

15-month rental period, beginning January 1, 1994, if an item has been paid for under the frequent and substantial servicing class and is subsequently paid for under another payment class, the rental period begins with the first month of continuous rental, even if that period began before January 1, 1994. For example, if the rental period began on July 1, 1993, the carrier must use this date as beginning the first month of rental. Likewise, for purposes of calculating the 10-month purchase option, the rental period begins with the first month of continuous rental without regard to when that period started. For example, if the rental period began in August 1993, the 10-month purchase option must be offered to the beneficiary in May 1994, the tenth month of continuous rental.

4. In § 414.228, the introductory text for paragraphs (b) and (b)(2) are republished, paragraph (b)(2)(ii) is revised, and new paragraphs (b)(2)(iii) and (b)(2)(iv) are added, to read as follows:

§ 414.228 Prosthetic and orthotic devices.

* * * * *

(b) *Fee schedule amounts.* The fee schedule amount for prosthetic and orthotic devices is determined as follows:

* * * * *

(2) The carrier determines a local purchase price equal to the following:

* * * * *

(ii) For 1991 through 1993, the local purchase price for the preceding year is adjusted by the applicable percentage increase for the year. The applicable percentage increase is equal to 0 percent for 1991. For 1992 and 1993, the applicable percentage increase is equal to the percentage increase in the CPI-U for the 12-month period ending with June of the previous year.

(iii) For 1994 and 1995, the applicable percentage increase is 0 percent.

(iv) For all subsequent years the applicable percentage increase is equal to the percentage increase in the CPI-U for the 12-month period ending with June of the previous year.

* * * * *

5. In § 414.229, the section heading is revised, the introductory text for paragraph (c) is republished and paragraph (c)(3) is revised, to read as follows:

§ 414.229 Other durable medical equipment—capped rental items.

* * * * *

(c) *Determination of purchase price.* The purchase price of other covered

durable medical equipment is determined as follows:

* * * * *

(3) *For years after 1991.* The purchase price is determined using the methodology contained in paragraphs (d) through (f) of § 414.220.

* * * * *

6. In § 414.232, paragraph (a) is revised to read as follows:

§ 414.232 Special payment rules for transcutaneous electrical nerve stimulators (TENS).

(a) *General payment rule.* Except as provided in paragraph (b) of this section, payment for TENS is made on a purchase basis with the purchase price determined using the methodology for purchase of inexpensive or routinely purchased items as described in § 414.220. The payment amount for TENS computed under § 414.220(c)(2) is reduced according to the following formula:

(1) Effective April 1, 1990—the original payment amount is reduced by 15 percent.

(2) Effective January 1, 1991—the reduced payment amount in paragraph (a)(1) is reduced by 15 percent.

(3) Effective January 1, 1994—the reduced payment amount in paragraph (a)(1) is reduced by 45 percent.

* * * * *

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

Dated: June 28, 1995.

Bruce C. Vladek,

Administrator, Health Care Financing Administration.

[FR Doc. 95-16805 Filed 7-7-95; 8:45 am]

BILLING CODE 4120-01-P

42 CFR Part 433

[MB-39-F]

RIN: 0938-AF11

Medicaid Program; Third Party Liability (TPL) Cost-Effectiveness Waivers

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Final rule.

SUMMARY: This final rule revises regulations concerning Medicaid agencies' actions where third party liability (TPL) may exist for expenditures for medical assistance covered under the State plan. It allows the Medicaid agencies to request waivers from certain procedures in our regulations that are not expressly

required by the Social Security Act. We will consider waiving nonstatutorily required procedures relating to identifying possible TPL where the agency finds that following a given required procedure is not cost-effective and is duplicative of another State activity. A nonstatutorily required activity is eligible for a waiver if the cost of the required activity exceeds the TPL recoupment and the required activity accomplishes, at the same or at a higher cost, the same objective as another activity that is being performed by the States. This change gives States greater flexibility in managing their Medicaid programs.

EFFECTIVE DATE: This final rule is effective September 8, 1995.

FOR FURTHER INFORMATION CONTACT: Mel Schmerler, (410) 966-5942.

SUPPLEMENTARY INFORMATION:

I. Background

Section 1902(a)(25) of the Social Security Act (the Act) requires that State or local Medicaid agencies take all reasonable measures to ascertain the legal liability of third parties to pay for care and services furnished to Medicaid recipients. A third party is any individual, entity, or program that is or may be liable to pay all or part of the expenditures for medical assistance furnished under a State plan. Medicaid is intended to be the payer of last resort; that is, other available resources must be used before Medicaid pays for the care and services of a Medicaid-eligible individual. These other resources are known as third party liability, or TPL.

Further, provisions under section 1902(a)(25)(A)(i) of the Act specify that the Medicaid State plan must provide for the collection of sufficient information to enable the State to pursue claims against third parties. Examples of liable third parties include commercial insurance companies through employment-related or privately purchased health insurance; casualty coverage resulting from an accidental injury; payments received directly from an individual who has either voluntarily accepted or been assigned legal responsibility for the health care of one or more Medicaid recipients; and fraternal groups, union, or State workers' compensation commissions. TPL also includes medical support provided by a parent under a court or administrative order.

Statutory provisions (sections 1137 and 1902(a)(25) of the Act) require States to obtain health insurance information at eligibility intake and redetermination interviews, perform the State Wage Information Collection

Agency (SWICA) data match, safeguard recipient information, obtain recipient assignment of rights, and submit a TPL action plan for HCFA approval. These statutory requirements are not affected by the provisions of this final rule.

Nonstatutory requirements, specified in the Medicaid regulations at § 433.138 (and subject to proposed waiver), include obtaining information (via data matching) with the State Workers' Compensation or Industrial Accident Commission files and State Motor Vehicle Accident report files. Another nonstatutory requirement is the requirement for agencies to identify all paid claims with trauma/diagnosis codes found in the International Classification of Disease, 9th Revision, Clinical Modification, Volume 1 (ICD-9-CM) 800 through 999, except 994.6. In § 433.139 (and subject to proposed waiver), State agencies are required to bill the third party resource within 60 days after the last day of the month the State learns of the available resource.

Under our regulations at § 433.138, pertinent health insurance information must be obtained (1) from Medicaid applicants or recipients during the determination and redetermination process; (2) by securing data match agreements with specific Federal and State agencies; (3) by conducting diagnosis and trauma code edits; and (4) by following specified procedures regarding the frequency of these activities.

Regulations at § 433.139 govern State payment of claims where TPL is involved. There are two methods of paying claims for recipients with known TPL: the cost-avoidance method and the pay-and-chase method. Under the cost-avoidance method, the Medicaid agency does not initially pay the claim, but returns the claim to the provider with information necessary for the provider to bill the third party. Under the pay-and-chase method, an agency may pay the total amount allowed under its payment schedule and then seek recovery from the liable third parties. The agency must initiate recovery within 60 days after the end of the month in which payment is made or the Agency learns of the existence of the third party resource.

Most States that implement the requirements in our regulations at § 433.138 achieve significant Medicaid savings. Whenever third party resources can be utilized instead of Medicaid, both Federal and State taxpayers save money. In some instances, however, TPL requirements are not cost-effective.

Some States have reported very poor results in terms of identifying new TPL leads through trauma and diagnosis

code edits. There are reports that some codes never yield TPL. Currently, States may obtain a partial waiver from HCFA of the requirement in § 433.138(e) to take action to identify those paid claims for Medicaid recipients that contain diagnosis codes 800 through 999 (except that no State has to pursue information concerning code 994.6, motion sickness). Under § 433.138(e), the State may obtain a waiver from complying with the requirements for specific codes.

In § 433.139(e), we also permit a State to request a waiver from HCFA of the cost-avoidance method of paying if the State could document that the pay-and-chase method is at least as cost-effective as the cost-avoidance method. The State is required to revalidate its cost-avoidance waiver request every 3 years and notify HCFA of any event that may change the cost-effectiveness of the waiver.

When these requirements were established by HCFA, the Medicaid TPL program was in its infancy. Many States were not pursuing TPL or only recovering TPL passively; that is, making recoveries when contacted by a provider or attorney who was making a third party settlement. We believed there were tremendous untapped TPL resources that were not identified by States. Therefore, the initial regulations were broad and did not allow States discretion to decide whether or not to perform required TPL activities based upon their cost-effectiveness. For this reason, we issued TPL regulations which we have determined are now too prescriptive and, at times, duplicative. On February 27, 1987, we published in the **Federal Register** (52 FR 5971) a response to State comments regarding cost-effectiveness of our discretionary regulations at §§ 433.138 and 433.139. We stated that we would reevaluate these requirements if we received substantial complaints. This rule is consistent with that statement.

Currently, the majority of the States have aggressive and comprehensive TPL programs and have reported substantial savings from TPL activities. However, program experience has identified situations where some activities required by our regulations duplicate some State agency requirements in identifying new TPL leads. Also, situations have been identified where some of our requirements in regulations are not cost-effective; that is, States can reasonably expect to spend more to perform a TPL activity than will be realized in savings. It is for these reasons that we are now offering States the opportunity to request waivers from the unproductive activities that are not

mandated by statute, and for which States have superior methods for accomplishing the same objectives as our regulations.

II. Issuance of Proposed Rule

On February 2, 1994, we published in the **Federal Register** (59 FR 4880) a proposed rule that would allow States to request a waiver from requirements in § 433.138(c), (d)(4), (d)(5), (e), (f), (g)(1), (g)(2), (g)(3), and (g)(4) or § 433.139(b), (d)(1), and (d)(2) that are not explicitly mandated by statute when it is found that performing the requirement is not cost-effective. We indicated that we would revise our rules to allow a State to request a waiver from the nonstatutorily required activities that concern specific types of third party information, exchange of data, diagnosis and trauma code edits, and follow-up activities for certain exchanges. A nonstatutorily required activity would be eligible for a waiver if the cost of the required activity exceeds the TPL recoupment and the required activity accomplishes, at the same or at a higher cost, the same objective as another activity that is being performed by the State.

We made this proposal to allow States to perform TPL operations more efficiently and at a greater savings to the Federal Government. We believed that duplicative efforts (and higher costs) would be eliminated when States have already identified third party resources through another more cost-effective means. We note that HCFA's financial participation in State Medicaid Management Information Systems costs, including costs related to data matches we require States to perform, may be as much as 90 percent. Therefore, it is not in the interest of the Federal Government to have States perform activities which are either duplicative or nonproductive.

We proposed relief from regulatory requirements in the form of a waiver. The State would submit a formal request to the HCFA regional office (RO). The State would be required to provide documentation that demonstrates that the cost of the required activity exceeds the TPL recoupment and the required activity accomplishes, at the same or at a higher cost, the same objective as another activity which is being performed by the State.

Documentation to support the waiver request could include past claims recovery data that demonstrate the administrative expenses involved in meeting that particular requirement, and a State analysis that documents a cost-effective alternative that accomplishes the same task. HCFA's ROs would

consider the individual merits of each waiver request and would grant or deny the waiver request based on cost-effectiveness and State alternatives presented.

We indicated that we would issue separate guidelines for developing and evaluating waiver requests for the new waivers. We currently have cost-effectiveness guidelines in place to govern our existing cost-avoidance waiver process. These guidelines were developed by a national work group comprised of HCFA Central Office (CO) and RO staff, whose purpose was to make the guidelines comprehensive and to ensure consistent application throughout the country. They are found in section 3904.2 of the State Medicaid Manual. We indicated that we would issue similar guidelines to review the new waivers. Sources of data would most likely include claims processing tabulations, State expenditure reports, and savings data from the TPL recovery units and the HCFA Form 64.9a report.

CO staff also would provide clarification to RO staff as needed through our regular teleconferences. Consultation on specific waiver requests would be provided routinely, as is currently done in the State plan amendment process, cost-avoidance waivers, trauma code edit waivers, and State TPL action plan submissions. As with our current waiver provisions, ROs would be required to report approvals and disapprovals to CO on an ongoing basis. When changes in waiver status occur, CO also would be notified.

III. Summary of Public Comments and Responses

We received four letters of comment on the February 1994 proposed rule. These comments and our responses are discussed below:

Comment: Several commenters expressed concern that the proposed rule did not go far enough to allow States the flexibility needed to achieve additional savings from TPL. One commenter cited section 1902(a)(25) of the Act which requires States to take all reasonable measures to ascertain the legal liability of third parties (including health insurers) to pay for care and services available under the plan. The commenter provided two examples of unique and innovative practices that enhance the State's TPL operations and should be permissible under Federal regulations. In the first example, the recipient receives a portion of the proceeds of settlements from tort actions taken against third parties. In the second example, the State has developed a program which pays county welfare departments incentive payments

("bounties") of \$50 for each new case certified for eligibility where other health insurance is identified.

Response: We agree that States should be allowed to implement unique and innovative practices that are reasonable measures and not prohibited by Federal statute. Medicaid services are provided using Federal matching funds. In the first example, the State has provided Medicaid services for recipients that were injured by liable third parties, and these recipients have subsequently taken legal action to receive compensation through the courts for their injuries. Section 1912(b) of the Act requires that when a State makes a recovery, the State reimburse itself (and the Federal government) before any remaining funds are given to the recipient. If the State is reimbursing the recipient from the amounts collected before fully refunding the Federal government its share, such practice violates section 1912(b) of the Act. The State is, however, free to pay State monies to the recipient as an incentive, without violating section 1912 of the Act.

In the second example, we take issue with the "county bounty" program where Federal matching funds were requested and denied for the bounty payments, because these expenditures are not authorized for Federal matching funds under title XIX of the Act. We agree, that in both examples, these practices could increase TPL identification and savings, and States may find it worthwhile to continue these programs with State-only funds. This rule will provide States with additional flexibility in their TPL programs within the confines of Federal law.

Comment: One commenter requested that we revise the regulations to define, interpret, and explain more positively the meaning of the statutory phrase "all reasonable measures."

Response: We have interpreted the language in section 1902(a)(25) of the Act that refers to "all reasonable measures" by specifying the requirements for TPL in regulations at §§ 433.138 and 433.139. These regulations include TPL activities specified by the statute, and other discretionary activities that we have deemed to be logical actions to take to identify and pursue TPL. We originally decided to offer TPL waivers of these regulatory requirements because several States expressed concern that our discretionary regulatory activities were not cost effective, and that other State activities were accomplishing the same objective. We believe waivers of discretionary TPL requirements can

provide States with some flexibility in managing their TPL programs without compromising the integrity of the TPL program. We have always supported States' innovative and unique measures to achieve TPL savings that are not prohibited by Federal statute. These innovative and unique measures have been issued several times by us in a compilation entitled, "Third Party Liability in the Medicaid Program . . . A Guide to Successful State Agency Practices." We are continuously supportive of approaches that do not violate the statute, and these regulations do not preclude States from developing such operations.

Comment: Two commenters suggested that in § 433.138(l) we provide considerable flexibility in our interpretation of "adequate documentation" for waiver consideration.

Response: We wish to stress that our "examples of documentation" in the proposed rule are strictly examples and not an inclusive list. It is our intention to employ flexibility when considering these waiver requests. While we will provide guidance to States for submissions of waiver requests through the State Medicaid Manual, we understand that the unique characteristics of each State Medicaid program will govern States' abilities to produce cost-effectiveness data.

Comment: One commenter questioned our intent regarding the requirements for "adequate documentation", as specified in proposed § 433.138(l)(ii), which states that "Examples of documentation are claims recovery data and a State analysis documenting a cost-effective alternative that accomplished the same task." The commenter noted that this language means that even if a State TPL practice is not cost-effective, the State must also demonstrate that it performs an alternative practice. The commenter also points out that in section II of the preamble of the proposed rule, an example of "adequate documentation" was given as ". . . claims recovery data or State analysis . . ." (emphasis added), and asserts that HCFA intended that States either document that a practice is not cost-effective or that another alternative practice is performed, but that the intent is that States do not have to provide both. In addition, the commenter requested that we add after the words ". . . claims recovery data . . ." the language "costs for the process(es) for which a waiver is being requested."

Response: The commenter was correct in pointing out the inconsistency in the use of the word "or" in section II of the preamble of the proposed rule which

was not used in proposed § 433.138(l)(ii). The use of "or" in the preamble was inadvertent, and we have deleted the word "or" and replaced it with "and" in this final rule. The intent of the proposed rule is elucidated in the summary of the preamble of the proposed rule. The summary stated the following: "We would consider waiving nonstatutorily required procedures relating to identifying possible TPL where the agency finds that following a given required procedure is not cost-effective and is duplicative of another State activity. A nonstatutorily required activity would be eligible for a waiver if the cost of the required activity exceeds the TPL recoupment and the required activity accomplishes, at the same or at a higher cost, the same objective as another activity that is being performed by the States." (59 FR 4880). We added this waiver consideration because we found through the Federal oversight process that some States have not achieved a satisfactory level of compliance with TPL requirements, and for these States, where processes can be highly manual and labor intensive, an argument can be made that certain TPL requirements are not cost-effective. Nevertheless, the objective of the requirement in question has not been accomplished, and potential TPL resources are lost. Our concern is that these States could theoretically receive waivers and remain in technical compliance, and yet still not accomplish the TPL objective. Therefore, our position is that a State can receive approval of a waiver of a current requirement only if it has an alternate activity that will accomplish the same objective.

In terms of the language that the commenter has requested to be added to the "examples of documentation", our response is the same as the response to the previous comment requesting flexibility in our interpretation of "adequate documentation." Our examples of documentation are not inclusive, and we will be flexible when considering these waiver requests. We therefore are not adding the requested language to our example in the final rule.

Comment: One commenter requested that States be allowed to request TPL waivers for certain family planning clients.

Response: The commenter appears to be requesting that this rule should provide relief from the general statutory requirement of section 1902(a)(25) of the Act to perform TPL activities for certain family planning clients. This request addresses a broader issue, the State's general responsibility to pursue and

determine the existence of third parties, than what is addressed by this rule. There is no statutory authority or regulation that permits HCFA to waive third party identification for a class of claims or recipients. If a State believes that cost avoidance of family planning claims for recipients with TPL is not cost-effective, the regulations at § 433.139(e) provide a recourse for States to follow. If a State identifies TPL but finds that pursuing a recovery is no longer cost-effective, the regulations at § 433.139(f) may provide relief.

In situations where it is determined that the recipient has "good cause" for not cooperating in pursuing the third party, the Medicaid agency would not pursue the third party by employing either the cost avoidance or pay and chase method.

IV. Provisions of the Final Regulations

We are adopting the February 2, 1994 proposed rule as final with a modification to the title of § 433.138 "Determining liability of third parties" to read "Identifying liable third parties" and a conforming change to § 433.137 to reflect this change. While section 1902(a)(25)(A) requires States to take reasonable measures to ascertain the legal liability of third parties to pay for care and services available under the plan, States must first identify third party resources. Section 433.138 explains the requirements for identifying third parties through data exchanges. It does not explain the process of determining liability of third parties. We believe § 433.139 explains that determination of the liability of a third party takes place when the Medicaid agency receives confirmation from the provider or third party resource indicating the extent of TPL. Therefore, we are changing the title of § 433.138 to accurately reflect the section's content.

V. Regulatory Impact Statement

We generally prepare a regulatory flexibility analysis that is consistent with the Regulatory Flexibility Act (RFA) (5 U.S.C. 601 through 612), unless the Secretary certifies that a final regulation will not have a significant impact on a substantial number of small entities.

Under the RFA, a small entity is a small business, a nonprofit enterprise, or a government jurisdiction (such as a county or township) with a population of less than 50,000. These final regulations will affect only States and individuals, which are not considered small entities.

Also, section 1102(b) of the Act requires the Secretary to prepare a

regulatory impact analysis for any final rule that may have a significant impact on the operations of a substantial number of small rural hospitals. Such an analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside a Metropolitan Statistical Area and has fewer than 50 beds.

This final rule requires States to submit a formal waiver request to be relieved of compliance with certain TPL requirements that are in our regulations when the cost of implementing the regulation's requirement is not cost-effective. It is extremely difficult to give an exact estimate of the cost savings that would accrue with the implementation of this regulation. This is largely because the cost of any single TPL data match or other procedure, as well as its relative effectiveness, varies from State to State.

In reviewing the need for this waiver, we recognized that some TPL claims reporting and payment regulations are expressly required by statute and that these and additional regulatory requirements are a valuable mechanism by which the Medicaid program has saved and recovered financial resources and that these regulations should be maintained. This waiver gives credence to valid concerns raised by States regarding the cost-effectiveness of certain portions of the TPL regulations in certain instances and allows States greater flexibility in managing their Medicaid programs.

An alternative to these regulatory enhancements would be to force States to comply with all regulations and not allow for any waiver provisions. In this scenario, States would either comply and lose money or discontinue the inefficient practice and risk HCFA sanctions through the system's performance review. Clearly, it was not the intent of the Congress for HCFA to promulgate regulations designed to save the taxpayers money, and then penalize States when the regulations are found by experience not to be cost-effective. This is consistent with our response to comments published in the **Federal Register** dated February 27, 1987 (52 FR 5971) stating that if HCFA received substantial complaints from State Medicaid agencies regarding the cost-effectiveness of State workers' compensation or Motor Vehicle Accident File data matches and diagnosis and trauma code edits, HCFA would reevaluate the data requirement.

We believe that implementation of the waiver procedures will work towards a realistic and cost-effective TPL program.

Allowing States to request waivers will also provide States with increased control over their individual TPL programs.

We have determined, and the Secretary certifies, that this final rule is not a significant regulatory action and will not have a significant economic impact on a substantial number of small entities. Also, this final rule will not have a significant impact on the operations of a substantial number of small rural hospitals. Therefore, we have not prepared a regulatory impact analysis, a small rural hospital analysis, or an initial regulatory flexibility analysis.

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

VI. Paperwork Reduction Act

Sections 433.138(l) and 433.139(e) of this final rule contain new information collection requirements that are subject to the Office of Management and Budget (OMB) approval under the Paperwork Reduction Act of 1980 (44 U.S.C 3504, et seq.). Reporting burden for the collection of information in §§ 433.138(1) and 433.139(e) is estimated to be 8 hours per request for waiver.

List of Subjects in 42 CFR Part 433

Administrative practice and procedure, Claims, Grant programs—health, Medicaid, Reporting and recordkeeping requirements.

42 CFR part 433 is amended as follows:

PART 433—STATE FISCAL ADMINISTRATION

1. The authority citation for part 433 continues to read as follows:

Authority: Secs. 1102, 1137, 1902(a)(4), 1902(a)(25), 1902(a)(45), 1903(a)(3), 1903(d)(2), 1902(d)(5), 1903(o), 1903(p), 1903(r), and 1912 of the Social Security Act (42 U.S.C. 1302, 1320b-7, 1396a(a)(4), 1396a(a)(25), 1396a(a)(45), 1396b(a)(3), 1396b(d)(2), 1396a(d)(5), 1396b(o), 1396b(p), 1396b(r), and 1396k, unless otherwise noted.

2. Section 433.137(a) is revised to read as follows:

§ 433.137 State plan requirements.

(a) A State plan must provide that the requirements of §§ 433.138 and 433.139 are met for identifying third parties liable for payment of services under the plan and for payment of claims involving third parties.

* * * * *

3. Section 433.138 is amended by revising the section title, paragraphs (a)

and (c), the introductory text of paragraph (d), and paragraphs (e), (f), and (j); by adding undesignated introductory language to paragraph (g); and by adding a new paragraph (l) to read as follows:

§ 433.138 Identifying liable third parties.

(a) *Basic provisions.* The agency must take reasonable measures to determine the legal liability of the third parties who are liable to pay for services furnished under the plan. At a minimum, such measures must include the requirements specified in paragraphs (b) through (k) of this section, unless waived under paragraph (l) of this section.

* * * * *

(c) *Obtaining other information.* Except as provided in paragraph (l) of this section, the agency must, for the purpose of implementing the requirements in paragraphs (d)(1)(ii) and (d)(4)(i) of this section, incorporate into the eligibility case file the names and SSNs of absent or custodial parents of Medicaid recipients to the extent such information is available.

(d) *Exchange of data.* Except as provided in paragraph (l) of this section, to obtain and use information for the purpose of determining the legal liability of the third parties so that the agency may process claims under the third party liability payment procedures specified in § 433.139(b) through (f), the agency must take the following actions:

* * * * *

(e) *Diagnosis and trauma code edits.* (1) Except as specified under paragraph (e)(2) or (l) of this section, or both, the agency must take action to identify those paid claims for Medicaid recipients that contain diagnosis codes 800 through 999 International Classification of Disease, 9th Revision, Clinical Modification, Volume 1 (ICD-9-CM) inclusive, for the purpose of determining the legal liability of third parties so that the agency may process claims under the third party liability payment procedures specified in § 433.139(b) through (f).

(2) The agency may exclude code 994.6, Motion Sickness, from the edits required under paragraph (e)(1) of this section.

(f) *Data exchanges and trauma code edits: Frequency.* Except as provided in paragraph (l) of this section, the agency must conduct the data exchanges required in paragraphs (d)(1) and (d)(3) of this section in accordance with the intervals specified in § 435.948 of this chapter, and diagnosis and trauma edits required in paragraphs (d)(4) and (e) of this section on a routine and timely

basis. The State plan must specify the frequency of these activities.

(g) *Follow-up procedures for identifying legally liable third party resources.* Except as provided in paragraph (l) of this section, the State must meet the requirements of this paragraph.

* * * * *

(j) *Reports.* The agency must provide such reports with respect to the data exchanges and trauma code edits set forth in paragraphs (d)(1) through (d)(4) and paragraph (e) of this section, respectively, as the Secretary prescribes for the purpose of determining compliance under § 433.138 and evaluating the effectiveness of the third party liability identification system. However, if the State is not meeting the provisions of paragraph (e) of this section because it has been granted a waiver of those provisions under paragraph (l) of this section, it is not required to provide the reports required in this paragraph.

* * * * *

(l) *Waiver of requirements.* (1) The agency may request initial and continuing waiver of the requirements to determine third party liability found in paragraphs (c), (d)(4), (d)(5), (e), (f), (g)(1), (g)(2), (g)(3), and (g)(4) of this section if the State determines the activity to be not cost-effective. An activity would not be cost-effective if the cost of the required activity exceeds the third party liability recoupment and the required activity accomplishes, at the same or at a higher cost, the same objective as another activity that is being performed by the State.

(i) The agency must submit a request for waiver of the requirement in writing to the HCFA regional office.

(ii) The request must contain adequate documentation to establish that to meet a requirement specified by the agency is not cost-effective. Examples of documentation are claims recovery data and a State analysis documenting a cost-effective alternative that accomplished the same task.

(iii) The agency must agree, if a waiver is granted, to notify HCFA of any event that occurs that changes the conditions upon which the waiver was approved.

(2) HCFA will review a State's request to have a requirement specified under paragraph (l)(1) of this section waived and will request additional information from the State, if necessary. HCFA will notify the State of its approval or disapproval determination within 30 days of receipt of a properly documented request.

(3) HCFA may rescind a waiver at any time that it determines that the agency

no longer meets the criteria for approving the waiver. If the waiver is rescinded, the agency has 6 months from the date of the rescission notice to meet the requirement that had been waived.

4. Section 433.139 is amended by revising paragraphs (b), (d)(1), (d)(2), and (e) to read as follows:

§ 433.139 Payment of claims.

* * * * *

(b) *Probable liability is established at the time claim is filed.* Except as provided in paragraph (e) of this section—

(1) If the agency has established the probable existence of third party liability at the time the claim is filed, the agency must reject the claim and return it to the provider for a determination of the amount of liability. The establishment of third party liability takes place when the agency receives confirmation from the provider or a third party resource indicating the extent of third party liability. When the amount of liability is determined, the agency must then pay the claim to the extent that payment allowed under the agency's payment schedule exceeds the amount of the third party's payment.

(2) The agency may pay the full amount allowed under the agency's payment schedule for the claim and then seek reimbursement from any liable third party to the limit of legal liability if the claim is for labor and delivery and postpartum care. (Costs associated with the inpatient hospital stay for labor and delivery and postpartum care must be cost-avoided.)

* * * * *

(d) *Recovery of reimbursement.* (1) If the agency has an approved waiver under paragraph (e) of this section to pay a claim in which the probable existence of third party liability has been established and then seek reimbursement, the agency must seek recovery of reimbursement from the third party to the limit of legal liability within 60 days after the end of the month in which payment is made unless the agency has a waiver of the 60-day requirement under paragraph (e) of this section.

(2) Except as provided in paragraph (e) of this section, if the agency learns of the existence of a liable third party after a claim is paid, or benefits become available from a third party after a claim is paid, the agency must seek recovery of reimbursement within 60 days after the end of the month it learns of the existence of the liable third party or benefits become available.

* * * * *

(e) *Waiver of requirements.* (1) The agency may request initial and continuing waiver of the requirements in paragraphs (b)(1), (d)(1), and (d)(2) of this section, if it determines that the requirement is not cost-effective. An activity would not be cost-effective if the cost of the required activity exceeds the third party liability recoupment and the required activity accomplishes, at the same or at a higher cost, the same objective as another activity that is being performed by the State.

(i) The agency must submit a request for waiver of the requirement in writing to the HCFA regional office.

(ii) The request must contain adequate documentation to establish that to meet a requirement specified by the agency is not cost-effective. Examples of documentation are costs associated with billing, claims recovery data, and a State analysis documenting a cost-effective alternative that accomplishes the same task.

(iii) The agency must agree, if a waiver is granted, to notify HCFA of any event that occurs that changes the conditions upon which the waiver was approved.

(2) HCFA will review a State's request to have a requirement specified under paragraph (e)(1) of this section waived and will request additional information from the State, if necessary. HCFA will notify the State of its approval or disapproval determination within 30 days of receipt of a properly documented request.

(3) HCFA may rescind the waiver at any time that it determines that the State no longer meets the criteria for approving the waiver. If the waiver is rescinded, the agency has 6 months from the date of the rescission notice to meet the requirement that had been waived.

(4) An agency requesting a waiver of the requirements specifically concerning either the 60-day limit in paragraph (d)(1) or (d)(2) of this section must submit documentation of written agreement between the agency and the third party, including Medicare fiscal intermediaries and carriers, that extension of the billing requirement is agreeable to all parties.

(Catalog of Federal Domestic Assistance Program No. 93.778—Medical Assistance Program)

Dated: June 28, 1995.

Bruce C. Vladeck,
Administrator, Health Care Financing Administration.

[FR Doc. 95-16806 Filed 7-7-95; 8:45 am]

BILLING CODE 4120-01-P

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 0

[FCC 95-213]

Changes in the Delegated Authority of Various Bureaus

AGENCY: Federal Communications Commission.

ACTION: Final rule.

SUMMARY: This Order amends Part 0 of the Commission's rules to reflect the establishment of the Wireless Telecommunications Bureau (WTB) and changes to the delegated authority of the various Bureaus. Changes to Part 0 include authority delegated to the WTB, Common Carrier Bureau (CCB) and International Bureau (IB) to resolve common carrier forfeiture proceedings involving \$80,000 or less and authority delegated to the WTB, IB, Mass Media Bureau and Cable Services Bureau to issue subpoenas. A conforming edit is also made to the Compliance and Information Bureau's subpoena power. This Order is intended to create a more effective organization in which to consolidate and administer the Commission's policies.

EFFECTIVE DATE: July 10, 1995.

FOR FURTHER INFORMATION CONTACT: Kathleen O'Brien Ham, Wireless Telecommunications Bureau, (202) 418-0660.

SUPPLEMENTARY INFORMATION: This is a synopsis of the Commission's Order adopted May 30, 1995 and released June 9, 1995. The full text of Commission decisions are available for inspection and copying during normal business hours in the FCC Docket Branch (Room 230), 1919 M Street, NW., Washington, DC. The complete text of this decision may also be purchased from the Commission's copy contractor, International Transcription Service, Inc., (202) 857-3800, 2100 M Street, NW., Washington, DC 20037.

Synopsis of the Order

1. In order to create an effective organization in which to consolidate and administer the Commission's policies, programs and rules governing domestic wireless telecommunications, the Commission recently established the new Wireless Telecommunications Bureau. Specifically, the Commission merged the Private Radio Bureau and a portion of the Common Carrier Bureau to create the Wireless Telecommunications Bureau. The rule amendments contained in this Order make changes to Part 0 of the