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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 405 and 424

[BPD–610–F]

RIN 0938–AE06

Medicare Program; Diagnosis Codes on Physician Bills

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

ACTION: Final rule.

SUMMARY: This final rule implements certain provisions of section 1842(p) of the Social Security Act regarding diagnosis codes on physician bills. Under this final rule, each bill or request for payment for a service furnished by a physician under Medicare Part B must include appropriate diagnostic coding for the diagnosis or the symptoms of the illness or injury for which the Medicare beneficiary received care.

DATES: Effective date: This final rule is effective April 4, 1994.

FOR FURTHER INFORMATION CONTACT: Pat Brooks, R.R.A. (410) 966–5318.

SUPPLEMENTARY INFORMATION:

I. Background

Medical services are furnished to Medicare beneficiaries by providers, suppliers, physicians, and other specified practitioners. Title XVIII of the Social Security Act (the Act) defines the term physician. Under section 1861(r) of the Act, the term physician, subject to limitations concerning the scope of practice by each State and other provisions of title XVIII of the Act, means a doctor of—(1) Medicine or osteopathy; (2) Dental surgery or dental medicine; (3) Podiatry; (4) Optometry; or (5) Chiropractic.

Under provisions of section 1848(g)(4) of the Act, as added by section 6102(a) of the Omnibus Budget Reconciliation Act of 1989 (Pub. L. 100–239), effective for services furnished on or after September 1, 1990, each physician must submit a standard claim form (HCFA–1500) directly to the Medicare carrier on behalf of the beneficiary, regardless of whether the physician provided the services on an assignment-related basis. (Under Medicare Part B, a physician may bill the patient directly for the physician's services, thus requiring the beneficiary to seek reimbursement from Medicare. Alternatively, under section 1842(b)(3)(B) of the Act, when a physician furnishes services on an assignment-related basis, the physician bills Medicare directly in exchange for the physician's agreement to accept the Medicare approved amount as payment in full. (Rules concerning assignment of claims are found at §§ 424.55, 424.56 and 424.70 *et seq.*) The HCFA–1500, which is also used by most third-party payers, including Medicaid and other Federal government health insurance programs, is, in effect, an itemized bill.

Before September 1, 1990, if a physician was not paid directly by Medicare for physician services, the physician either billed the Medicare beneficiary directly or billed another third-party payer. The beneficiary then sought payment from Medicare for expenses incurred in obtaining covered physician's services by submitting a Patient's Request for Medicare Payment (HCFA–1490 S) to the carrier. This form directs the beneficiary to attach itemized bills from his or her physician to the form. In limited cases, as provided under section 1842(b)(6)(B) of the Act and 42 CFR part 424 when a third party made payment to the physician, the third party sought reimbursement from Medicare for this payment by submitting a Request for Medicare Payment by Organizations which Qualify to Receive Payment for Paid Bills (HCFA–1490 U). We required the physician to fill out Part II of this form, which was similar to an itemized bill.

Previously, each bill or request for payment for physician services furnished to a Medicare beneficiary had to include, among other information, a narrative description of the diagnosis or the nature of the illness or injury for which the beneficiary received care. Although prior to April 1, 1989 there was no requirement for diagnostic coding (that is, a description of the diagnosis or the nature of the illness or injury in a numeric code), many physicians routinely provided this information. In addition, all physicians provided a narrative description of procedures, medical services, and supplies that were furnished to a beneficiary.

II. Legislation Requiring Diagnostic Coding

Section 202(g) of the Medicare Catastrophic Coverage Act of 1988 (Pub. L. 100–360), enacted July 1, 1988, added paragraph (p) to section 1842 of the Act. Under the provisions of section 1842(p)(1) of the Act, each bill or request for payment for physician services under Medicare Part B must include the appropriate diagnostic code "as established by the Secretary" for each item or service for which the Medicare beneficiary received treatment.

The conference report that accompanied Public Law 100–360 explained clearly the purpose of the requirement for physician diagnostic coding. After rejecting a Senate provision that would have required the use of diagnosis codes on all prescriptions, because they felt that the requirement would have been "unduly burdensome," the conferees agreed to require diagnostic coding for physician services under Part B. They explained their reasons for this requirement as follows: "This information would be available for immediate use for utilization review of physician services and could be used in the future to facilitate drug utilization review by merging Part B with drug claims data." H.R. Conf. Rep. No. 661, 100th Cong., 2nd Sess. 191 (1988).

Section 1842(p)(2) of the Act authorizes a denial of payment for a bill submitted by a physician on an assignment-related basis if it does not include the appropriate diagnostic coding.

Section 1842(p)(3) of the Act directs the Secretary to impose penalties if a physician who is not paid on an assignment-related basis fails to provide the appropriate diagnostic coding on the bill to the Medicare beneficiary. That is, section 1842(p)(3)(A) of the Act provides for a civil money penalty not to exceed $2,000 if the physician knowingly and willfully fails to provide the appropriate diagnostic coding. Section 1842(p)(3)(B) of the Act provides for a sanction under 1842(j)(2)(A) of the Act if the physician "knowingly, willfully, and in repeated cases fails, after being notified by the Secretary of the obligations and requirements of this subsection," to furnish appropriate diagnostic coding. Section 1842(p)(3) of the Act does not prohibit the payment of an unassigned claim solely because the physician did not provide diagnosis codes. As explained in section I of the preamble, effective for services furnished on or after September 1, 1990, regardless of whether they provide services on an assignment related basis, physicians submit claim forms directly to the Medicare carrier. The provisions of section 1848 of the Act, as added by 6102(a) of Public Law 101–239, do not affect the penalties set forth in this rule for failure to include diagnostic coding on physician bills. This final rule

implements the provisions of section 1842 (p)(1) and (p)(2) of the Act.

III. Provisions of the Proposed Rule

On July 21, 1989 we published a proposed rule (54 FR 30558) to implement the provisions of section 1842(p)(1) of the Act. We proposed that each bill or request for payment for physician services under Part B would have to include appropriate diagnostic coding "as established by the Secretary," relating to the nature of the illness or injury for which the Medicare beneficiary received care.

As noted above, generally, physician services furnished directly to a beneficiary are paid under Medicare Part B. In addition, under the regulations set forth at subpart D of 42 CFR part 405, we make payments to hospitals under Part A for physician services related to the supervision and teaching of interns and residents who participate in the care of hospital inpatients. Also, the proposed rule did not apply to suppliers or other providers whose services are covered under Part B.

We proposed that a physician would be required to furnish diagnosis codes instead of the narrative description that was previously required. We proposed to deny payment for a bill or request for payment for physician services furnished on an assignment-related basis if the bill or request for payment does not contain the appropriate diagnostic coding. This would not be true for a claim for physician services not furnished on an assignment-related basis. In other words, if the beneficiary seeks Medicare reimbursement for payment for physician services, we proposed not to deny payment solely because the claim does not contain diagnosis codes. If enough information were provided to enable a carrier to process the claim, it would be processed without the diagnosis codes. As explained in section II of the preamble, section 1842(p)(3)(B) of the Act provides for a sanction under section 1842(j)(2)(A) of the Act if the physician "knowingly, willfully, and in repeated cases fails, after being notified by the Secretary of the obligations and requirements of this subsection," to furnish appropriate diagnostic coding.

We proposed to use the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD–9–CM) as the most appropriate diagnostic coding system.

The ICD is a classification system developed by the World Health Organization (WHO) for recording morbidity and mortality information for statistical purposes, for indexing hospital records by diseases, and for storing and retrieving data. Effective with the Twentieth World Assembly of WHO, nomenclature regulations were adopted on May 22, 1967. Article 21(b)(2) of these regulations specifies that "members compiling mortality and morbidity statistics shall do so in accordance with the current revision of the International Statistical Classification of Diseases, Injuries and Causes of Death as adapted from time to time by the World Health Assembly. This Classification may be cited as the 'International Classification of Diseases'." The United States is signatory to the WHO's agreements, which include the above nomenclature regulations binding the United States to the use of the ICD system for official government health statistical purposes. The nomenclature regulations became effective on January 1, 1968.

The clinical modification of the ninth revision to ICD (that is, ICD–9–CM) is a coding system for reporting diagnostic information and procedures performed on patients in hospitals or other types of health care delivery systems.

ICD–9–CM was developed under the guidance of the National Center for Health Statistics (NCHS) to adapt the ninth revision of the ICD classification system to the needs of hospitals in the United States. The modifications were intended to provide a mechanism to present a clinical picture of the patient. Thus, ICD–9–CM codes are more precise than those included in ICD–9 since greater detail is needed to describe the clinical picture of a patient than for statistical groupings and trend analysis.

Effective January 1979, after nearly two years of development by numerous national experts on clinical technical matters, the ICD–9–CM became the single classification system intended for use by hospitals in the United States. This system replaced several earlier related but somewhat dissimilar classification systems. Once the ICD–9–CM classification system was in place, several errors and omissions were noted. Consequently, in September 1980 a second edition of ICD–9–CM was published. The preface to the second edition noted that the continuous maintenance of ICD–9–CM is the responsibility of the Federal government. The preface also stated that no future modifications to ICD–9–CM would be made by the Federal government without considering the opinions of representatives of major users of the classification system.

In September 1985, the ICD–9–CM Coordination and Maintenance Committee (the Committee) was formed. This is a Federal interdepartmental committee that maintains and updates the ICD–9–CM. This includes approving new coding changes, developing errata, addenda, and other modifications to the ICD–9–CM to reflect newly developed procedures and technologies and newly identified diseases. The Committee is also responsible for promoting the use of Federal and non-Federal educational programs and other communication techniques with a view toward standardizing coding applications and upgrading the quality of the classification system.

The Committee is co-chaired by NCHS and HCFA. NCHS has primary responsibility for the ICD–9–CM diagnosis codes included in Volume 1—Diseases: Tabular List, and Volume 2—Diseases: Alphabetic Index. HCFA has primary responsibility for the ICD–9–CM procedure codes included in Volume 3—Procedures: Tabular List and Alphabetic Index.

The Committee encourages participation in the development of diagnosis and procedure codes by health-related organizations, organizations in the coding field, and other members of the public. During each Federal fiscal year (FY), the Committee holds three public meetings during which coding changes are discussed. Taking into account the public comments made at each meeting and the public correspondence received after each meeting, the Committee formulates recommendations, which must be approved by the co-chair agency heads, the Administrator of HCFA and the Director of NCHS, before adoption for general use. Coding changes approved by the Committee and agency heads are published annually in the **Federal Register**.

Only official volumes and addenda of ICD–9–CM are to be considered in the assignment of diagnosis codes for Medicare patients. HCFA is not responsible for mistakes made by businesses in the replication of these official volumes and addenda, which are then sold to the public. Official addenda have become effective on May 1, 1986, and subsequently on October 1 of each year from 1986 through the present. Another addendum, containing the Human Immunodeficiency Virus (HIV) Infection Codes, became effective for Medicare patients discharged on or after July 1, 1988.

Before publication of the proposed rule on July 21, 1989, the GPO exhausted its supply of previously published addenda and announced that it had no plans to reprint more copies. However, the private sector continues to publish changes to the ICD–9–CM coding system annually by October 1st.

The GPO also announced that it would no longer provide addenda except to subscription purchasers of the third edition. ICD–9–CM, third edition, was published in March 1989; automatic addenda updates expired in 1991. The third edition incorporates all addenda that were previously published. We stated in the July 21, 1989 proposed rule that if a physician had not yet obtained ICD–9–CM, second edition, and had not updated the set with the addenda, he or she should obtain the recently updated Volumes 1 and 2 (that include all the addenda) (54 FR 30560). The American Health Information Management Association (AHIMA), previously known as the American Medical Records Association (AMRA), the national professional association of medical records practitioners, and the American Hospital Association (AHA) have indicated that they intend to reprint these future addenda and make them available for sale.

The price for Volumes 1 and 2 of ICD–9–CM, fourth edition, is $65.00 for delivery within the United States and $81.25 for delivery outside of the United States. A purchaser must furnish an address other than a post office box because the volumes will be delivered only to a place of business or a residence. When ordering, the purchaser should enclose a check, money order, or Visa or Mastercard account name, number, and expiration date. Checks should be made out to the Superintendent of Documents.

Updated volumes 1 and 2 may be purchased by writing to the following address: ICD–9–CM, Fourth Edition, Volumes 1 and 2, P.O. Box 371954, Pittsburgh, PA 15250–7954. (Telephone orders may be placed through the GPO order desk at (202) 783–3238.)

Section 424.32 sets forth the basic requirements for all claims. (The term "claim" is used when referring to the regulatory language instead of the term "bill or request for payment".) In § 424.32(a), all claims (including those filed directly with Medicare by physicians, beneficiaries or other persons or entities for physician services furnished to Medicare beneficiaries) must be filed in accordance with HCFA instructions. Section 424.34 provides additional requirements for claims filed with Medicare by beneficiaries. Under § 424.34(b)(4), the itemized bill must include a listing of services in sufficient detail to permit determination of reasonable charges. We proposed to make the following changes to the regulations text:

- Revise § 424.32(a) to state specifically that a claim for physician services must include appropriate diagnostic coding using ICD–9–CM.
- Revise § 424.34(b)(4) to state specifically that an itemized bill furnished by a physician to a beneficiary for physician services must include appropriate diagnostic coding using ICD–9–CM.
- Add to § 424.3 the definition of ICD–9–CM, which means the International Classification of Diseases, Ninth Revision, Clinical Modification.

Coding and reporting requirements and instructions for diagnostic coding were developed in order to take into account circumstances unique to care furnished by physicians. These coding and reporting requirements and instructions for completing bills and requests for payment were developed before publication of the proposed rule and were distributed to the carriers on March 3, 1989. The carriers then mailed this information, in the form of a Medicare Bulletin, to the physicians whom they service. During preparation of these procedures and instructions, we consulted with the American Medical Association (AMA) and provided the AMA an opportunity to comment on the material.

In the proposed rule, we proposed a limited grace period during which payments would not be denied and sanctions would not be imposed for failure to use diagnosis codes. We provided for a 6-month grace period until October 1, 1989 to allow physicians and their office staff to obtain training and purchase books. On August 8, 1989, we notified carriers of the extension of the grace period through a memorandum from the HCFA Bureau of Program Operations. For the convenience of the reader, we published the coding and reporting requirements as an appendix to the proposed rule.

AHIMA offered nationwide training classes and training materials for physician office staff for ICD–9–CM diagnostic coding, as did the AMA.

Suggestions concerning modification of the ICD–9–CM codes, or additions to the existing codes, may be submitted in writing to the following address: National Center for Health Statistics, 6525 Belcrest Road,room 9–58, Hyattsville, MD 20782.

In this final rule, we are adopting the requirements as stated in the proposed rule without modification.

IV. Discussion of Public Comments

In response to the proposed rule, we received 35 timely items of correspondence. Comments were received from physicians, professional health-related organizations, universities and colleges, medical facilities, state governments, laboratories, durable medical equipment suppliers and pharmaceutical companies.

Although the majority of commenters were not opposed to the diagnostic coding requirement in general, they were concerned with certain aspects of the proposed rule.

A. Coding Issues

Comment: One commenter inquired about the possibility of an indefinite delay of the ICD–9–CM diagnostic coding requirement. Another commenter asserted that the diagnostic coding requirement should not be implemented until final regulations are published, which should allow for a training period of 60 days before any adverse actions.

Response: The original implementation date of April 1, 1989 was extended by a 60-day grace period to allow physicians and their office staffs to purchase coding books and to obtain coding training. This grace period was further extended until October 1, 1989, at which time we required all physicians to use ICD–9–CM codes on bills or requests for payment. On August 8, 1989, we notified carriers of the extension through a memorandum from the HCFA Bureau of Program Operations. In total, we allowed a 6-month grace period. We believe we provided a reasonable time period for physicians and their staffs to prepare for the new coding requirements.

Comment: The American Psychiatric Association disagreed with HCFA that the ICD–9–CM is the only classification system acceptable for Medicare claims. They urged HCFA to allow the use of the Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revised (DSM–III–R) coding system for mental disorders. The American Medical Association also supports the DSM–III–R coding system for use by psychiatrists.

Response: DSM–III–R was designed to be compatible with ICD–9–CM, but the two systems are not identical. Systems such as DSM–III–R address only certain types of diagnoses, and cannot be used universally by all types of practitioners to code all types of diagnoses on claims submitted to Medicare. In fact, ICD–9–CM provides for greater specificity in coding mental disorders that DSM–III–R. Within the "mental disorders" range (codes 290–319) there are an additional 218 specific codes available in ICD 9–CM that are not in DSM–III–R. Thus, we continue to believe that the ICD–9–CM system is the only comprehensive

diagnostic coding system that is suitable for Medicare claims.

Comment: The College of American Pathologists stated that the ICD–9–CM coding system is limited in its description of disease states. The commenter asserted that the Systematized Nomenclature of Medicine (SNOMED), which it publishes, is more specific.

Response: The SNOMED is an excellent coding system. However, as stated above, the Department of Health and Human Services is signatory to the WHO's nomenclature regulations binding the United States to use of the ICD for official government purposes. Even though ICD–9–CM has recognized limitations, it can be updated as the need arises via the ICD–9–CM Coordination and Maintenance Committee.

Comment: One laboratory recommended that the burden of furnishing the proper diagnosis codes be placed on the physician ordering a test rather than the supplier of the service. The commenter expressed a concern that the laboratory performing the test should not be held responsible for performing a test that Medicare later determines to be not medically necessary.

Response: The proposed rule and this final rule address the requirement for diagnostic coding of only physicians' bills. This new coding requirement does not apply to bills from laboratories (except for physician laboratory services—see § 405.556).

Comment: One commenter suggested that referring physicians provide a reason for the biopsy or referral. It requested that this practice be encouraged and emphasized through carrier communication with the physicians.

Response: We have always encouraged that the referring physician communicate the reason for the referral or specimen so the proper medical interpretation is made or test is performed. We will continue to encourage carrier to convey this message to the physician community.

Comment: Three commenters were concerned that providing for only four diagnostic codes on the form HCFA–1500 is insufficient in many cases to adequately describe a patient's condition.

Response: Since the implementation of the diagnostic coding requirement, we have received few complaints concerning the form HCFA–1500. Thus, we believe that four diagnosis codes are sufficient in most instances. We note that this regulation is not intended to change the structure of the form HCFA–1500. Moreover, our contractors' claims processing systems, as currently constructed, would not be able to accommodate more than four diagnosis codes on a single claim.

The use of codes instead of a narrative description should enhance the physician's ability to describe the patient's condition with greater precision. If there are cases where the use of four codes is not sufficient, we suspect that they would arise when more than one procedure has been performed (for example, psychological counseling provided to a trauma patient). In such cases, the physician could submit one claim for the procedure that relates to four or fewer diagnoses, and submit another claim for the other procedures with their attendant diagnoses.

Comment: The American Ambulance Association requested that the final rule specify that the coding requirements do not apply to ambulance services.

Response: This final rule provides only that each bill or request for payment for physician services must include diagnostic coding. These provisions do not apply to ambulance services.

Comment: One commenter interpreted the proposed rule to imply that physicians must now submit claims for services that they would not have normally billed under the previous guidelines. The commenter requested that HCFA clarify this point in the final rule.

Response: Although the ICD–9–CM coding system permits classification of many services for which specific codes could be used, the mere presence of an ICD–9–CM code does not, of itself, mean that a bill or request for payment must include the code for that service. If a physician generally would not have submitted a bill or request for payment for a particular service prior to the physician diagnostic coding requirement, the physician may not be required to submit a bill for that service under the new rules. For instance, HCFA did not mean to imply, under an example in the guidelines published in the proposed rule (54 FR 30564), that a bill should be submitted for a service for X.3, attention to surgical dressings and sutures, if this service is included in the surgeon's global charge. However, if this service is performed by another physician, unrelated to the surgeon, it might be appropriate for the second surgeon to use this code to describe the reason for the encounter.

Comment: One commenter suggested that HCFA clarify in the final rule whether the new regulations supersede or supplement individual carrier coding policies since there are conflicts between the new and old coding practices.

Response: The requirements in this final rule supersede any individual carrier coding policies. Those carrier coding policies have been changed to comply with the requirements of this final rule.

Comment: Both the AMA and the American Society of Internal Medicine stated that supplying codes for signs and symptoms without also supplying codes indicating diagnoses that the physician has ruled out will not accurately describe the patient's conditions and explain the reasons for the care provided. Another commenter recommended that we allow the use of "suspected" and "rule out" codes.

Response: The coding guidelines state that each visit must be coded to describe the specific reason that the patient sought care or treatment. The guidelines also state: "Do not code diagnosis documented as "suspected," "rule out," "probable," or "questionable" as if they are established. Rather, code the condition to the highest degree of certainty for that encounter/visit to reflect symptoms, signs, abnormal test results, or other reasons for the visit." To require coding of "probable," "suspected," "questionable," or "rule out" conditions as if the conditions existed would lead to significant overcounting of conditions. This inaccurate recording would distort data and would artificially distort disease statistics. Therefore, physicians should report diagnosis codes for symptoms and signs but should exclude codes for diagnoses that the physician either suspects or rules out.

Comment: Several commenters asked how they should code for situations in which a patient presents disabling symptoms but no diagnosis exists for the patient. They recommended that the diagnosis codes include codes for symptoms.

Response: Diagnosis codes should reflect the diagnosis, condition, problem, or other reason for the encounter or visit shown in the medical record to be chiefly responsible for the services provided. However, the carrier will also accept codes for symptoms when no other more definite code can be given to describe the reason for the visit of the patient. This is explained further in guideline number four of the Appendix—Claims Review and Adjudication Procedures, published with the proposed rule (54 FR 30564, July 21, 1989).

Comment: Two commenters suggested that correlating the ICD–9–CM diagnosis codes and the CPT–4 procedures codes

is a redundant effort since a procedure may be performed as the result of several conditions. They urged that the requirement be deleted.

Response: Correlating the narrative diagnosis and the CPT–4 procedure code is a requirement of the Medicare carrier, and has been a standard requirement for years. It has only been modified by the new physician diagnostic coding requirements. Physicians must now correlate the ICD–9–CM code, instead of the narrative, to the CPT–4 code.

Comment: One commenter stated that suppliers cannot be required to include diagnostic coding on Part B bills even though they often provide the diagnostic codes identified by the physician on bills for equipment and supplies.

Response: We have never required suppliers to include diagnostic coding on their Part B bills. Section 1842(p)(1) of the Act requires physicians, as defined in section 1861(r) of the Act, and subject to limitations concerning the scope of practice by each State and other provisions of title XVIII of the Act, to furnish diagnostic coding. That is, only doctors of medicine or osteopathy, dental surgery or dental medicine, podiatry, optometry, or chiropractic must furnish diagnostic coding. Durable medical equipment suppliers are not included in this requirement.

Comment: One commenter inquired why his or her carrier included messages in the explanation of the Medicare benefit worksheet regarding both diagnostic coding requirements (ICD–9–CM) and procedural coding requirements (CPT–4) since the proposed rule (54 FR 30559, July 21, 1989) stated that there is no current requirement for diagnostic coding.

Response: The statement on page 54 FR 30559 referred to the policy before implementation of section 1842(p)(1) of the Act that requires physician diagnostic coding instead of the written narrative that was previously required. We are now conforming the regulations to the previously issued administrative instructions.

The CPT–4 coding (part of the HCFA Common Procedural Coding System) describes physician services and supplies, not diagnoses. If either fields 23 or 24c on the form HCFA–1500 are blank, the carrier will communicate with the physician via the explanation of the Medicare benefit worksheet requesting completion of this information.

Comment: A commenter asserted that as an incentive all bills or requests for payment without ICD–9–CM codes should be rejected and that properly coded bills and requests for payment should be expedited.

Response: The Act specifically provides for denial of payment for a bill submitted by a physician on an assignment-related basis if it does not include the appropriate diagnostic code. For a claim for an item or service not submitted on an assignment-related basis, the Act authorizes the Secretary to impose a civil money penalty, not to exceed $2,000, against a physician seeking payment who knowingly and willfully fails to promptly provide the appropriate diagnostic coding on the bill to the Medicare beneficiary upon the request of the Secretary or a carrier. If the physician knowingly, willfully, and in repeated cases fails, after being notified by the Secretary of the statutorily prescribed obligations, to include the requisite diagnostic codes, the physician may also be subject to administrative sanctions. However, the payment of an unassigned claim may not be prohibited solely because the physician has not furnished the diagnosis codes.

We considered, but rejected, the idea of expediting properly coded bills and requests for payment since we do not handle properly coded bills for Part A services in a special manner. Properly coding bills is a standard requirement to receive payment for services. However, payment would occur more quickly for properly coded bills because there would be no need for resubmission because of errors in coding.

Comment: A clinical laboratory stated that bills and requests for payment with diagnostic coding can be processed electronically at a much lower cost to Medicare than we projected in the proposed rule.

Response: The cost projections in the proposed rule for electronically processed claims are the expected costs for physicians to comply with the requirement for diagnostic coding on all bills and requests for payment rather than the costs of the carriers in processing the bills and requests for payment.

Comment: One association asked the implied meaning of the statement "* * * (diagnostic coding) could be used for prepayment screens" (54 FR 30559, July 21, 1989). The commenter asked where the ICD–9–CM and CPT–4 information is being collected and what future plans are being implemented for the use of the information. The association was informed by its carrier that the carrier does not believe the ICD–9–CM and CPT–4 codes will eventually be used for a prospective payment system for physicians.

Response: Billing information is compiled by each carrier and then electronically transmitted to HCFA's Bureau of Data Management and Strategy in Baltimore, Maryland. This Bureau is largely responsible for performing HCFA's mathematical and statistical programming and for managing HCFA's statistical data bases to support program decisions by various HCFA components. Current and possible applications for the ICD–9–CM and CPT–4 coding information include answering research queries from private sources, development of quality assurance monitoring mechanisms, assessment of the impact of proposals that affect health care financing programs, or special research and evaluation studies. The Bureau uses diagnostic coding information to design and develop periodic statistical tabulations to assess the characteristics of beneficiaries and the utilization and cost of program benefits. The CPT–4 codes also are now used for payment purposes under the fee schedule for physician services.

Comment: One commenter was concerned about the increased costs for manpower and the reformatting of her billing system associated with implementation of the diagnostic coding requirement.

Response: We cannot predict the increased costs or manpower that an individual office would incur as a result of the diagnostic coding requirement. However, in the impact analysis to this final rule, we discuss our estimate of the aggregate costs associated with coding training and ICD–9–CM coding books. Also, as discussed in the impact analysis, we now estimate that about 90 percent of physicians included diagnostic coding on bills before it was required by section 1842(p) of the Act. These physicians may not have experienced as significant an increase in costs as physicians who did not code before the requirement was established.

Comment: One commenter stated that since general practitioners care for the whole patient, it is sometimes difficult to find an applicable diagnosis even after looking through 2,000 pages of codes. The physician recommended that we allow three digit codes to be used for procedures for which physicians routinely charge less than $200.

Response: We are aware that general practitioners are responsible for coding a wide range of diagnoses. To determine the correct code, Volume 2, Index, must be consulted first. After the correct code has been determined, Volume 1 is then referenced to determine if there are other coding conventions that apply, such as "Includes" or "Excludes" notes.

We cannot accept the recommendation to allow the use of three digit codes in any circumstance where an applicable four or five digit code exists. Codes must be used to their highest level of specificity; this may include some three digit codes. If diagnoses are coded to the highest level, using the same data base for all bills and requests for payment will permit meaningful trend analysis and data comparisons.

Comment: Several commenters stated that the estimate of 1 minute to code a bill or request for payment is too short. The estimate does not consider the time a physician spends with office staff to select the correct diagnosis code.

Response: The estimate of 1 minute to code a bill or request for payment was made by AHIMA based on their professional coding experience and expertise. We believe that this is a realistic figure for several reasons. First, there are many physicians who are specialists, and who will use only a small portion of the coding manuals during their normal course of business. We anticipate that these physicians and their office staffs will quickly identify those parts of the coding books that apply to their practice. Additionally, many offices have developed reference lists pertaining to the codes frequently used in their particular practices. Once this list has been developed, very little physician involvement is required for the coding process.

The amount of time necessary for the physician to work with his or her clerical staff in the selection of the correct diagnosis code(s) was not factored into the estimate of 1 minute. That estimate reflected the use of the code book or reference list and the documentation process, whether manual or key entry. We anticipate that the diagnosis code(s) will become as familiar to the office staffs as the recording of the narrative diagnostic language, and that completion of the billing form will proceed as smoothly as it did prior to the implementation of this diagnostic coding requirement.

B. Patient Information and Confidentiality

Comment: The American Psychiatric Association (APA) stated that there may be instances when the diagnosis information provided to the patient (particularly in non-assigned claims) could have an adverse impact on the patient and course of treatment. The APA suggests that HCFA have an exceptions process that allows the physician to determine whether diagnosis information should be directly provided to the patient.

Response: We agree, and note that there is already an established procedure for such situations. The physician should file the form HCFA–1500 on behalf of the beneficiary as required by section 1848(g)(4) of the Act. The form should include the appropriate diagnostic codes and should be forwarded to the Medicare carrier. If a physician determines that diagnostic information should not be released directly to a patient, the physician may furnish bills to the patient without diagnostic information. In addition to psychiatric diagnoses, physicians also may choose to use this procedure for terminal illnesses or other conditions of a sensitive nature.

Comment: The APA expressed a concern that HCFA should have a mechanism in place to assure that diagnostic information is kept confidential and not released to third parties except when permitted by law. It recommended that the regulations be amended to include privacy protection.

Response: We share the APA's concerns about the confidentiality of patient information. To assure that the beneficiary is protected, when we release medical data, the data do not include any patient-specific identifiers. Patient-specific medical data in the custody of HCFA and its intermediaries and carriers are fully protected by the Privacy Act (5 U.S.C. 552a).

C. Utilization Review

Comment: A pharmaceutical company is concerned that utilization review of physician services and future drug utilization review may be less effective because of the limitation of four diagnostic codes on the bill or request for payment.

Response: Utilization review of physician services will be enhanced by the diagnostic coding requirement since the information can be categorized by code and made available for immediate use. At this time, we have no plans to implement a drug utilization review program using the diagnostic coding information on the form HCFA–1500. We will consider the effect of the four diagnostic code limitations if we propose a drug utilization review program.

Comment: One commenter questioned the possibility of the physician diagnostic coding requirement eventually becoming a tool to standardize physician practice patterns nationwide without physician input.

Response: The information obtained from the ICD–9–CM codes will be used for compiling statistical information. Any new requirements or procedures would not be implemented without physician input and, if appropriate, a notice of proposed rulemaking.

Comment: One commenter asserted that the ICD–9–CM coding system is a bulky, unreliable system for gathering data.

Response: The ICD–9–CM coding system was developed under the guidance of the National Center for Health Statistics for greater specificity in reporting illnesses and injuries in the United States. The ICD–9–CM coding system is the best system available for recording the diagnoses of Medicare beneficiaries. The system is not considered unreliable by most users; however, errors do occur as a result of physicians' incorrect application of the codes.

To help make the coding system meet the needs of all users, we welcome input from interested physicians, organizations and the public through the ICD–9–CM Coordination and Maintenance Committee meetings.

Comment: One commenter asked for the name of an agency that can give advice and answer questions concerning coding issues.

Response: The AHA is the official clearinghouse for questions concerning the ICD–9–CM system. They accept written questions and will provide a written reply. The AMA is also providing ICD–9–CM coding advice to its members through their CPT Clearing House Hotline (312) 464–4737. In addition, each carrier has designated a contact person to answer the concerns raised by the physicians they service. We encourage close communication between a physician and the carrier to avoid coding problems.

Comment: Several commenters expressed concern that requiring coding to the fifth digit is burdensome and will require a more skilled person to properly code the diagnoses. One commenter stated that prior to the new physician diagnostic coding requirement, coding by physicians was generally limited to three digits.

Response: We did not anticipate a significant burden upon physicians as a result of coding to the fifth digit level when the proposed rule was published, and have not had complaints from the physician community since that time. We continue to believe that most physicians or their office staff create reference lists of diagnoses encountered most often. Since 1979, the ICD–9–CM coding system has been in use and has contained five digit codes. Thus, we do not agree that coding by physicians previously was limited to three digits.

Comment: One commenter asserted that it would be advantageous if the format requirements for submitting bills

or requests for payment are published with the proposed rule.

Response: The Medicare Carriers Manual explains how to fill out bills and requests for payment. Basically, the only format requirement for the diagnostic coding is to put each appropriate code in the space that is provided for those codes under the heading "Nature of Illness or Injury."

The form HCFA–1500 and accompanying sections of the Carriers Manual are already subject to public comment, pursuant to the Paperwork Reduction Act of 1980. In accordance with that Act, OMB reviews the form HCFA–1500 and its instructions at least once every 3 years. The Department publishes a notice in the Federal Register that informs the public of OMB's review and solicits comments for OMB's consideration in the course of its review.

Comment: The AMA stated that pathologists have expressed a concern that failure to list a second diagnosis after V72.6, Laboratory examination, may lead to medical necessity review problems. The AMA requested that we inform the carriers that V72.6 code meets the Medicare coding requirements.

Response: We agree that in many instances one code (V72.6) will explain the reason for the patient's encounter. Carriers should identify a way of determining the proper coverage policy issue through the use of a screen. We recommend that all laboratory claims begin with the code V72.6, Laboratory examination. However, by supplying a second code to describe the reason for the referral, the bill or request for payment can clearly be identified as referrals to evaluate symptoms, signs, or diagnoses, instead of being part of a routine physical examination that is not covered by Medicare.

Comment: One commenter inquired about how the "V" codes should be sequenced for diagnostic services on the bill or request for payment.

Response: Ancillary diagnostic services, which are coded beginning with a "V," are provided in laboratories and radiology offices if the patient's main reason for the visit is to get an x-ray, (V72.5, Radiological examination, not elsewhere classified), or to have a test conducted (V72.6, Laboratory examination.) The condition for which the patient sought treatment will be reflected in the additional diagnoses. In coding ancillary diagnostic services, it may be helpful to question the reason for the encounter. The reason for the encounter is that the patient visited the laboratory or radiology office to have either an analysis performed or an x-ray taken.

D. Training

Comment: One commenter stated that HCFA's estimate that 70 percent of physicians and office staff will need ICD–9–CM coding training is a gross underestimate.

Response: We do not believe that our estimate of 70 percent of physicians and office staff in need of coding training was too low. In fact, we believe that most physicians and office staff did not require coding training. Immediately after implementation of the diagnostic coding requirement, medical review at the intermediary level did not reveal significant coding problems. Since that time, the majority of physician bills using ICD–9–CM coding have passed intermediary edits for accuracy. In addition, many physicians did not need training since they submitted ICD–9–CM codes prior to April 1989 due to the requirements of third party payers for non-Medicare patients. We believe that the lack of coding problems indicates that, if anything, we may have overestimated the proportion of physicians and office staff that needed training.

Comment: One commenter suggested that HCFA require the Medicare carriers to provide ICD–9–CM training and technical assistance to physicians and providers.

Response: The Medicare carriers were required by HCFA to provide initial ICD–9–CM coding training prior to the April 1, 1989 implementation date. A National Carriers Training program was held in February 1989 in preparation for the training done in each State by each carrier. The National Carriers Training was conducted by AHIMA, with input on the program from the AMA. Subsequently, each carrier was responsible for conducting its own training program on a state-by-state basis. In many cases, carriers worked with the State medical societies in conducting the training. Diagnostic coding training for physicians and physician office staffs has been ongoing since the implementation of this requirement, especially through courses and sessions sponsored by the private sector. For further information concerning coding training, physicians can contact their State medical society, the AMA, AHIMA, their State component of the medical record or medical health information association, or their carrier.

E. Sanctions Process and Civil Money Penalties

Comment: One commenter indicated that the sanction provisions for noncompliance with the coding requirements are illogical since coding bills or requesting payment with ICD–9–CM codes is essentially a clerical function. The civil monetary penalties and sanction actions by the Office of Inspector General are perceived as excessive since clerical errors of omission and inaccurately coded diagnoses will be inevitable. Another commenter recommended that the sanctions process should not apply to the ICD–9–CM coding requirement.

Response: Coding is a task routinely delegated by physicians to billing clerks or staff. However, this delegation does not relieve the physician of the responsibility to submit bills or requests for payment that meet the requirements of the law.

Comment: One medical association questioned whether the carrier considers the remarks on the explanation of the Medicare benefit (EOMB) form an advisement of a violation (for not including diagnostic coding on a bill or request for payment) that will be referred to the OIG for investigation and possible sanctions. The commenter asked why the carrier includes a remark in the EOMB stating that they will process this claim but will not process future claims. The association suggests that the message on the EOMB should contain a more complete and accurate statement.

Response: Messages that appear on the EOMB have been revised and are more clear and explanatory. It is not our intent to put the beneficiary at risk by not paying a bill or request for payment lacking an ICD–9–CM code. For claims submitted by physicians who do not accept assignment, the carrier will process the bill or request for payment as usual, substituting a "dummy" code for the ICD–9–CM coding.

The carrier will collect physician-specific information about the quantity of the dummy codes generated per physician. When a threshold of ten bills or requests for payment is reached, the carrier is instructed to contact the physician in order to explain the necessity of providing diagnostic coding and to help with training. If the physician subsequently knowingly, willfully, and in repeated cases fails to supply the requested codes, the Office of the Inspector General may invoke a civil money penalty.

F. Availability of the ICD–9–CM

Comment: Two commenters expressed concern that the Government

Printing Office (GPO) does not stock a sufficient supply of the ICD–9–CM coding books, which results in a 4-to-8 week delay in receiving the books.

Response: ICD–9–CM books are in stock at the special address mentioned elsewhere in this preamble. We are aware of the potential demand and have an adequate supply. All orders are sent by priority mail.

V. Impact Analysis

Unless the Secretary certifies that a final rule will not have a significant economic impact on a substantial number of small entities, we generally prepare a regulatory flexibility analysis that is consistent with the Regulatory Flexibility Act (RFA) (5 U.S.C. 601 through 612) . For purposes of the RFA, all physicians are considered to be small entities.

The statutory requirement that physicians use diagnostic coding has been in effect since April, 1989, and we believe that the vast majority of physicians were already using ICD–9–CM coding even before that time. Thus, the economic impact of this final rule on the physician community should be minimal.

In the proposed rule, we prepared a voluntary impact analysis and voluntary regulatory flexibility analysis because of our inability to quantify with any degree of precision the estimated costs of these provisions and the large number of physicians who were affected by the provisions of section 1842(p) of the Act. These provisions require that each bill or request for payment for a service furnished by a physician include appropriate diagnostic coding related to the illness or injury for which the Medicare beneficiary received treatment. Under section 1842(p) of the Act, a physician who is to be paid on an assignment-related basis will not be paid if he or she fails to include appropriate diagnostic coding on the bill. In this final rule we have revised the impact analysis based on public comment.

With one exception, any effects of this final rule will be a direct result of the legislative provisions in section 1842(p) of the Act. The exception is a result of the discretion that section 1842(p)(1) of the Act provides the Secretary in the choice of which system to use to code diagnoses. We chose to use ICD–9–CM because it is the only comprehensive coding system that includes all possible diagnoses for Medicare beneficiaries. For that reason, it is already widely used by physicians. Furthermore, we are already using ICD–9–CM in the Medicare program for classifying DRGs for payment under the inpatient hospital prospective payment system. Therefore, we believe that it is the easiest coding system for physician use.

Before April 1, 1989, physicians were not required to provide ICD–9–CM or any other type of diagnostic codes on their Medicare bills or requests for payment. Therefore, we believe that physicians who were not coding before the provisions of section 1842(p) of the Act were affected through increased paperwork, the cost of training themselves and their staff, and the probable need to purchase Volumes 1 and 2 of the ICD–9–CM, fourth edition.

As of December 31, 1986, there were 569,160 physicians practicing in the United States (Physician Characteristics and Distribution in the U.S., 1986. Department of Data Release Services, Division of Survey and Data Resources, American Medical Association, 1987). In the proposed rule, we estimated that at least 30 percent of physicians used ICD–9–CM codes before the requirements of section 1842(p) were established, presumably because of requirements of other third party payers that ICD–9–CM diagnosis or procedure codes be used on their claims. Thus, we estimated that up to 70 percent of practicing physicians did not report codes before the requirement was established (that is, approximately 398,000 physicians).

In this final rule, we have revised our estimate of the number of physicians who reported ICD–9–CM codes before the requirements of section 1842(p) of the Act were established. As stated in section III of this preamble, we provided for a 6-month grace period following the statutory implementation date of April 1, 1989, during which no claims would be denied for lack of coding. The grace period ended on October 1, 1989. It has been our experience that, when grace periods are established, providers usually do not comply with the required provisions until the end of the grace period, presumably because of lack of training or need for a preparation period. In this case, however, approximately 90 percent of the claims were coded using ICD–9–CM during the first month of the grace period, and the compliance rate remained at approximately 90 percent for the duration of the grace period. Moreover, intermediary review of these claims revealed no significant coding problems. Since the number of physicians that complied with the coding requirement remained stable throughout the grace period, we believe that the number of physicians who reported codes during the grace period is indicative of the number of physicians who were reporting codes before the requirement was established. Therefore, we now estimate that approximately 90 percent of physicians reported ICD–9–CM codes before April, 1989 (that is, approximately, 512,000 physicians). The discussion below reflects this revised estimate.

If all the physicians who did not report ICD–9–CM codes before April 1989 needed new coding books, ICD–9–CM Volumes 1 and 2 at a cost of $65.00 per set, the total cost would have been approximately $3,700,000. In practice, however, we believe that not all of these physicians needed to purchase new coding books. For example, some physicians belonged to group practices, some worked for hospitals and do not have their own patients, and some already owned coding books. For purposes of this impact analysis, however, we assume that all physicians who did not code before April, 1989 purchased new coding books.

In the proposed rule, in calculating costs of training and coding for physicians who did not code before April 1989, we estimated the average wages of a physician's office staff person at $4.50 an hour. In response to the July 21, 1989 proposed rule, we received several comments stating that we had underestimated the average hourly wages for a physician's office staff member. We agree that our estimate of $4.50 per hour was too low. In this final rule, we are revising our estimate of the hourly rate based on comments received on the proposed rule and our examination of the hourly wages of physicians' office staff in the monthly publication "Employment and Earnings" (U.S. Department of Labor Bureau of Labor Statistics, "Employment and Earnings" Vol. 37, No. 4, April 1990, p. 131 (Washington, DC)). Our revised estimate of the typical wage for a staff person at the time the requirement was established is $9.65 per hour.

Based on claims data, we believe there were approximately 320.1 million physician claims processed for the period from April 1, 1989 to March 31, 1990. We estimated that the clerical cost of coding each claim was $0.16 for a total of $51,216,000 for the first year that the requirement was in effect. We arrived at the $0.16 figure by assuming an hourly rate of the typical physician's office staff person to be $9.65 per hour, as explained above. We believe that it takes 1 minute to code a claim, therefore $9.65 divided by 60 minutes results in a $0.16 cost per claim. However, we believe that 90 percent of the claims were being coded prior to April 1, 1989. Thus, 10 percent of the cost of coding claims (approximately $5,120,000) can

be attributed to the provision of section 1842(p) of the Act.

We anticipated that each physician that did not report ICD–9–CM codes before April 1, 1989 would either send one or more persons for training, or may have determined that formal training was not needed. Some of those physicians may not have sent any staff since they are in a group practice, (in which case, one staff member may represent several physicians), or because they work for hospitals (in which case they would not submit Part B claims.)

Below, in two examples, we are providing the extremes of estimated training costs using the same methodology as set forth in the impact analysis of the proposed rule. In the first example, we assume that all physicians who did not code prior to April 1989 sent, on average, one of their office staff to attend a half-day session sponsored by a national firm. We anticipated that the cost of such a training session could have been as high as $100.00. Thus, for this estimate, we are assuming a cost of $100.00. Furthermore, we assume the physicians paid an hourly rate of $9.65 per hour to their employees while they attended the coding session. Given these assumptions, we estimated training costs as follows:

(All estimates are rounded to the nearest $10,000.)

Half-day (4 hours) at $9.65 per hour=$38.60; $38.60×57,000 employees	$2,200,000
Session cost $100.00×57,000 employees	5,700,000
Total training costs	$7,900,000

In the second example, we assume that physicians who did not code before the requirement was established in April 1989 sent, on average, one of their office staff to coding sessions sponsored by carriers or insurance companies at no cost. Assuming that the office employee was paid $9.65 an hour, we estimated the total training costs as follows:

Half-day (4 hours) at $9.65 per hour=$38.60; $38.60×57,000 employees	$2,200,000
Session costs	0
Total training costs	$2,200,000

Below, we show the total estimated first year costs for the two examples.

- For the first example, the total estimated first year costs consisted of:

Coding costs	$5,120,000
Training	7,300,000
Books	3,700,000
Total	$16,720,000

- For the second example, the total estimated first year costs consisted of:

Coding costs	$5,120,000
Training	2,200,000
Books	3,700,000
Total	$11,020,000

Therefore, we estimate that first year training costs were between $11 million and $16 million. The cost of updated books will be an ongoing expense. Training costs will be recurring to the extent that staff turnover will occur. Coding costs will be ongoing. However, we believe that coding time and costs will probably be reduced with experience.

Section 1102(b) of the Act requires the Secretary to prepare a regulatory impact analysis if a final rule will 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 of a Metropolitan Statistical Area and has fewer than 50 beds.

We are not preparing a rural impact statement since we have determined, and the Secretary certifies, that this final rule will not have an impact on a significant number of small rural hospitals.

This final rule was reviewed by the Office of Management and Budget.

V. Paperwork Reduction Act

Regulations at § 424.32(a) and § 424.34(b) contain information collection and recordkeeping requirements that are subject to review by the Office of Management and Budget under the Paperwork Reduction Act of 1980 (44 U.S.C. 3501 through 3511). These regulations and the information collection and record keeping requirements apply to the requirement that a physician provide appropriate diagnostic coding on each bill or request for payment for a physician service furnished under Medicare Part B. Public reporting burden for this collection of information is estimated to average one minute per submitted Part B claim. This includes time spent reviewing instructions, searching existing data sources, gathering and maintaining needed data, and completing and reviewing the collection of information. The information and record keeping requirements associated with this final rule have been approved by the Office of Management and Budget in accordance with the Paperwork Reduction Act of 1980 (approval number 0938–0008).

List of Subjects

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 Part 424

Assignment of benefits, Physician certification, Claims for payment, Emergency services, Plan of treatment.

I. 42 CFR part 405, subpart E is amended as set forth below:

PART 405—FEDERAL HEALTH INSURANCE FOR THE AGED AND DISABLED Subpart E—Criteria for Determination of Reasonable Charges; Payment for Services of Hospital Interns, Residents, and Supervising Physicians

A. The authority citation for Subpart E continues to read as follows:

Authority: Secs. 1102, 1814(b), 1832, 1833(a), 1834 (a) and (b), 1842 (b) and (h), 1848, 1861(b), (v), and (aa) 1862(a)(14), 1866(a), 1871, 1881, 1886, 1887, and 1889 of the Social Security Act as amended (42 U.S.C. 1302, 1395f(b), 1395k, 1395l(a), 1395m (a) and (b), 1395u (b) and (h), 1395 w-4, 1395x(b), (v), and (aa), 1395y(a)(14), 1395cc(a), 1395hh, 1395rr, 1395ww, 1395xx, and 1395zz).

B. In § 405.512 paragraph (c) introductory text is republished and paragraph (c)(8) is revised to read as follows:

§ 405.512 Carriers' procedural terminology and coding systems.

* * * * *

(c) *Guidelines.* The following considerations and guidelines are taken into account in evaluating a carrier's proposal to change its system of procedural terminology and coding:

* * * * * *

(8) Compatibility of the proposed system with the carriers methods for determining payment under the fee schedule for physicians' services for services which are identified by a single element of terminology but which may vary in content.

* * * * *

II. 42 CFR part 424 is amended as set forth below:

PART 424—CONDITIONS FOR MEDICARE PAYMENT

A. The authority citation for part 424 is revised to read as follows:

Authority: Secs. 216(j), 1102, 1814, 1815(c), 1835, 1842 (b) and (p), 1861, 1866(d), 1870 (e) and (f), 1871, and 1872 of the Social Security Act (42 U.S.C. 416(j),

1302, 1395f, 1395g(c), 1395n, 1395u (b) and (p), 1395x, 1395cc(d), 1395gg (e) and (f), 1395hh, and 1395ii)

Subpart A—General Provisions

B. In § 424.3, the introductory text is republished and a definition for "ICD–9–CM" is added in alphabetical order to read as follows:

§ 424.3 Definitions.

As used in this part, unless the context indicates otherwise—

ICD–9–CM means International Classification of Diseases, Ninth Revision, Clinical Modification.

* * * * *

Subpart C—Claims for Payment

C. In § 424.32, paragraph (a) is revised to read as follows:

§ 424.32 Basic Requirements for all claims.

(a) A claim must meet the following requirements:

(1) A claim must be filed with the appropriate intermediary or carrier on a form prescribed by HCFA in accordance with HCFA instructions.

(2) A claim for physician services must include appropriate diagnostic coding using ICD–9–CM.

(3) A claim must be signed by the beneficiary or the beneficiary's representative (in accordance with § 424.36(b)).

(4) A claim must be filed within the time limits specified in § 424.44.

* * * * *

D. In § 424.34, the introductory text of paragraph (b) is republished and paragraph (b)(4) is revised to read as follows:

§ 424.34 Additional requirements: Beneficiary's claim for direct payment.

* * * * *

(b) *Itemized bill from the hospital or supplier.* The itemized bill for the services, which may be receipted or unpaid, must include all the following information:

* * * * *

(4) A listing of the services in sufficient detail to permit determination of payment under the fee schedule for physicians' services; for itemized bills from physicians, appropriate diagnostic coding using ICD–9–CM must be used. (For example, a bill for ambulance service must specify the pick-up and delivery points.)

* * * * *

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

Dated: November 22, 1993

Bruce C. Vladeck,

Administrator, Health Care Financing Administration.

Dated: January 24, 1994.

Donna E. Shalala,

Secretary.

[FR Doc. 94–4900 Filed 3–3–94; 8:45 am]

BILLING CODE 4120–01–P

Administration for Children and Families

45 CFR Part 233

Aid to Families With Dependent Children Increase in Stepparent Income Disregard

AGENCY: Administration for Children and Families (ACF), HHS.

ACTION: Final rule.

SUMMARY: This final rule implements the change in the stepparent earned income disregards for the Aid to Families with Dependent Children (AFDC) program as provided under section 13742 of the Omnibus Budget Reconciliation Act (OBRA) of 1993. This provision increases the stepparent earned income disregard from $75 to $90.

EFFECTIVE DATE: March 4, 1994.

FOR FURTHER INFORMATION CONTACT: Mr. Mack A. Storrs, Administration for Children and Families, Office of Family Assistance, Fifth Floor, 370 L'Enfant Promenade, SW., Washington, DC 20447, telephone (202) 401–9289.

SUPPLEMENTARY INFORMATION:

Discussion of Rule Provision

Pursuant to section 402(a)(31) of the Social Security Act (the Act) the income of an AFDC dependent child's stepparent who lives in the same home as the child is counted in the monthly determination of eligibility and the amount of assistance. This provision is applied in States that do not have laws of general applicability holding a stepparent legally responsible to the same extent as a natural or adoptive parent. Section 402(a)(31) also provides for the disregard of certain portions of the stepparent's income in determining the amount to be counted, including the first $75 of the stepparent's monthly earned income.

Effective October 1, 1989, Public Law 100–485 amended section 402(a)(8)(ii) of the Act by increasing the standard work expense disregard for AFDC applicants and recipients from $75 to $90. However, it did not increase the comparable $75 earned income disregard for stepparents.

Thus, to be consistent, section 13742 of Public Law 103–66, the Omnibus Budget Reconciliation Act (OBRA) of 1993, amended section 402(a)(31)(A) of the Act by increasing the earned income disregard for stepparents from $75 to $90 per month. We have amended § 233.20(a)(3)(xiv)(A) to reflect this statutory change.

Regulatory Procedures

Justification for Dispensing With Notice of Proposed Rulemaking

The amendment to this regulation is being published as a final rule. The Administrative Procedure Act, 5 U.S.C. 553(b)(B), provides that, if the Department for good cause finds the Notice of Proposed Rulemaking is unnecessary, impractical or contrary to the public interest, it may dispense with such notice if it incorporates a brief statement of the reasons for doing so in the rules issued.

The Department finds that there is good cause to dispense with a Notice of Proposed Rulemaking with respect to this change. Publication of this rule in proposed form would be unnecessary as the change simply implements the statutory provision and does not involve administrative discretion.

Executive Order 12866

Executive Order 12866 requires that regulations be reviewed to ensure that they are consistent with the priorities and principles set forth in the Executive Order. The Department has determined that this rule is consistent with these priorities and principles. This rule has no costs and merely conforms the codified regulation to the statute.

Paperwork Reduction Act

This rule does not require any information collection activities and therefore no approval is necessary under the Paperwork Reduction Act.

Regulatory Flexibility Act

The Regulatory Flexibility Act (Pub. L. 96–354) requires the Federal Government to anticipate and reduce the impact of regulations and paperwork requirements on small businesses. The primary impact of this final rule is on State governments and individuals. Therefore, we certify that this rule will not have a significant economic impact on a substantial number of small entities because it affects benefits to individuals and payments to States. Thus, a regulatory flexibility analysis is not required.

List of Subjects in 45 CFR Part 233

Aliens, Grant programs—social programs, Public assistance programs,

Reporting and recordkeeping requirements.

(Catalog of Federal Domestic Assistance Programs 13.780, Assistance Payments-Maintenance Assistance)

Dated: November 20, 1993.

Mary Jo Bane,

Assistant Secretary for Children and Families.

Approved: February 7, 1994.

Donna E. Shalala,

Secretary of Health and Human Services.

For the reasons set forth in the preamble, part 233 of chapter II, title 45, Code of Federal Regulations is amended as set forth below:

PART 233—COVERAGE AND CONDITIONS OF ELIGIBILITY IN FINANCIAL ASSISTANCE PROGRAMS

1. The authority citation for part 233 continues to read as follows:

Authority: 42 U.S.C. 301, 602, 606, 607, 1202, 1302, 1352, and 1382 (note).

2. Section 233.20 is amended by revising paragraph (a)(3)(xiv)(A) to read as follows:

§ 233.20 Need and amount of assistance.

(a) * * *

(3) * * *

(xiv) * * *

(A) The first $90 of the gross earned income of the stepparent;

* * * * *

[FR Doc. 94–4899 Filed 3–3–94; 8:45 am]

BILLING CODE 4150–04–M

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Parts 61 and 69

[CC Docket No. 91–213, FCC 94–9]

Transport Rate Structure and Pricing

AGENCY: Federal Communications Commission.

ACTION: Final rule.

SUMMARY: This order modifies certain features of the price cap regulatory system applicable to local exchange carriers (LECs) to complement the FCC's recent restructure of the LECs' local transport rates. Specifically, the order moves transport services, including all the transmission-related elements, the tandem switching charge, and the interconnection charge, out of the price cap basket for traffic sensitive services, and places them into a combined "trunking" basket containing transport and special access services. The order realigns the service categories and subcategories within the trunking basket, and adapts the pricing bands applicable to these categories and subcategories, to reflect the similarities between certain special access and flat-rated transport services, and to accommodate the new density zone pricing system that the Commission adopted for both special access and transport. These rule changes encourage the LECs to align their transport rates to reflect more closely how costs are incurred, thus promoting more efficient usage and deployment of the country's telecommunications networks, advancing competition in both the long-distance and local access markets, and ultimately reducing access charges and long-distance rates and stimulating the economy by increasing demand for these services.

EFFECTIVE DATE: March 4, 1994.

FOR FURTHER INFORMATION CONTACT: David L. Sieradzki, Common Carrier Bureau, Policy & Program Planning Division, 202–632–1304.

SUPPLEMENTARY INFORMATION: This is a synopsis of the Commission's Second Report and Order in CC Docket No. 91–213, adopted on January 19, 1994 and released on January 31, 1994. The complete text of this Second Report and Order is available for inspection and copying during normal business hours in the FCC Reference Center, 1919 M St. NW., room 230, Washington, DC 20554.

Synopsis of Second Report and Order

1. The Commission adopts its proposal to remove the transport service categories from the traffic sensitive basket and place them into a combined basket that also contains special access services. The Commission renames this merged basket the "trunking basket." The Commission is placing the tandem switching charge in the newly formed trunking basket, and keeping it in the same service category as tandem-switched transport. The Commission is placing the interconnection charge service category in the trunking basket.

2. The Commission is adopting a modified version of its proposal in the Further Notice in this proceeding, 57 FR 54205 (Nov. 17, 1992), on the arrangement of service categories within the newly formed trunking basket. The Commission concludes that flat-rated transport (entrance facilities, direct-trunked transport, and dedicated signalling transport) should be incorporated into the corresponding special access service categories. Thus, demand for voice grade flat-rated transport will be assigned to the existing voice grade-WATS-metallic-telegraph service category in the current special access basket for the purposes of computing the service band index (SBI) and pricing bands for that category. Demand for DS1 and DS3 flat-rated transport will be assigned, respectively, to the DS1 and DS3 subcategories of the high capacity-DDS service category in the current special access basket for purposes of computing the SBIs and bands for those subcategories. Tandem-switched transport (including the tandem switching element) and the interconnection charge will be separate service categories in the trunking basket.

3. The Commission concludes that the density pricing zone subcategories within the flat-rated transport service category should be incorporated into the existing zone subcategories within the existing DS3 and DS1 special access subcategories, with one exception. In some cases, a LEC might implement density zone pricing for transport in a different tariff year than it implemented density zone pricing for special access. In such circumstances, the Commission will require LECs to retain separate zone bands for special access and flat-rated transport services until the end of the tariff year following the tariff year in which density pricing was implemented for the later service. After that time, the zone bands for special access and transport can be consolidated.

4. The Commission is not modifying the pricing bands applicable to the transport or special access service categories at this time. The service category bands constrain the LECs' ability to offset rate reductions in some categories with rate increases in other categories.

5. The Commission is setting forth the details of establishing the indexes and banding limits for the new trunking basket and the realigned service categories within that basket. First, the 2% upper and 5% lower bands for tandem-switched transport and the 0% upper band for the interconnection charge apply to changes from the initial rates for these services as of the transport rate restructure, regardless of whether the LECs raised or lowered their local transport rates prior to the rate restructure. ("Initial rates" refers to the rates that became effective as a result of the September 1, 1993 initial restructured transport tariff filing, or rates that subsequently go into effect as the result of the mid-course correction.) Thus, the LECs should set their initial bands and SBIs for the tandem-switched transport and interconnection charge service categories using the baseline of the initial restructured rate levels.

6. Because 47 CFR part 61 does not explicitly address the manner in which service categories are to be merged, the Commission adopts transition rules

governing how the initial banding limits and indexes should be set for the new trunking basket and the realigned service categories within that basket. The initial degree of pricing flexibility for the trunking basket will be set by taking into account both the pricing flexibility currently available in the special access basket and the pricing flexibility available in the traffic sensitive basket (which currently includes transport). Thus, while the pre-existing actual price index (API) for the special access basket will be used as the initial API for the trunking basket, the PCI for the trunking basket should be set as follows. LECs should calculate the ratio between the pre-existing PCI for the special access basket and the API for that basket, and the ratio between the pre-existing PCI for the traffic sensitive basket and the API for that basket. A weighted average of these ratios should be derived using the base period revenue weights of the special access and transport services included in the trunking basket, respectively. This weighted average should be multiplied by the pre-existing API for the special access basket to derive the PCI for the trunking basket. (Base period demand for flat-rated transport elements (i.e., demand for the 1992 base year) should correspond with the historical demand used in computing the initial interconnection charge. The rates used in this formula should be the rates effective on the date that the transport rate restructure became effective, or rates that subsequently go into effect as the result of the mid-course correction.)

7. Similarly, adjustments to the upper and lower pricing bands applicable to the existing voice grade and high capacity/DDS service categories and the DS1 and DS3 subcategories are necessary to reflect the incorporation of comparable flat-rated transport rate elements. While the SBIs for these categories are to remain the same, the upper and lower bands should reflect a weighted average of the pre-existing upper and lower bands for the special access services and the 5% upper and lower bands for the flat-rated transport services. This weighted average should be calculated using the base period revenue weights of the special access and transport services included in each service category and subcategory. A comparable procedure will be used to incorporate transport services into a density pricing zone category that has already been established for special access services (or vice versa).

8. The changes adopted in the order necessitate adjustments to the price cap indexes. Accordingly, the Commission directs all LECs subject to the price cap rules to recalculate their price cap indexes pursuant to the decisions in the order. The LECs should file such recalculated indexes with the Commission in a special filing not accompanied by rate changes. The Commission delegates authority to the Chief, Common Carrier Bureau, to specify the format and timing of this filing. In addition, such recalculated indexes should be used as the basis of any price cap filing that changes rates of services in the trunking or traffic sensitive baskets.

9. Finally, the Commission clarifies some miscellaneous implementation matters. First, the Commission clarifies that its decision in the Second Reconsideration Order, 58 FR 45266 (Aug. 27, 1993) (requiring use of historical demand for all components of the formula for computing the interconnection charge) applies only to price cap LECs. Rate-of-return LECs continue to be subject to 47 CFR 61.38 and 61.39, and should continue to use projected demand to set transport rates. Consistent with the First Reconsideration Order, 58 FR 41184 (Aug. 3, 1993), however, these projections should only forecast demand growth, and should *not* attempt to forecast IXCs' reconfigurations in response to the transport rate restructure. Second, due to the difficulty of applying non-premium charges to flat-rate transport elements, the Commission modifies its rules to clarify that non-premium charges must be established only for the interconnection charge, and not for the facility-based transport elements. Third, the Commission modifies the rules to clarify that the LECs must waive certain non-recurring charges for a six-month period following the effective date of their restructured transport tariffs. Finally, the Commission is making limited technical changes to 47 CFR part 69.

10. In the Further Notice in this proceeding, 57 FR 54205 (Nov. 17, 1992), the Commission certified that the proposed rule changes would not have a significant economic impact on a substantial number of small business entities, as defined by section 601(3) of the Regulatory Flexibility Act. Neither the Chief Counsel for Advocacy of the Small Business Administration nor any commenting party disagreed with that analysis. The Secretary shall send a copy of this Report and Order, including the certification, to the Chief Counsel for Advocacy of the Small Business Administration in accordance with section 605(b) of the Regulatory Flexibility Act, Public Law No. 69–354, 94 Stat. 1164, 5 U.S.C. 601 *et seq.* (1981).

Ordering Clauses

11. Accordingly, *it is ordered* that pursuant to authority contained in sections 1, 4(i) and (j), 201–205, 220, and 403 of the Communications Act of 1934, as amended, 47 U.S.C. §§ 151, 154(i) and (j), 201–205, 220, and 403, parts 61 and 69 of the Commission's rules are Amended as set forth below.

12. *It is further ordered* that the policies and rules adopted herein *shall be effective* upon publication in the **Federal Register**. Because the initial restructured transport rates went into effect on December 30, 1993, thus allowing LECs subject to price cap regulation to propose rate changes that do not comply with the policies adopted herein in the absence of these rule changes, good cause exists to make these rules effective less than 30 days from publication in the **Federal Register**.

13. *It is further ordered* that the Chief, Common Carrier Bureau is delegated the authority specified herein.

List of Subjects in 47 CFR Parts 61 and 69

Communications common carriers, Reporting and recordkeeping requirements. Telephone.

Federal Communications Commission.

William F. Caton,

Acting Secretary.

Amendatory Text

47 CFR parts 61 and 69 are amended as follows:

PART 61—TARIFFS

1. The authority citation for part 61 continues to read as follows:

Authority: Sec. 4, 48 Stat. 1066, as amended; 47 U.S.C. 154. Interpret or apply sec. 203, 48 Stat. 1070; 47 U.S.C. 203.

2. Section 61.3 is amended by redesignating paragraphs (jj) and (kk) as paragraphs (kk) and (ll), respectively, and adding a new paragraph (jj), to read as follows:

§ 61.3 Definitions.

* * * * *

(jj) *Tariff year.* The period from the day in a calendar year on which a carrier's annual access tariff filing is scheduled to become effective through the preceding day of the subsequent calendar year.

* * * * *

3. Section 61.42 is amended by removing paragraphs (e)(1)(iii), (e)(1)(iv), and (e)(1)(v); redesignating paragraphs (e)(1)(vi) and (e)(1)(vii) as paragraphs (e)(1)(iii) and (e)(1)(iv), respectively; revising paragraph (d)(3),

redesignated paragraph (e)(1)(iii), the introductory text of paragraph (e)(2), paragraph (e)(2)(i), paragraph (e)(2)(iii), and paragraph (e)(2)(iv); and adding paragraphs (e)(2)(v) and (e)(2)(vi), to read as follows:

§ 61.42 Price cap baskets and service categories.

* * * * *

(d) * * *

(3) A basket for trunking services as described in §§ 69.110, 69.111, 69.112, 69.114, 69.124, and 69.125 of this chapter;

* * * * *

(e)(1) * * *

(iii) Data base access services; and

* * * * *

(2) The trunking basket shall contain such transport and special access services as the Commission shall permit or require, including the following service categories and subcategories:

(i) Voice grade entrance facilities, voice grade direct-trunked transport, voice grade dedicated signalling transport, voice grade special access, WATS special access, metallic special access, and telegraph special access services;

* * * * *

(iii) High capacity flat-rated transport, high capacity special access, and DDS services, including the following service subcategories:

(A) DS1 entrance facilities, DS1 direct-trunked transport, DS1 dedicated signalling transport, and DS1 special access services; and

(B) DS3 entrance facilities, DS3 direct-trunked transport, DS3 dedicated signalling transport, and DS3 special access services;

(iv) Wideband data and wideband analog services;

(v) Tandem-switched transport, as described in § 69.111 of this chapter; and

(vi) Interconnection charge, as described in § 69.124 of this chapter.

* * * * *

4. Section 61.47 is amended as follows:

a. Paragraphs (f) and (g) are redesignated as paragraphs (f)(1) and (f)(2).

b. Paragraph (h)(1) is redesignated as paragraph (g)(1).

(c) Paragraph (i) is redesignated as paragraph (g)(4).

d. Paragraphs (e)(2) and (e)(3) are redesignated as paragraphs (g)(2) and (g)(3) and are revised.

e. Paragraph (h) is revised.

f. Headings are added to paragraphs (f) and (g).

g. The designation (1) in paragraph (e) is removed and paragraph (e) is revised.

(h) Add the words "or subcategories" after the words "service categories" in paragraphs (a) and (b).

i. Add the words "or subcategory" after the words "service category" in paragraphs (a) and (c).

j. Remove the words "Notwithstanding paragraphs (e) and (f) of this section" from redesignated paragraph (f)(2) and add in their place "Notwithstanding paragraph (f)(1) of this section".

k. Remove the words "Notwithstanding paragraph (e) of this section," from redesignated paragraphs (g)(1) and (g)(4) and capitalizing the word "the" in each sentence when the phrase is removed.

As amended above, § 61.47 reads as follows:

§ 61.47 Adjustments to the SBI; pricing bands.

* * * * *

(e) Pricing bands shall be established each tariff year for each service category and subcategory within a basket. Except as provided in paragraphs (f), (g), and (h) of this section, each band shall limit the pricing flexibility of the service category or subcategory, as reflected in its SBI, to an annual increase or decrease of five percent, relative to the percentage change in the PCI for that basket, measured from the levels in effect on the last day of the preceding tariff year.

(f) *Dominant interexchange carriers.*

* * * * *

(g) *Local exchange carriers—Service categories and subcategories.*

* * * * *

(2) The upper pricing band for the tandem-switched transport service category shall limit the annual upward pricing flexibility for this service category, as reflected in its SBI, to two percent, relative to the percentage change in the PCI for the trunking basket, measured from the levels in effect on the last day of the preceding tariff year. The lower pricing band for the tandem-switched transport service category shall limit the annual downward pricing flexibility for this service category, as reflected in its SBI, to five percent, relative to the percentage change in the PCI for the trunking basket, measured from the levels in effect on the last day of the preceding tariff year.

(3) The upper pricing band for the interconnection charge service category shall limit the annual upward pricing flexibility for this service category, as reflected in its SBI, to zero percent, relative to the percentage change in the PCI for the trunking basket, measured from the levels in effect on the last day of the preceding tariff year. There shall be no lower pricing band for the interconnection charge.

* * * * *

(h) *Local exchange carriers—Density pricing zones.*

(1) In addition to the requirements of paragraphs (g)(1) and (g)(2) of this section, those local exchange carriers subject to price cap regulation that have established density pricing zones pursuant to § 69.123 of this chapter shall use the methodology set forth in paragraphs (a) through (d) of this section to calculate separate subindexes in each zone for each of the following groups of services:

(i) DS1 entrance facilities, DS1 direct-trunked transport, DS1 dedicated signalling transport, and DS1 special access services;

(ii) DS3 entrance facilities, DS3 direct-trunked transport, DS3 dedicated signalling transport, and DS3 special access services;

(iii) Voice grade entrance facilities, voice grade direct-trunked transport, and voice grade dedicated signalling transport, and (if the Commission, by order, designates such services as subject to competition) voice grade special access;

(iv) Tandem-switched transport; and

(v) Such other special access services that the Commission may designate by order.

(2) The annual pricing flexibility for each of the subindexes specified in paragraph (h)(1) of this section shall be limited to an annual increase of five percent or an annual decrease of ten percent, relative to the percentage change in the PCI for the trunking basket, measured from the levels in effect on the last day of the preceding tariff year.

5. Section 61.48 is amended by revising paragraphs (g) and (h) and adding paragraph (i), to read as follows:

§ 61.48 Transition rules for price cap formula calculations.

* * * * *

(g) *Local Transport Restructure—Initial Rates.* Local exchange carriers subject to price cap regulation shall set initial transport rates, as defined in § 69.2(tt) of this chapter, according to the requirements set forth in §§ 69.108, 69.110, 69.111, 69.112, 69.124, and 69.125 of this chapter.

(h) *Local Transport Restructure—Price Cap Transition Rules*—(1) *Definitions.* The following definitions apply for purposes of paragraph (h) of this section:

Effective date is March 4, 1994.

Initial restructured rates are rates that are (or should have been) effective on the transport restructure date;

Revenue weight of a given group of services included in a basket, service category, or subcategory is the ratio of base period demand for the given service rate elements included in the basket, service category, or subcategory priced at initial restructured rates, to the base period demand for the entire group of rate elements comprising the basket, service category, or subcategory priced at initial restructured rates; and

Transport restructure date is the date on which local exchange carriers' initial transport rates, as defined in § 69.2(tt) of this chapter, became effective.

(2) *Trunking Basket PCI and API.* (i) On the effective date, the PCI value for the trunking basket, as defined in § 61.42(d)(3), shall be computed by multiplying the API value for the special access basket on the day preceding the transport restructure date, by a weighted average of the following:

(A) The ratio of the PCI value that applied to the special access basket on the day preceding the transport restructure date, to the API value that applied to the special access basket on the day preceding the transport restructure date, weighted by the revenue weight of the special access services included in the trunking basket; and

(B) The ratio of the PCI value that applied to the traffic sensitive basket on the day preceding the transport restructure date, to the API value that applied to the traffic sensitive basket on the day preceding the transport restructure date, weighted by the revenue weight of the transport services included in the trunking basket.

(ii) On the effective date, the API value for the trunking basket referred to in § 61.42(e)(2) shall be equal to the API value for the special access basket on the day preceding the transport restructure date.

(3) *Service Category and Subcategory Pricing Bands for Flat-Rated Transport and Special Access.* From the effective date through the end of the tariff year, the following shall govern instead of §§ 61.47(e) and 61.47(g)(1). The pricing bands established for the voice grade and high capacity service categories referred to in §§ 61.42(e)(2)(i) and 61.42(e)(2)(iii) and the DS1 and DS3 service subcategories referred to in §§ 61.42(e)(2)(iii)(A) and 61.42(e)(2)(iii)(B), shall limit the pricing flexibility of the service category or subcategory, as reflected in its SBI, as follows:

(i) The upper pricing band shall be a weighted average of the following:

(A) The upper pricing band that applied to the special access services included in the category or subcategory on the day preceding the transport restructure date, weighted by the revenue weight of the special access services included in the category or subcategory; and

(B) 1.05 times the SBI value for the special access services included in the category or subcategory on the day preceding the transport restructure date, weighted by the revenue weight of the transport services included in the category or subcategory.

(ii) The lower pricing band shall be a weighted average of the following:

(A) The lower pricing band that applied to the special access services included in the category or subcategory on the day preceding the transport restructure date, weighted by the revenue weight of the special access services included in the category or subcategory; and

(B) 0.95 times the SBI value for the special access services included in the category or subcategory on the day preceding the transport restructure date, weighted by the revenue weight of the transport services included in the category or subcategory.

(iii) On the effective date, the SBI value for the category or subcategory shall be equal to the SBI value for the corresponding special access category or subcategory on the day preceding the effective date.

(4) *Tandem-Switched Transport and Interconnection Charge SBIs.* On the effective date, the SBIs for the tandem-switched transport and interconnection charge service categories defined in § 61.42(e)(2) (v) and (vi) shall be assigned an initial value prior to adjustment of 100, corresponding to the initial restructured rates in those categories.

(5) *Tandem-Switched Transport and Interconnection Charge Service Category Pricing Bands.* From the effective date through the end of the tariff year, the following shall govern instead of § 61.47 (g)(2) and (g)(3):

(i) The upper pricing band for the tandem-switched transport service category shall limit the upward pricing flexibility for this service category, as reflected in its SBI, to two percent, measured from the initial restructured rates for tandem-switched transport. The lower pricing band for the tandem-switched transport service category shall limit the downward pricing flexibility for this service category, as reflected in its SBI, to five percent, measured from the initial restructured rates for tandem-switched transport.

(ii) The upper pricing band for the interconnection charge service category shall limit the upward pricing flexibility for this service category, as reflected in its SBI, to zero percent, measured from the initial restructured rate for the interconnection charge.

(i) *Transport and Special Access Density Pricing Zone Transition Rules*—(1) *Definitions.* The following definitions apply for purposes of paragraph (i) of this section:

Earlier date is the earlier of the special access zone date and the transport zone date.

Earlier service is special access if the special access zone date precedes the transport zone date, and is transport if the transport zone date precedes the special access zone date.

Later date is the later of the special access zone date and the transport zone date.

Later service is transport if the special access zone date precedes the transport zone date, and is special access if the transport zone date precedes the special access zone date.

Revenue weight of a given group of services included in a zone category is the ratio of base period demand for the given service rate elements included in the category priced at existing rates, to the base period demand for the entire group of rate elements comprising the category priced at existing rates.

Special access zone date is the date on which a local exchange carrier tariff establishing divergent special access rates in different zones, as described in § 69.123(c) of this chapter, becomes effective.

Transport zone date is the date on which a local exchange carrier tariff establishing divergent switched transport rates in different zones, as described in § 69.123(d) of this chapter, becomes effective.

(2) *Simultaneous Introduction of Special Access and Transport Zones.* Local exchange carriers subject to price cap regulation that have established density pricing zones pursuant to § 69.123 of this chapter, and whose special access zone date and transport zone date occur on the same date, shall initially establish density pricing zone SBIs and bands pursuant to the methodology in § 61.47(h).

(3) *Sequential Introduction of Zones in the Same Tariff Year.* Notwithstanding § 61.47(h), local exchange carriers subject to price cap regulation that have established density pricing zones pursuant to § 69.123 of this chapter, and whose special access zone date and transport zone date occur on different dates during the same tariff year, shall, on the earlier date, establish

density pricing zone SBIs and pricing bands using the methodology described in § 61.47(h), but applicable to the earlier service only. On the later date, such carriers shall recalculate the SBIs and pricing bands to limit the pricing flexibility of the services included in each density pricing zone category, as reflected in its SBI, as follows:

(i) The upper pricing band shall be a weighted average of the following:

(A) The upper pricing band that applied to the earlier services included in the zone category on the day preceding the later date, weighted by the revenue weight of the earlier services included in the zone category; and

(B) 1.05 times the SBI value for the services included in the zone category on the day preceding the later date, weighted by the revenue weight of the later services included in the zone category.

(ii) The lower pricing band shall be a weighted average of the following:

(A) The lower pricing band that applied to the earlier services included in the zone category on the day preceding the later date, weighted by the revenue weight of the earlier services included in the zone category; and

(B) 0.90 times the SBI value for the services included in the zone category on the day preceding the later date, weighted by the revenue weight of the later services included in the zone category.

(iii) On the later date, the SBI value for the zone category shall be equal to the SBI value for the category on the day preceding the later date.

(4) *Introduction of Zones in Different Tariff Years.* Notwithstanding § 61.47(h), those local exchange carriers subject to price cap regulation that have established density pricing zones pursuant to § 69.123 of this chapter, and whose special access zone date and transport zone date do not occur within the same tariff year, shall, on the earlier date, establish density pricing zone SBIs and pricing bands using the methodology described in § 61.47(h), but applicable to the earlier service only.

(i) On the later date, such carriers shall use the methodology set forth in paragraphs (a) through (d) of § 61.47 to calculate separate SBIs in each zone for each of the following groups of services:

(A) DS1 special access services;

(B) DS3 special access services;

(C) DS1 entrance facilities, DS1 direct-trunked transport, and DS1 dedicated signalling transport;

(D) DS3 entrance facilities, DS3 direct-trunked transport, and DS3 dedicated signalling transport;

(E) Voice grade entrance facilities, voice grade direct-trunked transport, and voice grade dedicated signalling transport;

(F) Tandem-switched transport; and

(G) Such other special access services as the Commission may designate by order.

(ii) From the later date through the end of the following tariff year, the annual pricing flexibility for each of the subindexes specified in paragraph (i)(4)(i) of this section shall be limited to an annual increase of five percent or an annual decrease of ten percent, relative to the percentage change in the PCI for the trunking basket, measured from the levels in effect on the last day of the tariff year preceding the tariff year in which the later date occurs.

(iii) On the first day of the second tariff year following the tariff year during which the later date occurs, the local exchange carriers to which this paragraph applies shall establish the separate subindexes provided in § 61.47(h)(1), and shall set the initial SBIs for those density pricing zone categories that are combined (specified in paragraphs (i)(4)(i)(A) and (i)(4)(i)(C), (i)(4)(i)(B) and (i)(4)(i)(D), and (i)(4)(i)(E) and (i)(4)(i)(G) of this section) by computing the weighted averages of the SBIs that applied to the formerly separate zone categories, weighted by the revenue weights of the respective services included in the zone categories.

§ 61.49 [Amended]

6. Section 61.49(c) is amended by removing the cite "§§ 61.47(e) and (f)" and adding, in their place, the cite "§ 61.47(e), (f)(1), (g), and (h)"; and by removing the cite "§ 61.47(g)" and adding in their place, the cite "§ 61.47(f)(2)".

7. Section 61.49(d) is amended by removing the cite "§ 61.47(e)" and adding, in their place, the cite "§ 61.47(e), (g), and (h)".

§ 61.58 [Amended]

8. Section 61.58(c)(3) is amended by removing the cite "§§ 61.47(e) and (f)" and adding, in their place, the cite "§ 61.47(e), (f)(1), (g), and (h)"; and by removing the cite "§ 61.47(g)" and adding in their place, the cite "§ 61.47(f)(2)".

9. Section 61.58(c)(4) is amended by removing the cite "§ 61.47(e)" and adding, in their place, the cite "§ 61.47(e), (g), and (h)".

PART 69—ACCESS CHARGES

1. The authority citation for part 69 continues to read as follows:

Authority: Secs. 4, 201, 202, 203, 205, 218, 403, 48 Stat. 1066, 1070, 1072, 1077, 1094, as amended, 47 U.S.C. 154, 201, 202, 203, 205, 218, 403.

§ 69.110 [Amended]

2. Sections 69.110(c)(1) and 69.110(c)(2) are amended by removing the words "to recover the costs" and adding, in their place, the words "for use".

§ 69.113 [Amended]

3. Section 69.113(a) is amended by removing the words "69.110, 69.111, 69.112".

4. Section 69.113(d) is amended by removing the words "Transport element or elements" and adding, in their place, the words "interconnection charge element".

5. Section 69.113(e) is amended by removing the words "transport or".

§ 69.126 [Amended]

Section 69.126 is amended by removing the words "May 1, 1994" and adding, in their place, the words "six months after the effective date of the tariffs introducing initial transport rates".

[FR Doc. 94–4672 Filed 3–3–94; 8:45 am]
BILLING CODE 6712–01–M

INTERSTATE COMMERCE COMMISSION

49 CFR Part 1312

[Ex Parte No. 218]

Filing of Tariff Adoption Publications

AGENCY: Interstate Commerce Commission.

ACTION: Final rule.

SUMMARY: The Commission adopts a regulation which establishes a 60-day deadline for the filing of adoption publications. The regulation is intended to remove any possible ambiguity with regard to the existing regulation, which requires that such publications be filed "promptly".

EFFECTIVE DATE: This regulation is effective April 3, 1994.

FOR FURTHER INFORMATION CONTACT: James W. Greene (202) 927–5597 or Charles E. Langyher, III (202) 927–5160. (TDD for hearing impaired: (202) 927–5721).

SUPPLEMENTARY INFORMATION: By decision served December 8, 1993 (58 FR 64717, December 9, 1993), the

Commission requested public comments on the desirability of amending § 1312.20(h) (49 CFR 1312.20(h)) to require that adoption publications be filed not more than 60 days after consummation of the event giving rise to their filing. The existing regulation specifies that adoption publications should be filed prior to consummation, if possible; and that, if for some reason filing cannot be accomplished prior to consummation, they should be filed as soon as possible thereafter, *i.e.* "promptly". The new regulation will replace "promptly" with the more specific requirement that adoption publications be filed no later than 60 days after consummation of the transaction.

The regulation is not controversial. The National Bus Traffic Association, Inc. filed the only response to our notice of proposed rulemaking, and it supported the regulation.

Timely filing of adoption publications is important. Absent a new carrier's filing of its own tariffs or adoption of the former carrier's tariffs, any operations conducted by the new carrier violate 49 U.S.C. 10761(a), which prohibits service by a carrier unless "the rate for transportation or service is contained in a tariff that is in effect * * *". Thus, the failure to timely file either new tariffs or adoption publications can result in a violation of the statute. Additionally, users and potential users of transportation services have no way of determining from the tariff system the rates for the new carrier's services unless adoption publications or new tariffs have been filed. We will adopt the regulation as proposed.

As indicated in the notice of proposed rulemaking, the 60-day deadline is intended only as the maximum allowable time; it should not be viewed as an opportunity to delay filings beyond the consummation date. As stated in both the old and new regulations, adoption publications should be filed prior to the consummation date whenever possible.

Environmental and Energy Considerations

This rule revision will not significantly affect either the quality of the human environment or the conservation of energy resources.

Regulatory Flexibility Analyses

Pursuant to 5 U.S.C. 605(b), we conclude that this action will not have a significant economic impact on a substantial number of small entities. The action merely clarifies the timing of a one-time filing requirement already required by the Commission's regulations. Thus, no new substantive requirements are being imposed.

List of Subjects in 49 CFR Part 1312

Motor carriers, Moving of household goods, Pipelines, Tariffs.

Decided: February 18, 1994.

By the Commission, Chairman McDonald, Vice Chairman Phillips, Commissioners Simmons and Philbin.

Sidney L. Strickland, Jr.,

Secretary.

For the reasons set forth in the preamble, title 49, chapter X, part 1312 of the Code of Federal Regulations is amended as follows:

PART 1312—REGULATIONS FOR THE PUBLICATION, POSTING AND FILING OF TARIFFS, SCHEDULES AND RELATED DOCUMENTS

1. The authority citation for part 1312 continues to read as follows:

Authority: 5 U.S.C. 553; 49 U.S.C. 10321, 10762 and 10767.

2. In § 1312.20, paragraph (h)(1) is revised to read as follows:

§ 1312.20 Transfer of operations—change in name and control.

* * * * *

(h) * * *

(1) The effective date of adoption publications is the date of consummation of the transaction for which such publications are required. Adoption publications shall be filed promptly and, if possible, prior to their effective date, but in no case later than 60 days thereafter.

* * * * *

[FR Doc. 94-4982 Filed 3-3-94; 8:45 am]

BILLING CODE 7035-01-P

DEPARTMENT OF THE INTERIOR

Fish and Wildlife Service

50 CFR Part 17

RIN 1018-AB89

Endangered and Threatened Wildlife and Plants; Determination of Endangered or Threatened Status for 21 Plants From the Island of Hawaii, State of Hawaii

AGENCY: Fish and Wildlife Service, Interior.

ACTION: Final rule.

SUMMARY: The U.S. Fish and Wildlife Service (Service) determines endangered status pursuant to the Endangered Species Act of 1973, as amended (Act), for 20 plants: *Clermontia lindseyana* ('oha wai), *Clermontia peleana* ('oha wai), *Clermontia pyrularia* ('oha wai), *Colubrina oppositifolia* (kauila), *Cyanea copelandii* ssp. *copelandii* (haha), *Cyanea hamatiflora* ssp. *carlsonii* (haha), *Cyanea shipmanii* (haha), *Cyanea stictophylla* (haha), *Cyrtandra giffardii* (ha'iwale), *Cyrtandra tintinnabula* (ha'iwale), *Ischaemum byrone* (Hilo ischaemum), *Isodendrion pyrifolium* (wahine noho kula), *Mariscus fauriei* (no common name (NCN)), *Nothocestrum breviflorum* ('aiea), *Ochrosia kilaueaensis* (holei), *Plantago hawaiensis* (laukahi kuahiwi), *Portulaca sclerocarpa* (po'e), *Pritchardia affinis* (loulu), *Tetramolopium arenarium* (NCN), and *Zanthoxylum hawaiiense* (a'e). The Service also determines threatened status for one plant, *Silene hawaiiensis* (NCN). All but eight of the taxa are endemic to the island of Hawaii, Hawaiian Islands; the exceptions were from the islands of Niihau, Kauai, Oahu, Molokai, Lanai, and/or Maui as well as Hawaii. The 21 plant taxa and their habitats have been variously affected or are currently threatened by competition, predation or habitat degradation from introduced species, habitat loss from development and other human activities, natural disasters and stochastic events. This rule implements the Federal protection provisions provided by the Act for these plants. One taxon, *Hesperocnide sandwicensis*, which had been proposed for listing with the above species, has been withdrawn from consideration as a result of additional information received indicating the species is more abundant than previously believed. A notice withdrawing the proposal is published in the **Federal Register** concurrently with this final rule.

EFFECTIVE DATE: This rule takes effect on April 4, 1994.

ADDRESSES: The complete file for this rule is available for public inspection, by appointment, during normal business hours at the U.S. Fish and Wildlife Service, Pacific Islands Office, 300 Ala Moana Boulevard, room 6307, P.O. Box 50167, Honolulu, Hawaii 96850.

FOR FURTHER INFORMATION CONTACT: Robert P. Smith, at the above address (808/541-2749).

SUPPLEMENTARY INFORMATION:

Background

Clermontia lindseyana, Clermontia peleana, Clermontia pyrularia, Colubrina oppositifolia Cyanea copelandii ssp. *copelandii, Cyanea hamatiflora* ssp. *carlsonii, Cyanea shipmanii, Cyanea stictophylla,*