Marietta Street N.W., Atlanta, Georgia 30303.

1. *First Sarasota Bancorporation,* Tampa, Flordia; to become a bank holding company by acquiring 50.5 percent of the voting shares of City Commercial Bank, Sarasota Florida.

B. **Federal Reserve Bank of Chicago** (Franklin D. Dreyer, Vice President) 230 South LaSalle Street, Chicago, Illinois 60690:

1. *Centra Financial, Inc.,* West Allis, Wisconsin; to become a bank holding company by acquiring 80 percent of the voting shares of Central Bank, West Allis, Wisconsin.

C. **Federal Reserve Bank of St. Louis** (Delmer P. Weisz, Vice President) 411 Locust State, St. Louis, Missiouri 63166:

1. *Aviston Bancorp, Inc.,* Aviston, Illinois; to become a bank holding company by acquiring 100 percent of the voting shares of State Bank of Aviston, Aviston, Illinois.

2. *F & M Bancshares, Inc.,* Trezevant, Tennessee; to become a bank holding company by acquiring 90 percent of the voting shares of Farmers & Merchants Bank, Trezevant, Tennessee.

3. *Marked Tree Bancshares, Inc.,* Marked Tree, Arkansas; to become a bank holding company by acquiring at least 80 percent of the voting shares of Marked Tree Bank, Marked Tree, Arkansas.

D. **Federal Reserve Bank of Kansas City** (Thomas M. Hoenig, Vice President) 925 Grand Avenue, Kansas City, Missouri 64198:

1. *Hillsboro Financial Corporation,* Wichita, Kansas; to become a bank holding company by acquiring 93.7 percent of the voting shares of The First National Bank of Hillsboro, Hillsboro, Kansas.

2. *Regency Bancorporation,* Pueblo, Colorado; to become a bank holding company by acquiring 97 percent of the voting shares of Pueblo Boulevard Bank, Pueblo, Colorado.

E. **Federal Reserve Bank of Dallas** (Anthony J. Montelaro, Vice President) 400 South Akard Street, Dallas, Texas 75222:

1. *Dallas Bancshares, Inc.,* Dallas, Texas; to acquire 100 percent of the voting shares of Americanbanc Corporation, Plano, Texas, thereby indirectly acquiring American National Bank of Plano, Plano, Texas.

2. *First Caprock Bancshares, Inc.,* Claude, Texas; to become a bank holding company by acquiring 80 percent of the voting shares of The First National Bank of Claude, Claude, Texas.

3. *RepublicBank Corporation,* Dallas, Texas; to acquire 100 percent of the voting shares of RepublicBank Delaware, Wilmington, Delaware, a *de novo* bank.

Board of Governors of the Federal Reserve System, July 25, 1985.

**James McAfee,**

*Associate Secretary of the Board.*

[FR Doc. 85-18090 Filed 7-30-85; 8:45 am]

BILLING CODE 6210-01-M

## Mercantile Bankshares Corp., et al.; Applications To Engage de Novo in Permissible Nonbanking Activities

The companies listed in this notice have filed an application under § 225.23(a)(1) of the Board's Regulation Y (12 CFR 225.23(a)(1)) for the Board's approval under section 4(c)(8) of the Bank Holding Company Act (12 U.S.C. 1843(c)(8) and § 225.21(a) of Regulation Y (12 CFR 225.21(a)) to commence or to engage *de novo,* either directly or through a subsidiary, in a nonbanking activity that is listed in § 225.25 of Regulation Y as closely related to banking and permissible for bank holding companies. Unless otherwise noted, such activities will be conducted throughout the United States.

Each application is available for immediate inspection at the Federal Reserve Bank indicated. Once the application has been accepted for processing, it will also be available for inspection at the offices of the Board of Governors. Interested persons may express their views in writing on the question whether consummation of the proposal can "reasonably be expected to produce benefits to the public, such as greater convenience, increased competition, or gains in efficiency, that outweigh possible adverse effects, such as undue concentration of resources, decreased or unfair competition, conflicts of interests, or unsound banking practices." Any request for a hearing on this question must be accompanied by a statement of the reasons a written presentation would not suffice in lieu of a hearing, identifying specifically any questions of fact that are in dispute, summarizing the evidence that would be presented at a hearing, and indicating how the party commenting would be aggrieved by approval of the proposal.

Unless otherwise noted, comments regarding the applications must be received at the Reserve Bank indicated or the offices of the Board of Governors not later than August 20, 1985.

A. **Federal Reserve Bank of Richmond** (Lloyd W. Bostian, Jr., Vice President) 701 East Byrd Street, Richmond, Virginia 23261:

1. *Mercantile Bankshares Corporation,* Baltimore, Maryland; to engage *de novo* through its subsidiary, Mercantile Mortgage Corporation, Baltimore, Maryland, in the activities of making, acquiring or servicing loans or other extensions of credit for its own account and for the account of others, such as would be made by a mortgage company; and acting as agent with respect to insurance limited to assuring repayment of the outstanding balance due on a specific extension of credit by a bank holding company or its subsidiary in the event of the death or disability of the debtor, pursuant to section 4(c)(8)(A) of the Act.

B. **Federal Reserve Bank of Chicago** (Franklin D. Dreyer, Vice President) 230 South LaSalle Street, Chicago, Illinois 60690:

1. *J.E. Coonley Company,* Dows, Iowa; to engage *de novo* directly in providing data processing facilities, through a lease relationship, to Sheffield Savings Bank, Sheffield, Iowa.

Board of Governors of the Federal Reserve System, July 25, 1985.

**James McAfee,**

*Associate Secretary of the Board.*

[FR Doc. 85-18091 Filed 7-30-85; 8:45 am]

BILLING CODE 6210-01-M

## Security State Agency of Aitkin, Inc.; Acquisition of Company Engaged in Permissible Nonbanking Activities

The organization listed in this notice has applied under § 225.23(a)(2) or (f) of the Board's Regulation Y (12 CFR 225.23(a)(2) or (f)) for the Board's approval under section 4(c)(8) of the Bank Holding Company Act (12 U.S.C. 1843(c)(8)) and § 225.21(a) of Regulation Y (12 CFR 225.21(a)) to acquire or control voting securities or assets of a company engaged in a nonbanking activity that is listed in § 225.25 of Regulation Y as closely related to banking and permissible for bank holding companies. Unless otherwise noted, such activities will be conducted throughout the United States.

The application is available for immediate inspection at the Federal Reserve Bank indicated. Once the application has been accepted for processing, it will also be available for inspection at the offices of the Board of Governors. Interested persons may express their views in writing on the question whether consummation of the proposal can "reasonably be expected to produce benefits to the public, such as greater convenience, increased competition, or gains in efficiency, that outweigh possible adverse effects, such as undue concentration of resources, decreased or unfair competition,

conflicts of interests, or unsound banking practices." Any request for a hearing on this question must be accompanied by a statement of the reasons a written presentation would not suffice in lieu of a hearing, identifying specifically any questions of fact that are in dispute, summarizing the evidence that would be presented at a hearing, and indicating how the party commenting would be aggrieved by approval of the proposal.

Comments regarding the application must be received at the Reserve Bank indicated or the offices of the Board of Governors not later than August 22, 1985.

A. **Federal Reserve Bank of Minneapolis** (Bruce J. Hedblom, Vice President) 250 Marquette Avenue, Minneapolis, Minnesota 55480:

1. *Security State Agency of Aitkin, Inc.*, Aitkin, Minnesota; to acquire John F. Solien Agency, Aitkin, Minnesota, thereby engaging in general insurance agency activities in a place with a population not exceeding 5,000, pursuant to section 4(c)(8)(C)(i) of the Act. These activities would be conducted in the Aitkin, Minnesota, trade area.

Board of Governors of the Federal Reserve System, July 25, 1985.

**James McAfee,**

*Associate Secretary of the Board.*

[FR Doc. 85-18088 Filed 7-30-85; 8:45 am]

BILLING CODE 6210-01-M

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Office of the Secretary

### Health Information Policy Council; 1984 Revision of the Uniform Hospital Discharge Data Set

**AGENCY:** Office of the Secretary, HHS.

**ACTION:** Notice.

**SUMMARY:** The purpose of this notice is to announce the 1984 Revision of the Uniform Hospital Discharge Data Set (UHDDS) which has been approved by the Secretary for use within the Department of Health and Human Services (DHHS). The purposes of the 1984 revision are to update and improve the original version of the UHDDS which was promulgated by the Secretary in 1974 as a minimum, common core of data for use in programs of the Department which require data on individual hospital discharges on a continuing basis. Revisions to definitions and categories have been developed to update certain items and to improve their accuracy.

**DATES:** The 1984 Revision of the UHDDS will become effective on January 1, 1986.

**FOR FURTHER INFORMATION CONTACT:** Dr. Gooloo S. Wunderlich, Division of Data Policy, Office of the Assistant Secretary for Health, Room 717-H, Hubert H. Humphrey Building, 200 Independent Avenue, SW., Washington, D.C. 20201. Commercial Phone: (202) 245-2100.

**SUPPLEMENTARY INFORMATION**

#### Background

A Uniform Hospital Discharge Data Set was promulgated by the Secretary of the U.S. Department of Health, Education, and Welfare in 1974 as a minimum, common core of data on individual hospital discharges in the Medicare and Medicaid programs. Its purpose was to improve the uniformity and comparability of hospital discharge data. Promulgation of the UHDDS was the culmination of a number of developmental activities involving both the public and private sectors.

In the eleven years since its promulgation, the UHDDS has achieved fairly widespread use as a minimum, common core of data within the Department in programs which require data on individual hospital discharges on a continuing basis. The data set is also used within other Federal Agencies and has gained acceptance and use as a standard in the non-Federal public and private sectors, such as in the operations of hospital discharge abstracting services.

The purposes of the 1984 Revision of the UHDDS are to update and improve the original version in the light of current needs and developments. Revisions to definitions and categories have been developed to update certain items and to improve their accuracy. In keeping with the original UHDDS concept, it is emphasized that the UHDDS is a minimum, common core of data on individual hospital discharges and is not intended to serve the entire data needs of a data program or activity. Individual programs and data collectors may obtain additional data elements beyond those in the UHDDS as necessary, and may obtain additional detail within the UHDDS items, provided that the detail can be aggregated to the UHDDS items, definitions, and categories.

The 1984 Revision of the UHDDS was developed by the Health Information Policy Council of the U.S. Department of Health and Human Services. The Council is the principal internal advisory body to the Secretary on departmentwide health data policy. In developing the 1984 Revision, the Council consulted both with the National Committee on Vital and Health Statistics, the principal public advisory body to the Secretary on health statistical matters, and with a departmentwide interagency task force comprised of representatives of programs which would be affected by the revision. The Secretary has approved the revision with an effective date of implementation of January 1, 1986.

#### 1984 Revision of the UHDDS

The 1984 Revision of the Uniform Hospital Discharge Data Set consists of the following items:

*Number and item*

1.—Personal Identification
2.—Date of Birth
3.—Sex
4.—Race and Ethnicity
5.—Residence
6.—Hospital Identification
7-8.—Admission and Discharge Dates
9-10.—Physician Identification: Attending and Operating
11.—Diagnoses
12.—Procedures and Dates
13.—Disposition of Patient
14.—Expected Payer for Most of This Bill (Anticipated Financial Guarantor for Services)

The following list contains an identification, definition, or subcategorization of each UHDDS element, and if appropriate, comments are given.

1. *Personal Identification.** The unique number assigned to each patient within a hospital that distinguishes the patient and his or her hospital record from all others in that institution.

2. *Date of Birth.* Month, day, and year of birth.

*Comment:* It is recommended that the year of birth be reported in four digits rather than usually accepted two digits. This will make the data element more accurate if dealing with persons over 100 years old.

3. *Sex.** Male or female.

4a. *Race.* White, Black, Asian or Pacific Islander, American Indian/Eskimo/Aleut, Other.

b. *Ethnicity.* Spanish origin/Hispanic. Non-Spanish origin/Non-Hispanic.

*Comment:* "Race" and "Ethnicity" have been separated for clarification purposes.

* Indicates no definitional change from the UHDDS recommended to the Secretary by the National Committee on Vital and Health Statistics in 1979, viz., National Committee on Vital and Health Statistics. *Uniform Hospital Discharge Data: Minimum Data Set.* DHEW Publication No. (PHS) 80-1157. U.S. Department of Health, Education and Welfare, Washington, April 1980.

5. *Residence.* Zip Code. Code for foreign residence.

*Comment:* A code (to be determined) has been added for foreign residence to include residences throughout the world.

6. *Hospital Identification.*[n] A unique institutional number within a data collection system.

7–8. *Admission and Discharge Dates.*[n] Month, day, and year of both admission and discharge. An inpatient admission begins with the formal acceptance by a hospital of a patient who is to receive physician, dentist, or allied services while receiving room, board, and continuous nursing service. An inpatient discharge occurs with the termination of the room, board, and continuous nursing services, and the formal release of an inpatient by the hospital.

9–10. *Physician Identification.*[n] Each physician must have a unique identification number within the hospital. The attending physician and the operating physician (if applicable) are to be identified.

9. *Attending Physician.* The clinician who is primarily and largely responsible for the care of the patient from the beginning of the hospital episode.

10. *Operating Physician.* The clinician who performed the principal procedure (see item 12 for definition of a principal procedure).

11. *Diagnoses.*[n] All diagnoses that affect the current hospital stay.

a. *PRINCIPAL DIAGNOSIS* is designated and defined as: the condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.

b. *OTHER DIAGNOSES* are designated and defined as: all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay. Diagnoses that relate to an earlier episode which have no bearing on the current hospital stay are to be excluded.

12. *Procedures and Date.* All significant procedures are to be reported.

a. A significant procedure is one that is:

(1) Surgical in nature, or

(2) Carries a procedural risk, or

(3) Carries an anesthetic risk, or

(4) Requires specialized training.

b. For significant procedures, the identity (by unique number within the hospital) of the person performing the procedure and the date must be reported.

c. When more than one procedure is reported, the principal procedure is to be designated. In determining which of several procedures is principal, the following criteria apply:

> The principal procedure is one that was performed for definitive treatment rather than one performed for diagnostic or exploratory purposes, or was necessary to take care of a complication. If there appear to be two procedures that are principal, then the one most related to the principal diagnosis should be selected as the principal procedure.

For reporting purposes, the following definitions and guidelines should be used:

(1) *Surgery* includes incision, excision, amputation, introduction, endoscopy repair, destruction, suture and manipulation.

(2) *Procedural risk.*—This term refers to a professionally recognized risk that a given procedure may induce some functional impairment, injury, morbidity, or even death. This risk may arise from direct trauma, physiologic disturbances, interference with natural defense mechanisms, or exposure of the body to infection or other harmful agents.

Traumatic procedures are those that are invasive, including nonsurgical procedures that utilize cutdowns, that cause tissue damage (e.g., irradiation), or introduce some toxic or noxious substance (e.g., caustic test reagents).

Physiologic risk is associated with the use of virtually any pharmacologic or physical agent that can affect homeostasis (e.g., those that alter fluid distribution, electrolyte balance, blood pressure levels, and stress or tolerance tests).

Any procedure in which it is obligatory (or usual) to utilize pre- or postmedications that are associated with physiologic or pharmacologic risk should be considered as having a "procedural risk," for example, those that require heavy sedation or drugs selected for their systemic effects such as alteration of metabolism, blood pressure or cardiac function.

Some of the procedures that include harmful exposures are those that can introduce bacteria into the blood stream (e.g., cardiac catheterization), those capable of suppressing the immune system, those that can precipitate idiosyncratic reactions such as anaphylaxia after the use of contrast materials, and those involving substances with known systemic toxicity.

Long-life radioisotopes pose a special kind of exposure risk to other persons as well as to the patient. Thus, these substances require special precautionary measures and the procedures using them carry procedural risk.

(3) *Anesthetic risk.*—Any procedure that either requires or is regularly performed under general anesthesia carries anesthetic risk, as do procedures under local, regional, or other forms of anesthesia that induce sufficient functional impairment necessitating special precautions to protect the patient from harm.

(4) *Specialized training.*—This criterion is important for procedures that are exclusively or appropriately performed by specialized professionals, qualified technicians, or clinical teams that are either specifically trained for this purpose or whose services are principally dedicated to carrying them out. Whenever specially trained staff resources are necessary or are customarily employed in the performance of a procedure, it is considered significant.

*Comment:* The categorization of procedures into classes has been eliminated. This will remove the difficulty currently being experienced in selecting the proper classification. It will also allow new procedures to be properly reported. "Special facilities" and "special equipment" have been removed as requirements for a significant procedure". It is believed that the other defined significant procedures encompass these two categories.

13. *Disposition of Patient.*

a. Discharged to home (routine discharge).

b. Left against medical advice.

c. Discharged to another short-term hospital.

d. Discharged to a long-term care institution.

e. Died.

f. Other.

*Comment:* "Other" has been added to this definition to make "disposition of patient" all inclusive.

14. *Expected Payer for Most of This Bill.* (Anticipated Financial Guarantor for Services).

Single major source that the patient expects will pay for his or her bill.

a. Blue Cross.

b. Other insurance companies.

c. Medicare.

d. Medicaid

e. Workers' compensation.

f. Other government payers.

g. Self-pay.

h. No charge (free, charity, special research or teaching).

i. Other.

*Comment:* This definition has been updated and a clarifying statement has been added.

Dated: July 25, 1985.

**James O. Mason,**

*Acting Agency Secretary for Health, and Chairperson, DHHS Health Information Policy Council.*

[FR Doc. 85-18132 Filed 7-30-85; 8:45 am]

BILLING CODE 4150-04-M

## Health Care Financing Administration

[BERC-347-NR]

## Medicare Program; Criteria for Medicare Coverage of Inpatient Hospital Rehabilitation Services

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

**ACTION:** Notice of HCFA ruling.

**SUMMARY:** This notice announces a HCFA ruling that restates HCFA's longstanding criteria for Medicare coverage of inpatient hospital rehabilitation services.

**FOR FURTHER INFORMATION CONTACT:** Tom Hoyer, (301) 594-9446.

**SUPPLEMENTARY INFORMATION:** We plan to compile and publish all HCFA Rulings in the "Health Care Financing Administration Rulings" booklet which will be indexed for citation purposes. When this Ruling is republished in the booklet, it will be known as HCFAR 85-2. The text of the HCFA ruling is as follows:

### MEDICARE COVERAGE OF INPATIENT HOSPITAL REHABILITATION SERVICES—HCFAR 85-2

#### Purpose

This Ruling provides further public notice of HCFA's criteria for Medicare coverage of inpatient hospital rehabilitation services.

#### Citations

Sections 1812, 1814, 1861 and 1862 of the Social Security Act (the Act) (42 U.S.C. 1395d, 1395f, and 1395x, and 1395y).

#### Petinent History

Under the Medicare program, there has always, been a statutory exclusion of-payment for services that" . . . are not reasonable and necessary for the diagonsis or treatment of illness or injury. . . ." (section 1862 of the Act). It is this authority, taken in conjunction with the descriptions of the various benefits, that the program uses to deny payment when services required by a patient could have been appropriately provided in inpatient setting which is less intensive than the hospital setting or in an outpatient setting. (See also section 1154 of the Act.)

Rehabilitation care is furnished in a variety of settings ranging from the inpatient hospital setting, through the skilled nursing facility setting, to various outpatient settings such as, for example, home health care, and outpatient physical therapy. To determine whether inpatient hospital care is necessary for the provision of rehabilitation services, it is first necessary to determine what rehabilitation services the patient requires and then to determine whether they need to be provided in the inpatient hospital setting.

Typically, a preadmission screening is done before a patient is admitted to a rehabilitation hospital. This screening is a preliminary review of the patient's condition and previous medical record to determine if the patient is likely to benefit significantly from an intensive hospital program or extensive inpatient assessment. Further inpatient assessment of a patient's potential for rehabilitation my be done if it is reasonable and necesary to perform the assessment in the hospital.

We developed criteria early in the program to assist medical review entities in applying the basic "reasonable and necessary" test to inpatient rehabilitation services under Part A. These criteria are used to help a medical review entity determine whether rehabilitative care in a hospital, rather than in a SNF or on an outpatient basis, is reasonable and necessary. The criteria have been revised from time to time to respond to new questions of interpretation which have arisen. Section 3101.11 of the Intermediary Manual contains the current version of these criteria. The HCFA Ruling published in this notices restates the criteria set forth in that manual.

#### Ruling

*Criteria for Medicare Coverage of Inpatient Hospital Rehabilitation Services*

A. *General*—Physicians generally agree on the circumstances that justify a medical or surgical patient's hospitalization, and, in some cases, an admission to a rehabilitation hospital or to the rehabilitation service of a short-term hospital can be justified on essentially the same medical or surgical grounds. In other cases, however, a patient's medical or surgical needs alone may not warrant inpatient hospital care, but hospitalization may nevertheless be necessary because of the patient's need for rehabilitative services.

A hospital level of care is required by a patient needing rehabilitative services if that patient needs a relatively intense rehabilitation program that requires a multidisciplinary coordinated team approach to upgrade his ability to function. There are two basic requirements which must be met for inpatient hospital stays for rehabilitation care to be covered:

1. The services must be reasonable and necessary (in terms of efficacy, duration, frequency, and amount) for the treatment of the patient's condition; and

2. It must be reasonable and necessary to furnish the care on the inpatient hospital basis, rather than in a less intensive facility, such as a SNF, or on an outpatient basis.

B. *Preadmission Screening*—Before a patient is admitted to a rehabilitation hospital for treatment, a preadmission screening is normally done. This screening is a preliminary review of the patient's condition and previous medical record to determine if the patient is likely to benefit significantly from an intensive hospital program or extensive inpatient assessment.

While preadmission screening is a standard practice in most rehabilitation hospitals and may provide useful information for claims review purposes, the absence of a preadmission screening in a particular case should not be the sole reason for denying a claim. However, in a case where an inpatient assessment showed a patient clearly was not a good candidate for an inpatient hospital program, then the presence or absence of preadmission screening information would be important in determining whether the inpatient assessment itself was reasonable and necessary. If preadmission screening information indicated that the patient had the potential for benefiting from an inpatient hospital program, a period of inpatient assessment could be covered, up to the point where it was determined that inpatient hospital rehabilitation was not appropriate, since preadmission screening cannot be expected to eliminate all unsuitable candidates.

C. *Inpatient Assessment of Individual's Status and Potential for Rehabilitation* 1. *General*—Coverage is available for inpatient assessment of a patient's potential for benefiting from an intensive coordinated rehabilitation program only if it was reasonable and necessary to perform the assessment in the hospital. This determination should be made on the basis of information available in the patients's medical record. It is important to note that the assessment process is not merely a paperwork review, but rather an onsite professional review of the patient's