

be obtained by calling the contact person listed in this final rule with comment period or by accessing the CMS Web site: <http://www.cms.hhs.gov>.

To date, we have not enforced § 411.54 (c)(2) or the portion of § 489.20(g) that is inconsistent with the court's decision. Because § 411.54(c)(2) was written without regard to the pre- and post "promptly" period, we are removing this section in its entirety, even though the AHA decision found it unenforceable only during the "promptly" period. This final rule with comment period does not establish lien rights that are not available to providers and suppliers (including physicians) under State law. The final rule with comment period does not alter the prohibition against double billing; that is, it does not allow a provider or supplier (including a physician) to bill Medicare and simultaneously bill the liability insurer or assert or maintain a lien against the beneficiary's liability insurance settlement.

II. Provisions of the Final Rule

The final rule with comment period removes § 411.54(c)(2) and revises paragraphs (c) and (d) of our regulations. It also removes the words "except when the primary payer is a liability insurer and except as provided in paragraph (j) of this section" from § 489.20(g).

III. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the **Federal Register** and solicit public comment when a collection of information requirement is submitted to the OMB for review and approval. In order to fairly evaluate whether OMB should approve an information collection, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

Therefore, we are soliciting public comment on each of these issues for the information collection requirements discussed below.

Section 411.54 Limitation on Charges When a Beneficiary Has Received a Liability Insurance Payment or Has a Claim Pending Against a Liability Insurer

Section 411.54(c) states that a hospital must, upon request, furnish to the beneficiary or his or her representative an itemized bill of the hospital's charges.

This requirement, which is subject to the PRA, is not being revised in this regulation. The burden associated with this requirement is currently captured under OMB control number 0938-0565, which is approved through November of 2005.

We have submitted a copy of this final rule with comment period to OMB for its review of the information collection requirements described above. These requirements are not effective until they have been approved by OMB.

If you comment on these information collection and recordkeeping requirements, please mail copies directly to the following: Centers for Medicare and Medicaid Services, Office of Strategic Operations and Regulatory Affairs, Division of Regulations Development and Issuances, Attn.: Dawn Willingham (Attn: CMS-1475-F), Room C5-14-03, 7500 Security Boulevard, Baltimore, MD 21244-1850.

Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503, Attn: Brenda Aguilar, CMS Desk Officer.

IV. Waiver of Proposed Rulemaking

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** and invite public comment on the proposed rule. The notice of proposed rulemaking includes a reference to the legal authority, under which the rule is proposed, and the terms and substances of the proposed rule or a description of the subjects and issues involved. This procedure can be waived, however, if an agency finds good cause that a notice-and-comment procedure is impracticable, unnecessary, or contrary to the public interest and incorporates a statement of the finding and its reasons in the rule issued. The AHA decision holds that the Medicare Secondary Payer provisions permit a provider to seek payment from that insurance or assert or maintain a lien against the beneficiary's insurance settlement during the "promptly" period. To the extent that § 411.54(c)(2) and a portion of § 489.20(g) are inconsistent with the court's decision, they are unenforceable. Good cause exists to waive notice and comment

because the agency's action to remove § 411.54(c)(2) and revise § 489.20(g) is compelled by the AHA decision.

Therefore, we find good cause to waive the notice of proposed rulemaking and to issue this final rule with comment period.

V. Regulatory Impact

We have examined the impacts of this final rule with comment period as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 16, 1980, Pub. L. 96-354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104-4), and Executive Order 13132.

Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects (\$100 million or more in any 1 year). We have determined that the effect of this final rule on the economy and the Medicare program is negligible. Therefore, this final rule is not a major rule as defined in Title 5, United States Code, section 804(2) and is not an economically significant rule under Executive Order 12866.

Because these regulations have been unenforceable since the AHA decision, the impact of this regulation is limited to the expected elimination of potential lawsuits that may be brought against hospitals by beneficiaries seeking to require hospitals to bill Medicare for the cost of their treatment. Since 1990 we have been aware of only several cases where beneficiaries have brought litigation against hospitals seeking State court orders requiring the hospitals to bill Medicare. The beneficiaries have based their cases on the published regulations. While we do not believe that many such suits have or will be filed, individual hospitals can spend substantial monies defending these types of lawsuits. Beneficiaries who bring these suits, only to lose based on the State court's reading of CMS' policy, also may be responsible for some attorneys' costs and may be responsible for fees for the hospital's attorneys in some cases. To the extent that this regulation clarifies CMS policy by eliminating unenforceable regulations, we believe that the number of lawsuits filed may decline.