Risks. This rule is not an economically significant rule and does not concern an environmental risk to health or risk to safety that may disproportionately affect children.

Environment

We considered the environmental impact of this proposed rule and concluded that, under figure 2–1, paragraph (32)(e), of Commandant Instruction M16475.1C, this proposed rule is categorically excluded from further environmental documentation because promulgation of drawbridge regulations have been found not to have a significant effect on the environment. A ''Categorical Exclusion Determination'' is available in the docket where indicated under **ADDRESSES.**

List of Subjects in 33 CFR Part 117

Bridges.

Regulations

For the reasons set out in the preamble, the Coast Guard proposes to amend 33 CFR part 117 as follows:

PART 117—DRAWBRIDGE OPERATION REGULATIONS

1. The authority citation for part 117 continues to read as follows:

Authority: 33 U.S.C. 499; 49 CFR 1.46; 33 CFR 1.05–1(g); section 117.255 also issued under the authority of Pub. L. 102–587, 106 Stat. 5039.

2. Section 117.787 is revised to read as follows:

§ 117.787 Gowanus Canal.

The draws of the Ninth Street Bridge, mile 1.4, the Third Street Bridge, mile 1.8, the Carroll Street Bridge, mile 2.0, and the Union Street Bridge, mile 2.1, at Brooklyn, shall open on signal if at least a two-hour advance notice is given to either the New York City Department of Transportation (NYCDOT) Radio Hotline or the NYCDOT Bridge Operations Office.

Dated: April 12, 2000.

Robert F. Duncan,

Captain, U.S. Coast Guard, Acting Commander, First Coast Guard District.

[FR Doc. 00–10454 Filed 4–26–00; 8:45 am]

BILLING CODE 4910–15–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Part 414

HCFA–1084–P

RIN 0938–AJ82

Medicare Program; Payment for Upgraded Durable Medical Equipment

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

ACTION: Proposed rule.

SUMMARY: This proposed rule would amend the Medicare regulations to permit Medicare suppliers to furnish upgraded durable medical equipment (DME) on an assignment basis. Medicare payment would be made to the supplier as if the DME were non-upgraded DME; and the beneficiary purchasing or renting the upgraded DME would pay the supplier an amount equal to the difference between the supplier's charge for the DME upgrade and the amount paid by Medicare for the non-upgraded DME. This proposed rule would also require the following consumer protection safeguards: determination of fair market prices, proof of full disclosure of the availability and cost of non-upgraded DME, and sanctions against suppliers who engage in coercive or abusive sales practices.

DATES: We will consider comments if we receive them at the appropriate address, as provided below, no later than 5 p.m. on June 26, 2000.

ADDRESSES: Mail written comments (1 original and 3 copies) to the following address only: Health Care Financing Administration, Department of Health and Human Services, Attention: HCFA–1084–P, P.O. Box 8013, Baltimore, MD 21244–8013.

If you prefer, you may deliver your written comments (1 original and 3 copies) to one of the following addresses (If you choose to mail your comments to one of the following addresses, we may be delayed receiving them, which could result in us considering those comments late.):

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

Room C5–16–03, 7500 Security Boulevard, Baltimore, MD

Because of staffing and resource limitations, we cannot accept comments by facsimile (FAX) transmission. In commenting, please refer to file code HCFA–1084–P. Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, in Room 443–G of the Department's office at 200 Independence Avenue, SW., Washington, DC, on Monday through Friday of each week from 8:30 a.m. to 5 p.m. (phone: (202) 690–7890).

FOR FURTHER INFORMATION CONTACT: William Long, (410) 786–5655.

SUPPLEMENTARY INFORMATION:

I Background

A. Durable Medical Equipment

Durable medical equipment (DME) is medical equipment furnished by a supplier or a home health agency that is primarily and customarily used to serve a medical purpose. DME is able to withstand repeated use and is generally not useful to an individual in the absence of a sickness or an injury. To be covered by Medicare, DME must be appropriate for use in a beneficiary's home or in an institution that is used as a home. A hospital, or a critical access hospital may not be considered an institution that is used as a home for this purpose. Similarly, a Medicare-certified SNF or other institution that is primarily engaged in providing skilled care to its residents may not be considered an institution that is used as a home.

While Medicare will pay for DME that is adequate and effective to meet the medical needs of the beneficiary, it will not pay extra for convenience or luxury features nor more than the applicable fee schedule amount.

B. Payment for DME

Payment for DME furnished under Part B of the Medicare program (Supplementary Medical Insurance) is made through contractors known as Medicare carriers. Section 1834(a) of the Social Security Act (the Act) provides that Medicare payment for DME is equal to 80 percent of the lesser of the actual charge for the DME or the fee schedule amount for the DME. Section 1834(a) of the Act classifies DME into the following payment categories:

- Inexpensive or other routinely purchased DME.
- DME requiring frequent and substantial servicing.
- Customized DME.
- Supplies and accessories used with DME
- Oxygen and oxygen equipment.
- Other items of DME (capped rental items).

There is a specific methodology for determining the fee schedule payment amount for each category of DME. In addition, for each of these categories there are restrictions governing

payment. For example, inexpensive or other routinely purchased DME may be rented or purchased. However, oxygen and DME requiring frequent and substantial servicing may only be rented and not purchased. Customized items and other supplies may only be purchased. Capped rental items, other than electric wheelchairs, may initially only be rented; however, the rental payments can be applied to the purchase of the item if the beneficiary selects the purchase option after the tenth rental month.

The fee schedules for DME are calculated using average reasonable charges from 1986 and 1987 and are generally adjusted annually by the change in the Consumer Price Index for all Urban Consumers (CPI–U) for the 12-month period ending June 30, of the preceding year. In addition, the fee schedules for DME are limited by a ceiling (upper limit) and floor (lower limit). The ceiling and floor are equal to 100 percent and 85 percent, respectively, of the median of the local (Statewide) fee amounts. The local fee schedule amounts for areas outside the continental United States are not included in the calculation of the ceiling and floor limits, nor are they subject to the ceiling or floor limits. This fee schedule payment methodology is stated in 42 CFR part 414, subpart D.

C. Medicare's Assignment Rules

An assignment is an agreement between a supplier and a Medicare beneficiary whereby the beneficiary transfers to the supplier his or her right to collect benefits for furnished covered services. The supplier in return agrees:

- To accept, as full charge for the service, the amount approved by the Medicare carrier as the basis for determining the Medicare Part B payment.
- To collect from the beneficiary only the difference between the Medicare-approved amount and the Medicare Part B payment, that is, any deductible and coinsurance amounts. A violation of the assignment occurs if the supplier collects from the beneficiary or anyone else any amount in excess of the approved amount.

If the supplier does not accept assignment, payment is made by the carrier directly to the beneficiary less any deductible and copayment and the beneficiary is then responsible to the supplier for the entire amount. Also, without assignment the supplier is not limited in his charges, and the beneficiary may have to pay more than he or she would have paid if the claim had been assigned. The rules governing assignment are stated in 42 CFR part 424, subpart D.

D. Current Payment Process for Upgraded DME

An item of DME may have certain convenience or luxury features that make it more expensive than non-upgraded DME however, these features are not necessary to adequately meet the medical needs of the beneficiary. Medicare does not cover medically unnecessary upgrades. If a supplier accepts assignment, it must accept the Medicare-approved amount as full payment for the upgraded DME.

The Medicare-approved payment amount for the more expensive DME cannot exceed the payment amount for the non-upgraded DME. If a beneficiary purchases or rents DME that has more expensive features than his or her condition requires, the supplier accepting assignment for the DME may not charge or collect any amount in excess of the Medicare-approved amount for the non-upgraded DME.

Currently, a supplier that wishes to charge and collect a greater price for upgraded DME must submit an unassigned claim. The carrier then pays the beneficiary an amount equal to the Medicare payment, less the deductible and coinsurance. The beneficiary is then responsible to the supplier for the full payment price of the upgraded DME. The current procedures for Medicare payment of assigned and unassigned DME claims are stated in 42 CFR part 414, subpart D.

II. Provisions of the Balanced Budget Act of 1997

On August 5, 1997, the Congress passed the Balanced Budget Act of 1997 (BBA). Section 4551(c) of the BBA added a second paragraph 1834(a)(17) to the Act, authorizing the Secretary to issue regulations under which an individual may purchase or rent upgraded DME from a supplier, and Medicare payment would be made to the supplier as if the upgraded DME were non-upgraded DME if the supplier presented an assigned claim.

Section 1834(a) second (17)(B) of the Act provides that (i) In the case of the purchase or rental of upgraded DME, the supplier shall receive payment for that upgraded DME as if the DME was non-upgraded DME; and (ii) the individual purchasing or renting the DME shall pay the supplier an amount equal to the difference between the allowed Medicare payment for the non-upgraded DME and the supplier's charge for the upgraded DME. In no event may the supplier's charge for the upgraded DME exceed the applicable fee schedule amount (if any). In the event that the upgraded DME is not on any fee schedule, the supplier's charge for the DME upgrade shall not exceed the fair market price to its other customers for the same DME. Our authority for this determination is section 1834(a) second (17)(B)and (C)(v) of the Act. Under section 1834(a) second (17)(B) of the Act, these rules only apply to assigned claims. Conversely, they do not apply to unassigned claims.

Section 1834(a) second (17)(C) of the Act requires that any regulations under section 1834(a) second (17)(A) must provide for consumer protection standards with respect to the furnishing of upgraded DME. These regulations must provide for the following:

(1) A determination of the fair market prices for upgraded DME.

(2) Full disclosure by the supplier of the availability and price of non-upgraded DME and proof of receipt of this disclosure information by the beneficiary before furnishing upgraded DME to the beneficiary.

(3) Conditions of participation for suppliers in the billing arrangement.

(4) Sanctions (including exclusion) on suppliers who we determine have engaged in coercive or abusive practices.

(5) Other safeguards that we determine are necessary.

This amendment to the Act would apply to purchases and rentals made after the effective date of the final regulations. Under section 1834(a) second (17)(B) of the Act, these rules only apply to assigned claims.

III. Provisions of This Proposed Regulation

We propose to add the acronym ''DME'' for durable medical equipment at § 414.202.

We propose to add a new § 414.231 that would permit suppliers to sell or rent upgraded DME on an assigned basis to a beneficiary and charge the beneficiary the difference between the supplier's charge for the upgraded DME and the allowed Medicare amount for the non-upgraded DME, provided that all consumer protection safeguards are met. Medicare's payment for the upgraded DME would be the same allowed amount as if the upgraded DME was non-upgraded DME.

In § 414.231(a), we propose to add the definition of upgraded DME.

We propose to add in § 414.231(c), the requirements that suppliers must meet before they are allowed to sell upgraded DME to Medicare beneficiaries on an assigned basis. These qualification rules address: (1) Disclosure of information, (2) Charge limitations, (3) Billing requirements, (4) Returns of upgraded

DME by dissatisfied beneficiaries, and (5) Conditions of participation.

We propose to add § 414.231(c)(1) to describe the disclosure information that the supplier must provide to the beneficiary. It is our intention to design a prescribed disclosure form that must be used by suppliers who sell upgraded DME and who accept assignment.

This section would also identify who is responsible for obtaining the signed disclosure form acknowledging that the beneficiary or representative was given, and understood, all of the required information. This signed disclosure form must also be signed by the supplier and must attest that the supplier informed the beneficiary that non-upgraded DME is available and medically adequate for the beneficiary's needs; and informed the beneficiary of the name of the manufacturer that made the upgraded DME, the manufacturer's model number for the upgraded DME, the manufacturer's suggested retail price for the upgraded DME, the supplier's usual or customary charge for the upgraded DME, the estimated charge for the DME without the upgraded features, the beneficiary's out-of-pocket cost for the DME without the upgraded features, the supplier's charge to the beneficiary for the upgraded DME, and the beneficiary's out of pocket cost for the upgraded DME. A copy of the completed disclosure form must be sent by the DME supplier to the physician prescribing the DME, if the beneficiary elects to notify the prescribing physician. The supplier must also retain the signed disclosure form in its file and upon request submit the disclosure form to the Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) carrier. We would require this signed statement under the authority of section 1834(a) second (17)(C)(v) of the Act, which provides for such other safeguards as the Secretary determines are necessary.

We propose that a beneficiary who receives an upgraded DME and is dissatisfied with the DME upgrade may return the upgraded DME within thirty days and receive a full refund for the upgraded portion of the DME from the DME supplier. The DME supplier would be required to furnish a non-upgraded item of DME to the beneficiary.

We propose, under the authority of section 1834(a) second (17)(C)(i) of the Act, to add § 414.231(c)(2) to prohibit the supplier's charge for any upgraded DME from exceeding the Medicare fee schedule amount. If there is no applicable fee schedule amount, the supplier's charge may not exceed the lower of its customary charge to the general public, or the manufacturer's suggested retail price.

We propose to add § 414.231(c)(3) to require a supplier to submit claims, with code modifiers, that indicate when upgraded DME was furnished to a Medicare beneficiary.

Section 1834(a) second (17)(B) requires that for upgraded DME, the Medicare payment amount must be based on the payment amount for non-upgraded DME. We propose to require suppliers to submit claims for upgraded DME as if the DME was non-upgraded DME. The rules governing the payment methodology contained in part 414, subpart D for non-upgraded DME, would apply to upgraded DME.

We believe that section 1834(a) second (17)(B)(i) precludes us from paying for the upgraded DME as an upgrade but requires that we pay as if the DME was non-upgraded DME. Therefore, we would use the same payment methodology for the upgraded DME as for the non-upgraded DME. This would be less administratively cumbersome, and would efficiently utilize the safeguards built into the current payment methodology.

For example, if a beneficiary wanted to upgrade capped rental DME and instead, obtain an upgraded DME that is in the routinely purchased payment category, the supplier would submit a claim for, and the payment would be based on, the non-upgraded capped rental DME. The supplier also would be required to use a code modifier on the claim form to indicate that upgraded DME had been furnished. The rules governing the capped rental payment category would therefore apply to the routinely purchased DME. Thus, the supplier would be required to submit rental claims, even if the upgraded DME was a routinely purchased DME, in accordance with the capped rental requirements. Likewise, the supplier would be required to offer the purchase option during the tenth rental month as if the upgraded DME were in the capped rental payment category. Finally, the supplier would also be required to comply with the capped rental maintenance and servicing requirements.

We propose to add § 414.231(c)(4) to require suppliers furnishing upgraded DME to comply with the supplier standards for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) at § 424.57.

Finally, we propose to add § 414.231(d) to require that the sanctions found in part 402 apply to any supplier that engages in coercive or abusive practices. These regulations also would allow us to sanction a supplier for failure to submit the documentation that we would require in § 414.231(c).

This new provision would change the nature of Medicare assignment in the context of DME, and the protection it has historically afforded beneficiaries from being charged extra for equipment or features of equipment that are not medically necessary. In light of this legislative departure from Medicare's long-established rules relating to assignment and in light of the statutory requirement for the Secretary to include such other safeguards as the Secretary determines are necessary, we are especially interested in receiving comments about the adequacy of the beneficiary protections proposed in this rule as well as the breadth of potential additional approaches to beneficiary protection. For example, it may be important to distinguish between an upgraded item that might be covered as medically necessary for a particular beneficiary from a slightly different item for which there was no Medicare fee schedule amount. In the former case, the beneficiary would have the advantage of Medicare payment for the item with additional features while in the latter case Medicare would pay only for the item without features and the beneficiary would pay, fully at their own expense, for the difference between the supplier's charge for the upgraded item and the Medicare payment for the non-upgraded item. Or, it might be appropriate to consider whether upgrade covers minor variations in an item of DME where the same code is used to bill for the item as the standard item. Therefore, we ask for comment about manageable ways to look at and quantify the extent of variation in DME that would constitute an upgrade and what might be the differences between non upgraded DME and upgraded DME. Because our experience in capturing these distinctions for purposes of payment is limited, we welcome suggestions relating to potential beneficiary protections which may need to be introduced in this rule. For example, we ask for comment about an approach that might phase-in the provision, focusing initially on certain kinds of DME which we believe from conversations with the industry to be the items for which there may be the greatest demand, and evaluating impacts before expanding application of the provision. We request comment about particular categories of DME, such as ultra light wheelchairs or total electric hospital beds, to which the provision might initially be applied if we were to pursue a targeted approach.

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. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, (PRA) 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 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 the information collection requirement discussed below.

Section 414.231 Upgraded durable medical equipment.

Section 414.231 (c) requires that the supplier of DME give to the beneficiary (or the beneficiary's representative renting or purchasing the DME on the beneficiary's behalf) a disclosure form, indicating (1) the supplier informed the beneficiary (or beneficiary's representative) that a non-upgraded DME was available and explained that the non-upgraded DME met the beneficiary's medical needs, (2) the supplier provided the beneficiary or beneficiary's representative with the estimated cost for both the non-upgraded DME and the additional out-of-pocket cost for the upgraded DME.

This information would be provided by the DME supplier on a one-time basis for each sale of upgraded DME. We would require the DME supplier to retain the disclosure form and submit it to the DMEPOS carrier upon request. The DME supplier would also be required to furnish a copy of the disclosure form to the prescribing physician, if the beneficiary elects to notify the prescribing physician. Our best estimate is that it would take 15 minutes or less for each sale of upgraded DME.

Section 414.231(c)(3)(ii) requires that the supplier use a code modifier, when submitting a claim, that indicates that the upgraded DME was furnished to a Medicare beneficiary.

The burden that would be added as a result of this reporting requirement is minimal over that already approved, through July 31, 2000, under OMB approval number 0938–0008, which is the approval number for the Medicare common claim form (HCFA 1500). That form currently has a field for a code modifier, further diminishing the burden of entering the modifier.

We have submitted a copy of this proposed rule to OMB for its review of the information collection requirement described above. This requirement is not effective until it has been approved by OMB.

If you comment on this information collection, please mail copies directly to the following:

Health Care Financing Administration, Office of Information Services, Security and Standards Group, Division of HCFA Enterprise Standards Room N2–14–26, 7500 Security Boulevard, Baltimore, MD 21244–1850. ATTN: Julie Brown, HCFA–1084–P, and Office of Information and Regulatory Affairs, Office of Management and Budget,

Room 10235, New Executive Office building, Washington, DC 20503 Attn: Allison Eydt, HCFA Desk Officer

V. Regulatory Impact Analysis

We have examined the impacts of this proposed rule as required by Executive Order (EO) 12866, the Unfunded Mandates Act of 1995, and the Regulatory Flexibility Act (RFA) (Public Law 96–354). Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits, including potential economic, environmental, public health and safety effects, distributive impacts, and equity. A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects of $100 million or more annually. Since we believe that this proposed rule would have no significant effect on program expenditures, we do not consider this to be a major rule. We have not prepared an RIA.

Section 1102(b) of the Act requires us to prepare a RIA 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 that is located outside of a Metropolitan Statistical Area and has fewer than 50 beds. We are not preparing a rural impact analysis since we have determined that this proposed rule would not have a significant economic impact on operations of a substantial number of small rural hospitals.

The Unfunded Mandates Reform Act of 1995 also requires (in section 202) that agencies perform an assessment of anticipated costs and benefits before proposing any rule that may result in expenditures, in any given year by State, local, or tribal governments, in the aggregate, or by the private sector, of $100 million. This rule would not have any effect on the Medicare expenditures or the solvency of the Medicare Trust Fund. 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 governmental agencies. Most hospitals and most other providers and suppliers are small entities, either by virtue of their nonprofit status or by having revenues of $5 million or less annually. Intermediaries and carriers are not considered to be small entities.

While we have estimated the time required to complete the required form as 15 minutes, we are unable to quantify the ''burden'' this imposes because we cannot predict the number of forms individual suppliers will be completing. A DME supplier has two options when a beneficiary seeks to purchase upgraded DME. One option is simply to sell the beneficiary the item and allow the beneficiary to submit an unassigned claim. This option imposes no burden on the supplier and the beneficiary is not required to complete the form. The second option is to accept assignment and to complete and submit the form. Given the resources at our disposal, we cannot determine the number of DME suppliers that would accept either option.

We believe that beneficiaries may use the upgrade provision to obtain only a relatively few categories of equipment. We also believe that this provision might be used mostly by more active beneficiaries who desire wheelchairs that contain features suited to their active lifestyles, such as upgrading from standard wheelchairs to ultra light

weight wheelchairs. Although there are perhaps 100 large DME suppliers, there is a total of more than 100,000 dealers. It is impossible to estimate the distribution of assigned claims that involve upgraded DME across either the smaller or the larger group. Based on the industry's own assertions, however, we do not believe that any one supplier will incur a significant burden. If we receive additional information as a result of this proposed rule, we would revisit the idea of calculating the burden arising from this provision.

We are not preparing an analysis for section 1102(b) of the Act because this rule is not a major rule as defined at 5 U.S.C. 804(2), nor will it have a significant economic impact on the operations of a substantial number of small rural hospitals.

We have reviewed this proposed rule under the threshold criteria of Executive Order 13132, Federalism. We have determined that it does not significantly affect the rights, roles and responsibility of States. In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

List of Subjects in 42 CFR Part 414

Administrative practice and procedure, Health facilities, Health professions, Kidney diseases, Medicare, Reporting and recordkeeping requirements, Rural areas, X-rays.

For the reasons stated in the preamble, the Health Care Financing Administration proposes to amend 42 CFR part 414 as follows:

PART 414—PAYMENT FOR PART B MEDICAL AND OTHER HEALTH SERVICES

1. The authority citation for part 414 continues to read as follows:

Authority: 42 U.S.C. 1302, and 1395hh.

2. Add the acronym ''DME'' to the definition of durable medical equipment in § 414.202 to read as follows:

§ 414.202 Definitions.

* * * * *

Durable medical equipment (DME) means equipment, furnished by a supplier or a home health agency that—

* * * * *

3. Add § 414.231 to subpart D to read as follows:

§ 414.231 Upgraded durable medical equipment.

(a) *Definition. Upgraded durable medical equipment* means DME that contains features that are not reasonable and necessary for the treatment of an illness or an injury, or to improve the functioning of a malformed body member.

(b) *General rules.* (1) HCFA pays for DME that meets the coverage requirements in § 410.38.

(2) For upgraded DME, HCFA pays a supplier an amount equal to the Medicare-approved amount that it pays for DME that does not contain upgraded features under § 414.210, less any applicable beneficiary deductible and coinsurance.

(3) If a beneficiary purchases or rents upgraded DME, the beneficiary is responsible for the difference in the payment between the supplier's charge for the upgraded DME and the Medicare-approved amount for the DME without the upgraded features, in addition to any applicable beneficiary deductible and coinsurance.

(c) *Rules for suppliers*—(1) *Disclosure of information.* Before furnishing upgraded DME to a beneficiary, a supplier must meet the following requirements:

(i) Give to the beneficiary (or the representative renting or purchasing the DME on the beneficiary's behalf) a disclosure form prescribed by HCFA containing the following information:

(A) The DME without the upgraded features effectively meets the beneficiaries medical needs and is as available as the upgraded DME.

(B) The name of the manufacturer that made the upgraded DME.

(C) The manufacturer's model number for the upgraded DME.

(D) The manufacturer's suggested retail price for the upgraded DME.

(E) The supplier's usual or customary charge for the upgraded DME.

(F) The estimated charge, and the beneficiary's out-of-pocket costs for the DME without the upgraded features.

(G) The supplier's charge to the beneficiary for the upgraded DME and the beneficiary's out-of pocket cost for the upgraded DME.

(ii) The supplier must obtain the beneficiary's or representative's signature on the disclosure form, attesting that the beneficiary or representative has read and understands the information provided on the form.

(iii) The supplier must furnish a copy of the signed disclosure form to the prescribing physician, provided the beneficiary elects to notify the prescribing physician, retain the signed disclosure form in its file and, upon request, submit the signed disclosure form to the DMEPOS carrier.

(2) *Charge limitations.* The suppliers charge for upgraded DME must not exceed the applicable Medicare fee schedule amount (if any) for the upgraded DME. If there is no fee schedule amount for the upgraded DME, the supplier's charge for the upgraded DME must not exceed the lower of its customary charge to the general public, or the manufacturer's suggested retail price.

(3) *Billing requirements.* A supplier must meet the following billing requirements:

(i) Follow the payment and billing requirements for the DME without the upgraded features.

(ii) Submit a claim, with a code modifier indicating that upgraded DME was furnished to a Medicare beneficiary.

(4) *Returns of upgraded DME.* (i) A supplier must refund any payments made by a beneficiary, for the upgraded portion of an item of upgraded DME if the beneficiary, or representative, returns the upgraded DME to the supplier within 30 days of receiving the upgraded DME.

(ii) The supplier must furnish the DME without the upgrade to the beneficiary at no additional cost.

(5) *Conditions of participation.* Suppliers submitting claims for upgraded DME must comply with the special payment rules for DMEPOS suppliers at § 424.57 of this chapter.

(d) *Supplier sanctions.* If a supplier engages in coercive or abusive practices regarding the sale or rental of upgraded DME, HCFA may apply to the supplier the same sanctions found in part 402 of this subchapter that it may apply to a physician.

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

Dated: January 24, 2000.

Nancy-Ann Min DeParle,

Administrator, Health Care Financing Administration.

Approved: March 17, 2000.

Donna E. Shalala,

Secretary.

[FR Doc. 00–10482 Filed 4–26–00; 8:45 am]

BILLING CODE 4120–01–P

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 73

[DA–00–890, MM Docket No. 00–68, RM–9854]

Digital Television Broadcast Service; Norfolk, VA

AGENCY: Federal Communications Commission.

ACTION: Proposed rule.

SUMMARY: The Commission requests comments on a petition filed by WTKR-