on EPA's proposed decision and collect comments on the proposed decision.

List of Subjects in 40 CFR Part 261

Environmental protection, Hazardous waste, Recycling, Reporting and recordkeeping requirements.

Authority: Sec. 3001(f) RCRA, 42 U.S.C. 6921(f).

Dated: July 18, 2003.

Jewell Harper,

Acting Director, Waste Management Division.

[FR Doc. 03–19005 Filed 7–24–03; 8:45 am]

BILLING CODE 6560–50–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 411 and 489

[CMS–1475–FC]

RIN 0938–AM65

Medicare Program; Third Party Liability Insurance Regulations

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

ACTION: Final rule with comment period.

SUMMARY: This final rule with comment period removes § 411.54(c)(2) and a portion of § 489.20(g) from our regulations. These regulations were held by a court to be inconsistent with the Medicare Secondary Payer provisions that are found in section 1862(b)(2)(a) of the Social Security Act. Specifically, the court held that § 411.54(c)(2) and a portion of § 489.20(g) are unenforceable to the extent that these regulations require providers and suppliers to only bill Medicare and prohibits them from billing a liability insurer or asserting or maintaining a lien against a beneficiary's liability insurance settlement during the ''promptly'' period.

DATES: *Effective date:* This final rule with comment period is effective on August 25, 2003.

Comment date: We will consider comments if we receive them at the appropriate address, as provided in the **ADDRESSES** section, no later than 5 p.m. on September 23, 2003.

ADDRESSES: In commenting, please refer to file code CMS–1475–FC. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission. Mail written comments (one original and two copies) to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1475–FC, PO Box 8013, Baltimore, MD 21244–8013.

Please allow sufficient time for us to receive mailed comments on time in the event of delivery delays.

If you prefer, you may deliver (by hand or courier) your written comments (one original and two copies) to one of the following addresses: Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201, or Room C5–14–03, 7500 Security Boulevard, Baltimore, MD 21244–8013.

(Because access to the interior of the HHH Building is not readily available to persons without Federal Government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available if you wish to retain proof of filing by stamping in and retaining an extra copy of the comments being filed.)

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and could be considered late.

For information on viewing public comments, *see* the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: Suzanne Ripley, (410) 786–0970.

SUPPLEMENTARY INFORMATION: *Inspection of Public Comments:* Comments received timely will be available for public inspection as they are recorded and processed, generally beginning approximately 4 weeks after the publication of the document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone (410) 786–7197.

I. Background

Under section 1862(b)(2)(A) of the Social Security Act (the Act), Medicare payments may not be made for any item or service for which payment has been made or can reasonably be expected to be made ''promptly'' (as determined in accordance with our regulations) under a liability insurance policy. The regulations at § 411.54(c)(2) and a portion of § 489.20(g) require providers and suppliers (including physicians) to bill Medicare for Medicare covered services. These regulations also prohibit those providers and suppliers from billing a liability insurer or asserting or maintaining a lien against the beneficiary's insurance settlement, regardless of when the liability insurer is billed or when the lien is asserted. After the regulations at § 411.54(c)(2) and § 489.20(g) were published, but before the effective date, the American Hospital Association (AHA), filed a lawsuit on behalf of its member hospitals to prevent us from implementing these sections. (*See American Hospital Association (AHA)* v. *Sullivan*, 1990 WL 274639 (D.D.C. May 24, 1990).) During the litigation, the parties stipulated to allow providers to bill liability insurers or assert or maintain a lien against a beneficiary's insurance settlement.

The court ultimately held that this statutory provision (that prohibits Medicare from making payment where liability insurance that is expected to pay promptly exists) permits a provider to seek payment from insurance or assert or maintain a lien against the beneficiary's insurance settlement during the ''promptly'' period. Therefore, we were unable to implement § 411.54(c)(2) and the portion of § 489.20(g) that states, ''except when the primary payer is a liability insurer and except as provided in paragraph (j) of this section.'' The court took no action affecting existing special rules for Oregon. The court also did not address billing a liability insurer or asserting or maintaining a lien after the expiration of the ''promptly'' period. The *AHA* decision has not been appealed. Therefore, to the extent that § 411.54(c)(2) and a portion of § 489.20(g) are inconsistent with the court's decision, they are unenforceable.

In light of the *AHA* decision, we are continuing the policy which we stipulated during the *AHA* case with respect to all providers and suppliers (including physicians); that is, we are allowing them to bill liability insurers or assert or maintain liens on a beneficiary's liability insurance settlement rather than billing Medicare. The Commerce Clearing House, Inc. (CCH) published two policy memoranda that addressed the issue of billing a liability insurer or asserting or maintaining a lien against a beneficiary's liability insurance settlement, referring to the holding in the *AHA* case. (Medicare & Medicaid Guide (CCH) 45, 187 at 53, 508–53, 512 (1997). The first policy memorandum entitled, ''Provider and Supplier Billing When Medicare is Secondary Payer to Liability Insurance—Information'', is dated August 21, 1995. The second policy memorandum entitled '' Charges to Beneficiaries and Handling Improper Collections By Providers and Suppliers When Medicare is Secondary Payer to Liability Insurance—Action'', is dated March 12, 1996. These memoranda can

be obtained by calling the contact person listed in this final rule with comment period or by accessing the CMS Web site: *http://www.cms.hhs.gov.*

To date, we have not enforced § 411.54 (c)(2) or the portion of § 489.20(g) that is inconsistent with the court's decision. Because § 411.54(c)(2) was written without regard to the pre- and post ''promptly'' period, we are removing this section in its entirety, even though the *AHA* decision found it unenforceable only during the ''promptly'' period. This final rule with comment period does not establish lien rights that are not available to providers and suppliers (including physicians) under State law. The final rule with comment period does not alter the prohibition against double billing; that is, it does not allow a provider or supplier (including a physician) to bill Medicare and simultaneously bill the liability insurer or assert or maintain a lien against the beneficiary's liability insurance settlement.

II. Provisions of the Final Rule

The final rule with comment period removes § 411.54(c)(2) and revises paragraphs (c) and (d) of our regulations. It also removes the words ''except when the primary payer is a liability insurer and except as provided in paragraph (j) of this section'' from § 489.20(g).

III. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the **Federal Register** and solicit public comment when a collection of information requirement is submitted to the OMB for review and approval. In order to fairly evaluate whether OMB should approve an information collection, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

Therefore, we are soliciting public comment on each of these issues for the information collection requirements discussed below.

Section 411.54 Limitation on Charges When a Beneficiary Has Received a Liability Insurance Payment or Has a Claim Pending Against a Liability Insurer

Section 411.54(c) states that a hospital must, upon request, furnish to the beneficiary or his or her representative an itemized bill of the hospital's charges.

This requirement, which is subject to the PRA, is not being revised in this regulation. The burden associated with this requirement is currently captured under OMB control number 0938–0565, which is approved through November of 2005.

We have submitted a copy of this final rule with comment period to OMB for its review of the information collection requirements described above. These requirements are not effective until they have been approved by OMB.

If you comment on these information collection and recordkeeping requirements, please mail copies directly to the following: Centers for Medicare and Medicaid Services, Office of Strategic Operations and Regulatory Affairs, Division of Regulations Development and Issuances, Attn.: Dawn Willinghan (Attn: CMS–1475–F), Room C5–14–03, 7500 Security Boulevard, Baltimore, MD 21244–1850.

Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503, Attn: Brenda Aguilar, CMS Desk Officer.

IV. Waiver of Proposed Rulemaking

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** and invite public comment on the proposed rule. The notice of proposed rulemaking includes a reference to the legal authority, under which the rule is proposed, and the terms and substances of the proposed rule or a description of the subjects and issues involved. This procedure can be waived, however, if an agency finds good cause that a notice-and-comment procedure is impracticable, unnecessary, or contrary to the public interest and incorporates a statement of the finding and its reasons in the rule issued. The *AHA* decision holds that the Medicare Secondary Payer provisions permit a provider to seek payment from that insurance or assert or maintain a lien against the beneficiary's insurance settlement during the ''promptly'' period. To the extent that § 411.54(c)(2) and a portion of § 489.20(g) are inconsistent with the court's decision, they are unenforceable. Good cause exists to waive notice and comment because the agency's action to remove § 411.54(c)(2) and revise § 489.20(g) is compelled by the AHA decision.

Therefore, we find good cause to waive the notice of proposed rulemaking and to issue this final rule with comment period.

V. Regulatory Impact

We have examined the impacts of this final rule with comment period as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 16, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), and Executive Order 13132.

Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year). We have determined that the effect of this final rule on the economy and the Medicare program is negligible. Therefore, this final rule is not a major rule as defined in Title 5, United States Code, section 804(2) and is not an economically significant rule under Executive Order 12866.

Because these regulations have been unenforceable since the AHA decision, the impact of this regulation is limited to the expected elimination of potential lawsuits that may be brought against hospitals by beneficiaries seeking to require hospitals to bill Medicare for the cost of their treatment. Since 1990 we have been aware of only several cases where beneficiaries have brought litigation against hospitals seeking State court orders requiring the hospitals to bill Medicare. The beneficiaries have based their cases on the published regulations. While we do not believe that many such suits have or will be filed, individual hospitals can spend substantial monies defending these types of lawsuits. Beneficiaries who bring these suits, only to lose based on the State court's reading of CMS' policy, also may be responsible for some attorneys' costs and may be responsible for fees for the hospital's attorneys in some cases. To the extent that this regulation clarifies CMS policy by eliminating unenforceable regulations, we believe that the number of lawsuits filed may decline.

The RFA requires agencies to analyze options for regulatory relief of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and government agencies. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $6 million to $29 million in any 1 year. Individuals and States are not considered to be small entities. Because this regulation merely deletes these unenforceable provisions from our regulations, we have determined and we certify that this final rule will not have a significant economic impact on a substantial number of small entities. Therefore, we are not preparing an analysis for the RFA.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule or notice having the effect of a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This 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 of a Metropolitan Statistical Area and has fewer than 100 beds. We have determined that this final rule will not have a significant effect on the operations of a substantial number of small rural hospitals. Therefore, we are not preparing an analysis for section 1102(b) of the Act.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule or notice having the effect of a rule that may result in expenditures in any 1 year by State, local, or tribal governments, in the aggregate, or by the private sector, of $110 million. This final rule has no consequential effect on State, local, or tribal governments or on the private sector.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a rule or notice having the effect of a rule that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. This final rule will not have a substantial effect on State or local governments.

In accordance with the provisions of Executive Order 12866, this final rule was reviewed by the Office of Management and Budget.

List of Subjects

42 CFR Part 411

Kidney diseases, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 485

Grant programs—health, Health facilities, Medicaid, Medicare, Reporting and recordkeeping requirements.

■ For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services amends 42 CFR chapter IV as follows:

PART 411—EXCLUSIONS FROM MEDICARE AND LIMITATIONS ON MEDICARE PAYMENT

■ 1. The authority citation for part 411 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

■ 2. Section 411.54 is amended by revising paragraphs (c) and (d) to read as follows:

§ 411.54 Limitation on charges when a beneficiary has received a liability insurance payment or has a claim pending against a liability insurer.

* * * * *

(c) *Itemized bill.* A hospital must, upon request, furnish to the beneficiary or his or her representative an itemized bill of the hospital's charges.

(d) *Exception—(1) Prepaid health plans.* If the services were furnished through an organization that has a contact under section 1876 of the Act (that is, an HMO or CMP), or through an organization that is paid under section 1833(a)(1)(A) of the Act (that is, through an HCPP) the rules of § 417.528 of this chapter apply.

(2) *Special rules for Oregon.* For the State of Oregon, because of a court decision, and in the absence of a reversal on appeal or a statutory clarification overturning the decision, there are the following special rules:

(i) The provider or supplier may elect to bill a liability insurer or place a lien against the beneficiary's liability settlement for Medicare covered services, rather than bill only Medicare for Medicare covered services, if the liability insurer pays within 120 days after the earlier of the following dates:

(A) The date the provider or supplier files a claim with the insurer or places a lien against a potential liability settlement.

(B) The date the services were provided or, in the case of inpatient hospital services, the date of discharge.

(ii) If the liability insurer does not pay within the 120-day period, the provider or supplier:

(A) Must withdraw its claim with the liability insurer and/or withdraw its lien against a potential liability settlement.

(B) May only bill Medicare for Medicare covered services.

(C) May bill the beneficiary only for applicable Medicare deductible and co-insurance amounts plus the amount of any charges that may be made to a beneficiary under 413.35 of this chapter (when cost limits are applied to these services) or under 489.32 of this chapter (when services are partially covered).

PART 489—PROVIDER AGREEMENTS AND SUPPLIER APPROVAL

■ 1. The authority citation for part 489 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

■ 2. Section 489.20 is amended by revising paragraph (g) to read as follows:

§ 489.20 Basic commitments.

* * * * *

(g) To bill other primary payers before Medicare.

* * * * *

Authority: Section 1862(b)(2)(A) of the Social Security Act (42 U.S.C. 1395Y)

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

Dated: June 6, 2003.

Thomas A. Scully,

Administrator, Centers for Medicare & Medicaid Services.

Approved: June 30, 2003.

Tommy G. Thompson,

Secretary.

[FR Doc. 03–18509 Filed 7–17–03; 10:06 am]

BILLING CODE 4120–01–P

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Parts 25 and 101

[ET Docket No. 98–206; RM–9147; RM–9245; FCC 03–97]

Order To Deny Petitions for Reconsideration of MVDDS Technical and Licensing Rules in the 12 GHz Band

AGENCY: Federal Communications Commission.

ACTION: Final rule.

SUMMARY: In this document the Commission affirms the technical rules and procedures dealing with sharing of