

additional medical information is needed, correcting a typographical error for repeating a data element, adding a qualifier to enable the provider to link a request with an attachment, and defining two segments that only support paper attachments. These requests have been reflected in the revised Addenda.

- Fourteen of the commenters asked for additional clarification on the appropriate use of the standard for referral certification and authorization as a two-way transaction. The Implementation Guide is modified to illustrate the model use of this transaction to include a follow-up EDI or non-EDI response.

- One commenter asked a question relating to whether a transaction should be rejected if there is no patient event tracking number (TRN) segment for the patient, when the patient is not the subscriber. ASC X12N clarified in the Addenda that the transaction should not be rejected. The TRN usage instruction was made specific about when the data are required.

- One of the commenters requested that a new code be developed to replace the Assigned By Receiver (ABR) code rather than use an existing code to define an element for which it was not intended. A data maintenance request has been approved to have a code added, but it will not be in effect for the ASC X12N 4010 Version of the Implementation Guide.

J. Transaction Standard for Health Care Claim Status

We proposed the adoption of the Addenda to Health Care Claim Status Request and Response, ASC X12N 276/277, Version 4010, October 2002, Washington Publishing Company, 004010X093A1 as the standard for the health care claim status transaction.

We did not receive significant comments on this proposal.

K. Transaction Standard for Enrollment and Disenrollment in a Health Plan

We proposed the adoption of the Addenda to Benefit Enrollment and Maintenance, ASC X12N 834 Benefit Enrollment and Maintenance, Version 4010, October 2002, Washington Publishing Company, 004010X095A1 as the standard for enrollment and disenrollment in a health plan transaction.

We did not receive significant comments on this proposal.

L. Transaction Standard for Health Care Claim Payment/Advice

We proposed the adoption of the Addenda to Health Care Claim Payment/Advice, ASC X12N 835,

Version 4010, October 2002, Washington Publishing Company, 004010X091A1 as the standard for dental, professional, institutional, and pharmacy health care payment and remittance advice transactions.

We did not receive significant comments on this proposal.

M. Transaction Standard for Health Care Premium Payments

Comment: A number of commenters pointed out that adoption of the ASC X12N 004010X061 and ASC X12N 004010X061A1 standards were not included in CMS-0005-P.

Response: We received comments pointing out that the transaction standard for Health Care Premium Payments, the ASC X12N 820, 004010X061 and Addenda, 004010X061A1, were omitted from CMS-0005-P. We did not specifically intend to exclude this transaction standard and its Addenda from the proposed rule. The modification for the Addenda to this Implementation Guide provides the same guidance as the Addenda for the other transaction standards; the modification provides guidance to the industry, in section A.1.3.1.2, in handling decimal points in monetary transactions. Nevertheless, we recognize that these Implementation Guide modifications were not expressly identified and separately listed in CMS-0005-P, and thus we are including them as follows in section IV below.

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 substance 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 public 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.

We find for good cause that it is unnecessary to undertake notice and comment rulemaking procedures for this final rule because the Addenda modifications for § 162.1702 "Standard for health care premium payments," § 162.1802 "Standards for coordination of benefits," and technical modifications approved by the DSMOs (relating to Initial Treatment Date, Spinal Manipulation Certifications for Medicare Part B, and the Test Date for

Dialysis Patients) offer no substantive changes to the standard and Addenda and merely provide explanatory guidance.

The Addenda for the Health Plan Premium Payments Transaction provides the same guidance to the industry as the Addenda for other adopted transactions that were proposed in the proposed rule at 67 FR 38050.

The Coordination of Benefits Transaction Standard is a variation of the health care claim transaction for institutional, dental, and professional providers that was proposed in CMS-0005-P.

The three modifications approved by the DSMOs but not included in the Addenda specifications are merely technical corrections relating to Initial Treatment Date, Spinal Manipulation Certifications for Medicare Part B, and the Test Date for Dialysis Patients for a single transaction standard. These corrections in essence correct a typographical error in the draft Addenda and do not require any data elements to be changed.

We received comments on the standard for the health care claim, and have responded to those in this final rule. Because each of the transaction standards adopted by the Transactions final rule has Addenda that were approved for use by the industry, we are adopting the Addenda for each of the proposed transactions so that implementation of the Addenda for each of the adopted standards will be consistent. Therefore, for good cause, we waive notice and public comment procedures under 5 U.S.C. 553(b)(B).

V. Collection of Information Requirements

Under the Paperwork Reduction Act (PRA) of 1995, we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the PRA 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.