services, reviewing stakeholder comments, drafting final recommendation documents, and participating in workgroups on specific topics and methods. Members can expect to receive frequent emails, can expect to participate in multiple conference calls each month, and can expect to have periodic interaction with stakeholders. AHRQ estimates that members devote approximately 200 hours a year outside of in-person meetings to their USPSTF duties. The members are all volunteers and do not receive any compensation beyond support for travel to in person meetings.

**Francis D. Chesley, Jr.,**

*Acting Deputy Director.*

[FR Doc. 2019–02643 Filed 2–15–19; 8:45 am]

**BILLING CODE 4160–90–P**

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Agency for Healthcare Research and Quality

### Patient Safety Organizations: Voluntary Relinquishment From Healthcare Improvement, Inc. PSO

**AGENCY:** Agency for Healthcare Research and Quality (AHRQ), Department of Health and Human Services (HHS).

**ACTION:** Notice of delisting.

**SUMMARY:** The Patient Safety and Quality Improvement Final Rule (Patient Safety Rule) authorizes AHRQ, on behalf of the Secretary of HHS, to list as a patient safety organization (PSO) an entity that attests that it meets the statutory and regulatory requirements for listing. A PSO can be ''delisted'' by the Secretary if it is found to no longer meet the requirements of the Patient Safety and Quality Improvement Act of 2005 (Patient Safety Act) and Patient Safety Rule, when a PSO chooses to voluntarily relinquish its status as a PSO for any reason, or when a PSO's listing expires. AHRQ has accepted a notification of voluntary relinquishment from the Healthcare Improvement, Inc. PSO, PSO number P0123, of its status as a PSO, and has delisted the PSO accordingly.

**DATES:** The delisting was applicable at 12:00 Midnight ET (2400) on December 31, 2018.

**ADDRESSES:** The directories for both listed and delisted PSOs are ongoing and reviewed weekly by AHRQ. Both directories can be accessed electronically at the following HHS website: *http://www.pso.ahrq.gov/listed.*

**FOR FURTHER INFORMATION CONTACT:** Cathryn Bach, Center for Quality Improvement and Patient Safety, AHRQ, 5600 Fishers Lane, MS 06N100B, Rockville, MD 20857; Telephone (toll free): (866) 403–3697; Telephone (local): (301) 427–1111; TTY (toll free): (866) 438–7231; TTY (local): (301) 427–1130; Email: *pso@ahrq.hhs.gov.*

**SUPPLEMENTARY INFORMATION:**

#### Background

The Patient Safety Act, 42 U.S.C. 299b–21 to 299b–26, and the related Patient Safety Rule, 42 CFR part 3, published in the **Federal Register** on November 21, 2008, 73 FR 70732–70814, establish a framework by which individuals and entities that meet the definition of provider in the Patient Safety Rule may voluntarily report information to PSOs listed by AHRQ, on a privileged and confidential basis, for the aggregation and analysis of patient safety events.

The Patient Safety Act authorizes the listing of PSOs, which are entities or component organizations whose mission and primary activity are to conduct activities to improve patient safety and the quality of health care delivery.

HHS issued the Patient Safety Rule to implement the Patient Safety Act. AHRQ administers the provisions of the Patient Safety Act and Patient Safety Rule relating to the listing and operation of PSOs. The Patient Safety Rule authorizes AHRQ to list as a PSO an entity that attests that it meets the statutory and regulatory requirements for listing. A PSO can be ''delisted'' if it is found to no longer meet the requirements of the Patient Safety Act and Patient Safety Rule, when a PSO chooses to voluntarily relinquish its status as a PSO for any reason, or when a PSO's listing expires. Section 3.108(d) of the Patient Safety Rule requires AHRQ to provide public notice when it removes an organization from the list of federally approved PSOs.

AHRQ has accepted a notification from Healthcare Improvement, Inc. PSO, a component entity of Inspirien Insurance Company, to voluntarily relinquish its status as a PSO. Accordingly, Healthcare Improvement, Inc. PSO, P0123, was delisted effective at 12:00 Midnight ET (2400) on December 31, 2018.

Healthcare Improvement, Inc. PSO has patient safety work product (PSWP) in its possession. The PSO will meet the requirements of section 3.108(c)(2)(i) of the Patient Safety Rule regarding notification to providers that have reported to the PSO and of section 3.108(c)(2)(ii) regarding disposition of PSWP consistent with section 3.108(b)(3). According to section 3.108(b)(3) of the Patient Safety Rule, the PSO has 90 days from the effective date of delisting and revocation to complete the disposition of PSWP that is currently in the PSO's possession.

More information on PSOs can be obtained through AHRQ's PSO website at *http://www.pso.ahrq.gov.*

**Francis D. Chesley, Jr.,**

*Acting Deputy Director.*

[FR Doc. 2019–02642 Filed 2–15–19; 8:45 am]

**BILLING CODE 4160–90–P**

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Centers for Medicare & Medicaid Services

**[CMS–9112–N]**

### Medicare and Medicaid Programs; Quarterly Listing of Program Issuances—October Through December 2018

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

**ACTION:** Notice.

**SUMMARY:** This quarterly notice lists CMS manual instructions, substantive and interpretive regulations, and other **Federal Register** notices that were published from October through December 2018, relating to the Medicare and Medicaid programs and other programs administered by CMS.

**FOR FURTHER INFORMATION CONTACT:** It is possible that an interested party may need specific information and not be able to determine from the listed information whether the issuance or regulation would fulfill that need. Consequently, we are providing contact persons to answer general questions concerning each of the addenda published in this notice.

| Addenda | Contact | Phone Number |
|---|---|---|
| **I** CMS Manual Instructions | Ismael Torres | (410) 786-1864 |
| **II** Regulation Documents Published in the **Federal Register** | Terri Plumb | (410) 786-4481 |
| **III** CMS Rulings | Tiffany Lafferty | (410)786-7548 |
| **IV** Medicare National Coverage Determinations | Wanda Belle, MPA | (410) 786-7491 |
| **V** FDA-Approved Category B IDEs | John Manlove | (410) 786-6877 |
| **VI** Collections of Information | William Parham | (410) 786-4669 |
| **VII** Medicare –Approved Carotid Stent Facilities | Sarah Fulton, MHS | (410) 786-2749 |
| **VIII** American College of Cardiology-National Cardiovascular Data Registry Sites | Sarah Fulton, MHS | (410) 786-2749 |
| **IX** Medicare's Active Coverage-Related Guidance Documents | JoAnna Baldwin, MS | (410) 786-7205 |
| **X** One-time Notices Regarding National Coverage Provisions | JoAnna Baldwin, MS | (410) 786-7205 |
| **XI** National Oncologic Positron Emission Tomography Registry Sites | Stuart Caplan, RN, MAS | (410) 786-8564 |
| **XII** Medicare-Approved Ventricular Assist Device (Destination Therapy) Facilities | David Dolan | (410) 786-3365 |
| **XIII** Medicare-Approved Lung Volume Reduction Surgery Facilities | Sarah Fulton, MHS | (410) 786-2749 |
| **XIV** Medicare-Approved Bariatric Surgery Facilities | Sarah Fulton, MHS | (410) 786-2749 |
| **XV** Fluorodeoxyglucose Positron Emission Tomography for Dementia Trials | Stuart Caplan, RN, MAS | (410) 786-8564 |
| **All Other Information** | Annette Brewer | (410) 786-6580 |

## I. Background

The Centers for Medicare & Medicaid Services (CMS) is responsible for administering the Medicare and Medicaid programs and coordination and oversight of private health insurance. Administration and oversight of these programs involves the following: (1) Furnishing information to Medicare and Medicaid beneficiaries, health care providers, and the public; and (2) maintaining effective communications with CMS regional offices, state governments, state Medicaid agencies, state survey agencies, various providers of health care, all Medicare contractors that process claims and pay bills, National Association of Insurance Commissioners (NAIC), health insurers, and other stakeholders. 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) and Public Health Service Act. We also issue various manuals, memoranda, and statements necessary to administer and oversee the programs efficiently.

Section 1871(c) 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**.

## II. Format for the Quarterly Issuance Notices

This quarterly notice provides only the specific updates that have occurred in the 3 month period along with a hyperlink to the full listing that is available on the CMS website or the appropriate data registries that are used as our resources. This is the most current up-to-date information and will be available earlier than we publish our quarterly notice. We believe the website list provides more timely access for beneficiaries, providers, and suppliers. We also believe the website offers a more convenient tool for the public to find the full list of qualified providers for these specific services and offers more flexibility and ≥real time≥ accessibility. In addition, many of the websites have listservs; that is, the public can subscribe and receive immediate notification of any updates to the website. These listservs avoid the need to check the website, as notification of updates is automatic and sent to the subscriber as they occur. If assessing a website proves to be difficult, the contact person listed can provide information.

## III. How To Use the Notice

This notice is organized into 15 addenda so that a reader may access the subjects published during the quarter covered by the notice 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 should view the manuals at *http://www.cms.gov/manuals.*

Dated: January 17, 2019.

**Kathleen Cantwell,**

*Director, Office of Strategic Operations and Regulatory Affairs.*

**BILLING CODE 4120–01–P**

**Publication Dates for the Previous Four Quarterly Notices**

We publish this notice at the end of each quarter reflecting information released by CMS during the previous quarter. The publication dates of the previous four Quarterly Listing of Program Issuances notices are: January 26, 2018 (83 FR 3716), May 4, 2018 (83 FR 19769), August 13, 2018 (83 FR 40043) and November 2, 2018 (83 FR 55174). We are providing only the specific updates that have occurred in the 3-month period along with a hyperlink to the website to access this information and a contact person for questions or additional information.

**Addendum I: Medicare and Medicaid Manual Instructions (October through December 2018)**

The CMS Manual System is used by CMS program components, partners, providers, contractors, Medicare Advantage organizations, and State Survey Agencies to administer CMS programs. It offers day-to-day operating instructions, policies, and procedures based on statutes and regulations, guidelines, models, and directives. In 2003, we transformed the CMS Program Manuals into a web user-friendly presentation and renamed it the CMS Online Manual System.

How to Obtain Manuals

The Internet-only Manuals (IOMs) are a replica of the Agency's official record copy. Paper-based manuals are CMS manuals that were officially released in hardcopy. The majority of these manuals were transferred into the Internet-only manual (IOM) or retired. Pub 15-1, Pub 15-2 and Pub 45 are exceptions to this rule and are still active paper-based manuals. The remaining paper-based manuals are for reference purposes only. If you notice policy contained in the paper-based manuals that was not transferred to the IOM, send a message via the CMS Feedback tool.

Those wishing to subscribe to old versions of CMS manuals should contact the National Technical Information Service, Department of Commerce, 5301 Shawnee Road, Alexandria, VA 22312 Telephone (703-605-6050). You can download copies of the listed material free of charge at: http://cms.gov/manuals.

How to Review Transmittals or Program Memoranda

Those wishing to review transmittals and program memoranda can access this information 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. This information is available at http://www.gpo.gov/libraries/

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. CMS publication and transmittal numbers are shown in the listing entitled Medicare and Medicaid Manual Instructions. To help FDLs locate the materials, use the CMS publication and transmittal numbers. For example, to find the manual for Home Health Rural Add-on Payments Based on County of Residence, use (CMS-Pub. 100-04) Transmittal No. 4190.

Addendum I lists a unique CMS transmittal number for each instruction in our manuals or program memoranda and its subject number. A transmittal may consist of a single or multiple instruction(s). Often, it is necessary to use information in a transmittal in conjunction with information currently in the manual. For the purposes of this quarterly notice, we list only the specific updates to the list of manual instructions that have occurred in the 3-month period. This information is available on our website at www.cms.gov/Manuals.

| Transmittal Number | Manual/Subject/Publication Number |
|---|---|
| | **Medicare General Information (CMS-Pub. 100-01)** |
| 118 | Issued to a specific audience, not posted to Internet/Intranet due to Confidentiality of Instructions |
| 119 | Update to Medicare Deductible, Coinsurance and Premium Rates for 2019 |
| 120 | Internet Only Manual Updates to Pub. 100-01, 100-02 and 100-04 to Correct Errors and Omissions (SNF) (2018 Q4) |
| 121 | Issued to a specific audience, not posted to Internet/Intranet due to Confidentiality of Instructions |
| 122 | Updated Instructions for the Change Request Implementation Report (CRIR) and Technical Direction Letter (TDL) Compliance Report (TCR) |
| | **Medicare Benefit Policy (CMS-Pub. 100-02)** |
| 247 | Issued to a specific audience, not posted to Internet/Intranet due to Sensitivity of Instructions |
| 248 | Issued to a specific audience, not posted to Internet/Intranet due to Confidentiality of Instructions |
| 249 | Internet Only Manual Updates to Pub. 100-01, 100-02 and 100-04 to Correct Errors and Omissions (SNF) (2018 Q4)<br>Medicare SNF PPS Overview |

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|---|---|
| | Three-Day Prior Hospitalization<br>Daily Skilled Services Defined<br>Services Furnished Under Arrangements With Providers |
| 250 | Implementation of Changes in the End-Stage Renal Disease (ESRD) Prospective Payment System (PPS) and Payment for Dialysis Furnished for ESRD PPS Case-Mix Adjustments Acute Kidney Injury (AKI) in ESRD Facilities for Calendar Year (CY) 2019 |
| 251 | Revision of Definition of the Physician Supervision of Diagnostic Procedures, Clarification of DSMT Telehealth Services, and Establishing a Modifier for Expanding the Use of Telehealth for Individuals with Stroke |
| 252 | Revision of Definition of the Physician Supervision of Diagnostic Procedures, Clarification of DSMT Telehealth Services, and Establishing a Modifier for Expanding the Use of Telehealth for Individuals with Stroke |
| 253 | Updates to the Inpatient Psychiatric Facility Benefit Policy Manual<br>Background<br>Statutory Requirements<br>Affected Medicare Providers<br>Conditions for Payment Under the IPF Prospective Payment System<br>Admission Requirements<br>Medical Records Requirements<br>Data<br>Psychiatric Evaluation<br>Certification and Recertification Requirements<br>Certification<br>Recertification<br>Delayed/Lapsed Certification and Recertification<br>Treatment Plan<br>Individualized Treatment or Diagnostic Plan<br>Services Expected to Improve the Condition or for Purpose of Diagnosis<br>Recording Progress<br>Discharge Planning and Discharge Summary<br>Director of Inpatient Psychiatric Services; Medical Staff<br>Nursing Services<br>Social Services<br>Benefit Limits in Psychiatric Hospitals<br>Benefits Exhaust |
| 254 | Implementation of Changes in the End-Stage Renal Disease (ESRD) Prospective Payment System (PPS) and Payment for Dialysis Furnished for Acute Kidney Injury (AKI) in ESRD Facilities for Calendar Year (CY) 2019 |
| **Medicare National Coverage Determination (CMS-Pub. 100-03)** | |
| 208 | Magnetic Resonance Imaging (MRI) |
| 209 | National Coverage Determination (NCD) 20.4 Implantable Cardiac Implantable Cardioverter Defibrillators (ICD) |
| 210 | National Coverage Determination (NCD90.2): Next Generation Sequencing (NGS) |
| 211 | National Coverage Determination (NCD) 20.4 Implantable Cardiac Defibrillators (ICDs) |

| **Medicare Claims Processing (CMS-Pub. 100-04)** | |
|---|---|
| 4143 | 2019 Annual Update of Healthcare Common Procedure Coding System (HCPCS) Codes for Skilled Nursing Facility (SNF) Consolidated Billing (CB) Update |
| 4144 | Fiscal Year (FY) 2019 Inpatient Prospective Payment System (IPPS) and Long Term Care Hospital (LTCH) PPS Changes |
| 4145 | Issued to a specific audience, not posted to Internet/ Intranet due to Sensitivity of Instructions |
| 4146 | Issued to a specific audience, not posted to Internet/ Intranet due to Sensitivity of Instructions |
| 4147 | Magnetic Resonance Imaging (MRI)<br>Magnetic Resonance Imaging (MRI) Procedures<br>Payment Requirements<br>Medicare Summary Notices (MSN), Claim Adjustment Reason Codes (CARCs), and Remittance Advice Remark Codes (RARCs) |
| 4148 | Issued to a specific audience, not posted to Internet/ Intranet due to Sensitivity of Instructions |
| 4149 | Issued to a specific audience, not posted to Internet/Intranet due to Confidentiality of Instructions |
| 4150 | Update to Bone Mass Measurements (BMM) Code 77085 Deductible and Coinsurance Payment Methodology and HCPCS Coding Table of Preventive and Screening Services |
| 4151 | Issued to a specific audience, not posted to Internet/Intranet due to Confidentiality of Instructions |
| 4152 | Redesign of Hospice Periods – Additional Requirements<br>Notice of Election (NOE)<br>Notice of Termination/Revocation (NOTR)<br>Change of Provider/Transfer Notice<br>Cancellation of an Election<br>Change of Ownership Notice<br>Hospice Election Periods and Benefit Periods in Medicare Data Required on the Institutional Claim to A/B MAC (HHH) |
| 4153 | Incomplete Colonoscopies Billed with Modifier 53 for Critical Access Hospital (CAH) Method II Providers |
| 4154 | Incomplete Colonoscopies (Codes 44388, 45378, G0105 and G0121) |
| 4155 | Issued to a specific audience, not posted to Internet/ Intranet due to Sensitivity of Instructions |
| 4156 | Issued to a specific audience, not posted to Internet/Intranet due to Confidentiality of Instructions |
| 4157 | Hospital and Critical Access Hospital (CAH) Swing-Bed Manual<br>Revisions and Shared Systems Changes<br>Swing-Bed Services<br>100.2/Payment for CRNA or AA Services<br>Addendum A - Provider Specific File<br>Payment for CRNA Pass-Through Services<br>Payment for CRNA Services (Method II CAH only<br>Types of Facilities Subject to the Consolidated Billing Requirement for SNFs |
| 4158 | Issued to a specific audience, not posted to Internet/Intranet due to |

| | |
|---|---|
| | Confidentiality of Instructions |
| 4159 | Issued to a specific audience, not posted to Internet/Intranet due to Confidentiality of Instructions |
| 4160 | Modifications to the National Coordination of Benefits Agreement (COBA) Crossover Process<br>Coordination of Benefits Agreement (COBA) Detailed Error Report Notification Process<br>Coordination of Benefits Agreement (COBA) Eligibility File Claims Recovery Process |
| 4161 | Issued to a specific audience, not posted to Internet/Intranet due to Confidentiality of Instructions |
| 4162 | Issued to a specific audience, not posted to Internet/Intranet due to Confidentiality of Instructions |
| 4163 | Issued to a specific audience, not posted to Internet/Intranet due to Confidentiality of Instructions |
| 4164 | Instructions for Retrieving the 2019 Pricing and Healthcare Common Procedure Coding System (HCPCS) Data Files through CMS' Mainframe Telecommunications Systems |
| 4165 | Calendar Year (CY) 2019 Participation Enrollment and Medicare Participating Physicians and Suppliers Directory (MEDPARD) Procedure |
| 4166 | Revisions to Medicare Claims Processing Manual Reference to Burn Medicare Severity-Diagnostic Related Groups (MS-DRGs) for Transfer Policy |
| 4167 | Remittance Advice Remark Code (RARC), Claims Adjustment Reason Code (CARC), Medicare Remit Easy Print (MREP) and PC Print Update |
| 4168 | Implement Operating Rules - Phase III Electronic Remittance Advice (ERA) Electronic Funds Transfer (EFT):<br>Committee on Operating Rules for Information Exchange (CORE) 360 Uniform Use of Claim Adjustment Reason Codes (CARC), Remittance Advice Remark Codes (RARC) and Claim Adjustment Group Code (CAGC) Rule – Update from Council for Affordable Quality Healthcare (CAQH) CORE |
| 4169 | New Waived Tests |
| 4170 | Quarterly Update of HCPCS Codes Used for Home Health Consolidated Billing Enforcement |
| 4171 | Instructions for Downloading the Medicare ZIP Code Files for April 2019 |
| 4172 | Ambulance Inflation Factor for Calendar Year 2019 and Productivity Adjustment |
| 4173 | Revision of Definition of the Physician Supervision of Diagnostic Procedures, Clarification of DSMT Telehealth Services, and Establishing a Modifier for Expanding the Use of Telehealth for Individuals with Stroke |
| 4174 | Issued to a specific audience, not posted to Internet/Intranet due to Confidentiality of Instructions |
| 4175 | Quarterly Update to the National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) Edits, Version 25.0 Effective January 1, 2019 |
| 4176 | Summary of Policies in the Calendar Year (CY) 2019 Medicare Physician Fee Schedule (MPFS) Final Rule, Telehealth Originating Site Facility Fee Payment Amount and Telehealth Services List, CT Modifier Reduction List, and Preventive Services List |
| 4177 | File Conversions Related to the Spanish Translation of the Healthcare Common Procedure Coding System (HCPCS) Descriptions |
| 4178 | Annual Update to the Per-Beneficiary Therapy Amounts |
| 4179 | Combined Common Edits/Enhancements Modules (CCEM) Code Set Update |
| 4180 | Issued to a specific audience, not posted to Internet/Intranet due to Sensitivity of Instructions |
| 4181 | Calendar Year (CY) 2019 Update for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule |
| 4182 | Calendar Year (CY) 2019 Annual Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment |
| 4183 | Claim Status Category and Claim Status Codes Update |
| 4184 | New Physician Specialty Code for Undersea and Hyperbaric Medicine |
| 4185 | January 2019 Integrated Outpatient Code Editor (I/OCE) Specifications Version 20.0 |
| 4186 | Issued to a specific audience, not posted to Internet/Intranet due to Sensitivity of Instructions |
| 4187 | Ensuring Only the Active Billing Hospice Can Submit a Revocation |
| 4188 | Medicare Claims Processing Manual Chapter 23 - Fee Schedule Administration and Coding Requirements |
| 4189 | Updates to Immunosuppressive Guidance |
| 4190 | Home Health Rural Add-on Payments Based on County of Residence |
| 4191 | January 2019 Update of the Ambulatory Surgical Center (ASC) Payment System |
| **Medicare Secondary Payer (CMS-Pub. 100-05)** | |
| | None |
| **Medicare Financial Management (CMS-Pub. 100-06)** | |
| 307 | Notice of New Interest Rate for Medicare Overpayments and Underpayments -1st Qtr Notification for FY 2019 |
| 308 | The Fiscal Year 2019 Updates for the Centers for Medicare & Medicaid Services (CMS) Internet Only Manual (IOM) Publication (Pub.) 100-06, Medicare Financial Management Manual, Chapter 7 - Internal Control Requirements |
| 309 | New Physician Specialty Code for Undersea and Hyperbaric Medicine |
| **Medicare State Operations Manual (CMS-Pub. 100-07)** | |
| 185 | Revisions to the State Operations Manual (SOM) Chapter 7 Survey Frequency: 15-Month Survey Interval and 12-Month State-wide Average Setting the Mandatory 3-Month and 6-Month Sanction Time Frames<br><br>Mandatory Immediate Imposition of Federal Remedies Criteria for Mandatory Immediate Imposition of Federal Remedies Prior to the Facility's Correction of Deficiencies<br>Effective Dates for Immediate Imposition of Federal Remedies<br>Responsibilities of the State Survey Agency and the CMS Regional Office (RO) when there is an Immediate Imposition of Federal Remedies |

| Medicare Program Integrity (CMS-Pub. 100-08) | |
|---|---|
| 829 | Glossary of Acronyms<br>LCD Definition and Statutory Authority for LCDs<br>LCD Process<br>General LCD Process Overview<br>Requests<br>Informal Meetings<br>New LCD Requests<br>New LCD Request Requirements<br>Proposed LCD<br>Proposed Decision and Posting of LCD Summary Sheet<br>Public Comment<br>Contractor Advisory Committee (CAC<br>Open Meeting<br>Final Determination<br>Response to Public Comment<br>Notice Period<br>Reconsideration Request<br>Web site Requirements for the LCD Reconsideration Process<br>Valid LCD Reconsideration Request Requirements<br>Process Requirements<br>Challenge of an LCD<br>LCD Content<br>General Requirements<br>Consultation<br>Consultation Summary<br>CAC Recommendations<br>Evidentiary Content<br>Reasonable and Necessary Provision in an LCD<br>Public Comment<br>Final Decision<br>Record |
| 830 | Issued to a specific audience, not posted to Internet/Intranet due to Confidentiality of Instructions |
| 831 | Update to Exhibit 16 - Model Payment Suspension Letters in Publication (Pub.) 100-08 |
| 832 | Modification to Chapter 6, Section 6.3 (Medical Review of Certification and Recertification of Residents in SNFs) of Publication (Pub.) 100-08<br>Medical Review of Certification and Recertification of Residents in SNFs |
| 833 | Templates in Medical Review<br>Progress Notes and Templates |
| 834 | Order Requirements When Prescribing Practitioner is Also the Supplier and is Permitted to Furnish Specific Items of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) |
| 835 | One-on-One Education |
| 836 | Medical Review of Diagnostic Laboratory Tests<br>Medical Review of Diagnostic Tests<br>Medical Review of Diagnostic Laboratory Tests |
| 837 | Issued to a specific audience, not posted to Internet/Intranet due to Confidentiality of Instructions |
| 838 | Issued to a specific audience, not posted to Internet/Intranet due to Confidentiality of Instructions |
| 839 | New Instructions for Home Health Agency Misuse of Requests for Anticipated Payments (RAPs)<br>Home Health Agency Misuse of Requests for Anticipated Payments<br>RAP Monitoring<br>Education and Additional Monitoring<br>Corrective Action Plans<br>Notification to the HHA<br>CAP Submission<br>CAP Acceptance and Monitoring<br>CAP Closeout<br>RAP Suppression<br>Notice of RAP Suppression<br>Monitoring During RAP Suppression<br>Result of Initial RAP Suppression Monitoring Period<br>Reinstatement of RAP Authorization<br>Continuation of RAP Suppression<br>Coordination and Referral to the UPIC |
| 840 | Issued to a specific audience, not posted to Internet/Intranet due to Confidentiality of Instruction |
| 841 | Issued to a specific audience, not posted to Internet/Intranet due to Confidentiality of Instructions |
| 842 | Issued to a specific audience, not posted to Internet/Intranet due to Confidentiality of Instructions |
| 843 | Issued to a specific audience, not posted to Internet/Intranet due to Confidentiality of Instructions |
| 844 | Issued to a specific audience, not posted to Internet/Intranet due to Confidentiality of Instructions |
| 845 | Issued to a specific audience, not posted to Internet/Intranet due to Confidentiality of Instructions |
| 846 | Issued to a specific audience, not posted to Internet/Intranet due to Confidentiality of Instructions |
| 847 | Issued to a specific audience, not posted to Internet/Intranet due to Confidentiality of Instructions |
| 848 | Update to Chapter 4, Section 4.18.1.4 and Exhibit 16 in Publication (Pub.) 100-08 |
| 849 | Issued to a specific audience, not posted to Internet/Intranet due to Confidentiality of Instructions |
| 850 | Medical Review of Diagnostic Laboratory Tests |
| 851 | Updates to Chapter 4 of Publication (Pub.) 100-08 |
| 852 | Update to Chapter 12 (The Comprehensive Error Rate Testing (CERT) Program) of Publication (Pub.) 100-08 (Medicare Program Integrity Manual) |
| **Medicare Contractor Beneficiary and Provider Communications (CMS-Pub. 100-09)** | |
| 40 | Medicare Contractor Beneficiary and Provider Communications Manual IOM Pub. 100-09 Chapter 5 Correct Coding Initiative |
| **Medicare Quality Improvement Organization (CMS- Pub. 100-10)** | |
| | None |

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| **Medicare End Stage Renal Disease Network Organizations (CMS Pub 100-14)** | |
| | None |
| **Medicaid Program Integrity Disease Network Organizations (CMS Pub 100-15)** | |
| | None |
| **Medicare Managed Care (CMS-Pub. 100-16)** | |
| | None |
| **Medicare Business Partners Systems Security (CMS-Pub. 100-17)** | |
| | None |
| **Demonstrations (CMS-Pub. 100-19)** | |
| 208 | Issued to a specific audience, not posted to Internet/Intranet due to Sensitivity of Instructions |
| 209 | Issued to a specific audience, not posted to Internet/Intranet due to Sensitivity of Instructions |
| 210 | Next Generation Accountable Care Organization (ACO) Model 2019 Benefit Enhancement |
| 211 | Issued to a specific audience, not posted to Internet/Intranet due to Sensitivity of Instructions |
| 212 | Issued to a specific audience, not posted to Internet/Intranet due to Sensitivity of Instructions |
| 213 | Next Generation Accountable Care Organization (NGACO) Model Post Discharge Home Visit HCPCS |
| 214 | Issued to a specific audience, not posted to Internet/Intranet due to Sensitivity of Instructions |
| 215 | Next Generation Accountable Care Organization (NGACO) Model Post Discharge Home Visit HCPCS |
| 216 | Next Generation Accountable Care Organization (NGACO) Model Post Discharge Home Visit HCPCS |
| **One Time Notification (CMS-Pub. 100-20)** | |
| 2144 | User CR: FISS to Add Location/Statuses to the 6H File Fix |
| 2145 | Shared System Enhancement 2018: Implementation of the Medicare Summary Notice (MSN) Zip Code Analyzer Tool |
| 2146 | Update to Common Working File (CWF) Benefit Period Logic for Occurrence Code 22 on Skilled Nursing Facility (SNF) and Swing Bed Inpatient Claims |
| 2147 | Update to the Long Description for Spanish Records on The Procedure Descriptor Master File for all Adds and Updates That Were Not Loaded with Change Request (CR) 10286 |
| 2148 | Claim Based Incentive Programs - Non-Assigned Claim Update |
| 2149 | Analysis to Implement the Skilled Nursing Facility (SNF) Patient Driven Payment Model (PDPM) |
| 2150 | Issued to a specific audience, not posted to Internet/ Intranet due to Sensitivity of Instructions |
| 2151 | Updating Calendar Year (CY) 2019 Medicare Diabetes Prevention Program (MDPP) Payment Rates |
| 2152 | Procedures for Shared Systems to Handle Foreign (non US) Addresses |
| 2153 | Medicare Cost Report E-Filing (MCReF) |
| 2154 | Shared System Enhancement 2018: Streamline National Provider Identifier (NPI) Processing in the VIPS Medicare System (VMS) |
| 2155 | Issued to a specific audience, not posted to Internet/ Intranet due to Sensitivity of Instructions |
| 2156 | Update to Common Working File (CWF) Edit of Medicare Advantage (MA) Enrollees' Inpatient Claims from Approved Teaching Hospitals Billed with Indirect Medical Education (IME) or Coverage with Evidence Development (CED |
| 2157 | Systems Changes to Address Acute Kidney Injury (AKI) Claims and Outlier Payments |
| 2158 | Shared System Enhancement 2018: Establish Beneficiary Data Streaming (BDS) Log Files |
| 2159 | Shared System Enhancement 2018: Remove Remaining Obsolete Access Restriction by Granular User Services (ARGUS) Processing |
| 2160 | Shared System Enhancement 2018: Eliminate action code logic |
| 2161 | Correct the CWF Handling of Beneficiaries with 14+ MSP Occurrences for HETS Shared System Enhancement 2018: Remove Default Automated Development System (ADS) and Field ADS Questions |
| 2162 | Modify Common Working File (CWF) Editing to Apply Code G0476 to Female Beneficiaries Only |
| 2163 | Shared System Enhancement 2018 ViPS Medicare Systems (VMS): Streamline the use of Assembler Language Code (ALC) Modules |
| 2164 | Shared System Enhancement 2018: Enhance Common Working File (CWF) Data Extract Process |
| 2165 | Fiscal Intermediary Shared System (FISS) AGILE Development and Implementation of Application Programming Interface (API) for Medicare Administrative Contractors (MACs) |
| 2166 | Shared System Enhancement 2018: Enhance Common Working File (CWF) Internal Testing Facility (ITF) Response Records |
| 2167 | Decommissioning of the Client Letter Application within VIPS Medicare System (VMS) |
| 2168 | Provider Enrollment Chain and Ownership System (PECOS) Data Source Change |
| 2169 | Issued to a specific audience, not posted to Internet/Intranet due to Sensitivity of Instructions |
| 2170 | Analysis of the Combined Common Edits/Enhancements Module (CCEM) and Intelligent Data Stream (IDS) Reporting Software to Ensure Effective Operation Under Java Version 8 |
| 2171 | Analysis to Implement Changes to Regulations Allowing Inpatient Prospective Payment System (IPPS)-Excluded Hospitals to Operate IPPS-Excluded Units |
| 2172 | Shared System Enhancement 2018: Remove Obsolete VIPS Medicare System (VMS) logic Related to the ViPS Medicare Automated Parameter (VMAP) Carrier Parameter Table |
| 2173 | Shared System Enhancement 2018: Renovate 2029 Serial Date Processing – Analysis Only |
| 2174 | Correction to Common Working File (CWF) Informational Unsolicited Response (IUR) 7272 for Intervening Stay |
| 2175 | Shared System Enhancement 2018: Establish a HMBI Query/Response Log |
| 2176 | Revision of Skilled Nursing Facility (SNF) Consolidated Billing (CB) Edits for Ambulance Services Rendered to Beneficiaries in a Part A SNF Stay |

| | |
|---|---|
| 2177 | Issued to a specific audience, not posted to Internet/ Intranet due to Sensitivity of Instructions |
| 2178 | Removal of the Provider Requirement for Reporting on an Institutional Claim a Value Code (VC) 05 - Professional Component-Split Implementation |
| 2179 | User Change Request (CR): ViPS Medicare System (VMS) Changes to Edit Dispensing and Supply Fee Codes Allowed when Related Drug Codes are Denied in Batch |
| 2180 | FISS Integrated Outpatient Code Editor (IOCE) Claim and Return Buffer Interface Changes Related to new Contractor Line Level Bypass Updates |
| 2181 | User CR: ViPS Medicare System (VMS) Changes to Bypass Claim Edit 0192 on an Adjustment Claim when Payment was Suppressed on the Previous Adjustment |
| 2182 | User Change Request (CR): Multi-Carrier System (MCS) - Analysis to Enhance the Maximum Claim Counter Process for Edits and Audits |
| 2183 | Shared System Enhancement 2018: Move Authorized Reason Code Override Processing to FSSBSTUF |
| 2184 | Issued to a specific audience, not posted to Internet/Intranet due to Sensitivity of Instructions |
| 2185 | User Change Request (CR): Multi-Carrier System (MCS) - Enhance System Control Facility (SCF) to Add Fraud Prevention System (FPS) Criteria |
| 2186 | Redesign of Flu Vaccines in Fiscal Intermediary Shared System (FISS) Shared System Enhancement 2018: Analysis to Minimize Data for Medicare Beneficiary Database (MBD) Extract |
| 2187 | Shared System Enhancement 2018: Rewrite Fiscal Intermediary Shared System (FISS) module FSSB6001, Common Working File (CWF) Unsolicited Response Function |
| 2188 | Fiscal Intermediary Standard System (FISS) Prepayment Review Report |
| 2189 | User CR: Update FISS Utility to Retain Original Claim Receipt Date |
| 2190 | Shared System Enhancement 2018: Improve Organization of the International Code of Diseases, Tenth Revision (ICD-10) File during Creation |
| 2191 | Multi-Carrier System (MCS) Prepayment Review File |
| 2192 | Implementation of Healthcare Common Procedure Coding System (HCPCS) Code J3591 and Additional Changes for End Stage Renal Disease (ESRD) Claims |
| 2193 | Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Update |
| 2194 | Medicare Cost Report E-Filing (MCReF) |
| 2195 | Analysis to Discuss and Resolve the Challenges Around the Design of (Pre-/Post-Pay) Electronic Medical Documentation Requests (eMDR) via the Electronic Submission of Medical Documentation (esMD) System |
| 2196 | Analysis to Create a Standard Coded List of Document Types to be used by Review Contractors (RC) for Requesting Documentation in Pre-Pay and Post-Pay Additional Documentation Request (ADR) Letters (and/or Electronic Medical Documentation Requests (eMDR) via the Electronic Submission of Medical Documentation (esMD) System) |
| 2197 | ViPS Medicare System (VMS) Prepayment Review File |
| 2198 | Enhancing the Verification Process of Common Working File (CWF) Part A Provider Inquiries |
| 2199 | Appeon PowerBuilder Upgrade Analysis Only |
| 2200 | International Classification of Diseases, Tenth Revision (ICD-10) and Other Coding Revisions to National Coverage Determinations (NCDs) |
| 2202 | International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs) |
| 2203 | User CR: FISS to Add Location/Statuses to the 6H File Fix |
| 2204 | Update to the Long Description for Spanish Records on The Procedure Descriptor Master File for all Adds and Updates That Were Not Loaded with Change Request (CR) 10286 |
| 2205 | Issued to a specific audience, not posted to Internet/Intranet due to Sensitivity of Instructions |
| 2206 | Implementation of a Bundled Payment for Multi-Component Durable Medical Equipment (DME) |
| 2207 | Targeted Probe and Educate |
| 2208 | Implementing the Insertion of a Sheet of Paper Promoting the Electronic Medicare Summary Notices (eMSNs) into Mailed Medicare Summary Notices (MSNs) |
| 2209 | Implementing the Insertion of a Sheet of Paper Promoting the Electronic Medicare Summary Notices (eMSNs) into Mailed Medicare Summary Notices (MSNs) |
| 2210 | Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Update |
| 2211 | Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Update |
| 2212 | New CWF Edit for Part A Outpatient Medicare Advantage (MA), Health Maintenance Organization (HMO) |
| 2213 | Implementing the Revised Patient's Request for Medical Payment Form CMS-1490S, Version 01/18 |
| 2214 | Transitioning the Pricing, Data Analysis and Coding (PDAC) to the New Contractor |
| 2215 | Analysis of the Combined Common Edits/Enhancements Module (CCEM) and MSSQL and Oracle Relational Data Base Management Systems |
| 2216 | Clarification of Part B Recovery Audit Contractor (RAC) Appeals Case File Sharing Process |
| 2217 | Multi-Carrier System (MCS) Prepayment Review File |
| **Medicare Quality Reporting Incentive Programs (CMS-Pub. 100-22)** | |
| 80 | Issued to a specific audience, not posted to Internet/Intranet due to Confidentiality of Instructions |
| 81 | Issued to a specific audience, not posted to Internet/Intranet due to Confidentiality of Instructions |
| **Information Security Acceptable Risk Safeguards (CMS-Pub. 100-25)** | |
| | None |

## Addendum II: Regulation Documents Published in the Federal Register (October through December 2018)

Regulations and Notices

Regulations and notices are published in the daily **Federal Register**. To purchase individual copies or subscribe to the **Federal**

**Register,** contact GPO at www.gpo.gov/fdsys. 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 available 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) through the present date and can be accessed at http://www.gpoaccess.gov/fr/index.html. The following website http://www.archives.gov/federal-register/ provides information on how to access electronic editions, printed editions, and reference copies.

This information is available on our website at: http://www.cms.gov/quarterlyproviderupdates/downloads/Regs-3Q18QPU.pdf

For questions or additional information, contact Terri Plumb (410-786-4481).

### Addendum III: CMS Rulings (October through December 2018)

CMS Rulings are decisions of the Administrator that serve as precedent final opinions and orders and statements of policy and interpretation. They provide clarification and interpretation of complex or ambiguous provisions of the law or regulations relating to Medicare, Medicaid, Utilization and Quality Control Peer Review, private health insurance, and related matters.

The rulings can be accessed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Rulings. For questions or additional information, contact Tiffany Lafferty (410-786-7548).

### Addendum IV: Medicare National Coverage Determinations (October through December 2018)

Addendum IV includes completed national coverage determinations (NCDs), or reconsiderations of completed NCDs, from the quarter covered by this notice. Completed decisions are identified by the section of the NCD Manual (NCDM) in which the decision appears, the title, the date the publication was issued, and the effective date of the decision. An NCD is a determination by the Secretary for whether or not a particular item or service is covered nationally under the Medicare Program (title XVIII of the Act), but does not include a determination of the code, if any, that is assigned to a particular covered item or service, or payment determination for a particular covered item or service. The entries below include information concerning completed decisions, as well as sections on program and decision memoranda, which also announce decisions or, in some cases, explain why it was not appropriate to issue an NCD. Information on completed decisions as well as pending decisions has also been posted on the CMS website. For the purposes of this quarterly notice, we are providing only the specific updates that have occurred in the 3-month period. There were no national coverage determinations (NCDs), or reconsiderations of completed NCDs published in the 3-month period. This information is available at: www.cms.gov/medicare-coverage-database/. For questions or additional information, contact Wanda Belle, MPA (410-786-7491).

| Title | NCDM Section | Transmittal Number | Issue Date | Effective Date |
|---|---|---|---|---|
| Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery | NCD 20.35 | 211 | 12/13/2018 | 02/15/2018 |
| National Coverage Determination (NCD90.2): Next Generation Sequencing (NGS) | NCD 90.2 | 210 | 11/30/2018 | 03/16/2018 |

### Addendum V: FDA-Approved Category B Investigational Device Exemptions (IDEs) (October through December 2018)

(Inclusion of this addenda is under discussion internally.)

### Addendum VI: Approval Numbers for Collections of Information (October through December 2018)

All approval numbers are available to the public at Reginfo.gov. Under the review process, approved information collection requests are assigned OMB control numbers. A single control number may apply to several related information collections. This information is available at www.reginfo.gov/public/do/PRAMain. For questions or additional information, contact William Parham (410-786-4669).

### Addendum VII: Medicare-Approved Carotid Stent Facilities, (October through December 2018)

Addendum VII includes listings of Medicare-approved carotid stent facilities. All facilities listed meet CMS standards for performing carotid artery stenting for high risk patients. On March 17, 2005, we issued our decision memorandum on carotid artery stenting. We determined that

carotid artery stenting with embolic protection is reasonable and necessary only if performed in facilities that have been determined to be competent in performing the evaluation, procedure, and follow-up necessary to ensure optimal patient outcomes. We have created a list of minimum standards for facilities modeled in part on professional society statements on competency. All facilities must at least meet our standards in order to receive coverage for carotid artery stenting for high risk patients. For the purposes of this quarterly notice, we are providing only the specific updates that have occurred in the 3-month period. This information is available at: http://www.cms.gov/MedicareApprovedFacilitie/CASF/list.asp#TopOfPage For questions or additional information, contact Sarah Fulton, MHS (410-786-2749).

| Facility | Provider Number | Effective Date | State |
|---|---|---|---|
| **The following facilities are new listings for this quarter.** | | | |
| Northside Hospital - Forsyth<br>1200 Northside Forsyth Drive<br>Cummings, GA 30041 | 110005 | 10/15/2018 | GA |
| Northside Hospital - Cherokee<br>450 Northside Cherokee Boulevard<br>Canton, GA 30115 | 110008 | 10/15/2018 | GA |
| Blessing Hospital<br>1005 Broadway Quincy, IL 62301 | 1760571699 | 11/30/2018 | IL |
| New York-Presbyterian/Weill Cornell Medical Center (NYP/WC)<br>525 East 68th Street<br>New York, NY 10021 | 330101 | 05/05/2005 | NY |
| **The following facilities have editorial changes (in bold).** | | | |
| **New York-Presbyterian/Columbia University Medical Center<br>622 West 168th Street<br>New York, NY 10032** | 330101 | 05/05/2005 | NY |
| **The following facility has been removed.** | | | |
| Tennova Healthcare – Physicians Regional Medical Center<br>900 E. Oak Hill Avenue<br>Knoxville, TN 37917 | 440120 | 10/11/2005 | TN |

## Addendum VIII: American College of Cardiology's National Cardiovascular Data Registry Sites (October through December 2018)

The initial data collection requirement through the American College of Cardiology's National Cardiovascular Data Registry (ACC-NCDR) has served to develop and improve the evidence base for the use of ICDs in certain Medicare beneficiaries. The data collection requirement ended with the posting of the final decision memo for Implantable Cardioverter Defibrillators on February 15, 2018.

For questions or additional information, contact Sarah Fulton, MHS (410-786-2749).

## Addendum IX: Active CMS Coverage-Related Guidance Documents (October through December 2018)

CMS issued a guidance document on November 20, 2014 titled "Guidance for the Public, Industry, and CMS Staff: Coverage with Evidence Development Document". Although CMS has several policy vehicles relating to evidence development activities including the investigational device exemption (IDE), the clinical trial policy, national coverage determinations and local coverage determinations, this guidance document is principally intended to help the public understand CMS's implementation of coverage with evidence development (CED) through the national coverage determination process. The document is available at http://www.cms.gov/medicare-coverage-database/details/medicare-coverage-document-details.aspx?MCDId=27. There are no additional Active CMS Coverage-Related Guidance Documents for the 3-month period. For questions or additional information, contact JoAnna Baldwin, MS (410-786-7205).

## Addendum X: List of Special One-Time Notices Regarding National Coverage Provisions (October through December 2018)

There were no special one-time notices regarding national coverage provisions published in the 3-month period. This information is available at www.cms.hhs.gov/coverage. For questions or additional information, contact JoAnna Baldwin, MS (410-786 7205).

## Addendum XI: National Oncologic PET Registry (NOPR) (October through December 2018)

Addendum XI includes a listing of National Oncologic Positron Emission Tomography Registry (NOPR) sites. We cover positron emission tomography (PET) scans for particular oncologic indications when they are performed in a facility that participates in the NOPR.

In January 2005, we issued our decision memorandum on **positron emission tomography** (PET) scans, which stated that CMS would cover PET scans for particular oncologic indications, as long as they were

performed in the context of a clinical study. We have since recognized the National Oncologic PET Registry as one of these clinical studies. Therefore, in order for a beneficiary to receive a Medicare-covered PET scan, the beneficiary must receive the scan in a facility that participates in the registry. There were no additions, deletions, or editorial changes to the listing of National Oncologic Positron Emission Tomography Registry (NOPR) in the 3-month period. This information is available at http://www.cms.gov/MedicareApprovedFacilitie/NOPR/list.asp#TopOfPage. For questions or additional information, contact Stuart Caplan, RN, MAS (410-786-8564).

### Addendum XII: Medicare-Approved Ventricular Assist Device (Destination Therapy) Facilities (October through December 2018)

Addendum XII includes a listing of Medicare-approved facilities that receive coverage for ventricular assist devices (VADs) used as destination therapy. All facilities were required to meet our standards in order to receive coverage for VADs implanted as destination therapy. On October 1, 2003, we issued our decision memorandum on VADs for the clinical indication of destination therapy. We determined that VADs used as destination therapy are reasonable and necessary only if performed in facilities that have been determined to have the experience and infrastructure to ensure optimal patient outcomes. We established facility standards and an application process. All facilities were required to meet our standards in order to receive coverage for VADs implanted as destination therapy.

For the purposes of this quarterly notice, we are providing only the specific updates to the list of Medicare-approved facilities that meet our standards that have occurred in the 3-month period. This information is available at http://www.cms.gov/MedicareApprovedFacilitie/VAD/list.asp#TopOfPage. For questions or additional information, contact David Dolan, JD, (410-786-3365).

| Facility | Provider Number | Date of Initial Certification | Date of Recertification | State |
|---|---|---|---|---|
| **The following facilities are new listings for this quarter.** | | | | |
| George Washington University Hospital<br>900 23rd Street, NW<br>Washington, DC 20037 | 090001 | 09/12/2018 | | DC |
| Other information: Joint Commission ID # 6310 | | | | |
| Jersey Shore University Medical Center<br>1945 Route 33<br>Neptune City, NJ 07753<br><br>Other information: DNV Certificate #: 277447-2018-VAD | 310073 | 10/16/2018 | | NJ |
| Rochester General Hospital<br>1425 Portland Avenue<br>Rochester, NY 14621<br><br>DNV GL Certificate #: 278376-2018-VAD | 330125 | 10/29/2018 | | NY |
| **The following facilities have editorial changes (in bold).** | | | | |
| **PeaceHealth St. Joseph Medical Center**<br>**2901 Squalicum Pakrway**<br>**Bellingham, WA 98225**<br><br>**Other information: Joint Commission ID #9574**<br><br>**Joint Commission Withdrawal Date: 2018-10-01** | 500030 | 09/17/2014 | 10/18/2016 | WA |
| Froedtert Memorial Lutheran Hospital<br>9200 West Wisconsin Avenue<br>Milwaukee, WI 53226<br><br>Other information: Joint Commission ID #7718<br><br>Previous Re-certification Dates: 2014-07-08; 2016-08-09 | 520177 | 08/01/2012 | **08/08/2018** | WI |
| **FROM: South Broward Hospital District DBA Memorial Regional Hospital**<br>**TO: Memorial Regional Hospital**<br><br>3501 Johnson Street<br>Hollywood, FL 33021<br><br>Other Information: | 100038 | 08/20/2014 | **08/15/2018** | FL |

| Facility | Provider Number | Date of Initial Certification | Date of Recertification | State |
|---|---|---|---|---|
| Joint Commission 6811<br><br>Previous Re-certification Dates: 2016-08-11 | | | | |
| **FROM: University Hospitals and Health System**<br>**TO: University of Mississippi Medical Center**<br>2500 North State Street<br>Jackson, MS 39216<br><br>Other information:<br>Joint Commission ID #8064 | 250001 | 08/17/2016 | **08/08/2018** | MS |
| Advocate Christ Medical Center.<br>4440 W. 95th Street<br>Oak Lawn, IL 60505<br><br>DNV Certificate #: 277350-2018-VAD | 140208 | 09/28/2005 | **10/01/2018** | IL |
| Sharp Memorial Hospital<br>7901 Frost Street<br>San Diego, CA 92123<br><br>Other information:<br>Joint Commission ID #3910<br><br>Previous Re-certification Dates: 2008-07-18; 2010-06-29; 2012-08-14; 2014-09-09; 2016-08-09 | 050100 | 12/01/2003 | **08/15/2018** | CA |
| Scripps Memorial Hospital – La Jolla<br>9888 Genesee Avenue<br>La Jolla, CA 92037<br><br>Other information:<br>Joint Commission ID #9880<br><br>VAD Previous Re-certification Dates: 2014-09-09; 2016-10-08 | 050324 | 11/16/2012 | **10/24/2018** | DC |
| Maimonides Medical Center<br>4802 Tenth Avenue<br>Brooklyn, NY 11219<br><br>Other information:<br>Joint Commission ID #5734 | 330194 | 08/24/2012 | **10/11/2018** | NY |
| VAD Previous Re-certification Dates: 2014-07-29; 2016-09-13 | | | | |
| Kaiser Sunnyside Medical Center<br>10180 SE Sunnyside Road<br>Clackamas, OR 97015<br><br>Other information:<br>Joint Commission ID #4858 | 380091 | 09/14/2016 | **09/19/2018** | OR |
| University of Maryland Medical Center<br>22 S Greene Street<br>Baltimore, MD 21201<br><br>Other information:<br>Joint Commission ID #6264<br><br>VAD Previous Re-certification Dates: 2008-09-16; 2010-08-25; 2012-08-15; 2014-08-19; 2016-09-20 | 210002 | 11/12/2003 | **09/26/2018** | MD |
| **FROM: Indiana University Health, Inc. (Methodist Hospital)**<br>**TO: Indiana University Health Methodist Hospital**<br>1701 N. Senate Boulevard<br>Indianapolis, IN 46206<br><br>Other information:<br>Joint Commission ID #188549<br><br>VAD Previous Re-certification Dates: 2008-10-06; 2010-08-17; 2012-08-17; 2014-08-19; 2016-10-04 | 340002 | 09/28/2016 | **09/19/2018** | IN |

| Facility | Provider Number | Date of Initial Certification | Date of Recertification | State |
|---|---|---|---|---|
| **FROM: North Shore University Health System TO: North Shore University Hospital** 300 Community Drive Manhasset, NY 11030<br><br>Other information: Joint Commission ID #2091<br><br>**Previous Re-certification Dates: 2008-03-27; 2010-03-18; 2012-03-07; 2014-02-04; 2016-03-15** | 330106 | 09/28/2016 | **09/19/2018** | NY |
| Maine Medical Center 22 Bramhall Street Portland, ME 04102<br><br>Other information: Joint Commission ID #5445<br><br>VAD Previous Re-certification Dates: 2016-09-28 | 200009 | 02/03/2009 | **10/03/2018** | ME |
| Mercy Hospital Springfield 1235 East Cherokee Springfield, MO 65804<br><br>**Other information: Joint Commission ID #4234**<br><br>**Joint Commission Withdrawal Date: 2018-12-06** | 260065 | 02/11/2015 | 04/04/2017 | MO |

## Addendum XIII: Lung Volume Reduction Surgery (LVRS) (October through December 2018)

Addendum XIII includes a listing of Medicare-approved facilities that are eligible to receive coverage for lung volume reduction surgery. Until May 17, 2007, facilities that participated in the National Emphysema Treatment Trial were also eligible to receive coverage. The following three types of facilities are eligible for reimbursement for Lung Volume Reduction Surgery (LVRS):

- National Emphysema Treatment Trial (NETT) approved (Beginning 05/07/2007, these will no longer automatically qualify and can qualify only with the other programs);
- Credentialed by the Joint Commission (formerly, the Joint Commision on Accreditation of Healthcare Organizations (JCAHO)) under their Disease Specific Certification Program for LVRS; and
- Medicare approved for lung transplants.

Only the first two types are in the list. There were no editorial updates to the listing of facilities for lung volume reduction surgery published in the 3-month period. This information is available at www.cms.gov/MedicareApprovedFacilitie/LVRS/list.asp#TopOfPage. For questions or additional information, contact Sarah Fulton, MHS (410-786-2749).

## Addendum XIV: Medicare-Approved Bariatric Surgery Facilities (October through December 2018)

Addendum XIV includes a listing of Medicare-approved facilities that meet minimum standards for facilities modeled in part on professional society statements on competency. All facilities must meet our standards in order to receive coverage for bariatric surgery procedures. On February 21, 2006, we issued our decision memorandum on bariatric surgery procedures. We determined that bariatric surgical procedures are reasonable and necessary for Medicare beneficiaries who have a body-mass index (BMI) greater than or equal to 35, have at least one co-morbidity related to obesity and have been previously unsuccessful with medical treatment for obesity. This decision also stipulated that covered bariatric surgery procedures are reasonable and necessary only when performed at facilities that are: (1) certified by the American College of Surgeons (ACS) as a Level 1 Bariatric Surgery Center (program standards and requirements in effect on February 15, 2006); or (2) certified by the American Society for Bariatric Surgery (ASBS) as a Bariatric Surgery Center of Excellence (BSCOE) (program standards and requirements in effect on February 15, 2006).

There were no additions, deletions, or editorial changes to Medicare-approved facilities that meet CMS' minimum facility standards for bariatric surgery that have been certified by ACS and/or ASMBS in the 3-month period. This information is available at www.cms.gov/MedicareApprovedFacilitie/BSF/list.asp#TopOfPage. For questions or additional information, contact Sarah Fulton, MHS (410-786-2749).

[FR Doc. 2019–02672 Filed 2–15–19; 8:45 am]

**BILLING CODE 4120–01–C**

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Centers for Medicare & Medicaid Services

**[CMS–3364–FN]**

### Application From the Joint Commission (TJC) for Continued Approval of Its Psychiatric Hospital Accreditation Program

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

**ACTION:** Final notice.

**SUMMARY:** This final notice announces our decision to approve the Joint Commission for continued recognition as a national accrediting organization for psychiatric hospitals that wish to participate in the Medicare or Medicaid programs.

**DATES:** The approval announced in this final notice is effective February 25, 2019 through February 25, 2023.

**FOR FURTHER INFORMATION CONTACT:** Mary Ellen Palowitch (410) 786–4496, Monda Shaver (410) 786–3410, Tara Lemons (410) 786–3030.

**SUPPLEMENTARY INFORMATION:**

### I. Background

Under the Medicare program, eligible beneficiaries may receive covered services from a psychiatric hospital provided certain requirements are met. Section 1861(f) of the Social Security Act (the Act) establishes distinct criteria for facilities seeking designation as a psychiatric hospital. Regulations concerning provider agreements are at 42 CFR part 489 and those pertaining to activities relating to the survey and certification of facilities are at 42 CFR part 488. The regulations at 42 CFR part 482 subparts A, B, C and E specify the minimum conditions that a psychiatric hospital must meet to participate in the Medicare program, the scope of covered services and the conditions for Medicare payment for psychiatric hospitals.

Generally, to enter into an agreement, a psychiatric hospital must first be certified by a State Survey Agency as complying with the conditions or requirements set forth in part 482 subpart A, B, C and E of our regulations. Thereafter, the psychiatric hospital is subject to regular surveys by a State Survey Agency to determine whether it continues to meet these requirements. There is an alternative, however, to surveys by State agencies.

Section 1865(a)(1) of the Act provides that, if a provider entity demonstrates through accreditation by an approved national accrediting organization that all applicable Medicare conditions are met or exceeded, we may treat the provider entity as having met those conditions, that is, we may ''deem'' the provider entity as having met the requirements. Accreditation by an accrediting organization is voluntary and is not required for Medicare participation.

If an accrediting organization is recognized by the Secretary of the Department of Health and Human Services as having standards for accreditation that meet or exceed Medicare requirements, any provider entity accredited by the national accrediting body's approved program may be deemed to meet the Medicare conditions. A national accrediting organization applying for approval of its accreditation program under part 488, subpart A, must provide the Centers for Medicare & Medicaid Services (CMS) with reasonable assurance that the accrediting organization requires the accredited provider entities to meet requirements that are at least as stringent as the Medicare conditions. Our regulations concerning the approval of accrediting organizations are set forth at § 488.5. The regulations at § 488.5(e)(2)(i) require accrediting organizations to reapply for continued approval of its accreditation program every 6 years or sooner as determined by CMS.

The Joint Commission's current term of approval for their psychiatric hospital accreditation program expires February 25, 2019.

### II. Application Approval Process

Section 1865(a)(3)(A) of the Act provides a statutory timetable to ensure that our review of applications for CMS-approval of an accreditation program is conducted in a timely manner. The Act provides us 210 days after the date of receipt of a complete application, with any documentation necessary to make the determination, to complete our survey activities and application process. Within 60 days after receiving a complete application, we must publish a notice in the **Federal Register** that identifies the national accrediting body making the request, describes the request, and provides no less than a 30-day public comment period. At the end of the 210-day period, we must publish a notice in the **Federal Register** approving or denying the application.

### III. Provisions of the Proposed Notice

On August 15, 2018, we published a proposed notice in the **Federal Register** (83 FR 40514), announcing the Joint Commission's (TJC's) request for continued approval of its Medicare psychiatric hospital accreditation