F. *The Office of International Policy:* Change Line 6 of Section F to read "SSA's OPA, with other public and * * *"

G. *The Office of Regulations:* Change Line 12 of Section G to read "SSA's OPA, negotiates with other * * *."

Dated: May 22, 1989.

Louis W. Sullivan,

Secretary of Health and Human Services.

[FR Doc. 89-13028 Filed 5-31-89; 8:45 am]

BILLING CODE 4190-11-M

Alcohol, Drug Abuse, and Mental Health Administration

Curent List of Laboratories Which Meet Minimum Standards To Engage in Urine Drug Testing for Federal Agencies

AGENCY: National Institute on Drug Abuse.

ACTION: Notice.

SUMMARY: The Department of Health and Human Services notifies Federal agencies of the laboratories currently certified to meet standards of Subpart C of Mandatory Guidelines for Federal Workplace Drug Testing Programs (53 FR 11986). A similar notice listing all currently certified laboratories will be published bi-monthly, and updated to include laboratories which subsequently apply and complete the certification process. If any listed laboratory fails to maintain its certification, it will be omitted from updated lists until such time as it is restored to full certification under the Guidelines.

FOR FURTHER INFORMATION CONTACT: Division of Applied Research (formerly the Office of Workplace Initiatives), National Institute on Drug Abuse, Room 10A-53, 5600 Fishers Lane, Rockville, Maryland 20857.

SUPPLEMENTARY INFORMATION: Mandatory Guidelines for Federal Workplace Drug Testing were developed in accordance with Executive Order 12564 and section 503 of Pub. L. 100-71. Subpart C of the Guidelines, "Certification of Laboratories Engaged in Urine Drug Testing for Federal Agencies," sets strict standards which laboratories must meet in order to conduct urine drug testing for Federal agencies. To become certified an applicant laboratory must undergo three rounds of performance testing plus an on-site inspection. To maintain that certification a laboratory must participate in an every-other-month performance testing program plus periodic, on-site inspections. In accordance with Subpart C of the Guidelines, the following laboratories meet the standards set forth in the Guidelines:

(Submitted for publication in the **Federal Register** on June 1, 1989.)

American BioTest Laboratories, Inc., 3350 Scott Boulevard, Building 15, Santa Clara, CA 95054, 408-727-5525

American Medical Laboratories, 11091 Main Street, P.O. Box 188, Fairfax, VA 22030, 703-691-9100

Bio-Analytical Technologies, 2356 North Lincoln Ave., Chicago, IL 60614, 312-880-6900

Center For Human Toxicology, 417 Wakara Way, Rm. 290, University Research Park, Salt Lake City, UT 84108, 801-581-5117

Chem-Bio Corporation, 140 E. Ryan Road, Oak Creek WI 53154, 800-365-3840

CompuChem Laboratories, Inc., Western Division, 600 West North Market Boulevard, Sacramento, CA 95834, 916-923-0840, (name changed: formerly ChemWest, Analytical Laboratories, Inc.)

CompuChem Laboratories, Inc., 3308 Chapel Hill/Nelson Hwy., P.O. Box 12652, Research Triangle Park, NC 27709, 919-549-8263

Doctors and Physicians Laboratory, 801 E. Dixie Ave., Leesburg, FL 32748, 904-787-9006

Laboratory of Pathology of Seattle, Inc., 1229 Madison Street, Suite 500, Nordstrom Medical Tower, Seattle, WA 98104 206-386-2672

Med Arts/South Community Hospital, 1001 Southwest 44th Street, Oklahoma City, OK 73109, 405-636-7041

MetPath, Inc., 1355 Mittel Boulevard, Wood Dale, IL 60191, 313-595-3888

MetPath, Inc., One Malcolm Ave., Teterboro, NJ 07608, 201-393-5000

MedTox Laboratories, Inc., 402 West County Road D, St. Paul, MN 55112, 612-636-7466

National Center for Forensic Science, A Division of Maryland Medical Laboratory, Inc., 1901 Sulphur Spring Road, Baltimore, MD 21227, 301-247-9100, (name changed: formerly Maryland Medical Laboratories, Inc.)

Nichols Institute, 7323 Engineer Road, San Diego, CA 92111, 619-278-5900

Northwest Toxicology, Inc., 1141 East 3900 South, Salt Lake City, UT 84124, 800-322-3361

PharmChem Laboratories, Inc., 3925 Bohannon Drive, Menlo Park, CA 94025, 415-328-6200

Poisonlab, Inc., 7272 Clairemont Mesa Road, San Diego, CA 92111, 619-279-2600

Roche Biomedical Laboratories, 6370 Wilcox Road, Dublin, OH 43017, 614-889-1061

SmithKline Bio-Science Laboratories, 2201 W. Campbell Park Drive, Chicago, IL 60612, 312-885-2010, (name changed: formerly International Toxicology Laboratories, Inc.)

SmithKline Bio-Science Laboratories, 8000 Sovereign Row, Dallas, TX 75247, (name changed: formerly International Clinical Laboratories), 214-638-1301

South Bend Medical Foundation, Inc., 530 North Lafayette Blvd., South Bend, IN 46601, 219-234-4176

Southgate Medical Laboratory, Inc., 21100 Southgate Park Boulevard, Cleveland, OH 44137, 800-338-0166

Richard A. Millstein,

Deputy Director, National Institute on Drug Abuse.

[FR Doc. 89-12982 Filed 5-31-89; 8:45 am]

BILLING CODE 4160-20-M

Advisory Committee Meeting in June

AGENCY: Alcohol, Drug Abuse, and Mental Health Administration, HHS.

ACTION: Correction of meeting notice.

SUMMARY: Public notice was given in the **Federal Register** on May 15, 1989, Volume 54, No. 92, on page 20924 that the Drug Abuse Epidemiology and Prevention Research Review Committee would meet on June 19-22. The meetings will take place June 19-23.

Date: May 25, 1989.

Peggy W. Cockrill,

Committee Management Officer, Alcohol, Drug Abuse, and Mental Health Administration.

[FR Doc. 89-12976 Filed 5-31-89; 8:45 am]

BILLING CODE 4160-20-M

Advisory Committee Meeting in June

AGENCY: Alcohol, Drug Abuse, and Mental Health Administration, HHS.

ACTION: Notice of meeting.

SUMMARY: This notice sets forth the schedule and proposed agenda of the forthcoming meeting of one of the agency's initial review committees in the month of June 1989. This committee will be performing initial review of applications for Federal assistance. Therefore, portions of the meeting will be closed to the public as determined by the Administrator, ADAMHA, in accordance with 5 U.S.C. 552(b)(6) and 5 U.S.C. app. 2 10(d). Notice of this meeting is required under the Federal Advisory Committee Act, Pub. L. 92-463.

Committee Name: Biochemistry Research Subcommittee of the Drug Abuse Biomedical Research Review Committee, NIDA

Date and Time: June 13–14: 8:30 a.m.

Place: Rockville Room, Crowne Plaza Holiday Inn, 1750 Rockville Pike, Rockville, MD 20852

Status of Meeting: Open—June 13: 8:30–9:00 a.m. Closed—Otherwise.

Contact: Rita Liu, Room 10–42, Parklawn Building, 5600 Fishers Lane, Rockville, Maryland 20857, (301) 443–2620

Purpose: The committee is charged with the initial review of applications for assistance from the National Institute on Drug Abuse for support of research and research training activities and makes recommendations to the National Advisory Council on Drug Abuse for final review.

Substantive information, summary of the meeting, and roster of committee members may be obtained as follows: Ms. Camilla Holland, NIDA Committee Management Officer, Room 10–42, Parklawn Building, 5600 Fishers Lane, Rockville, MD 20857, (301) 443–2620.

Date: May 25, 1989.

Peggy W. Cockrill,

Committee Management Officer, Alcohol, Drug Abuse, and Mental Health Administration.

[FR Doc. 89–12975 Filed 5–31–89; 8:45 am]

BILLING CODE 4160–20–M

Food and Drug Administration

[Docket No. 89F–0157]

Ciba-Geigy Corp.; Filing of Food Additive Petition

AGENCY: Food and Drug Administration.

ACTION: Notice.

SUMMARY: The Food and Drug Administration is announcing that Ciba-Geigy Corp. has filed a petition proposing that the food additive regulations be amended to provide for the safe use of 2-methyl-4,6-bis[(octylthio)methyl] phenol as a stabilizer for polymers used as adhesives, gaskets, cements, repeat-use rubber articles and paper additives in contact with food.

FOR FURTHER INFORMATION CONTACT: Julius Smith, Center for Food Safety and Applied Nutrition (HFF–335), Food and Drug Administration, 200 C Street SW., Washington, DC 20204, 202–472–5690.

SUPPLEMENTARY INFORMATION: Under the Federal Food, Drug, and Cosmetic Act (section 409(b)(5) (21 U.S.C. 348(b)(5))), notice is given that a petition (FAP 9B4144) has been filed by Ciba-Geigy Corp., 7 Skyline Drive, Hawthorne, NY 1052–2188, proposing that § 178.2010 *Antioxidants and/or stabilizers for polymers* (21 CFR 178.2010) be amended to provide for the safe use of 2-methyl-4,6-bis[(octylthio)methyl] phenol as a stabilizer for polymers used as adhesives, gaskets, cements, repeat-use rubber articles and paper additives in contact with food.

The potential environemntal impact of this action is being reviewed. If the agency finds that an environmental impact statement is not required and this petition results in a regulation, the notice of availability of the agency's finding of no significant impact and the evidence supporting that finding will be published with the regualtion in the **Federal Register** in accordance with 21 CFR 25.40(c).

Dated: May 19, 1989.

Fred R. Shank,

Acting Director, Center for Food Safety and Applied Nutrition.

[FR Doc. 89–12979 Filed 5–31–89; 8:45 am]

BILLING CODE 4160–01–M

[Docket No. 89F–0167]

Michelman, Inc.; Filing of Food Additive Petition

AGENCY: Food and Drug Administration.

ACTION: Notice.

SUMMARY: The Food and Drug Administration (FDA) is announcing that Michelman, Inc., has filed a petition proposing that the food additive regulations be amended to provide for the safe use of the partial sodium salt of ethlene-acrylic acid copolymer as an adhesive component in laminates that contact dry food.

FOR FURTHER INFORMATION CONTACT: Edward J. Machuga, Center for Food Safety and Applied Nutrition (HFF–335), Food and Drug Administration, 200 C St. SW., Washington, DC 20204, 202–472–5690.

SUPPLEMENTARY INFORMATION: Under the Federal Food, Drug, and Cosmetic Act (section 409(b)(5) (21 U.S.C. 348(b)(5)), notice is given that a petition (FAR 9B4146) has been filed by Michelman, Inc., Cincinnati, OH 45236, proposing that § 175.105 *Adhesives* be amended to provide for the safe use of the partial sodium salt of ethylene-acrylic acid copolymer as an adhesive component in laminates that contact dry food.

The potential environmental impact of this action is being reviewed. If the agency finds that an environmental impact statement is not required and this petition results in a regulation, the notice of availability of the agency's finding of no significant impact and the evidence supporting that finding will be published with the regulation in the **Federal Register** in accordance with 21 CFR 25.40(c).

Dated: May 19, 1989.

Fred R. Shank,

Acting Director, Center for Food Safety and Applied, Nutrition.

[FR Doc. 89–12980 Filed 5–31–89; 8:45 am]

BILLING CODE 4160–01–M

Health Care Financing Administration

[BERC–394–FN]

Medicare Program; Additions and Deletions From the Current List of Covered Surgical Procedures for Ambulatory Surgical Centers

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

ACTION: Final notice.

SUMMARY: This final notice announces additions and deletions to the current list of surgical procedures for which facility services are covered when the procedures are performed in an ambulatory surgical center (ASC). We are adding one procedure and deleting 48 procedures. The changes contained in this final notice result from our consideration of the public comments received in response to a proposed notice published on August 11, 1987 and from analysis of more recent data and subsequent consultation with medical organizations and professional societies.

This notice implements section 1833(i)(1) of the Social Security Act, as amended by section 9343 of the Omnibus Budget Reconciliation Act of 1986 that requires, in part, that the list of covered ASC procedures be reviewed and updated every 2 years.

EFFECTIVE DATES: For ASC procedures that are being removed from the current list, the effective date is August 30, 1989. The effective date for procedures being added to the list is July 3, 1989.

FOR FURTHER INFORMATION CONTACT: Rita McGrath, (301) 966–4635.

SUPPLEMENTARY INFORMATION:

I. Background

Section 934 of Pub. L. 96–499, the Omnibus Reconciliation Act of 1980, amended Title XVIII of the Social Security Act (the Act) to authorize Medicare Part B coverage for facility services furnished in connection with certain surgical procedures performed in an ambulatory surgical center (ASC).

With respect to the surgical procedures covered under this provision, section 1833 (i)(1) of the Act requires the Secretary to specify, in consultation with appropriate medical organizations, surgical procedures that, although appropriately performed in an inpatient hospital setting, can also be performed safely on an ambulatory basis. The report accompanying the legislation (Report of the Committee on the Budget to Accompany H.R. 7765, H.R. Rep. No. 96–1167, 96th Cong., 2d Sess. 390 (1980)) explained that Congress intended that procedures currently performed on an ambulatory basis, especially in physicians' offices, that do not generally require the more elaborate facilities of an ASC, should not be included on the list of covered procedures.

In line with this Congressional intent, our current regulations specify the following four requirements regarding the range of covered services:

1. Procedures on the list are to be those commonly performed on an inpatient basis but which also may be safely performed in an ambulatory surgical facility (42 CFR 416.65(a)(1)).

2. The list is to exclude procedures that are commonly performed, or that may be safely performed, in physicians' offices (§ 416.65(a)(2)).

3. Procedures are limited to those requiring a dedicated operating room and generally not requiring an overnight stay (§ 416.65(a)(3)).

4. The list may not contain procedures excluded from Medicare coverage (§ 416.65(a)(4)).

The list of covered procedures merely indicates procedures for which payment may be made if performed in the ASC. It does not require that these procedures be performed in an ASC, nor is any special review or justification required if listed procedures are performed on a hospital inpatient basis. The choice of operating site remains a matter for the professional judgment of the patient's physician who appropriately may decide that a procedure on the list may be safety performed only on an inpatient basis.

Section 1833(i)(2)(A) of the Act, as amended by section 9343 of the Omnibus Budget Reconciliation Act of 1986 (Pub. L. 99–509), provides that by July 1, 1987, and annually thereafter, the Secretary must review and update ASC payment rates. In addition, section 1833(i)(1) provides that the list of procedures must have been reviewed and updated every 2 years. Since the current list of covered procedures was published April 21, 1987, we must update that list by April 21, 1989.

Currently, ASC covered procedures are classified according to a four group payment classification system, as follows:

Group 1—$274
Group 2—$326
Group 3—$351
Group 4—$399

The ASC facility payment for all procedures in each group is at a single rate adjusted for geographic variation. This prospectively determined facility group rate does not include physicians' fees and other medical items and services (for example, prosthetic devices, except intraocular lenses) for which separate payment is authorized under other provisions of the Medicare program. Rather, the rate is a standard overhead amount which covers the cost of services such as nursing, supplies, equipment and use of the facility.

As required by section 1833(i) of the Act, we reviewed the ASC payment rates and proposed revisions to the rates and reimbursement methodology in the August 18, 1988 **Federal Register** (53 FR 31468).

Also, in accordance with section 1833(i) of the Act, the latest update to the list of covered ASC procedures was published in the **Federal Register** on April 21, 1987 (52 FR 13176). The update supplemented the original list of covered ASC procedures published on August 5, 1982 (47 FR 34099). Further, on August 11, 1987, we published a proposed notice (52 FR 29729) that announced proposed additions to and deletions from the list.

II. Provisions of the Proposed Notice

In the proposed notice, we announced proposed additions and deletions to the current list of surgical procedures for which facility services are covered when the procedures are performed in an ASC. The proposed deletions were based on analysis of new data that showed that some of the surgical procedures on the existing ASC list did not meet the criteria that they be commonly performed on an inpatient basis in hospitals or not be commonly performed in physicians' offices. In the notice, we also solicited public comments on additional procedures to be added to the current list of approved ASC procedures and specifically invited comments on extracorporeal shock wave lithotripsy.

We evaluated the usual site of service surgical procedures considered for coverage under the ASC benefit based on the Part B Medicare Data files (BMAD), which are maintained centrally as a component of the Medicare statistical system. One of the BMAD files is the procedure file, from which source data are extracted to create an array of every procedure code used by each carrier in processing Medicare claims. The procedure file includes such data elements as frequency, submitted charges, allowed charges, and denied services. These variables can be arrayed for each procedure code by site of service (for example, physician's office, ASC, inpatient hospital, outpatient hospital) and by type of service (for example, surgical service).

The procedure file is constructed from 100 percent of the bills processed annually by carriers reporting procedures using the HCFA Common Procedure Coding System (HCPCS). The source data that we used in assessing site of service were claims processed in calendar year 1984. The 1984 file excluded claims processed by carriers servicing Texas, Utah, Michigan, Georgia, and New Jersey because in that year those carriers did not report using HCPCS codes.

When we arrayed currently covered ASC services by site of service, we found that many of them were not commonly furnished on an inpatient basis or were furnished in physicians' offices a majority of the time. Based on these data, it would be contrary to our regulations and program objectives to continue to cover them when performed in an ASC. We decided that if a procedure is performed on an inpatient basis 20 percent of the time or less, or in physicians' offices 50 percent of the time or more, it should not be covered in an ASC. Subsequently, we identified 70 procedure codes that we proposed to delete.

III. Discussion of Public Comments on the Proposed Notice

We received 927 pieces of timely correspondence, most of which expressed opposition to the deletion of one or more of the procedures from the list. Many of the general comments expressed support for ASCs.

Approximately 400 comments were deleted from urologists and their patients, all opposed to the deletion of CPT code 52000, cystourethroscopy. The next largest group writing in opposition to the deletions were practicing podiatrists and podiatric medical students, the latter sending a signed petition. The remaining comments were spread among plastic surgeons, orthopedic surgeons, ophthalmologists, otolaryngologists, thoracic surgeons, hand surgeons, obstetricians/gynecologists, pathologists, and dentists. In addition, ASCs, hospitals and a lithotripsy center submitted comments.

The commenters' objections to many of our proposed deletions were supported by our subsequent analysis of

Medicare claims data processed in calendar year 1986. As a result of the analysis of this more recent complete billing data, we are retaining 22 of the 70 CPT–4 codes originally proposed for deletion. A summary of the comments, and our responses to them, follow:

A. Impact on Rural Areas

Comment: Several commenters expressed concern that the proposal would adversely affect rural health care because (1) elderly patients would be required to travel long distances to receive services that would no longer be available locally; (2) rural hospitals would lose income which would affect their ability to provide comprehensive care; and (3) the availability of health care in rural areas would be decreased if facilities for these procedures were unavailable. Also, it was suggested that the increased cost of providing the services in an urban area would negate any advantage gained.

Response: We believe the commenters overestimate the impact of the proposed deletions on ASCs and, to some extent, misunderstand the effect of deleting the procedures. First, the deletion of 48 procedures, mostly of the integumentary system, will not have a significant financial impact on an individual ASC. This is a small number of procedures to be deleted, especially in light of the approximate 1300 procedures that were added to the list of covered ASC procedures on April 21, 1987 (52 FR 13176). Second, since the deletion of a given procedure from HCFA's list does not mean that it may no longer be performed in an ASC (although the ASC would receive no facility fee for the procedure's performance) or in a hospital outpatient department, it is incorrect to assume that elderly patients will need to travel to urban areas to receive care.

B. Impact on Hospitals

Comment: Several commenters expressed concern that if a procedure was deleted from the ASC list, then no reimbursement would be made for the procedure in the hospital outpatient department since the outpatient department is paid for ASC listed procedures using ASC reimbursement guidelines. Others believed that rural hospitals would be forced to create a separate and distinct ASC in order to be reimbursed.

Response: As noted in our response to comments on the impact of our proposal on rural areas, we believe that the commenters misunderstand the effect of deleting a procedure from the list. The deletion of a procedure simply means that an ASC will no longer receive a facility fee for the performance of that procedure. It does not mean that hospitals will not be paid for performing the procedure in their outpatient departments. Payment for the performance of deleted procedures will be made to hospital outpatient departments on a reasonable cost basis. Hospitals do not need to build distinct and separate ASCs in order to be paid for performing procedures on the list.

C. Impact on Physicians' Offices

Comment: Some physicians expressed concern that the performance of several of the procedures proposed for deletion would be inappropriate if performed in an office setting because office surgical facilities are totally unregulated.

Response: We believe that the commenters are expressing concern that procedures performed in physicians' offices are not subject to the same quality of care and medical necessity reviews as are procedures performed in hospitals and ASCs. While that is true, we note that the deletion of a procedure from the ASC list does not mean it must be performed in a physician's office. We expect physicians to select the appropriate setting for the performance of any procedure, taking into account the circumstances of a particular patient.

Comment: Several physicians expressed concern that the performance of a procedure under general or spinal anesthesia in the office would require extensive equipping and additional special staff and that monitored anesthesia would be an additional liability.

Response: As noted above, we are not mandating that these procedures be performed in the office setting. Further, we are not precluding their performance in an ASC. The deletion of a procedure from the list simply means that the ASC will not be paid a facility fee for the performance of the procedure. The physician would continue to be paid on a reasonable charge basis regardless of the setting in which the procedure was performed (office, ASC, or hospital).

Comment: Several commenters noted that there is no additional facility fee paid to a physician's office and that the cost incurred for the performance of a procedure deleted from the ASC list would be borne directly by the physician and would result in a substantial loss each time a Medicare patient is treated. Commenters alleged that if the proposed deletions occurred, physicians would incur expenditures to (1) remodel and redesign areas in their offices; (2) maintain emergency supplies and equipment; (3) hire trained personnel; and (4) purchase sterile equipment and supplies. It was argued that this would lead to an unnecessary duplication of services already available at ASCs.

Response: First, as noted above, HCFA does not mandate that any surgery be performed in the office. Second, our billing data indicate that most of the procedures we are deleting from the list are routinely performed in physicians' offices. Although there are undoubtedly additional costs associated with the performance of these procedures in the office, we do not believe that they result in substantial losses given the extent to which physicians already perform them without additional payments over and above their professional fees.

D. Threshold Rule

Comment: Many commenters objected to our decision to delete from the ASC list any procedure that is performed on an inpatient basis 20 percent of the time or less or in physicians' offices 50 percent of the time or more. It was argued that the threshold rule is arbitrary and that its application would reduce the cost savings associated with ASCs.

Response: We acknowledge that the threshold levels are, to some extent, judgmental and that other levels (higher or lower) could have been selected. We decided that the fairest and least arguable level for "commonly performed in physicians' offices" would be 50 percent or higher. We rejected the application of a 50 percent level for "commonly performed on an inpatient basis" because that level would have led to a much greater number of deletions and because we recognized that in the past few years, more and more procedures that had been done on an inpatient basis are now being done on an outpatient basis. We recognize that the deletion of procedures from the list will have some effect on ASCs. However, to be consistent with Congressional intent and our regulations, we are obliged to assure that the list excludes procedures that are commonly performed in physicians' offices or not commonly performed on an inpatient basis.

We note that the threshold levels are intended to be general guidelines rather than absolute cut-off points. In some situations, we have made exceptions and not deleted procedures that would have been deleted by a strict application of the threshold rule. Such exceptions have been made in cases where the high level of ASC utilization has itself depressed the inpatient rate below the 20 percent level. In addition, some

procedures have remained on the approved list in order to maintain a clinically consistent approach. In some other cases, with borderline data, we accepted the comments of those arguing that quality of care could be threatened if the procedures were deleted from the ASC approved list.

E. Billing Data—(Deletions)

Comment: Several commenters questioned the validity of the BMAD file noting that the "place of service" indicator on a billing form may not be correctly completed since it does not affect payment. Others questioned the appropriateness of analyzing 1984 data that did not include information from all carriers.

Response: We acknowledge that the place of service indicator in the 1984 BMAD file was not validated. However, it was the best available information at the time the proposed notice was published and, to a large extent, contained information provided by physicians or their staff. Therefore, we are reasonably confident that it contained accurate information. Since the publication of the proposed notice, more recent and complete information has become available. We analyzed the 1985 and 1986 BMAD files which include information from all the carriers, and found that several of the procedures that we had proposed for deletion were not performed as frequently in physicians' offices as the 1984 BMAD file data suggested. Where these more current data were consistent with the comments we received, we retained the procedures on the list. We provide an analysis of the data and our response to comments for each of the proposed deletions in the following sections. We did not receive specific comments on every individual procedure code. However, since many of the commenters objected, in general, to the deletion of any procedures, we will provide the basis of our final decision for each of the individual procedures.

1. Integumentary System

a. *Excision of skin tags (procedure codes 11200 and 11201):* No specific comments were received on these procedures. BMAD data for 1986 indicate that these procedures are performed over 90 percent of the time in physicians' office. Therefore, they are deleted.

b. *Excision of benign lesions (procedure codes 11401, 11402, 11403, 11404, 11421, 11422, 11423, 11441, 11442, 11443, and 11444):* Several commenters objected to the proposed deletion of excisions of lesions of greater than 2.0 cm diameter. In particular, concern was expressed over the removal of larger lesions of the face and genitalia in an office setting. MVAD data for 1986 indicate that all of the proposed deletions are performed less than 5 percent of the time on an inpatient basis and more than 60 percent of the time in physicians' offices. Therefore, they are deleted. It is possible that the commenters' views that larger lesions of the genitalia and face should not be removed in an office setting would be supported if the data were based on more precise CPT–4 codes. For instance, procedure code 11444 includes lesions of the eyelids, ears, nose, lips and mucus membranes in addition to the face. At the present time, we have no means of distinguishing the specific site of the lesions that are excised. We will explore other methods to distinguish these procedures (for example, link narrative diagnosis and procedure codes). In the interim, however, the procedures will be deleted from the list based on BMAD data for 1986.

c. *Excision of malignant lesions (procedure codes 11600, 11601, 11602, 11603, 11604, 11620, 11621, 11622, 11623, 11624, 11640, 11641, 11642, 11643, and 11644):* The most frequently received comments were from urologists who expressed opposition to the deletion of excisions of malignant lesions of the scalp, neck, hands, feet and genitalia (procedure codes 11620 through 11624) because of their concern that malignant lesions of the male genitalia cannot be easily or safety performed in an office setting. Other commenters felt that skin lesions of any size that might be malignant should remain on the list because a frozen section diagnosis might be required. BMAD data for 1986 indicate that malignant lesions are excised more frequently on an inpatient basis than are benign lesions. All of the proposed deletions are performed 55–85 percent of the time in physicians' offices. As with benign lesions, we note the difficulty in distinguishing the location of lesions through the procedure codes that combine several locations in a single code. We will explore other methods of distinguishing the precise location of the lesions. In the interim, however, the procedures will be deleted from the list based on BMAD data for 1986. We note again that the deletion of these procedures from the ASC list does not mean that they must be performed in an office setting. If a physician believes that his office is not adequately equipped or staffed to perform a given procedure safely, the physician should arrange to perform the procedure in a setting appropriate to the patient's needs.

d. *Excision of nail and nail matrix, partial or complete, for permanent removal (procedure code 11750):* No specific comments were received on this procedure. BMAD data for 1986 indicate that it is performed over 80 percent of the time in physicians' offices. Therefore, it is deleted.

2. Musculoskeletal System

a. *Treatment of closed or open nasal fracture without manipulation (procedure code 21310):* No specific comments were received on this procedure. BMAD data for 1986 indicate that although it is performed 16 percent of the time on an inpatient basis, it is performed less than 50 percent of the time in physicians' offices. Therefore, it will not be deleted from the list.

b. *Tenotomy, hand or finger (procedure codes 26060 and 26460):* No specific comments were received. BMAD data for 1986 indicate that these procedures are perfomed more than 20 percent of the time on an inpatient basis and less than 50 percent of the time in physicians' offices. Therefore, they will not be deleted from the list.

c. *Tenotomy procedures, foot or toe (procedure codes 28010, 28011, 28230, 28232, 28234, and 28240):* For these and the other foot and toe procedures discussed below, many comments were received expressing concern that deleting the procedures would adversely affect quality of care. In particular, podiatrists were concerned that the deletion of a procedure from the list would force podiatrists to attempt the procedure in their offices where the appropriate staff and equipment might not be available. Commenters stated that ASCs would not permit podiatrists to use their facilities if a facility payment was not available and that many podiatrists do not have the option of using hospital outpatient departments since surgical privileges are not available to podiatrists in many parts of the country. Several orthopedic surgeons also objected to the deletion of the procedures but for different reasons. They claimed that the data were skewed by the podiatrists who frequently perform the procedures in their offices. They also indicated that for reasons of quality this was inappropriate and that the procedures can be performed safely only in an ASC or hospital. We acknowledge that podiatrists in some areas of the country may be unable to obtain surgical privileges at their local hospital, although we believe that this problem is diminishing with time. In response to the concern that the podiatrists are skewing the data, we performed a special analysis that confirmed that podiatrists perform in their offices the foot and toe procedures

proposed for deletion more frequently than other practitioners. However, we have no evidence that the quality of care provided in an office setting (by podiatrists or some orthopedic surgeons) is less than that provided in an ASC or hospital outpatient department. Also, BMAD data for 1986 indicate that all the tenotomies proposed for deletion are performed in an office setting between 54–77 percent of the time. Therefore, they are deleted.

d. *Osteotomy procedures (procedure codes 26567, 28306, 28308, 28310, and 28312):* The comments received on the proposed deletion of osteotomy procedures were comparable to those received on tenotomies. Unlike tenotomies, however, the more recent BMAD data for 1986 indicate that, with the exception of an osteotomy of the proximal phalanx of the first toe (procedure code 28310) and osteotomy of other phalanges, any toe (procedure code 28312), all the osteotomy procedures proposed for deletion are performed more than 20 percent of the time on an inpatient basis and less than 50 percent of the time in physicians' offices. Data on procedure codes 28310 and 28312 indicate that they are performed 18 and 25 percent of the time on an inpatient basis and 54 and 51 percent of the time in physicians' offices, respectively. In light of the comments received, the more recent data, and for the sake of clinical consistency, all of the osteotomy procedures that had been proposed for deletion will be retained on the list.

e. *Fasciotomy, plantar and/or toe, subcutaneous (procedure code 282008):* No specific comments were received on this procedure. BMAD data for 1986 indicate that it is performed more than 20 percent of the time on an inpatient basis and less than 50 percent of the time in physicians' offices. Therefore, it will not be deleted from the list.

f. *Repair of suture of tendon, foot, flexor, single (procedure code 28200):* No specific comments were received on this procedure. BMAD data for 1986 indicate that it is performed more than 20 percent of the time on an inpatient basis and less than 50 percent of the time in physicians' offices. Therefore, it will not be deleted from the list.

g. *Capsulotomy, midtarsal (Heyman type procedure) (procedure code 28264):* No specific comments were received on this procedure. BMAD data for 1985 indicate that it is performed more than 20 percent of the time on an inpatient basis and less than 50 percent of the time in physicians' offices. Therefore, it will not be deleted from the list.

h. *Capsulotomy for contracture, metatarsophalangeal joint (procedure code 28270) and interphalangeal joint (procedure code 28272):* No specific comments were received on this procedure. BMAD data for 1986 indicate that these procedures are performed over 70 percent of the time in physicians' offices. Therefore, they are deleted.

i. *Hammertoe procedures (procedure code 28285 and 28286):* No specific comments were received on this procedure. BMAD data for 1986 indicate that these procedures are performed more than 20 percent of the time on an inpatient basis and less than 50 percent of the time in physicians' offices. Therefore, they will not be deleted from the list.

3. Respiratory System

a. *Repair nasal septal perforations (procedure code 30630):* Several commenters objected to the deletion of this procedure which, in their opinion, should not be performed in an office setting. BMAD data for 1986 support the comments, indicating that this procedure is performed more than 20 percent of the time on an inpatient basis and less than 50 percent of the time in physicians' offices. Therefore, it will not be deleted from the list.

b. *Laryngoscopy procedures (procedure code 31505, 31510, and 31525):* Several commenters objected to the deletion of these procedures, which in their opinion, are rarely performed as office procedures and are invariably done in a surgical setting. BMAD data for 1986 indicate that laryngoscopy, indirect; with biopsy (procedure code 31510) is commonly performed on an inpatient basis and not commonly performed in physician's offices. Therefore, (procedure code 31510) will not be deleted from the list. BMAD data for 1986 indicate that direct laryngoscopies, diagnostic (procedure code 31525) are performed 53 percent of the time in physicians' offices. However, in light of the comments received and in view of the fact that comparable procedures (for example, procedure codes 31526 and 31527) will not be deleted from the list, procedure code 31525 will not be deleted. Because the data indicate that indirect diagnostic laryngoscopies (procedure code 31505) are performed more than 79 percent of the time in physicians' offices, procedure code 31505 will be deleted from the list.

4. Digestive System

a. *Biopsy of Tongue (procedure code 41100):* No specific comments were received on this procedure. BMAD data for 1986 indicate that it is performed less than 20 percent of the time on an inpatient basis and less than 66 percent of the time in physicians' offices. Therefore, it will be deleted from the list.

b. *Dialation of rectal stricture under anesthesia other than local (procedure code 45910)* Several commenters objected to the deletion of this procedure noting that anesthesia is required and that physicians' ofices are not equipped to provide this service. BMAD data for 1986 support the comments, indicating that this procedure is performed more than 20 percent of the time on an inpatient basis and less than 50 percent of the time in physicians' offices. Therefore, it will not be deleted from the list.

5. Urinary System

a. *Cystourethroscopy (procedure code 52000):* Objections to the proposed deletion of this procedure were received from more than 400 commenters who indicated that the procedure is inappropriate (particularly for male patients) for the office setting. Specifically cited reasons for opposition were (1) quality of care could not be assured in an office setting; (2) anesthesia is frequently required and should not be administered in a physician's office; and (3) greater expense to the Medicare program as a result of a shift from the ASCs to hospital outpatient departments. BMAD data for 1986 indicate that cystourethroscopy is performed more than 20 percent of the time on an inpatient basis. Although it is performed 52 percent of the time in physicians' offices, in light of the comments received, it will not be deleted from the list.

b. *Urethral dilation procedures (procedure codes 53600, 53601, 53620, 53621, 53660, 53661, and 53665):* Many commenters objected to the deletion of these procedures claiming that our proposal was arbitrary, capricious, and inconsistent with the practice of quality medicine. Several commenters noted that the performance of procedure code 53665 required general or spinal anesthesia that would be inappropriate in an office setting. We accept that comment since it is supported by the BMAD data for 1986 and will retain procedure code 53665 on the list. However, we have not accepted the other comments since the BMAD data for 1986 indicate that between 69 percent and 98 percent of the other procedures are performed in physicians' offices. Therefore, procedure codes 53600, 53601, 53620, 53621, 53660 and 53661 are deleted from the list.

6. Female Genital System

Dilation of vagina under anesthesia (procedure code 57400): Several commenters objected to the deletion of this procedure noting that anesthesia is required and that physicians' offices are not equipped to provide this service. BMAD data for 1986 support the comments indicating that this procedure is performed more than 20 percent of the time on an inpatient basis and less than 50 percent of the time in physicians' offices. Therefore, it will not be deleted from the list.

7. Eye and Ocular Adnexa

a. *Discussion of lens capsule (procedure code 66800):* No specific comments were received on this procedure. BMAD data for 1986 indicate that it is performed less than 20 percent of the time on an inpatient basis and less than 50 percent of the time in physicians' offices. However, although it is not commonly performed on an inpatient basis, the data indicate that it is performed 30 percent of the time in an ASC. Therefore, it will not be deleted from the list.

b. *Excision of chalazion (procedure code 67801):* One commenter objected to the deletion of this procedure and noted that the occurrence of a multiple lesions in an infant or child would require general anesthesia that could not be provided in a physician's office. BMAD data for 1986 indicate that this procedure is preformed 87 percent of the time in physicians' offices. Therefore, it will be deleted from the list. We note that the proper procedure code for the case described by the commenter is not procedure code 67801, but procedure code 67808 (excision of chalazion under general anesthesia and/or requiring hospitalization, single or multiple). This procedure code (67808) is on the list of covered ASC procedures.

c. *Plastic repair of canaliculi (procedure code 68700):* No specific comments were received on this procedure. BMAD data for 1986 indicate that it is performed less than 20 percent of the time on an inpatient basis and approximately 50 percent of the time in physicians' offices. Although it is not commonly performed on an inpatient basis, the data indicate that it is performed 10 percent of the time in an ASC. Therefore, it will not be deleted from the list.

d. *Probing of nasolacrimal duct with insertion of tube or stent (procedure code 68830):* No specific comments were received on this procedure. BMAD data for 1986 indicate that it is performed 7 percent of the time on an inpatient basis and 68 percent of the time in physicians' offices. Therefore, it will be deleted from the list.

8. Auditory System

Myringotomy including aspiration and/or eustachian tube inflation (procedure code 69420): Two commenters objected to the proposed deletion because it would then be performed as an inpatient procedure where costs would be higher. They noted that the procedure is not properly done in a physician's office, since a biopsy of the nasopharynx should be done before placing a tube in the ear of an elderly patient. It was argued that unilateral hearing loss in an elderly patient should be considered an indication of malignancy until proven otherwise. Another commenter noted that two different procedures are included under procedure code 69420 (Myringotomy and/or eustachian tube inflation) and that the former is an operating room procedure and the latter an office procedure. We believe that procedure 69420 is being performed for other indications in addition to that of hearing loss since the BMAD data for 1986 indicate that more than 84 percent are performed in physicians' offices. Also, as we noted in our response under the integumentary system, we are unable to distinguish between two procedures that are included in the description of a single CPT–4 code. In view of the high physician office frequency, this procedure will be deleted from the list.

F. Additions

In addition to the list of proposed deletions that was included in our proposed notice, we specifically requested comments on additions to the ASC list. In particular, we sought comments on the addition of extracorporeal shock wave lithotripsy (ESWL) because we had received several requests for the addition of this procedure after the close of the comment period for our proposed notice published on February 16, 1984 (49 FR 6023) on which we based our April 21, 1987 (52 FR 13176) expansion of the list of covered procedures.

1. Extracorporeal Shock Wave Lithotripsy

Comment: Commenters were divided in their recommendations for ESWL (procedure code 50590). Many of those in favor of adding the procedure to the list did not provide a specific rationale for their recommendation. On the other hand, those opposed, while fewer in number, provided specific objections to adding the procedure to the list. A State urological association indicated that the procedure carries with it the dangers of hemorrhage and infection and that it should be considered an inpatient procedure. Another commenter indicated that the procedure should be done on an inpatient basis and an overnight stay required because of the possibility of complications and the need of close monitoring. Another indicated that ESWL was appropriate for outpatient use in younger patients with small stones.

Response: We agree with the commenters who believe that the outpatient utilization of ESWL (procedure code 50590) is only safe with a carefully selected patient population, and that it will continue to be an inpatient procedure for the majority of Medicare patients. In view of the concerns over safety that were raised by several commenters and in considering our data, which indicate that ESWL is still most often an inpatient procedure, we have decided not to add it to the list at this time. As more information and data on the safety of ESWL become available, we will continue to evaluate the appropriateness of adding this procedure to the ASC list. In addition to our concerns about safety based on the comments received, we are not yet convinced that ESWL can be categorized as a "surgical" procedure. We note that this decision does not mean that ESWL can be covered only when performed on an inpatient basis. For certain patients, ESWL can be performed safely on an outpatient basis. The choice of site remains a matter for the professional judgment of the patient's physician.

2. Dental Procedures

Comment: One commenter suggested that dental cases requiring general anesthesia should be added to the list.

Response: Section 1862(a)(12) of the Act excludes from coverage any services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth. The ASC regulations at § 416.65 prohibit the inclusion of noncovered services on the list of covered services. Therefore, dental cases requiring general anesthesia cannot be added to the list.

3. Laser Procedures

Comment: Two commenters recommended adding procedures to the list that required the use of a surgical laser and specifically recommended the addition of retinal detachment repair (procedure code 67105) and prophylaxis of retinal detachment (procedure code 67145).

Response: A laser may be used for any surgical procedure on the ASC list provided that the Food and Drug Administration (FDA) has approved the use of the laser for that particular procedure. With a few exceptions, the procedures contained in CPT–4 do not specify the use of a laser. Procedure codes 67105 and 67145 are two of those exceptions. We reviewed BMAD data for 1986 that indicate that procedure code 67105 (retinal detachment repair) is performed more than 20 percent of the time on an inpatient basis and less than 50 percent of the time in physician offices. Therefore, it will be added to the list. On the other hand, procedure code 67145 (prophylaxis of retinal detachment) is performed less than 10 percent of the time on an inpatient basis and over 50 percent of the time in physician's offices. Therefore, it will not be added to the list.

4. Arthroscopy

Comment: One commenter recommended adding procedure codes 23356, 23357, and 23358 to the list.

Response: These three codes describe arthroscopic procedures of the shoulder. They were deleted from the CPT–4 in 1986 and replaced by procedure codes 29815 through 29825. Because there is not a one-to-one correlation with the new codes and we will not have a full year of data to review until BMAD data for 1987 are available, we will not add these procedures at this time. They will be considered when the list is next updated.

IV. Provisions of the Final Notice

This notice is being issued to finalize the list of proposed additions and deletions that we published on August 11, 1987. Additionally, this notice fulfills the requirements of section 1833(i)(1)(A) of the Act that the list of ASC procedures be reviewed and updated no less than every 2 years.

A. Deletions

The following 48 codes will be deleted from the current ASC list:

Integumentary System

11200 Excision (including simple closure or ligature strangulation), skin tags, multiple fibrocutaneous tags, any area: up to 15
11201 each additional ten lesions
11401 Excision, benign lesion, except skin tag (unless listed elsewhere), trunk, arms or legs; lesion diameter 0.6 to 1.0 cm
11402 lesion diameter 1.1 to 2.0 cm
11403 lesion diameter 2.1 to 3.0 cm
11404 lesion diameter 3.1 to 4.0 cm
11421 Excision, benign lesion, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia, lesion diameter 0.6 to 1.0 cm
11422 lesion diameter 1.1 to 2.2 cm
11423 lesion diameter 2.1 to 3.0 cm
11441 Excision, other benign lesion (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.6 to 1.0 cm
11442 lesion diameter 1.1 to 2.0 cm
11443 lesion diameter 2.1 to 3.0 cm
11444 lesion diameter 3.1 to 4.0 cm
11600 Excision, malignant lesion, trunk, arms, or legs; lesion diameter up to 0.5 cm
11601 lesion diameter 0.6 to 1.0 cm
11602 lesion diameter 1.1 to 2.0 cm
11603 lesion diameter 2.1 to 3.0 cm
11604 lesion diameter 3.1 to 4.0 cm
11620 Excision, malignant lesion, scalp, neck, hands, feet, genitalia; lesion diameter up to 0.5 cm
11621 lesion diameter 0.6 to 1.0 cm
11622 lesion diameter 1.1 to 2.0 cm
11623 lesion diameter 2.1 to 3.0 cm
11624 lesion diameter 3.1 to 4.0 cm
11640 Excision, malignant lesion, face, ears, eyelids, nose, lips; lesion diameter up to 0.5 cm
11641 lesion diameter 0.6 to 1.0 cm
11642 lesion diameter 1.1 to 2.0 cm
11643 lesion diameter 2.1 to 3.0 cm
11644 lesion diameter 3.1 to 4.0 cm
11750 Excision of nail and nail matrix, partial or complete, (eg, ingrown or deformed nail) for permanent removal

Musculoskeletal

28010 Tenotomy, subcutaneous, toe; single
28011 multiple
28230 Tenotomy, open, flexor; foot, single or multiple (separate procedure)
28232 toe, single (separate procedure)
28234 Tenotomy, open, extensor, foot or toe
28240 Tenotomy lengthening, or release, abductor hallucis muscle
28270 Capsulotomy for contracture; metatarsophalangeal joint, with or without tenorrhaphy, single each joint (separate procedure)
28272 interphalangeal joint, single, each joint (separate procedure)

Respiratory System

31505 Laryngoscopy, indirect (separate procedure); diagnostic

Digestive System

41100 Biopsy of tongue

Urinary System

53600 Dilation of urethral stricture by passage of sound or urethral dilator, male; initial
53601 subsequent
53620 Dilation of urethral stricture by passage of filiform and follower, male; initial
53621 subsequent
53660 Dilation of female urethra including suppository and/or instillation, initial
53661 subsequent

Eye and Ocular Adnexa

67801 Excision of chalazion; multiple, same lid
68830 Probing of nasolacrimal duct, with or without irrigation, unilateral or bilateral; with insertion of tube or stent

Auditory System

69420 Myringotomy including aspiration and/or eustachian tube inflation

B. Addition

The following will be added to the ASC list under payment Group 4:

Eye and Ocular Adnexa

67105 Repair of retinal detachment, photocoagulation (lasar of xenon arc, one or more sessions) with drainage of subretinal fluid

V. Regulatory Impact Statement

A. Executive Order 12291

Executive Order 12291 (E.O. 12291) requires us to prepare and publish a regulatory impact analysis for any final notice that will produce effects meeting one of the E.O. criteria for a "major rule"; that is, that will be likely to result in—

- An annual effect on the economy of $100 million or more;
- A major increase in costs or prices for consumers, individual industries, Federal, State, or local government agencies, or geographic regions; or
- Significant adverse effects on competition, employment, investment, productivity, innovation, or on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic or export markets.

This final notice does not meet the $100 million criterion nor do we believe that it meets the other E.O. 12291 criteria. Therefore, this final notice is not a major rule under E.O. 12291, and a final regulatory impact analysis is not required.

B. Regulatory Flexibility Act

We generally prepare a regulatory flexibility analysis that is consistent with the Regulatory Flexibility Act (RFA) (5 U.S.C. 601 through 612) unless the Secretary certifies that a final notice will not have a significant economic impact on a substantial number of small entities. For purposes of the RFA, all physicians, ASCs and hospitals are treated as small entities.

Although some commenters believed that the deletion of some procedures from the list of approved ASC procedures would have an adverse effect on some ASCs and hospitals, we pointed out in our responses to these commenters that dropping the procedures does not remove coverage for these procedures. It means only that we will not pay the facility amount that had been associated with the procedure (that is, the facility payment amount for one of the four payment groups into which the procedure had been classified.

Furthermore, in almost all instances of a procedure being deleted from the list of approved ASC procedures, fewer than one percent of the procedures were being performed in an ASC. The majority of cases involving deleted procedures were being treated in a physician's office. Thus, the effect of deleting the procedures listed in this document is expected to have only a slight economic effect on ASCs.

Although the effect of deleting the procedures listed in this notice is expected to be small, there may be a slight benefit to hospital outpatient departments. Approved ASC procedures performed in a hospital outpatient setting are subject to a payment limitation of the lower of the hospital's cost or charges, or a blend of the applicable ASC facility payment amount and the lower of the hospital's costs or charges. For procedures removed from the list of approved ASC procedures, the hospital will be subject only to the lower of costs or charges. In most cases, hospital outpatient costs or charges are higher than the applicable ASC facility payment amount. The benefit to hospitals, however, is expected to be very small. First, the difference between the payment amount hospitals receive under the blend of 50 percent of the hospital's facility costs and 50 percent of the standard ASC facility amount that is in effect now and the amounts they will be paid is negligible for the procedures being deleted. Second, since most of the procedures being deleted are already performed either in a hospital outpatient setting or in a physician's office, we do not expect a significant transfer of cases and payments from ASCs to hospital outpatient settings to occur.

For these reasons, we have determined, and the Secretary certifies, that this notice will not have a significant effect on a substantial number of small entities. Therefore, we have not prepared a regulatory flexibility analysis.

Section 1102(b) of the Act requires the Secretary to prepare a regulatory impact analysis if a final notice may have a significant impact on the operations of a substantial number of small rural hospitals. Such an analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital with fewer than 50 beds located outside of a Metropolitan Statistical Area.

We received some comments expressing concern about the effect on rural hospitals of deleting some procedures from the list of approved ASC procedures. However, as explained in our response to these comments and in the preceding discussion, we do not expect a significant effect on any small entities to follow from this notice. Therefore, we are not preparing a rural impact statement since we have determined, and the Secretary certifies that this final notice will not have a significant economic impact on the operations of a substantial number of small rural hospitals.

VI. Paperwork Reduction Act

This final notice contains no information collection requirements. Therefore, it does not come under the provisions of the Paperwork Reduction Act of 1980 (44 U.S.C. 3501.)

(Sec. 1833(i)(1) of the Social Security Act (42 U.S.C. 1395(i)(1); 42 CFR 416.65))

Catalog of Federal Domestic Assistance Program No. 13.774, Medicare—Supplementary Medical Insurance Program)

Dated: April 5, 1989.

Louis B. Hays,

Acting Administrator, Health Care Financing Administration.

[FR Doc. 89-13029 Filed 5-31-89; 8:45 am]

BILLING CODE 4120-01-M

[BPO-087-N]

Medicare Program; Meeting of the Supplemental Health Insurance Panel

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

ACTION: Notice of public meeting.

SUMMARY: This notice announces a meeting of the Supplemental Health Insurance Panel for the purpose of reviewing State Medicare supplemental health insurance programs. The Panel will determine whether such programs meet the minimum standards contained in section 1882 of the Social Security Act, as amended by the Omnibus Budget Reconciliation Act of 1987 (OBRA 87) and the Medicare Catastrophic Coverage Act of 1988 (MCCA). The meeting will be open to the public. Attendees will be seated on a first come, first served basis.

DATE: The meeting will be held on June 7, 1989 from 2:00 to 4:00 p.m., EDT.

ADDRESS: The meeting will be held at the Hyatt Regency Hotel, Cincinnati, Ohio. The room assigned is Section C.

FOR FURTHER INFORMATION CONTACT: Theresa DeGrange, (301) 966-7449.

SUPPLEMENTARY INFORMATION:

I. Purpose

The Supplemental Health Insurance Panel (Panel) was established in 1980 by section 507 of the Social Security Disability Amendments of 1980, Pub. L. 96-265, which added section 1882 to Title XVIII of the Social Security Act (the Act). This law established minimum standards for Medicare supplemental health insurance or "Medigap" policies in order to protect Medicare beneficiaries from abuses found to be prevalent in the marketing of such policies. The Panel is comprised of four State Insurance Commissioners and a chairperson. The chairperson is the Director, Bureau of Program Operations, HCFA (by delegation of authority from the Secretary of Health and Human Services). Panel meetings are open to the public. Initially, under section 1882(b)(2)(A) of the Act, State Commissioners were appointed to the Panel by the President. However, section 221(f) of the Medicare Catastrophic Coverage Act of 1988 (MCCA), Pub. L. 100-360, authorizes the Secretary to make these appointments.

The primary responsibility of the Panel is to review the States' legislative and regulatory requirements for Medicare supplemental health insurance policies to determine whether the individual State standards are equal to or more stringent than certain Federal requirements described in section 1882(b)(1) of the Act. States with Panel-approved programs are not subject to the Federal Voluntary Certification Program (VCP) for Medigap policies. There are at present 49 jurisdictions, including 46 States, that are not subject to VCP for Medigap policies. Also as specified in section 1882 of the Act, the VCP allows individual insurers in States with programs not approved by the