releases from the Site not be deleted from the NPL, however, no other information was included with this request. The other letter requested information about what happens once the releases from the Site are deleted from the NPL and expressed concerns about the effects of the Site on the health of people who live in the vicinity of the Site. A response letter was sent to each of these citizens and a responsiveness summary was prepared in regard to these two letters. A copy of the responsiveness summary is in the Site administrative record.

The EPA identifies releases which appear to present a significant risk to public health, welfare or the environment, and it maintains the NPL as the list of those sites. Releases on the NPL may be the subject of remedial actions financed by the Hazardous Substance Superfund Response Trust Fund (Fund). Pursuant to § 300.425(e)(e) of the NCP, any release deleted from the NPL remains eligible for Fund-financed remedial actions in the unlikely event that conditions at the Site warrant such action.

Deletion of a release from the NPL does not affect responsible party liability or impede agency efforts to recover cost associated with response efforts.

### List of Subjects in 40 CFR Part 300

Environmental protection, Air pollution control, Chemicals, Hazardous substances, Hazardous waste, Intergovernmental relations, Penalties, Reporting and recordkeeping requirements, Superfund, Water pollution control, Water supply.

Dated: September 22, 1999.

**W. Michael McCabe,**

*Regional Administrator, USEPA Region III.*

For the reasons set out in the preamble, 40 CFR part 300 is amended as follows:

## PART 300—[AMENDED]

1. The authority citation for part 300 continues to read as follows:

**Authority:** 33 U.S.C. 1321 (c)(2); 42 U.S.C. 9601–9657; E.O. 12777, 56 FR 54757, 3 CFR, 1991 Comp., p. 351; E.O. 12580, 52 FR 2923, 3 CFR, 1987 Comp., p. 193.

### Appendix B—[Amended]

2. Table 1 of appendix B to part 300 is amended by removing the site: Taylor Borough Dump, Taylor Borough, Pennsylvania.

[FR Doc. 99–25433 Filed 9–29–99; 8:45 am]

BILLING CODE 6560–50–U

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Health Care Financing Administration

### 42 CFR Part 405

**[HCFA–4121–FC]**

**RIN 0938–AG48**

## Medicare Program; Telephone Requests for Review of Part B Initial Claim Determinations

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

**ACTION:** Final rule with comment period.

**SUMMARY:** Currently, our regulations allow beneficiaries, providers, and suppliers (defined as physicians or other practitioners, or entities other than a provider), who are entitled to appeal Medicare Part B initial claim determinations, to request a review of the carrier's initial determination in writing. This final rule allows those review requests to be made by telephone and allows the carrier to conduct the review by telephone, if possible. The use of telephone requests supplements, and does not replace, the current written procedures for initiating appeals. This telephone option also improves carrier relationships with the beneficiary, provider, and supplier communities by providing quick and easy access to the appeals process. Carriers will make accommodations to enable a hearing impaired individual access to the telephone review process.

**EFFECTIVE DATE:** These regulations are effective on February 1, 2000.

Comment date: Comments will be considered if we receive them at the appropriate address, as provided below, no later than 5 p.m. on November 29, 1999.

**ADDRESSES:** Mail an original and 3 copies of written comments to the following address: Health Care Financing Administration, Department of Health and Human Services, Attention: HCFA–4121–FC, P.O. Box 9013, Baltimore, MD 21244–9013.

**FOR FURTHER INFORMATION CONTACT:** Rosalind Little, (410) 786–6972.

**SUPPLEMENTARY INFORMATION:**

### I. Background

Under current Medicare regulations at 42 CFR Part 405, Subpart H, a party (a person enrolled under Part B of Medicare, his or her assignee, or other entity having standing to appeal the determination in question), that indicates dissatisfaction with a Part B initial claim determination by a carrier, is entitled to have a carrier review conducted in accordance with regulations set forth in § 405.807 (Review of initial determination) and section 12010 of the Medicare Carriers Manual (MCM). However, if the appellant is not a proper party or the request for appeal review is not filed timely, the appellant's request may be dismissed.

Currently, a request for the carrier review of an initial claim determination is to be made in writing and filed with us, at an office of the carrier, or at an office of the Social Security Administration (SSA). The carrier must provide a period of 6 months after the date of the notice of its initial determination within which a party may request review. The carrier may, upon request by the party affected, extend the period for requesting the review.

On July 10, 1995, we published a proposed rule in the **Federal Register** (60 FR 35544) that would change the Medicare regulations to allow a party to request the carrier review of its Part B initial claim determination by telephone or by electronic transmission, in addition to the current provisions for a written request.

### II. Provisions of the Proposed Rulemaking

In the proposed rule, we stated that the reason for allowing parties to request the review of a carrier's initial claim determination by telephone or electronic transmission, in addition to submitting written requests, was that we recognized that both physicians and beneficiaries often call the carrier to dispute a determination, to ask for clarification, or to protest a denial. We also recognized that the current review process requiring a party to submit a written request for a review can take considerable time and effort. This is because at times it can be difficult to properly explain a problem or ask a question in writing. In addition, a written request provides no opportunity for the dialogue that allows parties to discuss the issues and provide detailed explanations.

The proposed rule stated that telephone or electronic requests for review of Health Maintenance Organizations (HMOs) and Peer Review Organizations (PROs) Part B initial determinations must be made in writing. This rule does not apply to HMO and PRO appeal determinations. A party can initiate an appeal of a determination by an HMO under 42 CFR 417.616 and a determination by a PRO under 42 CFR 473.18(a).

The July 10, 1995 rule proposed to limit electronic requests for review to those entities that electronically bill

their claims to a carrier system that has the capability to receive claims electronically and, therefore, would also be able to receive electronic requests for review.

We also proposed to change the current appeal period of 6 months to 180 days and to further provide a 150-day appeal period for telephone requests for review within that 180-day period. We made this proposal to allow an additional 30 days for the appellant to submit a written request for review in the event they were unable to reach the carrier by telephone.

The proposed rule also gave an overview of how we expected the telephone and electronic process to work.

**III. Analysis of and Responses to Public Comments**

In response to the July 10, 1995 proposed rule, we received 14 timely items of correspondence. The majority of the commenters supported our efforts to improve and expedite the review and appeals process. Six of the 14 comments received concerned, in part, the electronic request aspects of the proposed regulation. Since issuing the proposed rule, we have determined that technical circumstances beyond our control will not permit us to offer the option of electronically requesting reviews of initial claims determinations, and we are, therefore, withdrawing that provision of the proposed rule. In the future, however, we may consider offering providers, physicians, and suppliers the option of requesting a review of their intitial determnation electronically. In order to offer this option we would need to obtain an approved appeals data set from the ANSI X12 Committee which then would need to be adopted by the DHHS as a HIPAA data sandard. We are soliciting comments on the feasibility and benefit of providing this option. We would also like to know any cost you believe you would incur to use this option.

We are not responding in detail to specific comments relating to the electronic requests. However, we provide the following overview of those comments and our general response. Two commenters specifically supported our desire to offer this option. One commenter suggested that we should wait until the Medicare Transaction System comes online before making this option available. As noted, we are not offering this option due to technical circumstances beyond our control. There were three technical comments. One comment concerned the cost of processing electronic requests. The second comment concerned protecting the privacy of the beneficiary. The third comment concerned the complexity of handling non-assigned claims electronically.

With respect to the first comment, since we proposed to offer that option only to those providers that bill electronically and only where the carriers could receive and process claims electronically, there would have been no additional costs to the supplier, provider, or carrier. With respect to the second comment, we would protect the privacy of the beneficiary by maintaining the requirement to have either a letter signed by the beneficiary naming a representative, or an Appointment of Representative form signed by the beneficiary to be received by the carrier before any information could be released to someone other than that beneficiary. Finally, the same document used to verify assignment would have been required to be delivered to the carrier by courier, by mail, or by facsimile before any non-assigned claim would have been processed and before any Medicare payment would have been released.

The following is a summary of those comments received pertaining to telephone requests for reviews of initial claims determinations and our response.

*Comment:* One commenter questioned whether the rule included the Part B review process for Part A intermediaries.

*Response:* Yes, it does. For the purposes of 42 CFR part 405, Subpart H, the term ''carrier'' also refers to an ''intermediary'' that has entered into a contract with the Secretary under section 1816 of the Social Security Act (the Act) and is authorized to make determinations with respect to Part B provider or supplier services.

*Comment:* One commenter stated that currently HCFA determines the timeliness of filing a request for a Part B review by the postmark on the envelope of the written request and asked if timeliness of filing requests by telephone would be determined by a telephone log.

*Response:* Carriers may record requests for reviews received by telephone either in a manual log or in a computer database. The record will show the date of the incoming request and other pertinent information. The log date will be used to record whether the request was received within the 6-month period, and will show how long it took the carrier to complete the appeal.

*Comment:* One commenter recommended that the percentage of calls monitored be set at the carrier's discretion instead of the 10 to 15 percent level indicated in the proposed MCM instructions addressing this final rule that have been circulated to carriers.

*Response:* Issues dealing with how carriers will monitor telephone calls and what percentage of calls will be monitored each month will be included in forthcoming MCM instructions. When we issue the MCM instructions for the telephone review process, they will state the percentage of calls that must be monitored each month.

*Comment:* One commenter asked if we could outline what is considered a reasonable timeframe for the processing of an appeal.

*Response:* In many cases, telephone reviews will be handled at the time of the call. Some carriers do not have dedicated lines for telephone reviews. In these cases, when the parties call in, someone will take the information from the caller, then pass that information to the section that will return the call. When possible, the review will be performed at that time. When the telephone reviews are not handled during the initial call, we expect the return call to be processed within approximately 1 to 2 business days from the time of the initial call.

*Comment:* Several commenters asked if specific contractor performance evaluation (CPE) standards will be issued.

*Response:* We expect to establish CPE standards for telephone reviews. These standards will be included in the MCM instructions that will be issued at a later date.

*Comment:* One commenter asked how we will preserve confidentiality. Another asked, more specifically, how we will prevent someone who does not represent the provider from requesting a review.

*Response:* Carriers will be required to train their telephone reviewers to meet the requirements of the Privacy Act. For calls from individuals who purport to be the beneficiary involved or someone representing the beneficiary, each caller will be asked to verify his or her identity and, if necessary, his or her relationship to the beneficiary. An Appointment of Representative form or a signed letter from the beneficiary will be required when a caller purports to represent the beneficiary. For calls from practitioners or other suppliers regarding assigned claims, the carrier will verify the tax identification number, name, and telephone number. The carrier will give information only pertaining to the assigned claims of those practitioners or suppliers. On nonassigned claims, the only information the carrier will provide to

the physician or other supplier is the date the claim was processed, unless the physician or supplier can provide the carrier with a facsimile of a signed copy of the Appointment of Representative form or a copy of a letter signed by the beneficiary. Regarding the issue of preventing someone who does not represent the provider from making a request for review, other individuals may request a review on behalf of an appellant. The results of that review, however, will only be given to the party enrolled under Part B, their assignee, other entities having a standing to appeal the determination in question, or any individual appointed as his or her representative (unless the individual is disqualified or suspended from acting as a representative).

*Comment:* One commenter asked if the Appointment of Representative and Waiver of Right of Payment forms will be eliminated.

*Response:* We do not anticipate that the Appointment of Representative and Waiver of Right of Payment forms will be eliminated.

*Comment:* One commenter asked whether all providers and suppliers have the option of using telephone review procedures, or only those providers and suppliers who accept Medicare assignment.

*Response:* Normally, telephone reviews will be available only to providers and suppliers who accept assignment. That is, telephone reviews are limited to providers and suppliers on assigned claims, unless the beneficiary gives a nonparticipating supplier the right to represent him or her and the nonparticipating supplier provides the carrier with a signed copy of the Appointment of Representative form or a signed letter from the beneficiary designating the nonparticipating supplier to pursue the claim on behalf of the beneficiary. In those instances in which a nonparticipating supplier is required to refund any collected amount to the beneficiary in accordance with section 1842(l)(1)(A) of the Act, that supplier would have its own appeal rights. Otherwise, carriers may take information from nonparticipating suppliers, but cannot give any information concerning the result of the review to that caller.

*Comment:* One commenter asked whether the rule will require that the party who answers the telephone for the carrier be the primary receiver of calls and if that party will be required to give his or her name, if asked.

*Response:* Some carriers do not have dedicated lines for telephone reviews. In those instances, the party who answers the telephone call may only be obtaining certain information from the appellant (for example, completing a form) and then will forward the form to the party who will evaluate whether the request can be handled as a telephone review. If so, the reviewer will telephone the appellant and perform the review. We will also instruct the carriers to train their personnel to give their names to the callers, if asked. In addition, we will instruct the carriers that if the caller is requesting a telephone review, and the carrier verifies that the request is a request for a review, a confirmation number must be provided to the appellant at the end of the telephone call. Furthermore, we will instruct the carriers that their systems must record the date the appellant called as the date of the request for a review. Having the system annotate the date of the request and providing the appellant with a confirmation number will protect the appellant's appeal rights.

*Comment:* One commenter recommended that beneficiary eligibility and/or entitlement not be considered appropriate for telephone reviews. The commenter was also concerned that allowing beneficiaries access to the telephone review process will not be cost-effective since in most cases the beneficiary will not have the information needed for the review to be performed at the time of the review request.

*Response:* SSA handles all eligibility and/or entitlement issues. The only entitlement issue that a Medicare carrier could handle during a telephone review would be to advise the appellant that, as of a given date, the records show that he or she does not have entitlement. The forthcoming MCM instructions will list those issues we expect all carriers to be able to resolve during a telephone review. We believe that offering telephone reviews to beneficiaries will enhance customer service to the beneficiary community. Even if the review cannot be performed at the time that the telephone request is made, it is an opportunity for the carrier to explain to the beneficiary how the original claim was processed. Furthermore, we believe that with the information available to the carrier in its computer database, it will be able to effectively process many of the beneficiary requests for review.

*Comment:* Several commenters asked if the MCM instructions will impose a limit on the number of claims and reviews providers and suppliers could request for review by telephone.

*Response:* Carriers will be allowed to determine how many claims per review they can handle during each call. We anticipate that the carriers will evaluate their workloads and staffing to determine the number of claims their staff can handle. This self-imposed limit should restrict the time involved for each call and, as a result, give more appellants an opportunity to use the telephone review process.

*Comment:* One commenter asked if carriers should be required to have sufficient capacity to receive a reasonable volume of telephone review requests.

*Response:* As stated earlier, we will allow the carriers to determine the number of claims that they are able to handle on each call they receive so that the self-imposed limit will allow everyone to request a review by telephone. We, therefore, expect carriers to have sufficient staff to receive telephone requests for review. However, if we determine that there is a need for additional resources, some adjustments will be made. In addition, all parties will be informed about the telephone review process in advance to enable them to make effective use of this option.

*Comment:* One commenter questioned whether we intend for the carrier representative who receives a telephone request for an appeal to merely register the request, with the review itself occurring at a later date, or to actually conduct the review at the time of the call.

*Response:* As stated earlier, we expect many carriers will perform the review at the time of the initial call. There may be some carriers that do not have dedicated lines for telephone reviews. In those cases, parties will be informed in advance as to how that carrier will perform the telephone review.

*Comment:* One commenter asked that the secondary claim review (the commenter is referring to the first level of the appeal process) be performed by someone other than the party who made the initial determination.

*Response:* The original claim receives an initial determination. The initial determination is the first determination made by a carrier or intermediary following a request for Medicare payment for Part B claims under title XVIII of the Act. The notice of the initial determination informs each party of the determination and provides appropriate appeals information to the parties having standing to appeal. The first level of the Part B appeal is an independent review of the claim that is performed by someone other than the party who made the initial determination in accordance with current MCM instructions.

*Comment:* One commenter asked if we could modify existing Medicare regulations to require that the review be conducted by a ''qualified physician.''

*Response:* Reviews are conducted by contractor personnel who have expertise in resolving claims disputes. A physician may be consulted in an individual case. However, carriers do not normally employ physicians to conduct reviews because it is not cost-effective.

*Comment:* One commenter asked if we will establish a mechanism to guarantee that appellants initiating a telephone request for review are able to reach the carrier.

*Response:* This rule will require all carriers to implement a process by which they can receive telephone requests for review. We will require all carriers to ensure that they have sufficient staff to accommodate the number of calls they receive. If at any time it is determined that this is not the case, we expect the carrier to re-evaluate its process and take the necessary action to correct the deficiency.

*Comment:* One commenter expressed concern that if appellants are not limited by the number of appeals they can request per call, additional resources (such as a 24-hour appeals hotline) or additional staff should be provided.

*Response:* The forthcoming MCM telephone review instructions will give the carriers some instructions to guide them in determining how many claims can be appealed per call. The carrier will have to give some consideration to whether the actual appeal will take place during the initial call or whether the initial call will only be used to gather information and the appeal will be handled at a later time. Another issue that the carriers will have to consider is whether to set a limit on the number of appeals allowed per call or a time limit per call. We will not instruct the carriers to set a time limit, as this might be construed as limiting the party's right to a full review of his or her concerns. The carriers will inform the party in advance what the requirements or limitations are for requesting a review via telephone, as well as any limitations in those instances where the review is performed during the initial call. The carriers will inform the beneficiaries, providers, and suppliers via newsletters, stuffers, seminars, customer service representatives, beneficiary and physician advocacy groups, and others how the telephone process will work.

*Comment:* Several commenters asked about the specific documentation requirements.

*Response:* The information the carrier receives during the telephone review must be either: (1) documented on a review documentation form, or (2) logged and maintained on a computer system so that the information about the claim and request for review can be retrieved on an on-line basis. All documentation must be assigned a review control number (this can also be the confirmation number given to the appellant at the end of the review). The confirmation number that the carriers are required to provide an appellant can be their internal control number, correspondence number, or document control number. The carrier must be able to use the number to confirm the date of the appellant's call. Other documentation requirements will be established in the forthcoming MCM instructions.

*Comment:* One commenter stated that the rule does not indicate that reopening of initial claim determinations, as permitted under § 405.841, can be done by telephone appeals.

*Response:* This rule does not permit parties to request reopenings by telephone.

*Comment:* One commenter was concerned that, because carriers could be overwhelmed with requests for review sent in by facsimile, the option of submitting requests for review by facsimile should not be advertised.

*Response:* This rule does not permit parties to request reviews by facsimile. However, carriers may use facsimile machines to obtain additional documentation from an appellant or the appellant's representative. For example, carriers may use facsimile machines to obtain a copy of the Appointment of Representative form or other documentation.

*Comment:* One commenter asked whether, if the reviewer determines that additional written information is needed to complete the review, carriers have the option to suspend the review until that information is received.

*Response:* In those cases in which the provider or supplier needs to submit additional medical documentation and the information can be supplied (for example, by facsimile) during the telephone review, or within 24 hours of the telephone call, the carrier may suspend the telephone review. The carrier must inform the appellant that the telephone review will not be considered complete until the appellant provides the requested additional information. If the appellant is unable to provide the additional information during the telephone review, or within 24 hours of the telephone call, the carrier has the option to suspend the telephone review. If the information is not provided within the allowed time the carrier will conduct a written review or allow the appellant to call the carrier back when the additional information becomes available. In either situation, the carrier must provide the appellant with a confirmation number. If the appellant is a beneficiary who does not have the additional information on hand or does not have easy access to a facsimile machine, the carrier must advise the appellant that the request for review will be handled as a written review. In this instance also, the carrier must provide the appellant with a confirmation number.

*Comment:* Several commenters expressed concern about the feasibility and fairness of the 150-day limit for making requests for telephone reviews.

*Response:* In the proposed rule, we suggested establishing a 150-day timeframe after the date of the notice of the carrier's initial determination within which a party may request a telephone review, and a 180-day period for requesting reviews in writing, rather than the 6-month period currently allowed. The proposal was an attempt to give appellants, who we thought may be unsuccessful in their efforts to reach the carrier by telephone, an additional opportunity to initiate a request in writing before the time to appeal expired. We now believe that the proposed 150-day timeframe for requesting telephone reviews is confusing and that two different timeframes would not be cost-effective. Furthermore, based on a survey of our carriers regarding the timeframe within which they have been able to receive requests for review by telephone after they send out initial determinations, we believe that parties will not have difficulty reaching the carrier by telephone. Therefore, we will retain the currently-specified 6-month timeframe to request reviews of initial claims, regardless of the method used to make the request. We will instruct our carriers to advise parties, through their bulletins, workshops, and seminars to not wait until the last day of the 6-month period to request a review by telephone.

*Comment:* Several commenters were concerned that including details of the telephone review process on the Explanation of Medicare Benefits/Medicare Summary Notice (EOMB/MSN) and Remittance Advice forms will be confusing for the beneficiaries.

*Response:* Details about the telephone review process will not be provided on the EOMB/MSN or Remittance Advice forms; that information will be provided by other means, such as in newsletters,

seminars, and envelope stuffers. However, there will be a general statement on the EOMB/MSN form that informs the appellant that he or she can telephone the carrier to request a review.

*Comment:* One commenter was concerned that the requirement to advise the appellant of further appeal rights was redundant.

*Response:* We disagree. At the end of the review, the appellant should be given information about how to proceed in the event that he or she is still dissatisfied.

*Comment:* One commenter recommended that, if the telephone review is an affirmation, the review determination letter should be sent (following the telephone review) only when requested by the appellant.

*Response:* Whenever a review occurs, our current regulation at 42 CFR 405.811 requires the carrier to send a written notice of the review determination to a party that states the basis of the determination and advises the party of his or her appeal rights to a carrier hearing when the amount in controversy is $100 or more.

*Comment:* One commenter recommended that to ensure adequate notice of these new procedures, the notice sent with the carrier's initial determination should (in addition to those items noted in the proposed rule) clearly state that: (1) electronic transmissions may be submitted only by those who submit their claims electronically; (2) electronic transmission does not include facsimile transmissions; (3) if a request is made to an SSA or HCFA office (rather than to a carrier), the request must still be made in writing; (4) the carrier will resolve as many issues as possible during the telephone request, but parties have the opportunity to submit supporting documents; and (5) parties may request, and be granted, an extension of time for filing a review request if good cause is established by the carrier.

*Response:* As stated earlier, we are withdrawing the option of requesting reviews of initial claims determinations electronically (comment numbers (1) and (2)). With respect to comment (3), carriers will be required to describe the telephone review process to all beneficiaries, providers, and suppliers at least 30 days before implementation. We do not believe that it is necessary or cost-effective to describe in detail the telephone review procedures every time the carrier issues an initial determination. There are a number of ways the carrier can inform parties about the telephone review process, such as through bulletins, newsletters, beneficiary, provider, and supplier outreach seminars and meetings, or through contractor customer service and inquiry departments. The opportunity to submit supporting documentation (comment (4)) and the request for an extension of time for filing a review request (comment (5)) are covered by existing regulations. If circumstances warrant, parties will be advised of their opportunity to submit supporting documentation and be granted an extension of time.

*Comment:* Several commenters were concerned that requiring carriers to send a written response when they have reviewed a request and decided to pay a claim in full is an additional requirement.

*Response:* As stated earlier, whenever a review occurs, our current regulations at 42 CFR 405.811 require that a notice of review determination be sent to a party that states the basis for the determination and advises the party of his or her right to a carrier hearing when the amount in controversy is $100 or more. If the decision results in full payment, the EOMB/MSN or Remittance Advice notice is no longer sufficient unless it contains the basis of the determination and advises the party of his or her right to a carrier hearing.

*Comment:* One commenter asked if telephone inquiries would be screened to determine whether the party is requesting a review or is just requesting an explanation of the initial determination.

*Response:* The carriers will be required to train their customer service representatives and telephone reviewers to ask specific questions to determine whether the caller is only requesting an explanation of the initial determination or is requesting a review.

*Comment:* One commenter was concerned that, since payments as the result of a telephone review are not subject to the payment floor, the provider or supplier will be successful in receiving payment for these claims in less time than if they initially filed a correct claim.

*Response:* All payments are subject to the payment floor (the required waiting period that must occur before payment can be made) and cannot be paid before that time expires. This is true for initial claims, as well as for adjustments made as a result of a review. The waiting period for an electronic claim is 14 days after the claim is received, and the waiting period for a paper claim is 27 days after the claim is received. Therefore, a provider or supplier should not receive payment sooner, as the result of a telephone review, than he or she would have received payment for the initial claim; that is, either 14 days for an electronic claim or 27 days for a paper claim.

*Comment:* One commenter asked if our intent is to offer telephone reviews and electronic reviews as an option, or if our intent is to require telephone reviews and offer electronic reviews as an option.

*Response:* When this rule becomes effective, beneficiaries, providers, and suppliers will have the option of requesting a review by telephone or in writing. As stated earlier, we are withdrawing the option of requesting reviews of initial claims determinations electronically.

## IV. Provisions of the Final Regulations

For the most part, this final rule reflects the provisions of the July 1995 proposed rule, except that we are withdrawing our proposals to allow a party to request a review of a carrier's Part B initial claim determination by electronic transmission and we are withdrawing the proposed 150-day time period for a party to request a telephone review.

In addition to establishing the provisions of the proposed rule, except as noted above, this final rule: (1) continues the 6-month time period currently in regulations for requesting a review of a carrier's initial claim determination; (2) revises § 405.805 of the regulations to make a technical correction by removing the reference to subparagraph ''(b)'' after § 405.802; and (3) revises § 405.807 of the regulations for consistency with the wording in § 405.821(a).

## V. Regulatory Impact Statement

We have examined the impacts of this final rule as required by Executive Order 12866 and the Regulatory Flexibility Act (RFA) (Public Law 96–354). Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects; distributive impacts; and equity). The RFA requires agencies to analyze options for regulatory relief for small businesses. For purposes of the RFA, carriers and beneficiaries are not considered to be small entities. For purposes of the RFA, most hospitals, and most other providers, physicians, and other health care suppliers are small entities, either by nonprofit status or by having revenues of $5 million or less annually.

Under this final rule, beneficiaries, providers, and suppliers may request a

review of an initial claim determination by telephone in addition to the current writing procedure. A telephone review is the first level of appeal for Part B claims and is performed by carrier staff who had no part in making the initial claim determination in accordance with current MCM instructions. A telephone review is considered to be less costly to all parties and is a more expeditious way of handling appeals than a written review.

Also, section 1102(b)(2) of the Act requires us 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.

We are not preparing analyses for either the RFA or section 1102(b)(2) of the Act because we have determined and certify that this final rule will not have a significant economic impact on a substantial number of small entities or a significant impact on the operations of a substantial number of small rural hospitals.

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

We have reviewed this notice under the threshold criteria of Executive Order 12612, Federalism. We have determined that it does not significantly affect the States rights, roles, and responsibilities.

**List of Subjects in 42 CFR Part 405**

Administrative practice and procedure, Health facilities, Health professions, Kidney diseases, Medicare, Reporting and recordkeeping requirements, Rural areas, X-rays.

For the reasons set forth in the preamble, 42 CFR chapter IV is amended as set forth below:

## PART 405—FEDERAL HEALTH INSURANCE FOR THE AGED AND DISABLED

### Subpart H—Appeals Under the Medicare Part B Program

1. The authority citation for part 405, subpart H is revised to read as follows:

**Authority:** Secs. 1102, 1842(b)(3)(C), 1869(b), and 1871 of the Social Security Act (42 U.S.C. 1302, 1395u(b)(3)(C), 1395ff(b), and 1395hh).

2. Section 405.805 is revised to read as follows:

**§ 405.805 Parties to the initial determination.**

The parties to the initial determination (see § 405.803) may be any party described in § 405.802.

3. Section 405.807 is revised to read as follows:

**§ 405.807 Request for review of initial determination.**

(a) *General.* A party to an initial determination by a carrier, that is dissatisfied with the initial determination and wants to appeal the matter, may request that the carrier review the determination. The request for review by the party to an initial determination must clearly indicate that he or she is dissatisfied with the initial determination and wants to appeal the matter. The request for review does not constitute a waiver of the party's right to a hearing (under § 405.815) after the review.

(b) *Place and method of filing a request.* A request by a party for a carrier to review the initial determination may be made in one of the following ways:

(1) In writing and filed at an office of the carrier, SSA, or HCFA.

(2) By telephone to the telephone number designated by the carrier as the appropriate number for the receipt of requests for review.

(c) *Time of filing request.* (1) The carrier must provide a period of 6 months after the date of the notice of the initial determination within which the party to the initial determination may request a review.

(2) The carrier may, upon request by the party, extend the period for requesting the review of the initial determination.

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

Dated: October 6, 1998.

**Nancy-Ann Min DeParle,**

*Administrator, Health Care Financing Administration.*

Dated: February 22, 1999.

**Donna E. Shalala,**

*Secretary.*

**Editorial Note**: This document was received at the Office of the Federal Register September 27, 1999.

[FR Doc. 99–25477 Filed 9–29–99; 8:45 am]

BILLING CODE 4120–01–P

## DEPARTMENT OF DEFENSE

### 48 CFR Part 204

**[DFARS Case 99–D011/98–D017]**

### Defense Federal Acquisition Regulation Supplement; Fiscal Year 2000 Contract Action Reporting Requirements; Correction

**AGENCY:** Department of Defense, (DoD).

**ACTION:** Correction to the final rule.

**SUMMARY:** DoD is issuing a correction to the final rule published at 64 FR 45197–45207 on August 19, 1999. The correction reflects the change in name of the ''Defense Fuel Supply Center'' to the ''Defense Energy Support Center''.

**EFFECTIVE DATE:** October 1, 1999.

**FOR FURTHER INFORMATION CONTACT:** Ms. Michele Peterson, (703) 602–0311.

Correction

In the issue of Thursday, August 19, 1999, on page 45198, in the first column, in 204.670–2(c)(7)(ii), in the first line, remove the words ''Fuel Supply'' and add in their place the words ''Energy Support''.

**Michele P. Peterson,**

*Executive Editor, Defense Acquisition Regulations Council.*

[FR Doc. 99–25165 Filed 9–29–99; 8:45 am]

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## DEPARTMENT OF DEFENSE

### 48 CFR Parts 205, 206, 217, 219, 225, 226, 236, 252, and 253

**[DFARS Case 98–D007]**

### Defense Federal Acquisition Regulation Supplement; Reform of Affirmative Action in Federal Procurement

**AGENCY:** Department of Defense (DoD).

**ACTION:** Final rule.

**SUMMARY:** The Director of Defense Procurement is adopting as final, with changes, an interim rule amending the Defense Federal Acquisition Regulation Supplement (DFARS) policy concerning programs for small disadvantaged business (SDB) concerns. The amendments conform to a Department of Justice (DoJ) proposal to reform affirmative action in Federal procurement, and are consistent with the changes made to the Federal Acquisition Regulation (FAR) in Federal Acquisition Circulars (FACs) 97–06 and 97–13. DoJ's proposal is designed to ensure compliance with the constitutional standards established by the Supreme Court in *Adarand*