SUPPLEMENTARY INFORMATION: This notice is issued by authority delegated to the Asssistant Secretary for Indian Affairs by the Secretary of the Interior in 209 DM 8.

In the June 14, 1977, **Federal Register** (42 FR 30361) there was published a notice of a final rule on new general regulations governing the operation and maintenance of Indian Irrigation Projects. The revision consolidated the regulations for all Indian Irrigation Projects in a new Part 191 (recently renumbered as Part 171) of Title 25 of the Code of Federal Regulations. This was accomplished to reduce paperwork connected with changing operation and maintenance charges. The rule that is being rescinded has no impact on the public since all future changes to operation and maintenance charges will be done according to the provisions of 25 CFR Part 171 which authorize changes to be made by publication of a notice in the **Federal Register**. For that reason an opportunity for public comment on this action is unnecessary. In addition, since there will be no impact on the public by rescission of this rule there is no need to publish this document 30 days before its effective date. Accordingly, good cause exists to make this action effective immediately upon publication in the **Federal Register**. The updated provisions, as found in 25 CFR 171.1(e), provide for the Area Director to publish the annual operation and maintenance rates and related information by general notice document in the **Federal Register**.

The Department of the Interior has determined that because the provisions of 25 CFR Part 174 are no longer used to change operation and maintenance charges, the rescission of Part 174 is not a major rulemaking and will not have a significant effect on a substantial number of small entities under the requirements of the Regulatory Flexibility Act.

The primary author of this document is Paul S. Danis, Bureau of Indian Affairs, 1951 Constitution Avenue, NW., Washington, D.C. 20245, Telephone Number (202) 343–8249.

The next notice of water charges and related information on Irrigation Projects shall be published as a general notice in the **Federal Register** by March 1983.

List of Subjects in 25 CFR Part 174

Indians—lands, Irrigation.

Therefore, under the authority of 25 U.S.C. 385, Chapter I, Title 25 of the Code of Federal Regulations is amended as follows:

Part 174 of Chapter I of 25 CFR is hereby rescinded.

Kenneth Smith,

Assistant Secretary, Indian Affairs.

[FR Doc. 83-4230 Filed 2-17-83; 8:45 am]

BILLING CODE 4310-05-M

DEPARTMENT OF JUSTICE

28 CFR Part 0

[Tax Division Directive No. 42]

Organization of the Department of Justice; Appendix To Subpart Y—Redelegation of Authority To Compromise and Close Civil Claims

Correction

In FR Doc. 82–27527 beginning on page 44254 in the issue of Thursday, October 7, 1982, make the following corrections.

On page 44254, first column, second paragraph of "**Supplementary Information**" fourth line, "Tax Division Directive No. 1" should read "Tax Division Directive No. 41".

On the same page, third column, "Section 5", beginning with paragraph (F), should have read as follows:

(F) Reject offers in compromise, or disapprove administrative settlements or concessions, regardless of amount, *Provided*, That such action is not opposed by the agency or agencies involved, and provided further that the case is not subject to reference to the Joint Committee on Taxation.

* * * * *

BILLING CODE 1505-01-M

Office of the Attorney General

28 CFR Part 0

[Order No. 996–83]

Service of Process Upon the Attorney General

AGENCY: Justice Department.

ACTION: Final rule.

SUMMARY: This order amends 28 CFR 0.77(j) to limit the Assistant Attorney General for Administration's authority to accept service of process to service upon the Attorney General in his official capacity and service of process other than subpoenas.

EFFECTIVE DATE: February 4, 1983.

FOR FURTHER INFORMATION CONTACT: William J. Snider, Administrative Counsel, Justice Management Division, Department of Justice, Room 6239, 10th and Constitution Avenue, NW., Washington, D.C. 20530 ((202) 633–3452).

SUPPLEMENTARY INFORMATION: This order is occasioned by the holding in *Stafford* v. *Briggs*, 444 U.S. 527 (1980), that a government official is entitled to personal service (as opposed to mail service) when sued in his individual capacity. The Attorney General has determined that he will avail himself of this right and, further, that he will authorize members of his immediate staff to accept subpoenas directed to him rather than the Assistant Attorney General for Administration, who has organizational responsibility for records managment and mail and messenger service within the Department of Justice.

This order pertains to agency management. It is not subject to publication for notice and comment under 5 U.S.C. 553 and is not a rule within the meaning of, or subject to, the requirements of either the Regulatory Flexibility Act, 5 U.S.C. 601 *et seq.*, or Executive Order No. 12291.

List of Subjects in 28 CFR Part 0

Government employees, Organization and functions (Government agencies), and Authority delegations (Government agencies).

PART 0—[AMENDED]

Accordingly, by virtue of the authority vested in me by 28 U.S.C 510 and 5 U.S.C. 301, § 0.77 of Title 28, Code of Federal Regulations, is amended by revising paragraph (j) to read as follows:

§ 0.77 Operational functions.

* * * * *

(j) Accepting service of summonses, complaints or other papers, except subpoenas, directed to the Attorney General in his official capacity, as a representative of the Attorney General, under the Federal Rules of Civil and Criminal Procedure or in any suit within the purview of subsection (a) of Section 208 of the Department of Justice Appropriation Act, 1953 (66 Stat. 560 (43 U.S.C. 666(a))).

* * * * *

Dated: February 4, 1983.

William French Smith,

Attorney General.

[FR Doc. 83-4272 Filed 2-17-83; 8:45 am]

BILLING CODE 4410-01-M

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 761

[OPTS—62015E; TSH–FRL 2292–3]

Polychlorinated Biphenyls (PCBs) Manufacturing, Processing, Distribution in Commerce and Use Prohibitions; Use in Electrical Equipment; Statement of Policy

AGENCY: Environmental Protection Agency (EPA).

ACTION: Rule-Related Notice; Statement of General Policy.

SUMMARY: The final rule on the use of polychlorinated biphenyls (PCBs) in electrical equipment was published in the **Federal Register** of August 25, 1982 (47 FR 37342). In that rule, special restrictions are placed on the use and storage for reuse of any transformer, electromagnet, or large capacitor (those containing three pounds or more of dielectric fluid) that contains 500 parts per million (ppm) or greater PCBs and poses an exposure risk to food or feed products. This notice constitutes EPA's statement of policy as to how the Agency will determine whether this electrical equipment poses an exposure risk to food or feed.

EFFECTIVE DATE: February 18, 1983.

FOR FURTHER INFORMATION CONTACT: Chris C. Tirpak, Acting Director, Industry Assistance Office (TS–799), Office of Toxic Substances, Environmental Protection Agency, Rm. E–509, 401 M St., SW., Washington, D.C. 20460, Toll free: (800–424–9065), In Washington, D.C.: (554–1404), Outside the USA: (Operator–202–554–1404).

SUPPLEMENTARY INFORMATION: EPA promulgated a final rule, published in the **Federal Register** of August 25, 1982 (47 FR 37342), regarding the use of PCBs in electrical equipment. This rule is listed in the Code of Federal Regulations under 40 CFR Part 761 and became effective on September 24, 1982.

The rule amends the PCB regulations by authorizing the use of PCBs in electrical equipment in accordance with certain use and servicing conditions. Special restrictions apply to transformers, electromagnets, and large capacitors (those containing three pounds or more of dielectric fluid) that contain 500 ppm or greater PCBs and pose an exposure risk to food or feed. See 40 CFR 761.30(a), (h), and (l). The use and storage for reuse of such electromagnets or transformers requires a weekly inspection for leaks of dielectric fluid and is prohibited after October 1, 1985. The use and storage for reuse of large capacitors that pose an exposure risk to food or feed is prohibited after October 1, 1988.

Section 761.3(ll) (47 FR 37356) of the PCB rule states that "posing an exposure risk to food or feed" means being in any location where human food or animal feed could be exposed to PCBs released from a PCB Item. A PCB Item poses an exposure risk to food or feed if PCBs released in any way from the PCB Item have a potential pathway to human food or animal feed. Only food and feed that is used or stored in private homes is excluded from this definition.

Since publication of this definition EPA has received requests from the American Frozen Food Institute (AFFI) and the American Feed Manufacturers Association (AFMA) for further clarification of this definition. These requests raised concerns about how EPA will interpret this definition and explained that a clarification would aid the food and feed industry in developing a strategy for compliance with the regulations. EPA is publishing this notice to express the Agency's policy for interpreting the definition of "posing an exposure risk to food or feed." EPA plans to interpret this definition in a reasonable manner, according to the guidance provided in this notice.

The exposure risk from a PCB Item to food and feed products is clearly dependent on the specific location of the applicable PCB Item (transformer, capacitor, or electromagnet) in relation to food and feed products. If, after considering the location of an individual PCB Item and all other available evidence, there is a reasonable possibility of contact between PCBs and food or feed, the PCB Item will be considered to pose an exposure risk to food or feed under 40 CFR 761.3(ll). In evaluating the exposure risk from a particular PCB Item, it is useful to consider a hypothetical situation in which PCBs are discharged in any way from the PCB Item, such as through an equipment leak or rupture. Assuming such a discharge occurred releasing all or a portion of the contained PCBs and considering the PCB Item's location and any relevant factors, the question to be asked is whether contact between the PCBs and food or feed is reasonably possible. If, contact between PCBs and food or feed is reasonably possible, the PCB Item poses an exposure risk to food or feed. It is not EPA's intention to consider remote events that are unrelated to the use or storage for reuse of PCB Items when determining if these items pose an exposure risk to food or feed.

A determination whether or not a PCB Item poses an exposure risk to food or feed requires an individual evaluation of the circumstances regarding a PCB Item's location. PCB Items that are located directly adjacent to or above food or feed products pose an exposure risk unless there is some type of secondary containment or other physical structure that prevents discharges of PCBs from contaminating food or feed. The PCB rule provides a number of options for eliminating restrictions on the use of transformers, electromagnets, and large capacitors that contain 500 ppm PCBs and pose an exposure risk to food or feed, including:

1. Relocating the PCB Item to an installation which does not pose an exposure risk to food or feed.
2. Reducing the PCB concentration in the PCB Item to less than 500 ppm (transformers and electromagnets only).
3. Adequately isolating or containing the PCB Item to prevent it from posing an exposure risk.
4. Relocating the food or feed to a location that is not in a potential exposure risk area.
5. Replacing the PCB Item with equipment containing less than 500 ppm PCBs.

This regulation was submitted to the Office of Management and Budget for review as required by Executive Order 12291.

Dated: January 17, 1983.

John A. Todhunter,

Assistant Administrator for Pesticides and Toxic Substances.

[FR Doc. 83–3826 Filed 2–17–83; 8:45 am]

BILLING CODE 6560–50–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Part 405

Medicare Program; Assistants at Surgery

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

ACTION: Final rule.

SUMMARY: These regulations amend the interim final Medicare rules published on October 1, 1982, that implement section 113 of the Tax Equity and Fiscal Responsibility Act of 1982 (Pub. L. 97–248). Those regulations provide that Medicare will pay on a reasonable charge basis for the services of a physician who actively assists the physician in charge of a case in performing a surgical procedure (i.e., an assistant at surgery) in teaching

hospitals only under certain specific conditions. These regulations add as a result of public comments a new condition under which assistants at surgery may be reimbursed. They also clarify the rules for determining the amount of payment for services furnished by assistants at surgery in all settings.

EFFECTIVE DATE: October 1, 1982.

FOR FURTHER INFORMATION CONTACT: William Morse, (301) 594–1160.

SUPPLEMENTARY INFORMATION:

I. Background

On October 1, 1982, we published in the **Federal Register** an interim final rule with comment period to implement section 113 of Pub. L. 97–248, the Tax Equity and Fiscal Responsibility Act of 1982 (47 FR 43650).

The rule revised Medicare regulations to permit payment on a reasonable charge basis for assistants at surgery in teaching hospitals only under certain conditions. (Assistants at surgery are physicians who actively assist the physician in charge of a case in performing a surgical procedure.) The regulations eliminated program payment on a reasonable charge basis for assistants at surgery in teaching hospitals where a resident is available and qualified to perform the service.

The rule also established new limits on the amount of payment for services furnished by assistants at surgery in all settings.

II. Discussion of Major Comments

Over 100 comments on the October 1 publication were received from physicians and physician organizations, health care providers and provider organizations, and medical schools. The majority of comments were from ophthalmologists and doctors of osteopathy. The recommendations of the commenters and our responses follow.

1. *Comment:* Three commenters requested that the length of the comment period be extended to 90 days to permit time for an in-depth analysis of the implications of the rule.

Response: These regulations were issued as interim final rules with a comment period. The legislation specified that if the rules were issued on such an interim basis, that they be final no later than January 31, 1983. Therefore it was necessary to specify a 30-day comment period in order to have final rules in place by the January 31 deadline.

2. *Comment:* The interim final rule with comment period required that carriers presume that residents are available unless the hospital furnishes documentation to the contrary. Seventy commenters believe that the regulations inappropriately assume that if the hospital has a residency program in a specialty, residents are available to serve as assistants at surgery. The commenters believe that teaching hospitals should be used for the purpose of teaching and, therefore, residents should not be relied on primarily for service. These commenters indicated that, for a variety of reasons, residents are not always available to cover all surgeries. First, residents are involved in many other types of activities relating to their own educational activities, such as clinic duties, and are responsible for treating patients in capacities other than surgery. Second, there are many situations in which there are inadequate numbers of qualified residents in a program to furnish the necessary surgical assistant services. Several commenters suggested that we provide exemptions for small teaching hospitals and hospitals with small residency programs and that if, in such cases, a resident is not available, reimbursement of an assistant should be allowed.

Response: The statutory language states that, except under certain conditions, reasonable charge payment may not be made for the services of assistants at surgery if the hospital has a training program related to the specialty required for the surgical procedure, and a qualified resident is available to furnish such services. We believe the commenters have raised valid points on the issue of the availability of residents to act as assistants at surgery. We realize that residents have a full schedule of activities, and that the unavailability of residents to assist at surgery is more than simply a scheduling problem of the teaching hospital. The interim final rules, as well as these final rules, provide that if adequate written documentation is made available to the carrier that no qualified resident was available for a particular surgery case, payment may be made for the service.

3. *Comment:* Several physicians and a professional association opposed the regulations because, in their view, the regulations discriminate against teaching hospitals by establishing separate rules for teaching and nonteaching hospitals. The commenters said that as a result, physicians will move their patients to nonteaching hospitals, thereby threatening the existence of surgical residency programs in teaching hospitals. The commenters also believe that the regulations discriminate against Medicare patients because residents will assist during their surgery, while other patients receive the services of trained physicians. In a related comment, a medical school dean and a national organization representing teaching hospitals pointed out that there are physicians who perform surgery in teaching hospitals who do not involve residents in surgical procedures and use only nonresident physicians as assistants. Other physicians commented that a decision to use residents should be decided by the primary surgeon.

Response: The basic distinctions made by the regulation are compelled by the statute. The intent of the statute and the regulations is to eliminate payment for use of assistants at surgery if residents are available to assist. However, it was not the intent of Congress to jeopardize any surgical residency programs. Therefore, we are modifying the interim final rules by adding a condition to § 405.580 to allow reasonable charge payment for the services of an assistant at surgery where the primary surgeon does not involve residents in the preoperative, operative, or postoperative care of his or her patients. Generally this will apply to physicians who do not have compensation arrangements with a teaching hospital or entity for compensation of their services furnished by them in the hospital. In those cases, although the services take place in a teaching hospital, the circumstances are as if the surgical procedure is not being furnished in a teaching setting and the surgery is indistinguishable from surgery performed in nonteaching hospitals.

4. *Comment:* Several physicians suggested examples of specific types of surgery that require a team of physicians that should be considered complex medical procedures. In a related comment, physicians pointed out that there are procedures of such complexity that residents would not generally have the expertise or experience to serve as an assistant at surgery.

Response: The regulations take these situations into account. Based on accepted medical practice in the community, the carrier will establish a list of those procedures that fall into the category of complex medical procedures that require a team of physicians. The local carriers have considerable expertise in this area. Regarding the competence of residents to perform as surgical assistants in specific types of procedures, § 405.580(a) (2) provides in effect that payment on the basis of reasonable charges may be made for the services of an assistant at surgery if documentation is furnished to the carrier that no *qualified* resident was available to perform the function. If there is a question regarding the use of a resident

in a specific case, the carrier's medical staff will make the staff will make the necessary determination.

6. *Comment:* Twelve physicians requested that they be allowed to serve as assistants at surgery in teaching hospitals because they are the individuals most familiar with the case and because their patients request that they be present at surgery to provide moral and psychological support.

Response: The regulation does not preclude the presence of a Medicare beneficiary's personal physician in surgery to provide moral or psychological support, but prohibits Medicare reimbursement for such services. If a beneficiary wishes to have his or her personal physician present however, the physician may bill the patient for such service. The regulation provides for the situation in which a concurrent medical condition of the patient requires the presence of a physician of another specialty during surgery. In addition, payment is permitted for an assistant surgeon (one primarily engaged in the field of surgery) if there is no qualified resident available or, under the revised § 405.580(c)(4), if the primary surgeon does not involve residents in the care of his or her patients. The regulation does not, however, permit reimbursement for the services of a personal physician who is in attendance at the surgical procedure but does not meet any of the above critieria.

6. *Comment:* Several commenters, including a national association of physicians, expressed concern about the lack of specificity in the interim regulations and the possibility that carriers will interpret the provisions in many different ways.

Response: Carriers have discretion in implementing this provision and will consider local medical practice in determining payments for assistant at surgery services. It would not be administratively feasible to publish a comprehensive, uniform list of procedures that would have to be constantly modified in response to changes in medical practice. HCFA may, however, issue instructions from time to time about particular situations which require more uniform treatment.

7. *Comment:* A Medicare carrier has suggested that the 20 percent limitation on payment for services of assistants at surgery be implemented by establishing prevailing charges for the assistant at surgery at 20 percent of the prevailing charge for the procedure using the medical specialty of the assistant. The carrier points out that this accomplishes the intent of limiting payment without introducing delays and costly complexities into claims processing.

Response: In processing claims for assistant at surgery services that are subject to the § 405.502(a) limitation, the carrier may base payment on 20 percent of the prevailing charge for the service when performed by someone in the assistant's specialty. In this way the carrier will not have to wait to receive the primary surgeon's claim before making payment for the services of the assistant.

8. *Comment:* A national association of physicians commented on the preamble language regarding complex medical procedures that warrant the presence of a team of physicians. The preamble indicated that in these situations, each physician is performing a different level of activity than could properly be described as assistance, and is entitled to full reimbursement. The association commented that it expected that this recognition of such procedures would guarantee appropriate reimbursement for the medical team in the future, and that HCFA would assure proper recognition of such procedures by its contractors.

Response: The reference to full reimbursement in the preamble to the October 1 regulations was used to distinguish team and concurrent services from those subject to the assistant at surgery limitation. The regulations set a reimbursement ceiling, not a floor. These regulations are not a basis for raising Medicare reasonable charge payments in a way that is inconsistent with prevailing practices in the carrier's service area. Medicare payment should not exceed the lesser of the amount billed, the customary charge, the prevailing charge, or any other applicable reasonable charge criteria established in 42 CFR 405.502.

9. *Comment:* A Medicare Part B carrier indicated that these rules could encourage physicians to bill beneficiaries rather than accept assignments. The carrier also suggested that in the case of beneficiaries who are eligible for both Medicare and Medicaid, there could be a shifting of costs of denied Medicare claims to Medicaid.

Response: The modifications contained in these revised rules should temper these effects by reducing the number of claims that are denied or paid at the reduced rate. However, current payment rules in general allow physicians to bill beneficiaries, rather than accept assignment, if they choose to do so. We do not believe that these rules will encourage any changes in this behavior.

10. *Comment:* Several physicians have pointed out that often hospitals have rules requiring an assistant at surgery for particular types of procedures. They asked how this affects Medicare payment criteria.

Response: Such hospital requirements are not a consideration in determining reasonable charge payment. A carrier may determine that a service does not meet the conditions for payment despite the existence of hospital rules.

III. Provisions of These Final Regulations

After reviewing comments received on the interim rule, we have revised the existing regulations to include the following provisions.

Criteria for Determining Reasonable Charges

We have revised subparagraph (a)(10) to section 405.502 to clarify that prevailing practice in the carrier's service area, rather than the assistant at surgery limitation, applies where the team physician or the concurrent medical care exceptions are met. We have done this to avoid the possibility that this regulation is used to escalate program payments. The intent of the regulation is to eliminate unreasonable payments. We have also made several technical corrections in § 405.502(a) to clarify the language and correct inaccurate citations to other parts of the Medicare regulations.

Conditions for Payment

Section 405.580(c) of the regulations describes the conditions under which reasonable charge payment may be made for the services of assistants at surgery in teaching hospitals. Payment may be made for the services of assistants at surgery in teaching hospitals only if the services:

1. Are required due to exceptional medical circumstances;

2. Are performed by team physicians needed to perform complex medical procedures;

3. Constitute concurrent medical care relating to a medical condition which requires the presence of and active care by a physician of another specialty during surgery; or

4. Are medically required and are furnished by a physician who is primarily engaged in the field of surgery and the primary surgeon does not utilize interns or residents in the surgical procedures he or she performs (including preoperative and postoperative care).

The exception included in number 4 is added by this document and is explained more fully below. Under this exception, payment will be limited to situations in which the assistant surgeon

is a physician who is primarily engaged in the field of surgery.

This new exception applies to services furnished in teaching hospitals by surgeons who do not utilize interns or residents in surgical procedures, including the preoperative and postoperative care involved. Under such circumstances, the surgery is virtually indistinguishable from surgery performed in a nonteaching setting. Generally in this instance, the physician has an "across-the-board" policy of not utilizing residents in patient care.

The carrier should have a list of all teaching hospitals in its service area to which these regulations may apply. The carrier will presume that a resident is available if the hospital has a teaching program relating to the medical specialty required for the surgical procedure, unless satisfactory written documentation is made available to the carrier that a resident was not available. However, the carrier should take into account the fact that residents may be legitimately involved in various activities, that there may not be a sufficient number of residents in the program, and that there may be situations, particularly those involving small teaching programs, in which there may not always be a qualified resident available to serve as an assistant at surgery. Claims for payment for services of assistants at surgery in teaching hospitals should include a written description supported by relevant documentation of the exception which is the basis for payment. The appropriate manual instructions are being modified to reflect this change in policy.

In this document, we are also correcting an incomplete citation that appears in § 405.580(a) and a typographical error in § 405.580(c)(1).

Technical Revision

On October 1, 1982, two documents were published that amended 42 CFR Part 405, Subpart E. The authority citations, although correct for each individual document, were inconsistent. In reviewing the inconsistent citations, we discovered that an additional citation, to section 1832 of the Act, had been previously omitted at the time that § 405.522 was published. In both FR Doc. 82-27110, "Medicare Program; Limitation of Reasonable Charges for Services in Hospital Outpatient Settings", appearing at 47 FR 43610, and FR Doc 82-27148, "Medicare Program; Assistants at Surgery", appearing at 47 FR 43650, the authority citation for 42 CFR Part 405, Subpart E should read as follows:

Authority: Secs. 1102, 1814(b), 1832, 1833(a), 1842(b) and (h), 1861(v)(1)(K), and 1871 of the Social Security Act, as amended (42 U.S.C. 1302, 1395f(b), 1395k, 1395l(a), 1935u(b) and (h), 1395x(v)(1)(K), and 1395h(h) unless otherwise noted.

IV. Effective Date of the Regulations

In order for us to have implementing regulations in place by the October 1, 1982 effective date specified in section 113 of Pub. L. 97-248, we published an interim final rule with comment period on October 1, 1982 with an effective date of October 1, 1982. We believe that rapid implementation of these regulations was desirable in order to eliminate unnecessary Medicare payment for assistants at surgery. Also, Congress expressly addressed the issuance of interim final regulations as an option for the development of these regulations.

Based upon public comments, we are now adding a new condition under which assistants at surgery may be reimbursed on a reasonable charge basis. This addition expands the availability of reasonable charge reimbursement and is advantageous to all concerned. At the same time, the addition disadvantages no one. Therefore, we are making the revised rules effective retroactively to October 1, 1982. Since the revised rules grant a new exemption from the reimbursement limitations, a delayed effective date is unnecessary. Also, the use of a delayed effective date is impracticable because it would promote inconsistencies in the application of payment for assistants at surgery during the interim period. For these reasons, we find there is good cause to waive the usual 30-day delay in effective date.

These regulations are effective for services furnished on or after October 1, 1982. Claims for payment for the services of assistants at surgery that were denied during the period from October 1, 1982 until the publication of these revised regulations may be resubmitted to the Medicare carrier and will be reviewed for payment under these expanded criteria.

V. Impact Analysis

Executive Order 12291

We have determined that these final regulations are not likely to result in an annual economic impact of $100 million or meet other threshold criteria of section 1(b) of the Order.

These final regulations state the conditions under which payment will be made on a reasonable charge basis for the services of a physician who actively assists the physician in charge of a case, in performing a surgical procedure in teaching hospitals. We noted above the inclusion of one new condition as a result of public comment under which assistants at surgery may be reimbursed. Our actuaries have re-estimated their analysis contained within the October, 1, 1982 interim final rule, to include the effect of this new exception. They now estimate FY 1983 savings of $35 million and FY 1984 savings of $50 million.

As the estimated impact of these final regulations is significantly below the $100 million threshold, a regulatory impact analysis is not required.

Regulatory Flexibility Analysis

The Secretary certifies under 5 U.S.C. 605(b), enacted by Regulatory Flexibility Act (Pub. L. 96-354), that this final rule will not result in a significant impact on a substantial number of small entities.

The primary impact of these final regulations will be on physicians who continue to serve as assistants at surgery in teaching hospitals. The individual impact will be determined by the extent to which a physician continues to participate as an assistant. Actual Medicare revenue reduction will be the difference between the total Medicare payment physicians received prior to the implementation of this rule, and the Medicare payment physicians will not receive as a result of this rule.

We do not believe that a significant monetary impact will be generated. Payment record data indicate that payment for services of assistants at surgery represents only 2.6 percent of total reimbursement for Part B physicians' services to hospital inpatients. Thus, any revenue reduction to physicians resulting from these final provisions should not be a significant reduction in total physician revenue. Therefore, a regulatory flexibility analysis is not required.

VI. List of Subjects in 42 CFR Part 405

Administrative practice and procedure, Certification of compliance, Clinics, Contracts (Agreements), End-Stage Renal Disease (ESRD), Health care, Health facilities, Health maintenance organizations (HMO), Health professions, Health suppliers, Home health agencies, Hospitals, Inpatients, Kidney diseases, Laboratories, Medicare, Nursing homes, Onsite surveys, Outpatient providers, Reporting requirements, Rural areas, X-rays.

42 CFR Part 405 is amended as set forth below:

PART 405—FEDERAL HEALTH INSURANCE FOR THE AGED AND DISABLED

1. The authority citation for Part 405, Subpart E, is revised to read as follows:

Authority. Secs. 1102, 1814(b), 1832, 1833(a), 1842(b) and (h), 1861(v)(1)(k) and 1871 of the Social Security Act, as amended (42 U.S.C. 1302, 1395f(b), 1395k, 1395l(a), 1395u (b) and (h), 1395x(v)(1)(K) and 1395hh) unless otherwise noted.

2. In § 405.502, the introductory language for paragraph (a), and paragraph (a)(10) are revised to read as follows:

§ 405.502 Criteria for determining reasonable charges.

(a) *Criteria.* The law allows for flexibility in the determination of reasonable charges to accommodate reimbursement to the various ways in which health services are furnished and charged for. The criteria for determining what charges are reasonable include:

* * * * *

(10) In the case of services of assistants at surgery that meet the exception under § 405.580(c) (2) or (3) because the physician is performing a unique, necessary, specialized medical service in the total care of a patient during surgery, reasonable charges consistent with prevailing practice in the carrier's service area rather than the special assistant at surgery rate.

* * * * *

3. Section 405.580 is amended by revising paragraph (a), revising the introductory language for paragraph (c), and revising paragraphs (c)(1) and (4) as follows:

§ 405.580 Conditions of payment for assistants at surgery in teaching hospitals.

(a) *Basis, purpose, and scope.* This section describes the conditions under which Medicare will pay on a reasonable charge basis for the services of an assistant at surgery in a teaching hospital. This section is based on section 1842(b)(6)(D)(i) of the Social Security Act and applies only to hospitals with an approved teaching program. Except as specified in paragraph (c) of this section, reasonable charge reimbursement is not available for assistants at surgery in hospitals with—

* * * * *

(c) *Conditions for payment for assistants at surgery.* Beginning October 1, 1982, payment on the basis of reasonable charges may be made for the services of an assistant at surgery in a teaching hospital only if the services—

(1) Are required due to exceptional medical circumstances;

* * * * *

(4) Are medically required and are furnished by a physician who is primarily engaged in the field of surgery and the primary surgeon does not utilize interns and residents in the surgical procedures he or she performs (including preoperative and postoperative care).

(Catalog of Federal Domestic Assistance Program No. 13,774, Medicare—Supplementary Medical Insurance)

Dated: January 12, 1983.

Carolyne K. Davis,

Administrator, Health Care Financing Administration.

Approved: February 1, 1983.

Richard S. Schweiker,

Secretary.

[FR Doc. 83-4238 Filed 2-17-83; 8:45 am]

BILLING CODE 4120-03-M

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42 CFR Part 421

Medicare Program; Revisions to Criteria and Standards for Evaluating Intermediaries

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

ACTION: Final rule with comment period.

SUMMARY: This is a technical revision to Medicare regulations that will simplify and improve our system for evaluating the performance of fiscal intermediaries in the administration of the Medicare program. Currently, we evaluate intermediaries using performance criteria, described in regulations, and statistical standards issued through an annual notice in the **Federal Register.** We are removing the detailed description of the criteria from regulations in favor of issuing a combined **Federal Register** notice for both the criteria and the standards. This change will obviate the need to revise the description of the criteria in regulations as changes are made in the evaluation system.

DATES: This rule is effective February 18, 1983. It is being issued in final form for reasons explained in Waiver of Proposed Rulemaking in the Supplementary Information section below. However, we will consider any comments mailed by March 21, 1983, and revise the regulations, if necessary.

ADDRESSES: Please address comments in writing to: Administrator, Health Care Financing Administration, Department of Health and Human Services, P.O. Box 17073, Attn: BPO–15–FC, Baltimore, Maryland 21235.

If you prefer, you may deliver your comments to Room 309–G, Hubert H. Humphrey Building, 200 Independence Ave., SW., Washington, D.C., or to Room 132, East High Rise Building, 6325 Security Boulevard, Baltimore, Maryland. In commenting, please refer to BPO–15–FC.

Comments will be available for public inspection, as they are received, beginning approximately three weeks from today, in Room 309–G of the Department's offices at 200 Independence Avenue, SW., Washington, D.C. on Monday through Friday of each week from 8:30 a.m. to 5:00 p.m. (phone: 202–245–7890).

FOR FURTHER INFORMATION CONTACT: Newton Dikoff, 301–594–8190.

SUPPLEMENTARY INFORMATION:

I. Background

The hospital insurance program (Part A of Medicare, title XVIII of the Social Security Act) helps pay for medically necessary health care furnished to eligible individuals by providers of services (hospitals, skilled nursing facilities (SNFs), and home health agencies (HHAs)). Under section 1816 of the Act, the Secretary may contract with organizations and agencies to participate in the administration of Part A. These organizations and agencies are called fiscal intermediaries.

Intermediaries perform the bulk of actual bill processing and benefit payment functions for Part A of the Medicare program. These functions generally follow set procedures. First, a provider submits a bill to the intermediary, which determines whether the services are covered under Part A of Medicare, and determines the reasonable cost for the services. Second, the intermediary reimburses the provider on behalf of the beneficiary to whom the services were furnished. Third, the intermediary recoups from HCFA the program reimbursement it makes to providers as well as its administrative costs. Intermediaries similarly process bills for certain outpatient hospital services covered under Part B of Medicare (supplementary medical insurance).

Under section 1816(b) of the Act (originally enacted in section 14 of Pub. L. 95–142, the Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977), we evaluate intermediaries in the performance of their Medicare functions when we enter into or renew a contract. In addition, although providers may nominate a particular intermediary to serve them under section 1816(a) of the Act, we may assign or reassign providers to particular intermediaries or designate a national or regional intermediary for a class of providers under section 1816(e). We may take these actions if we determine that they would result in more effective and efficient administration of the Medicare program.