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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–9017–N]

Medicare and Medicaid Programs; Quarterly Listing of Program Issuances—January 2003 Through March 2003

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 January 2003 through March 2003, relating to the Medicare and Medicaid programs. This notice provides information on national coverage determinations affecting specific medical and health care services under Medicare. Additionally, this notice identifies certain devices with investigational device exemption numbers approved by the Food and Drug Administration that potentially may be covered under Medicare. Finally, this notice also includes listings of all approval numbers from the Office of Management and Budget for collections of information in CMS regulations.

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. (See Section III of this notice for how to obtain listed material.)

Questions concerning items in Addendum III may be addressed to Karen Bowman, Office of Strategic Operations and Regulatory Affairs, Centers for Medicare & Medicaid Services, C5–16–03, 7500 Security Boulevard, Baltimore, MD 21244–1850, or you can call (410) 786–5252.

Questions concerning national coverage determinations in Addendum V should be directed to Patricia Brocato-Simons, Office of Clinical Standards and Quality, Centers for Medicare & Medicaid Services, C1–09–06, 7500 Security Boulevard, Baltimore, MD 21244–1850, or you can call (410) 786–0261.

Questions concerning Investigational Device Exemptions items in Addendum VI may be addressed to Sharon Hippler, Office of Clinical Standards and Quality, Centers for Medicare & Medicaid Services, C5–13–27, 7500 Security Boulevard, Baltimore, MD 21244–1850, or you can call (410) 786–4633.

Questions concerning approval numbers for collections of information in Addendum VII may be addressed to Dawn Willingham, Office of Strategic Operations and Regulatory Affairs, Regulations Development and Issuances Group, Centers for Medicare & Medicaid Services, C5–09–26, 7500 Security Boulevard, Baltimore, MD 21244–1850, or you can call (410) 786–6141.

Questions concerning all other information may be addressed to Margie Teeters, Office of Strategic Operations and Regulatory Affairs, Regulations Development and Issuances Group, Centers for Medicare & Medicaid Services, C5–13–18, 7500 Security Boulevard, Baltimore, MD 21244–1850, or you can call (410) 786–4678.

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, national coverage determinations, and Food and Drug Administration-approved investigational device exemptions 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 (CIM) may wish to review the August 21, 1989 publication (54 FR 34555). Those interested in the procedures used in making national coverage determinations under the Medicare program may review the April 27, 1999 publication (64 FR 22619).

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; and

• Title of the regulation.

• Addendum V includes completed national coverage determinations (NCDs), or reconsiderations of completed NCDs, from the quarter covered by this notice. Completed decisions are identified by the section of the CIM in which the decision appears, the title, the date the publication was issued, and the effective date of the decision.

• Addendum VI includes listings of the Food and Drug Administration-approved 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 VII includes listings of all approval numbers from the Office of Management and Budget (OMB) for collections of information in CMS regulations in title 42 of the Code of Federal Regulations (CFR) and in title 45 CFR, subchapter C. These collections of information, which OMB has approved, are being included for the first time in this quarterly listing of program issuances.

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://cms.hhs.gov/manuals/default.asp.*

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://cms.hhs.gov/rulings.*

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 Part 3—Claims Process, (CMS Pub. 13–3) transmittal entitled ''Ambulance Services,'' use the Superintendent of Documents No. HE 22.8/6 and the transmittal number 1877.

(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 19, 2003.

Jacquelyn Y. White,

Director, Office of Strategic Operations and Regulatory Affairs.

Addendum I

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

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)
June 28, 2002 (67 FR 43762)
September 27, 2002 (67 FR 61130)
December 27, 2002 (67 FR 79109)
March 28, 2003 (68 FR 15196)

Addendum II—Description of Manuals, Memoranda, and CMS 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 (CIM) was published on August 21, 1989, at 54 FR 34555. 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

[January 2003 through March 2003]

Transmittal No.	Manual/subject/publication No.
	Intermediary Manual Part 2—Audits, Reimbursement, Program Administration (CMS–Pub. 13–2) (Superintendent of Documents No. HE 22.8/6–3)
421	• Provider Communications—Provider Education and Training
422	• Beneficiary Services
423	• Provider Services, Inquiries
	Intermediary Manual Part 3—Claims Process (CMS–Pub. 13–3) (Superintendent of Documents No. HE 22.8/6)
1872	• Prospective Payment for Outpatient Rehabilitation Services and the Financial Limitation
1873	• Pneumococcal Pneumonia, Influenza Virus and Hepatitis B Vaccines
1874	• Pneumococcal Pneumonia, Influenza Virus and Hepatitis B Vaccines
1875	• Review of Form HCFA–1450 for Inpatient and Outpatient Bills
1876	• Bill Review for Partial Hospitalization Services Provided in Community Mental Health Centers Hospital Outpatient Partial Hospitalization Services
1877	• Ambulance Services
1878	• Intestinal and Multi-Visceral Transplants Provider Education
	Carriers Manual Part 2—Program Administration (Superintendent of Documents No. HE 22.8/7–3) (CMS–Pub. 14–2)
146	• Provider/Supplier Communications—Provider/Supplier Education and Training
147	• Beneficiary Services
148	• Provider Services, Inquiries
	Carriers Manual Part 3—Claims Process (CMS–Pub. 14–3) (Superintendent of Documents No. HE 22.8/7)
1785	• Coding for Non-Covered Services and Services Not Reasonable and Necessary
1786	• Carrier Use of Undeliverable Notices for Utilization, Fraud, and Quality Control
1787	• Ordering Diagnostic Tests Payment Conditions for Radiology Services
1788	• HCPCS Coding
1789	• Railroad Retirement Beneficiary Carrier United Mine Workers of America Title XIX Beneficiaries Residing in California Disposition of Misdirected Claims
1790	• Zip Code File on the Direct Connect
1791	• Disposition of Misdirected Claims Parenteral and Enteral Nutrition (PEN) Claims Jurisdiction
1792	• Claims Processing Procedures for Physician/Supplier Services to HMO Members

ADDENDUM III.—MEDICARE AND MEDICAID MANUAL INSTRUCTIONS—Continued

[January 2003 through March 2003]

Transmittal No.	Manual/subject/publication No.
	Program Memorandum Intermediaries (CMS–Pub. 60A) (Superintendent of Documents No. HE 22.8/6–5)
A–02–128	• Revision to 42 CFR 405.371 Suspension, Offset and Recoupment of Medicare Payments to Providers and Suppliers of Services
A–02–129	• 2003 Update of the Hospital Outpatient Prospective Payment System
A–03–001	• January Medicare Outpatient Code Editor Specifications Version 18.1 For Bills From Hospitals That Are Not Paid Under the Outpatient Prospective Payment System
A–03–002	• Installation of Version 28.0 Add-On of the Provider Statistical and Reimbursement Report
A–03–003	• January Outpatient Code Editor Specifications Version (V4.0)
A–03–004	• Calculating Provider-Specific Medicare Outpatient Cost-to-Charge Ratios and Instructions on Cost Report Treatment of Hospital Outpatient Services Paid on a Reasonable Cost Basis
A–03–005	• Health Insurance Portability and Accountability Act Transaction 835v4010 Companion Document Update for Intermediaries
A–03–006	• Update the Medicare Secondary Payment Module to Apportion Prospective Payment System (PPS) Outlier Amounts to all Service Lines With Medicare Reimbursement That Are PRICER Related and Potential Outlier Service Lines
A–03–007	• Payment to Hospitals and Units Excluded from the Acute Inpatient Prospective Payment System for Direct Graduate Medical Education and Nursing and Allied Health Education for Medicare+Choice Enrollees
A–03–008	• Clarification of 3-Day Payment Window vs. 1-Day Payment Window for Hospitals Excluded from Inpatient Prospective Payment System
A–03–009	• Medical Nutrition Therapy Services for Beneficiaries with Diabetes or Renal Disease
A–03–010	• Manual Medical Review Indicator for the Comprehensive Error Rate Testing Program
A–03–011	• Changes in Payment for Certain Services Provided by Outpatient Physical Therapy Providers Under the Medicare Physician Fee Schedule
A–03–012	• The Report of Benefit Savings
A–03–013	• 3-Day Payment Window Refinements Under the Short-Term Hospital Inpatient Prospective Payment System
A–03–014	• Further Guidance Regarding Billing Under the Outpatient Prospective Payment System
A–03–015	• Electromagnetic Stimulation
A–03–016	• Continuous Home Care Under Medicare Hospice
A–03–017	• Payment for Services To Be Paid on a Fee Schedule But for Which There Is No Price
A–03–018	• Installation of Version 28.0 Second Add-On of the Provider Statistical and Reimbursement Report
A–03–019	• Reactivation of Outpatient Prospective Payment System Outpatient Code Editor Edit 15, ''Service Unit Out Of Range'' and Guidance on Editing for Low Osmolar Contrast Media Procedures
A–03–020	• April 2003 Update of the Hospital Outpatient Prospective Payment System
A–03–021	• Announcement of Medicare Rural Health Clinics and Federally Qualified Health Centers Payment Rate Increases, Clarification on Coverage and Payment of Diabetes Self-Management Training Services and Medical Nutrition Therapy Services
A–03–022	• Installation of Version 29.0 of the Provider Statistical and Reimbursement Reporting System—Modification
A–03–023	• Implementation of the Temporary Equalization of Urban and Rural Standardized Payment Amounts Under the Medicare Inpatient Hospital Prospective Payment System as Required by Section 402(b) of Public Law 108–7
	Program Memorandum Carriers (CMS–Pub. 60B) (Superintendent of Documents No. HE 22.8/6–5)
B–03–001	• Emergency Update to the 2003 Medicare Physician Fee Schedule Database
B–03–002	• DMERCs-VIPS Medicare System Implementation To Process ICD–9 CM Codes Using Date of Service and Not Date of Receipt
B–03–003	• Processing Initial Denials, of the DMEPOS Refund Requirements Implementation of Limits on Beneficiary Liability for Medical Equipment and Supplies—Change
B–03–004	• CWF Change for Billing for Glucose Test Strips and Supplies—Follow-up to Change Request 2156
B–03–005	• Reporting of Accident Date and Ambulance Certification Information on the X12N 837 (version 4010) Coordination of Benefits Transaction
B–03–006	• Program Integrity Management Reporting System for Part B—Correction of Multiple Reports of Savings by VIPS Standard Systems (*i.e.*, VIPS Medicare System and Durable Medical Equipment Regional Contractor System)
B–03–007	• Minimum Number of Pricing Files That Must Be Maintained Online for Medicare Physician Fee Schedule Services
B–03–008	• Medical Review Progressive Corrective Action Continuation of Work Begun in Compliance with Change Request 2433
B–03–009	• Durable Medical Equipment Regional Carriers—New Modifier Needed To Invoke Advanced Beneficiary Notice Logic for Hard Copy and Electronic Claims
B–03–010	• Program Integrity Management Reporting System for Part B—Implementation of an Automated Edit Description Module
B–03–011	• Correct Payment of January and February 2003 Physician Services
B–03–012	• Use of the National Drug Code for Drug Claims at the Durable Medical Equipment Regional Carriers
B–03–013	• Continuation of April 2003 Change Request 2424: Create Import/Export Functionality Between the Unique Provider Identification Number System and the Provider Enrollment Chain Ownership System
B–03–014	• Continuation of April 2003 Change Request 2425: Create Import/Export Functionality Between the Medicare Claims System (MCS) and the Provider Enrollment Chain Ownership System
B–03–015	• Continuation of April 2003 Change Request 2426: Process all Medicare Part B Provider Enrollments in the Provider Enrollment Chain Ownership System; Modify the Medicare Claims System To Incorporate All Claim Payment and Provider Correspondence Functionality That Is Included in the Provider Enrollment System But Will Not Be a Part of Provider Enrollment Chain Ownership System

ADDENDUM III.—MEDICARE AND MEDICAID MANUAL INSTRUCTIONS—Continued

[January 2003 through March 2003]

Transmittal No.		Manual/subject/publication No.
B–03–016	•	Continuation of April 2003 Change Request 2427: Process all Medicare Part B Provider Enrollments in the Provider Enrollment Chain Ownership System; Create Import/Export Functionality Between the Viable Medicare System and the Provider Enrollment Chain Ownership System
B–03–017	•	Add-On-Codes for Anesthesia
B–03–018	•	Changes to Correct Coding Edits, Version 9.2, Effective July 1, 2003
B–03–019	•	Durable Medical Equipment Regional Carriers and Part B Carriers on the VMS Standard System—Short Descriptions of National Modifiers on the Healthcare Common Procedure Coding System Tape
B–03–020	•	2003 DMEPOS Jurisdiction List
B–03–021	•	Provider Education Regarding Home Health Consolidated Billing and Provider Liability
B–03–022	•	Use of Statistical Sampling for Overpayment Estimation When Performing Administrative Reviews of Part B Claims
		Program Memorandum Intermediaries/Carriers (CMS–Pub. 60A/B) (Superintendent of Documents No. HE 22.8/6–5)
AB–03–001	•	Medicare Coverage of Non-Invasive Vascular Studies for End-Stage Renal Disease Patients
AB–03–002	•	Quarterly Update of HCPCS Codes Used for Home Health Consolidated Billing Enforcement
B–03–003	•	Noncoverage of Multiple Electroconvulsive Therapy
B–03–004	•	Installation of a Security Firewall for Deceased Beneficiary Files (Options B & C)
AB–03–005	•	FY 2003 Systems Security Activities and Due Dates
AB–03–006	•	April Quarterly Update for 2003 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Fee Schedule
AB–03–007	•	Second Clarification of Medicare Policy Regarding the Implementation of the Ambulance Fee Schedule
AB–03–008	•	Clarification of Physician Certification Requirements for Medicare Hospice
AB–03–009	•	The Medicare Exclusion Database Replaces Publication 69
AB–03–010	•	Shared System Maintainer Hours for Resolution of Problems Detected During Health Insurance Portability and Accountability Act Transaction Release Testing
AB–03–011	•	Identifying the Primary Payer Amounts To Send to the Medicare Secondary Payer Pay Module and the Shared Systems When There Are Multiple Primary Payers on Electronic and Hardcopy Claims
AB–03–012	•	Remittance Advice Remark and Reason Code Update
AB–03–013	•	New Waived Tests—December 17, 2002
AB–03–014	÷	Single Drug Pricer
AB–03–015	•	Shared Systems Changes for Name Change from HCFA to CMS (MCS and CWF External Changes Only)
AB–03–016	•	CR 2240 Question and Answer Document
AB–03–017	•	Scheduled Release for April Updates to Software Programs and Pricing/Coding Files
AB–03–018	•	Implementation of the Financial Limitation for Outpatient Rehabilitation Services
AB–03–019	•	Notice of Interest Rate for Medicare Overpayments and Underpayments
AB–03–020	•	Clarification of Transmittal AB–00–107, Change Request 1163, and Transmittal AB–00–129, Change Request 1460, Regarding the Coordination of Benefits Contractor and MSP Prepay Work Activities for Customer Service, MSP and Standard Systems Contractor Staff
AB–03–021	•	Additional Documentation Requests Requirements for Ordering Providers of Laboratory Services
AB–03–022	•	Use of the American Medical Association's *Physicians' Current Procedural Terminology, Fourth Edition* Codes on Contractors' Web Sites
AB–03–023	•	Deep Brain Stimulation for Essential Tremor and Parkinson's Disease
AB–03–024	•	Clarification of the Allocation of Initial Claim Entry Activities Where the Claim Is Paid Secondary by Medicare
AB–03–025	•	System Networking Electronic Correspondence Referral System 1.3 User and Installation Guides for Testing and Production
AB–03–026	•	Implementation of the Modifications (4010A1) to Transactions and Code Set Standards for Electronic Transactions Adopted Under the Health Insurance Portability and Accountability Act
AB–03–027	•	Payment Change for the 2003 Medicare Physician Fee Schedule and Further Extension of the 2003 Participation Enrollment Process
AB–03–028	•	Coverage and Billing of Sacral Nerve Stimulation
AB–03–029	•	Health Care Claims Status Category Codes and Health Care Claim Status Codes for Use With the Health Care Claim Status Request and Response ASC X12N 276/277
AB–03–030	•	Changes to the Laboratory National Coverage Determination Edit Software for April 1, 2003
AB–03–031	•	Addition or Modification of Temporary ''K'' Codes and Change in Status for Code A4232
AB–03–032	•	File Names, Descriptions and Instructions for Retrieving the 2003 Ambulatory Surgical Center HCPCS Additions, Deletions, and Master Listing
AB–03–033	•	Promoting Colorectal Cancer Screening As a Part of National Colorectal Cancer Awareness Month
AB–03–034	•	Medicare Fee for Service Contractor Guidance on the HIPAA Privacy Rule
AB–03–035	•	Emergency Changes to the 2003 Medicare Physician Fee Schedule Database
AB–03–036	•	270/271 Implementation and Direct Date Entry Eligibility
AB–03–037	•	Provider Education Article: Medicare Payments for Part B Mental Health Services
AB–03–038	•	Reporting Benefit Integrity Workload in CROWD
AB–03–039	•	Procedure for Granting Extension to File Requests for Appeal Under the New 120-day Timeframe Created by section 521 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000
AB–03–040	•	Provider Education Article: ''Hospice Care Enhances Dignity and Peace As Life Nears Its End''

ADDENDUM III.—MEDICARE AND MEDICAID MANUAL INSTRUCTIONS—Continued

[January 2003 through March 2003]

Transmittal No.	Manual/subject/publication No.
	Hospital Manual (CMS–Pub. 10) (Superintendent of Documents No. HE 22.8/2)
796	• Pneumococcal Pneumonia, Influenza Virus, and Hepatitis B Vaccines
797	• Pneumococcal Pneumonia, Influenza Virus, and Hepatitis B Vaccines
798	• Billing for Hospital Outpatient Partial Hospitalization Services
799	• Identifying Other Primary Players During the Admission Process
	Hospice Manual (CMS–Pub. 21) (Superintendent of Documents No.)
66	• Special Coverage Requirements
	Coverage Issues Manual (CMS–Pub. 6) (Superintendent of Documents No. HE 22.8/14)
166	• Multiple-Seizure Electroconvulsive Therapy
167	• Treatment of Motor Function Disorders with Electric Nerve Stimulation—Not Covered
167	• Deep Brain Stimulation for Essential Tremor and Parkinson's Disease
168	• Ambulatory Blood Pressure Monitoring
	Outpatient Physical Therapy (CMS Pub. 9) (Superintendent of Documents No. HE 2.8/9)
17	• Billing Instructions for Partial Hospitalization Services Provided in Community Mental Health Centers
	Provider Reimbursement Manual—Part 2 Provider Cost Reporting Forms and Instructions Chapter 35/Form CMS–2540–96 (CMS–Pub. 15–2–35)
12	• Skilled Nursing Facility Cost Report Form CMS–2540–96, and Is Effective for Cost Reporting Periods Ending on and After December 31, 2002
	Financial Management (CMS–Pub. 100–06)
13	• Intermediary Claims Accounts Receivable Physician/Supplier Overpayment Reporting System Summary Entry Debts Financial Reporting for Intermediary Claims Accounts Receivable
14	• General
15	• FMFIA and the CMS Medicare Contractor Risk Assessment Fiscal Year 2003 Medicare Control Objectives Documentation and Work Papers Requirements Certification Statement Executive Summary CPIC—Report of Material Weaknesses CPIC—Report of Reportable Conditions Definitions and Examples of Reportable Conditions and Material Weaknesses Corrective Action Plans Submission, Review, and Approval of Corrective Action Plans Universal Corrective Action Plan Report CMS Finding Numbers
	Program Integrity Manual (CMS–Pub. 100–08)
37	• Written Orders Written Orders Prior to Delivery
38	• Articles
39	• Overview of Prepayment and Postpayment Review for MR Purposes Determinations Made During Prepayment and Postpayment MR Documentation Specifications for Areas Selected for Prepayment or Postpayment MR Additional Documentation Requests During Prepayment of Postpayment MR

ADDENDUM III.—MEDICARE AND MEDICAID MANUAL INSTRUCTIONS—Continued

[January 2003 through March 2003]

Transmittal No.	Manual/subject/publication No.
	Handling Late Documentation Denials Documenting That a Claim Should Be Denied Spreading Workload Evenly Review That Involves Utilization Parameters Prepayment Review of Claims for MR Purposes Documentation Specifications for Areas Selected for MR Laboratory Claims Documentation for Non-Physician Claims Development of Claims for Additional Documentation Postpayment Review Case Selection Location of Postpayment Reviews Re-adjudication of Claims Calculation of the Correct Payment Amount and Subsequent Over/Underpayment Provider(s) Rebuttal(s) of Findings

ADDENDUM IV.—REGULATION DOCUMENTS PUBLISHED IN THE FEDERAL REGISTER

[January 2003 through March 2003]

Publication date	FR Vol. 68 page	CFR Part(s)	File code*	Regulation title
01/10/2003	1374	42 CFR 403, 416, 418, 460, 482, 483, 485.	CMS–3047–F	Medicare and Medicaid Programs; Fire Safety Requirements for Certain Health Care Facilities.
01/24/2003	3586	42 CFR 433 and 438	CMS–2015–F	Medicaid Program; External Quality Review of Medicaid Managed Care Organizations.
01/24/2003	3534		CMS–3113–N	Medicare Program; Meeting of the Medicare Coverage Advisory Committee—March 12, 2003.
01/24/2003	3532		CMS–2177–PN	Medicare and Medicaid Programs; Application by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) for Hospices.
01/24/2003	3482	42 CFR Chapter IV	CMS–6012–N4	Medicare Program; Negotiated Rulemaking Committee on Special Payment Provisions and Requirements for Prosthetics and Certain Custom-Fabricated Orthotics.
01/24/2003	3435	42 CFR 482	CMS–3050–F	Medicare and Medicaid Programs; Hospital Conditions of Participation: Quality Assessment and Performance Improvement.
02/10/2003	6750		CMS–4051–N	Medicare Program; Renewal of the Advisory Panel on Medicare Education (APME) and Notice of Meeting of the Advisory Panel—February 27, 2003.
02/10/2003	6682	42 CFR 413	CMS–1126–P	Medicare Program; Provider Bad Debt Payment.
02/10/2003	6636	42 CFR 405 and 419	CMS–1206–CN2	Medicare Program; Changes to the Hospital Outpatient Prospective Payment System and Calendar Year 2003 Payment Rates; and Changes to Payment Suspension for Unfiled Cost Reports; Correction.
02/20/2003	8334	45 DCFR 160, 162, 164	CMS–0049–F	Health Insurance Reform: Security Standards.
02/28/2003	9681		CMS–1225–GNC	Medicare Program; Criteria and Standards for Evaluating Intermediary, Carrier, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Regional Carrier Performance During Fiscal Year 2003.
02/28/2003	9680		CMS–3099–N	Medicaid Program; Annual Review of the Appropriateness of Payment Amounts for New Technology Intraocular Lenses (NTIOLs) Furnished by Ambulatory Surgical Centers (ASCs).

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

[January 2003 through March 2003]

Publication date	FR Vol. 68 page	CFR Part(s)	File code*	Regulation title
02/28/2003	9673		CMS–5002–N	Medicare Program; Demonstration: Capitated Disease Management for Beneficiaries With Chronic Illnesses.
02/28/2003	9672		CMS–2165–N	Medicaid Program; Infrastructure Grant Program To Support the Competitive Employment of People With Disabilities.
02/28/2003	9671		CMS–1245–N	Medicare Program; Request for Nominations To the Advisory Panel on Ambulatory Payment Classifications Groups.
02/28/2003	9567	42 CFR 410, 414, 485	CMS–1204–F2	Medicare Program; Physician Fee Schedule Update for Calendar Year 2003.
03/05/2003	10420	42 CFR 412	CMS–1243–P	Medicare Program; Proposed Change in Methodology for Determining Payment for Extraordinarily High-Cost Cases (Cost Outliers) Under the Acute Care Hospital Inpatient Prospective Payment System.
03/07/2003	11234	42 CFR 412	CMS–1472–P	Medicare Program; Prospective Payment System for Long-Term Care Hospitals: Proposed Annual Payment Rate Updates and Policy Changes.
03/07/2003	10987	42 CFR 412	CMS–1177–F2	Medicare Program; Prospective Payment System for Long-Term Care Hospitals: Implementation and FY 2003 Rates; Correcting Amendment.
03/28/2003	15268	42 CFR 416	CMS–1885–FC	Medicare Program; Update of Ambulatory Surgical Center List of Covered Procedures Effective July 1, 2003.
03/28/2003	15207		CMS–1230—N	Medicare Program; Public Meetings in Calendar Year 2003 for New Durable Medical Equipment Coding and Payment Determinations.
03/28/2003	15206		CMS–1474–N	Medicare Program; Town Hall Meeting on the Inpatient Rehabilitation Facility Prospective Payment System.
03/28/2003	15196		CMS–9016–N	Medicare and Medicaid Programs; Quarterly Listing of Program Issuances—October 2002 Through December 2002.
03/28/2003	15139	42 CFR Chapter IV	CMS–6012–N5	Medicare Program; Negotiated Rulemaking Committee on Special Payment Provisions and Requirements for Prosthetics and Certain Custom-Fabricated Orthotics; Meeting Announcement

Addendum V—National Coverage Determinations [January 2003 Through March 2003]

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, 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 became effective during the quarter covered by 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 an NCD. We identify completed decisions by section of the CIM in which the decision appears, the title, the date the publication was issued, and the effective date of the decision. Information on completed decisions as well as pending decisions has also been posted on the CMS website at *http://cms.hhs.gov/coverage.*

National Coverage Decisions for Quarterly Notices

COVERAGE ISSUES MANUAL (CIM) HCFA PUB. 06

CIM section	Title	Issue date	Effective date
50–42	Ambulatory Blood Pressure Monitoring	03/28/03	07/01/03
35–103	Multiple Monitored Electroconvulsive Therapy	01/10/03	04/01/03
65–19	Deep Brain Stimulation for Parkinson's	02/14/03	04/01/03
35–102	Electrical Stimulation for Wounds	01/15/03	04/01/03+

PROGRAM MEMORANDUM (PM)

PM No.	Title	Issue date	Effective date
AB–03–030	Clinical Laboratory Edit Update	02/28/03	04/01/03

Addendum VI—Categorization of Food and Drug Administration-AllowedInvestigational 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.) Category A refers to experimental/investigational device exemptions, and Category B refers to nonexperimental/investigational device exemptions. 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 and category (A or B) for the first quarter, January through March 2003.

Investigational Device Exemption Numbers, 1st Quarter 2003

IDE/Category

G000247 B
G003004 B
G010216 B
G020225 B
G020231 B
G020240 A
G020244 B
G020247 B
G020248 B
G020262 B
G020279 B
G020299 B
G020301 B
G020308 B
G020310 B
G020311 B
G020314 B
G020315 B
G020317 B
G020318 B
G020319 B
G020320 B
G020324 B
G030003 A
G030004 B
G030006 B
G030012 B
G030013 B
G030014 B
G030016 B
G030018 B
G030019 B
G030020 B
G030021 B
G030023 B
G030024 B
G030025 B
G030028 B
G030030 B
G030033 B
G030035 B
G030036 B
G030037 B
G030041 B
G030043 A
G030048 B
G030049 B
G030052 B
G030053 B

Addendum VII—Approval Numbers for Collections of Information

Below we list all approval numbers for collections of information in the referenced sections of CMS regulations in title 42 and title 45, subchapter C, of the Code of Federal Regulations, which have been approved by the Office of Management and Budget:

OMB control nos.	Approved CFR sections in title 42 and title 45
0938–0008	414.40, 424.32, 424.44
0938–0022	413.20, 413.24, 413.106
0938–0023	424.103
0938–0025	406.28, 407.27
0938–0027	486.100–486.110
0938–0034	405.821
0938–0035	407.40
0938–0037	413.20, 413.24
0938–0041	408.6
0938–0042	410.40, 424.124
0938–0045	405.711
0938–0046	405.2133
0938–0050	413.20, 413.24
0938–0062	431.151, 435.1009, 440.250, 440.220, 442.1, 442.10–442.16, 442.30, 442.40, 442.42, 442.100–442.119, 483.400 –483.480, 488.332, 488.400, 498.3–498.5
0938–0065	485.701–485.729
0938–0074	491.1—491.11
0938–0080	406.13
0938–0086	420.200–420.206, 455.100–455.106
0938–0101	430.30
0938–0102	413.20, 413.24
0938–0107	413.20, 413.24
0938–0146	431.800–431.865
0938–0147	431.800–431.865
0938–0151	493.1–493.2001
0938–0155	405.2470
0938–0170	493.1269–493.1285
0938–0193	430.10–430.20, 440.167
0938–0202	413.17, 413.20
0938–0214	411.25, 489.2, 489.20
0938–0236	413.20, 413.24
0938–0242	416.44, 418.100, 482.41, 483.270, 483.470
0938–0245	407.10, 407.11

OMB control nos.	Approved CFR sections in title 42 and title 45
0938–0251	406.7
0938–0266	416.41, 416.83, 416.47, 416.48
0938–0267	485.56, 485.58, 485.60, 485.64, 485.66, 410.65
0938–0269	412.116, 412.632, 413.64, 413.350, 484.245
0938–0270	405.376
0938–0272	440.180, 441.300–441.305
0938–0273	485.701—85.729
0938–0279	424.5
0938–0287	447.31
0938–0296	413.170
0938–0300	431.800
0938–0301	413.20, 413.24
0938–0302	418.22, 418.24, 418.28, 418.56, 418.58, 418.70, 418.74, 418.83, 418.96, 418.100
0938–0313	418.1—418.405
0938–0328	482.12, 482.22, 482.27, 482.30, 482.41, 482.43, 482.53, 482.56, 482.57, 482.60, 482.61, 482.62, 482.66
0938–0334	491.9
0938–0338	486.104, 486.106, 486.110
0938–0354	441.60
0938–0355	484.10–484.52
0938–0357	409.40–409.50, 410.36, 410.170, 411.4–411.15, 421.100, 424.22, 484.18, 489.21
0938–0358	412.20–412.30
0938–0359	412.40–412.52
0938–0360	405.2100–405.2184
0938–0365	484.10, 484.11, 484.12, 484.14, 484.16, 484.18, 484.20, 484.36, 484.48, 484.52
0938–0372	414.330
0938–0378	482.60–482.62
0938–0379	418.1–418.405
0938–0380	482.1–482.66
0938–0386	405.2100–405.2171
0938–0391	488.18, 488.26, 488.28
0938–0426	476.104, 476.105, 476.116, 476.134
0938–0429	447.53
0938–0443	473.18, 473.34, 473.36, 473.42
0938–0444	1004.40, 1004.50, 1004.60, 1004.70
0938–0445	412.44, 412.46, 431.630, 456.654, 466.71, 466.73, 466.74, 466.78
0938–0447	405.2133
0938–0449	440.180, 441.300–441.310
0938–0454	424.20
0938–0456	412.105
0938–0463	413.20, 413.24
0938–0465	411.404, 411.406, 411.408
0938–0467	431.17, 431.306, 435.910, 435.920, 435.940–435.960
0938–0469	417.107, 417.478
0938–0470	417.143, 417.408
0938–0477	412.92
0938–0484	424.123
0938–0486	498.40–498.95
0938–0501	406.15
0938–0502	433.138
0938–0512	486.301–486.325
0938–0526	475.100 Subpart C, 475.106, 475.107, 462.102, 462.103
0938–0534	410.38, 424.5
0938–0544	493.1–493.2001
0938–0565	411.20–411.206
0938–0566	411.404, 411.406, 411.408
0938–0567	498 Subpart D, E, and H and 20 CFR 404.933
0938–0573	412.256, 412.230
0938–0581	493.1–493.2001
0938–0599	493.1–493.2001
0938–0600	405.371, 405.378, 413.20
0938–0610	417.436, 417.801, 417.436, 422.128, 430.12, 431.20, 431.107, 434.28, 483.10, 484.10, 489.102
0938–0612	493.1–493.2001
0938–0618	433.68, 433.74, 447.272
0938–0653	493
0938–0655	493.180
0938–0657	405.2110, 405.2112
0938–0658	405.2110, 405.2112
0938–0667	482.12, 488.18, 489.20, 489.24
0938–0673	430.10
0938–0679	410.38
0938–0685	410.32, 410.71, 413.17, 424.57, 424.73, 424.80, 440.30, 484.12
0938–0686	493.551–93.557

OMB control nos.	Approved CFR sections in title 42 and title 45
0938–0688	486.301–486.325
0938–0690	488.4–488.9, 488.201
0938–0691	412.106
0938–0692	466.78, 489.20, 489.27
0938–0700	417.479, 417.500; 422.208, 422.210; 434.44, 434.67, 434.70; 1003.100, 1003.101, 1003.103 & 1003.106
0938–0701	422.152
0938–0702	*45 CFR* 146
0938–0703	*45 CFR* 148
0938–0714	411.370–411.389
0938–0717	424.57
0938–0721	410.33
0938–0722	422.370–422.378
0938–0723	421.300–421.318
0938–0730	405.410, 405.430, 405.435, 405.440, 405.445, 405.455, 410.61, 415.110, 424.24
0938–0732	417.126, 417.470
0938–0734	45 CFR 5b
0938–0739	413.337, 413.343, 424.32, 483.20
0938–0742	422.300–422.312
0938–0749	424.57
0938–0753	422.000–422.700
0938–0754	441.152
0938–0758	413.20, 413.24
0938–0760	484 Subpart E, 484.55
0938–0761	484.11, 484.20
0938–0763	422.1–422.10, 422.50–422.80, 422.100–422.132, 422.300 –422.312, 422.400–422.404, 422.560–422.622
0938–0768	417.800–417.840
0938–0770	410.2
0938–0778	422.64, 422.111, 422.560–422.622
0938–0779	417.470, 417.126, 422.210, 422.64
0938–0781	411.404–411.406, 484.10
0938–0786	438.360, 438.362, 438.364
0938–0787	406.28, 407.27
0938–0790	460.12, 460.22, 460.26, 460.30, 460.32, 460.52, 460.60, 460.70, 460.71, 460.72, 460.74, 460.80, 460.82, 460.98, 460.100, 460.102, 460.104, 460.106, 460.110, 460.112, 460.116, 460.118, 460.120, 460.122, 460.124, 460.132, 460.152, 460.154, 460.156, 460.160, 460.164, 460.168, 460.172, 460.190, 460.196, 460.200, 460.202, 460.204, 460.208, 460.210
0938–0792	491.3, 491.8, 491.11
0938–0797	*45 CFR* 148
0938–0798	413.24, 413.65, 419.42
0938–0802	419.43
0938–0810	482.45
0938–0818	410.141–410.145, 414.63
0938–0819	45 CFR 146.121
0938–0823	420.410
0938–0824	482.13, 440.10
0938–0827	45 CFR 146.141
0938–0829	422.568
0938–0832	489
0938–0833	483.350–483.376
0938–0840	422.152
0938–0841	431.636, 457.50, 457.60, 457.70, 457.340, 457.350, 457.431, 457.440, 457.525, 457.560, 457.570, 457.740, 457.750, 457.810, 457.940, 457.945, 457.965, 457.985, 457.1005, 457.1015, 457.1180
0938–0842	412, 413
0938–0846	411.1, 411.350–411.357, 424.22
0938–0857	419
0938–0860	419
0938–0866	*45 CFR* Part 162
0938–0872	483.20, 413.337
0938–0873	422.152
0938–0874	*45 CFR* Parts 160 and 162
0938–0878	422 Subpart F & G
0938–0883	45 CFR parts 160 and 164
0938–0884	405.940
0938–0885	403.804, 403.806, 403.808, 403.810, 403.811, 403.820

Note: Sections in title 45 are preceded by ''45 CFR.''

[FR Doc. 03–16058 Filed 6–26–03; 8:45 am]
BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–5003–N2]

Medicare Program; Extension of Date of Submissions and Informational Meeting on the Application Process for the End-Stage Renal Disease—Disease Management Demonstration

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

ACTION: Notice of later date of submission of applications and of meeting.

SUMMARY: This notice announces that the date of submission of applications for the End-Stage Renal Disease (ESRD) Disease Management Demonstration is being extended 30 days (until October 2, 2003). This notice also announces an informational meeting to answer questions for and provide guidance to the parties interested in applying for the ESRD Disease Management Demonstration. This demonstration plans to increase the opportunity for Medicare beneficiaries with ESRD to receive integrated disease management services and to test the effectiveness of paying for services received by these beneficiaries in a new way. The meeting is open to the public, but attendance is limited to space available.

DATES: *Meeting Date*—The Informational meeting announced in this notice will be held on Monday, July 14, 2003, from 1 p.m. to 3 p.m. (Eastern Daylight Time). *Deadline for Written Questions and Registration:* Any interested party must register and may send written questions by mail, fax, or electronically, on or before 5 p.m. July 9, 2003.

ADDRESSES: The Informational meeting will be held in the main auditorium of the Centers for Medicare & Medicaid Services building, 7500 Security Boulevard, Baltimore, MD 21244. (All inquires should state their interest in attending, and give contact information including organization and telephone number).

Written Questions: Send written questions *via mail to following address:* Centers for Medicare & Medicaid Services, Attn: Sid Mazumdar, Division of Demonstration Programs, Office of Research, Development, and Information, Centers for Medicare & Medicaid Services,C4–15–27, 7500 Security Boulevard, Baltimore, Maryland 21244–1850.

Please allow sufficient time for mailed comments to be timely received in the event of delivery delays. *E-mail* to the following e-mail address: *ESRDDemo@cms.hhs.gov fax to the following fax number:* (410) 786–1048

FOR FURTHER INFORMATION CONTACT: Sid Mazumdar, (410) 786–6673.

SUPPLEMENTARY INFORMATION:

I. Background

On June 4, 2003, we published a demonstration notice ''Medicare Program; Demonstration: End-Stage Renal Disease—Disease Management (CMS–5003-N) in the **Federal Register** (68 FR 33495), that informed interested parties of an opportunity to apply for a waiver that would allow them to participate in the End-Stage Renal Disease (ESRD) Disease Management Demonstration. This new demonstration will foster more types of integrated care for Medicare beneficiaries with ESRD. We seek to test innovative approaches to integrating the chronic care management services for patients with ESRD with other acute care services. The demonstration aims to test the effectiveness of disease management models to increase quality of care for ESRD patients while ensuring that this care is provided more effectively and efficiently. National organizations have defined approaches to disease management, in order to improve patient outcomes while containing health care costs. Disease management programs tend to target persons whose primary health problem is a specific disease, along with comorbid conditions. Interventions tend to be highly structured and emphasize the use of standard protocols and adherence to clinical guidelines.

II. Meeting Format

The initial portion of the meeting will be a presentation of an outline of the proposed demonstration project. The remainder of the meeting will be reserved for a question and answer session for interested parties.

III. Registration Instructions

The Division of Demonstration Programs is coordinating meeting registration. While there is no registration fee, all individuals must register to attend. Because this meeting will be located on Federal property, for security reasons, any persons wishing to attend this meeting must call Sid Mazumdar at (410) 786–6673 or e-mail *ESRDDemo@cms.hhs.gov* to register by close of business on July 9, 2003. Attendees must show photographic identification to the Federal Protective Service or Guard Service personnel before they will be permitted to enter the building. Individuals who have not registered in advance will not be allowed to enter the building to attend the meeting. Seating capacity is limited to the first 250 registrants. Our Atlanta, Boston, Chicago, Dallas, Denver, Kansas City, New York, Philadelphia, San Francisco, and Seattle, regional offices will host a Satellite Broadcast of the meeting for participants wanting to participate at these locations. These teleconference lines will be allotted on a first come, first serve basis.

Individuals requiring sign language interpretation for the hearing impaired or other special accommodations must contact Sid Mazumdar at least 10 days before the meeting.

Authority: Sections 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

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

Dated: June 24, 2003.

Thomas A. Scully,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 03–16398 Filed 6–26–03; 8:45 am]
BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–1259–N]

Medicare Program; Public Meeting in Calendar Year 2003 for New Clinical Laboratory Tests Payment Determinations

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

ACTION: Notice of meeting.

SUMMARY: This notice announces the date and location of a public meeting in accordance with section 1833 (h) of the Social Security Act and section 531 (b) of the Benefits Improvement and Protection Act (BIPA), Pub. L. 106–554. The meeting will be held on July 28, 2003 to discuss payment determinations for specific new Physicians' Current Procedural Terminology (CPT) codes for clinical laboratory tests. The meeting provides a forum for interested individuals to make oral presentations and/or submit written comments on the new codes that will be included in Medicare's Clinical Laboratory Fee