*Compliance:* Required as indicated, unless accomplished previously.

To detect and correct corrosion or plating cracks of the pin assemblies in the front trunnion support of the main landing gear (MLG), which could cause these assemblies to break and result in collapse of the MLG, accomplish the following:

(a) Perform a close visual inspection to detect corrosion or plating cracks of each 4330M Steel pin assembly in the forward trunnion support of the MLG, in accordance with Boeing Alert Service Bulletin 767–57A0047, Revision 1, dated May 9, 1996, at the later of the times specified in paragraphs (a)(1) and (a)(2) of this AD.

(1) Within 4 years since date of manufacture of the airplane, or 4 years since the last overhaul of the MLG. Or

(2) Within 18 months after the effective date of this AD.

(b) If no corrosion or crack is detected, repeat the close visual inspection thereafter at intervals not to exceed 48 months.

(c) If any corrosion or crack is detected, prior to further flight, replace it with a new pin assembly made from 15–5PH CRES with Class 3 chrome plating, in accordance with Boeing Alert Service Bulletin 767–57A0047, Revision 1, dated May 9, 1996.

(d) Accomplishment of replacement of a 4330M Steel pin assembly with a new pin assembly made from 15–5PH CRES with Class 3 chrome plating, in accordance with Boeing Alert Service Bulletin 767–57A0047, Revision 1, dated May 9, 1996, constitutes terminating action for the inspections required by this AD for that pin location.

**Note 2:** Replacement of a 4330M Steel pin assembly with a new pin assembly made from 15–5PH CRES with Class 3 chrome plating prior to the effective date of this AD, in accordance with Boeing Service Bulletin 767–57A0047, dated January 19, 1995, is considered an acceptable method of compliance with paragraph (d) of this AD for that pin location.

(e) An alternative method of compliance or adjustment of the compliance time that provides an acceptable level of safety may be used if approved by the Manager, Seattle Aircraft Certification Office (ACO), FAA, Transport Airplane Directorate. Operators shall submit their requests through an appropriate FAA Principal Maintenance Inspector, who may add comments and then send it to the Manager, Seattle ACO.

**Note 3:** Information concerning the existence of approved alternative methods of compliance with this AD, if any, may be obtained from the Seattle ACO.

(f) Special flight permits may be issued in accordance with sections 21.197 and 21.199 of the Federal Aviation Regulations (14 CFR 21.197 and 21.199) to operate the airplane to a location where the requirements of this AD can be accomplished.

Issued in Renton, Washington, on July 16, 1997.

**Gary L. Killion,**

*Acting Manager, Transport Airplane Directorate, Aircraft Certification Service.*

[FR Doc. 97–19176 Filed 7–21–97; 8:45 am]

BILLING CODE 4910–13–P

## DEPARTMENT OF VETERANS

## 38 CFR Part 17

**RIN 2900–AH66**

## Payment for Non-VA Physician Services Associated with Either Outpatient or Inpatient Care Provided at Non-VA Facilities

**AGENCY:** Department of Veterans Affairs.

**ACTION:** Proposed rule.

**SUMMARY:** This document proposes to amend Department of Veterans Affairs (VA) medical regulations concerning payment for non-VA physician services that are associated with either outpatient or inpatient care provided to eligible VA beneficiaries at non-VA facilities. We propose that when a service specific reimbursement amount has been calculated under Medicare's Participating Physician Fee Schedule, VA would pay the lesser of the actual billed charge or the calculated amount. We also propose that when an amount has not been calculated, VA would pay the amount calculated under a 75th percentile formula or, in certain limited circumstances, VA would pay the usual and customary rate. In our view, adoption of this proposal would establish reimbursement consistency among federal health benefits programs, would ensure that amounts paid to physicians better represent the relative resource inputs used to furnish a service, and, would, as reflected by a recent VA Office of Inspector General (OIG) audit of the VA fee-basis program, achieve program cost reductions. Further, consistent with statutory requirements, the regulations would continue to specify that VA payment constitutes payment in full.

**DATES:** Comments must be received on or before September 22, 1997.

**ADDRESSES:** Mail or hand deliver written comments to: Director, Office of Regulations Management (02D), Department of Veterans Affairs, 810 Vermont Ave, NW, Room 1154, Washington, DC 20420. Comments should indicate that they are submitted in response to ''RIN 2900-AH66''. All written comments will be available for public inspection at the above address in the Office of Regulations Management, Room 1158, between the hours of 8:00 a.m. and 4:30 p.m., Monday through Friday (expect holidays).

**FOR FURTHER INFORMATION CONTACT:** Abby O'Donnell, Health Administration Service (161A), Department of Veterans Affairs, 810 Vermont Avenue, NW, Washington, DC 20420; (202) 273–8307. (This is not a toll-free number)

**SUPPLEMENTARY INFORMATION:** This document proposes to amend the Department of Veterans Affairs (VA) medical regulations concerning payment (regardless of whether or not authorized in advance) for non-VA physician services associated with either outpatient or inpatient care provided to eligible VA beneficiaries at non-VA facilities.

Currently, VA pays for non-VA outpatient services based on fee schedules which are locally developed by VA health care facilities using a 75th percentile methodology. Payment under this 75th percentile methodology is determined for each VA medical facility by ranking all treatment occurrences (with a minimum of eight) under the corresponding Current Procedural Terminology (CPT) code during the previous fiscal year with charges ranked from the highest rate billed to the lowest rate billed. A value at the 75th percentile is then established as the maximum amount to be paid. Also, if there were fewer than eight occurrences in the previous fiscal year payment currently is made at the amount determined to be usual and customary. Further, inpatient non-VA physician services currently are paid at the usual and customary rate.

We propose to change the payment methodology for non-VA physician services (outpatient and inpatient) provided at non-VA facilities. More specifically, we propose to provide that payment would be the lesser of the amount billed or the amount calculated using the formula developed by the Department of Health & Human Services, Health Care Financing Administration (HCFA) under the Medicare's participating physician's fee schedule for the period in which the service is provided (see 42 CFR parts 414 and 415).

The payment amount for each service paid under Medicare's participating physician fee schedule is the product of three factors: A nationally uniform relative value for the service; a geographic adjustment factor for each physician fee schedule area; and a nationally uniform conversion factor for the service. There are three conversion factors (CFs)—one for surgical services, one for nonsurgical services, and one for primary care services. The conversion factors convert the relative values into payment amounts. For each physician fee schedule service, there are three relative values: An RVU for physician work; an RVU for practice expense; and an RVU for malpractice expense. For each of these components of the fee schedule, there is a geographic practice cost index (GPCI) for each fee schedule area. The GPCIs reflect the relative costs

of practice expenses, malpractice insurance, and physician work in an area compared to the national average. The GPCIs reflect the full variation from the national average in the costs of practice expenses and malpractice insurance, but only one-quarter of the difference in area costs for physician work. The general formula calculating the Medicare fee schedule amount for a given service in a given fee schedule area can be expressed as: Payment = [(RVUwork X GPCIwork) + (RVUpractice expense × GPCIpractice expense) + (RVUmalpractice × GPCImalpractice)] × CF.

In our view, adoption of this proposal would establish reimbursement consistency among federal health benefits programs, would ensure that amounts paid to physicians better represent the relative resource inputs used to furnish a service and, would, as reflected by a recent VA OIG audit of the VA fee-basis program, achieve program cost reductions. That audit covered all of fiscal year 1993 and the first half of fiscal year 1994 during which period VA made 2.3 million payments totaling $180 million for non-VA physician services associated with either outpatient or inpatient care. The audit compared the amount paid by VA for a random sample of 1122 fee-basis payments for care to the amount that would have been paid under Medicare's system of payment. Audit results showed that VA could save an estimated $25.6 million annually by adopting Medicare's participating physician fee schedule for payment of such services.

It is further proposed that when HCFA has not specified an amount under the Medicare Program Fee Schedule for Physicians' Services formula, VA would utilize the current 75th percentile methodology for non-VA physician services that are associated with either outpatient or inpatient care provided to eligible VA beneficiaries at non-VA facilities.

Further, it is proposed that in those circumstances when HCFA has not specified an amount under Medicare's participating physician fee schedule for participating physician and there are insufficient occurences for using the 75th percentile methodology, payment would be made at the usual and customary rate. This would continue the current practice for these payments.

The regulations would continue to specify that VA payment constitutes payment in full. Accordingly, the provider or agent for the provider could not impose any additional charge on a veteran or his/her health care insurer for any services for which payment is made by VA. In our view, the provisions of 38 U.S.C. 1710 require that VA, without assistance from the beneficiary, bear the amount paid for services provided.

The proposal also would make nonsubstantive changes for purposes of clarity.

The Secretary hereby certifies that this proposed rule would not have a significant economic impact on a substantial number of small entities as they are defined in the Regulatory Flexibility Act, 5 USC 601 through 612. The proposed rule would not cause significant economic impact on health care providers, suppliers, or entities since only a small portion of the business of such entities concerns VA beneficiaries. Therefore, pursuant to 5 U.S.C. 605(b), the proposed rule is exempt from the initial and final regulatory flexibility analysis requirements of sections 603 and 604.

The Catalog of Federal Domestic Assistance Numbers are 64.009, 64.010 and 64.011.

**List of Subjects in 38 CFR Part 17**

Alcoholism, Claims, Dental health, Drug abuse, Foreign relations, Government contracts, Grant programs-health, Health care, Health facilities, Health professions, Medical devices, Medical research, Mental health programs, Nursing home care, Philippines, Veterans.

Approved: July 10, 1997.

**Hershel W. Gober,**

*Acting Secretary of Veterans Affairs.*

For the reasons set out in the preamble, 38 CFR part 17 is proposed to be amended as set forth below:

## PART 17—MEDICAL

1. The authority citation for Part 17 continues to read as follows:

**Authority:** 38 U.S.C. 501, 1721, unless otherwise noted.

**§ 17.55 [Amended]**

2. In § 17.55, in the introductory text remove ''38 U.S.C. 1703 or 38 CFR 17.52'' and add, in its place ''38 U.S.C. 1703 and 38 CFR 17.52 of this part or under 38 U.S.C. 1728 and 38 CFR 17.120'; paragraph (h) is removed; and paragraphs (i), (j) and (k) are redesigned as paragraphs (h), (i) and (j), respectively.

3. Section 17.56 is redesignated as § 17.57 and a new § 17.56 is added to read as follows:

**§ 17.56 Payment for non-VA physician services associated with outpatient and inpatient care provided at non-VA facilities.**

(a) Payment for non-VA physician services associated with outpatient and inpatient care provided at non-VA facilities authorized under § 17.52, or made under § 17.120 of this part, shall be the lesser of the amount billed or the amount calculated using the formula developed by the Department of Health & Human Services, Health Care Financing Administration (HCFA) under Medicare's participating physician fee schedule for the period in which the service is provided (see 42 CFR Parts 414 and 415). This payment methodology is set forth in paragraph (b) of this section. If no amount has been calculated under Medicare's participating physician fee schedule, payment for such non-VA physician services associated with outpatient and inpatient care provided at non-VA facilities authorized under § 17.52, or made under § 17.120 of this part, shall be the lesser of the actual amount billed or the amount calculated using the 75th percentile methodology set forth in paragraph (c) of this section; or the usual and customary rate if there are fewer than 8 treatment occurrences for a procedure during the previous fiscal year.

(b) The payment amount for each service paid under Medicare's participating physician fee schedule is the product of three factors: a nationally uniform relative value for the service; a geographic adjustment factor for each physician fee schedule area; and a nationally uniform conversion factor for the service. There are three conversion factors (CFs)—one for surgical services, one for nonsurgical services, and one for primary care services. The conversion factors convert the relative values into payment amounts. For each physician fee schedule service, there are three relative values: An RVU for physician work; an RVU for practice expense; and an RVU for malpractice expense. For each of these components of the fee schedule, there is a geographic practice cost index (GPCI) for each fee schedule area. The GPCIs reflect the relative costs of practice expenses, malpractice insurance, and physician work in an area compared to the national average. The GPCIs reflect the full variation from the national average in the costs of practice expenses and malpractice insurance, but only one-quarter of the difference in area costs for physician work. The general formula calculating the Medicare fee schedule amount for a given service in a given fee schedule area can be expressed as: Payment=[(RVUwork × GPCIwork) + (RVUpractice expense × GPCIpractice expense) + (RVUmalpractice × GPCImalpractice)] × CF.

(c) Payment under the 75th percentile methodology is determined for each VA medical facility by ranking all

occurrences (with a minimum of eight) under the corresponding code during the previous fiscal year with charges ranked from the highest rate billed to the lowest rate billed and the charge falling at the 75th percentile as the maximum amount to be paid.

(d) Payments made in accordance with this section shall constitute payment in full. Accordingly, the provider or agent for the provider may not impose any additional charge for any services for which payment is made by VA.

4. Section 17.128 is revised to read as follows:

**§ 17.128 Allowable rates and fees.**

When it has been determined that a veteran has received public or private hospital care or outpatient medical services, the expenses of which may be paid under § 17.120 of this part, the payment of such expenses shall be paid in accordance with §§ 17.55 and 17.56 of this part.

(**Authority**: Section 233, Pub. L. 99–576)

[FR Doc. 97–19156 Filed 7–21–97; 8:45 am]

BILLING CODE 8320–01–P

## ENVIRONMENTAL PROTECTION AGENCY

## 40 CFR Part 52

**[IL145–1, IL152–1; FRL–5861–4]**

## Approval and Promulgation of Implementation Plan; Illinois Designation of Areas for Air Quality Planning Purposes; Illinois

**AGENCY:** Environmental Protection Agency (EPA).

**ACTION:** Proposed rule.

**SUMMARY:** On November 14, 1995, May 9, 1996, June 14, 1996, and February 3, 1997, the State of Illinois submitted a State Implementation Plan (SIP) revision request to meet commitments related to the conditional approval of Illinois' May 15, 1992, SIP submittal for the Lake Calumet (SE Chicago), McCook, and Granite City, Illinois, Particulate Matter (PM) nonattainment areas. The EPA is proposing limited approval and limited disapproval of the portion of the SIP revision request that applies to the Granite City area because it does not correct all of the deficiencies of the May 15, 1992 submittal, as discussed in the November 18, 1994, conditional approval notice. This action entails approval of the submitted regulations into the Illinois SIP for their strengthening effect, and disapproval of the submittal for not meeting all of the commitments of the conditional approval. All of the deficiencies were corrected, except that Illinois failed to provide an opacity limit for coke oven combustion stacks which is reflective of their mass limits. No action is being taken on the submitted plan corrections for the Lake Calumet and McCook areas at this time. They will be addressed in separate rulemaking actions.

On March 19, 1996, and October 15, 1996, Illinois submitted a request to redesignate the Granite City area to attainment for PM. The EPA is also proposing disapproval of this request because the area does not have a fully approved implementation plan.

**DATES:** Written comments on this proposed rule must be received on or before August 21, 1997.

**ADDRESSES:** Written comments should be mailed to: J. Elmer Bortzer, Chief, Regulation Development Section, Air Programs Branch (AR–18J), U.S. Environmental Protection Agency, Region 5, 77 West Jackson Boulevard, Chicago, Illinois 60604.

Copies of the State submittal and EPA's analysis of it are available for inspection at: Regulation Development Section, Regulation Development Branch (AR–18J), U.S. Environmental Protection Agency, Region 5, 77 West Jackson Boulevard, Chicago, Illinois 60604.

**FOR FURTHER INFORMATION CONTACT:** David Pohlman, Environmental Scientist, Regulation Development Section, Regulation Development Branch (AR–18J), U.S. Environmental Protection Agency, Region 5, 77 West Jackson Boulevard, Chicago, Illinois 60604, (312) 886–3299.

**SUPPLEMENTARY INFORMATION:**

### I. Background

Under section 107(d)(4)(B) of the Clean Air Act (Act), as amended on November 15, 1990 (amended Act), certain areas (''initial areas'') were designated nonattainment for PM. Under section 188 of the amended Act these initial areas were classified as ''moderate''. The initial areas include the Lake Calumet, McCook, and Granite City, Illinois, PM nonattainment areas. (See 40 CFR 81.314 for a complete description of these areas.) Section 189 of the amended Act requires State submission of a PM SIP for the initial areas by November 15, 1991. Illinois submitted the required SIP revision for the Lake Calumet, McCook, and Granite City, Illinois, PM nonattainment areas to EPA on May 15, 1992. Upon review of Illinois' submittal, EPA identified several concerns. Illinois submitted a letter on March 2, 1994, committing to satisfy all of these concerns within one year of final conditional approval. On May 25, 1994, the EPA proposed to conditionally approve the SIP. Final conditional approval was published on November 18, 1994, and became effective on December 19, 1994. The final conditional approval allowed the State until November 20, 1995 to correct the five stated deficiencies:

1. Invalid emissions inventory and attainment demonstration, due to failure to include emissions from the roof monitors for the Basic Oxygen Furnaces (BOFs) and underestimated emissions from the quench towers at Granite City Steel (GCS).

2. Failure to adequately address maintenance of the PM National Ambient Air Quality Standards (NAAQS) for at least 3 years beyond the applicable attainment date.

3. Lack of an opacity limit on coke oven combustion stacks.

4. Lack of enforceable emissions limit for the electric arc furnace (EAF) roof vents at American Steel Foundries.

5. The following enforceability concerns:

a. Section 212.107, Measurement Methods for Visible Emissions could be misinterpreted as requiring use of Method 22 for sources subject to opacity limits as well as sources subject to limits on detectability of visible emissions.

b. Inconsistencies in the measurement methods for opacity, visible emissions, and ''PM'' in section 212.110, 212.107, 212.108, and 212.109.

c. Language in several rules which exempts sources with no visible emissions from mass emissions limits.

The Illinois Environmental Protection Agency (IEPA) held a public hearing on the proposed rules on January 5, 1996. The rules became effective at the State level on May 22, 1996, and were published in the Illinois Register on June 7, 1996. Illinois made submittals to meet the commitments related to the conditional approval on November 14, 1995, May 9, 1996, June 14, 1996, and February 3, 1997. At this time, the EPA is only acting on the portions of those submittals that pertain to the Granite City PM nonattainment area conditional approval, including the following new or revised rules in 35 Ill. Adm. Code:

Part 212: Visible and Particulate Matter Emissions

**Subpart A: General**

212.107 Measurement Method for Visible Emissions

212.108 Measurement Methods for PM–10 Emissions and Condensible PM–10 Emissions

212.109 Measurement Methods for Opacity