

southerly to 61°02'32.5" N, 146°41'25" W; thence north west to 61°02'40.5" N, 146°41'47" W; thence north east to 61°04'07.5" N, 146°40'15" W; thence north east to 61°05'22" N, 146°37'38" W; thence south east back to the starting point at 61°05'15" N, 146°37'18" W.

(b) *Regulations.* (1) The general regulations in 33 CFR 165.33 apply to the security zones described in paragraph (a) of this section.

(2) Tank vessels transiting directly to the TAPS terminal complex, engaged in the movement of oil from the terminal or fuel to the terminal, and vessels used to provide assistance or support to the tank vessels directly transiting to the terminal, or to the terminal itself, and that have reported their movements to the Vessel Traffic Service, as required under 33 CFR part 161 and § 165.1704, may operate as necessary to ensure safe passage of tank vessels to and from the terminal.

(3) All persons and vessels must comply with the instructions of the Coast Guard Captain of the Port and the designated on-scene patrol personnel. These personnel comprise commissioned, warrant, and petty officers of the Coast Guard. Upon being hailed by a vessel displaying a U.S. Coast Guard ensign by siren, radio, flashing light, or other means, the operator of the vessel must proceed as directed. Coast Guard Auxiliary and local or state agencies may be present to inform vessel operators of the requirements of this section and other applicable laws.

Dated: September 23, 2005.

M.S. Gardiner,

*Commander, United States Coast Guard,
Captain of the Port, Prince William Sound,
Alaska.*

[FR Doc.05-20276 Filed 10-6-05; 8:45 am]

BILLING CODE 4910-15-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 421

[CMS-6022-P]

RIN 0938-AN31

Medicare Program; Termination of Non-Random Prepayment Review

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

ACTION: Proposed rule.

SUMMARY: This proposed rule would implement the statutory requirements

regarding the termination of non-random prepayment review under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. This proposed rule provides the criteria for terminating a provider or supplier from non-random prepayment review.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on December 6, 2005.

ADDRESSES: In commenting, please refer to file code CMS-6022-P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of three ways (no duplicates, please):

1. *Electronically.* You may submit electronic comments on specific issues in this regulation to <http://www.cms.hhs.gov/regulations/ecomments>. (Attachments should be in Microsoft Word, WordPerfect, or Excel; however, we prefer Microsoft Word.)

2. *By mail.* You may 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-6022-P, PO Box 8012, Baltimore, MD 21244-8012.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By hand or courier.* If you prefer, you may deliver (by hand or courier) your written comments (one original and two copies) before the close of the comment period to one of the following addresses. If you intend to deliver your comments to the Baltimore address, please call telephone number (410) 786-9994 in advance to schedule your arrival with one of our staff members.

Room 445-G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201; or 7500 Security Boulevard, Baltimore, MD 21244-1850.

(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 for persons wishing to retain a 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 received after the comment period.

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

FOR FURTHER INFORMATION CONTACT: Lieutenant Commander Marie Casey, (410) 786-7861 or Daniel Schwartz, (410) 786-4197.

SUPPLEMENTARY INFORMATION:

Submitting Comments: We welcome comments from the public on all issues set forth in this rule to assist us in fully considering issues and developing policies. You can assist us by referencing the file code CMS-6022-P.

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. CMS posts all electronic comments received before the close of the comment period on its public website as soon as possible after they have been received. Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a 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 1-800-743-3951.

I. General and Legislative History

Medicare contracting authority has been in place since the inception of the Medicare program in 1965. Section 1874 of the Social Security Act (the Act) authorizes the Secretary to perform Medicare program functions directly or by contract.

On August 21, 1995, the Congress enacted the Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104-191) (HIPAA). Section 202 of HIPAA added section 1893 to the Act that establishes the Medicare Integrity Program and allows us to contract with eligible entities to perform program integrity activities. Specifically, we contract with intermediaries as specified in section 1816(a) of the Act; and carriers as specified in section 1842(a) of the Act; and program safeguard contractors (PSCs) to perform medical, fraud, and utilization reviews, and cost report audits of Medicare claims. (Hereinafter, intermediaries, carriers, and PSCs that perform medical review functions are referred to as contractors). This program is funded by the Medicare Hospital Insurance Trust Fund for activities related to Medicare Part A and Part B.

On December 8, 2003, the Congress enacted the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). Section 934 of the MMA amended section 1874A of the Act by adding a new subsection regarding random prepayment reviews and non-random prepayment reviews including the termination date of non-random prepayment reviews.

Although section 934 of the MMA specifies requirements regarding random prepayment review, contractors do not perform random prepayment review. However, contractors do perform non-random prepayment review.

For purposes of this regulation, we are proposing the following definitions related to medical review activities:

Allowable charges means the dollar amount (including co-pay and deductibles) that the Medicare program will pay for a particular item or service.

Complex Medical Review means review of claim information and medical documentation by a licensed medical professional, for a billed item or service identified by data analysis techniques or probe review to have a likelihood of sustained or high level of payment error.

Error rate means the dollar amount of allowable charges for a particular item or service billed in error as determined by complex medical review, divided by the dollar amount of allowable charges for that medically reviewed item or service.

Initial error rate means the calculation of an error rate based on the results of a probe review prior to the initiation of non-random prepayment complex medical review.

Medical review means the process performed by Medicare contractors to ensure that billed items or services are covered and are reasonable and necessary as specified under section 1862(a)(1)(A) of the Act.

Non-clinician medical review staff means specially trained medical review staff that do not possess the knowledge, skills, training, or medical expertise of a licensed medical professional.

Non-random prepayment complex medical review means the prepayment medical review of claim information and medical documentation by a licensed medical professional, for a billed item or service identified by data analysis techniques or probe review to have a likelihood of sustained or high level of payment error.

Non-random prepayment medical review means the prepayment medical review of claims for a billed item or service identified by data analysis techniques or probe review to have a

likelihood of a sustained or high level of payment error.

Provider-specific probe review means the complex medical review of a small sample of claims, generally 20 to 40 claims, from a specific provider or supplier for a specific billing code to confirm that the provider or supplier is billing the program in error.

Quarterly error rate means the calculation of an error rate based on the results of non-random prepayment complex medical review for a specific billing code for a specific quarter.

Service-specific probe review means the complex medical review of a sample of claims, generally 100 claims, across the providers or suppliers that bill a particular item or service to confirm that the item or service is billed in error.

Termination of non-random prepayment complex medical review means the cessation of non-random prepayment complex medical review.

II. General Overview of the Medical Review Process

A. Medical Review

We enter into contractual agreements with contractors to perform medical review functions. One of the functions of a contractor is to ensure the fiscal integrity of the Medicare program by conducting medical review of claims to determine whether items or services are covered and are reasonable and necessary. When a claim is submitted for payment, it may be subject to medical review before payment is made.

There are three types of non-random prepayment medical review: Automated, routine, and complex. A non-random prepayment automated medical review is when decisions are made at the system level, using available electronic information, without the intervention of contractor personnel. A non-random prepayment routine medical review is limited to rule-based determinations performed by specially trained non-clinical medical review staff. Automated and routine non-random prepayment medical review does not create an administrative burden on the provider or supplier since additional medical documentation does not need to be submitted for these types of medical reviews and payments for covered, reasonable and necessary items or services are not delayed. Therefore, these types of reviews pose no discernable administrative burden on the provider or supplier because there is no interaction between the contractor and the provider or supplier during the medical review process. As indicated above, non-random prepayment complex medical review is the

evaluation of medical records or any other documentation by a licensed medical professional prior to Medicare payment. Complex medical review determinations require the reviewer to make a clinical judgment about whether an item or service is covered, and is reasonable and necessary. In order for this determination to be made the provider or supplier would submit a copy of the medical records that indicate that the items or services billed are covered, and are reasonable and necessary for the condition of the patient. This type of review delays payment until the contractor is able to make a determination that the items or services billed are covered and are reasonable and necessary. This proposed rule only applies to terminating a provider or supplier from non-random prepayment complex medical review. (A detailed description of the concepts for performing the different types of non-random prepayment medical review functions are located in our manual instructions at http://www.cms.hhs.gov/manuals/108_pim/pim83toc.asp).

The contractor employs data analysis procedures to identify claims that may be billed inappropriately. These procedures may be based on claims data (national and local) beneficiary complaints, and alerts from other organizations (for example, Office of Inspector General and Government Accountability Office). When a contractor identifies a likelihood of sustained or high level of payment error, the contractor may request supporting medical record documentation. Examples of a high level of payment error include unusual patterns such as prescribing the same items or services for a high number of patients, consistently prescribing inappropriate treatments, unexplained increases in volume when compared to historical or peer trends, or any other reasons as determined by the Secretary or his designees.

Before a contractor places a provider or supplier on non-random prepayment complex medical review, the contractor would perform a probe review (that is, complex medical review of a small sample of claims for a specific billing code, generally 20 to 40 claims to confirm that the provider or supplier is billing the program in error). In the case of a widespread "item or service-specific" problem, a larger sample of claims (generally 100 claims of the item or service in question) would be subjected to complex medical review. Performing medical review on a sample of claims for a specific billing code before placing the provider or supplier

on non-random prepayment complex medical review allows for a determination as to whether a problem exists and ensures that contractor medical review resources are targeted appropriately and that providers and suppliers are not unnecessarily burdened.

When a probe confirms that a provider or supplier is billing the program in error, and those billing errors present a likelihood of sustained or high level of payment error (for example, a high billing error rate or errors on claims representing high dollar value) this may result in the provider or supplier being placed on non-random prepayment complex medical review. Contractors target medical review activities at providers, items or services that place the greatest risk of making improper payments from the Medicare trust funds.

This activity may involve complex medical review. Complex medical review involves the application of clinical judgment by a licensed medical professional in order to evaluate medical records to determine whether an item or service is covered, and is reasonable and necessary.

Medical records include any medical documentation, other than what is included on the face of the claim that supports the item or service that is billed. For Medicare to consider coverage and payment for any item or service, the information submitted by the supplier or provider (that is, claims) must be supported by the documentation in the patient's medical records. The patient's medical records include—(1) physician's office records; (2) hospital records; (3) nursing home records; (4) home health agency records; (5) records from other healthcare professionals; and (6) diagnostic reports and other supporting documentation. The contractor specifies which pieces of documentation they want. Providers and suppliers may supply additional documentation not explicitly listed by the contractor. This supporting information may be requested by CMS and its agents on a routine basis in instances where diagnoses on the claims do not clearly indicate medical necessity. For example, documentation supporting the medical necessity of a power wheelchair would not be requested in the vast majority of cases where patients have definite medical conditions such as neurological spinal cord injury, cerebral palsy, multiple sclerosis or stroke with residual myoplegia (not all inclusive). On the other hand, it is more likely that documentation would be requested for patients whose diagnoses are limited to

non-neurological conditions such as chronic obstructive pulmonary disease, congestive heart failure, coronary artery disease, arthritis or obesity (not all inclusive).

Any determination must be documented and include the rationale for the decision. While medical review staff must follow National Coverage Determinations and Local Coverage Determinations, they are expected to use their expertise to make clinical judgments when making medical review determinations. They must take into consideration the clinical condition of the beneficiary as indicated by the beneficiary's diagnosis and medical history when making these determinations. At any time during the medical review process the contractor detects possible fraud, the contractor would refer the issue to the Benefit Integrity Program Safeguard Contractor.

Before the enactment of the MMA, we continued to perform non-random prepayment complex medical review until the provider or supplier demonstrated compliance with Medicare billing requirements as evidenced by an acceptable error rate. The contractor made the determination of "acceptable error rate." As a result, some providers and suppliers have remained on medical review for a considerable period of time.

B. Termination of Non-Random Prepayment Complex Medical Review

In accordance with section 934 of the MMA, we are proposing to terminate in most cases a provider or supplier from non-random prepayment complex medical review no later than 1 year from the initiation of the review or when the provider's or supplier's error rate decreases by 70 percent from the initial error rate. The initiation of review begins on the date the contractor sends a letter to the provider or supplier. The letter would notify the provider or supplier of the results of the probe review and would inform them that they would be subjected to non-random prepayment complex review. In addition, we are proposing terminating a provider or supplier from non-random prepayment complex medical review when medical review error rate findings indicate that the provider or supplier has corrected its billing errors resulting in at least a 70 percent decrease from its initial error rate. The initial error rate would be calculated based on the probe review prior to the initiation of non-random complex prepayment medical review. We initially considered whether a 90 to 95 percent decrease in a provider's or supplier's error rate was appropriate but determined that a 90 to

95 percent reduction in a provider's or supplier's error rate would be impracticable. Therefore, we believe an error rate reduction of 70 percent from the error rate calculated during probe review, the "initial error rate," would protect the financial integrity of the Medicare program and allow the provider or supplier a realistic opportunity to be terminated from non-random prepayment complex medical review.

When a provider or supplier is terminated from non-random prepayment complex medical review after 1 year of review and the contractor determines that the provider or supplier continues to have a high error rate despite educational interventions, the contractor must consider referring the provider or supplier to the Benefit Integrity Program Safeguard Contractor. Contractors must also consider continuing educational interventions without performing medical review or consider performing postpayment medical review.

We are also proposing that a contractor could extend a non-random prepayment complex medical review beyond the 1-year limit in certain situations. The contractor could extend non-random prepayment complex medical review if a provider or supplier stops billing the code under review or shifts billing to another inappropriate code to avoid the contractor's proper calculation of the error rate. If the reduction in the error rate is attributed to a 25 percent or greater reduction in the number of claims submitted for the specific billing code under review, non-random prepayment complex medical review for that provider or supplier could be extended. However, if the number of claims submitted for a specific code was reduced because the provider or supplier began billing claims using a new appropriate code, or there is another legitimate explanation for the reduced number of claims billed, at the contractor's discretion, the provider or supplier may not be required to undergo extended non-random prepayment complex medical review. If extended medical review is necessary, contractors would notify providers and suppliers in writing the reason for the need to perform additional prepayment complex medical review.

The contractor would evaluate the results of non-random complex prepayment medical review, and the length of time a provider or supplier remains on review, at least every quarter following the initiation of non-random prepayment complex medical review. Quarterly error-rate evaluations would

be for the discrete quarter; a rolling error rate average over more than one quarter would not be appropriate. After the contractor determines that the provider or supplier should be terminated from non-random prepayment complex medical review, the contractor would update the claims processing system within 2 business days to ensure that the provider's and supplier's claims are no longer suspended for that specific billing error.

Once a provider or supplier is terminated from non-random prepayment complex medical review contractors would periodically re-evaluate the provider or supplier's data. If necessary the contractor could place a provider or supplier that appears to have resumed a high level of payment error on complex medical review. This review would only be initiated if a probe review confirms that there continues to be a high level of payment error.

III. Provisions of the Proposed Regulations

To comply with section 934 of the MMA, we are proposing to amend 42 CFR part 421 by adding and reserving subpart D and adding a new subpart E entitled, "Medicare Payment Review." This subpart would establish the general criteria for terminating a provider or supplier from non-random prepayment complex medical review.

In § 421.401, we are proposing to define the following terms for purposes of this new subpart:

- Error rate.
- Initial error rate.
- Medical review.
- Non-random complex prepayment medical review.
- Non-random prepayment medical review.
- Provider specific probe review.
- Quarterly error rate.
- Service specific probe review
- Termination of non-random prepayment complex medical review.

In addition, we are proposing in § 421.405 to specify the termination criteria for non-random prepayment complex medical review.

IV. 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 before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, 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.

We are soliciting public comment on each issue for § 421.405 as summarized and discussed below that contain information collection requirements.

Section 421.405 Termination and Extension of Non-Random Prepayment Complex Medical Review

In summary, § 421.405 outlines the proposed requirements and process for the termination and extension of non-random prepayment complex medical review, a form of complex medical review. Contractors conduct complex medical review to determine whether items or services billed are covered, correctly coded, and are reasonable and necessary for the condition of the patient. Under complex medical review the provider or supplier must submit a copy of the medical records that support the items or services billed.

The burden associated with this section is the time and effort necessary for the provider or supplier of services to locate and obtain the supporting documentation for the claim to Medicare and to forward the materials for submission to Medicare contractors for review. We expect that this information would generally be maintained by suppliers and/or providers as a normal course of business and that this information will be readily available.

The burden associated with this requirement is estimated to be 10 minutes per provider or supplier, to locate, photocopy and transmit this information to the contractor upon request.

Over the past 3 years, Medicare contractors have performed complex medical review on an average of 2.9 million claims.

The total annual burden associated with this requirement is estimated to be 483,333 hours (2.9 million requests for medical records × 10 minutes).

If you comment on these information collection and recordkeeping requirements, please mail copies directly to the following: Centers for Medicare & Medicaid Services, Office of Strategic Operations and Regulatory

Affairs, Regulations Development Group, Attn: William N. Parham, III, CMS-6022-P, Room C4-26-05, 7500 Security Boulevard, Baltimore, MD 21244-1850; and

Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503, Attn: Christopher Martin, CMS Desk Officer, CMS-6022-P, *Christopher.Martin@omb.eop.gov*. Fax (202) 395-6974.

V. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We would consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, when we proceed with a subsequent document, we would respond to the comments in the preamble to that document.

VI. Regulatory Impact

We have examined the impact of this rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96-354), section 1102(b) of the Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104-4), and Executive Order 13132.

Executive Order 12866 (as amended by Executive Order 13258, which merely reassigns responsibility of duties) 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) be prepared for major rules with economically significant effects (\$100 million or more in any 1 year). This rule does not reach the economic threshold and thus is not considered a major rule.

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. Individuals and States are not included in the definition of a small entity. We are not preparing an analysis for the RFA because we have determined that this rule would not have a significant

economic impact on a substantial number of small entities. We believe that this rule would decrease the costs for providers and suppliers because it establishes guidelines for terminating a provider or supplier from non-random prepayment complex medical review. We believe this rule would eliminate inappropriate reviews and would ensure that Medicare payments would not be withheld for extended time periods.

Because a contractor would no longer be maintaining providers or suppliers on non-random prepayment complex medical review for extended periods, administrative expenses (for example, copying, mailing, and the retention of medical documentation) would be reduced.

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 603 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 are not preparing an analysis for section 1102(b) of the Act because we have determined that this rule would not have a significant impact on the operations of a substantial number of small rural hospitals.

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 \$100 million. This rule would have no consequential effect on the governments mentioned or on the private sector.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates 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. Since this regulation would not impose any costs on State or local governments, the requirements of E.O. 13132 are not applicable.

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 421

Administrative practice and procedure, Health facilities, Health

professions, Medicare, Reporting and recordkeeping requirements.

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

PART 421—INTERMEDIARIES, CARRIERS, AND PROGRAM SAFEGUARD CONTRACTORS

1. The authority citation for part 421 continues to read as follows:

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

2. The heading for Part 421 is revised to read as set forth above.

3. Add and reserve a new subpart D.

4. Add new subpart E, consisting of § 421.400 through § 421.405, to read as follows:

Subpart E—Medical Review

Sec.

421.400 Medicare review functions.

421.401 Definitions.

421.405 Termination and extension of non-random prepayment complex medical review.

Subpart E—Medical Review

§ 421.400 Medicare review functions.

CMS enters into contractual agreements with intermediaries, carriers, and program safeguard contractors (PSCs) (hereinafter, intermediaries, carriers, and PSCs that perform medical review functions are referred to as contractors) to perform medical review functions to ensure that items or services are covered and are reasonable and necessary in accordance with Medicare coverage policies and program instructions.

§ 421.401. Definitions.

As used in this subpart—

Allowable charges means the dollar amount (including co-pay and deductibles) that the Medicare program will pay for a particular item or service.

Complex Medical Review means all medical review of claim information and medical documentation by a licensed medical professional, for a billed item or service identified by data analysis techniques or probe review to have a likelihood of sustained or high level of payment error.

Error rate means the dollar amount of allowable charges for a particular item or service billed in error as determined by complex medical review, divided by the dollar amount of allowable charges for that medically reviewed item or service.

Initial error rate means the calculation of an error rate based on the results of a probe review prior to the initiation of

non-random prepayment complex medical review.

Medical review means the process performed by a contractor to ensure that billed items or services are covered and are reasonable and necessary as specified under section 1862(a)(1)(A) of the Act.

Non-clinician medical review staff means specially trained medical review staff that do not possess the knowledge, skills, training, or medical expertise of a licensed health care professional.

Non-random prepayment complex medical review means the prepayment medical review of claim information and medical documentation by a licensed medical professional, for a billed item or service identified by data analysis techniques or probe review to have a likelihood of sustained or high level of payment error.

Non-random prepayment medical review means the prepayment medical review of claims for a billed item or service identified by data analysis techniques or probe review to have a likelihood of a sustained or high level of payment error.

Provider-specific probe review means the complex medical review of a small sample of claims, generally 20 to 40 claims, from a specific provider or supplier for a specific billing code to confirm that the provider or supplier is billing the program in error.

Quarterly error rate means the calculation of an error rate based on the results of non-random prepayment complex medical review for a specific billing code for a specific quarter.

Service-specific probe review means the complex medical review of a sample of claims, generally 100 claims, across the providers or suppliers that bill a particular item or service to confirm that the item or service is billed in error.

Termination of non-random prepayment complex medical review means the cessation of non-random prepayment complex medical review.

§ 421.405 Termination and extension of non-random prepayment complex medical review.

(a) Except for cases described in paragraph (b) of this section, a contractor may terminate a provider or supplier from non-random prepayment complex medical review—

(1) No later than 1 year following the initiation of non-random prepayment complex medical review; or

(2) If calculation of the error rate indicates that the provider or supplier has reduced its initial error rate by 70 percent or more. A contractor must review claims for a specific billing code aberrancy for the quarter and calculate

the quarterly error rate for those claims medically reviewed in that quarter. In order for this determination to be made, the provider or supplier must submit a copy of the medical records that indicate that the items or services billed are covered, correctly coded, and are reasonable and necessary for the condition of the patient. When a provider or supplier is terminated from non-random prepayment complex medical review after 1 year of review and the contractor determines that the provider or supplier continues to have a high error rate despite educational interventions the contractor must consider referring the provider or supplier to the Benefit Integrity PSC. Contractors must also consider continuing educational interventions without performing medical review or must consider performing postpayment medical review.

(b) *Extension of non-random prepayment complex medical review.* (1) A contractor must extend non-random prepayment complex medical review beyond the 1 year timeframe if a provider or supplier stops billing the code under review or shifts billing to another inappropriate code to avoid proper calculation of the error rate. If the reduction in the error rate is attributed to a 25 percent or greater reduction in the number of claims submitted for the specific billing code under review, non-random prepayment complex medical review for that provider or supplier must be extended. However, if the number of claims submitted for a specific code were reduced because the provider or supplier began billing claims using a new appropriate code, or there is another legitimate explanation for the reduced number of claims billed, at contractor discretion, the provider or supplier may not be required to undergo extended non-random prepayment complex medical review.

(2) If extended medical review is necessary, contractors must notify providers and suppliers in writing the reasons for the need to perform additional prepayment complex review.

(c) *Quarterly termination evaluation—* (1) Contractors, at a minimum, must evaluate the length of time a provider or supplier has been on non-random prepayment complex medical review on a quarterly basis. A determination as to whether the provider's or supplier's initial probe review error rate for a specific billing code has been reduced by 70 percent must also be evaluated quarterly.

(2) Quarterly error rate evaluations must be for the discrete quarter; a rolling error rate average over more than

one quarter is not permitted. After the contractor determines that the provider or supplier should be terminated from non-random prepayment complex medical review, the claims processing system must be updated within 2 business days to ensure that a provider's or supplier's claims for a specific billing error is no longer suspended for non-random prepayment complex medical review.

(d) *Periodic re-evaluation.* Once a provider or supplier is terminated from non-random prepayment complex medical review, contractors must periodically re-evaluate the provider or supplier's data and if necessary must place a provider or supplier that appears to have resumed a high level of payment error on complex medical review. This review would only be initiated if a probe review confirms that there continues to be a high level of payment error.

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

Dated: October 26, 2004.

Mark B. McClellan,

Administrator, Centers for Medicare & Medicaid Services.

Approved: March 10, 2005.

Michael O. Leavitt,

Secretary.

Editorial Note: This document was received at the Office of the Federal Register on September 30, 2005.

[FR Doc. 05-19925 Filed 9-30-05; 2:47 pm]

BILLING CODE 4120-01-P

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

43 CFR Part 2560

[WO-350-1410-00-24 1A]

RIN 1004-AD60

Alaska Native Veterans Allotments

AGENCY: Bureau of Land Management, Interior.

ACTION: Proposed rule.

SUMMARY: The Bureau of Land Management (BLM) proposes to amend regulations published in the **Federal Register** on Friday, June 30, 2000 (65 FR 40953). The existing regulations allowed certain Alaska Native veterans another opportunity to apply for a Native allotment under the repealed Native Allotment Act of 1906. This proposed rulemaking would delete the

requirement that veteran applicants must post the land by marking all corners of the ground with their name and address prior to filing an application with the BLM. Enforcement of the posting rule for allotments adjudicated under the 1906 Act was previously waived by an Assistant Secretary. Therefore, the posting requirement is deemed unnecessary for Native veteran allotment cases.

DATES: *Comments:* Send your comments to reach the BLM on or before December 6, 2005. The BLM will not necessarily consider any comments received after the above date during its decision on the proposed rule.

ADDRESSES: You may mail comments to Director (630), Bureau of Land Management, Eastern States Office, 7450 Boston Boulevard, Springfield, Virginia 22153.

Hand Delivery: 1620 L. Street, NW., Suite 401, Washington, DC 20036.

E-mail:

comments_washington@blm.gov.

Federal eRulemaking Portal: <http://www.regulations.gov>.

FOR FURTHER INFORMATION CONTACT:

Mike Haskins, Division of Conveyance Management, Bureau of Land Management, 222 West 7th Avenue #13, Anchorage, Alaska 99513; telephone (907) 271-3351; or Kelly Odom, Bureau of Land Management, Regulatory Affairs Group, Mail Stop 401, 1620 L Street, NW., Washington, DC 20036; telephone (202) 452-5028. Persons who use a telecommunications device for the deaf (TDD) may contact these persons through the Federal Information Relay Service (FIRS) at 1-800-877-8339, 24 hours a day, seven days a week.

SUPPLEMENTARY INFORMATION:

- I. Public Comment Procedures
- II. Background
- III. Discussion of Proposed Rule
- IV. Procedural Matters

I. Public Comment Procedures

Written Comments

Written comments on the proposed rule should be specific, should be confined to issues pertinent to the proposed rule, and should explain the reason for any recommended change. Where possible, comments should reference the specific section or paragraph of the proposal which the commenter is addressing. The BLM may not necessarily consider or include in the Administrative Record for the final rule comments which the BLM receives after the close of the comment period (See **DATES**) or comments delivered to an address other than those listed above (See **ADDRESSES**).