AR–5 HIV Program Review Panel Requirements
AR–7 Executive Order 12372 Review
AR–9 Paperwork Reduction Act Requirements
AR–10 Smoke-Free Workplace Requirements
AR–11 Healthy People 2010
AR–12 Lobbying Restrictions

J. Where To Obtain Additional Information

This and other CDC announcements, the necessary applications, and associated forms can be found on the CDC Web site, Internet address: *http://www.cdc.gov.*

Click on ''Funding'' then ''Grants and Cooperative Agreements''.

For general questions about this announcement, contact: Technical Information Management, CDC Procurement and Grants Office, 2920 Brandywine Rd, Room 3000, Atlanta, GA 30341–4146, Telephone: 770–488–2700.

For business management and budget assistance, in the states, contact: LaKassa Wyatt, Procurement and Grants Office, Centers for Disease Control and Prevention, 2920 Brandywine Road, Room 3000, Atlanta, GA 30341–4146, Telephone: 770–488–2728, E-mail address: *Lwyatt@cdc.gov.*

For business management and budget assistance in the territories, contact: Charlotte Flitcraft, Centers for Disease Control and Prevention, 2920 Brandywine Road, Room 3000, Atlanta, GA 30341–4146, Telephone: 770–488–2632, E-mail address: *caf5@cdc.gov.*

For program technical assistance, contact: Rebecca Cabral, Ph.D., Division of Reproductive Health, Centers for Disease Control and Prevention, 4770 Buford Hwy, NE., Atlanta, GA 30341, Telephone: 770–488–6399, E-mail address: *Rcabral@cdc.gov.*

Dated: March 24, 2003.

Sandra R. Manning,

Director, Procurement and Grants Office, Centers for Disease Control and Prevention.

[FR Doc. 03–7452 Filed 3–27–03; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–9016–N]

Medicare and Medicaid Programs; Quarterly Listing of Program Issuances—October 2002 Through December 2002

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

ACTION: Notice.

SUMMARY: This notice lists CMS manual instructions, substantive and interpretive regulations, and other **Federal Register** notices that were published from October 2002 through December 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. Additionally, this notice identifies certain devices with investigational device exemption numbers approved by the Food and Drug Administration that potentially may be covered under Medicare.

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

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

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

Questions concerning national coverage determinations should be directed to Shana Olshan, Office of Clinical Standards and Quality, Centers for Medicare & Medicaid Services, C1–09–06, 7500 Security Boulevard, Baltimore, MD 21244–1850, (410) 786–3122.

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

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

SUPPLEMENTARY INFORMATION:

I. Program Issuances

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

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

II. How to Use the Addenda

This notice is organized so that a reader may review the subjects of manual issuances, memoranda, substantive and interpretive regulations, national coverage determinations, and Food and Drug Administration-approved investigational device exemptions published during the timeframe to determine whether any are of particular interest. We expect this notice to be used in concert with previously published notices. Those unfamiliar with a description of our

Medicare manuals may wish to review Table I of our first three notices (53 FR 21730, 53 FR 36891, and 53 FR 50577) published in 1988, and the notice published March 31, 1993 (58 FR 16837). Those desiring information on the Medicare Coverage Issues Manual 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 the quarter covered by this notice. Completed decisions are identified by title, a brief description, effective date, and section in the appropriate Federal publication.
- Addendum VI includes listings of the Food and Drug Administration-approved investigational device exemption categorizations, using the investigational device exemption numbers the Food and Drug Administration assigns. The listings are organized according to the categories to which the device numbers are assigned (that is, Category A or Category B), and identified by the investigational device exemption number.

III. How To Obtain Listed Material

A. Manuals

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

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

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

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

B. Regulations and Notices

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

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

C. Rulings

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

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

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

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

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

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

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

IV. How To Review Listed Material

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

In addition, individuals may contact regional depository libraries that receive and retain at least one copy of most

Federal Government publications, either in printed or microfilm form, for use by the general public. These libraries provide reference services and interlibrary loans; however, they are not sales outlets. Individuals may obtain information about the location of the nearest regional depository library from any library.

Superintendent of Documents numbers for each CMS publication are shown in Addendum III, along with the CMS publication and transmittal numbers. To help FDLs locate the materials, use the Superintendent of Documents number, plus the transmittal number. For example, to find the Part 3—Claims Process, (CMS Pub. 13–3) transmittal entitled ''Hearing Aide Exclusion,'' use the Superintendent of Documents No. HE 22.8/6 and the transmittal number 1868.

(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: March 18, 2003.

Jacquelyn Y. White,

Director, Office of Strategic Operations and Regulatory Affairs.

Addendum I

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

August 11, 1998 (63 FR 42857)
September 16, 1998 (63 FR 49598)
December 9, 1998 (63 FR 67899)
May 11, 1999 (64 FR 25351)
November 2, 1999 (64 FR 59185)
December 7, 1999 (64 FR 68357)
January 10, 2000 (65 FR 1400)
May 30, 2000 (65 FR 34481)
June 28, 2002 (67 FR 43762)
September 27, 2002 (67 FR 61130)
December 27, 2002 (67 FR 79109)

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

An extensive descriptive listing of Medicare manuals and memoranda was published on June 9, 1988, at 53 FR 21730 and supplemented on September 22, 1988, at 53 FR 36891 and December 16, 1988, at 53 FR 50577. Also, a complete description of the Medicare Coverage Issues Manual 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

[October 2002 Through December 2002]

Transmittal No.	Manual/Subject/Publication number
	Intermediary Manual Part 3—Claims Process (CMS Pub. 13–3) (Superintendent of Documents No. HE 22.8/6)
1863	• Prospective Payment System Pricer Program Provider-Specific Payment Data Provider-Specific Data Record Layout and Description
1864	• Mammography Screening Diagnostic and Screening Mammography Performed With New Technologies
1865	• Overpayments for Provider Services—General
1866	• Pneumococcal Pneumonia, Influenza Virus and Hepatitis B Vaccines
1867	• Immunosuppressive Drugs Furnished to Transplant Patients
1868	• Hearing Aide Exclusion
1869	• Payment for Services Furnished by a Critical Access Hospital
1870	• Payment for Services Furnished by a Critical Access Hospital
1871	• Heart Transplants
	Carriers Manual Part 3—Claims Process (CMS Pub. 14–3) (Superintendent of Documents No. HE 22.8/7)
1772	• Type of Service
1773	• Durable Medical Equipment Regional Carriers Only—Appeals of Duplicate Claims Introduction to the Appeals Process
1774	• Home Dialysis Patients' Options for Billing Payment for Method II Home Dialysis Supplies When the Beneficiary is an Inpatient
1775	• Identifying a Screening Mammography Claim and a Diagnostic Mammography Claim Diagnostic and Screening Mammography Performed With New Technologies
1776	• Evaluation and Management Services Codes—General
1777	• Overpayments—General
1778	• Healthcare Common Procedure Coding System Coding
1779	• Coding Physician Specialty Coding Type of Supplier and Non-Physician Practitioners
1780	• Supervising Physicians in Teaching Settings
1781	• Hearing Aid Exclusion
1782	• Mandatory Assignment and Other Requirements for Home Dialysis Supplies and Equipment Paid Under Method II
1783	• Type of Service
1784	• Recovery Where Fraud Is Suspected

ADDENDUM III.—MEDICARE AND MEDICAID MANUAL INSTRUCTIONS—Continued

[October 2002 Through December 2002]

Transmittal No.	Manual/Subject/Publication number
	Carriers Manual Part 4—Professional Relations (CMS Pub. 14–4) (Superintendent of Documents No. HE 22.8/7–4)
27	• Surrogate Unique Physician Identification Number
	Program Memoranda Intermediaries (CMS Pub. 60A) (Superintendent of Documents No. HE 22.8/6–5)
A–02–094	• Annual Desk Review Program for Hospital Wage Data: Cost Reporting Periods Beginning on or after October 1, 1999, Through September 30, 2000 (Fiscal Year 2004 Wage Index)
A–02–095	• Production Dates for the Provider Statistical and Reimbursement Report and Extension of Due Date for Filing Provider Cost Reports for Providers Having Their Claims Processed by the Arkansas Part A Standard System and Request for Wage Data for the FY 2004 Wage Index
A–02–096	• Payment of Skilled Nursing Facility Claims for Beneficiaries Disenrolling from Terminating Medicare+Choice Plans Who Have Not Met the 3-Day Hospital Stay Requirement
A–02–097	• Special Handling of New ''K'' Codes K0556, K0557, K0558, and K0559
A–02–098	• Changes in Transitional Outpatient Payment for 2003
A–02–099	• Scheduled Release for January Updates to Software Programs and Pricing/Coding Files
A–02–100	• Installation of Version 27.4 of the Provider Statistical and Reimbursement Report
A–02–101	• Changes to the Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities—Update as Published in the Federal Register, Fiscal Year 2001 (66 FR 39572, July 31, 2001), and Transmittal A–01–144, December 20, 2001 Hospice Wage Index Fiscal Year 2003, as published in the Federal Register (67 FR 56092, August 30, 2002) Update to the Prospective Payment System for Home Health Agencies for FY 2003; as Published in the FEDERAL REGISTER, (67 FR 43616, June 28, 2002)
A–02–102	• Medicare Certified Hospices—Clarification of Acceptable Parameters for Some Contractual Arrangements
A–02–103	• New Electronic Remittance Advice Coding for Home Health Prospective Payment System Adjustments
A–02–104	• Provider Education Article: Home Health Agencies Responsibilities Regarding Patient Notification
A–02–105	• Removal of Common Working File Edit on Non-Covered Hospice Claims
A–02–106	• Provider Education Article: Hospitals Responsibilities Re: Patient Notification at Discharge Planning and Home Health Consolidated Billing
A–02–107	• Revisions to Common Working File Editing to Accommodate Home Health Partial Episode Payment Claims and Rescheduling of Payment Adjustment Utility
A–02–108	• Multiple Patient Ambulance Transport
A–02–109	• Cost Based Payment for Certified Registered Nurse Anesthetists' Services Furnished by Outpatient Prospective Payment System Hospitals
A–02–110	• Financially Required Changes for the Fiscal Intermediary Standard System Paid Claim File
A–02–111	• October 2002 Update to the Hospital Outpatient Prospective Payment System—Correction—This instruction replaces PM A–02–076 (CR 2298) issued on August 7, 2002.
A–02–112	• Program Integrity Management Reporting System for Part A—Phase1
A–02–113	• Transmittal A–02–113 Has Been Rescinded
A–02–114	• Revisions to the Outpatient Prospective Payment System Pricer Software and Outpatient Code Editor for Blood Deductible and Technical Charges
A–02–115	• Medical Nutrition Therapy Services for Beneficiaries With Diabetes or Renal Disease—POLICY CHANGE
A–02–116	• Long Term Care Hospital Prospective Payment System: Requirements for Provider Education and Training
A–02–117	• Correction to Updated Instruction on Receipt and Processing on Non-Covered Charges on Other Than Part A Inpatient Claims (Transmittal A–02–071)
A–02–118	• Annual Update of Healthcare Common Procedure Coding System Codes for Skilled Nursing Facility Consolidated Billing Enforcement, Updated Skilled Nursing Facility Help File
A–02–119	• 0001 Revenue Line Direction for the Health Insurance Portability and Accountability Act Institutional 837 Health Care Claim
A–02–120	• Change in Requirements for Medicare Payment for Low Osmolar Contrast Material Under the Outpatient Prospective Payment System
A–02–121	• Skilled Nursing Facility Adjustment Billing: Adjustments to Health Insurance Prospective Payment System Codes Resulting From Minimum Data Set Corrections
A–02–122	• Notice Regarding Cost-to-Charge Ratios and Inpatient Outlier Payments
A–02–123	• Hospital Billing for Immunosuppressive Drugs Furnished to Transplant Patients—ACTION
A–02–124	• Necessary Changes to Implement Special Add-On Payments for New Technologies
A–02–125	• Installation of Version 29.0 of the Provider Statistical and Reimbursement Reporting System
A–02–126	• Instructions Regarding Hospital Outlier Payments
A–02–127	• Indian Health Service Hospital Payment Rates for Calendar Year 2002
	Program Memorandum Carriers (CMS Pub. 60B) (Superintendent of Documents No. HE 22.8/6–5)
B–01–062	• Payment to Registered Dietitians for Diabetes Outpatient Self-Management Training Services

ADDENDUM III.—MEDICARE AND MEDICAID MANUAL INSTRUCTIONS—Continued

[October 2002 Through December 2002]

Transmittal No.	Manual/Subject/Publication number
B–02–063	• Annual Updating of ICD –9–CM Codes Must Be Date of Services Driven
B–02–064	• Viable Information Processing System Implementation to Process ICD–9–CM Codes Using Date of Service and Not Date of Receipt
B–02–065	• Durable Medical Equipment Regional Carriers-Establishment Common Working File Override for Legitimate Duplicate Claims
B–02–066	• Ambulance Services: Maintaining Point-of-Pickup Zip Code
B–02–067	• Revision to Messages for Skilled Nursing Facility Consolidated Billing and Implementation of Common Working File Edits for Clinical Social Workers for Skilled Nursing Facility Consolidated Billing
B–02–068	• Revised X12N 4010 837 Professional Flat File
B–02–069	• Messages for Use With Drug Claims
B–02–070	• Reporting of Admission Date and Additional Edit Requirements for the X12N 837 (Version 4010) Coordination of Benefits Transaction
B–02–071	• Use of the National Drug Code for Drug Claims at the Durable Medical Equipment Regional Carriers
B–02–072	• Calendar Year 2003 Participation Enrollment and Medicare Participating Physicians and Supplies Directory Procedures
B–02–073	• Durable Medical Equipment Regional Carriers-Establishment Common Working File Override for Legitimate Duplicate Claims
B–02–074	• Clarification on System Changes in Change Request 2299
B–02–075	• Carrier Review of Payment Amounts for Portable X-Ray Transportation Services (HCPCS code R0070)—Request
B–02–076	• Annual Update for Skilled Nursing Facility Consolidated Billing for the Common Working File and Medicare Carriers
B–02–077	• Program Integrity Management Reporting System for Part B
B–02–078	• Medical Review Progressive Corrective Action—ACTION
B–02–079	• Contractor Reporting of Operational and Workload Data for Electronic Data Interchange and Manual Transactions
B–02–080	• Medicare Status Code System Standard System Financial Data Report Requirements for the Production Performance Monitoring System, Pulse System
B–02–081	• Migrate Medicare Carrier Provider/Supplier Enrollment Data From the Existing Carrier Provider Enrollment System into the Provider Enrollment Chain Ownership System
B–02–082	• Migrate Medicare Carrier Provider/Supplier Enrollment Data From the Existing Carrier Provider Enrollment System into the Provider Enrollment Chain Ownership System and Shut Down All Provider Enrollment Functions in Percutaneous Electrical Nerve Stimulation
B–02–083	• Create Import/Export Functionality Between the Unique Provider Identification Number System and the Provider Enrollment Chain Ownership System
B–02–084	• Create Import/Export Functionality Between the Medicare Claims System and the Provider Enrollment Chain Ownership System
B–02–085	• Process All Medicare Part B Provider Enrollments in the Provider Enrollment Chain Ownership System. Modify the Medicare Claims System to Incorporate All Claim Payment and Provider Correspondence Functionality That Is Included in the Provider Enrollment System But Will Not Be a Part of Provider Enrollment System. Shut Down All Provider Enrollment Functions in Provider Enrollment System
B–02–086	• Create Import/Export Functionality Between the Viable Medicare System and the Provider Enrollment Chain Ownership System
B–02–087	• Skilled Nursing Facility Consolidated Billing—New Requirements for Claims for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies
B–02–088	• Changes to Correct Coding Edits, Version 9.1, Effective April 1, 2003
B–02–089	• Further Instructions Regarding the Reasonable Charge Update for 2003 for Splints and Casts
B–02–090	• Implementation of the National Council for Prescription Drug Programs (NCPDP) Telecommunications Standard Version 5.1 and the Equivalent Batch Standard Version 1.1 for Retail Pharmacy Drug Transactions—CORRECTION
B–02–091	• Provider Education Article: Requirements for Payment of Medicare Claims for Foot and Nail Care Services
B–02–092	• Electromagnetic Stimulation
	Program Memoranda Intermediaries/Carriers (CMS Pub. 60A/B) (Superintendent of Documents No. HE 22.8/6–5)
AB–02–134	• Questions and Answers Related to Implementation of National Coverage Determinations for Clinical Diagnostic Laboratory Services
AB–02–135	• System Networking Electronic Correspondence Referral System 1.3 User and Installation Guides for Testing and Production
AB–02–136	• Reasonable Charge Update for 2003 for Splints, Casts, Dialysis Supplies, Dialysis Equipment, Therapeutic Shoes, and Certain Intraocular Lenses
AB–02–137	• Annual Update of Healthcare Common Procedure Coding System Codes Used for Home Health Consolidated Billing Enforcement
AB–02–138	• Instructions for Fiscal Intermediary Standard System and Multi-Carrier System Healthcare Integrated General Ledger Accounting System Changes
AB–02–139	• Additional Guidance for Applying the Medicare Self-Administered Drug Exclusion
AB–02–140	• Data Center Testing and Production—Electronic Correspondence Referral System User Manual 5.1 and Quick Reference Guide Replacement
AB–02–141	• Charging Fees to Providers for Medicare Education and Training Activities-Program Management
AB–02–142	• Remittance Advice Coding Update
AB–02–143	• Provider Education Article: Psychotropic Drug Use in Skilled Nursing Facilities
AB–02–144	• Virginia Cardiac Surgery Initiative Demonstration

ADDENDUM III.—MEDICARE AND MEDICAID MANUAL INSTRUCTIONS—Continued

[October 2002 Through December 2002]

Transmittal No.		Manual/Subject/Publication number
AB–02–145	•	Electronic Patient Records Via Non-Internet Means
AB–02–146	•	Revision to the Healthcare Provider Taxonomy Codes Crosswalk
AB–02–147	•	Promoting Influenza Vaccinations
AB–02–148	•	Remittance Advice Message for Ambulance Services
AB–02–149	•	Update to the Mammography Quality Standard Act File Record Layout for the Food and Drug Administration Certified Digital Mammography Centers
AB–02–150	•	Payment of Physician and Nonphysician Services for Certain Indian Providers
AB–02–151	•	Clarification Regarding Non-physician Practitioners Billing on Behalf of a Diabetes Outpatient Self-Management Training Services Program and the Common Working File Edits for Diabetes Outpatient Self-Management Training Services & Medical Nutrition Therapy. (NOTE: APASS has received a waiver for this Change Request
AB–02–152	•	Fee Schedule Update for 2003 for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies
AB–02–153	•	Claims Processing Instructions for the Medicare Disease Management Demonstration
AB–02–154	•	New Waived Tests—September 27, 2002
AB–02–155	•	Beneficiary Notification of Denials Based on Local Medical Review Policy
AB–02–156	•	Coverage and Billing for Neuromuscular Electrical Stimulation
AB–02–157	•	Codes Billable by Skilled Nursing Facilities and Suppliers for Skilled Nursing Facility Residents—Notice of New File Available via CMS Mainframe Telecommunication System
AB–02–158	•	Common Working File, Fiscal Intermediary, and Carrier Edits and Policy Clarification for Peripheral Neuropathy With Loss of Protective Sensation in People With Diabetes
AB–02–159	•	Medicare Deductible and Premium Rates for Calendar Year 2003
AB–02–160	•	Medicare Telehealth Update
AB–02–161	•	Coverage and Billing Requirements for Electrical Stimulation for the Treatment of Wounds
AB–02–162	•	Deported Medicare Beneficiaries
AB–02–163	•	2003 Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment Method
AB–02–164	•	Carrier, Durable Medical Equipment Regional Carrier, Intermediary and Regional Home Health Intermediary Processing Requirements for Claims Edited by Common Working File for Medicare Beneficiaries in State or Local Custody Under a Penal Authority
AB–02–165	•	Levocarnitine for Use in the Treatment of Carnitine Deficiency in End Stage Renal Disease Patients
AB–02–166	•	Editing of the Healthcare Provider Taxonomy Codes and Use of the Healthcare Provider Taxonomy Codes Crosswalk
AB–02–167	•	Notice of Interest Rate for Medicare Overpayments and Underpayments
AB–02–168	•	Advance Beneficiary Notice and Durable Medical Equipment Prosthetics, Orthotics & Supplies Refund Requirements—Corrections to PM AB–02–114
AB–02–169	•	Notice Requirement Related to Local Medical Review Policies
AB–02–170	•	File Descriptions and Instructions for Retrieving the 2003 Ambulatory Surgical Center Healthcare Common Procedure Code Additions and Deletions
AB–02–171	•	X12N Health Care Eligibility Benefit Inquiry/Response (270/271) Transaction Security and Connectivity Instructions
AB–02–172	•	Next Generation Desktop Data Center Connectivity—Security Information Clarification to Change Request 2079 (AB–02–073) Dated May 16, 2002
AB–02–173	•	Ambulance Fee Schedule Updates for 2003
AB–02–174	•	Single Drug Pricer
AB–02–175	•	Revisions to Common Working File Edits for Skilled Nursing Facility Consolidated Billing to Permit Payment for Certain Diagnostic Services Furnished to Beneficiaries Receiving Treatment for End Stage Renal Disease at an Independent or Provider-Based Dialysis Facility
AB–02–176	•	Prior Approval Requirement for Data Center and Front End Movement
AB–02–177	•	Independent Laboratory Billing for the Technical Component of Physician Pathology Services to Hospital Patients
AB–02–178	•	Clarification of the Comprehensive Error Rate Testing Program Contractor Resolution Process
AB–02–179	•	Complaint Screening
AB–02–180	•	Coverage and Billing for Home Prothrombin Time International Normalized Ratio Monitoring for Anticoagulation Management
AB–02–181	•	Medicare Physician Fee Schedule Update and the 2003 Participation Enrollment Process
AB–03–182	•	Coverage and Billing of Sacral Nerve Stimulation
AB–02–183	•	Coverage of Hyperbaric Oxygen Therapy for the Treatment of Diabetic Wounds of the Lower Extremities
AB–02–184	•	Provider Notification of Denials Based on Local Medical Review Policy
AB–02–185	•	Deletion of Q Codes and Reactivation of CPT Codes for Hepatitis B Vaccine
		Provider Reimbursement Manual—Part 1 (CMS Pub. 15–1) Superintendent of Documents No. HE 22.8/4
423	•	Regional Medicare Swing-Bed Rates
		Hospital Manual (CMS Pub. 10) (Superintendent of Documents No. HE 22.8/2)
791	•	Billing for Mammography Screening Diagnostic Mammography Diagnostic and Screening Mammograms Performed with New Technologies
792	•	Pneumococcal Pneumonia, Influenza Virus, and Hepatitis B Vaccines
793	•	Payment for Services Furnished by a Critical Access Hospital

ADDENDUM III.—MEDICARE AND MEDICAID MANUAL INSTRUCTIONS—Continued

[October 2002 Through December 2002]

Transmittal No.		Manual/Subject/Publication number
794	•	Payment for Services Furnished by a Critical Access Hospital
795	•	Heart Transplants
		Skilled Nursing Facility Manual (CMS—Pub. 12) Superintendent of Documents No. HE 22. 8/3
375	•	Coverage and Patient Classification
		Coverage Issues Manual (CMS—Pub. 6) Superintendent of Documents No. HE 22. 8/14
160	•	Neuromuscular Electrical Stimulation for Use by Spinal Cord Injured Patients for Walking
161	•	Electrical Stimulation for the Treatment of Wounds
		Durable Medical Equipment—Reference List
162	•	Photosensitive Drugs
		Levocarnitine for Use in the Treatment of Carnitine Deficiency in End Stage Renal Disease Patients
163	•	Home Blood Glucose Monitors
164	•	Hyperbaric Oxygen Therapy
165	•	Heart Transplants.
		Financial Management (CMS—Pub. 100–6)
12	•	Bankruptcy
		Glossary of Acronyms
		Basic Bankruptcy Terms and Definitions
		Bankruptcy is Litigation
		Types of Bankruptcies
		Filing Bankruptcy Draws a Line in the Sand
		Bankruptcy Affects Nearly All Medicare Operations
		Recoupment and Set-off Time is of the Essence
		Definitions
		Contractor's Establishment of Relationships to Ensure Effective Actions Regarding Providers in Bankruptcy
		Contractor Staff Must Establish Relationships to Ensure That the Regional Office and Regional Counsel Receive Prompt Notice of Provider Bankruptcies, So That Medicare Can Take Quick Action Contractors Must Recognize and Advise Regional Office Staff About Potential Provider Bankruptcies
		Contractor Staff Will Establish a Relationship With the Regional Office That has Jurisdiction Over the Bankruptcy Regional Office Jurisdiction Generally Parallels the Bankruptcy Court Where Case is Filed
		Contractor and Regional Office Bankruptcy Point of Contact Staff Member
		Actions to Take When a Provider Files for Bankruptcy
		Establish Effective Lines of Communication With Partners
		Respond to Regional Office Requests for Information
		Immediate Contractor Directives From the Regional Office
		Tracking Debts/Contract Officer Communications
		Chain Bankruptcies
		Chain Providers
		Single Providers Serviced by a National Contractor
		Affirmative Recovery Actions
		Working With the Regional Office and Regional Counsel's Office
		Assumption of the Medicare Provider Agreement
		Settlement Agreements or Stipulations
		Recoupment
		Administrative Freeze/Set-off
		Preparing and Filing Proof of Claim
		Closure of Bankruptcy Cases and Treatment of Overpayment Reporting
		Systems at End of Bankruptcy
		Closing the Bankruptcy Case
		Debt Located at the Debt Collection Center or Department of the Treasury
		Managing Bankruptcy Debt at the Contractor Location
		Peer Review Organization (CMS—Pub. 100–10) Superintendent of Documents No. HE 22.8/8–15
89	•	Citations and Authority
		Identification of Potential Violations
		Meeting With a Practitioner or Other Person
		Quality Improvement Organization Finding of a Violation
		Quality Improvement Organization Action on Final Finding of a Violation

ADDENDUM III.—MEDICARE AND MEDICAID MANUAL INSTRUCTIONS—Continued

[October 2002 Through December 2002]

Transmittal No.		Manual/Subject/Publication number
		Quality Improvement Organization Report to the Office of Inspector General Imposition and Notification of Sanctions Effect of an Exclusion Sanction on Medicare Payment and Services Reinstatement After Exclusion Appeal Rights of the Excluded Practitioner or Other Person
		End Stage Renal Disease Network (CMS—Pub. 100–14)
14	•	Authority Network's Role Prior to Initiating Sanction Recommendation Project Officer Role in Sanction Procedures Duration and Removal of Alternative Sanction Definitions for the End Stage Renal Disease Complaint and Grievance Process End Stage Renal Disease Complaints and Grievance Role of Network in Handling a Complaint/Grievance End Stage Renal Disease Complaints and Grievance Process Facility Awareness of the Complaint/Grievance Process Use of Facility Complaint/Grievance Process Determination of Your Involvement Receiving a Complaint/Grievance Request of Grievance in Writing Referring Complaints and Grievances Written Acknowledgement of Grievances Investigation of Complaints and Grievances Life-Threatening Situations Challenging Patient Situations Advocating for Patient Rights Addressing a Complaint or Grievance Follow-up of a Grievance Conclusion of a Grievance Investigation Report and Letter to the Grievant Potential Outcomes of Complaint/Grievance Process Improvement Plans Content of Improvement Plans Time Periods for Review and Acceptance/Rejection of Improvement Plans Improvement Plans Tracking System Conclusion of Improvement Plans Non-Compliance With Improvement Plans Confidentiality and Disclosure of Information Identity of Complainant/Grievant Identity of Practitioner Identity of Facility Personal Representative Conflict of Interest End Stage Renal Disease Network Complaint Process End Stage Renal Disease Grievance Process End Stage Renal Disease Inquiry Process Time Table for Complaints and Grievances Model Response Letter of Acknowledgement of a Written Complaint/Grievance Consent to Disclose Identity—Model Form Designation of a Representative—Model Form Final Response to Grievant—Model Letter

ADDENDUM IV—REGULATION DOCUMENTS PUBLISHED IN THE FEDERAL REGISTER

[October 2002 through December 2002]

Publication date	FR Vol. 67 page	CFR part(s)	File code *	Regulation title
10/01/2002	61496	42 CFR 413	.....	Principles of Reasonable Cost Reimbursement; Payment for End-Stage Renal Disease Services; Prospectively Determined Payment Rates for Skilled Nursing Facilities: OFR Correction.
10/01/2002	61496	42 CFR 460	CMS–1201–IFC	Medicare and Medicaid Programs; Programs of All-inclusive Care for the Elderly (PACE); Program Revisions.
10/01/2002	61632	.....	CMS–2160–N	State Children's Health Insurance Program; Final Allotments to States, the District of Columbia, and U.S. Territories and Commonwealths for Fiscal Year 2003.

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

[October 2002 through December 2002]

Publication date	FR Vol. 67 page	CFR part(s)	File code *	Regulation title
10/02/2002	61805	42 CFR 482	CMS–3018–N	Medicare and Medicaid Programs; Hospital Conditions of Participation: Clarification of the Regulatory Flexibility Analysis for Patients' Rights.
10/02/2002	61808	42 CFR 482, 483, 484.	CMS–3160–FC	Medicare and Medicaid Programs; Conditions of Participation: Immunization Standards for Hospitals, Long-Term Care Facilities, and Home Health Agencies.
10/02/2002	61956	42 CFR 457	CMS–2127–F	State Children's Health Insurance Program; Eligibility for Prenatal Care and Other Health Services for Unborn Children.
10/07/2002	62478	.....	CMS–4050–NR	Medicare Program; Changes in Medicare Appeals Procedures Based on Section 521 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000.
10/11/2002	63434	.....	CMS–3109–N	Medicare Program; Town Hall Meeting on the Hospital ''1-Hour'' Rule Related to the Use of Restraint and Seclusion.
10/16/2002	63966	.....	CMS–1201–IFC	Medicare and Medicaid Programs; Programs of All-inclusive Care for the Elderly (PACE); Program Revisions: OFR Correction.
10/21/2002	64641	.....	CMS–8013–N	Medicare Program; Inpatient Hospital Deductible and Hospital and Extended Care Services Coinsurance Amounts for 2003.
10/21/2002	64643	.....	CMS–8014–N	Medicare Program; Monthly Actuarial Rates and Monthly Supplementary Medical Insurance Premium Rate Beginning January 1, 2003.
10/21/2002	64649	.....	CMS–8015–N	Medicare Program; Part A Premiums for 2003 for the Uninsured Aged and for Certain Disabled Individuals Who Have Exhausted Other Entitlement.
10/25/2002	65504	42 CFR 431 and 438.	CMS–2104–F2	Medicaid Program; Medicaid Managed Care: New Provisions Correcting Amendment.
10/25/2002	65582	.....	CMS–2087–FN	Medicaid Program; State Allotments for Payment of Medicare Part B Premiums for Qualifying Individuals: Federal Fiscal Year 2001.
10/25/2002	65585	.....	CMS–2159–N	Medicare, Medicaid, and CLIA Programs; Clinical Laboratory Improvement Amendments of 1988 Continuance of Approval of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) as an Accrediting Organization.
10/25/2002	65588	.....	CMS–4038–N	Medicare Program; Meeting of the Advisory Panel on Medicare Education—November 19, 2002.
10/25/2002	65672	42 CFR 409, 417, 422.	CMS–4041–P	Medicare Program; Modifications to Managed Care Rules.
11/01/2002	66642	.....	CMS–2141–FN	Medicare and Medicaid Programs; Approval of the American Osteopathic Association for Deeming Authority for Ambulatory Surgical Centers.
11/01/2002	66718	42 CFR 405 and 419.	CMS–1206–FC and CMS–1179–F.	Medicare Program; Changes to the Hospital Outpatient Prospective Payment System and Calendar Year 2003 Payment Rates; and Changes to Payment Suspension for Unfiled Cost Reports.
11/05/2002	67318	42 CFR 410 and 414.	CMS–1204–N	Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2003, Notice of Delay of Final Rule.
11/15/2002	69146	42 CFR 405 and 419.	CMS–1206–CN	Medicare Program; Changes to the Hospital Outpatient Prospective Payment System and Calendar Year 2003 Payment Rates; and Changes to Payment Suspension for Unfiled Cost Reports; Correction.
11/15/2002	69182	42 CFR 405	CMS–4004–P	Medicare Program; Changes to the Medicare Claims Appeal Procedures.
11/22/2002	70322	42 CFR 411	CMS–1809–F2	Medicare and Medicaid Programs; Physicians' Referrals to Health Care Entities With Which They Have Financial Relationships: Extension of Partial Delay of Effective Date.
11/22/2002	70358	42 CFR 412, 413, 476, 484.	CMS–3055–P	Medicare Program; Photocopying Reimbursement Methodology.
11/22/2002	70363	42 CFR 418	CMS–1022–P	Medicare Program; Hospice Care Amendments.
11/22/2002	70373	42 CFR 482	CMS–1224–P	Medicare Program; Nondiscrimination in Posthospital Referral to Home Health Agencies and Other Entities.
11/22/2002	70435	.....	CMS–1241–NC	Medicare and Medicaid Programs; Announcement of Applications From Hospitals Requesting Waivers For Organ Procurement Service Areas.
11/22/2002	70437	.....	CMS–2154–FN	Medicare and Medicaid Programs; Application by the Joint Commission on Accreditation of Healthcare Organizations for Continued Deeming Authority for Ambulatory Surgical Centers.

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

[October 2002 through December 2002]

Publication date	FR Vol. 67 page	CFR part(s)	File code *	Regulation title
11/22/2002	70439		CMS–2155–FN	Medicare and Medicaid Programs; Approval of Application for Deeming Authority for Ambulatory Surgical Centers by the Accreditation Association for Ambulatory Health Care.
11/22/2002	70442		CMS–1220–N	Medicare Program; Fee Schedule for Payment of Ambulance Services' Update for CY 2003.
11/22/2002	70444		CMS–1217–N	Medicare Program; December 16, 2002, Meeting of the Practicing Physicians Advisory Council.
11/22/2002			CMS–6012–N3	Medicare Program; Establishment of the Negotiated Rulemaking Committee on Special Payment Provisions and Requirements For Prosthetics and Certain Custom-Fabricated Orthotics: January 6–7 and February 10–11, 2003 Meetings.
12/13/2002	76684	42 CFR 405	CMS–1908–IFC	Medicare Program; Application of Inherent Reasonableness to All Medicare Part B Services (Other Than Physician Services).
12/27/2002	79107		CMS–1231–N	Medicare Program; Re-Chartering of the Advisory Panel on Ambulatory Payment Classification Groups and Notice of Meeting of the Advisory Panel—January 21, 22, and 23, 2003.
12/27/2002	79109		CMS–3104–N	Medicare Program; Renewal and Amendment of the Charter of the Medicare Coverage Advisory Committee (MCAC).
12/27/2003	79109		CMS–9015–N	Medicare and Medicaid Programs; Quarterly Listing of Program Issuances—July-September 2002.
12/27/2003	79122		CMS–4055–N	Medicare Program; National Medicare+Choice Risk Adjustment Public Meeting—February 3, 2003.
12/27/2002	79123		CMS–1202–CN	Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities—Correction Notice.
12/27/2002	79124		CMS–3105–N	Medicare Program; Meeting of the Medicare Coverage Advisory Committee—February 12, 2003.
12/27/2002	79125		CMS–1234–N	Medicare Program; February 10, 2003, Meeting of the Practicing Physicians Advisory Council.
12/31/2002	79966	42 CFR 410, 414, 485.	CMS–1204–FC	Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2003 and Inclusion of Registered Nurses in the Personnel Provision of the Critical Access Hospital Emergency Services Requirement for Frontier Areas and Remote Locations.

Addendum V—National Coverage Determinations [October 2002 through December 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 became effective during the quarter covered by this notice. The entries below include information concerning completed decisions as well as sections on program and decision memoranda, which also announce impending decisions or, in some cases, explain why it was not appropriate to issue an NCD. We identify completed decisions by 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://cms.hhs.gov/coverage.*

NATIONAL COVERAGE DECISIONS FOR QUARTERLY NOTICES

[Coverage Issues Manual—CMS Pub. 06]

Section	Title	Effective date
35–10	Hyperbaric Oxygen Therapy	April 1, 2003.
35–87	Heart Transplants	April 1, 2003.
60–11	Home Blood Glucose Monitors	not applicable.

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

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

The following information presents the device number and category (A or B) for the third quarter, July through September 2002. (We inadvertently failed to include this information in our December 27, 2002, quarterly issuances notice).

INVESTIGATIONAL DEVICE EXEMPTION NUMBERS, 3RD QUARTER 2002

IDE	Category
G000137	B
G002018	B
G010155	B

INVESTIGATIONAL DEVICE EXEMPTION NUMBERS, 3RD QUARTER 2002—Continued

IDE	Category
G010192	B
G010193	B
G010235	B
G010260	B
G010261	B
G010270	A
G010355	B
G020043	B
G020067	B
G020081	B
G020086	B
G020088	B
G020102	B
G020104	B
G020118	B
G020128	B
G020129	B
G020134	B
G020138	B
G020140	B
G020141	B
G020142	B
G020143	B
G020144	B
G020145	B
G020147	B
G020148	B
G020151	B
G020155	B
G020156	B
G020157	B
G020158	B
G020159	B
G020163	A
G020164	B
G020166	B
G020170	B
G020171	B
G020172	B
G020173	B
G020175	B
G020176	B
G020178	B
G020179	B
G020183	B
G020186	B
G020187	B
G020188	B
G020189	A
G020191	B
G020192	B
G020194	B
G020196	B
G020199	B
G020203	B
G020204	B
G020206	B
G020208	B
G020209	B
G020214	B
G020215	B
G020216	B
G020218	B
G090193	B
G910133	B

The following information presents the device number and category (A or B) for the fourth quarter, October through December 2002.

INVESTIGATIONAL DEVICE EXEMPTION NUMBERS, 4TH QUARTER 2002

IDE	Category
G010035	B
G010268	B
G020020	B
G020035	B
G020053	B
G020064	B
G020160	B
G020182	B
G020185	A
G020193	B
G020211	B
G020223	B
G020224	B
G020227	B
G020228	B
G020229	B
G020230	A
G020232	B
G020233	B
G020234	A
G020238	B
G020241	A
G020244	B
G020249	B
G020250	B
G020254	B
G020255	B
G020258	B
G020260	B
G020263	B
G020269	B
G020270	B
G020271	A
G020272	B
G020275	B
G020276	B
G020277	B
G020281	B
G020283	B
G020284	B
G020285	A
G020287	B
G020288	B
G020289	B
G020291	B
G020295	B
G020296	B
G020297	B
G020300	B
G020303	B
G020304	B
G020309	B
G990155	B

[FR Doc. 03–7063 Filed 3–27–03; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–1474–N]

Medicare Program; Town Hall Meeting on the Inpatient Rehabilitation Facility Prospective Payment System

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

ACTION: Notice of meeting.

SUMMARY: This notice announces a town hall meeting to allow the public to discuss the inpatient rehabilitation facility (IRF) prospective payment system (PPS). Beneficiaries, providers, physicians, inpatient rehabilitation facilities staff, industry representatives, and other interested parties are invited to this meeting to present their views regarding the IRF PPS. The meeting is open to the public, but attendance is limited to space available.

DATES: *Meeting Date:* The town hall meeting announced in this notice will be held on Monday, May 19, 2003, from 10 a.m. to 1 p.m. (eastern daylight saving time).

ADDRESSES: The town hall meeting will be held in the auditorium at the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244.

FOR FURTHER INFORMATION CONTACT: August Nemec, 410–786–0612. You may also send inquiries about this meeting via e-mail to *ANemec@cms.hhs.gov.*

SUPPLEMENTARY INFORMATION:

I. Background

On August 7, 2001, we published a final rule entitled ''Medicare Program; Prospective Payment System for Inpatient Rehabilitation Facilities (CMS–1069–F)'' in the **Federal Register** (66 FR 41316), that established a prospective payment system (PPS) for inpatient rehabilitation facilities (IRFs) as authorized under section 1886(j) of the Social Security Act (the Act). The IRF PPS regulations are codified at 42 CFR part 412, subpart P. In the August 7, 2001 final rule, we set forth per discharge Federal prospective payment rates for the fiscal year (FY) 2002 that provided payment for inpatient operating and capital costs of furnishing covered rehabilitation services (that is, routine, ancillary, and capital costs) but not costs of approved educational activities, bad debts, and other services or items that are outside the scope of the IRF PPS. The provisions of that final rule were effective for cost reporting