effective validation and assessment of the organization's survey process.
—The adequacy of TÜVHS' staff and other resources, and its financial viability.
—TÜVHS' capacity to adequately fund required surveys.
—TÜVHS' policies with respect to whether surveys are announced or unannounced.
—TÜVHS' agreement to provide us with a copy of the most current accreditation survey together with any other information related to the survey as we may require (including corrective action plans).

IV. Analysis of and Response to Public Comments on the Proposed Notice

We received 12 comments in response to the proposed notice published on January 27, 2006. These comments were from hospitals, professional organizations, an accrediting body and other individuals. Summaries of the public comments we received and our responses to those comments are set forth below.

Comment: The majority of commenters expressed support for increased competition in the hospital accreditation arena.

Response: We appreciate the commenters' support and agree that the accreditation process can benefit from increased competition. CMS must, however, ensure that any national accreditation organization approved for deeming authority meets our requirements and can provide us with reasonable assurance that its accredited hospitals are in compliance with accreditation standards that meet or exceed the Medicare CoPs.

Comment: A few commenters expressed support specifically for the approval of TÜVHS' request for deeming authority. Conversely, one commenter expressed concerns about the TÜVHS accreditation process and provided specific technical comments regarding the ISO 9001 certification process.

Response: Based on our findings from the review of TÜVHS' application, TÜVHS has not demonstrated that it meets our requirements for approval as a national accreditation organization. Also, TÜVHS did not provide us with reasonable assurance that its accredited hospitals are in compliance with accreditation standards that meet or exceed the Medicare CoPs.

Comment: One commenter asked us to consider the apparent conflict of interest that is posed by TÜVHS offering consultative services to prepare hospitals for JCAHO's accreditation reviews, while requesting deeming authority for Medicare participating hospitals, which would be in direct competition to JCAHO.

Response: We agree that it is an unusual situation to have an organization apply for deeming authority while continuing to offer consultative services to prepare hospitals for accreditation surveys that are conducted by another accreditation organization. Because we are not granting deeming authority to TÜVHS at this time, the suggested conflict of interest is not relevant.

V. Provisions of the Final Notice

Based on the findings from our review, using the evaluation criteria described above, we determined that the TÜVHS accreditation requirements for hospitals, including the accreditation standards, standards application and interpretation, survey procedures, and corrective action requirements, are not equivalent to the CMS requirements for hospitals. Additionally, TÜVHS has not provided reasonable assurance that the hospitals they accredit are in compliance with accreditation standards that are at least as stringent as the Medicare Hospital CoPs.

The findings from the review, as described above, preclude us from granting TÜVHS deeming authority for hospitals.

VI. Executive Order 12866 Statement

In accordance with the provisions of Executive Order 12866, this regulation was not reviewed by the Office of Management and Budget.

Authority: Section 1865 of the Social Security Act (42 U.S.C. 1395bb)

(Catalog of Federal Domestic Assistance Program No. 93.778, Medical Assistance Program; No. 93.773, Medicare—Hospital Insurance Program; and No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: June 9, 2006.

Mark B. McClellan,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. E6–9907 Filed 6–22–06; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–9035–N]

Medicare and Medicaid Programs; Quarterly Listing of Program Issuances—January Through March 2006

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 2006 through March 2006, relating to the Medicare and Medicaid programs. This notice provides information on national coverage determinations (NCDs) affecting specific medical and health care services under Medicare. Additionally, this notice identifies certain devices with investigational device exemption (IDE) numbers approved by the Food and Drug Administration (FDA) that potentially may be covered under Medicare. This notice also includes listings of all approval numbers from the Office of Management and Budget for collections of information in CMS regulations. Finally, this notice includes a list of Medicare-approved carotid stent facilities.

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, and to foster more open and transparent collaboration efforts, we are also including all Medicaid issuances and Medicare and Medicaid substantive and interpretive regulations (proposed and final) published during this 3-month time frame.

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 Timothy Jennings, Office of Strategic

Operations and Regulatory Affairs, Centers for Medicare & Medicaid Services, C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850, or you can call (410) 786–2134.

Questions concerning Medicare NCDs in Addendum V may be addressed 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 FDA-approved Category B IDE numbers listed in Addendum VI may be addressed to John Manlove, Office of Clinical Standards and Quality, Centers for Medicare & Medicaid Services, C1–13–04, 7500 Security Boulevard, Baltimore, MD 21244–1850, or you can call (410) 786–6877.

Questions concerning approval numbers for collections of information in Addendum VII may be addressed to Melissa Musotto, Office of Strategic Operations and Regulatory Affairs, Regulations Development and Issuances Group, Centers for Medicare & Medicaid Services, C5–14–03, 7500 Security Boulevard, Baltimore, MD 21244–1850, or you can call (410) 786–6962.

Questions concerning Medicare-approved carotid stent facilities may be addressed to Sarah J. McClain, 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) 786–2994.

Questions concerning all other information may be addressed to Gwendolyn Johnson, Office of Strategic Operations and Regulatory Affairs, Regulations Development Group, Centers for Medicare & Medicaid Services, C5–14–03, 7500 Security Boulevard, Baltimore, MD 21244–1850, or you can call (410) 786–6954.

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 the two 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, all Medicare contractors 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, and to foster more open and transparent collaboration, we are continuing our practice of including Medicare substantive and interpretive regulations (proposed and final) published during the respective 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, NCDs, and FDA-approved IDEs published during the subject quarter 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 NCD Manual (NCDM, formerly the Medicare Coverage Issues Manual (CIM)) may wish to review the August 21, 1989, publication(54 FR 34555). Those interested in the revised process used in making NCDs under the Medicare program may review the September 26, 2003, publication (68 FR 55634).

To aid the reader, we have organized and divided this current listing into eight 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 or multiple instruction(s). 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 quarter 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 NCDs, or reconsiderations of completed NCDs, from the quarter covered by this notice. Completed decisions are identified by the section of the NCDM 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 FDA-approved IDE categorizations, using the IDE numbers the FDA 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 IDE 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; title 45, subchapter C; and title 20 of the CFR.
- Addendum VIII includes listings of Medicare-approved carotid stent facilities. All facilities listed meet CMS standards for performing carotid artery stenting for high risk patients.

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.gpoaccess.gov/fr/index.html,* by using local WAIS client software, or by telnet to swais.gpoaccess.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' 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, 2005. (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. For each CMS publication listed in Addendum III, CMS publication and transmittal numbers are shown. To help FDLs locate the materials, use the CMS publication and transmittal numbers. For example, to find the Medicare NCD publication titled ''Cardiac Catheterization Performed in Other Than a Hospital Setting,'' use CMS–Pub. 100–03, Transmittal No. 46.

(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 6, 2006.

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.

December 24, 2003 (68 FR 74590)
March 26, 2004 (69 FR 15837)
June 25, 2004 (69 FR 35634)
September 24, 2004 (69 FR 57312)
December 30, 2004 (69 FR 78428)
February 25, 2005 (70 FR 9338)
June 24, 2005 (70 FR 36620)
September 23, 2005 (70 FR 55863)
December 23, 2005 (70 FR 76290)
March 24, 2006 (71 FR 14903)

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 former CIM (now the NCDM) 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, at 57 FR 47468.

Addendum III.—Medicare and Medicaid Manual Instructions

[January through March 2006]

Transmittal No.	Manual/subject/publication No.
	Medicare General Information (CMS Pub. 100–01)
34	Change Management Process—Electronic Change Information Management Portal (eChimp).

ADDENDUM III.—MEDICARE AND MEDICAID MANUAL INSTRUCTIONS—Continued

[January through March 2006]

Transmittal No.	Manual/subject/publication No.
35	Revisions to Instructions for Contractors Other Than the Religious Nonmedical Health Care Institution Specialty Contractor Regarding Claims for Beneficiaries With Religious Nonmedical Health Care Institution Elections.
	Religious Nonmedical Health Care Institution Defined.
36	Scheduled Release for April 2006 Software Programs and Pricing/Coding Files.
	Medicare Benefit Policy (CMS Pub. 100–02)
44	Update to the End-Stage Renal Disease Composite Payment Rates.
	New End-Stage Renal Disease Composite Payment Rates Effective January 1, 2006.
45	Revisions to Instructions for Contractors Other Than the Religious Nonmedical Health Care Institution Specialty Contractor Regarding Claims for Beneficiaries With Religious Nonmedical Health Care Institution Elections.
	Religious Nonmedical Health Care Institution Services.
	Beneficiary Eligibility for Religious Nonmedical Health Care Institution Services.
	Election of Religious Nonmedical Health Care Institution Benefits.
	Revocation of Religious Nonmedical Health Care Institution Election.
	Religious Nonmedical Health Care Institution Election After Prior Revocation.
	Medicare Payment for Religious Nonmedical Health Care Institution Services and Beneficiary Liability.
	Coverage of Religious Nonmedical Health Care Institution Items Furnished in the Home.
	Coverage and Payment of Durable Medical Equipment Under the Religious Nonmedical Health Care Institution Home Benefit.
	Coverage and Payment of Home Visits Under the Religious Nonmedical Health Care Institution Home Benefit.
46	This Transmittal is rescinded and replaced by Transmittal 47.
47	Therapy Caps Exception Process.
	Coverage of Outpatient Rehabilitation Therapy Services (Physical Therapy, Occupational Therapy, and Speech-Language Pathology Services) Under Medical Insurance.
	Documentation Requirements for Therapy Services.
48	Glaucoma Screening Services.
	Preventive and Screening Services.
	Glaucoma Screening.
49	Payment of Federally Qualified Health Centers for Diabetes Self Management Training Services and Medical Nutrition Therapy Services.
	Rural Health Clinic and Federally Qualified Health Center Service Defined.
	Rural Health Clinic Services.
	Federally Qualified Health Center Services.
	Medicare National Coverage Determinations (CMS Pub. 100–03)
46	Cardiac Catheterization Performed in Other Than a Hospital Setting.
47	Changes to the Covered Indications for Tumor Antigen by Immunoassay CA 125 to Add Primary Peritoneal Carcinoma.
	Tumor Antigen by Immunoassay CA 125.
48	Technical Corrections to the NCD Manual.
	Hyperbaric Oxygen Therapy.
	Home Glucose Monitors.
	Vitrectomy.
	Abortion.
	Diathermy Treatment.
	Assessing Patients Suitability for Electrical Nerve Stimulation Therapy.
	Electroencephalographic Monitoring During Surgical Procedures Involving the Cerebral Vasculature.
	Diagnostic Pap Smears.
	Human Immunodeficiency Virus Testing (Diagnosis).
	Prostate Cancer Screening Tests.
	Screening Pap Smears and Pelvic Examinations for Early Detection of Cervical Or Vaginal Cancer.
	Non-Implantable Pelvic Floor Electrical Stimulator.
	Levocarnitine for Use in the Treatment of Carnitine Deficiency in End-Stage Renal Disease Patients.
	Adult Liver Transplantation.
	Obsolete or Unreliable Diagnostic Tests.
49	Microvolt T-Wave Alternans Diagnostic Testing.
50	External Counterpulsation Therapy.
	Medicare Claims Processing (CMS Pub. 100–04)
803	Administration of Drugs and Biologicals in a Method II Critical Access Hospital—Rescinds and replaces Change Request 3911.
	Costs of Emergency Room On-Call Providers.
	Coding for Administering Drugs in a Method II Critical Access Hospital.
	Coding for Low Osmolar Contrast Material.
	Coding for Administration of Other Drugs and Biologicals.
804	January 2006 Update of the Hospital Outpatient Prospective Payment System:
	Summary of Payment Policy Changes, Outpatient Prospective Payment System Pricer Logic Changes, and Instructions for Updating the Outpatient Provider Specific File.
805	Annual Update to the Therapy Code List.
	Healthcare Common Procedure Coding System Coding Requirement.

ADDENDUM III.—MEDICARE AND MEDICAID MANUAL INSTRUCTIONS—Continued

[January through March 2006]

Transmittal No.	Manual/subject/publication No.
806	Termination of Healthcare Common Procedure Coding System Codes Payable During the Transition to the Ambulance Fee Schedule.
807	Revision to IOM 100–4, Chapter 12, Sections 90.4.1.1 and 90.4.2. Carrier Web Pages. Health Professional Shortage Area Designations.
808	Nursing Facility Services (Codes 99304—99318).
809	Update to Payment Rates for Religious Nonmedical Health Care Institution Services Furnished in the Home, Calendar Year 2006.
810	Issued to a specific audience, not posted to Internet/Intranet due to Confidentiality of Instruction.
811	Teaching Physician Services. Payment for Physician Services in Teaching Settings Under the Medicare Physician Fee Schedule. Evaluation and Management Services. Surgical Procedures. Psychiatry. Time-Based Codes. Miscellaneous. Assistants at Surgery in Teaching Hospitals.
812	Medicare Payment for Pre-Administration-Related Services Associated With Intravenous Immune Globulin Administration.
813	Instructions for the Payment of Health Professional Shortage Area and Physician Scarcity Area Bonuses When the Place of Service is ''Home.''
814	Claim Status Category Code and Claim Status Code Update.
815	Healthcare Provider Taxonomy Codes Update.
816	Coverage and Billing for Ultrasound Stimulation for Nonunion Fracture Healing. Durable Medical Equipment Regional Carrier Billing Instructions.
817	Update to the Inpatient Provider Specific File and the Outpatient Provider Specific File to Retain Provider Information. Outpatient Provider Specific File.
818	Smoking and Tobacco-Use Cessation Counseling Services: Common Working File Inquiry for Providers. Common Working File Inquiry.
819	Modification to Quarterly Refund Modifier Edit for Automatic Implantable Cardiac Defibrillator Services.
820	Sites of Service Revenue Codes for Rural Health Clinics and Federally Qualified Health Centers. General Billing Requirements.
821	Billing and Payment of Certain Colorectal Cancer Screenings for Non-Patients. Type of Bill 14X. Payment. Billing Requirements for Claims Submitted to Fiscal Intermediaries.
822	Update of Radiopharmaceutical Imaging Agents Healthcare Common Procedure. Coding System Codes Applicable to Positron Emission Tomography. Tracer Codes Required for Positron Emission Tomography Scans.
823	New Temporary Code for Battery for Power Mobility Devices. Description of Healthcare Common Procedure Coding System.
824	Quarterly Update to Correct Coding Initiative Edits, V12.1, Effective April 1, 2006.
825	System Edits for Respiratory Assist Devices with Bi-Level Capability and a Back-Up Rate.
826	April Quarterly Update to the 2006 Annual Update of Healthcare Common Procedure Coding System Codes Used for Skilled Nursing Facility Consolidated Billing Enforcement.
827	Use of 12X Type of Bill for Billing Screening Mammography, Screening Pelvic Examinations, and Screening Pap Smears. Billing Requirements—Fiscal Intermediary Claims. Rural Health Center/Federally Qualified Health Center Claims With Dates of Service on or After January 1, 2002. Type of Bill and Revenue Codes for Form CMS–1450. Revenue Code and Healthcare Common Procedure Coding System Codes for Billing.
828	Mammography Facility Certification File—Updated Procedures and Content Mammography Quality Standards Act. Mammography Quality Standards Act File.
829	Modification of Roster Billing for Mass Immunizers Billing for Inpatient Part B Services (Type of Bills 12X and 22X). Claims Submitted to Intermediaries for Mass Immunizations of Influenza and Pneumococcal Pneumonia Vaccine.
830	Denial of Claims Not Timely Filed. Time Limitations for Filing Provider Claims to Fiscal Intermediaries and Carriers. Determination of Untimely Filing and Resulting Actions. Time Limitations for Filing Part B Reasonable Charge and Fee Schedule Claims. Time Limit for Filing.
831	Shared Systems Medicare Secondary Payer Balancing Edit and Administrative Simplification Compliance Act Enforcement Update. Crossover Claim Requirements. Enforcement.
832	This Transmittal is rescinded and replaced by Transmittal 868.
833	Medicare Remit Easy Print Enhancements, and Clarification of Check Issue/Electronic Funds Transfer Effective Date.
834	Revision to Health Professional Shortage Area and Physician Scarcity Area Bonus Billing for Some Globally Billed Services. Services Eligible for Health Professional Shortage Act and Physician Scarcity Bonus Payment.
835	New Temporary Codes for Adjustable Wheelchair Cushions.
836	This Transmittal is rescinded and replaced by Transmittal 843.
837	Coordination of Benefits Agreement Full Claim File Repair Process. Coordination of Benefits Agreement Detailed Error Report Notification Process.

ADDENDUM III.—MEDICARE AND MEDICAID MANUAL INSTRUCTIONS—Continued

[January through March 2006]

Transmittal No.	Manual/subject/publication No.
	Coordination of Benefits Agreement Full Claim File Repair Process.
838	Corrections to Common Working File Editing of Home Health Prospective Payment System Claims Regarding Non-Covered Episodes and Prior Inpatient Stays and Fiscal Intermediary Shared System Implementation of 2006 Therapy Code Update.
839	This Transmittal is rescinded and replaced by Transmittal 866.
840	This Transmittal is rescinded and replaced by Transmittal 882.
841	MCS Screen Expansion for the Prescription Order Number for the Competitive Acquisition Program for Part B Drugs to be Developed Over the July 2006 and October 2006 Release With Final Implementation on October 2, 2006.
842	Issued to a specific audience, not posted to Internet/Intranet due to Confidentiality of Instruction.
843	Inpatient Admission Followed by Discharge or Death Prior to Room Assignment.
	Charges to Beneficiaries for Part A Services.
844	This Transmittal is rescinded and replaced by Transmittal 890.
845	National Council for Prescription Drug Program Coordination of Benefits Workaround Instructions.
846	New Skilled Nursing Facility Consolidated Billing Web Site Address.
	Services Beyond the Scope of the Part A Skilled Nursing Facility Benefit.
	Skilled Nursing Facility Consolidated Billing Annual Update Process for Fiscal Intermediaries.
	Edit for Therapy Services Separately Payable When Furnished by a Physician.
	Annual Update Process.
	Billing for Medical and Other Health Services.
	Carrier Claims Processing for Consolidated Billing for Physician and Non-Physician Practitioner Services Rendered to Beneficiaries in a Non-Covered Skilled Nursing Facility Stay.
847	Hold on Medicare Payments.
848	Issued to a specific audience, not posted to Internet/Intranet due to Confidentiality of Instruction.
849	Update to the End-stage Renal Disease Composite Payment Rates.
	Drug Payment Amounts for Facilities.
850	Change Payment Floor Date for Paper Claims.
	Payment Floor Standards.
851	Revisions to Instructions for Contractors Other Than the Religious Nonmedical Health Care Institutions Specialty Contractor Regarding Claims for Beneficiaries With Religious Nonmedical Health Care Institutions Election.
	Religious Nonmedical Health Care Institution Admission.
	Designated Fiscal Intermediaries and Carriers.
	Billing and Processing Instructions for Religious Nonmedical Health Care Institutions Claims.
	Religious Nonmedical Health Care Institutions Election Process.
	Requirement for Religious Nonmedical Health Care Institutions Election.
	Revocation of Religious Nonmedical Health Care Institutions Election.
	Completion of the Uniform (Institutional Provider) Bill (Form CMS 1450) Notice of Election for Religious Nonmedical Health Care Institutions.
	Common Working File Processing of Elections, Revocations and Cancelled Elections.
	Billing Process for Religious Nonmedical Health Care Institutions Services.
	When to Bill for Religious Nonmedical Health Care Institutions Services.
	Required Data Elements on Claims for Religious Nonmedical Health Care Institution Services.
	Religious Nonmedical Health Care Institutions Claims Processing by Religious Nonmedical Health Care Institutions Specialty Contractor.
	Informing Beneficiaries of the Results of Religious Nonmedical Health Care Institutions Claims Processing.
	Billing and Payment of Religious Nonmedical Health Care Institutions Items and Services Furnished in the Home.
	Processing Claims For Beneficiaries With Religious Nonmedical Health Care Institutions Elections by Contractors Other Than the Religious Nonmedical Health Care Institutions Specialty Intermediary.
	Recording Determinations of Excepted/Nonexcepted Care on Claim Records Informing Beneficiaries of the Results of Excepted/Nonexcepted Care Determinations by the Non-specialty Contractor.
852	Ambulance Fee Schedule—CY 2006 Update: Correction to CR 4061 Ambulance Inflation Factor.
853	This Transmittal is rescinded and replaced by Transmittal 855.
854	Medicare Summary Notice Format Changes for Durable Medical Equipment.
	Medicare Administrative Contracts Transition.
	Title Section of the Medicare Summary Notice.
	Appeals Section.
855	Therapy Caps Exception Process.
	The Financial Limitation.
856	January 2006 Quarterly Average Sales Price Medicare Part B Drug Pricing File, Effective January 1, 2006, and Revisions to April 2005, July 2005, and October 2005 Quarterly Average Sales Price Medicare Part B Drug Pricing Files.
857	Medicare Part B Drug Pricing Update—Payment Limit for J7620.
858	This Transmittal is rescinded and replaced by Transmittal 873.
859	Remittance Advice Remark Code and Claim Adjustment Reason Code Update.
860	Remittance Advice Remark Code and Claim Adjustment Reason Code Update.
861	Sunset of the Policies for Provider Nominations for an Intermediary and the Provider Requests for a Change of Intermediary—Revisions to Publication 100–04, Chapter 1, Section 20.
	Provider Assignment to a Fiscal Intermediary.
	Provider Change of Ownership.
	Multi-State Provider Chains Billing Fiscal Intermediaries.
	CMS No Longer Accepts Provider Requests to Change Their Fiscal Intermediary.
	Solicitation of a Provider to Secure a Change of Fiscal Intermediary.
	Communications.

ADDENDUM III.—MEDICARE AND MEDICAID MANUAL INSTRUCTIONS—Continued

[January through March 2006]

Transmittal No.	Manual/subject/publication No.
862	Appeals of Claims Decisions: Administrative Law Judge; Departmental Appeals Board; U.S. District Court Review.
	Administrative Law Judge—The Third Level of Appeal.
	Right to an Administrative Law Judge Hearing.
	Requests for an Administrative Law Judge Hearing.
	Forwarding Request to Department of Health & Human Services/Office of Medicare Hearings and Appeals.
	Review and Effectuation of Administrative Law Judge Decisions.
	Effectuation Time Limits & Responsibilities.
	Duplicate Administrative Law Judge Decisions.
	Payment of Interest on Administrative Law Judge Decisions.
	Departmental Appeals Board—The Fourth Level of Appeal.
	Recommending Agency Referral of Administrative Law Judge Decisions or Dismissals.
	Effectuation of Departmental Appeal Board Orders and Decisions.
	Requests for Case Files.
	Payment of Interest on Departmental Appeals Board Decisions.
	U.S. District Court Review—The Fifth Level of Appeal.
	Requests for U.S District Court Review by a Party.
	Effectuation of U.S District Court Decisions.
	Payment of Interest of U.S. District Court Decisions.
863	Update to Chapter 20, ''Billing for Oxygen and Oxygen Equipment,'' Section 130.6.
	Billing for Oxygen and Oxygen Equipment.
864	Changes to the Laboratory National Coverage Determination Edit Software for April 2006.
865	Health Common Procedure Coding System Codes Subject to and Exclude from Clinical Laboratory Improvement Amendments Edits.
	Verifying Clinical Laboratory Improvement Act Certification.
	Certificate for Physician-Performed Microscopy Procedures.
	Clinical Laboratory Improvement Act License or Licensure Exemption.
866	Additional Requirements for the Competitive Acquisition Program for Part B Drugs.
	Duplicates.
	General Information Section.
	Duplicados.
	Seccion De Informacion General.
	The Competitive Acquisition Program of Outpatient Drugs and Biologicals Under Part B.
	Physician Election and Information Transfer Between Carriers and the Designated Carrier for Competitive Acquisition Program Claims.
	Physician Information for the Designated Carrier.
	Quarterly Updates.
	Format for Data.
	Physician Information for the Vendors.
	Claims Processing Instructions for Competitive Acquisition Program Claims for The Local Carrier.
	Competitive Acquisition Program Required Modifiers.
	Submitting the Administration/Evaluation and Management Services and the No Pay Service Lines.
	Submitting the Prescription Order Numbers and No Pay Modifiers.
	Competitive Acquisition Program Claims Submitted With Only the No Pay Line.
	Only Competitive Acquisition Program Related Services on a Claim.
	Use of the Restocking Modifier.
	Use of the Furnish as Written Modifier.
	Monitoring of Claims Submitted With the J2 and/or J3 Modifiers.
	Claims Submitted for Only Drugs Listed on the Approved CAP Vendors Drug List.
	Application of Local Medical Review Policies.
	Claims Processing Instructions for the Designated Carrier.
	Creation of Internal Vendor Provider Files.
	Submission of Paper Claims by Vendors.
	Submission of Claims from Vendors With the J1 No Pay Modifier.
	Submission of Claims from Vendors Without a Provider Primary Identifier for The Ordering Physician.
	New Medicare Summary Notice Message To Be Included on All Vendor Claims Additional Medical Information.
	Competitive Acquisition Program Fee Schedule.
	Matching the Physician Claim to the Vendor Claim.
	Denials Due to Medical Necessity.
	Denials For Reasons Other Than Medical Necessity.
	Changes to Pay/Process Indicators.
	Post-Payment Overpayment Recovery Actions.
	Pending and Recycling the Claim When All Lines Do Not Have a Match.
	Creation of a Weekly Report for Claims That Have Pended More Than 90 Days and Subsequent Action.
	Coordination of Benefits.
	National Claims History.
	Adding New Drugs to Competitive Acquisition Program.
	Updating Fee Schedule for New Drugs in Competitive Acquisition Program.
	Non-Participating Physicians Who Elect the Competitive Acquisition Program.
	Discarded Drugs and Biologicals.
	Carrier Specific Requirements for Certain Specialties/Services.

ADDENDUM III.—MEDICARE AND MEDICAID MANUAL INSTRUCTIONS—Continued

[January through March 2006]

Transmittal No.	Manual/subject/publication No.
867	Elimination of the Durable Medical Equipment Regional Carrier Information Form. Billing Drugs Electronically—National Council of Prescription Drug Programs. Certificate of Medical Necessity.
868	Payment of Same Day Transfer Claims Under the Inpatient Psychiatric Facility Prospective Payment System.
869	Installation of Pricing Software Containing the Customer Information Control System Formatting Update.
870	Type of Service Corrections.
871	2005 Revised American National Standards Institute X12N 837 Professional Health Care Claim Companion Document.
872	New Waived Tests.
873	Increase Remittance File Retention.
874	Instructions for Downloading the Medicare Zip Code File.
875	Maintenance and Update of the Temporary Hook Created to Hold Out Patient Prospective Payment System Claims That Include Certain Drug Healthcare Common Procedure Coding System Codes.
876	April 2006 Quarterly Average Sales Price Medicare Part B Drug Pricing File and Revisions to January 2005, April 2005, July 2005, October 2005, and January 2006 Quarterly Average Sales Price Medicare Part B Drug Pricing Files.
877	Changes in Transitional Outpatient Payments for Rural Sole Community Hospitals and Small Rural Hospitals for 2006.
878	Healthcare Integrated General Ledger Accounting System and 835 Implementation Guide Provider Adjustment Code Mapping and Standard Paper Remittance Advice Changes.
879	Announcement of Federally Qualified Health Centers Designation As Urban and Rural—Skilled Nursing Facility Consolidated Billing As It Applies to FQHC Services Furnished to Swing-Bed Patients.
880	April Quarterly Update for 2006 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Fee Schedule.
881	Outpatient Prospective Payment System Hospital Emergency Room Services Exceeding 24 Hours. Accurate Reporting of Surgical and Medical Procedures and Services.
882	Hospital Billing for Take-Home Drugs. Claims Processing Jurisdiction for Oral Anti-Emetic Drugs. Billing and Payment Instructions for Fiscal Intermediaries.
883	Claims Processing Requirements for Medicare Beneficiaries in State or Local Custody Under a Penal Authority—Manualization.
884	Issued to a specific audience, not posted to Internet/Intranet due to Confidentiality of Instruction.
885	Suppression of Standard Paper Remittance Advice to Providers and Suppliers Also Receiving Electronic Remittance Advice for 45 Days or More. Medicare Remit Easy Print Software for Carrier and Durable Medical Equipment Regional Carrier Provider/Supplier Use.
886	April 2006 Update to the Medicare Outpatient Code Editor Version 21.2 for Bills From Hospitals That Are Not Paid Under The Outpatient Prospective Payment System.
887	Correction to Change Request 4282—Application of Temporary 5 Percent Payment Increase for Home Health Services Furnished in a Rural Area for One Year Under the Home Health Prospective Payment System.
888	April 2006 Outpatient Prospective Payment System Code Editor Specifications Version 7.1.
889	This Transmittal is rescinded and replaced by Transmittal 897.
890	Guidelines for Payment of Vaccine (Pneumococcal Pneumonia Virus, Influenza Virus, and Hepatitis B Virus) Administration. Healthcare Common Procedure Coding System and Diagnosis Codes. Fiscal Intermediary Payment for Pneumococcal Pneumonia Virus, Influenza Virus, and Hepatitis B Virus Vaccines and Their Administration.
891	Redesignate HCPCS Codes J8597 and E1239 to Their Proper Common Working File Category.
892	Eligibility Transaction URL update. Eligiblity Extranet Workflow.
893	2006 Juridiction List.
894	Microvolt T-Wave Alternans Diagnostic Testing.
895	Expansion of Glaucoma Screening Services. Remittance Advice Notices. Medicare Summary Notice Messages.
896	April 2006 Update of the Hospital Outpatient Prospective Payment System: Summary of Payment Policy Changes.
897	April Update to the 2006 Medicare Physician Fee Schedule Database.
898	External Counterpulsation Therapy. Billing and Payment Requirements. Special Intermediary Billing and Payment Requirements.
899	Revised Health Insurance Claim Form CMS–1500. Items 14–33—Provider of Service or Supplier Information. Patient's Request for Medicare Payment Form CMS–1490S. Printing Standards and Print File Specifications Form CMS–1500.
	Medicare Secondary Payer (CMS Pub. 100–05)
47	Medicare Secondary Payer Debt Collection and Referral Updates. Debt and Debtor Definitions. Debt Selection and Verification. Debt Selection Criteria. Debts Excluded From Referral. Monitoring Debts Excluded From the Debt Collection Improvement Act Referral Process. Validation of Possible Eligible Debts for Referral. Issuance of the ''Intent to Refer'' Letter and Inquiries/Replies Related to Debt Collection Improvement Act Activities. Issuance of the ''Intent to Refer'' to Treasury Letter. Responding to Correspondence as a Result of the Issuance of the Intent to Refer Letter.

ADDENDUM III.—MEDICARE AND MEDICAID MANUAL INSTRUCTIONS—Continued

[January through March 2006]

Transmittal No.	Manual/subject/publication No.
	Debt Collection System and Debt Collection System Entry.
	Debt Collection System.
	Debt Collection System Entry of Delinquent Debt.
	Contractor Actions Subsequent to Debt Collection System Entry.
	Steps Contractors Shall Take Upon Knowledge or Receipt of Certain Information.
	Debt Collection Improvement Act Treasury Collection (Placeholder) Financial Reporting.
48	Request for Claims Detail in Support of Medicare's Debt.
	Medicare Financial Management (CMS Pub. 100–06)
88	Clarification to IOM 100–06, Sections 290.7 and 290.8.
	Completing Physician Scarcity Area Quarterly Report, Form CMS–1565F, CROWD Report 6.
	Checking Reports.
89	Mandated Use of Autoload Program in System Tracking for Audit and Reimbursement.
90	Recurring Update Notification for the Notice of New Interest Rate for Medicare Overpayments and Underpayments.
91	Clarification of Instructions in Pub. 100–6, Chapter 5 Financial Reporting, Section 310.4—Line 4(a) through (e), Reclassified CNC Debt (Principal and Interest).
92	Clarification of the Form CMS–1522 Monthly Contractor Financial Report Procedures for the Reconciliation of Total Funds Expended for Fiscal Intermediary Shared System Medicare Contractors Used in the Preparation of Form CMS–1522 Monthly Contractor Financial Report.
	Identification and Summarization of Detailed Claims Data Records For Use in the Financial Reconciliation of Total Funds Expended to Fiscal Intermediary Shared System Reports.
	Using the Electronic Spreadsheet to Complete the Reconciliation of the Detailed Claims Data File to Fiscal Intermediary Shared System Reports.
	Electronic Spreadsheet Input Schedule.
	Total Funds Expended (Net Disbursements and Adjustments to Net Disbursements).
	Reconciliation of Detailed Claims Data File to Fiscal Intermediary Shared Systems System Reports.
	Reconciliation of Non-Physician Incentive Plan Payments on Fiscal Intermediary Shared Systems System Reports.
	Reconciliation of Interest Received and Paid on Fiscal Intermediary Shared Systems System Reports.
	Categorization of Total Funds Expended by Category.
	Medicare State Operations Manual (CMS Pub. 100–07)
16	Revisions to Chapter 2, ''The Certification Process,'' Appendix E—''Providers of Outpatient Physical Therapy or Outpatient Speech Language Pathology Services,'' and Appendix K—''Comprehensive Outpatient Rehabilitation Facilities''.
17	Revisions to Chapter 2, The Certification Process.
18	Complete Revision to Chapter 5, ''Complaint Procedures.''
	Medicare Program Integrity (CMS Pub. 100–08)
135	Changes to the GTL Titles.
	Prepayment Edits.
	Location of Postpayment Reviews.
	Notification of Provider(s) or Supplier(s) and Beneficiaries of the Postpayment Review Results.
	Evaluation of the Effectiveness of Postpayment Review and Next Steps.
	Postpayment Files.
	Overpayment Procedures.
	Fraud or Willful Misrepresentation Exists—Fraud Suspensions.
	Overpayment Exists But the Amount Is Not Determined—General Suspensions.
	Payments to be Made May Not be Correct—General Suspensions.
	Provider Fails to Furnish Records and Other Requested Information—General Suspensions.
	CMS Approval.
	Prior Notice Versus Concurrent Notice.
	Content of Notice.
	Shortening the Notice Period for Cause.
	Mailing the Notice to the Provider.
	Opportunity for Rebuttal.
	Claims Review.
	Duration of Suspension of Payment.
	Removing the Suspension.
	Durable Medical Equipment Regional Carriers and Durable Medical Equipment Regional Carrier Program Safeguard Contractors.
	Other Multi-Regional Contractors.
	Informational Copies to Primary Government Task Leaders, Associate Government.
	Task Leaders, Subject Matter Experts, or CMS Regional Office.
	Notification of Provider or Supplier of the Review and Selection of the Review Site.
	Sampling Methodology Overturned.
136	Policy Changes to Program Integrity Manual.
	Contractor Medical Director.
137	Provider Enrollment Workload and Timeliness Reports.

ADDENDUM III.—MEDICARE AND MEDICAID MANUAL INSTRUCTIONS—Continued

[January through March 2006]

Transmittal No.	Manual/subject/publication No.
	Tracking Requirements.
138	This Transmittal is rescinded and replaced by Transmittal 142.
139	This Transmittal is rescinded and replaced by Transmittal 140.
140	Therapy Caps Exception Process.
	Exception from the Uniform Dollar Limitation.
	Prepay Complex Review Workload and Cost.
141	Modification to the Unique Physician Identification Number Process.
	National Registry of Physicians/Health Care Practitioners/Group Practices.
	Ongoing Data Collection on Physicians/Health Care Practitioners/Group Practices Applications.
	Physicians/Health Care Practitioners/Group Practices Record—Required Information and Format.
	Maintaining Physician/Health Care Practitioner/Group Practices Memberships.
	Validation of Physician/Health Care Practitioner/Group Practice Credentials, Certification, Sanction, and License Information for Prior Practices.
	Unique Physician Identification Number Cross-Referral Requirement.
	Maintenance of the Registry.
	General.
	Add Records.
	Adding Physician/Health Care Practitioner/Group Practice Setting.
	Update Records.
	Rejections.
	Exceptions.
	Batching Procedures.
	Privacy Act Requirements.
	Release of Unique Physician Identification Numbers.
	Release of Unique Physician Identification Numbers to Physicians, Nurse Practitioners, Clinical Nurse Specialists, and Physician Assistants.
	Automatic Notifications.
	Unique Physician Identification Number Directory.
	Unique Physician Identification Numbers for Ordering/Referring Physicians.
	Common Working File Edits and Claims Processing Requirements.
	Surrogate Unique Physician Identification Numbers.
	Carrier Registry Telecommunications Interface.
	AT&T Global Network Service/Compact Disc.
	File Transfer.
	Registry Customer Information Control System.
	T-Mail.
142	New Durable Medical Equipment Prosthetic, Orthotics & Supplies Certificates of Medical Necessity and Durable Medical Equipment Medicare Administrative Contractors Information Forms for Claims Processing.
	Documentation Specifications for Areas Selected for Prepayment or Postpayment Medical Review.
	Home Use of Durable Medical Equipment.
	Rules Concerning Prescriptions (Orders).
	Physician Orders.
	Verbal Orders.
	Written Orders.
	Written Orders Prior to Delivery.
	Requirement of New Orders.
	Certificates of Medical Necessity and Durable Medical Equipment Medicare Administrative Contractor Information Forms.
	Completing a Certificate of Medical Necessity or Durable Medical Equipment Medicare Administrative Contractors Information Form.
	Cover Letters for Certificates of Medical Necessity.
	Acceptability of Faxed Orders and Facsimile or Electronic Certificates of Medical Necessity and Durable Medical Equipment Administrative Contractors Information Forms.
	Durable Medical Equipment Medicare Administrative Contractors and Durable Medical Equipment Program Safeguard Contractor's Authority to Initiate an Overpayment or Civil Monetary Penalty When Invalid Certificates of Medical Necessity are Identified.
	Nurse Practitioner or Clinical Nurse Specialist Rules Concerning Orders and Certificates of Medical Necessity.
	Physician Assistant Rules Concerning Orders and Certificates of Medical Necessity.
	Documentation in the Patient's Medical Record.
	Supplier Documentation.
	Evidence of Medical Necessity.
	Evidence of Medical Necessity for the Oxygen Certificates of Medical Necessity.
	Evidence of Medical Necessity: Wheelchair and Power-Operated Vehicle Claims.
	Period of Medical Necessity—Home Dialysis Equipment.
	Safeguards in Making Monthly Payments.
	Guidance on Safeguards in Making Monthly Payments.
	Pick-up slips.
	Incurred Expenses for Durable Medical Equipment and Orthotic and Prosthetic Devices.
	Patient Equipment Payments Exceed Deductible and Coinsurance on Assigned Claims.
	Definitions of Customized Durable Medical Equipment.
	Advance Determination of Medicare Coverage of Customized Durable Medical Equipment.

ADDENDUM III.—MEDICARE AND MEDICAID MANUAL INSTRUCTIONS—Continued

[January through March 2006]

Transmittal No.	Manual/subject/publication No.
	Items Eligible for Advance Determination of Medicare Coverage.
	Instructions for Submitting Advance Determination of Medicare Coverage Requests.
	Instructions for Processing Advance Determination of Medicare Coverage Requests.
	Affirmative Advance Determination of Medicare Coverage Decisions.
	Negative Advance Determination of Medicare Coverage Decisions.
	Durable Medical Equipment Program Safeguard Contractor Tracking.
143	Demand Letters.
144	Various Benefit Integrity Revisions.
	The Medicare Fraud Program.
	Requests for Information From Outside Organizations.
	Closing Cases.
	Affiliated Contractor and Program Safeguard Contractor Coordination on Voluntary Refunds.
	Immediate Advisements to the Office of the Inspector General/Office of Investigations.
145	Eliminate the Use of Surrogate Unique Physician Identification Numbers (OTH000) on Medicare Claims.
	Medicare Contractor Beneficiary and Provider Communications (CMS Pub. 100–09)
00	None.
	Medicare Managed Care (CMS Pub. 100–16)
78	Revisions to Chapter 5, ''Quality Improvement.''
79	Change in Managed Care Manual Chapter 11, Medicare Advantage Application Procedures and Contract Requirements.
80	Revisions to Chapter 13, Medicare Managed Care Beneficiary Grievances, Organization Determinations, and Appeals Applicable to Medicare Advantage Plans, Cost Plans, and Health Care Prepayment Plans (collectively referred to as Medicare health plans).
	Medicare Business Partners Systems Security (CMS Pub. 100–17)
07	Business Partner Systems Security Manual.
	Demonstrations (CMS Pub. 100–19)
37	Revisions to CR 3816—Low Vision Rehabilitation Demonstration.
38	Issued to a specific audience, not posted to Internet/Intranet due to Confidentiality of Instruction.
39	This Transmittal is rescinded and replaced by Transmittal 41.
40	Amendments to Section 651 Chiropractic Services Demonstration—Changes to CPT 98943 rate published in CR 4225 Due to Passage of the Deficit Reduction Act, and revisions to CPT codes for 2006.
41	2006 Oncology Demonstration Project—Inclusion of Gynecological Oncology (Supplement to CR 4219).
42	2006 Oncology Demonstration Project.
43	Physician Voluntary Reporting Program (PVRP) Specification (Correction to CR 4183).
	One Time Notification (CMS Pub. 100–20)
200	Mandatory Transition to New Registry That Satisfies Medicare Data Reporting Requirements for Implantable Cardioverter Defibrilators.
201	Calculation of the Interim Payment of Indirect Medical Education Through the Inpatient Prospective Payment System Pricer for Hospitals That Received an Increase to their Full-time Equivalent Resident Caps Under Section 422 of the Medicare Modernization Act, Pub. L. 108–173.
202	Issued to a specific audience, not posted to Internet/Intranet due to Sensitivity of Instruction.
203	Revision for Prospective Payment System Payment for Blood Clotting Factor Administered to Hemophilia Inpatients.
204	Stage 1 Use and Editing of National Provider Identifier Numbers Received in Electronic Data Interchange.
205	Beneficiary Change of Address.
206	Modifications/Additions to CR 3730, Frequent Hemodialysis Network Payments for Approved Clinical Trial Costs.
207	New 2006 Payment Rate for Services Paid Under the Medicare Physician Fee Schedule.
208	Analysis of Systems Changes Needed to Generate Unsolicited Responses to the Veterans Administration.
209	Q4080—Change in Healthcare Common Procedure Coding System Code Descriptor.
210	Creation of a Second Participation Enrollment Period for 2006.
211	Temporary 5 Percent Payment Increase for Home Health Services Furnished in a Rural Area for One Year Under the Home Health Prospective Payment System, Change of the Home Health Prospective Payment System Calendar Year (CY) 2006 Update from that of 2.8 Percent Update (Home Health Market Basket Update of 3.6 Minus 0.8 Percentage Point) to that of a Zero Percent Update.
212	Full Replacement of CR 3980, Termination of Existing Crossover Agreements as Trading Partners Transition to the National Coordination of Benefits Agreement Program (CR 3980 is rescinded.).
213	Issued to a specific audience, not posted to Internet/Intranet due to Sensitivity of Instruction.
214	Procedures for Preventing Duplicate Crossover File Submissions to the Coordination of Benefits Contractor.
215	Payment for Power Mobility Device Claims.
216	Contractor Number Change for Noridian Administrative Services' Idaho and Oregon Part A Workloads.
217	2006 Revised American National Standards Institute X12N 837 Institutional Health Care Claim Companion Document.

ADDENDUM IV.—REGULATION DOCUMENTS PUBLISHED IN THE FEDERAL REGISTER

[January through March 2006]

Publication date	FR vol. 71 page No.	CFR parts affected	File code	Title of regulation
January 17, 2006	2617	419	CMS–1501–CN2	Medicare Program; Changes to the Hospital Outpatient Prospective Payment System and Calendar Year 2006 Payment Rates; Correction.
January 23, 2006	3616	412 and 424	CMS1306–P	Medicare Program, Impatient Psychiatric Facilities Prospective Payment System Payment Update for Rate Year Beginning July 1, 2006 (RY 2007).
January 27, 2006	4648	412	CMS–1485–P	Medicare Program; Prospective Payment System for Long-term Care Hospitals RY 2007: Proposed Annual Payment Rate Updates, Policy Changes, and Clarification.
January 27, 2006	4591		CMS–1318–N	Medicare Program; Meeting of the Practicing Physicians Advisory Council, March 6, 2006.
January 27, 2006	4590		CMS–1328–N	Medicare Program; February 15, 2006 Town Hall Meeting on the Practice Expense Methodology Including the Proposal From the Physician Fee Schedule Proposed Rule for Calendar Year 2006.
January 27, 2006	4589		CMS–3162–N	Medicare Program; Meeting of the Medicare Coverage Advisory Committee—March 30, 2006.
January 27, 2006	4586		CMS–3144–FN	Medicare Program; Approval of Adjustment in Payment Amounts for New Technology Intraocular Lenses Furnished by Ambulatory Surgical Centers.
January 27, 2006	4584		CMS–2228–PN	Medicare and Medicaid Programs; Application by the TUV Healthcare Specialists for Deeming Authority for Hospitals.
January 27, 2006	4518	414	CMS–1167–F	Medicare Program; Payment for Respiratory Assist Devices With Bi-Level Capability and a Backup Rate.
February 10, 2006	6991	413	CMS–1126–RCN	Medicare Program; Provider Bad Debt Payment; Extension of Timeline for Publication of Final Rule.
February 24, 2006	9564		CMS–2227–FN	Medicare and Medicaid Programs; Approval of Deeming Authority of the Accreditation Commission for Healthcare (ACHC) for Home Health Agencies.
February 24, 2006	9562		CMS–1332–NC	Medicare and Medicaid Programs; Announcement of an Application From a Hospital Requesting Waiver From Its Designated Organ Procurement Service Area.
February 24, 2006	9561		CMS–4115–N	Medicare Program; Request for Nominations for the Advisory Panel on Medicare Education.
February 24, 2006	9505	412 and 413	CMS–1306–CN	Medicare Program; Inpatient Psychiatric Facilities Prospective Payment System Payment Update for Rate Year Beginning July 1, 2006 (RY 2007); Correction and Extension of Comment Period.
February 24, 2006	9466	411 and 489	CMS–6272–IFC	Medicare Program; Medicare Secondary Payer Amendments.
February 24, 2006	9458	405, 410, 411, 413, 414, 424 and 426.	CMS–1502–F2 and CMS–1325–F.	Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2006 and Certain Provisions Related to the Competitive Acquisition Program of Outpatient Drugs and Biologicals Under Part B; Correcting Amendment.
March 3, 2006	11027	412 and 413	CMS–1306–CN	Medicare Program; Inpatient Psychiatric Facilities Prospective Payment Update for Rate Year Beginning July 1, 2006 (RY 2007); Correction and Extension of Comment Period.
March 15, 2006	13469	405, 410, 411, 413, 414, 424 and 426.	CMS–1502–F2 and CMS–1325–F.	Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2006 and Certain Provisions Related to the Competitive Acquisition Program of Outpatient Drugs and Biologicals Under Part B; Correcting Amendment.
March 24, 2006	14924		CMS–1281–N	Medicare Program; Public Meetings in Calendar Year 2006 for All New Public Requests for Revisions to the Healthcare Common Procedure Coding System (HCPCS) Coding and Payment Determinations.
March 24, 2006	14922		CMS–4117–PN	Medicare Program; Application for Deeming Authority for Medicare Advantage Health Maintenance Organizations and Local Preferred Provider Organizations Submitted by URAC.

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

[January through March 2006]

Publication date	FR vol. 71 page No.	CFR parts affected	File code	Title of regulation
March 24, 2006	14903		CMS–9034–N	Medicare and Medicaid Programs; Quarterly Listing of Program Issuances—October Through December 2005.
March 24, 2006	14901		CMS–3163–N	Medicare Program; Request for Nominations for Members of the Medicare Coverage Advisory Committee and Notice of Meeting of the Medicare Coverage Advisory Committee—May 18, 2006.
March 24, 2006	14900		CMS–1269–N7	Medicare Program; Emergency Medical Treatment and Labor Act (EMTALA) Technical Advisory Group (TAG): Announcement of a New Member.

Addendum V—National Coverage Determinations

[January Through March 2006]

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 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 were issued 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 pending decisions or, in some cases, explain why it was not appropriate to issue an NCD. We identify completed decisions by the section of the NCDM 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 Web site at *http://cms.hhs.gov/coverage*.

NATIONAL COVERAGE DETERMINATIONS

[January through March 2006]

Title	NCDM section	TN No.	Issue date	Effective date
Cardiac Catheterization Performed in Other Than a Hospital Setting	20.25	R46NCD	1/27/06	1/18/06
Tumor Antigen by Immunoassay CA125 to Add Primary Peritoneal Carcinoma	190.28	R47NCD	2/24/06	1/1/06
Technical Corrections to the NCD Manual	(*)	R48NCD	3/17/06	3/17/06
Microvolt T-Wave Alternans Diagnostic Testing	20.30	R49NCD	3/24/06	3/21/06
External Counterpulsation Therapy	20.20	R50NCD	3/31/06	3/20/06

* NA (not available).

Addendum VI—FDA-Approved Category B IDEs

[January Through March 2006]

Under the Food, Drug, and Cosmetic Act (21 U.S.C. 360c) devices fall into one of three classes. To assist CMS under this categorization process, the FDA assigns one of two categories to each FDA-approved IDE. Category A refers to experimental IDEs, and Category B refers to non-experimental IDEs. 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 list includes all Category B IDEs approved by FDA during the first quarter, January through March 2006: G040138, G050054, G050157, G050185, G050189, G050201, G050209, G050212, G050213, G050215, G050219, G050226, G050246, G050248, G050250, G050251, G050253, G050260, G060004, G060005, G060010, G060011, G060014, G060015, G060016, G060018, G060020, G060022, G060023, G060024, G060025, G060027, G060028, G060030, G060031, G060043, G060046, G060047, G060048, and G060051.

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; Title 45, Subchapter C; and Title 20 of the Code of Federal Regulations, which have been approved by the Office of Management and Budget:

OMB CONTROL NUMBERS

[Approved CFR Sections in Title 42, Title 45, and Title 20 (Note: Sections in Title 45 are preceded by "45 CFR," and sections in Title 20 are preceded by "20 CFR")]

OMB No.	Approved CFR sections
0938–0008	Part 424, Subpart C.
0938–0022	413.20, 413.24, 413.106.
0938–0023	424.103.
0938–0025	406.28, 407.27.
0938–0027	486.100–486.110.

OMB CONTROL NUMBERS—Continued

[Approved CFR Sections in Title 42, Title 45, and Title 20 (Note: Sections in Title 45 are preceded by "45 CFR," and sections in Title 20 are preceded by "20 CFR")]

OMB No.	Approved CFR sections
0938–0033	405.807.
0938–0034	405.821.
0938–0035	407.40.
0938–0037	413.20, 413.24.
0938–0041	408.6, 408.202.
0938–0042	410.40, 424.124.
0938–0045	405.711.
0938–0046	405.2133.
0938–0050	413.20, 413.24.
0938–0062	431.151, 435.151, 435.1009, 440.220, 440.250, 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	406.7, 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.
0938–0193	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.
0938–0251	406.7.
0938–0266	416.1–416.150.
0938–0267	485.56, 485.58, 485.60, 485.64, 485.66.
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	485.701–485.729.
0938–0279	424.5.
0938–0287	447.31.
0938–0296	413.170, 413.184.
0938–0301	413.20, 413.24, 415.60.
0938–0302	418.22, 418.24, 418.28, 418.56, 418.58, 418.70, 418.74, 418.83, 418.96, 418.100.
0938–0313	489.11, 489.20.
0938–0328	482.12, 482.13, 482.21, 482.22, 482.27, 482.30, 482.41, 482.43, 482.45, 482.53, 482.56, 482.57, 482.60, 482.61, 482.62, 482.66, 485.618, 485.631.
0938–0334	491.9, 491.10.
0938–0338	486.104, 486.106, 486.110.
0938–0354	441.50.
0938–0355	442.30, 488.26.
0938–0358	488.26.
0938–0359	412.40–412.52.
0938–0360	488.60.
0938–0365	484.10, 484.12, 484.14, 484.16, 484.18, , 484.36, 484.48, 484.52.
0938–0372	414.330.
0938–0378	482.60–482.62.
0938–0379	442.30, 488.26.
0938–0382	442.30, 488.26.
0938–0386	405.2100–405.2171.
0938–0391	488.18, 488.26, 488.28.
0938–0426	480.104, 480.105, 480.116, 480.134.
0938–0429	447.53.
0938–0443	478.18, 478.34, 478.36, 478.42.
0938–0444	1004.40, 1004.50, 1004.60, 1004.70.
0938–0445	412.44, 412.46, 431.630, 476.71, 476.74, 476.78.
0938–0447	405.2133.
0938–0448	405.2133, 45 CFR 5, 5b; 20 CFR Parts 401, 422E.
0938–0449	440.180, 441.300–441.310.
0938–0454	424.20.
0938–0456	412.105.
0938–0463	413.20, 413.24, 413.106.
0938–0467	431.17, 431.306, 435.910, 435.920, 435.94,–435.960.
0938–0469	417.126, 422.502, 422.516.

OMB CONTROL NUMBERS—Continued

[Approved CFR Sections in Title 42, Title 45, and Title 20 (Note: Sections in Title 45 are preceded by "45 CFR," and sections in Title 20 are preceded by "20 CFR")]

OMB No.	Approved CFR sections
0938–0470	417.143, 422.6.
0938–0477	412.92.
0938–0484	424.123.
0938–0501	406.15.
0938–0502	433.138.
0938–0512	486.304, 486.306, 486.307.
0938–0526	475.102, 475.103, 475.104, 475.105, 475.106.
0938–0534	410.38, 424.5.
0938–0544	493.1–493.2001.
0938–0564	411.32.
0938–0565	411.20–411.206.
0938–0566	411.404, 411.406, 411.408.
0938–0573	412.256.
0938–0578	447.534.
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, 422.128, 430.12, 431.20, 431.107, 483.10, 484.10, 489.102.
0938–0612	493.801, 493.803, 493.1232, 493.1233, 493.1234, 493.1235, 493.1236, 493.1239, 493.1241, 493.1242, 493.1249, 493.1251, 493,1252, 493.1253, 493.1254, 493.1255, 493.1256, 493.1261, 493.1262, 493.1263, 493.1269, 493.1273, 493.1274, 493.1278, 493.1283, 493.1289, 493.1291, 493.1299.
0938–0618	433.68, 433.74, 447.272.
0938–0653	493.1771, 493.1773, 493.1777.
0938–0657	405.2110, 405.2112.
0938–0658	405.2110, 405.2112.
0938–0667	482.12, 488.18, 489.20, 489.24.
0938–0686	493.551–493.557.
0938–0688	486.301–486.325.
0938–0691	412.106.
0938–0692	466.78, 489.20, 489.27.
0938–0701	422.152.
0938–0702	45 CFR 146.111, 146.115, 146.117, 146.150, 146.152, 146.160, 146.180.
0938–0703	45 CFR 148.120, 148.122, 148.124, 148.126, 148.128.
0938–0714	411.370–411.389.
0938–0717	424.57.
0938–0721	410.33.
0938–0723	421.300–421.316.
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.
0938–0749	424.57.
0938–0753	422.000–422.700.
0938–0754	441.151, 441.152.
0938–0758	413.20, 413.24.
0938–0760	484.55, 484.205, 484.245, 484.250.
0938–0761	484.11, 484.20.
0938–0763	422.250, 422.252, 422.254, 422.256, 422.258, 422.262, 422.264, 422.266, 422.270, 422.300, 422.304, 422.306, 422.308, 422.310, 422.312, 422.314, 422.316, 422.318, 422.320, 422.322, 422.324, 423.251, 423.258, 423.265, 423.272, 423.286, 423.293, 423.301, 423.308, 423.315, 423.322, 423.329, 423.336, 423.343, 423.346, 423.350.
0938–0770	410.2.
0938–0778	422.111, 422.564.
0938–0779	417.126, 417.470, 422.64, 422.210.
0938–0781	411.404, 484.10.
0938–0786	438.352, 438.360, 438.362, 438.364.
0938–0790	460.12–460.210.
0938–0792	491.8, 491.11.
0938–0796	422.64.
0938–0798	413.24, 413.65, 419.42.
0938–0802	419.43.
0938–0818	410.141–410.146, 414.63.
0938–0829	422.568.
0938–0832	Parts 489 and 491.
0938–0833	483.350–483.376.
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	412.23, 412.604, 412.606, 412.608, 412.610, 412.614, 412.618, 412.626, 413.64.
0938–0846	411.352–411.361.
0938–0857	Part 419.
0938–0860	Part 419.

OMB CONTROL NUMBERS—Continued

[Approved CFR Sections in Title 42, Title 45, and Title 20 (Note: Sections in Title 45 are preceded by "45 CFR," and sections in Title 20 are preceded by "20 CFR")]

OMB No.	Approved CFR sections
0938–0866	45 CFR Part 162.
0938–0872	413.337, 483.20.
0938–0873	422.152.
0938–0874	45 CFR Parts 160 and 162.
0938–0878	Part 422 Subparts F and G.
0938–0887	45 CFR 148.316, 148.318, 148.320.
0938–0897	412.22, 412.533.
0938–0907	412.230, 412.304, 413.65.
0938–0910	422.620, 422.624, 422.626.
0938–0911	426.400, 426.500.
0938–0915	421.120, 421.122.
0938–0916	483.16.
0938–0920	438.6, 438.8, 438.10, 438.12, 438.50, 438.56, 438.102, 438.114, 438.202, 438.206, 438.207, 438.240, 438.242, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.604, 438.710, 438.722, 438.724, 438.810.
0938–0921	414.804.
0938–0931	45 CFR 142.408, 162.408, and 162.406.
0938–0933	438.50.
0938–0935	422 Subparts F and K.
0938–0936	423.
0938–0939	405.502.
0938–0944	422.250, 422.252, 422.254, 422.256, 422.258, 422.262, 422.264, 422.266, 422.270, 422.300, 422.304, 422.306, 422.308, 422.310, 422.312, 422.314, 422.316, 422.318, 422.320, 422.322, 422.324, 423.251, 423.258, 423.265, 423.272, 423.279, 423.286, 423.293, 423.301, 423.308, 423.315, 423.322, 423.329, 423.336, 423.343, 423.346, 423.350.
0938–0950	405.910.
0938–0951	423.48.
0938–0953	405.1200 and 405.1202.
0938–0954	414.906, 414.908, 414.910, 414.914, 414.916.
0938–0957	Part 423 Subpart R.
0938–0964	403.460, 411.47.
0938–0975	423.562(a).
0938–0976	423.568.
0938–0977	Part 423 Subpart R.
0938–0978	423.464.
0938–0982	422.310, 423.301, 423.322, 423.875, 423.888.
0938–0990	423.56.
0938–0992	423.505, 423.514.

Addendum VIII—Medicare-Approved Carotid Stent Facilities

[January Through March 2006]

On March 17, 2005, we issued our decision memorandum on carotid artery stenting. We determined that carotid artery stenting with embolic protection is reasonable and necessary only if performed in facilities that have been determined to be competent in performing the evaluation, procedure, and follow-up necessary to ensure optimal patient outcomes. We have created a list of minimum standards for facilities modeled in part on professional society statements on competency. All facilities must at least meet our standards in order to receive coverage for carotid artery stenting for high risk patients.

Effective Date 1/4/06

Grant Medical Center
111 S. Grant Avenue
Columbus, OH 43215
Medicare Provider #360017

Effective Date 1/6/06

Genesis HealthCare System
2951 Maple Avenue
Zanesville, OH 43701
Medicare Provider #360039

St. Joseph Regional Health Center
2801 Franciscan Drive
Bryan, TX 77802
Medicare Provider #450011

Washington Hospital Healthcare System
2000 Mowry Avenue
Fremont, CA 94538–1716
Medicare Provider #050195

Effective Date 1/12/06

Sparrow Hospital
1215 E. Michigan
P.O. Box 30480
Lansing, MI 48909–7980
Medicare Provider #230230

St. Mary's of Michigan Hospital
800 S. Washington Ave.
Saginaw, MI 48601–2524
Medicare Provider #230077

Effective Date 1/18/06

Michael Reese Hospital
2929 South Ellis Avenue
Chicago, IL 06016
Medicare Provider #140075

St. Vincent Infirmary Medical Center
Two St. Vincent Circle
Little Rock, AR 72205–5499
Medicare Provider #040007

St. Vincent Mercy Medical Center
2213 Cherry Street
Toledo, OH 43608–2691
Medicare Provider #360112

Touro Infirmary
1401 Foucher Street
New Orleans, LA 70115–3593
Medicare Provider #190046

Effective Date 1/20/06

Carroll Hospital Center
200 Memorial Avenue
Westminster, MD 21157
Medicare Provider #210033

DeTar Healthcare System
P.O. Box 2089
Victoria, TX 77902
Medicare Provider #450147

Long Beach Memorial Medical Center
2801 Atlantic Avenue
Long Beach, CA 90806–1737
Medicare Provider #050485

Effective Date 1/23/06

California Pacific Medical Center-Pacific Campus
2333 Buchanan Street
P.O. Box 7999
San Francisco, CA 94102
Medicare Provider #050047

MacNeal Hospital
3249 South Oak Park Avenue
Berwyn, IL 60402
Medicare Provider #140054

Silver Cross Hospital
1200 Maple Road
Joliet, IL 60432
Medicare Provider #140213

St. Joseph Hospital Kirkwood
525 Couch Avenue
Kirkwood, MO 63122–5594
Medicare Provider #260081

Effective Date 1/24/06

North Hills Hospital
4401 Booth Calloway Road
North Richland Hills, TX 76180
Medicare Provider #450087

Effective Date 1/26/06

Advocate Good Samaritan Hospital
3815 Highland Avenue
Downers Grove, IL 60515–1590
Medicare Provider #140288

Saint Joseph Regional Medical Center
801 East LaSalle Avenue
South Bend, IN 46617
Medicare Provider #150012

St. Francis Health Center-Topeka Kansas
1700 SW 7th Street
Topeka, KS 66606–1690
Medicare Provider #170016

Effective Date 2/1/06

Centro Cardiovascular de Puerto Rico y del Caribe
P.O. Box 366528
San Juan, Puerto Rico 00936–6528
Medicare Provider #400124

Glenwood Regional Medical Center
P.O. Box 35805
West Monroe, LA 71294–5805
Medicare Provider #190160

Southern Ocean County Hospital
1140 Route 72 West
Manahawkin, NJ 08050
Medicare Provider #310113

Effective Date 2/2/06

CHRISTUS Hospital
2830 Calder Avenue
P.O. Box 5405
Beaumont, TX 77726–5405
Medicare Provider #450034

Potomac Hospital
2300 Opitz Boulevard
Woodbridge, VA 22191
Medicare Provider #490113

Trinity Hospitals
One Burdick Expressway West
P.O. Box 5020
Minot, ND 58702–5020
Medicare Provider #350006

Effective Date 2/3/06

Beloit Memorial Hospital
1969 West Hart Road
Beloit, WI 53511
Medicare Provider #520100

Effective Date 2/6/06

Blount Memorial Hospital
907 E. Lamar Alexander Pkwy
Maryville, TN 37804–5016
Medicare Provider #440011

Centinela Freeman Regional Medical Center, Centinela Campus
555 East Hardy Street
Inglewood, CA 90301
Medicare Provider #050739

Florida Medical Center
5000 West Oakland Park Blvd
Ft. Lauderdale, FL 33313
Medicare Provider #100212

Renaissance Hospital
5500 39th Street
Groves, TX 77619
Medicare Provider #450123

Effective Date 2/8/06

Anaheim Memorial Medical Center
1111 West La Palma Avenue
Anaheim, CA 92801–2881
Medicare Provider #050226

Baylor Regional Medical Center at Plano
4700 Alliance Boulevard
Plano, TX 75093–5323
Medicare Provider #450890

UMass Memorial Medical Center
University Campus 55 Lake Avenue North
Worcester, MA 01655
Medicare Provider #220163

Lake Forest Hospital
660 North Westmoreland Road
Lake Forest, IL 60045–9989
Medicare Provider #140130

Effective Date 2/10/06

OSF Saint Anthony Medical Center
5666 East State Street
Rockford, IL 61108
Medicare Provider #140233

St. Vincent's Hospital
P.O. Box 12407
Birmingham, AL 35202–2407
Medicare Provider #010056

Effective Date 2/17/06

Carondelet St. Joseph's Hospital
350 North Wilmot Road
Tucson, AZ 85711–2678
Medicare Provider #030011

Cedars-Sinai Medical Center
8700 Beverly Boulevard
Los Angeles, CA 90048
Medicare Provider #050625

Hemet Valley Medical Center
1117 East Devonshire Avenue
Hemet, CA 92543
Medicare Provider #050390

North Colorado Medical Center
1801 16th Street
Greeley, CO 80631
Medicare Provider #060001

Saddleback Memorial Medical Center
24451 Health Center Drive
Laguna Hills, CA 92653
Medicare Provider #050603

Southwest Florida Regional Medical Center
2727 Winkler Avenue
Fort Myers, FL 33901
Medicare Provider #100220

Effective Date 2/22/06

Bridgeport Hospital
267 Grant Street
Bridgeport, CT 06610
Medicare Provider #070010

Hillcrest Baptist Medical Center
3000 Herring Avenue
P.O. Box 5100
Waco, TX 76708–0100
Medicare Provider #450101

MCSA, LLC
dba Medical Center of South Arkansas
700 West Grove
El Dorado, AR 71730
Medicare Provider #040088

Union Hospital
659 Boulevard
Dover, OH 44622
Medicare Provider #360010

West Jefferson Medical Center
1101 Medical Center Boulevard
Marrero, LA 70072
Medicare Provider #190039

Effective Date 2/24/06

Aventura Hospital and Medical Center
20900 Biscayne Boulevard
Aventura, FL 33180
Medicare Provider #100131

CHRISTUS St. John Hospital
18300 St. John Drive
Nassau Bay, TX 77058
Medicare Provider #450709

Flowers Hospital
4370 West Main Street
P.O. Box 6907
Dothan, AL 36305
Medicare Provider #010055

North Okaloosa Medical Center
151 Redstone Avenue, East
Crestview, FL 32539
Medicare Provider #100122

St. Luke's Community Medical Center
71200 St. Luke's Way, Suite 230
The Woodlands, TX 77384
Medicare Provider #450862

University Hospital and Medical Center
7201 North University Drive
Tamarac, FL 33321
Medicare Provider #100224

Effective Date 3/6/06

Fort Hamilton Hospital
630 Eaton Avenue
Hamilton, OH 45013
Medicare Provider #360132

INTEGRIS Southwest Medical Center
4401 South Western
Oklahoma City, OK 73109
Medicare Provider #370106

Memorial Hermann Southeast Hospital
11800 Astoria Boulevard
Houston, TX 77089
Medicare Provider #450184

Temple University Hospital
3401 North Broad Street
Philadelphia, PA 19140
Medicare Provider #390027

UPMC Passavant
9100 Babcock Boulevard
Pittsburgh, PA 15237–5842

Medicare Provider #107920

Effective Date 3/9/06

Enloe Medical Center
1531 Esplanade
Chico, CA 95926
Medicare Provider #050039

Northwest Medical Center—Washington County
609 W. Maple Avenue
Springdale, AR 72764
Medicare Provider #040022

Effective Date 3/13/06

Northwest Medical Center—Bentonville
3000 Medical Center Parkway
Bentonville, AR 72712
Medicare Provider #040138

St. Rose Dominican Hospitals, Siena Campus
3001 St. Rose Parkway
Henderson, NV 89052
Medicare Provider #290045

Effective Date 3/20/06

Bayshore Community Hospital
727 North Beers Street
Holmdel, NJ 07733
Medicare Provider #310112

JFK Medical Center
65 James Street
Edison, NJ 08818
Medicare Provider #310108

Lakewood Regional Medical Center
P.O. Box 6070
3700 East South Street
Lakewood, CA 90712
Medicare Provider #050581

Memorial Hospital of Burlington
252 McHenry Street
P.O. Box 400
Burlington, WI 53105–0400
Medicare Provider #520059

Methodist Heart Hospital
7700 Floyd Curl Drive
San Antonio, TX 78229
Medicare Provider #450388

Methodist Specialty and Transplant Hospital
8026 Floyd Curl Drive
San Antonio, TX 78229
Medicare Provider #450388

Muhlenberg Regional Medical Center
Park Avenue & Randolph Road
Plainfield, NJ 07061
Medicare Provider #310063

Effective Date 3/23/06

Danbury Hospital
24 Hospital Avenue
Danbury, CT 06810
Medicare Provider #070033

Lake Hospital System, Inc.
10 East Washington Street
Painesville, OH 44077–3472
Medicare Provider #360098

Sinai Hospital of Baltimore
2401 West Belvedere Avenue
Baltimore, MD 21215–5271
Medicare Provider #210012

Sutter General Hospital dba Sutter Memorial Hospital
5151 F Street
Sacramento, CA 95819
Medicare Provider #050108

Valley Hospital Medical Center
620 Shadow Lane
Las Vegas, NV 89106
Medicare Provider #290021

Warren Hospital
185 Roseberry Street
Phillips, NJ 08865
Medicare Provider #310060

Effective Date 3/28/06

Aurora Medical Center—Kenosha
10400 75th Street
Kenosha, WI 53142–7884
Medicare Provider #520189

Caritas Good Samaritan Medical Center
235 N. Pearl Street
Brockton, MA 02301
Medicare Provider #220111

Medical City Dallas Hospital
7777 Forest Lane
Dallas, TX 75230
Medicare Provider #450647

Southeast Missouri Hospital
1701 Lacey Street
Cape Cirardeau, MO 63701
Medicare Provider #260110

St. Joseph Hospital
360 Broadway
P.O. Box 403
Bangor, ME 04402–0403
Medicare Provider #200001

[FR Doc. 06–5486 Filed 6–22–06; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–1295–N]

Medicare Program; Second Biannual Meeting of the Advisory Panel on Ambulatory Payment Classification (APC) Groups—August 23, 24, and 25, 2006

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (DHHS).

ACTION: Notice.

SUMMARY: In accordance with section 10(a) of the Federal Advisory Committee Act (FACA) (5 U.S.C. Appendix 2), this notice announces the second biannual meeting of the Advisory Panel on Ambulatory Payment Classification (APC) Groups (the Panel) for 2006. The purpose of the Panel is to review the APC groups and their associated weights and to advise the Secretary of Health and Human Services (the Secretary) and the Administrator of the Centers for Medicare & Medicaid Services (CMS) concerning the clinical integrity of the APC groups and their associated weights. The advice provided by the Panel will be considered as we prepare the final rule that updates the hospital Outpatient Prospective Payment System (OPPS) for CY 2007.

DATES: *Meeting Dates:* The second biannual meeting for 2006 is scheduled for the following dates and times:

- Wednesday, August 23, 2006, 1 p.m. to 5 p.m. (e.d.t.).
- Thursday, August 24, 2006, 8 a.m. to 5 p.m. (e.d.t.).
- Friday, August 25, 2006, 8 a.m. to 12 noon (e.d.t.).

Note: [1] We anticipate that there will be a meeting on Friday, August 25, 2006. However, if the business of the Panel concludes on Thursday, August 24, 2006, the Panel will not meet on August 25, 2006.

[2] The times listed above are approximate times; consequently, the meetings may last longer than listed above.

Deadlines:

Deadline for Hardcopy Comments/ Suggested Agenda Topics—5 p.m. (e.d.t.), Wednesday, August 2, 2006.

Deadline for Hardcopy Presentations—5 p.m. (e.d.t.), Wednesday, August 2, 2006.

Deadline for Attendance Registration—5 p.m. (e.d.t.), Wednesday, August 9, 2006.

Deadline for Special Accommodations—5 p.m. (e.d.t.), Wednesday, August 9, 2006.

Submission of Materials to the Designated Federal Officer (DFO): Because of staffing and resource limitations, we cannot accept written comments and presentations by FAX, nor can we print written comments and presentations received electronically for dissemination at the meeting.

Only hardcopy comments and presentations can be reproduced for public dissemination. All hardcopy presentations *must be accompanied by Form CMS–20017.* The form is now available through the CMS Forms Web site. The URL for linking to this form is as follows: *http://www.cms.hhs.gov/cmsforms/downloads/cms20017.pdf.*

We are also requiring electronic versions of the written comments and presentations (in addition to the hardcopies), so we can send them electronically to the Panel members for their review before the meeting.

Consequently, *you must send BOTH electronic and hardcopy versions of your presentations and written comments by the prescribed deadlines.* (Electronic transmission must be sent to the e-mail address below, and hardcopies—accompanied by Form CMS–20017—must be mailed to the Designated Federal Officer [DFO], as specified in the **FURTHER FURTHER INFORMATION CONTACT** section of this notice.)