States in transit from one country to another without the need of obtaining a visa may do so under the visa waiver provisions of § 41.6(e). Pursuant to paragraph (g) of Executive Order 12543, of January 7, 1986, (51 FR 875), which directed U.S. Government agencies to take appropriate measures to carry out the provisions of that Order, and given the nature and seriousness of Libyan sponsored terrorism against U.S. citizens and property, the Department has determined that it is in the national interest to withdraw the privilege to transit without a visa from citizens of Libya. Upon the effective date of this rule, all Libyans entering the United States for any purpose will be required to be in possession of valid visas and passports. The Immigration and Naturalization Service has also amended its regulations at 8 CFR 212.1(e) to withdraw this privilege from citizens of Libya. Because of the threat to United States national interests, the Department and the Immigration and Naturalization Service, acting jointly, amend the regulations to withdraw the transit without visa privilege as it applies to citizens of Libya and add its name to the list of countries whose nationals are precluded from transiting through the United States without a visa.

Due to the emergency nature of these actions relating to foreign affair functions the provisions of the Administrative Procedure Act, 5 U.S.C. 553, relative to notice of proposed rulemaking are impracticable and contrary to the public interest in this instance. In addition, this final rule is exempt from the requirements of Executive Order 12291 on the same basis. This rule is not considered to be a major rule for purposes of E.O. 12291 nor is it expected to have a significant impact on a substantial number of small entities.

List of Subjects in 22 CFR Part 41

Aliens, Nonimmigrants, Visas, Waivers.

In view of the foregoing, Part 41 is amended to read:

PART 41—PASSPORTS AND VISAS NOT REQUIRED FOR CERTAIN NONIMMIGRANTS

1. The authority citation for Part 41 is revised to read as follows:

Authority: Sec. 101, 84 Stat. 116, 8 U.S.C. 1101; 109(b), 91 Stat. 847; 104, 66 Stat. 174, 8 U.S.C. 1104.

2. The second sentence in § 41.6(e)(1) is revised to read:

§ 41.6 Nonimmigrants not required to present passports, visas, or border-crossing identification cards.

* * * * *

(e) *Aliens in immediate transit—(1) Aliens in bonded transit.* * * * This waiver of visa and passport requirement is not available to an alien who is a citizen of Afghanistan, Bangladesh, Cuba, India, Iran, Iraq, Libya, Pakistan or Sri Lanka. * * *

* * * * *

Dated: May 19, 1986.

Joan M. Clark,

Assistant Secretary for Consular Affairs.

[FR Doc. 86-11609 Filed 5-21-86; 8:45 am]

BILLING CODE 4710-06-M

DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Part 1

[T.D. 8089]

Income Taxes; Investment Credit Limitation in Regulated Companies; Synchronization of Interest

AGENCY: Internal Revenue Service, Treasury.

ACTION: Final regulations.

SUMMARY: This document contains final regulations relating to the limitation on the investment credit in the case of certain regulated companies. Questions have arisen concerning the permissibility of "synchronization of interest" and the "zero-cost capital" method under the ratable flow-through method of accounting for the investment credit with respect to public utility property. The regulations provide guidance on these issues and affect regulated companies that use the ratable flow-through method of accounting for the investment credit with respect to public utility property.

DATE: The regulations are generally effective with respect to public utility property constructed or acquired by the taxpayer after August 15, 1971.

FOR FURTHER INFORMATION CONTACT: Paulette Chernyshev of the Legislation and Regulations Division, Office of Chief Counsel, Internal Revenue Service, 1111 Constitution Avenue, NW., Washington, DC 20224, Attention: CC:LR:T, 202-566-3288, not a toll-free call.

SUPPLEMENTARY INFORMATION:

Background

On June 26, 1985, proposed amendments to the Income Tax Regulations (26 CFR Part 1) under section 46(f) of the Internal Revenue Code were published in the **Federal Register** (50 FR 26385). The amendments were proposed to clarify the manner in which the limitation imposed by section 46(f) applies in the case of regulated companies that use the ratable flow-through method of accounting for the investment credit with respect to public utility property.

Many written comments were received with respect to the proposed amendments, and a public hearing on the amendments was held on August 28, 1985. After consideration of all comments and testimony received on the proposed amendments, the amendments are adopted as revised by this Treasury decision.

Interest Synchronization

Section 46(f)(2) permits the use of a ratable flow-through method of accounting for the investment credit with respect to public utility property. Under this method of accounting, the taxpayer's cost of service for ratemaking purposes may be reduced by a ratable portion of the investment credit. The credit is disallowed, however, if the taxpayer's cost of service is reduced by more than a ratable portion of the credit or if the base to which the taxpayer's rate of return for ratemaking purposes is applied ("rate base") is reduced by any portion of the credit.

In determining whether a credit has been used to reduce rate base, § 1.46-6(b)(3) of the regulations requires reference to "any accounting treatment that affects the permitted return on investment by treating the credit in any way other than as though it were capital supplied by common shareholders to which a 'cost of capital' rate is assigned that is not less than the taxpayer's overall cost of capital rate." This requirement appears only in the definition of rate base and it is unclear whether the credit also must be treated as capital provided by common shareholders in determining cost of service. As a result, the Service has received a number of ruling requests asking whether a portion of the return on the rate base attributable to the credit may be characterized as interest expense and taken into account in computing Federal income tax expense for ratemaking purposes ("interest synchronization" or "synchronization of interest").

This issue is addressed, either directly or indirectly, in several cases reviewing rate orders. Although the permissibility of synchronization of interest was an issue in these reviews, the Internal Revenue Service was not a party to the

cases and the decisions did not determine the actual tax liability of the regulated companies. Two Federal Courts of Appeal have determined that interest synchronization does not violate section 46(f)(2) or the existing regulations. *Union Electric* v. *FERC*, 668 F.2d 389 (8th Cir. 1981); *Nepco Municipal Rate Commission* v. *FERC*, 688 F.2d 1327 (D.C. Cir. 1981); *Public Service of New Mexico* v. *FERC*, 653 F.2d 681 (D.C. Cir. 1981). In addition, several state courts have approved the use of interest synchronization in ratemaking proceedings. *See, e.g., Narragansett Electric Company* v. *Burke*, 475 A.2d 1379 (R.I. 1984); *New England Telephone & Telegraph Company* v. *Public Utilities Commission*, 448 A.2d 272 (Me. 1982). Other courts, however, have concluded that synchronization of interest is not permitted under section 46(f)(2) and the existing regulations. *See, e.g., Utilities Commission* v. *Carolina Telephone & Telegraph*, 300 S.E. 2d 395 (Ct. App. N.C. 1983).

The proposed regulations provided that interest synchronization would not constitute a reduction in cost of service for purposes of section 46(f)(2), thus generally permitting interest synchronization for purposes of the ratable flow-through method of accounting for the investment credit. The preamble of the notice of proposed rulemaking set forth two reasons for this provision. The first was the Service's conclusion that synchronization of interest does not result in a reduction of cost of service that is attributable to the credit. This conclusion is consistent with financial market realities since, in the absence of the credit, the additional capital needed to finance the investment property generally would be obtained from a similar proportion of debt and equity as in the existing capital structure of the utility. Synchronization of interest properly takes account of the additional interest expense that would have been incurred in those circumstances.

In addition, the Service believed that synchronization of interest under section 46(f)(2) would result in an appropriate accounting for the credit in establishing rates. The basis for this conclusion may be illustrated by a comparison of the rates that would be established without synchronization of interest with the rates that would be established if the credit were unavailable. Under certain factual circumstances (e.g., long-lived assets with respect to which the credit was allowed), the rates that would be established without synchronization of interest may actually exceed in one or more service years the rates that would be established if the credit were unavailable. In contrast, the rates that would be established with synchronization of interest cannot exceed in any year the rates that would be established if the credit were unavailable.

The Service received a number of comments from public service commissions and other regulatory authorities generally supporting the position in the proposed regulations. On the other hand, the Service also received many comments from regulated public utilities and their representatives, which, with some exceptions, opposed interest synchronization on the ground that it constitutes an impermissible reduction in cost of service under section 46(f)(2). After careful consideration of all comments received, the Service has concluded that interest synchronization should be permitted for the reasons stated in the preamble of the notice of proposed rulemaking. Accordingly, the final regulations clarify that interest synchronization is permitted under a ratable flow-through method of accounting.

Zero-Cost Capital

Another issue addressed by the public comments concerned the effect of "zero-cost capital" on the rate of return assigned to the credit. The issue arises if, for example, the reserve for deferred taxes established under sections 167 and 168 is included in rate base as no-cost capital, as permitted under section 1,167(e) of the regulations. The issue may similarly arise, for example, if non-interest-bearing liabilities such as customer deposits are included in a taxpayer's rate base. In such situations, a ratemaking commission may reduce the overall rate of return on account of the zero-cost capital (*e.g.*, deferred taxes or non-interest-bearing liabilities) included in rate base. The issue raised by the public comments is whether the rate of return assigned to the credit under section 46(f)(2)(B) may also be reduced on account of such zero-cost capital.

The proposed regulations provided that the cost of capital assigned to the credit must be at least equal to the overall cost of the capital, determined on the basis of a weighted average, that would have been provided by common and preferred shareholders and long-term creditors if the credit were unavailable. Under the proposed regulations, the composition of such capital depended, generally, on all the relevant facts and circumstances; however, a safe-harbor provision permitted determinations that additional capital would have been provided in the same proportions and at the same rates of return as the capital actually provided by shareholders and long-term creditors. Neither the general rule nor the safe-harbor provision of the proposed regulations would have permitted any reduction in the rate of return assigned to the investment credit on account of zero-cost capital. This position was based on the assumption that items of zero-cost capital would not increase if the credit were unavailable.

After consideration of the comments the Service has concluded that, although this assumption regarding zero-cost capital is generally true, it is not strictly correct in certain situations. For example, if the basis of a utility's property has been reduced under section 48(q), the additional capital provided if the credit were unavailable would include not only equity and long-term debt, but also deferred taxes. This occurs because the utility's basis in the property would increase if the credit were unavailable, eventually resulting in a greater amount of deferred taxes. Accordingly, the final regulations permit zero-cost capital to be taken into account for purposes of determining the cost of capital assigned to the credit, but only to the extent that additional amounts of such capital would be provided if the credit were unavailable. In the case of a utility that has a basis reduction under section 48(q), for example, the amount of capital provided in the form of deferred taxes will, as explained above, generally be less in each period than the amount of deferred taxes that would be provided if the credit were unavailable. For any period, the difference between these two amounts is the amount of additional deferred taxes that would be provided if the credit were unavailable. The regulations provide that only the amount of additional deferred taxes for a period may be taken into account in determining the rate of return assigned to the credit for that period. Thus, the deferred taxes actually included in the utility's rate base may not be taken into account for this purpose. Under the regulations, any amount of additional zero-cost capital must also be taken into account for purposes of determining the amount of additional interest that the taxpayer would pay or accrue if the credit were unavailable, thus reducing the amount subject to interest synchronization.

The Service continues to believe that additional capital typically would be provided primarily in the form of equity and long-term debt if the credit were unavailable. Accordingly, the safe-

harbor provision of the proposed regulations is generally unchanged, except to clarify that the safe harbor applies only if it is used to determine both the cost of capital assigned to the credit and the amount subject to interest synchronization.

Hypothetical Capital Structure

An additional issue raised by the public comments concerned the effect of using a hypothetical capital structure to determine a utility's overall rate of return. A hypothetical capital structure may be used if, for example, a regulatory commission determines that the actual capital structure of a utility does not include sufficient debt and imputes debt of a parent holding company to the utility. The issue in such cases is whether the composition of the capital that would be provided if the credit were unavailable is determined by reference to the change that would occur in the actual capital structure of the utility or, instead, by reference to the change in the hypothetical capital structure used by the ratemaking commission. The final regulations clarify that it is the change in the hypothetical capital structure that is taken into account for this purpose.

Transitional Rule

The Service received a number of inquiries requesting clarification of the transitional rule in § 1.46–6(b)(iii) of the proposed regulations. In general, this rule (as revised by this Treasury decision) provides that rate orders put into effect before June 23, 1986 do not violate section 46(f) if they satisfy the requirements of either the amended regulations or the regulations in effect before the amendment. This is significant because the regulations in effect before the amendment provided that the overall cost of capital rate depends on the practice of the regulatory body. The Internal Revenue Service is aware that certain ratemaking commissions, relying on this language, have required utilities to use zero-cost capital in determining the earnings rate to be assigned to the credit in a manner inconsistent with the amended regulations. The use of zero-cost capital in such cases will not be treated as a violation of section 46(f)(2) under the regulations in effect before the amendments.

Amendments Not Covered by These Proposed Regulations

The amendments do not reflect amendments made to section 46 after the enactment of the Revenue Act of 1971, other than the redesignation of section 46(e) as section 46(f) by the Tax Reduction Act of 1975. In addition, the regulations do not reflect the amendment made to section 167(l) (2) (C) by section 209(d)(3) of the Economic Recovery Tax Act of 1981 (Pub. L. 97–34; 95 Stat. 227). That amendment has the effect of eliminating the special rule for immediate flow-through under section 46(f)(3) for property placed in service after December 31, 1980.

Regulatory Flexibility Act; Executive Order 12291

The Commissioner of Internal Revenue has determined that this final rule is not a major rule as defined in Executive Order 12291 and that a Regulatory Impact Analysis therefore is not required. Although a notice of proposed rulemaking that solicited public comment was issued, the Internal Revenue Service concluded when the notice was issued that the regulations are interpretative and that the notice and public procedure requirements of 5 U.S.C. 553 do not apply. Accordingly, the final regulations are not subject to the Regulatory Flexibility Act (5 U.S.C. Chapter 6).

Drafting Information

The principal author of these regulations is Paulette Chernyshev of the Legislation and Regulations Division of the Office of Chief Counsel, Internal Revenue Service. However, personnel from other offices of the Internal Revenue Service and Treasury Department participated in developing the regulations on matters of both substance and style.

List of Subjects in 26 CFR Parts 1.0–1—1.58–8

Income taxes, Tax liability, Tax rates, Credits.

Amendments to the Regulations

Accordingly, 26 CFR Part 1 is amended as follows:

PART 1—[AMENDED]

Income Tax Regulations

Paragraph 1. The authority for Part 1 is amended by adding the following citation:

Authority: 26 U.S.C. 7805. * * * Section 1.46–6 also issued under 26 U.S.C. 46(f)(7).

Par. 2. Section 1.46-6 is amended by revising paragraph (b)(2)(i), (3), and (4)(ii) to read as follows:

§ 1.46-6 Limitation in case of certain regulated companies.

* * * * *

(b) *Definitions.* * * *

(2) *Cost of service.* (i) (A) For purposes of this section, "cost of service" is the amount required by a taxpayer to provide regulated goods or services. Cost of service includes operating expenses (including salaries, cost of materials, etc.) maintenance expenses, depreciation expenses, tax expenses, and interest expenses. For purposes of this section, any effect on a taxpayer's permitted return on investment that results from a reduction in the taxpayer's rate base does not constitute a reduction in cost of service, even though, as a technical ratemaking term, "cost of service" ordinarily includes a permitted return on investment. In addition, taking into account a deduction for the additional interest that the taxpayer would pay or accrue if the credit were unavailable in determining Federal income tax expense ("synchronization of interest") does not constitute a reduction in cost of service for purposes of section 46(f)(2). This adjustment to Federal income tax expense may be taken into account in determining cost of service for the regulated accounting period or periods that include the taxable year to which the adjustment relates or for any subsequent regulated accounting period.

(B) See paragraph (b)(3)(ii)(B) of this section for rules relating to the amount of additional interest that the taxpayer would pay or accrue if the credit were unavailable.

* * * * *

(3) *Rate base.* (i) For purposes of this section, "rate base" is the monetary amount that is multiplied by a rate of return to determine the permitted return on investment.

(ii)(A) In determining whether, or to what extent, a credit has been used to reduce rate base, reference shall be made to any accounting treatment that affects rate base. In addition, in those cases in which the rate of return is based on the taxpayer's cost of capital, reference shall be made to any accounting treatment that reduces the permitted return on investment by treating the credit less favorably than the capital that would have been provided if the credit were unavailable. Thus, the credit may not be assigned a "cost of capital" rate that is less than the overall cost of capital rate, determined on the basis of a weighted average, for the capital that would have been provided if the credit were unavailable.

(B) For purposes of determining the cost of capital rate assigned to the credit and the amount of additional interest that the taxpayer would pay or accrue, the composition of the capital that would have been provided if the credit were unavailable may be determined—

(*1*) On the basis of all the relevant facts and circumstances; or

(*2*) By assuming for both such

purposes that such capital would be provided solely by common shareholders, preferred shareholders, and long-term creditors in the same proportions and at the same rates of return as the capital actually provided to the taxpayer by such shareholders and creditors.

For purposes of this section, capital provided by long-term creditors does not include deferred taxes as described in section 167(e)(3)(G) or 168(e)(3)(B)(ii).

(C) If a taxpayer's overall rate of return is based on a deemed or hypothetical capital structure, paragraph (b)(3)(ii)(B) of this section shall be applied by treating the deemed or hypothetical capital as if it were the capital actually provided to the taxpayer and determining the composition of the capital that would have been provided if the credit were unavailable in a manner consistent with such treatment.

(iii) Whether, or to what extent, a credit has been used to reduce rate base for any period to which pre-June 23, 1986 rates apply will be determined under 26 CFR 1.46-6(b) (3) and (4) (revised as of April 1, 1985) if such a determination avoids disallowance of a credit that would be disallowed under paragraph (b)(3)(ii) or (4)(ii) of this section. For this purpose, a period of which pre-June 23, 1986 rates apply is any period for which the effect of the credit on rate base for ratemaking purposes is established under a determination put into effect (within the meaning of paragraph (f) of this section) before June 23, 1986.

(4) *Indirect reductions to cost of service or rate base.* * * *

(ii) One type of such indirect reduction is any ratemaking decision in which the credit is treated as operating income (subject to ratemaking regulation) or is treated less favorably than the capital that would have been provided if the credit were unavailable. For example, if the credit is accounted for as nonoperating income on a company's regulated books of account but a ratemaking decision has the effect of treating the credit as operating income in determining rate of return to common shareholders, then cost of service has been indirectly reduced by reason of the credit.

* * * * *

Roscoe L. Egger, Jr.,

Commissioner of Internal Revenue.

Approved: May 5, 1986.

J. Roger Mentz,

Assistant Secretary of the Treasury.

[FR Doc. 86-11596 Filed 5-21-86; 8:45 am]

BILLING CODE 4830-01-M

EQUAL EMPLOYMENT OPPORTUNITY COMMISSION

29 CFR Part 1601

Final Procedural Regulation

AGENCY: Equal Employment Opportunity Commission.

ACTION: Final rule.

SUMMARY: The Equal Employment Opportunity Commission is amending its procedural regulations to reflect a change in delegations of authority for issuance of administrative determinations on charges brought under Title VII of the Civil Rights Act of 1964, as amended.

EFFECTIVE DATE: May 22, 1986.

FOR FURTHER INFORMATION CONTACT: Nicholas M. Inzeo, Assistant Legal Counsel, Legal Services, Equal Employment Opportunity Commission, 2401 E Street, NW., Washington, DC 20507 (202) 634-6592.

SUPPLEMENTARY INFORMATION: Authority for issuing letters of determination on charges filed under Title VII of the Civil Rights Act generally has been delegated to Commission field offices. In the past the delegation in 29 CFR 1601.21(d) has included authority to issue determinations where previously issued Commission decisions or guidelines serve as precedent for the determination. In order to more effectively address issues of concern to the Commission, the Commission is amending its delegation of authority to issue letters of determination. The Commission will no longer use the criterion of existing decision or guideline precedent to determine when field offices are delegated authority to issue determinations on charges. Rather, the Commission periodically will identify issues which it wants to review and will delegate authority to issue determinations in all cases except those that contain such an issue. Those issues will be contained in Appendix A of Section 603 of Volume II of the EEOC Compliance Manual. Consistent with the change in delegation of authority in 29 CFR 1601.21(d), the Commission is amending 29 CFR 1601.77, to explain that the Commission will individually review charges closed by 706 agencies that contain an issue designated by the Commission for review.

This regulation has been reviewed in accordance with Executive Order 12291. It is not a major rule and does not require a regulatory impact analysis under section 3 of that Order. Similarly, the Commission certifies under 5 U.S.C. 3605(b), enacted by the Regulatory Flexibility Act (Pub. L. 96-354), that this rule will not result in a significant impact on a substantial number of small entities. Therefore, a regulatory flexibility analysis is not required.

List of Subjects in 29 CFR Part 1601

Administrative practice and procedure, Equal employment opportunity, Inter-governmental Relations.

By virtue of the authority vested in the Commission under section 713(a) of Title VII of the Civil Rights Act of 1964, 42 U.S.C. 2000e-12(a), the Equal Employment Opportunity Commission hereby publishes the amendment to § 1601.21 and § 1601.77 of its procedural regulations.

For the Commission.

Clarence Thomas,

Chairman.

Accordingly, EEOC amends 29 CFR Part 1601 as follows:

1. The authority citation for Part 1601 continues to read as follows:

Authority: Sec. 713(a), Title VII of the Civil Rights Act of 1964, as amended, 42 U.S.C. 2000e-12(a), otherwise noted.

§ 1601.21 [Amended]

2. Section 1601.21(d) introductory text is amended by removing the clause "in those cases in which previously issued Commission Decisions serve as precedent for the determination and in those cases in which the Commission's Guidelines provide a statement of policy which serves as authority for the determination" and replacing it with the clause "except in those cases involving issues currently designated by the Commission for priority review."

§1601.77 [Amended]

3. Section 1601.77 is amended by removing the clause "or where no previously issued Commission decision serves as precedent for the determination in the charge" and replacing it with the clause "or where the charge involves an issue currently designated by the Commission for priority review."

[FR Doc. 86-11370 Filed 5-21-86; 8:45 am]

BILLING CODE 6570-01-M

DEPARTMENT OF DEFENSE

Department of the Navy

32 CFR Part 732

Nonnaval Medical and Dental Care

AGENCY: Naval Medical Command, Navy, DOD.

ACTION: Final rule.

SUMMARY: The Naval Medical Command promulgated this regulation to disseminate the authority and policies involved in obtaining and having the Navy pay for nonnaval medical and dental care of active duty naval personnel and outpatient care from nonnaval sources for active duty members of North Atlantic Treaty Organization nations. Regulation also sets forth Third Party Liability Program recoupment for benefits received and collection action for subsistence furnished while such members are hospitalized in nonnaval facilities.

EFFECTIVE DATE: July 13, 1984.

FOR FURTHER INFORMATION CONTACT: Herbert L. Pelham, Program Analyst, Naval Medical Command, Washington, DC 20372–5120, (202) 653–1179.

SUPPLEMENTARY INFORMATION: This revision relates to internal naval management and personnel practices and largely reflects nonsubstantive changes adopted in NAVMEDCOMINST 6320.1. It was determined that invitation of public comment on these changes prior to adoption would be impracticable and is therefore not required under public rulemaking provisions of Parts 296 and 701 of 32 CFR.

List of Subjects in 32 CFR Part 732

Dental health, Health care, Military personnel.

Dated: May 15, 1986.

William F. Roos, Jr.,

Lt, JAGC, USNR Federal Register Liaison Officer.

Accordingly, 32 CFR Part 732 is revised to read as follows:

PART 732—NONNAVAL MEDICAL AND DENTAL CARE

Subpart A—General

Sec.

Subpart B—Medical and Dental Care From Nonnaval Sources

Authority: 5 U.S.C. 301; 10 U.S.C. 1071–1088, 5031, 6148, 6201–6203, and 8140; and 32 CFR 700.1202.

Subpart A—General

§ 732.1 Purpose.

To delineate and promulgate the authority and policies concerning inpatient and outpatient medical and dental care obtained from nonnaval sources by active duty Navy and Marine Corps members and outpatient care from nonnaval sources for active duty members of North Atlantic Treaty Organization (NATO) nations. Provides the conditions under which the costs of such care may be borne by the Navy.

§ 732.2 Scope.

The provisions of this part are applicable for:

(a) Both inpatient and outpatient medical and dental care of U.S. Navy and Marine Corps personnel who incur disease or injury while on active duty. Reservists are entitled to care under the provisions of this part for conditions occurring during active duty for training and inactive duty training (drill), including travel to and from training sites.

(b) The outpatient care of naval members of NATO Status of Forces Agreement (SOFA) nations (Belgium, Canada, Denmark, Federal Republic of Germany, France, Greece, Iceland, Italy, Luxembourg, the Netherlands, Norway, Portugal, Spain, Turkey, and the United Kingdom) who are stationed in or passing through the United States in connection with their official duties.

§ 732.3 Background.

(a) The special authority of the Manual of the Medical Department (MANMED), article 11–7(3)(b), applicable to patients under the jurisdiction of commanding officers of naval hospitals, remains in effect and is to be used for nonnaval medical and dental care of such patients. Guidelines concerning care for other eligible beneficiaries, not authorized care by this part, are contained in BUMED INST 6320.58 and Part 728 of this chapter. Subpart B provides guidelines and procedures whereby naval commands may:

(1) Arrange for appropriate care in other than naval facilities for authorized members under their jurisdiction.

(2) Assist in those instances when authorized personnel obtain civilian medical or dental care for themselves and seek reimbursement from the Navy.

(3) Authorize payment directly to providers of care when payment has not been made by the member or by someone acting on behalf of the member.

(4) Assist active duty Navy and Marine Corps maternity patients in obtaining care in civilian facilities, when appropriate, and arranging for payment of charges for the member and the routine care of the newborn in accordance with the Assistant Secretary of Defense for Health Affairs memo of 16 May 1979, Inpatient routine newborn care: Active duty female maternity episode, and Assistant Secretary of Defense for Health Affairs memo of 18 July 1979, Active duty female maternity episode.

(b) Subpart B also delineates areas over which geographic naval medical commands have responsibilities for administration of nonnaval medical and dental care program functions. Program management is vested in the Commander, Naval Medical Command, Washington, DC (MEDCOM–333).

(c) The Assistant Secretary of Defense (Comptroller) memo of 12 March 1981, Reimbursement for inpatient medical care provided foreign military and diplomatic personnel of their dependents in military hospitals in the United States, outlines the provisions of Pub. L. 96–527. This memo provides that inpatient care of foreign military members in the United States shall not be rendered at the expense of the United States Government. Accordingly, only the cost of outpatient care shall be paid under the provisions of this part for active duty members of NATO nations who are stationed in or passing through the United States in connection with their official duties.

§ 732.4 Action.

All commands shall ensure that personnel under their cognizance are made aware of the contents of this part. Failure to comply with the prescribed requirements could result in the Navy's denial of financial responsibility for the expenses of medical or dental care obtained.

Subpart B—Medical and Dental Care From Nonnaval Sources

§ 732.11 Definitions.

Unless otherwise qualified herein, the following terms when used throughout this part are defined as follows:

(a) *Active Duty.* Full-time duty in the active military service of the United States. This includes duty on the active list; full-time training duty; annual training duty; and attendance, while in the active military service, at a school designated as a service school by law or by the Secretary of the military department concerned.

(b) *Active Duty for Training.* A period of duty performed in the active military service by a member of a reserve component under orders by competent authority for a specified period which provides for automatic reversion to inactive duty when the specified period of active duty is completed. Includes not only the period of time from reporting to the time of release but also the time of travel to and from the duty station, not in excess of the allowable constructive travel time (see SECNAVINST 1770.3 and DOD Military Pay and Allowances Entitlements Manual (DODPM) paragraphs 10242 and 10243).

(c) *Constructive Return.* For purposes of medical and dental care, return of an unauthorized absentee to military control may be accomplished through notification of appropriate military authorities (§ 732.13(e) amplifies).

(d) *Designated Uniformed Services Treatment Facilities (Designated USTFs).* In accordance with Pub. L. 97–99, the following former U.S. Public Health Service (USPHS) facilities are now "designated USTFs" for the purpose of rendering medical and dental care to all categories of individuals entitled to care under the provisions of this part.

(1) *Hospitals.* (i) Wyman Park Health Systems, 3100 Wyman Park Drive, Baltimore, MD 21211, Telephone (301) 338–3000.

(ii) Allston-Brighton Aid and Health Group, 77 Warren Street, Boston, MA 02135, Telephone (617) 782–3400.

(iii) Hospital of St. John, 2050 Space Park Drive, Nassau Bay, TX 77058, Telephone (713) 757–7430.

(iv) Seattle Public Health Hospital, 1131 14th Avenue South, Seattle, WA 98144, Telephone (206) 324–7650.

(v) Bayley Seton Hospital, Bay Street and Vanderbilt Avenue, Staten Island, NY 10304, Telephone (212) 447–3010.

(2) *Clinics.* (i) Coastal Health Service, 331 Veranda Street, Portland, ME 04103, Telephone (207) 780–3210.

(ii) Lutheran Medical Center, Downtown Health Care Services, New Post Office Bldg., W. 3rd Street and Prospect Avenue, Cleveland, OH 44113, Telephone (216) 522–4524.

(iii) St. Mary's Hospital, 440 Avenue North, Galveston, TX 77550, Telephone (713) 757–7430.

(iv) St. Joseph Ambulatory Care Center, 204 U.S. Customs Bldg., 701 San Jacinto Street, Houston, TX 77002, Telephone (713) 757–7430.

(v) Family Practice Center, Port Arthur, TX 77640, Telephone (713) 757–7430.

(e) *Duty Status.* The performance category of the claimant at the time medical or dental care is received, either active duty or nonactive duty. Members, including reservists, on leave or liberty are considered in a duty status. Reservists, when performing active duty for training or inactive duty for training, are considered in a duty status, including their allowable constructive travel time to and from training.

(f) *Emergency.* A situation where the need or apparent need for medical or dental attention is such that time does not permit obtaining prior approval for civilian medical care.

(g) *Inactive Duty Training (Drill).* Includes that period between muster, dismissal, and allowable constructive travel time to and from such drills (see DODPM paragraphs 10242 and 10243).

(h) *Maternity Emergency.* A condition commencing or exacerbating during pregnancy in a manner such that a delay caused by referral to a USMTF or designated USTF would jeopardize the welfare of the mother or her unborn child.

(i) *Medical Management.* When an active duty member presents for treatment at a naval MTF, that patient is considered under the medical management of a naval physician when a naval physician exercises primary and continuing decision authority regarding diagnosis and treatment, regardless of whether the patient is actually treated by that physician.

(j) *Non-Federal Care.* Medical or dental care provided by civilian sources (includes State, local, and foreign MTFs).

(k) *Nonnaval Care.* Medical or dental care provided by other than naval MTFs. Includes care in other USMTFs, VA facilities, as well as from civilian sources.

(l) *Office of Medical Affairs (OMA) or Office of Dental Affairs (ODA).* Designated offices, under the program management control of COMNAVMEDCOM (MEDCOM–333) and the direct control of regional medical commands, responsible for the continued administration of the requirements of this part.

(m) *Prior Approval.* Permission granted to an individual for a specific episode of necessary but nonemergent maternity, medical, or dental care.

(n) *Reservist.* A member of the Naval or Marine Corps Reserve.

(o) *Supplemental Care.* When an active duty member is under the medical management (see § 732.11(i)) of a naval MTF physician and required care is not available at that facility, any additional materials or professional and personal services ordered by qualified naval MTF providers and obtained for the care of that patient are supplemental. This includes necessary referrals to civilian sources. Costs are chargeable to the operation and maintenance funds available for operation of the facility requesting care or services. For the exception to this policy, see § 732.18(c)(4).

(p) *Unauthorized Absence.* Absence without authority from a member's command or departure without authority from the assigned place of duty.

(q) *Uniformed Services Medical Treatment Facilities (USMTF).* Health care facilities of the Army, Air Force, Coast Guard, Navy, and the former U.S. Public Health Service facilities listed in § 732.11(d) that have been designated as USTFs in accordance with DOD and Department of Health and Human Services directives.

§ 732.12 Program management.

(a) *In the 48 Contiguous United States and Alaska.* Under program management control of COMNAVMEDCOM (MEDCOM–333) and direct control of regional medical commands, OMAs and the ODA listed in § 732.18(f)(1) shall:

(1) Exercise coordination over this program within their areas of responsibility including:

(i) Granting or denying approval for the procurement of nonemergency care from civilian sources.

(ii) Adjudicating medical and dental care claims.

(iii) Notifying COMNAVMEDCOM (MEDCOM–333, Autovon 294–1127 or Commercial 202–653–1127) in a situational report (MED 6320–30) when it appears that an episode of non-Federal care will extend beyond 15 days or will cost more than $25,000. Before calling, be prepared to furnish the following concerning the patient:

(A) Name, grade or rate, and social security number.

(B) Name of non-Federal medical facility rendering treatment.

(C) Date admitted.

(D) Reason patient cannot be or has not been moved to a Federal facility.

(E) Expected duration of non-Federal treatment.

(F) Expected total cost of non-Federal care.

(iv) Determining the need for medical boards subsequent to completion of nonnaval medical care and notifying COMNAVMEDCOM (MEDCOM–25), via the regional medical command, of the determination (see § 732.19 for further amplification).

(v) Issuing letters, upon written request, to recruiting offices far removed from USMTFs and designated USTFs granting blanket approval for civilian medical care of active duty recruiting office personnel. With a full realization that such blanket approval is an authorization to obligate the Government without individual prior approval, OMAs and the ODA shall ensure that:

(A) Each letter specifies a maximum dollar amount allowable in each instance of care.

(B) The location of each recruiting office authorized to obligate is clearly delineated.

(C) Travel distance and time required to reach the nearest USMTF, designated USTF, or VA facility have been considered.

(D) Certain conditions are specifically excluded, e.g., psychiatric care and elective surgical procedures. These conditions will continue to require individual prior approval.

(E) All requests for blanket authorization from other than recruiting offices are forwarded to COMNAVMEDCOM (MEDCOM–333), via the chain of command, for concurrence.

(F) COMNAVMEDCOM (MEDCOM–333) is made an information addressee on each letter of authorization.

(2) Furnish a monthly letter report (MED 6320–23) to COMNAVMEDCOM (MEDCOM–333), with a copy of the dental portion to MEDCOM–32, to reach the Command no later than the 15th day of the month following the month being reported. The report shall reflect the total cost of claims adjudicated and:

(i) The number of:

(A) Claims approved.

(B) Hospital days and dollar value of each.

(C) Outpatient visits and dollar value of each.

(D) Dental visits and dollar value of each.

(E) Ambulance trips and dollar value of each.

(F) Unadjudicated claims on hand at both the beginning and end of month.

(G) Claims on hand more than 30 days.

(H) Inpatient days, outpatient visits, and dollar value of each category of care provided by designated USTFs.

(I) Inpatient hospital days and dollar value of care provided by designated USTFs.

(J) Pharmacy, laboratory, and X-ray services (paid separately from care in § 732.12(a)(2)(i) (B) and (D)). Include the average cost of each and the total cost of all.

(K) Maternity episodes and average cost.

(ii) Name, grade or rate, social security number, and disposition (date and type) of each patient for whom notification is required in accordance with § 732.12(a)(1)(iii).

(iii) Amount of returned checks and overpayments submitted to OMA or ODA and fiscal year to which funds are being credited.

(iv) Personnel changes in OMA or ODA for the month.

(3) Coordinate, with each member and each member's command, convalescent leave granted in accordance with the Naval Military Personnel Manual (MILPERSMAN) and Marine Corps Order P1050.3E.

(4) Assume medical cognizance responsibility for members hospitalized in nonnaval facilities within the OMA's geographical area of responsibility.

(b) *Outside the 48 Contiguous United States and Alaska.* (1) In areas outside the 48 contiguous United States and Alaska, individual commanding officers are authorized to obtain required non-Federal care for members under their command when there are no Federal or NATO SOFA facilities available, or if available, are unable to render required care. If the commanding officer considers it in the best interest of the United States, immediate payment may be effected for such services. When payment is made out of any funds other than those specified for non-Federal medical or dental care, the commanding officer shall apply for reimbursement in accordance with the provisions of this part.

(2) The adjudicating authority at activities listed in § 732.18(f)(2) shall:

(i) Exercise coordination and technical control over this program outside the 48 contiguous United States and Alaska, including the coordination and cognizance responsibilities listed in § 732.12(a) (3) and (4), as appropriate.

(ii) Adjudicate medical and dental care claims.

(iii) Report non-Federal care expenditures as delineated in § 732.12(a)(1)(iii) and § 732.12(a)(2).

§ 732.13 General.

If medical or dental care is required and there are no naval facilities available, initial application shall always be made to other available Federal medical or dental facilities.

(FEDERAL FACILITIES: NAVY, ARMY, AIR FORCE, VETERANS ADMINISTRATION, AND DESIGNATED FORMER U.S. PUBLIC HEALTH SERVICE FACILITIES listed in § 732.11(d).)

Additionally, members shall obtain emergency and nonemergency care from military facilities of the host country, or if applicable, from civilian sources under the NATO SOFA when U.S. facilities are not available and the member is stationed in or passing through a NATO SOFA nation. When either emergency or nonemergency care is required and there are no Federal or NATO SOFA facilities available, care may be obtained from civilian sources under the following conditions:

(a) *Emergency Care.*—(1) *Maternity Emergency.* When a condition commences or exacerbates during pregnancy in a manner that a delay, caused by referral to a uniformed services or designated uniformed services medical treatment facility, would jeopardize the welfare of the mother or her unborn child, the following constitutes indications for admission to a non-Federal facility:

(i) Medical or surgical conditions which would constitute an emergency in the nonpregnant state.

(ii) Obstetric conditions:

(A) Spontaneous abortion, with first trimester hemorrhage.

(B) Premature term labor with delivery.

(C) Severe pre-eclampsia.

(D) Hemorrhage, second and third trimester.

(E) Ectopic pregnancy with cardiovascular instability.

(F) Premature rupture of membranes with prolapse of the umbilical cord.

(G) Obstetric sepsis.

(H) Any other obstetrical condition that, by definition, constitutes an emergent circumstance.

(2) *Medical or Dental.* A situation where the need or apparent need for medical or dental attention is such that time does not permit obtaining authority in advance.

(3) *Authority to Adjudicate.* Only in such a defined emergency shall medical, dental, or maternity services be obtained under this part by or on behalf of eligible personnel without the prior authority covered below. As soon as possible after obtaining such care, the

appropriate OMA or ODA listed in § 732.18(f) shall be provided the following information. This information will be used to make arrangements for transfer of the member and, if appropriate, newborn infant(s), to a Federal facility or for such other action as is appropriate. For the purpose of this part, this information shall be provided to the OMA or ODA in addition to the requirements of article 4210100 of MILPERSMAN or Marine Corps Order 6320.3B

(i) Name, grade or rate, and social security number of patient.

(ii) Name of non-Federal medical or dental facility rendering treatment.

(iii) Date(s) of such treatment.

(iv) Nature and extent of treatment or care already furnished.

(v) Need or apparent need for further treatment (for maternity patients, need or apparent need for further care of infant(s) also).

(vi) Earliest date on which transfer to a Federal facility can be effected.

(b) *Nonemergency Care.* The health benefits advisor (HBA) serving the regional medical command assigned responsibility for the OMA or ODA function shall:

(1) Receive information to complete sections I and III of NAVMED 6320/10's for coordination of requests for prior or after the fact approval of nonemergent medical or dental care and requests for approval of nonemergency maternity care (§ 732.13(f)).

(2) By endorsement, forward the request to the appropriate chief of service explaining non-Federal care regulations as they pertain to the request. The chief of service shall respond to the request within 24 hours.

(3) Upon return by the chief of service of an approved or disapproved NAVMED 6320/10 request for prior approval of nonemergency medical, dental, or maternity care, the HBA shall forward the original form to the member, a copy to the OMA or ODA, and retain a copy on file.

(c) *Eligibility.*—(1) *Regular Members.* To be eligible for non-Federal medical, dental, or emergency maternity care at Government expense. Regular active duty naval members must be in a duty status at the time care is provided.

(2) *Reservists.* Reservists on active duty for training and inactive duty training (drill), including leave and liberty therefrom, are considered to be in a duty status while participating in such training and while en route to and from such training. Accordingly, they are entitled to care for illnesses and injuries occurring while in such a status.

(3) *Absent Without Authority.* Naval members absent without authority during an entire episode of treatment are not eligible. The only exception occurs when the member's illness or injury is determined to have been the direct cause of the unauthorized absentee status. In such an instance eligibility shall be determined to have existed from the day and hour of such injury or illness, provided the member was not in an unauthorized absentee status prior to the initiation of treatment and the member is directly returned to military control.

(4) *Constructive Return.* When constructive return is effected in accordance with § 732.13(e), entitlement will be determined to have existed from 0001 of the day constructive return was accomplished, not necessarily the day and hour care was initiated.

(d) *Notification of Illness or Injury.* If able, members must notify or cause their parent command or the nearest naval activity to be notified of the circumstances requiring medical or dental attention in a non-Federal facility. The member's exact location shall be conveyed to facilitate movement, if appropriate, to a Federal facility. Transfer to a Federal facility shall be accomplished as soon as possible to ensure that disability benefits are not jeopardized. Should movement be delayed due to actions of the member of the member's family, payment may be denied for all care received after provision of written notification by the OMA or ODA. Denial shall be for care received after the member's condition has stabilized and after the cognizant OMA or ODA has made a request to the attending physician and hospital administration for the member's release from the civilian facility. This notification must specify the date and time the Navy will terminate its responsibility for payment. Care rendered subsequent to receipt of the written notification shall be at the expense of the member.

(1) When it becomes known that a member intends to seek medical care (inpatient or outpatient) from a non-Federal source and prior approval has not been granted for the use of the Nonnaval Medical and Dental Care Program, the member must be counseled by, or in the presence of, a Medical Department officer. The member should be requested to sign a statement on a Standard Form 600, Chronological Record of Medical Care, for inclusion in the member's Health Record, that counseling has been accomplished and that the member understands the significance of receiving civilian care which is unauthorized. This must be accomplished when either personal funds or third party payor (insurance) funds are intended to be used to defray the cost of care. Counseling shall include:

(i) Availability of care from a Federal source.

(ii) The requirement for prior approval if the Government may be expected to defray any of the cost of such care.

(iii) Information regarding the possible compromise of disability benefits should a therapeutic misadventure occur.

(iv) Notification that should hospitalization become necessary, or other time is lost from the member's place of duty, such lost time will be chargeable as "ordinary leave".

(v) Notification that the Government cannot be responsible for out-of-pocket expenses which may be required by the insurance carrier of when the member does not have insurance which covers the cost of contemplated care.

(vi) Direction to report to a uniformed services medical officer (preferably Navy) upon completion of treatment for determination of member's fitness for duty.

(2) When it becomes known that a member has already had non-Federal medical care without prior authorization, the member must be referred to a uniformed services medical officer (preferably Navy) to determine fitness for duty. At this time, the counseling measures delineated in § 732.13(d)(1) (iii), (iv), and (v) must be taken.

(e) *Constructive Return.* See § 732.11(c) for definition.

(1) For members in an unauthorized absentee status, constructive return to military control for the purpose of providing medical or dental care at Navy expense is effected when one of the following has occurred:

(i) A naval activity informs a civilian provider of medical or dental care, orally or in writing, that the Navy accepts responsibility for a naval member's care. The naval activity that provides this information shall also provide documentation of such notification to the appropriate OMA or ODA.

(ii) A member has been apprehended by civil authorities at the specific request of naval authorities and naval authorities have been notified that the member can be released to military custody.

(iii) A naval member has been arrested by civil authorities for a civil offense and naval authorities have been notified that the member can be released to military control.

(2) When a naval member has been arrested for a civil offense while in an unauthorized absentee status and the

offense does not allow release to military control, constructive return is not accomplished. The individual is thus responsible for medical or dental care required prior to arrest and the incarcerating jurisdiction is responsible for care required after arrest.

(f) *Maternity Care.* (1) All pregnant active duty members who reside outside the Military Health Services System (MHSS) catchment areas of uniformed services facilities with inpatient capability are permitted to choose whether to deliver in a closer civilian hospital or travel to a uniformed services facility. If the Government is to assume financial responsibility for non-Federal maternity care of any member regardless of where she resides, the member shall obtain authorization in accordance with §§ 732.13(b)(1) and 732.16. OMA officials shall not approve requests for care in non-Federal facilities for members residing within an MHSS catchment area unless:

(i) Capability does not (did not) exist at the uniformed services or other Federal MTF.

(ii) An emergency situation (as outlined in § 732.13(a)(1)) necessitated delivery or other treatment in a non-Federal facility.

(2) Inasmuch as confinement and delivery are foreseeable, prior approval shall be obtained for delivery in a non-Federal facility at Government expense. This approval shall be obtained from the HBA serving the OMA delineated in § 732.18(f) for the area where the duty station of the member is located. The provisions of this subpart do not apply to maternity emergency situations.

(i) Requests for prior approval shall be disapproved when members (residing in an MHSS catchment area) have been granted annual leave to commence just prior to the expected delivery date and to end after the expected delivery date. Requests for after-the-fact approval shall likewise not be honored in instances of normal delivery.

(ii) Members requiring maternity care while in a travel status in the execution of permanent change of station (PCS) orders shall be granted either prior or retroactive approval as the situation warrants.

(3) Normal delivery at or near the expected delivery date shall not be considered an emergency for members residing within an MHSS catchment area wherein delivery was expected to have occurred and, unless provided for in this part, shall not be reason for delivery in a civilian facility at Government expense.

(4) In a maternity emergency, the provisions of § 732.13(a)(3), relative to arrangements for transfer of the member, also apply to the newborn infant(s).

§ 732.14 Authorized care.

(a) *Medical.* Consultation and treatment provided by physicians or at medical facilities, as well as procedures not involving treatment when directed by COMNAVMED COM are authorized. Such care includes, but is not limited to: treatment by physicians, hospital inpatient and outpatient care, surgery, nursing, medicine, laboratory and x-ray services, physical therapy, eye examinations, etc.

(b) *Maternity Episode.* If an active duty Navy of Marine Corps member qualifies for care under the provisions of § 732.13(f) and delivers in a civilian hospital, routine newborn care (i.e., nursery, newborn examination, PKU test, etc.) is a part of the mother's admission expenses. Regardless of the circumstances which necessitated delivery in a civilian facility or the way in which the charges are separated on the bill, the charges shall be paid from funds available for the care of the mother. Should the infant become a patient in his or her own right—either through an extension of the birthing hospital stay because of complications, transfer to another facility, or subsequent admission—BUMEDINST 6320.56 or Part 728 of this chapter are applicable.

(c) *Dental.* (1) Includes:

(i) All types of treatment rendered (including operative, restorative, and oral surgical) to relieve pain and abort infection.

(ii) Prosthetic treatment rendered to restore extensive loss of masticatory function or the replacement of anterior teeth for esthetic reasons.

(iii) Repair of an existing dental prosthesis when neglect of the repair would result in unservice ability of the prosthesis.

(iv) Any type of treatment rendered as an adjunct to medical or surgical care.

(v) All x-rays, drugs, etc., required to accomplish treatment or care in § 732.14(c)(1)(i) through 732.14(c)(1)(iv).

(2) In emergencies (no prior approval), excluded are all measures except those appropriate to relieve pain or abort infection.

(d) *Eye Refractions and Spectacles.* Includes refractions of eyes by physicians and optometrists and the furnishing and repair of spectacles.

(1) *Refractions.* A refraction may be obtained from a civilian source only when Federal facilities are not available and no suitable prescription is in the member's Health Record.

(2) *Spectacles.* When a member has no suitable spectacles and the lack thereof, combined with the delay resulting from obtaining them from a Federal source, would prevent the performance of duty; repair, replacement, or procurement from a civilian source may be authorized upon initiation of a request in accordance with § 732.16. Otherwise, the prescription from the refractionist, with proper facial measurements, must be sent for fabrication to the appropriate dispensing activity set forth in BUMED INST 6810.4G.

(3) *Contact Lenses.* Neither examination for nor procurement of contact lenses is authorized by this part.

§ 732.15 Unauthorized care.

The following are not authorized by this part:

(a) Chiropractic services.

(b) Vasectomies.

(c) Tubal ligations.

(d) Breast augmentations or reductions.

(e) Psychiatric care, beyond the initial evaluation.

(f) Court ordered care.

(g) Other elective procedures.

§ 732.16 Authorizations.

Requests for prior or after the fact authorization shall be made on NAVMED 6320/10 and shall be submitted to the cognizant HBA after completion of sections I and III. The HAB will take the action indicated in § 732.13(b).

§ 732.17 NAVMED 6320/10, Statement of Civilian Medical/Dental Care.

In addition to its use as an authorization document (§ 732.16), a NAVMED 6320/10 is required in connection with payment for each instance of sickness, injury, or maternity care (except for the waiver outlined in § 732.18(b)) when treatment is received from a non-Federal source.

(a) *Preparation.* In preparation of claims for payment of nonnaval medical or dental care expenses, NAVMED 6320/10 shall be prepared in triplicate by a naval medical or dental officer, when practicable, by the senior officer present where a naval medical or dental officer is not on duty, or by the individual concerned when on detached duty where a senior officer is not present. The diagnosis shall be included and if prior approval was not obtained for the use of non-Federal facilities, the circumstances which necessitated their use shall also be stated.

(b) *Signing.* Signature by the certifying officer on the NAVMED 6320/10 will be considered certification that documentation has been entered in the

member's Health Record as directed in MANMED article 16–24. This responsibility is incumbent on the certifying officer for each episode of nonnaval medical or dental care. Signature by the member requesting reimbursement or payment implies agreement for release of information to the OMA or ODA receiving the claim for processing.

§ 732.18 Claims.

(a) *Preparation.* Claims shall be prepared using NAVMED 6320/10 and shall be submitted to the appropriate OMA or ODA. If a request has been made for prior or after the fact authorization in accordance with § 732.16, the NAVMED 6320/10 containing the approval shall be completed and submitted with the claim. Additionally, each claim shall include:

(1) Itemized bills submitted in quadruplicate to show:

(i) Dates on or between which services were rendered or supplies furnished.

(ii) Nature of and charges for each item.

(iii) Diagnosis.

(2) Acknowledgement of receipt of the services or supplies on the face of the bill, by separate certificate of the person receiving treatment or services, or by an officer having cognizance of the circumstances. This acknowledgement must include the statement "Services were received and were satisfactory."

(3) Separate bills for providers of care who charge on a "fee for service" basis unless the bill which includes such services is accompanied by:

(i) Receipts showing that the expenses have been defrayed by the physician, dentist, or other source of care submitting the bill.

(ii) A statement that the individual charging on a "fee for service" basis is a full-time employee of the payee.

(4) The complete address to which the check is to be mailed and the amount to be paid. This shall be indicated in sections IV and V of the NAVMED 6320/10.

(5) Paid receipts as well as itemized bills when expenses have already been paid by an individual, including a service member. In lieu of submission of paid receipts or itemized bills, the member may sign the face of the NAV COMPT Form 2160 as required by NAVCOMPT Manual 046393–1. Standard Form 1164, prepared in accordance with NAVCOMPT Manual 046377–2a and b, may be used to fill the requirement for a signed claim. Paid invoices supporting a claim for reimbursement on a Standard Form 1164 do not require certification. OMAs and the ODA shall certify the Standard Form 1164 and insert appropriate accounting classification thereon.

(b) *Processing.* Itemized bills, claims, or other documentary evidence of care received from non-Federal sources should be processed for payment by the cognizant OMA or ODA within 30 days of receipt. Advice on unusual or questionable instances of care may be requested from COM NAVMEDCOM (MEDCOM–333). When OMAs or the ODA already have information from messages of other correspondence which supports payment of a claim, the requirement for a NAVMED 6320/10 may be waived and the claim adjudicated. Claimants shall be advised by the OMA or ODA of any delay experienced in processing claims.

(c) *Adjudication of Claims.* When required documents have been received by the OMA or ODA, a determination shall be made whether:

(1) Claimant is entitled to benefits (i.e., was on active duty, active duty for training, inactive duty training (drill), was not an unauthorized absentee, etc.)

(2) Medical or dental care was rendered due to a bona fide emergency. Where questions arise as to the emergent nature of the care, the claim and all documentation shall be forwarded to the appropriate clinical specialist at the nearest naval hospital for review.

(3) Prior approval had been granted for the medical or dental care if a bona fide emergency did not exist. If prior approval was not obtained and the condition treated is determined to have been nonemergent, the claim shall be denied.

(4) Claimed medical or dental benefits resulted from a referral by a USMTF. Should it be determined that the member was an inpatient or an outpatient in a USMTF immediately prior to being referred to a civilian source of care, the care is supplemental and is the responsibility of the referring USMTF. EXCEPTION: the local USMTF will not assume financial responsibility (i) when the civilian health care *is not* supplemental to continuing health care that was being provided by the local USMTF, and (ii) when the local USMTF is not organized nor authorized to provide the needed health care services (e.g., a patient needing inpatient care is diagnosed at a clinic without inpatient capability). Under the latter two circumstances, the civilian care is payable under the provisions of this part. Saturation of USMTF services or facilities does not fall within this exception.

(5) Medical or dental care is payable under the provisions of this part. If a determination is made to disapprove a claim, the member (and provider of care, when applicable) shall be provided a prompt and courteous letter stating the reason for the denial. The appropriate avenues of appeal (§ 732.22) will be included in the denial letter.

(d) *Disbursing Activity.* Upon receipt of an approved claim, disbursing activities will forward a check to the appropriate payee and furnish the Authorization Accounting Activity (AAA) servicing COMNAVMEDCOM (i.e., NAVMEDCOM, National Capital Region, Bethesda, MD 20814) with copies of the NAVMED 6320/10 and with accounting data. OMAs, the ODA, and disbursing activities shall take precautions against duplicate payments in accordance with NAVCOMPT Manual 046073. For completion of the appropriate accounting classification data on the NAVMED 6320/10, the following are applicable:

Accounting Classification Code. This code shall include accounting data in the following sequence:

1	2	3	4	5	6	7	8	9
17*1804	1880	000	00018	0	000168	2D	000000	Cost Code **

* "For the third digit in coding element 1, enter the *last digit of the fiscal year current at the time claim is approved for payment,* e.g., a claim approved in November 1983 for care rendered in December 1982 would have the number "4" as the third digit in coding element 1, i.e., "1741804" wherein the third digit is the last digit of fiscal year 1984.

** This cost code, coding element 9, is a 12 digit coding element constructed as follows:

Digits	Data entry
1 thru 5	"99002" will always be entered.
6	"O" if the services were inpatient, outpatient, or dental, and "E" if for ambulance service.
7	"1" if the patient was active duty Navy. "2" if the patient was active duty Marine Corps.

Digits	Data entry
	"3" if the patient was Navy, Reservist.
	"4" if the patient was Marine Corps, Reservist.
	"5" for all others.
8***	"1" for inpatient care; "2" for outpatient care; "3" for dental care.
9 and 10	Number of visits, occupied bed days, ambulance trips, or dental procedures, e.g., the entry for ten occupied bed days would be "10", and for three outpatient visits "03". Enter "00" for invoices involving services related to but billed separately from hospitalization charges.
11	"A" for medical and dental care rendered in the District of Columbia; Maryland; West Virginia; the Virginia counties of Arlington, Fairfax, Loudoun, and Prince William; and the Virginia cities of Alexandria, Fairfax, and Falls Church.
	"B" for medical care rendered in Illinois, Indiana, Iowa, Kentucky, Michigan, Minnesota, Missouri, and Wisconsin.
	"C" for medical care rendered in Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont.
	"D" for medical care rendered in Connecticut and New York.
	"E" for medical care rendered in Delaware, New Jersey, Ohio, and Pennsylvania.
	"F" for dental care rendered in the entire Northeast Region which includes the States of Connecticut, Delaware, Illinois, Indiana, Iowa, Kentucky, Maine, Massachusetts, Michigan, Minnesota, Missouri, New Hampshire, New Jersey, New York, Ohio, Pennsylvania, Rhode Island, Vermont, and Wisconsin.
	"G" for medical and dental care rendered in the States of North Carolina, South Carolina, and all areas of Virginia south and west of Prince William and Loudoun counties.
	"H" for medical and dental care rendered in the States of Alabama, Arkansas, Florida, Georgia, Louisiana, Mississippi, Oklahoma, Tennessee, and Texas.
	"I" for medical and dental care rendered in the States of Arizona, Nevada, and New Mexico and the counties of Kern, San Luis, Obispo, San Bernadino, Santa Barbara, and all other counties of California south thereof.
	"J" for medical care rendered in the States of Colorado, Kansas, and Utah and the counties of Inyo, Kings, Tulare, and all other counties of California north thereof.
	"K" for medical and dental care rendered in the States of Alaska, Idaho, Montana, Nebraska, North Dakota, Oregon, South Dakota, Washington, and Wyoming.
	"L" for medical and dental care rendered in the Pacific Region.
	"M" for medical and dental care rendered in the European Region.
	"N" for medical and dental care rendered in all other areas.
12	Last digit of the fiscal year in which claim is approved.

***Ambulance trips shall be coded as "1", "2", or "3" according to subsequent treatment.

(e) *Amount Payable.* Amounts payable shall be those considered reasonable by the OMA or ODA after taking into consideration all facts. Normally, payment should be approved at rates generally prevailing within the geographic area where the services or supplies were furnished. Although rates specially established by the Veterans Administration or those used in Medicare are not controlling, they may be considered along with other facts.

(1) *Excessive Charges.* If any charge is considered excessive, the provider of care should be apprised of the conclusion reached and provided an opportunity to voluntarily reduce the amount of the claim. If this does not result in a proper reduction of the bill and the claim is that of a physician or dentist, the difference in opinions should be referred to the grievance committee of the provider's professional group for an opinion of the reasonableness of the charge. If satisfactory settlement of any claim cannot thus be made, all documentation should be forwarded to COMNAVMEDCOM (MEDCOM-333) for decision. Any charges above the allowable amount or charges for noncovered services are the responsibility of the service member.

(2) *Third Party Payment.* Payment shall not be withheld to seek payment from health benefit plans or from insurance policies for which premiums are paid privately by service members (see § 732.20 for possible recovery of payments action).

(3) *No-Fault Insurance.* In States with no-fault automobile insurance requirements, the OMA or ODA shall notify the insurance carrier identified in item 16 of the NAVMED 6320/10 that Federal payment of the benefits in this part is secondary to any no-fault insurance coverage available to the potentially covered member.

(f) *Adjudication Authority.*—(1) *In the United States (Less Hawaii).* For the 48 contiguous United States, the District of Columbia, and Alaska, the following six regions have been designated as cohesive units to accept responsibility for medical cognizance, medical and dental claims processing and adjudication, and prior or after the fact approval or disapproval of requests for nonemergent medical, dental, or maternity care within their areas of responsibility. In accordance with MANMED articles 2-22 and 6-54, controlling activities for medical care have been designated as "offices of medical affairs" (OMA) and for dental care, "office of dental affairs" (ODA). It is incumbent upon commanders of regional medical commands to communicate with other commands within their regions to ensure that proper messages and medical cognizance reports are furnished in accordance with higher authority directives.

(i) *Northeast Region.* The States of Connecticut, Delaware, Illinois, Indiana, Iowa, Kentucky, Maine, Massachusetts, Michigan, Minnesota, Missouri, New Hampshire, New Jersey, New York, Ohio, Pennsylvania, Rhode Island, Vermont, and Wisconsin are served by 1 ODA, 1 OMA, and 2 field office OMAs:

(A) Responsibility for dental matters for all States in the Northeast Region is vested in: Commander, Naval Medical Command, Northeast Region, Office of Dental Affairs, Naval Hospital, Great Lakes, IL 60088, Tele: (A) 792-3940, (C) 312-688-3940.

(B) Responsibility for medical matters for the States of Illinois, Indiana, Iowa, Kentucky, Maine, Massachusetts, Michigan, Minnesota, Missouri, New Hampshire, Rhode Island, Vermont, and Wisconsin is also vested in: Commander, Naval Medical Command, Northeast Region, Office of Medical Affairs, Naval Hospital, Great Lakes, IL 60088, Tele: (A) 792-3950, (C) 312-688-3950.

(C) Responsibility for medical matters for the States of Connecticut and New York is vested in: Commanding Officer, Office of Medical Affairs, Naval Station, 207 Flushing Avenue, Brooklyn, NY 11251, Tele: (A) 456-2716, 2343, or 2612, (C) 212-834-2716, 2343, or 2612.

(D) Responsibility for medical matter for the States of Delaware, New Jersey, Ohio, and Pennsylvania is vested: Commanding Officer, Naval Hospital, 17th Street and Pattison Avenue, Philadelphia, PA 19145, Attn: Office of Medical Affiairs, Tele: (A) 443-8236, (C) 215-755-8236.

(ii) *National Capital Region.* For the States of Maryland and West Virginia; the Virginia counties of Arlington, Fairfax, Loudoun, and Prince William; the Virginia cities of Alexandria, Falls Church, and Fairfax; and the District of Columbia, responsibility for medical and dental matters is vested in: Commander, Naval Medical Command, National Capital Region, Office of Medical Affairs, Bethesda, MD 20814, Tele: (A) 295-5322, (C) 301-295-5322.

(iii) *Mid-Atlantic Region.* For the States of North Carolina, South Carolina, and all areas of Virginia south and west of Prince William and Loudoun counties, responsibility for medical and dental matters is vested in: Commander, Naval Medical Command, Mid-Atlantic Region, 6500 Hampton Boulevard, Norfolk, VA 23502, Attn: Office of Medical/Dental Affairs, Tele: (A) 565-1074 and 1075, (C) 804-445-1074 and 1075.

(iv) *Southeast Region.* For the States of Alabama, Arkansas, Florida, Georgia, Louisiana, Mississippi, Oklahoma, Tennessee, and Texas, medical and dental responsibilities are vested in: Commanding Officer Naval Medical Clinic, Code 01A, New Orleans, LA 70146, Tele: (A) 485-2406, 2407, and 2408, (C) 504-361-2406, 2407, and 2408.

(v) *Southwest Region.* For the States of Arizona, Nevada, and New Mexico, the counties of Kern, San Bernadino, San Luis Obispo, Santa Barbara, and all other California counties south thereof, medical and dental responsibilities are vested in: Commander, Naval Medical

Command, Southwest Region, Office of Medical Affairs, San Diego, CA 92134, Tele: (A) 987–2611, (C) 619–233–2611.

(vi) *Northwest Region.* The States of Alaska, Colorado, Idaho, Kansas, Montana, Nebraska, North Dakota, Oregon, South Dakota, Utah, Washington, and Wyoming, and athe counties of Inyo, Kings, Tulare, and all other counties of California north thereof are served by 2 OMAs:

(A) Responsibility for medical and dental matters for the States of Colorado, Kansas, and Utah, and the California counties of Inyo, Kings, Tulare and all other counties of California north thereof is vested in: Commanding Officer, Naval Hospital, Oakland, CA 94627, Attn: Office of Medical Affairs, Tele: (A) 855–5705, (C) 415–633–5705.

(B) Responsibility for medical and dental matters for the States of Alaska, Idaho, Montana, Nebraska, North Dakota, Oregon, South Dakota, Washington, and Wyoming is vested in: Commanding Officer, Naval Medical Clinic, Naval Station, Seattle, WA 98115, Attn: Office of Medical/Dental Affairs, Tele: (A) 941–3823, (C) 206–526–3823.

(2) *Outside the Contiguous 48 United States, Except Alaska.* In all areas outside the contiguous 48 United States except Alaska, the following activities have been vested with responsibility for approval or disapproval of medical and dental care claims and requests for care:

(i) Executive Director, OCHAMPUSEUR, U.S. Army Medical Command, APO New York 09102, for care rendered within the U.S. European Command, Africa, the Malagasy Republic, and the Middle East.

(ii) Commanding Officer, U.S. Naval Hospital, FPO San Francisco 96652, for care rendered in Afghanistan, Bangladesh, Hong Kong, India, Nepal, Pakistan, the Philippines, Southeast Asia, Sri Lanka and Taiwan.

(iii) Commanding Officer, U.S. Naval Hospital, FPO Seattle 98765, for care rendered in Japan, Korea, and Okinawa.

(iv) Commanding Officer, U.S. Naval Hospital, FPO San Francisco 96630, for care rendered in New Zealand and Guam.

(v) Commanding Officer, U.S. Naval Communications Station, FPO San Francisco 96680, for care rendered in Australia.

(vi) Commanding Officer, U.S. Naval Air Station, FPO New York 09560, for care rendered in Bermuda.

(vii) Commander, U.S. Naval Forces, Southern Command, FPO Miami 34059, for care rendered in Central and South America.

(viii) Commanding Officer, U.S. Naval Hospital, FPO Miami 34051, for medical care and Commanding Officer, U.S. Naval Regional Dental Center, FPO Miami 34051, for dental care rendered in Puerto Rico, Virgin Islands, and other Caribbean Islands.

(ix) Commanding Officer, Naval Medical Clinic, Box 121, Pearl Harbor, HI 96860, for medical care and Commanding Officer, Naval Regional Dental Center, Box 111, Pearl Harbor, HI 96860, for dental care rendered in the State of Hawaii, Midway Island, and the Central Pacific basin.

(x) The OMA for either the Southeast Region, § 732.18(f)(1)(iv), or the Southwest Region, § 732.18(f)(1)(v) for care rendered in Mexico to members stationed within the respective areas of responsibility of these OMAs. Forward claims for care rendered in Mexico to all other personnel to Commander, Naval Medical Command, Washington, DC 20372 (MEDCOM–333).

(xi) Commander, Naval Medical Command, Washington, DC 20372 (MEDCOM–333):

(A) For inpatient and outpatient care of active duty Navy and Marine Corps members in Canada.

(B) For outpatient care rendered to NATO active duty personnel in accordance with the Assistant Secretary of Defense (Comptroller) memo of 12 March 1981, Reimbursement for inpatient medical care provided foreign military and diplomatic personnel or their dependents in military hospitals in the United States.

(C) In unusual circumstances requiring Departmental level review prior to approval, adjudication, or payment.

(xii) Outside the 50 United States, commanding officers of operational units may either approve claims and direct payment by the disbursing officer serving the command or forward claims to the appropriate naval medical command enumerated in § 732.18(f)(1)(i) through 732.18(f)(2)(x). This is a local policy decision to enhance the maintenance of good public relations.

(xiii) The commanding officer authorizing the care in geographical areas not specifically delineated in § 732.18(f)(1)(i) through 732.18(f)(2)(ix).

(xiv) The appropriate command enumerated in § 732.18(f)(2)(i) through 732.18(f)(2)(x) for care rendered aboard commercial vessels en route to a location within any of the geographical areas enumerated in those subparts.

(g) *Standard Document Number.* (1) To enhance accountability procedures and facilitate identification of documents in the accounting and disbursement process, each NAVMED 6320/10 approved for payment shall be assigned a unique 15 position alpha/numeric standard document number composed in accordance with the following example: N0016883MD00025.

1	2 thru 6	7 & 8	9 & 10	11 thru 15
N	00168	83	MD	00025

Position	Data entry
1	"N" identifies Navy.
2 thru 6	Unit Identification Code of document issuing activity.
7 and 8	Last two digits of the fiscal year in which the basic document was issued.
9 and 10	"MD" is the document type code identifying this as a Miscellaneous Financial Document.
11 thru 15	Serial Number (In the example, "00025" identifies the 25th miscellaneous document prepared in fiscal year 83 by the activity.)

(2) This standard document number shall be prominently displayed on the NAVCOMPT Form 2160, Public Voucher for Medical Services, and on all other accompanying documentation of the claim. Diligent use of this number facilitates the establishment of an auditing trail and thus reduces opportunities for fraud.

§ 732.19 Medical board.

When the adjudication process uncovers conditions which may be chronic or otherwise potentially disabling, a determination shall be made by OMAs (in conjunction with appropriate clinical specialists) as to the need for a medical board. MANMED, chapter 18 and the Medical Disposition and Physical Standards Notes, available from COMNAVMEDCOM (MEDCOM–25), provide guidance.

(a) Chronic conditions requiring a medical board include (but are not limited to): (1) Peptic ulcer disease, (2) asthma, (3) hypertension, (4) arthritis, (5) alcoholism, (6) diabetes, (7) psychriatric conditions, (8) gout, (9) heart disease, and (10) allergic conditions requiring desensitization.

(b) Other potentially disabling or chronic conditions may be referred to a medical board by the OMA with the concurrence of an appropriate naval clinical specialist and regional commander.

§ 732.20 Recovery of medical care payments.

Evidence of payments shall be submitted to the action JAG designee in accordance with JAG manual, chapter 24, in each instance of payment where a third party may be legally liable for causing the injury or disease treated, or when a Government claim is possible under workmen's compensation, no-

fault insurance, or under medical payments insurance (all automobile accident cases).

(a) To assist in identifying possible third party liability cases, item 16 of each NAVMED 6320/10 shall be completed whenever benefits are received in connection with a vehicle accident. OMAs and the ODA shall return for completion, as applicable, any claim received without item 16 completed.

(b) The front of a NAVJAG Form 5890/12 (Hospital and Medical Care, 3rd Party Liability Case) shall be completed and submitted by OMAs and the ODA with evidence of payment. Block 4 of this form requires an appended statement of the patient or an accident report, if available. To ensure that Privacy Act procedures are accomplished and documented, the person securing such a statement from a recipient of care shall show the recipient the Privacy Act statement printed at the bottom of the form prior to securing such a statement. The member shall be asked to sign his or her name beneath the statement.

(c) In States with no-fault insurance laws, the procedures outlined in § 732.18(e)(3) shall also be followed.

§ 732.21 Collection for subsistence.

(a) *General.* Each OMA shall initiate subsistence collection action for enlisted personnel upon receipt of a bill for inpatient care from nonnaval facilities or under circumstances described in § 732.21(c)(3). OMAs shall also ensure that pay adjustment action has been initiated by the member's command, as appropriate. Commands submitting claims to OMAs without a locally prepared pay checkage form or a DD 139 shall be requested to provide a copy. If the claim is otherwise payable, payment action shall be held in abeyance pending receipt of the form.

(b) *Officers.* The accounts of officers (Navy and Marine Corps) receiving treatment in Veterans Administration facilities, the Canal Zone Hospital, or in civilian hospitals at the Department of the Navy's expense are required to be checked for subsistence. Collection action is initiated by completion and submission of a DD Form 139, Pay Adjustment Authorization, by the officer's commanding officer or the Pay/Personnel Administrative Support System (PASS) office to the disbursing officer having custody of the member's pay record. The Pay/Personnel Administrative Support System officer is responsible for ensuring that checkage has been accomplished in accordance with DOD Military Pay and Allowances Entitlements Manual 30137. When officers are hospitalized in an Army, Air Force, or designated USTF, the charge for subsistence will be collected by the facility.

(c) *Enlisted Members.* (1) The passage of the Defense Officer Personnel Management Act (DOPMA) placed a requirement on the uniformed services to collect subsistence from hospitalized enlisted personnel. To accomplish collection, it is necessary establish a pay checkage system similar to that described in § 732.21(b) for officers. Generally, the DD Form 139 can be used for this purpose; however, the Medical Department representative (or other appropriate individual) who completes or assists in the preparation of the NAVMED 6320/10 may attach thereto a locally prepared statement in the following format before submission of the claim to the OMA:

(i) Name, rate, and social security number of the hospitalized member.

(ii) Inclusive dates of hospitalization.

(iii) "NAVMEDCOM 00018", COMNAVMEDCOM's Unit Identification Code (UIC), as the organization providing meals.

(iv) Date forwarded to disbursing office.

(2) The pay checkage form shall be forwarded to the disbursing officer (DO) or Personnel Support Detachment (PSD) holding the member's pay record. Copies shall be provided COMNAVMEDCOM (MEDCOM–112) and shall accompany each inpatient claim submitted to an OMA.

§ 732.22 Appeal of Denied Claims.

When a claim for care under this part is initially denied, the member shall be advised of the appeal procedure in the denial letter specified in § 732.18(c)(5). Responses at all levels shall be prompt and courteous. The appeal procedure consists of three levels:

(a) Reconsideration by the OMA or ODA making the initial denial. The member should submit any additional information that may mitigate the initial denial.

(b) Consideration by the commander of the regional medical command having cognizance over the OMA or ODA which upheld the initial denial on reconsideration.

(c) The third level is consideration by COMNAVEMED COM (MEDCOM–333).

§ 732.23 Records.

The NAVMED 6320/10 or a copy of the Public Voucher for Medical Services (NAVCOMPT Form 2160) or other paid voucher and the Accounting Card (NAVCOMPT Form 632) containing the accounting classification and cost code information received from Navy finance centers, provide all the management information needed by COMNAVMEDCOM under normal circumstances. Except for the monthly letter report required in § 732.12(a)(2), no other records need be forwarded to COMNAVMEDCOM by approving authorities except, when in the judgment of the approving officer, copies of correspondence of other pertinent documents of a controversial nature might assist in improving administration of the program.

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DEPARTMENT OF TRANSPORTATION

Coast Guard

33 CFR Part 117

[CGD13 86–02]

Drawbridge Operation Regulations; Lake Washington Ship Canal, Seattle, WA

AGENCY: Coast Guard, DOT.

ACTION: Final rule.

SUMMARY: The Coast Guard is changing the regulations governing operation of the City of Seattle's drawbridges across the Lake Washington Ship Canal by permitting the draws to remain in the closed position, after receiving an opening request, for periods of up to ten minutes, if needed to pass accumulated vehicular traffic. Bridges affected by this change are the: Ballard Bridge, Fremont Bridge, University Bridge, and Montlake Bridge. This will relieve vehicular traffic congestion and still provide for the reasonable needs of navigation.

EFFECTIVE DATE: These regulations become effective on June 23, 1986.

FOR FURTHER INFORMATION CONTACT: John E. Mikesell, Chief, Bridge Section, Aids to Navigation Branch, (Telephone: (206) 442–5864.

SUPPLEMENTARY INFORMATION: On February 10, 1986, the Coast Guard published proposed rules (51 FR 4933) concerning this amendment. The Commander, Thirteenth Coast Guard District, also published the proposal as a public notice dated February 19, 1986. In each notice interested parties were given until March 27, 1986 to submit comments.

Drafting Information

The drafters of this notice are: John E. Mikesell, project officer, and Lieutenant Commander Judith M. Hammond, project attorney.