

proposes to amend 14 CFR part 71 as follows:

PART 71—DESIGNATION OF CLASS A, CLASS B, CLASS C, CLASS D, AND CLASS E AIRSPACE AREAS; AIRWAYS; ROUTES; AND REPORTING POINTS

1. The authority citation for 14 CFR part 71 continues to read as follows:

Authority: 49 U.S.C. 106(g), 40103, 40113, 40120; E.O. 10854, 24 FR 9565, 3 CFR, 1959–1963 Comp., p. 389.

§ 71.1 [Amended]

2. The incorporation by reference in 14 CFR 71.1 of the Federal Aviation Administration Order 7400.9E, Airspace Designations and Reporting Points, dated September 10, 1997, and effective September 16, 1997, is amended as follows:

Paragraph 6005 Class E airspace areas extending upward from 700 feet or more above the surface of the earth.

* * * * *

ANM UT E5 Price, UT

Price, Carbon County Airport, UT

(Lat. 39°36'43" N, long. 110°45'02" W)

Carbon VOR/DME

(Lat. 39°36'11" N, long. 110°45'13" W)

That airspace extending upward from 700 feet above the surface within a 4.3-mile radius of the Carbon VOR/DME, and within 1.8 miles each side of the 200° radial of the Carbon VOR/DME extending from the 4.3-mile radius to 7 miles south of the Carbon VOR/DME; that airspace extending upward from 1,200 feet above the surface bounded by a line beginning at lat. 39°50'00" N, long. 111°00'00" W; to lat. 39°45'00" N, long. 110°30'00" W; to lat. 39°05'00" N, long. 110°30'00" W; to lat. 39°05'00" N, long. 111°00'00" W; to lat. 39°21'00" N, long. 111°05'00" W; thence to point of beginning; excluding that airspace within Federal Airways, the Moab, UT, and the Salt Lake City, UT, Class E airspace areas.

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Issued in Seattle, Washington, on June 8, 1998.

Joe E. Gingles,

Acting Assistant Manager, Air Traffic Division, Northwest Mountain Region.

[FR Doc. 98–16546 Filed 6–19–98; 8:45 am]

BILLING CODE 4910–13–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 410 and 414

[HCFA–1906–P]

RIN 0938–AI44

Medicare Program; Payment for Teleconsultations in Rural Health Professional Shortage Areas

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

ACTION: Proposed rule.

SUMMARY: This proposed rule would implement parts of section 4206 of the Balanced Budget Act of 1997 by amending our regulations to provide for payment for professional consultation by a physician and certain other practitioners via interactive telecommunication systems. Payment may be made if the physician or other practitioner is furnishing a service for which payment may be made under Medicare to a beneficiary residing in a rural area that is designated as a health professional shortage area.

This proposed rule would also establish a methodology for determining the amount of payments made for the consultation.

DATES: Comments will be considered if we receive them at the appropriate address, as provided below, no later than 5 p.m. on August 21, 1998.

ADDRESSES: Mail written comments (1 original and 3 copies) to the following address: Health Care Financing Administration, Department of Health and Human Services, Attention: HCFA–1906–P, P.O. Box 26676, Baltimore, MD 21207–0519.

If you prefer, you may deliver your written comments (1 original and 3 copies) to one of the following addresses:

Room 309–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201, or Room C5–09–26, 7500 Security Boulevard, Baltimore, MD 21244–1850.

Because of staffing and resource limitations, we cannot accept comments by facsimile (FAX) transmission. In commenting, please refer to file code HCFA–1906–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 309–G of the Department's offices 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:

Craig Dobyski, (410) 786–4584.

SUPPLEMENTARY INFORMATION:

I. Background

A. General

Telemedicine is the use of telecommunications to furnish medical information and services. Generally, two different kinds of technology are in use in telemedicine. One technology is two-way interactive video. This technology is used, for example, when a consultation involving the patient, the primary care giver, and a specialist is necessary. The videoconferencing equipment at two (or more) locations permits a “real-time” or “live” consultation to take place, providing for two-way exchange of information between the locations during the examination. We refer to this process as “teleconsultation.” Teleconsultation typically involves a primary care practitioner with a patient at a remote, rural (spoke) site and a medical specialist (consultant) at an urban or referral center (hub) facility, with the primary care practitioner seeking advice from the consultant concerning the patient's condition or course of treatment.

The other technology, called “store and forward,” is used to transfer video images from one location to another. A camera or similar device records (stores) an image(s) that is then sent (forwarded) via telecommunications media to another location for later viewing. The sending of x-rays, computed tomography scans, or magnetic resonance images are common store-and-forward applications. The original image may be recorded and/or forwarded in digital or analog format and may include video “clips” such as ultrasound examinations, where the series of images that are sent may show full motion when reviewed at the receiving location.

Currently, Medicare allows payment for those telemedicine applications in which, under conventional health care delivery, the medical service does not require face-to-face “hands on” contact between patient and physician. For example, Medicare permits coverage of teleradiology, which is the most widely used and reimbursed form of telemedicine, as well as physician interpretation of electrocardiogram and electroencephalogram readings that are transmitted electronically. In contrast, Medicare does not cover other physicians services delivered through telecommunications systems because,

under the conventional delivery of medicine, those services are furnished in person.

B. Legislation

In section 4206 of the Balanced Budget Act of 1997 (BBA) (Public Law 105-33), the Congress required that, not later than January 1, 1999, Medicare Part B (Supplementary Medical Insurance) pay for professional consultation via telecommunications systems. Under section 4206(a), the provision applies to consultations with a physician or with certain other practitioners (identified below) furnishing a service for which payment may be made under Part B, provided the service is furnished to a beneficiary who resides in a county in a rural area that is designated as a health professional shortage area, and notwithstanding that the physician or other practitioner furnishing the consultation is not at the same location as the physician or other practitioner furnishing the service to the beneficiary.

The practitioners listed in section 4206(a) are physicians (as defined in section 1861(r) of the Social Security Act (the Act)) and those practitioners described in section 1842(b)(18)(C) of the Act. The practitioners described in 1842(b)(18)(C) include: physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, anesthesiologist's assistants, nurse-midwives, clinical social workers, and clinical psychologists.

Section 4206(b) requires that the Secretary establish a methodology for determining the amount of payments made for a consultation, within the following parameters:

- The payment is to be shared between the referring practitioner and the consulting practitioner. The amount of the payment is not to exceed the current fee schedule amount that would be paid to the consulting practitioner.
- The payment is not to include any reimbursement for any telephone line charges or any facility fees, and a beneficiary may not be billed for these charges or fees.
- The payment is to be subject to the coinsurance and deductible requirements under section 1833(a)(1) and (b) of the Act.
- The payment differential of section 1848(a)(3) of the Act is to be applied to services furnished by nonparticipating physicians. (Section 1848(a)(3) specifies that, in the case of physicians services furnished by a nonparticipating physician, the payment basis is 95 percent of what it would have been had

the service been furnished by a participating physician.)

- The provisions of sections 1848(g) and 1842(b)(18) of the Act are to apply. (Section 1848(g) provides a limitation on charges to beneficiaries and provides sanctions if a physician, supplier, or other person knowingly and willfully repeatedly bills or collects for services in violation on the limitation. It also provides for sanctions if a physician, supplier, or other person fails (1) to timely correct excess charges by reducing the actual charge billed for the service to an amount that does not exceed the limiting charge for the service, or (2) to timely refund excess collections. In addition, it requires that physicians and suppliers submit claims, for services they furnished to a beneficiary, to a carrier on behalf of the beneficiary using a standard claim form specified by the Secretary. The statute imposes a penalty for failure to so submit the claim. In addition, section 1848(g) prohibits imposing any charge relating to completing and submitting the claim. Section 1842(b)(18) provides that services furnished by a physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, anesthesiologist's assistant, certified nurse-midwife, clinical social worker, or clinical psychologist for which payment may be made on a reasonable charge or fee schedule basis may be made only on an assignment-related basis. It also limits the beneficiary's liability to any applicable deductible and coinsurance amounts. It further provides for sanctions against a practitioner who knowingly and willfully bills (or collects an amount) in violation of the limitation.)

- Further, payment for the consultation service is to be increased annually by the update factor for physicians services determined under section 1848(d) of the Act.

In addition, the statute directs that, in establishing the methodology for determining the amount of payment, the Secretary take into account the findings of the report required by section 192 of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191), the findings of the report required by section 4206(c) of the BBA, and any other findings related to clinical efficacy and cost-effectiveness of telehealth applications.

C. HCFA Telemedicine Demonstration Program

In October 1996, we began a demonstration of Medicare fee-for-service payment for teleconsultation services. The demonstration is expected

to run through fiscal year 2001. Under the demonstration, providers at selected sites in Iowa, Georgia, North Carolina, and West Virginia have been furnishing teleconsultation services. These sites were selected as a result of proposals submitted during our 1993 and 1994 general research solicitations and a subsequent expansion request in 1998. Special data collection plans are in place for those health care providers participating in the demonstration. The demonstration is being independently evaluated through a cooperative agreement with the Center for Health Policy Research in Denver.

In this demonstration, we are experimenting with a variety of payment options beyond that proposed under this rule. Since relatively little is known at present about either the process or content of telemedicine service delivery, we expect to learn from the demonstration about the general characteristics and practice patterns of telemedicine practitioners. After completion of the demonstration, we will compare the results to operations under the reimbursement strategy that would be established under this proposed rule, and we may propose adjustments, as appropriate.

II. Provisions of This Proposed Rule

This rule proposes to establish policies for implementing the provisions of section 4206 of the BBA that address Medicare reimbursement for telehealth services.

A. Professional Consultation Services Via Telecommunications Systems

The title of section 4206 of the BBA refers to telehealth services, although the text specifically refers to professional consultation services via telecommunications systems as teleconsultations.

A consultation is a type of service provided by a physician (or, under section 4206, certain other health care practitioners) "whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source. A [physician] consultant may initiate diagnostic and/or therapeutic services. The request for a consultation from the attending physician or other appropriate source and the need for consultation must be documented in the patient's medical record. The consultant's opinion and any services that were ordered or performed must also be documented in the patient's medical record and

communicated to the requesting physician or other appropriate source.”¹ We do not consider a teleconsultation to be a new medical service; rather, we consider it to be a new way or process of delivering a consultation.

Earlier in this document we included a discussion of the two general technologies used in telemedicine, that is, store and forward, and interactive video. We believe that, although asynchronous transmission may be sufficient for diagnostic interpretation of images (such as radiological images), a teleconsultation is equivalent to a traditional, face-to-face consultation only if it permits the consultant to control the examination of the patient as the examination is taking place. With store-and-forward technology, the consultant is reviewing an examination that has already occurred and is limited to whatever information was recorded at that time.

We believe that a teleconsultation instead must be an interactive patient encounter. The teleconsultation must meet the criteria included in the descriptor quoted above for a given consultation service and include—

- Clinical assessment via medical examination directed by the consultant (specialist);
- The use of multimedia communications equipment that includes, at a minimum, audio-video equipment permitting two-way real time communication;
- Participation of the referring practitioner as appropriate to the medical needs of the patient and as needed to provide information to and at the direction of the consultant; and
- Feedback of the consultation assessment to the referring practitioner.

Note that, to qualify for Medicare payment, the patient must be present and the telecommunications technology must allow the consulting practitioner to control an interactive medical examination of the patient. Store and forward technologies would not allow a medical examination of the patient but would allow only a review of a prior examination, test, or diagnostic procedure, which would be outside the scope of this proposed rule. By requiring an interactive communications system, however, we are not mandating full motion video, but are requiring interactive real time audio-video communication. We recognize that full motion video requires large bandwidth that may be physically and/or financially unavailable to many

health care entities in rural areas. This rule would not prohibit the use of lower end interactive video technology in which less than full motion video is sufficient for the consulting practitioner to control an examination of the patient. As such, we would encourage the use of the simplest and least expensive equipment that meets the real time requirement proposed under this rule.

The [Physicians'] Current Procedural Terminology (CPT) is a systematic listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians and other medical practitioners. We propose to cover as teleconsultation services the following categories of services listed as consultant services in the 1998 CPT:

Office or Other Outpatient Consultations—CPT codes 99241 through 99245;

Initial Inpatient Consultations—CPT codes 99251 through 99255;

Follow-up Inpatient Consultations—CPT codes 99261 through 99263; and

Confirmatory Consultations—CPT codes 99271 through 99275.

Proposed Regulatory Provisions

Based on the above, we would specify, in paragraph (a) of proposed § 410.75 (Consultations via telecommunication systems), that Medicare Part B pays for professional consultations furnished by means of interactive telecommunications systems if the following conditions, and others discussed later in this preamble, are met:

- The medical examination of the beneficiary is under the control of the consultant practitioner.
- The consultation involves the participation of the referring practitioner, as appropriate to the medical needs of the patient and as needed to provide information to and at the direction of the consultant.
- The consultation results in a written report that is furnished to the referring practitioner.

In addition, at paragraph (b) of § 410.75, we would define “interactive telecommunications systems” as multimedia communications equipment that includes, at a minimum, audio-video equipment permitting two-way, real time consultation among the patient, consulting practitioner, and referring practitioner as appropriate to the medical needs of the patient and as needed to provide information to and at the direction of the consulting practitioner. We would also specify that telephones, facsimile machines, and electronic mail systems do not meet the

definition of interactive telecommunications systems.

B. Coverage and Eligibility Provisions

In addition to limiting telemedicine coverage to consultation services, section 4206 of the BBA limits coverage of teleconsultations to services furnished to Medicare beneficiaries residing in a “county in a rural area * * * that is designated as a health professional shortage area under section 332(a)(1)(A) of the Public Health Service Act * * *.” Section 332 of the Public Health Service Act authorizes the Secretary to designate health professional shortage areas (HPSAs) based on criteria established by regulation. HPSAs are defined in section 332 to include geographic areas, population groups, and facilities with shortages of health professionals. Section 332(a)(1)(A) speaks to geographic HPSAs.

We found the language “a county in a rural area * * * that is designated as a health professional shortage area” to be somewhat ambiguous. We considered that the Congress may have intended that the benefit apply only to county-wide HPSAs (an entire county that is designated as an HPSA), but have rejected that construction of the law. First, it would seem illogical to restrict coverage of teleconsultations to county-wide HPSAs. The purpose of this provision is to provide access to health care for beneficiaries who now may face barriers to that care because they reside in rural areas where there is a shortage of medical professionals. We do not believe the Congress intended that only beneficiaries in the largest HPSAs be entitled to the telemedicine benefit. We note that an existing statutory provision related to HPSAs, that is, the 10 percent incentive payment for physician services furnished in HPSAs, does not make a distinction between county-wide HPSAs and other HPSAs. Second, we found that, by limiting coverage of teleconsultations to county-wide HPSAs, we would perpetuate barriers to care because many HPSAs would be excluded. From a random review of HPSA listings, we found that beneficiaries in at least one eastern State would not be entitled to telemedicine coverage because there are no county-wide HPSAs in that State. In several western States, we found that between 50 percent and 95 percent of rural HPSAs would be excluded as sites for the telehealth benefit. Therefore, for purposes of this section, we would specify that teleconsultations are covered only in rural HPSAs as defined in the Public Health Service Act.

¹ [Physicians'] Current Procedural Terminology (4th Edition, 1998, copyrighted by the American Medical Association), p. 20.

We had a number of concerns about the statutory language that ties coverage of teleconsultations to services furnished to a beneficiary “residing in a county in a rural area * * *” [emphasis supplied]. Medicare claims processing systems are not geared to making such eligibility determinations. Therefore, such a provision would add another “gatekeeping” responsibility to the presenting practitioner by requiring him or her to screen the beneficiary’s address for eligibility for the teleconsultation benefit. To do this, the practitioner would need to develop and maintain a list of HPSAs for all areas covering the entire population base from which he or she would potentially draw patients. Moreover, the centralized beneficiary file, which contains the beneficiary’s address and is maintained by us, would also have to contain a list of HPSAs nationwide against which the beneficiary’s address would be compared. We note that, if an eligibility error were made, it would not be detected until a claim is submitted, which occurs only after the service has been furnished. At that point, Medicare payment on the claim would be denied, and the beneficiary would be liable for the full charges for the teleconsultation service. We believe that the Congress did not intend to expose Medicare beneficiaries to this financial risk. Therefore, we propose to use the location of the presenting practitioner at the time of the service, that is, where the beneficiary is receiving care, as proxy for the beneficiary’s residence. If the location of the presenting practitioner is in a rural HPSA (as defined above), we believe it can be reasonably presumed that the beneficiary resides in a rural HPSA. However, if a beneficiary can demonstrate that he or she lives in a rural HPSA, we would allow payment for the teleconsultation without regard to the location of the originating facility (site of presentation).

Section 4206(a) of the BBA specifically requires that Medicare make payments for professional consultation via telecommunications systems with a physician or “a practitioner (described in section 1842(b)(18)(C) of the Act.” Nonphysician practitioners who may provide a teleconsultation include physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists or anesthesiologists’ assistants, certified nurse midwives, clinical social workers, and clinical psychologists. However, for consultation services delivered via traditional face-to-face “hands on” methods, current Medicare policy does not permit certified registered nurse

anesthetists, anesthesiologist’s assistants, clinical social workers, or clinical psychologists to bill for these services. We note that, although section 4206 of the BBA provides for coverage of teleconsultations furnished by certain health practitioners other than physicians, this provision does not change current Medicare coverage policy for consultation services delivered in person.

Proposed Regulatory Provisions

Based on the above, we would provide at § 410.75 that, as a condition for Medicare Part B payment for the teleconsultation—

- The referring and consultant practitioner must be any of the following:
 - + A physician as described in existing § 410.20.
 - + A physician assistant as defined in existing § 491.2.
 - + A nurse practitioner as defined in existing § 491.2.
 - + A clinical nurse specialist as described in existing § 424.11(e)(6).
 - + A certified registered nurse anesthetist or anesthesiologist’s assistant as defined in existing § 410.69.
 - + A certified nurse-midwife as defined in existing § 405.2401.
 - + A clinical social worker as defined in existing § 410.73(a).
 - + A clinical psychologist as described in existing § 410.71(d).
- The services must be furnished to a beneficiary residing in a rural area as defined in section 1886(d)(2)(D) of the Act that is designated as an HPSA under section 332(a)(1)(A) of the Public Health Service Act. We would further specify that for purposes of this requirement, the beneficiary is deemed to be residing in such an area if the teleconsultation presentation takes place in such an area.

C. Payment Provisions

General Payment

Section 4206 of the BBA provides that payment for a teleconsultation may not exceed the amount in the current fee schedule for the consulting practitioner. Medicare payment for physicians services is made, under section 1848 of the Act, on the resource-based fee schedule. Payment to the other health care practitioners listed earlier, authorized under section 1833 of the Act, is based on a percentage of the physician fee schedule. Therefore, we would pay for teleconsultation services furnished by physicians at 80 percent of the lower of the actual charge or the fee schedule amount for physicians services, and those furnished by other practitioners at 80 percent of the lower

of the actual charge or that practitioner’s respective percentage of the physician fee schedule (that is, the fee schedule for clinical psychologists would be 100 percent of the physician fee schedule; for clinical social workers, the fee schedule would be 75 percent of the clinical psychologist fee schedule; and for all other eligible health care practitioners, the fee schedule would be 85 percent of the physician fee schedule).

Site of Service

We recognize that the consulting and presenting practitioners will likely be located a significant distance apart, raising the issue of where the service is being furnished. The site of service determines the pricing locality to be used for Medicare payment. In our view, the use of telecommunications to furnish a medical service effectively transports the patient to the consultant (a concept analogous to the traditional delivery of health care, in which the patient travels to the consultant’s office). Therefore, we believe that the site of service for a teleconsultation is the location of the practitioner providing the consultation. We thus would designate the location of the consultant at the time of the service as the applicable pricing locality for teleconsultation claims. As a result, the fee schedule for the consultation will reflect the geographic adjustment factor applicable to the consulting practitioner.

We considered designating the location of the beneficiary as the site of service (and pricing locality) but rejected this option because this alternative would likely result in lower payment levels than the consultant would have otherwise received if the beneficiary had traveled to his or her office for a consultation. This would probably occur because the consulting practitioner, who is a medical specialist, is usually affiliated with a “hub” facility, which is typically a major medical center located in an urban or metropolitan area. The referring practitioner is located at the “spoke” facility, which is typically a primary care facility and, under the provisions of section 4206 of the BBA, is in a rural HPSA area. In the majority of cases, we would expect that the different geographic adjustment factors used to adjust the relative value units (RVUs) under the physician fee schedule are somewhat higher for urban areas than for rural areas because the cost of operating a medical practice in an urban area is generally higher.

We also considered using a neutral site of service, which would be neither

practitioner's respective location. This option was based on the proposition that the service is furnished in "cyber space" rather than at a fixed location. Under this approach, payment would have been based on the RVUs for the service, with no geographic adjustment factor applied. As a result, payment would be the same nationwide, regardless of the practitioners' geographic locations. We rejected this option because the use of unadjusted national RVUs could result in a payment amount that exceeds the amount the consulting practitioner would have otherwise received, thereby exceeding the payment ceiling imposed by section 4206 of the BBA. Conversely, use of unadjusted national RVUs could result in a lower payment amount than the consulting practitioner would have otherwise received, thereby creating a disincentive for specialists to furnish teleconsultations.

Payment Allocation

Section 4206 further provides that payment be shared between the referring and consulting practitioners. We propose to allocate the payment in the following manner: the consulting practitioner will receive 75 percent of the applicable amount, and the presenting practitioner will receive the remaining 25 percent of the applicable amount. Using a hypothetical consultation payment of \$100, this would result in a payment of \$75 to the consultant and \$25 to the presenting practitioner.

We arrived at these percentages by developing a mean teleconsultation RVU to simulate the level of intensity for both a consulting practitioner and a presenting practitioner. In determining the mean RVUs for the consulting practitioner, we used fiscal year (FY) 1997 RVUs applicable to the proposed covered consultation services (that is,

CPT codes 99241–99245, 99251–99255, 99261–99263, and 99271–99275). In determining the mean RVUs for the presenting practitioner, we used FY 1997 RVUs applicable to office/inpatient visit services for established patients (that is, CPT codes 99211–99215, 99221–99223, and 99231–99233). We decided to use established visit codes to represent the presenting practitioner's role in the teleconsultation to reflect the fact that a primary care practitioner has already seen the patient to have determined that a consultation is necessary. RVUs were weighted by the frequency of 1997 national allowed services attributed to each CPT code. The weighted mean RVUs for both consulting and presenting practitioner were calculated as a percentage of the total simulated weighted mean teleconsultation RVUs. A summary of this process is shown in the following table.

PRACTITIONER ALLOCATION SUMMARY TABLE

	Model #1 w/50% work expense reduction to presentation component	Model #2 w/full RVUs
Intensity Simulation: *		
Mean Consultation RVU	3.21	3.21
Mean Established Office/Inpatient Visit RVU	0.91	1.35
Total RVU	4.12	4.56
Percentage Allocation: **		
Consulting Practitioner	80%	70%
	(3.21 ÷ 4.12 = 77.91%)	(3.21 ÷ 4.56 = 70.39%)
	Rounded to 80%	Rounded to 70%
Presenting Practitioner	20%	30%
	(0.91 ÷ 4.12 = 22.09%)	(1.35 ÷ 4.56 = 29.60%)
	Rounded to 20%	Rounded to 30%
Mid Point of Rounded Allocations:		
Consultant 75%; Presenter 25%.		

*FY 1997 National mean RVU weighted by FY 1997 national allowed services.

Consultation component includes CPT codes: 99241–99245; 99251–99255; 99261–99263; 99271–99275.

Presentation component includes CPT codes 99211–99215; 99221–99223; 99231–99233.

**Allocations rounded to nearest 5 percent.

The table illustrates two models. In the first model, the work RVUs for outpatient/inpatient evaluation and management (E&M) services were reduced by 50 percent to account for the fact that the presenting practitioner is performing no "new" work. This reduction factor is used under the current Medicare telemedicine demonstration project. Under the demonstration, the work expense for the primary care practitioner is reduced by 50 percent to reflect the fact that the practitioner would have already billed for an initial E&M service prior to initiating the teleconsultation. This model results in a payment allocation in which the consulting practitioner would receive 80 percent of the payment and

the presenting practitioner would receive 20 percent of the payment.

In the second model, we did not use a 50 percent reduction in developing the allocation methodology, on the theory that there may be instances in which the medical needs of the patient require a greater amount of work on the part of the presenting practitioner. This model resulted in an allocation in which the consulting practitioner would receive 70 percent and the presenting practitioner would receive 30 percent of the total payment. Because of our lack of information about likely teleconsultation scenarios, we believe that it is reasonable to set the allocations at the midpoint of the values resulting from the two models, that is, a 75

percent allocation for the consulting practitioner and a 25 percent allocation for the presenting practitioner.

We considered reducing the presenting practitioner's share in cases in which the presenting practitioner is a nonphysician practitioner. Thus, if a patient had been presented to a physician by a physician assistant (PA), for example, we considered applying the PA payment rule to the PA's allocation; that is, we would have used 85 percent of the proposed 25 percent allocation as the payment basis for the presenting practitioner. Using a hypothetical physician fee schedule amount of \$100, this would result in the following allocation for the consulting

practitioner and presenting practitioner (physician assistant):

Physician fee schedule for teleconsultation	\$100.00
Less 75 percent consultant allocation	- 75.00
Balance	\$25.00
PA percent of physician fee schedule	× .85
PA allocation	\$21.25

We rejected this option because we believe that only one service is being furnished and that service is a consultation; there is no "presentation" payable under the Medicare physician fee schedule. In teleconsultation, the presenting practitioner is acting as directed by the consultant. Therefore, in our view, he or she is acting as a surrogate for the consultant rather than as a nonphysician practitioner, and we decided that the payment rule for practitioners should not apply. Thus, the following payment allocation would apply for the consulting physician and a nonphysician presentation practitioner (using the hypothetical fee schedule amount of \$100):

Physician fee schedule for teleconsultation	\$100.00
75 percent consultant allocation	75.00
25 percent presentation allocation	25.00

However, when a consultation service is furnished by a nonphysician practitioner, rather than a physician, the amount of payment will be made according to the appropriate percentage of the physician fee schedule, which for most nonphysician practitioners is 85 percent. Using the same hypothetical physician fee schedule amount as above, the payment amounts for a nonphysician consulting practitioner and referring practitioner are as follows (when the nonphysician consulting practitioner's fee schedule is 85 percent of the physician fee schedule):

Physician fee schedule for consultation	\$100.00
Nonphysician payment rule	× .85
Nonphysician fee schedule amount	\$85.00
75 percent consultant allocation	- 63.75
Presenting practitioner allocation	\$21.25

Bundled Payment

We propose to use a bundled payment approach for teleconsultation services; that is, a single Medicare payment for the total amount due for the service will be made to the consulting practitioner. Under this approach, a claim for a

teleconsultation service will be submitted by the consulting practitioner to his or her Medicare carrier. The carrier will make the full payment to the consultant who, in turn, will remit 25 percent of the total to the presenting practitioner. The consultant will be responsible for billing the beneficiary for coinsurance and deductible amounts and also remitting 25 percent of the total to the presenting practitioner. This proposal is consistent with our view that only one service—a teleconsultation—is being provided. As stated earlier, we believe that the presenting practitioner is not providing a distinct service, but acting as a surrogate for the consultant. We believe, moreover, that this approach is better for Medicare beneficiaries because they would receive only one bill for the coinsurance and deductible amount.

Note that the method of payment we have chosen for teleconsultations raises some issues under the physician self-referral law in section 1877 of the Act. Under this provision, a physician is prohibited from referring a Medicare patient to an entity (which can include another physician or a nonphysician practitioner) for the furnishing of certain designated health services if the physician or a member of the physician's immediate family has a financial relationship with that entity. Section 1877 defines "financial relationship" as an ownership or investment interest in the entity or a compensation arrangement with the entity. It is the compensation aspect of the self-referral law that could have a negative impact on teleconsultation payments.

We believe that a presenting physician who refers a case to a consulting practitioner has made a referral under the self-referral law. Under section 1877(h)(5)(A), a physician's referral is defined, in the case of an item or service covered under Part B, as the request by a physician for the item or service, including the request for a consultation with another physician (and any test or procedure ordered by, or to be performed by (or under the supervision of) that other physician. These referrals could potentially be prohibited if the physician and the providing entity have a financial relationship, such as a compensation arrangement. A compensation arrangement is defined in the law broadly to include any arrangement involving any remuneration between a physician and an entity (other than certain very narrowly defined exclusions). "Remuneration," in turn, is defined to include any remuneration, paid directly

or indirectly, overtly or covertly, in cash or in kind. We have further defined the concept of "remuneration" in our regulations covering self-referrals for clinical laboratory services in 42 CFR 411.351 to include *any payment*, discount, forgiveness of debt, or other benefit made directly or indirectly, overtly or covertly, in cash or in kind, by an entity to a referring physician.

Our payment policy could place a presenting physician in the position of violating section 1877 if the presenting physician receives payments from the practitioner to whom he or she has referred and the services at issue are designated health services. In order to avoid such a result, we propose to interpret the payments that the consulting practitioner will forward to the presenting physician as falling outside of the definition of "remuneration." That is, we will not regard the consulting practitioner as actually making a payment to the presenting physician, but as simply serving as a "conduit" to pass a portion of the Medicare payment on to the presenting physician, strictly as an administrative convenience to us. We do not believe this interpretation violates the purpose of the self-referral law, which was specifically designed to prevent entities that furnish certain health services from purchasing referrals from physicians.

We considered requiring both the consulting and presenting practitioners to submit separate claims. This alternative was rejected because (1) two services are not being furnished; (2) the beneficiary would receive two cost sharing bills; and (3) the claims processing system would need to link claims from both practitioners to ensure that the total payment does not exceed the payment ceiling provided under section 4206 of the BBA. It would be difficult and costly to implement claims processing systems modifications that would be capable of identifying and linking related teleconsultation claims to prevent overpayments from occurring. Such an effort would become even more complex if two carriers were involved because the practitioners' locations fell within separate carrier jurisdictions. Moreover, total payment might exceed what the consultant would have otherwise received if the presenting practitioner were to submit a claim for a consultation at a higher intensity level than the consultant. For example, the consulting practitioner might bill for a consultation requiring only a detailed examination and low complexity medical decisionmaking, whereas the presenting practitioner might bill for a consultation with a

comprehensive examination and moderately complex decisionmaking. There is a 40 percent difference in the Medicare RVU values between these two services. Another overpayment could occur in those rare cases where the factor for the pricing locality for the presenting practitioner is higher than for the consulting practitioner.

Because of the difficulty in linking claims, we considered another approach that would have involved separate claims, but without linking. We considered establishing a new code for the presenting practitioner's role and pricing it at 25 percent of the average consultation amount. Under this option, the consultant's fee would be based on the appropriate fee schedule and adjusted by the geographic practice cost index, but would be reduced by the flat, national value paid to the presenting practitioner. However, this alternative achieves anomalous results; in several cases, the presenting practitioner would receive more than the consulting practitioner. Therefore, we rejected this option.

Coding: For teleconsultation coding purposes, we would develop modifiers to use in conjunction with existing CPT codes for consultation services. The purpose of the modifier is to identify the service as a consultation furnished via telecommunications systems. This approach conforms with our view that a teleconsultation is simply a new way of delivering a consultation, rather than a new service.

We considered developing a new coding structure for teleconsultations. We rejected this option, however, because it is administratively cumbersome for both the medical community and the Medicare program. First, the practitioner community is already familiar with the current codes for consultation. We believe it will be easier for practitioners to use a single modifier than an entirely new set of codes. Second, separate teleconsultation codes would unnecessarily double the number of current codes used for consultation services.

Proposed Regulatory Provisions

To reflect the above proposals and the payment provisions of section 4206 of the BBA, we would add a new § 414.62 (Payment for consultations via interactive telecommunication systems) to our regulations. We would specify, in paragraph (a), that Medicare total payments for a professional consultation

conducted via interactive telecommunications systems may not exceed the current fee schedule amount for the service when furnished by the consulting practitioner. We would further specify that the payment (1) may not include any reimbursement for any telephone line charges or any facility fees, and (2) is subject to the coinsurance and deductible requirements of section 1833(a)(1) and (b) of the Act. We would also specify that the payment differential of section 1848(a)(3) of the Act applies to services furnished by nonparticipating physicians.

In paragraph (b), we would specify that the beneficiary may not be billed for any telephone line charges or any facility fees. In paragraph (c), we would provide that payment to nonphysician practitioners is made only on an assignment-related basis. Paragraph (d) would provide that only the consultant practitioner may bill for the consultation, and paragraph (e) would require the consultant practitioner to provide the referring practitioner 25 percent of any payments, including any applicable deductible or coinsurance amounts, he or she received for the consultation.

Paragraph (f) would specify that a practitioner may be subject to the sanctions provided for in 42 CFR chapter V, parts 1001, 1002, and 1103 if he or she (1) knowingly and willfully bills or collects for services in violation of the limitations of § 414.62 on a repeated basis, or (2) fails to timely correct excess charges by reducing the actual charge billed for the service to an amount that does not exceed the limiting charge or fails to timely refund excess collections.

III. 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 comments in the preamble to that document.

IV. Regulatory Impact Statement

We have examined the impact of this rule as required by Executive Order 12866 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 must be prepared for proposed rules with economically significant effects (that is, a proposed rule that would have an annual effect on the economy of \$100 million or more or would adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or tribal governments or communities). The benefit changes in this proposed rule resulting from the BBA will not result in additional Medicare expenditures of \$100 million or more for any single FY through FY 2003. Therefore, this proposed rule is not considered economically significant, and, thus, we have not prepared a regulatory impact analysis.

The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, most hospitals, and most other providers, physicians, and health care suppliers are small entities, either by nonprofit status or by having revenues of \$5 million or less annually.

Section 1102(b) of the Social Security Act requires us to prepare a regulatory impact analysis for any proposed rule that 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 603 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 a Metropolitan Statistical Area and has fewer than 50 beds.

We estimate that the cost of providing consultation services in accordance with section 4206 of the BBA will be approximately \$20 million in FY 1999 and approximately \$90 million by FY 2003. Note that the FY 1999 estimate reflects only a partial year estimate, given the January 1, 1999 effective date for teleconsultation coverage. We estimate that teleconsultation will cost approximately \$270 million for the first 5 years of coverage, as indicated below:

MEDICARE COSTS
[In millions]

FY 1999	FY 2000	FY 2001	FY 2002	FY 2003
\$19	\$39	\$54	\$70	\$88

Additionally, this proposed rule would provide for payment exclusively for professional consultation with a physician and certain other practitioners via interactive telecommunication systems. Section 4206 of the BBA does not provide for payment for telephone line fees or any facility fees associated with teleconsultation that may be incurred by hospitals included in the telemedicine network.

Further, this rule does not mandate that entities provide consultation services via telecommunications. Thus, this rule would not require entities to purchase telemedicine equipment or to acquire the telecommunications infrastructure necessary to deliver consultation services via telecommunication systems. Therefore, this rule does not impose costs associated with starting and operating a telemedicine network.

For these reasons, we are not preparing analyses for either the RFA or section 1102(b) of the Act because we have determined, and we certify, that this proposed rule would not have a significant economic impact on a substantial number of small entities or a significant impact on the operations of a substantial number of small rural hospitals.

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

List of Subjects

42 CFR Part 410

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

42 CFR Part 414

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

42 CFR chapter IV would be amended as follows:

A. Part 410.

PART 410—SUPPLEMENTARY MEDICAL INSURANCE (SMI) BENEFITS

1. The authority citation for part 410 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

§ 410.1 [Amended]

2. Section 410.1, paragraph (a) is amended by adding a sentence at the end of the paragraph to read "Section 4206 of the Balanced Budget Act of 1997 (42 U.S.C. 1395j) sets forth the conditions for payment for professional consultations that take place by means of telecommunications systems."

3. A new § 410.75 is added to subpart B to read as follows:

§ 410.75 Consultations via telecommunications systems.

(a) *General rule.* Medicare Part B pays for professional consultations furnished by means of interactive telecommunications systems if the following conditions are met:

(1) Each of the referring and consultant practitioner is any of the following:

(i) A physician as described in § 410.20.

(ii) A physician assistant as defined in § 491.2 of this chapter.

(iii) A nurse practitioner as defined in § 491.2 of this chapter.

(iv) A clinical nurse specialist as described in § 424.11(e)(6) of this chapter.

(v) A certified registered nurse anesthetist or anesthesiologist's assistant as defined in § 410.69.

(vi) A nurse-midwife as defined in § 405.2401 of this chapter.

(vii) A clinical social worker as defined in section 1861(hh)(1) of the Act.

(viii) A clinical psychologist as described at § 417.416(d)(2) of this chapter.

(2) The services are furnished to a beneficiary residing in a rural area as defined in section 1886(d)(2)(D) of the Act, and the area is designated as a health professional shortage area (HPSA) under section 332(a)(1)(A) of the Public Health Service Act (42 U.S.C. 254e(a)(1)(A)). For purposes of this requirement, the beneficiary is deemed

to be residing in such an area if the teleconsultation presentation takes place in such an area.

(3) The medical examination of the beneficiary is under the control of the consultant practitioner.

(4) The consultation involves the participation of the referring practitioner, as appropriate to the medical needs of the patient and as needed to provide information to and at the direction of the consultant.

(5) The consultation results in a written report that is furnished to the referring practitioner.

(b) *Definition.* For purposes of this section, *interactive telecommunications systems* means multimedia communications equipment that includes, at a minimum, audio-video equipment permitting two-way, real time consultation among the patient, consulting practitioner, and referring practitioner as appropriate to the medical needs of the patient and as needed to provide information to and at the direction of the consulting practitioner. Telephones, facsimile machines, and electronic mail systems do not meet the definition of interactive telecommunications systems.

B. Part 414.

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

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

Authority: Secs. 1102, 1871, and 1881(b)(1) of the Social Security Act (42 U.S.C. 1302, 1395hh, and 1395rr(b)(1)).

2. Section 414.1 is revised to read as follows:

§ 414.1 Basis and scope.

This part implements the following:

(a) The indicated provisions of the following sections of the Act:

1833—Rules for payment for most Part B services.

1834(a) and (h)—Amounts and frequency of payments for durable medical equipment and for prosthetic devices and orthotics and prosthetics.

1848—Fee schedule for physician services.

1881(b)—Rules for payment for services to ESRD beneficiaries.

1887—Payment of charges for physician services to patients in providers.

(b) Sections 4206(a) and (b) of the Balanced Budget Act of 1997 (42 U.S.C. 1395j).

3. Section 414.62 is added to subpart A, to read as follows:

§ 414.62 Payment for consultations via interactive telecommunications systems.

(a) *Limitations on payment.* Medicare payment for a professional consultation conducted via interactive telecommunications systems is subject to the following limitations:

(1) The payment may not exceed the current fee schedule amount of the consulting practitioner for the health care services provided.

(2) The payment may not include any reimbursement for any telephone line charges or any facility fees.

(3) The payment is subject to the coinsurance and deductible requirements of section 1833(a)(1) and (b) of the Act.

(4) The payment differential of section 1848(a)(3) of the Act applies to services furnished by nonparticipating physicians.

(b) *Prohibited billing.* The beneficiary may not be billed for any telephone line charges or any facility fees.

(c) *Assignment required for nonphysician practitioners.* Payment to nonphysician practitioners is made only on an assignment-related basis.

(d) *Who may bill for the consultation.* Only the consultant practitioner may bill for the consultation.

(e) *Sharing of payment.* The consultant practitioner must provide to the referring practitioner 25 percent of any payments, including any applicable deductible or coinsurance amounts, he or she received for the consultation.

(f) *Sanctions.* A practitioner may be subject to the applicable sanctions provided for in chapter V, parts 1001, 1002, and 1003 of this title if he or she—

(1) Knowingly and willfully bills or collects for services in violation of the limitations of this section on a repeated basis; or

(2) Fails to timely correct excess charges by reducing the actual charge billed for the service to an amount that does not exceed the limiting charge for the service or fails to timely refund excess collections.

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

Dated: February 8, 1998.

Nancy-Ann Min DeParle,
Administrator, Health Care Financing Administration.

Dated: April 14, 1998.

Donna E. Shalala,
Secretary.

[FR Doc. 98-16278 Filed 6-19-98; 8:45 am]

BILLING CODE 4120-01-P

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Parts 22 and 64

[CC Docket No. 96-115; DA 98-971]

Telecommunications Carriers' Use of Customer Proprietary Network Information and Other Customer Information

AGENCY: Federal Communications Commission.

ACTION: Clarification; proposed rule.

SUMMARY: The Order released May 21, 1998 clarifies various issues pertaining to the *Second Report and Order and Further Notice of Proposed Rulemaking* released February 26, 1998.

FOR FURTHER INFORMATION CONTACT: Brent Olson, Attorney, Common Carrier Bureau, Policy and Program Planning Division, (202) 418-1580.

SUPPLEMENTARY INFORMATION: This is a summary of the Commission's Order adopted and released May 21, 1998. The full text of this Order is available for inspection and copying during normal business hours in the FCC Reference Center, 1919 M St., NW., Room 239, Washington, DC. The complete text also may be obtained through the World Wide Web, at <http://www.fcc.gov/Bureaus/Common Carrier/Orders/da98971.wp>, or may be purchased from the Commission's copy contractor, International Transcription Service, Inc., (202) 857-3800, 1231 20th St., NW., Washington, DC. 20036.

Synopsis of Order on Reconsideration

I. Introduction

1. On February 26, 1998, the Commission released a *Second Report and Order and Further Notice of Proposed Rulemaking*, 63 FR 20326, April 24, 1998 (*Second Report and Order*), interpreting and implementing, among other things, the portions of section 222 of the Communications Act of 1934, as amended, that govern the use and disclosure of, and access to, customer proprietary network information (CPNI) by telecommunications carriers. Since the

release of the *Second Report and Order*, a number of parties have requested that the Commission clarify various issues pertaining to that order. In response to these requests, the Common Carrier Bureau issues this order clarifying the *Second Report and Order* as follows:

(a) Independently-derived information regarding customer premises equipment (CPE) and information services is not CPNI and may be used to market CPE and information services to customers in conjunction with bundled offerings.

(b) A customer's name, address, and telephone number are not CPNI.

(c) A carrier has met the requirements for notice and approval under section 222 and the Commission's rules where it has both provided annual notification to, and obtained prior written authorization from, customers with more than 20 access lines in accordance with the Commission's former CPNI rules.

(d) Although a carrier must ensure that its certification of corporate compliance with the Commission's CPNI rules is made publicly available, it is not required to file this certification with the Commission.

II. Clarification of Marketing Uses of Customer Information Related to CPE or Information Services

2. Section 222(c)(1) establishes the limited circumstances in which carriers can use, disclose, or permit access to CPNI without first obtaining customer approval. In interpreting section 222(c)(1) in the *Second Report and Order*, the Commission adopted an approach that allows carriers to use CPNI, without first obtaining customer approval, to market improvements or enhancements to the package of telecommunications services the carrier already provides to a particular customer, which it referred to as the "total service approach."

3. The Commission's discussion, however, did not specifically address a carrier's ability to use CPNI when its customers obtain their telecommunications service as part of a bundled package that includes non-telecommunications service offerings, such as CPE or certain information services.

4. We make clear that, when a customer purchases CPE or information services from a carrier that are bundled with a telecommunications service, the carrier subsequently may use any customer information independently derived from the carrier's prior sale of CPE to the customer or the customer's subscription to a particular information service offered by the carrier in its