''oral/transdermal'' and ''narcotic''

Rationale: Correct typographical error.

• In Section B, question 7, the word ''permanent'' was omitted.

Rationale: To clarify the question.

• A box would be added under the Section B Header which says ''Question 5 reserved for other or future use''.

13. Form 852 Parenteral Nutrition

• Change the answers to question 5 to read 1 3 4 7.

• Change the verbiage to question 5 to read, ''Circle the number for the route of administration. 2, 5, 6—Reserved for other or future use.

1—Central Line; 3—Hemodialysis Access Line; 4—Peritoneal Catheter;

7—Peripherally Inserted Catheter (PIC).''

Rationale: Some parenteral dialysis solutions are administered via a beneficiary's peritoneal catheter. Use of this route of administration must be indicated on the CMN so that a coverage determination can be made accordingly.

14. Form 853 Enteral Nutrition

• Question 11 in section B would be changed to read ''Prescribed calories per day for each product?''

Rationale: To clarify that the number of calories ordered per day are not the number of calories the patient may or may not consume.

• Section B, question 7 the term ''permanent'' has been omitted.

Rationale: The DMERC can screen for the criterion by looking at the value entered by the physician in the Estimated Length of Need field.

• Section B, question 15 will be made to a multiple-choice question.

Rationale: To be consistent with the policy to supply additional information for the use of the pump.

• Section B, answer to question 13 would be changed to say ''Does not apply'' in replace of ''Oral''.

Rationale: To address situations when someone submits a CMN for orally administered enteral nutrients.

However, due to the Health Insurance Portability & Accountability Act Administrative Simplification implications, extensive system changes, cost implications and time limitations needed for educational efforts, CMS will continue to use the current CMNs. In addition, to fully evaluate the impact of CMNs before making a reasoned and rational decision regarding the future of CMNs and the disposition of the proposed technical changes, CMS has contracted with Tri-Centurion, LLC to perform a detailed study of CMNs. Tri-Centurion is objectively evaluating the usage and results of CMNs and will present CMS with recommendations in October of 2002 that will assist in the ultimate disposition of each CMN.

To obtain copies of the supporting statement and any related forms for the proposed paperwork collections referenced above, access CMN's Web Site address at http://www.hcfa.gov/regs/prdact95.htm, or E-mail your request, including your address, phone number, OMB number, and CMS document identifier, to Paperwork@hcfa.gov, or call the Reports Clearance Office on (410) 786–1326. Written comments and recommendations for the proposed information collections must be mailed within 60 days of this notice directly to the CMS Paperwork Clearance Officer designated at the following address: CMS, Office of Information Services, Security and Standards Group, Division of CMS Enterprise Standards, Attention: Melissa Musotto, Room N2–14–26, 7500 Security Boulevard, Baltimore, Maryland 21244–1850.

Dated: February 20, 2002.

John P. Burke III,

Reports Clearance Officer, Security and Standards Group, Division of CMS Enterprise Standards.

[FR Doc. 02–4971 Filed 3–1–02; 8:45 am]

BILLING CODE 4120–03–U

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare and Medicaid Services

[Document Identifier: CMS–R–193]

Agency Information Collection Activities: Submission for OMB Review; Comment Request

AGENCY: Centers for Medicare and Medicaid Services, HHS.

In compliance with the requirement of section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, the Centers for Medicare and Medicaid Services (CMS) (formerly known as the Health Care Financing Administration (HCFA), Department of Health and Human Services, is publishing the following summary of proposed collections for public comment. Interested persons are invited to send comments regarding this burden estimate or any other aspect of this collection of information, including any of the following subjects: (1) The necessity and utility of the proposed information collection for the proper performance of the agency's functions; (2) the accuracy of the estimated burden; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) the use of automated collection techniques or other forms of information technology to minimize the information collection burden.

Type of Information Collection Request: Reinstatement, with change, of a previously approved collection for which approval has expired; *Title of Information Collection:* ''Important Message from Medicare'' Title XVII Section 1866(a)(1)(M), 42 CFR 466.78, 489.20, 489.34, 489.27, 411.404, 412.42, 417.440 and Section 422.620; *Form No.:* CMS–R–193 (OMB# 0938–0692); *Use:* Hospital participating in the Medicare program have agreed to distribute the ''Important Message from Medicare'' to beneficiaries during the course of their hospital stay and inform them of their impending charges. Receiving this information will provide all Medicare beneficiaries with some ability to participate and/or initiate discussions concerning actions that may affect their Medicare coverage, payment, and appeal rights in response to hospital notification their care will no longer continue; *Frequency:* Other: Distribution; *Affected Public:* Individuals or households, business or other for-profit, not-for-profit institutions, Federal Government, State, Local or Tribal Government; *Number of Respondents:* 5,985; *Total Annual Responses:* 11,500,000; *Total Annual Hours:* 632,500.

Since the last version of form CMS–R–193, ''Important Message from Medicare'' (IM), was published, we have had several conversations with representatives of the hospital and managed care industry about how to make the IM a less burdensome, but equally effective, process. Most recently (this month), we consulted with representatives of the American Hospital Association, and the New Jersey Hospital Association, as well as with the Kaiser M+C organization staff to alert them to our plan to introduce a much less burdensome IM form and methodology. There has been general, unofficial agreement that the new approach would be viewed as a welcome improvement by the industry (although, we realize that some issues may remain). Because, we previously submitted this collection for OMB clearance, reduced burden on respondents and consulted with the industry, we believe that further review at the agency level is not justified. Therefore, we are proceeding directly with clearance through OMB.

To obtain copies of the supporting statement and any related forms for the proposed paperwork collections referenced above, access CMS's Web Site address at *http://www.hcfa.gov/regs/prdact95.htm,* or E-mail your request, including your address, phone number, OMB number, and CMS document identifier, to *Paperwork@hcfa.gov,* or call the Reports Clearance Office on (410) 786–1326.

Written comments and recommendations for the proposed information collections must be mailed within 30 days of this notice directly to the OMB desk officer: OMB Human Resources and Housing Branch, Attention: Allison Eydt, New Executive Office Building, Room 10235, Washington, D.C. 20503.

Dated: February 21, 2002.

John P. Burke, III,

CMS Reports Clearance Officer, CMS Office of Information Services, Security and Standards Group, Division of CMS Enterprise Standards.

[FR Doc. 02–4972 Filed 3–1–02; 8:45 am]

BILLING CODE 4120–03–U

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

Notice of Hearing: Reconsideration of Disapproval of Oklahoma State Plan Amendment 99–09

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Notice of hearing.

SUMMARY: This notice announces an administrative hearing on April 10, 2002, at 10 a.m., in Conference Room 1113; 1301 Young Street; Dallas, Texas 75202 to reconsider our decision to disapprove Oklahoma State Plan Amendment (SPA) 99–09.

CLOSING DATE: Requests to participate in the hearing as a party must be received by the presiding officer by March 19, 2002.

FOR FURTHER INFORMATION CONTACT: Kathleen Scully-Hayes, Presiding Officer, CMS, C1–09–13, 7500 Security Boulevard, Baltimore, Maryland 21244, Telephone: (410) 786–2055.

SUPPLEMENTARY INFORMATION: This notice announces an administrative hearing to reconsider our decision to disapprove Oklahoma's State Plan Amendment (SPA) 99–09. Oklahoma submitted SPA 99–09 on April 26, 1999.

The SPA would provide for coverage and payment of certain services as targeted case management services for children who receive medical services pursuant to an Individualized Education Program, Individualized Family Service Plan, or an Individualized Health Service Plan. Under the SPA, providers of school-based medical services would be the only qualified providers of these services, which would be diagnostic in nature, and payment would be limited to the provider of an underlying medical service.

Section 1116 of the Social Security Act (the Act) and 42 CFR part 430 establish Department procedures that provide an administrative hearing for reconsideration of a disapproval of a State plan or plan amendment. The Centers for Medicare & Medicaid Services (CMS) is required to publish a copy of the notice to a state Medicaid agency that informs the agency of the time and place of the hearing and the issues to be considered. If we subsequently notify the agency of additional issues that will be considered at the hearing, we will also publish that notice.

Any individual or group that wants to participate in the hearing as a party must petition the presiding officer within 15 days after publication of this notice, in accordance with the requirements contained at 42 CFR 430.76(b)(2). Any interested person or organization that wants to participate as *amicus curiae* must petition the presiding officer before the hearing begins in accordance with the requirements contained at 42 CFR 430.76(c). If the hearing is later rescheduled, the presiding officer will notify all participants.

The issues are: (1) Whether the proposed covered services are in compliance with the statutory definition of case management services at section 1915(g) of the Act; (2) whether the payment rates are consistent with ''efficiency, economy, and quality of care'' in light of their high levels and apparent duplication of provider services already included in the basic provider payment; (3) whether the proposed restriction on payment for case management services to providers furnishing other covered medical services violates the freedom of choice requirements of section 1923(a)(23)(A) of the Act; and (4) whether the proposed payment for services required under an individualized health services plan (IHSP), for which educational programs are legally liable to pay, is consistent with requirements at section 1902(a)(25) of the Act to pursue payment from all liable third parties.

As explained in the initial disapproval determination, CMS concluded that the State had not demonstrated that the proposed covered services were within the scope of section 1915(g) of the Act. The proposed services would consist of activities such as needs assessment, service planning, service coordination and monitoring, service plan review, and crisis assistance planning and were described by the State as generally diagnostic in nature. In contrast, case management services are described at section 1915(g) as directed at ''gaining access to needed medical, social, educational, and other services.'' In addition, CMS found that the services described in the amendment were inherent within the services performed by medical professionals in order to properly diagnose and treat their patients, and are integral to the services routinely paid through the basic fee-for-service rate paid to the providers. In light of the fact that the rates already being paid under the Oklahoma approved plan for school-based medical services were already higher than community rates and those paid generally, CMS therefore concluded that the proposed payments were not consistent with efficiency, economy and quality of care, as required by section 1902(a)(30)(A) because they effectively were duplicate payments for services covered by the basic payment rate. Furthermore, even if one were to assume that the proposed services were distinct from services included in the basic payment rate, CMS found that the proposed limitation of such payments to the provider furnishing the underlying services was inconsistent with beneficiary freedom-of-choice of provider, as required by section 1902(a)(23)(A) of the Act. And, finally, CMS concluded that the proposed specific authority to pay for services required under an IHSP was inconsistent with Medicaid requirements to pursue liable third party payers, under section 1902(a)(25) of the Act and implementing regulations at 42 CFR 433.136. CMS noted that educational programs are legally liable to fund IHSP activities, and thus should be required to pay primary to Medicaid.

Therefore, based on the reasoning set forth above, and after consultation with the Secretary as required under 42 CFR 430.15(c)(2), CMS disapproved Oklahoma SPA 99–09.

The notice to Oklahoma announcing an administrative hearing to reconsider the disapproval of its SPA reads as follows:

Michael Fogarty, Chief Executive Officer, Oklahoma Health Care Authority, Lincoln Plaza, 4545 North Lincoln Boulevard, Suite 124, Oklahoma City, Oklahoma 73105–3413.

Dear Mr. Fogarty:

I am responding to your request for reconsideration of the decision to disapprove Oklahoma State Plan Amendment (SPA) 99–09. Oklahoma submitted SPA 99–09 on April 26, 1999.

The issues are: (1) Whether the proposed covered services are in compliance with the statutory definition of case management services at section 1915(g) of the Social Security Act (the Act); (2) whether the payment rates are