(i) Nominations Related Standards (Version 1.2, July 31, 1997), with the addition of standards 1.1.17 through 1.1.19, 1.2.8 through 1.2.12, 1.3.39 through 1.3.44 (as approved March 12, 1998), the modification of standards 1.3.2, 1.3.20, 1.3.22, 1.3.32 (as approved March 12, 1998), and the deletion of standards 1.2.7, 1.3.10, and 1.3.12;

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[FR Doc. 98–19368 Filed 7–22–98; 8:45 am]

BILLING CODE 6717–01–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: Final rule.

SUMMARY: This document amends 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. Generally, 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. Also, when an amount has not been calculated or when the services constitute anesthesia services, VA would pay the amount calculated under a 75th percentile formula or, in certain limited circumstances, VA would pay the usual and customary rate. Adoption of this final rule is intended to establish reimbursement consistency among federal health benefits programs to ensure that amounts paid to physicians better represent the relative resource inputs used to furnish a service, and to achieve program cost reductions. Further, consistent with statutory requirements, the regulations continue to specify that VA payment constitutes payment in full.

DATES: Effective Date: August 24, 1998.

FOR FURTHER INFORMATION CONTACT: Abby O'Donnell, Health Administration Service (10C3), Department of Veterans Affairs, 810 Vermont Avenue, NW, Washington, DC 20420, (202) 273–8307. (This is not a toll-free number.)

SUPPLEMENTARY INFORMATION: In a document published in the **Federal Register** on July 22, 1997 (62 FR 39197), we proposed to amend the 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. We provided a 60-day comment period, which ended September 22, 1997. We received comments from seven sources.

For reasons explained below, the final rule contains only one conversion factor for calculations under Medicare's Participating Physicians Fee Schedule and the proposed provisions are not made applicable for anesthesia services. Otherwise, no changes are made in response to comments and, based on the rationale set forth in the proposed rule and this document, the provisions of the proposed rule are adopted as a final rule.

Comments

All of the comments opposed the proposal based on the assertion that VA should not lessen physician fees.

- Three commenters asserted that VA should not use Medicare's Participating Physicians Fee Schedule because it was designed for Medicare patient populations and not for VA populations.
- One commenter opposed the use Medicare's Participating Physicians Fee Schedule by asserting that VA should not use the geographic adjustment factors unless necessary ''to achieve explicit policy goals (e.g., targeted adjustments for demonstrated shortfalls in access to care).''
- Two commenters opposed the use of Medicare's Participating Physicians Fee Schedule by asserting that VA should not use Medicare's conversion factors. They recommended that VA establish a conversion factor that would not lessen physician payments. One of the commenters stated that the Medicare conversion factors should not be used because they are ''constrained by budget-neutrality and other considerations, such as the Medicare Volume Performance Standard system, that are not applicable to VA.''
- One commenter who practices psychiatry in a semi-rural area asserted that his expenses are high and that if VA adopted Medicare's Participating Physicians Fee Schedule some procedures would be billed at rates ''at or below'' his overhead expense.
- Three commenters questioned whether the availability and quality of care would be lessened by the adoption of Medicare's Participating Physicians Fee Schedule.
- One commenter asserted that before VA adopt payment methodology based on Medicare principles, VA should sponsor an independent study and consult with physician groups.
- Two commenters opposed the adoption of the Medicare fee schedule for anesthesia services.

Response to Comments

As stated in the proposed rule, one of the basic reasons for conducting this rulemaking proceeding was to achieve cost reductions. We believe, particularly in this budget-sensitive era, that it is sound policy to seek to achieve this objective. Also, we note that the Medicare formula does not merely relate to individuals eligible for Medicare. It is based on principles applicable to all individuals, including veterans. Moreover, even though we could establish different conversion factors and even though VA is not ''constrained by budget-neutrality and other considerations, such as the Medicare Volume Performance Standard system,'' we believe that we should not have to pay more than the Department of Health and Human Services pays for physician services.

Further, regardless of whether some physicians' ''overhead payments'' might be out of proportion to the amount of payment received from VA, we do not believe that this final rule would cause this to be a common occurrence. In addition, we do not expect that the adoption of this final rule would lessen significantly the availability and quality of physician care for veterans, and we believe that even without additional studies, the rationale in the proposed rule and this document provide an adequate basis for this final rule.

The proposed rule was intended to provide for reimbursement based on the lesser of the actual billed charge or the amount calculated under Medicare's Participating Physician Fee Schedule. The formula for Medicare's Participating Physician Fee Schedule has been changed (see 62 FR 59048, 59261). For services other than anesthesia, the Medicare formula was changed to have one conversion factor instead of three (previously, the Medicare formula contained a separate conversion factor for surgical services, nonsurgical services, and primary care services). Accordingly, the final rule also makes this adjustment in the Medicare formula.

Anesthesia Services

The Medicare formula includes separate provisions for anesthesia services. These separate anesthesia provisions were not included in the proposed rule. We intend to publish a new proposal concerning this issue in

the near future. Accordingly, this final rule does not make changes regarding anesthesia services. They remain subject to the payment provisions for those cases not covered by the Medicare formula (i.e., lesser of the actual amount billed or the amount calculated using the 75th percentile methodology; or the usual and customary rate if there are fewer than 8 treatment occurrences for a procedure during the previous fiscal year).

Regulatory Flexibility Act

The Secretary hereby certifies that this final rule will not have a significant economic impact on a substantial number of small entities as they are defined in the Regulatory Flexibility Act, 5 U.S.C. 601 through 612. The rule would not cause a 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 rule is exempt from the initial and final regulatory flexibility analysis requirements of sections 603 and 604.

Catalog of Federal Domestic Assistance Numbers

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

List of Subjects in 38 CFR Part 17

Administrative practice and procedure, Alcohol abuse, Alcoholism, Claims, Day care, Dental health, Drug abuse, Foreign relations, Government contracts, Grant programs—health, Grant programs—veterans, Health care, Health facilities, Health professions, Health records, Homeless, Medical and dental schools, Medical devices, Medical research, Mental health programs, Nursing home care, Philippines, Reporting and recordkeeping requirements, Scholarships and fellowships, Travel and transportation expenses, Veterans.

Approved: May 8, 1998.

Togo D. West, Jr.,

Acting Secretary.

For the reasons set forth in the preamble, 38 CFR part 17 is amended as follows:

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) Except for anesthesia services, 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 or if the services constitute anesthesia services, 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. The conversion factor converts 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. 98–19682 Filed 7–22–98; 8:45 am]

BILLING CODE 8320–01–U

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 52

[WI76–02–7305; FRL–6128–4]

Approval and Promulgation of State Implementation Plan; Wisconsin; Site-Specific SIP Revision for Amron Corporation

AGENCY: Environmental Protection Agency (EPA).

ACTION: Final rule.

SUMMARY: This rulemaking finalizes the Environmental Protection Agency's (EPA's) disapproval of a site-specific State Implementation Plan (SIP) revision for the Amron Corporation facility located at 525 Progress Avenue