2120 L Street NW., Washington, DC and at the local public document room located at the Athens Public Library, 405 E. South Street, Athens, Alabama.

Dated at Rockville, Maryland, this 7th day of October 1998.

For the Nuclear Regulatory Commission.

L. Raghavan,

Senior Project Manager, Project Directorate II–3, Division of Reactor Projects—I/II, Office of Nuclear Reactor Regulation.

[FR Doc. 98–27807 Filed 10–15–98; 8:45 am]

BILLING CODE 7590–01–P

NUCLEAR REGULATORY COMMISSION

Assessment of the Use of Potassium Iodide (KI) As a Public Protective Action During Severe Reactor Accidents; Withdrawal of Draft NUREG

AGENCY: Nuclear Regulatory Commission.

ACTION: Withdrawal of draft NUREG–1633.

SUMMARY: On July 20, 1998, the NRC announced the availability of Draft NUREG–1633, ''Assessment of the Use of Potassium iodide (KI) As a Public Protective Action During Severe Reactor Accidents,'' and requested comments by September 14, 1998. Based on the many useful public comments received, a substantially revised document that takes those comments into account will be issued in its place, and the draft NUREG is therefore being withdrawn.

FOR FURTHER INFORMATION CONTACT: Aby S. Mohseni, Incident Response Division, Office for Analysis and Evaluation of Operational Data, U.S. Nuclear Regulatory Commission, Washington, D.C. 20555–0001, telephone 301–415 6409, e-mail asm@nrc.gov.

SUPPLEMENTARY INFORMATION: On June 26, 1998, the Commission granted a petition for rulemaking on the use of KI around nuclear power plants and directed the staff to issue the draft NUREG–1633 for public comment. On September 30, 1998, the Commission directed the staff to issue a **Federal Register** notice stating that, in light of the many useful public comments on draft NUREG–1633, a substantially revised document that takes those comments into account will be issued in its place, and that the draft NUREG is therefore being withdrawn. The reissued document will include an improved discussion on how the practical problems in KI stockpiling, distribution, and use are handled in the States that already use KI as a supplement and in the numerous nations which use KI as a supplement. A discussion, in some detail, of the various guidance documents of the World Health Organization and International Atomic Energy Agency, as well as the U.S. Food and Drug Administration, on this subject will also be included in the revised document. The revised NUREG will be consistent with the policy adopted by the Commission in response to the petition for rulemaking and will fairly discuss the factors that need to be weighed in the State and local decisions. The staff anticipates making the revised draft NUREG–1633 in its final form by September, 1999. Subsequently, the staff will develop an information brochure based on NUREG–1633 to assist State and local planners in reaching an informed decision as to whether KI is an appropriate protective supplement.

Dated at Rockville, Maryland, this 2nd day of October 1998.

For the Nuclear Regulatory Commission.

Frank J. Congel,

Director, Incident Response Division, Office for Analysis and Evaluation of Operational Data.

[FR Doc. 98–27812 Filed 10–15–98; 8:45 am]

BILLING CODE 7590–01–M

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 two 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 FY 1999 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.E) and the rates for Ancillary Services Requested by Outside Providers (Section III.F) 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, 1998.

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 obligations from certain other accounts, such as Medicare and Medicaid collections and Contract Health funds that were used to support direct program operations. 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. These obligations are not a part of the traditional cost of hospital operations and do not contribute 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.

1. Department of Defense

For the Department of Defense, effective October 1, 1998 and thereafter:

Inpatient, Outpatient and Other Rates and Charge

I. Inpatient Rates [1 2]

	International military education per inpatient day	Interagency and other federal agency and training (IMET)	Other sponsored patients
A. Burn Center	$2,538.00	$4,632.00	$4,952.00
B. Surgical Care Services (Cosmetic Surgery)	1,236.00	2,255.00	2,411.00

C. All Other Inpatient Services (Based on Diagnosis Related Groups (DRG) [3])

1. FY99 Direct Care Inpatient Reimbursement Rates

Adjusted standard amount	IMET	Interagency	Other (full/third party)
Large Urban	$2,429.00	$4,552.00	$4,825.00
Other Urban/Rural	2,642.00	5,413.00	5,760.00
Overseas	2,989.00	6,823.00	7,234.00

2. Overview

The FY99 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 1997).

c. The DoD adjusted standardized amount to be charged is $4,825 (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 ($4,825) in 3.c., above.

e. Cost to be recovered is $14,364.

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	$4,825.00	$4,825.00

Patient	Length of stay	Days above threshold	Relative weighted product			TPC amount***
			Inlier*	Outlier**	Total	
#1	7 days	0	2.9769	0.0000	2.9769	$14,364
#2	21 days	0	2.9769	0.0000	2.9769	14,364
#3	35 days	5	2.9769	0.6297	3.6066	17,402

*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 & other federal agency sponsored patients	Other (full/third party)
	A. Medical Care			
BAA	Internal Medicine	$104.00	$186.00	$198.00
BAB	Allergy	48.00	86.00	92.00
BAC	Cardiology	78.00	140.00	149.00
BAE	Diabetic	57.00	102.00	108.00
BAF	Endocrinology (Metabolism)	90.00	162.00	173.00
BAG	Gastroenterology	114.00	205.00	219.00
BAH	Hematology	145.00	260.00	277.00
BAI	Hypertension	89.00	160.00	170.00
BAJ	Nephrology	138.00	245.00	261.00
BAK	Neurology	112.00	200.00	213.00
BAL	Outpatient Nutrition	33.00	59.00	63.00
BAM	Oncology	132.00	236.00	251.00
BAN	Pulmonary Disease	118.00	211.00	225.00
BAO	Rheumatology	84.00	151.00	160.00
BAP	Dermatology	68.00	122.00	130.00
BAQ	Infectious Disease	126.00	225.00	240.00
BAR	Physical Medicine	74.00	133.00	142.00
BAS	Radiation Therapy	91.00	164.00	174.00
	B. Surgical Care			
BBA	General Surgery	164.00	295.00	314.00
BBB	Cardiovascular and Thoracic Surgery	132.00	237.00	252.00
BBC	Neurosurgery	188.00	337.00	359.00
BBD	Ophthalmology	102.00	183.00	194.00
BBE	Organ Transplant	239.00	429.00	457.00
BBF	Otolaryngology	124.00	222.00	237.00
BBG	Plastic Surgery	129.00	231.00	247.00
BBH	Proctology	65.00	117.00	124.00
BBI	Urology	125.00	224.00	239.00
BBJ	Pediatric Surgery	91.00	163.00	174.00
	C. Obstetrical and Gynecological (OB–GYN) Care			
BCA	Family Planning	45.00	81.00	87.00
BCB	Gynecology	101.00	181.00	193.00
BCC	Obstetrics	72.00	129.00	137.00
BCD	Breast Cancer Clinic	171.00	307.00	327.00
	D. Pediatric Care			
BDA	Pediatric	63.00	113.00	120.00
BDB	Adolescent	60.00	108.00	115.00
BDC	Well Baby	40.00	71.00	76.00
	E. Orthopaedic Care			
BEA	Orthopaedic	118.00	212.00	226.00
BEB	Cast	50.00	90.00	96.00
BEC	Hand Surgery	61.00	109.00	116.00
BEE	Orthotic Laboratory	60.00	108.00	115.00
BEF	Podiatry	67.00	119.00	127.00
BEZ	Chiropractic	24.00	42.00	45.00
	F. Psychiatric and/or Mental Health Care			
BFA	Psychiatry	97.00	174.00	186.00
BFB	Psychology	79.00	141.00	150.00
BFC	Child Guidance	52.00	93.00	99.00
BFD	Mental Health	105.00	188.00	201.00
BFE	Social Work	77.00	137.00	146.00
BFF	Substance Abuse	82.00	147.00	156.00
	G. Family Practice/Primary Medical Care			
BGA	Family Practice	74.00	133.00	141.00
BHA	Primary Care	75.00	134.00	143.00
BHB	Medical Examination	66.00	118.00	126.00

MEPRS code [4]	Clinical service	International military education & training (IMET)	Interagency & other federal agency sponsored patients	Other (full/third party)
BHC	Optometry	48.00	86.00	91.00
BHD	Audiology	27.00	49.00	52.00
BHE	Speech Pathology	69.00	123.00	131.00
BHF	Community Health	48.00	87.00	92.00
BHG	Occupational Health	78.00	141.00	150.00
BHH	TRICARE Outpatient	44.00	79.00	84.00
BHI	Immediate Care	108.00	193.00	206.00
	H. Emergency Medical Care			
BIA	Emergency Medical	114.00	205.00	218.00
	I. Flight Medical Care			
BJA	Flight Medicine	103.00	185.00	197.00
	J. Underseas Medical Care			
BKA	Underseas Medicine	35.00	63.00	67.00
	K. Rehabilitative Services			
BLA	Physical Therapy	34.00	60.00	64.00
BLB	Occupational Therapy	48.00	86.00	91.00

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	$13.00	$22.00	$24.00
DGC	B. Hyperbaric Chamber [5]	191.00	343.00	366.00
	C. Ambulatory Procedure Visit (APV) [6]	926.00	1,657.00	1,765.00
	D. Family Member Rate (formerly Military Dependents Rate)	10.45	.....	.....

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

The FY 1999 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 32 CFR part 220 eliminates the high cost ancillary services' dollar threshold and the associated term ''high cost ancillary service.'' The phrase ''high cost ancillary service'' will be replaced with the phrase ''ancillary services requested by an outside provider'' on publication of final rule 32 CFR part 220. The list of drug reimbursement rates is too large to include here. These rates are available on request from OASD (Health Affairs).

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

Final rule 32 CFR part 220 eliminates the high cost ancillary services' dollar threshold and the associated term ''high cost ancillary service.'' The phrase ''high cost ancillary service'' will be replaced with the phrase ''ancillary services requested by an outside provider'' on publication of final rule 32 CFR part 220. The list of FY 1999 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).

G. Elective Cosmetic Surgery Procedures and Rates

Cosmetic surgery procedure	International Classification Diseases (ICD–9)	Current procedural terminology (CPT) [9]	FY 1999 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)

Cosmetic surgery procedure	International Classification Diseases (ICD–9)	Current procedural terminology (CPT) [9]	FY 1999 charge [10]	Amount of charge
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	15785	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	15785	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	15839	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 & training (IMET)	Interagency & other federal agency sponsored patients	Other (full/third party)
	Dental Services, ADA code and DoD established weight	$56.00	$101.00	$108.00

I. Ambulance Rate [14] Per Visit

MEPRS code [4]	Clinical service	International military education & training (IMET)	Interagency & other federal agency sponsored patients	Other (full/third party)
FEA	Ambulance	$56.00	$101.00	$107.00

J. Ancillary Services Requested by an Outside Provider [8] Per Procedure

MEPRS code [4]	Clinical service	International military education & training (IMET)	Interagency & other federal agency sponsored patients	Other (full/third party)
	Laboratory procedures requested by an outside provider CPT '98 Weight Multiplier.	$10.00	$17.00	$18.00
	Radiology procedures requested by an outside provider CPT '98 Weight Multiplier.	25.00	45.00	48.00
	Cardiology procedures requested by an outside provider CPT '98 Weight Multiplier.	17.00	31.00	33.00

K. AirEvac Rate [15] Per Visit

MEPRS code [4]	Clinical service	International military education & training (IMET)	Interagency & other federal agency sponsored patients	Other (full/third party)
	AirEvac Services—Ambulatory	$90.00	$161.00	$172.00
	AirEvac Services—Litter	256.00	459.00	489.00

Observation Rate [16] Per Hour

MEPRS code [4]	Clinical service	International military education & training (IMET)	Interagency & other federal agency sponsored patients	Other (full/third party)
	Observation Services—Hour	$14.50	$25.83	$27.50

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 ambulatory procedure visit (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 Sections 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 89 percent outpatient services and 11 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 Diagnosis Related Group (DRG) 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:

MEPRS Code

Outpatient Care (Functional Category) B
Medical Care (Summary Account) BA
Internal Medicine (Subaccount) BAA

[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 is defined in DOD Instruction 6025.8, ''Ambulatory Procedure Visit (APV),'' dated 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 (e.g., physicians or dentists) 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 only 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 (e.g., tablets or capsules) by the unit cost and adding a $5.00 dispensing fee per prescription. Final rule 32 CFR part 220 eliminates the high cost ancillary services' dollar threshold and the associated term ''high cost ancillary service.'' The phrase ''high cost ancillary service'' will be replaced with the phrase ''ancillary services requested by an outside provider'' on publication of final rule 32 CFR part 220. The elimination of the threshold also eliminates the need to bundle costs whereby a patient is billed if the total cost of ancillary services in a day (defined as 0001 hours to 2400 hours) exceeded $25.00. The elimination of the threshold is effective as per date stated in final rule 32 CFR part 220.

[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 by multiplying the DoD established weight for the Physicians' Current Procedural Terminology (CPT '98) code by either the cardiology, 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 only come to the MTF for ancillary services. Final rule 32 CFR part 220 eliminates the high cost ancillary services' dollar threshold and the associated term ''high cost ancillary service.'' The phrase ''high cost ancillary service'' will be replaced with the phrase ''ancillary services requested by an outside provider'' on publication of final rule 32 CFR part 220. The elimination of the threshold also eliminates the need to bundle costs whereby a patient is billed if the total cost of ancillary services in a day (defined as 0001 hours to 2400 hours) exceeded $25.00. The elimination of the threshold is effective as per date stated in final rule 32 CFR part 220.

[9] The attending physician is to complete the CPT '98 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 FY 1999 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 Sections 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 appropriate charges are billed only by the Air Force Global Patient Movement Requirement Center (GPMRC).

[16] Observation Services are billed at either the hourly or daily charge. Begin counting when the patient is placed in the observation bed, and round to the nearest hour. The daily rate for full/third party, for example, would be $660 based on 24 hours of service. If a patient status changes to inpatient, the charges for observation services are added to the DRG assigned to the case and not billed separately. If a patient is released from Observation status and is sent to an APV, the charges for Observation services are not billed separately, but are added to the APV rate in order to recover all expenses.

1. Department of Health and Human Services

For the Department of Health and Human Services, Indian Health Service, effective October 1, 1998 and thereafter:

Hospital Care Inpatient Day	
General Medical Care:	
Alaska	$1,798
Rest of the United States	1,049
Outpatient Medical Treatment	
Outpatient Visit:	
Alaska	$360
Rest of the United States	210

For the period beginning October 1, 1998, the rates prescribed herein superseded those established by the Director of the Office of Management and Budget October 31, 1997 (61 FR 56360).

Jacob Lew,

Director, Office of Management and Budget.

[FR Doc. 98–27813 Filed 10–15–98; 8:45 am]

BILLING CODE 3110–01–P

OFFICE OF PERSONNEL MANAGEMENT

Submission for OMB Review; Comment Request for Clearance of a Revised Information Collection: SF 3104 and SF 3104B

AGENCY: Office of Personnel Management.

ACTION: Notice.

SUMMARY: In accordance with the Paperwork Reduction Act of 1995 (Public Law 104-13, May 22, 1995), this notice announces that the Office of Personnel Management (OPM) has submitted to the Office of Management and Budget a request for clearance of a revised information collection. SF 3104, Application for Death Benefits/Federal Employees Retirement System, is used to apply for death benefits under the Federal Employees Retirement System based on the death of an employee, former employee or retiree who was covered by FERS at the time of his/her death or separation from Federal Service. SF 3104B, Documentation and Elections in Support of Application for Death Benefits when Deceased was an Employee at the Time of Death, is used by applicants for death benefits under FERS if the deceased was a Federal Employee at the time of death.

It is estimated that approximately 4,873 SF 3104s are expected to be processed annually. This form requires approximately 60 minutes to complete. An annual burden of 4,873 hours is estimated. Approximately 3,188 SF 3104Bs are expected to be processed annually. It is estimated that the form requires approximately 60 minutes to complete. An annual burden of 3,188 hours is estimated. The total annual burden is 8,061.

For copies of this proposal, contact Mary Beth Smith-Toomey on (202) 606–8358, or E-mail to mbtoomey@opm.gov

DATES: Comments on this proposal should be received on or before November 16, 1998.

ADDRESSES: Send or deliver comments to—John C. Crawford, Chief, FERS Division, Retirement and Insurance Service, U.S. Office of Personnel Management 1900 E Street, NW, Room 3313, Wshington, DC 20415, and Joseph Lackey, OPM Desk Officer, Office of Information & Regulatory Affairs, Office of Management & Budget, New Executive Office Building, NW, Room 10235, Washington, DC 20503.

FOR INFORMATION REGARDING ADMINISTRATIVE COORDINATION—CONTACT: Donna G. Lease, Budget & Administrative Services Division, (202) 606–0623.

U.S. Office of Personnel Management.

Janice R. Lachance,

Director.

[FR Doc. 98–27818 Filed 10–15–98; 8:45 am]

BILLING CODE 6325–01–P

OFFICE OF PERSONNEL MANAGEMENT

Submission for OMB Review, Comment Request Investigations Forms 41–44

AGENCY: Office of Personnel Management.

ACTION: Proposed collection; comment request.

SUMMARY: In accordance with the Paperwork Reduction Act of 1980 (Title 44, U. S. Code, Chapter 35), this notice announces that OPM has submitted to the Office of Management and Budget (OMB) a request for reclearance of four information collections and solicits comments on them. OPM uses these form to request information by mail for use in OPM investigations.

These investigations are conducted to determine suitability for Federal employment and/or the ability to hold a security clearance as prescribed in Executive Orders 10450, 12968 and 10577 (5 CFR Part V) and 5 U.S.C. 3301.

INV Form 41, Investigative Request for Employment Data and Supervisor Information, is sent to former employers and/or supervisors.

INV Form 42, Investigative Request for Personal Information, is sent to references.