Friday, November 7, 1997

8:30 A.M.—8:35 A.M.: Opening Remarks by the ACRS Chairman (Open)—The ACRS Chairman will make opening remarks regarding conduct of the meeting.

8:35 A.M.—9:35 A.M.: Severe Accident Management (Open)—The Committee will hear presentations by and hold discussions with representatives of the NRC staff regarding the staff evaluation of the BWR Owners Group emergency procedure and severe accident guidelines and the Westinghouse severe accident guidelines.

9:35 A.M.—10:30 A.M.: Staff Actions Related to the Development of a Revised Fire Protection Rule (Open)—The Committee will hear presentations by and hold discussions with representatives of the NRC staff regarding staff actions related to the development of a revised Fire Protection Rule.

10:45 A.M.—11:15 A.M.: Future ACRS Activities (Open)—The Committee will discuss the recommendations of the Planning and Procedures Sub-committee regarding items proposed for consideration by the full Committee during future meetings.

11:15 A.M.—11:30 A.M.: Reconciliation of ACRS Comments and Recommendations (Open)—The Committee will discuss responses from the NRC Executive Director for Operations to comments and recommendations included in recent ACRS reports. The EDO responses are expected to be provided to the ACRS prior to the meeting.

11:30 A.M.—12:00 Noon: Report of the Planning and Procedures Subcommittee (Open/Closed)—The Committee will hear a report of the Planning and Procedures Subcommittee on matters related to the conduct of ACRS business, qualifications of candidates nominated for appointment to the ACRS, and organizational and personnel matters relating to the ACRS.

[Note: A portion of this session may be closed to discuss organizational and personnel matters that relate solely to the internal personnel rules and practices of this Advisory Committee, and information the release of which would constitute a clearly unwarranted invasion of personal privacy.]

1:00 P.M.—1:30 P.M.: Miscellaneous (Open)—The Committee will discuss matters related to the conduct of Committee activities and matters and specific issues that were not completed during previous meetings, as time and availability of information permit.

1:30 P.M.—7:00 P.M.: Preparation of ACRS Reports (Open)—The Committee will continue its discussion regarding proposed ACRS reports on matters considered during this meeting.

Procedures for the conduct of and participation in ACRS meetings were published in the **Federal Register** on September 4, 1997 (62 FR 46782). In accordance with these procedures, oral or written statements may be presented by members of the public and representatives of the nuclear industry, electronic recordings will be permitted only during the open portions of the meeting, and questions may be asked only by members of the Committee, its consultants, and staff. Persons desiring to make oral statements should notify Mr. Sam Duraiswamy, Chief, Nuclear Reactors Branch, at least five days before the meeting, if possible, so that appropriate arrangements can be made to allow the necessary time during the meeting for such statements. Use of still, motion picture, and television cameras during this meeting may be limited to selected portions of the meeting as determined by the Chairman. Information regarding the time to be set aside for this purpose may be obtained by contacting the Chief of the Nuclear Reactors Branch prior to the meeting. In view of the possibility that the schedule for ACRS meetings may be adjusted by the Chairman as necessary to facilitate the conduct of the meeting, persons planning to attend should check with the Chief of the Nuclear Reactors Branch if such rescheduling would result in major inconvenience.

In accordance with Subsection 10(d) P.L. 92–463, I have determined that it is necessary to close portions of this meeting noted above to discuss matters that relate solely to the internal personnel rules and practices of this Advisory Committee per 5 U.S.C. 552b(c)(2), and to discuss information the release of which would constitute a clearly unwarranted invasion of personal privacy per 5 U.S.C. 552b(c)(6).

Further information regarding topics to be discussed, whether the meeting has been cancelled or rescheduled, the Chairman's ruling on requests for the opportunity to present oral statements and the time allotted therefor, can be obtained by contacting Mr. Sam Duraiswamy, Chief, Nuclear Reactors Branch (telephone 301/415–7364), between 7:30 A.M. and 4:15 P.M. EDT.

ACRS meeting notices, meeting transcripts, and letter reports are now available on FedWorld from the ''NRC MAIN MENU.'' The Direct Dial Access number to FedWorld is (800) 303–9672 or ftp.fedworld. These documents and the meeting agenda are also available for downloading or reviewing on the internet at http://www.nrc.gov/ACRSACNW.

Dated: October 10, 1997.

Andrew L. Bates,

Advisory Committee Management Officer.

[FR Doc. 97–27598 Filed 10–16–97; 8:45 am]

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OFFICE OF MANAGEMENT AND BUDGET

Cost of Hospital and Medical Care Treatment Furnished by the United States; Certain Rates Regarding Recovery From Tortiously Liable Third Persons

By virtue of the authority vested in the President by section 2(a) of Pub. L. 87–693 (76 Stat. 593; 42 U.S.C. 2652), and delegated to the Director of the Office of Management and Budget by Executive Order No. 11541 of July 1, 1970 (35 FR 10737), the three sets of rates outlined below are hereby established. These rates are for use in connection with the recovery, from tortiously liable third persons, of the cost of hospital and medical care and treatment furnished by the United States (Part 43, Chapter I, Title 28, Code of Federal Regulations) through three separate Federal agencies. The rates have been established in accordance with the requirements of OMB Circular A–25, requiring reimbursement of the full cost of all services provided. The rates are established as follows:

1. Department of Defense

The Fiscal Year 1998 (FY98) Department of Defense (DoD) reimbursement rates for inpatient, outpatient, and other services are provided in accordance with Section 1095 of title 10, United States Code. Due to size, the sections containing the Drug Reimbursement Rates (Section III.D) and the rates for Ancillary Services Requested by Outside Providers (Section III.E) are not included in this package. The Office of the Assistant Secretary of Defense (Health Affairs) will provide these rates upon request. The medical and dental service rates in this package (including the rates for ancillary services, prescription drugs or other procedures requested by outside providers) are effective October 1, 1997.

2. Health and Human Services

The sum of obligations for each cost center providing medical service is broken down into amounts attributable to inpatient care on the basis of the proportion of staff devoted to each cost center. Total inpatient costs and outpatient costs thus determined are

divided by the relevant workload statistic (inpatient day, outpatient visit) to produce the inpatient and outpatient rates. In calculation of the rates, the Department's unfunded retirement liability cost and capital and equipment depreciation cost were incorporated to conform to requirements set forth in OMB Circular A–25. In addition, each cost center's obligations include costs for certain other accounts, such as Medicare and Medicaid collections and Contract Health funds used to support direct program operation. Certain cost centers that primarily support workload outside of the directly operated hospitals or clinics (public health nursing, public health nutrition, health education) were excluded this year as not being a part of the traditional cost of hospital operations and not contributing directly to the inpatient and outpatient visit workload. Overall, these rates reflect a more accurate indication of the cost of care in HHS facilities.

In addition, separate rates per inpatient day and outpatient visit were computed for Alaska and the rest of the United States. This gives proper weight to the higher cost of operating medical facilities in Alaska.

3. Department of Veterans Affairs

Actual direct and indirect costs are compiled by type of care for the previous year, and facility overhead costs are added. Adjustments are made using the budgeted percentage changes for the current year and the budget year to compute the base rate for the budget year. The budget year base rate is then adjusted by estimated costs for depreciation of buildings and equipment, central office overhead, Government employee retirement benefits, and return on fixed assets (interest on capital for land, buildings, and equipment (net book value)), to compute the budget year tortiously liable reimbursement rates. Also shown for the tortiously liable inpatient per diem rates are breakdowns into three cost components: Physician; Ancillary; and Nursing, Room, and Board. As with the total per diem rates, these breakdowns are calculated from actual data by type of care.

The interagency rates shown are to be used when VA medical care or service is furnished to a beneficiary of another Federal agency, and that care or service is not covered by an applicable local sharing agreement. Government employee retirement benefits and return on fixed assets are not included in the interagency rates, but in all other respects the interagency rates are the same as the tortiously liable rates.

Inpatient charges will be at the per diem rates shown for the type of bed section or discrete treatment unit providing the care. Prescription Filled charge in lieu of the Outpatient Visit rate will be charged when the patient receives no service other than the Pharmacy outpatient service. This charge applies whether the patient receives the prescription in person or by mail.

When medical care or service is obtained at the expense of the Department of Veterans Affairs from a non-VA source, the charge for such care or service will be the actual amount paid by the VA for that care or service.

1. Department of Defense

For the Department of Defense, effective October 1, 1997 and thereafter:

Inpatient, Outpatient and Other Rates and Charges

I. Inpatient Rates [1 2]

Per inpatient day	International Military Education & Training (IMET)	Interagency and other Federal agency sponsored patients	Other (Full/Third party)
A. Burn Center	$2,618.00	$4,754.00	$5,079.00
B. Surgical Care Services (Cosmetic Surgery)	955.00	1,733.00	1852.00
C. All Other Inpatient Services (Based on Diagnosis Related Groups (DRG) [3])			

1. FY98 Direct Care Inpatient Reimbursement Rates

Adjusted standard amount	IMET	Other interagency	(Full/Third party)
Large Urban	$2,199.00	$4,131.00	$4,372.00
Other Urban/Rural	2,194.00	4,215.00	4,499.00
Overseas	2,450.00	5,614.00	5,960.00

2. Overview

The FY98 inpatient rates are based on the cost per DRG, which is the inpatient full reimbursement rate per hospital discharge weighted to reflect the intensity of the principal diagnosis, secondary diagnoses, procedures, patient age, etc. involved. The average cost per Relative Weighted Product (RWP) for large urban, other urban/rural, and overseas facilities will be published annually as an inpatient adjusted standardized amount (ASA) (see paragraph I.C.1., above). The ASA will be applied to the RWP for each inpatient case, determined from the DRG weights, outlier thresholds, and payment rules published annually for hospital reimbursement rates under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) pursuant to 32 CFR 199.14(a)(1), including adjustments for length of stay (LOS) outliers. The published ASAs will be adjusted for area wage differences and indirect medical education (IME) for the discharging hospital. An example of how to apply DoD costs to a DRG standardized weight to arrive at DoD costs is contained in paragraph I.C.3., below.

3. Example of Adjusted Standardized Amounts for Inpatient Stays

Figure 1 shows examples for a nonteaching hospital in a Large Urban Area.

a. The cost to be recovered is DoD's cost for medical services provided in the nonteaching hospital located in a large urban area. Billings will be at the third party rate.

b. DRG 020: Nervous System Infection Except Viral Meningitis. The RWP for an inlier case is the CHAMPUS weight of 2.9769. (DRG statistics shown are from FY 1996).

c. The DoD adjusted standardized amount to be charged is $4,372 (i.e., the third party rate as shown in the table).

d. DoD cost to be recovered at a nonteaching hospital with area wage index of 1.0 is the RWP factor (2.9769) in 3.b., above, multiplied by the amount ($4,372) in 3.c., above.

e. Cost to be recovered is $13,015.

FIGURE 1.—THIRD PARTY BILLING EXAMPLES

DRG No.	DRG description	DRG weight	Arithmetic mean LOS	Geometric mean LOS	Short stay threshold	Long stay threshold
020 ...	Nervous System Infection Except Viral Meningitis	2.9769	11.2	7.8	1	30

Hospital	Location	Area wage rate index	IME adjustment	Group ASA	Applied ASA
Nonteaching Hospital	Large Urban	1.0	1.0	$4,372.00	$4,372.00

Patient	Length of stay	Days above threshold	Relative weighted product			TPC
			Inlier*	Outlier**	Total	Amount***
#1	7 days	0	2.9769	0.0000	2.9769	$13,015
#2	21 days	0	2.9769	0.0000	2.9769	13,015
#3	35 days	5	2.9769	0.6297	3.6066	15,768

*DRG Weight

**Outlier calculation = 33 percent of per diem weight′ number of outlier days = .33 (DRG Weight/Geometric Mean LOS)′ (Patient LOS—Long Stay Threshold)

=.33 (2.9769/7.8) ′ (35–30)

=.33 (.38165)′ 5 (take out to five decimal places)

=.12594′ 5 (take out to five decimal places)

=.6297 (take out to four decimal places)

*** Applied ASA′ Total RWP

II. Outpatient Rates [1] [2] Per Visit

MEPRS Code [4]	Clinical service	International Military Education & Training (IMET)	Interagency and other Federal agency sponsored patients	Other (Full/Third party)
	A. Medical Care			
BAA	Internal Medicine	$105.00	$195.00	$208.00
BAB	Allergy	39.00	73.00	78.00
BAC	Cardiology	81.00	150.00	160.00
BAE	Diabetic	44.00	82.00	87.00
BAF	Endocrinology (Metabolism)	85.00	158.00	168.00
BAG	Gastroenterology	110.00	203.00	216.00
BAH	Hematology	145.00	269.00	287.00
BAI	Hypertension	81.00	149.00	159.00
BAJ	Nephrology	171.00	317.00	338.00
BAK	Neurology	109.00	202.00	215.00
BAL	Outpatient Nutrition	34.00	63.00	67.00
BAM	Oncology	114.00	211.00	225.00
BAN	Pulmonary Disease	141.00	260.00	278.00
BAO	Rheumatology	84.00	156.00	166.00
BAP	Dermatology	63.00	117.00	124.00
BAQ	Infectious Disease	141.00	260.00	278.00
BAR	Physical Medicine	78.00	145.00	155.00
BAS	Radiation Therapy	72.00	132.00	141.00
BAZ	Medical Care Not Elsewhere Classified (NEC)	84.00	156.00	166.00
	B. Surgical Care			
BBA	General Surgery	119.00	220.00	235.00
BBB	Cardiovascular and Thoracic Surgery	110.00	203.00	216.00
BBC	Neurosurgery	137.00	253.00	270.00
BBD	Ophthalmology	84.00	155.00	166.00
BBE	Organ Transplant	191.00	353.00	376.00
BBF	Otolaryngology	88.00	162.00	173.00
BBG	Plastic Surgery	100.00	184.00	196.00
BBH	Proctology	67.00	124.00	132.00

MEPRS Code [4]	Clinical service	International Military Education & Training (IMET)	Interagency and other Federal agency sponsored patients	Other (Full/Third party)
BBI	Urology	101.00	187.00	199.00
BBJ	Pediatric Surgery	89.00	164.00	175.00
BBZ	Surgical Care NEC	65.00	120.00	127.00
	C. Obstetrical and Gynecological (OB–GYN) Care			
BCA	Family Planning	45.00	83.00	89.00
BCB	Gynecology	74.00	136.00	146.00
BCC	Obstetrics	68.00	126.00	135.00
BCZ	OB-GYN Care NEC	112.00	207.00	221.00D
	D. Pediatric Care			
BDA	Pediatric	54.00	100.00	106.00
BDB	Adolescent	55.00	101.00	108.00
BDC	Well Baby	36.00	66.00	70.00
BDZ	Pediatric Care NEC	64.00	119.00	126.00
	E. Orthopaedic Care			
BEA	Orthopaedic	83.00	153.00	164.00
BEB	Cast	45.00	82.00	88.00
BEC	Hand Surgery	38.00	70.00	75.00
BEE	Orthotic Laboratory	59.00	110.00	117.00
BEF	Podiatry	49.00	91.00	97.00
BEZ	Chiropractic	21.00	38.00	40.00
	F. Psychiatric and/or Mental Health Care			
BFA	Psychiatry	97.00	179.00	191.00
BFB	Psychology	71.00	132.00	141.00
BFC	Child Guidance	59.00	109.00	117.00
BFD	Mental Health	80.00	147.00	157.00
BFE	Social Work	80.00	149.00	159.00
BFF	Substance Abuse	62.00	115.00	123.00
	G. Family Practice/Primary Medical Care			
BGA	Family Practice	67.00	124.00	132.00
BHA	Primary Care	64.00	118.00	126.00
BHB	Medical Examination	59.00	109.00	117.00
BHC	Optometry	42.00	77.00	82.00
BHD	Audiology	30.00	55.00	58.00
BHE	Speech Pathology	81.00	149.00	159.00
BHF	Community Health	41.00	75.00	80.00
BHG	Occupational Health	59.00	108.00	115.00
BHH	TRICARE Outpatient	42.00	78.00	83.00
BHI	Immediate Care	82.00	152.00	162.00
BHZ	Primary Care NEC	43.00	79.00	84.00
	H. Emergency Medical Care			
BIA	Emergency Medical	107.00	198.00	211.00
	I. Flight Medical Care			
BJA	Flight Medicine	85.00	157.00	167.00
	J. Underseas Medical Care			
BKA	Underseas Medicine	32.00	58.00	62.00
	K. Rehabilitative Services			
BLA	Physical Therapy	29.00	54.00	57.00
BLB	Occupational Therapy	53.00	98.00	104.00

III. Other Rates and Charges [1] [2] Per Visit

MEPRS code [4]	Clinical service	International Military Education & Training (IMET)	Interagency and other Federal agency sponsored patients	Other (Full/Third party)
FBI	A. Immunization	$10.00	$19.00	$20.00
DGC	B. Hyperbaric Chamber [5]	180.00	333.00	355.00
	C. Ambulatory Procedure Visit (APV) [6]	376.00	691.00	737.00
	D. Family Member Rate (formerly Military Dependents Rate)	10.20		

E. Reimbursement Rates For Drugs Requested By Outside Providers [7]

The FY98 drug reimbursement rates for drugs are for prescriptions requested by outside providers and obtained at a Military Treatment Facility. The rates are established based on the cost of the particular drugs provided. Final rule of 32 CFR part 220, estimated to be published October 1, 1997, will eliminate the high cost ancillary services' dollar threshold and the associated term ''high cost ancillary service.'' In anticipation of that change, the phrase ''high cost ancillary service'' has been replaced with the phrase ''ancillary services requested by an outside provider.'' The list of drug reimbursement rates is too large to include here. These rates are available on request from OASD (Health Affairs)—see Tab N for the point of contact.

F. Reimbursement Rates for Ancillary Services Requested By Outside Providers [8]

Final rule of 32 CFR part 220, estimated to be published October 1, 1997, will eliminate the high cost ancillary services' dollar threshold and the associated term ''high cost ancillary service.'' In anticipation of that change, the phrase ''high cost ancillary service'' has been replaced with the phrase ''ancillary services requested by an outside provider.'' The list of FY98 rates for ancillary services requested by outside providers and obtained at a Military Treatment Facility is too large to include here. These rates are available on request from OASD(Health Affairs)—see Tab N for the point of contact.

G. Elective Cosmetic Surgery Procedures and Rates

Cosmetic surgery procedure	International Classification Diseases (ICD–9)	Current Procedural Terminology (CPT) [9]	FY98 charge [10]	Amount of charge
Mammaplasty	85.50, 85.32, 85.31	19325, 19324, 19318	Inpatient Surgical Care Per Diem or APV or applicable Outpatient Clinic Rate.	(a b c)
Mastopexy	85.60	19316	Inpatient Surgical Care Per Diem or APV or applicable Outpatient Clinic Rate.	(a b c)
Facial Rhytidectomy	86.82, 86.22	15824	Inpatient Surgical Care Per Diem or APV or applicable Outpatient Clinic Rate.	(a b c)
Blepharoplasty	08.70, 08.44	15820, 15821, 15822, 15823.	Inpatient Surgical Care Per Diem or APV or applicable Outpatient Clinic Rate.	(a b c)
Mentoplasty (Augmentation Reduction).	76.68, 76.67	21208, 21209	Inpatient Surgical Care Per Diem or APV or applicable Outpatient Clinic Rate.	(a b c)
Abdominoplasty	86.83	15831	Inpatient Surgical Care Per Diem or APV or applicable Outpatient Clinic Rate.	(a b c)
Lipectomy suction per region [11].	86.83	15876, 15877, 15878, 15879.	Inpatient Surgical Care Per Diem or APV or applicable Outpatient Clinic Rate.	(a b c)
Rhinoplasty	21.87, 21.86	30400, 30410	Inpatient Surgical Care Per Diem or APV or applicable Outpatient Clinic Rate.	(a b c)
Scar Revisions beyond CHAMPUS.	86.84	1578__	Inpatient Surgical Care Per Diem or APV or applicable Outpatient Clinic Rate.	(a b c)
Mandibular or Maxillary Repositioning.	76.41	21194	Inpatient Surgical Care Per Diem or APV or applicable Outpatient Clinic Rate.	(a b c)
Minor Skin Lesions [12]	86.30	1578__	Inpatient Surgical Care Per Diem or APV or applicable Outpatient Clinic Rate.	(a b c)
Dermabrasion	86.25	15780	Inpatient Surgical Care Per Diem or APV or applicable Outpatient Clinic Rate.	(a b c)
Hair Restoration	86.64	15775	Inpatient Surgical Care Per Diem or APV or applicable Outpatient Clinic Rate.	(a b c)
Removing Tattoos	86.25	15780	Inpatient Surgical Care Per Diem or APV or applicable Outpatient Clinic Rate.	(a b c)
Chemical Peel	86.24	15790	Inpatient Surgical Care Per Diem or APV or applicable Outpatient Clinic Rate.	(a b c)
Arm/Thigh Dermolipectomy.	86.83	1583__	Inpatient Surgical Care Per Diem or APV or applicable Outpatient Clinic Rate.	(a b c)
Brow Lift	86.3	15839	Inpatient Surgical Care Per Diem or APV or applicable Outpatient Clinic Rate.	(a b c)

H. Dental Rate [13] Per Procedure

MEPRS code [4]	Clinical service	International military education and training (IMET)	Interagency and other federal agency sponsored patients	Other (Full/third party)
	oDental Services ..... ADA code and DoD established weight.	$35.00	$101.00	$106.00

I. Ambulance Rate [14] Per Visit

MEPRS code [4]	Clinical service	International military education and training (IMET)	nteragency and other federal agency sponsored patients	Other (Full/Third party)
FEA	Ambulance	$32.00	$60.00	$64.00

J. Laboratory and Radiology Services Requested by an Outside Provider [8] Per Procedure

MEPRS code [4]	Clinical service	International military education & training (IMET)	nteragency & other federal agency sponsored patients	Other (full/third party)
	Laboratory procedures requested by an outside provider CPT–4 Weight Multiplier.	$9.00	$13.00	$14.00
	Radiology procedures requested by an outside provider CPT–4 Weight Multiplier.	23.00	35.00	37.00

K. AirEvac Rate [15] Per Visit

MEPRS code [4]	Clinical service	International military education and training (IMET)	Interagency and other federal agency sponsored patients	Other (Full/third party)
	AirEvac Services—Ambulatory	$113.00	$209.00	$223.00
	AirEvac Services—Litter	323.00	598.00	638.00

Notes on Cosmetic Surgery Charges

[a] Per diem charges for inpatient surgical care services are listed in section I.B. (See notes 9 through 11, below, for further details on reimbursable rates.)

[b] Charges for ambulatory procedure visits (formerly same day surgery) are listed in section III.C. (See notes 9 through 11, below, for further details on reimbursable rates.) The APV rate is used if the elective cosmetic surgery is performed in an ambulatory procedure unit (APU).

[c] Charges for outpatient clinic visits are listed in section II.A–K. The outpatient clinic rate is not used for services provided in an APU. The APV rate should be used in these cases.

Notes on Reimbursable Rates

[1] Percentages can be applied when preparing bills for both inpatient and outpatient services. Pursuant to the provisions of 10 U.S.C. 1095, the inpatient Diagnosis Related Groups and inpatient per diem percentages are 96 percent hospital and 4 percent professional charges. The outpatient per visit percentages are 88 percent outpatient services and 12 percent professional charges.

[2] DoD civilian employees located in overseas areas shall be rendered a bill when services are performed. Payment is due 60 days from the date of the bill.

[3] The cost per DRG (Diagnosis Related Group) is based on the inpatient full reimbursement rate per hospital discharge, weighted to reflect the intensity of the principal and secondary diagnoses, surgical procedures, and patient demographics involved. The adjusted standardized amounts (ASA) per Relative Weighted Product (RWP) for use in the direct care system is comparable to procedures used by the Health Care Financing Administration (HCFA) and the Civilian Health and Medical Program for the Uniformed Services (CHAMPUS). These expenses include all direct care expenses associated with direct patient care. The average cost per RWP for large urban, other urban/rural, and overseas will be published annually as an adjusted standardized amount (ASA) and will include the cost of inpatient professional services. The DRG rates will apply to reimbursement from all sources, not just third party payers.

[4] The Medical Expense and Performance Reporting System (MEPRS) code is a three digit code which defines the summary account and the subaccount within a functional category in the DoD medical system. MEPRS codes are used to ensure that consistent expense and operating performance data is reported in the DoD military medical system. An example of the MEPRS hierarchical arrangement follows: Outpatient Care (Functional Category), B (MEPRS Code), Medical Care (Summary Account), BA (MEPRS Code), Internal Medicine (Subaccount), BAA (MEPRS Code).

[5] Hyperbaric services charges shall be based on hours of service in 15 minute increments. The rates listed in section III.B. are for 60 minutes or 1 hour of service. Providers shall calculate the charges based on the number of hours (and/or fractions of an hour) of service. Fractions of an hour shall be rounded to the next 15 minute increment (e.g., 31 minutes shall be charged as 45 minutes).

[6] Ambulatory Procedure Visit (APV) is defined in DOD Instruction 6025.8, September 23, 1996, as immediate (day of procedure) pre-procedure and immediate post-procedure care requiring an unusual degree of intensity and provided in an ambulatory procedure

unit (APU). Care is required in the facility for less than 24 hours. This rate is also used for elective cosmetic surgery performed in an APU.

[7] Prescription services requested by outside providers (physicians, dentists, etc.) are relevant to the Third Party Collection Program. Third party payers (such as insurance companies) shall be billed for prescription services when beneficiaries who have medical insurance obtain medications from a Military Treatment Facility (MTF) that are prescribed by providers external to the MTF. Eligible beneficiaries (family members or retirees with medical insurance) are not personally liable for this cost and shall not be billed by the MTF. Medical Services Account (MSA) patients, who are not beneficiaries as defined in 10 U.S.C. 1074 and 1076, are charged at the ''Other'' rate if they are seen by an outside provider and come to the MTF for prescription services. The standard cost of medications ordered by an outside provider includes the cost of the drugs plus a dispensing fee per prescription. The prescription cost is calculated by multiplying the number of units (tablets, capsules, etc.) by the unit cost and adding a $5.00 dispensing fee per prescription. Final rule of 32 CFR part 220, estimated to be published October 1, 1997, will eliminate the high cost ancillary services' dollar threshold (by changing it from $25 to $0) and the associated term ''high cost ancillary service.'' In anticipation of that change, the phrase ''high cost ancillary service'' has been replaced with the phrase ''ancillary services requested by an outside provider.'' The elimination of the threshold ipso facto eliminates the bundling of costs whereby a patient was billed if the total ancillary services costs in a day (defined as 0001 hours to 2400 hours) exceeded $25.00.

[8] Charges for ancillary services requested by an outside provider (physicians, dentists, etc.) are relevant to the Third Party Collection Program. Third party payers (such as insurance companies) shall be billed for ancillary services when beneficiaries who have medical insurance obtain services from the MTF that are prescribed by providers external to the MTF. Laboratory and Radiology procedure costs are calculated using the Physicians' Current Procedural Terminology (CPT)–4 Report weight multiplied by either the laboratory or radiology multiplier (section III.J). Eligible beneficiaries (family members or retirees with medical insurance) are not personally liable for this cost and shall not be billed by the MTF. MSA patients, who are not beneficiaries as defined by 10 U.S.C. 1074 and 1076, are charged at the ''Other'' rate if they are seen by an outside provider and come to the MTF for services. Final rule of 32 CFR Part 220, estimated to be published October 1, 1997, will eliminate the high cost ancillary services' dollar threshold (by changing it from $25 to $0) and the associated term ''high cost ancillary service.'' In anticipation of that change, the phrase ''high cost ancillary service'' has been replaced with the phrase ''ancillary services requested by an outside provider.'' The elimination of the threshold ipso facto eliminates the bundling of costs whereby a patient was billed if the total ancillary services costs in a day (defined as 0001 hours to 2400 hours) exceeded $25.00.

[9] The attending physician is to complete the CPT–4 code to indicate the appropriate procedure followed during cosmetic surgery. The appropriate rate will be applied depending on the treatment modality of the patient: Ambulatory procedure visit, outpatient clinic visit or inpatient surgical care services.

[10] Family members of active duty personnel, retirees and their family members, and survivors shall be charged elective cosmetic surgery rates. Elective cosmetic surgery procedure information is contained in Section III G. The patient shall be charged the rate as specified in the FY98 reimbursable rates for an episode of care. The charges for elective cosmetic surgery are at the full reimbursement rate (designated as the ''Other'' rate) for inpatient per diem surgical care services in section I.B., ambulatory procedure visits as contained in section III.C, or the appropriate outpatient clinic rate in section II A–K. The patient is responsible for the cost of the implant(s) and the prescribed cosmetic surgery rate. NOTE: The implants and procedures used for the augmentation mammaplasty are in compliance with Federal Drug Administration guidelines.

[11] Each regional lipectomy shall carry a separate charge. Regions include head and neck, abdomen, flanks, and hips.

[12] These procedures are inclusive in the minor skin lesions. However, CHAMPUS separates them as noted here. All charges shall be for the entire treatment, regardless of the number of visits required.

[13] Dental service rates are based on a dental rate multiplier times the American Dental Association (ADA) code and the DoD established weight for that code.

[14] Ambulance charges shall be based on hours of service in 15 minute increments. The rates listed in section III.I are for 60 minutes or 1 hour of service. Providers shall calculate the charges based on the number of hours (and/or fractions of an hour) that the ambulance is logged out on a patient run. Fractions of an hour shall be rounded to the next 15 minute increment (e.g., 31 minutes shall be charged as 45 minutes).

[15] Air in-flight medical care reimbursement charges are determined by the status of the patient (ambulatory or litter) and are per patient. The charges are billed only by the Air Force Global Patient Movement Requirement Center (GFMRC).

2. Department of Health and Human Services

For the Department of Health and Human Services, Indian Health Service, effective October 1, 1997 and thereafter:

	Hospital Care Inpatient Day	
General Medical Care	Alaska	$1,702
	Rest of the United States	1,049
	Outpatient Medical Treatment	
Outpatient Visit	Alaska	340
	Rest of the United States	209

3. Department of Veterans Affairs

For the Department of Veterans Affairs, effective October 1, 1997 and thereafter:

	Tortiously liable rates	Interagency rates
Hospital Care, Rates Per Inpatient Day		
General Medicine:		
Total	$1208	$1098
Physician	145	.....
Ancillary	315	.....
Nursing, Room, and Board	748	.....
Neurology:		
Total	1154	1042
Physician	169	.....
Ancillary	305	.....

	Tortiously liable rates	Interagency rates
Nursing, Room, and Board	680	.....
Rehabilitation Medicine:		
Total	808	729
Physician	92	.....
Ancillary	247	.....
Nursing, Room, and Board	469	.....
Blind Rehabilitation:		
Total	957	873
Physician	77	.....
Ancillary	475	.....
Nursing, Room, and Board	405	.....
Spinal Cord Injury:		
Total	886	801
Physician	110	.....
Ancillary	223	.....
Nursing, Room, and Board	553	.....
Surgery:		
Total	2079	1904
Physician	229	.....
Ancillary	631	.....
Nursing, Room, and Board	1219	.....
General Psychiatry:		
Total	557	518
Physician	54	.....
Ancillary	91	.....
Nursing, Room, and Board	432	.....
Substance Abuse (Alcohol and Drug Treatment):		
Total	333	300
Physician	32	.....
Ancillary	77	.....
Nursing, Room, and Board	224	.....
Intermediate Medicine:		
Total	396	356
Physician	19	.....
Ancillary	58	.....
Nursing, Room, and Board	319	.....
Nursing Home Care, Rates Per Day		
Nursing Home Care:		
Total	299	270
Physician	9	.....
Ancillary	40	.....
Nursing Room, and Board	250	.....
Outpatient Medical and Dental Treatment		
Outpatient Visit:		
Total	229	211
Emergency Dental	143	127
Outpatient Visit Prescription Filled	25	25

For the period beginning October 1, 1997, the rates prescribed herein superseded those established by the Director of the Office of Management and Budget, October 31, 1996 (61 FR 56360).

Franklin D. Raines,

Director, Office of Management and Budget.

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PENSION BENEFIT GUARANTY CORPORATION

Submission of Information Collection for OMB Review; Comment Request; Payment of Premiums

AGENCY: Pension Benefit Guaranty Corporation.

ACTION: Notice of request for extension of OMB approval.

SUMMARY: The Pension Benefit Guaranty Corporation (''PBGC'') is requesting that the Office of Management and Budget (''OMB'') extend approval, under the Paperwork Reduction Act, of the collection of information under its regulation on Payment of Premiums (29 CFR Part 4007), including Form 1–ES, Form 1, and Schedule A to Form 1, and related instructions (OMB control number 1212–0009; expires February 28, 1998). The collection of information also includes a certification (on Schedule A) of compliance with requirements to provide certain notices to participants under the PBGC's regulation on Disclosure to Participants (29 CFR Part 4011), and surveys of plan