hydroprene, (R)-hydroprene, and (S)-
hydroprene, are racemic and the gas
chromatography column is nonchiral.
Racemic isomers will not be separated
by a nonchiral analytical method, and
both will appear as one
chromatographic peak. Further, because
the proposed label use rate of (S)-
hydroprene in food-handling
establishments is approximately one
half of the use rate proposed for
hydroprene, the residue data performed
on hydroprene is applicable to
(S)-hydroprene.

The dietary risk assessment was
performed utilizing a Reference Dose
(RfD) of 0.02 mg/kg body weight/day
and the 0.2 ppm value derived from the
highest value from actual residue trials,
0.14 ppm, as the assumed level in food.

The RfD was based on a No
Observable Effects Level (NOEL) of 15
mg/kg/day (derived from the (S)-
hydroprene two-generation reproduction
study in rats in which parental,
reproductive, and developmental
toxicity were observed) and an
uncertainty factor of 1,000. The RfD was
determined to apply both to (S)-
hydroprene and hydroprene. This
determination was based on data
available to the Agency which indicated
that the (S)-isomer was generally more
toxic than racemlc hydroprene
containing both the (S)- and the (R)-
isomers.

For the general U.S. population (48
States), exposure to hydroprene was
estimated to be 0.005439 mg/kg body
weight/day or approximately 27 percent
of the RfD. The highest estimated
exposure for any of the subpopulations
analyzed was 0.020941 mg/kg body
weight/day for nonnursing infants, or
approximately 105 percent of the RfD.
These exposure estimates are known to be
significantly overstated because it was
assumed that all food consumed by
an individual came from food-handling
establishments, all food-handling
establishments use hydroprene or (S)-
hydroprene at maximum use rates, and
all food contains hydroprene or (S)-
hydroprene at a level (0.2 ppm) which is
greater than any actual level obtained in
residue trials designed to measure
maximum possible residues.

Based on the information cited above,
the Agency has determined that the use of
hydroprene or (S)-hydroprene under
the conditions of this regulation will be
safe and will protect the public health.
The pesticide is considered useful for
the purpose for which the tolerance is
sought and capable of achieving the
intended physical or technical effect.
Therefore, the tolerance is established
as set forth below.

Any person adversely affected by this
regulation may, within 30 days after the
date of publication of this document in
the Federal Register, file written
objections and/or a request for a
hearing with the Hearing Clerk at the
address given above. 40 CFR
178.20. The objections submitted must specify the
provisions of the regulation deemed
objectionable and the grounds for the
objections. 40 CFR 178.25. Each
objection must be accompanied by the
fee prescribed by 40 CFR
180.33(f). If a
hearing is requested, the objections must
include a statement of the factual
issue(s) on which a hearing is requested,
and a summary of any evidence
relied upon by the objector. 40 CFR
178.27. A request for a hearing will be
granted if the Administrator determines
that the material submitted shows the
following: there is a genuine and
substantial issue of fact; there is a
reasonable possibility that available
evidence identified by the requestor
would, if established, resolve one or
more of such issues in favor of the
requestor, taking into account
uncontested claims or facts to the
contrary; and resolution of the factual
issue(s) in the manner sought by the
requestor would be adequate to justify
the action requested. 40 CFR 178.32.

The Office of Management and Budget
has exempted this rule from the
requirements of section 3 of Executive
Order 12291. Pursuant to the
requirements of the Regulatory
1164, 5 U.S.C. 601-612), the
Administrator has determined that
regulations establishing new tolerances
or food additive regulations or raising
tolerance levels or food additive
regulations or establishing exemptions
from tolerance requirements do not have
a significant economic impact on a
substantial number of small entities. A
certification statement to this effect was
published in the Federal Register on
May 4, 1981 (40 FR 24550).

Dated: July 30, 1992.

Douglas D. Canty,
Director, Office of Pesticide Programs.

Therefore, 40 CFR part 185 is amended
as follows:

PART 185—(AMENDED)

The authority citation for part 185 is
revised to read as follows:


2. By adding new § 185.3825, to read as follows:

§ 185.3825 Hydroprene; tolerances for
residues.

A tolerance of 0.2 part per million is
established for combined residues of
both racemic components of
hydroprene, namely [(R)-(Ethyl (2E,4E)-
3,7,11-trimethyl-2,4-dodecadienoate)]
and [(S)-(Ethyl (2E,4E)-3,7,11-trimethyl-
2,4-dodecadienoate)] on all food items in
food-handling establishments in
accordance with the following
prescribed conditions:

(a) Application shall be limited solely to
spot or crack and crevice treatment in
food-handling establishments, including
food service, manufacturing, and
processing establishments such as
restaurants, cafeterias, supermarkets,
bakeries, breweries, dairies, meat
slaughtering and packing plants, and
canneries where food and food products
are held, processed, and served:
Provided, that the food is removed or
covered prior to such use, and food-
processing surfaces are covered during
treatment or thoroughly cleaned before
using.

(b) To assure safe use of the insect
growth regulator, its label and labeling
shall conform to that registered by the
U.S. Environmental Protection Agency,
and it shall be used in accordance with
such label and labeling.

[FR Doc. 92-19215 Filed 8-11-92; 8:45 am]

DEPARTMENT OF HEALTH AND
HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 405, 406, 409, 410, 411,
412, 413, 418, and 489

[RIN 0938-AF27]

Medicare Program; Self-Implementing
Coverage and PaymentsProvisions:
1990 Legislation

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

ACTION: Final rule with comment period.

SUMMARY: This rule updates Medicare
regulations to add or conform them to
certain self-implementing provisions on
coverage of services and payment
requirements under the Omnibus Budget
Reconciliation Act of 1990 (OBRA '90).
OBRA '90 was enacted November 5,
1990 and the cited changes to the statute
are already in effect. Certain related
self-implementing provisions of the
Omnibus Budget Reconciliation Act of
1990 (OBRA '89), and the Medicare
Catastrophic Coverage Act (MCCA) of 1988, are included as necessary for consistency and clarity of the OBRA '90 provisions.

DATES: Effective date: These regulations are effective September 11, 1992.

Comment period: Comments will be considered if we receive them at the appropriate address, as provided below, no later than 5 p.m. on October 13, 1992.

ADDRESSES: Address comments in writing to: Health Care Financing Administration, Department of Health and Human Services, Attention: BPD-725-FC, P.O. Box 20076, Baltimore, Maryland 21207.

Please address a copy of comments on information collection requirements to: Office of Information and Regulatory Affairs, Attention: Allison Herron Eydt, Office of Management and Budget, Room 3208, New Executive Office Bldg., Washington, DC 20503.

If you prefer, you may deliver your comments to one of the following locations:

Room 309-C, Hubert H. Humphrey Bldg., 200 Independence Ave., SW., Washington, DC 20501

or

Room 132, East High Rise Bldg., 6325 Security Boulevard, Baltimore, MD.

Due to staffing resource limitations, we cannot accept audio, video, or facsimile (FAX) copies of comments.

In commenting, please refer to file code BPD-725-FC. Comments will be available for public inspection as they are received, beginning approximately 3 weeks after publication, in room 309-C of the Departmental offices at 200 Independence Ave., SE., Washington, DC, on Monday through Friday of each week from 8:30 a.m. to 5 p.m. (202-245-7890).

FOR FURTHER INFORMATION CONTACT: Sue B. Brown, (410) 966-4658.

SUPPLEMENTARY INFORMATION:

I. Background

On November 5, 1990, Congress enacted the Omnibus Budget Reconciliation Act of 1990 (OBRA '90), Public Law 101-508. This law contains numerous provisions relating to coverage of services and payments for services furnished to Medicare beneficiaries. Some of these provisions are self-implementing—that is, the provisions are stated in terms that neither require nor permit exercise of discretion in implementing them. Under these circumstances the plain wording of the law causes a conflict with the provisions of several of our existing regulations or causes them to be incomplete. We are, therefore, making the necessary changes to incorporate the self-implementing provisions identified below in the Code of Federal Regulations.

In some cases, before we can amend our rules to reflect the OBRA '90 requirements, it is necessary for us also to incorporate certain self-implementing provisions of the Omnibus Budget Reconciliation Act of 1989 (OBRA '89), Public Law 101-239, and the Medicare Catastrophic Coverage Act of 1988 (MCCA), Public Law 100-360 (in cases where the provisions were not repealed by the Medicare Catastrophic Coverage Repeal Act of 1989 (MCCRA), Pub. L. 101-234) that have been further amended by OBRA '90. A discussion of the individual legislative provisions and the accompanying Federal regulation changes follows.

II. Capital-Related Inpatient Hospital Costs

A. Legislative Provision

Section 1886(g)(3) of the Social Security Act (the Act) provides for certain reductions to capital-related costs of inpatient hospital services of hospitals that are defined in section 1886(d). Section 6002 of OBRA '89 mandated a reduction by 15 percent of payments for capital-related costs of inpatient hospital services identified under section 1886(d) attributable to portions of cost reporting periods or discharges occurring during the period beginning January 1, 1990 and ending September 30, 1990. Section 4001(a) of OBRA '90 extended the 15-percent reduction applicable to prospective payment hospitals to September 30, 1991. These provisions were incorporated into the regulations at § 412.113 in a document issued on August 30, 1991 (56 FR 43448).

B. Changes in the Regulations

Because we had not published the OBRA '89 reductions provisions in the Code of Federal Regulations, we are amending § 413.130 by adding a new paragraph (j) to incorporate both the OBRA '89 and OBRA '90 provisions in the Medicare regulations.

IV. Non-Capital Related Outpatient Hospital Costs

A. Legislative Provision

Section 4151(b) of OBRA '90 amended section 1861(v)(1)(S) of the Social Security Act to add a new subsection (j) to incorporate both the OBRA '89 and OBRA '90 provisions in a new § 413.124.

B. Changes in the Regulations

We have incorporated the OBRA '90 provision in a new § 413.124.

V. Payment for Physician Pathology Services

A. Legislative Provision

Section 4104 of OBRA '90 amended section 1834(f) of the Social Security Act to provide that the prevailing charge for the professional component of physician pathology services furnished during 1991 is reduced 7 percent below the April 1, 1990 prevailing charge.

Section 4104 also
provides that the prevailing charge for a global physician pathology service furnished through an independent laboratory during 1991 is reduced by up to 7 percent from the applicable prevailing charge for the global physician pathology service furnished by independent laboratories on or after April 1, 1990. The reduction cannot result in a prevailing charge that is less than 115 percent of the professional component prevailing charge for physician pathology services. Section 4104 repeals the provision under section 4050 of OBRA '87 that required HCFA to conduct a study on a relative value scale for physician pathology services.

B. Changes in the Regulations

We have incorporated the provisions of section 4104 of OBRA '90 in § 405.556 of the Medicare regulations. A listing of the physician pathology codes that are being reduced as a result of the provisions of section 4104 has been incorporated in section 40318.2 of the Medicare Carrier's Manual.

VI. Payment for Services of Physicians as Assistants-at-Surgery

A. Legislative Provision

Section 4107(a)(1) of OBRA '90 amended section 1848(i) of the Social Security Act to provide that in the case of a surgical service furnished by a physician, if payment is made separately for the services of a physician serving as an assistant-at-surgery, the fee schedule amount may not exceed 16 percent of the fee schedule amount otherwise determined for the global surgical service involved. (Section 4107(a)(2) specifies that in applying the amendment made under section 4107(a)(1) in 1991, the prevailing charge is substituted for the fee schedule amount.) However, payment is precluded for the services of assistants-at-surgery for procedures that have been determined by the Secretary to involve the services of assistants-at-surgery on average in less than 5 percent of such procedures nationally. (HCFA has published a list of the surgical procedures that are subject to this prohibition under section 6639 of the Medicare Carrier's Manual, appendix A.)

In determining the procedures that are subject to this provision, we used the 1989 Part B Medicare Annual Data (BMAD) procedure file. The OBRA '90 language specifies that we use "... the most recent data available ..." and the 1989 BMAD data are the most recent data available. For every surgical procedure code, we compared the total number of surgical procedures done with the number of times an assistant-at-surgery was shown. If the number of times an assistant-at-surgery was shown was less than 5 percent of the total surgeries performed, it was placed on the list for prohibition of payment for the assistant-at-surgery. We had received comments from various physicians informing us that some procedures that we had identified as having less than 5 percent performed by assistants-at-surgery were almost always done with an assistant-at-surgery, but that since they were performed in teaching hospitals, the assistants-at-surgery were usually residents or interns and no Medicare Part B claims were made for their services. Residents and interns do not bill Part B for their services as assistants-at-surgery. We do not believe Congress intended to count interns and residents as physicians for purposes of the 5 percent threshold. Moreover, we would note that section 4107(b)(3) of OBRA '90 states that no payment may be made under Part B for services of an assistant-at-surgery when the national average percentage of such procedures "performed under this part" involving the use of a physician as an assistant-at-surgery is less than 5 percent. The phrase "under this part" refers to part B. Since the services of interns and residents are almost always part A services and are not part B physicians' services, they would not be counted for purposes of the assistants-at-surgery provision in most cases. We would modify our list of services if data were presented to show that interns and/or residents provide assistant-at-surgery services on an outpatient (part B) basis and would increase the percent to 5 percent or more nationally. We also have received some questions about the relationship of section 4107 of OBRA '90 to section 1848(i)(2)(B) of the Social Security Act. As noted above, section 4107 of OBRA '90 enacted a new section 1848(i)(2)(B) of the Social Security Act, which requires that we deny payment for the services of an assistant-at-surgery in connection with a surgical procedure that involves the use of a physician as an assistant-at-surgery less than 5 percent of the time. Section 1862(a)(15) of the Act provides that services of an assistant-at-surgery in a cataract operation are excluded from Medicare coverage unless a Peer Review Organization (PRO) gives prior approval. Thus, section 1862(a)(15) would permit a PRO to give prior approval only in those cases to which section 1848(i)(2)(B) is not applicable. This is confirmed by section 4107(b)(3) of OBRA '90, which amended section 1882(a)(15) of the Act specifically to exclude from Medicare coverage those "services of an assistant-at-surgery to which section 1848(i)(2)(B) applies.”

B. Changes in the Regulations

We have revised § 405.502 of the Medicare regulations to incorporate the amendments made by section 4107 of OBRA '90.

VII. Payments for Ambulatory Surgical Procedures in Hospital Outpatient Departments

A. Legislative Provision

Section 4151(c)(1)(A) of OBRA '90 amended section 1833(ii)(3)(B)(ii) of the Social Security Act to change the payment rate for ambulatory surgical center (ASC) procedures performed in an outpatient hospital department. Section 4151(c) modified both the cost and ASC proportions of the blended payment amount from a blend based on 50 percent cost and 50 percent ASC payment rates to a blend based on 42 percent cost and 58 percent ASC payment rates. This change is effective for portions of cost reporting periods beginning on or after January 1, 1991.

Section 4151(c)(1)(B) of OBRA '90 extended the effective date for qualified eye and ear specialty hospitals to receive an ASC blended payment based on 75 percent of the hospital-specific amount and 25 percent of the ASC payment amount. This section extends the benefit of the 75/25 blended payment amount to qualifying eye and ear specialty hospitals beyond the previous September 30, 1990 cut-off date to cost reporting periods beginning before January 1, 1995.

B. Changes in the Regulations

We have incorporated these two OBRA '90 changes under § 413.118(d) of the Medicare regulations.

IX. Payments for Radiology Services Performed in Hospital Outpatient Departments

A. Legislative Provision

Section 4151(c)(2) of OBRA '90 amended section 1833(n)(1)(B)(ii) of the Social Security Act to change the payment rate for radiology services performed in a hospital outpatient department. Section 4151(c)(2) modified both the cost and fee schedule proportions of the blended payment amount from a blend based on 50 percent cost and 50 percent fee schedule to a blend based on 42 percent cost and 58 percent fee schedule amount. This change is effective for portions of cost
B. Changes in the Regulations

We have revised §413.122 of the Medicare regulations to incorporate the changes made by section 4151(c)(2) of OBRA '90.

IX. Hospice Benefit Extension

A. Legislative Provision

Section 4006 of OBRA '90 reinstates an extension of hospice benefits that was included originally under MCCA, and repealed by MCCRA. Section 4006 of OBRA '90 amends sections 1812(a)(4), (d)(1) and (d)(2)(B), and section 1614(a)(7)(A)(i) and (ii) of the Social Security Act, and adds a new section 1614(a)(7)(A)(iii) to the Social Security Act to provide for a subsequent extension period of coverage for hospice care beyond the 210-day limit (that is, two 90-day periods and one subsequent 30-day period) during the individual's lifetime. To be eligible for this additional subsequent extension period, the beneficiary must be recertified as terminally ill by the medical director or the physician member of the interdisciplinary group of the hospice at the beginning of the period.

The amendments made by section 4006 apply to care and services furnished on or after January 1, 1990.

B. Changes in the Regulations

We have amended §§401.1, 401.21, and 418.22 of the Medicare regulations to incorporate the legislative changes under section 4006 of OBRA '90.

X. Enrollment of HMO Members in Medicare Part A

A. Legislative Provision

Section 4008(g) of OBRA '90 amended section 1818(c) of the Social Security Act by adding new paragraphs (7) through (9) to provide for a transfer enrollment period for part B-only beneficiaries who are members of Medicare-contracting health maintenance organizations (HMOs) and competitive medical plans (CMPs) to enroll in premium hospital insurance under Medicare part A. The transfer enrollment period is defined as a period that begins in any month during which the individual is enrolled in a Medicare-contracting HMO or CMP and ends with the last day of the 8th consecutive month in which the individual is no longer enrolled in the HMO or CMP. Previously, these individuals were limited to the general enrollment period or a special enrollment period. This sometimes meant a lengthy delay in the start of premium Medicare part A coverage or an increase in the part A premium when they disenrolled from the HMO or CMP. If the individual enrolls in premium hospital insurance while still enrolled in an HMO or CMP or during the first month when no longer enrolled in the HMO or CMP, part A coverage will begin on the first day of the month of hospital insurance enrollment, or at the option of the individual, on the first day of any of the following 3 months. If the individual enrolls in premium hospital insurance during any of the last 7 months of the transfer enrollment period, coverage will begin on the first day of the month after the month of hospital insurance enrollment.

The amendments made by section 4008(g) of OBRA '90 are effective on February 1, 1991.

B. Changes in the Regulations

We have amended §§406.21 and 406.33 of the Medicare regulations to incorporate the provisions of section 4008(g) of OBRA '90.

In addition, we have incorporated in §406.22 a self-implementing provision of section 103 of MCCA. Section 103 of MCCA amended section 1818(d) of the Social Security Act to provide a new formula for computing the basic premium amount for premium hospital insurance of Medicare part A.

XI. Coverage of Ostomy Supplies

A. Legislative Provision

Section 6112(e)(3) of OBRA '89 amended section 1866(a)(1) of the Social Security Act to add a paragraph (P) to section 6112(e)(3) of OBRA '89 amended sections 1861(s)(8) and 1834(a)(13) to provide for coverage of certain "ostomy supplies" as part of home health medical supplies furnished to Medicare beneficiaries. Section 4153(d) of OBRA '90 further amended section 1866(a)(1) as added by OBRA '89, to expand the term "ostomy supplies" to include specifically catheters, catheter supplies, ostomy bags, and supplies related to ostomy care. The OBRA '90 amendment is effective as if included in OBRA '89— that is, it applies to items furnished on or after January 1, 1990.

B. Changes in the Regulations

We have incorporated the provisions of section 6112(e)(1) and (3) of OBRA '89 and section 4153(d) of OBRA '90 in 42 CFR 409.40 and 409.20. The provisions of section 6112(e)(2) of OBRA '89 are being developed in a separate package.

XII. Coverage of Post-Cataract Eyeglasses

A. Legislative Provision

Section 4153(b)(2)(A) of OBRA '90 amended section 1861(b)(9) of the Social Security Act to provide for Medicare part B coverage of one pair of conventional eyeglasses or conventional contact lenses furnished subsequent to each cataract surgery with insertion of an intraocular lens. In addition, section 4153(b)(2)(B) of OBRA '90 amended section 1862(a)(7) of the Act to make a conforming amendment to the provision that specifies eyeglasses as an item excluded from Medicare part B coverage. Prior to the effective date of the OBRA '90 amendment, HCFA had covered conventional eyeglasses furnished to cataract patients after surgery as "prosthetic devices" under section 1861(e)(8) of the Social Security Act.

The amendments made by section 4153(b) of OBRA '90 apply to items furnished on or after January 1, 1991.

B. Changes in the Regulations

We have amended §410.36 on Coverage of Medical supplies, appliances, and devices and §411.15 on Specific services excluded from coverage to incorporate the provisions of sections 4153(b)(2) (A) and (B) of OBRA '90.

XIII. Application of Preentitlement Stay in Psychiatric Hospital To Limit on Payment for Inpatient Hospital Services

A. Legislative Provision

Section 4006(m)(1) of OBRA '90 amended section 101(b)(3)(B) of MCCA to provide that the preentitlement psychiatric limitations are applicable to an individual at the end of 1989 must carry over into 1990.

Under section 1612 of the Act, a Medicare beneficiary is entitled to have part A payments made on his or her behalf for no more than 150 days of inpatient hospital services in a spell of illness. Of these 150 days, 90 are regular benefit days that can be renewed with each new spell of illness, and 60 are lifetime reserve days that are not renewable. However, section 1612(c) of the Act establishes a special limit for certain inpatient mental health services (i.e., inpatient psychiatric hospital services, and inpatient hospital services for an individual who is hospitalized in a general hospital primarily for diagnosis or treatment of mental illness) If an individual is an inpatient of a psychiatric hospital on the first day of his or her Medicare entitlement, part A payments may not be made for inpatient...
mental health services in excess of the following: 150 days minus the number (0 to 150) of days (not necessarily consecutive) in which the individual was an inpatient in a psychiatric hospital during the 150 days immediately preceding his or her first day of entitlement. This limitation is called the preentitlement psychiatric limitation. The pre-MCCA, MCCA, and post-MCCA versions of section 1812(c) were substantially the same.

Under the pre-MCCA provisions, this limitation would cease to apply at the end of the individual's first spell of illness (that is, after a period of 60 consecutive days in which the individual was not an inpatient of either a hospital or a nursing facility). Under the MCCA provisions, this limitation would cease to apply with the passage of 60 consecutive days in which the individual did not receive inpatient mental health services. Under post-MCCA, the pre-MCCA provisions governing the cessation of the limitation are reinstated.

While section 101 of MCCRA reinstated the provisions of section 1812 of the Act as in effect before MCCA, it also included special provisions for the transition from MCCA to these reinstated, post-MCCA provisions. Among these were the following: Under section 101(b)(1)(A), no day before January 1, 1990 may be counted in determining the beginning (or period) of a spell of illness in applying the limitations of section 1812 of the Act to services furnished after January 1, 1990. Under section 101(b)(1)(B), no days of services provided before January 1, 1990, except lifetime reserve days used before January 1, 1990, may be counted in applying the limitations of section 1812 on payment for inpatient hospital services in a spell of illness beginning on or after January 1, 1990.

The preentitlement psychiatric limitation in section 1812(c) of the Act limits payment for inpatient mental health services in a spell of illness. After the enactment of MCCRA, it appeared that if an individual became entitled to part A before 1990, was subject to the preentitlement limitation when he or she became so entitled, and, under the provisions in effect under MCCA, would have remained subject to the limitation on January 1, 1990, that individual would, nevertheless, under section 101(b)(1)(B) of MCCRA, be free of that limitation as of that date. That is because there was no provision in MCCA for carrying over into 1990 and later years either inpatient mental health services actually furnished before 1990 or preentitlement days in a psychiatric hospital treated as inpatient mental health services under section 1812 of the Act (whereas there was specific provision in MCCRA for carrying over lifetime reserve days used before 1989 into 1990 and later years).

The effect of this interpretation would have been to expand substantially the Medicare program's liability for payment for inpatient mental health services. In the Congressional discussion of the budgetary implications of MCCRA, however, no such expansion of benefits was mentioned. Therefore, we concluded that Congress did not intend to free from the preentitlement psychiatric limitation beneficiaries who became entitled before January 1, 1990 and remained subject to that limitation as of that date. In other words, Congress did not intend that the transition from MCCA to post-MCCA should affect the operation of the preentitlement limitation.

Thus, in interpreting MCCRA in the Medicare Intermediary Manual instructions, we provided that if any individual became entitled to part A before 1990 and, under the provisions in effect before 1990 would still be subject to the preentitlement psychiatric limitation on January 1, 1990, that individual would remain subject to the limitation during his or her first spell of illness beginning after 1989. However, this provision would not apply if the individual has 60 consecutive days, beginning in 1989 or on January 1, 1990, during which he or she does not receive inpatient mental health services before that spell of illness begins.

Similarly, those days of inpatient mental health services actually furnished before 1990 (and which are days for which payment may have been made) while the individual was subject to the preentitlement psychiatric limitation are counted in determining the extent to which payment may be made for inpatient mental health services furnished after 1989 to an individual who remains subject to that limitation. Those days of inpatient mental health benefits are not restored to the individual while he or she remains subject to the preentitlement psychiatric limitation during his or her first spell of illness beginning after 1989.

Congress ratified this interpretation through the enactment of section 4008(m)(1) of OBRA '90. Section 4008(m)(1) amended section 101(b)(1)(B) of MCCRA by providing that the prohibition against counting days of inpatient hospital services before 1990 in applying the limitation on payment after 1989 does not apply in the case of the limitation on payment under section 1812(c) of the Act, the preentitlement psychiatric limitation. This amendment is effective as though it were part of section 101(b)(1)(B) as enacted on December 19, 1988.

We note that under section 1812(b)(9) of the Social Security Act there is a lifetime limitation of 190 days on payment for inpatient psychiatric hospital services. This limitation was in effect under pre-MCCA and MCCA and remains in effect under post-MCCA. The limitation is separate and distinct from the preentitlement psychiatric limitation.

B. Changes in the Regulations

We have not made any changes in the Medicare regulations relating to the preentitlement psychiatric limitation to reflect the effect of MCCRA or the amendment made to section 101(b)(1)(B) of MCCRA by 4008(m)(1) of OBRA '90. No final regulations containing the preentitlement psychiatric limitation under MCCA were issued. Since the post-MCCA provisions revert to the pre-MCCA provisions, the existing pre-MCCA regulations at § 408.60 reflect the limitation currently in effect. We have issued to intermediaries instructions that reflect the transition from MCCA to post-MCCA as governed by the MCCRA and OBRA '90 provisions.

XIV. Payments to Dialysis Facilities

A. Legislative Provision

Hospitals and free-standing facilities are reimbursed for services furnished to Medicare beneficiaries with end-stage renal disease (ESRD) under a composite rate formula that is weighted to reflect the proportion of patients dialyzing at home and the proportion of patients dialyzing in a facility. Prior to OBRA '90, under the composite rate, the average payment was estimated at $125 per dialysis treatment in free-standing facilities and $129 per dialysis treatment in hospital units. OBRA '89 required the Secretary to maintain these composite rates through October 1, 1990 and prohibited the Secretary from changing the rates in effect as of September 30, 1990 unless such changes are made through notice and comment rulemaking.

Section 4201(a) of OBRA '90 amended section 6203(a)(1) of OBRA '89 to require the Secretary to maintain the composite rate in effect on September 30, 1990 for services provided on or after January 1, 1990. The composite rate determined under the formula prescribed under OBRA '89 continues until December 30, 1990.

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B. Changes in the Regulations

We have not made any specific in the Code of Federal Regulations to incorporate this provision. The composite rate determined under the formula and any conforming changes have been issued as part of the Medicare Provider Reimbursement Manual.

XV. Payment Rates for Erythropoietin (EPO)

A. Legislative Provision

Section 4201(c) of OBRA '90 amended section 1881(b)(11) of the Social Security Act to provide that an allowance for erythropoietin (EPO) furnished to ESRD patients by providers of services, renal dialysis facilities, and other suppliers of home dialysis supplies and equipment is $11 per 1,000 units, rounded to the nearest 100 units, effective January 1, 1991. (This amount may be increased by the Secretary for each year after 1991.)

Section 4201(d)(2) and (3) of OBRA '90 amended section 1881(b) to specify that payment to supplier of home dialysis supplies and equipment that is not a provider of services, a renal dialysis facility, or a physician will be made at the rate paid to a renal dialysis facility. Payment will be made if it has been determined, in accordance with methods and standards published by the Secretary, that the patient receiving EPO from the supplier can safely and effectively administer it. (HCFA will issue criteria for determining the safe and effective self-administration of EPO as a separate regulation.) If a home dialysis patient is determined not competent to self administer EPO and the drug has been prescribed and the patient must obtain EPO from his or her physician (i.e., the patient cannot obtain EPO from his or her facility), the drug should be administered by the physician who receives the Monthly Capitation Payment (MCP) for furnishing all of the renal related services that the beneficiary may need. In this case, Medicare pays on a reasonable charge basis for the drug, but no additional payment is made to the physician for administration.

B. Changes in the Regulations

We are not making any changes in the regulations at this time. The EPO payment rate is promulgated annually through separate regulations, as required by OBRA '90.

XVI. Medicare Secondary Payer Provision for Individuals With ESRD

A. Legislative Provision

Section 4203(c) of OBRA '90 amended section 1862(b)(1)(C) of the Social Security Act to redefine and to temporarily expand from 12 to 18 months the period during which Medicare is secondary payer for persons entitled to Medicare solely on the basis of end-stage renal disease. We call the period during which Medicare is secondary the "coordination period." Under prior law, Medicare was secondary during a coordination period from 9 to 12 consecutive months, depending upon whether eligibility was based on a kidney transplant or a course of dialysis.

The amendments made by OBRA '90 are as follows:

- Effective upon enactment, section 4203(c)(1)(A) permanently redefines the 12-month period of section 1862(b)(1)(C) as a period beginning with the individual's first month of Medicare Part A entitlement, or eligibility if earlier, based solely on end-stage renal disease.
- Anyone who is in a 12-month period, as defined under prior law, and for whom an employer plan therefore was paying primary on November 5, 1990 (the date of enactment), is affected by this change. Thus, this change does not apply to anyone who began dialysis prior to December 1989, because their 12-month period, under prior law, expired before the effective date of OBRA '90. This change makes Medicare the secondary payer, for entitled individuals, during a fixed period of 12 months, and the employer plan the primary payer during a period of between 12 and 15 months, depending upon whether Medicare eligibility was based on a kidney transplant or a course of dialysis.
- Section 4203(c)(1)(B) temporarily expands the modified 12-month period to 18 months, but only for those modified periods beginning on or after February 1, 1990. This means that this extension will apply to those individuals who, with one exception, become eligible for or entitled to Medicare Part A solely on the basis of end-stage renal disease or on February 1, 1990. The exception: Individuals who began dialysis in November 1989 were subject to a 3-month waiting period and became eligible for or entitled to Medicare on February 1, 1990. These individuals are not affected because their 12-month periods under prior law expired before the effective date of OBRA '90. This change is effective for items and services furnished on or after February 1, 1991 and on or before January 1, 1996.

Under OBRA '90, as under prior law, the period during which an employer plan is primary payer does not necessarily coincide with the period during which Medicare is secondary payer. Under prior law, an employer plan was primary payer for a period of 12 months. However, Medicare was usually secondary only for the last 9 months of this period because, in most cases, the individual was not entitled to Medicare during the first 3 months of this period. Under OBRA '90, it is the employer plan's primary payment responsibility which may vary up to 3 months.

Since Medicare entitlement usually begins with the fourth month of a regular course of maintenance dialysis, the employer group health plan may be primary payer for a period of up to 21 months (the 3-month waiting period plus the first 18 months of Medicare eligibility or entitlement). However, for individuals who undertake a course in self-dialysis training during the 3-month waiting period, the employer group health plan will be primary payer for a total of 18 months, because the effective date of Medicare eligibility or entitlement coincides with the first month of dialysis. Where an individual receives a kidney transplant during the 3-month waiting period, the employer group health plan will be primary payer from 18 to 20 months, depending upon when the individual became entitled or could have been entitled, to Medicare based upon the kidney transplant.

B. Changes in the Regulations

We have amended §§ 411.60 and 411.62 of the Medicare regulations to incorporate the amendment made by section 4203(c) of OBRA '90.

XVII. Prior Authorization Requirement for Certain Durable Medical Equipment

A. Legislative Provision

Section 1834(a) of the Social Security Act establishes payment rules for durable medical equipment, prosthetic devices, orthotics, and prosthetics. Section 4152(e) of OBRA '90 amended section 1834(a) to require that, effective January 1, 1991, items for which payment may be made under section 1834(a) and which are subject to unnecessary utilization must receive prior authorization from Medicare carriers. Section 4152(e) specifies that the Secretary shall develop and periodically update a list of these items on the basis of prior payment experience. The law further specifies that the list developed by the Secretary shall include seat-lift mechanisms,
transcutaneous electrical nerve stimulators, and motorized scooters. Carriers must determine in advance, for items included on the list, whether payment is precluded because of section 1862(a)(1)(A) of the Act. Section 1862(a)(1)(A) precludes payment for items that are not "reasonable and necessary" for the treatment of the patient.

B. Changes in the Regulations

We are not making any changes in the regulations at this time. The specific list of the items of durable medical equipment subject to prior authorization by Medicare carriers that the Secretary develops (and periodically updates) will be issued as a separate document. In the interim, in accordance with the provisions of section 4152(e) of OBRA '90, at a minimum, seat-lift mechanisms, transcutaneous electrical nerve stimulators, and motorized scooters must receive prior authorization by Medicare carriers before payments under Medicare will be made.

XVIII. Waiver of Proposed Rulemaking

We ordinarily publish a notice of proposed rulemaking for a regulation in the Federal Register to provide a period for public comment. However, we may waive that procedure if we find good cause that prior notice and comment are impractical, unnecessary, or contrary to the public interest.

As noted earlier, this rule updates our rules to properly reflect explicit statutory requirements which are clear on their face and which we are not interpreting in any way beyond their commonly understood meanings. Without these changes, certain regulation requirements are in conflict with the statute, possibly misleading those who rely on our regulations, and certain statutory requirements are not included, possibly leading some to infer that we will be proposing changes above those required by law. In addition, some of the statutory changes included in these regulations have been enacted with retroactive effective dates or effective dates close to the date of enactment of OBRA '90. Under these circumstances, prompt publication of the correct up-to-date rules best serves those governed by these regulations. In addition, section 4207(f) of OBRA '90 allows for a waiver of the notice of proposed rulemaking to implement these provisions. Therefore, we find good cause to waive the notice of proposed rulemaking prior to issuance of a final rule as impracticable, unnecessary and contrary to the public interest. However, we are providing a 60-day comment period for public comments on the final rule as indicated at the beginning of this rule.

XIX. Technical Amendments—Application of Blood Deductible Under Medicare Part A

Section 102(1) of the MCCRA amended section 1813(a)(2)(A) of the Act to make the part A blood deductible applicable on the basis of the calendar year rather than the "spell of illness," which in HCFA regulations is referred to as the "benefit period." According to section 101(a)(2) of MCCRA, MCCRA did not repeal the change made by section 102(1) of the MCCRA. Accordingly, we are amending §§ 409.87 and 489.31 to change "benefit period" to "calendar year."

XX. Response to Public Comments

Because of the large number of items of correspondence we normally receive on a rule, we are not able to acknowledge or respond to them individually. However, we will consider all comments that we receive by the date specified in the "Comment Period" section of this preamble and respond to them in the preamble to any subsequent rule that we issue.

XXI. Paperwork Burden

These final regulations with comment period do not contain any additional requirements that are subject to review by the Office of Management and Budget under the Paperwork Reduction Act of 1980 (44 U.S.C. chapter 35).

XXII. Regulatory Impact Statement

Executive Order (E.O.) 12291 requires us to prepare and publish a final regulatory impact analysis with comment for any regulations that meet the criteria of E.O. 12291 for a major rule or will have a significant effect on a substantial number of small entities. For the most part, the legislative provisions incorporated into our regulations by this final rule will provide some extended benefits to patients while incurring incremental costs to hospitals and physicians by reductions in payments previously noted in this preamble.

Section 4203(c)(1) of Public Law 101-506—the provision that amended section 1862(b)(1)(C) of the Act to expand the coordination period during which employer plans must pay benefits primary to Medicare—will result in significant Federal cost savings. The impact of this provision is discussed further below. We do not believe that merely reflecting this provision, which is already in effect, in our regulations will produce any effect that will meet any of the criteria of E.O. 12291 for a major rule or will have a significant effect on a substantial number of small entities. Therefore, we have not prepared a final regulatory impact statement under E.O. 12291 or a regulatory flexibility analysis under the RFA.

To the extent that a legislative provision being incorporated into our regulations by this final rule may have a significant effect on beneficiaries or providers or may be viewed as controversial, we are providing the following discussion:

Section 4008(g) of Public Law 101-506 added sections 1818(c)(7), (8), and (9) to the Act to provide an opportunity for aged individuals who were enrolled in HMOs and CMPs and lost that enrollment, to enroll in premium hospital coverage outside of the usual initial, general, and special enrollment periods. Since encouragement of HMO/CMP enrollment is essential to the goals of the Medicare program, any change that removes disincentives relating to...
enrollment in premium hospital insurance from beneficiaries who take advantage of HMO/CMP enrollment is salutary for both the beneficiaries and the Medicare program. Most beneficiaries are eligible for premium-free hospital insurance. However, the number of people taking advantage of the provision should be less than 100 a year. The impact on the program should, therefore, be minimal.

Section 4203(c)(1) of Public Law 101-508 amended section 1862(b)(1)(C) of the Act to expand the coordination period during which employer plans must pay benefits primary for Medicare. Previously, there was a 12-month coordination period, generally beginning with the first month of dialysis. Under the new law, there is an 18-month period, which begins with the first month of Medicare part A eligibility or entitlement. This change is effective for services furnished on or after February 1, 1991 through January 1, 1996, with respect to coordination periods beginning on or after February 1, 1990. After January 1, 1996, the 18-month period reverts to a 12-month period.

Medicare beneficiaries affected by this provision are individuals who are covered by employer group health plans and who also become eligible for or entitled to Medicare, based solely on ESRD, on or after February 1, 1990. Employers/group health plans must pay primary benefits for these individuals for an additional 6 to 9 months. Medicare part A and part B savings estimates are as follows:

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Section 4203(c)(2) of Public Law 101-508 charges the General Accounting Office (GAO) with studying the effects of the extension of the coordination period from 12 to 18 months on ESRD beneficiaries and their family members, including effects on access to employment and employment-based health insurance. GAO must submit a preliminary report to the House Committees on Ways and Means and Energy, and Commerce and the Senate Committee on Finance, not later than January 1, 1993, with a final report due by January 1, 1995.

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

We have determined that the final rule with comment period will not have a significant economic impact on the operations of a substantial number of small rural hospitals, and therefore, have not prepared a rural hospital impact statement.

List of Subjects

42 CFR Part 405
Administrative practice and procedure, Health facilities, Kidney disease, Laboratories, Medicare, Nursing homes, Reporting and recordkeeping requirements, Rural area, X-rays.

42 CFR Part 406
Health facilities, Kidney diseases, Medicare.

42 CFR Part 409
Health facilities, Medicare.

42 CFR Part 410
Health facilities, Health professions, Kidney diseases, Laboratories, Medicare, Rural areas, X-rays.

42 CFR Part 411
Kidney diseases, Medicare, Recovery against third parties, Reporting and recordkeeping requirements, Secondary payments.

42 CFR Part 412
Administrative practice and procedure, Health facilities, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

42 CFR Part 413
Health facilities, Kidney disease, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 418
Health facilities, Hospice care, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 419
Health facilities, Medicare, Reporting and recordkeeping requirements.

PART 405—FEDERAL HEALTH INSURANCE FOR THE AGED AND DISABLED

A. Part 405 is amended as follows:
1. The authority citation for part 405, subpart E, continues to read as follows:
Authority: Secs. 1102, 1814(b), 1832, 1933(a), 1934(b), 1842(b) and (h), 1801 (b) and (v), 1862(a)(14), 1806(a), 1871, 1881, 1886, 1887, and 1889 of the Social Security Act as amended (42 U.S.C. 1320, 1329f(b), 1395k, 1395l(a), 1395m(b), 1395a(b) and (h), 1395x(b) and (v), 1395y(a)(14), 1395cc(a), 1395hh, 1395rr, 1395sw, 1395xx, and 1395zz).

2. In § 405.502, the introductory text of paragraph (a) is republished and paragraph (a)(6) is revised to read as follows:
§ 405.502  Criteria for determining reasonable charges.
(a) Criteria. The law allows for flexibility in the determination of reasonable charges to accommodate reimbursement to the various ways in which health services are furnished and charged for. The criteria for determining what charges are reasonable include:
   * * * * *
(b) Except as provided in paragraph (a)(10) of this section, in the case of services of assistants-at-surgery as defined in § 405.580 in teaching and non-teaching settings, charges that are not more than 16 percent of the prevailing charge in the locality, adjusted by the economic index, for the surgical procedure performed by the primary surgeon. Payment is prohibited for the services of an assistant-at-surgery in surgical procedures for which HCFA has determined that assistants-at-surgery on
average are used in less than 5 percent of such procedures nationally.

3. Section 405.556 is amended by adding a new paragraph (d) to read as follows:

§ 405.556 Conditions for payment: Physician laboratory services.

(d) Physician pathology services furnished by physicians or independent laboratories on or after January 1, 1991.

(1) The prevailing charge for the professional component of physician pathology services furnished by physicians on or after January 1, 1991 is 93 percent of the prevailing charge for the professional component of physician pathology services furnished on or after April 1, 1990.

(2) The prevailing charge for the global physician pathology service furnished through an independent laboratory during 1991 is reduced by up to 7 percent from the applicable prevailing charge for the global physician pathology service furnished by independent laboratories on or after January 1, 1990. The reduction cannot result in a prevailing charge that is less than 115 percent of the professional component prevailing charge for hospital-based physician pathology services.

PART 406—HOSPITAL INSURANCE ELIGIBILITY AND ENTITLEMENT

B. Part 406 is amended as follows:

1. The authority citation for part 406 continues to read as follows:

Authority: Secs. 202(t), 202(u), 226, 226A, 1102, 1103, 1104, 1395b(h), and 3103 of Pub. L. 89-97 (42 U.S.C. 428a) unless otherwise noted.

2. Section 406.21 is amended by revising paragraph (a) and adding a new paragraph (f) to read as follows:

§ 406.21 Individual enrollment.

(a) Basic provision. An individual who meets the requirements of § 406.20(b) or (c) may enroll for premium hospital insurance only during his or her "initial enrollment period", a "general enrollment period", a "special enrollment period", or, for HMO/CMP enrollees, a "transfer enrollment period", as set forth in paragraphs (b) through (f) of this section. * * *

(b) Transfer enrollment period for HMO/CMP enrollees. (1) Terminology. HMO or CMP means an eligible organization as defined in § 417.1301 which has a contract with HCFA under part 417, subpart B of this chapter.

(2) Basic rule. Effective February 1, 1991, individuals enrolled in an HMO or CMP under part 417, subpart K of this chapter who meet the requirements of § 406.20(b) may enroll in premium hospital insurance during a transfer enrollment period. This transfer enrollment period begins with any month or any part of a month in which the individual is enrolled in an HMO or CMP and ends with the last day of the 8th consecutive month in which the individual is no longer enrolled in the HMO or CMP.

(3) Effective date of coverage. (i) If the individual enrolls in premium hospital insurance while still enrolled in an HMO or CMP, or during the first month that he or she is no longer enrolled in the HMO or CMP, part A coverage will begin on the first day of the month of part A enrollment, or, at the option of the individual, on the first day of any of the following 3 months.

(ii) If the individual enrolls in premium hospital insurance during any of the last 7 months of the transfer enrollment period, coverage will begin on the first day of the month after the month of enrollment.

3. Section 406.23 is redesignated as § 406.33, paragraph (a) is revised, and a new paragraph (a)(4) is added to read as follows:

§ 406.33 Determination of months to be counted for premium increase: Enrollment.

(a) Enrollment before April 1, 1981 or after September 30, 1981. The months to be counted for premium increase are the months from the end of the initial enrollment period through the end of the general enrollment period, the special enrollment period, or the transfer enrollment period in which the individual enrolls, excluding the following: * * *

(4) Any months that the individual was enrolled in an HMO or CMP under part 417, subpart K of this chapter as described in § 406.21(f).

4. Section 406.32 is amended by revising paragraph (b) to read as follows:

§ 406.32 Monthly premiums.

(b) Monthly premiums: Determination of dollar amount.

(1) Effective for calendar years beginning January 1989, the dollar amount is determined based on an estimate of one-twelfth of the average per capita costs for benefits and administrative costs that will be payable with respect to individuals age 65 or over from the Federal Hospital Insurance Trust Fund during the succeeding calendar year.

(2) Before 1989, the dollar amount was determined by multiplying $33 by the ratio of the next year's inpatient deductible to $78, which was the inpatient deductible determined for 1973. (Because of cost controls, the deductible actually charged for that year was $72.)

(3) The amount determined under paragraphs (b)(1) and (2) of this section is rounded to the nearest multiple of $1. (Fifty cents is rounded to the next higher dollar.) * * *

PART 409—HOSPITAL INSURANCE BENEFITS

C. Part 409 is amended as follows:

1. The authority citation for part 409 continues to read as follows:

Authority: Secs. 1102, 1103, 1104, 1181, 1182(h), 1871, and 1881 of the Social Security Act (42 U.S.C. 1392, 1395d, 1395e, 1395j, 1395h, and 1395rr) * * *

2. In § 409.40, the undesignated introductory text is republished and paragraph (e) is revised to read as follows:

§ 409.40 Included services.

Subject to the requirements and conditions set forth in § 409.42, "home health services" means the following items and services: * * *

(e) Medical supplies (including catheters, catheter supplies, ostomy bags, and supplies related to ostomy care, but excluding drugs and biologicals) and the use of durable medical equipment; and * * *

§ 409.87 [Amended]

3. In paragraph (a)(3) of § 409.97, "benefit period" is revised to read "calendar year".

PART 410—SUPPLEMENTARY MEDICAL INSURANCE (SMI) BENEFITS

D. Part 410 is amended as follows:

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

Authority: Secs. 1102, 1182, 1334, 1335, 1861(r)(3), (s), (aa), and (cc), 1871, and 1881 of the Social Security Act (42 U.S.C. 1302, 1395k, 1395l, 1395m, 1395n, 1395x(r), (s), (aa), and (cc), 1395sh, and 1395rr) * * *

2. In 410.38, the undesignated introductory text is republished and paragraph (b) is revised to read as follows:
§ 410.35 Medical supplies, appliances, and devices: Scope.

Medicare part B pays for the following medical supplies, appliances, and devices:

(b) Prosthetic devices, other than dental, that replace all or part of an internal body organ, including colostomy bags and supplies directly related to colostomy care, including—

(1) Replacement of prosthetic devices; and

(2) One pair of conventional eyeglasses or conventional contact lenses furnished after each cataract surgery during which an intraocular lens is inserted.

PART 411—EXCLUSIONS FROM MEDICARE AND LIMITATIONS ON MEDICARE PAYMENT

E. Part 411 is amended as follows:

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

Authority: Secs. 1102, 1834, 1842(1), 1913, 1986, 1987, and 1879 of the Social Security Act (42 U.S.C. 1395m, 1395l(l), 1395x(f), 1395cc, 1395hh, 1385m, and 1385pp).

2. In § 411.15, the undesignated introductory text is republished, paragraph (b) is revised, and a new paragraph (n) is added to read as follows:

§ 411.15 Particular services excluded from coverage.

The following services are excluded from coverage:

(b) Eyeglasses or contact lenses, except for:

(1) Post-surgical prosthetic lenses customarily used during convalescence for eye surgery in which the lens of the eye was removed (e.g., cataract surgery);

(2) Prosthetic lenses for patients who lack the lens of the eye because of congenital absence or surgical removal; and

(3) One pair of conventional eyeglasses or conventional contact lenses furnished after each cataract surgery during which an intraocular lens is inserted.

(n) Certain services of an assistant-at-surgery.

(1) Services of an assistant-at-surgery in a cataract operation (including subsequent insertion of an intraocular lens) unless, before the surgery is performed, the appropriate PRO or a carrier has approved the use of such an assistant in the surgical procedure based on the existence of a complicating medical condition.

(ii) Services on an assistant-at-surgery in a surgical procedure (or class of surgical procedures) for which assistants-at-surgery on average are used in fewer than 5 percent of such procedures nationally.

3. Section 411.60 is amended by adding a definition of “coordination period” in alphabetical order under paragraph (b), Definitions, to read as follows:

§ 411.60 Scope and definitions.

(b) Definitions. As used in this part—

Coordination period means the period during which Medicare is secondary payer to an employer group health plan.

4. Section 411.62 is revised to read as follows:

§ 411.62 Medicare benefits secondary to employer group health plan benefits.

(a) General rules.

(1) Medicare benefits are secondary to benefits payable under an employer plan, for services furnished to an ESRD beneficiary during a coordination period as specified in paragraphs (b) and (c) of this section. An individual who has ESRD but who has not filed an application for entitlement to Medicare is eligible for Medicare based on ESRD for purposes of paragraphs (b)(2) and (c)(2) through (c)(4) of this section if the individual meets the other requirements of § 406.13 of this subchapter.

(ii) During the coordination period, the following rules apply:

(i) Medicare makes primary payments only for Medicare covered services that are—

(A) Furnished to Medicare beneficiaries who are not enrolled in the employer plan;

(B) Not covered under the employer plan; or

(C) Covered under the employer plan but not available to particular enrollees because they have exhausted their benefits.

(ii) Medicare makes secondary payments, within the limits specified in §§ 411.32 and 411.33, to supplement the amount paid by the employer plan if that plan pays only a portion of the charge for the services.

(b) Beginning of coordination period:

(1) For individuals who start a course of maintenance dialysis or who receive kidney transplant before December 1989, the coordination period begins with the earlier of—

(i) The month in which the individual initiated a regular course of renal dialysis; or

(ii) In the case of an individual who received a kidney transplant, the first month in which the individual became entitled to Medicare, or, if earlier, the first month for which the individual would have been entitled to Medicare benefits if he or she had filed an application for such benefits.

(2) For individuals other than those specified in paragraph (b)(1) of this section, the coordination period begins with the earlier of—

(i) The first month in which the individual becomes entitled to Medicare part A solely on the basis of ESRD; or

(ii) The first month the individual would have become entitled to Medicare part A solely on the basis of ESRD if he or she had filed an application for such benefits.

(c) End of coordination period.

(1) For individuals who start a regular course of renal dialysis or who receive a kidney transplant before December 1989, the coordination period ends with the earlier of the end of the 12th month of dialysis or the end of the 12th month of a transplant. The 12th month of dialysis may be any time from the 9th month through the 12th month of Medicare entitlement, depending on the extent to which the individual was subject to a waiting period before becoming entitled to Medicare.

(2) The coordination period for the following individuals ends with the earlier of the 12th month of eligibility or the 12th month of entitlement to Medicare part A:

(i) Individuals, other than those specified in paragraph (c)(1) of this section, who became entitled to Medicare part A solely on the basis of ESRD during December 1989 and January 1990.

(ii) Individuals, other than those specified in paragraph (c)(1) of this section, who could have become entitled to Medicare Part A solely on the basis of ESRD during December 1989 and January 1990 if they had filed an application.

(iii) Individuals who become entitled to Medicare part A solely on the basis of ESRD after January 1995.

(iv) Individuals who can become entitled to Medicare part A solely on the basis of ESRD after January 1995.

(3) The coordination period for the following individuals ends with the earlier of the 12th month of eligibility or the 12th month of entitlement to Medicare part A:

(i) Individuals, other than those specified in paragraph (c)(1) of this
section, who become entitled to Medicare part A solely on the basis of ESRD from February 1990 through July 1994.

(ii) Individuals, other than those specified in paragraph (c)(1) of this section, who could become entitled to Medicare part A solely on the basis of ESRD from February 1990 through July 1994 if they would file an application.

(4) The coordination periods for the following individuals ends January 1, 1996:

(i) Individuals who became entitled to Medicare part A solely on the basis of ESRD from August 1994 through January 1, 1995.

(ii) Individuals who could become entitled to Medicare part A solely on the basis of ESRD from August 1994 through January 1, 1995, if they would file an application.

(5) The examples specified in paragraphs (b) and (c) of this section and the rules specified in § 406.13 of this subchapter, the following examples illustrate how to determine, in different situations, the number of months during which Medicare is the primary payer.

(1) An individual began dialysis on November 4, 1989. He did not initiate a course in self-dialysis training nor did he receive a kidney transplant during the first 3 calendar months of dialysis. Thus, he became entitled to Medicare on January 2, 1990. Since this individual began dialysis before December 1988, the 12-month period began with the first month of dialysis, November 1989, and ended October 31, 1990. The coordination period in this case is 9 months, February 1990 through October 1990.

(2) An individual began dialysis on January 29, 1990. He did not initiate a course in self-dialysis training nor did he receive a kidney transplant during the first 3 calendar months of dialysis. Thus, he became entitled to Medicare on April 1, 1990. Since this individual began dialysis after December 1988, and became entitled to Medicare after January 1990, the coordination period began with the first month of entitlement, April 1990, and ended September 30, 1991, the end of the 18th month of entitlement.

(3) An individual began a regular course of maintenance dialysis on February 10, 1990. He did not initiate a course of self-dialysis training nor did he receive a kidney transplant during the first 3 calendar months of dialysis. Thus, he became entitled to Medicare on May 1, 1990. Medicare is secondary payer from May 1, 1990 through October 1991, a total of 18 months.

(4) The same facts exist as in the example under paragraph (d)(3), except that the individual began a course of self-dialysis training during the first 3 calendar months of dialysis. Thus, the effective date of his Medicare entitlement is February 1, 1990, and Medicare is secondary payer from February 1, 1990 through July 1991, a total of 18 months.

(5) An individual began dialysis on September 15, 1990. He did not initiate a course of self-dialysis training nor did he receive a kidney transplant during the first 3 calendar months of dialysis. Thus, he became entitled to Medicare effective December 1, 1990. Medicare is secondary payer from December 1, 1990 through May 1992, a total of 18 months.


(7) An individual began a regular course of dialysis on December 10, 1990. He does not initiate a course of self-dialysis training nor does he receive a kidney transplant. He decides to delay his enrollment in Medicare because his employer group health plan pays charges in full and he does not wish to incur part B premiums at this time. However, in March 1992, he files for part A and part B Medicare entitlement, and stipulates that he wants his Medicare entitlement to be effective March 1, 1992 (one year later than he could have become entitled). Since this individual could have been entitled to Medicare as early as March 1, 1991, Medicare is secondary payer only from March 1, 1992, through August 1992, a period of 6 months.

(While Medicare is secondary payer for only the last 6 months of this period, the Medicare program is effectively secondary payer for the full coordination period, due to the fact that the individual delayed his Medicare enrollment on account of his employer plan coverage and Medicare made no payments at all during the deferred period.)

(8) The same facts exist as in the example under paragraph (d)(7) of this section, except that the individual defers Medicare entitlement beyond August 1992. (For purposes of this example, Medicare entitlement is not retroactive, but rather takes effect after August 1992.) There would be no period during which Medicare is secondary payer in this situation. This is because Medicare entitlement does not begin until after the 18-month period of dialysis as specified in paragraph (c)(3)(ii) of this section.

Medicare would become primary payer as of the effective date of Medicare entitlement. The employer plan is required to pay primary from December 1, 1990, through August 1992, a total of 21 months.

(9) An individual becomes entitled to Medicare on January 1, 1995. The employer plan is primary payer, and Medicare is secondary payer, from January 1, 1995 through January 1, 1996, a period of 12 months plus 1 day. Medicare becomes primary payer on January 2, 1996, because the extension of the coordination period from 12 to 18 months applies only to items and services furnished on or before January 1, 1996.

(10) An individual becomes entitled to Medicare on September 1, 1995. Medicare is secondary payer from September 1, 1995 through August 31, 1996, a period of 12 months. Medicare becomes primary payer on September 1, 1996, because the coordination period has expired.

(e) Effect of changed basis for Medicare entitlement. If the basis for an individual’s entitlement to Medicare changes from ESRD to age 65 or disability, the coordination period terminates with the month in which the change is effective.

(f) Determinations for subsequent periods of ESRD eligibility. If an individual has more than one period of eligibility based solely on ESRD, a coordination period will be determined for each period of eligibility in accordance with this section.
§ 413.157 of this chapter) is reduced by—

(B) Seven percent for payments attributable to portions of cost reporting periods or discharges (as the case may be) occurring during fiscal year 1988 and before January 1, 1988;

(C) Twelve percent for payments attributable to portions of cost reporting periods or discharges (as the case may be) occurring during fiscal year 1988 occurring on or after January 1, 1988;

(D) Fifteen percent for payments attributable to portions of cost reporting periods or discharges (as the case may be) occurring during fiscal year 1989 and beginning on or after January 1, 1990 and ending on or before September 30, 1991; and

3. In § 413.122, a new paragraph (b)(4) is added to read as follows:

§ 413.122 Payment for hospital outpatient radiology services and other diagnostic procedures.

(b) Payment for hospital outpatient radiology services.

(4) For hospital outpatient radiology services furnished on or after January 1, 1991, the blended payment amount is equal to the sum of 42 percent of the hospital-specific amount and 50 percent of the fee schedule amount.

4. A new § 413.124 is added to read as follows:

§ 413.124 Reduction to hospital outpatient operating costs.

(a) Except for sole community hospitals, as defined in § 412.72, and primary care rural hospitals, the reasonable costs of outpatient hospital services (other than capital-related costs of such services) are reduced by 5.8 percent for services rendered during portions of cost reporting periods occurring on or after January 1, 1990 and before October 1, 1995.

(b) For purposes of determining the blended payment amounts of ambulatory surgical center approved surgical procedures performed in the hospital outpatient setting under § 413.116 and hospital outpatient radiology services and other diagnostic procedures under § 413.122, the reduction is applicable only to the hospital-specific portion of the blended payment amounts.

5. Section 413.130 is amended by adding a new paragraph (j) to read as follows:

§ 413.130 Introduction to capital-related costs.

(j) Reduction to capital-related costs.

(1) Except for sole community hospitals and rural primary care hospitals, the amount of capital-related costs of all hospital outpatient services is reduced by—

(i) 10 percent for portions of cost reporting periods occurring on or after October 1, 1989 through September 30, 1991; and

(ii) 10 percent for portions of cost reporting periods occurring on or after October 1, 1991 through September 30, 1995.

(2) For purposes of determining the blended payment amounts for hospital outpatient services under § 413.118 and § 413.122, the reduction is applicable only to the hospital-specific portion of the blended amounts.

PART 418—HOSPICE CARE

H. Part 418 is amended as follows:

1. The authority citation for part 418 continues to read as follows:

Authority: Secs. 1814(a)(7) and 1814(i) of the Act contain conditions and limitations on coverage of, and payment for, hospice care.

2. In § 418.21, paragraph (a) is revised to read as follows:

§ 418.21 Duration of hospice care coverage—Election periods.

(a) Subject to the conditions set forth in this part, an individual may elect to receive hospice care during one or more of the following election periods:

(1) An initial 90-day period.

(2) A subsequent 90-day period.

(3) A subsequent 30-day period.

(4) A subsequent extension period of unlimited duration during the individual’s lifetime.

3. In § 418.22, paragraph (a) is revised to read as follows:

§ 418.22 Certification of terminal illness.

(a) Timing of certification.—(1) General rule. The hospice must obtain written certification of terminal illness for each of the periods listed in § 418.21, even if a single election continues in effect for two, three, or four periods, as provided in § 418.24:

PART 489—PROVIDER AND SUPPLIER AGREEMENTS

I. Part 489 is amended as follows:
§ 489.20 Basic commitments.

The provider agrees to the following:

(k) In the case of home health agencies that provide home health services to Medicare beneficiaries under subpart E of part 408 and subpart C of part 410 of this chapter, to offer to furnish catheters, catheter supplies, ostomy bags, and supplies related to ostomy care to any individual who requires them as part of their furnishing of home health services.

§ 489.31 [Amended]

3. In paragraph (e)(1) of § 489.31, "benefit period" is revised to read "calendar year".

3:14 pm

[FR Doc. 92-19353 Filed 8-10-92; 8:45 am]

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OFFICE OF PERSONNEL MANAGEMENT

45 CFR Part 801

Voting Rights Program

AGENCY: Office of Personnel Management.

ACTION: Final rule with request for comments.

SUMMARY: The Office of Personnel Management (OPM) is establishing a new office for filing applications or complaints under the Voting Rights Act of 1965, as amended. The Attorney General has determined that this designation is necessary to enforce the guarantees of the Fourteenth and Fifteenth Amendments to the Constitution.

DATES: This rule is effective August 11, 1992. In view of the need for its publication without an opportunity for prior comment, comments will still be considered. To be timely, comments must be received on or before September 11, 1992.

ADDRESS: Send or deliver comments to Stephanie J. Peters, Attorney, Office of Personnel Management, room 7350, 1000 E Street, NW., Washington, DC 20415.


FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 73

Radio Broadcast Services; Conflicts Between Applications and Petitions for Rulemaking to Amend the FM Table of Allotments

AGENCY: Federal Communications Commission.

ACTION: Final rule.

SUMMARY: This Report and Order establishes new procedures for resolving conflicts between rulemaking petitions to amend the FM Table of Allotments and applications for new FM stations or for changes in FM facilities. The Commission has adopted a cut-off rule that protects FM applications from conflicting rulemaking proposals at the same time that those applications receive protection from mutually exclusive applications. See 56 FR 66006, December 20, 1991.


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