivable Instructions for Completing the HCFA–C751A/B Status of Non-Medicare Secondary Payer Debt Currently Not Collectible Instruction for Completing the HCFA–M751A/B Status of Medicare Secondary Payer Accounts Receivable Instruction for Completing the HCFA–MC751 A/B Status of Medicare Secondary Payer Debt Currently Not Collectible Provides Exhibits to be used to Prepare Contractor Financial Reports
		Intermediary Manual Part 2—Claims Process (HCFA Pub. 13–2) (Superintendent of Documents No. HE 22.8/6–3)
418	•	Beneficiary Services
		Intermediary Manual Part 3—Claims Process (HCFA Pub. 13–3) (Superintendent of Documents No. HE 22.8/6)
1828	•	Prospective Payment for Outpatient Rehabilitation Services and the Financial Limitation
1829	•	Overpayment for Provider Services—General
1830	•	Review of Form HCFA–1450 for Inpatient And Outpatient Bills
1831	•	Type of Bill Body of Report
1832	•	Requirements for Critical Access Hospital Services and Critical Access

ADDENDUM III.—MEDICARE AND MEDICAID MANUAL INSTRUCTIONS—Continued

Transmittal No.		Manual/Subject/Publication No.
		Hospital Long Term Care Service
		Payment for Services Furnished by a Critical Access Hospital
		Payment for Post-Hospital Skilled Nursing Facility Care Furnished by a Critical Access Hospital
1833	•	Provider Enrollment
1834	•	Dialysis for End Stage Renal Disease—General
1835	•	Cryosurgery of the Prostate Gland
1836	•	Diabetes Outpatient Self-Management Training Services
1837	•	Checking Reports
		Body of Report
		Quarterly Supplement to the Intermediary Workload Report—HCFA–1566A, Pages 1, 2, and 3
1838	•	Drugs and Biologicals
1839	•	Request for Anticipated Payment
		Home Health Prospective Payment System Claims
		Effective Date and Scope of Home Health Prospective Payment System for Claims
		Split Percentage Payment of Episodes and Development of Episode Rates
		Coding of Home Health Prospective Payment System Episode Case—Mix
		Groups on Home Health Prospective Payment System Claims: Health Research Groups and Health Insurance Prospective Payment System Codes
		Overview—Health Insurance Query System for Home Health Agency Inquiry System Shows Primary Home Health Agency
		Overview—Request for Anticipated Payment Submission and Processing
		Establishes Home Health Prospective Payment System Episode and Provides First Percentage Payment
		Overview—Claim Submission and Processing Complete Home Health Prospective Payment System Payment Closes Episode and Performs A–B Shift
		Definition of Transfer Situation Under Home Health Prospective Payment System Payment Effects
		Payment When Death Occurs During a Home Health Prospective Payment System Episode
		Adjustments of Episode Payment—''Special Submission Case: ''No Resource Allocation Plan'' Low Utilization Payment Adjustment
		Adjustment of Episode Payment—''Significant Change in Condition
		General Guidance on Line Item Billing under Home Health Prospective Payment System Home Health Prospective Payment System Consolidated Billing and Primary Home Health Agency
		Creation of the Health Insurance Query System for Home Health Agencies and hospices in the Common Working File—Replacement of Health Insurance Query System for Home Health Agencies
		Health Insurance Query System for Home Health Agencies Inquiry and Response
		Timeliness and Limitations of Health Insurance Query System for Home Health Agencies Responses
		Inquiries to Regional Home Health Intermediaries Based on Health Insurance Query System for Home Health Agencies Responses
		National Home Health Prospective Payment Episode History File
		Closing, Adjusting and Prioritizing Home Health Prospective Payment System Episodes Based on Resource Allocation Plan and Home Health Agencies Claim Activity
		Other Editing and Changes for Home Health Prospective Payment System Episodes
		Priority Among Other Claim Types and Home Health Prospective Payment System Consolidated Billing for Episodes
		Version 3051.4A.01 Line Level Reporting Requirements for the Claim Payment in an Episode (More than 4 Visits)
		Carriers Manual Part 1—Program Administration (HCFA Pub. 14–1) (Superintendent of Documents No. HE 22.8/7–2)
125	•	General
		Instructions for Completing the HCFA–750B Contractor Financial Reports
		Instructions for Completing the HCFA–751B Status of Accounts Receivable
		Instructions for Completing the HCFA–C751B Status of Non-Medicare Secondary Payer Debt Currently Not Collectible
		Instructions for Completing the HCFA–C751B Status of Medicare Secondary Payer Accounts Receivable
		Instructions for Completing the HCFA–M751B Status of Medicare Secondary Payer Accounts Receivable
		Carriers Manual Part 2—Program Administration (HCFA Pub. 14–2) (Superintendent of Documents No. HE 22.8/7)
143	•	Beneficiary Services
		Carriers Manual Part 3—Program Administration (HCFA Pub. 14–3) (Superintendent of Documents No. HE 22.8/7)
1699	•	Overpayments—General
1700	•	Billing for Pneumococcal, Hepatitis B, And Influenza Virus Vaccines
		General Claims Processing Requirements
		Billing Requirements

ADDENDUM III.—MEDICARE AND MEDICAID MANUAL INSTRUCTIONS—Continued

Transmittal No.		Manual/Subject/Publication No.
		Simplified Roster Bills
1701	•	The Do Not Forward Initiative
1702	•	Durable Medical Equipment Regional Carrier Pre-Discharge Delivery of DME Prosthetic, & Supplies for Fitting and Training
1703	•	Correct Coding Initiative
1704	•	Coverage of Medical Devices under Medicare
		Appeals Process for Investigational Device Exemption Categorization Decisions
		Certain Devices with a Food and Drug Administration Investigational Device Exemption
		Certain Devices with an Food & Drug Administration Investigational Device Exemption
		Payment of Certain Investigational Devices
		HCFA's Master File of Investigational Devices
		Adjudicating the Claim Executive Office of Management & Budget Messages
		Executive Office of Management & Budget Messages
1705	•	Professional Relations
		Professional Relations for HCFA Common Procedure Coding System
1706	•	Dual Eligibility/Entitlement Situations
1707	•	Preoperative Services Paid Under the Physician Fee Schedule
1708	•	Payment for Intravenous Iron Replacement Therapy Drugs
		Sodium Ferric Gluconate Complex in Sucrose Injection
		Iron Sucrose Injection
		Messages for Use with Denials
1709	•	Home Care And Domiciliary Care Visits
1710	•	Summary
		Payment and Coding Requirements
		Processing Claims to Ensure That Payment Conditions Are Met
1711	•	Simplified Roster Bills
1712	•	Review of Health Insurance Claim Form HCFA–1500
1713	•	Definition of Drug of Biologicals
1714	•	Billing Procedures and Modifiers for Certified Registered Nurse Anesthetist and Anesthesiologist in a Single Anesthesia Procedure
		Exempt Certified Registered Nurse Anesthetist as Rural Hospitals
1715	•	Responsibility to Download and Implement DME Prosthetic, Orthotics & Supplies Fee Schedules
		Carriers Manual Part 4—Program Administration (HCFA Pub. 14–4) (Superintendent of Documents No. HE 22.8/7)
24	•	Provider Enrollment
		Program Memorandum Intermediaries (HCFA Pub. 60A) (Superintendent of Documents No. HE 22.8/6–5)
A–01–48	•	Requirement for Line-Item Dates of Service for Ambulance Claims
A–01–49	•	Announcement of Medicare Rural Health Clinic and Federally Qualified Health Centers Payment Rate Increases, Changes to the Rural Health Clinic Benefit Made By the Medicare, Medicaid, and State Child Health Insurance Program Benefits Improvement and Protection Act (BIBA) of 2000 and Clarification Regarding Drugs Furnished by Rural Health Clinics Federally Qualified Health Center Manuals
A–01–50	•	Further Guidance Regarding Billing Under the Outpatient Prospective Payment System
A–01–51	•	Calculating Payment-to-Cost Ratios for Purposes of Determining Transitional Corridor Payment Under the Outpatient Prospective Payment System and Revising the Criteria Under Which a Provider May Request a Recalculation of Its Cost-to-Change Ratio
A–01–52	•	Medicare Payment for Ambulance Services Furnished by Certain Critical Access Hospitals
A–01–53	•	Discontinuing the Recognition and Financial Reporting of Accounts Receivables Due
A–01–54	•	Elimination of the Initial Request for Anticipated Payment Medicare Summary Notice Explanation of Medicare Benefits
A–01–55	•	Accelerated Referral of Non-Medicare Secondary Payor Active Delinquent Debts to the Debt Collection Center for Cross Servicing and Treasury Offset Program
A–01–56	•	Clarification to Health Insurance Prospective Payment System Coding and Billing Instructions
A–01–57	•	Health Insurance Portability Accountability Act of 1996 Administrative Simplification Implementation of Version 4010 of the Accredited Standards Committee X12N 835 (Payment/Remittance Advice) Transaction Standard Format
A–01–58	•	Clarification of Provider Cost Report Filing Requirements
A–01–59	•	Correction of Some Fiscal Year 2001 Hospice Wage Indices
A–01–60	•	Revised Processing and Reporting Requirement Timeframes for Resolution of Outpatient Prospective Payment System Implementation Issues
A–01–61	•	Processing of 1999 Bills Under the End Stage Renal Disease Composite Rate System
A–01–62	•	Extension of Due Date for Filling Provider Cost Reports
A–01–63	•	Further Guidance Regarding Health Insurance Portability and Accountability Act Health Care Claim and Coordination of Benefits
A–01–64	•	Providers Statistical and Reimbursement Report
A–01–65	•	HCFA Common Procedure Coding System Codes for Wheelchairs and Accessories
		Instructions for Regional Home Health Intermediaries

ADDENDUM III.—MEDICARE AND MEDICAID MANUAL INSTRUCTIONS—Continued

Transmittal No.	Manual/Subject/Publication No.
A–01–66	• July Outpatient Code Editor Specifications Version (V2.2)
A–01–67	• July Medicare Outpatient Code Editor Version 16.2
A–01–68	• Adjusting Clinical Diagnostic Laboratory Test Claims Furnished by Critical Access Hospitals
A–01–69	• Inclusion of Medicare Paid Provider Message and Removal of the Ambulatory Payment Classification Code from Medicare Summary Notice
A–01–70	• Frequently Asked Questions About Home Health Advance Beneficiary Notice Form HCFA–R–296
A–01–71	• Medicare Transitional Pass-Through Payments Under the Hospital Outpatient Prospective Payment System for Pacemakers and Neurostimulators
A–01–72	• Additional Problems with Processing of Non-Outpatient Prospective Payment System Claims Through the Outpatient Prospective Payment System Outpatient Code Editor
A–01–73	• July 2001 Update to the Hospital Outpatient Prospective Payment System
A–01–74	• Replace Therapy Abstract File
A–01–75	• Children's Hospital Graduate Medical Education
A–01–76	• Scheduled Release for October Updates to Software Programs and Pricing/Coding
A–01–77	• Advance Beneficiary Notices for Services for Which Institutional Part B Claims Will Be Processed by Fiscal Intermediaries
A–01–78	• Special Handling of Outpatient Prospective Payment System Claims Containing HCFA Common Procedure Coding System Code G0121 (Screening Colonoscopy)
A–01–79	• Medicare Program-Update to the Prospective Payment System for Home Health
A–01–80	• Use of Modifier—25 and Modifier—27 in the Hospital Outpatient Prospective Payment System
A–01–81	• Change in Hospice Payment Rates, Update to the Hospice Cap, Revised Hospice Wage Index and Hospice Pricer
	Program Memorandum Carriers (HCFA Pub. 60B) (Superintendent of Documents No. HE 22.8/6–5)
B–01–23	• New Temporary ''K'' Code for the Residual Limb Support System
B–01–24	• Notification to Providers of Centralized Influenza and Pneumococcal Vaccination Billing
B–01–25	• Implementation of Carrier Jurisdiction Manual Instructions Based on the Medicare Carriers Manual Part 3, §§ 3100–3101 for the Multi-Carrier System Standard System And Associated Medicare Carriers
B–01–26	• Claims Processing Instructions for the Durable Medical Equipment, Prosthetics, Orthotics and Supplies Competitive Bidding Demonstration
B–01–27	• Durable Medical Equipment Regional Carrier Common Working File
B–01–28	• Physician Supervision of Diagnostic Tests
B–01–29	• 2001 Jurisdiction List
B–01–30	• Deletion of the HCFA Common Procedure Coding System Codes A9160, A9170, and A9190 and the GX Modifier and Replacement with New Codes and Modifiers; Status Change to HCFA Common Procedure Coding System Code A9270
B–01–31	• Accelerated Referral of Non-Medicare Secondary Payor Delinquent Active Debts
B–01–32	• Health Insurance Portability and Accountability Act Health Care Claim and Coordination of Benefits
B–01–33	• Suspend the Transmission of Box 10 Development Inquiries to the Coordination of Benefits Contractor
B–01–34	• Payment for Services Furnished by Audiologists
B–01–35	• Health Insurance Portability and Accountability Act of 1996 Administrative Simplification—Implementation of Version 4010 of the Accredited Standards Committee X12 835 (Payment/Remittance Advice) Transaction Standard Format
B–01–36	• Corrections to the Correct Coding Edits, Version 7.2, Effective July 1, 2001
B–01–37	• Systems Changes for New Oxygen Testing Requirements
B–01–38	• Adjustment to Messages Required by Change Request 1553, Transmittal B–01–10, Systems Requirements for the Benefits Improvement and Protection Act of 2000 for Drugs and Biologicals Covered by Medicare, § 114, Mandatory Submission of Assigned Claims for Drugs and Biologicals
B–01–39	• Quarterly Do Not Forward Reports
B–01–40	• Expanded Coverage of Diabetes Outpatient Self-Management Training (This Change Request Replaces the Draft Change request 1423 and Includes Full Implementation Instructions.)
B–01–41	• Clarification—Durable Medical Equipment Regional Carrier Implementation of Mandatory Assignment for Drug Claims
B–01–42	• Changes to Correct Coding Edits, Version 7.3, Effective October 1, 2001
	Program Memorandum Intermediaries/Carriers (HCFA Pub. 60A/B) (Superintendent of Documents No. HE 22.8/6–5)
AB–01–50	• Release of Version 2.1.1 of the Electronic Correspondence Referral System
AB–01–51	• Clarification Related to Troponin
AB–01–52	• Payment of Physician and Nonphysician Services in Certain Indian Providers
AB–01–53	• July Updates for 2001 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Fee Schedule
AB–01–54	• Expanded Coverage of Positron Emission Tomography Scans and Related Claims Processing Changes
AB–01–55	• Information Collection Requirements from Medicare Contractor Call Centers
AB–01–56	• Questions and Answers Regarding Payment for the Services of Therapy Students under Part B of Medicare
AB–01–57	• Registration Process for, and Expectations for Use of, the Healthcare Integrity and Protection Data Bank
AB–01–58	• Intestinal and Multi-Visceral Transplantation
AB–01–59	• Second Update to the 2001 Medicare Physician Fee Schedule Database

ADDENDUM III.—MEDICARE AND MEDICAID MANUAL INSTRUCTIONS—Continued

Transmittal No.	Manual/Subject/Publication No.
AB–01–60	• New Temporary ''Q'' Codes for Splints and Casts Used for Reduction of Fractures and Dislocations
AB–01–62	• Fiscal Intermediary Durable Medical Equipment Regional Carrier and Common
AB–01–61	• Administrative Law Judge Case File Preparation, Request From the Department Appeals Board for Case File, and Retrieval of Master Files for the Departmental Appeals Board
AB–01–63	• Change of Interest Citation in the Overpayment Sections of the Medicare Intermediary Manual and the Medicare Carriers Manual from 42 Code of Federal Regulations § 405.376 to 42 Code of Federal Regulations § 405.378.
AB–01–64	• Notice of Interest Rate for Medicare Overpayments and Underpayments
AB–01–65	• Procedures Subject to Home Health Consolidated Billing
AB–01–66	• Implementation of Medicare, Medicaid, and State Child Health Insurance Program Benefits Improvement and Protection Act of 2000 Requirements for Payment Allowance of Drugs and Biologicals Covered by Medicare
AB–01–67	• Program Memorandum on Written Statements of Intent to Claim Medicare Benefits
AB–01–68	• Consolidation of Program Memorandums for Outpatient Rehabilitation Therapy Services
AB–01–69	• Revision of Medicare Reimbursement for Telehealth Services
AB–01–70	• Revision of Existing Home Health Prospective Payment System Consolidated Billing Edits
AB–01–71	• Billing for Audiologic Function Tests for Beneficiaries That are Patients of a Skilled Nursing Facility
AB–01–72	• New Zip Code File
AB–01–73	• Payment Instructions for Intestinal Transplants Furnished to Beneficiaries Enrolled in Medicare+Choice Plans With Dates of Service on or After April 1, 2001, but Before January 1, 2002
AB–01–74	• Claims Processing Instructions for Clinical Trials on Carotid Stenting With Category B Investigational Device Exemptions
AB–01–75	• Common Working File Access Change
AB–01–76	• Coordination of Benefits Contractor Fact Sheet for Providers
AB–01–77	• The Certification Package for Internal Controls for Fiscal Year Ending September 30, 2001
AB–01–78	• Common Working File Beneficiary Other Insurer Auxiliary File
AB–01–79	• Instructions for Coverage and Billing of Biofeedback Training for the Treatment of Urinary Incontinence
AB–01–80	• Data Center Management Controls and Standard System Source Code
AB–01–81	• Update of Codes and Payments for Ambulatory Surgical Centers
AB–01–82	• Clarification of Health Care Financing Administration Core Security Requirements
AB–01–83	• Medicare Secondary Payer Debt Collection Improvement Act of 1996 Activities
AB–01–84	• Correction to Second Update to the 2001 Medicare Physician Fee Schedule Database
AB–01–85	• Health Insurance Portability and Accountability Act Release Testing/Production
AB–01–86	• Deletion of Temporary ''K'' Codes K0008 and K0013
AB–01–87	• Disclosure Desk Reference for Call Centers
AB–01–88	• Prior Approval Requirement for Data Center and Front End Movement
AB–01–89	• Future Software Releases
AB–01–90	• Ocular Photodynamic Therapy
AB–01–91	• Contractor Updating of the International Classification of Diseases, Ninth Revision, Clinical Modification
AB–01–92	• Use of the American Dental Association's Current Dental Terminology Third Edition Codes on Medicare Contractors Web Sites
AB–01–93	• Claims Processing Instructions for the Medicare Coordinated Care Demonstration—Correction and Enhancement
	Program Memorandum Medicaid State Agencies (HCFA–Pub. 17) Superintendent of Documents No. HE 22.8/6–5
01–02	Title XIX, Social Security Act, Medicaid Coverage and Payment
	Medicare Regional Office Manual—Part 2 (HCFA Pub. 23–2) Superintendent of Documents No. HE 22. 8/8
331	• Contractor Performance Evaluation Contractor Performance Evaluation Strategy and Planning Process Conducting the Contractor Performance Evaluation Review Contractor Notification of Performance Evaluation Entrance and Exit Conferences Pre-Contractor Performance Evaluation Report Rebuttals from Medicare Contractors Team Dynamics/Professional Behavior on Contractor Performance Evaluation Reviews Contractor Performance Evaluation Review Protocols
	Hospice Manual (HCFA Pub. 10) (Superintendent of Documents No. HE 22.8/2)
772	• Criteria and Payment for Sole Community Hospitals and for Medicare Dependent Hospitals

ADDENDUM III.—MEDICARE AND MEDICAID MANUAL INSTRUCTIONS—Continued

Transmittal No.		Manual/Subject/Publication No.
		Requirements for Critical Access Hospital Services and Critical Access Hospital Long Term Care Services Payment for Services Furnished by a Critical Access Hospital Payment for Post-Hospital Skilled Nursing Facility Care Furnished by a Critical Access Hospital
773	•	Billing for Intravenous Iron Therapy
774	•	Cryosurgery of the Prostate Gland
775	•	Diabetes Outpatient Self-Management Training Services
776	•	Drugs and Biologicals
		Home Health Agency Manual (HCFA Pub. 11) (Superintendent of Documents No. HE 22.8/5)
297	•	Effective Date and Scope of Home Health Prospective Payment System for Claims Number, Duration and Claims Submission of Home Health Prospective Episodes Split Percentage Payment of Episodes and Development of Episode Rates Coding of Home Health Prospective Payment System Episode Case-Mix Groups on Home Health Prospective Payment System Claims Health Research Group and Home Health Prospective Payment System Codes Health Insurance Query System for Health Agencies Inquiry Systems Shows Primary Home Health Agency Request for Anticipated Payment Claim Submission and Processing Payment When Death Occurs During an Home Health Prospective Payment System Episode Adjustments of Episode Payment—Special Submission Case ''No-Request for Anticipated Payment Low Utilization Payment Adjustment Adjustments of Episode Payment—Therapy Threshold Adjustment of Episode Payment—Significant Change in Condition Adjustment of Episode Payment—Outlier Payments General Guidance on Line Item Billing Under Home Health Prospective Payment System Home Health Prospective Payment System Consolidated Billing and Primary Home Health Agency Creation of the Health Insurance Query for Home Health Agencies Health Insurance Query Access System Inquiry and Response Timeliness and Limitations of Health Insurance Query Access System Responses Inquiries to Regional Home Health Intermediary Health Insurance Query System for Home Health Agencies Responses National Home Health Prospective Payment Episode History File Closing, Adjusting and Prioritizing Home Health Prospective Payment System Episodes Based on Resource Allocation Plans and Home Health Agency Claim Activity Other Editing and Changes for Home Health Prospective Payment System Episodes Priority Among Other Claim Types and Home Health Prospective Payment System Consolidated Billing for Episodes Request for Anticipated Payment Home Health Prospective Payment System Claims Durable Medical Equipment and Other Items Not included in Home Health Prospective Payment System Episode Payment Line Level Reporting Requirements for Resource Allocation Plan Payments Line Level Reporting Requirements for the Claim Payment in an Episode (More than 4 Visits) Instructions for Versions Subsequent to Electronic 835 Version 3051.4A.01 Submitting the HCFA–838
		Skilled Nursing Facility Manual (HCFA–Pub. 12) Superintendent of Documents No. HE 22. 8/3
368	•	Hospital Insurance A Brief Description Inpatient Hospital Services Posthospital Home Health Services Benefits Annual Part B Deductible and Coinsurance Delayed Certification and Recertifications Disposition of Certifications and Recertifications Statements Coverage of Outpatient Physical Therapy, Occupational Therapy, and Services Speech Pathology Services Services Furnished under Arrangements with Providers Signature on the Request for Payment by Someone Other Than the Patient Time Limits For Requests Claims For Payment for Services Paid Under Prospective Payment System, Fee Schedule or a Reasonable Cost Basis Usual Time Limit Extension of Time Limit Where Late Filing is Due to Administrative Error Part B Services (HCFA–1450 Billings), and Section 315, Time Limit for Filing Part B Claims Rules Governing Charges to Beneficiaries 3-Day Stay and 30-Day Transfer Requirements Billing Medicare for the Professional Component of Skilled Nursing Facility-Based Physician's Services Skilled Nursing Facility Prospective Payment System Billing Where Charges Which Include Accommodation Charges Are Incurred in Different Accounting Years

ADDENDUM III.—MEDICARE AND MEDICAID MANUAL INSTRUCTIONS—Continued

Transmittal No.		Manual/Subject/Publication No.
		Retention of Health Insurance Records Duplicate Edits and Resolution
369	•	Drugs and Biologicals
		Renal Dialysis Facility Manual (Non-Hospital Operated) (HCFA Pub. 29) (Superintendent of Documents No. HE 22.8/13)
92	•	Billing for Intravenous Iron Therapy
		Coverage Issues Manual (HCFA Pub. 6) (Superintendent of Documents No. HE 22.8/14)
136	•	Positron Emission Tomography Scans
137	•	Percutaneous Transluminal Angioplasty
138	•	Biofeedback Therapy for the Treatment of Urinary Incontinence
139	•	Intravenous Iron Therapy
140	•	Cryosurgery of the Prostate
141	•	Diabetes Outpatient Self-Management Training
		Provider Reimbursement Manual—Part 2 Provider Cost Reporting Forms and Instructions Chapter 32/Form HCFA–1728–94 (HCFA Pub. 15–2–32)
10	•	Home Health Agency Cost Reporting Form HCFA 1728–94
		Medicare Program Integrity Manual (HCFA Pub. 83)
6	•	Maintaining the Confidentiality of Medical Review Records
		Business Partners Security Oversight Manual
1	•	Information Technology Systems Security Roles and Responsibilities Information Technology Systems Security Program Management Audit Protocols and the Contractor Assessment Security Tool
		Medicare/Medicaid Sanction—Reinstatement Report (HCFA Pub. 69)
04–01	•	Report of Physicians/Practitioners, Providers and/or Other Health Care Suppliers Excluded/Reinstated—March 2001
05–01	•	Report of Physicians/Practitioners, Providers and/or Other Health Care Suppliers Excluded/Reinstated—April 2001
06–01	•	Report of Physicians/Practitioners, Providers and/or Other Health Care Suppliers Excluded/Reinstated—May 2001
		July 2001 through September 2001
		Intermidiary Manual Part 3—Claims Process (CMS Pub. 13–3) (Superintendent of Documents No. HE 22.8/6)
1840	•	Review of Form CMS–1450 for Inpatient and Outpatient Bills Alphabetic Listing of Data Elements
1841	•	Prospective Payment System Pricer Program Provider-Specific Payment Data Provider-Specific Data Record Layout and Description
1842	•	Mammography Screening Diagnostic Mammography Diagnostic and Screening Mammograms Performed with New Technologies
		Carriers Manual Part 3—Program Administration (CMS Pub. 14–3) (Superintendent of Documents No. HE 22.8/7)
1716	•	Medicare Physician Fee Schedule Database 2002 File Layout
1717	•	Roster Billing Specialty Code/Place of Service Processing Requirements Centralized Billing for Flu and Pneumococcal Vaccination Claim
1718	•	Review of Health Insurance Claim Form CMS–1500
1719	•	Preoperative Services Paid under the Physician Fee Schedule

ADDENDUM III.—MEDICARE AND MEDICAID MANUAL INSTRUCTIONS—Continued

Transmittal No.	Manual/Subject/Publication No.
1720	• Evidence of Medical Necessity for Durable Medical Equipment
1721	• Introduction to the Appeals Process Initial Determination Steps in the Appeals Process: Overview Carrier Correspondence with Beneficiaries or Other Parties Regarding—Appeals Parties to an Appeal Appointment of Representative Introduction Who May Be a Representative How to Make and Revoke an Appointment When to Submit the Appointment Where to Submit the Appointment Rights and Responsibilities of a Representative Validity of an Appointment Over Time Timeliness of an Appeal Request and Completeness of Appointment Powers of Attorney Incapacitation or Death of Beneficiary Disclosure of Individually Identifiable Beneficiary Information to Representatives Amount in Controversy Defined General Requirements Calculating the Amount in Controversy Additional Considerations for Calculation of the Amount in Controversy Aggregation of Claims to Meet the Amount in Controversy Extension of Time Limit for Filing a Request for Review or Hearing Officer Hearing Good Cause General Procedure to Establish Good Cause Conditions that May Establish Good Cause for Late Filing by Beneficiaries Example of Situations Where Good Cause for Late Filing Exists for Physicians or Other Suppliers Conditions that May Establish Good Cause for Late Filing by Physicians or Other Suppliers Example of Situations Where Good Cause for Late Filing Exists for Physicians or Other Supplier Good Cause Not Found for Beneficiary, or for Physician or Other Supplier Fraud and Abuse Authority Inclusion and Consideration of Evidence of Fraud and /or Abuse Claims Where There Is Evidence That Items or Services Were Not Furnished, or Were Not Furnished as Billed Responsibilities or Reviewers and Hearing Officers Requests to Suspend the Appeals Process Continuing Appeals of Physicians or Other Suppliers who are Under Fraud or Abuse Investigations Appeals of Claims Involving Excluded Physicians or Other Suppliers Guidelines for Writing Appeals Correspondence General Guidelines Letter Format Required Elements in Appeals Correspondence Disclosure of Information General Information Fraud and Abuse Investigations Medical Consultants Used Multiple Beneficiaries The First Level of Appeal Filing a Request for Review Time Limit for Filing a Request for Review Recording of Inquires and Other Actions on the Carriers Appeal Report (Form Center for Medicare Services–2590) The Review The Review Determination Review Determination Letter Effect of the Review Determination Telephone Review Procedures Informing the Beneficiary and Provider Communities About Your Telephone Review Process Issues for Telephone Review Issues During the Telephone Review Time Limit for Requesting a Telephone Review Review Request Made on Behalf of the Party on the Telephone Conducting the Telephone Review Documenting the Call Timely Processing Requirements Review Determination Letters Education Monitoring Telephone Reviews Hearing Officers Hearing—The Second Level of Appeal Filing a Request for Hearing Officer Hearing

ADDENDUM III.—MEDICARE AND MEDICAID MANUAL INSTRUCTIONS—Continued

Transmittal No.		Manual/Subject/Publication No.
		Time Limit for Filing A Request for Hearing Officer Hearing
		Request for Hearing Officer Hearing Filed Prior to a Review Determination
		Exceptions to Filing Requirements
		Request for Hearing Officer Hearing
		Timely Processing Requirements
		Carrier Responsibilities
		Requests for Transfer of In-Person Hearings
		Acknowledgment of Request for HO Hearing
		Case File Development
		Case File Preparation
		Types of Hearing Officer Hearings
		In-Person Hearing
		Telephone Hearing
		On-the-Record Hearing and Decision
		Preliminary On-the-Record Hearing and Decision
		Hearing Officer Authority and Responsibilities
		Hearing Officer Authority
		Qualifications and General Responsibilities
		Disqualification of Hearing Officer
		Hearing Officer Hearing Procedures
		Preparation for the Hearing Officer Hearing
		Scheduling the Date, Time and Place of Hearing
		Adjournment and/or Postponement of Telephone or In-Person Hearing
		Pre-Hearing Review of the Evidence
		Forwarding Copies of Cast File Prior to Telephone Hearing
		In-Person and Telephone Hearing Procedures
		The Hearing Officer Hearing Decision Timeliness
		Effectuation of Hearing Officer Hearing Decisions
		General Rule
		Delaying Effectuation
		Elements of Written Request for Reopening
		Notice to Parties of Reopening Requests
		Hearing Officer Reply to Reopening Request
		Notice to Parties of Hearing Officer Determinations
		Requests for Part B Administrative Law Judge Hearing
		Right to Part B Administrative Law Judge Hearing
		Forwarding Requests to Social Security Administration/Office of Hearings & Appeals
		Case File Preparation
		Acknowledgement of Request for Part B Administrative Law Judge Hearings
		Model Format for Acknowledgement of Administrative Law Judge Hearing Request
		Review and Effectuation of Part B Administrative Law Judge Decisions/ Dismissals
		Review and Effectuation of Administrative Law Judge Decisions—General Effectuation Time Limits
		Administrative Law Judge Data Extraction Form
		Misrouted Administrative Law Judge Case Files
		Duplicate Administrative Law Judge Decisions
		Recommending Agency Referral of Part B Administrative Law Judge Decisions or Dismissals to the Centers for Medicare and Medicaid Services Regional Office (formerly known as the Agency Protest Process)
		Time Limits for Forwarding Agency Referral Memorandum to Centers for Medicare and Medicaid Services Regional Office
		Guidelines for Reviewing Administrative Law Judge Decisions/Dismissals
		Draft Agency Referral Memorandum Content
		Draft Memorandum Format
		Submission of Draft Agency Referral Memorandum to Centers for Medicare and Medicaid Services Regional Office
		Effectuation of Departmental Appeals Board Orders and Decisions
1722	•	Diagnosis or Nature of Illness of Injury
1723	•	Billing Procedures for Teaching Physician Services
1724	•	Screening Mammography and Diagnostic Mammography
		Identifying a Screening Mammography Claim and A Diagnostic Mammography Claim
		Adjudicating the Claim
		Diagnostic and Screening Mammograms Performed with New Technologies
1724	•	Diagnostic X-Ray, Diagnostic Laboratory, and Other Diagnostic Tests
		Program Memorandum Intermediaries (CMS Pub. 60A) (Superintendent of Documents No. HE 22.8/6–5)
A–01–82	•	Centers for Medicare and Medicaid Services Audit and Cost Report Settlement Expectations
A–01–83	•	Skilled Nursing Facility Annual Updated for Fiscal Year 2002
A–01–84	•	Problem With Processing Certain Clinical Diagnostic Laboratory Claims and Other Claims through the July Outpatient Code Editor
A–01–85	•	Notification of Access to Eligibility Vendor
A–01–86	•	New Patient Status Codes
A–01–87	•	Comprehensive Error Rate Testing Program—Requirements for Medicare Part A Contractor Operation

ADDENDUM III.—MEDICARE AND MEDICAID MANUAL INSTRUCTIONS—Continued

Transmittal No.	Manual/Subject/Publication No.
A–01–88	• Extension of Due Date for Filing Provider Cost Reports
A–01–89	• Payment for Blood Clotting Factor Administered to Hemophilia Inpatients
A–01–90	• Home Health Agency Prospective Payment System Correction in Financial Reporting For Trust Funds
A–01–91	• Clarification of Provider Billing Requirements Under the Outpatient Prospective Payment System
A–01–92	• Instructions for Implementing the Inpatient Rehabilitation Facility Prospective Payment System
A–01–93	• Hospital Outpatient Prospective Payment System Implementation Instructions
A–01–94	• Implementation of Fee Schedule for Additional Part B Services Furnished by a Skilled Nursing Facility or Another Entity Under Arrangements with the Skilled Facility
A–01–95	• Workaround for Home Health Prospective Payment System Transfer Claims Received Out of Sequence-Regional Home Health Intermediaries Only
A–01–96	• Clarification of the Regulations at 42 Code of Federal Regulations 413.134(1) To Mergers and Consolidations Involving Non-profit Providers
A–01–97	• Technical Corrections Under the Hospital Outpatient Prospective Payment System
A–01–98	• October Outpatient Code Editor Specifications Version (V2.3)
A–01–99	• Changes in the Paid Claim Record—Notification Process
A–01–100	• Upcoming Train the Trainer Session for Inpatient Rehabilitation Facility Prospective Payment System
A–01–101	• Changes to Fiscal Year 2001 Hospital Inpatient and Outpatient Prospective Payment System Policies As Required by the Medicare, Medicaid, and State Child Health Insurance Program Balanced Budget Refinement Act of 1999, P.L. 106–113
A–01–102	• Fiscal Year 2002 Prospective Payment System Hospital, Skilled Nursing Facility and Other Bill Processing Changes
A–01–103	• October Medicare Outpatient Code Editor Specifications Version 17.0 for Bills from
A–01–104	• File Descriptions and Instructions for Retrieving the 2002 Physician, Clinical Laboratory Durable Medical Equipment, Prosthetics/Orthotics and Supplies, and Therapy Fee • Schedule Payment Amounts through Centers for Medicare & Medicaid Services Telecommunications System
A–01–105	• Screening Glaucoma Services
A–01–106	• Instructions for Billing and Processing of Hospital Outpatient Claims Containing Charges for Epoetin Alfa Tradenames: Epogen and Procrit
A–01–107	• October 2001 Update to the Hospital Outpatient Prospective Payment System
A–01–108	• The Report of Benefit Savings
A–01–109	• The Supplemental Security Income/Medicare Beneficiary Data for Fiscal Year 2000 For Prospective Payment System Hospitals
A–01–110	• Instructions for Implementing the Inpatient Rehabilitation Facility Prospective Payment System
A–01–111	• Clarification of Activity Therapy (HCPC G0176) and Patient Education/Training Services (HCPC G0177) Under the Hospital Outpatient Prospective Payment System
A–01–112	• Removal of Category Code C1723 from the Pass-Through Device Category List under The Hospital Outpatient Prospective Payment System
A–01–113	• Prospective Payment System Patient Transfers Improperly Paid as Hospital Discharges
A–01–114	• Handling of Claims Containing CMS Common Procedure Coding System Codes G0204 and G0205
A–01–115	• Bypassing Medicare Secondary Payer Edits on Indirect Medical Education Claims for Medicare+Choice Organization Enrollees
A–01–116	• Medicare Secondary Payer Policies Relaxed for Hospitals
A–01–117	• Production Dates for the Provider Statistical and Reimbursement Report and Extension Of Due Date for Filing Provider Cost Reports
A–01–118	• Clarification of Cost Reporting Policy in Charge Request 1468, Concerning Submission of Home Office Cost Statements for Chain Home Offices
A–01–119	• Correction to Program Memorandum (PM) A–01–94 (CR 1689: Implementation of Fee Schedule for Additional Part B Services Furnished by a Skilled Nursing Facility Or Another Entity Under Arrangements with the Skilled Nursing Facilities
A–01–120	• Removal of CMS Common Procedure Coding System/Revenue Code Editing under The Outpatient Prospective Payment
A–01–121	• Skilled Nursing Facility Adjustment Billing: Adjustments to Health Insurance Prospective Payment System
A–01–122	• Payment of Skilled Nursing Facility Claims for Beneficiaries Disenrolling from Terminating Medicare+Choice Plans Who Have Not Met the 3-Day Hospital Stay Requirement
A–01–123	• Fiscal Year 2001 Prospective Payment System Hospital and Other Bill Processing Changes
A–01–124	• Clarification to Health Insurance Prospective Payment System Coding and Billing Instructions
A–01–125	• Guidance Regarding a Change in Reimbursement for Part B Inpatient Ancillary Services
	Program Memorandum Carriers (CMS Pub. 60B) (Superintendent of Documents No. HE 22.8/6–5)
B–01–43	• Clarification of Payment and Place of Service Requirements for Ambulatory Surgical Center Claims
B–01–44	• Medicare TeleMedicine Demonstration Ending Date
B–01–45	• Tracking and Reporting Requirements for Advance Determinations of Medicare Coverage
B–01–46	• Instructions for Billing for Claims for Screening Glaucoma Services
B–01–47	• Comprehensive Error Rate Testing Program—Requirements Update for Medicare Part B Contractor Operations
B–01–48	• Medical Nutrition Therapy Services for Beneficiaries with Diabetes or Renal Disease
B–01–49	• Additional Information Regarding Medicare Payment Allowance for Flu Vaccine
B–01–50	• Attestation Option for Submission Requirement for Clinical Laboratories Billing The Technical Component of Physician Pathology Services to Hospital Patients
B–01–51	• Common Working File Changes Required for Processing Native American and Alaskan Native Railroad Retiree Claims
B–01–52	• Changes to the Center for Medicare & Medicaid Services Part B Standard System Carrier CMS Part B Standard System Responsibility (Accelerate, Claims Collection Software)
B–01–53	• Change in Jurisdiction for Pessary Codes
B–01–54	• Implementation of New Fee Schedule for Parenteral and Enteral Nutrition Items and Services

ADDENDUM III.—MEDICARE AND MEDICAID MANUAL INSTRUCTIONS—Continued

Transmittal No.	Manual/Subject/Publication No.
B–01–55	• Changes to Correct Coding Edits, Version 8.0, Effective January 1, 2002
B–01–56	• Payment for Home Dialysis Supplies and Equipment
B–01–57	• New Specialty Code for Pain Management
B–01–58	• Coding for Non-Covered Services and Services Not Reasonable and Necessary
B–01–59	• Clarification of Medicare Contractor Financial Reporting Instructions Outlined In § 4923.2 of the Medicare Carriers Manual. (Issued May 2001)
B–01–60	• Schedule for Completing the Calendar Year 2002 Fee Schedule Updates and the Participating Physician Enrollment Procedures
B–01–61	• Interface Control Document
	Program Memorandum Intermediaries/Carriers (CMS Pub. 60A/B) (Superintendent of Documents No. HE 22.8/6–5)
AB–01–94	• Profiling Medicare Contractor Call Center
AB–01–95	• New Waived Test—July 12, 2001
AB–01–96	• Health Insurance Portability and Accountability Act Electronic Data Interchange Testing and Reporting Requirements
AB–01–97	• Claims Processing Instructions for the Medicare Participating Center of Excellence Demonstration and the Medicare Provider Partnership Demonstration
AB–01–98	• Durable Medical Equipment Regional Carrier Denial Code for Durable Medical Equipment Furnished in Skilled Nursing Facilities
AB–01–99	• This Transmittal Has Been Rescinded
AB–01–100	• Common Working File Health Master Record Redesign & Beneficiary Master File Expansion
AB–01–101	• Harkin Grants: Complaint Tracking System
AB–01–102	• Common Working File Y2K Wrapper Logic Removal Changes
AB–01–103	• Revised Guidelines for Processing Claims for Clinical Trial Routine Care Services
AB–01–104	• Modifications to the Common Working File to: (1) Suppress Hust Type Total Cost Transactions for Medicare+Choice and Adjustment Claims; and (2) Activate Coordination of Benefits Contractor #11100
AB–01–105	• Medical Review Progressive Corrective Action
AB–01–106	• Implementation of the Health Insurance Portability and Accountability Act Claims Status Request/Response Transaction Standard
AB–01–107	• Customer Services Plans Reporting Procedures
AB–01–108	• Final Update to the 2001 Medicare Physician Fee Schedule Database
AB–01–109	• Correction of Payment for Diabetes Outpatient Self-Management Training Services
AB–01–110	• Notice of Interest Rate for Medicare Overpayments and Underpayments
AB–01–111	• Completion of Home Health Prospective Payment System Consolidated Billing Enforcement
AB–01–112	• Installation of Digital Satellite Dishes at Medicare Contractors
AB–01–113	• Clarification of Comprehensive Error Rate Testing Program Requirements for Medicare Contractor Operations Regarding Prepayment Random Medical Review
AB–01–114	• Data Center Testing—Electronic Correspondence Referral System Software Version 3.0
AB–01–115	• Payment Instructions for Intestinal Transplants Furnished to Beneficiaries Enrolled in Medicare+Choice Plans With Dates of Service on or After April 1, 2001, but Before January 1, 2002
AB–01–116	• Provider/Supplier Plan Quarterly Report Format
AB–01–117	• Instruction Implementation Reporting
AB–01–118	• Reasonable Charge Update for 2002 for Items and Services, Other Than Ambulance and Laboratory Services
AB–01–119	• New Zip Code File
AB–01–120	• Correction to the Revision of Medicare Reimbursement for Telehealth Services
AB–01–121	• Update of Rates and Wage Index for Ambulatory Surgical Center Payments Effective October 1, 2001
AB–01–122	• Procedures for Re-issuance and Stale Dating of Medicare Checks
AB–01–123	• Useful Lifetime Expectancy for Breast Prosthesis
AB–01–124	• Health Insurance Portability and Accountability Act Budget Requests for Electronic Data Interchange Testing and Reporting
AB–01–125	• Clarification and Update to Medicare Payment for Code Q3014 (Telehealth Facility Fee)
AB–01–126	• Instructions for Implementing and Updating 2002 Payment Amounts for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies
AB–01–127	• Year 2002 Healthcare Common Procedure Coding System Annual Update Reminder
AB–01–128	• Annual Update of Non-Routine Medical Supply and Therapy Codes for Home Health Consolidated Billing
AB–01–129	• Medicare Coverage of Non-Invasive Vascular Studies for End Stage Renal Disease Patients
AB–01–130	• Claims Processing Instructions for Carriers, Durable Medical Equipment Regional Carrier, Intermediaries and Regional Home Health Intermediaries for Claims Submitted for Medicare Beneficiaries Participating in Medicare Qualifying Clinical Trials
AB–01–131	• Fiscal Intermediary Instructions on Applying Payment Bans on Skilled Nursing Facility Admissions
AB–01–132	• Further Guidance Concerning Implementation of the Health Insurance Portability and Accountability Act Transactions
AB–01–133	• Interim Instructions—Document and Correspondence Name Transition from Health Care Financing Administration to Centers for Medicare & Medicaid Services
AB–01–134	• New Source of Provider Information to be Available on CMS Website October 1, 2001
AB–01–135	• Medical Review of Services for Patients with Dementia
AB–01–136	• Supplemental Instructions on CMS Business Partners Systems Security Requirements
AB–01–137	• CMS Policy for Disclosure of Individually Identifiable Information: Provider Telephone Inquiries for Medicare Eligibility Information

ADDENDUM III.—MEDICARE AND MEDICAID MANUAL INSTRUCTIONS—Continued

Transmittal No.	Manual/Subject/Publication No.
AB–01–138	• New Zip Code File
AB–01–139	• Claims Processing Instructions for Claims Submitted With a Written Statement of Intent
AB–01–140	• Claims Processing Instructions for the Medicare Participating Centers of Excellence Demonstration and the Medicare Provider Partnership Demonstration
	State Operations Manual—Provider Certification
	(CMS–Pub. 7)
27	• Surveying Health Maintenance Organization Operated Home Health Agencies Providing Home Health Services Through Medicare Survey and Certification Process Classification of Maintenance Dialysis Facilities as Hospital-Based or Independent Prospective Pay • Regional Office Assessment of Provider and Supplier Identification Number
	Hospice Manual **(CMS Pub. 10)** **(Superintendent of Documents No. HE 22.8/2)**
777	• General Admission Procedures Identifying Other Primary Payers During The Admission Process Types of Admission Questions to Ask Medicare Beneficiaries Policy For Provider Records Retention of Medicare Secondary Payer Information
	Skilled Nursing Facility Manual **(CMS–Pub. 12)** **(Superintendent of Documents No. HE 22. 8/3)**
370	• This Transmittal is notification that the printed copy of Transmittal 368, Change Request 1323, dated May 24, 2001, is a final copy. The stamp ''Advance Copy of Final Issues'' was inadvertently printed on the Transmittal page.
	Coverage Issues Manual **(CMS Pub. 6)** **(Superintendent of Documents No. HE 22.8/14)**
142	• Adult Liver Transplantation
143	• Infusion Pumps
	Provider Reimbursement Manual—Part 1 **(CMS Pub. 15–1)** **(Superintendent of Documents No. HE 22.8/4)**
421	• Regional Medicare Swing-Bed Rates
422	• Reasonable Cost of Therapy and Other Services Furnished by Outside Suppliers
	Provider Reimbursement Manual—Part 2 **Provider Cost Reporting Forms and Instructions** **Chapter 18/Form CMS–2088–92** **(CMS Pub. 15–2–18)**
5	• Outpatient Rehabilitation Provider Cost Reporting Form CMS–2088–92
	Provider Reimbursement Manual—Part 2 **Provider Cost Reporting Forms and Instructions** **Chapter 35/Form CMS–2540–96** **(CMS Pub. 15–2–35)**
11	• Skilled Nursing Facility Cost Report Form CMS 2540–96
	Provider Reimbursement Manual—Part 2 **Provider Cost Reporting Forms and Instructions** **Chapter 36/Form CMS–2552–96** **(CMS Pub. 15–2–36)**
8	• Hospital and Hospital Health Care Complex Cost Report
	ESRD Network Organizations Manual **(CMS Pub. 81)** **(Superintendent of Documents No. HE 22.9/4)**
13	• Background/Authority Responsibilities System Capacity

ADDENDUM III.—MEDICARE AND MEDICAID MANUAL INSTRUCTIONS—Continued

Transmittal No.	Manual/Subject/Publication No.
	Hardware/Software Requirements Center Medicaid Services System Access Data Security Confidentiality of Data Database Management Patient Database Updates Center Medicaid Services-Directed changes to Your Patient Database
	Medicare Program Integrity Manual (CMS–Pub. 83)
8	• The Medicare Medical Review Program Quality of Care Issues Goal of the Medical Review Program Medical Review Manager Annual Medical Review Strategy Annual Quality Indicator Program Report National Coverage Decisions, Coverage Provisions in Interpretive Manual, Local Medical Review Policy, and Individual Claim Determinations National Coverage Decisions Coverage Provisions in Interpretive Manuals Local Medical Review Policy Individual Claim Determinations Local Medical Review Policy Development Process Identification of Services For Which a New or Revised Local Medical Review Process is Needed Techniques for Writing Local Medical Review Policies Evidence Supporting Local Medical Review Policy Benefit Category Statutory Exclusions on Grounds Other Than Section 1862 Reasonable and Necessary Coding Provisions in Local Medical Review Policies
9	• Local Medical Review Policy Comment Process Local Medical Review Policy Notice Process Local Medical Review Policy Format Retired Local Medical Review Policy American Medical Association Common Procedural Terminology Copyright Agreement Local Medical Review Policy Notice Process Format Local Medical Review Policy Notice Process Submission/Requirements
10	• Contractor Advisory Committees Process
11	• Certificates of Medical Necessity as the Written Order Cover Letters for Certificate of Medical Necessity Completing a Certificates of Medical Necessity DME Regional Carrier Authority to Assess an Overpayment and /oCMP When Invalid Certificates of Medical Necessity Acceptability of Faxed Orders and Facsimile or Electronic Certificates of Medical Necessity
12	• Certificates of Medical Necessity as the Written Order Cover Letters for Certificates of Medical Necessity Completing a Certificate of Medical Necessity Durable Medical Equipment Regional Coordinator's Authority to Assess an Overpayment and/or Civil Monetary Penalty When Invalid Certificates of Medical Necessity's are Identified Certificates of Medical Necessity Acceptability of Faxed Orders and Facsimile or Electronic Certificates of Medical Necessity
12	• Fiscal Intermediary, Carrier Durable Medical Equipment Regional Carriers and Regional Home Health Intermediary Interaction and Coordination with Program Safeguard Contractors Introduction Program Safeguard Contractors for Corporate Integrity Agreements
13	• Administrative Relief from Medical Review and Benefit Integrity in Disaster Situations
14	• Local Medical Review Policy Format Local Medical Review Policy Submission/Requirements
	Medicare/Medicaid Sanction—Reinstatement Report (CMS Pub. 69)
07–01	• Report of Physicians/Practitioners, Providers and/or Other Health Care Suppliers Excluded/Reinstated—June 2001
08–01	• Report of Physicians/Practitioners, Providers and/or Other Health Care Suppliers Excluded/Reinstated—July 2001
09–01	• Report of Physicians/Practitioners, Providers and/or Other Health Care Suppliers Excluded/Reinstated—August 2001

ADDENDUM III.—MEDICARE AND MEDICAID MANUAL INSTRUCTIONS—Continued

Transmittal No.	Manual/Subject/Publication No.
	October 2001 through December 2001
	Intermediary Manual Part 3—Claims Process (CMS Pub. 13–1) (Superintendent of Documents No. HE 22.8/6–3)
132	• Overpayments for Provider Services—General
	Intermediary Manual Part 3—Claims Process (CMS Pub. 13–3) (Superintendent of Documents No. HE 22.8/6)
1843	• Payment for Services Furnished by A Critical Access Hospital
1844	• Overpayments for Provider Services
1845	• CMS Common Procedure Coding System for Hospital Outpatient Radiology Services and Other Diagnostic Procedures
1846	• Special Coverage Requirements
1847	• Payment for Blood Clotting Factor Administered to Hemophilia Inpatients
1848	• CMS Common Procedure Coding System for Hospital Outpatient Radiology Service and Other Diagnostic Procedures Outpatient Therapeutic Services Immunosuppressive Drugs Furnished to Transplant Patients
1849	• Therapeutic Pheresis (Apheresis)
	Carriers Manual Part 3—Claims Process (CMS Pub. 14–3) (Superintendent of Documents No. HE 22.8/7)
1726	• The Destination
1727	• Overpayments—General
1728	• Claims Involving Beneficiaries Who Have Elected Hospice Coverage Processing Claims For Attending Physician Services Furnished to Hospice Patients Services Unrelated to a Hospice Patients Terminal Condition Non-Hospice Services Furnished to Hospice Patients Who Are M+C Enrollees Payment Safeguard Medicare Summary Notices and Explanation of Medicare Benefits and Remittance Advice Messages
1729	• End Stage Renal Disease Bill Processing Procedures
1730	• Durable Medical Equipment Regional Carrier Billing Procedures
1731	• Centralized Billing for Flu and Pneumococcal Vaccination Claims
1732	• Type of Service
1733	• Mandatory Submission of Assigned Claims for Drugs and Biologicals Claims for Drugs and Biologicals.
1734	• Physician Assistant Services Nurse Practitioner Services Clinical Nurse Specialist Services Billing for Physician Assistant Nurse Practitioner Or Clinical Nurse Specialist Services Billing Requirements for Physician Assistant Services Billing Requirements for Nurse Practitioner or Clinical Nurse Specialist Services Billing for Teaching Physician Services
1735	• Coverage Criteria Ambulatory Surgical Center Fee
1736	• Paying Claims Without Common Working File Approval Requesting to Pay Claims Without Common Working File Approval Procedures for Paying Claims Without Common Working File Approval
1737	• Glaucoma Screening Conditions of Coverage Claims Submission Requirements and Applicable HCPCS Codes Calculating the Frequency Common Working File Edits Claims Editing Diagnosis Coding Requirements Payment Methodology Remittance Advice Notices Medicare Summary Notice and Explanation of Medicare Benefits Messages
	Carriers Manual Part 4—Professional Relations (CMS Pub. 14–4) (Superintendent of Documents No. HE 22.8/7–4)
25	• The Attestation statement has been replaced by a new GV modifer

ADDENDUM III.—MEDICARE AND MEDICAID MANUAL INSTRUCTIONS—Continued

Transmittal No.	Manual/Subject/Publication No.
	Program Memorandum Intermediaries (CMS Pub. 60A) (Superintendent of Documents No. HE 22.8/6–5)
A–01–126	• Scheduled Release for January Updates to Software Programs and Pricing/Coding Files
A–01–127	• Common Working File Processing of Home Health Prospective Payment System Transfer Episodes Received Out of Sequence
A–01–128	• Common Working File Processing of Home Health Prospective Payment System (HH PPS) Transfer Episodes Received Out of Sequence
A–01–129	• Reporting Claims Accounting Information to the Healthcare Integrated General Ledger Accounting System (HIGLAS)
A–01–130	• Receipt and Processing of Non-Covered Charges on Other Than Part A Inpatient Claims
A–01–131	• Additional Instructions for Implementing the Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS)
A–01–132	• Screening Glaucoma Services
A–01–133	• Clarification of Payments Made to Hospital Outpatient Departments Under the Outpatient Prospective Payment System (OPPS)
A–01–134	• January Medicare Outpatient Code Editor (OCE) Specifications Version 17.1 For Bills From Hospitals That Are Not Paid Under the Outpatient Prospective Payment System (OPPS)
A–01–135	• HCPCS Code Updates and Corrections for SNF Part A PPS Consolidated Billing and SNF Part B Fee Schedule for 2002.
A–01–136	• Do not Forward Initiative
A–01–137	• Modifications to Form CMS–339 Requirements, Provider Cost Report
A–01–138	• Announcement of Medicare Rural Health Clinics and Federally Qualified Health Centers Payment Rate Increases, Changes to the Exception Criteria for the Payment Limit for Rural Health Clinics Based in Rural Hospitals
A–01–139	• Special Instructions for Handling of Outpatient Pa
A–01–140	• Special Payment for Outpatient Prospective Payment System Due to Delay in Implementing System Updates
A–01–141	• Center for Medicare and Medicaid Services Audit and Cost Report Settlement Expectations
A–01–142	• Clarification and HCPCs Coding Update: Part B Fee Schedule And Consolidated Billing For Skilled Nursing Facility Services
A–01–143	• Provider Education Article: CY 2002 Outpatient PPS Rate Implementation
A–01–144	• Additional Information Related to Section 212 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (Public Law 106–554) Affecting Medicare-Dependent, Small Rural Hospitals. Also, Clarifications and Corrections to: *Changes to the Hospital Inpatient Prospective Payment Systems and Rates and Costs of Graduate Medical Education; Fiscal Year 2002 Rates, Etc.; Final Rules,* as Published in the **Federal Register** on August 1, 2001 (66 FR 39828)
A–01–145	• Delay of the 2002 Update to the Outpatient Prospective Payment System
A–01–146	• Inpatient Rehabilitation Facility Prospective Payment System Revenue Code File Update
A–01–147	• Federal Fiscal Year (FY) 2003 Wage Index: Request for FY 1999 Wage Data from Hospitals Affected by the Filing Extensions Provided by Transmittal Numbers A–01–88 and A–01–117
A–01–148	• Changes to Fiscal Year (FY) 2001 Nursing and Allied Health Education Payment Policies as Required by the Benefits Improvement and Protection Act of 2000 (BIPA), P. L. 106–554
A–01–149	• Amended Production Dates for the Provider Statistical and Reimbursement Report and Extension of Due for Filing Provider Cost Reports
A–01–150	• Provider Education Article: CY2002 Outpatient Prospective Payment System Rate Implementation Delay
	Program Memorandum Carriers (CMS Pub. 60B) (Superintendent of Documents No. HE 22.8/6–5)
B–01–62	• Problem Resolution to Issues Raised by Implementation of Change Request 1646 for The Medicare Carriers Processing on the Multi-Carrier System
B–01–63	• New Modifier for Rental Items
B–01–64	• DMERCs—Advance Beneficiary Notices for Upgrades
B–01–65	• Calendar Year 2002 Participation Enrollment and Medicare Participating Physicians and Suppliers Directory Procedures
B–01–66	• Program Integrity Sampling Module for Part B and DME Carriers
B–01–67	• Updated Correct Coding Initiative Coding Policy Manual
B–01–68	• Provider Upgrades of Durable Medical Equipment, Prosthetics, Othotics and Supplies Without Any Extra Charge
B–01–69	• 2002 Anesthesia Conversion Factor
B–01–70	• Reporting Claims Accounting information to the Healthcare Integrated General Ledger Accounting System
B–01–71	• American National Standards Institute X12N 837 Professional Health Care Claims Companion Document
B–01–72	• Change in Common Working File for two immunosuppressive Drugs
B–01–73	• Reviewing Deceased Physicians' Unique Physician Identification Numbers on Durable Medical Equipment Regional Carrier Claims
B–01–74	• Supplier Billing for Glucose Test Strips and Supplies (Revised)
B–01–75	• Changes to Correct Coding Edits, Version 8.1, Effective April, 2002
B–01–76	• Issuance of Standard Paper Remittance Advice Notices and SPR–X12835V4010 Crosswalk
B–01–77	• Correction to Correct Coding Edits, Version 8.0, Effective January 1, 2002
B–01–78	• Correction to Fee Schedule File for Parenteral and Enteral Nutrition Items and Services

ADDENDUM III.—MEDICARE AND MEDICAID MANUAL INSTRUCTIONS—Continued

Transmittal No.	Manual/Subject/Publication No.
	Program Memorandum Intermediaries/Carriers (CMS Pub. 60A/B) (Superintendent of Documents No. HE 22.8/6–5)
AB–01–141	• Update of Codes and Payments for Ambulatory Surgical Centers (ASCs)
AB–01–142	• Revised Guidelines for Processing Claims for Clinical Trial Routine Care Services
AB–01–143	• Coverage and Billing of Sacral Nerve Stimulation
AB–01–144	• International Classification of Diseases, Ninth Revision, Clinical Modification Coding for Diagnostic Tests
AB–01–145	• New Waived Tests—September 13, 2001
AB–01–146	• Distribution of Revised Form CMS–855s—Medicare Provider/Supplier Enrollment Applications—(Formerly Form CMS–855) Dated November 1, 2001
AB–01–147	• Electronic Correspondence Referral System User Manual 3.0.1 and Electronic Correspondence Referral System Quick Reference Card
AB–01–148	• Ambulance Inflation Factor for 2002
AB–01–149	• Unsolicited Response and Auto Adjustment of Claims for the Medicare Participating Centers of Excellence Demonstration and the Medicare Provider Partnership Demonstration
AB–01–150	• Breakdown of the American Medical Association's Physicians' Current Procedural Terminology, Fourth Edition 2002 Codes
AB–01–151	• Clarification of Common Working File Y2K Wrapper Logic Removal Changes (Change Request 1774)
AB–01–152	• Breakdown of the American Medical Association's Physicians' Current Procedural Terminology, Fourth Edition 2002 Codes
AB–01–153	• Tracking the Number of Diabetes Outpatient Self-Management Training and Medical Nutrition Therapy Hour by the Common Working File
AB–01–154	• Medical Deduction and Premium Rates Calendar Year 2002
AB–01–155	• Information Collection Requirements from Medicare Contractor Call Centers
AB–01–156	• Expanding the Number of Source Identifiers for Common Working File MSP Records
AB–01–157	• New Common Working File Medicare Secondary Payer Edit to Reject Medicare Secondary Payer Records for Medicare Beneficiaries Who Are Only Entitled to Medicare Part B, and Are Covered by a Group Health Plan
AB–01–158	• New Common Working File Edits and Standard System Responses on Skilled Nursing Facility Claims
AB–01–159	• Common Working File Reject and Utilization Edits and Carrier Resolution for Consolidated Billing for Skilled Nursing Facility Residents
AB–01–160	• Standardize Common Working File Hosts' Processes and Procedures With Standard Software (AMEN Program)
AB–01–161	• Notice of Interest Rate for Medicare Overpayments and Underpayments
AB–01–162	• 2002 Clinical Laboratory Fee Schedule and Laboratory Costs Subject to Reasonable Charge Payment Methodology
AB–01–163	• Expand Standard Date Format and Remove Common Working File,Y2K Wrapper Logic for Part B Eligibility File, Part B (HUBC), and DME (HUDC) Incoming and Reponse Transactions
AB–01–164	• Correction to Program Memorandum AB–01–53: Elimination of DMEPOS Fee Schedules for Repair Codes E1340, L4205, L7520, and L8049
AB–01–165	• Implementation of an Ambulance Fee Schedule
AB–01–166	• Coverage and Billing of Sacral Nerve Stimulation
AB–01–167	• Correction to 2nd Update to 2001 Medicare Physician Fee Schedule Database
AB–01–168	• The Use of Gamma Cameras and Full Ring and Partial Ring Positron Emission Tomography Scanners for Positron Emission Tomography Scans
AB–01–169	• Transaction Certification and Testing
AB–01–170	• Clarification to Medicare Carrier Manual § 2130 Prosthetic Devices and Coverage Issues Manual § 60–9 Durable Medical Equipment Reference List—Coverage of Intermittent Catheterization
AB–01–171	• Request for Contractor's Business Contingency Plan—January 15, 2002
AB–01–172	• Promoting Medicare's Screening Pap Test Benefit in Support of Cervical Health Month (January)
AB–01–173	• Name Transition From Health Care Financing Administration to Centers for Medicare & Medicaid Services—Identity Mark Guidelines
AB–01–174	• The Certification Package for Internal Controls for Fiscal Year Ending September 30, 2002
AB–01–175	• Payment for Method II Home Dialysis Supplies
AB–01–176	• The Medicare Exclusion Database Replaces Publication 69
AB–01–177	• Emergency Changes to the 2002 Medicare Physician Fee Schedule Database
AB–01–178	• April Quarterly Updates for 2002 Durable Medical Equipment, Prosthetics, Orthotics, and Suppliers Fee Schedule
AB–01–179	• Zip Code File on the Direct Connect
AB–01–180	• Payment for Method II Home Dialysis Supplies
AB–01–181	• Coordination of Benefits Contractor Fact Sheet for Provider
AB–01–182	• Use of the American Medical Association's Physicians' Current Procedural Terminology, Fourth Edition Codes on Contractors' Web Sites
AB–01–183	• Appeals of Medicare Part A/Part B Coverage Determinations
AB–01–184	• Clarifications to Implementation of the Ambulance Fee Schedule
AB–01–185	• Implementation of the Ambulance Fee Schedule
AB–01–186	• Suspension of National coverage Policy on Electrical Stimulation for Wound Healing
AB–01–187	• Update to Waived Test—November 21, 2001
AB–01–188	• Coverage and Billing of Ambulatory Blood Pressure Monitoring
AB–01–189	• Medicare Coverage of Non-Invasive Vascular Studies for End Stage Renal Disease Patients

ADDENDUM III.—MEDICARE AND MEDICAID MANUAL INSTRUCTIONS—Continued

Transmittal No.	Manual/Subject/Publication No.
	Hospital Manual (CMS Pub. 10) (Superintendent of Documents No. HE 22.8/2)
778	• Critical Access Hospital
779	• CMS Common Procedure Coding System for Hospitals Outpatient Radiology Services and Other Diagnostic Procedures
780	• Payment for Blood Clotting Factor Administered to Hemophilia Inpatients
781	• Outpatient Therapeutic Services, and Section 439, Billing for Immunosuppressive Drugs Furnished to Transplant Patients
782	• Completion of Form CMS–1450 for Inpatient and/or Outpatient Billing Provider Electronic Billing File and Record Formats
783	• Addendum B—Alphabetic Listing of Data Elements
	Home Health Agency Manual (CMS Pub. 11) (Superintendent of Documents No. HE 22.8/5)
298	• Home Health Agency Arrangements by Home Health Agencies Home Health Prospective Payment System National 60 Day Episode Rate Adjustments to the 60 Day Episode Rate Continuous 60 Day episode Recertification Counting 60 Day Episodes Split Percentage Payment Approach to the 60 Day Episode Physician Signature Requirements for the Split Percentage Payment Low Utilization Payment Adjustment Partial Episode Payment Adjustment Significant Change in Condition Payment Adjustment Outlier Payment Discharge Issues Consolidated Billing Telehealth Change of Ownership Relationship to Episodes under Prospective Payment System Reasonable and Necessary Services Confined to the Home Services Are Provided Under a Plan of Care Established and Approved by a Physician Needs Skilled Nursing Care on an Intermittent Basis (Other than Solely Venipuncture For the Purposes of Obtaining a Blood Sample) or Physical Therapy or Speech-Language Pathology Services or Has Continued Need for Occupational Therapy Physician Certification Skilled Nursing Care Skilled Therapy Service Home Health Aide Services Medical Supplies (Except for Drugs and Biologicals) and the Use of Durable Medical Equipment Part-time or Intermittent Home Health Aide and Skilled Nursing Services Special Conditions for Coverage and Payment of Home Health Services Under Hospital Insurance (Part A) and Supplementary Medical Insurance (Part B) Beneficiaries Who Are Enrolled in Part A and Part B, but do Not Meet the Threshold for Post-Institutional Home Health Services Beneficiaries Who Are Part A Only or Part B Only Coinsurance, Copayments, and Deductibles Number of Home Health Visits under Hospital Insurance (Part A), Number of Home Health Visits under Supplementary Medical Insurance (Part B) Counting Visits Evaluation Visits Medical and Other Health Services Surgical Dressings, and Other Dressings Used for Reduction of Fractures and Dislocations Prosthetic Devices Outpatient Physical Therapy, Occupational Therapy, and Speech Pathology Services
	Skilled Nursing Facility Manual (CMS–Pub. 12) Superintendent of Documents No. HE 22. 8/3
371	• Drugs and Biologicals, and Section 542, Billing for Immunosupressive Drugs Furnished to Transplant Patients
	Hospice Manual (CMS–Pub. 21) Superintendent of Documents No. HE 22. 8/18
64	• Inpatient Respite Care

ADDENDUM III.—MEDICARE AND MEDICAID MANUAL INSTRUCTIONS—Continued

Transmittal No.	Manual/Subject/Publication No.
	Coverage Issues Manual (CMS–Pub. 6) Superintendent of Documents No. HE 22. 8/14
144	• Sacral Nerve Stimulation for Urinary Incontinence
145	• Treatment of Actinic Keratosis
146	• External Counterpulsation for Severe Angina
147	• Positron Emission Tomography
148	• Pneumatic Compression Devices
149	• Ambulatory Blood Pressure Monitoring
150	• Continuous Positive Airway Pressure
	Medicare Program Integrity Manual (CMS–Pub. 83)
15	• Medical Records of Partial Hospitalization Claims
16	• Medicare Benefits Integrity Unit Organizational Requirements Anti-Fraud Training Procedural Requirements Medicare Fraud Information Specialist Coordination of Medical Records and Benefit Integrity Units Request for Information from Outside Organizations Agency Agreement Memorandum of Understanding Between the Office of the Inspector General and the Department of Justice—Sharing Fraud Complaints Development of Complaints and Cases Fraud Alerts Types of Fraud Alerts Alert Specifications Editorial Requirements Coordination Distribution of Alerts Offices of the Inspector General Referrals and Appropriate Fraud Investigation Database Entries Table of Contents Consent Settlement Instructions Consent Settlement Budget and Performance Requirements Basis of Authority Purpose Enforcement Administrative Actions Documents Civil Monetary Penalty Authorities Civil Monetary Penalty Delegated to Centers for Medicare & Medicaid Services Civil Monetary Penalty Delegated to Offices of the Inspector General Referral Process to Centers for Medicare & Medicaid Services Referral to Offices of the Inspector General Centers for Medicare & Medicaid Services Generic Civil Monetary Penalty Case Contents Beneficiary Right to Itemized Statement Medicare Limiting Charge Violations Table of Contents Quality Improvement Program Reporting Vulnerability Report Table of Contents Definitions Request for Information from Outside Organizations Memorandum of Understanding Regarding Requests form Federal Bureau Investigation /Department of Justice Reporting Requirements Periodic Exchange of Information Among Offices of the Inspector General, Federal Bureau Investigation Department of Justice Reporting Requirements Periodic Exchange of Information Among Offices of the Inspector General, Federal Form Letter for Department of Justice Request Department of Justice Report (Excel Spreadsheet) National Medicare Fraud Alert Restricted Medicare Fraud Alert Organizational Requirements Request for Information from Outside Organizations Procedures for the benefit Integrity and Medical Review Units on Unsolicited Voluntary Refund Checks Anti-Kickback Statute Implications
17	• Overview of Prepayment and Postpayment Review for Medical Review Purpose Determinations Made During Prepayment and Postpayment Medial Review Documentation Specifications for Areas Selected to Prepayment or Postpayment or Postpayment Medical Review Additional Documentation Requests During Prepayment or Postpayment Medical Review Completing Complex Reviews Handling Late Documentation

ADDENDUM III.—MEDICARE AND MEDICAID MANUAL INSTRUCTIONS—Continued

Transmittal No.		Manual/Subject/Publication No.
		Denials
		Documenting That A Claim Should be Denied
		Internal Medical Review Guidelines
		Types of Prepayment and Postpayment Review
		Spreading Workload Evenly
		New Provider/ New Benefit Monitoring
		Review That Involves Utilization Parameters
		Prepayment Review of Claims for Medical Review Purposes
		Automated Prepayment Review
		Prepayment Edits
		Categories of Medical Review Edits
		Postpayment Review of Claims for Medical Review Purposes
		Postpayment Review Case Selection
		Location of Postpayment Reviews
		Re-adjudication of Claims
		Estimate of the Correct Payment Amount and Subsequent Over/Underpayment
		Notification of Provider (s) Rebuttal(s) of Findings
		Recovery of Overpayments
		Evaluation of the Effectiveness of Postpayment Review and Next Steps Postpayment Files
		Effect of Sections 1879 and 1870 of the Social Security Act During Postpayment Reviews
		Medicare Managed Care Manual (CMS-Pub. 86)
1	•	Payments to Medicare+Choice Organizations
		Effect of Change of Ownership and Leasing
		Contract Determination and Appeals
2	•	Minimum Specified Amount or ''Floor Rate
		Transition to a Comprehensive Risk Adjustment Method
		Transition Schedule for Implementation of the Risk Adjustment Method
		Exclusions from Risk Adjustment Factor
		Two Required Quality Indicators Designated Must be Met
		Reporting Extra Payment
		Questions About the Extra payment in Recognition of the Cost of Successful Outpatient Chief Care
		Implementation of 100 Percent Risk—Adjusted Payment for Qualifying Congestive Heart Failure Enrollees in 2001
		Encounter Data Collection for the Risk Adjustment Model
		Hospital Inpatient Encounter Data Requirements
		Deadlines for Submission of Encounter Data
		Announcement of Annual Capitation Rates and Methodology Changes
		Clarification of the Definition of ''Certified Institution'' for Adjusting Payments Under the Demographic-Only Method
		Payment for Institutional Status
		Previously Underserved Payment Area
		Eligibility for Bonus Payment-the Period of Application
		Reconciliation Process for Changes in Risk Adjustment Factors
		Reconciliation Schedule and Late Submission of Encounter Data
		Quality Indicators for Extra Payment in Recognition of the Costs of Successful Outpatient Treatment of Congestive Heart Failure
3	•	Quality Assurance
4	•	Marketing
		Medicare/Medicaid Sanction—Reinstatement Report (CMS Pub. 69)
01–10	•	Report of Physicians/Practitioners, Providers and/or Other Health Care Suppliers Excluded Reinstated—September 2001
01–11	•	Report of Physicians/Practitioners, Providers and/or Other Health Care Suppliers Excluded/Reinstated—October 2001
01–12	•	Report of Physicians/Practitioners, Providers and/or Other Health Care Suppliers Excluded/Reinstated—November 2001
		January 2002 through March 2002
		Intermediary Manual Part 3—Claims Process (CMS Pub. 13–3) (Superintendent of Documents No. 22.8/6)
1850	•	Ambulance Service
1851	•	Payment for Blood Clotting Factor Administered to Hemophilia Inpatients
1852	•	Release Software Diagnostic Mammography Diagnostic and Screening Mammograms Performed With New Technologies
1853	•	Clinical Laboratory Improvement Amendments
		Request for Anticipated Payment
		Home Health Perspective Payment System Claims

ADDENDUM III.—MEDICARE AND MEDICAID MANUAL INSTRUCTIONS—Continued

Transmittal No.	Manual/Subject/Publication No.
	Special Billing Situations Involving Outcome and Assessment Information Set Beneficiary-Driven Demand Billing Under Home Health Perspective Payment System New Software for the Home Health Perspective Payment System Environment Adjustments of Episode Payment—Exclusivity and Multiplicity of Adjustments General Guidance on Line Item Billing Under Home Health Prospective Payment System
	Carriers Manual Part 3—Program Administration (CMS Pub. 14–3) (Superintendent of Documents No. HE 22.8/7)
1738	• Transmittal 1738 has been rescinded and will not be printed or issued in the future
1739	• Air Ambulance Services
1740	• Beneficiaries Previously Enrolled In a Medicare Health Maintenance Organization Managed Care Program Who Transition to Traditional Fee for Service
1741	• Durable Medical Equipment Regional Carrier Instructions for Denying Claims for Drugs Billed and/or Paid to Suppliers Not Licensed To Dispense Drugs
1742	• Evidence of Medical Necessity Oxygen Claims
1743	• Home Dialysis Supplies and Equipment Payment for Method II Home Dialysis Supplies When the Beneficiary Is an Inpatient
1744	• Physician Assistant Services
1745	• Release Software Contractor Testing Requirements
	Program Memorandum Intermediaries (CMS Pub. 60A) (Superintendent of Documents No. HE 22.8/6–5)
A–02–001	• January Outpatient Code Editor Specifications Version
A–02–002	• Discontinuance of Contract With Integriguard To Conduct Community Mental Health Centers Site Visits After January 15, 2002
A–02–003	• Handling of Inpatient Claims Containing Healthcare Common Procedure Codes J7198, J7199, and Q2022 for Payment for Blood Clotting Factor Administered to Hemophilia Inpatients
A–02–004	• Critical Access Hospitals Exempt From the Ambulance Fee Schedule
A–02–005	• Correction of Production Problem With Home Health Prospective Payment System Claims Involving Medicare Secondary Payer
A–02–006	• Extended Repayment Schedules for Home Health Agencies Affected by the Interim Payment System
A–02–007	• Addendum to Periodic Interim Payments for Home Health Providers
A–02–008	• Processing of Home Health Prospective Payment System Mass Adjustments—Regional Home Health Intermediaries Only
A–02–009	• Payment of Skilled Nursing Facility Claims for Beneficiaries Disenrolling From Terminating Medicare+Choice Plans Who Have Not Met the 3-day Stay Requirement
A–02–010	• Changes to Common Working File Beneficiary Eligibility Checks for Medicare+Choice Encounter Data
A–02–011	• Receipt of Payment Data from the Healthcare Integrated General Ledger Accounting System by the Fiscal Intermediary Standard System
A–02–012	• Do Not Forward Initiative
A–02–013	• Implementation of the Health Insurance Portability and Accountability Act Health Care Eligibility Benefit Inquiry/Response Transaction (270/271) Standard
A–02–014	• Health Insurance Portability and Accountability Act Institutional 837 Health Care Claim Implementation Updates
A–02–015	• Installation of Version 27.1 of the Provider Statistical and Reimbursement Report
A–02–016	• Conversion of Hospital Swing Bed Facilities to the Skilled Nursing Facility Prospective Payment System Effective for Cost Reporting Periods Starting July 1, 2002
A–02–017	• Advance Beneficiary Notices Must Be Given to Beneficiaries and Demand Bills Must Be Submitted By Home Health Agencies
A–02–018	• Advance Beneficiary Notices Must Be Given To Beneficiaries and Demand Bills Must Be Submitted By Home Health Agencies
A–02–019	• Scheduled Release for April Updates to Software Program and Pricing/Coding Files
A–02–020	• Coverage and Billing of Sacral Nerve Stimulation
A–02–021	• Medicare Secondary Payer Information Collection Policies Changed for Hospitals
A–02–022	• Clarification of Program Memorandum A–01–86, New Patient Status Codes 62 and 63
A–02–023	• Accelerated Referral of Non-Medicare Secondary Payer Active Delinquent Debts to the Collection Center for Cross Servicing and Treasury Offset Program
A–02–024	• Off Label Use of Oral Chemotherapy Drugs Methotrexate and Cyclophosphamide
A–02–025	• April Outpatient Code Editor Specifications Version 9V3.0)
A–02–026	• 2002 Update of the Hospital Outpatient Prospective Payment System
	Program Memorandum Carriers (CMS Pub. 60B) (Superintendent of Documents No. HE 22.8/6–5)
B–02–001	• Transmittal B–02–001 has been rescinded and will not be printed or issued in the future

ADDENDUM III.—MEDICARE AND MEDICAID MANUAL INSTRUCTIONS—Continued

Transmittal No.	Manual/Subject/Publication No.
B–02–002	• Notification to Carriers and Providers of Skilled Nursing Facility Consolidated Billing Coding Information on Centers for Medicare and Medicaid Services Web site
B–02–003	• New Permanent Modifier for ''Specific Required Documentation on File''
B–02–004	• Payment for Services Furnished by Audiologists
B–02–005	• Transmittal B–02–005 has been rescinded and will not be printed or issued in the future
B–02–006	• Receipt of Payment Data from the Healthcare Integrated General Ledger Accounting System by the Fiscal Intermediary Standard System
B–02–007	• Use of Statistical Sampling for Overpayment Estimation When Performing Administrative Reviews of Part B Claims
B–02–008	• Type of Service Corrections
B–02–009	• Payment for Therapy Services Wrongfully Denied
B–02–010	• Correct Payment for Medical Nutrition Therapy Services Rendered by Registered Dietitians or Nutrition Professionals
B–02–011	• Revision and Clarification of Requirements for Quarterly Do Not Forward Reports
B–02–012	• Transmittal B–02–012 has been rescinded and will not be printed or issued in the future
B–02–013	• Changes to Correct Coding Edits, Version 8.2, Effective July 1, 2002
B–02–014	• Common Working File Changes for Emergency Home Dialysis Supplies for Method II Beneficiaries
B–02–015	• 2002 Jurisdiction List
B–02–016	• Addition of Four ''WW'' Codes to Identify a New Source for Methotrexate
B–02–017	• Standard System Acceptance of Primary Payer Information at the Line Level
B–02–018	• Implementation of Carrier Jurisdiction Manual Instructions Based On the Medicare Carriers Manual Part 3, §§ 3100–3101 for the Multi-Carrier System, Standard System and Associated Medicare Carriers
B–02–019	• Accelerated Referral of Non-Medicare Secondary Payer Active Delinquent Debts to the Debt Collection Center for Cross Servicing and Treasury Offset Program
B–02–020	• Coding for Non-Covered Services and Services Not Reasonable and Necessary
B–02–021	• Problem Resolution to Issues Raised By Implementation of Change Request 1646 for the Medicare Carriers Processing on the Multi-Carrier System
	Program Memorandum Intermediaries/Carriers (CMS Pub. 60A/B) (Superintendent of Documents No. HE 22.8/6–5)
AB–02–001	• New Temporary ''K'' Codes for Ostomy Devices and Supplies
AB–02–002	• Claims Processing Instructions for the Medicare Quality Partnerships Demonstration (formerly referred to as ''Centers of Excellence'') and the Medicare Provider Partnership Demonstration
AB–02–003	• Transmittal AB–02–003 has been rescinded and will not be printed or issued in the future
AB–02–004	• Harkin Grantees: Aggregate Report Dates
AB–02–005	• Elimination of Official Level III Healthcare Common Procedure Coding System Codes/Modifiers and Unapproved Local Codes/Modifiers
AB–02–006	• Customer Service Assessment Management System for Medicare Call Centers
AB–02–007	• Children's Hospital Graduate Medical Education Amendment to Change Request 1736
AB–02–008	• Form CMS–1522, Monthly Contractor Financial Report, Reconciliation
AB–02–009	• Clarification of Physician Certification Requirements for Medicare Hospice
AB–02–010	• Promoting Colorectal Cancer Screening as a Part of Colorectal Cancer Awareness Month
AB–02–011	• Notice of Interest Rate for Medicare Overpayments and Underpayments
AB–02–012	• Revised Backup Withholding Tax Rate
AB–02–013	• Improve the Out-of-Service-Area Claims Process in the Common Working File
AB–02–014	• Implementation of Common Working File Edits for Flu and Pneumonia Claims
AB–02–015	• Clarification of Payment Responsibilities for Fee-for-Service Contractors as it Relates to Hospice Members Enrolled in Managed Care Organizations and Claims Processing Instructions for Processing Rejected Claims
AB–02–016	• Effective Date for Q3017
AB–02–017	• Sending of HUSC Files from Common Working File to Recovery Management and Accounting System
AB–02–018	• First Update to the 2002 Medicare Physician Fee Schedule Database
AB–02–019	• Supplemental Systems Security Information for FY 02
AB–02–020	• Revised Timeliness for Health Insurance Portability and Accountability Act Requirements
AB–02–021	• Common Working File Unsolicited Response Edit and Carrier Resolution for Consolidated Billing for Skilled Nursing Facility Residents
AB–02–022	• Clarification of Transmittal AB–00–107, Change Request 1163, and Transmittal AB–00–129, Change Request 1460, Regarding the Coordination of Benefits Contractor and Medicare Secondary Payer Prepay Work Activities for Customer Service, Medicare Secondary Payer and Standard Systems Contractor Staff
AB–02–023	• Common Working File Edits with Unsolicited Responses for Skilled Nursing Facility Consolidated Billing
AB–02–024	• New Waived Tests—January 18, 2002
AB–02–025	• Non-Contact Normothermic Wound Therapy
AB–02–026	• System Networking Electronic Correspondence Referral System User Guide
AB–02–027	• Corrections to Program Memorandum A–01–135—Codes Billable by Skilled Nursing Facilities and Suppliers for Skilled Nursing Facility Residents
AB–02–028	• Centers for Medicare and Medicaid Services Office of the Inspector General Hotline Referrals
AB–02–029	• Electronic Medicare Provider/Supplier Enrollment Forms
AB–02–030	• Administrative Policies Related to Processing Claims for Clinical Diagnostic Laboratory Services
AB–02–031	• Payment Policy for Air Ambulance Transportation of Deceased Beneficiary
AB–02–032	• Data Center Testing and Production—Electronic Correspondence Referral System User Manual 4.0
AB–02–033	• Provider Education Training Activities to Implement Updates to the Ambulance Fee Schedule

ADDENDUM III.—MEDICARE AND MEDICAID MANUAL INSTRUCTIONS—Continued

Transmittal No.	Manual/Subject/Publication No.
AB–02–034	• Managing Medicare Appeals Workloads in FY 2001
AB–02–035	• Notification of Updates to Coding Files on Centers for Medicare and Medicaid Services Web Site for Skilled Nursing Facility Consolidated Billing
AB–02–036	• Temporary Codes for Ambulance Fee Schedule
AB–02–037	• Reissue of Information in Change Request 1955, Transmittal AB–02–021, Common Working File Unsolicited Response Edit and Carrier Resolution for Consolidated Billing for Skilled Nursing Facility Residents
AB–02–038	• Billing for Audiologic Function Tests for Beneficiaries That Are Patients of a Skilled Nursing Facility
AB–02–039	• Amplification of Annual Compliance Audit Requirements
AB–02–040	• Intestinal and Multi-Visceral Transplantation
AB–02–041	• Correction of Remark Code Message for Home Health Consolidated Billing
	State Operations Manual Provider Certification (CMS—Pub. 7) (Superintendent of Documents No. 22.8/12)
28	• Federally Qualified Health Centers—Citations and Description
	• Regional Office Approval Process for Federally Qualified Health Centers Attestation Statement for Federally Qualified Health Centers, and Model Letter to Applicants for Participation in Medicare as a Federally Qualified Health Center
	• Federally Qualified Health Center Crucial Data Extract
	• Notice to Accredited Psychiatric Hospital of Involuntary Termination
29	• Federal Monitoring Surveys—Definition and Purpose
	• Federal Monitoring Surveys—Expectations and Responsibility
	Hospital Manual (CMS Pub. 10) (Superintendent of Documents No. HE 22.8/2)
783	Payment for Blood Clotting Factor Administered to Hemophilia Inpatients
	Home Health Agency Manual (CMS Pub. 11) (Superintendent of Documents No. HE 22.8/5)
299	• Excluded Foot Care Services
300	• Billing Procedures for an Agency Being Assigned Multiple Provider Numbers or a Change in Provider Number More Than One Agency Furnished Home Health Services Transfer to Another Agency Under the Same Plan of Treatment Clinical Laboratory Improvement Amendments New Software for the Home Health Prospective Payment System Adjustments of Episode Payment—Significant Change in Condition Adjustments of Episode Payment—Exclusivity and Multiplicity of Adjustments General Guidance on Line Item Billing Under Home Health Prospective Payment System Request for Anticipated Payment Home Health Prospective Payment System Claims Special Billing Situations Involving Outcome and Information Assessment Set Beneficiary-Driven Demand Billing Under Home Health Prospective Payment System No-Payment Billing and Receipt of Denial Notices Under Home Health Prospective Payment System Billing and Payment for Medicare Secondary Payer Claims Under the Home Health Prospective Payment System
	Skilled Nursing Facility Manual (CMS–Pub. 12) (Superintendent of Documents No. HE 22. 8/3)
372	• Recertification Coverage and Patient Classification
	Coverage Issues Manual (CMS Pub. 6) (Superintendent of Documents No. HE 22.8/14)
151	• Pneumatic Compression Devices
152	• Noncontact Normothermic Wound Therapy

ADDENDUM III.—MEDICARE AND MEDICAID MANUAL INSTRUCTIONS—Continued

Transmittal No.	Manual/Subject/Publication No.
	Provider Reimbursement Manual—Part 2 **Provider Cost Reporting Forms and Instructions Chapter 29/Form CMS–222–92** **(CMS Pub. 15–2–29)**
5	• Cost Report Forms
	Provider Reimbursement Manual—Part 2 **Provider Cost Reporting Forms and Instructions Chapter 34/Form CMS–265–94** **(CMS Pub. 15–2–34)**
6	• Cost Report Forms
	Provider Reimbursement Manual—Part 2
	Provider Cost Reporting Forms and Instructions Chapter 38/Form CMS–1894–99 **(CMS Pub. 15–2–38)**
3	• Worksheet A—Reclassification and Adjustment of Trial Balance Expenses
	Program Integrity Manual **(CMS–Pub. 83)**
18	• Medical Review of Skilled Nursing Facility Prospective Payment System Types of Review Bill Review Requirements Bill Review Process Workload Data Analysis Medicare Integrity Program-Provider Education and Training Quality Issues in Skilled Nursing Facility and Referral to Other Agencies Reporting
19	• Security Requirements
20	• 20 Medical Review of Ambulance Services
21	• 21 Types of Claims for Which Contractors Are Responsible
22	• 22 Medical Review Workload, Cost, and Savings Allocations Medical Review Overview Reporting Medical Review Workload and Cost Information and Documentation in Contractor Administrative Budget and Financial Management Prepay Review for Medical Review Purposes Automated Prepay Review Workload and Cost (Activity Code 21001) Routine Manual Prepay Review Workload and Cost (Activity Code 21002) Complex Manual Prepay Reviews Workload and Cost (Activity Code 21003) Data Analysis Costs (Activity Code 21007) Policy Development Activities Workload and Costs (Activity Code 21008) Third Party Liability or Demand Bills Workload and Cost (Activity Code 21010) Postpayment Claim Review Activities for Medical Review Purposes Routine Manual Postpayment Claims Review Workload and Cost (Activity Code 21030) Complex Manual Service-Specific Postpayment Claims Review Workload And Cost (Activity Code 21032) Program Safeguard Contractor Support Services (Activity Code 21100) Reporting Medical Review Savings in Contractor Reporting of Operational and Workload Data Benefit Integrity Workload, Cost, and Savings Allocation Medicare Integrity Program Provider Education and Training Workload, Cost and Savings Allocation Medicare Integrity Program Provider Education and Training Overview Reporting Medicare Integrity Program Provider Education and Training Workload and Cost Information in Contractor Administrative Budget and Financial Management Reporting Medicare Integrity Program Provider Education and Training Savings in Contractor Reporting of Operational Workload and Data Provider Enrollment Workload, Cost, and Savings Allocation
23	• Home Health Certification and Plan of Care Data Plan of Care Medical Review of Home Health Claims General Types of Review Medical Review Process Claim Selection Record Request Record Review Outcome of Review

ADDENDUM III.—MEDICARE AND MEDICAID MANUAL INSTRUCTIONS—Continued

Transmittal No.		Manual/Subject/Publication No.
		Data Analysis Medical Review of Skilled Nursing and Home Health Aide Hours for Determining Part-Time or Intermittent Care Treatment Codes for Home Health Services Effectuating Favorable Final Appellate Decision That A Beneficiary is ''Confined to Home'' Reporting Description of Items on Form CMS–485 Treatment Codes Home Health Certification and Plan of Care
		Managed Care Manual (CMS Pub. 86)
5	•	Guidelines for Advertising (Pre-enrollment) Materials Must Use/Can't Use/Can Use Chart Final Verification Review Process Nominal Gifts Operational Considerations Related to Value-Added Items and Services Specific Guidance About the Use of Independent Insurance Agents Marketing of Multiple Lines of Business Under Medicare+Choice Performance Improvement Projects Non-Clinical Focus Areas—Non-Clinical Focus Areas Applicable to All Enrollees Sustained Improvement Over Time Process for Centers for Medicare and Medicaid Services Multi-Year QAIP Project Approvals Centers for Medicare and Medicaid Services Regional Office Representatives Subsection ''Project Completion Report'' Subsection ''When to Report'' Subsection ''Project Review Report'' Subsection ''Other Tools'' Subsection ''Corrective Action Process'' Obligations of Deemed Medicare+Choice Organizations
6	•	Medicare+Choice Enrollment and Disenrollment
7	•	Organization Compliance with State Law and Pre-emption by Federal Law
8	•	Medicare+Choice Contract Requirements
		Medicare/Medicaid Sanction—Reinstatement Report (CMS Pub. 69)
01–02	•	Report of Physicians/Practitioners, Providers and/or Other Health Care Suppliers Excluded/Reinstated-December 2001
02–02	•	Report of Physicians/Practitioners, Providers and/or Other Health Care Suppliers Excluded/Reinstated-January 2002
03–02	•	Report of Physicians/Practitioners, Providers and/or Other Health Care Suppliers Excluded/Reinstated-February 2002

ADDENDUM IV.—REGULATION DOCUMENTS PUBLISHED IN THE FEDERAL REGISTER

[October 1999 through March 2002]

Publication date	FR Vol. 64 page	CFR* Part(s)	File code**	Regulation title	End of comment period	Effective date
10/1/99	53394–53396		HCFA–1058–FN	Medicare Program; Sustainable Growth Rate for Fiscal Year 2000.		10/1/99
10/1/99	53394		HCFA–3025–N	Medicare Program; Notice of the Implementation of the Medicare Lifestyle Modification Program Demonstration Project.		
10/5/99	54030–54031		HCFA–1056–CN	Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities—Update; Correction.		10/1/99
10/6/99	54263–54268		HCFA–2004–P	Medicaid Program; Flexibility in Payment Methods for Services of Hospitals, Nursing Facilities, and Intermediate Care Facilities for the Mentally Retarded.	12/6/99	
10/14/99	55738		HCFA–1092–N	Medicare Program; October 29, 1999, Meeting of the Competitive Pricing Advisory Committee.		

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10/14/99	55738–55739		HCFA–3023–N	Medicare Program; Meeting of the Laboratory and Diagnostic Services Panel of the Medicare Coverage Advisory Committee—November 15 and 16, 1999.		
10/15/99	55949–55950		HCFA–1091–N	Medicare Program; Open Public Meeting on November 1, 1999 to Discuss Activities Related to the Collection of Encounter Data from Medicare+Choice Organizations for Risk Adjustment.		
10/19/99	56353		HCFA–5001–N	Medicare Program; Establishment of the Health Care Financing Administration's Management Advisory Committee.		
10/19/99	56353–56354			Notice of Hearing: Reconsideration of Disapproval of New Mexico Children's Health Insurance Program State Plan Amendment.		
10/22/99	57101–57103		HCFA–1060–N	Correction— Notice—Schedules of Per-Visit and Per-Beneficiary Limitations on Home Health Agency Costs for Cost Reporting Periods Beginning on or After October 1, 1999 and Portions of Cost Reporting Periods Beginning Before October 1, 2000.		10/1/99
10/22/99	57110–57112		HCFA–8004–N	Medicare Program; Part A Premium for 2000 for the Uninsured Aged and for Certain Disabled Individuals Who Have Exhausted Other Entitlement.	1/1/00	
10/22/99	57103–57104		HCFA–8005–N	Medicare Program; Inpatient Hospital Deductible and Hospital and Extended Care Services Coinsurance Amounts for 2000.		1/1/00
10/22/99	57105–57110		HCFA–8006–N	Medicare Program; Monthly Actuarial Rates and Monthly Supplementary Medical Insurance Premium Rate Beginning January 1, 2000.		1/1/00
10/25/99	57431–57436		HCFA–6003–P	Medicare Program; Appeals of Carrier Determinations That a Supplier Fails to Meet the Requirements for a Medicare Billing Number.	12/27/99	
10/25/99	57473–57474		HCFA–1105–N	Medicare Program; November 9, 1999 Notice of Meeting of the Competitive Pricing Demonstration Area Advisory Committee, Maricopa County, AZ.		
10/26/99	57612–57613		HCFA–1103–N	Medicare Program; Open Town Hall Meeting on November 8, 1999 to Present an Overview of the Home Health Prospective Payment System Proposed Rule Followed by a General Home Health Listening Session.		
10/28/99	58134–58209	409, 410, 411, 413, 424, 484.	HCFA–1059–P	Medicare Program; Prospective Payment System for Home Health Agencies.	12/27/99	
10/29/99	58419		HCFA–3026–N	Medicare Program; Open Town Hall Meeting to Discuss Transplant Center Criteria.		
11/2/99	59379–59590	410, 411, 414, 415, 485.	HCFA–1065–FC	Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2000.	1/3/00	1/1/00

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11/4/99	60122	409, 411, 413, 489.	HCFA–1913–CN	Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Correction.		9/28/99
11/8/99	60821–60822		HCFA–1093–N	Medicare Program; Request for Nominations for the Practicing Physicians Advisory Council.	12/15/99	
11/8/99	60882–60963	431, 433, 435, 457.	HCFA–2006–P	SCHIP Program; Implementing Regulations for the State Children's Health Insurance Program.	1/7/00	
11/15/99	61892–61893		HCFA–3027–N	Medicare Program; Meeting of the Executive Committee of the Medicare Coverage Advisory Committee—December 8, 1999.	11/18/99	
11/22/99	63819		HCFA–1079–N	Medicare Program; December 13, 1999, Meeting of the Practicing Physicians Advisory Council.		
11/24/99	66233–66304	460, 462, 466, 473, 476.	HCFA–1903–IFC	Medicare and Medicaid Programs; Programs of All-Inclusive Care for the Elderly (PACE); Final Rule.	1/24/00	11/24/99
11/26/99	66396–66402	420	HCFA–4000–FC	Medicare Program; Suggestion Program on Methods to Improve Medicare Efficiency.	1/25/00	12/27/99
11/30/99	67028–67052	403, 412, 431, 440, 442, 446, 456, 488, 489.	HCFA–1909–IFC	Medicare and Medicaid Programs; Religious Nonmedical Health Care Institutions and Advance Directives; Interim Rule.	1/31/00	1/31/00
12/1/99	67223–67235	433, 438	HCFA–2015–P	Medicaid Program; External Quality Review of Medicaid Managed Care Organizations.	1/31/00	
12/3/99	67920–67925		HCFA–4009–GNC	Medicare Program; Criteria and Standards for Evaluating Intermediary and Carrier Performance During FY 2000.	1/3/00	
12/7/99	68357–68364		HCFA–9004–N	Medicare and Medicaid Programs; Quarterly Listing of Program Issuances—First Quarter, 1999.		
12/13/99	69538–69539		HCFA–3029–N	Medicare Program; Meeting of the Medical and Surgical Procedures Panel of the Medicare Coverage Advisory Committee—January 19 and 20, 2000.	12/29/99	
12/20/99	71148–71149		HCFA–3024–NC	Medicare Program; Adjustment in Payment Amounts for New Technology Intraocular Lenses Furnished by Ambulatory Surgical Centers.	1/19/00	
12/22/99	71673–71678	422	HCFA–1011–F	Medicare Program; Solvency Standards for Provider-Sponsored Organizations.		1/21/00
12/23/99	72086		HCFA–1109–N	Meeting of the Competitive Pricing Advisory Committee, January 12, 2000.		
12/29/99	73057			Office of Strategic Planning; Statement of Organization, Functions, and Delegations of Authority.		
12/30/99	73561		HCFA–2024–FC2	CLIA Program; Transfer of Clinical Laboratory Complexity Categorization Responsibility.		1/31/00
1/5/00	498		HCFA–3029–WN	Medicare Program; Cancellation of the Meeting of the Medical & Surgical Procedures Panel of the MCAC—January 19 and 20, 2000.		
1/5/00	495		HCFA–3028–N	Medicare Program; Notice of the Solicitation for Proposals to Expand the Medicare Lifestyle Modification Program Demonstration.		
1/5/00	494		HCFA–1094–N	GME Consortia Demonstration		

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1/7/00		1081	HCFA–1125–N	Medicare Program; Meetings of the Negotiated Rulemaking Committee on the Ambulance Fee Schedule.		
1/10/00	1400		HCFA–9005–N	Medicare and Medicaid Programs; Quarterly Listing of Program Issuances—Second Quarter, 1999.		
1/12/00	1817	412, 413, 483, and 485.	HCFA–1053–CN2	Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2000 Rates; Correction.		
1/20/00	3136	412	HCFA–1124–IFC	Medicare Program; Medicare Inpatient Disproportionate Share Hospital Adjustment Calculation: Change in the Treatment of Medicaid Patient Days in States with Section 1115 Expansion Waivers.	3/20/00	
1/28/00	4545		HCFA–1002–N3	Medicare Program; Meeting of the Negotiated Rulemaking Committee on the Ambulance Fee Schedule.		
2/2/00	4986		HCFA–3031–N	Medicare Coverage Advisory Committee—Executive Committee Meeting on March 1, 2000.		
2/7/00	5933	412, 413, 483, and 485.	HCFA–1053–CN2	Medicare Program; Changes to the Hospital Inpatient Prospective Payment System and Fiscal Year 2000 Rates.		
2/9/00	6380		HCFA–1085–N	Update of Ambulatory Surgical Center Payment Rates Effective for Services on or after October 1, 1999.		
2/15/00	4617		HCFA–4012–N	Meeting of the Advisory Panel on Medicare Education—February 15, 2000.		
2/22/00	8725		HCFA–2059–FN	Medicare and Medicaid Programs; Reapproval of the Deeming Authority of the Community Health Accreditation Program, Incorporated (CHAP) for Home Health Agencies (HHAs).		2/22/00
2/22/00	8722		HCFA–2058–FN	Medicare and Medicaid Programs; Reapproval of the Deeming Authority of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) for Application of the JCAHO for Home Health Agencies.		2/22/00
2/22/00	8727		HCFA–2057–FN	Medicare and Medicaid Programs; Recognition of the American Osteopathic Association (AOA) for Continued Approval of Deeming Authority of the Community Health Accreditation Program, Incorporated (CHA) for Hospitals.		2/22/00
2/22/00	8660	413	HCFA–1860–FC	Medicare Program; Payment Amount if Customary Charges are Less than Reasonable Costs: Technical Amendments.		
2/22/00	8722		HCFA–1060–N2	Medicaid Program; Additional Comment Period for the Schedules of Per-Visit and Per-Beneficiary Limitations on HHA Costs for Cost Reporting Periods Beginning on or After October 1, 1999 and Portions Beginning October 1, 2000.		

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2/28/00	10450	405, 491	HCFA–1910–P	Medicare Program; Rural Health Clinics: Amendments to Participation Requirements and Payment Provisions; and Establishment of a Quality Assessment and Performance Improvement Program.	5/1/00	
2/29/00	10812		HCFA–1127–N	Medicare Program; Open Public Meeting on March 15, 2000 to Provide Overview of Data Requirements for Collection of Physician and Hospital Outpatient Encounter Data from Medicare+Choice Organizations for Risk Adjustment.		
3/10/00	13082	410	HCFA–3250–P	Medicare Program; Coverage and Administrative Policies for Clinical, Diagnostic, and Laboratory Services.	5/9/00	
3/10/00	13012		HCFA–1130–N	Meeting of the Practicing Physicians Advisory Council; March 27, 2000.		
3/15/00	13983		HCFA–3032–N	Medicare Program; Meeting of the Medical and Surgical Procedures Panel of the Medicare Coverage Advisory Committee—April 12 and 13, 2000.		
3/15/00	13911	405, 410	HCFA–1813–F	Medicare Program; Coverage of, and Payment for, Paramedic Intercept Ambulance Services.		
3/17/00	14510		HCFA–2233–N	CLIA Program; Cytology Proficiency Testing.		
4/7/00	18342		HCFA–3028–N2	Medicare Program; Notice of the Solicitation for Proposals to Expand the Medicare Lifestyle Modification Demonstration Project; Cancellation Notice.		4/7/00
4/7/00	18341		HCFA–1128–N	Medicare Program; Process for Requesting Recognition of New Technologies and Certain Drugs, Biologicals, and Medical Devices for Special Payment Under the Hospital Outpatient Prospective Payment System.		
4/7/00	18434	409, 410, 411, 412, 413, 419, 424, 489, 498, and 1003.	HCFA–1005–FC	Medicare Program; Prospective Payment Systems for Hospital Outpatient Services.	6/6/00	7/1/00
4/10/2000	18999		HCFA–2893–N	Medicare Program; Deductible Amount for Medigap High Deductible Options for Calendar Year 2001.		1/1/00
4/10/00	19188	411, 489	HCFA–1112–P	Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities—Update.	6/9/00	
4/10/00	19000		HCFA–1110–N	Medicare Program; Sustainable Growth Rate for Year 2000.		
4/11/00	19329		HCFA–1065–CN	Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2000, Correction Notice.		
4/27/00	24707		HCFA–1133–N	Medicare Program; May 12, 2000 Meeting of the Citizens Advisory Panel on Medicare Education.		
4/27/00	24666	414	HCFA–1084–P	Medicare Program; Payment for Upgraded Durable Medical Equipment.	6/26/00	

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4/28/00	24971		HCFA–3053–N	Medicare Program; Open Town Hall Meeting to Promote and Establish Partnerships Between the Medicare Peer Review Organizations (PROs) and Entities in the Health Care Community to Foster Health Care Quality Improvement—May 15, 2000.		
4/28/00	24970		HCFA–1132–N	Medicare Program; May 23, 2000 Notice of Meeting of the Competitive Pricing Advisory Committee.		
5/2/00	25492		HCFA–2117–N	Medicare, Medicaid, and CLIA Programs; CLIA of 1988 Removal of Exemptions of Labs in the State of Oregon.		
5/3/00	25738		HCFA–3030–N	Medicare Program; Lenses Eligible for an Adjustment in Payment Amount for New Technology Lenses Furnished by Ambulatory Surgical Centers.		
5/3/00	25493		HCFA–1134–N	Medicare Program; Open Public Meeting on May 18, 2000 to Discuss the Coverage of Drugs and Biologicals that Cannot be Self-Administered.		
5/3/00	25664	414	HCFA–1111–IFC	Medicare Program; Criteria for Submitting Supplemental Practice Expense Survey Data.	7/3/00	
5/5/00	26282	412, 413, and 485	HCFA–1118–P	Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2001 Rates.	7/5/00	
5/16/00	31124		HCFA–3432–NOI	Medicare Program; Criteria for Making Coverage Decisions Under Medicare.	7/17/00	
5/19/00	31917		HCFA–1136–N	Medicare Program; June 5, 2000 Meeting of the Practicing Physicians Advisory Council.		
5/24/00	33616	447, 457	HCFA–2114–F	State Children's Health Insurance Program; State Children's Health Allotments and Payment to States.		6/23/00
5/24/00	33638		HCFA–2067–N	State Children's Health Insurance Program; Final Allotments to States, the District of Columbia, and U.S. Territories and Commonwealths for Fiscal Year 2000.		
5/24/00	33634		HCFA–2064–N	State Children's Health Insurance Program; Final Allotments to States, Commonwealths, and Territories for Fiscal Years 1998 and 1999.		
5/30/00	34481		HCFA–9001–N	Medicare and Medicaid Programs; Quarterly Listing of Program Issuances for Third Quarter, 1999.		
5/31/00	34715		HCFA–2076–N	Medicaid Infrastructure Grant Program to Support the Competitive Employment of People with Disabilities.		
5/31/00	34478		HCFA–2063–N	Medicaid Program; State Allotments for Payment of Medicare Part B Premiums for Qualifying Individuals: Federal Fiscal Year 2000.		
6/1/00	34983	403	HCFA–4005–IFC	Medicare Program; State Health Insurance Assistance Program (SHIP).	7/31/00	7/3/00

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6/5/00	35654		HCFA–1137–N	Medicare Program; Announcement of a Series of National and Regional Training Sessions to Provide Training to Medicare+Choice Organizations and Others Concerning Data Requirements, and the Timely and Accurate Submission of Physician and Hospital Outpatient Encounter Data to Support a Comprehensive Risk Adjustment Model.		
6/6/00	35947		HCFA–1138–N	Medicare Program; Town Hall Meeting to Discuss the Documentation Guidelines for Evaluation and Management Services—June 22, 2000.		
6/15/00	37507		HCFA–3432–N3	Medicare Program; Criteria for Making Coverage Decisions; Extension of Comment Period.	7/17/00	
6/26/00	39314		HCFA–1139–N	Medicare Program; Town Hall Meeting on July 18, 2000 to Present an Overview of the Home Health Prospective Payment System Final Rule.		
6/29/00	40112		HCFA–1030–N	Medicare Program; Medicare+Choice Deeming Authority.		
6/29/00	40170		HCFA–1030–FC	Medicare Program; Medicare+Choice Program.	8/28/00	7/31/00
6/30/00	40535	409, 410, 411, 412, 413, 419, 424, 489, 498, and 1003.	HCFA–1005–N5	Medicare Program; Hospital Outpatient Prospective Payment Systems, Request for Delay of Effective Date.		8/1/00
7/3/00	58134		HCFA–1059–F	Medicare Program; Prospective Payment System for Home Health Agencies.		
7/5/00	41477		HCFA–1141–N	Medicare Program; Open Public Meeting on July 25, 2000 to Discuss the Coverage of Drugs and Biologicals that Cannot be Self Administered.		
7/7/00	42022		HCFA–1140–N	Medicare Program; Question and Answer Session on July 24, 2000 to Discuss Remaining Concerns About the Implementation of the Hospital Outpatient Prospective Payment System.		
7/17/00	44176	410, 414	HCFA–1120–P	Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2001.	9/15/00	
7/28/00	46473		HCFA–1144–N	Medicare Program; Announcement of a Series of Regional Training Sessions to Provide Training to Medicare+Choice Organizations, Physicians, Medicare+Choice Organization Non-Physician Practitioners, and Medicare+Choice Organization Medicare Directors, as well as Physician Organizations and Billing Associations Involved in the Timely and Accurate Submission of Physician Encounter Data to Support a Comprehensive Risk Adjustment Model.		
7/28/00	46466		HCFA–1115–N	Medicare Program; Solicitation for Proposals for the Medicare Coordinated Care Demonstration.		

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7/31/00	46770	411, 413, and 489	HCFA–1112–F	Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities—Update.		
8/1/00	47026–47211	410, 412, 413, 482, and 485.	HCFA–1131–IFC	Medicare Program; Provisions of the Balanced Budget Refinement Act of 1999, Hospital Inpatient Payments and Rates and Costs of Graduate Medical Education.	8/31/00	8/1/00
8/1/00	47054	410, 412, 413 and 485.	HCFA–1118–F	Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2001 Rates.		10/1/00
8/3/00	47706–47709	413	HCFA–1143–P	Medicare Program; Prospective Payment System for Hospital Outpatient Services: Revision of the Provider-Based Location Criteria for Certain PPS-Exempt Facilities.	10/2/00	
8/3/00	67798–68020	413, 419	HCFA–1005–IFC	Medicare Program; Prospective Payment System for Hospital Outpatient Services: Revisions to Criteria to Define New or Innovative Medical Devices, Drugs, and Biologicals Eligible for Pass-Through Payments and Corrections to the Criteria for the Grandfather Provision for Certain Federally Qualified Health Centers.	9/5/00	1/1/01
8/17/00	50171		HCFA–3432–N4	Medicare Program; Open Town Hall Meeting to Discuss Criteria for Making Coverage Decisions—August 31, 2000.		
8/17/00	50373		HCFA–0149–N	Administrative Simplification; Health Insurance Reform: Announcement of Designated Standard Maintenance Organizations.		10/16/00
8/17/00	50312	45 CFR Parts 160 and 162.	HCFA–0149–F	Health Insurance Reform; Standards for Electronic Transactions.		10/16/00
8/25/00	51839		HCFA–1149–N	Medicare Programs; September 11, and 12, 2000, Meeting of the Practicing Physicians Advisory Council.		
8/28/00	52042–52043	457	HCFA–2114–CN	State Children's Health Insurance Program; Allotments and Payments to States; Correction.		6/23/00
8/29/00	52432		HCFA–3432–N5	Medicare Program; Postponent of Open Town Hall Meeting to Discuss Criteria for Making Coverage Decisions from August 31, 2000 to September 31, 2000.		
9/1/00	53320–53321		HCFA–1146–N	Medicare Program; September 21, 2000, Meeting of the Advisory Panel on Medicare Education.		
9/6/00	53936	405	HCFA–6003–N	Medicare Program; Appeals of Carrier Determinations That a Physician or Other Supplier Fails to Meet the Requirements for Medicare Billing Privileges; Reopening of Comment Period.	1/4/01	
9/8/00	54537		HCFA–3036–N	Medicare Program; Meeting of the Medical and Surgical Procedures Panel of the Medicare Coverage Advisory Committee—October 17 and 18, 2000.		
9/8/00	54537		HCFA–1153–N	Medicare Program; Open Town Hall Meeting to Discuss Medicare Policy for Community Mental Health Centers on September 25, 2000.		

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9/12/00	55076		HCFA–2006–CN	State Children's Health Insurance Program; Allotments and Payments to States.		
9/12/00	55078–55100	410, 414	HCFA–1002–P	Medicare Program; Fee Schedule for Payment of Ambulance Services and Revisions to Physician Certification Requirements for Coverage of Nonemergency Ambulance Services.	11/13/00	
9/27/00	58992–58093		HCFA–1145–NC	Medicare and Medicaid Programs; Announcement of Additional Applications from Hospitals Requesting Waivers for Organ Procurement Service Areas.	11/13/00	
10/3/00	58919–58920	413, 489, and 498	HCFA–1005–CN4	Medicare Program; Prospective Payment System and Hospital Outpatient Services: Provider-Based Criteria; Delay of Effective Date and Correction.		1/10/01
10/6/00	60072		HCFA–1135–N	Medicare Program; Hospice Wage Index.		10/1/00
10/6/00	59748–59749	422	HCFA–1030–CN2	Medicare Program; Establishment of the Medicare+Choice Program; Correction.		7/31/00
10/6/00	59748	412, 413 and 489	HCFA–1005–CN2	Medicare Program; Prospective Payment System for Hospital Outpatient Services; Delay of Effective Date.		8/1/00
10/10/00	60151	447	HCFA–2071–P	Medicaid Program; Revision to Medicaid Upper Payment Limit Requirements for Hospital Services, Nursing Facility Services, Intermediate Care Facility Services for the Mentally Retarded, and Clinic Services.		11/9/00
10/10/00	60105–60108	440, 441	HCFA–2010–FC	Medicaid Program; Home and Community-Based Services.	12/11/00	10/1/97
10/10/00	60104–60105	413	HCFA–1883–F2	Medicare Program; Revision of the Procedures for Requesting Exceptions to Cost Limits for Skilled Nursing Facilities and Elimination of Reclassifications, Corrections.		9/9/99
10/11/00	60366–60378	424	HCFA–6004–FC	Medicare Program; Additional Supplier Standards.	12/11/00	12/11/00
10/16/00	6112–6113	413, 489, and 498	HCFA–1155–N	Medicare Program; Open Town Hall Meeting to Discuss Implementation of Provider-Based Regulations; October 31, 2000.		
10/19/00	62727–62733		HCFA–8009–N	Medicare Program; Monthly Actuarial Rates and Monthly Supplementary Medical Insurance Premium Rate Beginning January 1, 2001.		1/1/01
10/19/00	62733		HCFA–8008–N	Medicare Program; Part A Premium for 2001 for the Uninsured Aged and for Certain Disabled Individuals Who Have Exhausted Other Entitlement.		
10/19/00	6725–6727		HCFA–8007–N	Medicare Program; Inpatient Hospital Deductible and Hospital and Extended Care Services Coinsurance Amounts for 2001.		1/1/01
10/19/00	62645–62646	409, 410, 489, and 498.	HCFA–3045–F	Medicare Program; Removal of the Requirements for the Cardiac Pacemaker Registry.		10/19/00
10/19/00	62681	410	HCFA–1088–P	Medicare Program; Clinical Social Worker Services.	12/18/00	

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10/24/00	63604–63605		HCFA–3058–N	Medicare Program; Meeting of the Executive Committee of the Medicare Coverage Advisory Committee—November 7, 2000.	10/31/00	
10/31/00	64968–64974		HCFA–4010–GNC	Medicare Program; Criteria and Standards for Evaluating Intermediary and Carrier Performance During Fiscal Year 2001.	11/30/00	10/1/00
10/31/00	64966–64968		HCFA–2118–N	Medicare, Medicaid Programs and CLIA Programs; Continuance of the Approval of COLA as a CLIA Accreditation Organization.		10/31/00
10/31/00	64919–64924	435	HCFA–2086–P	Medicaid Program; Change in Application of Federal Financial Participation Limits.	11/30/00	
11/02/00	65376	410, 414	HCFA–1120–FC	Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule for Calendar Year 2001.	1/2/01	1/1/01
11/03/00	66304–66442	412, 413	HCFA–1069–P	Medicare Program; Prospective Payment System for Inpatient Rehabilitation Facilities.	2/1/01	
11/13/00	67798	419	HCFA–1005–IFC	Medicare Program; Prospective Payment System for Hospital Outpatient Services.	1/12/01	
11/16/00	69416–69424	482	HCFA–3014–P	Medicare and Medicaid Programs; Hospital Conditions of Participation: Laboratory Services.	1/16/01	
11/21/00	69946–69947		HCFA–1157–N	Medicare Program; December 12, 2000, Meeting of the Competitive Pricing Advisory Committee.	12/12/00	
11/21/00	69945–69946		HCFA–1151–N	Medicare Program; Ambulance Services Demonstration.		3/21/00
11/24/00	70575		HCFA–2118–CN	Medicare and Medicaid Programs; Continuance of the Approval of COLA as a CLIA Accreditation Organization; Correction.		11/24/00
11/24/00	70507	45 CFR 160, 162	HCFA–0149–CN	Health Insurance Reform; Standards for Electronic Transactions; Correction.		11/24/00
11/27/00	70729		HCFA–1165–N	Medicare Program; December 11, 2000, Meeting of the Practicing Physicians Advisory Council.		12/11/00
12/4/00	75720		HCFA–1156–N	Medicare Program; Request for Nominations for the Practicing Physicians Advisory Council.		12/30/00
12/5/00	75943–75944		HCFA–1162–N	Medicare Program; Establishment of the Advisory Panel on Ambulatory Payment Classification Groups and Request for Nominations for Members.	12/26/00	
12/21/00	80442–80443		HCFA–2092–N	Medicare Program; Deductible Amount for Medigap High Deductible Policy Options for Calendar Year 2001.		1/1/01
12/21/00	80443–80444		HCFA–1172–N	Medicare Program; January 10, 2001, Meeting of the Advisory Panel on Medicare Education.		1/10/01
12/27/00	81878–81879		HCFA–9006–N	Medicare Program; Correction of HHS Regulatory Plan and Unified Agenda.		12/27/00
12/27/00	81813	422	HCFA–1160–P	Medicare Program; Requirements for the Recredentialing of Medicare+Choice Organization Providers.	1/26/01	

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12/27/00	81813	412, 413	HCFA–1069–N	Medicare Program; Medicare; Prospective Payment System for Inpatient Rehabilitation Facilities; Extension of Comment Period.		
12/28/00	82462	45 CFR 160, 164	HCFA–0177–F	Standards for Privacy of Individually Identifiable Health Information.		2/26/01
12/29/00	83155		HCFA–3002–N	Medicare Program; Application Process for National Organizations to Obtain Deeming Authority for Diabetes Self-Management Training Programs.		1/29/01
1/3/01	376		HCFA–2089–N	State Children's Health Insurance Program; Final Allotments to States, the District of Columbia, and U.S. Territories and Commonwealths for Fiscal Year, 2001..		
1/4/01	856	411, 424	HCFA–1809–FC	Medicare and Medicaid Programs; Physicians' Referrals to Health Care Entities With Which They Have Financial Relationships,.		
1/9/01	1599	413, 489	HCFA–1005–F3	Medicare Program; Prospective Payment System for Hospital Outpatient Services; Correction.		
1/11/01	2490	431, 433, 435	HCFA–2006–F	State Children's Health Program; Implementing Regulations for the State Children's Health Insurance Program, Part II..		
1/11/01	2432		HCFA–2112–N	Medicaid Program; Infrastructure Grant Program to Support the Competitive Employment of People with Disabilities..		
1/12/01	2316	435	HCFA–2086–F	Medicaid Program; Change in Application of Federal Financial Participation Limits.		
1/12/01	3377	413	HCFA–1089–P	Medicare Program; Payment for Clinical Psychology Training Programs.		
1/12/01	3358	413, 422	HCFA–1685–F	Medicare Program; Payment for Nursing and Allied Health Education.		
1/12/01	3148	447	HCFA–2071–F	Medicaid Program; Revision to Medicaid Upper Payment Limit Requirements for Hospital Services, Nursing Facility Services, Intermediate Care Facility Services for the Mentally Retarded, and Clinical Services.		
1/16/01	3497	411, 413, 489	HCFA–1112–CN	Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities—Update; Correction.		
1/18/01	4674	416, 482, 485	HCFA–3049–F	Medicare and Medicaid Programs; Hospital Conditions of Participation: Anesthesia Services.		
1/19/01	6228	400, 430, 431,434, 435, 438, 440, 447.	HCFA–2001–FC	Medicaid Program; Medicaid Managed Care.		
1/22/01	7148	441,483	HCFA–2065–IFC	Medicaid Program; Use of Restraint and Seclusion in Psychiatric Residential Treatment Facilities Providing Psychiatric Services to Individuals Under Age 21.		
1/22/01	6630		HCFA–2089–FC	State Children's Health Insurance Program; Final Allotments to States, the District of Columbia, and U.S. Territories and Commonwealths for Fiscal Year 2001; Correction.		

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1/24/01	7593	422, 489	HCFA–4024–P	Medicare Program; Improvements to the Medicare+Choice Appeal and Grievance Procedures.		
2/2/01	8771	411, 424	HCFA–1809–F2	Medicare and Medicaid Programs; Physicians' Referrals to Health Care Entities with which They Have Financial Relationships: Delay of Effective Date of Final Rule and Technical Amendment.		
2/5/01	8974		HCFA–3061–N	Medicare Program; Meetings of the Medical Devices and Prosthetics Panel and the Executive Committee of the Medicare Coverage Advisory Committee; February 21 and 22, 2001.		
2/12/01	9857		HCFA–1174–N	Medicare Program; Meeting of the Advisory Panel on Ambulatory Payment Classification Groups.		
2/26/01	11547	431, 433, 435, 436, 457.	HCFA–2006–N	State Children's Health Insurance Program; Implementing Regulations for the State Children's Health Insurance Program: Delay of Effective Date.		
2/26/01	11546	400, 430, 431, 434, 435, 438, 440, 447.	HCFA–2001–F2	Medicaid Program; Medicaid Managed Care: Delay of Effective Date.		
3/2/01	13021	410, 412, 413, 485.	HCFA–1118–CN1	Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2001 Rates; Correction.		
3/2/01	13020	410, 412, 413, 485.	HCFA–1118–CN2	Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2001 Rates; Midyear Corrections Effective.		
3/5/01	13328		HCFA–2068–N	Medicare, Medicaid, and CLIA Programs; Continuance of the Approval of the American Society for Histocompatibility and Immunogenetics as a CLIA Accreditation Organization.		
3/9/01	14157		HCFA–1188–N	Medicare Program; March 26, 2001, Meeting of the Practicing Physicians Advisory Council.		
3/12/01	14343	435	HCFA–2086–F2	Medicaid Program; Change in Application of Federal Financial Participation Limits: Delay of Effective Date.		
3/12/01	14342	413, 422	HCFA–1685–F2	Medicare Program; Payment for Nursing and Allied Health Education: Delay of Effective Date.		
3/14/02	14906		HCFA–2079–PN	Medicare and Medicaid Programs; Recognition of the American Osteopathic Association for Ambulatory Surgical Centers Program.		
3/14/01	14861	410, 414, 424, 480, 498.	HCFA–3002–CN	Medicare Program; Expanded Coverage for Outpatient Diabetes Self-Management Training and Diabetes Outcome Measurements.		
3/19/01	15352	416, 482, 485	HCFA–3049–F2	Medicare and Medicaid Programs; Hospital Conditions of Participation: Anesthesia Services; Delay of Effective Date.		

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3/21/01	15800	441,483	HCFA–2065–F	Medicare Program; Use of Restraint and Seclusion in Residential Treatment Facilities Providing Inpatient Psychiatric Services to Individuals under Age 21: Delay of Effective Date.		
3/27/01	16607	410,414	HCFA–1120–CN	Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule for Calendar Year 2001.		
3/28/01	16950		HCFA–4020–N	Medicare Program; Renewal of the Advisory Panel for Medicare Education (APME).		
4/3/01	17657	447	HCFA–2100–P	Medicaid Program; Modification of the Medicaid Upper Payment Limit Transition Period for Inpatient Hospital Services, Outpatient Hospital Services, Nursing Facility Services, Intermediate Care Facility Services for the Mentally Retarded, and Clinic Services.		
4/4/01	17813	411,424	HCFA–1809–N	Medicare and Medicaid Programs; Physicians' Referrals to Health Care Entities with which they have Financial Relationships; Extension of Comment Period.		
4/12/01	18959		HCFA–3057–N	Medicare Program; Annual Review of the Appropriateness of Payment Amounts for New Technology Intraocular Lenses (NTIOLS) Furnished by Ambulatory Surgical Centers (ASCs).		
4/13/01	19178		HCFA–3068–N	Medicare Program; Educational Symposium to Discuss the Use of Evidence-Based Medicine in the Medicare Coverage Decision Process—May 3, 2001.		
4/16/01	19509		HCFA–2099–N	Medicare and Medicaid Programs; Application by the American Osteopathic Association (AOA) for Approval of Deeming Authority for Critical Access Hospitals.		
4/18/01	19961		HCFA–9007–N	Notice of Change of Address for the Provider Reimbursement Review Board, the Medicare Geographic Classification Review Board, the Health Care Financing Administration Hearing Officer, and the Office of Hearings.		
4/26/01	20997		HCFA–1561	Medicare Program; Evaluation Criteria and Standards for Peer Review Organization 6th Round Contract.		
4/30/01	21403		HCFA–3066–N	Medicare Program; Meeting of the Diagnostic Imaging Panel of the Medicare Coverage Advisory Committee—June 19, 2001.		
4/30/01	21402		HCFA–3067–N	Medicare Program; Request for Nominations for Members for the Medicare Coverage Advisory Committee (MCAC).		
5/1/01	21770		HCFA–1182–PN	Medicare Program; Revision of Payment Rates for End-Stage Renal Disease (ESRD) Patients Enrolled in Medicare+Choice Plans.		

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5/4/01	22646	405, 412, 413, 485, 486.	HCFA–1158–P	Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2002 Rates Parts I–IV.		
5/10/01	23984	410, 411, 413, 424, 482, 489.	HCFA–1163–P	Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities—Update, Part II.		
5/10/01	23946		HCFA–10037	Emergency Clearance: Public Information Collection Requirements Submitted to the Office of Management and Budget (OMB).		
5/18/01	27662		HCFA–3069–N	Medicare Program; Meeting of the Executive Committee of the Medicare Coverage Advisory Committee—June 14, 2001.		
5/18/01	27598	416, 482, 485	HCFA–	Medicare and Medicaid Programs: Hospital Conditions of Participation: Anesthesia Services: Delay of Effective Date.		
5/22/01	28183		HCFA–2125–N	Medicaid Program; Infrastructure Grant Program to Support the Design and Delivery of Long Term Services and Supports that Permit People and any Age who have a Disability or Long-Term Illness to Live in the Community.		
5/22/01	28110	441, 483	HCFA–2065–IFC2	Medicaid Program; Use of Restraint and Seclusion in Psychiatric Residential Treatment Facilities Providing Inpatient Psychiatric Services to Individuals Under Age 21.		
6/1/01	29824		HCFA–3071–N	Medicare Program; Meeting of the Drugs, Biologics, and Therapeutics Panel of the Medicare Coverage Advisory Committee—June 20, 2001.		
6/8/01	31028		HCFA–1170–PN	Medicare Program; Five-Year Review of Work Relative Value Units Under the Physician Fee Schedule, Part III.		
6/8/01	30936		HCFA–1194–N	Medicare Program; Meeting of the Practicing Physicians Advisory Council on June 25, 2001.		
6/11/01	31178	431, 433, 435, 436, 457.	HCFA–2006–F3	State Children's Health Program, Implementing Regulations for the State Children's Health Insurance Program: Further Delay of Effective Date.		
6/13/01	32172	410, 412, 413, 485.	HCFA–1178–IFC]	Medicare Program; Provisions of the Benefits Improvement and Protection Act of 2000; Inpatient Payments and Rates and Costs of Graduate Medical Education, Part VII.		
6/18/01	32777	409, 410, 411, 413, 424, 484.	HCFA–1059–F2	Medicare Program; Prospective Payment System for Home Health Agencies; Correction.		
6/18/01	32776	400, 430, 431, 434, 435, 438, 440, 447.	HCFA–2001–F3	Medicaid Program; Medicaid Managed Care: Further Delay of Effective Date.		

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6/20/01	33030	405	HCFA–3074–F	Medicare and Medicaid Programs; End-Stage Renal Disease—Waiver of Conditions for Coverage under a State of Emergency in Houston, TX area.		
6/21/01	33257		HCFA–2124–N	State Children's Health Insurance Program; Redistribution and Continued Availability of Unexpended SCHIP Funds from the Appropriation for FY 1998.		
6/25/01	33810	431, 433, 435, 436, 457.	HCFA–2006–IFC	State Children's Health Program; Revisions to the Regulations Implementing the State Children's Health Insurance Program, Part IV.		
6/26/01	33966		HCFA–4019–N	Medicare Program; Meeting of the Advisory Panel on Medicare Education—July 12, 2001.		
6/27/01	34223		HCFA–3072–PN	Medicare Program; Application by the American Diabetes Association for Recognition as a National Accreditation Program for Accrediting Entities to Furnish Outpatient Diabetes Self-Management Training.		
6/29/01	34693		HCFA–1186–N	Medicare Program; Public Meeting for New Clinical Laboratory Tests—Payment Determinations for Calendar Year 2002.		
6/29/01	34687		HCFA–1147–NC	Medicare Program; Update to the Prospective Payment System for Home Health Agencies for FY 2002.		
7/5/01	35395	416, 482, 485	HCFA–3070–P	Medicare and Medicaid Programs; Hospital Conditions of Participation: Anesthesia Services.		
7/5/01	35442		HCFA–1060–N3	Medicare Program; Cost-of-Living Adjustment for the Territory of Guam in the Schedules of Per-Visit Limitations on Home Health Agency Costs.		
7/3/01	35253		HCFA–1147–CN	Medicare Program; Update to the Prospective Payment System for Home Health Agencies for FY 2002, Correction.		
7/3/01	35260		HCFA–3073–N	Medicare Program; Town Hall Meeting on Physician Query Forms.		
7/30/01	39322		CMS–1135–CN	Medicare Program; Hospice Wage Index Fiscal Year 2001, Correction.		
7/31/01	39562	410, 411, 413, 424, 489.	CMS–1163–F	Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities—Update.		
7/31/01	39450		CMS–9010–FC	Medicare and Medicaid Programs; Change of Agency Name: Technical Amendments.		
8/1/01	39828	405, 410, 412, 413, 482, 485, 486.	CMS–1131–F, CMS–1158–F, CMS–1178–F	Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Rates and Costs of Graduate Medical Education: Fiscal Year 2002 Rates; Provisions of the Balanced Budget Refinement Act of 1999; and Provisions of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000.		

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8/1/01	39755		CMS–4025–PN	Medicare Program; Medicare+Choice Programs—Application by the National Committee for Quality Assurance (NCQA) for Approval of Deeming Authority for Medicare+Choice Organizations That are Licensed as a Health Maintenance Organization.		
8/1/01	39773		CMS–4023–PN	Medicare Program; Medicare+Choice Organizations—Application by the Accreditation Association for Ambulatory Health Care, Inc. for Approval of Deeming Authority for Medicare+Choice Organizations That are Licensed as a Health Maintenance Organization or a Preferred Provider Organization.		
8/2/01	40372	405, 410, 411, 414, 415.	CMS–1169–P	Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2002, Part III.		
8/2/01	40289		CMS–1196–N	Medicare Program; Notice of Practicing Physicians Advisory Council Rechartering and Request for Nominations.		
8/3/02	40706		CMS–1193–NC	Medicare and Medicaid Programs; Announcement of Applications From Hospitals Requesting Waivers for Organ Procurement Service Areas.		
8/10/02	42229		CMS–1107–N	Medicare and Medicaid Programs; Notice for the Solicitation of Proposals for the Private, For-Profit Demonstration Project for the Program of All-Inclusive Care for the Elderly.		
8/17/01	43090	400, 430, 431, 434, 435, 438, 440, 447.	CMS–2001–IFC	Medicaid Program; Medicaid Managed Care; Further Delay of Effective Date.		
8/20/01	43614	400, 430, 431, 434, 435, 438, 440, 447.	CMS–2104–P	Medicaid Program; Medicaid Managed Care, Part II.		
8/24/01	44672	413, 419, 489	CMS–1159–P	Medicare Program; Changes to the Hospital Outpatient Prospective Payment System and Calendar Year 2002 Payment Rates, Part II.		
8/24/01	44585	416, 482, 485	CMS–3070–CN	Medicare and Medicaid Programs; Hospital Conditions of Participation: Anesthesia Services.		
8/28/01	45173	414	CMS–1010–F	Medicare Program; Replacement of Reasonable Charge Methodology by Fee Schedules for Parenteral and Enteral Nutrients, Equipment, and Supplies.		
8/31/01	46015		CMS–1195–N	Medicare Program; September 17, 2001, Meeting of the Practicing Physicians Advisory Council.		
9/5/01	46397	447	CMS–2100–F	Medicaid Program; Modification of the Medicaid Upper Payment Limit Transition Period for Inpatient Hospital Services, Outpatient Hospital Services, Nursing Facility Services, Intermediate Care Facility Services for the Mentally Retarded, and Clinic Services.		

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9/7/01	46902	412	CMS–1176–F	Medicare Program; Payments for New Medical Services and New Technologies Under the Acute Care Hospital Inpatient Prospective Payment System, Part III.		
9/7/01	46763	431	CMS–2128–P	Medicaid Program; Continue to Allow States an Option Under the Medicaid Spousal Impoverishment Provisions to Increase the Community Spouse's Income When Adjusting the Protected Resource Allowance.		
9/12/01	47493		CMS–2119–N	Medicare, Medicaid, and CLIA Programs; Continuance of the Approval of the College of American Pathologists as a CLIA Accreditation Organization.		
9/12/01	47410	422	CMS–1160–F	Medicare Program; Requirements for the Recredentialing of Medicare+Choice Organization Providers.		
9/17/01	48078	411	CMS–1163–F	Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities-Update.		
9/18/01	48147		CMS–4026–N	Medicare Program; Medicare+Choice Organizations—Application by the Joint Commission on Accreditation of Healthcare Organizations for Approval of Deeming Authority for Medicare+Choice Organizations That Are Licensed as Health Maintenance Organizations or Preferred Provider Organizations.		
9/19/01	48262		CMS–3075–N	Medicare Program; Meeting of the Executive Committee of the Medicare Coverage Advisory Committee—October 17, 2001.		
9/27/01	49454		CMS–1175–N	Medicare Program; Hospice Wage Index Fiscal Year 2002, Part II.		
9/28/01	49677		CMS–2099–FN	Medicare Program; Approval of Deeming Authority for Critical Access Hospitals by the American Osteopathic Association.		
9/28/01	49544	402, 405	CMS–6145–FC	Medicare Program; Civil Money Penalties, Assessments, and Revised Sanction Authorities.		
10/1/01	49958		CMS–1182–FN	Medicare Program; Revision of Payment Rates for End-Stage Renal Disease Patients Enrolled in Medicare+Choice Plans.		
10/03/01	50440		CMS–4029–N	Medicare Program; Request for Nomination for the Advisory Panel on Medicare Education.		
10/04/01	50658		CMS–4028–N	Medicare Program; Meeting of the Advisory Panel on Medicare Education—Thursday, October 25, 2001.		
10/05/01	51095		CMS–1175–N	Medicare Program; Hospice Wage Index Fiscal Year 2002 (correction notice).		
10/12/01	52189		CMS–1175–N	Medicare Program; Hospice Wage Index Fiscal Year 2002 (correction notice).		

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10/26/01	54266		CMS–1197–N	Medicare Program; December 10–11, 2001 Meeting of the Practicing Physicians Advisory Council and Request for Nominations.		
10/26/01	54264		CMS–8012–N	Medicare Program; Part A Premium for 2002 for the Uninsured Aged and for Certain Disabled Individuals Who Have Exhausted Other Entitlement.		
10/26/01	54263		CMS–3072–FN	Medicare Program; Approval of Application by the American Diabetes Association for Recognition as a National Accreditation Program for Accrediting Entities to Furnish Outpatient Diabetes Self-Management.		
10/26/01	54262		CMS–3076–PN	Medicare Program; Application by the Indian Health Service for Recognition as a National Accreditation Organization for Accrediting American Indian and Alaska Native Entities to Furnish Outpatient Diabetes Self-Management Training.		
10/26/01	54261		CMS–3061–NC	Medicare Program; Adjustment in Payment Amounts for New Technology Intraocular Lenses Furnished by Ambulatory Surgical Centers.		
10/26/02	54255		CMS–8010–N	Medicare Program; Monthly Actuarial Rates and Monthly Supplementary Medical Insurance Premium Rate Beginning January 1, 2002.		
10/26/01	54253		CMS–3080–NR	Medicare Program; The National and Local Coverage Determination Review Process for an Individual With Standing as Defined in Section 522 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000.		
10/26/01	54251		CMS–8011–N	Medicare Program; Inpatient Hospital Deductible and Hospital Extended Care Services Coinsurance Amounts for 2002.		
10/26/01	54246		CMS–2133–N	State Children's Health Insurance Program; Final Allotments to States, the District of Columbia, and U.S. Territories and Commonwealths for Fiscal Year 2002.		
10/26/01	54186	408	CMS–4007–P	Medicare Program; Supplementary Medical Insurance Premium Surcharge Agreements.		
10/26/01	54179	403, 416, 418, 460, 482, 483.	CMS–3047–P	Medicare and Medicaid Programs; Fire Safety Requirements for Certain Health Care Facilities.		
11/01/01	55246	405, 410, 411, 414, 415.	CMS–1169–FC	Medicare Program; Revisions to Payment Policies and Five-Year Review of and Adjustments to the Relative Value Units Under the Physician Fee Schedule for Calendar Year 2002, Part II.		

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11/02/01	55857	419	CMS–1159–F1	Medicare Program; Announcement of the Calendar Year 2002 Conversion Factor for the Hospital Outpatient Prospective Payment System and Pro Rata Reduction on Transitional Pass-Through Payments, Part V.		
11/02/01	55850	419	CMS–1179–IFC	Medicare Program; Prospective Payment System for Hospital Outpatient Services: Criteria for Establishing Additional Pass-Through Categories for Medical Devices, Part V.		
11/02/01	55677		CMS–9012–NC	Medicare and Medicaid Programs; Plan to Create an Open and Responsive Federal Agency.		
11/13/01	56902		CMS–2133–N	State Children's Health Insurance Program; Final Allotments to States, the District of Columbia; and U.S. Territories and Commonwealths for Fiscal Year 2002.		
11/13/01	56762	416, 482, 485	CMS–3070–F	Medicare and Medicaid Programs; Hospital Conditions of Participation: Anesthesia Services.		
11/23/01	58788	410	CMS–3250–F	Medicare Program; Negotiated Rulemaking: Coverage and Administrative Polices for Clinical Diagnostic Laboratory Services, Part II.		
11/23/01	58786	411	CMS–1163–F	Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities—Update (Correction).		
11/23/01	58743		CMS–1190–NC	Medicare Program; Establishment of Procedures That Permit Public Consultation Under the Existing Process for Making Coding and Payment Determinations for New Clinical Laboratory Tests and for New Durable Medical Equipment.		
11/23/01	58742		CMS–3079–N	Medicare Program; Meeting of the Diagnostic Imaging Panel of the Medicare Coverage Advisory Committee—January 10, 2002.		
11/23/01	58741		CMS–3077–N	Medicare Program; Withdrawal of Medicare Coverage of Certain Positron Emission Tomography Scanners.		
11/23/01	58694	447	CMS–2134–P	Medicaid Program; Modification of the Medicaid Upper Payment Limit for Non–State Government-Owned or Operated Hospitals.		
11/30/01	58694	413, 419, 489	CMS–1159–F2	Medicare Program; Changes to the Hospital Outpatient Prospective Payment System for Calendar Year 2002, Part III.		
12/3/01	60154	411	CMS–1809–IFC	Medicare and Medicaid Programs; Physicians' Referrals to Health Care Entities With Which They Have Financial Relationships: Partial Delay of Effective Date.		
12/14/01	64839		CMS–4031–N	Medicare Program; Open Public Meeting on January 16, 2002 to Discuss Activities Related to the Collection of Diagnostic Data from Medicare+Choice Organizations for Risk Adjustment.		

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12/14/01	64838		CMS–1191–N	Medicare Program; Meeting of the Advisory Panel on Ambulatory Payment Classification Groups.		
12/28/01	67266		CMS–2135–N	Medicare Program; Deductible Amount for Medigap High Deductible Options for Calendar Year 2002.		
12/28/01	67257		CMS–4021–GNC	Medicare Program; Criteria and Standards for Evaluating Intermediary, Carrier, and Durable Medical Equipment, Prosthetics, Orthotics and Supplies Regional Carrier Performance During Fiscal Year 2002.		
12/28/01	67109	486	CMS–3064–IFC	Medicare and Medicaid Programs; Emergency Recertification for Coverage for Organ Procurement Organizations.		
12/31/01	67494	413, 419, 489	CMS–1159–F3	Medicare Program; Prospective Payment System for Hospital Outpatient Services; Delay in Effective Date of Calendar Year 2002 Payment Rates and the Pro Rata Reduction on Transitional Pass-Through Payments.		
1/18/02	2602	447	CMS–2134–F	Medicaid Program; Modification of the Medicaid Upper Payment Limit for Non-State Government-Owned or Operated Hospitals.		
1/25/02	3720		CMS–4034–N	Medicare Program; Meeting of the Advisory Panel on Medicare Education—February 13, 2002.		
1/25/02	3719		CMS–3081–N	Medicare Program; Peer Review Organization Contracts: Solicitation of Statements of Interest From In-State Organizations—Alaska, Hawaii, Idaho, Illinois, Kentucky, Maine, Nebraska, South Carolina, Vermont, and Wyoming.		
1/25/02	3716		CMS–4025–FN	Medicare Program; Medicare+Choice Organizations—Approval of the Deeming Authority of the National Committee for Quality Assurance for Medicare+Choice Managed Care Organizations That Are Licensed as Health Maintenance Organizations.		
1/25/02	3713		CMS–2087–PN	Medicaid Program; State Allotments for Payment of Medicare Part B Premiums for Qualifying Individuals: Federal Fiscal Year 2001.		
1/25/02	3712		CMS–2139–N	Medicaid Program; Infrastructure Grant Program To Support the Competitive Employment of People with Disabilities.		
1/25/02	3662	401	CMS–6011–P	Medicare Program; Reporting and Repayment of Overpayments.		

ADDENDUM IV.—REGULATION DOCUMENTS PUBLISHED IN THE FEDERAL REGISTER—Continued

[October 1999 through March 2002]

Publication date	FR Vol. 64 page	CFR* Part(s)	File code**	Regulation title	End of comment period	Effective date
1/25/02	3641		CMS–9877–P	Medicare and Medicare Programs; Terms, Definitions, and Addresses: Technical Amendments.		
2/22/02	8272		CMS–1214–N	Medicare Program; March 25–26, 2002, Meeting of the Practicing Physicians Advisory Council.		
2/22/02	8272		CMS–3087–N	Medicare Program; Meeting of the Executive Committee of the Medicare Coverage Advisory Committee—April 16, 2002.		
2/22/02	8270		CMS–3061–FN	Medicare Program; Disapproval of Alcon Laboratories' Request for an Adjustment in Payment Amounts for New Technology Intraocular Lenses Furnished by Ambulatory Surgical Centers.		
2/22/02	8267		CMS–4030–N	Medicare Program; Solicitation for Proposals for the Demonstration Project for Disease Management for Severely Chronically I11 Medicare Beneficiaries With Congestive Heart Failure, Diabetes, and Coronary Heart Disease.		
2/27/02	9100	410, 414	CMS–1002–FC	Medicare Program; Fee Schedule for Payment of Ambulance Services and Revisions to the Physician Certification Requirements for Coverage of Nonemergency Ambulance Services, Part IV.		
3/1/02	9556	413, 419, 489	CMS–1159–F4	Medicare Program; Correction of Certain Calendar Year 2002 Payment Rates Under the Hospital Outpatient Prospective Payment System and the Pro Rata Reduction on Transitional Pass-Through Payments; Correction of Technical and Typographical Errors, Part V.		
3/5/02	9936	457	CMS–2127–P	State Children's Health Insurance Program; Eligibility for Prenatal Care for Unborn Children.		
3/6/02	10293	403	CMS–4032–ANPRM	Medicare Program; Medicare-Endorsed Prescription Drug Discount Card Assistance Initiative for State Sponsors, Part II.		
3/6/02	10262	403	CMS–4027–P	Medicare Program; Medicare-Endorsed Prescription Drug Card Assistance Initiative, Part II.		
3/14/02	11549	410, 411, 413, 424, 489.	CMS–1163–F	Medicare Program; Prospective Payment System and consolidated Billing for Skilled Nursing Facilities—Update.		
3/15/02	11745	403	CMS–4027–P	Medicare Program; Medicare-Endorsed Prescription Drug Card Assistance Initiative (correction).		
3/18/02	11969		CMS–1206–N	Medicare Program; Town Hall Meeting on Payment for Certain Drugs, Biologicals, and Devices under the Hospital Outpatient Prospective Payment System for Calendar Year 2003.		
3/19/02	12479	447	CMS–2134–N	Medicaid Program; Modification of the Medicaid Upper Payment Limit for Non-State Government-Owned or Operated Hospitals: Delay of Effective Date.		

ADDENDUM IV.—REGULATION DOCUMENTS PUBLISHED IN THE FEDERAL REGISTER—Continued

[October 1999 through March 2002]

Publication date	FR Vol. 64 page	CFR* Part(s)	File code**	Regulation title	End of comment period	Effective date
3/22/02	13416	412, 413, 476	CMS–1177–P	Medicare Program; Prospective Payment System for Long-Term Care Hospitals: Proposed Implementation and FY 2003 Rates, Part II.		
3/22/02	13347		CMS–3089–N	Medicare Program; Annual Review of the Appropriateness of Payment Amounts for New Technology Intraocular Lenses Furnished by Ambulatory Surgical Centers.		
3/22/02	13345		CMS–3076–FN	Medicare Program; Approval of the Indian Health Service as a National Accreditation Organization for Accrediting American Indian and Alaska Native Entities To Furnish Outpatient Diabetes Self-Management Training.		
3/22/02	13344		CMS–2140–PN	Medicare and Medicaid Programs; Application by the Joint Commission on Accreditation of Healthcare Organization for Approval of Deeming Authority for Critical Access Hospitals.		
3/22/02	13341		CMS–2138–N	Medicare, Medicaid, and CLIA Programs; Continuance of Approval of the American Osteopathic Association as an CLIA Accreditation Organization.		
3/22/02	13337		CMS–4026–FN	Medicare Program; Medicare+Choice Organizations—Approval of the Joint Commission on Accreditation of Healthcare Organizations for Medicare+Choice Deeming Authority for Managed Care Organizations That Are Licensed as Health Maintenance Organizations or Preferred Provider Organizations.		
3/22/02	13297		CMS–6012–NOI	Medicare Program; Establishment of Special Payment Provisions and Standards for Suppliers of Prosthetics and Certain Custom-Fabricated Orthotics; Intent to Form Negotiated Rulemaking Committee.		
3/22/02	13278	417, 422	CMS–1181–F	Medicare Program; Modifications to Managed Care Rules Based on Payment Provisions of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, and Technical Corrections.		
3/22/02	13278	410, 411, 413, 424, 489.	CMS–1163–CN	Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Correction.		
3/28/02	15011	410, 411, 413, 424, 489.	CMS–1163–N	Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Correction.		
3/29/02	15149	483, 488	CMS–2131–P	Medicare and Medicaid Programs; Requirements for Paid Feeding Assistants in Long Term Care Facilities.		

*42 CFR except where noted

**N—General Notice; PN—Proposed Notice; NC—Notice with Comment Period; FN—Final Notice; P—Notice of Proposed Rulemaking (NPRM); F—Final Rule; FC—Final Rule with Comment Period; CN—Correction Notice; IFC—Interim Final Rule with Comment Period; GNC—General Notice with Comment Period

Addendum V—Categorization of Food and Drug Administration—Allowed Investigational Device Exemptions

Under the Food, Drug, and Cosmetic Act (21 U.S.C. 360c), devices fall into one of three classes. Also, under the new categorization process to assist CMS, the Food and Drug Administration assigns each device with a Food and Drug Administration-approved investigational device exemption to one of two categories. To obtain more information about the classes or categories, please refer to the **Federal Register** notice published on April 21, 1997 (62 FR 19328).

The following information presents the device number, category (A or B), and criterion code.

Investigational Device Exemption Numbers, October 1999–December 1999

G980094 B4
G990047 A1
G990118 B2
G990128 A
G990135 B2
G990151 B2
G990179 B
G990212 B
G990215 B
G990216 B2
G990217 B4
G990220 B3
G990221 B4
G990224 B4
G990226 A1
G990228 B4
G990234 B2
G990235 A2
G990240 B2
G990243 B2
G990247 B2
G990248 B1
G990250 B4
G990251 B2
G990252 B1
G990258 B4
G990261 B2
G990263 A2
G990267 A1
G990268 B2
G990269 B2
G990270 B2
G990273 B4
G990272 B3
G990275 B4
G990279 B1
G990280 B2
G990282 B4
G990283 B4
G990287 B1
G990288 B4
G990290 B4
G990292 B5
G990294 B3
G990296 B4
G990299 B3
G990300 B4
G990301 B4
G990303 A1

Investigational Device Exemption Numbers, January 2000–March 2000

G 970009 B
G 980242 B
G 990038 A
G 990110 B
G 990154 B
G 990190 B
G 990193 B
G 990208 B
G 990256 A
G 990257 B
G 990259 B
G 990260 B
G 990281 A
G 990304 B
G 990306 B
G 990307 B
G 990309 B
G 990313 B
G 990317 B
G 990321 B
G 990322 B
G 990323 B
G 990324 B
G 990327 B
G 990328 B
G 990329 B
G 990330 B
G 990331 B
G 990332 B
G 990333 B
G 000001 B
G 000002 B
G 000003 B
G 000004 B
G 000005 A
G 000006 B
G 000008 B
G 000010 B
G 000011 B
G 000013 B
G 000014 B
G 000015 B
G 000016 A
G 000017 B
G 000018 B
G 000019 B
G 000020 A
G 000021 B
G 000022 B
G 000023 A
G 000025 B
G 000026 B
G 000030 B
G 000032 B
G 000035 B
G 000036 B
G 000037 B
G 000039 B
G 000042 B
G 000043 B
G 000046 B
G 000049 B
G 000053 B
G 000054 B
G 000055 B
G 000057 B
G 000058 B
G 000059 B

Investigational Device Exemption Numbers, April 2000–June 2000

G 990060 B
G 990092 A
G 990227 B
G 990238 B
G 990297 B
G 990318 B
G 990325 B
G 000007 B
G 000050 B
G 000062 B
G 000063 B
G 000064 B
G 000065 B
G 000070 B
G 000073 B
G 000075 B
G 000076 B
G 000077 B
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G 000082 B
G 000083 B
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G 000112 B
G 000115 A
G 000118 B
G 000119 B
G 000121 B
G 000122 B
G 000125 A
G 000126 B
G 000128 B
G 000136 B
G 000139 B
G 000140 B
G 000141 B
G 000143 B
G 000145 B
G 000147 B

Investigational Device Exemption Numbers, July 2000–September 2000

G 99027 B
G 990320 B
G 000052 B
G 000068 B
G 000074 B
G 000109 B
G 000129 A
G 000152 B

G 000153 B
G 000156 B
G 000157 B
G 000158 B
G 000162 B
G 000164 B
G 000165 B
G 000168 B
G 000173 B
G 000175 B
G 000177 B
G 000179 B
G 000184 B
G 000190 B
G 000192 B
G 000195 B
G 000200 B
G 000201 B
G 000202 B
G 000204 B
G 000206 B
G 000207 A
G 000210 A
G 000211 B
G 000219 B
G 000221 B
G 000223 B
G 000224 A
G 000225 B
G 000231 B

Investigational Device Exemption Numbers, October 2000–December 2000

G 980253 B
G 990021 B
G 990191 B
G 990235 B
G 990302 B
G 000061 B
G 000137 A
G 000169 B
G 000176 B
G 000178 B
G 000217 B
G 000228 B
G 000229 B
G 000230 B
G 000234 B
G 000237 B
G 000238 B
G 000240 B
G 000245 B
G 000246 B
G 000248 A
G 000249 A
G 000253 B
G 000255 B
G 000256 B
G 000257 B
G 000258 B
G 000261 B
G 000264 B
G 000265 B
G 000266 B
G 000267 B
G 000268 B
G 000269 A
G 000272 B
G 000275 B
G 000276 B
G 000277 B
G 000278 B
G 000280 B
G 000281 B
G 000282 B
G 000284 B
G 000285 B
G 000287 B
G 000290 B
G 000203 B
G 000296 B
G 000297 B
G 000298 B
G 000299 B
G 000308 B
G 000311 B

Investigational Device Exemption Numbers, January 2001–March 2001

G000012 B
G000071 B
G000187 B
G000209 B
G000247 B
G000291 B
G000307 B
G000309 B
G000312 B
G000315 B
G000316 B
G000319 B
G000320 B
G000322 B
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G000324 A
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G000326 B
G000328 B
G000329 A
G000331 B
G000332 A
G000333 B
G010002 B
G010003 B
G010007 B
G010012 B
G010013 A
G010018 B
G010020 B
G010021 B
G010024 B
G010025 B
G010027 B
G010028 B
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G010042 B
G010043 B
G010045 B
G010048 B
G010050 B
G010051 B
G010053 B
G010054 B
G010056 A
G010057 B
G090014 A
G960194 B
G970097 B
G980034 B
G980223 B
G990025 B
G990034 B
G990188 B

Investigational Device Exemption Numbers, April 2001–June 2001

G000103 B
G010006 B
G010011 B
G010019 B
G010032 B
G010059 A
G010060 B
G010061 B
G010062 B
G010064 A
G010067 B
G010068 B
G010070 B
G010071 B
G010072 B
G010073 B
G010074 B
G010077 B
G010078 B
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G010099 A
G010101 B
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G010122 B
G010123 B
G010124 B
G010125 B
G010126 B
G010128 B
G010129 B
G010132 B
G010136 B
G010136 B
G010138 B
G010139 B
G010140 B
G010141 B
G010142 B
G010145 B
G010149 B

G980228 B

Investigational Device Exemption Numbers, July 2001–September 2001

G960015 B
G970299 B
G980164 B
G990092 B
G990263 B
G000060 B
G000243 A
G000321 B
G010017 B
G010079 B
G010114 B
G010133 B
G010147 B
G010148 B
G010151 B
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G010164 B
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G010174 B
G010177 B
G010180 B
G010184 B
G010185 B
G010186 B
G010189 B
G010190 B
G010191 B
G010195 B
G010198 B
G010199 B
G010200 A
G010202 B
G010204 B
G010205 B
G010206 B
G010208 A
G010211 B
G010213 B
G010214 B
G010219 B
G010224 B
G010225 B
G010226 B
G010229 B
G010232 B
G010236 B
G010253 B

Investigational Device Exemption Numbers, October 2001–December 2001

G000123 B
G001027 B
G010066 B
G010196 B
G010208 B
G010209 B
G010234 B
G010237 B
G010238 B
G010239 B
G010240 B
G010243 B
G010244 B
G010245 B
G010246 B
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G010251 B
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G010257 B
G010259 B
G010262 B
G010263 B
G010264 B
G010268 B
G010269 B
G010270 A
G010272 B
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G010277 B
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G010280 B
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G010308 B
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G010311 B
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G010319 B
G010333 B
G010334 B

Investigational Device Exemption Numbers, January 2002–March 2002

G990204 B
G000279 B
G010033 B
G010075 B
G010197 B
G010250 B
G010252 A
G010255 B
G010261 B
G010273 B
G010274 B
G010290 B
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G010324 B
G010330 B
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G010337 B
G010338 B
G010340 A
G010341 B
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G010348 B
G010349 A
G010351 B
G010356 B
G020001 B
G020002 B
G020003 B
G020005 B
G020004 B
G020006 B
G020008 B
G020009 B
G020010 B
G020011 B
G020016 B
G020017 B
G020019 B
G020022 B
G020024 B
G020026 B
G020027 B
G020028 B
G020029 B
G020033 B
G020036 B
G020037 B
G020040 A
G020041 B
G020044 B

Addendum VI—National Coverage Determinations

A national coverage determination (NCD) is a determination by the Secretary with respect to whether or not a particular item or service is covered nationally under Title XVIII of the Social Security Act, but does not include a determination of what code, if any, is assigned to a particular item or service covered under this title or a determination with respect to the amount of payment made for a particular item or service so covered. We include below all of the NCDs that have been effective since June 28, 1999, the effective date of Medicare's new coverage process. Please note that because we order the NCDs by effective date, some of the decisions are dated later than March 2002, the terminus for most of the other information listed in this notice. The entries below include information concerning completed decisions as well as sections on program and decision memoranda, which also announce impending decisions or, in some cases, explain why it was not appropriate to issue a NCD. We identify completed decisions by title, effective date, and section of the publication where the decision can be found. Also,

please note that in some cases more than one NCD was made affecting a single procedure. Information on completed decisions as well as pending decisions has also been posted on the CMS website at *http://www.hcfa.gov/coverage.*

NATIONAL COVERAGE DETERMINATIONS

[July 1999–July 2002]

Coverage Issues Manual HCFA Pub. 06 Section	Title	Effective date
35–74	Enhanced External Counterpulsation (EECP)	July 1, 1999.
35–82	Pancreas Transplants	July 1, 1999.
35–85.1	Implantation of Automatic Defibrillators	July 1, 1999.
	Transmyocardial Revascularization (TMR) for Treatment of Severe Angina	July 1, 1999.
35–96	Cryosurgery of the Prostate	July 1, 1999.
50–14	Magnetic Resonance Angiography	July 1, 1999.
50–36	Positron Emission Tomography (PET)	July 1, 1999.
50–54	Cardiac Output Monitoring by Electrical Bioimpedance	July 1, 1999.
	Vagus Nerve Stimulation for the Treatment of Seizures	July 1, 1999.
35–53	Adult Liver Transplantation	December 10, 1999.
50–55	Prostate Cancer Screening Tests	January 1, 2000.
	Stimulation	April 1, 2000.
35–48.1 35–74	External Counterpulsation (ECP) for Severe Angina	April 1, 2000.
60–14	Infusion Pumps	April 1, 2000.
30–1	Routine Costs of Clinical Trials	September 19, 2000.
35–30.1	Stem Cell Transplantation	October 1, 2000.
35–82	Pancreas Transplants	October 1, 2000.
35–90	Extracorporeal Immunoadsorption (ECI) Using Protein A Columns	October 1, 2000.
60–19	Air-Fluidized Beds (AFB's)	November 1, 2000.
45–29	Intravenous Iron Therapy	December 1, 2000.
35–48	Osteogenic Stimulation	January 1, 2001.
60–9	Durable Medical Equipment Reference List	January 1, 2001.
60–23	Speech Generating Devices	January 1, 2001.
65–15	Artificial Hearts & Related Devices	January 1, 2001.
80–2	Diabetes Outpatient Self-Management Training	February 27, 2001.
60–24	Non-Implantable Pelvic Floor Electrical Stimulation	April 1, 2001.
35–100	Photodynamic Therapy	July 1, 2001.
45–30	Photosensitive Drugs	July 1, 2001.
50–36	Position Emission Tomography (PET) Scans	July 1, 2001.
50–32	Percutaneous Transluminal Angioplasty (PTA)	July 1, 2001.
35–27.1	Biofeedback Therapy for the Treatment of Urinary Incontinence	July 1, 2001.
35–96	Cryosurgery of the Prostate	July 1, 2001.
35–53	Adult Liver Transplantation	September 1, 2001.
45–29	Intravenous Iron Therapy	October 1, 2001.
35–74	External Counterpulsation (ECP) for Severe Angina	November 15, 2001.
35–101	Treatment of Actinic Keratosis (AK)	November 26, 2001.
60–14	Infusion Pumps	January 1, 2002.
65–18	Sacral Nerve Stimulation	January 1, 2002.
50–36	Position Emission Tomography (PET) Scans	January 1, 2002.
60–16	Pneumatic Compression Devices	January 14, 2002.
50–42	Ambulatory Blood Pressure Monitoring	April 1, 2002.
60–17	Continuous Positive Airway Pressure (CPAP)	April 1, 2002.
60–25	Warm-Up Wound Therapy	July 1, 2002.
50–8.1	Services Provided for the Diagnosis and Treatment of Diabetic Sensory Neuropathy With Loss of Protective Sensation (aka Diabetic Peripheral Neuropathy).	July 1, 2002.
50–56	Home Prothrombin Time International Normalized Ration (INR) Monitoring for Anticoagulation Management.	July 1, 2002.

PROGRAM MEMORANDUM

PM No.	Title	Effective date
AB–01–58, reissued as AB–02–040	Intestinal and Multivisceral Transplantation	July 1, 2001.
AB–00–95, reissued as AB–01–150	Criteria for Medical Approval of Transplant Centers	October 11, 2000.

JOINT LETTER AND FEDERAL REGISTER PUBLICATIONS

Date	Title	Effective date
June 15, 2001	Liver Transplants in Non-Approved Centers During the Emergency in Houston.	June 15, 2001.

JOINT LETTER AND FEDERAL REGISTER PUBLICATIONS—Continued

Date	Title	Effective date
66 FR 33030–33031	HCFA–3074–F: Medicare Program; End Stage Renal Disease—Waiver of Conditions for Coverage under a State of Emergency in Houston, Texas Area.	June 15, 2001.

Decision Memoranda Announcing Maintenance of Existing National Coverage Determination

The following decision memoranda announce the agency's intention to issue NCDs or they announce the agency's determination that NCDs are inappropriate and thus reasonable and necessary determinations are left to contractor discretion. The relevant sections of the Coverage Issues Manual, however, have not yet been revised. The revisions will occur at a later date.

Date of Memo	Title	CIM section
September 27, 1999	Prolotheraphy for Chronic Low Back Pain	35–13
October 18, 1999	Helicobactor Pylori Testing	n/a
March 20, 2001	Cardiac Pacemakers	65–6
May 21, 2001	Noninvasive Positive Pressure RADs for COPD Patients	n/a
November 1, 2001	Cardiac Pacemakers	65–6
February 19, 2002	Air Fluidized Beds	60–19
February 28, 2002	Home Biofeedback for Urinary Incontinence	35–27.1
March 29, 2002	Ocular Photodynamic Therapy with Verteporfin	35–100, 45–30
April 30, 2002	Adult Liver Transplantation	35–53

[FR Doc. 02–16147 Filed 6–27–02; 8:45 am]

BILLING CODE 4120–01–P