rulemaking was not published in this proceeding. Therefore, sections 202 and 205 do not apply to EPA's action here.

Before EPA establishes any regulatory requirements that may significantly or uniquely affect small governments, including tribal governments, it must have developed under section 203 of UMRA a small government agency plan. The plan must provide for notifying potentially affected small governments, enabling officials of affected small governments to have meaningful and timely input in the development of EPA regulatory proposals with significant Federal intergovernmental mandates, and informing, educating, and advising small governments on compliance with the regulatory requirements. EPA has determined that this rule contains no regulatory requirements that might significantly or uniquely affect small governments. As explained above, today's rule withdrawals provisions and therefore, does not contain any regulatory requirements. Thus this rule is not subject to the requirements of section 203 of UMRA.

VII. Executive Order 12875

For the same reasons as stated above in section VI., EPA has determined this final rule does not impose federal mandates on State, local or Tribal governments. Therefore this rule is not subject to the provisions E.O. 12875.

Nonetheless, in compliance with Executive Order 12875, Enhancing the Intergovernmental Partnership, EPA has extensively involved Great Lakes State, Tribal and local governments in the development of the 1995 Guidance. The rulemaking which promulgated the Guidance in 1995 was subject to Executive Order 12875. The process used to develop the Guidance marked the first time that EPA had developed a major rulemaking effort in the water program through a regional public forum. The public process which lasted over a seven year period and involved Great Lakes States, EPA, and other Federal agencies in open dialogue with citizens, Tribal and local governments, and industry in the Great Lakes Basin is described further in the preamble to the final Guidance. *See* 56 FR 15383–15384 (March 23, 1995).

As described above, this action by EPA merely conforms the regulations to the Court order in *AISI* and therefore, does not create any federal mandates.

VIII. Paperwork Reduction Act

This action includes no information collection activities subject to the Paperwork Reduction Act (44 U.S.C. 3501 *et seq.*) Therefore, no Information Collection Request is required to be prepared or submitted to OMB for approval.

IX. National Technology Transfer and Advancement Act

Under section 12(d) of the National Technology Transfer and Advancement Act (NTTAA), the Agency is required to use voluntary consensus standards in its regulatory activities unless to do so would be inconsistent with applicable law or otherwise impractical. Voluntary consensus standards are technical standards (e.g., materials specifications, test methods, sampling procedures, business practices, etc.) that are developed or adopted by voluntary consensus standard bodies. Where available and potentially applicable voluntary consensus standards are not used by EPA, the Act requires the Agency to provide Congress, through the Office and Management and Budget, an explanation of the reasons for not using such standards.

This final rule does not prescribe any technical standards, so we have determined that the NTTAA requirements are not applicable.

List of Subjects in 40 CFR Part 132

Environmental protection, Administrative practice and procedure, Great Lakes, Indians-lands, Intergovernmental relations, Reporting and recordkeeping requirements, Water pollution control.

Dated: April 14, 1998.

Carol M. Browner,

Administrator.

For the reasons set out in the preamble Title 40, Chapter I of the Code of Federal Regulations is to be amended as follows:

PART 132—WATER QUALITY GUIDANCE FOR THE GREAT LAKES SYSTEM

1. The authority citation for part 132 continues to read as follows:

Authority: 33 U.S.C. 1251 *et seq.*

2. Procedure 3 of Appendix F to part 132 is amended by removing Procedure 3.C.

3. Procedure 8 of Appendix F to part 132 is amended by revising in the introductory text of 8.D. the second sentence and the third sentence; by revising paragraph 8.D.3; by revising paragraph 8.D.4; and by revising paragraph 8.D.5.c. to read as follows:

Procedure 8: Water Quality-based Effluent Limitations Below the Quantification Level

* * * * *

D. Pollutant Minimization Program. * * * The goal of the pollutant minimization program shall be to maintain the effluent at or below the WQBEL. In addition, States and Tribes may consider cost-effectiveness when evaluating the requirements of a PMP. * * *

1. * * *

2. * * *

3. Submittal of a control strategy designed to proceed toward the goal of maintaining the effluent below the WQBEL;

4. Implementation of appropriate, cost-effective control measures consistent with the control strategy; and

5. * * *

a. * * *

b. * * *

c. A summary of all action undertaken pursuant to the control strategy.

6. * * *

* * * * *

[FR Doc. 98–10717 Filed 4–22–98; 8:45 am]

BILLING CODE 6560–50–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 410, 417, 424, and 482

[HCFA–3706–F]

RIN 0938–AE99

Medicare Program; Scope of Medicare Benefits and Application of the Outpatient Mental Health Treatment Limitation to Clinical Psychologist and Clinical Social Worker Services

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

ACTION: Final rule.

SUMMARY: This rule addresses requirements for Medicare coverage of services furnished by a clinical psychologist or as an incident to the services of a clinical psychologist and for services furnished by a clinical social worker. The requirements are based on section 6113 of the Omnibus Budget Reconciliation Act of 1989, section 4157 of the Omnibus Budget Reconciliation Act of 1990, and section 147(b) of the Social Security Act Amendments of 1994 (SSA '94). This rule also addresses the outpatient mental health treatment limitation as it applies to clinical psychologist and clinical social worker services.

This final rule also conforms our regulations to section 104 of the Social Security Act Amendments of 1994. Section 104 provides that a Medicare patient in a Medicare-participating hospital who is receiving qualified psychologist services may be under the care of a clinical psychologist with respect to those services, to the extent permitted under State law.

In addition, this final rule requires that clinical psychologists and clinical

social workers use appropriate diagnostic coding when submitting Medicare Part B claims.

EFFECTIVE DATE: This final rule has been classified as a major rule subject to congressional review. The effective date is June 22, 1998. If, however, at the conclusion of the congressional review process the effective date has been changed, the Health Care Financing Administration will publish a document in the **Federal Register** to establish the actual effective date or to issue a notice of termination of the final rule action.

FOR FURTHER INFORMATION CONTACT: Regina Walker-Wren, (410) 786–9160.

SUPPLEMENTARY INFORMATION:

I. Background

A. Clinical Psychologist Services

Before section 6113 of the Omnibus Budget Reconciliation Act of 1989 (OBRA '89), Pub. L. 101–239, became effective, Medicare Part B paid for the services of clinical psychologists (CPs) if they were furnished as an incident to the services of a physician or if the services were furnished in certain settings. Section 6113(a) of OBRA '89 revised section 1861(ii) of the Social Security Act (the Act), which defined ''qualified psychologist services,'' to expand Part B coverage of CP services to services performed in all settings. The services, however, must be those that the psychologist is legally authorized to perform under State law and that would otherwise be covered if furnished by a physician or as an incident to a physician's services. This, in effect, allows payment to be made directly to a CP for qualified psychologist services furnished by the CP or incidental to the CP's services (except for services furnished to hospital patients). The provision was effective for services furnished on or after July 1, 1990. Section 1833(p) of the Act (now designated as section 1842(b)(18)(A) of the Act), which requires that payment for qualified psychologist services be made only on an assignment-related basis, was unchanged by the OBRA '89 amendments.

Section 6113(d) of OBRA '89 amended section 1833(d)(1) of the Act to eliminate a then-existing dollar limitation on payment for outpatient mental health treatment. It, however, retained a 62½ percent limitation that had been established by earlier legislation. (Note that section 1833(d)(1) has been redesignated as section 1833(c) by the Medicare Catastrophic Coverage Repeal Act of 1989, Pub. L. 101–234.) Section 1833(c) applies to expenses for mental health treatment services incurred on or after January 1, 1990.

Section 6113(c) of OBRA '89 requires the Secretary, while taking into consideration concerns for patient confidentiality, to develop criteria regarding direct payment to CPs under which the CPs must agree to consult with a patient's attending physician.

As a further development, section 4157(a) of the Omnibus Budget Reconciliation Act of 1990 (OBRA '90), Pub. L. 101–508, amended section 1861(b) of the Act, which defines ''inpatient hospital services,'' by revising paragraphs (3) and (4) to exclude, effective January 1, 1991, CP services furnished to a hospital inpatient from the definition. In addition, section 4157(c) of OBRA '90 amended section 1862(a) of the Act, which concerns exclusions from coverage, by revising paragraph (14) to permit direct billing by CPs for qualified psychologist services if furnished to hospital patients.

On December 29, 1993, we published a proposed rule, at 58 FR 68829, concerning Medicare coverage and payment of CP, other psychologist, and clinical social worker services. That proposed rule contains additional information on the legislative background of CP services.

Subsequent to the publication of the December 1993 proposed rule, Congress enacted the Social Security Act Amendments of 1994 (SSA '94), Pub. L. 103–432. Section 104 of SSA '94 amended section 1861(e)(4) of the Act. Prior to SSA '94, section 1861(e)(4) provided that each Medicare patient in a participating hospital be under the care of a physician. This provision was incorporated into our regulations at § 482.12(c). Section 482.12(c) allows a practitioner to assume responsibility for a patient's care only if the practitioner is included in the definition of ''physicians'' at section 1861(r) of the Act. That definition includes doctors of medicine and osteopathy (including psychiatrists) and other practitioners, but does not include CPs.

As amended by section 104 of SSA '94, section 1861(e)(4) of the Act now provides that a hospital patient receiving qualified psychologist services may be under the care of a CP with respect to services furnished by the CP, to the extent permitted under State law.

B. Diagnostic Psychological Tests

Before enactment of the qualified psychologist services benefit (that is, the CP benefit authorized under section 1861(ii) of the Act), we authorized, under section 1861(s)(3) of the Act, Medicare coverage for diagnostic psychological testing services performed by a qualified psychologist practicing independently of an institution, agency, or physician's office. In order to have his or her diagnostic services covered under this provision, the psychologist had to meet certain qualifications and the diagnostic services had to have been ordered by a physician. These services were covered as ''other diagnostic tests,'' and Medicare paid for them on a reasonable charge basis.

C. Clinical Social Worker Services

Before the enactment of OBRA '89, services of a clinical social worker (CSW) were payable by Medicare Part B when furnished in various settings, such as a risk-based health maintenance organization (HMO); as part of hospital outpatient services under sections 1861(s)(2)(B), 1861(s)(2)(C), and 1861(ff)(2)(C) of the Act; and as an incident to the services of a physician under section 1861(s)(2)(A) of the Act. (The applicable HMO statutory provision is contained at section 1861(s)(2)(H)(ii) of the Act, which includes these services in the list of ''medical and other health services.'')

Section 6113(b) of OBRA '89 amended section 1861(s)(2) of the Act to include CSW services in the definition of ''medical and other health services'' generally covered under Part B of Medicare at section 1861(s)(2)(N) of the Act. It also amended section 1861(hh), which defines a CSW, to define ''clinical social worker services'' as services performed by a legally authorized CSW for the diagnosis and treatment of mental illnesses (other than services furnished to an inpatient of a hospital and other than services furnished to an inpatient of a skilled nursing facility (SNF) that the facility is required to provide as a requirement for participation) and that would be covered if furnished by a physician or as an incident to a physician's professional service. This provision is effective for services furnished on or after July 1, 1990.

Section 6113(b)(3) of OBRA '89 amended section 1833(p) (now section 1842(b)(18)(A)) of the Act to specify that Part B payment for CSW services (as defined in section 1861(hh)(2) of the Act) is made only on an assignment-related basis.

Readers who desire additional information regarding the legislative background for CSW services are referred to the above-cited December 29, 1993, proposed rule. Note, however, that, subsequent to the publication of the December 1993 proposed rule, section 147(b) of SSA '94 amended the consultation requirement at section 6113(c) of OBRA '89 (discussed above with regard to CPs) to include CSWs.

Therefore, effective January 1, 1995, CSWs have been required by law, as a condition of payment for their professional services, to consult with their patients' primary care or attending physician.

D. Payment in Certain Facilities

In accordance with section 1876(a)(6) of the Act, payment for services furnished to an enrollee of a risk-based HMO or competitive medical plan (CMP) can only be made to the HMO or CMP. Thus, a CP or CSW who furnishes services in these settings may not bill Medicare directly for these services. Payment will continue to be made through the risk-based HMO or CMP under the appropriate payment methodology.

It should be noted, however, that the scope of services requirement for both cost and risk-based HMOs or CMPs is changed with the addition of CP and CSW services to the list of ''medical and other health services'' defined under section 1861(s) of the Act. The scope of services requirement for both cost and risk-based HMOs and CMPs is set forth in existing § 417.440(b) and includes all Part A and Part B services that are available to Medicare beneficiaries in the HMO's or CMP's geographic area. Therefore, both cost and risk contracting HMOs and CMPs must now furnish CP and CSW services as Medicare-covered services. Note, however, that under section 1861(hh) of the Act, there is no coverage under Part B for services and supplies incident to a CSW's services. Coverage, however, is provided, under section 1861(s)(2)(H)(ii) of the Act, for services and supplies furnished as an incident to a CSW's services if furnished in a risk-based HMO or CMP. Thus, services and supplies incident to a CSW's services are covered by Medicare only when furnished by risk-based HMOs and CMPs.

Comprehensive outpatient rehabilitation facilities (CORFs) could bill for CP services furnished through December 31, 1990. However, effective January 1, 1991, a separate claim must be submitted under Part B for services of a CP in a CORF furnished to patients of the facility. This is because, as of January 1, 1991, services of CPs are not included in the scope of CORF services described under section 1861(cc)(1)(D) of the Act. In that section, the law states that CORF services do not include any item or service that is not included under section 1861(b) of the Act if furnished to an inpatient of a hospital. As noted above, section 1861(b), which contains the statutory definition of ''inpatient hospital services,'' as amended by section 4157(a) of OBRA '90, provides that inpatient hospital services do not include qualified psychologist services. As a result, a separate claim must be submitted under Part B for CP services to hospital inpatients. The same policy applies to CORFs under section 1861(cc)(1) of the Act, as noted, to SNFs under section 1861(h)(7) of the Act, and to home health agencies under the language following paragraph (m)(7) of section 1861 of the Act.

Note also that, in accordance with section 1881(b) of the Act, § 405.2163(c), which governs services required for outpatient maintenance dialysis patients furnished in end stage renal disease facilities, includes the services of social workers. Payment for social worker services is included in the composite rate payment made to the dialysis facility. Therefore, when a CSW furnishes social services as required under § 405.2163(c), these services are billed by the end stage renal disease facility, and these services are paid for by Medicare as part of the composite rate. The composite rate, a payment rate provided for under section 1881(b) of the Act, is a comprehensive, all inclusive, prospective payment for all of the items and services required for outpatient maintenance dialysis.

Section 1861(aa)(3) and (4) of the Act includes the services of CPs and CSWs in the services of a Federally qualified health center. Section 1861(aa)(1)(B) of the Act includes the services of CPs and CSWs, and services and supplies furnished as an incident to those services, as rural health clinic services. Coverage for these services is addressed in §§ 405.2446, 405.2450, and 405.2452. We plan to address provisions related to these services in a separate rulemaking document.

II. Provisions of the Proposed Rule

As stated earlier, on December 29, 1993, we published a proposed rule that addressed the provisions of section 6113 of OBRA '89 and section 4157 of OBRA '90. Our proposal is summarized below.

A. Clinical Psychologist Services

1. Inclusion as ''Medical and Other Health Services''

We proposed to revise § 410.10, ''Medical and other health services: Included services,'' to include, in the list of medical and other health services covered under Part B, the diagnostic and therapeutic services furnished by a CP and services and supplies furnished as an incident to a CP's services.

2. Covered Services

We proposed, in a new § 410.71, that Medicare Part B cover (subject to the 62½ percent limitation for certain outpatient mental health treatment services) services that are furnished by a CP who meets certain requirements (discussed in section III, ''Analysis of and Response to Comments,'' of this preamble). The services must be those that are within the scope of the CP's State license and must be services that would be covered if furnished by a physician or as an incident to a physician's services. With regard to this provision, we proposed the following:

- The outpatient mental health treatment services of CPs and services and supplies furnished as an incident to those services are subject to the 62½ percent payment limitation set forth in proposed § 410.155.
- Payment for the services of CPs and incident-to services furnished to hospital inpatients and outpatients through December 31, 1990, is made to the hospital.
- Effective January 1, 1991, CPs may bill Medicare Part B directly for their services to hospital patients.
- When applying for a provider number and annually thereafter, CPs who bill Medicare Part B directly (including CPs who furnish services to hospital patients and bill Medicare Part B directly for the services) must submit an attestation statement agreeing to consult with the beneficiary's attending or primary care physician in accordance with accepted professional ethical norms, taking into consideration patient confidentiality.
- The CP must agree to inform the beneficiary, prior to a consultation, that it is desirable to consult with the beneficiary's primary care or attending physician to consider any medical conditions that may be contributing to the beneficiary's condition. We also proposed, in § 410.71(e)(2)(iii), that if the beneficiary assents, the CP must agree to consult with the physician within 1 week of obtaining the beneficiary's consent. We specifically requested public comment on this latter proposal.
- The annual attestation contains an agreement to include a notation in the beneficiary's medical records to the effect that he or she was notified of the desirability of a consultation between the CP and the beneficiary's primary care or attending physician, and the patient's response to the notification. We specifically requested public comment on this matter.
- In the attestation statement the CP agrees that, if he or she is unable to reach the physician after at least four attempts, he or she will notify the physician in writing about the provision of care to the beneficiary. We

specifically invited comments concerning this matter as well.

We also proposed that the definition of CP that appears in the HMO rules at § 417.416(d)(2) be revised to cross-refer to the qualifications we would set forth at § 410.71.

3. Incidental Services

We proposed, in § 410.71(a)(2), that Medicare Part B would cover services and supplies furnished as an incident to a CP's services if the incidental services and supplies would be covered if furnished by a physician or as an incident to a physician's services.

We also proposed that, in order for services and supplies furnished as an incident to the services of the CP to be covered by Medicare, they must meet the longstanding Medicare requirements that are applicable to services furnished as an incident to the professional services of a physician. That is, services must be—

- The type that are commonly furnished in a physician's or CP's office and are either furnished without charge or are included in the CP's bill;
- An integral, although incidental, part of professional services performed by the CP;
- Performed under the direct supervision of the CP (that is, the CP must be physically present and immediately available); and
- Performed by an employee of either the CP or the legal entity that employs the supervising CP under the common law control test of section 210(j) of the Act (42 U.S.C. 410(j)), as more fully set forth in 20 CFR 404.1007.

4. Consultation

We proposed, in § 410.71(c), that consultation between the CP and the beneficiary's primary care or attending physician would not be a separately-billable service for Medicare payment purposes. We also proposed that the primary care or attending physician also would not be permitted to bill Medicare for this consultation.

5. Payment on an Assignment-Related Basis

We proposed to revise § 410.150, ''To whom payment is made,'' to specify that payment is made directly to the CP on an assignment-related basis for CP services furnished by him or her and for services and supplies furnished as an incident to his or her services. We pointed out that the assignment requirement would not preclude a CP from furnishing his or her services as an incident to the services of another health care practitioner if these services meet all of the incident-to requirements. In such a case, the practitioner may bill Medicare for the incident-to services. In this case, payment would be made by Medicare to the practitioner.

6. Limitation on Mental Health Treatment Services

We proposed to revise § 410.152(a)(1)(iv), which concerns amounts of payment, to remove the annual dollar limitation on covered mental health treatment services as a factor in determining incurred expenses. (Incurred expenses are Part B covered expenses incurred by an individual during his or her coverage period.)

7. Payment Amount

We proposed to revise § 410.152, ''Amounts of payment,'' to specify that Medicare Part B pays, subject to the mental health treatment limitation of § 410.155(c), 80 percent of the lesser of the actual charge or the fee schedule amount for CP services.

8. Definition of ''Mental Health Treatment''

We proposed to add a definition of ''mental health treatment'' to paragraph (a) of § 410.155, ''Mental health treatment limitation.'' We proposed to define ''mental health treatment'' as ''therapy for the treatment of a mental, psychoneurotic, or personality disorder.'' We also proposed to specify a distinction between ''treatment'' and ''diagnosis,'' as discussed below.

We proposed to revise § 410.155(b) to include examples of services that are subject to, or excluded from, the application of the limitation.

- We proposed that the limitation does not apply to mental health treatment furnished to hospital inpatients, brief office visits to a physician for the purpose of monitoring or changing drug prescriptions used in the mental health treatment, partial hospitalization services that are not directly provided by a physician, and diagnostic services that are performed to establish a diagnosis.
- We proposed that the limitation will apply not only to mental health treatment furnished by physicians and CORFs but also to mental health treatment furnished as an incident to the services of a physician and to the mental health services of other health care practitioners whether the services are furnished directly by the practitioners or as an incident to their services. Thus, for example, the limitation would apply to the services of CPs, services furnished as an incident to the services of CPs, and to the services of CSWs.

With respect to diagnostic psychological testing and other diagnostic services, we proposed that services performed in order to establish a patient's diagnosis are not subject to the limitation, because those services do not represent *treatment* of a mental disorder. We stated that the limitation would apply to testing that is part of treatment (for example, when it is used to evaluate a patient's progress during treatment). Only diagnostic services used to establish a diagnosis for a patient's mental illness would be excluded from the limitation.

We proposed to revise § 410.155(c) of the regulations to remove the dollar limitation.

We also proposed to revise the heading of § 410.155, from ''Psychiatric services limitations: Expenses incurred for physician services and CORF services'' to ''Mental health treatment limitation.'' Further, we proposed to update the example, in existing § 410.155(d), of how the limitation is applied.

As a technical revision, we proposed to remove the reference to ''medical services for the diagnosis and treatment of tuberculosis'' from the definition of ''hospital'' in § 410.155(a). Section 2335 of the Deficit Reduction Act of 1984 (Pub. L. 98–369) repealed the special conditions and requirements associated with coverage of treatment of tuberculosis patients and eliminated the special provider category of tuberculosis hospitals.

9. Basis for Payment

We proposed to revise § 424.55(b)(1), which concerns accepting assignment, to reflect that, in accepting assignment, a supplier (which includes a CP) agrees to accept, as the full charge for the service, the charge approved by the carrier as the basis for determining the Medicare Part B payment. We proposed to revise paragraph (b)(2)(i) of this section, which currently reads: ''To collect nothing for those services for which Medicare pays 100 percent of the reasonable charge.'' We proposed to change ''reasonable charge'' to ''approved amount'' to reflect that, based on recent statutory changes, there are also fee schedules and other basis for payment, in addition to reasonable charge.

We proposed to revise paragraph (b)(2)(ii) of § 424.55. This paragraph currently limits the amount that the supplier may collect from the beneficiary or other source to only the amount of any unmet deductible, plus 20 percent of the difference between the reasonable charge and the unmet deductible for those services for which

Medicare pays 80 percent of that difference. We proposed to revise this to state that, for those services for which Medicare pays less than 100 percent of the approved amount, the supplier may collect only the difference between the Medicare-approved amount and the Medicare Part B payment (that is, the amount of any reduction in incurred expenses under § 410.155(c) and any applicable deductible and coinsurance amount). This change would recognize that a supplier may collect, from the beneficiary or other source, the 37½ percent differential that results from the mental health treatment limitation.

B. Diagnostic Psychological Tests

Diagnostic psychological testing services performed by an independent psychologist, other than a CP, practicing independently of an institution, agency, or physician's office are currently covered as other diagnostic tests under section 1861(s)(3) of the Act. We stated our intent to continue to cover this type of testing. We, however, invited public comment on methods to employ that would control the potential for excessive use of psychological testing.

In addition, we stated that we intend to address the coverage requirements for the psychological tests benefit in a separate rulemaking in the near future and that, at that time, we will invite public comment about the professional qualifications that should be required for the persons who perform these tests. We stated our intent, until the rule establishing these qualifications is effective, to continue to cover this type of testing if furnished by any psychologist who is licensed or certified to practice psychology in the State or jurisdiction where he or she is furnishing services or, if the jurisdiction does not issue licenses, if provided by any practicing psychologist.

C. Clinical Social Worker Services

1. We proposed to revise § 410.10, ''Medical and other health services: Included services,'' to include the services of CSWs in the list of medical and other health services covered under Part B.

2. We proposed, in a new § 410.73(a), to define a CSW as an individual who—

- Possesses a master's or doctor's degree in social work;
- After obtaining the degree, has performed at least 2 years of supervised clinical social work; and
- Either is licensed or certified as a CSW by the State in which the services are performed or, in the case of an individual in a State that does not provide for licensure or certification, has completed at least 2 years or 3,000 hours of post master's degree supervised clinical social work practice under the supervision of a master's degree level social worker in an appropriate setting such as a hospital, SNF, or clinic.

3. We proposed, in a new § 410.73(b), to specify that Medicare Part B pays for services performed by a CSW for the diagnosis and treatment of mental illness that the CSW is legally authorized to perform if the services would be covered if furnished by a physician or as an incident to a physician's professional services.

4. We proposed to specify, in a new § 410.73(c)(1), that payment for CSW services furnished to hospital inpatients and outpatients is made to the hospital (not to the CSW).

We proposed to specify, in a new § 410.73(c)(2), that payment for CSW services furnished to inpatients of an SNF, if the SNF is required to provide such services as a requirement for participation, is made to the SNF. Under the statute, however, any coverable CSW services furnished in an SNF that the SNF is not required to furnish as a requirement for participation could be billed by the CSWs directly under Part B. Thus, we specifically invited public comment and suggestions on how we can clearly identify or differentiate the level of services that would clearly qualify under the statute as CSW services performed in SNFs from those services that are required by the SNF requirements for participation.

As noted above, the conditions of coverage for end stage renal disease facilities require that social worker services be made available to dialysis patients. Therefore, we proposed to specify, in a new § 410.73(c)(3), that payment for social services furnished to dialysis patients that are required by the conditions for coverage for end stage renal disease facilities is made to the facility. We specifically invited public comment, however, regarding whether any CSW services to dialysis patients can be distinguished from the required facility services.

5. We proposed, in a new § 410.73(d), to hold those CSWs who bill Medicare Part B directly to the same consultation requirements as we would CPs. Accordingly, the CSW, when applying for a Medicare provider number and annually thereafter, would be required to submit to the carrier an attestation statement agreeing to consult with the beneficiary's attending or primary care physician in accordance with professional ethical norms, taking into consideration patient confidentiality. We would require that the attestation statement contain the same information we proposed to require for the attestation statement of CPs.

We also proposed to specify, in a new § 410.73(c)(5), that a CSW or attending or primary care physician may not bill Medicare or the beneficiary for the consultation that would be required by this rule.

6. We proposed to revise § 410.150, which explains to whom payment is made, to specify that payment may be made directly to the CSW, on an assignment-related basis, for services he or she furnished.

7. We proposed to revise §§ 410.152, ''Amounts of payment,'' and 410.155(b), ''Services subject to limitation,'' regarding application of the mental health treatment limitation. The provisions of proposed §§ 410.152 and 410.155(b), discussed in sections II.A.7. and II.A.8. of this preamble, respectively, would also apply to services of CSWs.

8. We proposed to further revise § 410.152 by adding a new paragraph (m), which would specify that Medicare Part B pays, subject to the mental health treatment limitation of § 410.155(c), 80 percent of the lesser of the actual charge for the therapeutic services of a CSW or 75 percent of the fee schedule amount for CP services.

9. We proposed to amend § 417.416, ''Qualifying condition: Furnishing of services,'' to specify that an HMO or CMP may permit the covered services of a CSW to be furnished without physician supervision. We also proposed that services incident to the professional services of a CSW are not covered by Medicare if furnished in a cost-based HMO or CMP.

10. The proposed revision to § 424.55, ''Payment to the supplier,'' discussed in section II.A.9. of this preamble, would also apply to CSWs.

D. CPs and CSWs Diagnostic Coding

We proposed that, beginning with the effective date of the final rule, CPs and CSWs would be required to use only ICD–9–CM diagnostic coding when submitting claims to our carriers.

III. Analysis of and Response to Comments

In response to the December 1993 proposed rule, we received approximately 740 public comments. Commenters included national, State, and local professional associations; State and local governmental agencies; psychologists, psychiatrists, CSWs, and other individuals.

The concerns expressed by the commenters focused predominately on the proposed definition of ''clinical psychologist,'' the attestation statement,

and the consultation requirements. There were also other issues addressed in the public comments, such as, which medical coding system CPs or physicians should use to report services, how to distinguish the professional services of CSWs from the social services that social workers are required to furnish to patients in SNFs that house 120 or more beds, psychological testing, and the grandfathering of master's level psychologists who were licensed by their respective States at the time licensure laws first became effective.

A summary of the comments and our responses are presented below.

A. The ''Clinical Psychologist'' Definition (§ 410.71)

The proposed CP definition is basically comprised of three requirements: the educational degree, State licensure, and clinical experience. For purposes of addressing public comments on the proposed definition of ''clinical psychologist,'' however, we believe it is helpful to analyze the various components of the definition. These are as follows:

- The individual must hold a doctoral degree in psychology.
- The doctoral degree in psychology must be from an accredited program.
- The psychology program must prepare the candidate to practice clinical psychology by providing appropriate clinical psychology training.
- The individual must be licensed or certified at the independent practice level of clinical psychology by the State in which he or she practices.
- The individual must possess 2 years of supervised clinical experience, at least one of which is postdoctoral degree experience.
- The 2 years of supervised clinical experience must have been supervised by a psychologist qualified at the doctorate level.

1. The Individual Must Hold a Doctoral Degree in Psychology

Comment: The majority of the comments we received on the CP definition supported maintaining the standard that requires a *doctoral* degree in psychology. On the other hand, many commenters objected to maintaining that standard. These latter commenters believed that the standard should be replaced with a standard that would enable psychologists with master's degrees to qualify as CPs. It was suggested by a few of these commenters, however, that these master's level psychologists be paid at the same rate as social workers with master's degrees who are also authorized to bill the Medicare program directly for professional diagnostic and treatment services.

Also, these commenters contend that in some States there is a shortage of psychologists with doctoral degrees, particularly in the rural areas. They further assert that, while psychologists with doctoral degrees are not very accessible to the elderly population in rural areas, there are psychologists in these areas who have a master's degree in psychology and are licensed by the State at the independent practice level to furnish diagnostic and treatment services. These commenters have urged us to defer to State Psychology Boards to determine who is eligible to furnish psychological services under the Medicare program, since professional licensure has always been controlled by the State.

Response: The statute, at section 1861(ii) of the Act gives the Secretary the authority to define the term ''clinical psychologist'' for the purpose of covering, under the Medicare Part B program, the professional diagnostic and treatment services of CPs and services and supplies furnished as an incident to their professional services.

Previously, we had established a definition of CP in regulations at § 417.416(d)(2). This definition was issued in final regulations in 1985 and has been used for purposes of coverage of CP services in HMOs and CMPs. Application of this definition in the community mental health center setting was addressed through instructions issued in September 1986; for purposes of the expanded CP benefit, instructions were issued in August 1990.

As we stated in the proposed rule, while this CP definition in its entirety may have been appropriate for psychologists furnishing services in limited settings such as HMOs, CMPs, and community mental health centers, its use for purposes of the expanded benefit caused extensive concern among CPs. While we believe that there are provisions of the definition that remain appropriate even under the expanded benefit, we believe other provisions of the definition require some modification.

Under the expanded CP benefit, CPs are authorized to perform services that would otherwise be furnished by a *physician,* as well as accept responsibility for services furnished by others incident to their professional services. We believe that it is prudent for these practitioners to have a level of education that is close to that which physicians receive if they are going to perform in this capacity. Even though a few States may license psychologists with master's degrees at the independent practice level to furnish both diagnostic and treatment services, we want to ensure that only those practitioners with the highest level of education, knowledge, and experience furnish services to Medicare beneficiaries.

Additionally, we believe that the requirement for a doctoral degree is the standard for psychologists who are qualified to furnish services and supervise the services of others, as evidenced by the industry and by other Federal programs. Information from the Association of State and Provincial Psychology Boards indicates that 32 States and the District of Columbia do not license or certify psychologists below the doctorate level, and most of the 18 States that do license or certify individuals at the masters level require supervision of the individual's services by a doctorate level psychologist. Over 90 percent of psychologists licensed or certified for independent clinical practice do have doctoral degrees.

We have concerns about the suggestion that the Medicare program allow psychologists with master's degrees who are licensed by the State at the independent practice level of psychology to qualify as CPs, but pay these psychologists at the same rate that the program pays CSWs for their professional diagnostic and treatment services. Although the Medicare program makes direct payment to independently practicing CSWs for their professional diagnostic and treatment services, the CSW benefit is a more restricted benefit than the CP benefit. For example, CSWs may not bill directly for services they furnish hospital inpatients and outpatients or for services in SNFs that participate in Medicare. Additionally, the program does not authorize direct payment to CSWs for services furnished incident to their professional services, except in certain limited situations.

Furthermore, the law provides direction on how the program must pay for the services of CPs as well as CSWs based on criteria that are specific to each of these categories of practitioners. Accordingly, we do not have the discretion to pay doctoral level psychologists at one rate and master's level psychologists at another—just as we do not have the discretion to pay master's level social workers at one rate and doctoral level social workers at another. Practitioners who meet the criteria for CPs and CSWs, respectively, will be paid at the established rate for that benefit.

The following may help to relieve the concerns expressed about the shortage

of psychologists with doctoral degrees in rural areas. Section 1861(aa)(1)(B) of the Act states that the term ''rural health clinic services'' includes services furnished by a CP (as defined by the Secretary). Therefore, in developing a notice of proposed rulemaking that will address Medicare coverage of services provided by rural health clinics, we must develop a definition of CP that is appropriate for practitioners who are employed by those entities. Under the rural health clinic benefit, the CP definition will take into account the shortage of psychologists with doctoral degrees in rural areas, particularly those designated as health professional shortage areas. We will not, however, discuss the requirements for CPs who are employed by rural health clinics in this final rule. Instead, the provisions of the definition for purposes of the rural health clinic benefit will be proposed in a separate notice of proposed rulemaking.

Comment: Many professional organizations and psychologists commended us for proposing a more comprehensive definition of a CP by removing the previous requirement that an individual must hold a doctoral degree from a program in *clinical psychology*. They stated that our efforts to develop an improved definition will help to provide Medicare beneficiaries with access to basic mental health care. These commenters, in most cases, indicated whether their local carriers have been interpreting the CP definition on a case-by-case basis (while awaiting a final rule) to include practitioners who have clinical experience, even though their doctoral degrees are from another program in psychology.

On the other hand, many commenters from professional associations and organizations stated that the existing requirement that an individual must hold a doctoral degree from a program in *clinical psychology* should be restored and that the proposed definition, which does not specify that the doctoral degree must be from a program in clinical psychology, is inappropriate. These commenters questioned how we could ensure that other doctoral level psychologists who have graduated from programs such as neuropsychology or school, developmental, educational, comparative, experimental, and industrial psychology have the appropriate education and clinical training and experience to treat Medicare patients. These commenters believed that removal of the existing requirement for a doctoral degree from a program in *clinical psychology* could present a danger to the medically vulnerable Medicare population.

Some commenters stated that, for purposes of determining who qualifies as a CP under the Medicare program, we should recognize those psychologists who are listed as health service providers in the National Register of Health Service Providers in Psychology, and they pointed out the following. The National Register is a way of identifying many clinicians who graduate with degrees from programs that do not specify the word ''psychology'' in their title, but are clearly programs in psychology. The Civilian Health and Medical Program of the Uniformed Services, which is another Federally funded and managed program, references the National Register as a mechanism for identifying CPs. Also, some States have added a certification to the psychology license that designates psychologists trained and experienced in the provision of clinical services as health service providers.

Response: We realize that there are many psychologists who, although their doctoral degree is labeled other than ''clinical psychology,'' graduated from psychology programs that provided them with the appropriate knowledge, training, and experience in clinical psychology. We are very concerned that we not indirectly deny beneficiaries access to the care of qualified psychologist services solely because the degree that a practitioner has earned is labeled something other than ''clinical psychology.'' Based on our carriers' experience in interpreting the CP definition on a case-by-case basis, we do not agree with those commenters who believe that removal of the existing requirement for a doctoral degree from a program in ''clinical psychology'' presents a danger to the Medicare population.

We believe that the National Register is a mechanism that can be instrumental in identifying psychologists who are qualified to furnish qualified psychologist services. We do not believe, however, that it should be used by carriers as the sole criterion to determine who is qualified to furnish psychologist services under the Medicare program because listing is optional and requires payment of a fee by the practitioner. Also, the register lists nonphysician practitioners who have received some clinical training and experience from programs that are not designated as *psychology* programs.

While we have made allowances for the types of psychology programs that can qualify a practitioner under Medicare's CP benefit, we require that the individual's doctoral degree at least be from a program that is designated as a *psychology* program. The CP benefit was created as a discrete benefit for *psychologists*, and not nonphysician practitioners who may receive some clinical training as part of their doctoral degree programs. We believe that Congress would have to create a separate benefit to recognize practitioners whose degrees are in a field other than psychology.

Therefore, in this final rule, we specify that an individual who seeks qualification as a CP must hold a doctoral degree in psychology.

2. The Doctoral Degree in Psychology Must Be From an Accredited Program

Comment: Many commenters stated that the requirement, under our CP definition, for institutional accreditation should be restored. In fact, many physicians opposed the proposed revisions to the CP definition because they believed the revisions are inappropriate in that they would remove the requirement that the doctoral degree program be from an educational institution that is accredited by an agency recognized by the Commission on Recognition of Postsecondary Accreditation (previously known as the Council on Postsecondary Accreditation). They believed that to ensure the quality of the psychology doctoral program these programs must be housed in accredited institutions of higher learning and be university-based. Additionally, they stated that merely requiring that a doctoral degree in psychology be from an accredited program is too open-ended because it does not specify who must perform the accreditation function. They maintain that our proposed requirement potentially dilutes the quality of psychologists who are eligible to treat Medicare patients.

Many psychologists and professional associations in California commented that the accreditation requirement in the original and the proposed CP definition would pose a serious problem for about one-fourth of the psychologists in California. The affected psychologists would be those whose doctoral degrees in psychology are either from schools that are not *regionally accredited* by the Commission on Recognition of Postsecondary Accreditation or are from psychology programs that are not accredited. These commenters stated that approximately one-fourth of the licenses granted by the Board of Psychology in California, for the period beginning January 1990 through 1991, were to psychologists who are graduates of State *approved* doctoral programs in psychology. The commenters further

stated that many of the institutions that house State approved psychology programs were specifically developed to train psychologists in clinical applications of health care. (The State of California regulates these institutions and their programs through the Council for Private Postsecondary and Vocational Education.) These commenters suggested that, in order to avoid inadvertently eliminating otherwise qualified professionals from participating in the Medicare program because of a semantic problem, we amend our proposed definition to require that a CP hold a doctoral degree in psychology from an accredited or State approved program.

Response: We have thoroughly examined the academic accreditation or approval requirements imposed by the various States for licensure or certification of psychologists. The wide degree of variation in the specifics of State requirements makes creation of a uniform Federal standard infeasible. We have concluded that reliance on State licensure or certification requirements provides adequate assurance that an individual's doctoral degree was obtained from a program that met appropriate academic standards.

3. The Individual Must be Licensed or Certified at the Independent Practice Level of Clinical Psychology by the State in Which He or She Practices

Comment: We received very many comments pertaining to the above requirement, which is included in the proposed CP definition. We were informed that 48 States generically license psychologists at the independent practice level of *psychology*, not *clinical* psychology and that the States, in the vast majority of cases, do not employ concepts of what constitutes ''clinical psychology.'' On the other hand, we received many comments that the addition of the word ''clinical'' to this requirement regarding State licensure and certification at the independent practice level actually strengthened the requirement overall.

Response: We have learned from the commenters, and as a result of our own investigation, that State licensure or certification laws are broadly based and, in combination with regulatory requirements for licensing or certifying psychologists, limit the scope of psychologists' activities to those for which they have received appropriate education, training, and experience. Additionally, the licensing law of every State either incorporates an ethics code or a State board's disciplinary code that makes it illegal for a psychologist to practice in an area for which he or she has not received training. Accordingly, to the extent that a psychologist, regardless of the type of doctorate possessed, were to provide services for which he or she had not received appropriate education and training, that psychologist would be practicing outside the scope or his or her competence and would be subject to both legal and ethical sanctions.

By inserting the word, ''clinical'' into this requirement under the proposed CP definition, we would exclude all of the otherwise-qualified psychologists in 48 states from participating under the Medicare program. Therefore, in this final rule we amend this requirement to specify that an individual who seeks qualification as a CP under Medicare must be licensed or certified at the independent practice level of psychology by the State in which he or she practices.

4. The Psychology Program Must Prepare the Candidate to Practice Clinical Psychology by Providing Appropriate Clinical Psychology Training

Comment: Several commenters believed that, to guard against erroneous interpretations, we need to further clarify the term ''clinical psychology training.'' They stated that, as written, this section uses the terms ''clinical psychology'' and ''clinical psychology training'' to describe a ''clinical psychologist.'' The commenters believe that the fact that no further explanation of these terms is provided could create considerable, but unnecessary, ambiguity in the definition. Therefore, these commenters have suggested a provision that they believe clarifies that the term ''clinical psychology training'' means education and practical experience that prepares the psychologist to provide diagnostic, assessment, preventive, and therapeutic services directly to individuals. It was suggested that this sentence be added to the end of this particular requirement under the CP definition.

Response: We believe that this suggestion clarifies the intent about the emphasis on the term ''clinical psychology.'' We wanted to stress that psychologists who furnish services under this benefit must have the education and experience to furnish diagnostic testing and assessment services and preventive or therapeutic intervention services directly to individuals whose mental growth, adjustment, or functioning is impaired or at risk of impairment. Accordingly, we believe that the focus should be on the actual observation and treatment of patients by the psychologist much more so than on services or work that is theoretical or experimental. In addition, we believe that the key element is the scope of practice authorized by State licensure or certification. Therefore, we are clarifying in this final rule that the individual must be licensed to furnish diagnostic, assessment, preventive, and therapeutic services directly to individuals.

5. The Individual Must Possess 2 Years of Supervised Clinical Experience, at Least 1 Year of Which is Postdoctoral Degree Experience

Comment: Many commenters stated that the above requirement should specify a minimum total number of hours for the required supervised clinical experience. These commenters stated that some States, for example, Florida, Kentucky, and Washington, require a specific number of hours, with Florida requiring 2 years or 4,000 hours of supervised experience. These commenters believed that establishment of a requirement for 2 years/4,000 hours of supervised experience for CPs would put in place a mechanism that would serve to protect the Medicare population.

A few commenters, however, stated that it is possible that the requirement under the proposed CP definition would eliminate doctoral level psychologists who lack a postdoctoral year of supervised clinical experience because they were licensed as a psychologist at the master's level and received their doctoral degree later in their career.

Response: All States have licensure/certification requirements for supervised experience, but they vary in terms of specific details. Therefore, adoption of a uniform Federal standard is not feasible. We have concluded that reliance on State licensure or certification requirements provides adequate assurance that an individual has completed appropriate supervised clinical experience.

6. The 2 Years of Supervised Clinical Experience Must Have Been Supervised by a Psychologist Qualified at the Doctoral Level

Comment: Many commenters expressed concern that the above requirement could inadvertently exclude a number of qualified psychologists from participating under the Medicare program. They explained that some highly qualified, doctorally trained psychologists who have been in practice for a long time received their clinical supervision from licensed master's level psychologists in States where licensed master's level supervision was, and continues to be,

acceptable to State licensing boards. Therefore, these commenters suggested language that reads, ''a CP must possess 2 years of supervised clinical experience, at least one of which is postdoctoral degree experience, and the supervision as provided by a *licensed psychologist*.'' We also received a suggestion that we recognize supervision that was provided by a physician.

Many commenters also stated that our proposed requirement would place an onerous task on Medicare carriers because it requires them to determine who provided the supervision of the psychologist's clinical experience.

On the other hand, many other commenters stated that the requirement pertaining to who supervises the clinical experience should be strengthened. These commenters stated that we should require that the clinical experience be supervised by a CP who has a doctorate degree in *clinical* psychology. Their rationale for strengthening this requirement is that if someone is going to learn about clinical practice from a supervisor, that supervisor is a superior teacher if he or she is licensed in what he or she is teaching/supervising.

Response: By relying on State licensure or certification (see previous response) this level of detail need not be addressed by a Federal standard.

7. Grandfathering Master's Level Psychologists

Comment: Many commenters expressed concern about whether this final rule will grandfather those psychologists who were grandfathered under their State's original licensing laws. They were concerned that the proposed CP definition would restrain the practice of some psychologists who have been practicing for at least 20 years prior to the implementation of the CP benefit. According to some comments we received on the grandfathering issue, the criteria that some States used to determine who was qualified for grandfathering was based on whether the individuals could demonstrate that they had an established practice in psychology for a number of years followed by a successful performance on the national licensing examination. The commenters stated that, while few independently practicing master's level psychologists remain in practice today, those who are still practicing would be excluded under the proposed CP definition from participating in the Medicare program. These commenters requested us to accept, for the purpose of qualifying psychologists under Medicare, certification as a health service provider for master's level psychologists who were grandfathered and have been practicing since State licensure laws went into effect and who are listed in the National Register of Health Service Providers in Psychology.

Response: The State licensing boards that adopted grandfathering clauses used criteria that varied from State to State to determine who qualified. Also, there was no one time period for purposes of grandfathering because all State licensing boards did not implement licensing laws for the psychology profession concurrently. Thus, there has been no uniformly recognized standard for grandfathering. Moreover, as discussed at length in our earlier response regarding the requirement for a doctoral degree, we do not believe it is appropriate to recognize as a CP any practitioner who lacks a doctorate. The few remaining masters level psychologists who have been grandfathered to practice in their individual States have not been recognized as CPs under our current instructions in the Medicare Carriers Manual. Therefore, continuing their exclusion from Medicare should not disrupt their practices and will have negligible impact on the overall availability of services to beneficiaries.

Comment: We also received several comments appealing to us to grandfather into the final rule those psychologists that, before publication of the final rule, carriers had determined were qualified as CPs. (On an interim basis, carriers were granted the discretion to interpret, on a case-by-case basis, the CP definition to include psychologists with doctoral degrees in psychology programs that were labeled other than ''clinical psychology'' provided they met all the other definitional requirements. Conversely, carriers had the discretion to adhere strictly to the requirement which stipulates that a CP must have a doctoral degree from a program in clinical psychology. During this interim measure, many psychologists who would have otherwise been excluded from coverage were granted provider numbers by carriers to participate in the Medicare program as CPs.) These commenters would like to ensure that coverage of these psychologists' services is not discontinued as a result of the provisions of the final rule.

Response: We do not believe that it is necessary to specify in this final rule that those psychologists who carriers qualified as CPs prior to the promulgation of this final rule must be grandfathered under the final CP definition. We believe that the decisions carriers have made about qualifying individuals as CPs, using the discretion that we granted them in the interim (which was to choose to issue provider numbers to psychologists with doctoral degrees from psychology programs labeled other than ''clinical psychology'' provided the individual had the appropriate knowledge, training, and experience in clinical psychology) will not conflict with the CP definition under this rule and will not require a reversal of their decisions.

8. Retraining of Psychologists

Comment: Many commenters strongly asserted that we should not establish standards for retraining psychologists to qualify for coverage under Medicare, as this could intrude or undermine State licensure and scope of practice authorities as well as accredited educational institutional training programs. They believed that we should limit Medicare coverage to CPs who qualify based on the current requirements. These commenters stated that there is no congressional mandate for us to establish new education and training criteria in order to cover nonqualified psychologists under Medicare. In fact, these commenters challenged us about our mission by questioning whether we plan to become a psychology training and payment agency. Lastly, they characterized our proposal to cover the services of psychologists who retrain as ''ridiculous'' and a wasteful expenditure of taxpayer's funds.

Conversely, we received as many or even more comments stating that the opportunity for professional retraining by psychologists is of great value to society, because it encourages and facilitates the unique contributions that can be made by psychologists with broadly diversified backgrounds. These commenters stated that they very much appreciate our acknowledgment that appropriate retraining should enable a psychologist to qualify for Medicare coverage purposes.

The latter commenters informed us, however, that the psychology profession refers to retraining as ''respecialization.'' They clarified that, under the respecialization process, psychologists receive a certificate, not a second doctoral degree as we stated in the preamble to the proposed rule. Also, in response to our request (under this particular proposal) for standards for retraining programs that prepare candidates to practice clinical psychology, these commenters have referred us to the professional, official standards in place that were established by the American Psychological

Association's Committee on Accreditation.

Response: We have concluded that there is no need to create a special provision to address this situation. This issue is generally rendered moot by our decisions not to specify a degree in ''clinical'' psychology but to rely on State licensure or certification. Individuals who have respecialized can qualify if they meet our criteria.

9. Summary

In summary, as a result of our consideration of public comments, proposed § 410.71(e)(1) is designated as § 410.71(d) and is revised to specify that a CP is an individual who—

(1) Holds a doctoral degree in psychology; and

(2) Is licensed or certified, on the basis of the doctoral degree in psychology, by the State in which he or she practices, at the independent practice level of psychology to furnish diagnostic, assessment, preventive, and therapeutic services directly to individuals.

B. Diagnostic Psychological Tests

We stated in the proposed rule that we will continue to cover diagnostic psychological tests under section 1861(s)(3) of the Act as a discrete benefit under the Medicare program. We intend to continue to cover these tests when furnished by any psychologist who is licensed or certified to practice psychology in the State or jurisdiction where he or she is furnishing services or, if the jurisdiction does not issue licenses, if provided by any practicing psychologist.

We explained in the proposed rule that we plan to do a separate rulemaking that will address the qualifications for persons who perform diagnostic psychological tests and that, at that time, we will invite public comments on this issue. In the meantime, however, we invited public comment on methods to employ that will control the potential for excessive use of psychological testing. We received a number of suggestions. We thank the respondents, and we will consider their comments as we develop the separate rulemaking.

C. Services Furnished as an Incident to CP Services (§ 410.71(a)(2))

Comment: We received comments from a professional association stating that the requirement under the ''incident to'' benefit that calls for the provision of services under the direct supervision of the CP (that is, the CP must be physically present in the office suite and immediately available) hampers the ability of the CP to provide necessary mental health services in an effective and efficient manner. This association believed that all ''incident to'' services should be performed under the direct supervision of the CP; it did not believe, however, that direct supervision requires the physical presence of the CP. The association claimed that mental health services are different from many health services that pertain exclusively to physical health. Therefore, according to the association, the CP's presence is not appropriate in this arena because mental health services are unlikely to create a risk that would necessitate the CP's immediate physical presence. This association believed that a more reasonable standard would require that the CP be readily available by telephone for consultation, if necessary, as is the customary practice in the profession. It believed that this would provide complete protection to the patient without impeding the ability of the psychologist to perform other services.

On the other hand, we received comments from a State psychological association that maintained the requirement that the CP be immediately present and available is appropriate. It stated, however, that the reference to the ''office suite'' is dated and no longer justified. The association recommended that the reference be removed because it seems to preclude services to patients in skilled nursing facilities or in settings other than an office.

Lastly, regarding the direct supervision requirement under the ''incident to'' benefit, one psychologist commented that the requirement is not clear about whether the CP should be in the building during the time of services.

Response: The statute limits coverage to services that would be covered if furnished as an incident to a physician's services. Therefore, we are using the same standard for ''incident to'' that applies to physicians, including mental health services that are furnished as an incident to a physician's service. That standard, as currently reflected in section 2050.1.B of the Medicare Carriers Manual (HCFA Pub. 14–3), states that ''supervision in the office setting does not mean that the physician must be present in the same room with his or her aide. However, the physician must be present in the office suite and immediately available to provide assistance and direction throughout the time the aide is performing services.'' We did not mean to imply, however, that ''incident to'' services must always be furnished in the office suite, and this final rule revises proposed § 410.71(a)(2)(iv) to clarify this point. As an example, a CP could directly supervise a service performed outside the office suite (such as in an SNF) if the CP is in the room with the aide while the aide performs the service. This also parallels the physician standard as expressed in section 2050.IB, which indicates that the requirement for direct supervision of a service performed in an institution is not satisfied merely by the physician being available by phone or being present somewhere in the institution.

Comment: One psychologist asked which services furnished by CPs in the hospital setting remain bundled and which services are unbundled. (''Bundled'' is a term used to indicate that payment for the service is included in the payment made to the hospital.) He was particularly interested in whether services furnished as an incident to the professional services of a CP are bundled into the payment that hospitals receive for their services.

Response: Coverage and payment for the direct professional services of a CP are unbundled by law from hospital services. Therefore, a CP (or the hospital on behalf of the CP) must bill the carrier for the direct professional services furnished to hospital patients. The payment that is made to hospitals for ''hospital services'' no longer includes payment for the professional services of CPs. However, coverage of services furnished in the hospital setting as an incident to the professional services of CPs remains bundled.

D. The Outpatient Mental Health Treatment Limitation (§ 410.155)

Comment: We received numerous comments on various issues pertaining to the limitation from a major professional association stating that we should use different terminology regarding the limitation when discussing how it applies to the services of physicians. First, the association suggested that when referring to the services of physicians, we use the term ''psychiatric medical services,'' instead of the term ''mental health treatment services.'' It believed that the term ''mental health treatment'' is appropriate only for psychologists. In addition, this association recommended that we consider revising the phrase, ''mental, psychoneurotic, and personality disorders'', and that, instead, we use the current language contained in the American Psychiatric Association's Diagnostic and Statistical Manual.

Second, this association pointed out that the listing of services that are exempt from the limitation is inaccurate and incomplete because it does not contain the diagnosis and medical

management of patients with Alzheimer's Disease or other related disorders. It stated that, for years, section 2472.4 of the Medicare Carriers Manual has listed these services among those excluded from the application of the limitation. Also, it believed that the appropriate interpretation of the statutory exclusion for monitoring or changing drug prescriptions used in the treatment of a *mental illness or mental disorder* should include the decision as to whether to prescribe such a drug. Thus, the association stated that the exclusion should read, ''brief office visits for the purpose of prescribing, monitoring, or changing drug prescriptions used in the treatment of a mental illness or mental disorder.''

Third, this association stated its belief that the limitation should apply to partial hospitalization services furnished by CPs, as it pertains to partial hospitalization services furnished by physicians.

Fourth, this association commented that the example under paragraph (d) of this section is incorrect. It believed that the $100 deductible should apply against the approved amount—$750 first; then the remaining $650 should be subject to the 62.5 percent limitation. Additionally, it suggested that we provide examples under this paragraph to illustrate single assigned and unassigned claims for both inpatient and outpatient services.

We received several other comments from psychologists on the limitation expressing that the limitation should be eliminated, that it should *never* apply to psychological testing, and that the limitation on treatment services requires patients to make higher copayments than many of them can afford, therefore forcing these patients to seek inpatient mental health care as a more affordable alternative.

Response: With regard to the association's first comment, we believe that no purpose would be served under the Medicare program by accepting, as suggested, the artificial distinction in terminology when discussing the services of physicians versus the services of CPs and CSWs. However, we are not defining the phrase ''mental health treatment,'' but rather adhering to the statutory language regarding expenses in connection with the treatment of a mental, psychoneurotic, or personality disorder. Clearly physicians, psychologists, and other practitioners all may furnish that treatment.

We agree that medical management for patients diagnosed with Alzheimer's disease or related conditions is not subject to the limitation and have added this exception to the list. Psychotherapy for these conditions, however, is subject to the limitation. This reflects current policy as stated in section 2472.4 of the Medicare Carriers Manual.

With regard to revising the wording that pertains to brief office visits for monitoring or changing drug prescriptions, the initial decision as to whether to prescribe a drug is beyond the scope of this exception as authorized by the statute. Consequently we have not made the suggested change.

Regarding the concern about whether the limitation applies to ''partial hospitalization services furnished by CPs,'' the situation does not exist so the concern is moot. As specified in § 410.43(b), CP services are separately covered and are not paid as partial hospitalization services. Thus, CP services are subject to the limitation when they are furnished to patients of a partial hospitalization program.

We cannot accept the suggestion to eliminate the outpatient mental health treatment limitation. It is not within our administrative authority to eliminate the statutory limitation; elimination of this limitation would require a change in the law. Neither are we in a position to specify that the limitation should never apply to psychological testing. In fact, we understand that testing frequently is performed in order to evaluate a patient's progress. Clearly in those cases the testing is part of treatment and, thus, is subject to the limitation.

We disagree with the comment that the example under paragraph (d) is incorrect. The example is correct. The Act specifies, at section 1833(c), that the limitation must be applied first in order to determine the amount of expenses to which the deductible is applied. We have, however, expanded the examples to illustrate how the limitation applies to single assigned and unassigned claims for both inpatient and outpatient services. We have also made revisions to the examples to make them easier to understand.

E. The Consultation Requirement, CPs and CSWs (§§ 410.71(e)(2) and 410.73(d))

Comment: We received a great many comments from psychologists, social workers, and professional organizations representing these nonphysician practitioners that supported the general attestation/consultation requirement. However, these commenters overwhelmingly opposed the specific proposed requirements under the general requirement for an attestation/consultation.

One of their concerns addressed the proposed requirement that would require either the CP or CSW to make at least four attempts to consult directly with the primary care or attending physician prior to resorting to written notification. The commenters believed that this proposal exceeds what Congress envisioned in terms of a consultation requirement, and that it imposes an unreasonable, unnecessary, and unjustifiable burden on practitioners who participate in the Medicare program. They stated that their review of the OBRA 89 legislative history reveals that Congress envisioned *either* written *or* direct consultation, with no expressed preference for one over the other, and with no requirement that more than one attempt at direct consultation take place. Also, they made a position for enabling CPs or CSWs to use their professional judgement about whether and when to consult a patient's physician based on the needs of the patient, not the needs of the reimbursement system. They suggested that the system's needs must never be elevated above the patient's needs. Moreover, they suggested that *either* one successful direct attempt to consult by telephone or written notification is appropriate, sufficient, and consistent with congressional intent. However, we received many comments that were contrary to the position taken above, in that they supported the proposed requirement for written notification to the patient's primary care or attending physician if the CP or CSW failed after four attempts to telephone the physician.

Response: We agree with the suggestion that there needs to be changes or exceptions made to the proposed provisions of the consultation requirement. In view of this, we have reconsidered our approach about the method used by a CP or CSW to establish a consultation with a patient's primary care or attending physician. If the goal is that, if a patient consents, a consultation occur in a timely manner, it really does not matter whether the CP's or CSW's approach is by telephone or in writing. Our initial preference for telephone calls was that a telephone call solicits a more immediate response (provided that the physician is available) than sending a letter by mail to the physician and awaiting a response.

We realize that requiring four phone calls by the CP or CSW to the patient's primary care or attending physician could be burdensome. Accordingly, in this final rule we require that if the beneficiary assents to a CP or CSW consultation with his or her primary care or attending physician, the CP or CSW must attempt to consult the

physician within a reasonable time after receiving the beneficiary's consent to the consultation. If attempts to consult directly with the physician are not successful, the CP or CSW must notify the physician, within a reasonable time, that he or she is furnishing services to the beneficiary. We believe that this effort represents a sincere attempt on behalf of the practitioner to comply with the consultation requirement regardless of whether the physician responds to the request. Unless the primary care or attending physician referred the beneficiary to the CP or CSW, the practitioner must document in the patient's medical record the date the patient consented or declined consent to consultation, the date of consultation, or if attempts to consult did not succeed, the date and manner of notification to the physician.

Comment: Many commenters stated that the requirement that consultation occur within 1 week after obtaining the beneficiary's consent is unnecessarily burdensome and does not give consideration to patients who visit their practitioners less often than weekly. These commenters suggested that, instead, we require a consultation within the first month of treatment, with documented notification in writing. Other commenters suggested that we maintain our proposed requirement for a consultation within 1 week of the patient's consent and add that it must take place by the time treatment is initiated.

Response: As we revisited this issue, we concluded that it is not necessary to specify that the attempt at consultation occur within 1 week of the patient's consent. Our focus for the consultation requirement is on whether CPs or CSWs are aware of their patient's medical condition and any medications that they may be taking that could interfere with treatment of their patient. Therefore, this final rule requires that the attempt(s) at consultation be made within a reasonable time after receiving the patient's's consent.

Comment: The above group of commenters also stated that CPs and CSWs should be required to sign the attestation statement only once—when requesting a provider number under the Medicare program. The commenters believed that CPs and CSWs should not be required to make the same attestation statement annually thereafter and that having the original consultation attestation statement on file should be sufficient to document adherence to the consultation requirement. They believed that a requirement such as the one that was proposed, results in unnecessary paperwork, delays in services, and an undue burden on both the practitioner and the carrier. Therefore, they urged us to abolish the stipulation that requires a CP or CSW to resubmit an attestation statement on an annual basis.

Response: Initially, we viewed the proposed annual resubmission of the attestation statement as a way to remind CPs and CSWs both of the significance of the consultation requirement and that the requirement is a condition of payment for their services. We agree, however, that an annual attestation may be an onerous task for carriers and for CPs and CSWs who participate under Medicare. Thus, in reexamining this issue with a goal to reduce paperwork and information collection burden, we have concluded that a less burdensome approach is for us to accept the CP's or CSW's signature on the certification statement that is part of the provider/supplier enrollment application as an indication of his or her agreement to the consultation requirement. In signing that statement, the applicant certifies to, among other things, the following: ''I am familiar with and agree to abide by the Medicare laws and regulations that apply to my provider type, including the Conditions of Participation.'' Therefore, in this final rule, we require that the attestation occur only at the time the CP or CSW requests a provider number. Thus, there is no burden on CPs and CSWs who already have a provider number.

Comment: Several commenters believed that some exceptions to a mandatory consultation would be appropriate. First, they stated that the proposed rules do not take into account the situation in which a patient is a hospital inpatient or in a skilled nursing facility and is ordered or referred to the CP or CSW by his or her primary care or attending physician. The commenters pointed out that, in these cases, the patient's physician is aware of the mental health intervention and treatment and that communication in these settings takes place via orders, consultation notes, and progress notes that the physician reads. The commenters suggested that, under these circumstances, a consultation is unwarranted and, therefore, exceptions be made to the consultation requirement and the rules simply require a notation in the patient's chart regarding the consultation. Conversely, others commented that the consultation requirement should apply to patients in all settings and that the contact should be with the patient's primary and specialist physicians who are treating the patient.

Response: We disagree with the suggestion that we establish an exception to the consultation requirement for services that CPs or CSWs furnish to patients in the hospital and skilled nursing facility settings or that an exception to this requirement be made based on the site of services. However, we see no reason to require CPs or CSWs to initiate consultation in cases in which it is the patient's primary care or attending physician who actually refers the patient to the CP or CSW. For CPs or CSWs who receive a patient based on a physician's referral, we believe it is sufficient to require the practitioners to make a note to that effect on the patient's chart, including the referring physician's name. This final rule revises our proposed requirement accordingly. (Note also that this final rule designates proposed § 410.71(e)(2) as § 410.71(e).)

Comment: Many commenters expressed a concern about patients who do not wish the CP or CSW to consult with their primary care or attending physician. These commenters contend that patients who do not desire such a consultation should have the right to withhold consent. In addition, these commenters believed that a request for a consultation with a beneficiary's physician could violate that person's rights because it makes public to the physician that the person is seeking mental health services. Accordingly, these commenters have urged us to include a specific provision under the attestation statement to address situations wherein a patient refuses consent to a consultation between his or her CP or CSW and their primary care or attending physician.

Response: We believe emphatically that Medicare beneficiaries must have the right to refuse consent to a consultation between their practitioner and their primary care or attending physician. No beneficiary should ever be coerced to consent to such a consultation. In this final rule, at § 410.71(e)(3). We require that, if a beneficiary does not consent to the consultation, the date the beneficiary declined consent to the consultation be documented in the beneficiary's medical record.

Comment: Some commenters expressed concern about situations in which physicians do not respond to the request for a consultation because it is not a billable service. The commenters maintain that often physicians are not available for a consultation and are not eager to return a phone call or respond to a letter if they cannot bill the Medicare program for their efforts to participate in a consultation with their patient's CP or CSW. Therefore, the

commenters suggest that we allow for monetary compensation to the participants of the consultation, or make some allowance in the final rule for a notation in patient's records, of a good faith attempt by the CP or CSW to consult with the patient's primary care or attending physician. Other commenters maintain that CPs and CSWs should not be permitted to bill for the required consultation.

Response: We maintain that the consultation between the CP or CSW and the patient's primary care or attending physician is not a billable service for any of the professionals involved. In addition, as stated in the proposed rule, the House Ways and Means Committee report that accompanied OBRA '89 (H.R. Report No. 247, 101st Cong., 1st Sess. 1015) indicated that the Committee intended that the consultation not be a billable service. Accordingly, neither a CP, CSW, or physician can bill the Medicare program or the beneficiary for the consultation. Also, we have made allowances to provisions of the consultation requirement that will accommodate CPs and CSWs in situations in which they make a good faith attempt to consult with their patient's primary care or attending physician even though that effort is not reciprocated.

Comment: Finally, numerous commenters urged us to direct our carriers to conduct regular reviews to determine compliance with the consultation requirement and to ensure appropriate treatment is being provided by CPs and CSWs.

Response: We do not believe it is necessary to hold CPs and CSWs to a higher standard of review than is required for other health care professionals. For example, we do not believe it is necessary to require CPs to routinely submit documentation supporting their communication, or attempts to communicate, with the attending physician nor would we expect our carriers to conduct regular reviews of CPs and CSWs absent an indication that inappropriate treatment is being furnished. Carriers may request documentation and conduct reviews of CPs and CSWs, as they may for any other health professional, to determine that the services furnished are medically necessary.

F. Diagnostic Coding Used by CPs and CSWs (§ 410.155(a))

Comment: Many commenters suggested that diagnosis codes from the fourth edition of the American Psychiatric Association's, Diagnostic and Statistical Manual—Mental Disorders (DSM–IV) should be recognized in addition to, or instead of, diagnosis codes from ICD–9–CM. They pointed out that the DSM–IV code numbers are fully compatible with ICD–9–CM codes. On the other hand, several other commenters asserted that only ICD–9–CM diagnosis codes should be used when submitting claims.

Response: After reviewing the DSM–IV codes as published in May 1994 and comparing them to the 1997 version of ICD–9–CM codes, we have concluded that this is a distinction without a difference. With only two minor exceptions, which appear to be inadvertent errors, the numerical codes under both systems now are identical. Therefore, the Medicare claims processing system will accept diagnosis code numbers derived from DSM–IV (except for the two discrepancies noted below) because they are indistinguishable from ICD–9–CM code numbers. One discrepancy is that ICD–9–CM code 305.1 has an additional zero shown in the fifth position in DSM–IV. The other discrepancy is that DSM–IV lists code 312.8 but the 1997 version of ICD–9–CM requires an additional digit (1, 2, or 9) in the fifth position.

We had proposed, in § 410.155(a), to continue defining a ''mental, psychoneurotic, or personality disorder'' which is subject to the outpatient mental health treatment limitation as the specific psychiatric conditions described in the American Psychiatric Association's Diagnostic and Statistical Manual—Mental Disorders. Those conditions are represented in the code range 290 through 319. Since DSM–IV and ICD–9–CM code numbers are now compatible, we agree that it is appropriate to recognize a definition that is consistent with both coding systems.

Because the American Psychiatric Associations's Manual is updated periodically and ICD–9–CM is updated annually, it seems desirable to avoid specifying any particular edition of either coding system. Therefore, this final rule removes the definition of ''mental, psychoneurotic, or personality disorder'' from § 410.155(a), and, instead, specifies in § 410.155(b) that ''mental, psychoneurotic, or personality disorder'' means any condition identified by a diagnosis code within the range of 290 through 319. This should contribute to the ease of understanding and operational simplicity, as well as avoid the need to update the regulation merely due to periodic code revisions within the overall range.

In addition, we are removing proposed § 410.71(d) because that paragraph made distinctions, based on date of service, as to who may bill for CP services furnished to hospital inpatients. That distinction is no longer necessary.

In the preamble of the December 1993 proposed rule we stated our intent to require CPs and CSWs to use ICD–9–CM coding when submitting Medicare claims. However, as an oversight, we failed to state how we would revise our regulations to set forth this requirement. This final rule revises § 424.32(a)(2) to add that claims for CP services or CSW services must include appropriate diagnostic coding using ICD–9–CM. Since the numerical codes under both ICD–9–CM and DSM–IV are identical, this should not create a burden for the submitters of claims.

G. The Clinical Social Worker Definition (§ 410.73(a))

Comment: We received several comments informing us that, while all States provide for some form of licensure or certification, not all States use the term ''clinical social worker'' to refer to master's or doctorate level social workers who have been licensed by the State. For example, in Kentucky the highest level of State licensure is called ''Independent Practice (Clinical).'' Accordingly, no person may hold himself or herself out to the public as a CSW in Kentucky unless he or she has been certified for independent practice by the Kentucky State Board of Examiners. The commenters asked whether a Board certified person in Kentucky would be recognized under Medicare as a CSW entitled to provide services under the program if the individual is not literally licensed as a CSW.

We were similarly informed that, in New York the title awarded by the State to individuals who meet the CSW qualifications is ''Certified Social Worker.'' It was suggested, therefore, that the easiest way to address the lack of uniformity of titles for social workers would be to amend one of the requirements under the CSW qualifications to read that the individual is either licensed or certified as a CSW (or at the highest level of practice provided by State law).

Response: We understand this concern, but the proposed definition was based on explicit language in the Federal statute. Therefore, we will continue to provide, as one way of meeting the definition, licensure or certification specifically as a CSW. However, under the authority of section 1861(hh)(1)(C)(ii)(II) of the Act, this final rule provides an alternative route to Medicare qualification. That is, this

final rule revises proposed § 410.73(a)(3) to provide, in the case of an individual in a State that does not provide for licensure or certification *as a clinical social worker*, that the individual meets the definition of ''clinical social worker'' if the individual—

- Is licensed or certified at the highest level of practice provided by the laws of the State in which the services are performed; and
- Has completed at least 2 years or 3,000 hours of post master's degree supervised clinical social work practice under the supervision of a master's degree level social worker in an appropriate setting, such as a hospital, SNF, or clinic.

Thus, individuals in States such as Kentucky or New York can qualify as CSWs.

H. Definition of CSW Services (§§ 410.73(b) and (c)(2))

In the December 1993 proposed rule, we discussed the difficulty we encountered in addressing the statutory definition of CSW services that excludes services furnished to SNF inpatients that an SNF is required to provide as a requirement for participation. We invited public comment and suggestions on the question of whether it is possible to identify any CSW services (that is, services that would be covered if furnished by a CSW to other than hospital or SNF inpatients) that an SNF is not required to provide.

Although, we asked specifically for comments on the SNF social services versus CSW services issue, we also received comments about the statutory coverage exclusion of CSW services to hospital inpatients.

Comment: One professional association commented, on behalf of social workers, that the proposed rule places an unnecessary emphasis on the site of services, rather than the availability of CSW services to Medicare beneficiaries. This association contends that section 1861(hh)(2) of the Act provides the specificity to avoid the confusion between social services and CSW services by limiting direct payment under the Part B outpatient mental health benefit to the diagnosis and treatment of mental illnesses as performed by CSWs who meet the qualifications of section 1861(hh)(1).

Additionally, this association asserted that the diagnosis and treatment of mental illnesses is not analogous to the broad range of tasks expected of an SNF's social services staff and neither is it analogous to the overall requirement that the SNF provide medically related social services to attain or to maintain the highest practicable physical, mental, or psychosocial well-being of each resident. It also asserted that, if this analogy were true, the need for clarification would extend far beyond the issue of reimbursement for CSW services in SNFs; the issue would become whether payment, under Part B, would be allowed for the diagnosis and treatment of mental illnesses of SNF residents by any mental health professional recognized by the statute, including CPs and psychiatrists.

Therefore, this association stated that, when submitting Medicare Part B claims, CSW services may be easily distinguished from the social services requirement of SNFs by the use of the ICD–9–CM coding system to describe the diagnosed mental illnesses and mental disorders, with the therapeutic services furnished reported using the appropriate CPT psychiatry codes. (CPT stands for [Physicians'] Current Procedural Terminology, 4th Edition, 1993 (copyrighted by the American Medical Association).) The association stated its belief that some functions of the SNF social services staff could be described by the E/M (evaluation/management) CPT codes, rather than the CPT psychiatry codes.

One commenter expressed the opinion that the qualifications required of a social worker who is hired by an SNF to furnish social services are far less than those of a CSW. A national federation representing CSWs commented that the social work services that SNFs are required to provide without additional charge to the patient include psychosocial assessment and treatment planning, linkage with other professional and community services, and supportive counseling; they do not include the formal diagnosis and treatment of mental or emotional disorders. Therefore, they have recommended that, whenever CSWs independently diagnose or treat a mental or emotional disorder, these services be paid separate and apart from the payment to the facility. This federation also suggested that separately paid services can be easily distinguished from social services by reference to the appropriate Medicare procedure codes; namely, 90801 for diagnosis and 90841 through 90853 for treatment.

One medical center recommended that social services that are required under the SNF requirements for participation include: psychosocial assessment, discharge planning, general casework services, case consultation, community contacts, patient correspondence, and patient referral. In contrast, CSW services that would be covered when furnished to SNF patients would include: individual therapy (treatment of adjustment disorders, personality disorders, psychoneurosis, and complicated grief/illness reactions), crisis intervention, family therapy, and group therapy.

Lastly, one professional association commented that it recognized our difficulty in distinguishing the SNF required social services from CSW services when furnished in an SNF setting. This association suggested that we consider using information contained in the Pre-Admission Screening and Annual Resident Review instrument or the annual resident assessment instrument to assist in documenting variances between these services.

Response: The emphasis on site of service is directly due to the distinctions that the statute makes on that basis. We must reiterate that the definition of CSW services in 1861(hh)(2) excludes services furnished to an inpatient of an SNF which the facility is required to provide as a requirement for participation.

We agree with the general consensus that medically related social services for SNF residents, identified in section 1819(b)(4)(A)(ii) of the Act and at 42 CFR 483.15(g), should not be covered as CSW services. These services involve assisting residents in maintaining or improving their ability to manage their everyday physical, mental, and psychosocial needs. They include discharge planning, counseling, assessment, and care planning. These services generally do not require performance by a CSW.

However, the commenters did not acknowledge that section 1819(b)(4)(A)(i) requires an SNF also to provide specialized rehabilitative services in order to fulfill the resident's plan of care. These services include mental health rehabilitative services for mental illness, as detailed in § 483.45. Our guidance to surveyors describes the intent of this requirement in the following terms: ''Specialized rehabilitative services are considered a facility service and are, thus, included within the scope of facility services.'' These services are described in the guidelines as including (among other services) individual, group, and family psychotherapy.

Individual and group psychotherapy comprise nearly all the services for which Medicare pays CSWs, in covered settings. As noted, these services are among the specialized mental health rehabilitative services that SNFs are required to provide. While data indicates that very few CSWs furnish services to SNF inpatients, that does not

diminish the fact that the few services they do furnish in SNFs are services that SNFs are required to provide.

The procedure codes used on Part B Medicare claims include CPT codes as a subset of the HCFA Common Procedure Coding System (HCPCS). No meaningful distinction regarding services furnished by CSWs to SNF inpatients can be made based on the use of HCPCS psychiatry procedure codes, because the same codes are used to report CSW services in various settings.

We cannot accept the suggestion that CSWs should be paid separate and apart from payment to the SNF for independently diagnosing or treating mental disorders of SNF patients, nor can we accept the suggestion that psychotherapy services furnished by CSWs to patients who have diagnosis codes indicating mental illness should be covered as CSW services rather than viewed as services that SNFs are required to provide. SNFs are explicitly required to provide not only medically related social services, but also mental health rehabilitative services for mental illness, as detailed in § 483.45.

We could not determine how information in the Pre-Admission Screening and Annual Resident Review instrument, or in the annual resident assessment instrument, could be used to distinguish any services that SNFs are not required to provide.

With respect to the concern regarding the distinction between services furnished to SNF inpatients by CSWs and similar services furnished by CPs and physicians, we must point out that this distinction is based on the statutory parallels between hospital and SNF services. Section 1861(b) of the Act excludes the services of physicians and CPs from coverage as inpatient hospital services, yet 1862(a)(14) of the Act compels a hospital to include CSW services in its billing. Section 1861(h) of the Act defines extended care services (the inpatient services for which SNFs are paid under Part A) as excluding any service that would not be included under 1861(b) if furnished to an inpatient of a hospital. Thus, the services of physicians and CPs are likewise excluded from coverage as SNF services, while the services of CSWs can be included.

The statute uses the identical term, ''medical social services,'' in defining both inpatient hospital services and extended care services. For hospitals, this term implicitly includes the full range of services furnished by CSWs. There is no basis for concluding that the term has a different meaning for SNFs.

Although physicians and CPs can be paid directly for services they furnish to SNF inpatients, CSWs are subject to a statutory restriction. The fact that a physician or CP can be paid directly for certain services does not lead to a conclusion that a CSW should be paid directly for similar services despite the CSW benefit restriction. An SNF cannot include physician or CP services as facility services, but it can include services performed by a CSW in its facility services.

After thoroughly examining this issue and the suggestions received, we are unable to identify any specific service performed by CSWs for SNF inpatients that SNFs are not required to provide. Consequently, we conclude that CSW services exclude all services furnished to SNF inpatients.

Comment: A major professional association commented that it is aware that medical social services are required services in hospitals and that medical social services are bundled into the hospital's payment rate. However, neither the Medicare statute nor regulations define the medical social services requirement nor the qualifications of professionals who may provide these services in the hospital. Accordingly, this association is concerned about the bundling issue as it relates to the Medicare Part B outpatient benefit for CSW services, particularly in psychiatric hospital outpatient departments. Therefore, the association asked that, if the diagnosis and treatment of mental illnesses and mental disorders provided by CSWs are indeed factored into the hospital's overall payment rate, how are CSW services currently mandated in outpatient hospital settings and what are the quality assurance mechanisms that ensure CSW services are made available to Medicare beneficiaries in hospital outpatient departments.

Response: In regard to the question about whether CSW services are currently mandated in the hospital outpatient setting, there is no mandate specifically for CSW services in this setting. However, the quality assurance conditions of participation for hospitals (which apply to both the inpatient and outpatient setting) under § 482.21(b) require the hospital to have an ongoing plan, consistent with available community and hospital resources, to provide, or make available, social work, psychological, and educational services to meet the medically related needs of its patients. The hospital must also have an effective, ongoing discharge planning program that facilitates the provision of followup care. Furthermore, the hospital must take and document appropriate remedial action to address deficiencies found through the quality assurance program, as well as document the outcome of the remedial action taken.

In addition to meeting the same quality assurance conditions of participation as general hospitals, psychiatric hospitals must meet the conditions at § 482.62 that pertain to the special staff requirements for psychiatric hospitals. Section 482.62(f) requires psychiatric hospitals to have on staff a director of social services who monitors and evaluates the quality and appropriateness of the social services furnished. The services must be furnished in accordance with accepted standards of practice and established policies and procedures.

The director of the social work department or services must have a master's degree from an accredited school of social work or must be qualified by education and experience in the social services needs of the mentally ill. If the director does not hold a master's degree in social work, at least one staff member must have this qualification. Additionally, the social service staff responsibilities must include, but are not limited to, participation in discharge planning, arranging for follow-up care, and developing mechanisms for exchange of appropriate information with sources outside the hospital. Conceivably, a CSW could serve as a social services staff director or staff member of a psychiatric hospital.

Comment: Another commenter suggested that the coverage exclusion of CSW services furnished to hospital inpatients under the Part B CSW benefit not pertain to nonparticipating hospitals. As rationale, the commenter stated that, since nonparticipating hospitals receive no Part A payment, there would be no risk of duplicate payment by both the intermediary and the carrier. Therefore, the commenter concluded that Medicare should make payment under Medicare Part B to nonparticipating hospitals for CSW services.

Response: We agree that, because ''bundling'' is not an issue for nonparticipating hospitals, there is no risk of duplicate payment in the case of services furnished in nonparticipating hospitals. However, we disagree with the conclusion the commenter reached concerning to whom payment should be made. Because the services of a CSW furnished to a patient in a nonparticipating hospital are covered, under section 1861(s)(2)(N) of the Act, as ''medical and other health services'' payment for these services is made directly to the CSW. This final rule clarifies that CSW services do not

include services furnished to inpatients of a Medicare participating hospital.

I. CSW Services Furnished in End Stage Renal Disease facilities (§ 410.73(c)(3))

As stated earlier, payment for social worker services is included in the composite rate payment made to the dialysis facility. Therefore, CSWs cannot bill directly for those services. We invited public comment, however, on whether any CSW services to dialysis patients can be distinguished from the required facility services.

Comment: A national federation representing CSWs commented that CSW services furnished in ESRD facilities should be treated the same way they are treated when furnished in SNFs. That is, whenever CSWs independently diagnose or treat a mental or emotional disorder, these services should be paid separately and apart from the composite rate paid to the ESRD facility. The federation recommended that CSW services be distinguished from ESRD required social worker services by reference to the appropriate Medicare procedure codes; namely, 90801 for diagnosis and 90841 through 90853 for treatment.

Similarly, another commenter recommended that the same guidelines and payment be established for CSW services under Part B to dialysis patients as those established for CSW services to SNF patients. Many dialysis patients, especially newly diagnosed or unstable patients, require and benefit from individualized CSW services. This commenter believed that the composite rate currently paid to dialysis facilities does not come close to covering these specialized services and therapy for treatment of a mental, psychoneurotic, or personality disorder.

Response: After examining the issue of CSW services to SNF inpatients, it is apparent that the issue of CSW services for patients of dialysis facilities differs significantly. The statutory site-based restrictions on CSW services apply only to inpatient settings—inpatient hospital and inpatient SNF. Inpatient facilities are expected to meet all of their patient's needs (including both social services and specialized rehabilitative services). In contrast, the statutory definition of CSW services does not restrict CSW professional services in other settings, such as dialysis facilities.

Dialysis facilities are expected to meet solely dialysis-related needs. Dialysis facilities are required, at § 405.2163(c), merely to provide ''social services'' that are directed at supporting and maximizing the social functioning and adjustment of the patient. Under these dialysis facility required social services, a qualified social worker (who need not be a CSW) is responsible for conducting psychosocial evaluations, participating in team review of patient progress and recommending changes in treatment based on the patient's current psychosocial needs, providing casework and groupwork services to patients and their families in dealing with the special problems associated with ESRD, and identifying community social agencies and other resources and assisting patients and families to use them. A dialysis facility, however, is not required to provide the full scope of services comparable to the specialized rehabilitative services for mental illness that section 1819(b)(4)(A)(i) of the Act requires an SNF to provide.

Accordingly, it would not be appropriate to require that all services that a CSW might furnish to a dialysis patient be bundled into the composite rate. Therefore, it is appropriate for a CSW to bill the Part B carrier separately for only those individualized professional mental health diagnostic and treatment services furnished to dialysis facility patients that are not included in the composite rate. This retains the current policy; CSWs have been permitted to bill the carrier directly for their individual professional mental health diagnostic and treatment services that do not reflect services that are included in the ESRD composite rate. However, carriers will deny any claims for services that reflect the dialysis-related social services that dialysis facilities are required to provide under § 405.2163(c). Thus, there will be no change in coverage for CSW services furnished to patients in dialysis facilities.

J. Regulatory Impact Analysis

We received comments concerning the regulatory impact analysis. We present and respond to those comments in section VI. of this document.

IV. Provisions of the Final Rule

The proposed rule is adopted, with the changes listed below. Many of these changes are discussed in section III of this preamble. If the change is not discussed in section III, the reason for the change is given below.

Changes to Proposed § 410.71

We revise the example in paragraph (a)(2)(iv).

We delete proposed paragraph (d) since the provision is dated.

In paragraph (e)(1), now designated as paragraph (d), we revise the requirements for qualification as a CP.

We designate proposed paragraph (e)(2) as paragraph (e) and revise the consultation requirements.

Changes to Proposed § 410.73

We revise paragraph (a)(3) to provide that, in the case of an individual in a State that does not provide for licensure or certification *as a clinical social worker,* an individual may meet the licensure/certification requirement if he or she is licensed or certified ''at the highest level of practice provided by the laws of the State in which the services are performed''.

We restructure proposed paragraphs (b) and (c)(1) through (c)(3) to combine their contents into a new paragraph (b) and the contents of paragraph (c)(4) and (c)(5) into a new paragraph (d). We believe the new paragraphs set forth the provisions in a clearer manner.

We designate proposed paragraph (d) as paragraph (c) and, rather than set forth the consultation requirements in detail, we cross refer to the requirements set forth in § 410.71(f).

Changes to Proposed § 410.152

The changes we proposed to make to paragraphs (a)(2) and (b) are not made. Further, paragraphs (k) through (m) are not added. These proposed provisions, which concern payment, are addressed for clinical psychologists in the final CP fee schedule rule published on October 31, 1997 (62 FR 59260). That rule also addresses, indirectly, payment provisions for clinical social workers since they are paid at 75 percent of the CP fee schedule.

Changes to Proposed § 410.155

We are not making the proposed changes to paragraph (a), ''Definitions.'' That is, we are not adding a definition of ''mental health treatment.'' In addition, we are removing the definition of ''hospital.'' We do not believe it is necessary to define these terms since they do not have a meaning that is different from the meaning either given in the Medicare statute or as used elsewhere in our regulations. Also, as discussed earlier, we now define ''mental, psychoneurotic, or personality disorder'' in paragraph (b). Therefore, existing § 410.155(a) is removed in its entirety.

Proposed paragraph (b) is revised to improve its readability. In addition, we add that medical management, as opposed to psychotherapy, furnished to a patient diagnosed with Alzheimer's disease or a related disorder, is not subject to the mental health treatment limitation.

Proposed paragraph (c) is revised to improve its readability, and it is designated as new paragraph (a).

The examples in proposed paragraph (d) are revised to add greater clarity, and the paragraph is designated as paragraph (c).

Revision of Existing § 424.32(a)

We revise existing § 424.32(a) to specify that claims for CP services or CSW services must contain appropriate diagnostic coding using ICD–9–CM.

Conforming Change

This final rule revises paragraph (c), ''Standard: Care of patients,'' of § 482.12, ''Conditions of participation: Governing Body'' to specify that a Medicare patient in a Medicare-participating hospital who is receiving qualified psychologist services may be under the care of a CP with respect to those services, to the extent permitted under State law. This revision is made to conform our regulations to section 104 of the Social Security Act Amendments of 1994, described in section I.A.1 of this preamble.

Other Changes

We have also made several editorial changes to improve the readability of the regulations. These changes do not affect the substance of the provisions.

V. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, agencies 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:

- Whether the information collection is necessary and useful to carry out the proper functions of the agency;
- The accuracy of the agency's estimate of the information collection burden;
- The quality, utility, and clarity of the information to be collected; and
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

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

The title and description of the individual information collection requirements are shown below with an estimate of the annual reporting and recordkeeping burden. Included in the estimate is the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information.

As indicated earlier in this preamble, § 410.71(e) references the education, training, and experience requirements necessary to participate in the Medicare program as a clinical psychologist. The specific information necessary to determine compliance with the requirements referenced in § 410.71(e) are captured on the Provider/Supplier Enrollment Application (HCFA–855), which is currently approved under OMB approval number 0938–0685 with an expiration date of May 31, 1998.

We estimate that the completion of form HCFA–855 will impose a one-time burden of approximately 90 minutes.

Again, we welcome comments on all aspects of the above material. Organizations and individuals that wish to submit comments on the information and recordkeeping requirements captured on the HCFA–855 as they relate to § 410.71(e) should direct them to the following address: Health Care Financing Administration, Office of Information Systems, Division of HCFA Enterprise Standards, Room C2–26–17, 7500 Security Boulevard, Baltimore, MD 21244–1850.

VI. Regulatory Impact Analysis

We have examined the impacts 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). The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, we consider all psychologists, social workers, and hospitals to be small entities.

In addition, section 1102(b) of the Act requires the Secretary to prepare a regulatory impact analysis for any rule that may have a significant impact on the operation 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 statement since we have determined, and the Secretary certifies, that this rule will not have a significant impact on the operations of a substantial number of small rural hospitals.

In accordance with sections 1861(s)(2)(M) and 1861(ii) of the Act, this rule allows payment to be made directly to a CP for qualified psychologist services furnished by the CP or (except for services furnished to hospital patients) as an incident to the CP's services. Further, under the authority of section 1861(ii), which looks to the Secretary to define ''clinical psychologist,'' this rule specifies that a CP is an individual who—

(1) Holds a doctoral degree in psychology, and

(2) Is licensed or certified, on the basis of the doctoral degree in psychology, by the State in which he or she practices, at the independent practice level of psychology to furnish diagnostic, assessment, preventive, and therapeutic services directly to individuals.

In accordance with sections 1861(s)(2)(N) and 1861(hh) of the Act, this rule allows payment to be made directly to a CSW for the services he or she furnishes, except for services furnished to an inpatient of a Medicare-participating hospital and certain services furnished to an inpatient of a Medicare-participating SNF or ESRD facility. Also, based on the definition of ''clinical social worker'' at section 1861(hh) of the Act, this rule establishes in regulations the qualifications a CSW must meet under Medicare.

In accordance with section 6113 of OBRA '89, as amended by SSA '94, this rule requires that CPs and CSWs agree to consult with the beneficiary's attending or primary care physician, if the beneficiary consents to the consultation, and establishes criteria regarding the consultation.

In accordance with section 1833(c) of the Act, this rule revises our regulations to eliminate the dollar limitation on payment for outpatient mental health treatment but retains the 62½ percent limitation.

This rule also requires that CPs and CSWs use ICD–9-CM coding when submitting Medicare Part B claims.

Lastly, this rule conforms our regulations to section 1861(e)(4) of the Act by providing that a Medicare patient in a Medicare-participating hospital who is receiving qualified psychologist services may be under the care of a CP with respect to those services, to the extent permitted under State law.

As stated in the December 1993 proposed rule, it has been a long-

standing requirement that, in order for his or her services to be covered under Medicare, the CP possess a doctoral degree from a program in clinical psychology. The literal wording of this requirement would exclude many qualified practitioners of psychology whose doctoral degrees are not labeled ''clinical psychology'' but who have analogous training and practical experience that qualifies them to practice clinical psychology.

However, as we discussed in the regulatory impact analysis section of the December 1993 proposed rule, in the absence of final regulations defining the criteria a CP must meet for Medicare purposes, the Medicare carriers have had the authority to determine whether a particular doctorate-level psychologist qualified to have services covered by Medicare. In using this authority, the carriers decided if the educational background and experience of a particular psychologist qualified him or her as a CP. In the proposed rule, we estimated that two-thirds of the carriers had recognized psychologists based on the education and experience factors that we proposed and we took that factor, along with others, into consideration in our estimate of Medicare expenditures for CP and CSW services during fiscal years 1994 through 1997.

We received two comments on the regulatory impact analysis contained in the proposed rule. The comments came from major associations; one represents psychiatrists and the other represents psychologists.

Comment: Although the impact analysis did not state how many psychologists we estimated might be added to the Medicare program because of our proposed definition, one commenter suggested that we may have underestimated the increase. (The commenter did not provide any data in this regard.) The commenter maintained that two different estimates should have been included, one with the proposed definition and one based upon the previously existing definition.

This same commenter disagreed with HCFA's statement that the anticipated increase in expenditures would be due primarily to an increase in the number of users rather than an increase in the average charge per service or the average number of services per beneficiary. The commenter cited a 1993 article that concluded that therapist supply creates demand rather than vice versa. (Behavioral HealthCare Tomorrow, November/December 1993, prepaid plan. 26–32). The commenter believed that we need to reevaluate the potential for significant cost increases because of increasing the number of CPs.

Additionally, this commenter was concerned that, in the impact analysis, we maintained that, because of the availability of the services of CPS and CSWs, these professionals would substitute for the services of psychiatrists and, thus, there would be an offsetting effect in terms of program outlays. The commenter stated that we offered no support for this assertion. Moreover, the commenter contended that while these nonphysician practitioners may furnish services within their limited training and ability, they do not substitute for the services of psychiatrists.

Response: In the proposed rule, we advised the public of our estimate of the budgetary effect of the legislative changes that removed the site of service restrictions, added coverage for additional providers, and eliminated the annual dollar limitation. Recent data indicate that, rather than underestimating, we greatly overestimated the effect of the changes. For example, we estimated that, as a result of these legislative changes concerning Medicare expenditures for CP and CSW services would increase by $260 million in fiscal year (FY) 1994, by $320 million in FY 1995, and by $390 million in FY 1996. Available data now indicate that the actual increases were far less, only $50 million in FY 1994, $60 million in FY 1995, and $30 million in FY 1996.

In the proposed rule, we stated that we believed that the increase in expenditures would be due *primarily* to an increase in the number of users rather than an increase in the average charge per service or the average number of services per beneficiary. More recent data indicates that, after factoring out the increase in population, there also has been a small increase in the total number of allowed services.

We also stated, in the proposed rule, that we expected that, because of the increased availability of CPs and CSWs, the services of these professionals would substitute for some of the services previously furnished by psychiatrists, thus, having an offsetting effect in terms of total program outlays. However, we also noted our expectation that the services of CSWs would be in addition to those of psychiatrists and CPs, rather than a substitute for them. While it does appear that the volume of some psychotherapy services performed by psychiatrists has decreased relative to the historic trend line, the volume of many other services performed by psychiatrists (services that require physician performance) has been gradually increasing relative to the overall increases in total physician services. Recent data show that, between 1992 and 1995, allowed services for CSWs, CPs, and psychiatrists continued to increase, and that, while the rate of growth in CP and CSW services showed a slight downward trend, there was a slight increase in the rate of growth in psychiatrist services.

Comment: Another commenter recommended that, in analyzing the budgetary effect of these changes, we keep in mind that mental health treatment intervention reduces overall health care costs and conserves valuable health care resources. The commenter stated that an accurate and complete analysis of the budgetary effect of the changes should include an analysis of the anticipated offset to overall health care costs that is likely to occur.

Response: With regard to the effect of early mental health treatment intervention on overall health care costs, we believe that because no data exist to separately identify the effect of this factor in comparison to the concurrent effects of the many other variables that affect overall health care costs, the budgetary analysis suggested by the commenter is not possible.

In addition to the above comments, we received comments related to payment issues (for example, the effect of the lack of a CP fee schedule on Medicare expenditures). Because payment for CP and CSW services was addressed in a proposed rule on the CP fee schedule on June 18, 1997 (62 FR 33158), and we addressed comments on this issue in the final fee schedule on October 31, 1997 (62 FR 59260), we are not addressing these comments in this document.

In general, this final rule merely conforms our regulations to statutory provisions and, in addition, relies on State licensure requirements when determining CP qualifications. Therefore, we believe it will have a negligible economic impact on CP, CSW, and other practitioners. Therefore, we are not preparing analyses for the RFA, and the Secretary certifies that this rule will not result in a significant economic impact on a substantial number of small entities.

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

VII. Waiver of Proposed Rulemaking

As required by the Administrative Procedure Act, we generally provide notice and opportunity for comments on regulations unless we can find good

cause for waiving the notice-and-comment procedure as impracticable, unnecessary, or contrary to the public interest. This final rule revises paragraph (c), ''Standard: Care of patients,'' of § 482.12, ''Conditions of participation: Governing Body'' to specify that a Medicare patient in a Medicare-participating hospital who is receiving qualified psychologist services may be under the care of a CP with respect to those services, to the extent permitted under State law. This revision is made to conform our regulations to section 1861(e)(4) of the Act. The language of section 1861(e)(4) is so specific that it leaves no room for alternative interpretations. Accordingly, we find good cause to waive the notice-and-comment procedure with regard to this change to our regulations as unnecessary.

List of Subjects

42 CFR Part 410

Health facilities, Health professions, Kidney diseases, Laboratories, Medicare, Rural areas, X-rays.

42 CFR Part 417

Administrative practice and procedure, Grant programs—health, Health care, Health facilities, Health insurance, Health maintenance organizations (HMO), Loan programs—health, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 424

Emergency medical services, Health facilities, Health professions, Medicare.

42 CFR Part 482

Grant programs—health, Hospitals, Medicaid, Medicare, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, 42 CFR chapter IV is amended as follows:

PART 410—SUPPLEMENTARY MEDICAL INSURANCE (SMI) BENEFITS

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

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

Subpart B—Medical and Other Health Services

2. In § 410.10, the introductory text is republished, and new paragraphs (v) and (w) are added to read as follows:

§ 410.10 Medical and other health services: Included services.

Subject to the conditions and limitations specified in this subpart, ''medical and other health services'' includes the following services:

* * * * *

(v) Clinical psychologist services and services and supplies furnished as an incident to the services of a clinical psychologist, as provided in § 410.71.

(w) Clinical social worker services, as provided in § 410.73.

3. New §§ 410.71 and 410.73 are added to read as follows:

§ 410.71 Clinical psychologist services and services and supplies incident to clinical psychologist services.

(a) *Included services.* (1) Medicare Part B covers services furnished by a clinical psychologist, who meets the requirements specified in paragraph (d) of this section, that are within the scope of his or her State license, if the services would be covered if furnished by a physician or as an incident to a physician's services.

(2) Medicare Part B covers services and supplies furnished as an incident to the services of a clinical psychologist if the following requirements are met:

(i) The services and supplies would be covered if furnished by a physician or as an incident to a physician's services.

(ii) The services or supplies are of the type that are commonly furnished in a physician's or clinical psychologist's office and are either furnished without charge or are included in the physician's or clinical psychologist's bill.

(iii) The services are an integral, although incidental, part of the professional services performed by the clinical psychologist.

(iv) The services are performed under the direct supervision of the clinical psychologist. For example, when services are performed in the clinical psychologist's office, the clinical psychologist must be present in the office suite and immediately available to provide assistance and direction throughout the time the service is being performed.

(v) The individual performing the service must be an employee of either the clinical psychologist or the legal entity that employs the supervising clinical psychologist, under the common law control test of the Act as more fully set forth in 20 CFR 404.1007.

(b) *Application of mental health treatment limitation.* The treatment services of a clinical psychologist and services and supplies furnished as an incident to those services are subject to the limitation on payment for outpatient mental health treatment services set forth in § 410.155.

(c) *Payment for consultations.* A clinical psychologist or an attending or primary care physician may not bill Medicare or the beneficiary for the consultation that is required under paragraph (e) of this section.

(d) *Qualifications.* For purposes of this subpart, a clinical psychologist is an individual who—

(1) Holds a doctoral degree in psychology; and

(2) Is licensed or certified, on the basis of the doctoral degree in psychology, by the State in which he or she practices, at the independent practice level of psychology to furnish diagnostic, assessment, preventive, and therapeutic services directly to individuals.

(e) *Agreement to consult.* A clinical psychologist who bills Medicare Part B must agree to meet the requirements of paragraphs (e)(1) through (e)(3) of this section. The clinical psychologist's signature on a Medicare provider/supplier enrollment form indicates his or her agreement.

(1) Unless the beneficiary's primary care or attending physician has referred the beneficiary to the clinical psychologist, to inform the beneficiary that it is desirable for the clinical psychologist to consult with the beneficiary's attending or primary care physician (if the beneficiary has such a physician) to consider any conditions contributing to the beneficiary's symptoms.

(2) If the beneficiary assents to the consultation, in accordance with accepted professional ethical norms and taking into consideration patient confidentiality—

(i) To attempt, within a reasonable time after receiving the consent, to consult with the physician; and

(ii) If attempts to consult directly with the physician are not successful, to notify the physician, within a reasonable time, that he or she is furnishing services to the beneficiary.

(3) Unless the primary care or attending physician referred the beneficiary to the clinical psychologist, to document, in the beneficiary's medical record, the date the patient consented or declined consent to consultation, the date of consultation, or, if attempts to consult did not succeed, the date and manner of notification to the physician.

§ 410.73 Clinical social worker services.

(a) *Definition: clinical social worker.* For purposes of this part, a clinical

social worker is defined as an individual who—

(1) Possesses a master's or doctor's degree in social work;

(2) After obtaining the degree, has performed at least 2 years of supervised clinical social work; and

(3) Either is licensed or certified as a clinical social worker by the State in which the services are performed or, in the case of an individual in a State that does not provide for licensure or certification as a clinical social worker—

(i) Is licensed or certified at the highest level of practice provided by the laws of the State in which the services are performed; and

(ii) Has completed at least 2 years or 3,000 hours of post master's degree supervised clinical social work practice under the supervision of a master's degree level social worker in an appropriate setting such as a hospital, SNF, or clinic.

(b) *Covered clinical social worker services.* Medicare Part B covers clinical social worker services.

(1) *Definition.* ''Clinical social worker services'' means, except as specified in paragraph (b)(2) of this section, the services of a clinical social worker furnished for the diagnosis and treatment of mental illness that the clinical social worker is legally authorized to perform under State law (or the State regulatory mechanism provided by State law) of the State in which the services are performed. The services must be of a type that would be covered if they were furnished by a physician or as an incident to a physician's professional service and must meet the requirements of this section.

(2) *Exception.* The following services are not clinical social worker services for purposes of billing Medicare Part B:

(i) Services furnished by a clinical social worker to an inpatient of a Medicare-participating hospital.

(ii) Services furnished by a clinical social worker to an inpatient of a Medicare-participating SNF.

(iii) Services furnished by a clinical social worker to a patient in a Medicare-participating dialysis facility if the services are those required by the conditions for coverage for ESRD facilities under § 405.2163 of this chapter.

(c) *Agreement to consult.* A clinical social worker must comply with the consultation requirements set forth at § 410.71(f) (reading ''clinical psychologist'' as ''clinical social worker'').

(d) *Prohibited billing.* (1) A clinical social worker may not bill Medicare for the services specified in paragraph (b)(2) of this section.

(2) A clinical social worker or an attending or primary care physician may not bill Medicare or the beneficiary for the consultation that is required under paragraph (c) of this section.

Subpart E—Payment of SMI Benefits

4. In § 410.150, the introductory text of paragraph (b) is republished, new paragraphs (b)(14) through (b)(16) are added and reserved, and new paragraphs (b)(17) and (b)(18) are added to read as follows:

§ 410.150 To whom payment is made.

* * * * *

(b) *Specific rules.* Subject to the conditions set forth in paragraph (a) of this section, Medicare Part B pays as follows:

* * * * *

(14) [Reserved.]

(15) [Reserved.]

(16) [Reserved.]

(17) To a clinical psychologist on the individual's behalf for clinical psychologist services and for services and supplies furnished as an incident to his or her services.

(18) To a clinical social worker on the individual's behalf for clinical social worker services.

5. In § 410.152, paragraph (a)(1) introductory text is republished, and paragraph (a)(1)(iv) is revised to read as follows:

§ 410.152 Amount of payment.

(a) *General provisions*—(1) *Exclusion from incurred expenses.* As used in this section, ''incurred expenses'' are expenses incurred by an individual, during his or her coverage period, for covered Part B services, excluding the following:

* * * * *

(iv) Expenses in excess of the outpatient mental health treatment limitation described in § 410.155.

* * * * *

6. Section 410.155 is revised to read as follows:

§ 410.155 Outpatient mental health treatment limitation.

(a) *Limitation.* Only 62½ percent of the expenses incurred for services subject to the limit as specified in paragraph (b) of this section are considered incurred expenses under Medicare Part B when determining the amount of payment and deductible under §§ 410.152 and 410.160, respectively.

(b) *Application of the limitation*—(1) *Services subject to the limitation.* Except as specified in paragraph (b)(2) of this section, the following services are subject to the limitation if they are furnished in connection with the treatment of a mental, psychoneurotic, or personality disorder (that is, any condition identified by a diagnosis code within the range of 290 through 319) and are furnished to an individual who is not an inpatient of a hospital:

(i) Services furnished by physicians and other practitioners, whether furnished directly or as an incident to those practitioners' services.

(ii) Services provided by a CORF.

(2) *Services not subject to the limitation.* Services not subject to the limitation include the following:

(i) Services furnished to a hospital inpatient.

(ii) Brief office visits for the sole purpose of monitoring or changing drug prescriptions used in the treatment of mental, psychoneurotic, or personality disorders.

(iii) Partial hospitalization services not directly provided by a physician.

(iv) Diagnostic services, such as psychological testing, that are performed to establish a diagnosis.

(v) Medical management, as opposed to psychotherapy, furnished to a patient diagnosed with Alzheimer's disease or a related disorder.

(c) *Examples.* (1) A clinical psychologist submitted a claim for $200 for outpatient treatment of a beneficiary's mental disorder. The Medicare approved amount was $180. Since clinical psychologists must accept assignment, the beneficiary is not liable for the $20 in excess charges. The beneficiary previously satisfied the $100 annual Part B deductible. The limitation reduces the amount of incurred expenses to 62½ percent of the approved amount. After subtracting any unmet deductible, Medicare pays 80 percent of the remaining incurred expenses. Medicare payment and beneficiary liability are computed as follows:

1. Actual charges	$200.00
2. Medicare approved amount	180.00
3. Medicare incurred expenses (0.625 × line 2)	112.50
4. Unmet deductible	0.00
5. Remainder after subtracting deductible (line 3 minus line 4)	112.50
6. Medicare payment (0.80 × line 5)	90.00
7. Beneficiary liability (line 2 minus line 6)	90.00

(2) A clinical social worker submitted a claim for $135 for outpatient treatment of a beneficiary's mental disorder. The Medicare approved amount was $120. Since clinical social workers must

accept assignment, the beneficiary is not liable for the $15 in excess charges. The beneficiary previously satisfied $70 of the $100 annual Part B deductible, leaving $30 unmet.

1. Actual charges	$135.00
2. Medicare approved amount	120.00
3. Medicare incurred expenses (0.625 × line 2)	75.00
4. Unmet deductible	30.00
5. Remainder after subtracting deductible (line 3 minus line 4)	45.00
6. Medicare payment (0.80 × line 5)	36.00
7. Beneficiary liability (line 2 minus line 6)	84.00

(3) A physician who did not accept assignment submitted a claim for $780 for services in connection with the treatment of a mental disorder that did not require inpatient hospitalization. The Medicare approved amount was $750. Because the physician did not accept assignment, the beneficiary is liable for the $30 in excess charges. The beneficiary had not satisfied any of the $100 Part B annual deductible.

1. Actual charges	$780.00
2. Medicare approved amount	750.00
3. Medicare incurred expenses (0.625 × line 2)	468.75
4. Unmet deductible	100.00
5. Remainder after subtracting deductible (line 3 minus line 4)	368.75
6. Medicare payment (0.80 × line 5)	295.00
7. Beneficiary liability (line 1 minus line 6)	485.00

(4) A beneficiary's only Part B expenses during 1995 were for a physician's services in connection with the treatment of a mental disorder that initially required inpatient hospitalization. The remaining services were furnished on an outpatient basis. The beneficiary had not satisfied any of the $100 annual Part B deductible in 1995. The physician, who accepted assignment, submitted a claim for $780. The Medicare-approved amount was $750. The beneficiary incurred $350 of the approved amount while a hospital inpatient and incurred the remaining $400 of the approved amount for outpatient services. Only $400 of the approved amount is subject to the 62½ percent limitation because the statutory limitation does not apply to services furnished to hospital inpatients.

1. Actual charges	$780.00
2. Medicare approved amount	$750.00
2A. Inpatient portion	$350
2B. Outpatient portion	$400
3. Medicare incurred expenses	$600.00
3A. Inpatient portion	$350
3B. Outpatient portion (0.625 × line 2B)	$250
4. Unmet deductible	$100.00
5. Remainder after subtracting deductible (line 3 minus line 4)	$500.00
6. Medicare payment (0.80 × line 5)	$400.00
7. Beneficiary liability (line 2 minus line 6)	$350.00

PART 417—HEALTH MAINTENANCE ORGANIZATIONS, COMPETITIVE MEDICAL PLANS, AND HEALTH CARE PREPAYMENT PLANS

1. The authority citation for part 417 is revised to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh), secs. 1301, 1306, and 1310 of the Public Health Service Act (42 U.S.C. 300e, 300e–5, and 300e–9), and 31 U.S.C. 9701.

2. In § 417.416, the introductory text of paragraph (d) is republished; paragraph (d)(2) is revised; and a new paragraph (d)(3) is added to read as follows:

§ 417.416 Qualifying condition: Furnishing of services.

* * * * *

(d) *Exceptions to physician supervision requirement.* The following services may be furnished without the direct personal supervision of a physician:

* * * * *

(2) When furnished by an HMO or CMP, services of clinical psychologists who meet the qualifications specified in § 410.71(d) of this chapter, and the services and supplies incident to their professional services.

(3) When an HMO or CMP contracts on—

(i) A risk basis, the services of a clinical social worker (as defined at § 410.73 of this chapter) and the services and supplies incident to their professional services; or

(ii) A cost basis, the services of a clinical social worker (as defined in § 410.73 of this chapter). Services incident to the professional services of a clinical social worker furnished by an HMO or CMP contracting on a cost basis are not covered by Medicare and payment will not be made for these services.

PART 424—CONDITIONS FOR MEDICARE PAYMENT

1. The authority citation for part 424 continues to read as follows:

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

2. In § 424.32, paragraph (a) introductory text is republished, and paragraph (a)(2) is revised to read as follows:

§ 424.32 Basic requirements for all claims.

(a) A claim must meet the following requirements:

(1) * * *

(2) A claim for physician services, clinical psychologist services, or clinical social worker services must include appropriate diagnostic coding for those services using ICD–9–CM.

* * * * *

3. In § 424.55, paragraph (b) introductory text is republished, and paragraphs (b)(1) and (b)(2) are revised to read as follows:

§ 424.55 Payment to the supplier.

* * * * *

(b) In accepting assignment, the supplier agrees to the following:

(1) To accept, as full charge for the service, the amount approved by the carrier as the basis for determining the Medicare Part B payment (the reasonable charge or the lesser of the fee schedule amount and the actual charge).

(2) To limit charges to the beneficiary or any other source as follows:

(i) To collect nothing for those services for which Medicare pays 100 percent of the Medicare approved amount.

(ii) To collect only the difference between the Medicare approved amount and the Medicare Part B payment (for example, the amount of any reduction in incurred expenses under § 410.155(c), any applicable deductible amount, and any applicable coinsurance amount) for services for which Medicare pays less than 100 percent of the approved amount.

* * * * *

PART 482—CONDITIONS OF PARTICIPATION FOR HOSPITALS

1. The authority citation for part 482 continues to read as follows:

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

2. In § 482.12, paragraph (c) introductory text and (c)(1) introductory text are republished; the period at the end of paragraph (c)(1)(v) is removed and ''; and'' is added in its place; paragraph (c)(1)(vi) is added; paragraph (c)(4) introductory text is republished; and paragraph (c)(4)(ii) is revised to read as follows:

§ 482.12 Conditions of participation: Governing body.

* * * * *

(c) *Standard: Care of patients.* In accordance with hospital policy, the

governing body must ensure that the following requirements are met:

(1) Every Medicare patient is under the care of:

* * * * *

(vi) A clinical psychologist as defined in § 410.71 of this chapter, but only with respect to clinical psychologist services as defined in § 410.71 of this chapter and only to the extent permitted by State law.

* * * * *

(4) A doctor of medicine or osteopathy is responsible for the care of each Medicare patient with respect to any medical or psychiatric problem that—

(i) * * *

(ii) Is not specifically within the scope of practice of a doctor of dental surgery, dental medicine, podiatric medicine, or optometry; a chiropractor; or clinical psychologist, as that scope is—

(A) Defined by the medical staff;

(B) Permitted by State law; and

(C) Limited, under paragraph (c)(1)(v) of this section, with respect to chiropractors.

* * * * *

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

Dated: December 2, 1997.

Nancy-Ann Min DeParle,

Administrator, Health Care Financing Administration.

Dated: December 11, 1997.

Donna E. Shalala,

Secretary.

[FR Doc. 98–10591 Filed 4–22–98; 8:45 am]

BILLING CODE 4120–01–P

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Parts 15 and 73

[ET Docket 97–206; FCC 98–36]

Technical Requirements To Enable Blocking of Video Programming Based on Program Ratings

AGENCY: Federal Communications Commission.

ACTION: Final rule.

SUMMARY: By this *Report and Order* (''R&O''), the Commission is amending the rules to require that television receivers with picture screens 33 cm (13 inches) or greater be equipped with technological features to allow parents to block the display of violent, sexual, or other programming they believe is harmful to their children. These features are commonly referred to as ''v-chip'' technology. This action is in response to the Parental Choice in Television Programming requirements. These rules are intended to give parents the ability to block video programming that they do not want their children to watch.

DATES: This regulation is effective May 26, 1998. The incorporation by reference of certain publications listed in the rule is approved by the Director of the Office of the Federal Register as of May 26, 1998.

FOR FURTHER INFORMATION CONTACT: Neal McNeil, Office of Engineering and Technology, (202) 418–2408, TTY (202) 418–2989.

SUPPLEMENTARY INFORMATION: This is a summary of the Commission's *Report and Order*, ET Docket 97–206, FCC 98–36, adopted March 12, 1998 and released March 13, 1998. The full text of this decision is available for inspection and copying during regular business hours in the FCC Reference Center, Room 239, 1919 M Street, NW, Washington, DC. The complete text of this decision also may be purchased from the Commission's duplication contractor, International Transcription Service, Inc., (202) 857–3800, 1231 20th Street, NW, Washington, DC 20036.

Summary of the Report and Order

1. In section 551(a)(9) of the Telecommunications Act of 1996 (''1996 Act''), Congress determined that parents should be provided ''with timely information about the nature of upcoming video programming and with the technological tools that allow them easily to block violent, sexual, or other programming that they believe harmful to their children * * *.'' Section 551(c) directs the Commission to adopt rules requiring that any ''apparatus designed to receive television signals that are shipped in interstate commerce or manufactured in the United States and that have a picture screen 13 inches or greater in size (measured diagonally) * * * be equipped with a feature designed to enable viewers to block display of all programs with a common rating * * *.'' Section 551(d) states that the Commission must ''require that all such apparatus be able to receive the rating signals which have been transmitted by way of line 21 of the vertical blanking interval * * *.'' That provision also instructs the Commission to oversee ''the adoption of standards by industry for blocking technology,'' and to ensure that blocking capability continues to be available to consumers as technology advances.

2. The *Notice of Proposed Rule Making* (''Notice'') in this proceeding, 62 FR 52677, October 9, 1997, began the process of fulfilling the requirements of section 551. In the *Notice* the Commission proposed to rely on industry standard EIA–608 to provide the methodology for television receivers to decode rating information transmitted on line 21 of the vertical blanking interval (''VBI''). A total of 26 parties filed comments, and 13 parties filed replies to comments in response to the *Notice*.

3. Comments received in response to the *Notice* were uniform in support of the Commission's proposal to adopt EIA–608 and EIA–744 as the transmission standards for program rating information. No commenters suggested other transmission standards that the Commission should consider. The Commission continues to believe that EIA–608 provides an appropriate means of transmitting program rating information on line 21. Therefore, the Commission is amending its rules to require that all television receivers with picture screens 33 cm (13 inches) or larger, measured diagonally, shipped in interstate commerce or manufactured in the United States, receive program ratings transmitted pursuant to industry standards EIA–608 and EIA–744 and block both the video and the associated audio on the main and second audio program (SAP) channels, based on a rating level specified by the user of the television receiver. By adopting EIA–608 and EIA–744 we are fulfilling our mandate under section 551(d) to oversee the adoption of standards by industry for blocking technology. The Commission is incorporating EIA–608 and EIA–744 into its rules by reference. To incorporate EIA–608–B by reference we will publish notice of the change in the **Federal Register** and amend the CFR.

4. The Commission is requiring that television manufacturers include blocking technology on at least half of their new product models with a picture screen 33 cm (13 inches) or greater in size by July 1, 1999. The remainder of the models would be required to contain blocking technology by January 1, 2000.

Final Regulatory Flexibility Analysis

5. As required by the Regulatory Flexibility Act (''RFA''),[1] an Initial Regulatory Flexibility Analysis (''IRFA'') was incorporated in the *''Notice of Proposed Rule Making*

[1] *See* 5 U.S.C. 603. The RFA, *see* 5 U.S.C. 601 *et seq.*, has been amended by the Contract with America Advancement Act of 1996, Pub. L. 104–121, 110 Stat 847 (1996) (CWAAA). Title II of the CWAAA is the Small Business Regulatory Enforcement Fairness Act of 1966 (SBREFA).