Dated: October 12, 1999.

Cynthia C. Dougherty,

Director, Office of Ground Water and Drinking Water.

[FR Doc. 99–27545 Filed 10–22–99; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Part 405

[HCFA–6003–P]

RIN 0938–AI49

Medicare Program; Appeals of Carrier Determinations That a Supplier Fails to Meet the Requirements for Medicare Billing Privileges

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

ACTION: Proposed rule.

SUMMARY: This proposed rule would extend appeal rights to all suppliers whose enrollment applications for Medicare billing privileges are disallowed by a carrier or whose Medicare billing privileges are revoked, except for those suppliers covered under other existing appeals provisions of our regulations. In addition, we propose to revise certain appeal provisions to correspond with the existing appeal provisions in those other sections of our regulations. We also would extend appeal rights to all suppliers not covered by existing regulations to ensure they have a full and fair opportunity to be heard. Although we are not required by the Administrative Procedure Act to publish this rule as a proposed rule (see 5 U.S.C. section 553(b)(3)(A), we are doing so in order to allow interested parties the opportunity for prior notice and comment.

DATES: Written comments will be considered if we receive them at the appropriate address, as provided below, no later than 5 p.m. Eastern time on December 27, 1999.

ADDRESSES: Mail written comments (1 original and 3 copies) to the following address: Health Care Financing Administration, Department of Health and Human Services, Attention: HCFA–6003–P, P.O. Box 26688, Baltimore, MD 21207–0488.

If you prefer, you may deliver your written comments (1 original and 3 copies) to one of the following addresses:

Room 443–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201–0001, or

Room C5–16–03, Central Building, 7500 Security Boulevard, Baltimore, MD 21244–1850.

Because of staffing and resource limitations, we cannot accept comments by facsimile (FAX) transmission. In commenting, please refer to file code HCFA–6003–P. Written comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, in Room 443–G of the Department's offices at 200 Independence Avenue, SW., Washington DC, on Monday through Friday of each week from 8:30 a.m. to 5 p.m. Eastern time (phone: (202) 690–7890).

FOR FURTHER INFORMATION CONTACT: Charles Waldhauser, (410) 786–6140.

SUPPLEMENTARY INFORMATION:

I. Background

A Medicare beneficiary generally may obtain covered Medicare services from any person, agency or institution that is qualified to participate in the Medicare program and that undertakes to furnish those services. Various provisions of the statutes and regulations establish conditions of participation or standards that a health care supplier or provider must meet in order to receive Medicare payment. These standards differ depending on the type of provider or supplier involved and whether the services are furnished under parts A, B, or C of the Medicare statute. There are also differences in qualifications between providers and suppliers of services, and differences among the various types of suppliers, in how they are enrolled in the Medicare program. For some classifications of providers and suppliers, an on-site survey is required. For other individuals or entities, a determination can be made based largely on the information provided by the applicant.

The Medicare regulations in Part 498 provide appeal rights for certain suppliers that have been found to not meet certain conditions of participation or established standards. For the purposes of part 498, these suppliers include independent laboratories; suppliers of portable x-ray services; rural health clinics; federally qualified health centers; ambulatory surgical centers; organ procurement organizations; end-stage renal disease treatment facilities; and chiropractors and physical therapists in independent practice.

In addition, our regulations at § 405.874 provide an appeals process for Durable Medical Equipment, Prosthetics and Orthotics and Supplies (DMEPOS) suppliers that wish to contest a disallowance of an application for a billing number or the revocation of an existing billing number. The § 405.874 appeals process afforded DMEPOS suppliers includes the right to a carrier hearing before a carrier official who was not involved in the original determination, and the right to seek a review before a HCFA official designated by the HCFA Administrator.

The purpose of this proposed rule would be to establish an administrative appeals process for certain other suppliers, such as physicians or physician assistants, who have had an application for billing privileges disallowed or existing billing privileges revoked, but who are not specifically included under either the Part 498 or § 405.874 appeals processes. Because the adverse determinations with respect to these other suppliers are similar to those described above for DMEPOS suppliers, we are proposing to amend the existing appeals process at § 405.874 to include appeal rights for these other suppliers.

In December, 1998, we issued HCFA Ruling 98–1, regarding the appeals process Medicare carriers must provide to physicians, non-physician practitioners, and to certain entities that receive reassigned benefits from physicians and non-physician practitioners. HCFA Rulings are decisions of the Administrator that serve as precedent final opinions and orders and statements of policy and interpretation. They provide clarification and interpretation of complex or ambiguous provisions of law or regulations relating to Medicare, Medicaid, Utilization and Quality Control Peer Review, private health insurance, and related matters. HCFA Rulings are binding on all HCFA components, Medicare contractors, the Provider Reimbursement Review Board, the Medicare Geographic Classification Review Board, the Departmental Appeals Board, and Administrative Law Judges (ALJs) who hear Medicare appeals. These Rulings promote consistency in interpretation of policy and adjudication of disputes. This proposed rule is very similar to HCFA Ruling 98–1, but expands the types of suppliers covered.

II. Provisions of the Proposed Rule

We are proposing to revise the scope of § 405.874 (''Appeals of carrier decisions that supplier standards are not met.'') to extend appeal rights to all

suppliers whose enrollment applications for Medicare billing privileges are disallowed or whose Medicare billing privileges are revoked, except for those suppliers covered under the appeals provisions of Part 498. These administrative appeal rights would now apply to suppliers of durable medical equipment, prosthetics, orthotics, and supplies; ambulance service providers; independent diagnostic testing facilities; physicians; and other entities such as physician assistants.

We would also revise the existing procedures in § 405.874. These procedural changes would be as follows:

Carrier Time Limit to Process Enrollment Application

Currently, § 405.874(a) provides that a carrier must accept or reject an entity's enrollment application for a billing number or request additional information within 15 days of the receipt of the enrollment application. We believe the 15-day requirement restricts our ability to properly evaluate enrollment applications. Although the majority of supplier applicants to the Medicare program are legitimate, our mandate to ensure the integrity of the Medicare program requires stringent review of supplier enrollment applications, including verifying information with outside agencies, for example State licensing boards. These application verifications require additional amounts of time, sometimes beyond the current 15-day period, and the amount of time is not always predictable. In addition, such a requirement is not germane to appeals provisions. Therefore, for the proposed revision to § 405.874(a), we would remove the 15-day requirement. In order to ensure that time frames do not become excessively burdensome to suppliers, we monitor the time required by carriers to process enrollment applications as part of our oversight of carrier operations. In addition, we are considering placing a timeliness requirement for processing of applications for supplier billing privileges in another part of our regulations.

Terminology

Current § 405.874(b) provides that a carrier can disallow or revoke an entity's request for a billing number but must notify the supplier of its right to appeal. The supplier then has 90 days after the postmark of the notice to request an appeal. For purposes of this section and to parallel language used in other appeals provisions of Part 405, in revised § 405.874(a) and § 405.874(b), we propose to clarify the language concerning when a notice is received by the supplier from ''postmark of the notice'' to ''the date of receipt of the carrier's notice.'' We would specify that ''the date of receipt of the notice'' is presumed to be five days after the date of the notice. The burden would be on the supplier to show that more than five days actually elapsed between the date of the notice and the date it received the notice in order for the supplier to be granted relief from the requirement to file an appeal within 65 days from the date of the notice. In § 405.874(b)(1), we would clarify also that a Medicare billing number is the identification number of a provider or supplier to which we have granted Medicare billing privileges.

Disallowances and Revocations

Current § 405.874(b) discusses the procedures that carriers follow in disallowing a request for a Medicare supplier billing number and in revoking an enrolled supplier's Medicare billing number. We would now set forth the procedures to be followed by carriers concerning notifying a supplier of the disallowance of an enrollment application for supplier billing privileges in the proposed revision to § 405.874(a) and the revocation of an already enrolled supplier's billing number in the proposed revision to § 405.874(b). We would separate these procedures because we believe the prior language was not sufficiently clear.

Also, existing § 405.874(b) provides a 90-day time frame under which a supplier may appeal a carrier's determination or a supplier or carrier may appeal a carrier hearing officer's decision. We are proposing the revision of the 90-day appeal period to a 60-day appeal period in new paragraphs (a)(3), (b)(1)(iii), and (c)(3)(iii) in order to expedite the proceedings and to parallel the standard time frames for Medicare appellants who file Part A or Part B claim appeals with administrative law judges. We believe 60 days is a sufficient amount of time in which to file an appeal.

In the proposed revision to § 405.874(b)(2), we would clarify that a revocation of a supplier billing number that is based on a Federal exclusion or debarment is effective with the effective date of the exclusion or debarment, regardless of the date of the notice from the carrier that the billing number is revoked. We would further clarify in the proposed revision to § 405.874(b)(3) that suppliers are not paid for services or supplies furnished during a period in which their supplier billing number has been revoked. With respect to DMEPOS suppliers, section 1834(j)(1) of the Act states that, with the exception of medical equipment and supplies furnished incident to a physician's service, no payment may be made by Medicare for items and supplies unless the supplier has a valid, active Medicare billing number. Therefore, any expenses for items or supplies furnished to a Medicare beneficiary on or after the effective date of the inactivation (or revocation) of a DMEPOS supplier's billing number are the DMEPOS supplier's responsibility. Unless the DMEPOS supplier has proof it notified the beneficiary, in accordance with section 1834(a)(18)(A)(ii) of the Act, that Medicare payment may not be made and that the beneficiary agreed to take financial responsibility, the DMEPOS supplier is responsible for the expenses incurred for the items and services furnished. Without this proof of beneficiary notification and agreement, the DMEPOS supplier is required to refund on a timely basis to the beneficiary (and is liable to the beneficiary for) any amounts collected from the beneficiary for items or services furnished during the period of inactivation or revocation. If the DMEPOS supplier fails to refund as required, sanctions such as civil money penalties, assessments, and exclusions may be imposed. (See section 1879(h)(3) of the Act). In contrast, other, non-DMEPOS suppliers, for example, physicians, currently may bill for services furnished before they are issued a supplier billing number, assuming they meet Medicare requirements. We propose that claims submitted to carriers for services or supplies furnished during a period of supplier ineligibility are to be rejected by the carrier, not denied. Rejections of claims by carriers are not appealable by suppliers.

Hearing by Carrier

In the proposed revision to § 405.874(c)(1), we would change the language in current § 405.874(c) that requires a carrier hearing officer to ''schedule a hearing to be held within one week,'' to require that the hearing must be held within ''60 days of receipt of the appeal request.'' The previous ''one week'' language was unclear as to the intent—whether it was the ''scheduling'' or the ''hearing'' that was required within one week. We believe that it is unreasonable to require that a hearing be scheduled or held within 1 week of receiving the request for appeal. The carrier needs time to prepare the case and forward it to the hearing officer. The person or entity seeking review may also need more than one

week to prepare for the case. With respect to the time frame for issuing hearing officer decisions, the new provision would parallel the timeliness requirement in § 405.834.

In addition, current § 405.874(c) also discusses the procedures to be followed in a carrier hearing in consideration of the disallowance or revocation of a supplier billing number. In the proposed revision to § 405.874(c)(2), we would change the language to clarify that the supplier is required to prove that it is in compliance with all Medicare requirements for billing privileges, and that the carrier incorrectly disallowed or revoked the supplier's billing number. The ultimate burden of proof is on the supplier to show that it meets all requirements upon application, and to show at any time that it continues to meet any requirements that may be in place to bill Medicare. It is presumed that the carrier made a reasonable determination to disallow or revoke a supplier's billing number based on information it had at the time of the decision. The supplier would be required to furnish the evidence that clearly shows the determination was in error at the time it was made.

In new § 405.874(c)(3), we would revise the timeliness requirement in current § 405.874(c) for the hearing officer to issue a decision from ''two weeks'' to ''as soon as practicable after the hearing'' because the hearing officer must be allowed sufficient time to adjudicate the facts and make a reasoned decision. In addition, the proposed revision requirement would parallel the timeliness requirement for other hearing officer decisions in part 405.

Implementation of Reversal of Carrier Determination

We propose to conclude our revision of current § 405.874(c) by adding paragraphs (5), (6), and (7) to allow carrier discretion in deciding whether to put into effect a carrier hearing officer's reversal of the carrier's determination to disallow or revoke a supplier billing number, pending a possible appeal by the carrier. If the carrier were to decide to appeal the carrier hearing officer's decision to HCFA, the carrier would be permitted to continue to hold the supplier billing number as disallowed or revoked, pending the HCFA official's decision. The carrier would also have the discretion to implement the reversal (that is, grant or reinstate billing privileges) even though it is appealing the carrier hearing officer's decision. A carrier would implement a reversal decision immediately if it decides not to appeal the carrier hearing officer's decision to HCFA.

In the event that a supplier were to decide to appeal a carrier hearing officer's partial reversal to HCFA, and the carrier were to decide not to appeal, the carrier would implement the partial reversal. A partial reversal could be, for example, a decision to reinstate a revoked billing number, but not back to the date of the revocation; thus, there would be a period of non-eligibility for the supplier from the date of revocation to the reinstatement date. If the supplier were to appeal to the HCFA official to be reinstated for full eligibility, and the carrier were to decide not to appeal, the carrier would still implement only the partial reinstatement until the HCFA official would issue a decision on the appeal for full reinstatement.

Hearing by HCFA

In the proposed revision to § 405.874(d), we would change the language that currently appears in § 405.874(d) to specify that the HCFA official bases his or her decision on the carrier hearing officer's decision and the case file (record) established by the carrier hearing officer. In other words, this is not a de novo hearing. However, the HCFA official would be permitted to supplement the record as deemed necessary to clarify any issues. The HCFA official would issue a decision as soon as practicable in light of the issues involved and his or her workload. The HCFA official's decision would be the last administrative process available to either the carrier or the supplier.

Reversal of Carrier Determination

We would revise current § 405.874(e) to clarify that we will not pay for services furnished by suppliers during a period in which the supplier's billing privileges have been revoked. Therefore, any reversals of carrier decisions must indicate the effective date of the reversal. No appeal rights for suppliers accrue to rejections of claims or parts of claims that were made because the services or items were furnished during a period of supplier ineligibility. Claims for items or services furnished during a period for which the supplier's eligibility is established upon reversal would be adjudicated by the carrier in accordance with normal procedures, and would be denied or approved on their own merits.

Reinstatement of Supplier Billing Number Following Corrective Action

Current § 405.874(f) addresses corrective action plans. We would revise this paragraph to clarify that the supplier must be in compliance with all requirements in order to have its billing number reinstated, and that we must be satisfied that the supplier is in compliance and will remain in compliance. The burden of proof again would be on the supplier to demonstrate that it can operate in accordance with Medicare requirements. It would not be enough for the supplier to submit a plan for corrective action. If we were to decide to reinstate a billing number, we would establish the date of reinstatement, and the carrier would be able to pay for services furnished on or after the effective date of reinstatement.

Reopening of Carrier Determination, Carrier Hearing Officer Decision, or HCFA Decision

We propose to add new § 405.874(g) to permit the carrier, carrier hearing officer, or HCFA official to reopen and revise its determination or decision in accordance with §§ 405.841 and 405.842. This means, for example, that the carrier would not be permitted to revise a carrier hearing officer's or HCFA official's decision.

Effective Date for DMEPOS Supplier Billing Number

We propose to add new § 405.874(h), wherein we would address the situation that a DMEPOS supplier may not be paid for items or services furnished prior to the date its billing number is issued. Any decision to change, either through appeal or reopening, a disallowance of an enrollment application would establish the effective date of the billing number. Any claims for services or items furnished prior to the effective date of the billing number would be rejected and no appeal rights would apply for those claims—see § 405.803. Further, sections 1834(a)(18)(A)(ii) and 1834(j)(4) of the Act apply to those claims and provide that no payment may be made, and that the supplier may not charge the beneficiary, for services furnished prior to the effective date, unless the beneficiary explicitly agreed to pay even though Medicare would not pay.

Submission of Claims

Finally, we would add new § 405.874(i) to describe the procedure for submitting claims after a reversal of a supplier enrollment application disallowance or billing number revocation, or after a billing number reinstatement. We would specify that if a supplier is reinstated, any claims for items or services, furnished during the period of supplier ineligibility that became a period of eligibility upon reinstatement, may be submitted for adjudication as long as the period for

filing claims has not elapsed. If the claims previously were filed timely but were rejected, they would be considered filed timely upon resubmission.

III. Regulatory Impact Statement

We have examined the impact of this proposed rule under Executive Order 12866 and the Regulatory Flexibility Act (RFA) (Pub. L. 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, most hospitals, and most other providers, physicians, and health care suppliers are small entities, either by nonprofit status or by having revenues of $5 million or less annually.

According to data submitted to us by carriers in calendar year 1997, 129,000 enrollment applications were submitted to the Medicare carriers by suppliers seeking to receive billing privileges. We believe that a vast majority of these applicants were small businesses. Of those applications, 2,310 were denied. A total of 291 applicants requested an appeal of their denial.

Also, section 1102(b) of the Act requires us to prepare a regulatory impact analysis for any proposed rule that may have a significant impact on the operations of a substantial number of small rural hospitals. That 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 50 beds.

We are not preparing analyses for either the RFA or section 1102(b) of the Act because we have determined, and we certify, that this proposed 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. As discussed in detail, under section II., Provisions of the Proposed Rule, the purpose of the proposed changes to our current regulations would be to extend appeal rights to all suppliers whose enrollment applications for Medicare billing privileges are disallowed or whose Medicare billing privileges are revoked, except for those suppliers covered under the appeals provisions of part 498.

We believe that this proposed rule would have no adverse impact on small entities; in fact, it would afford small suppliers a measure of protection against adverse actions by HCFA, and extend protection to a larger group of suppliers beyond the DMEPOS suppliers currently covered under § 405.874. Because this proposed rule would merely clarify, expand, and update our current policy and administrative appeal rights, we anticipate slight, if any, economic impact on small entities. We are, however, inviting comments as to whether this rule would have a significant impact on a substantial number of small rural hospitals or entities.

IV. Response to Comments

Because of the large number of items of correspondence we normally receive on **Federal Register** documents published for comment, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, when we issue the final rule, we will respond to the comments in the preamble to that document.

V. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995 (PRA), agencies are required to provide a 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 PRA requires that we solicit comment on the following issues:

- Whether the information collection is necessary and useful to carry out the proper functions of the agency;
- The accuracy of the agency's estimate of the information collection burden;
- The quality, utility, and clarity of the information to be collected; and
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

However, we believe the information collection activities referenced in § 405.874 are exempt under the terms of the PRA for the following reasons:

- As defined in 5 CFR 1320.4, information collections conducted or sponsored during the conduct of criminal or civil action, or during the conduct of an administrative action, investigation, or audit involving an agency against specific individuals or entities are exempt from the PRA;
- As described in 5 CFR 1320.3(h)(9), facts or opinions obtained or solicited through nonstandardized follow-up questions designed to clarify responses to approved collections, are exempt from the PRA; and/or
- Nonstandardized information collections directed to less than ten persons do not constitute information collections as outlined in 5 CFR 1320.3(c).

Since we believe that the collection requirements are either part of the administrative, audit and/or adjudicatory process, collected in a nonstandardized manner, and/or collected from less than ten persons, they fall under these exceptions.

If you comment on any of these information collection and recordkeeping requirements, please mail copies directly to the following:

Health Care Financing Administration, Office of Information Services, Information Technology Investment Management Group, Division of HCFA Enterprise Standards, Room C2–26–17, 7500 Security Boulevard, Baltimore, MD 21244–1850. Attn.: John Burke, HCFA–1907–P

Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503. Attn.: Allison Herron Eydt, HCFA Desk Officer

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.

42 CFR Chapter IV would be 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, continues to read as follows:

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

2. Section 405.874 is revised to read as follows:

§ 405.874 Appeals of carrier determinations that a supplier fails to meet the requirements for Medicare billing privileges.

(a) *Disallowance of supplier enrollment application.* If a carrier disallows a supplier's enrollment application, the carrier must notify the supplier by certified mail. The notice must include the following:

(1) The reason for the disallowance.

(2) The right to appeal.

(3) The date by which the supplier must file the appeal, that is, 60 days after the date of receipt of the carrier's notice. (The date of receipt of the carrier's notice is presumed to be 5 days after the date of the notice.)

(4) The address to which the written appeal must be mailed.

(b) *Revocation of Medicare billing number*—(1) *Notice of revocation.* If a carrier revokes a supplier's Medicare billing number, that is the identification number of a provider or supplier to which HCFA has granted Medicare billing privileges, the carrier must notify the supplier by certified mail. The notice must include the following:

(i) The reason for the revocation.

(ii) The right to appeal.

(iii) The date by which the supplier must file that appeal, that is, 60 days after the date of receipt of the carrier's notice. (The date of receipt of the carrier's notice is presumed to be 5 days after the date of the notice.)

(iv) The address to which the written appeal must be mailed.

(2) *Effective date.* Revocation of a supplier billing number is effective 15 days after the carrier mails the notice of its determination to the supplier. A revocation based on a Federal exclusion or debarment is effective with the date of the exclusion or debarment.

(3) *Payment.* Carriers do not pay for services furnished by the supplier beginning with the effective date of a revocation. Claims for services furnished to Medicare beneficiaries after the effective date of the revocation are rejected. Rejections of claims because a supplier does not have a valid billing number may not be appealed by the supplier. If the supplier is successful in overturning a revocation, rejected claims for services that were furnished during the overturned period of revocation may be resubmitted. (See paragraph (i) of this section).

(c) *Hearing by carrier.* (1) For suppliers, other than those whose appeal rights are defined in part 498 of this chapter, a carrier hearing officer, not involved in the original determination to disallow a supplier's enrollment application, or to revoke a current billing number, must hold a hearing within 60 days of receipt of the appeal request, or later if requested by the supplier.

(2) Both the supplier and the carrier may offer new evidence. The ultimate burden of proof is on the supplier to show that its enrollment application was incorrectly disallowed or that the revocation of its billing number was incorrect.

(3) The hearing officer issues a written decision as soon as practicable after the hearing and forwards the decision by certified mail to HCFA, the carrier, and the supplier. This decision includes the following:

(i) Information about the carrier's and supplier's further right to appeal.

(ii) The address to which the written appeal must be mailed.

(iii) The date by which the appeal must be filed, that is, 60 days after the date of receipt of the notice. (The date of receipt of the carrier's notice is presumed to be 5 days after the date of the notice.)

(4) Either the carrier or supplier may appeal the carrier hearing officer's decision to HCFA.

(5) A carrier hearing officer's partial or complete reversal of a carrier's determination is not implemented pending the carrier's decision to appeal the reversal to HCFA, unless the carrier, in its sole discretion, and without prejudice to its right to appeal, decides to implement the reversal pending an appeal.

(6) The carrier implements a reversal if it decides not to appeal a reversal to HCFA, or the time to appeal expires.

(7) A carrier may implement a carrier hearing officer's partial reversal even if the supplier has appealed the partial reversal to HCFA, or the time for the supplier to file an appeal has not expired.

(d) *Hearing by HCFA.* A HCFA official, designated by the Administrator of HCFA, issues a decision based on the decision and the record established by the carrier hearing officer. The HCFA official may supplement the record by requesting and obtaining any additional information from the carrier or the supplier. The HCFA official's decision—

(1) Is issued in writing as soon as practicable after the HCFA official determines that there is sufficient information to decide the appeal (or that no additional information is forthcoming), unless the party appealing the hearing officer's decision requests a delay;

(2) Is forwarded by certified mail to both the carrier and the supplier; and

(3) Contains information that no further administrative appeals are available.

(e) *Impact of reversal of carrier determination on claims processing.* If a revocation of a supplier billing number is reversed upon appeal, the appeal decision establishes the date the reinstated supplier number is effective. Claims for services furnished to Medicare beneficiaries during a period in which the supplier billing number was not effective are rejected. If a supplier is determined not to have qualified for a billing number in one period but qualified in another, carriers process claims for services furnished to beneficiaries during the period for which the supplier was Medicare-qualified. Subpart C of this part sets forth the requirements for recovery of overpayments.

(f) *Reinstatement of supplier billing number following corrective action.* If a supplier completes a corrective action and provides sufficient evidence to the carrier that it has complied fully with the Medicare requirements, the carrier may reinstate the supplier's billing number. The carrier may pay for services furnished on or after the effective date of the reinstatement. A carrier's refusal to reinstate a billing number is not an initial determination under § 405.803.

(g) *Reopening of carrier determination, carrier hearing officer decision, or HCFA decision.* An initial carrier determination, a decision of a carrier hearing officer, or a decision of a HCFA official may be reopened by the carrier, hearing officer, or HCFA official in accordance with §§ 405.841 and 405.842.

(h) *Effective date for DMEPOS supplier billing number.* If a carrier, carrier hearing officer, or HCFA official determines that a DMEPOS supplier's disallowed enrollment application meets the standards in § 424.57 of this chapter, the determination establishes the effective date of the billing number as not earlier than the date the carrier made the determination to disallow the supplier's enrollment application. Claims are rejected for services furnished before that effective date.

(i) *Submission of claims.* A supplier succeeding in having its enrollment application disallowance or billing number revocation reversed, or in having its billing number reinstated, may submit claims to the carrier for services furnished during periods of Medicare qualification, subject to the limitations in § 424.44 of this chapter regarding the timely filing of claims. If the claims previously were filed timely but were rejected, they will be considered filed timely upon resubmission.

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

Dated: July 7, 1999.

Nancy-Ann Min DeParle,

Administrator, Health Care Financing Administration.

Dated: July 13, 1999.

Donna E. Shalala,

Secretary.

[FR Doc. 99–27623 Filed 10–22–99; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 622

[I.D. 101299F]

Fisheries of the Caribbean, Gulf of Mexico, and South Atlantic; Coastal Migratory Pelagic Resources; Public Hearings

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Notice of public hearings; request for comments.

SUMMARY: The South Atlantic Fishery Management Council (Council) will convene six public hearings on Draft Amendment 12 to the Fishery Management Plan for the Snapper Grouper Fishery of the South Atlantic Region (Draft Amendment 12) and its draft supplemental environmental impact statement (draft SEIS).

DATES: Written comments will be accepted until 5 p.m. on November 29, 1999. The hearings will be held from November 3 to November 29, 1999. See SUPPLEMENTARY INFORMATION for specific dates and times.

ADDRESSES: Written comments should be sent to Bob Mahood, Executive Director, South Atlantic Fishery Management Council, One Southpark Circle, Suite 306, Charleston, SC 29407-4699. Copies of Draft Amendment 12 and the draft SEIS are available from Kerry O'Malley at 803-571-4366 and will also be available to the public at the hearings.

The hearings will be held in Florida, Georgia, South Carolina, and North Carolina. See SUPPLEMENTARY INFORMATION for locations of the hearings and special accommodations.

FOR FURTHER INFORMATION CONTACT: Kerry O'Malley, South Atlantic Fishery Management Council, 803-571-4366; Fax: 803-769-4520; E-mail address: kerry.omalley@noaa.gov.

SUPPLEMENTARY INFORMATION: The Council will hold public hearings on Draft Amendment 12 and the associated draft SEIS. Draft Amendment 12 includes management measures that would (1) prohibit the harvest and possession of red porgy; (2) require the Council to review the status of the red porgy resource every 3 years to determine whether the moratorium on harvest should be repealed; (3) establish a maximum sustainable yield of 5,285.4 metric tons (mt) for red porgy; (4) set optimum yield for red porgy at the yield produced by a stock size of 10,000 mt; (5) establish the two components of the overfishing definition for red porgy as: (a) the maximum fishing mortality threshold is the fishing mortality rate (F) in excess of F35% static spawning potential ratio (SPR) which is between 0.58 (F30%) and 0.33 (F40%) based on a 14 inch (35.6 cm) total length minimum size limit and data through 1996, and (b) minimum stock size threshold is the stock size associated with 20% SPR which is estimated at 3,000 mt. Current stock size was estimated to be 685 mt based on data through 1996; (6) set the rebuilding timeframe for red porgy at 18 years; (7) in the snapper grouper limited access system, allow same owner permit transfer regardless of vessel size for individuals harvesting snapper grouper species with a non-transferable 225 pound trip limit permit; and (8) modify the framework procedure for regulatory adjustments of the Fishery Management Plan for the Snapper-Grouper Fishery of the South Atlantic Region by adding the following list of management options and measures that could be implemented via such framework procedure as: Description, identification, and regulation of fishing activities to protect essential fish habitat (EFH) and EFH-habitat areas of particular concern (EFH-HAPC); management measures to reduce or eliminate the adverse effects of fishing activities or fishing gear on EFH or EFH-HAPCs; and regulation of EFH-HAPCs.

In the following locations the hearings will begin at 6 p.m. and end when all business is completed:

1. Wednesday, November 3, 1999—Sombrero Resort and Marina,19 Sombrero Blvd., Marathon, FL 33050; Phone: 305–743–2250;

2. Wednesday, November 10, 1999—Richmond Hill City Hall, 40 Richard R. Davis Drive, Richmond Hill, GA 31324; Phone: 912–756–3345;

3. Thursday, November 11, 1999—Carteret Community College, 3505 Arendell Street, Morehead City, NC 28557; Phone: 252–247–3093;

4. Monday, November 15, 1999—Ramada Inn Surfside, 3125 S. Atlantic Avenue, Daytona Beach Shores, FL 32118; Phone: 1–800–255–3838;

5. Wednesday, November 17, 1999—Town & Country Inn, 2008 Savannah Highway, Charleston, SC 29407; Phone: 843–571–1000; and

6. Monday, November 29, 1999—Blockade Runner, 275 Waynick Boulevard, Wrightsville Beach, NC 28480, Phone: 910–256–2251.

Special Accommodations

These meetings are physically accessible to people with disabilities. Requests for sign language interpretation or other auxiliary aids should be directed to the Council office (see **ADDRESSES**) by October 29, 1999.

Dated: October 19, 1999.

Bruce C. Morehead,

Acting Director, Office of Sustainable Fisheries, National Marine Fisheries Service.

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