PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

Subpart H—Payment to Hospitals Under the Prospective Payment Systems

■ 1. The authority citation for part 412 continues to read as follows:

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

■ 2. In § 412.115, revise paragraph (c) to read as follows:

§ 412.115 Additional payments.

* * * * *

(c) *QIO photocopy and mailing costs.* An additional payment is made to a hospital in accordance with § 476.78 of this chapter for the costs of photocopying and mailing medical records requested by a QIO.

PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES; PROSPECTIVELY DETERMINED PAYMENT RATES FOR SKILLED NURSING FACILITIES

Subpart J—Prospective Payment for Skilled Nursing Facilities

■ 1. The authority citation for part 413 continues to read as follows:

Authority: Secs. 1102, 1812(d), 1814(b), 1815, 1833(a), (i), and (n), 1871, 1881, 1883, and 1886 of the Social Security Act (42 U.S.C. 1302, 1395d(d), 1395f(b), 1395l(a), (i), and (n), 1395hh, 1395rr, 1395tt, and 1395ww).

■ 2. Add a new § 413.355 to read as follows:

§ 413.355 Additional payment: QIO photocopy and mailing costs.

An additional payment is made to a skilled nursing facility in accordance with § 476.78 of this chapter for the costs of photocopying and mailing medical records requested by a QIO.

PART 476—UTILIZATION AND QUALITY CONTROL REVIEW

Subpart C—Review Responsibilities of Quality Improvement Organizations (QIOs)

General Provisions

■ 1. The authority citation for part 476 continues to read as follows:

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

■ 2. In § 476.78, revise the introductory text to paragraph (b); revise paragraphs (b)(2), and the introductory text to paragraph (c); add new paragraph (c)(4); and revise paragraph (d) to read as follows:

§ 476.78 Responsibilities of health care providers.

* * * * *

(b) *Cooperation with QIOs.* Health care providers that submit Medicare claims must cooperate in the assumption and conduct of QIO review. Providers must—

* * * * *

(2) Provide patient care data and other pertinent data to the QIO at the time the QIO is collecting review information that is required for the QIO to make its determinations. The provider must photocopy and deliver to the QIO all required information within 30 days of a request. QIOs pay providers paid under the prospective payment system for the costs of photocopying records requested by the QIO in accordance with the payment rate determined under the methodology described in paragraph (c) of this section and for first class postage for mailing the records to the QIO. When the QIO does postadmission, preprocedure review, the facility must provide the necessary information before the procedure is performed, unless it must be performed on an emergency basis.

* * * * *

(c) *Photocopying reimbursement methodology for prospective payment system providers.* Providers subject to the prospective payment system are paid for the photocopying costs that are directly attributable to the providers' responsibility to the QIOs to provide photocopies of requested provider records. The payment is in addition to payment already provided for these costs under other provisions of the Social Security Act and is based on a fixed amount per page as determined by CMS as follows:

* * * * *

(4) CMS will periodically review the photocopy reimbursement rate to ensure that it still accurately reflects provider costs. CMS will publish any changes to the rate in a **Federal Register** notice.

(d) *Appeals.* Reimbursement for the costs of photocopying and mailing records for QIO review is an additional payment to providers under the prospective payment system, as specified in § 412.115, § 413.355, and § 484.265 of this chapter. Thus, appeals concerning these costs are subject to the review process specified in part 405, subpart R of this chapter.

PART 484—HOME HEALTH SERVICES

Subpart E—Prospective Payment System for Home Health Agencies

■ 1. The authority citation for part 484 continues to read as follows:

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

■ 2. Add a new § 484.265 to read as follows:

§ 484.265 Additional payment.

QIO photocopy and mailing costs. An additional payment is made to a home health agency in accordance with § 476.78 of this chapter for the costs of photocopying and mailing medical records requested by a QIO.

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

Dated: May 23, 2003.

Thomas A. Scully,

Administrator, Center for Medicare & Medicaid Services.

Approved: August 28, 2003.

Tommy G. Thompson,

Secretary.

[FR Doc. 03–30096 Filed 11–28–03; 11:32 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 414

[CMS–1232–FC]

RIN 0938–AM44

Medicare Program; Coverage and Payment of Ambulance Services; Inflation Update for CY 2004

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

ACTION: Final rule with comment period.

SUMMARY: This final rule provides the sunset date for the interim bonus payment for rural ambulance mileage of 18 through 50 miles as required by the Medicare, Medicaid and State Child Health Insurance Program Benefits Improvement and Protection Act of 2000 (BIPA) and provides notice of the annual Ambulance Inflation Factor (AIF) for ambulance services for calendar year (CY) 2004. The statute requires that this inflation factor be

applied in determining the fee schedule amounts and payment limits for ambulance services.

DATES: *Effective date:* These revisions are effective on January 1, 2004. The ambulance inflation factor for 2004 applies to ambulance services furnished during the period January 1, 2004, through December 31, 2004.

Comment date: Comments will be considered if we receive them at the appropriate address, as provided below, no later than 5 p.m. on January 29, 2004.

ADDRESSES: Mail written comments (one original and three copies) to the following address: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1232–FC, P.O. Box 8013, Baltimore, MD 21244–8013.

If you prefer, you may deliver your written comments (one original and three copies) to one of the following addresses: Hubert H. Humphrey Building, Room 443–G, 200 Independence Avenue, SW., Washington, DC 20201, or Centers for Medicare & Medicaid Services, Room C5–14–03, 7500 Security Boulevard, Baltimore, MD 21244–8013.

Comments mailed to those addresses designated for courier delivery may be delayed and could be considered late. Because of staffing and resource limitations, we cannot accept comments by facsimile (FAX) transmission. Please refer to file code CMS–1232–FC on each comment. Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of this document, in Room C5–12–08 of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland, Monday through Friday of each week from 8:30 a.m. to 4 p.m. Please call (410) 786–7197 to make an appointment to view comments.

FOR FURTHER INFORMATION CONTACT: Anne E. Tayloe, (410) 786–4546.

SUPPLEMENTARY INFORMATION:

I. Background

A. Legislative and Regulatory History

Under section 1861(s)(7) of the Social Security Act (the Act), Medicare Part B (Supplementary Medical Insurance) covers and pays for ambulance services, to the extent prescribed in regulations, when the use of other methods of transportation would be contraindicated. The House Ways and Means Committee and Senate Finance Committee Reports that accompanied the 1965 legislation creating the Social Security Act suggest that the Congress intended that (1) the ambulance benefit cover transportation services only if other means of transportation are contraindicated by the beneficiary's medical condition, and (2) only ambulance service to local facilities be covered unless necessary services are not available locally, in which case, transportation to the nearest facility furnishing those services is covered (H.R. Rep. No. 213, 89th Cong., 1st Sess. 37 and S. Rep. No. 404, 89th Cong., 1st Sess., Pt I, 43 (1965)). The reports indicate that transportation may also be provided from one hospital to another, to the beneficiary's home, or to an extended care facility.

Our regulations relating to ambulance services are located at 42 CFR part 410, subpart B and 42 CFR part 414, subpart H. Section 410.10(i) lists ambulance services as one of the covered medical and other health services under Medicare Part B. Ambulance services are subject to basic conditions and limitations set forth at § 410.12 and to specific conditions and limitations included at § 410.40. Part 414, subpart H describes how payment is made for ambulance services covered by Medicare.

The Medicare program pays for ambulance services for Medicare beneficiaries when other means of transportation are contraindicated. Ambulance services are divided into different levels of services based on the medically necessary treatment provided during transport as well as into ground (including water) and air ambulance services. These services include the levels of service listed below.

For ground:

- Basic Life Support (BLS)
- Advanced Life Support, Level 1 (ALS1)
- Advanced Life Support, Level 2 (ALS2)
- Specialty Care Transport (SCT)
- Paramedic ALS Intercept (PI)

For air:

- Fixed Wing Air Ambulance (FW)
- Rotary Wing Air Ambulance (RW)

Historically, payment levels for ambulance services depended, in part, upon the entity that furnished the services. Prior to implementation of the ambulance fee schedule on April 1, 2002, providers (hospitals, including critical access hospitals, skilled nursing facilities, and home health agencies) were paid on a retrospective reasonable cost basis. Suppliers, which are entities that are independent of any provider, were paid on a reasonable charge basis.

On February 27, 2002, a final rule was published in the **Federal Register** (67 FR 9100) that established a fee schedule for the payment of ambulance services under the Medicare program, effective for services furnished on or after April 1, 2002. This rule implemented section 1834(l) of the Act. The fee schedule described in the final rule replaced the retrospective reasonable cost payment system for providers and the reasonable charge system for suppliers of ambulance services. In addition, that final rule implemented that statutory requirement that ambulance suppliers accept Medicare assignment; codified the establishment of new Health Care Common Procedure Coding System (HCPCS) codes to be reported on claims for ambulance services; established increased payment under the fee schedule for ambulance services furnished in rural areas based on the location of the beneficiary at the time the beneficiary is placed on board the ambulance; and revised the certification requirements for coverage of nonemergency ambulance services. The final rule also provided for a 5-year transition period during which program payment for Medicare covered ambulance services would be based upon a blended rate comprised of a fee schedule portion and a reasonable cost (providers) or reasonable charge (suppliers) portion. We are now in the second year of that transition over to full payment based solely on the fee schedule amount.

B. Transitional Assistance for Rural Mileage 18 through 50—Section 221 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA)

Section 221 of BIPA provided that, for services furnished during the period July 1, 2001 through, December 31, 2003, a bonus payment, not less than one-half of the bonus paid under the ambulance fee schedule for rural mileage 1 through 17 miles, would be paid for rural mileage 18 through 50. This provision was implemented by § 414.610(c) with the ambulance fee schedule.

The statute provided for this bonus payment only for the interim period specified. We inadvertently omitted from the regulation the time period during which this benefit is payable. Therefore, we are revising § 414.610(c) to reflect that this bonus payment applies only for services furnished during the statutory period. This revision to the regulation is a technical correction to conform the regulation to the statute. Therefore, we believe that notice and comment are unnecessary, and we are waiving proposed rulemaking.

C. Ambulance Inflation Factor (AIF) for CY 2004

Section 1834(l)(3)(B) of the Act provides the basis for updating payment amounts for ambulance services. Our regulations at § 414.620(f) provide that the ambulance fee schedule must be updated by the AIF annually, based on the percentage increase in the consumer price index (CPI) for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year (§ 414.610(f)). The regulations also provide that notice of the AIF be published in the **Federal Register** without opportunity for prior notice and comment. We will follow applicable rulemaking procedures in publishing revisions to the fee schedule for ambulance services that result from any factors other than the inflation factor. In this preamble, we set forth the ambulance inflation factor applicable for services furnished in CY 2004.

II. Provisions of the Final Rule

A. Transitional Assistance for Rural Mileage 18 Through 50

Section 414.610(c)(5) is amended to clarify that this benefit is no longer payable for services furnished after December 31, 2003.

B. Ambulance Inflation Factor for 2004

Section 1834(l)(3)(B) of the Act, specified in § 414.620(f), provides for an update in payments for CY 2004 that is equal to the percentage increase in the CPI for all urban consumers (CPI–U), for the 12-month period ending with June of the previous year (that is, June 2003). For CY 2004, that percentage is 2.1 percent.

During the transition period (described in § 414.615, Transition to the ambulance fee schedule), the AIF is applied to both the fee schedule portion of the blended payment amount and to the reasonable charge/cost portion of the blended payment amount separately for each ambulance provider/supplier. Then, these two amounts are added together to determine the total payment amount for each provider/supplier.

III. Technical Corrections

We are also making the following technical corrections to § 414.605, Definitions.

- In the definition of ''*Advanced life support (ALS) intervention,*'' we are clarifying that an ALS intervention must be furnished by ALS personnel.
- A comma was inadvertently omitted in the definition of ''*Advanced life support, Level 2 (ALS2).*'' That comma is now inserted after the phrase ''or by continuous infusion'' and before the phrase ''excluding crystalloid. * * *''
- There was an inadvertent misuse of the term ''supplier'' in the definition of the term ''*emergency response*.'' The correct term is ''entity.'' Providers, as well as suppliers, may furnish an emergency response. We did not intend to exclude providers from receiving payment for this service.
- In the definition of ''*Rural area*'', we are clarifying that only New England County Metropolitan Areas (NECMAs) (and not MSAs) apply in New England. (NECMAs exist only in New England. All other areas have MSAs.) Also, the term ''NECMA'' was inadvertently omitted from the discussion of the Goldsmith modification. The phrase ''or NECMA'' is now inserted after the term ''MSA'' and before the phrase ''that is identified as rural by the Goldsmith modification.'' This clarifies that a Goldsmith modification can apply to a NECMA as well as an MSA.
- Section 414.610(c)(3) is revised to conform the first two sentences to reflect the fact that the process for determining payment for mileage is the same for ground and air miles.

IV. Waiver of Proposed Rulemaking

We ordinarily publish a proposed rule in the **Federal Register** and provide a period for public comment before we publish a final rule. We can waive this procedure, however, if we find good cause that notice and comment procedure is impracticable, unnecessary, or contrary to the public interest and we incorporate a statement of this finding and its reasons in the rule issued. We find it unnecessary to undertake notice and comment rulemaking in this instance because the statute specifies the method of computation of annual updates, and we have no discretion in this matter. Further, this rule does not change substantive policy, but merely applies the statutorily-specified update method. Therefore, under 5 U.S.C. 553(b)(B), for good cause, we waive notice and comment procedures.

We also find it unnecessary to undertake notice and comment rulemaking as to the technical changes because they merely provide technical corrections to the regulations and do not make any substantive changes to the regulations. Therefore, for good cause, we waive notice and comment procedures.

V. Collection of Information Requirements

This document does not impose information collection and recordkeeping requirements. Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995.

VI. Regulatory Impact Statement

We have examined the impacts of this rule 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). This final rule is not considered a major rule because it has an effect on the Medicare program of less than $100 million in any 1 year. Application of an AIF of 2.1 percent will result in an additional total program expenditure of approximately $65 million.

The RFA requires agencies to analyze options for regulatory relief of small businesses. 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. For purposes of the RFA, all ambulance providers/suppliers are considered to be small entities. Individuals and States are not included in the definition of a small entity.

HHS considers that a substantial number of entities are affected if the rule impacts more than 5 percent of the total number of small entities as it does in this rule. Although this rule impacts every ambulance provider and supplier because all ambulance payment rates are increased by the 2.1 percent ambulance inflation factor, we do not believe that this has a significant impact. We estimate the combined impact of this rule would be an approximate 2 percent increase in Medicare revenues, which, therefore, would be a somewhat less than 2 percent increase in total revenues (that is, Medicare plus non-Medicare revenues). This estimated impact does not meet the threshold established by

HHS to be considered a significant impact. Nonetheless, we have prepared the analysis below to describe the impact of this rule.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if 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. This rule applies to small rural hospitals that furnish at least one Medicare covered ambulance service to at least one Medicare beneficiary.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in expenditure in any 1 year by State, local, or tribal governments, in the aggregate, or by the private sector, of $110 million. This final rule does not result in an expenditure in any 1 year by State, local, or tribal governments of $110 million.

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

This final rule sunsets the rural mileage bonus for rural mileage 18 through 50 as required by statute, provides an update for inflation as mandated by statute, and changes the term ''supplier'' to the term ''entity'' in the definition of an emergency service. Elimination of the bonus payment for rural mileage 18 through 50 will result in a savings to the program of $6 million in CY 2004. Therefore, this is not a major rule.

We estimate that the total program expenditure for CY 2004 for ambulance services covered by the Medicare program is approximately $3 billion. Application of an AIF of 2.1 percent will result in an additional total program expenditure of approximately $65 million.

Our clarification that an ALS intervention must be furnished by ALS personnel will have negligible impact because generally ALS services are required to be furnished by ALS personnel.

The insertion of the comma that had been inadvertently omitted in the definition of ''Advanced life support, Level 2 (ALS2)'' will have no impact since it conforms the regulation to the existing implementing instructions.

Changing the term ''supplier'' to the term ''entity'' in the definition of ''emergency services'' is not a material change because it simply conforms the regulation to actual practice as the program is currently administered.

Our clarification in the definition of ''Rural area'' that NECMAs apply in New England and our addition of NECMA to the discussion of the Goldsmith Modification have a negligible impact because of the very few ambulance suppliers affected. Also, the statute requires that this policy be followed in updating rates by using the most recent Goldsmith modifications.

Our clarification for loaded mileage has no impact because it conforms the regulation to actual practice as the program is correctly administered.

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

List of Subjects in 42 CFR Part 414

Administrative practice and procedure, Health facilities, Health professions, Kidney diseases, Medicare, Reporting and recordkeeping requirements.

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

PART 414—PAYMENT FOR PART B MEDICAL AND OTHER HEALTH SERVICES

■ 1. The authority citation for part 414 continues to read as follows:

Authority: Secs. 1102, 1871, and 1881(b)(1) of the Social Security Act (42 U.S.C. 1302, 1395hh, and 1395rr(b)(1)).

Subpart H—Fee Schedule for Ambulance Services

§ 414.605 [Amended]

■ 2. In § 414.605, the following changes are made:

■ A. The definition of ''*Advanced life support (ALS) intervention*'' is revised by removing the phrase ''beyond the scope of authority of an emergency medical technician-basic (EMT-Basic)'' and adding in its place the phrase ''required to be furnished by ALS personnel.''

■ B. A comma is inserted in the definition of ''*Advanced Life Support, Level 2 (ALS2)*'' after the phrase ''or by continuous infusion'' and before the phrase ''excluding crystalloid. * * *''

■ C. The term ''supplier'' in the definition of ''Emergency response'' is removed and the term ''entity'' is added in its place.

■ D. The definition of ''Rural area'' is revised to read as follows:

§ 414.605 Definitions.

* * * * *

Rural area means an area located outside a Metropolitan Statistical Area (MSA), or, in New England, a New England County Metropolitan Area (NECMA), or an area within an MSA or NECMA that is identified as rural by the Goldsmith modification.

* * * * *

■ 3. Section 414.610 is amended by revising paragraphs (c)(3) and (c)(5) to read as follows:

§ 414.610 Basis of payment.

* * * * *

(c) * * *

* * * * *

(3) Loaded mileage. Payment is based on loaded miles. Payment for air mileage is based on loaded miles flown as expressed in statute miles. There are three mileage payment rates: a rate for FW services, a rate for RW services, and a rate for all levels of ground transportation.

* * * * *

(5) Rural adjustment factor (RAF). For ground ambulance services where the point of pickup is in a rural area, the mileage rate is increased by 50 percent for each of the first 17 miles and, for services furnished before January 1, 2004, by 25 percent for miles 18 through 50. The standard mileage rate applies to every mile over 50 miles and, for services furnished after December 31, 2003, to every mile over 17 miles. For air ambulance services where the point of pickup is in a rural area, the total payment is increased by 50 percent; that is, the rural adjustment factor applies to the sum of the base rate and the mileage rate.

* * * * *

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

Dated: September 2, 2003.

Thomas A. Scully,

Administrator, Centers for Medicare & Medicaid Services.

Approved: October 27, 2003.

Tommy G. Thompson,

Secretary.

[FR Doc. 03–30152 Filed 12–1–03; 12:43 pm]

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