DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–9014–N]

Medicare and Medicaid Programs; Quarterly Listing of Program Issuances—April 2002 Through June 2002

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

ACTION: Notice.

SUMMARY: This notice lists CMS manual instructions, substantive and interpretive regulations, and other **Federal Register** notices that were published from April 2002, through June 2002, relating to the Medicare and Medicaid programs. This notice also provides information on national coverage determinations affecting specific medical and health care services under Medicare.

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

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

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

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

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

Questions concerning all other information may be addressed to Glenn McGuirk, Office of Strategic Operations and Regulatory Affairs, Regulations Development and Issuances Group, Centers for Medicare & Medicaid Services, C5–12–18, 7500 Security Boulevard, Baltimore, MD 21244–1850, (410) 786–5723.

SUPPLEMENTARY INFORMATION:

I. Program Issuances

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

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

II. How to Use the Addenda

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

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

- Addendum I lists the publication dates of the most recent quarterly listings of program issuances.
- Addendum II identifies previous **Federal Register** documents that contain a description of all previously published CMS Medicare and Medicaid manuals and memoranda.
- Addendum III lists a unique CMS transmittal number for each instruction in our manuals or Program Memoranda and its subject matter. A transmittal may consist of a single instruction or many. Often, it is necessary to use information in a transmittal in conjunction with information currently in the manuals.
- Addendum IV lists all substantive and interpretive Medicare and Medicaid regulations and general notices published in the **Federal Register** during the quarters covered by this notice. For each item we list the—
  - Date published;
  - **Federal Register** citation;
  - Parts of the Code of Federal Regulations (CFR) that have changed (if applicable);
  - Agency file code number; and
  - Title of the regulation.
- Addendum V includes completed national coverage determinations from June 28, 1999, the effective date of Medicare's new coverage process. Completed decisions are identified by title, a brief description, effective date,

and section in the appropriate federal publication.

III. How to Obtain Listed Material

A. Manuals

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

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

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

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

B. Regulations and Notices

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

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

C. Rulings

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

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

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

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

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

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

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

IV. How to Review Listed Material

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

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

Superintendent of Documents numbers for each CMS publication are shown in Addendum III, along with the CMS publication and transmittal numbers. To help FDLs locate the materials, use the Superintendent of Documents number, plus the transmittal number. For example, to find the Part 3—Program Administration, (CMS Pub. 14–3) transmittal entitled ''Correct Coding Initiative,'' use the Superintendent of Documents No. HE 22.8/7 and the transmittal number 1746.

(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: September 16, 2002.

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)

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

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

ADDENDUM III—MEDICARE AND MEDICAID MANUAL INSTRUCTIONS

[April 2002 Through June 2002]

Transmittal No.	Manual/subject/publication number
	Intermediary Manual **Part 2—Audits, Reimbursement Program Administration** **(CMS Pub. 13–2)** **(Superintendent of Documents No. HE 22.8/6–2)**
418	Beneficiary Services.
419	Beneficiary Services.
	Intermediary Manual **Part 3—Audits, Reimbursement Program Administration** **(CMS Pub. 113–3)** **(Superintendent of Documents, No. HE 22.8/6)**
1854	Further Development Is Not Necessary.
	Further Development Is Required.
	Methodology for Review of Hospital Billing Data.
1855	Security-Related Requirements for Subcontractor Arrangements With Network Services.
	Advise Your Provider and Network Services Vendors.
	Network Services Agreement.
	Notification to Provider and Eligibility Verification Vendors.
1856	Overpayments for Provider Services—General.
1857	Body of Report, Section D: Miscellaneous Data
	Carriers Manual **Part 2—Program Administration** **(CMS Pub. 14–2)** **(Superintendent of Documents, No. HE 22.8/7.2)**
143	Beneficiary Services.
144	Beneficiary Services.
	Carriers Manual **Part 3—Program Administration** **(CMS Pub. 14–3)** **(Superintendent of Documents, No. HE 22.8/7)**
1746	Correct Coding Initiative.
1747	Claims Processing Procedures for Physician/Supplier Services to Health Maintenance Organization Members.
1748	The ''Do Not Forward'' Initiative.
1749	Security-Related Requirements for Subcontractor Arrangements With Network Services.
	Advise Your Providers and Network Services Vendors.
	Network Services Agreement.
	Notification to Providers and Eligibility Verification Vendors.
1750	Unprocessable Claims.
	Claims Processing Terminology.
	Handling Unprocessable Claims.
	Data Element Requirements Matrix.
	Data Element Requirements Exhibits.
1751	Payment to Supplier of Diagnostic Test for Purchased Interpretations.
	Area Carrier-Physician's Services.
	Disposition of Misdirected Claims.
	Physician or Supplier Information.
	Purchased Diagnostic Tests.
1752	Clarification of Billing Requirements for Maintenance and Servicing for Capped Rental Items.
1753	Physicians' Services Paid Under Fee Schedule.
	Group Therapy Services (Code 97150).
	Therapy Students.
1754	Overpayments—General.
1755	Furnishing Physician Fee Schedule Data for National Codes.
	Furnishing Fee Schedule (Excluding Physician Fee Schedule), Prevailing Charge and Conversion Factor Data to Palmetto.
	Government Benefits Administrators, Fiscal Intermediaries, State Agencies, Indian Health Services and United Mine Workers.
1756	Part C—Miscellaneous Claims Data.
	Carriers Manual **Part 4—Program Administration** **(CMS Pub. 14–4)** **(Superintendent of Documents No. HE 22.8/7)**
26	Provider of Service or Supplier Information.

ADDENDUM III—MEDICARE AND MEDICAID MANUAL INSTRUCTIONS—Continued

[April 2002 Through June 2002]

Transmittal No.	Manual/subject/publication number
	Program Memorandum Intermediaries (CMS Pub. 60A) (Superintendent of Documents No. HE 22.8/6–5)
A–02–027	Installation of Version 27.2 of the Provider Statistical and Reimbursement Report.
A–02–028	Upcoming Train-the-Trainer Session for Hospital Swing Bed Facility Prospective Payment System.
A–02–029	Implementation of the Health Insurance Portability and Accountability Act Health Care Eligibility Benefit Inquiry/Response Transaction (270/271) Standard.
A–02–030	Revisions to the Home Health Prospective Payment System Pricer Software—Regional Home Health Intermediaries Only.
A–02–031	Updates to Common Working File Editing of Intermediary Claims for Durable Medical Equipment and Prosthetic/Orthotic Devices.
A–02–032	Diabetes Self Management Training Payment.
A–02–033	Sending Payee Information From Fiscal Intermediary Standard System to the Health Care Integrated General Ledger Accounting System.
A–02–034	Submission of the Swing Bed Minimum Data Set Data for Swing Bed Hospitals.
A–02–035	Revision to the 837 Interface Format for Sending Claims Accounting Information From Fiscal Intermediary Standard System to the Healthcare Integrated General Ledger Accounting System.
A–02–036	Health Insurance Portability and Accountability Act Institutional 837 Health Care Claim—Outpatient Hospice Implementation Direction.
A–02–037	Health Insurance Portability and Accountability Act Institutional 837 Health Care Claim—Home Health Implementation Direction.
A–02–038	Modification of Common Working File Administrative Bulletin Crossover Edit 7111 and ''Alert'' 7531.
A–02–039	Coverage and Billing of the Diagnosis and Treatment of Peripheral Neuropathy With Loss of Protective Sensation in People With Diabetes.
A–02–040	Scheduled Release for July Updates to Software Programs and Pricing/Coding Files.
A–02–041	New Patient Status Code 64.
A–02–042	Clarification to Periodic Interim Payment For Home Health Provider and Clarification On Extension of Due Dates for Filling Provider Cost Reports.
A–02–043	Audit Guidance Pertaining to Write-offs of Small Debit Balances in Patients' Account Receivable.
A–02–044	Announcement of Medicare Rural Health Clinics and Federally Qualified Health Center Payment Rate Increases, Changes to the Rural Health Clinics Benefit Made by The Medicare, Medicaid, and State Child Health Insurance Program Benefits Improvement and Protection Act of 2000 Clarification Regarding Drugs Furnished By Rural Health Clinics Federally Qualified Health Center.
A–02–045	Frequently Asked Questions About Home Health Advance Beneficiary Notice.
A–02–046	Clarification of Part B Medicare Payment for 18 Health Common Procedure Coding System Codes to Skilled Nursing Facilities.
A–02–047	July Medicare Outpatient Code Editor Specifications Version 17.2 for Bills From Hospitals That Are Not Paid Under the Outpatient Prospective Payment System.
A–02–048	Extension of the Deadline for Hospitals to Make Elections to Reduce Beneficiary Coinsurance for 2002 Under the Outpatient Prospective Payment System.
A–02–049	Installation of Version 27.3 of the Provider Statistical and Reimbursement Report.
A–02–050	July 2002 Update to the Hospital Outpatient Prospective Payment System.
A–02–051	Health Insurance Portability and Accountability Act Testing and Certification Requirements and Date Changes.
A–02–052	July Outpatient Code Editor Specifications Version (V3.1)
A–02–053	Indian Health Service Hospital Payment Rates for Calendar Year 2002.
A–02–054	Use of Medical Review Indicators for Comprehensive Error Rate Testing.
A–02–055	Extended Repayment Schedules for Home Health Providers Who Received the Special Periodic Interim Payment.
A–02–056	Special Handling of End Stage Renal Disease Claims Containing Healthcare Common Procedure Coding System Code J1955 (Levocarnitine).
	Program Memorandum Carriers (CMS Pub. 60B) (Superintendent of Documents, No. HE 22.8/6–5)
A–02–022	Elimination of Certificate of Medical Necessity Requirement for Continuous Positive Airway Pressure Device.
A–02–023	Revision; The Do Not Forward Initiative Using ''Return Service Requested''.
A–02–024	Deceased Physician Unique Physician Identification Number Information—(Transmittal B–01–73).
A–02–025	Reporting the Obligated to Accept as Payment in Full Amount on the American Standards Institute Health Data Committee X12 File Format 837 Version 4010 as Adopted Under the Health Insurance Portability and Accountability Act for Medicare Secondary Payer Claims.
A–02–026	Revised: New Permanent Modifier for ''Specific Required Documentation on File''.
A–02–027	Annual Updating of Interface Control Document—9-Codes Must Be Date of Service Driven.
A–02–028	Sending Payee Information From Multi-Carrier System to the Healthcare Integrated General Ledger Accounting System.
A–02–029	Durable Medical Equipment Regional Carrier—New Message for Advanced Beneficiary Note Denials.
B–02–030	Reporting Claims Accounting Information to the Healthcare Integrated General Ledger Accounting System for the Durable Medical Equipment Regional Carriers.
B–02–031	Cessation of Certain Durable Medical Equipment Regional Carriers Activities.
B–02–032	Medical Review Progressive Corrective Action.

ADDENDUM III—MEDICARE AND MEDICAID MANUAL INSTRUCTIONS—Continued

[April 2002 Through June 2002]

Transmittal No.	Manual/subject/publication number
B–02–033	Implementation of the Health Insurance Portability and Accountability Act Health Care Eligibility Benefit Inquiry/Response Transaction (270/271) Standard.
B–02–034	Implementation of the National Council for Prescription Drug Programs Telecommunications Standard Version 5.1 and the Equivalent Batch Standard Version for Retail Pharmacy Drug-Transactions.
B–02–035	Elimination of Certificate of Medical Necessity Requirement for Continuous Positive Airway Pressure Device—Clarification.
B–02–036	Changes to Correct Coding Edits, Version 8.3, Effective October 1, 2002.
B–02–037	New Medicare Medical Review Guidelines for Claims for Diabetic Testing Supplies.
B–02–038	Health Insurance Portability and Accountability Act of 1996 Testing and Certification Requirements and Date Changes.
	Program Memorandum Intermediaries/Carriers (CMS Pub. 60A/B) (Superintendent of Documents, No. HE 22.8/6–5)
AB–02–042	Coverage and Billing of the Diagnosis and Treatment of Peripheral Neuropathy With Loss of Protective Sensation in People With Diabetes.
AB–02–043	Corrections to Program Memorandum A–01–135—Codes Billable by Skilled Nursing Facility and Suppliers for Skilled Nursing Facility Residents.
AB–02–044	July Quarterly Update for 2002 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Fee Schedule.
AB–02–045	Clarification of the Allocation of Initial Claim Entry Activities Where the Claim Is Paid Secondary by Medicare.
AB–02–046	Availability of Deceased Beneficiary Data of Death Files (Calendar Years 2000 and 2001).
AB–02–047	Amended Contractor Assessment Security Tool (Cast) Submission Instructions and Due Dates.
AB–02–048	Program Management Provider/Supplier Education and Training.
AB–02–049	New Source of Provider Information Available on Centers for Medicare Services Website April 22, 2002.
AB–02–050	Program Memorandum on Written Statements of Intent to Claim Medicare Benefits.
AB–02–051	Change of Interest Citation in the Overpayment Sections of the Medicare Intermediary Manual and the Medicare Carriers Manual from 42 Code of Federal Regulations § 405.37 to 42 Code of Federal Regulations § 405.378.
AB–02–052	Revision of Medicare Reimbursement for Telehealth Services.
AB–02–053	Correction to the Revision of Medicare Reimbursement for Telehealth Service.
AB–02–054	Generating an Outbound Coordination of Benefits X12N 837 (4010) When Required Data Is Missing or Invalid.
AB–02–055	Claims Processing Instructions to Conclude the Durable Medical Equipment Prosthetics, Orthotics, and Supplies Competitive Bidding Demonstration.
AB–02–056	Expand Standard Data Format and Remove Common Working File Y2K Wrapper Logic for Fiscal Intermediary Claims/Trailers and Carriers/Durable Medical Equipment Regional Carrier Trailers—Incoming and Response Transactions.
AB–02–057	Charging Fees to Providers for Medicare Education and Training Activities Program Management.
AB–02–058	Second Update to the 2002 Medicare Physician Fee Schedule Database.
AB–02–059	Additional Clarification for Medical Nutrition Therapy Services.
AB–02–060	Coverage and Billing for Intravenous Immune Globulin for the Treatment of Autoimmune Mucocutaneous Blistering Diseases.
AB–02–061	Common Working File of Claims for Medicare Beneficiaries in State or Local Custody Under a Penal Authority.
AB–02–062	Cost Per Treatment Code 55873 for Cryosurgery of the Prostate: Changes to Ensure Proper Payment for Outpatient Hospital Facility Fee and Professional Services.
AB–02–063	Instructions for Fiscal Intermediary Standard System and Multi-Carriers System Testing of 835 Interface With the Healthcare Integrated General Ledger Accounting System.
AB–02–064	Coverage and Billing for Home Prothrombin Time International Normalized Ratio Monitoring for Anticoagulation Management.
AB–02–065	Coverage an Related Claims Processing Requirements for Positron Emission Tomography Scans—for Breast Cancer and Revised Coverage Conditions for Myocardial Viability.
AB–02–066	Non-coverage of Perception Sensory Threshold/Nerve Conduction Threshold Test.
AB–02–067	Remittance Advice Coding and Health Insurance Portability and Accountability Act, Transaction 835v4010 Completion Update.
AB–02–068	Notice of Interest Rate for Medicare Overpayments and Underpayments.
AB–02–069	July 2002 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Fee Schedule Files.
AB–02–070	New Waived Tests—April 12, 2002.
AB–02–071	Health Insurance Portability and Accountability Act of 1996.
AB–02–072	Medicare Payment for Drugs and Biologicals Furnished Incident to a Physician's Service.
AB–02–073	Installation of a New Medicare Customer Service Center Next Generation Desktop Application.
AB–02–074	Healthcare Provider Taxonomy Codes (HPTC) Crosswalk.
AB–02–075	Payment Limit for Drugs and Biologicals.
AB–02–076	Registration Process for, and Expectations for Use of, the Healthcare Integrity and Protection Data Bank.
AB–02–077	Common Working File, Beneficiary Other Insurer Auxiliary File.
AB–02–078	Provider Education Article: Medicare Coverage of Rehabilitation Services for Beneficiaries With Vision Impairment.
AB–02–079	Customer Services Representative Response to Physician and Provider Correct Coding Initiative Questions.
AB–02–080	Payment for Services Furnished by Audiologists.
AB–02–081	Core Security Requirements and Associated Responsibilities.
AB–02–082	Coding Changes for Sodium Hyaluronate.
AB–02–083	Effective Date Revision for Medicare Intermediary Manual, Transmittal 1855, dated April 26, 2002, Change Request 2057, and Medicare Carriers Manual, Transmittal 1749, dated April 26, 2002, Change Request 2057.

ADDENDUM III—MEDICARE AND MEDICAID MANUAL INSTRUCTIONS—Continued

[April 2002 Through June 2002]

Transmittal No.	Manual/subject/publication number
AB–02–084	Additional Information Regarding Medicare Payment Allowance for Flu Vaccine.
AB–02–085	Medicare Contractor Annual Update of the International Classification of Diseases, Ninth Revision, Clinical Modification.
AB–02–086	Change in Procedure for State Requests for Retrospective Medicare Claims.
AB–02–087	Delay in Enforcement of National Coverage Determinations for Clinical Diagnostic Laboratory Services.
AB–02–088	System Networking Electronic Correspondence Referral System 1.2 User and Installation Guides.
AB–02–089	New Automatic Notice of Change to Medicare Secondary Payer Auxiliary File.
AB–02–090	Medicare Secondary Payer: (1) Procedures for ''Write-Off—Closed'' of Medicare Secondary Payer Accounts Receivable; (2) Elimination of Automated/Systems ''Write-Off—Closed'' Actions for Medicare Secondary Payer Accounts Receivable; Zero Backend Tolerance for Medicare Secondary Payer Account Receivable (Reminder); and (3) Date for Establishment of Medicare Secondary Payer Account Receivable (Reminder).
	Program Memorandum—Medicaid State Agencies (CMS Pub. 17) (Superintendent of Documents, No. HE 22.8/6–5)
02–1	Title XIX of The Social Security Act, Post-Eligibility Treatment of Income.
	State Operations Manual—Provider Certification (CMS Pub. 7)
30	Revisions to Appendix T—Swing-Bed Hospitals.
	Peer Review Organization (CMS Pub. 19) (Superintendent of Documents, No. HE 22.8/8–15)
87	Background. Eligibility Competing for a Quality Improvement Organization Contract. Additional Requirements for a Physician-Access or Physician-Sponsored Organization. Responsibilities of the Board. Health Care Affiliated Limitation. Consumer Representative. Prohibition Against Sanctioned Board Members Background. Renewal Determination.
88	Background. Statutory Authority for Memorandum of Agreements. Scope. Provider Memorandum Agreement Specifications. Memorandums of Agreements With Specific Providers. Memorandum of Agreement Cover Letter for Providers. Model Memorandum of Agreement for Providers. Model Memorandum of Agreement for State Licensing/Certification Agency.
	Hospice Manual (CMS Pub. 10) (Superintendent of Documents, No. HE 22.8/2)
784	Identifying Other Primary Payers During the Admission Process.
785	Transplantation.
786	Billing for Mammography Screening. Diagnostic Mammography. Diagnostic and Screening Mammograms Performed With New Technologies.
	Home Health Agency Manual (CMS Pub. 11) (Superintendent of Documents, No. HE 33.8/5)
300	Billing Procedures For and Agency Being Assigned Multiple Provider Numbers or a Change in Provider Number. More Than One Agency Furnished Home Health Services. Transfer to Another Agency Under the Same Plan of Treatment. Clinical Laboratory Improvement Amendments. New Software for the Home Health Prospective Payment System Environment Adjustments of Episode Payment—Exclusivity and Multiplicity of Adjustments. Adjustments of Episode Payment—Exclusivity and Multiplicity of Adjustments. General Guidance on Line Item Billing Under Home Health Prospective Payment System. Request for Anticipated Payment. Home Health Prospective Payment System Claims. Special Billing Situations Involving Outcome & Assessment Information Set Assessments. Beneficiary-Driven Demand Billing Under Home Health Prospective Payment Systems.

ADDENDUM III—MEDICARE AND MEDICAID MANUAL INSTRUCTIONS—Continued

[April 2002 Through June 2002]

Transmittal No.	Manual/subject/publication number
	No-Payment Billing and Receipt of Denial Notices Under Home Health Prospective Payment Systems.
	Billing and Payment for Medicare.
	Secondary Payer Claims Under the Home Health Prospective Payment System
301	Excluded Foot Care Services.
	Coverage Issues Manual (CMS Pub. 6) (Superintendent of Documents, No. HE 22.8/14)
152	Noncontact Normothermic Wound Therapy.
153	Services Provided for the Diagnosis and Treatment of Diabetic Sensory Neuropathy With Loss of Protective Sensation (Also Known as Diabetic Peripheral Neuropathy).
154	Medical Nutrition Therapy.
155	Intravenous Immune Globulins for the Treatment of Autiommune Mucocutaneous Blistering Diseases.
156	Home Prothrombin Time International Normalized Ratio Monitoring for Anticoagulation Management.
	Positron Emission Tomography Scans.
	Current Perception Threshold/Sensory.
	Nerve Conduction Threshold Test.
	Single Photo Emission Tomography—Covered.
	Provider Reimbursement Manual—Part 2 Provider Cost Reporting Forms and Instructions Chapter 33/Form CMS–216–94 (CMS Pub. 15–2–33)
2	Worksheet D.
3	Cost Report Forms.
	Kidney Placement Efforts—Documentation Requirements.
	Provider Reimbursement Manual—Part 2 Provider Cost Reporting Forms and Instructions Chapter 34/Form CMS–2540–96 (CMS Pub. 15–2–34)
6	Cost Report Forms Exhibit 1.
	Program Integrity Manual (CMS Pub. 83)
24	Medical Policy.
	National Coverage Determinations.
	Coverage Provisions in Interpretive Manuals.
	Local Medical Review Policy Articles.
	Individual Claim Determinations.
	When to Develop New/Revised Local Medical Review Policy.
	Content of a Local Medical Review Policy.
	Coding Provisions in Local Medical Review Policy.
	Documentation Provisions in Local Medical Review Policy.
	Least Costly Alternative.
	Use of Absolute Words in Local Medical Review Policy.
	Local Medical Review Policy Requirements That Alternative Service Be Tried First.
	Local Medial Review Policy Format.
	American Medical Association Current Procedural Terminology Copyright Agreement.
	Local Medical Review Policy Development.
	Process Development Process.
	Evidence Supporting Local Medical Review Policy.
	Local Medical Review Policy That Require a Comment and Notice Period.
	Local Medical Review Policy Comment and Notice Process.
	The Comment Period.
	Draft Local Medical Review Policy Web Site Requirements.
	The Notice Period.
	Final Local Medical Review Policy Web Site Requirements.
	The Local Medical Review Policy Advisory Committee.
	The Carrier Advisory Committee.
	Purpose of the Carrier Advisory Committee.
	Membership on the Carrier Advisory Committee.
	Role of Carrier Advisory Committee Members.
	Carrier Advisory Committee Structure and Process.
	Durable Medical Equipment Regional Carriers Advisory Process.
	Provider Education Regarding Local Medical Review Policy.

ADDENDUM III—MEDICARE AND MEDICAID MANUAL INSTRUCTIONS—Continued

[April 2002 Through June 2002]

Transmittal No.	Manual/subject/publication number
	Application of Local Medical Review Policy.
	Retired Local Medical Review Policy.
25	Types of Claims for Which Contractors Are Responsible.
26	Quality Issues in Skilled Nursing Facility and Referral to Other Agencies.
	Medicare/Medicaid Sanction—Reinstatement Report (CMS Pub. 69)
04–02	Report of Physicians/Practitioners, Providers and/or Other Health Care Suppliers Excluded/Reinstated—March 2002.
05–02	Report of Physicians/Practitioners, Providers and/or Other Health Care Suppliers Excluded/Reinstated—April 2002.
06–02	Report of Physicians/Practitioners, Providers and/or Other Health Care Suppliers Excluded/Reinstated—May 2002.

ADDENDUM IV—REGULATION DOCUMENTS PUBLISHED IN THE FEDERAL REGISTER

[April 2002 Through June 2002]

Publication date	FR Vol. 67 page	CFR part(s)	File code*	Regulation title
April 15, 2002	18216		CMS–0007–N	Health Insurance Reform: Standards for Electronic Transactions; Announcement of the Availability of a Model Compliance Plan.
April 15, 2002	18209		CMS–4042–N	Medicare Program; Solicitation for Proposals for Medicare Preferred Provider Organization (PPO) Demonstrations in the Medicare+Choice Program.
April 26, 2002	20804			Centers for Medicare & Medicaid Services (CMS), Statement of Organization, Functions, and Delegations of Authority.
April 26, 2002	20803		CMS–1215–N	Medicare Program; June 3, 2002, Meeting of the Practicing Physicians Advisory Council.
April 26, 2002	20802		CMS–4036–N	Medicare Program: Meeting of the Advisory Panel on Medicare Education—May 23, 2002.
April 26, 2002	20801		CMS–3097–N	Medicare Program; Meeting of the Medical and Surgical Procedures Panel of the Medicare Coverage Advisory Committee—June 12, 2002.
April 26, 2002	20800		CMS–4047–N	Medicare Program; Risk Adjustment Training, June 3–4, 2002, Las Vegas, NV; June 6–7, 2002, St. Louis, MO; June 10–11, 2002, Philadelphia, PA; and June 13–14, 2002, Orlando, FL.
April 26, 2002	20794		CMS–2137–N	State Children's Health Insurance Program (SCHIP); Redistribution and Continued Availability of Unexpended SCHIP Funds From the Appropriation for FY 1999.
April 26, 2002	20791		CMS–2149–N	Medicaid Program; Infrastructure Grants Program To Support the Design and Delivery of Long Term Services and Supports That Permit People of Any Age Who Have a Disability or Long Term Illness To Live in the Community.
April 26, 2002	20681		CMS–1169–CN	Medicare Program; Revisions to Payment Policies and Five-Year Review of and Adjustments to the Relative Value Units Under the Physician Fee Schedule for Calendar Year 2002; Correction.
May 1, 2002	21617	42 CFR 414	CMS–1084–WN	Medicare Program; Payment for Upgraded Durable Medical Equipment; Withdrawal.
May 9, 2002	31403	42 CFR 405, 412, 413, 482, 485, 489.	CMS–1203–P	Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2003 Rates.
May 17, 2002	35118		CMS–1215–N2	Medicare Program; June 3, 2002, Meeting of the Practicing Physicians Advisory Council.
May 24, 2002	36611		CMS–2141–PN	Medicare and Medicaid Programs; Application by the American Osteopathic Association (AOA) for Approval of Deeming Authority for Ambulatory Surgical Centers (ASCs).
May 24, 2002	36539	42 CFR Chap. IV and V	CMS–3088–FC	Office of Inspector General-Health Care; Medicare and Medicaid Programs; Peer Review Organizations: Name and Other Changes-Technical Amendments.

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

[April 2002 Through June 2002]

Publication date	FR Vol. 67 page	CFR part(s)	File code*	Regulation title
May 31, 2002	38128		CMS–1209–N	Medicare Program; Notice of Modification of Beneficiary Assessment Requirements for Skilled Nursing Facilities.
May 31, 2002	38009	45 CFR 160, 162	CMS–0047–F	Health Insurance Reform: Standard Unique Employer Identifier.
June 14, 2002	40989	42 CFR 400, 430, 431, 434, 435, 438, 440, 447.	CMS–2104–F	Medicaid Program; Medicaid Managed Care: New Provisions.
June 14, 2002	40988	42 CFR 400, 430, 431, 434, 435, 438, 440, 447.	CMS–2001–F4	Medicaid Program; Medicaid Managed Care.
June 24, 2002	42609	42 CFR 400, 430, 431, 434, 435, 438, 440, 447.	CMS–2104–F	Medicaid Program; Medicaid Managed Care: New Provisions.
June 28, 2002	43846	42 CFR 410, 414	CMS–1204–P	Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2003.
June 28, 2002	43762		CMS–9880–N	Medicare and Medicaid Programs; Quarterly Listing of Program Issuances—Fourth Quarter, 1999 through First Quarter, 2002.
June 28, 2002	43632			Centers for Medicare & Medicaid Services (CMS), Statement of Organization, Functions, and Delegations of Authority.
June 28, 2002	43629		CMS–4023–FN	Medicare Program; Medicare+Choice Organizations—Approval of the Accreditation Association for Ambulatory Health Care, Inc. (AAAHC) for Medicare+Choice (M+C) Deeming Authority of M+C Organizations That Are Licensed as Health Maintenance Organizations (HMOs) or Preferred Provider Organizations (PPOs).
June 28, 2002	43616		CMS–1198–NC	Medicare Program; Update to the Prospective Payment System for Home Health Agencies for FY 2003.
June 28, 2002	43613		CMS–3082–NC	Medicare Program; Revised Evaluation Criteria for the End-Stage Renal Disease (ESRD) Networks.
June 28, 2002	43612		CMS–2154–PN	Medicare and Medicaid Programs; Application by the Joint Commission on Accreditation of Healthcare Organizations for Continued Deeming Authority for Ambulatory Surgical Centers.
June 28, 2002	43610		CMS–2155–PN	Medicare and Medicaid Programs; Application by the Accreditation Association for Ambulatory Health Care, Inc. for Continued Deeming Authority for Ambulatory Surgical Centers.
June 28, 2002	43555	42 CFR 414	CMS–1223–IFC	Medicare Program; Criteria for Submitting Supplemental Practice Expense Survey Data Under the Physician Fee Schedule.

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

Addendum V—National Coverage Determinations (April 2002 Through June 2002)

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 have been effective since June 28, 1999, the effective date of Medicare's new coverage process. Please note that because we order the NCDs by effective date, some of the decisions are dated later than June 2002, the terminus for most other information listed in this notice. The entries below include information concerning completed decisions as well as sections on program and decision memoranda, which also announce impending decisions or, in some cases, explain why it was not appropriate to issue a NCD. We identify completed decisions by title, effective date, and section of the publication where the decision can be found. Also, please note that in some cases more than one NCD was made affecting a single procedure. Information on completed decisions as well as pending decisions has also been posted on the CMS Web site at *http://www.hcfa.gov/coverage.*

NATIONAL COVERAGE DECISIONS FOR QUARTERLY NOTICES

[Coverage Issues Manual CMS Pub. 6]

Section	Title	Effective date
35–100	Photodynamic Therapy	August 20, 2002.
40–31	Intravenous Immune Globulin (IVIg) for the Treatment of Autoimmune Mucocutaneous Blistering Diseases.	October 1, 2002.
45–30	Photosensitive Drugs	August 20, 2002.
50–36	Positron Emission Tomography (PET) Scans	October 1, 2002.
50–57	Current Perception Threshold/Sensory Nerve Conduction Threshold Test	October 1, 2002.
50–58	Single Photon Emission Tomography	October 1, 2002.
50–59	Percutaneous Image-Guided Breast Biopsy	January 1, 2003.
80–3	Medical Nutrition Therapy	October 1, 2002.

[FR Doc. 02–24108 Filed 9–26–02; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Grant to Child Trends

AGENCY: Family and Youth Services Bureau, Administration on Children, Youth and Families, ACF, DHHS

ACTION: Notice of award.

Catalog of Federal Domestic Assistance: #93.550.

SUMMARY: Notice is hereby given that a noncompetive grant award is being made to Child Trends, Inc., to support their efforts in the development of positive outcome measures for children and youth.

This one year project is being funded non-competitively because it is expected to provide immediate and useful information and guidance to this Department and other practitioners regarding positive outcome measures for early intervention programs, government indicator monitoring efforts and longitudinal research on healthy youth development. The field of youth services and policy is in significant need of consensus and clarity on ways of measuring positive inputs and outcomes, including definitions, valid data sources, methodological issues, *etc.* This is true particularly in areas impacting the population of youth in at-risk situations served by the Family and Youth Services Bureau.

This project will solicit and compile expert input from a variety of fields which affect young people, such as services to runaway and homeless youth, other social services, health, labor force preparation, juvenile justice and the like. Through a wide-ranging call for papers, a review of existing constructs, multidisciplinary consultations and scholarly analysis, the project will build a body of information and thinking which will then become the focus of a national conference of experts hosted by the National Institutes of Health.

One purpose of the conference will be to build consensus on a body of valid, logical, and practical indicators that reflect assets, strengths, and constructive experiences of youth, with particular emphasis on youth in at-risk situations such as being homeless or a runaway. An important focus is to relate these assets and factors to healthy outcomes among youth as they mature into adulthood. Interdisciplinary considerations are expected; for example, an evaluation of knowledge regarding the impact of outcomes in one field, such as education, upon outcomes in another area, such as health. Findings and recommendations of the conference will be disseminated through a variety of means.

The project builds upon Child Trends' depth of expertise and experience, including notable accomplishments in the field of analyzing and evaluating policy effects upon children and youth, particularly those in at risk situations. During the 1990's, Child Trends played a key role in a major study sponsored by the Department of Health and Human Services on the effects of mandatory welfare-to-work programs on children, youth and families placed at risk during the transition from AFDC to TANF. It should be noted that many runaway and homeless youth and those at risk for running away, come from economically stressed families and settings.

Child Trends' widely-recognized reputation, extensive efforts and longstanding leadership in the area of child and youth well-being indicator development will generate significant expert attention and ensure participation in the culminating conference in Spring 2003. The grantee will be awarded $100,000 for use during the project period, beginning September 30, 2002 and ending September 29, 2003.

Authority: This award will be made pursuant to 42 U.S.C. 5714–23(a) (section 343 (a) of the Runaway and Homeless Youth Act of 1999, as amended by Pub. L. 106–71), CFDA#93.550.

FOR FURTHER INFORMATION CONTACT: Deborah Yatsko, Administration on Children, Youth and Families, Family and Youth Services Bureau, 330 C Street SW, Room 2326, Washington, DC 20204, Phone: 202.690.7843.

Dated: September 23, 2002.

Joan E. Ohl,

Commissioner, Administration on Children, Youth and Families.

[FR Doc. 02–24660 Filed 9–26–02; 8:45 am]

BILLING CODE 4184–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Notices of Award of Non-Competitive Grant

AGENCY: Administration on Children, Youth and Families (ACYF), ACF, DHHS.

ACTION: Notice; opportunity to comment.

SUMMARY: Notice is hereby given that ACYF is considering awarding discretionary research grant funds without competition to Cornell University, Office of Sponsored Programs, 115 Day Hall, Ithaca, New York 14853, for up to $254,332 of Child Care and Development Block Grant funds in FY 2002. Pending the availability of Federal funds, and the continuing non-Federal support of the project from other sources, ACYF will award up to $254,526 of Child Care and Development Block Grant funds in FY 2003 and up to $245,543 in FY 2004. The project period will begin on September 30, 2002, and end on September 29, 2005. This award will provide Federal support for research to develop econometric models of the