

ADDENDUM III.—MEDICARE AND MEDICAID MANUAL INSTRUCTIONS
[April 2003 Through June 2003]

Transmittal No.	Manual/Subject/Publication No.
Intermediary Manual Part 3—Audits, Reimbursement Program Administration (CMS Pub. 13–3) (Superintendent of Documents No. HE 22.8/6)	
1879	• Clinical Diagnostic Laboratory Services Other Than To Inpatients Screening Pap Smears and Pelvic Examinations
1880	• Autologous Stem Cell Transplantation
1881	• Review of Form HCFA–1450 for Inpatient and Outpatient Bills
1882	• Frequency of Billing
1883	• Magnetic Resonance Angiography
1884	• Telehealth Services
1885	• Medicare Payment for Telehealth Services
1886	• Payment Without Common Working File Approval
1887	• Filing a Request for Payment Request for Payment Filing Claims for Payment Time Limits for Requests and Claims for Payment for Services Reimbursed Effects on Beneficiary and Provider of Beneficiary's Refusal to File a Request for Payment Filing Claims Where Usual Time Limit Has Expired Claims for Payment for Emergency Hospital Services and Services Outside the United States Appeals Time Limits for Filing Part B Reasonable Charge Claims Claims Processing Timeliness Time Limitations for Filing Provider Claims Incomplete or Invalid Claims Addendum L Paper and Electronic Data Element Requirements Bill Type Codes and Allowable Provider Numbers
1888	• Screening Pap Smears and Screening Pelvic Examinations
1889	• Billing of the Diagnosis and Treatment of Peripheral Neuropathy With Loss of Protective Sensation in People With Diabetes
1890	• Coverage and Billing of Sacral Nerve Stimulation Deep Brain Stimulation for Essential Tremor and Parkinson's Disease
1891	• International Classification of Diseases 9th Edition Clinical Modification Coding for Diagnostic Tests
Carriers Manual Part 3—Program Administration (CMS Pub. 14–3) (Superintendent of Documents No. HE 22.8/7)	
1793	• Incident to Physician's Professional Services (Subsection A—Commonly Furnished in Physicians' Offices)
1794	• The "Do Not Forward" Initiative (Subsection C—Internal Revenue Services—1099 Reporting)
1795	• Magnetic Resonance Angiography Coverage Summary Coding Requirements
1796	• Skilled Nursing Facility Consolidated Billing Determining the End of a Skilled Nursing Facility Stay Types of Facilities Included in and Excluded From Consolidated Billing Types of Services Included in and Excluded From Consolidated Billing Risk-Based Health Maintenance Organization Beneficiaries Clarification of Ambulance Services Information on a Skilled Nursing Facility Contracting With Outside Entities for Services Carrier Claims Processing Special Requirements for Claims for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Revisions to Common Working File Edits 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
1797	• Telehealth Claims
1798	• Medicare Payment for Telehealth Services
1799	• Payment Limit for Certain Drugs and Biologicals Procedures for Determining Payment Limit Injection Services Mandatory Assignment for Drugs and Biologicals
1800	• Drugs and Biologicals Definition of Drug or Biological Determining Self-Administration of Drugs or Biologicals Incident-To Requirements
1801	• Healthcare Common Procedure Coding System Coding Common Working File Edits for Flu and Pneumonia Claims Administrative Bulletin Crossover Edit Payment Requirements No Legal Obligation To Pay Roster Billing Health Maintenance Organization Processing