

claims processing cost for our contractors. (Where a provider believes that a service is not covered by Medicare but the beneficiary (or the State as the beneficiary's subrogee) requests the provider to bill Medicare regardless, the provider's Medicare provider agreement requires it to bill Medicare. Such a bill is known as a "demand bill." It requires full medical review because the fact that the provider initially believed that the service was not covered by Medicare raises the question of whether Medicare should pay it.)

Finally, we are cognizant that providers and suppliers sometimes file SOIs. We believe, however, that the filing periods in § 424.44 (15 to 27 months, depending on the date the service was rendered) are more than an adequate amount of time to submit claims.

Based on a survey of SOI requests filed with Medicare contractors for the claims filing period that ended December 31, 2001 (the latest year for which data was available), a very small percentage of claims were processed and paid compared to the total number of SOI requests received. The entire process of receiving an SOI request, determining if an SOI is valid or invalid, examining a later-submitted claim to determine whether the claim was in fact protected by the earlier-submitted SOI, and adjudicating the claim (which, in many cases involves full medical review) are all done manually, and the costs associated with such manual processing are not included in our contractors' budgets (contractors are not required to calculate costs at this level). Therefore, the expenditure of resources and money for such manual processing takes away from the resources needed to do the activities and functions that are included in our contractors' budgets. This proposed rule, if finalized, should have little financial impact on entities that currently submit SOI requests. The rule would simply require these entities to submit their claims six months or so earlier, to comply with Medicare's timely filing requirements (that is, 15 to 27 months after the date of service, depending on the particular month the service was rendered). Given that the requirements for submitting a claim are not much different than submitting a valid SOI, and given that an SOI must be filed within the timely filing period, we anticipate no significant difficulty for such entities to timely submit claims.

Therefore, for the above reasons, we propose removing § 424.45 from our regulations.

II. Provisions of the Proposed Regulation

This regulation proposes to remove 42 CFR 424.45. In the absence of § 424.45, providers, suppliers and beneficiaries still would have from 15–27 months to submit claims to Medicare.

III. Collection of Information Requirements

This document does not impose new information collection and recordkeeping requirements but does remove an old one.

The elimination of § 424.45 will reduce costs and workload burdens on providers and suppliers. Specifically, by eliminating the written SOI procedures, we hope to: (1) Reduce provider, supplier and Medicare contractor resource burdens; (2) reduce the burden placed on providers and suppliers from having to resubmit claims, and also from having to reimburse States for claims that were incorrectly paid for by the States; (3) reduce Medicare contractor administrative costs; (4) eliminate changes to existing intermediary/carrier claims payment systems; (5) encourage States to pursue cost-avoidance procedures to ensure that Medicaid is truly the payor of last resort, and thus reduce the need to use "pay and chase" procedures; (6) reduce the necessity for medical review at the contractor level; (7) strengthen Medicare and Medicaid program integrity efforts to ensure correct payment the first time; and (8) improve coordination efforts between the Medicare and Medicaid programs.

Given that CMS, in the past, did not specifically quantify the burden associated with this regulatory requirement, we are seeking public comment on the burden reduction associated with the elimination of section 42 CFR 424.45.

If you have any comments on any of these information collection and record keeping requirements, please mail the original and three copies directly to the following:

Centers for Medicare & Medicaid Services, Office of Strategic Operations and Regulatory Affairs, DRDI, DRD–B, Baltimore, MD 21244–1850, ATTN: Julie Brown, CMS–1185-P; and

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 CMS–1185-P.

Comments submitted to OMB may also be emailed to the following address: email: baguilar@omb.eop.gov; or faxed to OMB at (202) 395–6974.

IV. Response to Comments

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

V. Regulatory Impact Statement

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

Executive Order 12866 (as amended by Executive Order 13258, which merely reassigns responsibility of duties) directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects; distributive impacts; and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects (\$100 million or more annually). This is not a major rule. This proposed rule will have no substantial economic impact on either costs or savings to the Medicare or Medicaid programs.

The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and government agencies. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of \$6 million to \$29 million annually (see 65 FR 69432). Individuals and States are not included in the definition of small entities.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital located outside of a Metropolitan Statistical Area with fewer than 100 beds.