amendment, thus, would not have any appreciable economic impact on the United States Government or VA.

Officials and members of one organization stated their view that Federal chartering gives recognition to deserving and competent organizations. They expressed concern that the proposed amendment could have unspecified, far-reaching negative implications for veterans' organizations and for veterans. They therefore suggested that the proposed amendment be delayed pending a study of potential detrimental effects.

As noted above, however, because the amendment will not result in recognition as a national organization for any group undeserving of such status, there should be no detrimental effects to VA claimants from the amendment. It is possible that the amendment could result in increased competition among service organizations for available space at VA facilities. However, in light of the remaining criteria for recognition as a national organization, the number of additional groups which could qualify for such space is likely to be limited. Further, while VA in no way intends to denigrate the many accomplishments of chartered organizations, whether Federal chartering is a process which provides deserved recognition to organizations is not determinative for purposes of this rulemaking. The key significance of Federal chartering for purposes of this rulemaking is whether this criterion is helpful in determining whether an organization is a national organization for purposes of § 14.628(a) or whether it must instead seek VA recognition under § 14.628(c). VA believes that the other criteria of § 14.628(a)(2), which, unlike Federal chartering, specifically related to the size and scope of operations of an organization, provide a better test of whether an organization should be considered national.

Va appreciates the comments and suggestions of those concerned individuals and organizations that responded to publication of the proposed amendment. The amendment is adopted as proposed. The final amendment is set forth below.

Since this amendment relieves a restriction which VA believes no longer serves a useful purpose, this amendment is made effective the date of publication of this notice in the **Federal Register.**

In accordance with Executive Order 12291, Federal Regulation, the Secretary has determined that these regulatory amendments are non-major for the following reasons:

(1) They will not have an annual effect on the economy of $100 million or more.

(2) They will not cause a major increase in costs or prices.

(3) They will not have 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.

The Secretary hereby certifies that this regulatory amendment will not have a significant economic impact on a substantial number of small entities as they are defined in the Regulatory Flexibility Act, 5 U.S.C. 601–612. The reasons for this certification are that the amendment will affect only a small portion of those organizations or individuals recognized by VA for claim representation purposes, that the organizations affected will be national in scope, and that the economic impact on those organizations will not be significant. Therefore, pursuant to 5 U.S.C. 605(b), these regulations are exempt from the initial and final regulatory-flexibility-analyses requirements of sections 603 and 604.

There is no Catalog of Federal Domestic Assistance Number.

List of Subjects in 38 CFR Part 14

Administrative practice and procedure, Claims, Foreign relations, Government employees, Lawyers, Legal services, Organization and functions of government agencies, Reporting and recordkeeping requirements, Surety bonds, Trusts and trustees, Veterans.

For the reasons set forth in the preamble, it is proposed that 38 CFR part 14 be amended as set forth below:

PART 14—LEGAL SERVICES, GENERAL COUNSEL

1. The authority citation for part 14 is revised to read as follows:

Authority: 38 U.S.C. 501(a), 5502, 5902–5905, unless otherwise noted.

2. In § 14.628, the introductory text in paragraph (a)(2) is revised, and the authority citation for § 14.628 is revised to read as follows:

§ 14.628 Recognition of organizations.

* * * * *

(a) *National organization.*

* * * * *

(2) It satisfies the following requirements:

* * * * *

(Authority: 38 U.S.C. 501(a), 5902)

Approved: July 10, 1992.

Edward J. Derwinski,

Secretary of Veterans Affairs.

[FR Doc. 92–18105 Filed 7–30–92; 8:45 am]

BILLING CODE 8320–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 405, 410, 412, 413, and 482

[BPD–423–F]

RIN 0938–AD25

Medicare Program; Fee Schedules for the Services of Certified Registered Nurse Anesthetists

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

ACTION: Final rule.

SUMMARY: We are revising the Medicare regulations to allow certified registered nurse anesthetists (CRNAs) to receive Medicare payment for the anesthesia services and related care they furnish. In addition, this final rule sets forth the fee schedules under which payment is made for the services of CRNAs, except for the services of CRNAs in certain rural hospitals who are paid on a reasonable cost basis. This rule, which is effective for services furnished on or after January 1, 1989, implements section 9320 of the Omnibus Budget Reconciliation Act of 1986, as amended by section 4084 of the Omnibus Budget Reconciliation Act of 1987, section 411(i)(3) of the Medicare Catastrophic Coverage Act of 1988, section 608(c) of the Family Support Act of 1988, and sections 6106, 6107 and 6132 of the Omnibus Budget Reconciliation Act of 1989.

This final rule does not reflect the changes concerning the calculation of payment rates contained in section 1833(1)(4) of the Social Security Act, as enacted by section 4160 of the Omnibus Budget Reconciliation Act of 1990. Those changes apply to services furnished on or after January 1, 1991. Thus, the changes to the payment calculation provisions described and published below are applicable only to services furnished in calendar years 1989 and 1990.

DATES: This final rule is effective August 31, 1992, except for the final 1989 CRNA fee schedule rates, which apply to CRNA services furnished on or after January 1, 1989, and the policy that recognizes only the actual time for

fractional time units, which is effective for CRNA services furnished on or after April 1, 1990.

ADDRESSES: To order copies of the **Federal Register** containing this document, send your request to the Superintendent of Documents, U.S. Government Printing Office, ATTN: New Order, P.O. Box 371954, Pittsburgh, PA 15250–7954. Specify the date of the issue requested and enclose a check payable to the Superintendent of Documents, or enclose your Visa or Master Card number and expiration date. Credit card orders can also be placed by calling the order desk at (202) 783–3238 or by faxing to (202) 275–6802. The cost for each copy (in paper or microfiche form) is $1.50. In addition, you may view and photocopy the **Federal Register** document at most libraries designated as U.S. Government Depository Libraries and at many other public and academic libraries throughout the country that receive the **Federal Register.** Ask the order desk operator for the location of the Government Depository Library nearest to you.

FOR FURTHER INFORMATION CONTACT:

George Morey, (410) 966–4653. Definition of CRNA

James Menas, (410) 966–4507. All other issues

SUPPLEMENTARY INFORMATION:

I. Background

Anesthesiology services personally furnished by a physician are paid on a reasonable charge basis under Part B of the Medicare program (Supplementary Medical Insurance). In addition, payment may also be made on a reasonable charge basis for the personal medical direction that a physician furnishes to certified registered nurse anesthetists (CRNAs).

Anesthesia services furnished prior to January 1, 1989 by CRNAs employed and medically-directed by physicians were paid on a reasonable charge basis. Separate payment was not made for the CRNA service; rather, it was included with the reasonable charge payment for medical direction furnished by the physician. The reasonable charge was determined as the least of the physician's customary charge conversion factor, the prevailing charge conversion factor, each of which was multiplied by the number of allowable units, or the physician's actual charge. The number of allowable units was the sum of the base units assigned to the anesthesia procedure, time units that represent the elapsed time of the anesthesia procedure (limited to no more than one time unit for each 15 minutes or fraction thereof of anesthesia time), and modifier units that took into account special factors such as the age or physical condition of the patient, if the physician billed and the carrier recognized modifier units. (The base units were reduced 10 percent, 25 percent, or 40 percent, respectively, for two, three, or four concurrent procedures.)

If a physician furnished medical direction for anesthesia procedures prior to January 1, 1989 that involved CRNAs who were not employed by the physician, the reasonable charge was also determined as the least of the physician's customary charge conversion factor, the prevailing charge conversion factor, each of which was multiplied by the number of allowable units, or the physician's actual charge. However, in these cases, the number of allowable units was the sum of the base units assigned to the anesthesia procedure, time units, which were limited to no more than one time unit for each 30 minutes or fraction thereof of anesthesia time, and modifier units, if the physician billed and the carrier recognized modifier units. (The base units were reduced 10 percent, 25 percent, or 40 percent, respectively, for two, three, or four concurrent procedures.)

The difference in payment between a medically directed anesthesia procedure involving a CRNA who was the physician's employee and a medically directed anesthesia procedure involving a CRNA who was not the physician's employee was two time units per hour multiplied by the appropriate conversion factor.

Anesthesia services furnished prior to January 1, 1989 by CRNAs employed by hospitals or obtained under arrangements were paid to the hospital on a reasonable cost basis for anesthesia services furnished to hospital inpatients or outpatients. Anesthesia services furnished prior to January 1, 1989 by a CRNA employed by an ambulatory surgical center (ASC) or working as an independent contractor were included as part of the ASC's facility fee.

II. Summary of New Legislation

On October 21, 1986, the Omnibus Budget Reconciliation Act of 1986 (Pub. L. 99–509) was enacted. The provisions of section 9320 of Public Law 99–509 made the following changes (which are reflected in sections 1832(a)(2)(B), 1833(a)(1)(E), 1833(a)(1)(H), 1833(1), 1861(b)(4), (s)(11), and (bb), 1862(a)(14), and 1886(a)(4) of the Social Security Act (the Act)) that affect Medicare payment for the services of nurse anesthetists:

- Effective with services furnished on or after January 1, 1989, direct payment is provided for anesthesia services and related care furnished by CRNAs, subject to State licensure requirements and the requirements of the certifying body for nurse anesthetists.
- Medicare pays 80 percent of the lesser of the actual charge or the fee schedule amount for anesthesia services and related care after the Part B deductible has been met. Assignment is mandatory in order for CRNAs to receive payment for these services, and violators are subject to civil monetary penalties.
- The Secretary is directed to establish a fee schedule for CRNA services, using a system of time units, a system of base and time units, or any other appropriate methodology. The initial fee schedule must be based on audited data from cost reporting periods ending in Federal fiscal year (FY) 1985, and the fee schedule must be adjusted annually by the percentage increase in the Medicare economic index (MEI) in order to be effective on January 1st of each year. The fee schedule can be national or adjusted for geographic areas.
- No hospital that presents a claim or request for payment for services of a CRNA may treat any uncollected coinsurance amount imposed with respect to such services as a bad debt of the hospital.
- The reasonable cost pass-through provision ends effective for CRNA services furnished to hospital inpatients after December 31, 1988.
- The initial fee schedule must be set so that total payment for CRNA services, plus the applicable coinsurance in FY 1989, equals estimated total amounts that would have been paid in 1989 if the services were included as inpatient hospital services. The Secretary is also directed to adjust physician charges for medical direction or the fee schedule amounts, or both, to ensure that total payments plus coinsurance for all these services in 1989 and 1990 do not exceed the amounts that would have been paid absent this legislation. If this results in reductions in physician reasonable charges, a nonparticipating physician may not charge more than 125 percent of the reduced prevailing charge plus (in the first year) half the difference between his or her actual charge in the previous year and 125 percent of the reduced prevailing charge. Violators are subject to sanctions.

In addition, section 9320 of Pub. L. 99–509 added a new paragraph (11) to section 1861(s) of the Act to provide

specifically that "services of a certified registered nurse anesthetist (as defined in subsection (bb))" are among the medical and other health services that are covered under Part B of Medicare. Section 1861(bb)(1) of the Act states that "services of a certified registered nurse anesthetist" means anesthesia services and related care, furnished by a CRNA, which the CRNA is authorized to perform by the State in which the services are furnished. Section 1861(bb)(2) of the Act states that the term "CRNA" means a CRNA licensed by the State who meets such education, training, and other requirements relating to anesthesia services and related care as the Secretary may prescribe. Section 1861(bb)(2) of the Act further authorizes the Secretary, in prescribing these requirements, to use the same requirements as those established by a national organization for the certification of nurse anesthetists.

On December 22, 1987, the Omnibus Budget Reconciliation Act of 1987 (Pub. L. 100–203) was enacted. The provisions of section 4084 of Public Law 100–203, which amended sections 1833(l)(2) and (l)(5)(A) of the Act, made the following changes to the CRNA fee schedule legislation established by section 9320 of Public Law 99–509:

- The initial fee schedule could be developed from "other data as the Secretary determines necessary" in addition to using FY 1985 cost report data.
- The CRNA payment based on the fee schedule can be made to an ambulatory surgical center as well as the CRNA, the hospital, the physician, or group practice.

In addition to the changes made by section 4084 of Pub. L. 100–203, section 4048(a) of Public Law 100–203 amended section 1842(b) of the Act to provide that in determining the reasonable charge of a physician for medical direction of two or more CRNAs for anesthesia services furnished on or after April 1, 1988 and before January 1, 1991, the number of base units recognized for each concurrent procedure (other than cataract surgery or an iridectomy) is reduced by—

- Ten percent, in the case of medical direction of two CRNAs concurrently;
- Twenty-five percent, in the case of medical direction of three CRNAs concurrently; and
- Forty percent, in the case of medical direction of four CRNAs concurrently.

On July 1, 1988, the Medicare Catastrophic Coverage Act of 1988 (Pub. L. 100–360) was enacted. Section 411(i)(3) of Public Law 100–360 made technical amendments to section 4084 of Public Law 100–203 to provide that—

- The term "CRNA," as prescribed by the Secretary, also includes an anesthesiologist assistant (section 1861(bb)(2) of the Act); and
- With respect to CRNA services, the amounts paid would be 80 percent of the least of the—

—Actual charge;
—Prevailing charge that would be recognized if the services had been performed by an anesthesiologist; or
—Fee schedule amount (section 1833(a)(1)(H) of the Act).

Section 411 of Public Law 100–360 was not repealed by the Medicare Catastrophic Coverage Repeal Act of 1989, Public Law 101–234.

On October 13, 1988, the Family Support Act of 1988 (Pub. L. 100–485) was enacted. Section 608(c) of Public Law 100–485 amended section 9320 of Public Law 99–509 to allow certain hospitals that are located in a rural area (as defined for purposes of section 1886(d) of the Act) to continue to be paid on a reasonable cost basis for CRNA services during calendar years 1989, 1990, and 1991.

To qualify in 1989, a rural hospital must establish before April 1, 1989 to the satisfaction of the Secretary that—

- It employed or contracted with not more than one full-time equivalent CRNA as of January 1, 1988;
- It performed 250 or fewer surgical procedures, including inpatient and outpatient procedures, requiring anesthesia in calendar year 1987; and
- Each CRNA employed by or under contract with the hospital has agreed not to bill under Medicare Part B for professional services furnished at the hospital.

To qualify in 1990 or 1991, a rural hospital must establish before the beginning of the calendar year that, in the prior year, it did not perform more than 250 surgical procedures including inpatient and outpatient procedures requiring anesthesia services.

The provisions added by section 608(c) of Public Law 100–485 are to be implemented so as to maintain budget neutrality consistent with section 1833(l)(3) of the Act.

On December 19, 1989, the Omnibus Budget Reconciliation Act of 1989 (Pub. L. 101–239) was enacted. Section 6132 amended section 608(c) of Public Law 100–485 as follows:

- The limit has been raised from 250 surgical procedures, both inpatient and outpatient, requiring anesthesia services to 500 surgical procedures.
- The expiration provision that allowed certain qualified rural hospitals to continue reasonable cost payments only through calendar year 1991 has been eliminated. Rural hospitals can continue to elect on a calendar year basis reasonable cost payments for CRNA services.
- The budget neutrality provision, which required us to adjust CRNA fee schedule rates to reflect the election of reasonable cost payments, has been eliminated.

Section 6106 of Public Law 101–239 revised the method by which time units are counted for anesthesia services furnished by physicians or CRNAs. For anesthesia services furnished on or after April 1, 1990, time units are counted based on the actual time of the fractional time unit. For anesthesia services furnished prior to April 1, 1990, fractional time units were rounded to a full time unit.

Section 6107(a) of Public Law 101–239 delays the update of the CRNA fee schedule conversion factors for CRNA services furnished on or after January 1, 1990 to April 1, 1990. Section 6107(b) provides that the percentage increase in the MEI used to update CRNA conversion factors applicable to CRNA services furnished on or after April 1, 1990 is zero percent.

On November 5, 1990, the Omnibus Budget Reconciliation Act of 1990 (Pub. L. 101–508) was enacted. Section 4160 of Public Law 101–508 amended section 1833(1)(4) to provide for a system of statutorily established conversion factors for both medically directed and nonmedically directed services furnished by CRNAs beginning in calendar year 1991 and ending for CRNA services furnished after calendar year 1996. The conversion factors are index-adjusted to account for geographical differences. This final regulation does not reflect the provision of this new legislation. Thus, the amendments published below to the regulations concerning the calculation of payments are effective only for services furnished in calendar years 1989 and 1990.

III. Summary of Provisions of the January 26, 1989 Proposed Rule

On January 26, 1989, we published a proposed rule in the **Federal Register** (54 FR 3803) to allow CRNAs to receive Medicare payment for anesthesia services and related care and to set forth the fee schedules that would be used to make payment for these services, except for the services of CRNAs in certain rural hospitals, which would be paid on a reasonable cost basis. In that rule, we proposed to implement the provisions of Public Law 99–509, Public Law 100–203, Public Law 100–360, and Public Law 100–485, and

we requested public comment on these changes.

A. Services of a CRNA or an Anesthesiologist Assistant

We proposed adding "services of a CRNA or an anesthesiologist assistant" to the list of covered medical and other health services in the regulations.

We proposed defining "CRNA" as a registered nurse who is licensed as a professional registered nurse by the State in which he or she practices and meets any other licensure requirements the State imposes with respect to nonphysician anesthetists, and either—

- Is currently certified by either the Council on Certification of Nurse Anesthetists or the Council on Recertification of Nurse Anesthetists; or
- Has graduated within the past 18 months from a nurse anesthesia program that meets the standards of the Council on Accreditation of Nurse Anesthesia Educational Programs and is awaiting initial certification.

Further, we proposed defining an "anesthesiologist assistant" as an individual who is permitted by State law to administer anesthesia, has successfully completed a six-year program for anesthesiologist assistants, two years of which consist of specialized academic and clinical training in anesthesia, and who is under the direct supervision of an anesthesiologist who is physically present.

In addition, we proposed defining the term "anesthetist" to include both anesthesiologist assistants and CRNAs. The use of this term represents a clear and convenient means of referring to both types of practitioners.

B. General Method of Payment

We proposed that effective with services furnished on or after January 1, 1989, payment for the services of a CRNA would be made, after the Part B deductible has been met, at 80 percent of the least of the—

- Actual charge;
- Prevailing charge that would be recognized if the services had been performed by an anesthesiologist; or
- Fee schedule amount.

C. Time Units

We proposed that services of CRNAs be paid on a basis similar to that used for anesthesiologists, that is, a system based on base and time units. We believe that use of the same type of system for anesthesia services furnished by CRNAs and anesthesiologists would be simpler for carriers to administer. Thus, we proposed that, for purposes of the fee schedule, one time unit would be allowed for each 15 minutes of anesthesia time.

In addition, we described the recommendations made by the Office of Inspector General (OIG) to change the way an anesthesia time unit is computed. The options were presented by OIG in a report entitled "Medicare Part B Payments for Unexpended Physician Efforts Relating to Anesthesia Services" (A-07-88-00082 issued on August 9, 1988). (Copies of this report can be obtained by writing to OIG at 330 Independence Ave., SW., Washington, DC 20201.) The options were as follows:

- Pay for actual time expended, rather than treating all fractional units as whole units. That is, 65 minutes would equal four and one-third time units instead of five units.
- Round all fractional units down to the next lower whole unit, that is, disregard all fractional time units. (For example, any amount of time between 61 and 74 minutes would equal four units instead of five units.)
- Pay only for those fractional units in excess of one-half as whole units. That is, any fraction equal to or less than one-half time unit (7.5 minutes) would be disregarded. (For example, 65 minutes would equal four units, but 68 minutes would equal five units.)

In the preamble to the proposed rule, we also stated our intention to eliminate the separate time unit element of the anesthesia payment system within 2 years of the effective date of this final rule. We indicated that the elimination of time units would be the subject of a separate notice of proposed rulemaking and that comments submitted in response to that proposed rule would be carefully considered before implementation of a revised time unit policy.

D. Development of a Fee Schedule

Physician anesthesia services furnished on or after January 1, 1989, but prior to March 1, 1989, the date the uniform relative value guide for physician anesthesia services was implemented, were paid on the basis of the carrier's specific relative value system. (The uniform relative value guide was implemented by Transmittal No. 1287 to the Medicare Carriers Manual (HCFA-Pub. 14), issued in February 1989.) The uniform relative value was implemented for anesthesia services furnished on or after March 1, 1989. Under the uniform relative value guide, modifier units were eliminated. Final regulations to implement the uniform relative value guide were published on August 7, 1990 (55 FR 15150). In sections 5261 and 8312 of the Medicare Carriers Manual, we also provided for CRNA services furnished on or after January 1, 1989, but prior to March 1, 1989, to be paid under the carrier specific relative value system. We provided for CRNA services furnished on or after March 1, 1989, to be paid under the uniform relative value guide. Modifier units were not recognized for CRNA services under either the carrier specific system or the uniform relative value guide.

The CRNA fee schedule payment would be determined by multiplying an appropriate conversion factor by the sum of the base units for the anesthesia procedure and the time units. For CRNA services, one time unit would be allowable for each 15 minutes or fraction thereof of anesthesia time.

We proposed establishing the CRNA fee schedule based on the 1986 American Association of Nurse Anesthetists (AANA) calendar year survey (with certain adjustments), and structuring it on an individual State-level basis. Within each State, we established two separate fee schedules; one for CRNAs working under the medical direction of an anesthesiologist and one for CRNAs working only under the general supervision of the surgeon.

In using the AANA salary survey to develop the State level fee rate or conversion factor for medically directed hospital-employed CRNAs, the following adjustments, explained in detail in the notice of proposed rulemaking, were made:

Step 1. Updating the 1986 earnings to the 1989 level—We proposed a six percent rate of increase annually through 1989 (projecting this rate of change through 1989 would require an increase of 19 percent (that is, $1.06 \times 1.06 \times 1.06$] over 1986 average earnings.)

Step 2. Fringe Benefit Adjustments—Because the value of fringe benefits was not reported on the AANA survey, we proposed using 20 percent of the 1986 national average salary or income of CRNAs as a reasonable approximation of the costs of fringe benefits incurred by hospitals for their CRNA employees.

Step 3. Billing Costs—We proposed increasing salaries and fringe benefits by seven percent to account for billing costs.

Step 4. Constructing a Conversion Factor—The annual earnings figures resulting from the adjustment in steps 1 through 3 above were translated into a conversion factor by—

- Dividing the adjusted average annual CRNA compensation by the average annual anesthesia caseload performed by a full-time medically

directed CRNA (649 cases) to derive average per case earnings; and

• Dividing this figure by the average of 11.6 units per case (the total of average time and base units per case) to compute a conversion factor.

Step 5. Malpractice Adjustment—The fee schedule conversion factor computed in step 4 was further adjusted to reflect the cost of malpractice insurance incurred by hospitals for their CRNA employees.

We also calculated a separate State specific rate for physician-employed medically-directed CRNAs. This rate was calculated by multiplying the 1989 participating physician prevailing charge conversion factor by a factor of 101/30 and dividing this amount by 12.1 units.

Finally, we proposed establishing a single blended rate that weighs medically-directed hospital-employed CRNA data at 58 percent and medically-directed physician-employed CRNA data at 42 percent. (Excluding CRNAs who are not medically-directed, nationally approximately 58 percent of medically-directed CRNAs are employed by hospitals and 42 percent are employed by physicians. These weights are based on data in the 1986 AANA's Annual Salary Survey.)

We proposed to establish the State-level rate for CRNAs who are not medically-directed by comparing the relationship between the national cost per case of full-time CRNAs who are not medically-directed and full-time hospital-employed CRNAs who are medically-directed and applying this ratio to the State-level rates for medically-directed CRNAs.

Section 608(c) of the Family Support Act required that we maintain budget neutrality in implementing the rural hospital cost election. The rural hospitals electing cost reimbursement would receive greater reimbursement under the cost election than under the fee schedule. As a result, we had to make an adjustment to the nonmedically-directed rate.

E. Continuation of Reasonable Cost Payments for Rural Hospitals

As required by section 9320 of Public Law 99–509 (as amended by section 608(c) of Pub. L. 100–485), we proposed to allow certain hospitals located in rural areas to continue to be paid on a reasonable cost basis for CRNA services furnished during calendar years 1989, 1990 and 1991. To qualify in 1989, a rural hospital must have established before April 1, 1989, to the satisfaction of the Secretary, that—

• As of January 1, 1988, it employed or contracted with a CRNA but not more than one full-time equivalent CRNA:

• In 1987, it had a volume of 250 or fewer surgical procedures, including inpatient and outpatient procedures, requiring anesthesia services; and

• Each CRNA employed by or under contract with the hospital must have agreed not to bill under Medicare Part B for professional services furnished at the hospital.

To qualify in 1990 or 1991, a rural hospital must establish before the beginning of the respective calendar year that in the prior year it did not furnish more than 250 surgical procedures, including inpatient and outpatient procedures, requiring anesthesia services.

We proposed defining a full-time equivalent anesthetist as one or more anesthetists who, in total, work no more than 2,080 hours per year. These hours represent total hours at the hospital and include time spent in furnishing anesthesia services to patients and general services to the hospital. We also proposed defining surgical procedures requiring anesthesia services as those procedures in which the anesthesia is administered and monitored by a qualified nonphysician anesthetist, a physician other than the primary surgeon, or an intern or resident.

As required by section 9320(k) of Public Law 99–509 (as amended by section 608(c) of Public Law 100–485), a rural area would be defined in the same way it is defined for purposes of the inpatient hospital prospective payment system (in accordance with section 1886(d) of the Act). The definition is set forth at § 412.62(f) and provides that a rural area is any area outside of a Metropolitan Statistical Area (MSA), a New England County Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget, or the New England counties deemed to be parts of urban areas under section 601(g) of the Social Security Amendments of 1983.

Under section 1886(d)(8)(B) of the Act, hospitals in certain rural counties adjacent to one or more MSAs are considered to be located in one of the adjacent MSAs if certain standards are met. (These requirements are explained in greater detail in the September 30, 1983 final rule on the inpatient hospital prospective payment system (53 FR 38499).) Since for purposes of payment under section 1886(d) of the Act, these hospitals are no longer classified as rural, we proposed that these hospitals also would not qualify as rural hospitals under section 9320(k) of Public Law 99–509 and would not be eligible to continue to receive payment on a reasonable cost basis for CRNA services during 1989, 1990, and 1991.

The legislation also requires that this provision be implemented so as to maintain budget neutrality consistent with section 1833(1)(3) of the Act. As indicated in the preamble to the proposed regulation, we assumed that the budget neutrality adjustment would affect only the nonmedically-directed rate and not the medically-directed rate. The rural hospitals that would qualify for reasonable cost payments would likely be those hospitals with nonmedically-directed CRNAs. As a result, in the proposed regulations, we reduced the nonmedically-directed CRNA conversion factor by 5.7 percent to account for the continuation of reasonable cost payments to rural hospitals furnishing fewer than 250 surgical procedures requiring anesthesia. This adjustment was necessary because the AANA data did not specifically exclude those rural hospitals that would qualify for reasonable cost payments. Data from these rural hospitals would produce conversion factors for CRNA services that are higher than the conversion factors for CRNA services for other rural hospitals with higher anesthesia caseloads.

F. Updating the Fee Schedule for 1989 and 1990

We proposed that for calendar years 1989 and 1990 we would update the CRNA fee schedule by the percentage increase in the MEI, as required by section 1833(1)(2) of the Act.

G. Relationship of Payment Under the Fee Schedule to Payment to Physicians for the Medical Direction of CRNAs

We proposed to revise the method of payment to physicians who medically-direct anesthesia procedures involving CRNAs, on or after January 1, 1989, to allow no more than one time unit for each 30 minutes of anesthesia time. One time unit for each 15 minutes would be allowed only if the physician personally performs the anesthesia procedure.

H. Supervision of CRNAs by Physicians Other Than Anesthesiologists

We proposed that, effective January 1, 1989, medical direction payments could not be made to a surgeon who concurrently supervises CRNAs and performs surgery.

We proposed that medical direction payments not be made to a radiologist or psychiatrist who furnishes nominal supervision of the anesthesia services since we do not believe these services meet the medical direction requirements under § 405.552.

I. Bad Debts Associated With CRNA Services

We proposed revising § 413.80 to implement section 1833(1)(5)(C) of the Act, which requires that a hospital that files a claim or a request for payment for the services of a CRNA may not use any uncollected coinsurance amount for a CRNA service as a bad debt.

J. Related Care Furnished by CRNAs

Section 1861(bb)(1) of the Act defines services of a CRNA as "anesthesia services and related care furnished" by a CRNA. We proposed not recognizing additional payments for related care services, such as pain management services, specialized monitoring activities, and other services not directly connected to the anesthesia service associated with the surgical service because payment for these services has been reflected in the CRNA conversion factor rates.

IV. Discussion of Public Comments

We received approximately 4,500 comments on the proposed regulations to implement a CRNA fee schedule payment system. The bulk of these comments were from individual CRNAs, CRNA groups, individual anesthesiologists, and anesthesiology groups. We received comments from nursing associations, the American Hospital Association (AHA), regional and State hospital associations, the AANA and State associations of nurse anesthetists, the American Society of Anesthesiologists, and the Anesthesia Care Team Society. We also received comments from such groups as the National Rural Health Association and the Blue Cross/Blue Shield Association.

The majority of anesthesiologists and anesthesiologist groups reacted positively to the proposed regulations. They expressed the view that the rates were fair, reasonable, and not disruptive to "anesthesia care" team practice arrangements. The majority of anesthesiologists commented favorably on the way the rates were blended so as to avoid further reductions in medical direction allowances.

The majority of commenters, who were CRNAs, viewed the proposal unfavorably, alleging that the proposed rates were too low, the proposed methodology was flawed, and payment was not separately recognized for related care services furnished by CRNAs.

A. Structure and Geographic Basis for the Fee Schedule

Comment: Instead of a State-level payment system, the AANA and other commenters proposed a national CRNA fee schedule that would include a national medically-directed CRNA rate (that is, $14) and a national nonmedically-directed CRNA rate (that is, $21). The proposal of national rates is predicated on the basis that there is more variation in CRNA salary/incomes within a State than there is in CRNA salary/incomes across State lines.

Response: Additional discussions with the AANA indicated that some of the impetus for national rates was due to the extreme variation in the proposed CRNA rates between contiguous States. This was highlighted by Idaho, which had the lowest proposed rate, and Wyoming, which had the third highest proposed rate. We believe, however, that data problems resulted in Idaho's having had the lowest rate. These data problems have been overcome through the use of better data and a change in the method used to develop nonmedically-directed rates in this final rule. Whereas the proposed methodology produced State-specific nonmedically directed rates by multiplying the State-specific medically-directed rate by a uniform national statistic, the final nonmedically-directed rates are generally based on State-specific data. The final regulations recognize the State as the geographic area for construction of the CRNA fee schedule.

Comment: The AHA and other commenters recommend a CRNA payment system that uses a geographic area smaller than the State as a unit for payment purposes. These commenters indicate that the State-specific CRNA conversion factor rates do not reflect differences in the costs of CRNA services, given variations in cost of living and wage rates within States.

Response: In the proposed regulations, we clearly pointed out that we do not have data available on CRNA payment rates on a county-wide basis that would allow construction of payment rates by locality. (Most localities are made up of a single State, a county, or a group of counties). In addition, we were concerned that establishing CRNA rates by locality or county or some other smaller division of the State might introduce artificial incentives for CRNAs to cross county or divisional levels to maximize payments.

The commenters are essentially suggesting that we use an index such as the hospital wage index to establish CRNA rates. Use of an index such as this is not appropriate in establishing CRNA rates because CRNA wages are not necessarily correlated with hospital wages. The salaries of CRNAs are often higher in rural areas than urban areas. We believe, and the AANA concurs, that whether or not an anesthesiologist directs the service is the relevant factor in explaining variations in CRNA salaries/income within a State.

Comment: Under the proposed rule, the CRNA rates were calculated using national anesthesia caseload averages and State-specific salary data. Several commenters indicated that combining national anesthesia caseload averages with area-specific salary data would likely distort the area-specific rates. These commenters recommended that State (or geographic) payment rates should consistently use data specific to the selected geographic areas so that accurate area-specific rates could be calculated.

Response: We are adopting this recommendation. Except as noted, we are computing State-specific rates using reported State-specific anesthesia caseloads. However, we have made adjustments where the State-specific anesthesia caseloads reported on the AANA's survey seemed overstated. The use of the overstated caseload resulted in an artificially low conversion factor for that State. We attempted to overcome this data problem by substituting a national average caseload for the State-specific caseload. Specifically, if the State average caseload was at least twenty-five percent greater than the national average caseload, we have substituted the national average caseload for the reported State-specific caseload. There are four States in which this occurred: Delaware, Georgia, and Rhode Island for the medically-directed rate, and Oklahoma for the nonmedically-directed rate. The reported State-specific average caseload produced a conversion factor that was unusually low. The substitution of a national average caseload for the State-specific average caseload produced a higher rate than the rate calculated from State-specific data for the four States mentioned above.

Comment: A number of commenters contended that the CRNA fee schedule payment rates are too low and do not adequately incorporate the cost of fringe benefits or overhead costs. The AANA specifically provided various data to support as much as a 26 percent adjustment for overhead. They also provided data sources supporting a fringe benefit factor greater than 20 percent. Overall, the AANA proposed a 20 percent salary adjustment for fringe benefits, a 20 percent salary adjustment for general overhead and billing costs, and a 10 percent salary adjustment for malpractice costs.

Response: We reviewed data from hospital cost reports that began on or after October 1, 1984 and ended before October 1, 1985, (that is, the second Prospective Payment System (PPS–2) cost reporting period) as well as cost reports that began on or after October 1, 1985 and ended before October 1, 1986, (that is, the third Prospective Payment System (PPS–3) cost reporting period). For 3,021 PPS–2 cost reports for which CRNA costs were allowed, fringe benefits averaged 13 percent of salary and other allocated overhead averaged 19 percent of salary. For 3,081 PPS–3 cost reports for which CRNA costs were allowed, fringe benefits averaged 12 percent of salary and other allocated overhead averaged 20 percent of salary. Based on these results, we are providing for a 32 percent salary adjustment for fringe benefits and other overhead.

We are also providing an adjustment for malpractice insurance. This adjustment is made on the basis of the most current State-specific rates (that is, 1989 rates) on malpractice premiums for CRNAs. (The source of the malpractice data is the St. Paul Marine and Fire Insurance Company.) The actual adjustment is the State-specific malpractice rate divided by the product to the average State level CRNA caseload and the average number of base and time units per case. There are different State caseloads and average units per case for the two categories of CRNAs. Thus, there are different malpractice add-ons depending on whether the CRNA is or is not medically-directed.

Comment: The AANA, various State hospital associations, and other commenters claimed that the CRNA fee schedule rates do not appropriately reflect increases in CRNA salaries since 1986.

Response: At the time we published the proposed CRNA rates, we did not have salary/income data beyond 1986. Since then, the AANA has supplied us with data on salary/income levels for 1987 and 1988. Although the 1986 survey provided information on full-time medically-directed and nonmedically-directed CRNAs, the data at the State level for nonmedically-directed CRNAs was not sufficient in itself to establish State-specific rates. The 1987 survey has a much better response rate than both the 1986 and the 1988 survey for nonmedically-directed CRNA salaries/incomes. The 1987 survey includes responses from both full-time and part-time CRNAs. Because the 1987 survey overcomes some of the data problems inherent to the 1986 survey and because its results are more current, we have decided to use the 1987 annual survey to compute State-level rates for both medically and nonmedically-directed CRNAs. Therefore, we need to trend the salaries/incomes only for 1988 and 1989. Data from the AANA's 1988 survey indicated a 9.4 percent increase in salary/income, and the AANA predicts a 12.8 percent increase for 1989. The 12.8 percent increase for 1989 is an average of the increase in CRNA salaries/incomes during 1987 and 1988.

We have decided to use the 9.4 percent increase from the AANA's 1988 survey. However we have decided not to use the AANA "predicted rate" of 12.8 percent for 1989 because it is not derived from currently reported CRNA salary levels. Instead, we are using a rate of 8.2 percent for 1989. This rate is the compounded annual rate of increase in CRNA salaries from 1982 through 1988. The combined trend factor for 1988 and 1989 is 1.18 (that is, 1.094×1.082).

Comment: The AANA and other commenters argued that the methodology for the nonmedically-directed CRNA rates understates the nonmedically-directed rates because it does not consider the differences in both the average caseload and the complexity of cases between the medically-directed CRNA and the nonmedically-directed CRNA.

Response: We have reviewed the proposed methodology and find that it adequately reflects differences in average caseload volumes between the two practice arrangements. We do, however, agree that the methodology does not adequately reflect differences in average caseload complexity between the two practice arrangements. The proposed conversion factor for nonmedically-directed services should have been approximately 6.3 percent higher because of the differences in caseload complexity. This is illustrated below. As noted in these comments, the 1987 AANA survey, because of its response rate, allows us to establish State-specific nonmedically-directed rates based on State-specific salary and caseload information rather than based on national statistics. Under the proposed methodology, the nonmedically-directed rate was not based on data reported by nonmedically-directed CRNAs at the State level. Rather, the State-specific nonmedically-directed rate was 137.5 percent of the medically-directed rate. Also, in developing the final nonmedically-directed rates, we used an average base/time unit value (10.9 units) that is specific to nonmedically-directed CRNAs. This value differs from the average base/time unit value (11.6 units) for hospital-employed medically-directed CRNAs.

	Hospital-employed medically-directed 1986 CRNA average salary	Nonmedically-directed 1986 CRNA average salary
Salary	$46,152	$56,805
1986 average cases	641	541
1986 average salary cost per case	$72	$105
Budget neutrality adjusted rate	$72	$99
Fringe benefits	1.20	
Trend factor	1.19	
Billing cost	1.07	
Malpractice (avg)	.10	
Adjustment factors (1.20×1.19×1.07+.10)	1.63	1.63
1989 adjusted salary cost per case ($72×1.63)	$117.36	$161.37
Average units per case	11.6	10.9
Average conversion factor (adjusted salary cost per case divided by average units per case)	10.12	14.80
Actual differential	1.462	
Proposed differential	1.375	

Comment: The AANA and other commenters pointed out that the law provides for "related care" services furnished by CRNAs to be paid under the CRNA fee schedule. They recommended that a separate and identifiable payment system be established for "related care" services. According to the AANA, some CRNAs provide almost only "related care" services and failure to provide separate payment for these services will result in no Medicare payment to these practitioners.

Response: In the proposed rule, we described related care services as insertion of arterial lines, central venous pressure lines, or Swan Ganz catheters, pain management services, and other services not directly connected to the anesthesia service or associated with the surgical service. We did not provide for separate payment for related care services. Rather, we acknowledged that the salary of the CRNA, as reported on the AANA's annual survey, reflected compensation for all activities including related care services. Moreover, we did not have any data that would allow us to determine to what extent the conversion factor should be adjusted to allow separate payment for related care services. As a result, we proposed to pay for related care services indirectly through the establishment of a conversion factor that would be higher than it would have been if related care services were paid separately. Further,

on average, related care services do not represent a significant percentage of services furnished by a CRNA.

We reexamined this issue in the context of the physician fee schedule payment system that takes effect January 1, 1992. In the final physician fee schedule regulation published in the **Federal Register** on November 25, 1991, (56 FR 59502), we stated that we will recognize separate payment for the same related care services furnished by anesthesiologists or CRNAs subject to certain conditions. Separate payment can be made for these services regardless of whether they are furnished alone or in connection with the physician anesthesia service.

Anesthesia service furnished by CRNAs can be medically directed or nonmedically directed, but related care services are medical or surgical services, not anesthesia procedures, and are therefore not subject to the general medical direction rules. If a CRNA typically furnishes anesthesia services without medical direction, we assume that the CRNA furnishes the related care service without the involvement of an anesthesiologist. If a CRNA typically furnishes anesthesia services under medical direction, we will assume that the anesthesiologist will furnish the related care service, and we will not pay for the CRNA's involvement with the related care procedure. Thus, payment for related care services furnished by CRNAs on or after January 1, 1992, will be consistent with payment for physicians.

B. Rural Hospitals and CRNAs

Comment: The AHA, State hospital associations, and other commenters recommended that the procedures threshold of 250 anesthesia cases should be substantially increased so that rural hospitals that otherwise meet the eligibility criteria can receive the reasonable cost exemption. The AHA specifically suggests that HCFA set the threshold at 1,300 anesthesia procedures or higher.

Response: Section 608(c) of Public Law 100–485 did allow the Secretary to establish the anesthesia procedures threshold at a level higher than 250 procedures. We did not initially propose a level higher than 250 procedures because we had no evidence or information from the hospital industry suggesting a more appropriate threshold.

The AHA's recommendation would have the effect of allowing all rural hospitals to qualify for reasonable cost payments for CRNA services. The fact that section 608(c) of Public Law 100–485 imposed a specific criterion for the hospital's anesthesia caseload volume is an indication that Congress did not intend for all rural hospitals to qualify.

Subsequently, section 6132 of Public Law 101–239 raised the threshold from 250 procedures to 500 procedures for rural hospitals, to be effective for anesthesia services furnished on or after January 1, 1990. Under section 6132 of Public Law 101–239, a rural hospital that qualified and was paid on a reasonable cost basis for CRNA services during calendar year 1989 can continue to be paid on a reasonable cost basis for CRNA services furnished during calendar year 1990 if it can establish before January 1, 1990 that it did not provide more than 500 surgical procedures, both inpatient and outpatient, requiring anesthesia services during 1989. A rural hospital that was not paid on a reasonable cost basis for CRNA services furnished during calendar year 1989 can be paid on a reasonable cost basis for CRNA services furnished during calendar year 1990 if:

- As of January 1, 1988, the hospital employed or contracted with a CRNA (but not more than one full-time equivalent CRNA); and
- In both 1987 and 1989, the hospital had a volume of 500 surgical procedures or fewer, including inpatient and outpatient procedures, that required anesthesia services.

For both groups of hospitals, each CRNA employed by or under contract with the hospital must agree in writing not to bill on a fee schedule basis for patient care services furnished at the hospital.

Comment: Several commenters requested that HCFA extend the deadline for a rural hospital to apply for eligibility for payment on a reasonable cost basis for calendar year 1989 to 60 days after publication of this final rule.

Response: Section 608(c) of Public Law 100–485 specifically provided that a hospital must have applied before April 1, 1989, to receive reasonable cost payments for CRNA services furnished in 1989. The intermediaries advised hospitals of the procedure for continuing reasonable cost payments in December 1988. This process provided a hospital with a sufficient period of time, approximately 4 months, in which to apply to its intermediary. Moreover, approximately 25 percent of rural hospitals claiming costs for CRNA services initially qualified for reasonable cost payments. We find no reason to extend the initial period during which rural hospitals could have applied.

Comment: Several commenters suggested that because of confusion surrounding the implementation of section 608(c) of Public Law 100–485, some rural hospitals that would otherwise have been eligible for reasonable cost payments might have billed for CRNA services under Part B after January 1, 1989. These commenters requested that any rural hospital that could document by April 1, 1989, that it met the appropriate criteria should be allowed to continue to be paid on a reasonable cost basis regardless of whether bills were submitted prior to that date for the hospital's CRNA services.

Response: One of the legislative criteria for a qualifying rural hospital is that each CRNA employed by or under contract with the hospital has agreed not to bill under Medicare Part B for professional services at the hospital. If the CRNA or the hospital does not satisfy this requirement or allows Part B billing to occur, then one of the qualifying criteria is not met.

The Program Memorandum issued to the intermediaries for distribution to rural hospitals (Transmittal No. A88–32) in December 1988 entitled "Direct Medicare Billing by CRNAs" also highlighted this point. It specifically noted the following:

> "Hospitals that are considering the continuation of reasonable costs for anesthesia services furnished by CRNAs on or after January 1, 1989, must ensure that CRNAs do not bill under the fee schedule for anesthesia services furnished on or after January 1, 1989, but before the hospital's election. If the CRNA or the CRNA's employer or contractor bills under the fee schedule, it will preclude the hospital's opportunity to elect reasonable costs for CRNA services."

In view of the foregoing, we are not accepting the commenters' recommendation. Also, since the Congress made changes in Public Law 101–239 that are effective January 1, 1990, it appears that Congress also did not see a need to grant hospitals relief from the prior provision.

Comment: Rural hospitals that wish to elect reasonable cost payment for CRNA services effective January 1, 1990, must demonstrate that the volume of anesthesia procedures does not exceed 500 procedures for the previous 12 months. However, the statistics for that 12-month period will not be available at the time providers are to be notified. One commenter suggested that the language of the regulation be revised to state that nine months' data, annualized, will be acceptable to demonstrate continued eligibility for reasonable cost payment.

Response: We are accepting this commenter's recommendation that 9 months' worth of data on anesthesia

cases, that is, from January 1st to September 30th of the preceding year, be acceptable for determining the annual number of anesthetics. However, we will apply this requirement for hospitals that wish to qualify for calendar years 1991 or later. Because of the short timeframe between enactment of Public Law 101–239 and hospitals' compliance with the requirements for reasonable cost payments for CRNA services furnished during 1990, we allowed hospitals to establish their qualification before March 1, 1990 instead of January 1, 1990. As a result, qualification for 1990 is based on the calendar year 1989 anesthesia caseload.

Comment: To qualify during 1989, a rural hospital must have employed or contracted with a qualified nonphysician anesthetist as of January 1, 1988. One commenter suggested that if contracts are not in writing, HCFA should require that oral contracts be committed to writing and signed by both parties. This will enable intermediaries to determine whether a provider meets the requirements and will facilitate any future auditing.

Response: We agree with this comment and find it necessary, for compliance and auditing purposes, that oral agreements for the provision of anesthesia services be committed to writing and signed by both parties.

Comment: One commenter asked at what point a rural hospital that qualified for this exception can change from reasonable cost to the fee schedule payment system for CRNA services.

Response: The election of reasonable cost payment for CRNA services applies to the calendar year for which the election is made.

Comment: Section 5261.I. of the Medicare Carriers Manual indicates that the intermediary will inform the carrier of the hospital's decision to elect reasonable cost. One commenter, however, pointed out that the instructions do not assign responsibility for obtaining and maintaining the signed agreements by CRNAs not to bill Part B.

Response: The hospital is responsible for furnishing the intermediary with signed CRNA/hospital agreements that there will be no billing to Part B. We are not requiring the intermediary to forward copies of the signed agreements to the carrier. Rather, the intermediary must notify the carrier of the qualified hospitals and their CRNAs.

Comment: One commenter asked what action is taken if the intermediary discovers that a provider actually does not meet the criteria for reasonable cost payments for calendar year 1989.

Response: The intermediary must recover reasonable cost payments from the hospital. The hospital or its CRNA must bill under the CRNA fee schedule for CRNA services furnished on or after January 1 of the affected calendar year.

Comment: Some commenters asked whether a rural hospital which did not qualify for reasonable cost payments for CRNA services during 1989 could elect reasonable cost payments for CRNA services in calendar years 1990 or 1991.

Response: Under section 608(c) of Public Law 100–485, only those rural hospitals that qualified in 1989 could continue to elect reasonable cost payment for CRNA services in 1990 and 1991. Section 6132 of Public Law 101–239 removes this restriction by allowing a rural hospital to qualify annually based on its anesthesia caseload from the immediately preceding year. It also removes the earlier expiration provision that allowed hospitals to receive reasonable cost payments only through calendar year 1991. Section 6132 of Public Law 101–239 imposes no expiration date. A rural hospital can qualify and continue to be paid on a reasonable cost basis for CRNA services for calendar years beyond 1991 if the hospital can establish that before January 1, 1990, it did not provide more than 500 surgical service procedures, both inpatient and outpatient, requiring anesthesia services during the immediately preceding year.

Comment: We proposed to reduce the nonmedically-directed CRNA fee schedule rates by 5.7 percent to account for low volume rural hospitals electing reasonable cost payments for CRNA services. This was necessary because the AANA supplied us with data from rural hospitals with varying anesthesia caseloads. The rural hospitals with 250 or fewer anesthesia cases would raise the level of the nonmedically-directed CRNA conversion factor, yet these hospitals would be paid on a reasonable cost basis rather than on a fee schedule basis. Our estimate was based on data from the 1987 HCFA Survey of PPS–2 hospitals claiming reasonable cost payments. Several commenters objected to the methods used to calculate our estimate.

Response: Section 6132 of Public Law 101–239 eliminated the budget neutrality provision for rural hospitals, which required that we adjust CRNA fee schedule rates to reflect the election of reasonable cost. As a result, we are not, as we did in the proposed rule, providing an additional "budget neutrality" adjustment to either the medically-directed rates or nonmedically-directed rates.

C. Monitored Anesthesia Care

The Medicare Carriers Manual (HCFA-Pub. 14–3) recognizes as a covered physician service monitored anesthesia care performed by or medically-directed by a physician. Under section 8310.E. of the Medicare Carriers Manual, monitored anesthesia care means the intraoperative monitoring of the patient's vital physiological signs by a physician or by a qualified individual under the medical direction of a physician. Monitored anesthesia care is provided in anticipation of the need for administration of general anesthesia or in the case of a patient's development of adverse physiological reaction to the surgical procedure. It also includes performance of a pre-anesthetic examination and evaluation, prescription of the anesthesia care required, administration of necessary oral or parenteral medications (for example, Atropine, Demerol, or Valium), and provision of indicated postoperative anesthesia care. The fact that the physician personally furnished or medically-directed the monitored anesthesia care does not automatically mean the monitored anesthesia care is a covered Part B service. The monitored anesthesia care service must be reasonable and medically necessary under the given circumstances.

The proposed rule did not address the issue of payment for monitored anesthesia care performed by a CRNA.

Comment: Commenters specifically asked whether a CRNA can be paid under the fee schedule for performing monitored anesthesia care with or without medical direction.

Response: We have considered these comments and are specifically adopting the policy that a CRNA can be paid under the CRNA fee schedule for performing monitored anesthesia care that is reasonable and medically necessary. Medicare will pay for a CRNA performing monitored anesthesia care with or without the medical direction of an anesthesiologist. We will specifically incorporate this policy in the manual instructions to implement the CRNA fee schedule.

D. Anesthesia Care Furnished to a Single Patient by a CRNA and an Anesthesiologist

Our prior policies on payment for physician anesthesia services recognize that the anesthesia service may be:

- Personally performed by an anesthesiologist;

• Performed by a teaching anesthesiologist under an "attending physician" relationship;

• Performed by an anesthesiologist with assistance provided by an anesthetist (Under this circumstance, the anesthesia service is deemed to have been personally performed by the anesthesiologist); or

• Medically-directed by an anesthesiologist.

Under section 1842(b)(13) of the Act, medical direction refers to the circumstances under which an anesthesiologist medically directs two, three, or four concurrent procedures involving qualified anesthetists. Thus, we have always viewed medical direction as occurring with concurrent procedures, not with a single anesthesia procedure.

The instructions in section 5261.G of the Medicare Carriers Manual to implement the proposed CRNA fee schedule recognized that both a CRNA and an anesthesiologist may be involved in a single anesthesia procedure. The policy in this section is directed to circumstances under which it is necessary for both an anesthesiologist and a CRNA to be continuously involved in the anesthesia care of the patient. Section 5261.G of the Medicare Carriers Manual provides that if an anesthesiologist and an anesthetist are both involved in a single anesthesia procedure, the procedure is considered personally performed by the anesthesiologist. No separate payment is recognized for the CRNA's service unless the carrier has received medical documentation showing that the involvement of both the anesthesiologist and the anesthetist are medically necessary.

Comment: Commenters pointed out that the CRNA fee schedule legislation provides for fee schedule payment for all medically necessary anesthesia services furnished by CRNAs, and it does not eliminate payments to CRNAs based on activities of an anesthesiologist. The commenters suggested that we expand medical direction to cover a single procedure involving an anesthesiologist and a CRNA. In this way, each anesthesia practitioner would be paid for the service he or she furnishes.

Response: As noted above, medical direction refers to the circumstances under which an anesthesiologist medically directs two, three, or four concurrent procedures involving qualified anesthetists. For medical direction to be covered, the anesthesiologist must perform the activities described in § 405.552. We are not proposing to expand the concept of medical direction to apply when an anesthesiologist and anesthetist provide services during a single procedure. We believe that our interpretation is consistent with section 1842(b)(13). Moreover, we are concerned that recognizing medical direction in a single anesthesia procedure would encourage inefficiencies in anesthesia practice arrangements. Our policies should not encourage the involvement of both practitioners in a single anesthesia procedure if either practitioner could appropriately furnish the service alone. We do, of course, recognize that there will be limited situations where it will be medically necessary for an anesthesia procedure to be furnished by both an anesthesiologist and a CRNA. Under these circumstances, we will continue to recognize payments for the services of each practitioner. This principle has been incorporated into our final regulations.

E. Supervision of CRNAs by Physicians Other Than Anesthesiologists

In the proposed regulation, we provided for the elimination of medical direction payments for surgeons who perform surgery and also supervise the services of a CRNA. We provided that the oversight of a CRNA's services by a surgeon is a quality control function that represents either a service to the provider of the type described in § 405.480(a) or an ASC facility service.

We did not receive any unfavorable comments on this proposal. Anesthesiologists who commented supported the elimination of medical direction payments to surgeons.

Comment: One commenter recommended that the regulation text specifically include the provision that the surgeon's supervision of the CRNA is covered only as an ASC facility service.

Response: We are including in the regulations at § 416.61 the provision that the surgeon's supervision of the CRNA is covered only as an ASC facility service. If the surgeon bills the ASC patient for a supervisory anesthesia service, the ASC will be found in violation of its participation agreement with HCFA (see § 416.35), which may result in termination of that agreement.

F. Bad Debts

Section 1833(l)(5)(C) of the Act requires that a hospital that files a claim or a request for payment for the services of a CRNA may not consider any uncollected coinsurance amount for a CRNA service a bad debt. The proposed regulations included a revision to § 413.80 to implement this provision.

Comment: One commenter indicated that the Provider Reimbursement Manual, Part I, (HCFA-Pub. 15–1) does not recognize bad debts associated with physician services. The commenter further pointed out that since CRNA services are not physician services, but rather hospital services, this provision is not consistent with the Provider Reimbursement Manual, Part I instructions in Chapter 3 concerning bad debts attributable to hospital services.

Response: Previously, anesthesia services furnished to hospital patients by CRNAs employed by the hospital or obtained under arrangements were covered as hospital services. The CRNA fee schedule legislation specifically creates a new coverage category for CRNA services. Since CRNA services are no longer considered hospital services, the PRM policy on uncollected deductibles and coinsurance associated with hospital services does not apply.

G. Billing for Anesthesia Time

Payment under the CRNA fee schedule is made on the basis of a conversion factor multiplied by the sum of base and time units. One time unit is allowed for each 15 minutes of anesthesia time. Anesthesia time begins when the physician or anesthetist begins to prepare the patient for induction of anesthesia and ends when the patient may be safely placed under post-operative supervision and the physician or anesthetist is no longer in personal attendance. The time unit basis of payment implies that the anesthetist or physician must furnish continuous and uninterrupted anesthesia care. Although we did not receive any specific comments on the time unit basis of payment, we were advised of situations that may occur in the outpatient department of a hospital or in an ASC in which a CRNA is not in continuous attendance with the patient.

Whenever the CRNA is not continuously attending to the patient immediately preceding induction up to postrecovery, the CRNA must appropriately note that a reduced service has been furnished. The carrier will appropriately recognize time units only for the anesthesia time spent with the patient by the CRNA or determine payment on another basis, based on the advice of the carrier's medical consultants.

As previously noted, it is our intention to ensure consistency and similarity between the CRNA payment system and the payment system for physician anesthesia services. In both the proposed regulations to implement the CRNA fee schedule and the uniform

relative value guide, we discussed three OIG options, on which we solicited comments, to change the current time unit policy. One of these options was to recognize only the actual time associated with a fractional time interval.

Section 6106 of Public Law 101–239 revised the method by which time units are counted for anesthesia services furnished by either physicians or CRNAs. That is, for anesthesia services furnished on or after April 1, 1990, the time unit is counted based on the actual time of the fractional time unit. Previously a fractional time unit was counted as a full time unit. Since we previously solicited comments on this matter and the legislation is sufficiently clear and detailed as to be self-implementing, we are finalizing this policy without an additional comment period. We are revising § 414.450(c) to reflect the policy that recognizes only actual time associated with a fractional time unit. We are instructing the carriers to calculate time units to one decimal place. The example provided below illustrates the calculation of a fractional time unit.

Example: A CRNA who is not medically directed furnishes an anesthesia procedure after April 1, 1990. The procedure has a base unit of 8 units and lasts 68 minutes or 4.5 units. The nonmedically directed CRNA rate is $14. The CRNA fee schedule amount is $147.00, or $14×10.5 units. The carrier pays the CRNA § 117.60, which is 80 percent of $147.00.

In the final rule to implement the resource-based physicians' fee schedule effective January 1, 1992, published in the **Federal Register** on November 25, 1991 (56 FR 59502), we decided to continue actual time as a separate payment element for both CRNA and physician anesthesia services. We have also revised the definition of anesthesia time to lessen the wide variation in reported anesthesia times.

Comment: Some commenters asked how payment would be determined for the CRNA's services when an anesthesiologist does not medically-direct the entire anesthesia case. For example, would the CRNA be paid at the medically-directed rate during the portion in which the physician is medically-directing the case and at the nonmedically-directed rate when the anesthesiologist is not medically-directing the case?

Response: We are not establishing a specific national payment rule for these circumstances because they are not the normal circumstances for anesthesia practice. Under these circumstances, the carrier has the authority to make a payment determination based on all the facts surrounding the case. Under these circumstances, the CRNA must indicate on the claim the time periods during which he or she was medically directed and the time periods during which he or she was not medically directed. If, for example, the anesthesiologist is present 50 percent or more of the total time in a medically-directed case, the carrier may consider the entire case to be a medically-directed case.

Comment: At least one commenter asked whether the medically-directed CRNA conversion factor would be recognized for CRNA services when the anesthesiologist supervises more than four concurrent procedures. HCFA does not recognize medical direction if the anesthesiologist is involved in more than four concurrent procedures.

Response: CRNA fee schedule payments are calculated using the medically-directed conversion factor for CRNA services regardless of the number of concurrent procedures directed or supervised by an anesthesiologist. As a practical matter, as long as anesthesiologists are involved with CRNAs in anesthesia services, the CRNA would consider the procedure to be medically directed or medically supervised. The CRNA is not generally aware of the number of concurrent procedures being directed or supervised.

H. Payment for CRNA Education and Training Costs

Comment: The AANA and others stated that the CRNA fee schedule legislation, the January 26, 1989 proposed regulations, and the Carriers Manual instructions failed to explain how payment will be made for nurse anesthetist educational programs. The AANA asked for a clarification of this policy.

Response: The CRNA fee schedule does not alter the methodology under which hospitals are paid for the cost of approved CRNA educational programs. That is, a hospital continues to be paid on a reasonable cost basis for allowable costs associated with an approved CRNA educational program it operates. Costs incurred by a hospital in conjunction with an approved CRNA educational program that it does not operate are not paid on a reasonable cost basis. (The cost of these educational activities is recognized as a normal operating cost and payment for these services is made through the prospective payment system for hospital inpatients.) Rules concerning payment to hospitals for the cost of educational activities are located at § 413.85.

Comment: The AANA and several other commenters recommended that Medicare pay the costs of approved CRNA training programs under the same methodology used for paying the cost of approved graduate medical education training programs.

Response: The services of interns and residents under approved graduate medical education training programs are paid for differently than the services of nonphysicians engaged in approved paramedical training programs. The way in which costs of approved paramedical training programs are paid to a hospital is described in the previous response (see § 413.85). Section 1886(h) of the Act provides that for cost reporting periods beginning on or after July 1, 1985, services of interns and residents in approved training programs are paid on the basis of a prospectively determined rate, which is calculated as a per intern/resident amount. Section 1886(h) of the Act does not extend this treatment to approved CRNA training programs or to approved paramedical training programs.

Comment: The AANA and other commenters requested that a teaching or supervising CRNA receive payment under the CRNA fee schedule for each of two concurrent cases involving student nurse anesthetists. (This comment was prompted by the proposed policy for teaching anesthesiologists, which was included in our February 7, 1989 proposed regulations on teaching physicians. Under those proposed regulations, we would have paid an unreduced amount when the teaching anesthesiologist is involved in two concurrent cases with residents.)

Response: We did not finalize the policy proposed in the February 7, 1989 NPRM on teaching physicians. Instead, in the final physician fee schedule regulations published November 25, 1991, we stated that we would continue the policy that allows unreduced payments for two concurrent cases involving residents through December 31, 1993 (56 FR 59563). This would give teaching hospitals the opportunity to adjust their practices. For services furnished after that date, we will uniformly apply medical direction payment rules to concurrent procedures regardless of whom the anesthesiologist is directing.

We understand that, at times, a teaching CRNA may supervise two concurrent cases involving student nurse anesthetists. The initial CRNA fee schedule legislation (section 9320 of Pub. L. 99–509) did not address the issue of payment for the services of CRNAs who teach student nurse anesthetists. Moreover, while the 1990 CRNA fee schedule legislation provides for two levels of payment for CRNAs, a rate for

medically-directed CRNAs and one for nonmedically-directed CRNAs, it also does not address the teacher/student anesthetist issue. Thus, there is no specific statutory provision that requires that we pay a teaching CRNA an unreduced or a reduced fee for each of two concurrently supervised cases.

The law, however, is specific with regard to medical direction services of anesthesiologists. It provides that under specified circumstances, payment is made for medical direction, and that this payment rate is lower than the payment rate that would apply if the anesthesiologist personally performed the service. Thus, while we have the specific authority to make payment, although reduced, for the anesthesiologists' involvement in concurrent cases, there is not similar authority for the teaching CRNA's involvement in concurrent cases.

We also note that, prior to the implementation of the CRNA fee schedule, the services of hospital employed CRNAs or those under contract with a hospital had been paid to the hospital on a reasonable cost basis. However, we did not provide, under this system, for payments, even on a cost basis, for the teaching CRNA's involvement in two concurrent cases. Since we have not historically provided for payment for the CRNA's involvement in two concurrent cases and there is no statutory requirement that we must do so, we are not providing for separate fee schedule payment for the teaching CRNA's involvement in each of two concurrent cases.

Comment: The AANA and other commenters recommended that medical direction payments be recognized if an anesthesiologist directs concurrent procedures, some of which involve student nurse anesthetists. These commenters suggest that this would represent a continuation of our current policy.

Response: We have addressed this issue in § 405.552 (a)(1)(iv) of the final physician fee schedule regulations published in the **Federal Register** on November 25, 1991 (56 FR 59502). We have revised the regulation text to allow an anesthesiologist to medically direct a qualified individual as defined in program operating instructions. In the operating instructions, we will consider student nurse anesthetists to be qualified individuals as long as the anesthesiologist is not directing more than two concurrent procedures involving student nurse anesthetists.

Comment: Section 4048 of Public Law 100–203 provides for a reduction in the base units for the physician's concurrent medical direction of anesthesia services involving qualified anesthetists and furnished on or after April 1, 1988 but before January 1, 1991. (As noted, under current policy, a qualified anesthetist situation can exist when a teaching CRNA continuously supervises the services of a student CRNA.) The number of base units associated with the physician service is reduced by 10 percent for each of two concurrent procedures, by 25 percent for each of three concurrent procedures, or by 40 percent for each of four concurrent procedures. The AANA recommended that the 10 percent, 25 percent, and 40 percent cuts not apply when an anesthesiologist medically-directs concurrent procedures involving both a teaching CRNA and a student anesthetist, or only a student anesthetist. Presumably, this would encourage anesthesiologists to become involved in CRNA training programs and would not provide a financial incentive to utilize anesthesia interns and residents instead of teacher CRNAs and student anesthetists.

Response: Section 4048 of Public Law 100–203 specifically refers to reductions in base units of concurrent procedures involving "nurse anesthetists". It does not provide for any exceptions to the base unit reductions. Therefore, we will reduce base units for medical direction services in circumstances involving the anesthesiologist's concurrent medical direction of procedures involving teaching and student CRNAs.

Comment: Proposed regulations published on February 7, 1989 (54 FR 5946), provide that if all physicians in a teaching hospital elect assignment for payment of all physician services, then the customary charge for physician services would be calculated at 90 percent of the prevailing charge. The 90 percent payment rate is specifically provided for in section 1842(b)(7) of the Act. Some commenters requested that CRNAs also be paid 90 percent of the fee schedule amount since they are required to accept assignment for all cases.

Response: We believe there is some confusion as to the application of the 90 percent rate. For teaching hospitals where assignment is elected for all physician services, the customary charge would be 90 percent of the prevailing charge. If this customary charge becomes the basis for the reasonable charge, the reasonable charge would be the product of 80 percent, 90 percent, and the prevailing charge (80 percent × 90 percent × the prevailing charge). If this same methodology were applied to CRNA services, payment would be 80 percent × 90 percent × the fee schedule, (which would result in a lesser amount than the current payment amount). As noted, the 90 percent payment rate is specifically established by section 1842(b)(7) of the Act and is applicable by its own terms only to physician services furnished by teaching physicians in a hospital. It does not apply to nonphysician services such as CRNA services. Instead, section 1833(a)(1)(H) of the Act specifically provides that after the deductible is met, CRNA services are paid at 80 percent of the lesser of the actual charge, the fee schedule amount, or the amount recognized for the same anesthesia service furnished by an anesthesiologist.

I. Definition of Categories of Anesthetists

We proposed defining "CRNA" as a registered nurse who is licensed as a professional registered nurse by the State in which he or she practices and meets any other licensure requirements the State imposes with respect to nonphysician anesthetists, and is currently certified by either the Council on Certification of Nurse Anesthetists or the Council on Recertification of Nurse Anesthetists or has graduated within the past 18 months from a nurse anesthesia program that meets the standards of the Council on Accreditation of Nurse Anesthesia Educational Programs and is awaiting initial certification.

This definition relied on certification by either of the two nationally recognized certifying bodies for nurse anesthetists, and thus reflected the provision of section 1861(bb) of the Act that authorizes the use of requirements established by a national organization for the certification of nurse anesthetists.

Comment: A commenter stated that the Council on Certification of Nurse Anesthetists (the Council) allows graduates of approved nurse anesthesia programs to be considered certification-eligible, without meeting further criteria, for 24 months after completion of their training. The commenter also stated that 24 months is the maximum time period for which any State allows recent graduates to practice without passing a certification examination. In the interest of consistency with the Council on requirements and in consideration of the provision of section 1861(bb)(2) of the Act, which allows use of the same requirements as those established by a national organization for the certification of nurse anesthetists, the commenter recommended that we allow recent graduates of approved training programs who have not successfully completed the certification examination to be considered CRNAs for up to 24

months after graduation (rather than 18 months as proposed) if to do so is consistent with State law.

Response: We agree that it would be appropriate to adopt a less restrictive rule on how long recent graduates may practice and have revised the regulations as suggested by the commenter.

Comment: A commenter supported our proposed interpretation of section 1861(bb)(2) of the Act that requires that a CRNA be licensed by the State as a registered nurse (54 FR 3805). The commenter opposed any interpretation that would require a CRNA to be licensed as a CRNA and stated that this would preclude payment to CRNAs in some 40 States.

Response: We agree with this comment and have adopted the provision of the proposed regulations that require an individual who wishes to be considered a CRNA to be licensed as a professional registered nurse (rather than as a CRNA) by the State in which he or she practices and to meet any other licensure requirement the State imposes with respect to nonphysician anesthetists.

Comment: A commenter objected to the provision in the proposed rule which restated the part of the hospital conditions of participation that provides that anesthesia administration by a CRNA must be done under the supervision of the operating practitioner or of an anesthesiologist who is immediately available if needed. The commenter stated that the provision is contrary to the laws of some States that permit CRNAs to practice without supervision by a physician or other practitioner and that quality of care studies show there is no significant difference in outcomes whether the care is provided by CRNAs alone, anesthesiologists and CRNAs together, or anesthesiologists alone. In support of the latter statement, the commenter submitted synopses of several studies that addressed anesthesia care outcomes as they relate to the qualifications of the providers of care (anesthesiologists and CRNAs). These studies included a Report to Congress by the National Academy of Sciences (House Committee Print No. 36, "Health Care for American Veterans", p. 156, dated June 7, 1977); a study concerning anesthetic-related deaths from 1969 to 1976 by Albert Bechtoldt, Jr. and the Anesthesia Study Committee (North Carolina Medical Journal, April 1981); a study by Stanford Center for Health Care Research, "The Effect of the Provider," (published in Health Care Delivery in Anesthesia (1980), p. 137); and "Anesthesiology: Man, Machines and Morbidity" by Dr. Joseph A. Ricci (published in Physician Notes, December 1985). The commenter stated that these studies found no significant difference in anesthesia care outcomes between care provided by anesthesiologists and CRNAs.

Another commenter stated that there is no State that allows CRNAs to administer anesthesia without medical supervision although in some States CRNAs are allowed to practice on an independent contract or freelance basis without an anesthesiologist being present.

Response: We reviewed these comments carefully but did not make any changes to the proposed rule based on them. Regardless of whether some State laws allow CRNAs to practice independently, the laws of most States still require nonphysician anesthetists to administer anesthesia only under the supervision of a doctor of medicine or osteopathy. Moreover, the conditions of participation are intended to be minimum requirements that promote patient health and safety. We do not believe it would be practical to adopt as a national minimum standard for care a practice that is allowed in only some States. We also reviewed the information submitted in support of the statement that studies show no significant difference in outcomes according to whether services are performed by CRNAs alone, CRNAs and anesthesiologists together, or anesthesiologists alone. While some of the information supports the conclusion that similar results occur under each of these three sets of circumstances, we note that this commenter's submittal also states that existing studies of this issue do not correct for the differences in outcome caused by differences in age and in severity of illness among patients. We believe it would be wrong to conclude solely from the studies mentioned above that oversight by an anesthesiologist does not contribute significantly to the safety and quality of care. In view of the lack of definitive clinical studies on this issue, and in consideration of the risks associated with anesthesia procedures, we believe it would not be appropriate to allow anesthesia administration by a nonphysician anesthetist unless under supervision by either an anesthesiologist or the operating practitioner. Therefore, we did not adopt this comment.

We are adopting a change in the definition of "CRNA" that was not requested by commenters. Under this approach, a person could be designated as a CRNA for Medicare purposes if he or she: (1) Is licensed as a registered professional nurse by the State in which he or she practices, (2) meets any licensure requirements that State imposes with respect to nonphysician anesthetists, (3) has graduated from a nurse anesthesia educational program that meets the standards of the Council on Accreditation of Nurse Anesthesia Educational Programs, or of such other accreditation organization as may be designated by the Secretary, and (4) has passed a certification examination of the Council on Recertification of Nurse Anesthetists, or such other certification organization as may be designated by the Secretary.

The examination requirement would not apply to otherwise qualified persons who have graduated within the past 24 months from a nurse anesthesia educational program that meets the standards of a certification organization as described above.

Comment: A commenter objected to the definition of anesthesiologist's assistant that was included in the proposed regulations. The commenter stated that the definition is not consistent with that used by the Committee on Allied Health Education and Accreditation (CAHEA), which is the publicly constituted and recognized body that oversees the accreditation process for anesthesiologist's assistant educational programs. The commenter also stated that the proposed provision, which requires that the anesthesiologist's assistant be under the direct supervision of an anesthesiologist who is physically present, does not accurately reflect actual patterns of practice in those States where anesthesiologist's assistants are used. The commenter also recommended that we adopt a definition that does not specify the number of years of education an anesthesiologist's assistant must have while permitting recognition of anesthesiologist's assistants who received their training at either of the pilot anesthesiologist's assistants programs, that is, the program previously conducted at Case Western Reserve and the Emory University program.

Another commenter expressed different views on the treatment of anesthesiologist's assistants. This commenter stated that anesthesiologist's assistants are trained to work only under the direction of an anesthesiologist in no more than a one-to-two ratio. The commenter stated that, therefore, anesthesiologist's assistants would not be eligible for payment for nonmedically-directed care or for related care services. The commenter recommended that anesthesiologist's assistants not be designated as

"anesthetists" in our regulations and that their services be discussed in separate regulations, in order to emphasize the differences between their scope of practice and that of CRNAs.

A third commenter, representing a national anesthesiologist organization, explicitly avoided taking a position on the number of anesthesiologist's assistants to be supervised by an anesthesiologist. The commenter stated that the organization has no policy as to medical direction ratios, either for CRNAs or anesthesiologist's assistants, except to state that medical direction of CRNAs should be in such a geographic and numerical relationship as to make possible the continual exercise of the medical judgment of the anesthesiologist.

Response: After considering the comments we received on this issue, we have decided to define an anesthesiologist's assistant as a graduate of a medical school-based anesthesiologist's assistant educational program that is both accredited by CAHEA and includes approximately two years of specialized basic science and clinical education in anesthesia that builds on a premedical undergraduate science background. In addition, the anesthesiologist's assistant must work under the direction of an anesthesiologist and must comply with all applicable requirements of State law, including any licensure requirements the State imposes on nonphysician anesthetists.

In adopting this definition, we took several factors into account. First, we believe that adopting a definition consistent with that used by a national accrediting organization such as CAHEA will help ensure that our definition reflects current medical practice and will make it possible to use a definition that is less prescriptive with respect to the length of these programs than the current definition in the regulations at § 482.52(a)(5). We also believe it is desirable to adopt a definition which encompasses currently practicing anesthesiologist's assistants as well as future graduates.

We considered, but did not adopt, the comments suggesting that anesthesiologist's assistants be permitted to work in no more than a one-to-two ratio (that is, one anesthesiologist to two anesthesiologist's assistants). Our concern is to define the term "anesthesiologist's assistant" in a way that will protect patient health and safety and permit payment for anesthesia and related care in a manner that is reasonable, equitable, and consistent with other requirements of the Medicare law. We believe we can accomplish this goal most effectively by defining the term "anesthesiologist's assistant" as described above and by permitting anesthesiologist's assistants to function under the same general requirements as CRNAs, except for the additional requirement for direction by an anesthesiologist and any additional restrictions that may be imposed by State law or by medical staff rules in settings such as hospitals and ASCs.

We also did not accept the comments recommending that anesthesiologist's assistants not be designated as anesthetists and thus not be governed by the same regulations as CRNAs. Section 1861(bb)(2) of the Act explicitly states that anesthesiologist's assistants are to be considered CRNAs for purposes of the Medicare law, and we do not have authority to establish a separate designation or set of regulations for them.

Comment: A commenter noted that in some States, registered nurses who are not fully certified CRNAs or recent graduates of approved training programs are permitted by State law to administer anesthesia if they meet certain experience requirements and comply with any applicable licensing requirements. The commenter stated that there is no indication that Congress intended to prohibit anesthesia administration by these individuals and recommended that we include them in the definition of an anesthesiologist's assistant.

Response: By adopting a definition of anesthesiologist's assistant which relies heavily on completion of a CAHEA-accredited program, we have allowed for variation in the type and length of training required of anesthesiologist's assistants. However, we do not believe it would be appropriate to apply the anesthesiologist's assistant designation to a person who has no formal, specific training as an anesthesiologist's assistant and whose knowledge of anesthesia administration is based largely or entirely on informal or on-the-job training. Therefore, we did not adopt this comment. Moreover, because under section 1861(bb) of the Act the definition of services of a CRNA refers only to CRNAs and anesthesiologist's assistants, we do not believe there is any other basis on which anesthetists who are not qualified as either CRNAs or anesthesiologist's assistants could be permitted to furnish these services.

J. Medical Direction of a Qualified Anesthetist

The regulations at § 405.552(a)(1)(iv) provided that one of the conditions for payment to a physician for a medical-direction service was the requirement that the physician "ensures that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified individual." The preamble of the March 2, 1983 final rule (48 FR 8926) had indicated that a qualified individual could be a CRNA, anesthesiologist's assistant, intern or resident, or other qualified individual, consistent with State law and license requirements. We are making a change to § 405.552(a)(1)(iv) to replace the term "qualified individual" with "CRNA or an anesthesiologist's assistant". (As noted in a previous response, we will recognize medical direction when an anesthesiologist medically directs concurrent cases, one of which involves a student nurse anesthetist.) We are also including an intern or a resident as a qualified individual who can be medically directed.

The only individuals qualified to be paid under the CRNA fee schedule are CRNAs and anesthesiologist's assistants. Payment for the services of interns and residents is made to a hospital based on a prospectively determined rate for each intern or resident. Services furnished by other individuals, such as a registered nurse who is not a CRNA but licensed to administer anesthesia under State law, are neither paid under the fee schedule nor paid on a reasonable cost basis. As a result of our revision, the medical direction service furnished by a physician is not covered if the physician directs an individual other than a CRNA, a student anesthetist, anesthesiologist's assistant, intern or resident.

K. Update of the CRNA Fee Schedule

Section 1833(l)(1) of the Act provides that the CRNA fee schedule conversion factors are updated by the MEI. However, section 6107(a) of Public Law 101–239 delayed the implementation of the MEI update, including the MEI update of the CRNA fee schedule conversion factors for CRNA services furnished on or after January 1, 1990, to apply instead to CRNA services furnished on or after April 1, 1990. Section 6107(b) of Public Law 101–239 also provided that the percentage increase in the MEI used to update CRNA conversion factors applicable to CRNA services furnished on or after April 1, 1990, is zero. Thus, the 1989 final rates are also effective for CRNA services furnished in calendar year 1990.

V. Summary of Changes

A. Revised CRNA Fee Schedule Conversion Factors

- We are using a more current AANA survey to calculate the basic CRNA conversion factors. The AANA's 1986 survey was used in the proposed rule. The AANA's 1987 survey is used in this final rule.
- We are making a different adjustment for fringe benefits and overhead. In the proposed rule, an adjustment of 27 percent was made to take into account both fringe benefits and overhead. In this final rule an adjustment of 32 percent is made for both fringe benefits and overhead.
- We are using a different trend factor to update the basic conversion factors. In the proposed rule, the 1986 conversion factors were adjusted by a factor of 1.19, allowing for a 6.0 percent increase in CRNA salaries per year for 1987, 1988, and 1989. In this final rule, the 1987 conversion factors are adjusted by a factor of 1.18, allowing for a 9.4 percent increase in 1988 and an 8.2 percent increase in 1989.
- We have computed the nonmedically-directed conversion factors (with exceptions noted) on the basis of State-specific nonmedically-directed CRNA salaries, the State-specific average caseload of nonmedically-directed CRNAs, and the national average number of base and time units per case for a nonmedically-directed CRNA (see § 414.451(c)). (In the proposed rule, the nonmedically-directed conversion factors were computed by multiplying the State-specific medically-directed rate by a factor of 1.375.)
- We decreased the proposed nonmedically-directed conversion factors by 5.7 percent to account for rural hospitals that elect reasonable cost payments for CRNA services. Section 6132 of Public Law 101–239 eliminated the budget neutrality adjustment that existed previously for rural hospitals.

B. Payment for Related Care Services

CRNAs furnish services to patients in addition to anesthesia services. In the proposed rule, we did not provide for separate fee schedule payments for these related care services. In the November 25, 1991 Physician Fee Schedule final rule (56 FR 59502), we have provided for separate payments for certain related care services to be implemented with the effective date of the final physician fee schedule regulations (see § 410.69(b)). These related care services include certain medical and surgical services not specifically included under the CPT–4 anesthesia coding system.

C. Time Unit Policy Revision

The final regulations to implement the uniform relative value guide (published August 7, 1990 (55 FR 32078)) provide for a revision to the time unit payment system for physician anesthesia services furnished on or after April 1, 1990. Section 6106 of Public Law 101–239 revised the method by which time units are counted for anesthesia services furnished by physicians or CRNAs. For services furnished before April 1, 1990, a fractional time unit was considered a full unit. For services furnished on or after April 1, 1990, section 6106 of Public Law 101–239 provides that a time unit is determined based on the actual time represented by the fractional time interval (see § 414.450(c)). For example, if an anesthesia procedure is personally performed by an anesthesiologist and the procedure lasts 66 minutes, we would recognize 66/15 time units, that is 4.4 time units.

D. Definition of Anesthetists (Section 410.69(b))

- We are allowing recent graduates of approved training programs who have not yet successfully completed the certification examination to be considered CRNAs for up to 24 months after graduation (rather than for 18 months after graduation as proposed), if consistent with State law.
- We are defining an anesthesiologist's assistant as a graduate of a medical school-based anesthesiologist's assistant educational program that is accredited by the Committee on Allied Health Education and Accreditation (CAHEA) and that includes approximately two years of specialized basic science and clinical education in anesthesia that builds on a premedical undergraduate science background.
- The anesthesiologist's assistant must work under the direction of an anesthesiologist. However, we are removing the requirement previously in the hospital conditions of participation that allowed an anesthesiologist's assistant to provide anesthesia only under the direct supervision of an anesthesiologist who is physically present.

E. ASC Facility Service

We are specifically including in § 416.61(b) the policy that the operating physician's supervision of the CRNA is covered only as an ASC facility service. We are also revising the conditions of participation for surgical services for ASCs to make the definition of anesthesiologist and related requirements consistent with the hospital conditions of participation.

F. Technical Changes

1. We are changing the title of subpart E—"Criteria for Determination of Reasonable Charges; Reimbursement for Services of Hospital Interns, Residents, and Supervising Physicians," to read "Criteria for Determinations of Reasonable Charges; Payment for Services of Hospital Interns, Residents, and Supervising Physicians".

2. We have revised § 411.15(m) to clarify that services of all CRNAs and anesthesiologist's assistants, not merely those who are physician-employed, are excluded from the rebundling requirement imposed by that section. This change is being made to make the regulation consistent with section 1862(a)(14) of the Act, which does not differentiate among anesthetists based on their employment status.

3. In the final regulations, we have deleted the change made to § 405.502 and added a new paragraph (d) to § 405.501. This paragraph includes, as an exception to the reasonable charge provision, payments made to CRNAs and nurse anesthetists.

4. We have replaced the term "anesthesiologist assistant" with "anesthesiologist's assistant" to reflect current usage by health care professionals.

5. We have added § 414.450 to reflect the provisions dealing with time units for services furnished on or after April 1, 1990. We have incorporated the provisions of § 405.553(c) of the proposed rule in §§ 414.450 through 414.453 of the final rule, which is new subpart H, Payment for the Services of Anesthetists, in 42 CFR part 414, Payment for Part B Medical and Other Health Services.

6. We have amended the table of contents for part 410 by adding a new § 410.69, Services of a certified registered nurse anesthetist or an anesthesiologist's assistant: Basic rule and definitions. Section 410.66 of the proposed rule has been redesignated as § 410.69, and the definition of anesthesiologist's assistant in this section has been changed.

7. We have amended § 412.113(c) to incorporate the provisions of section 6132 of Public Law 101–239.

8. We have added a new 42 CFR part 414 subpart H, Payment for the Services of Anesthetists.

9. In § 489.20(d), we have added "services of an anesthetist as defined in § 410.69 of this chapter" as a category of services that the hospital does not have

to furnish directly or under arrangements to its inpatients. This corrects the earlier omission of these services and implements section 1866(a)(1)(H) of the Act.

VI. Methodology for Determining Final CRNA Fee Schedule Rates

We used the AANA's 1987 Annual Survey to establish the final CRNA fee schedule rates. We divided the State salaries reported by full-time and part-time CRNAs by the product of the total administered anesthetics and the national average base and time unit amount per case. For hospital-employed, medically-directed CRNAs, the national average base and time units per case were 11.6 units; for nonmedically-directed CRNAs, the national average base and time units per case were 10.9 units. In summary, we adjusted the 1987 salaries/incomes as follows:

- A factor of 32 percent of salary/income was used to account for fringe benefits and overhead.
- The adjusted salary/income was increased using a 1988 trend factor of 9.4 percent and a 1989 trend factor of 8.2 percent.
- An allowance was made for malpractice insurance based on the 1989 State-specific rates for malpractice insurance for CRNAs.
- No budget neutrality adjustment is necessary for the rural hospital exception.

We viewed the data separated for hospital-employed medically-directed CRNAs and all nonmedically-directed CRNAs. There were some States and the District of Columbia with low responses, which we define as fewer than ten responses. These States are listed as follows:

Low response: Medically-directed hospital employed CRNA areas	Low response: Non-medically directed CRNA areas
Alaska	Alaska.
Arizona	Connecticut.
Arkansas	Delaware.
District of Columbia	District of Columbia.
Idaho	Maine.
Indiana	Maryland.
Iowa	Massachusetts.
Montana	New Hampshire.
Nevada	New Jersey.
Oklahoma	Rhode Island.
Utah	Vermont.
Vermont	
Wyoming	

Only in two States and the District of Columbia was there a low response rate for both types of CRNA practitioners. In these areas, neither a medically-directed nor a nonmedically-directed rate could be computed. For the remaining areas, we could compute a rate for at least one type of practitioner. The other State level rate could then be derived by multiplying the State level rate computed based on reported data by a national statistic. This methodology is illustrated for Arizona and Connecticut. Arizona did not have a sufficient number of responses from hospital-employed medically-directed CRNAs. Connecticut did not have a sufficient number of responses from nonmedically-directed CRNAs.

Example 1: The nonmedically-directed rate for Arizona based on State level responses is $21.13. The relationship between the national mean nonmedically-directed rate and the national mean hospital-employed medically-directed rate is 1.69. The derived hospital-employed medically-directed rate is $12.50 ($21.13/1.69). The derived blended medically-directed rate for Arizona is $10.09.

$$(\$12.50 \times .58) + (\$6.77 \times .42) = \$10.09$$

In this example, the figure of $6.77 represents the conversion factor that would be paid for CRNA services if the CRNA is employed and medically directed by a physician. The figure of $6.77 is computed by multiplying the 1989 participating physician prevailing charge conversion factor by 101/30 and dividing by 12.1 units.

Example 2: The medically-directed rate for hospital-employed medically-directed CRNAs for Connecticut based on State responses is $10.19. The derived nonmedically-directed rate for Connecticut is $17.22 ($10.19 × 1.69).

Alaska, the District of Columbia, and Vermont had a low response rate for each type of practitioner. We decided to establish a conversion factor for each of these by using the regional rate. The regions are based on the regional designations used in the hospital prospective payment system.

To ensure budget neutrality, we are, as described in the proposed rule, calculating a blended medically-directed rate. The blended rate is composed of the hospital-employed medically-directed rate that is assigned a weight of 58 percent and the physician-employed medically-directed that is assigned a weight of 42 percent. The methodology to calculate the physician-employed medically-directed rate remains unchanged from the proposed rate. The physician-employed medically-directed rate is calculated as follows:

(CF × 101/30) divided by (12.1)

CF = State-specific participating physician prevailing charge conversion factor. In cases in which the State is not a single locality, a State-specific participating physician prevailing charge conversion factor was computed by weighing the locality participating physician prevailing charge conversion factor by the weight of locality-allowed anesthesia charges.

As noted in the proposed regulations, the average anesthesia procedure involving a physician-employed medically-directed CRNA lasts 101 minutes and has an average unit value of 12.1 units. Prior to 1989, the payment methodology provided that two time units an hour approximated Part B payment for the physician-employed medically-directed CRNA.

Since there were two different participating physician prevailing charge conversion factors in effect during 1989, there are two different State level medically-directed CRNA rates in 1989. One rate applies to CRNA services furnished on or after January 1, 1989 but before March 1, 1989. The other rate applies to medically-directed CRNA services furnished on or after March 1, 1989, but before January 1, 1990.

Since the blending process is not used to calculate the nonmedically-directed rate, there is only one nonmedically-directed rate applicable during 1989.

We have illustrated below the calculation of both the medically-directed and nonmedically-directed rates for Alabama for 1989 (See Tables 1 and 2). The medically-directed rate is calculated for services furnished on or after March 1, 1989.

Tables 1 and 2 each include an example for Alabama that explains the computation of the final March 1, 1989 blended medically-directed rate and the final 1989 nonmedically-directed rate for CRNA services. Table 3, column 1 provides the State-specific medically-directed rates effective for services furnished on or after January 1, 1989 and prior to March 1, 1989. Table 3, column 2 provides the State-specific medically-directed rates effective for services furnished on or after March 1, 1989. Table 3, column 3 provides the State-specific nonmedically-directed rates effective for services furnished in 1989. The carriers will determine adjustments based on the differences between the final rates and the proposed rates published in the January 26, 1989 proposed rule.

In general, the final medically-directed CRNA rates have increased on average by 7 percent from the proposed rates; the nonmedically directed CRNA rates have increased on average by 30

percent from the proposed rates. The fact that these rates have increased does not mean these rates are not budget neutral as required by law. The differences between the final and proposed rates are due to more current and reliable data on CRNA salaries/incomes and caseloads.

Table 1

Hospital Employed Medically-Directed Rate	
Total salaries based on 100 responses from full-time or part-time medically directed CRNAs in Alabama	$5,116,448
Total anesthetics administered by the 100 respondents in Alabama	59,583
Average salary cost per case	$85.87
Average number of base and time units per case involving CRNAs (units/care)	11.6
1987 conversion factor ($85.87/11.6)	$7.40
Adjustments for fringe benefits and overhead (7.40×1.32)	$9.77
Update adjustment ($9.77×1.18)	$11.53
Malpractice rate adjustment (Alabama)	$.77
1989 Hospital employed medically directed CRNA rate	$12.30
Physician Employed Medically-Directed Rate	
Average time per medically-directed case (minutes)	101
Average time and base units per Medicare case (units)	12.1
1989 weighted average prevailing charge conversion factor for participating anesthesiologists in Alabama	$16.10
March 1 conversion factor for medically-directed physician employed CRNAs ($16.10×101/30)/12.1)	$4.48
Blended Medically-Directed CRNA Rate	
National hospital-employed CRNA percentage (percent)	58
National physician-employed CRNA percentage (percent)	42
Hospital-employed medically-directed CRNA rate for Alabama	$12.30
Physician-employed medically-directed CRNA rate for Alabama	$4.48
Blended rate for Alabama (.58×$12.30)+(.42×$4.48)	$9.02

Table 2

Nonmedically-Directed CRNA Rate	
Total salaries/incomes based on 37 responses from full-time or parttime nonmedically-directed CRNAs in Alabama	$2,531,624
Total anesthetics administered by the 37 respondents in Alabama	21,067

Table 2—Continued

Average salary cost per case	$120.06
1987 conversion factor ($120.06/10.9)	$11.01
Adjustments for fringe benefits and overhead ($11.01×1.32)	$14.54
Update adjustment ($14.54×1.18)	$17.16
Malpractice adjustment (Alabama)	$.86
1989 nonmedically-directed rate for Alabama	$18.02

TABLE 3

State	Jan. 1, 1989 [1]	Mar. 1, 1989 [1]	1989 [2]
Alabama	8.64	9.02	18.02
Alaska	9.51	9.58	19.94
Arizona	9.45	10.09	21.13
Arkansas	7.67	7.93	17.40
California	9.92	9.97	21.00
Colorado	7.43	7.70	18.81
Connecticut	8.05	8.05	17.22
Delaware	7.56	7.61	16.90
DC	8.27	8.33	15.43
Florida	9.61	9.70	16.25
Georgia	9.15	9.24	16.34
Hawaii	10.40	10.76	16.80
Idaho	9.43	9.45	22.10
Illinois	9.18	9.22	15.87
Indiana	6.87	7.27	14.83
Iowa	8.25	8.65	16.51
Kansas	9.48	9.61	18.88
Kentucky	8.84	8.93	14.20
Louisiana	6.60	9.01	16.69
Maine	6.93	7.03	15.24
Maryland	7.12	7.16	14.31
Massachusetts	7.79	7.78	16.71
Michigan	8.15	9.48	16.80
Minnesota	7.72	7.81	17.07
Mississippi	[3]	8.24	16.40
Missouri	9.08	9.53	18.62
Montana	9.02	9.53	19.01
Nebraska	8.60	8.59	16.50
Nevada	11.39	12.27	24.53
New Hampshire	7.76	7.76	18.05
New Jersey	8.35	8.37	17.25
New Mexico	8.17	8.55	23.43
New York	9.37	9.49	14.46
North Carolina	7.80	7.67	13.84
North Dakota	8.27	8.27	21.07
Ohio	9.51	9.74	17.24
Oklahoma	7.72	8.13	17.79
Oregon	6.51	6.55	18.21
Pennsylvania	7.25	7.32	10.51
Rhode Island	7.15	7.11	16.12
South Carolina	8.04	8.06	14.67
South Dakota	9.22	9.66	18.64
Tennessee	8.36	8.62	18.35
Texas	9.06	9.29	21.19
Utah	9.62	9.99	21.17
Virginia	6.95	7.22	16.86
Vermont	7.76	7.76	16.78
Washington	8.91	8.93	19.18
West Virginia	7.08	7.30	14.89
Wisconsin	8.72	8.87	16.86
Wyoming	10.95	11.17	26.56

[1] Medically directed rate.
[2] Nonmedically directed rate.
[3] To be computed by carrier.

VII. Regulatory Impact Statement and Regulatory Flexibility Analysis

A. Executive Order 12291

Executive Order (E.O.) 12291 requires us to prepare and publish a regulatory impact analysis for any final rule that meets one of the E.O. 12291 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.

Under this final rule, aggregate payments plus coinsurance to hospitals, physicians, ASCs, and CRNAs for CRNA services are budget neutral with respect to previous program payments. However, this rule contains a provision that eliminates payment for medical direction services furnished by surgeons. This is an administrative initiative and was not part of the CRNA fee schedule legislation. This initiative provides benefit savings of $20 million for FY 1991, and $25 million for each of FYs 1992, 1993, 1994, and 1995.

Based on this projection, and the reasons discussed above, we do not expect any economic impact to result from this rule that will meet any of the E.O. 12291 criteria. We have, therefore, not prepared a regulatory impact analysis.

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 rule will not have a significant economic impact on a substantial number of small entities. For purposes of the RFA, we do not consider individuals or States to be small entities. We do consider hospitals, physicians, ambulatory surgical centers, and CRNAs (all of which could be affected by this final rule) to be small entities. Because of the large number of small entities that could potentially be affected and the significance of these provisions on hospitals, physicians and CRNAs, we are preparing a regulatory flexibility analysis for this rule.

1. Impact on Hospitals

We expect that hospitals that employ CRNAs whose services are medically-directed by anesthesiologists will experience an average 21 percent reduction in payments for CRNA services than would have been made but for this rule. This reduction is due to blending of the rates for medically-directed CRNAs employed by hospitals and rates for medically-directed CRNAs employed by physicians. The rates for hospital-employed CRNAs were generally higher; therefore the blending of the two rates will result in a reduced rate for the hospitals.

Some hospitals may continue to bill for services of CRNAs and experience this loss. Other hospitals may transfer the risk in payment reductions associated with the CRNA fee schedule to CRNAs by reducing CRNA salaries. Still other hospitals may stop employing CRNAs, which will allow the CRNAs to bill directly. We anticipate that the amount by which a hospital is able to reduce its payment to CRNAs for services, the hospital's Medicare patient volume, and the degree to which the hospital wishes to exercise control over CRNAs will be among the factors that will determine whether hospitals continue to employ CRNAs and bill for CRNA services.

Approximately 500, or 25 percent of rural hospitals claiming costs for CRNA services, qualified for reasonable cost payments in calendar year 1989. Section 6132 of Public Law 101–239 amended section 9320(k) of Public Law 99–509 to raise the yearly threshold from 250 to 500 for the number of surgical procedures requiring anesthesia that would be performed in a rural hospital before the hospital would have to give up payment on a reasonable cost basis for CRNA services. This provision is effective for anesthesia services furnished on or after January 1, 1989. We estimate that approximately 1,000 rural hospitals will now qualify for reasonable cost payments under this provision in calendar year 1990, resulting in payments to more rural hospitals for CRNA services.

2. Impact on Physicians

a. *Anesthesiologists.* Because of the way the blended medically-directed CRNA rate has been computed in this final rule, the Medicare program will pay higher amounts for physician-employed medically-directed CRNAs than was previously paid for these services on a reasonable charge basis. This increase in payment is a result of the physician-employed charges being blended with costs for hospital employed CRNAs.

In addition, in this final rule, we recognize medical direction only if an anesthesiologist medically directs concurrent anesthesia procedures. If an anesthesiologist and a CRNA are involved in a single anesthesia procedure, we consider the service to be performed by the anesthesiologist. We will recognize payment for the CRNA service only if documentation is submitted showing it is medically necessary for both individuals to be personally involved in the performance of the anesthesia procedure. If documentation is furnished and the carrier determines that the CRNA service is medically necessary, the carrier pays the physician anesthesia service at the personally performed physician payment rate and the CRNA service at the medically directed rate.

b. *Surgeons.* In the proposed rule, as well as this final rule, we provided for the elimination of medical direction payments for surgeons who perform surgery and also supervise the services of a CRNA. We believe the payment of a separate charge for medical-directed anesthesia services is not currently a widespread practice. This final rule will bring national consistency to the policy of denying such claims. We estimate the benefit savings associated with this policy to be $20 million for each of FYs 1992, 1993, 1994, and 1995. Effective on or after January 1, 1989, however, to the extent a surgeon employs or contracts with a CRNA, the surgeon is entitled to receive the CRNA fee schedule payment for services the CRNA furnishes.

3. Impact on CRNAs

The potential effects of the 21 percent reduction on the hospital-employed CRNAs is discussed in section B.1. of this impact statement.

The revisions to the time unit policy, required by section 6106 of Public Law 101–239, are effective for anesthesiologist services furnished on or after April 1, 1990. Since § 414.450(c)(2) requires that services of anesthetists be paid on a basis similar to that used for anesthesiologists, for CRNA services furnished on or after April 1, 1990, we recognize only the actual time of the fractional time interval. Before April 1, 1990, a fractional time unit was considered a full unit. (This time unit policy revision is explained in section V.D. of the preamble.) Since the payment for fractional time units is a small part of total payments, we believe there will be a minimal reduction in payment amounts as a result of not rounding the time interval upward.

4. Impact on ASCs

Prior to January 1, 1989, services furnished by CRNAs employed by ASCs were paid as part of the ASC facility rate. As required by section 9320 of Public Law 99–509, as amended by section 4084 of Public Law 100–203, this final rule allows an ASC to be paid under the CRNA fee schedule for CRNAs that are employed by or under contract to the ASC. The allowance of a separate payment for CRNA services may encourage more ASCs to employ or contract with CRNAs.

C. Rural Hospital Impact Statement

Section 1102(b) of the Act requires the Secretary to prepare a regulatory impact analysis if a rule 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 that is located outside of a Metropolitan Statistical Area and has fewer than 50 beds.

The provisions of this final rule will benefit some rural hospitals, including small rural hospitals, by allowing more rural hospitals to continue to employ CRNAs and be paid on a reasonable cost related basis if the hospital meets other requirements and selects this option. This final rule reflects current policy and procedures and serves to codify in regulations sections of Public Law 101–239 that have already been implemented by instructions. Therefore, we are not preparing a rural hospital impact statement since we have determined, and the Secretary certifies, that this final rule will not have a significant economic impact on the operations of a substantial number of small rural hospitals.

VIII. Other Required Information

Paperwork Reduction Act

This final rule 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 through 3511).

List of Subjects

42 CFR Part 405

Administrative practice and procedure, Health facilities, Health professions, Kidney diseases, Laboratories, Medicare, Nursing homes, Reporting and recordkeeping requirements, Rural areas, X-rays.

42 CFR Part 410

Health facilities, Health professions, Kidney diseases, Laboratories, Medicare, Rural areas, X-rays.

42 CFR Part 411

Medicare, Recovery against third parties, Secondary payments.

42 CFR Part 412

Health facilities, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 413

Health facilities, Kidney diseases, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 414

Fee Schedules for Services of Certified Registered Nurse Anesthetists.

42 CFR Part 416

Health facilities, Health professions, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 482

Hospitals, Medicaid, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 489

Health facilities, Medicare.

42 CFR chapter IV is amended as set forth below:

I. Part 405 is amended as follows:

PART 405—FEDERAL HEALTH INSURANCE FOR THE AGED AND DISABLED

A. The authority citation for subpart D continues to read as follows:

Authority: Secs. 1102, 1871 and 1887, of the Social Security Act as amended (42 U.S.C. 1302, 1395hh, and 1395xx).

B. In § 405.480, the introductory text in paragraph (a) is republished and paragraph (a)(2) is revised to read as follows:

§ 405.480 Payment for services of physicians to providers: General rules.

(a) *Allowable Costs.* Except as specified otherwise in § 413.102 of this chapter, § 405.465, or § 405.466, costs a provider incurs for services of physicians are allowable only if the following conditions are met:

* * * * *

(2) The services include a surgeon's supervision of services of a qualified anesthetist, but do not include physician availability services, except for reasonable availability services furnished for emergency rooms;

* * * * *

C. The authority citation for subpart E is revised to read as follows:

Authority: Secs. 1102, 1814(b), 1832, 1833(a), 1834(b), 1842(b) and (h), 1848, 1861(b), (v), and (aa), 1862(a)(14), 1866(a), 1871, 1881, 1886, 1887, and 1889 of the Social Security Act as amended (42 U.S.C. 1302, 1395f(b), 1395k, 13951(a), 1395m(b), 1395u(b) and (h), [1395w-4, 1395x(b), (v), and (aa), 1395y(a)(14), 1395cc(a), 1395hh, 1395rr, 1395ww, 1395xx, and 1395zz).

D. The heading of subpart E is revised to read as follows:

Subpart E—Criteria for Determination of Reasonable Charges; Payment for Services of Hospital Interns, Residents, and Supervising Physicians

E. In § 405.501, paragraph (a) is revised, paragraph (d) is redesignated as paragraph (e), and a new paragraph (d) is added to read as follows:

§ 405.501 Determination of reasonable charges.

(a) Except as specified in paragraphs (b), (c), and (d) of this section, Medicare pays no more for Part B medical and other health services than the "reasonable charge" for such service. The reasonable charge is determined by the carriers (subject to any deductible and coinsurance amounts as specified in §§ 410.152 and 410.160 of this chapter).

* * * * *

(d) For services furnished on or after January 1, 1989 and before January 1, 1991, by a certified registered nurse anesthetist or an anesthesiologist's assistant, payment is made after the Part B deductible is met based on 80 percent of the least of the—

(1) Actual charge;

(2) Prevailing charge that would be recognized if the services had been performed by an anesthesiologist; or

(3) Fee schedule amount, as described in §§ 414.451 and 414.452.

* * * * *

II. Part 410 is amended as follows:

PART 410—SUPPLEMENTARY MEDICAL INSURANCE (SMI) BENEFITS

A. The authority citation for part 410 continues to read as follows:

Authority: Secs. 1102, 1832, 1833, 1834, 1835, 1861(r), (s) and (cc), 1861(aa), 1871 and 1881 of the 7, Social Security Act (42 U.S.C. 1302, 1395k, 13951, 1395m, 1395n, 1395x(r), (s) and (cc), 1395x(aa) 1395hh, and 1395rr).

B. In § 410.10, the introductory text is republished, and a new paragraph (t) is added to read as follows:

§ 410.10 Medical and other health services: Included services.

Subject to the conditions and limitations specified in § 410.12, "medical and other health services" includes the following services:

* * * * *

(t) Services of a certified registered nurse anesthetist or an anesthesiologist's assistant.

* * * * *

C. In § 410.12, the introductory text of paragraph (a) and paragraph (a)(2) are revised to read as follows:

§ 410.12 Medical and other health services: Basic conditions and limitations.

(a) *Basic conditions.* The medical and other health services specified in § 410.10 are covered by Medicare Part B only if they are not excluded under subpart A of part 411 of this chapter, and if they meet the following conditions:

* * * * *

(2) *By whom the services must be furnished.* The services must be furnished by a facility or other entity as specified in §§ 410.14 through 410.69.

* * * * *

D. A new § 410.69 is added to read as follows:

§ 410.69 Services of a certified registered nurse anesthetist or an anesthesiologist's assistant: Basic rule and definitions.

(a) *Basic rule.* Medicare Part B pays for anesthesia services and related care furnished by a certified registered nurse anesthetist or an anesthesiologist's assistant who is legally authorized to perform the services by the State in which the services are furnished.

(b) *Definitions.* For purposes of this part—

Anesthesiologist's assistant means a person who—

(1) Works under the direction of an anesthesiologist;

(2) Is in compliance with all applicable requirements of State law, including any licensure requirements the State imposes on nonphysician anesthetists; and

(3) Is a graduate of a medical school-based anesthesiologist's assistant educational program that—

(A) Is accredited by the Committee on Allied Health Education and Accreditation; and

(B) Includes approximately two years of specialized basic science and clinical education in anesthesia at a level that builds on a premedical undergraduate science background.

Anesthetist includes both an anesthesiologist's assistant and a certified registered nurse anesthetist.

Certified registered nurse anesthetist means a registered nurse who:

(1) Is licensed as a registered professional nurse by the State in which the nurse practices;

(2) Meets any licensure requirements the State imposes with respect to non-physician anesthetists;

(3) Has graduated from a nurse anesthesia educational program that meets the standards of the Council on Accreditation of Nurse Anesthesia Programs, or such other accreditation organization as may be designated by the Secretary; and

(4) Meets the following criteria:

(i) Has passed a certification examination of the Council on Certification of Nurse Anesthetists, the Council on Recertification of Nurse Anesthetists, or any other certification organization that may be designated by the Secretary; or

(ii) Is a graduate of a program described in paragraph (3) of this definition and within 24 months after that graduation meets the requirements of paragraph (4)(i) of this definition.

III. Part 411 is amended as follows:

PART 411—EXCLUSIONS FROM MEDICARE AND LIMITATIONS ON MEDICARE PAYMENT

A. The authority citation for part 411 continues to read as follows:

Authority: Secs. 1102, 1834, 1842(l), 1861, 1862, 1866, 1871, 1877, and 1879 of the Social Security Act (42 U.S.C. 1302, 1395m, 1395u(l), 1395x, 1395y, 1395cc, 1395hh, 1395nn, and 1395pp).

B. In § 411.15, the introductory text and paragraph (m)(1) are republished and paragraph (m)(2) is revised to read as follows:

§ 411.15 Particular services excluded from coverage.

The following services are excluded from coverage.

* * * * *

(m) Services to hospital inpatients—

(1) *Basic rule.* Except as provided in paragraph (m)(2) of this section, any service furnished to an inpatient of a hospital by an entity other than the hospital, unless the hospital has an arrangement (as defined in § 409.3 of this chapter) with that entity to furnish that particular service to the hospital's inpatients.

(2) *Exception.* Physicians' services that meet the criteria of § 405.550(b) for payment on a reasonable charge basis, and services of an anesthetist as defined in § 410.69 of this chapter are not excluded.

IV. Part 412 is amended as follows:

PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

A. The authority citation for part 412 continues to read as follows:

Authority: Secs. 1102, 1815(e), 1871 and 1886 of the Social Security Act (42 U.S.C. 1302, 1395g(e), 1395hh, and 1395ww).

B. In § 412.1, paragraph (a) is revised to read as follows:

§ 412.1 Scope of part.

(a) *Purpose.* This part implements section 1886(d) of the Act by establishing a prospective payment system for inpatient hospital services furnished to Medicare beneficiaries in cost reporting periods beginning on or after October 1, 1983. Under the prospective payment system, payment for the operating costs of inpatient hospital services furnished by hospitals subject to the system (generally, short-term, acute-care hospitals) is made on the basis of prospectively determined rates and applied on a per discharge basis. Payment for other costs related to inpatient hospital services (capital-related costs, kidney acquisition costs incurred by hospitals with approved renal transplantation centers, direct costs of medical education, and the costs of qualified nonphysician anesthetists' services, as described in § 412.113(c)) is made on a reasonable cost basis. Additional payments are made for outlier cases, bad debts, and indirect medical education costs. Under the prospective payment system, a hospital may keep the difference between its prospective payment rate and its operating costs incurred in furnishing inpatient services, and is at risk for operating costs that exceed its payment rate.

* * * * *

C. In § 412.2, the introductory text of paragraph (d) is republished and paragraph (d)(5) is revised to read as follows:

§ 412.2 Basis of payment.

* * * * *

(d) *Excluded costs.* The following inpatient hospital costs are excluded from the prospective payment amounts and paid for on a reasonable cost basis:

* * * * *

(5) The costs of qualified nonphysician anesthetists' services, as described in § 412.113(c).

* * * * *

D. In § 412.71, the introductory text of paragraph (b) is republished and paragraph (b)(8) is revised to read as follows:

§ 412.71 Determination of base year costs.

* * * * *

(b) *Modifications to base-year costs.* Prior to determining the hospital-specific rate, the intermediary will adjust the hospital's estimated base-year inpatient operating costs, as necessary, to include malpractice insurance costs as described in § 413.55 of this chapter, and exclude the following:

* * * * *

(8) The costs of qualified nonphysician anesthetists' services, as described in § 412.113(c).

* * * * *

E. In § 412.113, paragraph (c) is revised to read as follows:

§ 412.113 Other payments.

* * * * *

(c) *Anesthesia services furnished by hospital employed nonphysician anesthetists or obtained under arrangements.* (1) For cost reporting periods beginning on or after October 1, 1984 through any part of a cost reporting period occurring before January 1, 1989, payment is determined on a reasonable cost basis for anesthesia services provided in the hospital by qualified nonphysician anesthetists (certified registered nurse anesthetists and anesthesiologist's assistants) employed by the hospital or obtained under arrangements.

(2)(i) For cost reporting periods, or any part of a cost reporting period, beginning on or after January 1, 1989, through any part of a cost reporting period occurring before January 1, 1990, payment is determined on a reasonable cost basis for anesthesia services provided in a hospital by qualified nonphysician anesthetists employed by the hospital or obtained under arrangement, if the hospital demonstrates to its intermediary prior to April 1, 1989 that it meets the following criteria:

(A) The hospital is located in a rural area as defined in § 412.62(f) and is not deemed to be located in an urban area under the provisions of § 412.64(b)(3).

(B) The hospital must have employed or contracted with a qualified nonphysician anesthetist, as defined in § 410.66 of this chapter, as of January 1, 1988 to perform anesthesia services in that hospital. The hospital may employ or contract with more than one anesthetist; however, the total number of hours of service furnished by the anesthetists may not exceed 2,080 hours per year.

(C) The hospital must provide data for its entire patient population to demonstrate that, during calendar year 1987, its volume of surgical procedures

(inpatient and outpatient) requiring anesthesia services did not exceed 250 procedures. For purposes of this section, a "surgical procedure requiring anesthesia services" means a surgical procedure in which the anesthesia is administered and monitored by a qualified nonphysician anesthetist, a physician other than the primary surgeon, or an intern or resident.

(D) Each qualified nonphysician anesthetist employed by or under contract with the hospital has agreed in writing not to bill on a reasonable charge basis for his or her patient care in that hospital.

(ii) To maintain its eligibility for reasonable cost payment under paragraph (c)(2)(i) of this section in calendar years after 1989, a qualified hospital must demonstrate prior to January 1 of each respective year that for the prior year its volume of surgical procedures requiring anesthesia service did not exceed 500 procedures.

(iii) A hospital that did not qualify for reasonable cost payment for nonphysician anesthetist services furnished in calendar year 1989 can qualify for reasonable cost payment in subsequent calendar years, if it meets the criteria in § 412.113(c)(2)(i) (A), (B) and (D) above, and demonstrates to its intermediary prior to the start of the calendar year that it met these criteria. The hospital must provide data for its entire patient population to demonstrate that, during calendar year 1987 and the year immediately preceding its election of reasonable cost payment, its volume of surgical procedures (inpatient and outpatient) requiring anesthesia services did not exceed 500 procedures.

(iv) For administrative purposes for the calendar years after 1990, the volume of surgical procedures for the immediately preceding year is the sum of the surgical procedures for the nine month period ending September 30, annualized for the twelve month period.

* * * * *

V. Part 413 is amended as follows:

PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES

A. The authority citation for part 413 continues to read as follows:

Authority: Secs. 1102, 1814(b), 1815, 1833 (a), (i), and (n), 1861(v), 1871, 1881, 1883, and 1886 of the Social Security Act (42 U.S.C. 1302, 1395f(b), 1395g, 1395l (a), (i), and (n), 1395x(v), 1395hh, 1395rr, 1395tt, and 1395ww); sec. 104(c) of Pub. L. 100–360 as amended by sec. 608(d)(3) of Pub. L 100–485 (42 U.S.C. 1395ww (note)); and sec. 101(c) of Pub. L. 100–234 (42 U.S.C. 1395ww (note)).

B. In § 413.1, paragraph (b) is amended by changing the reference in the first sentence from "paragraphs (c) through (e)" to "paragraphs (c) through (f)" and by adding a new paragraph (f) to read as follows:

§ 413.1 Introduction.

* * * * *

(f) *Services of qualified nonphysician anesthetists.* For cost reporting periods, or any part of a cost reporting period, beginning on or after January 1, 1989, costs incurred for the services of qualified nonphysician anesthetists are not paid on a reasonable cost basis unless the provisions of § 412.113(c)(2) of this chapter apply. These services are paid under the special rules set forth in § 405.553 of this chapter.

C. In § 413.80, paragraph (a) is revised and a new paragraph (h) is added to read as follows:

§ 413.80 Bad debts, charity, and courtesy allowances.

(a) *Principle.* Bad debts, charity, and courtesy allowances are deductions from revenue and are not to be included in allowable cost; however, except for anesthetists' services described under paragraph (h) of this section, bad debts attributable to the deductibles and coinsurance amounts are reimbursable under the program.

* * * * *

(h) *Exception.* Bad debts arising from services for anesthetists paid under a fee schedule, as described in § 414.450 of this chapter, are not reimbursable under the program.

VI. Part 414 is amended to read as follows:

PART 414—PAYMENT FOR PART B MEDICAL AND OTHER HEALTH SERVICES

1. The authority citation for part 414 continues to read as follows:

Authority: Secs. 1102, 1833(a), 1834(a), 1871, and 1881 of the Social Security Act (42 U.S.C. 1302, 1395l(a), 1395m(a), 1395hh, and 1395rr).

2. A new subpart H, consisting of §§ 414.450 through 414.453 is added to read as follows:

Subpart H—Payment for the Services of Anesthetists

Sec.

414.450 Payment for anesthetist services.
414.451 Basic methodology for calculating anesthetist fee schedules.
414.452 Updating and adjusting the anesthetist fee schedules.
414.453 Recipients of fee schedule payments.

Subpart H—Payment for the Services of Anesthetists

§ 414.450 Payment for Anesthetist Services.

(a) *Purpose.* This subpart implements section 1833(l) of the Act by specifying how payment is determined for the services of anesthetists furnished on or after January 1, 1989 and before January 1, 1991.

(b) *General rules.* For services furnished on or after January 1, 1989 and before January 1, 1991, the amount of payment for anesthetist services after the Part B deductible has been met is determined to be 80 percent of the least of the—

(1) Actual charge;

(2) Prevailing charge that would be recognized if the service had been performed by an anesthesiologist; or

(3) Fee schedule amount, which is the product of the applicable conversion factor, as described in paragraphs (b) through (d) of § 414.451, and the sum of the base and time units per case.

(c) *Medical direction and medical supervision.* If the physician medically directs two, three, or four anesthesia procedures involving anesthetists or medically supervises more than four concurrent anesthesia procedures involving anesthetists, the services of those anesthetists may be paid under the fee schedule. If a physician medically supervises more than four concurrent procedures involving anesthetists, the medically-directed conversion factor is used to determine payment.

(d) *Involvement of an anesthesiologist and an anesthetist in a single procedure.* If an anesthesiologist and an anesthetist are involved in a single procedure, the procedure is deemed to be furnished by the anesthesiologist. Payment may be made for the anesthetist service only if documentation is submitted to and approved by the carrier showing it is medically necessary for the anesthetist to be involved in the procedure.

(e) *Time intervals.* (1) For anesthesia services furnished by an anesthetist on or after January 1, 1989 and before April 1, 1990, no more than one time unit for each 15 minute interval or fraction thereof is recognized.

(2) For anesthesia services furnished by an anesthetist on or after April 1, 1990, the actual time associated with a fractional time interval is recognized.

§ 414.451 Basic methodology for calculating anesthetist fee schedules.

(a) *Fee schedules.* HCFA establishes separate State-level fee schedules for—

(1) Anesthetists whose services are medically-directed; and

(2) Anesthetists whose services are not medically-directed.

(b) *Calculation of conversion factors for anesthetists who are medically directed.*—(1) *Hospital-employed anesthetists.* State-specific conversion factors for medically-directed hospital-employed anesthetists are computed from the 1987 American Association of Nurse Anesthetists annual membership survey, as follows:

(i) An average cost per case is computed by dividing the total reported State salaries of full and part-time medically-directed hospital-employed anesthetists by the total reported anesthetics administered by the anesthetists.

(ii) A base conversion factor is computed by dividing the average cost per case by the estimated national average of base and time units for an anesthesia case involving a hospital-employed medically-directed anesthetist.

(iii) The conversion factor is adjusted to reflect an allowance that approximates fringe benefits and allowable hospital overhead associated with anesthetists' services.

(iv) The 1987 conversion factor is updated by an inflation factor through 1989.

(v) The conversion factor is increased to include a State specific amount for malpractice expense. The resultant amounts are considered to be State-specific conversion factors for medically-directed hospital-employed anesthetists.

(2) *Physician-employed anesthetists.* State-specific conversion factors for medically-directed physician-employed anesthetists are computed as follows:

(i) The 1989 Statewide locality prevailing charge conversion factor for anesthesia services of participating physicians, as adjusted by the MEI, is multiplied by the average time per anesthesia case involving a medically directed physician-employed anesthetist, and divided by 30 minutes. (If there are multiple localities within a State, or more than one carrier serves a State, a single, Statewide weighted average participating physician prevailing charge is applied.)

(ii) The resulting amount is divided by the average number of base and time units per anesthesia case involving a physician who medically directs and employs the CRNA.

(3) *Calculation of medically-directed conversion factors.* The applicable State-specific conversion factors for anesthetists who are medically directed are based on a blend of 58 percent of the hospital-employed conversion factor and 42 percent of the physician-employed conversion factor calculated under paragraphs (b)(1) and (b)(2) of this section, respectively.

(c) *Calculation of conversion factors for anesthetists who are not medically directed.* The State-specific conversion factors for anesthetists who are not medically directed are computed under the procedures in paragraph (b)(1) of this section except that:

(1) The total reported State salaries of full and part-time nonmedically-directed anesthetists and the total reported anesthetics administered by these anesthetists are used to compute an average cost per case; and

(2) A base conversion factor is computed by dividing the average cost per case by the estimated national average number of base and time units for an anesthesia case involving a nonmedically-directed anesthetist.

(d) *Exceptions.*—(1) *Insufficient State-level data for one conversion factor.* If only one of the State-level conversion factors can be calculated, the other conversion factor is calculated based on that factor and on national statistics.

(2) *Insufficient State-level data for both medically-directed and nonmedically-directed conversion factors.* If neither the State-level medically-directed nor nonmedically-directed conversion factors can be calculated from State-specific data, regional data are used to calculate both conversion factors.

§ 414.452 Updating and adjusting the anesthetist fee schedule.

(a) *General rules for updating the fee schedule conversion factors.* (1) Except as provided in paragraph (a)(2) of this section, for services furnished in calendar years after 1989, the fee schedule conversion factors applicable to each year are the previous year's conversion factors updated by the percentage increase in the Medicare Economic Index for that year.

(2) The fee schedule conversion factors for anesthetist services furnished in calendar year 1990 are the fee schedule conversion factors that were applicable to anesthetists' services furnished on December 31, 1989.

(b) *Adjusting the fee schedules.* The fee schedules may be adjusted for services furnished on or after January 1, 1990 to reflect data that are more accurate than the data used to construct the initial fee schedules.

§ 414.453 Recipients of fee schedule payments.

Fee schedule payments are made to the anesthetist who furnishes the service, or to a hospital, physician, group practice or ambulatory surgical center with which the anesthetist has an employment or contractual arrangement that provides for these payments to be made.

VII. Part 416 is amended as follows:

PART 416—AMBULATORY SURGICAL SERVICES

A. The authority citation for part 416 continues to read as follows:

Authority: Secs. 1102, 1832(a)(2), 1833, 1863, and 1864 of the Social Security Act (42 U.S.C. 1302, 1395k(a)(2), 1395l, 1395z, and 1395aa).

B. Section 416.42 is amended by revising paragraph (b) to read as follows:

§ 416.42 Condition for coverage—surgical services.

* * * * *

(b) *Standard: Administration of anesthesia.* Anesthetics must be administered by only—

(1) A qualified anesthesiologist; or

(2) A physician qualified to administer anesthesia, a certified registered nurse anesthetist or an anesthesiologist's assistant as defined in § 410.68(b) of this chapter, or a supervised trainee in an approved educational program. In those cases in which a non-physician administers the anesthesia, the anesthetist must be under the supervision of the operating physician, and in the case of an anesthesiologist's assistant, under the supervision of an anesthesiologist.

* * * * *

C. In § 416.61, a new paragraph (a)(8) is added and paragraph (b) is amended by adding a new sentence to the end.

§ 416.61 Scope of facility services.

(a) * * *

(8) Supervision of the services of an anesthetist by the operating surgeon.

(b) * * * In addition, they do not include anesthetist services furnished on or after January 1, 1989.

VIII. Part 482 is amended as follows:

PART 482—CONDITIONS OF PARTICIPATION FOR HOSPITALS

A. The authority citation for part 482 is revised to read as follows:

Authority: Secs. 1102, 1136, 1138, 1814(a)(6), 1861 (e), (f), (k), (r), (v)(1)(G), (z), and (ee), 1864, 1871, 1883, 1886, 1902(a)(30), and 1905(a)

of the Social Security Act (42 U.S.C. 1302, 1320b–6, 1338, 1395f(a)(6), 1395x (e), (f), (k), (r), (v)(1)(G), (z), and (ee), 1395aa, 1395hh, 1395tt, 1395ww, 1396a(a)(30), and 1396(a)).

B. In § 482.52, the introductory text of paragraph (a) is republished and paragraphs (a)(4) and (a)(5) are revised to read as follows:

§ 482.52 Condition of participation: Anesthesia services.

* * * * *

(a) Standard: Organization and staffing. The organization of anesthesia services must be appropriate to the scope of the services offered. Anesthesia must be administered by only—

* * * * *

(4) A certified registered nurse anesthetist

(CRNA), as defined in § 410.69(b) of this chapter, who is under the supervision of the operating practitioner or of an anesthesiologist who is immediately available if needed; or

(5) An anesthesiologist's assistant, as defined in § 410.69(b) of this chapter, who is under the supervision of an anesthesiologist who is immediately available if needed.

* * * * *

IX. Part 489 is amended as follows:

PART 489—PROVIDER AND SUPPLIER AGREEMENTS

A. The authority citation for part 489 continues to read as follows:

Authority: Secs. 1102, 1861, 1864, 1866, and 1871 of the Social Security Act (42 U.S.C. 1302, 1395x, 1395aa, 1395cc, and 1395hh).

B. In § 489.20, the introductory text is republished and paragraph (d) is revised to read as follows:

§ 489.20 Basic commitments.

The provider agrees—

* * * * *

(d) In the case of a hospital that furnishes inpatient hospital services to a beneficiary, to either furnish directly or make arrangements for all items and services (other than physicians' services as described in § 405.550(b) of this chapter and services of an anesthetist, as defined in § 410.69 of this chapter) for which the beneficiary is entitled to have payment made under Medicare; and

* * * * *

(Catalog of Federal Domestic Assistance Programs No. 93.773, Medicare—Hospital Insurance; and No. 93.774, Medicare—Supplementary Medical Insurance)

Dated: March 24, 1991.

Gail R. Wilensky,

Administrator, Health Care Financing Administration.

Approved: September 24, 1991.

Louis W. Sullivan,

Secretary.

Editorial Note: This document was received by the Office of the Federal Register on July 14, 1992.

[FR Doc. 92–16943 Filed 7–30–92; 8:45 am]

BILLING CODE 4120–01–M

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 215

[Docket No. 920526–2126]

Marine Mammals; Fur Seal Act Regulations

AGENCY: National Marine Fisheries Service (NMFS), NOAA, Commerce.

ACTION: Final rule.

SUMMARY: This rule eliminates the option, currently available in the Fur Seal Act regulations, for the Secretary to extend the subsistence harvest of fur seals on the Pribilof Islands beyond August 8 each year. The option is being eliminated to provide protection for female fur seals, which begin arriving on the beaches of the Pribilof Islands after the first week in August. This rule also changes the earliest possible start date of the subsistence harvest from June 30 to June 23. This change is made at the request of the Pribilof Aleuts to provide an additional week of potential harvesting in the face of the removal of the extension option.

EFFECTIVE DATE: July 31, 1992.

FOR FURTHER INFORMATION CONTACT: Michael Payne, Office of Protected Resources, NMFS, 1335 East-West Highway, Silver Spring, MD 20910 at 301–713–2332.

SUPPLEMENTARY INFORMATION: The northern fur seal (*Callorhinus ursinus*) population is considered depleted under the Marine Mammal Protection Act (MMPA) (51 FR 47156, December 30, 1986). The subsistence harvest of northern fur seals on the Pribilof Islands, Alaska, is governed by regulations found in 50 CFR part 215 subpart D—Taking for Subsistence Purposes. These regulations were published under the authority of the Fur Seal Act, 15 U.S.C. 1151 *et seq.*, and the MMPA, 16 U.S.C. 1316 *et seq.* (at 51 FR 24828, July 9, 1986). The purpose of these regulations is to limit the take of fur seals to a level providing for the subsistence needs of the Pribilof Islands communities of St. Paul and St. George using humane harvesting methods. The subsistence harvest has been regulated to minimize negative effects on the population by limiting the harvest to a 40-day harvest season (June 30–August 8) and limiting the age and sex of seals to be harvested to sub-adult males. The August 8 deadline was chosen to avoid an unacceptable taking of female fur seals. In early August, immature female seals begin arriving at the rookeries in large numbers and the immature females and males, which are not easily distinguished, become intermixed.

The Assistant Administrator for Fisheries, NOAA (Assistant Administrator, is required to terminate the harvest when it is determined that the subsistence demands of the Pribilof Aleuts have been met, or on August 8 of each year, whichever comes first. However, the regulations also establish criteria for extending the harvest period if the subsistence needs of the Pribilof Aleuts have not been met. Section 215.32(f)(2) authorized the Assistant Administrator to extend the harvest period until September 30 if, by August 8, the subsistence needs of the Pribilof Aleuts were not fulfilled, and the number of female seals taken during the harvest is low. With regard to the latter requirement, two standards of unacceptable levels of female take trigger termination of any harvest extension:

(1) If the total number of female seals taken during the harvest exceeds one half of one percent of the total number of seals taken; and

(2) If, during the extension period, five female seals are taken within 7 consecutive days.

Background

Between 1985 and 1991, extensions to the harvest season were requested and granted in 1986 and 1987. Extension of the harvest beyond the first week of August has resulted in an increase in the number of female seals taken. The harvest was suspended following the first day of the extension each time an extension was granted because of the unacceptable number of female seals taken. In response to the level of females taken during each of the extended harvest periods, NMFS announced its intent to amend 50 CFR 215.32(f) to eliminate the extension option for 1989 and subsequent years (53 FR 28887, August 1, 1988), although no further action was taken by NMFS at that time.

Following the August 1, 1988, notice by NMFS, the Aleut Community of St. Paul Island requested a change in the Fur Seal Act regulations to allow the subsistence harvest to begin June 23, 1 week earlier than the June 30 start date dictated by 50 CFR 215.32(c)(1). They cited a desire for seal meat by community members before June 30, a lack of meat remaining from the previous year's take, and the possible inability to harvest their quota of seals in the absence of the harvest extension option.

On June 3, 1991, NMFS published a proposed rule to eliminate the extension option and to begin the harvest 1 week earlier (on June 23 instead of June 30) (56 FR 25066). Because only sub-adult males dominate the harvest areas at that time, and all other mandatory controls upon the harvest still apply, no adverse impact on the seal population as a result of starting the harvest 1 week earlier is anticipated by NMFS. Because of the apparent inability of harvesters to distinguish subadult males from females despite best efforts, and because of the increased probability and demonstrated risk of taking females after August 8, NMFS proposed to eliminate the harvest extension option (50 CFR 215.32(f)(2)) of the Assistant Administrator (56 FR 25066, June 3, 1991).

This final rule adopts all changes proposed on June 3, 1991 (at 56 FR 25066).

Response to Comments

Comments on the proposed rule were to be postmarked on or before July 18, 1991. NMFS received one set of comments on this proposed rulemaking. That commenter agreed with NMFS proposal to eliminate the harvest extension option, but disagreed with NMFS suggestion of allowing the harvest to begin 1 week earlier. The commenter pointed to NMFS' own statements in the **Federal Register** notice announcing the emergency final rule to regulate the subsistence fur seal harvest to support its argument against an earlier start date.

In the July 9, 1986, **Federal Register** notice, NMFS explained its decision to open the harvest no earlier than June 30 by stating that an earlier start date would: (1) Focus harvesting on the wrong age group, (2) disrupt research data collection, and (3) be more costly to monitor (51 FR 24836). At that time, NMFS also observed that very few harvestable seals are present in the haul-out areas prior to the end of June; therefore, an earlier start date would not significantly increase the availability of seal meat.

The commenter felt that the reasons now advanced by NMFS to justify the earlier start date (the Pribilof Aleuts desire for seal meat before June 30, the inability to harvest the number of seals needed during the limited season, and the lack of meat left from the previous years harvest) were inadequate. In response to NMFS reasoning, the commenter responded that the record reflects that the fur seal harvest frequently does not begin until the 2nd week of July, and, pointing to the 1991 harvest as an example, the restricted time frame of the harvest has not been an obstacle to obtaining enough seals.

NMFS acknowledges both of these comments. Although the harvest has not started until well into July on some occasions, it must be understood that the subsistence harvest on the Pribilofs is conducted entirely by experienced volunteers. Because of this, it can be difficult to coordinate harvest personnel, equipment and weather conditions precisely on June 30 every year. On several occasions the start of the seal harvest season has coincided with halibut season and various construction projects, both of which otherwise employed many of the experienced sealers, making them unavailable for certain periods of time. Establishing the start date for the seal harvest 1 week earlier would merely make additional time available to conduct the harvest, it would of course not guarantee that all other factors would cooperate to allow the harvest to actually begin on June 23.

It is true that an earlier harvest start date would generally allow the taking of older animals, but the seals present in the haul-out areas by mid-June (3-and 4-year-old males) are still within the harvestable category of sub-adult males. And, although it is also true that an earlier start date will not significantly increase the availability of seal meat to the Pribilovians, even the small amounts that could be obtained would provide an important source of fresh meat, especially since by June there is generally little meat left from the previous year's harvest.

In the July 9, 1986, notice (51 FR 24828), NMFS did state that beginning the harvest before June 30 would increase the costs of monitoring, especially given the potential for harvest extensions requiring NMFS personnel to be present on the island for longer periods of time and perhaps having to make return trips to the islands to accommodate the additional harvesting. However, with the removal of the harvest extension option, NMFS believes the costs should approximately balance.

NMFS also established the June 30 start date in 1986 after considering the effect earlier harvesting would have on some continuing harvest research data collection taking place on the islands. However, the data now collected from the harvested animals is different from that collected during the commercial harvest and, as a result, this is no longer a valid concern.

Classification

For reasons discussed in previous environmental impact statements (EIS), it is hereby determined that the approval and implementation of this rule will not significantly affect the human environment, and that preparation of an EIS on this action is not required by section 102(2) of the National Environmental Policy Act or its implementing regulations.

The Under Secretary for Oceans and Atmosphere has determined that this rule is not a "major rule" requiring a regulatory impact analysis under Executive Order 12291. The present action will not have a cumulative effect on the economy of $100 million or more, nor will it result in a major increase in costs to consumers, industries, government agencies, or geographical regions. No significant adverse effects on competition, employment, investments, productivity, innovation, or competitiveness of U.S.-based enterprises are anticipated.

The General Counsel, Department of Commerce, certified to the Chief Counsel for Advocacy of the Small Business Administration that this proposed rule, if adopted, will not have a significant economic impact on a substantial number of small entities. The only impact will be on individual native Alaskan residents of the Pribilof Islands in the form of a revised schedule for the annual fur seal harvest. Therefore, a regulatory flexibility analysis was not prepared.

This rule does not contain a collection of information requirement subject to the Paperwork Reduction Act.

This final rule does not contain policies with Federalism implications sufficient to warrant preparation of a Federalism assessment under Executive Order 12612.

List of Subjects in 50 CFR Part 215

Administrative practice and procedure, Marine mammals, Penalties, Pribilof Islands, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, 50 CFR part 215 is amended as follows:

PART 215—PRIBILOF ISLANDS

1. The authority citation for 50 CFR part 215 continues to read as follows:

Authority: 16 U.S.C. 1151–1175, 16 U.S.C. 1361–1384.

2. Section 215.32 is amended by removing paragraph (f)(2) and redesignating paragraph (f)(1) as paragraph (f), and by revising paragraph (c)(1) to read as follows:

§ 215.32 Restrictions on taking.

* * * * *

(c)(1) No fur seal may be taken on the Pribilof Islands before June 23 of each year.

* * * * *

Dated: July 24, 1992.

Samuel W. McKeen,

Program Management Officer.

[FR Doc. 92–18063 Filed 7–30–92; 8:45 am]

BILLING CODE 3510-22-M

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50 CFR Part 672

[Docket No. 911176–2018]

Groundfish of the Gulf of Alaska

AGENCY: National Marine Fisheries Service (NMFS), NOAA, Commerce.

ACTION: Prohibition of retention.

SUMMARY: NMFS is prohibiting retention of sablefish for vessels using hook-and-line gear in the West Yakutat District of the Gulf of Alaska (GOA) and is requiring that catches of sablefish be treated in the same manner as prohibited species and discarded. This action is necessary because the share of the sablefish total allowable catch (TAC) assigned to hook-and-line gear in the West Yakutat District has been reached.

EFFECTIVE DATE: 12 noon, Alaska local time (A.l.t.), July 27, 1992, through 12 midnight, A.l.t., December 31, 1992.

FOR FURTHER INFORMATION CONTACT: Patsy A. Bearden, Resource Management Specialist, Fisheries Management Division, NMFS, (907) 586–7228.

SUPPLEMENTARY INFORMATION: The groundfish fishery in the U.S. GOA exclusive economic zone is managed by the Secretary of Commerce according to the Fishery Management Plan for Groundfish of the Gulf of Alaska (FMP) prepared by the North Pacific Fishery Management Council under authority of the Magnuson Fishery Conservation and Management Act. Fishing by U.S. vessels is governed by regulations implementing the FMP at 50 CFR parts 620 and 672.

The share of the sablefish TAC assigned to hook-and-line gear in the West Yakutat District was established by the final notice of specifications (57 FR 2844, January 24, 1992) as 3,553 metric tons.

The Director of the Alaska Region, NMFS, has determined that the share of the sablefish TAC assigned to hook-and-line gear in the West Yakutat District has been reached. Therefore, NMFS, in accordance with § 672.24(c)(3)(ii), is requiring that further catches of sablefish must be treated as a prohibited species by persons using that type of gear, effective from 12 noon, Alaska local time (A.l.t.), July 27, 1992, through 12 midnight, A.l.t., December 31, 1992.

Classification

This action is taken under 50 CFR 672.20 and is in compliance with Executive Order 12291.

List of Subjects in 50 CFR Part 672

Fisheries, Recordkeeping and reporting requirements.

Authority: 16 U.S.C. 1801 *et seq.*

Dated: July 27, 1992.

Joe P. Clem,

Acting Director of Office Fisheries Conservation and Management, National Marine Fisheries Service.

[FR Doc. 92–18052 Filed 7–27–92; 8:45 am]

BILLING CODE 3510-22-M

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50 CFR Parts 672 and 675

[Docket No. 920402–2102]

Groundfish of the Gulf of Alaska; Groundfish of the Bering Sea and Aleutian Islands Area

AGENCY: National Marine Fisheries Service (NMFS), NOAA, Commerce.

ACTION: Final rule.

SUMMARY: NMFS issues a final rule prohibiting federally permitted U.S. vessels from fishing in the international waters of the Central Bering Sea in an area called the "Donut Hole" and from retaining on board fish harvested from the Donut Hole as long as that vessel is in the exclusive economic zone (EEZ) of the Bering Sea and Aleutian Islands (BSAI) and the Gulf of Alaska (GOA). This rulemaking is necessary to reduce the further exploitation of the Aleutian Basin pollock stock (*Theragra chalcogramma*), which is found in both the Donut Hole and in the EEZ. The rulemaking will:

(1) Promote the goals and objectives of the North Pacific pollock stocks off Alaska; and

(2) Further U.S. efforts regarding the negotiations with Japan, Poland, China, Korea, and the Russian Republic to establish an international conservation regime on the living resources of the Central Bering Sea.

EFFECTIVE DATE: August 14, 1992.

FOR FURTHER INFORMATION CONTACT: Steven Pennoyer, Regional Director, National Marine Fisheries Service, Alaska Region, P.O. Box 21668, Juneau, AK 99802, telephone 907–586–7221.

SUPPLEMENTARY INFORMATION: The domestic and foreign ground fish fisheries in the EEZ of the GOA and the BSAI are managed by the Secretary of Commerce (Secretary) according to the Fishery Management Plans (FMPs) for Groundfish of the GOA and the BSAI. These FMPs were prepared by the Council under the authority of the Magnuson Fishery Conservation and Management Act (Magnuson Act; 16 U.S.C. *et seq.*) and are implemented by regulations at 50 CFR parts 611, 620, 672 and 675.

Two measures are implemented by this final rule. First, §§ 672.4 and 675.4, which govern the issuance of Federal fishing permits, are amended by prohibiting fishing in the Donut Hole by a federally permitted fishing vessel. Second, §§ 672.7 and 675.7, which govern general prohibitions, are amended to prohibit the entry of a U.S. fishing vessel into the EEZ if that vessel has fished in, or has on board any fish harvested from, the Donut Hole.

U.S. fishermen, who displaced foreign fleets of those nations that had a traditional fishery presence in the EEZ off Alaska, now fully utilize the groundfish resources of the EEZ off Alaska. Foreign fishermen have redirected their fishing effort to other fishing grounds, specifically the Donut Hole, and likely other such waters. By the mid-1980's, catches in the Donut Hole were reported to exceed catches in both the U.S. EEZ or the economic zone (EZ) of Russia. (Table 1).

TABLE 1.—REPORTED POLLOCK CATCHES IN THE DONUT HOLE AND IN THE U.S. EEZ AND THE EZ OF RUSSIA

[1,000s metric tons (mt)]

Year	Donut Hole	U.S. EEZ	Russian Federation
1985	336	1,179	662
1986	1,061	1,189	871